Public Quality Safety and Performance Committee

Thu 14 September 2023, 10:00 - 13:00

via Microsoft Teams

Agenda

10:00 - 10:30
30 min

1. PRESENTATIONS

1.1. Welsh Blood Service - Donor Story

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

1.1.0 WBS Donor Story link.pdf (1 pages)

10:30 - 10:45
15 min

2. STANDARD BUSINESS

2.1. Apologies

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

2.2. In Attendance

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

2.3. Declarations of Interest

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

2.4. Minutes from the meeting of the Public Quality, Safety & Performance Committee held on 13th July 2023

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

2.4.0 DRAFT Minutes - Public Quality Safety and Performance Committee 13th July 2023 (v3) (VM).pdf (17 pages)

2.5. Review of Action Log

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

2.5.0 PUBLIC QSP Action Log Aug-Sept.pdf (3 pages)

2.6. Matters Arising

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

2.6.1. Freedom of Information Requests Report

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

2.6.1 20230824- FOIA Report-FINAL.pdf (2 pages)

2.6.2. Fuller Inquiry Action Plan (Body Storage) - Interim Progress Report

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

2.6.2 QSP Fuller Inquiry Cover Paper final.pdf (8 pages)

2.6.2 Copy of Fuller Inquiry Action plan Sept 23.pdf (4 pages)

10:45 - 12:30
105 min

3. MAIN AGENDA

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

3.1. Trust Risk Register and Trust Assurance Framework

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

3.1.0 TRUST RISK REGISTER -QSP - 14.09.2023- V02.pdf (9 pages)
3.1.0 DATIX REPORTS - V01 - 04.09.2023.pdf (4 pages)
3.1.0 RISK GRAPHS - 31.08.2023 - APPENDIX 2.pdf (2 pages)
3.1.0 TAF Paper - QSP - 14.09.2023 - V02.pdf (7 pages)
3.1.0 Strategic Risk Refresh Summary - V02 - 05.09.2023.pdf (4 pages)

3.2. Workforce Supply and Shape & Associated Finance Risks

To be led by Susan Thomas, Deputy Director of Workforce & Organisational Development

3.2.0 Supply and Shape Paper QSP.pdf (13 pages)

3.2.1. Finance Report for the Period Ended 31st July 2023 (M4)

To be led by Matthew Bunce, Executive Director of Finance

3.2.1 Month 4 Finance Report Cover Paper - QSP.pdf (9 pages)
3.2.1 M4 VELINDRE NHS TRUST FINANCIAL POSITION TO JULY 2023 - QSP FINAL.pdf (23 pages)
3.2.1 Appendix 1 - Velindre 23-24 Month 4 monitoring return - Final.pdf (10 pages)
3.2.1 Appendix 2 - 2023-24 Velindre Core MMR Template M4.pdf (1 pages)

3.3. Bi-annual Value-Based Healthcare Programme Update

To be led by Matthew Bunce, Executive Director of Finance

3.3.0 QSP_VBH_Programme Update_September 2023 (002).pdf (9 pages)
3.3.0 Appendix 1_Value Intelligence Centre - Phase 1 Exec Summary.pdf (11 pages)

3.4. Quarterly Information Governance Assurance Report

To be led by Matthew Bunce, Executive Director of Finance

3.4.0 20230904-Quarterly IG Assurance Report-FINAL V2.pdf (13 pages)

3.5. Trust Estates Assurance Group Highlight Report

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

3.5.0 QSP 14th September - Trust Estates Assurnace Group Highlight Report.pdf (6 pages)

3.6. Quality, Safety and Performance Reports

3.6.1. Welsh Blood Service Quality, Safety and Performance Report

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

3.6.1 WBS Q+S Report September 2023 v2.pdf (26 pages)

3.6.2. Trust Quality, Safety & Performance Report

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

3.6.2 QSP Cttee 14.09.23 JULY PMF Performance Report FINAL version 007.pdf (69 pages)

3.6.3. Sickness Absence Key Performance Indicator

To be led by Susan Thomas, Deputy Director of Workforce & Organisational Development

3.6.3 Sickness Key Performance Indicator - QSP.pdf (10 pages)

3.7. Integrated Quality & Safety Group Highlight Report

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

Including:

- Quality, Safety & Improvement Tracker
- Safe Care Collaborative Group
- Duty of Quality & Duty of Candour Implementation

3.7.0 IQS Hilight report QSP September 2023 (002) (003).pdf (11 pages)
3.7.0 QS Tracker QSP Sept1.pdf (47 pages)

3.8. Highlight Report from the Infection Prevention and Control Management Group

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

3.8.0 IPCMG Higlight Report - QSP September 2023.pdf (10 pages)

3.9. Quality & Safety 2023-24 Quarter 1 Report

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

3.9.0 QSP coverpaper (002) (003) revised 05.09.2023 (002).pdf (4 pages)
3.9.0 Quality and Safety 2022-23 Quarter 1 report final change (002) 05.09.2023.pdf (20 pages)

3.10. The Medical Examiner's Service & Velindre University NHS Trust

To be led by Jacinta Abraham, Executive Medical Director

3.10.0 Aug 2023 QSP paper.docx2 (002) (002).pdf (11 pages)

3.11. Annual Medical Education Governance Report

To be led by Jacinta Abraham, Executive Medical Director

3.11.0 230914 Annual Medical Education Governance Report - front cover sheet (QS&P).pdf (9 pages)
3.11.0 Med Ed Gov Report 2022-2023.pdf (23 pages)
3.11.0 Med Ed Gov Report 2022-2023 - Annex 1 CU Undergraduate Annual Teaching Review.pdf (5 pages)
3.11.0 Med Ed Gov Report 2022-2023 - Annex 2 HEIW Commissioning Meeting Report.pdf (9 pages)

12:30 - 12:30
0 min

4. 2022-2023 ANNUAL REPORTS

4.1. For Approval

Nil items

4.2. Endorse for Trust Board Approval

Nil items

4.3. For Noting

4.3.1. Health & Safety Annual Report

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

Deferred from July 2023

4.3.1 QSP Committee - Annual Health and Safety Report - Cover Paper.pdf (5 pages)
4.3.1 QSP 14th September 2023 - Appendix 1 - HEALTH AND SAFETY ANNUAL REPORT.pdf (25 pages)

12:30 - 12:30
0 min

5. NHS WALES SHARED SERVICES PARTNERSHIP

5.1. Surgical Materials Testing Laboratory (SMTL) Annual Report

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

Deferred from July 2023

- 5.1.0 2023-09-SMTL-Briefing-Velindre-QSP.pdf (14 pages)
- 5.1.0 Appendix-1-2022-UKAS-Assessment-Report.pdf (12 pages)
- 5.1.0 Appendix-2-SMTL-UKAS-Certificate.pdf (1 pages)
- 5.1.0 Appendix-3-NWSSP-Audit-Report-SMTL.pdf (8 pages)
- 5.1.0 Appendix-4-Zimmer-Biomet-Audit-Report-SMTL.pdf (10 pages)

5.2. Medical Examiner Service (MES) Annual Report

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

Deferred from July 2023

- 5.2.0 QSP Velindre Medical Examiner report sept 2023.pdf (9 pages)

12:30 - 12:40
10 min

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. Trust Policies for Approval

To be led by Susan Thomas, Deputy Director of Workforce & Organisational Development; Zoe Gibson, Interim Corporate Head of Quality, Safety and Assurance; Matthew Bunce, Executive Director of Finance and Carl James, Executive Director of Strategic Transformation, Planning & Digital

- Recruitment and Selection Policy
- Annual Leave Policy
- National Incident Reporting and Management Policy
- NWSSP – Registration Authority Policy
- Sharps Policy and Divisional Sharps Exposure Procedures

- 6.1.0 WOD Policy Review Cover Paper Jul 2023.pdf (3 pages)
- 6.1.0a Recrutiment and Selection Policy v1.pdf (8 pages)
- 6.1.0b Annual Leave Policy and Procedure v5.pdf (16 pages)
- 6.1.0c National Incident Reporting and Management Policy.pdf (27 pages)
- 6.1.0d NWSSP Provision of Registration Authority Services Agreement_v1.pdf (8 pages)
- 6.1.0d 20230710-NWSSP Policy Paper-DRAFT V2.pdf (8 pages)
- 6.1.0d NWSSP Registration Authority Policy_v1.pdf (8 pages)
- 6.1.0e Board-Committee-Report-Template - Sharps Policy Cover Paper Sept 23.pdf (8 pages)
- 6.1.0e Appx 1 - SHARPS POLICY (highlighted changes).pdf (12 pages)
- 6.1.0e Appx 2 - VCC Amended for consultation - Procedure.pdf (22 pages)
- 6.1.0e Appx 3 - WBS Procedure.pdf (8 pages)
- 6.1.0e Appx 4 - NWSSP Sharps Injury and Exposure to High Risk Body Fluids Procedure June 2023.pdf (19 pages)

12:40 - 12:40
0 min

7. CONSENT ITEMS FOR ENDORSEMENT

There are currently no items for endorsement.

7.1. Revised Trust Handling Concerns Policy

To be led by Zoe Gibson, Interim Corporate Head of Quality, Safety and Assurance

7.1.0 Concerns Policy.pdf (29 pages)

7.2. Quality Impact Assessment Tool

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

7.2.0 Quality impact assessment.pdf (12 pages)

12:40 - 12:50
10 min

8. CONSENT ITEMS FOR NOTING

8.1. Professional Nursing Forum Update

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

8.1.0 Professional Nursing Paper (QSP) March to August 2023.pdf (8 pages)

8.2. Medicine Management Group Assurance Report

To be led by Jacinta Abraham, Executive Medical Director

8.2.0 MMG Assurance Report for QSP 14.09.2023.pdf (14 pages)

8.3. RD&I Sub Committee Highlight Report (20/07/2023)

To be led by Jacinta Abraham, Executive Medical Director

8.3.0 RDI Highlight Report to QSPC 14.09.2023.pdf (4 pages)

8.4. Transforming Cancer Services (TCS) Programme Scrutiny Sub Committee Highlight Report (19/07/2023)

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

8.4.0 Highlight Report - PUBLIC TCS 19.06.2023 QSP.pdf (3 pages)

12:50 - 13:00
10 min

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. September 2023 Analysis of triangulated meeting themes

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

9.2. September 2023 Analysis of Quality, Safety & Performance Committee Effectiveness

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

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

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

To be led by Emma Stephens, Head of Corporate Governance

9.3.0 QSP survey feedback _July 2023.pdf (1 pages)

13:00 - 13:00
0 min

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

13:00 - 13:00
0 min

11. ANY OTHER BUSINESS

Prior approval by the Chair required.

13:00 - 13:00
0 min

12. DATE AND TIME OF THE NEXT MEETING

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

Please visit the link below to view the WBS Donor Story, prior to the Quality, Safety and Performance Committee meeting:

https://youtu.be/j_DQnEgMXGw

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Minutes

Public Quality, Safety & Performance Committee

Velindre University NHS Trust

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

ATTENDANCE		
Professor Donna Mead OBE	Velindre University NHS Trust Chair	DM
Hilary Jones	Independent Member	HJ
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
Sarah Morley	Executive Director of OD and Workforce	SfM
Cath O'Brien	Chief Operating Officer	COB
Matthew Bunce	Executive Director of Finance	MB
Alan Prosser	Director of Welsh Blood Service	AP
Peter Richardson	Head of Quality Assurance and Regulatory Compliance, Welsh Blood Service	PR
Emma Stephens	Head of Corporate Governance	ES
Liane Webber	Business Support Officer (Secretariat)	LW

ADDITIONAL ATTENDEES		
Emma Rees	Deputy Head of Internal Audit (NWSSP)	ER
Michelle Fowler	Organisational Development Manager, Equalities, Diversity & Inclusion, Organisational Development & Workforce (for item 1.1.0)	MFo
Rebecca Leed	BSL interpreter (supporting Michelle Fowler for item 1.1.0)	RL
Mel Findlay	Business Support Officer (for item 3.1.0)	MFi
Phil Hodson	Deputy Director of Planning & Performance (deputising for Carl James, Executive Director of Strategic Transformation, Planning & Digital for items 3.4.0 & 4.2.1)	PH
Catherine Pembroke	Clinical Lead for Audit & Quality Improvement	CP
Edwin Massey	Medical Director, WBS (for item 4.1.1)	EM
Hayley Harrison Jeffreys	Head of Infection Prevention & Control (for item 4.1.2)	HHJ
Jason Hoskins	Assistant Director of Estates, Environment & Capital Development (for item 4.1.5 & 8.1.0)	JH
Jade Coleman	Quality, Safety and Assurance Manager (for item 4.2.2 & 4.2.3)	JC

Jayne Rabaiotti	Claims & Redress Manager (for item 4.2.2)	JR
Tina Jenkins	Interim Deputy Director Nursing, Quality & Patient Experience (for item 4.2.2, 4.2.3, 6.1.0 & 8.3.0)	TJ
Susan Myles	Director, Health Technology Wales (for item 4.3.1)	SM
Gareth Tyrell	Accountable Pharmacist, Procurement NWSSP (for item 5.1.0)	GT
Anna Harries	Head of Professional Standards & Digital (for item 7.2.0)	AH
Zoe Gibson	Interim Head of Quality & Safety, Welsh Blood Service (for item 8.3.0)	ZG
Michelle Evans	Head of QA Laboratory, Welsh Blood Service (attending as an observer)	ME
Annette Leponis	Clinical Psychologist for Staff and Teams	AL
Claire Budgen	Head of Organisational Development	CB
Stephen Allen	Regional Director, Llais Cymru	SA

1.0.0	PRESENTATIONS	ACTION
1.1.0	**Staff Story** Led by Michelle Fowler, Organisational Development Manager, Equalities, Diversity & Inclusion, Organisational Development & Workforce Supported by Rebecca Leed, BSL Interpreter The Committee had, in advance of the meeting received Michelle's staff story that outlined her experiences since being employed by the Trust and described her workplace challenges as a member of the deaf community. New to the NHS, Michelle spoke positively about her experiences since joining Velindre, but also outlined a number of challenges she continues to experience that include delays in booking British Sign Language interpreters to enable her attendance at workshops, conferences and other events. Michelle felt that much improvement is needed in this area. COB welcomed further discussion with Michelle around her experiences of the Velindre induction process, with a view to improving delivery to those new to the organisation, the NHS as a whole and those with additional needs/requirements. The Committee briefly discussed the wider equality issues in respect of how staff, regardless of their needs are supported to be effective in the workplace. The Committee conveyed its sincere thanks to Michelle for sharing her story and experiences that provides the Trust with an opportunity to significantly improve its inclusivity.	**COB/ MFo**

2.0.0	**STANDARD BUSINESS**	
2.1.0	**Apologies** received from: • Steve Ham, Chief Executive Officer • Carl James, Executive Director of Strategic Transformation, Planning & Digital • Paul Wilkins, Interim Director, Velindre Cancer Service • Stephen Harries, Independent Member • Katrina Febry, Audit Lead, Audit Wales	
2.2.0	**In Attendance** Attendees were as noted above.	
2.3.0	**Declarations of Interest** Led by Vicky Morris, Quality, Safety & Performance Committee Chair No declarations of interest were received.	
2.4.0	**Minutes from the meeting of the Public Quality, Safety & Performance Committee held on the 16th May 2023** Led by Vicky Morris, Quality, Safety & Performance Committee Chair The Committee **REVIEWED** and **APPROVED** the minutes from the 16th May 2023 Public Committee.	
2.5.0	**Review of Action Log** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science The action log was discussed and Committee members confirmed that they were assured that all actions identified as closed had been fully instigated and could therefore be closed. Items not yet due for completion were not discussed. The remaining action log was reviewed, and the following agreed: ***3.1.1 (17/01/2023) – LF to address governance process for new products prior to coming onstream with NWSSP –*** LF advised that a note to close this action which had not been finalised prior to the commencement of the meeting, has now been forwarded to the Chair and NW for information. ***Action to close.*** ***4.1.0 (17/01/2023) - 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*** – NW advised that the Terms of Reference for the Trust's Integrated Quality & Safety Group has been reviewed and the requested change made. It was agreed that the ***action could be closed.***	**LW** **LW**

	3.1.0 (16/05/2023) - Risk 2465 – PW to establish whether medics are being distracted by emails arriving during consultations – COB reported that an audit, undertaken by the Head of Information Governance, is due to commence to look at the management of email traffic. In the interim, some early interventions with the bookings team and clinic co-ordinators have already been implemented and a workshop with the medical secretaries has been held. **Action to remain open.**	
2.6.0 **2.6.1**	**Matters Arising** Led by Vicky Morris, Quality, Safety & Performance Committee Chair **Freedom of Information Requests Report** Led by Lauren Fear, Director of Corporate Governance & Chief of Staff The Committee received the Freedom of Information Requests Report which provides a summary of Freedom of Information activity for the period 1st January 2023 to 31st March 2023. 195 Freedom of Information Act requests had been made during the period. The following was highlighted from the report: • The Trust Freedom of Information Act Team and processes have changed, leading to improved compliance with required timescales in quarter 4. It is anticipated that this performance will be sustained going forward. • Systematic work was undertaken in quarter 4 in respect of repeat requests, many of which were from pharmaceutical organisations in respect of the level of usage of a defined list of medicines. DM suggested it would be useful for the Committee to receive a more detailed breakdown of the requests received. LF advised that most requests related to procurement in the areas of digital, pharmacy and estates, and agreed to provide the Committee with further detail. Regarding the requests which had not been completed on time, HJ queried the length of the delay and whether these had now been completed. LF reported that all requests had now been completed and advised that further detail would be provided to the September 2023 Committee. The Committee **NOTED** the report and agreed the additional assurance information required at the next meeting.	**LF** **LF**

3.0.0	**MAIN AGENDA** (This section supports the discussion of items for review, scrutiny and assurance).	
3.1.0	**Trust Risk Register / Trust Assurance Framework** Led by Lauren Fear, Director of Corporate Governance & Chief of Staff The Trust Risk Register / Trust Assurance Framework report was discussed. The following was highlighted: • The chair expressed concern about the absence of a TAF from the agenda and papers when the action had been for this to be presented in the July Committee. LF outlined that work is ongoing in respect of the refresh of the Trust Assurance Framework (TAF) risks and that whilst the Committee had been previously advised that this would be complete and brought to the July 2023 Committee, there has been a delay and the revised timeline is that this will now be completed for the September 2023 governance cycle. It was agreed that IMs and members of the Committee would receive the completed TAF as soon as completed in late July 2023, with a formal return to the Committee in September 2023. • The Risk Register Report contained 13 risks that are currently on Datix that meet the threshold for Committee and Board reporting. • The paper assurance rating had been reduced from a level 3 to a level 2 following discussion at the Executive Management Board Committee members expressed concern regarding the length of time a number of the risks had been open without any risk reductions, updates or trajectory for reduction / closure. Targeted urgent action was requested. This was echoed by SA who raised this in relation to risks 3011, 3092, 2465, and 3001 as all had a patient safety link with no clear plan in place to address these risks. COB advised that risks 3011 and 3092, which relate to the DHCR implementation, have now been reduced and are expected to be closed within the next few days. VM requested that the narrative in the risk register provide updates as each risk is progressed, rather than upon completion only. • A verbal deep dive was provided in respect of two risks: ○ ***Risk 3001: Workforce Risk*** – SM gave a brief overview of the risk, noting that whilst it describes issues around stress, anxiety and depression causing a clear risk to staffing levels, it is part of a long-standing, systemic issue. A number of steps are being taken to mitigate the issue, the systemic nature indicates that improvements are unlikely to be apparent month-on-month in terms of the impact and likelihood of the risk.	**LF** **LF**

	The long-term plans that are being enacted were described and CB advised the Committee of the positive work being undertaken by the new staff / team Clinical Psychologist along with the building and nurturing of a network of wellbeing champions who are stimulating conversations with colleagues and signposting to support services across the Trust. SA suggested that it would be useful, from a public perspective, to see how the considerable steps the Trust is taking towards staff wellbeing are impacting on the overall risk level. JA advised that consideration would need to be given as to how the results of the actions undertaken can be measured, captured and articulated. SM assured the Committee that regular discussions are being held within the Healthy and Engaged Steering Group at which this risk is managed, around measuring the impact of the various wellbeing interventions. ○ ***Risk 3042: Laboratory Information Management System (LIMS)*** – CT provided a high-level overview of the risk which relates to other NHS Wales bodies as well as Velindre, and is in relation to the 2019 contract with Citadel Health to provide an all-Wales solution. It was planned that this would be in place prior to 2025 when the current contract expires. This timescale is no longer achievable and the mitigation proposed is to extend the current contract to 2030. The Committee agreed that all future deep dive outcomes should be provided within the paper and not verbally at the meeting so that members can review prior to the meeting. 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 and requested urgent action to enhance the governance in respect of risk reporting 9 as detailed above). • **NOTED** the on-going developments of the Trust Assurance and risk frameworks and requested the revised TAF at the September Committee.	**LF** **LF** **LF**
3.2.0	**Finance Report for the period ended 31st May 2023** Led by Matthew Bunce, Executive Director of Finance The Committee received the month 2 Finance Report which outlined a balanced financial position for the period to the end of May 2023 and the year-end forecast of a breakeven position based on the assumption that all planned additional income is received, saving targets achieved, and financial risks appropriately mitigated throughout the year. The following was highlighted:	

	• The capital risk in relation to the new Velindre Cancer Centre project due to additional project management costs arising from the changing timelines, although assurance was provided that it is likely that these additional costs will be funded. • The Digital Health Care Record system financial risk which at month 2 was identified as a medium risk has been significantly reduced and is reporting as a low financial risk. • Since the report was published, confirmation has been received that protection of all provider income will continue for another year. • The risk relating to the non-delivery of savings schemes was discussed. VM queried whether recurring savings can be considered at this stage of the year as alternatives to those that have not yet commenced. MB suggested a potential focus on procurement savings and advised that discussions are due to be held around this, but that a review of savings overall would be undertaken. • DM queried why the DHCR risk detailed within the paper does not appear on the risk register despite the possibility that £2.000m income related to unrecorded activity could be lost. Whilst MB provided the Committee with assurance and advised that even with this risk a balanced position is still expected, DM advised this needed to be publicly transparent. MB highlighted that the attached detailed financial report provided the appropriate level of assurance but recognized that this could have been made clearer in the summary report. The Committee **NOTED** the May 2023 financial report, in particular the year-end financial performance which at this stage is reporting a breakeven position and the reduction in some of the financial risks since the report was generated.	
3.3.0	**Quality, Safety & Performance Report** Led by Cath O'Brien, Chief Operating Officer, Sarah Morley, Executive Director of Organisational Development & Workforce and Matthew Bunce, Executive Director of Finance The Committee received the Trust Quality, Safety and Performance Report which provided an overview of the performance of the Trust in respect of agreed metrics up to May 2023. The Committee were advised: • that the first Halcyon machine in radiotherapy is now in use which is a step towards addressing the risks caused due to the fragility of the radiotherapy LINAC fleet and were advised how the new	

	software is offering improved data intelligence and providing the opportunity for greater performance scrutiny. • of the actions being taken to ensure Systemic Anti-Cancer Treatments (SACT) can be provided within the required timescales as well as being able to implement the required additional services. Whilst there were no specific points to highlight within Welsh Blood, continued strong performance was noted. The Committee **DISCUSSED** and **REVIEWED** the contents of the May 2023 detailed performance report.	
3.4.0	**2023- 2026 Integrated Medium Term Plan (IMTP) Quarter 1 Report** Led by Phil Hodson, Deputy Director of Planning & Performance The Committee received the IMTP Quarter 1 Report which provides an update in respect of quarter 1 delivery as of 15th June 2023. The following was highlighted: • The 15 actions for Welsh Blood Service were all on target to be delivered. • Of the 22 actions for Velindre Cancer Service, 18 were on course to be delivered, with the remaining connected to the new Velindre Cancer Centre. SA commended the report for its presentation of the data in a clear and easy to read format from a public perspective and suggested that sharing learning on this with other organisations may be helpful. The Committee **NOTED** 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.	
4.0.0	**2022-2023 Annual Reports**	
4.1.0	**FOR APPROVAL**	
4.1.1	**Trust 2021 – 2023 Clinical Audit Annual Report** Led by Catherine Pembroke, Clinical Lead for Audit & Quality Improvement Edwin Massey, Medical Director, WBS and Jacinta Abraham, Executive Medical Director The Committee received the Trust 2021- 2023 Clinical Audit Annual Report which provided an overview of the clinical audit activity and programme of work on clinical effectiveness, undertaken at Velindre Cancer Centre and the Welsh Blood Service over the 2-year period. It was noted that no report was submitted for the year 2021/22 as per	

	strategic business continuity decisions taken during the COVID-19 pandemic. The Committee commended the work undertaken during this period despite the pandemic and **APPROVED** the Trust 2021 – 2023 Clinical Audit Annual Report for translation and publication on the Trust's website.	**JA**
4.1.2	**2022 – 2023 Infection Prevention & Control Annual Report** Led by Hayley Harrison Jeffreys, Head of Infection Prevention & Control The Committee received the Trust 2022 – 2023 Infection Prevention & Control 2022/2023 Annual Report which provided a comprehensive overview of the Trust's infection prevention and control efforts conducted throughout the year report. Key achievements were highlighted and NW wished to extend thanks to the IPCT and wider IPC group for the positive work completed over the reporting period. The Committee **APPROVED** the Trust 2022-2023 Infection Prevention and Control Annual Report for translation and publication on the Trust's website.	**HHJ**
4.1.3	**2022-2023 Medical Devices Annual Report** Led by Peter Richardson, Head of Quality Assurance and Regulatory Compliance, WBS The Committee received the 2022-2023 Trust Medical Devices Annual Report, which provided a summary of the Trust Medical Devices Group activities for the year and the activities undertaken in both divisions to ensure compliance with the Medical Devices Regulations. The Committee were advised that the Medical Devices Group continues to actively engage with the Welsh Government regarding the new Medical Devices Regulations. The working assumption is that the new regulations will closely align with the latest European legislation. This impacts the trust as we create and/or customise medical devices both at the Cancer Service and the Blood Service. The Medical Physics team at the Cancer Service are already working towards accreditation to ISO 13485 which will ensure that an appropriate quality management system is in place to support this activity. The Blood Service quality management system is more bespoke as it has to meet multiple regulatory frameworks but, with expansion to include in-use monitoring of the reagents manufactured in-house, will meet the requirements of an acceptable quality management system for medical devices. The Committee were also informed that the Regulatory Affairs Manager at the Blood Service successfully applied to the British	

	Standards Institute to represent UK Blood Services on the expert committee that will review and agree the future standards for in-vitro diagnostic devices and reagents. This will give the Trust an early insight into the future standards for these reagents and devices as they are developed. The Committee **APPROVED** the 2022-2023 Trust Medical Devices Annual Report for translation and publication on Trust's website.	**PR**
4.1.4	**2022-2023 Information Governance Annual Report** Led by Matthew Bunce, Executive Director of Finance and Senior Information Risk Owner (SIRO) The Committee received the 2022-2023 Trust Information Governance Annual Report which outlined how the Trust is meeting its mandatory and statutory obligations in respect of Information Governance by providing a summary of the key IG activities, achievements and issues for the period 1st April 2022 to 31st March 2023. The Committee considered and **APPROVED** the 2022-2023 Trust Information Governance Annual Report for translation and publication on the Trust's website.	**MB**
4.1.5	**2022-2023 Sustainability Annual Report (including decarbonisation)** Led by Jason Hoskins, Assistant Director of Estates, Environment & Capital Development The Committee received the 2022-2023 Trust Sustainability Annual Report which provides an overview of actions taken by the Trust during the year in support of the sustainable agenda and the key achievements were highlighted. The report was positively received in respect of the format and content, although SA suggested that the colour selection used in the report may present a challenge for those with impaired vision. VM suggested that the report did not include the appropriate levels of assurance and suggested that this be discussed further with NW for future reporting. The Committee **APPROVED** the 2022-2023 Trust Annual Sustainability Report 2022/23 for translation and publication on the Trusts website.	**JH** **JH**
4.2.0	**ENDORSE FOR TRUST BOARD APPROVAL**	
4.2.1	**2022-2023 Performance Annual Report** Led by Phil Hodson, Deputy Director of Planning & Performance	

	The Committee received the 2022-2023 Trust Performance Annual Report which will form part of the suite of Annual Report documents intended for publication as part of the formal Trust Annual Report. The report provided information about the performance of services provided by Velindre University NHS Trust during the year. The Committee were advised that positive feedback had been received from Audit Wales and that, pending Trust Board approval, the report will be submitted to Welsh Government. The Committee **ENDORSED** the Final Draft 2022-2023 Trust Annual Performance Report for onward submission to the Trust Board for approval.	**PH**
4.2.2	**2022-2023 Putting Things Right Annual Report** Led by Jade Coleman, Quality, Safety and Assurance Manager Jayne Rabaiotti, Claims & Redress Manager and Tina Jenkins, Interim Deputy Director Nursing, Quality & Patient Experience The 2022-2023 Trust Putting Things Right Annual Report was received, providing 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. It highlights concerns, compliments, claims, inquest and redress cases. The progress made during this year in respect of this agenda was recognised. The Committee **ENDORSED** the 2022-2023 Trust Putting Things Right Annual Report for onward submission to the Trust Board for approval.	**NW**
4.2.3	**2022-2023 Patient & Donor Experience Annual Report** Led by Jade Coleman, Quality, Safety & Assurance Manager and Tina Jenkins, Interim Deputy Director of Nursing, Quality & Patient Experience The Committee received the 2022-2023 Trust Patient & Donor Experience Annual Report which summarised 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. SA suggested that the substantial use of acronyms may present a challenge to the unfamiliar reader and requested that use of these be reduced in future reporting.	

	The Committee **ENDORSED** the 2022-2023 Trust Patient and Donor Experience Annual Report for onward submission to the Trust Board for approval.	**NW**
4.2.4	**Health & Safety Annual Report** Led by Carl James, Executive Director of Strategic Transformation, Planning & Digital **Deferred to next meeting on request of Executive Lead**	
4.2.5	**2022-2023 Local Partnership Forum Annual Report** Led by Sarah Morley, Executive Director of Organisational Development & Workforce The Committee received the 2022-2023 Trust Local Partnership Forum Annual Report which reflected the Local Partnership Forum's role and functions and summarised the key areas of Trade Union partnership activity undertaken across the Trust between 1st April 2022 and 31st March 2023. The report also provided an overview of the proposed key areas of focus for the Local Partnership Forum over the next 12 months. The ongoing work on the development of partnership working arrangements and the work that Trade Union colleagues are doing to work together to grow the Trust's Trade Union Representative base was highlighted. The Committee queried the description of the term 'action plan' in the report in relation to the work programme for the Local Partnership Forum and suggested that this be clarified in the paper prior to presentation to the Trust Board. The Committee **ENDORSED** the 2022 -2023 Trust Local Partnership Forum Annual report pending the change identified above for onward submission to the Trust Board for approval.	**SfM** **SfM**
4.2.6	**2022-2023 Annual Equality, Diversity & Inclusion Report** Led by Sarah Morley, Executive Director of Organisational Development & Workforce The Committee received the 2022-2023 Trust Annual Equality, Diversity & Inclusion Report which provided an overview of how the Trust has met its equality and diversity responsibilities during the year and demonstrated progress made against the Trust Strategic Equality Plan and objectives. It was highlighted that the Trust is about to embark on the development of its new Strategic Equality Plan which is to be published by March 2024. HJ reiterated a previous request for data to be included which compares the Trust with the demographics of the population. It was agreed that this should be included in the final version of the report.	**SfM**

	The Committee **ENDORSED** the 2022-2023 Trust Equality, Diversity and Inclusion Annual report, pending the change detailed above, for onward submission to the Trust Board for approval.	**SfM**
4.2.7	**2022-2023 Gender Pay Gap Annual Report** Led by Sarah Morley, Executive Director of Organisational Development & Workforce The 2022-2023 Gender Pay Gap Annual Report was received, which provided the Committee with a detailed overview of gender pay gap variations during the year. The report featured data that included as well as excluded the Shared Services position. The report outlined that the gender pay gap for the year was at 12% when looking at the core Trust as opposed to the Trust as a legal entity (inclusive of Shared Services). Six actions have been identified to further close the gender pay gap, these are focused on understanding what stands in the way of women progressing in the workplace by listening to their lived experience and understanding barriers to accessing development opportunities. In addition, the Trust will be implementing recruitment and retention plans developed through a gender lens. All of these actions are continuing to address the key contributing factor of gender balance in more highly paid posts. The Committee **ENDORSED** the 2022-2023 Gender Pay Gap report for onward submission to Trust Board for approval.	**SfM**
4.2.8	**2022-2023 Welsh Language Annual Report** Led by Sarah Morley, Executive Director of Organisational Development & Workforce The Committee received the 2022-2023 Trust Welsh Language Annual Report that outlined the progress made in the last year in respect of enhancing bi-lingual service provision and the implementation of the 'Active Offer'. The Committee discussed the importance of ensuring the availability of Welsh Language Awareness Training being available to staff and for explicit signposting for staff in relation to how they can enhance their Welsh language skills. The Committee discussed when papers and annual reports should be translated into Welsh and suggested that this should be prior to the publication of the papers. SfM agreed to explore this further. The Committee **ENDORSED** the 2022-2023 Welsh Language Annual Report for onward submission for Trust Board approval. .	**SfM** **SfM**
4.3.0	**FOR NOTING**	

4.3.1	**2022-2023 Health Technology Wales (HTW) Annual Report** Led by Susan Myles, Director Health Technology Wales The Committee received the 2022-2023 Health Technology Wales Annual Report which described the work carried out during 2022-23 by Health Technology Wales to improve health and social care in Wales. Discussion was limited due to time constraints, however SM advised that a full presentation will be provided during submission to the Trust Board. The Committee **NOTED** the Health Technology Wales (HTW) Annual Report in advance of the report being submitted to the Trust Board.	**SM**
5.0.0	**NHS Wales Shared Services**	
5.1.0	**Transforming Access to Medicine / Clinical Pharmacy Technical Services Update** Led by Gareth Tyrell, Accountable Pharmacist, Procurement NWSSP The Committee received the report which aims 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. The Committee **NOTED** the report.	
5.2.0	**Surgical Materials Testing Laboratory (SMTL) Annual Report** Led by Dr Gavin Hughes, Director, SMTL NWSSP **Deferred to next meeting on request of NWSSP**	
5.3.0	**Medical Examiner Service (MES) Annual Report** Led by Ruth Alcolado, Medical Director, Corporate Services NWSSP **Deferred to next meeting on request of NWSSP**	
6.0.0	**CONSENT ITEMS FOR APPROVAL** (The consent part of the agenda considers routine Committee business as a single agenda item. Members may ask for items to be moved to the main agenda if a fuller discussion is required).	
6.1.0	**2022-2023 Safeguarding & Vulnerable Adults Management Group Annual Report** Led by Tina Jenkins, Interim Deputy Director Nursing, Quality & Patient Experience and Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science The Committee received the 2022-2023 Trust Safeguarding and Vulnerable Persons Annual Report which provided an overview of key safeguarding and vulnerable persons activities and outcomes for the period 1st April 2022 to 31st March 2023.	

	The Committee **NOTED** the 2022-2023 Trust Safeguarding and Vulnerable Adults Management Group Annual Report.	
7.0.0	**CONSENT ITEMS FOR ENDORSEMENT**	
7.1.0	**2022-2023 Business Continuity & Emergency Planning Annual Report** Led by Alan Prosser, Director, Welsh Blood Service The Committee received the 2022-2023 Trust Business Continuity and Emergency Planning Annual Report which provided a summary of the Trust's business continuity and emergency planning activities during the period 1st April 2022-31st March 2023. The Committee **ENDORSED** the 2022-2023 Trust Business Continuity and Emergency Planning Annual Report.	
7.2.0	**2022-2023 Professional Registration / Revalidation Report** 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 The Committee received the 2022-2023 Trust Professional Registration / Revalidation Report, which summarised professional registration/revalidation lapses/breaches in respect of all staff requiring to be registered with a professional body to undertake their role for the period 1st April 2022-31st March 2023 The Committee **ENDORSED** the Professional Registration / Revalidation compliance across all professional groups prior to being submitted for Trust Board approval.	
8.0.0	**CONSENT ITEMS FOR NOTING**	
8.1.0	**2022-2023 Estates Annual Report** Led by Jason Hoskins, Assistant Director of Estates, Environment & Capital Development The Committee **NOTED** the contents of the 2022-2023 Trust Annual Estates Report.	
8.2.0	**2022-2023 People Strategy Annual Update Report** Led by Sarah Morley, Executive Director of Organisational Development & Workforce The Committee **NOTED** the 2022-2023 Trust People Strategy Annual Report.	
8.3.0	**Trust Integrated Quality & Safety Group Highlight Report**	

	Led by Zoe Gibson, Interim Head of Quality & Safety, Welsh Blood Service and Tina Jenkins, Interim Deputy Director Nursing, Quality & Patient Experience The Committee **NOTED** the discussions that took place during the Integrated Quality & Safety Group in May and June 2023.	
8.4.0	**Transforming Cancer Services Programme Scrutiny Sub Committee Highlight Report – 20th April 2023** Led by Stephen Harries, Vice Chair & Chair of the Transforming Cancer Services Programme Scrutiny Sub Committee The Committee **NOTED** the Transforming Cancer Services Programme Scrutiny Sub Committee Highlight Report – 20th April 2023.	
9.0.0	**INTEGRATED GOVERNANCE** (The integrated governance part of the agenda will capture and discuss the Trust's approach to mapping assurance against key strategic and operational risks).	
9.1.0	**July 2023 Analysis of triangulated meeting themes** Led by Vicky Morris, Quality, Safety & Performance Committee Chair supported by all Committee members It was identified by Committee members to have received the annual reports in one meeting. The amount that had been achieved during the year was recognised and commended. VM requested that a Trust Annual Report template be developed and Trust style determined to facilitate consistency for future annual reports – ES agreed to develop this.	**ES**
9.2.0	**July 2023 Analysis of Quality, Safety & Performance Committee Effectiveness** Led by Vicky Morris, Quality, Safety & 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.	

9.3.0	**Committee Effectiveness Survey Report – Reflective Feedback from May 2023 Committee** Led by Emma Stephens, Head of Corporate Governance ES outlined the results of the May 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 **DISCUSSED** and **REVIEWED** the May 2023 feedback results.	
10.0.0	**HIGHLIGHT REPORT TO TRUST BOARD**	
	Members to identify items to include in the Highlight Report to the Trust Board: • For Escalation • For Assurance • For Advising • For Information	
11.0.0	**ANY OTHER BUSINESS**	
	There were no additional items of business brought for discussion.	
12.0.0	**DATE AND TIME OF THE NEXT MEETING**	
	The Quality, Safety & Performance Committee will next meet on the: **14th September 2023 from 10:00-13:00**	
CLOSE		
The Committee is asked to adopt the following resolution: That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).		

QUALITY, SAFETY AND PERFORMANCE - 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	CLOSED
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	CLOSED
Actions agreed at the 16th May 2023 Committee					
3.1.0	***Risk 2465*** – PW to establish whether medics are being distracted by emails arriving during consultations.	Paul Wilkins	**Update 01/09/2023** - Following review of the risk at EMB Run on 31/08/23 the root cause of the risk has been established, which is not the amount of emails but the process and management around clinical information. The internal audit being conducted by the Head of Information Governance is underway with a completion date of 09/10/23	13/07/2023 Now 31/08/2023	OPEN

			Update 11/08/2023 - An initial plan was set to complete audit by end of July, however, other high priority Trust activity has necessitated a delay in completion. IB has realigned work with a new target date of 31/8/2023. An audit has commenced being led by Ian Bevan. Due for completion end of July.		
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	Peer Review report sent to Committee members following meeting. Improvement plan added to Quality & Safety Tracker.	14/09/2023	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	Update to go to September meeting for noting under Consent. Cover paper being drafted by Mark David	14/09/2023	CLOSED
Actions agreed at the 13th July 2023 Committee					
1.1.0	COB and MF to discuss induction process	Cath O'Brien	Cath has contacted Michelle to arrange a catch up so can be closed.	14/09/23	CLOSED
2.6.1	LF to provide full breakdown of the nature of FOI requests received and length of delays for those that were responded to outside of the required timescale	Lauren Fear	On agenda for meeting 14/09/23 as a matter arising	14/09/23	OPEN
3.1.0	IM's and Committee members to receive TAF as soon as completed in late July, with a formal return to the Committee in September.	Lauren Fear	Update on agenda for meeting 14/09/23	31/07/23	OPEN

3.1.0	LF, JA and NW to discuss reporting format of future deep dives	Lauren Fear/ Jacinta Abraham/ Nicola Williams	In Risk Paper on agenda for meeting 14/9/23	14/09/23	CLOSED
9.1.0	Trust Annual report template to be developed and Trust style determined to facilitate consistency for future annual reports	Emma Stephens	Update: 31/08/23 - Task & Finish group to be established to take forward.	31/01/24	OPEN
4.1.5	JH to seek advice from NW with regards to appropriate assurance reporting	Jason Hoskins	JH & NW met re assurance reporting (Sustainability Annual Report), NW advised re 7 Levels of Assurance Framework and provided all supporting information. Approach to be adopted for all reports for the next cycle.	14/09/23	CLOSED

This report has been compiled in response to QSP action 2.6.1. The tabular information and graphs below provide a full breakdown of the nature of FOI requests received and length of delays with where possible analysis for FOI activity for the period of 1st April 2022 to 31st March 2023.

Analysis for the Freedom of Information compliance for **ASSURANCE** is shown below:

Quarter	Number of requests	Number of requests completed within statutory timeframe	Percentage compliance
1	43	23	53.49%
2	57	47	82.45%
3	36	23	63.89%
4	58	54	93.10%
Total for FY 22/23	195	147	75.38%

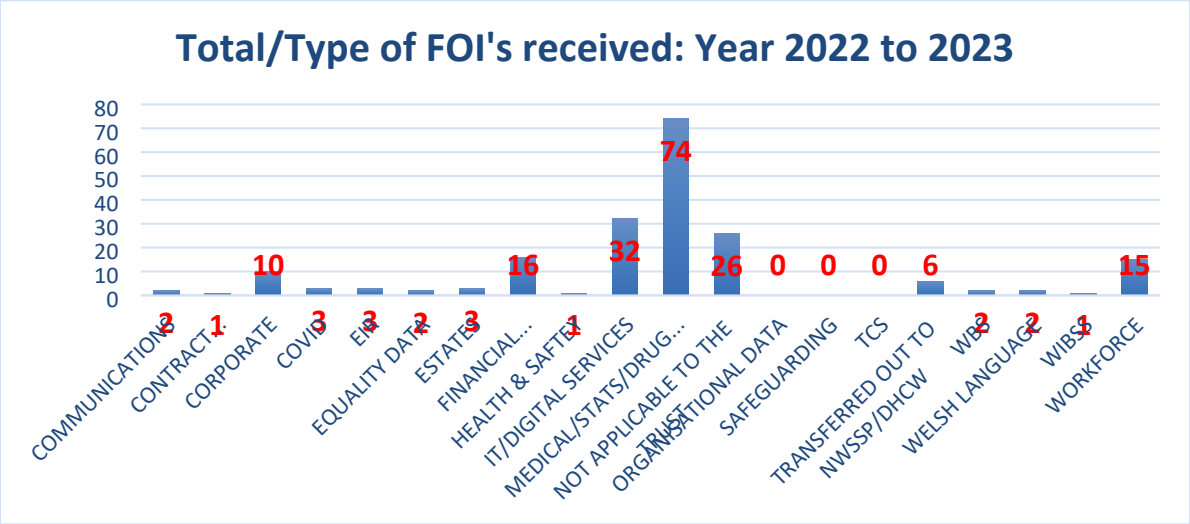
Analysis does not indicate one underlying factor which could identify the differing compliance rates. This is because there are multiple factors which can affect delay, these include leave, capacity, complexity of the request and timeliness of response from the providers of the data.

The Trust has improved how it requests the provision information from divisions, it communicates clear actions and deadlines in order to meet compliance.

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

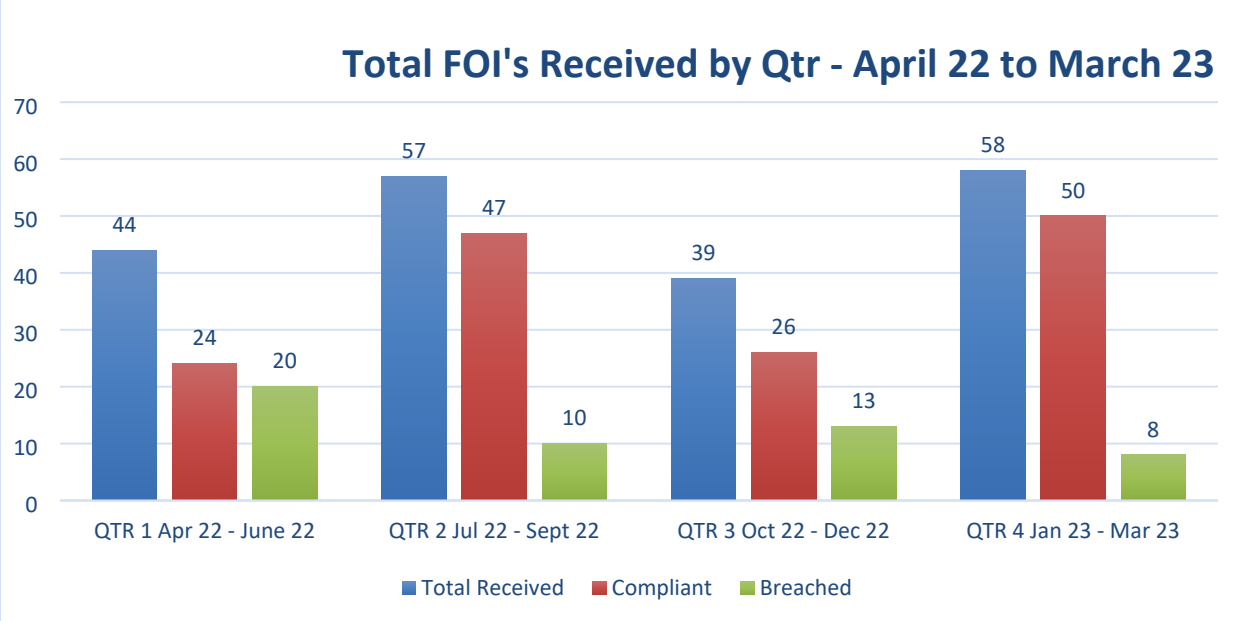
Quarter	Number of requests	Number of requests completed within statutory timeframe	Percentage compliance
1	1	1	100%
2	2	2	100%
3	0	0	100%
4	0	0	100%
Total for FY 22/23	3	3	100%

Total By Type Year 22/23



Highest proportion received being pharmaceutical (**74**) and digital (**32**). In addition to the Trust received and is legally obligated to respond to **25** which were "not applicable to the Trust." This is due to requestors sending blanket requests for information without conducting research into the Trust and what services it is responsible for and delivers. The types of those requests include but are not exclusive to; requests regarding miscarriage, epilepsy etc.

Total By compliance Year 22/23



QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Fuller Inquiry Action Plan (Body Storage) – Interim Progress Report

DATE OF MEETING	14th September 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	ASSURANCE
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Mark David, Senior Operational Manager, Katie Foward, Project Support Manager
PRESENTED BY	Cath O'Brien, Chief Operating Officer
APPROVED BY	Cath O'Brien, Chief Operating Officer
EXECUTIVE SUMMARY	The Fuller Inquiry was established to investigate how David Fuller was able to carry out inappropriate and unlawful actions in the mortuary of Maidstone and Tunbridge Wells NHS Trust and why they went apparently unnoticed. In November 2021 the Welsh Government asked all Health Boards to supply information on body storage facilities which fall outside of the current HTA licencing and regulatory oversight of premises where post-mortem examinations take place.

	Welsh Government have produced interim recommendations for Health Boards and Trusts to implement in areas where bodies of the deceased are kept, to safeguard the security and dignity of the deceased. Operational Leads at VCC have established the attached action plan against the published recommendations and continue to implement all recommendations as per the agreed timescales. Progress must now be presented to Welsh Government for assurance.

RECOMMENDATION / ACTIONS	The Committee are asked to note the progress of the Operational Teams against the recommendations to date. The plan is routinely monitored by Senior Management at the Cancer Centre and presentation of the plan to the Committee is to provide assurance that progress is continuing at pace.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Senior Leadership Team	14/08/2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The action plan against the interim recommendations has been presented to SLT on 14th August 2023 and was approved. It was agreed that the progress to date would be presented to Welsh Government as requested and the final plan will be provided to Welsh Government officers following presentation to QSP.	

7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 6 - Outcomes realised in full

	Please refer to the Detailed Definitions of 7 Levels of Evaluation to Determine RAG Rating / Operational Assurance and Summary Statements of the 7 Levels in Appendix 3 in the ***"How to Guide for Reporting to Trust Board and Committees"***

APPENDICES	
A	Fuller Inquiry Action Plan

1. SITUATION

Following the interim recommendations report from Welsh Government, Velindre Operational Teams have been working to implement the recommendations.

Of the 18 recommendations listed, to date, Velindre have implemented 13 recommendations with five remaining outstanding. Of the remaining five recommendations, all five have agreed completion dates, as per the attached plan and implementation will be monitored by Senior Managers at the Cancer Centre.

Welsh Government has now requested an updated position from all Health Boards and Trusts as to progress against the recommendations. The attached action plan will be provided to Welsh Government officers to provide assurance that work is continuing at pace.

2. BACKGROUND

The Fuller Inquiry was established to investigate how David Fuller was able to carry out inappropriate and unlawful actions in the mortuary of Maidstone and Tunbridge Wells NHS Trust and why they went apparently unnoticed.

In November 2021 the Welsh Government asked all Health Boards and Trusts to supply information on body storage facilities which fall outside of the current HTA licencing and regulatory oversight of premises where post-mortem examinations take place.

Welsh Government have produced interim recommendations for Health Boards and Trusts to implement in areas where bodies of the deceased are kept, to safeguard the security and dignity of the deceased.

Operational Leads at VCC have established the attached action plan against the published recommendations and continue to implement all recommendations as per the agreed timescales.

3. ASSESSMENT

The Trust must complete the recommendations required to meet the requirements set by Welsh Government. The report is presented to assure the QSP Committee that work is continuing and all actions that remain outstanding have clear deadlines for implementation, and actions to ensure outcomes are realised in full.

Of the five actions remaining, paperwork completion and audit reports are key components, all active changes such as staff training, identification of ROs, and records management are completed with outcomes realised in full.
There is one SOP remaining for completion, however, in the interim, the procedure is already operational. CCTV audits are awaited for wider work that will impact body storage premises, however, there are currently safe procedures in place to ensure all access points are fully monitored and secured at all times. An SLA is also required with local Funeral Homes to formalise current arrangements which are ad hoc in terms of our use as a contingency. An arrangement will be put in place with several homes.

4. SUMMARY OF MATTERS FOR CONSIDERATION

The Committee should be assured that work is continuing at pace and the report to Welsh Government on progress against the recommendations will be favourable. There are a limited number of actions outstanding but actions are underway to ensure these conclude swiftly.

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

<table>
<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>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).
Safe management of, and careful, appropriate handling of the deceased.
Patient centred care is important even in death, our responsibility to our patients extends to their post-mortem care whilst on our premises.
It is important that our patients and families can be assured that we provide safe care for patients post-mortem.</td></tr>
</table>

SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	If more than one Well-being Goal applies please list below:
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	An EQIA is not required in this instance as the recommendations have no specific impact on any protected characteristic, or select groups of individuals. The recommendations relate only to the control of body storage and not specifically to any handling of patients post-mortem.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

6. RISKS

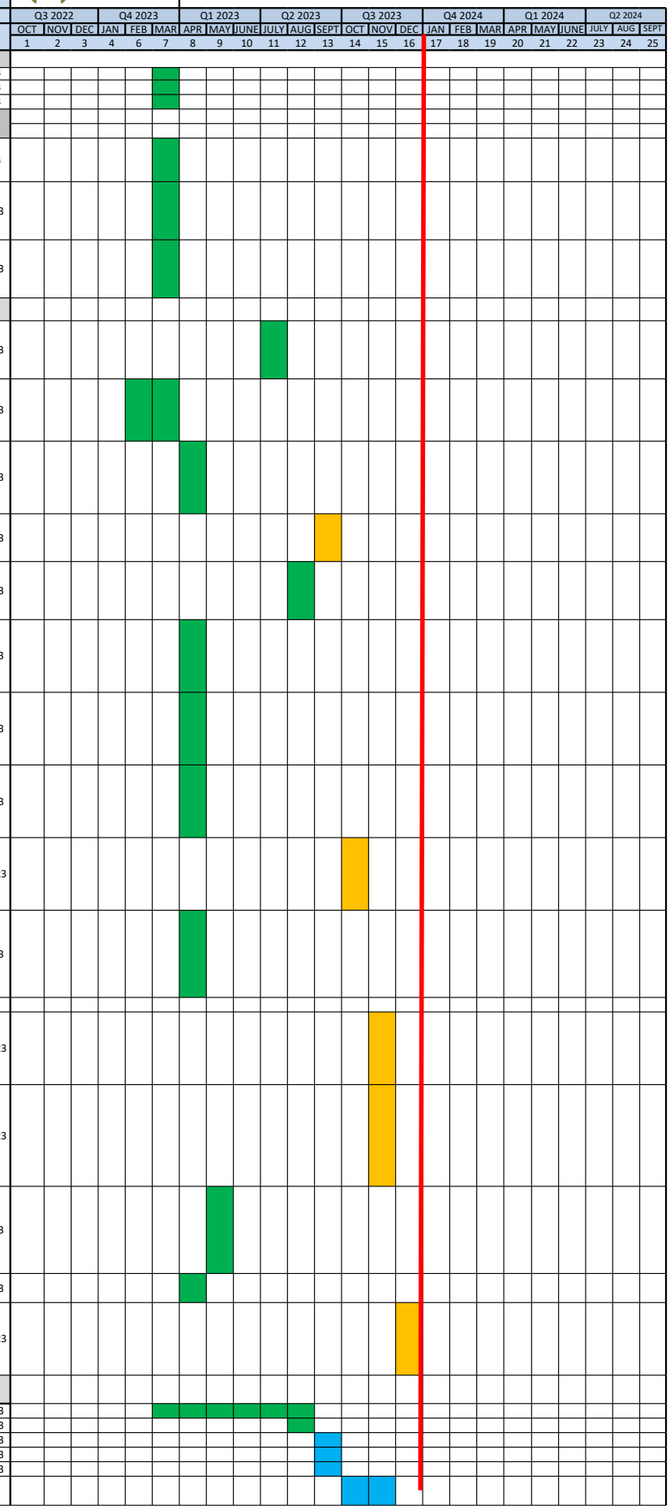
ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	
WHAT IS THE CURRENT RISK SCORE	
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	

BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix	

RED Milestone will not be met despite mitigating actions
AMBER Mitigating actions instigated in order to meet milestone
GREEN Milestone on track by time and benefit

Overall status

#	Key Milestone	Lead	Activity	Actions/ Comments	Corrective Actions Outstanding	Start	End
Project Governance							
1	Receipt of Fuller Interim Report	OSM	complete	Received	NA Outcomes realised in Full	1/3/23	1/3/23
2	Programme Plan	Deputy OSM	complete	Developed and agreed	NA Outcomes realised in Full	1/3/23	1/3/23
3	Work Commenced	Deputy OSM	complete	Work commenced	NA Outcomes realised in Full	1/3/23	1/3/23
	WORKSTREAM 1						
	Management and Governance Arrangements						
1	Identify and appoint a single accountable officer for body storage facilities who can oversee implementation of the recommendations and provide updates to Board/ Welsh Gov.	Deputy OSM	complete	Appoint an accountable officer within Velindre Cancer Centre SAO for Velindre cancer centre is Interim Head of Operations & Delivery.	Outcomes realised in Full	1/3/23	1/3/23
2	Review and consolidate where possible, the body storage arrangements, especially in community hospital settings	Deputy OSM	complete	The Cancer Centre is the only Directorate within the Velindre University NHS Trust to hold a cold room body store facility, we therefore have no requirement to align with community or other divisions within the Trust, as not applicable	Outcomes realised in Full	31/3/23	31/3/23
3	Consolidate the management of body stores and where possible, align them to the mortuary and post-mortem services	Deputy OSM	complete	The Cancer centre is the only Directorate within the Velindre University NHS Trust to hold a cold room body store facility, we therefore have no requirement to align to the mortuary and post mortem services, as not applicable	Outcomes realised in Full	31/3/23	31/3/23
Operational Management and Procedures - Apply relevant HTA post-mortem sector licensing standards and guidance to body storage areas							
1	SOPs in place	Deputy OSM	complete	Documented standard operating procedures (SOP) should take account of standard and out of hours arrangements and cover for storage of bodies, record keeping, receipt and release of bodies, lone working, access and where applicable viewing of bodies, transfer of bodies.	Outcomes realised in Full SOP has been reviewed and upadted to meet the standards	31/3/23	31/7/23
1,1	SOPs and policy in place and up to date	Deputy OSM	complete	Documented standard operating procedures (SOP), have been completed and are implimented to take into account access requirements for contractors, vistors, under escort	Outcomes realised in Full Policies and SOPs to be reviewed at regular intervals - BAU - Dcouments to be reviewed annually	31/3/23	31/3/23
1,2	Systems to track each body from admission to the body storage facility to release for burial or cremation e.g. body receipt and release details should be logged, including the date and name of the person who received/released the body and, in the case of release, to whom it was released.	Deputy OSM	complete	Systems are in place to track from admission to release. Measures in place include Authorised body release book in operation, which list undertaker, patient, inclusive of undertakers registration number. The body release book is held within the Body Store and is completed by both the persons releasing the deceased to the undertaker.	Outcomes realised in Full	31/10/23	30/4/23
1,3	Bodies should be identified using a minimum of three identifiers attached to the body that can be used to check the identification of the deceased. (e.g. name, date of birth/death)	TBC	Ongoing	Deceased are prepped at ward level with identification bracelet, Velindre notification of death which includes time of death, next of kin, jewellery, etc.	SOP to be developed for notification of Death	31/3/23	31/9/23
2	Control Procedures in place	Deputy OSM	complete	Access to bodies storage facilities should be strictly controlled with clear policies and procedures which protect bodies from harm and breaches of confidentiality. Procedure (SOP) are in place to control access to body store facilities.	Confirmed that divisional Nursing Policy/ SOP covers off this action	31/3/23	25/8/23
3	All staff appropriately trained	Deputy OSM	complete	All staff who may access body storage facilities should be appropriately trained, for example, Portering staff, site managers. All relevant staff are trained in IP&C, All Wales Manual Handling passport, and local procedure for access to the Cold room body store.	Individual departments to keep training logs, mandatory training information held on the Trust ESR system. Nursing to add training competency to the site manager training competency assessment .	31/3/23	30/4/23
4	Processes in place for external visitors	Deputy OSM	complete	Contractors, visiting and temporary staff should be made aware of policies and SOPs Contractors, complete induction, temp staff visiting site are made aware of procedure and escorted at all times whilst entering the cold room body store	Outcomes realised in Full	31/3/23	30/4/23
5	Records in place and maintained	Deputy OSM	complete	Records must include records of access to the body storage (by whom and for what purpose). Physical record kept of two persons signing out cold room keys, Secure door access reports are held digitally. Keys held on main reception and key log audited monthly	Outcomes realised in Full	31/3/23	30/4/23
6	All staff trained in Datix	Deputy OSM	Ongoing	Staff know how to identify and report incidents with Information about incidents is shared with all staff to avoid repeat errors. All relevant staff are aware of how to report incidents or concerns. Staff are also aware of the Datix procedure. Lessons learnt are shared with relevant divisional management groups.	Majority of actions implemented; If required, relevant staff to undertake Datix training in line with the SOP. Identify staff who may require Risk Assessment training and for them to complete this by end of October 2023.	31/3/23	31/10/23
7	Risk Assessments completed and logged	Deputy OSM	complete	Risk assessments should be undertaken and reviewed on a regular basis and cover risks to the security, dignity and integrity of bodies and stored tissue. Risk assessments are completed on the security elements of cold room body store. Current SOP addresses the dignity and integrity of bodies whilst stored..	Outcomes realised in Full Risk assessments are reviewed annually	31/3/23	30/4/23
8	Robust Security Arrangements in Place						
8,1	Premises are secure (for example there is controlled access to the body storage area(s) and the use of CCTV to monitor access). Security arrangements should be robust, with effective mechanisms to strictly control access. Security arrangements must protect against unauthorized access and ensure oversight of visitors and contractors who have a legitimate right of access.	Deputy OSM	Ongoing	CCTV has coverage of the front door only, not including the access corridor. We have security processes in place. audit of CCTV undertaken April 2023.	CCTV Audit has been received and a working group has been set up to respond to the action plan, Progress ongoing.	01/04/23	31/11/23
8,2	Entry to body storage facilities should include swipe card access with lists reviewed and updated regularly. Records of access (electronic and paper-based) and CCTV footage should be regularly audited to ensure adherence to relevant policies and procedures. Anyone entering should have a legitimate right of access and audits should scrutinise the purpose, frequency and duration of access and be particularly alert to unusual patterns, times of entry or other unexplained or suspicious activity which must be investigated immediately.	Deputy OSM	Ongoing	Secure door access was installed with double tap facility, enabling access by 2 s authorised member of staff, CCTV audit has been undertaken across the site, awaiting report. Audit of CCTV undertaken April 2023	CCTV Audit has been received and a working group has been set up to respond to the action plan. Review the need to monitor images. Completing actions within the CCTV audit.	01/04/23	31/11/23
8,3	Staff and authorised visitors and contractors should be aware of the establishment's security arrangements. Authorised visitors and contractors should also be supervised while in the body storage areas.	Deputy OSM	complete	Documented standard operating procedures (SOP) takes in to account access requirement s for contractors, visitors, under escort, they are supervised at all times. CCTV signage has been updated to include a contact number and placed at every entrance to the cancer centre in line with Audit Recommendations.	Outcomes realised in Full SOP Updated	01/04/23	31/5/23
9	Appropriate Management of Bodies	Deputy OSM	complete	Bodies should be shrouded or in body bags whilst in storage. Deceased are shrouded and placed in a body bags at ward level	Outcomes realised in Full	31/3/23	30/4/23
10	Formal Agreements in place with Funeral Homes	Deputy OSM	Ongoing	Establishments should have documented agreements with any funeral services that they may use for contingency storage. We have verbal agreement with local undertakers, Within the division we would introduce established and agreed contingency measures.	Clarify position. We do not have a designated local funeral home that we use. Develop SLA in conjunction with business planning. Linking in with NWSSP and local funeral homes to formalise arrangements.	31/3/23	31/12/23
Reporting and Ongoing Management							
1	Action plan to be completed by action owners	Deputy OSM	Ongoing			1/3/23	30/8/23
2	Outcomes to be reported to SLT	OSM	Ongoing			1/8/23	30/8/23
3	Outcomes to be reported to EMB	OSM	Not Started			1/9/23	15/9/23
4	Outcomes to be reported to QSP	OSM	Not Started			1/9/23	15/9/23
5	Outcomes to be reported to Welsh Government	OSM	Not Started	Once SLT approvepaln this will be sent to WG		1/9/23	15/9/23
6	Follow on actions to be owned and managed with robust reporting cycle	Deputy OSM	Not Started	All o/s actions listed above as follow on/ BAU to be captured and managed operationally		?	?



Project Name	Benefit ID	Benefits Description	Measure: Indicate how it will be measured	Performance	
				Baseline	Target

Timescale for Realisation	Benefit Type: (F = financial NF = non-financial)	Quantitative / Non-Quantitative	Category	Financial Value	Trust/VCC Strategic Objective

Status: Achieved/ Ongoing/ Not Started	Owner	Comments

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

TRUST RISK REGISTER

DATE OF MEETING	14.09.2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	DISCUSSION

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

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

EXECUTIVE SUMMARY	The purpose of this report is to: • Share the current extract of risk registers to allow the 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**
Executive Management Board – Run	31.08.2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The current position of the Risk Register was discussed and noted. In depth discussion took place in respect of risks 2465 and 2501.	

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

Level 7	Level 6	Level 5	Level 4	Level 3	Level 2	Level 1	Level 0
ASSURANCE RATING ASSESSED BY EXECUTIVE SPONSOR				2 – Comprehensive actions have been identified and addressed. The cause of the performance issue has been identified and is being actively managed.			

APPENDICES	
1	Current risk register data.
2	Risk data graphs

1. SITUATION

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

2. BACKGROUND

The risks currently held on Datix for the Trust are to be considered by the Trust Board.

3. ASSESSMENT

3.1 Trust Risk Register

There are a total of 11 risks to report to Board and Committee on Datix 14, this includes 9 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.
- In respect of TCS risks; some are reported with expired review date, this is due to there being no governance cycle in August. The next project meeting is 13.09.2023 following which relevant risks will be updated.
- To note all actions in the Datix action plan section have assigned owners – however given named individuals on the system, this is not included in reporting. If any member would like further details, this can be provided.
- The Quality, Safety and Performance Committee and the Audit Committee requested the inclusion of a date by which the target rating will be received. Where information has been available this has been included manually for the Quality, Safety and Performance Committee and will be further populated ahead of submission to the Trust Board on 28.09.2023, as information is available. A decision will be made during the governance cycle whether this will be included on reports going forward and potentially added to Datix.

4.2 Risk In Depth Review

The Executive Management Board (Run) discussed two risks, which have been open the longest to ensure effective plans ked to discuss risks open the longest, with a focus on the effectiveness of the action plans in place.

The Risks on the register which have been open the longest are:

2465

- Risk open 662 days
- Risk regarding email traffic

The Head of Information Governance (HOIG) joined EMB to discuss the risk. Following transfer of risk ownership to the HOIG, as an email risk further discussion with the Director of Velindre Cancer Centre resulted in the root cause of the risk not being an email risk but investigation into the risk it was concluded that the issue was not email traffic, as detailed in the risk title but is around management of communications in respect of patient information and the mechanisms in place to manage the risk appropriately.

It was agreed in the EMB meeting that the owner of the risk should be the Director of Velindre Cancer Centre, as the risk is specific to VCC and mechanisms in place there.

Since the meeting took place the risk has been fully reviewed; resulting in a changed title, risk owner and an updated action plan and date to reach the target risk grading. There was no change to the current risk grading, however an internal audit is underway to address the underlying causes, with a completion date of 09.10.2023.

2501

- Risk open 592 days
- Risk is regarding inflation rates

The risk has been reassessed, resulting in a reduction of the current risk rating. The review will be signed off at the next Project Board on 13.09.2023. Following sign off the changes will be reflected on Datix.

4.3 Digital Risks

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

4.4 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.
- Regular reminders are shared in communications across the Trust to remind staff to complete the Introduction to Risk Training.
- As of 29th August 2023 an Introduction to Risk training has a completion rate of 66.8% across VCS, WBS and Corporate.

Compliance Area	Compliance Rate
Corporate	67.88%
Research Development and Innovation	67.3%
Transforming Cancer Services	54.1%
Velindre Cancer Centre	62.99%
Welsh Blood Service	73.91%

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

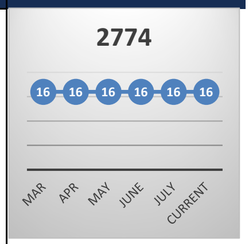
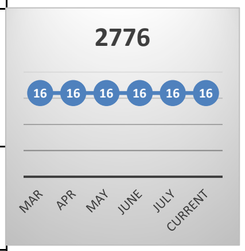
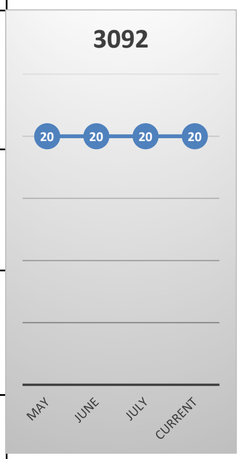
ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below

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	

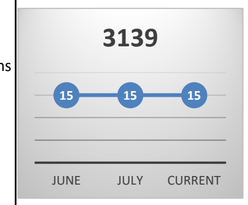
APPENDIX 1

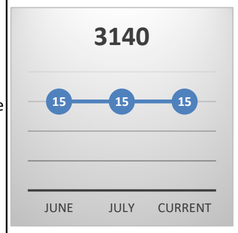
Detailed Definitions of 7 Levels of Evaluation to Determine RAG Rating / Operational Assurance and Summary Statements of 7 Levels

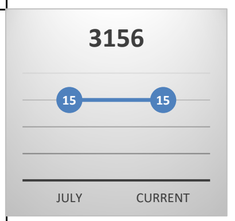
RAG rating	ACTIONS	OUTCOMES	RAG rating	SUMMARY STATEMENTS OF 7 LEVELS
Level 7	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, 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

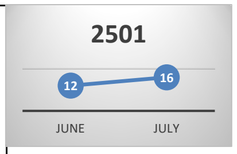
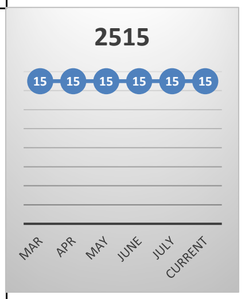
ID	Risk Title - New	Risk (in brief)	Risk Type	Opened	Amount of Days Open	Division	RR - Current Controls	Rating (initial)	Rating (current)	Rating (Target)	Date to Reach Target Rating	Review Date	Action Plan On target Overdue Complete		Risk Rating Trend
2774	There is a risk to Quality and Safety as a result of extensive manual workarounds due to outdated legacy IT systems, leading to increased risk of incorrect test results and patient harm.	Data entry/transcription errors introduced during overly complex manual workaround processes could potentially lead to issue of incorrect test results and clinical advice, which could impact patient safety. 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. Staff are required to check multiple spreadsheets to decide which tests need to be done. In an on call situation, a single member of staff is required to manually check information in multiple places. There are longer-term plans to implement a new system. Once implemented, the replacement system would mitigate this risk.	Quality	27/10/2022	312	Welsh Blood Service	Staff diligence - multiple manual checking stages prior to issue of results and associated clinical advice. Minimal updates progressed within constraints of the existing IT system.	20	20	4	31/03/2025	14/02/2023	31/07/2024	Complete actions for replacement LIMS - see risk 2776	
												29/09/2023	Tender for replacement IT System (Q2)		
												31/12/2025	Implement replacement IT System (Q3)		
2776	There is a risk to performance and service sustainability as a result of significantly limited IT expertise to support the ongoing use of outdated, legacy systems, leading to inability to provide core operational services.	Inability to provide core services could lead to patient harm for those requiring acute urgent services and reputational damage. Inability to enhance and develop new transplant services to meet business needs and/or other factors such as changes to external regulatory requirements. Transplant services are reliant on in-house developed IT applications 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. There are longer-term plans to implement a new system. Once implemented, the replacement system would mitigate this risk.	Performance and Service Sustainability	27/10/2022	312	Welsh Blood Service	Working group to manage prioritisation of a 'backlog' of urgent development work needed to maintain the system, and prevent critical failure. Minimal updates progressed within constraint of system and available IT Subject Matter Expert resource. In the event of IT system failure, a business continuity agreement is in place. Core transplant services would be referred to NHS England.	16	16	4	31/03/2025	14/02/2023	28/04/2023	Secure Funding for replacement LIMS	
												29/09/2023	Tender for replacement for IT System		
												31/12/2025	Implement replacement for IT System		
												01/09/2023	Review Risk Assessment		
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.	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.	Multipl Risk Domains	27/04/2023	130	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	20	20	8		31/07/2023	31/05/2023	Risk needs reviewing	
												07/06/2023	Risk needs reviewing		
												31/07/2023	use of WPAS		
												23/06/2023	Query why Chemocare is still part of this risk		

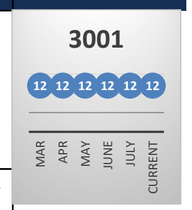
3139	Clearance Limitations There is a risk that the NRW Licence puts limitations on clearance resulting in delays to construction	There is a risk that the NRW Licence puts limitations on clearance resulting in delays to construction	Performance and Service Sustainability	21/06/2023	75	Transforming Cancer 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	12	15	6	15/09/2023	04/08/2023	04/08/2023	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
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.	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	75	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	12	15	6	16/10/2023	04/08/2023	04/08/2023	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
3156	Transfer of new Equipment There is a risk that delay to opening of the nVCC will lead to the necessity of transferring new equipment which has been procured in the interim leading to greater operational disruption, prolonged commissioning period and costs.	There is a risk that delay to opening of the nVCC will lead to the necessity of transferring new equipment which has been procured in the interim leading to greater operational disruption, prolonged commissioning period and costs.		17/07/2023	49	Transforming Cancer Services	1) Determine impact and seek WG support for revised cash flow - ongoing	10	15	10		04/08/2023	No Action Plan	No Action Plan
2465	There is a risk to patient safety, caused by the duplication of information, excessive use of email and a lack of alternative communication methods for the processing of clinical information.	There is a risk of severe harm due to the excessive use of email both internally and externally to the Trust. This is because processes and procedures are not carried out in a manner that is appropriate. in particular, emails containing time critical clinical information is being sent to and received by individuals who may not be in work. The impact is severe harm, which may result in National reportable incidents.	Safety	05/11/2021	668	Velindre Cancer Centre	There is a lack of current controls that enable the mitigation of this risk. As a result a formal internal audit of the underlying causes of this risk is underway. Reporting to VCC SLT is required on a regular basis in order to provide assurance that the issue is being addressed.	16	16	4	31/03/2024	29/12/2023	09/10/2023 30/06/2023 29/09/2023	Head of Information Governance (HOIG) has commenced the internal audit, as of 01.09.2023. Following areas have been interviewed: SACT Bookings SACT Preparation SACT Helpline Consultant Oncologist Following activity planned for week email etiquette to be developed as part of hybrid working tool kit and shared widely. To be closed pending All Wales email policy. Associated SOPS will need to be developed to reflect this updated policy. Development will be lead from a Trust level by Head of IG. Timelines - imminent. Reporting will be via QSMG and via EMB IB to undertake an audit into the use of email within the medical directorate and SACT booking meetings continuing to be undertaken. Progress delayed due to demands from COVID inquiry. completion date updated



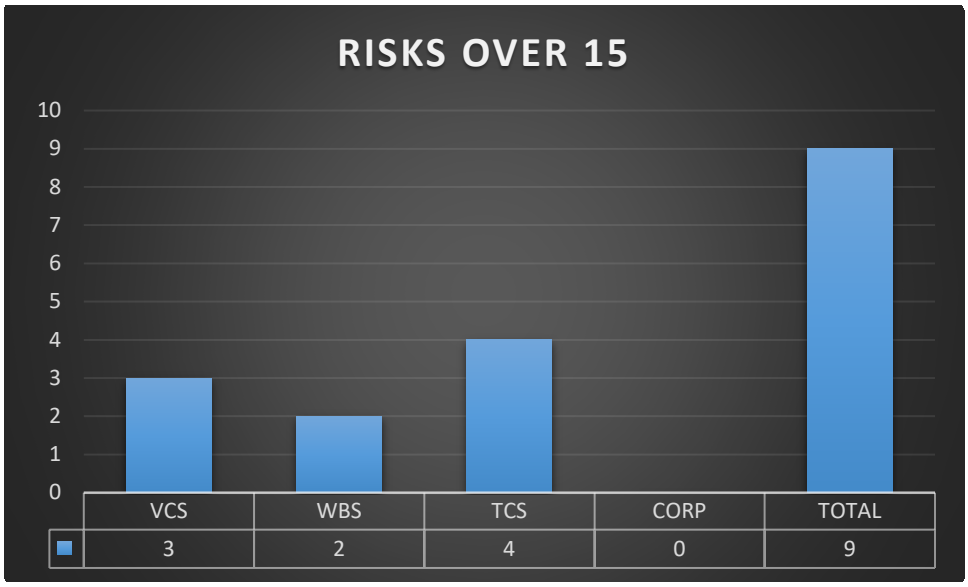




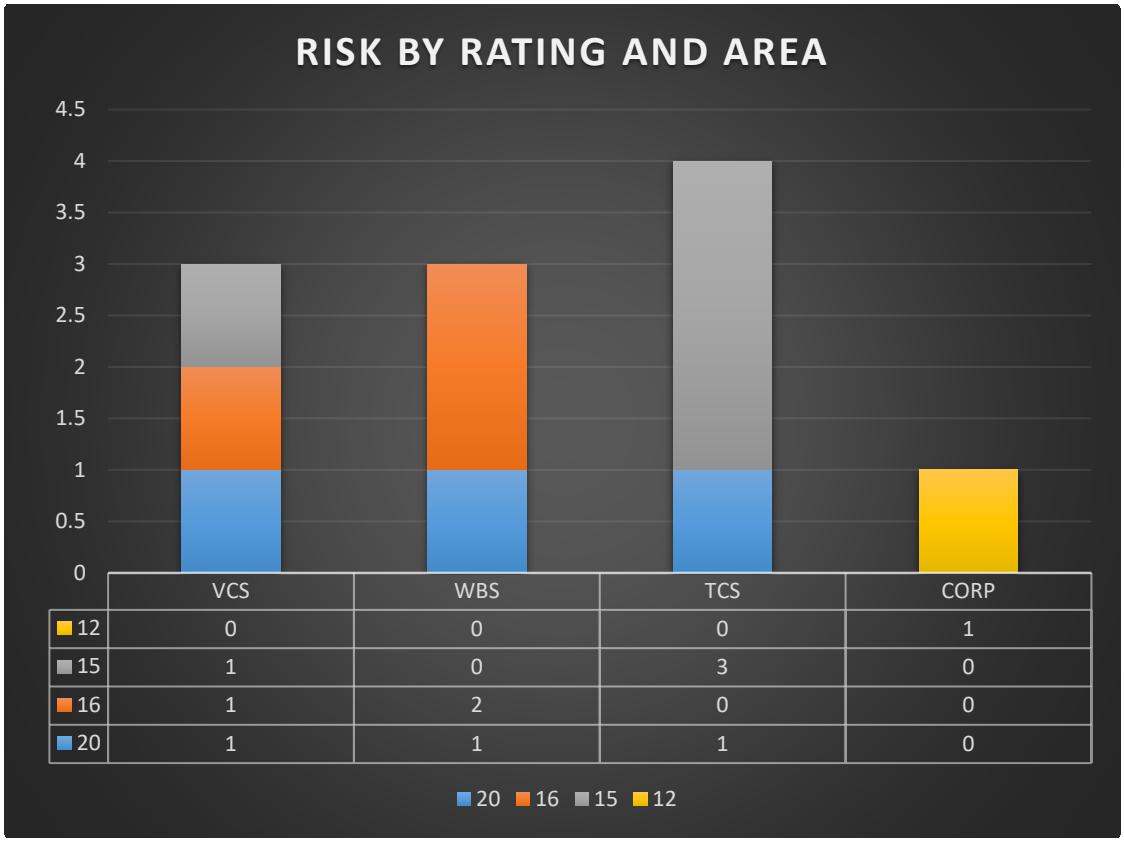
2501	Inflation - There is a risk that increased rates of inflation before financial close lead to the costs of the project exceeding the affordability envelope.	There is a risk that increased rates of inflation before financial close lead to the costs of the project exceeding the affordability envelope	Financial Sustainability	14/01/2022	598	Transforming Cancer Services	1. Discuss with Welsh Government. Increased CAPEX approved. Complete 2. Monitor inflation inline with the financial index. Ongoing	20	16	12		28/07/2023	No Action Plan	No Action Plan	
2515	There is a risk to performance and service sustainability as a result of the staffing levels within Brachytherapy services being below those required for a safe resilient service leading to the quality of care and single points of failure within the service.	Brachytherapy Staffing Levels at Velindre are at varied levels of resilience across the service. Clinical Oncology: There is one ARSAC Practioner Licence holder in urology and two in gynaecology and this is recognised as position of low resilience. A Speciality Doctor was appointed from Prostate Expansion Business case is currently working with Breast SST Radiotherapy: Not all Brachytherapy Advanced Practioners can cover all tasks required within the section to provide resilient service cross cover. Time demands from DXR administration and treatments conflict with brachytherapy service provision and training. Theatre: One member of the team is currently on long term sick. Return to work due May 2023. Physics: Currently two Brachytherapy MPEs appointed. A recent resignation (April 2023) of a staff member in MPE training and one MPE due to start maternity leave in July 2023 has left the service vulnerable to a future MPE single point of failure. This could lead to service discontinuity.	Performance and Service Sustainability	09/02/2022	572	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 Oncologist in Urology is currently practicing under ARSAC Delegated Authority. Application for an ARSAC Practioner Licence is to be submitted. A locum Consultant Clinical Oncologist was appointed in Nov 2022 is currently in Brachytherapy training. Previous experience in brachytherapy will expedite local training. On completion she may practice under Delegated Authority (September 2023) with the aim to apply for an ARSAC Practioner Licence. Radiotherapy: Four Brachytherapy Advanced Practioners (3.2WTE) were appointed in October 2022 to address lack of resilience within the team. A training schedule for staff is in place to ensure increased resilience from cross cover of tasks. A plan for capacity/demand management and to handover DXR administration tasks to RT is under construction. Timeframe not established. DXR treatments to be handed over with introduction of nVCC. Theatre: Staffing hours have been increased (March 2023) to improve resilience of the service provision. Training plans are under consideration to further increase resilience through cross cover of tasks. Vacant HCA post was filled (March 2023). Physics: A training plan is under implementation to increase the number of Brachytherapy MPE and Registered Clinical Scientists competent to perform MPE duties under written guidelines and supervision. Resourcing this plan has been recognised within Radiotherapy Physics at the highest priority level to ensure a safe and continued service. Future Planning: An options appraisal is to be agreed through the Brachytherapy Operational Group (May-2023) to determine the most appropriate service model to meet forecast demand over a 1 to 5 year period. A workforce paper will be drawn up to staff the model to include resilience and succession planning. A business case will be submitted if required. Staff model completion due September 2023	20	15	15		30/09/2023	30/09/2023	Brachy Workforce	
													14/03/2023	The risk review is overdue	
													28/03/2023	A SMART Action Plan needs to be developed	
													31/07/2023	Insufficient brachy MPE	

ID	Risk Title - New	Risk (in brief)	Risk Type	Opened	Amount of Days Open	Division	RR - Current Controls	Rating (initial)	Rating (current)	Rating (Target)	Expected Date to Reach Target Rating	Review date	Action Plan On target Overdue Complete		Risk Rating Trend
3001	There is a risk to safety as a result of work related stress leading to harm to staff and to service delivery.	There is a risk to safety as a result of work related stress leading to harm to staff and to service delivery. Work related stress is the adverse reaction people have to excessive pressure or other types of demand placed on them. Trust sickness absence figures show mental health issues and stress to be the highest cause of absence from work.	Safety	09/12/2022	269	Corporate Services	People Management Policies and Procedures Infrastructure and resources to support wellbeing Values, behaviours and culture work programmes Leadership development and management training Regular monitoring and analysis of feedback and data This risk is now a standing agenda item at the Healthy and Engaged Steering Group	16	12	9	30/12/2026	31/12/2023	31/03/2024	Divisions/Departments should have proactive stress risk assessments	
													09/12/2022	Formal arrangements not in place for the Healthy and Engaged Steering Group to evaluate wellbeing interventions	
													21/03/2023	This risk needs a SMART action plan	
													22/12/2023	Systemic factors that impact on levels of workforce stress to be described and associated actions plans developed	
													31/03/2024	Develop management training in managing stress	

Data Graphs


RISKS OVER 15
10
9
8
7
6
5
4
3
2
1
0
VCS
WBS
TCS
CORP
TOTAL
3
2
4
0
9


SAFETY RISK RATING 12
1.2
1
0.8
0.6
0.4
0.2
0
VCS
WBS
TCS
CORP
TOTAL
Series1
0
0
0
1
1



	VCS	WBS	TCS	CORP
12	0	0	0	1
15	1	0	3	0
16	1	2	0	0
20	1	1	1	0

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Trust Assurance Framework – Strategic Risk Review

DATE OF MEETING	14.09.2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	DISCUSSION

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

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

EXECUTIVE SUMMARY	A review of the Trust Assurance Framework, including a refresh of the Trust's Principal Strategic Risks has been undertaken. The Strategic Development Committee is requested to endorse for Board approval, the revised Strategic Risks detailed in this report, including any final articulation to facilitate effective operationalisation.

RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee is asked to review the Strategic Risk Refresh and **NOTE**. The Quality, Safety and Performance Committee is asked to **NOTE** the next steps.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board (EMB) Run – By Exception	**31.08.2023**
Strategic Development Committee	**05.09.2023**
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS EMB have been involved in the process via EMB Shape on 18.08.2023, a targeted session on 21.08.2023 and then EMB Run to arrive at the suggested summary of the strategic risk refresh attached to this paper. The Strategic Development Committee discussed the Strategic Risk refresh, endorsing 6 of the 8 strategic risks submitted. Strategic risks reportable to the Strategic Development Committee were endorsed in principle but require further development ahead of Trust Board.	

7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 2 - Symptomatic issues being addressed Symptomatic issues are being addressed**.**

APPENDICES	
1	New Trust Assurance Framework Template

1. SITUATION

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

Suggested Strategic Risks are included in this paper for discussion and noting, ahead of onward submission to committees and Board on the new TAF template, via an automated system.

2. BACKGROUND

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

A review of the TAF dashboard was undertaken in early 2023, with the intention to roll out in April 2023, it became evident that as part of the overall review of the TAF there needed to be a refresh of the Strategic Risks, as these remained relatively unchanged since 2020.

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

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

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

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

The Strategic Risks were discussed at the Strategic Development Committee on 05.09.2023 resulting in endorsement of 6 of the 8 Strategic Risks, including the two risks reportable to the Quality, Safety and Performance Committee.

3. ASSESSMENT

The concluded refresh outcome for consideration by the Quality, Safety and Performance Committee is attached as *Appendix 1*.

Next steps:

- Following endorsement from the Strategic Development Committee the Executive Management Board will have final review of the Strategic Risks. This will include articulation of risks 1 and 7, as well as assessment of the appropriate management of risk 8, detailed in Appendix 1.
- The final Strategic Risk refresh, including operationalisation of the new TAF template will be submitted to the Trust Board on 28.09.2023 for discussion, review and approval.
- The final Strategic Risk refresh will submitted to Audit Committee on 5.10.2023.

4. SUMMARY OF MATTERS FOR CONSIDERATION

The Quality, Safety and Performance Committee are asked to consider and **NOTE** the Strategic Risk Refresh, as detailed in Appendix 1 of this report.

In addition **NOTE** the next steps, both in respect of governance and operationalisation, as detailed in section 3 of this report.

5. IMPACT ASSESSMENT

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

<table>
<tr><td colspan="2">

- 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>Choose an item
All Strategic Risks are related.</td></tr>
<tr><td rowspan="3">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>The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021).

All domains are relevant to this work, as the strategic risks span all areas of the Trust business and are imperative to quality and safety.</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>Click or tap here to enter text.

There are no socio economic impacts linked directly to the current risks in paper.</td></tr>
</table>

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Source of Funding: **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Choose an item** **Scale of Change** Please detail the value of revenue and/or capital impact: **Click or tap here to enter text** **Type of Change** **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT *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 in respect of this paper, however each risk will have an impact assessment where appropriate.

ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

6. RISKS

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

Appendix 1 – Summary of Strategic Risk Refresh

Current "short-hand" Risk Theme	***Current Risk Title***	**Outcome of Recommendation of Review Process**	**Suggested New Risk Title [All to be confirmed with Risk Owners]**	**Suggested New "short-hand" risk theme**	**Risk Owners**	**Oversight Committee**
Demand and Capacity	*Failure to deliver sufficient capacity leading to deterioration in service quality, performance or financial control as a result of capacity or demand planning or the operational service challenges*	• Strategic risk theme should continue • However risk articulation should be broader in terms of service delivery, rather than focus on planning specifically	1. There is a strategic risk of failure to deliver sufficient capacity leading to deterioration in service quality, performance or financial control as a result XXXX *[COB, RH & AP to confirm articulation prior to Trust Board]*	Service capacity	COB, RH, AP	QSPC
Partnership Working/Stakeholder Engagement	*Failure to establish and maintain effective relationships with internal and external stakeholders, and/or align our operational actions or strategic approach with system partners, resulting in confusion, duplication or omissions; threatening collaborative working initiatives; and/or an inability to deliver required change to achieve our medium to long term objectives.*	• The context of this strategic risk has changed articulation • Consider there to be too many different aspects to this, with external and internal partners and stakeholders • Recommendation to refocus on alignment of strategic objectives with our external partners • Separate risk to be considered for patient, donor and community engagement • Staff engagement to be covered in refreshed Organisational Culture risk	2. There is a strategic risk of failure to align our strategic objectives and intent with system partners, including within the health and social care system, third sector and industry partners which could result in an inability to deliver required change to achieve our medium to long term objectives.	Partnership alignment	CJ, JA, NW	SDC
Workforce Planning	*Risk of not having the right staff in right place at right time with right capability, as a result of not having appropriate and effective workforce plan owned in the right place, resulting in deterioration of operational performance, decline in the safety/quality of service provision, threatening financial sustainability and/or impacting our transformation ambitions.*	• Strategic risk theme should continue • However risk articulation should be broader in terms of workforce supply and shape rather than focus on a workforce plan specifically	3. There is a strategic risk of an optimised workforce supply and shape in order to effectively deliver quality services and achieve our medium to long term objectives.	Workforce supply and shape	SM	SDC
Organisational Culture	*Failure to establish effective systems and structures built around shared values and behaviours.*	• Strategic risk theme should continue • However risk articulation should be broader in terms of staff engagement rather than focus on	4. There is a strategic risk of failure to have a positive working environment and high levels of staff engagement through the embedding of appropriate	Organisational Culture	SM	SDC

		values and behaviours specifically	values and behaviours in effective systems and processes.			
Organisational Change/ Strategic Execution Risk	*Risk that aggregate levels of organisational change underway across the Trust creates uncertainty and complexity, leading to a disruption to business as usual (BAU) operations; an adverse impact on our people/culture; deterioration or an unacceptable variation in patient/donor outcomes; and/or a failure to deliver on our strategic objectives and goals.*	• Recommendation to remove risk as a duplication	-	-	-	-
Quality and Safety	*Trust does not currently have cohesive and fully integrated Quality & Safety mechanisms, systems, processes and datasets including ability to on mass learn from patient feedback i.e. patient / donor feedback / outcomes / complaints / claims, incidents and ability to gain insight from robust triangulated datasets and to systematically demonstrate the learning, improvement and that preventative action has taken place to prevent future donor / patient harm. This could result in the Trust not meeting its national and legislative responsibilities (Quality & Engagement Bill (2020)) and a reduction in public/patient/donor, external agency, regulator and commissioner confidence in the quality of care the Trust provides.*	• Recommendation to remove risk as a duplication	-	-	-	-
Digital Transformation – failure to embrace new technology	*Risk that the Trust fails to sufficiently consider, exploit and adopt new and existing technologies (i.e., assess the benefits, feasibility and challenges of implementing new technology; implement digital transformation at scale and pace; consider the requirement to upskill/reskill existing employees and/or we*	• Strategic risk theme should continue • Additional aspects considered during review process, including Artificial Intelligence and Information Security • Risk articulation should be narrowed in other respects, as a duplication	5. There is a strategic risk that the Trust fails to sufficiently consider, optimise the opportunities and effectively manage the risks of new and existing technologies, including considerations of Artificial Intelligence and Information Security	Digital transformation	CJ	SDC

	underestimate the impact of new technology and the willingness of patients to embrace it/ their increasing expectation that their care be supported by it) compromising our ability to keep pace and be seen as a Centre of Excellence.					
Trust Financial Investment Risk	*There is a risk that the contracting arrangements between Velindre and its Commissioners do not adequately acknowledge future service developments and changes in clinical practices and thus ensure appropriate funding mechanisms are in place and agreed.*	• Recommendation to remove risk as a duplication	-	-	-	-
Future Direction of Travel	*Opportunity risk of the Trust's ability to develop new services and failure to take up and create opportunities to apply expertise and capabilities elsewhere in the healthcare system.*	• Recommendation to remove risk as a duplication	-	-	-	-
Governance	*There is a risk that the organisation's governance arrangements do not provide appropriate mechanisms for the Board to sufficiently fulfil role and the organisation to then be effectively empowered to deliver on the shaping strategy, culture and providing assurance, particularly through a quality and safety lens.*	• Strategic risk theme should continue • However risk articulation should be broader in terms of governance definition (not only Board)	6. There is a strategic risk that the organisational and clinical governance arrangements do not provide appropriate mechanisms and culture to achieve our medium to long term objectives.	Organisational and clinical governance	LF	AC
-	-	• Recommendation is that there is a new strategic risk regarding Patient Outcomes • Although it is recognised that many other strategic risks would impact on patient outcomes, it is recommended to articulate in a consolidated risk • Additional considerations as part of refresh process to be included, including: Advances in Medicine; Technical clinical care advances; Aging population; Pandemic 2; Deliver national clinical guidance	7. *To confirm articulation prior to Trust Board*	Patient Outcomes	JA, NW, COB	QSPC

-	-	• Recommendation is that there is a new strategic risk regarding patient, donor and community engagement	8. There is a strategic risk that patient, donor and community engagement arrangements do not provide appropriate mechanisms and culture to achieve our medium to long term objectives	Engagement	LF, AP	SDC

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

WORKFORCE SUPPLY AND SHAPE & ASSOCIATED FINANCE RISKS

DATE OF MEETING	14th September 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	INFORMATION / NOTING
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Susan Thomas, Deputy Director of W&OD Chris Moreton, Deputy Director of Finance
PRESENTED BY	Susan Thomas, Deputy Director of W&OD
APPROVED BY	Sarah Morley, Executive Director of Organisational Development & Workforce
EXECUTIVE SUMMARY	The workforce challenges in Velindre are centered around the Supply and Shape of the workforce. The availability (**Supply**) of the right workforce in the right place with the right skills and the need to move away from traditional staffing models to deliver a changing service requires a different **shape** to the workforce. This will require finance to be allocated across different teams and different staff groups. The purpose of this report is to highlight the key integrated actions the Trust is taking to address the challenges, to ensure risk mitigation and performance improvement. The

	associated financial risk of supply issues is also noted in this paper.

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

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date n/a**
Executive Management Board	(31/08/2023)
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS N/A	

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

APPENDICES	
	No Appendices

1. SITUATION/BACKGROUND

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

report is to highlight the key integrated actions the Trust is taking to address the challenges, to ensure risk mitigation and performance improvement. The associated financial risk of supply issues is also noted in this paper.

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

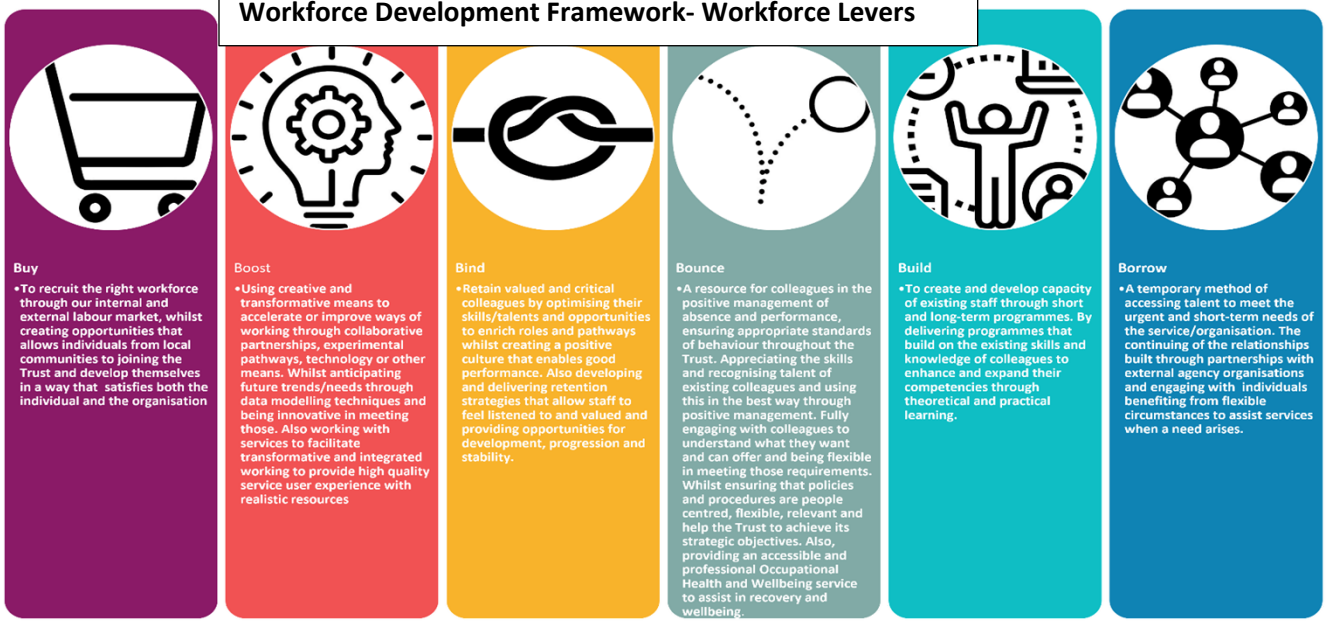
The framework includes a series of workforce levers – (see figure 1) to ensure we plan, recruit, retain, skill and develop our workforce and manage the health and engagement of our staff effectively to ensure we are the employer of choice, meeting the commitments laid out in our people strategy. This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

2. ASSESSMENT/ SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Quarterly update: Workforce Development Framework Actions and Outputs

Using the structure of the workforce development framework the table below highlights the workforce hotspot areas against the workforce levers (what we are doing to Buy, Boost, Build, Bounce, Bind and Borrow our workforce). Interventions, timescales and outputs are articulated.

Workforce Development Framework- Workforce Levers



WP Activity	Hotspot areas	Actions	Timelines	Outputs
Buy/Build	**Recruitment**	Develop marketing / brand attraction campaign for Trust Welsh language focus	*October 2023*	• VCC careers page / targets job videos • Trust wide marketing campaign video showcasing the strategy and values of the Trust

WP Activity	Hotspot areas	Actions	Timelines	Outputs
	Widening access	Widening Access Programme	*Up to December 2023*	• Engagement with local schools/collages on career options within the Trust • Signed the agreement to take Nursing Cadets on placement • Disability Confident Level 2 renewed to set benchmark for how to support people with disabilities to join our workforce • Signed the agreement to support Army veterans coming into the workplace • Links with Centre for Learning and School of Oncology work

WP Activity	Hotspot areas	Actions	Timelines	Outputs
Boost	**Work plans: Radiotherapy Satellite Unit at NHH**	Focus on building, construction and contract.	*December 2024*	The Radiotherapy Satellite Unit Project has been formally accepted into Velindre Futures Major Programme Boards. Workstreams are being defined and a collaborative approach with workforce and PM teams to assess joint working is underway
	Neville Hall Cancer Unit – SACT OUTREACH	Discussions ongoing between Trust and HB	*TBC*	Discussions with ABUHB on governance of the programme and collaborative working has been held and arrangements are now agreed. First joint meeting between VCC and AB has been completed. Ongoing discussion with HBs is progressing and a final agreement as to approach will be concluded. A planning event will be held in September to re-scope the collaborative arrangements for the

WP Activity	Hotspot areas	Actions	Timelines	Outputs
				Cancer Unit at Nevill Hall.
	TrAMS	All Wales service provisions	*TBC*	All Wales service for pharmacy technical services. A paper has been circulated from NWSSP highlighting issues with the budget and timescales. OCP1 completed and delays in OCP2 being implemented due to programme delays and no service model in place.
Bind	**Retention**	All Wales Nurse Retention Work stream	*September 2023*	• Develop standard retention toolkit for NHS Wales • Understand the retention issues though exit process analysis • Implement 'pre-exit' interview process
		Corporate Induction Review	*Completed*	Induction Programme upgraded and launched

WP Activity	Hotspot areas	Actions	Timelines	Outputs
Bounce	**Wellbeing**	Occupational Health and Employee Assistance Programme	*Healthy and Engaged work plan to September 2023*	• Fatigue and Facilities Charter for Medical Staff has been adopted and all arrangements put in place to meet the criteria. • Healthshield payment plan introduced to support staff with health costs • Complementary Therapies provided to staff via Cardiff Met • Menopause cafes established • Cancer support network for staff
		Staff Engagement		• Review of feedback on staff experience and values and culture shared with EMB • Black History Month and British Sign Language Week celebrated • Equality Impact Assessment

WP Activity	Hotspot areas	Actions	Timelines	Outputs
				process updated and Toolkit published on intranet
Borrow	See below financial information on agency spend- page 7			

The above framework is operationally managed and progressed via the Healthy and Engaged Steering Group and the Education Steering Group. Both these operational groups meet quarterly and monitor workforce and OD developments in support of the People Strategy. This includes how we commission CPD and pre-registration training with HEIW, in reference to wellbeing, Equality Diversity & Inclusion and Workforce Planning.

2.2 Quarterly update: The associated financial risk to Workforce Supply and Shape

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

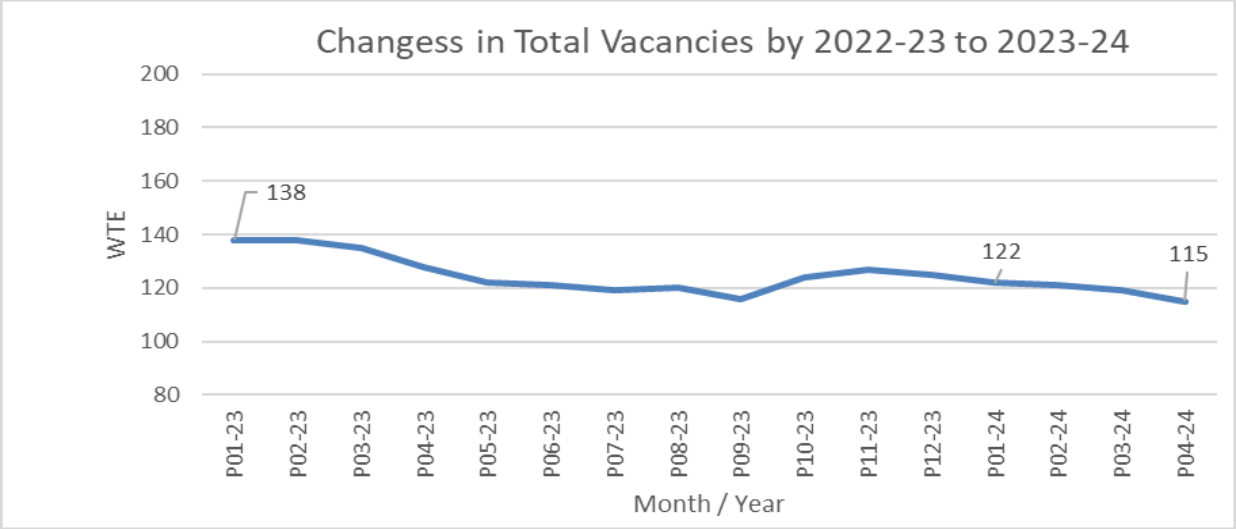
Pay Budget 2023/24

The full year pay budget as at end of July 2023 is £82.74m based on 1,595 WTE. The Trust has reported cumulative year to date spend of £28.698m on pay against a budget of 28.905.m resulting in an underspend of £0.207m as at July 2023. The pay costs include the costs of agency staff, on-call and overtime.

As at July 2023, the current staff in post is 1,480 WTE. The number of vacancies is 115 WTE, which represents a vacancy rate of 7.2%. The vacancy gap is largely being met by the use of agency staff or overtime and is also supporting the Divisional vacancy factor saving target.

Vacancies throughout the Trust remain high, however last year significant improvement was made through targeted recruitment interventions in SACT (in VCC and outreach), reducing the Nursing and HCSW vacancies. Ongoing recruitment interventions are being

assessed for SACT nursing. The reduction in vacancies can be seen in the historic trend as demonstrated in the chart below which covers from April 2022 to July 2023:



The service is exploring workforce and service redesign with the intention to take forward some fundemental changes that will enable a more efficient and productive service.

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

Pay Award

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

3. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☒ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☒ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	03 - Workforce Planning
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required

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

4. RISKS

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

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

QUALITY, SAFETY & PERFORMANCE COMMITTEE

FINANCE REPORT FOR THE PERIOD ENDED 31ST JULY (M4)

DATE OF MEETING	14/09/2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Choose an item
REPORT PURPOSE	INFORMATION / NOTING
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Steve Coliandris – Head of Financial Planning & Reporting / Chris Moreton Deputy Director of Finance
PRESENTED BY	Matthew Bunce, Executive Director of Finance
APPROVED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SUMMARY	The attached report outlines the financial position and performance for the period to the end of July 2023.
RECOMMENDATION / ACTIONS	**QSP** is asked **NOTE** the contents of the July 2023 financial report and in particular the yearend financial performance which at this stage is reporting a **breakeven** position.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
EMB Run	31/08/2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The finance paper was noted at EMB Run on the 31/08/2023	

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

APPENDICES	
	Trust Finance Report - July 2023
Appendix 1	Velindre - WG Monthly Monitoring Return (MMR) letter – July 2023
Appendix 2	Velindre Core – WG Monthly Monitoring Return (MMR)
Appendix 3	TCS Finance Report – July 2023 (to follow)

1. SITUATION/ BACKGROUND

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

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

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 . Performance against Key Financial Targets:

	Unit	Current Month £m	Year to date £m	Year End Forecast £m
Revenue	Variance	0.002	0.004	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	4.477	10.330	26.259
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	98.2%	98.4%	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 July'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.

NHS Wales Financial Pressures

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

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

Title	In year 2023/24 financial impact £m	Description of Option / Choice
VCS Contract Protection	1.250	The Trust will work with Commissioners to assess the opportunity to relinquish the LTA income protection which was agreed as part of the LTA/ SLA with the Trust Commissioners. This would reduce the costs of VCS services for the Trust's Commissioners providing a contribution towards the wider deficit reduction of c£1.250m across all LHBs.
Energy	0.436	The latest energy forecast position for 2023-24 from NWSSP suggests that as at month 4 there is a reduction of c£0.436m from the forecast presented at the IMTP planning stage. The range of savings that will be available will be depended on forecast wholesale prices which are provided by the supplier and led by NWSSP as part of the all Wales Energy Group, however expectation is that an opportunity will arise that can be released to support the NHS deficit.
Review Utilisation of Reserves and Commitments (Inc Emergency Reserve)	TBC	Review of third year of investment strategy for corporate infrastructure to support the delivery of front line services.
Medicines Management	TBC	The Trust continues to work with NWSSP Medicines Unit to evaluate the use of generics / biosimilars which could deliver potential savings to our Commissioners. The savings passed through to Commissioners will be net of any internal resource costs required to deliver the change.
Total	**1.686**	

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

2.3 Savings

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

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

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

2.4 PSPP Performance

PSPP performance for the whole Trust is currently 98.1% against a target of 95%, with the performance against the Core Trust excluding NWSSP currently achieving a target of 98.4% as at the end of July.

2.5 Covid Expenditure

Covid Programme Costs

In line with the WG approval letter the Trust is at present only expecting to draw funding from WG towards PPE costs with current forecast for 2023/24 reduced to £0.134m.

Covid Recovery and Planned Care Capacity

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

2.6 Reserves

The financial strategy for 2023-24 facilitated the development of a recurrent and non-recurrent reserve in support of the Trust transformation and delivery agenda. These reserves could only be accommodated on the basis that all income expectations are received, planned savings schemes delivered and new emerging cost pressures managed. In addition, the Trust holds an emergency reserve of £0.522m.

A review of reserves and commitments is currently underway in response to the letter received from Judith Paget with a request to support the overall NHS Wales Deficit.

2.7 **Financial Risks**

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

DHCR – Risk 1.500m / Likelihood – Medium

The Digital Health Care Record system was implemented in 2022/23. However, there have been challenges in the operational use and accurate data capture within the system. This means that activity data is not being fully captured and consequently Commissioners are not being charged based on the correct activity levels. The VCS operational team have reviewed the situation and put in place plans to address the issues. However, if these plans do not resolve the data capture issue there is a risk that c£1.500m income related to unrecorded activity could be lost.

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

2.8 Capital

All Wales Programme

Capital funding has not been allocated to the nVCC Project with costs being incurred due to the delay of Financial Close. This risk is being mitigated by a request to WG for funding for the Project with latest forecast being c£1.8m as at the end of July.

Other than the nVCC Project 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.

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

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

3. IMPACT ASSESSMENT

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

SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	**Choose an item**
	N/A. **Click or tap here to enter text**
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	If more than one Well-being Goal applies please list below:
	N/A
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	The Trust reported a financial position of **£0.004m** for July'23 which is in line with the IMTP
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	There is no requirement for this report.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	N/A

4. RISKS

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

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

WHAT IS THE RISK?	N/A
WHAT IS THE CURRENT RISK SCORE	N/A
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	N/A
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	N/A
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Choose an item
	N/A
All risks must be evidenced and consistent with those recorded in Datix	

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 JULY 2023/24

QUALITY, SAFETY & PERFORMANCE COMMITTEE
14/09/2023

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.

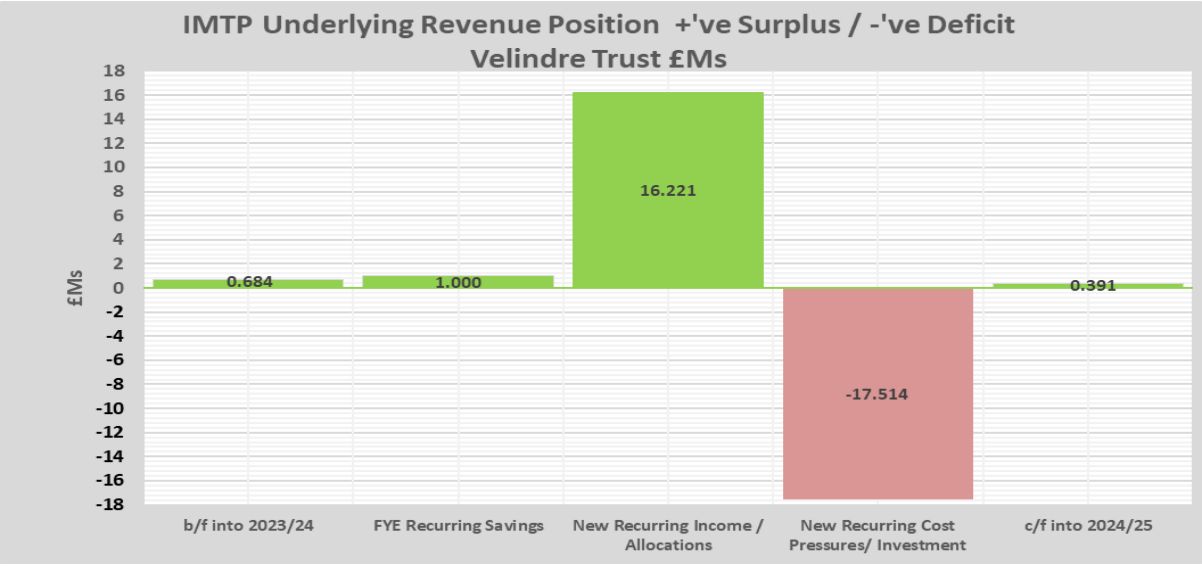
- The Trust submitted a balanced three year IMTP, covering the period 2023-24 to 2025-26 to Welsh Government on the 31 March 2023.

- 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	0.002	0.004	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	4.477	10.330	26.259
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	98.2%	98.4%	95.0%

Performance against Planned Savings Target

	Unit	Current Month £m	Year to date £m	Year End Forecast £m
Efficiency / Savings	Variance	(0.041)	(0.012)	0.000

Revenue

The Trust has reported a **£0.002m** in-month underspend position for July'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 July 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 July'23 of £10.333m 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**

Capital funding has not been allocated to the nVCC Project with costs being incurred due to the delay of Financial Close. This risk is being mitigated by a request to WG for funding for the Project with latest forecast being c£1.8m.

PSPP

During July '23 the Trust (core) achieved a compliance level of **98.2%** of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **98.4%** as at the end of month 4, and a Trust position (including hosted) of **98.1%** compared to the target of 95%.

Efficiency / Savings

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

Revenue Position

Cumulative				Forecast		
£0.004m Underspent				Breakeven		
Type	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)	Full Year Budget (£m)	Full Year Forecast (£m)	Forecast Variance (£m)
Income	(61.761)	(62.317)	0.556	(191.458)	(191.458)	0.000
Pay	28.905	28.698	0.207	82.774	82.774	0.000
Non Pay	34.029	34.788	(0.759)	108.684	108.684	0.000
Total	**1.173**	**1.169**	**0.004**	**0.000**	**0.000**	**0.000**

The overall position against the profiled revenue budget to the end of July 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 revised planned savings targets are achieved, and that all financial risks are mitigated during 2023-24.

4.1 Revenue Position Highlights / Key Issues

NHS Wales Financial Pressures

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

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

Title	In year 2023/24 financial impact £m	Description of Option / Choice
VCS Contract Protection	1.250	The Trust will work with Commissioners to assess the opportunity to relinquish the LTA income protection which was agreed as part of the LTA/ SLA with the Trust Commissioners. This would reduce the costs of VCS services for the Trust's Commissioners providing a contribution towards the wider deficit reduction of c£1.250m across all LHBs.
Energy	0.436	The latest energy forecast position for 2023-24 from NWSSP suggests that as at month 4 there is a reduction of c£0.436m from the forecast presented at the IMTP planning stage. The range of savings that will be available will be depended on forecast wholesale prices which are provided by the supplier and led by NWSSP as part of the all Wales Energy Group, however expectation is that an opportunity will arise that can be released to support the NHS deficit.
Review Utilisation of Reserves and Commitments (Inc Emergency Reserve)	TBC	Review of third year of investment strategy for corporate infrastructure to support the delivery of front line services.
Medicines Management	TBC	The Trust continues to work with NWSSP Medicines Unit to evaluate the use of generics / biosimilars which could deliver potential savings to our Commissioners. The savings passed through to Commissioners will be net of any internal resource costs required to deliver the change.
Total	**1.686**	

Underlying Position

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

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

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

Income Highlights / Key Issues

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

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

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

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

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.

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

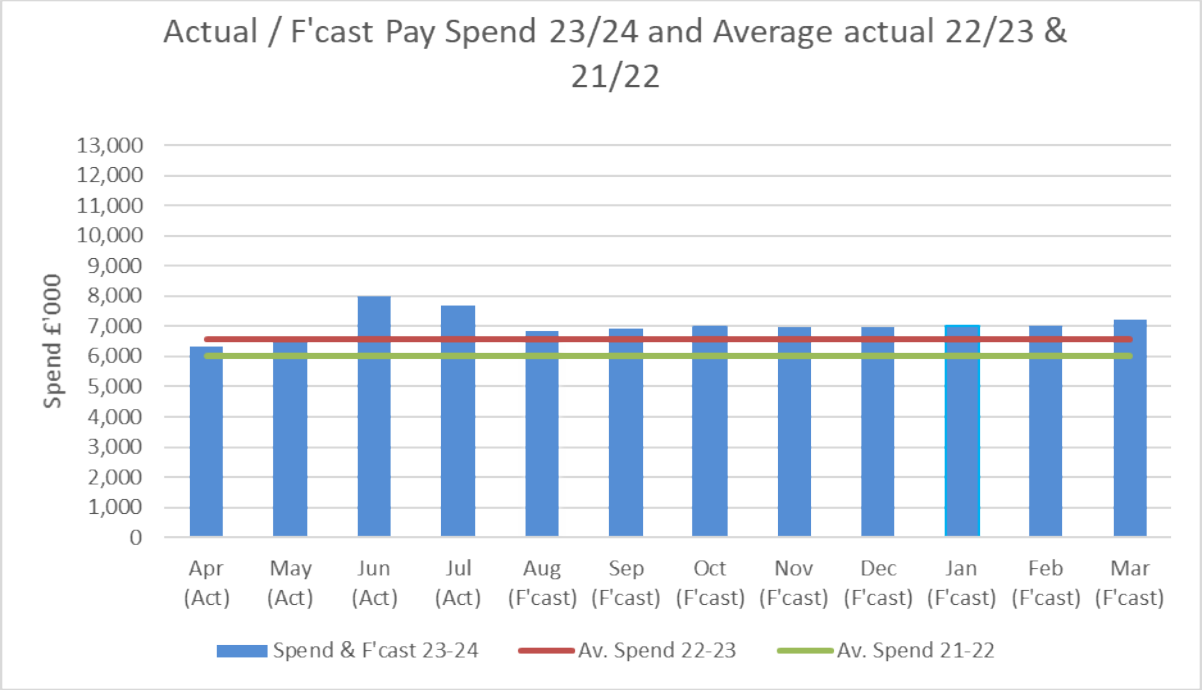
Non Pay Key Issues

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

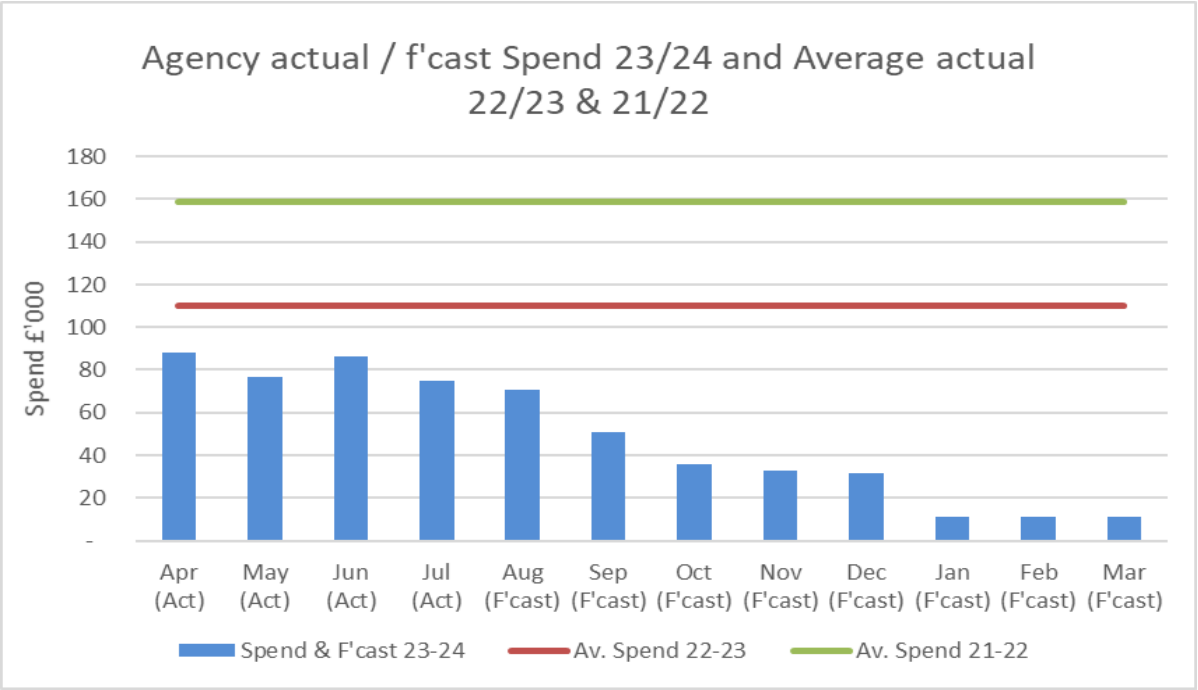
The Trust reserves and previously agreed unallocated investment funding is currently under review following the letter received from Judith Paget with a request to support the overall NHS Wales Deficit. The budget for the reserves is held in month 12 and will be released into the position to match agreed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

4.2 Pay Spend Trends (Run Rate)

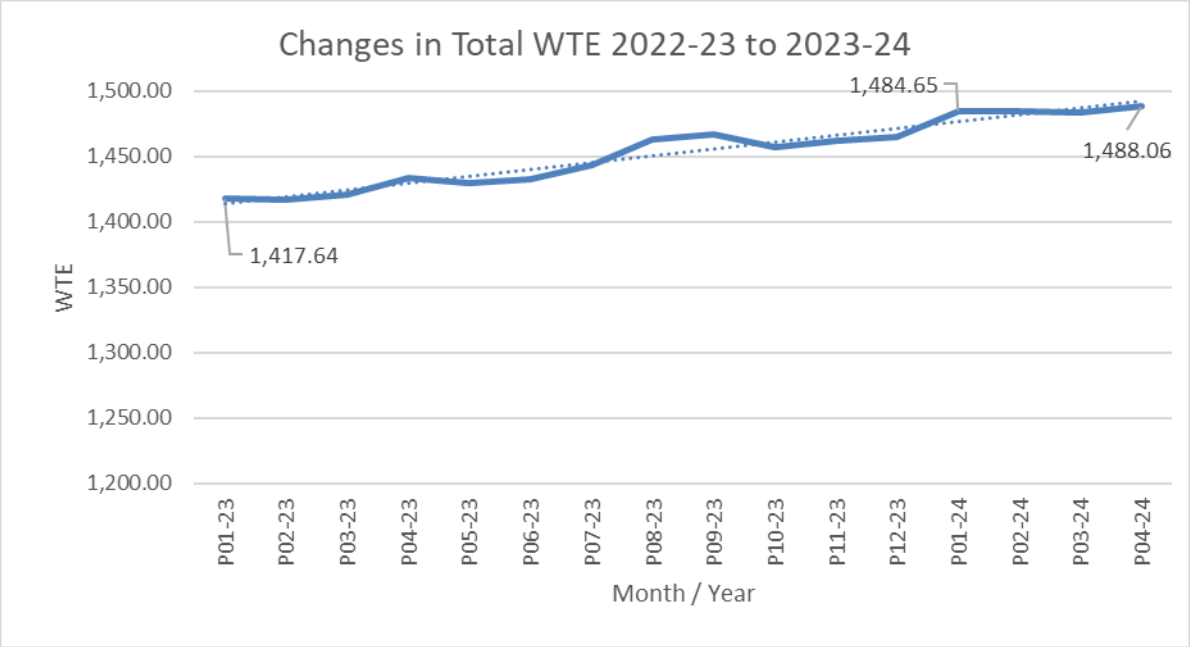
Per the IMTP the Trust is aiming to decrease the use of agency during 2023-24 by recruiting staff required on a permanent basis. At this stage of the year we are still expecting to transition the Radiotherapy, Medical Physics and Estates staff into substantive positions within the Trust which is following 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.

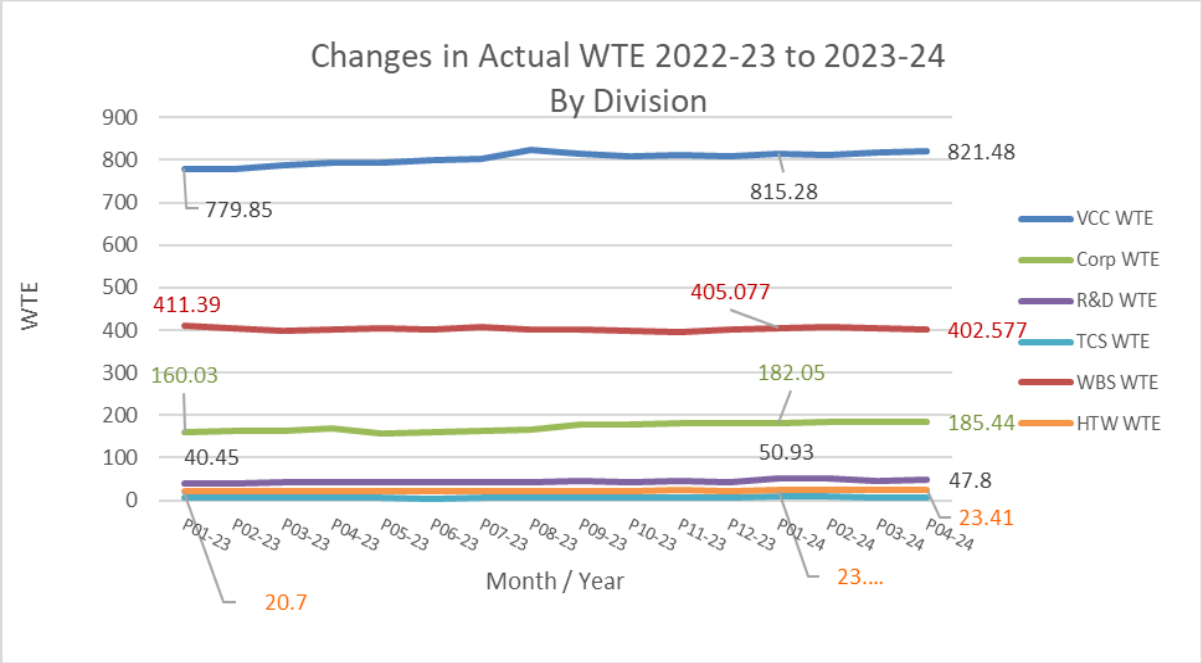


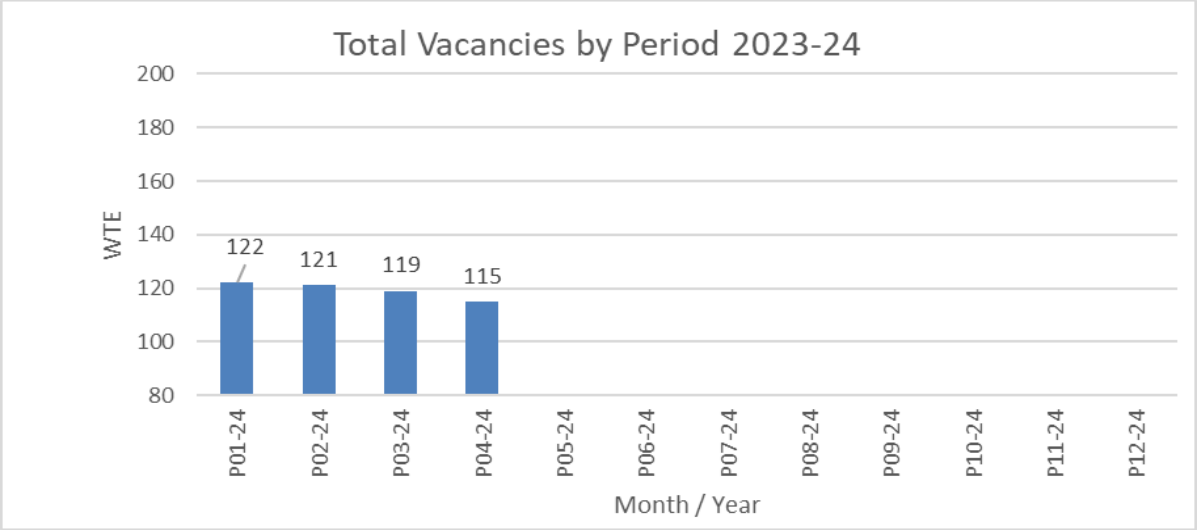
*The spike in pay during June relates to the non-consolidated recovery pay award.
*The Spike in pay during July relates to the 5% consolidated pay award backdated to April 2023.



The spend on agency for July'23 was **£0.075m,** which gives a cumulative year to date spend of £0.325m and a current forecast outturn spend of circa **£0.580m** (£1.323m 2022/23).


Changes in Total WTE 2022-23 to 2023-24
1,500.00
1,450.00
1,400.00
1,350.00
1,300.00
1,250.00
1,200.00
WTE
1,484.65
1,488.06
1,417.64
P01-23
P02-23
P03-23
P04-23
P05-23
P06-23
P07-23
P08-23
P09-23
P10-23
P11-23
P12-23
P01-24
P02-24
P03-24
P04-24
Month / Year

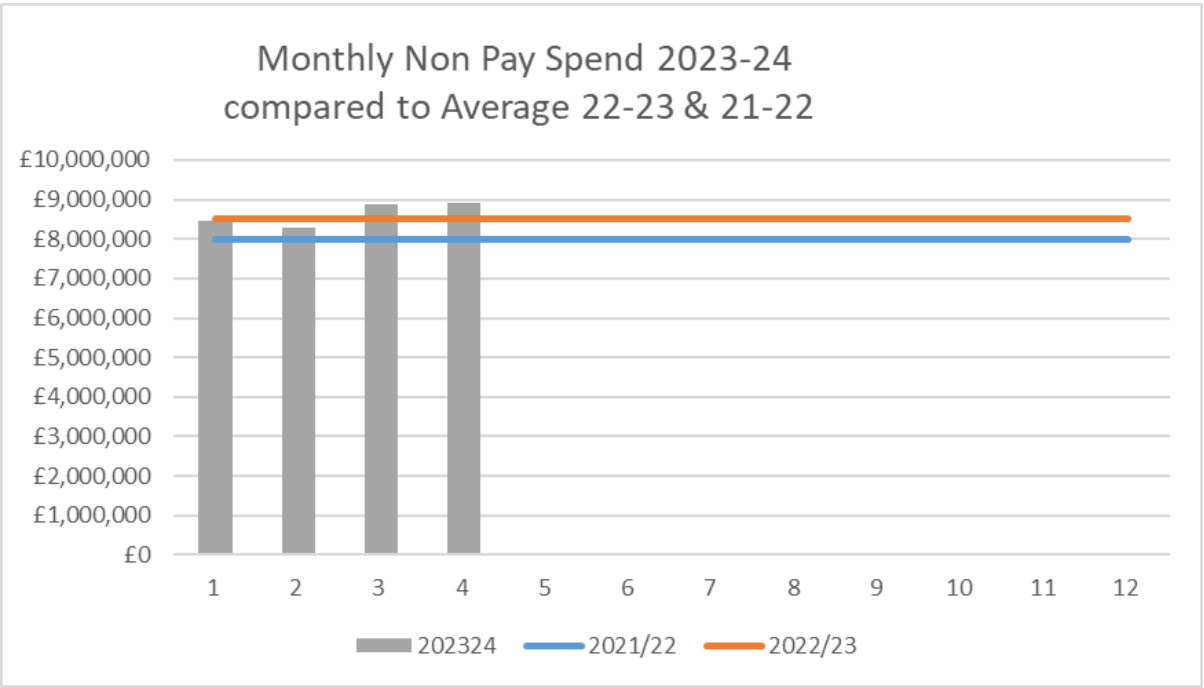

Changes in Actual WTE 2022-23 to 2023-24
By Division
900
800
700
600
500
400
300
200
100
0
WTE
821.48
815.28
779.85
411.39
405.077
402.577
160.03
182.05
185.44
40.45
50.93
47.8
23.41
20.7
23....
VCC WTE
Corp WTE
R&D WTE
TCS WTE
WBS WTE
HTW WTE
Month / Year



The total Trust vacancies as at June 2023 is 119wte, VCC (76wte), WBS (25wte), Corporate (9wte), R&D (3wte), TCS (0wte) and HTW (2wte).

4.3 Non Pay

The average monthly spend for 2022-23 was £8.5m which was £0.5m higher than the reported monthly average spend for 2021-22. Most of the monthly average increase related to the WBS wholesaling costs, along with the growth in energy costs and general inflation. Average non-pay spend so far for 2023/24 is £8.6m per month which is a slight increase from the previous whole year average. Largest movement is in drug spend which has increased by £1.4m ytd, or £0.3m average per month when compared with the previous year's spend for the same period. Energy costs have decreased by £0.146m ytd.



4.4 Covid-19

Covid Programme Costs

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

At present the Trust is only expecting to draw funding from WG towards PPE costs with the forecast requirement for 2023/24 as at July 23 being £0.134m, which is a reduction of £0.106m from the £0.240m requested as part of the IMTP. However, whilst unlikely 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

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

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

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

4. Savings

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

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

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

Failure to enact several recurrent savings schemes and replacing with those that are non-recurrent in nature has reduced the underlying position to be carried into 2024-25 from £0.391m to a latest position of £0.086m.

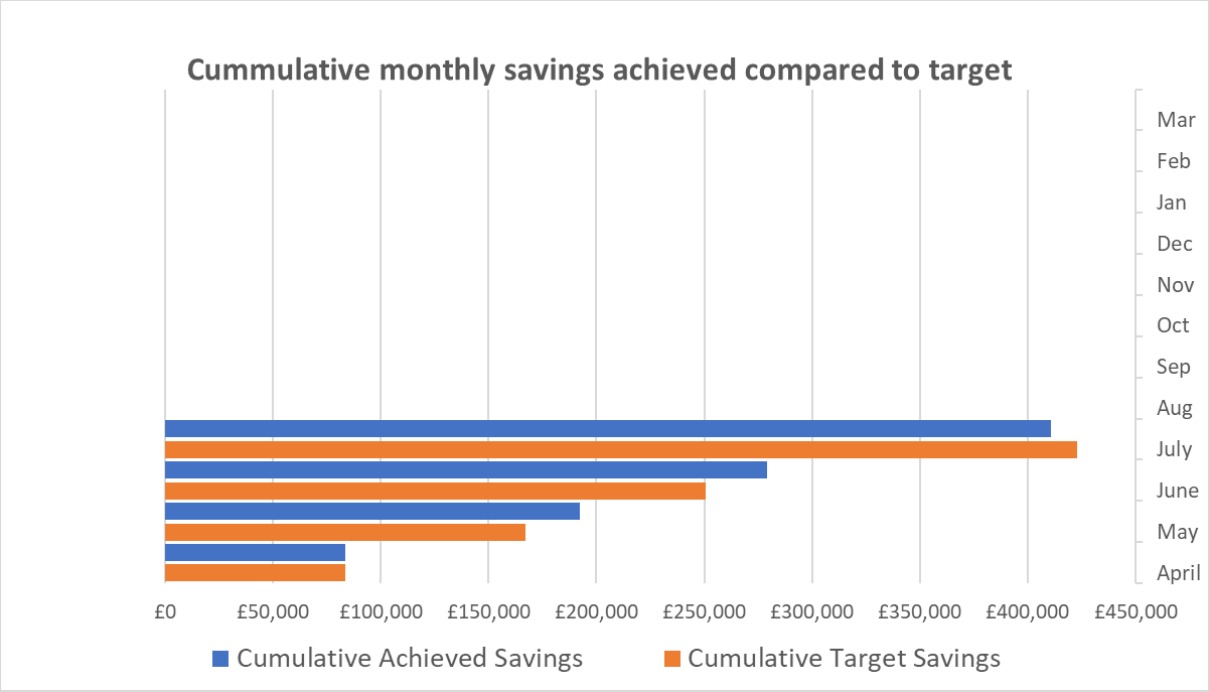
Service redesign and supportive structures continues to be a key area for the Trust which is about focusing on finding efficiencies in the ways that we are working. Whilst this remains a high priority the ability to enact change has been challenging due to both the high level of vacancies and sickness.

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

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

ORIGINAL PLAN	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	F'cast Full Year £000	F'cast Variance Full Year £000
VCS TOTAL SAVINGS	**950**	**211**	**237**	**26**	**950**	**0**
			112%		**100%**	
WBS TOTAL SAVINGS	**700**	**162**	**124**	**(38)**	**700**	**0**
			77%		**100%**	
CORPORATE TOTAL SAVINGS	**150**	**50**	**50**	**0**	**150**	**0**
			100%		**100%**	
TRUST TOTAL SAVINGS IDENTIFIED	**1,800**	**423**	**411**	**(12)**	**1,800**	**0**
			97%		**100%**	

Scheme Type	RAG RATING	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	F'cast Full Year £000	F'cast Variance Full Year £000
Savings Schemes							
Establishment Control (N/R) (Corporate)	Green	75	25	25	0	75	0
Procurement Supply Chain (R) (WBS)	Red	100	11	0	(11)	0	(100)
Collection Team Costs Reduction (R) (WBS)	Green	10	3	3	0	10	0
Collection Team Costs Reduction (NR) (WBS)	Green	8	3	3	0	8	0
Establishment Control (R) (WBS)	Green	60	20	20	0	60	0
Reduced use of Nitrogen (R) (WBS)	Red	55	6	0	(6)	0	(55)
Reduced Research Investment (R) (WBS)	Green	25	8	0	(8)	25	0
Stock Management (NR) (WBS)	Green	125	42	42	0	125	0
Reduced Transport Maintenance (NR) (WBS)	Amber	30	3	0	(3)	30	0
Demand Planning - Volume Driven Benefits (NR) (WBS)	Amber	137	15	0	(15)	137	0
Service Workforce Re-design (R) (VCS)	Red	50	6	0	(6)	0	(50)
Establishment Control (NR) (VCS)	Green	175	19	45	26	175	0
Non Pay Controls - Rationalisation of Service (NR) VCS	Amber	150	17	17	0	150	0
Reduction in use of Agency - Radiation Services (R) (VCS)	Green	125	42	42	0	125	0
Reduction in use of Agency - Radiation Services (NR) (VCS)	Green	50	17	17	0	50	0
Procurement Supply Chain (R) (VCS)	Red	100	11	0	(11)	0	(100)
Total Saving Schemes		**1,275**	248	213	(35)	970	(305)
Income Generation							
Bank Interest (R) (Corporate)	Green	75	25	25	0	75	0
Sale of Plasma (R) (WBS)	Green	150	50	50	0	150	0
Expand SACT Delivery (R) (VCS)	Green	200	67	67	0	200	0
Private Patient Income (R) (VCS)	Green	50	17	17	0	50	0
Private Patient Income (N/R) (VCS)	Green	50	17	17	0	50	0
NEW Medicines at Home (N/R) (VCS)	Green		0	17	17	150	150
NEW Sale of Plasma (NR) (WBS)	Green		0	6	6	155	155
Total Income Generation		**525**	175	198	23	830	305
TRUST TOTAL SAVINGS		**1,800**	**422**	**411**	**(12)**	**1,800**	**0**
				97%		**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.

As highlighted earlier a review of reserves and commitments is currently underway in response to the letter received from Judith Paget with a request to support the overall NHS Wales Deficit.

6. End of Year Forecast / Risk & Opportunities Assessment

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

.

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

Risks

DHCR activity data income risk – *Risk £1.500m / Likelihood – Medium*

The Digital Health Care Record system was implemented in 2022/23. However, there have been challenges in the operational use and accurate data capture within the system. This means that activity data is not being fully captured and consequently Commissioners are not being charged based on the correct activity levels. The VCS operational team have reviewed the situation and

put in place plans to address the issues. However, if these plans do not resolve the data capture issue there is a risk that c£1.500m income related to unrecorded activity could be lost.

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 2024/25 – *Risk £0.935m / Likelihood - Medium*

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

Opportunities

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

Recovery and Planned Care Capacity- *Opportunity / Likelihood - Medium*

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

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

Vacancy Turnover – (Low)

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

Contract Currency Review – (low)

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

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

7. CAPITAL EXPENDITURE

Administrative Target

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

	Approved CEL £m	YTD Spend £m	Committed Orders Outstanding £m	Budget Remaining @ M4 £m	Full Year Foreast Spend £m	Forecast Year End Variance £m
All Wales Capital Programme						
nVCC - Enabling Works	10.896	7.522	0.000	3.374	10.896	0.000
nVCC - Project costs	0.000	0.938	0.000	(0.938)	1.843	(1.843)
Integrated Radiotherapy Solutions (IRS)	10.326	1.806	0.000	8.520	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	10.266	0.000	12.467	24.576	(1.843)
Discretionary Capital	1.683	0.067	0.000	1.616	1.683	0.000
Total	24.416	10.333	0.000	14.083	26.259	(1.843)

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

Capital funding has not been allocated to the nVCC Project with costs being incurred due to the delay of Financial Close. This risk is being mitigated by a request to WG for funding for the Project with latest forecast being c£1.8m as at the end of June.

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

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

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

Performance to date

The actual expenditure to July 2023 on the All-Wales Capital Programme schemes was £10.266m, this is broken down between spend on the nVCC enabling works £7.522m, nVCC Project Costs £0.938. and the IRS £1.806m.

Spend to date on Discretionary Capital is currently £0.067m.

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. The financial year cashflows for the IRS and IRS Satellite projects require re-profiling due to delays in the nVCC project and RSC project. This is currently being worked on. The TCS nVCC cash flows will also be revised due to the n VCC project delays for inclusion in the final FBC. The schemes included within the IMTP are provided below:

All Wales Approved and Unapproved Capital Schemes	2023-24 £m	2024-25 £m	2025-26 £m	2026-27 £m	Further Years £m	Total All Wales Schemes £m
All Wales Approved Schemes						
TCS nVCC enabling works	10.896	0.000	1.547			12.443
Integrated Radiotherapy Solution (IRS)	10.326	14.697	6.150			31.173
IRS Satellite Centre	1.347	10.065				11.412
Digital Priority Fund - WHIAS Project	0.167					0.167
Total Approved Capital Schemes	**22.736**	**24.762**	**7.697**	**0.000**	**0.000**	**55.195**
All Wales Unapproved Schemes						
TCS nVCC	7.168	34.132	7.147			48.447
TCS nVCC Enabling works	1.000					1.000
WBS HQ	0.120	1.016	12.808	9.996	10.961	34.901
Plasma Fractionation (under development)						0.000
WBS Fleet Replacement		1.400				1.400
WTAIL Lims Case	0.826	0.066				0.892
WBS Blood Establishment Computer System (BECS) (under development)						0.000
WBS Blood Group Analyser Replacement		0.480				0.480
WBS Asset Replacement		0.300	0.400	0.500		1.200
VCC Replacement Brachytherapy Applicators			0.300			0.300
Digital Services	0.650	0.400	0.400	0.400		1.850
Digital 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 in NHS Financial Statements is known as the Statement of Financial Position (SoFP). It provides a snapshot of the Trust's financial position including the hosted divisions at a point in time.

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

	Opening Balance Beginning of Apr 23	Closing Balance End of Jul-23	Movement from 1st April Jul-23	Forecast Closing Balance End of Mar 24
Non-Current Assets	**£'m**	**£'m**	**£'m**	**£'m**
Property, plant and equipment	170.418	181.304	10.886	181.304
Intangible assets	11.194	11.262	0.068	11.262
Trade and other receivables	1,111.634	1,111.822	0.188	1,111.822
Other financial assets	0.000	0.000	0.000	0.000
Non-Current Assets sub total	1,293.246	1,304.388	11.142	1,304.388
Current Assets				
Inventories	34.070	34.035	(0.035)	34.035
Trade and other receivables	565.641	551.807	(13.834)	536.482
Other financial assets	0.000	0.000	0.000	0.000
Cash and cash equivalents	31.136	11.936	(19.200)	27.261
Non-current assets classified as held for sale	0.000	0.000	0.000	0.000
Current Assets sub total	630.847	597.778	(33.069)	597.778
TOTAL ASSETS	1,924.093	1,902.166	(21.927)	1,902.166
Current Liabilities				
Trade and other payables	(226.254)	(208.206)	18.048	(208.206)
Borrowings	(1.123)	0.00	1.123	0.00
Other financial liabilities	0.00	0.00	0.000	0.00
Provisions	(392.525)	(432.194)	(39.669)	(432.194)
Current Liabilities sub total	(619.902)	(640.400)	(20.498)	(640.400)
NET ASSETS LESS CURRENT LIABILITIES	1,304.191	1,261.766	(42.425)	1,261.766
Non-Current Liabilities				
Trade and other payables	(3.092)	(7.336)	(4.244)	(7.336)
Borrowings	(2.421)	0.00	2.421	0.00
Other financial liabilities	0.00	0.00	0.000	0.00
Provisions	(1,113.507)	(1,069.027)	44.480	(1,069.027)
Non-Current Liabilities sub total	(1,119.020)	(1,076.363)	42.66	(1,076.363)
TOTAL ASSETS EMPLOYED	185.171	185.403	0.232	185.403
FINANCED BY: **Taxpayers' Equity**				
General Fund	0.000	0.000	0.000	0.000
Revaluation reserve	34.708	34.833	0.125	34.833
PDC	131.461	131.047	(0.414)	131.047
Retained earnings	19.002	19.523	0.521	19.523
Other reserve	0.000	0.000	0.000	0.000
Total Taxpayers' Equity	185.171	185.403	0.232	185.403

9. CASH FLOW (Includes Hosted Organisations)

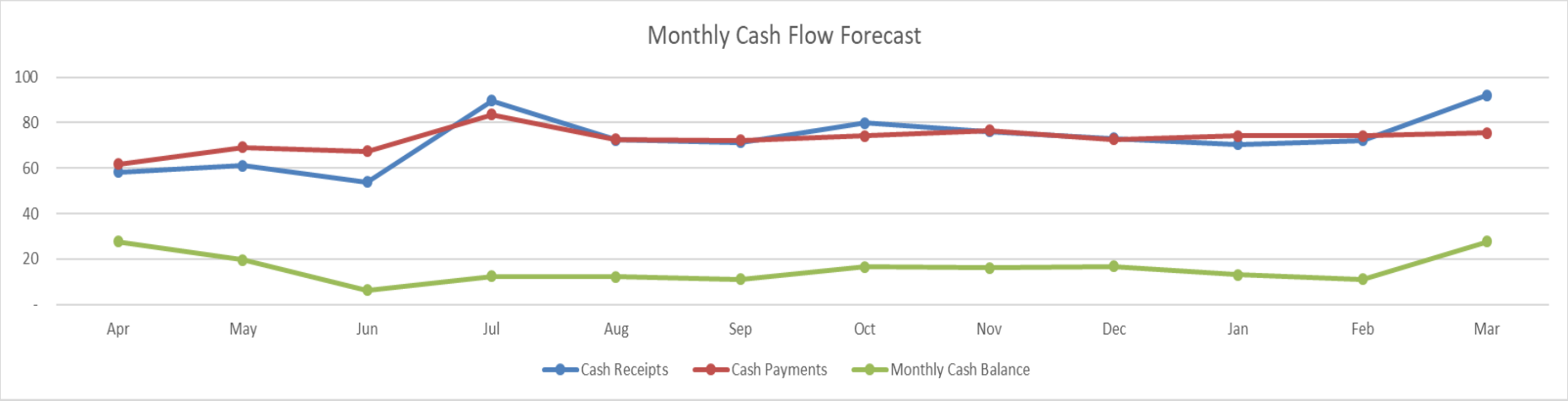
The cash-flow forecast is important to enable the Trust to plan for sufficient cash availability throughout the financial year to pay its debts, such as payroll, services provided by other health bodies and private companies. The cash-flow forecast ensures that the Trust has an early understanding of 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	37.581	38.378	41.097	40.905	41.974	41.674	46.542	42.597	41.697	42.597	42.297	41.335	498.673
2	WG Income	14.460	18.799	9.707	42.966	24.263	23.215	24.832	27.325	25.325	21.486	23.525	24.800	280.703
3	Short Term Loans													0.000
4	PDC				0.000								16.404	16.404
5	Interest Receivable	0.149	0.162	0.143	0.126	0.100	0.100	0.100	0.100	0.100	0.100	0.100	0.100	1.380
6	Sale of Assets													0.000
7	Other	6.156	3.753	2.953	5.651	6.150	6.250	8.265	6.150	6.050	6.350	6.250	9.325	73.302
8	TOTAL RECEIPTS	**58.346**	**61.092**	**53.900**	**89.648**	**72.487**	**71.239**	**79.739**	**76.172**	**73.172**	**70.533**	**72.172**	**91.964**	**870.463**
	PAYMENTS													
9	Salaries and Wages	31.801	34.720	38.993	34.802	33.238	33.366	33.419	33.424	33.432	33.464	33.476	33.636	407.771
10	Non pay items	28.883	33.947	26.186	46.813	37.325	36.425	37.253	39.583	37.798	38.746	38.524	38.023	439.507
11	Short Term Loan Repayment											0.000		0.000
12	PDC Repayment													0.000
14	Capital Payment	1.122	0.394	2.160	1.949	2.170	2.490	3.591	3.477	1.328	1.987	2.202	3.775	26.645
15	Other items													0.000
16	TOTAL PAYMENTS	**61.807**	**69.062**	**67.339**	**83.564**	**72.733**	**72.281**	**74.263**	**76.484**	**72.558**	**74.197**	**74.202**	**75.434**	**873.923**
17	Net cash inflow/outflow	(3.461)	(7.970)	(13.438)	6.085	(0.246)	(1.042)	5.476	(0.312)	0.614	(3.664)	(2.031)	16.529	
18	Balance b/f	31.136	27.675	19.705	6.266	12.351	12.105	11.063	16.539	16.227	16.841	13.177	11.146	
19	Balance c/f	27.675	19.705	6.266	12.351	12.105	11.063	16.539	16.227	16.841	13.177	11.146	27.676	



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	(10.486)	(10.487)	(0.000)	(37.761)	(37.761)	0.000
RD&I	(0.273)	(0.273)	(0.000)	0.091	0.091	0.000
WBS	(5.292)	(5.292)	(0.000)	(20.226)	(20.226)	0.000
Sub-Total Divisions	**(16.052)**	**(16.052)**	**0.000**	**(57.896)**	**(57.896)**	**0.000**
Corporate Services Directorates	**(3.061)**	**(3.059)**	**0.002**	**(11.670)**	**(11.670)**	**0.000**
Delegated Budget Position	**(19.113)**	**(19.111)**	**0.002**	**(69.566)**	**(69.566)**	**0.000**
TCS	(0.186)	(0.186)	(0.000)	(0.638)	(0.638)	0.000
Health Technology Wales	(0.025)	(0.025)	(0.000)	(0.025)	(0.025)	0.000
Trust Income / Reserves	19.323	19.323	(0.000)	70.229	70.229	0.000
Trust Position	0.000	0.002	0.002	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	**23.064**	**23.470**	**0.406**	**71.893**	**71.893**	**0.000**
Expenditure						
Staff	**16.942**	**16.851**	**0.091**	**48.267**	**48.267**	**0.000**
Non Staff	**20.778**	**21.275**	**(0.497)**	**63.801**	**63.801**	**0.000**
Sub Total	**37.720**	**38.126**	**(0.406)**	**112.068**	**112.068**	**0.000**
Total	**(14.656)**	**(14.656)**	(0.000)	**(40.175)**	**(40.175)**	**0.000**

VCS Key Highlights/ Issues:

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

Income at Month 4 represents a surplus of **£0.406m**. Overachievement on Private Patients drugs due to both activity and the VAT savings from delivery of SACT homecare is offsetting the divisional management savings target.

VCS have reported a year to date underspend of **£0.091m** against staff. The division continues to have high levels of vacancies, sickness, and maternity leave across several services, this along with recruitment challenges, is largely offsetting both the vacancy savings target and the

requirement to support posts appointed into without funding agreement i.e. Advanced recruitment and Capacity investments.

Non-Staff Expenditure at Month 4 was **£(0.497)m** overspent which is a result of increased activity pressures which can be linked to contract performance and in areas such as PICC and SACT following treatment returning to 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	**8.621**	**8.663**	**0.042**	**26.554**	**26.554**	**0.000**
Expenditure						
Staff	**6.359**	**6.308**	**0.050**	**18.361**	**18.361**	**0.000**
Non Staff	**9.680**	**9.772**	**(0.092)**	**29.696**	**29.696**	**0.000**
Sub Total	**16.039**	**16.081**	**(0.042)**	**48.057**	**48.057**	**0.000**
Total	**(7.417)**	**(7.418)**	0.000	**(21.503)**	**(21.503)**	**0.000**

Key Highlights/ Issues:

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

Income overachievement of **£0.042m** to month 4. 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, however the year to date target is currently underachieving by c35%.

Staff reported a **£0.050m** underspend to July. Vacancies are helping to offset the overspend from posts supported without identified funding source. This includes advanced recruitment and service developments which have been incurred as a divisional cost pressure particularly in relation to Component development where no WHSSC funding has been secured.

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

Non-Staff reported an overspend of **£(0.092)m** to July. Energy price rises expected to be funded centrally by the Trust as agreed at the IMTP planning stage, along with venue hire costs pressures previously funded by WHSSC, are being offset by reduced spend from lower activity.

Corporate

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected £m
Income	**0.809**	**1.164**	**0.355**	**1.973**	**1.973**	**0.000**
Expenditure						
Staff	**3.883**	**3.821**	**0.062**	**11.245**	**11.245**	**0.000**
Non Staff	**1.157**	**1.550**	**(0.393)**	**3.039**	**3.039**	**0.000**
Sub Total	**5.040**	**5.371**	**(0.331)**	**14.284**	**14.284**	**0.000**
Total	**(4.231)**	**(4.207)**	0.024	**(12.311)**	**(12.311)**	**0.000**

Corporate Key Highlights / Issues:

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

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

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

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

RD&I

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**0.658**	**0.671**	**0.013**	**3.229**	**3.229**	**0.000**
Expenditure						
Staff	**0.945**	**0.943**	**0.002**	**2.876**	**2.876**	**0.000**
Non Staff	**0.072**	**0.087**	**(0.015)**	**0.262**	**0.262**	**0.000**
Sub Total	**1.017**	**1.030**	**(0.013)**	**3.137**	**3.137**	**0.000**
Total	**(0.359)**	**(0.359)**	0.000	**0.091**	**0.091**	**0.000**

RD&I Key Highlights / Issues

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

Trials Income fluctuations expected throughout the year

Small Pay underspend due to vacancies.

TCS – (Revenue)

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**0.000**	**0.000**	**0.000**	**0.000**	**0.000**	**0.000**
Expenditure						
Staff	**0.266**	**0.264**	**0.002**	**0.730**	**0.730**	**0.000**
Non Staff	**0.006**	**0.028**	**(0.022)**	**0.015**	**0.015**	**0.000**
Sub Total	**0.272**	**0.292**	**(0.020)**	**0.744**	**0.744**	**0.000**
Total	**(0.272)**	**(0.292)**	(0.020)	**(0.744)**	**(0.744)**	**0.000**

TCS Key Highlights / Issues

The reported financial position for the TCS Programme at the end of July 2023 is breakeven with a forecasted outturn position of **Breakeven.**

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

HTW (Hosted Other)

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**0.506**	**0.506**	**0.000**	**1.677**	**1.677**	**0.000**
Expenditure						
Staff	**0.510**	**0.509**	**0.000**	**1.545**	**1.545**	**0.000**
Non Staff	**0.051**	**0.051**	**0.000**	**0.248**	**0.248**	**0.000**
Sub Total	**0.561**	**0.560**	**0.000**	**1.794**	**1.794**	**0.000**
Total	**(0.054)**	**(0.054)**	(0.000)	**(0.117)**	**(0.117)**	**0.000**

HTW Key Highlights / Issues

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

HTW is funded directly by WG.

Pencadlys Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University NHS Trust Headquarters

2 Cwrt Charnwood
Heol Billingsley
Parc Nantgarw
Caerdydd/Cardiff
CF15 7QZ

Ffôn/Phone : (029) 20196161
www.velindre-tr.wales.nhs.uk

Our Ref: M4/MB/SC

Direct Dial: 029 20 316955
Fax: 01443 843259
e-mail:Matthew.Bunce@wales.nhs.uk

11th August 2023

Matthew Denham-Jones
Deputy Director of Finance
Health & Social Services Group
Welsh Government

Dear Matthew,

Velindre Month 4 (July) Monitoring Return

In line with the guidance issued, please find attached the tables required for Month 4.

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 2023-24 IMTP the Core Trust had 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.

The Trust expects to secure Covid recovery and planned care backlog funding from Commissioners through LTA activity performance related marginal income. All

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

Welsh Blood Service
Gwasanaeth Gwaed Cymru

Canolfan Ganser Felindre
Velindre Cancer Centre

Pencadlys Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University NHS Trust Headquarters

2 Cwrt Charnwood
Heol Billingsley
Parc Nantgarw
Caerdydd/Cardiff
CF15 7QZ

Ffôn/Phone : (029) 20196161
www.velindre-tr.wales.nhs.uk

LTA/ SLA documents were issued and signed by the 30th June in line with the funding flows mechanism agreed at Directors of Finance Forum. The final funding flows agreement included income protection measures for Velindre Cancer Services, which were not included within the Trust's Medium Term Financial Plan.

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 expected underlying surplus to be carried into 2024-25 has reduced from £0.391m to £0.086m as underlying recurrent cost pressures are forecast to exceed recurrent savings schemes. Further details are provided below.

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

3. Table A2 – Risks & Opportunities

Risks

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

Non-Delivery of Savings - (REMOVED)

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

The ability to enact several savings schemes has been impacted by both market conditions and the ongoing legacy impact of the pandemic which has resulted in

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

Welsh Blood Service
Gwasanaeth Gwaed Cymru

Canolfan Ganser Felindre
Velindre Cancer Centre

Pencadlys Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University NHS Trust Headquarters

2 Cwrt Charnwood
Heol Billingsley
Parc Nantgarw
Caerdydd/Cardiff
CF15 7QZ

Ffôn/Phone : (029) 20196161
www.velindre-tr.wales.nhs.uk

higher than usual sickness levels throughout the Trust. Four of the saving schemes identified at the IMTP planning stage have therefore turned Red with replacement schemes identified to ensure that the overall savings target is met for 2023/24.

This risk has now been removed from the table.

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 year which may be beyond divisional control or the Trust ability to manage through its overall income envelope.

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. This may impact 2024/25 position as recurrent costs of c. £1m are committed against delivering this service.

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

Response to Financial Pressures: Financial Improvement Options

Following the letter received from Judith Paget on the 31st July which provided a view on the overall financial position of Welsh NHS organisations for 2023/24, and a request for those organisations with balanced plans to support the delivery of a reduction in the overall NHS Wales deficit, the Trust has identified the following financial improvement options which were endorsed by the Trust Board on the 9th August, and will be submitted to WG on the 11th August.

Velindre Cancer Services (VCS) Contract Protection - c£1.250m

Pencadlys Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University NHS Trust Headquarters

2 Cwrt Charnwood
Heol Billingsley
Parc Nantgarw
Caerdydd/Cardiff
CF15 7QZ

Ffôn/Phone : (029) 20196161
www.velindre-tr.wales.nhs.uk

The Trust will work with Commissioners to assess the opportunity to relinquish the LTA income protection which was agreed as part of the LTA/ SLA with the Trust Commissioners. This would reduce the costs of VCS services for the Trust's Commissioners providing a contribution towards the wider deficit reduction of c£1.250m across all LHBs.

Energy - c£0.436m

The latest energy forecast position for 2023-24 from NWSSP suggests that as at month 4 there is a reduction of c£0.436m from the forecast presented at the IMTP planning stage. The range of savings that will be available will be depended on forecast wholesale prices which are provided by the supplier and led by NWSSP as part of the all Wales Energy Group, however expectation is that an opportunity will arise that can be released to support the NHS deficit.

Review Utilisation of Reserves and Commitments (Inc Emergency Reserve) (£tbc)

Review of third year of investment strategy for corporate infrastructure to support the delivery of front line services.

Medicines Management (£tbc)

The Trust continues to work with NWSSP Medicines Unit to evaluate the use of generics / biosimilars which could deliver potential savings to our Commissioners. The savings passed through to Commissioners will be net of any internal resource costs required to deliver the change.

Opportunities

Recovery and Planned Care Capacity- (Medium)

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

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

Pencadlys Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University NHS Trust Headquarters

2 Cwrt Charnwood
Heol Billingsley
Parc Nantgarw
Caerdydd/Cardiff
CF15 7QZ

Ffôn/Phone : (029) 20196161
www.velindre-tr.wales.nhs.uk

Further details are provided below under Covid Recovery and Planned Care Capacity.

Vacancy Turnover – (Low)

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

Contract Currency Review – (low)

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

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

Table B – Monthly Positions

The Trust position for the period ended July 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.

WG Income increase relates to anticipated 5% pay award funding of c£3.5m.

Pay movement largely reflect the inclusion of the 5% consolidated pay award of c(£3.500m), less forecast slippage due to recruitment delays for posts with non NHS funding secured.

Drug cost reduction is netted off with income movement that has been shared with Health Boards.

DEL and AME depreciation reflects the latest the non-cash position submitted on the 30th June. Per the submission the profile on the accelerated depreciation is likely to change in November once we have a clearer position on the nVCC following financial close.

Pencadlys Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University NHS Trust Headquarters

2 Cwrt Charnwood
Heol Billingsley
Parc Nantgarw
Caerdydd/Cardiff
CF15 7QZ

Ffôn/Phone : (029) 20196161
www.velindre-tr.wales.nhs.uk

Several factors contributed to the £1.100m underspend on non-pay costs in June including WBS Wholesale costs not currently realising the growth expectation as at IMTP planning stage, although it is anticipated that costs will increase as we approach the winter period. Likewise, other service growth investments such as investment in R&D through Charitable funds is yet to crystallise. Other costs controls include reduction in energy costs and the use of PPE. **(Action Point 3.1)**

The table was updated in anticipation of the baseline for DEL owned asset depreciation being reset, however we understand that this will take place as part of August non-cash submission. Therefore, the DEL owned asset depreciation has been updated to reflect the current reported position for the baseline and strategic Charges. **(Action Point 3.2)**

Pay & Agency (Table B2)

Of the £0.664m agency spend reported in the table as at the end of July, £0.325m 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.

As previously described the Trust is 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 is largely supporting vacancies and whilst there is ambition to fill these posts, recruitment issues may continue to prove challenging.

4. Covid-19 (Table B3)

Covid Programme Costs

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 still only expecting to draw funding from WG towards PPE costs. However, if the Trust is required to support the LHBs with any further vaccination programme then it is assumed that funding will be provided by WG to support any incurred costs.

Pencadlys Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University NHS Trust Headquarters

2 Cwrt Charnwood
Heol Billingsley
Parc Nantgarw
Caerdydd/Cardiff
CF15 7QZ

Ffôn/Phone : (029) 20196161
www.velindre-tr.wales.nhs.uk

Covid Recovery and Planned Care Capacity:

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

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

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.

5. Savings (Table C – C4)

Following an in depth assessment of savings schemes in July, several schemes have turned red., The impacted schemes relate to workforce and the supply chain. Replacement schemes have been identified to ensure that the overall target is achieved for 2023/24 **(Action Point 3.3).**

Service redesign and supportive structures continues to be a key area for the Trust which is about focusing on finding efficiencies in the ways that we are working. Whilst this remains a high priority the ability to enact change has been challenging due to both the high level of vacancies and sickness.

The procurement supply chain saving schemes have again been affected by both procurement constraints and current market conditions during 2023-24, where we have seen a significant increase in costs for both materials and services. We continue to collaborate with procurement colleagues to identify further opportunities to deliver savings through the supply chain.

Pencadlys Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University NHS Trust Headquarters

2 Cwrt Charnwood
Heol Billingsley
Parc Nantgarw
Caerdydd/Cardiff
CF15 7QZ

Ffôn/Phone : (029) 20196161
www.velindre-tr.wales.nhs.uk

6. 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 4.

7. Invoiced Income (Table E1)

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

Non-Cash requirements has been updated to reflect latest forecast position submitted to WG on the 30th June.

8. SoFP (Table F)

The latest Velindre Trust SoFP has been included for month 4.

The opening balances on the SoFP have been checked and agree to the final audited accounts **(Action 3.5)**

9. Cash Flow (Table G)

In line with the guidance the cash flow has been completed for month 4.

10. PSPP (Table H)

We are pleased to report that the Trust continues to achieve the 95% target of Non-NHS invoices being paid within 30 days.

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

11. Capital Tables (Table I-K)

The Capital tables have been completed for month 4.

Capital funding has not been allocated to the nVCC Project, with a current overspend as costs are still being incurred due to the delay of Financial Close. This risk is being mitigated by a request to WG for Project funding. The latest forecast is c1.843m.

Pencadlys Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University NHS Trust Headquarters

2 Cwrt Charnwood
Heol Billingsley
Parc Nantgarw
Caerdydd/Cardiff
CF15 7QZ

Ffôn/Phone : (029) 20196161
www.velindre-tr.wales.nhs.uk

12. EFL (Table L)

In line with the guidance the EFL has been completed for month 3.

The IFRS 16 lease payment amounts have been included within line 11 of the full year WG column **(Action Point 3.6)**

13. Aged Debtors (Table M)

There are no invoices over 17 weeks for Velindre Core.

All invoices relating to March have now been resolved and removed from the table. **(Action Point 3.7)**

14. Ringfenced (Table P)

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

15. Other

This letter and relevant tables from the MMR will be going to the Trust Quality, Safety and Performance Committee in September 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
Velindre UNHS Trust

Steve Ham
Chief Executive
Velindre UNHS Trust

Pencadlys Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University NHS Trust Headquarters

2 Cwrt Charnwood
Heol Billingsley
Parc Nantgarw
Caerdydd/Cardiff
CF15 7QZ

Ffôn/Phone : (029) 20196161
www.velindre-tr.wales.nhs.uk

On behalf of

Matthew Bunce
Executive Director of Finance
Velindre UNHS Trust

Velindre Trust

Period : **Jul 23**

Summary Of Main Financial Performance

Revenue Performance

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

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Bi-annual Value-Based Healthcare Programme Update

DATE OF MEETING	14/09/2023
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	Chris Moreton, Deputy Director of Finance
PRESENTED BY	Chris Moreton, Deputy Director of Finance
APPROVED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SUMMARY	This report provides an overview of the development of the Value Intelligence Centre as part of the Value Based Healthcare programme of work over the past 8 months. It presents some key considerations and matters for QSP consideration as the Value Based Healthcare programme moves forward.

RECOMMENDATION / ACTIONS	QSP is asked to **NOTE** the continued development of the Value Based Healthcare Programme including: ○ Phase 1 completion and Executive Summary in Appendix 1 ○ Phase 2 extension of third-party support until October 2023 to continue the development of the Value Intelligence Centre ○ The development of a Velindre Food Strategy with Welsh Government support.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
EMB Shape	**14/08/2023** **19/06/2023**
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	

7 LEVELS OF ASSURANCE	
N/A – Report for Discussion	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	**Select Current Level of Assurance**

APPENDICES	
Appendix 1	Value Intelligence Centre – Phase 1 Exec Summary

1. SITUATION

The Trust has commenced its Value-Based Healthcare journey having secured funding from Welsh Government to progress with this programme of work as part

of the Trust's Building Our Futures Together initiative. This report provides a summary of the work completed to date with regards to the development of the Value Based Healthcare Programme and key areas for EMB consideration as the programme moves forward.

2. BACKGROUND

The Value Based Healthcare Programme received funding from Welsh Government to progress two key Value Based Healthcare initiatives across the Trust as follows:

- Preoperative Anaemia Pathway Project with the Welsh Blood Service
- Value Intelligence Centre at the Trust

VBH Programme update was provided to EMB Shape in June 2023.

The scope of this report is the development of the Value Intelligence Centre and work completed to date on the Velindre Food Strategy, which has been progressed with funding support from WG.

3. ASSESSMENT

3.1 Value Intelligence Centre Phase 1

Phase 1 of the Value Intelligence Centre has now concluded with the Value Based Healthcare Steering Group signing off the following deliverables:

1. Baseline Data Assessment
2. User Personas
3. Document Use Case
4. Proof of Concept Urology Dashboard
5. Value Intelligence Cycle and an agile process for dashboard development
6. Value Intelligence Centre vision and roadmap

Further details and an Executive Summary of the output from Phase 1 are provided in Appendix 1 for information.

Following discussion at EMB Shape in June 2023, feedback has been taken on board and a decision taken by the Programme SRO, with support from the VBH Steering Group, to extend the third-party contract support in line with Commitment of Expenditure agreed by Trust Board in January 2023. This

support will now run through to October 2023 in order to allow for a smooth transition and onboarding of the Head of Value Based Healthcare post.

3.2 Value Intelligence Centre Phase 2

The agreed scope of work for this extension is outlined below including an overview of the benefits that will be delivered.

Value Based Healthcare Governance
Ownership of plans and clarity in decision-making is essential to sustain engagement and momentum therefore this workstream will develop the following:

- A proposed VBH Governance Framework within Trust-wide governance, including processes for prioritization of the Value Intelligence Centre resource allocation / budget management and internal SLAs between functions.
- Terms of Reference for the Steering Group and Sub-Groups in the VBH Programme, including processes for prioritization of the work programme.
- A defined reporting cycle for the VBH Programme (including external reporting)

Benefits: *Clarity, ownership and transparency in governance arrangements to support maturation of the VBH programme.*

Value Based Healthcare Training and Change Management Materials

The Trust is on a journey towards digital maturity. As such, training and change management materials can help to support the further development of the Value Intelligence Cycle and iterative, agile approaches will help maintain progress. This initiative will deliver the following:

- A set of training materials for Velindre's 'VBH way of working' and a set of 'trainers' trained in onboarding and upskilling staff needing to work aligned with VBH ways of working (which will, in time, be most staff at Velindre as the approach matures and becomes embedded as a BAU)
- A data quality and assurance approach to support the continued enhancement of the data and build in 'sense-making' and data quality considerations into all VBH work
- Support for onboarding and up-skilling Velindre's VBH/Value Intelligence Centre (VIC) team members as they come into post.

Benefits: *maturing the ways of working and sustaining the engagement across the organisation to continue increasing the profile of the VBH programme – further demonstrating how this work will affect and improve activity across the organisation.*

Value Intelligence Centre Programme Plan
A detailed programme plan is required to develop the first stage of the VBH Roadmap presented to EMB Shape in June 2023. This will include specific, prioritised work packages and resource requirements with assessment of the following:

- Programme interdependencies:
    - with other Velindre programmes (e.g. BI Warehouse, Workforce changes, Quality and Safety, Digital etc.)
    - with national programmes
- PROMs roll-out plans
- The Dashboard 'pipeline' – maintaining and expanding existing dashboards, the plans for developing new dashboards, resource requirements
- Varian's Noona development plan
- Links to governance (meeting structure & budgeting)

This work will include wide engagement with Velindre's frontline teams, corporate services and Divisions including:

- Clinical teams to cover SST prioritization and their views on PROMs roll-out (new tools and potential for 'All Wales' leadership)
- Trust wide and Divisional groups re. interdependencies and existing programmes

The Value Intelligence Cycle will be presented as central to this strategic programme plan – it will guide the decision-making processes that link the plan to the governance structures described above.

Benefits: *clear and actionable plan with which the Exec can engage and allocate resource.*

3.3 Velindre Food and Value

In March 2023, VUNHST was successful in being awarded grant funding of £30,000 to develop a mission for local food sourcing and an agroecological food supply chain.

The purpose of the project is to produce a policy briefing note which helps Velindre University NHS Trust to develop a strategy to establish a shorter, more environmentally friendly food supply chain. This should help to enable local, healthy, good quality and sustainable food for future generations, improving the

wellbeing of patients, donors, staff, food communities and supporting local food suppliers/producers.

The initiative has adopted a participatory approach with a Velindre food working group established through nominations from the Healthy and Engaged Steering group. The group contained representatives from across the Trust and two workshops run through June and July 2023. Further, a staff survey on food was available on the Trust's intranet to provide all staff with the opportunity to feed into the process from June to August 2023.

The feedback from these sessions will inform a strategy report, which is due to be finalised by September 2023 and will inform the Value Based Healthcare wider programme of work.

4. SUMMARY OF MATTERS FOR CONSIDERATION

NOTE continued development of the Value Based Healthcare Programme.

5. IMPACT ASSESSMENT

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

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	**Choose an item** VBH Programme is cross cutting and will support mitigation of multiple strategic risks.
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 Value Based Healthcare Programme will support across Quality and Safety domains.* **Click or tap here to enter text**
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
	n/a **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:
	Value Based Healthcare Programme will support the delivery across all of the Trust's Wellbeing Objectives
	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: Welsh Government Please explain if 'other' source of funding selected: n/a **Type of Funding:** **Revenue** **Scale of Change** Please detail the value of revenue and/or capital impact: Funded through VBH Programme Budget **Type of Change** **Major Programme** Please explain if 'other' source of funding selected: Value Based Healthcare is part of the Building our Futures Together Programme
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 applicable for this report

ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	n/a

6. RISKS

Not Applicable for this report

ARE THERE RELATED RISK(S) FOR THIS MATTER	Choose an item
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?	Choose an item
All risks must be evidenced and consistent with those recorded in Datix	

GIG CYMRU NHS WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

Value Based Healthcare
Value Intelligence Centre Development

Phase 1 Output

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

Executive Summary

Value Based Healthcare
Value Intelligence Centre Phase 1 Summary

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

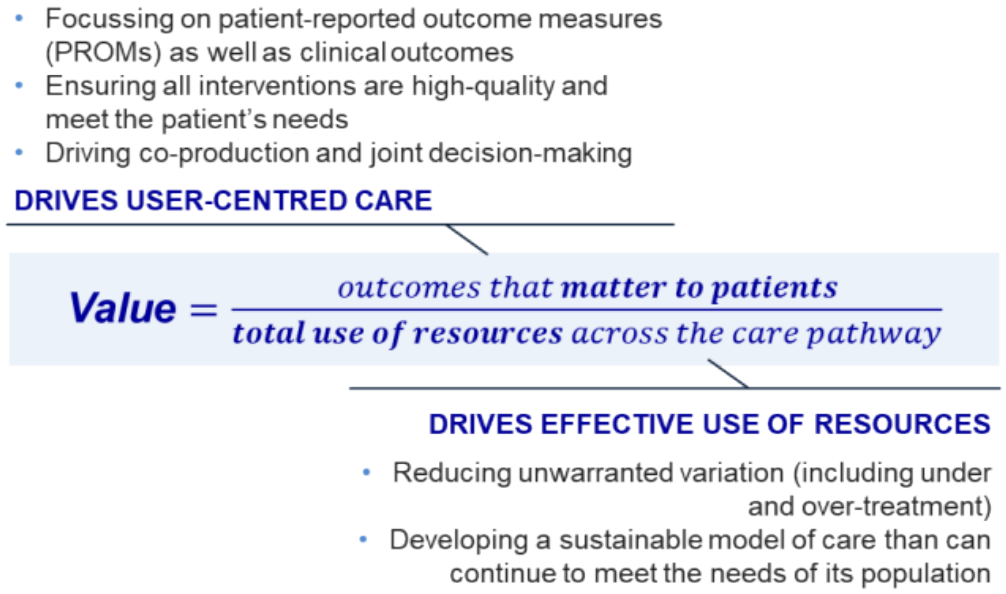
Velindre is on a transformation journey towards a more value-based way of working. Work conducted collaboratively by Velindre and the PSC over the course of ~18 weeks from March to June 2023 has delivered a set of outputs and demonstrated ways of working that will support this journey. This pack presents the outputs of that work, including the framing of the vision and/or opportunity; descriptions of the activities & outputs, and the recommendations for next steps:

- **Opportunity:** Velindre have set an ambitious vision to improve healthcare delivery, research, education, and sustainability. Data maturity and analytics are central to this journey, and the development of the Value Intelligence Centre is intended to be a catalyst and accelerate progress on this journey.

- **Activities & Outputs:** through wide engagement across Velindre and beyond it, a set of outputs have been created that support VBHC and the longer-term ambition to transition more of the Trust's activities onto a more value-based approach.

- **Recommendations:** a set of next steps over the short-, medium- and long-term for the programme to build on this work.

The programme is situated within the emerging Value Intelligence Centre.



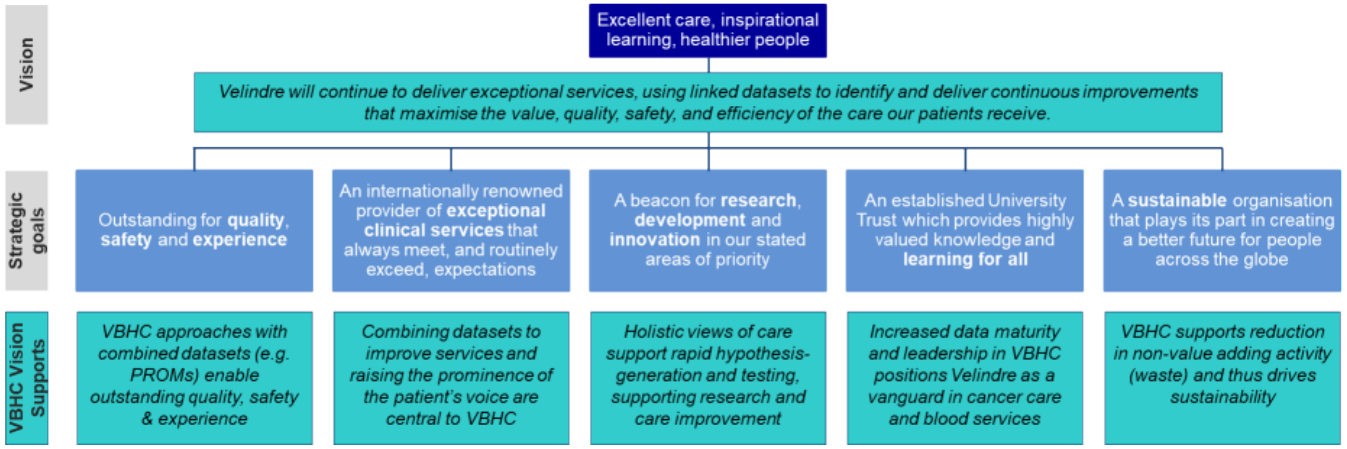
The Opportunity:
Velindre's Vision and how VBH supports it

- **Velindre can't stay where it is – the Burning Platform:** For a variety of internal and external reasons, Velindre cannot continue with its current style of operation regarding data. There are national imperatives around improved collection & availability of data, as well as a wide-spread view within the organisation that the right data are either not available, too hard/time-consuming to obtain, or not sufficiently comparable across areas to be useful.

- **Better data and better use of data are essential:** to deliver Velindre's vision and enable both prudent management and continuous improvement of care, the kinds of data enabled and enabling VBH are essential – it is a virtuous cycle of better data leading to better use of data, which then improves the quality of data inputs and outputs.

- **The vision touches all levels of the organisation:** creating these common views improves function across the organisation horizontally (between functional areas, such as clinical, finance, and operational areas) and vertically (at different scales of the organisation, from individual clinics or SSTs, to a Board-level view). This common view, centering the patient, is the long-term aim.

To be coherent, VBH must clearly support delivery of those goals and the overall vision – it cannot be an 'add-on,' sitting alongside the organisations main activities or priorities.

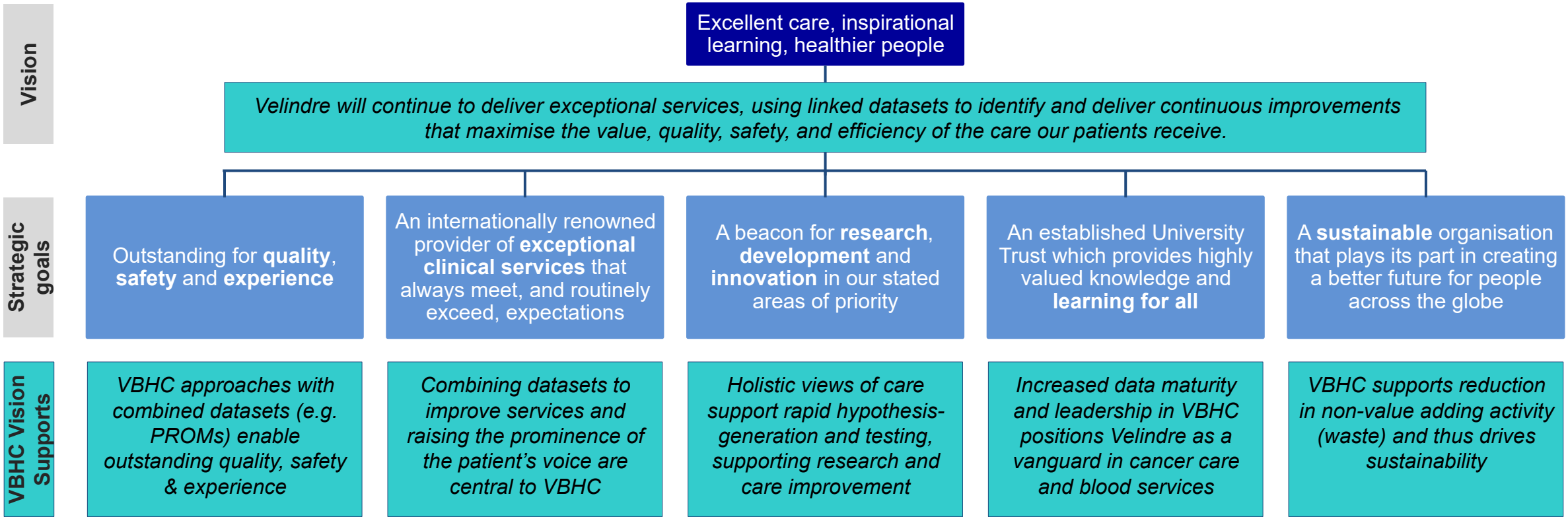


For more detail on the vision, see next slide

Velindre's Vision and how VBHC supports it

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

To be coherent, VBHC must clearly support delivery of those goals and the overall vision – it cannot be an 'add-on,' sitting alongside the organisations main activities or priorities.



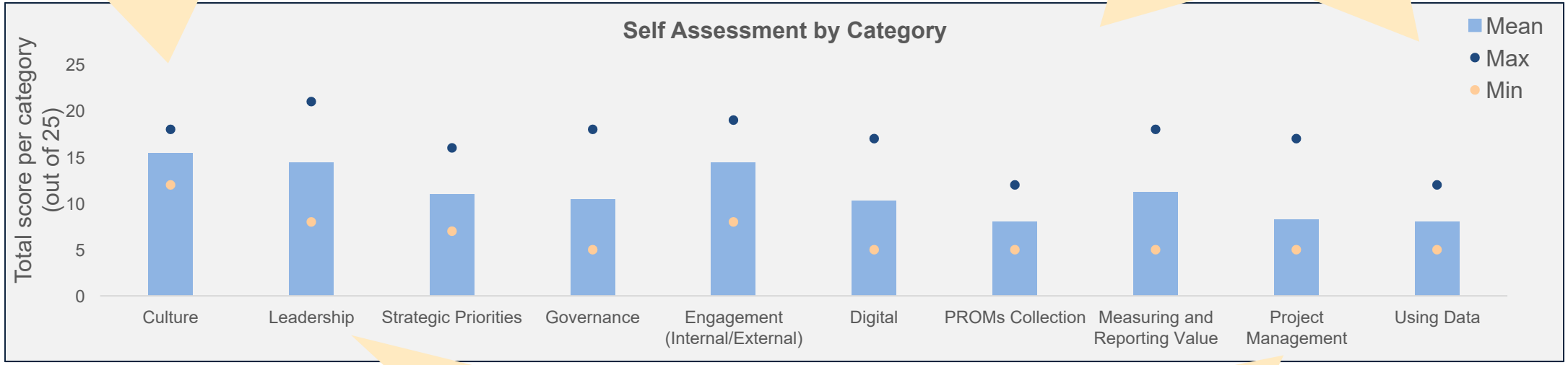
Value Based Healthcare: Leadership Self-Assessment

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Over the last few weeks, members of the Board have completed a VBH Capacity and Maturity Assessment. The results show varying readiness across the Welsh Value in Health Centre themes:

Culture scores highest, with respondents particularly agreeing that the Board are aware of and support the need for change.

PROMs collection and **Using Data** were the areas of greatest concern, including a lack of an interoperable data collection platform and processes to analyse service value.



Results based on 5 respondents. Slide will be updated if more results received before Monday's session.

There is significant disagreement regarding **leadership**, specifically including whether there is collective ownership of the overall performance of the organisation & whether middle management is sufficiently engaged and enthusiastic about the programme.

There are varying views on **project management** readiness with a large disparity in scoring in this section. Whether the project has sufficient project management resource and stakeholder engagement are of greatest disagreement.

Activity & Outputs:
Project Engagement & Outputs

Improved **data analytics and capabilities** are a key part of the Trust's value-based healthcare (VBHC) programme. To support the VBHC analytics programme, **a range of outputs have been co-developed** with VCC staff through extensive engagement and user research:

100+ *Stakeholders engaged*

10 *User research workshops*

12 out of 12 *SSTs involved in Baselining*

6 *Cross-functional VBHC Steering Group meetings*

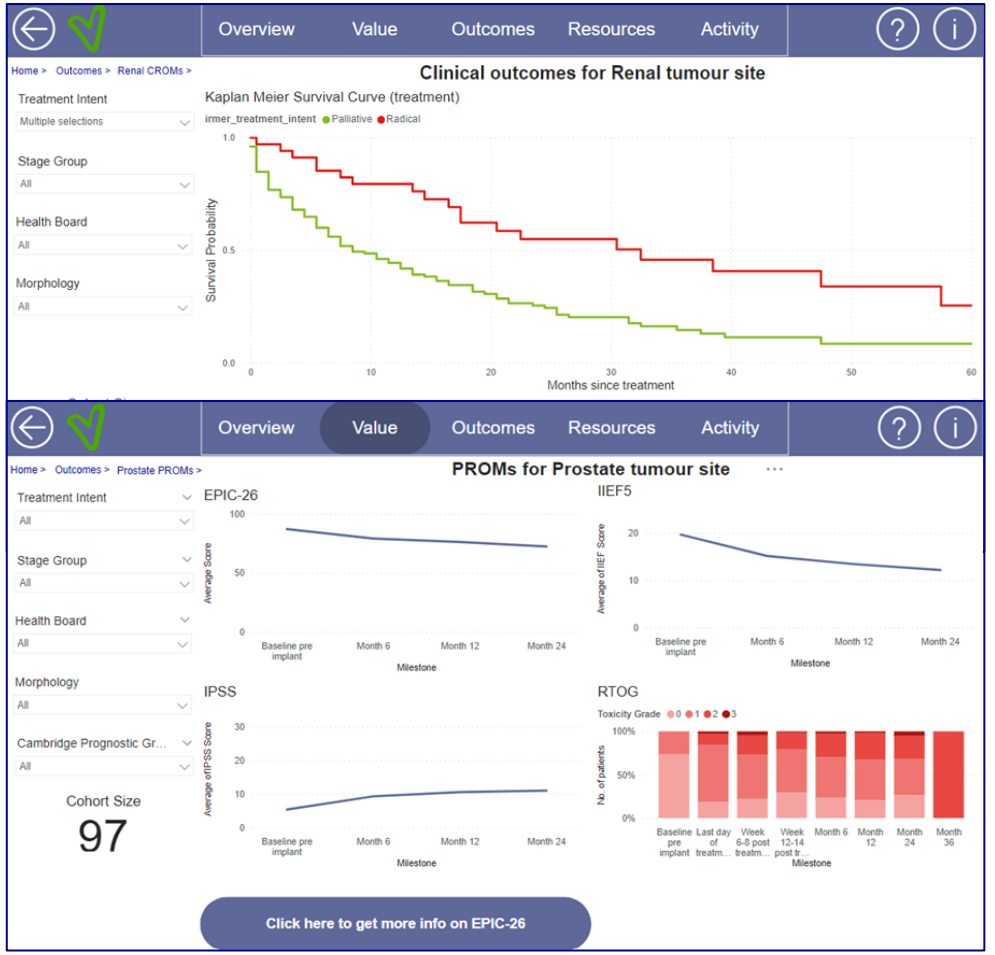
4 *Sessions with the National VBHC team*

Data baseline	Use case and user personas	Proof-of-concept dashboard	Vision and roadmap
Collating **VBHC data assets** across the organisation and outlining how data maturity could be progressed.	Detailing the challenges and **user needs** of staff within the VCC & **how the dashboard will enable VBHC**	To show the **feasibility & viability** of developing dashboards and explore what data is **valuable**	Describing the **vision for VBHC** at Velindre and how this will be delivered over the coming years.

All products have been co-developed with local teams, with additional handovers with the BI and Digital teams conducted to ensure capability to sustain and utilize delivered assets, and to build on them to deliver the wider roll-out envisaged in the roadmap.

Value Based Healthcare
User Personas and Dashboard Proof of Concept

- The dashboard has been co-developed through numerous **rounds of user testing** with stakeholders.
- Over the last couple of months, the dashboard has been through several rounds of iteration to ensure **user-centred design and development of user personas (e.g. below).**
- This dashboard is a **proof-of-concept** and will be iterated over time (refining and adding new functionality) and later be expanded to include other SSTs and directorate views.

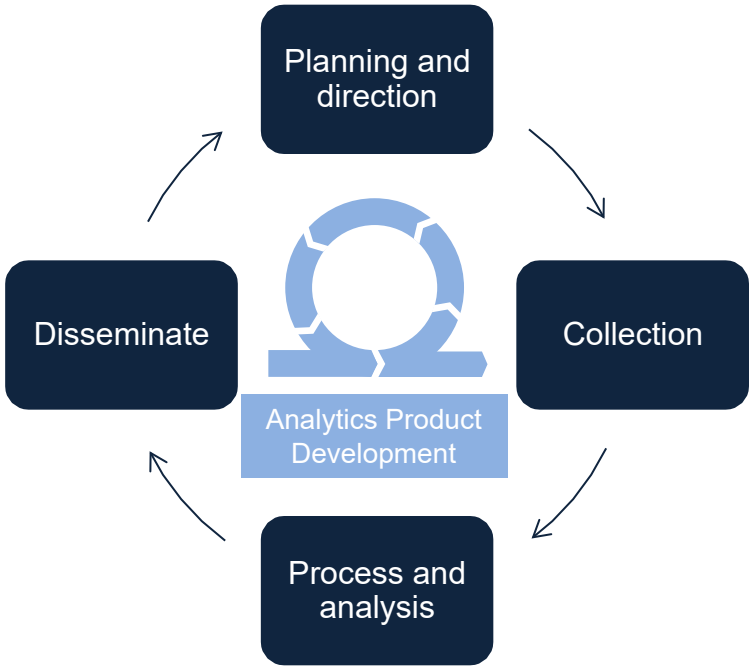


Governance & Ways of Working: Value Intelligence Cycle

At the programme / portfolio level the Intelligence Cycle is the guiding framework

The Intelligence Cycle

- Where an Agile Development Process is ideal for product development, another framework lends itself to the overall programme perspective: the Intelligence Cycle.
- This Cycle is also an **iterative** way of **assessing priorities, delivering change, and ensuring learning** through feedback to the next cycle of planning or initiatives.
- This approach is already in use at Velindre (represented in the Value Intelligence Centre briefing papers), but has not yet reached scale or maturity. The development of the Value Intelligence Centre is thus an opportunity to continue increasing that maturity in the use of the Intelligence Cycle to support governance.



Role in the programme

- At a VBH portfolio level, the Intelligence Cycle can be used to think about **wider initiatives, investments, priorities and decisions** - as well as the occasional bespoke piece of analysis.
- This complements the **Agile process for dashboard development** (existing or new), which is about rapidly developing technical products on a recurring basis – creating new dashboard functionality, improving usability, and so on.
- Therefore, the Intelligence Cycle is for **defining VBH strategy, setting priorities, and monitoring the outputs** of the Agile analytics product development projects.

Stakeholders

- Central to VBH and the programme at Velindre, is the need that this cycle **drives collaboration** across clinical, operational, finance, BI and digital teams.
- The Steering Group will **include stakeholders from all groups** and thus drive integration and joint decision-making about the programme.

The Roadmap:
The 3-year Roadmap

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Velindre's VBHC Programme are aware of the scale of the journey and the steps to take to reach the full vision, with major gains to be achieved at each stage of that journey as Velindre's VBHC maturity increases. **Note**: proposed SST ordering requires testing and confirmation, and can be adjusted during delivery.

	3 Months	6 Months	12 Months	24 Months	36 Months +
Governance & Ways of Working	Mature VBHC Programme governance & confirm ToR Pilot strategic decision-making based on Intelligence Cycle	Link VBHC work to existing Velindre groups/forums	Increased VBHC-aligned reporting Wider engagement – system & patients	Pilot commissioner-partnered VBHC projects Initiate discussions for system-level views – shared data	Assess 1st wave of commissioner-partner projects
Teams & Resources	Onboard new Head of VBHC Data & Insight Team sustain VBHC Analytics programme	Recruitment of additional Data & Insight resource Clinical job-planning (SST) to support dashboard development	Establish digital and data champions across relevant areas Review of clinical-coder and/or data management resource	Increased resource for training in VBHC	Examine potential AI-leveraged resource for data quality
The Data Maturity Journey	Linking VBHC programme to Data Warehouse timelines Agree process & accountability for PROMs collection journey	Each SST establishes process for agreeing PROMs collection Procurement of PROMs collection tool commenced	All SSTs have SST-specific PROMs collection plans in place 1st wave of 'common' PROMs collection across all SSTs	PROMs collection tool in place, SST-specific PROMs collection Workforce & Finance (PLICs) data alignment to VBHC working	Continued development of PROMs collection to fill gaps
Technical Capabilities	Sustain Urology Proof of Concept, working through and expanding backlog Other: Develop Radiation Services from MVP to full, working through and expanding backlog		SST: Second wave of SSTs initiated	SST: Expand existing SSTs, start third wave Other Planning for SACT & Int. Care, plus org-wide (board)	SST: Expand existing SSTs, start fourth wave Other: expand existing Velindre dashboards & plan system-level
Assurance	Establish assurance processes Assessment for use in regular reporting		Ongoing clinical assurance of data in and data out Ongoing testing of outputs for finance, ops, and tech		

Note: this is a roadmap indicating direction of travel, it would need to be complemented by a more detailed programme plan to support delivery.**Ordering of SSTs is provisional pending testing**

Recommendations

Short-Term

- **Continue to support VBH Programme:** continue with Steering Group meetings, afford agenda time and bandwidth to review outputs

Medium-Term

- **Develop Value Intelligence Centre (VIC)**: support the onboarding of the new VIC resources, and create space for changes to leadership thinking (VBH mindset) and what that means across different areas of Velindre. This will support the increasing maturity of data collection and data quality with specific resourcing to progress, as well as the maturity of analytical products to drive added VBHC insights
- **Resource allocation:** both from within the VIC, from other supporting teams (BI and Digital in particular), and from end users (clinical, finance, ops), allocation of appropriate resource to support development of technical capabilities and changes to uses of data as the organisation increases its data maturity will be essential. The resource requirements will be different at different stages and for different teams
- **PROMs Tool Procurement:** Establish project to procure PROMs tool in collaboration with WViHC
- **Changes to governance and ways of working:** Continue to consider VBHC in thinking about changes to governance (e.g. Clinical & Scientific Board), with VBHC principles supporting any changes (e.g. patient/donor voice at centre of thinking). This would include changes to ways of working supporting governance – trialling iterative feedback via the Intelligence Cycle and aligning VBHC outputs to current/required reporting (this will be a long-term action as VBHC and general data maturity increases)
- **Support SSTs on data maturity journey**: development of forums, empowering champions & role models for new ways of working, additional clinical coders and/or data manager resources. Dashboards themselves provide a positive feedback loop – more/better data available increases incentives to improve data

Long-Term

- **System engagement:** Continue engagement beyond Velindre as programme continues to expand - dialogue with national programme and commissioners on joint projects

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

2023/2024 Quarter 1 (1st April to 30th June 2023) and Quarter 2 (1st July 2023 to 31st July 2023)

QUARTERLY INFORMATION GOVERNANCE ASSURANCE REPORT

DATE OF MEETING	14/09/2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	ASSURANCE
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Ian Bevan, Head of Information Governance Matthew Bunce, Executive Director of Finance
PRESENTED BY	Matthew Bunce, Executive Director of Finance
APPROVED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SUMMARY	The purpose of this report is to provide **ASSURANCE** about the way VUNHST manages its information in respect of patients, donors, service users and staff, highlighting compliance with IG legislation and standards, actions to improve management of IG risks and reporting IG incidents and actions from lessons learned. The report highlights 3 out of the 8 domains for reporting within the period, so that over a 12 month

	period all 8 domains are reported on to EMB and consequently QSP. The domains reported on for the period of this report are: The NHS Wales IG Toolkit, Information Management and Information Security. As a standing set of items, risks are reported on via the DPIA's process, incidents that have taken place within the reporting period and their analysis and training provision and attainment for the reporting period. The inclusion of the domains and the standard items are to provide assurance to the Committee that the Trust manages information in accordance with legislation, codes of practice, statutory guidance and Trust Policy.

RECOMMENDATION / ACTIONS	The Committee is asked to note the contents of this report for **ASSURANCE**

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	31/08/2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS N/A	

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

APPENDICES	
N/A	The full Quarterly Information Governance Assurance Report - 2023/2024 Quarter 1 (1st April to 30th June 2023) and Quarter 2 (1st July 2023 to 31st July 2023) was presented to EMB on 31/08/2023. A copy is available for perusal by the Committee should it wish to do so.

1. SITUATION

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

The report outlines key **ASSURANCE** activities, (1) NHS Wales IG Toolkit Assessment 2022/23, (2) Information Management (3) Information Security. The report also includes data security incidents & investigations for the reporting periods of 1st April 2023 to 30th June 2023 and 1st July 2023 to 31st July 2023.

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

2. BACKGROUND

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

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

3. ASSESSMENT OF MATTERS FOR CONSIDERATION

The following are the key highlights as detailed within the Quarter 1 for the period of 1st April 2023 to 30th June 2023 and the first month of Quarter 2, 1st July 2023 to 31st July 2023.

- The three IG Assurance Framework areas being focused on are:

(1) NHS Wales IG Toolkit Assessment 2022/23

(2) Information Management

(3) Information Security

Work in these areas will lead to improvements in IG systems & processes.

- An extract of current DPIA activity is included to provide assurance that DPIA's are undertaken as routine business to impact assess the risk of data processing for existing services/systems and the delivery of new services/systems.

(1) NHS Wales IG Toolkit Assessment 2022/23

The All-Wales Information Governance Toolkit 2022/23 has undergone a radical re-design and update from the previous 2021/22 version. The 2021/22 Toolkit was a change from previous years. A pilot version which was still undergoing testing was released for completion by NHS Wales Trust's and Health Boards in February 2023 with a deadline of 30th June 2023. The Trust completed the 2022/23 Toolkit within the specified deadline successfully, the result being that the workplan derived from the 2020/21 Toolkit remains unchanged.

The main feature of the 2022/23 pilot toolkit was the removal of the four (4) numerical levels of attainment which were replaced with three (3) levels of attainment, these being "achieved minimum requirement" and "achieved maximum requirement", the lowest level would mean that by not achieving the minimum level of attainment this was the de-facto level achieved, but it is not stipulated in the Toolkit.

The pilot version remains subject to further testing and change during 2023/24 as the Toolkit is intended to be rolled out further to Primary Care providers and Community Pharmacies across Wales in order to ensure compliance with NHS England security requirements.

Due to "*teething problems*" with the Toolkit within DHCW, e.g. the inability to provide a contrast and comparison with the previous iteration of the Toolkit for assurance purposes, the inability to provide numerical scoring to Trusts and Health Boards, the removal and some amalgamations of subjects within the Toolkit post-submission within DHCW and further development activity needed to provide confidence to Trust's and Health Boards, means that the Toolkit is not presented for review by the Committee within this report.

This is because, whilst the overall assessment achieved in this year's Toolkit submission aligns with previous assessments made by SIRO and HoIG and the Audit Report of March 2023 (reported upon in the previous quarterly report), it will allow internal review by SIRO, and enable discussion with the vice-Chair of the Board (Board Champion for IG) and Chair of the Committee for them to clearly understand the challenges being experienced by DHCW and the changes in the Toolkit since the previous submission of 2021/22.

(2) Information Management

Provides assurance that the Trust manages its information compliantly in line with applicable legislation, codes of practice and statutory guidance, this includes the Data Protection Act 2018, Freedom of Information Act 2000, Environmental Information Regulations 2004 and the NHS Wales Records Management Code of Practice for Health and Social Care 2022.

Specific work undertaken in Information Management during the reporting period includes an audit into the Subject Access Process in VCC in June 2023 and significant activity in supporting COVID Inquiry work.

Information Security

Provides assurance that the Trust processes data securely by means of appropriate "technical and organisational measures", it is known as the security principle and is contained in both the Caldicott and Data Protection principles.

In undertaking appropriate technical and organisational measures, the Trust considers things such as risk analysis, organisational policies and physical and technical measures. The primary risk management tool is the Data Protection Impact Assessment.

In the reporting period, work has been undertaken in relation to Information Security. Further information is in the Quarterly Information Governance report.

The Committee is asked to note that during the reporting period, there have not been any significant events in relation to Information Security. The incidents and investigations section of this report contains further information on the types of information security incidents that have taken place within the reporting period.

SAR'S, DPIAs, contract register and associated Data Processing/Sharing Agreements (included from previous reporting period to provide assurance) Data security incidents & investigations.

Data Protection SARs for clinical information and requests from third parties

For Quarters 1 and 2 2023/24, the following SAR's were submitted:

	Number of requests	Number of requests completed within statutory timeframe	Percentage compliance
1	51	43	84.3%
2	14*	7	100%

*The Committee is requested to note that the timeline for July 23 remains extant, as such there have been no breaches for July 2023 at the time of writing, a full picture of Q2 2023/24 will be reported upon in the next report. .

The Health Records Manager reviews the VCC SAR register weekly and the Head of IG receives the VCC SAR register monthly. The aim of this approach remains to provide professional advice and guidance to the VCC Medical Records Department.

The SAR process in Medical Records has undergone an Audit in June 2023. Further information is in the Quarterly Information Governance report.

Data Protection SARs for non-clinical information

For Quarters 1 and 2 2023/24, the following SAR's were submitted:

Quarter	Number of requests	Number of requests completed within statutory timeframe	Percentage compliance
1	0	0	100%
2	2*	2	100%

The request in Q4 which was paused due to the need to reduce the data set to a manageable level within available resources was refused as manifestly unreasonable in accordance with ICO guidance.

*2 requests were received in July 2023. 1 request was completed within 10 days of the request, the second request was completed within the timeframe, but delivery is delayed by the requestor who due to their absence on holiday outside the UK requested a face-to-face meeting with Workforce, where due to its complex nature and high volume the information will be presented. An audit trail of the request to delay presentation of the information by the requestor is held by HoIG.

SARs for non-clinical information – NWSSP

For Quarters 1 and 2 2023/24, the following SAR's were submitted:

Quarter	Number of requests	Number of requests completed within statutory timeframe	Percentage compliance
1	1	1	100%
2	0	0	100%

Data Protection Impact Assessments

The Register records the amount of Trust DPIA's that have been completed or are in process between 1st January 2023 to 31st July 2023.

Division	On register	Completed	Not Started	Ongoing	Paused	Cancelled	Total
Corporate	8	2	4	2	0	0	8
VCC	25	6	10	5	1	3	25
WBS	12	3	2	6	0	1	12
TCS	0	0	0	0	0	0	0
HTW	1	1	0	0	0	0	1
Total	**46**	**12**	**16**	**13**	**1**	**4**	**46**

- 4 Trust DPIA's have been approved during Quarter 1 and July 2023/24.
- The 4 Corporate DPIA's that are not yet started relating to the following:
  - NHS Wales App
  - LMS ThinkQI
  - Robotic Processing Automation – Blue Prism
  - Mentimeter
- Of the 10 VCC DPIA's not yet started, 6 relate to Apps, these Apps are as follows:
  - Mindfulness App
  - BAPS App
  - Acute Oncology Service App
  - IRS App
  - ChemoPro App
  - Consultant Connect App
- 1 VCC DPIA is paused, this is because the project has not yet been approved within the IMTP process by VCC SLT.

Work remains ongoing in Service areas across the Trust to progress DPIA's with regular catch ups undertaken between HoIG and Service Leads in a workshop format to ensure that support is provided where necessary.

Quarter 1 (1st April 2023 to 30th June 2023) NWSSP Data Protection Impact Assessments (DPIAs)

DPIAs completed in Q1 (April to June 2023) – **0**

Legitimate Interests Assessments (LIA) engaged with IG service / completed or in progress in Q1 (April to June 2023) – **3**

Quarter 2 (1st July 2023 – 31st July 2023) NWSSP Data Protection Impact Assessments (DPIAs)

DPIAs completed or ongoing in Q2 (1st to 31st July 2023) – **2**

LIA's engaged with IG service / completed or in progress in Q2 (1st to 31st July 2023) – **2**

NWSSP Overview

There are others not recorded that are still being worked through and are in the process of review with the project owners, hence they are classed as work in progress (WIP) and will be completed once the assessments and further evidence, responses and details have been satisfied and approved.

There are others from 2022/23 that are also classed as WIP as projects and their procurement/implementations are ongoing and things will change. This informs the need to update the initial DPIAs (as continual working documents until all risks are known and answers provided).

Data security incidents & investigations

There has been one incident of note since the last report which is an incident whereby PII was disclosed via email misdirection within VCC. The incident resulted via an incorrect email address being used, this was caused by the copy /paste of the email address which resulted in a cross domain incident, e.g. the outgoing destination domain was BTOpenWorld, the recipient domain was BTInternet.

BT's DPO was contacted and the incident discussed. After further investigation it was found that a punctation mark had caused the incident. The incident was reported to the ICO, and an investigation number assigned, the ICO was updated via email on 27th July 2023 and after internal confirmatory discussions with the service area (VCC Head of Nursing) was closed as the affected individual was content with the Trust's approach and there was deemed to be no further risk to that individual. To date, the ICO has not contacted the Trust for any further information post the initial report and update on 27th July 2023.

Incidents & Investigations for the period 1st April 2023 to 30th June 2023 (Quarter 1)

Service	DATIX Incidents	Incidents Reported outside DATIX	Total Incidents	Reported to ICO	Investigation			Investigation		
					Low Risk / No Harm	Root Cause Analysis	Total	Open	Closed	Total
Corporate Services	2	0	2	0	2	0	2	1*	1	2
Velindre Cancer Services	7	0	7	1	6	1	7	1*	6	7
TCS	0	0	0	0	0	0	0	0	0	0
WBS	4	0	4	0	4	0	4	2*	2	4
NWSSP	15**	0	15	0	15	0	15	0	15	15

Total Trust	**28**	**0**	**28**	**1**	**27**	**1**	**28**	**4***	**24**	**28**

* IG element complete, awaiting service to close the incident.
** 15 Incidents, 4 of which were outside NWSSP, leaving 11 NWSSP Incidents reported in DATIX

Incidents & Investigations for the period 1st July to 31st July 2023 (Quarter 2)

Service	DATIX Incidents	Incidents Reported outside DATIX	Total Incidents	Reported to ICO	Investigation			Investigation		
					Low Risk / No Harm	RCA	Total	Open	Closed	Total
Corporate Services	0	0	0	0	0	0	0	0	0	0
Velindre Cancer Services	7	0	7	0	7	0	7	6	1	7
TCS	0	0	0	0	0	0	0	0	0	0
WBS	1	0	1	0	1	0	1	1	0	1
NWSSP	3*	0	3	0	3	0	3	1	2	3
IT incidents with IG impact	0	0	0	0	0	0	0	0	0	0
Total Trust	**11**	**0**	**11**	**0**	**11**	**0**	**11**	**8**	**3**	**11**

* 3 Incidents reported of which 1 reported as a concern and outside NWSSP, leaving 2 incidents that are directly within NWSSP.

The top three themes of incidents 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.
- The remaining areas are split between
  - other
  - patient records/information inappropriately divulged
  - Staff records sent to wrong recipient
- It remains the case that most incidents could be avoided with improved IG awareness & training of staff as human error remains the common factor
- **100% of the incidents closed were graded as no harm to the continuity of patient care, donor services or to staff**
- Corporate division has no incidents reported, nor under investigation.
- TCS division has no incidents reported, nor under investigation.
- IT incidents with IG implications added to reporting; Effective Q2 2023/24.

- Quarterly IG assurance meetings between Stephen Harries (IM champion for IG), Matthew Bunce (SIRO), Ian Bevan (Head of IG/DPO) and Carl Taylor (Chief Digital Officer) continue to take place to provide additional assurance to the committee.
- Timing for the next Caldicott Meeting is under consideration, this is because adjustments have had to be made to the meeting schedule due to higher priority activity within the Trust in Q2 2023/24.

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.
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)** A financial penalty would be set by the ICO which would require significant Trust Board involvement
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*	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;* *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

Trust Estates Assurance Group – Highlight Report

DATE OF MEETING	14/09/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not applicable

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

REPORT PURPOSE	FOR NOTING

ACRONYMS	
VCC	Velindre Cancer Centre
WBS	Welsh Blood Service
NWIS	NHS Wales Informatics Service
CSTF	Core Skills Training Framework
NWSSP	NHS Wales Shared Services Partnership
HTW	Health Technology Wales
HSE	Health and Safety Executive
RIDDOR	Reporting of Diseases and Dangerous Occurrences Regulations
nVCC	New Velindre Cancer Centre

1. PURPOSE

1.1 This paper had been prepared to provide the Quality, Safety and Performance Committee with a summary of the key issues considered, and actions taken, by the Trust Estates Assurance Group during quarter 1 (2023 /2024)

1.2 The Trust Estates Assurance Group considered reports from the Trust services in relation to Health and Safety, Fire Safety, Environment and Statutory Compliance as of quarter 1 (2023 / 2024).

1.3 Key highlights from the meeting are reported in section 2.

1.4 The Quality, Safety and Performance Committee is asked to **NOTE** the contents of the report and the actions which are being taken.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	**Health and Safety** Training compliance in the RD&I, TCS and VCC division remains below the 85% Welsh government target. There has however been a steady improvement over the last 12 months and it is anticipated that this will continue. Across the corporate functions and the VCS it has been identified that there is a requirement for additional violence and aggression training. The departmental managers have been contacted, and, the required training is being arranged. **Fire Safety** Statutory and Mandatory Training levels are below required levels across the whole organisation. An action plan has been developed in order to improve compliance and this has resulted in improved training compliance in quarter 1 (2023 / 2024). Ongoing compliance will be monitored during quarter 2 and a follow-up report will be submitted to the Trust Executive Management Board. **Environmental / Sustainability** Utility costs remain at an inflated level; this provides a cost pressure to the Trust. However, Trust utility costs are being closely monitored and reported and we are also working closely with NWSSP and Health Board colleagues to reduce costs if/where possible. This topic is currently an agenda item for the All-Wales Financial Managers Forum.
ADVISE	**Health and Safety** There have been two incidents relating to chairs within waiting areas at VCC. The Trust Estates department are currently completing an audit of all chairs at VCC. This will be completed by the end of quarter 2 (2023 / 2024). In parallel, the potential need for replacement patient chairs has been highlighted to the Trust Capital Planning Group. **IOSH Managing Safely** 30 licenses have been issued to WBS and VCC. Two candidates to date have successfully gained their accreditation.

Health and Safety Risk Register

The Health & Safety Risk Register includes all Health & Safety risks with a current rating of 12 or above and H&S safety risks with an impact of 5.

Fire Safety

Three major projects to increase fire safety compliance are nearing completion. These projects will vastly improve the safety of the estate. Works have been delivered on Programme (time) and have addressed deficiencies identified by external audit to include,

- Compartmentation
- Fire doors
- Emergency lighting arrangements

A programme of works to validate the cause-and-effect arrangements at the Velindre Cancer center fire alarm system is underway and is due for completion by the end of March 2024.

Environmental

The Welsh Government is introducing new regulations that will require all workplaces to separate recyclable materials in the same way that most domestic householders are currently required do undertake. In response, the Trust Waste Management Policy has been reviewed, updated and submitted for approval by the Trust Estates Assurance Group.

Sustainability

A key enabling action within the Trust Sustainability Delivery Plan is the requirement to produce a Decarbonisation Action Plans (DAP) for submission to the Welsh Government in April 2024. The Trust is currently on target to achieve this national requirement.

Estates and Statutory Compliance

Staffing

Staffing levels have improved since the last update provided to the Executive Management Board. However, the department still holds a number of vacancies. It is planned that these key positions will be filled by the end of 2023.

Trust Discretionary Capital Programme

The capital programme for 2023/2024 has been approved. A summary of progress against each Estates scheme is provided below.

	Linear Accelerator (LA) 5 Replacement LA5 replacement, and associated bunker refurbishment works, has started with an anticipated completion date of October 20th 2023. Machine delivery is scheduled for October 21st 2023 and it is then planned that the linac will become operational in January 2024. **Boiler Replacement at VCC** Funding has been agreed to undertake the refurbishment of the CIU Boilers at VCC. This is as a result of a catastrophic failure of the existing system. It is anticipated that works will take in the region of 4-5 weeks to replace the boilers and commission all associated works. The anticipated completion date is October 2023. **Electrical Safety** All identified electrical safety actions are in the process of being addressed and an implementation plan has been developed to ensure successful delivery. In parallel the Trust has recently recruited appropriately trained staff to support the delivery of the implementation plan.
ASSURE	**Health and Safety** • The Trust currently is out to recruitment for the post of the Trust Health and Safety Manager. In the interim professional support arrangements have been agreed with Cwm Taff Morgannwg University Health Board and with Gleeds consultants. • WBS received a visit from the HSE to look at their blood irradiator and associated controls. Although work had taken place on improving the emergency contingency plans it was highlighted, during the visit, that further work is needed. An action plan is currently being developed to address these recommendations. **Fire Safety** It has been agreed that a review of the Trust strategic fire safety management policy is required. **Environmental / Sustainability** **Travel survey** The Trust travel survey is now live and communication and events campaigns have been planned in order to engage as many staff as possible. **Decarbonisation Update** A key enabling action within the Sustainability Delivery Plan is the requirement for NHS Organisations to produce and submit Decarbonisation Action Plans (DAP) to the Welsh Government in April 2024. These plans will outline how we are implementing the Delivery Plan initiatives and, more generally, demonstrate the organisation's contribution to the collective ambition and target. Extensive work has been progressed to prioritise the action plan. A draft plan has been developed and is under review.

	CYCLE TO WORK SCHEME The Cycle to Work Scheme has been launched and will run through to September 2023. **ENERGY INITATIVES** A proposal is currently being considered which aims to reduce energy usage at the Trust HQ by revising current working patterns and arrangements. **Estates and Statutory Compliance** Current performance / compliance, as of quarter 1 (2023/2024), is summarised below: • VCC Compliance - 91% • WBS Compliance - 93% • Trust HQ Compliance - 75% • Dafen WBS Compliance 100% • Pembroke House WBS Compliance 88% • Bangor WBS Compliance – 100%
INFORM	**Health and Safety** Several Health & Safety Policies are due for review during quarter 2 of the current financial year (2023 / 2024). The revised documents will be submitted to the Divisional Health Safety & Fire Group and to the Trust Health Safety & Fire Board for consultation by end of quarter 2. **World Health & Safety Day** To celebrate World Health & Safety Day, on the 28th April 2023, and to support the rollout of the Trusts new Skin Surveillance Procedure, the Health & Safety Teams held lunch time drop in sessions at WBS & VCC. These sessions provided information to staff on looking after their hands and avoiding work related skin conditions. **Fire Safety** Trust priorities in relation to fire and safety (quarter 2 - 2023 / 2024) are summarised below: • Undertake validation of the VCC fire alarm system • Commence annual fire audit • Regain traction around fire safety action plans with divisional groups. • Focus on review of FRAs and existing fire safety policies, procedures and strategies [with input from dedicated fire safety professional]. **Environmental / Sustainability** Trust priorities in relation to environmental and sustainability (quarter 2 - 2023 / 2024) are summarised below: • Development of the revised Sustainability Implementation Plan • Hosting the Sustainable Summer Jamboree • Implementation of the Trust-wide decarbonisation plan implementation

	• Completion of the Biodiversity External Audit **<u>Estates and Statutory Compliance</u>** Trust priorities in relation to estates and statutory compliance (quarter 2 - 2023 / 2024) are summarised below: • Recruitment of key positions to support estates and statutory compliance • Delivery of linac 5 to VCC • Delivery of CIU Boiler refurbishment at VCC • Key Appointments of AP & CP Roles • Implementation of Synbiotix
APPENDICES	**NOT APPLICABLE**

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

WELSH BLOOD SERVICE QUALITY SAFETY AND PERFORMANCE REPORT

DATE OF MEETING	14/09/2023

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	Peter Richardson, Head of Quality and Regulatory Compliance, WBS
PRESENTED BY	Alan Prosser, Director WBS & Peter Richardson, Head of Quality and Regulatory Compliance
APPROVED BY	Cath O'Brien, Chief Operating Officer

EXECUTIVE SUMMARY	This report is a summary of key operational, quality, safety and performance related matters being considered by the Welsh Blood Service between February 2023 and July 2023, and has been prepared in readiness for Velindre University NHS Trust Board and Committee governance arrangements. The report also highlights key programmes taking place across the Division. The main report summarises :

	• Key performance outliers and associated actions to resolve • Key quality and safety related indicators and remedial action identified • Feedback from Donors and the responses to it. • Regulator and Audit Feedback, assurance and learning themes • An outline of key service developments in WBS

RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee are asked to **NOTE** the information in this report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Welsh Blood Service Senior Leadership Team	09/08/2023
	(DD/MM/YYYY)
	(DD/MM/YYYY)
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The Senior Leadership team at the Welsh Blood Service have considered the report and noted the overdue actions. Progress in completing these action will be monitored at the Welsh Blood Service Integrated Quality and Safety Hub and updates provided to Senior Leadership Team in September 2023	

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

APPENDICES	
1	**WELSH BLOOD SERVICE - QUALITY, SAFETY & PERFORMANCE COMMITTEE REPORT February to July 2023**

ACRONYMS	
WBS	Welsh Blood Service
WTAIL	Welsh Transplant and Immuno-genetics Laboratories
MHRA	Medicines and Healthcare products Regulatory Agency
RAGG	Regulatory assurance and governance group
SAE	Serious Adverse Events
CA/PA	Corrective Action/Preventative Action
SABRE	Serious Adverse Blood Related Event
UKAS	United Kingdom Accreditation Service
DPIA	Data Protection Impact Assessment

1. SITUATION

This paper is to provide the Quality, Safety & Performance Committee with an update on the key quality, safety and performance outcomes and metrics for the Welsh Blood Service for the period February to July 2023

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

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

2. BACKGROUND

This report is a summary of key operational, quality, safety and performance related matters being considered by the Welsh Blood Service between February 2023 and July 2023, and has been prepared in readiness for Velindre University NHS Trust Board and Committee governance arrangements.

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

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The main report summarises :

- Key performance outliers and associated actions to resolve
- Key quality and safety related indicators and remedial action identified
- Feedback from Donors and the responses to it.
- Regulator and Audit Feedback, assurance and learning themes
- An outline of key service developments in WBS

3.1 Triangulated Analysis

The report provides assurance to the Quality, Safety and Performance Committee that WBS is continuing to meet its Quality, Safety and Performance standards. In summary, for the reporting period (February to July 2023):

- All clinical demand was met for red cells and platelets although mutual aid was requested immediately after Easter due to an unexpected increase in demand.
- The service entered Blue Alert for A negative blood group on May 25th as demand exceeded supply in over the early May bank holidays, and with a limited ability to make up the deficit due to a further Bank Holiday and upcoming industrial action. This alert was stood down on June 1st
- A further Blue alert was issued on June 27th and stood down on July 3rd
- Closure of quality incidents within the required 30 days has remained stable and consistently achieved between 96% and 98% for the whole reporting period.
- During the period 3 Serious Adverse Blood-Related Events (SABRE) were reported to the Medicines and Healthcare products Regulatory Agency (MHRA) and 2 incidents were reported to the Human Tissue Authority.
- 41 concerns were reported, 40 of which were managed within timeline as early resolution as detailed in the report.
- Overall donor satisfaction improved slightly and continues to exceed target at 96.5% over the reporting period.
- Inspections by UK Accreditation Service (UKAS) were completed successfully, and the relevant accreditation maintained or extended.
- The UK Health and Safety Executive team also inspected the irradiation facilities at WBS in May 2023, findings from the inspection are being addressed under a formal action plan and on target for completion by the end of September 2023.

3.2 Key Actions / Areas of focus during next period

Quality and safety and donor experience remains at the heart of our service during this period in all aspects of service delivery as well as the well-being of our staff. During the period August to December 2023 the following areas will continue to be a priority:

- Continue to monitor and sustain blood stocks, whilst continuing to pursue prudent use across NHS Wales.
- Implement the strategy to increase both the number and diversity of bone marrow donor volunteers.
- Ensuring that actions relating to quality and safety incidents are completed in a timely manner.

4. SUMMARY OF MATTERS FOR CONSIDERATION

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). *[Please include narrative to explain the selected domain in no more than 3 succinct points].* This report summarises the Welsh Blood Service performance across all six domains of quality and is divided into sections covering each domain.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not yet completed (Include further detail below why)
	[In this section, explain in no more than 3 succinct points why an assessment is not considered applicable or has not been completed]. Paper is for noting and therefore out of scope of the legislation

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	A 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
	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.
	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*	Yes - please outline what, if any, actions were taken as a result
	No specific actions identified
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

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

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	*[Please insert detail here in 3 succinct points].*
WHAT IS THE CURRENT RISK SCORE	Insert Datix current risk score
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	*[In this section, explain in no more than 3 succinct points what the impact of this matter is on this risk].*
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Insert Date
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	**Choose an item**
	[In this section, explain in no more than 3 succinct points what the barriers to implementation are].

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

WELSH BLOOD SERVICE - QUALITY, SAFETY & PERFORMANCE COMMITTEE REPORT

February to July 2023

INTRODUCTION

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

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

1. Safety

Incidents linked to donors are reported into the Donor Quality and Safety Group and scrutinised at the Divisional Integrated Quality and Safety Hub, These include failed venepuncture where a needle is not properly sited in a vein, and part bags where a donation stops before the full quantity is collected. Instances of failed venpunctures remained stable at low levels and within tolerance during the reporting period (to end of July) for whole blood. For apheresis an increase in venepuncture events, such as pain and/or bruising has been recorded since March, this has been attributed to two new team members undergoing training. Overall, the numbers of safety incidents remain low and within tolerance.

1.1 For reporting purposes, WBS sub-divides incidents into two types:

- **Good Manufacturing Practice (GMP) Incidents**, in which our routine process monitoring and checking identifies non-compliance with expected processes or outcomes and responds to prevent further processing or harm to patients. These are reported into the Q-pulse electronic Quality Management System and monitored as a critical part of the overall Quality Management System (QMS) in line with regulatory standards.

There were 198 GMP incidents occurring between February 2023 to July 2023 reported via QPulse. All of these incidents were closed i.e. reviewed and Corrective/Preventative Actions (CAPA) assigned within 30 days.

Incidents which may lead to redress or could result in harm to donors, patients or staff – these are reported in Datix Cymru for consistency across the Trust. Between February and July 2023 43 incidents were reported in Datix Cymru all were classified as low risk.

- No significant trends were identified in quality incidents reported between February and July 2023.
- Quality incident investigations continue to exceed the target of 90% closed within 30 days.
- Performance is closely monitored with each (QPulse) incident report being reviewed within a working day of being reported to ensure all information needed for effective risk assessment and investigation is captured. The review identifies complex investigations that may need multi-disciplinary support to establish a root cause.
- The progress of all actions to address incidents is closely monitored. The Quality Assurance (QA) team send weekly updates alerting owners/managers of actions recorded within QPulse that are likely to breach close-out deadlines.

1.2 Areas of concern:

All QPulse incidents have been reviewed by Quality Assurance (QA). All rationales and risks of late reporting have been recorded in QPulse and assessed by the QA team; where the rationale has not been deemed satisfactory this has been fed back to the reporter and relevant department head.

- Main categories of incidents were Blood Pack Incidents (31%) and Laboratory Errors (24%), and Equipment Problems (10%). Also to note 17 events (9%) were categorised as 'incident', 11 of these were related to documentation.
- Main locations of incidents were within Distribution (Hospital Services), Manufacturing Laboratory and the Stock Holding Unit (SHU).
- Twelve incidents had a significant risk rating and were subject to a detailed root cause analysis investigation and include the following:

INV-588	Error in transformation of an irradiated red cell
INV-596	BactAlert Hardware failure not detected by middleware
INV-605	Kell negative not accredited but sent via EDN
INV-614	Contractors removed commercial products from temperature controlled room
INV-664	Time cards with two time slots and printed in black and white instead of colour
INV-725	CIPC used to issue unreleased platelet
INV-727	eProgeas 'unknown' errors on some Bacteriology monitoring results(integration into eProgesa issue)
INV-729	Red Cell Donation labelled with an inaccurate pack weight.
INV-733	Defective reagent used for Luminex Antibody Testing, which has resulted in reporting of incorrect test results
INV-738	Pooled platelet with negative bacterial monitoring result, was investigated for contamination on Day 7
INV-769	Platelet Yield for donations collected using Trima Accel Machines with Version 7 software drops below 75%
INV-773	Luminex antibody result incorrecty imported into SPRES from Fusion

1.3 Regulatory Inspections

There have been two United Kingdom Accreditation Service (UKAS) assessments within the reporting period:

Accreditation surveillance of the Welsh Assessment of Serological Proficiency Scheme (WASPS) was undertaken in May. One mandatory finding was raised, however UKAS do not require evidence to be formally submitted and accreditation status was maintained

Assessment against ISO 15189:2012 standards took place in July. This was the second surveillance assessment in the four-year cycle, and also included extension to scope activities to include accreditation of the following:

- Next Generation Sequencing – method for high resolution HLA typing
- Light-cycler - instrument used in HLA and HPA typing
- New kits for HLA and HNA antibody testing (on existing Luminex analysers)
- Neo Iris analysers - for blood grouping, antibody screening and red cell phenotyping

Eight mandatory findings and two recommendations were raised.

The UKAS Assessment Manager has recommended that accreditation is maintained, subject to satisfactory close-out of the findings. Evidence to support close out was submitted by the deadline of 07/08/2023.

Extension to scope for Neo Iris analysers returned one mandatory finding. recommended that accreditation is extended to include additional testing, The UKAS Assessment Manager has recommended accreditation for activities included under the extension to scope, following submission of evidence and satisfactory close-out of the finding. Evidence must be submitted by 06/10/2023. The UKAS assessors were highly complimentary about the staff, systems, and processes they inspected.

The UK Health and Safety Executive team also inspected the irradiation facilities at WBS in May 2023, findings from the inspection are being addressed under a formal action plan and on target for completion by the end of September 2023.

1.4 Serious Incidents Reportable to Regulators

There were three reportable events submitted to the Medicines and Healthcare Products Regulatory Agency (MHRA) in this reporting period, one in February and a further 2 in May. Each incident has been investigated by a multi-disciplinary team involving subject matter experts and members of the clinical and quality teams. Root cause analyses and corrective actions have been reviewed by the divisional Integrated Quality and Safety Hub before submission to the relevant regulator:

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.

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.

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.

All three reports have been reviewed by MHRA and closed within the SABRE reporting system, although MHRA have suggested WBS review how to manage reduced stock to avoid issuing units via the CIPC (SABRE 107). Evidence detailing the outcome of the WBS review will be added to the associated SABRE report.

Two reportable events were submitted to HTA during this reporting period (February - July)

CAS-66484-W4W1 *Weld seal failure, giving rise to the potential for bacterial contamination* The probability fo bacterial contamination was deemed low and it was subsequently established, via investigation, that bacterial contamination was not present in the pack despite the weld seal failing. HTA have reviewed and closed this report.

CAS-68122-L3L9 *Positive blood culture result from a stem cell harvest product sample*. Gram positive bacilli for *paenibacillus durus* was confirmed after 3 days incubation. HTA were notified as there is an increased risk to the recipient, however relevant processes have been followed and the issue was picked up by routine process monitoring. Sample testing at the transplant centre did not detect any contamination which indicates that contamination of the original test sample occurred at the point of inoculation and was not linked to the collection itself. This report is still under review by HTA.

1.5 15 Step Challenge Action plans

There have been no 15 Step Challenge visits during the reporting period. Action plans from previous visits have two longer-term actions outstanding

1.5.1 The action plan arising from the 15-step Challenge visit to the North Wales Collection team in August 2022 is complete from an operational perspective. There is one remaining action relating to network connectivity for collections staff which is part of a longer term ambition to roll-out cellular connectivity.

1.5.2 The action plan arising from the 15-step Challenge visit to the Transfusion Laboratories at Talbot Green included an observation about limiting the use of paper records. This has been incorporated into a wider trial of the use of electronic signatures which is currently underway and due for review during Q3.

2. Effectiveness

2.1 Blood Supply

During the reporting period WBS has also continued to work closely with hospitals across Wales to promote appropriate use of Blood and reduce the stock levels held in hospital

blood banks. Despite this, demand over the Easter period was higher than anticipated, and stocks of some blood groups to dropped below target minimum levels (3.6 days stock). Stock was imported from NHS Blood and Transplant in England to avoid impacting service to hospitals.

Stock issued in May exceeded supply, largely linked to the succession of Bank Holidays which reduced collection team availability. A blue alert was issued for A negative red cells on May 25th. This, combined with a focus on donors with priority blood groups, allowed stocks to recover within 7 days and helped to avoid a potential similar alert for O positive red cells. A further blue alert was issued on June 26th and stood down on July 3rd.

2.2 Bone Marrow / Stem Cell collections

Bone marrow and stem cell collection activity has increased over the reporting period with 24 collections being completed between February 2023 and July 2023. April and June were particularly encouraging with 6 collections in each month and 3 collections each for the other months. A review of the donor recruitment and retention strategy continues.

2.3 Audit Summary

There were 29 internal audits scheduled for completion between February and July. Three audits were also carried over from January (now complete).

2 audits were postponed for one month due to auditor/auditee availability: Information Governance (now complete) and Business Continuity (in progress).

The risk from late completion has been assessed as low due to coverage within external and internal ISO audits as standard.

Where audit reports are still in progress all findings raised have been approved during and following audit by auditees/HODs/Section Heads.

2.3.1 Corrective and Preventative Actions Summary:

- No Major or Critical findings raised February 2023 to April 2023
- 3 Major Non-Conformances raised in May 2023 and one raised in July 2023:

IA40 – Raised against Automated Testing, under Supplier Audit 22/01(S) NHSBT Colindale (Information Governance)
The WBS has not submitted a Data Protection Impact Assessment (DPIA), as mandated in Article 35 of UK GDPR, and Section 3.3 of the NHS Wales Records Management Code of Practice for Health and Social Care 2022.

IA41 – Raised against QA Systems, under Audit 22/37 Verto and Change Control (Procedural)
A number of closely associated issues with the Verto Change Management Process have been encapsulated within this one Major finding.

IA42 – Raised against Collection Team (East B), under Audit 22/34 (Documentation – Version Control)
Incorrect version Before you Donate Booklet (CSD-044E) located within Screening Booths (Version 9.0, currently at version 10.0). Although the update does NOT pose a risk to the quality and safety of the donation, it does mean that donors may not be fully informed about the risks of donation if unaware of the update.

IA 60 – Raised against Hospital Services under Audit 23/01 Procedural - Vertical Audit of Full Donation Cycle
The incorrect version of 5 printed documents (SOPs) were in use within the department (updated versions available via QPulse), two documents were not printed on official paper and one archived document had not been removed from use. A root cause investigation is in progress, with CAPA to be completed accordingly.

2.3.2 Audit Corrective/Preventative Action (CAPA) Trending:

- No significant trends were identified in this reporting period.

- CAPA (from April 2023 to July 2023):
  Major - Consistent with 2022/2023 categories
  Minor - The top 4 categories remain consistent with the top 4 categories raised throughout 2022/2023

- A full deep dive into trending of major and minor findings raised across the 2022/23 audit schedule was been provided to the WBS Integrated Quality & Safety Hub in May, including a comparison against the previous year. An action is being taken forward by QA Systems to propose an improvement initiative.

- All CAPA carrying over from 2022 was completed before the end of February 2023.

3. Service-User Centred Feedback

3.1 The introduction of CIVICA across WBS has seen a significant number of survey responses being received from donors about their real time feedback relating to their donation experience. Donor feedback between February and July 2023 is detailed below and demonstrates that our donor experience scores are above the benchmarks.

3.1.1 Donors who have been referred by the Donor Contact Centre to the Clinical Services support team for help with eligibility queries or post-donation care and advice are selected at random for a follow-up survey:

Clinical Services

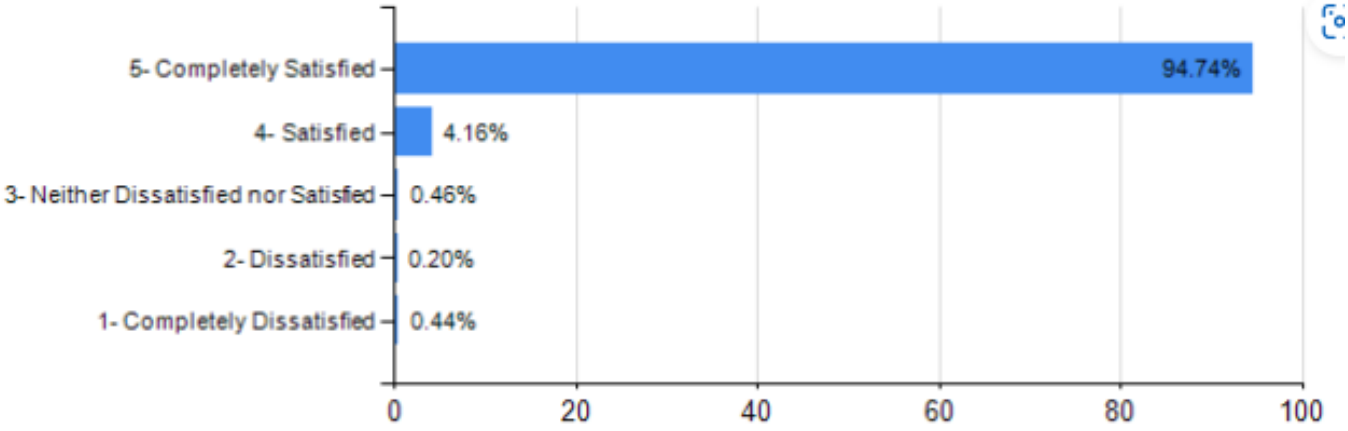
Responses	1 - The time taken to be contacted following the initial interaction was adequate	2 - The member of the Clinical Services support team introduced themselves in a warm and friendly manner	3 - The member of the Clinical Services support team made me feel at ease	4 - The member of the Clinical Services support team demonstrated knowledge and experience within their	5 - The member of the Clinical Services support team communicated effectively and used appropriate langu	6 - Appropriate and professional responses were given to the questions I raised	7 - I was actively listened to and was given the opportunity to ask questions	Overall
	Clinical Services	Clinical Services	Clinical Services	Clinical Services	Clinical Services	Clinical Services	Clinical Services	
110	100	100	100	100	100	100	100	100
Overall	100	100	100	100	100	100	100	100
Benchmarks	95	95	95	95	95	95	95	

3.1.2 All donors are given the opportunity to feedback on their experience before leaving a donation session via a table-top electronic survey

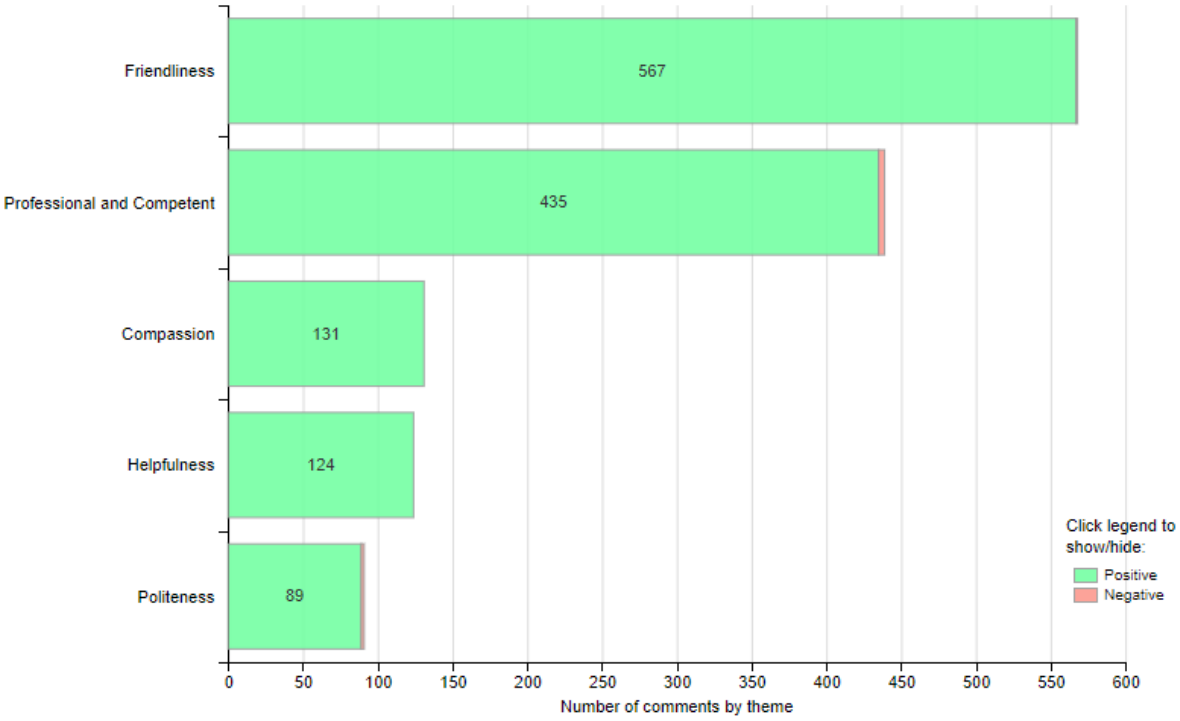
Collection Services

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

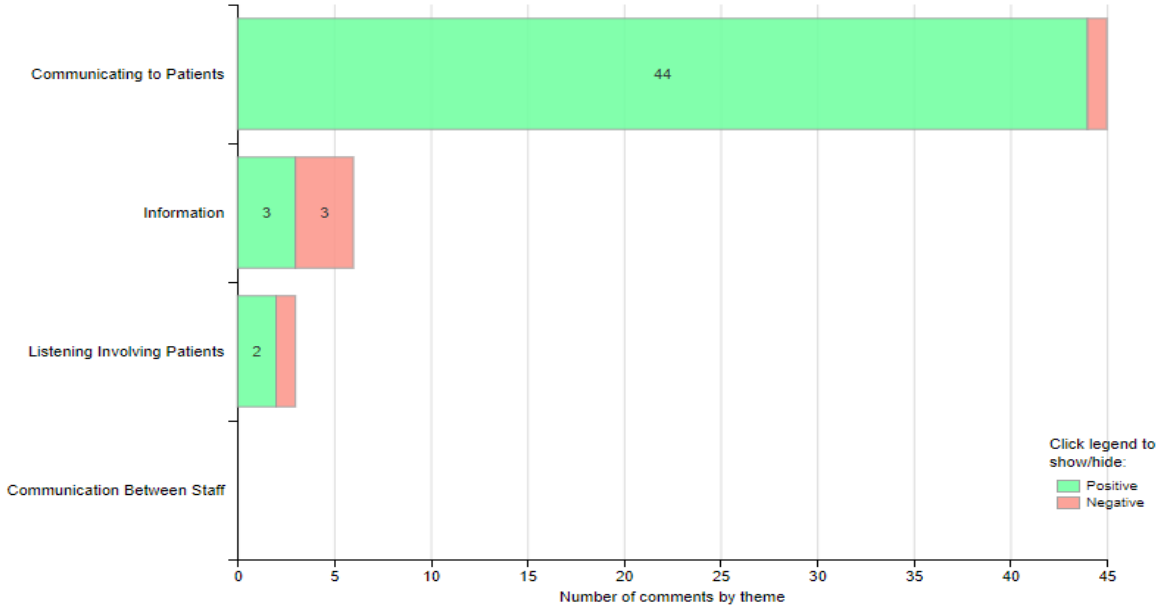
Available Answers	Responses	Score (%)
5- Completely Satisfied	4739	94.74%
4- Satisfied	208	4.16%
3- Neither Dissatisfied nor Satisfied	23	0.46%
2- Dissatisfied	10	0.20%
1- Completely Dissatisfied	22	0.44%
Total	**5002**	**100%**



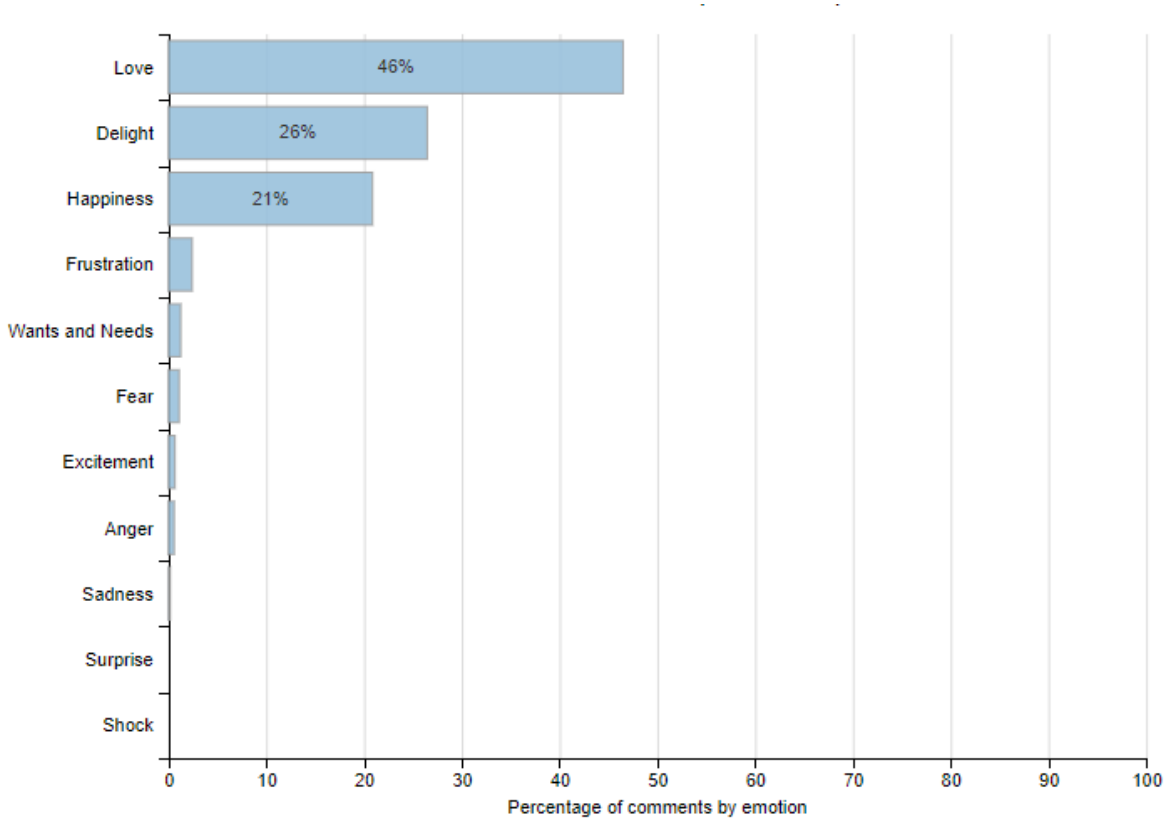
Staff Attitude & Capability



Communication



Donor Emotions



3.2 Changes in response to Donor Feedback

In response to donor feedback the following actions have been taken:

- Introduction of dairy free milk for donors to enjoy a hot beverage following donation.
- Service Improvement Project (SIP) in place to helps combat the issues raised around lack of suitable signage directing donors to a blood session venue once inside a building.
- Spell checker for Welsh translation on survey iPad changing wording or giving incorrect spelling options. Advise sort from IT to remove predictive text option from device.
- Toilets at one particular venue at a very low standard of hygiene and repair. Planning department working with venue host to resolve issue prior to next WBS visit.

3.3 Concerns

3.3.1 In the reporting period of February to July 2023, 41 concerns were reported. 1 concern was recorded by staff relating to a donors conduct, linked to an Incident and is being managed by heads of department. 1 concern being managed as early resolution outside of timeline due to being unable to contact donor. All other concerns were managed within timeline as early resolution, where contact was made, concerns were resolved to donor satisfaction, where contact with donor was unable to be achieved via telephone and or email a letter had been issued inviting donor to make contact with relevant head of department if wished to do so. No return contacts had been received at time of writing this report.
During this reporting period two themes of complaints were noted, and measures put in place to alleviate donors concerns as below: -

- **Donors being turned away due to being later for their appointment time:** Operational Managers meet with Clinic RN's and Supervisors to find a solution, donors are now given a ten minute grace for late arrivals meaning a significant reduction of this concern theme being recorded in the month of May, June and July.
- **Staff attitude and behavious including communication skills:** Ongoing review of issues raised with staff working across the Mobile Donor Unit (MDU) (since discussions concerns have decreased in the month of May, June and July)

Re-opened concern, on-going.
Original concern recorded in October 2022) Donor would like the Welsh Blood Service to be able to prove to its users, both donors and recipients, that it is collecting and recording accurate data when it comes to the sex of its donors.
Re-opened April 2023 by Corporate team Donor is concerned the WBS does not have a robust procedure in place for the safety of recipients. A formal response was issued by Chief Executive on 30/05/23 and the record closed.
Re-opened June 2023. Donor would like to be provided with a copy of the further review carried out by WBS and Velindre Corporate team. Draft response in progress.

3.4 WBS continues to invite every blood donor to complete a feedback survey in the month after their donation. The feedback highlights are:

a. During the period February 2023 to July 2023, 6,827 responses were received (21.6% response rate)

b. Donor satisfaction for those who had successfully donated was 96.5%

c. In total 5,507 donors scored themselves as ‘Totally Satisfied’ and were invited to provide more details (80.7%).

d. Out of 6,827 responses from February 2023 to July 2023, 92 donors (1.3% of responses) described themselves as ‘Dissatisfied’ or ‘Totally Dissatisfied’ and were invited to provide more details. The responses are analysed and followed up by the Collections Leadership team through their monthly operational service group.

In addition, the re-introduction of Donor Awards evenings have received overwhelmingly positive feedback from attendees and have given us the opportunity to engage with and learn from our most loyal donors.

4. Timeliness

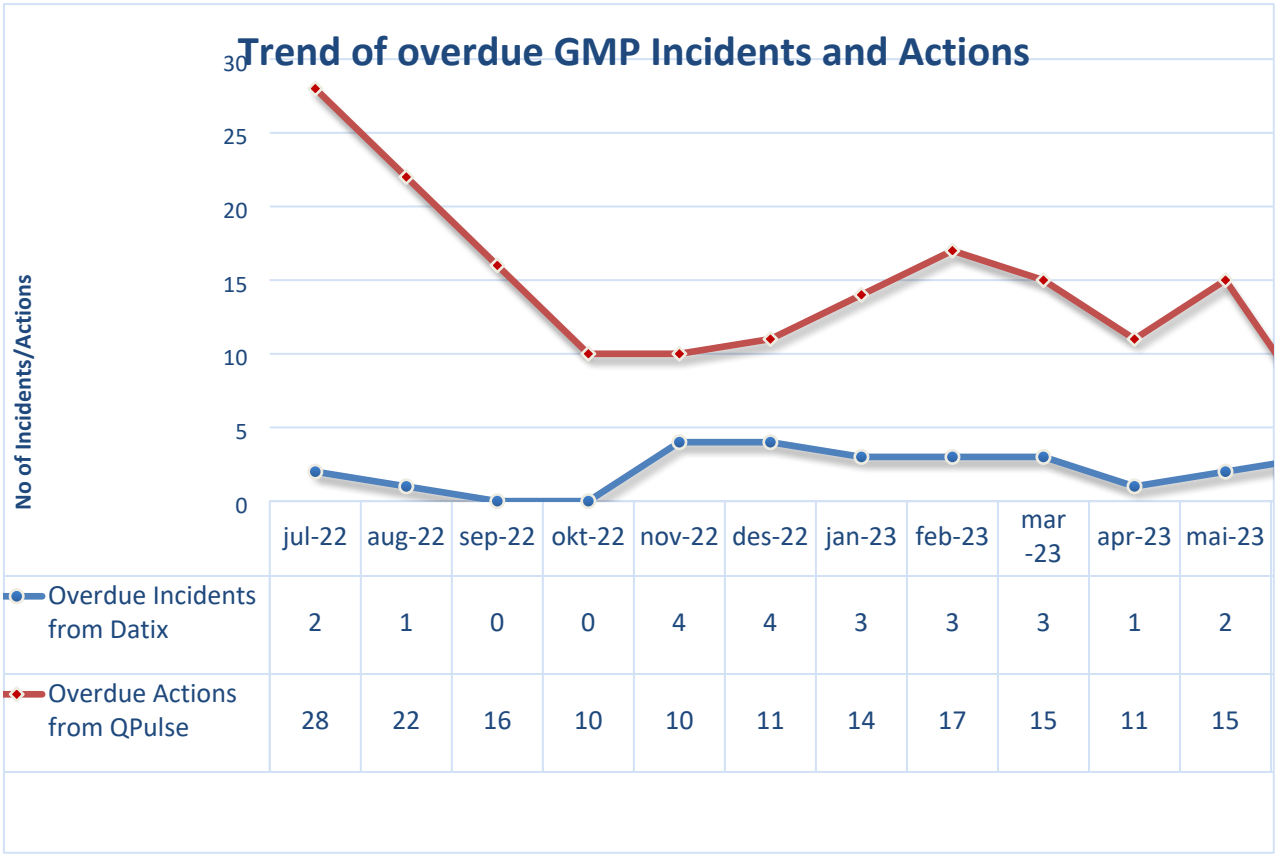
4.1 Reference Serology Turn-around times

Reference Serology 'turnaround' performance showed a significant improvement between February and May 2023, with turnaround times improving every month and exceeding the target of 80% of results provided within 2 working days in both April and May. This performance has not been sustained in June and July partly as a result of annual leave but June, in particular, saw an increase in requests of 16% above the average demand.

Compatibility testing (38% of referrals) continues to meet clinical target and all time-critical tests are being completed on time whilst the volume of testing requests remains above previous years.

4.2 Overdue activity performance trends

The following graph provides an overview of the overdue activity performance trends for incidents and preventive actions overdue for closure over the past year.



	jul-22	aug-22	sep-22	okt-22	nov-22	des-22	jan-23	feb-23	mar -23	apr-23	mai-23
Overdue Incidents from Datix	2	1	0	0	4	4	3	3	3	1	2
Overdue Actions from QPulse	28	22	16	10	10	11	14	17	15	11	15

There is an upward trend in Datix GMP incidents open more than 30 days since March, however, overall numbers remain low. There is no identifiable cause for the upward trend and the QA team continue to work with operational teams to ensure that incidents are investigated and closed effectively, and in a timely manner, reasons for delays are understood and any associated risks are recognised. Relevant managers have been advised of the requirement to review and close overdue reports, and to update the 'progress' field when reports remain open beyond the expected completion deadline.

There was a downward trend in overdue actions from February through to April, with variability from May to July; it is noted that Laboratory Services reported an increased number of events during May and therefore had a higher number of actions to manage. This area has experienced some operational challenges recently which may be affecting the ability to complete actions in a timely manner. Preventive action includes ensuring sufficient staff are available to cover increased workload in the days just prior to Bank Holiday weekends.

QA Systems have engaged with operational departments to recognise challenges to late completion; the findings were reported to RAGG and QA Triage have adopted an 'early engagement' approach with action owners to help ensure deadlines can be met, or risk-based extensions are granted.

Quarterly Corrective and Preventative Actions (CA/PA) effectiveness monitoring is ongoing for previously reported significant risk incidents; no concerns have been identified to date.

In addition, the WBS QA Triage Team monitor timely closure of non-GMP incidents reported via Datix Cymru. Where reports have not been progressed or closed in a timely manner the relevant personnel are advised and their Senior Manager is made aware. The majority of reports open for more than 30 days are Health & Safety related events which can take some time to investigate fully.

4.3 Areas for concern:

4.3.1 The WBS is carrying a risk that lessons learnt from a SABRE reportable incident are not being applied in a timely manner as two actions originally due for completion in February, then extended to May 31st, remain outstanding. This was escalated to the Head of Digital Delivery at the August WBS Senior Leadership Team (SLT) and is expected to be resolved by the September 2023 SLT meeting.

Action 1: *Review and restructure process for User Acceptance Testing in line with requirements for different systems and software developments*
Action 2*: Include reference to testing electronic messaging in the appropriate order as a standard step in User Acceptance Testing*

This concern was raised with the WBS Integrated Quality & Safety Hub and will be escalated to the WBS Senior Management Team, at the request of the IQ&SH Chair.

Quarterly Corrective and Preventative Actions (CA/PA) effectiveness monitoring is ongoing for previously reported significant risk incidents; no concerns have been identified to date. There are no quality incidents more than 3 months overdue.

5. Equity

The Welsh Blood Service strives to give everyone in Wales the opportunity to donate, this has traditionally been achieved through a peripatetic model of collection teams based in

regional hubs and visiting community venues across Wales, supplemented by mobile collection vehicles where suitable premises are not available.

Recent donor feedback continues to indicate demand from donors to return to some of the more remote locations and to visit other locations more frequently. WBS continues to review clinic plans but the reluctance of some organisations to resume on-site collection clinics remains a challenge.

The Welsh Bone Marrow Donor Registry team have held productive meetings with several charities and partners to help in the overall recruitment of swab donors with particular emphasis on the recruitment of ethnic minority donors. These included Team Margot, African Caribbean Leukaemia Trust (ACLT), National Black, Asian, Minority Ethnic Transplantation Alliance (NBTA) and Race Against Blood Cancer.

6. Efficiency

6.1 Whole Blood Collection Efficiency (Target 1.25 units by WTE per hour)

Collection productivity has risen slightly from 1.12-1.18 over the period but continues to be below target. Contributory factors influencing the recent performance include:

- Reduced clinics duration due to short notice sickness absence.
- Reduction of clinic hours because of I.T and transport issues.
- Existing vacancies yet to be filled across Wales, which, along with 8 staff in training has impacted staffing capacity at larger sessions.
- Delivery of Statutory & Mandatory training across all donor teams.
- 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.

6.2 Manufacturing Efficiency (392 Components per WTE)

Manufacturing efficiency has continued to fluctuate from 332 in February to 465 in June. This has been partly linked to the variation on blood collections as well as the large number of bank holidays during the reporting period.

6.3 Manufacturing Losses (Tolerance 0.5%)

Controllable losses remained variable but below tolerance and reduced from 0.2% in February to 0.06% in July.

6.4 Time Expired Red Cells (Target 1%)

Red cell expiry fluctuated between 0.1% in February 2023 up to 0.7% in May 2023 but fell during June and July. Overall, red cell expiry remains extremely low and within target. Bank holidays and ongoing industrial action present a risk to collections and the mitigation of the risks is to increase stock holding which may mean that stock holding is higher than optimal levels leading to increased waste.

6.5 Time Expired Platelets (Target 10% expired)

Platelet wastage performance has improved from 26% in February 2023 to 7.7% in May 2023 although the figure did increase above target in July. This improvement has been driven by recent changes to the production schedule for platelets but has also benefitted from a higher than expected demand in April and May. A formal platelet strategy project is now underway with workstreams looking at near and medium term forecasting, clinic planning and longer term changes driven by clinical research.

Quality Safety and Performance Committee

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

Date of meeting	14/09/23
PUBLIC OR PRIVATE REPORT	**Public**
IF PRIVATE PLEASE INDICATE REASON	**Not Applicable - Public Report**
REPORT PURPOSE	**INFORMATION / NOTING**
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	**NO**
Prepared by	**Peter Gorin, Head of Strategic Planning and Performance Rachel Hennessy, Head of Operational Services and Delivery, Sarah Richards, Interim General Services Manager**
PRESENTED BY	**Cath O'Brien, Chief Operating Officer, Sarah Morley, Executive Director OD & Workforce, Matthew Bunce, Executive Director of Finance**
APPROVED BY	**Carl James, Executive Director of Strategic Transformation, Planning and Digital**

EXECUTIVE SUMMARY	**1. VELINDRE NHST PERFORMANCE MANAGEMENT FRAMEWORK (PMF) FOR THE PERIOD TO JULY 2023/24** 1.1 This paper reports on the performance of our Trust for the month of July 2023, against a range of national targets, best practice standards and locally identified outcome measures for our cancer and blood and transplant services, as well as incorporating measures of patient and donor satisfaction, staff wellbeing, support functions and financial balance. 1.2 The overview, in Section 2, draws attention to key areas of performance across the organisation as a whole, highlighting the interconnection between many of these areas 1.3 The Performance Management Framework (PMF) Scorecards, in Section 3, are based on the 'six domains' of the Quality Safety Framework (QSF), namely safe, effective, patient/donor centred, timely, efficient and equitable care. 1.4 Each KPI is supported by data, in Appendices 1 to 3, that explain the current performance, using wherever possible, Statistical Process Control (SPC) Charts or other relevant information to allow the distinction to be made between 'natural variations' in activity, trends or performance requiring investigation. 1.5 Individual VCC and WBS PMF reports were presented initially to the respective VCC and WBS Senior Leadership Teams (SLT), followed by the Chief Operating Officer Divisional Performance Review meetings. 1.6 During 2023/24, the PMF Development Project Group will look to evaluate potential Business Intelligence solutions that automate KPI collection, analysis and reporting, and approach potential benchmarking partners for both tertiary cancer and blood services.

RECOMMENDATION / ACTIONS	**The Quality Safety and Performance Committee is asked to:** • **The QSP Committee is asked to NOTE the contents of this report and the detailed performance analysis provided in the PMF Scorecards and supporting Data Analysis Templates in Appendices 1 to 3.** • **The new style PMF Performance reports continue to be developed by the PMF Project Group, with a number of potential new measures currently under consideration.**

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
WBS SMT / Performance Review	**16 August 2023**
VCS SLT / Performance Review	**18 August 2023**
Executive Management Board – Run	**31 August 2023**
Summary and outcome of previous governance discussions **The report has been considered and endorsed at the VCS and WBS Performance Review meetings and EMB and is presented to the QSP Committee for information and noting.**	

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	**Select Current Level of Assurance**

APPENDICES	
1	**Velindre Cancer Services – PMF Supporting KPI Data Graphics and Analysis**
2	**Blood and Transplant Services – PMF Supporting KPI Data Graphics and Analysis**
3	**Trust-wide Services – PMF Supporting KPI Data Graphics and Analysis**

ACRONYMS	
VUNHST	**Velindre University NHS Trust**
QSP	**Quality Safety and Performance Committee**

EMB	**Executive Management Board**
SLT	**Senior Leadership Team**
PMF	**Performance Management Framework**
QSF	**Quality Safety Framework**
KPI	**Key Performance Indicators**
SPC	**Statistical Process Control Charts**

2. SITUATION AND BACKGROUND

VELINDRE NHST PERFORMANCE REPORT FOR JULY 2023

The following paragraphs provide an overview of our Trust-wide performance against key performance metrics through to the end of July 2023 for the Velindre Cancer Centre, the Welsh Blood Service and for VUNHST Corporate Services respectively.

2.1 Cancer Centre Services Overview

There has been significant improvement in SACT since the last reporting period with compliance for July for 21-day time-to-treatment performance target increasing from 90% to 94%. Challenges remain with nursing and pharmacy workforce capacity and a recruitment and resource plan is under development to meet the revised forecasts.

Targets were met for Pressure Ulcers, Falls, SEPSIS, Hospital Acquired Thrombosis (HAT), Occupational Therapy and Speech and Language Therapy waiting times. Staffing remains a challenge within the dietetics department due to vacancies and in physiotherapy services, impacting on waiting time. In dietetics, we have recruited locums to cover the gaps but start date was delayed to administrative issues associated with DBS checks. Physiotherapy staffing issues relate to pressures due to a combination of annual leave and training requirements on WPAS for a member of staff only recently returning to work following a period of maternity leave.

There were eight Delayed Transfers of Care in July. Delays were related to bed capacity challenges that are being experienced across the wider healthcare system which impacts the ability of Velindre Cancer Centre to discharge patients without delay. Velindre Cancer Centre Nurse leads are active members of the All Wales Pathways of Care Delays (PoCD) National Group who are looking at delayed discharges. Discussions continue to take place with Health Boards and Community teams to progress delays. "*Pathways of Care All Wales*" have scheduled visits at Velindre Cancer Centre to provide additional training on the Six Goals of Emergency Care to provide further support in facilitating patient discharge.

Radiotherapy capacity continues to be a challenge due to requests for rescans/replans, late delineation, and linac capacity. Current staffing vacancies and extended periods of annual leave across all Directorates associated with the summer period is impacting on the capacity available to undertake delineation planning in a timely manner. Requests for rescans/replans are due to changes in patients' condition, meaning that do not meeting the clinical specification for the treatment plan which is reviewed on a case by case basis. Due to the fragility of the machinery periods of downtime are being experienced. In order to maintain service delivery for patients, extended working days and weekend working are in place. There are a number of patient delays being experienced in Urgent Symptoms Controlled pathways and Scheduled Elective radiotherapy pathways – each of these patients has been fully reviewed (ie the fuill data has been fully validated) . The data for the Elective delay radiotherapy pathways are still in the process of validation. Any patients waiting longer than 28 days (previous JCCO target) have had a clinical harm review undertaken and no harm deemed to have occurred.

We are still experiencing some data quality issues related to the implementation of the DH&CR which continues to cause significant administrative challenges across Velindre Cancer Centre. The Medical Records team continue to make significant progress against the backlog of unprocessed documents through the support of additional resource and ensure that these are enacted in time for the resultant activity. As the system use continues to bed in, a review of use has been undertaken to draw feedback from system users. The DH&CR Operational Group, through a series of resource impact assessments, identified the additional resources needed to meet the requirements associated with the new system. This paper was presented to the DH&CR Project Board and the ongoing resource requirements are now being considered by the senior team and finance colleagues.

To further mitigate the data quality issues that have been experienced, a revised staff training plan, that greater meets the needs of individual users or groups in relation to their specific role, was developed by the IT Applications Support Team and Operational Services and is to be presented to the DH&CR Operational Group in August for review and approval.

2.2 Welsh Blood Service Overview

WBS have continued to perform well during July and all clinical demand was met.

Quality incident investigations closed within 30 days remains well above target (90%) at 96%. There were no reportable events submitted to the Medicines and Healthcare products Regulatory Agency (MHRA) in July. One report was submitted to Human Tissue Authority (HTA) regarding a positive blood culture from a stem cell donation after 3 days incubation. The HTA were notified as there is an increased risk to the patient. All relevant processes were followed, and the issue was picked up via routine monitoring. Following an investigation there was no risk to the patient.

Donor satisfaction continues to stay above the 95% target and has remained at 97% in July. 7,488 donors were registered at donation clinics with no formal concerns raised during July and only 4 informal concerns (0.05%) reported during this period which is a decrease from June. One of the informal concerns was managed outside of the required timeline as the service was unable to reach the donor by telephone within 2 days. An email was issued to the donor following attempts to contact by telephone.

Reference Serology performance improved on last month but did not meet target in July. The ongoing training activities of junior members of staff contributed to prolonged turnaround times of non-urgent requests. Training and development of two of the four junior members of staff will be completed between July and November 2023 and performance levels are expected to continue to improve during this period.

All clinical demand for platelets was met representing a strong performance against this metric. Platelet wastage just missed target in July after meeting target for the last three months. This is mainly attributed to a reduction in average weekly demand for the month.

Collection productivity has improved in July but is slightly below 1.25% target at 1.18%. Contributory factors influencing the performance include short term staff sickness and staff vacancies.

Performance for new bone marrow volunteers improved for July but remained below target. The summer months are typically lower due to the reduced blood donor clinics in educational establishments. In addition, the blood supply was under pressure during July, and the targeting of blood groups took place with regular donors being called, which negatively impacted on the number of new donors called to clinic. Work is ongoing to understand how we can address this by considerably increasing swab recruitment. We are currently analyzing the data from previous swab recruitment campaigns to inform the way forward. 519 eligible donors attended blood sessions with a 26% conversion rate.

The total number of collections in July was 6 (comprising of 4 Peripheral Blood Stem Cell and 2 Peripheral Blood Lymphocyte collections). The total cell provision for the service was 9 (6 collected and 3 imported for a Welsh patient). The service is seeing a gradual increase in activity for this year with a current projected outturn of 50-55 at year end (against a target of 80). The WBMDR five-year strategy, re-appraising the existing collection model and its ambition, is in development and will be informed by the assessment of the Recovery Plan for Bone Marrow Volunteer recruitment and will be managed under WBS Futures.

2.3 Workforce and Wellbeing

The ability of skilled people to provide the key services within the Trust remains one of the most significant risks for the Trust, alongside ensuring those we do employ are supported, valued and feel their wellbeing is central while in the workplace. The Trust's People Strategy ensures progress towards; a planned and sustained workforce with skilled and developed people who are healthy and engaged in the workplace. Alongside these work programmes there are key metrics the Trust analyses and evaluates to ensure the effective performance of the workforce.

Trust wide sickness absence data continues to remain high month on month with the current rolling absence of 5.71% to July 2023 still above the Welsh Government Target of 3.54%. Trust wide PADRs this month has a marginal increase to 74% lower than the 85% target, whereas Statutory and Mandatory training remains above target at 88% and has been consecutively on target for the whole year to July 2023. Details of interventions can be found in the SPC's for these metrics and corresponding action plans.

The Workforce Race Equality KPI's are not going to be available to us until at least June next year as they are dependent on the national implementation of the Workforce Race Equality Standard (WRES).

2.4 Nursing and Quality

The Trust's Quality & Safety Framework continues to be developed by the Integrated Quality & Safety Governance Group at its monthly meetings. The Divisions are also developing a range of Service level Quality and Safety metrics to be included within future Performance Management Framework reports.

A new KPI measuring compliance against the World Health Organisation's 5 moments of hand hygiene best practice continues to meet target compliance of 100%.

2.5 Patient and Donor Experience

Velindre Cancer Centre uses two patient satisfaction surveys: 'Would you recommend us?' (97%) and 'Your Velindre experience?' (91%) both set against a 95% target. The Welsh Blood and Transplant service has maintained a high level of donor satisfaction at 97% that continues to meet the target.

2.6 Digital Services

Performance largely stable, with a slight improvement on performance in June 2023.

Rolling 12-month number of significant IT business continues remains stable at 10, a significant improvement on reported performance earlier in the year. Progress continues to be made in terms of removing legacy IT infrastructure and improving the resilience across both the WBS and VCC sites. This work will continue through 2023/24

Resolution timescales for service requests and incidents logged with the Digital Service Desk improved slightly in July 2023, but remains under the 85% target for both indicators. The Digital Services Desk is now back up to full capacity, and the new Digital Operations Manager has been tasked with developing a service improvement plan, with the aim of instigating processes to ensure targets are achieved by the end of this financial year. Progress has also been made with the recruitment of 2nd and 3rd line support, with two new starters commencing work in September 2023. This should help improve the overall responsiveness of the team.

Reporting arrangements for two remaining (2) indicators are still being developed, delayed due to recruitment challenges and capacity:

- Digital Cyber Security % of employees clicking on internal phishing campaigns/exercises – campaigns to be re-started following recruitment into the Cyber Security Manager role – this role has now been filled, with the new member of staff due to commence work in September 2023.
- % uptime of critical digital systems which may have direct clinical or business implications – a number of critical systems have been identified as 'in scope' of this indicator. Delivery of routine reporting has been delayed due to competing priorities within the team.

2.7 Estates Infrastructure and Sustainability

The period through to July has realised high levels of compliance for PPM and reactive tasks which are currently listed as green. Recruitment has stalled, with no appointable candidates available for selection for the three advertised posts. Posts have been re-advertised with candidates assessed early September. Two H&S posts are progressing through the recruitment process with a view to get to advert during September. 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, minor improvements are witnessed month on month. Divisions have reinvigorated H&S meeting which will support improvement of training, by approaching issues at operational level, working with trainers and departments to tailor a package that meets departmental requirements, this is underpinned by support from SLT.
June Patient manual handling figures for WBS appear to have dropped from 90% to 45% was confirmed as an error.

2.8 Finance

The overall position against the profiled revenue budget to the end of July 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 revised planned savings targets are achieved, and that all financial risks are mitigated during 2023-24.

The approved Capital Expenditure Limit (CEL) as at July 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 July'23 of £10.333m and is forecasting to remain within the CEL of £24.416m. A risk to delivery of the Capital programme exists where Capital funding has not been allocated to the nVCC Project with costs being incurred due to the delay of Financial Close., however this risk is being mitigated by a request to WG for funding for the Project with latest forecast being c£1.8m.

During July '23 the Trust (core) achieved a compliance level of **98.%** of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **98.4%** as at the end of month 3, and a Trust position (including hosted) of **98.1%** compared to the target of 95%.

At this stage the Trust is currently planning to fully achieve the savings target of £1.8m during 2023-24. During July replacement savings plans were identified to support several schemes that had turned Red.

The expected underlying surplus to be carried into 2024-25 has reduced from £0.391m to £0.086m as underlying recurrent cost pressures are now forecast to exceed recurrent savings schemes.

On the 31st July the Trust received a letter from Judith Paget (NHS Wales Chief Executive) which provided a view on the overall financial position of Welsh NHS organizations for 2023/24. In response to the financial challenges set out by Health Boards in 2023/24 the Trust has been asked to support the delivery of a reduction in the overall NHS Wales deficit.

In response to the letter the Trust considered options at the extraordinary Board meeting on the 09th of August and have submitted several financial improvement options to WG on the 11th of August to support the NHS Wales Deficit.

3. ASSESSMENT OF PERFORMANCE AND MATTERS FOR CONSIDERATION VELINDRE NHST PERFORMANCE SCORECARDS FOR JULY 2023

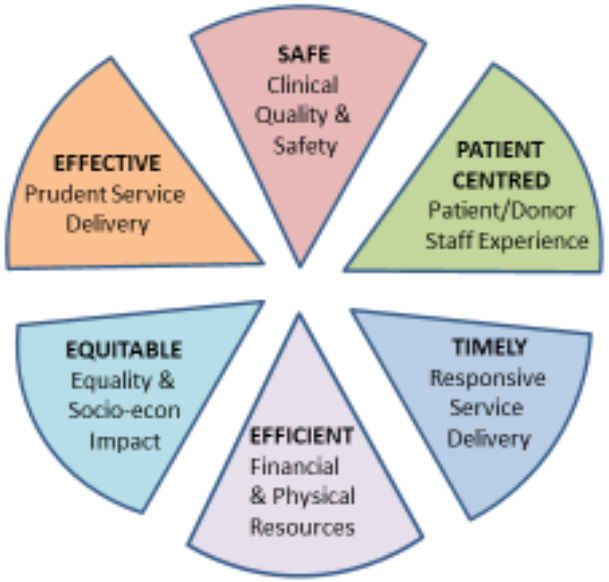
3.1 The following QSF Scorecard tables show the current performance of VCS and WBS Divisions and Trust-wide services against a range of National mandatory and local stretch targets, highlighting variances in performance. The scorecards incorporate hyperlinks to supporting KPI data, enabling switching between the high-level positions to detailed analysis provided in Appendices 1 to 3, as below.

3.2 Navigating our PMF Performance Report

Each QSF domain in the PMF scorecards is populated with a range of KPIs for VCC and WBS services plus a range of KPIs for Support Services functions. Performance is assessed as either 'within standard' ✓ or 'outside standard' ✗ against any particular target or best practice measure for the current month, plus an assessment of the 15 month 'rolling data trend' seen, as either 'improving' ↑ or 'stable' → or fluctuating ↑↓ or 'declining' ↓ The actual performance for each KPI is measured against a national standard or local stretch target on a monthly, quarterly or annual improvement basis.

Canolfan Ganser Felindre
Velindre Cancer Centre

Consolidated Performance Management Framework



Welsh Blood Service

Quality Safety & Performance (QSP) Committee Scorecard as at July (Month 04) 2023/24

QSF Domain	QSP Committee Performance Scorecard			Performance as at Month 04 (July 2023)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Safety	% compliance for staff who have completed the Core Skills and Training Framework Level 1 competencies	National	Monthly	87%	85%	88%	✓	↑	WOD.19
	Number of VCC Inpatient (avoidable) falls	National	Monthly	4	0	0	✓	→	KPV.02
	Number of Potentially (avoidable) Hospital Acquired Thromboses (HAT)	National	Monthly	2	0	0	✓	↓	KPV.07
	Number Healthcare acquired Infections (HAIs) MRSA	National	Monthly	0	0	1	✗	→	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	2	✗	→	KPV.04
	Number Healthcare acquired Infections (HAIs) C Difficile	National	Monthly	0	0	2	✗	→	KPV.04
	Number Healthcare acquired Infections (HAIs) E Coli	National	Monthly	0	0	1	✗	→	KPV.04
	Number Healthcare acquired Infections (HAIs) Gram negative bacteraemia	National	Monthly	0	0	0	✓	→	KPV.04
	Number of Velindre Cancer Centre acquired (avoidable) patient pressure ulcers	National	Monthly	1	0	0	✓	→	KPV.01
	% Compliance with World Health Organization 5 moments of Hand Hygiene standard	National	Monthly	100%	100%	100%	✓	→	KPV.08
	Number of National VCS Serious Untoward Incidents recorded with Welsh Government	National	Monthly	0	0	0	✓	→	KPV.60
	Number of WBS Incidents reported to Regulator / Licensing Authority	Local	Monthly	0	0	1	✗	↓	KPI.30
	Number of Health and safety incidents recorded	Local	Monthly	15	0	15	✗	↑↓	H&S.55
	Carbon Emissions – carbon parts per million by volume	National	Annually	2018/19 C/m3	99.9 C/m3	85.3 C/m3	✓	→	EST.06

QSF Domain	QSP Committee Performance Scorecard			Performance as at Month 04 (July 2023)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Effectiveness	Number of Delayed Transfers of Care (DToCs)	National	Monthly	1	0	8	✗	🡻	KPV.05
	% Demand for Red Blood Cells Met	Best practice	Monthly	104%	100%	105%	✓	🡻	KPI.04
	% Time Expired Red Blood Cells (adult)	Local	Monthly	0.02%	Max 1%	0%	✓	🡹	KPI.26
	% Demand for Platelet Supply Met	Best practice	Monthly	133%	100%	119%	✓	🡹	KPI.05
	% Time Expired Platelets (adult)	Local	Monthly	20%	Max 10%	12%	✗	🡹	KPI.25
	Number of Stem Cell Collections per month	Local	Monthly	6	7	6	✗	🡻	KPI.13
	% Rolling average Staff sickness levels	National	Monthly	6.22%	3.54%	5.71%	✗	🡻	WOD.37
	% Personal Appraisal Development Reviews (PADR) compliance staff appraisal carried out by managers	Prof. Std.	Monthly	73%	85%	74%	✗	🡹🡻	WOD.36
Patient/Donor/ Staff Experience	% of Patients Who Rate Experience at VCC as very good or excellent	Prof. Std.	Monthly	95%	95%	97%	✓	🡺	KPV.11
	% Donor Satisfaction	Local	Monthly	95%	95%	97%	✓	🡹	KPI.09
	% of 'formal' VCC concerns responded within 30 working days	Local	Monthly	100%	85%	100%	✓	🡺	KPV.12
	% Responses to Formal WBS Concerns within 30 Working Days	Local	Monthly	100%	90%	NIL	✓	🡺	KPI.03
Timeliness	Scheduled Radiotherapy Patients Treated 80% within 14 Days and 100% within 21 Days (COSC)	National	Monthly	29% 47%	80% 100%	21% 52%	✗	🡺	KPV.14
	Urgent Symptom Control Radiotherapy Patients Treated 80% within 2 Days and 100% within 7 days (COSC)	National	Monthly	6% 50%	80% 100%	2% 68%	✗	🡺	KPV.15
	Emergency Radiotherapy Patients Treated 100% within 1 Day (COSC)	National	Monthly	94% 100%	80% 100%	100% 100%	✓	🡹	KPV.16

QSF Domain	QSP Committee Performance Scorecard			Performance as at Month 04 (July 2023)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
	Elective delay Radiotherapy Patients Treated 80% within 7 Days and 100% within 14 Days (COSC)	National	Monthly	27% 32%	80% 100%	73% 76%	✗	→	KPV.17
	% Patients Beginning Non-Emergency SACT within 21 days	National	Monthly	98%	98%	94%	✗	↑↓	KPV.20
	% Patients Beginning Emergency SACT within 5 days	National	Monthly	100%	98%	100%	✓	↑	KPV.21
	% Antenatal Turnaround Times (within 3 working days)	Best practice	Monthly	96%	90%	97%	✓	→	KPI.18
	% Turnaround Times (Antenatal -D & -c quantitation) within 5 working days	Best practice	Quarterly	83%	90%				KPI.17
Efficient	Financial Balance – achievement of Trust forecast (£k) in line with revenue expenditure profile	National	Monthly	0	0	(£0.004m)	✓	→	FIN.71
	Financial Capital spend (£m) position against forecast expenditure profile	National	Monthly	N/A	£10.333m	£10.333m	✓	→	FIN.73
	Trust expenditure (£k) on Bank and Agency staff against target budget profile	National	Monthly	N/A	£0.58m	£0.75m	✗	→	FIN.72
	Cost Improvement Programme £1.3M achievement of savings (£k) in line with profile	National	Monthly	N/A	£0.172m	£0.69m	✓	↑	FIN.74
	Public Sector Payment Performance (% invoices paid within 30 days)	National	Monthly	95%	95%	98%	✓	→	FIN.60
Equitable	Diversity of Workforce – % of women in senior leadership positions (defined as Band 8 and above)	Local	Quarterly	TBA	TBA	TBA	✓	→	WOD.78
	Diversity of Workforce – % Black, Asian and Minority Ethnic people (based on Wales version of WRES)	Local	Quarterly	TBA	TBA	TBA	✓	→	WOD.79
	Diversity of Workforce – % People with a Disability within workforce	Local	Quarterly	TBA	TBA	TBA	✓	→	WOD.80
	% of Workforce declared Welsh Speakers at Level 1	National	Quarterly	TBA	TBA	TBA	✓	→	WOD.81

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

4. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety Quality and Safety considerations form an integral part of PMF to monitor our performance and progress against our strategic objectives
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒

	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). Quality and Safety considerations form an integral part of PMF to monitor our performance and progress against our strategic objectives
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
	Click or tap here to enter text

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	If more than one Well-being Goal applies please list below:
	If more than one wellbeing goal applies please list below: Click or tap here to enter text
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Source of Funding: **Choose an item** Please explain if 'other' source of funding selected: Click or tap here to enter text **Type of Funding:** **Choose an item** Please explain if 'other' source of funding selected: Click or tap here to enter text

	Scale of Change Please detail the value of revenue and/or capital impact: Click or tap here to enter text **Type of Change** Choose an item Please explain if 'other' source of funding selected: Click or tap here to enter text
EQUALITY IMPACT ASSESSMENT *For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	PMF report is focused upon monitoring performance against statutory and local stretch targets
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	
WHAT IS THE CURRENT RISK SCORE	
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	*[In this section, explain in no more than 3 succinct points what the impact of this matter is on this risk].*
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Insert Date
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Choose an item
All risks must be evidenced and consistent with those recorded in Datix	

Performance Management Framework supporting KPI Data Graphics and Analysis

SAFETY

KPI Indicator KPV.02

Return to Top

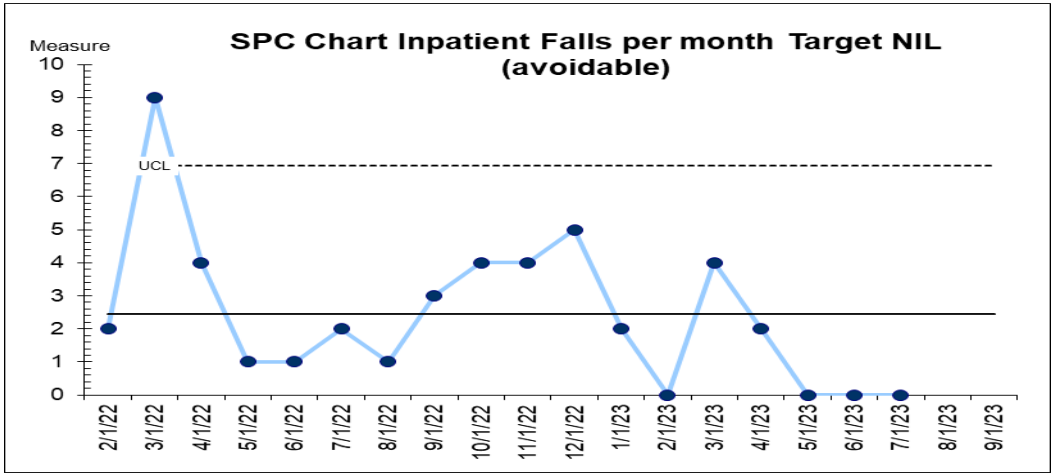
Number of VCC Inpatient Falls per month

Target: 0 Avoidable

SLT Lead: Head of Nursing

Current Performance against Target or Standard

VCC	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	Jul 23
Actual Number	1	1	2	1	3	4	4	5	2	0	4	2	0	3	5
Avoidable Falls	1	0	2	0	1	2	2	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 over the last 15 months, with a 'special cause' variation of 9 falls in March.

Performance

No avoidable falls in July 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.01

Return to Top

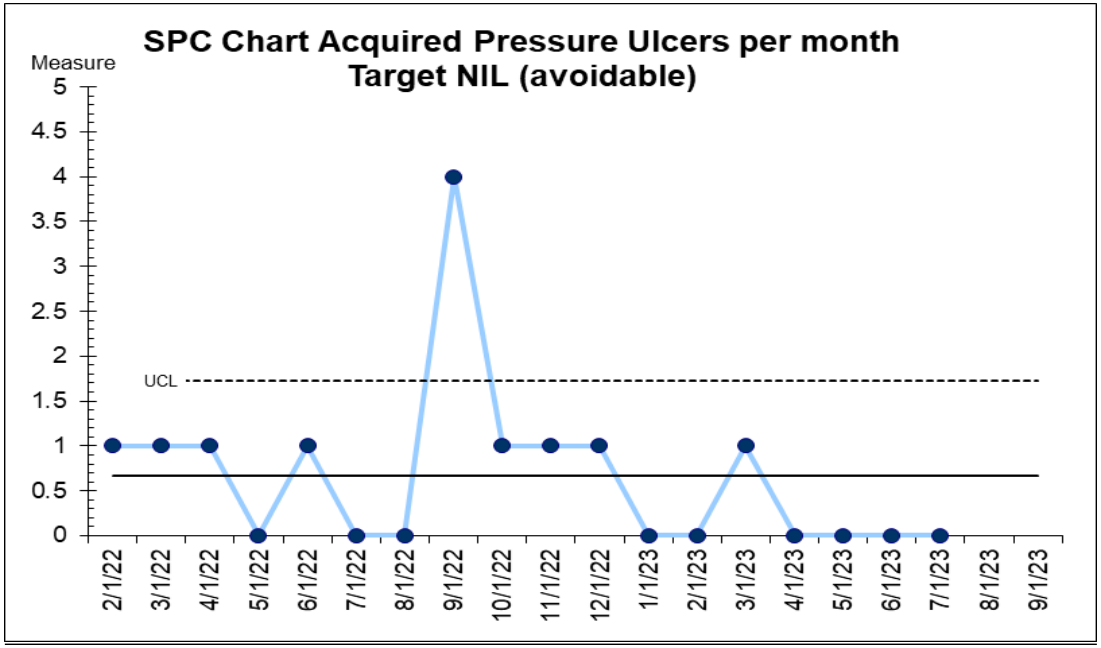
Number of VCC Acquired Pressure Ulcers per month (Inpatients)

Target: 0 Avoidable

SLT Lead: Head of Nursing

Current Performance against Target or Standard

VCC	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	Jul 23
Actual Number	0	1	0	0	4	1	1	1	0	0	1	0	0	0	2
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 July 2023.

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 WOD.19

Return to Top

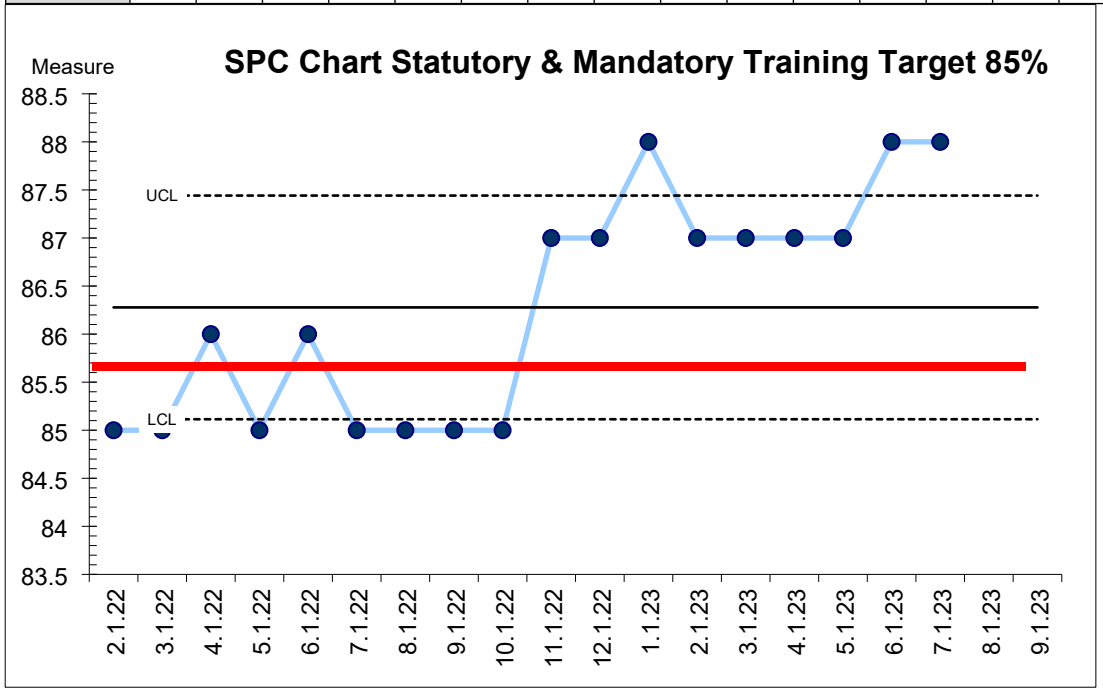
Statutory and Mandatory (S and M) Training Compliance

Target: 85%

SLT Lead: WOD Business Partner

Current Performance against Target or Standard

Trust Position	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	July 23
Actual %	85	86	85	85	85	85	87	87	88	87	87	87	87	88	88
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 KPV.07

Return to Top

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	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	Jun 23	Jul 23
Hospital Acquired Thromboses	0	0	1	0	0	0	0	0	0	0	2	1	0	0	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

Return to Top

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	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	Jul 23
C.diff	0	0	0	0	0	0	0	1	1	0	0	0	0	0	2
MRSA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
MSSA	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
E.coli	0	0	1	0	0	0	0	1	3	1	0	1	0	0	1
Klebsiella	0	0	0	0	0	0	0	0	1	0	0	1	1	0	2
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	1	4	1	0	1	1	0	0

Performance

Assessment of current performance, set out key points:

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

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	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

KPI Indicator KPV.08

Return to Top

Hand Hygiene % Compliance with WHO 5 moments of hand hygiene by (VCS WBS) Department

Target: 100%

SLT Lead: Clinical Director

Current Performance against Target or Standard

Hand Hygiene Compliance by Clinical Department

VCS WBS Trust	My 22	Jun22 2	Jul 22	Au 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23
VCS Hand Hygiene														100 %	100 %
WBS Hand Hygiene														100 %	99.2 %
Trust Hand Hygiene														100 %	99.5 %
IPC Validation														100 %	100 %
Target l00%	0	0	0	0	0	0	0	0	0	0	0	0	0	100 %	100 %

Hand Hygiene % Compliance with WHO 5 moments of hand hygiene by Department based on 20 weekly hand hygiene observations over the month

Plus Infection Prevention Control Team Validation Audits % compliance

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:
• Weekly validation audit by IPCT		IPC

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

-

KPI Indicator KPV.60

Return to Top

Number of National VCS Serious Untoward Incidents(SUIs) recorded with Welsh Government in a calendar month

Target: NIL

SLT Lead:

Current Performance against Target or Standard

	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	June 23	July 23
Actual															
Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

[SUI data to be input]

Performance

Assessment of current performance, set out key points:

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

KPI Indicator KPI.30

Return to Top

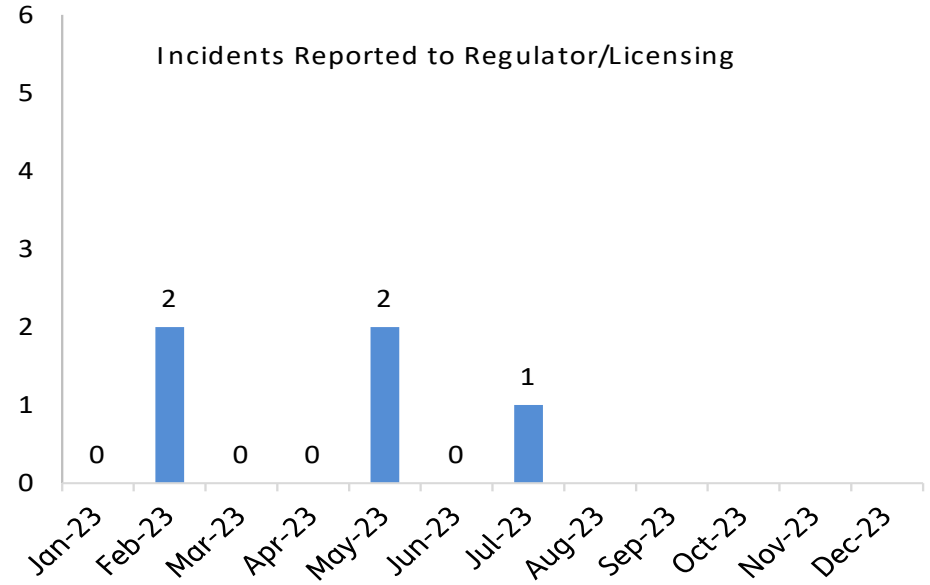
Number of Serious Adverse Blood Reactions & Events (SABRE) Incidents reported to the MHRA in a calendar month

Target: NIL

SLT Lead: Peter Richardson

Current Performance against Target or Standard

	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	June 23	July 23
Actual	0	0	1	1	0	0	0	2	0	2	0	0	2	0	1
Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0



Performance

Assessment of current performance, set out key points:

There were no reportable events submitted to the MHRA (Medicines and Healthcare products Regulatory Agency) in July and both reports submitted in May have now been closed to the satisfaction of regulators.

In July, one report was submitted to HTA (Human Tissue Authority) regarding a positive blood culture from a stem cell donation after 3 days incubation, post collection. The HTA were notified as there is an increased risk to the recipient. All relevant processes have been followed and the issue was picked up via routine monitoring. Following investigation there was no risk to the recipient as there was contamination detected in the product which indicated an issue with the sampling.

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 and HTA reports, is monitored via existing processes and reported to the WBS Integrated Quality & safety Hub	Progress is monitored via monthly reporting into the WBS Integrated Quality & Safety Hub.	Peter Richardson

Expected Performance gain - immediate

N/A

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	**Timescale:**	**Lead:**
Actions have been introduced as outcome of root cause analysis of these incidents.		

Expected Performance gain – longer-term

N/A

Risks to future performance

N/A

KPI Indicator H&S.55

Return to Top

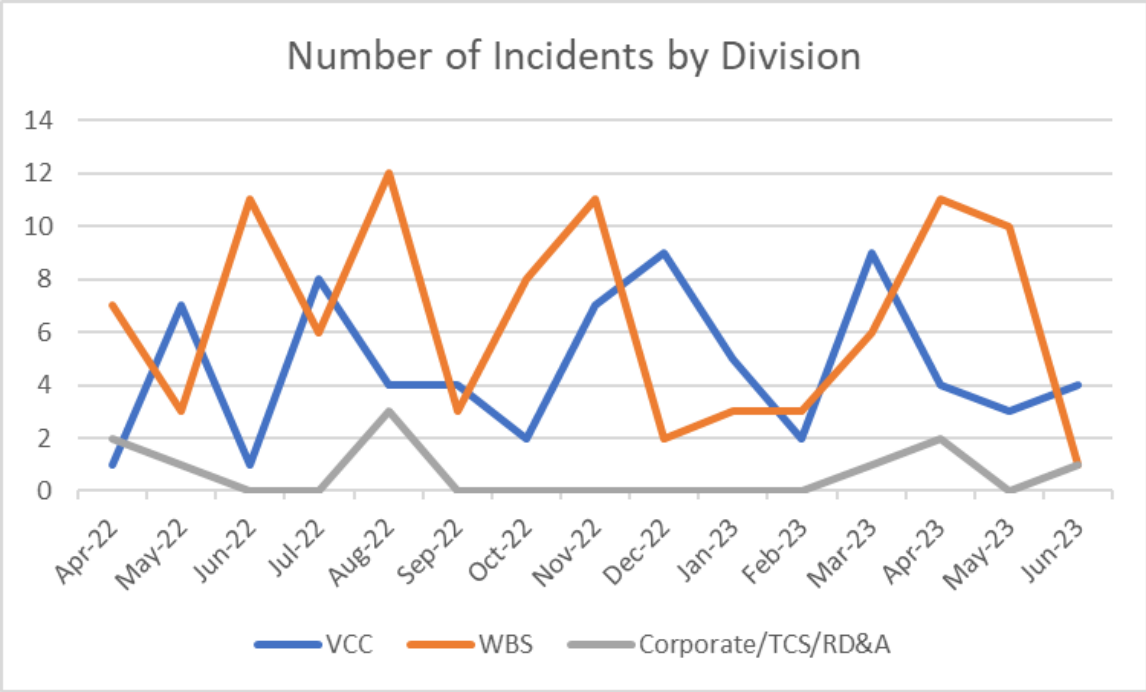
Graph title - Number of staff/contractor/Organisational/patient/donor health and safety H&S incidents by Division

Target: 0

SLT Lead: Carl James

Current Performance against Target or Standard - Level

	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	June 23	Jul 23
VCC	1	7	1	8	4	4	2	7	9	5	2	9	4	3	4	6
WBS	7	3	11	6	12	3	8	11	2	3	3	6	2	10	1	9
Corporate	1	1	0	0	2	0	0	0	0	0	0	0	2	0	1	0



Performance - remains stable

Behavioural issues displayed by patient – considering issue of Behaviour Contract

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

VCS – 6 incidents Staff incident – 3 accidents • fall in the car park observed by member of staff no further action. • Staff attacked by dog, no injury sustained. Reported via 101 • Patient exposed to hazardous substance. Additional training identified Inappropriate Behaviour - 1 incident • Patient family member continually being aggressive toward staff and patients Infrastructure – 1 Incident • Staff driving incorrect way down a one way system presenting risk to pedestrians. Department Managers informed, situation being monitored by security Equipment Devices /Manual handling – 1 Incident • New wheelchairs deployed, with locking system which is counter to provision of responsive service. Discussion with the porters had surrounding use of this equipment **WBS** – 9 Incidents Accident Injury – 6 accidents • Road Traffic accident ford Ka crashed into collection lorry • Vehicle damaged while parked in Singleton Hospital • Staff member lost balance getting out of a chair. Fell and bumped head – Under investigation • Staff Member bumped head reaching for their bag – No further action required • Staff member bumped head while plugging device into an electrical socket – No further action required • Staff member cut finger on sharp edge while cleaning cabinet – SOP in place to prevent future occurance Infrastructure – 1 incident • Tree adjacent to car park at Talbot Green collapsed striking a staff members car. Inappropriate Behaviour - 2 Incident • Donor spoke aggressively to a Contact Centre Adviser not the first incident – management review ongoing • The second incident involved a donor that was turned away from donating for travel reasons. Threw pen at CCA and left session.	

KPI Indicator EST.06

Return to Top

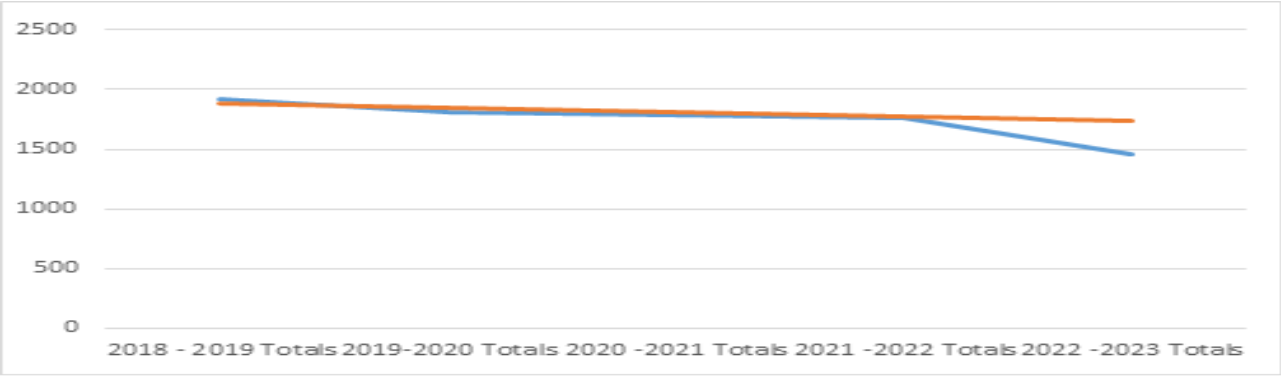
% reduction in Carbon Footprint/Emissions by 2025 against 2018/19 baseline

Target: -16% by 2025

SLT Lead: Asst. Director of Estates

Current Performance against Target or Standard

Trust Position	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	Jun 23	July 23
Actual Number	134.31	97.97	103.01	95.85	102.66	122.08	172.82	155.55	212.01	179.31	187.06	130.20	111.83	86.13	85.33
Target (-3% from previous year emissions)	179.7298	113.2977	110.6551	104.4917	104.8802	133.9711	190.288	201.7611	217.2733	189.9079	194.9325	160.9681	130.2845	95.03259	99.91858



We are currently 'on track' (blue line) to meet the Target of -16% Carbon Footprint/Emissions (Orange line) Statutory Regulations reduction by 2025 against 2018/19 baseline – measure carbon parts per million by volume

Performance

Assessment of current performance, set out key points:

- Carbon footprint data comprises of electricity and gas
- The comprehensive carbon footprint (including procurement) is submitted to Welsh Government in September 2023.
- VCC Gas data for June / July is currently under review, therefore the carbon figure for June & July may be updated in due course.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Deacrbonisation Action Plan • Site Based Sustainability Implementation Plan	XX/XX/XX XX/XX/XX	AN Other AN Other

Expected Performance gain – immediate

Ongoing communication and engagement with staff to reduce consumption.
Amendments to the BMS across all sites for better controls.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• Continuing monitoring • Improvement to monitoring energy through the BMS	XX/XX/XX XX/XX/XX	AN Other 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

-

EFFECTIVENESS

KPI Indicator KPV.05

Return to Top

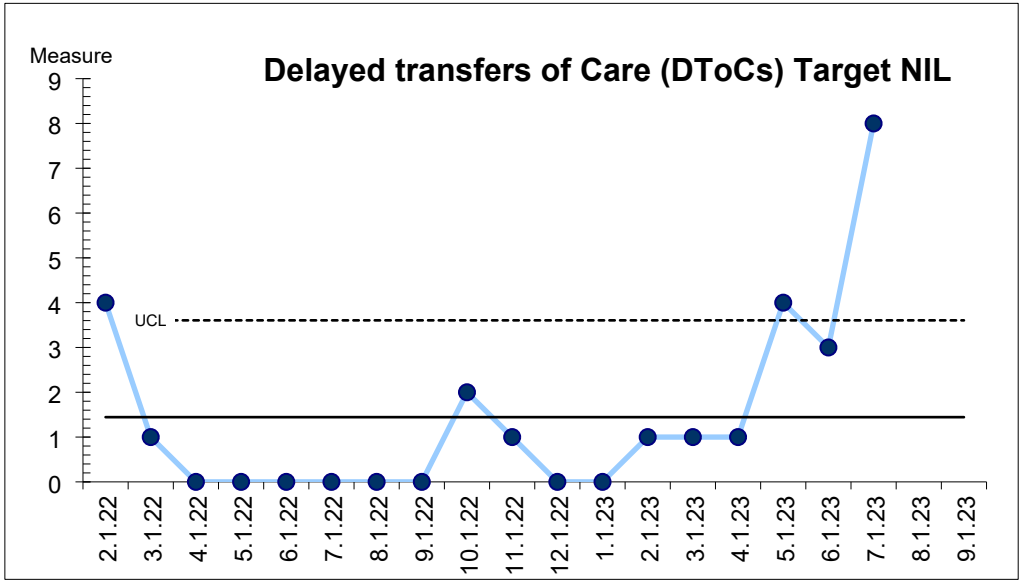
Number of Delayed Transfers of Care (DToC) Should we change this to the new WG descriptor i.e. Pathways of Care Delays (PoCD)

Target: NIL

SLT Lead: Head of Nursing

Current Performance against Target or Standard

VCC	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	Jul 23
Actual %	0	0	0	0	0	2	1	0	0	1	1	1	4	3	8
Target NIL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0



SPC Chart Analysis

The SPC Chart shows 'special cause' or exceptional variations in May and July for pathways of care delays.

Performance

Assessment of current performance, set out key points:

There were 8 DToC reported in July 2023.

Social DToC

Patient 1: Awaiting fast track discharge home with a delay of 3 days.

Patient 2: Awaiting fast track discharge home with a delay of 5 days.

Patient 3: Awaiting package of care allocation with a delay of 8 days.

Repatriation DToC

Patient 1: Awaiting repatriation to local hospital with a delay of 2 days.

Patient 2: Awaiting repatriation to local hospital with a delay of 5 days.

Patient 3: Awaiting repatriation to local hospital with a delay of 1 day.

Patient 4: Awaiting repatriation to local hospital with a delay of 8 days.

Patient 5: The patient was initially planned for discharge home, however the patient required ongoing therapies input and therefore was repatriated to their local hospital for convalescence.

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 NHS Exec PoCD group, BI have provided assistance and data is now being uploaded nationally as required. Individual patient discussions are taking place daily with HB and community teams to progress any delays. It is acknowledge that there are bed pressures across the whole system which impacts on patient discharge/transfer. Pathways of Care All Wales leads are visiting VCC to provide additional training on the Six Goals of Emergency Care to further support and facilitate patient discharge.		**Matthew Walters Operational Senior Nurse** **Matthew Walters Operational Senior Nurse**

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

	Actions: what we are doing to improve Membership of all Wales POCD group, opportunity to discuss with HB colleagues and review national data including VUNHST data identifying themes and patterns.	**Timescale:**	**Lead:** **Matthew Walters** **Operational Senior Nurse**
	Expected Performance gain – longer-term		
	Risks to future performance		
	Set out risks which could affect future performance		

KPI Indicator KPI.04

Return to Top

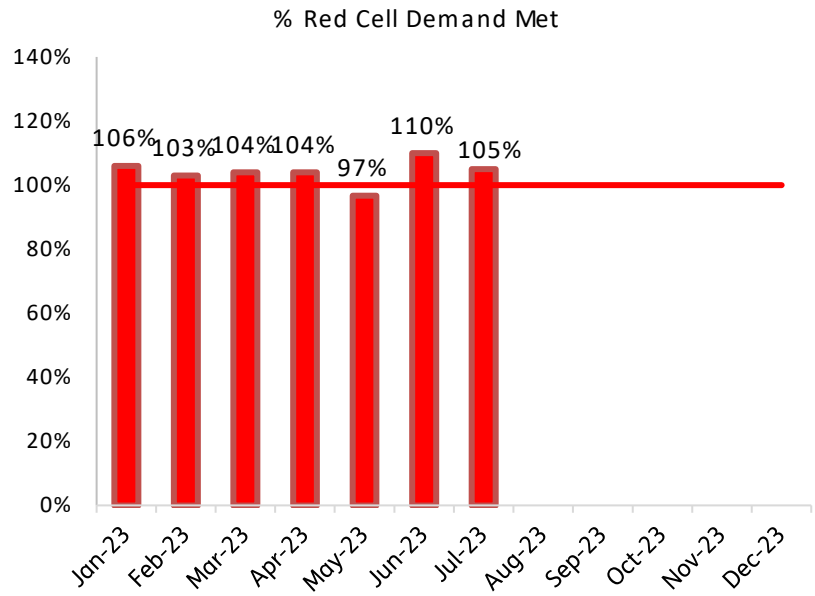
% Red Blood Cell Demand Met as number of bags manufactured as % of Issues to Hospitals, with no mutual aid required from NHSE

Target: 100%

SLT Lead: Jayne Davey / Tracey Rees

Current Performance against Target or Standard

	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	June 23	July 23
Actual %	102	100	107	112	105	115	115	94	106	103	104	104	97	110	105
Target 100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100



Performance

Blood collected in July exceeded the demand.

The average weekly demand in July was slightly higher than June (from 1376 to 1433 units per week).

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.

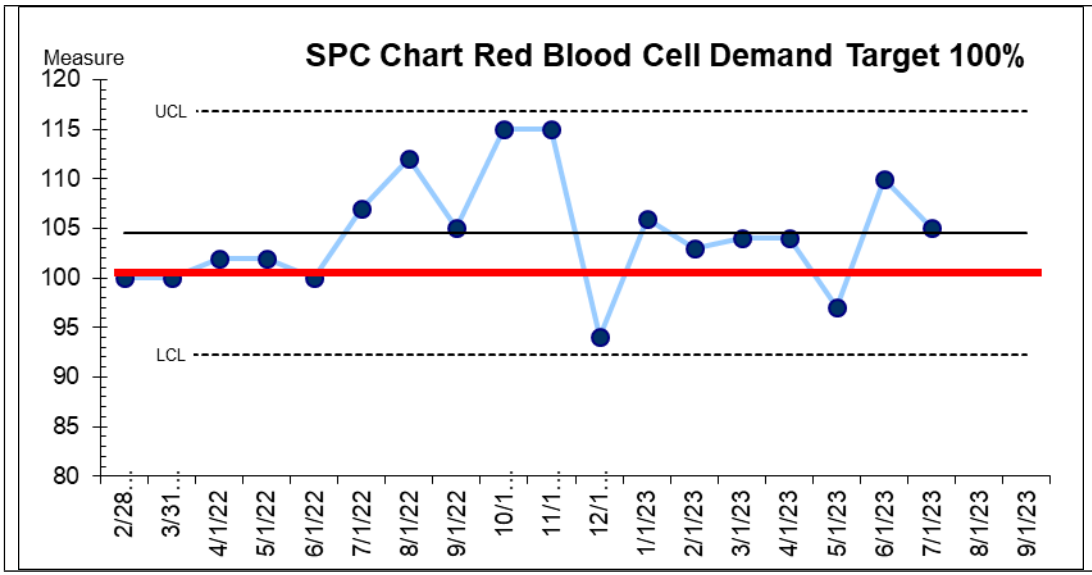
Service Improvement Actions – tactical (12 months +)

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.
N/A



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.26

Return to Top

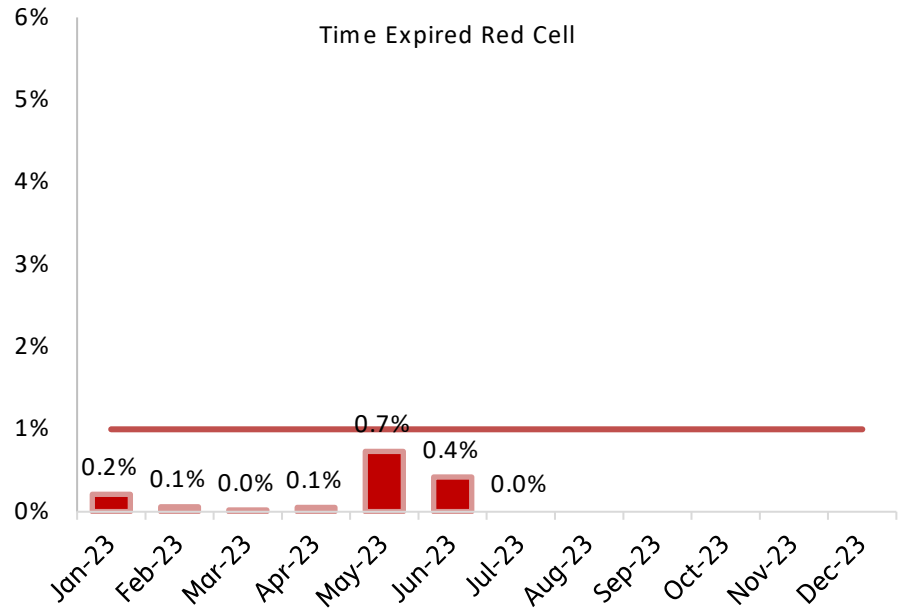
Time Expired Red Blood Cells - number of red blood cells, excluding paediatric bags, which have a time expired, as % of the total number of red blood cell bags

Target: Maximum Wastage 1%

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	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	June 23	July 23
Actual %	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	0.42	0
Target Max 1%	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0



Performance

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

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

Balanced stocks for each blood group are managed through the daily Resilience meetings where priorities are set as needed. This supports the recovery of specific blood groups when they are at lower level but also minimises excess collections to minimise wastage.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Daily monitoring of age of stock as part of the resilience meetings.	Daily (BAU)	Tracey Rees

Expected Performance gain - immediate.
Continued effective management of blood stocks to minimise the number of wasted units.

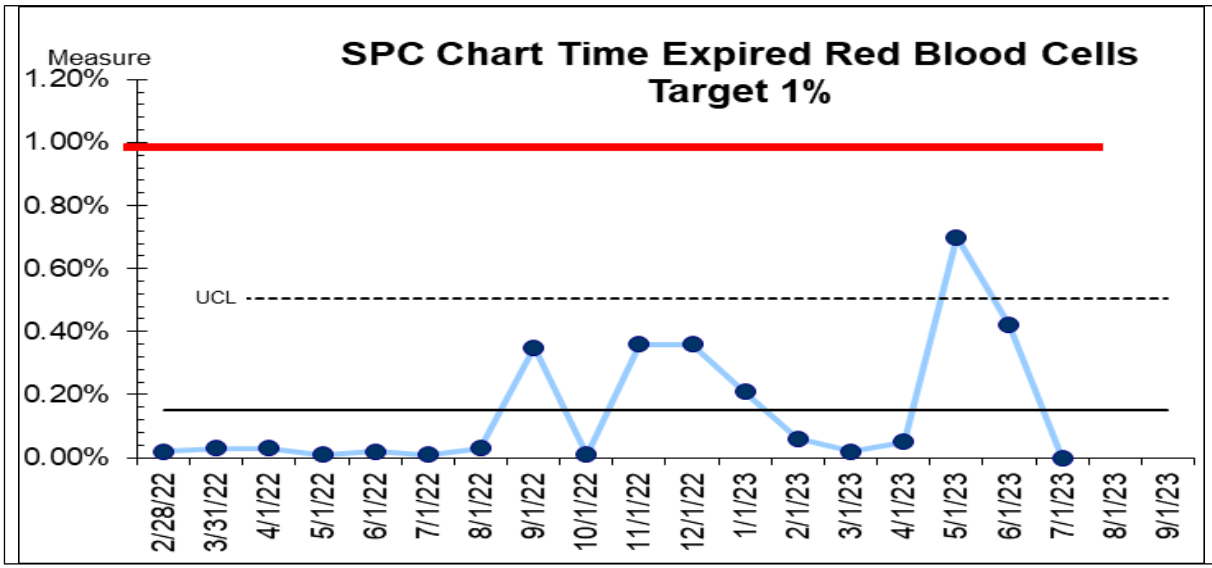
Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
N/A		

Expected Performance gain – longer-term.
N/A

Risks to future performance

High stock levels lead to a risk of increased time expiry.



SPC Chart Analysis
The SPC chart shows common cause variation over the last 6-month period, with one 'special cause variation' in the month of May. However, the average performance of 0.15% remains well within the maximum 1%

KPI Indicator KPI.05

Return to Top

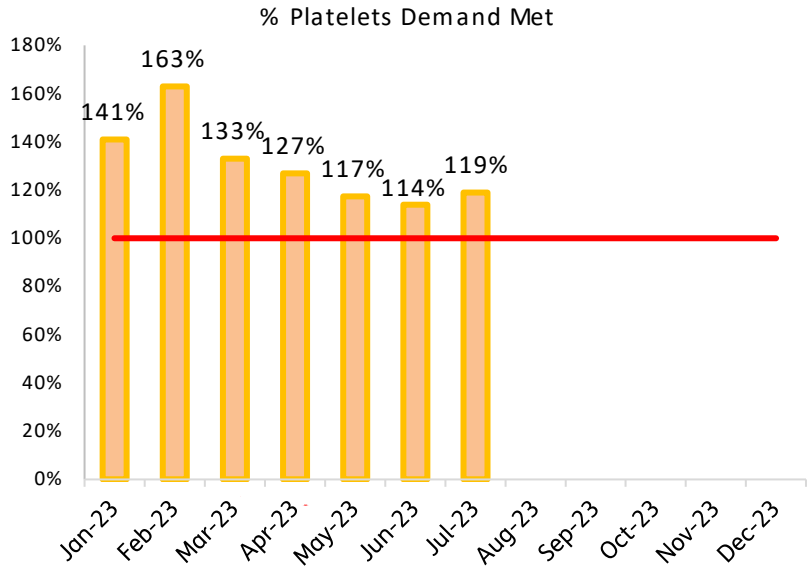
Platelet Supply meeting Demand – number of bags manufactured as % the number issued to Hospitals

Target: 100%

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	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	July 23
Actual %	125	128	145	164	132	126	139	145	141	168	133	127	117	114	119
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 in July was 150 units per week on average. This is lower than June's average demand of 166 units per week.

Service Improvement Actions – Immediate (0 to 3 months)

Daily monitoring of platelet stock position and assessment of likely demand in the upcoming days. Controlled adjustments in production of pooled platelets to better align overall stock holding to daily demand.	**Lead:** Tracey Rees Daily - BAU **Timescale:** Ongoing – Business As Usual

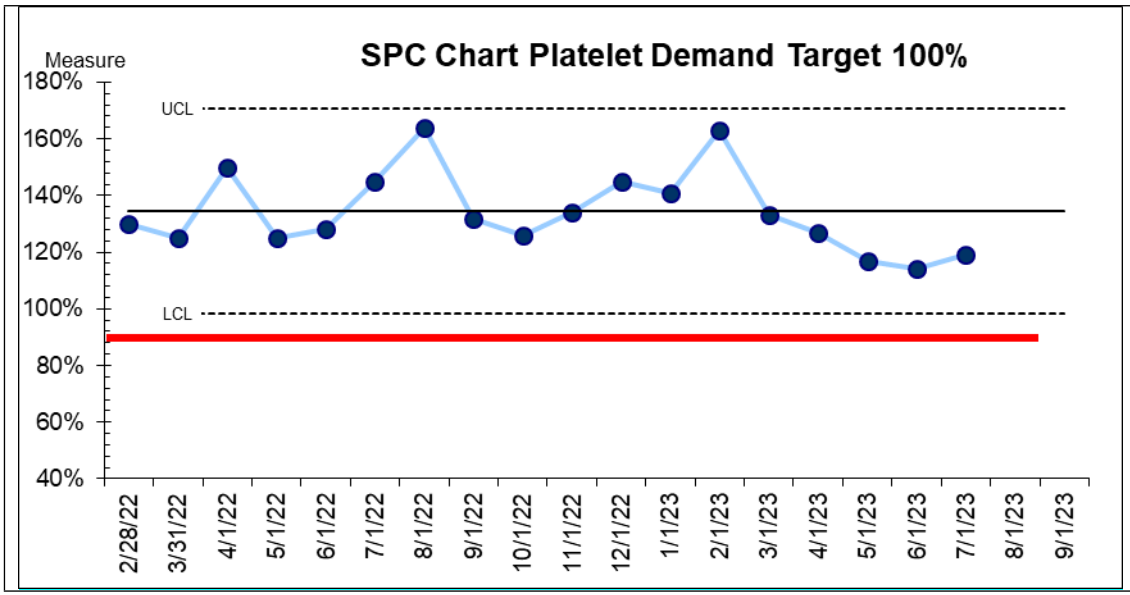
Expected Performance gain - immediate.
Daily agile responses to variations of stock levels and service needs. Reduced platelet wastage

Service Improvement Actions – tactical (12 months +)

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



SPC Chart Analysis
The SPC chart shows common cause or normal variation over the 15-month period. The average performance of 132% consistently exceeding the 100% target.

KPI Indicator KPI.25

Return to Top

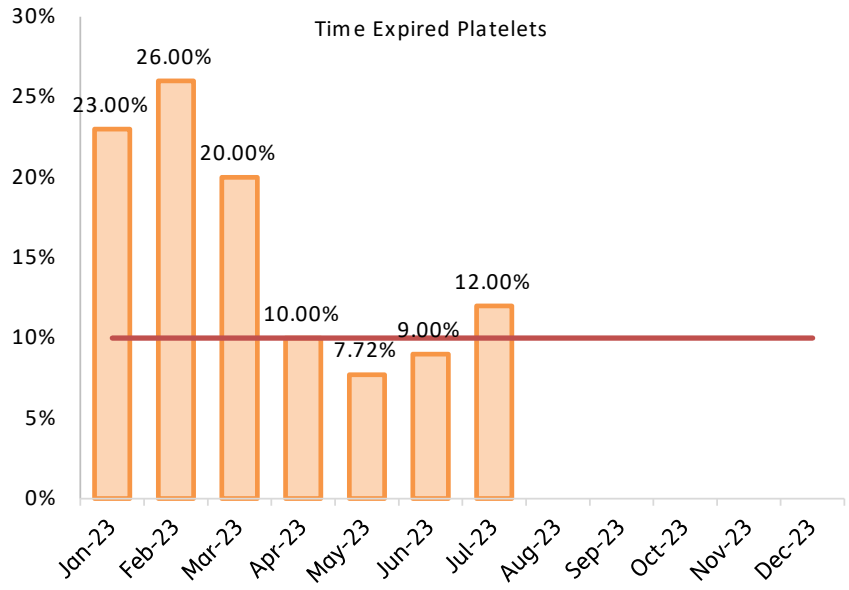
Time Expired Platelets – number of platelets which have time expired as a % of the total number of platelets manufactured

Target: Maximum Wastage 10%

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	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	June 23	July 23
Actual %	15	23	19	30	25	14	15	27	23	25	20	10	8	9	12
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:

July performance slightly breached target, with contributory factors attributed to:

- Reduction in average weekly demand for the month
- Collection model for apheresis platelets is not aligned to 7-day expiry – this is being reviewed under WBS Futures. *Essentially the appointment capacity on a Wed is too big for what we need sometimes and is not always easy to switch on and off. We normally manipulate it by altering the pooled platelets but on one instance last month we had 40 just from apheresis when we only needed a total of 30. Even in these instances we still need to make some pools to make sure we have the group mix correct and to ensure we sufficient stock within expiry dates.*
- Excess apheresis production against target on 19th July. There were 40 apheresis platelets in process against a total target of 30 platelets. Due to expiry dates production could not be reduced later in the week.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Lead:** Tracey Rees
a. Daily monitoring of the 'age of stock' as part of the 'Resilience' meetings. b. Pooled platelet reductions have been implemented and are being reviewed as a measured approach to the declining demand trend. c. A Platelet Strategy is being developed. This will sit under WBS Futures under the Lab Services Modernisation Programme. d. Develop a forecasting tool to inform decisions around pooled platelet manufacture. This action has been delayed due to insufficient capacity within the Business Intelligence Team.	**Timescale:** Daily (BAU) Timelines to be confirmed as part of WBS Futures

Expected Performance gain – immediate.
Controlled platelet production leading to reduced wastage

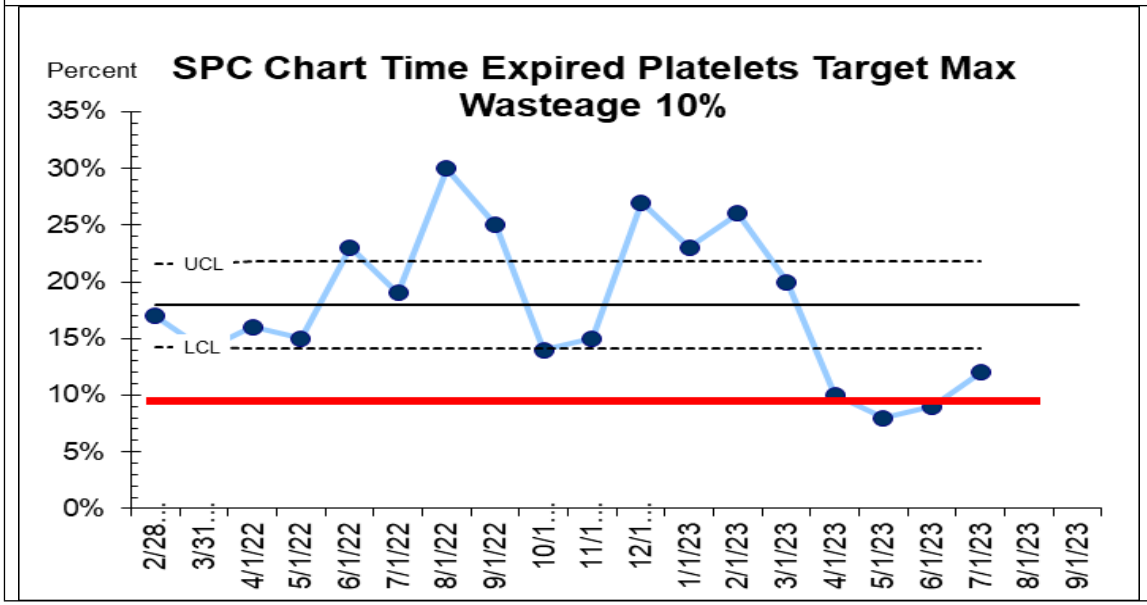
Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	**Timescale:**
Reviewing the clinic collection plan for Apheresis to ensure the clinic times are optimised to reflect changes to 7-day platelet expiry. Embedding the demand planning tools for platelets into routine practice.	Qtr 3&4 onwards **Lead:** Jayne Davey/Tracey Rees

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.13

Return to Top

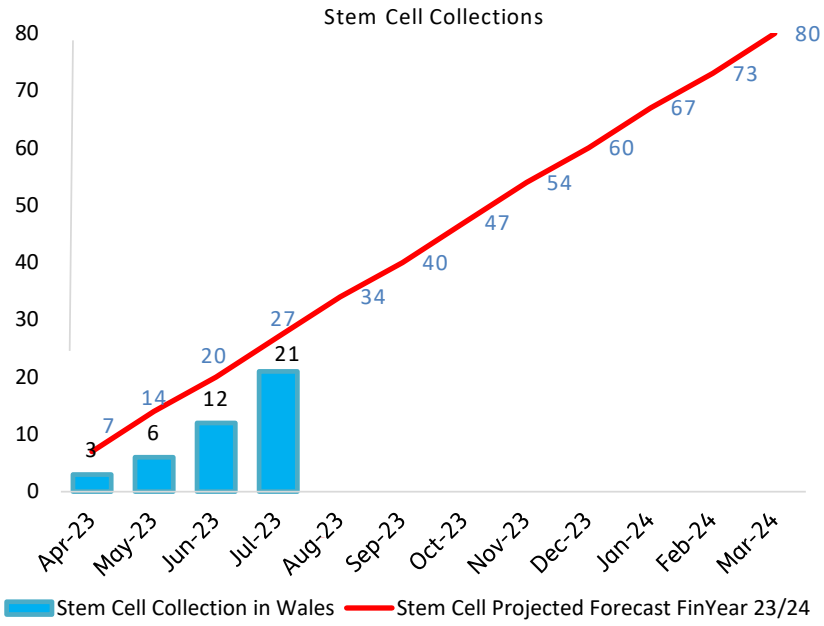
Number of stem cell collections supported year to date. Annual figure 80 per annum reported against cumulative monthly target

Target: 80 per annum

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	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	June 23	July 23
Cumulative Actual	2	8	8	12	14	14	15	19	23	26	32	3	6	12	18
Cumulative Target p/a	14	21	28	35	42	49	56	63	70	77	84	7	14	20	27



Performance

The total cell provision for the service was 9 with 6 collections (4 Peripheral Blood Stem Cell, 2 Peripheral Blood Lymphocyte) and 3 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.

The service is seeing a gradual increase in activity for this year with a current projected outturn of 50-55 at year end (against a target of 80).

NB: The Projected Forecast detail does not include stem cells collection sourced globally for patients in Wales.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve

The WBMDR five-year strategy, re-appraising the existing collection model and its ambition, is being finalised to support the ongoing development of the WBMDR. This will form part of the WBS futures programme

A recovery plan has been implemented to improve recruitment of new donors to the Register which over time will increase the number of collections see KPI.20

Timescale:
Q3

Lead:
Tracey Rees

Expected Performance gain - immediate.

As above

Service Improvement Actions – tactical (12 months +)

	Implementation of the five-year strategy.	**Timescale:** 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 WOD.37

Return to Top

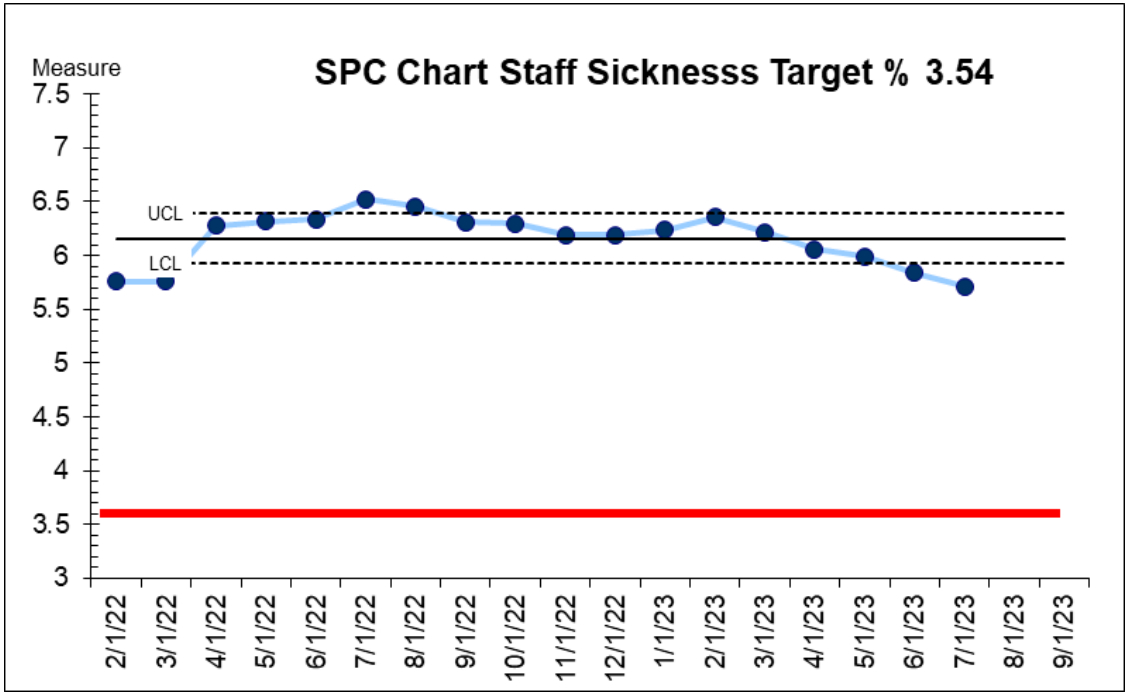
Staff Sickness levels against Target

Target: 3.54%

SLT Lead: WOD Director

Current Performance against Target or Standard

Trust Position	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	July 23
Actual %	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	5.84	5.71
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. Corporate Services has significantly reduced their rolling 12 months from 5.37 to 2.85 in the year to date.

Short-term absence remains relatively low across the Trust.

Focused management on resolving long-term absence has seen in month figured reduce from 4.97% to 2.91% in the past 6 months. This continued reduction should see the overall rolling target reduce also.

Anxiety/stress/depression/other psychiatric illnesses, remaining as highest reason for absence, both in month and on a rolling average.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Quarterly random sickness audits to be undertaken in: • ICT • RD&I • Private Patients (Closed)	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	30/04/2024	Head of OD

	• Launch benefit platforms (HealthShield, Wagestream etc.) • Reaccreditation of platinum corporate health standards • Implementation of the anti-racist plan Quarterly meetings with Wellbeing champions to review ongoing requirements within the organisation	Ongoing	Head of OD and Trust Board
	Expected Performance gain – longer-term The proactive actions taken to enhance wellbeing and engagement in the workplace offers support to individuals before they even report absent with sickness.		
	Risks to future performance		
	Set out risks which could affect future performance • Not having enough staff available due to sickness absence could impact on delivery of services across the Trust • Staff who feel unsupported during absence may chose to leave the organisation increasing turnover		

KPI Indicator WOD.36

Return to Top

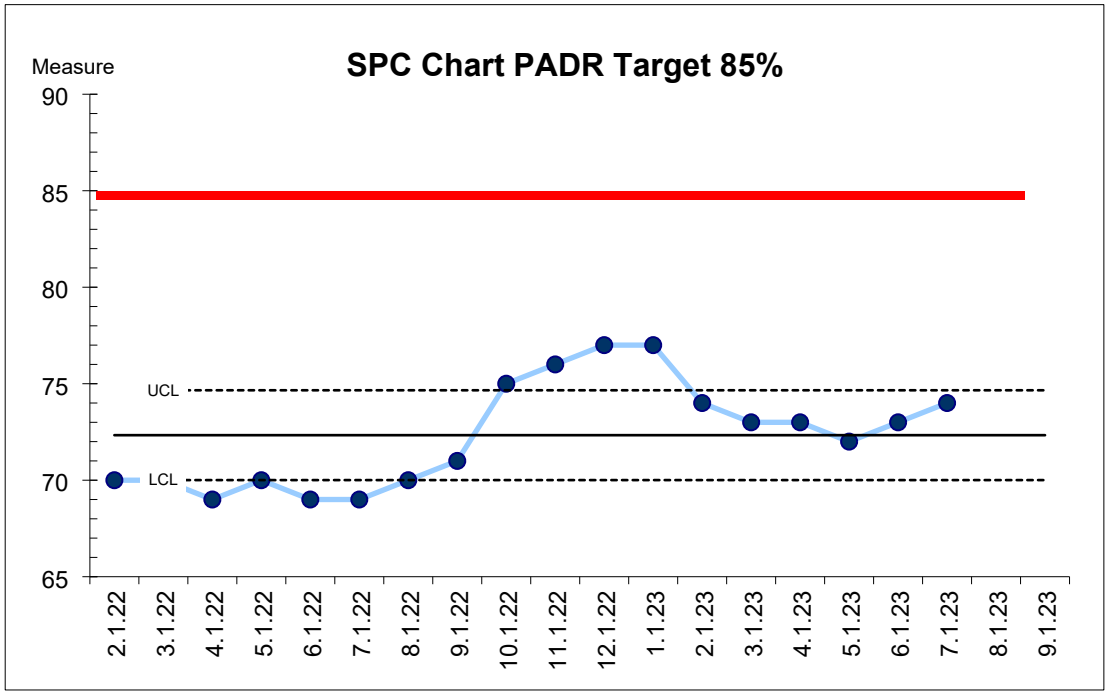
Performance and Development Reviews (PADR) % Compliance

Target: 85%

SLT Lead: WOD Director

Current Performance against Target or Standard

Trust Position	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	July 23
Actual %	70	69	69	70	71	75	76	77	77	74	73	73	72	73	74
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 this remains significantly below the Welsh Government target. Transforming Cancer Services remains the biggest cause for concern reporting 8 months consecutively below 50%

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Support TCS with improvement plan	01/09/2023	Senior BP Head of Workforce
Continue to monitor for hotspot areas of concern and provide interventions for improvement.	01/09/2023	

Expected Performance gain - immediate

With targeted interventions in hotspot areas that are continually preforming significantly below the expectations this should see a growth in the overall compliance within the Trust.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
The Senior Business Partners will report trends and updates monthly at division performance meetings highlighting hotspot areas for improvement.	Ongoing Monthly	Business Partners alongside SMT/SLT

Expected Performance gain – longer-term

As regular monitoring and reviews of compliance is undertaken in the divisional operational meetings the Trust's compliance will improve.

Risks to future performance

Set out risks which could affect future performance

- People have lack of clarity and objectives casing them to be less engaged and motivated in the workplace
- Higher turnover rates due to lack of engagement and motivation

PATIENT & DONOR EXPERIENCE

KPI Indicator KPV.11

Return to Top

% 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	May 22	Jun 22	Jul22	Aug22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	Jul 23
Would you recommend us? %				89	89	88	nda	nda	93	96	95	95	98	96	97
Your Velindre Experience? %							nda	nda	84	86	82	82	68	71	91
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 97% in June was due to 78 survey responses to the VCC 'Would you recommend us? CIVICA survey.

42 patients responded to "Your Velindre Experience" CIVICA survey. Of these 42 responses, 30 responded 9/10 and 10/10 with 4 patients scoring 2 or below. Review of the responses showed 2 respondents sometimes or never felt listened to, 1 reported sometimes or never understood what was happening with their care, and 11 respondents said they waited a bit or much too long. However, 31 respondents felt they waited less or about right, and 37 people felt they were always listened to, 39 they usually or always felt cared for.

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		
• Q+S team to review the difference in positive percentages for both surveys		

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 KPI.09

Return to Top

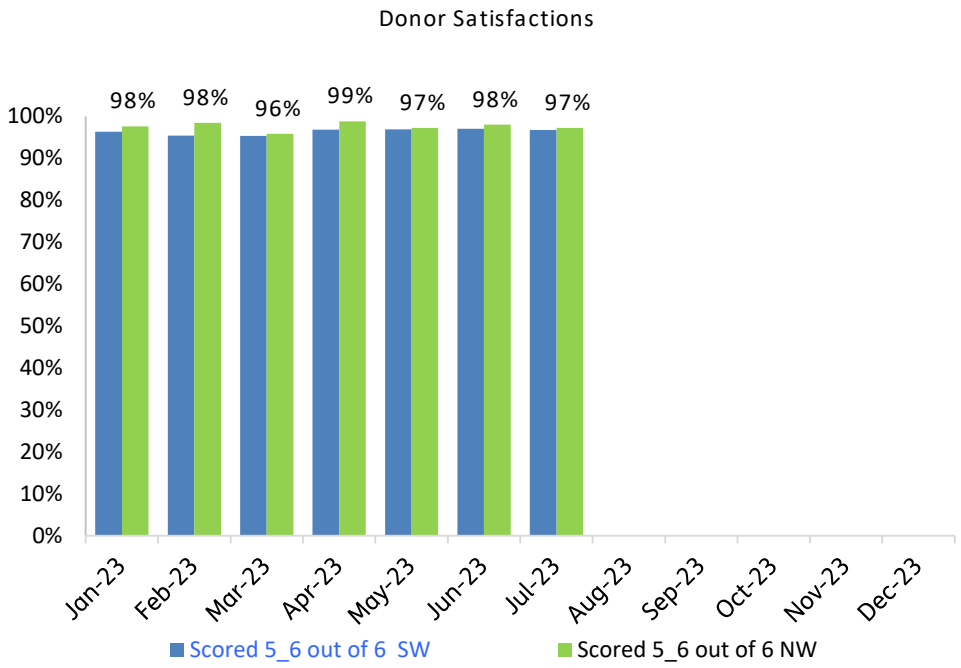
% Donor Satisfaction - donors that scored 5 or 6 out of 6 with their "overall" donation experience after they have been registered on clinic

Target: 95%

SLT Lead: Jayne Davey

Current Performance against Target or Standard

	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	June 23	July 23
Actual %	96	97	96	97	97	96	96	95	97	97	95	97	97	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 96.8%, Donor Satisfaction exceeded target for July. In total there were 1,288 respondents to the donor survey, 195 from North Wales (scoring satisfaction at 97.2%), and 1,012 from South or West Wales (scoring satisfaction at 96.7%).

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Findings are reported at Collections Services Monthly Performance Meetings (OSG) to address any actions for individual teams. 'You Said, We Did' actions are taken from the report.	Business as usual, reviewed monthly	Jayne Davey

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Following analysis of the donor satisfaction survey from the Service Improvement team there are nine metrics statistically linked to the donor satisfaction score. These metrics are now being explored to evaluate if improvements can be made in these areas	**Q4 2023/24**	Andrew Harris

Expected Performance gain – longer-term.
N/A

Risks to future performance

Set out risks which could affect future performance.

N/A

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	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	June 23	Jul 23
Actual %			100	100	100	100	100	100	100	100	100	100	100	100	100
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85

Performance

Assessment of current performance, set out key points:

- Target deadline has consistently been achieved

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

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 KPI.03

Return to Top

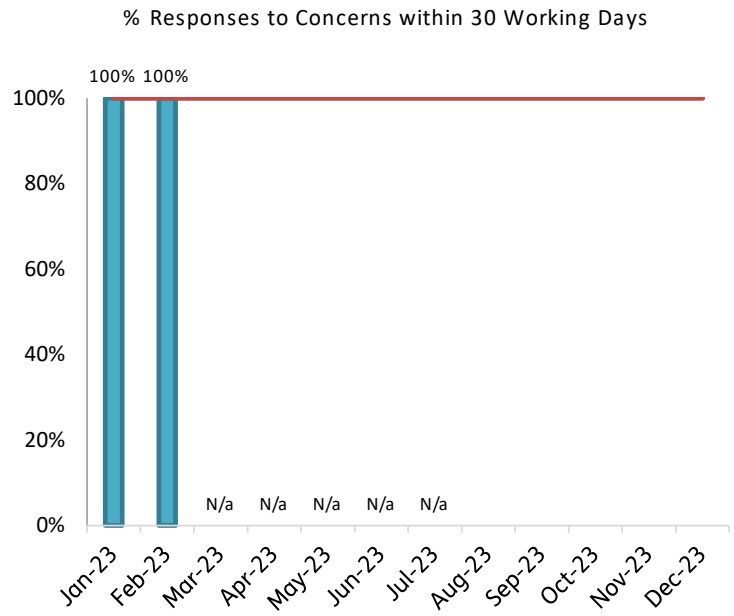
% Formal Concerns responded to under "Putting Things Right" (PTR) within required 30-day Timescale

Target: 100%

SLT Lead: Edwin Massey

Current Performance against Target or Standard

WBS	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	June 23	July 23
Actual %	n/a	100	100	n/a	n/a	100	100	N/A	100	100	N/A	N/A	N/A	N/A	N/A
Target 100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%



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 July 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. – Work closer with relevant departments to ensure proactive and thorough investigations and learning outcomes. – Adherence to Duty of Candour requirements.	Ongoing **Lead:** Edwin Massey

Expected Performance gain – immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:
Continue to monitor and have oversight of concerns management in line with PTR.	Ongoing **Lead:** Julie Reynish

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance.

TIMELINESS

KPI Indicator KPV.14

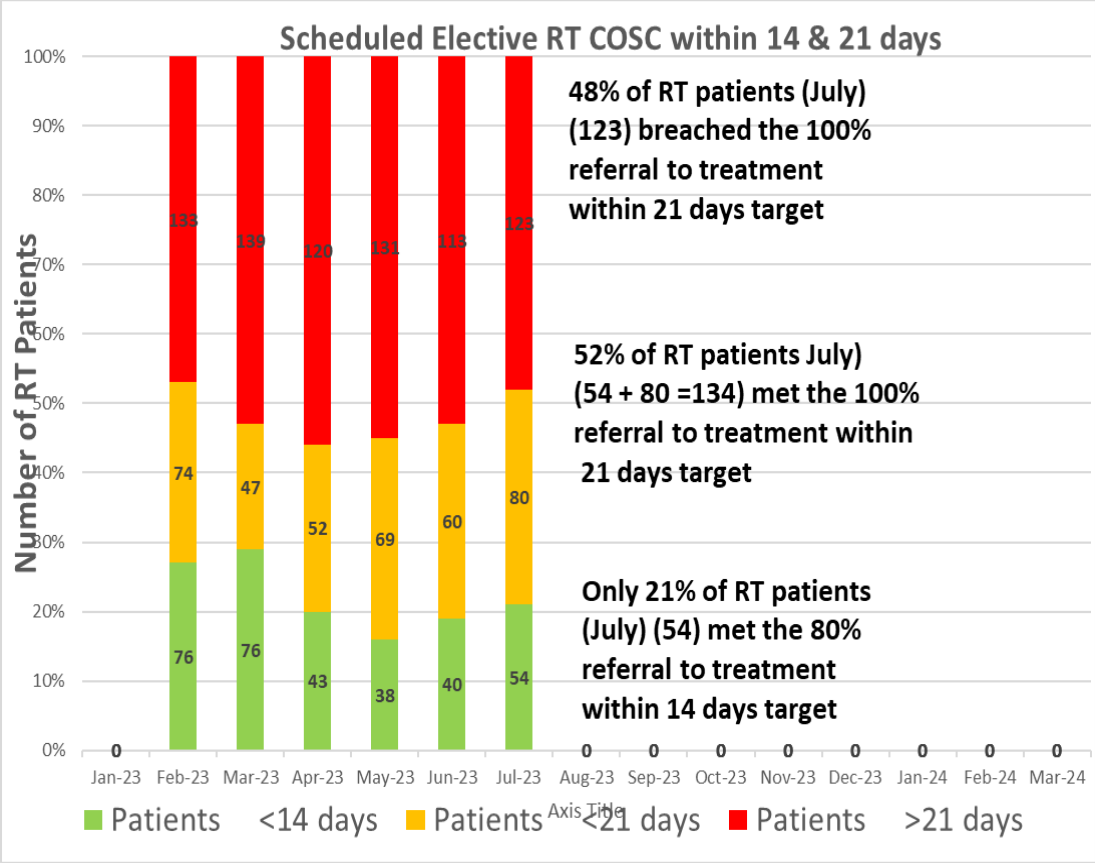
Return to Top

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



SPC Chart Analysis

The SPC chart analysis is not possible until well over 6 month's performance data available using the new COSC measures to ensure the results are statistically valid.

Performance

Assessment of current performance, set out key points:

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

Number of referrals	257	
treated within 14 days of referral (80% target)	54	21%
treated within 21 days of referral (100% target)	134	52%

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 plan in place to implement Care path by end of June- completed	Helen Payne Kathy Ikin
Task and finish group established to provide detailed action plan to address immediate challenges and short term pathway improvements- care path implementation		

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 time to radiotherapy timings

Risks to future performance

Set out risks which could affect future performance

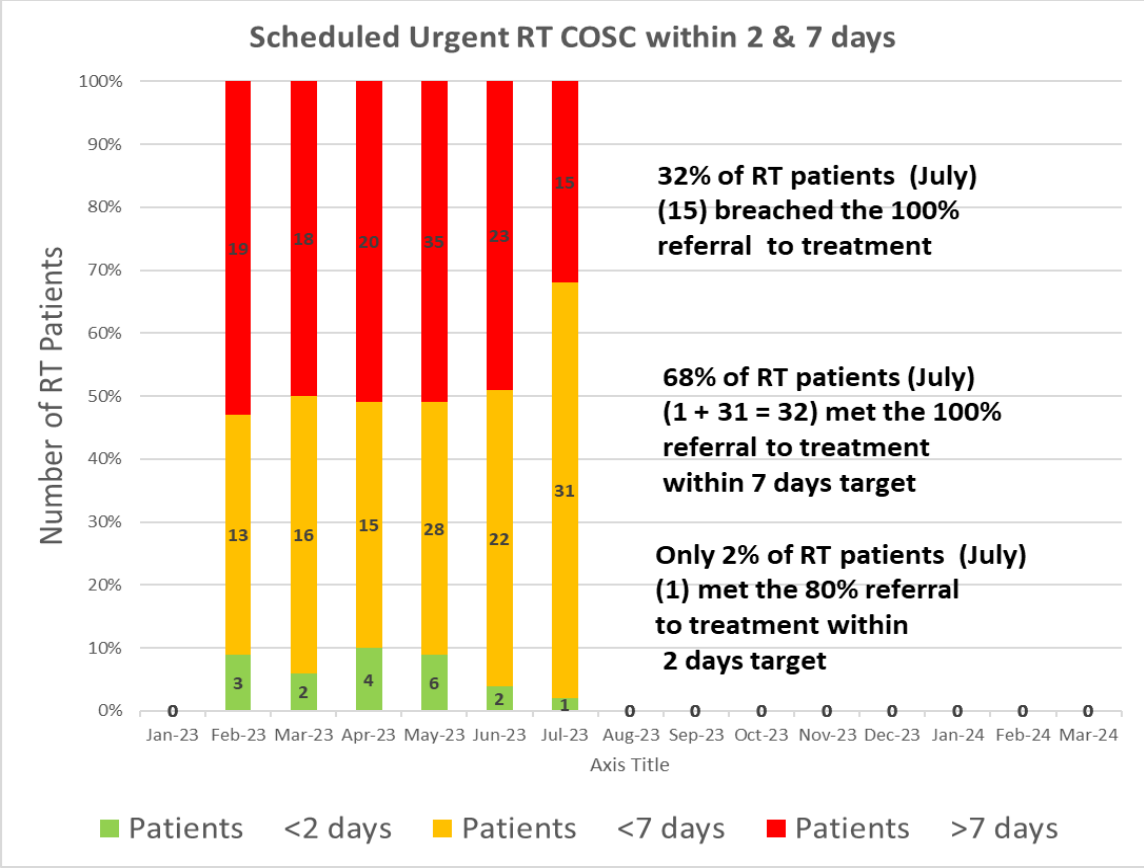
Linac replacement programme which has commenced

KPI Indicator KPV.15

Return to Top

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 well over 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	47	
treated within 2 days of referral (80% target)	1	2%
treated within 7 days of referral (100% target)	32	68%

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

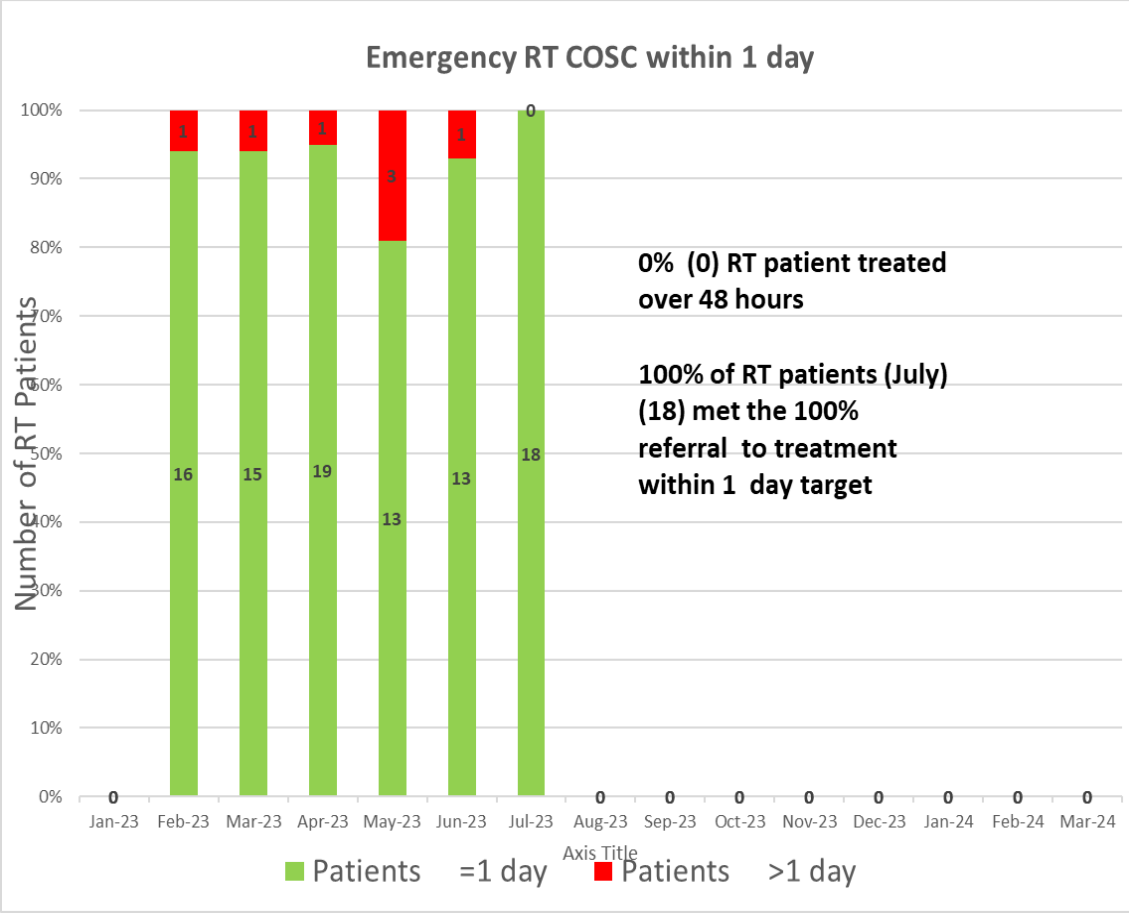
•

KPI Indicator KPV.16

Return to Top

Emergency Radiotherapy Patients Treated Within 1 Day (COSC)	
Target: 100%	**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 well over 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:

Target Achieved

Number of referrals	18	
% treated within 24 hours of referral	18	100%
% treated within 48hours of referral		

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

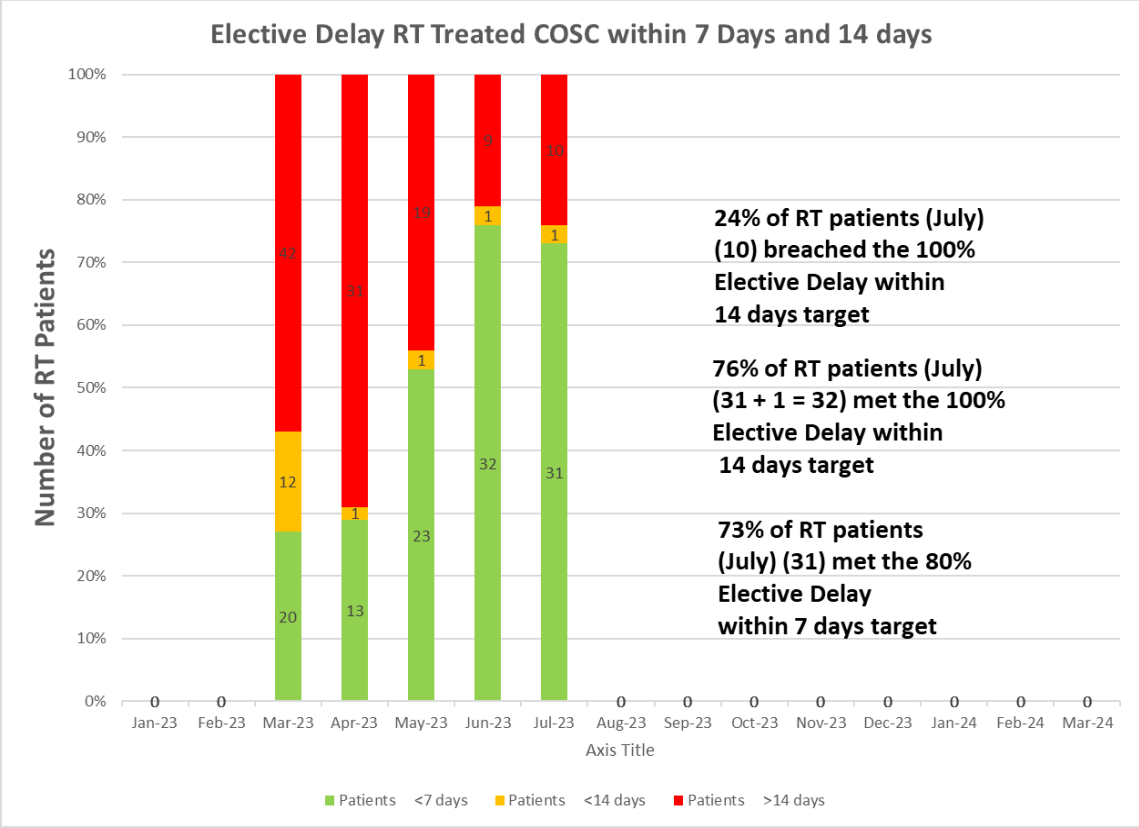
KPI Indicator KPV.17

Return to Top

Elective delay Radiotherapy Patients Treated 80% within 7 Days and 100% within 14 Days (COSC)	
Target: 80%	**SLT Lead: Head of Radiation Services / Clinical Director**

Current Performance against Target or Standard

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 well over 6 month's performance data available using the new COSC measures to ensure the results are statistically valid.

Performance

Assessment of current performance, set out key points:

Issues as Scheduled elective patients above

Number of referrals	42	
treated within 7 days of referral (80% target)	31	73%
treated within 14 days of referral (100% target)	32	76%

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

Return to Top

Non-Emergency SACT Patients Treated Within 21-Days

Target: 98%

SLT Lead: Head of Medicines Management and SACT

Current Performance against Target or Standard

	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	June 23	Jul 23
Actual %	61	59	66	77	89	96	98	96	97	98	98	93	90	90	94
Target 98%	**98**	**98**	**98**	**98**	**98**	**98**	**98**	**98**	**98**	**98**	**98**	**98**	**98**	**98**	**98**
More than 21 days	**146**	**147**				**14**	**6**	**12**	**9**	**9**	**8**	**26**	**40**	**40**	**25**
Within 21 days	**375**	**355**				**341**	**354**	**322**	**336**	**388**	**409**	**343**	**354**	**378**	**279**

The number of patients scheduled to begin non-emergency SACT treatment in July 2023 was 404.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021/22 Attendances	2,165	2,105	2,166	2,315	2,259	2,186	2,105	2,242	2,270	2,269	2,101	2,392
2022/23 Attendances	2,297	2,297	2,336	2,302	2,558	2486	2463	2572	2297	2455	2162	2557
2023/24 Attendances	2,220	2,545	2,622	2,483								

Performance

Of 404 new patients started patients started, 25 patients waited over 21 days = performance of 94%. Target Not Achieved

Intent /Days -	22-28	29-35	36-42	43 da1ys +
Non-emergency (21-day target)	24	0	1	0

20 patients breached due to joint nursing and pharmacy capacity

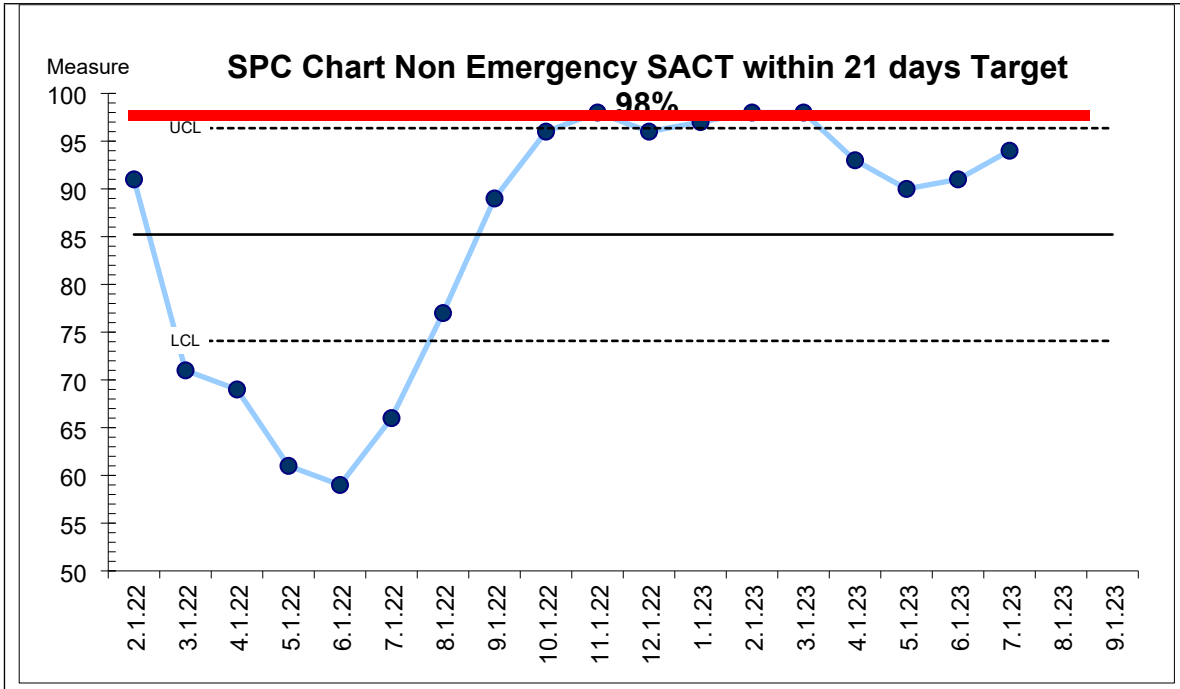
1 x patient breached as they were awaiting a PET scan

1x patient breached because ChemoCare was altered by one of the Clinical Team. This meant that the booking team was unaware of the need to schedule. The Chemocare team are linking with the staff involved to improve their knowledge of chemocare & avoid any repetition.

1 X patient did not appear on scheduling list – this is being investigated by the Chemocare team & CIS

1 x pt – booking requests misinterpreted the booking request.

1 booked alongside RT



SPC Chart Analysis

The chart shows normal variation over the last 10 months after a significant period of improvement. However, current performance falls short of 95% target.

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. -	**complete**	BT
Review and confirm resource requirements of PICC service	**complete**	MW
Continue to progress SACT nurse and booking review recommendations.	**~~31/07/23~~ Timescale updated to 01/1023**	BT
Review "allocation" field in ChemoCare to mitigate risk of user error		

Expected Performance gain – immediate

No patients to breach due to incorrect allocation of treatment location.

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	**01/09/23**	BT/WJ
• Determine additional staff resources/ recruitment plan to meet revised forecasts across all staffing groups (nursing, pharmacy and booking teams)		BT
• Engage with HB partner to deliver on VCC strategy to deliver care closer to home	**01/11/23**	

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- Staff recruitment and retention: nursing and pharmacy. Availability of suitably skilled workforce
- Financial ability to recruit ahead of increased demand, in order for training
- Timescales for on-boarding of HB partner outreach locations and available VCC accommodation capacity
- Overall capacity of aseptic services across SE Wales

KPI Indicator KPV.21

Return to Top

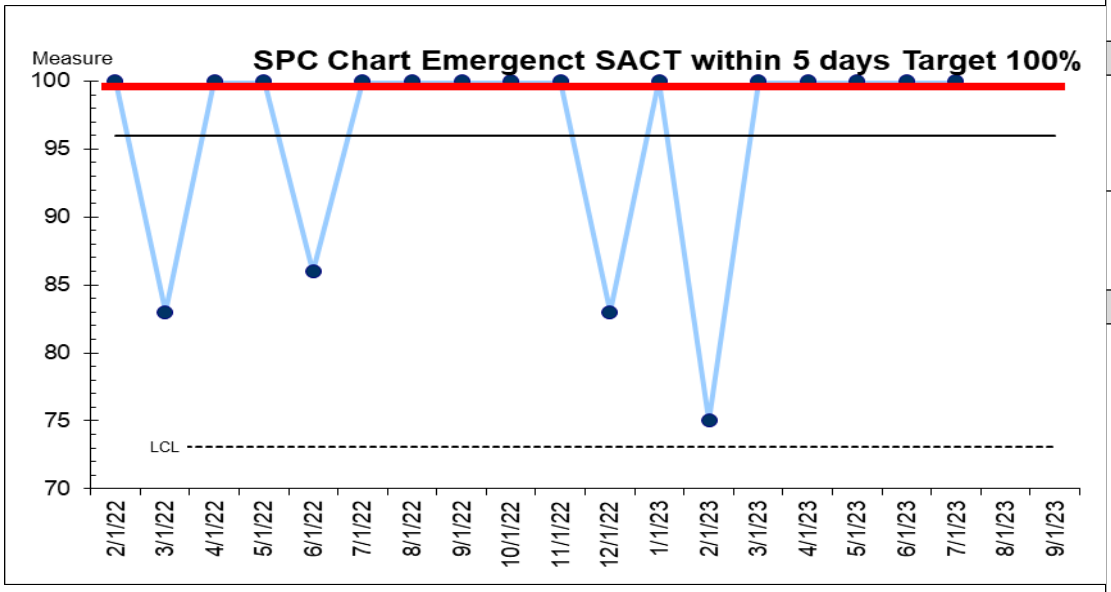
Emergency SACT Patients Treated Within 5 Days

Target: 100%

SLT Lead: Head of Medicines Management and SACT

Current Performance against Target or Standard

VCC	My 22	Jun 22	Jul22	Au22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23
Actual %	100	86	100	100	100	100	100	83	100	75	100	100	100	100	100
Target 100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
More than 5 days	0	2	0	0	0	0	0	1	0	1	0	0	0	0	0
Within 5 days	9	7			0	5	6	5	8	3		5	0	12	10



SPC Chart Analysis

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

Performance

10 patients referred for emergency SACT treatment were scheduled to begin treatment in July 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 +)

		Lead:

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

•

KPI Indicator KPI.18

Return to Top

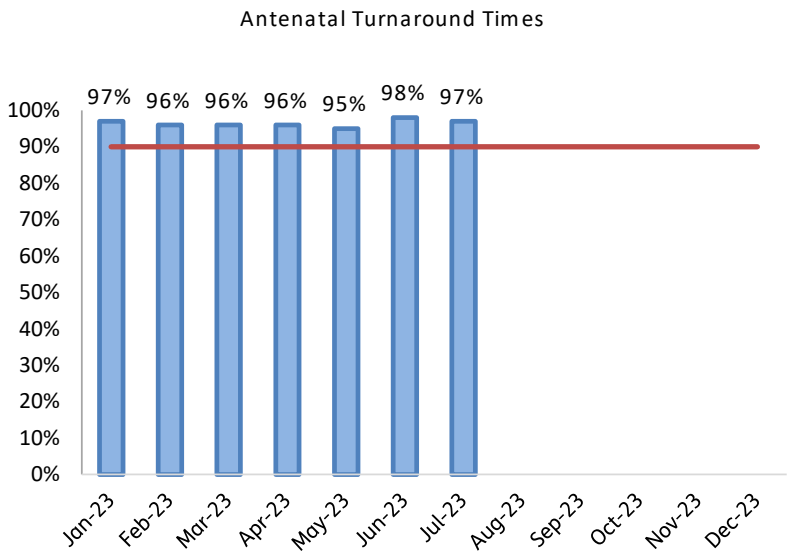
Antenatal Turnaround Times - Patient Results provided to customer Hospitals within 3 working days of receipt of sample

Target: 90%

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	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	June 23	July 23
Actual %	96	95	96	97	97	98	96	87	97	96	96	96	95	98	97
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 97% the turnaround time performance for routine Antenatal tests continued to exceed target in July 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.

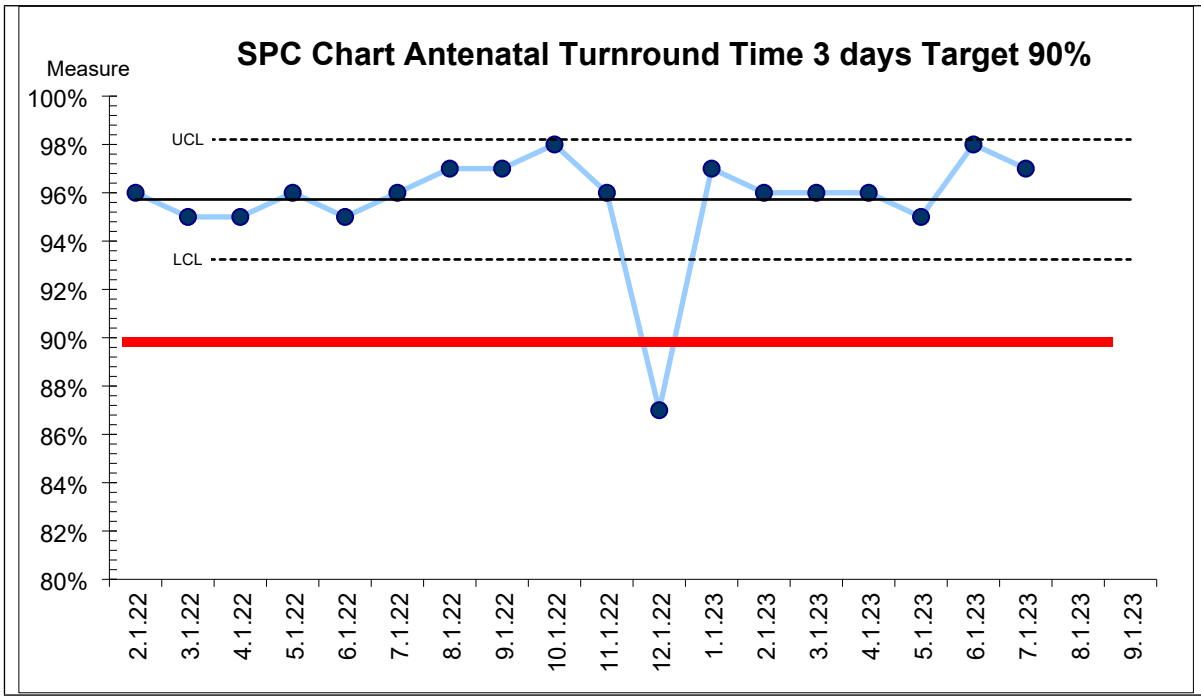
Service Improvement Actions – tactical (12 months +)

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 92% exceeds the 90% target.

KPI Indicator KPI.17

Return to Top

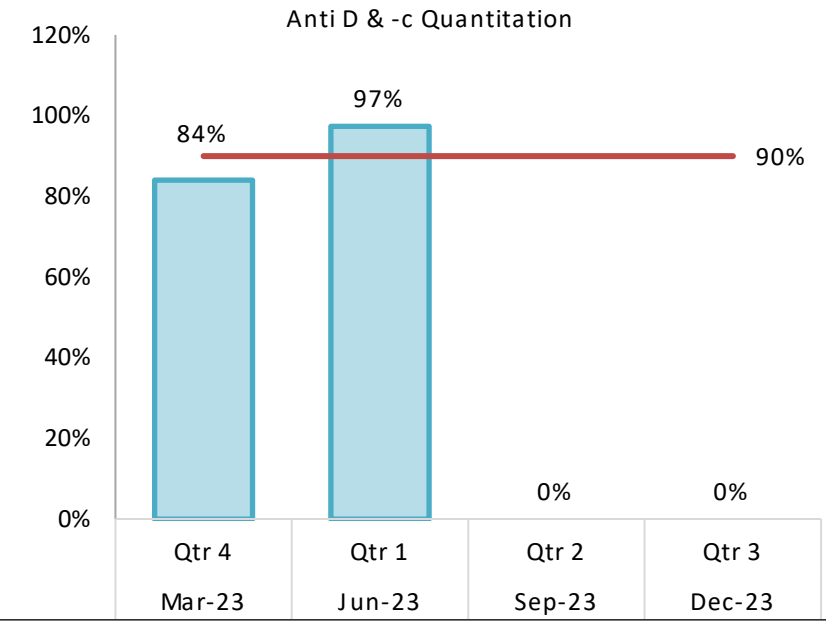
% Antenatal -D & -C quantitation results provided to customer hospitals within 5 working days

Target: 90% per quarter

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	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	June 23	July 23
Actual %	99	83	99	96	99	99	96	97	96	60	92	97	98	97	
Target 90%	90	90	90	90	90	90	90	90	90	90	90	90	90	90	



Performance

On Target. Excellent performance March through to June despite the increase in anti-D referrals and training commitment on the auto analysers concerned.

Service Improvement Actions – Immediate (0 to 3 months)

N/A	**Timescale:**	**Lead:**

Expected Performance gain - immediate.

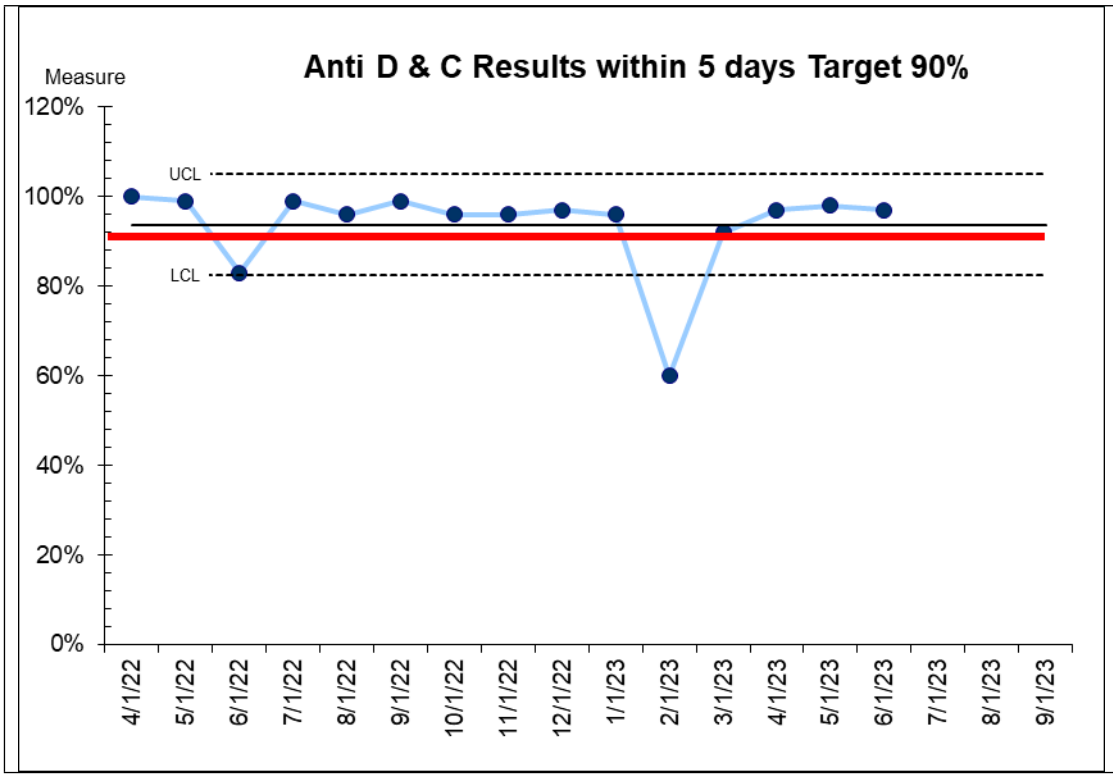
Service Improvement Actions – tactical (12 months +)

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.

EFFICIENT

KPI Indicator FIN.71

Return to Top

Financial Balance – Revenue Position

Target: Net Zero Trajectory

SLT Lead: Director of Finance

Current Performance against Target or Standard

Trust Position (core)	22/23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual £k	64	1	4	2	4								
Target Net Zero		0	0	0	0	0	0	0	0	0	0	0	NIL

Trust-wide Revenue Position as at July 23

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
VCC	(14.656)	(14.656)	0.000	(40.175)	(40.175)	0.000
RD&I	(0.359)	(0.359)	(0.000)	0.091	0.091	0.000
WBS	(7.417)	(7.418)	(0.000)	(21.503)	(21.503)	0.000
Sub-Total Divisions	**(22.432)**	**(22.433)**	**0.000**	**(61.587)**	**(61.587)**	**0.000**
Corporate Services Directorates	**(4.231)**	**(4.207)**	**0.024**	**(12.311)**	**(12.311)**	**0.000**
Delegated Budget Position	**(26.663)**	**(26.640)**	**0.023**	**(73.897)**	**(73.897)**	**0.000**
TCS	(0.272)	(0.292)	0.020	(0.744)	(0.744)	0.000
Health Technology Wales	(0.054)	(0.054)	(0.000)	(0.117)	(0.117)	0.000
Trust Income / Reserves	26.990	26.990	0.000	74.758	74.758	0.000
Trust Position	0.000	0.004	0.004	0.000	0.000	0.000

In response to the letter received from Judith Paget the Trust considered options at the extraordinary Board meeting on the 09th August and submitted the following financial improvement options to WG on the 11th August.

Performance

The overall position against the profiled revenue budget to the end of June 2023 is an underspend of £0.00m and is currently expecting to achieve an outturn forecast of Breakeven.

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

On the 31st July the Trust received a letter from Judith Paget (NHS Wales Chief Executive) which provided a view on the overall financial position of Welsh NHS organisations for 2023/24. In response to the financial challenges set out by Health Boards in 2023/24 the Trust has been asked to support the delivery of a reduction in the overall NHS Wales deficit.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	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

Title	In year 2023/24 financial impact £m	Description of Option / Choice
VCS Contract Protection	0.436	The Trust will work with Commissioners to assess the opportunity to relinquish the LTA income protection which was agreed as part of the LTA/ SLA with the Trust Commissioners. This would reduce the costs of VCS services for the Trust's Commissioners providing a contribution towards the wider deficit reduction of c£1.250m across all LHBs.
Energy	1.250	The latest energy forecast position for 2023-24 from NWSSP suggests that as at month 4 there is a reduction of c£0.436m from the forecast presented at the IMTP planning stage. The range of savings that will be available will be depended on forecast wholesale prices which are provided by the supplier and led by NWSSP as part of the all Wales Energy Group, however expectation is that an opportunity will arise that can be released to support the NHS deficit.
Review Utilisation of Reserves and Commitments (Inc Emergency Reserve)	TBC	Review of third year of investment strategy for corporate infrastructure to support the delivery of front line services.
Medicines Management	TBC	The Trust continues to work with NWSSP Medicines Unit to evaluate the use of generics / biosimilars which could deliver potential savings to our Commissioners. The savings passed through to Commissioners will be net of any internal resource costs required to deliver the change.
Total	**1.686**	

Risks to future performance

Set out risks which could affect future performance

- Further Non Delivery of recurrent savings plans
- Whilst improving 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.73

Return to Top

Financial Balance – Capital Expenditure Position

Target: Expenditure in line with Capital Forecast

SLT Lead: Finance Director

Current Performance against Target or Standard

Performance

Trust Position	22/23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual(Cum)	27.8	1.389m	1.637m	5.646m	**10.333m**								
Target £24.416m CEL		1.389m	1.637m	5.646m	10.333m								

Capital Position as at July 2023

	Approved CEL £m	YTD Spend £m	Committed Orders Outstanding £m	Budget Remaining @ M4 £m	Full Year Foreast Spend £m	Forecast Year End Variance £m
All Wales Capital Programme						
nVCC - Enabling Works	10.896	7.522	0.000	3.374	10.896	0.000
nVCC - Project costs	0.000	0.938	0.000	(0.938)	1.843	(1.843)
Integrated Radiotherapy Solutions (IRS)	10.326	1.806	0.000	8.520	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	10.266	0.000	12.467	24.576	(1.843)
Discretionary Capital	1.683	0.067	0.000	1.616	1.683	0.000
Total	24.416	10.333	0.000	14.083	26.259	(1.843)

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

Capital funding has not been allocated to the nVCC Project with costs being incurred due to the delay of Financial Close. This risk is being mitigated by a request to WG for funding for the Project with latest forecast being c£1.8m as at the end of June.

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

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

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

Performance to date

The actual expenditure to July 2023 on the All-Wales Capital Programme schemes was £10.266m, this is broken down between spend on the nVCC enabling works £7.522m, nVCC Project Costs £0.938. and the IRS £1.806m.

Spend to date on Discretionary Capital is currently £0.067m.

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:** XX/XX/XX	**Lead:** AN Other
	Expected Performance gain - immediate		
	Service Improvement Actions – tactical (12 months +)		
	Actions: what we are doing to improve •	**Timescale:** XX/XX/XX	**Lead:** AN Other
	Expected Performance gain – longer-term		
	Risks to future performance		
	Set out risks which could affect future performance • NVCC not securing the additional funding request from WG of c£1.8m for project support costs.		

KPI Indicator FIN.72

Return to Top

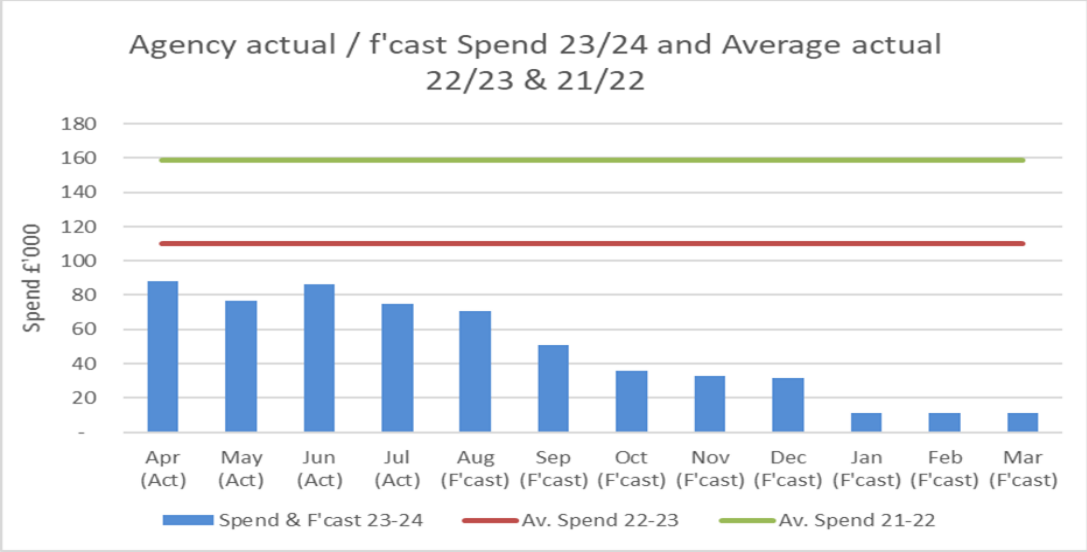
Usage of Overtime Bank and Agency Staff within Budget

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	86	75								
Target (per IMTP) £0.543M Forecast		115	115	115	58	50	50	16	16	0	0	0	0



Performance

The spend on agency for July'23 was **£0.075m,** which gives a cumulative year to date spend of £0.325m and a current forecast outturn spend of circa **£0.580m** (£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.74

Return to Top

Cost Improvement Programme delivery against plan

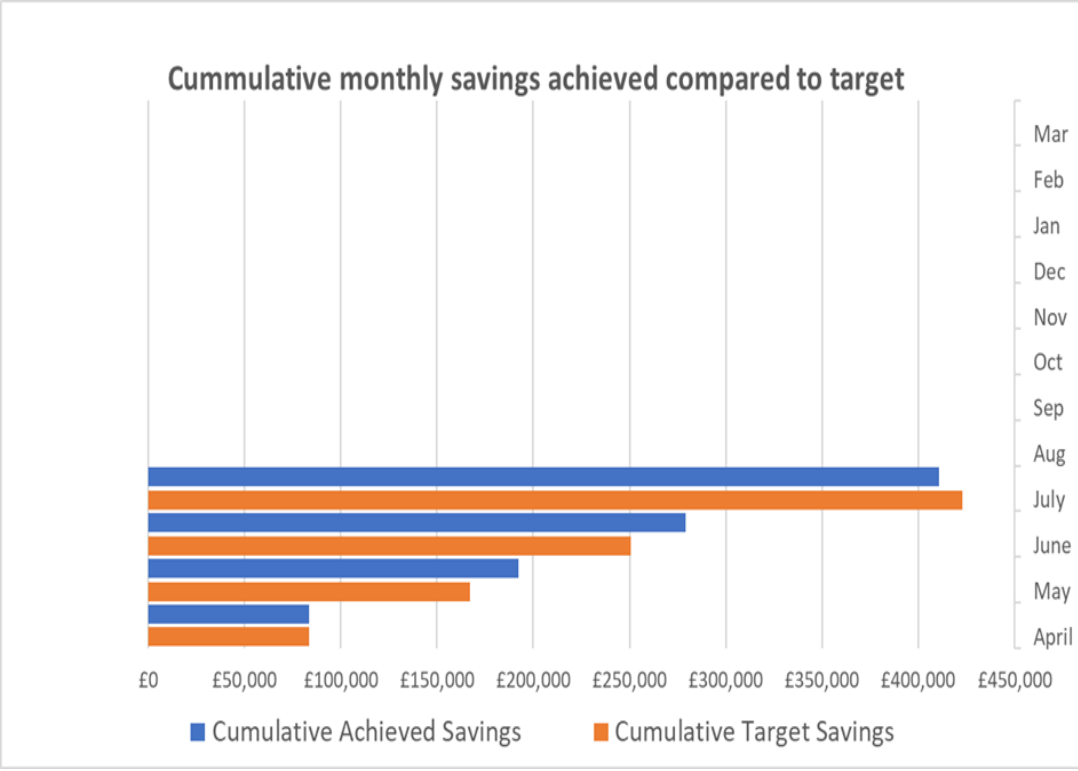
Target: Savings in line with Forecast CIP

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	0.080m	0.069m								
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%).

Following an in depth assessment of savings schemes in July, several schemes have turned red. The impacted schemes relate to workforce and the supply chain with replacement schemes having been identified to ensure that the overall target is achieved for 2023/24.

Failure to enact several recurrent savings schemes and replacing with those that are non-recurrent in nature has reduced the underlying position to be carried into 2024-25 from £0.391m to a latest position of £0.086m.

Service redesign and supportive structures continues to be a key area for the Trust which is about focusing on finding efficiencies in the ways that we are working. Whilst this remains a high priority the ability to enact change has been challenging due to both the high level of vacancies and sickness.

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

KPI Indicator FIN.60

Return to Top

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
Trust Position													
Capital & Revenue Invoices	95	98	98	99	98								
Target 95%	95	95	95	95	95	95	95	95	95	95	95	95	95

Performance

During July '23 the Trust (core) achieved a compliance level of **98.2%** of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **98.4%** as at the end of month 4, and a Trust position (including hosted) of **98.1%** compared to the target of 95%

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	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

EQUITABLE

KPI Indicator WOD.81

Return to Top

% 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	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	July 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

Return to Top

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	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	July 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

Return to Top

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	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	July 23
Actual %															
Target TBA%															

The Workforce Race Equality KPI's are not going to be available to us until at least June next year as they are dependent on the national implementation of the Workforce Race Equality Standard (WRES).

Total VUNHST headcount 1624

White 1424 (88%)

Black, Asian and Minority Ethnic people 200 (12%)

SPC Chart Analysis

The SPC chart shows

Performance

Assessment of current performance, set out key points:

- insert text
-

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
-

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	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	July 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 XX/XX/XX	AN Other AN Other

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
-

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Sickness Absence Key Performance Indicator

DATE OF MEETING	14th September 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	Amanda Jenkins, Head of Workforce
PRESENTED BY	Susan Thomas, Deputy Director of Organisational Development and Workforce
APPROVED BY	Sarah Morley, Executive Director of Organisational Development & Workforce
EXECUTIVE SUMMARY	This paper considers the current KPI for sickness absence of 3.54% within Velindre University NHS Trust and benchmarks this against the current labour market in health and social care to demonstrate this is not an achievable measure for the interim given this information. The paper does not seek to replace the Welsh Government target however it looks to consider if an additional internal KPI, that is more realistic, should be used when assessing the performance of the divisions in respect of sickness absence management.

RECOMMENDATION / ACTIONS	EMB is asked to **ENDORSE FOR APPROVAL**, an internal sickness target of 4.7%, as a stepping stone towards improvement, while Welsh Government are considering targets nationally.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	(31/08/2023)
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS *NA*	

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

Welsh Government sets a tier one target in respect of sickness absence for each organisation within NHS Wales and performance against this target is reported within the Trust on a monthly basis. The Trust's current sickness absence target is 3.54% and was set by Welsh Government more than ten years ago. The landscape of the labour market has significantly changed since this target was set therefore this paper will present more recent benchmarking and provide an analysis to support the local implementation of a more sustainable internal target within the Trust.

This Target will not replace the expectation from Welsh Government but aid as a stepping stone for the organisation to better understand if improvements are being made towards the tier one target within the current employment landscape.

2. BACKGROUND

UK Labour Market

The Office of National Statistics produce an annual dataset on sickness absence within the current UK labour market, providing us with key benchmarking as an organisation in comparison to the national average sickness rates.

The sickness rates recorded by the ONS is proportional to the total hours lost because of sickness or injury divided by total hours multiplied by 100 within a year starting on 01st January and ending on 31st December.

The following information shows annual sickness absence rates from the ONS dataset:

Year	*Sickness Rate in the UK Labour Market*	*Sickness Rate in Health and Social Care*
2022	2.6%	4.2%
2021	2.2%	3.4%
2020	1.8%	3.0%
2019	1.9%	2.9%
2018	2.0%	No data
2017	1.9%	No data

While the UK labour market has seen marginal increases in sickness absence rates it is important to take note that COVID-19 has had significant impact on the data due to government policies on furlough and the wider ability to work from home. In comparison in the Health and Social Care Sector where these schemes are less viable due to service needs, the UK has seen a more marked growth in sickness absence rate.

NHS Wales Sickness Absence

Information on sickness absence rates are provided to Welsh Government via NHS Wales Shared Services Partnership (NWSSP) with an annual data set

equivalent to that of the ONS being produced for each NHS Wales organisation by Stats Wales.

The following information shows the annual sickness rates from the Stats Wales data set sorted by 2022 performance.

Organisation	***2022***	***2021***	***2020***	***2019***	***2018***	***2017***
Welsh Ambulance Services NHS Trust	10.01%	9.7%	7.0%	7.2%	7.4%	6.8%
Swansea Bay University LHB	8.0%	7.3%	7.4%	6.1%	.	.
Cwm Taf Morgannwg University LHB	7.6%	7.2%	7.0%	6.1%	.	.
Cardiff & Vale University LHB	7.2%	6.6%	6.0%	5.4%	5.2%	5.0%
Aneurin Bevan University LHB	6.9%	6.1%	6.1%	5.6%	5.3%	5.2%
All Wales	**6.9%**	**6.3%**	**6.0%**	**5.5%**	**5.3%**	**5.1%**
Betsi Cadwaladr University LHB	6.6%	6.0%	5.5%	5.3%	5.0%	4.9%
Hywel Dda University LHB	6.6%	5.7%	5.2%	5.1%	4.9%	4.9%
Velindre University NHS Trust[1]	**6.3%**	**4.3%**	**3.7%**	**4.2%**	**4.1%**	**3.9%**
Powys Teaching LHB	6.1%	5.3%	4.9%	4.7%	4.6%	4.6%
Public Health Wales NHS Trust	4.6%	4.1%	3.5%	3.8%	4.0%	4.0%
NHS Wales Shared Services Partnership	3.1%	2.9%	.	.	.	.
Digital Health and Care Wales	2.9%	2.4%	.	.	.	.
Health Education and Improvement Wales	2.2%	2.2%	2.0%	2.6%	1.7%	.

When considering the data across NHS Wales there is a clear and significant increase in sickness absence rates across all health organisations post the COVID-19 pandemic.

[1] *The data for Velindre University NHS Trust includes NWSSP staff until June 2021*

Cancer and Blood Services

As well as considering our position within the wider NHS Wales system it is important to provide a comparative analysis against other Cancer and Blood Services within the UK, where their sickness absence data has been publicly reported.

The following data represents the most recent public reports on rolling sickness absence for December 2022. As demonstrated above in the NHS Wales figure Velindre University NHS Trust was reporting 6.3% at this time.

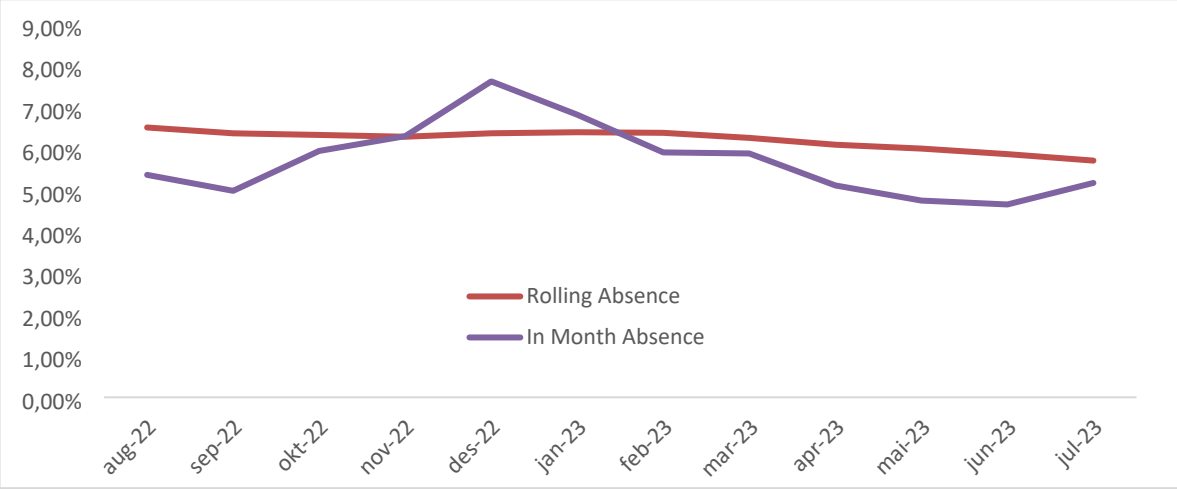
Organisation	*Reporting Month*	*Sickness Absence Rate*	*Sickness Absence Target*
The Christie NHS Foundation Trust	December 2022	6.22%	3.4%
The Clatterbridge Cancer Centre NHS Foundation Trust	December 2022	5.9%	4%
The Royal Marsden NHS Foundation Trust	December 2022	4.5%	3%
NHS Blood and Transplant	December 2022	5.79%	4%

Prior to 2022 the average sickness absence rate from 2017 to 2021 for the Trust was 4.04% however the benchmarking data presented within this report, clearly demonstrates that the growth in sickness absence for the Trust is not unprecedented across the wider health system.

It is clear that Velindre University NHS Trust needs to consider this wider picture in coming to a conclusion as to a realistic internal target for sickness absence.

3. SUMMARY OF MATTERS FOR CONSIDERATION

Current Sickness Absence Analysis (July 2023)



The graph above demonstrates the rolling sickness absence rate as of July 2023 and shows the 0.66% decline in rolling absence since December 2022. Given the Trust is continuing its efforts to effectively manage staff absence and proactively support wellbeing it is anticipated this position will continue to improve across the service.

It would be realistic to predict in the coming year based on the current sickness trends the Trust's sickness absence rate will achieve a approximately a 1% reduction in sickness absence.

Based on this anticipated decline in sickness absence as cases are managed within the Trust and considering the benchmarking data across the sector, it would be reasonable to set an internal target of 4.7% to be reviewed in September 2024. This 4.7% target will be a rolling absence target to be reached by September 2024 at which point this will be reviewed. This target is set as a stepping stone to ongoing improvement in absence levels.

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>03 - Workforce Planning</td></tr>
<tr><td rowspan="2">QUALITY AND SAFETY IMPLICATIONS / IMPACT</td><td>Yes -select the relevant domain/domains from the list below. Please select all that apply
Safe ☒
Timely ☒
Effective ☒
Equitable ☒
Efficient ☒
Patient Centred ☒</td></tr>
<tr><td>Not effectively managing sickness absence will have a significant impact on the availability of skilled and developed people to deliver services in a safe, timely, effective, equitable, efficient manner that is centred around the patient or donor.</td></tr>
</table>

SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	Financial resources are impacted by the level of absence across all staff groups in the Trust.
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
	Policies that relate to absence management are subject to individual EQIA processes
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	

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Integrated Quality and Safety Group Highlight Report.

DATE OF MEETING	14th September 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	DISCUSSION

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Zoe Gibson, Interim Corporate Head of Quality, Safety And Assurance
PRESENTED BY	Zoe Gibson, Interim Corporate Head of Quality, Safety And Assurance & Tina Jenkins, Interim Deputy Director Nursing, Quality & Patient experience
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences

EXECUTIVE SUMMARY	This paper provides an overview of the key deliberations, and outcomes of the Trust Integrated Quality & Safety Group meetings between May and July 2023. Key areas to highlight include: • Duty of Quality required 'Always on Reporting' commenced in August 2023 with patient and donor experience measures. • The development of the proposed list of Trust Quality prioritised measures for the Performance Management framework and Quality Dashboard has been delayed due to Business Intelligence Capacity. It is anticipated that this will be provided to the September Integrated Quality & Safety Group.

RECOMMENDATION / ACTIONS	The Quality, Safety and Assurance Committee is asked to ***DISCUSS*** the report and NOTE the content. In particular: • The commencement of 'Always on Reporting' on the Trusts website and the further development work that is required. • The close down of the Duty of Quality & Duty of Candour Implementation Group. • The work to develop the Trust Quality Management system. •

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Trust Integrated Quality and Safety Group	May - July 2023.
Executive Management Board	31st July 2023.
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Items for inclusion agreed at Integrated Quality & Safety Group. Executive Management Board: • Asked that lead officer for ensuring monthly publication of 'Always on Reporting' to be identified. • Approved the 'close down' of the Duty of Candour and Duty of Quality Implementation Group and move to business-as-usual monitoring and oversight through the Integrated Quality & safety Group. • Endorsed the implementation of the national Quality Impact Assessment Tool.	

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 4 - Increased extent of impact from actions

APPENDICES	
1.	Quality Management System development to date (presentation)
2.	Quality & Safety Tracker (August 2023) 3.6.0 QS Tracker QSP Sept1.xlsx

1. SITUATION/ 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 and brings together the Corporate and Divisional Quality and Safety Hubs to provide integrated analysis and assurance / escalation to the Executive Team and Quality, Safety & Performance Committee on behalf of the Board in respect of the Trust meeting its Quality and Safety responsibilities in line with legislative and national requirements and ensuring the Trust is learning from internal and external events, and always improving.

2. ASSESSMENT

2.1 Trust Quality Metrics

Work to develop the prioritised list of Trust Quality metrics (to be included in the performance management framework and quality dashboard) has progressed but has taken longer than anticipated due to availability of key personnel. The wide consultation across corporate services and divisions / directorates and data gathering is complete and a master spreadsheet developed. This spreadsheet contains details of quality measures to be considered to inform the prioritised list of proposed quality metrics for inclusion in the PMF and Trust Quality Dashboard. The final list of quality measures and prioritisation for each should now be provided at the Integrated Quality & Safety Group in September 2023.

2.2 Duty of Quality/ Duty of Candour Update

The Trust has continued to prepare and implement the requirements of the Duties following the publication of the final statutory guidance with a high degree of confidence to meet the requirements of the Duties.

A number of staff engagement sessions have been arranged since the 1st April 2023 to deliver the necessary updates and information for all Trust employees, with excellent attendance and staff engagement. The latest event held on the 4th July 2023 had 151 attendees.

Divisions have pursued managing incidents on a live basis, reviewing moderate and greater harm events as they arise and that would trigger the duty. To support the implementation of the requirements of both the Duty of Quality and Duty of Candour the Trust Handling of Concerns and Incident Reporting policies have been reviewed and

endorsed at both the Integrated Quality and Safety Group and Executive Management Board.

During this period two incidents at VCS have triggered Duty of Candour requirements. Both are being managed and investigated in line with requirements of the Duty of Candour procedures.

Priority work is the determination of the Quality Metrics (detailed above) and the Trusts Quality Management System.

The Trust has commenced the required monthly 'Always on Reporting' on the Trust website from August 2023 with patient and donor experience measures. A trust responsible officer for ensuring monthly publication going forward is being agreed. A roll out plan of measures is being agreed.

Given the move of this work into business as usual it was agreed by both the Duty of Candour / Quality Implementation Group, the Integrated Quality & Safety Group and Executive Management Board that the August 2023 Duty of Quality & Duty of Candour Implementation Group will be the last meeting and oversight will transfer to the Integrated Quality & Safety Group. A full closure report has been completed and an agreement that both outstanding actions and ongoing requirements will be the responsibility of the Integrated Quality and Safety Group. The closure report will be provided to the Integrated Quality and Safety Group and Executive Management Board during August 2023.

3.3 Quality Management system Developments

Discussions to date in respect of the Trusts Quality Management System approach concluded that the Trusts long term Quality Management System will be 'Quality as an Organisational Design'. This approach required high value external procurement. It was recognised that this approach would take 5 years from commencement to achieve the intended outcomes. However, subsequent discussions have identified that due to the financial outlay required to embark on this programme and the current NHS Wales financial situation that procurement of this would need to be paused at present.

It had been agreed that in the short term the Trust needed to develop a Quality Management system that will be cognisant with the Quality as an organisational design work but meet the national requirements and it was agreed that the (nationally endorsed) Hywel Dda University Health Board approach would be adopted.

A slide deck has been developed based on the Hywel Dda Quality Management system approach to outline the proposed aspects of the Trust Quality Management System (***Appendix 1***). Monthly dedicated Executive Management Board time has been agreed to develop the Quality Management System further.

3.4 Safe Care Collaborative Project Updates (to deliver Trusts Quality Priorities)

- ***Donor Adverse Event Reporting:*** Significant work undertaken and staff engagement. Tests of change (PDSA) are being planned over the next month.
- ***Haemochromatosis*:** The project is progressing, data capture continues and a patient information database to support the project has been developed. The pilot is being planned to start in the next month with Cwm Taf Morgannwg University Health Board.
- ***SACT Treatment Helpline*:** The project has started to gain momentum with significant work undertaken to redesign the escalation process and enhance the UKONS triage tool. Both due to be put in place during September 2023. An external peer review is being arranged and A Consultant Oncology Nurse from Devon has agreed to conduct the review. Terms of reference are under development.
- ***Malignant Spinal Cord Compression Pathway*:** The project is underway, and a project team established. However, there has been limited engagement in the Safe Care Collaborative meetings from the project team and a deep dive meeting is planned for the 7th September 2023.
- ***Leadership:*** The driver diagram for the enhancing the psychological safety culture ambition for the Trust is in the final stages of development. The baseline staff survey questionnaire is under development and this will be undertaken after the NHS Staff Survey is completed.

Once the collaborative matures the work of the group will migrate to the Integrated Quality & Safety Group. However, significant work is required before this is achieved.

3.5 Trust Quarter 4 National Reportable Incident (NRI) Overview and Learning Report

The NHS Executive produced report was discussed that covered quarter 4 2022/23. During the quarter 2 NRIs reported in this period, one relating to a patient fall and the second relating to treatment delays. Both incidents were managed within Welsh Government requirements and associated timescales. No incident trends identified. The Group identified that the national reportable incident rate per 100,000 population was a useful comparator to be included in the performance management framework alongside the number as the benchmarked comparator provides greater context and more effective assurance. The Trust benchmarked favourably compared with national average rate.

Figure 1.1 – NRIs reported by Velindre between 14 June
March 2023 and rate per 100,000 population
2021 – 31

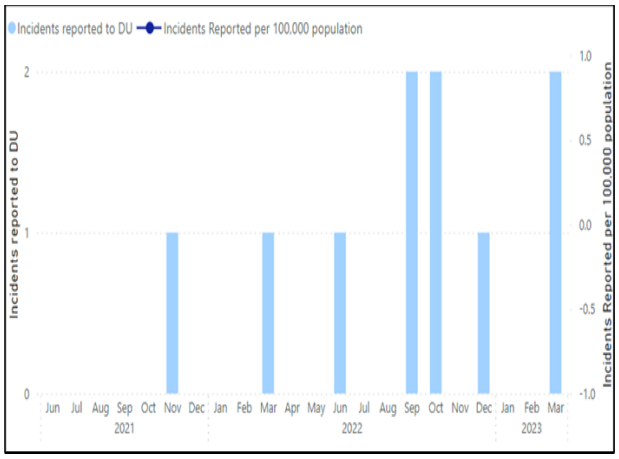
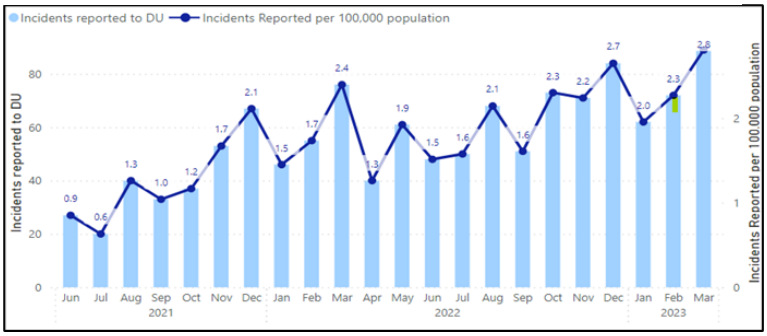


Figure 1.2 – All-Wales NRIs reported between 14 June
2021 – 31 March 2023 and rate per 100,000 population



3.6 Notifying Significant Accidental and Unintended Exposures Under IR(ME)R Guidance for Employers and Duty Holders Version 3, April 2023

Both the Integrated Quality and Safety Group and Executive Management Board received details of the revised HIW IR(ME)R reporting requirements that has been implemented across VCS Radiation Services. Ionising Radiation (Medical Exposure) Regulations 2017 and the Ionising Radiation (Medical Exposure) Regulations (Northern Ireland) 2018 are designed to protect people while undergoing examinations and treatment using ionising radiation. When there is an accidental or unintended exposure to ionising radiation, and the IR(ME)R employer knows or thinks that it is significant, they must investigate the incident and report it to the appropriate UK IR(ME)R enforcing authority (under Regulation 8(4)).

The guidance was updated in April 2023. The following are the key requirements:

4.2a	Radiotherapy treatment verification images	Set-up error leads to 3 or more imaging exposures in a single fraction (including the intended image, 3 images in total). *This applies to all radiotherapy treatment regimes, including radical short course fractionation (defined as 10 fractions or less).*
4.2b	Radiotherapy treatment verification images	When the number of additional imaging exposures is 50% greater than intended over the course of treatment as a result of **protocol failure**. *This applies to all radiotherapy treatment regimes, including radical short course fractionation (defined as 10 fractions or less).*
4.2c	Radiotherapy treatment verification images	When the number of additional imaging exposures is 50% greater than intended over the course of treatment as a result of **thematic hardware or software failure**. *This applies to all radiotherapy treatment regimes, including radical short course fractionation (defined as 10 fractions or less).*

3.7 Deaths within 30 days of Systemic Anti-Cancer Therapy (SACT)/ Deaths within 30 days of Palliative Radiotherapy and 90 days of Radical Radiotherapy

Both reports were received by the group in July 2023 and discussed at length.

During the discussion it was reported that data validity relating to these reports cannot currently be assured, due to issues associated with data transfer that have been identified following implementation of WPAS system. The clinical audit team have been working with DHSW to resolve, however, to date no timescales for resolution have been provided. Trust Chief Digital officer to further investigate and seek urgent resolution.

Opportunities to further strength these reports were considered and suggestions made to obtain and include national comparative benchmarking data and provision of expert clinical interpretation to provide understanding and context of report findings, these requirements will be considered and progressed by the Clinical Audit Lead for inclusion in future reports.

It was identified that mortality was the number one priority quality metric for the Trust.

3.8 Duty of Quality, Quality Impact Assessment

The Duty of Quality describes the need for Quality-driven decision-making, particularly for those decisions that are strategic in nature.

The N.H.S. Executive initially developed a Quality-Driven Decision-Making Tool. However, this has been superseded by the development of a national Quality Impact Assessment Tool based on the Health & Care Quality Standards (2023) (separate paper on Quality, Safety & Performance Committee).

Integrated Quality & Safety Group considered both tools. Both Integrated Quality & Safety Group and Executive Management Board have endorsed the use of the National Quality Impact Assessment Tool.

3.9 Complaints Validation Report Quarter 4 (01/01/23 to 31/03/2023)

The Welsh Risk Pool have undertaken a validation exercise relating to 2022-23 quarterly complaints data prepared for submission by all Health Boards and Trusts across Wales, with the aim of to providing support to the Trust in relation to the assurance of local processes aligning with the requirements of the Putting Thing Right regulations and guidance and ensuring the maintenance of accurate and consistent information within the Datix Cymru system.

The validation exercise consisted of verifying complaints source data provided by the Trust and comparing with a prepared proforma. This exercise has now been completed and a validation report provided to the Trust with an assurance rating of '***Reasonable Assurance'***, with reports of some data entry which have since been addressed.

A further validation exercise has been undertaken during Quarter 1, with an initial report of one hundred percent compliance, which supports the address of initial issues identified, validation report awaited.

3.10 Quality and Safety Regulatory Tracker

The current version of the tracker is available via 3.6.0 QS Tracker QSP Sept1.xlsx

Tracker Development
The Quality & Safety Regulatory Compliance Tracker still requires considerable work and is not currently in a state where it can provide the required assurance. This is a priority for the Quality and Safety Team. The Corporate Quality and Safety team are responsible for the development, improvement, and management of the tracker, with the Integrated Quality & Safety Group having operational oversight.

As this work has progressed, it has become evident that numerous action trackers are in existence across the Trust, which although improvements have been progressed, the ability to provide oversight and assurance has been challenging. To enhance assurance mechanisms, reduce duplication of effort, and reduce risk, a single Trust Wide Quality and Safety Regulatory tracker has been developed and is currently available to all operational responsible officers upon Microsoft team channel as a short-term measure, whilst tracker inclusion upon a Trust agreed digital platform e.g., QPulse or AMaT is progressed as a permanent solution. This has enabled operational responsible officers to access and update a single tracker. The current quality, safety and regulatory tracker includes actions arising from:

- Inspectorate body recommendations
- Regulatory compliance recommendations

- Externally commissioned Quality related reports
- Peer review recommendations.
- Llais visits.
- Details of pending inspections
- Actions arising following Nationally reportable incidents.
- Actions arising following Welsh Risk Pool audits.
- Gap analysis recommendations following receipt of external reports containing learning and improvement opportunities relevant to the Trust.

The ongoing programme of development is based upon four key priority areas previously agreed:

i. To define the Quality & Safety Regulatory function across Velindre University NHS Trust.
ii. Production of an annual Quality & Safety Regulatory Compliance Assurance plan, with objectives and priorities for 2023/24.
iii. Further development of the quality & safety tracker and prepare options for the automation of the Trust Quality & Safety Improvement Tracker (using the AMaT automated electronic quality management system.
iv. Development of an organisation wide quality management (assurance) system for Quality & Safety Regulatory Compliance, which will align with the Trust overarching assurance framework.

During this time further actions have been added to the tracker (77) relating to National Reportable Incidents, Welsh Risk Pool Validation Assessments, Brachytherapy service and WBS Health & Safety Executive Irradiator report.

Currently 186 actions remain open upon the tracker, with 72 actions being reviewed and closed.

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	**Select all relevant domains below**
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	Provides Executive Management Board with details of discussions and decisions made at an integrated divisional level which impact upon all domains of quality.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
	This report provides details of discussions and decisions made within Integrated Quality and Safety Group as opposed to service delivery and approach change with a direct impact upon Socio Economic Duty.

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	This report provides details of discussions and decisions made within Integrated Quality and Safety Group as opposed to service delivery and approaches change that would require an equality assessment.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

Corporate Quality & Safety Tracker, Oversight of VCC & WBS

Definitions of 7 Levels Framework for Evaluating Delivery of Improvement Plans

DETAILED DEFINITIONS OF 7 LEVELS OF EVALUATION TO DETERMINE RAG RATING / OPERATIONAL ASSURAI

RAG rating	ACTIONS	OUTCOMES
Level 7	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes over a defined period of time i.e., 3 months.
Level 6	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement also of desired outcomes.
Level 5	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with little or no evidence of the achievement of desired outcomes.
Level 4	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of several agreed actions being delivered, with little or no evidence of the achievement of desired outcomes.
Level 3	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Some measurable impact evident from actions initially taken AND an emerging clarity of outcomes sought to determine sustainability, with agreed measures to evidence improvement.
Level 2	Comprehensive actions identified and agreed upon to address specific performance concerns.	Some measurable impact evident from actions initially taken.
Level 1	Initial actions agreed upon, these focused upon directly addressing specific performance concerns.	Outcomes sought being defined. No improvements yet evident.
Level 0	Emerging actions not yet agreed with all relevant parties.	No improvements evident.

SUMMARY STATEMENTS OF 7 LEVELS

RAG rating	SUMMARY
7	Improvements sustained over time - BAU
6	Outcomes realised in full
5	Majority of actions implemented; outcomes not realised as intended
4	Increased extent of impact from actions
3	Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes
2	Symptomatic issues being addressed
1	Actions for symptomatic issues, no defined outcomes
0	Enthusiasm, no robust plan

Status

- Green - Action complete
- Yellow - Action on target to be completed by agreed date
- Orange - Action not on target for completion by agreed date
- Red - Implementation date passed - Action not complete

Ref	Recommendation	Priority	Man	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update January 2023	Requested Extension Date	Extension (Months)
Matters Arising 1	**Meeting Structure** 1.1 As part of the review of quality and safety governance and reporting mechanisms, the Trust should: 1.1a. review the flow of patient and donor experience reporting 'from floor to Board' to ensure it is clear and efficient, avoiding unnecessary duplication;	Medium	a. A patient / eedback procedure to be developed and published on intranet identifying reporting flow service level to Board.	Nicola Williams, Director of Nursing, AHP's & Medical Scientists	Tina Jenkins, Deputy Director Nursing, Quality & Patient Experience	31/03/2023	On Target	**January :** Patient/Donor experience feedback procedure under development. The procedure will be reviewed by the Integrated Quality prior to upoloading to the Trust's Intranet site. **February:** No further update **March:**The BI team is working on dashboard reporting of data collated from CIVICA, including all patient and donor feedback. BI is currently working with CIVICA to a 2 week deadline. This report will need approval prior to publication **April:** Overdue due to change in Personnel and absense. **May:** No Further update extension date agreed for extar 2 months **June**: No further update **July**: No further update as yet	Extension Request Agreed April 2023 Audit Committee:	2 Months
	1.1c ensure relevant staff are clear on the above, e.g., though publicising the new quality and safety governance and reporting mechanisms at team meetings on the intranet.	Medium	See 1.1 a	Nicola Williams, Director of Nursing, AHP's & Medical Scientists	Tina Jenkins, Deputy Director Nursing, Quality & Patient Experience	31/03/2023 Extension Request Agreed April 2023 Audit Committee: 30 May 2023	On Target	See update relating to 1.1a above.	Extension Request Agreed April 2023 Audit Committee:	2 Months
	2.1a	Medium	All BI dashboards to include CIVICA patient / donor experience outcomes from service level to Board	Nicola Williams, Director of Nursing, AHP's & Medical Scientists	Emma Powell, Head of Information	30/04/2023	On Target	**January:** Work is underway on the Specifications for the Quality and Safety Dashboard. This will include the specification for the reports required from CIVICA outcome measures. **February:** Meeting with CIVICA is schedule for the 13th Feb to provide access to the data to intergrate with the Data Warehouse. **March:** Meeting with CIVICA was held on the 13th Feb. Work in ongoing to get access to the data so that it can be integrate with the Data Warehouse. **April:** BI Dashboard yet to be delivered. **May:** Awaiting CIVICA to finalise connection into Trust data warehouse. **June:** No update **July:** No update August: Measures for inclusion in Dashboard have been identified and are being submitted to IQSG for approval.	30-May-23	

Matters Arising 3	**Feedback to Staff** 3.1 The Trust should incorporate how it effectively communicates patient and donor experience feedback to all staff as part of its review of quality and safety governance and reporting mechanisms.	**Medium**	The patient / Donor experience feedback procedure (detailed under 1.1a) to include expectations of how feedback should be communicated to staff at all levels and how staff are involved in the 'so what' analysis.	Nicola Williams, Director of Nursing, AHP's & Medical Scientists	Tina Jenkins, Deputy Director Nursing, Quality & Patient Experience	31/03/2023 Extension Request Agreed April 2023 Audit Committee: 30 May 2023	**On Target**	See update relating to 1.1a above. Staff brieifing of Patient and Donor Annual Experience Report issued.		2 Months

Ref No	Recommendation	Monitoring and Evaluation	Responsible Person	Action & Progress	Deadline for Completion	Status
R4	**The process for collation and verification of source data should be mapped into an SOP or procedure document and applied for each reporting period. Data should be authorised by a member of the leadership team prior to submission.**	Head of Quality and Safety will, review, verify and approve the data generated by the QSA Managers each quarter prior to submission.	Quality, Safety and Assurance Managers / Head of Quality and Safety	An SOP has been drafted and has been shared with the Head of Quality and Safety for final review. Going forward the newly appointed Head of Quality and Safety will, review, verify and approve the data generated by the QSA Managers each quarter prior to submission.	**30th June 2023**	open

Ref No	Recommendation	Monitoring and Evaluation	Responsible Person	Action & Progress	Deadline for Completion	Open/Closed
Compliments Data	**To ensure WG data includes all written compliments to be matched and validated.**	A suggestion to allocate a "compliments" lead to collate all compliments received across the Trust, review, upload and disseminate valuable positive areas of learning	Head of Quality and Safety	Going forward this data will be generated from Datix Cymru by the QSA Managers and reviewed and approved by the Head of Quality and Safety	**Q2 2023-24**	Closed
Validation Process	To implement a process for the validation of complaint data whilst the complaint is active To ensure a SOP (process) captures the approval/authorisation of the leadership team prior to submitting the validation of data to WG and Public Service Ombudsman of Wales.	An SOP has been drafted and has been shared with the Head of Quality and Safety for final review. Going forward the newly appointed Head of Quality and Safety will, review, verify and approve the data generated by the QSA Managers each quarter prior to submission.	Quality, Safety and Assurance Managers / Head of Quality and Safety	Head of Quality and Safety will, review, verify and approve the data generated by the QSA Managers each quarter prior to submission	**30th June 2023**	Closed
R1	**A full review of the recording of complaint information in Datix Cymru should be undertaken to ensure an effective approach is in place.**	A dedicated Quality, Safety and Assurance Manager will manage, oversee and continuously review all PTR concerns data entered onto Datix Cymru. Early resolution concerns and enquiries will be handled by the Divisional Concerns and patient experience lead.	Quality, Safety and Assurance Manager Divisional Concerns and patient experience manager	A full audit of data is being undertaken by the Quality, Safety and Assurance Manager in relation to concerns data for 2022-23. A dedicated Quality, Safety and Assurance Manager will manage, oversee and continuously review all PTR concerns data entered onto Datix Cymru. Early resolution concerns will be handled by the Divisional Concerns and patient experience lead.	**30th June 2023**	Closed
R2	**The correct process for resetting the Complainant Chain if the first received date is changed, and the importance of this being undertaken should be shared. A process for the validation of this data whilst the complaint is active should be implemented.**	A dedicated Quality, Safety and Assurance Manager will manage, oversee and continuously review all PTR concerns data entered onto Datix Cymru.	Quality, Safety and Assurance Manager	The Trust have now been made aware of the system work around to reset the complainant chain, and the Corporate & Divisional teams have been notified of the steps to take to correct the complainant chain when adding new cases onto Datix Cymru. Comments: it would be beneficial if the system automatically recalculated the complainant chain removing human error and the manual work around.	**10th March 2023**	Closed

R3	**Ensure users responsible for producing Complaint data are familiar with the Definitions Document which should be used as a resource when extracting data from Datix Cymru.**	A dedicated Quality, Safety and Assurance Manager will manage, oversee and continuously review all PTR concerns data entered onto Datix Cymru.	Quality, Safety and Assurance Manager	The definitions document has been circulated to the Corporate and Divisional Quality and Safety teams including all individuals who are involved with generating concern data.	**13th June 2023**	Closed
Complaints Closed Data	Of the total number of Closed Complaints closed by the organisation during the quarter, the submission did not match the source data. Information must match the proforma	A dedicated Quality, Safety and Assurance Manager will manage, oversee and continuously review all PTR concerns data entered onto Datix Cymru.	Quality, Safety and Assurance Manager	The Trust completed a complex OCP during 2021-22 with no established Concerns Team in place. Concerns management during this time was managed predominately outside of Datix Cymru which led to the discrepancies in the data submission. Datix Cymru is now fully utilised to manage all Concerns received on a live basis.	**10th March 2023**	Closed
Complaint Chain	Response due date/complaint chain not correctly reset. In addition, the Complainant Chain is not being managed in line with system user guide and national training and 'Putting Things Right Regulations'.	A dedicated Quality, Safety and Assurance Manager will manage, oversee and continuously review all PTR concerns data entered onto Datix Cymru.	Quality, Safety and Assurance Manager	Training received from WRP on the 10th March 2023 to the Corporate and Divisional teams and now following the process for manually resetting the complainant chain for concerns raised. It would be beneficial if the system automatically recalculated the complainant chain removing human error and the manual work around.	**10th March 2023**	Closed
Definitions Document	Ensure users responsible for producing Complaint data are familiar with the Definitions Document which should be used as a resource when extracting data from Datix Cymru.	A dedicated Quality, Safety and Assurance Manager will manage, oversee and continuously review all PTR concerns data entered onto Datix Cymru.	Quality, Safety and Assurance Manager	The definitions document has been circulated to the Corporate and Divisional Quality and Safety teams including all individuals who are involved with generating concern data.	**13th June 2023**	Closed
Key Field Data	Completion of key fields in Datix Cymru is required, in accordance with system user guide. Key fields were identified as not being completed in Datix Cymru	A dedicated Quality, Safety and Assurance Manager will manage, oversee and continuously review all PTR concerns data entered onto Datix Cymru.	Quality, Safety and Assurance Manager	Training received from WRP on the 10th March 2023 to the Corporate and Divisional teams and now following the process aligned with Datix Cymru Concerns Management.	**10th March 2023**	Closed
Regulation 24 Complaints	Of the total number of Complaints managed through the PTR Regulations closed during the quarter, there were several records closed with 'no response date' completed. This is a data quality issue - the response date is required to calculate the number of days.	A dedicated Quality, Safety and Assurance Manager will manage, oversee and continuously review all PTR concerns data entered onto Datix Cymru.	Quality, Safety and Assurance Manager	Training received from WRP on the 10th March 2023 to the Corporate and Divisional teams and now following the process aligned with Datix Cymru Concerns Management.	**10th March 2023**	Closed

Complaints Standards Authority re-submission	As the validation programme arose from concerns raised by the Ombudsman, WRP encourages the Trust to resubmit the data to the Complaints Standards Authority for the entire year 2022-23, to ensure it matches the validated data provided to Welsh Government. (OFWCMS has offered to assist)	A dedicated Quality, Safety and Assurance Manager will manage, oversee and continuously review all PTR concerns data entered onto Datix Cymru. Early resolution concerns and enquiries will be handled by the Divisional Concerns and patient experience lead.	Quality, Safety and Assurance Manager Divisional Concerns and patient experience manager	A full audit of data is being undertaken by the Quality, Safety and Assurance Manager in relation to concerns data for 2022-23.A dedicated Quality, Safety and Assurance Manager will manage, oversee and continuously review all PTR concerns data entered onto Datix Cymru. Early resolution concerns will be handled by the Divisional Concerns and patient experience lead.	**30th June 2023**	Closed

Inspection	Date of Inspection	Date Report Received	Actions Completed By	Document
United Kingdom Accreditation Service (UKAS)	05/10/2022-06/10/2022	12/10/2022		UKAS October 2022
Commissioner Report - Welsh Transplantation and Immunogenetics Laboratory	10/11/2022	10/01/2023	03/01/2023	Commissioner's Report Jan 2023

Ref No	Service	Recommendation	Outcomes Required	Operational Lead	Operational Oversight	Delivery Date	Summary of Progress
HIW visit to VCC First Floor Ward 12th / 13th July 2022							
REF031	**VCC Inpatient Wards**	Trust to consider implementing a Medical Devices electronic tracking system that recalls devices requiring service	Trust to consider implementing a Medical Devices electronic tracking system that recalls devices requiring service	Medical Physicist	Head of Nursing, Quality, Patient Experience and Integrated Care	Mar-23	*Awaiting update from medical devices lead. 040723 arequested update 10/07/23 Implementing device tracking system requires some work and cost. Not sure if it can be possible for VCC, due to the time frame, money, and manpower but we have suggested that nVCC should have the system. I (Jingnesh) will discuss this HIW action in upcoming Medical Devices meeting.*
CHC visit to VCC Outpatients Department 8th February 2023							
REF053	**VCC Outpatients Department**	The Trust should consider improving the current system of calling patients ensuring the system meets the needs of patients with hearing and sight loss.	The electronic calling system is being repaired but the trust is also looking at an alternative calling system which would provide a visual system for those hard of hearing.				040723 One tannoy currently working. One waiting for repair

CHC Outpatients Visit 8.2.23

			The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they a				
Ref No	**Service**	**Recommendation**	**Outcomes Required**	**Standard/Regulation**	**Operational Lead**	**Progress**	**Delivery Date**
RAD 1	**RADIOTHERAPY**	The Trust is required to provide HIW with details of the action taken to make patient information leaflets in the department available in Welsh and other languages taking into consideration the needs of the patient population.	Environmental review already completed and determined Swipe access door controls required	Standard - Person Centred	Infrastructure and Design Manager		31st October 2023
RAD 2	**RADIOTHERAPY**	As Above	Door replacements being installed within 4-6 weeks	Standard - Person Centred	Infrastructure and Design Manager		31st October 2023
RAD 3	**RADIOTHERAPY**	As Above	Access control permissions to be developed into a Standard Operating Procedure (SOP)	Standard - Person Centred	Infrastructure and Design Manager		31st October 2023
RAD 4	**RADIOTHERAPY**	As Above	Communication of revised access control permission to staff in Velindre Cancer Centre	Standard - Person Centred	Infrastructure and Design Manager		31st October 2023
Rad 5	**RADIOTHERAPY**	The Trust is required to provide HIW with details of the action taken to make patient information leaflets in the department available in Welsh and other languages taking into consideration the needs of the patient population.	Trust Radiotherapy Team are working with Wales Cancer Network (WCN) and the other Wales Radiotherapy centres to review current patient information leaflets in use with the view to reduce duplication, have consistency and to ensure availability in English, Welsh and other core languages aligned to the needs of the patient population.	Standard - Equitable	Radiotherapy Service Manager	Gap analysis of information leaflets currently in use and available is underway. Meeting arranged September 2023 with Wales Cancer Network to review patient population requirements. revised information availability to meet language requirements identified. Gap analysis of information leaflets in use.	31st January 2024

RAD 6	**RADIOTHERAPY**	The Trust is required to provide HIW with details of the action taken to:•ēncourage those staff who are Welsh speaking to wear a suitable badge or lanyard to show patients they are happy to converse in Welsh •tō consistently ask patients to confirm their preferred language.	Lanyards are not permitted within clinical areas due to infection risks. Corporate communications to release periodic update reminders to all staff to wear Iaith gwaith badge if Welsh Speaking and able to converse in Welsh or Welsh learner badge if learning to speak Welsh	Standard - Equitable	Welsh Language Officer / Corporate Communication team	complete	Initial Communications 31st July 2023
RAD 7	**RADIOTHERAPY**	As Above	Uniforms with embroidered with Iaith gwaith logo to be sourced and provided to all Welsh speaking staff	Standard - Equitable	Radiotherapy Services Manager	**8/8/23** update- supplier sourced and uniforms awaiting collection **14/8/23** Uniforms with Iaith gwaith logo distributed to Welsh speaking staff	31st January 2024
RAD 8	**RADIOTHERAPY**	As Above	Baseline audit to be undertaken to assess current level of information gained on language preference, and detailed actions to target specific aspect of patient pathway to follow. Implement changes based on the audit findings and follow with a review to ensure patients are asked to confirm their preferred language.	Standard - Equitable	Deputy Radiotherapy Service ManagerRadiotherapy Oncology Lead		31st January 2024
RAD 9	**RADIOTHERAPY**	As Above	Investigate most appropriate information system location to indicate preferred language.	Standard - Equitable	Deputy Radiotherapy Service Manager Lead Radiotherapy Clinical Oncologist Deputy Head of Radiotherapy Physics	Review undertaken, identified that Iaith 'gwaith logo' can be recorded on Aria OIS-system is in use for all patients receiving radiotherapy	30th August 2023
RAD 10	**RADIOTHERAPY**	The employer is required to provide HIW with details of the action taken to better reflect the referral guidelines for the range of exposures performed at the department in the joint protocols, taking into account relevant guidance.	Update all joint Clinical protocols and update format more in keeping with template included in Ionising radiation Medical Exposure) Regulations: Implications for clinical practice in radiotherapy. Guidance from the radiotherapy board. Starting with Joint breast protocol in preparation for treatment on Halcyon then each document to be updated at annual review. Each joint Clinical protocols will be updated on rolling monthly update and complete within one year.	Standard - Equitable	Radiotherapy Clinical Governance Manager Deputy Head of Radiotherapy Physics		1st document to be ready for January 2024 document issue. All Joint protocols expected will be updated by 31st July 2024

RAD 11	**RADIOTHERAPY**	The employer is required to provide HIW with details of the action taken better reflect the governance arrangements for research trials in the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R 2017 in Radiotherapy document.	Update IR(ME)R in RT document to include governance arrangements for research trials. IRMER training to be moved to ESR to provide a more reliable and robust method of monitoring compliance.	IR(ME)R - Regulation 11 (1)(d)	Radiotherapy Clinical Governance Manager		30th November 2023
RAD 12	**RADIOTHERAPY**	The employer is required to provide HIW with details of the action taken to better reflect the entitlement of Clinical Oncologists in the local employer's written procedures.	Update IR(ME)R in RT document to include the entitlement of Clinical Oncologists in the local employer's written procedures.	IR(ME)R Regulation 6 (1) (a) and Schedule 2 (1)(b)	Radiotherapy Clinical Governance Manager		30th November 2023
RAD 13	**RADIOTHERAPY**	The employer is required to provide HIW with details of the action taken to show Clinical Oncologists have read the employer's written procedures relevant to their roles.	SOP to be developed to define process for monitoring, follow up and escalation of any non- compliance with the SOP	IR(ME)R - Regulation 6 (2)	Clinical Director / Clinical Oncologist Lead for Radiotherapy		31st October 2023
RAD 14	**RADIOTHERAPY**	As Above	IRMER training to be moved to ESR to provide a more reliable and robust method of monitoring compliance	IR(ME)R - Regulation 6 (2)	Clinical Director / Clinical Oncologist Lead for Radiotherapy		31st October 2023
RAD 15	**RADIOTHERAPY**	The employer is required to provide HIW with details of the action taken to revise the employer's written procedures to show carers or comforters are not allowed to remain with patients during any medical exposure.	Update IR(ME)R in RT document by adding a statement to show carers or comforters are not allowed to remain with patients during any medical exposure.	IR(ME)R – Regulation 6 (1)(a) Schedule 2 (1)(n)	Radiotherapy Clinical Governance Manager		30th November 2023

RAD 16	**RADIOTHERAPY**	The employer is required to provide HIW with details of the action taken to update the electronic system in a timely manner when equipment checks have been completed and to show the rationale where a decision is made to delay annual equipment checks.	A simplified process is to be established to ensure engineering equipment tasks are logged within the electronic system in a timely manner. This will include the addition of a simple check box.	IR(ME)R - Regulation 15 (3)	Deputy Head of Radiotherapy Physics		31st October 2023
RAD 17	**RADIOTHERAPY**	As Above	The machine QA procedure is to be updated to include the process to be followed when a decision is made to rearrange scheduled preventative maintenance and QC. If a decision is made to reschedule a service or Quality Control (QC) review, then the rearranged (QC) or service, will be scheduled for a date as soon as reasonably practicable. This will trigger a concession raised in the Q-Pulse Quality Management System containing the justification for the postponement	IR(ME)R - Regulation 15 (3)	Deputy Head of Radiotherapy Physics		31st October 2023
RAD 18	**RADIOTHERAPY**	The Trust is required to provide HIW with details of the action taken to repair or replace areas of the floor which are visibly worn and presenting a hazard.	Estates to review all flooring for any hazards and make safe	Standard - Safe	Estates Manager	30th August- Awaiting confirmation schedule of planned repair	30th August 2023
RAD 19	**RADIOTHERAPY**	As Above	Set up a reactive focus group to discuss and address staff concerns when they arise. Safety concerns outside of our control will be escalated and timely responses back to staff.	Standard - Safe	Radiotherapy Services Manager Clinical Director Head of Radiotherapy Physics	21st August 2023 Multidisciplinary focus group set up to address concerns as they arise	30th August 2023
RAD 20	**RADIOTHERAPY**	As Above	Psychological safety and safe reporting to be included on agendas for all staff meetings.	Standard - Safe	Radiotherapy Services Manager Clinical Director Head of Radiotherapy Physics	Within Radiotherapy this will be included on the agenda of the staff meeting commencing 5th September 2023 Within RT Physics this will be included on the agenda for monthly 1 to 1 and section meetings.	30th August 2023
RAD 21	**RADIOTHERAPY**	As Above	Trust Safe Care Collaborative leadership priority identified as enhancing psychological safety across the Trust. An element of this is to engender a positive reporting culture.	Standard - Safe	Executive Team		Long term culture change programme commenced in April 2023
RAD 22	**RADIOTHERAPY**	The Trust is required to provide HIW with details of the action taken to address the less favourable staff comments described in this report.	All disciplines to review all staff comments on report, consider the different views and identify any associated follow up if not addressed elsewhere in existing work plans.	Standard -Workforce	Radiotherapy Services Manager	Radiotherapy - staff comments reviewed- focus group established to work through views and concerns and direct work plans to ensure sustainable solutions RT Physics Comments have been reviewed and will be discussed at a department meeting on 12th September 2023	30th August 23

RAD 23	**RADIOTHERAPY**	As Above	Set up an MDT group consisting of representation of all three disciplines to address comments, amend processes and discuss feedback to staff. Produce an action plan for immediate commencement of delivery reflecting differences for different staff groups.	Standard -Workforce	Clinical Director Head Of Radiotherapy Physics Radiotherapy Services Manager		30th September 2023
RAD 24	**RADIOTHERAPY**	As Above	Address specific actions within own department as appropriate.	Standard -Workforce	Clinical Director Head Of Radiotherapy Physics Radiotherapy Services Manager		All outcomes from actions to complete 31st December 23
RAD 25	**RADIOTHERAPY**	The Trust is required to provide HIW with details of the action taken to recruit to Clinical Lead, Professional Lead, Radiotherapy Services Manager and Deputy positions.	RSM and DRSM posts undergoing job evaluation for JDs and active recruitment.	Standard - Leadership	Head Of Radiation Service	24th August 2023 Complete - RSM post out to advert	30th August 23
RAD 26	**RADIOTHERAPY**	As Above	Finalise the new approach to clinical leadership to update current approach and finalise the approach to ensuring robust professional leadership roles are sufficient and aligned appropriately	Standard - Leadership	Director of Cancer		30th October 23
RAD 27	**RADIOTHERAPY**	The Trust is required to provide HIW with details of the action taken to improve the amount of information displayed or available, so patients know how to make a complaint and are aware of other organisations they may contact for help and advice.	Work ongoing with Velindre Quality and Safety Team to improve CIVICA access. Discussions ongoing regarding increasing the size/access of the touch screen terminal in RT reception. Potential second screen in pre-treatment area to promote feedback opportunity.	Standard - Culture	Radiotherapy Services Manager		30th October 23
RAD 28	**RADIOTHERAPY**	As Above	Develop and issue updated patient leaflet regarding sharing thoughts, opinions, and concerns.	Standard - Culture	Deputy Radiotherapy Service Manager		1st August 2023
RAD 29	**RADIOTHERAPY**	As Above	Make leaflet available in all RT pathway patient contact points.	Standard - Culture	Radiotherapy Clinical Governance Manager		1st August 2023
RAD 30	**RADIOTHERAPY**	As Above	Trust wide how to raise a concern poster to be developed and provided to each department.	Standard - Culture	Head of Quality & Safety		31st August 2023
RAD 31	**RADIOTHERAPY**	As Above	Review opportunity for poster display across the service for Trust wide how to raise a concern poster and other appropriate organisations, particularly Llais.	Standard - Culture	Radiotherapy Clinical Governance Manager	30th August 2023 Awaiting updates for Head of quality and safety	30th August 2023.

RAD 32	**RADIOTHERAPY**	The Trust is required to provide HIW with details of the action taken to improve the information available on how the department has acted on patient feedback received.	We have reviewed the 'you said, we did' notice areas. We will be enlarging the area and developing large display boards and reviewing publications in a range of languages following the assessment of population language distribution.	Standard - Culture	Radiotherapy Services Manager		30th September 2023.
RAD 33	**RADIOTHERAPY**	The Trust is required to provide HIW with details of the action taken to improve staff awareness of the system for seeking patient feedback.	Radiotherapy Clinical Governance Manager to work with Information and Support Radiographer and the radiotherapy department Patient support group, to improve staff awareness of the system. This will be shared with staff through targeted information sharing sessions, covering why it is so important and how we collect patient feedback, and how we respond to it.	Standard - Culture	Radiotherapy Clinical Governance Manager		1st December 2023.
RAD 34	**RADIOTHERAPY**	As Above	Issue updated patient leaflet regarding sharing thoughts, opinions, and concerns and share with staff via Radiotherapy weekly update how to access and share this information with patients.	Standard - Culture	Radiotherapy Clinical Governance Manager		1st August 2023.
RAD 35	**RADIOTHERAPY**	As Above	Patient feedback to be discussed at each radiotherapy staff meeting, and shared through departmental meetings and SST leads	Standard - Culture	Radiotherapy Service Manager Deputy Radiotherapy Service Manager Clinical Director		30th October 2023

Key	
Bk	Completed
G	On track
A	Risks with project delivery
R	Overdue
H	On Hold
B	Not started
CP	Project / work prematurely closed
Milestone	

	ID	Task	Responsible person	Start	Finish	Status	Progress / comments
1	1.6	VCC Approval of escalation process		12/07/2023	01/09/2023	G	
1	1.11	Senior Leadership Team	Bethan Tranter	10/08/2023	10/08/2023	Bk	Update 10/08/23: Approved
1	1.12	Escalation Flowchart / Process Live	Escalation Flowchart Process Live	31/08/2023	31/08/2023	B	
1	1.13	Communicate/educate all staff on changes	Amy Quinton Rosie Roberts IC lead	11/08/2023	01/09//2023	B	
1	1.14	Formal go-live 04/09/23	Amy Quinton Rosie Roberts IC lead	04/09/2023	04/09/2023	B	
1	1.15	Review of pathway to consider amendments	Amy Quinton Rosie Roberts	01/09/2023	21/09/2023	B	
1	1.16	Amend and circulate amendments for approval	Amy Quinto Rosie Roberts	22/09/2023	30/09/2023	B	
1	1.17	Audit appropriate use of flowchart (using recorded calls)	Rosie Roberts	01/09/2023	01/11/2023	B	
1	1.18	Present audit finding to SMMDDG / onwards as determined at time	Rosie Roberts	01/12/2023	31/12/2023	B	
1	New Task added 24.07.23	~~Submit to EMB for final approval~~ Next meeting is 14 Aug, after that the next meeting is 28 Aug	Bethan Tranter Rosie Roberts	14/08/2023	28/08/2023	A	Update - 10/08/23 Submitted to EMB,subject to 2.11
1	2.13	Formal go live week of 04/09/23		04/09/2023	08/09/2023	B	
1	2.14	Communicate and train SACT TH team of changes	Rosie Roberts	11/08/2023	01/09/2023	B	
1	2.15	Review of pathway to consider amendments if identified on go-live	Amy Quinton/ Rosie Roberts	01/09/2023	21/09/2023	B	
1	2.16	Amend and circulate amendments for approval - as required	Amy Quinton/Rosie Roberts	22/09/2023	30/09/2023	B	
1	2.17	Audit appropriate use of triage tool (using recorded calls)	Rosie Roberts	01/09/2023	01/11/2023	B	
1	2.18	Present audit finding to SMMDDG / onwards as determined at time	Rosie Roberts	01/12/2023	31/12/2023	B	
1	3.8	Produce VCC specific Telephone Triage Training - closed as UKONS developing training which VCC will use (see action below)	Hannah Russon Sarah Owen Rosie Roberts	18/01/2023	31/03/2023	CP	~~Update - 18.01.23 - L&D Team sourced Telephone Triage course (not 100% fit with need) which can be used whilst VCC specific~~ course produced. Commence using external Telephone Triage training (availability in March) Produce VCC specific Telephone Triage training course with plan to start using April Update - 25.01.23 - RR and HR have met - UKONS are currently developing a course that would fit the needs of VCC and it wouldn't be prudent for us to develop our own. RR and HR are now both part of the Working Group developing this programme. However, in

1	3.9	Produce UKONS Telephone Triage Training VCC will use this as staff training once available	UKONS Working Group	23/01/2023	30/10/2023	G	Update - 01.02.23 - Steering group meeting for the UKONS triage training package on 1st Feb to which both Hannah and RR are invited to glean more ideas about timelines after that. RR thinks thay have quite an ambitious timeframe as are holding meetings every 2 weeks Update - 06.04.23 - Work is progressing don't yet have a definite date for completion Update - 15.05.23 - Same
1	3. 10	VCC staff to attend UKONS Telephone Triage training	Rosie Roberts	31/10//2023	31/12/2023	B	Are these dates realistic - need confirmation from UKONS Update - 01.02.23 - Steering group meeting for the UKONS triage training package on 1st Feb to which both Hannah and RR are invited to glean more ideas about timelines after that. RR thinks thay have quite an ambitious timeframe as are holding meetings every 2 weeks Update - 06.04.23 - This will not be able to be completed – we will aim to do some refresher / update training for staff Update - UKONS plan to lunch training package in Oct 23 so due date extended (from 30.04.23) to reflect
1	3.33	Teams training update and record it (like we did the new Triage tool training) and maybe have some questions to test learning	Rosie Roberts	01/02/2023	28/02/2023	CP	Update - 06.04.23 - This has not been done yet – realistic timescale will be end of May to record training end of June for staff to have completed Closed as staff now being sent on external training course
1	3.17	Standard 4.3 Guidelines / process (clear and approved by all) to be in place: - clarifying route for getting hold of correct Medical person (24 hour access) - Medical staff to put Out of Offices on - Medical staff contact details etc to be up to date - Update STH Standards to include: 'STH utilises SpR or SST to provide Medical advice 24 hours a day'	Rosie Roberts Nicola Hughes Eve Gallop-Evans	20/07/2022	31/03/2023	CP	provided by the patients consultant team or on call SpR or SHO as appropriate.' added Update - 06.04.23 - Escalation to clinical decision maker guidance that has been drafted is now with Amy Quinton to review and lead on Update - 15.05.23 - Still with Amy Now with Safe Care Collaborative Update - 19.06.23 - Escalation process, see section 1 above. Update 28.06.23 - Medical staff "who to contact" intranet pages being updated, led by Amy Quinton. Included within work plan to reduce out of scope calls, see section 3 below. Action closed
1	3.19	Book courses (liaise with Ed & Dev)	Rosie Roberts Hannah Russon	29/06/2023	14/07/2023	R	RR e-mailed Hannah Russon to ask to book courses 05/07/23: prices being sought. RR to check with Hannah progress by 07/07/23 - company ready to progress and will confirm discount for group booking Update 12/07/23 - Awaiting course fees. BT to check with HR progress Update - 18.07.23 - AAR e-mailed HR for update Update - 20.07.23 - no response from HR and not showing as on line Update - 20.07.23 - HR is awaiting confirmation of payment details from Provider company, BW will support release of staff once course is booked, course is virtual so can be attended at any time by relevant staff (4 Call Handlers, 13 Nurses and 4 Night Sisters) Update - 27.07.23 - Firewalls have stopped the invoices coming through from the company so IT are working to resolve this. There will be no need to book sessions as it is online learning and the individuals can start the course at any time Update - 07.08.23 - AAR chased HR for update Update 10/08/23 -IT issues resolved, emerging query re procurement process,
1	3. 20	Send Call Handlers on courses	Rosie Roberts	14/07/2023	31/09/2023	A	Update 1/08/23
1	3.21	Identify and arrange booking for key nursing staff	Rosie Roberts/ Barbara Wilson	14/07/2023	31/09/2023	A	Update - 20.07.23 - HR is awaiting confirmation of payment details from Provider company, BW will support release of staff once course is booked, course is virtual so can be attended at any time by relevant staff (4 Call Handlers, 13 Nurses and 4 Night Sisters). Update 09/08/23: SACT nursing challenges noted for Sept. Staff will be offered overtime (if they wish) to undertake in own time but no service expectation. Given delay to accessing training (and lesser so staff challenges) , deadline amended to 14.10.23
1	4.4	Produce supporting information	Communications	03/07/2023	20/08/2023	R	Update - 03.07.23 - Due dates amended as above Update 09/08/23 - Plan is for VCC wide communicaton via newsletter, screen saver etc. Date extended to 20/08/23. Aim for go-live 21 Aug 2023, Carys will liase with comms team
1	4.6	Submit Risk Assessment to SLT for approval and acceptance of risk BEFORE sending out Poster	Bethan Tranter	10/07/2023	10/08/2023	Bk	Update- 05/07/23 - to note in communications Q and S aspect Update - 07.08.23 - Going to SLT on 10 Aug, therefore due date extended to reflect Update 10/08/23 - Approved by SLT
1	4.7	Obtain SLT approval of Risk Assessment and acceptance of risk	Bethan Tranter	12/07/2023	10/08/2023	A	if this timescale is too tight, 10th Aug wil be the next SLT mtg - due date extended to reflect Update 10/08/23: approved by SLT

1	4.3	Turn content into a POSTER (i.e. add graphics etc.)	Carys Jones Communications	11/08/2023	18/08/2023	A	Update - 03.07.23 - Due dates amended to reflect delay Update - 07.08.23 - due dates extended to reflect further delays and requirement to wait for SLT approval on 10 August before doing graphics work
1	4.8	Send out Poster	TBC - Very Senior Managers x 2	approval from SLT and acceptance of	18/08/2023	A	Earliest SLT approval date is 10 August then time required to turn into poster - due dates thereofre extended (from 1 Aug)
1	4.9	To be done in the background (engagement) before 1 August 23	Rosie Roberts	01/07/2023	08/08/2023	G	Update: -09/08/23 : CNS mtgs x 3 and 1 x med sec mtg held. Next steps to link wih medical team. To aim for SMSC Sept, Amy and Rosie. Amy to arrange invite Update 10/08/23: SLT request to ensure Head of Ops aware pre roll out. BT to action w/b 14 Aug
	4.16	Present to Medics	Amy Quinton Rosie Roberts	08/08/2023	18/08/2023	B	Update 10/08/23 - RR to present to Sept SMSC
	4.16	Present to Switchboard Manager	Rosie Roberts	09/08/2023	18/08/2023	B	Update 09/08/23 - BT to arrange mtg with MD.
	4.16	Present to Switchboard staff	Rosie Roberts	10/08/2023	18/08/2023	B	Mop up - dates to be confirmed
1	4.18	Produce communication for patients explaining what the STH can deal with and what it cannot (i.e. appointment and general queries etc.)	Amy Quinton SCC Leigh Porter	20/06/2023	18/08/2023	A	communicated Update - 10.07.23 - draft produced and Leigh confirmed approval - RR still to comment Update - 07.08.23 - Needs to go to Comms Team to check, approve and upload to website - due dates extended (from 18.07.23) to
1	4.19	Send out Patient communication and put info on website	Leigh Porter Communications	01/08/2023	18/08/2023	A	Update - 07.08.23 - Needs to go to Comms Team to check, approve and upload to website - due dates extended (from 01.08.23) to reflect need to have SLT approval of staff communication
1	5.4	Agree functionality for system that is required	Rhianydd Jones Rosie Roberts Barbara Wilson	05/07/2023	07/07/2023	R	Update - 10.07.23 - Rhianydd and BT have been meeting to discuss Update - 07.08.23 - RR has e-mailed RJ for update - will need cross-directorate working
1	5.5	Timescales to be confirmed of how / when the functions can be put in place		TBC	TBC	B	
1	5.8b	Write message for answer machine for patients Welsh	Jo Williams		07/07/2023	H	Call recording went live on 7 July Is Welsh messgage required?
	5.8c	Meet with Jo Williams to clarify requirements re Welsh language	Rosie Roberts	08/08/2023	30/08/2023	B	
1	5.9b	Record message for answer machine in line with functionality availability (linked to 4.5) - Welsh	Rosie Roberts Jo Williams		07/07/2023	H	Call recording went live on 7 July Is Welsh messgage required?
	5.9a	Need to identify how to access recordings	Rhianydd Jones Ian Bevan	TBC		B	Update - 97.08.23 - Software download requirements need to be agreed and put in place - dates TBC
1	5. 10	Develop checklist / assessment tool to facilitate quality audits of STH calls (linked to 1.16 and 2.14 above)	Rhianydd Jones	30/06/2023	01/09/2023	B	

							Update - 16.01.23 - start delayed at request of Digital Team then RR on A/L until 17 Jan
1	5.11	**Re-platforming of UKONS Triage Tool**	David Mason-Hawes Emyr Adlam Rosie Roberts	17/01/2023	04/09/2023	H	Update - 23.01.23 - Likely to take longer than initially planned - IT to confirm timelines 8 to10 March Update - 05.04.23 - RR is having weekly meetings with IT re the re-platforming of the helpline UKONS database and they are hoping to have a demo version to test within a couple of weeks as part of this Amy Q and I are reviewing the formatting of the triage questions
	5. 21	Re-platformed Launch of UKONS Triage Tool	Rosie Roberts	25/07/2023	31/07/2023	H	Update - 03.07.23 - this date will be dependent on approval or changes being made to the Triage Tool - may need to defer Update 05/07/23 - Date amended to 21 Aug to align with other training Update - 07.08.23 - On hold pending approval of updated Triage Tool
1	5. 22	Post July staff training	Rosie Roberts	01/08/2023	04/09/2023	H	Replatforming - technical glitches which are being resolved - whilst this is happening, RR is adding in some additional functionality - training won't happen until this is complete, Update: completion date amended to reflect date for revised triage tool completion Update - 07.08.23 - RR to schedule / book training sessions pending approval of updated Triage Tool
1	5. 23	Meeting weekly to resolve technical issues	David Howells Rosie Roberts Steve Mosely	01/02/2023	30/07/2023	H	05/07/23 - date extended to reflect revised timescales as 5.21 above (from 30.07.23)

Ref No	Service	Recommendation	Outcomes Required	Operational Lead	Delivery Date	Summary of Progress	Level of Assurance
NG Alert			As a result of recent incidents and a Coroners Regulation 28 report it has become evident that further clarity is required on the initial placement of nasogastric and orogastric tubes. Therefore, a resource set* is being shared to provide clarity on the steps provided. **Actions** **When:** To commence as soon as possible and be completed by 30 November 2017. **Who:** All organisations where Nasogastric or orogastric tubes are used for patients receiving NHS funded care. Share any learning from local investigations or locally developed	Viv Cooper	All Areas to give Assurance by 31st July 2023	*040723 Requested update of assurance 090823 requested update*	
NG 1	VCS	1. Identify a named Executive Director who will take responsibility for the delivery of the actions required in this alert	As Above	Viv Cooper	All Areas to give Assurance by 31st July 2023	*040723 Requested update of assurance 090823 requested update* **11/08/23** Nicola Williams is the confirmed Executive lead for this alert	
NG 2	VCS	2. Provide local policies and protocols that reflect all the safety critical requirements summarised in the resource set	As Above	Viv Cooper	All Areas to give Assurance by 31st July 2023	040723 Requested update of assurance 090823 requested update **11/08/23** The VCC enteral feeding tube policies currently sit separately (jejunostomy and gastostomy), both policies are being amalgamated as one document and the existing Nasogastric (NG) tube policy will remain separate and aim to be replaced by the All Wales NG tube policy when it is approved. This work is currently being progressed via the VCC Enteral T&F group.	
NG 3	VCS	3. Ensure the supply and use of safe equipment. Nasogastric tubes used for feeding should be radio□opague throughout their length and have externally visible length markings. pH paper should be CE marked for use on human aspirate.	As Above	Viv Cooper	All Areas to give Assurance by 31st July 2023	040723 Requested update of assurance 090823 requested update **11/08/23** 'AspHirate' pH strips were awarded the pH paper category in the recent All Wales Enteral Feeding Tender. Which came into effect on the 1st of April and training and implementation at VCC commenced shortly after. NG tubes only with external visible length are used at VCC.	
NG 4	VCS	4. 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 theses procedures, regardless of the level of seniority,	As Above	Viv Cooper	All Areas to give Assurance by 31st July 2023	040723 Undertaking training need analysis within Divisions. This will align with All Wales training when availabe. 090823 requested update **11/08/23** There is currently a VCC workbook that nursing staff are required to complete prior to being assessed to insert NG tubes. The competency assessment then consists of three observed insertions prior to the nurse being deemed as competent to place fine bore NG feeding tubes. This approach is subject to change following publication of the new All Wales NG tube guidelines.	

NG 5	VCS	5. Ensure that clinical documentation reflects all the safety-critical requirements summarised in this resource set. This should also include an assessment of whether naso/ orogastric feeding is the most appropriate plan for the patient.	As Above	Viv Cooper	All Areas to give Assurance by 31st July 2023	040723 Requested update of assurance 090823 requested update **11/08/2023** A formal consent process for NG insertion on the All Wales Consent form 1 and a risk assessment prior to NG tube insertion work is being progressed via the VCC Enteral T&F group.	
NG 6	VCS	6. Implement an ongoing audit of compliance to assess the sustainable implementation of the safety critical measures in this resource set	As Above	Viv Cooper	All Areas to give Assurance by 31st July 2023	040723 Requested update of assurance 090823 requested update **11/08/2023** A record of all patients that have had NG placement is documented on the Ambulatory Care database. An ongoing audit is being implemented to assess the safety critical measures. This work is curerrently being progressed via the VCC Enteral T&F group.	
NG 7	VCS	7. Share the findings of audits with the organisation's Quality and Safety Committee and ensure action plans agreed and implemented	As Above	Viv Cooper	All Areas to give Assurance by 31st July 2023	040723 Requested update of assurance 090823 requested update **11/08/2023** The above data and audits will be shared at local VCC departmental meetings and at VCC QSMG and Trust QSP.	
Urology NRI 1	Urology	To ensure that for the 254 patients where a letter was not written, the patients GPs are provided with updated communication.		EGE/NH/SO		Complete	
Urology NRI 2	Urology	To strengthen medical documentation to ensure that the job role of the person who has reviewed the patient is clear, and also that the purpose of the annotation / clinic attendance is clear.		EGE/NH			
Urology NRI 3	Urology	To strengthen communication with the patient's GP and ensure that letters are provided after every significant follow up visit, especially annual or 6 monthly follow up reviews.		EGE/NH			
Urology NRI 4	Urology	To review the follow up Urology pathways to ensure that there is standardisation, to review opportunities for early discharge, and to review opportunities for a change in the model for follow up reviews, including virtual management and undertaken by a Clinical Nurse Specialist rather than a Clinician What has Sian Dobbin done so far? Lot of work probably been done already	Work in progress - being looked at in the deep dive. Part of transformational work	NH/ CG/Urology SST			
Urology NRI 5	Urology	To consider the Duty of Candour requirements relating to this incident		EGE/NH/SO	complete		
Urology NRI 6	Urology	The harm review is to be completed and appropriate next steps agreed.		AE	complete		
Urology NRI 7	Urology	A formal review of the role of the medical secretary should be undertaken with a consistent role profile and requirement.		TB/AMS			
Urology NRI 8	Urology	Standard Operating procedures should be developed and introduced in relation to Medical Secretaries clinical related discussions with patients		TB/AMS			
Urology NRI 9	Urology	Review of training & competency sign off for medical secretaries to be undertaken. To include scope of role and professional boundaries		TB/ AMS	complete		
Urology NRI 10	Urology	With immediate effect adequate supervision and support mechanisms should be put in place for medical secretaries including 1-1 work oversight discussions through the line management chain.		TB			

Urology NRI 11	Urology	With immediate effect the Professional matters arising through this incident and investigation should be determined and appropriate procedures followed			complete	
Urology NRI 12	Urology	To complete Closure Report		EGE/NH SO		
Brachy NRI 1	Brachytherapy	Formalise Brachytherapy specific training for Anaesthetic and theatre staff	RT Radiographers in process of updating working instructions to include.	Ceri Doherty and Brachytherapy Advanced Practitioners	complete	
Brachy NRI 2	Brachytherapy	Recommendation to use emergency off not interrupt when required to stop treatment suddenly.	RT Radiographers in process of updating working instructions to include.	Ceri Doherty and Brachytherapy Advanced Practitioners		
Brachy NRI 3	Brachytherapy	Always check applicator position against pen marks on legs if treatment is interrupted due to patient movement during treatment.	RT Radiographers in process of updating working instructions to include.	Ceri Doherty and Brachytherapy Advanced Practitioners		
Brachy NRI 4	Brachytherapy	Recommendation to record dwell position and time remaining before resuming if interrupt or emergency off pressed.	Physics checker is always on site during any brachytherapy treatment. Physics and RT to work together to establish process for ensuring RT radiographers know which physics checker is available and how they can be contacted if required. Rota of routine cover to be issued to RT so that contact can be made when required.	Ceri Doherty and Brachytherapy Advanced Practitioners		
Brachy NRI 5	Brachytherapy	Greater awareness of physics presence during treatment.	Improve reporting within the brachytherapy team for all incidents. Difficulty in communication with off-site staff to be added to brachytherapy risk register. Brachytherapy incident tracking spreadsheet being introduced, and added to the Brachytherapy Operational Group meeting agenda.	Head of Brachytherapy Services		
Brachy NRI 6	Brachytherapy	Improve methods of communication for future dissemination of incident occurrence to full team, particularly those off site	Gap in communication identified. Difficulty in communication with off-site staff to be added to section risk register.	Head of Brachytherapy Services		
LTFU NRI 1	Lost to follow up	With immediate effect, (2 weeks following report sign off) that the patient, if in agreement, is updated regarding the investigation findings, or a nominated representative.	Will contact afterPTR panel Conclusion	Sarah Owen	complete	
LTFU NRI 2	Lost to follow up	With immediate effect (1 month) that the process by which a patient is registered to a named consultant on admission to the ward should be clarified, and that this consultant is informed when the patient is admitted, and must be consulted before discharge. The registration of the named consultant should also be reviewed during admission in order that the appropriate consultant is assigned responsibility for the care of that patient. All relevant staff must be made aware of this process in this timeframe.		Nicola Hughes and Ann Marie Stockdale		
LTFU NRI 3	Lost to follow up	With immediate effect (1 month) the existing VCC discharge and transfer policy (2019), including the discharge checklist, Discharge Advice Letter and leaflet (DAL) should be reviewed and implemented across all wards, to ensure that all patients receive (if appropriate) oncology outpatient appointments for follow up.		Matthew Walters		
LTFU NRI 4	Lost to follow up	Within 3 months, that an audit of a selection of patient case notes is undertaken to ensure compliance with the VCC discharge and transfer policy (2019).	Nusing to review with input from medical, therapies, and pharmacy	Matthew Walters		
LTFU NRI 5	Lost to follow up	With Immediate effect (1 month) all relevant staff responsible for producing the Discharge Advice Letter and discharge medication list should be made aware of this incident, and receive training on the importance of oncological follow up, and that repeat medications are highlighted to the GP especially those that are oncology drugs.	Add discharge learning to training events after induction for junior docs. Ensure it is a rolling programme for every cohort	Nicola Hughes		
LTFU NRI 6	Lost to follow up	Within 3 months develop or modify the existing process and tool for transfer of patients between organisations to ensure that all relevant information is shared, and to apportion responsibility for the appropriate MDT referral and outpatient follow up of cancer patients.		Matthew Walters		
LTFU NRI 7	Lost to follow up	Within 3 months, the role of the ward clerk and digital systems (WPAS) in patient discharge and follow up is clarified. This could be a final check in the system of prevention.		Diane Rees		
LTFU NRI 8	Lost to follow up	With immediate effect (1 month) for the investigation to be shared with the Putting things right panel to consider a breach of duty.	Trust Q+S team to organise	Trust Q+S	complete	
LTFU NRI 9	Lost to follow up	With immediate effect (1 month) to consider holding a post incident reflection meeting to discuss the findings and future learning/support for all involved in the	Learning event organised	Sarah Owen	complete	
SACT NRI 1	SACT Planning	To having a robust & resilient SACT bookings team with headroom and contingency	Achievement of recommendation	Rebecca Membury	open	Out to recruitment Capacity and Demand model in place SMOG meetings will record current staffing levels
SACT NRI 2		Cancer Centre wide mechanism for clinical communication to be urgently developed.	Achievement of recommendation	Ian Bevan	open	Email/ communication SPO to be drafted by Ian Bevan - currently working on it
SACT NRI 3		SOP to be developed for the medical secretaries as a standardised process around clinical communications.	Achievement of recommendation	Ann Marie Stockdale	open	Ann Marie to re-visit an existing SOP
SACT NRI 4		Development of one active, live digitally generated report that reflect a patient's place in relation to target treatment dates.	Achievement of recommendation	Rebecca Membury/Elizabeth Hanlon/Emma Powell	open	Improve/revise/update the current report due to BI restrictions
SACT NRI 5		A monthly audit of the unscheduled patient list to be undertaken by the SACT and MM Directorate Support Manager to be undertaken to add assurance that this incident does not occur again.	Achievement of recommendation	Paul Mugleston/Rebecca Membur	open	BI to provide a report for RM to work from

SACT NRI 6	A clear and agreed point of contact for clinical management of patients, when the treating clinician is not available i.e., on leave, other commitments outside VCC.	Achievement of recommendation	Eve Gallop-Evans	open	To agree some kind of formal Out Of Office
SACT NRI 7	The report and the findings to be managed under the Putting Things Right Process.	Achievement of recommendation	Sarah Owen	open	

Ref No	Recommendation	Outcomes Required	Operational Lead	Delivery Date	Summary of Progress	Action Status
NG Alert	To ensure all actions relating to Welsh HEalth Circular	As a result of recent incidents and a Coroners Regulation 28 report it has become evident that further clarity is required on the initial placement of nasogastric and orogastric tubes. Therefore, a resource set* is being shared to provide clarity on the steps provided. **Actions** **When:** To commence as soon as possible and be completed by 30 November 2017. **Who:** All organisations where Nasogastric or orogastric tubes are used for patients receiving NHS funded care. Share any learning from local investigations or locally developed good practice resources by emailing: ImprovingPatientSafety@Wales.gsi.	Viv Cooper	All Areas to give Assurance by 31st July 2023	*040723 Requested update of assurance 090823 requested update*	
NG 1	1. Identify a named Executive Director who will take responsibility for the delivery of the actions required in this alert	As Above	Viv Cooper	All Areas to give Assurance by 31st July 2023	*040723 Requested update of assurance 090823 requested update* **11/08/23** Nicola Williams is the confirmed Executive lead for this alert	
NG 2	2. Provide local policies and protocols that reflect all the safety critical requirements summarised in the resource set	As Above	Viv Cooper	All Areas to give Assurance by 31st July 2023	040723 Requested update of assurance 090823 requested update **11/08/23** The VCC enteral feeding tube policies currently sit separately (jejunostomy and gastostomy), both policies are being amalgamated as one document and the existing Nasogastric (NG) tube policy will remain separate and aim to be replaced by the All Wales NG tube policy when it is approved. This work is currently being progressed via the VCC Enteral T&F group.	
NG 3	3. Ensure the supply and use of safe equipment. Nasogastric tubes used for feeding should be radio□opague throughout their length and have externally visible length markings. pH paper should be CE marked for use on human aspirate.	As Above	Viv Cooper	All Areas to give Assurance by 31st July 2023	040723 Requested update of assurance 090823 requested update **11/08/23** 'AspHirate' pH strips were awarded the pH paper category in the recent All Wales Enteral Feeding Tender. Which came into effect on the 1st of April and training and implementation at VCC commenced shortly after. NG tubes only with external visible length are used at VCC.	
NG 4	4. 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 theses procedures, regardless of the level of seniority	As Above	Viv Cooper	All Areas to give Assurance by 31st July 2023	040723 Undertaking training need analysis within Divisions. This will align with All Wales training when availabe. 090823 requested update **11/08/23** There is currently a VCC workbook that nursing staff are required to complete prior to being assessed to insert NG tubes. The competency assessment then consists of three observed insertions prior to the nurse being deemed as competent to place fine bore NG feeding tubes. This approach is subject to change following publication of the new All Wales NG tube guidelines.	
NG 5	5. Ensure that clinical documentation reflects all the safety-critical requirements summarised in this resource set. This should also include an assessment of whether naso/ orogastric feeding is the most appropriate plan for the patient.	As Above	Viv Cooper	All Areas to give Assurance by 31st July 2023	040723 Requested update of assurance 090823 requested update **11/08/2023** A formal consent process for NG insertion on the All Wales Consent form 1 and a risk assessment prior to NG tube insertion work is being progressed via the VCC Enteral T&F group.	
NG 6	6. Implement an ongoing audit of compliance to assess the sustainable implementation of the safety critical measures in this resource set	As Above	Viv Cooper	All Areas to give Assurance by 31st July 2023	040723 Requested update of assurance 090823 requested update **11/08/2023** A record of all patients that have had NG placement is documented on the Ambulatory Care database. An ongoing audit is being implemented to assess the safety critical measures. This work is curerrently being progressed via the VCC Enteral T&F group.	
NG 7	7. Share the findings of audits with the organisation's Quality and Safety Committee and ensure action plans agreed and implemented	As Above	Viv Cooper	All Areas to give Assurance by 31st July 2023	040723 Requested update of assurance 090823 requested update **11/08/2023** The above data and audits will be shared at local VCC departmental meetings and at VCC QSMG and Trust QSP.	

Ref No	Owner	Service	Theme	Recommendation	Outcomes Required	Outstanding management Action	Action to date	Action Status
5	Service planning manager Business Continuity Head of Brachytherapy	Brachytherapy	HASS Regulations and Afterload Security	Review access route from the HDR room and control area to any adjacent public areas and consider whether any additional access control (e.g. swipe access or fixed partitioning) is appropriate.	Achieve recommendation	Investigate with VCC Estates suitable solutions to increase security via physical barriers to area. Compare site security levels (CCTV surveillance, 24/7security response and on call physics phone cover) with CCC provision. Review Operational Services access to treatment room and all other aspects of source security and staff safety.	Daytime access is under key operated control by radiographers and documented within procedures	open
9	Head of Brachytherapy	Brachytherapy	Radiation Safety and Contingency Rehearsal	All staff groups involved in the care of HDR patients should be trained against documented emergency procedures and be clear on their roles and responsibilities	Achieve recommendation	BOG to identify remaining emergencies and training/schedules required. Time to be identified for all staff involved to train in required procedures Induction training pack under construction (BOG Action BOG 24)	Transferred to BOG 01-02-23. Staff training logged and schedule monitored by BOG	open
10	Head of Brachytherapy	Brachytherapy	Radiation Safety and Contingency Rehearsal	All staff should be given time to periodically rehearse contingencies, including the removal of applicators as described in the SOP, and this practice regularly audited	Achieve recommendation	Remaining contingency reheasals to be identified (BOG Action log BOG 23b) and scheduled	Periodic rehearsals commenced for source stick emergencies. Time identified for all staff involved to train in required procedure. RT Brachy Advanced Practioner removal training schedule monitored by BOG.	open
12	Head of Brachytherapy	Brachytherapy	Radiation Safety and Contingency Rehearsal	Purchase additional electronic personal dosimeters that can be worn during contingency procedure including spares in the event of a malfunction	Achieve recommendation	Purchase of monitors and return of loan monitors - quotes under review RT BAPs Action Log BOG 44	Loan EPDs from RPS until pruchased	open
13	Head of Brachytherapy	Brachytherapy	Document Control and Quality Management System	A full review should be carried out of the policies and procedures available within the quality system and gap analysis performed across the service to identify missing areas of documentation	Achieve recommendation	Develop list of all relevant policies and procedures . Review and gap analysis for all area. schedule for policy review to be completed at next BOG -April 23 BOG Action 25 &26	Current theatre policies under review. RT: current reviewed, bar 1 outstanding. 3US WI under constructions Physics list under construction.	open
14	Head of Brachytherapy	Brachytherapy	Document Control and Quality Management System	Outstanding draft policies and procedures should be approved in a timely manner, and staff engaged with updates and process changes as part of business as usual	Achieve recommendation	ensures process in place for all specialties prior to new Qpulse being implemented	Reviewed exiting processes and procures	open
15	Head of Brachytherapy	Brachytherapy	Document Control and Quality Management System	Investment should be made and a robust system implemented to anticipate quality system updates rather than to be reactive to overdue deadlines	Achieve recommendation	Trust procurement process for Qpulse replacement ongoing	Consenus Trust QMS / document mangement system to be extended and utilised in Brachytherapy. JP to escalte through RT physics	open
16	Head of Brachytherapy	Brachytherapy	Document Control and Quality Management System	Consider a single electronic source for storage of policies and procedures, such as Q-Pulse, which can automate review reminders, track change requests and capture distribution and acknowledgement of new or updated protocols and work instructions	Achieve recommendation	Trust procurement process for Qpulse replacement ongoing	Consenus Trust QMS / document mangement system to be extended and utilised in Brachytherapy. JP to escalte through RT physics	open
17	Head of Brachytherapy	Brachytherapy	Document Control and Quality Management System	Consider consistent evidencing of clinician (practitioner) authorisation for clinical protocols	Achieve recommendation	Trust procurement process for Qpulse replacement ongoing	Consenus Trust QMS / document mangement system to be extended and utilised in Brachytherapy. JP to escalte through RT physics	open
23	Head of Brachytherapy	Brachytherapy	Line Management/ Reporting Structure	Review the staff reporting structure, consider redesign and provide clarity over reporting lines	Achieve recommendation	A consensus needs to be reached on service model, giving consideration to alternative models.	Recommendation considered. Clarity exist for line management reporting as per contracts. Professional accountability remains as per professional group.	open
26	Head of Planning and Performance Head of Brachytherapy	Brachytherapy	Efficiency & Workflow	Perform a comprehensive review of the way the service is delivered to ensure the principle of having the right staff with the right training for the right task at the right time is embedded across the service	Achieve recommendation	D&C plan and forecasting to be developed service delivery model to be reviewed in light of D&C plans	Workforce and patient pathway planning workshops underway	open
27	Head of Planning and Performance Head of Brachytherapy	Brachytherapy	Efficiency & Workflow	Perform a comprehensive review of all processes and pathways to identify barriers and bottlenecks. Translate this into Project & action plans initally looking for quick wins and small improvements that can be delivered easily. In turn, this will create the momentum and engagement for larger scale improvements that may be required, plus efficiency release from within the team to support larger improvements	Achieve recommendation	linked to #6	Workforce and patient pathway planning workshops underway	open
31	Head of Brachytherapy	Brachytherapy	Efficiency & Workflow	Review checking processes to ensure both radiographer checks are completely independent and both radiographers cross check the same data sources	Achieve recommendation	audit to be undertaken of new practice	checking processes reviewed by Head of Service	open
38	Head of Brachytherapy	Brachytherapy	Workforce	Explore and implement medical succession planning options including developing own talent in current medical workforce	Achieve recommendation	Discussion required regarding option for extended medical roles	Email correspondece with Clinical Director	open
39	Head of RT / RSM	Brachytherapy	Workforce	Consider the role of consultant radiographers to support both urology and gynae services	Achieve recommendation	Consensus between medics and non-medical workforce on extended roles	reviewed role of consultant radiographers	open
40	Head of Brachytherapy	Brachytherapy	Workforce	Consider adopting prescription protocol for MPEs to authorise Brachytherapy exposures in accordance with written practitioner guidelines	Achieve recommendation		recommendation reviewed. Decision to consider as part of next round of IMTP planning 2023/24	open
41	Head of Brachytherapy	Brachytherapy	Workforce	Continue to train physics staff on a regular basis, in particular with a view to expanding MPE support			recommendation reviewed. Decision to consider as part of next round of IMTP planning 2023/25	open
42	Head of Brachytherapy	Brachytherapy	Workforce	Develop a clear plan of workforce requirements; this should be robust, have in-built succession planning, and should include a training and development framework		Succession plans will be developed in all areas where required including review of possible options including Consultant Radiographer development. 1-5 year plan linked to ID 26	Workforce and patient pathway planning workshops currently underway to review the staff currently within the pathway.	open
45	Head of Planning and Performance Head of Brachytherapy	Brachytherapy	Workforce	Review staffing allocation against guidelines		linked to #26		open
46	Head of Planning and Performance Head of Brachytherapy	Brachytherapy	Workforce	Explore service redesign within current staffing model to explore release of theatre capacity		linked to #26	VCC service improvement staff tasked to review theatre utiisation and develop expansion options	open
50	Theatre Nurse Lead	Brachytherapy	Nursing & Theatre	Regular independent peer audit to include observation and documentation of the full five-step process			Incorporated into clinical audit plan for service . Clinical audit on BOG agenda (BOG action log 48)	open
51	Head of Planning and performance Head of Brachytherapy	Brachytherapy	Patient Pathway Management	Create additional planned gynae capacity via service redesign with the existing workforce and equipment or via a business case for additional resource		as #26		open
52	Head of Planning and performance Head of Brachytherapy	Brachytherapy	Patient Pathway Management	Take a collaborative approach to scheduling based on an agreed set of priorities that consider the whole MDT		as #26	Collaborative approach to working in place. Prioritisation linked to D&C planning	open
61	Service Planning Manager Business Continuty Theatre Lead	Brachytherapy	Medicines Management	COSHH risk assessments to be developed, if not already in place		Review current COSHH risk assessments in conjunction with Operational Services - H&S lead		open
63	Service leads	Brachytherapy	Training & Professional Development	Develop competency documents for all staff groups and method for ongoing competency updates		Theatres: Competency framework will be developed RT: All training documentation and competency assessments provided to KF to incorporate into exempplar training plans Physics Checker/MPE training for review April 23	Physics: Competencies for operators are reviewd March 23. Training packs redesigned.	open
66	Service Planning Business continuty Head of Brachytherapy	Brachytherapy	Training & Professional Development	Full multidisciplinary team to be involved in regular scenario based contingency practices for removal of applicators, resus, local toxicity, bleed, fire evacuation. Attendance should be documented		review business continuity plan		open
70	Sonographer Brachy AP/ THeatre Lead	Brachytherapy	Miscellaneous	Sterile probe cover cut with non-sterile scissors, non sterile gloves used to perform scan. Risk assessment to be in place if this is acceptable practice, or do not cut the probe cover and scrub in and use sterile gloves instead		Risk assessment - brachy APs sonography & JW for issue	Staff training and awareness of fields in place . Added to BOG Agenda and action log 51	open
75	Theatre Lead	Brachytherapy	Miscellaneous	Visitor risk assessment should be in place and available in accordance with the Health and Safety at Work Act and the Management of Health and Safety at Work Regulations			The SOP and risk assessment are current and up to date We have a 'Visitors to Theatre policy' clearly displayed at the Theatre entrance and can be found on clinical intranet.	open
76	Medical Devices Lead	Brachytherapy	Miscellaneous	Ensure the Trust's medical devices policy is fit-for-purpose and implemented		JR/JP to review on 20th April 2023	JR and JMcC contacted and advise given. Theatre/ RT/ Physics med devices inventory created	open

77	Head of Brachytherapy	Brachytherapy	Miscellaneous	Perform monthly out medical devices checks and audits	JR to assist audit set up	All anaesthetic medical devices are controlled by 'RAS' Respiratory and Anaesthetic support. Daily documented checks in theatres supported by C&V medical devices who undertake audits All HDR equipment is quality assured within the RT Physics ISO9000 system	open
78	Eve Gallop- Evans RSM	Brachytherapy	Patient Management Pathway-Radiotherapy (VVBT / Skins)	Review both services from operational perspective; how they work together, resource requirements, and map clinician availability and job plan to treatment sessions	Mapping of resources and staff required to meet sustainable service delivery model. Job planning for medical staff required Further review of A4C staff due to staff changes	Initial mapping of resources and staff availability in progress.	open
79	Head of Planning and Performance RSM	Brachytherapy	Patient Management Pathway-Radiotherapy (VVBT / Skins)	Perform capacity and demand review then work out appropriate staffing allocation across the working week	Demand and capacity plan to be developed	Mapping of treatment sessions and capacity completed	open
81	Head of Planning and Performance Head of Radiotherapy physics	Brachytherapy	Patient Management Pathway-Radiotherapy (VVBT / Skins)	Perform regular and ongoing reviews of staffing levels and workforce plans and submit business cases to reflect the staffing requirements for the workload	service delivery model to be developed in response to D&C planning		open
82	Directorate Manager Medics RSM	Brachytherapy	Patient Management Pathway-Radiotherapy (VVBT / Skins)	Consider electronic rostering and rosters being shared among teams so teams can see when other staff will be available	annual leave for medics to be shared with Radiation services	Annual leave rota for radiation services in Teams and updated weekly	open
83	Head of Planning and Performance Head of Brachytherapy	Brachytherapy	Demand & Capacity Modelling	Ring fence adequate resource to review activity over the last five years and use modelling tools to predict demand for next five years	service delivery model to be developed in response to D&C planning and forecasting		open
84	Head of Planning and Performance Head of Brachytherapy	Brachytherapy	Demand & Capacity Modelling	Revisit modelling annually to ensure it is reflective of service provision	Annual review as part of IMTP forecasting informed through monthly trends	BOG meeting monthly to discuss demand BPG monthly performance meetings	open
85	Head of Brachytherapy	Brachytherapy	Demand & Capacity Modelling	Run automated reports (if possible) prospectively and retrospectively and use this to inform ongoing service provision and redesign	IRS/Brachy implementation group to be established Analysis system and reporting to be IRS output		open
86	Head of Planning and Performance Head of Brachytherapy	Brachytherapy	Demand & Capacity Modelling	Embed capacity and demand modelling and workforce planning as they are dependent on each other	D&C plan and forecasting	manual data set available D&C discussion at monthly brachy meeting	open
87	Clinical Director RSM	Brachytherapy	Communication & Collaboration	Radiographer involvement with the full patient journey should be promoted including presence within theatre and involvement in the insertion procedure	Develop agreed training plan for radiographers Identify trainers undertake training		open
88		Brachytherapy	Communication & Collaboration	Regular contingency rehersal should be carried out involving all members of the MDT as described in section 3.3	see #10	Duplicate of #10, 66,68	open
93	Eve Gallop- Evans RSM	Brachytherapy	Training & Professional Development	Protect time for training and writing and updating SOPs should be allocated by factoring this into the workforce plans and job plans for the radiographers	to be reviewed alongside medical job plans	draft job plan for radiographers with enhanced SPA requirements is complete	open
94	duplicate #87	Brachytherapy	Training & Professional Development	Radiographers should not only be trained to check and deliver treatment but should also be educated, have understanding, and be involved in the insertion, planning process and delivery of treatment	duplicate #87	duplicate #87	open
95	Eve Gallop- Evans RSM	Brachytherapy	Training & Professional Development	Radiographers should be integrated further into the Brachytherapy MDT: they have a wealth of knowledge and skill and are versatile, and this will cement their underpinning knowledge	Discussions with Medical Directorate required to agree consensus on service delivery model		open
96	RSM	Brachytherapy	Training & Professional Development	A Brachytherapy training and competency package should be developed to include background knowledge of Brachytherapy Principles, planning of procedures, and pre-treatment pathway. Formal Brachytherapy training is limited to a small number of M level modules and the ESTRO teaching course. Radiographers should actively collect and share resources to supplement learning	Knowledge of planning to be addressed. Emailed HP and CT for closure response	Requirements were reviewed Oct 2022.	open
98	RSM	Brachytherapy	Training & Professional Development	Consider further role development and role extension for rotational Band 6 Brachytherapy radiographers to help support the service to be more robust. This could include HDR contingency training, insertion of vault applicators, gynae ultrasound, and dilator counselling with appropriate underpinning policy	Discussion on intended direction of travel for Trust Ultrasound training: need to identify training delivery resource and agree timeframe	Rotational rads currently have the opportunity to complete competency in Vault and IGBT removals and dilator counselling. There is now a subsequent insertions training package also available for VVBT which the APs have now completed.	open
100	Eve Gallop- Evans RSM	Brachytherapy	Training & Professional Development	When implementing further advanced practice responsibilities ensure there is more than one member of staff trained to cover planned/unplanned absenses	Discussion to take place regarding Trust intention and resilience planning single handed practitioner in physics - need to determine appropriate service model single handed medic gynae - need to determine service model	Staff now recruited into AP posts within Radiotherapy Training is funded and backfill supported through appointment of Locum Radiographer with Sonography skills (in place until all relevant competencies achieved)	open
102	RSM	Brachytherapy	Ultrasound	Urgently develop an in-house clinical skills training package for ultrasound Brachytherapy to expedite training in a timelier manner and to train more staff to cover the service. Consider then supplementing it with M level module when service is more robust	HEIW develop training package and robust QA processes and will need to deliver the training - anticipated timeframe 2years	Currently no training programme in Wales Discussion with Clatterbridge re: providing training, unable to do so due to capacity issues Discussion taken place with HEIW (August 2022) as no ability to provide in-house training	open
103	duplicate #98 #102	Brachytherapy	Ultrasound	Within advanced practice frameworks, policies, and training, ensure that services have more than one trained member of staff before the service can operate. This will prevent future single points of failure	duplicate #98 #102	duplicate #98 #102	open
109	Lead Brachytherapy MPE	Brachytherapy	Digital Security & Best Practice	Consider individual log-ins designed to minimise the opportunity for unauthorised access	Risk assessment needs to be completed to document decision	requriement for indiviudal log-in reviewed in line with recommendation	open
117	Lead Brachytherapy MPE	Brachytherapy	Treatment Planning (Prostate)	The calibration measurement should be checked independently by a second person	to be included in WIs	review of practice undertaken to confirm compliance with recommendation	open
123	Lead Brachytherapy MPE/ CCO	Brachytherapy	Treatment Planning (Prostate)	Free lengths - Consider this check being done independently by a pair of scrubbed radiographers, one to the initial measure and one to check. Any discrepancies can be resolved prior to the plan being produced or indeed delivered. Needle measurements are also then independent to those planning the treatment	Risk assessment to be completed to confirm management of variation - to be signed off at next BOG	way of working reviewed and confirmed in light of the recommendation.	open
124	Lead Brachytherapy MPE/ CCO	Brachytherapy	Treatment Planning (Prostate)	Needle positions should be checked against the underlying ultrasound image and adjusted as necessary so final planned distribution matches delivered distribution as closely as possible. The team would need to ensure that the superior end of the needle is included in scan to achieve this		Reviewed recommendation locally in discussion with Clatterbridge Clatterbridge to adopt our process.	open
131	Lead Brachytherapy MPE	Brachytherapy	Treatment Planning (Cervix)	Review employers scope of entitlement procedure for duty holders under IRMER and consider whether current practice with respect to operator roles is represented adequately	response to outcome from HIW revew	review of entitlement procedures underway and reported to RPSG	open
132	Lead Brachytherapy MPE/CCO	Brachytherapy	Treatment Planning (Cervix)	Consider introducing Venezia vaginal caps to provide additional rectal dose sparing in cases where they may be clinically suitable	Consider as part of applicator replacement project. Pt comfort & emergency procedure impact will need to be considered.	Applicator project established	open
133	Lead Brachytherapy MPE/CCO	Brachytherapy	Treatment Planning (Cervix)	Consider aligning prescribing practice to ICRU89 recommendations, in particular the use of HR CTV D90%	Audit to be undertaken of current practice - paused due to resource issues		open
134	Lead Brachytherapy MPE/CCO	Brachytherapy	Treatment Planning (Cervix)	Consider implementing EMBRACE II optimal contraints for targets and OARs to guide dose optimisation and alert the clinicians where a particular structure maybe outside the optimal range	Consensus between medics and non-medical workforce on implementation of trial findings required.	Project ongoing to adapt to VCC requirements, ensure necessary QA in place and implement in to clinical workflow	open

Ref No	Recommendation	Outcomes Required	Standard/Regulation	Operational Lead	Progress	Delivery Date
RAD 6	The Trust is required to provide HIW with details of the action taken to:•encourage those staff who are Welsh speaking to wear a suitable badge or lanyard to show patients they are happy to converse in Welsh •to consistently ask patients to confirm their preferred language.	Lanyards are not permitted within clinical areas due to infection risks. Corporate communications to release periodic update reminders to all staff to wear Iaith gwaith badge if Welsh Speaking and able to converse in Welsh or Welsh learner badge if learning to speak Welsh	Standard - Equitable	Welsh Language Officer / Corporate Communication team	complete	Initial Communications 31st July 2023

Ref No	Service	Recommendation	Outcomes Required	Suggested SMART Actions	Operational Lead	Executive Lead	Operational Oversight	Strategic Oversight	Evidence of Delivery	Delivery Date	Level of Assurance		
REF002	Infection Prevention & Control	Upon inspection it was clear a number of policy documents, specific to endoscope use, are undergoing revision, it is recommended such are reviewed at periodic intervals in response to changes at local/national level.	Audit of decontamination processes will be undertaken to assess compliance within 6 months of implementation.		Infection Prevention and Control Team	Executive Director of Nursing, AHPs and Health Science	Infection Prevention & Control Management Group	Quality, Safety & Performance Committee	All relevant policies have been revised and updated. Endoscopes are not currently used in VCC.	Dec-19	7		
REF042	Nuclear Medicine Department	The Trust is required to ensure that action is taken to promote the availability of Welsh speaking staff or support within the department to help deliver the 'Active Offer'	HIW IRMER Visit June 2022	A Trust wide audit of 'Active Offer' to be undertaken across all patient / donor facing clinical areas and local action taken to ensure any 'Active Offer' deficits are addressed .	Trust Welsh Language Manager				The Dept have been proactive in providing visual aids for patients asking them if they require a Welsh language service. Patients have identified themselves and communication has been provided, bilingually. Action is complete and department continues their efforts to promote the Active Offer.	Mar-23	7		
REF010	VCC Radiology	The process for maintaining documented informatino was not found to be fully effective.	To the extent necessary, the Trust shall maintain documented information to support the operation of its processes and retain documented	A draft document with updated guidance was drafted immediately and at conclusion of the audit, was awaiting appropriate review and approval by the Lead Radiologist prior to	Radiology Manager	Chief Operating Officer		Quality, Safety & Performance Committee		New process in place following review and approval			Radiology ISO visit report Feb 23
REF001	Infection Prevention & Control	It is recommended the Trust holds a workshop to raise awareness of decontamination within the organisation. It is proposed that the day covers items such as the principles of decontamination, manual cleaning, infection control and trace-ability. The idea is to enhance awareness but not replace dedicated training supplied by individual manufacturers.		A workshop will be arranged post implementation of the high level disinfection systems & ultraviolet light environmental decontamination system.	Head of Infection Prevention & Control	Executive Director of Nursing, AHPs and Health Science	Infection Prevention & Control Management Group	Quality, Safety & Performance Committee	Mar-20	To be considered when established in the new build. Presently to continue to develop engagement within different teams. An All Wales Decontamination workshop was held on 16th July 2022 and attended by the IPC team members. IPC		Trust Decon group yet to be establis hed.	Decon. assurance update 2023.docx Decon. assurance update 2023.docx
REF007		Continue to develop the CAT service.	Acknowledging that the CAT service accepts referrals from outside VCC, to include Cwm Taf Morgannwg UHB,	Work with Dr Pease CAT service lead and haematology colleagues as part of the work of the VCC Thrombosis Working Group.	Clinical Director		VCS Thrombosis Working Group	Quality, Safety & Performance Committee	Plan to be developed by Dec-22	CAT service are receiving referrals from other health boards for VCC patients diagnosed with VTE in other health boards. Work being			
REF008		All All-Wales checklist for the investigation of HAT is developed in order to maintain a uniform investigative approach across NHS Wales.		All Wales checklist when agreed to be used to investigate all incidences of VCC related HAT and checklist included as part of the Datix	SACT and Medicines Management Lead/Chief Pharmacist		VCS Medicines Management Group / VCS Q&S Group	Quality, Safety & Performance Committee	Once All Wales checklist agreed	All Wales checklist has not been developed. However, VCC has devised our own checklist to undertake investigation of all			Welsh Risk Pool VTE Report

REF009		VTE risk assessment compliance and all HAT data is shared at appropriate health body governance meetings.		VCC VTE risk assessment compliance to be incorporated into VCC Performance Management Framework and reported	Assistant Director of Planning VCS		VCS SLT		Sep-22	All potentially avoidable HATs (asceetained from REF008 above) are uploaded onto the Performance Management			
HIW visit to VCC First Floor Ward 12th / 13th July 2022														
REF012	VCC Inpatient Wards	The Trust must ensure that there is a close focus on the dementia provision on the ward. This may include implementing a patient identification system on the ward and a review of the current non-mandatory approach to training.	The Enhanced Supervision Policy to be fully implemented. The policy will identify the requirements of patients with confusion or cognitive impairment e.g. closer supervision, open visiting.		Operational Senior Nurse and First Floor Ward Manager	Head of Nursing, Quality, Patient Experience and Integrated Care			Oct-22	Enhanced supervision approved and is being implemented on FF Ward			HIW FFW Visit July 2022
REF013	VCC Inpatient Wards	See above (line 13)	Compliance with the Enhanced Supervision Policy to be reviewed quarterly for the first year to		First Floor Ward Manager	Head of Nursing, Quality, Patient Experience and Integrated Care			From 3 months post implementation - Jan 23	*Ongoing audit of nursing documentation by ward manager*			
REF014	VCC Inpatient Wards	See above	First Floor ward to implement “This is me” booklet for patients with dementia and cognitive impairment		Operational Senior Nurse and First Floor Ward Manager	Head of Nursing, Quality, Patient Experience and Integrated Care			Nov-22	Cardiff and Vale 'This is me' booklet currently being used on ward for eligible patients.			
REF015	VCC Inpatient Wards	See above	The implementation of “This is Me” booklet will be audited quarterly for the first year to		First Floor Ward Manager	Head of Nursing, Quality, Patient Experience and			From 3 months post implementation - Feb 23	Cardiff and Vale 'This is me' booklet currently being used on ward for eligible patients.			
REF016	VCC Inpatient Wards	See above	A dementia awareness/ update session to be provided to all staff within a ward meeting		First Floor Ward Manager	Head of Nursing, Quality, Patient Experience and Integrated Care			Nov-22	Dementia training at UHW being delivered. Mandatory module on ESR. Link nurses on the ward have been identified			
REF017	VCC Inpatient Wards	See above	All staff to receive formal dementia training via the arrangement with Cardiff and Vale Heath Board		First Floor Ward Manager	Head of Nursing, Quality, Patient Experience and Integrated Care			Mar-23	*Ongoing, staff have and are being booked onto dementia training*			
REF018	VCC Inpatient Wards	See above	Ward to develop as part of patient status at a glance board, above beds & handover process a visual mechanism for all patients with cognitive impairment that’s a visual reminder to all personnel.		First Floor Ward Manager	Head of Nursing, Quality, Patient Experience and Integrated Care			Nov-22	Logo currently being confirmed to identify cognitively impaired patients			
REF019	VCC Inpatient Wards	The Trust must continue to carefully monitor falls incidents on the ward to ensure that the anticipated improvements are realised in a timely and effective	All actions from the recent corporate nursing falls audit to be fully implemented.		Operational Senior Nurse and First Floor Ward Manager	Head of Nursing, Quality, Patient Experience and Integrated Care			Nov-22	*Monthly Falls Scrutiny Panels are undertaken to ensure ongoing scrutiny of falls and identifying learning to inform practice.*			

REF020	VCC Inpatient Wards	The Trust may wish to consider implementing intentional (safe) rounding as an additional proactive measure.	The Ward Manager and Operational Senior to formally consider implementing		Operational Senior Nurse and First Floor Ward Manager	Head of Nursing, Quality, Patient Experience and Integrated Care			Oct-22	*Discussed and decided that intentional grounding is not to be implemented currently. Staff perform regular checks of patients and their surrounding environment.*			
REF021	VCC Inpatient Wards	See above (line 21)	Enhanced Supervision Policy to be fully implemented which identifies the level of supervision a patient requires dependent on risk of		Operational Senior Nurse and Quality & Safety Manager	Head of Nursing, Quality, Patient Experience and Integrated Care			Oct-22				
REF022	VCC Inpatient Wards	See above (line 21)	Compliance with the Enhanced Supervision Policy to be reviewed quarterly		First Floor Ward Manager	Head of Nursing, Quality, Patient Experience and			3 months post-implementation - Jan-23	*Ongoing audit of nursing documentation by ward manager to ensure the Enhanced Supe* *Ongoing audit of nursing documentation by ward manager to ensure the Enhanced Supervision Policy is being used as appropriate.*			
REF023	VCC Inpatient Wards	The Trust must ensure that COVID-19 risk assessments continue to be completed and evidenced within patient records.	All patients receive a COVID PCR test on admission. Information risk assessments are currently being done		Acute Oncology Lead Nurse	Head of Nursing, Quality, Patient Experience and Integrated Care			Oct-22	*COVID testing on admission is standard. Patients are risk assessed and nursed accordingly i.e. nursing in a cubicle is respiratory symptoms are displayed.*			
REF024	VCC Inpatient Wards	The Trust must ensure that, following completion of risk assessments, patients are followed up at the required intervals and that these checks are evidenced within patient notes. This includes evidencing a plan of care or referrals to specialist services (e.g. dieticians)	The Trust is implementing the WNCR and is aware that there are 2 systems both digital and paper in place at ward level at present, this is an All Wales position. Many of the WNCR nursing		Operational Senior Nurse and First Floor Ward Manager	Head of Nursing, Quality, Patient Experience and Integrated Care			Dec-22	*The transition to digitalization of nursing/ medical records is being guided and supported by Anna Harries and Cheryl Lewis. The ward team work closely to implement digital changes that are required on the ward.*			
REF025	VCC Inpatient Wards	See above (line 24)	Documentation, including risk assessments and care plans will be		Operational Senior Nurse and First Floor Ward Manager	Head of Nursing, Quality, Patient Experience and			Dec-22	*Ongoing audit of nursing documentation by ward manager to ensure high standards are*			
REF026	VCC Inpatient Wards	The Trust must ensure that Patient Names / IDs are recorded on all pages.	All staff (doctors, nurses, AHPs) reminded to include patient ID on all pages. Included in		Operational Senior Nurse and First Floor Ward Manager	Head of Nursing, Quality, Patient Experience and Integrated Care			Sep-22	*Patient ID on all documentation has been communicated to all health professional groups and will be continually audited as part of the documentation audit.*			
REF027	VCC Inpatient Wards	The Trust must ensure that oxygen is prescribed.	All staff (nurses and doctors) reminded that oxygen must be prescribed – included in Big 4, emailed to		Operational Senior Nurse and First Floor Ward Manager	Head of Nursing, Quality, Patient Experience and Integrated Care			Sep-22	*Oxygen prescription requirement has been communicated to the Nursing, Medical and Pharmacy teams and will be part of an ongoing audit.*			
REF028	VCC Inpatient Wards	The Trust must ensure that medication fridges are locked when not in use.	All staff (nurses and pharmacy) reminded of safe storage of medication. Emailed to all pharmacy staff, included in Big 4, put on nurses Whatsapp		Chief Pharmacist / Head of Therapies / Clinical Director	Head of Nursing, Quality, Patient Experience and Integrated Care			Sep-22	*Locking of medication fridges has been widely communicated with the nursing teams an*			
REF029	VCC Inpatient Wards	The Trust must ensure that medical devices / equipment on the ward are serviced at the	Ward manager and medical physics to undertake a spot check of all medical		First Floor Ward Manager / Medical Physicist	Head of Nursing, Quality, Patient			Sep-22	*Ongoing checks of medical devices is being supported by medical physics.*			
REF030	VCC Inpatient Wards	See above (line 29)	Ward manager and medical physics to ensure a robust system is in place for		First Floor Ward Manager / Medical Physicist	Head of Nursing, Quality, Patient			Oct-22	*Ongoing checks of medical devices is being supported by medical physics.*			
REF032	VCC Inpatient Wards	The Trust must ensure that sepsis training is delivered on a consistent basis and that evidence of attendance is maintained.	Sepsis training is delivered to all registered nursing staff as a core part of the Acute Oncology		First Floor Ward Manager / Acute Oncology Lead Nurse	Head of Nursing, Quality, Patient Experience and Integrated Care			Oct-22	*Sepsis training and NEWS Cymru training is provided to all staff. Clinical educators ensu*			
REF033	VCC Inpatient Wards	See above (line 33)	Training compliance to be reviewed and be further rolled out as part of the		First Floor Ward Manager / Acute Oncology Lead Nurse	Head of Nursing, Quality, Patient Experience and			Mar-23	*Sepsis training and NEWS Cymru training is provided to all staff. Clinical educators ensure staff are booked onto the training and monitor*			

REF034	VCC Inpatient Wards	The Trust must ensure that where DNACPR discussions or forms of escalation are not considered necessary that details of the decision making are recorded within the patient notes to evidence an appropriate	Spot checks to be undertaken by ward manager / Senior Nurse regularly and fed back to clinical team. Ward daily midday safety huddle to include question		Operational Senior Nurse and First Floor Ward Manager	Head of Nursing, Quality, Patient Experience and Integrated Care			?	*TEP's for completion are raised with the medical and on call teams.*				
REF035	VCC Inpatient Wards	The Trust must consider how care plans are completed and reviewed to ensure that individualised patient care can be captured and demonstrated	The Trust is implementing the WNCR and is aware that there are 2 systems both digital and paper in place at	The ward manager, senior operational nurse, ward clinical educator, and digital CNS to formulate and roll out an improvement plan for	Operational Senior Nurse and First Floor Ward Manager	Head of Nursing, Quality, Patient Experience and Integrated Care			Dec-22	*The transition to digitalization of nursing/ medical records is being guided and supported by Anna Harries and Cheryl Lewis. The ward team work closely to implement digital changes that are required on*				HIW FFW Visit July 2022
REF036	VCC Inpatient Wards	See above (line 36)	Documentation, including risk assessments and care plans will be audited on a quarterly		Operational Senior Nurse and First Floor Ward Manager	Head of Nursing, Quality, Patient Experience and Integrated Care			From Sep-22	*Ongoing audit of nursing documentation by ward manager to ensure high standards are*				
REF037	VCC Inpatient Wards	The Trust should consider how its patient record systems align (or otherwise) to ensure that there is a unified and streamlined approach to the access and review of patient notes by all staff groups		The Trust is implementing the WNCR and is aware that there are 2 systems both digital and paper in place at ward level at present, this is an All Wales position. The Velindre Cancer Centre (VCC) is implementing	Operational Senior Nurse	Head of Nursing, Quality, Patient Experience and Integrated Care			Dec-22	*The transition to digitalization of nursing/ medical records is being guided and supported by Anna Harries and Cheryl Lewis. The ward team work closely to implement digital changes that are required on the ward. WPAS is now fully implemented at VCC.*				
REF038	VCC Inpatient Wards	Given the improvements identified above, the Trust should increase its record keeping audit activity.	Following improvements being made to documentation [illegible] audits		Operational Senior Nurse and First Floor Ward Manager	Head of Nursing, Quality, Patient Experience and Integrated Care			Dec-22	*Ongoing audit of nursing documentation by ward manager to ensure high standards are*				
REF039	VCC Inpatient Wards	The Trust may wish to reflect on the staff findings to determine if any further actions or forms of staff engagement are required.	reflected on the staff feedback, there are in place multiple ways of receiving staff feedback, in relation		Operational Senior Nurse and First Floor Ward Manager	Head of Nursing, Quality, Patient Experience and Integrated Care			Oct-22	*Communication to the ward team is supported via regular monthly ward meetings and 'Big 4' communication. Staff are supported day to day by the ward manager and operational senior nurse*				
REF040	VCC Inpatient Wards	See above (line 40)	Civica for regular staff feedback, pulse surveys, implement and monitor feedback		Operational Senior Nurse and First Floor Ward Manager	Head of Nursing, Quality, Patient Experience and			Oct-22	*CIVICA patient feedback has been implemented and is being offered regularly to patients. The learning from feedback is being actioned*				
REF043	Nuclear Medicine Department	The employer must ensure that the entitlement matrix is updated to include dates, as opposed to ticks, so that management are aware of when the documents need to be reviewed. The documentation must also be in a consistent format as part of the document quality	This and other documents will be transitioned to an electronic document management system to ensure a robust document management and review system is in place for all		Head of Operations / Head of Nuclear Medicine				Feb-23	The Dept have been proactive in providing visual aids for patients asking them if they require a Welsh language service. Patients have identified themselves and communication has been provided, bilingually. Action is complete and department continues their efforts to promote the Active Offer.				
REF043	Nuclear Medicine Department	The employer must ensure that the entitlement matrix is updated to include dates, as opposed to ticks, so that management are aware of when the documents need to be reviewed. The documentation must also be in a consistent format as part of the document quality	This and other documents will be transitioned to an electronic document management system to ensure a robust document management and review system is in place for all		Head of Operations / Head of Nuclear Medicine				Feb-23	The Dept have been proactive in providing visual aids for patients asking them if they require a Welsh language service. Patients have identified themselves and communication has been provided, bilingually. Action is complete and department continues their efforts to promote the Active Offer.				

REF044	Nuclear Medicine Department	The employer must ensure that a consistent system of document control is introduced into employer's procedures. This must include the document review timescale, review dates, who is involved in establishing or reviewing procedures and how they are agreed by the employer.	Documents will be transitioned to an electronic document management system to ensure a robust document management and review system is in place for all documentation. This will include either the purchase of		Head of Operations / Head of Nuclear Medicine				Feb-23	Radiology ISO visit report Feb 23 In progress as longer burning projects.	
Patient Discharge from Hospital to General Practice (HIW)											
REF045		NHS Wales healthcare organisations should ensure there is clarity in relation to the roles staff play in the discharge process, and to communicate this across their respective organisations therefore helping to increase staff and patient understanding of the discharge process, and improve consistency.	Develop an inpatient VCC Discharge Policy to define the discharge process at VCC (Velindre Cancer Centre) with clear staff roles and responsibilities around safe discharge. Include in the policy the following: •Provide advice to		Operational Senior Nurse / Lead Pharmacist				Oct-22	In VCC, it is the nursing staffs who issue the discharge prescriptions to the patient at th	
REF046		NHS Wales healthcare organisations need to audit and monitor compliance with their own policy timeframes and Health and Care Standard 2.6	An annual audit in respect of Healthcare Standard 2.6 regarding take out medication to be undertaken (more		Lead Pharmacist				Oct-22	What we need here is a SMART objective for us to measure against. If this objective ha	
REF047		NHS Wales healthcare organisations need to ensure that patients are provided with appropriate information about the medication they have been prescribed in a timely manner prior to discharge. Compliance against this	An annual audit in respect of medication information to be undertaken to be undertaken (more frequently if significant issues identified) and reported through to						Oct-22	Will again have to come up with some sort of SMART way to measure this. All patients	
REF049		Measures should be taken to improve inpatient, family and carer engagement to ensure people are fully consulted about their care and treatment NHS Wales healthcare organisations. This is in line with Health and Care Standard 4.2 Patient Information and Standard 5.1 Timely Access.	Develop an inpatient VCC Discharge Policy to define the discharge process at VCC (Velindre Cancer Centre) with clear staff roles and responsibilities around safe discharge. Include in the policy the following:							*CIVICA patient feedback has been implemented and is being offered regularly to patients. The learning from feedback is being actioned as required. Monthly CIVICA feedback reports are made available to staff via the ward communication board.* Patient Discharge Action Plan	
CHC visit to VCC Outpatients Department 8th February 2023											
REF051	VCC Outpatients Department	The Trust should explore the possibility of having easy access to wheelchairs for patients parking in the car park at the rear of the	There are wheelchairs available at the start of the day for patients entering from the rear car park							Extra wheel chairs now available, RT outpatients looking for an area to be placed or sig	

REF052	VCC Outpatients Department	Introducing signage requesting visitors to park in the Whitchurch site rather than in the streets nearby would lessen the reliance on the parking staff directing people to this facility.	Patients are not expected to park in the Whitchurch site, this is for staff only.							No action needed	CHC Outpatients Visit 8.2.23		
REF054	VCC Outpatients Department	While there is drinking water available in the department, it is not well signposted and improving this would help patients.	Signs have been put up in the department directing patients.							Signs have gone up			
CHC visit to VCC First Floor Ward 24th February 2023													
REF055	VCC First Floor Ward	The Managers pass on the thanks of the patients to the staff for the excellent level of service and care on the ward and for the initiatives to improve the welfare of patients	The First Floor Ward team are to be informed of the excellent standard of care and service being delivered to patients	ACTION PLAN Attached						ACTION PLAN received			CHC First Floor Ward Visit 24.2.23
REF056	VCC First Floor Ward	Ensure that the design of the ward in the new hospital has sufficient storage space for equipment and space	To ensure that storage space is considered for the inpatient ward in the	ACTION PLAN Attached						ACTION PLAN above in ref 55			Copy of VCC CHC Action Plan Feb 23.x
REF057	VCC First Floor Ward	Ensure that prescriptions are available in one location for the patients on their discharge from hospital.	ACTION PLAN AWAITED	ACTION PLAN Attached						ACTION PLAN above in ref 55		HIW FFW Visit July 2022	Patient Dis Action
Patient Discharge from Hospital to General Practice (HIW)													
REF048		NHS Wales should ensure that any potential benefits identified as part of PKB pilot studies, are shared across healthcare organisations.	PKB is currently not being utilised by the Trust.	This will be reviewed by the Trust to ensure the learning and benefits of the study are shared across the trust.	Operational Senior Nurse				Sep-22	PKB is currently not being utilised by the Trust.	HIW FFW Visit July 2022		
All Wales Quality Assurance Pharmacist (on behalf of WG) 26th / 27th April 2022													

REF011	VCC Pharmacy	Outcome was as follows: Red deficiencies - 0 Amber Deficiences -12 Yellow Deficiencies - 47 Green Compliance - 412	Action plans for all of the deficiencies has been added to the iQAAPS website, a high number of deficiencies are linked and they have been linked into the relevant action plans and is overseen by Martin Rees-Milton, who submits 6 monthly progress reports on line via the iQAAPS website. Action plan resolution times and reminder alerts have been set up, as the action plans are resolved they will be closed on iQAAPS.		Chief Pharmacist	Medical Director	Progress monitored via Medicines Management Group	Quality, Safety & Performance Committee	May-23	Reaudited 16 - 17/05/2023, previous audit reviewed and superceded by new audit. Audit report to be avaialble by 31st May, local action plan to correct any deficiencies to be produced by 30th June. REF011 to be closed and new REF set up for May 2023	Welsh Risk Pool VTE Report HIW IRMER Visit June 2022 HTA October 2022		
Matters Arising 2	**Experience Feedback Reporting** 2.1 As part of the intended review of quality metrics and reporting, the Trust should: 2.1a. Review the patient and donor experience information required to achieve the objectives of each forum and tailor the reports as appropriate; and	**Medium**	a. A full review of CIVICA reports / dashboards to be undertaken to identify level of information and type of report required as a minimum at each meeting – aligning to work detailed in 1.1 a and 1.1b.	Nicola Williams, Director of Nursing, AHP's & Medical Scientists	Viv Cooper (VCC) & Zoe Gibson (WBS), Head of Nursing Professional Standards & Digital & Tina Jenkins, Deputy Director Nursing, Quality & Patient Experience	31/03/2023	**Action Closed**	The WBS Regulatory Assurance and Governance Group is being reviewed and re-shaped to become the WBS Quality Hub. The new ToR will incorporate Donor feedback surveys, Civica feedback and concerns/compliments allowing for triangulation with other quality markers. VCC - The Quality and Safety team are meeting with the directorate leads to identify what is included in their meeting structures to ensure Civica reports are a key feature also providing support to ensure that feedback is shared and is added to the 'knowing how we are doing' boards. Working with the meeting chairs to develop dashboards and identify the level of information and type of report required, developing individual	VCC - The Quality and Safety team are meeting with the directorate leads to ensure Civica is included as a key feature in each directorates meeting structures. The Q&S team are providing reports to ensure that feedback is widely shared and is regaulraly update using the 'knowing how we are doing' boards. the Q&S team are working with the meeting chairs to develop dashboards and identify the level of information and type of report required, developing individual questions which are department specific as requested and increasing use of the departement specific QR code. VCC now has a part time patient experince lead in place with responsibility and objectives set in relation to Civica - this post will become full time from April 1st 2023.	**Complete.** **VCC -** Communication made with all directorates to include CIVICA/ patient experience to their directorate management meetings TOR and standing agenda item. The Q+S team continue to work with meeting chairs to develop dashboards and identify the level of information and type of report required. This includes developing a monthly CIVICA patient feedback report to be sent to each directorate in readiness for their monthly meetings. From 1st April 2023 there will be a full time Patient Experience and Concerns Manager in post who will work closely with directorates to develop individual questionnaires applicable to each area. The Integrated Care lead has met with the Value Based Health Care project consultants to discuss the the PROMS and PREMS work that has commenced and further work/meetings are planned with the PSC. **WBS** - Regulatory and Assurance Governance (RAGG) Review is being completed. Until	n/a	n/a	n/a

	1.1b update relevant meeting terms of reference to ensure clarity over the purpose of patient and donor experience reporting at each forum; and	**Medium**	b. Review all Divisional Departmental to SLT/SMT & Quality Group Terms of References to include oversight of patient / donor CIVICA feedback (including volume feedback, outcomes, improvement actions and ongoing trend and theme monitoring and the utilisation of feedback to inform prioritisation and decision making at all levels.	Nicola Williams, Director of Nursing, AHP's & Medical Scientists	Divisional Director WBS & VCC Alan Prosser, Director of WBS & Rachel Hennessy/Paul Wilkins Director of VCC	31/03/2023	**Action Closed**	The WBS Regulatory Assurance and Governance Group is being reviewed and re-shaped to become the WBS Quality Hub. The new ToR will incorporate Donor feedback surveys, Civica feedback and concerns/compliments allowing for triangulation with other quality markers. VCC - The Quality and Safety team has a plan to liaise with the directorates to identify all of the meetings that need to be included. Working with the chairs to update the terms of reference and ensure robust systems in place for the chairs to idenify the CIVICA/ patient feedback information including themes and trends - how to access it and how to demonstarte actions have been taken. A new postholder will join the Q&S team specifically for patient	VCC - The Quality and Safety team are meeting with the directorate leads to ensure Civica is included as a key feature in each directorates meeting structures. The Q&S team are providing reports to ensure that feedback is widely shared and is regaulraly update using the 'knowing how we are doing' boards. the Q&S team are working with the meeting chairs to develop dashboards and identify the level of information and type of report required, developing individual questions which are department specific as requested and increasing use of the departement specific QR code. VCC now has a part time patient experince lead in place with responsibility and objectives set in relation to Civica - this post will become full time from April 1st 2023.	**Complete.** **VCC -** Communication made with all directorates to include CIVICA/ patient experience to their directorate management meetings TOR and standing agenda item. The Q+S team continue to work with meeting chairs to develop dashboards and identify the level of information and type of report required. This includes developing a monthly CIVICA patient feedback report to be sent to each directorate in readniess for their monthly meetings. From 1st April 2023 there will be a full time Patient Experience and Concerns Manager in post who will work closelywith directorates to develop individual questionnaires applicable to each area. The Integrated Care lead has met with the Value Based Health Care project consultants to discuss the the PROMS and PREMS work that has commenced and further work/meetings are planned with the PSC. **WBS -** Regulatory and Assurance Governance (RAGG) Review is being completed. Until	n/a	n/a	n/a
	2.1b. Ensure that reports contain succinct, concise executive summaries that clearly highlight key messages.	**Medium**	b. As outlined in 2.1.a	Nicola Williams, Director of Nursing, AHP's & Medical Scientists	Emma Powell, Head of Information	30/04/2023	**Action Closed**	As 2.1a	As 2.1a	**Complete.** See update for 2.1a	n/a	n/a	n/a
CHC visit to VCC First Floor Ward 24th February 2023														
REF055	VCC First Floor Ward	The Managers pass on the thanks of the patients to the staff for the excellent level of service and care on the ward and for the initiatives to improve the welfare of patients.	The First Floor Ward team are to be informed of the excellent standard of care and service being delivered to patients.		Operational Senior Nurse and First Floor Ward Manager	Head of Nursing, Quality, Patient Experience and Integrated Care								
REF056	VCC First Floor Ward	Ensure that the design of the ward in the new hospital has sufficient storage space for equipment and space between the beds for privacy.	To ensure that storage space is considered for the inpatient ward in the new hospital.		Operational Senior Nurse and First Floor Ward Manager	Head of Nursing, Quality, Patient Experience and Integrated Care								
REF057	VCC First Floor Ward	Ensure that prescriptions are available in one location for the patients on their discharge from hospital.	On discharge from VCC discharge prescriptions will be available in one location.		Usman Malik Principle Pharmacist Velindre Cancer Centre	Head of Nursing, Quality, Patient Experience and Integrated Care								

PDF

CHC First Floor Ward Visit 24.2.23

REF001	**VCC OPD**	The Trust should explore the possibility of having easy access to wheelchairs for patients parking in the car park at the rear of the Cancer Centre.	The portering team ensure regular check of wheelchairs throiughout the day and ensure wheelchairs are availble at the entrances. If required, radiotheray receptionsts will contact porters for patients entering through the radiotherapy reception from the rear car park if wheel chairs are not available at that point		Senior Nurse Outpatient	Head of Operations and Services Delivery							
REF002	**VCC OPD**	Introducing signage requesting visitors to park in the Whitchurch site rather than in the streets nearby, would lessen the reliance on the parking staff directing people to this facility.	Whitchurch site car park is overflow car park for staff to allow carparking space on VCC site for patients and visitors. A reminder to staff to park in Whitchurch will be included in the weekly staff communication.		Senior Nurse Outpatient	Head of Operations and Services Delivery							
REF004	**VCC OPD**	While there is drinking water available in the department it is not well signposted and improving this would help patients.	Signs have been put up in the department directing patients to the drinking water		Senior Nurse Outpatient	Head of Operations and Services Delivery							

	ID	Task	Responsible person	Start	Finish	Progress / comments
1	1.1	Draft escalation interim flowchart - internal escalation to VCC	Rosie Roberts Angharad Rudkin	01/11/2022	16/11/2022	review / feedback / input
1	1.2	Review/ revise draft escalation flowchart	Rosie Roberts Amy Quinton	19/06/2023	28/06/2023	26/06/23 - revised escalation flowchart developed based on informal discussions to date
1	1.3	Share revised draft escalation flowchart with key stakeholder reps: IO, SACT, IC, Medic, SMMOG	Rosie Roberts/ Amy Quinton	29/06/2023	10/07/2023	RR sent out by e-mail 03.07.23 - meeting on 11 July to discuss
1	1.4	Set up meeting with key stakeholder representatives to agree draft pathway	Laura Perks	28/06/2023	11/07/2023	
1	1.5	Amend escalation pathway and obtain final approval of flowchart from key stakeholder rep	Amy Quinton Rosie Roberts	12/07/2023	21/07/2023	Update - 10.07.23 - Meeting on 11 July Risks with achieving agreement with all stakeholders Update - 12.07.23 - agreement reached on Escalation Pathways for in and out of hours. RR to make final updates (12 and 13 July) then send to AAR
1	1.6	Make required updated to Visio Flowchart when information available from RR	Angharad Rudkin	12/07/2023	21/07/2023	Update - 12.07.23 - agreement reached on Escalation Pathways for in and out of hours. RR to make final updates (12 and 13 July) then send to AAR. AAR had reserved time on 12 July to do this task but info not yet ready. AAR on A/L 13 and 14 July so unable to make updates before 17 July Update - 19.07.23 - 3 new flowcharts produced and sent to RR
1	1.7	Write cover paper to support escalation process	Amy Quinton	12/07/2023	21/07/2023	Is this the overall Principles or something different? Update - 25.07.23 - RR has used Intro to SOP
1	1.8	SACT and Medicines Management Operational Group	Bethan Tranter	08/08/2023	08/08/2023	Update - 20.07.23 - AAR e-mail RM to check SMMOG slot booked - slot confirmed. Update 09/08/23 - approved a SMMOG on 08/08/23
1	1.9	VCC Senior Nurse Forum	Rosie Roberts	01/08/2023	01/08/2023	Endorsed for approval by Senior Nurses
1	1.1	Clinical Advisory Group	Amy Quinton	09/08/2023	09/08/2023	Update 10/08/23. Endorsed for approvalsubject to amendment of wording of role of OP holder by Exec Nurse Lead.
1	1.11	Senior Leadership Team	Bethan Tranter	10/08/2023	10/08/2023	Update 10/08/23: Approved
1	2.1	Confirm / determine which version of the UKONS triage tool will be utilised / whether amendments required	Rosie Roberts	29/06/2023	01/07/2023	28/06/23: Amendments to aid clarification as to when escalation may be required.
1	2.2	If amendments required, update	Rosie Roberts	01/07/2023	07/07/2023	
1	2.3	Share draft triage tool with key stakeholder reps: IO, SACT, IC, Medic, SMMOG (as 1.3)	Laura Perks	28/06/2023	04/07/2023	Sent out by RR 29 June Meeting 4 July to discuss
1	2.4	Set up meeting with key stakeholder representatives to agree draft tool	Laura Perks	28/06/2023	04/07/2023	28/06/23: meeting arranged 05/07/23: second (follow up) meeting arranged for 10/07/23 Update - 10.07.23 - RR making changes following meetings and will send out to stakeholders for approval Update: 12/07/23 - Updated triage shared for further feedback
1	2.5	Take to UKONS group for comments / input ahead of UKONS formal update of UKONS tool	Rosie Roberts	11/07/2023	11/07/2023	For info only Update - 10.07.23 - RR also meeting with 111 Team on 11 July re-Chest Pain algorithm Update 12.07.23 - UKONS tool with be about 8 mths, therefore VCC to progress independently. Action complete
1	2.6	Amend triage tool (then proceed to obtain final approval of tool from key stakeholder reps as listed below)	Roise Roberts	12/07/2023	21/07/2023	Update: 12/07/23 - updated triage tool shared for further feedback
1	2.8	Write cover paper to support tool	Rosie Roberts	12/07/2023	26/07/2023	Update: 12/07/23 - paper to be written by 26th July (instead of 21 July) in readiness for Nurse Forum. Agreed cover paper not required for MMG given that RR and AQ on group and can verbally present to MMG the tool
1	2.9	Submit to: Medicines Management Group	Amy Quinton	22/07/2023	26/07/2023	MMG endorsed
1	2.1	Submit to: VCC Senior Nurse Forum	Rosie Roberts	01/08/2023	01/08/2023	Senior Nurses endorsed
1	2.11	Submit to: Clinical Advisory Group	Amy Quinton	09/08/2023	09/08/2023	Update 10.08/23. Approved for endorsal subject to discussion with CAG members to further understand detail
	2.11a	Submit to: SMMOG	Rosie Roberts	08/08/2023	08/08/2023	Update 09/08/23 - approved for endorsal at SMMOG 08/08/23
1	2.12	Submit to: Senior Leadership Team	Bethan Tranter	10/08/2023	10/08/2023	Update 10/08/23: Approved for endorsal subject to 2.11
	New Task added 07.08.23 '2.13a	Complete EMB Cover Report Template	Zoe Gibson Rosie Roberts	07/08/2023	09/08/2023	Update: 09/08/23. Completed
1	3.1	Remind all STH staff about the UKONS Triage Guidelines	Rosie Roberts	Aug-22	Sep-22	Guidelines sent to al STH staff, Operational Pager Holders and Medical colleagues This is practice now (BAU)
1	3.2	All STH Nurses to undertake a full triage using the UKONS Triage tool when a call back is suggestive that a patient's condition has in any way deteriorated	Rosie Roberts STH Nurses	Aug-22	Sep-22	All staff informed of this and is current practice (BAU)
1	3.3	E-mail all relevant staff on the Escalation Process from STH staff to Senior Nurse / Medic	Rosie Roberts	Aug-22	Sep-22	Guidelines sent to al STH staff, Operational Pager Holders and Medical colleagues This is practice now (BAU)
1	3.4	Put in place additional support for band 6 STH Nurses by the Advanced Nurse Practitioners on their Clinical Support Shifts	Rosie Roberts Ceri Stubbs	Aug-22	Sep-22	ANP Clinical Support Shifts currently in place. Emailed Ceri Stubbs to ensure all ANP's aware treatment helpline included in the remit ANP's aware to include the treatment helpline support within their clinical support shifts Operational pager holders attend the treatment helpline periodically throughout day for handover of calls
1	3.5	Produce flow chart on who to contact for advice e.g. NIC, ANP, SHO, SpR in and out of hours (Working plan to contact NIC first, if NIC unavailable bleep OP who can plan the support needed)	Rosie Roberts Angharad Rudkin	Sep-22	Nov-22	Update - 17/01/23 - flowchart and SOP sent out to relevant parties for feedback in Nov / Dec 22 - none rec'd to date
1	3.6	Review telephone triage course packages available	Education & Development Team Hannah Russon Sarah Owen	01/12/2022	15/01/2023	Ed and Dev sourcing training Update – 16.01.23 - AAR chased Angela Voyle-Smith for update
1	3.7	Source appropriate training package for STH staff	Education & Development Team Hannah Russon Sarah Owen	01/12/2022	18/01/2023	Update – 18.01.23 - E&D Team sourced Telephone Triage course (not 100% fit with need) which can be used whilst VCC specific course produced. Commence using external Telephone Triage training (availability in March) Produce VCC specific Telephone Triage training course with plan to start using April
1	3.11	Work through the UKONS triage tool online educational presentation	Core STH staff	Aug-22	Sep-22	This is done as standard before staff use the tool - RR to get staff to re-done - dates TBC
1	3.12	Work through the UKONS triage tool online educational presentation	All other Nurses that work on the STH	Aug-22	Sep-22	This is done as standard before staff use the tool - RR to get staff to re-done - dates TBC
1	3.14	Staff who work on the STH to do so regularly in order to maintain competence	Rosie Roberts	21/02/2023	15/03/2023	SACT to scope / establish what "regular" means SACT currently scoping Currently reviewing the standard will need to define regularly as some operational pager holders may only do this once per month Update - 21.02.23 - 'Regular' to be defined as 'at least one shift every two months' and this has been added to the STH Standards
1	3.15	Conduct Sepsis training (Recognition of Sepsis) / sessions to all STH staff	Ceri Stubbs Rosie Roberts	23/01/2027	30/04/2023	Sessions to be recorded and made available via Intranet so staff can complete them flexibly Update - 23.01.23 - RR to drive forward with Ceri / AOS Team Update - 27.01.23 - Investigation Closure Report rec'd and timelines added to relevant receommendations Update - 21.02.23 - AOS / ANPs are developing the Sepsis Training for staff (staff to have attended by 30.04.23) - AOS / ANPs are aware of the deadline Update - 03.04.23 - Sepsis Training now mandatory for all clinical / Nursing staff - training sessions booked for April and all staff encouraged to attend Update - 15.05.23 - RR to check all STH staff have attended
1	3.16	Implement SACT Update including STH update for all SACT Nurses and OP Holders	Rosie Roberts Angharad Rudkin	29/11/2022	05/06/2023	Update - 23.01.23 - Update did happen, but didn't include Operational Pager Holders - to explore how to provide regular updates. Need clinical de-briefing opportunities Update - 21.02.23 - RR to draft format and suggest frequency for wider approval- AAR has sent examples of the Pharmacy newsletter and Top Tips to RR for design ideas - due date amended (from end Nov) to reflect work on this starting back up Update - 15.05.23 - RR is working on this today and will send bullet points to AAR to format before sending out w/c 22 May 23 Update - 23.05.23 - RR has approved the draft - just need to have guidelines uploaded to Intrante (RM) then add link ad send Update - 01.06.23 - Aim to have this send out to staff on 5 June 23 - due date extended (from 15.03.23) to reflect

1	3.18	Review products appraised by Hannah Russon / Rosie Roberts back in Dec 22 / Jan 23 and send relevant info to AAR	Review products appraised by Hannah Russon / Rosie Roberts back in Dec 22 / Jan 23 and send relevant info to AAR	20/06/2023	28/06/2023	Update 28.06.23 - 2 products identifed, both have been determined as appropriate
1	4.1	Draft content for staff poster	Nicola Williams	12/06/2023	16/06/2012	
1	4.2	Agree content for poster	Rosie Roberts	19/06/2023	30/06/2023	Update - 03.07.23 - RR currently working on Final version - est copmletion 11 July Update - 10.07.23 - RR has received comments which now need to be actionned
1	4.5	Conduct Risk Assessment for sending out Poster beofre other departments have resoruce in place	Rosie Roberts Bethan Tranter	20/06/2023	30/06/2023	Update - 30.06.23 - Draft Risk Assessment produced by AAR and sent to BT / RR for input Update - 03.07.23 - BT and RR considering content and updating - est. completion 7 July
1	4. 10	Meet with Carolyn Gent to discuss what else Navigators could do	Rosie Roberts	Once approval from SLT and acceptance of risks 26/06/23	30/06/2023	VME to arrange meeting as part of CNS Review Update - 23.01.23 - CNSs are currently completing Activity Sheets and there is a Workshop on Friday 27 Jan looking at Compentency Framework (benchmarked with Clatterbridge). Mapping from the Activity Sheets is planned to commence this week along with a Time and Motion Study. Four sites are being focused on (Urology, H&N, Gynae and 1 other) RR will be involved in the mapping work - Mark Evans, Callum Hague leading this work with input from Vicky Davies from Workforce Update - 19.06.23 - Work to now re-commence as directed by SLT and separate from SCC work as this is delayed Update - 03.07.23 - closed as nothing further Navigators can do at present - will be reviewed once communication and poster ready to go out a part of Engagement Sessions
1	4.11	Produce slides detailing in and out of scope calls for the STH (include rationale for both)	Rosie Roberts	20/06/2023	16/07/2023	Can use the slides that AAR has already drafted as starting point - slides sent to RR
1	4.12	Meet with AMS or Tracey Bell to explain need for sessions for Secretaries to explain in and out of scope calls	Rosie Roberts	Once approval from SLT and acceptance of risks 26/06/23	30/06/2023	Update - 03.07.23 - AMS and TB have been unavailable as delaing with priority Directorate issues Update - 05/07/23 - First secretary workhop w/b 10th July, VME will ensure highlighted at this meeting - RR to check outcome of workshop with VME on 12 July
1	4.13	Set up sessions for Secretaries and Med Records staff to explain in and out of scope calls	Laura Perks	03/07/2023	14/07/2023	Sessions MUST occur BEFORE Poster is sent out - therefore, aim to schedule for w/c 24 July Update - 17.07.23 - Laura is waiting for confirmation of date from Tracey Bell re sessions with Med Records and Secs - (hoping it will be 28 July)
1	4.14	Conduct sessions with Secretaries	Rosie Roberts	24/07/2023	28/07/2023	Telephone calls must be diverted to Secretaries at home when they are working from home Update - 19.07.23 - Sessions set up for 28 July
1	4.15	Set up sessions with CNSs and Navigators	Laura Perks	03/07/2023	14/07/2023	Update - 20.07.23 - CG will liaise with RR on 24 July to agree dates for 3 sessions for CNSs / Navigators
1	4.16	Conduct sessions with Navigators / CNS	Rosie Roberts	31/07/2023	04/08/2023	Sessions MUST occur BEFORE Poster is sent out - therefore, aim to schedule for w/c 24 July Update - 26.07.23 - Sessions booked for w/c 31 July
1	4. 20	Ensure that Medical Secretaries / Medical Records are aware of planned change to enable them to be informed for secretarial working group review	Bethan Tranter Ann Marie Stockdale	24/07/2023	28/07/2023	Update 28/06/23. Email sent to AP/ AMS and TB outlining action and offer to folow up wih verbal communication This will occur in Engagement Sessions - dates ammended to reflect changes above
1	5.1	Put in place the digital / telephony infrastructure required to be able to record and review calls	David Mason-Hawes	01/12/2022	31/03/2023	David Mason-Hawes aware, action sits with digital – raised in SLT 19/10/22. Nicola Williams to escalate following meeting on 26/10/2022 Facilities to record treatment helpline calls have been prioritised and will be delivered as part of Digital Services plans for deployment of new SIP service into VCC. Update - 20.02.23 - DMH confirmed that this work is still on track to be delivered by 31.03.23 Update - 05.04.23 - AAR chased DMH for update Update - 05.04.23 - DMH confirmed this should be going in this week, they had the order sorted thru end of year capital, but due to supplier availability weren't able to get them in last week
1	5.2	Put in place the digital solution to enable STH calls to be recorded / reviewed	David Mason-Hawes Facilities	01/12/2022	31/03/2023	Update - 20.02.23 - DMH confirmed that this work is still on track to be delivered by 31.03.23 Update - 05.04.23 - DMH confirmed this should be going in this week, they had the order sorted thru end of year capital, but due to supplier availability weren't able to get them in last week Update - 15.05.23 - Technically possible now (April 23) - Go live put back to allow adequate comms to staff and patients (including change to automated message to patients when calling)
1	5.3	Understand potential of the functionality of the new telephony system	Bethan Tranter Mark David Rhianydd Jones	26/06/2023	04/07//2023	Update - 03.07.23 - Meeting scheduled for afternoon of 3 July Update 05.07.23 - Meeting undertaken, assurance gained that, in principle, required functionality is deliverable
1		Draw up Visio flowchart of what is required	Carys Jones	24/07/2023	25/07/2023	
1	5.6	Meet with digital colleagues to re-plan next steps to enable call recording to be switch on on safely and with all GDPR requirements fulfilled	Rhianydd Jones Bethan Tranter	28/06/2023	04/07/2023	
1	05-Jul	Ensure that there is a sctandard script in place to support the call recording functionality: staff training	Rhianydd Jones	04/07/2023	21/07/2023	Update - 07.07.23 - Staff have been provided with standard script
1	5.8a	Write message for answer machine for patients English	Rhianydd Jones (Jo Williams)	04/07/2023	21/07/2023	
1	5.9a	Record message for answer machine in line with functionality availability (linked to 4.5) - English	TBC -	TBC	TBC	
1	5.9	Call recording Live	Rosie Roberts	07/07/2023	07/07/2023	
1	5.12	Initial planning meeting	Rosie Roberts Angharad Rudkin Emyr Adlam David Howells	19/01/2023	19/01/2023	Emyr - Head of Digital Application for Trust (will provide task details and timeline etc.) David - System Analyst for Trust Steve Mosely - Software Developer Brett Kittletey - Junior Software Developer Update - 19.01.23 - RR confirmed requirement of STH - using UKONS Triage Tool etc., current Access Database issues, need to feed into demographics to auto populate info (from DHCR / WPAS) and increase functionality, links directly to relevant guidance (up to 40 users). Required outputs - currently have to copy and paste info input (summary notes) from Tool into Clinical Record then copy and paste into e-mail for external (hospitals etc.)
1	5.13	Secure permissions for Emyr / David to access and look at current UKONS Triage Tool Database (contact Paul Mugleston)	Rosie Roberts Paul Mugleston	23/01/2023	03/02/2023	Update - 27.01.23 - AAR e-mailed Emyr for update Update - 30.01.23 - Permissions being set up this week - due dates extended to reflect
1	5.14	Meet with ABUHB to discuss a joint piece of work to look at outcomes of calls to STH etc.	Rosie Roberts	19/01/2023	19/01/2023	
1	5.15	Meet with Paul Mugleston	Emyr Adlam David Howells	23/01/2023	27/01/2023	Update - 27.01.23 - AAR e-mailed Emyr for update Met on 24 Jan
1	5.16	Agree initial core spec / how we can platform	David Howells Rosie Roberts Paul Mugleston	24/01/2023	13/02/2023	Update - 27.01.23 - AAR e-mailed Emyr for update - work in progress and ongoing - finish date TBC Update - 01.02.23 - David Howells has started building requirements and RR has provided input Update - 20.02.23 - Developers have started work using spec produced by David Howells (Phase 1 - re-platforming). Phase 2 work planned significant developments to support integration with other systems and will be built on the platform created in phase 1. There is a level of planning and organisation to be done regarding phase 2 which should work alongside plans for a "Once for Wales" solution - NB this is different to the call recording infrastructure work being managed by DMH
1	5.17	Workshop (x2) with Rosie and Call Handlers		13/02/2023	24/02/2023	Avoid Friday mornings (until 2.20pm) - RR on A/L 13 and 14 Feb
1	5.18	Send plan to AAR	Emyr Adlam David Howells	08/03/2023	10/03/2023	
1	5.19	Detail and agree full specifications of requirements	David Howells Rosie Roberts			Essential, Mandatory, Desireable (Agile approach) - Considered training and roll out as staff using system work across services and 24/7 - Call Handlers are key contacts (can identify issues etc.) - Needs to allow future add-ons / developments (future proof and configurable by VCC 'Super User' staff as required) - Needs to be user led system - Ability to share / configure for All Wales use (core functionality and bolt-ons)
1	5. 20	Send Hywel Dda contacts to Emyr		19/01/2023	19/01/2023	Update - 27.01.23 - AAR e-mailed Emyr for update

Ref No	Owner	Service	Theme	Recommendation	Outcomes Required	Action to date	Action Status
1	Head of Brachytherapy	Brachytherapy	engagement with improvement	The Brachytherapy Project Board should identify areas for service improvement and apply for the necessary investment from appropriate funding sources.	achievement of recommendation	Service Improvement now a standing agenda item at BOG Project Board: Escalation request for Brachytherapy to be include in TRUST Q pulse programme. Request for BI and Workforce support for 1-5 year service delivery plan. BOG agenda: Raise identified service improvements with project board	closed
2	Head of Brachytherapy	Brachytherapy	engagement with improvement	Ensure that improvement is led from within the team to encourage ownership of the service by those working within it	achievement of recommendation	Operational Group are owning the changes required following the peer review, work will be supported by the Project Manager Ownership of actions established and on BOG agenda for formal review each quarter through SLT	closed
3	Head of Brachytherapy	Brachytherapy	engagement with improvement	Consider thought boards in the department, staff surveys, team meetings, and team away time to identify areas of improvement and to allow the staff to focus on solutions	achievement of recommendation	Reviewed by BOG. Dedicated time for BOG to discuss these and other ideas for better communication and service quality improvements.	closed
4	Head of Brachytherapy	Brachytherapy	engagement with improvement	Consider training and education in service improvement for team members. There are free courses such as NHSEI Improvement Fundamentals, which provide simple tools and insight	achievement of recommendation	Discussed at BOG. Reminders issued for all staff to discuss training requiurements at PADR's and annual appraisals	closed
6	Head of Brachytherapy	Brachytherapy	HASS Regulations and Afterload Security	With regard to the new building planned for 2024/25, VCC should consider housing the Flexitron within a dedicated treatment suite behind limited swipe access (confirmed above).	achievement of recommendation	Head of Brachytherapy has raised design recommendation to nVCC team. To be adopted within the nVCC plans ensuring appropriate source security within a practical working environment.	closed
7	Lead Brachytherapy MPE/ Head of RT Governance	Brachytherapy	HASS Regulations and Afterload Security	Alarm codes and software passwords should be removed immediately from documentation within the quality system and only known to and shared with authorised users	achievement of recommendation	Alarm codes have been removed from documentation within the RT quality system Passwords removed from physics documentation	closed
8	Heads of Brachytherapy, & Radiotherapy Service Manager	Brachytherapy	Radiation Safety and Contingency Rehearsal	Complete a full review of HDR radiation safety instructions and emergency procedures (contingencies) and documentation, led by the RPA and RPS and contributed to by wider MDT. HDR contingency and business as usual applicator removal should be aligned where possible and appropriate to do so	achievement of recommendation	The procedures have been reviewed with RPA and MPE, and RPS. A new procedure has been issued. Staff training logged and schedule monitored by BOG. Agreement between RT and consultant oncologists BAU applicator removal complete, including anaesthetic review for gynae. RT Brachy Advanced Practioner removal training schedule monitored by BOG.	closed
11	Head of Brachytherapy	Brachytherapy	Radiation Safety and Contingency Rehearsal	Review the staff roles and responsibilities. If radiographers are to be expected to remove an applicator in an emergency, they should be involved in the insertion	achievement of recommendation	Review of staff roles and responsibilities related to emergency procedures completed and incorporated into the operational procedure. Agreed staff to discuss process of insertion as they would during junior medical training. relevant removal training /competency in place	closed
18	Head of Brachytherapy	Brachytherapy	Document Control and Quality Management System	Key performance indicators for the service should be agreed upon, frequency and schedule created, audits performed and results reported via the governance structure	achievement of recommendation	agreement on TIER 1 performance target of 56 days RTT from start of RT. Prostate IRMER to treatment. Datix 30 day investigation target.	closed
19	Head of Brachytherapy	Brachytherapy	Reporting of Incidents and Risk Management	Staff should be encouraged to systematically capture all information on incidents, on errors and near misses to improve the quality and safety in all areas of the department	achievement of recommendation	All incidents, errors and near misses are now being entered into Datix and staff are engaged with process.	closed
20	Head of Brachytherapy	Brachytherapy	Reporting of Incidents and Risk Management	Questioning and discussion of clinical colleagues irrespective of position and professional hierarchy within the department should be actively encouraged	achievement of recommendation	Encouraged within the service by all.	closed
21	Theatre Lead	Brachytherapy	Reporting of Incidents and Risk Management	Regular debriefs after each theatre session is advocated as per National Patient Safety Agency (NPSA) whether there is an incident or not	achievement of recommendation	Brief and Debrief for theatre staff now documented by Administrator	closed
22	Head of Brachytherapy	Brachytherapy	Reporting of Incidents and Risk Management	Staff are introduced to the Just Culture https://www.england.nhs.uk/patient-safety/a-just-culture-guide/	achievement of recommendation	Recommendation reviewed at Jan BOG on behaviours - complete and minuted. NHSE guidance not replicated in Wales	closed
24	Head of Brachytherapy	Brachytherapy	Line Management/ Reporting Structure	At Superintendent level there should be some degree of technical understanding, and understanding of Brachytherapy processes and workflow to support operational management, service improvement, and integration with main department	achievement of recommendation	Discussion and review with Ops Supts completed. Future changes to be led by Dep RSM for Therapy Radiographers. Service changes being discussed as part of line management 1:1's and service meetings. Clinical and technical refresher undertaken March 23	closed
25	Head of Brachytherapy	Brachytherapy	Line Management/ Reporting Structure	Staff should have time to attend meetings, planned into the working week, unless unexpected circumstances occur	achievement of recommendation	Action reviewed and agreed	closed
28	Head of Brachytherapy	Brachytherapy	Efficiency & Workflow	VCC should adopt a fully paperless or paper-light workflow removing or reducing the need for manual data transcription and increasing the use of primary data source where possible. Several studies on paperless environments for radiotherapy are now published demonstrating clear safety and efficiency improvements over legacy paper-based systems, and the VCC clinical team are keen to move in this direction	achievement of recommendation	Agreement to delay to brachy phase of IRS to be minuted at SMAM to delay until Brachy phase of IRS	closed
29	Head of Brachytherapy	Brachytherapy	Efficiency & Workflow	Use primary sources of data for cross checking as much as possible and avoid duplication of checks, ensure the checking process adds value	achievement of recommendation	Agreement to delay to brachy phase of IRS to be minuted at SMAM to delay until Brachy phase of IRS	closed
30	Head of Brachytherapy	Brachytherapy	Efficiency & Workflow	Consider whether manual transcribing of values is checked at each stage such that the risk of transcription error is suitably mitigated and highlighted as a risk. Eliminate manual transcription and data duplication to the maximum possible extent consistent with the clinical requirements	achievement of recommendation	Agreement to delay to brachy phase of IRS to be minuted at SMAM to delay until Brachy phase of IRS	closed

32	Head of Brachytherapy	Brachytherapy	Efficiency & Workflow	Continue to work with Elekta to find a solution for removal/archive of historical data from the TCC and store securely or find an export solution for future patients to be removed	achievement of recommendation	Discussion taken place with Elekta. Elekta have no current solution for dearchive of patient data, but state they are actively investigating and the problem will be resolved in a future Flexitron upgrade.	closed
33	Head of Brachytherapy	Brachytherapy	Efficiency & Workflow	Investment is required to provide more workstations and chairs for staff to access in both areas	achievement of recommendation	Refiguration of theatre office and control area, but still not ideal. Addressed within nVCC	closed
34	Head of Brachytherapy	Brachytherapy	New Build Considerations	Ensure key clinical stakeholders are heavily involved in the design and planning for the new department in the new hospital	achievement of recommendation	Head of Service ensures engagement of appropriate staff with nVCC. Engagement with nVCC team. Review CCC suit design. Ongoing engagement with Acorns monitored by BOG	closed
35	Head of Brachytherapy	Brachytherapy	New Build Considerations	Ensure the new build is designed with future proofing in mind and takes account of the way VCC may want to work in the future	achievement of recommendation	Brachytherapy service requirements incorporated into the Schedule of Accomdation for nVCC target for design completion1:200 Jan 2023	closed
36	Head of Brachytherapy	Brachytherapy	New Build Considerations	The treatment console control areas for HDR and skin should consider being kept separate but adjacent to each other if services are to be run combined. Review also recommendations within section 5.3 relating to the use of silent cockpit	achievement of recommendation	Recommendation reviewed. Not possible due to estate contraint at VCC but will be considered as part of nVCC Ongoing engagement with Acorns monitored by BOG	closed
37	Head of Brachytherapy	Brachytherapy	New Build Considerations	Ensure adequate and appropriately designed storage for consumables and specialist equipment	achievement of recommendation	Head of Service ensures engagement of appropriate staff with nVCC. Engagement with nVCC team. Review CCC suit design. Ongoing engagement with Acorns monitored by BOG	closed
43	Head of Brachytherapy	Brachytherapy	Workforce	Flexible working for team members should be approved in line with business need and not at the detriment of the clinical service	achievement of recommendation	CCC misunderstood that service was to pause due to lack of staff in August. Acknowledged in revision, but recommendation remained	closed
44	Head of Brachytherapy	Brachytherapy	Workforce	Consider creating a stable team for a sustained period to accelerate training and improvement	achievement of recommendation	Resilient team in development. Additional Radiographers and Medical Physicists due to take up posts as result of prostate expansion BC; 3 AP Radiographers appointed, 1 due to return from Maternity leave in October 1 MPE role and 0.5 Checker role successfully through scrutiny. Theatres increased hours. Staff to be trained to required competencies once in post with a view to whole team progression and succession planning	closed
47	Theatre Nurse Lead	Brachytherapy	Nursing & Theatre	The policy should be rewritten to reflect the full process; the LocSSIPs should include all five steps	achievement of recommendation	New ops policies have been written by theater lead.Governance identified at SPIRE and policy verified.	closed
48	Theatre Nurse Lead	Brachytherapy	Nursing & Theatre	Standardised 'team brief' and 'debrief' documentation should be produced as part of the policy. Copies of these should be saved for reference and audit purposes	achievement of recommendation	Team brief and debrief has now been addressed and a form has been developed to be used for every case. The form records all information shared and who was present at those moments i.e. Theatre team members, Consultants, RT, radiology, physics. This information is added to the Theatre TEAMS system for reference and audit purposes. The new Theatre administrator both records and saves the information to the new TEAMS admin group, set up by Theatre Lead and new admin assistant.	closed
49	Theatre Nurse Lead	Brachytherapy	Nursing & Theatre	Team brief and debrief should be carried out on every session. If formal debrief cannot include all team members, advocate the opportunity for comments or to revisit the policy and in practice	achievement of recommendation	The WHO checklist including 'WHO HUG' at the beginning of the patient journey and debrief at the end was undertaken but not recorded. A new form has been developed that lists all actions taken before and after surgery as 5 steps to safer surgery requires.	closed
53	Theatre Lead	Brachytherapy	Patient Pathway Management	Ensure there is a risk assessment in place for transfer of an unconcious patient and that all risks mitigated as much as possible	achievement of recommendation	Risk has been mitigated as far as possible. A panel is placed into the door grove to level the surface during transfer (was used during CCC visit).	closed
54	Head of Brachytherapy	Brachytherapy	Patient Pathway Management	Consider specifying within the new building a larger treatment room to allow insertion of needles for prostate cases without moving the patient	achievement of recommendation	Route for prostates has been considered in depth in 1:200 nVCC design.	closed
55	Theatre Lead	Brachytherapy	Patient Pathway Management	Consider purchasing a pre-printed swab board and swab save containers to enable clear counting of swabs	achievement of recommendation	swab collection is acceptable to the AFPP guidelines.	closed
56	Head of Brachytherapy / Head of Integrated Care	Brachytherapy	Patient Pathway Management	Ward areas for the opposite sex to be admitted must be sought. In extreme cases, if this is unavoidable, a risk assessment should be in place along with a reporting system to investigate and track these incidents. Every effort should be made to ensure a private space maintaining patient dignity, for example curtains drawn at all times	achievement of recommendation	This was immediately addressed, all patients are nursed in a 4 bedded ward and when we perform Gynae cases on a prostate day. The male patients are cared for in a side room (if there is one available) or to a different area on CIU or vice versa. The booking of patients in on 'chemo care' by new admin assistant and we check the beds are allocated to the same sex each time. The new hospital will provide the brachytherapy service with it's own purpose built ward area staffed by Brachytherapy staff. Booking rules update to disallow.	closed
57	Head of Brachytherapy / Head of Integrated Care	Brachytherapy	Patient Pathway Management	Consider single bedrooms for Brachytherapy patients in the new building	achievement of recommendation	Head of Service ensures engagement of appropriate staff with nVCC. Engagement with nVCC team. Review CCC suit design. Ongoing engagement with Acorns monitored by BOG	closed
58	Head of Brachytherapy	Brachytherapy	Patient Pathway Management	Consider a review of perioperative pathway for applicator removal	achievement of recommendation	The current patient pathway for applicator removal has been reconsidered by MDT and assessed as best practice by CCOs and the theatre team and the anaesthetic consultant. Patients are seen by the anaesthetist during the pre-op assessment and are provided with the option of being awake for the removal if preferred, in this instance, an epidural would be used. This supports hollistic, patient centred care, and is only possible because of the support Velindre have from its' anaesthetics colleagues. The process is also quicker, causing less overall trauma for the patient. The theatre team and anaesthetist were disappointed that there were no consultants in attendance as they would have agreed that the practice was perfectly appropriate and allowed patients to have a choice on their treatment options.	closed
59	Head of Brachytherapy / Clinical Director	Brachytherapy	Patient Pathway Management	Consider alternatives to heavy sedation for applicator removal to release theatre time/capacity for patients	achievement of recommendation	Alternatives to heavy sedation reviewed and rejected by BOGAs Brachy Cardiff is fortunate to have an anaesthetist/ anaesthetic ODP available, to offer heavy sedation, this is the preferred method for removal. Conscious sedation is offered if this is not available. No sedation would be both painful and unpleasant for the patient. There are no trained staff available on the wards to remove the Gynae Instruments. No sedation would be both painful and unpleasant for the patient.	closed
60	Theatre Lead	Brachytherapy	Medicines Management	Perform monthly out of date stock checks and audits	achievement of recommendation	Monthly out of date checks are performed and documented.	closed
62	Theatre Lead	Brachytherapy	Medicines Management	Ensure appropriate storage of any substances	achievement of recommendation	All substances are stored in line with guidance from pharmacy, they have confirmed they are content with current storage process. Audit schedule (BOG Action log 48)	closed
64	Service leads	Brachytherapy	Training & Professional Development	Consider extended courses, for example POA	achievement of recommendation	Exetended courses considered. Where relevant covered in PADRs	closed

65	Nursing Line Manager	Brachytherapy	Training & Professional Development	Human Factors training for those working in theatre environments as recommended by NHS England	achievement of recommendation	Have reviewed this as NHSE training required - not replicated in Wales	closed
67	Theatre Lead	Brachytherapy	Miscellaneous	Policy and guidelines should be available. At minimum, a copy of Association of Anaesthetists of Great Britain and Ireland Guidelines should be available and easily accessible to staff. Consider a laminate copy of the guidelines to be displayed in the theatre area	achievement of recommendation	A copy of the Association of Anaesthetitsts of Great Britain and Northern Ireland guidelines have been printed off and are now kept on the shelf in the office to provide easy access for all staff. This is a large document and can be found on line.	closed
68	Theate Lead	Brachytherapy	Miscellaneous	Staff to have training and be able to locate equipment in the event of local toxicity.	achievement of recommendation	duplicate 10, 66,68,88	closed
69	Theatre Lead	Brachytherapy	Miscellaneous	Consider a portable difficult airway trolley with Difficult Airway Society Guidelines available for reference	achievement of recommendation	all staff mandatory training is up to date and regularly audited. All members of the team have re validated, difficult airway society guidelines are available in the Theatre office. BOG Action log 48	closed
71	Theatre Lead	Brachytherapy	Miscellaneous	Reduce number of staff within the perioperative environment and utilise the 'scrub' door instead of theatre doors if at all	achievement of recommendation	Discussed at BOG. Scrub door to be used during procedure raised at Feb BOG. Now in practice. Vistors booking system in practice . If theatres become too busy, clinical staff will ask trainees and visitors to leave theatre or clinical areas.	closed
72	Theatre Lead	Brachytherapy	Miscellaneous	Staff to work in another area when not directly involved in the procedure	achievement of recommendation	Recommendation reviewed. Review of nurse establishment complete and addtional posts recruited. On the rare occasion there are no patient treatments planned the agreed business process is for staff to report to their line manager for reallocation of duties	closed
73	Theatre Lead	Brachytherapy	Miscellaneous	Implement routine checks of all equipment for out-of-date items	achievement of recommendation	Routine checks in theatres are now in place. BOG Action log 48	closed
74	Theatre Lead	Brachytherapy	Miscellaneous	Consider moving to single patient use airways	achievement of recommendation	Anaesthetic team reviewed. All re - usable LMA's will not be renewed when they have finished their use and theatres will move to single use . There is a cost implication but it was agreed most theatre services, since COVID pandemic have now moved to single use. We will phase them out by the end of the year. BOG Action log 48 (audit schedule)	closed
80	RSM	Brachytherapy	Patient Management Pathway- Radiotherapy (VVBT / Skins)	Trained staff should not perform routine administrative tasks	achievement of recommendation	dedicated admin resource to Brachy in place	closed
89	Head of Brachytherapy	Brachytherapy	Communication & Collaboration	Better communication between teams and better understanding and insight into roles and responsibilities	achievement of recommendation	Training and comminication routes being trialled and reviewed and monitored by BOG	closed
90	RSM	Brachytherapy	Communication & Collaboration	Adopt a silent or 'sterile cockpit' approach during pre-treatment checks and treatment delivery in order to promote a safety culture	achievement of recommendation	Bilingual signs/posters have gone up as a reminder to other staff groups. Revised working practice in place and routine way of working. Continued monitoring through datix if incidents occur	closed
91	Head of Brachytherapy	Brachytherapy	Communication & Collaboration	Collaborative leadership for the service across the MDT should be emphasised and promoted rather than silo working in small teams	achievement of recommendation	BOG reporting to SLT and appointment of service lead foreum established for disciplines to come together on a regular basis	closed
92	Head of BRachytherapy	Brachytherapy	Communication & Collaboration	Introduction of MS Teams, electronic shared calendars, or other electronic methods of team communication should be considered where services are running parallel to each other	achievement of recommendation	MS TEAMS booking system in place. Monitored by BOG	closed
97	RSM Head of Brachytherapy	Brachytherapy	Training & Professional Development	Those working in Brachytherapy should join the Society of Radiographers Speical Interest Group for peer support and shared learning	achievement of recommendation	Discussions taken place within Directorate staff encouraged to engage with the Society	closed
99	RSM	Brachytherapy	Training & Professional Development	Consider the use of Patient Group Directions for all radiographers to be able to support side effect management and the needs of patients on treatment. Guidance can be sourced from the SoR and the specialist pharmacy services website	achievement of recommendation	change in service delivery model agreed PGDs withdrawn to follow new patient pathway	closed
101	RSM	Brachytherapy	Training & Professional Development	Consider, if possible, a stable team for a prolonged period to accelerate training and improvement	achievement of recommendation	3 AP Radiographers appointed &returned from Maternity leave in October Resilient team in development. 1 MPE role and 0.5 Checker role out for advert Staff to be trained to required competencies once in post with a view to whole team progression and succession planning. Staffing issues monitored by BOG	closed
104	Theatre Lead	Brachytherapy	Imaging Non-Medical Referrer	Nurses and AHPs should receive the appropriate training prior to being entitled to be an NMR for imaging. The training may be delivered in-house, e-learning or a combination of both. A policy or protocol should support the team to deliver this to allow trained staff to NMR scans, ensuring several team members are trained to avoid single points of failure	achievement of recommendation	Competancy records held within Diagnostic Radiology for non-medical authorisation of MRI and US imaging.	closed
105	Lead Brachytherapy MPE	Brachytherapy	Physics & Treatment Planning - RAKR	Consider commissioning the live for-treatment source within the Oncentra Brachy and Oncentra Prostate systems instead of a standard reference source, including incorporation of this into regular source change procedures, in line with recommendations within the dosimetery code of practice. The software with ten decay the source and this decay can be independently verified. This would also allow the planning system to produce dwell times directly comparable to the Flexitron and remove the need for an intermediate radiographer protocol sheet	achievement of recommendation	This is a recommendation in the Code of Practice, not a mandatory requirement. A robust and independent Flexitron source decay check process in place. An 'Intermediate radiographer protocol' is in place t Link to justification in #107 Mismatch of activity, and therefore planned and treated dwell times if the 'predicted time of treatment' does not match the treated time in practice. clinical review undertaken which has rejected this recommendation on clinical grounds by appropraitely qualified and regulated MPE and clinical governance manager. documented risk assessment in place	closed
106	Lead Brachytherapy MPE	Brachytherapy	Use of Off-Label Devices & Software	Consider if the in-house grid mount is required for prostate and consider reducing and removing use of in-house applicators where possible. If it is considered unavoidable to use non-CE marked devices and software then ensure a risk assessment is in place with appropriate mitigations identified	achievement of recommendation	No requirement to use CE marked devices. In-house manufactured are produced under quality standard likely to be recommended this year ISO9001:2015	closed

107	Lead Brachytherapy MPE	Brachytherapy	Use of Off-Label Devices & Software	Review the advice from the MHRA on off-label use of a medical device in the context of the clinical pathways when considering in-house software and in-house manufactured medical devices	achievement of recommendation	review complete	closed
108	Duplicate #106	Brachytherapy	Use of Off-Label Devices & Software	If it is considered unavoidable to use non-CE marked devices and software then ensure a risk assessment is in place with appropriate mitigations identified	achievement of recommendation	Duplicate #106	closed
110	Lead Brachytherapy MPE	Brachytherapy	Digital Security & Best Practice	Passwords should be removed immediately from documentation in the quality system and only known to and shared with authorised users	achievement of recommendation		closed
111	Lead Brachytherapy MPE	Brachytherapy	Digital Security & Best Practice	The team may wish to review whether any rationalisation is required on systems running Oncentra. A regular backup schedule of the Oncentra databases and key system files is also advisable if not currently in place, as well as documented recovery procedures that can be followed in the event of a non-recoverable system failure	achievement of recommendation	Recommendation reviewed Change request in QPULSE for BRAC 144 made to implement new procedure	closed
112	Lead Brachytherapy MPE	Brachytherapy	Treatment Planning (Prostate)	The BK ultrasound should be returned to the manufacturer for investigation prior to this issue becoming unrecoverable	achievement of recommendation	BK US unit returned for investigation. Repairs completed. US unit tp be monitored through routine QA and for any further recurrence of issues.	closed
113	Lead Brachytherapy MPE	Brachytherapy	Treatment Planning (Prostate)	Consider holding the MDT meeting prior to the theatre sesssion to discuss clinical and technical aspects of the procedure	achievement of recommendation	already in place at time of review	closed
114	Head of Brachytherapy	Brachytherapy	Treatment Planning (Prostate)	Review room layout to maximise access to all sides of the patient	achievement of recommendation	review of room set up undertaken	closed
115	Lead Brachytherapy MPE/ CCO	Brachytherapy	Treatment Planning (Prostate)	Consider turning the lights down to improve image viewing conditions, this may be helpful particularly for the post implant imaging	achievement of recommendation	Patients already considered on case by case basis at time of review	closed
116	Lead Brachytherapy MPE/ CCO	Brachytherapy	Treatment Planning (Prostate)	It may be helpful for the oncologist to discuss optimal set up with the physics/dosimetry team, particularly around position of the 1 line in relation to prostate and rectum	achievement of recommendation	Physics and clinicians liaise closely during pt set up, as recognised within physics WIs that sucess of the implant relies on this stage.	closed
118	Head of Brachytherapy	Brachytherapy	Treatment Planning (Prostate)	Consider use of the prostate outlining model available within Oncentra Prostate as this may be useful for outlining prostate	achievement of recommendation	use of the outlining tool considered. Clinicians confirmed utilisation would be requested for relevant patients	closed
119	Lead Brachytherapy MPE/ CCO	Brachytherapy	Treatment Planning (Prostate)	Planning with fewer needles tends to be better for the patient (less trauma) and provides improved plans by minimising dose to urethra	achievement of recommendation	Regular review of plans undertaken to determine appropriate needle usage with clinical oncologists and physics Formal review at BOG	closed
120	Lead Brachytherapy MPE/ CCO	Brachytherapy	Treatment Planning (Prostate)	Consider loading needles outside of prostate to improve coverage at base and apex	achievement of recommendation	Project link to #119	closed
121	CCO	Brachytherapy	Treatment Planning (Prostate)	One of our oncologists finds locking needles useful especially for small prostates which are prone to move	achievement of recommendation	Practice ceased in 2019 as previously not felt useful and impared image quality Confirmation at BOG	closed
122	Lead Brachytherapy MPE/ CCO	Brachytherapy	Treatment Planning (Prostate)	turn the lights down to improve image viewing conditions, as this may be helpful particularly for the post-implant imaging. Also, consider adjusting the ultrasound parameters to further optimise image quality	achievement of recommendation	Comments from VCC clinicians are very positive regarding image quality. It was noted by CCC during visit that the VCC image quality was superior to the CCC system. CCC have since investigated their system further, finding fault with their probe and it has been sent back for repair.	closed
125		Brachytherapy	Treatment Planning (Prostate)	As previously mentioned, it may be helpful for the oncologist to discuss optimal set up with the physics/dosimetry team, particularly around position of the 1 line in relation to prostate and rectum	achievement of recommendation	Duplicate of Rec #116	closed
126		Brachytherapy	Treatment Planning (Prostate)	Suggest exploring options of loading superiorly and inferiorly to improve coverage. Inserting fewer needles may reduce trauma to the patient	achievement of recommendation	Duplicate of #119 &120	closed
127		Brachytherapy	Treatment Planning (Prostate)	As noted in section 6.1, the RAKR should be updated in the TPS software at source change to the actual RAKR of the source, thus only requiring a single and verified entry. The software will then decay the source and this decay can be independently verified	achievement of recommendation	Duplicate of Rec 105	closed
128		Brachytherapy	Treatment Planning (Prostate)	As mentioned in section 6.2 the MHRA recommends that all medical devices for patient use have a CE mark as it shows that it has met the legal requirements for safety, quality performance when it is used as the manufacturer instructs, therefore should consider if this in-house software is required	achievement of recommendation	Duplicate of Recs #106, #107, #108	closed
129		Brachytherapy	Treatment Planning (Prostate)	As documented in section 3.7, consider paperless working to improve efficiency and reduce reliance on secondary data sources	achievement of recommendation	Duplicate of Rec #28	closed
130	Lead Brachytherapy MPE	Brachytherapy	Treatment Planning (Cervix)	Consider using the plan approval function within Oncentra Brachy to lock the plan while it is being checked, to reduce the risk of introducing an inadvertent change. If a partial intermediate check is required before final optimisation, consider whether additional checks later in the process are also required to ensure the first check remains valid	achievement of recommendation	Plan approval was in place prior to and during peer review. Checking process has recently been reviewed and updated by MPEs and checkers.	closed

Ref No	Service	Recommendation	Outcomes Required	Action to date	Action Due Date
HSE Irradiator 1	WBS Laboratories	Section 28(8) of the Health and Safety at Work etc Act 1974 requires me to inform your employees about matters affecting their health and safety.	Address Recommendation		
HSE Irradiator 2	WBS Laboratories	You have failed to prepare and rehearse adequate contingency plans to secure, so far as is reasonably practicable, the restriction of exposure to ionising radiation and the health and safety of persons who may be affected by reasonably foreseeable radiation accidents involving your blood irradiator	In consultation with your Radiation Protection Adviser, prepare detailed contingency plans for each reasonably foreseeable radiation accident identified in the radiation risk assessment for your blood irradiator.	Contingency plans agreed locally - discussion included Fire Safety Manager, Business Continuty Manager, Health and Safety Officer, Radiation Protection Advisors	
HSE Irradiator 3		Update your local rules to identify and incorporate summary of contingency plan	Address Recommendation	Contingency plans drafted into local rules Consultation with Fire Brigade held on 06/07/2023 Consultation with Police scheduled 12/07/2023	
HSE Irradiator 4		Give suitable and sufficient instruction to employees who may be involved with, or affected by arrangements and plans	Address Recommendation	Training cource developed by RPS (1 hour level 2), includes radaition safety and contigency plans. scheduled : 13/07/2023, 17/07/2023, 28/07/2023. Training to be delivered by Radiation Protection Services initially and then by local Radiation Protection Supervisors. Training to be added to Induction program for lab staff & security/estates staff. Training required for following staff groups : Lab staff (who use irradiator), security staff, estates staff. Other staff groups to be considered. Potential for further training at level for for all WBS staff - after consultation with Police and HSE	
HSE Irradiator 5		Rehearse the arrangements in the contingency plans at suitable intervals	Address Recommendation	Scheduled for 25th July 2023 - lessons learned will be sent	
HSE Irradiator 6		Take any other equally effective measure to remedy the said contravention	Address Recommendation	to be included in ongoing fire drill program	
HSE Irradiator 7		You have failed to provide radiation protection training to employees engaged in work with your blood irradiator to ensure they know the risks to health created by exposure to ionising radiation as a result of their work, the radiation protection procedures and precautions that should be taken in connection with that work and any specific requirements to prepare them for any events involving the irradiator	Address Recommendation		
HSE Irradiator 8		In consultation with your Radiation Protection Adviser, develop the scope of, and provide, appropriate radiation protection training for your employees who work with the blood irradiator;	Address Recommendation	Training cource developed by RPS (1 hour level 2), includes radaition safety and contigency plans. scheduled : 13/07/2023, 17/07/2023, 28/07/2023. Training to be delivered by Radiation Protection Services initially and then by local Radiation Protection Supervisors. Training to be added to Induction program for lab staff & security/estates staff. Training required for following staff groups : Lab staff (who use irradiator), security staff, estates staff. Other staff groups to be considered. Potential for further training at level for for all WBS staff - after consultation with Police and HSE	
HSE Irradiator 9		Set an appropriate frequency for periodic refresher training;	Address Recommendation	to be confirmed, but 2-3 years or after significant change	
HSE Irradiator 10		Employees not closely involved in work with the irradiator should be given suitable and proportionate information or instruction for them to avoid being unnecessarily exposed to ionising radiation.	Address Recommendation	To be considered following advice from Police	

Ref No	Recommendation	Outcomes Required	Action to date	Status
	In consultation with your Radiation Protection Adviser, prepare detailed contingency plans for each reasonably foreseeable radiation accident identified in the radiation risk assessment for your blood irradiator.	Development of Risk Assessment	Risk Assessment completed	Closed

Ref No	Service	Recommendation	Outcomes Required	Suggested SMART Actions	Operational Lead	Operational Oversight	Evidence of Delivery	Delivery Date	
Welsh Risk Pool Safety & Learning Team National Review of Venous Thromboembolisms (VTE) October - December 2020									
REF005		Implement a formal VTE Risk Assessment Tool for use in all patients admitted to VCC that is fully in line with the All-Wales Thromboprophylaxis Policy.	This should be incorporated within all inpatient clerking proforma's and be audited for compliance on a 3 month basis. These results should then be fed back to VCC Quality and Safety Committee for scrutiny and recommendation.	Once working group established (action point 1), to review current national Risk Assessment Tools (RAT) in use (including recommended DoH RAT). Agree RAT to be used in VCC, along with frequency of audit and feedback.	Principal Pharmacist, Clinical Services	VCS Medicines Management Group / VCS Q&S Group	Dec-22	Risk Assessment tool now in all clerking proforma's used across VCC. Monthly audit undertaken and fed back to thrombosis group	
REF006		Ensure all relevant front line clinical staff have formal training, awareness and understanding of Venous Thromboembolisms.	Training to be included as part of VCC clinical staff training requirements	Adopt the 2 national modules that have been developed on the recognition of symptoms and prevention of HAT into VCC. Include as part of Mandatory and Statutory training for all clinical staffs; or set completion targets (e.g. 50% of all relevant clinical staff by year 1 and 80% by year 2) Re-validation of training every 3-4 years.	Head of Nursing, Quality, Patient Experience and Integrated Care . W&OD Lead / Chief Pharmacist	VCS Q&S Group	Training plan and requirement to be agreed and in place by Sep-22	Training packages now available on ESR. Working being undertaken, lead by thrombosis group in collaboration with workforce and OD to make ESR training packages mandaoty. SBAR written and to be discusse at Medicines Management Group on Wednesday 24th May. If accepted, will then go to Quality, Safety and Performance and the Senior Leadership Team (SLT) If	Welsh Risk Pool VTE Report
REF041	WBS (North Wales)	Suitable premises, equipment and trained personnel had not been maintained to support the authorised activity of collecting plasma by apheresis at the Wrexham site, following suspension of the convalescent	A retrospective change control will be raised to record those actions already undertaken to remove the facility from use. This change control will also cover the suspension of other WBS plasma collection centres at the Welsh Wound Innovation Centre and Dafen, along with any associated risk(s). The BEA licence will be updated accordingly. The target date for submitting the BEA variation is 13/08/2022; the inspectors shall be copied in as requested.		Operational Senior Nurse		Aug-22	Action plan complete, with the exception of the BEA license update; this is currently being reviewed by MHRA (email received from MHRA 03/05/23). The MHRA inspector for WBS is aware of the delay (which is external to WBS). **040723** Awaiting external update.	HTA October 2022 HIW FFW Visit July 2022 MHRA North Wales Inspection June 2022
REF050	Welsh Blood Service	The establishment's systems and procedures for the oversight of one of the procurement satellites are not sufficiently robust to provide assurance that requirements for temperature monitoring and raw data retention will be met, or that any deviations or serious adverse events and	An investigation has been undertaken of the VCC Pharmacy temperature monitoring system and a CAPA plan agreed.	A review of the process for alerting VCC and WBMDR staff to temperature excursions has been completed and a new SOP put in place to cover this process (SOP 057, v1.0). Permanent temperature monitors have been placed in each of the 3 rooms used by the WBMDR at the VCC and WBDMR staff have been added as users to TempTrak software to enable monitoring of temperature profile and alarms (this will be in addition to VCC staff who will also be performing monitoring as per SOP 057). Stand-alone data loggers have also been placed in each room as back up for any system downtime due to connectivity issues. The SOP also requires VCC	Peter Richardson/Maria Cheadle		31/03/2023	HTA have been advised that the action plan is complete (evidence submitted via email 31/03/23). WBS are awaiting a formal response from HTA. **040723** Awaiting external update	

	1.1b update relevant meeting terms of reference to ensure clarity over the purpose of patient and donor experience reporting at each forum; and	**Medium**	b. Review all Divisional Departmental to SLT/SMT & Quality Group Terms of References to include oversight of patient / donor CIVICA feedback (including volume feedback, outcomes, improvement actions and ongoing trend and theme monitoring and the utilisation of feedback to inform prioritisation and decision making at all levels.	Nicola Williams, Director of Nursing, AHP's & Medical Scientists	Divisional Director WBS & VCC Alan Prosser, Director of WBS & Rachel Hennessy/Paul Wilkins Director of VCC	**Action Closed**	VCC - The Quality and Safety team are meeting with the directorate leads to ensure Civica is included as a key feature in each directorates meeting structures. The Q&S team are providing reports to ensure that feedback is widely shared and is regaulraly update using the 'knowing how we are doing' boards. the Q&S team are working with the meeting chairs to develop dashboards and identify the level of information and type of report required, developing individual questions which are department specific as requested and increasing use of the departement specific QR code. VCC now has a part time patient experince lead in place with responsibility and objectives set in relation to Civica - this post will become full time from April 1st 2023.	**Complete.** **VCC -** Communication made with all directorates to include CIVICA/ patient experience to their directorate management meetings TOR and standing agenda item. The Q+S team continue to work with meeting chairs to develop dashboards and identify the level of information and type of report required. This includes developing a monthly CIVICA patient feedback report to be sent to each directorate in readniess for their monthly meetings. From 1st April 2023 there will be a full time Patient Experience and Concerns Manager in post who will work closelywith directorates to develop individual questionnaires applicable to each area. The Integrated Care lead has met with the Value Based Health Care project consultants to discuss the the PROMS and PREMS work that has commenced and further work/meetings are planned with the PSC. **WBS -** Regulatory and Assurance Governance (RAGG) Review is being completed. Until the review is complete CIVICA Donor Satisfaction Survey results and concerns and compliments report are received, reviewed and reported within the monthly Donor

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Trust Infection Prevention Management Group Highlight Report

DATE OF MEETING	14th September 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	DISCUSSION

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Hayley Harrison Jeffreys – Head of Infection Prevention and Control
PRESENTED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences Hayley Harrison Jeffreys – Head of Infection Prevention and Control
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences

EXECUTIVE SUMMARY	The key highlights in the paper are: • Areas the Group requested escalation included ongoing challenge with IPC training compliance, no planned date for repairing of long-standing flooring repairs at VCC, dress code compliance, IPC assurance in respect of the new cancer centre and water safety at WBS. • Fungal growth had been identified in the VCC Pharmacy aseptic Unit in August 2023. The

	situation was managed robustly by the pharmacy team, external expertise sough and risk reduction measures put in place. All present, including the Infection Control Doctor, were assured in respect of actions taken at the time to reduce risk, ongoing actions and functioning of the Unit.

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

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 (IPCMG)	17th August 2023
Executive Management Board	31st August 2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Draft report **ENDORSED**. The Executive Management Board requested urgent action to be taken by both divisions in respect of the items identified for alerting and escalating. urgent make safe work requested in respect of the flooring in radiotherapy and plans to resolve the water pipe issue at the Welsh Blood Service as well as leadership and management action to resolve the uniform and IPC training compliance issues.	

7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 4 - Increased extent of impact from actions

APPENDICES	
	N/A

1. SITUATION

The Trust Infection Prevention and Control Management Group (IPCMG) has a core membership of Departmental Leads/Managers who are responsible for ensuring infection prevention and control training requirements, standards, and practices within their designated areas. Programmes for audit, training, surveillance, and policy provision are managed as key strategies for infection prevention and control. There is also an opportunity to share Good News Stories and share lessons.

2. BACKGROUND

The IPCMG meets quarterly. Divisional IPC meetings occur monthly and feed into this meeting, progress against the IPC standards is discussed, and priorities determined.

3. ASSESSMENT

The following is a summary of the key outcomes from the IPCMG held on the 17th August 2023:

ALERT / ESCALATE	• ***VCC Clinical Area Flooring*** – Several departments and main thoroughfares in the cancer centre require new flooring due to age and wear and tear. In particular, the flooring in public areas of the radiotherapy department was highlighted during a 15-step challenge and during the recent Healthcare Inspectorate Wales Inspection as being a Health and Safety and Infection Control hazard. The issue has been known for over 12-months and to date, there is no definitive plan to making the flooring safe and reduce the risks.

The estates team are compiling a business case for capital funds to replace the flooring and a formal risk assessment is also required. The Executive Management Board discussed the concern regarding the flooring and the VCC division is going to progress through capital programmes. Following the meeting it has been confirmed that the work will be completed between 28/10 2023 and 27/11 2023.

- ***Water safety in Welsh Blood Service*** – Progress has continued against the Trust Water Safety Plan with regular sampling undertaken. There have been repeated issues identified in the WBS which have been investigated and are potentially due to old pipework in the platelet laboratory and blast freezer. Extra filters and automatic flushing have been put in place to mitigate the risk; however further intervention is required to replace the pipework where it is thought the positive legionnaires is due to a biofilm in the pipe. A formal risk assessment has been requested.
  The Executive Management Board discussed the potential works which may be required to rectify to problems with water safety and the WBS division is going to progress this work.

- ***Compliance with Uniform Standards –*** An increasing issue of non-compliance with uniform standards is being reported across both Divisions. Appropriate management action is inconsistent when issues are flagged. In particular, compliance with the national bare below the elbow (BBE) and no nail attire requirements is a theme with, on occasions, unacceptable behavioural responses when staff are being challenged for being non-compliant with standards. It is the responsibility of department managers to ensure all staff comply with uniform and dress code standards.

  A revised All Wales Dress Code is expected to be released imminently via a Welsh Health Circular. Upon publication significant communication and engagement is required to make all staff and managers aware of the revised standards (not greatly different from the current except for strengthening requirements to meet cultural and religious requirements) and Trust expectations in relation to compliance.

  In the interim, the Executive Director of Nursing, AHPs and Health Sciences is making contact with the professional / departmental leads of the areas with repeated non-compliance / lack of appropriate management response to request leadership oversight and positive communications in respect of compliance with dress code.

	• ***Design Plans for the new Velindre Cancer Centre (nVCC)–*** It was escalated that there has been minimal progress of the Infection Prevention and Control agenda in relation the new cancer centre. Whilst sign-off of the design plans are progressing, they are accompanied by a list of derogations. There is also limited progress with finishes that are planned for use in the design. Not knowing what products are going to be used for areas in impacting decisions that need to be made regarding cleaning. SMART glass has been requested for window dressings as opposed to curtains and a decision is yet to be made and cost may be a factor which influences the final decision. It was agreed, that given the risks associated here the Executive Director of Nursing, AHP & Health Science would escalate to the senior nVCC team. • ***IPC Training Compliance –*** There have been fluctuations in IPC related training compliance across departments and divisions of the Trust. The infection prevention and control team will undertake a formal risk assessment on training compliance. The expectation is compliance of 95% is achieved and maintained. Departmental reports and action plans to achieve the expected compliance are reported into monthly divisional Infection Prevention and Control meetings.
ADVISE / ASSURE	• ***Aseptic Unit, VCC Pharmacy*** – A detailed report was submitted (and received by EMB) by the pharmacy department detailing fungal environmental deviations in the aseptic unit at Velindre Cancer Centre Pharmacy Department. Monitoring systems identified the organism and the National Quality Assurance lead investigated the aseptic unit in VCC and two other units in Cardiff. Recommendations including regular fogging with Hydrogen Peroxide have been made and the pharmacy team are working though the action plan, the progress of which will be brought to the next meeting. All present, including the Infection Control Doctor, were assured in respect of actions taken at the time to reduce risk, ongoing actions and functioning of the Unit. The full report is available via Nicola Williams if required. • ***Window cleaning at VCC*** – A window cleaning company has been identified for the cancer centre. The Trust Water Safety Group is awaiting a method statement to include how they clean and maintain their equipment, for assurance, before work can commence.

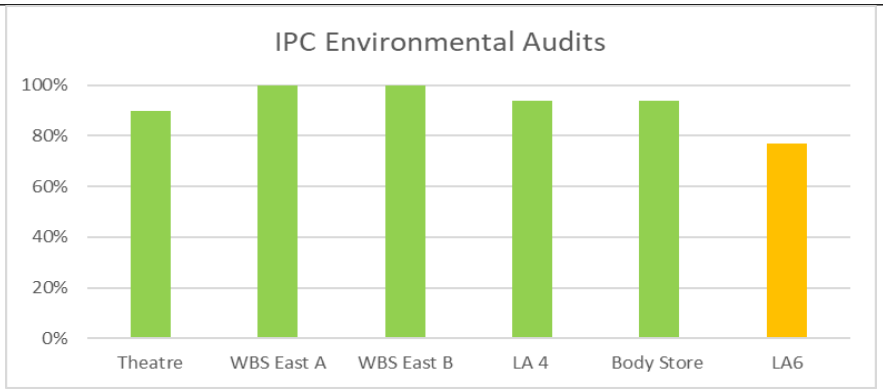
- The group **ENDORSED** the proposal that IPC 00 – Framework Policy for Infection Prevention and Control and IPC 11 – Transport of Specimens are to remain extant until November 2023 while they are being reviewed and updated. The Executive Management Board also ***ENDORSED*** this proposal.

- ***IPC Policy 09 – Infection Prevention and Control in the Built environment*** has been incorporated as a separate chapter in the National Infection Prevention and Control Manual (IPC 05). The chapter covers all the same information and includes all the relevant Health Building Notes and Health Technical Memorandum, which are required. The group **ENDORSED** the proposal to remove IPC Policy 09 from circulation. The Executive Management Board also ***ENDORSED*** this proposal.

- ***Carbapenemase Producing Organisms (CPO)*** are a group of gram-negative bacteria that usually live in the bowel however infection caused by these organises can be difficult to treat as they can produce enzymes which make most available antibiotics ineffective. Screening for this organism is a national requirement as is part of the in-patient admission screen which needs to be completed within 48 hours of admission. This practice has been embedded in practice since December 2022 with a launch of a standard operating procedure to detail the swabbing.

  Compliance with screening at VCC is recorded monthly has it has been slow to improve, the ward manager and clinical services managed have been asked to provide an action plan to improve compliance. To note two positive cases were identified on screening in the last month.

- **IPC Environmental Audits** – During the reporting timeframe several areas have been audited across both divisions of the Trust, results recorded in figure below.



To be recorded as compliant areas need to score 85% or more. All audited departments are provided with an action plan and a two-week timescale for completion, the same is shared with operational services and estates teams. Any areas not achieving compliance are re-audited following this time. Main areas of non-compliance are connected to flooring and paintwork which is part of the ongoing programme of work by estates.

- ***Healthcare Associated Infections -*** There were three cases of healthcare associated Klebsiella bacteraemia and two E. Coli bacteraemia during the reporting period. There have also been two cases of Clostridioides *diffilcle* identified.

HCAI Review April to July 2024						
Month	*C. difficile*	Bacteraemia cases				
		MRSA	MSSA	*E. coli*	*P. aeruginosa*	Klebsiella species
	2022-23 total no. of cases = 2	2022-23 total no. of cases = 0	2022-23 total no. of cases = 2	2022-23 total no. of cases = 6	2022-23 total no. of cases = 0	2022-23 total no. of cases = 1
Apr-2023	ZERO	ZERO	ZERO	1	ZERO	1
May-2023	ZERO	ZERO	ZERO	ZERO	ZERO	1
Jun-2023	ZERO	ZERO	ZERO	ZERO	ZERO	ZERO
Jul-2023	2	ZERO	ZERO	1	ZERO	1

Genomic testing, by PHW, of the C. difficile cases identified no links to each other or to any previous cases identified in Velindre cancer centre. RCA's have been completed for all cases and identified that although multiple causative risk factors were found, the gram-negative bacteria had the opportunity to translocate and cause infection due to extensive disease.
There was no evidence of transmission of infection or poor clinical practices or environmental hygiene standards.

	• ***Antimicrobial Representation*** - There has been no anti-microbial pharmacist at the last two IPCMG to provide assurance in relation to the Trust's Anti-Microbial reduction strategy. An Antimicrobial pharmacist has been appointed but is not yet in post. Anti-microbial reports have been provided but could not be discussed without pharmacy attendance.
INFORM	▪ **Public Health Wales** (PHW) shared a briefing from the Centre for Communicable Disease Surveillance (CDSC) which requested Health boards and Trusts in Wales review their ***preparedness for the management of potential measles cases***. This is in response to an outbreak being reported in England. Previous measles outbreaks in Wales have resulted in Trust staff working with OCCH service and offering MMR vaccinations to staff. Whilst awaiting further instruction from PHW if further escalation is required a suite of documents is being completed to support staff. A formal risk assessment with be completed for addition to the Trust risk register.

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)	06 - Quality and Safety

For more information: STRATEGIC RISK DESCRIPTIONS	
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). Trust IPCMG covers all aspects of Quality and Safety from an IPC perspective.
SOCIO-ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	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:
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	This is a highlight report following the Trust Infection Prevention and Control Management Group meeting.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

Quality, Safety and Performance Committee

Quarter 1 2023-24 – Quality & Safety Report

DATE OF MEETING	14th September 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
REPORT PURPOSE	DISCUSSION
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Trust Corporate Quality, Safety and Assurance Team
PRESENTED BY	Tina Jenkins, Interim Deputy Director of Nursing & Patient Experience.
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences

EXECUTIVE SUMMARY	The Velindre University NHS Trust Quarter 1, Quality & Safety 2023-2024 report covers the period 1st April 2023 to 30th June 2023 and describes the key outcomes, trends and themes in respect of: Complaints; Redress; Claims; Duty of Candour; Safety Alerts; Infection Prevention & Control; and Safeguarding. The report includes reporting data for the quarter and also to provide appropriate contextualisation two-year comparison data. Report highlights include: • **56** concerns were received. **45** were managed successfully as an early resolution (verbally resolved within 48 hours). **11** were managed as formal complaints under Putting Things Right regulations and all investigated and responded to within 30 working days. • All complaints were a low grade: **55** grade **1** and one grade **2.** • No complaints or incidents triggered either the Duty of Candour or were reportable to the NHS Executive as Nationally Reportable Incidents. There were **3** incidents

	reportable to Health Inspectorate Wales as IR(ME)R breaches. • **566** incidents were reported: **3** relating to Corporate Services, **464** Velindre Cancer Service and **99** within the Welsh Blood Service. **565** incidents after the initial management review were graded as no or low harm, 1 incident remained graded as moderate at the end of June in Quarter 1 and was identified as triggering the Duty of Candour Act in Quarter 2 (21st July 2023) following further investigation. • 56 safety alerts were received mainly pharmacy/drug related safety alerts. Following review, only **16 of the 56 alerts were deemed applicable** to Trust, **14** were pharmaceutical alerts, **1** Welsh Health Circular and **1** Patient Safety alert.

RECOMMENDATION / ACTIONS	To ***DISCUSS*** the quarter 1 Quality & Safety report and its findings.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Integrated Quality & Safety Group	29/08/2023
Executive Management Board	31/08/2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS • Recognised the collaborative working between the Corporate and division teams to improve quality and safety processes. • Recognised the importance of including learning and themes in future reports and the work being undertaken to strengthen this reporting.	

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 4 - Increased extent of impact from actions

APPENDICES	
N/A	N/A

1. SITUATION

The Quality & Safety Agenda across the Trust has been developing and refining over the past 4 years. The Integrated Quality & Safety Group continues to mature in respect of oversight and reporting. It is recognized that further work is required in particular in relation to evidencing learning and improvement as a result of concerns, incidents and claims.

2. BACKGROUND

This report sets out how the Corporate Quality and Safety team supports the delivery of Velindre University NHS Trust statutory functions and contributes to delivering its strategic aims.

This report is evolving through discussions at the Trust Integrated Quality & Safety Group and will continue to develop further in forthcoming months.

<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>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 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></td></tr>
</table>

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximized and in which choices and behaviors that benefit future health
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	Source of Funding: Other (please explain) The report contains details of legal claims against the Trust which give rise to financial impact in addition to potential reputational damage and lack of confidence in the services provided, all of which has the potential for adverse financial consequences. **Type of Funding:** **Revenue** Financial impact of the Trust claims is outlined in the Claims Policy, Welsh Risk Pool Procedures and Welsh Risk Pool Indemnity arrangements. **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*	Not required - please outline why this is not required
	A quarterly outcome report
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	In addition to litigated claims, the Trust is responsible for addressing Part 6 of the Putting Things Right Regulations. This places an onus on the Trust to ensure that concerns are properly investigated and appropriate Redress remedies offered. When both a breach of duty and harm and/or loss have been identified, amounting to a qualifying liability, the Trust is required to make a suitable financial offer within the PTR threshold (i.e. up to the maximum limit of £25,000). Concerns (consisting of complaints, incidents and claims), have legal and financial implications, as outlined above.
	Potential financial implications arise when it is identified that errors have occurred, omissions to act or there have been system failures

3. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

Welsh Blood Service
Gwasanaeth Gwaed Cymru

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

Canolfan Ganser Felindre
Velindre Cancer Centre

TRUST 2023/2024 QUALITY AND SAFETY REPORT QUARTER 1:

1ST APRIL 2023 – 30TH JUNE 2023

CONTENTS

1. INTRODUCTION

The Trust 2023/2024 Quality and Safety Quarter 1 report provides an analysis and summary of activities undertaken and compliance achieved in relation to Concerns, Ombudsman, Redress, Claims, Incidents, Safety alerts, Safeguarding and Infection Prevention and Control.

The report highlights compliance, legislation and actions taken to improve risk, manage concerns and lessons learned, the aim of which is to provide overall assurance to the Board on the actions taken. The purpose of this report builds on the strategic aims outlined within the Trust's Quality and Safety Framework.

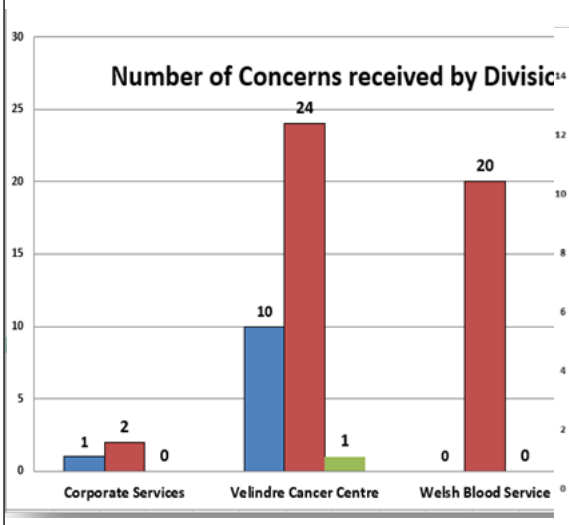
2. QUARTERLY PUTTING THINGS RIGHT INDICATORS AT A GLANCE (Concerns, Claims, Incidents, Safety Alerts, Safeguarding and Infection Prevention and Control.

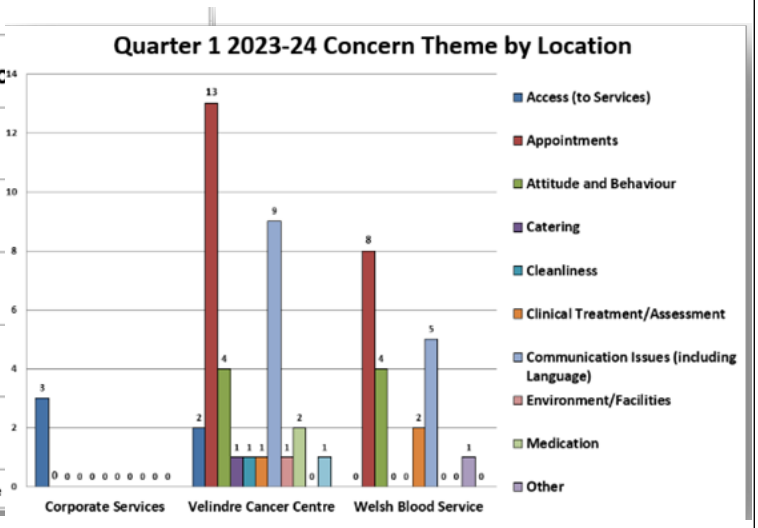
Velindre University NHS Trust Quarterly Indicators for 2022/2023 – 2023-2024					
	Q1 22/23	**Q2 22/23**	**Q3 22/23**	**Q4 22/23**	**Q1 23/24**
CONCERNS					
Trust Early Resolution (resolved within 48 hours**)**					
Early Resolution	***40***	***20***	***24***	***24***	***45***
Trust Putting Things Right (PTR) (formal**)**					
Trust wide PTR opened	***13***	**12**	**9**	**11**	**11**
Acknowledged within 48 hours	**13**	**12**	**9**	**11**	**11**
PTR closed within 30 days	**13**	**12**	**4**	**11**	**11**
PTR closed after 30 days	**0**	**0**	**5**	**0**	**0**
Concerns raised through Welsh language communication	**1**	**0**	**0**	**1**	**0**
OMBUDSMAN					
New Ombudsman cases	**0**	**3**	**0**	**1**	**0**
Open Ombudsman cases	**3**	**6**	**3**	**3**	**4**
Closed Ombudsman cases	**0**	**0**	**3**	**1**	**0**

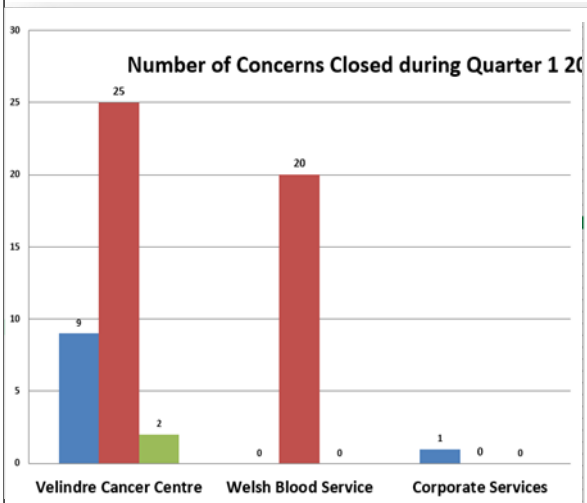
REDRESS					
New redress cases	**1**	**0**	**1**	**2**	**1**
Open redress cases	**3**	**4**	**3**	**4**	**5**
Closed redress cases	**0**	**0**	**1**	**0**	**0**
CLAIMS					
New claims received	**0**	**0**	**0**	**1**	**0**
Open claims	**8**	**7**	**6**	**5**	**5**
Closed claims	**0**	**1**	**1**	**2**	**0**
INQUESTS					
New inquests relating to Trust	**1**	**1**	**1**	**0**	**1**
Number of open inquests	**4**	**5**	**5**	**6**	**3**
Closed inquests	**0**	**0**	**1**	**1**	**0**
INCIDENTS REPORTED					
Corporate incidents	**6**	**7**	**2**	**2**	**3**
Velindre Cancer Service incidents	**388**	**444**	**385**	**501**	**473**
Welsh Blood Service incidents	**82**	**73**	**67**	**74**	**89**
National Reportable Incidents	**0**	**1**	**3**	**2**	**0**
IR(ME)R reported incidents	**3**	**4**	**5**	**7**	**4**
Total opened during quarter	**479**	**529**	**462**	**586**	**569**
SAFETY ALERTS RECEIVED					
Pharmaceutical alerts	**29**	**25**	**31**	**37**	**33**
Patient safety alert	**0**	**0**	**2**	**1**	**1**
Patient safety notice	**2**	**1**	**2**	**1**	**0**
Medical Device	**4**	**2**	**0**	**3**	**3**
Estates and facilities alerts	**1**	**0**	**3**	**14**	**14**
Welsh Health Circulars	**3**	**1**	**7**	**3**	**5**
Total received during quarter	**39**	**29**	**45**	**59**	**56**
SAFEGUARDING					
Adult Safeguarding reports raised	**3**	**2**	**4**	**2**	**5**
Child Safeguarding reports raised	**0**	**1**	**1**	**1**	**1**
Allegations of Abuse involving Trust treatment or Services at VCS	**0**	**0**	**0**	**0**	**0**
MARRAC Referrals	**0**	**1**	**0**	**1**	**0**
Concerns about Trust Practitioners	**1**	**0**	**2**	**0**	**3**
Deprivation of Liberty Safeguards	**7**	**1**	**7**	**1**	**2**
HEALTHCARE ASSOCIATED INFECTIONS					
Number of Clostridioides *difficile*	**0**	**0**	**1**	**1**	**0**
Number of Gram Negative Bacteraemia	**0**	**1**	**2**	**4**	**3**
Number of Staphylococcus Bacteraemia (including Meticillin Resistant)	**0**	**0**	**1**	**1**	**0**
Total Healthcare Acquired Infections	**0**	**1**	**4**	**6**	**3**

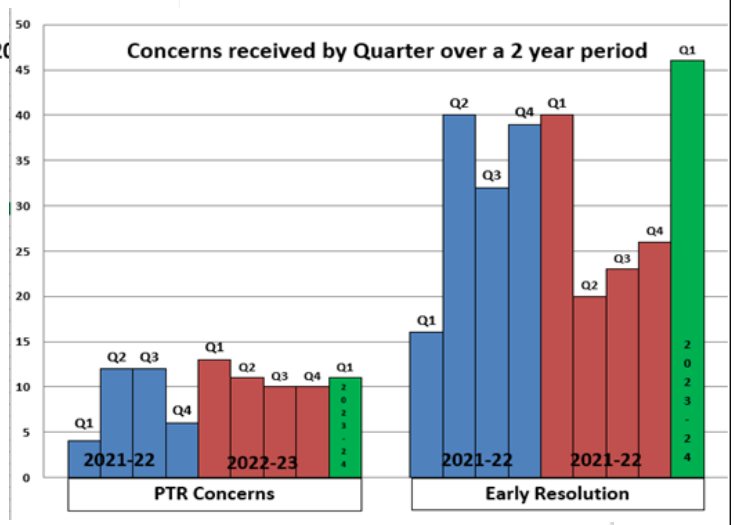
3. CONCERNS

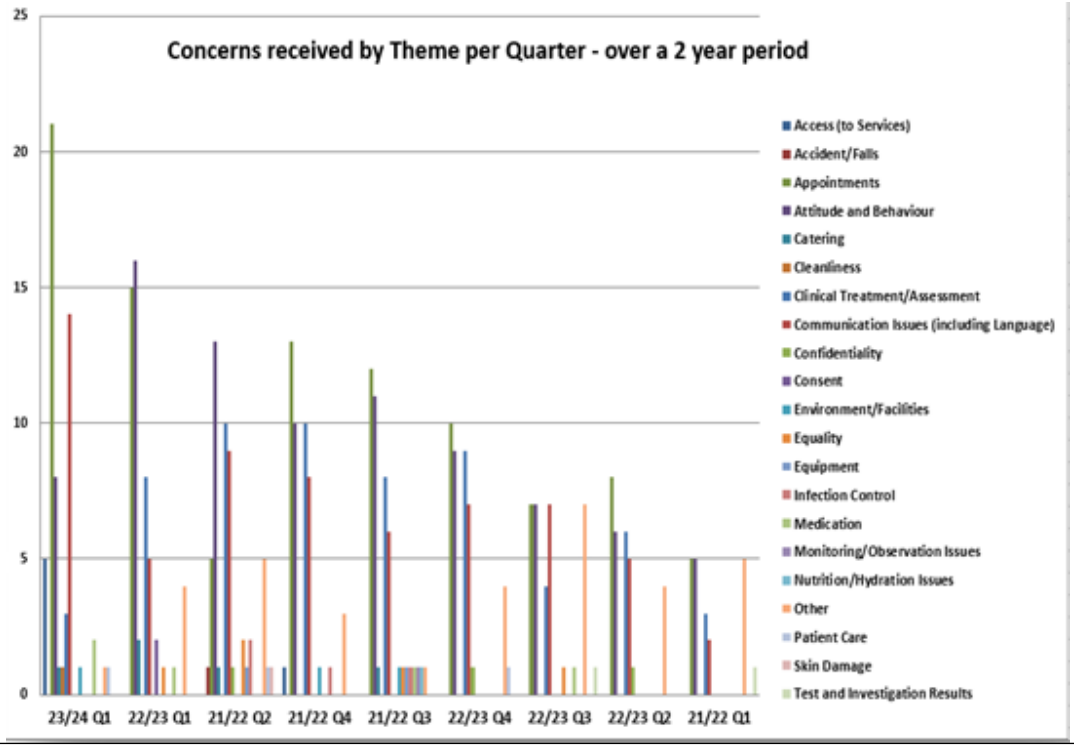
Concerns Summary	
***Velindre Cancer Service*:** **25** early resolution and **11** Putting Things Right concerns were raised, which is an increase in comparison to the previous quarter. (**5** early resolution and **11** Putting Things Right concerns) **1** concern was reopened. The **48-hour acknowledgement** and **30-day** investigation through to closure targets were **achieved** meaning that Velindre Cancer Service gained 100% compliance with the Putting Things Right regulatory requirements. **Top concern themes** related to clinical treatment & assessment, communication issues and attitude & behaviour.	***Welsh Blood Service*:** **20** early resolution and **no** Putting Things Right concerns were raised. The **48-hour resolution** targets were **achieved** meaning that Welsh Blood service gained 100% compliance with the Putting Things Right regulatory requirements. **Telephone** was recorded as the preferred method of contact. There were no **Covid related concerns** raised. **Top concern themes** continued to relate to appointments, attitude, and behaviour issues. There were no concerns graded higher than grade 1. All complainants were contacted to discuss their concerns raised and were happy with the outcomes of conversations and actions.


Number of Concerns received by Divisic
Corporate Services
Velindre Cancer Centre
Welsh Blood Service


Quarter 1 2023-24 Concern Theme by Location
Access (to Services)
Appointments
Attitude and Behaviour
Catering
Cleanliness
Clinical Treatment/Assessment
Communication Issues (including Language)
Environment/Facilities
Medication
Other
Corporate Services
Velindre Cancer Centre
Welsh Blood Service


Number of Concerns Closed during Quarter 1 20
Velindre Cancer Centre
Welsh Blood Service
Corporate Services


Concerns received by Quarter over a 2 year period
2021-22
2022-23
2021-22
2021-22
PTR Concerns
Early Resolution


Concerns received by Theme per Quarter - over a 2 year period
Access (to Services)
Accident/Falls
Appointments
Attitude and Behaviour
Catering
Cleanliness
Clinical Treatment/Assessment
Communication Issues (including Language)
Confidentiality
Consent
Environment/Facilities
Equality
Equipment
Infection Control
Medication
Monitoring/Observation Issues
Nutrition/Hydration Issues
Other
Patient Care
Skin Damage
Test and Investigation Results
23/24 Q1
22/23 Q1
21/22 Q2
21/22 Q4
21/22 Q3
22/23 Q4
22/23 Q3
22/23 Q2
21/22 Q1

EXAMPLE OF LEARNING:
A number of concerns raised relate to not being unable to contact departments on the telephone and booking appointments.

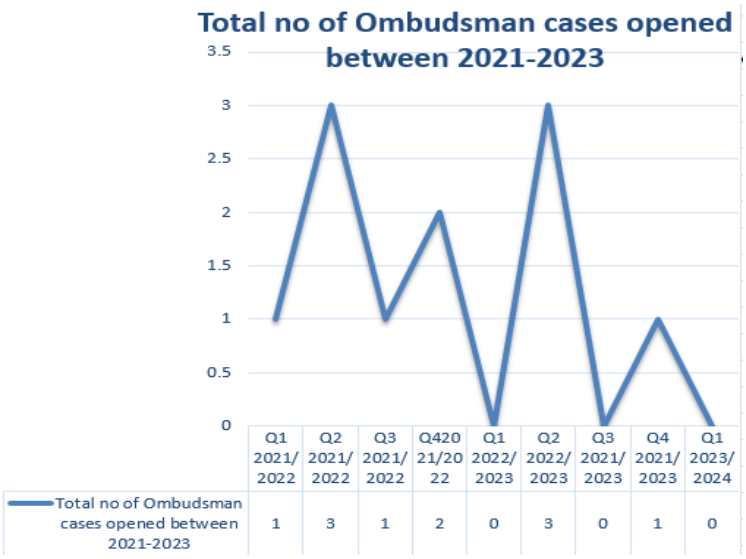
- Action has been taken to review the appointment booking Standard Operating Procedure and monitor compliance.
- Also, all medical secretaries have been requested to ensure all answer phone messaging is up to date and patients have clear instruction for contacts and call back.
- 3 concerns involved communication in the same team, multidisciplinary communication improvements have been made and the issues have resolved.

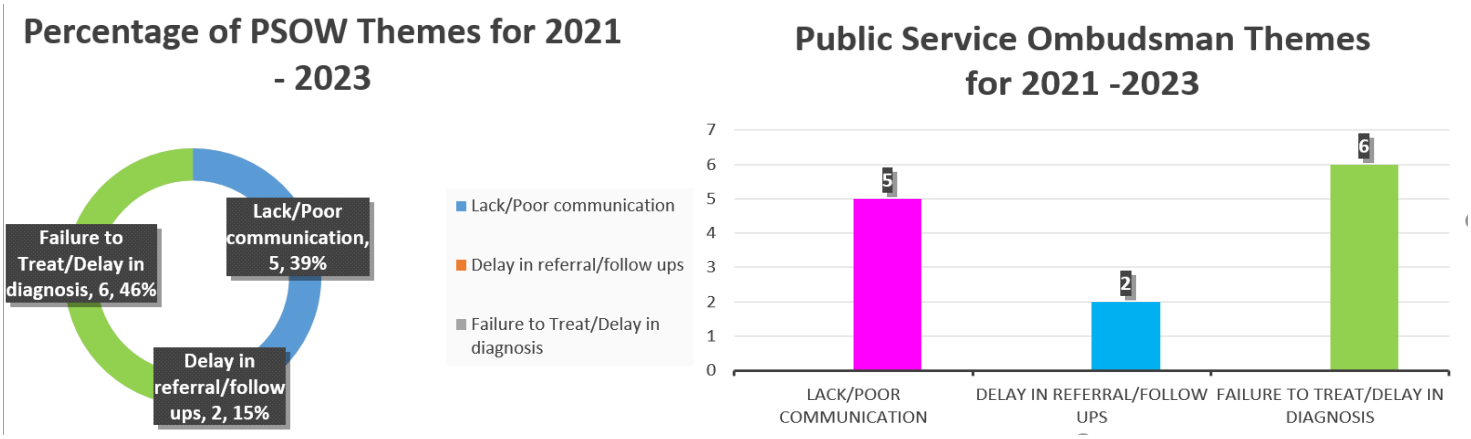
The Corporate team are supporting the divisions to ensure that learning is recorded on Datix when concerns are closed on the system. This will assist in identify learning and action taken for improvement.

4. PUBLIC SERVICE OMBUDSMAN OF WALES (PSOW)

The graph run below displays Ombudsman cases opened within the last 2 years:

No new Ombudsman cases were opened and no cases closed. At the end of June 2023 4 Ombudsman cases remained open. These relate to: delays in diagnosis and poor communication; delays in referral and appointment/follow up and; delay in treatment.





***Please note that in some instances, the figures for themes comprise of more than theme per complaint*.**

Ombudsman Overview

Overall, the Public Services Ombudsman investigates very few Trust-related concerns. When raised they are usually in relation to the Cancer Service and not the Welsh Blood Service.

Despite every effort to provide a comprehensive response to the issues raised, there will, on occasion, be complainants who will remain dissatisfied with a response. To help mitigate against this, the Trust offers the opportunity to meet with clinical teams to address any unresolved issues in the hope of reaching an amicable resolution to their concerns.

Look Back Analysis of PSOW Ombudsman Themes

During the quarter a look back comparison of PSOW investigations for 2021-2023 was undertaken to identify the main themes arising from PSOW complaints. It is identified that the highest themes relate to delays/failure to treat and poor/lack of communication.

Theme	Learning
Delays in treatment	It is the Trust's priority to ensure that patients are seen in a timely manner. The Trust has contributed to the development of an All-Wales multidisciplinary cancer workforce strategy to ensure that continuity of high quality care in the face of rapidly increasing demand is met to prevent delays in treatments. As part of addressing delays, the implementation of a Standard Operating Procedure (SOP) outlines the use of the Document Management System (DMS), which facilitates automatic transfer of approved letters to GP Practices. The SOP includes an escalation process whereby medical secretaries can escalate unsigned letters to the Medical Records Manager, and from there to the Directorate Lead, thereby minimising delays.
Failure to treat	When allegations are made in relation to the failure to treat, lack of treatment or allegations concerning treatment delays or delayed referrals, a review of the records and the concerns raised are undertaken by a senior clinical lead, to consider if there are any missed opportunities or failings identified. On reviewing the Trust's responses to the Ombudsman over the past two years, the Trust recognises the importance of professionals in using their appropriate clinical judgement when considering the safety, the risks of harm and benefits of investigations and whether such invasive action would be in the service user's best interests. In the vast majority of service users, treatment can lead to worsening fatigue and muscle weakness. Decisions around fitness for treatment are complex and rely on detailed experience of service user fitness, past and present, the cancer subtype and likely response rates to any treatment initiated. It is recognised that in many cases, despite appropriate clinical judgement, service users and families find it difficult in coming to terms with often complex diagnoses which are life threatening and have poor prognosis' in terms of outcomes. Managing expectation is crucial and can often be difficult, both for the service user, family and professionals involved.
Poor/Lack of Communication	As part of improving communication, the Clinical Director for Velindre Cancer Centre raised awareness amongst clinicians and clinical teams of the importance of improving communication with patients, families and other health professionals in a discussion at the Cancer Site Team Leads Meeting at Velindre Cancer Centre on the 19th May 2021. This message is also reiterated regularly as part of the Clinical Director's verbal report at monthly Trust Senior Medical Staff Committee meetings. Clinicians and clinical staff are reminded of the Department of Health Copying Letters to Patients, Good Practice Guidelines and the BMA Welsh Standards 12 to improve communication with their patients/service users. Following the implementation of the Welsh Patient Administration System (WPAS) in Velindre Cancer Centre in November 2022, this system will be the repository for a comprehensive Digital Healthcare Patient Record and is designed to improve communication between the Trust and Health Board teams, including community palliative and primary care services (i.e. GP practices).

Public Service Ombudsman of Wales' Public Interest Report – Significant Failings against Cardiff and Vale University Health Board

To ensure that the Trust persistently maintains a focus on learning and continuous improvement, the Public Interest Report, issued against Cardiff and Vale University Health Board, has served to highlight failings from which all Welsh NHS bodies can learn. In Q1 the Trust shared the findings of the Report with the Trust's Integrated Quality and Safety Group. In so doing, this helps to create an opportunity to proactively learn from the mistakes of others to prevent similar outcomes occurring within the Trust.

The report found significant failures following the admission of a patient who attended the Emergency Department of the University Hospital of Wales in March 2020 and was discharged home without proper assessment. The Patient was subsequently admitted to hospital, but sadly died despite undergoing emergency surgery. The Ombudsman identified that the patient had suffered a significant injustice and, the Trust failure to adequately deal with the concerns raised thereafter, resulted in tremendous distress to the family at a time when they were already suffering distress at the loss of their family member.

The learning from this case included:

- The need to balance and evaluate conservative management with risks and benefits
- To ensure that the patient's care does not fall below an adequate clinical standard
- To apply national, statutory and regulatory guidance.
- To communicate appropriately regarding decisions made concerning "Do not Resuscitate".
- To discuss cases in mortality reviews, identifying any inadequate assessments and produce an account of patient outcomes with reference to appropriate guidance and pathways
- To follow the Putting Things Right Regulations and Ombudsman's Principles of Good Administration, which provides a framework for all public services providers to fulfil their duties
- To scope and thoroughly investigate concerns to ensure a robust investigation is undertaken to prevent distress to bereaved families.

Key learning and actions taken forward by the Trust include:-

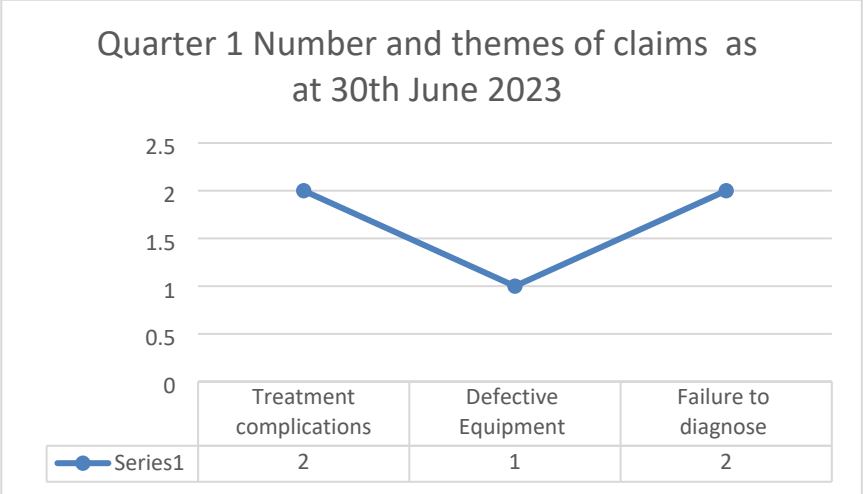
- The importance of robust concerns investigations involving families in an open, honest and transparent manner. This has been strengthened since the duty of candour came into force. Staff have been provided information and briefing, have been held and well attended.
- The corporate team are planning some Datix masterclass sessions, across the Trust. This will promote good record keeping and robust patient safety incident investigations.
- Reiterating the need to maintain good and accurate clinical records concerning treatment plans and the discussions had with service users and families are appropriately captured.
- A reminder for clinicians and staff to engage in effective communication to ensure there is efficient sharing of information, which not only reassures service users and their families/carers, but also aids in the decision-making process.

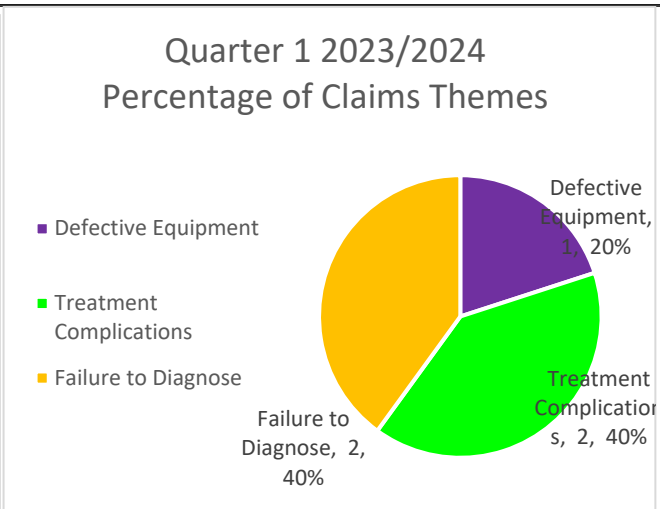
During Q1, the main actions taken to address learning are addressed below:-

Case Summary	Main Learning Points

Service user wrongly informed of cancer diagnosis following inaccurate data disclosure.	There has been a drive to implement new digital systems and functionality to enhance patient care and safety across NHS organisations and improve the data collated. Measures have since been introduced by the Trust to undertake quality checks before information is released to NHS health bodies. Additional digital data fields have been created in the system, thereby preventing a similar occurrence from happening in the future. It is envisaged that these improvements will contribute to an efficient and equitable service and ultimately improve service outcomes.
Failure to recognise and treat arterial bleed following donor donation.	Staff have been reminded of the importance of when to suspect an arterial bleed. Relevant standard operating procedures have been revised. The donor donation training package has been updated to include the key criteria for identifying an arterial bleed. The importance of recording accurate clinical information has been reiterated.
Failure to undertake appropriate UKONS triage assessment and escalate for medical review, following contact with the SACT Helpline.	A number of meetings have taken place to strengthen the processes concerning the SACT Helpline with the aim of preventing a future occurrence. This Redress case has been selected for consideration by the Safe Care Collaborative, a new initiative, whereby NHS colleagues from across Wales come together to discuss improvements in learning, with the aim of improving patient safety and care and mitigating against loss and risk. The following learning actions have been taken:- • Enhanced SACT training to include assessing and completing the UKONS triage tool; • Development of an escalation pathway for patients requiring urgent medical reviews • A SACT Treatment helpline Peer review is being commissioned.
Incorrect radiotherapy treatment administered, resulting in a potentially reduced dose of radiotherapy.	The following learning has been addressed as follows:- • The pathway to prescribe and justify the dose and fractionation for vaginal vault brachytherapy has been changed. The treatment must be justified by a practitioner licence holder before the exposure is delivered by an operator. • A refreshed formal medical induction programme has been introduced, and all new consultant staff have arranged meetings with Heads of Department including Radiotherapy, Medical Physics, Radiology and Nuclear Medicine. • All new junior medical staff receive induction training from relevant departments including Radiotherapy, Radiation Protection etc. This incorporates a formal 3-month period at the start of a consultant appointment (locum and substantive) for the doctor to meet with a senior colleague mentor to go through new cases and treatment plans for discussion. • Medical business team will now review and report against training compliance.

	• All Tumour Site leads will now ensure compliance with Peer Review of radiotherapy outlining as recommended by the Royal College of Radiologists. • Following the HIW inspection in 2019 an action plan is in place to ensure training is delivered and recorded accurately, and is accessible to relevant departmental leads. This includes the use of a radiotherapy passport for trainees.





Risk to Future Assurance/Performance: No immediate risk has been identified during the reporting period. 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.

Learning

When learning is identified, remedial actions are taken, and measures put in place with a view to preventing an occurrence. The learning is required to be submitted to the Welsh Risk Pool for approval of the actions taken within 60 working days when a decision is made to make an admission of liability or when it is agreed that there will be need to settle a claim given the litigation risk posed.

During the quarter an approval was granted to settle a clinical negligence claim involving the alleged failure to manage and treat appropriately an Oxaliplatin extravasation (Oxaliplatin is a chemotherapy drug used to treat certain types of cancers and is given as an infusion into a vein through a cannula. There is a risk that the Oxaliplatin can escape into the surrounding tissues by leakage or as an involuntary injection of the drug into the tissues. Whilst extravasation cannot be totally avoided because Oxaliplatin requires administration through IV or central vein injection, care is required to be taken to prevent and reduce the risk of extravasation and minimise tissue damage). Whilst no admissions were made, there are, nonetheless, vulnerabilities in continuing the defence of the claim given conflicting views expressed between senior clinical staff. Given the risk if the matter were to proceed to trial and the spiralling cost this would entail, Legal and Risk advised the Trust to settle the claim on an economic basis.

As part of learning, meetings have taken place with the divisional leads to explore and identify the learning. It has been agreed by the divisional leads that a review of the Trust's processes regarding extravasation will be

undertaken to assess whether these require strengthening. Work is being progressed to collate the evidence in readiness to submit a Learning from Events Report to the Welsh Risk Pool within the required timescale. It has emerged that a lack of clarity exists nationally in relation to the approach to be taken with regard to the management of related Oxaliplatin extravasation. Given the lack of national clarity surrounding this, the matter has now been taken forward by senior clinical leads and raised at the All Wales Cancer Network, in addition to discussing the issue with UKONS nationally, with a view to developing a national framework/guidance on the management of Oxaliplatin extravasation.

5. INQUESTS OVERVIEW

For a Coroner to determine the cause of death there is, on occasion, the need to obtain witness statements and information from staff engaged in the care and treatment provided to the service user, especially when death is unexpected, violent, sudden or unnatural. Witness statements are valuable in assisting the Coroner in the fact-finding inquiry concerning the circumstances surrounding a death, where the cause of death is unknown. It does not set out who is responsible for a death nor does it attach civil or criminal liability or attempt to apportion blame.

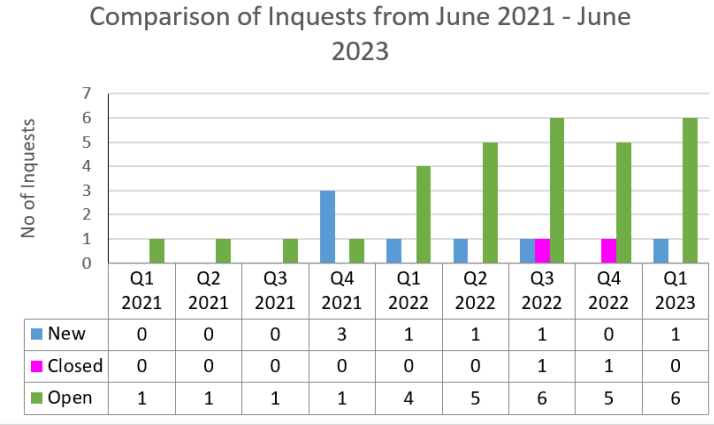
The following comparison of data collated for the period between June 2021-June 2023, indicate a rise in the number of inquests involving the Trust / Trust personnel. There was reduced inquests being held during the pandemic.

- No inquest hearings were held involving the Trust / Trust personnel
- One new inquest was opened, details of which are outlined below:

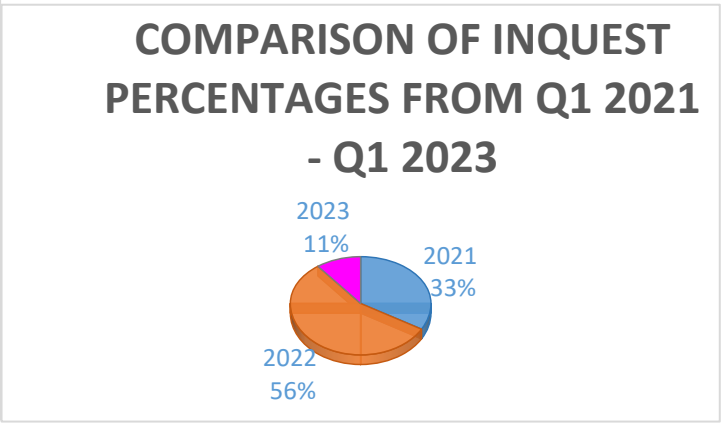
Inquest Case Summary	Progress of Inquest case
Patient admitted to hospital from home with a history of increased confusion, drowsiness, reduced oral intake, abdominal pain, vomiting and multiple falls prior to passing away. Patient was suffering with progression of known peritoneal mesothelioma secondary to asbestos exposure which had failed to respond to palliative chemotherapy and immunotherapy.	• His Majesty's Coroner requested a statement with regard to Velindre's involvement regarding the care and treatment provided to the patient concerning the oncology input provided. A Witness Statement was disclosed on behalf of the treating clinician within the time specified. • The findings were that whilst the patient tolerated treatment well there was continued deterioration from cancer progression. • A decision was taken to stop treatment and refer the patient to the community palliative care team. No further oncology input was required. • No issues have been flagged concerning the Trust's involvement regarding the care and treatment provided. • The Trust awaits the inquest hearing date.

- No inquests were closed

- No witnesses for the Trust were summoned to attend a hearing to give evidence
- At the end of June 2023, 6 inquests are awaiting hearing dates.



	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023
New	0	0	0	3	1	1	1	0	1
Closed	0	0	0	0	0	0	1	1	0
Open	1	1	1	1	4	5	6	5	6



Learning

When an inquest is received, the Trust looks at any learning that might be applicable to the circumstances surrounding death and if there is anything that can be done or put in place to address any inefficiencies. Learning was identified following an inquest that took place during quarter 3 last year which is detailed below:

Case Summary	Outcome	Main Learning Points
Patient receiving radiotherapy treatment at Velindre Cancer suffered PEG in-situ infection, leading to sepsis and death.	The Coroner issued a Regulation 28 Prevention of Future Deaths Report against Cardiff and Vale University Health Board and Abbots Care for failings in the care provided	It has been identified that there is a need for 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. The following actions are being progressed: 1. **Review and update** of Velindre Cancer Centre policies and Standard Operating Procedures in relation to care of head and neck cancer patients are in the process of being updated 2. **Sustainable Change –** Staff participation in Wales 'spread and scale' workshop in March 2023. This training will be used as the methodology for making sustainable change. 3. **Roll out** NEWS Cymru, Sepsis Bundle update and update Acute Kidney Injury bundle throughout April 2023 4. **Introduction** of alert cards from the UK Sepsis Trust. 5. **Wider learning** shared across Trust, including Velindre Cancer Centre Professional Nursing Forum, Velindre Cancer Centre Quality and Safety Management Group and the Head and Neck Site Specific Team Leads meeting.

6. INCIDENT REPORTING

Patient safety incidents are any unintended or unexpected incidents, which could have, or did, lead to harm for one or more patient's/ donor's receiving healthcare. Incidents are reported on Datix, the reporting. Incidents are reviewed at site and area level via their respective Quality and Safety leads.

Overall, across the Trust **566** incidents were reported: **3** related to corporate services, **464** reported within Velindre Cancer Service and **99** within the Welsh Blood Service**. 565** incidents after the initial management review, were graded as no or low harm, 1 incident remained graded as moderate at the end of June in Quarter 1.

514 incidents were investigated and closed during the quarter. **52** remained after a 30-day period. Monthly meetings have been arranged between the corporate team and divisions to assist the timely investigation and appropriate closure of incidents.

The Highest number of incidents are at VCS the themes a shown in the graph 3 below, and relate to treatment and procedures, Medication and Communication.

LEARNING:

Although incident figures have seen a rise during this reporting period, this is an indication that staff are reporting and capturing more incidents than seen previously. This enables the Trust to undertake an in-depth analysis of incidents, identifying where the incident was reported, the reasons giving rise to it and an evaluation of key themes.

Further work is required to develop and effective Datix system and dashboards that allow information analysis, learning and actions. The corporate team are supporting the divisions to ensure that learning from incidents is identified and reported through the divisions.

7. NATIONAL REPORTABLE INCIDENTS

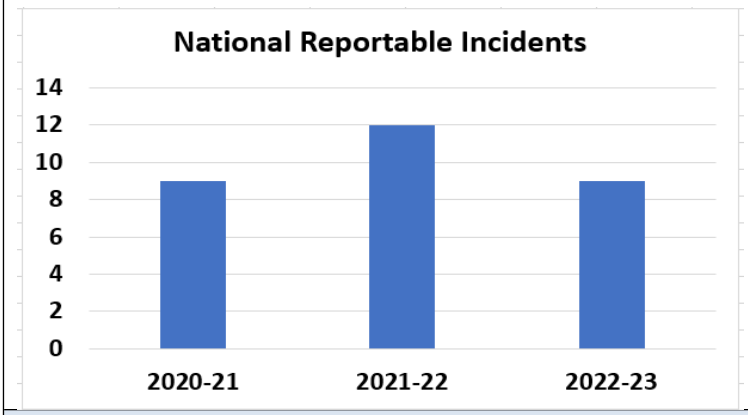
National Reportable Incident

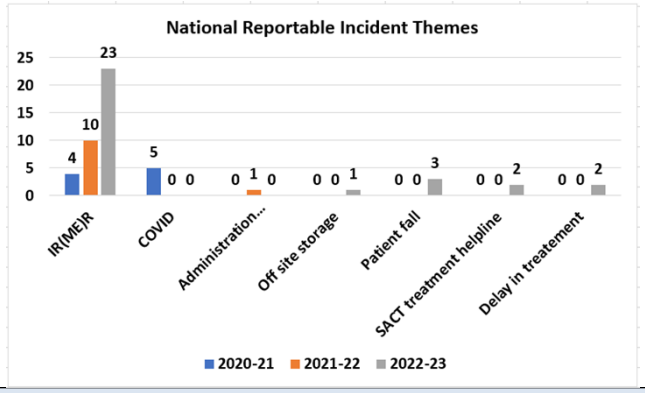
A safety incident should be nationally reported if it is assessed or suspected an action or inaction in the course of treatment has or could have caused or contributed to their severe harm or death. This is now referred to as a nationally reportable incident. There were **no** nationally reportable incidents.

Health Inspectorate Wales

Radiotherapy remains the area recording the highest number of incidents, a number of these incidents are in relation to a known international manufacturer fault with the radiotherapy system. The Radiation Service is continuously look to new ways of mitigating this known fault as the company cannot resolve the issues.

The Ionising Radiation (Medical Exposure) Regulations 2017 are designed to protect people while undergoing examinations and treatment. Where there is unintended or accidental exposure to ionising radiation this must be investigated. IR(ME)R notifications are reported to HIW The Trust reported **3** ionising radiations (medical exposure) regulation IR(ME)R incidents to Health Inspectorate Wales, investigations are underway.





LEARNING:

1 national reportable incident was closed within 90 days and reported to the NHS Executive, as per nation process, within 90 working day timescales. It related to a patent who had not received appropriate follow up, on discharge. Learning identified includes.

Task Factors: There is some lack of clarity of the role of the named consultant and the consultant on-call in the discharge process. It needs to be established if the VCS discharge policy and checklist is being used and fit for purpose.

Communication

- Lack of clear guidance and documentation on which team and organisation was to follow up the patient.
- Lack of communication with GP about one vital aspect regarding the patient's hormone medication
- Lack of communication with the VCS named registered Consultant about the patient's care and discharge.

- Consistent and clear training for ward clerks, junior doctors, and all other staff on the importance of MDT referral, oncology medications and outpatient appointments for patients undergoing ward discharge.

VCS have developed an action plan that will be included and monitored through the Trust Quality and Safety Tracker.

8. DUTY OF CANDOUR

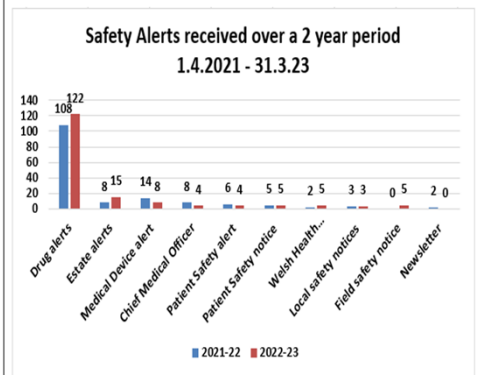
The Duty of Candour applies if the care we provide has or may have contributed to unexpected or unintended moderate or severe harm, or death.

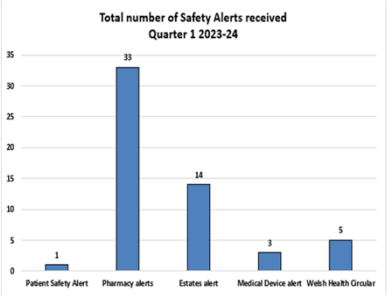
There were **no** incidents during the reporting period that have triggered the Duty of Candour, however one incident reported in Quarter 1 was identified as triggering the Duty of Candour Act in Quarter 2 (21st July 2023) following further investigation. The Corporate quality and safety team have introduced a process to review all incidents that have been graded as moderate harm or above. The divisions are working closely with the quality and safety team to ensure that these are investigated in a timely manner to ensure that the Trust is able to comply with the Duty of Candour timescales.

There were however, **18** incidents reported with a harm grading of moderate or above. Following harm review all were regraded and the level of harm reduced. All incidents were assessed against the Duty of Candour criteria and no cases were reported.

There is no definition of harm graded on the system when an incident is initially reported. This has been discussed with the Once for Wales Team as a consideration to improve incident reporting. This would assist reporters to grade incidents more accurately at time of reporting. The divisions are supporting staff to accurately grade incidents in departments.

9. SAFETY ALERTS





The Trust received **56** safety alerts: **1** patient safety alert; **3** medical device alerts; **14** estates alerts; **5** Welsh Health Circulars; and **33** pharmaceutical alerts. All were reviewed by the Quality and Safety team on receipt and the detail of each alert was circulated via the Datix version 14 system. Following review, only **16 of the 56 alerts were deemed applicable** to Trust, **14** were pharmaceutical alerts, **1** Welsh Health Circular and **1** was a Patient Safety alert.

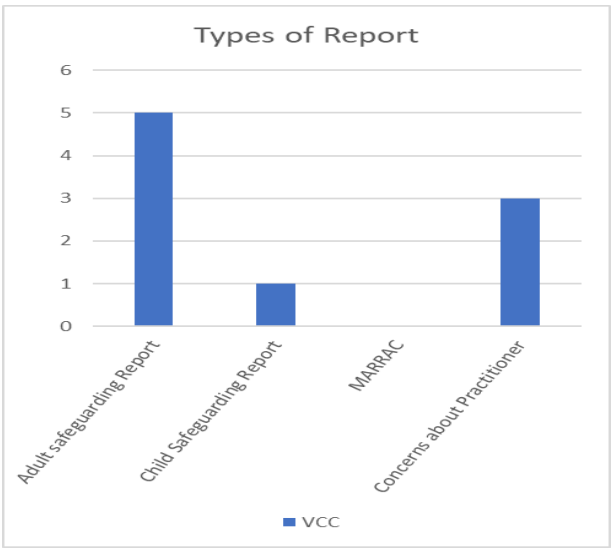
The patient safety alert was PSA008: Nasogastric tube misplacement: continuing risk of death and severe harm.

- The detail of the alert was reviewed and circulated across the Trust. Many of the actions from the Patient Safety Alert are being addressed within the Enteral Tube task & Finish group. The Jejunostomy and gastrostomy tubes policies will combined as one document and the existing Nasogastric (Ng) tube policy will remain separate and aim to be replaced by the All Wales Ng tube policy once it is released.
- Actions implemented are as follows:
  - Training on the use of the AspHirate pH strips effective from 1st April 23.
  - Competency Assessment to be completed by nursing staff to insert Ng tubes.
  - Formal consent process being introduced.
  - Risk assessment to be carried out prior to the insertion of any Ng tube.
  - Data to be shared with ICOG.

The Trust's Chief Pharmacist has provided assurance that the required risk assessment has been completed and actions are being progressed to ensure the Trust will be fully compliant with the alert.

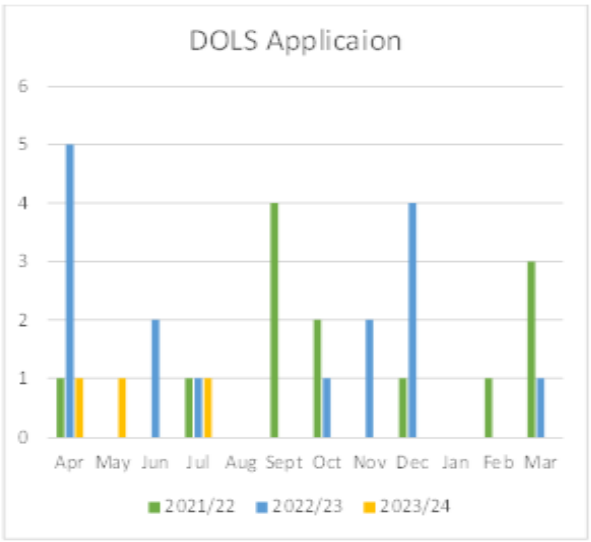
10. SAFEGUARDING

Safeguarding summary
5 duties to reports were raised to the local authority in line with the Wales Safeguarding procedures, following disclosures or allegations of abuse. **None of these** allegations related to care within the Trust. **2** were allegations of neglect, **2** were allegations of emotional abuse and there was **1** allegation of financial abuse. All reports were raised by Velindre staff following concerns raised by patients or family members. All Safeguarding reports are managed through the Safeguarding module in the Once for Wales Datix system. This ensures that information is sensitive information is stored securely. **2** applications for Deprivation of Liberty Safeguards (DoLS) were made for patients unable to consent to their care arrangements. Safeguarding supervision and support has been accessed across the Trust. Domestic abuse disclosures remain the most common theme that requires safeguarding supervision. There was an increase in professional concerns with **3** reports were made, there were no themes or trends in respect of these. **2** allegations were relating to issues that occurred in employee's personal life. **1** concern was regarding allegations of inappropriate conduct in the workplace, this was not relating to patients or donors. There has been a vacancy for the Head of Safeguarding post between 1st of July 2023 and 15th October 2023. The Interim Deputy director of Nursing is providing safeguarding supervision and advice pending the recruitment of the new head of Safeguarding and Vulnerable Groups.



10.

H



11. INFECTION PREVENTION & CONTROL

Healthcare Associate Performance Summary

HCAI Review Quarter 1 – April – June 2023						
Month	*C. difficile*	Bacteraemia cases				
		MRSA	MSSA	*E. coli*	*P. aeruginosa*	Klebsiella species
	2022-23 total no. of cases = 2	2022-23 total no. of cases = 0	2022-23 total no. of cases = 2	2022-23 total no. of cases = 6	2022-23 total no. of cases = 0	2022-23 total no. of cases = 1
Apr-2023	ZERO	ZERO	ZERO	1	ZERO	1
May-2023	ZERO	ZERO	ZERO	ZERO	ZERO	1
Jun-2023	ZERO	ZERO	ZERO	ZERO	ZERO	ZERO

There was one case of E. coli and two Klebsiella bacteraemia's during the reporting period.

Route cause analysis investigations have been completed for all cases and identified that although multiple causative risk factors were found, the gram-negative bacteria had the opportunity to translocate and cause infection due to extensive disease. There was no evidence of transmission of infection or poor clinical practices or environmental hygiene standards.

12. CONCLUSION

In summary the report provides positive assurance on the Trust position. There has been continued improvement in organisational compliance with the concerns process. Concerns, Claims and Patient Safety Incidents have been managed effectively in line with putting things right, local, and national policy. There is evidence of action taken to identify learning within the report, however more work is required to identify themes and triangulate the learning.

The report in quarter 1, also includes oversight of Safeguarding and Infection, Prevention and Control activity for assurance. There are low numbers of hospital acquired infections and evidence of a robust investigation process. The Trust is meeting its safeguarding requirements and no reports have been made that involve allegations of abuse or neglect, involving our services across all divisions.

13. PRIORITIES FOR QUARTER 2, 2023-24

The following are the priorities being taken during Quarter 2:

- Both divisions to focus on reviewing departmental incidents raised via the Datix system and that have been open for over 30 days, to successfully investigate and close any outstanding incidents.
- To strengthen investigations and to effectively capture learning and outcomes from new concerns and incidents reported during Quarter 2 2023-24.
- To improve the quality report and include patient experience information.

- To work closely with the divisions to identify learning from concerns and incidents.
- Commence the SACT Treatment Helpline Peer Review.

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

The Medical Examiner Service and Velindre University NHS Trust

DATE OF MEETING	14th September 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	Viv Cooper, Head of Nursing & Integrated Care
PRESENTED BY	Jacinta Abraham, Executive Medical Director
APPROVED BY	Jacinta Abraham, Executive Medical Director
EXECUTIVE SUMMARY	The report provides an update regarding the implementation of the Medical Examiner Service and the wider work of mortality and morbidity within VCC. VCC continues to meet the statutory requirements around the MES. There is progress being made in the formal reviews of mortality and morbidity including VCC inpatient deaths and death within 30 days of SACT and 30/90 days of radiotherapy by the clinical teams. This work will now progress at pace due to the new appointment of the

	Mortality and Improvement Facilitator who started her role at VCC on 21st August 2023. An issue on the accuracy of the death data recorded within Velindre's Welsh Patient Administration System (WPAS) since the implementation of the Digital Health & Care Record has been identified and is urgently being investigated. Inpatient data is not affected, 30-day Mortality data reporting is affected by this, and whilst this being resolved a contingency for the data to be checked and validated before publishing is in place.

RECOMMENDATION / ACTIONS	The QSP Committee is asked to NOTE the contents of the report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
VCC Quality and Safety Management Group	24/08/2023
VCC SLT	23/08/2023
Executive Management Board	31/08/2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Approved by SLT Approved by EMB	

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 2 - Symptomatic issues being addressed *Dedicated mortality and morbidity resource now in place and BI issues escalated appropriately currently being addressed.*

APPENDICES	

1. SITUATION

1.1 This report is provided as an update to the Quality, Safety and Performance (QS&P) Committee regarding the implementation of the Medical Examiner Service requirements within Velindre University NHS Trust.

This paper is provided for the QS&P Committee to:

- Have an overview of the high-level outcomes.
- **NOTE** the progress that has been made in implementing the revised mortality review process, the progress made since the last update was provided and the priorities and plans for the next 6-month period.

2. BACKGROUND

2.1 The Medical Examiner Service (MES) was implemented in England and Wales in response to The Shipman Inquiry and Mid Staffordshire NHS Foundation Trust Public Inquiries. These require a common approach to death certification and independent scrutiny of all deaths to allow the cause of death to be more accurately identified, and the circumstances surrounding the death to be more objectively assessed in order to identify any concerns about the treatment or care provided that may require further investigation.

2.2 Since autumn 2021, the MES reviews the medical records for all patients who die at Velindre and consults with the treating team to determine the cause of death so that the death certificate can be completed at VCC. As part of this process, the MES completes a comprehensive mortality review and feeds back any issues they identify to VCC / relevant Health Board. The MES also contacts the Next of Kin to discuss the cause of death and allow them the opportunity to raise any issues about the care the patient may have received (at any point in their illness). This process has now become fully embedded and operational across Wales.

2.3 Health Boards and Trusts within Wales must have in place arrangements to meet statutory requirements, which include:

a) Arrangements to provide timely notification of the death (within one working day) to the relevant Medical Examiner Office.

b) Arrangements for electronic access (within the same working day) to relevant clinical records, via "scan and send" paper records or direct access to clinical systems (data sharing agreements already exist to support this).

c) A mechanism for providing timely access to the Qualified Attending Practitioner (within three working days of notification of death). The Qualified Attending Practitioner is a doctor representing the clinical team that last treated the deceased before they died.

d) A named contact and email drop box, to receive and act upon any referrals from the Medical Examiner Service for further review or investigation.

2.4. The Trust is currently meeting the minimum inpatient requirements by absorbing the requirements described above into the role of ward administrator, though there remains further work to do. The Cancer Centre has been working to develop a sustainable delivery model for the overall coordination of mortality requirements.

3. ASSESSMENT

3.1 **Progress achieved since the last reporting period.**

3.1.1. <u>The MES Case Review Panel</u>

This panel meets when required to discuss any referrals from the MES. In the period 1st February 2023 – 31st July 2023, there were 20 deaths in VCC and 3 referrals from the MES (the same number of referrals as the previous reporting period). Two of the referrals were due to the patient receiving SACT within 30 days of death, and one was due to feedback from the patient's family.

The referrals are reviewed in the MES Review meetings, the purpose of which is to highlight where improvements may be required and to identify learning. This learning is then fed back to the individual consultant or Site-Specific Teams.

3.1.2. Re-establish the VCC Inpatient Mortality Review Group

The VCC Inpatient Mortality Review Group has been re-established and is chaired by Dr Jillian Mclean. It is a monthly meeting that reviews the inpatient deaths from the previous meeting by utilising the MES reviews, receiving feedback from the patient's consultant and the ward doctors and nurses. The review focuses on identifying areas of good practice and areas for improvement and ensure the learning is actioned. In the period 1st February 2023 – 31st July 2023, there were 20 deaths in VCC. The Inpatient Mortality Review Group re-established in May. All inpatient deaths from May have been reviewed by the Inpatient Mortality Review Group as well as the MES (and all cases before May have been reviewed by the MES). The deaths were all anticipated and had appropriate Do Not Attempt Resuscitation orders in place. All patients were also appropriately cared for using the All-Wales Care Decision Guidelines and there was evidence of good communication with the patients and their families. All patients had a high level of palliative care input. The learning identified from the reviews is mainly around the completion of assessment paperwork and identifying clear referral routes for dietetic input.

3.1.3. Appointment of band 5 Mortality and Improvement Facilitator

An appointment has been made into the role and the successful candidate due has started the role on 21st August 2023. The priorities for this role will be:

a) allow VCC to move forward with the mortality and morbidity review of patients who have died within 30 days of SACT and 30/90 days of radiotherapy. Initial work will be to review the pilot that was undertaken in colorectal SST and build on that.
b) establish an overarching Mortality Group for VCC which will oversee the delivery of the Trust's mortality review and improvement processes, in line with All Wales Learning from the Mortality Review Model Framework, National Chemotherapy Advisory Group and the Department of Health. This group will support the collation and analysis of all mortality data, providing a statistical and thematic base to support quality improvement and clinical audit and inform the research agenda and aid the development of services.
c) continue the strong working relationship VCC hold with MES
d) support the Inpatient Mortality Review Group

3.2. National Reporting Requirements for 30 day Mortality

- **3.2.1.** Implementation of the additional national reporting requirements from April 2023:

  30-day mortality - Radiotherapy & SACT (Systemic Anti-Cancer Therapy)
  - % patients who passed away during 30 days of curative SACT
  - % patients who passed away during 30 days of palliative SACT
  - % patients who passed away within 30 days of palliative radiotherapy
  - % patients who passed away within 90 days of curative radiotherapy

An issue has been identified in July 23 regarding the accuracy of the death data recorded within Velindre's Welsh Patient Administration System (WPAS). Since the implementation of the Digital Health & Care Record there has been heavy reliance on the Master Patient Index (MPI) to feed death updates from systems across Wales into Velindre WPAS. There are a number of complex technical issues affecting WPAS from processing and receiving the updates from the MPI, this has impacted on the validity of 30 day mortality reporting and the extent of the implications of this is currently unknown but is being urgently investigated. A full report into this issue is currently being prepared by the digital team for discussion and action at SLT and reporting to EMB.

Update from MES

The MES was placed on a statutory footing via the Health and Care Act 2022 and whilst a ministerial announcement in June 2022 confirmed plans to implement it on a statutory basis with effect from 1 April 2023, a further ministerial announcement in April 2023 confirmed that the implementation date has been deferred until April 2024.

4. SUMMARY OF MATTERS FOR CONSIDERATION

VCC continues to meet the statutory requirements around the MES. There is progress being made in the formalised processes relating to mortality and morbidity within the cancer centre however challenges remain in providing the national reporting requirements around death within 30 days of SACT and 30/90 days of radiotherapy.

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	**Select all relevant domains below**
	Safe ☒ Timely ☒ Effective ☒ Equitable ☐ Efficient ☐ Patient Centred ☒

	Unable to submit mortality data for deaths within 30 days of SACT and 30/90 days of radiotherapy as per the national requirements of April 2023 due to; An issue on the accuracy of the death data recorded within Velindre's Welsh Patient Administration System (WPAS) since the implementation of the Digital Health & Care Record has been identified and is urgently being investigated. The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). *[Please include narrative to explain the selected domain in no more than 3 succinct points].* **Click or tap here to enter text**
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	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	**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.
	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
	[In this section, explain in no more than 3 succinct points what the equality impact of this matter is or not (as applicable)].
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	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

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

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	*[Please insert detail here in 3 succinct points].*
WHAT IS THE CURRENT RISK SCORE	Insert Datix current risk score
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	*[In this section, explain in no more than 3 succinct points what the impact of this matter is on this risk].*
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Insert Date
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Yes - please detail below
	Unable to submit mortality data for deaths within 30 days of SACT and 30/90 days of radiotherapy as per the national requirements of April 2023 due to; *Business Intelligence reporting capacity.*
All risks must be evidenced and consistent with those recorded in Datix	

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

ANNUAL MEDICAL EDUCATION GOVERNANCE REPORT

DATE OF MEETING	14/09/2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	ASSURANCE
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Dr Louise Hanna, Associate Medical Director of Medical Education
PRESENTED BY	Dr Jacinta Abraham, Executive Medical Director
APPROVED BY	Dr Jacinta Abraham, Executive Medical Director
EXECUTIVE SUMMARY	The purpose of the report is to provide assurance that we are meeting our commissioning and GMC requirements for Medical Education within Velindre NHS Trust. This report is the second annual report for medical education governance for VUNHST and details the activities and performance for the reporting period August 2022 to August 2023 for both WBS and VCC.

RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee is asked to **NOTE** the Medical Education Governance Report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	31/08/2023

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

The report has been prepared by members of the Medical Education Board and has been discussed within the core Medical Education Team. A number of challenges and corresponding actions to address these have been detailed in sections 3.2 and 3.3 below.

The EMB noted the report on 31 August 2023.

7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 3 - Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes *Please refer to the Detailed Definitions of 7 Levels of Evaluation to Determine RAG Rating / Operational Assurance and Summary Statements of the 7 Levels in Appendix 3 in the **"How to Guide for Reporting to Trust Board and Committees"***

APPENDICES	
1	Medical Educational Governance Report 2022/23

2	Annex 1 – Cardiff University Undergraduate Annual Teaching Review (November 2022)
3	Annex 2 – HEIW Commissioning Meeting Report (July 2023)

1. SITUATION

The purpose of the report is to provide assurance to the Quality, Safety a Performance Committee that we are meeting our commissioning and GMC requirements for Medical Education within Velindre NHS Trust. This is the sixth report in total, although it is the second report covering both VCS and WBS.

The original purpose of the document was to report on the state of medical education in Velindre with respect to the 2016 GMC standards for training. These standards refer to curriculum-based learning and assessments for undergraduate medical students and postgraduate doctors in GMC-approved training programmes, such as the training and education that is commissioned by Health Education and Improvement Wales (postgraduate) and Cardiff University (undergraduate). This remains the primary aim of the document, however the scope of the document is now broadened to include other aspects of medical education not necessarily linked to commissioned training programmes.

The most recent report was submitted in August 2022 and this document will cover the period from then until August 2023.

2. BACKGROUND

In 2015 the General Medical Council published new standards for medical education and training that incorporated both undergraduate and postgraduate training and included a requirement that educational and clinical governance systems are integrated.[1] These standards came into effect on 1st January, 2016. In response, the Velindre NHS Trust Medical Educational Governance Framework was written that includes the requirement of an annual report to be submitted by the Medical Education Board to the Safety, Quality and Performance Committee on the state of medical education within Velindre.[2] The report should include:

- Results of surveys (undergraduate, postgraduate, trainer), with particular focus on any areas of exception (positive or negative)
- Any items relating to Velindre NHS Trust that appear on the Health Education and Improvement Wales (HEIW) Risk Register

[1] 2015. Promoting excellence: standards for medical education and training. GMC.
[2] 2016. Medical Educational Governance Framework. Velindre NHS Trust.

- Any other points considered important to highlight

Previous reports have covered the time periods:

- 2016
- 2017
- 2018
- 2019 to mid-2020
- July 2020 to Aug 2022

3. ASSESSMENT

This report summarises the key activities and performance undertaken by the Medical Education Board from August 2022 to August 2023, and highlights some of the key issues that will progress over the next 12 months and beyond.

3.1 Notable events and highlights in 2022-2023

- Large number of 'above outlier' green flags in 2023 GMC survey for Palliative Medicine
- Engagement: good response rates to GMC surveys.
- No patient safety concerns reported in GMC trainee surveys.
- No undermining or bullying concerns reported in GMC trainee surveys.
- Foundation Programme doctors started at Velindre Cancer Centre
- Further development of Specialty doctor posts which help with rota gaps but increasingly seen as valuable training experiences.
- Commissioning meeting HEIW and Teaching Review meeting with Cardiff University
- Local Faculty Team appraisal undertaken in 2023
- Continuing Junior Medical Staff Committee
- Junior medical staff representatives on Local Negotiating Committee (LNC)
- Trainers have national roles in medical education e.g. College examiners, membership of Royal College Training Committees, UK clinical leadership roles for national recruitment and quality of medical education, Wales Training Programme Directorships, forthcoming membership of Royal College Officer group.
- Involvement of audit department in medical student SSC projects and showcase presentation event with awards.
- Trainee and student authors in peer review publications and conference presentations.
- Continued roll-out of Acute Oncology training within the University Hospital of Wales. The trainees were the first group to attend UHW AOS, and VCC consultants now attend.

- ‘Immunobuddies’ regular podcast on Immunotherapy.

3.2 Summary of challenges, including from the 2023 GMC survey

- Managerial/admin support for medical education
- Time for training (clinical and medical oncology)
- Burnout especially among trainees (especially in F2, clinical oncology, GP and IMT)
- Below outliers in GP, IMT, clinical oncology, medical oncology including workload for clinical oncology

3.3 Summary of actions in response to challenges

- Finalise action plan in response to GMC survey results
- Present GMC survey results and associated action plan proposal to VCS SLT
- Series of Medical Education Strategy workshops with Medical Educational Leads, Educators and Trainees
- Review of administrative and management support for Medical Education
- Review of Medical Education Board terms of reference and position within Trust governance and reporting structure
- Review of Trust Job Planning principles and process

4. SUMMARY OF MATTERS FOR CONSIDERATION

The Quality, Safety & Performance Committee is asked to NOTE the Annual Medical Educational Governance Report, including the challenges and associated actions.

5. IMPACT ASSESSMENT

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

• An established 'University' Trust which provides highly valued knowledge for learning for all. ☒ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	10 - Governance
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**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). *[Please include narrative to explain the selected domain in no more than 3 succinct points].* **Click or tap here to enter text**
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	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 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	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
	[In this section, explain in no more than 3 succinct points what the equality impact of this matter is or not (as applicable)].
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	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

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

ARE THERE RELATED RISK(S) FOR THIS MATTER	**Choose an item**
WHAT IS THE RISK?	*[Please insert detail here in 3 succinct points].*
WHAT IS THE CURRENT RISK SCORE	Insert Datix current risk score
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	*[In this section, explain in no more than 3 succinct points what the impact of this matter is on this risk].*
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Insert Date
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	**Choose an item**
	[In this section, explain in no more than 3 succinct points what the barriers to implementation are].
All risks must be evidenced and consistent with those recorded in Datix	

Medical Education Governance Report for August 2022 to August 2023

Document control

Version	Date	Written by	Comments
1 DRAFT	23 07 23	CLH	For EE and RF review
2 DRAFT	29 07 23	CLH	For Med Ed leads review
Update in progress			

Contents

Acronyms

AOS	Acute Oncology Service
ARC	Advancing Radiotherapy Cymru
C&V	Cardiff and Vale University Health Board
CPD	Continuing Professional Development
CU	Cardiff University
FRCR	Fellowship of the Royal College of Radiologists

FRCPath	Fellowship of the Royal College of Pathologists
GMC	General Medical Council
HCP	Healthcare Professional
HEIW	Health Education and Improvement Wales
IMT	Internal Medicine Trainee
LTFT	Less Than Full-time
MSCC	Metastatic Spinal Cord Compression
NM	Nuclear Medicine
NMO	Non-Medical Outliner
PA	Physician Associate
QI	Quality Improvement
RCGP	Royal College of General Practitioners
SSA	Senior Student Assistantship
StR	Specialty Registrar
UHW	University Hospital of Wales
VCC	Velindre Cancer Centre
VCS	Velindre Cancer Service
WBS	Welsh Blood Service

Purpose of document

To report to the Velindre Quality and Safety Committee on Medical Education within Velindre NHS Trust. This is the sixth report.

The original purpose of the document was to report on the state of medical education in Velindre with respect to the 2016 GMC standards for training. These standards refer to curriculum-based learning and assessments for undergraduate medical students and postgraduate doctors in GMC-approved training programmes, such as the training and education that is commissioned by Health Education and Improvement Wales (postgraduate) and Cardiff University (undergraduate). This remains the primary aim of the document, however the scope of the document is now broadened to include other aspects of medical education not necessarily linked to commissioned training programmes.

The most recent report was submitted in August 2022 and this document will cover the period from then until August 2023.

Background

In 2015 the General Medical Council published new standards for medical education and training that incorporated both undergraduate and postgraduate training and included a requirement that educational and clinical governance systems are integrated.[1] These standards came into effect on 1st January 2016. In response, the Velindre NHS Trust Medical Educational Governance Framework was written that includes the requirement of an annual

[1] 2015. Promoting excellence: standards for medical education and training. GMC.

report to be submitted by the Medical Education Board to the Safety, Quality and Performance Committee on the state of medical education within Velindre.[2] The report should include:

- Results of surveys (undergraduate, postgraduate, trainer), with particular focus on any areas of exception (positive or negative)
- Any items relating to Velindre NHS Trust that appear on the Health Education and Improvement Wales (HEIW) Risk Register
- Any other points considered important to highlight

Previous reports have covered the time periods:
2016
2017
2018
2019 to mid-2020
July 2020 to Aug 2022

Overview of training

For information, Health Education and Improvement Wales (HEIW), the new Special Health Authority, started on 1st October 2018, having worked in shadow form since 1st April 2018. This was formed by amalgamating the Wales Deanery, NHS Wales's Workforce Education and Development Services (WEDS) and the Wales Centre for Pharmacy Professional Education (WCPPE).

Velindre Cancer Centre/Hospices

The GMC survey considers 'Velindre NHS Trust' to have two training locations – 'Velindre Hospital' and 'Holme Tower Marie Curie Hospice'. Although these are separate organisations, there are strong links between Velindre and the Cardiff Hospices and the training teams meet in a single Medical Education Board.

Velindre Cancer Centre has trainees within the following GMC-approved postgraduate training schemes that are commissioned by HEIW: Clinical Oncology; Medical Oncology; Palliative Medicine; Clinical Radiology; Internal Medicine Training (IMT); General Practice; Foundation Programme Year 2. Some trainees in Palliative Medicine at Specialty Registrar, IMT and Foundation Programme levels are based in other locations such as Marie Curie Hospice or City Hospice.

Velindre University NHS Trust also provides undergraduate training and education by agreement with the Cardiff University Medical School. This training includes the Oncology Project, Student Selected Components (SSCs) and Non-surgical Bookends.

Velindre NHS Trust is visited annually by Health Education and Improvement Wales (commissioning visit and faculty team appraisal) with regard to postgraduate medical education and training, and Cardiff University for an undergraduate teaching review. See Annexes 1 and 2 for details of the most recent visits.

[2] 2016. Medical Educational Governance Framework. Velindre NHS Trust.

Other aspects of medical education include non-commissioned elements such as sixth form work experience, taster experiences, out of programme experiences and training courses such as the FRCR course.

With the establishment of Health Education and Improvement Wales, and in keeping with national trends, there is an increasing emphasis on multidisciplinary and multi-professional teaching and training. Velindre also provides, and takes part in, multi-professional training.

Welsh Blood Service

The Welsh Blood Service undertakes an extensive programme of training throughout Wales. This includes teaching specialty registrars, medical students, nurses and clinical scientists. All the consultants are involved in teaching and two consultants are RCPath examiners. The medics together with nurses are responsible for cascading learning to WBS staff, including on adverse events management.

Sources of evidence

Evidence	Examples
Primary evidence	GMC survey of trainees GMC survey of trainers Internal questionnaires End of placement evaluation forms Feedback questionnaires Informal feedback
Secondary evidence	Wales annual specialty report on Clinical Oncology Wales annual specialty report on Medical Oncology HEIW Medical Deanery Risk Register

Results of the 2023 GMC survey of trainees and trainers are shown in the appendices. The colour codes are as given in the following table:

Type	Colour code
Green flag (above outlier)	
Upper quartile	
Within interquartile range	
Lower quartile	
Red flag (below outlier)	
Insufficient responses for results	

The numerical scores are out of 100 and are calculated by the GMC using responses to questions.

Contributors

Contributions to this report have been gratefully received from members of the Velindre Medical Education Board and others involved in medical education.

Notable events and highlights

Notable events and highlights in 2022-2023

- Large number of 'above outlier' green flags in 2023 GMC survey for Palliative Medicine
- Engagement: good response rates to GMC surveys.
- No patient safety concerns reported in GMC trainee surveys.
- No undermining or bullying concerns reported in GMC trainee surveys.
- Foundation Programme doctors started at Velindre Cancer Centre
- Further development of Specialty doctor posts which help with rota gaps but increasingly seen as valuable training experiences.
- Commissioning meeting HEIW and Teaching Review meeting with Cardiff University
- Local Faculty Team appraisal undertaken in 2023
- Continuing Junior Medical Staff Committee
- Junior medical staff representatives on Local Negotiating Committee (LNC)
- Trainers have national roles in medical education e.g. College examiners, membership of Royal College Training Committees, UK clinical leadership roles for national recruitment and quality of medical education, Wales Training Programme Directorships, forthcoming membership of Royal College Officer group.
- Involvement of audit department in medical student SSC projects and showcase presentation event with awards.
- Trainee and student authors in peer review publications and conference presentations.
- Continued roll-out of Acute Oncology training within the University Hospital of Wales. The trainees were the first group to attend UHW AOS, and VCC consultants now attend.
- 'Immunobuddies' regular podcase on Immunotherapy.

Summary of challenges, including from 2023 GMC survey

- Time for training (clinical and medical oncology)
- Burnout especially among trainees (especially in F2, clinical oncology, GP and IMT)
- Below outliers in GP, IMT, clinical oncology, medical oncology including workload for clinical oncology
- Managerial/admin support for medical education

Summary of actions in response to challenges

- Finalise action plan in response to GMC survey results
- Present GMC survey results and associated action plan proposal to VCS SLT
- Series of Medical Education Strategy workshops with Medical Educational Leads, Educators and Trainees
- Review of administrative and management support for Medical Education

- Review of Medical Education Board terms of reference and position within Trust governance and reporting structure
- Review of Trust Job Planning principles and process

Postgraduate medical specialty training programmes

Clinical Oncology Training Programme – Velindre Cancer Centre
Positives
• Continued presence of registrars in Cardiff and Vale Health Board to meet curriculum requirements. Expanded presence of VCC consultants in UHW. • Exam success in final FRCR examination. • Involvement of trainees in leadership roles – induction programme, undergraduate teaching • 2023 GMC survey – 'above outlier' status for handover • Consultant post take ward round and acute oncology morning session continue to be a priority for clinical directorate • Specialty doctor posts fill rota gaps • Continued support of training number expansion in Wales agreed with Welsh Government • Provision of internationally renowned FRCR course for local trainees and excellent examination pass rates for the FRCR Part 2 examination. • All South Wales Training Programme posts recruited to.
Challenges
• 'Below outlier' again in 2023 GMC survey for Workload (trainees) • Lower quartile results for induction and local teaching in 2023 GMC survey. • 77% of clinical oncology trainees in Wales score high/moderate for burnout, an increase compared with last year (30.8% high, 46.2% moderate). • Rota coordination providing acute oncology/on-call cover in Velindre and providing acute oncology experience within Health Board • 66.67% of vacant training posts in Wales filled in Spring Round of National Recruitment, all unfilled posts within North Wales Training Programme.
Actions
• Steps taken to address induction and local teaching from September 2023 • Acute Oncology training at Cardiff and Vale for 1 week every 6 months, for all trainees from September 2023. • Trainee workload (meet with trainees to find solutions) • Work within the Trust on employee well-being

Medical Oncology Training Programme – Velindre Cancer Centre
Positives
• Continued presence of registrars in Cardiff and Vale Health Board to meet curriculum requirements. Expanded presence of VCC consultants in UHW. • Involvement of trainees in leadership roles • Specialty doctor posts fill rota gaps • Consultant post take ward round and acute oncology morning session continues to be a priority for clinical directorate – (in the last 6 months one Medical Oncology consultant has taken on an AOS remit, and another new consultant has just been recruited to a melanoma /AOS post In Velindre Cancer Centre) • Continued support of training number expansion in Wales agreed with Welsh Government • 2023 GMC survey results – upper quartile for Teamwork • High degree of retention of trainees: most medical oncology Trainees in the last several years have wished to stay on in Wales and have obtained consultant posts in S Wales. • 'Immunobuddies' podcast
Challenges
• 75% of Medical Oncology trainees in Wales have moderate burnout • 2023 GMC survey results – 'below outlier' for Adequate Experience and lower quartile for Educational Supervision, Regional Teaching and Overall Satisfaction. • 66.67% of vacant training posts in Wales filled in Spring Round of National Recruitment • 2023 GMC survey – 60% of medical oncology trainees score high/moderate for burnout. This compares with 75% last year, but 20% score 'high' in 2023 compared with 0% in 2022.
Actions
• Work within the Trust on employee well-being • Introduce new Acute Oncology Service training timetable and rota

Palliative Medicine Training Programme
Positives
• 4 new posts were created in HEIW education and training Commissioning plan for NHS Wales, 2 posts to commence in August 2022 and 2 posts in August 2023 • Palliative medicine became a dual training specialty with IM from August 2022, the fill rate in Wales for Palliative Medicine Training Programme is improving • August 22: 4 posts, 0 fill • Feb 23: 4 posts, 0 fill • Aug 23: 5 posts, 3 filled • Previous lower quartile results in GMC survey for Curriculum Coverage and Feedback have disappeared and note they have been removed by the survey across other specialties

- 2023 GMC survey post specialty results in Palliative Medicines show 10 'above outlier' responses (Overall Satisfaction, Clinical Supervision, Workload, Teamwork, Handover, Supportive Environment, Induction, Adequate Experience, Local Teaching and Rota Design) and upper quartile in Reporting Systems. Commended by HEIW at 2023 commissioning meeting.
- Trainer response rate was 71% (high), trainers note time available to train can be challenging

Challenges

- Responses for individual units are not included as the number of trainees are so small and can be identified, this is a problem recognised at SAC level
- 2023 GMC survey regarding burnout for trainees the data does not include trainees in Wales, the information presented for 2022 only includes feedback from 4 trainees.
- Change from Velindre to Shared Services has not been a smooth process and many trainees have expressed dissatisfaction with the present situation and trying to achieve resolution of queries
- Swansea Bay HR and Velindre HR are looking into the issue of on call pay for trainees who work LTFT as it appears the payslips between different trainees varies significantly, information has to be run through 'allocate' to determine correct banding

Actions

- Trainees in South West Wales (Swansea Bay) have access to clinical psychology, trainees in South East Wales to trial this.
- Await outcome HR review regarding pay issue from both Health Boards.

Radiology Training Programme – Velindre Cancer Centre
Positives
• Ongoing ST4/ST5 placement in VCC. For the last training year (2022-2023) this has been linked to the nuclear medicine subspecialty training programme. • 100% fill rate in National Recruitment for Clinical Radiology training. • Excellent exposure to a wide range of cancer related pathology not commonly seen in other South Wales training centres, and particularly acute complications via AOS meeting / duty radiology work (MSCC, treatment related e.g. pneumonitis, CASH, SOS)
Challenges
• Not enough trainees for results from GMC survey • Not enough out of hours work at VCC for on call banding; therefore trainees are part of the on-call rota at C&V. • PETIC and VCC training split has not worked for department due to lack of training time in VCC, compounded by days off on lieu for on call. These trainees should have been spending 3-4 days per week in VCC, but changes were made to their timetables that impacted the time spent in the department and limiting their exposure to cross sectional imaging.
Actions

- Continue to provide placement but with adjustments for this training year so that trainee is no longer part of the NM subspecialty rotation, commencing February 2024.
- There will be a second ST4/ST5 trainee rotating from NM to VCC in future so that the training opportunities as part of the NM subspecialty training programme are still available although their timetables will require careful thought to maximise experience.

Postgraduate medical training – Welsh Blood Service
Positives
• Agreement from Training Committee for a Haematology trainee rotation to the Blood Service. Discussed in Commissioning visit July 2023. Proposed application to HEIW. • Haematology StRs: A twice-yearly course is provided with practical work, lectures, and case-based theory. Each course lasts for 2 weeks. Each StR attends once during training. • A monthly lunchtime hour of transfusion CPD is provided for all haematology trainees in Wales via Teams. • Haematology StRs also have training half days throughout the year and at least one (typically 2) will be focussed on transfusion related topics • Two Higher Specialist Scientific Trainees in Transfusion are in post at the WBS. They are expected to gain the exit doctorate qualification of DClinSci in 2024 and 2027 respectively upon which they will be qualified as Consultant Clinical Scientists. • Patient Blood Management Education session delivered to all F1/F2 medics in Wales
Challenges
• Transfusion is ¼ of the FRCPath Haematology examination (and curriculum) whereas the trainees have much less than ¼ of their time spent within transfusion, although acknowledge that will also gain experience through their other placements. This discrepancy in supervised training has been highlighted by trainees and trainers. • The training is provided by a small team with finite resources.
Actions
• Continue with application to develop a formal rotational post in transfusion for 3-6 months to be more consistent with other parts of the curriculum (e.g. haemostasis, malignant haematology).

Internal Medicine Training – Velindre Cancer Centre and Marie Curie Hospice
Positives
• Clinical fellows doctor posts to help fill rota gaps • For the whole Trust, 2023 GMC survey above outlier for Handover and Facilities, and upper quartile for Reporting Systems (but see below for VCC results)

• Consultant post take ward round and acute oncology morning session continues to be a priority for clinical directorate • Joint working with Velindre and Hospice for clinic attendance – Hospice trainees attend VCC outpatient clinics. • Provision of clinic experience in Velindre adds value to the rotation • Previous IMT trainees have joined Velindre in specialty training posts
Challenges
• Rota gaps • 2023 GMC survey for Velindre Cancer Centre – below outlier for Local Teaching and Regional Teaching and lower quartile for Feedback and Clinical Supervision.
Actions
• Medical business team to continue recruitment drives for non-training specialty doctors to cover rota gaps • Evaluate current rota • Review induction • Overhaul teaching programme

GP training – Velindre Cancer Centre
Positives
• 2023 GMC survey above outlier for Teamwork and upper quartile for Reporting Systems • Consultant post take ward round and acute oncology morning session continues to be a priority for clinical directorate • Provision of clinic experience adds value to rotation
Challenges
• 2023 GMC survey seven below outliers for Overall Satisfaction, Clinical Supervision, Clinical Supervision out of hours, Adequate Experience, Local Teaching, Regional Teaching, Rota Design. Lower quartile results for Supportive Environment, Educational Supervision and Feedback.
Actions
• Medical business team to continue recruitment drives for non-training specialty doctors to cover rota gaps • Evaluate current rota • Review induction • Overhaul teaching programme

Foundation Programme
Positives
• Three new F2 posts established in August 2022 – two based in Velindre Cancer Centre and one based in Marie Curie Hospice • Educational and clinical supervisors identified • First cohort of trainees August 2023. Good informal feedback.
Challenges
• Incorporating new posts and ensuring learning needs are met

• Core post only is funded (no on-call) • Identifying additional resource for supervision and admin support
Actions
• Close monitoring of trainee experience • Next cohort of trainees due August 2023.

Undergraduate – medical student teaching and training

Undergraduate training – oncology project
Positives
• Lead role for trainees in management of project • Highly regarded part of undergraduate curriculum • Provision of project in Welsh • Students value direct and longitudinal patient interactions • On-line marking scheme introduced
Challenges
• Recruiting tutors • Identifying suitable patients in a timely fashion • Tight turnaround times in marking projects
Actions
• Proactive work to recruit tutors • Review process of patient identification and allocation • Review documentation re: Welsh language

Undergraduate training – non-surgical bookends
Positives
• Lead role for trainee in management of project • Widening exposure of students to aspects of oncology that they might not see much of in their training elsewhere • Consultant and trainee oncologists contributing to plenary lectures in bookend weeks • Sessions are small group, allowing more participation and discussion from students
Challenges
• Recruiting tutors due to the dates of the sessions – bookends are falling on rotation dates for junior doctors, which makes recruitment very challenging, and clinical commitments for StRs make Wednesday mornings very difficult.
Actions
• Discuss possibility of changing timing of sessions to allow consistent recruitment of tutors

Undergraduate training – SSC projects- palliative care and oncology
Positives
• Many projects undertaken, resulting in national/international presentations for students • Lead role for trainee in management of project • Excellent support from VCC audit department • Opportunity to present work at virtual showcase event, and local Velindre prize • Six year 3 and eight year 4 students • Starting to take year 2 students (one week experience) • A number of interesting short virtual sessions on key oncological topics including immunotherapy, radiotherapy and clinical trials are available for students to attend.
Challenges
• Popularity of placements requires adequate resource and support • Identifying tutors
Actions
• Highlight the work of the audit department in supporting the projects • Create a project bank

Undergraduate training – Welsh Blood Service
Positives
• All 5th year medical students in Wales have to complete senior student assistantship training and competency assessment (SSA) in transfusion prior to qualification and commencing as junior doctors. This is organised by the WBS and transfusion teams across Wales. Lectures and 4 rotational interactive workstations (staffed by two SMEs each) provide whole day of training at all Health Boards in Wales. WBS Blood Health Team staff and Transfusion Practitioners from other Health Boards mutually assist each other in delivering the programme across Wales.
Challenges
• There is a small team delivering the training with finite resources. Travel is required for SSA. • Approx 50% of the students will leave to continue practice outside Wales
Actions
• We will continue to support these sessions even with the large percentage of students leaving Wales as this contributes to UK practice.

Trainers

Trainers
Positives
• 2023 GMC survey of trainers – above outlier for Palliative Medicine for Educational Governance, Appraisal, Resources to Train and upper quartile for Supportive Environment and Professional Development.

• 2023 GMC survey of trainers – above outlier for Clinical Radiology for Professional Development, Appraisal, Support for Training and upper quartile for Resources to Train. • 2023 GMC survey of trainers – above outlier for Medical Oncology for Supportive Environment and upper quartile for Professional Development and Resources to Train. • 2023 GMC survey of trainers – above outlier for Clinical Oncology for Handover. • Trainers have national roles in medical education e.g. College examiners, membership of Royal College Training Committees, UK clinical leadership roles for national recruitment and quality of medical education, Wales Training Programme Directorships, keeping them up to date with medical education developments.
Challenges
• 'Below outlier' for Clinical Oncology for Support for Training. • Medical oncology trainer added to HEIW risk register in August 2022.
Action
• Finalise action plan in response to GMC survey results • Present GMC survey results and associated action plan proposal to VCS SLT

Non-commissioned posts

Specialty Doctors and Clinical Fellows
Positives
• Ongoing appointment to these posts which supports the on-call rota and provides education experience/career development opportunities for doctors. • Specialty doctor positions to support new Immunoncology toxicity service
Challenges
• Limited budgets and difficult to recruit to all posts
Action
• Continue to provide and recruit to these roles.

International Clinical Fellows
Positives
• International clinical fellows in oncology • FRCR exam success
Challenges
• Admin and set-up
Action
• Continue to promote these posts

Physicians Associates
Positives
• Two new PA posts appointed
Challenges
• How to incorporate new posts into service

Action
• Continue to monitor and support development of these posts

Library

Library
Positives
• Assistant Librarian named on the list of the top 125 movers and shakers of the next generation of library and information specialist leaders.
Challenges
• The library funding, while no longer coming from charitable funds is still not confirmed as a permanent repeating budget and needs to be re-applied for every 2 years.
Actions
• Focus on ensuring that library facilities in the new Velindre Cancer Centre can support our educational provision going forwards. • Clarify funding arrangements. We are currently working with a Cancer Service intern to look at the managerial position of the library service within the Trust and he is attempting to clarify the library funding source as part of that project.

FRCR course

FRCR course
Positives
• Internationally renowned course, attended by over 60 trainees each year • Mirrors the examination format well – updated in 2023 to reflect the new FRCR exam structure • Velindre course ran during pandemic, converting to a fully on-line course. Now back to a mixed virtual/in person course based on feedback from delegates • High quality bank of lectures available for local trainees – both for exam preparation and other learning. • Multi-professional faculty from Wales and beyond • Faculty up to date with exam content. We suspect (but cannot prove) that this helps trainees on the S Wales programme with their overall exam preparation/success: pass rates on the S Wales oncology rotation are very high • Third Velindre-Kolkata FRCR course held in 2023 – combination of face to face and virtual. First Hong Kong course delivered in 2023 • Excellent collaboration between Velindre and Kolkata • Leadership opportunity for trainees in course organisation/development • Supports VCC QI and undergraduate prizes. • Supports overall training (high local FRCR Part 2 exam pass rates) • Supports recruitment and promotion of VCC: consultants, clinical fellows and non-training roles filled from outside Wales/international medical graduates
Challenges
• Delivering the course in addition to clinical/service pressures

• Physical facilities at Velindre – quite limited for what the course needs
Actions
• Continue to develop course, building international links • Explore other/additional uses for educational materials e.g. team inductions etc • Plan to deliver FRCR course in Hong Kong September 2023.

Other education and training activities

Work experience – sixth form
Positives
• Week-long experience • Worked with Widening Access Lead
Challenges
• Admin support – no-one currently in work experience admin role
Actions
• Continue to deliver as resources allow.

Taster weeks
Positives
• Demand for taster weeks – popular • Bespoke experience • Important experience to help recruitment
Challenges
• Admin support
Actions
• Continue to provide as resources allow.

Multi-professional training – Advanced Nurse Practitioners
Positives
• Core workforce for Assessment Unit • Completion of Higher Training qualifications including Masters degrees • Designated clinical examination teaching time • ANP development roles
Challenges
• Time for training/clinical supervision • Time to co-create scopes of practice and summative examinations • Staff retention
Actions
• Review of training structure and resource for training

Primary Care Oncology
Positives
• Education programme for community/primary care clinical teams delivered collaboratively with CU

• Multi-professional attendees including trainees • Now planning to deliver a specific session for GP trainees, a study day with RCGP Wales + further sessions highlighting key oncology updates for primary care HCPs to improve clinical work/decision making, connections • Improved professional links with community teams
Challenges
• Delivering the course in addition to clinical/service pressures • The faculty are clinicians, which impacts on availability and service • Physical facilities at Velindre – quite limited for what the course needs
Actions
• Continue to develop this area, exploring possible funding streams and alignment with the Velindre Oncology Academy programme

Multi-professional training - other
Positives
• Numerous examples of multi-professional training – supervision of non-medical outliners (NMO) in radiotherapy; non-medical prescribers (NMP), expert practice modules, paramedics. • Other professional groups have role in training medics – e.g. paracentesis, radiotherapy planning
Challenges
• Time for training
Actions
• Continue to promote multi-professional training. This aligns with HEIW focus.

Grand round
Positives
• Multi-disciplinary event with the aim of promoting education and research. • Mixture of internal and external speakers, including international speakers, which promotes collaboration and networking. • Sessions are recorded so can be listened to again or if unable to attend the live presentation. • CPD points available for attendance. • Opportunity to showcase local developments
Challenges
• Finding speakers • Ensuring talks remain relevant to all attendees
Actions
• Continue to provide Grand Round programme

Organisational
Positives
• This is the 6th annual Medical Educational Governance report which is reported through the Trust structure. • It is the second report that has included the whole Trust (VCC, Hospice, WBS). • Plans for Velindre Oncology Academy, Advancing Radiotherapy Cymru (ARC) Academy, and Centre for Learning in new Velindre Cancer Centre
Challenges
• Medical education administrative support including how medical education fits in with Trust structures/committees • Continuing to provide high quality medical education within a busy clinical schedule with a high demand and finite capacity. • Ensuring high quality medical training is carried forward in future reconfiguration plans (e.g. Transforming Cancer Services programme) • Burnout • Assistant Medical Director unable to take up full duties due to time constraints
Actions
• Continue to highlight challenges within VUHNST because many potential solutions lie within the organisation as a whole, not just in the Education Department.

National and local changes coming up in 2023 and beyond

Important changes will take place in medical education are occurring in 2023 and beyond. These include:

1) Transforming Cancer Services and review of Acute Oncology Service Provision
2) Construction of a new Velindre Cancer Centre and Centre for Learning
3) Need for excellence in medical education despite workforce and capacity pressures
4) Continued need to recruit and retain to support the service
5) New initiatives – ARC Academy and Velindre Oncology Academy

Appendix A - GMC survey results 2023 – trainees – all Health Boards

Trust / Board	Overall Satisfaction	Clinical Supervision	Clinical Supervision out of hours	Reporting Systems	Work Load	Teamwork	Handover	Supportive Environment	Induction	Adequate Experience	Educational Governance	Educational Supervision	Feedback	Local Teaching	Regional Teaching	Study Leave	Rota Design	Facilities
Aneurin Bevan University Lhb	78.31	87.83	85.49	73.18	43.73	73.45	65.37	74.86	77.77	78.83	69.42	84.10	74.02	74.10	65.34	58.83	55.33	66.67
Betsi Cadwaladr University Lhb	78.53	88.23	85.46	70.82	48.96	71.84	65.38	74.74	79.07	79.06	73.02	85.10	74.56	73.91	69.66	63.17	58.26	65.47
Cardiff & Vale University Lhb	75.75	88.26	85.37	68.54	43.18	71.56	63.25	70.33	76.24	76.15	67.89	83.29	73.12	67.17	57.73	56.27	49.69	60.79
Cwm Taf Morgannwg University Local Health Board	76.25	87.03	86.79	65.40	48.02	71.16	64.46	73.75	76.09	76.51	69.01	84.02	77.25	68.08	64.34	58.79	49.83	63.48
Hywel Dda University Lhb	75.98	85.77	83.40	67.39	50.03	71.13	66.20	72.88	78.45	77.72	69.30	82.93	74.96	75.69	69.35	60.23	51.49	64.96
Powys Teaching Local Health Board	85.33	94.73	92.45	81.54	54.31	84.09		83.33	85.33	85.83	77.78	91.25	97.44	91.11	78.33	76.80		64.86
Public Health Wales NHS Trust	78.64	91.07		63.33	56.25			80.91	89.77	80.68	78.79	82.39	79.63	75.00	49.62	84.37		43.57
Swansea Bay University Local Health Board	76.92	86.54	84.80	69.35	46.47	72.93	63.04	73.75	76.59	75.51	69.01	83.34	75.43	71.81	61.35	58.14	52.85	66.19
Velindre NHS Trust	75.42	86.35	86.59	76.09	50.09	84.28	80.02	74.38	78.65	69.79	73.61	82.55	69.01	53.61	48.96	66.49	55.98	69.88

Appendix B - GMC survey results 2023 – trainees by Programme Group – VUNHST and VCC

Trust / Board	Overall Satisfaction	Clinical Supervision	Clinical Supervision out of hours	Reporting Systems	Work Load	Teamwork	Handover	Supportive Environment	Induction	Adequate Experience	Educational Governance	Educational Supervision	Feedback	Local Teaching	Regional Teaching	Study Leave	Rota Design	Facilities
Clinical oncology																		
Velindre NHS Trust	86.88	95.31	92.19	73.75	49.48	79.69	80.47	77.50	74.38	87.50	76.04	83.59	91.67	66.04	61.46	75.52	65.63	60.47
Clinical radiology																		
Velindre NHS Trust																		
GP Prog - Radiology																		
Velindre NHS Trust	43.75	63.75	75.00	76.25	45.31	91.67	70.31	62.50	71.25	37.50	64.58	65.63	33.33	19.17	20.84	50.00	14.06	
Internal Medicine Training Stage One																		
Velindre NHS Trust	78.33	80.83	79.86	80.00	50.00	81.25	87.50	73.33	84.17	68.75	75.00	92.71	57.50	53.06	39.58	50.00	54.17	81.46
Medical oncology																		
Velindre NHS Trust	65.00	90.00	91.67	76.67	47.92	83.33	70.14	73.33	80.00	62.50	75.00	75.00		64.45	58.33	75.00	66.67	
Palliative medicine																		
Velindre NHS Trust																		

Trust / Board	Site	Overall Satisfaction	Clinical Supervision	Clinical Supervision out of hours	Reporting Systems	Work Load	Teamwork	Handover	Supportive Environment	Induction	Adequate Experience	Educational Governance	Educational Supervision	Feedback	Local Teaching	Regional Teaching	Study Leave	Rota Design	Facilities
Clinical oncology																			
Velindre NHS Trust	Velindre Cancer Centre - RQFH5	86.88	95.31	92.19	73.75	49.48	79.69	80.47	77.50	74.38	87.50	76.04	83.59	91.67	66.04	61.46	75.52	65.63	60.47
GP Prog - Radiology																			
Velindre NHS Trust	Velindre Cancer Centre - RQFH5	43.75	63.75	75.00	76.25	45.31	91.67	70.31	62.50	71.25	37.50	64.58	65.63	33.33	19.17	20.84	50.00	14.06	
Internal Medicine Training Stage One																			
Velindre NHS Trust	Velindre Cancer Centre - RQFH5	68.75	75.00	76.04	75.00	48.44	75.00	85.42	62.50	77.50	56.25	79.17	93.75	36.11	35.42	29.17	51.56	35.94	87.50
Medical oncology																			
Velindre NHS Trust	Velindre Cancer Centre - RQFH5	65.00	90.00	91.67	76.67	47.92	83.33	70.14	73.33	80.00	62.50	75.00	75.00		64.45	58.33	75.00	66.67	

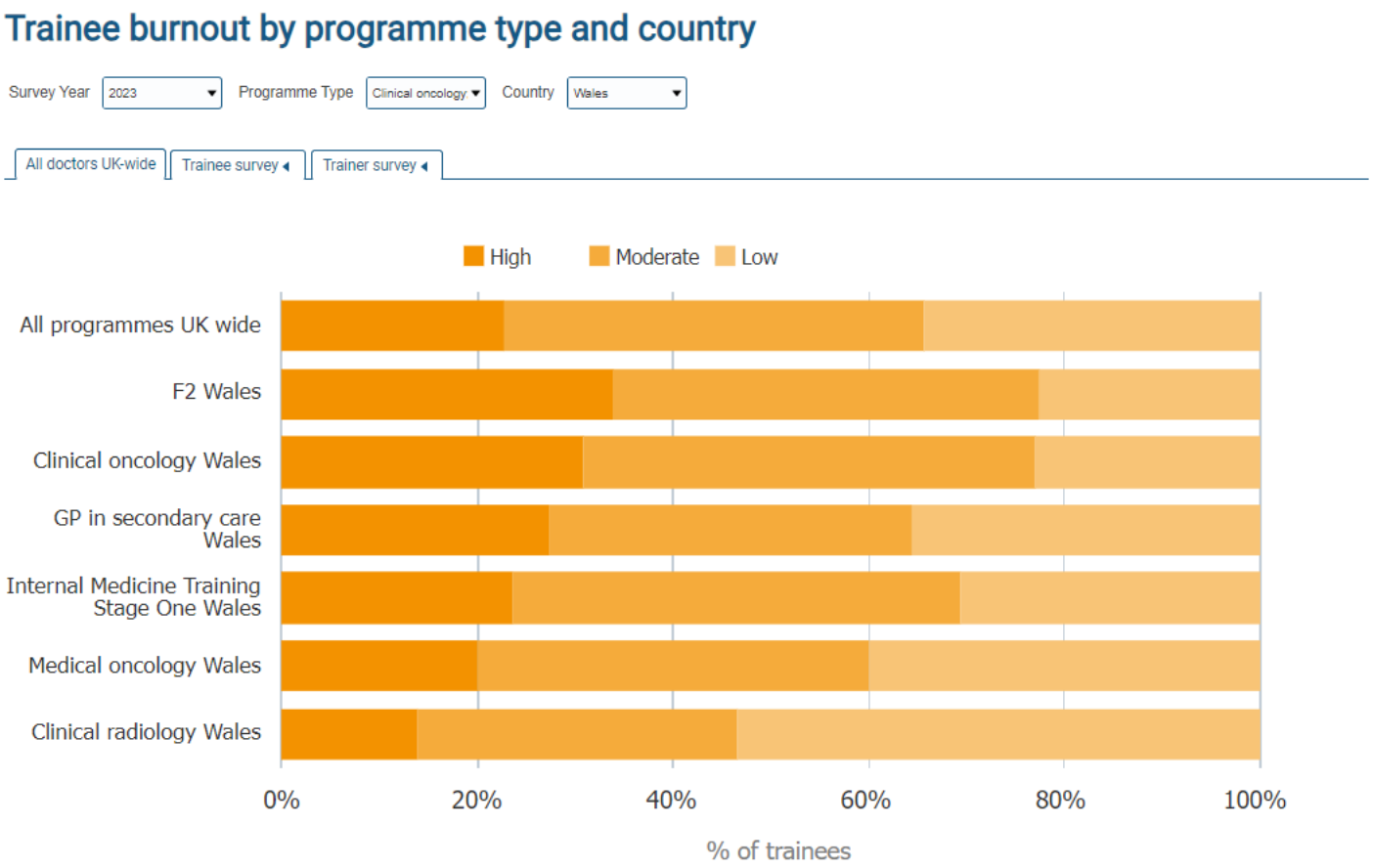
Appendix C – GMC survey results 2023 – trainees by Post Specialty

Trust / Board	Overall Satisfaction	Clinical Supervision	Clinical Supervision out of hours	Reporting Systems	Work Load	Teamwork	Handover	Supportive Environment	Induction	Adequate Experience	Educational Governance	Educational Supervision	Feedback	Local Teaching	Regional Teaching	Study Leave	Rota Design	Facilities
Clinical oncology																		
Velindre NHS Trust	71.56	82.34	83.85	74.69	48.18	81.95	79.17	70.00	74.38	67.19	73.96	81.64	60.61	46.67	43.23	63.15	45.31	71.34
Clinical radiology																		
Velindre NHS Trust																		
Medical oncology																		
Velindre NHS Trust	65.00	90.00	91.67	76.67	47.92	83.33	70.14	73.33	80.00	62.50	75.00	75.00		64.45	58.33	75.00	66.67	
Palliative medicine																		
Velindre NHS Trust	96.25	96.25	93.75	81.25	59.38	100.00	94.44	92.50	92.50	90.63	72.92	95.31	88.89	86.67	67.71	67.19	90.63	62.19

Appendix D – GMC survey results 2023 – trainers

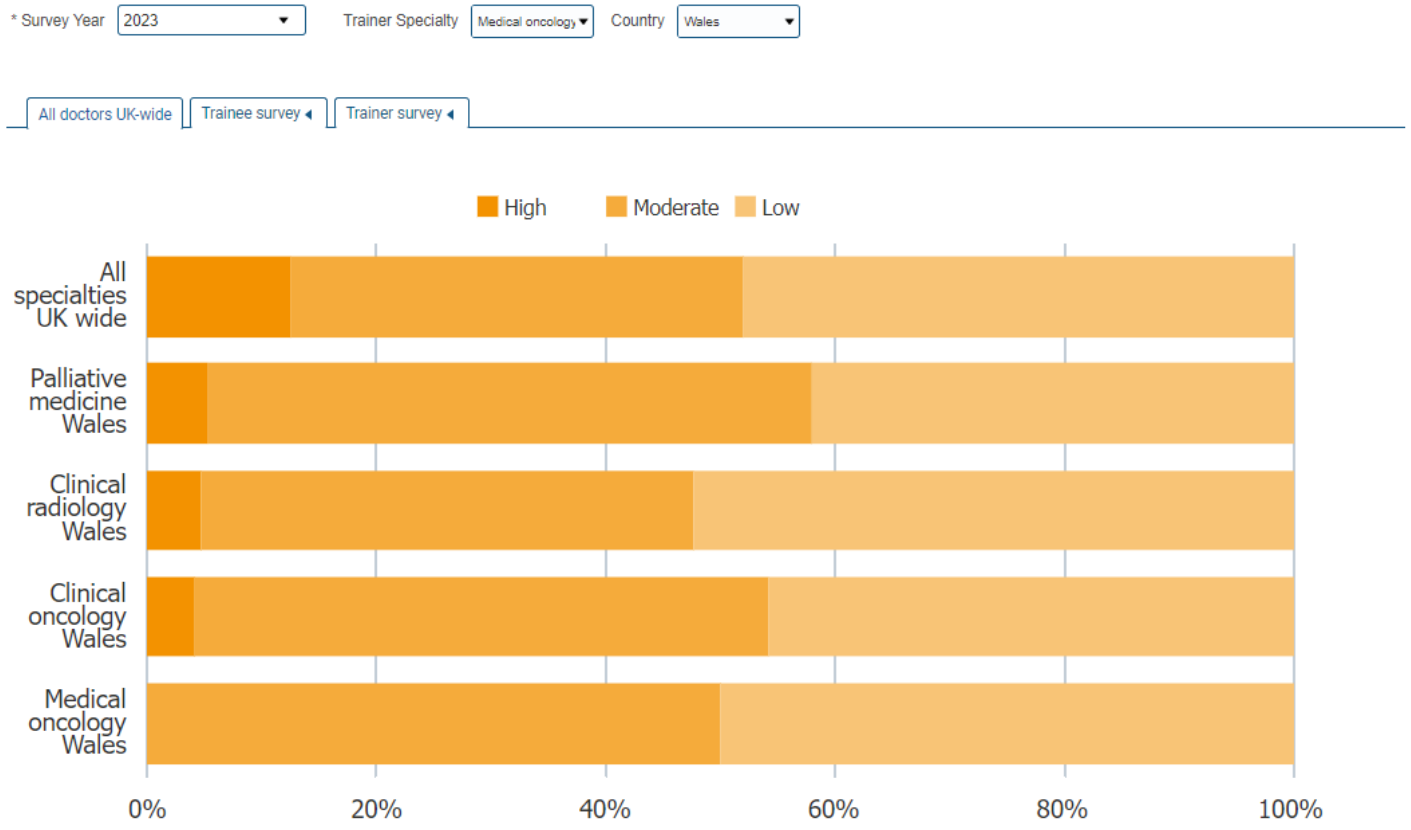
Trust / Board	Response Rate	Supportive Environment	Educational Governance	Professional Development	Appraisal	Support for Training	Time to Train	Rota Issues	Handover	Resources to Train
Clinical oncology										
Velindre NHS Trust	76%	65.35	62.94	64.80	50.00	57.68	42.11	56.58	80.26	63.16
Clinical radiology										
Velindre NHS Trust	75%	66.67		83.33	79.17	86.11	68.06			83.33
Medical oncology										
Velindre NHS Trust	75%	84.72	64.58	77.08	37.50	69.45	43.06	58.33	75.00	79.17
Palliative medicine										
Velindre NHS Trust	100%	79.17	81.25	78.13	78.13	77.08	62.50	75.00	62.50	87.50

Appendix E – GMC survey results 2023 – trainee burnout



Appendix F – GMC survey results 2023 – trainer burnout

Trainer burnout by specialty and country



School of Medicine
Ysgol Meddygaeth

Annual Teaching Review 2021/22
Velindre University NHS Trust

Ref:	20222811VELINDRE
Date:	28th November 2022
Time:	14:00-16:00
Location:	MS Teams

Chair:	Rhian Goodfellow, C21 Programme Director

Present Velindre University NHS Trust:	
Steve Ham	Chief Executive (TBC)
Jacinta Abraham	Executive Medical Director
Matthew Bunce	Executive Director of Finance
Sarah Morley	Executive Director, Organisation Development
Nicola Williams	Executive Director of Nursing, Allied Health Professionals & Health Science
Robert Jones	Honorary Senior Lecturer, Oncology Project Lead
Rhiannon Evans	Honorary Lecturer
Louise Hanna	Assistant Medical Director
Eamon McGreal	Year 3 Deputy Director
Katherine Belbin	Medical Education Co-ordinator
Ciara Cosgrove	Medical Education Co-ordinator
Bernadette Coles	Librarian
Eve Gallop-Evans	Clinical Director
Alister Jones	Welsh Blood Service, Better Blood Transfusion
Mick Button	Consultant Clinical Oncologist
Kieran Gingell	Management Accountant
Present Cardiff University:	
Dr Jamie Read	Dean of Medical Education and Director of the Centre for Medical Education
Prof Rhian Goodfellow	C21 Programme Director – **Chair**
Tracey Stanley	Director of University Libraries
Ruth Coomber	Manager, Centre for Medical Education
Kerry Sullivan	Quality, Enhancement and Liaison Manager
Sarah Gape	Team Leader - Evaluations and NHS Relations

Apologies:	
Ricky Dylan Frazer	Oncology Consultant
Sara Wilkins	Revalidation and Appraisal Manager
Dr John Green	C21 Deputy Director
Joshna Patel	C21 Manager
Amanda Tonks	Director of Quality and Governance
Meg Gorman	Senior Health Librarian Cardiff University
Cheryl Davies	Welsh Blood Service, Laboratory Services
Tentative:	
Edwin Massey	Consultant Haematologist
Lee Wong	Welsh Blood Service, Team Lead

Part I – Preliminaries

1 Welcome and Apologies

1.1 The Chair, Professor Rhian Goodfellow welcomes everyone to the meeting.

2 Notes of the Previous Meeting

2.1 The notes from the previous meeting were accepted as accurate. There were no actions from the previous meeting.

Part II – Undergraduate Medical Education 2021/22

3 Clinical Placement Evaluation

Velindre University NHS Trust - Annual Summary Report

3.1 The Velindre University NHS Trust Clinical Placement Evaluation Report 2021-22 (Document 2) was included in the agenda for information along with a verbal update by *Kerry Sullivan*.

- Oncology Project had an overall positive response from students with a very positive response recorded for eight out of the eleven Core Questions (Annex A). *Organisation of Placement* and *Opportunities to Witness Patient's Social Situation and Impact of Disease* were marked as areas that required improvement. The overall positive response for Core Questions equalled the previous year of 89%.

- A very positive response was recorded for five out of nine Project Specific Questions (Annex B) with a further four recording a positive response for the project responses. Overall percentage for Project Specific Questions decreased by 5% from the previous year, although remaining positive with 90% overall.

- The following Velindre staff responded to the report:

  - Dr Robert Jones, Honorary Senior Lecturer, Oncology Project Lead at Velindre University NHS Trust addressed the areas where students recorded areas for improvement. It was thought that COVID may have had an impact with less home visits, etc. The Year 3 Director, Dr Eamon McGreal, commented that students do seem to be slightly different from previous cohorts, and seem to be less experienced dealing with difficult situations.

  - Jacinta Abraham, Executive Medical Director at Velindre University NHS Trust and Dr Louise Hanna, Assistant Medical Director at Velindre University NHS Trust echoed Dr Jones comments.

  - Year 3 Director, Dr Eamon McGreal commented that the cohort seemed different in that they are slightly desocialised, and maybe not so experienced in dealing with difficult situations as students were before COVID.

  - Professor Rhian Goodfellow, C21 Programme Director Cardiff University commented that the cohort (currently in year 4) with more students having a differential experience. There is some desocialisation and students used to virtual learning and working from home.

  - Tutorials have improved with virtual learning helping as students on different attachments with different timetables.

4 Health Board: Undergraduate Medical Education – Education Report and Response to Evaluations

4.1 Annual Undergraduate Medical Education Report 2021-22 (Document 3) was included in the agenda for information.

- *Alister Jones*, Welsh Blood Service gave a verbal update based on the information in the report. Provide SSA students with blood transfusion training across all health boards.

- Dr Robert Jones gave a brief verbal update for Oncology Project. Best time for students to be with the patients in when they are receiving chemotherapy, this is possible again this year. Tutors encouraging students to engage face to face interactions with patients. Looking at introducing an online marking system and using doodle poll and incentives to encourage people to act as tutors.

- Dr Rhiannon Evans, one of the registrars at Velindre, helps lead the Oncology Project through Welsh. Increase in numbers with 16 students submitting in Welsh. Also support North Wales as they don't have any Welsh speaking tutors. Similar issues as to English speaking students and hopefully increased interactions with patients.

- Dr Jacinta Abraham updated the group on a meeting organised to discuss the concerns around time and resource for training and supporting the UG students.

- Matthew Bunce, Executive Director of Finance noted that resources need to be mapped to better direct the SIFT funding.

- Dr Mick Button, Oncologist & AMD for medical workforce. Look at the wider topic of recognition and reward of work done and how it aligns with organisational aims and ambitions, and not just about finance. Important to look at workloads and looking after people's wellbeing as well as delivering a good service.

- Dr Louise Hanna, AMD, acknowledged the work of trainees in leadership in oncology project and other aspects of undergraduate teaching.

- Very pleased to be able to host more SSC projects and quite a lot submitted as posters at national conferences. Introduced virtual presentations and students are judged on their presentations and then top 3 projects go on to present at FRCR Innovation Awards. Excellent feedback and will continue into next academic year.

5 Health Board: General Update and Plans for 2022/23

5.1 Jacinta Abraham gave a verbal update.

- Acknowledged the Medical Directorate including *Eve Gallop-Evans*, Clinical Director, *Nicky Hughes*, Business Manager. Building a clinical team that are committed to education and training and understand how it impacts the workforce and shapes the future.

- Executive Board have signed up to develop a School of Oncology, starting at the Cancer Centre, with the potential of developing further, with *Nicola Williams* as the Executive of this concept.

- Plans in place for a new hospital. Radiotherapy service has been approved by the Welsh Government.

- Velindre will have a base on UHW site, which will be joint with Velindre, Cardiff & Vale and Cardiff University to deliver complex studies. It will mean that Velindre will have a footprint within Cardiff and Vale around acute oncology.

5.2 Sarah Morley, Executive Director, Organisation Development, gave an update on the strategic work across the organisation to support and deliver the new trust strategy Destination 2032, aiming to be a beacon for research,

development, and innovation. Programme established called Building Our Future Together to set in place the levers and parts in order to deliver those ambitions such as Destination 2032.

5.2 Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science, a business case is being finalised for the School of Oncology, including proof of concept work and benchmarking with the goal of developing and delivering bespoke specialist oncology training.

6 Cardiff University: Updates and Discussion (C21)

6.1 *Rhian Goodfellow* gave a verbal update for Cardiff University:

- NSS scores improved from the previous year, with students receiving a good experience despite COVID-19 pandemic.
- Staff changes within School of Medicine. Dr Jamie Read is the new Dean of Medical Education after Professor Helen Sweetland retired. There are quite a few changes in community team, Dr Frances Gerrard and Dr Sue Emerson have both retired with Dr Bethan Stephens and Dr Naomi Stanton taking up the roles, Naomi is also the Director of Admissions and Recruitment.
- University revalidation is currently underway for the curriculum, although no major changes are predicted. Currently looking at transitions within the programme, from school leavers to year 1, and transition from year 2 to 3 with more clinical timetable, and again to year 5.
- Medical Licensing Assessment (MLA) to be introduced for students graduating 2024-25, 2-part exam and the clinical professional skills assessment will be the year 4 ISCE and the applied knowledge test which will take place in the final year.
- Bangor University is currently seeking GMC approval for an independent medical school, and we will be the contingency school, and Bangor will follow our curriculum for the first five years. Starting with a cohort of 60 students and we will need to look at placements across Wales and we are all working together to ensure all students within Wales (Cardiff, Swansea and Bangor Universities) get a great experience.
- Dr Eve Gallop-Evans questions if there is a commitment to ensure that training places are available to students in Wales especially with the expansion of medical student places. *Rhian Goodfellow* noted that there will need to be an expansion of F1 posts with commitment for training in Wales.
- Dr Jamie Reed, Dean of Medical Education and Director of the Centre for Medical Education suggests that struggles to recruitment into medicine won't happen for a very long time. Making the most of the increasing student placement numbers to retain and keep those students in Wales is a big challenge as Wales is a net exporter of qualified doctors to London and further afield in England. Work needs to be done to ensure that the increasing student numbers serve the population of Wales.

7 Other Reports:

7.1 GMC Guidance on UG Clinical Placements (Document 4) was included in the agenda for information.

8 Library Report 2021/22

Velindre University NHS Trust

8.1 The Library Service Report for 2021-22 (Document 5a) was included in the agenda for information with a brief verbal update by Bernadette Coles, Librarian.

Cardiff University

8.2 The Library Service Report for 2021-22 (Document 5a) was included in the agenda for information with a brief verbal update by Tracey Stanley, Director of University Libraries.

Part III – Hospital Medical Sift

9 Hospital Board SIFT Expenditure Return 2021/22

9.1 The Welsh Government SIFT Expenditure schedule 2021-22 (Document 6) was included with the agenda for information. Verbal update by Matthew Bunce, Executive Director of Finance and Kieran Gingell, Management Accountant.

9.2 Rhian Goodfellow noted that the SIFT Expenditure document should be reviewed to show spending more accurately, as White Coats and Bleeps have not been used for quite a few years.

Part IV – Any other Business

- There was no other business.

2022/23 Education and Training Commissioning and Quality Meeting Report

Velindre University NHS Trust

Meeting Reference: CM/22-23/V
Meeting Date: 31 July 2023

Contents

1. Attendees

Attendees from Health Education and Improvement Wales (HEIW)
Alex Howells, Chief Executive
Pushpinder Mangat, Medical Director
Anton Saayman, Director of Educational Improvement (Medical Deanery)
Caroline Groves, Lead for Quality Unit
Kaye Walters, Postgraduate Education Support and Development Manager
Joe Draper-Orr, Head of Resources
Malcolm Gajraj, Director of Quality Management
Margaret Allen, Pharmacy Dean
Martin Riley, Deputy Director of Education, Commissioning and Quality

Attendee from School of Medicine, Cardiff University
Jamie Read, Dean of Medical Education *(observer)*

Lay Representation
David Lunt, Lay Representative

Attendees from Velindre University NHS Trust
Jacinta Abraham, Medical Director
Louise Hanna, AMD Medical Education and Training
Ricky Frazer, Faculty Lead (Velindre)
Nicola Williams, Director of Nursing, AHPs and Medical Scientists
Matthew Bunce, Director of Finance
Sarah Morley, Director of Organisational Development and Workforce
Eve Gallop-Evans, Clinical Director, Velindre Cancer Service
David Osborne, Head of Finance Business Partnering
Nicola Hughes, Medical Directorate Manager
Elizabeth Eddie, Executive Medical Business Manager
Victoria Davies, Workforce Development Manager
Edwin Massey, Medical Director, Welsh Blood Service
Tracey Rees, Chief Scientific Officer, Welsh Blood Service
Claire Budgen, Head of Organisational Development
Susan Thomas, Deputy Director of Organisational Development and Workforce
Tina Jenkins, Senior Nurse, Safeguarding and Public Protection
Helen Payne, Interim Radiotherapy Services Manager

Apologies
Lisa Llewelyn, Director of Nurse and Health Professional Education, HEIW
Steve Ham, Chief Executive, Velindre University NHS Trust

2. Overview of the Education and Training Commissioning and Quality Meeting

2.1 The Commissioning process has been established and developed by Health Education and Improvement Wales (HEIW) to meet its obligations to the regulators and Welsh Government.

2.2 Commissioning also forms the cornerstone of HEIW's Quality Planning activity for high quality education and training in clinical learning environments in line with HEIW's Multiprofessional Quality Framework and standards for education and training. To this end, Commissioning meetings have now been reframed as 'Education and Training Commissioning and Quality' meetings. These

meetings also reflect an increased emphasis on the learning environment and the importance of aligning educational and clinical governance.

2.3 The Commissioning process provides an annual opportunity to review education and training provision within a Local Education Provider, to ensure compliance with education and training standards and the delivery of obligations detailed in the Expectations Agreement.

2.4 The process also provides an opportunity to consider challenges and opportunities for the year ahead and to identify good practice which can be shared across NHS Wales.

2.5 Commissioning postgraduate medical education in isolation is not effective in integrating the whole population need and should be considered along with other professional commissioning activity. Therefore, although meetings predominantly have a medical focus, in recent years contributions from representatives of other health professional groups including Pharmacy, Dental, Nursing and Allied Health Professionals have been welcomed with a view to developing a more multiprofessional approach to activity. This approach continues for the 2023 meetings.

2.6 HEIW is keen for Commissioning to be an open and transparent process which promotes a collaborative approach with LEPs to support, deliver and manage high quality education and training across NHS Wales.

3. Training and the Future Workforce

3.1 Training Matters with National or Strategic Impact for Local Education Providers (LEPs)

3.1.1 In advance of the meeting, HEIW provided the Trust with a paper on 'Training Matters with National or Strategic Impact for Local Education Providers (LEPs)'. The paper provided an overview of important updates and developments relating to education and training. Of particular note for Velindre University NHS Trust were the following items:

.1 The Medical Licensing Assessment (MLA) will be implemented from early 2024. All International Medical Graduates (IMG) who apply for a licence to practice in the UK will be required to undertake the MLA which will replace the GMC's Professional and Linguistic Assessments Board (PLAB) test that they were previously required to pass. UK medical students graduating from 2024-25 onwards will also need to pass the MLA as part of their medical school degree before they can join the medical register.

.2 HEIW is committed to supporting SAS doctors in Wales and is considering the development of a pathway for SAS doctors to achieve CCT if they choose to do so. Support already in place for SAS doctors includes the development of a Certificate of Eligibility for Specialist Registration (CESR) support network across Wales, the launch of the HEIW SAS CESR advice line, and the extension of specialty training educational opportunities to SAS doctors. HEIW is currently piloting CESR support for three Anaesthesia SAS doctors in a rotation between Swansea and Cardiff, who will be supported by two CESR Support Educational Advisers, one based in Cardiff and one in Swansea, with a Clinical Lead. This pilot will be assessed in two years and, if successful, could be rolled out in other specialties.

.3 The numbers of Anaesthesia Associates (AA) in Wales continues to gradually increase with two new trainee roles appointed in Swansea Bay UHB in March 2023. An all-Wales AA job description has been developed to support this, as has an all-Wales educational agreement for new trainee AAs. The Trust may wish to consider any opportunities it may be able to offer to AAs (e.g. pain management in palliative care).

.4 HEIW is keen to increase the number of Physician Associates (PA) working across NHS Wales and is committed to working with Health Boards / Trusts to identify where PAs could be incorporated into the medical model to assist in delivering high quality patient care. HEIW is developing a strategic framework to fully embed the PA role across primary and secondary

care. An All-Wales PA education programme is also being developed. The Trust is currently reviewing how best to utilise and support its PAs.

.5 HEIW has developed a 'Professional Framework for Enhanced, Advanced and Consultant Clinical Practice' that replaces the NILIAH (2010) Framework for Advanced Nursing, Midwifery and Allied Health Professional Practice, recognising the changes in workforce across Wales. The framework defines these levels of practice, the education that underpins them, and provides support and guidance for employers, Higher Education Institutions (HEIs), and clinical practitioners or those aspiring to practice at these levels.

.6 HEIW's multi professional Primary and Community Care Education & Training (PaCCET) Unit is working to develop multi professional education and training for the primary and community care workforce. It is working to establish Primary and Community Care Academies within Health Boards/Trusts across Wales that will facilitate local education and training by bringing together HEIW and local expertise, skills and resources. Governance arrangements for these academies are currently being developed.

.7 Apprenticeship models of training are beginning to be seen in medicine in England and HEIW needs to be aware of this and be in a position to embrace this new way of training.

3.2 Future Workforce Planning

3.2.1 HEIW is committed to working with Health Boards/Trusts across Wales to ensure that the requirements set out in their IMTPs are considered in relation to the development of the annual education and training plan for Wales.

3.2.2 Recruitment to certain specialties remains challenging across the UK and more rural and geographically dispersed LEPs generally face the greatest challenges. HEIW is keen to work collaboratively with all Health Boards/Trusts to develop and maximise innovative training opportunities which may help to improve recruitment and retention. A particular challenge is recruitment to some of the higher medicine and higher psychiatry training programmes.

3.2.3 HEIW has agreed an expansion in Foundation programme posts to match the output of medical students from Welsh Universities so that every medical student graduating in Wales has an opportunity to take up a Foundation post in Wales. It is hoped that this will help to boost the medical workforce in Wales and improve retention, although there are some concerns around sufficient training capacity for additional students and trainees. The number of Foundation posts are likely to increase further with the opening of the North Wales Medical School in 2024. Since the previous Commissioning meeting one year ago, the Trust has taken on new F2 trainees.

3.2.4 There are national challenges with recruitment to oncology however Wales is proud to have the best recruitment rates in oncology and palliative medicine.

3.3 LEP Strategic Priorities

3.3.1 The development of the new Cancer Centre is moving forwards and, whilst the importance of delivering high quality education and training is well understood throughout the Trust and individuals are committed to providing this, the Trust acknowledges that its workforce models will need to be transformed in order to maximise both education and training opportunities and high quality patient care in this new environment.

3.3.2 The new Cancer Centre will include a Collaborative Centre for Learning that will bring together learning, innovation, audit and quality improvement into one physical space and should therefore help to enhance collaboration. The Trust is keen to work with HEIW to develop this.

3.3.3 The Trust continues to offer taster placements to potential students and trainees in order to engage individuals at an early stage in their career which it is anticipated will help with future recruitment. The Trust is also investing in Fellows and specialty doctors to support the workforce.

3.3.4 The Trust has been working with colleagues in HEIW to develop a business case in relation to the Velindre Oncology Academy. The majority of non-surgical cancer training is currently provided outside of Wales, so the network is proposing some courses as a minimum requirement for cancer services that are not available within Wales. The Trust has linked in with the University of Trinity St David's around course and module accreditation and is working on a model of self-funding from year 4 of the Academy being established. It is anticipated that the Academy will provide a fantastic opportunity for the Trust to attract, recruit and retain its staff, but also that it will create some great opportunities across NHS Wales. A number of concept courses have been developed, including enhanced communication skills, which have proved very successful during the last year. HEIW is keen to be involved in discussions to develop the Academy and looks forward to working with the Trust to take this forward.

3.3.5 The Trust is grateful for HEIW's 'Professional Framework for Enhanced, Advanced and Consultant Clinical Practice' that was published in June 2023. The Trust is currently reviewing the framework to determine the opportunities that it may provide and to consider the transformational workforce models that will be required in order to take advantage of these opportunities. The Trust believes that professional equity around research capacity, development time, etc would be essential in this to enable individuals to work at the top of their licence. The Trust also understands that to develop its own enhanced, advanced and consultant practitioners, individuals would need access to specialist training and support and it is therefore anticipated that the Velindre Oncology Academy will help to achieve this.

4. Learning Environments

4.1 Financial Considerations

4.1.1 In 2021/22, Velindre University NHS Trust was allocated circa £600k for training grade salaries (TGS) that are funded 50% by the Trust and 50% by HEIW.

4.1.2 The actual cost associated with these training grade salaries at the Trust for the same period was circa £1.1 million. In addition, the Trust spent £384k on 100% Trust funded training posts and an additional £600k on banding costs.

4.1.3 The Trust reported circa £10k of locum costs which is comparatively low, largely due to other staff in the Trust covering gaps and picking up work rather than locums being hired. The Trust acknowledges that this approach is not going to be sustainable long term as workload and pressures increase further and it is therefore currently undertaking work to understand the additional staffing resources and associated costs that it will need in the future.

4.1.4 In 2021/22 the percentage of TGS funding to actual cost for the Trust is reported as circa 40% which is comparable with the average of 39% over the last three years.

4.1.5 In addition to TGS allocations, HEIW also provided the Health Board with an allocation of circa £55.5k (comprising circa £15k for study leave, circa £31k towards library costs and circa £9.5k for postgraduate centre premises and postgraduate education support) to support the development, delivery and management of postgraduate medical and dental education and training locally. The Health Board's reported expenditure was circa £64k.

4.1.6 The deficit between funding and costs for the Trust's library provision is circa £15k and the Trust asked HEIW to consider if there are any opportunities for additional funding in that area. This request will be considered as part of the overarching postgraduate medical education support funding review.

4.1.7 The Trust sought clarification on whether or not the 31% gap between funding and its costs for training were consistent with other Health Boards / Trusts across NHS Wales. HEIW confirmed that once all of the Education and Training Commissioning and Quality Meetings for 2022/2023 are complete it will undertake further analysis which will include consideration of the funding gaps

across the piste. HEIW will look at the variations that exist and ascertain what is driving them so that it can be sure that it is supporting all Health Boards / Trusts across Wales in the best possible way.

4.1.8 The Trust is currently undertaking an exercise to understand the trainer impact on cost of training based on an approach that is utilised by Cardiff and Vale UHB.

4.2 Educational Governance and Local Education Support

4.2.1 Education and training is one of the Trust's strategic priorities and it has a highly engaged, multiprofessional Education and Training Team who are proactive in managing, developing and delivering training.

4.2.2 One of the key drivers of the Trust's People Strategy is ensuring a sustainable workforce. The Trust has recently agreed a Workforce Development Framework, aligned to the All-Wales Workforce Plan and Strategy, which focuses on an interdependent, multiprofessional way of planning, recruiting, training and developing the workforce for the future.

4.2.3 With the scope and reach of the Trust's activity set to expand moving forwards, there will be a need to strengthen the support for medical education across the whole Trust and understand where it fits in relation to the transformed, multiprofessional workforce of the future.

4.2.4 The Trust remains light in terms of its administrative support for medical education and training and is keen to address this moving forwards.

4.3 Training Developments and Future Allocations

4.3.1 There are currently 34 trainees in radiology and medical specialties across the Trust. There are no free-standing GP rotations associated with the Trust.

4.3.2 Trainer declaration data indicates that 82% of medical trainers recognised by the GMC are able to utilise the time in their job plans for their training role compared to the Wales average of 67% of medical trainers, however the Trust does still have some challenges around supporting its trainers. *(see 5.5 – 5.6)*

4.3.3 The Trust is committed to multiprofessional working to enhance patient care along with education and training opportunities. It therefore already undertakes a lot of cross professional training (e.g. medics supervising non-medical prescribers, non-medical outliners, and Advanced Nurse Practitioners (ANP)). Increasingly those individuals with advanced skills then go on to teach less senior medics, demonstrating that multiprofessional training can work both ways.

4.3.4 Whilst a quarter of the curriculum and examination marks for haematology trainees are in blood transfusion, trainees currently only receive two weeks of lectures and virtual monthly case reviews in this element of the curriculum in Wales. There is no other supervised transfusion specific training. In contrast, the haematology training curriculum currently comprises at least one year of supervised training in each of the other three areas (haemostasis and thrombosis; laboratory; and malignant and transplantation). The Trust is concerned about this discrepancy and the lack of training in transfusion and is keen for the issue to be addressed in order to support the future recruitment of consultants into the Welsh Blood Service. Around 6 – 7 years ago, the first consultant clinical scientists in transfusion qualified and the Welsh Blood Service has been using this route to help with the supply and demand issue in transfusion. It is now keen to develop a specific registrar rotation in transfusion and this idea has the support of the Training Programme Director for Haematology as well as the trainees. The Welsh Blood Service would like to submit an application for an additional rotating SpR into a joint Cwm Taf Morgannwg UHB and Velindre University NHS Trust training post to gain specialist experience in the area. A current trainee who is approaching the end of their training has an interest in blood transfusion and would like to undertake an out of programme (OOP) experience in this area. The Welsh Blood Service is working hard to try to enable this. The Welsh Blood Service should provide the above information and

proposal to the Head of School for Medicine and Training Programme Director for Haematology for discussion and consideration. In addition, Haematology and its associated training numbers are scheduled for review in next year's training plan so this issue can also be picked up as part of these discussions.

4.3.5 The Trust faces challenges in recruiting and supporting biomedical and clinical scientists through qualifications to take up senior level posts (e.g. specialist and senior biomedical scientists). It has therefore taken the position of using Annexe 21 to employ individuals into those posts as trainees and this seems to work well. The Trust also uses this approach when recruiting individuals with non-accredited biomedical science degrees to band 4 and then trains them to become band 5. Whilst the approach currently works well, the Trust has concerns about the training resource available to support it, particularly with the announcement and introduction of diagnostic hubs that will likely employ some of the Trust's current biomedical scientists and an increase in the training requirements for biomedical scientists which puts additional training pressures on the Trust.

4.3.6 The Trust urged HEIW to consider providing funding to provide some training overhead in terms of staffing and capacity and to set out a route for organisations to be able to apply for that funding. HEIW is conscious of the limited post registration and advanced practice budgets and is aware that Velindre utilises all of the funding that is provided to it for this purpose. HEIW is currently reviewing whether or not the funding could be increased for next year. HEIW is also involved in discussions to separate out the post registration element of funding for Cancer Services and the Welsh Blood Service so that more tailored support can be provided individually to the two separate areas.

4.3.7 HEIW confirmed that the equivalence funding around healthcare sciences to support individuals undertaking the Practitioner Training Programme or the Scientist Training Programme has been built into the education and training plan and will therefore be provided recurrently.

4.3.8 The Trust is aware that the national Pathology Strategy Board is having early-stage discussions around setting up an Academy to provide opportunities for collaborative working. HEIW assured the Trust that it is in discussion with the School of Pathology to ensure that these academies are established on a sustainable basis and will be underpinned by appropriate educational governance arrangements. Work is expected to continue on this over the next 12 months.

4.3.9 HEIW is aware of the significant issues around placement capacity in radiotherapy and oncology. It is therefore working with Cardiff University and Velindre University NHS Trust to pilot a multiprofessional Practice Education Facilitator to provide clinical supervision and support undergraduate placements. The impact of this post will be evaluated in 6 months' time.

4.3.10 The Trust has worked with HEIW to consider the commissioned training places in radiotherapy to ensure that the student experience is maintained at a high level whilst the service goes through significant change and experiences reduced capacity at the current Velindre Cancer Centre site.

4.3.11 There are challenges around developing radiotherapists to enhanced, advanced and consultant practice roles and the Trust is looking at training provisions available for individuals to transition into practitioner status under the Ionising Radiation (Medical Exposure) Regulations (IRMER). To date there has not been much support around that transition across the UK however it is something that will likely need to be developed for the future.

4.3.12 HEIW is very satisfied with the level of engagement that the Trust has with pharmacy training and appreciates the training opportunities afforded by the Trust.

4.3.13 By August 2026, all pharmacists at the point of registration will have enhanced clinical skills and Independent Prescribing (IP) status. The revised undergraduate training programme for pharmacy therefore places increased emphasis on clinical training placements to enable individuals to develop the necessary skills. HEIW provides a significant amount of funding towards the enhanced clinical experiences required.

4.3.14 HEIW is keen for multiprofessional learning opportunities to be maximised for its pharmacy students and trainees and it is anticipated that by sharing learning opportunities across professional

boundaries that this will assist with overcoming the challenges around training capacity and encourage more multiprofessional approaches within the workforce of the future.

4.3.15 HEIW has recently launched the Pharmacy Workforce Plan which aims to develop the pharmacy workforce of the future across all sectors of practice including the acute sector, community pharmacy and GP pharmacy. It is anticipated that the Plan will be well aligned to the outcomes of the Acute Service Review commissioned by Welsh Government to look at developing the pharmacy services of the future. HEIW is keen to work with the Trust as it plans its workforce for the new Cancer Centre to ensure that training opportunities in pharmacy are identified and optimised.

5. Quality Management and Quality Assurance of Training

5.1 The Trust has a very engaged and motivated Education and Training Team that strives to deliver the best education and training possible. As such, it is very proactive in supporting education and training, often identifying and resolving potential issues before they become significant.

5.2 The relationship between the Trust's AMD (Education and Training) and Faculty Lead (Velindre) and colleagues within HEIW is positive and constructive, with regular two-way communication ensuring good quality management of education and training.

5.3 The Trust does not have any issues in Enhanced Monitoring status with the GMC and no current high risk training quality concerns.

5.4 Some lower-level training concerns have been added to the medical training risk register for the Trust following the receipt of results from the 2023 GMC Training Surveys, but this is in line with other Health Boards / Trusts. The general deterioration in recent GMC National Training Survey results across the piste can likely be attributed, at least in part, to the challenging training landscape post COVID-19.

5.5 The trainer concern in oncology (Targeted Process Ref TP565) raised via the 2022 GMC National Trainer Survey remains on the HEIW risk register for the Trust with below outliers reported for overall satisfaction, support and appraisal, and time and training resources. The Trust has taken steps to emphasise the importance of whole practice appraisal in considering training roles alongside other clinical roles. The time and resources outliers have been reviewed and are reported to be a result of increased service demand and the launch of a new clinical information system. Recruitment of new staff is being taken forward and steps are being taken to consider how to allocate SPA time to inform job planning.

5.6 The Trust is aware of how its consultants go above and beyond to support education and training across the multiprofessional workforce. This workload is acknowledged in job planning but a lot of work becomes displaced out of hours. The Trust understands the importance of ensuring ring-fenced time for undertaking a trainer role within hours. Education and training is embedded within the workforce model and the Trust's senior leaders support this. Over the next 12 months the Trust plans to review how it will release its consultants and other staff to undertake other elements of their role that are required by the Trust and HEIW (e.g. education and training, leadership development, research, etc). HEIW is keen to work collaboratively with the Trust on this issue to ensure that time for training is appropriately provided moving forwards.

5.7 The Trust continues to achieve some outstanding GMC Training Survey results for Palliative Care and should be commended for its ongoing work in this area.

6. Future Considerations

6.1 The increasing pressures on the NHS across the UK over the past few years is recognised and is reflected in the increased number of targeted visits required across Wales in 2023. Adaptations to

the ways in which training and service are delivered will be likely in order to continue working effectively in the face of this increased pressure.

6.2 Whilst the Commissioning meetings provide a brief, annual opportunity for multiprofessional discussion around education and training, there is an appetite for additional opportunities throughout the year for colleagues to come together to share information and good practice, consider challenges and develop collaborative and innovative solutions.

6.3 The 2023 GMC National Training Survey results are currently being processed and HEIW will inform all Health Boards of the trends arising from the results in due course.

6.4 Notable Practice

6.4.1 HEIW commended the Trust on having the best recruitment rates in the UK for oncology and palliative medicine, particularly in light of the national challenges with recruitment to oncology. *(vide 3.2.4)*

6.4.2 HEIW commended the Trust on the work it is already doing to utilise cross professional models of training to best support its trainees across a range of medical and healthcare professions. *(vide 4.3.3)*

6.4.3 The Trust is highly engaged with pharmacy training and HEIW appreciates the training opportunities afforded by the Trust. *(vide 4.3.12)*

6.4.4 The Trust's commitment to education and training and its approach to the quality management of training is exemplary, with a proactive team often identifying and resolving potential training issues before they become significant. *(vide 5.1)*

6.4.5 The Trust continues to achieve some outstanding GMC Training Survey results for Palliative Care and should be commended for its ongoing work in this area. *(vide 5.7)*

6.5 Actions Arising from the meeting

6.5.1 The following specific actions arose during discussions:

A1 The Trust will work collaboratively with HEIW on the development of the new Cancer Centre and the Collaborative Centre for Learning to ensure that education and training is appropriately considered and to maximise training opportunities for the future. *(vide 3.3.1, 3.3.2 and 4.3.15)*

A2 The Trust will continue to involve HEIW in discussions around the development of the Velindre Oncology Academy. *(vide 3.3.4)*

A3 Following completion of the 2023 round of Education and Training Commissioning and Quality meetings, HEIW will undertake further analyse of funding for and costs of training to identify the variations that exist and ascertain what is driving them so that it can be sure that it is supporting all Health Boards / Trusts across Wales in the best possible way. *(vide 4.1.7)*

A4 The Welsh Blood Service should take the issues around transfusion training and the idea of developing a transfusion specific rotation to the Head of School for Medicine and Training Programme Director for Haematology for discussion and consideration. *(vide 4.3.4)*

A5 HEIW to continue work in relation to the funding for post registration and advanced practice budgets. *(vide 4.3.6)*

A6 HEIW will work collaboratively with the Trust and other Health Boards / Trusts across NHS Wales to ensure that protected time for training is appropriately provided moving forwards. *(vide 5.6)*

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Annual Health and Safety Report - 2022 / 2023

DATE OF MEETING	14th September 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE
REPORT PURPOSE	INFORMATION / NOTING
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Jason Hoskins, Assistant Director of Capital Planning, Estates and Environmental Development
PRESENTED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital
APPROVED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital
EXECUTIVE SUMMARY	The Trust is required to produce an annual report in relation to Health and Safety performance across the Trust (see appendix 1).
RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee asked to: • **NOTE** the Trust Annual Health and Safety Report for 2022 / 2023

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
TRUST HEALTH SAFETY AND FIRE MANAGEMENT BOARD	16th May 2023
VCC CYNEFIN HS&F GROUP	31st July 2023
WBS CYNEFIN GROUP	29th June 2023
EXECUTIVE MANAGEMENT BOARD	31st August 2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS: The Annual Health and Safety Report was noted by the groups listed above.	

7 LEVELS OF ASSURANCE – NOT APLLICABLE

APPENDICES	
Appendix 1	Health and Safety Annual Report – 2022 / 2023

1. SITUATION

It is a recommendation from the Trust internal audit function, as part of the Trust assurance process, that an annual report is submitted to the Trust Board in relation to the management of Health and Safety across the organisation. This paper has been prepared to provide the Trust Board, following endorsement by the Trust Quality, Safety and Performance Committee, with the annual Health and Safety report from the Trust Health Safety and Fire Board for the financial year 2022 / 2023.

2. BACKGROUND

This Trust Annual Health and Safety report has been produced to provide an overview of the management and performance of Health and Safety across Velindre University NHS Trust for the period 1st April 2022 – 31st March 2023.

3. ASSESSMENT

The Trust received no prosecutions or Improvement Notices from any of the enforcing agencies of the HSE, or Fire & Rescue Service during 2022 / 2023. This status has now been maintained for many years and is a direct result of the '*good Safety Culture*' and the high standards throughout the Trust for health & safety compliance.

The Trust Incident Reporting process is a significant part of this culture and continues to remain strong during the past year as a well-established part of the Trust and its values.

The increasing incident reporting culture remains strong and continues to improve with a measured increase in reporting across the many Trust departments.

There were several issues improvements made across the Trust's Health and Safety and Fire management systems during the financial year. These are highlighted within the Annual report (Appendix 1). During the year there were only 4 RIDDOR reportable accidents reported to the HSE. This is a reduction on the previous year.

There have, however, been a number of instances of violence and aggression toward staff, which are in the main verbal. All such instances are assessed and there have been occasions where the Trust has issued Behavioural Agreements.

RIDDOR numbers remain low which again confirms the resilience of the Trust safety management systems.

4. SUMMARY OF MATTERS FOR CONSIDERATION

The Quality, Safety and Performance Committee is asked to:

- **NOTE** the Trust Annual Health and Safety Report for 2022 / 2023

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 Annual Health and Safety Report for 2022 / 2023 is a factual report based upon recorded performance during that timeframe. The Trust has established robust management systems and processes to support the management and reporting of Health and Safety across the Trust.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
	The Annual Health and Safety Report for 2022 / 2023 is a factual report based upon recorded performance during that timeframe and therefore there is no requirement for a socio economic duty assessment.

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 equality impact considerations in relation to the Trust Annual Health and Safety report.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	There are no additional legal considerations in relation to the Trust Annual Health and Safety report.

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
	The Annual Health and Safety Report for 2022 / 2023 is a factual report based upon recorded performance during that timeframe. Any 'live' / current Health and Safety risks which are identified 'in-year' are recorded on the Trust Health & Safety Risk Register.
All risks must be evidenced and consistent with those recorded in Datix	

Velindre NHS Trust Health and Safety Annual Report 2022-2023

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Canolfan Ganser Felindre
Velindre Cancer Centre

Health and Safety Annual Report 2022-2023
Version - 01

Purpose of the report:

Annual quality management review to ensure continuing suitability, adequacy and effectiveness of the quality management systems and alignment with the strategic direction of the organisation.

Prepared by:

Jason Hoskins, Assistant Director of Estates

Ceri Pell, H&S Adviser

Matthew Bellamy, H&S Adviser

Reporting Period:

Financial Year 2022/2023

Report date:

July 2023

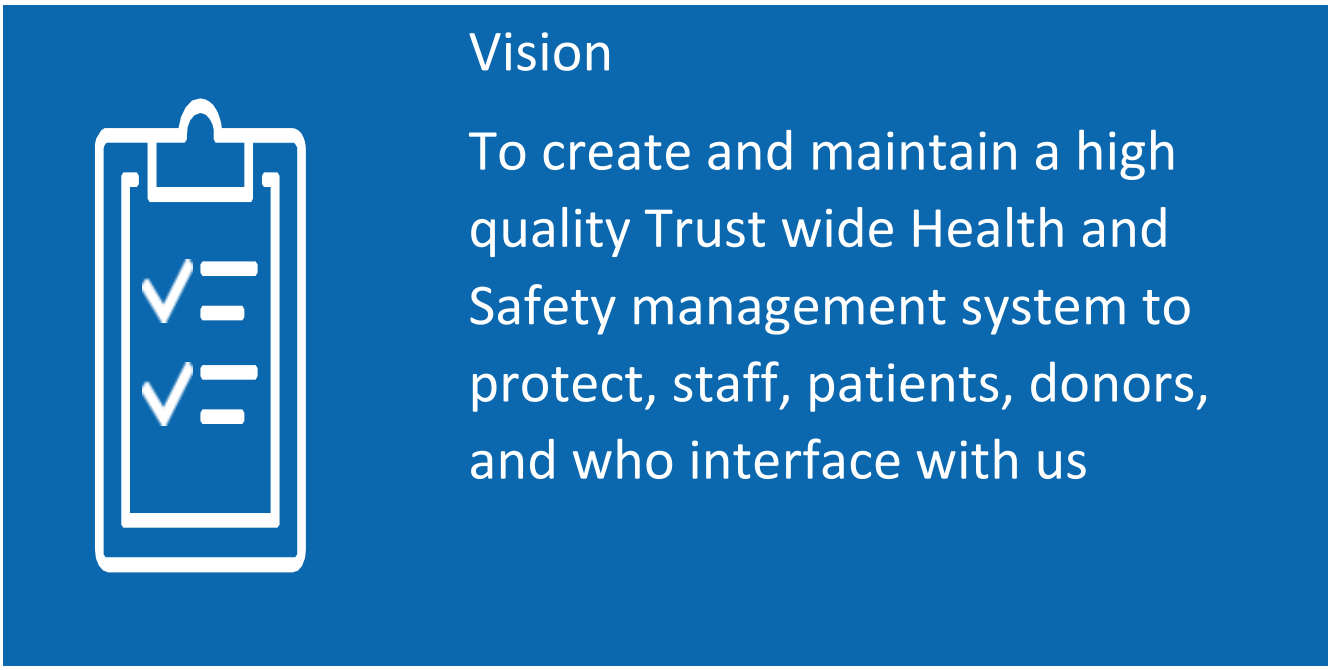
Contents

1 Introduction

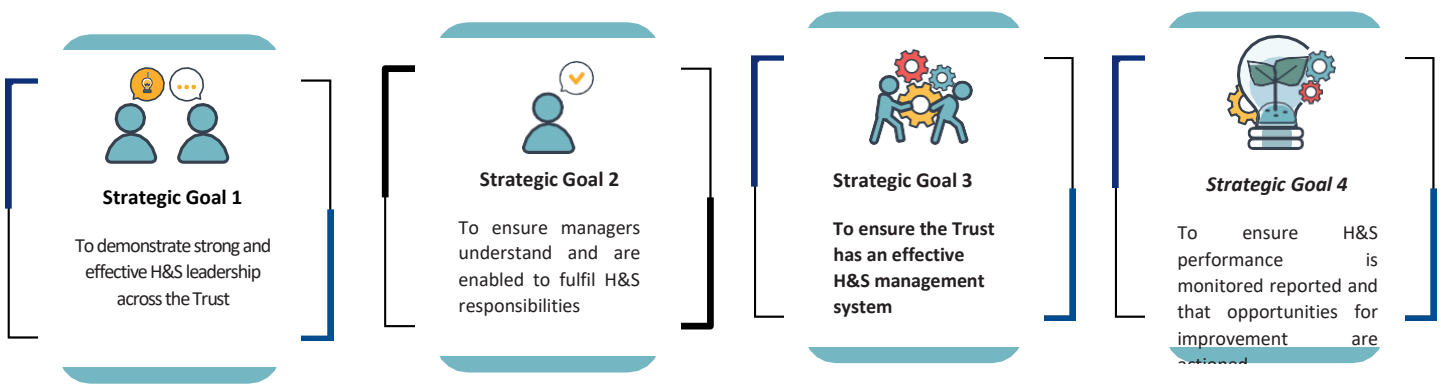
This Health and Safety annual report has been produced to provide an overview of the management of Health and Safety within Velindre University NHS Trust for the period 1st April 2022 – 31st March 2023.

1.1 Our Vision & Strategic Goals

The Trust has developed a strategy to include a vision and 4 strategic goals, to support improving and enhancement of the H&S culture within the Trust



Trust Strategic Goals 2022-2023



2. Executive Summary

The Trust received no prosecutions or Improvement Notices from any of the enforcing agencies of the HSE, or Fire & Rescue Service during 2022/23. This status has now been maintained for many years and is a direct result of the 'good Safety Culture' and the high standards throughout the Trust for health & safety compliance.

The Trust Incident Reporting is a significant part of this culture and continues to remain strong during the past year as a well-established part of the Trust and its values.

The increasing incident reporting culture remains strong and continues to improve with a measured increase in reporting across the many Trust departments. The Trust reported 140 incidents during the year which was an increase of 11% on the 12,847 Incidents reported during 2022/2023

There were several issues identified and improvements made across the Trust's H&S, Fire management systems during the financial year, which are highlighted within the report. During the year there were only 4 RIDDOR reportable accidents reported to the HSE which is a reduction on the previous year

This equates to a 10% increase in relation to the previous year. Root cause analysis investigations have been completed.

RIDDOR numbers remain low which again confirms the resilience of the Trust safety management systems. Root cause analysis investigations are completed in all cases and the learning is built back into the relevant processes & procedures.

Other main reporting categories consisted struck by object moving/stationary, slip/trip/fall incidents. Although there are no trends the above categories remain in the highest recorded and will be monitored going forward.

There have also been a number of instances of violence and aggression toward staff, which are in the main verbal. All such instances are assessed and there have been occasion where the Trust has issued Behavioural Agreements.

3 Health and Safety Management

3.1 Health and Safety governance was upheld through the course of the year through a framework of Health, Safety and Fire meetings at both divisional and Trust level. The Trust Health Safety and Fire Board consists of senior managers and reports to the Executive Management Board. Divisional Health Safety and Fire meeting was established at Velindre Cancer Centre and Welsh Blood Service, with Estates related matters discussed within the Estates Management Group. These forums bring together management level representatives from departments to monitor and actively engage in health and safety planning and management. Meetings are supported by a monthly Health, Safety and Fire subgroup who provides operational support to the Health and Safety Lead for the division.

3.2 The Velindre Cancer Centre, Welsh Blood Service and Trust meetings for 2022/23 are scheduled quarterly and monthly and dates are in the diary. Additional meetings have been added to the cycle of business to support the Health and Safety Agenda building on works achieved in the previous year, meeting include;

- VCC Operational & Delivery Health Safety and Fire Group
- WBS Health Safety & Fire Group

Table 1 – Health and Safety governance – meeting schedule

Health and Safety Governance	Chair	Agreed Frequency	Number of meetings held 2021/22
Trust Health Safety and Fire Board	Director of Strategic Transformation, Planning & Digital, Corporate Services	Quarterly	3
VCC Health and Management Group	Operations Manager	Quarterly	2
VCC Operational & Delivery Health Safety and Fire Group	Operations manager	Monthly	10
WBS Estates and Facilities management Group (Cynefin Group)	Interim General Services Manager	Quarterly	4
WBS Health Safety & Fire Group	Interim General Services Manager	Quarterly	1

Table 2 – Health and Safety Groups providing specialist advice and governance

Health and Safety Strategic Groups	Chair	Agreed Frequency	Actual
Electrical Safety Group	Head of Estates	6 monthly	2
Water Safety Group	Head of Estates	3 monthly	4
Ventilation Group	Assistant Director of Estates, Environment & Capital Development, Corporate Services	3 monthly	4
Medical Gas Group	Chief Pharmacist	3 monthly	4

3.3 Additional resource requirements have been discussed during quarter 4, which will be progressed through next financial year.

3.4 The Health and Safety Advisors for both Velindre Cancer Centre and Welsh Blood Service commenced studying for the NEBOSH Diploma in Health and Safety Management. WBS Advisor has completed the training.

Table 3 – Health and Safety resource

Department	Resource
Trust	Trust Health and Safety Manager
VCC	Health and Safety Advisor
WBS	Health Safety and Environment Manager

4 Health and Safety Priority Improvement Plan

4.1 The Trust Priority Improvement Plan has been the core document used through the year to develop and implement Health and Safety.

4.2 There has been sustained progress with the development and implementation of the Plan. The Trust Health, Safety and Fire Board have been provided with updates on progress to enable monitoring. The Priority Improvement Plan was reviewed and refreshed supporting the adoption of the 7 Levels of Assurance Framework with Divisional plans produced to support focus across all levels.

The plan translated the strategic vision and goals into actions to be delivered by the Trust.

5 Health and Safety Related Policies

5.1 Eight Policy reviews are scheduled in the next reporting period 2023/2024

Table 4 – Policies reviewed or in date

Reference no	Policy Title
QS18	Health Safety and Welfare policy
QS14	Safer Manual Handling
QS15	Management of Violence and Aggression
QS26	Safe use of Display Screen Equipment
QS09	Management of Latex and Latex Allergy
QS24	Medical Devices and Equipment Policy
QS30	Lone Working Policy
QS33	Control of Substances Hazardous to Health
QS36	Workplace Equipment Policy

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

Table 5 – Number of incidents by division by month

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Total
VCC	1	7	1	8	4	4	2	7	9	5	2	9	**59**
WBS	7	3	11	6	12	3	8	11	2	3	3	6	**75**
Corporate Division	1	1	0	0	2	0	0	0	0	0	0	2	**6**
Total	9	11	12	14	18	7	10	18	11	8	12	15	**140**

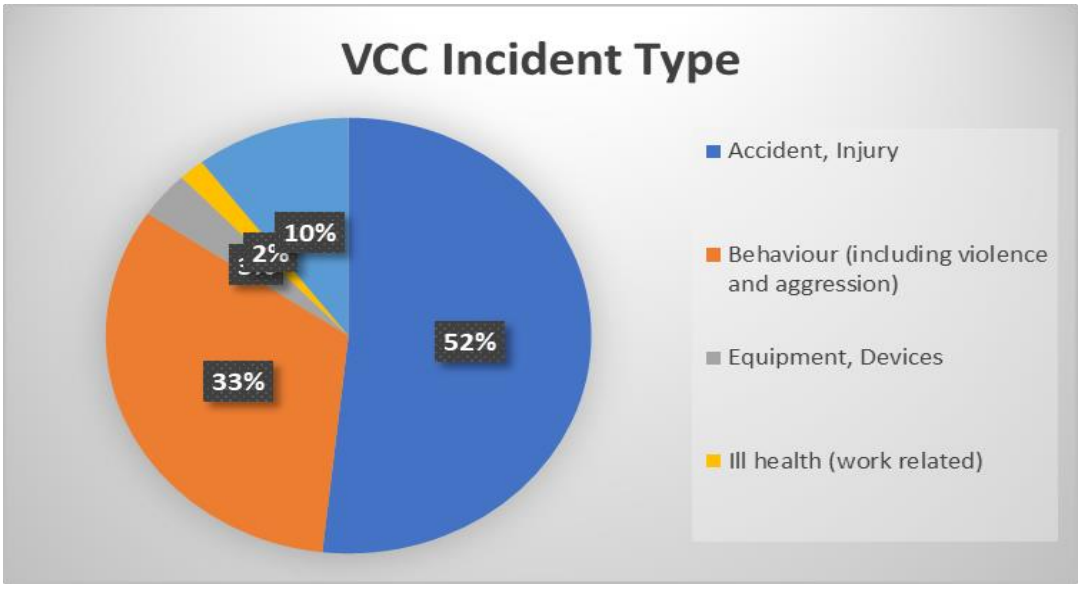
6.1 Table 4 details the number of incidents which occurred in each month and were recorded on the Datix system. Incidents are investigated, additional control measures are implemented when required and lessons learned are shared.

6.2 Incidents are monitored by the Trust and Divisional Health, Safety and Fire meetings and by the Estates Management Group. The manager responsible for the area/activity where the incident occurred is responsible for allocating a manager to investigate. Investigation training organised by Quality and Safety has been rolled out to a cohort of managers across the Trust to enhance the quality of incident investigations. Further support for incident investigation and recording on the Once for Wales Datix system is provided by the Health and Safety team.

Current trend analysis of the incidents experienced suggest that levels and types recorded do not require further investigation or training. However, where issues are identified addition training and support has been put in place. This trend analysis also identified the requirement to conduct a Training Needs Analysis exercise, which was concluded in quarter 3, and identified the need to expand training to meet the needs of the Trust.

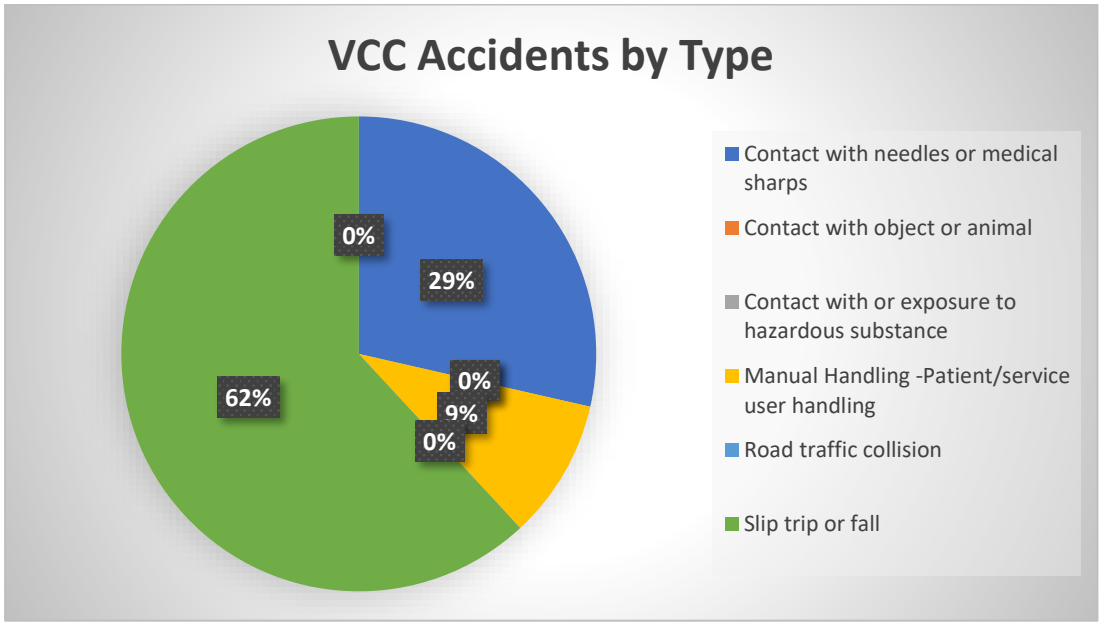
6.3 Chart 1 shows the percentage of incidents by type in VCC. The Accident/Injury coding has the largest percentage of incidents and contains the highest number of subtypes related to health and safety.

Chart 1 – VCC incidents by type (%)



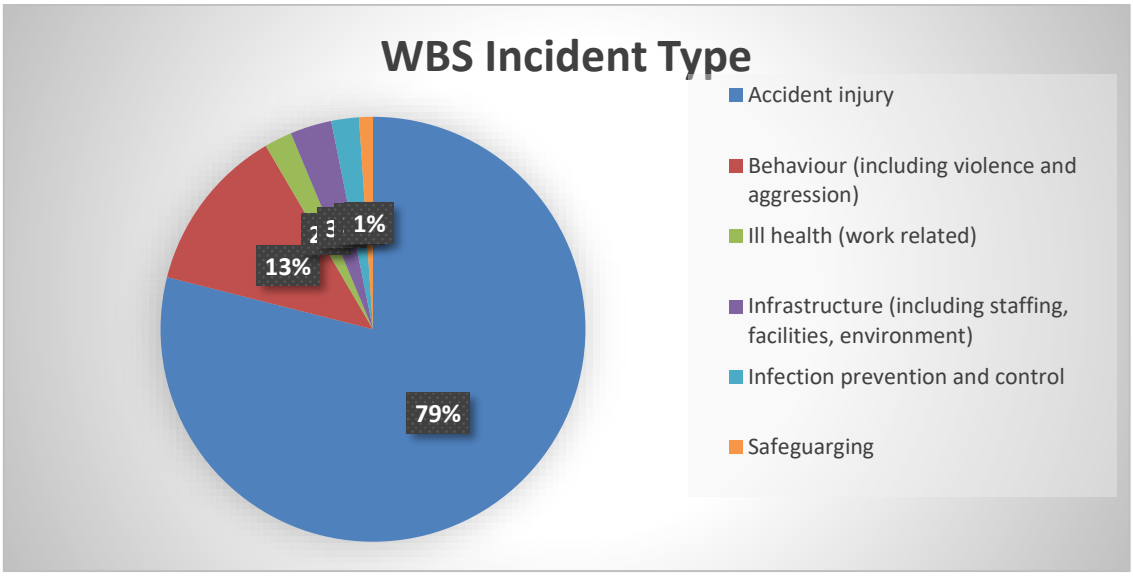
6.4 Chart 2 provides further details of the accident/incident coding. A further breakdown of sharps incidents and information about actions to address these incidents is contained in section 8. Accident numbers and types are such that there is no apparent trend identified that warrants any focus.

Chart 2 – VCC accidents by subtype (%)



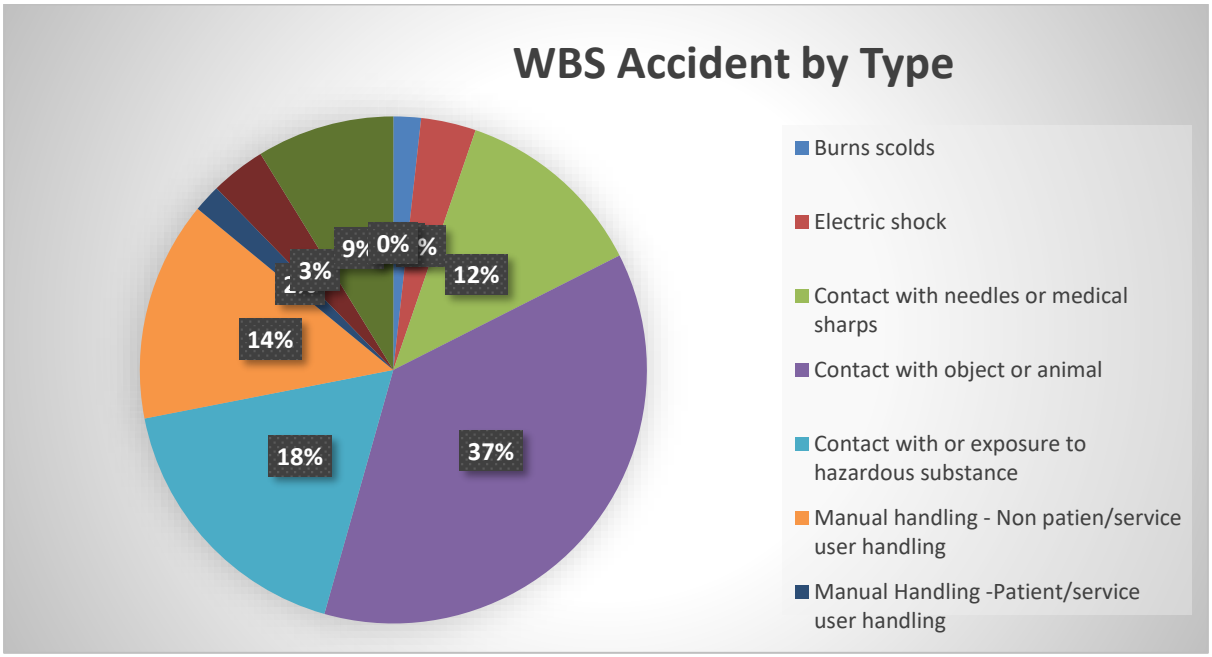
6.5 At WBS Accident/injury is the highest incident type which reflects the pattern in previous years and the high number of incident subtypes contained within this Datix OFW code. Accident numbers and types are such that there is no apparent trend identified that warrants any focus. Although it is evident that Accident injury accounts for most incidents.

Chart 3 – WBS Incidents by type



6.6 Chart 4 provides further details of the accident/incident coding section 8. Accident numbers and types are such that there is no apparent trend identified that warrants any focus, but contact with objects are the highest reported number of incidents

Chart 4 Accidents by subtype



6.7 There have been a number of incidents during the reporting period involving the collection teams when setting up collection venues. These have been recorded under accident, contact with object or manual handling incident categories. An ongoing investigation has ben under way involving a group of all necessary areas including safety, collections managers and transport. The Health and Safety adviser has met with the team to observe the problem and discuss. This is a complex problem and has been resolved initially by providing the team with additional equipment and exploring companies that can provide roll cages that are of the correct size to meet the requirements of the equipment vehicles. Further work will be undertaken to look at ordering new roll cages and we will continue to work with the teams over the next financial year.

6.8 WBS has seen a number of improvements during the reporting period to the outside space that will benefit staff health and wellbeing.

Improvements were made to the safety of the walk way around the WBS site. This followed on from the work to replace the rotten unsafe wooden steps with paved steps. Improvements in 2022/23 included resurface the pathway and replacing rotten picnic benches with new safer benches made from recycled plastic. The walk and the benches are used regularly by staff during breaks helping with their mental health and wellbeing and reduce stress levels by allowing them to get away from the stresses of the workplace and enjoy the grounds of the WBS site.

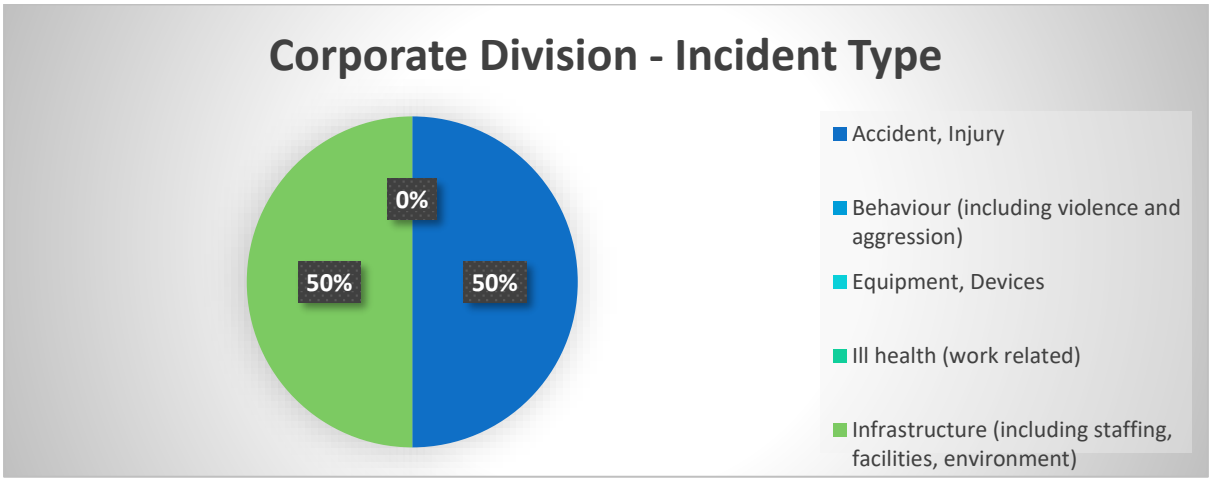
The improved path and seating area allow staff to spend their breaks enjoying the outside space helping relieve stress and anxiety. The pathway around sit allows staff to walk in their breaks helping with health.

6.9 The list below outlines learning and actions stemming from accident that occurred at VCC through the reporting period. All will be compiled into a document and communicated through the H&S forums. Slips trips and falls were identified as the most frequent accident type recorded.

Lessons Learnt	Improvement Plan
• Regular Internal and external site inspections	• Actions reported through the Health, Safety & Fire Divisional Meeting
• Modifications made to external walkways and pedestrian thoroughfares.	• Regular monitoring of pedestrian routes and behaviours
• Implementation of emergency lifting training	• Enhanced lighting during autumn and winter
• Incident Investigation Template for non-in-patient Falls	• Share lessons learnt across VCC site
• Robust reporting for workplace inspection actions	• Continue to promote the reporting of slips trips and falls on datix.
• Enhanced monitoring of internal floors and walkways	• Implement STF checklist to manage and prioritise risk
• Review of the workplace inspection audits	• Digital solutions for completing self-audits

6.10 There were only four incidents recorded in Corporate Division – thermal comfort, a road traffic incident, theft of earthing cables at Velindre Cancer Centre and one sharps incident.

Chart 5 Corporate Division Incidents by type



6 **Reporting of Incidents Diseases and Dangerous Occupancies Regulations 2012 (RIDDOR)**

6.1 There were four incidents reported to the Health and Safety Executive during 2022-2023. Three occurred at Velindre Cancer Centre and one instance was reported within the Corporate Directorate. The Health and Safety Executive took no further action on either occasion. An overview of RIDDOR incidents are included in Table 5 below.

Table 6 Incidents Reported Under RIDDOR

Date	Reporting type	Reporting Department
02/06/2022	Specified Injury	SACT
01/08/2022	> 7day absence	Estates
10/11/2022	> 7day absence	Integrated Care
14/11/2022	Specified Injury	Integrated Care

6.2 The list below outlines learning and actions stemming from investigation of the RIDDOR incidents that occurred through the reporting period. All will be compiled into a document and communicated through the H&S forums.

Lessons Learnt	**Improvement Plan**
• All incidents to be reported within the RIDDOR time frame.	• Improve communication across sites between Managers and H&S leads
• Raise awareness on RIDDOR report requirements	• Develop RIDDOR guidance for managers
• Review all incidents within 48 hours for RIDDOR reporting	• All RIDDOR incidents to be centrally reported by the H&S leads

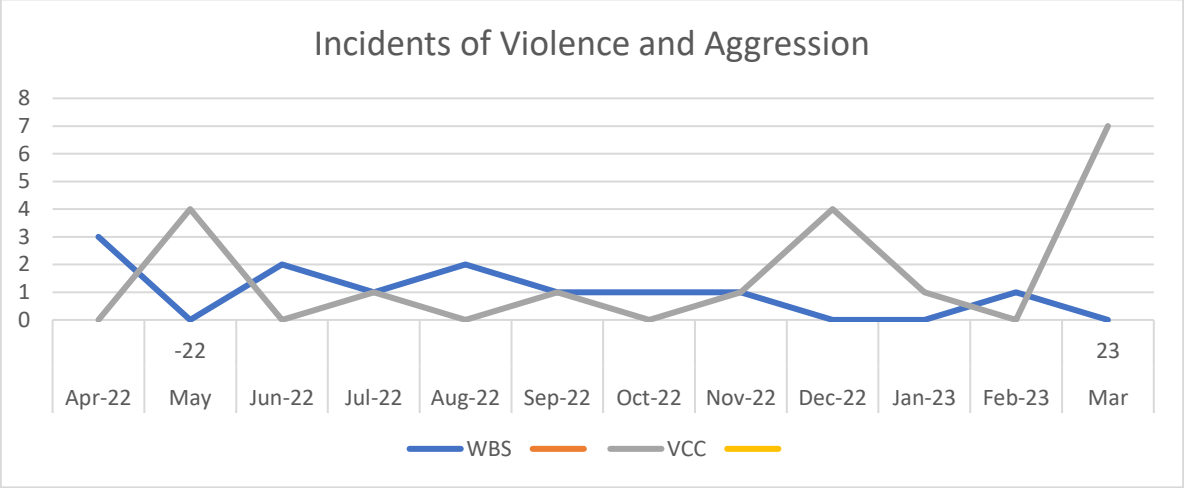
7 Violence and Aggression

7.1 Incidents of violence and aggression although remain at a relatively low level across the Trust it is the second highest reported incident in both VCC & WBS. Incidents reported within Inpatient settings have identified additional training needs delivered under the All Wales Passport. Case management support was provided by the Trust Health and Safety Manager, the SLA with Cardiff and Vale has been assessed and is not required at this time. This activity is currently being delivered by the H&S Advisor at VCC.

7.2 The Trust has escalated an incident which resulted a letter and Behaviour Agreement issued to the individual concerned.

7.3 At Welsh Blood Services cases of verbal aggression by donors often relate to frustration around being turned away from donating due to medical or travel reasons. An SOP is in place for repeated/serious incidents. Each incident is reviewed on a case by case basis by a group of Safety, Collections and Donor Contact Centre managers. The Collection Team will receive focused bespoke training during the next financial year to ensure that the teams have the necessary skills to deal with these types of incidents.

Chart 6 and Table 6 – Incidents of Violence and aggression at VCC and WBS by month



7.4 The list below outlines learning and actions stemming from investigation of incidents related to Violence and Aggression incidents that occurred through the reporting period. All will be compiled into a document and communicated through the H&S forums.

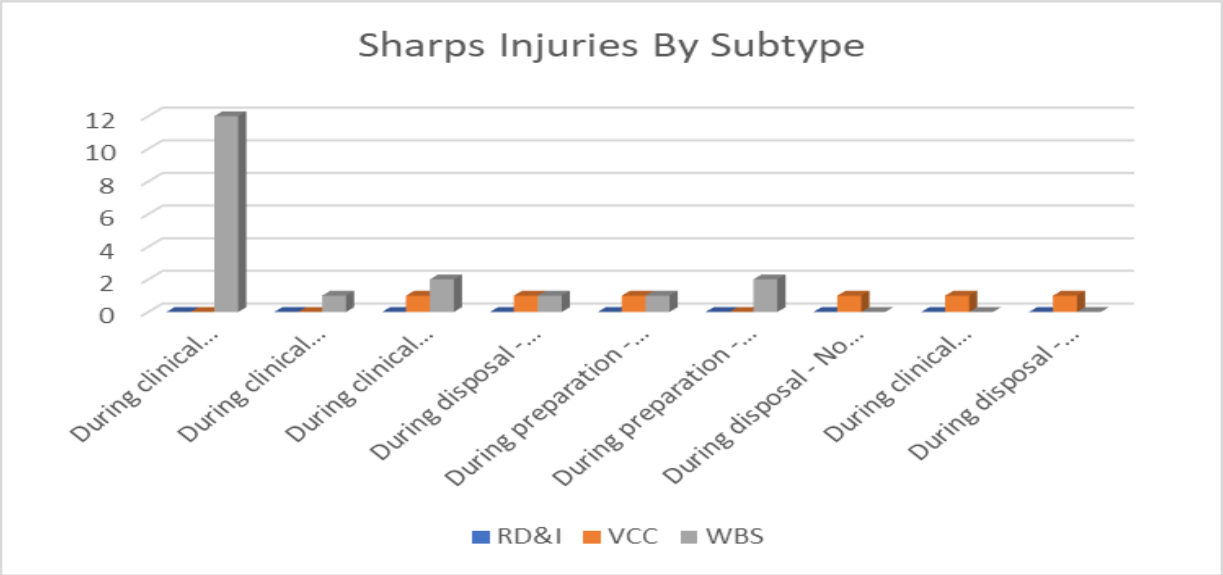
Lessons Learnt	**Improvement Plan**
• All incidents of violence and aggression to be reported on the datix OfW system	• Ensure lessons learnt are communicated back to the staff and departments.
• Promote zero tolerance amongst staff and managers – taking action against every incident	• Continue to support areas with reporting and investigating incidents
• Review risks associated with individuals' roles to ensure the right training received	• Establish links with local police teams and identify SPOC within South Wales Police
• Implement an investigation tool, leading to improvement and consistency of V&A investigations	• Develop additional training needs for inpatient areas.
• Training needs analysis undertaken for Module C under the All Wales Passport and Information Scheme	• Joint working with the Quality & Safety Team to develop procedures in caring for patients who lack capacity.
• Patient supervision policy enhanced to include wandering, confused patients.	• Review current alarms systems and procedures (staff attack alarms)
• Revise individual and departmental lone worker risk assessments	• Review community lone worker risks, develop and implement safe systems of work

- Actively promote the NHS Anti-violence Collaborative agreement 'Obligatory Response to violence in Healthcare'

- Velindre representation at the Anti Violence Collaborative meetings to promote effective and efficient communication and the exchange of information

8 Sharps injuries

Chart 7 Sharps Injuries by Subtype



8.1 In all cases the referral process to Occupational Health has been followed. Infection Protection and Control are working with Health and Safety to review non-safety sharps risk assessments, and to review of areas ordering non safety to identify any gaps. Where appropriate the 'Focused Review' function is used on Datix to enhance investigations and guidance is provided to departments to support investigations to ensure causes are identified and lessons learned.

Overall sharps injuries are generally low in number with no obvious trends that require address.

9 Recording of risks

9.1 All Divisions are recording risks on Datix Version 14. All Health and Safety risks rated above 12 were reported to divisional Health, Safety and Fire meetings and to the Trust Health Safety and Fire Board for scrutiny.

9.2 The adequacy of Health and Safety risk assessments is captured as part of the departmental HSG65 audits. This is an ongoing process.

9.3 Additional risk assessment training to support the process was delivered during 2022-2023. This was delivered by the in house H&S Team at VCC. WBS formerly review Risk Assessment as part of FMEA SOP's.

10 Health and Safety Statutory and Mandatory Training Compliance

10.1 Health and safety training requirements are identified by training needs analysis. This exercise was undertaken during 2022/23 by The Education and Development Department which has informed and updated Trust Training needs. This exercise has impacted overall figures as further training needs were identified highlighting increased training requirements. In

November 2022 there where a total of 7128 assignments and 7452 in February 2023, this is an increase of 324. Table 8 shows the training compliance for individual courses for the Trust as a whole. The majority of courses are provided on-line through the ESR system with two moving and handling courses (inanimate loads and people handling) provided face to face in line with the requirements of the All Wales Passport Scheme.

10.2 Compliance on most courses has risen steadily during the year but remains below the 85% target set by the Welsh Government. Multiple channels are used to communicate with managers and staff to enable increased compliance including monitoring at Trust and divisional health and safety meetings, escalation to senior management meetings, auditing of compliance during departmental HSG65 audits and contact with individual managers.

Table 7 – Trust wide compliance with Health and Safety statutory and mandatory training by month

	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
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%

Table 8 - Health and Safety statutory and mandatory training compliance by division by month

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Corporate Division	74%	76%	76%	72%	73%	74%	75%	76%	77%	78%	81%	82%
RD&I	82%	78%	80%	79%	78%	81%	82%	83%	78%	73%	74%	74%
TCS	75%	73%	71%	73%	71%	75%	76%	76%	74%	70%	77%	77%
VCC	78%	78%	79%	76%	76%	76%	77%	78%	76%	75%	75%	75%
WBS	82%	83%	87%	85%	85%	86%	87%	90%	92%	91%	93%	93%
Trust Compliance	79%	79%	81%	78%	79%	79%	80%	81.20%	80%	79%	80%	80%

11 Manual Handling Training

11.1 There are three levels of manual handling training provided to staff across the Trust, the syllabus for which is defined in the All Wales Manual Handling Passport Scheme which is adopted by all NHS Trusts and Health Boards in Wales. The requirement for each course is identified by Training Needs Analysis

- Module A – available on-line
- Inanimate Load – face to face training
- Patient Handling – face to face training

11.2 The training compliance in some divisions is below the target level of 85% set by the Welsh Government.

11.3 Training compliance is monitored at divisional Health Safety and Fire meetings/ Cynefin Group, at the Joint Estates Management Group meeting and at the Trust Health, Safety and Fire Board. Health and Safety training compliance has also been escalated to Senior

Management meetings within the divisions. Compliance is also discussed during the HSG65 Health and Safety Audit.

11.4 Module A – compliance is monitored, and managers continue to be reminded to ensure that staff complete mandatory training. Arrangements are in place to enable access to IT to enable completion of the training.

11.5 Inanimate Load Training – Courses have been run in house, further courses have been delivered through internal resource via H&S Advisor and ED & Dev Trainer. Velindre Cancer Centre and Corporate Division take up is not always to capacity due to operational staff pressures.

11.6 A number of staff at Velindre Cancer Centre have been trained as Manual Handling Workplace Assessors and have been supporting staff with assessment of competency. An initiative to monitor arrangements is under development.

11.7 People Handling – the Service Level Agreement with Cardiff and Vale University Health Board remains in place and offers places on training course to supplement in house training. The provision of in-house training has received positive feedback. People handling training at WBS will continue to be delivered by the Clinical Training Team to the Collection Teams with compliance figures exceeding target.

11.8 Further discussions are continuing with operational departments and support services to identify any / more flexible solutions that enable higher numbers of staff to attend the training courses available.

11.9 The list below outlines learning and actions stemming from investigation of the RIDDOR incidents that occurred through the reporting period. All will be compiled into a document and communicated through the H&S forums.

Lessons Learnt	**Improvement Plan**
• Advise and implement Manual Handling risk assessment templates (TILE)	• Improve and develop user friendly templates
• Complete hazard analysis tasks for all manual handling activities	• Review corporate risk assessment policies for adherence to guidance
• Additional staff to gain IOSH accredited train the trainer course for continuity planning	• Lapsed accreditation due to COVID to be re-instated
• Clear protocols for equipment hire including Bariatric	• Circulate and publish equipment hiring process for 24/7 requirements
• Joint working between Nursing, H&S and physiotherapy	• Set up regular meetings to include Education & Development to ensure best practice and consistency with neighbouring HB's in Wales
• Provide clear advice on equipment available via the NHS supply chain	• Implement equipment trialled in departments throughout the Trust

12 Additional training

12.1 There have been several additional training courses run to promote the Health & Safety function across the trust. The Trust H&S Manager and H&S Advisors and Compliance Manager have supported the delivery of training and will continue to identify and respond to the needs of the organisation.

12.2 A continual focus in training has been promoted to improve behaviour and attitudes towards Health & Safety Training and Compliance. The message to all staff at every level within the organisation have include:

Table 10 – Additional Health and safety Training Delivered 2022/23

Training Course	Benefactor
First Aid Training	31 staff across the Trust have gained the Emergency First Aid at Work certificate.
Electrical Safety Training	Both Estates and Operational Services Teams have completed the new on-line Electrical Safety Training on ESR
Risk Assessment workshops	3-hour practical workshops were run at VCC to improve consistency of risk assessment documentation and templates
Investigations workshops	3-hour practical workshops were run at VCC to improve consistency of investigation reports
Spill Management Training	Face to face spill kit training has been re-introduced since the pandemic
Medical Gas Training	Face to face Medical Gas Training delivered annually and to all new starters
Emergency Lifting (Hoverjack)	Emergency lifting incorporated in Patient Handling training and Cascade trainers within Integrated Care and Therapies Departments
Asbestos Awareness	All estates staff

13 DSE Assessments

13.1 A number of face-to-face DSE assessments have been completed whereby the ESR online training module has identified further interventions. The DSE policy has been revised to reflect the Home Working Policy and the Extraordinary Ad hoc Home Working policy and Procedures for Managers and Staff.

13.2 The list below outlines learning and actions stemming from DSE assessments carried out through the reporting period. All will be compiled into a document and communicated through the H&S forums.

Lessons Learnt	Improvement Plan
• Improved focus on individual and departmental risks	• Timely referral to Occupational Health where identified
• Enhance DSE assessor provision on all sites	• Library of equipment for individuals to trial
• Improved access to equipment identified on assessment	• Develop Training programme for departmental assessors
• Enhanced reporting through the governance structure on the ESR training module	• Develop joint working plan with the Physiotherapy team

14 COVID 19

14.1 Whilst other Welsh NHS sites and premises reduced there COVID measures in line with Welsh Government (WG) guidance, the COVID Cell at VCC and Welsh Blood took a more cautious, step-by-step approach in their reduction of safety measures. Initiatives and actions identified in support of managing covid include;

- A risk assessment guidance template was devised to assist individual departments in recording their risks on the Datix v14 system.
- 64 COVID Risk Assessments were completed and uploaded on to Datix.
- Staff rapid assessment templates were developed to investigate all staff cases of COVID for the purpose of regulatory reporting and identify patterns and trends.
- Audits of fit tester competency were undertaken at VCC and an additional IP&C fit tester put forward for the Fit2Fit accreditation scheme endorsed by BSIF and the HSE.
- Staff absence indicators scrutinised at each COVID Cell meeting.
- COVID checklists added to the Contractor Control Policy
- Jan 2023 - Terms of Reference of COVID response cell updated to include all respiratory illnesses. – COVID surgery drop-in sessions continued
- March 2023 – WBS and Trust identified through risk assessment the impact on Staff, Doners and Visitors and a decision was made to remove the mandatory wearing of face coverings.
- April 2023 – The requirement for face coverings was stepped down in the Cancer Centre except for the inpatient ward and SACT areas.

15.0 HSG65 Audits

15.1 The HSG65 audit implementation was trialled in three areas across Velindre in 2022/23 and the gaps identified prompted a shift in focus to provide training and guidance to managers to enhance the work needed against the key areas being audited.

1. Leadership
2. Procedures
3. Risk Assessments
4. Training
5. Workplace inspections
6. DSE
7. Inanimate Load Training
8. Patient Manual Handling
9. Sharps compliance
10. CoSHH
11. Skin Care
12. Violence and Aggression
13. First Aid
14. Control of Contractors
15. Equipment Safety
16. Workplace Environment
17. Incident Reporting and Investigation
18. Fire Safety
19. COVID 19

15.2 There has been significant improvement in the above key areas in the last year and HSG65 monitoring will continue in 2023/24.

15.3 HSG65 templates have been revised to sit within the Nursing and Quality Audits (Tendable). The system will enhance the reporting and actions created through the divisional governance structures.

16 Progress against Health and Safety Strategic Goals 2020 -2023

16.1 There has been good progress against the Health and Safety Strategic Goals with further action schedules until the end of the period (2023) for which these goals have been set.

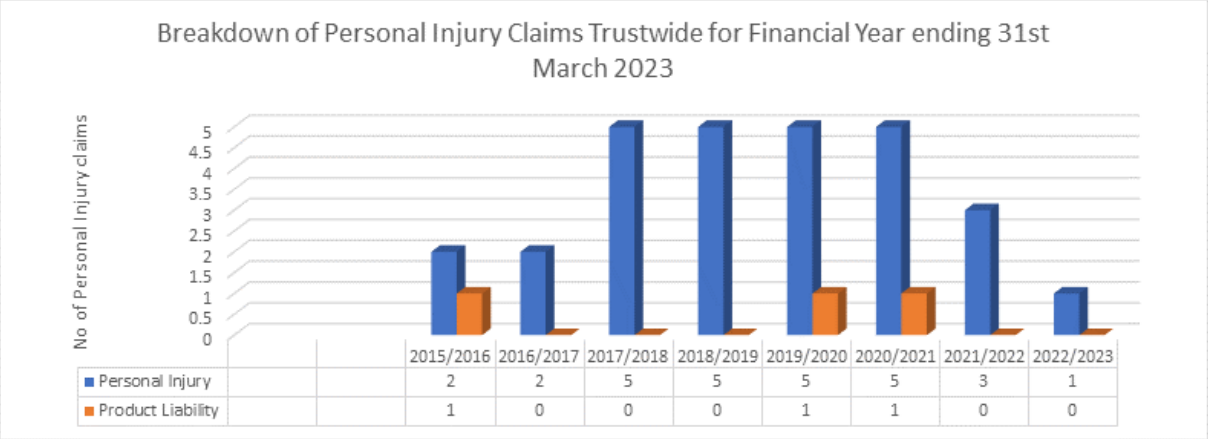
Table 11 – Progress with Health and Safety Strategic Goals 2020-2023

	Topic area	Strategic Goal	Progress	Timescale
1	Leadership	To demonstrate strong and effective health and safety leadership across the Trust	IOSH Training for Executives Identified. Training provider established. Training to be scheduled	Q1/Q2 2023
2	Mangers	To develop Health and Safety training course for managers	Development and roll out of VUNHST specific course for managers. Supported by managers information on staff intranet. IOSH	Q1 Q2 2023

			Managing Safely Licenses purchased training ongoing	
3	Management System	To ensure that the Trust has an effective health and safety management system across all divisions	Development of Division Priority Improvement Plans complete. Progress monitored through the Year	Q4
4	Monitoring	To ensure that health and safety performance is monitored and reported and that opportunities for continual improvement are actioned.	Monitoring of Trust Health Safety and Fire KPI'S, and Priority Improvement Plans by Trust H&S Fire Board	Q1,Q2,Q3,Q4 2023

17 Health and Safety Related Personal Injury Claims

Table 12 – Personal Injury Claims 2015-2023



17.1 During the reporting period: 2 Personal Injury claims were closed in relation to slip, trip and falls, following settlement of the cases, with 1 case being reimbursed by the Welsh Risk Pool.

18 Fire Safety

18.1 The Trust fire safety policy [PP01] was reviewed and updated in September 2022 taking into consideration the findings of relevant assessments, audits and inspections.

18.2 Welsh Government funded capital works were concluded during the reporting period, to improve fire stopping, fire doors, emergency lighting and a full validation of the fire alarm "cause & effect" at the Cancer Centre has been carried out with identified remedial action carried out.

18.3 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.

18.4 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.

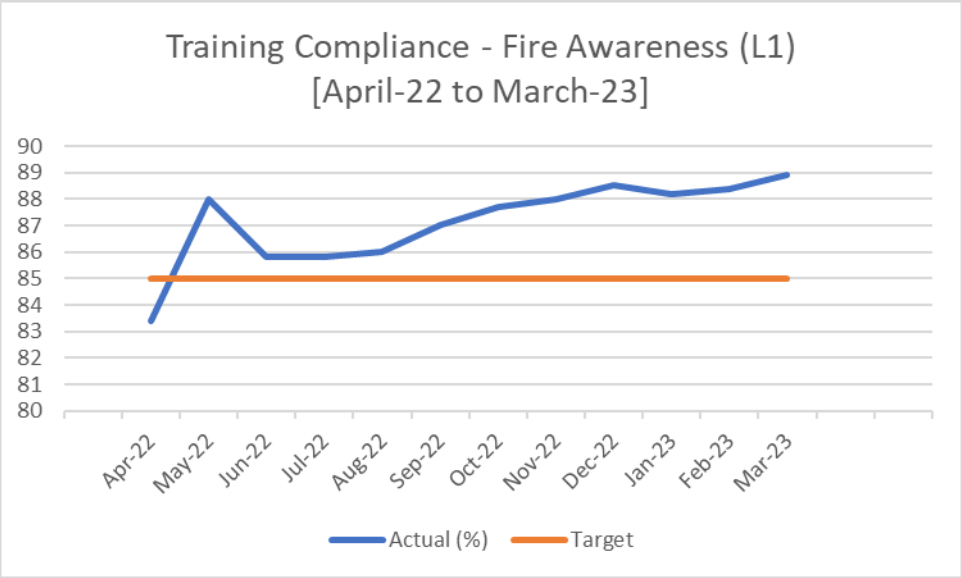
18.5 Following completion of the 2021/22 annual fire safety, fire risk assessments were reviewed to reflect findings and, where necessary, assessments have also been reviewed following any material changes to buildings and/or occupancy as required under the Fire Safety Order. The 2022/23 annual audit has also been completed and submitted to NWSSP – SES [in accordance with SESN 23-01.

18.6 Neither NWSSP-SES nor NWSSP Internal Audit undertook audits during this financial year and no sites were inspected by local fire and rescue services.

18.7 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.

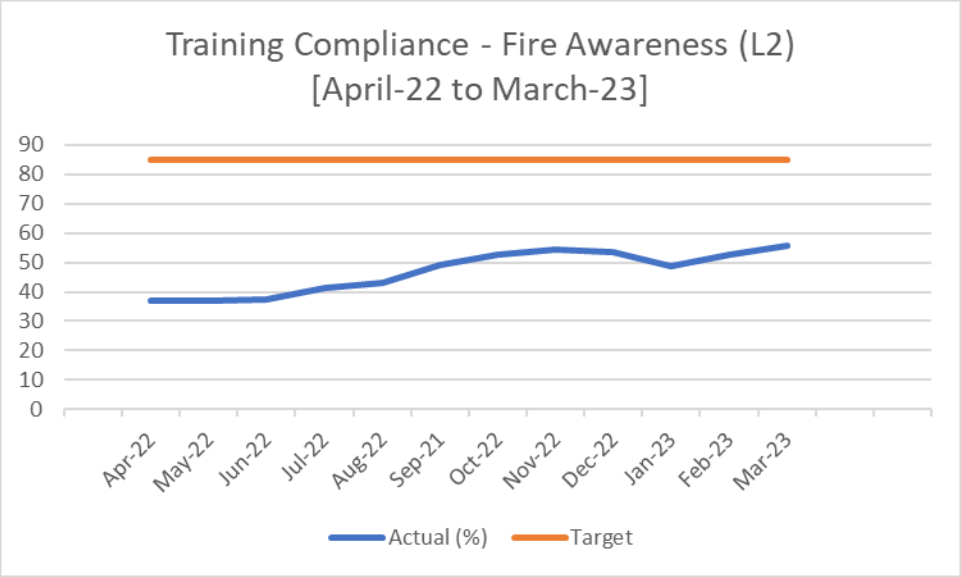
18.8 In the last financial year, the compliance for basic fire awareness training has continued to improve and remains above the Trust's benchmark of 85%:

Table 13 – Fire Safety Compliance Training - Basic



18.9 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.

Table 14 -Fire safety Training Compliance – Clinical



18.10 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.

18.11 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.

18.12 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.

18.13 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.

18.14 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. Recorded incidents and unwanted fire alarm activations are listed in table 15 below.

Table 15 – Fire safety Incidents

Site	Fire	UWFS
Velindre Cancer Centre	1	10

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.

18.15 There were 10 recorded unnecessary fire alarm activations, all occurring at VCC over the last financial year as demonstrated in Table 16.

Table 16 – Fire safety Incidents

Item	Value	%
Other environmental effect		50
Alarm activated by patient public		10
Accidental Damage		30
System fault/design		10
Total	10	100

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.

1816 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.

19 Conclusion

19.1 The Annual Report includes information on the reporting framework, trends, incidents, training, and the audit of management processes, demonstrating the continued work of the Health Safety and Fire Board Meeting over the year 2022/23.

19.2 Health and Safety continues to embed within the portfolio of the Director of Strategic Transformation, Planning and Digital, and the opportunity has been taken in 2022/23 to review the structures and reporting mechanisms outlined in this report, to ensure continual improvement in the management of Health and Safety within the Trust.

Quality, Safety and Performance Committee

Surgical Materials Testing Laboratory (SMTL)

DATE OF MEETING	14/09/2023
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	GAVIN HUGHES (DIRECTOR, SMTL) PAUL EDWARDS (QUALITY MANAGER, SMTL) JAMES EVANS (R&D MANAGER, SMTL)
PRESENTED BY	Ruth Alcolado (Medical Director, NWSSP)
APPROVED BY	Choose an item
EXECUTIVE SUMMARY	The Surgical Materials Testing Laboratory (SMTL) is part of NHS Wales Shared Services Partnership (NWSSP). SMTL's core service is to provide medical device testing and technical services to the Welsh NHS. SMTL also provides commercial testing and technical assurance services to the UK Health

	Service and the international medical device industry. This paper provides an overview of the key aspects of the SMTL service for NHS Wales, the significance of medical device testing and the quality management system employed to provide assurance on laboratory output.

RECOMMENDATION / ACTIONS	Note the contents of the report

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

7 LEVELS OF ASSURANCE	
N/A	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Select Current Level of Assurance

APPENDICES	
1	2022 UKAS Inspection Report for SMTL
2	SMTL UKAS Accreditation Certificate
3	2022 NWSSP Audit Report for SMTL
4	2022 Zimmer Biomet Audit Report for SMTL

1. SITUATION

The SMTL has been part of NHS Wales Shared Services Partnership (NWSSP) since 2016. The laboratory consists of 26 members of staff who are based at the Princess of Wales Hospital, Bridgend and a second satellite testing laboratory recently established at Imperial Park (IP-5), Newport.

SMTL is funded mainly by the Welsh Government to provide the Welsh NHS with a range of testing and technical support services related to medical devices:

- Testing of medical devices specifically to support NWSSP Procurement Services and others in the NHS to undertake evidence-based purchasing;
- Medical device defect and incident investigative work for NHS Wales as recognised in the Welsh NHS notice MDA/2004/054 (Wales);
- Manage the services of the Evidence Based Procurement Board (EBPB) who promote, develop and implement value and evidence-based procurement of medical technologies for NHS Wales (http://medidex.com/evidence-based-procurement-board-ebpb.html);
- Technical support for Welsh Government and NHS Wales on medical device initiatives, such as:
  - introduction of single use tonsillectomy and adenoidectomy instruments following the detection of variant Creutzfeldt–Jakob disease (vCJD) prions in tonsil tissue;
  - implementation of small bore connectors into the Welsh NHS;
  - explore the implementation of reusable surgical gowns and drape;

SMTL also provides commercial testing and technical assurance to the UK Health Service (Department of Health and Social Care {DHSC}, Medicines and Healthcare products Regulatory Agency {MHRA}, NHS England, NHS Scotland) and the global medical device and personal protective equipment (PPE) industry.

SMTL is active in the medical device standards field and represents NHS Wales on a number of British and European standard committees.

SMTL is recognised as a leading UK expert in testing and technical assurance for medical devices. SMTL staff are listed as medical device experts with the MHRA register and have been called as expert witnesses in coroners inquests and police investigations, where medical devices have been implicated in patient deaths or criminal incidents respectively.

2. BACKGROUND

The laboratory was originally established in the 1970s as a pharmaceutical quality control department to assess the quality of surgical dressings purchased for use in Welsh hospitals. The department implemented a monitoring programme to ensure that quality was maintained for the duration of the contract, addressed quality complaints with manufacturers and undertook research projects to examine new surgical materials as they became available.

The general principles of independently assessing quality for NHS Wales purchasing and contracting matured during the 1980's and SMTL were requested to expand its testing services to include disposable medical devices such as medical gloves, urology products, sharps containers, needles and syringes, administration lines etc.

In the early 1990's the laboratory was encouraged to offer its testing services on a commercial basis to the medical device industry. This expansion coincided with the laboratory gaining UKAS (United Kingdom Accreditation Service) accreditation to *ISO/IEC 17025 General requirements for the competence of testing and calibration laboratories*. SMTL has maintained its accredited status since the initial award in 1995 and has added to its accredited schedule over the intervening years as medical device technology develops.

During this period SMTL developed technologies to produce sterile maggots for wound care. In 2001 SMTL was awarded the Queen's Award for Enterprise and Innovation for the development of this novel medicinal product for use in healthcare. The use of larval therapy products for patients suffering from chronic wounds was so successful that the business became the UK's first commercial spin out from the NHS in March 2005 trading under the name BioMonde.

The role of SMTL is unique within the UK, with no equivalent NHS organisation undertaking similar services. This was evident during the COVID-19 pandemic, where SMTL was requested to work with the UK Government and DHSC to perform technical assurance and testing projects assessing medical devices and PPE. SMTL continues to work with the UK Government and NHS Wales assessing the quality of remnant stock holdings.

3. ASSESSMENT

3.1 Medical Device Testing

In the UK, the MHRA is responsible for regulating medical devices. Before a medical device can be marketed or used in clinical practice, it must receive regulatory approval

from the MHRA. The approval process depends on the device's risk classification (class 1 – 3), with higher-risk devices requiring more rigorous assessment.

Because of their lower risk level, class 1 medical devices are subject to the fewest regulatory requirements and are generally the easiest devices to bring to market. The majority of class 1 medical devices are brought to market via self certification by the manufacturer without any independent third party involvement.

Over the 40 years SMTL has tested medical devices, we have seen a continual lack of quality control on the products tendered for NHS Wales contracts. The laboratory regularly identifies high numbers of products that do not meet the quality criteria claimed by manufactures, and which if used in the healthcare setting, would undoubtedly cause patient and user harm.

In recent years this problem has been exacerbated. The COVID-19 pandemic increased demand across the world for medical devices and PPE which, coupled with disruptions in supply chains and the high concentration of PPE manufacturers in only a few countries, led to widespread shortages globally. This has resulted in increased incidences of quality concerns, product recalls and the presence of counterfeit products in supply chains.

The independent assessment of medical devices and PPE using a critical and rigorous process ensures the safety, effectiveness, and reliability of medical devices before they are made available to healthcare professionals and patients that ultimately contribute to improved patient care and outcomes.

3.2 Governance

3.2.1 UKAS and ISO/IEC 17025

SMTL is accredited by the UKAS to the International Standard for Calibration and Testing Laboratories *ISO/IEC 17025*. An organisation's fulfilment of the requirements of *ISO/IEC 17025* means the laboratory meets technical competence, impartiality and management system requirements. Accreditation drives confidence by underpinning quality of results, ensuring their traceability, comparability and validity.

UKAS is the sole National Accreditation Body for the UK and is the highest technical authority in the UK to assess organisations that provide conformity assessment services such as calibration, certification, inspection, testing and verification against nationally and internationally agreed standards.

UKAS visits SMTL on an annual basis, and the inspection consists of a combination of inspectors assessing our quality management system (QMS), examining test reports

and test methods whilst observing our technical staff performing a range of accredited tests.

(*Appendix 1 – 2022 UKAS Inspection Report ; Appendix 2 SMTL UKAS Accreditation Certificate*)

3.2.2 NWSSP

SMTL provides monthly key performance indicator (KPI) reports to NWSSP Planning Performance and Informatics division.

SMTL also reports to senior colleagues via Quarterly Performance reviews which include:

- Progression of Integrated Medium Term Plan (IMTP) projects
- Performance against agreed KPIs
- Risks and issues review
- Finance and budget
- Workforce metrics
- Complaints

3.2.2.1 NWSSP Audit & Assurance

The adequacy and effectiveness of systems and controls for the management of SMTL processes are assessed by NWSSP Audit and Assurance Division. The recent audit report is presented as *Appendix 3 – 2022 NWSSP Audit Report for SMTL*.

3.2.3 Client Audits

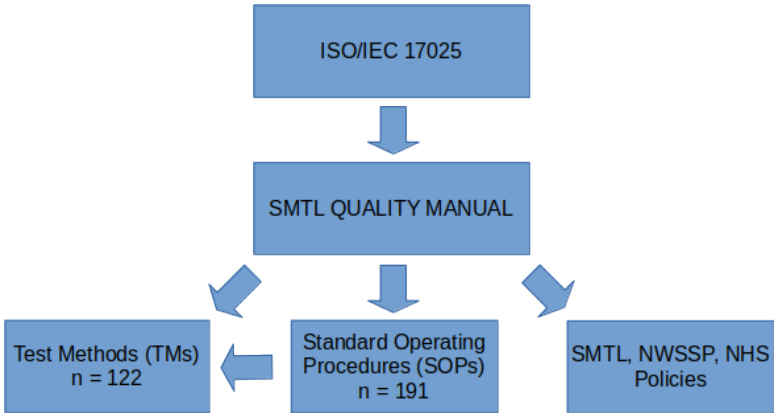
SMTL is regularly audited by external clients. Our most recent client audit was performed by Zimmer Biomet in August 2022 and this report is presented in *Appendix 4 – 2022 Zimmer Biomet Audit Report for SMTL.*

3.2.4 SMTL Assurance – Quality Management System (QMS)

ISO/IEC 17025 specifies that a laboratory must have a master quality manual (QM) document which outlines the system for running the laboratory and controlling the quality of data generated by the laboratory. The SMTL operates a hierarchy of quality system documentation with the QM at the peak of the system (Figure 1). The QM is written in accordance with the requirements of the *ISO/IEC 17025* which in turn feeds

down to sub-tier policies and controlled working documents (Standard Operating Procedures {SOPs} and Test Methods {TMs}).

Figure 1. Tier of SMTL Quality System Controlled Documents



In addition to controlled documents, there are a number of additional assurance measures which contribute to the QMS including:

3.2.4.1 Internal Reviews

- Technical Group (TG) Meetings

Quality Manager chairs monthly TG meetings to discuss matters appropriate to the laboratory's QMS and UKAS accreditation requirements. The TG agenda covers many different aspects, examples include a section by section review of the *ISO/IEC 17025* standard, uncertainty of measurement, new regulatory publications, complaints, anomalies and out of specifications.

- Quality System Review (QSR)

The Laboratory Director chairs an annual QSR to establish what changes, if any, are necessary to ensure that quality arrangements for the laboratory continue to meet both the laboratory's needs and UKAS requirements.

3.2.4.2 Internal Audits

- Quality System Audits

SMTL has a programme of 15 quality system audits that are performed on a rolling basis over the year.

1. Organisation
2. Staff & Training
3. Equipment

4. Planned Preventative Maintenance
5. Calibration
6. Test Methods
7. Standard Operating Procedures
8. Accommodation & Environment
9. Health & Safety
10. Sample Handling
11. Records
12. Complaints & Anomalies
13. Services & Supplies
14. Reagents & Consumables
15. Risks & Opportunities

- Project Audits

All projects are audited by SMTL Quality Department and test reports are reviewed by the Quality Manager and Laboratory Director before release to the client. In 2022/23 SMTL completed 201 testing projects, generating 643 test reports and testing 3,326 products.

3.2.4.3 Inter-Laboratory Testing

SMTL participates in numerous proficiency assessments to evaluate the degree of similarity of our laboratory's results with the results of other accredited laboratories. These schemes are operated in accordance with the international standard *ISO/IEC 17043 Conformity assessment — General requirements for proficiency testing* in most instances and are UKAS approved.

3.2.4.4 Intra-Laboratory Testing

Performed internally to ensure there are no wide variations of test results between trained operators. Information obtained from proficiency testing helps to identify and ultimately lead to solutions to problems within a laboratory.

4. SUMMARY OF MATTERS FOR CONSIDERATION

The committee is asked to note the functions of SMTL and its governance arrangements.

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 X • 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 X Timely ☐ Effective X Equitable X 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). *[Please include narrative to explain the selected domain in no more than 3 succinct points].* SAFE - SMTL services ensure user and patient safety is of paramount importance when centrally procuring medical devices for NHS Wales.EFFECTIVE - SMTL use prudent evidence based principals to ensure high value care for our patients.EQUITABLE - SMTL is an independent All-Wales service which is available to all NHS Wales Health Boards and Trusts.
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	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.
	This section should outline the financial resource requirements in terms of revenue and/or capital implications that will result from the Matters for Consideration and any associated Business Case. Narrative in this section should be clear on the following: **Source of Funding**: Choose an item Please explain if 'other' source of funding selected: Click or tap here to enter text **Type of Funding:** Choose an item **Scale of Change** Please detail the value of revenue and/or capital impact: Click or tap here to enter text **Type of Change** Choose an item Please explain if 'other' source of funding selected: Click or tap here to enter text

EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Choose an item.
	[In this section, explain in no more than 3 succinct points what the equality impact of this matter is or not (as applicable)].
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	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

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

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	*[Please insert detail here in 3 succinct points].*
WHAT IS THE CURRENT RISK SCORE	Insert Datix current risk score
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	*[In this section, explain in no more than 3 succinct points what the impact of this matter is on this risk].*
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Insert Date
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Choose an item
	[In this section, explain in no more than 3 succinct points what the barriers to implementation are].
All risks must be evidenced and consistent with those recorded in Datix	

ASSESSMENT REPORT

Name & Address of Organisation	NHS Wales SSP, trading as Surgical Materials Testing Lab Princess of Wales Hospital Coity Road Bridgend Mid Glamorgan CF31 1RQ	**Type of Assessment**	Surveillance
		UKAS Reference Number	5527
		Date(s) of Assessment	27th September 2022
Assessment Location(s)	As above	**Project References**	232240-02-01
Assessment Standard / Criteria	ISO/IEC 17025:2017	**Schedule Issue No(s)**	030
Name & Role of UKAS Assessment Team	Chris Arthur – Assessment Manager & Technical assessor Dave Phillips – QMS assessor Lorraine Wadley - Technical Assessor	**Date(s) of Assessment Plan**	19th August 2022
		No. of (M) Findings: Action Mandatory	1
Name of Organisation Representative(s)	Paul Edwards	**No. of (M) Findings: Require Evidence to UKAS**	1
Report Issued By	Chris Arthur	**No. of (R) Findings: Action Recommended**	3
Report Issued Date	30th September 2022	**Method of Reviewing Evidence**	Remote
Report Acknowledged By	Paul Edwards	**Quote for Reviewing Evidence**	0.25 Day Quote to follow
Report Acknowledged Date	30th September 2022	**Agreed Action Completion Date**	11th November 2022
Report Acknowledged Method	e-mail	Please return evidence to: cusotmerservices@ukas.com Quoting the UKAS Ref. No in the subject field	

AREAS SAMPLED AT ASSESSMENT (*marked as 'X'*)			
ORGANISATION		*IMPARTIALITY & INTEGRITY*	
Legal Status		Independence, Impartiality & Integrity	X
Liability Cover (CB / IB only)	NA	Confidentiality	X
Management of Finances (CB/IB only)	NA	**EVALUATION PROCESSES**	
Resources	X	Design & Development of Methods / Schemes	X
Organisation Structure	X	Enquiries, Tenders, Contracts	X
Responsibility & Authority	X	Planning & Resource Allocation	
MANAGEMENT		Testing/ Calibration/ Inspection/ Audit *	X
Management System Including Documented Policies & Procedures	X	Reports & Certificates	X
Roles & Responsibilities for Quality	X	Decisions/ Opinions	
Control of Documents and Records	X	Certification & Maintenance of Certification (CB only)	NA
Management of Sub Contractors and Purchases		**TECHNICAL COMPETENCE**	
Service to Clients (Test / Cal only)	X	Personnel	X
Handling of Complaints / Appeals / Disputes	X	Methods / Schemes	X
Control of Nonconforming Items Dealing with Corrective & Preventive Actions and Improvements		Facilities / Equipment (Test/Cal/IB only) / Environmental conditions (Test/Cal only)	X
Internal Audit and Management Review	X	Assurance of Quality of test / calibration Cooperation (IB only)	X
Supervision & Monitoring of Staff	X	Witnessed Activities	X
Conditions for Granting & Maintaining Certification (CB only)	NA	***OTHER (specify)**	

*Delete as applicable

EXECUTIVE SUMMARY

The laboratory was able to demonstrate throughout this surveillance assessment that the management system in accordance with ISO/IEC 17025:2017 and the relevant UKAS requirements is being adhered to and implemented effectively.

•Strengths and weaknesses

Well established laboratory, with a Mature and well managed QMS which effectively underpins and supports the ongoing technical activity.

•Extent of competence and conformity

Excellent levels of competency and conformity seen, evidenced by the low number of improvement actions and the universally positive feedback from all members of the assessment team

•Effectiveness of management system

The QMS is mature and well managed and makes good use of the RT ticket system to manage and control QMS activity. The planned introduction of the LIMS systems will only serve to further enhance the QMS effectiveness, but care will need to be taken in its introduction.

•Effectiveness of internal audits

There is a well-maintained programme of both system and technical audits performed by the laboratory. These audits are of sufficient breadth and depth to give a good level of confidence in the ongoing competence and conformity of the QMS and technical activities undertaken. In addition, the project audit completed on every completed project provide an additional level of confidence.

•PTP Quality assurance techniques- effectiveness

The laboratory participates in a number of formal PT schemes, the results of which has demonstrated good agreement with peers. The laboratory continues to actively seek out opportunities for formal PT, and also implements other appropriate techniques such as vertical audits on each complete project and ongoing equipment checks. As a whole the above provide good levels of confidence in the quality of the result derived for the laboratories accreted technical activities.

•Where applicable useful comparison with previous assessments

It is clear that the laboratory continues to demonstrate high levels of compliance to the requirement of the standard, and the results generated by the accredited technical activities produce technically valid results. The introduction of a new LIMS systems and additional site will need to be planned and executed with care to ensure the excellent performance seen during the assessment is not impacted in the future.

RECOMMENDATION

Accreditation in accordance with the requirements of ISO/IEC 17025:2017 is to be maintained for the current scope for testing subject to the satisfactory discharge of the mandatory finding that requires evidence to be supplied within the agreed timescale. For those findings identified as M/N, then a submission of actions proposed or taken is to be provided on the IASF.

Changes to the schedule are outlined in technical assessors notes for Chris Arthur for updated to BS EN ISO 6717:2021

Next Steps

1. Evidence should be submitted together with the completed improvement action summary form (IASF) describing the evidence submitted by email to the following email address: customerservices@ukas.com. If attachments to the email exceed 20 MB, please send as a zipped file or as discrete packages for each individual assessor.

2. It is expected that the lab will address the findings raised in accordance with their corrective action procedure and/or the procedure for dealing with non-conforming work.

3. UKAS to update the schedule of accreditation to issue 031.

Health and Safety Considerations

Relevant risks were considered and shared with the assessment team. There were no significant issues to report.

Scope

The scope of the assessment was to ensure the continued competence and compliance to ISO/IEC 17025:2017. All witness activities were taken from the scope

This assessment was undertaken to confirm the competence and conformity of the MS and accredited technical activities performed by the laboratory, for testing as detailed in the schedule of accreditation # 1419, Issue 30 to the requirements of ISO/IEC 17025:2017 and UKAS. The structure of the visit was described in the assessment plan below:

2022 SU3 SMTL
232240-02-01 Assess

Organisation

Since the last assessment the lab are progressing with the Satellite laboratory in Newport Imperial Park (IP-5) which is up and running and lab will be looking to extend their accreditation in part to this before the next planned assessment as an Extension To Scope.
The lab is also looking to change over their quality management system to a lims system from the current Linux system currently being utilised.

In terms of personnel Pete Philips has retired as director of the lab being replaced by Gavin Hughes who has been acting as his deputy for several years. Pete will still be available on a consultancy basis for the foreseeable future. Physical testing remains largely un-changed since last year other than Louise moving into the departmental management left when Gavin moved up with some changes in the biological test team still headed up by Pamela.

Matt is operational manager and James is dealing with more of the management of research and development.

Main contact for UKAS remains Paul Edwards who is also the Quality Manager.

General Requirements

Impartiality (4.1)

High level policy in Section 3.1 of QM contains appropriate guidance and compliance requirements along with undertaking / commitment for activities to be performed in an impartial manner. Includes requirement to comply with NWSSP (NHS Wales) corporate conflicts policy requiring annual declaration of any conflict of interest. All staff sign Employee Interest Form SOP-139 on induction and these are reviewed annually.

Impartiality risks are identified on an ongoing basis and recorded in SMTL risk register, and impartiality is a standing agenda on the TG (Technical Group) monthly meetings. As declarations become due for renewal, automatic email reminders are sent to ensure completion. Example of blank SOP-139 form and several completed forms were reviewed along with current status of NWSSP conflict declarations. All were up to date with records of appropriate perceived or possible conflict of interests logged.

Confidentiality (4.2)

Appropriate high-level policy in section 3.2 of the QM including commitment to confidentiality, and not to disclose unless required by law. Supplemented by SOP-429 which contains appropriate and compliant procedure. NDAs are used to implement legally enforceable commitments between SMTL and customers / suppliers. Example reviewed of two-way NDA with external customer.

Staff confidentiality is implemented using signed job descriptions. Staff are subject to SSP Velindre (NHS Wales) standards of behaviour framework. Page 34 of framework contains appropriate references to confidentiality requirements and that these be included in all job descriptions. Section 29 of job descriptions contain compliant confidentiality clauses, and binding acceptance is by signed contract of employment including acceptance of job description and associated requirements. Completed examples seen for both recent starter and established member of staff.

Resource Requirements

Externally provided products and services (6.6)

Documented requirement to sub-contract to laboratories who are accredited. When reporting sub-contracted work, it is clearly and unambiguously identified.

Process Requirements

Review of request, tenders and contracts (7.1)

Appropriate high level policy supplemented by the use of Request For Work (RFW) form SOP-81, and includes requirement to record any deviation for standard methods, for the contract review process to be repeated when a change is made and where there is use of external providers to reference the requirements of section 6.3.3 Sub-Contracting, in the QM to ensure customer is informed of tests to be subcontract and permission gained as per SOP-429. Policy to use most up to date standard where possible and advise customer where a selected method is inappropriate.

Each job / quote is given a unique project number from a project database and RT ticket number for the RT system. The form contains appropriate levels of detail and guidance to enable an effective contract review process to take place and the final output is checked by section manger and Quality manger / Laboratory Director the before being issued to the customer.

Statements of conformity are included within the RFW form although the statement used was not aligned with the actual activity of the lab. This was raised by a technical assessor during the assessment but is included for completeness here.

For the vertical audits performed both RFW / job packs had been appropriately completed with sufficient detail and additional records to evidence that an effective contract review process had taken place.

Ensuring the validity of results (7.7)

Section 7.6 of the QM contains compliant policy to ensure the validity of results using an extensive list of appropriate methods and techniques with a sperate section detailing the requirements for Inter and Intra-laboratory comparison (QM section 7.6.1). Section 7.6 of the QM details a number of additional techniques including internal audit, project reviews and equipment checks.

Schemes which the lab participate in, and results / outcomes are recorded in appropriate locations on the main server. Activity is planned and controlled and includes intra and inter lab where available with the Intra-Laboratory / proficiency work supported by a supplementary procedure SOP-160. Data is monitored and analysed by QA and technical managers using appropriate indicators such as Z-score. Where results fall outside predefined criteria action is taken taken with reference to QM section 7.9 control of non-conforming

Example of Contact Plate proficiency testing undertaken by an accredited provider was reviewed with appropriate analysis performed. Good agreement via Z-score was evidenced and the outcomes were suitable recorded within the QMS. The plan ensures all activity is covered by the most appropriate available method over a two-year cycle and was seen to be up to date. Overall, the system is detailed and well maintained and gives a good level of confidence in the ongoing validity of the results produced by the laboratory. In addition, the laboratory is continuing efforts to establish formal inter-laboratory comparison with other accredited laboratories or manufacturers where appropriate to enhance their coverage, with three projects currently underway.

Reporting of results (7.8)

Appropriate high-level policy and procedure in QM section 7.7 QM with supplementary procedure SOP-47 detailing the approach and implementation when reporting statements of compliance. In

addition, it includes requirement for appropriate authorisation of test reports and results and a detailed list of requirements to ensure compliance. Test reports reviewed were compliant with the requirements of the standard and applicable UKAS documents such BEIS Use of National Logos and Symbols.

One example reviewed contained a section of non-accredited work, this was clearly and unambiguously disclaimed and there was no risk of misunderstanding when reviewing the test results.

Reporting statements of conformity (7.8.6)

Statements of conformity are made on test reports and included in a tabular and graphical format for each test performed is the probability of false accept / reject, for various measurement levels around the tolerance / limit values used for each particular test. This allows the customer to evaluate with ease the risk associated with each statement of conformity made.

Amendments to reports (7.8.8)

Appropriate high-level policy contained within QM section 7.7 also detailing procedure and requirements for amendments to reports in draft format and once issued. Where an amendment is made all reports have a unique number utilising a version suffix and the new report clearly and unambiguously references the old report.

Complaints (7.9)

Appropriate high-level policy in QM section 7.8 which is supplemented by procedure SOP-434. Outline complaints handling process is available for interested parties and where this is deemed insufficient a copy of the full procedure is given. Procedure includes compliant requirements referenced to the standard including acknowledgment of the complaint, and the requirement that the outcome shall be reviewed and approved by an individual not involved the laboratory activity that is the subject of the complaint.

A total of 5 complaints have been received in the last 12 months with 4 relating to typographical errors and minor in nature and one (TR #57261) where samples were sent to the wrong address. In all cases the complaint was appropriately recorded using the TR ticket systems with investigation, approval and corrective / preventative action performed, including a full root cause and extent analysis.

Nonconforming work (7.10)

Non-conforming work is referred to as anomalies with the QM. There is an appropriate and compliant high-level policy and supplementary procedure SOP-434 within the QMS which contains responsibilities and authorities in compliance with the standard. Identified non-conforming work is recorded with the RT ticket system, which each instance having a unique ticket number assigned. Ticket system is templated to ensue appropriate root cause analysis and action is undertaken.

Identified anomalies are reviewed monthly in the TG meetings. Review of RT system for tickets show the vast majority are punctuation errors with a small number of equipment issues. All were recorded and dealt with using appropriate corrective and preventative actions where appropriate.

Management System Requirements

Options (8.1)

The laboratory system is structured around Option A and wishes to be assessed against Option A.

Control of records (8.4)

QM section 8.3 contains ahigh level policy management and control of records including record retention with reference to QM section 7.4 and SOP 41. Included are the requirements for retrieval, backup and retention time along with disposal. Retention times consistent with contractual obligations showing appropriate control implemented.

SOP-41 details document retention periods with a tabular format and contains appropriate procedure for the retention, archiving and disposal of records and documents. All records / documents requested were readily available.

Actions to address risks and opportunities (8.5)

QM section 8.4 details the policy to evaluate risks and opportunities on an ongoing basis utilising a number of appropriate activities and areas such as complaints, customer feedback and analysis of ongoing laboratory performance. Risks and opportunities are appropriately recorded, actions to mitigate risks or implemented improvements are promotional to the magnitude of the risk / opportunity identified and are planned and implemented utilising elements listed in the section in the most appropriate form.

Improvement (8.6)

Section 8.5 of the QM contains high level policy and commitment to identify and select opportunities for improvement with reference to those identified as described in QM section 8.4. Where improvements are identified they actioned as a preventive action, as described in SOP-429 and are manged through the RT ticket systems to allow for appraise action plans to be developed and implemented, with appropriate responsibilities and ongoing review of the effectiveness of implemented actions.

Feedback from a customer (8.6.2)

High-level policy to seek feedback by the use of questionnaires, with a target of one questionnaire completed per customer on an annualised basis, using SOP-388 feedback form and includes a reminder process where feedback is not received after the initial request.

Received feedback is reviewed monthly as a standing agenda item for the SMT meeting. Examples of feedback received, and overall Feedback scores were reviewed and were largely

positive. All feedback is appropriately recorded and analysed utilising the RT ticket system and where additional comments are made evidence of review carried out at SMT was available.

Corrective actions (8.7)

There is an appropriate and compliant high-level policy and supplementary procedure SOP-434 within the QMS. Corrective actions are recorded with the RT ticket system, which each instance having a unique ticket number assigned. Ticket system is templated to ensue appropriate root cause analysis and action is undertaken. Includes the requirement to review implemented actions for ongoing effectiveness and where a system issue is identified for additional internal auditing to be performed.

Internal audits (8.8)

Appropriate high-level policy in QM section 8.8 with responsibility of Laboratory director and Quality / Technical managers to organise and conduct audits in accordance with the published audit plans.

Internal audit is split in to 3 separate workstreams. Quality Systems Audit is the QMS system audits, these are performed to ensure complete coverage of the QMS over annual rolling periods. Audits are planned using QSA audit schedule and schedule was seen to be up to date. SOP-39 supports the performance of system audits. Review of QSA audit #57410 showed three minor non-conformities but they were recorded, actioned and closed out as per the required process described in the QM and associated procedures. Audits were detailed and gave a good level of challenge to the QMS system and its effectiveness.

Technical Audits are referenced as witnessed audits and are planned and controlled using the Whatness Audit spreadsheet and RT system. All activities and staff are assessed over a rolling two-year timeframe. Again, the internal audit schedule was reviewed and found to be up to date.

The third and final audit is referred to as project audit as every completed project is subjected to a full vertical audit before approval of results and release of report, which provides an extra level or assurance above and beyond the previous system and technical audits.

Any identified non-conformances or anomalies are appropriately recorded and actioned using the RT tickets system. Any identified issue is risk assessed an actioned with CAPA, actions are reviewed at yearly QSR and also the monthly technical group meetings.

Management Reviews (8.9)

Appropriate high-level policy within QM section 8.8 supported by detailed requirements in SOP-166. Quality Systems Review (QSR) is performed yearly and is compliant with the requirements of the standard. Last review performed Oct 2021 with appropriate attendance including Laboratory Director, Quality manger and all Technical / Dept managers. Detailed and well documented discussions were evidenced, with actions arising and outputs recorded along with responsivity and target dates using the RT ticket system.

Vertical Audit

Witnessed Activity (Vertical audit)	Performed By	Technical Assessor	Comments
Vertical audit of job PN 6719 RT 57461 Wound Dressing to BS13726:2002 BS13726-3:2003	H Davies and R Fuller	David Phillips	Appropriate contract review completed. Worksheets present and approved. Equipment was present on calibration register. Staff member was present on training matrix for test performed. Report was compliant for symbol use and also statements of conformity.
Vertical audit of job PN 6724 57462 Examination Glove Testing EN 455 Part 1 EN 455 Part2:2015 BS EN ISO 21171 BS EN 455-3 2015.	H Davies and R Fuller	David Phillips	Appropriate contract review completed. Worksheets present and approved. Equipment was present on calibration register. Staff member was present on training matrix for test performed. Report was compliant for symbol use and also statements of conformity.

Evaluation Processes - Technical Activities

Technical Assessors Report –

Detailed in the Assessors Report embedded below is the evidence of competence and conformity from technical evaluation process.

2022 SU3 SMTL Assessor Notes CA.do

2022 SU3 SMTL Assessor Notes LW.dc

References

- ISO/IEC 17025:2017 General requirements for the competence of testing and calibration laboratories.

Relevant Publications

Accreditation Logo & Symbols. The National Accreditation Logo and Symbols: conditions for use by UKAS and UKAS accredited organisations. (Sept 2021)

National accreditation logo and symbols: conditions for use (www.gov.uk)

M3003 - The Expression of Uncertainty and Confidence in Measurement (Edition 4, October 2019)

M3003 Expression of Uncertainty and Confidence in Measurement (ukas.com)

GEN 4 - UKAS Policy and General Guidance on the Implementation and Management of Flexible Scopes of Accreditation (Edition 1, October 2019)

GEN 4 UKAS Policy on Flexible Scopes (ukas.com)

GEN 6 – Reference to Accreditation and Multilateral Recognition Signatory Status by UKAS Accredited Bodies (Edition 1, October 2021)

GEN 6 Reference to Accreditation (ukas.com)

ILAC-G8:09/2019 - Guidelines on Decision Rules and Statements of Conformity

Publications - UKAS (ukas.com)

ILAC-17:01/2021 - ILAC Guidelines for Measurement Uncertainty in Testing

Publications - UKAS (ukas.com)

Laboratory Related Publications

LAB 12 - The expression of Uncertainty in Testing (Edition 3, Nov 2019)

LAB 12 Expression of Uncertainty in Testing (ukas.com)

LAB 13 - UKAS Guidance on the Application of ISO/IEC 17025:2017 Dealing with Expressions of Opinions and Interpretations (Edition 3 April 2019)

LAB 13 Opinions and Interpretations (ukas.com)

LAB 15 - Traceability: Volumetric Apparatus (Edition 3, April 2019)

LAB 15 Traceability - Volumetric Apparatus (ukas.com)

LAB 46 - UKAS Policy for Participation in Measurement Audits and ILCs (Edition 4 May 2019)

LAB 46 Measurement Audit and ILC (ukas.com)

LAB 48 - Decision Rules and Statements of Conformity (Edition 3 June 2020)

LAB 48 Decision Rules and Statements of Conformity (ukas.com)

TPS Publications

TPS37 - Simplified Test Reports (Edition 5, October 2020)

TPS 37 Simplified Test Reports (ukas.com)

TPS 41 - UKAS Policy on Traceability of Measurement. (Edition 5, October 2019)

TPS 41 UKAS Policy on Metrological Traceability (ukas.com)

TPS 47 UKAS Policy on Participation in Proficiency Testing (Edition 4, February 2020)

TPS 47 UKAS Policy on Participation in Proficiency Testing (ukas.com)

TPS 57 UKAS Policy on Selection and Use of Reference Materials (Edition 4, June 2020)

TPS 57 Use of Reference Materials (ukas.com)

TPS 63 UKAS Policy on Deviating Samples (Edition 2, December 2019)

TPS 63 UKAS Policy on Deviating Samples (ukas.com)

TPS 68 UKAS Policy on Accreditation of Infrequently Performed Conformity Assessment Activities (Edition 2, Jun 2020)

TPS 68 Infrequently Performed Activities (ukas.com)

Appendices (Separately issued)

- 2022 SU3 SMTL 232240-02-01 IAR & IASF – Issued.

END OF REPORT

Certificate of Accreditation

UKAS United Kingdom Accreditation Service

NHS Wales Shared Services Partnership trading as Surgical Materials Testing Laboratory

Testing Laboratory No. 1492

Is accredited in accordance with International Standard ISO/IEC 17025:2017 – General Requirements for the competence of testing and calibration laboratories.

This accreditation demonstrates technical competence for a defined scope specified in the schedule to this certificate, and the operation of a management system (refer joint ISO-ILAC-IAF Communiqué dated April 2017). The schedule to this certificate is an essential accreditation document and from time to time may be revised and reissued.

The most recent issue of the schedule of accreditation, which bears the same accreditation number as this certificate, is available from www.ukas.com.

This accreditation is subject to continuing conformity with United Kingdom Accreditation Service requirements.

Matt Gantley, *Chief Executive Officer*
United Kingdom Accreditation Service

Initial Accreditation: 27 November 1995
Certificate Issued: 25 January 2021

ilac-MRA UKAS United Kingdom Accreditation Service

Scan QR Code to verify

UKAS is appointed as the sole national accreditation body for the UK by The Accreditation Regulations 2009 (SI No 3155/2009) and operates under a Memorandum of Understanding (MoU) with the Department for Business, Energy and Industrial Strategy (BEIS).

Surgical Materials Testing Laboratory Final Internal Audit Report

September 2022

NHS Wales Shared Services Partnership

Contents

Review reference:	NWSSP-2223-08
Report status:	Final
Fieldwork commencement:	6th September 2022
Fieldwork completion:	27th September 2022
Debrief meeting:	27th September 2022
Draft report issued:	27th September 2022
Management response received:	27th September 2022
Final report issued:	28th September 2022
Auditors:	Laura Leavesley (Principal Auditor) Gareth Heaven (Internal Audit Manager)
Executive sign-off:	Dr Gavin Hughes (Director of SMTL)
Distribution:	Matthew Alderman (Operations Manager – SMTL) Paul Edwards (Quality Assurance Manager)
Committee:	Velindre University NHS Trust Audit Committee for NWSSP

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

Acknowledgement
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during this review.

Executive Summary

Purpose

The overall objective of this audit was to assess the adequacy and effectiveness of systems and controls for the management of Surgical Materials Testing Laboratory (SMTL).

Overview

The SMTL have established governance arrangements and risk management processes in place. Robust invoicing and pricing of commercial testing arrangements were also evident.

We identified no matters for reporting in our review and have issued **substantial** assurance on this area.

Report Opinion

		Trend
Substantial 	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure	 2017/2018

Assurance summary[1]

Objectives		Assurance
1	Appropriate governance arrangements are in place to monitor and provide assurance on key objectives and risk areas	Substantial
2	Risk management processes ensure risks are identified, assessed, mitigated and escalated where appropriate	Substantial
3	Pricing methodology for commercial testing is robust and ensures contracts are financially viable	Substantial
4	Income due from commercial contracts is identified, invoiced and received	Substantial

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

1. Introduction

1.1 The Surgical Materials Testing Laboratory (SMTL) provides accredited medical device testing and technical services to NHS Wales to enable evidence-based procurement of medical devices, and commercially to the international medical device industry. The laboratory is based at the Princess of Wales Hospital in Bridgend and operates with a team of 26.

1.2 In March 2021, the laboratory attained reaccreditation from the United Kingdom Accreditation Service (UKAS) to undertake testing in accordance with the requirements of ISO/IEC 17025:2017.

1.3 The risk considered in this review is that the Surgical Materials Testing Laboratory is not appropriately governed or operating effectively, potentially resulting in:

- materialisation of risks due to poor risk management arrangements; and
- commercial activity is not financially viable, potentially resulting in financial loss and reputational damage.

1.4 The scope of this audit is further limited to governance and risk management arrangements, and income from commercial testing contracts. We have not reviewed medical device testing processes or outputs, as we understand that these have been reviewed as part of the recent ISO/IEC 17025 accreditation.

2. Detailed Audit Findings

Objective 1: Appropriate governance arrangements are in place to monitor and provide assurance on key objectives and risk areas

2.1 SMTL has an established Senior Management Team (SMT) that meet monthly. Whilst there is no terms of reference for the SMT, a review of the minutes for the period February – August 2022 noted consistent agenda items that address the SMTL business goals and objectives, and were well attended.

2.2 Weekly meeting between the Director of SMTL, the Executive Director and the Deputy Director of Finance & Corporate Services are established, whilst the SMTL submit papers and updates to the Shared Services Partnership Committee on an exception basis.

2.3 SMTL maintain a wide range of Statements of Process documents which were observed to be up-to-date and retained on the department's shared folder that is accessible to staff.

2.4 All SMTL employees have completed a declaration of interest form in addition to high levels of completion of mandatory and statutory training within ESR.

Conclusion:

2.5 Noting the above, we have concluded **Substantial** assurance of this objective.

Objective 2: Risk management processes ensure risks are identified, assessed, mitigated, and escalated where appropriate

2.6 SMTL maintain a risk register in line with the extant Velindre NHS Trust *Risk Register Policy*. The risk register is submitted and reviewed at the monthly SMT meetings and also discussed between at the monthly meetings between the Director of SMTL and Executive Director.

2.7 A review of the risk register noted that all risks had been scored, risk leads identified and progress listed. We did note that target dates for the next action had not been listed, this was raised during fieldwork with the Director of SMTL and subsequently addressed.

Conclusion:

2.8 Noting the above, we have concluded **Substantial** assurance of this objective.

Objective 3: Pricing methodology for commercial testing is robust and ensures contracts are financially viable

2.9 Pricing methodology uses rates cards which are reviewed and inflated on an annual basis and are available to all technical managers with the 2022/23 pricing schedule agreed in October 2021.

2.10 The vast proportion of commercial testing undertaken by SMTL is now standardised work on a repeat basis resulting in charges remaining the same year-on-year with an inflationary uplift.

2.11 Ad-hoc and bespoke pieces of work where a rate card does not have a relevant value are costed individually. A review of a sample of costing schedules provided a comprehensive breakdown including hourly rates for specific members of the technical team and costing per hours of equipment or item volumes used.

Conclusion:

2.12 Noting the above, we have concluded **Substantial** assurance of this objective.

Objective 4: Income due from commercial contracts is identified, invoiced, and received

2.13 Payment schedules are generated and signed by Technical Managers and recorded on the work ticketing system and the information used to populate an NOI. The NOI can only be raised by the Office Administrators to ensure segregation of duties. The NOI is sent to NWSSP Accounts Receivable where an invoice is raised on the Oracle system. SMTL also maintain an in-house ledger to manage project incomes.

2.14 A review of 35 invoices for 2022-23 accurately reconciled to approved NOI and payment schedule. Two invoices where a delay of 45 days between the NOI date and invoice date was identified. In both instances, invoices had been raised in error by NWSSP Accounts Receivable and subsequently amended.

Conclusion:

2.15 Noting the above, we have concluded **Substantial** assurance of this objective.

Appendix A: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

ZIMMER BIOMET

Supplier Audit Report

AUDIT INFORMATION

Zimmer Biomet Site(s) Performing Audit	**Zimmer Biomet Bridgend (UKB)**		**Zimmer Biomet Site(s) Using Supplier**	**Zimmer Biomet Bridgend**	
Subject:	**Supplier Quality Audit Report for SMTL**				
Supplier ID #:	SP-03336	**Assessment / Audit #**	00449	**Report Date:**	23 Sep 2022
Company Address:	Surgical Materials Testing Laboratory, Princess of Wales Hospital, Bridgend, CF31 1RQ, Wales			**Audit Start Date:**	23 Aug 2022
				Audit End Date:	23 Aug 2022
Supplier's Representative:	**Paul Edwards** (Name)			**Quality Manager** (Title)	
Zimmer Biomet Lead Auditor Name and Title:	Siôn Owens – Senior Development Engineer				
Zimmer Biomet Auditor Name and Title:	Sarah Gregory – Senior Microbiologist				

Audit Scope(s) (e.g. 21 CFR Part 820):	ISO 17025:2017	**Audit Type:**	On-Site	**Supplier Type (i.e. Shared/Site Specific):**	Shared

AUDIT EXECUTIVE SUMMARY

The audit was performed on-site by Zimmer Biomet Bridgend (UK) on 23 Aug 2022. No non-conformities were discovered through the course of the audit.

Number of Nonconformance(s)	0	**Total Critical Nonconformance(s)**	0	**Total Major Nonconformance(s)**	0	**Total Minor Nonconformance(s)**	0

Supplier Overview:	Surgical Materials Testing laboratory (SMTL) are located in Bridgend, Wales, and test the solution used during the implant cleaning process on behalf of Zimmer Biomet. They follow a Quality management System based on ISO 17025.

ZIMMER BIOMET

Supplier Audit Report

Audit Scope Overview:	The audit was performed to the elements of ISO 17025:2017 and GBLF01010 Global Procedures and Regulations Matrix as specified in the audit plan. The audit was conducted on-site. The audit was a sampling of the supplier Quality Management System.

Impartiality & Confidentiality (ISO 17025 - Section 4.1 & 4.2)	Element Details: Quality Manual received, revision 3.29, approved 29 Sep 2021. Signed by Pete Philips. SMTL Quality manual states that all staff undertake their activities impartially. All staff sign an Employee Interest Form – SOP-139. Example of SOP-139, rev 0.4, issued 17 Aug 1995 seen for Jae Taylor, declaring there is no conflict of interest. No further comments. Risk to impartiality is assessed in the Technical group meeting. TG meeting minutes reviewed to see te topic is discussed. Risk register is also used to assess the risk to impartiality. No example of when a conflict or risk to impartiality had been identified. They follow Velindre Standards of Behaviors Framework Policy and NWSSP Managing Personal Relationship at Work Policy if a risk to impartiality is identified. Procedure to inform customer in advance of the information it intends to place in the public domain - SOP-429, Rev 0.37, Issue 21 Jan 2020. States NDA's are signed between the sub-contractors and SMTL. Quality manual states data is confidential. SOP-429, Rev 0.37, Issue 21 Jan 2020. States NDA's are signed between the sub-contractors and SMTL. SOP-246, rev 0.8 08 May 2018, a confidentiality and non-disclosure agreement for all employees. Nonconformance Number: N/A Quality System Regulation/Standard/Specification/Procedure Nonconformance was found: Nonconformance Classification: ☐ Critical ☐ Major ☐ Minor ☒ N/A Provide detailed information to support the nonconformance, any objective evidence to supplier the audit nonconformance. N/A

ZIMMER BIOMET

Supplier Audit Report

General (Resource Requirements (ISO 17025 - Section 6.1)	Element Details: Supplier states they have available to them the personnel, facilities, equipment, systems and support service necessary to manage and perform its laboratory services. Currently fully staffed with no vacancies. 27 employees on-site, and expanding to Newport so will be having more employees with time. Expanding. Nonconformance Number: N/A Quality System Regulation/Standard/Specification/Procedure Nonconformance was found: Nonconformance Classification: ☐ Critical ☐ Major ☐ Minor ☒ N/A Provide detailed information to support the nonconformance, any objective evidence to supplier the audit nonconformance. N/A

Personnel - (ISO 17025 - Section 6.2)	Element Details: All employees receive induction training. Training requirements found on their website, which is not a controlled document, but lists what they need to be trained to. A training log exists where you can search the test method, or SOP, and it shows who's trained to it. Only personnel trained in the test methods or SOP can carry out the test method. SOP-160, Rev 0.36 Issued: 28 Jan 2022 Staff Training. Specifies the procedure for providing training to staff and to retain training records. The laboratory authorizes personnel to develop, modify, verify and validate testing methods if they are deemed competent based on training records. SOP-160, Rev 0.36 Issued: 28 Jan 2022 Staff Training. Specifies the procedure for providing training to staff and to retain training records. Job descriptions for managerial, technical and key support personnel involved in tests and/or calibrations are specified in the Quality Manual for Technical Manager, Quality Manager, approved signatories, and management-general. The list of staff authorised to discuss, explain and interpret data with customers is detailed within the SMTL Wiki. They have job descriptions specifying the qualifications and experience required to do the job. Nonconformance Number: N/A Quality System Regulation/Standard/Specification/Procedure Nonconformance was found: Nonconformance Classification: ☐ Critical ☐ Major ☐ Minor ☒ N/A Provide detailed information to support the nonconformance, any objective evidence to supplier the audit nonconformance. N/A.

ZIMMER BIOMET

Supplier Audit Report

Facilities and Environmental Conditions - (ISO 17025 - Section 6.3)	Element Details: Calibration and specifications requested for the following: Spec 76 – Certificate of analysis received, with MSDS Spec 120 – Certificate of analysis received, with MSDS Equip 1008 – Justification provided for calibration not needed. Equip 602 & 604 – calibration not required and justified Quality manual specifies the laboratory shall monitor, control and record required environmental conditions. The conditions are monitored. The laboratory takes care when sampling and tests are undertaken at other sites if the standard they test to requires certain environmental conditions. All Biomet products are tested on-site. The limits of the temperature and humidity (if required) is located on the website reading the wifi and humidity probes. Nonconformance Number: N/A Quality System Regulation/Standard/Specification/Procedure Nonconformance was found: Nonconformance Classification: ☐ Critical ☐ Major ☐ Minor ☒ N/A Provide detailed information to support the nonconformance, any objective evidence to supplier the audit nonconformance. N/A

Equipment - (ISO 17025 - Section 6.4)	Element Details: They have all the equipment required. SOP036, rev 0.109, issues 23 Feb 2022, Equipment and re-calibration procedure. Equipment not owned will have necessary evidence to show that the requirements of 17025 are met. Nonconformance Number: N/A Quality System Regulation/Standard/Specification/Procedure Nonconformance was found: Nonconformance Classification: ☐ Critical ☐ Major ☐ Minor ☒ N/A Provide detailed information to support the nonconformance, any objective evidence to supplier the audit nonconformance. N/A

ZIMMER BIOMET

Supplier Audit Report

External Provided Products and Services (ISO 17025 - Section 6.6)	Element Details: SMTL SOP 196 Rev 0.109 is the procedure for the selection and purchasing of services and supplies it uses that affect the quality of the tests. This was reviewed as well as SOP 429 Rev 0.37 which was the SOP for Sub-Contracted Suppliers. SOP 196 also includes the process for the purchase, reception and storage of reagents and laboratory consumables. The laboratory ensures purchased supplies that affect the quality of tests are not used until they are signed off by a technical member of staff after receipt. The TOC testing of the water is performed by ALS in Cambridge. SG asked PA to take her through the process of taking on that external Supplier. SMTL require that the majority of their suppliers are also UKAS accredited. The company Supplier Register was viewed which showed ALS as UKAS approved test laboratory 1282. The UKAS certificate had been checked by QA on 30/05/2022. The current expiry date for the ALS certificate was 18/05/2023. SMTL provided a signed Request for Work for Biomet project 6636. This record contained the SMTL lab requirements for the testing of water samples from the Biomet Orion RO water system. The requirements for samples sent for TOC analysis at ALS were included on this record. There had been a number of non-conformances from the laboratory at ALS which had resulted in two SCARs being raised against SMTL – SCAR-03385 and SCAR-03520. There is a corresponding SMTL Anomaly ticket still open due to the slow response of ALS in progressing actions. SMTL have started looking at other suppliers that are UKAS accredited that can perform TOC testing in water and also considered bringing the testing in-house to have more control. The preference from Biomet UK (RM) was to develop the existing supplier and manage them more effectively. Nonconformance Number: N/A Quality System Regulation/Standard/Specification/Procedure Nonconformance was found: Nonconformance Classification: ☐ Critical ☐ Major ☐ Minor ☒ N/A Provide detailed information to support the nonconformance, any objective evidence to supplier the audit nonconformance. N/A

ZIMMER BIOMET

Supplier Audit Report

Selection, Verification, and Validation Methods - (ISO 17025 - Sec. 7.2)	Element Details: The method for TVC (Total Viable Count) of Fluid Samples no 372 Rev 0.66 was reviewed. Biomet UK water samples are tested for TVC using this method which is referenced on the final reports. The microbiological media used for this testing is R2A Agar 90mm plates supplied by Thermofisher or E & O Group. These plates are stored at 2-10°C up to the label expiry date. The media certificates are stored electronically in the following location:- COA Data/accreditation media certificate – year. Although the media suppliers perform QC testing on the batches SMTL review the certificates and perform additional checks as per SOP 196. As E & O are a relatively new supplier SG asked to see their inclusion on the Supplier Register. E & O group were listed on the register as UKAS accredited – number 1894 with a certificate expiry of 24/02/2023. SOP 463 Rev 0.9 Validation of Transport and Storage Containers for Endotoxin testing was reviewed. It was requested to see the most recent copy of a validation of a 250ml bottle used for endotoxin testing. Bottle 250 ml lot number: B0218A was tested and found to be in specification on 1/7/2022. Nonconformance Number: N/A Quality System Regulation/Standard/Specification/Procedure Nonconformance was found: Nonconformance Classification: ☐ Critical ☐ Major ☐ Minor ☒ N/A Provide detailed information to support the nonconformance, any objective evidence to supplier the audit nonconformance. N/A

ZIMMER BIOMET

Supplier Audit Report

Complaints - (ISO 17025 - Sec. 7.9)	Element Details: The method for TVC (Total Viable Count) of Fluid Samples no 372 Rev 0.66 was reviewed. Biomet UK water samples are tested for TVC using this method which is referenced on the final reports. The microbiological media used for this testing is R2A Agar 90mm plates supplied by Thermofisher or E & O Group. These plates are stored at 2-10°C up to the label expiry date. The media certificates are stored electronically in the following location:- COA Data/accreditation media certificate – year. Although the media suppliers perform QC testing on the batches SMTL review the certificates and perform additional checks as per SOP 196. As E & O are a relatively new supplier SG asked to see their inclusion on the Supplier Register. E & O group were listed on the register as UKAS accredited – number 1894 with a certificate expiry of 24/02/2023. SOP 463 Rev 0.9 Validation of Transport and Storage Containers for Endotoxin testing was reviewed. It was requested to see the most recent copy of a validation of a 250ml bottle used for endotoxin testing. Bottle 250 ml lot number: B0218A was tested and found to be in specification on 1/7/2022. SOP-434, rev 0.29, issues 25 Sep 2019. Complaints Process was reviewed with no comments. All information and communication related to complaints is recorded in the complaint ticket. The progress of the complaint is communicated to the complainant, and even after it's resolved. Nonconformance Number: N/A Quality System Regulation/Standard/Specification/Procedure Nonconformance was found: Nonconformance Classification: ☐ Critical ☐ Major ☐ Minor ☒ N/A Provide detailed information to support the nonconformance, any objective evidence to supplier the audit nonconformance. N/A

Management System Documentation (ISO 17025 - Section 8.2)	Element Details: The Quality Manual specifies the relevant SOPs to each clause in the ISO standard. Revision 3.29, approved 29 Sep 2021. Signed by Pete Philips There is a procedure for impartiality, competence/training and lab operations (Test methods). There is a Technical group meeting every month where the Quality Manual's compliance to ISO 17025 is reviewed. Meeting minutes reviewed to see evidence the quality manual is reviewed. All procedures relevant to a clause in the standard is stated in the Quality Manual. Everyone internally has access to all the procedures and test methods required as read only. Only certain people can adjust the documents. ISO 17025 certification reviewed. Certified by UKAS, with SMTL identified as Testing Laboratory 1492. Issued on 25 Jan 2021, and updated schedule on 03 Mar 2022. A new certification Is not issued annually, but a review of the certification is held annually. Saw the latest management Review. No further comments. Review held 25th of October 2021 Nonconformance Number: N/A Quality System Regulation/Standard/Specification/Procedure Nonconformance was found: Nonconformance Classification: ☐ Critical ☐ Major ☐ Minor ☒ N/A Provide detailed information to support the nonconformance, any objective evidence to supplier the audit nonconformance. N/A

ZIMMER BIOMET

Supplier Audit Report

Control of Management System Documents (ISO 17025 - Section 8.3)	Element Details: All procedures or processes are approved electronically and controlled. SOP-1, rev 0.32, issued 11th of Sep 2019, is the procedure detailing the process to write a procedure. Each document and procedure has an unique document number. The first page of each document identifies the revision and issue date. Obsoleted and superseded documents are saved, or stored elsewhere away from the database of procedures and cannot be accessed. (SOP-151). Nonconformance Number: N/A Quality System Regulation/Standard/Specification/Procedure Nonconformance was found: Nonconformance Classification: ☐ Critical ☐ Major ☐ Minor ☒ N/A Provide detailed information to support the nonconformance, any objective evidence to supplier the audit nonconformance. N/A

Improvement - (ISO 17025 - Sec. 8.6)	Element Details: Opportunities for improvement is discussed in the Technical group meeting and the QSR (Quality System Review) meeting that happens annually. It was asked to see evidence that the laboratory had been seeking feedback from Biomet UK. A questionnaire was sent to the person who receives the SMTL final reports (End of Line QE) on 24/08/2021. After chasing up the response at the end of March 2022 a reply had been received and logged on 04/04/2022. Nonconformance Number: N/A Quality System Regulation/Standard/Specification/Procedure Nonconformance was found: Nonconformance Classification: ☐ Critical ☐ Major ☐ Minor ☒ N/A Provide detailed information to support the nonconformance, any objective evidence to supplier the audit nonconformance. N/A

ZIMMER BIOMET

Supplier Audit Report

AUDIT CONCLUSION

Supplier Quality Auditor Recommendation	New Supplier	☐ Approved	☐ Not Approved
	Existing Supplier	☐ Approved (Category Change)	☐ Not Approved for Category Change
		☒ Approved (Continue Business)	☐ Not Approved
Audit Corrective Action Response Required?	☐ Yes	Applicable SCAR Number	
	☒ No	**Comment(s):** N/A	

NOTE: The Zimmer Biomet Lead Auditor or requesting site will assign the SCAR within the CAPA system. The SCAR will be tracked to closure within the Zimmer Biomet CAPA system.

Audit Report Signoff	Siôn Meirion Owens – Senior Development Engineer	23-Sep-2022 |	05:02:59 EDT DocuSigned by Sion Owens Sion Owens I am the author of this do 23-Sep-2022 | 04:58:58 E 1D3C240954864237A31B793A1941D68A
	Supplier Quality Name and Title	Date	Signature

Audit Report Disposition ☒ Approved ☐ Not Approved		Comments / Actions:	
Supplier Quality Management Disposition	Rhys Miles – Quality Excellence Associate Director	23-Sep-2022 |	09:40:05 EDT DocuSigned by Rhys Miles Rhys Miles I approve this document 23-Sep-2022 | 09:39:56 E
	Supplier Quality Management Name and Title	Date	Signature 723E [illegible] 4C869FBE14D1E0ECC03B

ZIMMER BIOMET

Supplier Audit Report

Appendix A - Audit Non-conformance Categorization

Refer to **GBLW06015 Supplier Corrective Action Report (SCAR)** for audit non-conformance requirements.

NC	Description
Critical	The non-fulfillment of a requirement that represent a high level of risk to the quality, safety/effectiveness of the medical product, integrity of the Quality Management System, or regulatory compliance. **Examples of Critical Nonconformities:** • A situation that has resulted, or has the potential to result in an immediate or foreseeable health risk. • Failure to define, document, or implement a quality system process or one of the subsystems (e.g., absence of management controls, CAPA, training, etc.). • Issues that could lead to a market field action or regulatory action by a competent authority.
Major	The non-fulfillment of a requirement that represent a medium level of risk to the quality, safety/effectiveness of the medical product, integrity of the Quality Management System, or regulatory compliance. **Examples of Major Nonconformities:** • Failure to maintain a quality system process or one of the subsystems. • Failure to meet the requirements of medical product regulations, standards or applicable regulatory requirements related to the design, manufacturing and/or distribution of medical products, or a situation in which the probability of an immediate or significant health risk is likely. • A condition or issue that could indirectly have an impact on the quality of the product or service provided. • A pattern of minor observations or a repeat observation in the same system could lead towards elevation to a major observation.
Minor	The non-fulfillment of a requirement that needs to be corrected but only represents a low risk to product safety/effectiveness or to the integrity of the Quality Management System or regulatory compliance. **Examples of Minor Nonconformities:** • An issue that indicates relevant essential requirements or any part of Medical Device Regulations have not been appropriately applied or implemented. • Minor documentation errors or minor procedural deficiencies that have no impact on the product or process. • Deficiencies that do not exhibit a pattern of an immediate or significant health risk as procedures are in place to mitigate the risk.

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

MEDICAL EXAMINERS SERVICE IMPLEMENTATION

DATE OF MEETING	14/9/2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Choose an item
REPORT PURPOSE	INFORMATION / NOTING
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	RUTH ALCOLADO MEDICAL DIRECTOR NWSSP ANDREW EVANS DIRECTOR OF PRIMARY CARE SERVICES DIVISION NWSSP
PRESENTED BY	RUTH ALCOLADO
APPROVED BY	Choose an item
EXECUTIVE SUMMARY	The **Coroners and Justice Act 2009: *Notification, certification and registration of deaths*** includes the following: • Section 19, requires Medical Examiners to be appointed. • Section 20, which enables regulations to be made (in both Wales and England) setting out the requirements for the preparation, scrutiny, and certification of Medical Certificate of the Cause of Death.

	Recurrent delays to secondary legislation have pushed back the statutory implementation date of the Medical Examiners Service. Statutory implementation is scheduled for April 2024. This paper outlines the work undertaken in NHS Wales, in preparation for statutory status.

RECOMMENDATION / ACTIONS	Note the contents of the report

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

7 LEVELS OF ASSURANCE	
N/A	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	**Select Current Level of Assurance**

APPENDICES	

1. SITUATION

In 2019 a National Medical Examiner, Dr Alan Fletcher, was appointed to provide professional and strategic leadership for a medical examiner system that would see the creation of Medical Examiner Services across England and Wales in line with the requirements of the Coroner and Justice Act 2009.

Dr Jason Shannon was appointed as Lead Medical Examiner for Wales and Daisy Shale as Lead Medical Examiner Officer for Wales in 2019, both are employed by NWSSP as they have a national remit and are working independently of Health Boards and Trusts.

The Medical Examiner service has been set up in Wales to provide:

- **Scrutiny of every death not referred directly to a Coroner, to systematically answer 3 key questions**
  - What did the person die from?
  - Does the death need to be reported to a Coroner?
  - Are there any potential clinical governance/patient safety issues evident that may need further consideration (including proportionate investigation) by the care provider?

- **Delivered by independent, trained Medical Examiners, supported by trained Medical Examiner Officers, using a standard methodology**
  - Employed by NWSSP, independently of care providers

- **Using 3 key component sources of information**
  - Relevant clinical records (paper and electronic information)
  - Discussion with the Qualified Attending Practitioner/Clinical Team
  - Discussion with the bereaved (ordinarily the Next of Kin)

- **With reporting links to other systems**
  - Care Providers (e.g. Health Board governance links)
  - Coroner Services
  - Registration Services

There are number of local stakeholder reference groups along with a national group with representation from Health and Care providers, funeral directors, Registrars of Deaths, Coroners and faith groups to look at developments in wider field of death certification and how they impact on the work of the Medical Examiner Service.

Regular reporting arrangements have been agreed with HBs and Trusts to provide quarterly reports demonstrating the Medical Examiner Service activity for each trust and HB and the % of deaths returned to HB and Trust governance systems for potential learning. Reports will also highlight any All-Wales themes and trends.

2. BACKGROUND

Background to the creation of Medical Examiners

The drivers for the creation of Medical Examiners can be summarised under three headings as follows:

- **Patient Safety**
  - Numerous reviews (e.g. Shipman, Mid Staffs, Morecombe Bay, Gosport) concluded that there was insufficient scrutiny of the cause of death and recommended the introduction of Medical Examiners
- **Death Certification Accuracy**
  - A Department of Health and Social Care Impact Assessment identified several issues around the accuracy and completeness of Medical Certificates of Cause of Death (MCCD)
- **Distress for the bereaved**
  - Not always at the centre of the process
  - Not always given the opportunity to raise questions
  - Not always satisfied with independence of responses

The Medical Examiner Service for Wales

The Medical Examiner Service for Wales has been designed to directly address the drivers for change identified above. The vision is for a single, all Wales Medical Examiner Service, working on behalf of health boards and trusts that will deliver the following benefits:

- **Strengthen safeguards for the public. Achieved by:**
  - Providing robust, systematic, and independent scrutiny of all deaths not referred directly to a Coroner (cause of death and circumstances impacting on the death).
  - Providing intelligent analysis and system level reporting of potential issues found during scrutiny, and
  - Ensuring that the right deaths are referred to a Coroner.
- **Improve the quality of death certification. Achieved by:**
  - Agreeing a cause of death, based on scrutiny of relevant health records and interaction with attending doctors.
- **Avoid unnecessary distress for the bereaved. Achieved by:**
  - Answering questions about the certified cause of death or care given, or that arise from unexpected delays when registering a death
  - Preventing rejection of the MCCD by the Registration Service by ensuring it meets their requirements for registration.

3. ASSESSMENT

Although still in a non-statutory phase, it is expected that medical examiner scrutiny of all deaths not referred directly to a coroner will be a legislative requirement from April 2024.

Currently between 40 and 50% of all expected deaths are scrutinised by the Medical Examiners Service for Wales.

- 95% of deaths in the acute sector
- 50% of deaths in community hospitals and hospice settings
- 6% of deaths in primary care

The aim is to have all deaths, not investigated by the HMCoroner, scrutinised by the statutory implementation date.

Work is ongoing to implement a data sharing agreement with primary care providers to facilitate access to patient records.

Current Governance Arrangements:

Quarterly performance review of the Medical Examiners Service includes:

- Review of performance against agreed KPIs.
- Review of implementation timeline and Gannt Chart.
- Review of workforce metrics.
- Finance holding to account.
- Risks and Issues log.

The National Medical Examiner provides professional leadership and guidance to services in both Wales and England. In England each trust manages its own service, in contrast to the All Wales approach.

The Medical Examiner Service for Wales reports quarterly to the National Medical Examiner using a standard template.

The service has a standard operating procedure for escalation of themes and trends to clinical executives at an early stage where it is felt to have potentially significant patient safety implications.

4. SUMMARY OF MATTERS FOR CONSIDERATION

The Medical Examiners Service should enter statutory mode in 2024.
The committee are asked to note the current preparatory work of the service.

The committee are asked to note the current governance arrangements including the role of the Justice Department's appointed National Medical Examiner for England and Wales.

It is suggested that once the service is statutory and annual report on the service is brought to Velindre QSP for noting.

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	**Select all relevant domains below** Safe ☒ Timely ☐ Effective ☒ Equitable ☒ Efficient ☐ Patient Centred ☒

	1) SAFE & EFFECTIVE: The Medical Examiners Service will provide direct feedback to HBs and Trusts where the independent scrutiny process has identified any potential learning. 2) EQITABLE: The Service provides an independent and equitable service to all HBs and trusts within Wales. Medical Examiners will not scrutinise deaths from the HB or Trust where they have substantive employment. 3) PERSON CENTRED: The Medical Examiners service will ensure that the bereaved have an opportunity to raise any issues they have with the care of the deceased and will be able to give an independent view of the cause of death, based on proportionate scrutiny of the medical record.
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	**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: Other (please explain) Please explain if 'other' source of funding selected: The Medical Examiners service sits under the Justice department, a non-devolved responsibility. Funding is therefore provided from the Westminster Government **Type of Funding:** **Revenue** **Scale of Change** **Type of Change** **Other (please explain)** Please explain if 'other' source of funding selected: New service
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	**Choose an item**
	[In this section, explain in no more than 3 succinct points what the equality impact of this matter is or not (as applicable)].

ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The implementation of the medical examiners service is an England and Wales Justice Department service

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	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?	No
All risks must be evidenced and consistent with those recorded in Datix	

TRUST BOARD

WORKFORCE AND OD POLICY UPDATES

DATE OF MEETING	27th 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	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Safeguarding Group	19/12/2022	NOTED
EMB	03/01/2023	ENDORSED
QSP	17/01/2023	ENDORSED

ACRONYMS	
EMB	Executive Management Board

1. SITUATION / BACKGROUND

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

2. ASSESMENT / SUMMARY OF MATTERS FOR CONSIDERATION

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

2.1.1 Recruitment and Selection Policy (Agenda for Change) - Version 1

- New Policy developed in partnership with Trade Union Colleagues
- Recommendation by the internal audit committee
- The policy highlights best practice and expectations for those involved within the Recruitment and Selection process

Changes following EMB include:

- Updated and correct Trust logo
- Consideration of internal recruitment options for retention and talent management

2.1.2 Annual Leave Policy (Agenda for Change) – Version 5

- Rename to 'Annual Leave and Bank Holiday Policy and Procedure'
- Updated annual leave entitlements following following Pay Circular AFC, M&D & ESP (W) 01/2021 issued in December 2021
- Added in policy statement on the importance of annual leave for managing health and wellbeing
- Removal of reference to terms under the 'General Whitley Council' under carry-over of annual leave
- Update reference to other Trust Polices (Managing Attendance at Work and Respect and Resolution etc.)

2.2 There are not updated All Wales Polices to approve for adoption at this time.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Staff and Resources
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
	Each policy has been individually assessed to ensure compliance with EQIA's
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Not complying with Trust policy and procedure can result in legal challenges from staff at Employment Tribunal. Not complying with legislative requirements could result in fines and prosecutions against the Trust from respective government agencies.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Non-compliance could result in significant costs due to legal challenges, fines and prosecutions against the Trust.

4. RECOMMENDATION

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

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Ref: TBC NEW POLICY

RECRUITMENT AND SELECTION POLICY (AGENDA FOR CHANGE)

Executive Sponsor & Function	Director of OD and Workforce
Document Author:	Head of Workforce
Approved by:	Trust Board
Approval Date:	TBC
Date of Equality Impact Assessment:	December 2022
Equality Impact Assessment Outcome:	Approved
Review Date:	3 years or upon legislative change
Version:	1

1. Policy Statement

To ensure the Velindre University NHS Trust (the Trust) delivers its strategic aims, objectives, responsibilities and legal requirements transparently and consistently, we will ensure that the recruitment and selection of our people is conducted in a systematic, comprehensive and fair manner, promoting equality of opportunity at all time, eliminating discrimination and promoting good relations between all.

The Trust recognises our employees are fundamental to the success of the organisation and we are committed to attracting, appointing and retaining qualified, motivated people with the right skills and experience to ensure the delivery of a quality service for patient and donors.

In order to achieve this we will:

- Provide a well-defined Policy and supporting Procedures for managers to work within and ensure they are clear about the principles underlying the recruitment and selection processes
- Promote the values of the Trust and ensure that this is reflected in the selection of candidates
- Work at all times within current employment legislation and best practice guidelines to ensure a fair and equitable recruitment process
- Provide a workforce planning structure to ensure recruiting managers are fully considering the needs of the service before advertising
- Ensure that every post has a written job description and person specification that has been appropriately evaluated in line with Agenda for Change Handbook
- Employ staff on permanent contracts of employment as the norm, with fixed term contracts only used where necessary and appropriate. *NB: Any employee engaged on a fixed term contract will be entitled to terms and conditions of employment that are no less favorable on a pro-rata basis than the terms and conditions of a comparable permanent employee, unless there is an objective reason for offering different terms.*

2. Introduction and Aim

This policy aims to provide the framework for managers to recruit talented and motivated staff to deliver for our patients and donors within a positive legal and regulatory framework.

By following this Policy, appointing managers can be assured that they are operating within the confines of current employment legislation, and they are able to avoid discrimination and recruit safely without putting the Trust, our staff or patients and donors at risk.

3. Objectives

The objectives of this policy are to:

- Ensure that appointing managers and applicants are clear about their role and the role of other stakeholders in the recruitment and selection process
- Ensure that appointing managers and applicants are clear about the principles underlying the recruitment and selection processes
- Support managers in appointing the best candidate for each position
- Ensure that all necessary steps are taken before a new member of staff starts with the Trust
- Promote the Trust's vision and values ensuring that these are embedded into the recruitment and selection process and wider organisational culture

4. Scope

This procedure applies to all managers and staff who are involved in the recruitment and selection of staff employed under Agenda for Change Terms and Conditions and any other workers, except for those appointed onto Medical and Dental Terms and Conditions.

For information on the appointment of employees under the Medical and Dental Terms and Conditions of Service please contact the People and OD team.

5. Responsibilities

Applicants are responsible for:

- Submitting an accurate, honest and complete application
- Rising requests for reasonable adjustment during the assessment process
- Notifying the appointing manager if they are unable to attend an assessment
- Providing the appropriate documentation to enable pre-employment checks to be undertaken

Mangers must:

- Effectively workforce plan their services ensuring vacancies are designed to meet the Trust's goals and objectives
- Detail the skills and requirements for the role in line with the Job Evaluation Procedure and DBS Procedure.
- Ensure that they follow this Policy and adhere to the recruitment and selection principles set out in the relevant documents
- Act in a way that ensures the Trust's recruitment, selection and appointment of staff is undertaken in a fair, anti-discriminatory and safe manner, and that the Trust's vision and values are considered as an integral part of the recruitment process
- Understand their role as recruiting manager and the role played by People and OD and Employment Services Team (NWSSP) and ensure that those elements of the process that they are responsible for are completed thoroughly and in a timely way
- Seek advice from the People and OD Team before making an offer of employment if they are unsure about the appointment or starting salary

The People and OD team is required to:

- Ensure individuals involved in the recruitment process are appropriately trained to undertake their roles
- Provide advice on legislation and the principles that govern the recruitment and selection process
- Provide advice on starting salaries and authorise any applications under the Incremental Credit Procedure.
- Ensure that managers have adequate information, guidance and support to fulfil their role in the recruitment and selection of staff
- Offer support and guidance to managers to help them meet the Disability Confident requirements
- Maintain close links with NWSSP to ensure compliance, quality and efficiency in all aspects of the recruitment and selection process

NHS Wales Shared Services Partnership provides recruitment services for all non-medical and dental appointments in NHS Wales. The Employment Services team is responsible for advertising and on-boarding into vacant posts in a professional, timely manner and ensuring that all the required pre-employment checks take place.

6. Values Based Recruitment

Values Based Recruitment is an approach to help attract and select employees whose personal values and behaviours align with those of the Trust. It is about enhancing existing processes to ensure that we recruit the right workforce not only with the right skills and in the right numbers, but with the right values to support effective team working and excellent patient and donor care.

Values Based Recruitment can be delivered in a number of ways, for example through pre-screening assessments, values based interviewing techniques or assessment centre approaches. It can sit within a competency based interview through asking questions that address matters such as ethical questions, interpersonal relationships or decision making.

6. The Recruitment and Selection Process

6.1 Before deciding to advertise a post, managers should be certain that a real vacancy exists and be clear about the requirements of the job. Like for like replacements should not be taken for granted. Consideration should be given to whether or not there is scope for modernisation before replacing posts – when determining this managers may want to undertake a workforce planning exercise with support from the People and OD team. If there is a fundamental change to the post or this is a new post, the vacancy will need Scrutiny approval.

6.2 Each job should have a written job description and person specification that has been evaluated in line with the Agenda for Change Job Evaluation Procedure. These should be reviewed every time a vacancy occurs to ensure that they remain relevant and flexible, including making reasonable adjustments should people with disabilities apply. Changes to the job description or personal specification will need to be

reviewed by the People and OD team to ensure there is no impact to the pay band of the post.

6.3 Managers need to consider the role requirements to undergo criminal records checks through the Disclosure and Barring Service (DBS CHECK) to ensure the safety or our patients and donors. The requirement and level of checks needs to be clearly articulated on the Job Description. The DBS Procedure provides detailed information on assessing the role requirements for a DBS check.

6.4 When the appointing manager is satisfied that the vacancy details and job description are correct they should submit this for approval to the Head of Service, Finance Business Partner and People and OD team.

6.5 Permanent posts can be advertised internally to support our people development principles, however to ensure all staff have equal and fair opportunities, this must be internal to Velindre NHS Trust as a whole.

6.6 On occasion where a vacancy is short-term (less than 12 months) or a Temporary Movement to a higher band in line with Agenda for Change terms and conditions, managers may be able to advertise through and expression of interest, with approval from the People and OD Team.

6.8 Applicants must provide detailed information regarding their full employment history to date in all cases.

6.9 All applicants will be shortlisted for interview on the basis of the information they provide on their application form. It is the responsibility of the appointing manager to oversee the shortlisting process to ensure that all decisions are based on the criteria set out in the person specification and that the decisions are valid, justifiable and fair. It is best practice for more than one person to shortlist candidates. Candidates who do not meet all of the essential criteria should not be shortlisted. In order to ensure a fair and transparent process, reasons for the selection or rejection of all candidates must be recorded on Trac.

6.10 The Trust is committed to improving the diversity of our people and to being a fully inclusive employer. Research has shown that diverse teams make better decisions and are more productive. This means we actively look to recruit from underrepresented groups, provide a fully inclusive and accessible recruitment process, offer an interview to disabled people who meet the minimum criteria for the job, and are flexible when assessing people's skills so applicants have the best opportunity to demonstrate that they can do the job. We also proactively offer and make reasonable adjustments as required.

6.11 All applicants must have a formal interview before an appointment can be made. This is essential as it provides an opportunity to discuss the candidate's application and employment history fully, and explore any areas of doubt or concern prior to an appointment being made. It is the responsibility of the appointing manager to oversee the interview process to ensure that all decisions are based on the criteria set out in the person specification and that the decisions are valid, justifiable and fair. It is expected that more than one person will interview candidates, and where

possible, best practice would be for of an interview panel representing various gender and ethnicities undertake the interview process.

Discriminatory questions must be avoided (see Managers Guide to Conducting an Interview). To avoid discrimination during an interview, managers should bear in mind the following guidelines:

- Candidates should not be asked about their marital status, family commitments and/or domestic arrangements, nor should they be asked about any actual or potential pregnancy/maternity leave
- Ensure that questions focus on the applicant's ability to perform the role, not on potential difficulties he or she might have on account of an actual or potential disability
- Frame questions in a positive way so as to avoid the risk of the applicant believing you are looking for or anticipating problems
- Remember that there is no duty on applicants to voluntarily disclose a disability to a prospective employer and that it is unlawful to ask about an applicant's health (including any disability) before offering him or her a job.
- Don't place too much importance on length of experience as this will place younger applicants at a disadvantage. Instead, concentrate on the interviewee's type and breadth of experience, and their skills, competencies and talents.

6.12 Pre-employment checks seek to verify that an individual meets the preconditions of the role they are applying for. All offers of employment are therefore conditional and subject to the following pre-employment checks (as applicable to the post):

- Right to work checks (It is a criminal offence to appoint a candidate without the appropriate right to work in the UK)
- Identity checks
- Professional registration and/or qualification checks
- Employment history and references checks
- Work health assessments
- Discourse and Barring Checks

These checks are carried out by NWSSP Recruitment Services on behalf of the Trust more information can be found on the Trust's Attraction, Recruitment and Retention intranet page.

7. Recruitment and the Welsh Language

The Trust is committed to providing quality care for patients and donors through the medium of Welsh and Welsh language skills must be actively considered as part of the workforce planning and role design process.

Welsh language skills are needed to ensure patients and donors have access to services in their preferred language. Welsh language provision has been identified as a clinical need as well as a communication need as it enables a deeper understanding of patient outcomes and donor care.

To support these outcomes recruitment mangers are required to complete the following process:

- Complete the Welsh Language Assessment providing evidence of the language skills required for the specific post
- Ensure that the post has Welsh language support from the wider team should Welsh language skills not be needed for the specific role
- State the level of Welsh language skills required clearly
- State whether the post is Welsh language 'Desirable' or 'Essential'
- Ensure the Job description and advert are translated by sending it to Velindretranslations@wales.nhs.uk
- Send the completed language assessment form to the Trust Welsh language Manager

8. Making a Salary Offer

Velindre NHS Trust fully supports the principle of fair pay and want our people to be paid fairly and consistently for the work undertaken. The Agenda for Change NHS Terms and Conditions of Service Handbook (The Handbook), Section 12.2 gives the Trust discretion to take into account any period or periods of employment outside of the NHS judged to be relevant to NHS employment.

The appointing manager should not make a salary offer above the minimum of the pay band however managers can make an applicant aware of Incremental Credit Procedure and application process where reckonable service or equivalent relevant experience may apply.

9. Induction

It is vital for line managers to prepare for how a person is welcomed into their role and the Trust. Failure to do this can create a poor impression and undo much of the work which attracted the candidate to the job. As soon as the successful applicant accepts the job offer, managers should start to organise a carefully planned programme to settle them into the role, team and organisation, so they become effective as soon as possible, and want to stay.

In addition, the People and OD team delivers provides a Corporate Induction which is suitable for all new staff and which must be completed within eight weeks of starting employment. Line Managers must ensure that new starters are given time to undertake this programme.

10. Right to Recruitment Information

A candidate, both successful and unsuccessful, is entitled to make a request for their recruitment information, including shortlisting and interview criteria and scores or observations made on the candidate. It is therefore important that the process is accurately documented and the information is retained by the recruiting manager in the most secure and safe manner. The information should be destroyed after six months, unless there is a legal obligation on the Trust to retain this for longer (i.e. the

recruitment process is subject to an employment tribunal claim against the organisation).

11. Audit and Monitoring

The People and OD Department will monitor the application of this policy and documentation will be audited on a regular basis. All confidential records will be stored in line with the General Data Protection Regulations.

Anonymised data may be analysed to identify trends in recruitment relating to protected characteristics under the Equalities Act 2010 or other Trust initiatives. These findings may be used to inform future plans and activities for the Trust.

12. Review

The People and OD Department will review the operation of the policy as necessary and at least every 3 years.

REF: WF35

Annual Leave and Bank Holiday Policy and Procedure (Agenda for Change)

Executive Sponsor & Function:	**Executive Director of Workforce and OD**
Document Author:	Senior People & OD Business Partner
Approved by:	Trust Board
Approval Date:	TBA
Date of Equality Impact Assessment:	June 2022
Equality Impact Assessment Outcome:	Approved
Review Date:	January 2026
Version:	5

Table of Contents

1. Policy Statement

Annual leave is an important wellbeing entitlement, which is encouraged to be taken by all employees to assist them to achieve a healthy balance between their work and home life. The Trust recognises that the effective management of annual leave by individual employees and line managers is essential to the health, safety and well-being of our employees and the ability of the Trust to continue to deliver high quality services which meet the requirement of its service users.

There is a requirement to provide a statutory minimum amount of annual leave each year. However, NHS employers want to reward and retain high quality, hardworking staff and therefore offer an enhanced annual leave entitlement. Whilst it is important to book annual leave at regular intervals for adequate rest breaks, it is also recognised that annual leave requests may be declined due to operational requirements and in exceptional situations, an employee may be asked not to take previously agreed annual leave or previously agreed annual leave may need to be cancelled, if not doing so would cause a detriment to the operation of the service. In these cases, managers will be mindful of providing as much notice as possible and will seek to be as flexible as possible with the employee.

2. Scope

This document provides a uniform and equitable approach to the management of annual leave and bank holiday entitlements for agenda for change staff groups employed within Velindre NHS Trust.

3. Aims and Objectives

The aim of this document is to provide guidance on how to manage annual leave and bank holiday entitlements, including when transferring or leaving the organisation, and the provisions relating to the carrying over of annual leave due to absence from work.

4. Responsibilities

4.1. Individual Employee Responsibilities

Employees are responsible for:

- Ensuring that their annual leave is planned and taken at regular intervals throughout the leave year, subject to approval and the needs of the service.

- Ensuring that where staff work shifts, weekends and bank holidays, they request their annual leave (which includes their bank holiday entitlement) generally proportionate to these working arrangements e.g. there is not a disproportionate taking of annual leave on particular shifts. If this occurs managers will speak to staff to discuss reasons and agree an outcome that takes account of business and personal needs.

- Requesting leave via ESR providing a minimum of 72 hours' notice, prior to taking such approved leave. In exceptional circumstances shorter notice periods may be approved by departmental managers. Ensuring that, in

exceptional circumstances, where the provision of notice has not been possible, ESR should be completed (and authorised by management) within 72 hours of the employee's return to work.

- Ensuring that the Bank Holiday process below is followed.

  Bank Holidays **<u>are included</u>** in all employee's annual leave entitlement balances. Therefore, any bank holidays not worked (that fall on an employee's normal working day) needs to be booked off as leave on ESR in the same way as annual leave.

  If an employee is not scheduled to work on any of the bank holidays, the relevant number of days (up to the maximum for that year* days (pro-rata part time staff) needs to be booked at the start of the annual leave year. Staff should book these days on ESR at the commencement of the new annual leave year (or when they commence in post), but in any event no later than the actual bank holiday date(s).

  If an employee is scheduled to work, or as part of their shift pattern may be required to work on a bank holiday, they are not required to this day / these days off on ESR at the start of the annual leave year. Where an employee is required to work or be on-call on a bank holiday they are entitled to take the equivalent of their bank holiday day off, at another time. By not booking their Bank Holiday entitlement off on ESR in advance this ensures that the corresponding number of hours are still available within the employee's annual leave allowance to be taken at another time.

  Employees should note that the Trust regularly undertakes audits to ensure ESR is up to date and to provide assurance that leave is being accurately recorded. Should an employee not book their bank holiday leave and this results in them overtaking their annual leave entitlement, the monetary value of these days will be claimed back as an overpayment of salary, via payroll, in accordance with the Trust's Recovery of Overpayments Policy. It is an employee's responsibility to maintain accurate records and their manager is accountable for ensuring this compliance. If an audit shows that records are repeatedly not up to date, both the employee and their line manager may be asked to explain the reason. If this is identified as a conduct concern the matter may need to be dealt with under the Trust's Disciplinary Policy.

N.B **The Bank Holiday entitlement may vary each year depending on when they fall and therefore will be calculated accordingly*. * Noting that where the annual leave year runs from 1st April to 31st March, the Easter bank holiday dates may fall in the same annual leave year, resulting in one year having more bank holidays than the annual statutory days and the next one having fewer.

4.2. Managers Responsibilities

Managers are responsible for:

- Working with their employees to ensure that they appropriately manage their annual leave throughout the leave year and ensuring that they apportion their leave so they can have regular rest breaks across the year.

- Calculating the annual leave entitlement for those staff employed on part-time contracts, who have not completed a full 'ESR' month who are, reaching 5 or 10 years' service during the annual leave year; who have requested to change their contracted hours during the annual leave year. In these circumstances the manager is responsible for checking the accuracy of the leave calculation on ESR and recalculating where necessary. (ESR will calculate annual leave entitlement automatically for staff where applicable and managers can use the annual leave calculators on the intranet for this purpose).

- Checking that where a bank holiday(s) fall on an employee's normal working day and they are not required to work it, that the leave has been requested and approved. Should an employee not book a bank holiday(s), the manager will bring this matter to their attention immediately and request that they submit retrospective and if appropriate prospective bank holiday leave requests. Where this becomes a regular pattern and a cause for concern, the manager should seek advice from the People and OD Department.

- Approving annual leave requests in a timely manner when an employee submits it through ESR. Until leave is approved on ESR it will not be deducted from the employee's annual and bank holiday leave total, resulting in an inaccurate entitlement.

- Ensuring that employees take the minimum statutory leave per year, in accordance with the Working Time Regulations (advice on this can be sought from People and OD).

- Encouraging staff to use their full contractual entitlement to support and promote their health and wellbeing.

- Ensuring service delivery is maintained by arranging appropriate cover for staff on annual leave. This may mean that managers have to decline annual leave requests where it would have an extreme negative impact on the service, or not agreeing to colleagues in the same team, taking their leave at the same time.

- Ensuring that where staff work shifts, weekends and bank holidays, they take their annual leave (which includes their bank holiday entitlement) generally proportionate to these working arrangements e.g. there is not a disproportionate taking of annual leave on weekend shifts and discussing the reasons with staff where there are any business concerns or wellbeing concerns around how leave is being taken.

5. Booking Leave and Compliance

5.1 Annual Leave Year

Agenda for Change Staff

The annual leave year will run from 1st April to 31st March for all staff groups covered by Agenda for Change NHS Terms and Conditions of Service.

5.2 Annual Leave Entitlements

Part-time employees will be entitled to a pro-rata share of the whole-time equivalent annual leave and bank holiday entitlement (as defined in ***Appendix 1 and 2)***
All employees are required to book and take their annual leave in hours. Their leave application will be based on the actual hours due to be worked on the day in line with normal working patterns.

Please Note: *The calculation of annual leave entitlements in hours contained in Appendix 1 have been rounded up or down to the nearest 0.5 decimal point (i.e. the nearest ½ hour). Velindre NHS Trust* may use of their discretion to round to the nearest ¼ hour.

5.3 Bank Holiday

The NHS terms and conditions of service allows for 8 bank holiday days per year*: Good Friday, Easter Monday, May Day, Spring Bank Holiday, August Bank Holiday, Christmas Day, Boxing Day and New Year's Day.

To ensure consistency and equal allocation of bank holidays for all employees the Trust also converts this element of leave into hours **which are** then added to an employee's overall annual leave entitlement. *This will result in a deduction of hours, equivalent to those that would have been worked, from the employee's aggregated entitlement on each bank holiday that falls on a scheduled working day, on which they are not required to work.*

*Staff who are not rostered to work on a bank holiday but agree to do so on a voluntary basis, will be entitled to paid overtime. They are **not** however, entitled to an additional day off in lieu, as this day is already added into their annual leave / bank holiday entitlement and can therefore be taken off on an alternative date.*

N.B **The Bank Holiday entitlement may vary each year depending on when they fall and therefore will be calculated accordingly*

5.4 Calculation of Annual Leave

- Annual Leave entitlements are set out in Appendix 1
  An annual Leave calculator is available on the People and OD pages of the Trust intranet, under the policies and procedures section". Search for the Annual Leave and Bank Holiday Policy and Procedure. The annual leave calculator is an accompanying document.

5.5 Entitlement on Joining the Trust

Annual leave and bank holiday entitlement in the first year will be pro-rata, based on the number of complete days worked after the date of joining and before the end of the annual leave year (rounded up or down to the nearest *½ hour)*.

For Example*:*
Mr. Jones joins the Trust on 12th September and works 32 hours per week.

Annual Leave

(Full annual entitlement ÷ days per year) x No of calendar days remaining in the leave year
(173hrs ÷ 365 days) x 201 days = 95.25 hours (*Rounded to **95 hours**).*

Bank Holidays

(Pro rata bank holiday entitlement in hours ÷ 8) x No of bank holidays remaining in the leave year in days.

(51 ÷ 8) x 3 = 19.12 (Rounded to **19 hours** bank holiday leave).

Total entitlement for that year: = 95 +19 *= 114 hours.*

In some annual leave years, there may be 9 bank holidays, if Easter is early and falls in March. In this situation the formula should be (51÷ 9) x 4 = 22.66 (Rounded to **23 hours** bank holiday leave).

5.6 Booking Annual Leave and Bank Holiday Leave

Staff should book annual leave or bank holiday leave, according to the number of hours they would have been due to work during the shift or working day on which they wish to take leave.

For example:

Part-time employee works 22 hours;
Monday and Tuesday's – 7.5 hour days;
Wednesday and Thursday's 3.5 hour days.

For recording purposes for a day's leave on ESR, the employee would book either 7.5 or 3.5 hours depending on the working day the annual leave falls.

5.7 Entitlement on Termination from the Trust

Employees who leave the Trust will be entitled to the pro-rata of their annual leave and bank holiday entitlement for each completed day worked in the current leave year (round up to the nearest ***½ hour***).

For Example
Mr. Jones works 22.5 hours per week and leaves the Trust on 27th July. .
Annual Leave
(Yearly entitlement ÷ days per year) x No of days worked up until & including termination date (121.5 hrs ÷ 365 days) x 118 days = 39.27 hrs (*Rounded to **39.5 hours** annual leave).*

Bank Holidays
(Pro rata bank holiday entitlement ÷ number of bank holidays in the year) x No of days worked in the leave year.

(4 ÷ 8) x 36 = **18 hours** bank holiday leave).

Total entitlement for the year: = 39.5 + 18 *= 57.5 hours.*

***Please note** - Managers need to remember to deduct any annual leave and bank holidays already taken to calculate if there is any outstanding leave accrual due to be paid upon leaving.*

5.8 Transferring to another post within the same Trust (Velindre)

Both positive and negative annual leave balances will be carried with the individual when they transfer to another post within the Trust.

5.9 Outstanding Leave on Termination from the Trust

The manager will work with the employee to ensure that all outstanding annual leave is taken before their termination date, where possible.

Where service provisions, long term sickness or maternity/adoption leave prevent the employee taking their leave, the Trust will make a payment to the employee for outstanding leave due. Advice from the People and OD Department needs to be sought in all cases of this nature.

5.10 Carry Over of Annual Leave

5.10.1 Normal circumstances

Employees are responsible for managing their annual leave throughout the leave year, ensuring that they take regular annual leave for rest breaks across the whole year.

NHS Terms and Conditions of Service Annex 0, confirms existing arrangements (Section 1) which state that where employees are prevented from taking their full allowance, they shall be allowed to carry forward annual leave into the next holiday year.

Subject to the exigencies of the service up to a maximum of 5 days can be carried forward on application and approval by the line manager to be taken in the following leave year. Any one-off exceptions to this, will be agreed by the Executive Management Team and communicated as appropriate.

5.10.2. Long Term Sickness Absence

Where staff return from long term sickness absence, they should be expected to take any outstanding leave within the current leave year. This should be managed carefully, taking account of the needs of the service and the practicalities of the employee being able to use up all of their entitlement in that leave year.

Employees on long term sick leave will be given the opportunity to take annual leave during their sick leave period. Please refer to Trust Managing Attendance at Work Policy.

Where the employee has not taken their annual leave entitlement during the period of sickness absence, and the sickness absence spans two or more leave years, they will accrue annual leave for the period of their sick leave and can be asked to take all of their accrued, but untaken annual leave, by the end of the leave year in which they return.

The leave entitlement for the previous year/years will be the ***statutory*** element of their leave not their full contractual annual leave and bank holidays.

Where an employee returns to work in a new leave year, after a period of long term sickness absence, they are entitled to carry over the statutory element of their leave, in line with (Working Time Regulations. - refer to the Trust Managing Attendance at Work Policy, Section 8.4). Managers need to remember to deduct any annual leave and/or bank holidays that they took before or during their period of sickness absence.

Any annual leave accrued, at the time of the return to work, may also be taken to extend an agreed phased return to work i.e. in exceptional circumstances whereby a phased return to work is extended beyond the maximum 4 weeks period (in line with the Trust Managing Attendance at Work Policy).

5.11 Sickness Occurring during Annual Leave

When an employee falls sick during annual leave they will be required to report that episode of sickness in line with normal notification procedures and produce a fit note covering the period from the first day of sickness (in line with Section 7 of the Trust Managing Attendance at Work Policy).

In order to allow annual leave to be reinstated a medical fit note needs to be received within 3 working days of the beginning of the illness (unless abroad). In such cases the employee will be deemed to have been on sickness absence rather than annual leave from the date of the certificate.

Only in exceptional cases will a foreign medical certificate of more than one month be accepted for payment purposes. A United Kingdom fit note should be obtained on return to the country.

5.12 Maternity/ Adoption and Parental Leave

5.12.1. Annual Leave

Annual leave will continue to accrue during all forms of paid and unpaid parental leave, as set out in the NHS Terms and Conditions of Service. Employees are encouraged to take any outstanding annual leave due to them before the commencement of Occupational Maternity Leave / adoption or parental leave, or towards the end of the leave period, if the leave period falls within the current annual leave year and there is sufficient time to take this leave. It should be noted that the provisions relating to the carry forward of annual leave will apply equally to staff on all forms of parental leave.

Employees returning to work on reduced hours need to take any accrued annual leave either prior to the commencement of all forms of parental leave or prior to their return. Thereafter, annual leave will be calculated pro rata to the new hours worked.

Employees not intending to return to work following all forms of parental leave should take any outstanding annual leave prior to commencement of that leave. The date of termination of service will then be calculated as the last working day plus any outstanding annual leave days, plus the full parental leave period.

As statutory paternity leave is shorter in length, the above provisions do not apply, apart from leave continuing to accrue during periods of paternity leave.

5.12.2. Accrual of Bank Holidays

In accordance with the Maternity and Parental Leave Regulations 2008, employees are entitled to accrue bank holidays (pro rata) that fall during their parental leave. Please refer to the Maternity, Adoption, Paternity and Parental Leave Policy for further information.

5.13 Annual Leave Entitlement on Changing Contracted Hours

Where employees change their contracted hours / sessions, this will result in a re-calculation of their annual leave entitlement based on completed days on the new and the old contracted hours /sessions to give the full year entitlement. Depending on the change, the annual leave entitlement may go up or go down. *For staff on ESR the system will calculate this automatically, managers should however check the accuracy of this calculation (please refer to section 4.2).*

If a reduction in contracted hours /sessions results in leave being overtaken, upon agreement with the individual, this will either be deducted from the following years annual leave entitlement, or a financial deduction made from their salary.

5.14 Annual Leave Entitlement for Term-time Working

An employee who wishes to work term time will have their annual leave and bank holiday entitlement annualised, and the entitlement *included* in their salary payments, over the period of the year.

Please liaise with the Trust's Payroll Department, should you wish to see your calculations.

5.15 Annual Leave Entitlement for Annualised Hours Working

The calculation of annual leave for employees who work annualised hours is as follows:

Total hours worked in the year = 850.
Annual weekly average = 850 ÷ 52.143 = 16½ hours (to the nearest ½ hour).

Refer to **Appendix 1** for appropriate entitlements.

e.g. 89 hours annual leave, 26½ hours bank holiday leave.

Total entitlement = **115½ hours.**

*** Employees may opt to reduce their annualised hours by deducting their annual leave entitlement. Any subsequent time off with then be unpaid and agreed by the manager.*

5.16 Annual Leave accrual for regular overtime

The Trust's position on this is to pay as overtime rather than given as annual leave.

6. Bank Holidays Falling on Saturday or Sunday

When any of the Christmas /New Year bank holidays falls on a Saturday or Sunday arrangements will be made to ensure that the right of staff to receive three public holidays are preserved. The Trust will communicate this, as relevant, on the years that it applies.

7. Sickness Occurring during a Bank Holiday

Employees **will not** be entitled to an additional day if they fall sick or are already away from work sick on a bank holiday. Please refer to the Managing Attendance at Work Policy for further information Statutory Entitlements during long term sickness absence.

8. Annual Leave When Under Suspension

Please refer to the Trust's Disciplinary Policy and Procedure Section 10.7.

9. Purchase of Annual Leave

The Trust operates an Annual Leave Purchase Scheme, which provides staff with the opportunity to apply to purchase additional annual leave, with the associated cost being deducted from their salary on a monthly basis, if approved. The purchase of additional annual leave is subject to certain conditions and is at the line manager's discretion. Please refer to the Trust's Purchase of Annual Leave Scheme Procedure.

10. Equality Impact Assessment Statement

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

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

The assessment found that there was no impact to the equality groups mentioned and this policy will have a positive impact on all of the 'protected characteristic' groups. Where appropriate the Trust will make plans for the necessary actions required to minimise any stated impact to ensure that it meets its responsibilities under the equalities and human rights legislation.

11. Getting Help

Further information and support is available from your divisional People and OD Department.

NWSSP staff should refer any queries to nwssp.hrcontactpoint@wales.nhs.uk.

12. Related Policies

Recovery of Overpayments Policy;
Purchase of Annual Leave Scheme;
Sickness Absence Policy;
Maternity, Adoption, Paternity and Parental Leave Policy;
NHS Terms and Conditions Handbook;

Appendix 1 – Annual Leave Entitlement – Agenda For Change (A4C) Staff

In accordance with Section 12 of the NHS Terms and Conditions of Service annual leave entitlement, all previous NHS service, whether continuous or not, will be aggregated. The Trust will verify as much previous NHS service as possible e.g. contacting the previous employer using an Inter Authority Transfer (IAT).

In circumstances where it is not possible for the Trust to confirm all of the employees previous NHS service (i.e. previous NHS employer no longer exists) the employee will be required to provide evidence to confirm these periods of employment e.g. contract of employment, offer letter, payslips etc.

Employees are entitled to receive extra annual leave at defined intervals, as shown in the table below.

Annual Leave entitlement increased by 1 day per annum following Pay Circular AFC, M&D & ESP (W) 01/2021 issued in December 2021

Table 1:- ANNUAL LEAVE ENTITLEMENT (COMPLETE YEAR) FOR A4C STAFF EXCLUSIVE OF BANK HOLIDAYS

-

Formula: Weekly contracted hours ÷ 5 x No. of annual leave days' entitlement based on 28 days, 30 and 34 days

WEEKLY BASIC CONTRACTED HOURS	ON APPOINTMENT	AFTER 5 YEARS' SERVICE	AFTER 10 YEARS SERVICE
	28-DAYS	30-DAYS	34- DAYS
HOURS EQUIVALENT:			
37.5	210	225	255
37.0	207.25	222	251.75
36.5	204.5	219	248.25
36.0	201.75	216	245
35.5	199	213	241.5
35.0	196	210	238
34.5	193.25	207	234.75
34.0	190.5	204	231.25
33.5	187.75	201	228
33.0	185	198	224.5
32.5	182	195	221
32.0	179.25	192	217.75
31.5	176.5	189	214.25
31.0	173.75	186	211
30.5	171	183	207.5
30.0	168	180	204
29.5	165.25	177	200.75
29.0	162.5	174	197.25
28.5	159.75	171	194
28.0	157	168	190.5
27.5	154	165	187
27.0	151.25	162	183.75
26.5	148.5	159	180.25

26.0	145.75	156	177
25.5	143	153	173.5
25.0	140	150	170
24.5	137.25	147	166.75
24.0	134.5	144	163.25
23.5	131.75	141	160
23.0	129	138	156.5
22.5	126	135	153
22.0	123.25	132	149.75
21.5	120.5	129	146.25
21.0	117.75	126	143
20.5	115	123	139.5
20.0	112	120	136
19.5	109.25	117	132.75
19.0	106.5	114	129.25
18.5	103.75	111	126
18.0	101	108	122.5
17.5	98	105	119
17.0	95.25	102	115.75
16.5	92.5	99	112.25
16.0	89.75	96	109
15.5	87	93	105.5
15.0	84	90	102
14.5	81.25	87	98.75
14.0	78.5	84	95.25
13.5	75.75	81	92
13.0	73	78	88.5
12.5	70	75	85
12.0	67.25	72	81.75
11.5	64.5	69	78.25
11.0	61.75	66	75
10.5	59	63	71.5
10.0	56	60	68
9.5	53.25	57	64.75
9.0	50.5	54	61.25
8.5	47.75	51	58
8.0	45	48	54.5
7.5	42	45	51
7.0	39.25	42	47.75
6.5	33.75	39	44.25
6.0	33.75	36	41
5.5	31	33	37.5
5.0	28	30	34
4.5	25.25	27	30.75
4.0	22.5	24	27.25
3.5	19.75	21	24
3.0	17	18	20.5
2.5	14	15	17
2.0	11.25	12	13.75

1.5	8.5	9	10.75
1.0	5.75	6	7
0.5	3	3	3.5

Appendix 2 – Calculation of Bank Holiday Entitlement

CALCULATION OF BANK HOLIDAY ENTITLEMENT (COMPLETED YEAR)

Formula: Weekly Contracted Hours ÷ 5 x No. of Bank Holiday Days Entitlement

WEEKLY BASIC CONTRACTED HOURS	HOURLY ENTITLEMENT FOR FULL LEAVE YEAR	WEEKLY BASIC CONTRACTED HOURS	HOURLY ENTITLEMENT FOR FULL LEAVE YEAR
	(8 BANK HOLIDAYS)		(8 BANK HOLIDAYS)
37.5	60.0	**20.0**	32.0
37.0	59.0	**19.5**	31.0
36.5	58.5	**19.0**	30.5
36.0	57.5	**18.5**	29.5
35.5	57.0	**18.0**	29.0
35.0	56.0	**17.5**	28.0
34.5	55.0	**17.0**	27.0
34.0	54.5	**16.5**	26.5
33.5	53.5	**16.0**	25.5
33.0	53.0	**15.5**	25.0
32.5	52.0	**15.0**	24.0
32.0	51.0	**14.5**	23.0
31.5	50.5	**14.0**	22.5
31.0	49.5	**13.5**	21.5
30.5	49.0	**13.0**	21.0
30.0	48.0	**12.5**	20.0
29.5	47.0	**12.0**	19.0
29.0	46.5	**11.5**	18.5
28.5	45.5	**11.0**	17.5
28.0	45.0	**10.5**	17.0
27.5	44.0	**10.0**	16.0
27.0	43.0	**9.5**	15.0
26.5	42.5	**9.0**	14.5
26.0	41.5	**8.5**	13.5
25.5	41.0	**8.0**	13.0
25.0	40.0	**7.5**	12.0
24.5	39.0	**7.0**	11.0
24.0	38.5	**6.5**	10.5
23.5	37.5	**6.0**	9.5
23.0	37.0	**5.5**	9.0
22.5	36.0	**5.0**	8.0
22.0	35.0	**4.5**	7.0
21.5	34.5	**4.0**	6.5
21.0	33.5	**3.5**	5.5
20.5	33.0	**3.0**	5.0
		2.5	4.0
		2.0	3.0
		1.5	2.5
		1.0	1.5
		0.5	1.0

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

NATIONAL POLICY ON PATIENT SAFETY INCIDENT REPORTING AND MANAGEMENT

DATE OF MEETING	14th September 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Zoe Gibson, Interim Corporate Head of Quality, Safety and Assurance
PRESENTED BY	Zoe Gibson, Interim Corporate Head of Quality, Safety and Assurance
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences
EXECUTIVE SUMMARY	A new NHS Wales National Policy on Patient Safety Incident Reporting and Management was published by the NHS Executive in May 2023. All NHS Bodies are requested to adopt this revised national policy in full. The policy has been developed to enable a consistent approach to Patient Safety Incident Reporting and Management across NHS Wales through the identification of clear expectations for patient safety incident reporting and management across NHS Wales. It supersedes and replaces the section on "Serious Incidents" within the 2013 'Putting Things Right' (PTR) guidance document.

	The incident reporting and management approach described within this policy concentrates upon both the support and development of a 'just culture' where organisations and staff feel supported to identify, report and learn from patient safety incidents, without the fear of punitive response or action, and to maximise opportunities for learning and improvement. Once approved this policy will directly replace Trust Policy QS01 Incident Reporting and Investigation. To support the implementation of the policy an Incident Reporting and Investigation Toolkit has been developed. This will come to November 2023 Committee for approval.
RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee are asked to **APPROVE** the Trust's adoption of the NHS Wales National Policy on Patient Safety Incident Reporting and Management.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Integrated Quality and Safety Group	25th July 2023.
Executive Management Board	31st July 2023.
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Implementation of the national policy ***ENDORSED*** for onward approval by both Integrated Quality and Safety Group and Executive Management Board. The development of a Trust implementation procedure commissioned.	
7 LEVELS OF ASSURANCE	
Report for Approval	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	**Select Current Level of Assurance** ***Not required***

APPENDICES	
Appendix 1	NHS Wales National Policy on Patient Safety Incident Reporting Version 2, May 2023.

1. SITUATION / BACKGROUND

This National Policy has been developed to set out clear expectations for patient safety incident reporting and management across NHS Wales and enable a consistent approach to Patient Safety Incident Reporting and Management.

The policy is aimed at all services directly provided or managed by a Health Board, Trust or Special Health Authority and it supersedes and replaces the section on "Serious Incidents" within the 2013 'Putting Things Right' (PTR) guidance document.

The revised approach described within the policy both aligns with the requirements of the Health and Social Care (Quality and Engagement) (Wales) 2020 and concentrates upon the support and development of a 'just culture' where organisations and staff feel supported to identify, report and learn from patient safety incidents, without the fear of punitive response or action through:

- learning from what has gone wrong and what could have been done differently, by using the incident as a prompt to undertake an investigation and take action in order to make changes to improve the safety of patients and donors
- identifying and addressing emerging risks by looking for trends, themes and patterns of incident reports
- oversight and assurance particularly where significant harm has occurred in the delivery of healthcare, in line with The National Health Services (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011- also known as 'Putting Things Right'.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

To ensure the Trust discharges its responsibilities regarding incident reporting and management the Integrated Quality & Safety Group and Executive Management Board have ***ENDORSED*** the adoption of this policy across the Trust.

A Trust procedure to support the implementation has under development.

3. IMPACT ASSESSMENT

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

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	This policy impacts positively on all 6 domains of quality.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
	Not applicable
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	Click or tap here to enter text
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Not applicable for this report
EQUALITY IMPACT ASSESSMENT *For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not yet completed - Include further detail below why
	For expediency the equality impact assessment is currently being undertaken, report submitted prior to completion to prevent delay in implementation.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Click or tap here to enter text
	This policy ensures Trust compliance with legal responsibilities relating to handling of concerns

NHS Wales

National Policy on

Patient Safety Incident Reporting

& Management

Date to be reviewed:	31 March 2024	**No of pages:**	23
Document author & owner:	NHS Wales Executive		
Contact email:	PatientSafety.Wales@wales.nhs.uk		
Approved by:	Welsh Government		
Approval date:	4 May 2023		
Effective date (live):	11 May 2023		
Version:	v2.0		

Contents

Supporting sections:

1. Changes from previous version

- Merged the content of the policy and the guidance document into a single document
- Removed references to “Phase 1” and “Phase 2” of policy implementation. Phase 2 related to the establishment of systems to thematically analyse incident data, this work has been superseded by the plans to undertake thematic analysis at a national level through the use of the Once for Wales Concerns Management system (Datix Cymru)
- Clarification of the scope of applicability of the policy, particularly with regard to independent service providers
- Improved clarity of roles & responsibilities of all organisations involved in policy delivery, alongside use of more inclusive terminology throughout the document
- Improved clarity on the requirements of the initial assessment process following identification of a patient safety incident
- Strengthened references to the use of Datix Cymru for the reporting and management of patient safety incidents, including the use of the in-built Yorkshire Contributory Factors Framework tool
- Clarified the principles for NHS organisations to consider in determining whether an incident should be nationally reported
- Incorporated the NHS Wales Never Events list
- Endorsement of the just culture guide as a supporting tool
- New/strengthened sections on:
    - Duty of Candour, including alignment of harm definitions
    - Joint safety incident investigations
    - Incidents occurring in relation to commissioned services
- Clarification of accountability for completion (closure) of an incident investigation
- Provision of introductory guidance relating to the use of Safety-II thinking into current incident management processes
- Updated guidance and definitions in relation to specific incident types based on feedback throughout 2021/22 including:
    - patient & service user falls to be retrospectively reported where the investigation has determined the fall was avoidable
    - alignment of reporting requirements associated with maternal & perinatal and infant deaths to National Confidential Enquiry (MMBRACE-UK) definitions
- Clarity on the relationship between Nationally Reportable Incident (NRI) reporting and Welsh Government (WG) Early Warning Notifications

2. Introduction

Patient safety incident reporting is changing across Wales. Historically, incident reporting has been used as a key safety indicator in healthcare to attempt to understand where things go wrong to learn and improve safety, experience and outcomes for future patients and service users. As a nation, our understanding of how to best use intelligence from incident data is continuing to evolve. New conceptual approaches to safety, such as Safety-II, will help us shift the narrative from focusing purely on "what went wrong?" and balance this line of inquiry alongside "what goes right, and how can we learn from that as well?" (see Supporting Section 5 for more information on Safety-II). These new approaches require us to think differently and consider how incident reporting is one component of a whole safe system of care. We must continue to ensure our national processes and approaches to this complex and sensitive area of healthcare are aligned to maximise learning opportunities for the benefit of patients, service users, their families, carers and loved ones, staff and our NHS organisations.

To achieve these ambitions, our national processes must support a just culture for organisations and staff to feel supported to identify, report and learn from patient safety incidents, without the fear of punitive response or action throughout all levels of NHS Wales.

The previous version of this policy (in effect from 14 June 2021) aimed to empower organisations to think differently about what should be reported, taking more ownership and accountability for incident reporting and management. Through this updated version of the Policy, the NHS Wales Executive will take these aims further and continue to work collaboratively with NHS Wales organisations and other key stakeholders in delivering a new system for collecting and analysing incident data which is for the NHS, by the NHS.

3. Purpose of this policy

A patient safety incident occurs when an unintended or unexpected incident could have or did lead to harm for one or more patients or service users receiving NHS-funded healthcare.

While many incidents will not result in significant harm to an individual, the exploration of incident reports can help provide a source of intelligence which can be used by healthcare providers for a variety of purposes, including:

- to **learn** from what has gone wrong and what could have been done differently, by using the incident as a prompt to undertake an investigation and take action in order to make changes to improve the safety of patients;
- to identify and address **emerging risks** by looking for trends, themes and patterns of incident reports; and
- as a mechanism for oversight and **assurance** particularly where significant harm has occurred in the delivery of healthcare, in line with *The National Health Services*

(Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011- also known as 'Putting Things Right' (referred to forthwith as 'the Regulations').

Incident reports can be a valuable signal to healthcare providers about where to focus resource and attention to improve patient safety. However, they are only one part of the puzzle and should be examined in the wider context of other sources of safety intelligence. This includes triangulation with other data sources (for example, patient experience and complaint data) as well as looking at what goes well the majority of the time, and what we can learn from that (e.g. Safety-II). Throughout 2023 and beyond, the NHS Wales Executive will be working to improve how this triangulation of multiple data sources is undertaken at a national level.

The purpose of this Policy is to set out clear expectations for patient safety incident reporting and management across NHS Wales. It supersedes and replaces the section on "Serious Incidents" within the 2013 'Putting Things Right' (PTR) guidance document.

4. Strategic policy context

The following national programmes and concepts provide context to this Policy:

- **Health and Social Care (Quality and Engagement) (Wales) Act 2020**, which underpin the statutory **Duties of Candour and Quality**:
    - The **Duty of Candour** is intrinsically linked to incident management. The Duty focusses on the need to be open with patients and service users and anyone acting on their behalf when things go wrong, building on the requirements already set out in the Regulations.
    - The **Duty of Quality** has two aims – to improve the quality of services, and to improve outcomes for people in Wales.
- **Quality & Safety Framework: learning and improving**: the overarching national Framework setting out the national ambitions for Wales in relation to quality and safety in the NHS. In particular, this Policy relates to Action 4 – **the development of a new National Incident Reporting Framework focussing on maximising and sharing learning from incidents**.
- **National Clinical Framework: A Learning Health and Care System**: the overarching national Framework setting out the national ambitions for Wales in relation to the development of clinical services across NHS Wales.
- **NHS Wales Executive**: in fulfilment of an objective set down in A Healthier Wales, a number of organisations have brought together under the banner of the NHS Wales Executive from 1 April 2023. National systems for incident reporting will be established, maintained and developed by the NHS Wales Executive.

- **National Quality Management System (NQMS)**: a visionary system for NHS Wales which will ultimately bring together data from a number of sources, including patient safety incidents, for triangulation and to inform a range of activities in relation to learning and assurance.
- **Once for Wales Concerns Management System**: the national IT system enabling consistent approaches to a range of processes across NHS Wales. In relation to incident reporting and management, this system is also known as **Datix Cymru.**
- **COVID-19 pandemic & the National Nosocomial COVID-19 Programme (NNCP):** NHS Wales is still recovering from the effects of the COVID-19 pandemic and this must continue to be taken into consideration in relation to patient safety incident reporting and management. Importantly, learning and changes to process which were brought about by the pandemic must be capitalised on, including in particular learning from the NNCP, which will be incorporated into this and future versions of the policy as applicable.

5. Scope of Policy

This Policy applies to **all** services directly provided or managed by a Health Board, Trust or Special Health Authority in NHS Wales.

NHS Wales organisations that contract, agree or arrange for care to be provided by a non-NHS Wales provider (independent provider) on their behalf, retain responsibility for national incident reporting. This is in keeping with position outlined in the *Health and Social Care (Quality and Engagement) (Wales) Act 2020* for Duty of Candour reporting. The requirement to report extends to Primary Care services providing care as part of NHS Wales.

6. References and related documents

- Health and Social Care (Quality and Engagement) (Wales) Act 2020
- The National Health Services (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 as amended by National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) (Amendment) Regulations 2023
- The Duty of Candour Procedure (Wales) Regulations 2023
- The Duty of Candour Statutory Guidance 2023
- Putting Things Right guidance document (v3, 2013)

7. Aims and objectives of this policy

- Provide a clear and consistent national approach to incident reporting, management and investigation across NHS Wales.
- Provide clear guidance on what types of incident should be nationally reported, and how this should occur.

8. Responsibilities in relation to this policy

Welsh Government:

- Setting legislation, statutory guidance and government policy.
- Ensuring that intelligence and learning derived from the outputs of this policy are taken into account in setting legislation, statutory guidance and government policy.
- Publishing official statistics based on reported incidents.

NHS Wales Executive:

- Oversee and deliver national policy and processes in relation to reporting, management and investigation of safety incidents.
- Identification of cross-system learning, ensuring that learning is disseminated.
- Ensuring consistency of application of this policy, including provision of assurance mechanisms in relation to incident reporting, management and investigation.
- Provide national analysis on nationally reported incident data.
- Provide advice, guidance and support to organisations in relation to implementation of this policy, including the reporting, management and investigation of safety incidents.

Health Boards, NHS Trusts and Special Health Authorities

- Accountable for the quality and safety of care and services provided to their respective populations, including care that they contract, agree or arrange for their populations.
- Implementing this policy including endorsement through their Quality & Safety governance framework.
- Ensuring there are appropriate governance and assurance mechanisms in place, facilitating a flow of information across all parts of the organisation.

- Ensuring local systems and processes for incident reporting are in place and embedded.
- Ensuring that there are systems and processes for incident reporting, management and learning for any health care they contract, agree or arrange on behalf of their populations.
- Undertaking analysis of locally reported incidents, including identifying trends and themes from incident data.
- Establishing mechanisms to extract and share learning from incidents, and taking action to reduce the risk of recurrence and improve patient and service user safety, experience and outcomes.
- Ensuring staff are familiar with the requirements of this Policy.

Primary Care (General Medical Services) contractors in NHS Wales

- Accountable for the quality and safety of care and services provided to their respective populations
- Required to locally report incidents that have occurred within their organisations using the Datix Cymru system. The Health Body whose system they report into is responsible for assessing whether incidents have met the NRI threshold and undertaking any subsequent reporting.
- Primary Care Contractors must notify the relevant Health Board of occurrences where the Duty of Candour is triggered in respect of the health care they provide under a contract or other arrangement.
- Establishing mechanisms to extract and share learning from incidents, and taking action to reduce the risk of recurrence and improve patient and service user safety, experience and outcomes.

Once for Wales Concerns Management System programme:

- Responsible for overseeing the development and delivery of relevant Datix Cymru modules to support the implementation of this Policy.

9. Key Definitions

General definitions:

Policy Term	Applicable Definition
Concern	As defined in the *NHS Wales (Concerns, Complaints and Redress Arrangements) (Wales) (Amendment) Regulations 2011,* a concern is any complaint, claim or reported patient safety incident
Patient Safety Incident	An unintended or unexpected incident that could have or did lead to harm for one or more patients or service users receiving NHS-funded healthcare Note: the term "patient safety incident" refers to an incident occurring in the course of the delivery of healthcare. It is recognised that this may not always be to a patient but can also affect other service users in receipt of NHS-funded healthcare. The language throughout this document has been updated where possible to reflect this but for the avoidance of doubt, the definition of a patient safety incident applies equally to a service user in receipt of NHS funded healthcare even if they are not classified as a patient.
Patient or Service user	A person to whom healthcare is or has been provided Healthcare includes services for the prevention, diagnosis or treatment of illness as well as the promotion and protection of public health. It also includes NHS staff accessing treatment and care through wellbeing/occupational health services
Action	Something done intentionally or unintentionally
Inaction	Something **not** done intentionally or unintentionally including as a result of indecision, unnecessary delay, failure to act
Nationally Reported Incident (NRI)	A patient safety incident which is nationally reportable in line with this policy
"Must report"	A sub-set of Nationally Reportable Incidents where national reporting is mandated through this Policy

Harm definitions

The following definitions align with the definitions set out in the Duty of Candour Statutory Guidance

No harm	Any patient safety incident that had the potential to cause harm but impact resulted in no harm having arisen
Low harm	Any patient safety incident that resulted in a minor increase in treatment and which caused minimal harm to one or more persons receiving NHS-funded care
Moderate harm	Any significant but not permanent harm, or harm that requires a 'moderate increase in treatment' relating to the incident. A 'moderate increase in treatment' is further defined as an unplanned return to surgery, an unplanned readmission, a prolonged episode of care, extra time in hospital or as an outpatient or transfer to another treatment area such as intensive care
Severe Harm	The permanent lessening of the bodily, sensory, motor, physiologic or intellectual functions, including the removal of the wrong limb or organ or brain damage, which is related directly to the incident and not related to a natural course of the service user's illness or underlying condition
Death	A death caused or contributed to by a patient safety incident, as opposed to a death which occurs as a direct result of the natural course of the patient or service user's illness or underlying condition

10.Governance & assurance requirements

Organisations must ensure they have robust systems and processes in place in relation to local and national incident reporting, including:

- systems and processes to enact this policy in all areas of the organisation;
- all incidents should be reviewed within an appropriate governance framework to determine required risk management activities as well as any national reporting requirement. Whilst advice and support can be sought from the NHS Wales Executive, it will be expected that organisations are responsible and accountable for their judgements and decisions in line with the policy;
- integration with other relevant clinical and corporate governance processes e.g. management of complaints and claims, mortality review processes etc.;
- internal oversight, scrutiny and quality assurance of all incident reporting and investigation processes, including Executive level sign off on national incident notification and investigation outcome forms;
- clear and demonstrable lines of reporting across all parts of the organisation, including through relevant Committees of the Board;

- mechanisms for ensuring joint investigations with other responsible bodies and external agencies where applicable and appropriate;
- mechanisms for recording the outcomes of decisions around national reporting and investigation, including decisions on appropriate investigation methodology. In particular, organisations must ensure they keep robust records around the decisions not to report/investigate incidents as this will be needed for quality assurance purposes;
- mechanisms for capturing and demonstrating shared learning;
- mechanisms for ensuring engagement with any affected patient or service user or anyone acting on their behalf, in line with the legal Duty of Candour.

11. Local incident reporting, management & investigation requirements

11.1. Context

Patient safety incidents can be single isolated events, or multiple recurring events which can signal more systemic failures in care or demonstrate system weaknesses. They can also include events which indirectly impact patient safety or an organisation's ability to deliver a service, such as a failure of an IT system. Consequently, there is no definitive list of what constitutes a patient safety incident and accordingly NHS organisations will need to apply judgment when considering what should be reported, both at a local and a national level.

11.2. Systems and processes

All organisations are required to ensure that they have systems and processes for local incident reporting, management and investigation in line with this Policy. This must include systems and processes to analyse incident data, extract learning and disseminate it throughout the organisation, with relevant actions taken to improve patient and service user safety, outcomes and experience.

Organisations should also have systems in place for monitoring and nationally reporting incidents that occur within services that are provided on their behalf by non-NHS Wales providers.

These processes must include the use of Datix Cymru where available to ensure a consistent national approach to data collection and analysis. These processes should be sufficient to capture and analyse data from across all parts of the patient or service user pathway, including (but not limited to):

- secondary and acute care settings
- primary and community care, including community pharmacy, optometry, dentistry services

- urgent and emergency services including emergency departments & ambulance services
- out of hours' services
- public health services
- relevant IT services
- prisons
- commissioned services, and
- incidents identified through the course of other clinical and corporate governance processes, for example Medical Examiner and Mortality Reviews.

The systems and processes must fully align with the organisation's governance and assurance mechanisms, ensuring clear reporting across the entire organisation for relevant information.

Organisations must ensure local processes are reviewed, amended and/or adapted to incorporate the requirements of this Policy.

11.3. Initial assessment to determine risk management activities and next steps

All patient safety incidents will require an initial assessment in order to assess the circumstances, identify the relevant make safe actions required, and determine the next steps to manage the incident. This initial assessment should take place as soon as practicable after the incident has occurred or otherwise been identified.

This initial assessment must include:

- review of known information about the incident and consideration of further information to be obtained to inform the next steps;
- assessment of risk and determination of make safe actions in relation to:
    - all patient(s) or service user(s) affected by the incident, and
    - the organisation, or other safety systems, to prevent recurrence in similar circumstances;
- determination of the depth and parameters of an appropriate investigation;
- consideration of engagement with the patient or service user and anyone acting on their behalf as appropriate. This assessment will need to balance the desire to engage transparently and compassionately with all affected by the incident whilst having due regard for legal matters of consent and capacity.

- consideration and, where required, escalation e.g.:
    - as a Nationally Reported Incident (NRI);
    - through to relevant national frameworks (e.g. multiagency safeguarding processes); and/or
    - through to relevant external bodies;
- any relevant communications handling required;
- next steps in terms of incident management.

The depth of the initial assessment will vary depending on the circumstances of the incident. The initial assessment must be undertaken by someone of sufficient seniority and experience in incident management proportionate to the circumstances of the incident, and in many cases will require a multi-disciplinary approach. In some cases, including where the incident requires reporting as an NRI, this may require Executive level oversight.

Depending on the circumstances of the incident, this may be the point at which the organisation considers whether the Duty of Candour has been triggered and if so, who should make the initial "in person" notification – see Section 4 of the Statutory Guidance.

11.4. Use of Datix Cymru

All patient safety incidents should be reported through Datix Cymru (part of the Once for Wales Concerns Management System) in line with the applicable User Guide operational at the date of reporting.

Employees of Health Boards, Trusts and Special Health Authorities should have access to report directly into their employer's Datix Cymru system.

Primary Care Contractors in NHS Wales are required to report incidents that have occurred within their organisations. More information can be obtained from the Primary Care Wales Incident Reporting - NHS Wales Shared Services Partnership website.

11.5. Welsh Government Early Warning Notifications (EWN)

Early Warning Notifications (EWN) (previously No Surprise Reporting) is a communication function established by Welsh Government. Its purpose is to provide rapid information to Welsh Government on a range of issues, which may or may not relate to patient safety incidents.

The EWN process is independent of the incident reporting systems described in this Policy, which are overseen and managed by the NHS Wales Executive.

For clarity, where a patient safety incident meets both the requirements of a EWN and a NRI, then both processes must be followed.

12. National incident reporting requirements

12.1. Context

A subset of patient safety incidents will require national reporting to the NHS Wales Executive. The reporting of patient safety incidents at a national level:

- provides oversight and assurance relating to incidents that cause the most harm to patients and service users during healthcare;
- provides oversight and assurance relating to incidents that cause high levels of service impact, disruption or risk;
- enables the identification of organisational and/or system risks; and
- informs learning and action, including e.g. development of patient safety alerts and notices, policies and improvement programmes, national priorities, outcome measures and potential service reforms.

Building on the foundation of the previous version of the Policy, there is a need to move away from prescriptive "trigger list" approaches to determining what incidents require national reporting. This is because of the complexity of healthcare and the incidents that can occur, it would never be possible to determine and list all the types of incidents which should be reported.

Accordingly, NHS organisations must have systems and processes in place to review all incidents on an individual basis and apply judgement to determine what should be reported nationally.

12.2. Nationally Reportable Incidents (NRIs)

As part of the initial assessment process described above, NHS organisations will need to consider whether an incident requires reporting nationally, taking the following principles into account:

Principle 1 - 'Must reports'

Incidents related to the following are always nationally reportable (please see Supporting Section 3 for more guidance on definitions):

- Never Events, as specified within this Policy, even where no harm has occurred. The current NHS Wales Never Event list can be found in Supporting Section 1 of this Policy;
- suspected mental health homicides;
- suspected suicide or self-inflicted death
    - in any clinical setting; or

    - during authorised/agreed leave, following recent planned discharge, or following unplanned leave/discharge; and

- maternal, perinatal and infant deaths.

Principle 2 - outcome/harm

A safety incident should be nationally reported if it is **assessed or suspected** an **action or inaction** in the course of a patient or service user's treatment or care, in any healthcare setting, **has**, or **could have caused or contributed** to their **severe harm** or **death**.

It will not always be possible to rapidly determine the extent to which a safety incident caused or contributed to the harm or death of a patient or service user within seven working days. In this case, organisations should nationally report the incident, specifying that the position is unclear and/or investigations are ongoing. Incidents can be downgraded at a later date.

Acts and inactions can relate equally to human interactions, technical failures and/or delays in systems and processes.

Principle 3 - number of patients or service users involved

Special consideration must be given to incidents where the numbers of patients or service users affected is significant, even where direct harm has not been, or is difficult to, identify. This includes but is not limited to incidents involving significant:

- screening services;
- IT failures;
- data breaches;
- national system failures; and/or
- service disruptions.

Principle 4 - learning opportunities

Incidents should be nationally reported where they present new learning opportunities, particularly where a similar risk may be present in other NHS organisations. This may include:

- near misses and/or no or low harm incidents where the learning would be beneficial to be shared nationally with other organisations to help raise awareness and mitigate risks for other patients or service users; and/or

- incidents may present which are unusual, unexpected or surprising, where seriousness of the incident requires it to be nationally reported and the learning would be beneficial for others.

Principle 5 - joint decision making around reporting and investigation

Some patient safety incidents will require joint investigation with another organisation. Early consideration must be given to involving relevant stakeholders in any discussions around incidents potentially requiring joint investigation, to ensure relevant information is obtained from all sources in order to inform the discussion. Guidance on the joint investigation process can be found in Supporting Section 4.

12.3. Reporting process

A patient safety incident will be nationally reported to the NHS Wales Executive within seven working days from the date of knowledge of the incident.

The reporting process is set out in Supporting Section 2.

13. Duty of Candour

The provisions of the statutory Duty of Candour, as set out in the Health and Social Care (Quality and Engagement) (Wales) Act 2020 came into effect on 1 April 2023. This is an organisational duty on all NHS bodies and primary care providers. More information on the Duty of Candour, including the statutory guidance, can be found on the Welsh Government website.

Incident reporting, management and investigation is intertwined with the principles of *Being open: communicating patient safety incidents with patients and their carers* and must adhere to the Duty of Candour, so in practice these activities should be fully integrated. In preparation for the Duty of Candour, NHS organisations have been reviewing their systems and processes in relation to concerns and incident reporting, investigation, and management to ensure that they are aligned as far as possible, in order to provide a seamless patient or service user experience.

The Duty of Candour is triggered when:

- an adverse patient safety event (usually an incident) occurs, and the service user sustains or could sustain harm which is
    - unintended or unexpected, and
    - more than minimal e.g., moderate, severe or death, and
- the provision of healthcare was or could have been a factor in that harm occurring.

At the point the incident is reviewed, and it is recognised that the above triggers for the Duty of Candour have been met, the organisation becomes 'aware'. It is at this point that the Duty of Candour procedure should be initiated.

The Duty of Candour is not intended to operate retrospectively and therefore will only apply where the conditions triggering the Duty of Candour as set out in Section 3 of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 occur after the date on which Section 3 was brought into force (i.e. 1 April 2023). In practical terms, this means that the provision of health care and the harm which ensued, must have taken place after 1 April 2023.

For the avoidance of doubt, the Duty of Candour may be triggered following a retrospective case review but that the conditions which gave rise to the notifiable adverse outcome must have occurred after Section 3 was brought into force.

14. Patient safety incident investigations

14.1. Legislation

All concerns reported in NHS Wales, including patient safety incidents, must be subject to an appropriate and proportionate investigation in line with the *NHS Wales (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011*. In particular,

Regulation 23 outlines the requirements of the investigation to be undertaken and requires the organisation to undertake the investigation in the manner that appears, to that organisation, to be most appropriate to reach a conclusion in respect of those matters thoroughly, speedily and efficiently.

14.2. Methodologies

NHS organisations must have systems and processes for determining the appropriate and proportionate investigation to be undertaken in response to each reported safety incident, taking into account considerations such as scale, complexity and type of incident.

Organisations should therefore ensure they have access to a range of suitable investigation approaches/tools to support a proportionate approach across a range of outcomes. It will not be appropriate to conduct in-depth investigations for all incidents, and so it is important to determine as accurately as possible from the outset what will be proportionate in the circumstances.

Methodologies in use by an organisation should ensure the involvement throughout the investigation of appropriate staff and patient, service user or a person acting on their behalf.

For certain incident types, to support a consistent national approach there are a number of focussed review tools built into Datix Cymru, which should be used where they are available. This includes safety incidents relating to:

- Falls
- Pressure damage
- Extravasation

This section will be expanded during 2023 in line with the NHS Wales Executive's work.

14.3. Use of Yorkshire Contributory Factors Framework

The Yorkshire Contributory Factors Framework (YCFF) has been built into Datix Cymru to support a consistent approach to the analysis of incidents, including the identification of cross-cutting themes to enable targeting of improvement activities.

Accordingly, the use of the YCFF is required for NRIs and encouraged for other patient safety incidents.

14.4. Just culture guide

Staff who have been involved in a patient safety incident should be treated in a consistent, constructive and fair way.

NHS Wales endorses the use of the NHS England just culture guide as a tool to support the fair treatment of staff who have been involved in an incident. It supports a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely.

The just culture guide should **not** be used as a routine or integral part of a patient safety investigation – it should only be used when consideration needs to be given to whether an individual member of staff requires support or management to work safely.

The just culture guide, along with supporting reference materials, can be found on the NHS England website - https://www.england.nhs.uk/patient-safety/a-just-culture-guide/

14.5. Joint investigations

Some safety incidents will require joint investigations, including between:

- different departments within the same organisation;
- where patients have been moved between organisations, including patient handovers at emergency departments; and

- where services have been commissioned, including relating to social care.

NHS organisations should have systems and processes in place to manage these types of investigations.

For joint investigations involving multiple organisations, please refer to the joint investigation process in Supporting Section 4.

15. Investigation of incidents occurring to a patient or service user while in receipt of commissioned services

Whilst the reporting of patient safety incidents at a national level remains the responsibility of the NHS Wales organisations that provided, managed or commissioned the care at the time of the incident, guidance on the investigation of such incidents is provided within the *The National Health Services (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011* ("the Regulations"). The Regulations require all 'responsible bodies' to investigate incidents which occur to services users in receipt of NHS funded care.

A responsible body is defined under the Regulations as:

- a Welsh NHS body:
    - a Health Board;
    - an NHS Trust managing a hospital or other establishment or facility wholly or mainly in Wales;
    - a Special Health Authority
- a primary care provider; or
- an independent provider:
    - a person or body who provides healthcare in Wales under arrangements made with a Welsh NHS body; and is not an NHS body or a primary care provider.

When a patient safety incident occurs, Regulation 23 states that "the responsible body must investigate the matters raised in the notification of a concern in the manner which appears to that body to be most appropriate to reach a conclusion in respect of those matters thoroughly, speedily and efficiently, having particular regard to additional criteria set out in the Regulations". The Regulations also detail what actions responsible bodies must take in terms of *redress*[1], when harm is deemed to have been 'caused' to a patient or service user through a 'breach in duty of care' to that patient or service user.

When healthcare is funded by another Welsh NHS body (Health Board or Trust), the Regulations require a full investigation up to and including consideration of qualifying

[1] Redress is a range of actions which include an apology, learning lessons, and/or in certain circumstances, financial compensation.

liability (QL). Organisations are required to undertake a joint investigation with a lead organisation agreed.

There are however distinct differences in how the Regulations are applied when healthcare provision has not been provided by a 'Welsh NHS body' (Health Board or Trust) through NHS funding arrangements. The degree in variation is predicated on which other type of 'responsible body' provided the healthcare, and particularly when the healthcare has been provided outside of Wales.

The way in which the Regulations vary can be divided into two categories;

1. NHS Wales funded healthcare provided by another UK NHS provider, i.e.:
    - NHS England; or
    - NHS Scotland; or
    - NHS Northern Ireland; and
2. NHS Wales funded healthcare provided by an 'independent provider', either:
    - provided in Wales under arrangements made with a Welsh NHS body and is not an NHS body or a primary care provider; or
    - provided outside of Wales.

NHS Wales funded healthcare provided by another UK NHS provider

When the Regulatory duty is applied to other UK NHS organisations through cross-border and other commissioning arrangements, it is anticipated that local procedures for managing concerns and investigations will be of a sufficient standard to support investigations in keeping with the Regulations. The Regulations require other UK nations to consider a qualifying liability (QL) and refer the matter back to the NHS Wales commissioning organisation where they consider a QL **does**, or **may** exist. However, there is no requirement on other UK NHS organisations to inform an NHS Wales commissioning organisation where they **do not** consider a QL exists.

NHS Wales funded healthcare provided by an 'independent provider'

The Regulations state any responsible body, who provides healthcare **in Wales** under arrangements made with a Welsh NHS organisation, and who is not an NHS Wales Health Board or Trust, must have arrangements in place to manage and undertake investigations when a concern, including a patient safety incident, is raised.

The first element to highlight is that the Regulations do not apply to private provision of healthcare *outside* of Wales.

The second element relates to private provision *within* Wales. In this regard, this will include healthcare provision in care and residential home settings through continuing healthcare

(CHC) and funded nursing care (FNC) arrangements, including local authority managed, third sector/charitable/not for profit sector, and private business. This also extends to any other privately provided healthcare which is NHS funded.

Responsibility to Investigate

Whilst the Regulations require an investigation to be undertaken when a patient or service user is subject of a concern during funded provision of healthcare, there are two key differences when a concern is raised in this regard:

1. the investigation is to be **undertaken by the provider** and not the NHS commissioning organisation, in keeping with the requirement on them to have arrangements in place to do so; and
2. there is no requirement on the provider to consider a QL as part ofthe investigation process.

Joint investigations in relation to commissioned services

Although the Regulations require the provider to undertake investigations when a concern is raised (including a patient safety incident), it is envisaged that when a concern is raised both in respect of the commissioned healthcare provider, and the commissioning organisation, it will be for the NHS Wales organisation to lead a joint investigation. The Regulations still however limit the independent provider element of the investigation to a factual response and not as far as considering QL, but the NHS element of the investigation is required to consider QL.

Post discharge

Concerns which occur during healthcare provision by an NHS Wales body prior to, or during a transfer of care to an independent provider through NHS funding arrangements, will remain the responsibility of NHS commissioning organisation to manage and investigate, fully in keeping with the Regulations up to and including consideration or QL.

16.Investigation outcomes

16.1. Learning from incident investigations

A fundamental part of undertaking incident investigations is to learn from previous experience in order to identify areas for improvement to reduce the risk of similar incidents occurring in the future.

NHS organisations should ensure they have robust systems and processes in place to support the extraction and dissemination of learning from incident investigations throughout the organisation, and include key learning as part of sharing investigation outcomes with the NHS Wales Executive.

This section will be expanded during 2023 in line with the NHS Wales Executive's work.

16.2. Completing (closing) an incident investigation

The accountability for completing (closing) an incident investigation sits with the NHS organisation who undertook the investigation.

NHS organisations must ensure there are robust processes in place to ensure the timely completion of incident investigations in line with this policy, which incorporate processes for patient or service user involvement, quality assurance, and Executive sign off.

To allow Boards to be assured that incidents within their organisation have been dealt with appropriately, all NHS organisations must ensure robust processes are in place to inform and assure their Boards that:

- the quality of their investigation processes is of a high standard;
- investigations are being undertaken and completed in a timely manner;
- patients or service users or anyone acting on their behalf are being engaged and supported during the investigation process and the findings and outcomes of the investigation are shared with them; and
- appropriate actions are being taken and learning is being shared across the organisation.

16.3. Process for reporting outcomes of an investigation into an NRI

Detailed guidance on the process for reporting NRI investigation outcomes to the NHS Wales Executive is in Supporting Section 2.

16.4. NHS Wales Executive's role in relation to investigation outcomes

The NHS Wales Executive does not "close" incident investigations related to NRIs. As stated above, the completion of an incident investigation is the responsibility and accountability of the NHS organisation who undertook the investigation.

The NHS Wales Executive has an assurance function to ensure that the information shared in relation to the investigation outcomes is of good quality, using a suitable approach, and undertaken in a timely manner. This is to support a patient or service user focussed approach, as patients or service users affected by safety incidents and people acting on their behalf require good quality information to be provided to them in a timely manner. Where gaps in assurance are identified, the NHS Wales Executive will liaise with the relevant NHS organisation to seek further assurance.

In addition to the extraction and utilisation of learning from incidents, data and intelligence from NRIs will be used to inform local and national assurance activities.

17. Future thinking in relation to incident reporting and analysis

As described in the introduction section, new conceptual approaches to safety including resilience in healthcare and Safety-II, will be increasingly considered by the NHS Wales Executive to determine how these new ways of thinking can help support continual improvement and evolution of our safety management systems in healthcare.

Some preliminary guidance on how to incorporate elements of Safety-II thinking into current incident management practices is included in Supporting Section 5.

This section will be expanded during 2023 in line with the NHS Wales Executive's work.

18.Getting Help

Please contact PatientSafety.Wales@wales.nhs.uk if help and support in application of this policy is required.

THIS AGREEMENT

Is made on ……

BETWEEN

NHS Wales Shared Services Partnership (NWSSP) whose registered office is situated at:

Corporate Headquarters, Unit 4/5 Charnwood Court, Parc Nantgarw, Nantgarw, Cardiff. CF15 7QZ

And

Velindre University NHS Trust ("the Trust"), whose registered office is situated at:

Corporate Headquarters, Unit 2 Charnwood Court, Parc Nantgarw, Nantgarw, Cardiff. CF15 7QW

For the provision of Registration Authority services in accordance with NHS England (formerly NHS Digital) Registration Authority Policy include the *Registration Authorities: Governance Arrangements for the NHS Organisations* (Gateway Reference Number 6244):

1. Background

It is of paramount importance that patients of the NHS are confident that their medical records are being appropriately kept secure and confidential and accessed appropriately in line with the NHS Care Records Guarantee. To achieve this objective, all NHS Care Records Service compliant applications require healthcare professionals/workers who require access, to be registered and issued with a Smartcard and have appropriate access profile(s) managed for their specific job role.

The registration process is operated at a local level by a Registration Authority ("RA"). The NWSSP has been an RA since 2008 for a small, specific number of Smart Cards.

All NHS organisations who are responsible for the registration of NHS Care Records Service users, including staff employed by independent contractors, independent providers, voluntary organisations and other public bodies need to ensure that a governing policy, procedure and guidance around the process is in place and administered effectively.

2. Aim of the Agreement

This Agreement is intended to outline the arrangement between the Parties for the delivery and management of Smartcards to NHS Care Record Service users employed by NHS Wales Shared Services Partnership (NWSSP) (hosted by Velindre University NHS Trust) and furthermore concerning the issuing and

management of smartcards to specified locations (including General Medical Practices) by NWSSP, whilst ensuring compliance with all statutory requirements as well as guidance adopted by NHS Wales in relation to Registration Authority protocol.

3. Duration

This Agreement shall continue for the term of three years commencing upon the date hereof and shall continue from year to year thereafter, unless determined in accordance with clause 14.

4. Interpretation

4.1. References to statutory provisions shall be construed as references to those provisions as respectively amended or re-enacted whether before or after the date of this Agreement from time to time and shall include any provisions of which there are re-enactments whether with or without modification.

5. Complete Agreement

This Agreement embodies the Agreement between NWSSP and the Trust and supersedes all other understandings and written agreements relating to the matters referred to herein.

6. Appointment of RA Sponsors

6.1. NWSSP Primary Care Services (PCS) will nominate suitable members of staff to be appointed as RA Sponsors (Appendix A). Provided the NWSSP RA Manager is satisfied that these individuals are suitable to undertake their respective nominated roles, the NWSSP RA Manager will duly appoint them and arrange for Smartcards to be issued to each of them, as necessary.

6.2. The NWSSP RA Manager reserves the right to terminate any or all of the RA Sponsor appointments for any reason and at any time.

7. Obligations of NWSSP RA Sponsors

The NWSSP RA Sponsors:

7.1. Are responsible for sponsoring users, in respect of NHS Care Record Service, on behalf of the agreed service providers (Appendix A), including validating the users' identify to e-GIF level 3[1] and assessing the appropriate level of access.

7.2. Ensure that Smartcards are only issued to those members of staff employed by the agreed service providers (Appendix A) and who have a clinical and/or administrative need to access NHS patient records.

[1] The verification of identify for NHS smartcard registrations is subject to the inter-governmental standard known as eGIF Level3. This provides assurance that the identity is valid across any organisation an individual works within.

7.3. Ensure that Smartcards are not issued to persons not employed by the agreed service provider.
7.4. Be responsible for alerting the NWSSP Information Governance Manager (as first point of contact) and the NWSSP RA Manager of all known or suspected breaches of security, confidentiality and/or any misuse of Smartcard(s).
7.5. Provide to the organisation, a list of current Smartcard users employed by agreed service provider whenever requested to do so by the NWSSP.
7.6. Be responsible for arranging cancellation of Smartcards where necessary and appropriate, for example, cancellation in respect of those who leave or terminate employment in a specific role within the NHS, those who move to another role and do not require a Smartcard and any Smartcards that are lost or stolen.

8. Obligation of the NWSSP Information Governance Manager

The NWSSP Information Governance Manager shall conduct periodic internal audits, not less that once every quarter, to ensure the Registration process is being appropriately and competently delivered and managed in accordance with ISO9001. Each internal audit shall include verification of a random sample of at least three Smartcard users and a written report setting out the findings of each internal audit shall be promptly forwarded to the Trust.

9. Obligations of the NWSSP

The NWSSP shall:

9.1. Be responsible for ensuring those members of the staff nominated to the NWSSP for the position of RA Sponsor are suitable and competent to undertake their respective roles.
9.2. Be responsible for ensuring the NWSSP RA Sponsors comply with their obligations as stated in clause 7 above.
9.3. Be responsible for ensuring that all RA Sponsors are provided with appropriate training, resources and supervision to properly discharge their respective duties.
9.4. Assist with all oral and written enquiries submitted by the Trust in respect of the Registration process and assist with any audits undertaken.
9.5. Ensure compliance with all applicable legislation, all application Department of Health guidance, including all RA policies and procedures, Information Governance and confidentiality policies.
9.6. Ensure compliance with the UK Data Protection legislation and the NHS Confidentiality Code of Practice.
9.7. Immediately inform the NWSSP Information Governance Manager (as first point of contact) in writing of any concerns or investigations or disciplinary action taken against any employee or other individual in relation to breaches of security, confidentiality and/or any misuse of Smartcard(s).
9.8. Immediately arrange for the revocation of Smartcard(s) from NWSSP user(s) upon written instructions from the NWSSP Information Governance Manager.

10. Partnership

Nothing in this Agreement shall be deemed to constitute a partnership between the Parties nor constitute any Party with the agent of the other Party.

11. Employment Status

The agreed service providers that nominate RA Sponsors will, at all times, remain in the employment of the agreed service provider and nothing in this Agreement shall be deemed to confer any employment relationship between the Trust and those individuals.

12. Indemnity

The Trust hereby undertakes to indemnify and keep indemnified the NWSSP and its successors and servants and agents against all direct, indirect or consequential losses, damages, costs, expenses, liabilities, claims, actions, demands or proceedings which may be taken or made against the NWSSP arising out of or in connection with this Agreement by any person howsoever arising whether under any statute or common law caused by negligence, omission, default or breach by the Trust or any of its servants, employees or agents. This clause 12 shall survive expiry or termination of this Agreement howsoever arising.

13. Freedom of Information

13.1. The Trust recognises that the NWSSP is subject to legal duties which may require the release of information under the Freedom of Information Act 2000 or the Environmental Information Regulations 2004 or any other applicable legislation or codes governing access to information and that the NWSSP may be under an obligation to provide information on request. Such information may include matters relating to or arising out of or under this Agreement in any way including without limitation information provided by or relating to the Trust.

13.2. Notwithstanding anything in this Agreement to the contrary, in the event that the NWSSP receives a request for information under any applicable code or legislation governing access to information, the NWSSP shall be entitled to disclose all information and documentation (in whatever form) as the NWSSP considers necessary to respond to that request. The NWSSP shall be under no obligation to inform or consult the Trust, although the Trust has reasonable expectations that appropriate communication will be made. The NWSSP shall be entitled to include any such information as part of its publication scheme as it deems appropriate.

14. Termination

14.1. This Agreement may be terminated by either Party for any reason at any time by either Party giving the other at least 7 days written notice of termination,

such notice to be served at the address of the Party set out on the front page of this Agreement.

14.2. The Trust shall arrange for all Smartcards issued to Trust employees pursuant to this Agreement to be revoked upon the date of termination or expiry of this Agreement and shall provide written confirmation to the NWSSP that this clause 14.2 has been duly complied with.

Signed for and on behalf of the NHS Wales Shared Services Partnership:

Signature ……..

Name ……..

Full title/position ……..

Witnessed by:

Signature ……..

Name ……..

Full title/position ……..

Signed for and on behalf of Velindre NHS Trust:

Signature ……..

Name ……..

Full title/position ……..

Witnessed by:

Signature ……..

Name ……..

Full title/position ……..

GP practices (Wales) *Variable addresses*	Digital Health & Care Wales (DHCW) Technium 2 Swansea Waterfront Innovation Quarter Kings Road Swansea SA1 8PH
Pharmacy Contractors (Wales) *Variable addresses*	Digital Health & Care Wales (DHCW) 17 Oldfield Road Bocam Park Pencoed CF35 5LJ
Public Health Wales Headquarters Screening Division 4th Floor, 2 Capital Quarter Tyndall Street Cardiff CF10 4BZ	Digital Health & Care Wales (DHCW) 1st Floor, Cwmbran House Mamhilad Park Estate Pontypool NP4 0YP
Cervical Screening Wales 18 Cathedral Road Cardiff CF11 9LJ	Digital Health & Care Wales (DHCW) Tŷ Glan-yr-Afon 21 Cowbridge Road East Cardiff CF11 9AD
Cervical Screening Wales 1st Floor, Matrix House Northern Boulevard Matrix Park Swansea Enterprise Park SWANSEA SA6 8DP	Digital Health & Care Wales (DHCW) Media Point – Unit 3 Mold Business Park Mold CH7 1XY
Cervical Screening Wales Preswylfa Hendy Road Mold Flintshire CH7 1PZ	Breast Screening Wales 18 Cathedral Rd Pontcanna Cardiff CF11 9LJ
Breast Screening Wales Maesdu Road Llandudno LL30 1QY	Sandra Williams, RA Manager NWSSP-Primary Care Services 3rd Floor, Matrix House Northern Boulevard Matrix Park Swansea Enterprise Park SWANSEA

	SA6 8DP
Kelly Dixon, RA Manager NWSSP-Primary Care Services 1st Floor, Cwmbran House Mamhilad Park Estate Pontypool NP4 0YP	Sandra Williams, RA Manager NWSSP-Primary Care Services Alder House Alder Court St Asaph Business Park St Asaph LL17 0JL
Kelly Dixon, RA Manager NWSSP-Primary Care Services 3rd Floor, Companies House Crown Way Cardiff CF14 3UB	

EXECUTIVE MANAGEMENT BOARD - RUN

NWSSP – REGISTRATION AUTHORITY POLICY

DATE OF MEETING	31/08/2023

PUBLIC OR PRIVATE REPORT	Private

IF PRIVATE PLEASE INDICATE REASON	THE MEETING IS HELD IN PRIVATE

REPORT PURPOSE	ENDORSE FOR APPROVAL

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	YES

PREPARED BY	IAN BEVAN, HEAD OF INFORMATION GOVERNANCE / CERI EVANS, HEAD OF TRANSACTION SERVICES NWSSP
PRESENTED BY	MATTHEW BUNCE, EXECUTIVE DIRECTOR OF FINANCE
APPROVED BY	Matthew Bunce, Executive Director of Finance

EXECUTIVE SUMMARY	NWSSP has acted as the Registration Authority for the issue of smart cards predominantly in its own organisation but also for Public Health Wales in order to support cervical and breast screening services. Historically this is a small amount of cards being processed (about 180 cards) With the advent of ePMA , the requirement for the cards will increase and will include Primary Care and Community Pharmacies. The

	processing will increase to approximately 20,000 cards. The change has necessitated that NWSSP establishes a Registration Authority Policy and inter-organisational agreement which requires endorsement by EMB and if appropriate approval by the Quality, Safety and Performance Committee. The Trust as the legal entity for NWSSP is the signatory for the Agreement and its governance.

RECOMMENDATION / ACTIONS	It is recommended that the Executive Management Board: • **ENDORSE** the attached Registration Authority Policy for approval by the Quality and Safety Performance Committee. • **ENDORSE** the attached Agreement for the Provision of Registration Authority Services between NHS Wales Shared Services Partnership and Velindre University NHS Trust for approval by the Quality and Safety Performance Committee.

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

7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	**Select Current Level of Assurance** ***N/A***

APPENDICES	
One	Registration Authority Policy
Two	Agreement for the Provision of Registration Authority Services between NHS Wales Shared Services Partnership and Velindre University NHS Trust

1. SITUATION

The purpose of this paper is to seek the endorsement of the Executive Management Board in relation to the proposed changes governing the use of Smartcards by NHS Wales Shared Services Partnership (NWSSP) Primary Care Services and in particular the requirement to establish a policy to support the rollout of Electronic Prescription Services in Wales and the increased volume of issued Smartcards required in NHS Wales. In consideration of the All-Wales impact of the rollout of the Smartcards linked to the fact that NWSSP is a hosted body, this policy requires approval by Velindre University NHS Trust prior to implementation.

2. BACKGROUND

The NHS Care Records Service (NHS CRS) and related National Programmes use a common approach to protect the security and confidentiality of every patient's personal and health care details.

NWSSP and its predecessor organisations have acted in the capacity as Registration Authority (RA) since circa 2008. This role has supported the issuing and management of Smartcards to users predominantly in NWSSP as well as Public Health Wales for the purposes of cervical and breast screening services and some to Digital Health and Care Wales (DHCW). The number of Smartcards currently in use equates to small numbers that have seen steady volumes managed and held by users (circa 180 Smartcard users). Smartcards are issued for the purposes of accessing applications linked to the NHS spine, i.e., Patient Demographic Services (PDS).

With the introduction of Electronic Prescribing Services (EPS) in Wales, the requirement for the application and use of Smartcards will further extend to Primary Care providers across Wales (GP practices and Community Pharmacies). This extension of use will significantly broaden the capture of demographic data and greatly increase the number of Smartcard users. It is

therefore both timely and necessary to ensure that policy and agreement that are fit for purpose are in place to govern the use of such applications.

3. ASSESSMENT

In accordance with NHS England's (formerly NHS Digital) Registration Authority Policy, it is a mandatory requirement that organisations that run local RA activity have in place a policy that outlines their management of Registration Authority activities.

A Registration Authority Policy has been prepared for approval and an Inter Organisational Agreement has been updated which will be presented for signature by the Trust once the Policy has been approved.

4. SUMMARY OF MATTERS FOR CONSIDERATION

The following is a summary of matters which is intended to support the recommendation at Paragraph 5 of this paper.

- The current smartcard service will no longer be fit for purpose once the new ePMA is in place in Wales
- There will be a significant increase in card processing which requires the implementation of;
    - A new Registration Authority Policy that enables the governance of the smartcard process to be robust and timely, which be further supported by;
    - A Service Level Agreement that sets out the obligations of NWSSP in managing the Smartcard process

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*	10 - Governance
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below** Safe ☒ Timely ☒ Effective ☒ Equitable ☐ Efficient ☒ Patient Centred ☒ *The adoption of the Policy will ensure that [Please include narrative to explain the selected domain in no more than 3 succinct points].* The approval and adoption of the Policy will ensure that the Trust is compliant with NHS England's Registration Authority Policy, this means that it meets the domains of Safe, Timely and Effective. Furthermore as it is linked to the delivery of the All-Wales ePMA it meets the domain requirement of Patient Centered care and improves Efficiency.
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].* The approval and adoption of the policy meets a regulatory requirement which does not require the consideration of socio-economic duty for EMB prior to consideration of approval.

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
	Source of Funding: Other (please explain) Please explain if 'other' source of funding selected: Funding to be sourced from the Digital Medicines Transformation Portfolio **Type of Funding:** **Revenue** **Scale of Change** Please detail the value of revenue and/or capital impact: Equipment/Hardware - £12k Resource - £106,505 **Type of Change** **Service Development** Please explain if 'other' source of funding selected: N/A

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 approval and adoption of the policy meets a regulatory requirement which does not require the consideration of Equality as defined in the Equality Act 2010 for EMB to consider prior to approval.
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

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	Yes - please complete sections below
WHAT IS THE RISK?	EPS is included in the Welsh Government's agenda with delivery expected in 2023. Without NWSSP having an up-to-date Registration Authority Policy in place, NHS England will not want to delegate authority for Welsh GP practices and community pharmacies to NWSSP meaning that the Electronic Prescription Service cannot be rolled out in Wales.
WHAT IS THE CURRENT RISK SCORE	Risk captured in the Digital Medicine Transformation Portfolio RAID Log – Score 20 (Red)
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	Enables delegated authority
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Policy required to enable programme delivery commencing September 2023

ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
	[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	

Registration Authority Policy

NHS Wales Shared Services Partnership

May 2023

Version Number: 0.1	Issue/approval date:
Status: Draft	Next review date:

Document Control

Document Name:	Registration Authority Policy		
Version:	0.1	Status:	DRAFT
Approvals	NWSSP PCS Senior Management Team		14th June 2023
	Executive Management Board, Velindre NHS Trust		
	Quality, Safety & Performance Committee, Velindre NHS Trust		

Version Control

Date	Author	Version	Page	Reason for change

Reviewers/contributors

Name	Position	Version Reviewed & Date

Contents

1. INTRODUCTION

The purpose of this policy is to provide guidance to all NHS Wales Shared Services Partnership (NWSSP) staff on Registration Authority (RA) issues.

The NHS Care Records Service (NHS CRS) and related National Programmes use a common approach to protect the security and confidentiality of every patient's personal and health care details.

It is essential that everyone who is given access to patient information within NHS Wales and the following national applications has been through the same rigorous identity checks.

The NHS has set out the principles that govern how patient information is held in the NHS CRS and the way it is shared. This is further to the already pre-defined organisational Information Governance policies and procedures that is already established within NWSSP that provides a set of working practices that complement the culture of confidentiality within the organisation.

To access the NHS CRS users require a Smartcard to access the national applications linked to the NHS spine (these include patient demographic services (PDS), electronic prescriptions) and the issuance of Smartcards to access these systems is governed by the Registration Authority (in this case, NWSSP) policy and process.

2. SCOPE AND DEFINITIONS

Scope

It is the responsibility of all NWSSP staff including those working full or part time, on temporary or honorary contracts, bank or agency staff, work placements, apprenticeships and students to comply with this policy, and associated RA Operating Guidance and procedures.

This policy applies to those members of staff directly employed by NWSSP and for whom the NWSSP has legal responsibility. For those staff covered by a letter of authority/honorary contract or work experience, the organisation's policies governing confidential information and use of such are also applicable whilst undertaking duties for or on behalf of NWSSP.

Definitions

Smartcard: NHS smartcards can be likened to chip and PIN bank cards; they enable healthcare professionals to access identifiable (clinical, patient and personal) information appropriate to their role.

A Registration Authority: is a function, usually within an NHS organisation, which carries out the identity checks of prospective smartcard users and assigns an appropriate access profile to the staff members role as approved by the employing

organisation. Staff member is defined as a health professional, department manager, team leader, patient information officer and other staff roles that require access to identifiable patient information.

Care Identity Service: Registration authorities use the Care Identity Service (CIS) to control NHS smartcard access for the NHS Spine's 800,000+ smartcard users. It is a unified application that provides a single location for all registration authority activities.

3. DETAILS OF THE REGISTRATION AUTHORITY (RA) POLICY

NWSSP Registration Authority (RA) will:

- Produce quarterly reports
- Identify how RA services are delivered (e.g., partner with other organisations to provide RA services, etc.) and the nature of the service delivery (which sites, what hours, etc.) This will include provision of RA services to non-NHS organisations where appropriate
- Identify to the NWSSP Senior Leadership Group, for approval, any proposed agreement with another organisation to provide RA services (this includes other NHS and non-NHS organisations)
- Develop the procedure guidelines for issuing of Smartcards by NWSSP Registration Authority staff
- Ensure the necessary support functions are in place and are aligned with the needs of the RA including training and awareness raising, IT, IG, HR and RA support
- Ensure the national policies and procedures for RA are considered when developing the arrangements within NWSSP for Information Governance purposes (these include assessment and advice as and when required)
- Ensure an annual review of the RA policy and procedures is undertaken and updated as required
- Establish and update the incident and risk management register and report on this on an annual basis to the NWSSP Senior Leadership Group.

RA Managers

- The RA Managers will be responsible for ensuring the adherence to policy and governance related to the RA, for the efficient day-to-day operation and capacity planning of the RA services.

RA Agent(s)

- The RA Agent(s) will be responsible for ensuring RA services are delivered in accordance with the RA procedures and governance to users of RA services.

RA Sponsors

- The Sponsors will be responsible for approving the registration and access profiles granted to users. Additionally, they may be responsible for resetting of

Passcodes – all subject to agreed RA procedures and governance for internal control of access.

4. ROLES AND RESPONSIBILITIES

Overall accountability for policy documents across the organisation lies with the NWSSP Managing Director who has responsibility for meeting all statutory requirements and adhering to guidance issued in respect of policy documents.

NWSSP Primary Care Services are responsible for Registration Authority services provided to all customers in accordance with this policy.

Overall responsibility for the Registration Authority Policy lies with Registration Authority Managers who have delegated responsibility for managing the development and implementation of Registration Authority policy and procedural documents.

All NHS employees, contractors and other staff who have been issued with Smartcards for use in their work with the NHS are responsible for their Smartcards and must abide by all current Terms and Conditions of use.

Failure to adhere to national RA Policy and guidance may lead to revocation of the Smartcard and/or disciplinary procedures.

The principles of the Registration Authority procedures are to ensure that:

- All Smartcards are issued in accordance with the relevant NWSSP procedures
- All Users issued with a Smartcard are made aware of their roles and responsibilities for the use of their Smartcard and comply with those requirements
- All Users comply with the guidance in the RA Operating Guidance
- NWSSP audit of Smartcard use is conducted in accordance with the RA Operating Guidance in conjunction with customer organisations

5. TRAINING

The Registration Authority Team will ensure training opportunities are provided in the use of the Care Identity System and application of this policy and underpinning processes, procedures and standards.

6. MONITORING COMPLIANCE AND EFFECTIVENESS

Performance against Key Performance Indicators will be reviewed on an annual basis and used to inform the development of future policy and procedural documents. The Registration Authority Manager will monitor service performance and provide reports to IT Services Senior Leadership Team.

This policy will be reviewed on an annual basis and in accordance with the following, as and when required:

- Legislative changes
- NHS good practice guidance
- Significant incidents reported
- Changes to organisational infrastructure
- Changes to national Registration Authority Policy

7. REVIEW

The policy will be reviewed at least annually by NWSSP Primary Care Services.

8. REFERENCES AND ASSOCIATED DOCUMENTS

National Registration Authority Policy can be found here: https://digital.nhs.uk/services/registration-authorities-and-smartcards#registration-authorities

Equality Impact Assessment pending

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Sharps Policy and Divisional Sharps Exposure Procedures

DATE OF MEETING	14th September 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	Ceri Pell, VCC Health & Safety Advisor
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	Healthcare workers are at risk of blood borne viruses including hepatitis B Virus (HBV), hepatitis C virus (HCV), human immunodeficiency virus (HIV), due to sharps incidents and other high risk contact with high risk body fluids. The aim of this Policy is to ensure the safe and effective management of sharps to reduce the likelihood of injury and harm. The divisional procedures outline the actions to be taken by the Manager following sharps incidents and other high risk contacts with high risk body fluids

	including the management of staff and outlining the risk assessment of the source patient and obtaining permission to test for blood borne viruses. Most sharps injuries can be avoided using safer sharps and by adherence to the principles of safe practice outlined within the policy document.

RECOMMENDATION / ACTIONS	The Quality & Safety Performance Committee is requested to approve the policy and procedures.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Trust Health Safety & Fire Board Meeting	28/02/2023
VCC Cynefin Divisional meeting	21/03/2023
WBS Cynefin Group	29/03/2023
WBS SMT	10/05/2023
Trust H&S Board Meeting (Amended version following comments received)	16/05/2023
Executive Management Board - RUN	31/08/2023

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

Further amendments to the policy have been made following the consultation process to improve readability and timely information to staff following a sharps incident.

IP&C were consulted on the redrafting of this policy and the work was carried out at the request of the Director of Nursing during a scheduled review of the policy.

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 5 - Majority of actions implemented; outcomes not realised as intended

APPENDICES

1	Sharps Policy
2	VCC procedure for sharps injuries and occupational exposure to high risk body fluid
3	WBS procedure for sharps injuries and occupational exposure to high risk body fluid
4	NWSSP procedure for sharps injuries and occupational exposure to high risk body fluid

1. SITUATION

The Trust Sharps Policy has undergone a comprehensive consultation process in both VCC & WBS following a joint review by the IP&C and Health & Safety teams. The main revision was to expand the policy to include the divisions of the Trust and the inclusion of the divisional SOP's. Further amendments to the policy have been made following the consultation process to improve readability and timely information to staff following a sharps incident.

The opportunity has been taken to pass ownership of the policy from Infection Prevention and Control to Health and Safety to reflect the Enforcing Authority for the regulations, which is the Health and Safety Executive.

The Trust Health and Safety Manager is jointly responsible with Infection Prevention and Control for monitoring and reviewing this Policy and the associated divisional procedures for actions to take in the event of an incident.

Infection Protection and Control will provide education on Safety Sharps as part of mandatory Infection Prevention and Control training. The safe use and disposal of sharps will be monitored through clinical practice audits.

The revised policy is supported by the divisional procedures which include steps to take following a 'Sharps Injuries and Occupational Exposure to High Risk Body Fluid'

2. BACKGROUND

The objective of the policy is to ensure safe practice by effective sharps management in accordance with the European Council Directive 2010/32/EU 'Prevention from sharp injuries in the hospital and healthcare sector', which has formed part of the national legislation since 11th May 2013.

To comply with the legal duties in relation to protection against sharps injuries placed on the Trust by the following:

- Health and Safety at Work etc. Act 1974
- Management of Health and Safety at Work Regulations 1999
- Health and Safety (Sharps Instruments in Healthcare) Regulations 2013.
- Control of Substances Hazardous to Health Regulations 2002 (as amended)
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013

3. ASSESSMENT

3.1 The policy requires;

- Where practicable the use of sharps to be eliminated
- Safer sharps must be used wherever practicable.
- If safer sharps are not used a risk assessment must justify that decision – agreed by the Head of Department and Divisional H&S meeting – review annually.

3.2 Systems must be in place to prevent unauthorised procurement of non-safer sharps and records must be kept where non-safer sharps are ordered.

3.3 Non-safer sharps must be stored separately from safer sharps.

3.4 Sharps must be disposed of immediately after use and at the point of use in a sharps bin.

3.5 The policy provides guidance on the management of any incorrectly discarded sharps discovered.

3.6 The policy requires staff to be trained, informed of the findings of risk assessments and to know the actions to be taken following an incident.

3.7 Separate procedures are in place for VCC, WBS and NWSSP providing guidance on actions to be taken in the event of a needlestick incident.

3.8 A one page briefing note has been prepared to assist managers to become familiar with this Policy.

3.9 Information about sharps has been included in the new all Trust Health and Safety Induction.

3.10 The divisions need to review their training to ensure that all staff who use sharps are familiar with the contents of this policy and have received the necessary training.

4. SUMMARY OF MATTERS FOR CONSIDERATION

Velindre NHS Trust shall assess the risk of exposure to biological hazards including blood-borne viruses and risk of sharps injuries from procedures and activities.

This is a refresh of an existing Policy and there has been consultation with IP&C at VCC and WBS. The Policy will be available on the Trust web pages and will be communicated via the Trust Health, Safety and fire Board, the Divisional Health Safety and Fire meetings, SLT, SMT, the Trust IP&C meeting and Divisional IP&C meetings.

The policy protects the health of staff and patients by reducing the risk of needlestick injuries and possible exposure to blood borne viruses.

The Quality and Safety Performance Committee is requested to approve the Policy and Divisional 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*	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 Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). This policy specifically prevents needlestick injuries and the potential spread of blood bourne viruses to potential both patients, donors and staff as a result of needlestick incidents.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	This policy applies to all staff patients and donors equally regardless of the social economic status and has a positive impact on all groups in terms of preventing needlestick injuries.

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:
	This policy contributes to a healthier Wales by reducing the risk of transmission of Blood Bourne Viruses in Healthcare and reducing the negative mental health impact and anxiety associated with needlestick injuries.
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*	Yes - please outline what, if any, actions were taken as a result
	This policy has been screened for relevance to equality. No potential negative impact has been identified.

ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Health and Safety at Work etc. Act 1974 Management of Health and Safety at Work Regulations 1999 Health and Safety (Sharps Instruments in Healthcare) Regulations 2013. Control of Substances Hazardous to Health Regulations 2002 (as amended) Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	*[Please insert detail here in 3 succinct points].*
WHAT IS THE CURRENT RISK SCORE	Insert Datix current risk score
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	*[In this section, explain in no more than 3 succinct points what the impact of this matter is on this risk].*
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Insert Date
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
	[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	

THE SAFE USE OF SHARPS POLICY

Executive Sponsor & Function	Director of Strategic Transformation Planning and Digital
Document Author:	Trust Health and Safety Manager
Approved by:	Trust Quality and Safety Committee
Approval Date:	
Date of Equality Impact Assessment:	March 2022
Equality Impact Assessment Outcome:	This policy has been screened for relevance to equality. No potential negative impact has been identified.
Review Date:	March Sharps 2025
Version:	5

Key related documents – action to take in the event of an incident

- Velindre Cancer Centre - Sharps Incidents and Occupational Exposure to Blood and High Risk Body Fluids Procedure
- Welsh Blood Service - SOP: 016/ORG Procedure following an inoculation injury and/or contact with blood/body fluids
- NWSSP – Procedure for Sharps Injuries and Occupational Exposure to high Risk Body Fluids

Contents

ABBREVIATIONS

BBV	Blood Bourne Viruses
HCW	Health Care Worker
PPE	Personal Protection Equipment
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HSE	Health and Safety Executive
IP&C	Infection Protection and Control
PPE	Personal Protective Equipment
UHW	University Hospital of Wales
VCC	Velindre Cancer Centre
WBS	Welsh Blood Service

1 POLICY STATEMENT

1.1 Velindre University NHS Trust (VUNHST) and its Hosted Organisations acknowledge the risk of injury from medical sharps as a health and safety and infection prevention and control issue. Sharps injuries may result in the exposure of staff, contractors, patients, donors, visitors or others to blood borne viruses (BBV) such as Hepatitis B and C and Human Immunodeficiency Virus (HIV) and/or exposure to chemicals in drugs.

1.2 This Policy requires the elimination of the use of medical sharps where possible. Where sharps must be used, these must to be where possible safer sharps (with engineered safety mechanisms) to reduce the risk of sharps injuries. Non-safer sharps must only be used in exceptional circumstances and following a robust risk assessment.

1.3 This policy should be read (where relevant) in conjunction with the following divisional documents that outline the action required after a needlestick injury or an occupational exposure to high risk body fluids.

- **Velindre Cancer Centre - Sharps Incidents and Occupational Exposure to Blood and High Risk Body Fluids Procedure**
- **Welsh Blood Service - SOP: 016/ORG Procedure following an inoculation injury and/or contact with blood/body fluid**
- **NWSSP Procedure for Sharps injuries and Occupational Exposure to High Risk Body Fluid**

2 SCOPE OF POLICY

2.1 This Policy applies to all staff at VUNHST and Hosted Organisations who undertake activities which involve the use, handling and disposal of medical sharps.

3 AIMS AND OBJECTIVES

3.1 The aim of this Policy is to ensure the safe and effective management of sharps to reduce the likelihood of injury and harm.

3.2 The objectives of this policy are:

- To comply with the Trust's legal duties to manage sharps including the following:
  - Health and Safety at Work etc. Act 1974
  - Management of Health and Safety at Work Regulations 1999
  - Health and Safety (Sharps Instruments in Healthcare) Regulations 2013.
  - Control of Substances Hazardous to Health Regulations 2002 (as amended)
  - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013

4 RESPONSIBILITIES

4.1 Roles and Responsibilities

The Chief Executive: has overall accountability for the management of health and safety within the Trust.

Director of Strategic Transformation Planning and Digital: has delegated corporate responsibility for health and safety and is accountable for this to the Trust Executive Management Board and is accountable and responsible for this policy, its contents and infrastructure for delivery.

The Director of Nursing, Allied Health Professionals and Health Science: has delegated corporate responsibility for Infection Prevention and Control (IPC) and is accountable for this to the Trust Executive Management Board. These responsibilities include ensuring that the organisation receives competent infection prevention and control advice and that adequate staff infection prevention and control training, and monitoring is in place.

Trust Health and Safety Manager: is the responsible author for this policy and ensuring it is regularly reviewed and in line with legislative requirements and will in conjunction with the Infection Prevention and Control team monitor and have oversight of the effective implementation of this policy and the associated divisional procedures for actions to take in the event of an incident (see 1.4). They are also be responsible for regular Health and safety audits to monitor safe use of sharps.

Head of Infection Protection and Control: will provide support to the Health & Safety Manager in the oversight and review of this policy and provide education on Safer Sharps as part of mandatory Infection Prevention and Control training. The safe use and disposal of sharps will be monitored through clinical practice audits.

Workforce and Organisational Development: is responsible for managing the contractual relationships with the Occupational Health provider. The Occupational Health provider will be contracted to be responsible for an appropriate vaccination programme for staff at risk of sharps injuries and the provision of post exposure and follow up treatment services.

Divisional Directors and Heads of Departments: must ensure:

- this policy is fully implemented across all areas of their responsibility and that there are adequate resources available for its effective implementation.
- all required safer sharps are available. (see section 7),
- systems are in place to ensure that sharps containers are compliant, suitably located, correctly assembled and disposed of.
- all sharps incidents are reported on Datix, responded to appropriately, investigated and lessons learned and implemented.
- staff are aware of this policy and the relevant divisional procedures for actions to take in the event of an incident (see 1.4).

Line Managers: have responsibility to ensure that:

- the use of sharps is eliminated. Where this is not possible safer sharps are used unless a risk assessment determines no appropriate safer sharp is available or the procedure cannot be done with a safer sharp.

- Staff are aware of this policy and the associated divisional needlestick injury procedures (see 1.4).

- staff have been trained in the use and disposal of safer sharps including the use, assembly, labelling, locking, storage, location and disposal of sharps containers

- sharps injuries are reported on Datix and fully investigated..

- a risk assessment is in place for the use of sharps within their area including identification where injuries may occur and an assessment of device suitability.

Managers Responsible for Procurement / Purchasing: must ensure that safer sharps are procured / purchased when they exist. They must also highlight where alternative sharps equipment become available which would enable non-safer sharps to be withdrawn from service.

Systems must be in place to prevent unauthorised ordering of non-safer sharps.

Systems must be in place to ensure non-safer sharps are not procured where safer alternatives are available. Managers must maintain records of when and where non-safer sharps are procured and ensure that risk assessments are in place prior to their procurement and use.

All Employees: have a responsibility to:

- complete mandatory Infection Prevention and Control training and other sharps safety related training where need is identified and to be aware of this policy and the associated procedures for actions to take after an incident (see 1.4).

- use the correct equipment (safer sharps unless the need for non-safer sharps is identified by risk assessment) and to adhere to safe working practices in relation to use and disposal of sharps.

- raise any concerns regarding the safe use of sharps as soon as it occurs and with their line manager if it is a serious and/or ongoing issue.

- report any incidents or injuries promptly and ensure that they are recorded on Datix and to cooperate with any investigation.

5. Distribution

This policy will be available via the Trust and divisional intranet sites. Where staff do not have access to the intranet, their line manager must ensure that they are aware of the contents of this policy.

6 Definitions

Sharps are needles, blades (such as scalpels) and other medical instruments that are necessary for carrying out healthcare work and could cause an injury by cutting or piercing the skin.

Sharps injury is an incident, which causes a needle, blade (such as scalpel) or other medical instruments to penetrate the skin (percutaneous injury)

.

A puncture wound with a clean needle still constitutes a sharps injury.

Safer Sharps are sharps which incorporate features or mechanisms to prevent or minimise the risk of accidental injury.

7 IMPLEMENTATION / POLICY COMPLIANCE

7.1 Eliminate the risk of Occupational Exposure /Sharps Injuries

Line managers must ensure that where practicable the use of sharps is eliminated.

Where sharps are used, they should be safer sharps.

Where safer sharps are not used, a risk assessment must justify that decision. Reasons why a safer sharp cannot be used may include (other reasons may also occur):

- no safer sharp for that clinical application
- the safer sharp introduces additional risks for patients, donors or staff
- the safer sharp adversely affects clinical outcomes
- poor design of the safety features e.g. unclear how the safety feature is deployed.

Personal preference to use a non-safer sharp when suitable products are available (and widely used in the NHS) is **not** acceptable.

The risk assessment for the use of non-safer sharps should consider and record:

- if safer sharps are used in the Trust for similar clinical work.
- what assessments have been made of possibly suitable safer sharps available
- specific clinical need for this product
- the effectiveness of control measures implemented to control the risk of sharps injuries

The risk assessment for the use of a non-safer sharp must be agreed by the Head of Department and must be scrutinised and agreed by the Divisional health and safety meeting. Risk assessments must be reviewed at least annually to ensure that the circumstances which required the use of non-safer sharps have not changed and to consider the availability of new technology and product design.

7.2 Substitute sharps with safer sharps

The following factors should be considered when selecting a safer sharp:

- the device must not compromise patient care
- the reliability of the device
- other safety hazards or sources of blood exposure that the device may introduce
- ease of use
- is the safety mechanism design suitable for the application
- the care giver should be able to maintain appropriate control over the procedure

Introduction of safer sharps should include:

- evaluation of suitable available devices.
- involvement of users in evaluations
- consideration of any All Wales evaluations of safer sharps
- requirements for training and information for users

7.3 Safe use of sharps

Most sharps injuries can be avoided by the use of safer sharps and by adherence to the principles of safe practice as detailed below

- Safer sharps should be stored separately from non-safer sharps, with controls implemented to prevent unauthorised access to the non-safer products.
- Dispose of sharps **immediately after** and **at the point of use** – take a sharps bin with you on a tray or on a trolley.
- Never pass sharps from person to person by hand – use a receptacle or 'clear field' to place them in
- Never walk around with exposed sharps in your hand
- Never put hands inside a sharps container
- Dispose of syringes and needles as a single unit – do not separate the needle form the syringe before disposal
- When there is need to transport a blood sample in a syringe (e.g. blood gas syringe) remove the needle using a removal device and attach a blind hub prior to transport) – IPC 11 Transport of Specimens Policy.

7.4 Disposal of Sharps

The person using the sharp has a personal responsibility to ensure that the sharp is disposed of safely, as soon as possible after use.

Sharps must only be disposed of in designated sharps bins conforming to UK Standard: BS 7320 in the appropriate coloured container (see Appendix 1). (Waste Management Policy QS20)

- All sharps including needles, safer sharps devices blades, glass slides, drug ampoules, razors, disposable scissors, intravenous cannula's and guide wires must be discarded into a sharps container

- Sharps bins must be:

    - correctly assembled correctly according to manufacturer instructions and correctly labelled.
    - placed in a suitable, safe location away from children, members of the public and vulnerable adults. Do not store on the floor.
    - an appropriate size for the activity and equipment used.
    - available at the point of use of the sharp e.g. at the bedside/donor couch and must be available on drug, phlebotomy, cannulation and cardiac arrest trolleys

- Use the temporary closure aperture on the bin between uses to prevent spillage if the container is knocked over.
- Carry sharps bins by the handle held away from the body, or using the carry tray provided (for smaller bins)
- Do not overfill – replace it when 3/4 filled to the line marked
- Complete the container label on disposal with:
    - Date Locked
    - Disposed By
- Do not place sharps or sharps bins in clinical waste bags for disposal.
- Used sharps bins must be stored in a designated area i.e. locked, segregated cupboard or clinical waste bin provided for the purpose. Seek advice from the waste manager for disposal of genetically modified sharps waste
- Sharps containers are not intended to be leak proof so it may be necessary to place designated absorbent matt or paper towels in the bottom of the bin on assembly to mop up any excess fluid.
- Avoid prolonged use of sharps containers – maximum period of use is three months.

7.5 Failure of a Safer Sharps Device

Failure of a sharps device, related equipment or container must be reported on Datix under the medical devices reporting system of the Medicines and Health products Regulatory Agency as described in the QS24 Medical Devices Policy and to the line manager for the area where the incident happened and to the Trust Medical Devices Officer.

7.6 Actions in the Event of Incorrectly Discarded Sharps

If a sharp has been found incorrectly disposed of/discarded e.g. waste bag, found on the floor, patient locker etc.

Assess the risk: make the area around the sharp safe to prevent others being exposed or injured e.g. move patients who may be at risk of contact with the sharp away from the area.

Inform the manager: inform the person in charge of the area/department and manager/supervisor (if different)

Remove and dispose of safely: do not pick up the item by hand, use PPE and a secondary device to retrieve the item(s) e.g. dustpan and brush or forceps. Non-

clinical staff and those who do not routinely handle or use sharps must **not** undertake these themselves e.g. clerical, cleaning or catering staff

Complete an incident Datix report: include details of exact location and how the item was discovered. The staff manager/supervisor must investigate how the incident had occurred, the possible source, the staff involved and possible reasons for the error and include the departmental manager in the investigation (if different). Training needs must be identified as part of the investigation summary and an outcome provided.

Managing Implicated Staff: Any member of staff found to have discarded a sharp inappropriately must be interviewed by their manager to ascertain the circumstances and any competence issues that may need to be addressed. If this is a repeat issue the relevant Workforce and Operational Development policy should be invoked.

If staff encounter an object which they are unsure may be a sharp, they should follow the above steps until the nature of the object is established.

7.7 Actions in the Event of a Sharps Injury

Please refer to the divisional procedures for actions to take in the event of an incident (see 1.4).

If a sharps injury does occur, the following action must be taken **IMMEDIATELY:**

- **Bleed it -** encourage bleeding ideally by holding under running water – but do not massage or scrub the site**.** Do not suck the wound.
- **Rinse it –** if splashed with bodily fluids to the eyes or mouth, rinse with plenty of running water
- **Wash it** - wash the injury under warm running soapy water
- **Cover it** – cover with a water proof dressing
- **Report it** – inform you manager immediately and complete incident report
- **Manage it** – If assessed as a high risk injury contact Occupational Health immediately during working hours or Accident and Emergency out of hours in accordance with divisional procedures for actions to take in the event of an incident (see 1.4).

7.9 Training

Managers should ensure that staff receive appropriate training on preventing sharps injuries and the action to be taken should such an incident occur.

Managers must ensure that staff are aware of the following:

- the correct use of safer sharps including information on individual types of device;
- the findings of any risks assessments related to use of sharps and the precautions they should take to protect themselves and other persons, for example the use of medical devices, safe systems of work or local procedures and the correct use and disposal of sharps;
- procedures to follow in the event of an emergency, including measures to be taken in the event of a sharps injury and how to report incidents (see 1.4).

The training provision should also take into account:

- appropriate intervals for refresher training; and,
- Induction for all new and temporary staff.
- Supervision or new/inexperienced staff until competent

8. Monitoring Arrangements

Arrangements for safer use of sharps will be monitored as part of health and safety audits and outcomes with be monitored by divisional and Trust wide health and safety meetings. Findings from these audits will also be provided by Divisions and the Health & Safety Manger to the Trust Infection Prevention and Control Management Group.

The safe use and disposal of sharps will be monitored through clinical practice audits by Infection Prevention and Control Team.

Compliance with this policy will also be measured by review of incident investigations and observation of clinical practice by managers. Oversight will be provided by the Health & Safety Manager.

9. REFERENCES

Health and Care Standards for Wales (2015)

- British Standard: BS EN ISO 23907/ 2012 Sharps Injury Protection. Requirements and Test Methods Sharps Containers.
- WHTM 07-01 Safe management of Healthcare Waste (2013)
- HSE Sharps Injuries
- HSE Health Services Information Sheet 7

10 GETTING HELP

10.1 Further information and support:

Trust Health and Safety Manager – Helenjones56@wales.nhs.uk
Divisional Health and Safety Advisors
VCC CeriPell@wales.nhs.uk
WBS MatthewBellamy@Wales.nhs.uk
Infection Prevention and Control Team 02920615888 ext. 6129.
02920615888 ext. 6129.

10.2 Telephone Numbers:

A&E

UHW: 02920 748792 or ext. 48792, 02920 748285 or ext. 48285 (VCC)

Royal Glamorgan: 01443 443157 (WBS)

Occupational Health Departments

University Hospital of Wales
Tel : 02920 74 3264 or ext 43264
Fax: 02920 74 4411 or ext 44411

University Hospital of Llandough
Tel: 02920 72 5140 or ext 25140
Fax: 02920 72 5432 or ext 25432

Specialist Virology Centre for Wales, NPHS Microbiology Cardiff

Monday to Friday, 9am to 5pm: Tel: 02920 74 2178. Out of hours: Contact on call Microbiologist via UHW Switchboard: Tel: 02920 747747

11 RELATED POLICIES/PROCEDURES

11.1 This policy should be read in conjunction with:

- QS 24 – Medical Devices and Equipment Management Policy
- QS 20 – Waste Management Policy
- VCC Sharps Incidents and Occupational Exposure to Blood and High Risk Body Fluids Procedure
- WBS SOP: 016/ORG Procedure following an inoculation injury and/or contact with blood/body fluid
- IPC 11 Transport of Specimens Policy

APPENDIX 1 - Colour Coding for Sharps Containers

Infection. Prevention. Control.
You're in safe hands

NHS

Correct sharps disposal

Is the sharp cytotoxic or cytostatic?

YES

Dispose into purple lidded sharps container

Has the sharp been contaminated with medicines?

NO

Dispose into orange lidded sharps container

YES

Dispose into yellow lidded sharps container

Community Infection Prevention and Control, Harrogate and District NHS Foundation Trust
Tel: 01423 557340 www.infectionpreventioncontrol.co.uk October 2019

PROCEDURE FOR SHARPS INJURIES AND OCCUPATIONAL EXPOSURE TO HIGH RISK BODY FLUID

Quick Reference Guide – In the event of an inoculation injury

An Inoculation Injury Occurs

The injured staff member will:	The manager/operational manager will:
First Aid Needlestick/Sharp/Bite injury: • Encourage bleeding • Wash the site immediately with soap and warm running water, do not scrub the skin and do not suck the wound • Splash Injury: • Wash and rinse the area/mucous membrane immediately (if eye splashed remove any contact lenses first) • Keep a record of the patients name and location • Report to manager **immediately** • Complete DATIX form **For your own protection do not delay, act immediately**.	• Ensure First Aid has been carried out • Ensure source patient risk assessment by medical staff or trained manager **within 30 minutes of the injury**, using **Form 1** (Appendix 1) • If **HIGH RISK** refer injured person to C&VUHB Occ Health/A&E – **to attend within 1 hour of injury occurring** • Ensure Risk **Form 2** (Appendix 2) is completed and sent with the injured worker • If **LOW RISK** to be seen in Occupational Health within 24 hours • Ensure that a DATIX form is completed documenting all steps taken

Guidance on risk assessing the source patient can be found in: sections 11-14

If the source patient is known **they must be asked for permission to sample blood** for a HBV test.
If the patient refuses or is unable to give consent then it must be treated as an unknown source.

If known BLOOD BORNE VIRUS contact Occ Health/EU **immediately** for advice.

If it is an unknown source, or if patient refuses, a risk assessment should be carried out to determine the likelihood that the inoculation injury, bite or splash, may have come from a patient with a BLOOD BORNE VIRUS infection.

VCC staff contact:

- Occupational health department between 9am and 5pm
- UHW (WHTN 01872) or 02920743264 or EU at hospital closest to where the incident occurred.
- Out of hours: EU at UHW 02920 748047

The injured party **must not** be involved in the risk assessment of the source patient and **must not** approach the source patient for permission to test for BLOOD BORNE VIRUSES.

Speak to on-call microbiologist for advice if difficult to take blood from source patient

Approved by: VCC Health Safety and Fire Management Group
VCC IP&C Management Group

Equality Impact Assessment

Author(s) Trust Health and Safety Manager
Head of Infection Prevention & Control

Contents Page

1. Introduction

Healthcare workers are at risk of blood borne viruses including hepatitis B Virus (HBV), hepatitis C virus (HCV), human immunodeficiency virus (HIV), due to sharps incidents and other high risk contact with high risk body fluids.

2 Aim

This procedure outlines the actions to be taken following sharps incidents and other high risk contacts with high risk body fluids.

3 Objectives

To outline responsibility for the management of actions following a sharps injury and other high risk contacts with high risk body fluids including procedures to be followed and management of staff and others involved including the source patient.

To outline responsibilities for making a risk assessment of the source patient and obtaining permission to test for blood borne viruses.

4. Scope

This procedure applies to all Velindre Cancer Centre staff in all locations where they work.

5. Documents to read alongside this Procedure

- The Sharps Safety Policy
- The Risk Management Policy

6. Definitions

Occupational Exposure for the purposes of this policy includes:

- Percutaneous injury from sharps (including needles, instruments, bone fragments, human bites which break the skin) which are contaminated with blood or other body fluid.
- Exposure of broken skin (abrasions, cuts, eczema etc.) to body fluids which may be of risk of causing infection.
- Exposure of mucus membranes including eye, nose and mouth to body fluids which may be of risk of causing infection.

Sharps are needles, blades (such as scalpels) and other medical instruments that are necessary for carrying out healthcare work and could cause an injury by cutting or pricking the skin.

Sharps injury is an incident, which causes a needle, blade (such as scalpel) or other medical instruments to penetrate the skin. Sometimes called a

percutaneous injury. A puncture wound with a clean needle still constitutes a sharps injury.

Post- Exposure Prophylaxis (**PEP)** is the use of antiretroviral drugs after a single high-risk event to stop HIV seroconversion. PEP must be started as soon as possible to be effective—and always within 72 hours of a possible exposure.

Safer Sharps are sharps which incorporate features or mechanisms to prevent or minimise the risk of accidental injury.

High Risk Body Fluids – Blood, low risk fluid if bloodstained, amniotic fluid, breast milk, pericardial fluid, peritoneal fluid, pleural fluid, Cerebral Spinal Fluid, Saliva associated with dentistry, seamen, synovial fluid, unfixed organs or tissues, vaginal secretions.

Low Risk Body Fluids (unless blood-stained) - Urine, Vomit, Saliva, Faeces

7 Risks from Blood Bourne Viruses (BBV)

Hepatitis B Virus - For HBV there is effective vaccination, post exposure prophylaxis (PEP) with vaccine +/- immunoglobulin (HBIG) for those not vaccinated, and post exposure HBIG for HCW's who fail to respond to the vaccine.

Vaccinated HCW's who have developed immunity are at extremely low risk of infection. Unvaccinated persons have a risk from a single needlestick injury or cut exposure of 6-30% (depending on viral load) to HBV infected blood.

Hepatitis C Virus - There is no vaccine or Post Exposure Prophylaxis (PEP) available for HCV but effective treatment is available for those exposed.

The risk of infection after a needlestick or cut exposure to HCV infected blood is approximately 1.8%. The risk following blood splashes is unknown.

HIV - For HIV there is no vaccine available but there is PEP but this requires immediate action.

The risk of HIV infection after needlestick or cut exposure to HIV infected blood is low at approximately 0.3%. The risk after exposure of the eye, nose or mouth is less than 0.1%. There is no risk of HIV transmission where intact skin is exposed to HIV infected blood.

8 Testing Source Patients

Testing source patients for HBV, HCV and HIV is the most effective way of providing reassurance to those injured. The majority of patients will not be infected. A universal approach to asking source patient to agree to have BBV tests avoids the need to make difficult judgements and avoids any appearance of discrimination against people perceived as being in 'risk groups'. In practice, there has been some reluctance to seek patients' consent to be tested, yet patients have usually been found willing to co-operate if approached in a sensitive manner.

9 Responsibilities

Staff Responsibilities - Staff should take all reasonable precautions to avoid sharps injuries. This includes avoiding the use of medical sharps so far as is practical, using safer sharps where possible and correctly following protocols for sharps disposal.

In the event of a needlestick or similar injury all staff should know:-

- What action to take.
- Who has responsibility to ensure proper assessment.
- Where to go for treatment of the injury and follow-up.
- How to report the incident so that future injuries are reduced or avoided.

The Injured Person must:-

- Immediately apply first aid.
- Report to the appropriate manager.
- Collect Risk Assessment form 2 (Appendix 2) to take to Occupational Health/ EU.
- Complete an incident form on Datix.

UHW Occupational health department (9am and 5pm) Tel 02920743264

Out of hours: EU at UHW Tel 02920 748047

Managers Responsibilities - The manager responsible for the injured person at the time of the injury must:-

- Ensure first aid has been carried out.
- Refer injured person to C&VUHB Occupational Health/Emergency Unit
- Ensure Form 2 is completed and sent with the injured worker in a sealed envelope.
- Ensure that source patient risk assessment is carried out by liaising with the Clinical Manager covering the area of the source patient.

The Clinical Manager should:-

- Liaise with the Consultant responsible for source patient.
- Ensure that Datix incident is completed.
- Investigate the cause of the injury and put in place any appropriate preventative measures to reduce likelihood of any further injuries

The risk assessment of the source patient is the responsibility of the Consultant responsible for their care.

The injured party must not be involved in the risk assessment of the source patient and must not approach the source patient for permission to test for blood borne viruses.

10. Procedure for needlestick and similar injuries

10a First Aid

First Aid should be performed immediately after the injury occurs.

Skin/Tissue

- Encourage local bleeding by gently squeezing, do not suck area.
- Wash the affected area with soap and running warm water. Do not scrub the area.
- Cover area with waterproof dressing.

Eyes or Mouth

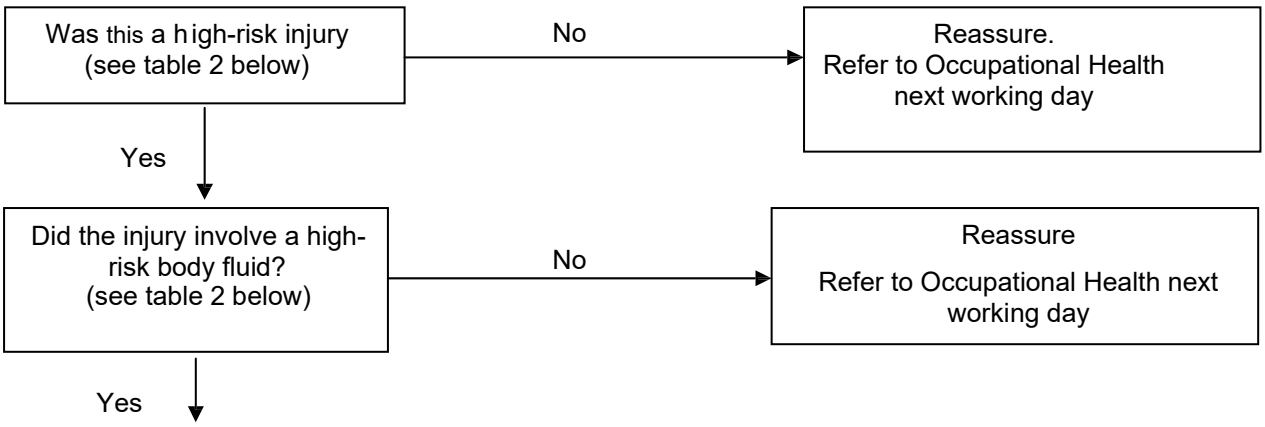
- Rinse out / irrigate with copious amounts of water (use eye washout kits if available).
- If wearing contact lenses irrigate eyes before and after removing them.
- Do not swallow water used for rinsing mouth.

10b Injury Assessment

Injury Assessment other than Human Bites (to be completed as far as possible within 30 minutes of the incident)

For an injury to be considered significant, both the type of injury incurred and the body fluid involved must be high risk.

Table 1: Flow diagram for injury risk assessment



Treat as Significant Injury. The staff member now becomes a PATIENT

Refer to: Occupational Health during working hours
OR Emergency Unit out of hours

Manager must establish risk status of source by completing forms 1 and 2 (Appendix 1 +2) as appropriate and communicating outcome to Occ Health/EU

Table 2: Injury Type

High-Risk Injury	Low-Risk Injury
Percutaneous exposure e.g. needlestick or other sharps injury Exposure on broken skin Mucous membrane exposure (e.g. eye)	Splash on intact skin.

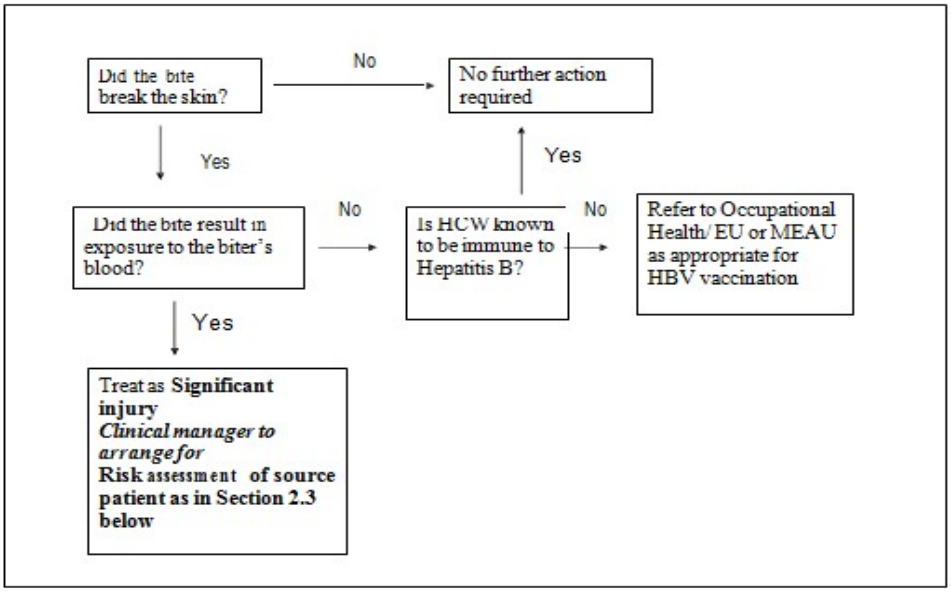
Table 3: Body Fluids

High-Risk Body Fluid		Low Risk Body Fluid (unless blood-stained)
Blood Low risk fluid if bloodstained Amniotic fluid Breast milk Pericardial fluid Peritoneal fluid	Pleural fluid CSF Saliva associated with dentistry Semen Synovial fluid Unfixed tissues or organs Vaginal Secretions	Urine Vomit Saliva Faeces

Injury Assessment for Human Bites (to be completed as far as possible within 30 minutes of the incident)

- Apply first aid (See section 2.1).
- Refer to EU at UHW.
- Refer to Occupational Health.
- Assess the risk of BBV transmission. The clinical evaluation should include the possibility that both the person bitten and the person inflicting the bite may have been exposed.

Table 4: Flow diagram for injury assessment for human bites



10c Establishing risk status of source

The clinical team caring for the source patient are responsible for establishing the risk status of the source patient, even if the staff member has been referred to Occupational Health or the Emergency Unit.

The clinical manager for the area where the source of blood is located should:-

- Locate the source patient if possible.
- Arrange for a source patient risk assessment to be carried out **IMMEDIATELY** and for the source patient's informed consent to be sought for HBV, HCV and HIV testing ideally within 30 minutes of the incident occurring.

The source patient risk assessment should be carried out by an experienced health care professional e.g. senior nurse or doctor from the clinical team caring for the patient, not by Occupational Health or Emergency Unit. The injured health care worker must not carry out the source patient risk assessment.

Inform Occupational Health or out of hours Emergency Unit whether or not a source patient risk assessment has been arranged and provide them with contact details of the person carrying out the risk assessment.

Inform the Consultant responsible for the source patient if not already involved.

10d Known Source Patient - guidance on approach to risk assessment and permission to test

In the case of a known source patient, a risk assessment should be carried out and consent for testing sought. The situation must be handled sensitively. The patient must not be approached by the injured healthcare worker.

Case notes should be reviewed to establish if there is known infection with any BBV. If this is not clear from case notes then it will be necessary to seek information from the patient themselves.

There is no single approach that will cover every interview, but it is recommended that the following points be observed:

- The discussion should take place in a location where proper privacy can be maintained.
- The patient should be informed that someone has been injured in an accident involving their blood/other body fluid. Injuries of this kind can cause considerable anxiety and worry to healthcare workers because infections such as hepatitis B, hepatitis C and HIV can be transmitted in this way (see appendix 5).
- Patients should be asked if they would consent to answering some personal questions, which would help to address the concern. Emphasise that the questions are very personal and might very well not apply to them, but they are now asked routinely, for example, by the Blood Transfusion Service before accepting blood donations.
- If the patient agrees, ask them the questions detailed on Form 1 (Appendix 1).

If any of the answers to the questions on Form 1 is Yes then the patient should be considered as high risk for blood borne viral infections.

Permission to test for Hepatitis B, Hepatitis C and HIV

Unless there are reasons for not testing, all source patients should be asked if they would be willing to allow a sample of their blood to be taken for testing for HIV, HBV and HCV, as a negative result gives reassurance to the injured person.

Explain that testing is also in their interest as these diseases may be entirely asymptomatic, but have effective treatment if diagnosed and are best diagnosed at the earliest opportunity. It is important that undue pressure is not applied and that the decision lies entirely with the patient and this must be explained clearly to the patient. The outcome of the discussion should be recorded in the patient's notes.

Inform source patient that he/she will be notified of the result. Inform source patient that the test result will be passed to their medical team.

Patients may be concerned that consenting to an HIV test might adversely affect insurance policies. Patients can be advised that a negative HIV test will not affect their insurance premiums although a positive result may have implications. The great advances in treatment of HIV mean that early diagnosis facilitates the best outcome.

After testing, permission will be sought to communicate any positive result to the GP. *Would the GP have access via the clinical portal?*

If the request raises serious anxiety, or if the source patient requests anonymous testing (where a code is used on the request form and sample rather than the patient name), then refer for specialist management to Infectious Diseases Department or Genitourinary Medicine Department.

Document the risk assessment outcome on Form 2 (Appendix 2), along with whether or not consent for blood testing has been obtained and samples sent. Send the completed Form 2 to Occupational Health or Emergency unit by giving the form the injured worker in a sealed envelope.

Record that an assessment has been carried out in the source patient's case notes, but do not record the assessment outcome.

Record the name and contact details of the person carrying out the assessment in source patient's case notes.

Destroy Form 1.

Where the patient declines any engagement with the risk assessment process, and a risk assessment cannot be carried out from patient notes, proceed as per "unknown source"

10e Sending samples once obtained

Specimens taken for storage and for blood borne virus testing should be sent to the Specialist Virology Centre, PHW Microbiology, University Hospital of Wales, Cardiff.

The preferred sample for both storage and source patient testing is a 9ml EDTA sample (2 purple cap vacuum tubes).

During working hours (i.e. Monday to Friday, between 9am – 5pm) the Specialist Virology Centre will test patients for blood borne viruses to establish that the exposed individual is not already HIV infected. Where possible, specimens should be sent during working hours. Contact details are listed in appendix 3. All positive HIV antibody tests will require confirmatory testing which will be carried out on the next working day.

If the sample is being sent out of hours (e.g during the weekend) the on call virology consultant should be contacted to discuss processing of the sample and its effect on immediate management. They may request that the virology laboratory technician is informed separately (see appendix 3 for contact details) to inform them that a specimen is being sent and the agreed processing time.

Ensure that the specimen is labelled with the contact details of the person who should be telephoned with the results. Only positive or equivocal results will be telephoned. Negative results will be automatically authorised and available for review via the clinical portal.

Mark request form “copy to Occupational Health”.

10f Managing results of source patient test

It is the responsibility of the person carrying out the source patient risk assessment to ensure the results of the source patient blood tests are telephoned to the doctor or nurse managing the injured person.

If the person carrying out the risk assessment is not going to be on duty when the results become available then the name of nominated deputy should be given to the laboratory. The nominated deputy must then take responsibility for passing the results on to the doctor or nurse managing the injured person.

The person carrying out the source patient risk assessment must ensure that the source patient is informed of their test results within 24 hours of them becoming available.

In the event of the source patient test results being positive, specialist advice should be sought from an infectious diseases consultant before the patient is informed (see appendix 3 for contact details).

10g Unknown source

If it is not possible to identify the source patient for a particular needle or sharp implement, a risk assessment should be carried out to determine the likelihood that the needle may have been used on a patient with a blood borne virus infection. Are there patients known to be infected with a BBV in the clinical area concerned?

If no further information is available background prevalence rates can be used in the risk calculation (appendix 4)

10h Testing when source patient is unable to give consent

When the source patient is deceased, unconscious or unable to give informed consent for any other reason, testing should not be carried out without first seeking further advice from the on call ID (see appendix 3 for contact details). However, if the source patient has died, consent for testing can be given by a “nominated representative” (if appointed) or by a person with a “qualifying relationship” to the deceased”. The decision to start PEP should be taken by Occupational Health or the Emergency Unit on the basis of the source patient risk assessment.

10i Risk assessment and testing when source is a child

For children and their parents / guardians all the above considerations including privacy must be maintained. To establish the risk status of the child, the questions in the source patient assessment tool should be asked, not only regarding the child, but also the mother. If the child is deemed to have sufficient understanding, whatever his/her age, an appropriate explanation should be given, and consent sought from the child. If the child refuses, blood should not

be taken or tested. If the child consents, consent should also be sought from the child's parents / guardian.

As the route of transmission to children is usually vertical (from mother to child), testing the child may be a surrogate for testing the mother, so she should be aware of this prior to testing. The reason for refusal of consent may be the distress of venepuncture. If this is the case, in young children with no history of foreign travel, blood transfusion or needlestick injury, the mother's blood may be tested instead of the child's.

10j Management of the injured person

This is carried out by Occupational Health / Emergency Unit.

Patients should be triaged and treated as a priority, within one hour if possible.

Ensure first aid has been carried out (see section 10a)

Confirm that a significant injury has occurred (see section 10b). If not a significant injury, the injured person can be reassured.

Check whether the source patient is known to have a blood borne virus or at high risk of infection with a BBV.

Check if source patient has given consent for testing and if so, when will the results be known. Arrange for results of source patient blood test to be phoned to a named doctor or nurse responsible for managing the injured person. If the source patient HIV antibody test is negative, and PEP has been started, then the injured person must be contacted as soon as possible and advised to discontinue PEP.

Assess the need for HIV PEP, remember that therapy should be started as soon as possible following injury, ideally within one hour.

Assess the need for hepatitis B vaccination +/- hepatitis B immunoglobulin. HCWs should know their vaccination status and whether they responded to HB vaccine (i.e. ever attained a level of >1OIU/L)

Consider the need for hepatitis C follow-up

Offer to take blood for storage (all significant injuries). Explain that testing will be carried out only with consent. Request form should state type of injury and 'blood for storage'.

Ensure all appropriate follow-up is arranged:

Appointment with ID physicians if HIV PEP started.

Occupational Health (HCW) or GP (others) follow-up if further hepatitis B vaccination / testing or HCV screening is required.

Referral to counselling services including specialist services if required.

For all injuries in the workplace, advise the injured HCW to inform the Occupational Health Department at the earliest opportunity, regardless of outcome of the assessment.

Advise staff to report the incident on Datix.

10k Management of patients exposed to blood from a Health Care Worker (HCW)

Circumstances that could allow the transmission of blood borne viruses from HCW to patient include:

- Visible laceration occurring to a HCW's hand where the patient's open tissue or mucous membranes could be contaminated with the HCW's blood.

- Visible bleeding form a HCW from any other site, e.g. nosebleed, leading to significant bleed-back into a patient's open tissues or mucous membranes.

- An instrument or needle contaminated with the blood of the HCW is inadvertently introduced into the patient's tissues.

The injured worker should:

- Stop the procedure as soon as possible, wash and dress the wound and stem the bleeding.

- Clean and disinfect any contaminated areas.

- Report the incident to the manager.

- Inform the Occupational Health department (EU out of hours)

- Complete a Datix form

A risk assessment should then be carried out by someone other than the injured HCW, e.g. a senior doctor, to ascertain whether or not a significant exposure has occurred. If the incident is considered to be a significant exposure, involving bleed-back into the patient, a source HCW risk assessment should be carried out IMMEDIATELY using Forms 1 and 2 (Appendix 1 and 2) and the injured HCW should routinely be asked to consent to testing for HIV, HBV and HCV.

If the HCW tests positive for any blood borne virus, the patient should be notified of an intra-operative exposure without revealing which member of the clinical team is infected. Only in exceptional circumstances would a patient be given PEP for HIV in the absence of a positive blood test in the HCW (eg high risk of having been infected with HIV and refusal to undergo a test). National Guidance

indicates that it is unnecessary to tell the patient if the HCW's tests are all negative.

A written record of the incident and test results should be entered in the HCW's occupational health notes.

11 Training

Mandatory infection prevention and control training updated every two years.

Further departmental based training as identified by training needs analysis.

12 Implementation

5.1 The document will be available on the VCC Health and Safety intranet site and the Infection Prevention and Control site. Individual directorates will be responsible for the implementation of the protocol document in clinical areas.

13 Equality

This procedure has had an equality impact assessment and has shown there has been no adverse effect or discrimination made on any particular individual or group.

14 Audit

Audit of compliance with the protocol document will be carried out by the Infection Prevention and Control department as part of their audit programme.

15. Review

This procedure will be reviewed every three years or sooner if the national guidelines are updated.

Appendix 1

Source patient risk assessment Form 1

CONFIDENTIAL For use following needlestick injury or similar	
Is source patient known to have hepatitis B	**Yes/No**
Is source patient known to have hepatitis C	**Yes/No**
Is source patient known to have HIV	**Yes/No**
If the answer to any of these is YES, the patient is considered "High risk". If all answers are NO, then ask the following in an area where confidentiality can be assured. (based on questions asked routinely of blood donors)	
For men – Has he ever had sex with a man	**Yes/No**
For women, have she ever had sex with a man who has had sex with a man	**Yes/No**
Have he/she ever paid for or sold sex	**Yes/No/Not known**
Has he/she had a blood transfusion in a country outside Western Europe, Australia, New Zealand, Canada or the USA	**Yes/No**
Has he/she ever injected drugs	**Yes/No**
Has he/she ever had sex with someone who has injected drugs	**Yes/No**
If source patient answers "yes" to any of above should be considered "high risk"	
ON completion of risk assessment: • **Document outcome on Form 2** • **Forward part 2 to Emergency Unit or Occupational Health in sealed envelope to be carried by injured worker** **In patient case notes** • **Record assessment has been done but NOT outcome** • **Record your name, grade and contact details**	

• Destroy this form

Appendix 2 **Source patient risk assessment Form 2**

You should contact the nurse or doctor managing the injured person PROMPTLY with an initial verbal report with results of risk assessment and when and to whom any lab test results will be notified. This form can be taken to Emergency Unit or Occ Health by the injured worker could take it with them **in a sealed envelope**

To be completed by practitioner performing source patient risk assessment

Name of Injured Person_____Place where injury happened _____

Consultant/ GP responsible for source patient_____Date__

Source patient reference

I have scrutinised the case notes of the identified source patient	Yes/No
I have spoken to the medical team responsible for source patient	Yes/No
I have spoken to source patient and carried out risk assessment	Yes/No
Outcome of Risk assessment	
Has patient been diagnosed with a blood borne virus infection	Yes/No
Does patient have any possible syndrome suggesting acute HIV infection	Yes/No/Not known
Is patient HIGH RISK for BLOOD BORNE VIRUS infection	Yes/No
Has Occupation Health or Emergency Unit been informed of risk status of source patient	Yes/No
Source patient blood test	
Has consent be sought and granted for blood to be taken and tested	Yes/No
Has blood been taken	Yes/No
When will result be available	
Has injured staff member been informed of source risk assessment and /or lab result	Yes/No

Post _____ **Practitioner's name** **Page/contact no** _____	

To be completed by doctor or nurse managing injured person

Hepatitis B vaccine given	Yes/No	/ /200
HBIG given	Yes/No	/ /200
PEP for HIV started	Yes/No	/ /200
Has follow up been arranged	Yes/No	/ /200
Post _____ **Name**_____ **Page/contact no** _____		

Appendix 3 - Contact Telephone Numbers

Occupational Health Departments - University Hospital of Wales Tel : 02920 74 3264

Paediatrics

For specialist advice, contact on-call Paediatric ID consultant via UHW switchboard on 02920 747747. Referrals to consultant paediatrician for follow-up testing.

Specialist Virology Centre for Wales, NPHS Microbiology Cardiff

Monday to Friday, 9am to 5pm: Tel: 02920 74 2178.

Out of hours: Contact on call Microbiologist via UHW Switchboard: Tel: 02920 747747

Genitourinary medicine, Cardiff Royal Infirmary

Health Advisors: 02920 498900
GUM Secretaries: 02920 335169

Monday	08:15 – 12:30 and 13:15 – 16.30
Tuesday	08:15 – 12:30 and 13:15 – 16:30
Wednesday	Closed
Thursday	08:15 – 12:30 and 13:15 – 16:30
Friday	08:15 – 12:30 only - closed pm

Appendix 4 - Risk that Source is HIV Positive

Community Group	HIV Seroprevalence	Risk
1. Known HIV Positive people	100%	High
2. Homosexual Men London/Manchester/Brighton	Up to 15%	High
Elsewhere in UK including Wales	Up to 5%	Medium
3. Heterosexuals Sub Saharan Africa	Up to 39%	High
Caribbean	Up to 6%	Medium
Latin America	< 2.7%	Medium
South & SE Asia	< 2.7%	Medium
N Africa & Middle East	< 2.6%	Medium
UK	< 1%	Low
W Europe	< 1%	Low
E Europe and Central Asia	< 1%	Low
N America	< 0.6%	Low
Australia and New Zealand	0.1%	Low
4. Intravenous Drug Users		
S Europe	>50%	High
London	4.7%	Medium
E Europe	Variable	Medium/High
Elsewhere in UK (Wales)	0.23%	Low

Appendix 5 Suggested form of Words for approaching Source Patient

"Unfortunately one of the members of staff has had an accidental injury where your blood *(or specify relevant body fluid)* has been "involved". I am here to ask if you would let me take a blood sample for testing for the viral infections, which can be transmitted to staff in this way. This is something that we ask for routinely whenever a patient's blood *(or specify relevant body fluid*) is involved in such an accident. We need your agreement to do this and would appreciate your help.

The purpose of the testing is to reassure staff where the results are negative. This may allow them to stop taking precautionary medication, which often causes unpleasant side effects. In the unlikely event that a test is positive you will receive specialist advice and management including treatment if required. The staff member may also be offered additional treatment.

The tests are for hepatitis B, hepatitis C and HIV. The test results should be available within a few days (but may take several weeks if extra investigations are required for clarification) and will normally be given to you by a member of the medical staff. The results are confidential, but they will appear in your health record and the affected staff member will also be informed.

Do you have any concerns? A common concern is whether having these tests done will affect any existing life insurance policies or future life insurance applications. The Association of British Insurers has issued guidance stating; "Existing life insurance policies will not be affected in any way by taking an HIV test, even if the result is positive." For new life insurance applications, companies should only enquire about positive test results, not whether a test has been performed. A positive test result may affect the outcome of a life insurance policy application. Do I have your permission to take a blood sample for hepatitis B, C and HIV testing? I should remind you that you can refuse to have some or all of these tests performed and that if you do choose not to be tested it will not affect your future care and regardless of the results from your recent blood tests your Trust consultant will contact you. If the results are positive a meeting will be arranged to explain them to you."

Taken from: Draft "Policy for the Prevention and Control of Blood Borne Viruses" 2010 NHS Plus

APPENDIX 6 – Definitions and Acronyms

BLOOD BORNE VIRUS	Blood Borne Viruses referred to in this policy include Hepatitis B, Hepatitis C and Human Immunodeficiency Virus
Donor	Person who is the origin of blood or body fluid. The preferred term is 'source.'
EU	Emergency Unit (also known as A&E)
EPP	Exposure Prone Procedure
HBIG	Hepatitis B immunoglobulin
HBsAb	Hepatitis B surface antibody
HBsAg	Hepatitis B surface antigen
HBV	Hepatitis B Virus
HCV	Hepatitis C virus
HCW	Health Care Worker
HIV	Human Immunodeficiency virus
Inoculation incident	consists of exposure to blood or other body fluids involving: • Broken skin – such as abrasions, fresh cuts, eczema • Percutaneous exposure - when contaminated material penetrates the skin e.g. needlestick injury, bites • Mucocutaneous exposure- exposure of blood or other body fluids to the lining of eyes, nose or mouth
PEP	Post Exposure Prophylaxis against HIV which is given following exposure in cases considered high risk for possible HIV exposure
Recipient	Person who was exposed to the body fluid
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995
Sharps	Are objects with sharp edges such as suture needles, hollow needles, scalpels, blades lancets, surgical instruments, broken ampoules, bone, teeth or equipment used in dentistry e.g. burr which carry the risk of transmission of blood borne viruses.
Source	Person who is the origin of blood or body fluid. Also known as 'donor.'
Victim	Person who was exposed to the body fluid. The preferred term is 'recipient.'

ORF-049, Issue 5.0, Effective Date 19/11/2021

PROCEDURE FOLLOWING AN INOCULATION INJURY AND/OR CONTACT WITH BLOOD/BODY FLUID

A member of staff may only perform this task if authorised to do so by the individual in charge of the working area

INTRODUCTION

An inoculation injury is an incident which causes a needle or sharp instrument, such as a scalpel (collectively referred to as 'sharps'), to penetrate the skin. If the sharp is contaminated with blood or other body fluid, there is a potential for transmission of blood borne viruses (BBV) or other pathogens.

Inoculation injuries and contact with blood/body fluid can occur to donors or staff and this SOP is to be followed for any such injuries.

Blood borne viruses in infected blood may also be spread through contamination of open wounds, skin abrasions, skin damaged due to a condition such as eczema, or through splashes to the eyes, nose or mouth.

These viruses can also be found in body fluids other than blood and this should be taken into account when handling pathological specimens. Some body fluids or materials such as urine, faeces, saliva, sputum, sweat, tears and vomit carry a minimal risk of BBV infection due to the potential of containing blood. Care should still be taken with all such body fluids as the presence of blood is not always obvious. If any such contact occurs, this SOP must be followed as a precaution.

RESPONSIBILITIES

- The injured person has the responsibility to instigate immediate first aid and to report the incident to their manager/supervisor
- The manager/supervisor is responsible for ensuring that procedures are followed correctly

DEFINITIONS

- **Injured Person** – the person who has received the inoculation or splash injury
- **Source** – the material (blood / body fluid) that has caused contamination

PROCEDURE FOLLOWING AN INOCULATION INJURY AND/OR CONTACT WITH BLOOD/BODY FLUID

SAFETY PRECAUTIONS

As identified in departmental SOPs for handling pathological specimens
Normal precautions taken by staff

MATERIALS/EQUIPMENT

Confidential Incident Form (ORF 008)
Reporting of Incidents, Accidents, Near Misses or Hazards (**SOP: 025/ORG**)
Sample Return Form for Sample Save (ORF 016)
Consent Form for a PPT (Gel) Sample to be Taken (ORF 015)
Inoculation Injury and Blood/Body Fluid Contact Accident Form (ORF 019)
IPC 06 Policy for the Management of Occupational Exposure to Blood and High Risk Body Fluids (Needlestick Injury)
PPT (Gel) sample tube

PROCEDURE

1. Known Source where microbiology samples have been taken (eg full donation or part bag)

1.1 **Inoculation injury – contaminated**

1.1.1 Immediately following **any** exposure – whether or not the source is known to pose a risk of infection – the site of exposure, e.g. wound or non-intact skin, should be washed liberally with soap and water but without scrubbing. Gently encourage the site to bleed. Wounds should not be sucked.

1.1.2 Dry the site and apply a dressing.

1.1.3 Seek urgent clinical advice (Specialist RN / WBS Consultant)

1.1.4 Inform your line manager of the incident.

Go to section 5 of this SOP

1.2 **Contact with Blood/Body fluid**

1.2.1 If it is certain that a blood splash has occurred to intact skin there is no risk of infection. Ensure the area is cleaned and any soiled clothing removed appropriately. Complete a

PROCEDURE FOLLOWING AN INOCULATION INJURY AND/OR CONTACT WITH BLOOD/BODY FLUID

confidential incident report form (ORF 008). Record the implicated donation number for information. There is no requirement to contact a Specialist RN or a Consultant for advice or to collect a blood sample from the injured person.

1.2.2 If the blood splash has occurred to broken or damaged skin or exposed mucous membranes, there is a risk of infection. Wash the site liberally with soap and water. Exposed mucous membranes, including conjunctivae, should be irrigated copiously with water, before and after removing any contact lenses. Contact a Specialist RN or a Consultant for advice.

1.2.3 Inform your line manager of the incident.

Go to section 5 of this SOP

2. Known source where microbiology samples have not been taken. (eg FST)

2.1 For any incident where microbiology samples have not been taken, a PPT (Gel) sample for microbiology testing can be requested from the identifiable source individual with consent (ORF 15). It must be labelled with the injured person's first name, last name, D.O.B, first line of home address and the date the sample taken.

2.2 The sample and consent form must be taken to the Automated Testing Laboratory (as per point 5.5). Microbiology testing can be performed at the WBS in this instance.

2.3 If a donor sustains a contamination injury they must be deferred accordingly and advised of any microbiology results once available.

Go to section 5 of this SOP

3. Injury with a clean object

3.1 If it is certain that a sharps injury has been with a **clean** needle/object, ensure area is cleaned and a dry dressing is applied. Complete a confidential incident report form (ORF 008). There is no requirement to contact a Specialist RN or a Consultant for advice or to collect a blood sample from the injured person or to complete any other forms.

PROCEDURE FOLLOWING AN INOCULATION INJURY AND/OR CONTACT WITH BLOOD/BODY FLUID

4. Non Donor Source/Unknown Donor- information for managers/supervisors

4.1 If the inoculation injury is attributed to a source other than a donor e.g. from a patient blood sample in the laboratories, or from staff to staff sharps injury, then the microbiology status of the source will not be known and risk cannot be managed as per usual WBS processes.

4.2 Inform a Specialist RN (Ext 2301) who will notify a Consultant. The Line Manager will refer the injured person to Occupational Health, as per instruction in Trust Policy **IPC 06-**Policy for the Management of Occupational Exposure to Blood and High Risk Body Fluids (Needle stick Injury).

4.3 Velindre University NHS Trust has a Service Level Agreement with Cardiff & Vale Occupational Health Department.

4.4 A Consultant will decide on the urgency of the referral based on the risk assessment of the injury as instructed in the policy. All donors when assessed for suitability to donate are considered to be low risk before giving a sample or donation. Therefore, used needles/body fluids from these donors are deemed to be low risk of contamination.

If in doubt treat as a contaminated injury as follows:

5. All Contamination Injuries

5.1 The Line Manager must contact a Specialist RN, or if outside of normal working hours a WBS Consultant, so that the injured person can be given the appropriate advice.

5.2 The Specialist RN records details of the incident in excel file E:\MEDICAL\LOOKBACK NSI contamination LKB.

5.3 The line manager completes:

- Parts A & B of the Inoculation Injury and Blood/Body Fluid Contact Accidents Form (ORF 019)
- Consent Form for a PPT (Gel) Sample to be Taken (ORF 015)
- Sample Return Form for Sample Save (ORF 016)

PROCEDURE FOLLOWING AN INOCULATION INJURY AND/OR CONTACT WITH BLOOD/BODY FLUID

- Confidential Incident Form (ORF 008)

5.4 A PPT(Gel) blood sample must be taken prior to the end of the injured person's working day and must be labelled with:

- the injured person's first and last names
- D.O.B
- first line of home address
- date the sample was taken

5.5 Place the sample and completed Sample Return form (ORF 16) into a clear plastic bag which must be secured and labelled "FAO Head of Automated Testing". It must be taken to the Automated Testing laboratory immediately, if from within the centre, or on the next available pick-up if at a collection clinic. The person taking the sample should contact Automated Testing to inform them that a sample has been obtained (if possible).

5.6 The sample is sent back with the pink top microbiology samples, so it is not confused with the routine NAT samples.

5.7 The 'sample save' is stored but not tested. Should the sample require testing for any reason in the future appropriate consent must be obtained from the injured individual.

5.8 If the injury occurs outside of normal working hours, the sample and completed Sample Return Form (ORF 016) is to be placed in the fridge in the Automated Testing Laboratory and an email sent to Automated Testing advising them of the same.

5.9 A Specialist RN must notify the individual of the results of the microbiology markers, malaria test if taken and for platelet donors any information on component infectivity as soon as they are available. The Specialist RN then completes parts C, D & E of the Inoculation Injury and Blood/Body Fluid Contact Accidents form (ORF 019).

5.10 If the microbiology markers are negative no treatment is required.

PROCEDURE FOLLOWING AN INOCULATION INJURY AND/OR CONTACT WITH BLOOD/BODY FLUID

5.11 If any of the microbiology screening tests (HIV, HCV, HBV) are reactive a Consultant needs to apply the Velindre NHS Trust Needlestick Policy (IPC 06)

5.12 If treatment/prophylaxis or immunization is required staff must be referred urgently to-

South East;
Denbigh House
University Hospital Wales
Heath Park Way
Cardiff
CF14 4YU
Tel (02920) 743264

South West;
Glangwili General Hospital,
Dolgwili Road,
Carmarthen,
SA31 2AF
Tel (01267) 227429

Wrexham;
Wrexham Occupational Health Department
1 Bron Y Nant
Wrexham
LL13 7TD
(01978) 291100

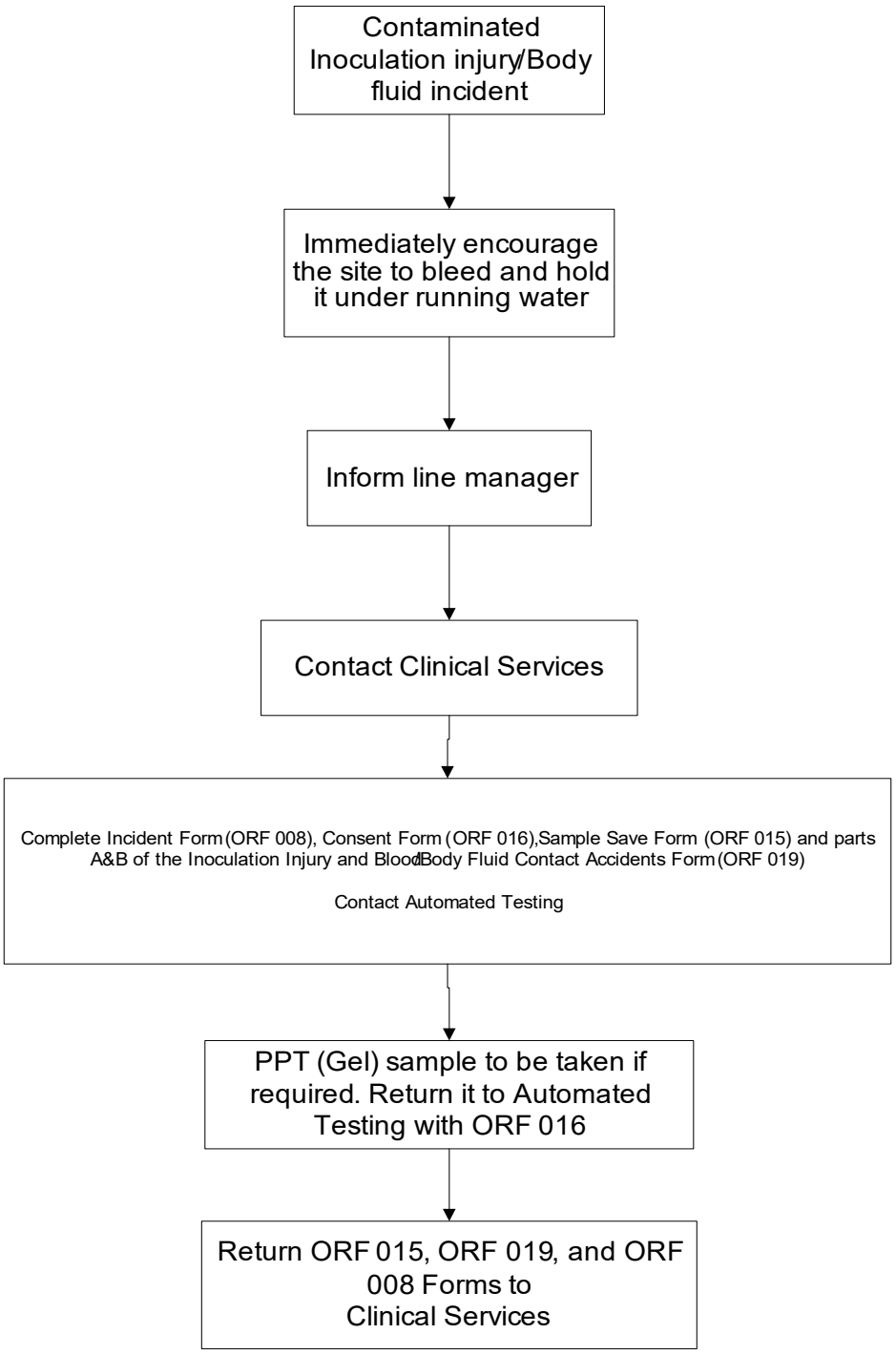
Bangor;
Occupational Health Department
Mountain View
Penrhos Road
Bangor
LL57 2NA
(01248) 384384

PROCEDURE FOLLOWING AN INOCULATION INJURY AND/OR CONTACT WITH BLOOD/BODY FLUID

ATTACHMENTS

Attachment 1 Flowchart of Procedure

Flowchart Outlining Procedure Following A Contamination Injury



Tîm Iechyd a Diogelwch PCGC
NWSSP Health & Safety Team

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Shared Services Partnership

NHS WALES
SHARED SERVICES PARTNERSHIP
(NWSSP)

Procedure for Sharps Injuries and Occupational Exposure to High Risk Body Fluid

As at June 2023

1 Introduction

NWSSP acknowledge the risk of injury from medical sharps as a health and safety and infection prevention and control issue. Sharps injuries may result in the exposure of staff, contractors, patients, donors, visitors or others to blood borne viruses (BBV) such as Hepatitis B and C and Human Immunodeficiency Virus (HIV) and/or exposure to chemicals in drugs.

2 Aim

This procedure outlines the actions to be taken following sharps incidents and other high risk contacts with high risk body fluids.

3 Objectives

To outline responsibility for the management of actions following a needle stick (sharps) injury and other high-risk contacts with high-risk body fluids including procedures to be followed and management of staff and others involved including the source patient where this can be identified.

To outline responsibilities for making a risk assessment of the source patient and obtaining permission to test for blood borne viruses where this is carried out.

4 Scope

This procedure applies to all NWSSP staff in all locations where they work. Staff employed under the Single Lead Employer Scheme are to follow the Sharps Policy within the organisation they are operating at the time.

5 Documents to read alongside this Procedure

- The Velindre NHS Trust Sharps Safety Policy

6 Definitions

Occupational Exposure for the purposes of this policy includes:

- Percutaneous injury from sharps (including needles, instruments, bone fragments, human bites which break the skin) which are contaminated with blood or other body fluid.
- Exposure of broken skin (abrasions, cuts, eczema etc.) to body fluids which may be of risk of causing infection.
- Exposure of mucus membranes including eye, nose and mouth to body fluids which may be of risk of causing infection.

Sharps are needles, blades (such as scalpels) and other medical instruments that are necessary for carrying out healthcare work and could cause an injury by cutting or pricking the skin.

Sharps injury is an incident, which causes a needle, blade (such as scalpel) or other medical instruments to penetrate the skin. Sometimes called a percutaneous injury. A puncture wound with a clean needle still constitutes a sharps injury.

Post- Exposure Prophylaxis (**PEP)** is the use of antiretroviral drugs after a single high-risk event to stop HIV seroconversion. PEP must be started as soon as possible to be effective—and always within 72 hours of a possible exposure.

Safer Sharps are sharps which incorporate features or mechanisms to prevent or minimise the risk of accidental injury.

High Risk Body Fluids – Blood, low risk fluid if bloodstained, amniotic fluid, breast milk, pericardial fluid, peritoneal fluid, pleural fluid, Cerebral Spinal Fluid, Saliva associated with dentistry, seamen, synovial fluid, unfixed organs or tissues, vaginal secretions.

Low Risk Body Fluids (unless blood-stained) - Urine, Vomit, Saliva, Faeces

7 Risks from Blood Bourne Viruses (BBV)

Hepatitis B Virus - For HBV there is effective vaccination, post exposure prophylaxis (PEP) with vaccine +/- immunoglobulin (HBIG) for those not vaccinated, and post exposure HBIG for HCW's who fail to respond to the vaccine.

Vaccinated persons who have developed immunity are at extremely low risk of infection. Unvaccinated persons have a risk from a single needlestick injury or cut exposure of 6-30% (depending on viral load) to HBV infected blood.

Hepatitis C Virus - There is no vaccine or Post Exposure Prophylaxis (PEP) available for staff but effective treatment is available for those exposed.

The risk of infection after a needlestick or cut exposure to HCV infected blood is approximately 1.8%. The risk following blood splashes is unknown.

HIV - For HIV there is no vaccine available but there is PEP but this requires immediate action.

The risk of HIV infection after needlestick or cut exposure to HIV infected blood is low at approximately 0.3%. The risk after exposure of the eye, nose or mouth is less than 0.1%. There is no risk of HIV transmission where intact skin is exposed to HIV infected blood.

8 Testing Source Patients

If it can be identified, it should be identified as part of the rapid investigation process, the NWSSP Manager will work with partner organisations to identify the source patient as quickly as possible.

Testing source patients for HBV, HCV and HIV is the most effective way of providing reassurance to those injured. The majority of patients will not be infected. A universal approach to asking source patient to agree to have BBV tests avoids the need to make difficult judgements and avoids any appearance of discrimination against people perceived as being in 'risk groups'. In practice, there has been some reluctance to seek patients' consent to be tested, yet patients have usually been found willing to co-operate if approached in a sensitive manner.

9 Responsibilities

Staff Responsibilities - Staff should take all reasonable precautions to avoid sharps injuries.

In the event of a needlestick or similar injury all staff should know:-

- What action to take.
- Who has responsibility to ensure proper assessment.
- Where to go for treatment of the injury and follow-up.
- How to report the incident so that future injuries are reduced or avoided.

The Injured Person must:-

- Report to the appropriate manager or speak to the on-call manager.
- Complete the Risk Assessment form 2 (Appendix 2) with the support of your manager and take to Occupational Health/ A&E/Emergency Unit.
- Complete an incident form on Datix Cymru.

Managers Responsibilities - The manager responsible for the injured person at the time of the injury must:-

- Ensure first aid has been carried out.
- Refer injured person to the appropriate Occupational Health provider or Emergency Unit/A&E if out of hours. Refer to appendix 3 for telephone numbers of occupational health providers for NHS Wales.
- If the source patient is identifiable then the details should be captured and, where possible, Form 2 should be completed. Managers should ensure that Form 2 is completed and sent with the injured worker in a sealed envelope.

The Health and Safety team should:-

- Where appropriate liaise with the organisation responsible for the care of the source patient.
- Ensure that Datix Cymru incident is completed.
- In conjunction with the manager, assist in the investigation of the cause of the injury and put in place any appropriate preventative measures to reduce likelihood of any further injuries.

Where incidents may occur in NWSSP, it is possible that the source patient is not identifiable. However, even where the source patient can be identified the injured member of staff must not be involved in the risk assessment of the source patient and must not approach the source patient for permission to test for blood borne viruses.

10 Procedure for needlestick and similar injuries

10a First Aid

First Aid should be performed immediately after the injury occurs.

<u>Skin/Tissue</u>

- Encourage local bleeding by gently squeezing, do not suck area.
- Wash the affected area with soap and running warm water. Do not scrub the area.
- Cover area with waterproof dressing.

Eyes or Mouth

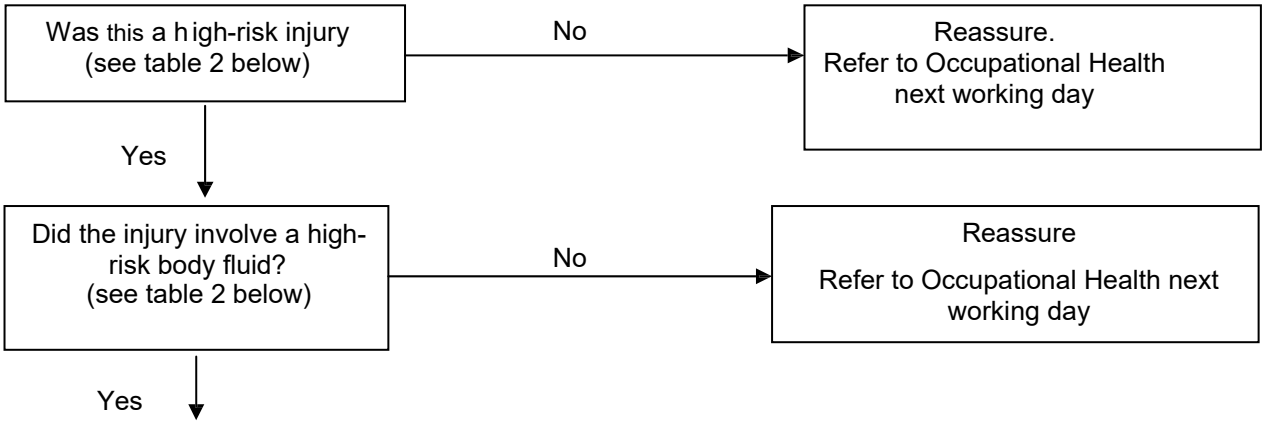
- Rinse out / irrigate with copious amounts of water (use eye washout kits if available).
- If wearing contact lenses irrigate eyes before and after removing them.
- Do not swallow water used for rinsing mouth.

10b Injury Assessment

Injury Assessment other than Human Bites (to be completed as far as possible within 30 minutes of the incident)

For an injury to be considered significant, both the type of injury incurred and the body fluid involved must be high risk.

Table 1: Flow diagram for injury risk assessment



Treat as Significant Injury.

Refer to: Occupational Health during working hours
OR Emergency Unit out of hours

Manager must establish risk status of source by completing forms 1 and 2 (Appendix 1+2) as appropriate and communicating outcome to Occupational Health/A&E Emergency Unit

Table 2: Injury Type

High-Risk Injury	**Low-Risk Injury**
Percutaneous exposure e.g. needlestick or other sharps injury Exposure on broken skin Mucous membrane exposure (e.g. eye)	Splash on intact skin.

Table 3: Body Fluids

High-Risk Body Fluid		Low Risk Body Fluid (unless blood-stained)
Blood Low risk fluid if bloodstained Amniotic fluid Breast milk Pericardial fluid Peritoneal fluid	Pleural fluid CSF Saliva associated with dentistry Semen Synovial fluid Unfixed tissues or organs Vaginal Secretions	Urine Vomit Saliva Faeces

10c Establishing risk status of source

The clinical team caring for the source patient are responsible for establishing the risk status of the source patient, even if the staff member has been referred to Occupational Health or the Emergency Unit.

The clinical manager for the area where the source of blood is located should:-

- Locate the source patient if possible.
- Arrange for a source patient risk assessment to be carried out **IMMEDIATELY** and for the source patient's informed consent to be sought for HBV, HCV and HIV testing ideally within 30 minutes of the incident occurring.

The source patient risk assessment should be carried out by an experienced health care professional e.g. senior nurse or doctor from the clinical team caring for the patient, not by Occupational Health or Emergency Unit. **The injured worker must not carry out the source patient risk assessment.**

Inform Occupational Health or out of hours Emergency Unit whether or not a source patient risk assessment has been arranged and provide them with contact details of the person carrying out the risk assessment.

Inform the Consultant responsible for the source patient if not already involved.

10d Known Source Patient - guidance on approach to risk assessment and permission to test

In the case of a known source patient, a risk assessment should be carried out and consent for testing sought. The situation must be handled sensitively. The patient must not be approached by the injured worker.

Case notes should be reviewed to establish if there is known infection with any BBV. If this is not clear from case notes then it will be necessary to seek information from the patient themselves.

There is no single approach that will cover every interview, but it is recommended that the following points be observed:

- The discussion should take place in a location where proper privacy can be maintained.
- The patient should be informed that someone has been injured in an accident involving their blood/other body fluid. Injuries of this kind can cause considerable anxiety and worry to employees because infections such as hepatitis B, hepatitis C and HIV can be transmitted in this way (see appendix 6).
- Patients should be asked if they would consent to answering some personal questions, which would help to address the concern. Emphasise that the questions are very personal and might very well not apply to them, but they are now asked routinely, for example, by the Blood Transfusion Service before accepting blood donations.
- If the patient agrees, ask them the questions detailed on Form 1 (Appendix 1).

If any of the answers to the questions on Form 1 is Yes then the patient should be considered as high risk for blood borne viral infections.

Permission to test for Hepatitis B, Hepatitis C and HIV

Unless there are reasons for not testing, all source patients should be asked if they would be willing to allow a sample of their blood to be taken for testing for HIV, HBV and HCV, as a negative result gives reassurance to the injured person.

Explain that testing is also in their interest as these diseases may be entirely asymptomatic, but have effective treatment if diagnosed and are best diagnosed at the earliest opportunity. It is important that undue pressure is not applied and that the decision lies entirely with the patient and this must be explained clearly to the patient. The outcome of the discussion should be recorded in the patient's notes.

Inform source patient that he/she will be notified of the result. Inform source patient that the test result will be passed to their medical team.

Patients may be concerned that consenting to an HIV test might adversely affect insurance policies. Patients can be advised that a negative HIV test will not affect their insurance premiums although a positive result may have implications. The great advances in treatment of HIV mean that early diagnosis facilitates the best outcome.

After testing, permission will be sought to communicate any positive result to the GP.

If the request raises serious anxiety, or if the source patient requests anonymous testing (where a code is used on the request form and sample rather than the patient name), then refer for specialist management to Infectious Diseases Department or Genitourinary Medicine Department.

Document the risk assessment outcome on Form 2 (Appendix 2), along with whether or not consent for blood testing has been obtained and samples sent. Send the completed Form 2 to Occupational Health or Emergency unit by giving the form the injured worker in a sealed envelope.

Record that an assessment has been carried out in the source patient's case notes, but do not record the assessment outcome.

Record the name and contact details of the person carrying out the assessment in source patient's case notes.

Destroy Form 1.

Where the patient declines any engagement with the risk assessment process, and a risk assessment cannot be carried out from patient notes, proceed as per "unknown source"

10e Sending samples once obtained

Specimens taken for storage and for blood borne virus testing should be sent to the Specialist Virology Centre, PHW Microbiology, University Hospital of Wales, Cardiff.

The preferred sample for both storage and source patient testing is a 9ml EDTA sample (2 purple cap vacuum tubes).

During working hours (i.e. Monday to Friday, between 9am – 5pm) the Specialist Virology Centre will test patients for blood borne viruses to establish that the exposed individual is not already HIV infected. Where possible, specimens should be sent during working hours. Contact details are listed in appendix 3. All positive HIV antibody tests will require confirmatory testing which will be carried out on the next working day.

If the sample is being sent out of hours (e.g during the weekend) the on call virology consultant should be contacted to discuss processing of the sample and its effect on immediate management. They may request that the virology laboratory technician is informed separately to inform them that a specimen is being sent and the agreed processing time.

Ensure that the specimen is labelled with the contact details of the person who should be telephoned with the results. Only positive or equivocal results will be telephoned. Negative results will be automatically authorised and available for review via the clinical portal.

Mark request form "copy to Occupational Health".

10f Managing results of source patient test

It is the responsibility of the person carrying out the source patient risk assessment to ensure the results of the source patient blood tests are telephoned to the doctor or nurse managing the injured person.

If the person carrying out the risk assessment is not going to be on duty when the results become available then the name of nominated deputy should be given to the laboratory. The nominated deputy must then take responsibility for passing the results on to the doctor or nurse managing the injured person.

The person carrying out the source patient risk assessment must ensure that the source patient is informed of their test results within 24 hours of them becoming available.

In the event of the source patient test results being positive, specialist advice should be sought from an infectious diseases consultant before the patient is informed.

10g Unknown source

If it is not possible to identify the source patient for a particular needle or sharp implement, a risk assessment should be carried out to determine the likelihood that the needle may have been used on a patient with a blood borne virus infection. Are there patients known to be infected with a BBV in the clinical area concerned?

If no further information is available background prevalence rates can be used in the risk calculation (appendix 4).

10h Testing when source patient is unable to give consent

When the source patient is deceased, unconscious or unable to give informed consent for any other reason, testing should not be carried out without first seeking further advice from the on call ID. However, if the source patient has died, consent for testing can be given by a "nominated representative" (if appointed) or by a person with a "qualifying relationship" to the deceased". The decision to start PEP should be taken by Occupational Health or the Emergency Unit on the basis of the source patient risk assessment.

10i Risk assessment and testing when source is a child

For children and their parents / guardians all the above considerations including privacy must be maintained. To establish the risk status of the child, the questions in the source patient assessment tool should be asked, not only regarding the child, but also the mother. If the child is deemed to have sufficient understanding, whatever his/her age, an appropriate explanation should be given, and consent sought from the child. If the child refuses, blood should not be taken or tested. If the child consents, consent should also be sought from the child's parents / guardian.

As the route of transmission to children is usually vertical (from mother to child), testing the child may be a surrogate for testing the mother, so she should be aware of this prior to testing. The reason for refusal of consent may be the distress of venepuncture. If this is the case, in young children with no history of foreign travel, blood transfusion or needlestick injury, the mother's blood may be tested instead of the child's.

10j Management of the injured person

This is carried out by Occupational Health / Emergency Unit.

Patients should be triaged and treated as a priority, within one hour if possible.

Ensure first aid has been carried out (see section 10a)

Confirm that a significant injury has occurred (see section 10b). If not a significant injury, the injured person can be reassured.

Check whether the source patient is known to have a blood borne virus or at high risk of infection with a BBV.

Check if source patient has given consent for testing and if so, when will the results be known. Arrange for results of source patient blood test to be phoned to a named doctor or nurse responsible for managing the injured person. If the source patient HIV antibody test is negative,

and PEP has been started, then the injured person must be contacted as soon as possible and advised to discontinue PEP.

Assess the need for HIV PEP, remember that therapy should be started as soon as possible following injury, ideally within one hour.

Assess the need for hepatitis B vaccination +/- hepatitis B immunoglobulin.
HCWs should know their vaccination status and whether they responded to HB vaccine (i.e. ever attained a level of >1OIU/L).

Consider the need for hepatitis C follow-up.

Offer to take blood for storage (all significant injuries). Explain that testing will be carried out only with consent. Request form should state type of injury and 'blood for storage'.

Ensure all appropriate follow-up is arranged:

Appointment with ID physicians if HIV PEP started.

Occupational Health (HCW) or GP (others) follow-up if further hepatitis B vaccination / testing or HCV screening is required.

Referral to counselling services including specialist services if required.

For all injuries in the workplace, advise the injured HCW to inform the Occupational Health Department at the earliest opportunity, regardless of outcome of the assessment.

Advise staff to report the incident on Datix Cymru.

10k Management of patients exposed to blood from a Health Care Worker (HCW)

Circumstances that could allow the transmission of blood borne viruses from HCW to patient include:

- Visible laceration occurring to a HCW's hand where the patient's open tissue or mucous membranes could be contaminated with the HCW's blood.

- Visible bleeding form a HCW from any other site, e.g. nosebleed, leading to significant bleed-back into a patient's open tissues or mucous membranes.

- An instrument or needle contaminated with the blood of the HCW is inadvertently introduced into the patient's tissues.

The injured worker should:

- Stop the procedure as soon as possible, wash and dress the wound and stem the bleeding.

- Clean and disinfect any contaminated areas.

- Report the incident to the manager.

- Inform the Occupational Health department (EU out of hours)

- Complete a Datix Cymru form

A risk assessment should then be carried out by someone other than the injured HCW, e.g. a senior doctor, to ascertain whether or not a significant exposure has occurred. If the incident is considered to be a significant exposure, involving bleed-back into the patient, a source HCW risk assessment should be carried out IMMEDIATELY using Forms 1 and 2 (Appendix 1 and 2) and the injured HCW should routinely be asked to consent to testing for HIV, HBV and HCV.

If the HCW tests positive for any blood borne virus, the patient should be notified of an intra-operative exposure without revealing which member of the clinical team is infected. Only in exceptional circumstances would a patient be given PEP for HIV in the absence of a positive blood test in the HCW (eg high risk of having been infected with HIV and refusal to undergo a test). National Guidance indicates that it is unnecessary to tell the patient if the HCW's tests are all negative.

A written record of the incident and test results should be entered in the HCW's occupational health notes.

11 Training

Mandatory infection prevention and control training updated every two years.

Further departmental based training as identified by training needs analysis.

12 Further Information and support:

- NWSSP Health and Safety Team - nwssp.safety@wales.nhs.uk
- Infection Prevention and Control Team – 02920615888 ext. 6129
- Specialist Virology Centre for Wales, NPHS Microbiology Cardiff
  Monday to Friday, 9am to 5pm: Tel: 02920 74 2178. Out of hours: Contact on call Microbiologist via UHW Switchboard: Tel: 02920 747747

13 Implementation

The document will be available on the NWSSP Health and Safety intranet site. Individual directorates will be responsible for the implementation of the protocol document in clinical areas.

Appendix 1

Source Patient Risk Assessment Form 1

CONFIDENTIAL **For use following needlestick injury or similar**	
Is source patient known to have hepatitis B	**Yes/No**
Is source patient known to have hepatitis C	**Yes/No**
Is source patient known to have HIV	**Yes/No**
If the answer to any of these is YES, the patient is considered "High risk". If all answers are NO, then ask the following in an area where confidentiality can be assured. (based on questions asked routinely of blood donors)	
For men – Has he ever had sex with a man	**Yes/No**
For women, have she ever had sex with a man who has had sex with a man	**Yes/No**
Have he/she ever paid for or sold sex	**Yes/No/Not known**
Has he/she had a blood transfusion in a country outside Western Europe, Australia, New Zealand, Canada or the USA	**Yes/No**
Has he/she ever injected drugs	**Yes/No**
Has he/she ever had sex with someone who has injected drugs	**Yes/No**
If source patient answers "yes" to any of above should be considered "high risk"	
On completion of risk assessment: • **Document outcome on Form 2** • **Forward part 2 to Emergency Unit or Occupational Health in sealed envelope to be carried by injured worker** **In patient case notes** • **Record assessment has been done but NOT outcome** • **Record your name, grade and contact details**	

• **Destroy this form**

Appendix 2 **Source Patient Risk Assessment Form 2**

If you think you need to complete the Source patient risk assessment form then contact the NWSSP Health and Safety corporate team

You should contact the nurse or doctor managing the injured person PROMPTLY with an initial verbal report with results of risk assessment and when and to whom any lab test results will be notified. This form can be taken to Emergency Unit or Occupational Health by the injured worker **in a sealed envelope**

To be completed by practitioner performing source patient risk assessment

Name of Injured Person_____Place where injury happened _____

Consultant/ GP responsible for source patient_____Date__

Source patient reference

I have scrutinised the case notes of the identified source patient	Yes/No
I have spoken to the medical team responsible for source patient	Yes/No
I have spoken to source patient and carried out risk assessment	Yes/No
Outcome of Risk assessment	
Has patient been diagnosed with a blood borne virus infection	Yes/No
Does patient have any possible syndrome suggesting acute HIV infection	Yes/No/Not known
Is patient HIGH RISK for BLOOD BORNE VIRUS infection	Yes/No
Has Occupation Health or Emergency Unit been informed of risk status of source patient	Yes/No
Source patient blood test	
Has consent be sought and granted for blood to be taken and tested	Yes/No
Has blood been taken	Yes/No
When will result be available	
Has injured staff member been informed of source risk assessment and /or lab result	Yes/No

To be completed by doctor or nurse managing injured person

Post _____ **Practitioner's name** **Page/contact no** _____		
Hepatitis B vaccine given	Yes/No	/ /200
HBIG given	Yes/No	/ /200
PEP for HIV started	Yes/No	/ /200
Has follow up been arranged	Yes/No	/ /200
Post _____ **Name**_____ **Page/contact no** _____		

Appendix 3

Occupational Health Contact Numbers NHS Wales

- Aneurin Bevan UHB – Telephone: St Woolos Hospital; 01633 238349 - Ysbyty Ystrad Fawr; 01443 802442
- Betsi Cadwaladr UHB – Telephone: 03000 853853
- Cardiff and Vale UHB – Telephone: 02920 74 2531
- Cwm Taf Morgannwg UHB – Telephone: 01443 443231
- Hywel Dda UHB – Telephone: 0300 3039674
- Nevill Hall Hospital; 01873 732849
- Powys THB – Telephone - 01874 712600
- Swansea Bay UHB – Telephone: 01792 703610

- WAST Occupational Health & Wellbeing Service number is 0300 123 9850 occupationalhealth.amb@wales.nhs.uk

---

Specialist Virology Centre for Wales, NPHS Microbiology Cardiff

- Monday to Friday, 9am to 5pm: Tel: 02920 74 2178.
- Out of hours: Contact on call Microbiologist via UHW Switchboard: Tel: 02920 747747

Appendix 4

Hospital Switchboard Contact Numbers NHS Wales

Hospital	Service Offered	Switchboard Contact Number
Bronglais Hospital	A&E	01970 623131
Glan Clwyd Hospital	A&E	01745 583910
Glangwili Hospital	A&E	01267 235151
Morriston Hospital	A&E	01792 702222
Nevil Hall Hospital	Minor Injury Unit	01873 723732
The Grange Hospital	A&E	01633 493100
Prince Charles Hospital	A&E	01685 721721
Princess of Wales Hospital	A&E	01656 752752
Royal Glamorgan Hospital	A&E	01443 443443
University Hospital of Wales	A&E	02920 747747
Withybush Hospital	A&E	01437 764545
Wrexham Maelor Hospital	A&E	01978 291100
Ysbyty Gwynedd	A&E	01248 384384

Appendix 5 - Risk that Source is HIV Positive

Community Group	HIV Seroprevalence	Risk
1. Known HIV Positive people	100%	High
2. Homosexual Men London/Manchester/Brighton	Up to 15%	High
Elsewhere in UK including Wales	Up to 5%	Medium
3. Heterosexuals Sub Saharan Africa	Up to 39%	High
Caribbean	Up to 6%	Medium
Latin America	< 2.7%	Medium
South & SE Asia	< 2.7%	Medium
N Africa & Middle East	< 2.6%	Medium
UK	< 1%	Low
W Europe	< 1%	Low
E Europe and Central Asia	< 1%	Low
N America	< 0.6%	Low
Australia and New Zealand	0.1%	Low
4. Intravenous Drug Users		
S Europe	>50%	High
London	4.7%	Medium
E Europe	Variable	Medium/High
Elsewhere in UK (Wales)	0.23%	Low

Appendix 6 Suggested form of Words for approaching Source Patient

"Unfortunately one of the members of staff has had an accidental injury where your blood *(or specify relevant body fluid)* has been "involved". I am here to ask if you would let me take a blood sample for testing for the viral infections, which can be transmitted to staff in this way. This is something that we ask for routinely whenever a patient's blood *(or specify relevant body fluid*) is involved in such an accident. We need your agreement to do this and would appreciate your help.

The purpose of the testing is to reassure staff where the results are negative. This may allow them to stop taking precautionary medication, which often causes unpleasant side effects. In the unlikely event that a test is positive you will receive specialist advice and management including treatment if required. The staff member may also be offered additional treatment.

The tests are for hepatitis B, hepatitis C and HIV. The test results should be available within a few days (but may take several weeks if extra investigations are required for clarification) and will normally be given to you by a member of the medical staff. The results are confidential, but they will appear in your health record and the affected staff member will also be informed.

Do you have any concerns? A common concern is whether having these tests done will affect any existing life insurance policies or future life insurance applications. The Association of British Insurers has issued guidance stating; "Existing life insurance policies will not be affected in any way by taking an HIV test, even if the result is positive." For new life insurance applications, companies should only enquire about positive test results, not whether a test has been performed. A positive test result may affect the outcome of a life insurance policy application. Do I have your permission to take a blood sample for hepatitis B, C and HIV testing? I should remind you that you can refuse to have some or all of these tests performed and that if you do choose not to be tested it will not affect your future care and regardless of the results from your recent blood tests your Trust consultant will contact you. If the results are positive a meeting will be arranged to explain them to you."

Taken from: Draft "Policy for the Prevention and Control of Blood Borne Viruses" 2010 NHS Plus

Appendix 7 – Definitions and Acronyms

BLOOD BORNE VIRUS	Blood Borne Viruses referred to in this policy include Hepatitis B, Hepatitis C and Human Immunodeficiency Virus
Donor	Person who is the origin of blood or body fluid. The preferred term is 'source.'
EU	Emergency Unit (also known as A&E)
EPP	Exposure Prone Procedure
HBIG	Hepatitis B immunoglobulin
HBsAb	Hepatitis B surface antibody
HBsAg	Hepatitis B surface antigen
HBV	Hepatitis B Virus
HCV	Hepatitis C virus
HCW	Health Care Worker
HIV	Human Immunodeficiency virus
Inoculation incident	consists of exposure to blood or other body fluids involving: • Broken skin – such as abrasions, fresh cuts, eczema • Percutaneous exposure - when contaminated material penetrates the skin e.g. needlestick injury, bites • Mucocutaneous exposure- exposure of blood or other body fluids to the lining of eyes, nose or mouth
PEP	Post Exposure Prophylaxis against HIV which is given following exposure in cases considered high risk for possible HIV exposure
Recipient	Person who was exposed to the body fluid
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995
Sharps	Are objects with sharp edges such as suture needles, hollow needles, scalpels, blades lancets, surgical instruments, broken ampoules, bone, teeth or equipment used in dentistry e.g. burr which carry the risk of transmission of blood borne viruses.
Source	Person who is the origin of blood or body fluid. Also known as 'donor.'
Victim	Person who was exposed to the body fluid. The preferred term is 'recipient.'

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

REVISED TRUST HANDLING CONCERNS POLICY

DATE OF MEETING	14th September 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	ENDORSE FOR APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Zoe Gibson, Interim Corporate Head of Quality, Safety and Assurance
PRESENTED BY	Zoe Gibson, Interim Corporate Head of Quality, Safety and Assurance
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences

EXECUTIVE SUMMARY	To ensure the Trust discharges its responsibilities regarding concerns handling the Trust Handling Concerns Policy (Complaints, Claims, Patient Safety Incidents and Duty of Candour) QS03 has been reviewed and updated to ensure alignment with: • The Health and Social Care (Quality and Engagement) (Wales) (2020) (Duty of Quality and Duty of Candour). • National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations ('the Regulations) (2011). • The Putting Things Right Guidance (PTR) (2023). • Public Service Ombudsman for Wales Act (2019). • Duty of Candour Procedure (Wales) (2023).

	• NHS Wales National Policy on Patient Safety Incident Reporting & Management (2023).
RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee are asked to **ENDORSE** the revised Trust Handling Concerns Policy (QS03) for onward Board approval.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Integrated Quality and Safety Group	25th July 2023.
Executive Management Board	31st July 2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Policy endorsed for onward approval at both Integrated Quality and Safety Group and Executive Management Board.	

7 LEVELS OF ASSURANCE	
Report for Approval	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	**Select Current Level of Assurance** Not required

APPENDICES	
1.	Revised Trust Handling Concerns Policy

1. SITUATION / BACKGROUND

The Trust Handling Concerns Policy has been revised to include the requirements of:

- The Health and Social Care (Quality and Engagement) (Wales) (2020) (Duty of Quality and Duty of Candour).
- Revised national Putting Things Right Guidance (PTR) (2023).
- Duty of Candour Procedure (Wales) (2023).
- NHS Wales National Policy on Patient Safety Incident Reporting & Management (2023).

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The revised Handling Concerns Policy is attached in ***Appendix 1***. This policy has been extensively reviewed and amended to ensure alignment with the legislative requirements of the Health and Social Care (Quality and Engagement) (Wales) (2020) Act, the requirements of the Duty of Candour procedures (2023) and updated Putting Things Right Guidance (2023).

3. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety, and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development, and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	All 6 domains of quality are positively impacted by this policy.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
	Not applicable
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	Click or tap here to enter text
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	There are financial requirements in respect of executing responsibilities within this policy relating to NHS redress procedures.

EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not yet completed - Include further detail below why
	Click or tap here to enter text. For expediency the equality impact assessment is currently being undertaken, report submitted prior to completion to prevent delay in approval and implementation.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Click or tap here to enter text
	This policy ensures Trust compliance with legal responsibilities relating to handling of concerns

Ref QS03

Handling Concerns Policy (Complaints, Claims, Patient Safety Incidents and Duty of Candour)

Executive Sponsor & Function:	Executive Director Nursing, Allied Health Professionals and Health Science
Document Author:	Corporate Head of Quality, Safety and Assurance
Approved by:	
Approval Date:	
Date of Equality Impact Assessment:	
Equality Impact Assessment Outcome:	
Review Date:	
Version:	5

TABLE OF CONTENTS

1. Executive Summary

This policy has been developed to ensure that Velindre University NHS Trust (the Trust) discharges its statutory responsibilities for the robust, effective, and timely handling of concerns (complaints, claims, and patient safety incidents) through ensuring organisation wide learning and continuous improvement, in line with the requirements set out within:

- The Health and Social Care (Quality and Engagement) (Wales) (2020) (Duty of Quality and Duty of Candour).
- National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations ('the Regulations) (2011).
- The Putting Things Right Guidance (PTR) (2023).
- Public Service Ombudsman for Wales Act (2019).
- Duty of Candour Procedure (Wales) (2023).
- NHS Wales National Policy on Patient Safety Incident Reporting & Management (2023).

2. Policy Statement

The Trust fully acknowledges that, as a provider of specialist and complex healthcare services, there will be occasions where things will go wrong.

When such occasions occur the Trust will ensure a robust response that is in line with the key principles and statutory requirements of Health and Social Care Quality and Engagement (Wales) Act (2020), the Duty of Quality (2020), the Duty of Candour (2022) and National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations ('the Regulations) (2011), to ensure an open and transparent concerns handling, with and a strong focus upon learning and continuous improvement, required to ensure the provision of safe, timely, effective, efficient, equitable and person centred care.

2.1 Policy Key Principles

A culture of psychological safety, openness, and transparency.	**Robust & proportionate Investigations.**	**Local procedures will be in place to support delivery in line with the requirements of National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations (2011). Putting Things Right Guidance.**
Staff will be equipped with role appropriate concerns handling knowledge and information.	**Individuals raising concerns will be engaged in the handling process.**	**Staff involved in a concern will be able and encouraged to access support.**
Consistent concern management and reporting Systems in place across the Trust.	**Continuous improvement through learning.**	**A bi-lingual service will be provided through an active Welsh Language offer.**
Learning will be shared across the Trust.	**Early resolution of concerns will be promoted, and unnecessary escalation avoided.**	**Concerns will be managed in a timely manner in line with Putting Things Right Regulations.**

3. Scope of Policy

This policy applies to all people engaged in work for the Trust and host organisations, including those employed on a contract of employment and those working on a bank or agency contract

There is an acknowledgement that the Putting Things Right Regulations and Duty of Candour may not apply in their entirety to some hosted organisations, however, the principles and requirements of the Regulations should be adopted where appropriate as good practice.

The Policy relates to concerns regarding:

- Services, care, and treatment provided by the Trust.
- Services provided by the Trust's employed staff.
- Services provided by independent contractors.
- Services provided by independent or voluntary sector(s) funded by the Trust.

This policy ***does not*** apply to concerns relating to:

- Clinical services provided privately, even when provided within Trust premises.
- Staff contract of employment, e.g., concerns raised though the Respect and Resolution Policy or The Procedure for NHS Staff to Raise Concerns (whistleblowing).
- Public Services Ombudsman investigations.
- Alleged failure of the Trust to comply with a request for information under the Freedom of Information Act (2000).
- Trust disciplinary proceedings arising from the investigation of a concern.
- Civil Proceedings.
- Individual Patient Funding Request (IPFR).
- Police criminal investigations.

If a concern raised is excluded from the scope of Putting Things Right Regulations (PTR) the Trust will advise the complainant, in writing as soon as reasonably practicable of the reason(s) for the decision. If any excluded matter forms part of a wider concern, the issues within scope of the Putting Things Right Regulations can be managed under this policy.

4. Aims & Objectives

The Trust is committed to dealing with concerns in a timely, open, honest, transparent, accessible, and equitable manner, with a strong focus upon ensuring that organisational learning and continuous improvement takes place, in accordance with the NHS Wales Duty of Candour.

The aim of this Policy is to:

- Ensure the Trust has robust arrangements in place for the effective handling and monitoring of concerns.
- Provide assurance to the Board and external bodies of the commitment to implement the requirements of the regulations National, the Health and Social Care Quality and Engagement (Wales) Act 2020 and Duty of Candour Procedure (2023).
- Define concern handling roles, responsibilities, and processes.

5. Definitions

Adverse event/incident	An event which causes or has the potential to cause unexpected or unwanted effect involving the safety of the patients, users, or other persons.
Claim	Allegations of negligence and/or demand for compensation made following an untoward incident resulting in clinical negligence or personal injury to a member of staff, patient, member of the public or damage to property.
Complainant	A person notifying the concern/complaint.
Complaint	Any expression of dissatisfaction.
Concern	Any complaint, claim or reported patient/ donor incident to be handled under the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.
Duty of Candour	A requirement to ensure healthcare providers are open and transparent with people who use services when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.
Duty of Quality	A legal responsibility for Welsh Ministers and NHS bodies secure improvements in the quality of services they provide, supporting the achievement of ever higher standards of person-centered care services in Wales.
Early Resolution	Concerns that could potentially be resolved to the complainant's satisfaction either immediately or within 2 working of receipt.
External body / Agency	An organisation that has an official advisory or regulatory role that has been mandated to regulate the corporate and professional activities of NHS Trusts.
Investigation	A formal approach of gathering information in a systematic and methodical way.
Nationally Reportable Incident	A patient or donor safety incident which caused or contributed to the unexpected or avoidable death, or severe harm, of one or more patients, staff, or members of the public, during NHS funded healthcare.
Never Event	Serious Incidents that are wholly preventable because guidance or safety recommendations are available at a national level and should have been implemented by all healthcare providers.
Near Miss	An occurrence, which but for the luck or skilful management would in all probability have become an incident.

Qualifying Liability	A liability in tort owed in respect of, or consequent upon, personal injury or loss arising out of or in connection with breach of duty of care owed to any person in connection with the diagnosis of illness, or in the care or treatment of any patient/ donor/ service user in consequence of any act or omission by a health care professional and which arises in connection with the provision of qualifying services.
Redress	The making of an offer of compensation in satisfaction of any right to bring civil proceedings in respect of a qualifying liability in tort; the giving of an explanation; the making of a written apology and the giving of a report on the action that has been, or will be, taken to prevent similar occurrence
Root Cause Analysis	A process for identifying the basic or causal factor(s) that underlies variation in performance, including the occurrence or possible occurrence of a sentinel event.

---

6. Roles and Responsibilities

In line with the Regulations the roles and responsibilities for Concern Handling at VUNHST are:

6.1 Chief Executive Officer

The Trust Chief Executive Officer has overall responsibility for dealing with concerns and ensuring investigations are undertaken in an appropriate manner, within appropriate timescales and that lessons learned are implemented within the Trust.

6.2 Responsible Officer

The Responsible Officer is accountable for the effective day to day operation of the Trust's arrangements for dealing with concerns in an integrated manner. The Director of Nursing, Allied Health Professionals and Health Science is the Responsible Officer for the Trust and ensures arrangements are in place to:

- Deal with concerns in line with the Regulations.
- Ensure a Duty of Candour is applied where appropriate.
- Allow for the consideration of qualifying liabilities; and
- For incidents, complaints and claims to be dealt with under a single governance arrangement.

6.3 Strategic Oversight

A nominated Independent Member is responsible for maintaining a strategic overview of the Putting Things Right arrangements and the Duty of Candour and their operation, including:

- Overseeing how organisational arrangements are operating at a local level.
- Ensuring that concerns are dealt with in compliance with the regulations.
- Ensuring the Duty of Candour is triggered where relevant.
- Ensuring arrangements are in place to review the outcome of all investigated concerns to ensure that any failure in provision of service identified during the investigation are acted

upon, learnt from, and monitored to prevent recurrence. The nominated Independent Member is the individual with responsibility for the Quality, Safety & Performance Committee.

6.4 Corporate Quality and Safety Team

The Corporate Quality & Safety team is responsible for ensuring the Trust has appropriate policies, procedures, support, and training in place for the management of Concerns across the organisation through.

- Receipting and grading PTR Concerns and providing acknowledgement letters within required timescales.
- Developing Concerns / Putting Things Right/ Duty of Candour related policies and procedures.
- Providing/sourcing concerns handling, investigation and Datix Cymru training to ensure staff across the organisation are equipped with the knowledge and skills to undertake their role in concerns handling and investigation.
- Overseeing appropriate divisional investigative processes and adherence with national timescales
- Leading on 'Serious Harm' investigations
- Leading on all Public Services Ombudsman Reviews / investigations
- Leading on all Redress processes
- Leading on all Duty of Candour reporting
- Leading on Vexatious Concerns Management
- Auditing compliance with Putting Things Right and Duty of Candour
- Oversight of learning and dissemination of learning
- Development of Concern reports for Executive Management Board, Quality, Safety & Performance Committee and Trust Integrated Quality and Safety Group
- Development and Publishing Trust Annual Concern Report
- Leading on liaison and meeting requirements of other external bodies such as: Coroner's Office; Shared Services – Legal and Risk, Police; and Citizen Voice Body for Health and Social Care, Wales
- Representing the Trust at National Concern related meetings.

6.5 Executive Management Board

The Executive Management Board is responsible for overseeing the Trust's Concerns Management process and outcomes, including policies, procedures, and reporting in line with legislative and national requirements; training provision and compliance; identification of and compliance with key performance indicators; meaningful analysis; investigative processes; audit and operational assurance mechanisms; ensuring that remedial action is taken; Duty of Candour mechanisms are in place; and appropriate lessons are identified and shared.

6.6 Quality Safety and Performance Committee

The Quality, Safety and Performance Committee provide assurance reports to the Executive Management Board detailing how the Trust is meeting its responsibilities under the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations ('the Regulations) (2011) and Duty of Candour Procedure (Wales) (2023), whilst highlighting any exceptions, risks, or potential risks in respect of this.

The Quality Safety and Performance Committee is responsible, on behalf of the Trust Board, for the scrutiny, receipt of assurance and / or exceptions relating to its handling of concerns and Duty of Candour legislative functions. This includes ensuring the provision of appropriate policies, procedures, and reports in line with legislative and national requirements; training. Identification of and compliance with key performance indicators; meaningful analysis. investigative processes; audit and operational assurance mechanisms; ensuring that all remedial action is taken; and appropriate learning is identified, addressed, and shared.

6.7 Corporate Head of Quality, Safety and Assurance

The Head of Quality, Safety and Assurance is responsible as the Senior Investigations Manager (SIM) for the Trust in line with the requirements of the PTR regulations, and is responsible for:

- Oversight of the handling and consideration of concerns in accordance with this policy.
- Auditing Trust and Divisional concern handling arrangements.
- Ensuring robust interface arrangements with the Divisions are in place to ensure effective divisional concern handling processes and outcomes.
- Development, integration and embedment of a comprehensive concern investigation and redress systems.
- Embedment of robust Duty of Candour processes and procedures.
- Providing assurance to the Executive Management Board (EMB) and Quality, Safety and Performance Committee on the Trust concern management performance.
- Ensuring mechanisms are in place for learning, and continuous improvement initiatives to be shared across the Trust.

6.8 Service Directors (including hosted Organisations)

(Corporate / Divisional Directors, Clinical Directors, Medical Directors, Chief Scientific Officers, and Heads of Nursing.)

Service Directors are responsible for achieving compliance with the Regulations, the Duty of Candour, and this policy through ensuring:

- The provision of robust local concern handling arrangements across all provided and commissioned services.
- Concerns are managed within required timescales and performance measures.
- Datix Cymru is the primary repository for all concerns and associated documentation
- All investigations are fully and accurately recorded and stored in Datix Cymru.
- A culture of openness, transparency, psychological safety, learning, improvement is promoted, encouraged, and embedded into practice.
- Employees receive role appropriate concerns handling training
- Employees understand their individual roles and responsibilities in concerns handling.
- Cross-divisional and Trust wide approach to concern handling, communication, co-ordination, liaison, and reporting.
- Adequate and appropriate support is available and offered to employees who are involved in, or are the subject of a concern
- Availability and release of employees trained in investigations analysis to support required investigations.
- All identified learning is addressed and shared to enable continuous improvement to prevent re-occurrence of issues arising and optimise quality and safety of service provision.

6.9 Departmental Managers

All managers across the Trust are responsible for ensuring:

- Employees and volunteers are aware of this policy and their roles and responsibilities within it.
- A culture of openness, transparency, psychological safety, empowerment, learning, improvement, and timely concerns handling is promoted, encouraged, and sustained in practice.
- Processes are in place to ensure effective management of concerns and discharge responsibilities in line with Putting Things Right Guidance and Duty of Candour Procedure.
- Ensuring all concerns and associated communications and documentation are recorded at time of report and stored within Datix Cymru system.
- Provision of robust and timely feedback of concern outcomes, lessons learnt and improvement opportunities with colleagues.
- Employees are provided with role specific training for both concerns handling and operation of Datix Cymru system.
- Display and provision of relevant patient/ donor concern reporting information and sign posting within clinical areas e.g. 'How to raise a concern' and Llais (Citizen Voice Body for Health and Social Care).
- All identified lessons learnt, and improvement actions are addressed, implemented, or escalated as appropriate.

6.10 Putting Things Right Panel

The Trust Putting Things Right panel are responsible for the consideration and progress of Regulation 26 concerns where a breach in the duty of care has been identified. Responsibilities identified include:

- Determination and or validation of whether a breach of duty has occurred.
- Determination of whether the breach of duty described has caused harm.
- Consideration of engaging an independent clinical expert if a decision on breach of duty cannot be reached.
- Consideration of engaging of an independent clinical expert in collaboration with the person raising the concern where causation is in question or further clarity as to the degree of harm is required.
- Agreement of communication pathways to communicate the decision of the panel to both the person raising the concern and staff affected by the concern.
- Agreement of award of financial compensation in cases where a Redress remedy applies.
- Ensuring robust systems to capture and record decision making processes and outcomes.

6.11 Responsibility of all Staff

All staff must ensure:

- Adherence to this policy, divisional/ departmental concerns, and Duty of Candour procedures.
- All individuals notifying/reporting concerns are treated with honesty, transparency, respect, and courtesy.
- All concerns are treated confidentially.
- Understanding of their individual role and responsibilities for reporting, handling and

escalating concerns, incidents, and near misses.
- Awareness of available supportive resources.
- Co-operation and engagement in investigation processes.
- All concerns are addressed or escalated at time of report.
- Role specific concern management and Datix Cymru training and education is undertaken.
- Report all near misses, safety incidents and concerns in line with divisional and departmental processes.

7. Duty of Candour

The Trust will adhere to the legal requirements and discharged its responsibilities in line with the Health and Social Care (Quality and Engagement) (Wales) Act (2020) and Duty of Candour Procedure (Wales) (2023).

7.1 When does the Duty of Candour apply?

For the Duty of Candour to be triggered the following two conditions must be met:

- **A service user experienced, or may have experienced, unintended, or unexpected harm (physical or psychological harm or in the case of an individual that is pregnant, loss or harm to the unborn child) that is "more than minimal." Although there is no legal definition of minimal harm, in practice this relates to moderate harm or above:**

  ''Moderate Harm: A service user experiences a moderate increase in treatment and significant but not permanent harm, e.g., being given medication, that they have a known allergy to, and this leads to a significant reaction requiring 4 or > days in hospital before recovery.'

  'Severe Harm: A service user experiences a permanent disability or loss of function e.g., being given medication, that they have a known allergy to, and this leads to brain damage or other permanent organ damage.'

  'Death: A service user dies e.g., being given medication, they have a known allergy to, and this leads to their death.'

- **The provision of healthcare "was" or "may have been" a factor in the patient or donor suffering that outcome.**

To ensure appropriate consideration of the Duty of Candour requirements the Trust will consider each event upon an individual basis and determine whether a 'notifiable adverse outcome' has occurred, and the Duty triggered.

7.2 Requirements of Duty of Candour

- The trust is legally required to adhere to the conditions of the Duty of Candour and will therefore ensure that Duty of Candour Procedure (Wales) 2023 is followed.

7.3 Duty of Candour Procedure

- To ensure the Trust fulfils its legal obligations it will ensure the following robust process is in place:

7.3.1 Stage 1 – Rapid Review- Identification of a 'Notifiable Adverse Outcome'

Incidents or Concerns graded at moderate harm or higher will receive a rapid review that is undertaken within 48 hours of report to determine whether a notifiable adverse outcome has occurred, and the Duty of Candour triggered. All rapid reviews will be recorded in the Datix Cymru system in line with Trust Incident Reporting policy and processes.

7.3.2 Stage 2 – 'In Person Notification'

The Trust will ensure that the 'In Person Notification is undertaken in line with the Duty of Candour procedure (2023), by a suitably trained and skilled individual, either in person, via telephone or audio visually, and completed at the time the Trust first become aware the Duty of Candour procedure has been triggered.

The in-person notification will consistently include:

- A meaningful apology
- An explanation of the actions and further enquiries that the Trust will undertake to investigate the circumstances of the notifiable adverse outcome
- Details of the nominated point of contact,
- An offer of support and details of any appropriate support information
- If the in-person notification is made later than 30 working days after the Trust first became aware of the notifiable adverse outcome an explanation for delay should be included.

7.3.3 Stage 3 - Written Communication

The Trust will ensure a formal letter is issued by the Service Director or nominated deputy to the service user/ person acting on their behalf within five working days of the "in-person" notification.

The formal letter will include:

- Reiteration of the verbal apology
- Date of notification
- An account of the incident to date and explanation of the actions that the organisation will take as part of the procedure and the investigation
- Point of Contact details
- Details of available support
- If "in-person" notification was later than 30 days after the date on which the incident occurred, an explanation of the reason for the delay is required.

7.3.4 Stage 4 - The Review/Investigation

The division in collaboration with the service user or person acting on their behalf will conduct an open, transparent, and proportionate investigation of the incident in accordance with the Regulations and Duty of Candour procedure (2023). Once complete the investigation outcome will be

communicated to the service user or their representative in accordance with regulation 24 or regulation 26 and 31, where the Redress arrangements apply.

7.4 Record Keeping

The Trust will ensure that all correspondence, decisions made, actions and relevant documents are kept in accordance with the Duty Candour Procedure within Datix Cymru. Documentation should include but is not limited to:

- Outcomes of Rapid Review to establish whether the duty has been triggered.
- Notification of the Duty.
- Attempts to contact the service user/person acting on their behalf.
- Any decision by the service user/person acting on their behalf not to be contacted in relation to the Duty of Candour
- Investigation of the notifiable adverse outcome, which is undertaken by the Trust, including the response or interim report issued under regulations 24, 26 or 31 of the 2011 Regulations.

7.5 Consent

The Trust will ensure that relevant consent procedures are followed in line with the Putting Things Right guidance and Duty of Candour procedure. In cases where a representative is acting on behalf of a service user with capacity, consent for the representative to act will be obtained from the service user and will be kept under review throughout the process.

In situations where the service user/person acting on their behalf indicate that they do not wish to engage or communicate with the Trust, the individuals wishes should be respected, but investigation of the incident must continue so that lessons can be learned, and quality improvements made.

7.6 Serious Case Reviews

In the event of adverse outcomes effecting large numbers of patients/ donors are identified following retrospective serious case reviews, or following a decision made by the medical examiner service or a coroner's inquest, where the cause of death attributed was not known at the time of the incident, the Trust will ensure Duty of Candour Procedures are followed for all affected individuals.

7.7 Incidents that occurred before 1st April 2023

The Duty of Candour is not intended to operate in respect of adverse outcomes which occurred before the 1st of April 2023.

7.8 Reporting to External Bodies

The Trust will fulfil its external reporting responsibilities in line with the requirements of the Health and Social Care (Quality and Engagement) (Wales) (2020) ((Duty of Quality and Duty of Candour), National Serious Incident reporting procedure, regulators, Medical Examiner Service, His Majesty's Coroner and Welsh Government.

7.9 When more than one NHS organisation is involved in the Duty of Candour Procedure

In situations where the Trust is part of an episode of care with other NHS Organisation(s) in which the Duty of Candour is triggered, the Trust will fulfil its responsibilities in line with the Duty of Candour procedures (Wales) (2023).

8. Concerns Management

8.1 Early Resolution Concerns

The Trust will manage Early Resolution Concerns in line with The Putting Things Right Guidance, ensuring resolution achieved to the satisfaction of the complainant within 2 working days from receipt. In circumstances where resolution has not been achieved within this period, but the complainant does not wish to raise a formal concern, the Trust will aim to resolve the concern(s) within 5 working days from receipt. If following this time, the concern remains unresolved, the concern(s) will be managed in line with the regulations as a formal concern.

8.2 Concerns Notified by a Third Party

The Trust will ensure that concerns notified by a third party acting as a representative on behalf of another are handled in line with the Regulations ensuring a best interest assessment is completed and proportionate response considered.

8.3 Concerns Received from Assembly Members/Members of Parliament

The Trust will ensure that concerns received from the Welsh Government, an Assembly Member, Member of Parliament, or other elected members on behalf of their constituent, are dealt with as soon as possible and a response provided at the earliest opportunity. For the sharing of personal data, the Trust will adhere to the requirements of The Data Protection (Processing of Sensitive Personal Data) (Elected Representatives) Order (2002).

8.4 Concerns Relating to Children and Young People

Where a concern is notified by a child or young person, the Trust will ensure it meets its support, assistance, and advocacy responsibilities in line with the Welsh Government's 'Model for Delivering Advocacy Services to Children and Young People in Wales.'
In the event of concerns being received on behalf of a child or young person the Trust will determine whether the child or young person wishes to raise a concern themselves, or if they are happy for the person who raised the concern to represent them. In cases where the child or young person is not willing to allow the concern to be investigated, the Trust will assess the individual situation and where appropriate seek specialist advice to support decision making. In any circumstance where safeguarding issues are identified the Trust will evoke the Wales Safeguarding procedures.

8.5 Concerns Raised by Prisoners

The Trust will handle and investigate concerns raised by prisoners in the same manner as all concerns, in accordance with the Regulations and with the offer and right of access to advocacy services provided by Llais, Social Care or mental health services as appropriate.

8.6 Concerns raised by Individuals Lacking Capacity or Vulnerable Adults

The Trust will ensure that all concerns raised by individuals lacking capacity or vulnerable adults and handled in an equitable and accessible manner with reasonable adjustments and enhanced support and advocacy services provided as required.

In circumstances where concerns regarding mental capacity are raised the Trust will ensure all assessments align with the requirements of Mental Capacity Act (2005). During this process, if any safeguarding and public protection issues are identified the Trust will evoke the All-Wales Safeguarding Procedures.

8.7 Concerns raised through Advocacy Services

The Trust will work in collaboration with Advocacy services and ensure that concerns raised on behalf of patients/ donors are managed in line with the Regulations.

8.8 Concerns from Solicitors / Intention to Litigate / Requests for Compensation

The Trust will ensure that concerns, litigation intents and compensation requests are managed by the Corporate Quality and Safety Team, in accordance with the governance and framework of the regulations, with exception of a concern in respect of which court proceedings have already been issued, including the pre-action stage of those proceedings which should not be further investigated.

8.9 Concerns from People with a Disability

In line with the Equality Act (2010), the Trust will make reasonable adjustments to ensure that the concerns process is accessible, and reasonable adjustments provided for service users who have a disability.

8.10 Concerns and British Sign Language (BSL)

The Trust recognises BSL as a recognised language and will ensure the concerns process is accessible to service users who communicate through BSL through the provision of services and reasonable adjustments as appropriate.

8.11 Concerns from Blind and Partially Sighted Individuals

The Trust will ensure that it has in place alternative methods for communication, including access to Braille and large print versions to support and enable concerns to be raised by individuals who are blind or partially sighted.

8.12 Concerns involving Contracted Services

The Trust will ensure that all contracted services are aware of and understand this policy, its application in practice, and their role and responsibilities in concerns management and adherence with the Regulations.

9. Welsh Language

When dealing with concerns the Trust will take account of its statutory duties in relation to the provision of services in Welsh and will ensure compliance with the duties set under the Welsh Language (Wales) measure (2011) and Welsh Language Standards. All concerns received in Welsh will be responded to in Welsh under the regulations and the Trust will ensure:

- All written communication is provided in Welsh.
- Welsh interpretation for telephone or face-to-face meetings.
- Provision of bilingual information resources.
- Adopt a proactive approach to language choice and need in Wales.
- Ensure Welsh Language Needs are met.

10. Reporting Concerns

In line with the Regulations, the Trust has a single point of contact for raising a concern:

Executive Director Nursing AHP's & Health Science Velindre Trust Head Quarters
2 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Email: handlingconcernsvelindre@wales.nhs.uk

Telephone: 029 20196161

10.1 Management and Investigation of Concerns

The Trust will ensure that concerns are managed and investigated in the most relevant, proportionate, efficient, and effective way in line with the Regulations, Duty of Candour Procedure, this policy, and local procedures.

10.2 Acknowledging PTR Concerns

The Trust will ensure that all concerns managed under the Regulations and Duty of Candour Procedure with acknowledgement being issued in writing within 5 working days of receipt and will include:

- Point of Contact details
- An offer of a meeting or discussion to review and discuss their concern and the concerns process.
- The opportunity to meet with relevant staff involved in relation to the concern/s raised.
- Response timescales.
- Details of advocacy and support services.
- Information advising that a patient's clinical records will need to be accessed as part of the investigation.
- A copy of the Putting Things Right leaflet.

10.3 Formal Response Timescales limit

The Trust will provide a full and comprehensive response/interim report within 30 working days from the date the concern is received, if the Trust is unable to comply with this standard, the Trust will:

(a) notify the service user, outline the reason for the delay, and advise when the response will be available; and
(b) send the comprehensive response/interim report as soon as reasonably practicable and within 6 months, or 12 months for concerns being handled under Regulation 33 of the Regulations.

10.4 Concerns Received from Medical Examiners

The Trust will ensure robust corporate procedures are in place to receive and respond to concerns received from the Medical Examiner's office.

10.5 Concerns Referred to Coroner's Inquest

The Trust will ensure that robust procedures are in place to investigate concerns referred to HM Coroners Service in line with the Regulations.

10.6 Consent to Investigate Concerns

The Trust will ensure that the consent policy is followed, and patient/ donor consent obtained for all concern investigations that require access to medical records, if the patient/donor does not provide consent the Trust will take a view on whether an investigation without access to the medical records would be possible and beneficial.

10.7 Consent Involving Other Organisations

Where the Trust is notified of a concern that involves the functions of more than one responsible body/organisation, it will firstly seek the consent of the complainant (within 2 working days of concern receipt), Within 2 days of consent receipt the Trust will contact all relevant organisations and the lead organisation will be identified in discussions with the complainant and involved organisations.

11. Time Limits for Notification of a Concern

The Trust aligns the time limits for notification of a concern with the Regulations and requires concerns to be notified no later than 12 months from the date on which the concern occurred, or if later,12 months from the date the person raising the concern realised they had a concern. Concerns received after these timescales will be considered by the Trust to determine the reason for the delay in reporting and the possibility of investigation being thorough and fair due to the time lapse.

12. Withdrawal of Concerns

The Trust acknowledges that a concern can be withdrawn at any time by the complainant, with such withdrawal requests can be provided in writing or verbally and will be acknowledged in writing by the trust. Despite withdrawal the Trust will ensure the concern continues to be investigated.

13. Nationally Reportable Incidents

The Trust will ensure a concern raised by a complainant that has already been reported and investigation commenced as a nationally reportable incident will be managed in accordance with the Regulations, with the investigation progressing in line with Nationally Reportable Incident policy, ensuring the person raising the concern is kept informed of investigations and outcomes.

Where a concern is received, and it becomes apparent that there has been a serious incident that the Trust was previously unaware of, the Trust will ensure the incident is reported within Datix Cymru system and the National Reportable incident process followed, whilst informing the complainant of the process, the potential that 30-working day response timeframe will not be achieved, and details of expected timing of response.

13.1 No Qualifying Liability – Regulation 24

The Trust will ensure that requirements of the Regulations and associated investigations and reporting requirements are met.

In events where further correspondence is received from the person raising the concern, expressing dissatisfaction, the Trust will ensure the concern is l be reopened, investigated, and acknowledged within 2 days. If a complainant is dissatisfied with their response and there are no new issues to investigate, the Trust will manage in accordance with the Regulations with the concern not being reopened and a meeting with the complainant offered, if the complainant remains dissatisfied following this the Trust will advise the complainant to refer their concerns to the Public Services Ombudsman of Wales.

13.2 Interim Report (Regulation 26) – When a Breach of Duty is identified and harm has, or likely to have occurred, resulting in a possible qualifying liability

- The Trust will ensure compliance with the Regulations, in cases where the Trust considers following investigation that both breaches in the duty of care have been identified and potential for harm, or actual harm identified in line with the requirements of establishing a qualifying an interim report under Regulation 26 will be issued within 30 working days from whichever is the later from: The day upon notification of the concern was received or
- Where the Duty of Candour is triggered, the day upon which the “in person” notification under Regulation 4(1) of the Duty of Candour Regulations was given.

The Trust will ensure that i in cases where a breach in the duty of care is identified that the case will be progressed and considered by the Trust’s Putting Things Right Panel to inform the interim Regulation 26 response, ensuring the inclusion of the following detail:

- A summary of the nature and substance of the issues contained in the concern.
- A description of the investigation undertaken to date
- A description of why in the opinion of the Trust there is or may be a qualifying liability.
- A copy of any relevant medical records.
- An explanation of how to access legal advice without charge.
- An explanation of advocacy and support services which may be of assistance.
- An explanation of the process for considering liability and Redress.
- Confirmation that the full investigation report will be made available to the person seeking Redress.

- An offer of an opportunity to discuss the contents of the interim report with appropriate staff.
- The interim report should receive final approval and signed off by the Executive Director Nursing, AHP's and Health Science.

If it is not possible to issue a Regulation 26 interim response within the required 30 working day timeframe, the Trust will ensure the person raising the concern will be informed of the reason for the delay and the interim response sent within 6 months of whichever is the later, either:

- The day upon notification of the concern was received or
- Where the Duty of Candour is triggered, the day upon which the "in person" notification under Regulation 4(1) of the Duty of Candour Regulations was given.

Once the interim response is issued, the Trust will ensure the matter is forwarded to the Trust Claims Manager for further investigation under the Redress arrangements as referenced within the Regulations.

13.3 Post Closure contact - Public Service Ombudsman of Wales (PSOW)

The Trust will ensure compliance with the Public Services Ombudsman (Wales) Act (2019) and inform any individuals that are dissatisfied with the Trust final response of their right to contact the Public Service Ombudsman for Wales, who will review the matter on their behalf.

The Ombudsman's contact details are: Phone: 0300 790 0203
E-mail: ask@ombudsman.wales Website: www.ombudsman.wales
Address: Public Services Ombudsman for Wales
1 Ffordd yr Hen Gae
Pencoed
CF35 5LJ

13.4 Investigation by the Public Service Ombudsman of Wales (PSOW) - timeframes

On receiving a complaint from the PSOW, the Trust will provide an acknowledgement of receipt to the PSOW within 5 days and will investigate and respond to the PSOW within 20 days. If for any reason required timescales are difficult to achieve the Trust will request an extension from PSOW.

In response to conclusions received from the PSOW the Trust will ensure that identified opportunities for learning and improvement are actioned and shared.

13.5 Redress

The Trust will ensure compliance with the Redress requirements of the Regulations, including.

- The making of an offer of compensation in satisfaction of any right to bring civil proceedings in respect of a qualifying liability.
- The giving of an explanation.
- The making of a formal apology.
- The provision of a report on the action/s which has been, or will be, taken to prevent a similar occurrence from arising.
- Care/remedial treatment.

Following an opinion from an independent expert, the report findings are shared with the appropriate division and relevant staff members involved in the investigation, as required. If a breach of duty exists, a Regulation 26 response is issued, and the matter is referred to the Trust Claims Manager for ongoing management of the concerns under the Redress arrangements.

In circumstances when a person is seeking Redress, the Trust will ensure findings of the investigation are recorded in an investigation report in accordance with Regulation 31, with the report that contains:

- copies of any independent expert advice used to determine whether there is a liability.
- a statement by the Trust confirming whether there is a liability and
- the rationale for the Trust decision.

The Trust will ensure the report is provided in line with the Regulations to the person who raised the concern.

Where an investigation report cannot be provided within the set 12-month timescale, the Trust will inform the person raising the concern of both the reason for the delay and expected date for response.

13.6 Regulation 33 Response

The Trust will ensure compliance with Regulation 33 ensuring that when financial compensation is due, a Regulation 33 response will be completed by the Trust Concern Manager, to provide an appropriate financial offer to settle the matter on a full and final basis with approval from the Executive Director of Nursing, Allied Health Professionals and Health Science. Following the issue of this response the person raising the concerns will have six months to accept the offer, If, after that time, no response is received, the concern will be closed within 9 months.

13.7 CRU Certificate

The Trust Claims Manager is responsible for requesting a CRU certificate from the Department of Work and Pensions where it is established that harm may have occurred. This is in accordance with the Trust's statutory obligation. Where harm is found to have occurred in relation to the NHS Charges/recoverable benefits (CRU), the Trust Claims Manager will arrange the appropriate payment and discharge of the CRU Certificate, as necessary. Where the NHS charges/CRU amounts to over £3,000 the matter is passed to NWSSP Legal and Risk Services for advice in accordance with the Welsh Risk Pool guidance.

14. Behaviour, Conduct and Unreasonable Demands during a Concerns Investigation

The Trust will ensure that people raising concerns are heard, understood, and respected. On occasions there may be times when persons raising the concern acts out of character and become determined, forceful, angry and make unreasonable demands of staff, in such circumstances the Trust has a zero-tolerance policy on unreasonable, unacceptable abusive or aggressive, or violent behaviour.

For the purpose of this policy, unreasonable, unacceptable, abusive, or aggressive, or violent behaviour is considered as:

- Behaviour that produces damaging or harmful effects, physically or emotionally on other

people.

- Persistent unacceptable behaviour is demonstrated on several occasions within a given period of time.

Examples of unacceptable or aggressive or abusive behaviour recognised by the Trust include:

- Verbal threats unsubstantiated allegations or offensive statements can also be termed as abusive violent behaviour.
- Threatening remarks e.g., both written and oral.
- Demands for responses within unrealistic timescales, repeatedly phoning, writing, or insisting on speaking to particular members of staff.

15. Monitoring Arrangements

The Trust will ensure a record is held of the following matters:

- Each concern notified.
- The outcome of each concern.
- The time taken to investigate the concern.
- The reasons where any investigation exceeded the 30-day time period.

The Trust will ensure that this information, and comprehensive analysis of concerns activity and learning will be reported to the Executive Management Board and Trust Quality and Safety Performance Committee on a quarterly basis. The Trust Integrated Quality &Safety group will provide oversight for the quarterly reports and will ensure the triangulation and robust analysis of data.

The Trust will prepare and publish an annual PTR report annually by the 31st of October regarding the delivery of the Regulations and application of the Duty of Candour in line with the requirements of the Regulations, Duty of Candour, and PTR Guidance, and will be clearly displayed on the Trusts internet site.

16. Learning from Concerns

The Trust will ensure that it has arrangements in place to review and assess the outcome of any concern that has been subject to an investigation under the Regulations, to ensure that any deficiencies in its actions or its provision of services, identified during the investigation, are:

- Recognised, acknowledged, owned, and acted upon
- Where improvement requires embedding, an improvement plan will be developed using the template action plan within the complaint's manual
- Identify learning for wider sharing across the Trust and share as appropriate, including the means to share across the wider NHS sector if suitable.
- Reviewed and reported regularly within the service divisions and Trust wide to ensure improvements are established minimising the risk of reoccurrence.
- Ensure that learning is used to target any problem areas and consider if there is potential to improve policies, procedures, and services.

17. Supporting Staff

17.1 Staff involved in Concerns

The Trust will ensure it discharges its responsibilities for staff involved in concerns and will provide a psychologically safe environment for staff involved in Concerns investigations through:

- Actively promote an open and fair culture that fosters peer support and discourages the attribution of blame. Velindre University NHS Trust will work towards a culture where human error is understood to be a consequence of flaws in the systems, not necessarily the individual.
- Providing ongoing support via Line Managers, Clinical Supervisors, Workforce department, Occupational health colleagues and Trade Union representatives.
- Ensuring the provision of mentorship and coaching as required.
- Signposting staff to their Employee Wellbeing Service/Occupational Health/Employee Assistance Programmes.
- Providing and maintaining up to date information on the support systems currently available for staff including counselling services offered by professional bodies.

17.2 Concerns Containing Allegations against Staff

Where concerns raised contain allegations against a staff member(s), the Trust will ensure relevant staff member/s receive a copy of the key issues identified at the beginning of the investigation and provide support as required throughout the process.

18. Concerns and Disciplinary Procedure

Any Disciplinary Proceedings undertaken in relation to a concern will be managed under the Trust Disciplinary policy. Equality Impact Assessment

This policy has been screened for relevance to equality. No potential negative impact has been identified so a full equality impact assessment is not required.

The Trust will develop an understanding of why some members of the community who may wish to raise a concern might not feel able to do so. This may be due to cultural, social, gender and other reasons, including sensory loss, any of which might result in ineffective communication. Staff should be mindful of the issues which might act as a barrier to people raising a concern and look for ways to assure people that it is safe for them to raise an issue.

19. Policy Compliance

The Trust and its Divisions will ensure adherence to this policy and will provide role specific concern and Duty of Candour training to enable staff to possess the required knowledge to fulfil both their concern management roles and responsibilities and compliance with the Regulations and Duty of Candour procedure.

20. Information Governance

The Duty of Confidentiality is an important aspect in relation to concerns handling. All Trust Staff are required to maintain the complainant's confidentiality and are required to protect personal data as outlined by legislation including the Common Law Duty of Confidentiality and the Data Protection Act 2018 which includes the retained EU GDPR 679/2016 (known as UK GDPR). UK GDPR sets out the key data protection principles, rights of individuals (known as Data Subjects), and obligations for processing personal information.

The Trust acts as a “Data Controller” in respect of personal data as defined in Article 4 UK GDPR. Staff responsible for processing personal data are to follow the 'seven data protection principles' which are contained in Article 5 UK GDPR, this means that whenever they process Personal Data, they must do so; lawfully, fairly and transparently; Only process it for specific, explicit and legitimate purposes; Ensure that in relation to the purposes of processing that the data is adequate, relevant and limited for that purpose; Ensure that the data processed is accurate, kept up to date and stored in a format which permits the data subject to be identified and kept for no longer than is absolutely necessary. Staff must also ensure that when the data is processed that appropriate technical and organisational measures are in place to protect the integrity and confidentiality of the Data. The final data protection principle is accountability; all Staff are accountable for the data that they process. The obligation to comply with the data protection principles sits alongside the eight Caldicott principles, Section 8 of the Human Rights Act 1998, Section 40 of the Freedom of Information Act 2000, and Section 13 of the Environmental Information Regulations 2004.

Information in relation to complaints should not be disclosed/copied/ shown to any external agency without the permission of the Responsible Officer or nominated deputies on a “need to know basis.”

All requests for access to such information should be directed in the first instance to the appropriate manager or nominated deputy or service lead for the subject of the concern.

The Trust has adopted the NHS Wales Records Management Code of Practice Health and Social Care 2022, as well as supporting the development of the Wales Accord on the Sharing of Personal Information (WASPI) as a legally binding framework.

All staff are bound by their Contractual Duty of Confidentiality regardless of their role and are required to respect the personal data and privacy of others. All staff must not access information about any individual who they are not providing care or treatment for, or in relation to the administration of services unless in a professional capacity. They are not permitted to access their own data, any request for their own personal data must be made as a Subject Access Request. The Trust Head of Information Governance can provide further information and advice if required in relation to access rights and the lawful sharing of personal data.

The Information Commissioner’s Office (ICO) has detailed guidance on data sharing on its website and has issued a data sharing code of practice, the Code of Practice can be accessed https://ico.org.uk/for-organisations/guide-to-data-protection/ico-codes-of-practice/data-sharing-a-code-of-practice/

It must be noted that the threshold for reporting a data breach to the Information Commissioner is much higher than that contained within the Duty of Candour, this is because Article 33(1) UK GDPR states:

> "In the case of a personal data breach, the controller shall without undue delay and, where feasible, not later than 72 hours after having become aware of it, notify the personal data breach to the Commissioner, unless the personal data breach is unlikely to result in a risk to the rights and freedoms of natural persons. Where the notification under this paragraph is not made within 72 hours, it shall be accompanied by reasons for the delay".

The Trust Head of Information Governance must be contacted where a data breach has occurred so that an assessment of risk to the rights and freedoms of the natural person (data subject) can be made, this is to ensure alignment between Duty of Candour and Data Protection legislation requirements.

Advice and guidance in relation to any aspect of Information Governance considerations can be obtained from the Trusts Head of Information Governance.

VelindreInformationGovernance@wales.nhs.uk

21. Managing Media Interest / Media Communications

The management of media interest/ in relation to incidents, either individually or generally, will be undertaken by the Trust's Communications Department.

22. References

- The Health and Social Care (Quality and Engagement) (Wales) (2020) (Duty of Quality and Duty of Candour).
- National Health Service (Concerns, Complaints and Redress Arrangements) 6+lesgulations ('the Regulations) (2011).
- The Putting Things Right Guidance (PTR) (2013).
- Putting Things Right Guidance update (2023)
- Public Service Ombudsman for Wales Act (2019).
- Duty of Candour Procedure (Wales) (2023).
- NHS Wales National Policy on Patient Safety Incident Reporting & Management (2023).
- Civil Procedural Rules

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

QUALITY IMPACT ASSESSMENT TOOL

DATE OF MEETING	14th September 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	Nicola Williams, Executive Director Nursing, AHP & Health Science
PRESENTED BY	Nicola Williams, Executive Director Nursing, AHP & Health Science
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences

EXECUTIVE SUMMARY	The national (NHS Wales) beta (trial) Quality Impact Assessment was provided to NHS bodies on the 4th August 2023 earlier than anticipated to support NHS Wales with required financial proposals. The tool is designed to support NHS bodies in meeting their Duty of Quality responsibilities to ensure that quality is considered as part of all strategic decision making. The Quality Impact Assessment is designed around the NHS Wales Health & Care Quality Standards (2023) and covers the six domains of quality and the six enablers.

RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee are asked to **ENDORSE FOR APPROVAL** the use of the national beta version of the Quality Impact Assessment Tool for all strategic decisions at Divisional, Executive and Board level ad to request hosted bodies to also adopt the tool. This will require a review of the new Board paper template.

GOVERNANCE ROUTE	
Executive Management Board	14/08/2023
ENDORSED for onward approval. ***APPROVED*** to be used with immediate effect for financial savings plans.	

7 LEVELS OF ASSURANCE	
N/A as a proposal for implementation – currently Trust has no quality impact assessment process	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 0 - Enthusiasm, no robust plan

APPENDICES	
1.	Beta version of the National Quality Impact Assessment Tool
2.	Supporting Information
3.	Quality Impact Assessment process

1. SITUATION / BACKGROUND

NHS bodies in England have, for many years used Quality Impact Assessments when major strategic changes are being considered / proposed. This has not, been mandated in Wales, although a few Health Boards in Wales have adopted over recent years the use of a Quality Impact Assessment Tool to support strategic decision making.

The Duty of Quality (Wales Quality & Engagement Act 2020) requires Ministers and NHS Bodies to demonstrate that Quality has been considered as part of all strategic decision making. A national Tool has been developed as a suggested tool but use of this is not mandated currently. If organisations have pre-existing arrangements / processes that meet the requirements of the Duty of Quality these can be used.

Velindre University NHS Trust does not currently have a Quality Impact Assessment Tool.

2. ASSESSMENT

The beta (not final draft) version of the national Quality Impact Assessment Tool is attached in ***Appendix 1***. In addition, there is supportive guidance (***Appendix 2***) and process flow chart (***Appendix 3***).

The supportive guidance refers to a proportionate process depending on the size, risk and complexity of the decision and for Clinical sign off.

It is proposed, in the absence of an alternative tool, that the Trust adopts the use of this beta Quality Impact Assessment Tool with immediate effect for all strategic decision making by Divisional Senior Management / Leadership Teams, Executive Management Board, Transforming Cancer Services Team and Trust Board. The completed tool is to be brought long with the proposal to the relevant decision-making group and the Corporate Governance Team will be responsible for recording such decisions.

As the responsible body for the Duty of Quality includes hosting and well as hosted organisations it is proposed that NWSSP and Health Technology Wales are asked to adopt the use of the Quality Impact Assessment Tool to support their strategic decision making and to include an overview of this in reporting through to the Trust Quality, Safety & Performance Committee.

If approved an electronic mechanism for completing and capturing the Quality Impact Assessments will need to be developed as this will assist with the Trust in collating reports and the annual quality report to publicly demonstrate how the Duty of Quality has been enacted.

3. SUMMARY OF MATTERS FOR CONSIDERATION

The Quality, Safety & Performance Committee is asked to:

- ***ENDORSE*** the adoption of the beta version of the National Quality Impact Assessment Tool with immediate effect for all strategic decision making at a divisional and corporate / board level for onward Board approval.
- ***ENDORSE*** the need to develop an electronic mechanism for completing and capturing use of the tool and outcomes.
- ***ENDORSE*** the proposal to request hosted organisations adopt the tool for all strategic decision making.

4. IMPACT ASSESSMENT

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

• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	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 undertaking of Quality Impact Assessments will impact on all 6 quality domains
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
	Proposal will not require this assessment
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.
	Undertaking Quality Impact Assessments will not have a direct financial implication
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
	N/A is respect of proposal to undertake Quality Impact Assessments

ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)

	It is a legal require to consider quality as part of all strategic decision making

5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
All risks must be evidenced and consistent with those recorded in Datix	
There is a risk of non-compliance with Duty of Quality legislative requirements if the national Quality Impact Assessment tool is not endorsed / approved as the Trust does not have an alternative tool in place.	

Quality-driven decision-making

Quality Impact Assessment

Part 1: Developing the QIA

Proposal / decision being assessed	
QIA completed by / on date	Insert name/s and designation and date
QIA agreed by / on date	Insert name/s and designation and date *<e.g. Directorate manager>*

Part 2a: Clinical review and sign off of QIA

Reflecting the **proportionate** nature of the QIA to the proposal, each QIA should be reviewed and agreed by clinician(s) at an appropriate level (i.e. a more significant proposal should be subject to more senior clinical review and sign-off)

QIA clinically agreed by / on date	Insert name/s and designation and date *<e.g. Head of nursing / head of midwifery / clinical director>*

Part 2b: Executive clinical review and sign off of QIA if required

Reflecting the **proportionate** nature of the QIA to the proposal, each QIA should be reviewed and agreed by clinician(s) at an appropriate level (i.e. a more significant proposal should be subject to more senior clinical review and sign-off)

Clinical Executive 1 sign off / date	Insert name/s and designation and date *<e.g. Executive director of nursing / executive director of therapies and health sciences / executive medical director>*
Clinical Executive 2 sign off / date	Insert name/s and designation and date *<e.g. Executive director of nursing / executive director of therapies and health sciences / executive medical director>*
Clinical Executive 3 sign off / date	Insert name/s and designation and date *<e.g. Executive director of nursing / executive director of therapies and health sciences / executive medical director>*

Part 3: Outline of the proposal / decision to be made

1. Broadly outline what is being proposed and the decision that needs to be made
2. Why is the proposal / decision needed?
3. What are the drivers and influencing factors around the decision to be made? (e.g. legislation, national policy, professional body guidance, cost savings, ministerial priorities)
4. Who is directly affected by this proposal / decision? Please also consider people who may be indirectly affected
5. How have you engaged with the people affected? If you have not yet engaged, what are your plans?
6. What are the main benefits of this proposal / decision?
7. i) What are the main risks of implementing this proposal / decision? ii) What are the main risks of not implementing it?
8. How does the proposal / decision impact on delivery of the organisation's strategic objectives or ministerial priorities?
9. Is the proposal / decision planned to be temporary or permanent?

Part 4: Quality Impact Assessment

- This assessment tool should be completed for all strategic decisions.
- The response should be **proportionate** to reflect the significance, scale, risk, impact on delivery of strategic objectives and drivers of the proposal being made.
- Consider how the proposal / decision impacts on each of the Health and Care Quality Standards.

Health and Care Quality Standards	Briefly outline how the proposal / decision impacts on each of the Health and Care Quality Standards What specific risks have been identified? What mitigation will you implement to manage adverse impact? What measures and evidence will you use to monitor the impact?	Identify if the overall impact of the proposal / decision is **positive, neutral or negative**
Safe		
Timely		
Effective		
Efficient		
Equitable		
Person-centred		
Leadership		
Workforce		
Culture		

Health and Care Quality Standards	Briefly outline how the proposal / decision impacts on each of the Health and Care Quality Standards What specific risks have been identified? What mitigation will you implement to manage adverse impact? What measures and evidence will you use to monitor the impact?	Identify if the overall impact of the proposal / decision is **positive, neutral or negative**
Information		
Learning, improvement and research		
Whole systems approach		

Part 5: Summary of the Quality Impact Assessment

Based on the assessment in Section 2, what are the key messages, risks and recommendations for the clinical review and sign-off process?
What are the proposed monitoring arrangements and frequency of QIA Review?

Quality-driven decision-making
Quality Impact Assessment

Supporting information

Introduction

The duty of quality requires quality-driven decision-making for all strategic decisions. In discharging the duty of quality, NHS organisations are required to take into account the Health and Care Quality Standards when making decisions about healthcare services.

A Quality Impact Assessment (QIA) is a mechanism for considering and capturing the impact of proposals / decisions on the Quality of our healthcare system, to inform strategic decision-making. Key to the success of the implementation of a Quality Impact Assessment across healthcare in Wales is that it must be proportionate, have clinical sign-off, and feed into existing corporate processes rather than creating new ones. Organisations must be able to evidence that their strategic decisions have been made through a Quality lens.

The purpose of the QIA can therefore be described as:

- To inform strategic quality-driven decision-making
- To identify and assess the effect or influence of a proposal on the quality and safety of the healthcare system, in line with the Health and Care Quality Standards
- To ensure that we identify any actions needed to reduce risks where quality or safety could be negatively affected, and to ensure these risks and mitigations feed into existing corporate monitoring processes
- To provide assurance of quality-driven decision-making, together with audit trail.

This QIA tool is directly linked to the Duty of Quality and Health and Care Quality Standards that we have here in Wales. All strategic decisions should go through this process.

Using the tool

The suggested process for undertaking and agreeing the Quality Impact Assessment, and the beta QIA tool, are embedded below.

The QIA tool should be completed to support any proposal for a strategic decision to be made and be presented with the proposal to the appropriate decision-making forum.

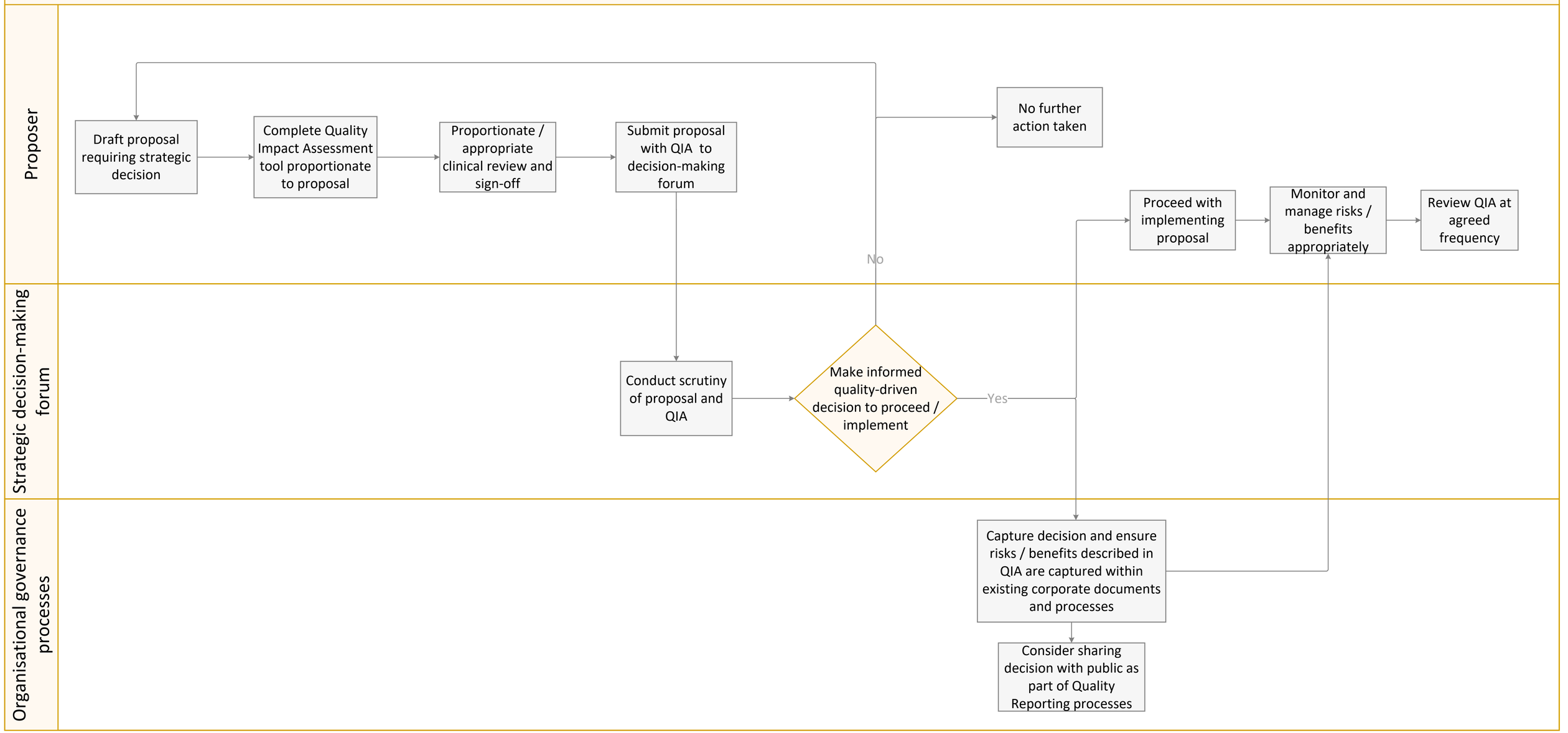
As mentioned above, the detail required to populate the QIA tool should be **proportionate** to the scale, risk, impact on delivery of strategic objectives, drivers and financial implications of the proposal and decision to be made. The more significant the decision to be made, the more detail required in the QIA.

All QIAs **must** be reviewed and signed-off by a clinician. Again, the significance of the decision should determine the seniority of the clinician who would need to review and authorise the QIA before it is presented to the decision-making forum.

If the decision makers agree that the proposal should proceed, then risks and benefits that are identified through the QIA process should feed into existing corporate monitoring processes.

[A final version of the QIA tool and formal supporting guidance will be issued in the future.]

Quality Impact Assessment process



QUALITY, SAFETY AND PERFORMANCE COMMITTEE

PROFESSIONAL NURSING FORUM UPDATE

DATE OF MEETING	14th September 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	Anna Harries, Head of Nursing Professional Standards and Digital
PRESENTED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Science
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences
EXECUTIVE SUMMARY	The following are the key highlights from the report: • The plans to participate in the national International Nurse Recruitment programme with the aim of recruiting 15 overseas nurses by March 2024 for both Divisions. • The Trust's first Assistant Practitioner completed her training and competency programme early August 2023. • Extremely successful completion of the Trust's first RCN cadets' placements for 4 days at the Welsh Blood Service during August 2023. • Ten posters accepted within the UK Oncology Nursing Society Conference, two of which are presentations.

	• Successful Nursing Conference held on the 12th May 2023 where the Trust's Nursing Strategy was launched. • 6-monthly establishment reviews were completed and no nurse establishment issues of significance were identified. • Overall increased compliance with nursing assurance Tendable audits.

RECOMMENDATION / ACTIONS	To **NOTE** the Professional Nursing update for the period March 2023 and August 2023.

GOVERNANCE ROUTE	
Professional Nurse Forum	02/03/2023; 06/04/2023; 04/05/2023; 01/06/2023; 06/07/2023 and 03/08/2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS During each meeting it agreed which items are reported through this paper to accurately reflect each workstream and nursing updates. It may be that a particular agenda required a standalone paper submission to highlight the significance or for specific consideration or approval.	

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 4 - Increased extent of impact from actions

APPENDICES
N/A

1. SITUATION

This paper provides the Quality, Safety and Performance Committee with an overview of key discussions and outcomes at the Trust Professional Nursing forums held between March and August 2023.

2. BACKGROUND

The Professional Nursing Forum meets monthly and is the forum at which all strategic professional nursing issues and standards are discussed, strategic direction agreed and priorities determined. It has a core attendance of senior nursing leaders across the Trust, there are regular agenda headings covering -

Good news stories, action log, feedback from National meetings, Items for discussion/approval, workforce, education and development, digital, Nursing workforce, senior nursing priorities, consultations, shared learning with also items for noting and there is often an opportunity to welcome guest speakers to support the nursing agenda.

3.0 PROFESSIONAL NURSING FORUM (PNF) HIGHLIGHTS

The following is a summary of the key outcomes from the Professional Nursing forums held in March 2023 and August 2023:

3.1.1 Nursing Successes:

- There have been several successful recruitments in key corporate and divisional specialist and senior nursing posts. Including: Informatics Clinical Nurse Specialist, Head of Safeguarding & Vulnerable Adults, Infection Prevention and Control Specialist Nurse, Lead Nurse for Quality and Governance, Welsh Blood Service, Temporary Mental Capacity Act, Clinical Practice educator (national funding).

- A foundation has been established in memory of a patient of Velindre, by her parents, to fund nursing scholarships going forward.

- Jodie Treble, Interim Lead Nurse AOS, has secured a place on the Climb Wales Leadership Programme and has also been accepted to present at the International Cancer Nursing Conference at Glasgow in September.

- Rhoswen McKnight amazingly gained the only nursing place on the first ever Commonwealth Climb Leadership programme following her previously completing her Climb Wales Leadership Programme.

- Launch of the Trust Nursing Strategy on the 12th May 2023. Significant work coordinated by a small group of senior leaders and supported by the whole organisation resulted with publication of the first Nursing Strategy for the Trust.

- An extremely successful Nursing conference was held on the 12th May, which exceeded all expectations on the day. The main aim was to launch the Strategy but place Nursing on the map within the organisation. This was achieved and extended, with expressions of more of this required moving forward.

- During the Conference, A Chief Nursing Officer for Wales Excellence Award was presented to the Paracentesis Team at Velindre Cancer Service.

- Infection Prevention and Control leads have been working with HEIW on educational infection control and have been nominated for an award with the Nursing Times.

- First RCN cadets' scheme in Welsh Blood Service, the placement was for 4 days in August and initial reports from cadets and RCN were extremely positive.

- Ten posters accepted within the UK Oncology Nursing Society Conference, two of which are presentations.

- Ceri Stubbs, Advanced Nurse Practitioner was successful in her application for the PhD Trust Research Fellowship.

3.1.2 International Recruitment.

Due to the challenges in recruiting into critical nursing posts with the Trust, PNF proposed the Trust participates for the first time in the national International Nurse Recruitment Programme. This proposal has been approved by Executive Management Board. 15 posts (12 VCS and 3 WBS) will be recruited to during November 2023, and it is anticipated these will be in post (although OSCE examinations will not be completed) by March 2024.

3.1.3 Nursing Strategy/Conference event 12th May 2023

The Trust's First Velindre University NHS Trust Nursing Strategy 2023-26 was launched at the Trust-wide Nursing Conference at the All-Nations Centre in Cardiff on International Nurses' Day (12th May 2023). The Strategy has been approved by Trust Board.

During the Conference an engagement session was held for attendees to be involved in developing the strategy delivery work plan.

The Nursing Conference provided an opportunity for nursing staff from Welsh Blood Service, Velindre Cancer Centre and the Trust itself to celebrate past successes and get excited about future achievements. The day included a keynote speech by Sue Tranka, Chief Nursing Officer for Wales, and had sessions featuring the three aims of the strategy with a focus on psychological safety and empowering nurses to lead with compassion.

Extremely favourable feedback was received from 50 of the attendees with 95% rating the speakers and content at over 8 out of 10, 65% attendees reported that their learning outcomes from the event exceeded expectations and 100% scored the venue over 8 out of 10. Staff feedback included comments that it helped the staff feel part of an incredible team, helped inform practice and boost wellbeing. The conference also satisfied revalidation requirements for registered nurses and helped to unite both divisions of the organisation with common goals.

3.1.4 Assistant Practitioner Role

In October 2022 the Assistant Practitioner (Nursing) Governance Framework was approved by both the All-Wales Executive Nurse Directors Group and the all Wales Executive Directors of Workforce Group and was adopted by Velindre University NHS Trust. Following this the first two trainee Assistant Practitioners were recruited in the Outpatient Department of Velindre Cancer Service. One was already on the required academic pathways and in addition, the Trust developed and implemented a development programme. The two trainee assistant practitioners have been working as level 3 trainees. One completed her training and competencies by early August 2023 and is now working as a fully-fledged Assistant Practitioner. The other trainee will complete in 12 months' time and recruitment for a further trainee is underway.

An audit of compliance with national requirements has been undertaken and some small changes to the programme made.

3.1.5 Multi-professional Advanced Practice

The National Multi-Professional Advanced Practice Framework was launched on the 9th June 2023 (previously provided). This has been approved for full implementation within the Trust by PNF and the Executive Management Board.

PNF have commissioned a Trust wide mapping for each team regarding what this means for the team and how it will help workforce re-design.

A Trust-wide Advanced Practice peer group and Framework implementation group have been established, a separate paper was presented to July Executive Management Board detailing the current position and implementation plan. This approach is very much welcomed in practice by the multidisciplinary team.

3.1.6 Tendable outcome reports WBS and VCC

Since March 2023, the two Divisions have been presenting their Tendable nursing assurance audit outcome reports on alternate months. These reports are highlighting compliance with audit, areas to improve, areas to celebrate and provide vital data on suitability of audit questions to further improve suitability and value from data.

WBS presented their data in July PNF using data from 1st March to 31st May 2023 61 audits were carried out, with an average score of 99.6%. Overall there was good compliance in relation to nursing standards.

Velindre Cancer Centre reported their data in August PNF which included an action plan to address issues from the previous report. Significant improvement in compliance and accuracy was demonstrated. Whilst recognising further improvements are required there is a clear increase in practice of Tendable and audit compliance.

3.1.7 Establishment Review

The 6-monthly establishment reviews were all completed, chaired by the Executive Director of Nursing, AHP & Health Science. In summary all areas across the Trust where nursing staff are deployed was reviewed and there were no areas of concerns identified in respect of nurse staffing levels as required by the Nurse Staffing act.

A full summary paper will be provided to the September PNF.

3.1.8 Nursing Research

Significant developments are taking place in respect of nursing research opportunities. The first ever Velindre Healthcare Cancer Research Fellowship Scheme has been launched. This is an investment by the Velindre Charity to enable Velindre Cancer Centre to strengthen leadership in quality cancer care. The fellowships will be awarded to nurses and therapists*, staff groups historically underserved by education and opportunity to drive evidence-based service improvement and innovation.

3.1.9 Digitalisation of Nursing Documents

The standardisation and digitisation of nursing documents is continuing across Wales, however the release of new documents into the Welsh Nursing Care Record (WNCR) needs to be balanced alongside the implementation of system improvements that have arisen from the request for change process, in addition to making the overall technical management of the system more efficient. As such, the next version update (V2.3) which is planned for release in September 2023, will comprise of the introduction of a single instance system across all Health Board's and Trusts in Wales, and also several minor wording amendments to the existing documents. Whilst version 2.3 was initially due to be released in June/July 2023 the recent issues experienced in the Master Patient Index (MPI) and the WPAS merger in BCU have resulted in a slight delay.

The proposed WNCR roadmap provided by DHCW indicates that currently V2.4 will contain the Urinary Catheter Bundle, IV Access Bundle, and Adverse Reactions as well as further request for change solutions. Version 2.5 will contain new documents to include Wound Care Assessment, Post Falls Assessment, Food Chart and Fluid Balance charts.

Since the WNCR can be accessed via the Welsh Clinical Portal (WCP) platform, there is now a national plan to make this the electronic patient record and not just cover nursing records.

3.1.10 Clinical Supervision

There is a national team developing a Framework for Clinical Supervision, however there is no immediate publication date expected. A small Trust task force has been

in place to develop a clear ambition of Clinical supervision for the Trust, as there is currently no formal structure in place. This was presented in July PNF and expecting approval in September following comments and discussion within previous PNF meetings, task force discussion and attendance and contribution to the Florence Nightingale Foundation launch of Resilience based Clinical supervision.

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="3">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>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).
PNF covers all aspects of Quality and Safety domains from a nursing perspective.</td></tr>
</table>

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 Prosporous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities
	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
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Yes - please outline what, if any, actions were taken as a result
	The Nursing strategy Equality impact Assessment was completed throughout the process of consultation and approval of final document
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
All risks must be evidenced and consistent with those recorded in Datix	

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Medicines Management Group Assurance Report

DATE OF MEETING	14/09/2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	ASSURANCE
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Bethan Tranter, Head of SACT and Medicines Management Usman Malik, Principal Pharmacist, Clinical Services
PRESENTED BY	Usman Malik, Principal Pharmacist, Clinical Services
APPROVED BY	Jacinta Abraham, Executive Medical Director
EXECUTIVE SUMMARY	The purpose of this report is to provide assurance that the roles and responsibilities of the Medicines Management Group are being executed in line with accepted current best practices. This report focusses primary on the work between January – June 2023.

RECOMMENDATION / ACTIONS	The recommendation is that the QS&P Committee approve this report as one that provides assurances of the ongoing work of the Medicines Management Group in line with its main functions.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Medicines Management Group	26/07/2023
Executive Management Board	31/08/2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Endorsed by MMG Awaiting outcome of VCC Quality and Safety Performance Group	

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. SITUATION/BACKGROUND

The function of the Medicines Management Group (MMG) is to hold strategic, operational and clinical governance oversight of all medicines management practices within VCC to ensure that medicines are used safely, effectively and in line with accepted current best practices.

In line with the cycle of business for the MMG a Trust Quality Safety and Performance (QPS) Committee, below is the 6 monthly assurance report covering January – June 2023, outlining the work of MMG.

2. ASSESSMENT/SUMMARY OF MATTERS

2.1 Strategy, Leadership and Governance

2.1.1 Plan

The Pharmacy and Medicines Management strategic document (2018 – 2023) contains progress targets against its six principles named below:

Principle 1: Safe and Effective use of medicines

Principle 2: Access to Medicines

Principle 3: Access to Information

Principle 4: Effective use of staff and resources/sustainable workforce

Principle 5: Driving Efficiency

Principle 6: Innovation and Digital

The document will be reviewed in Autumn 2023 to ensure alignment with professional and NHS strategies such as, Pharmacy Delivering a Healthier Wales, Health Education Improvement Wales Pharmacy Strategic Workforce Plan, Welsh Government Review of Secondary Care Hospital Services and the nVCC Clinical Service Model.

Implementation of e-prescribing for general medicines at VCC over the next 3 years will aid delivery of Principle 6. This work is being managed as a VCC wide project and will be reported via Velindre Futures Board.

2.1.2 Regulatory and legislative compliance and good practice standards

VCC has previously remained compliant across all 4 sub-criteria of the Health and Care Standards (H&CS) for Medicines Management, (2.6) namely:

- Compliance with legislation,
- Fitness to practice,
- Access to information and medical advice, and
- Incident reporting and investigation

'The Duty of Quality Statutory Guidance 2023 and Health and Care Quality Standards 2023' are to replace these H&C Standards. Once these new standards are in place, MMG will work with Trust QSP Committee and VCC Quality & Safety Management Group (QSMG) to ascertain appropriate performance criteria to record compliance against the new standards.

The following actions continue to be maintained by the Pharmacy department:

1. Clinically verification of SACT prescriptions in line with the national British Oncology Pharmacy Association Verification Standards
2. Update of SST specific treatment algorithms in line with new approved treatments.
3. Leading on the work to introduce a full Blood Borne Virus (BBV) screen for patient's pre-SACT (as per UK Chemotherapy Board recommendations for routine Hep B testing for all patients pre-SACT). This requires pathway development in collaboration with our health board partners. Planned implementation by Q3 2023/24.

2.2 Working Groups

Responsibilities of the MMG are discharged via the use of sub-groups and reports which each oversee dedicated aspects of medicines management across VCC. The groups report to the MMG and their outputs are summarised as below:

2.2.1 Medicines at Home (M@H) service

The M@H team within pharmacy oversee and manage the provision of specified oral SACT direct to a patient's home and of the M@H parenteral SACT daycase service, which is delivered on a mobile unit based near Trust HQ.

Service delivery performance is monitored via nationally agreed Key Performance Indicators (KPIs), which are reported to MMG three times per year. The KPIs capture third party provider performance, such as treatment deliveries within agreed timeslots and

patient safety incidents. VCC finance team maintain close oversight of the financial savings generated by the M@H team to both VCC and its Health Board partners, with VCC over-achieving against the target income.

As of June 2023, there are approximately 1350 patients currently registered with VCC's M@H service, of which almost 1100 patients receive their oral SACT delivered to their homes.

2.2.2 VCC Controlled Drugs (CD) Oversight Group

The VCC Controlled Drugs Oversight Group meets twice per year to ensure the safe use of CDs across VCC. It ensures compliance with Controlled Drugs Regulations and NICE Guidance NG46. In its February 2023 meeting, revised Terms of Reference (ToR) was agreed to re-align reporting of this group to MMG as requested by Board.

It undertakes point prevalence review, (2 x 1 month of data per year) of the prescribing of CDs on WP10 (HPs) to ensure triangulation between patient, their need for pain control and contact with a VCC clinician at the time of the WP10 (HP) being written. This is to ensure that CDs are being appropriately prescribed for dispensing in the community. The group also maintains oversight of ward stock checks undertaken by the Pharmacy Team. These reviews have not any identified any concerns.

The group ensures that there is VCC representation and formal report submission at all of VCC's neighbouring health board Local Intelligence Network (LIN) meetings. LIN meetings are a useful source for information gathering and sharing and VCC's attendance ensures that we remain informed of local issues related to controlled drugs which may impact VCC.

The VCC CD Oversight Group receives all incidents which involve Controlled Drugs . In this reporting period 4 incidents were recorded; 2 of which were related to administration of a CD and 2 concerned record keeping. No patient harm was caused. In each case staff undertook reflective practice to learn for the incidents.

At February's meeting, a SOP outlining how patient's own CDs can safely and appropriately be used on VCC's daycase units was approved.

In February, VCC also renewed it's environmental permit with National Resource Wales allowing the destruction of Controlled Drugs on site. This permit is valid until 2026.

2.2.3 Medical Gases Group

The Medical Gases Group also meets twice per year to oversee the safe use of medical gases at VCC. The group comprises of clinical, estates and facilities and operational services colleagues. The focus of the group is on the safe use of medical gases and medical gas cylinders with the oversight of the medical gas pipeline systems being undertaken through Estates and Facilities colleagues.

The group has approved a revision to it's ToR to re-align it's reporting to MMG. It has also acted as the expert group to provide advice to the nVCC Estates and Facilities team as to the medical gas (and pipeline systems) requirements of the new hospital. In addition, a SLA has been agreed between VCC and National Wales Shared Services Partnership to provide a Quality Control Pharmacist for medical gases pipeline services as a contingency resource in case of emergency.

The group monitors the use of medical gas cylinders across VCC and consequently has removed nitrous oxide cylinders as they are no longer required, can be harmful to the environment if they leak and have resale attraction for non-medicinal purposes.

2.2.4 – Medication Safety Group

The Medication Safety Group (MSG) is a key multidisciplinary subgroup of MMG, which maintains oversight of medication safety related work-streams. The group also link in with the all-Wales medication safety group for learning and sharing of good practices.

The group, chaired by the Medication Safety and Governance Pharmacist, along with the Medicines Management Nurse maintain oversight of all medicines related incidents and consider themes and learning opportunities. These key staff members link with nursing and pharmacy colleagues on a regular basis with the group reporting to MMG twice per year.

From Jan – June 2023, the total number of medication-related DATIX incidents submitted were 88, of which 80 have been investigated and closed. Eight of the more recently submitted DATIX incidents are currently under investigation. Medication incidents are investigated in accordance with the 'Medication Error Policy' which utilizes the nationally endorse 'BESS scoring tool'. This tool provide structure on how incidents are investigated along with ensuring self-reflection exercises are undertaken by individual staffs when appropriate.

As part of the investigation, if common trends and themes are highlighted, these are then utilised to inform changes to practices. As an example, on identifying that there was an increased number of missed and incorrect doses given on the in-patient environment,

pharmacy and nursing colleagues worked collaboratively to improve communication and training with the teams with ongoing monitoring and review of similar incidents being led by the nurse in charge.

2.2.5 Cancer and Hospital Acquired Thrombosis (CHAT) Group

In accordance with the Welsh Risk Pool (WRP) 'National Review into the Prevention of Venous Thromboembolisms (VTE) in NHS Wales', VCC established its Cancer and Hospital Acquired Thrombosis (CHAT) group in November 2022.

Several of the recommendations within the national report have been achieved over the first 6 months of 2023, including:

- Re-establishing the thrombosis group
- Implementation of a formal risk assessment tool into practice
- Development of a checklist to investigate potentially avoidable Hospital Acquired Thrombosis (HATs)
- Feedback to appropriate governance committees (which for VCC is the Performance Management Framework report)

In June 2023, the group has successfully implemented all Wales training packages onto front line clinical staffs ESR matrices. Work is continuing to further establish the Cancer Associated Thrombosis (CAT) clinic service, and how it links in with its health-board partners.

VCC's first Independent Prescriber for CAT registered with the Royal Pharmaceutical Society this month.

As reported via the Performance Management Framework, there has been 3 potentially avoidable hospital acquired thromboses with the involved clinicians receiving feedback from the Chair of CHAT.

2.3 Access to Medicines

2.3.1 VCC Individual Patient Funding Requests (IPFR) Advisory Group/ Access to medicines

VCC IPFR Advisory Group continue to meet on a weekly basis to review all IPFR applications for clinical appropriateness prior to submission to the health boards, and to consider whether VCC are able to fund applications through it's discretionary "High Cost Drugs" budget. Importantly the group also provides advise to consultant colleagues in

terms of IPFR process and systems and liaises with HB teams clinically and operationally when required.

Between Jan – June 2023, 29 IPFR requests have been reviewed by the VCC IPFR Advisory Group, of which VCC have funded 9 applications through the use of the discretionary budget, and 20 have been referred to the patient's health boards for their consideration.

2.3.2 Early Access of Medicines Schemes and Compassionate Use Programs

Early Access of Medicines Scheme (EAMS) and Compassionate Use Programs (CUPs) allow access to medicines that are either not license or not funded, but early evidence shows a clinical benefit.

Between Jan – June 2023, VCC pharmacy had set up 3 new access schemes, which makes a total of 13 access schemes currently open. As of June 2023, there are 25 patients receiving SACT via one of these access schemes.

2.3.3 Medication alerts, shortages and discontinuations

Pharmacy manages the response to WG and Pharma initiated medication alerts, shortages and discontinuation notices, playing an active role in both the All Wales Medicines Shortage Group and All Wales Medicines Procurement and Logistics Group. Each notice is assessed for its potential impact on patient care at VCC with the pharmacy team ensuring that corrective actions are undertaken including sourcing alternative clinical options when necessary.

Between Jan – June 2023, there have been 26 national drug recall alerts and 39 drug shortage alerts, all of which were action within required timeframes without any detriment to patient safety.

2.3.4 Patient Safety Notice (PSN)

Patient Safety Notices (PSN) and Patient Safety Alerts (PSA) are guidance documents issued by Welsh Government, which identify significant safety risks along with a series of recommendations which NHS organisations are mandated to implement.

Between Jan – June 2023, there have only been two new PSNs, one relating to the use of oxygen cylinders (PSA 015) which the VCC medical gases group has completed all actions, and another relating to temporary identification for unidentified patients in an A+E setting, which does not apply to VCC.

In March 2023, all the work associated with the implementation of PSN 055 'Safe Storage of Medicines' was completed and therefore VCC are now compliant with this Notice.

2.4 Medicines expenditure

Expenditure against the various VCC drug budgets is monitored by the MMG. All expenditures are within approved budgetary limits. VCC purchases all pharmaceuticals according to best practice through All Wales Drug Contracts and supports national best practice guidance in it's proactive adoption of biosimilar and generic medicines at the earliest opportunity. Please see graphs below that demonstrate quick uptake of generic abiraterone by VCC along with associated savings. This information is monitored by the NHS Executive and is one of the 6 priorities for optimizing medicines value within NHS Wales (The other 5 are not applicable to VCC).

VCC Pharmacy Procurement Team ensure that all drugs which are available as part of a simple patient access scheme (discount at point of invoicing) are sourced appropriately at point of ordering and that those with a complex patient access scheme (retrospective discount or require additional administration paperwork) are managed according to each scheme's requirements. VCC Finance Team capture this information and are considering how to better ensure that HB partners are sighted on this in order to help demonstrate that VCC is managing these budgets effectively.

Priority #3: Abiraterone

Fig3: Abiraterone Ordered by Month (No of Tablets)

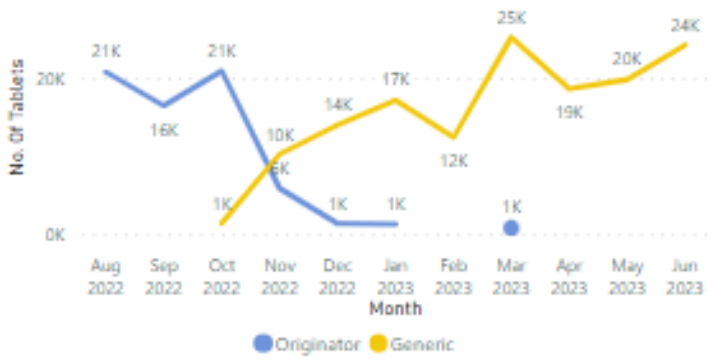
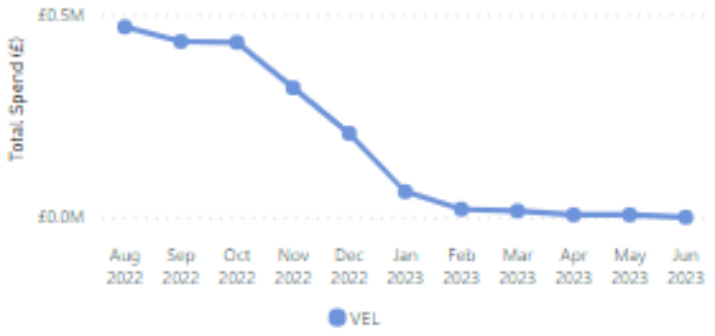


Fig6: Abiraterone: Total Originator Spend (3-Month Rolling)



Savings Achieved Through Ordering of Generic Product:

£3,039,356

Abiraterone: Savings Achieved Since Oct-22

Fig12: Abiraterone: Savings Achieved Since Oct-22 (3 Month Rolling)

2.5 Clinical Effectiveness

2.5.1 Unlicensed and Off-label use of medicines

MMG continue to review, approve and have clinical governance oversight of all unlicensed and 'off-label' medications. Between Jan – June 2023, there have been 10 requests that have fall under this category, all of which were clinically appropriate, and approved by MMG.

2.5.2 Antimicrobial Stewardship

Assurances of good Antimicrobial Stewardship (AMS) involves pharmacy undertaking a monthly audit against the national 'Start Smart Then Focus' (SSTF) measures; these measures form part of the Welsh Government Improvement Goals for 2021/22 (and remain to be the measures for 2022/23 2023/24).

Of the four SSTF measures, between Jan – June 2023, VCC performed above the all-Wales average for 3 of the 4 and the same for the 4th measure. Performance of these measures is regularly fed back to junior medical staff (SHOs) and is highlighted within their induction.

Since April 2023, the antimicrobial pharmacist post has been vacant, interviews for the post will take place on 26th July 2023. During the vacancy, the work has been managed by the Principal Pharmacist.

2.6 Pharmacy Service

2.6.1 Workforce

Pharmacy has not yet reported on the it's recent capacity review as planned for March 2023. The process of reviewing and amending the data capture was more complex than originally anticipated and focus has been on maintaining front line services. Since the work was undertaken there have been a number of additional factors that need to be considered, such as the Strategic Pharmacy Workforce Plan which has just been published, an internal focus at VCC of identifying additional IP pharmacist resource and a refreshment of SACT daycase demand and capacity work which is currently being undertaken. All of these elements will be included in Pharmacy's response which is now expected to be complete by Sept 2023.

3. RECOMMENDATION

EMB are asked to note the activity of the Medicines Management Group and endorse this assurance report.

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	**Select all relevant domains below**
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒

	The report summarises the work of MMG over the previous 6 months (January – June 2023) and provides assurances that MMG continue to perform its duties as outlines in the Terms of Reference to ensure safe and effective use of medicines across Velindre Cancer Centre.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	If more than one Well-being Goal applies please list below:
	The report gives several examples whereby patients health and wellbeing are maximised from the work undertaken by pharmacy and medicines management, e.g., providing treatment closer to home, ensuring access to medications through the use of early access schemes and individual funding requests, to ensuring safe prescribing through good antimicrobial stewardship.
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT	Not required - please outline why this is not required

For more information: *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	No areas of inequality identified within 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

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?	Choose an item
All risks must be evidenced and consistent with those recorded in Datix	

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

PUBLIC RESEARCH, DEVELOPMENT & INNOVATION SUB-COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	14/09/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Sarah Townsend, Head of Research & Development
PRESENTED BY	Professor Andrew Westwell, Chair of the Research, Development & Innovation Sub-Committee
EXECUTIVE SPONSOR APPROVED	Dr Jacinta Abraham, Executive Medical Director

REPORT PURPOSE	FOR NOTING

ACRONYMS	
CCRH	Cardiff Cancer Research Hub
HSST	Higher Specialist Scientist Training
IMTP	Integrated Medium Term Plan
nVCC	New Velindre Cancer Centre
RD&I	Research, Development and Innovation
QS&P	Quality, Safety and Performance Committee
TCS	Transforming Cancer Services
VCC	Velindre Cancer Centre
WBS	Welsh Blood Service

1. **PURPOSE**

This paper has been prepared to provide the Quality, Safety and Performance Committee with details of the key issues and items considered by the Public Meeting of the Research, Development and Innovation Sub-Committee on the 20/07/2023. Key highlights from the meeting are reported in Section 2. The Quality, Safety and Performance Committee is requested to NOTE the contents of the report and actions being taken.

2. **HIGHLIGHT REPORT**

ALERT / ESCALATE	There were no items identified for **ALERT** or **ESCALATION** to the Quality, Safety & Performance Committee.
ADVISE	**HEAD OF INNOVATION** The new Head of Innovation, Jennet Holmes, joined the Trust on 30th June 2023, previously from Welsh Government where she was Head of Innovation and Collaborative Partnerships. Jennet will take the lead on the implementation of the Trust's innovation strategy and ensure alignment with the Wales Innovation Strategy. **RADIOTHERAPY RESEARCH** A Radiotherapy Research Working Group has been set up to bring representatives from the three departments in Radiotherapy together, along with representatives from TCS. This collaborative group will share information with oversight of the Research Bunker in nVCC as well as relevant bids going into Charitable Funds and Advancing Radiotherapy Funds. From this group, a Task and Finish Subgroup has been formed to conduct an options appraisal, identifying the preferred type of machine to go into the research bunker that will facilitate and enhance the status of the nVCC/VCC/Trust as a UK/International research leader. Dr James Powell gave a brief overview of the project to date. The aim of this process was to identify the type of machine that would be best placed to go into the research bunker and the new Velindre Cancer Centre (nVCC).
ASSURE	**TRUST RD&I SUB-COMMITTEE RISK REGISTER EXTRACT** No open risks were recorded on Datix for escalation to July's 2023 Research, Development & Innovation Sub-Committee, in line with the Trust Board Risk Appetite. The Committee referenced that it will be important as we develop the implementation plans for the Cardiff Cancer Research Hub (CCRH), identifying potential risk and mitigating strategy, to be an agenda item going forward and noted that anything above the threshold, will be escalated through the governance structures. **TRUST RESEARCH, DEVELOPMENT AND INNOVATION PERFORMANCE ANNUAL REPORT 2022/23** An overview of the Trust Research, Development & Innovation Performance Annual Report 2023-23 was presented. The report reflects on the four RD&I Strategic Priorities, updated for 2022-23 with key achievements as published in the Trust's IMTP including the Financial Summary and Outputs. • **Summary of Performance Indicators** Overall, there has been marked improvement in the Trust run number of studies that have been RAG rated "GREEN" for the Health and Care Research Wales (HCRW) key indicators:

	○ OPEN studies – Percentage of studies recruiting to time and to target at NHS organisations in Wales with open studies being up 21% for non-commercial studies and up 11% for commercial studies. ○ CLOSED studies – Percentage of studies recruiting to target at NHS organisations in Wales with closed studies being up 37% for non-commercial studies; up 21% for commercial studies since last year. The RD&I Sub-Committee acknowledged and congratulated the Team on a tremendous and impressive Annual Report which included a substantial list of publications e.g. 29 pages of publications, in leading international journals including posters and presentations.
INFORM	**WELSH BLOOD SERVICE PRESENTATIONS:** Two presentations were received from WBS Colleagues on the following: • PROD Study Led by Felicity May, Clinical Scientist • Measuring the Immune Response after Kidney Transplantation led by Deborah Pritchard, Welsh Transplantation and Immunogenetics Laboratory Manager The RD&I Sub-Committee congratulated both WBS colleagues on their excellent research presentations, articulating the very complex nature of the studies into a very clear presentation. **EXECUTIVE SUMMARY HIGHLIGHTS** The Executive Medical Director Summary reported high-level activities relating to Research, Development and Innovation that took place during Quarter 4, Financial Year (FY) 2022/23. Key highlights included : **WELSH BLOOD SERVICE** • Advancing Kidney Transplant Treatments • WBS RD&I Strategy Update **RESEARCH & DEVELOPMENT** • Joint Executive Team Meeting • Cardiff Cancer Research Hub • First in the World and Europe • OnCovid Publications • Health and Care Research Wales: Research Framework • BioWales 2023 London **INNOVATION** • Innovation Lead • Wales Innovation Strategy • RITA – "Talking Heads" Sub-Project **WELSH SERVICE UPDATE** Felicity May was awarded 'Doctor of Clinical Science' after fulfilling the five-year rigorous demands of the NHS's Higher Specialist Scientist Training (HSST) programme. Felicity undertook an NHS Research study during the programme, looking at improving desensitisation treatments for renal patients.

APPENDICES	**NOT APPLICABLE**

3. RECOMMENDATION

The Quality, Safety & Performance Committee are asked to **NOTE** the key deliberations and highlights from the Public Meeting of the Research, Development & Innovation Sub-Committee held on the 20/07/2023.

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

HIGHLIGHT REPORT FROM THE CHAIR OF THE TCS PROGRAMME SCRUTINY SUB-COMMITTEE

DATE OF MEETING	14th September 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Jessica Corrigan, Business Support Officer
PRESENTED BY	Stephen Harries, Independent Member and Chair of the TCS Programme Scrutiny Sub-Committee
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning & Digital
REPORT PURPOSE	FOR NOTING

ACRONYMS	
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 19th June 2023.

1.2 Key highlights from the meeting are reported in section 2.

1.3 The Committee is requested to **NOTE** the contents of the report and actions being taken.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for alert/escalation to the Quality, Safety & Performance Committee.
ADVISE	There were no items identified to advise the Quality, Safety & Performance Committee.
ASSURE	**Programme Director's Report** The Programme Director's Report was received and discussed as follows: • Within Project 6: Service Delivery, Transformation and Transition states "has been deferred a few months given the delays in the nVCC programme". It was confirmed the timings are vague, but it would be helpful to have clarity around the timeline. The Sub-Committee were assured there is a lot of work happening regarding the service delivery, transformation and transition. Following financial close we will be in a good position to formally launch as an internal project. • It was confirmed the Sub-Committee will still receive reports from Projects 1 to 6 to make up that programme of work. • It was confirmed there has been no change in the governance and approvals arrangements. • A paper will be circulated to the Sub-Committee showing the clear scope demonstrating what projects or pieces of work are sat where and who's accountable for them. Showing the governance for each of these pieces of work ensuring there are no gaps. This is to provide clarification to the Sub-Committee and will feed up into Trust Board for information and assurance. The Sub-Committee **noted** the Programme Director's Report.

INFORM	**Communications & Engagement** The Sub-Committee received and **noted** the Communications & Engagement update.
APPENDICES	None.

QUALITY, SAFETY & PERFORMANCE COMMITTEE – JULY 2023 REFLECTIVE EVALUATION FEEDBACK

Questions Asked	Response 1	Response 2	Response 3	Proposed Action	Action Owner
Was sufficient time allocated to enable focused discussion for the items of business received at today's Committee?	Yes	It was a very busy agenda with a significant number of annual reports, so had to be very directional about high level discussion and keeping to key points. The monthly performance report had to be cut short in order to finish on time.	It was a lot to get through in the time available, however salient points did have enough time to be discussed.	N/A	
Was open and productive debate achieved within a supportive environment?	Yes	It felt that everyone had an opportunity to discuss key points	Some Committee members used the time to make more general points about the subject matter covered by the Annual Report which may have distracted the Committee from the key points presented.	Paper authors and Executive leads to ensure presentation of Annual Reports are concise and focused on key messages for the targeted audience.	Executive Leads
Was it possible to identify cross-cutting themes to support effective triangulation?	Not really	Yes the themes came across clearly.	This was very difficult given the range of topics covered.	Paper authors and Executive leads to ensure papers are concise and contain focused detail targeted for the audience.	Executive Leads
Was sufficient assurance provided to Committee members in relation to the Annual Reports and core essential business?	Yes	Inconsistent application of the written levels of assurance in executive covers.	The purpose of some of the annual reports wasn't to provide assurance but for those that did the information did provide sufficient assurance.	Further refining of meeting papers. Full implementation of the 7 levels of assurance.	Executive Leads & Director of Corporate Governance & Chief of Staff