Public Quality, Safety & Performance Committee

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

Microsoft Teams

Agenda

1. PRESENTATIONS

1.1. Welsh Blood Service - Donor Story

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

Link to video:
https://youtu.be/nMMquiCYpfg

2. STANDARD BUSINESS

2.1. Apologies

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

2.2. In Attendance

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

2.3. Declarations of Interest

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

2.4. Review of Action Log

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

📄 PUBLIC QSP Action Log March 2023.pdf (4 pages)

2.5. Matters Arising

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

2.5.1. Medical Devices Report - Oral Update

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

3. CONSENT ITEMS FOR APPROVAL

3.1. Draft Minutes from the meeting of the Public Quality, Safety & Performance Committee held on the 17th January 2023

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

📄 Public Quality Safety Performance Committee Minutes 17.01.23(v4approved).pdf (19 pages)

3.2. Trust Policies for Approval

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

3.2.1. QS19 - Ionising Radiation Safety Policy

Jacinta Abraham

📄 QS19 - Ionising Radiation Safety Policy.pdf (66 pages)

3.2.2. IPC13 - Policy for the prevention and control of transmissible spongiform encephalopathies (Creutzfeldt-Jakob Disease (CJD)) minimising the risk of transmission.

Nicola Williams

📄 IPC13 - CJD Policy - 2023-03-08 1.pdf (26 pages)

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4. CONSENT ITEMS FOR ENDORSEMENT

4.1. Committee Terms of Reference and Operating Arrangements

To be led by Emma Stephens, Head of Corporate Governance

📄 QSP Terms of Reference.pdf (28 pages)

4.2. Committee Cycle of Business

To be led by Emma Stephens, Head of Corporate Governance

📄 QSP Cycle of Business.pdf (13 pages)

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5. NHS Wales Shared Services Partnership

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

To be led by Gareth Tyrrell, Head of Technical Services, CIVAS@IP5

📄 CIVAS@IP5 Report.pdf (32 pages)

5.2. Implementation of Duty of Quality Update

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

📄 NWSSP Duty of Quality for QSP.pdf (8 pages)

5.3. Update - NWSSP Self-Assessment of Health and Care Standards

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

📄 QSP Cttee Health and Care Feb 2023.pdf (5 pages)

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6. MAIN AGENDA

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

6.1. Trust Risk Register / Trust Assurance Framework

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

6.1.1. Trust Risk Register

Lauren Fear

📄 RISK REGISTER - QSP - 16.03.2023 - vfinal.pdf (8 pages)
📄 RR - Appendix 1 -RISK REGISTER - QSP- ALL RISK DATA - V05.pdf (5 pages)
📄 RR - Appendix 2 - Level 12 Risks Scrutiny Assurance Statements.pdf (1 pages)

6.1.2. Trust Assurance Framework

Lauren Fear

📄 TAF PAPER - QSP -16.03.2023 - vfinal.pdf (4 pages)
📄 V28 - TAF DASHBOARD - QSP CUT - 16.03.2023.pdf (19 pages)

6.2. Triangulated Workforce & Organisational Development Performance Report / Finance Report

To be led by Sarah Morley, Executive Director of Workforce & Organisational Development and Matthew Bunce, Executive Director of Finance

📄 QSP Finance Workforce Key Risks Paper - March paper final.pdf (14 pages)

6.2.1. Finance Report

To be led by Matthew Bunce, Executive Finance Director

📄 FINANCE REPORT (inc. TCS Programme Finance Report).pdf (45 pages)

6.3. Performance Management Framework Report

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

📄 QSP Cttee 16.03.23 JANUARY PMF Performance Report FINAL version 010.pdf (58 pages)

6.3.1. Welsh Blood Service Quality, Safety & Performance Divisional Report

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

📄 WBS Q+S Report March 2023 Final.docxAP.pdf (16 pages)

6.4. IMTP 2022-2023 Quarterly Actions Progress Report (Q3)

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

📄 IMTP 2022-2023 Quarterly Progress Report Q3.pdf (83 pages)

6.5. Value Based Healthcare

To be led by Matthew Bunce, Executive Finance Director

📄 VBHC Programme Update_QSP_Mar 2023.pdf (4 pages)

6.6. Medical Examiner's Service & Mortality Framework Report

To be led by Dr Jacinta Abraham, Executive Medical Director

📄 MES Mortality Update February 2023 Final QS&PC 17.03.2023.pdf (7 pages)

6.7. Quality & Safety Quarter 3 Report

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

📄 Quality and Safety 2022-23 Quarter 3 report (MASTER) 2023-03-08 1.pdf (21 pages)

6.8. Palliative and End of Life Care Quality Statement

To be led by Helen Way, ANP / Lead Nurse Palliative Care

📄 Palliative and End of Life Care.pdf (15 pages)
📄 quality-statement-palliative-and-end-life-care-wales.pdf (13 pages)

7. CONSENT ITEMS FOR NOTING

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.

7.1. Draft unapproved minutes from the meeting of the Private Quality, Safety & Performance Committee held on 17th January 2023

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

📄 Private Quality Safety and Performance Committee 17.01.2023(v3approved).pdf (3 pages)

7.2. Highlight Report from the Infection Prevention & Control Management Group

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

📄 IPCMG highlight report February 2023 QSPv1 2023-03-08 1.pdf (4 pages)

7.3. Professional Nursing Update Report

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

📄 Professional Nursing paper- Oct 22-Feb 23 QSPv1 2023-03-08 4.pdf (11 pages)

7.4. Transforming Cancer Services (TCS) Programme Scrutiny Sub Committee Highlight Report

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

📄 Highlight Report - PUBLIC TCS 26.01.2023 (002).pdf (2 pages)

7.5. Highlight Report from the Trust Estates Assurance Group

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

📄 Trust Estates Group Highlight Report QSP.pdf (6 pages)

7.6. Assurance Report Medicines Management Group

To be led by Dr Jacinta Abraham, Executive Medical Director

📄 Medicines Management Group Report_QS&PC 16.03.23.pdf (12 pages)

7.7. Nosocomial Transmission Update

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

📄 Nosocomial Programme Board paper 2023-03-02 QSPv1 2023-03-08.pdf (5 pages)

7.8. Internal Audit Reports

To be led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science and Dr Jacinta Abraham, Executive Medical Director

- Patient / Donor Experience Internal Audit Report
- Clinical Audit Final Internal Audit Report

7.8.1. Patient / Donor Experience Internal Audit Report

Nicola Williams

📄 Patient & Donor Experience Internal Audit Report.pdf (20 pages)

7.8.2. Clinical Audit Internal Audit Report

Jacinta Abraham

📄 Clinical Audit Internal Audit Report.pdf (25 pages)

7.9. Trust-wide Policies and Procedures Compliance Report

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

📄 Policy Compliance Report v8.pdf (40 pages)

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8. INTEGRATED GOVERNANCE

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

8.1. March 2023 Analysis of triangulated meeting themes

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

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

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

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

8.3. Committee Effectiveness Survey Report - Reflective Feedback from January 2023 Committee

To be led by Emma Stephens, Head of Corporate Governance

📄 QSP Committee Effectiveness Survey Cover Report_FINAL.pdf (7 pages)

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9. HIGHLIGHT REPORT TO TRUST BOARD

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

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

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10. ANY OTHER BUSINESS

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

Prior approval by the Chair required.

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11. DATE AND TIME OF NEXT MEETING

The Quality, Safety & Performance Committee will next meet on the 16th May 2023 from 10:00 - 13:00.

QUALITY, SAFETY AND PERFORMANCE - PART A					
Minute ref	**Action**	**Action Owner**	**Progress to Date**	**Target Date**	**Status (Open/Closed)**
Actions agreed at the 14th July 2022 Committee					
4.4.0	ND to confirm Trust position re Putting Things Right in comparison to other organisations in the next quarterly PTR report.	Nigel Downes	**Update 07/03/2023** - Summary included in Quarter 3 report as agreed. **Update 17/01/2023** - A review of other Health Boards' Putting Things Right reports had been undertaken and a summary will be included in the Quarter 3 report received at the March 2023 Committee.	16/03/2023	CLOSED
Actions agreed at the 10th November 2022 Committee					
17.02.2022 (superseded)	Supersedes action closed at the November 2022 Committee in relation to invitation of a Public Health Wales representative to a future Board Development Session to facilitate a discussion in relation to the Trust's role / requirements & public health. This will require an alternative approach.	Lauren Fear	**Update 17/02/2023** - LF advised that a session on the Public Health agenda will be included in the 2023-24 Board Development schedule. It was therefore agreed that the action would remain open with a revised narrative agreed by LF / DM, outlining the significant amount of work to date and anticipated progress during 2023-24.	17/01/2023 now 2023/24	OPEN

3.0.0	Signed off actions identified following the self-assessment of Health and Care Standards to be sighted at the March QSP Committee.	Peter Stephenson	**Update 07/02/2023** - An action plan and progress will be presented at the March QSP Committee.	16/03/2023	CLOSED
3.0.0	Discussion re reporting requirements to QSP Committee to be undertaken with NWSSP in relation to reporting requirements.	Vicky Morris/ Nicola Williams/ Emma Stephens/ Lauren Fear/ Secretariat	**Update 16/12/2022** - Meeting scheduled for 18/01/2023.	16/03/2023	CLOSED
4.1.0	Discussion required in relation to how an appropriate level of detail regarding objectives and target dates which support the IMTP progress report can be included.	Carl James/Hilary Jones	**Update 17/02/2023 -** Discussion undertaken 13/02/2023.	17/01/2023 now 16/03/2023	CLOSED
4.1.0	A review of narrative around Radiotherapy and SACT performance (within IMTP quarterly progress report) to be reviewed to align with VCS performance report.	Cath O'Brien	**Update 10/01/2023** - A further update will be provided at the March 2023 Committee.	17/01/2023 now 16/03/2023	OPEN
4.4.1	Recommendations from the Human Tissue Authority (HTA) inspection of WBS to be sighted at the January 2023 Committee.	Alan Prosser/Peter Richardson	**Update 17/01/2023** - This report had been omitted from the January Committee papers in error and it was agreed to circulate the report following the meeting. This has since been completed.	17/01/2023	CLOSED

			Update 17/01/2023 - This narrative is now included in the report. It was agreed to ensure this level of detail does not become patient identifiable and it was agreed to include whether breached patients are risk assessed and the risk managed appropriately and subsequent timeliness of treatment. An update will follow at the March 2023 Committee.Update 10/01/2023 - **A further update will be provided at the March 2023 Committee.**		
4.4.2	Further narrative in relation to SACT breaches detailing when patients <u>not</u> managed within National timescales received treatment to be circulated to Committee members.	Paul Wilkins		17/01/2023 now 16/03/2023	OPEN
Actions agreed at the 17th January 2023 Committee					
1.5.0 (10/11/22)	Secretariat to confirm with COB whether equality impact assessment has been undertaken in relation to Oral SACT Education.	Secretariat/Cath O'Brien	**Update 18/01/2023 -** Confirmation requested.	16/03/2023	OPEN
3.1.1	LF to address governance process for new products prior to coming onstream with NWSSP.	Lauren Fear	**Update 07/03/2023** - An update is to be provided at the March 2023 Committee.	16/03/2023	OPEN
3.1.2	QS02 Management of Safety Alerts and Important Notifications Policy to be amended as discussed at the January Committee prior to Trust Board.	Nicola Williams	**Update 26/01/2023** - This item is complete.	16/03/2023	CLOSED
3.3.5	Medical Devices Report update to be sighted by QSP Committee prior to July 2023.	Cath O'Brien		16/05/2023	OPEN

5.1.0	Secretariat to circulate Committee Effectiveness questions to members/attendees following the meeting to encourage feedback.	Secretariat	**Update 17/01/2023** - This item is complete.	16/03/2023	CLOSED
4.1.0	NW/JA to refine wording of Trust Integrated Quality & Safety Group document in terms of accountability and delivery during six-month review.	Nicola Williams/Jacinta Abraham		13/07/2023	OPEN
4.1.0	NW to update group membership of Trust Integrated Quality & Safety Group to include Patient Engagement member.	Nicola Williams	**Update 01/03/2023** - This item has been actioned and relevant Patient Engagement Member added to the Terms of Reference.	16/03/2023	CLOSED
4.3.0	NW/DM to discuss cessation of streamlining process for Radiotherapists and impact on recruitment.	Nicola Williams/Donna Mead	**Update 01/03/2023** - This item is to be discussed at the next 1:1	16/03/2023	OPEN
4.4.1	NW/PW to address misalignment of VCS Divisional Report and Summary Performance Report.	Nicola Williams/Paul Wilkins	**Update 01/03/2023** - This item has been actioned and revised reporting timescales will be provided for future meetings.	16/03/2023	CLOSED
4.4.1	PW to amend the narrative in the VCS report to avoid confusion in relation to transport delays for emergency patients.	Paul Wilkins	**Update 07/03/2023** - An update is to be provided at the March 2023 Committee.	16/03/2023	OPEN

Minutes

Public Quality, Safety & Performance

Committee Velindre University NHS Trust

Date:	17th January 2023
Time:	10:00 – 13:00
Location:	Microsoft Teams
Chair:	Vicky Morris, Independent Member

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

1.0.0	PRESENTATIONS	Action Lead
1.1.0	**Velindre Cancer Service – Patient Story** Led by Michele Pengelly – Specialist Nurse (Supportive Care) Prior to the meeting, the Committee had received a heart-warming patient story by means of a PowerPoint presentation, relating to the arrangement of a wedding blessing at Velindre Cancer Centre for a patient who had received a terminal prognosis and wished to have their 25 years of marriage blessed before the end of their life, before being discharged home the next day to continue end of life care. What was important (what mattered most) to the patient had been identified and staff from a number of departments went well over and above and worked together to ensure that this was met (which was a wedding blessing and to be able to die at home). The importance of ascertaining what mattered most to the patient and working as a team to go above and beyond to achieve this for the patient was recognised and commended by the Committee and it	

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	was noted that understanding patients' needs and desires during their journey is as important as treatment and clinical care. SH queried whether support is in place for staff who would not normally have first hand experience of distressing situations (e.g. catering) when supporting such situations. MP advised that a range of wellbeing resources are in place within the Trust to support staff in a number of ways and that staff wellbeing checks were undertaken following this event. The patient's family was thanked for generously allowing the sharing of this very personal and emotive story and MP was asked to convey thanks to all staff who had been involved.	
2.0.0	**STANDARD BUSINESS**	
2.1.0	**Apologies** had been received from: • Cath O'Brien, Chief Operating Officer • Katrina Febry, Audit Lead, Audit Wales • Carl James, Director of Strategic Transformation, Planning & Digital • Rachel Hennessy, Interim Head of Operational Services *SH left the meeting at 11:05am, returning at 11:30am* *SHa left the meeting at 11:20am, returning at 12:15pm*	**COB** **KF** **CJ** **RH**
2.2.0	**Additional Attendees:** • Heledd Thomas, Senior Auditor, Audit Wales • Stephen Allen, Chief Officer *(South Glamorgan Community Health Council)* • Emma Rees, Deputy Head of Internal Audit *(NWSSP)* • Viv Cooper, Head of Nursing, Quality, Patient Experience & Integrated Care • Phil Hodson, Assistant Director of Planning & Performance *(deputising for Carl James)* • Rhiannon Freshney, Environmental Development Officer *(for item 4.7.0)* • Michele Pengelly, Specialist Nurse *(for item 1.1.0)* • Melanie Findlay, Business Support Officer *(to observe item 4.8.0)*	**HT** **SA** **ER** **VC** **PH** **RF** **MP** **MF**
2.3.0	**Declarations of Interest** Led by Vicky Morris, Quality, Safety & Performance Committee Chair No declarations of interest were raised.	
2.4.0	**Review of Action Log** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science The action log was discussed in detail. Committee members confirmed that they were assured that the 15 actions identified as complete on the action log	

	had been fully instigated and could therefore be formally closed. The items not yet due for completion were not discussed and will remain open. The remaining actions were reviewed and the following was agreed: • **4.4.0 (14//07/2022) – Confirm Trust position regarding Putting Things Right in comparison to other organisations** – NW confirmed that a review of other Health Boards' Putting Things Right annual reports had been undertaken and that a summary would be included in the Quarter 3 report, to be received at the March 2023 Committee. • **0.0.1 (15/09/2022) – VCS team to explore options for improved ambulance transport for Radiotherapy day case patients** – PW advised that regular dialogue with the Welsh Ambulance Service continues, in addition to leading a pathway review for same day patient transfer. SA advised that a meeting would shortly take place between Velindre and South Glamorgan Community Health Council to further progress this with the Welsh Ambulance Service. It was agreed to close the action as this work is underway. • **Superseded action from 17/02/2022 (10/11/2022) – Invitation of a Public Health Wales representative to a future Board Development session to ascertain the Trust's role / requirements** - LF advised that a session on the Public Health agenda will be included in the 2023-24 Board Development schedule. It was therefore agreed that the action would remain open with a revised narrative to place this on the Board Development Schedule for 2023-24. • **1.5.0 (10/11/2023) – Information available to patients in relation to Oral SACT Education to be provided at SH's request** – PW confirmed that a link containing information had been provided to SH and the action was closed. It was agreed that the Committee Secretariat would seek confirmation that an equality impact assessment had been undertaken. • **1.5.0 (10/11/2023) – CJ to review reporting of risks presented in areas of limited assurance against potential clinical issues and escalation of these to the Committee** – PH advised that this action has been completed and was closed. It was advised that Trust Risk Management Procedures and policies are being adhered to. • **4.1.0 (10/11/2022) – Discussion required in relation to including appropriate level of detail regarding objectives and target dates to support the IMTP progress report** – PH advised that this action needs to remain open as meeting is yet to be arranged. • **4.4.1 (11/10/2022) – Recommendations from the Human Tissue Authority (HTA) inspection of WBS to be sighted at the January 2023 Committee** – This report had been omitted from the Committee papers in error and AP advised that this would be circulated following the meeting.	**NW** **Secretariat** **LF/DM** **Secretariat** **Secretariat** **PH** **AP**

	• *4.4.2 (11/10/2022) – Further narrative in relation to Radiotherapy / SACT breaches detailing when patients are not managed within National timescales received treatment to be sighted by Committee members* – PW advised that this had now been included in the report. It was agreed that it is critical that all information remains totally anonymous and not in any way identifiable. DM suggested that reporting need only include information regarding whether breached patients were clinically risk assessed, appropriate management of identified risks and subsequent timeliness of treatment.	**PW**
	• *4.7.0 (11/10/2022) – Estates Annual Report to be amended, removing reference to years outside the reporting period and to provide clarity around completed recommendations and timescales* – PH advised that this action has been completed retrospectively and would be taken forward into future annual reporting. It was agreed that the action could be closed.	**Secretariat**
2.5.0	**Matters Arising** Led by Vicky Morris, Quality, Safety & Performance Chair	
2.5.1	**Committee Effectiveness Survey – Updated Action Plan** Led by Emma Stephens, Head of Corporate Governance ES discussed the updated Committee Effectiveness Survey Action Plan that included three additional areas going forward (frequency of meetings, constructive scrutiny and continual review of effectiveness). Additionally, a series of short, targeted questions (included under item 5.1.0) will be circulated to members and attendees following each meeting, with immediate effect and outcomes reported at the subsequent meeting.	
2.5.2	**Updated Private Patient Improvement Plan** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science NW presented the revised Patient Improvement Plan following discussion of achievability with the external expert support team. There was only one action that the external team advised could not be achieved by the timescale previously provided to the Committee relating to the re-negotiation of contracts with large insurers. It was proposed that this could be achieved by the end of June 2023 (previous date March 2023). DM queried whether an equality impact assessment would be required for this paper. NW advised it was not undertaken for this paper as was just a slight date adjustment. VM advised the Committee that the revised Improvement Plan had also been considered at Audit Committee. SH queried whether any unforeseen issues had arisen following the move from the CANISC Patient Administration System to the Digital Health & Care	

	Record System. NW advised that a small number of emerging challenges resulting from the changeover are currently being addressed via the 'Business As Usual Management Group' for private patients and escalations would follow as required. The Committee **APPROVED** the amendment made to the Patient Improvement Plan and DM acknowledged the significant amount of work involved.	
3.0.0	**CONSENT ITEMS** (The consent part of the agenda considers routine Committee business as a single agenda item. Members may ask for items to be moved to the main agenda if a fuller discussion is required).	
3.1.0	**ITEMS FOR APPROVAL**	
3.1.1	**Draft Minutes from the meeting of the Public Quality & Safety Committee held on the 10th November 2022** Led by Vicky Morris, Quality, Safety and Performance Committee Chair **Accuracy:** *Item 3.3.0 (Shared Services)* – "It was agreed that the Quality, Safety & Performance Committee is to receive notification of any new products <u>prior</u> to formal introduction." DM indicated that the discussion agreeing that the Committee requires assurance that a process is in place to ensure that new products have progressed through request and due appraisal process from the Health Boards had not been captured in the minutes or action log. LF advised that a meeting was scheduled to take place between the Trust and Shared Services this week at which the above would be addressed. The above will be noted on the action log. The Committee **APPROVED** the minutes from the 10th November 2022 Public Quality, Safety & Performance Committee subject to the addition of the above action to the action log.	**LF** **Secretariat**
3.1.2	**Trust-wide Policies for Approval** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science The Management of Safety Alerts and Important Notifications revised Policy **(QS02)** was received. The Committee were advised that the following additional changes would be made prior to providing to Board for final approval: • Welsh Blood Service Nominated Assigned Leads will be added to appendix 1 • Reporting lines to be amended if the Committee provides approval to the proposal to transfer the work of the Patient Safety Alerts Group to the Trust Integrated Quality Group (item 4.1.0).	

	The Committee **APPROVED** the policy, subject to amendments noted above. Following this, the policy will be circulated to Committee Members.		**NW**
3.2.0	**ITEMS FOR ENDORSEMENT**		
3.2.1	There were no items for endorsement.		
3.3.0	**ITEMS FOR NOTING**		
3.3.1	**Draft Summary of the unapproved Minutes from the meeting of the Private Quality, Safety & Performance Committee held on 10th November 2022** Led by Vicky Morris, Quality, Safety and Performance Committee Chair The Committee **NOTED** the summary minutes from the Private Quality, Safety & Performance Committee held on 10th November 2022.		
3.3.2	**RD&I Sub Committee Highlight Report (15th November 2022)** Led by Jacinta Abraham, Executive Medical Director The Committee **NOTED** the content of the RD&I Sub Committee Highlight report of the meeting held on the 15th November 2023 and actions being taken.		
3.3.3	**Transforming Cancer Services Programme Scrutiny Sub Committee Highlight Report (17th November 2022)** Led by Stephen Harries, Vice Chair and Chair of the Transforming Cancer Services Scrutiny Sub Committee The Committee **NOTED** the content of the Transforming Cancer Services Programme Scrutiny Sub Committee Highlight Report of the meeting held on the 17th November 2022 and actions being taken.		
3.3.4	**Datix Project Report** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science The Committee **NOTED** the key outcomes from the October and December 2022 Datix Project Board meetings and the Executive Management Board's **approval** to close the Datix Project Board down following the January 2023 meeting and initiate a quarterly Datix Operational Group.		
3.3.5	**Medical Devices Report** Led by Paul Wilkins, Director of Velindre Cancer Service The report was removed from consent by DM to allow for further discussion. The Medical Devices report provided an update on Trust compliance with the medical devices regulations. DM noted and commended the comprehensive cycle of maintenance and preparations for the new Velindre Cancer Centre and requested that the Committee receives a further update prior to the next annual report (July 2023) as new regulations will come into effect and the		

	Trust will be required to monitor compliance against these. PW agreed to ask Cath O'Brien to provide this. Following a query from VM, PR advised that in the absence of a track and trace system in relation to regular checks / recalibration of devices, a dedicated database for the management of devices is currently being populated. Additionally, an inventory of equipment is in place. The Committee **NOTED** the content of the report and actions being taken and agreed to receive an update prior to the annual report.	**PW** Secretariat
3.3.6	**Information Governance Assurance Report** Led by Matthew Bunce, Executive Finance Director The Committee **NOTED** the Information Governance Assurance report.	
3.3.7	**Vaccination Programme Update** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science DM queried whether Digital Health & Care Wales had resolved the issues reported in relation to the Velindre instance of the Welsh Immunisation System (WIS) and Trust access, to enable the Trust to administer COVID-19 booster vaccinations during Autumn 2023. NW advised that further discussions would take place at the next Vaccination Programme Board (24/01/2023), in addition to an evaluation as to whether it is preferable for staff to receive their COVID-19 vaccination via their local Health Boards or via the Trust. An update will follow at a future Committee. The Committee **NOTED** the completion of the Autumn 2022 Influenza vaccination programme and proposed action to ascertain COVID-19 booster vaccination status of Trust staff.	**NW**
3.3.8	**Safe Care Collaborative** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science The Committee **NOTED** the national and Trust Safe Care Collaborative plans as detailed in section 3.2.3 of the report.	
3.3.9	**Hepatitis E Virus Testing of Apheresis Platelet Donors** Led by Alan Prosser, Director of Welsh Blood Service DM asked regarding the non-issue of a small number of units of platelets earmarked for neonatal services that were subsequently discarded. AP advised that the service is required to have available 'just in case' units for unexpected emergencies and is therefore considered acceptable as 'planned wastage'. The Committee **NOTED** the incident and the requirement to report it to	

	regulators the decision to test individual Apheresis Platelet donation until the SaBTO (Advisory Committee on the Safety of Blood, Tissues and Organs) guidance is confirmed.	
4.0.0	**MAIN AGENDA** (This section supports the discussion items for review, scrutiny and assurance).	
4.1.0	**Trust Integrated Quality & Safety Group** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science An overview of the newly established Trust Integrated Quality & Safety Group was received, including key deliberations and outcomes of the three initial group meetings held between October and December 2022, in addition to the Group's Terms of Reference for Committee approval. The following was highlighted: • The group has been established to provide Executive operational oversight to support the Trust in meeting its Quality and Safety responsibilities, including the legislative and national requirements in relation to the 'Duty of Quality' responsibilities. • The group identified the need to develop a robust automated business intelligence system and to identify and report on the Trust's comprehensive suite of quality, harm and safety metrics. • A number of pieces of work will be undertaken to embed the above into the performance framework, in addition to development of automatic and electronic data capture for collation via a dashboard, enabling informed triangulation and meaningful analysis across multiple Quality & Safety experience areas. • It is intended that the work of the Patient Safety Alerts Group is incorporated into the Integrated Quality & Safety Group and that the Datix Project Board is stood down following this Committee. The Committee was advised that assurance and escalation mechanisms would be maintained. • It is anticipated that emerging triangulated themes and outputs from the Group would be sighted by the Committee in May 2023 at the earliest. MB advised that the recruitment of business intelligence and digital staff to support the group is imminent. However, a procurement process had been undertaken to enable the provision of expert support in the interim. HJ queried the timeframe for the development of quality, harm and safety metrics / the business intelligence system. NW advised that prior to the development of automated data capture, the first phase would focus on high level discussions around strategic measures and 'what good looks like', defined across both divisions followed by agreed measures for implementation (by 1st April 2023). DM queried the wording of the report in relation to accountability, delivery	

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	and escalation and it was agreed that this would be refined by NW / JA during the six-month review.	**NW/JA**
	SA noted the absence of a Patient Engagement group member. NW advised that following first draft of the Terms of Reference the new Patient Engagement Lead has agreed to be a member. The Terms of Reference will be amended to reflect this.	**NW**
	The Committee:	
	• **APPROVED** the Integrated Quality & Safety Group Terms of Reference, pending the addition of the Patient Engagement Lead to the Terms of Reference. • **APPROVED** the proposal to incorporate the work of the Safety Alerts Group into the Integrated Quality & Safety Group, and to close down the Datix Project Board (separate paper on the Committee agenda).	
4.2.0	**Duty of Quality Gap Analysis** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science The Duty of Quality Gap Analysis report was received, which provided an initial gap analysis and draft initial implementation plan against the Duty of Quality draft Statutory Guidance (currently out for consultation and closing today). The following was highlighted: • Finalisation of the Trust's submission to the consultation is underway. • The Duty of Quality is far more complex and comprehensive than the Duty of Candour, requiring extensive change (including cultural) from service delivery to Board, ensuring quality informs decision-making at both divisional and Board level. • The final Statutory Guidance document is unlikely to be published until a few weeks prior to the 1st April 2023, (when the Duty must be enacted); therefore current plans are based on the Consultation documentation. • A number of timescales will be challenging in terms of delivery, however the Trust is committed to supporting these. Resource requirements for delivery have been identified and will be included within the IMTP. • Work has been undertaken in conjunction with the national Duty of Quality & Duty of Candour Implementation Board to identify minimum requirements to be in place by the 1st April 2023 and legal advice on behalf of NHS bodies is currently being sought in this regard. • Commissioning and hosted bodies require further work in terms of the Statutory Guidance document and there will be a national requirement for commissioning for Quality. It was recognised that the Trust Integrated Quality & Safety Group will be integral to demonstrating the Trust's compliance with both Duties. The Committee will receive an implementation update at the next meeting, including draft reporting templates and Trust Quality Impact Assessment Tool.	

	HJ queried the colour coding of the implementation plan and coding of some items as red despite not having exceeded their target date. NW advised that this was due to actions potentially being at risk; however, this information will be transferred to the new '7 levels of assurance' template, providing further clarity and scoring consistency. The Committee **DISCUSSED** the paper and **NOTED** the implementation resource requirements and the draft Duty of Quality implementation plan*.*	

4.3.0	**Workforce and Organisational Development Performance Report / Financial Report**
	Led by Sarah Morley, Executive Director of Workforce and Organisational Development and Matthew Bunce, Executive Director of Finance
	
	The combined finance and Workforce and Organisational Development report that highlighted the key workforce and associated finance risks currently being faced by the Trust, including required management action to ensure risk mitigation and performance improvement was discussed. SfM advised that:
	
	• Positive progress has been made in relation to the recruitment process. Although a significant number of vacancies remain, targeted recruitment intervention in hotspot areas has resulted in improvement, leading to an anticipated 16% year on year reduction in agency spend for 2022-23. This was achieved by:
	    o Efforts to identify root causes of recruitment issues in certain areas, providing one to one training to support Managers in administering the recruitment process.
	    o Temporarily removing the necessity for Welsh Language Translation of a number of core job descriptions before advertising.
	    o Reviewing the scrutiny process, removing the requirement for additional scrutiny for like-for-like replacements.
	
	• The National Recruitment Modernisation Board has analysed each element of the recruitment process to identify improvements and changes to streamline the process, resulting in a reduction in 'time to hire'.
	• Regular quarterly meetings between Workforce, Finance and Service Managers will also ensure continued triangulated conversations around any challenges in this regard.
	• A number of projects are underway to explore 'cultural' hotspots within the organisation, looking at values and employment relations issues, collating verbal feedback / feedback through the work in confidence platform. Bespoke interventions will be developed to target areas of challenge.
	
	VM queried whether the current 'time to recruit' position would be sustained. SfM advised that the combination of targeted interventions and national changes would allow a more sustainable route going forward.
	
	MB advised that:
	• The Trust is currently addressing the need to change the workforce model	

to achieve service sustainability, requiring collective input to develop a workforce able to deliver services in an alternative way and redeployment of funding resource among service areas. This, in turn, will also provide financial sustainability.

- Risk remains in relation to income to cover COVID backlog, additional capacity costs and alignment of income received with this.
- The Trust currently has an overall combined sickness and vacancy level of approximately 13% of the workforce, impacting service delivery. However, this is reducing.

DM queried whether there is a bank resource in place that can be drawn on to avoid agency spend. MB advised that while creating banks within the Cancer Centre is currently being explored, additional capacity required is mostly covered by overtime, costing less than agency.

DM requested further discussion with NW in relation to the discontinuation of streamlining for Radiotherapists and the impact on the Trust's ability to recruit directly. This will be discussed further outside the Committee.

NW/DM

The Committee **NOTED** and **CONSIDERED** the combined workforce risks, opportunities and associated financial impacts as outlined within the content of the report.

4.3.1	**Finance Report**

Finance Report
Led by Matthew Bunce, Executive Finance Director

The Finance Report outlining the financial position and performance to the end of November 2022 was discussed. The following was highlighted by MB:

- The financial Key Performance Indicators are on target in terms of forecast year end, with a projected year-end position of break-even.
- Ongoing management of the Capital Programme, with a projected spend of £23m.
- Public Sector Payment Policy performance achieved a compliance rate of 96%, resulting in a cumulative Trust compliance figure of 95.72%.
- It has not been possible to deliver two savings schemes relating to workforce redesign during this financial year for a number of reasons (sickness and vacancy levels, service pressures); this has been recognised and alternative schemes implemented which are delivering.
- Risk remains in terms of investment made in staffing to establish COVID capacity for recovery and generation of income to cover this. A review of the investment is currently underway to allow the Committee sight of identified quality improvements, reduction in waiting times etc. to enable identification of actions required to close the deficit.

The Committee **NOTED** the content of the November 2022 financial report and in particular, the financial performance to date and year-end forecast to achieve financial break-even and key risk in relation to income to cover COVID backlog additional capacity costs. The Committee also **NOTED** the Transforming Cancer Services Programme financial report for November

	2022.	
4.3.2	**Workforce Report** Led by Sarah Morley, Executive Director of Workforce and Organisational Development The Workforce Report was received and the following Key Performance Indicators were discussed by SfM: • Ongoing reduction in sickness levels (from 6.3% Oct 2022 to 6.19% Nov 2022). Welsh Government has been approached by the Trust and is currently reviewing the historic 3.54% sickness absence target with the aim to agreeing a more realistic target. • PADR –The Committee were assured that 85% compliance with the PADR process within Corporate areas would be achieved by the end of March 2023 (currently standing at 63.64%). The Committee **NOTED** the content of the report.	
4.3.3	**Gender Pay Gap Report** Led by Sarah Morley, Executive Director of Workforce and Organisational Development The Annual Gender Pay Gap report that provided data / activity for the mean and median gender pay gaps, bonus gaps, proportion of bonuses received by each gender and proportion of employees within each pay quartile as at 30th March 2022 was presented by SfM. The Committee were advised that the Trust is legally required to publish a Gender Pay Gap report annually and to include NHS Wales Shared Services as this is the Trust's largest hosted organisation. Therefore, the overall mean gender pay gap for the Trust is 4%. However, the mean gender pay gap for core (Trust provided) services alone is 14%. Actions were detailed in the report outlining actions for the Trust to reduce this 14% gap. DM queried the use of the word gender within the report as the Trust does not collect gender-related data. SfM advised that the use of 'gender' in the title and narrative of the report is a legal requirement. The Committee **ENDORSED** the report for Trust Board approval.	
4.4.0	**Quality, Safety & Performance Reporting** Led by Cath O'Brien, Chief Operating Officer *This item was not discussed and is covered in further detail under items 4.4.1 and 4.4.2*	
4.4.1	**Velindre Cancer Service Quality Safety & Performance Divisional Report** Led by Paul Wilkins, Director of Velindre Cancer Service The Velindre Cancer Service report provided an update on performance against key metrics for the period until the end of November 2022. The	

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following areas were highlighted:

- An update on the investigation status relating to the two previously reported National Reportable Incidents (NRIs) (Part B). Both investigations are almost concluded and a number of learning and improvement actions have been identified. The improvement action plan was provided.
- Medical Examiners' Service – The Trust is not yet fully compliant with Medical Examiner Service requirements. A successful colorectal pilot was undertaken and reviewed by the Senior Leadership Team. Resources to roll the requirements out fully are required.
- Generally positive feedback was received following two Healthcare Inspectorate Wales (HIW) inspections: Nuclear Medicine and First Floor Ward. Some improvements were identified and the Committee received assurance on the completion within identified timescales of the improvement plans.
- Introduction of a new Immunotherapy service (formally launched in September 2022), has received positive feedback from Welsh Government. This is now fully staffed and it is the intention to strengthen the internal governance arrangements around the service.
- A robust dashboard is now in place for the Altered Airways patient safety improvement project. The service will address any concerns regarding altered airway patients and provide a point of contact for such patients. 59 staff have recently undertaken training for management of altered airways.
- 100% compliance relating to management of concerns (22 concerns were raised, 9 of which were early resolutions).
- A comprehensive action plan is in place to facilitate the implementation of improvements to the Brachytherapy Service.

VM raised the recurring issue of misalignment of the timings of the Velindre Cancer Service Divisional Report (October 2022) and Summary Performance Report (November 2022) and it was agreed that revised reporting periods would be provided for Divisional reports.

NW/KP

PW advised that immediate action had been taken where falls had occurred and assured the Committee that mitigating measures had been identified and implemented. It was noted that the number of reported falls was reflective of an increasingly unwell, complex inpatient caseload. A peer review of the Falls Scrutiny Panel has also been undertaken, resulting in a small number of recommendations which will be taken forward.

DM requested that the narrative in relation to transport delays for emergency patients is amended to avoid confusion as the document is in the public domain.

PW

SA requested further explanation of the SACT mortality data (% of deaths within 30 days) and JA advised that providing a summary of the full context is challenging. However, the Committee was assured that the Trust falls well within the national expected ranges for 30-day mortality and that data

	is collated on an ongoing basis. JA also advised that a specific paper on the Medical Examiners' Service would be sighted at the March 2023 Committee, which would include more detailed narrative on this topic. It was agreed to include assurance that the Trust falls within range in the report, to provide further context for the public. The Committee **NOTED** the content of the report.	
4.4.2	**Welsh Blood Service Performance Report** Led by Alan Prosser, Director of Welsh Blood Service The Welsh Blood Service report provided an update on performance against key metrics for the period until the end of November 2022. The following areas were highlighted: • *Supply chain activity* – The national supply chain remains under immense pressure and NHS Blood and Transplant England remained on Amber alert at the time of reporting. The Trust was in a position to provide mutual aid to northern Ireland Blood Service and satisfactory stock levels across all priority blood groups were maintained throughout the Christmas period and periods of industrial action. • *Bone marrow volunteer recruitment* – an increase had been evidenced over the period, reflecting the effectiveness of targeted education campaigns and recovery plans. Following closure of educational establishments over the holiday period, a more sustainable result is anticipated from Quarter 1 2023-24 onwards. • *% part bags and failed venepuncture rates* – the upward trend in monthly figures is currently being explored. It was reported that the part bag figures relate to new members of staff having joined a team in south Wales and following intervention, a reduction in the rate has been evidenced. Local intervention within the Wrexham team in relation to failed venepuncture rates has resulted in improved performance in this area. • *Provision of mutual aid support*- In addition to units of blood, the Welsh Blood Service has also supported the Northern Ireland Blood Service in relation to planning and appointment systems, collections activity and contact centre activity with the aim to improve their service as a whole. VM commended the support / mutual aid provided to Northern Ireland and queried whether there had been any national recognition of this. AP advised that as Chair of a UK-wide forum, this had been reported on and recognised by peer colleagues within the sector. It was agreed that internal promotion of the successful position that the service finds itself in would be beneficial as this should be celebrated. SA noted that the report is difficult to read due to the small size of the text on the performance report. AP advised that a new performance management tool would be in use from the March Committee going forward,	

	enabling more defined actions and an improved level of clarity of reporting in general. SA also noted that there are no specific delivery dates for areas where staff training / support is required (including mandatory training and PADRs) and this had been noted as 'ongoing'. AP advised that whilst it had not been possible to include the required level of detail in this report due to staff pressures, specific intervention teams are in place to support training staff members at differing stages. This may take time given the part-time nature of some staff. The Committee **NOTED** the content of the report.	
4.5.0	**Annual Equality, Diversity & Inclusion Report 2021-22** Led by Sarah Morley, Executive Director of Workforce and Organisational Development The report was received, which provided the equality monitoring data for the period, in line with the Equality Act 2010 and Public Sector Equality Duty (2011). SfM highlighted the following: • The current requirement to publish the 2021-22 report by the end of March 2023 has resulted in a significant time lag in terms of up to date information contained within the report. However, a review of the Committee Cycle of Business has ensured that all future annual reports are provided at the July Committee. • Significant work has been undertaken following the reporting period to develop an anti-racism action plan and a newly appointed Organisational Development Manager (Equalities, Diversity & Inclusion) will seek to further work already undertaken, aligned with the strategic quality plan and its objectives. • The Race Pay Gap Report will be embedded over the course of the year. HJ queried whether the report was reflective of the population served by the Trust and SfM advised that further information would be included in subsequent reports to provide a more rounded picture. The Committee **ENDORSED** the report for onward submission to Trust Board. (*The cover paper of the report is to be amended from Private to Public*).	
4.6.0	**Business Continuity & Emergency Planning** Led by Alan Prosser, Director of Welsh Blood Service The report was received, which provided a high-level overview of the Trust's Business Continuity and Emergency Preparedness work programme and priorities for 2023-2024. AP advised the following: • There had been challenges in the last year in maintaining regular Working Group meetings due to prioritisation of other emergency planning work	

	(COVID, supply chain issues, etc.). The team is providing proactive support to the Industrial Action Cell and nominated areas and leads have supported a Trust-wide approach. However, the Trust is continuing to make progress in terms of Business Continuity and Emergency Preparedness.
	• Key areas of work will be undertaken over the course of the year to support the framework, policies and activities required within each Division.
	• Progress will be monitored and reported into the Trust's Business Continuity & Emergency Preparedness Steering Group and on a Quarterly basis to Executive Management Board. The Committee will receive an update at the July 2023 Committee by means of an Annual Report.
	The Committee **NOTED** the work programme outlined in the report.
4.7.0	**Sustainability Report 2021-22 (including Decarbonisation)** Led by Rhiannon Freshney, Environmental Development Officer The report was received, which provided a summary of the Sustainability works for the period 1st April 2021 – 31st March 2022 within the Sustainability Team. RF advised the following key achievements: • Notable ***reduction in electricity consumption*** within Trust Headquarters (39.5% decrease against baseline figures of 2018-19), resulting from a combination of hybrid working and upgrade to the LED lighting system. • ***ISO 14001:2015 External Surveillance Audit*** – The Trust successfully maintained the Environmental Management System with no non-conformities identified for the fourth year running. The full ratified report has now been received and will be provided to the Committee in due course. • Launch of the ***Travel Plan***, designed to inform and enact change in the lives of staff, both within and outside the workplace. The plan will be in place from 2022-2027 and includes a number of incentives, competitions and cycle confidence training / bicycle maintenance sessions which have been positively received. • ***Green Social Prescribing*** – The project includes weekly sessions, aiming to connect patients, families / carers and staff with nature, using natural / found materials. This also provides those affected by cancer to connect with others on the same journey. It is intended to run sessions all year round, facilitated by the use of a recycled shipping container furnished with heat and light, for use during colder seasons. • ***Industrial Placement Scheme*** – The Trust employed a Sustainability Placement student over the year, working closely with the Sustainability Team and Transforming Cancer Services Team. This is expected to continue and a new Sustainability Placement student commenced their role during November 2022. DM noted the significant amount of community engagement as a result of the

	range of projects undertaken and commended the enthusiasm of the staff involved. The Committee **ENDORSED** the recertification audit of the Internal Annual Sustainability Report for Trust Board approval and commended the layout, reflecting achievements over the course of the year.	
4.8.0	**Trust Risk Register / Trust Assurance Framework** Led by Lauren Fear, Director of Corporate Governance and Chief of Staff The Committee received the current extract of risk registers, which provided oversight and assurance of the management of risks across the Trust and outlining the current risks scoring 15 and above. LF advised the following: • Ongoing work continues regarding Velindre Cancer Service Risk Register Management. • A review of the Welsh Blood Service Risk Register is underway, to identify potential duplications and to assess risk scores. • Risk appetite refresh had been undertaken. It was noted that it remains challenging to track changes since the last report and actions being taken to achieve the target scores and demonstrate mitigation of risk. The Committee referenced the Quality Governance Review (Audit Wales) regarding the same issues and recommendations and triangulation of this with the discussion in a recent Audit Committee. A proposed enhanced template format will be developed via active engagement with Audit Committee members and the Chair of the Quality, Safety & Performance Committee. The Committee: • **NOTED** the revised Risk Appetite level, following initial discussions at the Board Development session on the 8th November 2022 and the outcome of the January Audit Committee, prior to January Trust Board; • **NOTED** the risks level 20, 16 and 15 reported in the Trust Risk Register and highlighted in this paper, and; • **NOTED** the ongoing developments of the Trust's Risk Framework. **Trust Assurance Framework** Led by Lauren Fear, Director of Corporate Governance and Chief of Staff The report provided the current position in relation to principal risks which fall within the remit of the Quality, Safety & Performance Committee and management thereof. Subsequent to discussions at Audit Committee and Executive Management Board, LF advised that following cross-reference with the Audit Tracker and Legislative Compliance Register, the Trust Assurance Framework template will be redeveloped to include:	

	• The capture of explicit actions / reasons in relation to how identified gaps will be managed / accepted; • Clear corresponding actions in response to partial assurance ratings and / or gaps in controls; • Clear impact of 'closed' actions on the assurance rating. The Committee was also advised that a refresh of the Trust Strategic Risks is underway, which will align with the development of the Trust Integrated Medium Term Plan for presentation to the March 2023 Trust Board. The Committee **DISCUSSED** and **REVIEWED** the update to the Trust Assurance Framework Dashboard.	
5.0.0	**INTEGRATED GOVERNANCE** (The integrated governance part of the agenda will capture and discuss the Trust's approach to mapping assurance against key strategic and operational risks)	
5.1.0	**Analysis of triangulated meeting themes** Led by Vicky Morris, Quality, Safety and Performance Committee Chair, supported by all Committee members Members were asked to feed back their considerations regarding key points and outputs arising throughout the meeting and the following feedback was noted: • Evidence across a number of papers that the overall quality focus of the organisation is strengthening, including preparedness for both Duties of Quality and Candour, in addition to strengthening of the governance around risk. • Evidence that ensuring points discussed at Committee are embedded in the Trust's approach to ways of working, in particular the approach to the quality agenda and tracking of outcomes. • Continuing changes to the Trust's patient population and the need for the Trust to be cognisant of how this may not only affect figures, but impact on ways of working and how the Trust will ensure systems are safe and able to maintain the quality required going forward. • Evidence that the Trust continues to reach out beyond the core organisation in terms of sustainability work (including provision of mutual aid). • It was suggested that ore meaningful collation and visual representation of metrics would evidence the direct link between vacancy levels and a variety of performance metrics and quality and safety outcome measures and impact in a number of areas. VM indicated that issues regularly discussed at the Committee are now gaining traction and progressing more effectively, also acknowledging that the undertaking by the Trust Integrated Quality & Safety Group would enhance this.	

	Analysis of committee effectiveness Led by Vicky Morris, Quality, Safety and Performance Committee Chair, supported by all Committee members It was agreed that to continually monitor the effectiveness of the Committee a short questionnaire will be circulated after each Committee requesting completion by all attendees. The aggregated outcomes will be provided at the following Committee and facilitate in year adjustments to be made. The questions agreed were: • 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?	**Secretariat All attendees**
6.0.0	**HIGHLIGHT REPORT TO TRUST BOARD**	
	Members were asked to identify items to include in the Highlight Report to the Trust Board: • For Alert / Escalation • For Assurance • For Advising • For Information Items to be agreed by the Committee Chair, Executive Director of Nursing and Committee Secretariat following the meeting.	
7.0.0	**ANY OTHER BUSINESS**	
7.1.0	**Infected Blood Inquiry** The Committee **NOTED** the written submission of the Welsh Blood Service to the Infected Blood Inquiry, following the close of evidence.	
8.0.0	**DATE AND TIME OF THE NEXT MEETING**	
	The Quality, Safety & Performance Committee will next meet on the: **16th March 2023 from 10:00 – 13:00 via Microsoft Teams**	
CLOSE		
The Committee is asked to adopt the following resolution: That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).		

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Ionising Radiation Safety Policy

DATE OF MEETING	16/03/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	

PREPARED BY	ARNOLD RUST
PRESENTED BY	Jacinta Abraham, Executive Medical Director
EXECUTIVE SPONSOR APPROVED	Jacinta Abraham, Executive Medical Director

REPORT PURPOSE	APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME
Radiation Protection Operational Group	07/12/2022	ENDORSED FOR APPROVAL
Radiation Protection Strategic Group	06/10/2022	
EMB	02/03/2023	NOTED

ACRONYMS	

1. SITUATION/BACKGROUND

The Quality, Safety & Performance Committee is requested to approve the updated version of the Ionising Radiation Safety Policy. The policy is subject to a three-year review period.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

Whilst there have been no changes to the prevailing legislation since the last policy review, the document has been updated reflecting developments in interpretation of the legislation as evidenced by the approach taken by the relevant regulatory bodies. All managers with operational responsibility for radiation protection and relevant radiation protection supervisors have been invited to provide input.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The policy governs the use of ionising radiation within the Trust.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	No (Include further detail below)
	In line with the requirements of the Trust Ionising Radiation Framework Policy, no specific issues have been identified.
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The use of ionising radiation within the Trust is subject to the provisions of several legal instruments. Full compliance with these is essential in order to avoid potential enforcement by the relevant regulators.

FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The commitment of Trust financial resources is required to ensure compliance with legislation.

4. RECOMMENDATION

4.1 The Quality, Safety & Performance Committee is recommended to approve the updated policy.

Ref: QS 19

IONISING RADIATION SAFETY POLICY

Executive Sponsor & Function:	Director, Velindre Cancer Centre
Document Author:	Head of Radiation Protection Service
Approved by:	Quality & Safety Committee
Approval Date:	
Review Date:	.
Version:	

EXECUTIVE SUMMARY

Overview:	This Policy establishes a framework for controlling the use of ionising radiation and restricting exposure to persons within all Services provided by the Trust. The Trust will only adopt those practices that are consistent with the ALARP Principle. ALARP stands for As Low As Reasonably Practicable and the ALARP Principle is that the residual risk shall be as low as reasonably practicable.
Who is the policy intended for:	All Trust Staff working with ionising radiation
Key Messages included within the policy:	Identification of the legislation governing the use of Ionising Radiation Roles and responsibilities of key personnel in the management of radiation protection issues in terms of safety of staff, public and patients. Introduction and implementation of control measures to restrict exposure to ionising radiation. Roles and responsibilities of personnel holding entitlements to take responsibility for aspects of the medical exposure of individuals. Responsibility of all staff to work in accordance with the control measures and to report any non-compliances
PLEASE NOTE THIS IS ONLY A SUMMARY OF THE POLICY AND SHOULD BE READ IN CONJUNCTION WITH THE FULL POLICY DOCUMENT.	

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1. INTRODUCTION

1.1 This document establishes a framework for controlling the use of ionising radiation and restricting exposure to persons within all Services provided by the Velindre University NHS Trust.

1.2 The Trust will only adopt those practices that are consistent with the ALARP Principle. ALARP stands for As Low As Reasonably Practicable and the ALARP Principle is that the residual risk shall be as low as reasonably practicable.

1.3 Within the Trust ionising radiation is primarily employed in medical diagnosis and therapy, medical research, quality assurance, the irradiation of blood components and other related applications. These applications are confined to the Velindre Cancer Centre site and the Welsh Blood Service site at Llantrisant.

1.4 The use of ionising radiation within the UK is governed by the following statutory instruments and the Trust is committed to ensuring that the provisions of these regulations, together with the highest standards of best practice in ionising radiation safety, are fully implemented at all times:

- The Ionising Radiations Regulations 2017 (IRR 17)

- The Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R17)

- Environmental Permitting Regulations 2016,(as amended 2018 and 2020)

- The Carriage of Dangerous Goods and Use of Transportable Pressure Equipment Regulations 2009 (as amended 2011 and 2019) (CDG2009)

1.5 These regulations are supported by various approved codes of practices (ACoP) and guidance notes published by the enforcing agencies and other organisations (Health and Safety Executive, Department of Health and Social Care, Welsh Government, Natural Resources Wales, Public Health England (formerly Health Protection Agency or NRPB)) and professional bodies (Royal College of Radiologists, Institute of Physics and Engineering in Medicine, College of Radiographers, Society for Radiation Protection etc.).

1.6 The Trust has followed the general guidance on good practice with respect to the radiation protection issues and legislation as detailed in the document "Medical and Dental Guidance Notes" 2002 (MDGN) and subsequent versions published by the Institute of Physics and Engineering in Medicine (IPEM).

1.7 The specific details regarding the implementation of all radiation protection requirements and associated issues are contained within the individual departments' Local Rules, Employers Procedures (IR(ME)R 17 documents) and other associated documents.

1.8 This Policy must be read in conjunction with other relevant Trust and Division Policies, including those on Waste Management, Clinical Evaluation, Pregnancy Tests, etc.

2   RESPONSIBILITIES

2.1   The Trust's Chief Executive carries the overall responsibility for implementing the requirements of the regulations governing work involving ionising radiation throughout all Services managed by the Trust.

2.2   To assist in discharging this responsibility the Chief Executive requires all Service Directors and Service Managers, whose services are involved in working with ionising radiation, to assume the general responsibility for ensuring that radiation safety arrangements throughout their Services are representative of best practice and satisfy the requirements of the regulations.

2.3   The Medical Director carries specific responsibilities relating to compliance with ionising radiations legislation as detailed within this Policy.

2.4   To assist the Service Directors and Service Managers in discharging these responsibilities the Chief Executive requires managers, whose departments are associated with work involving ionising radiation, to implement all necessary radiation protection arrangements outlined in this policy and as advised by the Radiation Protection Adviser (RPA), Radioactive Waste Adviser (RWA) and Medical Physics Expert (MPE).

2.5   It is the responsibility of Service Directors, Service Managers and Department Managers to keep themselves aware of radiation protection issues within their Service and consult with the Radiation Protection Supervisors (RPS), the RPA, RWA and the MPE over any issues that have radiation protection implications.

2.6   It is the responsibility of Service Directors, Service Managers and Department Managers where appropriate to ensure that radiation risk assessments are prepared in respect of all work undertaken with ionising radiation. Radiation risk assessments must be updated no less frequently than two-yearly to ensure that they remain relevant to the work undertaken. A radiation risk assessment must be undertaken;

a) in advance of a new practice being introduced,

b) whenever a significant change in the work activity takes place

2.7   It is the responsibility of Service Directors, Service Managers and Department Managers where appropriate to ensure that local rules for radiation protection are drawn up to govern all work with ionising radiation undertaken within the department or area within the department. Local rules for radiation protection must be periodically updated to ensure that they remain relevant to the work undertaken and take into account the findings of relevant radiation risk assessments.

2.8   It is the responsibility of Service Directors and Service Managers to ensure that all managers responsible for operational and estates facilities maintain an

awareness of potential problem areas associated with all work with ionising radiation. This may include drainage systems for departments using unsealed radioactive sources, roof spaces with restricted access above areas where work with ionising radiation is conducted, any known weaknesses in radiation shielding, prevailing security measures, etc.

2.9   All managers responsible for operational and estates facilities must, in consultation with the RPAs, RPSs and Department Managers, formulate systems to facilitate access by contractors, service engineers and other persons, into these problem areas. Such arrangements will involve facilities managers in the production and issuing of "Permits to Work" that detail the conditions under which work may be carried out as specified by the RPAs, the RPSs supervising the work with ionising radiation in the affected area and the department manager.

2.10   It is the responsibility of all Service Directors and Service Managers and managers responsible for departments where the medical exposure of individuals takes place to establish procedures in accordance with the IR(ME)R 17 regulations. These are listed in schedule 2 of the regulations.

2.11   Service Directors and Service Managers are required to ensure that sufficient funds are made available to department managers to implement all relevant radiation protection requirements and risk reduction measures associated with this policy or as advised by the RPA, RWA, RPS and the MPE.

2.12   Service Directors and Service Managers, Department Managers and managers responsible for operational and estates facilities are required to involve the RPA, RWA, RPS and MPE at the earliest opportunity in the planning for refurbishment or site development work, changes to existing services or the development of new services. They are further required, based on risk assessments, to make arrangements for the funding and implementation of all necessary radiation protection requirements as advised by the RPA, RWA and the MPE.

2.13   It is a requirement that all staff, working with ionising radiation, to;

   a.   exercise reasonable care and follow the provisions of the Local Rules, IR(ME)R 17 Policies and Procedures, Natural Resources Wales Permits and other related working instructions

   b.   use, as instructed, any protective equipment and personal radiation dose meters provided, to report to the Trust's Chief Executive via the line manager, and to inform the Radiation Protection Supervisor, of any defects in such equipment and dose meters

   c.   undertake any training specified by the Service Director, Service Manager or Department Manager.

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    d. report immediately to the Service Director, Service Manager or Department Manager if an incident occurs in which a member of staff or public is unintentionally exposed to radiation

    e. report immediately to the Service Director, Service Manager or Departmental Manager if they suspect that a radioactive source has been damaged, lost or stolen. Further advice on managing the incident should be sought from the Radiation Protection Adviser and Radioactive Waste Adviser.

    f. not recklessly endanger the safety of others

    g. report to the departmental manager when it is suspected that an "accidental or unintended exposure due either to equipment malfunction or failure of IR(ME)R 17procedures has taken place.

2.14 All medical, radiotherapy, radiology, nuclear medicine, medical physics, clinical trials and nursing staff must pay particular attention to their roles and responsibilities as detailed in the IR(ME)R 17 Policies and Procedure.

2.15 It is a requirement that Velindre University NHS Trust holds the appropriate authorisations to work with ionising radiations. This includes the provisions for prior notification, registration and consent under IRR 17, the issue of permits for the use and disposal of radioactive materials under EPR16 and having an Employer licence to authorise the administration of radioactive medicinal products to patients under IR(ME)R17.

2.16 All medical practitioners who intend to administer radioactive medicinal products for diagnostic investigations or therapy applications must also have an appropriate licence granted under the IR(ME)R 17 by the Administration of Radioactive Substances Advisory Committee (ARSAC) on behalf of the Secretary of State. It is the responsibility of the Medical Director to ensure that all such medical practitioners are appropriately licensed in advance of commencement of a new procedure for the first time and continue to remain licensed.

2.17 It is the responsibility of departmental managers to ensure that periodic reviews are undertaken of individual's compliance with the provisions of local rules for radiation protection made under the IRR 17. Reviews of procedures should also be undertaken no less frequently than annually to identify any necessary amendments. A record should be kept of these reviews.

2.18 Based on risk assessment the departmental managers will make arrangements to prioritise funding, to cover the cost of implementing unforeseen expenditure with respect to radiation safety, patient dosimetry and security issues from changes in the regulations, technological advances in radiation protection, as advised by the RPA, RPS and MPE.

2.19 Failure to follow the provisions of this policy and the local arrangements in place for radiation safety within a department or service may result in disciplinary action.

3   ORGANISATION

3.1   The Chief Executive has established a Radiation Protection and Medical Exposures Strategic Group (RPMESG) and a Radiation Protection and Medical Exposures Operational Group (RPMOSG) to formulate appropriate policies, monitor the level of compliance in the various components of the Trust, identify areas of non-compliance and initiate remedial action, and to keep him/her informed of specific issues that require his attention. The terms of reference and membership of the RPMEOG and RPMESG are linked in Appendix 1.

3.2   The Chairperson of the RPMESG reports directly to the Chief Executive.

4   ADVICE and ASSISTANCE

4.1.   Radiation Protection Adviser

4.1.1 In accordance with the requirements of the Ionising Radiation Regulations 17 the Chief Executive will appoint in writing one or more individuals as the Trust's Radiation Protection Adviser (RPA). The appointment requirements and the scope of advice required under IRR 17 are given in Appendix 2.

4.1.2 Suitably experienced individuals who hold certificates issued by a body recognised by the Health and Safety Executive that enable them to act as radiation protection advisers are appointed as the Trust's RPAs.

4.1.3 Apart from fulfilling the function of an RPA as detailed in IRR 17 and the accompanying approved code of practice (ACoP), these individuals are required to be proactive in advising the Chief Executive, and those persons assigned specific tasks, on the general requirements for ionising radiation safety and the specific means of achieving compliance with the requirements of all regulations governing the use of ionising radiation in the UK.

4.1.4 The RPA is required to be proactive in keeping the Chief Executive, Chairperson of the RPMESG, Service Directors and Service Managers, Department Managers, RPSs and MPEs up to date with advances in radiation protection practice, pertinent guidance from professional bodies, Government Organisations and Enforcement Agencies, etc., and proposals to amend existing legislation or introduce new legislation associated with work involving ionising radiation as applicable to the health care environment.

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4.1.5 In instances where such changes only affect the working practices within specific departments or across a Service the RPA will advise the Service Directors and Service Managers, department managers, RPSs and MPEs as to the appropriate means of implementing such changes.

4.1.6 In instances where such changes must be implemented on a Trust wide basis the Chairperson of the RPMESG with the RPA will convene a sub group (to include representatives from the services) to scrutinise the changes, formulate an action plan for the production of any new policy or the amendment of existing policies as required, the implementation of the changes into working practices and the production of all necessary documentation associated with the changes. The Chairperson of the RPMESG will be responsible for ensuring that changes in Trust-wide Policy documents (new, replacement or amended) will be developed and approved in accordance with the Trust's Policy for Policies.

4.1.7 The RPAs are ex officio members of the RPMESG and RPMEOG, and normally report to the Chief Executive through the committee structure. In instances where the RPAs believe that immediate action is required to remedy instances of non-compliance or potential noncompliance the RPAs are required to report directly to the Service Directors and Service Manager and if necessary to the Chief Executive.

4.1.8 The RPAs are required to;

a. Respond to requests to advise and assist the Chief Executive and all Service Directors and Service Managers, department managers and staff in performing all duties and tasks associated with radiation protection issues

b. Maintain and make available to all Trust employees a comprehensive library of all relevant radiation protection documents. These will include Statutory Instruments, ACoP, Guidance Notes, advice and guidance provided by the government, its agencies and professional bodies, text books, advice and guidance provided by the European Community, advice and guidance provided by international organisations (International Commission of Radiological Protection), etc.

c. Advise and assist Service Directors and Service Managers, Department Managers and Radiation Protection Supervisors in all safety, security and transport issues (in consultation with a Dangerous Goods Safety Adviser, (DGSA), and a Radioactive Waste Adviser (RWA) where necessary) associated with the delivery, keeping, use and disposal of radioactive materials.

d. Advise and assist Divisional Directors, Department Managers, Clinical Staff and Radiation Protection Supervisors in all relevant patient safety issues.

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e. Be involved in the tendering for an approved dosimetry service to provide radiation monitoring facilities in accordance with the requirements of IRR 17.

f. In conjunction with department managers, formulate an effective personal radiation dose monitoring programme for staff working with ionising radiation reflecting the outcome of relevant radiation risk assessments.

g. To assist Departmental Managers in assessing the results of the personal radiation dose monitoring programme and initiating all appropriate action. To interface, on behalf of the Chief Executive, with the approved dosimetry service, on matters relating to dose results and record keeping issues, as required by IRR 17.

h. Ensure that, in instances where individuals may be required to be designated as "Classified Persons" under the requirements of IRR 17, the matter is referred to the head of the department concerned and that the Chairman of the RPMESG is notified.
When designating classified workers the Chief Executive will assign the task of ensuring compliance for the medical surveillance of such employees as required under IRR 17, for classified persons, cases of overexposure, etc., to the Trust Medical Director.

i. Interface on behalf of the Chief Executive with individuals responsible for enforcing or monitoring compliance with legislation governing work with ionising radiation

4.2   Radioactive Waste Adviser

In accordance with the requirements of the Environmental Permitting Regulations 2016 (EPR16) the Chief Executive will appoint in writing one or more individuals as the Trust's Radioactive Waste Adviser (RWA). The appointment requirements and the scope of advice required under IRR 17 are given in Appendix 3.

Suitably experienced individuals who hold certificates issued by a body recognised by the Environmental Agencies that enable them to act as RWAs are appointed as the Trust's RWAs.

The RWAs are required to;

a. Make all necessary arrangements for the permitting of radioactive substances and of radioactive waste for each of the Trusts sites under the requirements of the EPR.

b. Set individual department limits for the holding of radioactive substances on each of the Trusts sites and monitor compliance with each of the sites' EPR permits.

c. Set individual department limits for the accumulation and disposal of radioactive waste from Trust sites, co-ordinate the disposal records from all departments on each of the Trust's sites and monitor overall compliance with each of the sites' EPR permits.

d. Provide advice on and undertake compliance audits with respect to the requirements of the EPR regulations including the management of sealed sources (including High-activity Sealed Radioactive Sources)

e. Liaise with Natural Resources Wales regarding regulatory matters including (but not limited to) pollution inventory and other submissions.

f. Undertake environmental impact assessments regarding the discharges of radioactive wastes within the Trust.

h. Produce a Trust statement of the application of Best Available Techniques (BAT) within the Trust to minimise the radiological impact of radioactive discharges on the environment.

4.3   Radiation Protection Supervisor

4.3.1 The Radiation Protection Service will arrange for departmental managers' nominated Radiation Protection Supervisors to be appointed in writing by the Chief Executive in accordance with the requirements of IRR 17. The suitability of the individual for this role will be assessed by the departmental manager with input from the RPA who will advise on suitable training schemes for the RPS. Managers must draw up a role specification for the RPS that details all of the tasks delegated to him or her by the manager and this can either be issued to the individual or incorporated into the individual's Job Description.

4.3.2 Under IRR 17, the only duty assigned to the RPS is to supervise the work undertaken with ionising radiation to ensure that this is carried out in accordance with the Local Rules. Other tasks, associated with the day to day practical aspects and or management of radiation protection issues, may be assigned to the RPS by the department managers. A template role description for the Radiation Protection Supervisor is included in Appendix 5, including both the supervision duty and other duties which department managers may wish to delegate to them in the context of a broader supervisory role.

4.3.3 Department managers will consult with the RPA over documents (copies of legislation, ACoP, Guidance Notes, etc) to be provided to the RPS to assist in discharging the duties, and as reference documents for all staff working within the department. The manager will ensure that all such documents are purchased and available to the RPS.

4.3.4 All RPSs are automatically members of the RPMEOG.

4.4   Medical Physics Expert

4.4.1 It is a requirement of IR(ME)R 17 that a Medical Physics Expert (MPE) is involved as appropriate in providing expert advice for every medical exposure.

a. There shall be at least one MPE available to be involved in standardised therapeutic nuclear medicine practices and in diagnostic nuclear medicine practices. In non-standard radionuclide therapy the MPE will be closely involved in each procedure.

b. There shall be at least one MPE closely involved in every radiotherapy exposure.

c. In diagnostic radiology, MPEs shall be available to be involved as appropriate for consultation and optimisation and to be involved with high dose interventional radiology and high dose computed tomography.

4.4.2 The MPE must contribute to the matters detailed in appendix 4.

4.4.3 The Head of Radiation Services, with advice from the heads of nuclear medicine, radiation protection and radiotherapy physics, is responsible for advising the Chief Executive on making appropriate and sufficient MPE appointments.

4.4.4 All MPEs appointed on behalf of the Employer must hold certification as MPEs in their specialty by a body recognised by the Department of Health and Social Care that enables them to act in that capacity.

4.5   Qualified Person

4.5.1 The Head of the Radiation Protection Service is responsible for appointing suitably qualified individual(s) to act as the Qualified Person for the purposes of testing radiation protection instruments in accordance with IRR 17.

5.   DUTY HOLDERS under IR(ME)R 17

The mechanism for entitlement of operators and practitioners is considered in section 6.2.

5.1   Employer:

In the context of IR(ME)R 17, the employer is considered to be Velindre University NHS Trust. If the Trust contracts a third party to provide services then the Trust will be the employer as regards the operators for the purpose of the Regulations, but the third party is the employer of the operators for employment law purposes.

Equipment ownership has no impact on the employer responsibilities under IR(ME)R 17.

5.2   Operator:

The operator is any person who is entitled, in accordance with departmental written procedures, to undertake the practical aspects of a medical exposure and is adequately trained. Operators may include radiographers, medical practitioners, clinical scientists/medical physicists, clinical technologist/medical physics technicians and nurses.

5.3   Practitioner:

The practitioner is a registered medical practitioner, dental practitioner or other health professional who is entitled in accordance with the Trust's written procedures to take responsibility for an individual medical exposure. The primary responsibility of the practitioner is to justify medical exposures.

In some cases the practitioner may also undertake practical aspects of an exposure and so become an operator with regard to these specific functions.

The practitioner in Nuclear Medicine must hold an ARSAC licence specifying the range of radionuclides and pharmaceuticals that they may prescribe.

Arrangements may be put in place for an individual to authorise justification of the medical exposure on behalf of the practitioner under a Delegated Authorisation Guideline (DAG) drawn up by the practitioner. Under such an arrangement, the individual acts as IR(ME)R 17 operator for this function. This arrangement may also apply to justification of exposures involving radionuclides and pharmaceuticals.

Arrangements must also be put in place for the justification of exposures to carers and comforters.

5.4   Referrer:

The referrer is a registered medical practitioner, dental practitioner or other health professional who is entitled in accordance with departmental written procedures to refer individuals to a practitioner for medical exposure.

6.   **ARRANGEMENTS for COMPLIANCE with IR(ME)R 17**

6.1   Written procedures

a. Employer's standard operating procedures, covering the areas specified in schedule 2 of IR(ME)R 17 and specific to individual departments where medical exposures are undertaken, must be formulated and maintained within the work instructions and local policies and procedures of those departments. A listing is maintained by each department summarising, as a minimum, the local versions

of the fourteen standard operating procedures specified. Further standard operating procedures may be added as required, but it should be borne in mind that such procedures will then be legally binding upon the organisation and its employees. The MPE must be involved in the formulation and maintenance of these procedures.

b. Clinical protocols for all standard procedures involving medical exposures are maintained within the work instructions of each department and are made available for use by all staff.

c. Where patient referrals under IR(ME)R 17 are made, referral procedures are part of each department's IR(ME)R 17 standard operating procedures and permit the referral of patients for diagnostic radiological/nuclear medicine investigations and therapy applications. Appropriate instruction regarding the referral process must be given to all relevant staff.

d. All new IR(ME)R 17 policies and standard operating procedures must be submitted to the RPMOSG for ratification and formal adoption on behalf of the Trust. Only those documents that have been confirmed as "suitable for purpose" will be ratified.

e. Quality Assurance programmes must be introduced, in consultation with the MPEs, to assess the effectiveness of policies and procedures.

f. All IR(ME)R 17 Policies, Procedures, Inventory, Protocols (Standard Operating Procedures), Diagnostic Reference Levels and all written arrangements concerning IR(ME)R 17 must be reviewed no less frequently than once every two years or whenever there are changes of equipment or working practices.

g. Whenever departments' activities overlap the managers must liaise to ensure compatibility between both departments IR(ME)R 17 Policies and Procedures. Formal written procedures must be established between these departments to detail all agreed arrangements.

6.2   Entitlement of Practitioners and Operators

a. The Medical Director has delegated authority from the Chief Executive to entitle duty holders including Referrers, Operators and Practitioners. The Medical Director further delegates authority to the departmental managers or service leads to entitle duty holders for specific IR(ME)R 17 functions in accordance with the flow chart in appendix 6. Entitlement of RPAs, RWAs, MPEs and Medical Director is by letter from the Chief Executive. Further cascaded entitlement is undertaken according to local procedure.

b. It is the responsibility of departmental managers or service leads to ensure that only individuals formally identified and entitled by the Employer can undertake Practitioner and/or Operator roles.

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c. Before any individual is formally entitled to act as Practitioner or Operator, arrangements must be made to assess their experience and to determine what training must be undertaken before entitlement can take place. If an individual is entitled to undertake an IR(ME)R role by another organisation, this does not lead to automatic entitlement by Velindre University NHS Trust to undertake a similar role. Any relevant certification held by an individual (e.g. the holding of a licence issued by ARSAC) may be taken into consideration in establishing their competence to be entitled to undertake an IR(ME)R role. Systems must be in place to provide new staff with the necessary training and expertise to permit them to act as practitioners or operators.

d. Entitlement should only be undertaken by authorised individuals as per delegation pathways from the Chief Executive and reflect prevailing professional guidance. The entitlement must follow an auditable pathway and documentation kept to show

i) the date on which entitlement took place

ii) the task and scope of practice for which entitlement has taken place

iii) the identity of the person undertaking the entitlement and their delegated authority

Details of this process are recorded in the procedures of each department. The individual being entitled shall receive formal notification and details of the scope of the entitlement

e. A list will be held by each department of its practitioners and operators, detailing the specific functions for which they are entitled to act. This list forms part of the IR(ME)R documentation and it must be made readily available to all departmental staff. This list must be updated whenever there are changes in personnel.

f. Individual procedures are in place in each department detailing how entitlement of Practitioners and Operators takes place within the framework in Appendix 6.

6.3 Referrers

a. Entitlement of Referrers is via the process described in 6.2.a.

b. It is the responsibility of departmental managers or service leads to ensure that only individuals formally identified and entitled by the Employer can undertake Referrer roles.

c. Individuals entitled to refer patients must be identified and their names recorded on the divisional list. This list forms part of the IR(ME)R 17 documentation and it must be made available to all departments. The list must be updated whenever there are changes in personnel. It is the

responsibility of the Director of Cancer Services to ensure that administrative arrangements are in place to enable all those justifying a medical exposure or authorising a medical exposure on behalf of a practitioner to have at their disposal a current list of entitled IR(ME)R 17 referrers.

c. The Employer must establish referral criteria for medical exposures, reflecting prevailing national professional guidance and these are referenced in departmental documentation.

d. Systems must be in place to provide new staff with the necessary training and expertise to permit them to act as referrers. Department managers must ensure that appropriate instruction regarding the referral process must be given to all relevant staff.

e. Medical staff wishing to refer patients for radiological/nuclear medicine investigations must be given instruction on completing request forms and information on referral criteria during their induction. Referrals from General Practitioners for radiological imaging procedures are accepted according to radiology department policies.

f. Policies/procedures are required to enable referrals for diagnostic radiological/nuclear medicine investigations from non-medically qualified registered health care professionals where this is to be undertaken. In all such instances referral guidelines and the scope of referral must be agreed in consultation with the senior radiologist and department manager.

6.4 Practitioners and Operators

a. The IR(ME)R 17 Practitioner and Operator have a legal duty to comply with the procedures established by the Employer.

b. All staff acting as practitioners and operators must be aware of and conversant with the IR(ME)R 17 policies, procedures, protocols and the relevant Standard Operating Procedures. This may also include delegated authorisation guidelines issued by the practitioner.

c. Systems must be introduced to monitor and audit compliance with the IR(ME)R 17 Policies and Procedures and Standard Operating Procedures and the Results of the Audits will be submitted to the RPMEOG for comment and where necessary advice on remedial action.

6.5 Optimisation of exposure

a. Arrangements must be made, in consultation with the MPE, to implement a dose optimisation strategy for all radiological practices and introduce and monitor Diagnostic Reference Levels (DRL), as required by IR(ME)R 17, for all standard radiological investigations and standard nuclear medicine procedures.

b. Quality Assurance programmes must be introduced, in consultation with the MPEs, to assess the effectiveness of equipment.

c. All IR(ME)R Policies, Procedures, Inventory, Protocols (Standard Operating Procedures), Diagnostic Reference Levels and all written arrangements concerning IR(ME)R 17 must be reviewed annually or whenever there are changes of equipment or working practices.

6.6   Administration of radioactive substances to patients

a. In departments employing sealed and unsealed radioactive sources for diagnostic or therapeutic purposes, cross reference with the Employer licence and practitioner ARSAC licence must be undertaken before new radioactive medical products are introduced into clinical practice. Where the licence(s) does not cover such products the medical practitioner and/or Employer must obtain an endorsement to their licence to cover this new work in accordance with the requirements of IR(ME)R 17.

b. Research ARSAC licence applications are required for clinical trial procedures if they are not covered by existing licences.

c. Arrangements must be in place that medical practitioners are reminded, well in advance of the date of expiry of their licence, of the need to renew their licence issued under the IR(ME)R 17 or certificates under previous legislation. At present, an automatic reminder is generated by the ARSAC secretariat in advance of expiry of current certificates or licences.

7 ARRANGEMENTS FOR COMPLIANCE WITH IRR 17

7.1   Radiation risk assessments must include all reasonably foreseeable fault or accident situations and a consideration of the radiation dose received by relevant individuals under such circumstances. This should include the patient under examination, other patients, staff and public. They will consider the need for and type of personal radiation dosimetry to be undertaken and whether classified radiation worker status is required. An RPA must be consulted in the preparation of any radiation risk assessment.

7.2   The Local Rules are intended to protect staff, the general public and the environment and they will specify general radiation protection requirements and specific requirements identified in IRR 17. The RPMEOG must be kept aware via RPS reports of when local rules are reviewed and the broad extent of any revisions made.

7.3   Systems must be in place to ensure that all new or modified installations that are used in connection with ionising radiation(s) are subject to a critical examination under IRR 17 prior to first use.

7.4   The Local Rules identify potential hazards and provide measures that enable staff to work safely and arrangements must be in place to ensure that all staff

working within the department are made aware of all issues detailed in the Local Rules and given training in their implementation and observance.

7.5   The service manager is responsible for ensuring that all staff are adequately supervised. The RPS is responsible for ensuring that the provisions of the local rules for radiation protection are followed. The RPS must report any noncompliance with the Local Rules to the department manager who, in consultation with the RPA, will investigate the reasons for the noncompliance and put in place measures to ensure that such breaches are not repeated. In instances where breaches are identified by the RPA as serious or in instances where breaches cannot be resolved within the department the department manager will seek a solution by referring the issue to the Service Directors and Service Manager and the chairman of the Radiation Protection and Medical Exposures Operational Group.

7.6   Arrangements must be in place to ensure that Local Rules are reviewed at a frequency advised by the RPA and that radiation risk assessments are reviewed no less frequently than every two years or whenever there are changes to equipment or working practices.

7.7   A handover document must be used when transferring managerial control of a radiation controlled area between parties from within VUNHST and between VUNHST employees and those employed by other parties.

7.8   Systems must be in place to communicate with the employer of any Outside Worker who needs to enter a designated area. Outside Workers are defined as any party not employed by VUNHST who need to enter a radiation controlled or supervised area which has been designated as such by VUNHST in order to provide a service. This communication must include sufficient information to enable the employer to comply with their obligations under IRR 17 and must, in all but exceptional cases, happen before the outside worker is required to enter the designated area.

7.9   Systems must be implemented to ensure that any radiation protection instruments used to demonstrate compliance with IRR 17 are fit for use and are sent for testing before first use, for annual testing, or for testing after repair, to the Qualified Person. Before purchasing any new or replacement instruments the department manager will seek the advice of the RPA and Qualified Person with respect to the selection of the most appropriate instrument.

8 ARRANGEMENTS for RADIOACTIVE SUBSTANCES

8.1   In departments where unsealed radioactive materials are employed (Nuclear Medicine and radioisotope cubicles) detailed instructions must be included in or referenced by the Local Rules regarding the transportation, delivery, storage, security, use, and disposal of the radioactive materials. Additional instructions will be required with respect to hygiene, the care of patients, monitoring for the presence of radioactive materials and the selection and testing of radiation protection instruments.

8.2   In departments where sealed radioactive sources are employed (Nuclear Medicine, Research, Radiotherapy, Brachytherapy, Welsh Blood Service and RPS Cardiff) detailed instructions must be included in or referenced by the Local Rules regarding the transportation, delivery, storage, security, use, leak testing and ultimate disposal or transfer of the radioactive materials.

8.3   For security reasons suitable procedures must be in place to ensure that all necessary signage and notices do not advertise the details of radioactive materials to the general public.

8.4   The department manager will ensure that detailed records are kept of the purchase, storage, use and disposal of all radioactive materials together with quantitative records of the disposal of sealed and unsealed radioactive materials. They will make arrangements to return copies of the disposal records to the RWA on a regular basis as determined by the RWA.

8.5   Control measures must be introduced to check at appropriate intervals the presence of all sources on a regular basis or whenever used and to monitor that activities detailed in the EPR 2016 permits and associated department limits are not breached. An annual audit should be undertaken to ensure that this process is taking place. With respect to the disposal of sealed or unsealed radioactive materials, monitoring to prevent breaches will be based on the department limits assigned by the RWA.

9 GENERAL ARRANGEMENTS for RADIATION PROTECTION

9.1   Before any individual is permitted to work with ionising radiation, arrangements must be made to assess the individual's training requirements and implement means of delivering any required training (as identified by the department manager with support from the MPE and RPA if required), monitoring the training programme and assessing the individual's performance.

9.2   Department managers must discuss any new proposed or planned uses of ionising radiation with the RPA and MPE at the planning stage.

9.3   Department Managers must ensure that any member of the department staff who has been allocated duties associated with ionising radiation is given written instructions regarding the role involvement: e.g. formulating and documenting Local Rules, quality assurance activities, IR(ME)R 17 policies and procedures; performing specific duties under the provisions of these documents; or performing other tasks directly related to or loosely associated with the Trust's radiation protection policy or general radiation protection matters. The manager must ensure that all such individuals are given adequate resources and protected time in which to carry out the assigned tasks.

9.4   Systems must be in place to keep all staff aware of their general responsibilities with regard to radiation protection (2.10) and keep all staff aware of the need to report any incident or near misses involving ionising radiation that may have

resulted in the uncontrolled release of radioactive materials or the unintended exposure of patients, staff or other persons.

9.5   All incidents, involving unintended exposures of patients or staff, significant spillages of unsealed radioactive materials, theft/loss/damage of radioactive materials, breaches of disposal limits etc., must be investigated by the department manager in consultation with the RPS, the RPA/RWA and relevant MPE where appropriate. The department manager must ensure that a written report is produced following the investigation to detail the circumstances, findings and remedial measures required to reduce the possibility of such incidents occurring in the future. The MPE will be involved for the purposes of estimating doses to patients and the necessity for reporting such incidents to government agencies. The RPA may also need to be involved in to assess the risks associated with the incident and to provide any further advice. The following examples are not exhaustive;

a)   Incidents of significant accidental or unintended exposure (SAUE) of patients, whether due to breakdown in procedures or equipment fault,,are reportable under IR(ME)R 17 to the Healthcare Inspectorate Wales (HIW). It should be noted that such incidents may also be regarded as clinically significant (CSAUE), as defined by relevant professional guidance.

b)   Incidents involving over-exposure of staff or public are reportable under IRR 17 to HSE.

c)   Incidents involving radioactive materials are reportable to Natural Resources Wales under the Environmental Permitting Regulations 2016 and the Health and Safety Executive under IRR 17.

d)   Loss or theft of radioactive materials must also be reported to the police.

All such incidents must be reported following the Trusts normal incident reporting procedure.

9.6   The Divisional Directors shall ensure that adequate arrangements are in place for reporting radiation incidents, obtaining advice from Radiation Protection Advisers and Medical Physics Experts, and making external reports to enforcing agencies.

9.7   Disposal of radiological equipment shall be undertaken with advice from the Specialist Estates Services branch of NHS Wales Shared Services Partnership (NWSSP).

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Appendix 1 – Radiation Protection and Medical Exposures Strategic and Operational Groups (RPMESG and RPMOSG)

The Terms of Reference are available via the following Link:
http://howis.wales.nhs.uk/sitesplus/972/page/51682

{Update links to terms of reference for RPMESG and RPMEOG here}

Appendix 2

RPA appointment requirements and Scope of Advice

RPA Appointment

Under the requirements of the Ionising Radiation Regulations 2017 (IRR 17) radiation employers are required to appoint and consult with a Radiation Protection Adviser (RPA). The Health and Safety Executive requires that the individuals wishing to act as an RPA must demonstrate that they meet the HSE's criteria of competence and that employers select from such RPAs one or more who have suitable knowledge and experience for the employers type of work [Regulation 14 and Paragraphs 257 to 270 of the Approved Code of Practice (ACOP)].

If more than one RPA is appointed, duties will be shared between them The scope of the advice that will be provided by these individuals will include the items for statutory consultation listed in IRR 17, Schedule 4 and the issues listed in the draft Approved Code of Practice, paragraph 263 as detailed below.

<u>Scope of Advice.</u>

In general the RPA will be required to advise on the measures to be taken to comply with IRR 17, together with other relevant legislation on use of ionising radiation. The scope of the advice required will include:

<u>IRR 17, Schedule 4</u> RPA <u>must</u> be consulted on the following:-

1. Implementation of requirements as to controlled and supervised areas.

2. The prior examination of plans for installations and the acceptance into service of new or modified sources of ionising radiation in relation to any engineering controls, design features, safety features and warning devices provided to restrict exposure to ionising radiation.

3. The regular calibration of equipment provided for monitoring levels of ionising radiation and the regular checking that such equipment is serviceable and correctly used.

4. The periodic examination and testing of engineering controls, design features, safety features and warning devices and regular checking of systems of work provided to restrict exposure to ionising radiation.

Approved Code of Practice (ACOP), Paragraph 263

The advice of the RPA should cover, where relevant, but not limited to, the following:

  (a) Optimisation and establishment of appropriate dose constraints;

(b) Plans for new installations and the acceptance into service of new or modified radiation sources in relation to any engineering controls, design features, safety features and warning devices relevant to radiation protection;

(c) Categorisation of controlled and supervised areas;

(d) Classification of workers;

(e) Outside workers;

(f) PPE;

(g) Workplace and individual; monitoring programmes for exposed workers;

(h) Investigation and analysis of accidents and incidents and appropriate remedial actions;

(i) Employment conditions for pregnant and breastfeeding workers;

(j) Preparation of appropriate documentation such as prior risk assessments and written procedures.

In addition to the specific matters set out in Schedule 4, radiation employers are required to consult a Radiation Protection Adviser where advice is necessary for the observance of the Regulations.

Additional guidance on these matters is given in ACOP paragraphs 257 to 270.

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Appendix 3

Radioactive Waste Adviser

The Basic Safety Standards Directive (BSSD)[1] requires employers to appoint 'qualified experts' to advise them about work with radioactivity that may affect people and the environment. Parts of the BSSD place specific requirements on permit holders and require qualified experts to be involved in the discharge of specific duties. The BSSD also requires that arrangements are in place to recognise the capacity of such qualified experts.

The UK environment agencies have issued a joint statement on radioactive waste advisers[2] which includes requirements in terms of appointment of individuals in this capacity and arrangements for their accreditation.

Recognition of Radioactive Waste Adviser

To be recognised formally in this capacity, an individual must be able to demonstrate that they are competent in radioactive waste management and environmental radiation protection. A syllabus has been developed detailing the competences required of a radioactive waste adviser. An approvals board established by the UK environment agencies is charged with assessing the competence of radioactive waste advisers and of maintaining a register.

The environment agencies consider a suitable Radioactive Waste Adviser (or Corporate Radioactive Waste Adviser) to have "the specific knowledge, experience and competence required for giving advice on the particular radioactive waste management and environmental radiation protection issues for which the permit holder is making the appointment".

Appointment of Radioactive Waste Adviser

A permit holder (Employer) must appoint suitable Radioactive Waste Advisers if the permit is for the accumulation or disposal of radioactive waste. The permit holder is responsible for ensuring that any Radioactive Waste Adviser appointed is "suitable" to give relevant advice on the permit holder's business. This appointment must be in writing and should include the scope of advice which the Radioactive Waste Adviser is required to give.

The permit holder is required to consult a Radioactive Waste Adviser on the following matters and will have due regard to the advice provided by the Radioactive Waste Adviser:

- Achieving and maintaining an optimal level of protection of the environment and the population

- Checking the effectiveness of technical devices for protecting the environment and the population

- Acceptance into service, from the point of view of surveillance of radiation protection, or equipment and procedures for measuring and assessing, as appropriate, exposure and radioactive contamination of the environment and the population

- Regular calibration of measuring instruments and regular checking that they are serviceable and correctly used.

Staff of the Radiation Protection Service holding accreditation act as Radioactive Waste Adviser and are formally appointed by the permit holder (Employer).

1. Council Directive 96/29/EURATOM 1996 (laying down basic safety standards for the protection of the health of workers and the general public against the dangers arising from ionising radiation).

2. Environment Agencies' Statement on Radioactive Waste Advisers, RWA-S-01 v 1.0 7 May 2011

Appendix 4

Medical Physics Expert

A medical physics expert must contribute to the following matters:

(a) Optimisation of the radiation protection of patients and other individuals subject to exposures, including the application and use of diagnostic reference levels.

(b) The definition and performance of quality assurance of the equipment

(c) Acceptance testing of equipment

(d) The preparation of technical specifications for equipment and installation design

(e) The surveillance of the medical radiological installations

(f) The analysis of events involving or potentially involving accidental or unintended exposures

(g) The selection of equipment required to perform radiation protection measurements

(h) The training of practitioner and other staff in relevant aspects of radiation protection

(i) The provision of advice to an employer relating to compliance with these regulations.

Appendix 5

Radiation Protection Supervisor role specification

Base Location

Department

Accountable to

Reports to

Liaises with　　　　　　　Radiation Protection Adviser

Job Summary: The Radiation Protection Supervisor (RPS) will play a supervisory role in assisting the Trust to comply with the requirements of the Ionising Radiation Regulations 2017 (IRR 17). The RPS will be directly involved in the work with ionising radiation and will exercise close supervision to ensure that the work is done in accordance with Local Rules.

The only responsibility of the Radiation Protection Supervisor specified under IRR 17 is to supervise the work with ionising radiations. Overall responsibility for radiation protection matters lies with the departmental manager. However, additional duties may be delegated to the RPS as detailed below.

MAIN DUTIES AND RESPONSIBILITIES

1.　　**Restriction of Exposure**

　　To observe, from time to time, all procedures involving ionising radiation and to and to keep a record of this process for audit purposes. To issue instructions necessary to maintain radiation doses as low as reasonably practicable.

2.　　**Notification of work and certain occurrences**

　　To notify, in writing, the responsible manager:

　　(i) of any proposed changes in, or additions to, work activity

　　(ii) immediately of any damage to a radioactive source, spillage, loss or suspected loss of radioactive substances.

　　(iii) of any change of equipment, usage or conditions, which might affect radiological safety; of any monitoring instrument used to demonstrate compliance with the Regulations which has not been calibrated to acceptable national standards.

(iv) immediately of any incident involving equipment malfunction resulting in patient exposure much greater than intended or significantly lower than those considered proportionate (in radiotherapy).

(v) immediately of any incident or suspected incident involving staff exposure much greater than intended.

3.   Local Rules and Systems of Work

(i) To assist in the writing of Local Rules and Systems of Work and to ensure that these are adhered to.

4.   Information, Instruction and Training

(i) To attend courses and receive training as recommended by the RPA.

(ii) To promulgate local Rules and Systems of Work to ensure that necessary safety information and guidance is given to all staff, outside contractors and any other persons who enter controlled or supervised radiation areas.

5.   Additional Duties

(i) Dependent on the work carried out in the Department the responsible manager may delegate to the RPS specific tasks to comply with IRR 17 These requirements must be listed and attached to both this Role Specification and to the Local Rules.

(ii) The RPS must provide a six-monthly report to the Radiation Protection and Medical Exposures Operational Group.

<u>NOTE:</u>

The duties and responsibilities outlined in this role specification should be read in conjunction with the following where relevant to the work undertaken:

(a) The Ionising Radiations Regulations 2017

(b) Working with ionising radiation-draft Approved Code of Practice and Guidance 2017

(c) The Ionising Radiation (Medical Exposure) Regulations 2017

(d) The Carriage of Dangerous Goods and Use of Transportable Pressure Equipment Regulations 2009 Amended 2011

(e) The Environmental Permitting Regulations 2016 and subsequent versions.

Appendix 6

IR(ME)R 17 Entitlement Responsibilities
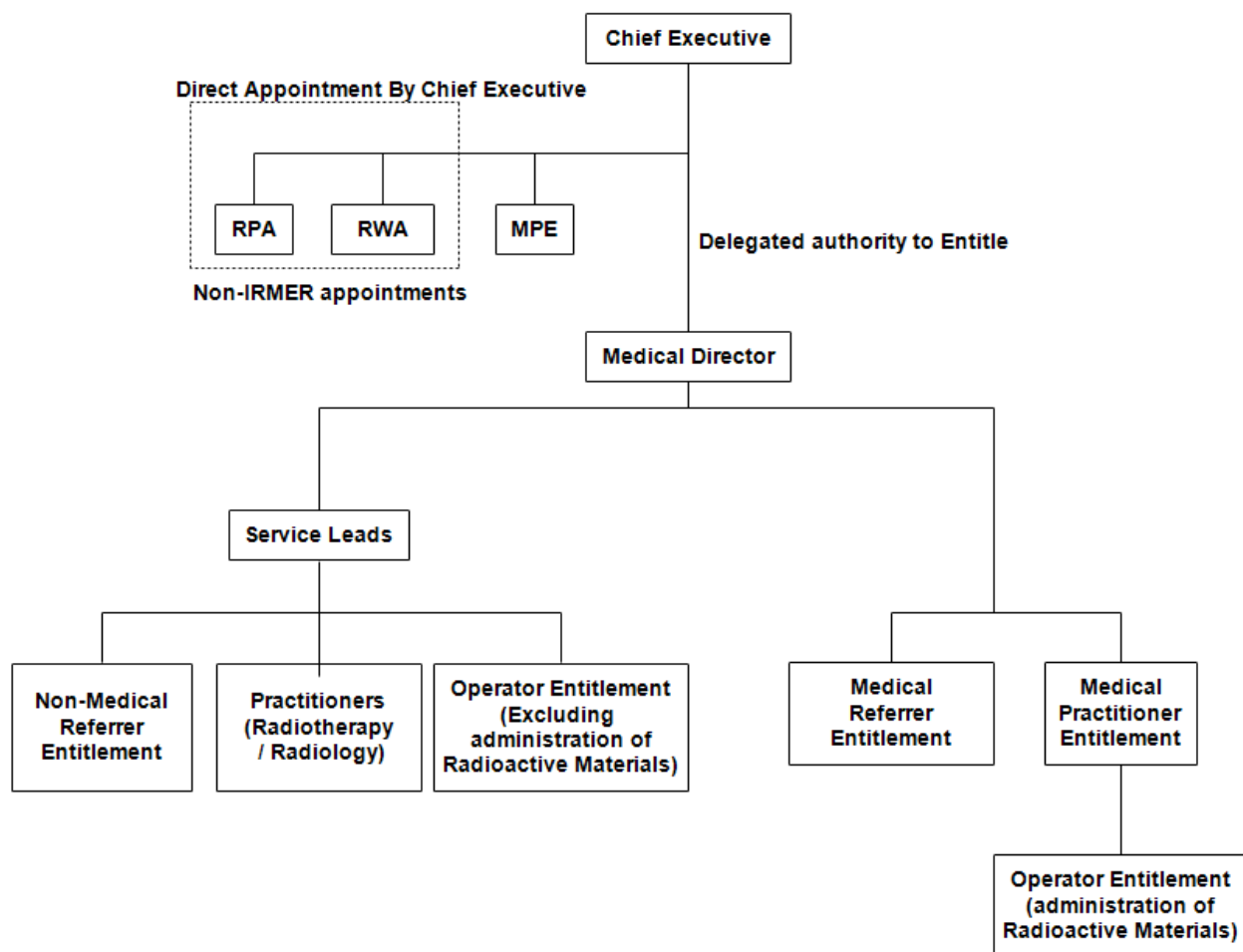
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Ref: QS 19

IONISING RADIATION SAFETY POLICY

Executive Sponsor & Function:	Director, Velindre Cancer Centre
Document Author:	Head of Radiation Protection Service
Approved by:	Quality & Safety Committee
Approval Date:	November 2019
Review Date:	.November 2021.
Version:	4.7

EXECUTIVE SUMMARY

Overview:	This Policy establishes a framework for controlling the use of ionising radiation and restricting exposure to persons within all Services provided by the Trust. The Trust will only adopt those practices that are consistent with the ALARP Principle. ALARP stands for As Low As Reasonably Practicable and the ALARP Principle is that the residual risk shall be as low as reasonably practicable.
Who is the policy intended for:	All Trust Staff working with ionising radiation
Key Messages included within the policy:	Identification of the legislation governing the use of Ionising Radiation RolesRole and responsibilities of key personnel in the management of radiation protection issues in terms of safety of staff, public and patients. Introduction and implementation of control measures to restrict exposure to ionising radiation. Roles and responsibilities of personnel holding entitlements to take responsibility for aspects of the medical exposure of individuals. Responsibility of all staff to work in accordance with the control measures and to report any non-compliances

PLEASE NOTE THIS IS ONLY A SUMMARY OF THE POLICY AND SHOULD BE READ IN CONJUNCTION WITH THE FULL POLICY DOCUMENT.

CONTENTS

Role specification

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1. INTRODUCTION

1.1 This document establishes a framework for controlling the use of ionising radiation and restricting exposure to persons within all Services provided by the Velindre University NHS Trust.

1.2 The Trust will only adopt those practices that are consistent with the ALARP Principle. ALARP stands for As Low As Reasonably Practicable and the ALARP Principle is that the residual risk shall be as low as reasonably practicable.

1.3 Within the Trust ionising radiation is primarily employed in medical diagnosis and therapy, medical research, quality assurance, the irradiation of blood components and other related applications. These applications are confined to the Velindre Cancer Centre site and the Welsh Blood Service site at Llantrisant.

1.4 The use of ionising radiation within the UK is governed by the following statutory instruments and the Trust is committed to ensuring that the provisions of these regulations, together with the highest standards of best practice in ionising radiation safety, are fully implemented at all times:

- The Ionising Radiations Regulations 2017 (IRR 17)

- The Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R17)

- Environmental Permitting Regulations 2016,(as amended and 2018 and 2020Amendment (EPR16, 18)

- The Carriage of Dangerous Goods and Use of Transportable Pressure Equipment Regulations 2009 (as amended 2011 and 2019) (CDG2009)

1.5 These regulations are supported by various approved codes of practices (ACoP) and guidance notes published by the enforcing agencies and other organisations (Health and Safety Executive, Department of Health and Social Care, Welsh Government, Natural Resources Wales, Public Health England (formerly Health Protection Agency or NRPB)) and professional bodies (Royal College of Radiologists, Institute of Physics and Engineering in Medicine, College of Radiographers, Society for Radiation Protection etc.).

1.6 The Trust has followed the general guidance on good practice with respect to the radiation protection issues and legislation as detailed in the document "Medical and Dental Guidance Notes" 2002 (MDGN) and subsequent versions published by the Institute of Physics and Engineering in Medicine (IPEM).

1.7 The specific details regarding the implementation of all radiation protection requirements and associated issues are contained within the individual departments' Local Rules, Employers Procedurespatient protection documentation (IR(ME)R 17 documents) and other associated documents.

1.8   This Policy must be read in conjunction with other relevant Trust and Division Policies, including those on Waste Management, Clinical Evaluation, Pregnancy Tests, etc.

2   RESPONSIBILITIES

2.1   The Trust's Chief Executive carries the overall responsibility for implementing the requirements of the regulations governing work involving ionising radiation throughout all Services managed by the Trust.

2.2   To assist in discharging this responsibility the Chief Executive requires all Service Directors and Service Managers, whose services are involved in working with ionising radiation, to assume the general responsibility for ensuring that radiation safety arrangements throughout their Services are representative of best practice and satisfy the requirements of the regulations.

2.3   The Medical Director carries specific responsibilities relating to compliance with ionising radiations legislation as detailed within this Policy.

2.4   To assist the Service Directors and Service Managers in discharging these responsibilities the Chief Executive requires managers, whose departments are associated with work involving ionising radiation, to implement all necessary radiation protection arrangements outlined in this policy and as advised by the Radiation Protection Adviser (RPA), Radioactive Waste Adviser (RWA) and Medical Physics Expert (MPE).

2.5   It is the responsibility of Service Directors, Service Managers and Department Managers to keep themselves aware of radiation protection issues within their Service and consult with the Radiation Protection Supervisors (RPS), the RPA, RWA and the MPE over any issues that have radiation protection implications.

2.6   It is the responsibility of Service Directors, Service Managers and Department Managers where appropriate to ensure that radiation risk assessments are prepared in respect of all work undertaken with ionising radiation. Radiation risk assessments must be updated no less frequently than two-yearly to ensure that they remain relevant to the work undertaken. A radiation risk assessment must be undertaken;

a) in advance of a new practice being introduced,

b) whenever a significant change in the work activity takes place

2.7   It is the responsibility of Service Directors, Service Managers and Department Managers where appropriate to ensure that local rules for radiation protection are drawn up to govern all work with ionising radiation undertaken within the department or area within the department. Local rules for radiation protection must be periodically updated to ensure that they remain relevant to the work undertaken and take into account the findings of relevant radiation risk assessments.

2.8   It is the responsibility of Service Directors and Service Managers to ensure that all managers responsible for operational and estates facilities maintain an awareness of potential problem areas associated with all work with ionising radiation. This may include drainage systems for departments using unsealed radioactive sources, roof spaces with restricted access above areas where work with ionising radiation is conducted, any known weaknesses in radiation shielding, prevailing security measures, etc.

2.9   All managers responsible for operational and estates facilities must, in consultation with the RPAs, RPSs and Department Managers, formulate systems to facilitate access by contractors, service engineers and other persons, into these problem areas. Such arrangements will involve facilities managers in the production and issuing of "Permits to Work" that detail the conditions under which work may be carried out as specified by the RPAs, the RPSs supervising the work with ionising radiation in the affected area and the department manager.

2.10 It is the responsibility of all Service Directors and Service Managers and managers responsible for departments where the medical exposure of individuals takes place to establish procedures in accordance with the IR(ME)R 17 regulations. These are listed in schedule 2 of the regulations.

2.11 Service Directors and Service Managers are required to ensure that sufficient funds are made available to department managers to implement all relevant radiation protection requirements and risk reduction measures associated with this policy or as advised by the RPA, RWA, RPS and the MPE.

2.12 Service Directors and Service Managers, Department Managers and managers responsible for operational and estates facilities are required to involve the RPA, RWA, RPS and MPE at the earliest opportunity in the planning for refurbishment or site development work, changes to existing services or the development of new services. They are further required, based on risk assessments, to make arrangements for the funding and implementation of all necessary radiation protection requirements as advised by the RPA, RWA and the MPE.

2.13 It is a requirement that all staff, working with ionising radiation, to;

   a. exercise reasonable care and follow the provisions of the Local Rules, IR(ME)R 17 Policies and Procedures, Natural Resources Wales Permits and other related working instructions

   b. use, as instructed, any protective equipment and personal radiation dose meters provided, to report to the Trust's Chief Executive via the line manager, and to inform the Radiation Protection Supervisor, of any defects in such equipment and dose meters

    c. undertake any training specified by the Service Director, Service Manager or Department Manager.

    d. report immediately to the Service Director, Service Manager or Department Manager if an incident occurs in which a member of staff or public is unintentionally exposed to radiation

    e. report immediately to the Service Director, Service Manager or Departmental Manager if they suspect that a radioactive source has been damaged, lost or stolen. Further advice on managing the incident should be sought from the Radiation Protection Adviser and Radioactive Waste Adviser.

    f. not recklessly endanger the safety of others

    g. report to the departmental manager when it is suspected that an "accidental~~overexposure~~ or unintended exposure due either to equipment malfunction or failure of IR(ME)R 17procedures has taken place.

2.14 All medical, radiotherapy, radiology, nuclear medicine, medical physics, clinical trials and nursing staff must pay particular attention to their roles and responsibilities as detailed in the IR(ME)R 17 Policies and Procedure.

2.15 It is a requirement that Velindre University NHS Trust holds the appropriate authorisations to work with ionising radiations. This includes the provisions for prior notification, registration and consent under IRR 17, the issue of permits for the use and disposal of radioactive materials under EPR16 and having an Employer licence to authorise the administration of radioactive medicinal products to patients under IR(ME)R17.

2.16 All medical practitioners who intend to administer radioactive medicinal products for diagnostic investigations or therapy applications must also have an appropriate licence granted under the IR(ME)R 17 by the Administration of Radioactive Substances Advisory Committee (ARSAC) on behalf of the Secretary of State. It is the responsibility of the Medical Director to ensure that all such medical practitioners are appropriately licensed in advance of commencement of a new procedure for the first time and continue to remain licensed.

2.17 It is the responsibility of departmental managers to ensure that periodic reviews are undertaken of individual's compliance with the provisions of local rules for radiation protection made under the IRR 17. Reviews of procedures should also be undertaken no less frequently than annually to identify any necessary amendments. A record should be kept of these reviews.

2.18 Based on risk assessment the departmental managers will make arrangements to prioritise funding, to cover the cost of implementing unforeseen expenditure with respect to radiation safety, patient dosimetry and security issues from

changes in the regulations, technological advances in radiation protection, as advised by the RPA, RPS and MPE.

2.19 Failure to follow the provisions of this policy and the local arrangements in place for radiation safety within a department or service may result in disciplinary action.

3   ORGANISATION

3.1   The Chief Executive has established a Radiation Protection and ~~Committee (RPC), which incorporates the functions of a~~ Medical Exposures Strategic Group (RPMESG) and a Radiation Protection and Medical Exposures Operational Group (RPMOSG)~~Committee (MEC),~~ to formulate appropriate policies, monitor the level of compliance in the various components of the Trust, identify areas of non-compliance and initiate remedial action, and to keep him/her informed of specific issues that require his attention. The terms of reference and membership of the RPMEOG and RPMESG~~RPC~~ are linked~~detailed~~ in Appendix 1.

3.2   The Chairperson of the RPMESG~~RPC~~ reports directly to the Chief Executive.

4   ADVICE and ASSISTANCE

4.1. Radiation Protection Adviser

4.1.1 In accordance with the requirements of the Ionising Radiation Regulations 17 the Chief Executive will appoint in writing one or more individuals as the Trust's Radiation Protection Adviser (RPA). The appointment requirements and the scope of advice required under IRR 17 are given in Appendix 2.

4.1.2 Suitably experienced individuals~~Clinical Scientists~~ who hold certificates issued by a body recognised by the Health and Safety Executive that enable them to act as radiation protection advisers are appointed as the Trust's RPAs.

4.1.3 Apart from fulfilling the function of an RPA as detailed in IRR 17 and the accompanying approved code of practice (ACoP), these individuals are required to be proactive in advising the Chief Executive, and those persons assigned specific tasks, on the general requirements for ionising radiation safety and the specific means of achieving compliance with the requirements of all regulations governing the use of ionising radiation in the UK.

4.1.4 The RPA is required to be proactive in keeping the Chief Executive, Chairperson of the RPMESG~~RPC~~, Service Directors and Service Managers, Department Managers, RPSs and MPEs up to date with advances in radiation protection practice, pertinent guidance from

professional bodies, Government Organisations and Enforcement Agencies, etc., and proposals to amend existing legislation or introduce new legislation associated with work involving ionising radiation as applicable to the health care environment.

4.1.5 In instances where such changes only affect the working practices within specific departments or across a Service the RPA will advise the Service Directors and Service Managers, department managers, RPSs and MPEs as to the appropriate means of implementing such changes.

4.1.6 In instances where such changes must be implemented on a Trust wide basis the Chairperson of the RPMESGRPC with the RPA will convene a sub group (to include representatives from the services) to scrutinise the changes, formulate an action plan for the production of any new policy or the amendment of existing policies as required, the implementation of the changes into working practices and the production of all necessary documentation associated with the changes. The Chairperson of the RPMESGRPC will be responsible for ensuring that changes in Trust-wide Policy documents (new, replacement or amended) will be developed and approved in accordance with the Trust's Policy for Policies.

4.1.7 The RPAs are ex officio members of the RPMESG and RPMEOG,RPC and normally report to the Chief Executive through the committee structure. In instances where the RPAs believe that immediate action is required to remedy instances of non-compliance or potential noncompliance the RPAs are required to report directly to the Service Directors and Service Manager and if necessary to the Chief Executive.

4.1.8 The RPAs are required to;

a. Respond to requests to advise and assist the Chief Executive and all Service Directors and Service Managers, department managers and staff in performing all duties and tasks associated with radiation protection issues

b. Maintain and make available to all Trust employees a comprehensive library of all relevant radiation protection documents. These will include Statutory Instruments, ACoP, Guidance Notes, advice and guidance provided by the government, its agencies and professional bodies, text books, advice and guidance provided by the European Community, advice and guidance provided by international organisations (International Commission of Radiological Protection), etc.

c. Advise and assist Service Directors and Service Managers, Department Managers and Radiation Protection Supervisors in all safety, security and transport issues (in consultation with a Dangerous Goods Safety Adviser, (DGSA), and a Radioactive Waste Adviser (RWA) where necessary) associated with the delivery, keeping, use and disposal of radioactive materials.

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d. Advise and assist Divisional Directors, Department Managers, Clinical Staff and Radiation Protection Supervisors in all relevant patient safety issues.

e. Be involved in the tendering for an approved dosimetry service to provide radiation monitoring facilities in accordance with the requirements of IRR 17.

f. In conjunction with department managers, formulate an effective personal radiation dose monitoring programme for staff working with ionising radiation reflecting the outcome of relevant radiation risk assessments.

g. To assist Departmental Managers in assessing the results of the personal radiation dose monitoring programme and initiating all appropriate action. To interface, on behalf of the Chief Executive, with the approved dosimetry service, on matters relating to dose results and record keeping issues, as required by IRR 17.

h. Ensure that, in instances where individuals may be required to be designated as "Classified Persons" under the requirements of IRR 17, the matter is referred to the head of the department concerned and that the Chairman of the RPMESGRPC is notified.
When designatingIf it ever becomes necessary to designate classified workers then the Chief Executive will assign the task of ensuring compliance for the medical surveillance of such employees as required under IRR 17, for classified persons, cases of overexposure, etc., to the Trust Medical Director.

i. Interface on behalf of the Chief Executive with individuals responsible for enforcing or monitoring compliance with legislation governing work with ionising radiation

4.2 Radioactive Waste Adviser

In accordance with the requirements of the Environmental Permitting Regulations 2016 (EPR16) the Chief Executive will appoint in writing one or more individuals as the Trust's Radioactive Waste Adviser (RWA). The appointment requirements and the scope of advice required under IRR 17 are given in Appendix 3.

Suitably experienced individualsclinical scientists who hold certificates issued by a body recognised by the Environmental Agencies that enable them to act as RWAs are appointed as the Trust's RWAs.

The RWAs are required to;

a. Make all necessary arrangements for the permitting of radioactive substances and of radioactive waste for each of the Trusts sites under the requirements of the EPR.

b. Set individual department limits for the holding of radioactive substances on each of the Trusts sites and monitor compliance with each of the sites' EPR permits.

c. Set individual department limits for the accumulation and disposal of radioactive waste from Trust sites, co-ordinate the disposal records from all departments on each of the Trust's sites and monitor overall compliance with each of the sites' EPR permits.

d. Provide advice on and undertake compliance audits with respect to the requirements of the EPR regulations including the management of sealed sources (including High-activity Sealed Radioactive Sources)

e. Liaise with Natural Resources Wales regarding regulatory matters including (but not limited to) pollution inventory and other submissions.

f. Undertake environmental impact assessments regarding the discharges of radioactive wastes within the Trust.

h. Produce a Trust statement of the application of Best Available Techniques (BAT) within the Trust to minimise the radiological impact of radioactive discharges on the environment.

4.3 Radiation Protection Supervisor

4.3.1 The Radiation Protection Service will arrange for departmental managers' nominated Radiation Protection Supervisors to be appointed in writing by the Chief Executive in accordance with the requirements of IRR 17. The suitability of the individual for this role will be assessed by the departmental manager with input from the RPA who will advise on suitable training schemes for the RPS. Managers must draw up a role specification for the RPS that details all of the tasks delegated to him or her by the manager and this can either be issued to the individual or incorporated into the individual's Job Description.

4.3.2 Under IRR 17, the only duty assigned to the RPS is to supervise the work undertaken with ionising radiation to ensure that this is carried out in accordance with the Local Rules. Other tasks, associated with the day to day practical aspects and or management of radiation protection issues, may be assigned to the RPS by the department managers. A template role description for the Radiation Protection Supervisor is included in Appendix 5, including both the supervision duty and other duties which department managers may wish to delegate to them in the context of a broader supervisory role.

4.3.3 Department managers will consult with the RPA over documents (copies of legislation, ACoP, Guidance Notes, etc) to be provided to the RPS to assist in discharging the duties, and as reference documents for all staff working within the department. The manager will ensure that all such documents are purchased and available to the RPS.

4.3.4 All RPSs are automatically members of the RPMEOGRPC.

4.4 Medical Physics Expert

4.4.1 It is a requirement of IR(ME)R 17 that a Medical Physics Expert (MPE) is involved as appropriate in providing expert advice for every medical exposure.

a. There shall be at least one MPE available to be involved in standardised therapeutic nuclear medicine practices and in diagnostic nuclear medicine practices. In non-standard radionuclide therapy the MPE will be closely involved in each procedure.

b. There shall be at least one MPE closely involved in every radiotherapy exposure.

c. In diagnostic radiology, MPEs shall be available to be involved as appropriate for consultation and optimisation and to be involved with high dose interventional radiology and high dose computed tomography.

4.4.2 The MPE must contribute to the matters detailed in appendix 4.

4.4.3 The Head of Radiation Servicesthe Medical Physics Department, with advice from the heads of nuclear medicine, radiation protection and radiotherapy physics, is responsible for advising the Chief Executive on making appropriate and sufficient MPE appointments.

4.4.4 All MPEs appointed on behalf of the Employer must hold certification as MPEs in their specialty by a body recognised by the Department of Health and Social Care that enables them to act in that capacity.

4.5 Qualified Person

4.5.1 The Head of the Radiation Protection Service is responsible for appointing suitably qualified individual(s) to act as the Qualified Person for the purposes of testing radiation protection instruments in accordance with IRR 17.

5.   DUTY HOLDERS under IR(ME)R 17

The mechanism for entitlement of operators and practitioners is considered in section 6.2.

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5.1 Employer:

In the context of IR(ME)R 17, the employer is considered to be Velindre University NHS Trust. If the Trust contracts a third party to provide services then the Trust will be the employer as regards the operators for the purpose of the Regulations, but the third party is the employer of the operators for employment law purposes.

Equipment ownership has no impact on the employer responsibilities under IR(ME)R 17.

5.2 Operator:

The operator is any person who is entitled, in accordance with departmental written procedures, to undertake the practical aspects of a medical exposure and is adequately trained. Operators may include radiographers, medical practitioners, clinical scientists/medical physicists, clinical technologist/medical physics technicians and nurses.

5.3 Practitioner:

The practitioner is a registered medical practitioner, dental practitioner or other health professional who is entitled in accordance with the Trust's written procedures to take responsibility for an individual medical exposure. The primary responsibility of the practitioner is to justify medical exposures.

In some cases the practitioner may also undertake practical aspects of an exposure and so become an operator with regard to these specific functions.

The practitioner in Nuclear Medicine must hold an ARSAC licence specifying the range of radionuclides and pharmaceuticals that they may prescribe.

Arrangements may be put in place for an individual to authorise justification of the medical exposure on behalf of the practitioner under a Delegated Authorisation Guideline (DAG) drawn up by the practitioner. Under such an arrangement, the individual acts as IR(ME)R 17 operator for this function. This arrangement may also apply to justification of exposures involving radionuclides and pharmaceuticals.

Arrangements must also be put in place for the justification of exposures to carers and comforters.

5.4 Referrer:

The referrer is a registered medical practitioner, dental practitioner or other health professional who is entitled in accordance with departmental written procedures to refer individuals to a practitioner for medical exposure.

6.   ARRANGEMENTS for COMPLIANCE with IR(ME)R 17

6.1 Written procedures

     a. Employer's standard operating procedures, covering the areas specified in schedule 2 of IR(ME)R 17 and specific to individual departments where medical exposures are undertaken, must be formulated and~~are~~ maintained within the work instructions and local policies and procedures of those departments. A listing is maintained by each department summarising, as a minimum, the local versions of the fourteen standard operating procedures specified. Further standard operating procedures may be added as required, but it should be borne in mind that such procedures will then be legally binding upon the organisation and its employees. The MPE must be involved in the formulation and maintenance of these procedures.

     b. Clinical protocols~~Protocols~~ for all standard procedures involving medical exposures are maintained within the work instructions of each department and are made available for use by all staff.~~.~~

     c. Where patient referrals under IR(ME)R 17 are made, referral procedures are part of each department's IR(ME)R 17 standard operating procedures and permit the referral of patients for diagnostic radiological/nuclear medicine investigations and therapy applications. Appropriate instruction regarding the referral process must be given to all relevant staff.

     d. All new IR(ME)R 17 policies and standard operating procedures must be submitted to the RPMOSG~~RPC~~ for ratification and formal adoption on behalf of the Trust. Only those documents that have been confirmed as "suitable for purpose" will be ratified.

     e. Quality Assurance programmes must be introduced, in consultation with the ~~RPAs and~~ MPEs, to assess the effectiveness of policies and procedures.

     f. All IR(ME)R 17 Policies, Procedures, Inventory, Protocols (Standard Operating Procedures), Diagnostic Reference Levels and all written arrangements concerning IR(ME)R 17 must be reviewed no less frequently than once every two years~~annually~~ or whenever there are changes of equipment or working practices.

     g. Whenever departments' activities overlap the managers must liaise to ensure compatibility between both departments IR(ME)R 17 Policies and Procedures. Formal written procedures must be established between these departments to detail all agreed arrangements.

6.2 Entitlement of Practitioners and Operators

     a. The Medical Director has delegated authority from the Chief Executive to entitle duty holders including Referrers, Operators and Practitioners. The Medical Director further delegates authority to the departmental managers or service leads to entitle duty holders for specific IR(ME)R 17 functions in

accordance with the flow chart in appendix 6. Entitlement of RPAs, RWAs, MPEs and Medical Director is by letter from the Chief Executive. Further cascaded entitlement is undertaken according to local procedure.

b. It is the responsibility of departmental managers or service leads to ensure that only individuals formally identified and entitled by the Employer can undertake Practitioner and/or Operator roles.

c. Before any individual is formally entitled to act as Practitioner or Operator, arrangements must be made to assess their experience and to determine what training must be undertaken before entitlement can take place. If an individual is entitled to undertake an IR(ME)R role by another organisation, this does not lead to automatic entitlement by Velindre University NHS Trust to undertake a similar role. Any relevant certification held by an individual (e.g. the holding of a licence issued by ARSAC) may be taken into consideration in establishing their competence to be entitled to undertake an IR(ME)R role. Systems must be in place to provide new staff with the necessary training and expertise to permit them to act as practitioners or operators.

d. Entitlement should only be undertaken by authorised individuals as per delegation pathways from the Chief Executive and reflect prevailing professional guidance. The entitlement must follow an auditable pathway and documentation kept to show

i) the date on which entitlement took place

ii) the task and scope of practice for which entitlement has taken place

iii) the identity of the person undertaking the entitlement and their delegated authority

Details of this process are recorded in the procedures of each department. The individual being entitled shall receive formal notification and details of the scope of the entitlement

e. A list will be held by each department of its practitioners and operators, detailing the specific functions for which they are entitled to act. This list forms part of the IR(ME)R documentation and it must be made readily available to all departmental staff. This list must be updated whenever there are changes in personnel.

f. Individual procedures are in place in each department detailing how entitlement of Practitioners and Operators takes place within the framework in Appendix 6.

6.3 Referrers

a. Entitlement of Referrers is via the process described in 6.2.a.

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b.   It is the responsibility of departmental managers or service leads to ensure that only individuals formally identified and entitled by the Employer can undertake Referrer roles.

c. Individuals entitled to refer patients must be identified and their names recorded on the divisional list. This list forms part of the IR(ME)R 17 documentation and it must be made available to all departments. The list must be updated whenever there are changes in personnel. It is the responsibility of the Director of Cancer Services to ensure that administrative arrangements are in place to enable all those justifying a medical exposure or authorising a medical exposure on behalf of a practitioner to have at their disposal a current list of entitled IR(ME)R 17 referrers.

c. The Employer must establish referral criteria for medical exposures, reflecting prevailing national professional guidance and these are referenced in departmental documentation.

d. Systems must be in place to provide new staff with the necessary training and expertise to permit them to act as referrers. ——Department managers must ensure that appropriate instruction regarding the referral process must be given to all relevant staff.

e. Medical staff wishing to refer patients for radiological/nuclear medicine investigations must be given instruction on completing request forms and information on referral criteria during their induction. Referrals from General Practitioners for radiological imaging procedures are accepted according to radiology department policies.

f. Policies/procedures are required to enable referrals for diagnostic radiological/nuclear medicine investigations from non-medically qualified registered health care professionals where this is to be undertaken. In all such instances referral guidelines and the scope of referral must be agreed in consultation with the senior radiologist and department manager.

6.4 Practitioners and Operators

a. The IR(ME)R 17 Practitioner and Operator have a legal duty to comply with the procedures established by the Employer.

b. All staff acting as practitioners and operators must be aware of and conversant with the IR(ME)R 17 policies, procedures, protocols and the relevant Standard Operating Procedures. This may also include delegated authorisation guidelines issued by the practitioner.

c. Systems must be introduced to monitor and audit compliance with the IR(ME)R 17 Policies and Procedures and Standard Operating Procedures and the Results of the Audits will be submitted to the RPMEOGRPC for comment and where necessary advice on remedial action.

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d. ~~Whenever departments' activities overlap the managers must liaise to ensure compatibility between both departments IR(ME)R 17 Policies and Procedures. Formal written procedures must be established between these departments to detail all agreed arrangements.~~

6.5   Optimisation of exposure

a. Arrangements must be made, in consultation with the MPE, to implement a dose optimisation strategy for all radiological practices and introduce and monitor Diagnostic Reference Levels (DRL), as required by IR(ME)R 17, for all standard radiological investigations and standard nuclear medicine procedures.

b. Quality Assurance programmes must be introduced, in consultation with the MPEs, to assess the effectiveness of equipment, ~~policies and procedures~~.

c. All IR(ME)R Policies, Procedures, Inventory, Protocols (Standard Operating Procedures), Diagnostic Reference Levels and all written arrangements concerning IR(ME)R 17 must be reviewed annually or whenever there are changes of equipment or working practices.

6.6   Administration of radioactive substances to patients

a. In departments employing sealed and unsealed radioactive sources for diagnostic or therapeutic purposes, cross reference with the Employer licence and practitioner ARSAC licence must be undertaken before new radioactive medical products are introduced into clinical practice. Where the licence(s) does not cover such products the medical practitioner and/or Employer must obtain an endorsement to their licence to cover this new work in accordance with the requirements of IR(ME)R 17.

b. Research ARSAC licence applications are required for clinical trial procedures if they are not covered by existing licences.

c. Arrangements must be in place that medical practitioners are reminded, well in advance of the date of expiry of their licence, of the need to renew their licence issued under the IR(ME)R 17 or certificates under previous legislation. At present, an automatic reminder is generated by the ARSAC secretariat in advance of expiry of current certificates or licences.

7 ARRANGEMENTS FOR COMPLIANCE WITH IRR 17

7.1   Radiation risk assessments must include all reasonably foreseeable fault or accident situations and a consideration of the radiation dose received by relevant individuals under such circumstances. This should include the patient under examination, other patients, staff and public. ~~7~~They will consider the need for and type of personal radiation dosimetry to be undertaken and whether classified radiation worker status is required. An RPA must be consulted in the preparation of any radiation risk assessment.

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7.2   The Local Rules are intended to protect staff, the general public and the environment and they will specify general radiation protection requirements and specific requirements identified in IRR 17. The RPMEOG must be kept aware via RPS reports of when local rules are reviewed and the broad extent of any revisions made.

7.3   Systems must be in place to ensure that all new or modified installations that are used in connection with ionising radiation(s) are subject to a critical examination under IRR 17 prior to first use.

7.4   The Local Rules identify potential hazards and provide measures that enable staff to work safely and arrangements must be in place to ensure that all staff working within the department are made aware of all issues detailed in the Local Rules and given training in their implementation and observance.

7.5   The service manager is responsible for ensuring that all staff are adequately supervised. The RPS is responsible for ensuring that the provisions of the local rules for radiation protection are followed. The RPS must report any noncompliance with the Local Rules to the department manager who, in consultation with the RPA, will investigate the reasons for the noncompliance and put in place measures to ensure that such breaches are not repeated. In instances where breaches are identified by the RPA as serious or in instances where breaches cannot be resolved within the department the department manager will seek a solution by referring the issue to the Service Directors and Service Manager and the chairman of the Radiation Protection and Medical Exposures Operational Group.

7.6   Arrangements must be in place to ensure that Local Rules are reviewed at a frequency advised by the RPA and that radiation risk assessments are reviewed no less frequently than every two years or whenever there are changes to equipment or working practices.

7.7   A handover document must be used when transferring managerial control of a radiation controlled area between parties from within VUNHST and between VUNHST employees and those employed by other parties.

7.8   Systems must be in place to communicate with the employer of any Outside Worker who needs to enter a designated area. Outside Workers are defined as any party not employed by VUNHST who need to enter a radiation controlled or supervised area which has been designated as such by VUNHST in order to provide a service. This communication must include sufficient information to enable the employer to comply with their obligations under IRR 17 and must, in all but exceptional cases, happen before the outside worker is required to enter the designated area.

7.9   Systems must be implemented to ensure that any radiation protection instruments used to demonstrate compliance with IRR 17 are fit for use and are sent for testing before first use, for annual testing, or for testing after repair, to the Qualified Person. Before purchasing any new or replacement instruments

the department manager will seek the advice of the RPA and Qualified Person with respect to the selection of the most appropriate instrument.

8 ARRANGEMENTS for RADIOACTIVE SUBSTANCES

8.1 In departments where unsealed radioactive materials are employed (Nuclear Medicine and radioisotope cubicles) detailed instructions must be included in or referenced by the Local Rules regarding the transportation, delivery, storage, security, use, and disposal of the radioactive materials. Additional instructions will be required with respect to hygiene, the care of patients, monitoring for the presence of radioactive materials and the selection and testing of radiation protection instruments.

8.2 In departments where sealed radioactive sources are employed (Nuclear Medicine, Research, Radiotherapy, Brachytherapy, Welsh Blood Service and RPS Cardiff) detailed instructions must be included in or referenced by the Local Rules regarding the transportation, delivery, storage, security, use, leak testing and ultimate disposal or transfer of the radioactive materials.

8.3 For security reasons suitable procedures must be in place to ensure that all necessary signage and notices do not advertise the details of radioactive materials to the general public.

8.4 The department manager will ensure that detailed records are kept of the purchase, storage, use and disposal of all radioactive materials together with quantitative records of the disposal of sealed and unsealed radioactive materials. They will make arrangements to return copies of the disposal records to the RWA on a regular basis as determined by the RWA.

8.5 Control measures must be introduced to check at appropriate intervals the presence of all sources on a regular basis or whenever used and to monitor that activities detailed in the EPR 2016 permits and associated department limits are not breached. An annual audit should be undertaken to ensure that this process is taking place. With respect to the disposal of sealed or unsealed radioactive materials, monitoring to prevent breaches will be based on the department limits assigned by the RWA.

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9 GENERAL ARRANGEMENTS for RADIATION PROTECTION

9.1 Before any individual is permitted to work with ionising radiation, arrangements must be made to assess the individual's training requirements and implement means of delivering any required training (as identified by the department manager with support from the MPE and RPA if required), monitoring the training programme and assessing the individual's performance.

9.2 Radiation risk assessments must include all reasonably foreseeable fault or accident situations and a consideration of the radiation dose received by relevant individuals under such circumstances. They will consider the need for

and type of personal radiation dosimetry to be undertaken and whether classified radiation worker status is required. An RPA must be consulted in the preparation of any radiation risk assessment.

7.3   The Local Rules are intended to protect staff, the general public and the environment and they will specify general radiation protection requirements and specific requirements identified in IRR 17. The RPC must be kept aware via RPS reports of when local rules are reviewed and the broad extent of any revisions made.

7.4   Department managers must discuss any new proposed or planned uses of ionising radiation with the RPA and MPE at the planning stage.

7.5   Systems must be in place to ensure that all new or modified installations that are used in connection with ionising radiation(s) are subject to a critical examination under IRR 17 prior to first use.

7.6   The Local Rules identify potential hazards and provide measures that enable staff to work safely and arrangements must be in place to ensure that all staff working within the department are made aware of all issues detailed in the Local Rules and given training in their implementation and observance.

7.7   The service manager is responsible for ensuring that all staff are adequately supervised. The RPS is responsible for ensuring that the provisions of the local rules for radiation protection are followed. The RPS must report any noncompliance with the Local Rules to the department manager who, in consultation with the RPA, will investigate the reasons for the noncompliance and put in place measures to ensure that such breaches are not repeated. In instances where breaches are identified by the RPA as serious or in instances where breaches cannot be resolved within the department the department manager will seek a solution by referring the issue to the Service Directors and Service Manager and the chairman of the RPC.

7.8   Arrangements must be in place to ensure that Local Rules are reviewed at a frequency advised by the RPA and that radiation risk assessments are reviewed annually or whenever there are changes to equipment or working practices.

7.9   A complete set of patient protection procedures, protocols and equipment inventory as required under IR(ME)R 17 must be formulated, in conjunction with the RPA and MPE, and implemented in each department where medical radiation exposures take place.

7.10 A set of clinical protocols detailing each diagnostic radiological/nuclear medicine investigation or therapy application performed in the department must be produced for use by all staff.

7.11 Systems must be in place to provide new staff with the necessary training and expertise to permit them to act as practitioners, referrers and/or operators.

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7.12 Quality Assurance programmes must be introduced, in consultation with the RPAs and MPEs, to assess equipment performance and consistency.

9.3   7.13 Department Managers must ensure that any member of the department staff who has been allocated duties associated with ionising radiation is given written instructions regarding the role involvement: e.g. formulating and documenting Local Rules, quality assurance activities, IR(ME)R 17 policies and procedures; performing specific duties under the provisions of these documents; or performing other tasks directly related to or loosely associated with the Trust's radiation protection policy or general radiation protection matters. The manager must ensure that all such individuals are given adequate resources and protected time in which to carry out the assigned tasks.

7.14 Systems must be in place to facilitate an exchange of written information, including any hand over forms or permissions to work, on radiation safety matters with contractors' Outside Workers who install, maintain or service equipment either associated with any work activity involving ionising radiation or located in a radiation area or restricted area.

9.4 7.15   Systems must be in place to keep all staff aware of their general responsibilities with regard to radiation protection (2.10) and keep all staff aware of the need to report any incident or near misses involving ionising radiation that may have resulted in the uncontrolled release of radioactive materials or the unintended exposure of patients, staff or other persons.

9.5 7.16   All incidents, involving unintended exposures of patients or staff, significant spillages of unsealed radioactive materials, theft/loss/damage of radioactive materials, breaches of disposal limits etc., must be investigated by the department manager in consultation with the RPS, and the RPA/RWA and relevant MPE where appropriate. The department manager must ensure that a written report is produced following the investigation to detail the circumstances, findings and remedial measures required to reduce the possibility of such incidents occurring in the future. The MPE will be involved for the purposes of estimating doses to patients and the necessity for reporting such incidents to government agencies. The RPA may also need toRPA will be involved in all instances to assess the risks associated with the incident and to provide any further advice. advise the department manager with regard to the necessity for reporting such incidents to government agencies. The following examples are not exhaustive;

   a)   a) Incidents of significant accidental or involving equipment faults and the unintended exposure (SAUE) of patients, whether due to breakdown in procedures or equipment fault,,-are reportable under IR(ME)R 17 to the Healthcare Inspectorate Wales (HIW). It should be noted that such incidents may also be regarded as clinically significant (CSAUE), as defined by relevant professional guidance.

   b)   Incidents involving over-exposure of staff or public are reportable under IRR 17 to HSE.

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c~~b~~) Incidents involving radioactive materials are reportable to Natural Resources Wales under the Environmental Permitting Regulations 2016 and the Health and Safety Executive under IRR 17.

d~~e~~) Loss or theft of radioactive materials must also be reported to the police.

All such incidents must be reported following the Trusts normal incident reporting procedure.

7.17 ~~In departments where unsealed radioactive materials are employed (Nuclear Medicine and radioisotope cubicles) detailed instructions must be included in or referenced by the Local Rules regarding the transportation, delivery, storage, security, use, and disposal of the radioactive materials. Additional instructions will be required with respect to hygiene, the care of patients, monitoring for the presence of radioactive materials and the selection and testing of radiation protection instruments.~~

7.18 ~~In departments where sealed radioactive sources are employed (Nuclear Medicine, Research, Radiotherapy, Brachytherapy, Welsh Blood Service and RPS Cardiff) detailed instructions must be included in or referenced by the Local Rules regarding the transportation, delivery, storage, security, use, leak testing and ultimate disposal or transfer of the radioactive materials.~~

7.19 ~~For security reasons suitable procedures must be in place to ensure that all necessary signage and notices do not advertise the details of radioactive materials to the general public.~~

7.20 ~~The department manager will ensure that detailed records are kept of the purchase, storage, use and disposal of all radioactive materials together with quantitative records of the disposal of sealed and unsealed radioactive materials. They will make arrangements to return copies of the disposal records to the RWA on a regular basis as determined by the RWA.~~

7.21 ~~Control measures must be introduced to check at appropriate intervals the presence of all sources on a regular basis or whenever used and to monitor that activities detailed in the EPR 2016 permits and associated department limits are not breached. An annual audit should be undertaken to ensure that this process is taking place. With respect to the disposal of sealed or unsealed radioactive materials, monitoring to prevent breaches will be based on the department limits assigned by the RWA.~~

7.22 ~~Systems must be implemented to ensure that any radiation protection instruments used to demonstrate compliance with IRR 17 are fit for use and are sent for testing before first use, for annual testing, or for testing after repair, to the Qualified Person. Before purchasing any new or replacement instruments the department manager will seek the advice of the RPA and Qualified Person with respect to the selection of the most appropriate instrument.~~

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9.67.23   The Divisional Directors shall ensure that adequate arrangements are in place for reporting radiation incidents, obtaining advice from Radiation Protection Advisers and Medical Physics Experts, and making external reports to enforcing agencies.

9.7.24 Disposal of radiological equipment shall be undertaken with advice from the Specialist Estates Services branch of NHS Wales Shared Services Partnership (NWSSP).

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Appendix 1 – <u>Radiation Protection and Medical Exposures Strategic and Operational Groups (RPMESG and RPMOSG)</u>

The Terms of Reference are available via the following Link:
<u>http://howis.wales.nhs.uk/sitesplus/972/page/51682</u>

<u>{Update links to terms of reference for RPMESG and RPMEOG here}</u>

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Appendix 2

RPA appointment requirements and Scope of Advice

RPA Appointment

Under the requirements of the Ionising Radiation Regulations 2017 (IRR 17) radiation employers are required to appoint and consult with a Radiation Protection Adviser (RPA). The Health and Safety Executive requires that the individuals wishing to act as an RPA must demonstrate that they meet the HSE's criteria of competence and that employers select from such RPAs one or more who have suitable knowledge and experience for the employers type of work [Regulation 14 and Paragraphs 257 to 270 of the Approved Code of Practice (ACOP)].

If more than one RPA is appointed, duties will be shared between them The scope of the advice that will be provided by these individuals will include the items for statutory consultation listed in IRR 17, Schedule 4 and the issues listed in the draft Approved Code of Practice, paragraph 263 as detailed below.

Scope of Advice.

In general the RPA will be required to advise on the measures to be taken to comply with IRR 17, together with other relevant legislation on use of ionising radiation. The scope of the advice required will include:

IRR 17, Schedule 4 RPA must be consulted on the following:-

1. Implementation of requirements as to controlled and supervised areas.

2. The prior examination of plans for installations and the acceptance into service of new or modified sources of ionising radiation in relation to any engineering controls, design features, safety features and warning devices provided to restrict exposure to ionising radiation.

3. The regular calibration of equipment provided for monitoring levels of ionising radiation and the regular checking that such equipment is serviceable and correctly used.

4. The periodic examination and testing of engineering controls, design features, safety features and warning devices and regular checking of systems of work provided to restrict exposure to ionising radiation.

Approved Code of Practice (ACOP), Paragraph 263

The advice of the RPA should cover, where relevant, but not limited to, the following:

(a) Optimisation and establishment of appropriate dose constraints;

(b) Plans for new installations and the acceptance into service of new or modified radiation sources in relation to any engineering controls, design features, safety features and warning devices relevant to radiation protection;

(c) Categorisation of controlled and supervised areas;

(d) Classification of workers;

(e) Outside workers;

(f) PPE;

(g) Workplace and individual; monitoring programmes for exposed workers;

(h) Investigation and analysis of accidents and incidents and appropriate remedial actions;

(i) Employment conditions for pregnant and breastfeeding workers;

(j) Preparation of appropriate documentation such as prior risk assessments and written procedures.

In addition to the specific matters set out in Schedule 4, radiation employers are required to consult a Radiation Protection Adviser where advice is necessary for the observance of the Regulations.

Additional guidance on these matters is given in ACOP paragraphs 257 to 270.

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Appendix 3

Radioactive Waste Adviser

The Basic Safety Standards Directive (BSSD)[1] requires employers to appoint 'qualified experts' to advise them about work with radioactivity that may affect people and the environment. Parts of the BSSD place specific requirements on permit holders and require qualified experts to be involved in the discharge of specific duties. The BSSD also requires that arrangements are in place to recognise the capacity of such qualified experts.

The UK environment agencies have issued a joint statement on radioactive waste advisers[2] which includes requirements in terms of appointment of individuals in this capacity and arrangements for their accreditation.

Recognition of Radioactive Waste Adviser

To be recognised formally in this capacity, an individual must be able to demonstrate that they are competent in radioactive waste management and environmental radiation protection. A syllabus has been developed detailing the competences required of a radioactive waste adviser. An approvals board established by the UK environment agencies is charged with assessing the competence of radioactive waste advisers and of maintaining a register.

The environment agencies consider a suitable Radioactive Waste Adviser (or Corporate Radioactive Waste Adviser) to have "the specific knowledge, experience and competence required for giving advice on the particular radioactive waste management and environmental radiation protection issues for which the permit holder is making the appointment".

Appointment of Radioactive Waste Adviser

A permit holder (Employer) must appoint suitable Radioactive Waste Advisers if the permit is for the accumulation or disposal of radioactive waste. The permit holder is responsible for ensuring that any Radioactive Waste Adviser appointed is "suitable" to give relevant advice on the permit holder's business. This appointment must be in writing and should include the scope of advice which the Radioactive Waste Adviser is required to give.

The permit holder is required to consult a Radioactive Waste Adviser on the following matters and will have due regard to the advice provided by the Radioactive Waste Adviser:

- Achieving and maintaining an optimal level of protection of the environment and the population

- Checking the effectiveness of technical devices for protecting the environment and the population

- Acceptance into service, from the point of view of surveillance of radiation protection, or equipment and procedures for measuring and assessing, as appropriate, exposure and radioactive contamination of the environment and the population

- Regular calibration of measuring instruments and regular checking that they are serviceable and correctly used.

Staff of the Radiation Protection Service holding accreditation act as Radioactive Waste Adviser and are formally appointed by the permit holder (Employer).

1. Council Directive 96/29/EURATOM 1996 (laying down basic safety standards for the protection of the health of workers and the general public against the dangers arising from ionising radiation).

2. Environment Agencies' Statement on Radioactive Waste Advisers, RWA-S-01 v 1.0 7 May 2011

Appendix 4

Medical Physics Expert

A medical physics expert must contribute to the following matters:

(a) Optimisation of the radiation protection of patients and other individuals subject to exposures, including the application and use of diagnostic reference levels.

(b) The definition and performance of quality assurance of the equipment

(c) Acceptance testing of equipment

(d) The preparation of technical specifications for equipment and installation design

(e) The surveillance of the medical radiological installations

(f) The analysis of events involving or potentially involving accidental or unintended exposures

(g) The selection of equipment required to perform radiation protection measurements

(h) The training of practitioner and other staff in relevant aspects of radiation protection

(i) The provision of advice to an employer relating to compliance with these regulations.

Appendix 5

Radiation Protection Supervisor role specification

Base Location

Department

Accountable to

Reports to

Liaises with   Radiation Protection Adviser

Job Summary: The Radiation Protection Supervisor (RPS) will play a supervisory role in assisting the Trust to comply with the requirements of the Ionising Radiation Regulations 2017 (IRR 17). The RPS will be directly involved in the work with ionising radiation and will exercise close supervision to ensure that the work is done in accordance with Local Rules.

The only responsibility of the Radiation Protection Supervisor specified under IRR 17 is to supervise the work with ionising radiations. Overall responsibility for radiation protection matters lies with the departmental manager. However, additional duties may be delegated to the RPS as detailed below.

MAIN DUTIES AND RESPONSIBILITIES

1.   Restriction of Exposure

To observe, from time to time, all procedures involving ionising radiation and to and to keep a record of this process for audit purposes. To issue instructions necessary to maintain radiation doses as low as reasonably practicable.

2.   Notification of work and certain occurrences

To notify, in writing, the responsible manager:

(i) of any proposed changes in, or additions to, work activity

(ii) immediately of any damage to a radioactive source, spillage, loss or suspected loss of radioactive substances.

(iii) of any change of equipment, usage or conditions, which might affect radiological safety; of any monitoring instrument used to demonstrate compliance with the Regulations which has not been calibrated to acceptable national standards.

(iv) immediately of any incident involving equipment malfunction resulting in patient exposure much greater than intended or significantly lower than those considered proportionate (in radiotherapy).

(v) immediately of any incident or suspected incident involving staff exposure much greater than intended.

3. Local Rules and Systems of Work

(i) To assist in the writing of Local Rules and Systems of Work and to ensure that these are adhered to.

4. Information, Instruction and Training

(i) To attend courses and receive training as recommended by the RPA.

(ii) To promulgate local Rules and Systems of Work to ensure that necessary safety information and guidance is given to all staff, outside contractors and any other persons who enter controlled or supervised radiation areas.

5. Additional Duties

(i) Dependent on the work carried out in the Department the responsible manager may delegate to the RPS specific tasks to comply with IRR 17 These requirements must be listed and attached to both this Role Specification and to the Local Rules.

(ii) The RPS must provide a six-monthly report to the Radiation Protection and Medical Exposures Operational GroupCommittee.

NOTE:

The duties and responsibilities outlined in this role specification should be read in conjunction with the following where relevant to the work undertaken:

(a) The Ionising Radiations Regulations 2017

(b) Working with ionising radiation-draft Approved Code of Practice and Guidance 2017

(c) The Ionising Radiation (Medical Exposure) Regulations 2017

(d) The Carriage of Dangerous Goods and Use of Transportable Pressure Equipment Regulations 2009 Amended 2011

(e) The Environmental Permitting Regulations 2016 and subsequent versions.

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Appendix 6

IR(ME)R 17 Entitlement Responsibilities

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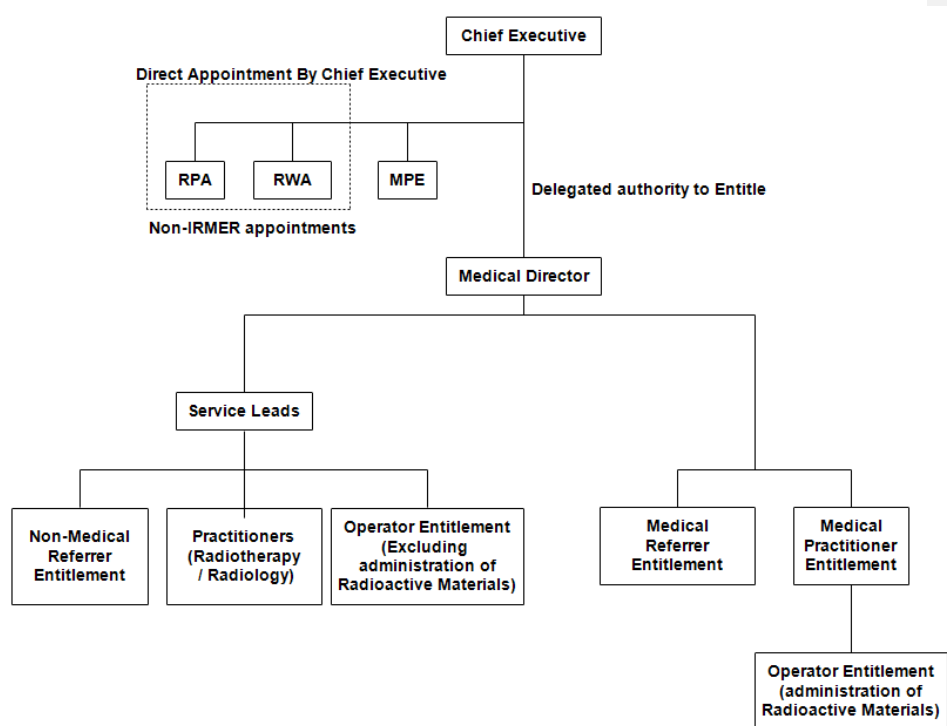
QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Policy for the Prevention and Control of Transmissible Spongiform Encephalopathies (Creutzfeld-Jakob Disease) Minimising the Risk of Transmission

DATE OF MEETING	16/03/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

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

REPORT PURPOSE	FOR APPROVAL

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

COMMITTEE OR GROUP	DATE	OUTCOME
Infection Prevention & Control Management Group	02/02/2023	Areas for inclusion agreed
EMB	02/03/2023	ENDORSED FOR COMMITTEE APPROVAL

ACRONYMS

IPCMG	Infection Prevention & Control Management Group

1. SITUATION/BACKGROUND

The Quality, Safety & Performance Committee is requested to approve the Policy for the Prevention and Control of Transmissible Spongiform Encephalopathies (Creutzfeld-Jakob Disease) Minimising the risk of transmission. The policy is subject to a three-year review period.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The revised policy has followed the consultation process and was endorsed by the Infection Prevention & Control Management Group (IPCMG) and the Executive Management Board (EMB).

The changes made to the policy were:

- **Amendments to policy.** Removed from V7.
- Blood transfusion position statement updated reference P5.
- Reference to H&S Management of Occupational Exposure to Blood and High Risk Body Fluids policy P12.
- Risk assessment before surgical procedure or endoscopy P13 (V6).
- 6.6 Surgical instruments P14 (V6).
- 6.7 Decontamination of surgical instruments P15 (V6).
- National Organisations able to give advice updated P17.
- Appendix 1 Quarantining Surgical Instruents P 24 (V6).
- Related polices updated P18.
- References updated P19.
- References updated to reflect updates.
    - Department of Health and Social Care (2021). Minimise transmission risk of CJD and vCJD in healthcare settings. Prevention of CJD and vCJD by the Advisory Committee on Dangerous Pathogens' Transmissible Spongiform Encephalopathy (ACDP TSE) subgroup. **Updated to include laboratory containment and control measures.**
    - Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee (2022). Position Statement. Variant Creutzfeldt-Jakob disease. **Position statement regarding COVID-19 Vaccines and Blood Transfusion**.
    - NICE (2020): Reducing the risk of transmission of Creutzfeldt-Jakob disease from surgical instruments used for interventional procedures on high-risk tissues. **Interventional procedures guidance.**
- Reformatted to comply with Trust policy.

The amended policy is attached within **Appendix 1**, below.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	No (Include further detail below)
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **APPROVE** the policy.

Ref: IPC 13

POLICY FOR THE PREVENTION AND CONTROL OF TRANSMISSIBLE SPONGIFORM ENCEPHALOPATHIES (CREUTZFELDT-JAKOB DISEASE) MINIMISING THE RISK OF TRANSMISSION

Executive Sponsor & Function	Executive Director of Nursing, AHPs & Medical Science
Document Author:	Julianne Golding-Sherman Infection Prevention & Control Nurse
Approved by:	Quality, Safety & Performance Committee
Approval Date:	
Date of Equality Impact Assessment:	29/01/2019
Equality Impact Assessment Outcome:	This policy has been screened for relevance to equality. No potential negative impact has been identified.
Review Date:	November 2022
Version:	7.0 draft

CONTENTS

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ABBREVIATIONS

ACDP	Advisory Committee on Dangerous Pathogens
BSE	Bovine Spongiform Encephalopathy
CFS	Cerebral spinal fluid
CNS	Central nervous system
CJD	Creutzfeldt-Jacob Disease
COSHH	Control of substance hazardous to health
CSSU	Central Sterile Services Unit
DOH	Department of health
FRSM	Fluid Resistant Surgical Mask
HCW	Health Care Worker
JPAC	Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee
IPCT	Infection Prevention & Control Team
LP	Lumbar Puncture
NPC	National Prion Clinic
OCCH	Occupational Health
PPE	Personal Protection Equipment
SICPS	Standard Infection Control Precautions
TSE	Transmissible Spongiform Encephalopathies
vCJD	Variant CJD

1. POLICY STATEMENT

The purpose of this policy is to:

1.1 Prevent transmission of transmissible spongiform encephalopathies (TSE) including Creutzfeldt-Jakob disease (CJD) in the healthcare setting.

1.2 To provide all staff with clear instructions for the efficient management of CJD and variant Creutzfeldt-Jakob disease (vCJD) to reduce potential risk.

At the present time Velindre University NHS Trust does not carry out surgical procedures involving medium or high risk tissues or endoscopic procedures but should the need arise proper decontamination procedures, documentation of decontamination procedures and mechanisms by which surgical instruments can be traced, must be put in place.

2. SCOPE OF POLICY

2.1 This policy outlines the approach to the management of patients with Transmissible Spongiform Encephalopathies such as CJD and similar diseases.

2.2 This policy applies to all healthcare workers (HCWs) employed within the Trust that undertake patient care, or who may come into contact with affected patients and others working within the Trust in a contracted capacity. Welsh Blood Service should also refer to the document library of the Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee (JPAC) Position Statement November 2022 for guidance, https://www.transfusionguidelines.org/document-library/documents/jpac-position-statement-covid-19-vaccines-and-blood-transfusion-nov-2022 and Department of Health and Social Care (DOH) Minimise transmission risk of CJD and vCJD in healthcare settings Laboratory containment and control measures, last updated Nov 2021.

3. AIMS AND OBJECTIVES

3.1 The aim of this policy is to ensure that all staff within the Trust understand the risks associated with TSE's. It will provide HCWs with the information necessary to provide appropriate care for patients with TSE including CJD and to prevent transmission to other patients and HCWs. This will enable staff to ensure appropriate procedures are in place to minimise the risk of transmission within the Trust as a consequence of healthcare delivered to the patient via invasive clinical activities (Iatrogenic transmission) and surgical instruments.

4. RESPONSIBILITIES

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

4.2 Executive Director of Nursing, Allied Health Professionals & Health Science
The Director of Nursing, AHP's & Medical Scientists has delegated Executive responsibility for Prevention and Control of Infection and is accountable for this to the

Trust Executive Management Board. These responsibilities include ensuring that the organisation receives competent infection prevention and control advice and that adequate staff Infection Prevention and control training, and monitoring is in place.

4.3 Departmental Managers/ Clinical Directors
- Ensure staff have access to this policy and associated guidance and legislation, ensuring staff adhere to the procedures set out in this policy.
- Ensure there are effective and adequately resourced arrangements for the management of CJD and vCJD within the trust;
- Ensure that the Infection Prevention and Control Team (IPCT) is informed of any patient who is known, suspected of, or at risk for CJD.
- Ensure appropriate departments are informed before any invasive procedures are carried out.
- Have a key role in the co-ordination of actions required.
- Ensure records of meetings are maintained.
- Staff within their area of responsibility adhere to the procedures outlined in this policy.
- Adverse incidents are reported and managed as per Trust policy.
- Staff are provided with suitable information, instruction and training as required.
- Should maintain an accurate record of patient placement within the ward at all times to facilitate accurate retrospective information gathering if required.
- Staff have access to appropriate personal protective equipment (PPE).
- Ensure necessary documentation has been completed as per policy.
- Support staff to correct any action or intervention that may have resulted in transmission of infection.

4.4 Clinical staff
- Familiarise themselves with the policy.
- Should be aware of CJD/vCJD risk existence and be responsible for ensuring their own practice complies with this policy and encouraging others to do so.
- Ensure the infection prevention and control precautions detailed in this policy are followed for any patient with suspected or confirmed CJD or vCJD.
- Inform the IPCT if a patient is confirmed or suspected as having CJD or vCJD.
- When appropriate risk assess patients for their risk of CJD.
- Understand and apply the infection prevention and control principles in this policy.
- Maintain competence, skills and knowledge in infection prevention and control by attending education events and/ or completing training.
- Communicate the infection prevention and control practices to be carried out by colleagues, those being cared for, relatives and visitors, without breaching confidentiality.
- Do not provide care while at risk of transmitting infectious agents to others; if in doubt, they must consult their line manager, IPCT or occupational health (OCCH) department.
- Report to their manager inadequate facilities, equipment or products and deficits in their own knowledge or training.
- Inform Manager, IPCT, health and safety Manger and OCCH provider if they receive a needle stick/ inoculation or other contamination injury from a patient with confirmed or suspected CJD or vCJD.
- Ensure that whole blood and platelet collection processes adhere to UK legislation to maintain optimal safety of the supply chain.

4.5 Theatre Staff
- All patients should be checked for infection control alerts, including CJD status.
- Consent forms should be complete including the CJD question where present, and the answer appropriately acted upon.

- Ensure that all surgical instruments, medical devices are tracked according to Trust policies, and that instruments do not migrate between sets.
- Ensure that single use instruments are disposed of appropriately.
- Ensure that Tracking and Traceability systems are in place and effective for instruments and devices processed in the department.
- Managers have responsibility to support the IPCT by ensuring that staff are able to attend training sessions in response to identified needs.

4.6 Infection Prevention and Control (IPCT)

Will:

Advise and support clinical teams in taking appropriate infection control measures.
Monitor, evaluate and review the policy in the light of new evidence.

4.7 Distribution

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

5. DEFINITIONS

Creutzfeldt - Jakob disease is a progressive degenerative disease of the brain which causes dementia, decline of motor and other brain functions and death, usually within a year of diagnosis. It is one of a number of diseases collectively known as TSEs caused by unconventional transmissible agents known as prions. Prion diseases are caused by one of the body's normal proteins, called the prion protein, changing its shape and forming clumps of protein in the brain. This process damages and eventually kills brain cells. Prions can also accumulate in other specific tissues depending on the type of CJD.

The worldwide incidence is about 1 per million people each year. In humans, there are three different ways these diseases can start. The commonest form, occurring in 85-94% is called sporadic CJD and this is seen all over the world. It appears to occur at random as an unlucky event when the production of prions in the brain is triggered spontaneously. Secondly, in about 15% of cases the disease can be passed down from generation to generation as a genetic condition in some families with a faulty prion protein gene. Thirdly, someone can "catch" a prion infection by being exposed to infectious prions either through accidental exposure associated with healthcare intervention (iatrogenic CJD) or consumption of products contaminated with prions (vCJD).

The incubation period of sporadic cases of CJD is unknown, but iatrogenic cases appear to have an incubation period of 2 to 15 years or more, depending on the route of inoculation.

Transmissible Spongiform Encephalopathies - A group of neurological diseases affecting both humans and animals thought to be caused by a build-up of prions in the brain, which do not share the normal properties of viruses and bacteria.

Creutzfeldt-Jakob disease - A human form of transmissible spongiform encephalopathy, which causes a variety of neurological symptoms including dementia and personality changes. The outcome is invariably fatal.

Iatrogenic CJD - A form of CJD which occurs when CJD is accidentally transmitted during medical or surgical procedures.

Prions - Infectious proteins which do not share the normal properties of viruses and bacteria and are resistant to conventional chemical and physical decontamination methods.

Variant Creutzfeldt Jakob Disease - A form of CJD first identified in 1996, thought to be linked to ingesting meat from cattle infected with Bovine Spongiform Encephalopathy (BSE).

High Risk Procedure – Procedures that involve handling of tissue with high risk of CJD transmission. High risk tissues include brain, spinal cord, cranial nerves, specifically the entire optic nerve and the intracranial components of the other cranial nerves, cranial ganglia, posterior eye, specifically the posterior hyaloid face, retina, retinal pigment epithelium, choroid, subretinal fluid and pituitary gland.

Medium Risk Procedure – Procedures that involve handling of tissue with medium risk of CJD transmission. Medium risk tissues are spinal ganglia and olfactory epithelium. In patients with suspected or confirmed vCJD the following tissues are also medium risk; tonsil, appendix, spleen, thymus, adrenal gland, lymph nodes and gut-associated lymphoid tissues.

Lymphoid Tissue – Lymph nodes, appendix, spleen, thymus, tonsil, adenoids and gastro intestinal tract sub- mucosa.

Low Risk Procedure - All procedures other than the high and medium risk procedures. Operations on the anterior eye have recently been downgraded to low risk procedures.

Human forms of TSE fall into 3 groups as shown in Table 1. These cause a variety of neurological symptoms including dementia and personality changes as well as neuromuscular symptoms such as unsteadiness and involuntary muscular jerking. All human TSEs are extremely rare. There is currently no effective treatment available and the outcome is invariably fatal.

Table 1: Classification of TSEs

Idiopathic diseases	Sporadic CJD Sporadic fatal insomnia Variably Protease-Sensitive Prionopathy (VPSPr)
Familial diseases	Familial CJD Gerstmann-Straussler-Scheinker disease (GSS) Fatal familial insomnia (FFI)
Acquired diseases	Iatrogenic CJD Kuru Variant CJD

5.1 Transmission

There is no evidence that TSEs can be spread from person to person by close or normal social contact, but can be transmitted via exposure to infected tissues by direct inoculation from contaminated surgical instruments. Other possible routes of infection are blood transfusion or, in the past eating contaminated meat. There have been documented cases of spread via the administration of hormones prepared from human pituitary glands, dura mater grafts and following neurosurgical procedures with inadequately decontaminated instruments.

In routine clinical contact, no additional precautions are needed for the care of patients with or at risk of developing TSE. However, when certain invasive interventions involving high or medium infectivity risk tissues are performed there is the potential for exposure to the agents of TSEs. In these situations it is essential that appropriate standard infection control measures are in place to prevent the iatrogenic transmission of TSEs.

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Unlike microorganisms, prions are resistant to conventional decontamination processes including normal moist heat sterilisation (autoclaving) or chemical disinfection measures normally appropriate for endoscopes, surgical instruments and other reusable medical devices. Therefore a risk assessment must be undertaken before any clinical procedure where there is considered to be a risk of potential transmission.

- Brain, cerebral spinal fluid (CSF), eye and nerve tissues are infectious and there have been rare cases of transmission due to inadequate decontamination of surgical instruments. Cross infection has occurred in neurosurgery and via certain tissue grafts, e.g. corneas.
- There is no evidence of occupational transmission of the disease to medical, nursing or laboratory staff in contact with affected patients or material from them.
- The Department of Health and Social Care has reported a few cases of vCJD where prior blood transfusion has been implicated. To minimise the risk of TSE/CJD transmission from blood, exclusion criteria are in place for blood donation. The JPAC ensures blood provided for patients is as safe as possible and have taken a number of measures to try to reduce the risk of transmission of vCJD by blood, plasma and tissue products.
- Transmission due to needle stick injury has not been documented, but a very small (as yet unquantified) risk may exist.
- To prevent transmission of TSEs in medical practice it is necessary to take a two stage risk based approach. First patients affected with or at risk of developing a TSE must be reliably identified, and second measures must be taken to ensure that any invasive device used on such patients are not used on other patients.
- Occupational transmission of CJD, vCJD or any other TSE has never been confirmed in either healthcare or any other occupational setting. If TSEs could be transmitted, this would most likely be due to exposure to high risk tissues by direct inoculation from a sharp injury or puncture wound.

5.2 Infectivity
TSE agents are not uniformly distributed through the tissues of affected individuals and certain tissues pose a higher risk. In all TSEs central nervous tissues (including the retina) have the highest infectious risk, with cornea and dura mater having a lower infectious risk.

In vCJD tissues outside the central nervous system have also been shown to be potentially infectious, especially lymphoid organs and tissues containing lymphoid structures. Most body fluids and other tissues are of negligible risk, however blood donations from people with or incubating vCJD have been linked to transmission of vCJD.

5.3 Definition of Patient Groups
In order to ensure that appropriate infection prevention and control measures are put in place, symptomatic patients (i.e. those who fulfil the diagnostic criteria for definite, probable or possible CJD or vCJD) and asymptomatic patients considered at risk of developing CJD (i.e. those with no clinical symptoms but who are potentially at risk of developing the familial disease or at risk due to iatrogenic exposures) must be appropriately identified. This is especially important if they are to undertake any surgical or endoscopic procedure.

5.3.1 Diagnosis of Definite, Probable and Possible CJD
For symptomatic cases there are internationally accepted diagnostic criteria for definite, probable and possible CJD or vCJD. These can be found via Advisory Committee on Dangerous Pathogens (ACDP) guidance at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/209761/Annex_B_-_Diagnostic_criteria.pdf.

Patients suspected of having CJD or vCJD must be referred to a neurologist or consultant with appropriate expertise for investigation.

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5.3.2 Asymptomatic Patients at risk from familial forms of CJD linked to genetic mutations:

- Individuals who have or have had two or more blood relatives affected by CJD or other prion disease, or a relative known to have a genetic mutation indicative of familial CJD.
- Individuals who have been shown by specific genetic testing to be a significant risk of developing CJD or other prion disease.

5.3.3 Asymptomatic Patients potentially at risk from iatrogenic exposure:

- Recipients of hormone derived from human pituitary glands, e.g. growth hormone, gonadotrophin.
- Individuals who have received a graft of dura mater. (People who underwent neurosurgical procedures or operations for a tumour or cyst of the spine before August 1992 may have received a graft of dura mater, and should be treated as at risk, unless evidence can be provided that dura mater was not used).

- Individuals who have been contacted as potentially at risk because of exposure to instruments used on, or receipt of blood, plasma derivatives, organs or tissues donated by, a patient who went on to develop CJD or vCJD.

- Variant CJD has been reported in recipients of blood transfusion from donations taken from individuals who later developed vCJD. There is no evidence of transmission of sporadic CJD from blood or its products.

- Patients who have been specifically contacted as potentially at risk for public health purposes, including individuals considered to be at risk of: CJD/vCJD due to exposure to certain instruments used on a patient who went on to develop CJD/vCJD, or was at risk of vCJD; CJD/vCJD due to receipt of tissues/ organs; vCJD due to receipt of blood components or plasma derivatives*; vCJD due to the probability they could have been the source of infection for a patient transfused with their blood who was later found to have vCJD.

*Some recipients of UK sourced blood products from 1980 to 2001 will fall into the 'at risk' (for vCJD) group.

6. IMPLEMENTATION/POLICY COMPLIANCE

6.1 General Hospital Care

General Ward Procedures

Isolation of patients with CJD is not necessary, and they can be nursed in an open ward using standard infection control precautions (SICPs) in line with those used for all other patients. There is no evidence that normal social or routine clinical contact of a CJD patient presents a risk to HCWs, relatives and others. However, when procedures are undertaken that carry a risk of contamination with CSF, biopsy or blood samples, the precautions outlined below should be observed. Disposable gloves, apron, fluid resistant surgical mask (FRSM) and eye protection should be worn where splashing may occur.

Although cases of CJD/vCJD have been reported in HCWs, there have been no confirmed cases linked to occupational exposure. The highest potential risk in the context of occupational exposure is from exposure to high infectivity tissues through direct inoculation, for example as a result of sharps injuries, puncture wounds or contamination of broken skin, and exposure of the mucous membranes.

All HCWs who care for patients with patients with definite, probable or possible CJD/vCJD, or with potentially infected tissues, should be appropriately informed and

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knowledgeable in the nature of the risk to themselves or others, including which body tissues pose greatest risk of contamination, which procedures would lead to possible exposure to high risk body tissues and the relevant safety procedures if there is potential exposure to these body tissues.

Body secretions, body fluids (including saliva, blood and cerebrospinal fluid (CSF) and excreta) are all low risk for CJD. See above for information on tissue infectivity's for CJD. It is therefore likely that the majority of samples taken or procedures performed will be low risk. Contact with small volumes of blood (including inoculation injury) is considered low risk, (though it is known that transfusion of large volumes of blood and blood components may lead to CJD transmission).

6.1.1 Used or Foul Linen (contaminated with body fluids or excreta)
- Place in a red water-soluble alginate bag and white linen bag. The linen can be washed in accordance with the IPC 05 National Infection Prevention and Control Manual no further processing requirements are necessary.

6.1.2 Precautions during Ward Based Invasive Procedures
- Ward based invasive procedures must only be taken by trained and competent personnel.
- Single use/ disposable items must be used and disposed of as clinical waste for incineration.

6.1.3 Laboratory Specimens
- Blood and other specimens can be collected and processed in the same way for other patients.
- The laboratory must be informed in advance that a sample is being sent. High risk material including any specimen from, the brain, spinal cord, eye, or likely to include olfactory epithelium or lymphoid tissue must only be submitted for examination after prior consultation with the appropriate laboratory.
- Samples from known or suspected patients should be clearly marked with a Biohazard label. CJD is classified as Hazard Group 3 by the ACDP. The Approved List of biological agents provides the approved classification of biological agents into hazard groups (as referred to in control of substances hazardous to health (COSHH). The hazard groups are defined in the Table 2; when classifying a biological agent it should be assigned to one of these four groups according to its level of risk of infection to humans.

Table 2: Hazard Groups

Group	Definition
Group 1	Unlikely to cause human disease
Group 2	Can cause human disease and may be a hazard to employees; it is unlikely to spread to the community and effective prophylaxis or treatment is usually available
Group 3	Can cause severe human disease and may be a serious hazard to employees; it may spread to the community, but effective prophylaxis or treatment is usually available
Group 4	Causes severe human disease and is a serious hazard to employees; it is likely to spread to the community and usually no effective prophylaxis or treatment is available

6.1.4 Drug Administration
Only personnel aware of the hazard involved should carry out injections.

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Drug administration by injection and collection of blood, CSF and body fluid samples from patients with, or "at increased risk" of, CJD, should be performed as for any other patient in-line with SIPCs, i.e. as potentially infectious:

- o use of disposable gloves and eye protection where splashing may occur;
- o avoidance of sharps injuries and other forms of parenteral exposure;
- o safe disposal of sharps and contaminated waste; and
- o single-use disposable equipment should be used wherever possible.

6.2 CARE OF PATIENTS KNOWN, SUSPECTED OR 'AT RISK' FOR TSE/CJD

6.2.1 Patient Groups Requiring Specific Precautions
(See section 5.3 for definitions of these groups)

- Symptomatic Patients
- Asymptomatic, but 'at-risk' Patients
- Familial 'at-risk' Patients
- Iatrogenic 'at-risk' Patients

- The IPCT should be notified of patients in the above categories.
- Used and fouled bed linen – no additional precautions.
- Waste material should be handled as clinical waste and disposed of by incineration.

6.2.2 Invasive Medical Procedures (peripheral central catheters, venepuncture, biopsy, lumbar puncture)
For invasive procedures e.g. lumbar puncture (LP), carried out on the ward for definitive, probable, possible or at risk CJD or vCJD patients follow the guidelines in this document. As mentioned prions are particularly resistant to standard physical and chemical methods of inactivation and decontamination.

6.2.3 Precautions to be taken
- Special care must be taken by staff performing invasive procedures particularly LP and/or tissue biopsy to avoid inoculation injury. Particular care should also be taken with lymphoid tissue specimens from patients. Any inoculation injury to staff must be managed as per Health and Safety policy for the management of occupation exposure to blood and high risk body fluids, including first aid and reporting. It must be emphasised that no case of infection transmitted in this way has ever been reported. Staff should wear personal protective equipment (PPE) which includes; disposable gloves, apron, gown, eye protection and FRSM
- Bedding should be protected with an impervious towel/ drape whilst performing a LP.
- Single-use disposable instruments/ equipment must be used wherever practicable, these include surgical trays, LP sets. All small items contaminated by cerebral spinal fluid (CSF) or neural tissue must be destroyed by incineration.
- The collection of blood specimens should involve the same precautions used for all work of this type with any patient, *i.e.* avoidance of sharps injuries and other forms of parenteral exposure.

6.3 PROCEDURES FOR DISINFECTION OF SURFACES, SPILLAGES, SKIN

6.3.1 Procedure for Disinfection of Surfaces and Spillages (Not Skin)

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When a spillage of any fluid (including blood and CSF) from a patient with, or "at increased risk" of, CJD/vCJD occurs in a healthcare setting, the main defence is efficient removal of the contaminating material and thorough cleaning of the surface.

Protect surfaces from contamination wherever possible.
Standard infection control precautions should be followed for any spillages, which should be cleared up as quickly as possible, keeping contamination to a minimum. PPE should be worn – gloves, aprons, eye protection. Any other waste (including cleaning tools such as mop heads etc.) should be also be disposed of as clinical waste (see Table 3).
For spillages of large volumes of liquid, absorbent material should be used to absorb the spillage, for which a number of proprietary absorbent granules are available.
Standard disinfection for spillages (e.g. 10,000ppm chlorine-releasing agent) should be used to decontaminate the surface after the spillage has been removed. A full risk assessment may be required.
Ensure adequate ventilation where possible.

6.3.2 Procedure for the decontamination of skin / mucous membranes
If skin becomes visibly contaminated with blood or body fluids, wash thoroughly with soap and water.
Exposed mucous membranes or conjunctivae should be bathed with copious clean tap water where available/or bottled water from eye wash stations.
Always report exposure incidents immediately to line manager and inform occupational health and recorded as an adverse incident.
Refer to Health and Safety Policy (TBC) for the management of occupational exposure to blood and high risk body fluids.

6.3.3 CSF and Biopsy Tissue Other Than Neural Tissue
Only staff aware of the hazard should collect CSF and tissue biopsy specimens from known, suspected or at risk TSE/CJD patients. They should wear gloves and eye protection if splashing could occur.

The samples from these patients and any equipment used including that which is not disposable should be destroyed by incineration.

6.4 CLINICAL WASTE

Clinical waste generated from patients with definite, or probable, or at increased risk of CJD should be disposed of differently according to whether it has been exposed to high, medium or low-risk tissues or body fluids.

General guidance on the safe management of clinical waste is given in the guidance document Welsh Health Technical Memorandum 07-01: Safe Management of Healthcare Waste', available at http://www.wales.nhs.uk/sites3/Documents/254/WHTM%2007-01.pdf

According to this guidance, "Waste known or suspected to be contaminated with transmissible spongiform encephalopathy (TSE) agents, including CJD, must be disposed of by high temperature incineration in suitable authorised facilities."

The ACDP TSE Risk Management Sub Group have considered the disposal of clinical waste, and have agreed that tissues, and contaminated materials such as dressings and sharps, from patients with, or "at increased risk" of, CJD/vCJD, should be disposed of as described in Table 3.

Table 3 Disposal of clinical waste from patients with, or "at increased risk" of, CJD or vCJD

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Diagnosis of CJD	High or medium risk tissue*	Low risk tissue and body fluids**
Definite	Incinerate	Normal clinical waste disposal
Probable	Incinerate	Normal clinical waste disposal
"At increased risk"	Incinerate	Normal clinical waste disposal

* See Annex A1 Distribution of TSE infectivity in human tissues and body fluids. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/444243/Annex_A1_update.pdf.

** Tissues and materials deemed to be low risk include body fluids such as urine, saliva,sputum, blood, and faeces. Blood from vCJD patients is considered to be low risk except when transfused in large volumes.

6.5 INNOCULATION INJURIES

- For any incident involving 'sharps', or contamination of abrasions with blood or body fluid(s), wounds should be gently encouraged to bleed, gently washed (avoid scrubbing) with warm soapy water, rinsed, dried and covered with a waterproof dressing, or further treatment given appropriate to the type of injury.
- Splashes in the eyes or mouth should be dealt with by thorough irrigation.
- The incident should be reported to the Ward Manager/ Ward Sister/ Health and Safety Manager and an adverse event report submitted. The ward manager/ sister should report as per RIDDOR guidelines as applicable.
- Staff **must** telephone OCCH department and report injury. (Refer to Health and Safety sharps safety policy TBC). OCCH will keep a record of all accidents and occurrences with an infectious or potentially infectious material involving the exposure of staff.
- There is no evidence to date that transmission through occupational exposure has occurred.

6.6 ACTIONS TO BE TAKEN UPON NOTIFICATION OF SUSPECTED CJD OR vCJD IN A PATIENT WHO HAS PREVIOUSLY UNDERGONE SURGERY OR ENDOSCOPY

The IPCT **must** be informed of any suspected case of CJD or vCJD regardless if they are currently an in-patient of the Trust or not, to allow for appropriate actions to be taken.

An incident review committee will be convened by the Head of Infection Prevention & Control to manage the incident and decide the actions that are required:

- The Executive Director of Nursing, Allied Health Professionals and Health Sciences;
- The Head of Infection Prevention & Control or deputy;
- The Trust Infection Prevention and Control Doctor/Microbiologist;
- The Health and Safety Manager or deputy;
- Head of Nursing VCC or deputy;
- Decontamination Lead;
- The Medical Director or deputy.

In the event of an incident the Public Health Wales (Health Protection Team) will be informed and theNational CJD Research and Surveillance Unit (NCJDRSU).

6.7 CARE OF THE DECEASED

On the death of a CJD patient (or patient at risk of developing CJD) the removal of the body from the ward to the cold room/ mortuary, should be carried out using normal infection control measures. No additional precautions are necessary when laying out the body.The deceased patient is placed in a body bag prior to transportation to the cold room/mortuary, in line with normal procedures for bodies where there is a known infection risk. Full details of the proposed/ confirmed diagnosis using an infection hazard notification

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sheet, must be given to the undertakers concerned with the deceased prior to their handling of the body (**Appendix 1**).

The infection hazard notification sheet is one way of providing those who will handle the deceased with the necessary information to do so safely. It is intended to highlight hazards associated with the deceased, which can include infection risk, implantable devices and radioactive sources. As the information is of a personal nature, it should be handled sensitively and shared only with those who need it to carry out an appropriate risk assessment and to enable appropriate precautions to be taken.

Following the death of a patient, their cultural/ religious needs and wishes, which were expressed prior to death, will be carried out as far as possible. The dignity of the deceased person will be respected throughout the whole process. Staff should endeavor to meet the needs of both the relatives/ carers and the deceased, and if necessary ask the patient's faith representative to attend the ward if required.

6.7.1 Post-Mortem
If a post-mortem examination is required please contact a Consultant Histopathologist to discuss further.

Post-mortem examinations are required in order to confirm a clinical diagnosis and the cause of death in patients with suspected CJD or vCJD. Post-mortem examinations on CJD cases can be undertaken in any mortuary, provided that appropriate care is taken to minimise contamination of the working environment.

6.7.2 Undertakers
The undertakers should be informed of the known or potential CJD/vCJD diagnosis, prior to handling the body of the deceased. Concern about possible unknown CJD cases does not warrant a level of precaution for undertakers handling intact bodies other than those used generally for all work of this nature.

6.7.3 Viewing the Deceased
Relatives of the deceased may wish to view or have some final contact with the body. Such viewing and possible superficial contact, such as touching or kissing need not be discouraged.

6.7.4 Environmental Concerns
There is no need to discourage burial of a patient with known or suspected CJD of vCJD, and no special arrangements for burial are required. Similarly, there is no need for any extra precautions to be taken for cremation.

6.7.5 Transporting the deceased
No additional precautions are needed for transporting the body within the UK.

7. RELEVANT NATIONAL REQUIREMENTS

Department of Health (2008) The Health and Social Care Act 2008, Code of Practice for health and social care on the prevention and control of infections and related guidance (updated 2015).

The Department of Health and Social Care website below carries all the guidance on Prevention of CJD and vCJD produced by the Advisory Committee on Dangerous Pathogens' Transmissible Spongiform Encephalopathy (ACDP TSE) Subgroup

https://www.gov.uk/government/publications/guidance-from-the-acdp-tse-risk-management-subgroup-formerly-tse-working-group

List of guidance documents available on the website (as at 24th November 2022)

- Health and Safety Management of Transmissible Spongiform Encephalopathy (TSE).
- Laboratory containment and control measures (updated November 2021)
- Infection Control of CJD, vCJD and other human prion diseases in healthcare and community settings
- Annex A1: Distribution of TSE infectivity in human tissues and body fluids
- Annex A2: Distribution of infectivity in animal tissue and body fluids
- Annex B: Diagnostic criteria
- Annex C: General principles of decontamination and waste disposal
- Annex D: Transport of TSE infected material
- Annex E: Quarantining of surgical instruments
- Annex F: Endoscopy
- Annex H: After death
- Annex I: Outline protocol for management of instruments and tissues from brain biopsy procedures on patients with progressive neurological disorders.
- Annex J: Assessment to be carried out before surgery and / or endoscopy to identify patients with, or at risk of CJD / vCJD
- Annex K: Guidelines for pathologists and pathology laboratories for the handling or tissues from patients with, or at risk of CJD / vCJD
- Annex L: Managing CJD / vCJD risk in ophthalmology
- Annex M: Managing vCJD risk in general surgery and liver transplantation
- CJD guidance for ophthalmologists
- Information sheet for funeral directors, relatives and others following a CJD death.

Alert to urological surgeons regarding the equipment used for patients at risk of vCJD requiring trans-rectal prostatic biopsy

Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee. Donor Selection Guidelines. https://www.transfusionguidelines.org/dsg

Welsh Health Technical Memorandum 01-01: Decontamination of surgical instruments (medical devices) used in acute care. Part A: Management and Provision. http://www.nwssp.wales.nhs.uk/sitesplus/documents/1178/WHTM%2001-01%20Decontamination%20Part%20a%20protected0119.pdf

8. **REFERENCES, BIBLIOGRAPHY, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS**

Advisory Committee on Dangerous Pathogens (ACDP)
https://www.gov.uk/government/groups/advisory-committee-on-dangerous-pathogens

Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO)
https://www.gov.uk/government/groups/advisory-committee-on-the-safety-of-blood-tissues-and organs

Association of British Neurologists
http://www.theabn.org/

CJD International Surveillance Network
http://www.eurocjd.ed.ac.uk/

CJD Support Network
http://www.cjdsupport.net/

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Creutzfeldt-Jakob disease guidance for health workers. Department of Health 2000
http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4082370.pdf

Department of Health and Social Care (2021). Minimise transmission risk of CJD and vCJD in healthcare settings. Prevention of CJD and vCJD by the Advisory Committee on Dangerous Pathogens' Transmissible Spongiform Encephalopathy (ACDP TSE) subgroup.
https://www.gov.uk/government/publications/guidance-from-the-acdp-tse-risk-management-subgroup-formerly-tse-working-group

DA (81)22 Report of the Advisory Group on the Management of Patients with Spongiform Encephalopathy (Creutzfeldt-Jakob Disease) (CJD).

DA (84)16 Management of Patients with Spongiform Encephalopathy (Creutzfeldt-Jakob disease) (CJD).

Health and Care Standards Standard 2.4 (2015) Welsh Government.

HSE (2013). The Approved List of biological agents. Advisory Committee on Dangerous Pathogens. Health and Safety Executive. http://www.hse.gov.uk/pubns/misc208.pdf

HSE (2019). Managing infection risks when handling the deceased. Guidance for the mortuary, post-mortem room and funeral premises, and during exhumation.HSG283.
http://www.hse.gov.uk/pUbns/priced/hsg283.pdf

Infection prevention and control of CJD and variant CJD in healthcare and community settings Department of health (2015)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/427854/Infection_controlv3.0.pdf

Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee (2022). Position Statement. Variant Creutzfeldt-Jakob disease. https://www.transfusionguidelines.org/document-library/documents/jpac-position-statement-covid-19-vaccines-and-blood-transfusion-nov-2022

Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee. Guidelines for the Blood Transfusion Services in the UK 8TH Edition. https://www.transfusionguidelines.org/red-book

National CJD Research Surveillance Unit (NCJDRSU)
http://www.cjd.ed.ac.uk/

National Prion Clinic (London)
http://www.prion.ucl.ac.uk/clinic-services/

NEUROPRION Network of Excellence
 https://www.neuroprion.org/
NHS Blood and Transplant
http://www.nhsbt.nhs.uk/

NICE interventional procedures guidance
https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-interventional-procedures-guidance

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NICE (2020): Reducing the risk of transmission of Creutzfeldt-Jakob disease from surgical instruments used for interventional procedures on high-risk tissues
https://www.nice.org.uk/guidance/ipg666/resources/reducing-the-risk-of-transmission-of-creutzfeldtjakob-disease-cjd-from-surgical-instruments-usedfor-interventional-procedures-on-highrisk-tissues-pdf-1899874227866821

Public Health England
https://www.gov.uk/government/collections/creutzfeldt-jakob-disease-cjd-guidance-data-and-analysis

Public Health Wales
http://www.wales.nhs.uk/sitesplus/888/page/43948

University of Edinburgh's Centre for Clinical Brain Sciences
http://www.ed.ac.uk/clinical-brain-sciences
Welsh Blood Service
https://www.welsh-blood.org.uk/

Welsh Health Technical Memorandum 07-01: Safe Management of Healthcare Waste'.
https://nwssp.nhs.wales/ourservices/specialist-estates-services/specialist-estates-services-documents/whtms-library/whtm-07-01-safe-management-of-healthcare-waste-pdf/

9. GETTING HELP

9.1 Further information and support:

Velindre IPCT: 02920 196129

9.2 National Organisations able to give advice

The following resources are available to health professionals dealing with cases of CJD:

- The National CJD Surveillance Unit in Edinburgh can provide advice on all clinical and neuropathological aspects of CJD. It can be contacted at:

  The National CJD Research & Surveillance Unit
  Bryan Matthews Building
  Western General Hospital
  Crewe Road
  Edinburgh
  EH4 2XUT

  Telephone:
   Main Office: 0131 537 1980/2128/3103
   Neuropathology Laboratory: 0131 537 3084
   CSF Referrals: 0131 242 6253

  http://www.cjd.ed.ac.uk/

Email: loth.securecjd@nhslothian.scot.nhs.uk (please use this email address for sending emails containing patient identifiable information):

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Email: contact.cjd@ed.ac.uk (for general enquiries)

- The National Prion Clinic (NPC) is the national referral centre for prion disease and is part of the University College London Hospitals NHS Foundation Trust (UCLH). It is funded by the NHS to provide diagnosis and care for patients with, or suspected to have, any form of human prion disease (Creutzfeldt-Jakob disease, CJD). The clinic is integrally linked with the MRC Prion Unit at the Institute of Prion Diseases, a Postgraduate Research Institute of University College London. The NPC provides diagnosis and care for all forms of prion disease (inherited, iatrogenic, sporadic and variant CJD). We aim to review new patients within a week of referral. The NPC also plays a key role in facilitating research to promote early diagnosis and the development of potential therapies.

It can be contacted at:

National Prion Clinic
Institute of Prion Diseases, Courtauld Building, 33 Cleveland Street, London, W1W

Tel: 020 7679 5142 / 020 7679 5036

uclh.prion.help@nhs.net

http://www.nationalprionclinic.org/

- The CJD Support Network is a voluntary organisation set up to provide help and support for patients of all types of CJD and their families. The Network has undertaken a case coordination initiative aimed at facilitating the co-ordination of care for patients affected by all types of CJD, and gives advice on all case co-ordination enabling cost effective care and ensuring appropriate responses to carers' needs. It can be contacted at:

CJD Support Network,
PO BOX 3936
Chester
CH1 9NG

Tel:
For admin - +44 (0)7494 211 476
For support, contact our helpline - 0800 774 7317

http://www.cjdsupport.net/

Email:
For admin - admin@cjdsupport.net
For support - support@cjdsupport.net

10.   RELATED POLICIES

10.1   This policy should be read in conjunction with:

IPC 04 Decontamination of Equipment Policy
IPC 05 National Infection Prevention and Control Manual (NIPCM) (covers care of the deceased patient)
H&S TBC Management of Occupational Exposure to Blood and High Risk Body Fluids
H&S TBC Sharps safety

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IPC 11 Transport of Pathological specimens
Verification of Expected/ Anticipated Death by a Registered Nurse Policy (Nursing Policy)
QS 24 Medical Devices and Equipment Management Policy
PP 08 Trust Waste Management Policy
Green 25 Waste Management Procedure
TRUSTENV06 – Waste Management
TRUSTENV07 – Spillages

11. INFORMATION, INSTRUCTION AND TRAINING

11.1 Training

Mandatory Infection Prevention and Control annual training
Further development based training as identified by training needs analysis

12. MAIN RELEVANT LEGISLATION

Compliance with the following legal documents will ensure the safety of devices and substances to prevent cross contamination to patients or HCW's:

Health and Safety at Work etc. Act 1974 The Stationery Office
www.legislation.gov.uk/ukpga/1974/37

Management of Health and Safety at Work Regulations 1999
The Stationery Office www.legislation.gov.uk/uksi/1999/3242/contents/made

Control of Substances Hazardous to Health Regulations 2002 (revised 2020)
The Stationery Office www.legislation.gov.uk/uksi/2002/2677/contents/made

The Health and Safety (Sharp Instruments in Healthcare) Regulations 2013
www.legislation.gov.uk/uksi/2013/645/pdfs/uksi_20130645_en.pdf

Health and Safety (Sharp Instruments in Healthcare) Regulations 2013:
Guidance for employers and employees www.hse.gov.uk/pubns/hsis7.pdf

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013
The Stationery Office www.legislation.gov.uk/uksi/2013/1471/made

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Appendix1: Infection Hazard notification sheet (HSE Document)

1	Name of deceased	
2	Date and time of death	
3	Source (hospital, ward or other)	
4	Infection risk from the deceased [1]	
4a	Does the deceased present an infection risk? (ring as appropriate)	

Yes	Suspected	None suspected

4b	If yes, what are the likely routes of transmission? (ring all that apply) [2]

Airborne	Droplet	Contact

4c	Infection (if permitted to disclose) [3]

4d	Provide any relevant information to enable the deceased to be handled safely [4]

5	Condition of the deceased [5]
5a	Is the deceased leaking body fluids? Please provide details
5b	Have accessories that present a risk of sharps injury been removed?
5c	If yes, have the puncture points been covered or sealed?
5d	If no, please provide details and location
5e	Does the deceased have an implantable device? (ring as appropriate)

No	Yes and switched off	Yes but not switched off

5f	If yes please provide details and location

5g	Was the deceased receiving radiotherapy? (If yes, please provide details)	
6	Signed [6]	
	Print name	
	Hospital	

Infection Hazard Notification Sheet v1 June 2019

This information needs to be handled sensitively and securely to ensure confidentiality of the deceased's personal information. It should be shared only with those who need it to handle the deceased safely (as required by the Health and Safety at Work etc. Act 1974). This form provides one means of sharing the pertinent information.

Notes

[1.] Providing sufficient information on infection risks from handling the deceased will enable the appropriate precautions to be taken. Where infection is the primary cause of death, please ring 'Yes' for Q4a. Infection may not be the primary cause of death but if the deceased was suffering from an infection, please ring 'Yes' or 'Suspected' for Q4a. Where there are no indications that the deceased was suffering from an infection, or where the deceased was on a course of antimicrobial medication that would minimise the infection risk, please ring 'None suspected' for Q4a and proceed to section 5, 'Condition of the deceased'.

[2.] When handling the deceased, standard infection control precautions (SICPs) are considered the minimum protective measures to be used. In Q4b provide information on how exposure to infection may occur. This will help those handling the deceased to consider adopting additional control measures (transmission-based precautions or TBPs) appropriate to the route by which they can be exposed and transmission can occur.

3. If the infection is known it is helpful, though not essential, to provide specific details in Q4c of the infectious agent, to inform the risk assessment and assist with possible treatment should exposure occur. This information may only be disclosed with prior permission of the deceased or their family.

4. In Q4d provide any information relevant to infection risk that may assist in deciding whether and how the deceased should be handled during viewing, preparing (hygienic preparation), embalming, post-mortem examination or exhumation. For example, indicate why a body bag has been used, whether a body bag is necessary, and details of any counter-indications that may prevent specific activities (e.g. embalming) being performed. It may be appropriate to consult Appendix 1 of this publication (*Managing infection risks when handling the deceased*) for further information.

5. In section 5 provide information on the condition of the deceased that would be helpful in deciding whether and how they should be handled. It highlights important issues, e.g. sharp medical devices or implantable devices (e.g. pacemakers), their location and whether they need to be removed.

6. In hospital cases, the doctor and/or nursing staff with knowledge of the deceased's condition is asked to sign section 6 of this form. Where a post-mortem examination has been undertaken, the pathologist (or qualified anatomical pathology technologist) is asked to sign. In non-hospital situations (e.g. community setting), the doctor with knowledge of the deceased's condition is asked to sign.

QUALITY, SAFETY & PERFORMANCE COMMITTEE

AMENDMENT TO STANDING ORDERS – SCHEDULE 3 QUALITY, SAFETY & PERFORMANCE COMMITTEE TERMS OF REFERENCE REVIEW

DATE OF MEETING	16th March 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	N/A

PREPARED BY	Kyle Page, Business Support Officer
PRESENTED BY	Emma Stephens, Head of Corporate Governance
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, AHPs & Health Science

REPORT PURPOSE	ENDORSE FOR BOARD APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME
Executive Management Board	02/03/2023	ENDORSED

ACRONYMS	
	N/A

1. SITUATION

The proposed revised Terms of Reference for the Trust Quality, Safety & Performance Committee are provided to the Quality, Safety & Performance Committee for **ENDORSEMENT** prior to onward approval by the Trust Board. These are therefore proposed changes to the Trust Standing Orders – Schedule 3 *(ref. Appendix 1 [Terms of Reference sighted at November 2022 Committee] and Appendix 2 [revised Terms of Reference]).*

2. BACKGROUND

The Velindre University NHS Trust Standing Orders form the basis upon which the Trust's governance and accountability framework is developed and, together with the adoption of the Trust's Standards of Behaviour Framework Policy, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

3. ASSESSMENT /SUMMARY OF MATTERS FOR CONSIDERATION

The amendments detailed in this report have been agreed via the Executive Lead and Chair of the Quality, Safety & Performance Committee and are set out in *Appendix 2.* The annual review cycle for the Terms of Reference will now be March each year in line with full annual reporting cycle.

The proposed amendments include the following changes:

Terms of Reference & Operating Arrangements	Summary of Amendments
Quality, Safety & Performance Committee	**Section 6 (Relationships & Accountabilities with the board and its Committees / Groups):** - Addition of confirmation that the Committee has approved the establishment of an Integrated Quality & Safety Group, to support the Committee in effectively executing its responsibilities by undertaking quality and safety intelligence triangulation / analysis and learning assurance to facilitate enhanced efficiency of reporting to the Committee (6.6).
Quality, Safety & Performance Committee	**ANNEX 2 – Wider Governance & Accountability Framework:** - Addition of Trust Integrated Quality & Safety Group and associated reporting structure.

The Reporting lines will change in forthcoming months once the review being undertaken through the Integrated Quality & Safety Group is concluded.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Evidence suggests there is a correlation between governance behaviours in an organisation and the level of performance achieved at the same organisation. Therefore, ensuring good governance within the Trust can support quality care.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

5. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **ENDORSE** the amendments to the Trust Board Standing Orders – **Schedule 3** as outlined in section **3** of this report, and included in *Appendix 2.*

Subject to formal **ENDORSEMENT** by the March Quality, Safety & Performance Committee, the revised Terms of Reference will then be received at the next meeting of the Trust Board Audit Committee for formal **ENDORSEMENT** and recommendation to the Trust Board for **APPROVAL**.

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

Quality, Safety and Performance Committee

Terms of Reference & Operating Arrangements

Reviewed:	November 2022
Approved:	
Next Review Due:	March 2023

1. INTRODUCTION

1.1 The Trust's standing orders provide that "The Board may and, where directed by the Assembly Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees".

1.2 In line with standing orders and the Trust's scheme of delegation, the Board shall nominate annually a Committee to be known as the **Quality, Safety and Performance Committee.** The detailed Terms of Reference and operating arrangements set by the Board in respect of this Committee are set out below.

2. PURPOSE

2.1 The purpose of the Quality, Safety and Performance Committee "the Committee" is to provide:

- Evidence based, timely **advice** and **assurance** to the Board, to assist it in discharging its functions and meeting its responsibilities through its arrangements and core outcomes with regard to:

  - quality, safety, planning and performance of healthcare;
  - safeguarding and public protection;
  - patient, donor and staff experience;
  - all aspects regarding the workforce;
  - digital delivery and information governance;
  - relevant statutory requirements e.g. the Health and Social Care (Quality and Engagement) (Wales) Act 2020, Well-being of Future Generations (Wales) Act 2015;
  - Health and Care Standards (2015);
  - financial performance;
  - regulatory compliance; and,
  - organisational and clinical risk.

3. DELEGATED POWERS AND AUTHORITY

3.1 The Committee will, in respect of its provision of **advice** and **assurance** to the Board use where possible a triangulated approach to:

- Seek assurance that governance arrangements are appropriately designed and operating effectively to ensure the provision of high quality, safe healthcare and services across the whole of the Trust's activities;

- Ensure the Trust has in place a robust Quality Management System and is working towards meeting the requirements outlined in the Wales Quality Framework: Learning & Improving (2021) and the Duties of Quality and Candour;

- Consider the implications for quality, safety, patient / donor experience / outcomes, planning and performance, workforce, finance, digital and information governance arising from the development of the Trust's corporate strategies and plans or those of

- Consider the implications for the Trust's quality, safety, patient / donor experience / outcomes, planning and performance, workforce, finance, digital and information governance arrangements from review/investigation reports and actions arising from the work of external regulators;

- Monitor progress against the Trust's Integrated Medium-Term Plan (IMTP) ensuring that areas of weakness or risk and areas of best practice are reported to the Board;

- Align service, workforce and financial performance matters into an integrated approach in keeping with the Trust's commitment to the Sustainable Development Principle defined by the Well-being of Future Generations (Wales) Act 2015.

- Monitor the Trust's sustainability activities and responsibilities;

- Monitor progress against cost improvement programmes;

- Monitor and review performance against the Trust's Assurance Framework.

- Ensure areas of significant patient / donor / service / performance improvement are highlighted to the Board and other relevant Board Committees as necessary to ensure best practice is shared across the organisation;

- Monitor outcomes / outputs from patient / donor / service improvement programmes to provide assurance on sustainable improvements in the quality and efficiency of service delivery;

- Assess implications of any relevant existing, new or amended statutory and regulatory requirements e.g. the Health and Social Care (Quality and Engagement) (Wales) Act 2020 and oversee the Trust's implementation;

- Ensure the Trust Policies, Procedures and Strategies are consistent with internal and external legislative and regulatory requirements and are implemented effectively.

- Ensure the Trust, at all levels (divisional/team) has a citizen centred approach, putting patients, patient / donor experience, safety and safeguarding above all other considerations;

- Ensure that care and services are planned and delivered in line with relevant national / statutory / regulatory and best practice standards;

- Ensure the Trust has the right systems and processes in place to deliver patient /donor focused, efficient, effective, timely and safe services;

- Ensure the workforce is appropriately selected, trained, supported and responsive to the needs of the Trust, ensuring recruitment practices safeguard adults and children at risk, that professional standards and registration/revalidation requirements are maintained, and there is compliance with the requirements of the Nurse Staffing Levels (Wales) Act 2016;

- Ensure there is effective collaboration with partner organisations and other stakeholders in relation to the sharing of information in a controlled manner, to provide the best possible outcomes for its citizens (in accordance with the Wales Accord for the Sharing of Personal Information and Caldicott requirements);

- Ensure the integrity of data and information is protected, valid, accurate, complete and timely data and information is available to support decision making across the Trust;

- Ensure there is an ethos of learning and continual quality improvement and a safety culture that supports safe high-quality care;

- Ensure there is good team working, collaboration and partnership working to provide the best possible outcomes for our citizens;

- Ensure risks are actively identified and robustly managed at all levels of the Trust;

- Ensure the Health and Care Standards (2015) are used to monitor and improve standards across the Trust;

- Ensure all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality, safety and performance of care provided, and in particular that:

  - sources of internal assurance are reliable
  - recommendations made by internal and external reviewers are considered and acted upon on a timely basis; and
  - lessons are learned from concerns, incidents, complaints and claims.

- Ensure there is an effective clinical audit and quality improvement function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board; and,

- Advise the Board about key indicators of quality, safety and performance, which will be reflected in the Trust's performance framework, against which performance will be regularly assessed and reported on through Annual Reports.

Authority

3.2   The Committee is authorised by the Board to investigate or commission investigation of any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Trust relevant to the Committee's remit, ensuring patient, and donor and staff confidentiality, as appropriate. The Committee may seek relevant information from:

- Employees (and all employees are directed to co-operate with any reasonable request made by the Committee), and any other Committee, Sub-Committee or Group set up by the Board to assist it in the delivery of its functions.

- Obtain legal / other providers of independent professional advice, and to secure the attendance of individuals external to the Trust who have relevant experience and expertise if necessary, and in accordance with the Board's procurement, budgetary and other requirements.

- By giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Trust at any meeting of the Committee.

3.3 Approve policies relevant to the business of the Committee as delegated by the Board.

Access

3.4 The Chair of the Quality, Safety & Performance Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.5 The Committee has, with approval of the Trust Board, established the:
- Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee; and the
- Research, Development & Innovation Sub-Committee.
- Integrated Quality & Safety Group.

Note: an overarching summary of the Trust's Governance & Accountability Framework is provided at Annex 1. In addition, the wider governance and accountability reporting arrangements in place at a local divisional level that feed upwards into the Quality, Safety & Performance Committee structure are also summarised at **Annex 2**.

The sub-committees will have a dual reporting line to both the Quality, Safety and Performance Committee and the Strategic Development Committee as illustrated below:

Quality, Safety & Performance Committee	Strategic Development Committee
Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee - Programme Highlight Report	Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee - TCS Future Direction Setting - Proposed Actions to be taken forward
Research, Development & Innovation Sub-Committee - Highlight Report	Research, Development & Innovation Sub-Committee - Trust RD&I Strategy Updates - Steering Group Updates
Integrated Quality & Safety Group	

Although the Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee and Research, Development & Innovation Sub-Committee, are sub-committees with dual reporting lines, they will both retain the delegated authority for decision making granted by the Trust Board. Further details regarding delegated powers and authority are set out in each of the Sub-Committee Terms of Reference. The Research, Development & Innovation Sub-Committee will also feed into the Trust Charitable Funds Committee for alignment with strategy and funding. Further details are set out in each of the respective Terms of Reference.

4.	MEMBERSHIP

Members

4.1   A minimum of two (2) members, comprising:

Chair   Independent member of the Board (Non-Executive Director)
             One independent member of the Board (Non-Executive Directors)

             The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

4.2   **Attendees:**

- Chief Executive Officer
- Executive Director of Nursing, Allied Health Professionals and Health Science (Committee Lead Executive Officer)
- Executive Medical Director *(also Caldicott Guardian)*
- Chief Operating Officer
- Welsh Blood Service and Velindre Cancer Centre Divisional Directors
- Directors of Hosted Organisations or representatives
- Director of Corporate Governance and Chief of Staff
- Executive Director of Finance
- Executive Director of Organisational Development and Workforce
- Director of Strategic Transformation, Planning & Digital
- Deputy Director of Planning and Performance
- Deputy Director of Nursing, Quality and Patient Experience
- Deputy Director of OD & Workforce
- Chief Digital Officer (*also cyber/data outages/performance)*
- Head of Quality, Safety & Assurance
- Head of Corporate Governance

4.3   **By invitation**

The Committee Chair may extend invitations to individuals from within or outside the organisation, taking account of the matters under consideration at each meeting.
The Committee welcomes attendance at Committee meetings by staff from within the Organisation, representatives of independent and partnership organisations and our regulators including:

- Healthcare Inspectorate Wales
- Audit Wales

- Trade Unions
- Community Health Council

Secretariat

4.4   Secretary - as determined by the Director of Corporate Governance and Chief of Staff

Member Appointments

4.5   The membership of the Committee shall be determined by the Board, based on the recommendation of the Trust Chair - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

4.6   Members shall be appointed for a maximum of 3 consecutive years before formally reviewing their role on the Committee. During this time a member may resign or be removed by the Board.

Support to Committee Members

4.7   The Director of Corporate Governance and Chief of Staff, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and

  Ensure the provision of a programme of development for Committee members as part of the Trust's overall OD programme.

5.   COMMITTEE MEETINGS

Quorum

5.1   At least two independent members must be present to ensure the quorum of the Committee. If the Chair is not present an agreement as to who will chair from the independent members in their absence.

Frequency of Meetings

5.2   Meetings shall be held no less than bi-monthly and otherwise, as the Chair of the Committee deems necessary.

Withdrawal of individuals in attendance

5.3   The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

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

6.1   Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and

accountability for ensuring the quality, safety and performance of healthcare for its citizens through the effective governance of the organisation.

6.2   The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.3   The Committee, through its Chair and members, shall work closely with the Board's other Committees, including Joint (Sub) Committees and Groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business; and
- sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

6.4   The Committee will consider the assurance provided through the work of the Board's other Committees and Sub-Groups to meet its responsibilities for advising the Board on the adequacy of the Trust's overall framework of assurance.

6.5   The Committee shall embed the Trust's corporate objectives, priorities and requirements, e.g., equality and human rights through the conduct of its business.

7.   REPORTING AND ASSURANCE ARRANGEMENTS

7.1   The Committee Chair shall:

- Provide a formal report to the Board of the Committee's activities. This includes updates on activity and triangulated assurance outcomes through the submission of written Committee Highlight Reports and other relevant written reports, as well as the presentation of an annual Quality, Safety & Performance Committee report;

- Bring to the Board's specific attention any significant matters under consideration by the Committee;

- Ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive or Chairs of other relevant Committees of any urgent/critical matters that may compromise patient / donor care and affect the operation and/or reputation of the Trust.

7.2   The Director of Corporate Governance and Chief of Staff, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any Sub Committees established.

8.   APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1   The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

Cross referenced with the Trust Standing Orders.

9.	REVIEW

9.1 Terms of reference and operating arrangements, and the Committees Programme of Work will be reviewed annually by the Committee, with reference to the Board.

10.	CHAIR'S ACTION ON URGENT MATTERS

10.1 There may, occasionally, be circumstances where decisions normally made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance and Chief of Staff as appropriate, may deal with the matter on behalf of the Board, after first consulting with one other Independent Members of the Committee. The Director of Corporate Governance and Chief of Staff must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

10.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

ANNEX 1 – GOVERNANCE & ACCOUNTABILITY FRAMEWORK

Statutory, Public
Trust Board
Committees

Quality, Safety & Performance Committee (Bi-Monthly)	Strategic Development Committee (Bi-Monthly)	Audit Committee (Quarterly)	Remuneration Committee (Bi-Monthly)	Charitable Funds Committee (Quarterly)	Audit Committee (NWSSP) (Quarterly)
Quality & Safety Compliance & Standards Commissioning Arrangements Risk Management Trust Assurance Framework Annual Plan / IMTP Monitoring Listening & Learning Workforce Digital Delivery Information Governance	Strategy for Commissioning Innovation TCS future direction setting & other Major Programmes Trust Strategies Development of IMTP Partnerships (Academia / Industry / Third Sector) Digital Developments Organisational Development	Governance & Risk Accounts Internal Audit External Audit Counter Fraud Audit Tracker	Executives Objectives Executive Performance Anonymous Correspondence Voluntary Early Release Scheme (VERS)	Governance & Risk Strategy & Performance Financial Reporting Investment Fundraising Activity Advanced Radiotherapy Programme Board	Partnership Committee between NHS Wales Shared Services Partnership and Velindre University NHS Trust

Sub Committee: TCS Scrutiny
- Programme Highlight Report
- Risks & Issues
- Close Out Report

Sub Committee: TCS Scrutiny
- TCS Future Direction Setting
- Proposed Actions to be taken forward

Sub Committee: R,D & I
- Highlight Report
- Progress against Trust R, D & I Annual Operational Plan

Sub Committee: R,D & I
- Trust R, D & I Strategy Updates
- Steering Group Updates

Sub Committee: R,D & I
- Alignment to Strategy & Funding

Sub Committee: Investment Performance Review

Forums & Advisory Groups:
Local Partnership Forum & Advisory Groups / Advisory Consultants Appointment Committee / Academic Partnership Board / Integrated Governance

Mission: Partnering people to live well
Vision: *By 2025 we will have helped more people to live longer, better lives and be the organisation others come to learn from*

MANAGEMENT GROUP HIERACRCHY

TRUST BOARD

- STRATEGIC DEVELOPMENT COMMITTEE
- QUALITY, SAFETY & PERFORMANCE COMMITTEE
- CHARITABLE FUNDS COMMITTEE
- REMUNERATION COMMITTEE
- AUDIT COMMITTEE
- NWSSP AUDIT COMMITTEE

- TRANSFORMING CANCER SERVICES SCRUTINY
- RESEARCH, DEVELOPMENT & INNOVATION COMMITTEE
- INVESTMENT PERFORMANCE REVIEW SUB–COMMITTEE

EXECUTIVE MANAGEMENT BOARD

- TRANSFORMING CANCER SERVICES PROGRAMME BOARD

- WELSH BLOOD SERVICE SENIOR MANAGEMENT TEAM (SMT)
- INFECTION PREVENTION & CONTROL MANAGEMENT BOARD
- WELSH LANGUAGE DEVELOPMENT GROUP
- EDUCATION STEERING GROUP
- ESTATES STATUTORY COMPLIANCE GROUP
- HEALTH AND SAFETY GROUP
- SAFEGUARDING AND PUBLIC PROTECTION MANAGEMENT BOARD
- VELINDRE CANCER CENTRE STRATEGIC LEADERSHIP (SLT) PARTS 1 & 2

- DIVISIONAL INFECTION PREVENTION & CONTROL GROUPS

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WBS SMT

- Education and Training Panel
- Business Planning Group (BPG)
  - Change Review Panel (CHIRP)
- Capital and Procurement Planning Group (CPPG)
- Regulatory Assurance and Governance Group (RAG)
  - Patient Clinical Governance
    - Change Notification Implementation Group
  - Donor Clinical Governance
    - Apheresis Quality Monitoring Group
  - WBMDR Clinical Governance
  - Infection Prevention and Control Group
- Research, Development and Innovation Group (RD&I)
- Cynefin Group (formerly Estates and Facilities Management Group)
  - Time Limited Projects/Programmes
- Welsh Language Task and Finish Group
- WBS Local Partnership Forum (LPF)
- OSG Meetings Collections General Services WT/AL Laboratory Services
- Time Limited Projects/Programmes
- Demand Planning Group
  - Daily Resilience Group

Note: WBS also feed into Trust specific Project Groups

VCC SLT PART 1

- VCC Quality & Safety Management Group
- SACT & Medicine Management Directorate
- Medical Directorate
- Radiation Services Directorate
- VCC Medicine Management Group
  - VCC Controlled Drugs Oversight Group

VCC SLT PART 2

- Velindre Futures
- Business Planning Group Part 1
- Business Planning Group Part 2 – Change Board
- Operational Service & Delivery Directorate
- Integrated Services Directorate

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

Quality, Safety and Performance Committee

Terms of Reference &

Operating Arrangements

Reviewed:	November 2021
Approved:	January 2022
Next Review Due:	October 2022

1.   INTRODUCTION

1.1   The Trust's standing orders provide that "The Board may and, where directed by the Assembly Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees".

1.2   In line with standing orders and the Trust's scheme of delegation, the Board shall nominate annually a Committee to be known as the **Quality, Safety and Performance Committee.** The detailed Terms of Reference and operating arrangements set by the Board in respect of this Committee are set out below.

2.   PURPOSE

2.1   The purpose of the Quality, Safety and Performance Committee "the Committee" is to provide:

- Evidence based, timely **advice** and **assurance** to the Board, to assist it in discharging its functions and meeting its responsibilities through its arrangements and core outcomes with regard to:

    - quality, safety, planning and performance of healthcare;
    - safeguarding and public protection;
    - patient, donor and staff experience;
    - all aspects of workforce;
    - digital delivery and information governance;
    - relevant statutory requirements e.g. the Health and Social Care (Quality and Engagement) (Wales) Act 2020, Well-being of Future Generations (Wales) Act 2015;
    - Health and Care Standards (2015);
    - financial performance;
    - regulatory compliance; and,
    - organisational and clinical risk.

3.   DELEGATED POWERS AND AUTHORITY

3.1   The Committee will, in respect of its provision of **advice** and **assurance** to the Board use where possible a triangulated approach to:

- Seek assurance that governance arrangements are appropriately designed and operating effectively to ensure the provision of high quality, safe healthcare and services across the whole of the Trust's activities;

- Ensure the Trust has in place a robust Quality Management System and is working towards meeting the requirements outlined in the Wales Quality Framework: Learning & Improving (2021);

- Consider the implications for quality, safety, patient / donor experience / outcomes, planning and performance, workforce, finance, digital and information governance arising from the development of the Trust's corporate strategies and plans or those of

its stakeholders and partners, including those arising from any Joint (Sub) Committees of the Board;

- Consider the implications for the Trust's quality, safety, patient / donor experience / outcomes, planning and performance, workforce, finance, digital and information governance arrangements from review/investigation reports and actions arising from the work of external regulators;

- Monitor progress against the Trust's Integrated Medium-Term Plan (IMTP) ensuring that areas of weakness or risk and areas of best practice are reported to the Board;

- Align service, workforce and financial performance matters into an integrated approach in keeping with the Trust's commitment to the Sustainable Development Principle defined by the Well-being of Future Generations (Wales) Act 2015.

- Monitor the Trust's sustainability activities and responsibilities;

- Monitor progress against cost improvement programmes;

- Monitor and review performance against the Trust's Assurance Framework.

- Ensure areas of significant patient / donor / service / performance improvement are highlighted to the Board and other relevant Board Committees as necessary to ensure best practice is shared across the organisation;

- Monitor outcomes/outputs from patient / donor / service improvement programmes to provide assurance on sustainable improvements in the quality and efficiency of service delivery;

- Assess implications of any relevant existing, new or amended statutory and regulatory requirements e.g. the Health and Social Care (Quality and Engagement) (Wales) Act 2020 and oversee the Trust's implementation;

  Ensure the Trust Policies, Procedures and Strategies are consistent with internal and external legislative and regulatory requirements and are implemented effectively.
- Ensure the Trust, at all levels (divisional/team) has a citizen centred approach, putting patients, patient / donor experience, safety and safeguarding above all other considerations;

- Ensure that care and services are planned and delivered in line with relevant national / statutory / regulatory and best practice standards;

- Ensure the Trust has the right systems and processes in place to deliver patient /donor focused, efficient, effective, timely and safe services;

- Ensure the workforce is appropriately selected, trained, supported and responsive to the needs of the Trust, ensuring recruitment practices safeguard adults and children at risk, that professional standards and registration/revalidation requirements are maintained, and there is compliance with the requirements of the Nurse Staffing Levels (Wales) Act 2016;

- Ensure there is effective collaboration with partner organisations and other stakeholders in relation to the sharing of information in a controlled manner, to provide

the best possible outcomes for its citizens (in accordance with the Wales Accord for the Sharing of Personal Information and Caldicott requirements);

- Ensure the integrity of data and information is protected, valid, accurate, complete and timely data and information is available to support decision making across the Trust;

- Ensure there is an ethos of learning and continual quality improvement and a safety culture that supports safe high-quality care;

- Ensure there is good team working, collaboration and partnership working to provide the best possible outcomes for our citizens;

- Ensure risks are actively identified and robustly managed at all levels of the Trust;

- Ensure the Health and Care Standards (2015) are used to monitor and improve standards across the Trust;

- Ensure all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality, safety and performance of care provided, and in particular that:

  - sources of internal assurance are reliable
  - recommendations made by internal and external reviewers are considered and acted upon on a timely basis; and
  - lessons are learned from concerns, incidents, complaints and claims.

- Ensure there is an effective clinical audit and quality improvement function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board; and,

- Advise the Board about key indicators of quality, safety and performance, which will be reflected in the Trust's performance framework, against which performance will be regularly assessed and reported on through Annual Reports.

Authority

3.2 The Committee is authorised by the Board to investigate or commission investigation of any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Trust relevant to the Committee's remit, ensuring patient, and donor and staff confidentiality, as appropriate. The Committee may seek relevant information from:

- Employees (and all employees are directed to co-operate with any reasonable request made by the Committee), and any other Committee, Sub-Committee or Group set up by the Board to assist it in the delivery of its functions.

- Obtain legal / other providers of independent professional advice, and to secure the attendance of individuals external to the Trust who have relevant experience and expertise if necessary, and in accordance with the Board's procurement, budgetary and other requirements.

- By giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Trust at any meeting of the Committee.

3.3   Approve policies relevant to the business of the Committee as delegated by the Board.

Access

3.4   The Chair of the Quality, Safety & Performance Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.5   The Committee has, with approval of the Trust Board, established the:
- Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee; and the
- Research, Development & Innovation Sub-Committee.

Note: an overarching summary of the Trust's Governance & Accountability Framework is provided at Annex 1. In addition, the wider governance and accountability reporting arrangements in place at a local divisional level that feed upwards into the Quality, Safety & Performance Committee structure are also summarised at *Annex 2*.

The two sub-committees will have a dual reporting line to both the Quality, Safety and Performance Committee and the Strategic Development Committee as illustrated below:

Quality, Safety & Performance Committee	Strategic Development Committee
Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee - Programme Highlight Report	Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee - TCS Future Direction Setting - Proposed Actions to be taken forward
Research, Development & Innovation Sub-Committee - Highlight Report	Research, Development & Innovation Sub-Committee - Trust RD&I Strategy Updates - Steering Group Updates

Although the Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee and Research, Development & Innovation Sub-Committee, are sub-committees with dual reporting lines, they will both retain the delegated authority for decision making granted by the Trust Board. Further details regarding delegated powers and authority are set out in each of the Sub-Committee Terms of Reference. The Research, Development & Innovation Sub-Committee will also feed into the Trust Charitable Funds Committee for alignment with strategy and funding. Further details are set out in each of the respective Terms of Reference.

| **4.** | **MEMBERSHIP** |

Members

4.1   A minimum of two (2) members, comprising:

Chair   Independent member of the Board (Non-Executive Director)
               One independent member of the Board (Non-Executive Directors)

               The Committee may also co-opt additional independent 'external' members
               from outside the organisation to provide specialist skills, knowledge and
               expertise.

4.2   **Attendees:**

- Chief Executive Officer
- Executive Director of Nursing, Allied Health Professionals and Health Science
  (Committee Lead Executive Officer)
- Executive Medical Director *(also Caldicott Guardian)*
- Chief Operating Officer
- Welsh Blood Service and Velindre Cancer Centre Divisional Directors
- Directors of Hosted Organisations or representatives
- Director of Corporate Governance and Chief of Staff
- Executive Director of Finance
- Executive Director of Organisational Development and Workforce
- Director of Strategic Transformation, Planning & Digital
- Deputy Director of Planning and Performance
- Deputy Director of Nursing, Quality and Patient Experience
- Chief Digital Officer (*also cyber/data outtages/performance*)
- Quality & Safety Manager
- Head of Corporate Governance

4.3   **By invitation**

The Committee Chair may extend invitations to individuals from within or outside the
organisation, taking account of the matters under consideration at each meeting.
The Committee welcomes attendance at Committee meetings by staff from within the
Organisation, representatives of independent and partnership organisations and our
regulators including:

- Healthcare Inspectorate Wales
- Audit Wales
- Trade Unions
- Community Health Council

Secretariat

4.4   Secretary - as determined by the Director of Corporate Governance and Chief of Staff

Member Appointments

4.5   The membership of the Committee shall be determined by the Board, based on the recommendation of the Trust Chair - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

4.6   Members shall be appointed for a maximum of 3 consecutive years before formally reviewing their role on the Committee. During this time a member may resign or be removed by the Board.

Support to Committee Members

4.7   The Director of Corporate Governance and Chief of Staff, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and
-
- Ensure the provision of a programme of organisational development for Committee members as part of the Trust's overall OD programme developed by the Executive Director of Organisational Development & Workforce.

5.   COMMITTEE MEETINGS

Quorum

5.1   At least two independent members must be present to ensure the quorum of the Committee. If the Chair is not present an agreement as to who will chair from the independent members in their absence.

Frequency of Meetings

5.2   Meetings shall be held no less than bi-monthly and otherwise, as the Chair of the Committee deems necessary.

Withdrawal of individuals in attendance

5.3   The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

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

6.1   Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality, safety and performance of healthcare for its citizens through the effective governance of the organisation.

6.2   The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.3   The Committee, through its Chair and members, shall work closely with the Board's other

Committees, including Joint (Sub) Committees and Groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business; and
- sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

6.4   The Committee will consider the assurance provided through the work of the Board's other Committees and Sub Groups to meet its responsibilities for advising the Board on the adequacy of the Trust's overall framework of assurance.

6.5   The Committee shall embed the Trust's corporate objectives, priorities and requirements, e.g., equality and human rights through the conduct of its business.

6.6   The Committee has approved the establishment of an Integrated Quality & Safety Group to support the Committee in effectively executing its responsibilities by undertaking quality and safety intelligence triangulation / analysis and learning assurance to facilitate enhanced efficiency of reporting to the Committee.

7.   REPORTING AND ASSURANCE ARRANGEMENTS

7.1   The Committee Chair shall:

- Provide a formal report to the Board of the Committee's activities. This includes updates on activity and triangulated assurance outcomes through the submission of written Committee Highlight Reports and other relevant written reports, as well as the presentation of an annual Quality, Safety & Performance Committee report;

- Bring to the Board's specific attention any significant matters under consideration by the Committee;

- Ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive or Chairs of other relevant Committees of any urgent/critical matters that may compromise patient / donor care and affect the operation and/or reputation of the Trust.

7.2   The Director of Corporate Governance and Chief of Staff, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any Sub Committees established.

8.   APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1   The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

Cross referenced with the Trust Standing Orders.

9. REVIEW

9.1 Terms of reference and operating arrangements, and the Committees Programme of Work will be reviewed annually by the Committee, with reference to the Board.

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10. CHAIR'S ACTION ON URGENT MATTERS

10.1 There may, occasionally, be circumstances where decisions normally made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance and Chief of Staff as appropriate, may deal with the matter on behalf of the Board, after first consulting with one other Independent Members of the Committee. The Director of Corporate Governance and Chief of Staff must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

10.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

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ANNEX 1 – GOVERNANCE & ACCOUNTABILITY FRAMEWORK

Statutory, Public
Trust Board
Committees

Quality, Safety & Performance Committee (Bi-Monthly)	Strategic Development Committee (Bi-Monthly)	Audit Committee (Quarterly)	Remuneration Committee (Bi-Monthly)	Charitable Funds Committee (Quarterly)	Audit Committee (NWSSP) (Quarterly)
Quality & Safety Compliance & Standards Commissioning Arrangements Risk Management Trust Assurance Framework Annual Plan / IMTP Monitoring Listening & Learning Workforce Digital Delivery Information Governance	Strategy for Commissioning Innovation TCS future direction setting & other Major Programmes Trust Strategies Development of IMTP Partnerships (Academia / Industry / Third Sector) Digital Developments Organisational Development	Governance & Risk Accounts Internal Audit External Audit Counter Fraud Audit Tracker	Executives Objectives Executive Performance Anonymous Correspondence Voluntary Early Release Scheme (VERS)	Governance & Risk Strategy & Performance Financial Reporting Investment Fundraising Activity Advanced Radiotherapy Programme Board	Partnership Committee between NHS Wales Shared Services Partnership and Velindre University NHS Trust

Sub Committee: TCS Scrutiny
- Programme Highlight Report
- Risks & Issues
- Close Out Report

Sub Committee: TCS Scrutiny
- TCS Future Direction Setting
- Proposed Actions to be taken forward

Sub Committee: R,D & I
- Highlight Report
- Progress against Trust R, D & I Annual Operational Plan

Sub Committee: R,D & I
- Trust R, D & I Strategy Updates
- Steering Group Updates

Sub Committee: R,D & I
- Alignment to Strategy & Funding

Sub Committee: Investment Performance Review

Forums & Advisory Groups:
Local Partnership Forum & Advisory Groups / Advisory Consultants Appointment Committee / Academic Partnership Board / Integrated Governance

Mission: Partnering people to live well
Vision: *By 2025 we will have helped more people to live longer, better lives and be the organisation others come to learn from*

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Management Group Hierarchy

Trust Board

- NWSSP Audit Committee
- Charitable Funds Committee
  - Investment Performance Review Sub-Committee
- Audit Committee
- Remuneration Committee
- Strategic Development Committee
- Quality, Safety & Performance Committee

- Transforming Cancer Services Scrutiny
  - Transforming Cancer Services Programme Board
- Research Development & Innovation Committee
- **Executive Management Board**
- **Trust Integrated Quality & Safety Group**

- Welsh Blood Service Senior Management Team
  - Go to page 2
- Infection Prevention & Control Management Board
  - Divisional Infection Prevention & Control Groups
- Welsh Language Development Group
- Education Steering Group
- Estates Statutory Compliance Group
- Health and Safety Group
- Safeguarding & Public Protection Management Group
- Velindre Cancer Service Strategic Leadership (SLT) Part 1&2
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WBS SMT

Education and Training Panel	Business Planning Group (BPG)	Capital and Procurement Planning Group (CPPG)	Regulatory Assurance and Governance Group (RAG)	Research, Development and Innovation Group (RD&I)	Cynefin Group (formerly Estates and Facilities Management Group)	Welsh Language Task and Finish Group	WBS Local Partnership Forum (LPF)	O&G Meetings Collections General Services WT/AL Laboratory Services	Time Limited Projects/ Programmes	Demand Planning Group

Change Review Panel (CHIRP)

Time Limited Projects/ Programmes

Daily Resilience Group

Patient Clinical Governance

Donor Clinical Governance

WBMDR Clinical Governance

Infection Prevention and Control Group

Change Notification Implementation Group

Apheresis Quality Monitoring Group

Note: WBS also feed into Trust specific Project Groups

VCC SLT PART 1

VCC SLT PART 2

Velindre Futures

Business Planning Group Part 1

Business Planning Group Part 2 – Change Board

VCC Quality & Safety Management Group

SACT & Medicine Management Directorate

Medical Directorate

Operational Service & Delivery Directorate

Integrated Services Directorate

Radiation Services Directorate

VCC Medicine Management Group

VCC Controlled Drugs Oversight Group

NHS

GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre

Velindre University
NHS Trust

QUALITY, SAFETY & PERFORMANCE COMMITTEE

QUALITY, SAFETY & PERFORMANCE COMMITTEE
CYCLE OF BUSINESS

DATE OF MEETING	16th March 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Kyle Page, Business Support Officer
PRESENTED BY	Emma Stephens, Head of Corporate Governance
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, AHPs & Health Science

REPORT PURPOSE	ENDORSEMENT

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME
Executive Management Board	02/03/2023	ENDORSED

1.   SITUATION

The purpose of this paper is to seek **ENDORSEMENT** by the Quality, Safety & Performance Committee for the proposed amendments to the Committee Cycle of Business.

2. BACKGROUND

Following agreement at the November 2022 Quality, Safety & Performance Committee, the Quality, Safety & Performance cycle of business has been formally reviewed throughout the month of February 2023, in conjunction with the Executive Lead for the Committee and accountable Executive Directors across the Trust that span all portfolios within the agreed remit and responsibilities of the Committee.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Review

The purpose of the review is to serve a number of key factors:

i. to enable the revision of the annual reporting cycle in line with the financial reporting year and support the preparation of the Trust Annual Governance Statement.
ii. incorporate any outputs and recommendations arising following the establishment of the Trust Integrated Quality & Safety Group.
iii. reflect the reporting requirements of the new Duty of Quality and Duty of Candour when these come into force as a statutory requirement.
iv. the ongoing review of the Trust hosted organisations' reporting requirements, in line with the standards required for good corporate governance. Discussions continue in relation to items to be included on the Cycle of Business.

3.2 Proposed amendments to the Cycle of Business

The Cycle of Business has been updated to align with the financial reporting year and therefore now runs from ***March 2023 to January 2024***.

The proposed amendments have been incorporated into the work programme (***Appendix 1***). For ease of reference, the proposed changes are summarised below:

- ***Items currently reported not captured:***
  i. The **CIVAS@IP5 Report** (NWSSP) has been received by the Quality, Safety & Performance Committee as a standard item since November 2021; however this was not previously detailed on the work plan. As such, this has now been formally incorporated into the Cycle of Business to reflect the agreed established arrangements.
  ii. The **Vaccination Programme Board Update** has also been formally incorporated into the Cycle of Business and will be received on an ad hoc basis as required.

- *New items of business:*
  A number of key reports, not previously reported to the Quality, Safety & Performance Committee, have been identified for inclusion in the work plan (outlined below), to ensure effective oversight and governance arrangements in line with the Committee's remit and responsibilities:

Proposed New Item of Business	Report Frequency	Report Purpose
• Trust Integrated Quality & Safety Group	• Each meeting (May 2023 onwards)	• For Assurance
• Health Technology Wales Annual Report	• Annually	• For Assurance
• Quality Report	• Bi-Annually	• For Assurance
• IMTP Quarterly Actions Progress	• Quarterly	• For Assurance
• Transforming Access to Medicine / Clinical Pharmacy Technical Services Update (NWSSP)	• Quarterly	• For Assurance
• Implementation of Duty of Quality Update (NWSSP)	• Quarterly	• For Assurance
• Surgical Materials Testing Laboratory (SMTL) Annual Report (NWSSP)	• Annually	• For Assurance
• Medical Examiners' Service (MES) Annual Report (NWSSP)	• Annually	• For Assurance
• Duty of Quality Annual Report (NWSSP)	• Annually	• For Assurance

- *Frequency of reports:*
  The frequency with which a number of reports are to be received by the Quality, Safety & Performance Committee has been reduced to facilitate and ensure a more targeted and focused approach, namely:

Existing Reporting Frequency	Revised Reporting Frequency
• Welsh Blood Service Donor Story *(Quarterly)*	• Welsh Blood Service Donor Story *(Three times a year)*
• Velindre Cancer Service Patient Story *(Quarterly)*	• Velindre Cancer Service Patient Story *(Three times a year)*
• Welsh Blood Service Quality Safety & Performance Divisional Report *(Quarterly)*	• Welsh Blood Service Quality Safety & Performance Divisional Report *(Three times a year)*
• Velindre Cancer Service Quality, Safety & Performance Divisional Report *(Quarterly)*	• Velindre Cancer Service Quality, Safety & Performance Divisional Report *(Three times a year)*
• *Digital Service Operational Report (Previously TBC)*	• *Digital Service Operational Report (6 monthly)*

- *Revised reporting categories:* All items of business to be reported to the Quality, Safety & Performance Committee have been assigned to one of the following reporting categories to more accurately reflect the nature and purpose of the report:

  - Annual Report
  - Highlight Report
  - Exception Report
  - Assurance Report

- *Removal of previous items of business:*

  - **Datix Project Report** – As previously agreed, the Datix Project Report has now been replaced with a quarterly Operational Group that will report into the Trust's Integrated Quality & Safety Group.

3.3 Further Areas for Review

A number of additional areas have been identified that are currently being progressed to inform and underpin the Quality, Safety & Performance Committee Cycle of Business, this included but will not be limited to the following:

- The quality and level of detail of reports received by the Quality, Safety & Performance Committee with a focus on assurance and escalation.

- Review of relevant statutory responsibilities.
- Review of the Divisional Committee performance reporting formats.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

5. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **ENDORSE** the proposed revisions to the Quality, Safety & Performance Committee Cycle of Business outlined in section **3.2** and *Appendix 1*.

Quality, Safety & Performance Committee Cycle of Business 2023-24 (commencing March 2023)

Key:
🟨 = Annual Report
🟪 = Highlight Report
🟦 = Exception Report
🟩 = Assurance Report

Item of Business	Executive Lead	Author	Session	Reporting Frequency	Mar 2023	May 2023	Jul 2023	Sep 2023	Nov 2023	Jan 2024
DONOR / PATIENT / STAFF STORY										
Welsh Blood Service Donor Story	Chief Operating Officer (Cath O'Brien)	Director of Welsh Blood Service (Alan Prosser)	Public	Three times a year	✓			✓	✓	
Velindre Cancer Service Patient Story	Chief Operating Officer (Cath O'Brien)	Interim Director of Velindre Cancer Service (Rachel Hennessy)	Public	Three times a year		✓				✓
Staff Story	Executive Director of Organisational Development & Workforce (Sarah Morley)	Variable	Public	Annual			✓			
DIVISIONAL / DIRECTORATE REPORTS										
Welsh Blood Service Quality & Safety Divisional Report	Chief Operating Officer (Cath O'Brien)	Director of Welsh Blood Service (Alan Prosser)	Public	Three times a year	✓			✓	✓	
Velindre Cancer Service Quality & Safety Divisional Report	Chief Operating Officer (Cath O'Brien)	Interim Director of Velindre Cancer Service (Rachel Hennessy)	Public	Three times a year		✓				✓
Digital Service Operational Report	Director of Transformation, Planning & Digital (Carl James)	Deputy Chief Digital Officer (Carl Taylor)	Public	6-monthly		✓			✓	
PERFORMANCE REPORTS										
Welsh Blood Service Performance Management Framework (PMF) Report	Chief Operating Officer (Cath O'Brien)	Director of Welsh Blood Service (Alan Prosser)	Public	Three times a year	✓	✓	(by exception)	✓	✓	✓
Velindre Cancer Service Performance Management Framework (PMF) Report	Chief Operating Officer (Cath O'Brien)	Interim Director of Velindre Cancer Service (Rachel Hennessy)	Public	Three times a year	✓	✓	(by exception)	✓	✓	✓
Workforce & Organisational Development Performance Report/Finance Report	Executive Director of OD & Workforce (Sarah Morley) / Executive Finance Director (Matthew Bunce)	Deputy Director of OD & Workforce (Susan Thomas) / Deputy Director of Finance (Chris Moreton)	Public	Each Meeting	✓	✓	(by exception)	✓	✓	✓
Trust-wide Workforce Performance Management Framework exception (PMF) Report	Executive Director of OD & Workforce (Sarah Morley)	Deputy Director of OD & Workforce (Susan Thomas)	Public	Each Meeting	✓	✓	(by exception)	✓	✓	✓
Finance Report	Executive Director of Finance (Matthew Bunce)	Head of Financial Reporting (Steve Coliandris)	Public	Each Meeting	✓	✓	✓	✓	✓	✓

Quality, Safety & Performance Committee Cycle of Business 2023-24 (commencing March 2023)

Key:
- ☐ = Annual Report
- ☐ = Highlight Report
- ☐ = Exception Report
- ☐ = Assurance Report

Item of Business	Executive Lead	Author	Session	Reporting Frequency	Mar 2023	May 2023	Jul 2023	Sep 2023	Nov 2023	Jan 2024
MEDICAL & RESEARCH DEVELOPMENT										
Assurance Report Medicines Management Group (including Medical Gases & CDs)	Executive Medical Director (Jacinta Abraham)	Head of SACT and Medicines Management (Bethan Tranter)	Public	Bi Annually	✓			✓		
RD&I Sub Committee Highlight Report	Executive Medical Director (Dr Jacinta Abraham)	Head of Research & Development (Sarah Townsend)	Public	Quarterly		✓		✓		✓
QUALITY, SAFETY & ASSURANCE										
Highlight Report from the Trust-wide Infection Prevention & Control Management Group	Executive Director of Nursing, AHPs and Health Science (Nicola Williams)	Head of Infection Prevention & Control (Hayley Jeffreys)	Public	Quarterly	✓			✓		✓
Highlight Report from the Trust-wide Safeguarding & Vulnerable Adults Group (SVAG)	Executive Director of Nursing, AHPs and Health Science (Nicola Williams)	Head of Safeguarding & Vulnerable Groups (Tina Jenkins)	Public	Bi Annually (or by exception)		✓			✓	
Highlight Report from the Trust-wide Patient Safety Alerts Group (PSAG)	Executive Director of Nursing, AHPs and Health Science (Nicola Williams)	Quality, Safety & Assurance Manager (TBC)	Public	Bi Annually (or by exception)		✓			✓	
Trust Integrated Quality & Safety Group	Executive Director of Nursing, AHPs and Health Science (Nicola Williams)	Deputy Director Nursing, Quality & Patient Experience / Head of Quality & Safety	Public	Each meeting from May 2023		✓	✓	✓	✓	✓
Quality Report	Executive Director of Nursing, AHPs and Health Science (Nicola Williams)	Head of Quality & Safety (TBC)	Public	Bi Annually (Nov and July annually)					✓	
Medical Devices Report	Chief Operating Officer (Cath O'Brien)	Head of Quality Assurance (Peter Richardson)	Public	Bi Annually			✓ (Annual)			✓
Infected Blood Inquiry Proceedings	Chief Operating Officer (Cath O'Brien)	Business Support Officer (Suzanne Jones)	Public & Private	Bi Annually (or by exception)		✓			✓	
Putting Things Right Report (inc. Incidents, SIs, Complaints, Compliments, Claims & Patient Experience)	Executive Director of Nursing, AHPs and Health Science (Nicola Williams)	Quality, Safety & Assurance Manager (TBC)	Public	Quarterly	✓	✓		✓	✓	
Quality & Safety Framework	Executive Director of Nursing, AHPs and Health Science (Nicola Williams)	Executive Director of Nursing, AHPs and Health Science (Nicola Williams)	Public	Bi-Annually		✓			✓	
Value based Healthcare	Executive Director of Finance (Matthew Bunce)	Deputy Director of Finance (Chris Moreton)	Public	Bi-Annually	✓			✓		

Quality, Safety & Performance Committee Cycle of Business 2023-24 (commencing March 2023)

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Item of Business	Executive Lead	Author	Session	Reporting Frequency	Mar 2023	May 2023	Jul 2023	Sep 2023	Nov 2023	Jan 2024
Private Patient Improvement Plan	Executive Director of Nursing, AHPs and Health Science (Nicola Williams)	Deputy Director of Nursing, Quality & Patient Experience (Nigel Downes)	Public	Bi-Annually		✓			✓	
Radiation Protection and Medical Exposures Strategic Group Highlight Report	Executive Medical Director (Jacinta Abraham)	Head of Radiation Services (Kathy Ikin)	Public	Bi Annually		✓			✓	
Medical Examiner's Service & Mortality Framework Report	Executive Medical Director (Jacinta Abraham)	Head of Radiation Services (Kathy Ikin)	Public	Bi Annually	✓			✓		
Patient Nosocomial Transmission Review Update	Nicola Williams (Executive Director of Nursing, Allied Health Professionals & Health Science)	Deputy Director of Nursing, Quality & Patient Experience (Nigel Downes)	Public	Quarterly	✓		✓		✓	
Business Continuity & Emergency Planning	Chief Operating Officer (Cath O'Brien)	Director of Welsh Blood Service (Alan Prosser) (both divisions)	Public	Bi-Annually (Annually from July 2023 onwards)			✓ (Annual)			
STRATEGIC TRANSFORMATION, PLANNING & ESTATES										
Highlight Report from the Trust Estates Assurance Group	Director of Strategic Transformation, Planning and Digital (Carl James)	Assistant Director of Estates, Environment & Capital Development (Jason Hoskins)	Public	Bi-Annually	✓			✓		
Sustainability Report (inc. decarbonisation)	Director of Strategic Transformation, Planning and Digital (Carl James)	Assistant Director of Environmental, Estates and Capital Development (Jason Hoskins)	Public	Bi-Annually			✓ (Annual)			✓
IMTP Quarterly Actions Progress	Director of Strategic Transformation, Planning and Digital (Carl James)	Head of Strategic Planning & Performance (Peter Gorin)	Public	Quarterly	✓		✓		✓	
Transforming Cancer Services (TCS) Programme Scrutiny Sub Committee Highlight Report	Director of Strategic Transformation, Planning & Digital (Carl James)	Business Support Officer (Jessica Corrigan / Liane Webber)	Public & Private	Each meeting	✓	✓	✓	✓	✓	✓

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WORKFORCE										
Anti-Racist Wales Action Plan	Executive Director of Organisational Development & Workforce (Sarah Morley)	Head of OD (Claire Budgen)	Public	Bi-annually		✓			✓	
Gender Pay Gap Report	Executive Director of OD & Workforce (Sarah Morley)	Head of OD (Claire Budgen)	Public	Annually			✓ Annual from July 23			
Annual Equality, Diversity & Inclusion Report	Executive Director of OD & Workforce (Sarah Morley)	Head of OD (Claire Budgen)	Public	Annually		✓	✓ Annual from July 23			
ANNUAL REPORTS										
Medical Education Governance Framework	Executive Medical Director (Dr Jacinta Abraham)	Interim Medical Business Manager (Nicola Hughes) Louise Hanna	Public	Annually			✓			
Trust Clinical Audit Annual Report	Executive Medical Director (Dr Jacinta Abraham)	Clinical Audit Manager/Head of Quality Assurance (Sara Walters/Peter Richardson)	Public	Annually			✓			
Trust Clinical Audit Plan	Executive Medical Director (Dr Jacinta Abraham)	Clinical Audit Manager/Head of Quality Assurance (Sara Walters/Peter Richardson)	Public	Annually		✓				
Trust-wide Nurse Staffing Levels (Wales) Act 2016 Annual Report	Executive Director of Nursing, AHPs and Health Science (Nicola Williams)	Head of Nursing for Professional Standards & Digital (Anna Harries)	Public	Annually			✓			
Health Technology Wales (HTW) Annual Report	Executive Director of Nursing, AHPs and Health Science (Nicola Williams)	(TBC)	Public	Annually			✓			
Annual Quality Report	Executive Director of Nursing, AHPs and Health Science (Nicola Williams)	Head of Quality & Safety (TBC)	Public	Annually			✓			
Infection Prevention & Control Annual Report	Executive Director of Nursing, AHPs and Health Science (Nicola Williams)	Head of Infection Prevention Control (Hayley Jeffreys)	Public	Annually			✓			

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Item of Business	Executive Lead	Author	Session	Reporting Frequency	Mar 2023	May 2023	Jul 2023	Sep 2023	Nov 2023	Jan 2024
Safeguarding & Public Protection Annual Report	Executive Director of Nursing, AHPs and Health Science (Nicola Williams)	Head of Safeguarding & Vulnerable Groups (Tina Jenkins)	Public	Annually			✓			
Putting Things Right Annual Report	Executive Director of Nursing, AHPs and Health Science (Nicola Williams)	Quality Safety, & Assurance Manager (TBC)	Public	Annually			✓			
Annual Performance Report	Director of Strategic Transformation, Planning, Performance and Estates (Carl James)	Assistant Director of Planning and Performance (Phil Hodson)	Public	Annually			✓			
Annual Estates Update	Director of Strategic Transformation, Planning, Performance and Estates (Carl James)	Assistant Director of Environmental, Estates and Capital Development (Jason Hoskins)	Public	Annually			✓			
Annual Sustainability Report (inc. decarbonisation)	Director of Strategic Transformation, Planning, Performance and Estates (Carl James)	Assistant Director of Environmental, Estates and Capital Development (Jason Hoskins)	Public	Annually			✓			
Health & Safety Annual Report	Director of Strategic Transformation, Planning, Performance and Estates (Carl James)	Health & Safety Manager (Helen Jones)	Public	Annually			✓			
Local Partnership Forum Annual Report	Executive Director of OD & Workforce (Sarah Morley)	Deputy Director of OD & Workforce (Susan Thomas)	Public	Annually			✓			
Annual Report Workforce & Organisational Development (inc. Workforce Planning)	Executive Director of OD & Workforce (Sarah Morley)	Deputy Director of OD & Workforce (Susan Thomas)	Public	Annually			✓			
Welsh Language Annual Report	Executive Director of OD & Workforce (Sarah Morley)	Head of OD (Claire Budgen)	Public	Annually			✓			
Professional Registration/Revalidation	Executive Medical Director (Jacinta Abraham)/ Executive Director of Nursing, AHPs & Health Science (Nicola Williams)	Consultant Clinical Oncologist (Mick Button) / Head of Nursing for Professional Standards and Digital (Anna Harries)	Public	Annually			✓			
Patient & Donor Experience Annual Report	Executive Director of Nursing, AHPs and Health Science (Nicola Williams)	Deputy Director of Nursing, Quality & Patient Experience(Nigel Downes)	Public	Annually			✓			

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Committee Annual Report for Trust Board	Director of Corporate Governance and Chief of staff (Lauren Fear)	Head of Corporate Governance (Emma Stephens)	Public	Annually			✓			
Annual progress report – Cyber Security Strategic Plan	Director of Transformation, Planning & Digital (Carl James)	Deputy Chief Digital Officer (Carl Taylor)	Private	Annually			✓			
Annual Information Governance Report	Executive Director of Finance (Matthew Bunce)	Head of Information Governance (Ian Bevan)	Public	Annually			✓			
Risk Annual Report	Director of Corporate Governance and Chief of Staff (Lauren Fear)	(Melanie Findlay)	Public	Annually			✓			
Clinical & Scientific Strategic Board Highlight Report	Executive Medical Director (Jacinta Abraham)/ Executive Director of Nursing, AHPs & Health Science (Nicola Williams)	TBC	Public	Bi-annually (from July 2023)						
Communications Annual Report	Director of Corporate Governance & Chief of Staff (Lauren Fear)	Assistant Director of Communications (Non Gwilym)	Public	Annually			✓			
Annual Risk Summary	Director of Corporate Governance & Chief of Staff (Lauren Fear)	Risk & Assurance Officer (TBC)	Public	Annually			✓			
Freedom of Information Requests Annual Report	Director of Corporate Governance & Chief of Staff (Lauren Fear)	Communication and Compliance Officer (TBC)	Public	Annually			✓			
Information Governance Assurance Report	Executive Director of Finance (Matthew Bunce)	Head of Information Governance (Ian Bevan)	Public	Quarterly		✓		✓		✓
PROFESSIONAL REGULATION										
Professional Nursing Update Report	Executive Director of Nursing, AHPs & Health Science (Nicola Williams)	Head of Nursing Professional Standards & Digital (Anna Harries)	Public	Bi-Annually	✓			✓		
INTEGRATED GOVERNANCE										
Health & Care Standards / Quality Standards	Executive Director of Nursing, AHPs & Health Science (Nicola Williams)	Head of Quality, Safety & Assurance (TBC)	Public	Bi Annually		✓			✓	

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Item of Business	Executive Lead	Author	Session	Reporting Frequency	Mar 2023	May 2023	Jul 2023	Sep 2023	Nov 2023	Jan 2024
Trust Risk Register (Board level reporting threshold & TAF)	Director of Corporate Governance & Chief of Staff (Lauren Fear)	Risk & Assurance Officer (TBC)	Public	Each meeting	✓	✓	✓	✓	✓	✓
Freedom of Information Requests (IG & IM&T)	Director of Corporate Governance & Chief of Staff (Lauren Fear)	Communication and Compliance Officer (TBC)	Public	Bi Annually		✓			✓	
Trust-wide policies and procedures for approval	Executive Policy Lead (various)	Policy Lead (various)	Public	Each meeting (as required)	✓	✓	✓	✓	✓	✓
Trust-wide policies and procedures compliance report	Director of Corporate Governance & Chief of Staff (Lauren Fear)	Head of Corporate Governance (Emma Stephens)	Public	Each meeting (as required until backlog cleared)	✓	✓	✓	✓	✓	✓
COMMITTEE EFFECTIVENESS										
Committee Terms of Reference and Operating Arrangements	Director of Corporate Governance & Chief of Staff (Lauren Fear)	Head of Corporate Governance (Emma Stephens)	Public	Annually	✓					
Committee Cycle of Business	Director of Corporate Governance & Chief of Staff (Lauren Fear)	Head of Corporate Governance (Emma Stephens)	Public	Annually	✓					
Committee Effectiveness Survey Report	Director of Corporate Governance & Chief of Staff (Lauren Fear)	Head of Corporate Governance (Emma Stephens)	Public	Annually	✓					
Hosted Organisations (e.g. NHS Wales Shared Services Partnership (NWSSP) TBC										
Transforming Access to Medicine / Clinical Pharmacy Technical Services Update (NWSSP)	TBC	Service Director, TRaMS (Colin Powell) / Head of Technical Services (Gareth Tyrrell)	Public	Quarterly	✓		✓		✓	
Implementation of Duty of Quality Update (NWSSP)	Executive Director Nursing, AHP & Health Science (Nicola Williams)	Deputy Director Nursing, Quality & Patient Experience / Head of Quality & Safety	Public	Quarterly	✓		✓		✓	
Surgical Materials Testing Laboratory (SMTL) Annual Report (NWSSP)	TBC	Director of Surgical Materials Testing Laboratory (Dr Gavin Hughes)	Public	Annually			✓			
Medical Examiner Service (MES) Annual Report (NWSSP)	Medical Director, Corporate Services (Ruth Alcolado)	Lead Medical Examiner Officer (Daisy Shale) / Medical Examiner (Jason Shannon)	Public	Annually			✓			

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Duty of Quality Report (NWSSP)	Medical Director, Corporate Services (Ruth Alcolado)	Medical Director, Corporate Services (Ruth Alcolado)	Public	Annually or by exception					✓	
CIVAS@IP5 Report	TBC	Head of Technical Services (Gareth Tyrrell)	Public							
Ad-hoc reports by exception (dependent on external schedules) e.g. COVID-19, staff surveys, inspection reports, internal audit and Audit Wales reports, internal high level task & finish work e.g. Occult Hepatitis B										
Vaccination Programme Board Update	Executive Director of Nursing, AHPs & Health Science (Nicola Williams)	Business Support Officer (Kyle Page)	Public	As required		✓				

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

QUALITY, SAFETY & PERFORMANCE COMMITTEE

(CIVAS@IP5)

DATE OF MEETING	16/03/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	

PREPARED BY	GARETH TYRRELL – HEAD OF TECHNICAL SERVICES - CIVAS@IP5
PRESENTED BY	GARETH TYRRELL
EXECUTIVE SPONSOR APPROVED	

REPORT PURPOSE	FOR NOTING

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

ACRONYMS	
CIVAS	Centralised Intravenous Additives Service
IP5	Imperial Park Building No.5, Celtic Way, Newport, NP10 8BE
TMU	Temporary Medicines Unit

GMP	Good manufacturing Practice https://ec.europa.eu/health/documents/eudralex/vol-4_en
GDP	Good Distribution Practice https://ec.europa.eu/health/documents/eudralex/vol-4_en
MHRA	Medicines and Healthcare products Regulatory Agency
MS	MHRA Manufacturers' "Specials" license
WDA	MHRA Wholesale Distribution Authorisation

GLOSSARY	
Drug	A substance used to prevent, diagnose, treat or relieve symptoms of disease
Immunotherapy	A type of cancer treatment that activates or suppresses the immune system to treat disease
Cytotoxic	A substance toxic to cells, preventing replication or growth and used to treat cancer as well as some other diseases

1.   SITUATION/BACKGROUND

1.1   CIVAS@IP5 is an MHRA Licenced "Specials" Manufacturer, Wholesale Dealer and Home Office Licenced holder funded by Welsh Government and Hosted by NHS Wales Shared Services Partnership.

1.2   The service is hosted by NHS Wales Shared Services Partnership with legal responsibility for adherence to Medicines Law residing solely with the names Head of Production and Head of Quality Assurance

1.3 The purpose of this service is to provide Licenced "Specials" to Health Boards and Trusts across Wales where there is a clinical need, and local aseptic service capacity does not support local manufacture.

1.4 Subsequently, CIVAS@IP5 has also expanded services to incorporate other Licenced "Specials" products, COVID-19 Vaccine Packdown and Wholesale Dealer activities

1.5 The CIVAS@IP5 application for General Pharmaceutical Council (GPhC) Premises registration was accepted in March 2021. CIVAS@IP5 has also obtained Home office Domestic Controlled Drugs license, MHRA Manufacturers' "specials" license (MS) and Wholesale Distribution Authorisation (WDA).

1.6 Due to facilities and design restrictions, as well as regulatory guidance, the service is unable to handle cytotoxic therapies and as such future products will focus on CIVAS medicines.

1.7 The CIVAS@IP5 service has prepared over 35000 doses of ready to administer intravenous infusions, which have been supplied to health boards to support critical care during the COVID-19 Pandemic CIVAS@IP5 has packed down under the MHRA Specials Licenced just

1.8 On February 15th-16th 2022 CIVAS@IP5 was subject to a GMP Inspection against the Human Medicines Regulations 2020 (SI 2012/1916). This inspection was undertaken to identify adherence to the principles and guidelines of Good Manufacturing Practice (GMP) and Good Distribution Practice (GDP).

1.9 The inspection outcome has assigned the CIVAS@IP5 unit with the **lowest risk rating** and the **longest inspection interval** available. The facility will now be inspected again in February 2024

1.10 As well as the regulatory, compliance and assurance framework for the activity itself, it was also important to consider the wider quality governance framework in which this part of the NWSSP model operates in. To support consideration of this, appendix one was compiled which outlines, from various internal and external sources, key elements which make up an Organisational quality governance framework. The right-hand column then articulates how TMU and NWSSP fulfill these elements. The document has been previously discussed and approved in advance of the Committee with Medical Director NWSSP, Executive Medical Director Velindre University NHS Trust and Executive Director of Nursing, AHPs and Health Science.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Attached to this document is the CIVAS@IP5 Service Board Report for 22/23 for M10. This report identifies the following

- Performance metrics for operational output up to February 2023
- Regulatory performance against EU Good Manufacturing Practice
- Service development progress

2.2 Operational output has stabilized over June/July due to temporal stability of service. It is anticipated that all current vacant posts be recruited into by year end 2022. Performance metrics to highlight:

- 100% Internal Audit compliance
- 92% Documentation Review dates met
- Environmental failure rates for critical area and operators of 0% respectively (target of <5%)
- 2 service complaints for December in relation to the Strep A Antibiotics Shortages support
- 90% Production yield (target >95%)
- 100% compliance with CD checks

2.3 Compliance with Healthcare Standards

See Appendix 2

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below: Staff and Resources Safe Care Timely Care Effective Care
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
	The CIVAS@IP5 was specifically commissioned to ensure equality of access to medicines by supplementing existing aseptic manufacturing capacity.
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	CIVAS@IP5 is operating in compliance with relevant legislation, specifically the Medicines Act (1968), The Human medicines regulations (2012) and the misuse of Drugs act (1971). Legal responsibility of this compliance lies with the Head of Production and Head of Quality named on the MS Licence
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Welsh Government has confirmed continuing funding of revenues for the project to 31/3/23.

4. RECOMMENDATION

4.1 The Quality, Safety and Performance Committee is asked to **note** current levels of service performance against the framework of standards set out in EU GMP and which we are legally required to comply with as an MHRA "Specials" and Wholesale Dealer license

holder. Further update on new products introduced into the CIVAS@IP5 portfolio will be provided in future meetings.

The Quality, Safety and Performance Committee is asked to **note** the findings and CIVAS@IP5 risk status assigned by the MHRA. The action plan and progress update will be provided as part of this agenda item.

Appendix 1 - CIVAS@IP5 Governance Arrangements – notes

1.1	Quality as drive for organisational strategy	Quality and safety priorities clearly defined, documented and periodically reviewed	CIVAS@IP5 operates in compliance with Good Manufacturing Practice (GMP) and Good Distribution Practice (GDP) these internationally recognised standards designed to ensure safe manufacturing, storage and distribution of medicines are clearly defined: https://ec.europa.eu/health/documents/eudralex/vol-4_en https://ec.europa.eu/health/human-use/good_manufacturing_distribution_practices_en The facility and its operation are clearly defined in the CIVAS@IP5 site master file and in standard operating procedures. The CIVAS@IP5 was inspected by the MHRA against GMP and GDP on 15-16th December 2020, and for pack down of covid vaccines on the 6TH Sept 2021. All newly licensed manufacturing units are inspected within 12 months of the first inspection. A further inspection in Feb 2022 resulted in a low risk rating applied to the facility. The CIVAS@IP5 will be inspected against GMP and GDP on behalf of WG and the Welsh Chief Pharmacists Group by the All Wales QA Pharmacist during 2021.
1.2		These priorities are reflected in organisation's IMTP	The CIVAS@IP5 development is fully supported by the Shared Service Partnership Committee and Welsh Government. The Minister has provided funding for CIVAS@IP5 project in response to COVID requirements

			and continuity of supply. It is also integral to supporting the COVID vaccination Program. Funding is currently assured until March 2023
1.3		Quality and safety strategic risks are reflected in Board Assurance Framework	The CIVAS@IP5 Board Agenda includes an agenda item on project risk. Any significant quality and safety risks will be also highlighted and discussed at the Shared Service Partnership Committee and the NWSSP Senior Leadership Team as part of the normal operational management and reporting within NWSSP. A separate paper outlines the proposed addition of NWSSP business, including CIVAS@IP5, into the Velindre University NHS Trust Quality, Safety & Performance Committee going forwards, the agenda will include a section on associated risks.
1.4		Quality and safety risks central in the risk management strategy and processes of the organisation	Quality and Safety is integral to GMP and GDP quality improvement and quality by design are inherent within the approach to processes within CIVAS@IP5. As above in terms of reporting risks within NWSSP and to the NWSSP part of the Velindre University NHS Trust Quality, Safety & Performance Committee if approved.
2.1	Leadership of quality and safety	Collective responsibility for quality and patient safety across the executive team and clearly defined roles for professional leads	The CIVAS@IP5 lines of accountability are clearly defined. There are clearly defined professional roles. The CIVAS@IP5 Head of Technical Services now reports to the NWSSP Service Director for TrAMS

| | | | managerially and to the Chief Pharmaceutical Advisor to WG professionally.

The CIVAS@IP5 Head of Technical Services also reports to the Service Board, which in turn reports to the Shared Services Partnership Committee.

The CIVAS@IP5 Head of Technical Services is the Superintendent Pharmacist for the CIVAS@IP5 General Pharmaceutical Council Premises Registration, and the Site lead, and Person Responsible for Security on the Home Office Domestic Controlled Drugs license.

A suitably qualified and experienced individual is employed in the Accountable Pharmacist role. A new accountable pharmacist has been appointed to take over from the incumbent's retirement.

The QA and Production Leads report to the CIVAS@IP5 Head of Technical Services. The QA and Production lead are named on the MHRA Manufacturers' "specials" (MS) license as being responsible for Quality and Production respectively.

The QA lead is the named Responsible Person on the MHRA Wholesale Distribution Authorisation (WDA).

All staff working in the CIVAS@IP5 will be formally engaged to job roles within NWSSP, to ensure accountability for the work undertaken. These engagements will be a mixture of: |
|---|---|---|---|

			• Honorary Secondments of staff already employed by Health Board or Trust Pharmacy units • Bank Staff engagements • Permanent or where appropriate temporary employment contract All staff have a quality element to their role and an understanding of quality assurance of the operation of the service.
2.2		There is sufficient capacity and support, at corporate and directorate level, dedicated to quality and safety	The CIVAS@IP5 board provides scrutiny of safety, quality and performance and of the service. The board also provides strategic and operational support. The board has met monthly since the service was envisaged in April 2020. The capacity of the board to carry out the oversight and support roles is evidence by the successful MHRA license applications and service delivery, respectively, within the projected project timescales. All health boards through the support of Chief Pharmacists have helped support the creation of the TMU and they are fully supportive and committed to the Unit. NWSSP is about collaboration and support service provision.
3.1	Organisational scrutiny of quality and patient safety	The roles and function of the Quality and Safety Committee is fit for purpose and reflects the Quality Strategy, Quality and Safety	It is proposed that the following are submitted to the Quality and safety Committee • Annual Quality Statement • Inspection reports (as and when received)

		Governance Framework and key corporate risks for quality and safety	• MHRA Update/Action plan
3.2		Independent/Non-Executive Members are appropriately supported to meet their responsibilities through the provision of an adequate induction programme and ongoing development so they can effectively scrutinise the information presented to them	A separate paper outlines the proposed addition of NWSSP business, including CIVAS@IP5, into the Velindre University NHS Trust Quality, Safety & Performance Committee going forwards.

Regular updates will be provided as part of the normal course of business to the Shared Service Partnership Committee, which includes representatives from every NHS organisation as the responsible body for shared services. |
| | | | |
| 4.0 | Clinical Audit | There is visibility and oversight of clinical audit and improvement activities across divisions/groups/directorates and at corporate level. This includes identification of outliers and maximising opportunities for sharing good practice and learning | The CIVAS@IP5 service is a professional technical service whereby all clinical decisions are made by health board clinicians and not the CIVAS@IP5 staff. The unit is an accredited production unit which has a self-inspection programme for GMP and GDP.

The unit is independently inspected by the All Wales QA Pharmacist.

Best practice is shared through the Welsh Chief Pharmacists Group's pharmacy technical services sub-group (CPTS) and lessons learned from the development of the TMU have been captured. A number of senior health board technical pharmacy staff have been involved in putting in place the quality and operating procedures. |

5.1	Organisation promotes a quality and safety focused culture	Organisational values and behaviours support a quality and safety focused culture	The organisational structure of CIVAS@IP5 is designed to ensure adequate supervision of all processes. All grades of staff are empowered and supported in identifying process deviations. The service will operate in line with the values and culture of NWSSP
5.2		Organisation actively participating in quality improvement initiatives	The service has a robust Corrective Action/Preventative Action (CAPA) system built into the Pharmaceutical Quality System (PQS). This ensures lessons are learnt and appropriate actions taken, within an appropriate timescale. The CAPA system also ensure continuous quality improvement.
5.3		Organisation takes steps to listen to staff and involve them in monitoring service change/improvement	All grades of staff are empowered and supported in identifying process deviations, during manufacturing process or at daily pre and post manufacturing session meetings. Feedback is provided on issues raised.
5.4		Strong culture of learning lessons from staff feedback or concerns	The CAPA system is an essential component of the Pharmaceutical Quality system. Staff training encompasses the PQS and the role of team members in its operation. The management recognize the importance of responding appropriately to staff concerns and providing feedback.
5.5		Quality and safety an integral part of workforce management processes	Quality and safety are pre-requisites for compliance with GMP and GDP

6.1	Organisational structures and processes support delivery of high-quality, safe and effective services	Clear lines of accountability for quality and patient safety across the organisational structure ie 'floor to Board'	Included as point 9 of PQS in Internal Assurance section
6.2		Effective corporate and operational controls to support delivery of high-quality and safe services	Operational controls in PQS in Internal Assurance section Current corporate and operational controls have been extended to cover the operation in line with existing processes. Once fully established the Q&S Committee for Shared Services will also provide an additional level of assurance for NWSSP Committee members
6.3		The oversight and governance of DATIX and other risk management systems ensures they are used as an effective management and learning tool. This should also include triangulation of information in relation to concerns, at a divisional/group/ directorate or corporate level, and formal mechanisms to identify and share learning	The DATIX is used to report clinical incidents and health and safety incidents. It is recognised that the DATIX system does not have the level of detail in classification of incidents for a CAPA system which meets the expectation of the MHRA. The Q-Pulse system is therefore used in addition to DATIX for management of CAPA and other components of the PQS. Complaints will be managed through Q-Pulse, the NWSSP Complaints Management Protocol and if these relate to product quality and or patient safety the MHRA's Defective Medicines Report Centre (DMRC). There is a Recall Procedure, the effectiveness of which is tested annually.
6.4		Enough resource and expertise to support and improve quality governance arrangements	The CIVAS@IP5 Head of Technical Services is an appropriately qualified and experienced Pharmacist. The CIVAS@IP5 Head of Technical Services is supported by QA lead, Production Lead and Production

			Managers with the necessary qualifications, skills and experience.

The senior team is supported by a workforce designed, recruited and trained specifically for the operation of the service.

The team has a clear understanding of their required contribution to the PQS.

Capacity planning carried out as part of workforce design has ensured that the PQS is appropriately resourced. |
| 6.5 | | Organisation has comprehensive and timely information for monitoring and reporting on quality and safety | Q-pulse is used to manage the PQS. This system is used to record, monitor and report on information relevant to the PQS: CAPA, facilities and equipment, customer, suppliers, external audit and self-inspection,

The working environment is monitored by the team. End of batch tryptone soya broth fills are carried out at the end of each manufacturing batch. Public Health Wales provides Microbiological services, including incubation, species level identification and reporting for the environmental monitoring and end of batch testing.

Finished product is quarantined pending confirmation of satisfactory environmental and end batch testing data. |
| 6.6 | | Quality and patient safety receives effective coverage at both corporate and operational management meetings | The Board receives and reviews a monthly operational report, which includes both quality, safety and operational performance. |

Appendix 2 – Adherence to Health and Care Standards

Standard	Criteria	Evidence of Achievement
Governance, Leadership and Accountability	Setting direction, igniting passion, pace and drive, and developing people.	
	Focus on outcomes and choices based on evidence and insight. Approach through collaboration building on common purpose.	Medicines preparations and manufacturing processes based on evidence-based literature and collaboration with clinical colleagues across Wales to ensure medicines are provided in professionally recommended presentations.
	Services innovate and improve delivery, plan resource, and prioritise. Develop clear roles and responsibilities, manage performance and value for money.	CIVAS@IP5 service manages resource via the internally completed UK Aseptic Services Capacity Plan, a regulatory requirement to ensure resources do not exceed 80% utilization.

Innovation for improved delivery and resource utilization include Once-for-Wales purchasing, manufacture and distribution of wholesale and manufactured medicines. The roles and responsibilities for these activities are detailed on MHRA licenses for Wholesale Dealing, Specials manufacture and handling of controlled drugs via the Home Office License.

Innovative new products and manufacturing techniques developed and introduced internally via Change Control and Validation processes with |

		engagement of end user to identify safety, efficiency, and value for money outcomes.
	Foster a culture of learning and self-awareness, and personal and professional integrity.	Service hosts and contributes to All Wales study days, where learning and development from within the service is shared with partners across the UK.
Safe Care – managing risk and promoting health and safety	Best practice to manage and mitigate risk and safety notices and alerts acted on	Internal processes in place for identifying relevant safety notices and drug alerts, with approved pathway for customer and clinician notification. Fully validated recall procedure, tested annually, ensures the robust and expedient identification of affected medicines and their immediate removal from health service circulation for quarantine and destruction.
	Compliance with legislation, regulatory and professional guidance.	Internal Pharmaceutical Quality System (PQS) in place to ensure compliance with Human Medicines Regulations 2012 and EU Good Manufacturing Practice. Monthly internal audit completed and periodic inspection by MHRA/Home Office to ensure legal compliance.
	Qualified in respect to regulatory bodies and fit to practice within professional competencies	All staff required to complete CPD to maintain professional registration. 2 Yearly refresher training provided for QC Medical Gas Testing to maintain competency.

Safe Care – Medical devices, equipment, and diagnostic systems	Processes to ensure equipment in maintained, calibrated, and cleaned ensuring appropriateness for intended use and environment.	Asset register and validation master plan, housed on the ePQS within NWSSP provides a schedule of maintenance, calibration & revalidation for all facilities, equipment & processes within CIVAS@IP5. Intervals based on regulatory guidance, manufacturer recommendation and service requirements.
	Timely reporting of faults and issues.	Asset module on ePQS provides mechanism for documenting, reporting, and trending faults with all assets. Service Level and Technical agreements as well as service contracts in place with all suppliers/manufacturers.
Effective Care – Safe and clinically effective care	People are protected from avoidable harm	All medicines quarantined until confirmation of quality and sterility received. Immediate batch rejection and destruction if release criteria not met. Automated preparation of production documentation and medicines preparation remove human error from internal manufacturing processes.
	Practice evolves to reflect new evidence and promote clinically effective care.	Quarterly review of manufacturing performance with corrective actions plans implemented where evidence requires. Program of clinical review in relation to products prepared to identify any changes in clinical landscape that require a modification to quantities prepared,

		preparations required or packaging presentations which are currently designed along a "design for quality" approach.
	Systems and processes comply with safety directives	All systems and processes are fully validated and comply with EU GMP and MHRA guidelines. Manufacturing within CIVAS@IP5 is a needle-free.
	Non-compliance is reported and investigated.	All non-compliance is reported via the internal PQS. This is also submitted as an interim compliance report to the MHRA every 6 months.
	Practice keeps up to date with best practice, national and professional guidance, new technologies and innovation.	6 monthly review of site master file and quality policies take place, and built into this is a review of all regulatory and guidance documents for Good Manufacturing and Distribution Practice.
Effective Care – Safe and clinically effective care	Local capacity is developed to support and enable teams to identify improvement opportunities.	Capacity managed via the UK Aseptic Services capacity plan and operational activities are kept to below 80% in order to allow regulatory and continuous improvement activities to take place. This is a key regulatory requirement and compliance is mandatory.
	Progress is measured and shared.	Service improvement is measured and shared monthly via the CIVAS@IP5 Service Board. KPI's tie in with operational objectives based on EU GMP requirements.

|	Research has a direct impact on improving efficiency and effectiveness of services.	The R&D program within CIVAS@IP5 focusses on two key improvement metrics. Product quality and improved efficiency. All service developments are centred around work in these areas and are managed via the change control process. Outputs are presented locally via governance boards and nationally as published or presented work
	Visible leadership and collaboration with industry partners.	The service development work is shared nationally and locally via service board and national forums. CIVAS@IP5 have actively engaged commeric al partners win relation to technology improveements and development and also the pharmaceutical industry such as having the UKs first direct national purchasing contracts. This has improved financial expenditure on these medicines and improved medicines resilience during shortage issues nationally.
Effective Care – Information governance		All aspects of the CIVAS@IP5 service adhere to the ALCOA+ and regulatory principles for information governance and data integrity.
Effective Care – Record Keeping	Good record keeping is essential to ensure that people receive effective and safe care. Services must ensure that all records are maintained in accordance with legislation and clinical standards guidance.	All documentation is completed and recorded in line with legislation and EU GMP guidance. Adherence is monitored via internal audit

Workforce	Effective workforce plans integrated with service and financial plans	Workforce requirements are reviewed 6 monthly to develop a workforce that meets the service requirements and falls within the agreed operating budget.
	Have appropriate skill mix of staff	Capacity plan ensures the right mix off staff are available to perform tasks daily.
	Promote continuous improvement through better ways of working	Periodic workforce meetings to review working practices against performance metrics and regulatory changes take place.
	Staff are appropriately recruited and trained	All staff undergo nationally recognized technical services training programs as well as internal validation of processes, methods and equipment usage. These are reviewed and updated every 6 months.
	Staff able to raise concerns over service delivery, treatment, or management	Staff are provided the opportunity during team meetings, individual discussion or via annual PADR process to raise concerns Staff have access to all relevant NWSSP and All Wales policies in relation to raising concerns.
	Dealt with equitably and fairly when performance causes concern	Concerns with staff performance are dealt with via the relevant All Wales policies around performance management and dignity at work.
	Maintain workforce support around training, appraisals, CPD and have access for collaborative working	All staff receive support and time out to undertake adequate appraisals, training and CPD as required. Each staff member is given communication around

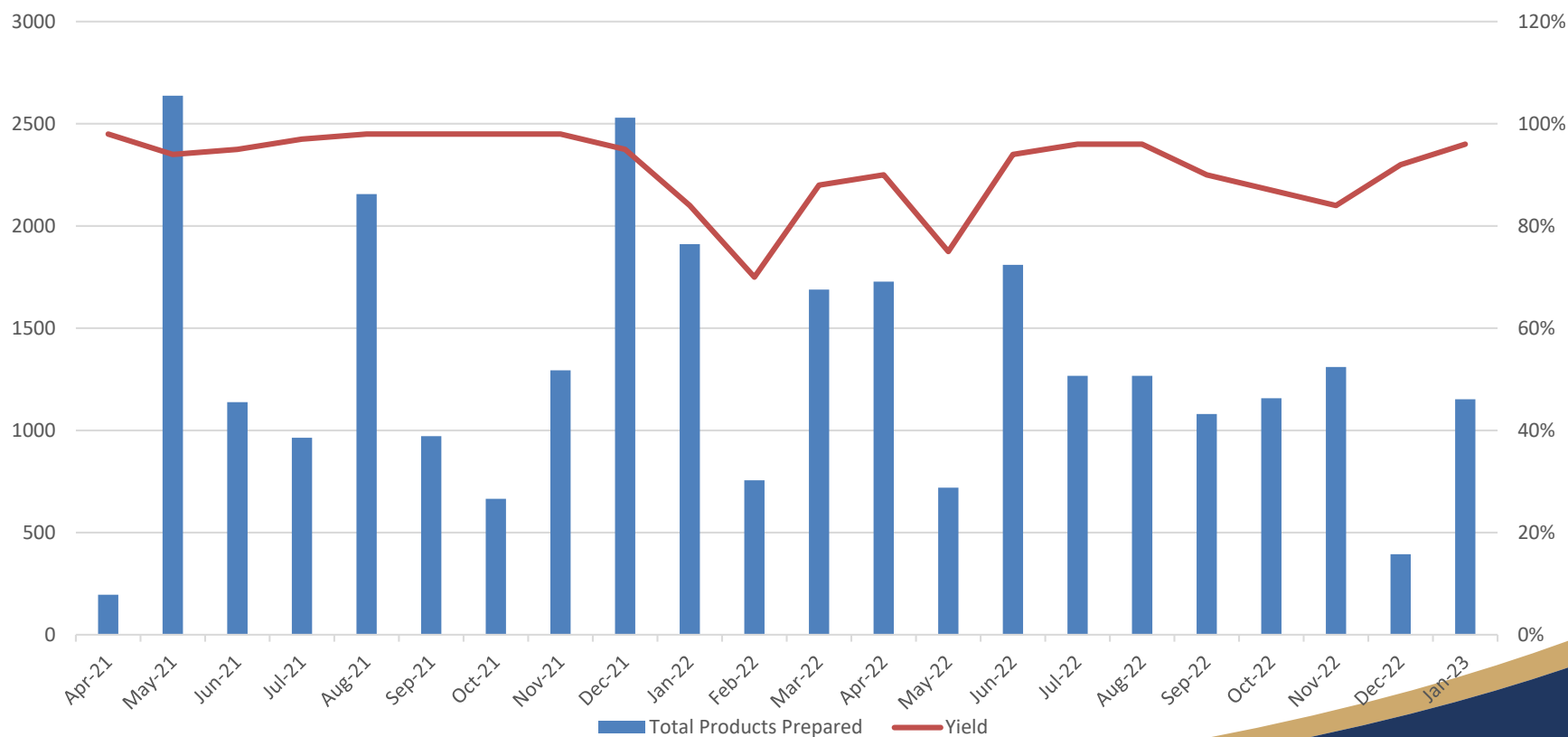|		opportunities for further development via internal and external training.

CIVAS@IP5 Service Board

Service and Quality Report
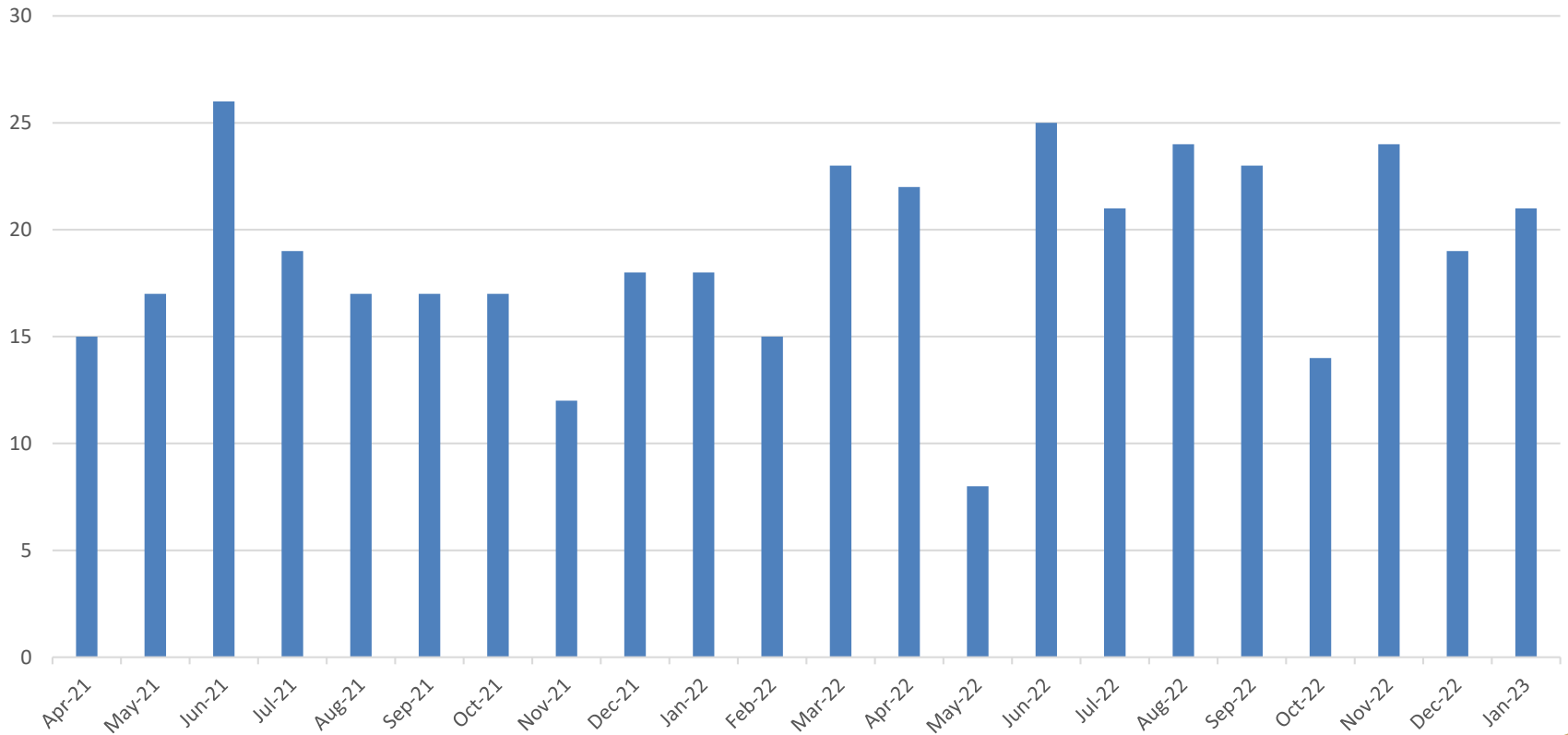
Batches Prepared
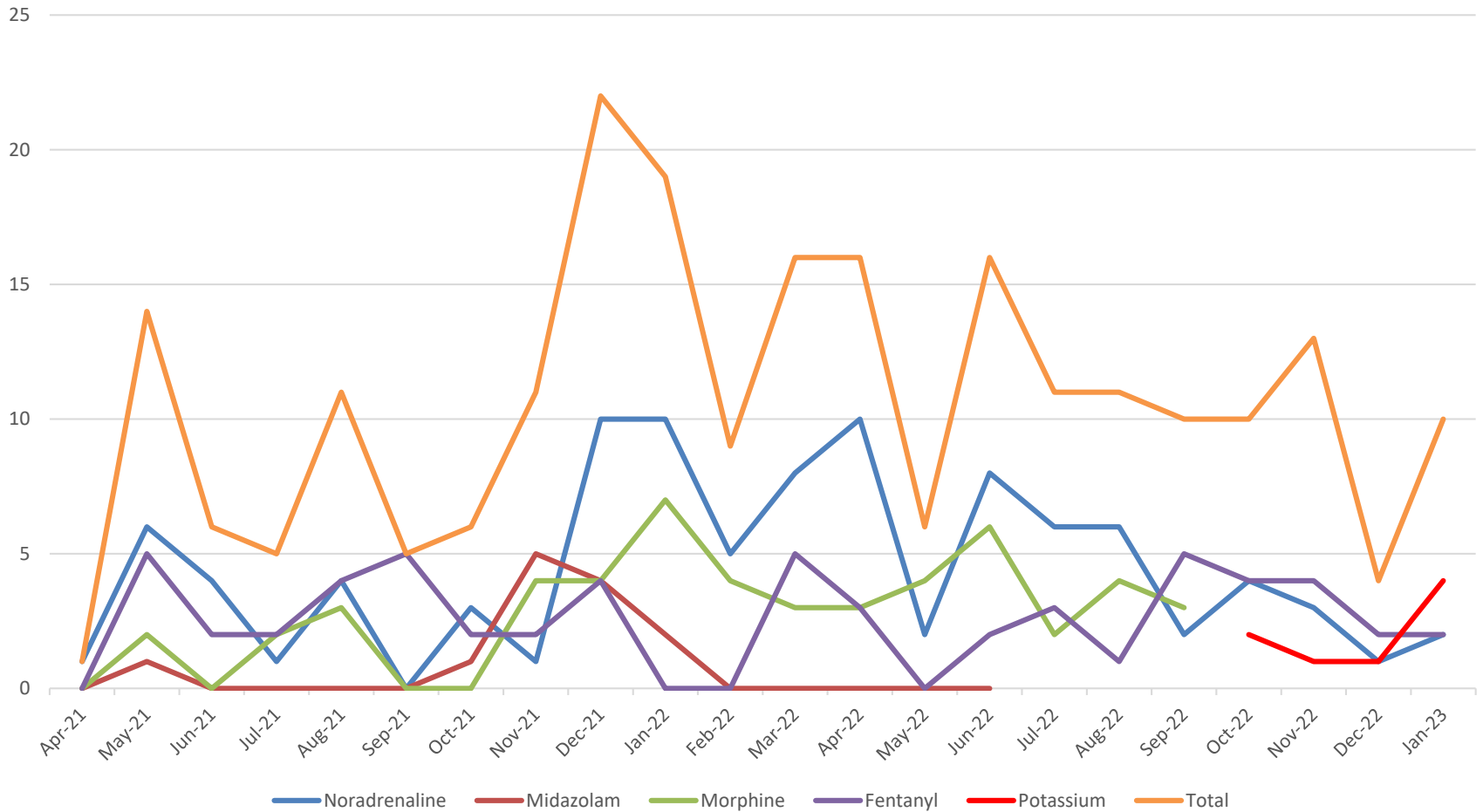
Total Production and % Yield

Monthly Production Numbers and % Yield
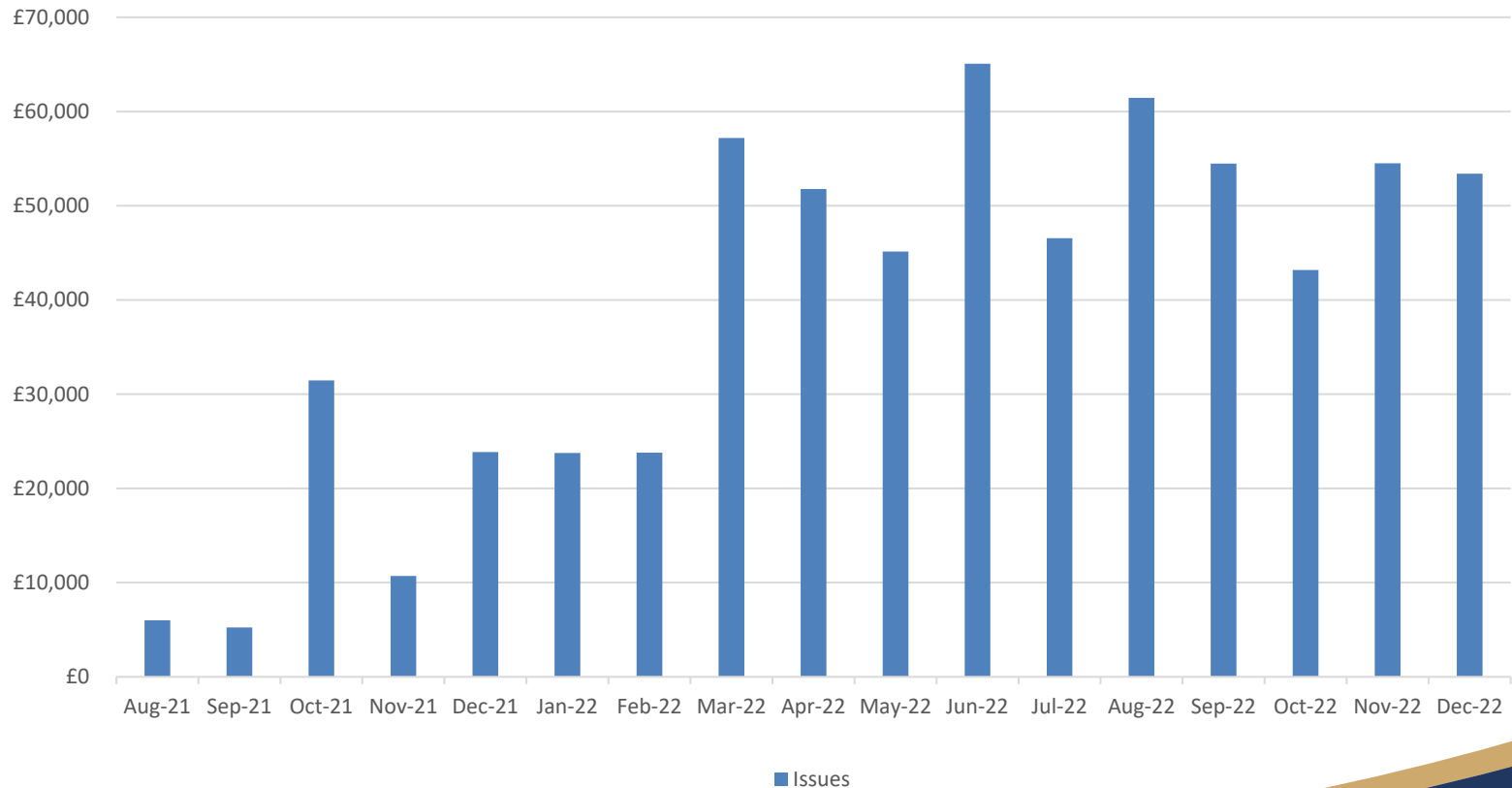
Production Orders Received

Rixathon Wholesale Dealing Service

Monthly Rixathon Issue Values

COVID-19 Vaccine Service

Errors & Critical Deviations

Errors & Critical Process Deviations
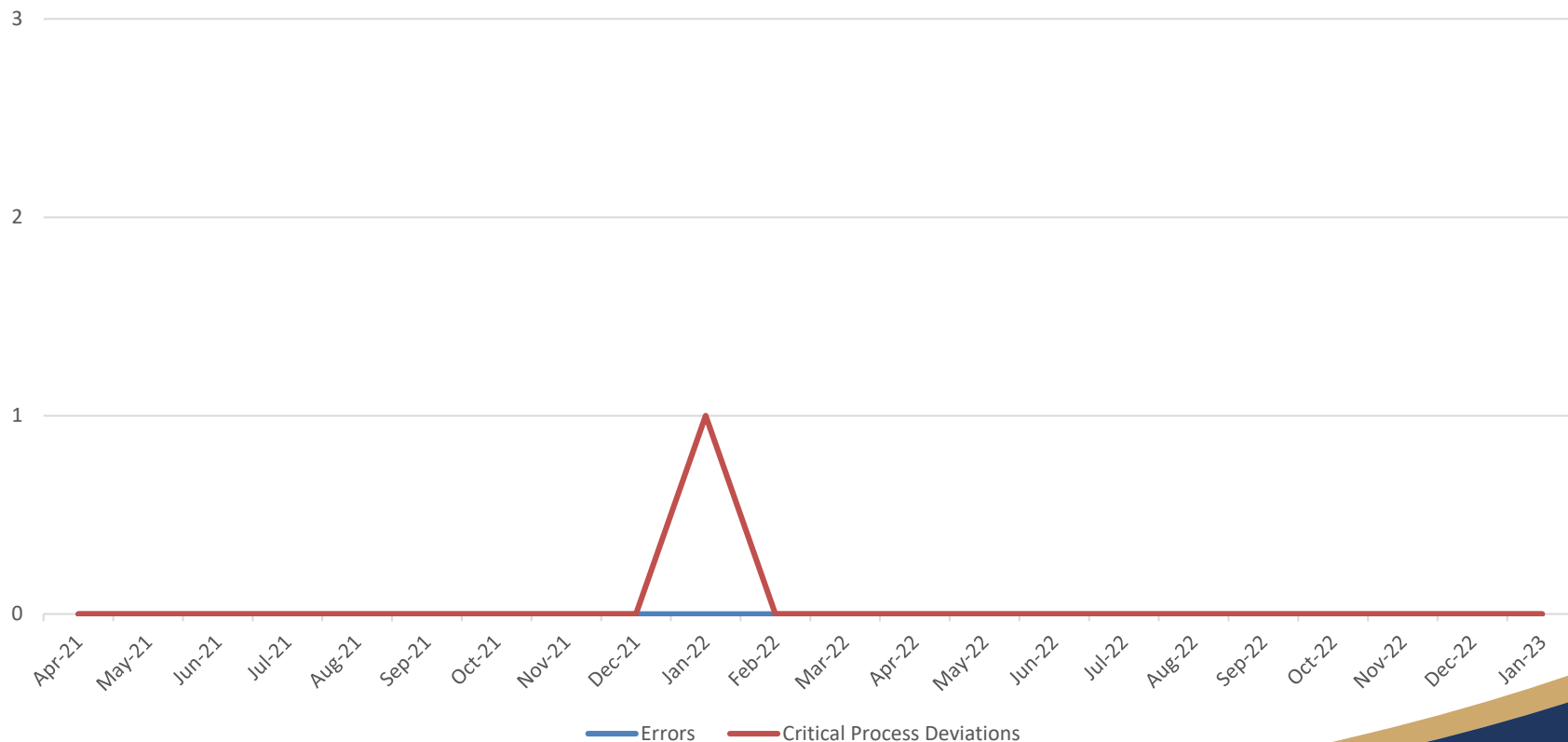
Facilities & Equipment Deviations

Quality Management System Metrics

Internal Audit Compliance
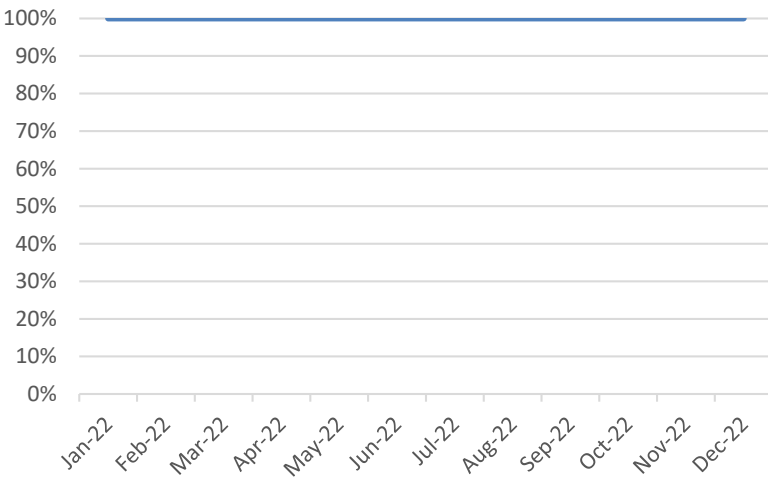
Service Complaints
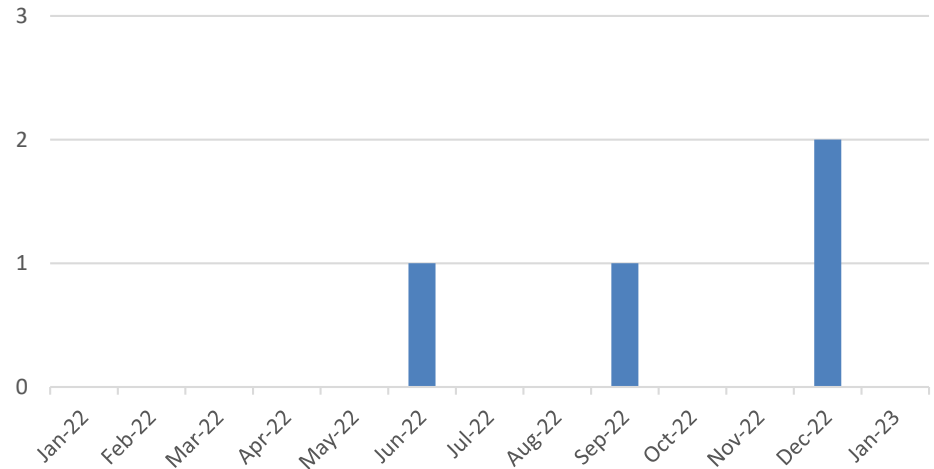
Environmental Failure Rates of Rooms and Operators
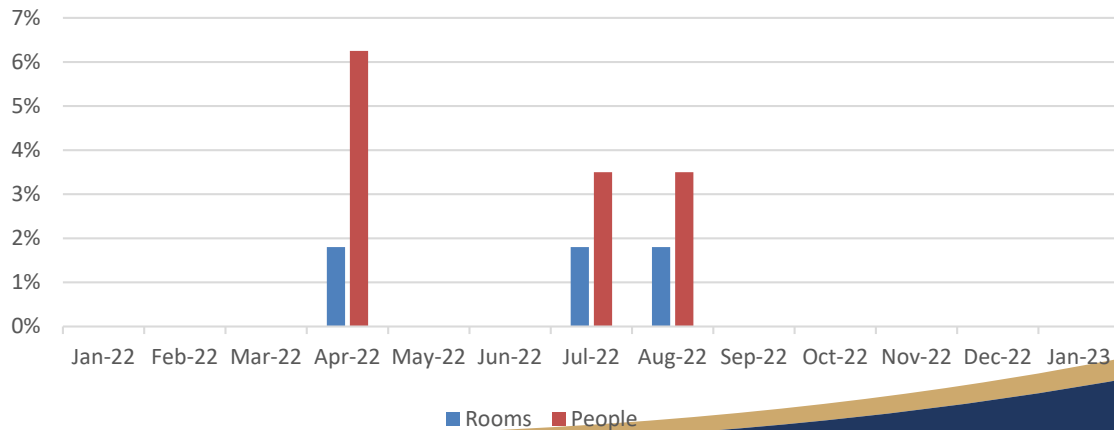
Other Quality Metrics – Nov 22

Operator Revalidation within target date – 80%

Documentation review rate – 92% (92% Target)

Equipment Service/Calibration – 100%

Service Development/Updates

- Potassium Chloride 50mmol in 50mL product now being supplied to 2/7 health boards.

- Welsh Government Flu Contingency stock now being issued on ad hoc basis via Wholesale Dealing services.

- Atezolizumab batches have commenced manufacture and engagement with UHB underway for ordering – Velindre to supply orders in March-23

GIG CYMRU NHS WALES | Partneriaeth Cydwasanaethau Shared Services Partnership

QUALITY, SAFETY & PERFORMANCE COMMITTEE

DUTY OF QUALITY NWSSP READINESS

DATE OF MEETING	16th March 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	N/A

PREPARED BY	DR RUTH ALCOLADO
PRESENTED BY	Dr Ruth Alcolado
EXECUTIVE SPONSOR APPROVED	Dr Ruth ALCOLADO

REPORT PURPOSE	FOR NOTING

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

ACRONYMS

1. SITUATION

The paper is to provide the Quality, Safety & Performance Committee with an assessment of NWSSP readiness to comply with the requirements of the Duty of Quality.

2. BACKGROUND

The Health and Social Care (Quality and Engagement) (Wales) Act 2020 introduces the Duty of Quality (the Duty):

- Guidelines issued for consultation in October 2022
- Consultation process closed on 17 January 2023
- Quality standards are yet to be issued

The legislation will come into force 1 April 2023 and the first annual report will be due in June 2024.

"Quality is defined as continuously, reliably, and sustainably meeting the needs of the population that we serve.

In achieving this, Welsh Ministers and NHS bodies will need to ensure that health services are "safe, timely, effective, efficient, equitable and person-centred"

The former duty was to "monitor and improve healthcare" whereas the new duty is to "secure quality in health services".

The main difference is that the new Duty applies to clinical and non-clinical NHS Services, and therefore the services and functions of NWSSP will be captured by the new legislation.

Quality by Design
To drive quality forward requires a positive effort: good quality does not happen by accident.

There are 4 key organisational elements that need to be in place to drive quality service delivery and create a learning environment:

- designing services and processes that drive quality
- aligned strategic objectives and values which prioritise quality

Quality PLanning

- having an agreed way of verifying process integrity and adressing non-compliance.
- includes audit, benchmarking, external QA schemes, peer review

Quality Assurance

- Using proven methodology to improve delivery of the 6 domains of quality: STEEPE
- Using improvement methodology to answer complex problems where the answers are not yet known

Quality Improvement

Quality Control

- Real time processes that ensure systems are performing to agreed quality standards

There are 6 Domains of Quality set out in the Duty and 5 Quality Enablers:

6 Domains of Quality:
- **S**afe
- **T**imely
- **E**ffective
- **E**fficient
- **E**quitable
- **P**erson Centred

5 Quality Enablers:
- Leadership
- Culture and Valuing People
- Data to knowledge
- Learning, improvement, and research
- Whole system perspective
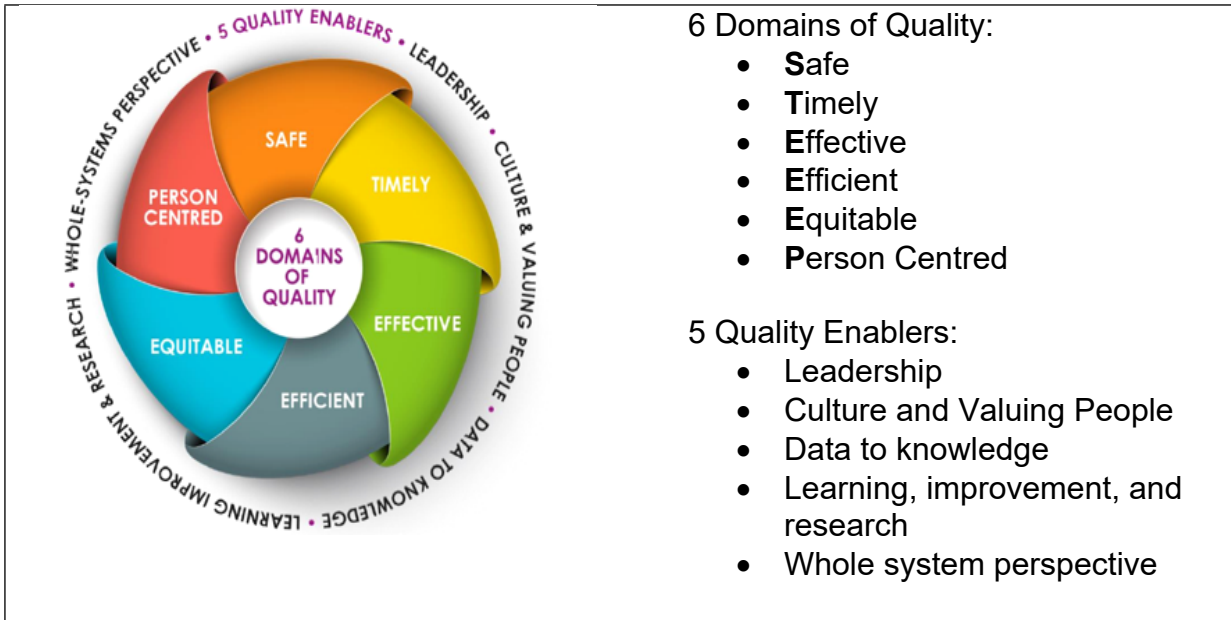
3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

All NHS organisations in Wales have been required by the Welsh Government (WG) to complete an assessment of readiness. The NWSSP Lead for Duty of Quality is a member of the WG Duty of Quality and Candour Implementation Group which has been set up as part of the implementation process.

This is included as **Appendix A.**

Responsibilities within the Act:

- Primary responsibility in the context of NWSSP rests with the Neil Frow as Managing Director and Accountable Officer.

- Dr Ruth Alcolado, NWSSP Medical Director appointed as lead for strategic implementation and oversight.

- 'Board' oversight will be provided through the Partnership Committee arrangements.

- Statutory Guidance due to be issued March 2023.

Readiness:

- Informal SLG discussion session on 16 March 2023.

- Proposal for Duty of Quality reporting to be presented at Partnership Committee identifying:
  - Proposal for reporting to Partnership Committee our own Quality measures, both 'always on' reporting and annual report.

  - Process for providing Health Boards, Trusts, and Strategic Health Authorities with relevant information for them to use as part of their own DoQ reporting.

  - Reporting via Velindre Quality & Safety Committee (approx. quarterly) and via the Velindre University NHS Trust annual quality report (from 2024) as a NWSSP separate chapter.

- Creation of a working group to support the strategic lead in the implementation throughout the NWSSP organisation.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

5. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **NOTE** the **Duty of Quality NWSSP Readiness**.

Appendix A

QSP 13/3/2023 Duty of Quality NWSSP Readiness

Appendix A – NWSSP Assessment of Readiness

Level 1	Exploring and Preparing
Level 2	Planning and Resourcing
Level 3	Implementing and Operationalising
Level 4	Full Implementation

Theme	**Roadmap Milestones**	**Baseline @ Dec 2022**	**Position @ January 2023**	**Position @ February 2023**	**Comments for latest update**
Leadership and culture	Senior responsible leadership in place and driving implementation work	2	4	4	Medical Director appointed lead for DoQ
	All staff recognise and understand the organisation's Quality vision, and their roles within it	2	3	3	Confident that in line with our values and quality statements that staff recognise the quality vision and their role. Line of sight and all staff responsibility work ongoing
	Commitment, resources and infrastructure in	2	2	2	Planning work ongoing to split the dual role of NWSSP in providing HBs and trusts with data to

	place to implement Duty effectively				allow them to report on DoQ of work we undertake on their behalf and then work that we provide which will be reported to Partnership Board and through VNHST as host organisation. Proposal for March Partnership Board
Decision-making	Processes and systems in place to provide demonstrable evidence that Board decisions have been made through Quality lens	3	3	3	In place, but taking opportunity of the implementation of the DoQ to review and provide Partnership Board with all appropriate information
Governance and accountability structures	Board are assured that DoQ is being considered across system	1	2	2	Impact of DoQ on internal and external reporting under review
	Routine governance documentation is DoQ-ready	1	2	2	Impact of DoQ on internal and external reporting under review and awaiting statutory guidance documents
Reporting and information (data to knowledge)	Mechanism and publication schedule / plan in place for sharing DoQ progress information externally	1	1	2	Discussions on hosting arrangements and dovetailing with existing governance arrangements in progress
	Quality-related information escalation mechanisms in place, with plans for review and consideration at appropriate level	3	3	3	Existing quality metrics and reporting is part of an ongoing review
Commissioning	A clear and corporately agreed understanding of changes required to incorporate DoQ requirements into all	1	1	2	Under review what impact this will have

	commissioning arrangements				
Hosting	A clear and corporately agreed understanding of changes required to incorporate DoQ requirements into hosting arrangements	1	1	2	As noted above – hosting arrangements under discussion
Quality Standards	A clear understanding of changes required to existing quality infrastructure and agreed programme of work to align with Quality Standards 2023	2	2	2	NWSSP were already looking at aligning quality outcomes to other policy drivers and the infrastructure required. DU quality standards are likely to be predominantly clinical and not applicable – guidance awaited.
Quality management system – general	A clear understanding of, and commitment to, a quality management system, with plans in place to identify requirements and current gaps	2	2	2	QMS via quarterly divisional reviews as well as use of national quality metrics feed into processes which identify new developments and gaps within existing services. Benchmarking and external accreditation are quality measures in regular use.
Communication and engagement	All staff are aware of key DoQ messages tailored to their organisation	2	2	2	Planning further comms and engagement including all staff coffee morning
Training and education	At least one member of Board trained, knowledgeable and able to influence Board in relation to DoQ	3	4	4	In place

QUALITY, SAFETY & PERFORMANCE COMMITTEE

NWSSP HEALTH AND CARE STANDARDS ACTION PLAN

DATE OF MEETING	16th March 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	N/A

PREPARED BY	Roxann Davies, Corporate Services Project Manager, NWSSP
PRESENTED BY	Roxann Davies, Corporate Services Project Manager, NWSSP
EXECUTIVE SPONSOR APPROVED	Ruth Alcolado, Medical Director, NWSSP

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME
Senior Leadership Group, NWSSP	23/02/2023	ENDORSED FOR APPROVAL

ACRONYMS	
NWSSP	NHS Wales Shared Services Partnership
SLG	Senior Leadership Group

1. SITUATION

The paper is to provide the Quality, Safety & Performance Committee with an update as to the NWSSP Health and Care Standards Action Plan.

2. BACKGROUND

The Standards for Health Service in Wales provide a framework for consistent standards of practice and delivery across NHS Wales and for continuous improvement. In accordance with the programme of Internal Audits, the process is tested and is an integral part of the organisation's assurance framework process. The Framework comprises seven main themes and sub criteria against which NHS bodies need to demonstrate compliance:

- Governance, Leadership & Accountability
- Staying Healthy
- Safe Care
- Effective Care
- Dignified Care
- Timely Care
- Individual Care
- Staff and Resources

At the Informal Senior Leadership Group meeting on 13 October 2022, the Health and Care Standards Self-Assessment was presented for discussion and consultation at a Directorate level. Feedback was reviewed and incorporated into the Self-Assessment and the document was subsequently approved. The Self-Assessment was endorsed by the Velindre University NHS Trust Quality and Safety Committee in November 2022 and was presented to the Partnership Committee and Audit Committee in January 2023, for further endorsement.

The overall rating against the mandatory Governance, Leadership and Accountability module and the seven themes reflects NWSSP's overall compliance against the Health and Care Standards and was rated as a 4. This rating is based on the work undertaken to address staff well-being across the organisation, in line with A Healthier Wales and as a result of the recovery and response work undertaken in relation to the pandemic. An assessment level rating of 4 sets out that "*we have well-developed plans and processes can demonstrate sustainable improvement throughout the organisation*".

3. ACTION PLAN

Following approval of the Self-Assessment, an Action Plan to manage and monitor areas whereby we may develop and strengthen our compliance against the Standards has been developed, linked to the wider well-being agenda, which is attached at **Appendix 1**, for progress to be **NOTED**.

The actions identified in the Action Plan will be monitored corporately, working towards achieving a self-assessment rating of 5, which sets out that "*we can demonstrate sustained good practice and innovation that is shared throughout the organisation, and which others can learn from*".

4. QUALITY DUTY

In light of the commencement of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 and the associated duty that this brings upon the organisation, this is likely to alter the way in which we report and approach this Self-Assessment, going forward. It is hoped that the Duty will lend itself better to NWSSP and the Services that we provide to NHS Wales.

The approach supports the five ways of working (Sustainable Development Principle) in the Well-being of Future Generations (Wales) act 2015, to achieve a Healthier Wales. The Duty will see active consideration of whether decisions will improve service quality and secure improvement in outcomes and applies to all health services functions (not just clinical), requiring health services to demonstrate that quality is at the heart of all we do. There will be a system-wide approach to achieving quality of care in a way that secures continuous improvement and in addressing this, we will consider the domains of quality and how these apply to NWSSP:

- *Safe*: Avoiding harm to patients from the care that is intended to help them;
- *Effective*: Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively);
- *Patient-centred*: Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions;
- *Timely*: Reducing waits and sometimes harmful delays for both those who receive and those who give care;
- *Efficient*: Avoiding waste, including waste of equipment, supplies, ideas, and energy; and
- *Equitable*: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

In recognising the role that NWSSP plays in terms of the Services that we deliver within NHS Wales and our contributions through these Services (both directly and indirectly) towards the well-being of the wider population of Wales, we have chosen to include links to case studies within the current Self-Assessment, to help to tell the story of the organisation's impact.

5. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	• Health and Care Standards Self-Assessment for NWSSP
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required

LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

6. RECOMMENDATION

- The Quality, Safety & Performance Committee is asked to **NOTE** the progress made towards the NWSSP Health and Care Standards Action Plan.

APPENDIX 1
NWSSP Health and Care Standards Self-Assessment
Action Plan

No.	Action	Standard	Responsibility	Timescale
1.	To host an annual virtual Health and Well-being Conference for staff across NWSSP.	Staying Healthy	People & Organisational Development	31/10/2022 Complete
2.	To develop and launch NWSSP's Health and Well-being Strategy.	Staying Healthy	People & Organisational Development	31/10/2022 Complete
3.	To continue to develop the equality, diversity and inclusion offering for staff within NWSSP.	Staff and Resources	People & Organisational Development	31/03/2023
4.	To analyse the Agile Working Staff Survey data to inform the redesign of the NWSSP Travel Plan.	Governance, Leadership and Accountability	Corporate Services / Planning, Performance and Informatics	31/03/2023
5.	To review the Equality Integrated Impact Assessment (EQIIA) process and suite of documentation.	Governance, Leadership and Accountability	Corporate Services	31/03/2023
6.	To review the approach taken by NWSSP as to the Health and Care Standards with the introduction of the Quality Bill and associated duties.	Governance, Leadership and Accountability	Medical Director / Corporate Services	31/03/2023

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

TRUST RISK REGISTER

DATE OF MEETING	16.03.2023

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	02.03.2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
The Executive Management Board discussed and noted the contents of the report. Challenge provided on ensuring there are SMART actions for all risks.	

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	1 – Action Plan for each risk needs strengthening. (To note assessment discussed at EMB on 02.03.2023, following the challenge provided further work has been completed on action plans which may result in enhanced recommendation in the next reporting cycle.

APPENDICES	
1	Current risk register data.
2	Level 12 Risks – Scrutiny Assurance Statements

1.   SITUATION

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

2.   BACKGROUND

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

3.   ASSESSMENT

3.1   Trust Risk Register

There are a total of 19 risks to report to Board and Committee on Datix 14, this includes 13 risks with a current score over 15 and 6 risks with a current score of 12, reported in the 'Safety' domain.   The information is pulled from Datix 14.

4.   SUMMARY OF MATTERS FOR CONSIDERATION

4.1   The Risk Register
- The risk register detail in Appendix 1 is for consideration by the Quality, Safety and Performance Committee.
- Action plans for risks are currently under review in divisions with transition to SMART actions being undertaken.   Action plans can be viewed in the risk register on Appendix 1.
- 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.
- To note that during the focus on SAMRT actions during this reporting period has resulted in agreement for the need for a more specific guidance section to be added into the Datix How To Guide – this will be completed by end April 2023.
- Risk 2393 current had no up to date action plan, however it is judge this is likely to be closed given the extent to which IPC learning from Covid-19 now embedded in the operation and once confirmed via the owner, this will be updated.
- There were two specific risks discussed in January Quality Safety and Performance Committee:

- o Risk ID 2187: Radiotherapy Physics Staffing – on review, score has decreased t0 10 based on current assessment, In future, based on outcome of 2023/4 IMTP approval and any further risks resulting from that will be reassessed at that point in upcoming report cycles.
- o Risk ID 2465 - Number of emails medics are receiving, especially those related to clinical tasks. The title has been updated to more clearly reflect the matter. The risk remains at 16 with the actions, assigned timescales and owners now recorded in Datix.

4.2 Risk Appetite Next Steps in Engagement and Embedding

- The approved Policy and Procedure are now on the intranet, with links on both divisional intranet pages.
- Part of level 2 training already included the concept and importance of risk appetite. This cohort will also receive specific regular risk briefings – including on Risk Appetite refresh outcome.
- All challenging each other in strategic decision making to active and relevant.

4.3 Level 12 Risks – Scrutiny Assurance

- Following a request from Audit Committee and Quality, Safety and Performance Committee statements were submitted to the Executive Management Board for consideration (Appendix 3). These statements are being strengthened in divisions and will updated to ensure specifically addressing requirements ahead of the next reporting cycle.

4.4 Training

- Level 1 mandatory training for all staff completed and loaded onto ESR. Initial management of initial completion will be tracked via the Trust risk weekly meeting and reported into Executive Management Board. The on-going requirement will be to complete it every two years.

5. IMPACT ASSESSMENT

RELATED TRUST STRATEGIC GOAL(S)	Please indicate whether or not any of the matters outlined in this report impact the Trust's strategic goals.
	Please indicate here
Please tick all relevant goals:	
. Outstanding for quality, safety and experience ☒	

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

RELATED STRATEGIC TRUST ASSURANCE FRAMEWORK RISK	06 - QUALITY & SAFETY

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

SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED	Not required
	There are no socio economic impacts linked directly to the current risks in paper.

TRUST WELL-BEING GOAL IMPLICATIONS/IMPACT	Choose an item.
	There are no direct well-being goal implications or impact in the current risks in this paper.

	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	This section should outline the financial resource requirements in terms of revenue and / or capital implications that will result from the Matters for Consideration and any associated Business Case. Narrative in this section should be clear on the following: **Source of Funding**: Choose an item. Please explain if 'other' source of funding selected: Click or tap here to enter text. **Type of Funding:** Choose an item. **Scale of Change** Please detail the value of revenue and/or capital impact: Click or tap here to enter text. **Type of Change** Choose an item. Please explain if 'other' source of funding selected: Click or tap here to enter text.
EQUALITY IMPACT ASSESSMENT	No - Include further detail below
	There is no direct equality impact in respect of this paper, however each risk will have an impact assessment where appropriate.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

	Click or tap here to enter text.

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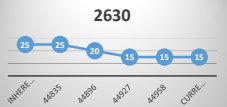
ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	The risk register is detailed in Appendix 1 and throughout the paper.
WHAT IS THE CURRENT RISK SCORE	NA
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	Actions plans for individual risk require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

APPENDIX 1

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

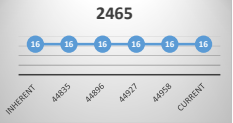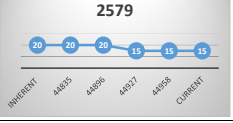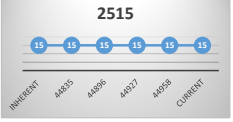| RAG rating	ACTIONS	OUTCOMES	RAG rating	SUMMARY STATEMENTS OF 7 LEVELS
Level 7	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions,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

ID	Risk Title - New	Risk Type	Opened	Approval status	Division	RR - Current Controls	Risk (in brief)	Rating (current)	Rating (Target)	Review date	Action Plan	Number of Days Risk has been open	Risk Trend
2774	There is a risk to quality/complaints/audit/GxP as a result of use of outdated legacy systems, leading to increased risk of incorrect test results and clinical advice.	Quality	27/10/2022	Accepted	Welsh Blood Service	Middleware has been developed in house to support interfacing to transfer data from a single laboratory software (HLA Fusion) to WHAIS IT. Minimal updates progressed within constraint of system and available IT SME resource.

Patient results are verified prior to issue. | (This refers to line reference number 2.0 on FMEA) WHAIS in-house developed IT applications are built using legacy FoxPro and DOS based technology that is no longer supported. There is only one FoxPro developer within WBS Digital Services team and there is limited ability to access agency resource with required level of FoxPro expertise. Staff are required to print results from analysers and manually enter complex, scientific results into IT systems that require either double entry or verification by a 2nd scientist. Increased risk of data entry/transcription errors could potentially lead to incorrect test results and clinical advice which could impact patient safety. | 16 | 4 | 14/04/2023 | Complete actions for replacement LIMS - see risk 2776 due date 31.07.2024
Review risk 14.04.2023 | 133 | 2774 |
| 2776 | There is a risk to performance and service sustainability as a result of the ongoing use of outdated, legacy systems, leading to the inability to enhance services to meet business needs. | Performance and Service Sustainability | 27/10/2022 | Accepted | Welsh Blood Service | Working group to manage prioritisation of a 'backlog' of urgent development work, shore up the system, and prevent critical failure.

Minimal updates progressed within constraint of system and available IT SME resource.

Patient results are verified prior to issue. | (This refers to line reference number 6.0 on FMEA) WHAIS in-house developed IT applications are built using legacy FoxPro and DOS based technology that is no longer supported. There is only one FoxPro developer within WBS Digital Services team and there is limited ability to access agency resource with required level of FoxPro expertise. This may lead to inability to enhance WHAIS services to meet business needs and/or other factors such as changes to external regulatory requirements. Increased risk of data entry/transcription errors could lead to incorrect test results and clinical advice, potentially impacting patient safety.
This could also lead to reputational damage as unable to update systems in line with stakeholders requests. | 16 | 4 | 14/04/2023 | Secure Funding for replacement LIMS due date 28.04.2023
Tender for replacement LIMS - due date 31.05.2023
Review risk - due date 14.04.2023
Implement replacement LIMS - due date 31.07.2024 | 133 | 2776 |
| 2800 | Newly discovered services at Asda | Performance and Service Sustainability | 02/11/2022 | Accepted | Transforming Cancer Services | 1. Secure site investigation from Welsh Water | There is a risk that the high-pressure water main at Asda, which have recently been discovered, will need to be moved, which may lead to a delay of several months to Asda's works. | 16 | 6 | 16/01/2023 | No action plan | 127 | 2800 |
| 3011 | There is a risk that the continuation of safe patient care may be adversely affected resulting in harm | Safety | 22/12/2022 | Accepted | Velindre Cancer Centre | Immediate escalation to DHCW for investigation.
2. Identified bugs to be resolved.
3. An amendment to the shredding scheduler.
4. DHCW to extend the Contractor to apply identified development to support resolution of issue.
5. Rewrite the VCC import process to complete a full reconciliation between what is held by DHCW and what is held by VCC each refresh

6. Patient appointment and test requests to be completed in due date order to reduce risk of missed appointments.
7. Additional support to be identified and put in place to process and book all patient activity.
8. Patients to br contacted by telephone and verbally advised of appointment due within 14 dyas to reduce risk
9. Phlebotomy to be completed at VCC to reduce risk of delay to treatment (where the next appointment is scheduled to take place within 14 days) | Technical failure of the data shredding process within the national service has meant that not all clinic outcome instructions are being made available within the Outpatient Oncology Note Report, and therefore not acted upon. | 20 | 5 | 21/03/2023 | Risk to be reviewed - due date 09.02.2023 | 77 | 3011 |
| 3042 | There is a risk that IF the new Laboratory Information Management System (LIMS) service is not fully deployed before the contract for the current LIMS expires in June 2025 THEN operational delivery of pathology services may be severely impacted RESULTING IN potential delays in treatments, affecting the quality and safety of a broad spectrum of clinical services and the potential for financial and workforce impact. **NATIONAL LINC RISK** | Performance and Service Sustainability | 07/02/2023 | Accepted | Velindre Cancer Centre | Business continuity options are being explored including extending the contract for the current LIMS to cover any short term gap in provisions. An expert stock take review of the LINC programme has been completed with findings presented to Collaborative Executive Group (CEG) to inform next steps. | The current (InterSystems) contract for TrakCare Lab is due to end in June 2025. The LINC programme has been established to deliver a replacement all-Wales LIMS system - the contract has been awarded to Citadel Health.

VCC pathology services are provided to Velindre by C&V ULHB. If the Citadel Health solution is not deployed into C&V UHB before June 2025, there is a risk to service delivery for the C&V-managed pathology laboratory.

The national DHCW / LINC programme team have requested this risk be recorded on all HB/Trust risk registers, to ensure appropriate visibility and ongoing monitoring. | 20 | 5 | 07/08/2023 | No action plan | 30 | NEW RISK - NOT ENOUGH DATA TO SHOW TREND |

3048	DHCR118(R) - There is a risk that patient's records in WPAS will not be updated correctly or at all. Caused by a reduced level of knowledge on the actual events that have occurred and lack of access to medical records e.g. paper notes, specialist clinical systems to make the appropriate decision on what should/shouldn't not be done in the record. The impact being inaccurate patient records and potential errors in patient pathways.	Performance and Service Sustainability	20/02/2023	Accepted	Velindre Cancer Centre	For the Project/Apps teams to cease making changes to patient record and to reinstate the data quality processes (as was pre go-live) i.e. Information Department send out daily DQ reports to service owners, who would review record and correct the data at source, feeding back to user to ensure correct next time. Or if the service unable to update, the service provide auditable, explicit instructions to Apps Support Team to manually update the record.	Please note this risk has been raised as part of the Digital Health & Care Record (DHCR - Canisc Replacement) programme and is ratified and managed via the DH&CR Project Board. DHCR118(R) - There is a risk that patient's records in WPAS will not be updated correctly or at all. Caused by a reduced level of knowledge on the actual events that have occurred and lack of access to medical records e.g. paper notes, specialist clinical systems to make the appropriate decision on what should/shouldn't not be done in the record. The impact being inaccurate patient records and potential errors in patient pathways.	20	9	13/03/2023	Internal discussions underway to help identify the re-occurring DQ issues, with a view to create associated service DQTLs	17	NEW RISK - NOT ENOUGH DATA TO SHOW TREND
2714	Interest Rates There is a risk that increased rates of interest before financial close lead to the costs of the project exceeding the affordability envelope.	Financial Sustainability	09/09/2022	Accepted	Transforming Cancer Services	1. Discuss with Welsh Government. CAPEX was increased during CD. Complete 2. Undertake a debt funding competition. If required this will be undertaken 3-4 months before financial close. Not started 3. Monitor interest in line with the financial index. Monitor inflation, maintain the contingency buffer within budget. NB this risk will be the responsibility of the participant after financial close. Ongoing	Interest Rates There is a risk that increased rates of interest before financial close lead to the costs of the project exceeding the affordability envelope.	16	12	22/12/2022	1. Discuss with Welsh Government. CAPEX was increased during CD. Complete 2. Undertake a debt funding competition. If required this will be undertaken 3-4 months before financial close. Not started 3. Monitor interest in line with the financial index. Monitor inflation, maintain the contingency buffer within budget. NB this risk will be the responsibility of the participant after financial close. Ongoing	181	2714
2612	Acute Oncology Service (AOS) Workforce Gaps	Workforce	28/07/2022	Accepted	Velindre Cancer Centre	Consultant on call is made aware of the AOS gap and will take responsibility for the 24 hour period that they are on call. AOS sessions have been put into consultant job plans going forward.	There is a risk that the AOS service at Velindre Hospital is not sufficiently resourced. As a result this could result in periods of time in which the service is not sufficiently covered and other medic's providing a limited service. This may lead to medic's becoming overworked and stretched due to their responsibilities and a full AOS gap specification not being delivered.	15	6	30/09/2023	reset' of local and national AOS programme or work to be undertaken due by 30.09.2023	224	
2630	DHCR062(R) - There is a risk that patients will still be live in Canisc at the end of the 12-week dual running period, caused by an increased number of patient treatment delays/suspensions. There will be a negative impact on service capacity with the additional need to manually migrate IRMER forms that are nearly complete or fully complete. This may further negatively impact BAU activities, such as the Mosaiq upgrade.	Performance and Service Sustainability	12/08/2022	Accepted	Velindre Cancer Centre	Working group has been established to consider all options and discuss potential measures and mitigations. An impact assessment and project plan is being written, requiring further review. Following the dual running period, may have to consider manual input of admissions and increased number of manually migrated IRMERs at the end of the duel running period. This would require a significant increase in resource.	Please note this risk has been raised as part of the Digital Health & Care Record (DH&CR - Canisc Replacement) programme and is ratified and managed via the DH&CR Project Board. Dual running initially estimated to be 6-8 weeks post go-live, in meeting 20/06/22 it was established it's now likely to be 12 weeks minimum - 6 weeks + 6 weeks of fractions - finish W/c 6th Feb - finish Friday 10th. Risk is that there are still patients in Canisc who haven't finished treatment at the end of dual running period. Following decision to run dual entry up to 12 weeks, there will be a resource requirement, which is planned for and now in place, but there are further specialist resource interdependencies beyond 12 weeks for which there is currently no mitigation, which will impact on other project timescales.	15	10	31/03/2023	Review to be undertaken within the next few weeks to align with end of 12 week dual running period. this will establish whether the issues still remains. if no longer an issue, risk will be closed - due date 31.03.2023	209	2630

ID	Description	Category	Date	Status	Location	Current Controls	Risk Detail			Review Date	Actions		Trend
2465	Number of emails medics are receiving, especially those related to clinical tasks.	Safety	05/11/2021	Accepted	Velindre Cancer Centre	No current controls - emails come in daily (including over the weekend) from within Velindre and outside (AOS teams, HB teams, primary care teams). An audit has been proposed to be undertaken on clinical emails, this will identify how many emails per day, time spent on clinical queries, where the emails originate from, how clinicians communicate that this is not the best route to forward clinical queries. Task and finish group to be established with key staff members in attendance.	The volume of emails received by medical staff is unmanageable. There is a risk of missing critical emails especially critical clinical questions. Clinical questions may not be responded to in a timely way or responses may not be accurate due to the pressure of responding to the number of emails received. This may lead to impact on patient care and staff wellbeing through stress, working additional hours to catch-up and potential for medical error due to distraction from other critical tasks. There is a secondary risk when colleagues are away so emails are not being actioned, and when they return, there is a huge backlog of messages to catch up on.	16	4	30/06/2023	An audit/survey to be undertaken to identify themes in order to determine how best to minimise taking into account clinical and service needs email etiquette to be developed as part of hybrid working tool kit and shared widely. Due date - 30.06.23	489	
2579	there is a risk to performance and service sustainability as a result of training curriculum changing to include acute oncology leading to inability to secure the required number of Palliative Care Trainees	Performance and Service Sustainability	10/06/2022	Accepted	Velindre Cancer Centre	Due to not recruiting through the national training programme, we are out to advert to fill the gaps by recruiting speciality doctors in their place. Where we are unable to cover gaps, we are temporarily providing support via oncology. this is a short term solutions as there is an impact on the ability to cover rota within the cancer centre. Where necessary the consultant will act down to cover the specialist registrar gap.	Due to the change in the content of the training position to include acute oncology, VCC has be unsuccessful in securing trainees. this is leading to significant gaps in the training rota. There is a national shortage for these roles	15	6	10/04/2023		272	
2515	There is a risk that staffing levels within Brachytherapy services are below those required for a safe resilient service. This may result in a lack of resource to develop the service, investigate incidents and cover for absences. This may impact on the quality of care due to a reduction in resilience and development of the service	Performance and Service Sustainability	09/02/2022	Accepted	Velindre Cancer Centre	Capacity is managed by careful examination of rotas, refusing leave and redeployment of staff from other areas. A programme of training sufficient staff to cover all areas and a review of staff numbers is taking place. An options appraisal is to be agreed through the Brachytherapy Operational Group (15-Mar-2023) to determine the most appropriate service model to meet forecast demand. A workforce paper will be drawn up to staff adequately staff the model and a business case will be submitted if required.	"Brachytherapy Staffing Levels at Velindre are low and recruitment and retainment of staff is not at the level required. There are a number of staff nearing retirement. There are also staff on maternity leave, sick leave, sabaticals etc. affecting staffing levels day to day." "There are a number of single points of failure within the service with a lack of cross cover, loss of single members of key staff could interupt patient treatment. Loss of trained staff leaves the service with a number of additional single points of failure. Training times are often long and impact on staff's current role. Staff can be sought from university cohorts but these are limited and the time required to train them to work within the Velindre service means they are not direct replacement for lost staff"	15	5	10/04/2023	workforce review in Q1/2 2023 to look at demand for next 5 years. Due date 10.04.2023	393	

ID	Risk Title - New	Risk Type	Opened	Approval status	Division	RR - Current Controls	Risk (in brief)	Rating (current)	Rating (Target)	Review date	Action Plan	Number of Days Risk has been open	Risk Trend
3001	There is a risk to safety as a result of work related stress leading to harm to staff and to service delivery.	Safety	09/12/2022	Accepted	Corporate Services	Policies and Procedures Managing Attendance @ Work Policy, Training and Toolkit Respect and Resolution Policy, Training and Toolkit Equality, Diversity and Inclusion Policy Managing Organisational Change Policy and Toolkit Hybrid working Flexible working Job descriptions/PADR process Training Development of 'Building our futures together programme' – Leadership Development, Behaviours, Compassionate Leadership Training and education managers on compassionate leadership (Inspire Programme) Access to internal and external training/career development Online resources Wellbeing and Engagement online resources Work in Confidence Platform External awards Corporate Health Standard Platinum Award Time to Change Wales signatory Monitoring of staff wellbeing Annual Staff Engagement Survey Monitoring of sickness absence figures by Board External wellbeing audits Organisational support Staff networks Occupational Health Employee Assistance Programme Mental Health First Aider network Access to Complementary therapy Mindfulness App Individual Stress risk assessments completed by manager Purchase of annual leave Financial advice, Salary sacrifice schemes. Blue light discounts. Car lease scheme. Cycle to work scheme Wellbeing activities/events Wellbeing rooms/facilities Healthy and Engaged Steering Group Clinical Psychologist for staff and teams – including proactive programme of engagement. Dialogue with Trade Unions	There is a risk to safety as a result of work related stress leading to harm to staff and to service delivery. HSE defines stress as 'the adverse reaction people have to excessive pressure or other types of demand places on them'. Staff employed by the Trust have a wide variety of roles including clinical and non-clinical, administrative support and patient/donor facing. Work in carried out at VUNHST premises, donation venues, in outreach centres. Some staff work in an agile way, working both at VUNHST premises and other locations including at home. Trust sickness absence figures show mental health issues and stress to be the highest cause of absence from work. Not all of this will be work related. The risk relates to all Trust employees HSE identifies six main areas that may lead to work-related stress if not properly managed: demands, control, support, relationships, role and change. Demand – workload, ability to do work required, conflicting priorities, work patterns, physical environment and violence and aggression. Control – pace of work and ability to take breaks. Development and use of professional skills. Support – lack of support for staff from managers and colleagues. Staff not know what support is available and how to access it. Relationship – negative behaviours, interpersonal and/or inter-team conflict, perceived unfairness. Bullying. Poor communication. Resolution procedures not accessed in a timely way. Role – lack of clarity and communication around roles and responsibilities. Change – lack of communication or poorly understood communication about proposed changes. Lack of support for staff during periods of change. Home/family/personal issues which may add to stress at work	12	9	01/04/2023	Stress risk assessments to be monitored by the Healthy and Engaged Steering Group	90	
2395	Deficiencies in compartmentation (fire-resisting construction, fire doors and fire dampers) – Velindre Cancer Centre	Safety	26/05/2020	Accepted	Corporate Services	1.As noted above, site has holistic fire strategy where compartmentation plays a key role 2.Site has high level of fire detection to WHTM 05 (Firecode) 3.Provision of fire safety training to support implementation of fire safety strategy 4.Program of fire safety risk assessments and annual fire safety audits including the identification and assessment of compartmentation 5.Inspection of compartmentation by 3rd party accredited surveyors and receipt of report and remedial actions in 2020 6.In support of management and prevent, Department managers responsible for regular workplace inspections including the monitoring of local fire precautions 7.Fire doors subject to regular visual inspection as part of Estates planned preventative maintenance regime 8.Consideration of fire risk assessment findings (including compartmentation issues) as part of Capital Refurbishment schemes.	Deficiencies in compartmentation (fire-resisting construction, fire doors and fire dampers) – Velindre Cancer Centre	12	9	28/04/2023	In support of management and prevent, Department managers responsible for regular workplace inspections including the monitoring of local fire precautions Fire doors subject to regular visual inspection as part of Estates planned preventative maintenance regime Consideration of fire risk assessment findings (including compartmentation issues) as part of Capital Refurbishment schemes.	1017	
2393	Infection control	Safety	19/06/2020	Accepted	Corporate Services	To be inserted	There is a risk that staff could contract COVID-19 in their working environment as a result of poor social distancing or hygiene Majority of control measures in Welsh Government guidance now in place. However the work on site utilisation and linking of this to the capacity planning framework is complex	12	9	10/04/2023		993	

| 2389 | Risk that patients with altered airways may not receive appropriate care from the MDT clinical team | Safety | 28/05/2021 | Accepted | Velindre Cancer Centre | UPDATE 02.11.22 - Risk score remains unchanged; still have challenges with reduced SLT workforce and training still ongoing with staff.
UPDATE 15.09.22 - Risk has been reviewed by Operational Senior Nurse and Head of Therapies and as a result of challenges with completing sufficient training for staff and reduced SLT workforce, this risk remains and should be re-opened. The risk score is also increased due to ongoing concerns around the management of patients with altered airways.
Update 29.06.22 - Head and Neck ANP has completed induction; she is working with the H&N team in clinic for exposure and scope of practice agreement and sign off. She is working on an Altered Airways Training Package for all staff at VCC with S&LT.
Update 27.05.22 - H&N ANP now completed induction and undergoing final competency checks. Working with Therapies team to develop training package.
Update 21.04.22 - Head & Neck ANP now in post. Recruitment for SDEC posts progressing well with B7 & B6 SLT appointed.
Update 10.12.21 - Recruitment underway for a Head & Neck Advanced Nurse Practitioner with interviews taking place w/c 13.12.21. MDT discussions take place pre-admission for this group of patients to assess needs and treatment requirements.
Update 03.11.21 - additional mitigating actions:
We are currently in the process of recruiting a Head & Neck Advanced Nurse Practitioner whose role will be to provide training for staff in the management of altered airways and ensure that there is appropriate cover for this service. MDT discussions take place pre-admission for this group of patients to assess needs and treatment requirements. Additional training has been sourced from C&V UHB and a Speech & Language Therapist with the relevant skills and expertise has recently been appointed to the VCC Therapies team.

•Group 1 patients
•1 x SLT works Mon/Tues and Thursday and able to see these patients with good skill level
•Advice available from PSU nursing team Mon-Fri in basic competency levels - needs scoping as there is potential for enhancing straining and assessment through this service.
•Ward Nursing staff – some basic skills – training needs analysis needs to be completed
•H&N CNS and consultant radiographer – skills need scoping but these work Mon-Fri, what are the opportunities for cover across the 7 days?
•Training being sourced by nurse education lead

•Group 2 & 3 patients
•Recent survey of competencies of VCC physios (available on request) with an action plan for roll out to the other disciplines
•Establish competencies and work out how best to complete/maintain them
•Link with Pall Care to determine a clearer pathway for when suction is required
•Benchmark as to what other areas do, i.e. Rookwood, Hospices, Cancer centres.
•Explore research further to identify clear precautions/contraindications for certain respiratory techniques for oncology patients
•Link with C&V physios and critical care team to access competency based training.
•Staff competencies across the organisation to be scoped and potentially access the C&V training for all.
•Re-instate the Altered Airways training for clinical staff asap | There is a risk that patients with altered airways may not receive care from the MDT clinical team with the necessary skills and competencies due to the frequency of staff being required to use these competencies (months between patients) and therefore their ability to train and maintain. This situation has been exacerbated by the retirement of a specialist nurse with expertise in airways management.
Definition of these patients fall into 3 groups;
• Head and neck patients with tracheostomy or laryngectomy stoma.
• Respiratory patients requiring suction
• Palliative patients requiring suction | 12 | 6 | 04/04/2023 | No action plan | 650 | |
| 2816 | There is a risk to the Cancer Centre from the uncontrolled spread of heat, flame, fumes and smoke as a result of errors in the fire alarm system | Safety | 15/11/2022 | Accepted | Velindre Cancer Centre | 1) Fire alarm system is subject to weekly test [including checks on cause & effect localised to the location of the activation] by VUNHST Estates.
2) Whole system subject to annual [4 no. quarterly visits] inspection, test and maintenance by competent contractor in line with BS5839-1 and manufacturer's recommendations.
3) VUNHST Estates have agreement with competent contractor for reactive maintenance in response to identification of any faults on the system with agreed response times based on level of severity/impact of the fault(s). | As well as giving appropriate warning to building users and the fire & rescue service, in order to limit the spread of heat, flame, fumes and smoke to protect unaffected areas of the building and preserve the integrity of escape routes, the fire alarm system at the Cancer Centre is set up to take control of identified fire doors, air handling units, dampers and other plant/equipment within a designated part [fire alarm zone]in the event of activation. During recent weekly tests, it has been identified that some of the anticipated outputs ["effects"] are not as understood. Additionally, there have been amendments to relevant NHS Wales guidance such WHTM 03 – Ventilation which need to be adopted by the system cause & effect. | 12 | 6 | 28/04/2023 | | 114 | |

Level 12 Risks – Scrutiny Assurance Statements

Assurance was requested during the last reporting cycle from the Audit Committee and the Quality, Safety and Performance Committee, that mechanisms are in place to review, and scrutinise risks that fall below the level reportable to Board and committees.

The following statements from divisions look to provide assurance regarding suitable scrutiny:

Welsh Blood Service:
All Open risks including Critical and Significant risks are reported monthly and presented to WBS SMT and Regulatory Assurance and Governance Group (RAGG) meetings. All risks are accepted by the Risk Owner (SMT member) and WBS Risk Management team review and monitor the management of risks on an ongoing basis.

Velindre Cancer Service:
The risk register is presented to VCC Quality Safety Management Group (QSMG) via bi-monthly meetings (12+ only) where any issues are discussed. The risk register is presented to SLT every month, which is presented by the Head of Nursing, Quality, Patient Experience and Integrated Care. Risk Leads are responsible for ensuring that risks are regularly updated and to provide assurance to the SLT and the Head of Nursing, Quality, Patient Experience and Integrated Care that the information contained in the Risk Register is accurate and kept up to date. It is the responsibility of the risk lead, or their nominated representatives, to ensure that any changes/updates to risk narrative arising from discussions at meetings are fed back to their directorate teams in a timely manner.

QUALITY, SAFETY AND PERFORMANCE COMMITTEE	
TRUST ASSURANCE FRAMEWORK	
DATE OF MEETING	16.03.2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	N/A
PREPARED BY	Mel Findlay, Business Support Officer
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance & Chief of Staff
REPORT PURPOSE	FOR DISCUSSION / REVIEW

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
CIRCULATED TO EMB MEMBERS OUT OF COMMITTEE	07.03.2023	Paper reviewed

1. SITUATION / BACKGROUND

1.1 The purpose of this paper is to provide the Quality, Safety and Performance Committee with an update on:

- The status of the Principal Risks identified in the Trust Assurance Framework (TAF) included at *Appendix 1,* which may affect the achievement of the Trust's Strategic Objectives, and the level of assurances in place to evidence the effectiveness of the management of those risks.
- The ongoing work to support the continued development of the Trust Assurance Framework across the organisation.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Key points from previous governance cycle:
Key points discussed in January/February governance cycle were:

- Many aspects of feedback from January Audit Committee, Quality Safety and Performance Committee and Trust Board, which resulted in agreement to review the core template to support the Trust Assurance Framework in reaching the next level of maturity.
  Update:
  - The Trust Assurance Framework template has been reviewed and updated, Independent Members who sit on the Audit Committee will be reviewing the template, which is anticipated for roll out in April 2023.

- Where there are gaps in 2nd and 3rd line of defence across the TAF risks, as part of the regular review Executive Leads now ensure cross reference to all 2nd and 3rd line related activity is captured, ensuring the information is captured correctly.
  Update:
  - As part of the regular review cycle the Risk and Assurance team support in respect of cross reference to the Audit Tracker and Legislative and Regulatory Tracker.
  - This will also form part of the Trust Assurance Framework updated supporting guide, which will be published alongside a new 'How to guide' following May governance sign off.

- Action logs continually developing to ensure where there are any partial assurance ratings or gaps in controls there are corresponding actions.
  Update:
  - To supporting the embedding of this, the template now includes seven levels of assurance for all actions.

2.2 Summary of Development of Framework in this reporting period:

- During sessions with both WBS SMT and VCC SLT the Strategic risk are being reviewed and refreshed; the outcome of which will be shared through the April (Committees) and May (Trust Board) 2023 governance cycle.

- Alongside the refresh of Strategic Risks the Trust Assurance Framework, effectively the policy level document, will be reviewed and refreshed ahead of the April/May 2023 governance cycle.

- The Trust Assurance Framework template has been reviewed and updated, Independent Members who sit on the Audit Committee will be reviewing the template, which is anticipated for roll out in April 2023.

- Sitting alongside the refreshed Trust Assurance Framework and Dashboard a 'How to guide' will be developed to assist in the completion

and update of the Trust Assurance review cycle and Dashboard.

- The Performance Framework and Quality Framework are considered in the new Trust Assurance Framework Dashboard template for further review.

- It is also important to note that the current work with Internal Audit on the 2023/4 plan, which will be brought to April Audit Committee, has used the Trust Assurance Framework as a key input.

3.0   Actions on specific strategic risks

TAF 01: Demand and Capacity
- **Residual Risk Score –** 12. This remains unchanged since the previous review and there is no specific evident trend emerging in the data.
- **Overall Level of Control Effectiveness –** This remains as Partially Met (PE)
- **Sources of Assurance –** There have been no changes to the sources of assurance.
- **Action Plan for Gaps Identified –** The action plan has been updated is largely progressing on target.

TAF 03: Workforce Planning
- **Residual Risk Score –** 12. The residual risk increased from 9 to 12 in the September 2022 governance reporting cycle and has remained at this level since that time.
- **Overall Level of Control Effectiveness –** This remains as Partially Met (PE)
- **Sources of Assurance –** The sources of assurance have been strengthened to include 2nd and 3rd lines of defence for all key controls.
- **Action Plan for Gaps Identified –** The action plan has been updated to provide a further level of detail and assurance on the planned timetable for delivery of the associated programme of work to mitigate this risk.

TAF 06: Quality and Safety
- **Residual Risk Score –** 15. This remains unchanged since the previous review with no trend emerging since March 2022.
- **Overall Level of Control Effectiveness** – This remains as Partially Effective (PE), unchanged since the last review**.**

- **Sources of Assurance –** Gaps in assurance remain unchanged since the last review.
- **Action Plan for Gaps Identified –** The action plan remains unchanged since the last review.

TAF 08: Trust Financial Investment
- **Residual Risk Score –** 12. The residual risk decreased from 16 to 12 in the July 2022 governance reporting cycle and has remained at this level since that time.
- **Overall Level of Control Effectiveness -** This remains as Partially Met (PE)
- **Sources of Assurance –** There have been no changes to the sources of assurance.
- **Action Plan for Gaps Identified –** There have been no changes to the gaps in assurance.

3. **IMPACT ASSESSMENT**

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes
	Please refer to *Appendix 1* for relevant details.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. **RECOMMENDATION**

The Quality, Safety and Performance Committee is asked to:

DISCUSS AND REVIEW the update to the Trust Assurance Framework Dashboard, included at Appendix 1.

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

08	**Trust Financial Investment Risk**	There is a risk that the contracting arrangements between Velindre and its Commissioners do not adequately acknowledge future service developments and changes in clinical practices and thus ensure appropriate funding mechanisms are in place and agreed.	**Matthew Bunce** Executive Director of Finance
09	**Future Direction of Travel**	Opportunity risk of the Trust's ability to develop new services and failure to take up and create opportunities to apply expertise and capabilities elsewhere in the healthcare system.	**Carl James** Director of Strategic Transformation, Planning & Digital,
10	**Governance**	There is a risk that the organisation's governance arrangements do not provide appropriate mechanisms for the Board to sufficiently fulfil role and the organisation to then be effectively empowered to deliver on the shaping strategy, culture and providing assurance, particularly through a quality and safety lens.	**Lauren Fear** Director of Corporate Governance & Chief of Staff

LEVELS OF ASSURANCE DESCRIPTORS

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

KEY CONTROLS

KEY CONTROLS

CONTROL TYPE	DESCRIPTION	EXAMPLES
Preventative	These controls are designed to limit the possibility of an undesirable outcome being realised. The more important it is to stop an undesirable outcome then the more important it is to implement appropriate preventative controls.	• Authorisation limits of and separation of duties • Pre-employment screening of potential staff
Mitigating	These controls are designed to limit the scope for loss and reduce any undesirable outcomes that have been realised. They may also provide a route of recourse to achieve some recovery against loss or damage.	• Passwords or other access controls • Staff rotation and regular change of supervisors • Exposure reduction by installation on hours worked
Detective	Control is designed to locate problems after they have occurred. Once problems have been detected, management can take steps to mitigate the risk that they will occur again in the future, usually by altering the underlying process.	• Periodic performance reporting • Regular review

STRATEGIC GOALS

1 - Outstanding for quality, safety and experience

2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations

3 - A beacon for research, development and innovation in our stated areas of priority

4 - An established 'University' Trust which provides highly valued knowledge and learning for all

5 - A sustainable organisation that plays it part in creating a better future for people across the globe

RISK DESCRIPTORS

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

DEFINITIONS

CONTROL EFFECTIVENESS

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

ASSURANCE RATING

Positive assurance	the assuring committee is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the threat or opportunity	PA

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

RISK SCORE
IMPACT MATRIX

Domains	Impact, Consequence score (severity levels) and examples				
	1	2	3	4	5
	Negligible	Minor	Moderate	Major	Catastrophic
Impact on the safety of patients, staff or public (physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment	Minor injury or illness, requiring minor intervention	Moderate injury requiring professional intervention	Major injury leading to long-term incapacity /disability	Incident leading to death
	No time off work	Requiring time off work for >3 days	Requiring time off work for 4-14 days	Requiring time off work for >14 days	Multiple permanent injuries or irreversible health effects
		Increase in length of hospital stay by 1-3 days	Increase in length of hospital stay by 4-15 days	Increase in length of hospital stay by >15 days	An event which on a large number of patients
			RIDDOR/agency reportable incident	Mismanagement of patient care with long-term effects	
			An event which impacts on a number of patients		
Quality/complaints/ audit	Peripheral element of treatment or service suboptimal	Overall treatment or service suboptimal	Treatment or service has significantly reduced effectiveness	Non-compliance with national standards with significant risk to patients if unresolved	Totally unacceptable level or quality of treatment/service
	Informal complaint/enquiry	Formal complaint (stage 1) Local resolution	Formal complain (stage 2) complaint	Multiple complaints/ independent review	Gross failure of patient safety if findings not acted on
		Single failure to meet internal standards	Local resolution (with potential to go to independent	Low performance rating	Inquest/ombudsman inquiry
		Minor implications for patient safety if unresolved	Repeated failure to meet internal standards	Critical report	Gross failure to meet national standards
		Reduced performance rating if unresolved	Major patient safety implications if findings are not acted on		
Human resources/ organisational development/staffing/competence	Short term low staffing level that temporally reduces service quality (<1day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff	Uncertain delivery of key objective/service due to lack of staff	Non-delivery of key objective/service due to lack of staff
			Unsafe staffing level or competence (>1 day)	Unsafe staffing level or competence (>5 days)	Ongoing unsafe staffing levels or competence
			Low staff morale	Loss of key staff Very low staff morale	Loss of several key staff
			Poor staff attendance for mandatory/key training	No staff attending mandatory/ key training	No staff attending mandatory training /key training on an ongoing basis

	Negligible	Minor	Moderate	Major	Catastrophic
Statutory duty/ inspections	No or minimal impact or breach of guidance/statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage short-term reduction in public confidence Elements of public expectation not being met	Local media coverage long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business Objectives/ Projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5-10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance Including Claims	Small loss risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5-1.0 percent of budget Claim(s) between £100,000 and £1million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage loss of contract/payment made by results claim(s) >£1million
Service/ business interruption environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

LIKELIHOOD MATRIX

LIKELIHOOD (*)					
LIKELIHOOD SCORE	1	2	3	4	5
DESCRIPTOR	RARE	UNLIKELY	POSSIBLE	PROBABLE	EXPECTED
Frequency: How often might it/does it happen	Not expected to occur for 10 years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Probability: Will it happen or not?	Less than 0.1% chance	01.-1% chance	1-10% chance	10-50% chance	Greater than 50% chance

RISK RATING MATRIX - IMPACT X LIKELIHOOD

RISK MATRIX	LIKELIHOOD(*)				
CONSEQUENCE(**)	1- Rare	2- Unlikely	3 - Possible	4 - Probable	5 - Expected
1 -Negligible	1	2	3	4	5
2 - Minor	2	4	6	8	10
3 -Moderate	3	6	9	12	15
4 - Major	4	8	12	16	20
5 - Catastrophic	5	10	15	20	25

TAF DASHBOARD

WORKFORCE PLANNING

RISK ID:	TAF 03	WORKFORCE PLANNING: Risk of not having the right staff in right place at right time with right capability, as a result of not having appropriate and effective workforce plan owned in the right place, resulting in deterioration of operational performance, decline in the safety/quality of service provision, threatening financial sustainability and/or impacting our transformation ambitions.							
LAST REVIEW	Feb-23	1 - Outstanding for quality, safety and experience							
NEXT REVIEW	Mar-23				RISK DOMAIN		Workforce and Organisational Development		

EXECUTIVE LEAD	Sarah Morley	RISK SCORE (See definitions tab)							
		INHERENT RISK			RESIDUAL RISK			TARGET RISK		
		Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
		4	4	16	4	3	12	2	3	6

Overall Level of Control Effectiveness: Rating and Rag (see definitions tab)	RATING	Overall Trend in Assurance	THIS WILL INCLUDE A TREND GRAPH
	PE		

KEY CONTROLS / SOURCES OF ASSURANCE

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Trust People Strategy, approved in May 2022, clearly noting the strategic intent of Workforce Planning - 'Planned and Sustained Workforce'	Sarah Morley	X			PE	Tracking key outcomes and benefits map – aligned to Trust People Strategy	PA	Performance reporting to Executives and Trust Board	PA	Internal Audit Reports	PA
C2	Workforce Planning Methodology approved by Executive Management Board	Susan Thomas	X			PE	Staff Feedback	PA	Trust Board reporting against Trust People Strategy	PA	To be completed as per compliance/ reg tracker update	PA
C3	Workforce Planning – Skills Development	Susan Thomas	X			PE	Provide operational managers with skills and capabilities to undertake effective workforce planning. Provide formal training and produce a suit of workforce planning tools.	PA	Joint Finance and Workforce Report to QSP	PA	Wales Audit Workforce Planning National Review	PA

WORKFORCE PLANNING

C4	Workforce Planning embedded into our Inspire Programme to develop Mangers and leaders in WP skills	Susan Thomas	X			PE	Evaluation Sheets	PA	Joint Finance and Workforce Report to QSP	PA	Wales Audit Workforce Planning National Review	PA
C5	Additional workforce planning resources recruitment to support development of workforce planning approach and facilitate the utilisation of workforce planning methodology	Susan Thomas	X			PE	Staff meeting to feedback on implementation plan	PA	Joint Finance and Workforce Report to QSP	PA	Wales Audit Workforce Planning National Review	PA
C6	Educational pathways in place for hard to fill roles in the Trust to support the recruitment of new skills and development of new roles	Susan Thomas	X			PE	Recruitment and retention reports via Board	PA	Education and Training Steering Group quarterly reports	PA	Education commissioning audit to reflect commissioning of new skills sets	PA
C7	Widening access Programme in train to support development of new skills and roles	Susan Thomas	X			PE	Reports via Trust Committee cycle on updates from the Education and Training Steering Group	PA	ESR reports on number on widening access programmes	PA	Internal Audit Reports	PA
C8	Workforce analysis available via ESR and Business Intelligence support	Susan Thomas	X			PE	Performance reports monthly to operational managers with improvement plans/actions set out.	PA	Performance reporting to Executives and Trust Board	PA	Internal Audit Reports	PA
C9	Hybrid Working Programme established to assess implications for planning a workforce following COVID and learning lessons will include technology impact assessments.	Sarah Morley			X	PE	Agile Project and Programme Board	PA	Policies and procedures to be imbedded with Hybrid Working Principles	PA	Staff engagement sessions to feedback on hybrid working	PA

GAPS IN CONTROLS	GAPS IN ASSURANCE
Gaps are evident in understanding agreed service models – both internally and regionally	
Each of the controls requires further development and progression, the plans for which are at varying levels of maturity	

TAF DASHBOARD   WORKFORCE PLANNING

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE				
	Action Plan	**Owner**	**Progress Update**	**Due Date**
1.1	Attraction, Retention and Recruitment Programme established to deliver outputs to support the supply and shape of the workforce	Sarah Morley	The Programme Group has been established and a range of outputs defined to deliver between September 2022 and March 2023.	Mar-23
1.2	The Healthy and engaged workplan to be implemented to support workforce capacity within the Trust	Sarah Morley	The annual workplan has been reviewed at the Healthy and Engaged Steering Group for Quarters 1, 2, & 3 2022-23. The Trust has appointed a staff psychologist to support mental health and wellbeing and they have developed a model for a staff psychology service which has been shared at the Healthy and Engaged Steering Group. In addition all elements of the Trust wellbeing offer have been added to the national GWELLA platform and on the Trust intranet allowing them to be more easily accessible for staff.	Mar-23
1.3	Establish Hybrid working arrangements as a core way in which the Trust undertakes some of its work.	Sarah Morley	The Hybrid Working project is presenting the details of a desk top booking approach to EMB in January 2023. This business case will then be further developed following EMB feedback. The Hybrid Working Toolkit has been developed in draft and will be finalised and published in February 2023.	Mar-23

TAF DASHBOARD

ORGANISATIONAL CULTURE

RISK ID:	TAF 04	ORGANISATIONAL DESIGN: Failure to establish effective systems and structures built around shared values and behaviours.							
LAST REVIEW	Feb-23	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations							
NEXT REVIEW	Mar-23				RISK DOMAIN		Performance and Service Sustainability		

EXECUTIVE LEAD	Sarah Morley	RISK SCORE (See definitions tab)								
		INHERENT RISK			RESIDUAL RISK			TARGET RISK		
		Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
		3	4	12	3	3	9	2	2	4

Overall Level of Control Effectiveness: Rating and Rag (see definitions tab)	RATING	Overall Trend in Assurance	THIS WILL INCLUDE A TREND GRAPH
	PE		

KEY CONTROLS							SOURCES OF ASSURANCE					
ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Trust Strategies and enabling strategies (including people, RD&I and Digital) to be agreed to provide clarity and alignment on strategic intent of the Organisation	Carl James	X			PE	Working group led by CJ	PA	Trust Board reporting on strategy and controls via cycle of business	PA	To be completed as per compliance/ reg tracker update	PA
C2	Developing Capacity of the Organisation – set out in the Education Strategy and implementation plan to support the educational development of the Organisation to support the Trust direction	Susan Thomas	X			PE	Education and training Steering Group	PA	Trust Board reporting on strategy and controls via cycle of business	PA	To be completed as per compliance/ reg tracker update	PA

ORGANISATIONAL CULTURE

C3	Management and Leadership development in place to provide a infrastructure to develop compassionate leadership and managers established via the creation of the Inspire Programme with development from foundations stages in management to Board development	Susan Thomas	X			PE	Education and training Steering Group	PA	Trust Board reporting on strategy and controls via cycle of business	PA	Intermediate level evaluation audit in place to monitor the effectiveness of the programme	PA
C4	Values to be reviewed and Behaviour framework to be considered Values of the Organisation used in induction, recruitment and via PADR processes	Susan Thomas	X			PE	Healthy and Engaged Steering Group Education and Training Steering Group	PA	Trust Board reporting on strategy and controls via cycle of business	PA	Staff surveys in place to feedback values in action	PA
C5	Communication infrastructure in place to support the communication of leadership messages and engagement of staff	Lauren Fear	X			PE	Healthy and Engaged Steering Group	PA				
C6	Health and Wellbeing of the Organisation to be managed –with a clear plan to support the physical and psychological wellbeing of staff	Susan Thomas	X			PE	Health & Wellbeing Steering Group	PA	Trust Board reporting on strategy and controls via cycle of business	PA	Staff survey feedbacks	PA
C7	Governance arrangements in place to monitor and evaluate the implementation of plans	Lauren Fear	X			PE	Executive Management Board	PA				
C8	Performance Management Framework in place to monitor the finance, workforce and performance of the Organisation	Carl James	X			PE	PMF Working Group	PA				

ORGANISATIONAL CULTURE

C9	Service models in place to provide clarity of service expectations moving forward	Cath O'Brien	X			PE	SLT Meetings		PA			
C10	Aligned workforce plans to service model to ensure the right workforce is in place	Cath O'Brien	X			PE	SLT Meetings		PA			
							Education and Training Steering Group		PA			
C11	Development and implementation of a Management Framework that supports cohesive work across the organisation	Carl James	X			PE	To be determined		PA			

GAP IN CONTROLS	GAPS IN ASSURANCE
Each of the controls requires further development and progression, the plans for which are at varying levels of maturity	Development of 3rd Line of defence assurance to be completed
Requires a cohesive and holistic Organisation alignment between performance management, service improvement, leadership behaviours and people practices to deliver the desired culture	Mapping of relevant sources of assurance and development of that assurance will sit alongside the development of the key controls

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Embedding of Organisational Design approach for the Trust to encapsulate both process and cultural elements that need to be in place to allow the organisation to achieve its strategic goals	Sarah Morley	The Building our Future Together (BOFT) draft Portfolio Initiation Document has been presented to EMB in December 2022. Whilst the PID is a live document and therefore is continuing to evolve the individual Projects within it are progressing with Highlight Reports going to EMB. The BOFT Steering Group will begin meeting in March 2023 which will provide the opportunity to engage with a wider stakeholder group on progress against these individual elements of work.	Mar-23
1.2	A staff engagement project to understand levels of staff engement and also review the Trust Values	Sarah Morley	A first report against the review of the Trust values was presented to EMB in December 2022. It was decided at that meeting that a broader piece of work was needed to ensure that Trust values were built on the culture the organisation was striving to achieve to deliver its ambitions under the Destination 2032 strategy. This broader work is being scoped during January 2023 with details being presented to EMB in March 2023.	Apr-23

QUALITY AND SAFETY

RISK ID:	TAF 06	Trust has just approved (July 2022) its integrated Quality & Safety Framework and is in the process of setting up the required mechanisms, systems, processes and datasets. This includes the ability to on mass learn from patient feedback i.e. patient / donor feedback / outcomes / complaints / claims, incidents and ability to gain insight from robust triangulated datasets and to systematically demonstrate the learning, improvement and that preventative action has taken place to prevent future donor / patient harm. These are not currently in place and could result in the Trust not meeting its national and legislative responsibilities (Quality & Engagement Bill (2020)) and a reduction in public/patient/donor, external agency, regulator and commissioner confidence in the quality of care the Trust provides.
LAST REVIEW	Oct-22	1 - Outstanding for quality, safety and experience
NEXT REVIEW	Nov-22	Goal 1	RISK DOMAIN	Quality and Safety/ Comliance and Regulatory

RISK SCORE (See definitions tab)

EXECUTIVE LEAD	Nicola Willams	INHERENT RISK			RESIDUAL RISK			TARGET RISK		
		Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
		5	5	**25**	3	5	**15**	2	5	**10**

Overall Level of Control Effectiveness: Rating and Rag (see definitions tab)	RATING	Overall Trend in Assurance	THIS WILL INCLUDE A TREND GRAPH
	PE		

KEY CONTROLS						SOURCES OF ASSURANCE					
ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Once for Wales Datix System implemented	Nicola Williams			X	PE	Staff feedback	PA	Internal Audit Reviews	Not Assessed	Audit Wales Reviews	Not Assessed
C2	CIVICA pt/donor feedback system being implemented	Nicola Williams			X	PE	Patient/Donor Feedback	PA	Quality, Safety & Performance Committee	IA	HIW Inspect	PA
C3	Trust wide Divisional to Board level Quality & Safety meeting structure in place	EXECS	X	X	X	PE	15 Step challenge	IA	Peer reviews	Not Assessed	MHRA	Not Assessed
							EMB	IA			Professional bodies	Not Assessed
C4	Quality & Safety Teams in place corporately & in each Division	NW, AP, PW	X	X	X	PE	Divisional Q&S Groups	IA			Delivery Unit	Not Assessed
							PMF	IA				Not Assessed

QUALITY AND SAFETY

C5	PMF in place & under review to include experience & outcomes	Carl James			X	NE	Perfect Ward audits	IA				
							PMD	IA				
C6	Trust Risk Register in place	Lauren Fear	X	X	X	PE	Mortality reviews	IA				
C7	Regular Staff Feedback sought	Sarah Morley			X	PE							
C8	Staff Q&S training & Education	Nicola Williams	X			PE			IA	Internal Audit Reviews	Not Assessed		

GAP IN CONTROLS	GAPS IN ASSURANCE
National standards / best practice standards (including benchmarkable outcome & experience measures) are not explicit across all departments of the Trust & /or regularly reviewed	Currently mechanisms to automatically & systematically review and triangulate & integrate quality & safety information at corporate and VCC Divisional level are insufficiently robust due to lack of cohesive infrastructure
Data / information infrastructure currently insufficient and unable to provide triangulation	Currently the mechanisms to evidence learning and improvement service level to Board remains under development
Quality & Safety Framework approved in July 2022, implementation commenced. Quality & Safety Operational Group Planning meeting held, inagural meeting arranged in October 2022.	There are gaps in the Quality & Safety reporting mechanisms from service level to Board in respect of meeting structures and reporting lines
National Duty of Quality statutory guidance 12 week consulation due in October 2022 & Duty of Candour regulation changes 12 week consultation commenced on 20th September 2022.	Trust Quality, Safety & Performance Committee needs to further refine its work plan, quality of papers and triangulation methodologies
Work required to ensure consistent and recognized Floor to Board lines accountability & responsibility for Quality & Safety	The current mapped meeting reporting structure does not cover floor to board at divisional level
Work required to ensure robust links between incidents, feedback, complaints, mortality review outcomes clinical audit and improvement plans and to be able to demonstrate improvement	Quality & Safety assurance infrastructure for hosted organisations is unclear
Trust wide and VCC Quality & Safety Teams have insufficient capacity and capability to currently be able to fully execute responsibilities	Quality & Safety Operational Group requires full establishment - to operationally pull together all stands and feed into EMB & QSP

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Trust Quality & Safety Framework to be finalized and implementation plan developed.	Nicola Williams	Framework finalised and approved by Board in July 2022	COMPLETE
1.2	Corporate & Divisional Quality Hubs to be established	Nicola Williams	Corporate OCP completed and recruitment commenced. Update 13.01.23: Integrated Quality & Safety Group established - Corporate Hub not fullly established due to delay in populating OCP posts	Oct-22
		Alan Prosser	WBS Quality Hub requirements determined – minor changes required from existing arrangements. Update 13.01.23: WBS Hub development in final stages	
		Paul Wilkins	VCC Quality Hub high level requirements determined - additional / realignment of resources maybe required. Detail needs to be worked through. Update 13.01.23: VCC hub design under consideration by VCC SLT	
1.3	Trust Quality & Safety Framework implementation plan to be completed in line with agreed timescales	Exec Team	Implementation plan developed and approved	Mar-23
		Divisional Directors		
1.4	Instigate a Quality & Safety operational meeting where cross cutting outcome review & triangulation takes place	Nicola Williams	Planning meeting held, draft terms of reference developed and membership agreed. Inagural meeting planned for October 2022. Update 13.01.23: Meeting underway - Quality BI work underway to support the active triangualtion	Oct-22
1.5	Ensure the Action & learning sections within the Once for Wales Datix System are robustly implemented & audited	Nicola Williams	Being picked up through the Datix project Board. Update 13.01.23: Formal Audit to assess compliance has been comissioned	Dec-22
1.6	Implement a robust compassionate leadership programme	Sarah Morley	Compassionate Leadership is woven through the Trust 'Inspire' Leadership Programme. A broader Trust wide programme is being developed for all leaders and managers which forms part of the 'Building our Future Together' Portfolio.	Apr-23
1.7	Ensure all responsible officers receive Investigation Training	Nicola Williams	Investigation training provided to officers within corporate quality & safety team and both divisions. Update 13.01.23: Training provided - a scope of who has undertaken it underway	Jun-22
		Cath O'Brien		
1.8	Implement National Duty of Candour guidelines / requirements	Jacinta Abraham	Awaiting National statutory Guidance. Nicola Williams Chairing national Duty Quality / Duty Candour Steering group. Consultations planned for Autumn 2022.	Apr-23
1.9	Implement National Duty of Quality guidelines / requirements	Nicola Williams		Apr-23

QUALITY AND SAFETY

1.10	Explicitly define the required Quality, Safety & Governance assurance mechanisms for Hosted Organisations	Lauren Fear	Governance and Assurance mechanisms have been agreed and established for Shared Services, reporting through to the Quality, Safety and Performance Committee, Shared Services Audit Committee and Shared Services Partnership Committee. A review is underway of Health Technology Wales and required Governance and Assurance mechanisms. This will be progressed in quarter 1 2022/23. Update 06.10.2022 - Defined project as part of the Building Our Future Together work programme.	Mar-23
1.11	Complete Risk Register Review, transmission onto Datix v14 (04W when available) & ensure regular reviews at all levels in line with Quality and Safety outcomes	Lauren Fear	Regular reviews are taking place and work is ongoing to transfer of all risks to Datix V14, followed by Once for Wales when available.	COMPLETE

TAF DASHBOARD

TRUST FINANCIAL INVESTMENT RISK

RISK ID:	TAF 08	There is a risk that the contracting arrangements between Velindre and its Commissioners do not adequately acknowledge future service developments and changes in clinical & scientific practices and thus ensure appropriate funding mechanisms are in place and agreed.								
LAST REVIEW	Jan-23	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations								
NEXT REVIEW	Mar-23	Goal 2			RISK DOMAIN		Financial Sustainability			

EXECUTIVE LEAD	Matthew Bunce	RISK SCORE (See definitions tab)								
		INHERENT RISK			RESIDUAL RISK			TARGET RISK		
		Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
		4	4	16	3	4	12	2	4	8

Overall Level of Control Effectiveness: Rating and Rag (see definitions tab)	RATING	Overall Trend in Assurance	GOING FORWARD THIS WILL INCLUDE A TREND GRAPH
	PE		

KEY CONTROLS · SOURCES OF ASSURANCE

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Trust Financial Strategy	Matthew Bunce	X			PA	Tracking forecast delivery against financial strategy via Performance Committees and Trust Board	PA	Monthly Performance Review with Executives and Senior Management Teams	PA	Internal Audit cycle of assurance on financial strategy	PA
C2	Active engagement with Commissioners and Welsh Government to ensure inclusion of Velindre requirements within their Financial Planning	Matthew Bunce		X		PE	Inclusion in Health Board IMTP Financial Plans	IA	Monthly Commissioner Meetings held to confirm financial planning requirements	IA		

TAF DASHBOARD

TRUST FINANCIAL INVESTMENT RISK

	KEY CONTROLS						**SOURCES OF ASSURANCE**				
ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C3	Active engagement with Trust & Divisions to ensure investment does not exceed available funding	David Osborne	X			PA	Monthly Financial Performance Review Reported to Execs and Senior Management Teams	PA	Quarterly Directorate financial reviews established across both Divisions	PA	Monthly Budget Holder Meetings with Business Partners	PA
C4	Continuous review of contracting currencies and direct WHSCC funding to ensure reflective of efficient cost of delivery	Matthew Bunce		X		PE	Frequent formal Reviews to be established, combined with routine contract reporting	IA	Routine meetings with Depts to support business cases and any impacts on currencies	IA	Annual Review of Contracting Model (focus on pandemic legacy impact)	IA
C5	Benchmarking with appropriate services to ensure value	Matthew Bunce			X	PE	Non Surgical Benchmarking Group with Welsh Cancer Centres	PA	National Costing Cycle	PA		
C6	Routine contracting reporting and discussion with Commissioners to review activity and early identify income volatilities	David Osborne			X	PE	Monthly Financial Performance Review Reported to Commissioners with Monthly Meetings	PA	Annual Review of Contracting Model (focus on pandemic legacy impact)	IA	Introduction of Service Line Reporting	IA

TAF DASHBOARD

TRUST FINANCIAL INVESTMENT RISK

C7	Establish Investment Prioritisation Framework at a Trust and Divisional level to ensure no investment creep and strategic priority alignment	Matthew Bunce	X			PE	Chief Executive Consideration of Investment at a Trust Level	IA	Divisional Senior Management Team investment review	IA		

GAP IN CONTROLS	GAPS IN ASSURANCE
C3 – Governance of investment at Velindre Cancer Centre is being enhanced through the embedding of resource authorization, prioritization and allocation process, linked to Velindre Futures. Framework not fully embedded at present.	Inclusion of Velindre funding requirements with respective Commissioner financial planning requires formal clarification from Commissioners. Whilst requirements may be acknowledged, the financial challenges that Commissioners are prioritizing may not align with Velindre intents, consequently, assurance cannot be given that Velindre requirements will be met.
C4 – Whilst the contracting model has been continuously reviewed, the impact of COVID related measures has had a potential significant shift in cost base. This requires further understanding to identify mitigations.	The impact of COVID on current performance and cost base remains volatile, with recurrent funding also unclear. Capacity and demand modelling being undertaken in key risk areas. Welsh Government and Commissioners engaged on current and future consequences.
C7 – Trust Investment Prioritisation Framework to be established.	Investment is limited in it's prioritisation to the Executive Team and Senior Management Teams discretion and not formally supported by a framework for decision making.

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	**Support the embedding of investment framework within Divisions**	**David Osborne**	**Process continues to be embedded, terms of reference and process established. Communications throughout Division and "live" operation to follow.**	**Mar-23**
	Investment scrutiny with services against commitments made and intended.	David Osborne	Completed and subject to continuous review	Completed
	Key objectives of investment framework and relationship to contract performance and value identified	David Osborne	Completed	Completed
	Investment framework to be articulated and agreed by Divisions and Exec	David Osborne	Due through Q3	Jan-23
	Investment framework to be applied within IMTP process	David Osborne	Due through Q3	Mar-23

TRUST FINANCIAL INVESTMENT RISK

1.2	Review of contracting model for impact of COVID related measures	David Osborne	Areas of concern identified, discussions to inform are underway with Services. Board to be advised of present volatility and Commissioners engaged.	Mar-23
	Protected Enhanced rates secured for 22-23	David Osborne	Completed	Completed
	Contract currencies of concern identified and impact assessed	David Osborne	Impact of hyperfractionation reviewed	Completed
	Business Cases completed for Brachytherapy	David Osborne	Business case prepared and agreed	Completed
	Engage with National Funding Flows Group for contract agreements for future financial years	David Osborne	Ongoing. National Funding flows workstream has been delayed due to capacity constraints in the national group therefore November milestone missed. Work is ongoing with the National team and an outcome is expected by Feb-23 with regards to contract arrangements	Feb-23
	Internal Review of investment in Covid-related capacity for VCS	David Osborne	An internal review is being conducted to understand the impact of funding made available to VCS in response to Covid. A meeting is scheduled for 18th January to review the initial outcome from this work.	Feb-23
1.3	Establish Trust Investment Prioritisation Framework	Matthew Bunce	Programme of work developed across the following workstreams: Benchmarking / good practice; Investment Categorisation; Governance process; Prioritisation Criteria; Business case templates and Decision Support Tools.	Jul-23
	Benchmarking / good practice assessment	Chris Moreton	Work has been conducted to understand where good practice exists within other LHBs / wider NHS.	Completed
	Investment Categorisation	Chris Moreton	Draft set of categories have been produced which contain the Scale of Change; Type of Change; Source of Funding and Type of Funding. Draft categories to be reviewed and finalised / agreed as part of framework.	Mar-23
	Governance and processes	Chris Moreton	Terms of Reference for Strategic Capital Board have been reviewed by Chris Moreton with suggested updates aligned to the SFIs. Once SCB ToR agreed, Capital Financial Control Procedures to be updated. High level process review for capital investment in progress. Revenue investment review process to be completed.	Apr-23
	Prioritisation criteria	Chris Moreton	Criteria need to be developed and agreed - work in progress	May-23
	Business Case Templates and Decision Support Tools	Chris Moreton	Updated draft investment categories have been incorporated within the Trust Board report template.\n\nGap analysis of business case templates and decision support tools to be completed.	Jul-23

QUALITY, SAFETY & PERFORMANCE COMMITTEE

WORKFORCE & ASSOCIATED FINANCE RISKS

DATE OF MEETING	16th March 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

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

REPORT PURPOSE	FOR NOTING

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

ACRONYMS	
IMTP	Integrated Medium Term Plan
ED&I	Equality, Diversity & Inclusion
HB	Health Board
LTA	Long Term Agreement
TOIL	Time off in Lieu
WBS	Welsh Blood Service

WTAIL	Welsh Transplantation and Immunogenetics Laboratory
WG	Welsh Government
VCC	Velindre Cancer Centre

1. SITUATION/BACKGROUND

1.1 The purpose of this report is to highlight the key workforce and associated financial risks that the Trust is currently facing and that might crystalise in 2023-24, together with the required management actions to ensure risk mitigation and performance improvement.

1.2 The paper is structured under the risks identified within the key People strategy themes of Workforce Supply and Shape; Wellbeing; Attraction and Retention. Each theme and section of the report will be structured as follows:

1.2.1 Key Workforce and Associated Financial Risks

1.2.2 Actions to be taken to address these risks

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Workforce Supply and Shape

Key issues currently and expected to continue through 2023-24 are:

*2.1.1 **Key Workforce and Associated Financial Risks***

Key workforce risk: In response to service demand, traditional staffing models cannot deliver service need, the **shape** of the workforce has to change. This may require finance to be allocated across different teams and different staff groups. The Trust has key hotspot areas in diagnostic radiation services, nuclear medicine, SACT Nursing and medical oncology. However based on the current pressures in the NHS and the volatile labor market we dynamically review workforce shape and supply to ensure significant changes are being measured, and emerging hotspot areas are considered.

Financial risk: The financial risk associated with workforce planning will be monitored and managed through the pay budget monitoring process. This includes staff who were permanently recruited in response to Covid where guaranteed funding from Welsh

Government is no longer available as funding is now linked to activity delivered compared to 2019-20 levels as part of the Long-Term Agreements with Commissioners.

The full year pay budget as at end of January is £77,190m based on 1,581 WTE.

As at January 2023, the current staff in post is 1,457WTE. The number of vacancies is 124 WTE, which represents a 7.8% vacancy rate. The vacancy gap is largely being met by the use of agency staff and overtime, which is reported on further in section 3, Attraction and Retention.

Vacancies throughout the Trust remain high, however significant improvement has been made due to the targeted recruitment interventions in SACT (in VCC and outreach), reducing the Nursing and HCSW vacancies. This improvement has given the service opportuntiy to explore workforce and service redesign and to take forward some fundemental changes that will enable a more efficient and productive service

In addition, a number of posts in both VCC and WBS have been appointed at risk in response to Covid. There has also been forward recruitment on service developments without agreed funding pending activity undertaken or FBC approval by WG and Commissioners. Work is underway in both divisions to either secure additional funding to support these posts or looking at options to migrate staff into vacancies to help mitigate the current risk exposure.

The Trust has reported a cumulative year-to-date spend of £63.664m on pay against a budget of £64.403m resulting in an underspend position of £0.739m as at January 23. The pay costs include the costs of agency staff, on-call and overtime.

2.1.2 *Actions taken to mitigate WOD and Finance Risks related to Workforce Supply and Shape*

Using the nationally agreed Workforce Planning (WP) Principles (Appendix A), the Trust is taking forward a number of projects, focused on hotspot areas, to address the need to change the workforce model. The planning principles have been adopted into a Work plan, utilising a Workforce Repository and Planning Tool with actions and timescales as noted below.

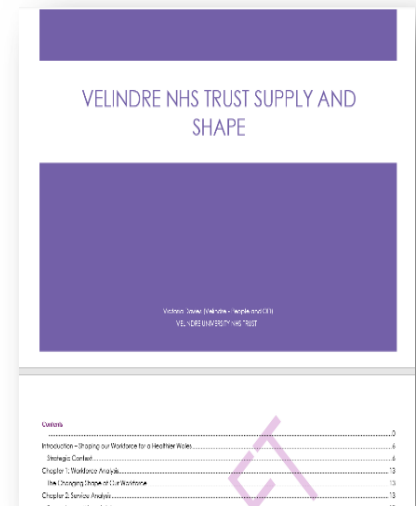Workforce planning steps based on the Workforce planning principles

Workforce Planning steps
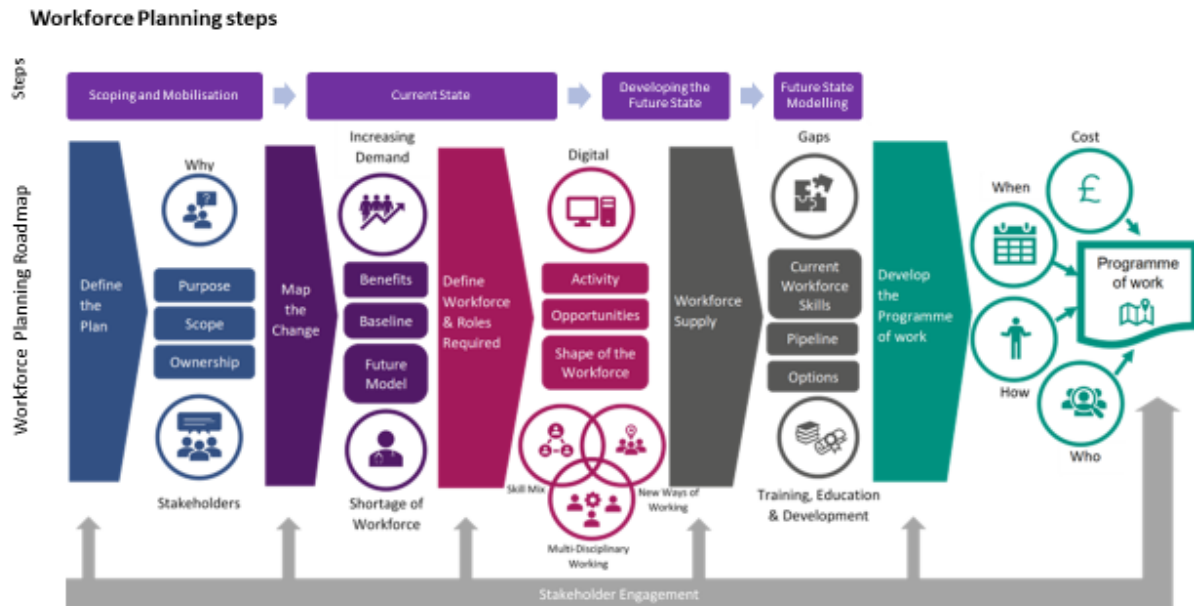
To support this the Trust is developing the Velindre University NHS Trust Supply and Shape Working Document. This document will provide an overarching structure as to how we workforce plan in the Trust.

The document aims to provide a holistic picture of the current workforce, through the completion of a baseline assessment that includes analysis of workforce trends, challenges and risks.

Interventions currently available to the organisation that aim to mitigate risk, and challenges are also included.

Based on known assumptions and available data, the document will also attempt to project the workforce needs of the future.

To strengthen our current workforce planning approach, the document also introduces a workforce development framework. The framework is aligned to the developing All Wales Nursing Retention Project and is based on the '7 B's of action planning'[1] that includes a series of workforce levers – see figure 1. Initiatives identified as part of the baseline assessment will be mapped to each of the levers along with any new interventions identified.

The framework will provide a structure to enable the strategic and local development of our workforce and associated plans.
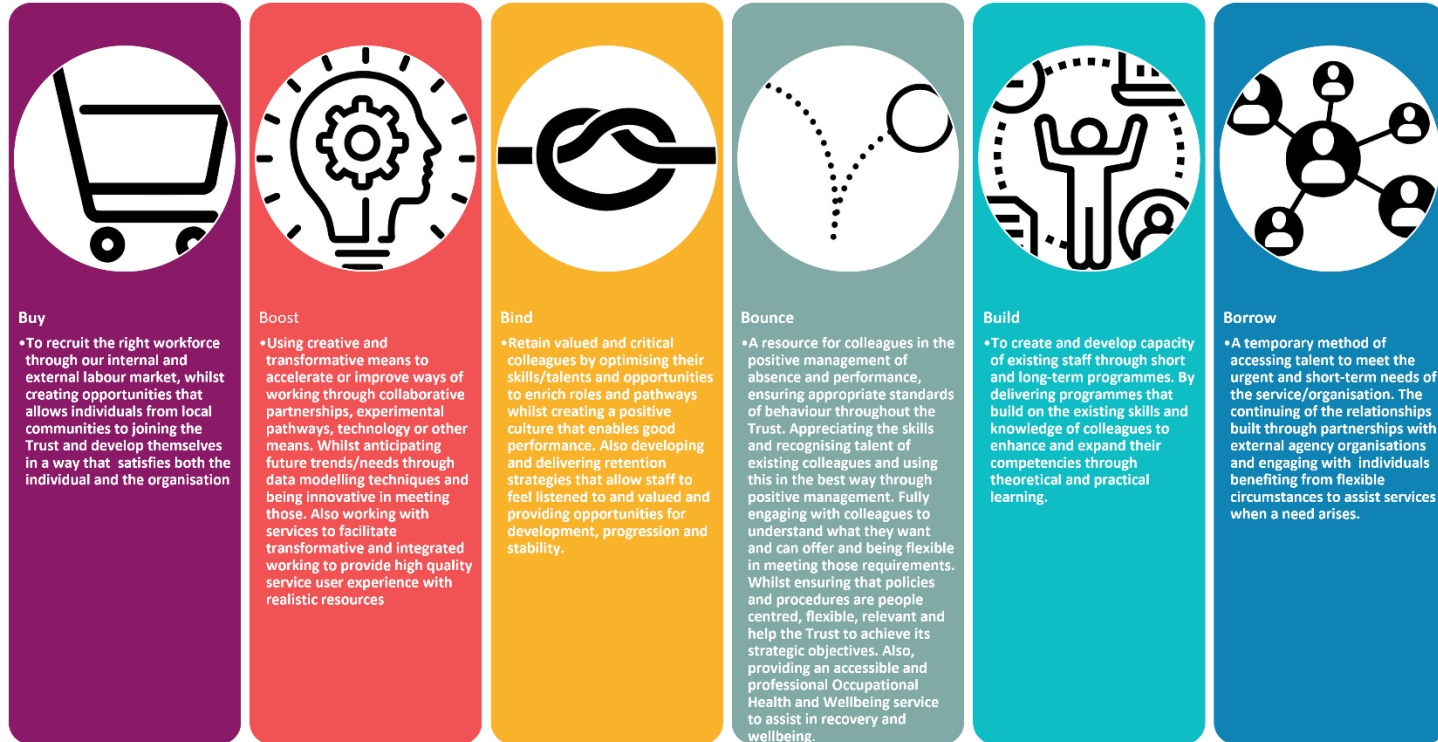
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[1] Gibson, A (2021) Agile Workforce Planning. How to Align People with Organisational Strategy for Improved Performance' KoganPage:London

Figure 1

Buy	Boost	Bind	Bounce	Build	Borrow
•To recruit the right workforce through our internal and external labour market, whilst creating opportunities that allows individuals from local communities to joining the Trust and develop themselves in a way that satisfies both the individual and the organisation	•Using creative and transformative means to accelerate or improve ways of working through collaborative partnerships, experimental pathways, technology or other means. Whilst anticipating future trends/needs through data modelling techniques and being innovative in meeting those. Also working with services to facilitate transformative and integrated working to provide high quality service user experience with realistic resources	•Retain valued and critical colleagues by optimising their skills/talents and opportunities to enrich roles and pathways whilst creating a positive culture that enables good performance. Also developing and delivering retention strategies that allow staff to feel listened to and valued and providing opportunities for development, progression and stability.	•A resource for colleagues in the positive management of absence and performance, ensuring appropriate standards of behaviour throughout the Trust. Appreciating the skills and recognising talent of existing colleagues and using this in the best way through positive management. Fully engaging with colleagues to understand what they want and can offer and being flexible in meeting those requirements. Whilst ensuring that policies and procedures are people centred, flexible, relevant and help the Trust to achieve its strategic objectives. Also, providing an accessible and professional Occupational Health and Wellbeing service to assist in recovery and wellbeing.	•To create and develop capacity of existing staff through short and long-term programmes. By delivering programmes that build on the existing skills and knowledge of colleagues to enhance and expand their competencies through theoretical and practical learning.	•A temporary method of accessing talent to meet the urgent and short-term needs of the service/organisation. The continuing of the relationships built through partnerships with external agency organisations and engaging with individuals benefiting from flexible circumstances to assist services when a need arises.

Development of a Power BI Workforce Planning Dashboard

Using people data for effective workforce planning is essential if we are to ensure that the interventions we put in place are evidence based, effective, and sustainable. Working in collaboration with Digital Health and Care Wales, we are further developing our people analytics resource to include a Power BI Workforce Planning Dashboard. The dashboard will aim to bring together multiple strands of people data to provide an overall understanding of the shape of our workforce.

N.B. This image is for illustrative

2.2 Wellbeing

2.2.1 Key Workforce and Associated Financial Risks

Key workforce risk: The COVID pandemic has left a legacy of higher levels of sickness absence compared to pre-Covid. The main reason for absence remains stress and anxiety. The Trust, provide a raft of wellbeing interventions to support staff and the Workforce teamwork work to ensure targeted interventions are provided – Please refer to January Monthly Performance report.

Financial risk: The cost of sickness is reflected as an indicative productivity/ efficiency loss. The indicative productivity loss and cost for the last 12 months related to sickness is £2.114m, which is 24,274 days. High levels of sickness may also increase the need to use more staff through agencies and to therefore incur the associated costs. This risk is reported under the Attraction and Retention section below. Reduction in sickness absences rates has a direct impact on reducing the variable pay bill.

2.2.2 Actions taken to mitigate Workforce and OD and Finance Risks related to Wellbeing

In addition to the raft of physical and mental wellbeing resources available to staff the following actions are being undertaken, monitored via the Healthy and Engaged Steering group,:

- The Trust was re-accredited at Gold for Corporate Health Standards in January 2023 in respect of having an Organisational-wide approach towards health and wellbeing of staff. Platinum re-accreditation is being organised for April 2023.
- Work-related stress has been added to the Trust's risk register to highlight the risk of harm to staff and to service delivery. This entry also sets out the controls which are in place and being implemented across the Trust.
- The contract for an Employee Assistance Programme with Workplace Options was renewed from April 2022 and now runs until March 2024. This gives staff access to information and support in relation to managing money
- Salary Finance provide a service to all NHS Organisations in Wales including help and support with budgeting and the ability to provide a loan repaid through salary deductions. Links to their services are available on the intranet.

- Contact has been made with the government's independent Money and Pensions Service and their resources, branded Money Helper, have been added to the intranet
- The Trust ran the childcare subsidy scheme over the summer holidays and it was accessed by 35 staff with a total of £7,750 paid out to support childcare costs in 2022. These have been advertised for Easter 2023. Complementary Therapies are available to staff to help alleviate physical and psychological problems.
- Healthshield has been launched which offers all staff health cover through payroll deductions
- The Fatigue and Facilities Charter for Medical Staff has been adopted in the Trust and arrangements are in hand to ensure the Trust complies with all standards.

3. Attraction and Retention

3.1.1 *Key Workforce and Associated Financial Risks*

Key workforce risk: The Trust is currently carrying 124 WTE vacancies as at the end of January 2023. An Attraction and Retention plan has been developed with targeted specific interventions in hotspot areas together with work ongoing with regional partners to develop regional interventions.

Financial risk: The cost is reflected in the pay costs through use of agency and overtime and provision of TOIL.

The cumulative spend year-to-date as at January 2023 on measures to bridge the vacancy gap include:

- Agency spend £1,482k (£264k directly related to Covid)
- Overtime spend £487k

The 2022/23 full year forecast outturn for Agency spend is circa £1,717k (£316k Covid related) compared to £1,906k 2021/22, which is a £189k (10%) expected year-on-year reduction
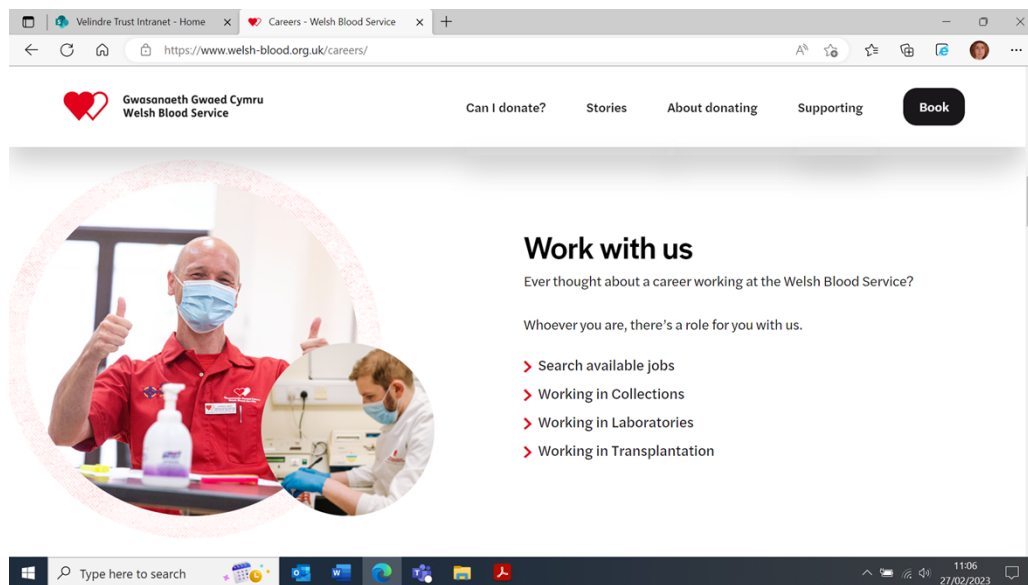
Based on the full year 2022/23 cost forecast, £515k is estimated to be premium cost that could be saved if the Trust were able to recruit permanently rather than utilise Agency.

3.1.2 *Actions taken to mitigate Workforce and OD and Finance Risks related to Attraction and Retention*

The Trust has established a Recruitment, Attraction and Retention group to address the issues related to its key recruitment and retention hotspots.

An example of this work is in WBS who have finalised a recruitment project, promoting the service as a great employer. A number of departmental videos have been produced, to showcase careers at WBS. These videos feature WBS staff, carrying out their roles and showing the pride they have in working for Velindre. The website content has been translated into Welsh with Welsh subtitles applied to the videos and we have built a careers section of the WBS website for candidates to access information on working for WBS. The website also features a summary of the functions of each of the different teams in WBS and highlights the staff benefits to attract candidates. There is a direct link from the website to NHS Wales jobs, in time, this link may be changed to simply feature WBS job vacancies.

The impact of this website in attracting new candidates will be monitored. We will also add the website link to TRAC adverts for WBS and we will gather feedback on its impact. We have already received lots of extremely positive feedback on the recruitment videos. The website and recruitment videos are accessible via https://www.welsh-blood.org.uk/careers/ and the Welsh language version via https://www.welsh-blood.org.uk/cy/careers/
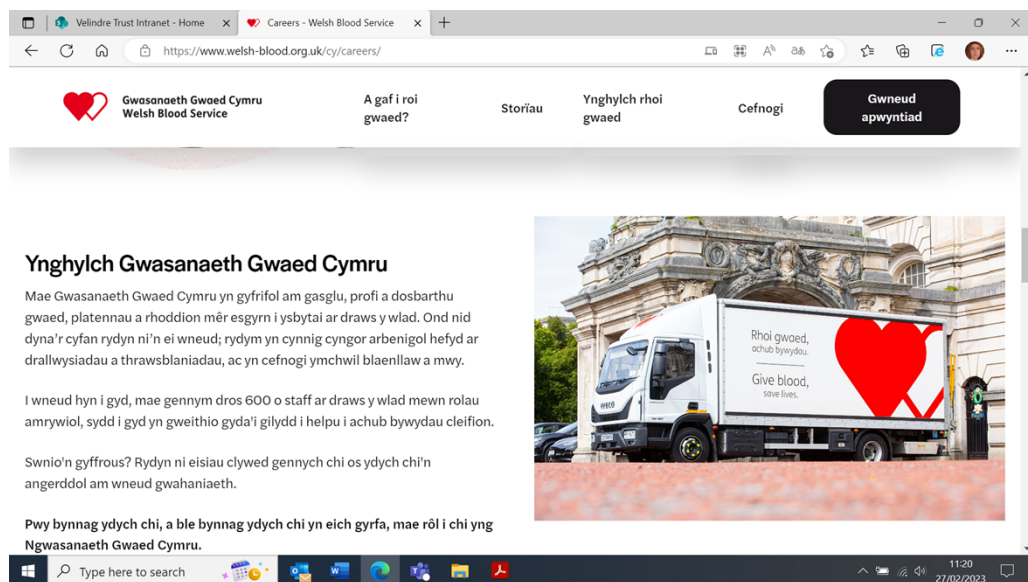
The recruitment and retention project is working on similar projects in VCC on hotspot areas. It has also streamlined the scrutiny recruitment process making time to hire quicker and developed a recruitment policy to ensure clarity on the recruitment process for all Managers in the Trust.

4. Measures to Monitor Improvement

To address improvement the following Key Performance Indicators are being reviewed monthly:

WOD Risk	Hotspot Risk Areas – Reviewed and Updated monthly via Service and Workforce Performance reports	Key Performance Indicator
Supply and Shape	Monthly Performance reports to address and monitor improvement trajectories	Fixed term contracts reviewed
Wellbeing		Sickness Absence Rates Indicative productivity loss (Hrs.) and cost (£)
Attraction and Retention		Vacancy Rate Vacancy turnover rate Agency spend

5. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Quality and safety of services are directly impacted by the workforce risks described in this paper and therefore mitigated by the actions being taken.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
	Individual elements of work described in this paper may be subject to EQIA.
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Covid staff costs that may not be fully covered by WG or Commissioner income
	Ongoing premium cost of agency

5. RECOMMENDATION

a. The Quality, Safety and Performance Committee is asked to **NOTE and CONSIDER** the workforce risks, opportunities and associated financial impacts as outlined within the contents of the report.

12

Appendix A

Workforce Planning Principles

Agile, workforce will work flexibly and across traditional professional, physical, psychological, Organisational and geographical boundaries

Transformative, embrace opportunities for workforce transformation because of changes within digital, technological and medical advances

Intelligence Led, information and analysis that will support intelligence-based decision making.

Health and Wellbeing focus, ensuring the psychological wellbeing of staff and that staff are only required to work within their level of competence

ED&I Focus, reflective of the population and that workforce demographics are considered including ageing workforce, gender balance, flexible and part-time working and inclusivity

Welsh Language Considerations, Welsh language legislation will be considered as part of all workforce plans

Sustainable, appropriately skilled and competent multi-disciplinary team members are enabled to undertake tasks rather than traditional roles. Plans to be resilient and workforce deployed effectively

MDT Focus, workforce plans will have a clear scope and assumptions will be clearly stated. This will ensure that the outcomes of the planning are robust, feasible, affordable and that they will be supported

Whole System, Safety, quality and affordability will be equal key cornerstones of workforce planning.

Co-Produced, strong engagement and collaboration with key stakeholders to ensure that all plans are co-produced and that any actions are owned and agreed at the outset.

Consistent Approach, the development of a workforce plan will be based on the Six Step Methodology adopted across NHS Wales

Clearly Defined, workforce plans will have a clear scope and assumptions will be clearly stated.

QUALITY, SAFETY & PERFORMANCE COMMITTEE

FINANCE REPORT FOR THE PERIOD ENDED
31ST JANUARY 2022 (M10)

DATE OF MEETING	16/03/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

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

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME
EMB	01/03/2023	Noted

ACRONYMS	
IMTP	Integrated Medium Term Plan
WBS	Welsh Blood Service
WTAIL	Welsh Transplantation and Immunogenetics Laboratory
WG	Welsh Government
VCC	Velindre Cancer Centre
MMR	Monthly Monitoring Returns
HTW	Health Technology Wales

1.   SITUATION/BACKGROUND

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

1.2   This financial information included within this report relates to the Core Trust (Including HTW). The financial position reported does not include NWSSP as they are directly accountable to WG for their financial performance. Only the balance sheet (SoFP) and cash flow provides the full Trust position as this is reported in line with the WG monthly monitoring returns (MMR).

2.   ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1   **Performance against Key Financial Targets:**

	Unit	Current Month £m	Year to date £m	Year End Forecast £m
Revenue	Variance	(0.004)	0.002	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	2.550	14.537	27.760
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	90.2%	94.4%	95.0%

2.2   Revenue Budget

At this stage of the financial year the overall revenue budget (excl. Covid and the exceptional cost pressures) remains broadly in line with expectations as planned within the IMTP, with a projected forecast outturn position of breakeven.

The overall position against the profiled revenue budget to the end of January 23 is an underspend of **£0.002m**, with an outturn forecast position of **Breakeven**.

The Trust has now received funding towards both the pay award and the temporary increase in Employers NI.

The Trust has now received confirmation from WG that funding will be provided for the both the incremental increase in energy prices and Covid response costs.

It is expected that any potential cost pressures are managed by budget holders to ensure the delegated expenditure control limits are not exceeded in line with budgetary control procedures.

Two saving schemes relating to service redesign and supportive structures have turned red with contingency plans have been put in place to ensure that the saving target is met for this financial year.

The Trust continues to report a year end forecast breakeven position which is following confirmation from WG that the Exceptional National cost pressures and Covid response costs will be funded. Covid funding towards recovery from commissioners remains a risk, however, will be mitigated on a non-recurrent basis during 2022-23.

2.3   PSPP Performance

During January '23 the Trust (core) achieved a compliance level of **90.15%** (December 22: 92.54%) of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **94.37%** as at the end of month 10.

PSPP compliance levels have temporarily dropped in performance over the last couple of months which is under urgent review. The finance team are working with NWSSP Accounts payable to understand the reasons behind the recent dip performance with a view to specifically target the invoices that are failing which should support a quick recovery in order for the 95% target to be achieved during 2022-23.

2.4   Covid Expenditure

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Covid-19 Revenue Spend / Funding 2022/23					
	WG £m	Commissioners £m	Total £m	IMTP Plans £m	Cost Reduction £m
Mass Vaccination	0.199		0.199	0.375	0.176
PPE	0.070		0.070	0.335	0.265
Cleaning	0.289		0.289	0.427	0.138
Other Covid Response	0.286		0.286	0.967	0.681
Covid Recovery - Internal Capacity		3.167	3.167	6.056	2.889
Covid Recovery - Outreach		0.261	0.261	4.150	3.889
	0.845	3.428	4.273	12.310	8.037

The overall gross funding requirement related to Covid has reduced further and currently stands at £4.273m, with £0.845m being recognised for funding from WG, and the balance of £3.428m being sought from our Commissioners.

The £4.273m represents a significant reduction in outsourcing costs from the Trust IMTP plan as of 31st March, largely due to the liquidation of the Rutherford Cancer Centre (RCC).

Other funding / cost reduction reflects control measures and review of service delivery models to reflect latest WG Covid de-escalation guidance.

2.5   Reserves

The financial strategy for 2022-23 facilitated the development of a recurrent and non-recurrent reserve in support of the Trust transformation and delivery agenda. These reserves could only be accommodated on the basis that all income expectations are received, planned savings schemes delivered and new emerging cost pressures managed. In addition, the Trust holds an emergency reserve of £0.522m.

A review of the reserves position is currently underway which is following confirmation from WG that both Covid and the Exceptional National Costs will be funded, however any potential release of reserves which are recurrent in nature will need to be ringfenced to support next years expected financial pressures on both energy and Covid recovery staff capacity.

Unavoidable cost pressures and investment decisions will still be considered for reserves funding during 2022/23.

2.6   Financial Risks

Covid

The Trust continues to be in dialogue with Commissioners with regards to the costs of additional capacity required to meet the demands placed on our Planned Care services. To date, the full requirement of £3.458m, which has been invested in securing additional capacity, has not been agreed by Commissioners. The Trust is managing any shortfall this year however next year when it is anticipated income protection will cease in part or fully, the Trust is expecting to take the full financial shortfall of c£1.5m into 2023-24. The shortfall will need to be met next year through the 1.5% discretionary uplift, additional Trust savings or disinvestment from a proportion of the Covid recovery staffed capacity

2.7   Capital

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

Slippage on the nVCC Enabling works has resulted in the Trust returning £7.102m of funding to WG during 2022/23 which will be re-provided next financial year.

The Trust (during November) received the funding award letter from WG in relation to IRS. The total funding allocated is £41.602m for the period April 22 to March 2026 with £7.9m of the total to be provided during 2022/23.

The Trust CEL was fixed on the 31st October. At this point WG expect any further slippage to be managed internally by the Trust.

b) Discretionary Programme

The Trust discretionary capital allocation for 2022/23 is £1.454m. This represents a 24% reduction in capital allocation compared to £1.911m in 2021/22 and is reflective of the reduced overall NHS capital budget position.

The Trust Discretionary Programme for 2022/23 was approved by EMB in August and is expected to deliver and remain within the CEL.

3.   IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The Trust financial position at the end of January 2023 is an underspend of £0.002m with a year-end forecast break-even position in accordance with the approved IMTP

4. RECOMMENDATION

QSP is asked to **NOTE**

4.1 the contents of the January 2023 financial report and in particular the financial performance to date, and the year-end forecast to achieve financial break-even and key risk in relation to income to cover Covid backlog additional capacity costs.

4.2 the TCS Programme financial report for January 2023 attached as **Appendix 1**.

FINANCIAL PERFORMANCE REPORT

FOR THE PERIOD ENDED JANUARY 2022/23

## QUALTY, SAFETY & PERFORMANCE
16/03/2023

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 2022-23.

2. Background / Context

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

- The Trust submitted a balanced three year IMTP, covering the period 2022-23 to 2024-25 to Welsh Government on the 31 March 2022.

- For 2022-23 the Plan (excl Covid) included;
  - an underlying **deficit of -£0.5m** brought forward from 2021-22,
  - FYE **of new cost pressures / Investment** of -**£11.461m,**
  - offset by **new recurring Income** of **£11.161m,**
  - and Recurring FYE **savings schemes** of **£0.8m,**
  - Allowing **a balanced position** to be carried into 2023-24.

- The underlying deficit is expected to be eliminated during 2022/23 through the discretionary uplift in funding, enabling a balanced position to be carried into 2023/24.

- **To eliminate the brought forward underlying deficit, the savings target set for 2022-23 must be achieved, all anticipated income is received, and any new emerging costs pressures are either mitigated at Divisional level or managed through the Trust reserves.**
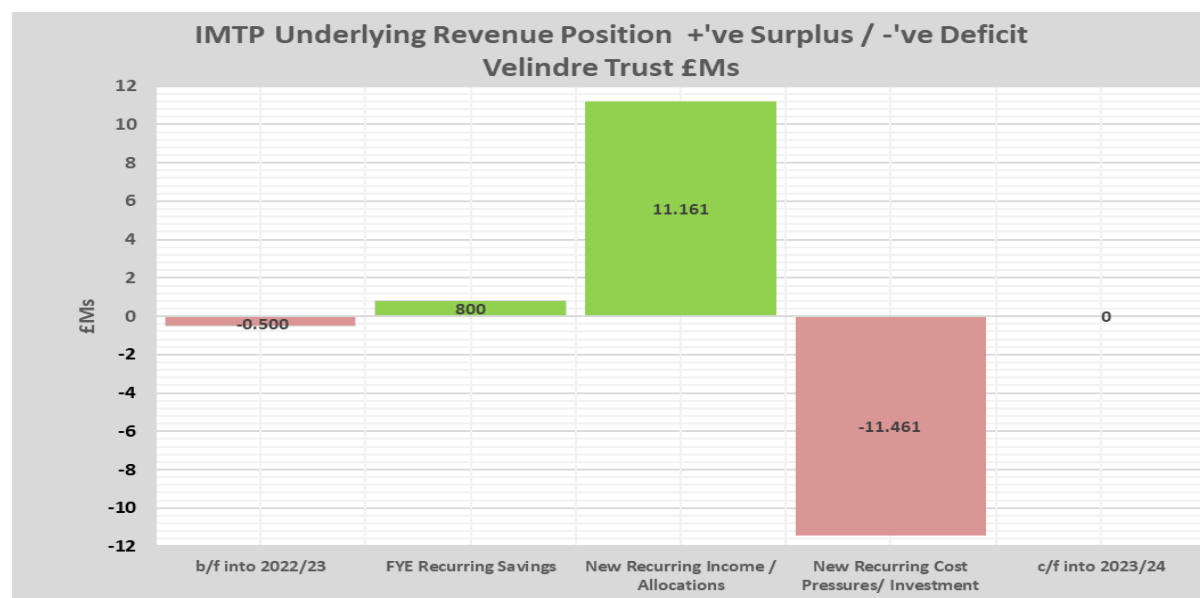
Underlying Position +Deficit/(-Surplus) £Ms	b/f into 2022/23	Recurring Savings	New Recurring Income / Allocations	FYE New Cost Pressures/ Investment	c/f into 2023/24
Velindre NHS Trust	-0.500	0.800	11.161	-11.461	0

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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	(0.004)	0.002	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	2.550	14.537	27.760
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	90.2%	94.4%	95.0%

Performance against Planned Savings Target

	Unit			
Efficiency / Savings	Variance	0	0	0

Revenue

The Trust has reported a £(0.004)m overspend for January '23, with a cumulative position of £0.002m underspent, and an outturn forecast position of **Breakeven**.

Capital

The approved Capital Expenditure Limit (CEL) as at January '22 is **£27.760m**. This represents all Wales Capital funding of **£26.306m**, and Discretionary funding of **£1.454m.** The Trust reported Capital committed spend to January'23 of £14.537m and is forecasting to remain within its CEL of £27.760m for 2022-23.

The Trust's CEL is broken down as follows:

	£m Opening	£m Movement	£m January 2023
Discretionary Capital	1.454	0.000	1.454
All Wales Capital:			
Fire Safety	0.500	0.000	0.500
CANISC Cancer Project	0.000	0.579	0.579
TCS Programme	23.902	-7.102	16.800
IRS		7.900	7.900
Priority Year end Spend		0.370	0.370
WBS Infrastructure Fees		0.157	0.157
Subtotal All Wales Capital	24.402	1.904	26.306
Total CEL	25.856	1.904	27.760

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With WG agreement, slippage on the TCS Programme has led to a further £0.709m being handed back during January, in total of £7.102m has been provided back to WG during 2022-23. This funding will be re-provided to the programme during 2023/24. WG have now stated that they cannot accept any further slippage this financial year so the programme will need to be manged to the latest CEL.

The Trust has now received approval from WG for the Integrated Radiotherapy Solution (IRS) capital expenditure with £7.900m being provided during 2022-23 and has also been awarded £0.370m as part of the request for year-end priority schemes, along with £0.157, towards the OBC fees for the WBS infrastructure case which gives a revised Trust CEL of £27.760m for 2022-23.

PSPP

During January '22 the Trust (core) achieved a compliance level of **90.15%** December 22: 92.54%) of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **94.37%** as at the end of month 10, and a Trust position (including hosted) of **94.91%** compared to the target of 95%.

PSPP compliance levels have temporarily dropped in performance over the last couple of months which is under urgent review. The finance team are working with NWSSP Accounts payable to understand the reasons behind the recent dip performance with a view to specifically target the invoices that are failing which should support a quick recovery in order for the 95% target to be achieved during 2022-23.

Efficiency / Savings

At this stage the Trust is currently planning to fully achieve the savings target during 2022-23. Replacement schemes have been put in place to support under delivery on two schemes that have turned RAG rated red and will not be achieved during this financial year.

Revenue Position

Cumulative				Forecast			
£1,771 Underspent				Breakeven			
Type	YTD Budget (£'000)	YTD Actual (£'000)	YTD Variance (£'000)	Full Year Budget (£'000)	Full Year Forecast (£'000)	Forecast Variance (£'000)
Income	(146,758)	(146,800)	43	(180,772)	(180,796)	24
Pay	64,403	63,664	739	77,190	76,387	803
Non Pay	82,355	83,135	(780)	103,582	104,408	(827)
Total	0	(2)	2	(0)	(0)	(0)

The overall position against the profiled revenue budget to the end of January 2023 is an underspend of **£0.002m**, along with an overall outturn forecast position of **Breakeven**.

The Trust continues to report a year end forecast breakeven position which is following confirmation from WG that the Exceptional National cost pressures and Covid response costs will be fully funded. Covid funding towards recovery from commissioners remains a risk, however, will be mitigated on a non-recurrent basis during 2022-23.

4.1 Revenue Position Key Issues

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Income Key Issues

Income is lower than planned on Bone Marrow and Plasma Sales in WBS, with plans having already been put in place to support recovery particularly around plasma sales which has seen a significant overachievement over the last few months.

VCC and Corporate over achievement to date on private patient, SACT homecare and Bank interest.

Pay Key Issues

The total Trust vacancies as at January 2023 is 124wte, VCC (65wte), WBS (33wte), Corporate (15Wte), R&D (9wte), TCS (0wte) and HTW (2wte).

The Trust has now received the pay award funding of £3.065m from WG relating to 2022/23. Following review by Divisions the funding gap remains at £450k which relates to unfunded incremental drift. The funding gap for this year will be met through the high level of vacancies that has been carried through the Trust across the period, along with the release of the additional annual leave provision carried forward from last year. The recurrent financial impact into future years will need to be considered as part of the IMTP process which is currently underway.

The Trust has now received the full funding of £0.339m from WG towards the temporary increase in Employers NI rates (1.25%).

Vacancies throughout the Trust although reducing remain high, however several posts in both VCC and WBS have been appointed at risk in response to Covid activity backlog and additional capacity required for forward recruitment on service developments without agreed funding pending activity undertaken or FBC approval by WG and Commissioners. In addition, work continues to be underway in both divisions to either secure additional funding to support these posts or looking at options to migrate staff into vacancies to help mitigate the current risk exposure.

Both VCC and WBS hold a £0.450m vacancy factor target, which will need to be achieved during 2022/23 in order to balance the overall Trust financial position.

Non Pay Key Issues

The expected increase in energy prices for December currently stands to £0.671m (December £0.676m). The stepped increase of £0.671m has been recognised as an Exceptional National cost pressures by WG with confirmation now received that this will be fully funded.

Each Division holds both a general reserve to meet unforeseen costs and a savings target / Cost improvement Plan (CIP). The savings target for each division was set as VCC £0.700m, WBS £0.500m and Corporate £0.100m as part of the IMTP for 2022/23.

The Trust reserves and previously agreed unallocated investment funding is held in month 12 and is released into the position to match spend as it occurs throughout the year.
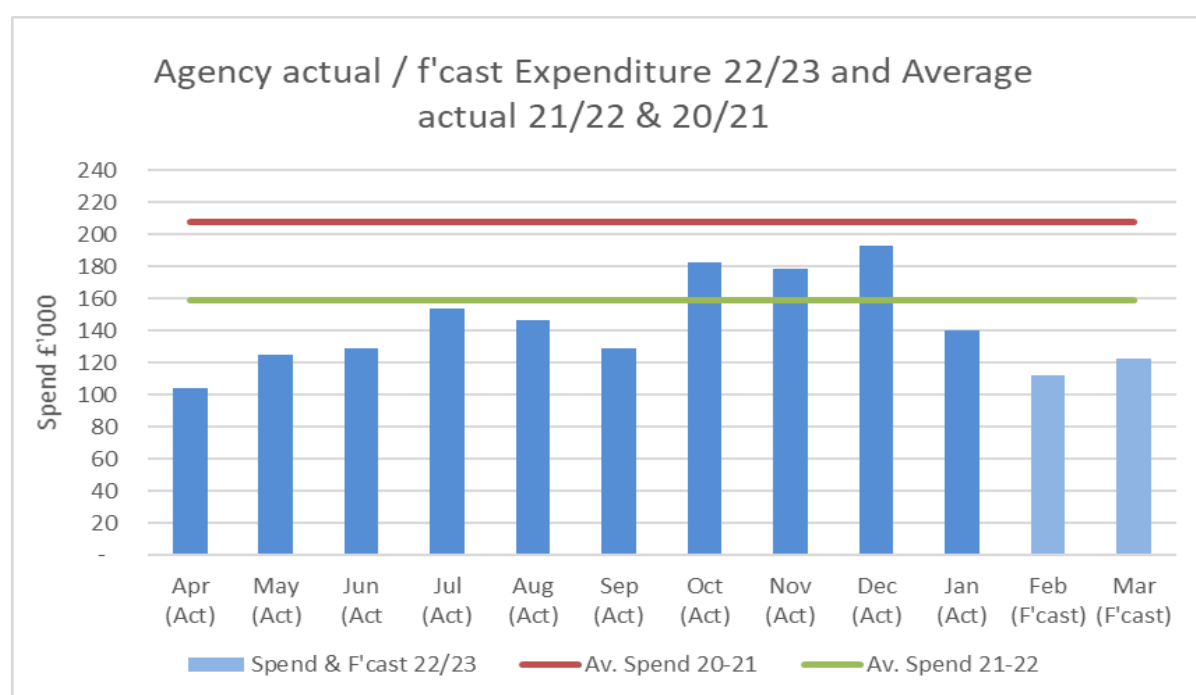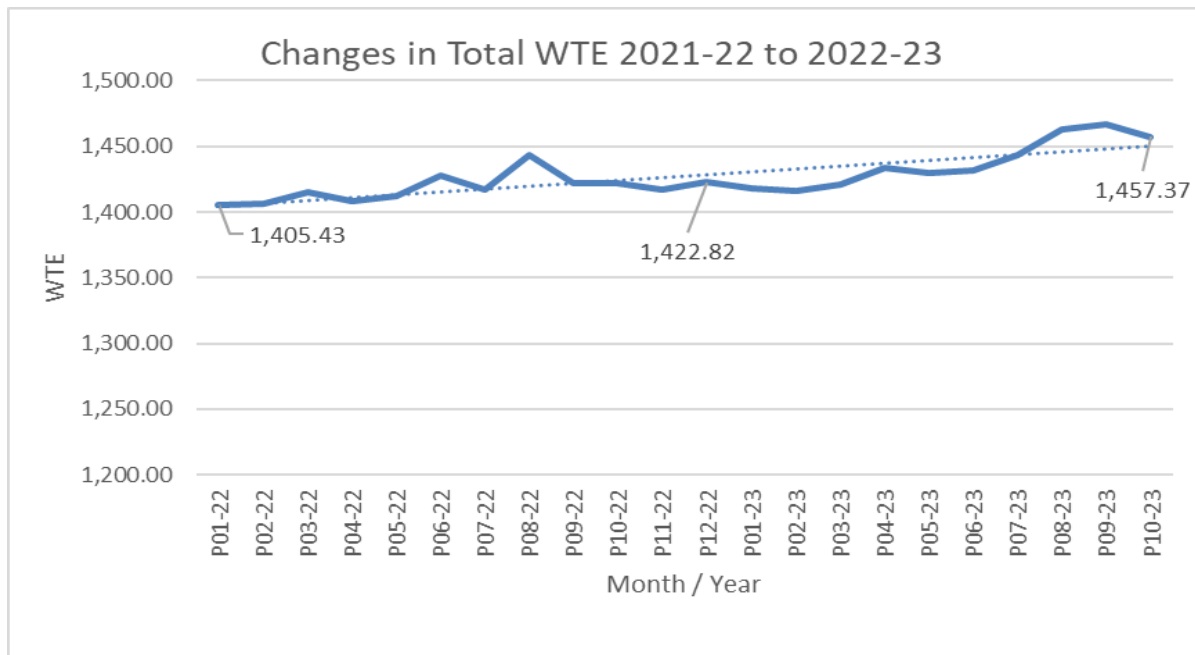
4.2 Pay Spend Trends (Run Rate)

The pay award for 2022/23 was paid in September (back dated to April) as demonstrated in the spike in pay spend shown in the graph below. Agency costs have decreased this year from the 2021/22 levels which is due to the reduction of agency staff previously recruited to support Covid response. Further reductions in the use of agency were expected in 2022/23 by recruiting staff required on a permanent basis. However, more agency staff have been required recently in

particular to support the running of estates in VCC to ensure delivery of ongoing maintenance and statutory compliance duties. The service are actively trying to recruit into current vacancies in order to reduce the need of agency support however this is proving to be a challenge.
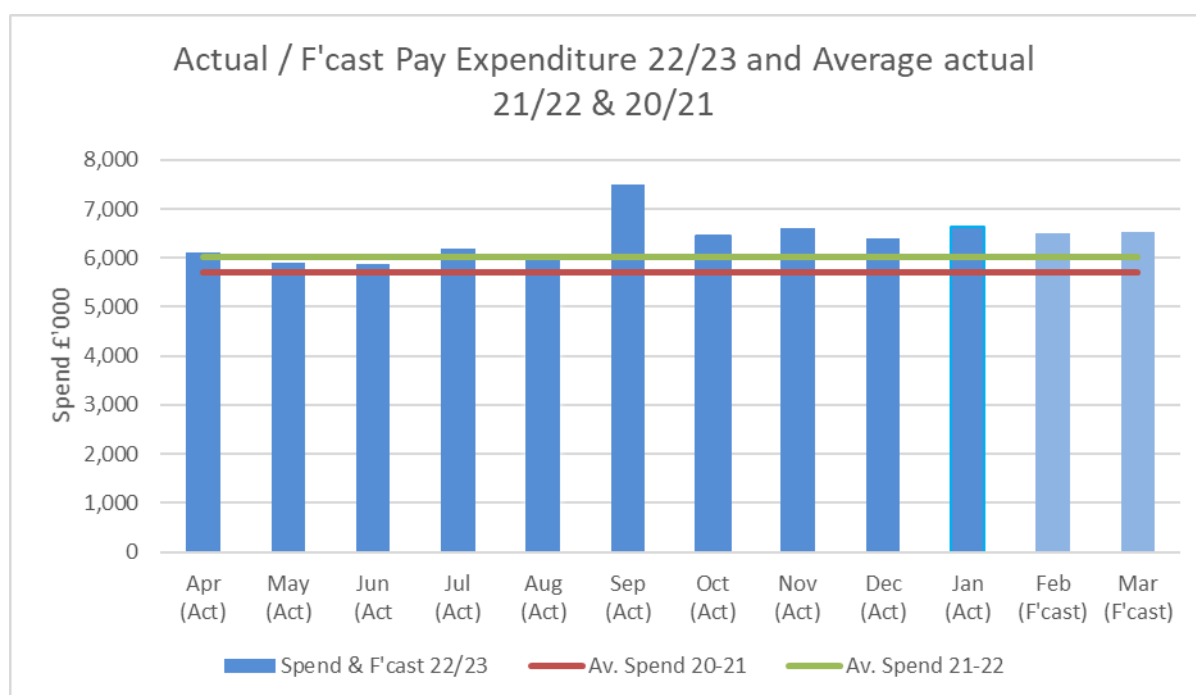
Actual / F'cast Pay Expenditure 22/23 and Average actual 21/22 & 20/21

The spend on agency for January 23 was £0.140m (December £0.193m), which gives a cumulative year to date spend of **£1.482m** and a current forecast outturn spend of circa **£1.717m** (£1.906m 2021/22). Of these totals the year to date spend on agency directly relating to Covid as at the end of January is £0.264m and forecast spend is circa £0.316m (£0.826m 2021/22).

Agency actual / f'cast Expenditure 22/23 and Average actual 21/22 & 20/21

Changes in Total WTE 2021-22 to 2022-23

The increase in WTE (20) during November is largely within VCC and relates to the recruitment of Nurses and HCSW into service area's such as inpatients, Chemotherapy and Prince Charles.

Changes in WTE 2021-22 to 2022-23 By Division
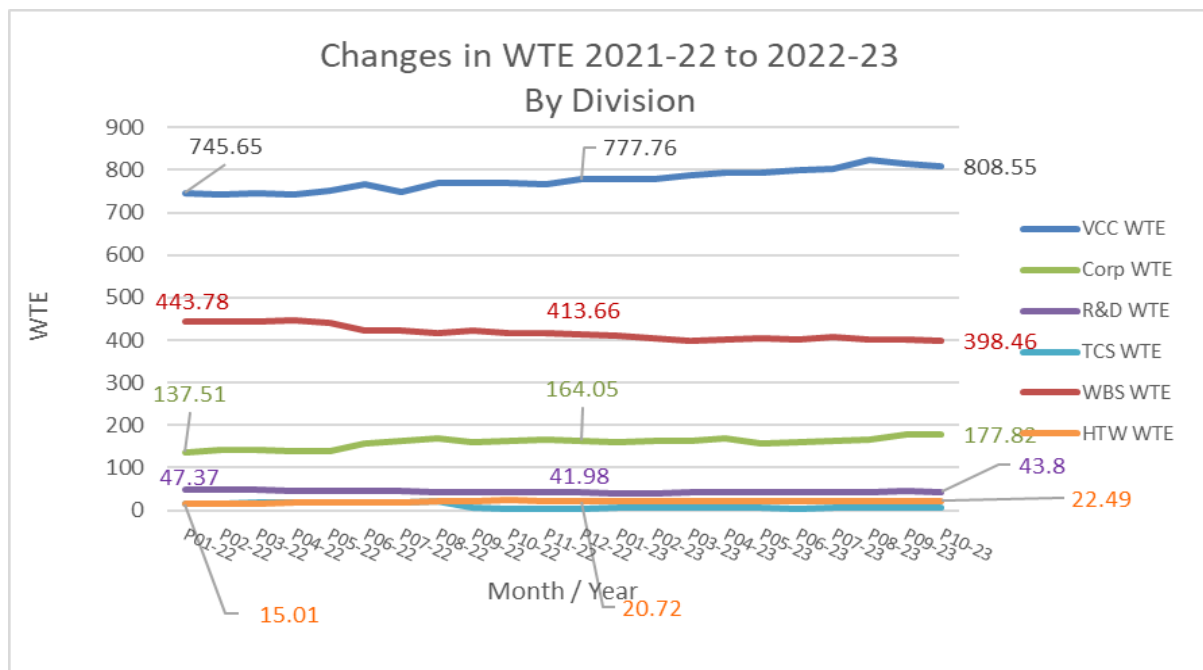
4.3 Non Pay

Non-pay 21/22 (c£96m) average monthly spend of £8m was £1.2m higher than the reported monthly average spend for 20/21 (£6.8m). Most of the monthly average increase (circa £0.9m) related to the growth in NICE / High Cost drug usage following the recovery and associated surge related to Covid and an increase in WBS wholesaling (circa £0.3m). The average monthly spend for 22-23 is currently £8.3m which is an average increase of circa £0.3m against 21/22 expenditure and is mainly due to the increase in NICE / High Cost drugs.

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Monthly Non Pay Spend 2022-23 compared to Average 21-22 & 20-21
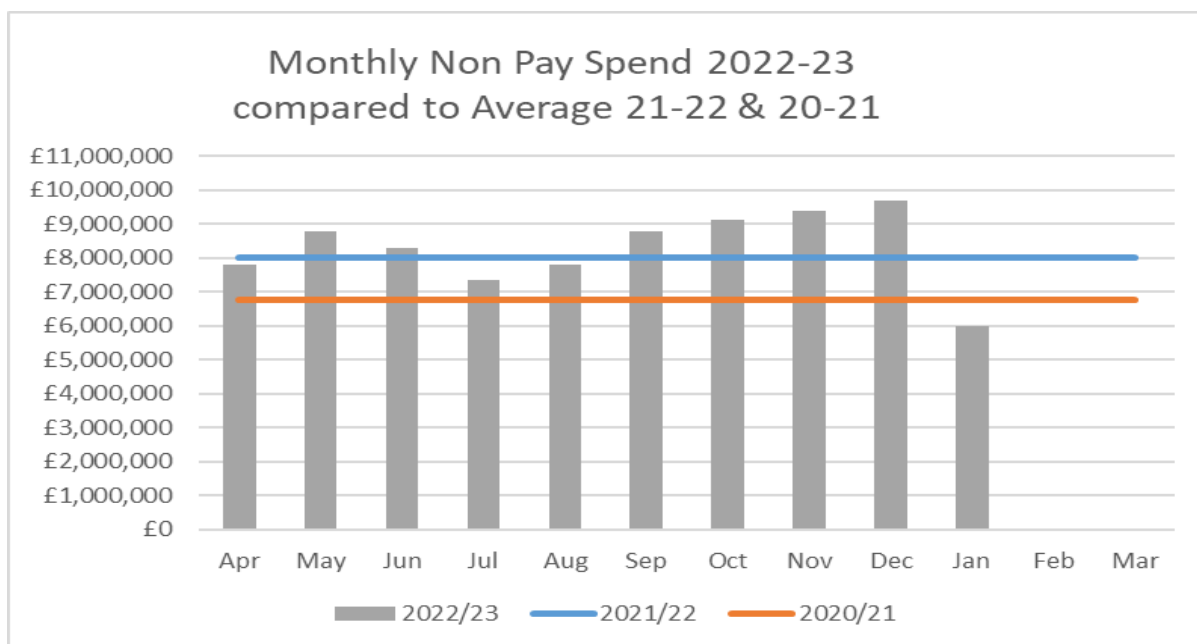
Drugs movement during January relates to receipt of rebates on a significantly higher scale than anticipated which has been relayed to and will be passed on to the Health Boards and WHSSC. In addition, there has been delays in implementation of new NICE drug treatments for SACT compared to the horizon scanning used to forecast patient volumes and cost.

4.4 Covid-19

The latest forecast funding requirement as at 31st January in relation to Covid for 2022-23 has been further revised down to £4.273m (December £4.388m) which is a significant reduction from the £12.310m that was submitted as part of the Trust IMTP. Of the £4.273m total Covid requirement £0.845m (IMTP plans £2.104m) is being requested directly from WG, and the balance of £3.428m (IMTP plans £10.206m) being sought from our commissioners.

Covid-19 Revenue Spend / Funding 2022/23					
	WG £m	Commissioners £m	Total £m	IMTP Plans £m	Cost Reduction £m
Mass Vaccination	0.199		0.199	0.375	0.176
PPE	0.070		0.070	0.335	0.265
Cleaning	0.289		0.289	0.427	0.138
Other Covid Response	0.286		0.286	0.967	0.681
Covid Recovery - Internal Capacity		3.167	3.167	6.056	2.889
Covid Recovery - Outreach		0.261	0.261	4.150	3.889
	0.845	3.428	4.273	12.310	8.037

The latest forecast spend and funding requirement from WG has decreased by a further £0.035m from £0.880m reported in December to £0.845m. Cost reduction on Mass Vaccination with WBS no longer providing storage and distribution support to NHS Wales.

The Trust has now received confirmation that funding will be provided from WG for all associated Covid response costs.

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The Trust Covid expenditure is based on activity demand forecast modelling which commenced in 2021/22 and has been updated regularly working with Health Board operational teams. The Trust has already invested £2.943m in additional capacity. The anticipated funding requirement of £4.150m for outsourcing has been removed as the Rutherford went into liquidation earlier this year. The Trust had also been working up plans to expand internal capacity which it has now established in its outreach Centre at Prince Charles Hospital (from October) for SACT, with forecast additional cost above that already invested in Covid capacity of circa £0.261m. In addition, the Trust has developed plans for expanding Radiotherapy capacity internally through use of weekend working which will require existing staff to work additional hours as WLIs with enhanced pay rates. The full cost and operational deliverability of this additional capacity is still being worked up. These additional investments in capacity to meet the activity demand from Health Boards will not be fully covered through LTA marginal income leading to an additional financial pressure to the Trust which it is managing through use of non-recurrent measures in 2022-23. However, with the anticipated removal of the LTA income protection in 2023-24 there will be a significant financial risk of c£1.5m which the Trust may not be able to cover depending on demand and its ability to deliver activity within the current capacity.

Other cost reduction from IMTP plans reflects financial control measures and review of service delivery models to reflect latest WG Covid de-escalation guidance.

4. Savings

The Trust established as part of the IMTP a savings requirement of £1.300m for 2022-23, £0.800m recurrent and £0.500m non-recurrent, with £0.750m being categorised as actual saving schemes and £0.550m being income generation.
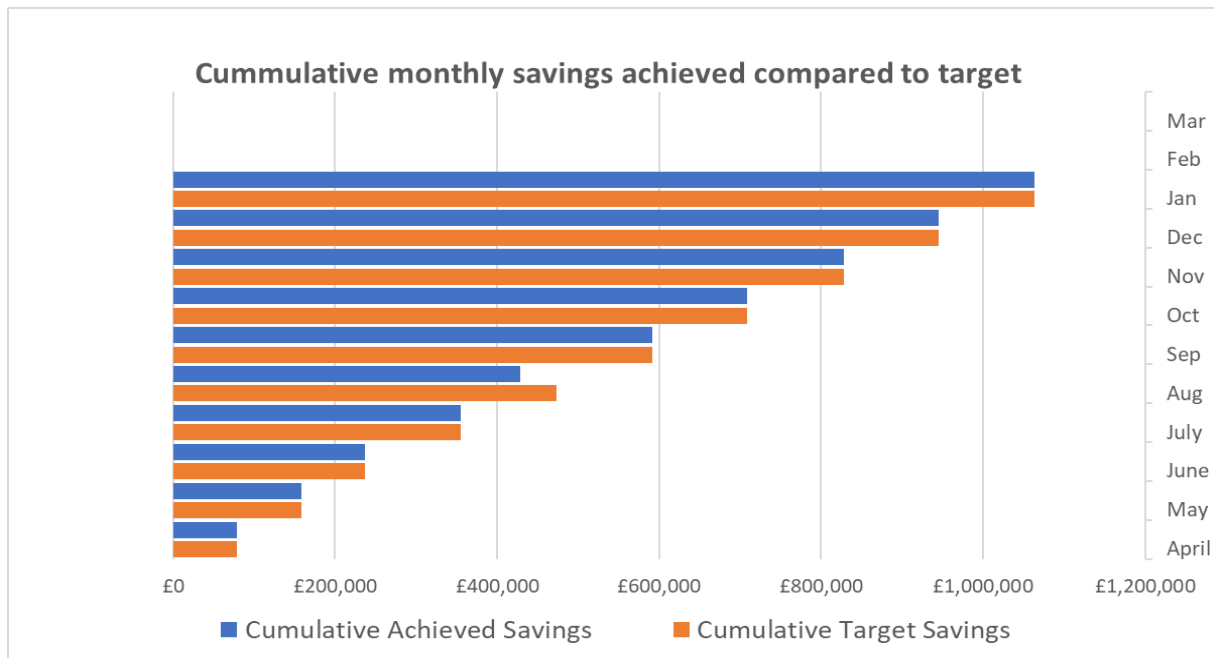
The divisional share of the overall Trust savings target has been allocated to VCC £0.700m (54%), WBS £0.500m (38%), and Corporate £0.100m (8%).

Two schemes continue to be impacted by Covid during 2022-23 have now turned red which relate to service redesign and supportive structures.

Service redesign and supportive structures is a key area of savings for the Trust which are focused on removing inefficiencies in the ways the Trust are working. These plans are aligned to a number of the Trust VBHC bids that sought funding for new posts to support medical workforce redesign but were unsuccessful. The ability to enact these saving schemes is proving to be difficult due to the legacy of the pandemic and current workforce situation, particularly the high number of vacancies along with the high level of sickness that is currently being experienced throughout the Trust. Plans are still being developed by the Trust divisions however, it is recognised due to the current challenges that these saving schemes will not be achieved in the short term and therefore delivery has been removed from this financial year.

Contingency measures have been put in place on the basis that these savings schemes will not achieved this year, however these replacement schemes are both recurrent and non-recurrent in nature. **It is extremely important that divisions continue to review their current savings schemes, and where delivery is not going to be achieved this year consider the impact on next year's financial position especially where those schemes were classified as recurrent.**

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ORIGINAL PLAN	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	Full Year Actual £000	Variance Full Year £000
VCC TOTAL SAVINGS	700	564	408	(156)	500	(200)
			72%		71%	
WBS TOTAL SAVINGS	500	417	417	0	500	0
			100%		100%	
CORPORATE TOTAL SAVINGS	100	83	83	0	100	0
			100%		100%	
TRUST LEVEL TOTAL SAVINGS			155	155	200	200
TRUST TOTAL SAVINGS IDENTIFIED	1,300	1,063	1,064	0	1,300	0
			100%		100%	

Scheme Type	RAG RATING	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	F'cast Full Year £000	Variance Full Year £000
Savings Schemes							
Establishment Control (Corporate)	Green	100	83	83	0	100	0
Laboratory & Collection Model (WBS)	Green	50	42	42	0	50	0
Laboratory & Collection Model (WBS)	Green	50	42	42	0	50	0
Stock Management (WBS)	Green	100	83	83	0	100	0
Stock Management (WBS)	Green	150	125	125	0	150	0
Procurement - Supply Chain (WBS)	Green	50	42	42	0	50	0
Service Redesign (VCC)	Red	100	78	0	(78)	0	(100)
Supportive Stuctures (VCC)	Red	100	78	0	(78)	0	(100)
Procurement - Supply Chain (VCC)	Green	50	42	42	0	50	0
Bank Interest (Trust - In Year)	Green		0	122	122	167	167
Vacancy Factor (Trust - In Year)	Green		0	33	33	33	33
Total Saving Schemes		750	614	614	(0)	750	0

Income Generation							
Maximinsing Income Opportunities - Income Attraction (WBS)	Green	50	42	42	0	50	0
Maximinsing Income Opportunities - Income Attraction (WBS)	Green	50	42	42	0	50	0
Maximinsing Income Opportunities - Private Patients (VCC)	Green	150	117	117	0	150	0
Maximinsing Income Opportunities - Private Patients (VCC)	Green	100	83	83	0	100	0
Maximinsing Income Opportunities - Income Attraction (VCC)	Green	200	167	167	0	200	0
Total Income Generation		550	450	450	0	550	0

TRUST TOTAL SAVINGS		TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	F'cast Full Year £000	Variance Full Year £000
TRUST TOTAL SAVINGS		1,300	1,063	1,064	(0)	1,300	0
			100%		100%	

Cummulative monthly savings achieved compared to target

Legend: ■ Cumulative Achieved Savings   ■ Cumulative Target Savings

5. Reserves

The financial strategy for 2022-23 facilitated the development of a recurrent and non-recurrent reserve in support of the Trust transformation and delivery agenda. These reserves could only be accommodated on the basis that all income expectations are received, planned savings schemes delivered and new emerging cost pressures managed. In addition, the Trust holds an emergency reserve of £0.522m.

A review of the reserves position is currently underway which is following confirmation from WG that both Covid and the Exceptional National Costs will be funded, however any potential release of reserves which are recurrent in nature will need to be ringfenced to support next years expected financial pressures on both energy and Covid recovery staff capacity.

Unavoidable cost pressures and investment decisions will still be considered for reserves funding.

6. End of Year Forecast / Risk Assessment

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

Covid Funding via Commissioners – *Risk TBC, Likelihood - Low*

Commissioners have not committed to providing the full funding ask of £3.428m as a block funding arrangement but have all stated that any funding required to cover additional Covid recovery costs will flow through the LTA under the national funds flow mechanism. This mechanism, whilst providing enhanced income protection over the normal LTA arrangements, does not cover the additional costs of enhanced pay rates for WLI's or additional costs above marginal when establishing new capacity. The Trust has received signed LTA's back from our commissioners, however the funding for planned care & Covid backlog capacity remains a risk for the Trust.

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Whilst this remains a risk, the Trust is managing any shortfall this year.

WG have now confirmed that the full funding will flow for both Covid response costs and the Exceptional national cost pressures, so these risks have been removed from the position from 2022/23.

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 @ M10 £m	Full Year Actual Spend £m	Year End Variance £m
All Wales Capital Programme						
nVCC - Project costs	2.394	2.496	0.000	-0.102	2.923	-0.529
nVCC - Enabling Works	14.406	8.913	0.000	5.493	13.877	0.529
Canisc Cancer Project	0.579	0.579	0.000	0.000	0.579	0.000
Fire Safety	0.500	0.294	0.000	0.206	0.500	0.000
Integrated Radiotherapy Solutions (IRS)	7.900	1.554	0.000	6.086	7.640	0.260
WG Priority Year end Spend	0.370	0.000	0.000	0.370	0.370	0.000
WBS Infrastructure OBC Fees	0.157	0.000	0.000	0.157	0.157	0.000
Total All Wales Capital Programme	26.306	13.836	0.000	12.210	26.046	0.260
Discretionary Capital	1.454	0.510	0.191	0.753	1.714	-0.260
Total	27.760	14.346	0.191	12.963	27.760	0.000

The approved 2022/23 Capital Expenditure Limit (CEL) as at January 2023 was £27.760m. This includes All Wales Capital funding of £26.306m, and discretionary funding of £1.454m. The approved CEL has increased in year by £1.904m which reflects approval of the Canisc Cancer Project (0.579m), IRS (7.900m), Velindre's share of the WG yearend spend request (£0.370m) and support fees for the WBS infrastructure OBC (£0.157m). This is offset by a reduction of £7.102m on the nVCC Enabling works project to reflect the latest forecast requirement for 2022/23. Following agreement with WG the £7.102m will be re-provided to the programme during 2023/24.

WG colleagues have agreed a further movement of £0.529m between the nVCC enabling and project costs which is reflected in the table above but represented as a variance rather than a CEL adjustment.

In January 2022 WG informed the Trust that the discretionary allocation will be significantly reduced during 2022/23 (previously £1.911m), which is reflective of the reduced overall NHS capital budget position.

Allocation of the discretionary programme was approved by EMB Shape on the 27th August.

Following a request from WG a list of prioritised bids was approved by EMB on 26th October for submission to WG should any Capital funding become available. The Trust received confirmation

during November that £0.370m of additional funding would be provided to support delivery of the priority one schemes which includes replacement Hemoflows in WBS £0.238m, Patient Monitors in VCC £0.062m and £0.070m towards Digital priorities.

On the 22nd November the Trust received the award funding letter from WG in relation to IRS. The total funding allocated is £41.602m for the period April 22 to March 2026 with £7.900m of the total to be provided during 2022/23 with future years funding cash flow to be agreed with WG.

Within the £7.900m of IRS funding, £0.694m has been released back into the discretionary programme which was previously either spent or ringfenced to support the procurement stage of the IRS project. Of the £0.694m, £0.434m was ringfenced from discretionary in 2022/23 and £0.260m will be reimbursed from the WG funding allocation as the spend was incurred last financial year.

The £0.694m will be utilised to support the remaining priority one schemes that were submitted to EMB on the 26th October but not supported by WG.

The Trust CEL was fixed on the 31st October. At this point WG expect any further slippage to be managed internally by the Trust.

On the 16th December the Trust was awarded funding of £11.400m in respect of the Integrated Radiotherapy Solution for the Satellite Centre at Nevil Hall. The funding will be drawn down from 2023/24 and beyond to match the profiled spend.

Performance to date

The actual cumulative expenditure to January 2023 on the All-Wales Capital Programme schemes was £13.836m, this is broken down between spend on the nVCC enabling works £8.913m, nVCC project costs of £2.496m, Canisc Cancer Project £0.579m, fire safety £0.294m, and IRS £1.554m.

Spend and committed spend to date on Discretionary Capital is currently £0.701m leaving a remaining balance of £0.753m as at the 31st January.

Year-end Forecast Spend

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

Major Schemes in Development

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

Major Schemes in development that will be considered during 2022/23 and beyond in conjunction with WG include both WBS HQ and nVCC:

	Scheme	Scheme Total	Stage (i.e. OBC development, FBC development, scoping etc.)	21/22 £m	22/23 £m	23/24 £m	24/25 £m	25/26 £m	26/27 £m	27/28 £m	28/29 £M	29/30	30/31
1	WBS HQ	34.646*	FBC under development	0.221	0.180	0.120	1.016	12.808	9.996	4.434	5.215	0.608	0.048
2	NVCC	*TBC	FBC Under development										

*Scheme totals and Cash flow of these schemes is still under review alongside WG.

Other Major schemes which are under discussion internally and WG are sighted on include VCC outpatients, ventilation, and plasma fractionation.

8. BALANCE SHEET (Including Hosted Organisations)

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

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

	Opening Balance Beginning of Apr 22	Closing Balance End of Jan-23	Movement from 1st April Jan-23	Forecast Closing Balance End of Mar 23
Non-Current Assets	£'m	£'m	£'m	£'m
Property, plant and equipment	143.136	159.486	16.350	154.486
Intangible assets	8.667	7.803	(0.864)	7.303
Trade and other receivables	1,092.008	1,293.459	201.451	1,293.459
Other financial assets	0.000	0.000	0.000	0.000
Non-Current Assets sub total	1,243.811	1,460.748	216.937	1,455.248
Current Assets				
Inventories	65.207	50.019	(15.188)	45.000
Trade and other receivables	540.227	282.004	(258.223)	319.336
Other financial assets	0.000	0.000	0.000	0.000
Cash and cash equivalents	30.404	45.313	14.909	18.500
Non-current assets classified as held for sale	0.000	0.000	0.000	0.000
Current Assets sub total	635.838	377.336	**(258.502)**	382.836
TOTAL ASSETS	1,879.649	1,838.084	**(41.565)**	1,838.084
Current Liabilities				
Trade and other payables	(277.601)	(231.562)	46.039	(231.562)
Borrowings	0.00	0.00	0.000	0.00
Other financial liabilities	0.00	0.00	0.000	0.00
Provisions	(341.123)	(342.274)	(1.151)	(342.274)
Current Liabilities sub total	**(618.724)**	**(573.836)**	44.888	**(573.836)**
NET ASSETS LESS CURRENT LIABILITIES	1,260.925	1,264.248	3.323	1,264.248
Non-Current Liabilities				
Trade and other payables	(7.336)	(7.336)	0.000	(7.336)
Borrowings	0.00	0.00	0.000	0.00
Other financial liabilities	0.00	0.00	0.000	0.00
Provisions	(1,094.206)	(1,091.599)	2.607	(1,091.599)
Non-Current Liabilities sub total	**(1,101.542)**	**(1,098.935)**	2.61	**(1,098.935)**
TOTAL ASSETS EMPLOYED	159.383	165.313	5.930	165.313
FINANCED BY:				
Taxpayers' Equity				
General Fund	0.000	0.000	0.000	0.000
Revaluation reserve	30.935	30.934	(0.001)	30.934
PDC	112.982	118.911	5.929	118.911
Retained earnings	15.466	15.468	0.002	15.468
Other reserve	0.000	0.000	0.000	0.000
Total Taxpayers' Equity	**159.383**	**165.313**	**5.930**	**165.313**

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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 uncertain situation with Covid and potential impact on supply chains the Trust continues to hold this stock with assessments ongoing. NWSSP however have now released the stock and the £4.5m will be repaid to WG during February.

Due to the high levels of purchases relating to Covid within NWSSP, the cash levels over the past year or so have been significantly higher than usual, however by the end of this financial year expectation is that cash balances should return to pre-Covid levels.

Following a request from WG the Trust transferred £5.9m of cash into the Escrow holding account during May for the nVCC programme. These funds were consequently drawn down in July from WG to reimburse the Trust ensuring that there was no cash risk to the organisation.

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

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		Apr £'m	May £'m	Jun £'m	Jul £'m	Aug £'m	Sep £'m	Oct £'m	Nov £'m	Dec £'m	Jan £'m	Feb £'m	Mar £'m	Totals £'m
	RECEIPTS													
1	LHB / WHSSC income	33.135	40.208	40.042	37.491	47.836	36.522	43.649	41.695	38.513	45.628	41.970	40.018	486.707
2	WG Income	20.937	24.551	17.010	24.552	15.002	26.148	32.585	33.410	26.654	16.898	24.687	23.482	285.916
3	Short Term Loans													0.000
4	PDC				5.928								14.811	20.739
5	Interest Receivable	0.019	0.027	0.030	0.025	0.037	0.062	0.075	0.105	0.103	0.174	0.080	0.080	0.817
6	Sale of Assets													0.000
7	Other	7.106	7.289	4.321	6.094	4.246	6.395	8.220	6.982	11.052	6.891	3.283	4.047	75.927
8	TOTAL RECEIPTS	61.197	72.074	61.403	74.090	67.121	69.127	84.529	82.192	76.323	69.591	70.020	82.438	870.105
	PAYMENTS													
9	Salaries and Wages	21.735	29.243	29.483	29.705	29.549	34.417	36.535	33.118	32.231	32.387	32.266	32.738	373.407
10	Non pay items	30.543	33.079	54.139	17.703	44.384	20.200	63.158	29.085	55.738	30.845	44.404	47.882	471.160
11	Short Term Loan Repayment												4.500	4.500
12	PDC Repayment													0.000
14	Capital Payment	1.926	2.567	1.420	1.215	1.428	0.446	1.469	2.732	1.152	1.105	10.108	7.374	32.942
15	Other items													0.000
16	TOTAL PAYMENTS	54.205	64.889	85.042	48.623	75.361	55.063	101.162	64.935	89.121	64.337	86.778	92.494	882.009
		1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
17	Net cash inflow/outflow	6.993	7.185	(23.639)	25.467	(8.240)	14.064	(16.633)	17.257	(12.798)	5.254	(16.757)	(10.055)	
18	Balance b/f	30.404	37.397	44.582	20.943	46.410	38.170	52.234	35.601	52.858	40.060	45.313	28.556	
19	Balance c/f	37.397	44.582	20.943	46.410	38.170	52.234	35.601	52.858	40.060	45.313	28.556	18.500	

Monthly Cash Flow Forecast

Cash Receipts — Cash Payments — Monthly Cash Balance

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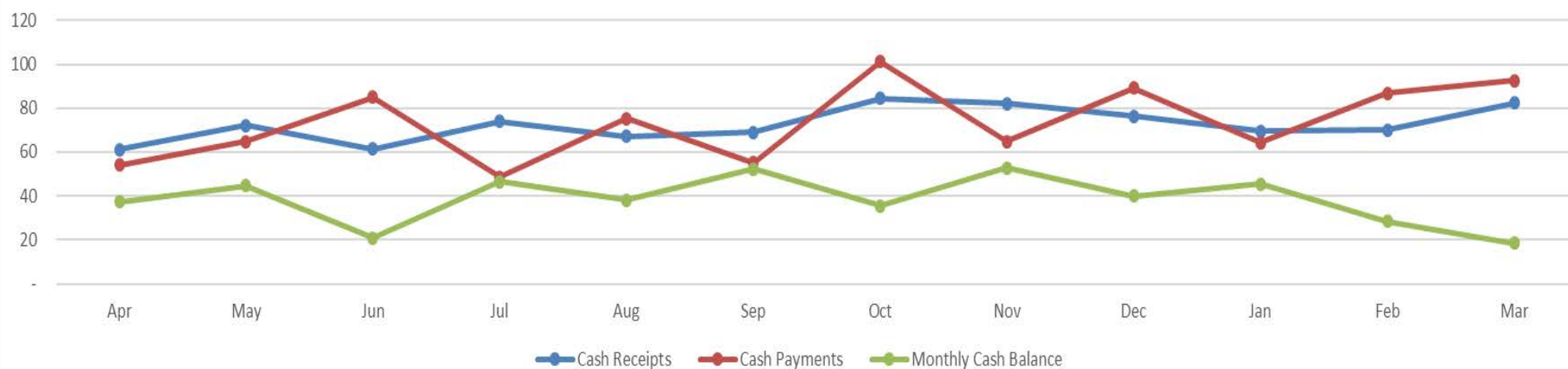
DIVISIONAL ANALYSIS

(Figures in parenthesis signify an adverse variance against plan)

Core Trust

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Variance £000
VCC	(31,365)	(31,366)	0	(38,364)	(38,364)	0
RD&I	(617)	(617)	(0)	175	175	0
WBS	(17,207)	(17,207)	(0)	(20,856)	(20,856)	0
Sub-Total Divisions	**(49,190)**	**(49,190)**	**0**	**(59,046)**	**(59,046)**	**0**
Corporate Services Directorates	(9,216)	(9,213)	(3)	(11,515)	(11,515)	0
Delegated Budget Position	**(58,405)**	**(58,403)**	**(3)**	**(70,561)**	**(70,561)**	**0**
TCS	(551)	(551)	0	(797)	(797)	(0)
Health Technology Wales	(43)	(44)	(1)	(48)	(48)	0
Trust Income / Reserves	59,000	59,000	0	71,406	71,406	0
Trust Position	**(0)**	**2**	**(2)**	**0**	**0**	**(0)**

VCC

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Full Year Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	**55,278**	**55,888**	**610**	**68,303**	**68,801**	**498**
Expenditure						
Staff	37,855	37,852	3	45,476	45,362	**114**
Non Staff	48,788	49,402	(614)	61,191	61,803	**(612)**
Sub Total	**86,643**	**87,253**	**(610)**	**106,667**	**107,165**	**(498)**
Total	**(31,365)**	**(31,366)**	0	**(38,364)**	**(38,364)**	**0**

VCC Key Issues:

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

Income at Month 10 represents a surplus of **£0.610m** and a forecast outturn overachievement of **£0.498m**. This is largely from an increase in activity from the VAT savings made from providing SACT homecare, an over achievement on private patient income due to drug performance, along with a one-off drug rebate. This is offsetting the divisional income savings target of £0.691m as at the end of January.

VCC have reported a year-to-date underspend of **£0.003m** against staff, and a forecast of **£0.114m** underspent. As at month 10 the Division is still carrying a large number of vacancies with the savings generated being above the divisional vacancy factor target and offsetting the cost of agency (£1.055)m to end of January, £0.233m being directly related to Covid). In addition, the savings from vacancies are also supporting the costs of advanced recruitment into IRS.

Medical costs have increased due to additional temporary staff recruited at risk to ensure that all Jnr Dr rotation placements are filled, and to provide additional resilience against pressured consultants. Additionally, enhanced out of hours service, for advanced life support which will be nursing led continues at this stage covered by Jnr Dr's with transition to nursing having begun but being phased.

Early recruitment into the delayed Integrated Radiotherapy Solution (IRS) has led to year to date committed cost of £0.469m.

Non-Staff Expenditure at Month 10 was **£(0.614)m** overspent, forecast **£(0.612)m** overspend. The overspend largely relates to the facilities management office pressures which were previously supported by Covid, maintenance and repair of the Linacs, transport SLA overspend, consumable spend from increased activity, and unexpected prior year invoices being received from Virgin Media, which are being partly offset by an underspend on general drugs.

WBS

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	22,097	21,606	(491)	25,774	25,259	(515)
Expenditure						
Staff	14,263	14,231	32	16,960	17,123	(163)
Non Staff	25,042	24,582	460	29,670	28,993	677
Sub Total	39,304	38,813	492	46,630	46,116	514
Total	(17,207)	(17,207)	0	(20,856)	(20,857)	(0)

WBS Key Issues:

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

Income underachievement to date is **£(0.491)m** forecast **£(0.515)m**, where activity is lower than planned on Bone Marrow and Plasma Sales. Targeted income generation YTD from plasma sales to research is not achieving desired levels, however contract one of two awarded for new supplier in October which includes increased selling price. Benefits of new contract reflected with significant overachievement over the past quarter, with expectation that the underachievement will recover by the year end for plasma sales with a forecast overachievement now anticipated . Transitional operating sites for Bone Marrow and increasingly curtailed procedures is resulting in activity being considerably lower than target. The WHSSC income for supressed income is reflected as an

underspend within the non-pay position, however WHSSC income support for the underachievement has now been fully utilised.

Staff reported a small year-to-date underspend of **£0.032m** to January, forecast **£(0.163)m**. Outturn overspend expected from posts supported without identified funding source which 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. WG bid has been submitted to support Plasma Fractionation staffing costs.

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

Non-Staff underspend of **£0.460m,** forecast **£0.677m** is largely due to reduced costs from suppressed activity underspends within Laboratory Services and WTAIL. WTAIL underspend is inclusive of £0.251m relating to Bone Marrow reflected to contra income underachievement as described above.

Corporate

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected £000
Income	1,488	1,736	248	1,583	1,937	354
Expenditure						
Staff	8,335	7,901	434	10,104	9,616	**488**
Non Staff	2,368	3,048	(680)	2,994	3,836	**(842)**
Sub Total	10,703	10,949	(246)	13,098	13,452	(354)
Total	(9,216)	(9,213)	3	(11,515)	(11,515)	0

Corporate Key Issues:

The reported financial position for the Corporate Services division at the end of January 2023 was an underspend of **£0.003m**. The Corporate division is currently expecting to achieve an outturn position of **breakeven**.

The Trust is currently benefiting from receiving greater returns on cash being held in the bank due to the rise in interest rates.

Significant number of vacancies being carried in Corporate (circa 8% of the total divisional workforce) which will lead to a large underspend against staff. This will offset use of agency and ensure achievement the £0.100m divisional savings target.

Non pay overspend is **£(0.680)m,** as at month 10 which largely relates to the divisional savings target FYE £(0.160)m, Microsoft agreement, Welsh Risk Pool (WRP) contribution, and the increased running costs associated with the hospital estate.

RD&I

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	**1,795**	**1,649**	**(147)**	**3,233**	**2,920**	**(314)**
Expenditure						
Staff	2,235	2,084	150	2,826	2,493	**333**
Non Staff	178	182	(4)	232	252	**(19)**
Sub Total	**2,412**	**2,266**	**147**	**3,058**	**2,745**	**314**
Total	**(617)**	**(617)**	**0**	**175**	**175**	**0**

RD&I Key Issues

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

Staff vacancies remain relatively high although active recruitment slowly reducing vacancy levels, however several posted will not be filled before the year end. The underspend on staff is offsetting the innovation income target which has been challenging and not expected to be met this year.

TCS – (Revenue)

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	**0**	**0**	**0**	**0**	**0**	**0**
Expenditure						
Staff	482	482	0	598	567	**31**
Non Staff	70	70	0	76	107	**(31)**
Sub Total	**551**	**551**	**0**	**674**	**674**	**(0)**
Total	**(551)**	**(551)**	**0**	**(674)**	**(674)**	**(0)**

TCS Key Issues

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

Preapproved reserves budget for strategic transformation £0.060m, non-pay costs of £0.030m, along with the total associated costs of the judicial review £0.033m has now been transferred into the TCS budget for 2022-23.

HTW (Hosted Other)

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	**1,386**	**1,209**	**(177)**	**1,664**	**1,664**	**0**
Expenditure						
Staff	1,234	1,114	119	1,476	1,476	**0**
Non Staff	196	139	57	235	235	**0**
Sub Total	**1,430**	**1,253**	**177**	**1,712**	**1,712**	**0**
Total	**(43)**	**(44)**	**(1)**	**(48)**	**(48)**	**0**

HTW Key Issues

The reported financial position for Health Technology Wales at the end of January 2023 was **breakeven,** with a forecasted outturn position of **breakeven** on the basis that any potential slippage will be handed back to WG**.**

Appendix 1 – TCS Programme Board Finance Report

TCS Programme Board Finance Repo
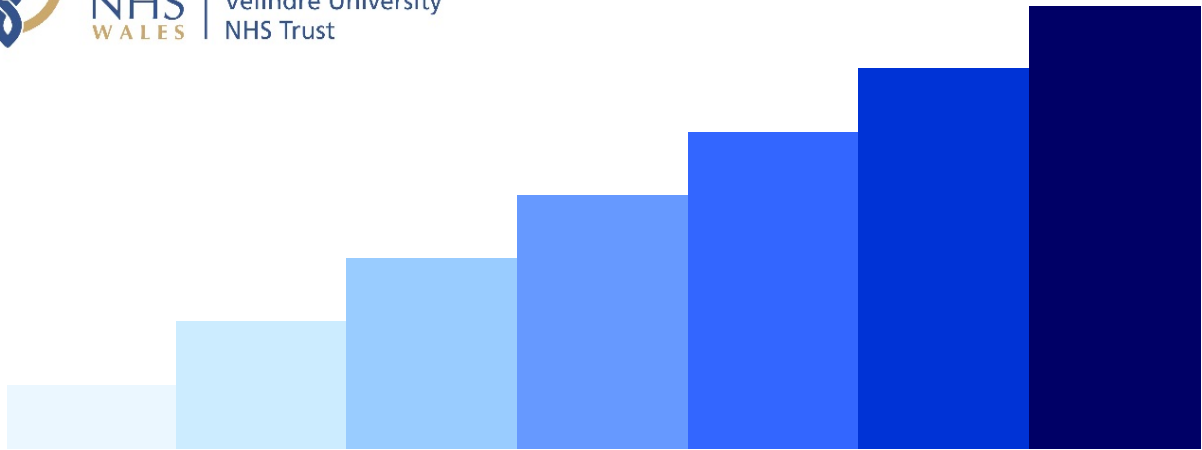
TCS PROGRAMME
FINANCE REPORT 2022-23

Period Ending January 2023

**Presented to the
TCS Programme Delivery Board on
15th February 2023**

Contents   Page

1. INTRODUCTION

1.1 The purpose of this report is to provide a financial update for the Transforming Cancer Services (TCS) Programme for the financial year 2022-23, outlining spend to date against budget as at January 2023 and the current year-end forecast.

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

2. EXECUTIVE SUMMARY

2.1 The summary financial position for the TCS Programme for the year 2022-23 as at 31st January 2023 is provided below. A detailed table of budget, spend and variance for the capital and revenue expenditure is provided in Appendix 1.

Expenditure Type	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Capital	£11.590m	£16.801m	£16.800m	£0.001m
Revenue	£0.551m	£0.674m	£0.674m	£0m
Total	**£12.141m**	**£17.475m**	**£17.474m**	**£0.001m**

2.2 The Programme is currently forecasting an overall underspend of £0.001m against a budget of £17.475m for the financial year 2022-23.

2.3 The Enabling Works forecast position reflects an under-spend of £0.530m, which will support the nVCC Project. This will be provided from the Enabling Works QRA and poses a low financial risk for the Enabling Works Project. The approach has been agreed with WG and we are awaiting formal approval.

2.4 A review of the Enabling Works Project funding requirements in January 2022 has resulted in a further virement of £0.709m from 2022-23 into 2023-24, as agreed with WG. This reduces the overall **capital** funding for 2022-23 to **£16.979m**. To date the EW Project has undertaken the following adjustments into 2023-24:

- Adjustment of £1.900m in May 2022 – delay in EW Project;
- Adjustment of £1.472m in August 2022 – delay in the Asda works;
- Adjustment of £3.021m in October 2022 – delay in the Asda works; utilities and Added Value works;
- Virement of £0.305m to the nVCC Project; and
- Adjustment of £0.709m in January 2023 – further delay in the Asda works; utilities and Added Value works.

2.5 Following the above reviews, the EW Project has confirmed its funding requirements to deliver the EW FBC in 2022-23. The project will need to manage its financial position, and any further 'slippage' will need to be managed by the Trust's Capital Programme or returned to WG without reprovision.

2.6 In December 2022, a virement of £0.305m was made from the Enabling Works Project to the nVCC Project, as agreed with WG.

2.7 Following Ministerial approval of the IRS Final Business Case during November 2022, the IRS Procurement Project was closed on 30th November 2022. The final costs for the Project at this time were £0.178m. Therefore, of the £0.434m funding ring fenced from the core Trust discretionary programme for the project in lieu of FBC approval, only the final requirement of £0.178m was drawn down by the Project. However, as there is provision to fund these costs in the IRS FBC, this amount was reimbursed back to the discretionary programme for utilisation elsewhere within the Trust. Moreover, the final costs for this Project will now be reported by the IRS Implementation Project, as this is where the IRS FBC funding is allocated to. The final budget and outturn for the IRS Procurement Project for 2022-23 with therefore be nil.

2.8 Provisional revenue funding of £0.020m towards pay award costs was provided to the Programme in September 2022 from the WG allocation to the Trust. However, following a review of the Programme's revenue budget and forecast expenditure for the year, there is sufficient resource from within the Programme to cover its increased pay costs. Therefore, this additional funding will not be drawn down in 2022-23. These increased costs will however be take into account when forecasting future pay costs.

2.9 The Trust has approved a budget of £0.033m for the Judicial Review matter, a decrease of £0.010m from the original budget ring fenced for this matter (further details in Section 7). The **revenue** budget has now reverted to **£0.674m** for 2022-23.

2.10 There are currently three key financial risks to the Programme:

- Increased advisory fees to conclude the tender evaluation stage and Successful Participant to Financial Close stage;

- Further legal fees relating to the Judicial Review matter; and

- An underspend within the PMO and SDT Projects.

2.11 These risks have mitigation plans in place or in development by the relevant Project Teams.

3. BACKGROUND

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

3.2 By 31st March 2022, the Welsh Government (WG) had provided a total of £25.904m funding (£23.283m capital, £2,261m revenue) to support the TCS Programme. In addition, the Trust provided £0.264m from its discretionary capital allocation and £0.111m from non-recurrent revenue funding.

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

3.4 The current funding provided to support the TCS Programme in 2022-23 is £17.628m capital and £0.674m revenue, as outlined in Appendix 2. The sources of funding are summarised below.

Sources of Capital Funding
Initial Allocation (as at April 2022)

Project	WG Capital	Trust Discretionary Programme	Total Funding
Enabling Works Project	£21.813m	£0m	£21.813m
nVCC Project	£2.089m	£0m	£2.089m
IRS Procurement Project	£0m	£0.434m	£0.434m
Total	**£23.902m**	**£0.434m**	**£24.336m**

Overall Change to Allocation

Project	WG Capital	Trust Discretionary Programme	Total Funding
Enabling Works Project	-£7.406m	£0m	-£7.406m
nVCC Project	£0.305m	£0m	£0.305m
IRS Procurement Project	£0m	-£0.434m	-£0.434m
Total	**-£7.101m**	**-£0.434m**	**-£7.535m**

Current Allocation (as at November 2022)

Project	WG Capital	Trust Discretionary Programme	Total Funding
Enabling Works Project	£14.407m	£0m	£14.407m
nVCC Project	£2.394m	£0m	£2.394m
IRS Procurement Project	£0m	£0m	£0m
Total	**£16.801m**	**£0m**	**£16.801m**

Sources of Revenue Funding
Initial Allocation (as at April 2022)

Project	LHB Commissioners	Trust Reserves	Total Funding
PMO	£0.240m	£0m	£0.240m
nVCC Project	£0m	£0.073m	£0.073m
SDT Project	£0.180m	£0.131m	£0.311m
Total	**£0.420m**	**£0.204m**	**£0.624m**

Overall Change to Allocation

Project	LHB Commissioners	Trust Reserves	Total Funding
PMO	£0m	£0.060m	£0.060m
nVCC Project	£0m	-£0.010m	-£0.010m
SDT Project	£0m	£0m	£0m
Total	**£0m**	**£0.050m**	**£0.050m**

Current Allocation (as at November 2022)

Project	LHB Commissioners	Trust Reserves	Total Funding
PMO	£0.240m	£0.060m	£0.300m
nVCC Project	£0m	£0.063m	£0.063m
SDT Project	£0.180m	£0.131m	£0.311m
Total	**£0.420m**	**£0.254m**	**£0.674m**

4. CAPITAL POSITION

4.1 The current capital funding is outlined below:

- EW Project   £14.407m   Capital Expenditure Limit (CEL)
- nVCC Project   £2.394m   Capital Expenditure Limit (CEL)
- IRS Project   £0   See section 7
  Total   £16.801m

4.2 The capital position as at 31st January 2023 is outlined below, with a forecast underspend for 2022-23 of £0.001m.

Capital Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Enabling Works Project	£8.912m	£14.407m	£13.877m	£0.530m
nVCC Project	£2.496m	£2.394m	£2.923m	-£0.529m
IRS Procurement Project	£0.182m	£0m	£0m	£0m
Total	**£11.590m**	**£16.801m**	**£16.800m**	**£0.001m**

4.3 The forecast overspend of £0.529m for the nVCC Project will be supported by the Enabling Works Project underspend of £0.530m. This will be provided from the Enabling Works QRA and poses a low financial risk for the Enabling Works Project. The approach has been agreed with WG and we are awaiting formal approval.

4.4 Following Ministerial approval of the IRS Final Business Case during November 2022, the IRS Procurement Project was closed on 30th November 2022. The final costs for the Project at this time were £0.178m. Therefore, of the £0.434m funding ring fenced from the core Trust discretionary programme for the project, only the final requirement of £0.178m was drawn down by the Project. However, as there is provision to fund

these costs in the IRS FBC, this amount will reimbursed back to the discretionary programme for utilisation elsewhere within the Trust. Further details are provided in Section 7. Moreover, the final costs for this Project will now be reported by the IRS Implementation Project, as this is where the IRS FBC funding is allocated to. The final budget and outturn for the IRS Procurement Project for 2022-23 with therefore be nil.

5. REVENUE POSITION

5.1 The current revenue funding is outlined below:

- PMO   £0.300m   NHS Commissioners & Trust Reserves
- nVCC Project   £0.063m   Trust Reserves
- SDT Project   £0.311m   NHS Commissioners & Trust Reserves
  Total   **£0.674m**

5.2 Following the implementation of the annual NHS pay award in September 2022, a review of the forecast revenue pay for 2022-23 took place in November 2022. Adjustments were been made in to the relevant pay and non-pay budgets, allowing increased revenue pay costs in 2022-23 to the covered from within the Programme.

5.3 The revenue position as at 31st January 2023 is outlined below, with a forecast breakeven outturn for 2022-23 against a revised budget **of £0.674m**.

Revenue Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	**Forecast**	**Variance**
PMO	£0.232m	£0.300m	£0.290m	£0.010m
nVCC Project	£0.060m	£0.063m	£0.073m	-£0.010m
SDT Project	£0.259m	£0.311m	£0.311m	£0m
Total	**£0.551m**	**£0.674m**	**£0.674m**	**£0m**

5.4 There is a risk of increased costs for the nVCC Judicial Review. However, this may be offset by a potential underspend in both the PMO and the SDT Project, therefore mitigating this risk.

6. CASH FLOW

6.1 The projected capital cash flow for the **EW Project** is outlined below. The run rate indicates that, following the capital funding adjustment in January 2023, around 75% of the costs will be incurred in the second half of the financial year. This is due to the delay in the start of the works.

EW Project Cash Flow 2022/23
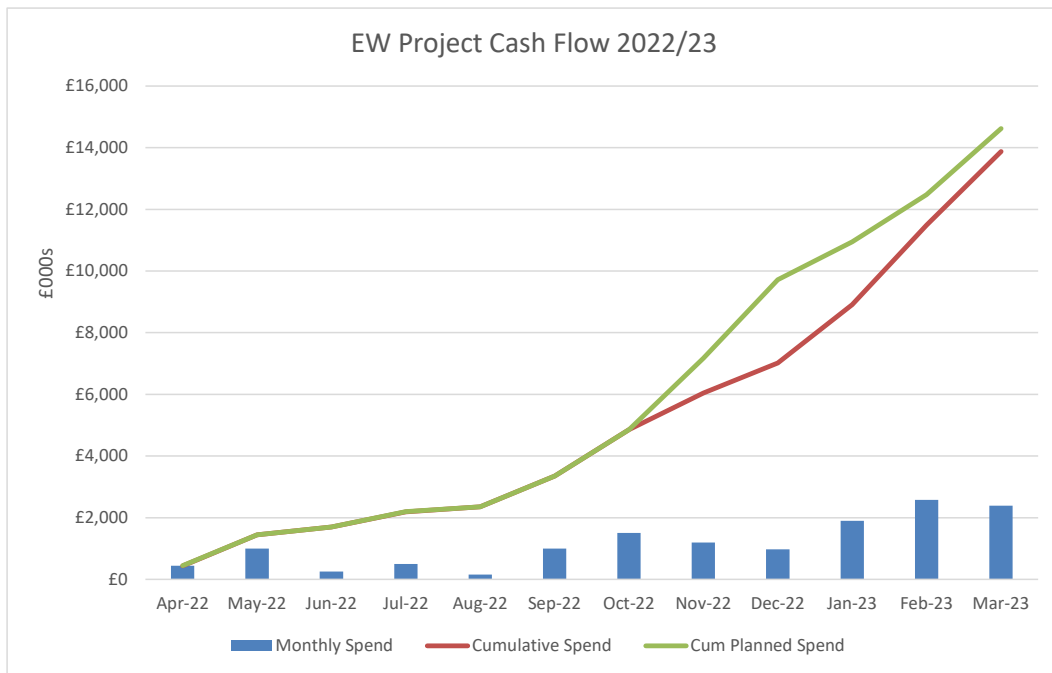
6.2   The projected capital cash flow for the **nVCC Project** is outlined below. The run rate
        for the nVCC Project is relatively 'flat' and reflects planned activities in respect of the
        successful participant stage.

nVCC Project Cash Flow 2022/23
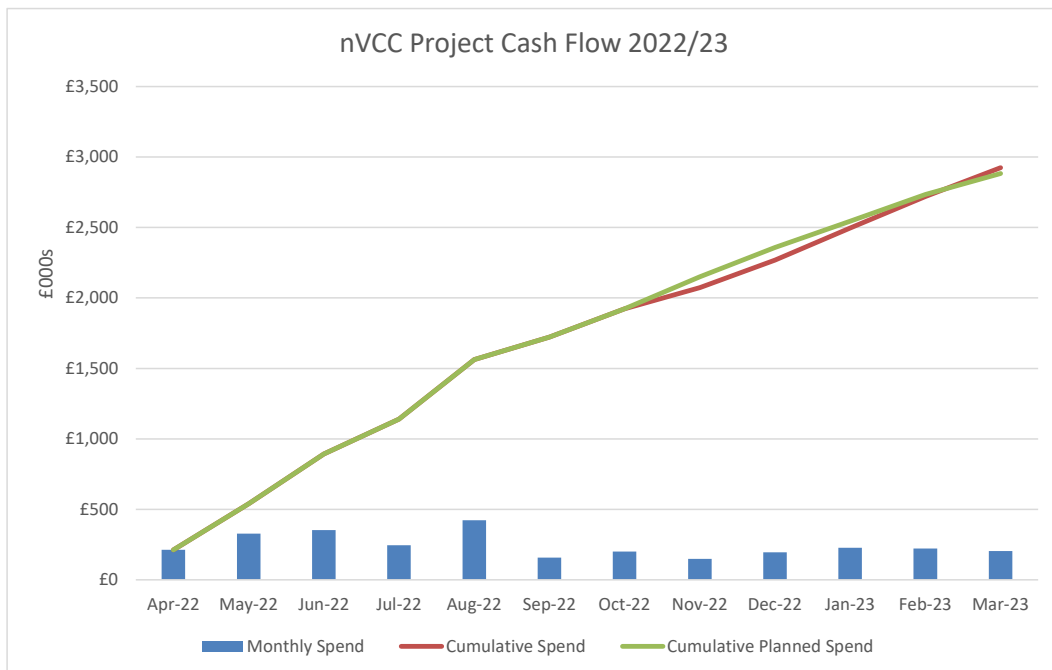
6.3   The cash flow for the remainder of the Programme is not reported as it is not of a
        material nature.

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

Programme Management Office

7.2 The total revenue funding for 2022-23 is **£0.300m**. £0.0240m of this is from NHS Commissioners' funding, and the remaining £0.060m from the Trust Reserves. The provisional pay award funding of £0.010m in 2022-23 previously reported will not be drawn down as the increased costs will be covered from within the PMO financial year.

7.3 There is no capital funding requirement for the PMO in 2022-23.

7.4 The revenue position for the PMO as at 31st January 2023 is shown below.

PMO Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Pay	£0.223m	£0.287m	£0.276m	£0.011m
Non Pay	£0.010m	£0.013m	£0.014m	-£0.001m
Total	**£0.232m**	**£0.300m**	**£0.290m**	**£0.010m**

7.5 The forecast spend review in November 2022 has resulted in an adjustment to the pay and non-pay budgets to align them with the new forecasts.

7.6 There is a forecast underspend of £0.010m due to a delay in project and support work carried out by the PMO. However, this will be used to offset increased costs incurred by the nVCC Judicial Review, therefore mitigating this risk.

Enabling Works Project

7.7 In February 2022, the Minister for Health and Social Services approved the EW FBC. This has provided capital funding of £28.089m in total.

7.8 For 2022-23 the EW Project initially received a CEL for £21.813m but after several reviews the final CEL is **£14.407m**, with a total virement to date of £7.405m from 2022-23 to 2023-24, as agreed by Welsh Government. Following reviews, the EW Project has confirmed its funding requirements to deliver the EW FBC in 2022-23. The project will need to financially manage its position, and any further 'slippage' will need to be managed by the Trust's Capital Programme or returned to WG without reprovision.

7.9 The Project's financial position for 31st January 2023 is shown below. The forecast position reflects an underspend of £0.530m due to a delay in key activities, which will be used to support the nVCC Project as agreed by WG.

Enabling Works Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Pay	£0.274m	£0.220m	£0.327m	-£0.108m
Non Pay	£8.638m	£14.187m	£13.550m	£0.638m
Total	**£8.912m**	**£14.407m**	**£13.877m**	**£0.530m**

7.10 The spend relates to the following activities:

Description	Year to Date Budget Jan-23 £	Spend Jan-23 £	Variance Jan-23 £	Financial Year Annual Budget £	Annual Forecast £	Annual Variance £
PAY						
Project 1b - Enabling Works FBC	183,120	273,802	-90,682	219,744	327,402	-107,658
Pay Capital Total	**183,120**	**273,802**	**-90,682**	**219,744**	**327,402**	**-107,658**
NON-PAY - PROJECTS						
EF01 Construction Costs	0	40,981	-40,981	0	40,981	-40,981
EF02 Utility Costs	62,576	62,576	0	710,613	710,613	0
EF03 Supply Chain Fees	447,678	454,251	-6,573	527,481	534,054	-6,573
EF04 Non Works Costs	204,070	306,014	-101,944	225,603	347,559	-121,956
EF05 ASDA Works	1,746,841	1,942,728	-195,887	2,584,385	2,798,271	-213,886
EF06 Walters D&B	5,627,078	5,431,191	195,887	8,735,418	8,521,532	213,886
EF07 Other (Decant Works, Surveys & Investigations, IM&T etc.)	0	0	0	174,000	0	174,000
EFQR Quantified Risk	817,983	190,878	627,106	922,798	405,078	517,720
EFQS QRA - SCP	307,200	316,895	-9,695	307,200	316,895	-9,695
EFRS Enabling Works FBC Reserves	0	-107,428	107,428	0	-125,427	125,427
Enabling Works Project Capital Total	**9,213,426**	**8,638,085**	**575,341**	**14,187,499**	**13,549,556**	**637,942**
TOTAL ENABLING WORKS FBC CAPITAL EXPENDITURE	**9,396,546**	**8,911,887**	**484,659**	**14,407,243**	**13,876,959**	**530,284**

7.11 There is a risk of a further underspend within the Enabling Works Project as a result of the delay in key project activities, however at present this represents a low risk, which will be monitored by the Project.

New Velindre Cancer Centre Project
Capital

7.12 In March 2021, the Minister for Health and Social Services approved the nVCC OBC. This has provided capital funding of £5.550m in total, with a CEL for 2022-23 of £2.089m. During December 2022 a virement of £0.305m was made to the Project from the Enabling Works Project, increasing the CEL to **£2.394m**.

7.13 The capital financial position for the nVCC Project for 31st December 2022 is shown below, with a further breakdown provided in Appendix 4. The forecast position reflects an overspend of £0.775m, which will be supported from the Enabling Works Project as agreed by WG.

nVCC Capital Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	**Forecast**	**Variance**
Pay	£0.969m	£1.274m	£1.163m	£0.110m
Non Pay	£1.527m	£1.120m	£1.760m	-£0.640m
Total	**£2.496m**	**£2.394m**	**£2.923m**	**-£0.529m**

7.14   The spend relates to the following activities:

Description	Year to Date Budget Jan-23 £	Year to Date Spend Jan-23 £	Year to Date Variance Jan-23 £	Financial Year Annual Budget £	Financial Year Annual Forecast £	Financial Year Annual Variance £
PAY						
Project Leadership	173,980	173,502	478	208,776	208,085	691
Project 2a - New Velindre Cancer Centre OBC	894,060	795,016	99,044	1,065,097	955,306	109,790
Pay Capital Total	1,068,040	968,518	99,522	1,273,873	1,163,391	110,481
NON-PAY						
nVCC Project Delivery	66,220	64,144	2,076	84,000	84,000	0
Work Packages						
VC08 Competitive Dialogue - Dialogue & SP to FC	696,423	1,348,309	-651,886	731,127	1,497,909	-766,782
VC10 Legal Advice	0	14,660	-14,660	0	14,660	-14,660
VC11 S73 Planning	0	89,169	-89,169	0	89,169	-89,169
VC12 nVCC FBC	81,453	68,170	13,283	106,453	93,170	13,283
VCRS nVCC Reserves	99,274	-57,252	156,525	198,547	-18,997	217,544
nVCC Project Capital Total	877,150	1,463,056	-585,907	1,036,127	1,675,911	-639,784
TOTAL nVCC OBC CAPITAL EXPENDITURE	2,011,409	2,495,719	-484,309	2,394,000	2,923,303	-529,303

7.15   There is a financial risk relating to advisory fees to conclude the tender evaluation stage, and Successful Participant to Financial Close stage. The additional fees could be in the range of c£0.100m. The Project's financial position will be monitored closely over the remaining months of the financial year.

Revenue

7.16   No revenue funding has been provided for the nVCC Project by WG in 2022-23. Therefore, the Trust has provided **revenue** budget of **£0.063m** from the Trust reserves. This is £0.010m less than was previously reported due to a budget of £0.033m provided for the Judicial Review matter as opposed to the original ring fenced budget of £0.043m. This revised budget was based on a revised forecast spend for the year.

7.17   The revenue financial position for the nVCC Project for 31st January 2023 is shown below, reflecting a forecast breakeven spend against a budget of **£0.063m**.

nVCC Revenue Expenditure	Year to Date Spend	2022-23 Full Year Budget	2022-23 Full Year Forecast	2022-23 Full Year Variance
Project Delivery	£0.027m	£0.030m	£0.030m	£0m
Judicial Review	£0.033m	£0.033m	£0.043m	-£0.010m
Total	**£0.060m**	**£0.063m**	**£0.073m**	**-£0.010m**

7.18   The legal team has provided an estimated final cost for the Judicial Review matter of £0.134m. £0.084m of this was expended in 2021/2022, and the remaining £0.050m is expected during 2022-23. Therefore there is a risk of an overspend in this financial year. However, this will be offset by a potential underspend in the PMO Project, therefore mitigating this risk.

Integrated Radiotherapy Solution Procurement Project

7.19   Ministerial approval of the IRS Final Business Case during November 2022, and subsequent signing of the contract with the preferred bidder, instigated the closure of the IRS Procurement Project on 31st November 2022. Continuation of the overall project will continue with the IRS Implementation Project, managed by Velindre Cancer Centre.

7.20   The final costs for the IRS Procurement Project are £0.182m, as outlined below.

        Pay   £0.083m
        Legal Advisors   £0.096m
        Other Costs   £0.003m
        Total costs   £0.182m

7.21   Estimated costs of £0.127m in 2022-23 for bunker refurbishment LA5 previously reported by the Project will now be covered directly by funding provided directly from the FBC, and will be reported by the IRS Implementation Project, who will also manage this work. These costs have been removed from the final Project costs.

7.22   Of the £0.434m funding ring fenced from the core Trust discretionary programme for the project, only the final requirement of £0.178m was drawn down. However, as there is provision to fund these costs from the FBC funding letter provided by WG, this was reimbursed back to the discretionary programme for utilisation elsewhere within the Trust. Moreover, as the FBC funding was allocated to the IRS Implementation project, the costs for 2022-23 will be allocated to the Implementation project, resulting in a budget and outturn of nil for the IRS Procurement Project for the financial ear 2022-23.

7.23   There is no revenue requirement for the Project in 2022-23.

7.24   The capital position for the IRS Project for 31st January 2023 is outlined below, with an adjusted budget and outturn of nil at year end.

IRS Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	**Forecast**	**Variance**
Pay	£0.083m	£0m	£0m	£0m
Non Pay	£0.100m	£0m	£0m	£0m
Total	**£0.182m**	**£0m**	**£0m**	**£0m**

7.25   There are no financial risks associated with this Project.

Service Delivery and Transformation Project

7.26   The total revenue funding for 2022-23 is £0.180m from NHS Commissioners' funding and £0.131 from Trust reserves. The provisional pay award funding of £0.010m in 2022-23 previously reported will not be drawn down as the increased costs will be covered from within the SDT project for this financial year. The resulting budget is **£0.311m** for this financial year.

7.27   There is no capital funding requirement for the Project in 2022-23.

7.28 The SDT Project revenue position as at 31st January 2023 is shown below.

SDT Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Pay	£0.259m	£0.291m	£0.291m	£0m
Non Pay	£0m	£0.020m	£0.020m	£0m
Total	**£0.259m**	**£0.311m**	**£0.311m**	**£0m**

7.29 The forecast spend review in November 2022 has resulted in an adjustment to the pay and non-pay budgets to align them with the new forecasts.

7.30 There is a financial risk of an underspend due to a delay in work carried out by the Project. However, this may be utilised to offset possible increased costs incurred by the nVCC Judicial Review, therefore mitigating this risk.

8. KEY RISKS AND MITIGATING ACTIONS

8.1 There are currently three key financial risks to the Programme:

- Increased advisory fees to conclude the tender evaluation stage and Successful Participant to Financial Close stage;

- Further legal fees relating to the Judicial Review matter; and

- An underspend within the PMO and SDT Projects.

These risks have mitigation plans in place or in development by the relevant Project Teams

9. TCS SPEND REPORT SUMMARY

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

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

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

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

Programme Management Office £1.656m
Project 1 Enabling Works £10.559m
Project 2 nVCC...£13.234m
Project 3a Integrated Radiotherapy Solution.............£0.1.049m
Project 3b Digital Strategy £0.200m
Project 4 Radiotherapy Satellite £0.385m
Project 5 SACT and Outreach.....................................£0.002m
Project 6 Service Delivery and Transformation £3.266m
Project 7 Decommissioning...£0m

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

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

APPENDIX 1: TCS Programme Budget and Spend 2022-23 as at 31st January 2023

CAPITAL	Year to Date Budget Jan-23	Year to Date Spend Jan-23	Year to Date Variance Jan-23	Financial Year Annual Budget	Financial Year Annual Forecast	Financial Year Annual Variance
	£	£	£	£	£	£
PAY						
Project Leadership	173,980	173,502	478	208,776	208,085	691
Project 1b - Enabling Works FBC	183,120	273,802	-90,682	219,744	327,402	-107,658
Project 2a - New Velindre Cancer Centre OBC	894,060	795,016	99,044	1,065,097	955,306	109,790
Project 3a - Radiotherapy Procurement Solution	82,882	82,882	0	0	0	0
Capital Pay Total	**1,334,041**	**1,325,201**	**8,840**	**1,493,617**	**1,490,794**	**2,823**
NON-PAY						
nVCC Project Delivery	66,220	64,144	2,076	84,000	84,000	0
Project 1b - Enabling Works FBC	9,213,426	8,638,085	575,341	14,187,499	13,549,556	637,942
Project 2a - New Velindre Cancer Centre OBC	877,150	1,463,056	-585,907	1,036,127	1,675,911	-639,784
Project 3a - Radiotherapy Procurement Solution	95,119	99,531	-4,413	0	0	0
Capital Non-Pay Total	**10,251,914**	**10,264,817**	**-12,903**	**15,307,626**	**15,309,468**	**-1,842**
CAPITAL TOTAL	**11,585,955**	**11,590,018**	**-4,063**	**16,801,243**	**16,800,261**	**981**

REVENUE	Year to Date Budget Jan-23	Year to Date Spend Jan-23	Year to Date Variance Jan-23	Financial Year Annual Budget	Financial Year Annual Forecast	Financial Year Annual Variance
	£	£	£	£	£	£
PAY						
Programme Management Office	222,715	222,715	0	286,809	275,551	11,258
Project 6 - Service Change Team	259,160	259,160	0	291,376	291,376	0
Revenue Pay total	**481,875**	**481,875**	**0**	**578,185**	**566,927**	**11,258**
NON-PAY						
nVCC Project Delivery	27,003	27,003	0	30,000	30,000	0
nVCC Judicial Review	33,000	33,000	0	33,000	43,215	-10,215
Programme Management Office	9,600	9,600	0	13,191	14,100	-909
Project 6 - Service Change Team	0	0	0	19,624	19,624	0
Revenue Non-Pay Total	**69,603**	**69,603**	**0**	**95,815**	**106,940**	**-11,124**
REVENUE TOTAL	**551,478**	**551,478**	**0**	**674,000**	**673,866**	**134**

APPENDIX 2: TCS Programme Funding for 2022-23

Description	Funding Type	
	Capital	**Revenue**
Programme Management Office	**£0m**	**£0.300m**
Commissioner's funding		£0.240m
Trust Revenue Funding		£0.060m
Pay Award Funding – assumed (September 2022)		£0.010m
Pay Award Funding – reversed (November 2022)		-£0.010m
Enabling Works OBC	**£14.406m**	**£0m**
2022-23 CEL from Welsh Government funding for Enabling Works FBC approved in February 2022	£21.813m	
Virement of funds from 2022-23 to 2023-24 financial year (May 2022)	-£1.900m	
Virement of funds from 2022-23 to 2023-24 financial year (August 2022)	-£1.472m	
Virement of funds from 2022-23 to 2023-24 financial year (October 2022)	-£3.021m	
Virement of funds to the nVCC Project (December 2022)	-£0.305m	
Virement of funds from 2022-23 to 2023-24 financial year (January 2023)	-£0.709m	
New Velindre Cancer Centre OBC	**£2.394m**	**£0.063m**
2022-23 CEL from Welsh Government funding for nVCC OBC (March 2021)	£2.089m	
Virement of funds to the nVCC Project (December 2022)	£0.305m	
Trust revenue funding from reserves		£0.063m
Integrated Radiotherapy Procurement Solution	**£0m**	**£0m**
Trust Discretionary Capital Allocation	£0.434m	
Reduction in requirement of capital funding	-£0.256m	
Reimbursement of funds back to the Trust discretionary programme	-£0.178m	

43/45

Description	Funding Type	
	Capital	**Revenue**
Radiotherapy Satellite Centre	**£0m**	**£0m**
No funding requested or provided for this project to date		
SACT and Outreach	**£0m**	**£0m**
No funding requested or provided for this project to date		
Service Delivery, Transformation and Transition	**£0m**	**£0.311m**
Commissioner's funding		£0.180m
Trust revenue funding from reserves		£0.131m
Pay Award Funding – assumed (September 2022)		£0.010m
Pay Award Funding – reversed (November 2022)		-£0.010m
VCC Decommissioning	**£0m**	**£0m**
No funding requested or provided for this project to date		
Total	**£16.801m**	**£0.674m**

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

SUMMARY OF CUMULATIVE TCS SPEND
TO 31 MARCH 2022

SPEND PER PROJECT PER YEAR

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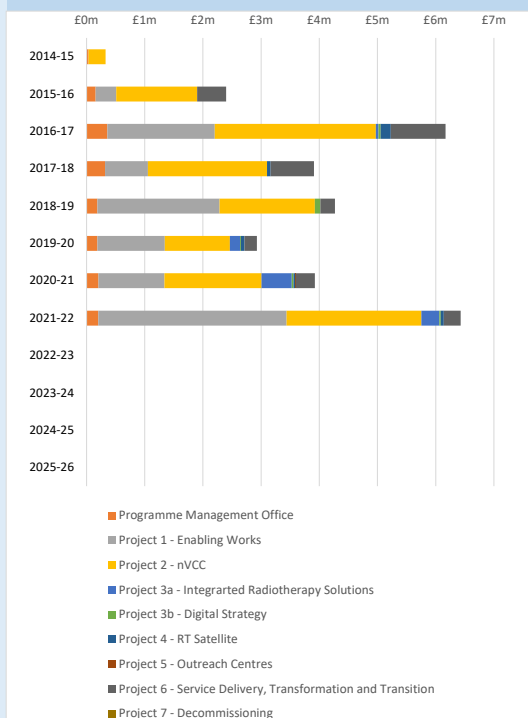
SPEND FOR EACH PROJECT ACROSS ALL YEARS

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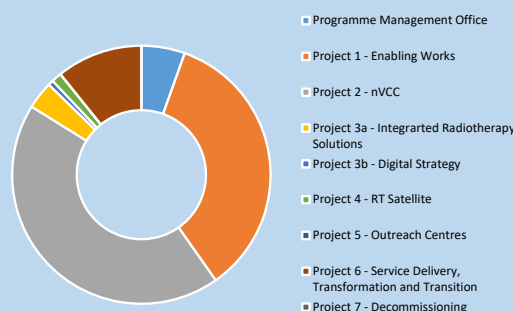
SPEND FOR EACH YEAR ACROSS ALL PROJECTS

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

Legend:
- 2014-15
- 2015-16
- 2016-17
- 2017-18
- 2018-19
- 2019-20
- 2020-21
- 2021-22
- 2022-23
- 2023-24
- 2024-25
- 2025-26
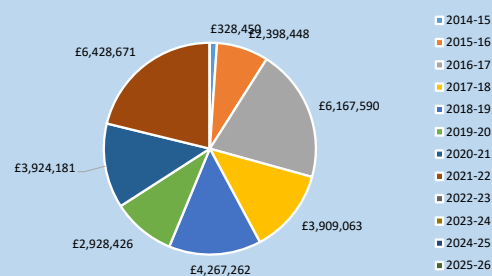
TOTAL SPEND BY PROJECT TO DATE — £30,352,092

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

SUPPLIERS WITH HIGHEST EXPENDTITURE TO DATE

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

PROPORATIONAL SPEND FOR EACH DELIVERABLE ACROSS ALL YEARS

45/45

QUALITY SAFETY AND PERFORMANCE COMMITTEE

VELINDRE UNIVERSITY NHS TRUST PERFORMANCE MANAGEMENT FRAMEWORK REPORT AND SUPPORTING ANALYSIS FOR THE PERIOD TO JANUARY 2023

DATE OF MEETING	16/03/23

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Draft Status - Final Version will be Published in Public Domain

PREPARED BY	Peter Gorin, Head of Strategic Planning and Performance Wayne Jenkins, Assistant Director, Sarah Richards, Interim General Services Manager
PRESENTED BY	Cath O'Brien, Interim Chief Operating Officer
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning, Performance & Estates

REPORT PURPOSE	ENDORSE FOR BOARD APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
WBS SMT	22nd February 2023	**NOTED**
VCC SLT	24th February 2023	**NOTED**
EMB	2nd March 2023	**APPROVED**

ACRONYMS	
VUNHST	Velindre University NHS Trust
QSP	Quality Safety and Performance Committee
EMB	Executive Management Board
SLT	Senior Leadership Team
PMF	Performance Management Framework
QSF	Quality Safety Framework
KPI	Key Performance Indicators
SPC	Statistical Process Control Charts

1. VELINDRE NHST PERFORMANCE REPORT FOR THE PERIOD APRIL TO JANUARY 2023

1.1 This report provides an overview, <u>now presented in the 'new PMF format',</u> of the performance our Trust for the period April to January 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. <u>The January reporting cycle will be the first time that the Quality Safety and Performance Committee and the Trust Board will receive performance reports in the new style PMF format.</u>

1.2 The new performance report format adopts a 'balanced scorecard' or 'dashboard' approach which seeks to 'triangulate' the interplay between operational delivery, service quality and safety, our people and physical/finance resources. The Executive Summary, in Section 5, gives a high-level overview, drawing attention to key areas of performance across the organisation as a whole, showing the interconnection between many of these areas.

1.3 The Performance Management Framework (PMF) Scorecards, in Section 6, are based on the 'six domains' of the Quality Safety Framework (QSF), namely safe, effective, patient/donor centred, timely, efficient and equitable care. The Scorecards incorporate hyperlinks to data analysis of our performance against each Key Performance Indicator (KPI) for Cancer and Blood and Transplant services. PMF scorecards have also been developed for Trust-wide Services, including Estates, Health and Safety, Digital, Workforce and Finance.

1.4 Individual 'service level' VCC and WBS PMF reports were presented initially to the VCC and WBS Senior Leadership Teams (SLT) and have been reviewed by the Chief Operating Officer at their divisional performance review meetings.

1.5 The Trust Board Scorecard KPIs
The Velindre Cancer Centre, Welsh Blood and Transplant and Support Services Scorecards in Section 6 focus on a selection of critical measures that provide an overview of performance in the areas of clinical quality and safety, operational delivery, patient and donor experience, staff wellbeing and financial balance.

2.	**PERFORMANCE MANAGEMENT FRAMEWORK SCORECARDS AS AT MONTH 10 JANUARY 2022/23**

2.1	**The New Trust Board PMF Reporting Format**

The Performance Report for the period April to January 2023 is presented in the new reporting format, endorsed by both the EMB and the Strategic Development Committee (SDC). This consolidated format replaces the previous separate VCC, WBS, Workforce and Finance performance reports. However, introducing new reporting structures and presenting KPI performance in different ways, employing new statistical techniques and graphics, needs to be managed carefully, and opportunities to improve the presentation will be taken as the move towards the new financial year.

The process of developing the new PMF performance reporting style has involved extensive engagement and discussion with Independent Members, Executive Directors, Community Health Council Representatives plus detailed work with Directorate Leads and key staff responsible for gathering, collating and reporting performance. In particular, suggestions around the presentation of performance to the public, the development of new KPIs measures and the general support for the direction of travel, have been particularly helpful. A range of potential KPI measures that will further enhance our performance reporting are being considered for development.

The development of our new PMF reporting processes and enhanced KPI metrics will be an evolving process with ownership and support at all levels, including exploring more efficient and streamlined methods of performance data collection. During 2023/24, the PMF Development Project Group will look to evaluate potential Business Intelligence solutions that automate KPI collection, analysis and reporting, and approach potential benchmarking partners for both tertiary cancer and blood services.

2.2	**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 against individual KPIs is no longer 'RAG rated' in the traditional way. Performance is now 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. A baseline, as at April 2022, has also been set as a default for each KPI to reflect our current average performance at the beginning of the current financial year.

Each KPI is supported by data that explains the current performance, using wherever possible and / or relevant Statistical Process Control (SPC) Charts, to enable the distinction to be made between 'natural variations' in activity, and trends or performance requiring investigation. The scorecards incorporate hyperlinks to supporting KPI data, enabling switching from the high-level position to detailed analysis and back.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes (Please see detail below)
	Quality and Safety considerations form an integral part of IMTP 2022/23 to 2025/26 plans and PMF to monitor and report on progress against our strategic objectives
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below: • Staff and Resources • Safe Care • Timely Care • Effective Care • Staying Healthy
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	VUNHST IMTP 2022/23 to 2025/26 plans must be delivered within the Trust's financial envelope

4. **VELINDRE NHST PERFORMANCE REPORT EXECUTIVE SUMMARY TO JANUARY 2023**

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

4.1   Cancer Centre Service Overview

VCC continues to experience challenge in providing capacity to meet the overall demand for services within SACT and Radiotherapy, with referrals increasing as Health Boards undertake additional activity to address their longest waiting patients. There continues to be variation in demand and tumour sites. Regular operational meetings continue to take place between VCC and the local Health Boards, which help to provide a more detailed picture of the expected number of referrals to VCC from Health Boards and changes to specialist teams and practice that are likely to impact on demand for services from VCC.

Alongside better intelligence on demand to support planning, there is a comprehensive programme of work supported by activity plans to maximise efficiency and productivity to demonstrate the most effective use of resources. However, it should be noted that variation in referral patterns occurring continues to be a challenge as Health Boards undertake focused activity within specific specialist areas.

In January, this led to a specific notable raise in Breast referrals. However, despite this pressure and the operational impact of the digital system changes which are outlined further below, we continue to deliver at target with emergency SACT treatment reaching 100% and Non-emergency SACT being 1% below the 98% target.

There is currently no fully validated performance data available for radiotherapy services, due to the transition to the new data warehouse and reporting following the implementation of the new Digital Health and Care Record (DHCR) phase 1 in November 2022. This required a full rebuild of the data warehouse that enables this data to be produced. In such major projects, this is well recognised and work cannot commence until the system has gone live and initial adaptations have been completed. Due to the fact that SACT activity information is derived from the Chemocare system, the requirement to re-build the warehouse reports has not stopped SACT activity data being made available.

Originally intended to be completed in February, a small but significant number of further changes have had to be made as the system has been adapted post go live. As a result, the data is not yet fully available and will require further work. Furthermore, the opportunity has been taken to build reporting functionality for the new Radiotherapy Time to Treatment targets that have been mandated by Welsh Government; the data standards for which have been confirmed at the end of March. A substantial data validation exercise is now required to provide patient level reporting on breaches and it is anticipated that this will be completed by the end of April (requires specific staff resource). This will however give us an opportunity to report against the new metrics.

The introduction of the new Digital Health and Care Record (DHCR) system has ensured that there is now a sustainable electronic system in place that can support the Cancer Centre in the safe management of their patients into the future and brings VCC in line with the standardized approach to management of the patient administration system across the Health system in Wales. DHCR has removed the risk of the CANISC system stability and made our records more widely accessible in Health Boards, particularly with the Radiotherapy and SACT treatment summaries.

The DHCR implementation has presented a substantial change on the way in which we plan, manage and record the care of our patients. The move away from the previous CANISC system which had been in place for over 20 years, was the culmination of 2 years of planning and created multiple changes in processes and work flows. Whilst these changes were planned, it is recognised that in any major service change, there will be a period of 'settling down' whilst service users get used to the system, ways of working are confirmed, and technical teething problems are addressed. As we move through the post implementation phase, we have continued to make adaptation to the system and ways of working.

The system has been configured to meet our need by DHCW as well as its integration with other VCS digital systems, for example for radiotherapy. A small number of technical issues were experienced which have been addressed, together with some system configuration adaptation as we use the system in day-to-day practice. Unlike CANISC DHCR is a linear system, which means each episode of care relating to the patient needs to be 'outcomed' in a timely manner on the system before they can record the next stage of their treatment pathway and this is a change of the way in which we work.

Digital and operational services are continuing to work together and will be undertaking an operational impact to understand the challenges being faced by service groups. This will help to identify if there are further technical system changes which may require the support of DHCW to address, and also provide the opportunity to review current ways of working, resource changes or gaps, and additional training needs. In addition, through our networks with Health Boards we are comparing system practices and undertaking benchmarking to inform the ways in which we can benefit from using the new DHCR system with the experience of using the system that we now have.

Whilst activity data for radiotherapy from the DHCR system is being recorded, it is currently undergoing significant validation, there is also ongoing work to include radiotherapy data that is currently entered manually for costing views. In the interim, safeguards are in place to minimise any risk of missing individual patients. An activity list is produced from the system and a manual review is undertaken to cross check the activity list against the system. This is continuing to take place whilst we address the reporting issues within the system and ensures that patients are not missed. Patients are also continuing to be prioritised in line with national guidance.

Whilst bedding in and adjustments are still taking place, some early post go live issues, particularly in relation to system interfaces, resulted in an increase in patient waiting times breaches due to the appointment process and notification issues during the first weeks. A small number of patients reported not receiving appointments and therefore did not attend at the planned time. These we immediately followed up. There have also been administrative challenges in processing appointment outcomes which have been prioritised to ensure timely access to appointments for SACT and Radiotherapy but a backlog of documentation is still being worked through.

All targets have been met for Pressure Ulcer, Falls, Sepsis and Delayed Transfers of Care. In December and January we experienced an unusual increase in Healthcare Associated Infections. Each has been reviewed within the MDT and there is no evidence of infection transmission. This increase mirrors the experience nationally.

4.2   Welsh Blood Service Overview

At 98% quality incident investigations closed within 30 days continues to exceed target (90%) for January.

No adverse event reports were submitted to the Medicines and Healthcare Regulatory Agency (MHRA) or the Human Tissue Authority (HTA) and no serious hazards of Transfusion (SHOT) incidents were reported this month.

Collection performance exceeded demand for the month, resulting in stock growth, helping the service recover its stock holding post the Christmas holiday period and lifting the blue alert on O negative stocks on January 11th 2023.

Red cell expiry wastage continues to perform strongly a result of close alignment of supply and demand for red cells.

All clinical demand for platelets was met representing a strong performance against this metric. However, platelet wastage continues to be above target at 23%. The main contributory factor is high variability in demand over the month, making pre-planning more difficult. A Platelet Group will be established in March 2023 to consider the opportunities to improve supply and demand alignment into the new financial year.

The number of new donors recruited to the Welsh Bone Marrow Donor Registry (WBMDR) increased from 137 to 213 in January. A trend which is expected to continue into February as the recovery plan continues to focus on Schools/College/University engagement programme, paid advertising, marketing campaigns aimed at existing donors and engagement with external marketing companies to explore wider recruitment opportunities.

The total stem cells collected in January was 4. The total stem cell provision for the service was 7 (4 collected and 3 imported for Welsh patients). 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.

At 97% donor satisfaction continues to perform above target.

In January, 7,522 donors were registered at donation clinics with 6 concerns (0.08%) reported within this period. Of these 6 concerns, 2 were formal and were follow ups to concerns originally raised and responded to in December 2022, from donors who were dissatisfied with our initial responses. Both were responded to within timescale. The remaining 4 concerns were informal and new to the service.

Antenatal turnaround times provided to customer hospital within 3 working days has returned to above target for January and quarterly reporting of D and -C quantitation results provided to customer hospital within 5 working days continues to strongly perform.

4.3 Workforce and Wellbeing

The key workforce risk for the Trust is the availability of skilled people to provide services and how we support their wellbeing while in the workplace. Trust wide sickness absence data continues to remain high month on month with the current cumulative absence at 6.24% to January 2023 still above the Welsh Government Target of 3.54%. Winter cold and flu viruses have resulted in short-term sickness, throughout the Trust. A raft of wellbeing interventions and actions are taking place across the service.

Trust wide PADRs this month remains at 77% and there are ongoing interventions to support managers in completing reviews following the implementation of the All Wales Pay Progression Policy. Statutory and Mandatory training remains above target at 88% and has been consecutively on target for the whole year form Jan 22 – Jan 23.

4.4 Nursing and Quality

The Trust's Quality & Safety Framework was approved at the Trust Board in July 2022. The Integrated Quality & Safety Governance Group has been established and inaugural meeting held. The Divisions will need to develop Service level Quality and Safety metrics and these to be included within the Performance Management Framework. Corporate and Divisional Quality Hubs are in the process of being established. The Trust's Nursing Standards have been approved and launched.

4.5 Patient and Donor Experience

Velindre Cancer Centre experience uses 0-10 patient satisfaction rating against an 85% target. The Welsh Blood and Transplant service has maintained a high level of donor satisfaction at 95% that continues to meet the target.

4.6 Finance

At this stage of the financial year the overall revenue budget (excl. Covid and the exceptional cost pressures) remains broadly in line with expectations as planned within the IMTP, with a projected forecast outturn position of breakeven. The overall position against the profiled revenue budget to the end of January 23 remains underspent by £0.002m, with an outturn forecast position of Breakeven.

The Trust has now received confirmation from WG that funding will be provided for the both the incremental increase in energy prices and Covid response.

It is expected that any potential cost pressures are managed by budget holders to ensure the delegated expenditure control limits are not exceeded in line with budgetary control procedures.

Performance against both the currently agreed All Wales Capital and Discretionary programme budget allocations are at this stage expected to deliver to within the CEL.

The Trust has now dipped under the PSPP performance target of processing 95% of Non-NHS Supplier invoices within the 30-day target which is under urgent review. The finance team is working with the NWSSP accounts payable and the service to understand reasons for recent under performance with a view to target specific failures and bottlenecks in the process.

4.7 The following section 6 contains the VCC, WBS and Trust-wide Services PMF Scorecards using the six Quality Safety Framework domains to report the Trust's overall performance against a range of National and local targets.

5. RECOMMENDATIONS

5.1 The QSP Committee is asked to **ENDORSE FOR BOARD APPROVAL** the contents of this report and the detailed performance analysis provided in the PMF Scorecards and supporting Data Analysis Templates in Annexures 1 to 6.

5.2 The new style PMF Performance reports will continue to be developed by the PMF Project Group, taking account of suggested changes and ensuring ownership at all levels and full engagement with both Independent Members and CHC representatives.
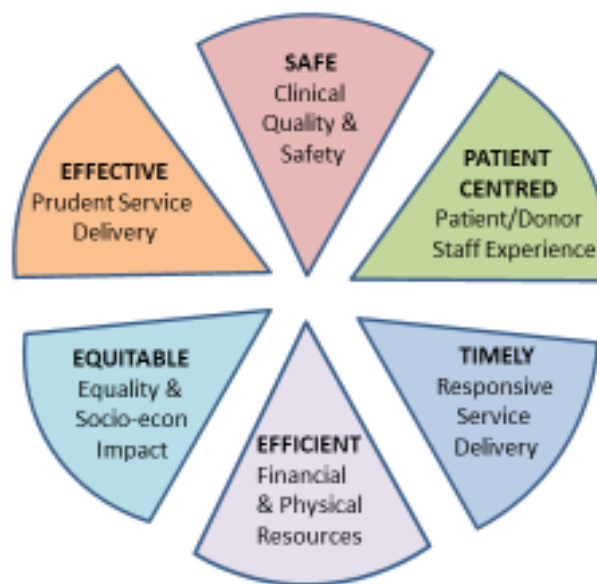
Quality Safety & Performance (QSP) Committee Scorecard as at January (Month 10) 2022/23

QSF Domain	Key Performance Indicator (KPI)	Target	Reported	Baseline April '22	Target	Actual	In Month Position	Cumulative data trend	Data Link
	QSP Committee Performance Scorecard			**Performance as at Month 10 (January)**			**Compliance against Target or Standard**		**Data Link**
Safety	% compliance for staff who have completed the Core Skills and Training Framework Level 1 competencies	National	Monthly	85%	85%	88%	✓	↑	WOD.19
Safety	Number of VCC Inpatient (avoidable) falls	National	Monthly	4	0	0	✓	↑↓	KPV.02
Safety	Number of Potentially (avoidable) Hospital Acquired Thromboses (HAT)	National	Monthly	0	0	0	✓	→	KPV.07
Safety	Number Healthcare acquired Infections (HAIs) MRSA	National	Monthly	0	0	0	✓	→	KPV.04
Safety	Number Healthcare acquired Infections (HAIs) MSSA	National	Monthly	0	0	0	✓	→	KPV.04
Safety	Number Healthcare acquired Infections (HAIs) P. aeruginosa cumulative	National	Monthly	0	0	0	✓	→	KPV.04
Safety	Number Healthcare acquired Infections (HAIs) Klebsiella spp	National	Monthly	0	0	1	✗	→	KPV.04
Safety	Number Healthcare acquired Infections (HAIs) C Difficile	National	Monthly	0	0	1	✗	→	KPV.04
Safety	Number Healthcare acquired Infections (HAIs) E Coli	National	Monthly	0	0	3	✗	→	KPV.04
Safety	Number Healthcare acquired Infections (HAIs) Gram negative bacteraemia	National	Monthly	0	0	4	✗	→	KPV.04
Safety	Number of Velindre Cancer Centre acquired (avoidable) patient pressure ulcers	National	Monthly	1	0	0	✓	→	KPV.01
Safety	Number of Incidents reported to Regulator / Licensing Authority	Local	Monthly	3	0	0	✓	↓	KPI.30
Safety	Carbon Emissions – carbon parts per million by volume	National	Annually	TBA	TBA	TBA	✓	→	EST.06
Effectiveness	Number of Delayed Transfers of Care (DToCs)	National	Monthly	0	0	0	✓	↑↓	KPV.05
Effectiveness	% Demand for Red Blood Cells Met	Best practice	Monthly	102%	100%	106%	✓	↑	KPI.04
Effectiveness	% Time Expired Red Blood Cells (adult)	Local	Monthly	0.08%	Max 1%	0.21%	✓	↑	KPI.26

QSF Domain	QSP Committee Performance Scorecard			Performance as at Month 10 (January)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline April '22	Target	Actual	In Month Position	Cumulative data trend	
	% Time Expired Platelets (adult)	Local	Monthly	16%	Max 10%	23%	✗	↑↓	KPI.25
	Number of Stem Cell Collections per month	Local	Monthly	1	7	4	✗	→	KPI.13
	% Rolling average Staff sickness levels	National	Monthly	6.31%	3.54%	6.24%	✗	↓	WOD.37
	% Personal Appraisal Development Reviews (PADR) compliance staff appraisal carried out by managers	Prof. Std.	Monthly	69%	85%	77%	✗	↑	WOD.36
Patient/Donor/ Staff Experience	% of Patients Who Rate Experience at VCC as very good or excellent	Prof. Std.	Monthly	N/A	85%	93%	✓	→	KPV.11
	% Donor Satisfaction	Local	Monthly	96%	95%	97%	✓	→	KPI.09
	% of 'formal' concerns responded to within 30 working days	Local	Monthly	100%	85%	100	✓	→	KPV.12
	% Responses to Formal Concerns within 30 Working Days	Local	Monthly	100%	90%	100%	✓	→	KPI.03
Timeliness	% Patients Beginning Radical Radiotherapy Within 28 days (JCCO)	National	Monthly	87%	98%	NDA	✗	↑↓	KPV.14
	% Patients Beginning Palliative Radiotherapy Within 14 days (JCCO)	National	Monthly	79%	98%	NDA	✗	→	KPV.15
	% Patients Beginning Emergency Radiotherapy Within 2 days (JCCO)	National	Monthly	84%	98%	NDA	✗	↑↓	KPV.16
	% Patients Beginning Non-Emergency SACT within 21 days	National	Monthly	69%	98%	97%	✓	↑↓	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	97%	90%	97%	✓	→	KPI.17

PMF Performance Report JANUARY GO LIVE

QSF Domain	QSP Committee Performance Scorecard			Performance as at Month 10 (January)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline April '22	Target	Actual	In Month Position	Cumulative data trend	
Efficient	Financial Balance – achievement of Trust forecast (£k) in line with revenue expenditure profile	National	Monthly	0	0	£0.002 m	✓	➜	FIN.71
	Financial Capital spend (£m) position against forecast expenditure profile	National	Monthly	0	£14.346M	£14.346M	✓	➜	FIN.73
	Trust expenditure (£k) on Bank and Agency staff against target budget profile	National	Monthly	N/A	£0.128 m	£0.140 m	✗	➜	FIN.72
	Cost Improvement Programme £1.3M achievement of savings (£k) in line with profile	National	Monthly	N/A	£1.064 m	£1.064 m	✓	⬆	FIN.74
	Public Sector Payment Performance (% invoices paid within 30 days)	National	Monthly	95%	95%	94%	✗	➜	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 ⬇

Performance Management Framework supporting KPI Data Graphics and Analysis

SAFETY

KPI Indicator KPV.02

Number of VCC Inpatient Falls per month															
Target: 0 Avoidable															

VCC	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Actual Number	1	4	3	2	9	4	1	1	2	1	3	4	4	5	2
Avoidable Falls	0	0	1	0	0	1	1	0	2	0	1	2	2	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.

SLT Lead: Head of Nursing

Performance

There were no avoidable inpatient falls in January 2023. Performance on Target.

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

Number of VCC Acquired Pressure Ulcers per month (Inpatients)															
Target: 0 Avoidable															SLT Lead: Head of Nursing
Current Performance against Target or Standard															Performance

VCC	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Actual Number	0	1	0	0	1	1	0	1	0	0	4	1	1	1	0
Avoidable Ulcers															0
Target NIL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Performance

There were no VCC acquired Pressure ulcers in January 2023. Performance on target

Service Improvement Actions – Immediate (0 to 3 months)

	Timescale:	Lead:

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

**SPC Chart Acquired Pressure Ulcers per month Target NIL**

SPC Chart Analysis
The SPC chart shows common cause or normal variation over the last 15 months, except for 4 pressure ulcers in September.

Statutory and Mandatory (S and M) Training Compliance															
Target: 85%												**SLT Lead: Carl James**			

Current Performance against Target or Standard

Trust Position	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Actual %	86	86	86	85	85	86	85	86	85	85	85	85	87	87	88
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85

Performance

Assessment of current performance, set out key points:
- Compliance target is being met
- VCC at 85%
- WBS at 94%
- Corporate Services at 88%

SPC Chart Analysis

The SPC chart shows common cause or normal variation averaging nearly 86% against the 85% target, with the target being met for the last year.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Continue to support managers in monthly 121's ensuring compliance is regularly reviewed	Ongoing	People and OD Team

Expected Performance gain - immediate
Improved performance with all areas across the Trust above the target level.

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term
Maintain and continue to improve on statutory and mandatory training compliance across the Trust and within the independent divisions.
Having well trained and developed workforce will ensure the safe and quality delivery of services across the Trust.

Risks to future performance

Set out risks which could affect future performance
- Future predicated wave of COVID and Flu may affect staffing levels and ability to release staff to undertake training.

Number of Potentially (avoidable) Hospital Acquired Thromboses (HAT)	
Target: NIL	**SLT Lead: Clinical Director**
Current Performance against Target or Standard	**Performance**

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

VCC	No 21	Dec 21	Jan 22	Feb 22	Mr 22	Apr 22	My 22	Jun 22	Jul 22	Au 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Hospital Acquired Thromboses	0	0	1	0	1	0	0	0	1	0	0	0	0	0	0
Target Nil	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Assessment of current performance, set out key points:

- Performance on target

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance
-

Healthcare Acquired Infections (Inpatients)															
Target: NIL															

SLT Lead: Head of Nursing

| **Current Performance against Target or Standard** | **Performance** |

Incidence of Healthcare Acquired Infections for the period July 2021 to September 2022

VCC	Nov 21	Dec 21	Jan 22	Feb 22	Mr 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
C.diff	0	0	1	0	1	0	0	0	0	0	0	0	0	1	1
MRSA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MSSA	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
E.coli	0	0	0	0	0	0	0	0	1	0	0	0	0	1	3
Klebsiel la	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Pseudo Aerugi	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Gram Neg	0	0	0	0	0	0	0	0	0	0	0	0	0	1	4

Assessment of current performance, set out key points:
- The increase in infections noted is reflective of the national picture
- RCA for all reported infections in progress
- There is no evidence of VCC transmission in the RCA's to date.

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance
- Engagement with medical colleagues in the RCA process impacted by workload and rotation.

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	**Performance**

Performance

Assessment of current performance, set out key points:

No Serious Adverse Blood-Related Event (SABRE) reports were submitted to the Medicines and Healthcare Product Regulatory Agency (MHRA) in January 2023.

No adverse event reports were submitted to the Human Tissue Authority (HTA) in January.

There were no Serious Hazards of Transfusion (SHOT) incidents reported during the month.

	Nov 21	Dec 21		Jan 22	Feb 22	Mr 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Actual	2	0		0	1	0	3	0	0	1	1	0	0	0	2	0
Target	0	0		0	0	0	0	0	0	0	0	0	0	0	0	0

Incidents Reported to Regulator/Licensing

(bar chart)
- Apr-22: 3
- May-22: 0
- Jun-22: 0
- Jul-22: 1
- Aug-22: 1
- Sep-22: 0
- Oct-22: 0
- Nov-22: 0
- Dec-22: 2
- Jan-23: 0
- Feb-23:
- Mar-23:

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate
N/A

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	**Timescale:**	**Lead:**
N/A - Actions will be introduced as outcome of root cause analysis of these incidents.		

Expected Performance gain – longer-term
N/A

Risks to future performance

N/A

% reduction in Carbon Footprint/Emissions by 2025 against 2021/22 baseline	
Target: -16%	**SLT Lead: Asst. Director of Estates**
Current Performance against Target or Standard	**Performance**

Trust Position	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23
Actual Number															
Target -16%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	

[Graph and data to be inserted under development]

Assessment of current performance, set out key points:
- insert text
- insert text
- insert text

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance
- insert text
- insert text

EFFECTIVENESS

KPI Indicator KPV.05

Number of Delayed Transfers of Care (DToC)															
Target: NIL														**SLT Lead: Head of Nursing**	
Current Performance against Target or Standard														**Performance**	

VCC	Nov21	Dec 21	Jan 22	Feb 22	Ma 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Actual %	0	0	1	4	1	0	0	0	0	0	0	2	1	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:

There were 0 DTOC in January 2023. Performance on target.
.

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 from February with reporting requirements commencing March 2023 once system access has been granted.	**End of March 2023**	**Head of Nursing**

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
-

Delayed transfers of Care (DToCs) Target NIL
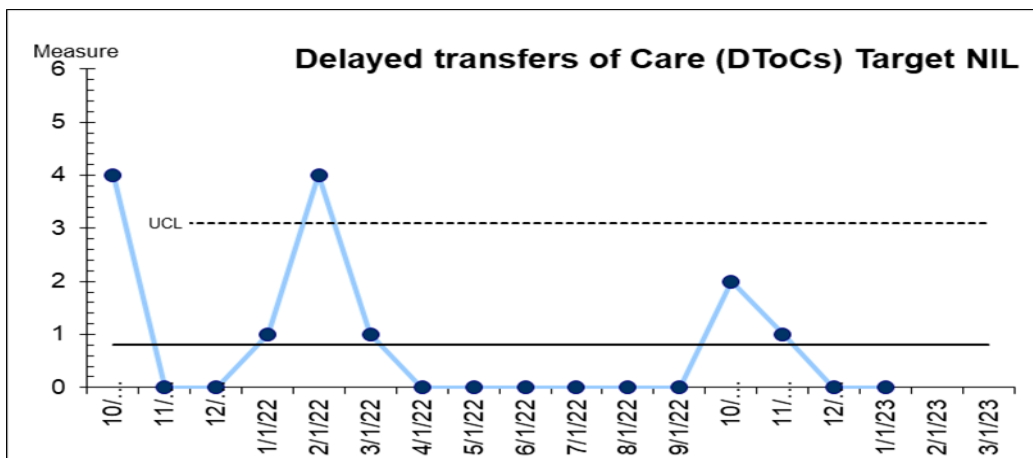
SPC Chart Analysis

The SPC Chart shows two 'special cause' or exceptional variations in October 2021 and February 2022.

% 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

	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Actual %	101	99	110	100	100	102	102	100	107	112	105	115	115	94	106
Target 100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

% Red Cell Demand Met

Performance

All clinical demand was met during this period, whilst collection also exceeded demand over this period indicating potential stock growth.

Demand (full weeks) averaged at 1451 units per week, and the 'Blue Alert' for O negative blood group shortage that had commenced on 30th December 2022, ended on 11th January 2023 once stocks had recovered.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
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	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:	Lead:
N/A	N/A	Jayne Davey / Tracey Rees

Expected Performance gain – longer-term   N/A

Risks to future performance

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

SPC Chart Red Blood Cell Demand Target 100%

SPC Chart Analysis

The SPC chart shows common cause or normal variation over the 15-month period. The average performance of 104% consistently exceeding the 100% target.
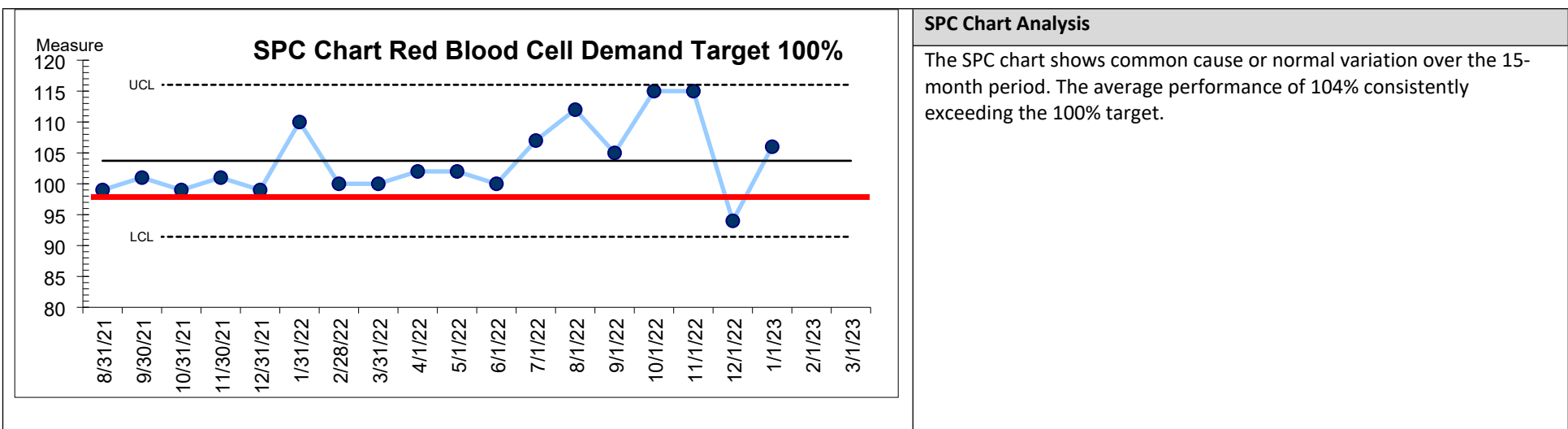
Time Expired Red Blood Cells - number of red blood cells, excluding paediatric bags, which have a time expired, as % of the total number of red blood cell bags														

Target: Maximum Wastage 1%

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Actual %	0.08	0.05	0.05	0.04	0.08	0.08	0.00	0.02	0.01	0.03	0.35	0.01	0.33	0.36	0.21
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

Time Expired Red Cell

Apr-22: 0.1%
May-22: 0.0%
Jun-22: 0.0%
Jul-22: 0.0%
Aug-22: 0.0%
Sep-22: 0.4%
Oct-22: 0.0%
Nov-22: 0.3%
Dec-22: 0.4%
Jan-23: 0.2%

Performance

Assessment of current performance, set out key points:
This metric remains within the target.
Red cell shelf life is 35 days, with all blood stocks stored in blood group and expiry date order and issued accordingly.

Service Improvement Actions – Immediate (0 to 3 months)

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

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

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term
N/A

Risks to future performance

High stock levels lead to a risk of increased time expiry

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

SPC Chart Time Expired Red Blood Cells Target Max 1%

SPC Chart Analysis

The SPC chart shows some special cause variation over the 4 of the last 6 month period. However, the average performance of 0.10% remains well within the maximum 1%
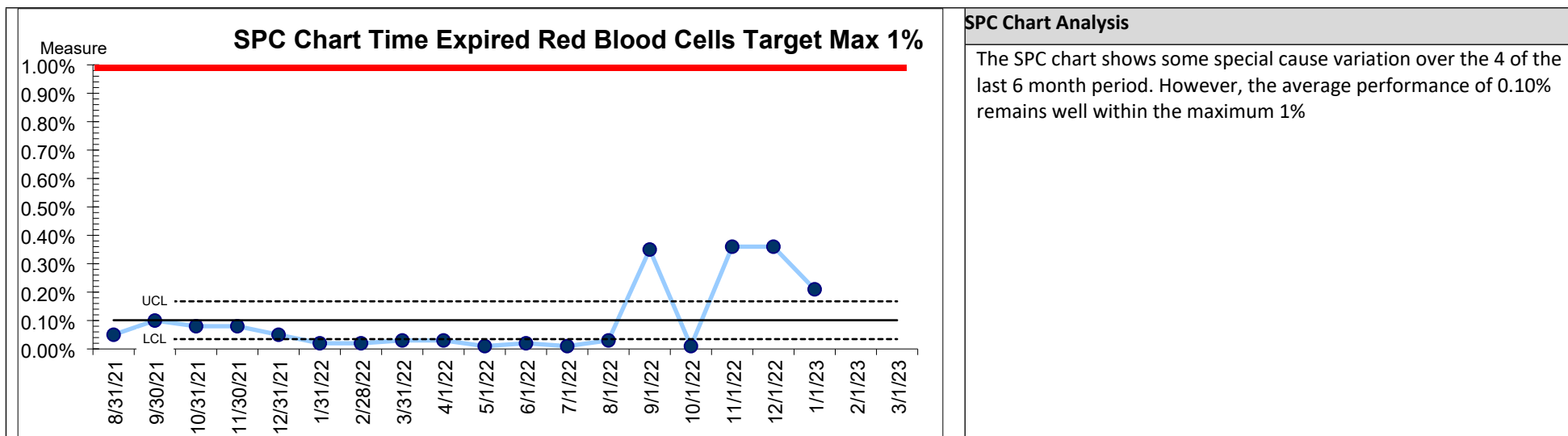
KPI Indicator KPI.25

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

	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Actual %	10	17	15	17	14	16	15	23	19	30	25	14	15	27	23
Target Max 10%	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10

Time Expired Platelets

Bar chart values: Apr-22 16.06%, May-22 14.65%, Jun-22 23.32%, Jul-22 19.37%, Aug-22 30.11%, Sep-22 24.56%, Oct-22 13.66%, Nov-22 15.00%, Dec-22 27.00%, Jan-23 23.00%, Feb-23, Mar-23

NB: Platelet production takes account of the average expected issues and is a balance to ensure sufficiency of supply where production occurs 2.5 days before they are available for issue. This means in shortage there tends to be over production. Decreasing production would reduce waste but increase the probability of shortage, which in turn may create a need to rely on mutual aid support.

Performance

Assessment of current performance, set out key points:

Platelet wastage performance exceeded target and is due to:
- Planned increased production to counterbalance the expected deficit because of bank holidays resulting in units produced in December expiring in early January.
- Increased wastage is caused by reduced demand. Pre planning for production occurs based on previous week's issues as it takes a least 2.5 days for a platelet to be available for issue with a shelf life of 7 days.

Variability in demand during January was not consistent making pre-planning more difficult.

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
A Platelet Strategy Board will be established to co-ordinate the work of the two Task and Finish Groups that were convened following the platelet review that took place in November 2022 and other ongoing work streams in Clinical Services.	Qtr 4	Tracey Rees
Develop a forecasting tool to inform decisions around pooled platelet manufacture (Task & Finish Group 1).	Trial in March 23	Peter Richardson

Expected Performance gain - immediate

Improved wastage rates - tool has been designed to provide more granular detail to allow subtle changes in production.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Review the clinic collection pan for Apheresis (Task & Finish Group 2) to ensure the clinic times are optimised, given to additional 2 day shelf life of platelets.	Qtr 1 23 onwards	Jayne Davey

	Expected Performance gain – longer-term
	A risk-based approach balancing platelet expiry against ability to supply platelets for clinical needs. Platelet expiry at WBS will reduce.
	Risks to future performance
	Set out risks which could affect future performance

SPC Chart Time Expired Platelets Target Max Wasteage 10%

SPC Chart Analysis

The SPC chart shows special cause variation over 4 of the last 6 month period. With the average performance of 17% consistently exceeding the maximum wastage limit of 10%.

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

	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 21	Aug 21	Sep 21	Oct 22	Nov 22	Dec 22	Jan 23
Cumulative Actual	32	33	39	44	47	1	2	8	8	12	14	14	15	19	23
Cumulative Target p/a	54	60	67	73	80	7	14	20	27	34	40	47	54	60	67

Performance

Performance for January did not meet target. The total number of stem cells collections for January was 4 (4 collections were cancelled during January for patient reasons) and 1 peripheral blood lymphocyte collection.

The total stem cell provision for the service was 7 (4 collected and 3 imported for Welsh patients).

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.

Stem Cell Collections

Legend: Stem Cell Collection in Wales; Stem Cell Projected Forecast

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	imescale:	Lead:
The WBMDR five-year strategy, re-appraising the existing collection model and its ambition, is being finalised to support the ongoing development of the WBMDR. A recovery plan has been implemented to improve recruitment of new donors to the Register which over time will increase the number of collection see KPI..20	Qtr 4	Tracey Rees

Expected Performance gain - immediate
As above

Service Improvement Actions – tactical (12 months +)

Implementation of the five-year strategy.	imescale: Qtr 1 2023 onwards	Lead: Tracey Rees

Expected Performance gain – longer-term

Risks to future performance
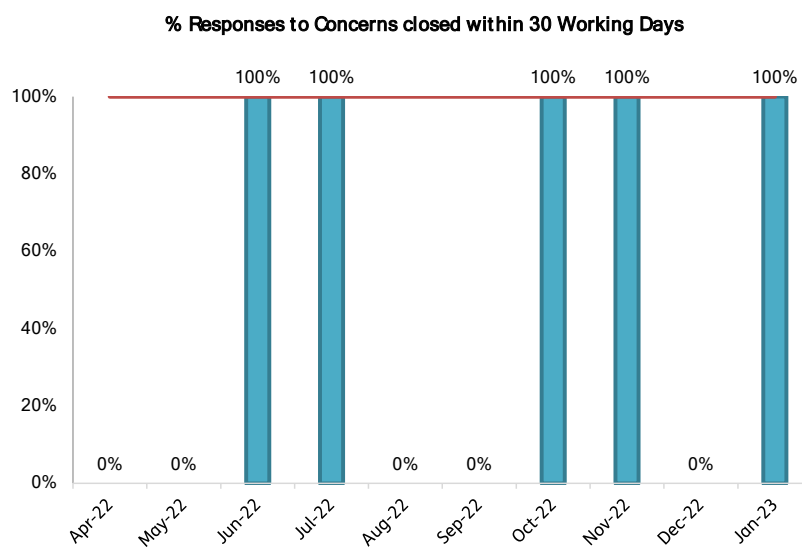
Set out risks which could affect future performance
Identified risks are being managed.

Staff Sickness levels against Target															
Target: 3.54%															

SLT Lead: WOD Director

Current Performance against Target or Standard

Performance

Trust Position	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Actual %	5.58	5.63	5.73	5.81	6.07	6.30	6.36	6.42	6.53	6.50	6.36	6.30	6.19	6.19	6.24
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 Staff Sicknesss Target % 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

Assessment of current performance, set out key points:

There is a slight decline in sickness this month as the People and Relationship Team continue to support managers in the application of the sickness policy. There is growing concern that short-term absences will continue to grow with the COVID19 guidance that requires 48hour isolation for any cold or flu like symptom. There are ongoing discussions at Covid cell to monitor this activity. Anxiety/stress/depression/other psychiatric illnesses remain the highest reason for absence across the Trust.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Roll out of fundamentals in managers training including the management of absence under the fundamentals of training package.	31/03/2023	People and OD Team

Expected Performance gain - immediate

As part of the development in the people management training package there will be practical support for managers on managing stress in the workplace and completing stress risk assessments.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Feedback from the Wellbeing sessions, held by the OD team, are being analysed and this will inform future wellbeing plans	31/03/2023	Head of OD

Expected Performance gain – longer-term

The actions above will have an impact on management of sickness absence. Active sickness absence management has been shown to reduce the duration of individual sickness absences.

Risks to future performance

Set out risks which could affect future performance

- Not having enough staff available due to sickness absence could impact on delivery of services across the Trust
- Staff who feel unsupported during absence may chose to leave the organisation increasing turnover

Performance and Development Reviews (PADR) % Compliance

Target: 85%		SLT Lead: WOD Director

Current Performance against Target or Standard	**Performance**

Trust Position	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Actual %	72	71	69	70	70	69	70	69	69	70	71	75	76	77	77
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85

Assessment of current performance, set out key points:

PADRs have remained relatively stable the past 12 months with an upward trend that has continued following the implementation of the new Pay Progression Policy in October 2022 which ties incremental pay progression into the PADR process for all Agenda for Change Staff.

Service Improvement Actions – Immediate (0 to 3 months)

SPC Chart Analysis

The SPC chart shows a special cause improving trend over the last 6 months. However, performance falls consistently short of the 85% target.

Actions: what we are doing to improve	Timescale:	Lead:
• Support divisions in plans to target hotspot areas (Divisions KPI plans)	31/03/2022	Senior BP

Expected Performance gain - immediate

As the impact of PADR compliance will be related to people's incremental credit progression it is expected that in the short term we will see a growth in compliance.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• Monthly reports to be presented to Divisions for monitoring and review.	Ongoing Monthly	Business Partner SMT/SLT

Expected Performance gain – longer-term

As regular monitoring and reviews of compliance is defined in the divisional operational meetings, and training is rolled out 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	**Performance**

VCC	Nov21	Dec21	Jan 22	Feb 22	Ma 22	Apr 22	My 22	Jun 22	Jul22	Aug22	Sep22	Oct 22	Nov 22	Dec 22	Jan 23
Actual %										89	89	88	nda	nda	93
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85			

Performance

Assessment of current performance, set out key points:
There are 2 surveys used in VCC – VCC Friends and Family, and Your Velindre Experience. The Your Velindre experience uses 0-10 in the question about rating VCC, whereas friends and family used Very good, good etc. The majority of surveys completed in VCC is the Friends and Family one.

The 93% achieved in January was due to 122 survey responses to the VCC Friends and Family CIVICA survey.

51 patients responded to "Your Velindre Experience" CIVICA survey. Of these 51 responses, 43 responded 9/10 and 10/10. The remaining patients responded 7/10 and 8/10. No further narrative was provided to assess the reason for the 7 and 8/10 response.

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 SLT
• Directorate Reports are provided monthly to enable detailed review and 'You Said We Did' feedback	Ongoing	
• Directorates to develop plans to increase response rate.	February 2023	SLT

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

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

Target: 95%		SLT Lead: Jayne Davey

| **Current Performance against Target or Standard** | | **Performance** |

	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Actual %	98	96	95	95	97	96	96	97	96	97	97	96	96	95	96.6
Target 95%	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95

Assessment of current performance, set out key points:
At 96.6% donor satisfaction exceeded target for January.

In total there were 1,079 respondents to the donor survey, 219 from North Wales, and 848 from South or West Wales.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Findings are reported on at Collections Services Monthly Performance Meetings (OSG) to address any actions for individual teams. 'You Said, We Did' actions are taken from the reporting.	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:
N/A		

Expected Performance gain – longer-term
N/A

Risks to future performance

Set out risks which could affect future performance

N/A

Donor Satisfaction chart — Scored 5_6 out of 6 SW, Scored 5_6 out of 6 NW

Number VCC formal complaints received under Putting Things Right within 30 days															
Target: 85%															

SLT Lead: Head of Nursing

Current Performance against Target or Standard

Performance

VCC	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	M 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Actual %									100	100	100	100	100	100	100
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85

Assessment of current performance, set out key points:
- Target deadline has 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

% Formal Concerns responded to under "Putting Things Right" (PTR) within required 30-day Timescale

Target: 90%	SLT Lead: Alan Prosser

Current Performance against Target or Standard

WBS	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Actual %			n/a	100	n/a	n/a	n/a	100	100	n/a	n/a	100	100	N/A	100
Target 90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Note: performance against target only shown the month when a formal concern has been raised

% Responses to Concerns closed within 30 Working Days

NB. Under PTR guidelines, organisations have 30 working days to address/close formal concerns. This can result in concerns being received and subsequently closed within separate reporting periods.

Performance

Assessment of current performance, set out key points:
All concerns were managed in line with PTR regulations, all timescales achieved.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale: Ongoing	Lead: Janet Birchall
Continue to monitor this measure against the '30 working day' target compliance. Continued reemphasis of concerns reporting timescale needs to all staff involved in concerns management reporting		

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Ongoing monitoring and oversight of concerns management in line with PTR.	Ongoing	Julie Reynish

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

TIMELINESS

KPI Indicator KPV.14

Radical Radiotherapy Patients Treated Within 28 Days (JCCO)	
Target: 98%	**SLT Lead: Head of Radiation Services / Clinical Director**
Current Performance against Target or Standard	**Performance**

Radical RT Patients treated within and outside JCCO 28 day Target98%

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
■ > 28days	7	5	7	15	44	16	16	16	33	20	41	67	55	28	12
■ < 28days	179	158	156	171	156	184	184	184	218	230	200	173	182	186	233

Assessment of current performance, set out key points:

Due to the implementation of DH & CR, there are no waiting list reports yet available to accurately report Radiotherapy performance. These are being rewritten to match the interface issues between the existing operational systems and the new DH & CR. We are expecting this to be functioning during late February, following which a period of data validation will ensue. The targets affected by this are the 3 Radiotherapy waiting time targets.

Service Improvement Actions – Immediate (0 to 3 months)		
Actions: what we are doing to improve	**Timescale:**	**Lead:**
• Gradual increase in LINAC capacity by 8% has occurred from Mid-July onwards. Work being undertaken within the Directorate extended working days and increased utilisation of LINAC capacity from 73.5 planned hours in June to up to 76.5 hours delivered in December	January 2023 complete Ongoing	Radiation Services Lead
• Fleet configuration changes to support Breast patient treatment options have been implemented.		
• Escalation processes continue to monitor predicted failures to meet time to treatment metrics and prioritise patients to commence treatment and minimise delay where possible, undertaken through weekly capacity meetings.	Ongoing January 2023	
• Delays and cancellations are monitored weekly and reported back to Radiotherapy Management Group and the pathway sub-group.		
• Review of patients who were not ready for treatment to assess whether treatment planned too soon. Collate lessons learnt and review pathway.		SI Manager
• The Prostate HDR business case was approved by Senior Leadership Team at the Velindre Futures Programme Board in June 2022. The preferred option		

SPC Chart Radical RT (JCCO) within 28 days Target 98%

Measure

SPC Chart Analysis
The SPC chart shows common cause or normal variation over the last 15 months. However, the average performance of 89% consistently falls below the 98% target.

of extended days will be the model utilised in the expansion.		Radiation Services Manager
Expected Performance gain - immediate		
Service Improvement Actions – tactical (12 months +)		
Actions: what we are doing to improve	**Timescale:**	**Lead:**
• Working with each SST to develop a tailored capacity delivery plan based on demand projections and treatment options e.g. Brachytherapy, molecular radiotherapy. • Recruitment and appointments in progress for additional front-line resources.	Q3/4	Heads of Service and SST's Leads
Expected Performance gain – longer-term		
Risks to future performance		
Set out risks which could affect future performance		
• Risks remain however to provide specific Brachytherapy capacity and Radiotherapy Physics capacity and there are significant risks associated with the age of the equipment and potential breakdown, and lack of specialist workforce.		

Palliative Radiotherapy Patients Treated Within 14 Days (JCCO)	
Target: 98%	**SLT Lead: Head of Radiation Services / Clinical Director**
Current Performance against Target or Standard	**Performance**

<table>
<tr>
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Palliative RT Patients treated within and outside JCCO 14 day Target 98%

Numbers of RT Patients

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
■ > 14days	18	16	18	22	14	25	9	17	21	19	15	14	11	16	14
■ < 14days	81	74	81	61	76	81	81	73	79	81	73	68	64	89	74

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Due to the implementation of DH & CR, there are no waiting list reports yet available to accurately report Radiotherapy performance. These are being rewritten to match the interface issues between the existing operational systems and the new DH & CR. We are expecting this to be functioning during late February, following which a period of data validation will ensue. The targets affected by this are the 3 Radiotherapy waiting time targets.

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<tr>
<td colspan="3">**Service Improvement Actions – Immediate (0 to 3 months)**</td>
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Actions: what we are doing to improve
- Review of Palliative Treatment Pathway to access viable and funded models of delivery
- In relation to 3D planning: A proposal is being developed following review COSC implications and an improvement programme to support delivery of the revised targets will need to be agreed as a priority (Quality Performance indicators QPIs

</td>
<td>**Timescale:**</td>
<td>**Lead:** Heads of Service / Medical Lead</td>
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<tr>
<td colspan="3">**Expected Performance gain - immediate**</td>
</tr>
</table>

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 Palliative RT (JCCO) within 14 days
Target 98%

SPC Chart Analysis
The SPC chart shows common cause or normal variation with a dip in performance June to November. However, the average performance of 84% consistently falls below the 98% target.

Emergency Radiotherapy Patients Treated Within 2 Days (JCCO)	
Target: 98%	SLT Lead: Head of Radiation Services / Clinical Director
Current Performance against Target or Standard	Performance

Emergency RT Patients treated within and outside JCCO 2 day Target 100%

Numbers of RT Patients

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
> 2days	0	1	0	3	3	0	2	1	4	3	0	0	1	2	2
< 2days	24	27	22	19	22	25	23	25	19	21	25	21	16	26	35

Performance

Due to the implementation of DH & CR, there are no waiting list reports yet available to accurately report Radiotherapy performance. These are being rewritten to match the interface issues between the existing operational systems and the new DH & CR. We are expecting this to be functioning during late February, following which a period of data validation will ensue. The targets affected by this are the 3 Radiotherapy waiting time targets.

.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Review of patient whose intent changed to assess if any lessons can be learnt or due to clinical condition.	20th December 2022	Medical RT 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 Emergency RT (JCCO) within 2 days   Target 98%

Measure

SPC Chart Analysis

The SPC chart shows common cause or normal variation over the last 15 months. The average performance of 95% just falling below the 98% target.

KPI Indicator KPV.20

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Non-Emergency SACT Patients Treated Within 21-Days		

Target: 98%	SLT Lead: Head of Medicines Management and SACT

Current Performance against Target or Standard	Performance

	No 21	Dec 21	Jan 22	Feb 22	Mar22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Actual %	99	99	94	91	71	69	61	59	66	77	89	96	98	96	97
Target 98%	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98
More than 21 days	5	4	21	32	118	116	146	147				14	6	12	9
Within 21 days	367	347	329	319	400	375	375	355				341	354	322	336

The number of patients scheduled to begin non-emergency SACT treatment in August 2022 (409) was higher than the number in July (389).

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019/20 Attendances	2,189	2,344	2,015	2,315	2,357	2,214	2,316	2,180	2,047	2,276	2,017	1,832
2020/21 Attendances	1,219	1,212	1,375	1,537	1,641	1,696	1,941	1,891	1,982	1,957	1,975	2,253
2021/22 Attendances	2,165	2,105	2,166	2,315	2,259	2,189	2,105	2,242	2,270	2,269	2,101	2,392
2022/23 Attendances	2,297	2,297	2,336	2,302	2,488	2488	2464	2500				

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

Performance

Of 345 patients treated, 9 patients waited over 21 days = performance of 97%.

Intent /Days -	22-28	29-35	36-42	43 days +
Non-emergency (21-day target)	6	1	1	1

1 x patient waited 56 days. There were challenges associated with contacting the patient for outpatient & SACT appointments. Administrative processes impacted by the DHCR implementation and postal strike affected normal appointment processes. Consultant confirmed no harm occurred.
2 patients waited > 28 days. At the time of the report SACT&MM are awaiting feedback from the relevant consultant re: any clinical concern for each of these patients.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Incremental gains in pharmacy capacity are being delivered through reviews of working practices and the focus on maximising SACT provision. • Discussions with Aneurin Bevan UHB regarding the reintroduction of services at Nevill Hall Hospital (NHH) as an interim solution taking place.		BT BT

Expected Performance gain – immediate

Service Improvement Actions – tactical (12 months +)

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

SPC Chart Non Emergency SACT within 21 days Target

98%

SPC Chart Analysis

The period January to June 2022 saw a significant fall and 'special cause' variation. However, the position has recovered over the last six months.

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

-

KPI Indicator KPV.21

Emergency SACT Patients Treated Within 5 Days

| Target: 100% | SLT Lead: Head of Medicines Management and SACT |

Current Performance against Target or Standard | **Performance**

VCC	No 21	Dec 21	Jan 22	Feb 22	Ma 22	Apr 22	My 22	Jun 22	Jul2 2	Au2 2	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Actual %	60	100	100	100	83	100	100	86	100	100	100	100	100	83	100
Target 100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
More than 5 days	2	0	0	0	1	0	0	2	0	0	0	0	0	1	0
Within 5 days	3	9	10	9	6	7	9	7			0	5	6	5	8

Performance

8 patients referred for emergency SACT treatment were scheduled to begin treatment in January 2023. All were treated in target with 100% performance.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Continue to balance demand and ring fencing with capacity.	Continuous	BT

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance
•

SPC Chart Emergenct SACT within 5 days Target 100%

SPC Chart Analysis

The SPC chart shows relatively stable process that meets the 100% target, with the exception of four data points. (note small numbers)

KPI Indicator KPI.18

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	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Actual %	97	96	96	96	96	95	96	95	96	97	97	98	96	87	97
Target 90%	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90

Antenatal Turnaround Times - Patient Results provided to customer Hospitals within 3 working days of receipt of sample

Target: 90%

SLT Lead: Tracey Rees

Current Performance against Target or Standard

Performance

Assessment of current performance, set out key points:
At 97% the turnaround time for routine Antenatal tests has returned to above target in January 2023.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve
Efficient and embedded testing systems are in place. Continuation of existing processes are maintaining high performance against current target.

Timescale:

Lead: Tracey Rees

Expected Performance gain - immediate
Business as usual, reviewed daily.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve
N/A

Timescale:

Lead:

Expected Performance gain – longer-term
N/A

Risks to future performance

Set out risks which could affect future performance

Antenatal Turnaround Times

SPC Chart Antenatal Turnround Time 3 days Target 90%

SPC Chart Analysis

The SPC chart shows common cause or normal variation over the 15-month period. However, a special cause variation has occurred in December (as discussed above). The average performance of 96% exceeds the 90% target.

% Antenatal -D & -C quantitation results provided to customer hospitals within 5 working days																

Target: 90% per quarter ||||||||||||||| SLT Lead: Tracey Rees

| Current Performance against Target or Standard |||||||||||||||

Performance

	Jan 22	Feb 22	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Actual %	99	99	96	100	99	83	99	96	99	99	96	97			
Target 90%	90	90	90	90	90	90	90	90	90	90	90	90			

On target this quarter.

Service Improvement Actions – Immediate (0 to 3 months)

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

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

Anti D & C Results within 5 days Target 90%

SPC Chart Analysis

The SPC chart shows common cause or normal variation during the first and third quarter, with a special cause dip in performance in quarter two. However, the average performance of 96% exceeds the 90% target overall.

EFFICIENT

KPI Indicator FIN.71

Financial Balance – Revenue Position		SLT Lead: Finance Director
Target: Net Zero Trajectory		**SLT Lead: Finance Director**
Current Performance against Target or Standard		**Performance**

Trust Position	21/22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 22	Mar 23
Actual £k	28	1	3	7	6	5	3	5	3	6	2		
Target Net Zero													NIL

Trust-wide Revenue Position as at January 2023

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Variance £000
VCC	(31,365)	(31,366)	0	(38,364)	(38,364)	0
RD&I	(617)	(617)	(0)	175	175	0
WBS	(17,207)	(17,207)	(0)	(20,856)	(20,856)	0
Sub-Total Divisions	**(49,190)**	**(49,190)**	**0**	**(59,046)**	**(59,046)**	**0**
Corporate Services Directorates	(9,216)	(9,213)	(3)	(11,515)	(11,515)	0
Delegated Budget Position	**(58,405)**	**(58,403)**	**(3)**	**(70,561)**	**(70,561)**	**0**
TCS	(551)	(551)	0	(797)	(797)	(0)
Health Technology Wales	(43)	(44)	(1)	(48)	(48)	0
Trust Income / Reserves	59,000	59,000	0	71,406	71,406	0
Trust Position	**(0)**	**2**	**(2)**	**0**	**0**	**(0)**

Assessment of current performance, set out key points:
The overall position against the profiled revenue budget to the end of January 2023 is an underspend of £0.002m, along with an overall outturn forecast position of Breakeven.
The Trust continues to report a year end forecast breakeven position which is following confirmation from WG that the Exceptional National cost pressures and Covid response costs will be fully funded.
Covid funding towards recovery from Commissioner's remains a risk, however, will be mitigated on a non-recurrent basis during 2022-23.

Service Improvement Actions – Immediate (0 to 3 months)

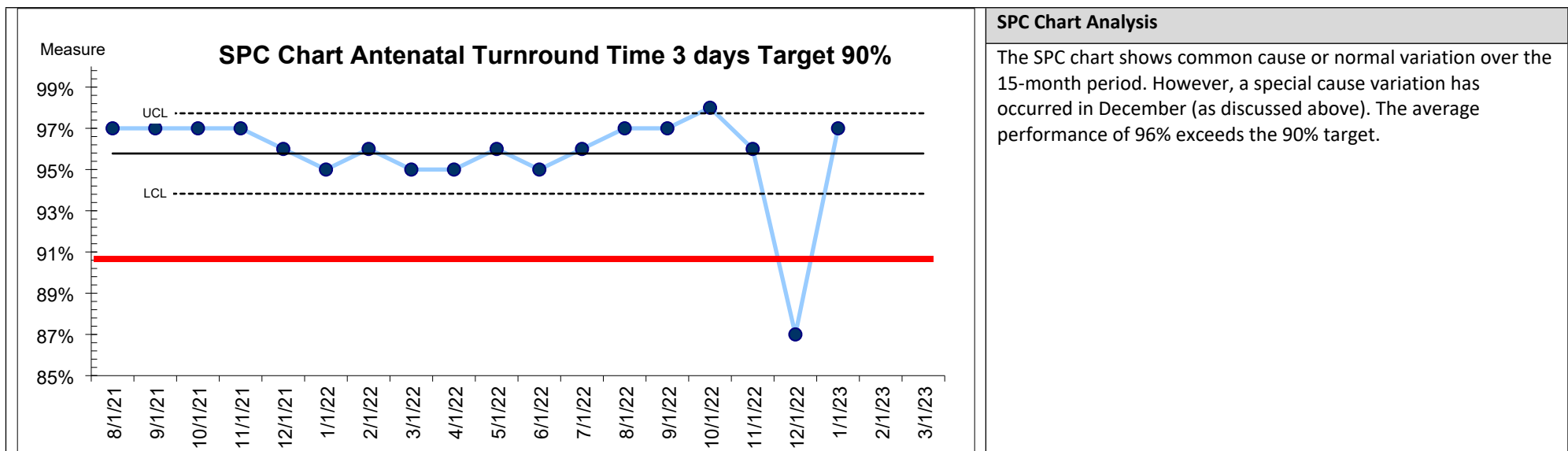| Actions: what we are doing to improve	Timescale:	Lead:
Actions addressed through Divisional Action Plans		M Bunce
Expected Performance gain - immediate		

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
•		
Expected Performance gain – longer-term		

Risks to future performance

Set out risks which could affect future performance
•

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	21/22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 22	Mar 23
Actual	12.4	1.0	1.411	3.134	3.989	4.615	5.954	7.884	9.681	11.796	14.346		
Target £27.760M CEL		1.0	1.411	3.134	3.989	4.615	5.954	7.884	9.681	11.796	14.346		20.042

Trust-wide Capital Position as at January 2023

	Approved CEL £m	YTD Spend £m	Committed Orders Outstanding £m	Budget Remaining @ M10 £m	Full Year Actual Spend £m	Year End Variance £m
All Wales Capital Programme						
nVCC - Project costs	2.394	2.496	0.000	-0.102	2.923	-0.529
nVCC - Enabling Works	14.406	8.913	0.000	5.493	13.877	0.529
Canisc Cancer Project	0.579	0.579	0.000	0.000	0.579	0.000
Fire Safety	0.500	0.294	0.000	0.206	0.500	0.000
Integrated Radiotherapy Solutions (IRS)	7.900	1.554	0.000	6.086	7.640	0.260
WG Priority Year end Spend	0.370	0.000	0.000	0.370	0.370	0.000
WBS Infrastructure OBC Fees	0.157	0.000	0.000	0.157	0.157	0.000
Total All Wales Capital Programme	26.306	13.836	0.000	12.210	26.046	0.260
Discretionary Capital	1.454	0.510	0.191	0.753	1.714	-0.260
Total	27.760	14.346	0.191	12.963	27.760	0.000

Performance

The approved 2022/23 Capital Expenditure Limit (CEL) as at January 2023 was £27.760m. This includes All Wales Capital funding of £26.306m, and discretionary funding of £1.454m. The approved CEL has increased in year by £1.904m which reflects approval of the Canisc Cancer Project (0.579m), IRS (7.900m), Velindre's share of the WG yearend spend request (0.370m) and support fees for the WBS infrastructure OBC (£157k). This is offset by a reduction of 7.102m on the nVCC Enabling works project to reflect the latest forecast requirement for 2022/23. Following agreement with WG the £7.102m will be re-provided to the programme during 2023/24.

WG colleagues have agreed a further movement of £0.529m between the nVCC enabling and project costs which is reflected in the table above but represented as a variance rather than a CEL adjustment.

On the 22nd November the Trust received the award funding letter from WG in relation to IRS. The total funding allocated is £41.602m for the period April 22 to March 2026 with £7.900m of the total to be provided during 2022/23 with future years funding cash flow to be agreed with WG.

In January 2022 WG informed the Trust that the discretionary allocation will be significantly reduced during 2022/23 (previously £1.911m), which is reflective of the reduced overall NHS capital budget position.

Allocation of the discretionary programme was approved by EMB Shape on the 27th August.

Performance to date

The actual cumulative expenditure to January 2022 on the All-Wales Capital Programme schemes was £12.210m, this is broken down between spend on the nVCC enabling works £8.913m, nVCC project costs of £2.496m, Canisc Cancer Project £0.579m, fire safety £0.294m, and IRS £1.554m.

Spend and committed spend to date on Discretionary Capital is currently £0.701m leaving a remaining balance of £0.753m as at the 31st January.

Year-end Forecast Spend

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

Service Improvement Actions – Immediate (0 to 3 months)		
Actions: what we are doing to improve	Timescale:	Lead:
•	XX/XX/XX	AN Other

	Expected Performance gain - immediate

	Service Improvement Actions – tactical (12 months +)		
	Actions: what we are doing to improve •	**Timescale:** XX/XX/XX	**Lead:** AN Other
	Expected Performance gain – longer-term		
	Risks to future performance		
	Set out risks which could affect future performance •		

Usage of Overtime Bank and Agency Staff within Budget														
Target: Spending within budget													SLT Lead: Finance Director	
Current Performance against Target or Standard													Performance	

Trust Position	21/22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 22	Mar 23
Actual	1.906	103	125	130	**154**	146	129	183	179	193	140		
Target £1.533M Forecast		128	128	128	128	128	128	128	128	128	128	128	128

The spend on agency for January 23 was £0.140m (December £0.193m), which gives a cumulative year to date spend of **£1.482m** and a current forecast outturn spend of circa **£1.717m** (£1.906m 2021/22). Of these totals the year to date spend on agency directly relating to Covid as at the end of January is £0.264m and forecast spend is circa £0.316m (£0.826m 2021/22).

Agency actual / f'cast Expenditure 22/23 and Average actual 21/22 & 20/21

Legend: Spend & F'cast 22/23 — Av. Spend 20-21 — Av. Spend 21-22

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead: Matthew Bunce
• Actions addressed via Divisional action plans		

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance
•

Cost Improvement Programme delivery against plan	
Target: Savings in line with Forecast CIP	**SLT Lead: Finance Director**
Current Performance against Target or Standard	**Performance**

Trust Position	21/22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 22	Mar 23
Actual	1.100	0.75	.016 0	0.25 4	**0.35 5**	0.42 9	0.59 2	0.70 9	0.7 95	0.94 5	1.06 4		
Target £1.3M Forecast		0.75	0.16 0	0.25 4	0.35 5	0.47 4	0.59 2	0.70 9	0.7 95	0.94 5	1.06 4		1.300

Overall VUNHST Cost Improvement Programme £1.3M

Cummulative monthly savings achieved compared to target

The Trust established as part of the IMTP a savings requirement of £1.300m for 2022-23, £0.800m recurrent and £0.500m non-recurrent, with £0.750m being categorised as actual saving schemes and £0.550m being income generation.

The divisional share of the overall Trust savings target has been allocated to VCC £0.700m (54%), WBS £0.500m (38%), and Corporate £0.100m (8%).

Two schemes continue to be impacted by Covid during 2022-23 have now turned red which relate to service redesign and supportive structures.

Service redesign and supportive structures is a key area of savings for the Trust which are focused on removing inefficiencies in the ways the Trust are working. These plans are aligned to a number of the Trust VBHC bids that sought funding for new posts to support medical workforce redesign but were unsuccessful. The ability to enact these saving schemes is proving to be difficult due to the legacy of the pandemic and current workforce situation, particularly the high number of vacancies along with the high level of sickness that is currently being experienced throughout the Trust. Plans are still being developed by the Trust divisions however, it is recognised due to the current challenges that these saving schemes will not be achieved in the short term and therefore delivery has been removed from this financial year.

Contingency measures have been put in place on the basis that these savings schemes will not achieved this year, however these replacement schemes are both recurrent and non-recurrent in nature. **It is extremely important that divisions continue to review their current savings schemes, and where delivery is not going to be achieved this year consider the impact on next year's financial position especially where those schemes were classified as recurrent.**

Service Improvement Actions – Immediate (0 to 3 months)		
Actions: what we are doing to improve Actions delivered through Divisional Action Plans	**Timescale:**	**Lead:** M. Bunce
Expected Performance gain - immediate		

Service Improvement Actions – tactical (12 months +)		
Actions: what we are doing to improve •	**Timescale:** XX/XX/XX	**Lead:** AN Other
Expected Performance gain – longer-term		
Risks to future performance		
Set out risks which could affect future performance •		

Public Sector Payment Performance Target Non NHS Invoices paid within 30 days															
Target: 95%															**SLT Lead: Finance Director**

Current Performance against Target or Standard															
Trust Position	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	My 22	Jun 22	Jul 21	Aug 21	Sep 21	Oct 22	Nov 22	Dec 22	Jan 23
Capital & Revenue Invoices						95	95	96	96	96	96	96	96	95	94
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:
During January '22 the Trust (core) achieved a compliance level of **90.15%** December 22: 92.54%) of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **94.37%** as at the end of month 10, and a Trust position (including hosted) of **94.91%** compared to the target of 95%.
 PSPP compliance levels have temporarily dropped in performance over the last couple of months which is bring urgently reviewed in order to understand the reason for the dip.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Working with both NWSSP and the service the finance teams are urgently reviewing the invoices that have failed in month with a view to target both bottlenecks and repeat offenders	28/02/2023	M Bunce

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

EQUITABLE

% Workforce declared Welsh Speakers in Trust at Level 1															
Target: TBA%															

Current Performance against Target or Standard

Trust Position	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 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]

SPC Chart Analysis
The SPC chart shows

SLT Lead: Director of Workforce and OD

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

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	**Performance**

Trust Position	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 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]

SPC Chart Analysis
The SPC chart shows

Assessment of current performance, set out key points:
- insert text
-

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance
- insert text
-

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	**Performance**

Trust Position	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Actual %															
Target TBA%															

Assessment of current performance, set out key points:
- insert text
-

[Indicator and targets are under development and ESR data validation required so figures should be treated with caution at this stage]

SPC Chart Analysis
The SPC chart shows

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance
- insert text
-

Diversity of Workforce – People with a Disability															
Target: TBA%												SLT Lead: Director of Workforce and OD			

Current Performance against Target or Standard

Trust Position	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 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]

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

WELSH BLOOD SERVICE QUALITY SAFETY AND PERFORMANCE REPORT

DATE OF MEETING	16/03/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	N/A

PREPARED BY	PETER RICHARDSON, HEAD OF QUALITY ASSURANCE AND REGUALTORY COMPLIANCE, WBS
PRESENTED BY	Alan Prosser, Director WBS & Peter Richardson, Head of Quality and Regulatory Compliance
EXECUTIVE SPONSOR APPROVED	CATH O'BRIEN, CHIEF OPERATING OFFICER

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME
WBS Regulatory Assurance and Governance Group	23/03/2023	Noted and discussed
WBS Senior Management Team	08/03/2023	Noted and discussed
Executive Management Board	02/03/2023	Noted and discussed

ACRONYMS	
WBS	Welsh Blood Service
WTAIL	Welsh Transplant and Immuno-genetics Laboratories
MHRA	Medicines and Healthcare products Regulatory Agency
RAGG	Regulatory assurance and governance group
SAE	Serious Adverse Events
CA/PA	Corrective Action/Preventative Action
SABRE	Serious Adverse Blood Related Event

1. SITUATION

This paper is to provide the Quality, Safety & Performance Committee with an update on the key quality, safety and performance outcomes and metrics for the Welsh Blood Service for the period October 2022 to January 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 October 2022 to January 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 (October 2022 to January 2023 and updates for the month of February 2023):

- All clinical demand was met for red cells and platelets without a need to request mutual aid during the period.
- During the reporting period WBS has been able to support other UK blood services (Celtic Nations) who have not been able to recover and sustain their stock holding as fast as in Wales. 300 Red cell units were exported in October and a further 120 units in November.
- The service entered Blue Alert for O negative blood group on December 30th as demand exceeded supply over the holiday period with a limited ability to make up the deficit due to Bank Holidays and industrial action. This alert remained in place for a period of 2 weeks to allow this position to recover.
- Closure of quality incidents within the required 30 days has stabilised and consistently achieved 96% or above for the whole reporting period.
- During the period 2 Serious Incidents were reported to the Human Tissue Authority and 2 Serious Adverse Blood-Related Events (SABRE) were reported to the Medicines and Healthcare products Regulatory Agency (MHRA).
- 24 concerns were reported, 20 were managed within timeline as early resolution as detailed in the report. 4 formal complaints were dealt with under the Putting Things Right process.
- Overall donor satisfaction dipped slightly but continues to exceed target at 95.7%.
- Inspections by the Human Tissue Authority (HTA), UK Accreditation Service (UKAS) and the European Federation of Immunogenetics (EFI) were all completed successfully and the relevant accreditations maintained.

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 February to May 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.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The current performance reporting and monitoring system identifies performance issues and supports effective decision making at service and operational levels to drive forward continuous improvement in quality, safety and the overall experience of patients and donors.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below: • Staff and Resources • Safe Care • Timely Care • Effective Care.
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATIONS

The Quality, Safety & Performance Committee are asked to **NOTE** the information in this report.

WELSH BLOOD SERVICE - QUALITY, SAFETY & PERFORMANCE COMMITTEE REPORT

October 2022 to January 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

1.1 Safety Incidents linked to donors are reported into the Donor Clinical Governance Group and scrutinised at the Regulatory Assurance and Governce Group (RAGG), These include failed venepuncture where a needle is not properly sited in a vein, and part bags where a donation stops before the full quantity is collected. All of these measures have remained at low levels and within tolerance during the reporting period:

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

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

  There were 109 GMP incidents occurring between October 2022 to January 2023 reported via QPulse. All of these incidents were closed within 30 days

- **Incidents which may lead to redress or could result in harm to donors, patients or staff** – these are reported in Datix Once for Wales (OfW) for consistency across the trust.

- No significant trends were identified in quality incidents reported between Oct 2022 to Jan 2023.
- Quality incident investigations continue to exceed the target of 90% closed within 30 days [i.e. 97% Oct, 96% Nov, 96% Dec, 98% Jan]
- 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.

1.3 Areas of concern:

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

- Main categories of incidents were Blood Pack Incidents, Laboratory Errors, Quality Monitoring and Equipment Problems.
- Main locations of incidents were within Distribution (Hospital Services), Manufacturing Laboratory, WTAIL Serology and QA Laboratory
- One incident (INV-389) has a significant risk rating: Frequency converter error in manufacturing laboratory centrifuges due to an ongoing electrical issue. An operational work-around is in place pending completion of the necessary electrical work.

1.4 Regulatory Inspections

1.4.1 The Welsh Blood Service was inspected by the Human Tissue Authority (HTA) in early October. As reported at the November meeting, this included the first inspection of the stem cell collection facility at Velindre Cancer Centre. One mandatory finding was raised by the inspectors which has now been addressed and WBS has successfully maintained registration with the HTA.

1.4.2 United Kingdom Accreditation Service (UKAS) inspected the Talbot Green site twice in early October. No critical observations were raised and accreditation to ISO 15189 and ISO 17043 has been maintained.

1.4.3 The Welsh Blood Service have now completed all outstanding actions in line with the agreed action plan from the Medicines and Healthcare Products Regulatory Agency (MHRA) inspection of Pembroke House in June.

1.5 Serious Incidents Reportable to Regulators

A recent increase in incidents reported to regulators is being closely monitored to identify any common root causes.

October 2022: No adverse event reported to regulators

November 2022: Serious Adverse Blood-Related Event (SABRE) 103

- A report was made for a near miss – a donation tested positive for Hepatitis E Virus (HEV) in a pool of 16 donations. There was a potential risk to patient safety, although the affected units had not been issued/transfused. WBS have introduced single donation testing as a risk reduction measure and a national review of HEV testing is underway.
- MHRA have closed the SABRE report, no further action requested. The Serious Hazards of Transfusion Scheme (SHOT) had access to the SABRE report and did not require any further details or a questionnaire to be completed. SHOT is a non-regulatory, voluntary haemovigilance reporting scheme.
- In addition, there was one Donor Adverse Event recorded whereby duty of care was breached: **(DAER 8394)** The donor developed a lump at the venepuncture site, this was treated as bruise, but was not examined by the RN at the time. This was managed as a Concern and a Regulation 26 letter was sent to the donor. This event will be included in the annual report to SHOT.

December 2022: SABRE 104

- This incident concerned a little c antigen result which was displaying incorrectly in the blood establishment computer system.
- The root cause was a bug in the interface software that had not been detected via validation, the scenario causing the bug had not been identified as a potential issue. The bug has been fixed and changes have been validated. Standard validation test scripts have been reviewed and updated to ensure this scenario is included in future testing.
- MHRA have closed the SABRE report, no further action requested.

  In addition, two related adverse events were reported to HTA:

  CAS-65884-W3R3 and CAS-65882-C3B6

- A discrepancy was detected between WBS and transplant centre test results for CD34+ leucocyte count. The root cause of the discrepancy is related to lack of a specific return to use check following emergency maintenance on the instrument. The decision not to undertake this check was based on advice from the supplier, but this advice had not been formally assessed in terms of operational impact.
- This incident is a near miss as, although the WBS cell count was incorrect the dose requested by the transplant centre was met.

- As a result of the erroneous CD34 cell count the stem cell donor was recalled unnecessarily for a second day collection, where an extra dose of G-CSF was administered. There was no harm to the donor as a result of the second collection, but HTA were informed as the second day collection was unnecessary.

  The donor was made aware of the issue immediately it was discovered and counselled on the potential impacts. The donor has made it clear that they do not intend to pursue the matter.

January 2023 – no adverse events reported to regulators

February 2023 – Two reportable incidents are under investigation and will be reported in more detail to the next Quality, Safety and Performance Committee meeting.

SABRE 105

- A Bact-Alert instrument failure leading to a risk of undetected bacterial contamination in platelets stored for 7 days. Monitoring results were not being sent to the blood establishment computer system. The current instrument is over 20 years old and in the process of being replaced.
- Customer hospitals were advised of the issue immediately, and all units over 5 days old were quarantined for recall. WBS immediately reverted to a 5 day shelf life of platelets which does not require bacterial monitoring,
- A replacement Bact-Alert system is in the process of being commissioned.

HTA reportable event: IR-624, HTA reference CAS-66484-W4W1

- A weld seal failure on a peripheral stem cell collection during processing. The unit was potentially compromised, but the seal failure was on the tail of product bag meaning that

  the likelihood of patient harm is very low, the recipient would routinely be on broad spectrum antibiotics pre transplant and the transplant centre have been notified and agreed to take the unit.

1.6 15 Step Challenge Action plans

1.6.1   The action plan arising from the 15-step Challenge visit to the North Wales Collection team in August 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.

1.6.2   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 commenced in Q4 2022/23.

1.6.3   The action plan arising from the 15-step challenge visit to University Hospital of Wales is complete.

2. Effectiveness

2.1 Blood Supply

During the reporting period WBS has recovered it's stocks of blood components to optimum levels across all blood groups. WBS has also continued to work closely with hospitals across Wales to promote appropriate use of Blood and reduce the stock levels held in hospital blood banks. Mutual Aid was provided to other UK blood services during October and November.

Demand over the period between Christmas and New Year was higher than anticipated, and coupled with the impact of industrial action immediately before Christmas caused stocks of some blood groups to drop below target minimum levels. A blue alert was issued to hospitals but there was no need to import stock during this period.

2.2 Bone Marrow / Stem Cell collections

Bone marrow and stem cell collection activity has increased slightly over the reporting period with 9 collections being completed between October 2022 and January 2023. December and January have been particularly encouraging with 4 collections in each month. A review of the donor recruitment and retention strategy continues.

2.3 Audit Summary

There were 17 internal audits scheduled for completion between October and January.

- 15 audits have been conducted as planned
  2 audits have carried over into Q3, the risk from late completion has been assessed as low as this activity as they cover areas already inspected by the HTA and UKAS

x13 Audits Conducted October 2022 – January 2023 (inclusive)
x8 - Procedural Audits conducted within schedule
x1 - ISO 15189 Audit conducted within schedule
x4 - Procedural Audits carried over from previous quarter and completed within October & November   Slippage due to auditor/auditee availability.

Risk by late completion: Low
Audits carrying over have been subject to external (3rd Party) and other internal (1st Party) audits throughout 2022 - 2023

Corrective and Preventative Actions Summary
- **No Major or Critical findings raised October 2022 – January 2023**
- **'Major' Non-conformances raised May – September carrying over (see below):**

CAPA No	Audit/CAPA Details	Current Status
Raised August 2022 - Document Control		
IA38	**(Process) – Document Control** Evidence of systematic breakdown	**Completed Closed 07/02/2023**
Raised July 2022 - Collections		
IA37	**(Process - Trending identified) - Collections** x5 incidents in Q-Pulse where 11 donations are present in polar bags, exceeding the maximum number of 10 units (Incidents raised between Sept 2021 – April 2022). Preventative measures to be put in place.	**Completed Closed 13/10/2022**
Raised May 2022 – General Services		
IA35 & IA36	**(Data Integrity) - Supplier Audit (Transmedia – Archiving Company)** The WBS has not submitted a Data Protection Impact Assessment. This is 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. DPIA to be created and submitted.	**Completed Closed 06/02/2023**
	A Data Sharing Agreement was requested from the WBS and could not be located – it is assumed that one has not been completed. DPA to be created and submitted.	**Completed Closed 10/02/2023**

3. Service-User Centred

3.1 WBS has introduced the Civica system to collect feedback from donors before they leave a donation session.

Available Answers	Responses	Score (%)
5- Completely Satisfied	5410	94.17%
4- Satisfied	247	4.30%
3- Neither Dissatisfied nor Satisfied	20	0.35%
2- Dissatisfied	11	0.19%
1- Completely Dissatisfied	57	0.99%
Total	**5745**	**100%**

Q1: 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).
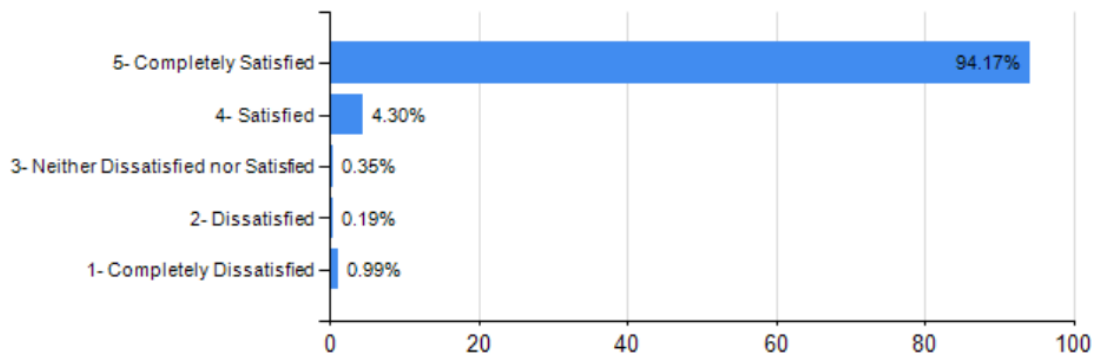
Positive and Improvement Themes

Positive Trends	Improvement Trends
Comfortable and relaxed atmosphere	Venue Heating
Welcoming environment	Donation Chair Comfort
Staff attitude	Storage of donor's belongings during donation
Staff capability	
High Standard of Cleanliness	
High level positive feedback	
Facilities	

Staff Attitude, Capability and communication

Staff Attitude & Capability

Number of comments by theme

- Friendliness — 3.0k (Positive)
- Professional and Competent — 1.9k (Positive)
- Politeness — 596 (Positive)
- Helpfulness — 497 (Positive)
- Compassion — 414 (Positive)

Click legend to show/hide:
- Positive
- Negative

Donor Emotions

Patient Emotions % (All Records)

Percentage of comments by emotion

- Love — 66%
- Happiness — 20%
- Delight — 12%
- Frustration
- Wants and Needs
- Fear
- Surprise
- Sadness
- Anger
- Excitement
- Shock

3.2 WBS continues to invite every blood donor to complete a feedback survey in the month after their donation. This is available online, by text message or by completion of a feedback form. The feedback highlights are:

a. During The period October 2022 to January 2023, 4320 responses were received (18.6% response rate)
b. Donor satisfaction for those who had successfully donated was 95.7%

c. In total 3077 donors scored themselves as 'Totally Satisfied' and were invited to provide more details.

d. Out of 20,945 donation attendances in October 2022 to January 2023, 60 donors (1.4% 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:

3.3 Changes in response to Donor Feedback

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

- Introduction of soya milk for vegan donors.
- Reintroduction of Cowbridge Leisure Centre, Culverhouse Cross, and Ebbw Vale blood donation sessions.
- Increased frequency of donation clinics at the Newtown venue.

With the support of Business Intelligence, WBS has identified which metrics were statistically important to providing a positive donation experience, working groups are being created to improve across these areas.

3.4 Concerns

3.4.1 In the period October 2022 to January 2023, 24 concerns were reported, 20 were managed within timeline as early resolution as detailed in the table below. 4 formal complaints were dealt with and closed within 30 days but in one case the donor remains unhappy with the outcome and has indicated an intent to seek further redress.

4. Timeliness

4.1 Reference Serology Turn-around times

Reference Serology 'turnaround' performance failed to meet the 80% target between October 2022 and January 2023, although turnaround times did improve. Recent

performance is due to continued staff absences and vacancies, continued high levels of testing requests & planned annual leave.

Compatibility testing (40% of referrals) continues to meet clinical target and all time-critical tests are being completed on time whilst the volume of testing requests increased to 269 per month compared to Average 226/month for 2021 and 235 for 2022.

4.2 Overdue activity performance trends

The following graph provides an overview of the overdue activity performance trends for incidents and preventive actions overdue for closure over the past year. Incident closure has improved significantly over the reporting period, following the re-prioritisation of resources to support blood collections in June and July which led to an increase in overdue actions. The QA team will continue to work with operational teams to ensure that incidents are investigated and closed effectively, and in a timely manner

Trend of overdue GMP Incidents and Actions

	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
Incidents from Datix	6	4	2	4	4	3	3	2	1	0	0	4	4	3
Actions from QPulse	4	2	6	5	12	2	11	28	22	16	10	10	11	5
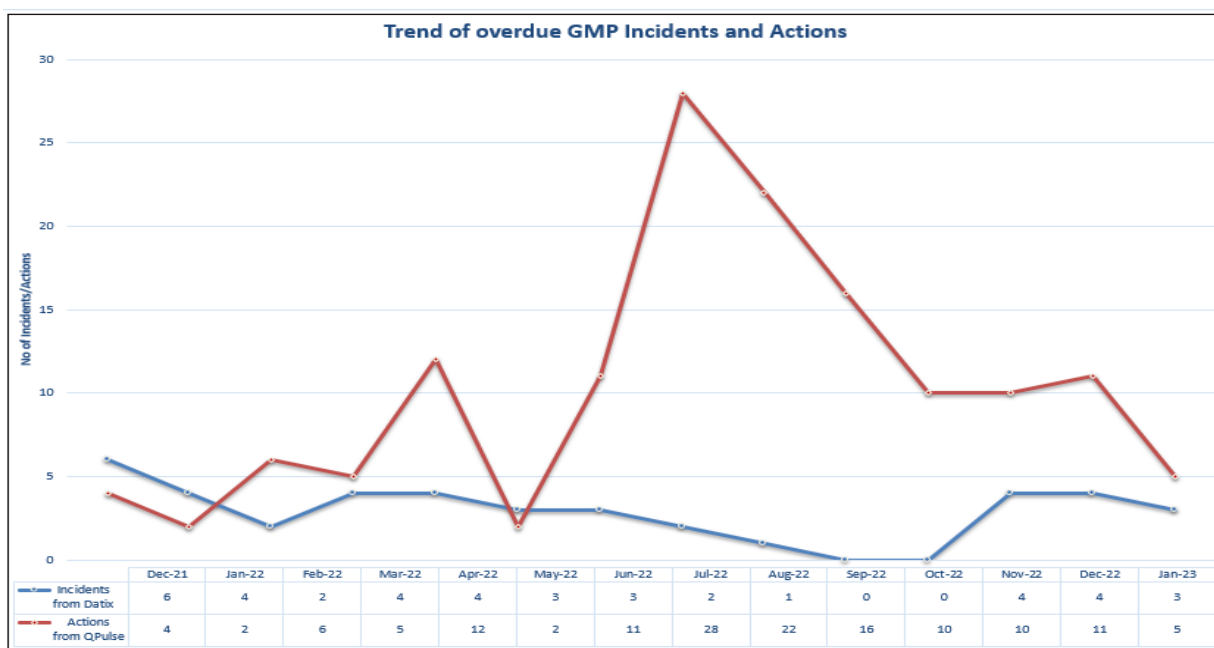
4.3 Areas for concern:

There are no quality deviations (incidents) more than 3 months overdue.

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

5. Equity

The Welsh Blood Service strives to give everyone in Wales the opportunity to donate, this has traditionally been achieved through a peripatetic model of collection teams based in regional hubs and visiting 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 this alsohas to be balanced with demand for blood products to prevent waste and unnecessary collections.

6. Efficiency

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

Collection productivity has fluctuated over the period to 1.2 in January but continues to be below target. Contributory factors influencing the recent performance include:

- Adverse weather conditions had a direct impact on 3 sessions due to restrictions in travel.
- Reduction in venue capacity due to short term sickness.
- Sessions at educational establishments are staffed in greater numbers and with reduced venue capacity due to expected increases in donors becoming unwell at donation.

6.2 Manufacturing Efficiency (392 Components per WTE)

Manufacturing efficiency has continued to fluctuate from 372 in October, peaking at 401 in October but dropping back below target in December. The performance in January is slightly higher than the previous month which reflects increased activity (less bank holidays and strikes in January compared to December).

6.3 Manufacturing Losses (Tolerance 0.5%)

Controllable losses for October 2022 to January 2023 continue to fluctuate between 0.03% and 0.15% but remain below tolerance.

6.4 Time Expired Red Cells (Target 1%)

Red cell expiry for October 2022 to January 2023 has increased slightly but remains extremely low and within target. Ongoing industrial action presents a risk to collections and mitigation of the risks from industrial action are to increase stock holding, if the strikes do

not affect collection, then stock holding may be higher than optimal levels leading to increased waste.

6.5 Time Expired Platelets (Target 10% expired)

Platelet wastage performance continues to exceed target due to high variability in demand during December and January, making pre-planning more difficult. Following the analysis of platelet usage completed during the summer of 2022 some immediate changes have been implemented but further work is ongoing to deliver a more sustained improvement.

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

TRUST INTEGRATED MEDIUM TERM PLAN – PROGRESS UPDATE AGAINST THE APPROVED QUARTERLY ACTIONS FOR 2022 / 2023

DATE OF MEETING	16/03/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	N/A

PREPARED BY	Philip Hodson, Assistant Director Planning & Performance
PRESENTED BY	Carl James, Director Strategic Transformation, Planning, Performance and Digital
EXECUTIVE SPONSOR APPROVED	Carl James, Director Strategic Transformation, Planning, Performance and Digital

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME
Executive Management Board	February 2023	Noted

ACRONYMS	
IMTP	Integrated Medium Term Plan
IQPD	Integrated Quality Planning & Development (Welsh Government Review Meeting)
VCC	Velindre Cancer Centre
WBS	Welsh Blood Service

1.   SITUATION/BACKGROUND

1.1   The Integrated Medium Term Plan (2022-2025) was approved by the Minister for Health and Social Service in July 2022. Included within the approved IMTP were action plans for both cancer and blood and transplant services. Delivery of these action plans are integral in supporting the delivery of the Trust's strategic aims and objectives.

2.   ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1   The attached papers (Appendices A and B) provide quarter 3 (2022/2023) progress updates in the form of IMTP Quarterly Actions Progress Monitoring templates for WBS and VCC.

2.2   Please Note that the update provided reflects our position as of the end of quarter 3 (December - 2022/2023). An end of year (quarter 4) IMTP progress report for 2022/2023 will be prepared for the next Committee meeting.

3.   IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required

LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

4.1 The Quality, Safety and Performance Committee is asked to **NOTE** the progress made, as of Quarter 3 (2022/2023), in delivering the key Trust actions included within the approved IMTP for 2022 – 2025.

Welsh Blood Service IMTP Quarterly Progress Report 2022/23 for Quarter 3 as at 20/01/2023

IMTP Strategic Priorities WBS Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables / Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**					
		2022/23				**Quarterly Progress Update for Q3**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
SP1: Provide an efficient and effective collection Service, facilitating the best experience for the donor, and ensuring blood products and stem cells are safe and high quality and modern	**1.** Develop and introduce Plasma For Fractionation - Medicine Service Model for Wales.	Scope service need. Project group established.	Business case to Welsh Government.	Develop draft service model.	Service model approved.	UK wide MOU in place and induction activities are underway.

Governance of the UK and Welsh Programme being considered. Timetable for UK programme has shifted and is being re-assessed | |
| | **2.** Develop and implement Donor Strategy. | Scope service need. Project structure established. Draft strategy produced. | Consultation on strategy. | Implementation plan developed. | Implementation of eDRM phase 1 to support delivery of implementation plan. | Strategy under development – consultation underway. | |
| | **3.** Develop and implement WBMDR strategy. | Scope service need project structure established draft strategy produced. | Consultation on strategy. | Implementation plan developed. | Implementation commence. | The WBMDR five-year strategy is in development and will reappraise the existing collection model and its ambition.

The Recovery Plan is being implemented to increase recruitment of bone marrow volunteers. | |

IMTP Strategic Priorities WBS Service Delivery Framework 2022/23

Strategic Priorities 2022/23 to 2024/25	Key Deliverables / Objectives	Key Quarterly Actions 2022/23 Timescales and Progress					
		2022/23				Quarterly Progress Update for Q3	Progress Rating
		Q1	Q2	Q3	Q4		
	4. Review blood collection clinic model in light of COVID changes to ensure the service model moving forward remains fit for purpose.	Establish project structure review service models to meet need & undertake service/data review in light of COVID and proposed contract variation.	Undertake service/data review in light of COVID and proposed contract variation.	Complete OCP process in relation to service model.	Complete OCP process in relation to service model.	OCP concluded and the plan for implementation has been developed.	
SP2: Meet the patient demand for blood and blood products through facilitiating the most appropriate use across Health organisations	**5.** Introduction of 'live connectivity' to allow 'real-time' information to be shared WBS, laboratories and health board transfusion/clinical teams.	Scope opportunities for digital technology to support sharing real time data and transfer of goods between WBS and customers.	Establish technology solutions.	Identify resources to support implementation.	Implementation commence.	Collaboration with Cardiff & Vale UHB to secure Welsh Government funding to support electronic blood management system continues.\n\nResubmission of the business case is scheduled for February 2023.	
SP3: Provide safe, high quality and the most advanced	**6.** Assess and implement SaBTO (guidelines 2021 release date) recommendations	Confirm role of WBS with Welsh Government establish project structure.	Complete OCP process in relation to service mode.	Establish workforce model.	Implementation.	The referral pathway is in operation with no new OBI confirmed cases identified to date. Communication documents agreed for	

IMTP Strategic Priorities WBS Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables / Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**				**Quarterly Progress Update for Q3**	**Progress Rating**
		2022/23					
		Q1	**Q2**	**Q3**	**Q4**		
manufacturing, distrbution and testing laboratory services	on blood donor testing to reduce the risk of transmission of Hepatitis B infection as required.					implementation and Wales will be the first to initiate the recipient lookback pathway. Wales went live with lookback pathway on 16th January 2023. Working closely with Health Boards closely on identifying patient cases.	🟧
SP4: Provide safe, high quality and the most advanced diagnostic, transplant and transfusion services	**7.** Deliver WLIMS modules for Blood Transfusion (BT)	Scope service specification.	Undertake procurement.	Undertake procurement.	Complete USR procurement.	This project being transferred to DHCW for future management and implementation.	🟧
	8. Implementation of Foetal DNA typing.	Engage with Antenatal Screening services to develop implementation plan.	Agree implementation plan.	Take forward implementation.	Take forward implementation.	Project groups progressing, and procurement process for the kits has started with samples for validation identified by WBS and supplied by NHSBT.	🟩
SP5: Provide, services that are environmentally sustainable and benefit our local	**9.** Establish a quality assurance modernisation programme to develop and implement strategy which support more efficient and effective	Project to be scoped. Project structure established. Phased work plan.	Develop implementation plan.	Take forward implementation.		Tender for eQMS complete: extension to QPulse licenses for a further 12 months to December 2023. eQMS user specification considerations being addressed to support re-procurement exercise (ongoing).	🟩

IMTP Strategic Priorities WBS Service Delivery Framework 2022/23

Strategic Priorities 2022/23 to 2024/25	Key Deliverables / Objectives	Key Quarterly Actions 2022/23 Timescales and Progress				Quarterly Progress Update for Q3	Progress Rating
		2022/23					
		Q1	Q2	Q3	Q4		
communities and Wales	management of regulatory compliance and maximising digital technology.					Electronic signature system (Docusign) contracts signed and system activated (rollout in Q4 following initial use in Labs). Presentation to WBS SMT regarding 7 levels of Assurance Framework, Duty of Candour and Duty of Quality.	
	10. Develop an estate and supporting infrastructure service model which delivers improved energy efficiency and reduction of carbon emissions.	Submit OBC for Talbot Green infrastructure Project	Procure support to develop FBC.	Appoint Healthcare planner to develop FBC.	FBC submitted to Welsh Government.	Feasibility study to commence in January 2023 to fully understand phasing in light of Laboratory Modernisation Programme and Plasma for Medicines and the impacts on this programme.	
SP6: Be a great organisation with great people dedicated to improving outcomes for	**11.** Develop a sustainable workforce model for WBS which provides leadership, resilience and succession planning.	Engagement with teams in relation to review of Clinical Services. Review of Facilities model. Review of BI.	Development of service model paper to be developed for approval.	Development of service model paper to be developed for approval.	Implementation plan developed.	Structure drafted and consultation document being prepared for consultation in Q4.	

GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

IMTP Strategic Priorities WBS Service Delivery Framework 2022/23

Strategic Priorities 2022/23 to 2024/25	Key Deliverables / Objectives	Key Quarterly Actions 2022/23 Timescales and Progress				Quarterly Progress Update for Q3	Progress Rating
		2022/23					
		Q1	Q2	Q3	Q4		
patients and donors.							
	12. Establish a laboratory modernisation programme to review and develop service processes, practices and workforce requirements which support an efficient and effective service model across all laboratories in WBS.	Scope programme of work. Establish project structure.	Develop implementation plan.	Business case submitted to WHSSC to support implementation of new standards and guidance in component development lab.	Funding secured.	Programme governance structure in place. Feasibility study underway to understand how this programme integrates with Talbot Green Infrastructure Programme.	
	13. Lead the All Wales approach to implementation of Welsh Government Statement of Intent for Advanced Therapies.	Secure funding review structure and develop work plan 2022/23.	Clinical lead appointed. Implementation of work plan.	Implementation of work plan.	Implementation of work plan.	New working group meetings started in September 2022, and the new Delivery Plan is in development. The Apheresis Status Review project start is imminent, and a new Clinical Lead position being considered. The re-engagement with Health Boards is to start in Dec/Jan	
	14. Support UK Infected Blood	IBI continues	IBI continues	IBI continues	IBI continues	Oral submissions have now concluded, with final written	

IMTP Strategic Priorities WBS Service Delivery Framework 2022/23

Strategic Priorities 2022/23 to 2024/25	Key Deliverables / Objectives	Key Quarterly Actions 2022/23 Timescales and Progress				Quarterly Progress Update for Q3	Progress Rating
		2022/23					
		Q1	Q2	Q3	Q4		
	Inquiry and delivery of its Terms of Reference.					submission prepared by Trust Counsel in consultation with the other UK Blood Services. The deadline for submission was 16th December 2022. Final Inquiry oral statement will be delivered on behalf of WBS by the KC representing the Trust on January 26th 2023. Initial report expected in the Summer/Autumn of 2023.	

KEY:

BLUE	Action successfully completed with benefits being realised
GREEN	Satisfactory progress being made against action in line with agreed timescale
YELLOW	Issues with delivery identified and being resolved with remedial actions in place
AMBER	Delays in implementation / action paused due to external issues beyond our control
RED	Challenges causing problems requiring recovery actions to be identified

Velindre Cancer Centre IMTP Quarterly Progress Report 2022/23 for Quarters 1, 2 and 3 as at 24/01/2023									
Strategic Priorities 2022/23 to 2024/25	Key Deliverables/Objectives	Key Quarterly Actions 2022/23 Timescales and Progress							
		Q1	Q2	Q3	Q4	Quarterly Progress Q1	Quarterly Progress Q2	Quarterly Progress Q3	Progress Rating Q3
Strategic Priority 1: Access to equitable and consistent care, no matter where; To meet increasing demand	**1.** SACT Capacity Plan	Maintain high level of chair utilisation at VCC to support capacity growth. (see 2023/24)	Implement programme to attract and retain SACT trained staff, and increase nurse led 'protocol' clinics to shift to a greater nurse led are model for SACT	New nursing staff in post and trained	Commence booking service review.	Task and finish group established with work plan for short term options. Impact assessments undertaken and weekly tracking of data undertaken. Capacity review of bookings team complete, nursing team underway and review of pharmacy services to commence in September. Discussions ongoing with regard to where injectable	Additional clinics commenced on 6th August and planned to mid October 2022. Plan under development to increase capacity within Macmillan Unit at PCH. Recruitment campaign has been successful. Discussions ongoing with Executive Director of Nursing and Chief Operating Officer regarding workforce plan.	Additional chair capacity supported at the Macmillan Unit at Prince Charles Hospital by the deployment of new nursing resource. Chair capacity at VCC maintained.	

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		Q1	Q2	Q3	Q4	Quarterly Progress Q1	Quarterly Progress Q2	Quarterly Progress Q3	Progress Rating Q3
						treatments are best placed to be undertaken with a view to releasing SACT capacity.			
		Finalise interim facility plan at Neville Hall Hospital.	Work with ABUHB to identify appropriate accommodation	Review workforce requirements to support interim service model across PCH and NHH	implement plan to support interim NHH model	Initial accommodation challenges at NHH resulted in a re-focus to expand capacity at PCH. NHH are continuing to explore options which VCC will need to consider as fit for purpose. Expansion to either/both is	Data modelling of geographical flows underway to determine level of demand.	Cooperative work with ABUHB to prepare site/unit. Date for re-opening agreed (end of March 2023).	

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		Q1	Q2	Q3	Q4	Quarterly Progress Q1	Quarterly Progress Q2	Quarterly Progress Q3	Progress Rating Q3
						subject to staffing capacity modelling and resourcing.			
		Commence contract with third party provider to deliver SACT chair capacity while Neville Hall is progressing	Implement staffing review agreed actions.	Develop business case for SACT Consultant Nurse/ Pharmacist.		Substantial readiness work undertaken throughout Q1. However, RCC went into liquidation June and therefore objective has to be withdrawn.			

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		Q1	Q2	Q3	Q4	Quarterly Progress Q1	Quarterly Progress Q2	Quarterly Progress Q3	Progress Rating Q3
		Commence the SACT Improvement / Transformation programme to develop a robust service which is 'fit for the future' to include review staffing model and assess workforce options.	Review of booking clerk capacity to be undertaken	Review of nursing capacity to be undertaken review of pharmacy capacity to be undertaken	Review pharmacy capacity to be completed	Task and finish group established with workplan for short term options. Impact assessments undertaken and weekly tracking of data undertaken. Capacity review of bookings team complete, nursing team underway and review of pharmacy services to commence in September. Discussions ongoing with regard to where injectable	Performance relative to key performance indicators improving during quarter 2. SACT task and finish group continue to meet, nurse modelling completed, pharmacy review commenced. Additional clinics commenced on 6th August and planned to mid October 2022. Plan under development to increase	Compliance against time to treatment Key Performance Indicators returned to within tolerance in November. SACT Task and Finish Group recommendations issued and action plan for improvement in development.	

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		Q1	Q2	Q3	Q4	Quarterly Progress Q1	Quarterly Progress Q2	Quarterly Progress Q3	Progress Rating Q3
						treatments are best placed to be undertaken with a view to releasing SACT capacity.	capacity within Macmillan Unit at PCH.		
	2. Radiation Services Capacity Plan	Maximise Rutherford contract – revised service	MRI refurbishment in radiology	Streamline plan complexity for certain palliative scenarios.		RCC has gone into liquidation therefore this option is withdrawn Discussions are currently underway with			

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Velindre Cancer Centre IMTP Quarterly Progress Report 2022/23 for Quarters 1, 2 and 3 as at 24/01/2023										
Strategic Priorities 2022/23 to 2024/25	Key Deliverables/Objectives	Key Quarterly Actions 2022/23 Timescales and Progress								
		Q1	Q2	Q3	Q4	Quarterly Progress Q1	Quarterly Progress Q2	Quarterly Progress Q3	Progress Rating Q3
						the new private provider around contrating options for RCC.			
		Begin project to increase Linac capacity to 80 hours (73 currently)	Implement 80 hours Linac capacity	Finalise proposals for capacity increase to 80 hours	Implement 80 hours Linac capacity	Capacity Planning meeting in place with RT treatment team – dependencies linked to recruitment start dates quarter 4	Linac capacity increased to 75 hours from July. Further expansion to 76 hours planned to take place at beginning of October. Capacity Planning meeting in place with RT treatment team – dependencies linked to recruitment	Linac capacity periodically reduced as various upgrades carried out on TrueBeam machines as part of IRS implementation. Anticipated that expansion to 78 hours will be effected from March 2023.	

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		Q1	Q2	Q3	Q4	Quarterly Progress Q1	Quarterly Progress Q2	Quarterly Progress Q3	Progress Rating Q3
							start dates quarter 4.		

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		Q1	Q2	Q3	Q4	Quarterly Progress Q1	Quarterly Progress Q2	Quarterly Progress Q3	Progress Rating Q3
		Complete Brachytherapy Peer Review and submit Business Case for additional planned capacity to meet demand.	Brachytherapy action plan delivery business case potentially here as will need to follow the action plan from the peer review and workforce review			Peer Review complete and action plan in development.	Engagement with WHSSC undertaken. Commitment secured to fund expansion of prostate service to a maximum of 78 patients per year. Following benchmarking exercise undertaken with the Clatterbridge Cancer Centre a capacity and workforce review and gap analysis of gynae service ahead of the development of	Workforce recruitment to support prostate service expansion underway. Implementation and staff training ongoing alongside review to inform future service model.	

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Strategic Priorities 2022/23 to 2024/25	Key Deliverables/Objectives	Key Quarterly Actions 2022/23 Timescales and Progress							
		Q1	Q2	Q3	Q4	Quarterly Progress Q1	Quarterly Progress Q2	Quarterly Progress Q3	Progress Rating Q3
							a service development business case for submission to WHSSC in late 2022/23.		
		Review demand and capacity for clinical trials	Explore dose and fractionation schedules and alternative			Medical decision required on alternative treatment options			

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		Q1	Q2	Q3	Q4	Quarterly Progress Q1	Quarterly Progress Q2	Quarterly Progress Q3	Progress Rating Q3
			treatment approaches			trial capacity specifically detailed in service capacity plan			■
		Review the Linac transition capacity for IRS implementation.	Agree the position on temporary/mobile/ fully commissioned leased bunkers while IRS process takes down fleet.				IRS updated paper approved by to Executive Management Board September with plan for first linac replacement. Radiotherapy recruitment complete, medical physics underway	Recruitment to identified medical physics roles complete.	■
	3. Radiotherapy Pathway/COSC target	Programme to review efficiency of	Develop standard operating	Evaluate roles for advanced practice	Implement agreed pathway and	Requires VCC wide response linked to	Pathway and practice review on a site by site	Site-by-site pathway review	■

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Strategic Priorities 2022/23 to 2024/25	Key Deliverables/Objectives	Key Quarterly Actions 2022/23 Timescales and Progress							
		Q1	Q2	Q3	Q4	Quarterly Progress Q1	Quarterly Progress Q2	Quarterly Progress Q3	Progress Rating Q3
	achievement and radiotherapy clinical treatment developments	existing pathways continues including reduction in variation in ways of working /action plan developed.	procedures for pathway management, building on those developed in Lung Pathways and emerging themes/challenges with SST leads.	particularly Non-Medical Outliners in optimal pathways with SST leads.	workforce models developed to meet COSC target requirements.	demand profile and pathway development. Requires medical leadership and decision making to implement improved ways of working identified from initial pathway work.	basis progressed (led by Dr Tom Rackley). Process intended to identify and scale good practice/learning, to identify and address systemic issues via the Radiotherapy Management Group and other groups.

Data analysis undertaken to identify trends in breaches, missed appointments and cancellations to | continued to progress.

Radiotherapy pathway improvement project identified for inclusion in proposed pathway improvement programme. Scope of project to be defined and Terms of Reference to be developed. | |

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Strategic Priorities 2022/23 to 2024/25	Key Deliverables/Objectives	Key Quarterly Actions 2022/23 Timescales and Progress							
		Q1	Q2	Q3	Q4	Quarterly Progress Q1	Quarterly Progress Q2	Quarterly Progress Q3	Progress Rating Q3
							determine areas for improvement.

Further support commissioned through Improvement Cymru for pathway development/review.

VCC actively involved in the Wales Cancer Network Lung cancer pathway review.

All Site Specialist Teams (SST's) have now undertaken one | | |

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		Q1	Q2	Q3	Q4	Quarterly Progress Q1	Quarterly Progress Q2	Quarterly Progress Q3	Progress Rating Q3
						deep dive session.			
						This manual data capture to deliver gap analysis.			
						Support commissioned through Improvement Cymru for pathway development/review.			
						VCC actively involved in the Wales Cancer Network Lung cancer pathway review.			

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Strategic Priorities 2022/23 to 2024/25	Key Deliverables/Objectives	Q1	Q2	Q3	Q4	Quarterly Progress Q1	Quarterly Progress Q2	Quarterly Progress Q3	Progress Rating Q3
						All Site Specialist Teams (SST's) have now undertaken one deep dive session.			🟥
		Engage with WHSSC on PRRT service to deliver patient benefit (awaiting WHSSC decision)	Engage with WHSSC on PRRT service to deliver patient benefit	PRRT business case if able to progress	Finalise business case and Delivery of PRRT plan	Service specification required from WHSSC. Initial WHSSC response to open service Q1 2023.	WHSSC have established a national MRT programme board with Velindre input. Programme board will lead on the development of a service specification, in conjunction with clinical stakeholders. Work scheduled	Service developing business case and preparing to engage in WHSSC facilitated appraisal process in anticipation of possible commissioning of new service in 2023-24 (formal appraisal scheduled to begin in	🟩

Velindre Cancer Centre IMTP Quarterly Progress Report 2022/23 for Quarters 1, 2 and 3 as at 24/01/2023

Key Quarterly Actions 2022/23 Timescales and Progress

Velindre Cancer Centre IMTP Quarterly Progress Report 2022/23 for Quarters 1, 2 and 3 as at 24/01/2023									
Strategic Priorities 2022/23 to 2024/25	Key Deliverables/Objectives	Key Quarterly Actions 2022/23 Timescales and Progress							
		Q1	Q2	Q3	Q4	Quarterly Progress Q1	Quarterly Progress Q2	Quarterly Progress Q3	Progress Rating Q3
							to begin in autumn 2022.	March/April 2023).	■
		Review proposed RT treatment developments including IMRT to establish capacity and commissioning approach	Active engagement with commissioners with priority treatment development plan and delivery	Active engagement with commissioners with priority treatment development plan and delivery	Active engagement with commissioners with priority treatment development plan and delivery	Active engagement with commissioners remains in place. Specific business cases to be provided to Commissioners, with a focus on the highest priority developments, inclusive of clinical benefits to patients and service benefits in terms of	New quarterly meeting instituted between VCC and WHSSC to review specialist services and inform planning and development work.

ToRs of VCC Collective Commissioning Group reviewed and governance and reporting links | Prostate treatment planning group established to support transfer of activity to newly commissioned linac and to consider adoption of new radiotherapy techniques.

Prioritisation of new techniques identified within IMTP 2023/24 | ■ |

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		Q1	Q2	Q3	Q4	Quarterly Progress Q1	Quarterly Progress Q2	Quarterly Progress Q3	Progress Rating Q3
						productivity. Radiotherapy developments prioritisation completed a number of years ago so needs to be reviewed radiotherapy	strengthened. Specific business cases to be provided to Commissioners, with a focus on the highest priority developments, inclusive of clinical benefits to patients and service benefits in terms of productivity. Radiotherapy developments prioritisation completed a number of years ago so needs to be reviewed.		

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		Q1	Q2	Q3	Q4	Quarterly Progress Q1	Quarterly Progress Q2	Quarterly Progress Q3	Progress Rating Q3
	4. Outpatient Services/Medical Directorate	SST and Outpatient Transformation programmes to commence building on pre-pandemic work. (interdependent with radiotherapy projects)	The transformation objectives for the SSTs and Outpatient workforce will continue as previously described in quarter 1.	Deliver transformation programmes-estate, pathways and workforce	Deliver transformation programmes-estate, pathways and workforce	Transformation programme structure in place with reporting into Velindre Futures. A draft high level outpatient work programme has been developed has been discussed with further work progressing on providing more details plans. The transformation programme is built upon the National aims and objectives. The programme is	SST reviews commenced July and continuing into August 2022. Draft Outpatient Work Programme developed in collaboration with the Medical Directorate. This has been reviewed, feedback provided, plan to be adjusted and submitted for final approval. Performance Management	Work initiated in Outpatients to describe patient flow, to support development of activity baselines and to determine capacity and capacity constraints. Outpatient work identified as a project/workstream under within new pathway improvement programme. Scope of project and Terms of	

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		Q1	Q2	Q3	Q4	Quarterly Progress Q1	Quarterly Progress Q2	Quarterly Progress Q3	Progress Rating Q3
						interdependent upon all other services.	Framework will include National tagrets regarding outpatient services.	Reference to be developed.	
		Rolling programme of SST 'supportive reviews' to commence to work to ensure that pathways are effective, efficient and smooth, and to inform modernisation of the multidisciplinar							

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		Q1	Q2	Q3	Q4	Quarterly Progress Q1	Quarterly Progress Q2	Quarterly Progress Q3	Progress Rating Q3
		y workforce model.							
		Commence workforce modelling and planning within the SSTs and Outpatient teams (and link to radiotherapy); maximising opportunities for enhancing skill mix and embracing more efficient				**OPD** capacity and demand plan under development. Nursing establishment review completed leading to a review of skill mix leading to advertisement of band 4 apprenticeship nursing roles which is the first		Workforce capacity modelling in Outpatients commenced for CNSs	

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		Q1	Q2	Q3	Q4	Quarterly Progress Q1	Quarterly Progress Q2	Quarterly Progress Q3	Progress Rating Q3
		ways of working				of its type at VCC.			
						· Upskilling of HCSW's			
						· All trained nurses to complete SACT passport to support the demand for injectables			

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		Maximise use of virtual consultations and embed into 'business as usual'. (50% at present).				Utilisation of virtual consultations has continued and is firmly embedded in to service, via telephone and video conferencing technology. Virtual group sessions have also been introduced and further extended within the Therapies service. Positive feedback received from Welsh Government on use of virtual technology.	Utilisation of virtual consultations has continued and is firmly embedded in to service. Welsh Government refers to Velindre Cancer Centre as an 'exemplar' due the rapid transformation and modernisation of outpatient appointments and group sessions.	Virtual consultations continue to be utilised as standard. Rates of utilisation continue to be actively monitored.	

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						Usage data is monitored by the Outpatient Management Group.			
						Phlebotomy services continues function at an activity rate of an average of 100 patients per day with activity aligned to an increase in SACT. Electronic test requests are	The ratio of face to face/virtual consultations is continually monitored by the Outpatient Management Group.	Active monitoring of activity continues as standard.	

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						completed and issued to patients (excluding patients under Cardiff and Vale University Health Board as Velindre Cancer Centre is contracted to undertake this service) to attend their local primary or secondary care service for pre clinic bloods, however, it is noted that a number of GP practices have refused to complete 'hospital			

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						bloods'. The scale of this is under review.			
		Establish optimum levels of Phlebotomy provision and notify HBs of changes in access.				Outpatient Nursing Team and Reception Staff have implemented extended working hours from 08:00 to 18:00 hours to provide support to meet increased demand.	Opportunities to increase activity have been explored with further SACT injectable treatment delivered within the Department (within the Outpatient Treatment Room).		

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		Provide increased capacity incl. at evenings/weekends to meet demand initially while the more fundamental pathway changes and ways of working are introduced pending service improvement efficiency delivery.				Feedback from the SST deep dives and discussions with the Medical Directorate Manager are underway in respect of demand/request for evening/weekend working without the outpatient department. Weekend working is in place and fully established for phlebotomy during bank holidays. Opportunities to increase activity	Discussions remain on-going in relation to further opportunities.		

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						within the Outpatient Treatment Room are under discussion.			███
		Work to reduce demand within the Outpatient setting, including: review and streamlining of patient pathways and the implementation of the 'supported self-				Patient pathways under review by each SST and explored during deep dive sessions. The Cancer Centre has commenced a PSA self-management project with the view to extending self-management		Review of workforce and physical capacity utilisation and patient pathways commenced in Outpatients.	███

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		management' model				models across other sites.			
		Re-commence the pre Covid Outreach Clinics	outreach project group to be reestablished outreach project manager to be appointed	review of data assumptions and workforce requirements to support outreach clinics identification of gaps to support service delivery		Most outreach clinics have been repatriated. The remaining clinics are mainly within Aneurin Bevan University Health Board and have been escalated for resolution.	Engagement with Aneurin Bevan UHB undertaken to address key challenges currently being worked through to progress the return the remaining oncology clinics to Neville Hall and Royal	The majority of outpatient activity previously undertaken at the Royal Gwent Hospital now reinstated at that location. Ongoing discussions with ABUHB on return of outpatient	

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							Gwent Hospitals.	activity to the Nevill Hall site.	
Strategic Priority 2: Access to state-of-the-art, world-class, evidence-based treatments	5. Digital Health Care Record (CANISC Replacement)	Finalise development	Testing and training	Commence Go Live Phases– dry run	Review impact of implementation on operational delivery	DHCW have delivered much of the software as outlined in the re-profiled plan. There are elements of the individual developments that require further work. VCC along with colleagues from across the wider NHS Wales Oncology service are		DHCW 'go live' in November. Record adopted for use by all services at VCC. Ongoing support for implementation provided by DHCR project and applications teams and DHCW.	

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						continuing to work closely with DHCW to resolve these issues and find a solution that aligned with both national and local requirements.			
		Functional testing	Operational Go Live planning	Dry run weekend planned

Complete Go Live

review impact on service delivery and lessons learned | Plan phase 2 | All required functional testing has been completed and the data migration plan is on schedule to compete the final sign off in Q3. The training plan was completed in | | | |
| | | User Acceptance Testing | Go Live readiness assessment | | | | | | |
| | | | Go Live run through | | | | | | |

Strategic Priorities 2022/23 to 2024/25	Key Deliverables/Objectives	Key Quarterly Actions 2022/23 Timescales and Progress							
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		Data Migration	SOP development			readiness for the operational review. Implementation and operational readiness planning commenced as planned, these will be refined as the organisation moves toward the go-live scheduled for November 2022.			
		Operational service change planning							
		Training sign off							
	6. Integrated Radiotherapy Solution	Complete Tender Evaluation and Identify Winning Bidder, issue	Complete hybrid OBC/FBC and submit to WG and await approval.	LA6 Bunker Decommissioning commences	LA6 Bunker Refurb complete.	Project team evaluations concluded in April 2022.	Engagement with Varian continued. Negotiation with Elekta to ensure ongoing	Delivery of first replacement linac (LA5) agreed for January 2023. Preparatory	

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		standstill letter.				Minimum Threshold Scored Questions (MTSQ) and Pricing clarifications developed by the team, were issued and responses received from bidders were subsequently reviews for final evaluation	maintenance of machines undertaken and commitment of expenditure papers developed for consideration by the Trust Board.	work in anticipation of delivery and equipment commissioning undertaken.	
			Award IRS contract once approval of capital and revenue funding.		Service plans for second machine replacement confirmed.	Draft Procurement outcome report was developed for mid-April with a Legal			

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			Receive vendors detailed implementation plans			review scheduled. Work was ongoing with the team for drafting approvals and to finalise OBC/FBC including agreement of resource for implementation, risk and benefit owners to ensure alignment and a smooth transition from procurement to implementation transition			

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					Initial scoping works on TPS/OIS replacement and Phase 1 additional functionality.	Multiple legal reviews for finalisation of the IRS Procurement Outcome Evaluation Report were scheduled and attended by the team. Development of Alcatel report with the legal team for issue to bidders on procurement award outcome was developed for Board approval			
						Issued to bidders following SRO			

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						approval in early June			
					Plans for Satellite and nVCC confirmed				
						June			
						IRS Contract development was ongoing with the support of Legal for finalisation of the contract. Meetings were scheduled throughout July & August to finalise the IRS contract with Varian			
		Appoint Radiation Services	Prepare recruitment of IRS			Actions on track managed through IRS	Actions on track managed through IRS	Actions on track managed through IRS	

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		Programme Manager to lead implementation and commence design of 1st bunker.	implementation posts.	Recruit to IRS implementation posts		Implementation programme Board	implementation programme board.	implementation programme board.	
		Establish Shadow Implementation Board		Commence formal IRS implementation – shadow implementation board stands up as a formal board.			The shadow IRS implementation board continues to meet with good engagement between the procurement team and the implementation team.	The shadow IRS implementation board continues to meet with good engagement between the procurement team and the implementation team.	

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									█
	7. Acute Oncology Service- local delivery	Recruit ANPs and other staff	Pathway design with region	Pathway implementation	Pathway implementation	ANP Lead Nurse has recently completed an Establishment Review of the ANP workforce to ensure appropriate staffing levels and skill mix for the AOS service going forward.	Ongoing recruitment within the ANP team to ensure 36ppropriate staffing levels and skill mix. Dedicated ANP to provide outreach clinical support for teams.	2 new trainee ANPs recruited. Undergoing active and ongoing training/development.	█
	8. Integrated care	Scope bed plans/model for assessment unit aligned to the VCC element of AOS.	Continue to review the unscheduled care patient pathway aligned to the			Work continues with regional AOS teams to develop robust AOS model. Ongoing work to improve lunchtime AOS	Work being progressed via the Clinical Model Review Group led by Annie Evans. Presentation to the Integrated	Work undertaken to develop suite of measures / indicators to support	█

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			VCC element of AOS.			meetings with Health Boards. Work also ongoing with service leads to discuss the model for Unscheduled care and a VCC Clinical Model Review Group established and action plan developed.	Care Operational Group by Annie Evans to define next steps.	monitoring of activity locally.

MSCC pathway identified as eligible for service improvement input as part of the national Safe Care Collaborative initiative. Working group to be identified and scope of work to be defined. | |

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		Develop plans for delivering national projects e.g. Immuno Oncology (SDEC) Immunohematology Service – Recruit staff	Immunohematology Service Increase capacity	Immunohematology Service- further pathway work with HBs	Immunohematology Service- grow service delivery	Nursing team and administrator is in post (in line with funding), the 0.2 BI post remains outstanding and has been escalated to Cath O'Brien/Rachel Hennessy for decision.	Immunotherapy Toxicity Service launched early September. Draft SLA has been formulated for specialist endocrine sessions - awaiting instruction on signoff steps from VCC governance;	Further draft SLAs developed in order to secure further specialist support for MDT. These include gastro- and respiratory services.	
						Modelling of the new service, Standard Operating Procedures, clinical guidelines and the patient IO	An IO data application (with associated DPIA) has been developed by BI, this has been tested throughout September		

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						pathway is under review;	before handed to Digital.		
						Draft SLA has been formulated for specialist endocrine sessions - awaiting instruction on signoff steps from VCC governance;	IO Intranet and Internet page have been set up and are in process of being populated in line with service developments/guidance document sign off;		
						An IO data application (with associated DPIA) has been developed by the Business	A suite of clinical guidelines/pathways has been issued to interested		

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						Intelligence Team. This will be user acceptance tested via the pilot stage – awaiting confirmation that digital will support this App;	parties for feedback.		
						Scrutiny agreed in July to advertise 3 of the 7 funded Consultants sessions externally:			
						A pilot of the IO service will commence 16th August 2022 to test virtual			

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						scenarios in readiness for proposed launch of service early September 2022.			
		(SDEC) Ambulatory Care – finalise staff recruitment	Ambulatory Care- increase weekday opening	Ambulatory Care- weekend opening		Recruitment of nursing and therapies staff (bid funded) is complete.	Excellent progress made as defined in quarter 1. All staff now in place and extended days implemented. Sunday opening commenced in July and is working well.	Extended hours of operation sustained.

Work commenced to develop appropriate suite of performance indicators to support ongoing monitoring of activity and to allow reporting | |
| | | | | | | The Ambulatory Care Operational Policy and the Weekend Working Standard Operating Procedure have been finalised and proceeding through | | | |

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						approval process.		to national structures.	
						Patient Experiences (PREMS) and Patient Outcomes (PROMS) continue to be captured via the CIVICA Patient Experience system, following rollout of handheld devices and the App.			
						An end-to-end process review of data capture within Integrated care			

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						is ongoing with service leads and service improvement to allow for more accurate, consistent and sustainable data capture.			
						RD&I preparing to expedite a Head and Neck Patient Support Unit peer review;			
						Sunday extended hours have commenced. Lessons learnt are being captured as a 'plan, do, study,			

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						act cycle in readiness for extension of Saturday hours from August 2022.			
			Deliver requirements of national projects e.g. Immuno Oncology			As above			
	9. Palliative Care	Review Cancer Associated Thrombosis clinic service: establish working SLA with Oncology	Undertake Peer Review as planned	Review of Chronic pain service.	Preparing the move from CANISC (No solution yet identified)	Review of Chronic pain service. Preparing the move from CANISC (no solution yet identified).	Initial meeting to re-establish Cancer and Hospital Acquired Thrombosis Group held. Draft terms of reference developed to progress the		

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							finding of the April 2022 All Wales HAT audit.. This will include review of the CAT clinic.		████
	10. Key Treatment Development– IMN SABR Lutetium PSMA HDR Brachytherapy	Finalise the priority of implementation of key treatments where external funding is required and agree timescales.	Take forward agreed business cases in a phased approach as agreed.	Take forward agreed business cases in a phased approach as agreed.	Take forward agreed business cases in a phased approach as agreed.	Capacity paper to Executive Management Board in December 2021 confirmed no additional capacity available, and loss of capacity will occur during essential major change programme delivery - DHCR / IRS	WHSSC have established a national MRT programme board with Velindre input. Programme board will lead on the development of a service specification, in conjunction with clinical stakeholders. Work scheduled	Recruitment and service planning in support of HDR Brachytherapy expansion undertaken. Preparation for engagement with formal WHSSC appraisal process related	████

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	Clinical team priorities – gaps in service therapies access to trials research MDT attendance/cover arrangements					implementation / RSC / nVCC. Risk and Harm impact assessments will be required when extra capacity above core commissioned activity is required to implement to change / amend pathways for new service provision.	to begin in autumn 2022. Engagement with WHSSC undertaken. Commitment secured to fund expansion of prostate service to a putative maximum of 78 patients per year.	to possible commissioning of PRRT service undertaken (process scheduled to begin in March/April 2023).	

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									🟥
		Commence business case developments for agreed treatments in phased approach according to priority and timetable agreed.	Apply 'Just do it' criteria where appropriate for clinical team	Apply 'Just do it' criteria where appropriate		Not applicable no extension / service changes yet agreed through triumvirate risk assessment			🟥
		Finalise the priority of clinical team priorities.	Begin development of implementation plans for clinical team priorities requiring	Continue the development of implementation plans for clinical team priorities requiring				Planning group established to consider feasibility of introduction of new prostate treatment techniques	🟥

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			support/wider discussions.	support/wider discussions.				when activity transferred to newly commissioned linac (LA5). A similar group to consider the feasibility of new breast treatments likely to be established in late quarter 4 in anticipation of delivery and commissioning of second new linac.	

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	11. Radiotherapy Satellite Centre	Support Strategic case development and review of FBC.	FBC approval-WG implement Arts strategy for RSC operational model development aligned to IRS	Ongoing liaison with ABUHB regarding build, IRS alignment project board, project team meetings	operaitonal model delivery plan preparation	Managed through IRS Implementation Board	Managed through IRS Implementation Board.	Managed through IRS Implementation Board.	
		Workforce Plan.							
		Finance case.							
		IRS alignment and FBC.							
		FBC scrutiny and approval by service lead and through Boards							

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	12. Radiology	Commission reconditioned MRI scanner. Phase 1 capacity delivery	Review Radiology demand and align to capacity plan		Full additional capacity plan is delivered	Not started – interdependency required for radiology demand for pathway changes Treatment pathways requires completion and sign off to assess demand requirement	Commissioning of refurbished MR scanner completed. Fully operational.	Introduction of DHCW and associated disruption to routine activity reporting restricted ability to undertake demand and capacity planning.	

| | 13. Patient treatment helpline | Implement new handover arrangement into SACT service. | Develop action plan to address issues identified and changes required. | Implement actions identified. | Implement associated workforce or training plans | No response provided | SACT Treatment Helpline handed over to SACT and MM Directorate.

Review of why the helpline is currently being accessed towards near end of completion with view of Options appraisal being presented Autumn 2022.

Initial work to stabilise the platform for recording calls completed. Further work to be considered in conjunction with digital teams, including functionality of | Review of reasons for Helpline calls from patients completed October.

Options appraisal on future operating model undertaken for review by VCC SLT.

Treatment helpline identified as subject of service improvement support as part of the national Safe Care Initiative. Working group to be identified | |

							the telephony system	and scope of work defined.	

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		Commence review of service functionality and fitness for purpose.	Engage with stakeholders at VCC and externally in developing plans to ensure all calls are appropriately directed from 1st contact.,	Implement any identified telephony systems to allow signposting to all areas.	Roll out new system and ways of working				
		Engage with digital team to explore system capability and options for future.							
	14. Implementation of patient engagement strategy to strengthen our conversations with patients, families and wider partners	Commence Patient panel	Commence establishment of Patient Engagement Hub and Patient Leadership Group	Patient Leadership Group recruitment and training	Continue to develop Group, staff team and patient engagement delivery. Includes underpinning nVCC.	New strategy approved Trust Board in May 2022.	Pilot of new CIVICA engage platform to enable establishment of patient panel to commence autumn 2022.	Inidivudal appointed to work within Comms team and focus on developing patient engagement hub pilot, supported by Charities	
						Final documentation and infographic have been finalised. Funding has been agreed for				

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		Implement patient panel management software programme	Establish initial Patient Engagement activity for Velindre Futures projects			Patient Engagement Manager which is due to be advertised in late July 2022.	Launch and recruitment plan also for early autumn 2022.		

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	15. Establish Primary Care project under Velindre Futures					Task and finish group to be established to scope of project and associated actions. The original IMTP did not include any objectives so will be added retrospectively.			red
Strategic Priority 4: To be an international leader in research, development, innovation	16. R & D Hub (Development at UHW)	Progress the clinical scientist and clinical academic business cases.	Progress the clinical scientist and clinical academic business cases.	Business case and costs	Establish Governance Arrangements for the Hub.	**Progress the clinical scientist and clinical academic business cases.**	New south-east Wales Prehab2Rehab collaborative group formed. Inaugral meeting of group, chaired by Suzanne Rankin (CEO	Engagement with Prehab2Rehab collaborative and with the Wales Cancer Network National Prehabilitation Group	green

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and education						· Funding for 0.5FTE Clinical Academic post (an Early Phase Trialist) was recently approved at the Velindre Charitable Funds committee and the plan will be to secure match funding by Cardiff University. The business case is currently going through Cardiff University processes. · A number of posts are going through recruitment and	C&VUHB) on behalf of the Cancer Collaborative Leadership Group (CCLG), held.	continued. Active contribution to work to define the remit and scope of both groups.	

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						selection; these include a Band 8a Senior Nurse (12 months secondment), a Band 6 nurse and a Clinical Research Fellow.			
						Business case costing and funding agreements in place.			
						· ECMC, Cardiff's 5year renewal bid to CRUK (2023-2028) was submitted on the 30th June. If successful, the ECMC bid includes some			

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						research nurse capacity that will support the research delivery within the Hub.			
						· WCRC's bid was submitted to HCRW for the next 2 years (2023-2025). Included in the bid were Clinical Research Fellows that would support the Hub as well as undertake postgraduate training. Also included were other opportunities to build further			

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		Q1	Q2	Q3	Q4	Quarterly Progress Q1	Quarterly Progress Q2	Quarterly Progress Q3	Progress Rating Q3
						collaboration with Cardiff University and VUNHST. WCRC is awaiting initial feedback from HCRW.			
						· An approach has been made to HCRW regarding the additional 3.6 WTE posts. Both VUNHST and CVUHB are supplying further information with regard to this request. **Establish Governance**			

Velindre Cancer Centre IMTP Quarterly Progress Report 2022/23 for Quarters 1, 2 and 3 as at 24/01/2023									
Strategic Priorities 2022/23 to 2024/25	Key Deliverables/Objectives	Key Quarterly Actions 2022/23 Timescales and Progress							
		Q1	Q2	Q3	Q4	Quarterly Progress Q1	Quarterly Progress Q2	Quarterly Progress Q3	Progress Rating Q3
						Arrangements for the Hub.			

					The Head of R&D and her team continue to work closely with the Joint Research Office (JRO) to ensure process is in place to efficiently and effectively deliver collaborative research studies that will be delivered through the Cardiff Cancer Research Hub. Areas of focus will be managing activity coming into the JRO that will be delivered through the hub. The Early project review process, which has been			

						established to manage projects from CU and CV UHB, to undertake an early assessment of their projects by the JRO team to iron out any potential issues in setting up projects continues with VUNHST now contributing to the process development to ensure alignment. The intention is to ensure synergy in a streamlined process to speed up the setup process and expand capacity to deliver contracts more quickly. The			

						Research Governance Groups will move to a joint Research Governance Group within the JRO with Velindre included as required, bringing organisational governance together. This work also includes the development and execution of a Heads of Terms agreement which will be at a high level as well as the inclusion of Velindre in a Memorandum of Understanding (MOU) between			

						the three organisations. The JRO memorandum of understanding is currently still in draft and between C&VUHB and CU only. Work on this agreement has been on hold pending the appointment of the JRO's new Partnership and Business Development Manager who is expected to join the JRO soon. The Head of R&D and the Senior Research Contracts manager will work with the JRO to ensure that the further			

						development of the MoU will include the Trust's requirements. Work on the Heads of Terms agreement has commenced and it was requested by the Cardiff Cancer Research Hub Project Board at their meeting of 6 July 2022 that this document should be finalised for their next meeting in October 2022.			
						Project Board established to take place in September	-		

Velindre Cancer Centre IMTP Quarterly Progress Report 2022/23 for Quarters 1, 2 and 3 as at 24/01/2023									
Strategic Priorities 2022/23 to 2024/25	Key Deliverables/Objectives	Key Quarterly Actions 2022/23 Timescales and Progress							
		Q1	Q2	Q3	Q4	Quarterly Progress Q1	Quarterly Progress Q2	Quarterly Progress Q3	Progress Rating Q3
						2022. Awaiting further detail via the National TrAMS model to better inform potential impact on VCC.			
						VCC Therapies Team are working collaboratively with Health Board partners to progress prehabilitation programme. Participating in newly established South-East Wales Prehab 2 Rehab Collaborative which aims to			

Velindre Cancer Centre IMTP Quarterly Progress Report 2022/23 for Quarters 1, 2 and 3 as at 24/01/2023									
Strategic Priorities 2022/23 to 2024/25	Key Deliverables/Objectives	Key Quarterly Actions 2022/23 Timescales and Progress							
		Q1	Q2	Q3	Q4	Quarterly Progress Q1	Quarterly Progress Q2	Quarterly Progress Q3	Progress Rating Q3
						support a system wide transformation, initiated and delivered closer to the patient's home. Participation within the collaborative will help define the service delivery need for VCC in conjunction with the work happening in our partner organisations.			

Velindre Cancer Centre IMTP Quarterly Progress Report 2022/23 for Quarters 1, 2 and 3 as at 24/01/2023									
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**							
		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Quarterly Progress Q3**	**Progress Rating Q3**
	17. TrAMS	Establish VCC programme board and supporting sub groups: - clinical serices model - clinical trials via Trams - workforce and staff impact - finance incl private pt impact	Progress programme aims and objectives through full engagement externally and internally.	Progress programme aims and objectives through full engagement externally and internally.	Progress programme aims and objectives through full engagement externally and internally.	A strategic workforce programme group has been established, and this group will work to provide strategic direction to the VCC Senior Leadership Team regarding the workforce modernisation. Much of the initial phase of this work will involve benchmarking with other UK and International Cancer Centres to identify best practice models	Project Board established September 2022. national TRAMS Service Model awaited.	National TrAMS service model not now anticipated until quarter 1 2023-24 at earliest due to recruitment timescales of national TRAMS posts. Internal VCC Pharmacy/SACT service change continues in anticipation of most likely service model.	

Velindre Cancer Centre IMTP Quarterly Progress Report 2022/23 for Quarters 1, 2 and 3 as at 24/01/2023									
Strategic Priorities 2022/23 to 2024/25	Key Deliverables/Objectives	Key Quarterly Actions 2022/23 Timescales and Progress							
		Q1	Q2	Q3	Q4	Quarterly Progress Q1	Quarterly Progress Q2	Quarterly Progress Q3	Progress Rating Q3
						and ways of working			
	18. Therapies incl. collaborative work across region	Participate in regional Prehabilitation programme and scope development plan.	Review funding streams and commissioning models to facilitate prehabilitation service development.	Continue participation in regional service	Bring forward proposals for therapies development	Workforce planning owned by service leads review with Health Education Improvement Wales on 'route 2' role extension training planned for September 2022.	New south-east Wales Prehab2Rehab collaborative group formed. Inaugural meeting of group, chaired by Suzanne Rankin (CEO C&VUHB) on behalf of the Cancer Collaborative	Engagement with Prehab2Rehab collaborative and with the Wales Cancer Network National Prehabilitation Group continued. Active contribution to work to define	

Strategic Priorities 2022/23 to 2024/25	Key Deliverables/Objectives	Key Quarterly Actions 2022/23 Timescales and Progress							Progress Rating Q3
		Q1	Q2	Q3	Q4	Quarterly Progress Q1	Quarterly Progress Q2	Quarterly Progress Q3	
							Leadership Group (CCLG), held.	the remit and scope of both groups.	
	19. Workforce Modernisation:	Establish a workforce modernisation programme – with a 2 phased approach - 'Stabilise and Modernise' Finalise proposals for revised clinical leadership arrangements.	Align workforce plans for regional developments e.g. AOS, RSC. Advanced practice plan the potential for 'pump priming' advanced practice roles to 'kick start'	Implement Physicians Associate posts. Prepare plan for advanced practice and non-medical Consultant level roles.	Workforce modernisation programme continues	Network SCP Project Manager leading review of referral pathways with lung cancer National project used as a pilot site.	Value business case to support development of new non-medical outliner roles developed.	Two new physician's associates recruited. Value Based Healthcare business case unsuccessful in bid to secure funding for new non-medical outlining posts. Further work to	

Velindre Cancer Centre IMTP Quarterly Progress Report 2022/23 for Quarters 1, 2 and 3 as at 24/01/2023									
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		Q1	Q2	Q3	Q4	Quarterly Progress Q1	Quarterly Progress Q2	Quarterly Progress Q3	Progress Rating Q3
			the workforce Advanced Practice Radiographers and Therapeutic Radiographers					be undertaken to demonstrate benefits and to alternative means of supporting the innovation being actively explored.	
	20. Single Cancer Pathway	Focus on front end of the pathway for all tumour sites:	Develop dashboards and pathway data to make all patients' pathway points visible.	Focus on whole Breast Pathway:	Commence Action plan implementation.	SCP Project Manager requested to review data and current process with regard to referral management. Work programme and project plan awaited.	Work initiated to focus on earlier part of VCC pathways (MDT management, referrals, initial outpatient appoinments, etc). Work designed to identify and address issues and to inform future work to	Work on early part of VCC pathways and on administrative interface between referring health boards and VCC identified as a project/workstream for inclusion in new pathway improvement	

Velindre Cancer Centre IMTP Quarterly Progress Report 2022/23 for Quarters 1, 2 and 3 as at 24/01/2023									
Strategic Priorities 2022/23 to 2024/25	Key Deliverables/Objectives	Key Quarterly Actions 2022/23 Timescales and Progress							
		Q1	Q2	Q3	Q4	Quarterly Progress Q1	Quarterly Progress Q2	Quarterly Progress Q3	Progress Rating Q3
							standardise working practices.	programme. Scope of work and ToRs to be developed. Engagement with Wales Cancer Network continued. Discussions on recruitment of project resource by the WCN to support activity at VCC ongoing. Job description to be developed by WCN.	
		Aims to Standardise patient referrals to VCC.		Mapping of Breast Pathway from patient referral to service to treatment commenced.		Joint improvement project agreed with CTUHB regarding referral management.			
		Timely receipt of all diagnostic test results and		Identify touch points along pathway and		Pathway development required to manage			

Velindre Cancer Centre IMTP Quarterly Progress Report 2022/23 for Quarters 1, 2 and 3 as at 24/01/2023									
Strategic Priorities 2022/23 to 2024/25	Key Deliverables/Objectives	Key Quarterly Actions 2022/23 Timescales and Progress							
		Q1	Q2	Q3	Q4	Quarterly Progress Q1	Quarterly Progress Q2	Quarterly Progress Q3	Progress Rating Q3
		treatment pre-requisites prior to MDT.		potential bottlenecks		implementation of COSC measures.			
		Improve patient outcomes by early genomic testing where indicated. Develop training plans		Measure how currently delivering against the National Optimal Pathways (NOP)		No response received with regard to genomic project.			
Strategic Priority 5: To work in partnership with stakeholders	21. Engagement with HB's	Agree terms of reference and priorities for joint working with each HB.	Share patient pathway challenges in developing improvement plans.				Monthly meetings established with Cwm Taf Morgannwg, Aneurin Bevan	Meetings continued with a more developed focus on key operational issues (this	

Velindre Cancer Centre IMTP Quarterly Progress Report 2022/23 for Quarters 1, 2 and 3 as at 24/01/2023									
Strategic Priorities 2022/23 to 2024/25	Key Deliverables/Objectives	Key Quarterly Actions 2022/23 Timescales and Progress							
		Q1	Q2	Q3	Q4	Quarterly Progress Q1	Quarterly Progress Q2	Quarterly Progress Q3	Progress Rating Q3
to improve prevention and early detection of cancer		Commence meetings to deliver on these priorities.	Agree outreach plans for outpatients and SACT with all HBs.				and Cardiff UHBs. Standardised agendas and datasets agreed. Regular discussions around outreach facilities	includes the review and development of SLAs supporting key services).	

KEY:

BLUE	Action successfully completed with benefits being realised
GREEN	Satisfactory progress being made against action in line with agreed timescale
YELLOW	Issues with delivery identified and being resolved with remedial actions in place
AMBER	Delays in implementation / action paused due to external issues beyond our control
RED	Challenges causing problems requiring recovery actions to be identified

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Value-Based Healthcare Programme Update

DATE OF MEETING	16/03/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Chris Moreton, Deputy Director of Finance
PRESENTED BY	Matthew Bunce, Director of Finance
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Director of Finance

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME
Previous updates have been provided and Noted at EMB Run in Nov 2022 and Strategic Development Committee in Dec 2022		

ACRONYMS	
VBH	Value-Based Healthcare
VCS	Velindre Cancer Services
WBS	Welsh Blood Service
WG	Welsh Government
WHSSC	Welsh Health Specialised Services Commissioner

1. SITUATION/BACKGROUND

The Trust is at an early stage in its Value-Based Healthcare journey having secured funding from Welsh Government in July 2022 to progress with this programme of work.

The outcome of Velindre's VBH bid to WG was reported to EMB in August 2022.

VBH Programme updates have previously been provided to and noted at EMB Run in November 2022 and Strategic Development Committee in December 2022.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

A brief update on progress of the Trust's Value Intelligence Centre initiative and Preoperative Anaemia pathway project is provided below for consideration.

Welsh Blood Service
Preoperative Anaemia project update/priorities:
- Anaemia team establishment almost complete. 7/8 roles in post end of financial year.
- Clinical Governance Framework for the project has been agreed.
- Baseline Dataset agreed and to be made available via DHCW end Feb 2023.
- Engagement with National VBHC leads to support anaemia team in local HBs.
- HB user testing of the Pre-operative anaemia test set in WLIMS is in progress.

Next Steps:
- Develop individualised baseline reports utilising team resources
- Draft action plans by Health Board for pathway implementation to be agreed to HB stakeholder groups

Value Intelligence Centre Update
- Project initiation document drafted and presented to Exec Management Board in Nov 2022
- Board development session on VBH delivered in December 2022
- Worked with National Value in Health group to validate resourcing proposals and align job descriptions and skill requirements.
- Head of VBH advertised and closed on 27th February 2023. 7 from 12 applicants shortlisted for interview on 21st March 2023.

- Continued engagement with National Value in Health team and with national procurement exercise regarding specification and selection of PROMs collection system
- Developed tender specification to accelerate approach to developing Trust's BI and Analytics capability to support VBH implementation. Third party provider now appointed with work now underway through March 2023.
- Drafted Terms of Reference for Velindre VBH Delivery Group – to be finalised and confirmed through governance structures

Next steps:
- Delivery of analytics capability work with third party provider
- Recruitment of Value Intelligence Centre staff
- Establishment of the VBH Delivery Group and sign off Terms of Reference

Value Based Healthcare Expenditure 2022/23
The full year forecast expenditure for the Value Based Healthcare programme is as follows:

Preoperative anaemia pathway: £21k
Value Intelligence Centre: £75k
Total: **£96k**

An update has been provided to Welsh Government and the Finance Delivery Unit in order to draw down the funds on a cost-incurred basis.

3.   **IMPACT ASSESSMENT**

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required

LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	All resource requirements are included within the programme budget allocated by Welsh Government.

4. RECOMMENDATION

4.1 Quality, Safety and Performance Committee should **NOTE** the progress of the Value-Based Healthcare Programme.

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

The Medical Examiner Service and Velindre University NHS Trust

DATE OF MEETING	16/03/2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Viv Cooper, Head of Nursing & Integrated Care
PRESENTED BY	Jacinta Abraham, Executive Medical Director
EXECUTIVE SPONSOR APPROVED	Jacinta Abraham, Executive Medical Director

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
EMB	02/03/23	NOTED

ACRONYMS	
MES	Medical Examiner Service
SACT	Systemic Anti-Cancer Therapy
RT	Radiotherapy
SST	Site Specific Teams
VCC	Velindre Cancer Centre

1. SITUATION / BACKGROUND

1.1 This report is 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.

1.2 The Medical Examiner Service (MES) was implemented in England and Wales in response to The Shipman Inquiry and Mid Staffordshire NHS Foundation Trust Public Inquiries. These require a common approach to death certification and independent scrutiny of all deaths to allow the cause of death to be more accurately identified, and the circumstances surrounding the death to be more objectively assessed in order to identify any concerns about the treatment or care provided that may require further investigation.

1.3 Since autumn 2021, the MES reviews the medical records for all patients who die at Velindre and consults with the treating team to determine the cause of death so that the death certificate can be completed at VCC. As part of this process, the MES completes a comprehensive mortality review and feeds back any issues they identify to VCC / relevant Health Board. The MES also contacts the Next of Kin to discuss the cause of death and allow them the opportunity to raise any issues about the care the patient may have received (at any point in their illness). This process has now become fully embedded and operational across Wales.

This paper is provided for the 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. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 From April 2023, 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.

2.2 The Trust is currently meeting the minimum 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. This is detailed in section 2.4 and 2.5.

2.3 Summary of steps taken since the introduction of the MES service at Velindre Cancer Service.

- The introduction of the MES for death certification and Part 1 mortality reviews for patients who die in Velindre University NHS Trust was introduced in 2021, using an incremental approach to allow time for capacity and processes to be put in place.

- To support the introduction of the new MES process and improved mortality reporting within VCC, the VCC MES and Mortality Project Group was established and led by Dr Jillian MacLean. The work of the group was underpinned by a robust project plan and support provided by the Programme Management Office.

- Six-week pilot was undertaken in Velindre Cancer Centre on the First-Floor ward which commenced in October 2021. The pilot included the reporting of all deaths occurring in VCC to the MES and the sharing of all relevant documentation for death certification and Part 1 mortality review. The pilot was successful and positive feedback has been received from the Medical Examiner's office.

- Following the successful pilot, the service fully implemented the new process and is working closely with the MES to review all patient deaths that occur in VCC. The MES will discuss the circumstances of patients' deaths with the treating teams at Velindre (even when patients die outside of Velindre) to facilitate the MES mortality reviews.

- The Once for Wales (OfW) DATIX Mortality Module is now available for use. The Cancer Service Quality & Safety team are working with the OfW DATIX team to agree roles and responsibilities and to schedule training for relevant staff.
- The MES are feeding back to VCC findings they have identified, concerns or questions regarding care at Velindre University NHS Trust from mortality reviews they have carried out when patients have died elsewhere (via a dedicated inbox). In certain circumstances these findings will also be reported to Welsh Government and Velindre will be required to demonstrate actions and learning from this feedback.
- Whilst the MES main role is regarding statutory requirements of death certification and mortality review, there is an opportunity for the MES and VCC to work together to improve information sharing regarding patients under the care of VCC who die outside of VCC (the majority of VCC patient deaths). To this end the MES has agreed to share information with VCC regarding certain patients under the care of Velindre who die in the Health Boards (in hospital, hospice or at home) to facilitate Velindre reviews of deaths within 30 days of systemic anti-cancer therapy (SACT), or where non-surgical cancer treatments are deemed to have contributed to or be a cause of death.

2.4 Progress achieved since the last reporting period

We continue to meet our statutory requirements regarding engagement with the MES service and the minimal requirements for reviewing deaths within 30 days of SACT. However, we also need able to progress the development of a more comprehensive mortality and morbidity (M&M) process as a best practice standard. Now that the additional resource for a Band 5 Mortality Review and Improvement facilitator has been approved at the March 2023 Executive Management Board, there are a number of initiatives which have been on hold, that will now be progressed accordingly as described in section 2.4.4 and 2.4.5 below.

2.4.1 The MES Case Review Panel
This panel meets when required to discuss any referrals from the MES. In the period August 2022 - January 2023, there were 23 deaths in VCC and three referrals from the MES. One of the referrals was also referred to H.M. Coroner.

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.

2.4.2 Pilot Update
An initial Mortality and Morbidity Review pilot within the Colo-rectal SST has been completed. The pilot reviewed data on deaths within 30 days of SACT; death within 30 / 90 days of palliative / radical radiotherapy; sharing of best practice and lessons learnt. A report summarising the finding of the pilot identified issues that need addressing before roll out to other sites. The report has been submitted to the VCC Senior Leadership Team who are considering the approach needed in order to progress this work.

2.4.3 Work closely with the MES
We are continuing to meet our requirements and have a face-to-face meeting with MES lead for South East Wales in March 2023 to discuss the strengths and challenges of how we work together.

2.4.4 Re-establish the VCC Inpatient Mortality Review Group
Now that we have the resource available through the Band 5 facilitator role, we aim to fulfil the objective of obtaining the MES reviews for **all** patients who die at Velindre. The pathway to establish this will be discussed during the meeting with the MES lead this month.

2.4.5 Establish an overarching VCC Mortality Group
With this new role in place, we will 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. It will be key in supporting the development of SST mortality and morbidity meetings where the cases of patients who have died within 30 days of SACT and 30/90 days of Radiotherapy are reviewed. 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.

There may be further challenges to address in terms of clinical staff time to participate in the process but this needs to be clinically prioritised and supported within job plans.

2.4.6 <u>Reporting and Learning</u>

Reporting of all VCC deaths is ongoing with regular reports being submitted to the VCC Quality & Safety Management Group. Deaths within 30 days of SACT are also reported via the SST Annual Review and the Divisions Quality & Safety function.

The Cancer Centre continues to work with the MES to refine our processes and learn from any issues highlighted by them. VCC has requested that the MES share their mortality reviews for all deaths and not just those requiring referrals so that learning and good practice can be shared.

2.5 **Priorities for the next period**

- To appoint the Mortality Review & Improvement Facilitator as a matter of urgency.
- Continue to work with the MES to ensure maximum mutual benefit from their input – meeting as described in section 2.5.3 above.
- Trial of new electronic process for deaths within 30 days of SACT – registrars are willing to support this.
- Re-pilot Mortality and &Morbidity meetings in the colorectal SST with electronic data recording process and registrars given protected time to complete the initial reviews
- Implement additional national reporting requirements from April 2023:

  30-day M&M RT & SACT & LD (< 1% out of total patients):
  - % 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

This information will need to be produced and validated by the VCC Business Intelligence Team. Further work is needed in order for the BI team to produce these reports monthly as standard system generated reports.

3.   IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes (Please see detail below)
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	Staff and Resources, Safe Care, Individual Care, Timely Care, Dignified Care, Effective Care
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
	In line with the requirements of the Trust Quality & Safety Framework Policy, no specific issues have been identified.
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Currently scoping out the need for resourcing to fulfill this implementation

4.   RECOMMENDATION

The Quality Safety and Performance Committee are asked to **NOTE** the developments to date and the next steps being taken to ensure the Trust is meeting fully its Medical Examiner Statutory responsibilities as well as establishing a robust Mortality and Morbidity process for the Trust.

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

2022 / 2023 QUARTER 3 TRUST QUALITY AND SAFETY REPORT

DATE OF MEETING	16th March 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	N/A

PREPARED BY	Trust Claims Manager Quality, Safety & Assurance Managers
PRESENTED BY	Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science

REPORT PURPOSE	FOR ASSURANCE

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME
Integrated Quality & Safety Group	Oct-Feb 2023	Items for inclusion agreed
Executive Management Board	2nd March 2023	Approved

ACRONYMS	
WBS	Welsh Blood Service
VCS	Velindre Cancer Service
SLT	Senior Leadership Team
Q&S	Quality and Safety
PTR	Putting Things Right

1. SITUATION

This paper provides an overview of the Trust and execution of its responsibilities in respect of key elements of Quality and Safety for quarter 3: 1st October – 31st December 2022. The report covers the following areas:

- NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.
- Management of Claims, Inquests and Ombudsman cases.
- Management of Safety Alerts.
- Inquest Guidance Protocol.

The Quality, Safety and Performance Committee is asked to **DISCUSS and APPROVE** the report.

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 integrated Quality & Safety Group and will continue to develop further in forthcoming months.

3. ASSESSMENT/SUMMARY OF MATTERS FOR CONSIDERATION

The following were the three areas of risk that required focus during the quarter:

No.	Risk area / priority
1	**Priority**: Implementation of Duty of Candour. Statutory compliance required by 1st April 2023 **Risk**: Welsh Government has not provided final implementation documents, including training materials, for the Duty of Candour to NHS Wales organisations, which may affect the Trust's ability to meet all statutory requirements by 1st April 2023 **Impact**: If final implementation documents are not received, not all statutory requirements may be met by 1st April 2023

	Assurance: If final implementation documents received in sufficient time, Reasonable Assurance that the Trust will meet statutory requirements by 1st April 2023. **Mitigation:** • Once for Wales Datix Cymru system now has a facility to trigger the Duty of Candour incidents. • The Corporate Team has oversight of all incidents reported via Datix, which will assist in assessing/identifying risk of harm to service users, which will trigger Duty of Candour. • The Handling Concerns Trust policy is currently under review. • Professional Healthcare Duty, similar to the Duty of Candour requirements of being open and transparent, exist in tandem with the Duty of Candour. • The Putting Things Right regulations also remain in force. This aligns with the Duty of Candour requirements of NHS Wales organisations to be open and transparent.
2	**Priority:** Preparation for Welsh Risk Pool Quarter 4 Assessment in relation to analysis of compliance with the learning from claims and redress cases. **Risk:** Anomalies have been identified within the Trust Datix records for a number of these cases that require remedial work. **Impact:** There is the potential that the Trust will not meet the required substantial assurance level as work continues to remedy the anomalies. **Assurance:** Reasonable Assurance the Trust will be prepared for review. **Impact from actions and emerging outcomes:** Addressing systemic issues to improve system and assurance following Welsh Risk Pool Assessments.
3	**Priority:** Divisional Senior Management to focus on reviewing departmental incidents raised via the Datix system and that have been open for over 30 days, in an effort to successfully investigate and close any outstanding incidents. **Risk:** Anomalies have been identified within the Datix Cymru system that require remedial work. **Impact:** There is the potential that the Trust will not meet the required substantial assurance level during the Welsh Risk Pool assessment as work continues to remedy the anomalies. **Assurance:** Limited assurance - more significant matters require management attention. Moderate impact on residual risk exposure until resolved.

Putting Things Right (PTR) Reporting – Benchmarking Outcomes

During 2022, benchmarking of NHS Bodies' Putting Things Right reporting was undertaken by the Executive Director of Nursing, AHPs and Health Science. The outcomes have been used to inform revised Trust reporting in a more amalgamated (including Claims & Redress) and succinct way (Cardiff & Vale 2019-2022 PTR report key benchmark).

Due to the impact of the COVID-19 pandemic, most organisations did not provide a comprehensive separate Putting Things Right report during 2020-2021 and 2021-2022, rather the key outcomes were detailed in the organisations' annual reports. A review of all Health Boards and Public Health Wales reports identified that similar high-level data, themes and core lessons learnt were included and reported within the Trust as the PTR reporting requirements are set within the national guidance document.

From 2023-2024, the reporting requirements will be amended to reflect the Duty of Candour requirements.

4. IMPACT ASSESSMENT

RELATED HEALTHCARE STANDARD	Yes
	Safe Care and Individual Care
EQUALITY IMPACT ASSESSMENT COMPLETED	No
	Not required
LEGAL IMPLICATIONS / IMPACT	Yes
	Putting Things Right Regulations
FINANCIAL IMPLICATIONS / IMPACT	Yes
	In the event of complaints, claims & incidents where errors have occurred or system failures are evident.

5. RECOMMENDATION

The Quality, Safety and Performance Committee is asked to **DISCUSS** and **APPROVE** the 2022/23 Quarter 3 Corporate Quality and Safety report.

1. INTRODUCTION

The Corporate Quality and Safety Quarter 3 report provides an analysis and summary of activities undertaken and compliance achieved in relation to the Trust's concerns function and specifically includes data in relation to Concerns, Ombudsman, Redress, Claims, Incidents and Safety alerts.

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.

The new style report format is under development and will be aligned to the Trust's commitment to implement the duty of quality and duty of candour in delivering enhanced outcomes and assurance to the Board in readiness for the 1st April 2023.

2. QUARTERLY INDICATORS AT A GLANCE (Concerns, Claims, Incidents and Safety alerts)

VELINDRE UNIVERSITY NHS TRUST QUARTERLY INDICATORS 2022/23				
	Q1	**Q2**	**Q3**	**YTD**
CONCERNS				
Trust Early Resolution (ER) (resolved within 48 hours**)**				
ER opened & closed in quarter	**40**	**20**	**24**	**84**
Trust Putting Things Right (PTR) (formal**)**				
Trust wide PTR opened	**13**	**12**	**9**	**34**
Acknowledged within 48 hours	**13**	**12**	**9**	**34**
PTR closed within 30 days	**13**	**12**	**4***	**29***
PTR closed after 30 days	**0**	**0**	**5***	**5***
Concerns raised through Welsh language communication	**1**	**0**	**0**	**1**
OMBUDSMAN (OMBS)				
OMBS cases opened	**0**	**3**	**0**	**3**
Open OMBS cases	**3**	**6**	**3**	**-**
OMBS cases closed	**0**	**0**	**3**	**3**
REDRESS				
Redress cases opened	**1**	**0**	**1**	**2**
Open redress cases	**3**	**4**	**3**	**-**
Redress cases closed	**0**	**0**	**1**	**1**
CLAIMS				

Claims opened	0	0	0	0
Open claims	8	7	6	-
Closed claims	0	1	1	2
INQUESTS				
Inquests opened	1	1	1	2
Open inquests	4	5	5	-
Closed inquests	0	0	1	1
INCIDENTS REPORTED				
Corporate incidents	6	7	2	15
Velindre Cancer Service	388	444	385	1217
Welsh Blood Service incidents	82	73	67	222
National Reportable Incidents	0	1	3	4
IR(ME)R reported incidents	3	4	5	12
SAFETY ALERTS RECEIVED				
Pharmaceutical alerts	29	25	31	85
Patient safety alert	0	0	2	2
Patient safety notice	2	1	2	5
Medical Device	4	2	0	6
Estates and facilities alerts	1	0	3	4
Welsh Health Circulars	3	1	7	11

* Please note

Due to a recent validation of the PTR closure within 30-day return figures (noted in table above) by the Welsh Risk Pool, an anomaly was found where the day on which a PTR concern was received being classed by the Trust as "day zero", when this should have been classed as "day one". The outcome has meant that for this quarter (Quarter 3), only 4 of the 9 PTR concerns have been completed within 30 days. However, all 9 PTR concerns were completed within 31 working days of receipt.

This issue has been addressed and all future PTR concerns will be classed as "day one" on the date of receipt.

All information will also be corrected and realigned within this year's Annual Report.

3. QUARTER 3 IN MORE DETAIL

3.1 CONCERNS
EARLY RESOLUTION and PUTTING THINGS RIGHT

Velindre Cancer Service:	Welsh Blood Service:
4 early resolution and **8** Putting Things Right concerns were raised. The **48 hour acknowledgement** and **30 day** investigation through to closure targets were **achieved. Email** remains the preferred method of contact. There was **1 Covid related concern** raised which related to Velindre Cancer Service, Digital Healthcare Wales and Cardiff & Vale Health Board system and process mechanisms. **Top concern themes** related to clinical treatment & assessment, communication issues and attitude & behaviour. The outpatients department received the **highest numbers of concerns** raised. There were no concerns graded higher than grade 1 and grade 2.	**20** early resolution and **1** PTR concerns were raised. The **48 hour acknowledgement** and **30 day** investigation through to closure targets were **achieved. Telephone** was recorded as the preferred method of contact. There was **1 Covid related concern** raised which related to the closure and lack of donation clinics. **Top concern themes** continued to relate to appointments, attitude and behaviour issues. The community blood donation clinics received the **highest numbers of concerns** raised. There were no concerns graded higher than grade 1 and grade 2.

How many concerns were reported:

Where was the concern reported:
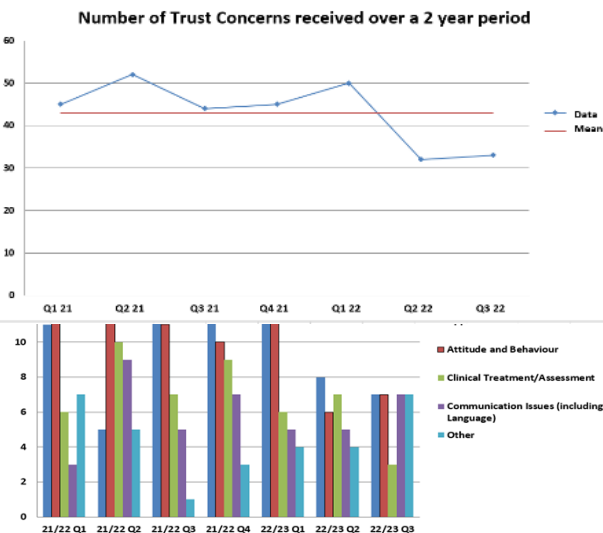
Why was the concern reported:
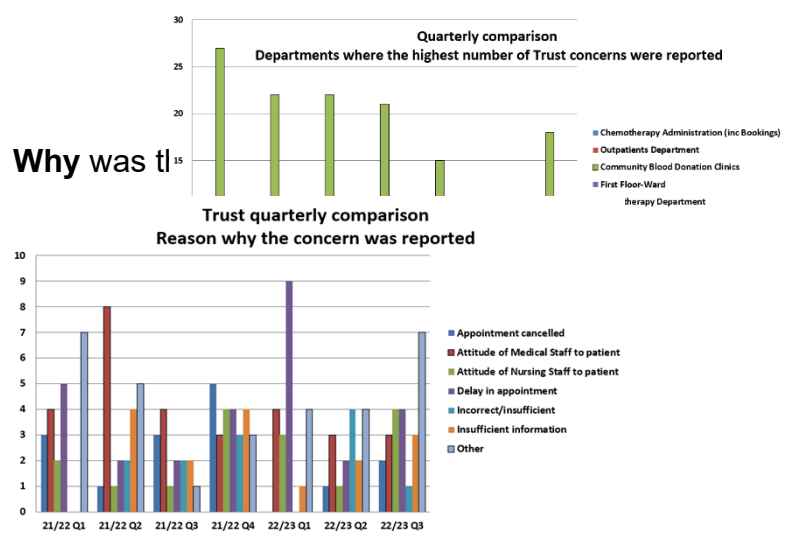
LEARNING:
The standard of investigations remains high with no concern investigations being reopened during the quarter. That said, the Trust continue to see attitude and behaviour recorded as one of the highest concern themes. Both Velindre Cancer Service and Welsh Blood Service offer support to members of staff if and when involved in concerns raised. A number of team and individual meetings take place to address behaviours and ways of working within the teams effected. Welsh Blood Service continue to receive concerns raised in relation to the closure and lack of available community blood donation clinics, this follows a number of clinic locations closing during the Covid pandemic. The Trust has recognised the issue and having completed a risk assessment, have more widely utilised the mobile donor unit.

3.2 OMBUDSMAN

There were **no new** Ombudsman cases opened against the Trust during the quarter. **3** Ombudsman cases were closed, leaving 3 remaining cases under investigation at the end of Quarter 3. The **3 ongoing cases relate to**: Commination issues with the patient, family and other health organisations; delays in referral and appointment and; delays in treatment.

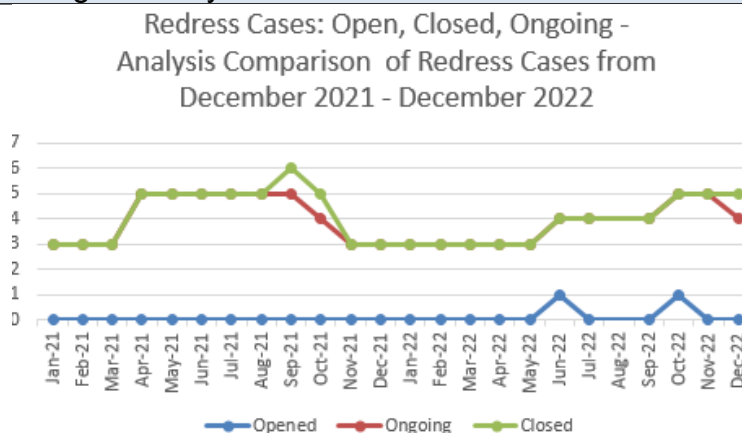**The run graph below displays Ombudsman cases opened within the last 2 years:**

Trust Ombudsman cases opened per Quarter over a 2 year period

Trust Ombudsman cases opened per month over a 2 year period
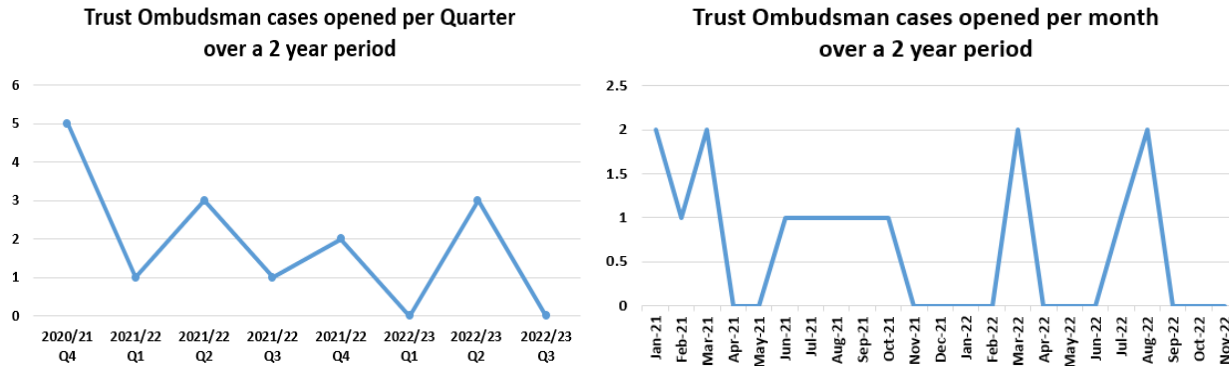
LEARNING:

The Trust continue to receive relatively low numbers of new Ombudsman cases, which is evident looking at the 2 year run graphs. We can also see a decrease in new Ombudsman cases opened, indicating that the Trust's overall clinical service and management of initial concerns raised are investigated to high standard with satisfactory closure outcomes. The concern team remain focused on prioritising concerns that are raised by service users and the Ombudsman and manage the communication and investigations effectively to efficiently respond within the tight time frames set.

3.3 REDRESS

3 Redress matters continue to be investigated in accordance with the Putting Things Right process in addition to 1 offer to settle Redress has been made and is awaiting acceptance. Redress matter was approved by the WRP Learning and Safety Committee and was reimbursed and closed in Q3, following scrutiny of learning by the Welsh Risk Pool Learning Advisory Committee.

Redress Cases: Open, Closed, Ongoing – Analysis Comparison of Redress Cases from December 2021 – December 2022

LEARNING: Case Summary following closure: Patient was unaware of a histology report that recommended a biopsy. It was found that, on a balance of probabilities, had the patient been told of the histology report, an alternative treatment plan would have been put in place. This would have reduced a number of significant side effects suffered by the patient.

A number of actions were undertaken in partnership with the Multi-Disciplinary Teams, South Wales Sarcoma Morbidity and Mortality Group, Cwm Taf Morgannwg University Health Board and Swansea Bay University Health Board, thereby raising awareness across a number of key NHS Welsh organisations, on the importance of information sharing of supplemental reports. The following actions were undertaken:

1. **Awareness/reflective** practice session undertaken at the South Wales Sarcoma Morbidity and Mortality Group.
2. **Liaison** with Multi-Disciplinary Teams to improve clinical and radiologist information to inform next steps.
3. **Look Back Review** undertaken by the clinical support services at Velindre Cancer Centre and Cwm Taf Morgannwg University Health Board.
4. **Audits** introduced by Cwm Taf Morgannwg University Health Board. Medical secretaries are tasked to ensure histology reports are received back on referred patients.
5. **Improved healthcare systems** - Histology supplemental reports are now made available on the Welsh Clinical Portal.
6. **Training:**
   (a) Clinical staff have been reminded on the importance of copying letters to patients when needed, as indicated by the Department of Health Guidance and British Medical Association Welsh Standards 12.

Clinical staff have completed webinar training in relation to Montgomery and Informed Consent in March 2021 with further training delivered by NWSSP Legal and Risk on Informed Consent and Practicalities and case review at SMSC.

3.4 CLAIMS

Current performance: All claims are notified to the service directorate leads and staff continue to be supported throughout the duration of the claim with regular updates on the decisions taken to defend or concede claims following expert and legal advice. The Trust's aim is to ensure that where there are inefficiencies in the services that are provided, relevant lessons are learnt and disseminated throughout the organisation.

Following settlement of cases over £25,000 an NHS organisation is required to seek reimbursement from the Welsh Risk Pool. As part of this process, the Welsh Risk Pool Learning Advisory Committee undertakes a detailed scrutiny of the learning submitted with evidence in support. This ensures that the learning undertaken improves service user experience and reduces the potential for future harm and recurrence. The sharing of learning with key NHS organisations helps to enhance and strengthen improvements across NHS Wales, which ultimately reduces harm and mitigates against loss. During Q3, 1 claim was reimbursed by the Welsh Risk Pool, following scrutiny of learning.
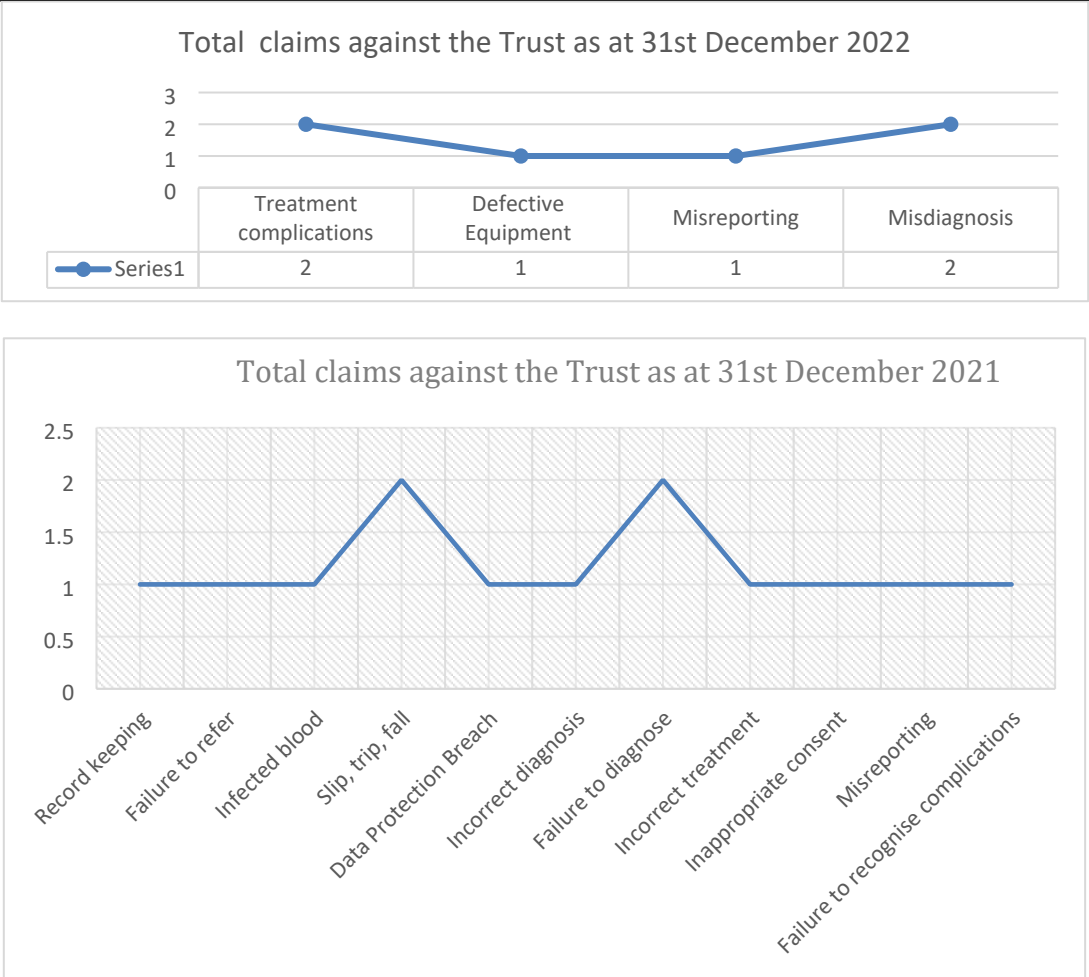
Risk to Future Assurance/Performance: No immediate risk has been identified during the reporting period. Assurance is provided by way of approvals received from the Welsh Risk Pool following submission of Learning from Events Reports and submission of requests for reimbursements of claims, settled in 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.

Compliance/Assurance –Level 7

Q3 has seen a reduction in the number of claims litigated against the Trust in comparison to Q3 2021 data analysis.

Trust Liability: £824,576.23

Anticipated Trust Liability: £94,244.00

Total claims against the Trust as at 31st December 2022

	Treatment complications	Defective Equipment	Misreporting	Misdiagnosis
Series1	2	1	1	2

Total claims against the Trust as at 31st December 2021

Combined run chart showing comparison of claims and themes: 31/12/2021 – 31/12/2022
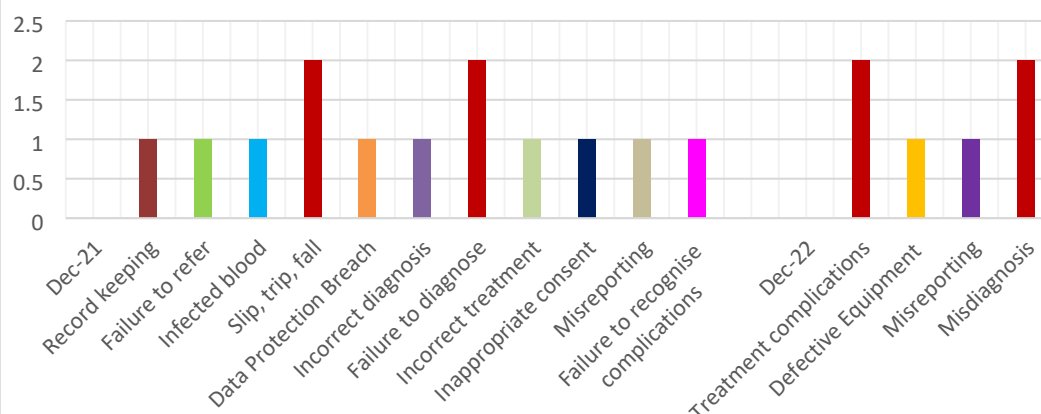
LEARNING: Amber deferral on learning approved: Claim Closed

Case summary: Whilst attending for treatment in the radiotherapy department at Velindre Cancer Centre, the Claimant suffered a fall from a chair, which had collapsed, resulting in injury.

Following submission of the Learning from Events report in February 2022, the Welsh Risk Pool requested further evidence in April 2022, regarding the outcome of the falls management review and what had been implemented as a result of it. As the information was not available for the Welsh Risk Pool Learning Advisory Committee, the Learning Advisory Committee issued an amber deferral in May 2022.

Further evidence of the learning actions undertaken, was provided to the Welsh Risk Pool in September 2022 and approved by the Learning Advisory Committee.

Revision of standard operating procedures and policies - Essential Care Post Falls Assessment, Monitoring of Care for Patients document and Velindre Cancer Centre Falls Policy. These now include an appropriate escalation process when an outpatient service user suffers a fall, including a step-by-step flow chart on the actions to be taken.

Wider learning and sharing - Learning from this claim has been shared with the Quality Safety Performance Group, Falls Scrutiny Panel, Radiology Departmental Team and Operational Services Delivery Meeting as follows:-

- **Awareness** email issued to Radiotherapy Department of the revisions made to the Monitoring of Care Review.
- **Learning Brief** presented to the Quality Safety and Performance Group.
- **Highlight Report** presented to the Health, Safety and Fire Sub Group raising awareness and learning undertaken regarding the case.
- **Discussion** at Falls Scrutiny Panel for ongoing monitoring and learning. All outpatients who suffer a fall now receive an outpatient clinical check-up and follow up the day after.

Tendable audit of outpatient chairs undertaken

Quality Assurance Walks introduced on a monthly basis

Inspection Report produced for general estate checks and maintenance of chairs

Removal and replacement of outdated chairs – 15 Steps Challenge Action Plan completed

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3.5 INQUESTS:

4 inquests continue to be investigated and statements and records have been disclosed to the coroner. All matters remain up to date and ongoing.

LEARNING: Inquest hearing: December 2022. Case Summary: Patient receiving radiotherapy treatment at Velindre Cancer suffered PEG in-situ infection, leading to sepsis and death. Following the Coroner's issue of a Regulation 28 Prevention of Future Deaths Report against Cardiff and Vale University Health Board and Abbots Care, the case provided an opportunity to undertake an after action review to assess if any learning was identified that needed to be addressed by Velindre Cancer Centre. 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.

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.

Adult Symptom Cards | The UK Sepsis Trust

Recommendation	Action & progress	Responsible Person	Deadline for Completion
Set up task and finish group to review all VCC SOPs and Policies in relation management of patients with head and neck cancer receiving treatment at VCC and requiring care and management of feeding tubes. Clarify provider responsibilities.	Lead ANP identified, t&f group members identified, attendance at 'spread and scale' workshop to implement sustainable change 8th, 9th and 10th March 2023.	Head and Neck and Altered Airways. Head of Nursing, Quality, Patient Experience and Integrated Care	June 2023
Roll out NEWS Cymru training to include Sepsis bundle update and AKI bundle update by end of April 2023. Source and provide patient alert cards in relation to sepsis.	Training plan in place, resources identified for Sepsis alert cards.	Head and Neck and Altered Airways. Head of Nursing, Quality, Patient Experience and Integrated Care	April 2023

GREEN	Complete
AMBER	In progress, within deadline
RED	Missed deadline for completion - escalate

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A "Getting it Right First Time" Inquest Guidance and Protocol has been prepared and is attached at ***Appendix 1 for APPROVAL.*** Its aim is to ensure that staff are supported when requests are made by His Majesty's Coroner for statements and attendances at Court.
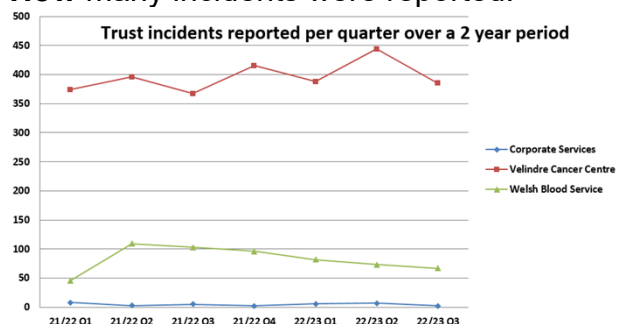
3.6 INCIDENTS

Velindre Cancer Service:
Radiotherapy remains the area recording the highest number of incidents, a number of these incidents are in relation to a known manufacturer fault with the radiotherapy system. The Executive Management Board is fully aware of this situation and continuously look to new ways of mitigating this known fault as the company cannot resolve the issues.

During the quarter **104** incidents were recorded as no harm occurring, **197** as low harm and **9** incidents as moderate harm being caused. There was **1** catastrophic incident reported which was also reported as a National reportable incident. The Trust undertook a full investigation into the incident which related to contact that had been made with the SACT Treatment helpline. The patient passed away whilst awaiting an ambulance. A full root cause investigation has been concluded and a number of recommendations made. A full review of the SACT Treatment helpline is underway.

Incident graphs

How many incidents were reported:

Trust incidents reported per quarter over a 2 year period

Where was the incident reported:

Top 10 departmental highest number of incidents reported
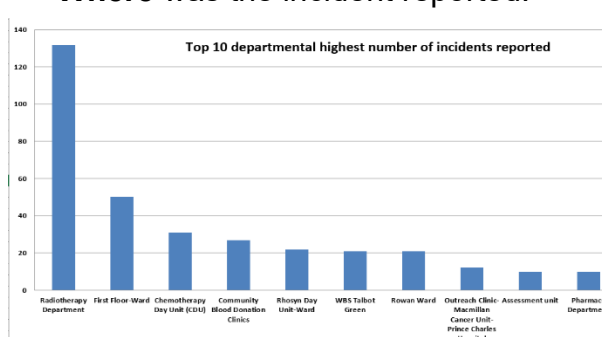
What was the incident related to:

Highest number of reported incident themes

Why was the incident reported:
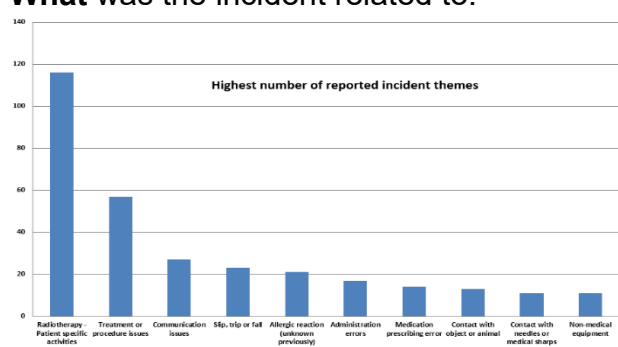
Reason why the Incident was reported
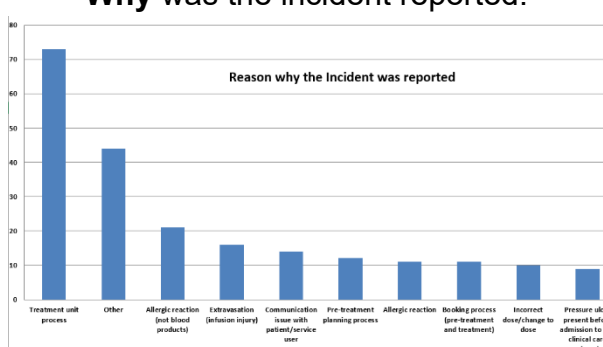
LEARNING:

Following the significant incident reported during quarter 3 and the completion of the internal investigation the Velindre Cancer Service have committed to the consistent adherence to national telephone treatment tools and standards, as well as, strengthening governance and processes to provide accurate patient assessments. Further learning will see the development of a clear pathway for escalation to respond to deteriorating patients. Clinical supervision for staff working on the treatment helpline has been implemented and all report recommendations have been considered as part of the wider treatment helpline model review.

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4. SAFETY ALERTS

45 Safety alerts were received into Trust during quarter 3, which is consistent with the numbers of alerts received during previous quarters. The total figure equates to **2** patient safety alerts, **2** patient safety notices, **3** estates alerts, **7** Welsh Health Circulars, and **31** pharmaceutical alerts. Following review, only **8 alerts were deemed applicable** to Trust and were all linked to **pharmaceutical alerts** received.
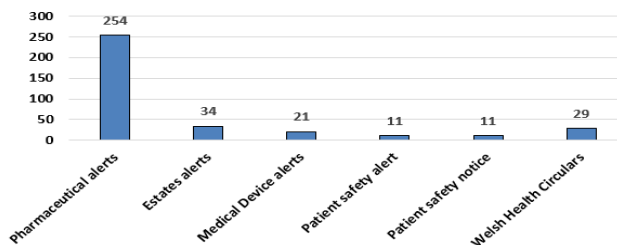
One safety alert continues to be worked through in order for the Trust to deem itself compliant and relates to the **safe storage of medicines** alert that was issued in October 2020. The alert was initially reviewed

and led on an All Wales basis and in November 2022, the Trust secured capital funding to complete the four outstanding actions within the alert. Estates colleagues are currently working through the final stages. The Trust is on track to complete the outstanding work by the 31st March 2023.

Safety alerts received into Trust over a 2 year period

2020/21 Q4	2021/22 Q1	2021/22 Q2	2021/22 Q3	2021/22 Q4	2022/23 Q1	2022/23 Q2	2022/23 Q3
47	32	36	46	41	39	30	45
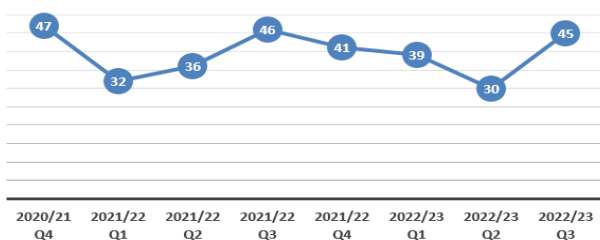
Total number of alerts received per subject matter over a 2 year period

Pharmaceutical alerts	Estates alerts	Medical Device alerts	Patient safety alert	Patient safety notice	Welsh Health Circulars
254	34	21	11	11	29

LEARNING:

During the quarter, an internal audit of safety alerts received into Trust was completed covering the period of the 1st April – 31st December 2022.

The Trusts audit recorded **substantial assurance** for the alerts audited, details of which are included as *Appendix 2* in this report.

5. TRUST INTEGRATED QUALITY AND SAFETY GROUP

The Integrated Quality & Safety Group was established in October 2022 in order 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 in particular the 'Duty of Quality' responsibilities to help to ensure quality is at the centre of all decision making across the Trust.

The Group is the coming together of the Corporate and Divisional Quality & 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.

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6. TRUST PUTTING THINGS RIGHT & INCIDENT MANAGEMENT POLICY REVIEWS

It was anticipated that both policies would be reviewed and approved by March 2023 due to changes required to implement the Duty of Candour. However, as the final statutory guidance and national Putting Things Right policy are yet to be published completion of the policy review has not been possible. As soon as these national documents are published the policy reviews will be completed and consultation and approval processes commenced.

7. **PRIORITIES FOR QUARTER 4**

   The following are the agreed priorities for Quarter 4:

   - Further development of the Trust Integrated Quality and Safety Group to facilitate effective triangulation.
   - Implementing the requirements of the Duty of Candour and Duty of Quality by 1st April 2023 including completing the revision of the Trusts Putting things Right (concerns policy).
   - Continued establishment of the Trusts Safe Care Collaborative.
   - Complete requirements for the Welsh Risk Pool Audit.
   - Velindre Cancer Service Senior Management to focus on reviewing departmental incidents raised via the Datix system and that have been open for over 30 days, in an effort to successfully investigate and close any outstanding incidents.
   - To learn from all concerns and incidents raised, to strengthen our ability to objectively and comprehensively investigate and learn from all concerns and incidents.

8. APPENDICES

APPENDIX 1. SAFETY ALERT AUDIT REPORT

1. SITUATION

The purpose of this paper is to provide the outcomes from the Trust Safety Alert audit that was completed by the Corporate Quality and Safety Team for alerts received by Welsh Government between the 1st April - 31st December 2022 and to provide details of any exceptions to complying with Safety Alert requirements.

2. BACKGROUND

The Velindre University NHS Trust regularly receives various types of Safety Alerts which include:
- Patient Safety Notices (advising the Trust on changes to practices and procedures to prevent possible harm to patients)
- Dangerous Incident notifications (which relate to Estates concerns such as high voltage hazards)
- Medicine updates (such as shortages of particular drugs and medications)
- Medical device notifications
- Welsh Health Circulars

The Trust must be able to demonstrate that it has responded appropriately to the requirements of each applicable Safety Alert in order to reduce the risk of harm occurring to patients, staff and service users.

To increase assurance and ensure a robust approach is taken toward Safety Alerts received by Welsh Government, a programme of audits has been introduced.

3. AUDIT FINDINGS (alerts received 1st April 2022 – 31st December 2022)

113 Safety alerts were received between the 1st April - 31st December 2022. Only **20** of the 113 safety alerts received were applicable to the Trust. Out of the **20** alerts that were applicable to the Trust, **18** related to pharmaceutical alerts and **3** alerts received were patient safety notice's, which had the potential to impact processes carried out at the Velindre Cancer Service.

The **2** patient safety notice's related to, 1) *Nasogastric tube placement using correct pH strips* and 2) *Safe use of ultrasound gel.* Both of these alerts were reviewed and assurance was provided from Divisional safety alert leads that the Trust were fully compliant with the requirements of the alerts. The Trust has received a further notification, specifically relating to formally training medics in nasogastric tube placement. The All Wales team are currently finalising a training package which will be rolled out across all NHS organisations by the end of March 2023.

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The Trust, Management of Safety Alerts and important Notifications Policy, requires 20% of all alerts received to be audited. A randomized selection identified 20 alerts that had been deemed to be applicable to Trust and, 3 alerts that had been deemed non applicable to the Trust were identified to be audited. A summary of the audit outcomes are detailed in the table below:

An assurance rating matrix was used to provide an overall score for each (attached at end of report)

Substantial Assurance			
Alerts below had few matters requiring attention and following action the Trust was noted as being compliant. These alerts were:			
Alert received	**Alert subject**	**Details of alert**	**Audit findings**
11/05/2022	Pharmacy alert Ref (1072) Supply issue	Glycerol 1g suppositories are out of stock until mid-June 2022.	VCS only stock 4g suppositories, 10 boxes in stock. No impact to VCS stock.
26/05/2022	Pharmacy alert Ref (1084) Product recall	Hameln pharma Ltd recalling Water for Injections BP – 100ml vials.	Received effected batches in November 2019. No remaining stock.
13/06/2022	Pharmacy alert Ref (1094) Supply issue	Contrast media agents have been impacted by supply issues.	Extra stock ordered each week to mitigate against the supply issue.
05/07/2022	Pharmacy alert Ref (1099) Supply issue	Phosphate Polyfusors® will be limited for the foreseeable future.	VCS have 6 weeks supply, an appropriate alternative drug ordered to use in the interim.
20/07/2022	Pharmacy alert Ref (1108) Recall	Amiodarone Hydrochloride 50 mg.ml solution for injection infusion.	VCS received 14 units. The effected boxes were removed and quarantined.
20/07/2022	Pharmacy alert Ref (1105) Supply issue	Alendronic acid 70mg tablets.	Low usage. Mitigated by swapping to appropriate alternative drug.
04/08/2022	Pharmacy alert Ref (1113) Supply issue	Shortage of Aripiprazole 10mg tablets	Only 2 units issued in the last 5 years. No to low usage.
04/08/2022	Pharmacy alert Ref (1111) Supply issue	Shortage of alteplase and tenecteplase injections	Changed over to Taurolock as an alternative until alteplase is back in stock.
19/08/2022	Pharmacy alert Ref (1117) Supply issue	Hydrocortisone sodium phosphate 100mg/1ml	VCS only stock the suggested replacement drug. No impact to VCS stock.
21/09/2022	Pharmacy alert Ref (1125) Supply issue	Shortage of Temazepam 10 and 20 mg tablets	Low usage at VCS. 1 box of 10mg tablets in stock. 1 bottle of liquid in stock.

04/10/2022	Pharmacy alert Ref (1130) Supply issue	Shortage: Dioralyte oral rehydration sachets	Alternative supply looked at for interim period.
07/10/2022	Pharmacy alert Ref (1134) Recall	Aventis Pharma Limited Stemetil 5mg / 5ml syrup	One bottle of the affected batch in stock. Stock quarantined and arranged for it to be returned to supplier and destroyed.
07/10/2022	Pharmacy alert Ref (1132) Supply issue	Dulaglutide (Trulicity®) solution for injection devices	Not routinely ordered. No impact on VCS stock.
12/10/2022	Pharmacy alert Ref (1136) Recall	Amiodarone Hydrochloride.	Affected batch received. 7 affected batches destroyed as requested by Hameln.
07/11/2022	Pharmacy alert Ref (1152) Supply issue	NovoRapid FlexPen® 100units/ml solution	Drug stocked and cartridges ordered to enable the refill of devices.
21/11/2022	Pharmacy alert Ref (1158) Patient information leaflet error	Morningside Healthcare Hyoscine Butylbromide 20mg Film-coated Tablets	Drug stocked, but none of the affected batches received. No impact on VCS stock.
05/12/2022	Pharmacy alert Ref (1169) Patient information leaflet error	ADVANZ PHARMA MacroBID 100mg Prolonged-release capsules	VCS have 4 of the affected batches in stock. The correct patient information leaflet was printed off and attached to the packaging.
22/12/2022	Pharmacy alert Ref (1173) Supply issue	Dalteparin (Fragmin®)	Fragmin in stock and stock continuously monitored.
19/6/2022	Patient Safety Notice Ref (1098) Compliance deadline: 31st August 2022	Nasogastric pH testing of aspirate.	VCS are fully utilising the Avanos asphirate PH indicator strips. The Trust do not have any old Merc PH strip stock on site and now order the Avanos asphirate PH indicator strips from the Bridgend stores, where procurement arrangements are set up.
19/12/2022	Patient Safety Notice Ref (1112) Compliance deadline: 28th Mach 2023	The safe use of ultrasound gel to reduce infection risk	The alert actions were worked through during 2021 and again during August 2022. VCS do not re-fill from bulk bags and the SOP has been updated to reflect the alert requirements.

Assurance Not Applicable			
Alert received	**Alert subject**	**Details of Alert**	**Audit findings**
16/05/2022	**Welsh Risk Pool Patient Safety Briefing Ref (1076)**	The Welsh Risk Pool's monthly Learning Advisory Panel has seen three cases over recent years relating to the shortening of Penrose drains. All cases have been identical.	Noted as not applicable to the Trust as it relates to abdominal surgical procedures which are not carried out at Velindre University NHS Trust.
05/05/2022	**Medical device alert Ref (1069)**	Paclitaxel drug-coated balloons/drug-eluting stents on use in patients with critical limb ischaemia and intermittent claudication.	Trust pharmacy, nursing and medical physics leads deemed this alert not applicable as process not carried out at VCS.
07/11/2022	**Pharmacy alert Ref (1151) Supply issue**	Molybdenum-99 for Technetium-99 radionuclide generator.	Deemed not applicable to the Trust as the drug is not stocked or used for Velindre Cancer Service patients.

4. CONCLUSION

Overall the audit provided robust assurance in respect of the Safety Alert assurances provided by the responsible safety alert leads.

Assurance Matrix

Green	**Substantial Assurance**	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
Yellow	**Reasonable Assurance**	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
Orange	**Limited Assurance**	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
Red	**No Assurance**	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.

Grey	**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.

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

QUALITY, SAFETY & PERFORMANCE COMMITTEE

GAP ANALYSIS ALL WALES PALLIATIVE QUALITY STANDARDS

DATE OF MEETING	16th March 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	N/A

PREPARED BY	HELEN WAY ANP/ LEAD NURSE PALLIAITVE CARE
PRESENTED BY	HELEN WAY ANP/ LEAD NURSE PALLIAITVE CARE
EXECUTIVE SPONSOR APPROVED	

REPORT PURPOSE	FOR DISCUSSION / REVIEW

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Integrated Services Quality and Safety	Oct 2022	IN SUPPORT

ACRONYMS	
ACP	Advance Care Planning
A/FCP	Advance and Future Care Planning
ANP	Advanced Nurse Practitioner
AHPs	Allied Health Professionals
AOS	Acute Oncology Service

CANISC	Cancer National Informatics System Cymru
CNS	Clinical Nurse Specialist
DHCR	Digital Health and Care Record
DNACPR	Do Not Attempt Cardio Pulmonary Resuscitation
EOL	End of Life
C & V	Cardiff and Vale
CDG	Care Decisions Guidance for the last days of life
CHC	Community Health Council
HIW	Health Inspectorate Wales
LPA	Lasting Power of Attorney
MEO	Medical Examiners Officer
NACEL	National Audit of Care at the End of Life
NHS	National Health Service
POS - S	Patient Outcome Symptoms Score
PPC	Preferred Place of Care
PPD	Preferred Place of Death
SDEC	Same Day Emergency Care
SEWS	Symptom Early Warning Score
SPCT	Specialist Palliative Care Team
VCC	Velindre Cancer Centre
WPAS	Welsh Patient Administration System
WCP	Welsh Clinical Portal

1. SITUATION

The paper is to provide the Quality, Safety & Performance Committee with assurance that the Velindre UHBT Specialist Palliative Care Team is meeting the All Wales Palliative Quality Standards published in October 2022.

2. BACKGROUND

The Palliative Implementation board is being replaced by a National Clinical Framework for Palliative and end of life care, In line with other National Clinical Frameworks. The national body producing and making recommendations on standards and quality will be known as the All Wales Palliative and End of Life Programme Board. The All Wales Quality Standards document published in October 2022 is the first publication from the Palliative and End of Life Programme board. The Velindre UHBT Specialist Palliative Care team is involved in and often leading on local, regional and national initiatives and service developments and is therefore able to demonstrate in the attached Gap analysis how the quality standards are being met. Work streams and projects aligned to the quality standards are currently being

developed the Velindre Specialist Palliative Care Team are already involved in all of the relevant proposed work streams and projects. Please note The Palliative and end of life National Clinical Framework and Programme Board is not exclusively for specialist palliative care, it applies to generalist palliative and end of life care in all services and settings; including Paediatrics, primary care, general wards, care of the elderly, frailty, chronic conditions and many other services where people will have life limiting illnesses or be approaching end of life.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

Gap analysis attached.

4. IMPACT ASSESSMENT

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

5. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **DISCUSS / REVIEW** the All Wales Palliative quality standards gap analysis document.

Welsh Government Quality Statement for Palliative and End of Life Care . Velindre Specialist Palliative Care team
GAP Analysis completed December 2022

Key Met , Partially met , Unmet

Broad Statements Macro Level				
Theme	Standard	Current Velindre Position	Met/ Unmet	Comment/ Action
Safe	Reduction of national and local variation of standards across care settings and voluntary and statutory care settings by the palliative and eol care direction being set by the National Programme Board for Palliative and End of Life Care Board.	The National Programme Board for Palliative and End of Life Care is currently being set up and membership not established yet. VCC SPCT are currently updated by participating in the Palliative Care Implementation Board Monthly meetings, The monthly Palliative Lead Nurse meetings and , monthly local C & V Palliative care Reference Group.	Met	The National Programme Board for Palliative and End of Life Care will have a much broader range than specialist palliative care including groups such as frailty, chronic illness, care of the elderly, paediatrics, neonatal car etc. so membership is being reviewed to ensure input from these areas and from UHBs, primary care, voluntary sector etc. **Metrics** An All wales Palliative and end of life care dashboard is in discussion and development with agreed metrics to be reported on across Wales with local and national access to data.

				The Lead Nurse reports through Integrated Services Directorate currently regarding numbers of in patient referrals and numbers of same day unscheduled care referrals. These are currently collated by hand and paper forms. The development of the Palliative Module within WCP will enable improved data collection and scrutiny regarding number and type of care and intensity / frequency of interventions . HIW and CHC inspections.
Timely	People from the point of diagnosis or recognition that they are dying will receive timely person centred care. Family and carers will be informed and prepared in a timely way. Care will be underpinned by equity. People will access good information about dying and end of life care appropriately communicated and delivered	7 day/ 365 ANP/ CNS SPCT working 24/7 Palliative Consultant advice line. ANP/ CNS extended working day Monday-Friday to Match AOS assessment unit hours. Attendance at AOS meetings and post take rounds twice daily to identify patients before	Met	**Metrics** NACEL (National Audit of Care at the End of Life). Annual audit and benchmarking. Please note this is an English audit based on the 5 priorities for End of Life Care in England and NHS England strategy and policies/ guidance. Also as VCC is a small hospital we can only complete part of the audit as we do not meet the minimum number of deaths

| | | arrival or as soon as possible after arrival to identify patients with specialist palliative care needs. We removed paper referral process to facilitate instant/ prompt access to SPCT. Prof Taubert All Wales lead on Advance and Future Care Planning and DNACPR. Prof Taubert and Lead Nurse contributed to/ advised on competency framework for nurses / AHPs to complete part 5 of DNACPR form. Lead Nurse/ ANP participates in Paracentesis service to combine undertaking the procedure with palliative review, ACP and communication with community SPCT ; | | within the audit period to complete the full audit.

All Wales Care Decisions Guidance for Last Days of Life is used in VCC, we are one of the moist consistent and highest users of this in Wales. We participate in 6 monthly and annual audits and All Wales benchmarking of CDG data.

All Wales DNACPR audit every 2 years (All Wales standard is every 2 years) |

| | | she is the only palliative care nurse in Wales to be competent and undertake this procedure to facilitate safe and prompt management of ascites in palliative patients.

The VUHT SPCT have developed Advanced Nurse Practioner roles within the SPCT with 50% of the nursing team also independent prescribers to deliver timely, safe and effective care and communication .

VCC SPCT are part of the mortality and morbidity group alongside the MEO process. | | |
|---|---|---|---|---|

Effective	National systematic public engagement and involvement for palliative and end of life care will be central to decisions on quality and improvements. A national approach to digital and informatics systems will ensure important information is readily available, across borders and providers to ensure joined up, efficient care. Agreed national outcomes and experience measures for patients and those close to them., ensuring self-reported experience measures should drive forward improvements and share what is "good"	SPCT engaged in preparation and implementation for changeover from CANISC to WPAS/ WCP. SPCT currently dual running WCP and Canisc as other palliative care teams still using CANISC . WCP Palliative Module has been developed and user acceptance testing to begin in March 2023 with plan for Palliative Care in all settings/ services in Wales to change over totally to WCP at a date agreed with DHCR Wales. POS – S (Palliative outcome scores)	Met	**Metrics** Civica - my Velindre experience questionnaires currently used . Development of a specific All Wales Palliative patient experience questionnaire based on patient led outcome measures. VUHBT SPCT are on the All Wales user experience feedback group. Velindre Palliative Care Team will be piloting the palliative specific All Wales Civica feedback questionnaires. Concerns, complaints and compliments records and incident reporting.

		currently recorded on each patient seen by the palliative care team to record their physical symptoms on a measurable scale. This is audited annually. POS – S will be replaced by an improved patient assessment/ outcomes measure in the palliative WCP module. VUHBT SPCT have engaged with a Marie Curie Research Centre survey on patient reported outcome measures to design a new suite of outcome measures based on patient and carers views. The SPCT are also using CIVICA patient experience questionnaires and are		

		represented on an All Wales Palliative patient experience/ feedback group to design a palliative questionnaire for Civica . This would feed into both local VUHT reporting and All Wales palliative reporting and benchmarking.		
Person Centred Care	Any modernisation or transformation of the design and delivery of palliative care will build on what we know from existing research. People and their families preferred place of care and death are identified, respected and achieved where possible. A national approach to providing accessible information. Digital technology will be used to support high quality clinical	VCC SPCT engagement in all All Wales groups re palliative and end of life care and digital working / solutions. VUHT SPCT engagement with transforming cancer services, the new Velindre Cancer Centre. Close working with Acute Oncology colleagues to move towards more	**MET**	VCC SPCT is one of the first if not the first SPCT to adopt a "front door" approach to palliative care , removing the need for referrals and gatekeeping by integrating with the Acute Oncology, Immunotherapy and integrated services teams as well as a consistent presence of the wards, day units and outpatient units.

		care in all settings , making care more equitable and reducing the need	unscheduled and Same Day Emergency Care (SDEC). Preferred Place of Care and death and any preferences, or equality, diversity requirements are recognised, recorded and care planned accordingly. Digitalisation of the All Wales Care Decisions Guidance for the Last Days of Life is benchmarked and reviewed 6 monthly with an annual report and update and work is in progress to digitalise the CDG document and Symptom Early Warning Score (SEWS) chart.		
Efficient		All people identified as having palliative care needs will be given the opportunity and	Opportunities for Advance and Future care planning form part	**MET**	Single point of access is being reviewed on an All Wales basis to find local solutions e.g. in Cardiff and Vale

	support for conversations to discuss their wishes , preferences and advance and Future Care planning. Single 24/ 7 point of access to co ordinated care, medication and advice about end of life care , to reduce distress and likelihood of unwarranted admission to secondary care . All efforts will be made to recognise dying in a timely manner. The All Wales Care Decisions Guidance for the LAST Days of Life is recommended to support best practice interventions an d to emphasise a partnership approach with informal carers of the dying person	of the SPCT assessment and information is recorded and shared with community teams. PPC/ PPD/ LPA/ Ceilings of treatment/ DNACPR Prescribing of anticipatory medication to be kept at home in case needed. Prof Taubert is All Wales lead for A/FCP and DNACPR. 2 yearly All Wales DNACPR audits . Dr Nikki Pease is all Wales Lead for Serious Illness Conversations. Lead Nurse is a Sage and Thyme communication trainer and Advanced Communication Skills		the palliative advice calls now go through the 111 service and central OOHs hub instead of through the hospice to facilitate links to GP, District Nurses, Social Care etc. Hubs would be community based not within acute hospitals.

		and Real Talk communication skills trainer. The availability and rapid access to on site face to face palliative care and 24/7 OOHs palliative care enables rapid review and decision making and recognition of the dying patient. VCC SPCT are one of the most consistent and highest users of the Care Decisions Guidance in Wales. Completion of the CDG case review sheets after death provide statistics on how the priorities at end of life have been met.		

			The VUHT SPCT work closely with the supportive care team to provide pre and post death bereavement support consistent with the All Wales Bereavement Standards.		
	Equitable	A single Wales offer or service specification of "what good looks like" and what structures and models should be in place from both specialist and generic, adult and paediatric palliative and end of life care services will help define and determine the types of services , the health and care outcomes and the workforce needed to provide and deliver palliative and end of life care. Peoples priorities for place of care, such as closer to home (including care homes) for the growing number of people who	VUHT SPCT already meet the previous recommendations from the previous document "Together for Health End of Life Care Delivery Plan" and are engaged on discussions at an all Wales level regarding future developments and direction. The development of ANP roles alongside CNS roles has enabled flexibility and extended	MET	VUHT are engaging with the Single cancer pathway work and the Same Day Emergency Care Pathways and joint working with The Acute Oncology Service. The Lead Nurse has previously received a safeguarding award from C & V safeguarding board for work with extremely vulnerable patients at the end of life.

| | will want and need it, will be reflected in workforce planning and in investment. | skills and competency within the nursing team to deliver safe, timely, equitable and effective care.

There is a close working relationship with the supportive care team and the SPCT act as advocates for minority groups or patients with specific cultural or individual needs or adaptations | | |

Quality statement for palliative and end of life care for Wales

The quality statement describes what good quality palliative and end of life care services should look like.

First published: 7 October 2022

Last updated: 7 October 2022

Contents

This is our vision for palliative and end of life care delivered in Wales for all who need it by people working closely together, at home when appropriate, determined by what matters to the person and underpinned by what works.

Quality statement: palliative and end of life care

This Quality statement sets out high-level Welsh Government policy intention for children, young people and adult Palliative and End of Life Care.

It will be supported by the NHS Executive and implemented through a series of health board enabling plans, collaborations with other networks and programmes (such as dementia, cardiovascular, neurological, diabetes and cancer) and the work programme of the National Programme Board for palliative and end of life care. Palliative and end of life care is inextricably linked to bereavement; the Wales Bereavement Framework and the recent UK Commission on Bereavement recommendations will help to provide the best possible experience of bereavement to all people[glossary] in Wales.

Around 33,000 individuals die each year in Wales, equivalent to over 1,000 citizens for most local authority areas, or several thousand for Wales's larger cities. Deaths in England and Wales are projected to rise by 27.0% by 2040, with a 53.6% increase in deaths in over those over 85[footnote1] associated with a higher complexity of care needs, and an increasing number having more than one serious illness contributing to their need for palliative care. Projections indicate that the need for palliative care will rise substantially over coming years especially at home or in care homes. Some evidence was suggesting pre-pandemic that care homes will be the most likely common place of death by 2040[footnote1], however, evidence continues to emerge post-pandemic that may challenge that prediction.

A large and growing proportion of adults will have a life-shortening illness for a

period of time when care needs are intensive; children are more likely to need long term care often with intensive care episodes. Good palliative care can make a huge difference to the quality of life for people and those who care for them, helping them to live as well as possible and to die with dignity. Anyone requiring palliative and end of life care in Wales should have access to the best possible care. To achieve this, a much broader Programme focus across the spectrum of health and social care and third-sector provision rather than on specialist palliative care services will be required to make this happen as a whole system effort.

There is a need to ensure that equity of palliative and end of life care access is provided for those people who have faced inequality, such as, for example, ethnic minority communities and the LGBQT+ communities and some pathways will need to be reimagined to incorporate more flexibility and innovation to deliver this.

The Welsh Government's '**More than just words plan**' to strengthen Welsh language in health and care services through the 'active offer' principle should become an integral part of palliative and end of life care provision. Service providers should build on current best practice and plan, commission and provide care based on this principle.

There is a need to develop greater resilience, coproduction and investment within the work and volunteer forces and unpaid carers. This will be underpinned by a review of the distribution of resources and model utilisation taking into account the current financial and economic environment. The principles of Value Based Health and Care will guide our improvements. Continuous citizen involvement will be at the centre of these improvements using the outcomes that matter to people to ensure the choices made about care design and access to services, are co-produced in line with the principles in '**A Healthier Wales**'.

Health Boards and Trusts, along with local authorities and regional partnership boards are responsible for planning services for people facing life shortening

illnesses in line with professional standards, clinical guidance and the quality attributes set out below. They will work closely with the third sector, charitable hospices, care homes, domiciliary care agencies, local authorities, Compassionate Cymru, informal carers/families and friends to deliver and continually strive to improve services for all people across all services in Wales.

The National Clinical Framework (NCF) places specific emphasis on the development of national clinical pathways, and the **Quality and Engagement Act** and **Framework** emphasises the importance of systemic local use of the quality assurance cycle. This Quality Statement will form the basis of a quality assurance cycle for palliative and end of life care to support local improvement in the quality of services and address unwarranted variations in care.

Detailed service specifications will also be developed to support the planning and accountability arrangements for the NHS and partners in Wales; these will be set out in Annex A as they become available.

Safe

The overall palliative and end of life care direction and ambition including public involvement will be set by the National Programme Board for Palliative and End of Life Care, with a clear account of what should be decided locally, reflecting local circumstances.

National variation and standards in care will be addressed by clinical leaders in palliative and end of life care services working collaboratively across voluntary and statutory services with the National Programme Board for End of Life Care.

Other Welsh Government and NHS end of life care work-streams will work together with the National Programme Board for Palliative and End of Life Care to ensure a whole systems approach to any transformation or reform.

A national quality assurance system for palliative and end of life care including measurement of relevant outcomes and user involvement will provide a systematic approach to improvement, planning and quality.

Timely

National evidenced-based seamless pathways for how people will access palliative care, including specialist palliative care, will follow the principles set out in the National Clinical Framework.

People from the point of diagnosis or recognition that they are dying, will receive timely, person-centred care, reflecting current knowledge, standards, and guidance to maintain as good a quality of life as possible and to reduce the distress of life shortening illness for the person and those close to them.

Family and carers will be informed and prepared in a timely way about how they can provide care in a safe and supported way and at the level in which they feel able to provide it should they choose to.

Palliative and end of life care access will be underpinned by equity, with active measures to identify and reduce those evidenced inequities including diagnosis, mental health, dementia, age, geography, ethnicity, sexual and gender identity, and poverty and those with Welsh language needs.

People will access good information about dying and end of life care, appropriately communicated and delivered, wherever they are located in Wales at any time.

Effective

National systematic public engagement and involvement for palliative and end of

life care will be central to decisions on quality and improvements.

A national approach to digital and informatics systems will ensure important clinical/personal information is easily and rapidly accessible to those providing and receiving care in any setting, including where possible across borders, to ensure care is joined up, efficient, timely and reliable with relevant, high quality, standardised data to drive service improvement.

Agreed national outcomes and experience measures for people and where appropriate, for those close to them, will be utilised, ensuring people's self-reported experience should drive forward improvements and share what is 'good'.

Research into adult and paediatric palliative and end of life care is promoted, facilitated, and invested in as a funded programme. This will include the dissemination of findings and links to policy and service development to improve quality of life, influence care, and make the best use of resources.

Person centred care

Any modernisation or transformation of the design and delivery of palliative and end of life care will build on what we already know from existing research to prioritise the voice of the public, patients and those close to them and will be co-produced to focus it on the outcomes that matter.

People and their families' preferences for place of care, place of death, and place after death and those factors most important to them are identified, respected, and achieved when possible – that might be short break services for children and young people, care at home (including care home), hospital, hospice, the secure estate, or other place of care.

A national approach to providing accessible information (including consideration

of both Welsh and other language needs) around dying and the care that can be expected will ensure that the public and patients and informal carers are adequately informed of the support and systems that are available to them.

People, approaching the end of their lives and their families and carers are treated with dignity and respect and have their personal beliefs and needs, including Welsh language (and other language need) and any spiritual or religious beliefs, considered as part of their core care.

Nationally agreed evidenced-based seamless pathways, careful planning and close collaboration is in place between services for transition from paediatric and young persons to adult services.

Digital technology will be used to support high quality clinical care in all settings, making care more equitable and reducing the need for unplanned change of care setting.

Efficient

All people identified as having palliative care needs will be given the opportunity and support for conversations with someone well placed to discuss their personal needs, wishes and preferences for care at the end of life, through regularly reviewed Advance and Future Care Planning.

People can have 24/7 single point of access to co-ordinated care, medication, and advice about end of life care, wherever they are located in Wales to reduce distress and the likelihood of unwarranted admission to secondary care.

All efforts will be made to recognise dying in a timely manner and communicate this to those close to the person. The All Wales Care Decisions Guidance for the Last Days of Life is recommended to support best practice interventions and to emphasise a partnership approach with informal carers of the dying person

wherever this is appropriate.

Adult and paediatric palliative care services including statutory and voluntary, across care settings are measured and held accountable using national metrics that reflect the quality of care, including accessibility, its outcomes, and people's experience of it.

The National Bereavement Framework and pathways and the recommendations of the UK Commission on Bereavement sets out clear guidance for our services around bereaved people. This will improve timely and equitable access and signposting to the appropriate level of pre and post bereavement services to reduce the burden of grief on caregivers and family members.

Equitable

A 'single Wales offer' or service specification of 'what good looks like' and what structures and models of integration should be in place from both specialist and generic, adult, and paediatric palliative and end of life care services will help define and determine the types of services, the health and care outcomes and the workforce needed to provide and deliver palliative and end of life care.

Children and young people with life-shortening conditions and their families should be able to access 'wrap around' care that offers therapeutic services which enable them to live their best lives and reach their full potential.

Children and young people with life-shortening conditions and their families should be able to access 'wrap around' care that offers therapeutic services which enable them to live their best lives and reach their full potential.

People's priorities for place of care, such as care closer to home (including care homes) for the growing number of people who will need and want it, will be reflected in workforce planning and in investment.

Development of an end- of-life care learning culture and framework for the health and social care workforce to enhance skills and competencies will build confidence in the workforce in providing palliative and end of life care in all care settings. The impact of language on the quality of care should also be a core element of all training programmes.

Example Metrics (evolving list)	**Cross- working groups**
- Referrals and clinician interactions - Social care - National Audit of Care at the End of Life (NACEL) - Workforce Training across care settings - Voluntary hospice services interventions - National Outcome measures – Patient-Reported Outcome Measures (PROMS) and Patient-Reported Experience Measures (PREMS) - Heath Inspectorate Wales / Care Inspectorate Wales - Citizen Voice Body (Community Health Council) - National palliative and end of life care patient Feedback System - Single Cancer Pathway (SCP) - Unsolicited feedback including compliments/ concerns, incident reporting and adverse events - All Wales Care Decisions Guidance for the last days of life audit data	- Third Sector organisations - Faith and Belief Groups - Primary and community care - Other Programmes and Networks - Shared decision making/ public-citizen activation systems

Glossary

Palliative and end of life care

Palliative and End of Life Care includes, 'the care and support of people and their families with progressive life shortening conditions, particularly those who may be in the last year of life, and including the various elements often described as palliative care, end of life care or the last days of life.'

People

Throughout this document people includes children, young people, and adults

Pathways

The common journey/route a person takes through health care services. An NHS Pathway is a clinical tool used for assessing, triaging and directing people though healthcare services. Care pathways can provide patients with clear expectations of their care, provide a means of measuring patient's progress, promote teamwork on a multi-disciplinary team and facilitate the use of guidelines.

Patient Reported Experience Measures (PREMs), Patient Reported Outcome Measures (PROMs)

Used to assess the quality of healthcare experiences, focusing on patients. These measures help healthcare providers, commissioners and other stakeholders to make informed changes to their services.

Quality statement

High-level statement of intent for what "best" looks like for palliative and end of life care services.

Service specifications

Written guidelines that set out details on how specific services will be delivered and measured.

NHS Executive

The bringing together of 4 national bodies to work as one single national team to help deliver priorities across the NHS:

- NHS Wales Health Collaborative
- Improvement Cymru
- the NHS Delivery Unit
- Finance Delivery Unit

Annex A: service specifications

The NHS Executive will support the local implementation of nationally agreed, optimised clinical pathways. These will be added as they become available as set out in the implementation plan

Footnotes

[1] Bone et al (2017) What is the impact of population ageing on the future provision of end-of-life care? **Population-based projections of place of death. Palliative Medicine 2018 Feb;32(2):329-336**.

Minutes

Private Quality, Safety & Performance Committee

Velindre University NHS Trust

Date: 17th January 2023
Time: 13:15-13:45
Location: Teams
Chair: Mrs Vicky Morris, Independent Member

ATTENDANCE		
Vicky Morris	Independent Member and Quality, Safety & Performance Committee Chair	VM
Stephen Harries	Vice Chair and Independent Member	SH
Hilary Jones	Independent Member	HJ
Prof. Donna Mead	Velindre University NHS Trust Chair	DM
Steve Ham	Chief Executive Officer	SHa
Nicola Williams	Executive Director of Nursing, Allied Health Professionals & Health Science	NW
Lauren Fear	Director of Corporate Governance and Chief of Staff	LF
Matthew Bunce	Executive Director of Finance	MB
Sarah Morley	Executive Director of Organisational Development & Workforce	SfM
Alan Prosser	Director, Welsh Blood Service	AP
Paul Wilkins	Director of Cancer Services	PW
Jacinta Abraham	Executive Medical Director	JA
Emma Stephens	Head of Corporate Governance	ES
Kyle Page	Business Support Officer (Secretariat)	KP

1.0.0	STANDARD BUSINESS	Action Lead
1.1.0	**Apologies** received from: • Katrina Febry, Audit Lead, Audit Wales • Cath O' Brien, Chief Operating Officer • Carl James, Director of Strategic Transformation, Planning & Digital • Rachel Hennessy, Interim Head of Operational Services	
1.2.0	**In Attendance** There were no additional attendees.	
1.3.0	**Declarations of Interest** Led by Vicky Morris, Quality, Safety & Performance Committee Chair	

	No declarations of interest were raised.	
1.4.0	**Review of Action Log** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science There was only one open action: • ***2.2.3 (24/03/2022) - Governance, including the reporting of TCS projects on hold to be determined to allow the Board a holistic view*** – As the update had not been received prior to the meeting, it was agreed that KP would request this from Carl James and circulate it to members outside the meeting. Once undertaken the action can be closed.	**Secretariat**
1.5.0	**Matters Arising** Led by Vicky Morris, Quality, Safety & Performance Committee Chair There were no matters arising.	
2.0.0	**CONSENT ITEMS** (The consent part of the agenda considers routine Committee business as a single agenda item. Members may ask for items to be moved to the main agenda if a fuller discussion is required).	
2.1.0	**ITEMS FOR APPROVAL**	
2.1.1	**Draft Minutes from the meeting of the Private Quality, Safety and Performance Committee held on the 10th November 2022** Led by Vicky Morris, Quality, Safety & Performance Committee Chair The draft minutes of the Private Quality, Safety & Performance Committee held on the 10th November 2022 were **APPROVED** as an acurate record of the meeting.	
2.2.0	**ITEMS FOR NOTING**	
2.2.1	**Transforming Cancer Services (TCS) Programe Scrutiny Sub Committee Highlight Report** Led by Stephen Harries, Vice Chair and Chair of the Transforming Cancer Services Scrutiny Sub Committee The Committee received the report, providing details of the key issues considered at the TCS Programme Scrutiny Sub-Committee meeting held on 17th November 2022. No further comments were raised and the Committee **NOTED** the content of the report and actions being taken.	

3.0.0	**MAIN AGENDA**	
3.1.0	**Analysis of today's meeting outputs and Highlight Report** Led by Vicky Morris, Quality, Safety & Performance Committee Chair NW noted that over the last year there have been less papers provided at the Private Committee evidencing the Committee's ongoing commitment to clear and transparent reporting.	
4.0.0	**HIGHLIGHT REPORT TO TRUST BOARD**	
	Members are asked to identify items to include in the Highlight Report to the Trust Board: • For Alert/Escalation • For Assurance • For Advising • For Information	
5.0.0	**ANY OTHER BUSINESS**	
	No other business was raised.	
6.0.0	**DATE AND TIME OF THE NEXT MEETING**	
	The Quality, Safety & Performance Committee will next meet on: **16th March 2023 from 13:15 – 13:45 via Microsoft Teams.**	
CLOSE		

QUALITY, SAFETY & PERFORMANCE COMMITTEE

INFECTION PREVENTION & CONTROL MANAGEMENT GROUP HIGHLIGHT REPORT

DATE OF MEETING	16th March 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	N/A
PREPARED BY	Hayley Harrison Jeffreys, Head of Infection Prevention and Control
PRESENTED BY	Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science
REPORT PURPOSE	**ASSURANCE**

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

COMMITTEE OR GROUP	DATE	OUTCOME
INFECTION NFECTION PREVENTION & CONTROL MANAGEMENT GROUP	02/02/2023	Areas for inclusion agreed
EXECUTIVE MANAGEMENT BOARD	02/03/2023	NOTED

ACRONYMS

AMR	Antimicrobial Resistance
HCAI	Healthcare Associated Infections
IPC	Infection Prevention & Control
IPCMG	Infection Prevention & Control Management Group
IPCT	Infection Prevention & Control team
RA	Risk Assessment
RCA	Route Cause Analysis
RD&I	Research Development and Innovation
VCS	Velindre Cancer Service
VCCSMT	Velindre Cancer Centre Senior Management Team
WBS	Welsh Blood Service
WHC	Welsh Health Circular
DHCW	Digital Health & Care Wales
Nvcc	New Velindre Cancer Centre
PICC	Peripherally Inserted Central Catheter
NWSSP	NHS Wales Shared Services Partnership#

1. PURPOSE

This paper is to provide the Quality, Safety & Performance Committee with details of the key issues considered by the Infection Prevention & Control Management Group (IPCMG) during the meeting held on 2nd February 2023.

2. BACKGROUND

Velindre University NHS Trust's (the Trust) Infection Prevention & Control Management Group is chaired by the Executive Director of Nursing, Allied Health Professionals and Healthcare Science, and is attended by key personnel from both Divisions. The Group considers all national guidelines relating to Infection Prevention and Control (IPC), and all internal compliance and performance data regarding infection prevention and control standards. The Group reports to the Executive Management Board and the Quality, Safety and Performance Committee.

3. INFECTION PREVENTION & CONTROL MANAGEMENT GROUP (IPCMG) HIGHLIGHT REPORTS

The following are the Highlights from the Infection Prevention & Control Management Group meeting held on the 2nd February 2023:

ESCALATE/ALERT	There were no items to escalate or Alert
ADVISE	**Reduced engagement in completion of Root Cause Analysis -** the group were informed that there has been reduced engagement in completing the medical section of HCAI RCAs to identify lessons learnt, this process should be completed within 2 weeks of the infection result. This issue has been escalated to the Velindre Senior Management Team and medical staffing to address immediately. **Antimicrobial Stewardship report:** The group were advised that the Pharmacy team have been in discussion with DHCW to resolve issues with antimicrobial usage data from Public Health Wales as there is a national issue resulting in no validated data being available across NHS Wales since September 2021. DHCW have advised that this data should be available by end of March 2023. The Group were assurance by Pharmacy colleagues that previous data demonstrated that Velindre Cancer Service has consistently and significantly met the target of >55% of all antimicrobial prescribing being from the 'access category. *Infection Prevention & Control Policies*: The Group reviewed the policy tracker and identified all IPC Policies are in date /

	extant except for the Transport of Specimens policy (due for renewal December 2022. This has been reviewed by the IPCT and is out for consultation. The policy will be submitted to the next Group for endorsement and onward approval.
ASSURE	• ***ANTT Accreditation:*** The Trust achieved Gold ANTT Accreditation in January 2023 which is valid for 3 years and is the first Health Body in Wales to achieve this. It reflects on all the good work and high standards of asepsis within both VCS and WBS and the Trusts low infection rates. • ***Infection Prevention & Control Improvement Plan:*** The Group received an amended IPC Improvement Plan that had been transcribed onto the 7 levels of assurance improvement template. • **Policy for the Prevention and Control of Transmissible Spongiform Encephalopathies (Creutzfeldt-Jakob Disease)** The revised policy followed the policy consultation process and was endorsed by the Group. The amended policy has been submitted for approval to the Executive Management Board and will be submitted to the Quality, Safety and Performance Committee for approval. • **nVCC** A new agenda item added to IPCMG agenda to inform the group of discussions and progress regarding IPC and the built environment. Discussions ongoing with regards to Hand Hygiene / Personal Protective Equipment dispensers, curtains v's blinds and interior finishes. • **Decontamination** – the group were assured that the action plan developed following the informal review of decontamination practices in VCS are completed. IPC Validation Audits are carried out quarterly for Theatres, Radiology and PICC clinics whilst individual departments complete monthly audits. Standard Operating Procedures have been updated to include documentation of manual cleans for all areas. All relevant staff have undergone their Annual User update training & this will be further refreshed after March 2023. NHS Wales Shared Services Partnership Authorised Person (Decontamination) audit of Sterile Services identified that the Velindre visit will be Spring / Summer, the date has yet to be confirmed. • **IPC audits:** The IPCT have continued using the MEG audit tool which is backed by the Infection Prevention Society. The IPCT

3/4

	are reviewing Tendable with the aim of moving over once validation can be achieved.
	• **Incidents and Risks:** The group were advised of continuing issues gathering DATIX and risk information for learning and reporting. The plan to resolve this issue in December did not occur. Trust DATIX manager has escalated again to National DATIX group and is scheduled to be resolved in April 2023, for assurance the Head of IPC has sight of all DATIX submitted.
	There are 19 Infection Prevention and Control risks registered on the Trust Dashboard, with score ranging from 1-12, seven of these are COVID-19 related with no new reported since April 2022. All will be reviewed, and a report will be submitted to the next Infection Prevention and Control Management Group.
	• ***Ventilation Study Day:*** The Trust IPCT are hosting a Ventilation Study Day for Infection Prevention and Control Nurses across Wales in March 2023. The speaker Malcolm Thomas, Senior AE (V) in England and Ventilation consultant. He regularly advises NHSE&I and HBs throughout England and teaches on ventilation through Leeds university.
	• ***Hand Health Working Group***: IPCT and Health and Safety are working collaboratively to create a Hand Health Working Group to establish a skin surveillance to monitor the health of staff hands and provide information and training.
	• ***Infection Prevention and Control Team Research Project***: the group were informed that the team are working with SCJohnson, all Wales contract holder for hand hygiene products, to undertake a study on behaviour change and if a skincare education programme would improve hand hygiene compliance amongst healthcare workers. The proposal is under development and will also include swabbing of hands to look at transient organisms that are on staff hands/rings etc. The aim of the project is to promote changes to practice.
APPENDICES	**NOT APPLICABLE**

4. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to:

• **DISCUSS** and **NOTE** the Infection Prevention & Control Highlight Report from the meeting held on the 2nd February 2023 and actions being taken to address the areas where compliance / standards are not at the required level.

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<tr><td colspan="2" align="center">**QUALITY, SAFETY & PERFORMANCE COMMITTEE**</td></tr>
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<tr><td colspan="2" align="center">**PROFESSIONAL NURSING FORUM UPDATE**</td></tr>
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DATE OF MEETING	16th March 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	N/A

PREPARED BY	Anna Harries Senior Nurse Professional Standards and Digital
PRESENTED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Science
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, AHPs and Health Science

REPORT PURPOSE	NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Professional Nursing Forum	18.10.2022	Items for inclusion agreed
Professional Nursing Forum	17.11.2022	Items for inclusion agreed
Professional Nursing Forum	22.12.2022	Items for inclusion agreed
Professional Nursing Forum	02.02.2023	Items for inclusion agreed
Executive Management Board	02.03.2023	NOTED

1. SITUATION

This paper provides the Quality, Safety & Performance Committee with:

- A summary of key discussions and outcomes of the Professional Nursing Forums (PNF) held between October 2022 and February 2023.

- An overview of the proposed Trust Nursing Strategy themes and priorities.

- A summary of plans for the Trusts Nursing Conference (12th May 2023).

- An update in respect of nursing led critical projects including the status of work on the introduction of the Assistant Practitioner role (Band 4 HCSW roles) and the development of a Trust wide Multi-professional Advanced Practice framework and development pathway.

2. BACKGROUND

The Professional Nursing Forum Meets monthly and it is the forum at which all strategic professional nursing issues and standards are discussed, strategic direction agreed and priorities determined. Reporting to Executive Management board is quarterly based on content of meetings held during the period.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The following are the key highlights from the report:

- Trust is fully compliant with all 14 Royal College of Nursing (RCN) workforce standards.

- Trust has appointed its first two trainee Assistant Practitioners (Band 4 HCSW) roles in Velindre Cancer Centre Outpatients department.

- The Trust's Nursing Strategy is in final draft.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Robust professional governance is a critical element of having safe high quality patient care
RELATED HEALTHCARE	

STANDARD	Effective Care Safe Care
EQUALITY IMPACT ASSESSMENT COMPLETED	No (Include further detail below)
	Programme specific, but not for paper reporting
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Programme specific, but not for paper reporting
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Programme specific, but not for paper reporting

5. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **NOTE** the Professional Nursing update for the period October 2022 to February 2023 including the Nursing Strategy agreed themes and principles.

PROFESSIONAL NURSING FORUM PAPER: October 2022 – February 2023

1. PROFESSIONAL NURSING FORUM HIGHLIGHTS

The following is a summary of the key outcomes from the Professional Nursing forums held between October 2022 and February 2023:

1.1 Nursing Successes:

- Two flexible route registered nurse trainees have successfully completed their degree programmes and are now settled into their qualified nurse posts on the First Floor Ward, Velindre Cancer Centre.

- The Trust is supporting two further flexible route HCSWs / students from the Welsh Blood Service North Wales Team.

- Four nominees had been shortlisted for advancing healthcare awards Wales.

- Alison Edwards (Lung Cancer specialist Nurse) poster acceptance for the UK Oncology Nursing Society Annual Conference 2022. Topic: *The impact of a Lung Cancer Clinical Nurse Specialist role on person-centered and equitable care: a service improvement and evaluation project.*

- Five members of staff have successfully completed facilitator training for the Sage and Thyme Communication Course with licences in place. This training reminds staff how to listen and how to respond in a way which empowers the patient. It discourages staff away from "fixing" and demonstrates how to work with patients' own ideas first.

1.2 Assistant Practitioner Role

The new nationally approved Assistant Practitioner Governance Framework was approved for implementation within Velindre University NHS Trust including the nationally agreed titles. The Trust wide working group have as agreed translated the national framework into a workable Trust Framework and developed an implementation plan. The first two Trust Assistant Practitioner posts in Velindre Cancer Service Outpatients department commenced on the 27th February 2023 using the framework and recruited as training posts (annex 21).

The Assistant Practitioner is: *'A worker who competently delivers health and social care to and for people. They have a required level of knowledge and skill beyond that of the traditional healthcare assistant or support worker. The Assistant Practitioner would be able to deliver elements of health and social care and undertake clinical work in domains that have previously only been within the remit of registered professionals. The assistant practitioner may transcend professional boundaries. They are accountable to themselves, their*

employer and, more importantly, the people they serve.' (Skills for Health, 2009).

1.3   Advanced Practice

The development of the Trust's Advanced Practice Framework was discussed at each meeting. The revised national (Wales) clinical competency-based framework is not expected soon therefore the Trust's framework has been developed using the NHS England Framework. Helen Way represents the Trust on the Welsh Advisory Group for Advanced Clinical Practice (WAGACP). A draft was provided to PNF in February meeting; the framework will be presented to EMB at the next quarterly update from this paper.

1.4   Nursing Research

Nursing Research ambition has been discussed at each meeting. The nursing & AHP element of the ambition statement for Research and Innovation (**Appendix 1**) was well received by the Trust Research, Development and Innovation committee in November. This set out the ambition to establish a Velindre Healthcare Cancer Research and Innovation Centre of Excellence, which will be recognised nationally and internationally for service improvements led by nurse and therapies research and innovation.

It was recognised that a culture change will be needed to achieve this, a fellowship type scheme will be required to support in relation to training and education in research methods to complement nurses' professional qualifications, in addition to development of a career framework which includes capacity for research and innovation.

The multi-professional business case to progress this ambition was approved by the Charity in December 2023. The Trust vision mirrors that of the Chief Nursing Office Wales and HEIW and a national framework for clinical academic career pathways for nurses and therapists is under development.

Jane Hopkinson, Professor of Nursing and Interdisciplinary Cancer Care is progressing discussions with the Welsh Blood Service Head of Nursing to identify and initiate engagement with nursing groups within WBS.

Discussions are planned with Cardiff University regarding the longevity of the Professor of Nursing and Interdisciplinary Cancer Care post.

1.5   Nursing Strategy

The Group has overseen the development of the Trust's Nursing strategy. This is almost complete. The strategy is fully aligned with the Professional Nursing standards and work has been completed to agree the wording of the aims and associated priorities. The strategy was developed through full consultation with

nursing staff (registered & non- registered (including Collection Assistants) at all levels). The Strategy aims and objectives are attached in *Appendix 2*.

The next stage will be to develop a work plan with agreed objectives and timescales for completion. The consultation for this will be undertaken at the Nursing Conference 12th May 2023.

1.6   Nursing Conference (International Nurses Day 12th May 2023)

The Trust first nursing conference for many years is planned to be held on the 12th May 2023, at the All Nations Centre. Extensive planning has taken place for this event with venue secured, delegates agreed, events planned, staff identified from each division to share footage on the day, sponsors approach with booked stalls secured and planning discussions with Communications Team. Conference speakers have been secured with a request to PNF.

The Trust Nursing Strategy will be formally launched at this event. There is a commitment from divisions to release of registered and non-registered nursing staff to attend. Divisions were advised on the date for roster planning a year in advance.

1.7   Professional Nursing Standards

The Approved Trust Professional Nursing Standards were formally launched on the 13th October 2022 and work has since moved to the next phase of agreeing how compliance will be measured and monitored. Following consultation across the organisation these will be finalised in the March 2023 Professional Nurse Forum.

1.8   Royal College of Nursing (RCN) Workforce Standards Nursing Standards

The 14 RCN workforce standards were presented to the Group and a subsequent gap analysis undertaken and approved in February 2023. The gap analysis identified that there is compliance with all 14 standards (those that are relevant). If required, analysis is available from Nigel Downes, Interim Deputy Director of Nursing, Quality and Patient Experience.

1.9   Digitalisation of Nursing Documents

The national work on digitalisation of nursing documents continues. The Trust and NHS Wales continue to work with a hybrid of paper and digital nursing documentation. The new documents introduced in February 2023 included: bowel assessments; re-positioning; ymouth care; and medical legal. The next documents for release in Tranche 3 (summer 2023) re: wound care assessment; fragility assessment; food chart; Infection Prevention Risk assessment; urinary / catheter / care bundle; and IV access bundle.

1.10 Clinical Supervision

There is a national team developing a Framework for Clinical Supervision, however there is no immediate publication date expected. It was agreed at PNF in February 2023 that a small Trust task force would undertake baseline scope for the Trust to be in line with the requirements of the duties Quality and Candour. This will include a clear ambition of Clinical supervision for the Trust. as there is currently no formal structure in place.

1.11 Electronic prescribing and Medicines Administration (ePMA)

The ePrescribing programme for Wales, set out by the Minister for Health and Social Care, includes implementation of electronic prescribing and medicines administration (ePMA) across hospitals in Wales. Work is underway to produce an All-Wales ePMA Framework Agreement and once this has achieved 'sign off' all Health Boards in Wales will be able to formally commence the 'Call Off' procedure to establish their own agreements for ePMA solutions. A business case is in progress, however leading up to this Anna Harries (Head of Nursing for Professional Standards and Digital) will attend the event in Cardiff and Vale Health board where the three potential products will be presented to stakeholders.

Appendix 1

VELINDRE HEALTHCARE CANCER RESEARCH AND INNOVATION:
THE AMBITION 2022-2026 – summary of the nursing & AHP elements

The situation now

THE KNOWN BENEFITS OF RESEARCH AND INNOVATION

Research active healthcare providers deliver higher quality services (safe, personalised, equitable, effective).

Research active clinicians analyse their practice seeking solutions to old and new problems. They are important to the development of the health professions and to improvements in cancer care.

Offering opportunity to influence patient care through research and innovation can be important to workforce recruitment and retention.

THE LIMITED VELINDRE RESEARCH AND INNOVATION CAPACITY

Velindre has a small number of nurses and therapists who research their practice. The contribution of nurses and therapists to evidence-based quality improvement is limited. They are underserved in the education and training needed if they are to fulfil their potential contribution to an improvement culture.

Strategy and workplan are needed for sustained leadership and growth in healthcare research and innovation.

What we aim to achieve

Our ambition is to establish a Velindre Healthcare Cancer Research and Innovation Centre of Excellence with a programme for transforming the safety and quality of cancer care.

The Velindre Health Care, R&I Centre will be recognised nationally and internationally for service improvement informed by nurse and therapies led research and innovation.

How will we get there

- Improvement and innovation culture – change culture to recognise and value

- Training and education – development of career framework

What will success look like

- Velindre healthcare clinical academic career pathway – benefits for health of people in Wales and beyond.

- Healthcare research leaders – Professional lead required

- Healthcare research support infrastructure – portfolio required

- Healthcare research programme - aligned with Welsh cancer care priorities

- Quality and safety - Integration of nurse and therapies led research into the VUNHST quality agenda

- Metrics - measures

- Velindre healthcare research reputation - Success will be evidenced by awards, publication, and/or invitations to present at Welsh and UK meetings

Appendix 2: Velindre Nursing Strategy proposed strategic aims / objectives and priorities

1. **Nurses will actively listen to our patients (their family/carers) and donors and deliver kind, safe, and effective evidence-based care.**

   Our priorities are:

   - To deliver individualised care, actively listen and involve patients (their carers) and donors placing them at the centre, making every contact count to strive to improve the health and wellbeing of the population.
   - To communicate effectively with patients (their carers) and donors, check their understanding and, share information within multi-disciplinary teams to enhance the experience of patients and donors and deliver safe care.
   - To promote equitable treatment for all where discrimination of any kind is not tolerated.
   - To be empowered to be strong advocates and to always safeguard patients and donors.
   - To ask all patients and donors to provide feedback in respect of care and treatment provided.
   - To reflect on feedback received and demonstrate how we have listened to what matters to our patients and donors.
   - To ensure that reasonable adjustments are made for patients and donors with additional needs whatever they may be.
   - To ensure that the NMC code and the Trust nursing standards are demonstrated in the practices of all.

2. **Nurses will continually develop our nursing knowledge and skills. We will promote psychological safety in our teams to create a workforce fit for the future.**

   Our priorities are:

   - To ensure nursing teams (and multi-professional teams) are designed around patients and donors and are regularly reviewed to reflect patient / donor needs including skill mix, maximisation of top of license working, optimising advanced clinical practice opportunities and introducing new roles such as Nursing associates.
   - To promote psychological safety for nurses and develop a supervision and reflective practice framework.
   - To demonstrate effective & compassionate leadership and create a nursing workforce that feels valued and respected.
   - To develop equitable pathways for personal and professional development through access to training, coaching, and mentoring.

- To develop the role of the nurse champion within a supportive framework will allocated time to enhance knowledge and skills and to effectively undertake the champion role.
- To develop highly skilled nurses, with a fair and equitable (through a multi-professional lens) nursing career pathway that is free from discrimination or marginalisation.
- To regularly recognise and celebrate success and ensure that nurses are recognised for achievements and contributions.
- To promote a positive and progressive nursing culture where nurses can voice concerns without fear, and regular health and wellbeing discussions are taking place.
- To create an environment where everyone feels empowered to raise ideas, suggestions and concerns and have these supported / act on.

3. Nurses will maximise research innovation and continual improvement opportunities.

Our priorities are:

- To provide opportunities for nurses to gain research and audit skills to provide evidence-based care, and to be involved/participate in research studies.
- To provide opportunities for nurses to undertake or be involved in audits, to assure adherence to standards and improve practice.
- To provide nurses with the opportunity to undertake research in their specialist field of work sharing outcomes via a number of platforms.
- To have the opportunity to participate in peer reviews and bench marking, to learn from others and best practice.
- To be trained in quality improvement methodology and use this to improve patient and donor care, services outcomes and experience.
- To actively take part in patient / donor safety incident reviews and will identify opportunities for quality improvement and learning.
- To provide the infrastructure for nurses to be reflective practitioners through a culture where learning and service improvement is everyone's business.
- To enhance opportunities for the development of enhanced critical thinking and professional judgement through education, evidence based practice and research.

QUALITY, SAFETY & PERFORMANCE COMMITTEE

HIGHLIGHT REPORT FROM THE CHAIR OF THE TCS PROGRAMME SCRUTINY SUB-COMMITTEE

DATE OF MEETING	16th March 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Liane Webber, Business Support Officer
PRESENTED BY	Hilary Jones, 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	
WG	Welsh Government
nVCC	New Velindre Cancer Centre
FBC	Full Business Case

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 26th January 2023.

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

1.3 The Board 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	**New Velindre Cancer Centre Full Business Case - Strategic Case** The nVCC FBC – Strategic Case was presented. It was noted that the Commercial Case was not currently available due to ongoing negotiations around key commercial aspects of the project. The Sub-Committee noted that Welsh Government have been informed of the four cases moving through the Trust's internal governance process and a meeting to commence scrutiny with WG colleagues is scheduled to take place next week. Noted that this process is estimated to take approximately 8-10 weeks. The all-electric design was queried and clarity on backup arrangements in the event of disruption to the electricity supply was sought. The Sub-Committee were advised that twin feeds would supply the site, with an additional backup of biofuel/oil providing sufficient cover. The Sub-Committee **endorsed** the New Velindre Cancer Centre Full Business Case – Strategic Case for Trust Board approval and agreed the recommendations.
ASSURE	There were no items identified to assure the Quality, Safety & Performance Committee.
INFORM	There were no items identified to inform the Quality, Safety & Performance Committee.
APPENDICES	None.

QUALITY, SAFETY & PERFORMANCE COMMITTEE

Highlight report from the Chair of the Trust Estates Assurance Meeting

DATE OF MEETING	16/03/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

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

REPORT PURPOSE	FOR NOTING

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

1. PURPOSE

1.1 This paper has been prepared to provide the Quality, Safety and Performance Committee with details of the key issues considered by the Trust Estates Assurance Meeting which includes Health and Safety, Fire Safety, Environment and Statutory Compliance.

1.2 The Committee is requested to **NOTE** the contents of the report and actions being taken`.

2. HIGHLIGHT REPORT

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ALERT / ESCALATE

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Health and Safety

Mandatory Training levels are below the required levels. Action has been taken to address the situation through:

- Inanimate Load courses planned and delivered in-house through Education & Development, which was not previously available due to availability of resource. Recent recruitment has increased internal training capacity.
- Additional Patient Handling courses are being delivered and scheduled for March, April and June to support staff attendance. This supplements training that is already available and delivered under an SLA with Cardiff and Vale.
- Availability of training to support demand of Module C in place.

Focus continues on this area with positive steps and responses received. Manual handling courses scheduled to meet the needs of the organisation; it is anticipated that this action will have a positive impact in the coming months.

Fire Safety

Mandatory Training levels are below the required levels. Action has been taken to address the situation through provision of targeted training, conducted to meet specific department needs and availability of staff, as well as scheduled training. This provides greater opportunity for staff to access training.

Training figures have improved slightly through the last quarter of 2022/23.

Environmental / Sustainability

Utility costs remain at a high level but are being closely monitored and reported, working with NWSSP and Health Board colleagues to review costs. This is an ongoing concern although the Director of Finance is aware and is updated regularly. This topic is currently an agenda item for the All Wales Financial Managers Forum.

Estates and Statutory Compliance

The Trust has received a limited assurance result on a recent LV Audit conducted by Specialist Estates Services. This is largely due to the instability of the workforce whilst planned recruitment is taking place. Actions to address and improve the position are underway and include:

- Planned recruitment activities
- Training of new personnel to Competent and Authorised Person status
- Rectification of minor issues identified within the report
- Review of site drawings

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ADVISE	**Health and Safety** Health and Safety training for managers has been discussed and agreed at SLT and SMT. Meetings are now being held with H&S lead in both Divisions to discuss funding, numbers to be trained and mode of delivery and venue. Courses are to be delivered by external training provider. VCC have already identified 60 managers for training. In the longer term there is definite interest in the development of a blended learning approach of online training based on the course being developed by CTMUHB, supported by face-to-face short courses. WBS are currently transferring risks from Datix v12 to Datix v14. **Fire Safety** Three major projects to increase fire safety compliance are drawing to a close and will vastly improve the safety of the estate. Works have been delivered on the programme 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 arrangement of the Cancer Centre fire alarm is underway and is due for completion by the end of March. **Environmental / Sustainability** The Environmental Protection (Single-use Plastic Products) (Wales) Bill and Explanatory Memorandum has been approved by Senedd Cymru. This Bill is a key step in halting the flow of plastic pollution into our environment and forms part of the Senedd response to the climate and nature emergency. This action will assist the Trust ambitions laid out within the Sustainability Strategy to reduce the use of single-use plastic. A Trust Decarbonisation Action Plan is being developed, with significant progress made. The plan is expected to be available for consultation by early April. British Gas have announced they are leaving the I&C market, meaning once our contract ends NHS Wales will need to change suppliers. This is being addressed by an All Wales Forum. **Estates and Statutory Compliance** Staffing still remains a major focus for the department and will do for the foreseeable future while recruitment is ongoing. Key appointments have been delayed and the team is expected to be at full strength by the end of May 2023 which will have a positive impact on the management and delivery of Estates Services. The capital programme 2022/23 has been a huge success with all committed works due to be delivered by the financial close. The programme included a

	number of projects that significantly improve compliance and the patient and staff experience across the Trust. The Water Safety Audit undertaken by external body in Quarter 4 underpins the ambition of the Trust and highlights the efforts of all departments that play a role in water hygiene. The Trust achieved The Significant Assurance standard which is a very rare accomplishment. Electrical Safety Actions are in the process of being addressed with an action plan in place for monitoring and close out purposes.
ASSURE	**Health and Safety** Training has been provided to Estates and Digital in Control of Contractors paperwork. Discussions with directorates ongoing. A task and finish group has been set up to review the requirements of Departmental Health, Safety and Fire inspections. The primary purpose of the group is to explore the content of the existing workplace Health, Safety and Fire inspection, to ensure that all departments are conducting inspections and that action plans are in place to address matters arising. Departments will be required to feed back to the Divisional Health and Safety Meeting. Findings to be taken to SLT by mid-April. Divisional Health and Safety meetings have been scheduled by both divisions for Quarter 4. Electrical Safety Training rolled out to Operational Services in VCC and Collection Team Supervisors at WBS. Digital to trial it for Corporate Division. **Fire Safety** Review of strategic fire safety management required to ensure the "golden thread" between policy strategy and implementation is clearly visible. **Environmental / Sustainability** Following the success of last year's event plans have been made for an Easter Jamboree and longer-term Hefyd plans, including the return of the tipi and green social prescribing programmes. GREEN SOCIAL PRESCRIBING & WASTE INTIATIVE Down to Earth launch a new green prescribing session to construct wooden units to house bins. The units will have a green roof, contributing to enhancing biodiversity. To promote this installation February will be "Waste" month for communications. Each Wednesday will be "Waste Wednesday" which will cover different educational information as well as ideas to get involved. The next project will look at (potentially) creating the Fruit and Veg stand. The stand seeks to address the cost of living, individual food waste and utilising food packaging – contributing to circular economy.

Consideration of whether to carry out a similar project in Talbot Green to create bike storage with a green roof is ongoing (contributing to the Trust Travel Plan and Biodiversity Plan).

CANCER CARE SYMPOSIUM

The Sustainability Team and RD&I Project Manager have been selected to present in the VIDEO + POSTER format from 178 submissions following a highly competitive evaluation process. A capacity audience of over 500 participants are anticipated to attend, with each session also streamed LIVE online to many hundreds more around the world. Recordings will be available to both in-person and virtual delegates for two months within the virtual event platform. The presentation will be at the European Healthcare Design 2023 Congress & Exhibition, from 12th-14th June at the Royal College of Physicians, London.

Estates and Statutory Compliance

Funding has been approved to appoint key positions within the estates Team to support focus on compliance and to aid transition and management of nVCC. Roles identified have been approved through the scrutiny and job matching process and have been appointed. It is understood that all new positions will be in post by the end of May 2023.

The appointment of the Estates Officers roles has proven to be beneficial to the overall compliance situation. Figures have consistently improved since this appointment due to effective management of the Estates team:

- VCC Compliance - 94%
- Park Road Compliance - 93%
- WBS Compliance - 93%
- HQ - 80%
- Dafn Compliance - 100%
- Pembroke House Compliance - 90%

The roles will provide continued focus on compliance with a view to continually improving the team's approach and compliance figures.

Pseudomonas samples in January: x58 samples taken, x4 positive from last month ongoing resamples.

Legionella samples: x39 samples taken, x0 positives reported. Filters fitted to taps as a safety precaution and further samples taken for reassurance.

Staff training has been scheduled to capture the various competent person and authorised person obligations. This is assessed and delivered in line with recruitment.

Asbestos re-inspection has been undertaken and action plan is being developed for review. A number of recommendations have been completed in Zone 2 with plans to complete further works in Zone 14.

INFORM	**Health and Safety** Priorities for the coming period include: • Sharps Policy and VCC Needle Stick Injuries Procedure redrafted and consulted on • Review of Datix codes to enable production of H&S Incidents Dashboard • Development of a Trust wide Health and Safety Induction • Hot weather planning has begun to assess requirements for VCC ahead of the summer period • Development of Trust and Divisional Priority Improvement Plans **Fire Safety** Priorities for the coming period include: • Undertake validation of VCC fire alarm C&E – February to March 2023 • 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** Priorities for the coming period include: • Sustainability Strategy Key Measures of Success • Decarbonisation Plan implementation • Internet / Intranet – updated in line with the Travel Plan, Strategy, Green Social Prescribing, Biodiversity audit – the team are working on the new layout / presentation Biodiversity External Audit **Estates and Statutory Compliance** Priorities for the coming period include: • Closure of the CAFM role out • Ducting cleaning • BMS & energy management contract • Recruitment The team continue to support a number of schemes: • nVCC • IRS • RSU
APPENDICES	Not applicable.

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Medicines Management Group Report

DATE OF MEETING	16/03/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Bethan Tranter, Head of SACT and Medicines Management Usman Malik, Principal Pharmacist, Clinical Services
PRESENTED BY	Usman Malik, Principal Pharmacist, Clinical Services
DIRECTOR SPONSOR APPROVED	Dr Jacinta Abraham, Executive Medical Director

REPORT PURPOSE	FOR ASSURANCE

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME
EMB	02/03/2023	NOTED

ACRONYMS	
WG	Welsh Government
VCC	Velindre Cancer Centre
ePMA	Electronic Prescribing Medicines and Administration
BOPA	British Oncology Pharmacy Association
SACT	Systemic Anti-Cancer Therapy
ToR	Terms of Reference

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

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.

Historically this group have provided highlight reports to the Trust Quality Safety and Performance (QS&P) Committee. As requested by the Trust QS&P Committee, this is now being replaced with a 6 monthly assurance report. As this is the first of these assurance reports, there is more narrative included which can be streamlined for future editions.

2. ASSESSMENT/SUMMARY OF MATTERS

2.1 Strategy, Leadership and Governance

2.1.2 Plan

The Pharmacy and Medicines Management strategic document (2018 – 2023) will be refreshed during 2023 to ensure alignment with recent WG and Trust plans. The plan contained progress targets against 6 principles as 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 IT

Given the evolving nature of medicines management and the continual introduction of new medicines to market the work associated within each of the principles is ongoing with much embedded as business as usual. Implementation of e-PMA 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.

2.1.3 Regulatory and legislative compliance and good practice standards

VCC remains compliant across all 4 sub-criteria of the Health and Care Standards for medicines management, (2.6) namely

- Compliance with legislation,

- Fitness to practice,
- Access to information and medical advice, and
- Incident reporting and investigation

In line with accepted best practice standards in oncology, Pharmacy has also completed the implementation of BOPA verification standards for the clinical verification of SACT prescriptions and has led on the development of SST specific treatment algorithms. Pharmacists are also leading on the work to introduce routine Hepatitis B testing for patients pre-SACT initiation as per UK Chemotherapy Board guideline, which is anticipated to be completed by Q2 2023, all of which promote safe care.

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 (MaH) 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 MaH parenteral SACT daycase service which is delivered on a mobile unit based near Trust HQ. This service supports the strategic vision of providing care closer to home. This oversight and management includes procurement of the services, contract management and ensures that VCC maintains clinical oversight and responsibility for all prescriptions delivered within the service. There are approximately 1300 patients currently registered with VCC's MaH service with 600 patients receiving their medication each month through the team.

Service delivery performance is monitored via nationally agreed 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. An example summary report is included as Appendix 1. VCC finance team maintain close oversight of the financial savings generated by the MaH team to both VCC and it's HB partners. In both aspects, the service continues to perform well, with no concerns to note.

2.2.2 Horizon Scanning Group

The VCC Horizon Scanning Group for new drugs continues to systematically review all available information sources to determine which new SACT agents are likely to receive funding approval by the NHS in Wales over the forthcoming year. With this information, the lead pharmacist determines likely patient numbers, provides a high-level view of the impact on VCC services in terms of

additional patient numbers and determines the potential financial impact. This work also informs VCC discussions with its commissioners. Inclusion of new agents on this forecast facilitates subsequent funding approval for VCC to implement the drugs within the 60-day timeframe as stipulated under the WG New Treatment Fund guidance. VCC has implemented all 12 new agents/ indications as approved by NICE within this timeframe between April and December 2022. There are a further 12 new drugs/indications on the NICE workplan for 2023/2024. Safe and timely implementation of new drugs and SACT regimens is a key medicines management function which Pharmacy oversees and requires sustained resource input in order to ensure that the WG timeframes are met.

Impact on demand across VCC of these new agents is incorporated within the total projected SACT service demand increase of 12% (8% parenteral SACT, 4% oral SACT) for 2023/2024.

The Horizon Scanning Group has previously highlighted that there is potential for the scope of its work to broaden and include, e.g. new radiotherapy modalities. This is now acknowledged and the ToR of the group will be reviewed in 2023 by Cancer Services Management Office to capture the current needs of VCC. The group currently reports to MMG three times per year but this will be reviewed with revised ToR during 2023.

2.2.3 VCC Controlled Drugs Oversight Group

The VCC Controlled Drugs Oversight Group meets twice per year to ensure the safe use of Controlled Drugs across VCC. It ensures compliance with Controlled Drugs Regulations and NICE Guidance NG46. In its February 2023 meeting, revised ToR were agreed to re-align reporting of this group to MMG instead of VCC Trust Quality and Safety Group.

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. It also maintains oversight of ward stock checks undertaken by the Pharmacy Team. No concerns have been identified.

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 useful source for information

gathering and sharing and VCC's attendance ensures that it remains informed of local issues related to controlled drugs which may impact VCC.

It receives all incidents which involve Controlled Drugs via the Medication Safety Pharmacist and advises on the development or amendment of local SOPs accordingly.

Safe prescribing of CDs was included as a topic within November's Medication Safety Week with a filmed presentation delivered by the Palliative Care Pharmacist.

2.2.4 Medical Gases Group

The Medical Gases Group 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. In 2023, the group approved a revision to its ToR to re-align it's reporting to MMG instead of directly to VCC Quality and Safety Group. 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.

In 2022 the group updated the VCC Medical Gas Cylinder Policy and introduced a process for the electronic ordering of cylinders by clinical teams. No NHS Estates and Facilities Safety Notices were received in relation to medical gases and there was no patient safety alerts for medical gases of relevance to VCC.

Monthly site stock and expiry checks alongside the annual medical gas cylinder audit have taken place. No serious findings were identified with minor findings addressed at the time of audit or shortly afterwards.

Staff training in the safe use and handling of medical gases continues. Three of VCC's senior nursing team attained Designated Nursing Officer status for medical gases to enable safe site oversight.

A second manifold room for medical oxygen has been installed. This will improve resilience of the oxygen supply at VCC in case of future surges in demand or operational issues with the original piped stock holding.

2.2.5 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.

Throughout 2022, 48 IPFR requests have been reviewed by the VCC IPFR Advisory Group, of which VCC have funded 18 applications through the use of the discretionary budget, and 30 have been referred to the patient's health boards for their consideration.

Linked to the above, NHS Wales recently gained funding approval from the Once for Wales Interim Commissioning Group, for the provision of 2 specialist drugs for the treatment of immunotherapy related colitis. This work, undertaken between the Immuno Oncology team and pharmacy, is to be celebrated as it ensures equity of access across Wales for patients and enables VCC to deliver these treatments as opposed to having to request support from the patient's resident HB with associated potential time delays to treatment. Similarly, a VCC pharmacist and consultant were also instrumental in securing the availability of abiraterone for a specific cohort of prostate cancer patients via the same funding mechanism.

2.3 Medication Safety

The Medication Safety Group 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

In 2022 there were a total 206 medication related incidents reported.

- 178 are closed
- 4 are awaiting closure
- 14 new incidents
- 1 rejected – (repeat DATIX put in for the same incident)
- 9 under investigation

Medicine related incidents are included within VCC Q and S group Datix reporting agenda items and both the Medical Gas Group and VCC CD Accountability Oversight Group have "incidents" as a standing agenda item.

The group reviews the national Medication Safety Thermometer measures, which comprise of the proportion of inpatients who have their medication allergy status completed, Venous Thromboembolism (VTE) risk completed and medicines reconciliation completed on admission. Velindre perform well for all 3 measures, with no concerns to note.

2.3.1 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.

Over 2022, there have been 59 national drug recall alerts and 50 national drug shortage alerts, all of which were actioned within the required timeframes.

2.3.2 Patient Safety Notice (PSN)

Work has continued in all clinical areas throughout 2022 to ensure compliance with PSN 055 – 'Safe Storage of Medicines'.

Remaining areas of outstanding compliance required capital monies, which has been secured. Completion of these outstanding actions, led by colleagues from estates, is expected by end of March 2023 at which point VCC will be fully compliant with the notice.

2.4 Medicines expenditure

Expenditure against the various VCC drug budgets is monitored by the MMG. All expenditures are within approved budgetary limits and will remain so to the end of the financial year 2022/2023. VCC purchases all pharmaceuticals according to best practice through All Wales Drug Contracts and supports national best practice guidance in its proactive adoption of biosimilar and generic medicines at the earliest opportunity.

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.

2.5 Clinical Effectiveness

2.5.1 Management of Guidelines

The number of clinical guidelines has significantly increased over the past 2-3 years which is a reflection of the introduction of new indications and novel therapies. When a guideline has been approved, it is automatically given a 3-year review date (or sooner if there is a change in practice or clinical need). As there are now in excess of 100 guidelines on the intranet, an average of 35 guidelines will need to be reviewed each year.

During 2020 – 2021, upkeep of these guidelines was proving challenging, mainly due to staffing pressures and clinical staff having to prioritise front line services. As a result of this, 21 guidelines were reviewed in 2020, and 15 guidelines in 2021.

MMG recognised the challenges of maintaining the upkeep of all guidelines as the process requires an independent medical, nurse and pharmacist review. This is especially true as this role is not included within individual clinician's job plans. Thereafter, MMG has streamlined this review process, prioritising those clinical guidelines where there have been changes in practice or new treatment options identified. This new streamlined process has resulted in 43 clinical guidelines having a review undertaken during 2022.

There are currently 13 remaining guidelines that have passed their review date, but all are in the process of being reviewed by the various clinical staffing groups, of which one guidelines is being reviewed at a Wales Cancer Network (WCN) level. It is envisaged that the remaining 12 guidelines which fall within VCC's remit will be reviewed by Q2 2023. Timeframes for those undergoing WCN are not known at the time of writing this paper.

Given the volume and intensity of this work, dedicated capacity from pharmacy and Medical is being identified to ensure we can continue to meet our requirements for maintaining up to date clinical guidelines.

2.5.2 Unlicensed and Off-label use of medicines

MMG continue to review, approve and have clinical governance oversight of all unlicensed and 'off-label' medications. In 2022, there have been 14 medication requests that have fall under this category, all of which were clinically appropriate, and approved by MMG.

2.5.3 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. There are 4 measures in total; for 3 out of 4 of these measures VCC consistently performs above the All-Wales Average, for the 4th measure (indication for antimicrobial use to be documented on the drug treatment chart) performance can fluctuate but the indication is usually included in the medical notes. Performance of these measures is regularly fed back to junior medical staff (SHOs) and is highlighted within their induction. Thus, as individual junior medical staff rotation at VCC progresses performance in this area improves.

The VCC Advanced Oncology Pharmacist - Antimicrobials is changing roles within the organization in April 2023. Recruitment to replace this post is ongoing.

2.6 Pharmacy Service

2.6.1 Workforce

Pharmacy has recently undertaken a service review to determine if there are opportunities to increase its capacity. The remit of this review was to consider the total roles and responsibilities of the pharmacy and medicines management service and thus to include the portion of time each role should spend on clinical care and other specified supporting clinical activities, including those which add value to patients but may not be patient facing.

The senior pharmacy team are reviewing the data capture utilized to inform the tool and are in the process of updating the data inputs. Alongside the tool, there were a number of recommendations which the team have considered, most of which are accepted.

Early indication is that the tool will demonstrate a deficit within the pharmacy team resource and therefore the senior pharmacy team are considering workforce options that will efficiently help to mitigate this deficit. This will be presented to VCC Senior Leadership Team in March 2023.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
RELATED HEALTHCARE STANDARD	Safe Care
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
	Equitable provision of medicines and pharmaceutical advice is a core function of the pharmacy service

9

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

4. RECOMMENDATION

The Quality, Safety and Performance Committee are asked to **NOTE** the activity of the Medicines Management Group and endorse this assurance report.

Appendix 1 – Medicines Management Report March 2023.

Example of KPIs received for VCC Medicines @ Home Service

Meds@Home Oral SACT (LPCH) 2022

KPI Reference and Description		May 22	June 22	Jul 22
D1	Total number of patients registered for the homecare service.	1025	1081	1137
D7	Total number of prescriptions received during the reporting period	499	510	510
K3	Prescriptions received without correct clinical validation as % of total prescriptions received. KPI 3 = D9 / D7 x %	1.6%	2.7%	1.2%
K7	Failed deliveries as % of total number of deliveries. KPI 7 = D16 / D13 x %.	1.7%	1.6%	1.1%
K21	Formal C/Is opened as a % of the total number of active patients. KPI = D51 / D2 x %	0.0%	0.1%	0.0%
K24	Patient safety incidents as a % of active patients. KPI 24 = D57 / D2 x %	0.0%	0.1%	0.0%
K25	Total number of reported adverse drug reaction incidents as % of active patients. KPI 25 = D59/ D2 x %	0.0%	0.0%	0.0%
K26	Adverse drug event incidents as % of active patients. KPI 26 = D60 / D2 x %	0.0%	0.0%	0.0%
K27	Faulty medicinal product and device incident reports as % of active patients. KPI 27 = (D61+D62) / D2 x %	0.0%	0.0%	0.0%
K28	Safeguarding incidents as % of active patients. KPI 28= D63 / D2 x %	0.0%	0.0%	0.0%
K29	Information governance incidents as % of active patients. KPI 29 = D64 / D2 x %	0.0%	0.0%	0.0%

 The above KPIs are nationally agreed by the Welsh National Homecare Committee.

VCC Medicines @ Home Service reviews the KPIs on receipt and provides summary of points to note or consider to the MMG.

Please note K7 "Failed Deliveries" refers to deliveries that were made outside of the agreed time slot between the 3rd party provider and the patient. The patients still received their treatment.

MaH service feedback/analysis

K3

- Much improved position since last paper
- Ongoing mismatching quantities (particularly with regards to Prednisolone differing in duration to Abiraterone and differing doses of Prednisolone OD/BD).
- Fed back to pharmacists

K7

- 19 failed/late deliveries in total
- Improvement numbers from previous report (34)
- 9 due to patients not being available at pre-arranged delivery time
- 9 deliveries due LPCH service failure
- 1 delivery failures due to VCC

K21

- LPCH unable to contact patient after 3 attempts but did not inform VCC so Complaint raised

K24

- Same incident as K21

QUALITY, SAFETY & PERFORMANCE COMMITTEE

PATIENT NOSOCOMIAL COVID-19 UPDATE

DATE OF MEETING	16th March 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	N/A

PREPARED BY	Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience
PRESENTED BY	Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATES	OUTCOME
Executive Patient Nosocomial (COVID-19) Panel	13/10/2023 23/01/2023 10/02/2023	Cases discussed and next steps agreed
Executive Management Board	02/03/2023	NOTED

1. SITUATION

This paper is to provide the Quality, Safety & Performance Committee with progress in respect of patient nosocomial COVID-19 reviews prior to submission to the Quality, Safety & Performance Committee.

The Quality, Safety & Performance is Committee asked to **NOTE** the position in relation to patient nosocomial COVID-19 reviews.
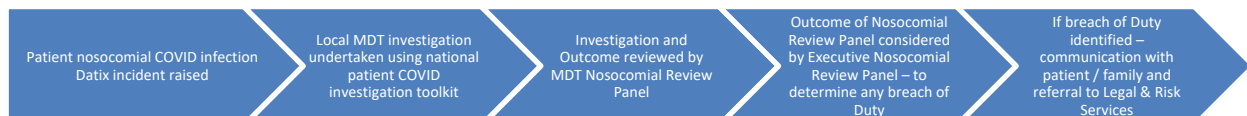
2. BACKGROUND

As previously reported, the Trust is part of the National Nosocomial Programme Board, and the Trust is implementing the national requirements in relation to patient Nosocomial COVID-19 reviews in line with the NHS Wales National Framework for the Management of Patient Safety Incidents following Nosocomial Transmission of COVID-19, published in March 2021.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Current position in relation to patient Nosocomial COVID-19 reviews:

As of 17th February 2023, there have been 48 potential incidences of patient nosocomial COVID-19 infection within Velindre Cancer Service. As reported previously, the numbers are continuing to slowly increase, and this is due to recent COVID-19 infection outbreaks on the First Floor Ward.

A Trust wide nosocomial investigation / review process continues in place.

Patient nosocomial COVID infection Datix incident raised → Local MDT investigation undertaken using national patient COVID investigation toolkit → Investigation and Outcome reviewed by MDT Nosocomial Review Panel → Outcome of Nosocomial Review Panel considered by Executive Nosocomial Review Panel – to determine any breach of Duty → If breach of Duty identified – communication with patient / family and referral to Legal & Risk Services

There were 27 cases up to 30th April 2022 and the remaining 21 cases (48 in total) between 1 May 2022 and 17th February 2023. The Peer Review Panel has held 11 meetings and the Executive Nosocomial Panel has met on 4 occasions.

Number of COVID-19 cases to be reviewed (as of 17/02/23)	Number of Completed Nosocomial investigation Toolkits	Number of cases reviewed and concluded by Scrutiny Panel	Number of cases reviewed and concluded by Executive Nosocomial Panel
48	48	36	19

A summary of the status of all patient COVID-19 nosocomial investigations, as of the 17th February 2023, is detailed below:

	No Harm	Low Harm	Moderate Harm	Severe Harm	Death	TOTAL
Indeterminate 3-7 days of admission	5	2	0	0	1	8
Probable 8-14 days of admission	2	0	0	0	0	2
Actual > 14 days of admission	5	2	1	0	1	9
TOTAL	12	4	1	0	2	19

As previously reported, the review by the Executive Nosocomial Panel has brought an added robustness and scrutiny to the process, and to agree the next steps in relation to each case, i.e. No further action or instigate patient / family contact and the Putting Things Right Procedures.

3.2 Patient / Family Contact

Patient and family contact will take place on a case-by-case basis. Each case will be reviewed by the Executive Nosocomial Panel, who will take a risk benefit approach (including considering the time that may have passed and/or the severity of the infection since acquiring a nosocomial COVID-19 infection at the Trust) into determining whether a patient or family member would be contacted regarding a nosocomial COVID-19 infection taking place at the Trust.

The patients / families of all cases of nosocomial COVID acquired in the last nine months have been contacted following discharge from the Trust. This has been well received.

The Executive Nosocomial Panel have agreed a process for patient and/or family contact following nosocomial COVID-19 infection. An initial telephone call would be made by the Deputy Director Nursing, AHP & Health Science and a follow up letter from the Executive Director Nursing, AHP & Health Science using agreed template will be sent within a few days.

3.3 Next Steps

The plan for the next steps is that all remaining cases (currently 48) to be reviewed by the Scrutiny Panel and the Executive Nosocomial Panel by the 24th March 2023.

In all likelihood, further nosocomial COVID-19 cases will continue to occur at the Trust, and these cases will be reviewed using similar methodology and process in the future.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Potential Quality & Safety implications/impact of patient safety, quality of patient experience and harm, including legal implications, on patients who acquired nosocomial COVID-19.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Potential legal implications of any patient who has suffered harm through nosocomial COVID-19.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)

	Potential financial implications, i.e. damages through legal implications of any patient who has suffered harm through nosocomial COVID-19.

5. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **NOTE** the position in relation to patient nosocomial COVID-19 reviews.

QUALITY, SAFETY & PERFORMANCE COMMITTEE

PATIENT AND DONOR EXPERIENCE INTERNAL AUDIT REPORT

DATE OF MEETING	16th March 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	N/A

PREPARED BY	Kyle Page, Business Support Officer
PRESENTED BY	Nicola Williams, Executive Director of Nursing, AHPs & Health Science
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, AHPs & Health Science

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME
EMB	2nd March 2023	NOTED

1. SITUATION

The paper is to provide the Quality, Safety & Performance Committee with an overview of the Internal audit findings and recommendations following the review of Patient and Donor Experience, conducted during Autumn 2022. The paper is provided for **ASSURANCE** purposes.

2. BACKGROUND

Velindre University NHS Trust is currently seeking to enhance collection and use of patient and donor experience feedback with a view to identifying and driving service improvements. This has, to date, been facilitated by a number of governance processes, reporting and scrutiny mechanisms and data capture technology. An Internal Audit review of Patient and Donor Experience was completed during Autumn 2022 in line with the 2022/2023 Internal Audit Plan.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Assurance Rating

The audit sought to provide the Trust with assurance over current patient and donor experience data capture processes and the effectiveness of the use of experience data in informing service improvement. The report and agreed management actions are attached in *Appendix 1*.

Overall, a '*Reasonable*' assurance rating was reported across all 4 objectives (Governance, Reporting, Technology and Service Improvement).

3.2 Risks

The following key risks were identified:

- Robust, Trust-wide governance framework may not be in place, resulting in poor or inappropriate service improvement decisions;
- Patient and Donor Experience reporting mechanisms not being used to their full potential;
- Incorrect investment in technology resulting in capture of data which does not improve the Patient and Donor Experience.

3.3 Recommendations

The following areas were identified where further work is required to ensure current mechanisms are effective and embedded across the Trust:

- Clarity of meeting structure for patient and donor experience reporting;
- Streamlining of experience reports;
- Ensure that Trust staff are sighted on experience feedback.

A Management Action Plan has been developed to address all 6 recommendations resulting from the review and it is expected that all actions will be delivered by the end of March 2023, with the exception of one, targeted for completion end of April 2023. It is anticipated that the Trust's newly formed Integrated Quality and Safety Group will provide oversight of experience monitoring and associated learning and service improvements at Trust level.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Poor Patient / Donor Experience resulting from the risks identified above (see 3.1)
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

5. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **NOTE** the findings of the Patient and Donor Experience Internal Audit Report (January 2023) and resulting Management Action Plan.

Patient and Donor Experience

Final Internal Audit Report

January 2023

Velindre University NHS Trust

Contents

Review reference:	VT-2223-11
Report status:	Final
Fieldwork commencement:	20th October 2022
Fieldwork completion:	23rd November 2022
Draft report issued:	7th December 2022
Management response received:	23rd December 2022
Final report issued:	4th January 2023
Auditors:	Simon Cookson, Director of Audit & Assurance
	Emma Rees, Deputy Head of Internal Audit
	Rhian Gard, Principal Auditor
Executive sign-off:	Nicola Williams, Director of Nursing, AHP's & Medical Scientists
Distribution:	Nigel Downes, Deputy Director of Nursing
	Viv Cooper, Head of Nursing (VCC)
	Zoe Gibson, Head of Nursing (WBS)
	Peter Richardson, Head of Quality Assurance (WBS)
Committee:	Audit Committee

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 & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - please note

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of NHS Wales Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Velindre University NHS Trust and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Executive Summary

Purpose

To review the Velindre University NHS Trust's (the Trust) processes for capturing patient and donor reported experience measures, and how data is used to effectively inform service improvement.

Overview

The Trust is on a journey to enhance its collection and use of patient and donor experience feedback to drive service improvement.

Our review identified that the Trust has patient and donor experience governance, reporting and scrutiny mechanisms in place, is using technology to capture feedback data, and is using this data to identify and implement service improvements.

We identified the following areas where further work is needed to ensure the mechanisms in place are robust and embedded throughout the Trust:

- improving clarity in the meeting structure for patient and donor experience reporting;
- streamlining experience reports; and
- enhancing communication of experience feedback to Trust staff.

All recommendations are detailed in Appendix A.

The Trust has identified that survey response rates for Velindre Cancer Centre are currently low. VCC could demonstrate that it is receiving and responding to other forms of patient feedback and is undertaking benchmarking on the response rates. We have identified good practice guidance to potentially improve response rates in Appendix B.

Report Classification

Reasonable	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.

Assurance summary[1]

Assurance objectives	Assurance
1 Governance	Reasonable
2 Reporting	Reasonable
3 Technology	Reasonable
4 Service Improvement	Reasonable

Key recommendations

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1.1	Clarifying the patient and donor experience meeting structure / reporting flow	1	Design	Medium
2.2	Streamlining experience reports	2	Design	Medium
3.1	Enhancing communication of experience feedback to Trust staff	4	Design	Medium

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[1] The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

1. Introduction

1.1 The review of Patient and Donor Experience was completed in line with the 2022/23 Internal Audit Plan. The review sought to provide Velindre University NHS Trust (the Trust) with assurance over the processes for capturing patient and donor reported experience and the effectiveness of the use of experience data in informing service improvement.

1.2 The Trust is on a journey to enhance patient and donor feedback and its use in driving service improvement. In recent years, it has tailored the NHS Wales Patient Reported Experience Measure (PREM) questionnaire to form the "Your Velindre Experience" survey and has also developed a friends and family survey. It recently started using CIVICA to capture experience data, providing a more efficient way for patients and donors to give feedback and allowing real-time monitoring of the data.

1.3 The Trust's Divisions should monitor experience metrics and implement service improvements through the quality and safety governance structures. As part of its remit, the newly formed Integrated Quality and Safety group (part of the Trust's new Quality and Safety Framework – inaugural meeting was in October 2022) will provide Trust-level oversight of experience monitoring and related learning and service improvement.

Associated risks

1.4 The key risk is that poor patient or donor experience resulting from:

- the Trust not having a robust governance framework in place resulting in poor service improvement decisions being made;
- patient and donor experience reporting mechanisms not being used to their full potential through the Trust; and
- incorrect investment in technology resulting in capturing data which does not improve the patient and donor experience.

2. Detailed Audit Findings

2.1 The table below summarises the recommendations raised by priority rating:

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	-	3	-	3
Operating Effectiveness	-	-	-	-
Total	-	3	-	3

2.2   Our detailed audit findings are set out below. All matters arising and the related recommendations and management actions are detailed in Appendix A.

Audit objective 1: Suitable patient and donor experience governance mechanisms are in place at all levels throughout the Trust

2.3   The Trust reports patient and donor experience to:

- the Board, Quality Safety & Performance Committee (QSPC) and Strategic Development Committee (SDC);

- Executive Management Board; and

- various operational and divisional forums (see audit objective 2).

2.4   Our testing on reporting is considered under audit objective 2.

2.5   We reviewed Board, QSPC and SDC papers for the previous 12 months, where we saw that patient and donor experience updates and escalation were evidenced when needed. This included the annual Patient & Donor Experience report, feedback performance in divisional performance reports and updates on the implementation of the All Wales CIVICA system.

2.6   Alongside reporting specifically relating to the patient and donor experience survey, we also saw that these meetings considered other patient and donor experience mechanisms (not within the scope of this review) to provide a more rounded view, including patient / donor stories, patient engagement and complaints / concerns.

2.7   The Trust's new Quality & Safety Framework (approved July 2022), which includes patient and donor experience, sets out the quality and safety assurance / meeting structure and the requirements for each meeting therein. From our work, we could see that there are patient and donor experience governance and scrutiny mechanisms within the Trust and that reporting on patient and donor experience is taking place.

2.8   However, we identified in our review of relevant meeting papers/ minutes (see audit objective 2) that, due to reporting taking place at many different forums and the volume of information reported, it was sometimes difficult to:

- see whether the patient and donor experience reporting / escalation routes ensure scrutiny and escalation is taking place at the appropriate forum; and

- follow the flow of reporting from floor to Board.

2.9   We also identified that:

- the Velindre Cancer Centre (VCC) forums had more specific patient experience objectives in their terms of references whereas Welsh Blood Service (WBS) forums had more governance focused objectives and were not specific to donor experience; and

- there was a lack of clarity in the flow of patient and donor experience reporting from 'floor to Board' amongst staff interviewed, including around the purpose of the experience reports at some forums.

2.10 We understand that, as part of the Quality & Safety Framework Implementation Plan, the Trust is reviewing its quality and safety governance and reporting mechanisms. This will include patient and donor experience. See matter arising 1 in Appendix A for recommendations to support this process.

2.11 We reviewed a sample of three job descriptions (two for VCC, one for WBS) for staff with specific patient and donor experience responsibilities. We could see the necessary objectives within the job descriptions.

2.12 We were informed that the VCC Quality & Safety team structure is under review and that the Patient Experience Manager post has been vacant since April 2022. The Trust is in the process of recruiting to this role.

Conclusion:

2.13 There are governance and scrutiny mechanisms within the Trust for patient and donor experience. However, as the Trust is aware, further work is required to ensure these mechanisms are streamlined, clearly defined and communicated. Therefore, we have provided **reasonable assurance** over this audit objective.

Audit objective 2: Robust patient and donor experience reporting mechanisms are in place at all levels of the Trust

2.14 From a comprehensive review of minutes from a selection of Trust forums (see figure 1 below), we saw evidence of scrutiny, reporting and discussions on patient and donor experience.

Trust-wide	VCC	WBS
Board	Senior Leadership Team	Senior Management Team
Quality Safety & Performance Committee	Quality Safety Management Group	Regulatory Assurance & Governance Group
Strategic Development Committee	Integrated Care Operational Group	Donor Governance Group
Executive Management Board		Operational Services Groups (Clinical Services and Collections)
Integrated Quality & Safety Group		

Figure 1: Forums reviewed during the audit

2.15 Our review of patient and donor experience reports highlighted that the information therein is comprehensive. However, we identified that:

- the reports often contained a high level of information which may or may not be needed by that forum; and

- there is some duplication in reporting to the various forums.

2.16 The volume of information reported could lead to key messages being missed.

2.17 In the new Performance Management Framework (PMF, subject to a separate 2022/23 internal audit), the Trust has a key performance indicator (KPI) and target for overarching patient / donor satisfaction which will be reported separately for each division.

2.18 As part of the Wales-wide vision for PREMS[2] (led by Welsh Government), development and roll out of national PREM sets (i.e., performance metrics) is scheduled to take place in Q2/3 of 2023/24. This will provide the Trust with a consistent mechanism to monitor patient and donor experience performance at all levels.

2.19 As the Executive Director of Nursing lead on this work, the Trust's Director of Nursing, AHPs and Health Scientists has offered to provide support in this development work and informed us that the Trust's experience reporting will be aligned to the national PREM sets once they are available.

2.20 As part of its work on the new PMF and on the Quality & Safety Framework Implementation Plan, we understand the Trust intends to review its quality metrics to ensure streamlined reporting at all levels of the Trust. See matter arising 2 for recommendations to support this process.

Conclusion:

2.21 Patient and donor experience is being reported throughout the Trust. However, further work is required to ensure the reporting is fully streamlined and effective. Therefore, we have provided **reasonable assurance** over this audit objective.

Audit objective 3: Efficient and effective use of technology to capture meaningful patient and donor experience data

2.22 The Trust uses electronic means to capture patient and donor experience feedback. Paper surveys were used prior to the pandemic but have now been phased out.

2.23 We understand there was an early challenge with accessing WIFI from the various devices used. However, we were informed this has now been resolved.

2.24 The Trust is moving to the All Wales CIVICA system to capture patient and donor experience feedback (see further details below). A CIVICA Project Board was established to oversee implementation of the system and to develop supporting mechanisms such the infrastructure for reporting and a Patient and Donor Experience Strategy.

2.25 CIVICA enables users to produce reports at the click of a button. Each team within the Trust will have access to produce reports and view real-time feedback for their service.

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[2] The vision is to "… triangulate reported experience with quality and safety intelligence to get a more rounded picture of services…' with the ability to '… benchmark services based on patient experience'. National Clinical Framework (Welsh Government) 2021

2.26 The Trust is reviewing the patient and donor experience survey questions as part of its move to CIVICA. As CIVICA is a new system, we understand that the questions will be kept under review to ensure the right data is being captured. We were informed that the Trust is also seeking feedback on the CIVICA system itself from staff and patients/donors.

Velindre Cancer Centre

2.27 In July 2021, the Trust began implementing CIVICA in VCC. All VCC teams are now using CIVICA for patient feedback.

2.28 Within the Cancer Centre, there are three fixed devices for patients to access CIVICA, supported by iPads where fixed devices were not appropriate.

2.29 To allow patients to use their own devices, QR codes linking to the survey are publicised in all areas and included in appointment letters.

2.30 The Trust has noted that patient response rates for VCC are low. We understand that it can be difficult due to the nature of the treatment being received by patients.

2.31 This has likely been exacerbated by the lack of a Patient Experience Manager in post (see paragraph 2.12) and due to the Trust not currently using volunteers due to the Covid-19 pandemic. Both would provide a more personal approach to requesting and supporting feedback, so could support an increase in the response rate.

2.32 Due to the low response rates, the Trust's Independent Members requested a benchmarking exercise be undertaken against response rates across other NHS Wales organisations. We were informed this exercise was in progress at the time of our audit.

2.33 We understand that there is constant dialogue between patients and staff within VCC, which helps to pick up informal feedback from patients. Staff highlighted several examples of informal feedback and action taken in recent months, including acting upon feedback received through the Dignity Forum. So, whilst response rates could be improved, we can see that VCC is also receiving and responding to other forms of patient feedback.

2.34 We have provided some guidance on improving survey response rates in Appendix B for the Trust's consideration.

Welsh Blood Service

2.35 Implementation of CIVICA in WBS commenced in August 2022 and was ongoing at the time of our review.

2.36 Per the implementation plan, most of the division will be using CIVICA by early 2023, with the only survey to be transferred at that point being the donor communications one which is currently on the SNAP platform.

2.37 WBS uses iPads to collect donor experience feedback at collection sessions. The donor communications survey is sent out via email from the SNAP platform one month after a donation.

2.38 Response rates for WBS have been good, with almost 4,500 responses being received on CIVICA between August and October 2022. We understand that WBS has received national recognition at the Once 4 Wales Programme Board for this.

Conclusion:

2.39 The Trust uses electronic means to capture patient and donor experience feedback and is in the final stages of implementing the All Wales CIVICA system to ensure consistency and efficiency in this process. Given the status of CIVICA implementation and the need to improve VCC survey response rates, we have provided **reasonable assurance** over this audit objective.

Audit objective 4: Effective use of patient and donor experience data to drive service improvement

2.40 Through review of meeting papers / minutes and discussions with relevant staff, we could see that patient and donor experience data is being used to drive service improvement. We also saw evidence that feedback data is being triangulated with other quality and safety mechanisms, such as clinical audit and concerns / complaints, to provide a more rounded view of experience and outcomes.

2.41 We were provided with evidence demonstrating examples of improvements that have been made based on feedback received.

2.42 There is a six-monthly Establishment Review (chaired by the Director of Nursing, AHPs & Health Scientists) which brings together key staff from across the Trust. The meetings cover operational matters, including sharing learning from concerns and patient/donor feedback. CIVICA responses are also discussed at this meeting.

2.43 As part of its Quality & Safety Framework Implementation Plan, the Trust will implement Quality & Safety Hubs (Corporate, VCC and WBS) to oversee quality and safety matters. Additionally, the Trust is looking to have Patient / Donor Experience Champions in each area to drive local ownership. These planned mechanisms should further support the use of experience data in service improvement.

Communicating feedback and action taken

2.44 The Trust uses a "you said, we did" approach to communicating its response to feedback. This is incorporated into reporting within the Trust and is fed back to patients / donors via "you said, we did" boards.

2.45 Our discussions with key staff during the audit highlighted that, whilst upwards reporting within the Trust and feedback to patients is taking place, there is a need to strengthen patient and donor feedback to staff to fully ensure the process is embedded and service improvements are effectively implemented. See matter arising 3 in Appendix A.

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Benchmarking and sharing good practice with other organisations

2.46 Due to the relatively unique nature of the Trust, benchmarking performance / sharing good practice with other organisations can be challenging. However, we were informed that the divisions undertake this where they can. For example, we understand that:

- the Trust engages with the NHS Wales Safety Learning Network, which we understand has incorporated good practice in terms of patient and donor experience alongside learning and service improvement;

- VCC shares learning and best practice with the Clatterbridge Cancer Centre (Liverpool) in terms of immunotherapy services, policies, etc; and

- WBS benchmarks against service improvement with blood services across the UK and work upon UK-wide improvement programmes.

Conclusion:

2.47 We saw evidence that patient and donor experience data is being used in service improvement. We identified a medium priority finding to support strengthening this process and note that the Trust is also taking action to set up Quality & Safety Hubs and use Patient / Donor Experience Champions. Therefore, we have provided **reasonable assurance** over this audit objective.

Appendix A: Management Action Plan

Matter arising 1: Meeting Structure	Impact
We identified, through our review of relevant meeting papers / minutes, that due to reporting taking place at many different forums and the volume of information reported it was sometimes difficult to: • see whether the patient and donor experience reporting / escalation routes ensure that scrutiny and escalation is taking place at the appropriate forum; and • follow the flow of reporting from floor to Board. We also found that further clarity is needed in the purpose of patient and donor experience at some forums (see paragraph 2.9 for further details).	Potential risk of: • inefficiencies in reporting or key messages being missed; • issues not being appropriately escalated; and • poor patient / donor experience due to feedback not being acted upon.

Recommendations	Priority
1.1 As part of the review of quality and safety governance and reporting mechanisms, the Trust should: a. review the flow of patient and donor experience reporting 'from floor to Board' to ensure it is clear and efficient, avoiding unnecessary duplication; b. update relevant meeting terms of reference to ensure clarity over the purpose of patient and donor experience reporting at each forum; and c. 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 (Design)

Management response		Target Date	Responsible Officer
1.1	a. A patient / Donor experience feedback procedure to be developed and published on intranet identifying reporting flow service level to Board.	31/03/2023	Deputy Director Nursing, Quality & Patient Experience
	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.	31/03/2023	Divisional Director WBS & VCC
	c. See 1.1 a		

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Matter arising 2: Experience Feedback Reporting	Impact
We identified that: • patient and donor experience reports often contained a high level of information which may or may not be needed by that forum; and • there is some duplication in reporting to the various forums.	Potential risk of: • inefficiencies in reporting; • key messages being missed; • issues not being appropriately escalated; and • poor patient / donor experience due to feedback not being acted upon.

Recommendations	Priority
2.1 As part of the intended review of quality metrics and reporting, the Trust should: a. Review the patient and donor experience information required to achieve the objectives of each forum and tailor the reports as appropriate; and b. Ensure that reports contain succinct, concise executive summaries that clearly highlight key messages.	Medium (Design)

Management response	Target Date	Responsible Officer
2.1 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.	31/03/2023	Head of Nursing Professional Standards & Digital & Deputy Director Nursing, Quality & Patient Experience
All BI dashboards to include CIVICA patient / donor experience outcomes from service level to Board	30/04/2023	Head of Information
b. As outlined in 2.1.a		

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Matter arising 3: Feedback to Staff	Impact
Our discussions with key staff during the audit highlighted that, whilst upwards reporting within the Trust and feedback to patients / donors is taking place, there is a need to strengthen patient and donor feedback to staff to fully ensure the process is embedded and service improvements are effectively implemented.	Potential risk of poor patient / donor experience due to feedback not being acted upon.

Recommendations	Priority
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 (Design)

Management response		Target Date	Responsible Officer
3.1	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.	31/03/2023	Deputy Director Nursing, Quality & Patient Experience

Appendix B: Improving Survey Response Rates

Considerations[3] to support improved response rates

- Use of social media channels, emails or SMS / text messages to promote surveys

- Consideration of completion rate (i.e., how many people completed the survey after starting it) alongside response rate – completion rate is a useful metric to help identify whether the survey is easy to complete and whether there are any barriers to completion

- Considering factors that affect survey completion / response rates, including:

  – survey content: question wording, question type, survey flow, survey length, etc

  – survey invitation wording: e.g., on the appointment letter or advertising posters:

    ▪ use of positive labels (e.g., helpful, kind, generous) in communications about surveys which helps respondents to identify with the behaviour and act accordingly

    ▪ use of enticing language, e.g., 'Want to help us improve our services? Tell us about your experience at [survey link]' or 'share your experience with us at [survey link]'

  – respondent motivation: whether the survey appeals to patients / donors, e.g.:

    ▪ framing the survey in line with patient / donor values to encourage responses

    ▪ further increasing awareness of the impact of survey responses so respondents know that feedback is acted upon

- Encouraging survey completion at the point of treatment / donation – this helps to increase response rates and provide a more accurate reflection of experience than surveys completed later

- Informing respondents upfront how long the survey will take;

- Giving respondents a clear idea of how much of the survey is left – using cues such as 'nearly there' or 'just a few more question to go' tends to be more effective than a progress bar;

- Reassuring respondents about confidentiality and data privacy

Target response rates

There is no set level that defines a 'good' survey response rate. However, the consensus from our review of good practice guidelines is that a response rate of 10-30% is considered good and above 50% is considered excellent. Response rates of less than 10% are considered low.

It is also important to consider the number of responses alongside the response rate. The smaller the number of responses, the higher the chances of bias in the survey results and the more challenging it is to undertake effective analysis.

Survey fatigue

Anecdotal evidence suggests there has been an increased number of online surveys due to the Covid-19 pandemic, both in and out of the workplace. The Trust should be mindful that patients / donors may be suffering from survey fatigue, i.e., a lack or loss of interest in completing surveys. This could impact the response rate and quality of feedback provided. A Userpilot article on survey fatigue quotes survey analysis by CustomerThermometer (provider of customer feedback solutions), which shows that only 9% of

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[3] Source: Qualtrics (experience management company), Smart Survey (digital survey solution), Userpilot (product growth platform)

respondents complete long questionnaires and that 67% of respondents report having abandoned an ongoing survey due to survey fatigue.

Pre-response fatigue discourages potential respondents from taking the survey. This can be avoided through:

- not over-surveying patients / donors;
- keeping surveys short –; and
- providing an estimated completion time.

Mid-survey fatigue causes respondents to leave surveys incomplete. This risk may be reduced by:

- using direct questions;
- asking one question at a time;
- limiting the number of free text responses;
- using consistent response scales; and
- not asking repetitive questions.

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Appendix C: 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.

19/20

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QUALITY, SAFETY & PERFORMANCE COMMITTEE

CLINICAL AUDIT INTERNAL AUDIT REPORT

DATE OF MEETING	16/03/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Sara Walters, Clinical Audit Manager
PRESENTED BY	Jacinta Abraham, Executive Medical Director
EXECUTIVE SPONSOR APPROVED	Jacinta Abraham, Executive Medical Director

REPORT PURPOSE	FOR DISCUSSION / REVIEW

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME
VCCQSMG	16/02/2023	NOTED

1. **SITUATION**

The paper is to provide the Quality, Safety & Performance Committee with an overview of the Internal audit findings and recommendations following the review of clinical audit, conducted during December 2022, in line with internal audit requirements. The paper is provided for **ASSURANCE** purposes.

2. BACKGROUND

Velindre University NHS Trust has developed its clinical audit activities, moving towards a Trust-wide approach.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1.1 Assurance Rating

The audit sought to provide the Trust with assurance that Velindre University NHS Trust has effective processes in place to embed a culture of clinical audit best practice and continuous quality improvement in all services. The report and agreed management actions are attached in **Appendix 1.**

Overall, a '**Reasonable'** assurance rating was reported across all 5 objectives (Strategy, Plans, action plans, monitoring and learning)

3.2 Risks

The key risk considered during this review was poor patient / donor experience or patient / donor harm resulting from:

- poor clinical audit governance and failure to act on the results of clinical audit;
- lack of robust clinical audit planning leading to inability to identify areas where practice needs to be improved; and
- inability to identify and mitigate some areas of clinical risk.

3.3 Overview

The Trust has an approved clinical audit approach. The Trust-wide Clinical Audit Plan incorporates national clinical audits and the local clinical audit programmes for each division. Mechanisms are in place within Velindre Cancer Centre (VCC) to monitor progress against its local Clinical Audit Programme, and implementation of actions, and to disseminate learning. Three medium priority recommendations were identified to enhance these mechanisms.

3.4 Recommendations

The following areas were identified where further work is required to ensure current mechanisms are effective and embedded across the Trust:

- Clinical Audit Actions
- Clinical Audit Best Practice
- Centralised Clinical Audit Function

- Robustness of SST Minutes
- Clinical Audit Reporting and Oversight Mechanisms

A Management Action Plan has been developed to address all recommendations resulting from the review and it is expected that all actions will be delivered by the end of July 2023.

It is anticipated that the Trust's newly formed Integrated Quality and Safety Group will provide oversight of experience monitoring and associated learning and service improvements at Trust level.

4 IMPACT ASSESSMENT

QUALITY AND SAFET IMPLICATIONS/IMPACT	Yes (Please see detail below)
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please l below:
EQUALITY IMPACT ASSESSMEN COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to th activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of th activity outlined in this report.

5 RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **NOTE** the findings of the Clinical Audit Internal Audit Report (January 2023) and resulting Management Action Plan.

Clinical Audit (Velindre Cancer Centre)

Final Internal Audit Report

January 2023

Velindre University NHS Trust

Contents

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Debrief meeting:	6th December 2022
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Auditors:	Simon Cookson, Director of Audit & Assurance
	Emma Rees, Deputy Head of Internal Audit
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Executive sign-off:	Jacinta Abraham, Medical Director
Distribution:	Nicola Hughes, Acting Medical Directorate Manager
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	Catherine Pembroke, Oncology Consultant (Medical Clinical Audit Lead)
	Zoe Gibson, Head of Nursing, Welsh Blood Service
	Peter Richardson, Head of Quality Assurance, Welsh Blood Service
	Dr. Edwin Massey, Deputy Medical Director, Welsh Blood Service
	Nicola Williams, Director of Nursing
Committee:	Audit Committee
	Quality, Safety & Performance Committee

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 & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - please note

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Executive Summary

Purpose

To provide assurance that Velindre University NHS Trust (the Trust) has effective processes in place to embed a culture of clinical audit best practice and continuous quality improvement in all services.

Overview

The Trust has an approved clinical audit approach. The Trust-wide Clinical Audit Plan incorporates national clinical audits and the local clinical audit programmes for each division.

Mechanisms are in place within Velindre Cancer Centre[1] (VCC) to monitor progress against its local Clinical Audit Programme, and implementation of actions, and to disseminate learning. We identified three medium priority recommendations to enhance these mechanisms.

Other recommendations / advisory points are detailed within section 2.

Report Classification

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[2]

Assurance objectives	Assurance
1 Clinical Audit Strategy / approach	Reasonable
2 Clinical Audit Plan[1]	Reasonable
3 Clinical audit action plans[1]	Reasonable
4 Clinical audit action monitoring, implementation and benefits realisation[1]	Reasonable
5 Learning from clinical audit and triangulation with other quality governance mechanisms[1]	Reasonable

Key recommendations

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1.1	Developing SMART clinical audit actions	3	Operation	Medium
1.2	Independent verification of action implementation	4	Design	Medium
4.1	Ensuring robustness of SST meeting minutes	2,4,5	Operation	Medium

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[1] Due to the limitation of scope identified in paragraph 1.5, our work under these objectives focused on clinical audit within VCC only. We were unable to undertake detailed testing on Welsh Blood Service (WBS) clinical audit activities.

[2] The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

1. Introduction

1.1 A review of Clinical Audit was completed in line with the 2022/23 internal audit plan. The review sought to provide Velindre University NHS Trust (the Trust) with assurance that there are effective processes in place to manage local and national clinical audit plans.

1.2 Over the previous few years, the Trust has developed its clinical audit activities, moving towards a Trust-wide approach. The annual Clinical Audit Plan was disrupted during the Covid-19 pandemic to release clinical time to focus on care / treatment delivery and to allow for a Covid-focused clinical audit programme to be undertaken.

Associated risks

1.3 The key risk considered during this review was poor patient / donor experience or patient / donor harm resulting from:

- poor clinical audit governance and failure to act on the results of clinical audit;
- lack of robust clinical audit planning leading to inability to identify areas where practice needs to be improved; and
- inability to identify and mitigate some areas of clinical risk.

Limitations of scope

1.4 The WBS quality management system, as set out in its Quality Manual and supporting documents (i.e., non-clinical audit assurance mechanisms) was not in scope for this review.

1.5 Additionally, due to unplanned absence during the audit (see paragraph 2.44), we were unable to undertake the planned testing of clinical audit processes within WBS. The Division forms a small part of the Trust's overall clinical audit activities and has only recently started completing clinical audits. Therefore, the WBS function / activities are still in the early stages of development. We were able to obtain an overview of the Division's governance structures before the absence. This is detailed in paragraph 2.44.

1.6 We recommend that the Trust considers the findings of this review for application within WBS to ensure consistency between the divisions.

2.   Detailed Audit Findings

2.1   The table below summarises the recommendations raised by priority rating:

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	-	1	3	4
Operating Effectiveness	-	2	-	2
Total	-	3	3	6

2.2   Our detailed audit findings are set out below. All matters arising and the related recommendations and management actions are detailed in Appendix A.

Audit objective 1: There is an approved clinical audit strategy / approach and clinical risk register in place

2.3   The clinical audit approach is documented within the Trust Clinical Audit Plan (the Plan, see audit objective 2).

2.4   Clinical risks are included on the Trust's Risk Register. Review of the register confirmed clinical risks were present and we identified instances where clinical audit was specifically mentioned to be used to help mitigate certain risks.

Best practice

2.5   We were informed that the Plan is developed using the Healthcare Quality Improvement Partnership's (HQIP) best practice guidance, 'Clinical Audit: A simple guide for NHS Boards & Partners'.

2.6   We undertook a high-level review of the Trust's clinical audit approach (design only) against this best practice guidance. The results are summarised below in figure 1, with further detail set out in Appendix B.

2.7   Except for the need to ensure clinical audit actions are SMART (**matter arising 1**[3]), no significant matters were identified in this review. The Trust's Quality & Safety Framework Improvement Plan will likely address most of the areas where the Trust is not yet fully following best practice. **Matter arising 2**.

2.8   In short, whilst the Trust is still on a journey to have fully robust clinical audit activities, it is making good strides and can have assurance that it is on the right path.

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[3] This matter arising does not impact the assurance rating for audit objective 1. Its impact is considered in audit objective 3.

Figure 1: Comparison of the Trust's clinical audit approach against HQIP best practice

Best practice	Status	Best practice	Status
Clinical audit as a broader quality improvement tool	T	Agreeing what constitutes unacceptable variation in results compared to evidence-based standards, etc	
Considering the full range of quality improvement tools for appropriateness	V	Clinical audits cross care boundaries and encompass the whole patient pathway	V
Strategy includes national and local priorities and resource requirements	T	Clear strategy for patient and stakeholder engagement throughout the clinical audit cycle.	V
Consideration of timescales and resources for each clinical audit	V	Sharing clinical audit results with other providers, commissioners, regional networks, etc	V
Rolling clinical audit programme focused on outcome improvements	V	Education and training in clinical audit beyond the clinical audit team	

Status key:

	Approach in line with best practice		Approach partly in line with best practice		Approach not in line with best practice		Out of scope, no review undertaken
T	Whole Trust consideration	V	VCC consideration only due to limitation of scope (paragraph 1.5)				

Clinical audit function

2.9　The Trust's Medical Director is responsible for clinical audit. Within VCC, clinical audit is within the remit of the Medical Directorate. This is consistent with other NHS Wales organisations where we have recently undertaken clinical audit reviews.

2.10　All staff interviewed during our internal audit were content with the current structure for clinical audit within VCC.

2.11　The Trust does not currently have a centralised clinical audit team, so there is a potential risk of inconsistency in approach and inefficient or ineffective triangulation of clinical audit findings. Additionally, there has been resource challenges within the divisional clinical audit teams (paragraphs 2.27-2.28, 2.32, 2.40 and 2.44), highlighting the need for a more resilient approach. The Trust is taking action to address this. **Matter arising 3**.

Conclusion:

2.12　The Trust has a clinical audit approach and clinical risks are managed through the Trust Risk Register. We identified two low priority recommendations relating to best practice and considering a centralised clinical audit team. Therefore, we have provided **reasonable assurance** over this audit objective.

Audit objective 2: An annual clinical audit plan is developed, approved and monitored by appropriate forums. The plan includes applicable audits from the NHS Wales National Clinical Audit and Outcome Review Plan, particularly National Cancer Audits Error! Bookmark not defined.

Development and approval of the Clinical Audit Plan

2.13　The VCC Clinical Audit Programme (the Programme) is predominantly made up of key indicators of practice, NICE guidelines, patient experience, local concerns and

national audits. It is developed in collaboration with the VCC Site Specific Teams (SSTs), directorates and the Division's Quality & Safety Team.

2.14 The Division's Clinical Audit Manager keeps the Programme under continuous review. It is a live document which can be added to throughout the year. Where audits are not concluded at year end, these are rolled over to the next year's Programme.

2.15 The SSTs must complete a proposal form prior to the audit commencing. This form must be authorised by the clinical lead and director. This form outlines considerations including the audit scope, resources, timescales and reason for the audit. We have identified best practice which could enhance this process. **Matter arising 2**.

2.16 Relevant sections of the Programme are discussed and agreed by each SST.

2.17 Directorates receive the final Programme. The VCC Quality and Safety Management Group (QSMG) approves the Programme, which is then sent to the Division's Senior Leadership Team (SLT) for noting.

2.18 The VCC Programme is combined with the WBS Programme to form the annual Trust Clinical Audit Plan.

2.19 The overarching Trust Plan is approved by the Public Quality, Safety & Performance Committee (QSPC). The 2022/23 Plan was approved in July 2022.

National clinical audit

2.20 VCC participates in all appropriate national audits within the NHS Wales National Clinical Audit and Outcome Review Plan.

2.21 The Wales Cancer Network (WCN) is responsible for completing national cancer audits. VCC contributes data for the national audits via the WCN as required.

2.22 We were informed by the Medical Director that she had not been notified of any VCC specific improvements resulting from the national cancer audits, but that she would be informed by email from the WCN should any arise.

Monitoring progress against the VCC Clinical Audit Programme

2.23 The Clinical Audit Manager has a standing agenda item on each monthly SST meeting in which progress against the Division's Programme for that area should be discussed.

2.24 However, our review of a sample of SST minutes highlighted that there is variation in whether the minutes robustly evidence these discussions. **Matter arising 4**.

Conclusion:

2.25 The Trust has an approved, Trust-wide Clinical Audit Plan and VCC participates in the national cancer audits. We identified a medium priority recommendation relating to the robustness of SST minutes and a low priority finding relating to best practice. Therefore, we have provided **reasonable assurance** over this audit objective.

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Audit objective 3: SMART action / improvement plans are developed in response to clinical audits undertaken^{Error! Bookmark not defined.}

2.26 The VCC Clinical Audit Manager maintains a combined action plan (spreadsheet) for all SSTs that identifies actions arising from clinical audits. The action plan is monitored by the Division's Clinical Audit Team, and the team consists of two full time and two part time members of staff.

2.27 Due to sickness absence within the VCC Clinical Audit Team, the Clinical Audit Manager has been unable to keep the action plan up to date.

2.28 The VCC Acting Medical Directorate Manager informed us that the Team is now fully resourced, and that the Division will be shortly addressing areas impacted by the sickness absence. **Matter arising 3**.

2.29 Through review of the VCC clinical audit action plan, we identified that the actions are often not SMART, but instead are more of a commentary of what happened during the audit. **Matter arising 1.**

2.30 We understand that the implementation of AMaT (see paragraph 2.38) will assist in resolving the above two points, as Clinical Leads will be responsible for inputting and updating clinical audit actions, and the system templates / fields will support standardisation of actions in a SMART format.

Conclusion:

2.31 We have raised a medium priority recommendation around timely updates to the action plan with SMART objectives and a low priority recommendation relating to potential enhancements to resource for clinical audit. Therefore, we have given this area **reasonable assurance**.

Audit objective 4: Results of clinical audits undertaken (including action / improvement plans) are reported to appropriate forums. Actions are monitored to ensure implementation and benefit realisation^{Error! Bookmark not defined.}

Reporting results and monitoring action implementation

2.32 Each VCC clinical audit has a Clinical Lead. A member of the Division's Clinical Audit Team should periodically follow up on clinical audit results / outcomes with the relevant Clinical Lead and via SST meetings. However, due to sickness absence within the Division's Clinical Audit Team, the Clinical Audit Manager attends all monthly SST meetings but further follow up is limited. **Matters arising 1 and 3**.

2.33 Within the clinical audit standing agenda item on each monthly SST meeting, completed clinical audits should be discussed, alongside monitoring the implementation of clinical audit actions. However, our review of a sample of SST minutes highlighted that there is variation in whether the minutes robustly evidence these discussions. **Matter arising 4**.

Oversight of actions arising from cross-SST clinical audits

2.34 Currently there is no designated forum that provides overarching oversight of actions resulting from clinical audits that span multiple SST's. We were informed that this will be reviewed in line with the quality hub structure.

2.35 This is an issue the Division has already identified and flagged with the VCC SLT. We understand this matter has been passed to the Trust's Interim Clinical Transformation Lead for further consideration.

2.36 We were also informed that clinical audit governance and reporting mechanisms are being considered as part of the Trust's wider review of quality and safety governance and reporting within the Quality & Safety Implementation Plan. We understand that there is representation from clinical audit in the newly formed Trust Integrated Quality & Safety Group, which is responsible for this process. **Matter arising 5**.

Independent verification of action implementation and benefit realisation

2.37 The action plan does not identify audits that require re-auditing, e.g., because of identified poor performance, although we note that the VCC Programme includes and identifies re-audits. There is also no process to independently verify that actions have been implemented and benefits have been realised where re-audits are not planned. **Matter arising 1**.

Clinical audit management and tracking software

2.38 The Trust has procured AMaT, a web-based Audit Management and Tracking tool. AMaT provides control over audit activity and gives real-time insight and reporting for clinicians, wards, audit departments and healthcare trusts. AMaT is currently being piloted within VCC and has been funded for a two-year trial period. It is being reviewed by the VCC Senior Leadership Team to ensure value for money is being achieved prior to further roll-out.

Conclusion:

2.39 Whilst mechanisms for monitoring action implementation / benefit realisation exist, we identified three medium priority recommendations concerning verification of implementation, the robustness of SST minutes and oversight for cross-SST clinical audits. We also identified one low priority recommendation. Therefore, we have provided **reasonable assurance** over this audit objective.

Audit objective 5: Learning from clinical audit is disseminated across the Trust and triangulated with learning other quality governance mechanisms as appropriate Error! Bookmark not defined.

2.40 Learning from clinical audit is distributed across VCC in several ways:

1. SST meetings: Within the clinical audit standing agenda item on each monthly SST meeting, learning should be discussed. However, our review of a sample

of SST minutes highlighted that there is variation in whether the minutes robustly evidence these discussions. **Matter arising 4**.

2. Virtual clinical audit event: Virtual events have been developed and replace the clinical effectiveness presentation events that were halted due to Covid. These virtual events provide SSTs with the opportunity to present results from clinical audits and discuss lessons learnt. Two events took place last year to present results from the SSC projects and the team are working to establish a bi-annual quality learning event in addition to the SSC presentations. **Matter arising 3**.

3. Clinical Audit Highlight reports: The VCC QSMG receives these reports which include feedback from audits and key issues identified.

2.41 The Trust is developing Quality Hubs (Trust-wide and divisional) as part of its new Quality & Safety Framework. The plan is that this will support improved triangulation of all quality improvement and assurance activities by formalising the process and providing a forum for triangulation to take place.

2.42 During our fieldwork for the 2022/23 Patient & Donor Experience internal audit (ref 2223-11), we saw evidence that clinical audit is being informally triangulated with other quality and safety mechanisms, such as patient / donor experience and concerns / complaints.

Conclusion:

2.43 The Trust has several channels to disseminate lessons learnt. Planned development of the Trust's quality governance mechanisms will further enhance this and triangulation with other quality governance mechanisms. We have raised one medium priority recommendation concerning the robustness of SST minutes and one low priority recommendation. Therefore, we have provided **reasonable assurance** over this audit objective.

Welsh Blood Service

2.44 In depth testing within this area was not completed due to unplanned sickness absence in the WBS clinical audit team (the role is undertaken by a senior nurse as a small part of a broader operational role) during our fieldwork. The Trust had recognised this single point of failure prior to our internal audit review and had very recently taken action to improve resilience; the Deputy Medical Director for WBS will oversee the Division's clinical audit activities going forward. **Matter arising 3**.

2.45 Whilst we were unable to undertake in-depth testing at WBS in line with the agreed internal audit scope, we were able to identify that:

- the Division has an annual Clinical Audit Programme which is included within the overall annual Trust Plan; and

- per the approach documented in the Trust Plan, progress on the WBS Programme should be discussed at the Division's Regulatory Assurance

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Governance Group (RAGG); however, we found that there is minimal evidence of this taking place. **Matter arising 5**.

Conclusion:

2.46 Given the given the limitations to the testing we were able to undertake in this area, we have not provided an assurance rating.

Appendix A: Management Action Plan

Matter arising 1: Clinical Audit Actions	Impact
Action plan: Due to sickness absence, the VCC Clinical Audit Manager has been unable to update the clinical audit action plan in a timely manner. The action plan was not up to date at the time of our audit. **SMART actions:** We identified that actions arising from clinical audits are often not SMART, but instead are more of a commentary of what happened during the audit. **Informal follow up on actions:** Due to sickness absence, the Clinical Audit Manager attends all monthly SST meetings but further follow up is limited. **Formal follow up on actions:** Currently the action plan does not identify audits that require re-auditing, although we note that the Clinical Audit Plan includes and identifies re-audits. There is also no process to independently verify that actions have been implemented and benefits have been realised where re-audits are not planned.	Potential risk of: • actions not achievable, effective or implemented; and • poor patient / donor experience or patient / donor harm.

Recommendations	Priority

1.1   a.   The clinical audit action plan should be updated in a timely manner. We understand the implementation of AMaT will support this, as the Clinical Leads will be responsible for inputting and updating action plans.
 	
      b.   Where clinical audits lead to clear actions, Clinical Leads should ensure actions noted within the clinical audit action plan are SMART. The use of AMaT will provide the foundation for standardisation and should assist with creating SMART actions. The Clinical Audit Team should undertake spot checks on the actions to verify this.
 	
      c.   Guidance and training on developing SMART actions should be provided to Clinical Leads.
	Medium (Operation)

1.2 a. The clinical audit action plan should identify whether a re-audit is required, along with the reason and timescales therefor. b. The Trust should develop a process for independently verifying implementation of actions and benefits realisation where re-audit is not planned. This could be undertaken on a spot-check / sample basis and could be done by the Clinical Audit Team or, to create resilience, by a clinician who was not involved in the original audit.	Medium (Design)

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Management response	Target Date	Responsible Officer
1.1 A. The Clinical Audit Team is currently piloting AMaT with the anticipation to roll the system out across all audits in the team. A review of audit systems in the organisation is being undertaken to ensure no duplication of systems and explore how AMaT can support other areas of the Trust.	June 2023	Medical Directorate Manager
B. Once the SMART action guide (see 1.1c below) has been produced, the Clinical Audit Team will undertake spot checks on actions to ensure they are SMART.	April 2023	Clinical Audit Manager
C. Produce a SMART action training guide for all audit leads to follow.	April 2023	Clinical Audit Manager
1.2 A. Where re-audit is required, this is included in the action plan, a section will be added to document the reason for re-audit. Timescales are usually recorded. Not all audits require re-audit this is identified via the recommendation or documented on the proforma. Ensure where re-audits are required that all documentation reflects this clearly.	March 2023	Clinical Audit Manager
B. Formalise the current process to evidence actions and benefits have been undertaken or realised.	June 2023	Clinical Audit Manager

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Matter arising 2: Clinical Audit Best Practice	Impact
Our review of HQIP best practice for clinical audit identified several areas where the Trust could enhance its clinical audit activities. We have outlined below those not raised via other matters arising in this report: • using clinical audit in strategic management as part of the broader quality improvement programme; • only choosing clinical audit when it is the best methodology to assess the issue at hand; • consider local clinical audits (i.e., beyond the National Cancer Audits) that cross organisational boundaries and encompass the whole patient pathway; and • engaging patients, donors & stakeholders throughout the full clinical audit cycle, including annual planning and audit fieldwork. The following best practice areas were out of scope for this review, but are included here for completeness: • agreeing what constitutes unacceptable variation in clinical audit results compared to available best practice; and • providing education and training in clinical audit beyond the clinical audit team, inclusion of clinical audit in objectives and appraisals. Further details are included in Appendix B.	Potential risk of: • inability to maximise the effectiveness of clinical audit activities; and • ineffective clinical audit activity that does not provide value for money.

Recommendations	Priority
2.1 The Trust should consider the above points and the wider HQIP clinical audit best practice guidance as it continues to develop its clinical audit activities, and reviews quality governance mechanisms as part of the Quality & Safety Framework Implementation Plan.	Low (Design)

Management response	Target Date	Responsible Officer
2.1 All best practice identified in this report to be reviewed and applied where possible to improve the effectiveness of clinical audits.	July 2023	Medical Clinical Audit Lead (Oncology Consultant)

Matter arising 3: Centralised Clinical Audit Function	Impact
The Trust does not currently have a centralised clinical audit team, which could potentially lead to silo working. Additionally, there have been resource challenges within the divisional clinical audit teams due to sickness absence. Specifically, this has impacted: • maintenance of the VCC clinical audit action plan (paragraphs 2.27-2.28); • informal follow up of implementation of actions within VCC (paragraph 2.32); • rolling out further VCC virtual clinical audit events (paragraph 2.40); and • our ability to undertake detailed testing of WBS clinical audit activities (paragraph 2.44). The Trust is taking action to improve resilience within the divisional clinical audit teams.	Potential risk of: • inconsistency in clinical audit approach; • inefficient or ineffective triangulation of clinical audit findings; • lack of resilience potentially leading to ineffective clinical audit; and • poor patient / donor experience or patient / donor harm.

Recommendations	Priority
3.1 The Trust should consider joining the divisional clinical audit teams into a centralised Trust clinical audit team.	Low (Design)

Management response		Target Date	Responsible Officer
3.1	Discuss the options regarding feasibility of a centralised clinical audit team or exploring how WBS and VCC can work together ensuring processes are aligned across the organisation.	July 2023	Medical Director

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Matter arising 4: Robustness of SST Minutes	Impact
Our review of a sample of SST minutes highlighted that there is variation in whether scrutiny of clinical audit activity (Programme progress, audit findings, learning, action implementation, etc) is robustly evidenced in the meeting minutes.	Potential risk of: • inability to evidence scrutiny and accountability of clinical audit activities; • lack of progress on clinical audit plan or action implementation not being identified; and • poor patient / donor experience or patient / donor harm.

Recommendations	Priority
4.1　The Trust should ensure that SST meeting minutes clearly demonstrate discussions around clinical audit (plan progress, audit findings, learning, action implementation, etc).	Medium (Operation)

Management response	Target Date	Responsible Officer
4.1　Annual audit engagement with each SST with robust documented discussion including annual plan, progress, learning and actions.	July 2023	Clinical Audit Manager
Review of SST meetings to establish how discussions are documented with progress of clinical audits.	July 2023	Clinical Audit Manager

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Matter arising 5: Clinical Audit Reporting and Oversight Mechanisms	Impact
Velindre Cancer Centre Currently there is no designated forum that provides overarching oversight of actions resulting from clinical audits that span multiple SST's. This will be reviewed in line with the quality hub structure. This is an issue the Division has already identified and flagged with the VCC SLT. We understand this matter has been passed to the Trust's Interim Clinical Transformation Lead for further consideration. We were also informed that clinical audit governance and reporting mechanisms are being considered as part of the Trust's wider review of quality and safety governance and reporting within the Quality & Safety Implementation Plan. We understand that there is representation from clinical audit in the newly formed Trust Integrated Quality & Safety Group, which is responsible for this process. **Welsh Blood Service** The Trust's clinical audit approach (set out in the Trust Clinical Audit Plan) requires that progress on the WBS Clinical Audit Programme be reported to the Division's RAGG meetings. However, we found that there is minimal evidence of this taking place.	Potential risk of: • lack of collaboration between the SSTs resulting in actions not implemented; • trends that affect multiple SSTs going unidentified; and • poor patient / donor experience or patient / donor harm.

Recommendations	Priority
5.1 a. As part of the review of quality and safety governance and reporting mechanisms, the Trust should address the above points to further enhance the efficiency and effectiveness of the scrutiny and oversight of clinical audit activities from 'floor to Board'. b. The Trust should ensure that the agreed clinical audit reporting mechanisms are clearly communicated to relevant staff and adhered to at all levels of the Trust.	Low (Design)

Management response	Target Date	Responsible Officer
5.1 a. The new Trust Integrated Quality and Safety Governance group will help with the triangulation of clinical audit outcomes across the Trust and ensure escalation to the Quality and Safety committee as appropriate. VCC will develop a process map to evidence the report structures within VCC for clinical audit. Reporting requirements are being reviewed in line with the quality hubs.	December 2023	Clinical Audit Manager

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Management response (continued)	Target Date	Responsible Officer
b. **VCC:** Current process map of the VCC governance and reporting mechanism to be added to the clinical audit intranet page.	May 2023	Clinical Audit Manager
WBS: We have strengthened the reporting of Clinical Audit within the WBS by making it an integral part of the Welsh Blood Service Clinical Governance Groups, reporting to the Regulatory Assurance and Governance Group (RAGG). We have recently added a separate report including national comparative audits.	Completed	Deputy Medical Director WBS

Appendix B: Comparison against clinical audit best practice

We reviewed the Trust's clinical audit approach (design only) against the best practice guidance in HQIP's 'Clinical Audit: A simple guide for NHS Boards & Partners'. We have identified within the table where we have been unable to consider the WBS approach due to the limitation of scope (paragraph 1.5).

Status key

Approach in line with best practice	Approach partly in line with best practice	Approach not in line with best practice	Out of scope, no review undertaken

Best practice for robust clinical audit activities	Status	Trust approach
Use clinical audit as a tool in strategic management as part of the broader quality improvement programme; obtain assurance that the strategy for clinical audit is aligned to broader interests and targets that the board needs to address	Trust	The Trust Clinical Audit Plan confirms the audits have been mapped against the Health & Care Standards for Wales and we saw evidence of clinical audit findings being informally triangulated with other quality mechanisms. Improved coordination of quality governance mechanisms and alignment of the mechanisms with the Trust's strategy and goals are among the aims of the Trust's new Quality & Safety Framework and supporting Implementation Plan. **Matter arising 2**.
Consider the full range of quality improvement tools and choose clinical audit if its methodology is best suited to assess the issue at hand and develop an improvement plan	VCC only	VCC Clinical Leads must identify the reason for a clinical audit on the clinical audit proposal form when submitting the audit for inclusion in the VCC Clinical Audit Programme. However, this does not fully address the best practice to consider if clinical audit is the most appropriate mechanism. **Matter arising 2**.
A clinical audit strategy must include a combination of national and local priorities with sufficient resources to complete the cycle for each element of the programme	Trust	The Trust's Clinical Audit Programme includes national and local priorities. However, there are some resource constraints with the divisional clinical audit teams. The Trust is taking action to address this, and we have made a recommendation for further consideration. **Matter arising 3**.
Agree on the timescale and resources required for each clinical audit activity upfront but have a process in place to deal with variations and additional requirements	VCC only	Anticipated timescales and resources are considered on the clinical audit proposal form (note: we reviewed the template form but further testing on the completion of the forms was not within the scope of our internal audit). The timescales are included in the VCC Clinical Audit Programme which is approved by the SSTs.
Operate a rolling clinical audit programme that covers the different stages of individual projects on a continuous basis focused on outcome improvements for each area	VCC only	The Trust's clinical audit activities aim to support outcome improvements. However, we identified that: • clinical audit actions are often not SMART, limiting the effectiveness of monitoring implementation, assessing benefit realisation and achieving outcome improvements (**matter arising 1**); • there is variation in the robustness of SST meeting minutes evidencing monitoring action implementation (**matter arising 4**); • informal follow up on implementing actions has been limited due to sickness absence in the VCC Clinical Audit Team (**matter arising 1**); and • except where a full re-audit is scheduled, there is no process to independently verify that actions have been implemented and benefits realised / outcomes improved (**matter arising 1**).
Ensure the professionalism of clinical audit by agreeing what constitutes unacceptable variation in clinical audit results compared to evidence-based standards, outcomes at similar organisations, or with standards developed within the organisation where national guidelines are not available		Whilst out of scope for this internal audit, we saw evidence of this in practice in the clinical audits sampled as part of our 2021/22 Infection, Prevention & Control internal audit.

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Best practice for robust clinical audit activities	Status	Trust approach
Ensure with others that clinical audit crosses care boundaries and encompasses the whole patient pathway	VCC only	VCC participates in national cancer audits via the Wales Cancer Network. We were informed that the Division also undertakes multi-centred audits and cross-site projects. Currently, VCC does not participate in local audits that follow the patient pathway across organisational boundaries. **Matter arising 2**.
Develop a clear strategy to ensure patient and stakeholder engagement at the different stages of the clinical audit cycle, make clinical audit reports patient-friendly and publicly available, and disseminate summaries of results to stakeholders and patients in a variety of ways	VCC only	VCC publicly publishes or shares clinical audit related reports with stakeholders in a variety of ways, including: • Trust Clinical Audit Plan and Annual Report available via public QSPC papers; • pertinent findings from clinical audits are included in the Annual Report; and • for individual audits, results may be shared with relevant health boards where relevant; some projects are published, and others are publicised via posters or abstracts at different conferences. At present, VCC does not engage patients and stakeholders at other stages of the clinical audit cycle, e.g., annual planning, during fieldwork, etc. **Matter arising 2**.
Share clinical audit results with other providers, commissioners, regional clinical networks and local patient networks. Publish outcome statistics and evaluations	VCC only	As noted above, where relevant, VCC clinical audit data is shared with health boards to inform second stage commissioning requests.
Provide sufficient education and training in clinical audit beyond the clinical audit team, ensure that clinical audit is included in objectives and appraisals, and use clinical audit and quality improvement projects as a valuable resource.		N/a

Appendix C: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	Substantial assurance	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	Reasonable assurance	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	Limited assurance	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	No assurance	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	Assurance not applicable	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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QUALITY, SAFETY AND PERFORMANCE COMMITTEE

VELINDRE UNIVERSITY NHS TRUST
POLICY MANAGEMENT REVIEW AND COMPLIANCE
STATUS: FEBRUARY 2023

DATE OF MEETING	16/03/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable

PREPARED BY	Lenisha Wright, Business Support Officer Kay Barrow, Corporate Governance Manager Emma Stephens, Head of Corporate Governance
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance & Chief of Staff

REPORT PURPOSE	For **ASSURANCE**

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME
Executive Management Board	02/03/2023	Endorsed
ACRONYMS		
EMB	Executive Management Board	
VUNHST	Velindre University NHS Trust	
QSPC	Quality, Safety and Performance Committee	

IPCMG	Infection Prevention and Control Management Group
MMG	Medicines Management Group
IPC	Infection Prevention and Control

1. SITUATION

1.1 The purpose of this report is to provide the Quality, Safety and Performance Committee (QSPC) with the annual overview of the progress that has been made following the launch of the policy management and review programme in March 2022. In addition, this report provides the latest position following the sixth tranche of the audit programme.

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

   a) **NOTE** the progress that has been made over the last twelve months in respect of Policy Compliance Status for those policies that fall within the remit of the Quality, Safety and Performance Committee.

   b) **NOTE** the Quality, Safety and Performance Committee Policy Extract Compliance Report as of **February 2023**, included in *Appendices 1 to 8*.

   c) Receive **ASSURANCE** that progress is being managed via the Executive Management Board.

2. BACKGROUND

2.1 A comprehensive review was initiated towards the end of February 2022, of the existing arrangements in place for the management and reporting of Trust wide Policies. The purpose of which was to identify any areas for improvement to strengthen the operation of the governance framework, increase control to enable effective assurance arrangements and build firm foundations for a step change in the management and reporting of all Trust wide Policies.

2.2 The scope of the audit applies to all Trust wide policies. As such, any locally managed controlled documentation, for example Standard Operating Procedures that only apply to one of the core Divisions i.e. the Welsh Blood Service or Velindre Cancer Centre of the Trust, are excluded from the scope of this work.

2.3 A total of **157** Trust wide policies were included in the assessment as part of the audit underway. As such, due to the scale and rigor required to complete a comprehensive and robust audit, a phased approach has been undertaken.

2.4 The **first and second tranche** of the review, reported through the March to May 2022 Governance reporting cycle included:

   i. Approval of the revised Trust Policy and Procedure for the Management of Trust Wide Policies and Other Trust Wide Written Control Documents, following a Pan-Wales benchmarking review of the 'Policy on Policy Management' from other Health Boards and Trusts.

   ii. Root and branch audit of the status of the Trust wide policies that fall within the remit of the Quality, Safety and Performance Committee.

iii.   Creation of a new Document Control Register to accurately record the status and risk profile of all Trust wide policies that fall within the remit of the Quality, Safety and Performance Committee, to underpin future reporting and enhanced governance arrangements.

iv.   Assessment of the existing document control management systems in operation across the Trust to consider options available for the electronic management of all Trust wide Policies going forward, and action required to facilitate this.

2.5   The **third to fifth tranche** of the review work was reported in the July, September and November 2022 Governance reporting cycles and was focussed on monitoring of progress.

2.6   **Policy Status***:* In the assessing and recording of the Policy Status, Table 1 below has been used to capture various aspects of the policies status, including whether policies were in date or if review dates had passed. For those policies where review dates had passed, actions currently underway and other actions required were also captured which will form part of the ongoing monitoring by the Corporate Governance Team and have been reported for scrutiny and providing assurance.

Table 1: Policy Status Key

POLICY STATUS KEY:
Policy in date
Policy review date passed – action underway/required
All Wales Policy review date passed – awaiting national review
Policies Archived

2.7   **Policy Risk Assessment***:* For each policy passed its review date a Policy Risk Assessment has been undertaken to assess any risks associated with policies with review dates that have passed, and the associated actions required to address this. Table 2 below captures the outcome of this assessment.

Table 2: Policy Risk Assessment Key

POLICY RISK ASSESSMENT KEY:
Policy in date with no risk assessment required
Policy review date passed with low risk
Policy review date passed with moderate risk
Policy review date passed with high risk

2.8 *Document Control Register:* A Document Control Register was compiled during tranche one and has been updated through to tranche six to explain the outcome of the audit for effective monitoring and reporting purposes. This is included at *Appendices 1 to 8*. Ongoing updates and progress will continue to be captured and recorded in the Document Control Register and reported against with each reporting cycle.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Overall Annual Summary of Progress - February 2022 to February 2023

3.1.1 During the review period, the number of policies outside their review dates has reduced by **4.5%**. Table 3 details the policies outside their review dates at the start of the audit review programme compared to the current position, and the number of policies approved by the QSP Committee to January 2023.

Table 3: Overview of Policy Progress

Number of policies outside their review date February 2022	**66**
Number Policies outside their review date February 2023	**63**
Number of approved by QSPC	**32**

3.1.2 Directorate Progress
Table 4 highlights the progress that has been made by each Directorate in reviewing their policy position during the review period. More detail is provided in paragraph 3.2.1 for each of the policies.

3.1.3 The importance of planning the review of the policy *in advance* of its review date to ensure it remains in date has been highlighted to each of the policy leads during the audit review. The policy database has also been updated to incorporate a trigger point to help facilitate this. As part of the continuous life cycle of a policy, there will never be a fixed static point as a result, during the last 12 months further policies fell outside of their review date.

Table 4: Progress of the Audit Review Programme

Directorate/ Department	Policies outside review date Feb 2022	Policies approved Feb 2022 – Jan 2023	Policies outside review date Feb 2023
Quality & Safety	7	7	5
Health & Safety	0	*1	2
Infection, Prevention & Control	4	6	9
Information Governance	4	4	3
Corporate Communications	1	0	1
Estates	9	4	5
Digital	6	5	2
Workforce & Organisational Development	**35	5	36

To Note: *The figures in Table 4 include All Wales Policies.*
  *The policy approved for Health and Safety was reviewed and approved but was not outside its review date.
  **Workforce & Organisational Development policies were not included until tranche two commencing in April 2022.

3.1.4 **Policies Approved**

As part of the governance process, policies have been submitted for approval to QSPC at six meetings held March 2022 to January 2023. Table 5 provides a list of the policies approved by QSPC at each of their meetings.

Table 5: Policies Approved by the Quality, Safety and Performance Committee

Directorate/ Department	Policies
Health & Safety	– Health Safety & Welfare Policy
Infection, Prevention & Control	– Decontamination Policy – Viral Gastro Enteritis (including Norovirus) Policy & Addendum – Methicillin Resistant Staphylococcus Aureus (MRSA) – Framework Policy for Infection Prevention and Control – Hand Hygiene Policy – Infection Prevention and Control Policy for the Management of Respiratory Infections and Addendum
Quality & Safety	– Handling Concerns Policy – Incident Reporting and Investigation Policy – Safety Notices and Important Documents Management Procedure – Preceptorship Policy for Newly Registered Nurses and Allied Health Care Professionals
Information Governance	– Freedom of Information Act Policy – Records Management Policy – Data Protection & Confidentiality Policy – Confidentiality Breach Reporting Policy
Digital	– Internet Use Policy – Software Policy – Anti-Virus Policy – Data Quality Policy – Information Asset Policy
Estates	– Asbestos Policy – Control of Contractors – Water Safety Policy – Environmental Policy
Workforce & Organisational Development	– Pay Progression Policy – Procedure for NHS Staff to Raise Concerns (Whistleblowing) – Special Leave Policy – Equality & Diversity Policy – Working Time Regulations

3.2 **Sixth Tranche Policy Compliance Status**

As outlined earlier, a risk-based phased approach has been adopted for the Policy Compliance Audit. A summary of the outcome of the **sixth tranche** of the policy review work is included at **Appendices 1 to 8.** The following summarises the **sixth tranche** of the policy review work undertaken during January and February 2023 and highlights the following:

i.   Progress of policies identified for review, updates and approval by the Quality, Safety and Performance Committee (QSPC) tracked from March through 2022 to February 2023.
ii.   An update of the Policy Audit Compliance Status is included in paragraph 3.2.1.
iii. Ongoing monitoring focuses on the status of policies under review, a breakdown of some of the detail is included in sections 4 and 5.

There is an ongoing review, consultation and follow up of the latest policies held on record in order to collate a report including information on document control, review dates, policy status and risk assessments for the following directorates/departments:

- Quality and Safety
- Infection, Prevention and Control
- Health and Safety
- Estates, Planning and Performance
- Information Governance
- Digital Services
- Corporate Communications
- Workforce and Organisational Development

Following the initial collation of data a compliance report was compiled in March 2022 followed by progress and update reports in May, July, September 2022 and November 2022. This report provides progress and update of the compliance work undertaken during January and February 2023. A summary of the outcome of this exercise is included at *Appendices 1 to 8*.

3.2.1   Collaborative Engagement Exercise

As indicated above, following an assessment of the policies currently held on record, regular collaborative engagement has been undertaken with each of the respective policy leads on a regular basis. Table 6 details the Policy Leads for each Directorate:

Table 6: Directorate Policy Leads

Directorates	Policy Lead(s)
Quality and Safety	Quality & Safety Manager, Claims Manager, Chief Pharmacist, Quality & Safety Facilitator, Senior Nurse Safeguarding & Public Protection, Head of Radiation Protection Services, Interim Deputy Director of Nursing, Quality & Patient Experience Health and Safety Manager
Infection, Prevention & Control	Head of Infection Prevention and Control Health and Safety Manager Operations Manager
Health and Safety	Health and Safety Manager
Information Governance	Head of Information Governance

Directorates	Policy Lead(s)
Digital Services	Head of Digital
Corporate Communications	Head of Information Governance
Estates, Planning & Performance	Assistant Director of Estates Fire Safety Manager
Workforce and Organisational Development	Deputy Director of OD and Workforce Head of Workforce, Equality and Diversity Manager

The purpose of the ongoing collaborative engagement exercise is to confirm and validate the following:

- Clarification on the status of existing policies.
- A risk assessment of policies passed their review date.
- Monitoring and updates of the review and approval status of policies currently outside their review date.

A summary is provided below of information gathered from the collaborative engagement exercise in the **sixth tranche** of this work undertaken during January and February 2023:

- ***Quality and Safety***

A total of 11 Quality and Safety Policies were included in the review process, one of which is an All Wales policy. In summary:

- o At the start of the review in February 2022, seven policies were outside their review date and four policies in date.
- o In February 2023, five policies are outside their review date, and six in date.
- o During 2022, seven policies were taken through the governance process and approved at QSPC.

Table 7 provides detail on the status of the policies from the outset of the audit in February 2022 to the most recent review in February 2023. Refer to *Appendix 1* for more detail.

Table 7: Quality and Safety Policy Progress Update February 2022 – February 2023

Policy Titles	Policy Status February 2022	Summary of work undertaken March 2022 – January 2023	Policy status February 2023	Next steps
Medical Gas Cylinders Policy	Policy outside its review date	– Decision taken on remit of policy and policy lead assigned (Chief Pharmacist) – Review and updates undertaken – Consultation carried out	Ongoing updates and amendments following consultation	Policy will go through MMG for endorsement following which, it will be taken to EMB for approval

Policy Titles	Policy Status February 2022	Summary of work undertaken March 2022 – January 2023	Policy status February 2023	Next steps
Ionising Radiation Safety Policy	Policy outside its review date	– Policy lead assigned (Head of Radiation and Protection) – Review and update of policy undertaken – Consultation process carried out – Approval of policy obtained from Radiation committee – Submitted to Senior Leadership December 2022	Feedback awaited from the Chair of the Radiation Protection Steer Group	– Updates have been finalised – Awaiting final approval from the Chair of the Radiation Protection Steering Group before submission through the governance process expected April 2023
International Health Partnership Related Activity Policy	Policy outside its review date	– After initial review it was established that a complete rewrite of the policy is required – Review and updates undertaken – Consultation carried out	Finalise updates following consultation	Policy to be taken through approval process April 2023
Preceptorship Policy for Newly Registered Nurses and Allied Health Care Professionals	Policy outside its review date	– Review and updates undertaken – Submission for approval to professional nursing forum – Consultation carried out – Taken through approval process Nov 2022	Policy in date	Policy in date until November 2025
Safety Notices and Important Documents Management Procedure	Procedure outside its review date	– Review and updates undertaken – Alignment with latest guidance and legislation	Procedure in date	– In date until January 2024 – Further review of the policy will be undertaken in April 2023 with the introduction of the Once for Wales Safety Alerts module reporting system

Policy Titles	Policy Status February 2022	Summary of work undertaken March 2022 – January 2023	Policy status February 2023	Next steps
Compensation Claims Policy & Procedure	Policy in date	– Policy went outside its review date Sept 2022 – Review and updates to reflect latest legislation and National requirements underway	– Review and updates to be finalised – To undergo consultation following updates	Submission to approving body June 2023
Consent to Examination or Treatment - All Wales	Policy in date	– Policy went out of date July 2022 – Policy reviewed on an All Wales basis	All Wales review ongoing	Policy to be adopted by Trust once approved on an All Wales basis
Handling Concerns Policy	Policy outside its review date	– Policy reviewed in line with legislative and National requirements – Policy approved by QSPC March 2022	Policy in date	Policy in date until April 2023. Review process underway
Incident Reporting and Investigation Policy	Policy outside its review date	Policy reviewed, updated and approved by QSPC March 2022	Policy in date	Policy in date until March 2025
Policy for the management of Safeguarding Allegations/ Concerns about Practitioners and those in a position of trust	Policy in date	Policy in date	Policy in date	Policy in date until March 2023. Review process underway.
Safeguarding & Public Protection Policy	Policy in date	Policy in date	Policy in date	Policy in date until March 2023. Review process underway

- *Health and Safety*

A total of nine policies have been included in the review process:

- o At the start of the review in February 2022, all nine policies were in date.
- o In February 2023, seven policies are in date however, two policies went outside their review date, one in September 2022 and one in January 2023.
- o The Health Safety and Welfare Policy, although in date was reviewed and updated to reflect latest guidance. This policy was approved by QSPC in July 2022.

Table 8 provides detail on the status of Health and Safety policies from the outset of the audit in February 2022 to February 2023. Refer to *Appendix 2* for more detail.

Table 8: Health and Safety Policy Progress Update February 2022 to February 2023

Policy Titles	Policy Status February 2022	Summary of work undertaken March – January 2023	Policy status February 2023	Next steps
Latex Policy	Policy in date	Policy in date	Policy in date	Policy in date until March 2023. Review process underway
Safer Manual Handling Policy	Policy in date	Policy in date	Policy in date	Policy in date until March 2023. Review process underway
Management of Violence & Aggression Policy	Policy in date	Policy in date	Policy in date	Policy in date until March 2023. Review process underway
Health Safety & Welfare Policy	Policy in date	Policy in date	Policy in date	Policy in date until July 2025
Medical Devices & Equipment Management Policy	Policy in date	Policy in date	Policy went outside its review date in Jan 2023	Policy under review
Safe Use of Display Screen Equipment & Appendices	Policy in date	Policy in date	Policy in date	Policy in date until May 2023
Lone Working Policy	Policy in date	Policy in date	Policy in date	Policy in date until March 2023. Review process underway
Control of Substances Hazardous to Health (COSHH)	Policy in date	Policy in date	Policy in date	Policy in date until March 2023. Review process underway
Workplace Equipment Policy	Policy in date	- Policy went outside its review date in Sept 2022 - Policy reviewed and update.	Policy under review by Exec Lead	- Finalise amendments - Submit to QSPC in May 2023

- *Infection, Prevention and Control (IPC)*

A total of 17 IPC policies have been included in the review, three of which are All Wales policies

- o At the start of the review in February 2022, four policies were outside their review date.
- o In February 2023, eight policies are in date, nine policies are outside their review (including All Wales policies). Seven of the policies went outside their review dates during 2022.
- o During 2022 six policies were approved at QSPC.

Table 9 provides detail on the status of the policies from the outset of the audit in February 2022 to February 2023. Refer to *Appendix 3* for more detail.

Table 9: Infection, Prevention and Control Policy Progress Update February 2022 to February 2023

Policy Title	Policy status February 2022	Summary of work undertaken during March - December 2022	Policy status February 2023	Next Steps
Cleaning Manual	Policy outside review date	– Decision taken that the policy falls within the remit of Operations – Policy lead identified – During initial review there was a challenge reflecting changing circumstances due to COVID – During late 2022, the policy – policy name changed to Cleaning Manual and assigned for review on an All Wales basis	– Review on All Wales basis	– All Wales policy approval awaited – Following approval on an All Wales basis policy to be adopted by the Trust
Sharps Safety Policy & Addendum	Policy in date, no action required	– Policy passed its review date in July 2022 – Health and Safety manager assigned as policy lead	Updated policy submitted to Executive Lead for comment	– Finalise amendments – Submit to QSPC in May 2023
Viral Gastro Enteritis (including Norovirus) Policy & Addendum	Policy outside its review date	Policy approved at QSPC March 2022	Policy in date	Policy in date until March 2025
Decontamination Policy	Policy outside its review date	Policy approved at QSPC March 2022	Policy in date	Policy in date until March 2025
Methicillin Resistant Staphylococcus Aureus (MRSA)	Policy outside its review date	Policy approved at QSPC May 2022	Policy in date	Policy in date until May 2025

Policy Title	Policy status February 2022	Summary of work undertaken during March - December 2022	Policy status February 2023	Next Steps
National Infection Prevention and Control Manual (NIPCM)	Manual published 2012 with plans to further develop the manual	Scottish electronic National Infection Control Manual adopted for use by all healthcare organisations in Wales	Further development of the manual will be undertaken	Current manual in place until development work completed and approved. Following approval, the Trust to adopt
Aseptic Non Touch Techniques (ANTT)	Policy in date	Policy went outside its review date July 2022	– Reviewed on All Wales basis – Decision being taken by IPCMG as to whether policy should be archived and superseded	Decision awaited from IPCMG
Framework Policy for Infection Prevention and Control	Policy in date	– Policy went outside its review date, was reviewed and updated – Approved by QSPC Nov 2022	Policy in date	Policy due for review Nov 2025
Hand Hygiene Policy	Policy in date	– Policy went outside its review date, was reviewed and updated – Submitted & approved by QSPC Nov 2022	Policy in date	Policy due for review Nov 2025
IPC and Control Policy for the Management of Respiratory infections and Addendum	Policy in date	– Policy went outside its review date, was reviewed and updated – Submitted & approved by QSPC Nov 2022	Policy in date	Policy due for review Nov 2025
Control and Management of Multi Drug Resistant Bacteria	Policy in date	Policy in date	Policy in date	Policy due for review June 2024

Policy Title	Policy status February 2022	Summary of work undertaken during March - December 2022	Policy status February 2023	Next Steps
Infection Prevention and Control within Building Development, Change and Adaptation Policy	Policy in date	– Policy went outside its review date Sept 2022 – Policy assigned as All Wales	Policy under review on an All Wales basis	– All Wales policy approval awaited – Following approval on an All Wales basis policy to be adopted by the Trust
Specimen Collection, Handling & Transport Policy	Policy in date	– Policy went outside its review date Dec 2022 – Review and updates finalised	Policy sent out for comment	Following comments, final updates and submission through approval process during April 2023
Policy for the Prevention and Control of Transmissible Spongiform	Policy in date	– Policy went outside its review date	– Review & updates finalised	Policy to be taken through approval process in April 2023
Tuberculosis Management	Policy in date	Policy in date	Policy in date	Policy due for review Nov 2024
Policy for the Management of Occupational Exposure to Blood and High Risk Body Fluids	Policy in date	– Policy went outside its review date Sep 2022 – Health and Safety manager assigned as policy lead – Policy reviewed and updated	Submitted to Exec Lead for review	Finalise amendments before going through the approval process in April 2023
Guidelines on Single Use Medical Devices	Policy in date	– Policy went outside its review date July 2022	– Decision taken that policy falls within the remit of the Exec Medical Director	– Policy lead to be identified – Policy to be reviewed and updated to go through approval process in April 2023

- ***Information Governance***

A total of seven Information Governance policies have been included as part of the review process.

- o In February 2022, four policies were outside their review dates.
- o Two All Wales policies went outside their review date in January 2023. The Head of Information Governance has flagged this with the IGMAG, and these policies are currently under review.
- o In February 2023, one procedure is outside its review date and two All Wales policies outside their review dates are currently under review.
- o During 2022 four policies were approved at QSPC.

Table 10 provides detail on the status of the policies from the outset of the audit in February 2022 to February 2023. Refer to ***Appendix 4*** for more detail.

Table 10: Information Governance Policy Progress Update February 2022 to February 2023

Policy Title	Policy status February 2022	Summary of work undertaken during March - December 2022	Policy status February 2023	Next Steps
Information Governance Policy	Policy in date	Policy in date	Policy went outside its review date Jan 2023	– All Wales policy review and approval awaited – Following approval on an All Wales basis policy to be adopted by the Trust
Information Security Policy	Policy in date	Policy in date	Policy went outside its review date Jan 2023	– All Wales policy review and approval awaited – Following approval on an All Wales basis policy to be adopted by the Trust

Policy Title	Policy status February 2022	Summary of work undertaken during March - December 2022	Policy status February 2023	Next Steps
Freedom of Information Act Policy	Policy outside its review date	Following review and update, policy approved at QSPC July 2022	Policy in date	Policy in date until 2025
Records Management Policy	Policy outside its review date	Following review and update, policy approved at QSPC July 2022	Policy in date	Policy in date until 2025
Data Protection & Confidentiality Policy	Policy outside its review date	Following review and update, policy approved at QSPC July 2022	Policy in date	Policy in date until 2025
Confidentiality Breach Reporting Policy	Policy outside its review date	Following review and update, policy approved at QSPC July 2022	Policy in date	Policy in date until 2025
FOI Standard Operating Procedure	Policy in date	– Procedure went outside its review date April 2022 – Complete redraft required	Redraft of Procedure to be finalised	Submission to QSPC in May 2023

- *Corporate Communications*

One Corporate Communications policy was included in the review process, the Social Media Policy. This is a Wales policy with Health Education and Improvement Wales (HEIW) leading on the review of this policy. Refer to *Appendix 5.* Updates will be provided in future reporting.

- *Estates, Planning & Performance (EPP)*

A total of 15 Estates, Planning and Performance policies were included in the review process:

   o In February 2022 nine policies were outside their review date.
   o With the latest review in February 2023 10 policies are in date, 5 policies are outside their review date.
   o During 2022 four policies were approved at QSPC.

Table 11 provides detail on the status of policies from the outset of the audit in February 2022 to February 2023. Refer to *Appendix 6* for more information.

Policy title	Policy status February 2022	Summary of work undertaken during March - December 2022	Policy status February 2023	Next Steps
Asbestos Policy	Policy outside its review date	– Policy reviewed and updated – Submitted to QSPC Nov 2022	Policy in date	Policy in date until 2025
Control of Contractors	Policy outside its review date	– Policy reviewed and updated – Submitted to QSPC Nov 2022	Policy in date	Policy in date until 2025
Electrical Low Voltage Policy	Policy in date	Policy in date	Policy in date	Policy in date until Sept 2023
Environmental Policy	Policy outside its review date	– Policy reviewed and updated – Submitted to QSPC May 2022	Policy in date	Policy in date until 2025
Fire Safety Policy	Policy in date	Policy in date	Policy in date	Policy in date until Sept 2023
Medical Gas Piped Systems Policy	Policy in date	Policy in date	Policy in date	Policy in date until Aug 2023
Operational Policy for High Voltage Electricity Supply Systems	Policy in date	Policy in date	Policy in date	Policy in date until Aug 2023
Operational Policy for High Voltage Electricity Supply Systems using a contractor as the Authorised Person (HV)	Policy in date	Policy in date	Policy in date	Policy in date until Aug 2023
Ventilation Policy	Policy in date	Policy in date	Policy in date	Policy in date until Aug 2023
Water Safety Policy	Policy outside its review date	– Policy reviewed and updated – Submitted to QSPC Nov 2022	Policy in date	Policy in date until Nov 2025
Business Continuity Policy	Policy outside its review date	– Policy lead assigned (Head of Validation & Risk) – Policy under review within scope of work under business continuity agenda	Policy currently undergoing review and updates	Policy expected to be submitted to QSPC in May 2023 following finalisation of review and consultations

Policy title	Policy status February 2022	Summary of work undertaken during March - December 2022	Policy status February 2023	Next Steps
Protocol for dealing with suspect packages and bomb threats	Policy outside its review date	Review and update of policy	Ongoing review and update of policy	Policy expected to be submitted to QSPC in May 2023 following finalisation of review and consultations
Safety and Protocol Prevention of Fire and Arson	Protocol outside its review date	Review and update of policy	Ongoing review and update of policy	Decision to be taken as to whether protocol forms part of the fire safety policy
Security Policy	Policy outside its review date	Review and update of policy	Review of policy	Expected to be submitted to QSPC in May 2023
Waste Management Policy	Policy outside its review date	Review and update of policy	Review of policy	Expected to be submitted to QSPC in May 2023

- *Digital Services*

A total of six policies were included as part of the review process:

  o In February 2022, six policies were outside their review dates which included two All Wales policies.
  o In December 2022, an additional policy was added under the remit of Digital Services and this policy was outside of its review date.
  o In February 2023, five policies are in date and two policies are past their review date.
  o During 2022, five policies were approved by QSPC.

Table 12 provides detail on the status of policies from the outset of the audit in February 2022 to February 2023. Refer to *Appendix 7* for more detail.

Table 12: Digital Services Policy Progress Update February 2022 to February 2023

Policy title	Policy status February 2022	Summary of work undertaken during March - December 2022	Policy status February 2023	Next Steps
Internet Use Policy	Policy outside its review date	Following review and updates, policy approved at QSPC 2022	Policy in date	Policy in date until July 2025

Policy title	Policy status February 2022	Summary of work undertaken during March - December 2022	Policy status February 2023	Next Steps
Email Use Policy	Policy outside its review date	Policy to be reviewed on All Wales basis	Policy undergoing review on All Wales basis	– All Wales policy review and approval awaited – Following approval on an All Wales basis policy to be adopted by the Trust
Software Policy	Policy outside its review date	Following review and updates, policy approved at QSPC 2022	Policy in date	Policy in date until July 2025
Anti-Virus Policy	Policy outside its review date	Following review and updates, policy approved at QSPC 2022	Policy in date	Policy in date until July 2025
Data Quality Policy	Policy outside its review date	Following review and updates, policy approved at QSPC 2022	Policy in date	Policy in date until July 2025
Information Asset Policy	Policy outside its review date	Following review and updates, policy approved at QSPC 2022	Policy in date	Policy in date until July 2025
Staff Mobile Phone Policy	Policy outside its review date	Policy assigned to Digital Services December 2022	Policy undergoing review and updates	Policy to be taken through governance process in June 2023 following finalisation of updates from review

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

A total of 54 policies were included in the audit review process for Workforce and Organisational Development (WOD) however, eight policies were archived at the start of the review with 46 policies remaining as part of the review process.

It should be noted that the audit review work for WOD policies commenced in tranche two and included in the reporting cycle from May 2022.

In summary, the status is:

- o In April 2022, 35 policies were outside of their review date, of which 14 were All Wales policies.
- o During May to date six policies went outside their review.
- o In February 2023, 36 policies are outside their review date, of which 12 are All Wales policies. Nine policies are in date.
- o During 2022, two policies were approved by QSPC and three All Wales Policies were Endorsed by QSPC for adoption by the Trust and were subsequently approved by the Trust Board for adoption.
- o All Trust policies are under review (excluding All Wales) are expected to be taken through the governance process in March 2023.

Table 13a provides detail on the status of the All Wales policies from the outset of the audit review commenced in April 2022 to February 2023. Refer to *Appendix 8a* for more detail.

Table 13b provides detail on the status of all Trust policies (excluding All Wales policies) from the outset of the audit in April 2022 to February 2023. Refer to *Appendices 8b & 8c* for more detail.

Table 13a: Workforce and Organisational Development All Wales Policies Update February 2022 to February 2023

Policy title	Policy status February 2022	Work undertaken during March – January 2023	Status February 2023	Next steps
Exit Policy & Procedure	Policy outside its review date	Policy under review on All Wales basis	Policy under review on All Wales basis	– All Wales policy review and approval awaited – Following approval on an All Wales basis policy to be adopted by the Trust
Flexible Working Policy and Procedure	Policy outside its review date	Policy under review on All Wales basis	Policy under review on All Wales basis	– All Wales policy review and approval awaited – Following approval on an All Wales basis policy to be adopted by the Trust

Policy title	Policy status February 2022	Work undertaken during March – January 2023	Status February 2023	Next steps
Protocol on Collective Consultation of Proposed Redundancy	Policy outside its review date	Policy under review on All Wales basis	Policy under review on All Wales basis	– All Wales policy review and approval awaited – Following approval on an All Wales basis policy to be adopted by the Trust
Dress Code and Uniform Policy	Policy outside its review date	Policy under review on All Wales basis	Policy under review on All Wales basis	– All Wales policy review and approval awaited – Following approval on an All Wales basis policy to be adopted by the Trust
Upholding Professional Standards in Wales (Medical Staff Only)	Policy outside its review date	Policy under review on All Wales basis	Policy under review on All Wales basis	– All Wales policy review and approval awaited – Following approval on an All Wales basis policy to be adopted by the Trust
Organisational Change Redeployment Policy	Policy outside its review date	Policy under review on All Wales basis	Policy under review on All Wales basis	– All Wales policy review and approval awaited – Following approval on an All Wales basis policy to be adopted by the Trust
Capability Policy and Procedure	Policy outside its review date	Policy under review on All Wales basis	Policy under review on All Wales basis	– All Wales policy review and approval awaited – Following approval on an All Wales basis policy to be adopted by the Trust

Policy title	Policy status February 2022	Work undertaken during March – January 2023	Status February 2023	Next steps
Managing Attendance at Work Policy	Policy outside its review date	Policy under review on All Wales basis	Policy under review on All Wales basis	– All Wales policy review and approval awaited – Following approval on an All Wales basis policy to be adopted by the Trust
Menopause Policy	Policy outside its review date	Policy under review on All Wales basis	Policy under review on All Wales basis	– All Wales policy review and approval awaited – Following approval on an All Wales basis policy to be adopted by the Trust
Disciplinary Policy	Policy outside its review date	Policy under review on All Wales basis	Policy under review on All Wales basis	– All Wales policy review and approval awaited – Following approval on an All Wales basis policy to be adopted by the Trust
Employment Break Scheme	Policy in date	Policy in date	Policy outside review date Jan 2023	– All Wales policy review and approval awaited – Following approval on an All Wales basis policy to be adopted by the Trust
Reserve Forces Training and Mobilisation Policy	Policy in date	Policy in date	Policy in date	Policy in date until Mar 2024
Respect and Resolution Policy	Policy in date	Policy in date	Policy in date	Policy in date until April 2024
Secondment Policy	Policy in date	Policy in date	Policy in date	Policy in date until July 2024

Policy title	Policy status February 2022	Work undertaken during March – January 2023	Status February 2023	Next steps
Pay Progression Policy	Policy outside its review date	Policy reviewed on All Wales basis	Policy in date	Policy in date until Sept 2025
Procedure for NHS Staff to Raise Concerns (Whistleblowing)	Policy outside its review date	Policy reviewed on All Wales basis	Policy in date	Policy in date until Sept 2025
Special Leave Policy	Policy outside its review date	Policy reviewed on All Wales basis	Policy in date	Policy in date until Sept 2025
Accessing NHS Pension and Retirement Policy	Policy outside its review date	Policy under review on All Wales basis	Policy under review on All Wales basis	– All Wales policy review and approval awaited – Following approval on an All Wales basis policy to be adopted by the Trust

Table 13b: Workforce and Organisational Development Policy Progress Update February 2022 to February 2023

Policy title	Policy status February 2022	Work undertaken during March – January 2023	Status February 2023	Next steps
Study Leave Policy, Procedure & Guidelines	Policy outside its review date	Complete rewrite of policy undertaken	Ongoing rewrite of policy	Policy to go through governance process in March 2023
Voluntary Early Release Scheme	Policy outside its review date	Review and rewrite of policy	Ongoing review and write of policy	Submission to QSPC in March 2023
Maternity, Paternity, Adoption and Parental Leave Policy	Policy outside its review date	Update and review of policy	Review completed	Policy to go through governance process in March 2023
Recruitment of Locum Doctor Policy	Policy outside its review date	Rewrite of policy undertaken	Ongoing and review and rewrite	Policy to go through governance process in March 2023

Policy title	Policy status February 2022	Work undertaken during March – January 2023	Status February 2023	Next steps
Annual Leave and Bank Holiday Policy	Policy outside its review date	– Review and update of policy – Discussions taking place regarding protocol for Medical and Dental Terms and Conditions	Ongoing and review and update	Policy to go through governance process in March 2023
PADR Policy	Policy outside its review date	Policy review and updates undertaken	Ongoing and review and updates	Policy to go through governance process in March 2023
Sabbatical Leave Policy for Consultant Medical Staff	Policy outside its review date	Policy review and updates undertaken	Ongoing review and updates	Policy to go through governance process in March 2023
Mental Health, Wellbeing & Stress Management Policy	Policy outside its review date	Policy review and updates undertaken	Ongoing and review and update	Policy to go through governance process in March 2023
Policy for Employing Ex-Offenders and people with a criminal record	Policy outside its review date	Policy review and updates undertaken	Ongoing and review and update	– Finalisation of updates – Policy to go through governance process in March 2023
Close Personal Relationships in the Work Place	Policy outside its review date	Policy review and updates	Finalisation of review and updates	Submission to Approving Body in March 2023
Adverse Weather Policy	Policy outside its review date	Policy review and updates	Finalisation of review and updates	Policy to go through governance process March 2023
Homeworking Policy	Policy outside its review date	Policy review and updates	Submitted to Agile Working Programme Board for feedback / input	– Finalise updates – Following updates to be taken through governance process in March 2023

Policy title	Policy status February 2022	Work undertaken during March – January 2023	Status February 2023	Next steps
Redeployment Policy (Ex OCP Redeployments)	Policy outside its review date	Policy review and updates	Ongoing review and updates	Following updates to be taken through governance process in March 2023
Redundancy and Security of Employment Policy	Policy outside its review date	– Policy lead assigned – Policy Rewrite	Ongoing review and updates	Expected to go through governance process in March 2023
Applying for Incremental Credit for Staff starting or re-joining the NHS	Policy outside its review date	– Policy lead assigned – Review and update of policy undertaken	Finalise amendments	Policy to be taken through governance process in March 2023
Policy on Reimbursement of Removal and Associated Expenses	Policy outside its review date	– Policy lead assigned – Review and update of policy undertaken – Consultation Dec 2022	Finalisation of amendments following consultations	Expected to go through governance process in March 2023
Supporting Transgender Policy	Policy outside its review date	Policy lead assigned Review and update of policy	Ongoing updates and amendments	Policy to be taken through governance process in March 2023
Dealing with Anonymous Communication Policy	Policy outside its review date	– Discussions and decision on remit of policy – Decision to add policy to WOD Policy Register – Policy lead assigned – Policy review and updates undertaken	Ongoing update and amendment	Policy taken through governance process in March 2023
Supporting Staff who are Carers	Policy outside its review date	Review and updates of policy undertaken	Ongoing update and amendment	March 2023 submission to Approving Body
Smoke Free Policy	Policy in date	– Policy went outside its review date June 2022 – Review and update of policy	Ongoing update and amendment	Policy to be taken through governance process in March 2023

Policy title	Policy status February 2022	Work undertaken during March – January 2023	Status February 2023	Next steps
Standards of Behaviour Policy	Policy in date	– Policy went outside its review date November 2022 – Review and update of policy undertaken	Ongoing update and amendment	Policy to be taken through governance process in March 2023
Violence, Domestic Abuse & Sexual Violence Workplace Policy & Procedure	Policy in date	Policy in date	Policy in date	Policy in date until July 2023
Welsh Language Policy	Policy in date	– Policy went outside its review date May 2022 – Review and update of policy undertaken	Ongoing review and updates	Policy to be taken through governance process in March 2023
Working Time Regulations	Policy outside its review date	– Policy review and updates undertaken – Policy taken through governance process	Policy in date	Policy in date until September 2025
Alcohol, Drugs and Substance Misuse Policy	Policy in date	– Policy went outside its review date June 2022 – Policy review and updates undertaken	Ongoing review and updates	Policy to be taken through governance process in March 2023
Equality & Diversity Policy	Policy outside its review date	– Policy reviewed and updated – Policy taken through governance process	Policy in date	Policy in date until September 2025
Professional Registration Policy	Policy in date	– Policy went outside its review date June 2022 – Review and update of policy undertaken	Ongoing review and updates	Policy to be taken through governance process in March 2023

3.2.2 Policy Audit Compliance Status

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

- o Policies reviewed by directorate
- o An overview of the status of the policies
- o Rationale for policies archived
- o Policies passed review dates
- o Policy risk assessment

- *Number of Policies under review*

As of February 2023, a total of 123 Trust wide Policies that fall within the remit of this Committee have been included in the review for ongoing monitoring and updates which includes archived policies (see paragraph 3.1.3), and an additional policy assigned to the remit of Digital Services. A breakdown of the number of policies reviewed across each of the directorates is shown in Figure 4 below.

Figure 1: Number of Policies audited by Directorate
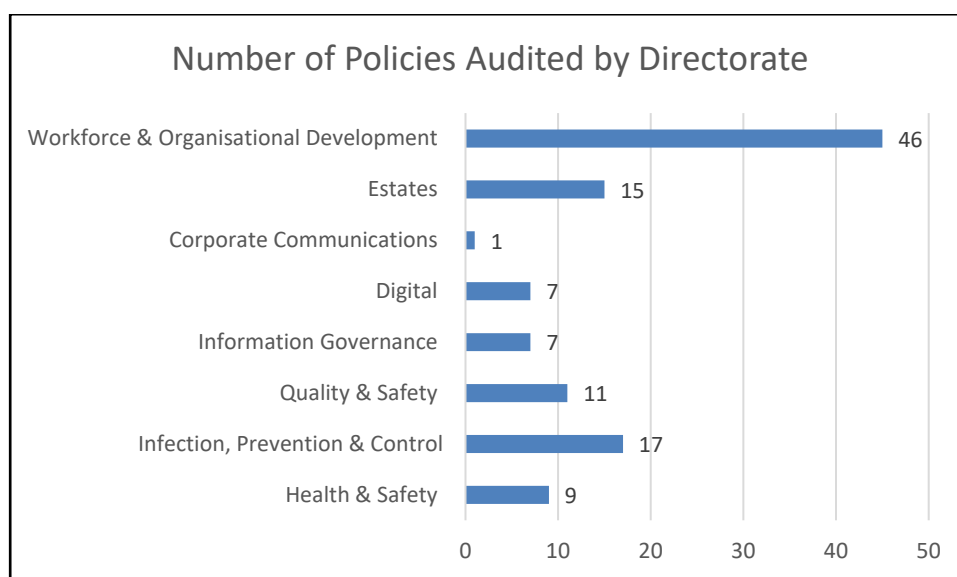
- *Policy Status*

As at February 2023, of the policies 112 under review, **50 (45%)** are in date and **62 (55%)** have passed their review date. Of the 62 policies that have passed their review date, **16** are classified All Wales policies, and **11** have been archived.

Table 14 below provides an overview of the overall policy status for those policies that fall within the remit of the Quality, Safety & Performance Committee.

Table 14: Overall Policy Status – February 2023

Policy Status	Number of Policies
Policies in date	50
Policies review date passed – action underway/required	62
All Wales Policies with review dates passed – awaiting national review	16
Policies Archived	11

3.2.3 Archived Policies

A total of 15 policies to date have been archived. Table 12 below provides information on the rationale for these archived policies.

Table 15: Rationale for Archived Policies

Directorate/ Department	Policy Title	Rationale
Infection, Prevention and Control	Standard Infection Control and Transmission Based Precautions	Superseded by National IPC manual
Infection, Prevention and Control	Outbreak Management Policy	Superseded by National IPC manual
Infection, Prevention and Control	Policy for the Management of Prevention and Control of Legionellosis	Superseded by Water Safety Policy (under Estates)
Workforce & OD	Framework for the Development of Consultant Practitioner Posts	This is a framework not a Policy
Workforce & OD	Time off and Facilities for Trade Union Representatives	This is a framework agreed by NHS employers not a policy
Workforce & OD	Procedure for Delivering Interpreter Services	This is a procedure not a Policy
Workforce & OD	Recruitment & Retention Payment Protocol	This is a managers guide not a Policy
Workforce & OD	Grievance Policy	Superseded by Respect and Resolution Policy
Workforce & OD	Childcare Voucher Policy	Policy no longer relevant due to Legislation change
Workforce & OD	Shared Parental Leave Policy	Superseded by new Maternity and Parental Leave Policy
Workforce & OD	NHS Wales Consistency of National T&C's (AFC) Band Outcome Following merger of Organisations	Confirmed by NHS Wales that this is no longer a policy

4. POLICIES PASSED THEIR REVIEW DATES

Table 16 below provides a summary of the number of policies currently passed their review dates excluding All Wales Policies.

Table 16: Policies passed their review dates

	Jan 2010 to Dec 2016	Jan 2017 to Dec 2018	Jan 2019 to Dec 2020	Jan 2021 to Dec 2021	Jan 2022 to Feb 2023
Infection Prevention and Control	1	0	0	0	11
Quality & Safety	0	0	1	2	7
Information Governance	0	0	0	0	3
Corporate Communications	0	1	0	0	1
Digital Services	1	1	0	0	5
Estates	0	0	0	5	9
Health and Safety	0	0	0	0	2
Workforce & OD	4	6	4	16	22

Note: Policies with review dates between 2010 and 2016 have reduced from six to four with all four policies currently undergoing review. It should also be noted that the above figures exclude All Wales policies that have passed their review dates and therefore fall outside of the Trust policy review programme.

5. Policy Risk Assessment

The policy audit included an exercise to establish any risks associated with policies that have passed their review date, including All Wales policies. Table 13 below provides an overall breakdown of policies audited that have passed their review dates by Directorate.
- o 50 policies are in date
- o 58 policies are outside their review date with low risk
- o 4 policies outside their review dates with moderate risk

Table 17: Policy Risk Assessment

Policy Directorate	Policy in date with no risk assessment required	Policy review date passed with low risk	Policy review date passed with moderate risk	Policy review date passed with high risk
Health and Safety	7	2	0	0
Quality and Safety	6	5	0	0

Policy Directorate	Policy in date with no risk assessment required	Policy review date passed with low risk	Policy review date passed with moderate risk	Policy review date passed with high risk
Information Governance	5	3	0	0
Corporate Communications	0	1	0	0
Digital Services	5	1	1	0
Infection, Prevention and Control	8	6	3	0
Estates, Planning and Performance	10	5	0	0
Workforce and Organisational Development	9	35	0	0

5.1.1 Overall Policy Compliance Status

Figure 2 below represents the overall compliance status of the audit work undertaken on policies as of February 2023 that fall within the remit of the Quality, Safety and Performance Committee.

Figure 2: Overall Compliance
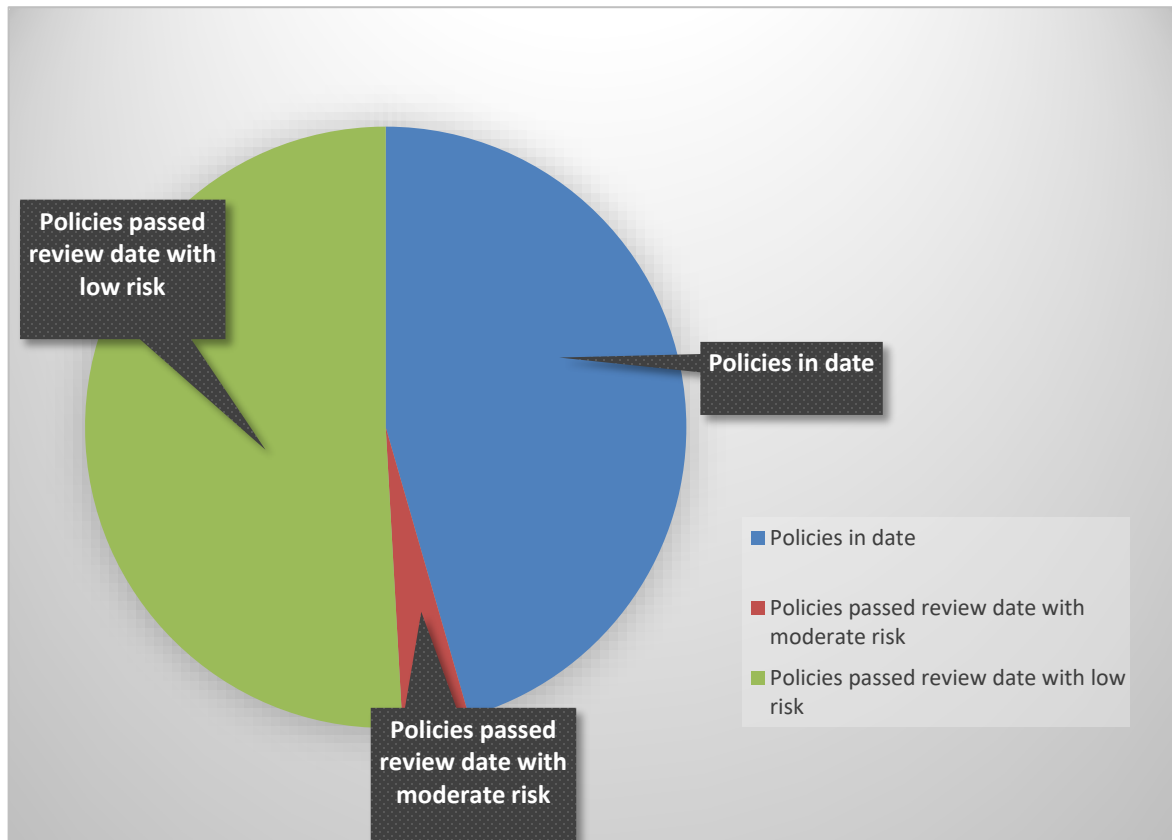
6. NEXT STEPS

6.1 In addition to providing the established standard update report on the progress of the audit review programme as per previous reporting cycles, the following will be included in the next cycle of reporting:

- Information will be included on next steps and actions to ensure the ongoing review work by Directorates to maintain policy compliance.
- A summary of the status of the All Wales policy position and updates of these policies outside their review dates.

7. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	A robust and clear governance framework for the management of policies is essential to minimise risk to patients, employees and the organisation itself; therefore, the Trust has developed a system to support the development or review, approval, dissemination and management of polices.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

8. RECOMMENDATIONS

The Quality, Safety and Performance Committee is asked to:

a) **NOTE** the progress that has been made over the last twelve months in respect of Policy Compliance Status for those policies that fall within the remit of the Quality, Safety and Performance Committee.

b) **NOTE** the Quality, Safety and Performance Committee Policy Extract Compliance Report as of **February 2023**, included in *Appendices 1 to 8.*

c) Receive **ASSURANCE** that progress is being managed via the Executive Management Board.

APPENDIX 1: QUALITY AND SAFETY POLICY REGISTER

Directorate/ Department	Policy Reference	Policy Title	Accountable Executive Lead	Approving Body	Policy Review Date (3 year cycle)	Updated Policy Approval Status	Policy status	Policy Risk assessment
Quality & Safety	All Wales	Consent to Examination or Treatment - All Wales	Executive Medical Director	EMB - Endorsing for adoption QSP - Approval for adoption Trust Board - Noting	Jul-22	All Wales	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Quality & Safety	QS 25	Preceptorship Policy for Newly Registered Nurses and Allied Health Care Professionals	Chief Operating Officer	EMB - Endorsing QSP - Approval Trust Board - Policy Update	Nov-25		Policy in date	Policy in date with no risk assessment required
Quality & Safety	QS 01	Incident Reporting and Investigation Policy	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsing QSP - Approval Trust Board - Policy Update	Mar-25		Policy in date	Policy in date with no risk assessment required
Quality & Safety	QS 02	Safety Notices and Important Documents Management Procedure	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsing QSP - Approval Trust Board - Policy Update	Jan-24		Policy in date	Policy in date with no risk assessment required
Quality & Safety	QS 03	Handling Concerns Policy	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsing QSP - Approval Trust Board - Policy Update	Apr-23		Policy in date	Policy in date with no risk assessment required
Quality & Safety	QS 08	Policy for the management of Safeguarding Allegations/ Concerns about Practitioners and those in a position of trust	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsing QSP - Approval Trust Board - Policy Update	Mar-23		Policy in date	Policy in date with no risk assessment required
Quality & Safety	QS 12	Safeguarding & Public Protection Policy	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsing QSP - Approval Trust Board - Policy Update	Mar-23		Policy in date	Policy in date with no risk assessment required
Quality & Safety	QS 04a&b	Compensation Claims Policy & Compensation Claims Procedure	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsing QSP - Approval Trust Board - Policy Update	Sep-22	April 2023: Review/ Consultation June 2023: Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Quality & Safety	QS 07	Medical Gas Cylinders Policy	Executive Medical Director	EMB - Endorsing QSP - Approval Trust Board - Policy Update	Dec-21	April 2023 Approving body	Policy review date passed – action underway/required	Policy review date passed with low risk
Quality & Safety	QS 19	Ionising Radiation Safety Policy	Executive Medical Director	EMB - Endorsing QSP - Approval Trust Board - Policy Update	Nov-21	Sept 2022 Review/Consultation April 2023 Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Quality & Safety	QS 31	International Health Partnership related Activity Policy	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsing QSP - Approval Trust Board - Policy Update	Dec-19	Sept 2022 Review/Consultation April 2023 Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk

APPENDIX 2: HEALTH AND SAFETY POLICY REGISTER

Directorate/ Department	Policy Reference	Policy Title	Accountable Executive Lead(s)	Approving Body	Policy Review Date (3 year cycle)	Policy Approval Status	Policy status	Policy Risk assessment
Health and Safety	QS 09	Latex Policy	Director of Strategic Transformation, Planning & Digital	EMB - Endorsement QSP - Approval	Mar-23		Policy in date	Policy in date with no risk assessment required
Health and Safety	QS 14	Safer Manual Handling Policy	Director of Strategic Transformation, Planning & Digital	EMB - Endorsement QSP - Approval	Mar-23		Policy in date	Policy in date with no risk assessment required
Health and Safety	QS 15	Management of Violence & Agression Policy	Director of Strategic Transformation, Planning & Digital	EMB - Endorsement QSP - Approval	Mar-23		Policy in date	Policy in date with no risk assessment required
Health and Safety	QS 18	Health Safety & Welfare Policy	Director of Strategic Transformation, Planning & Digital	EMB - Endorsement QSP - Approval	Jul-25		Policy in date	Policy in date with no risk assessment required
Health and Safety	QS 26	Safe Use of Display Screen Equipment & Appendices	Director of Strategic Transformation, Planning & Digital	EMB - Endorsement QSP - Approval	May-23		Policy in date	Policy in date with no risk assessment required
Health and Safety	QS 30	Lone Working Policy	Director of Strategic Transformation, Planning & Digital	EMB - Endorsement QSP - Approval	Mar-23		Policy in date	Policy in date with no risk assessment required
Health and Safety	QS 33	Control of Substances Hazardous to Health (COSHH)	Director of Strategic Transformation, Planning & Digital	EMB - Endorsement QSP - Approval	Mar-23		Policy in date	Policy in date with no risk assessment required
Health and Safety	QS 24	Medical Devices & Equipment Management Policy	Director of Strategic Transformation, Planning & Digital	EMB - Endorsement QSP - Approval	Jan-23		Policy review date passed – action underway/required	Policy review date passed with low risk
Health and Safety	QS 36	Workplace Equipment Policy	Director of Strategic Transformation, Planning & Digital	EMB - Endorsement QSP - Approval	Sep-22	EMB - April 2023 QSPC - May 2023	Policy review date passed – action underway/required	Policy review date passed with low risk

APPENDIX 3: INFECTION, PREVENTION AND CONTROL POLICY REGISTER

Directorate/ Department	Policy Reference	Policy Title	Accountable Executive Lead(s)	Approving Body	Policy Review Date (3 year cycle)	Updated Policy Approval Status	Policy status	Policy Risk assessment
Infection, Prevention and Control	All Wales (IPC 05)	Scottish Manual for IPC	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting	No date	N/A	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Infection, Prevention and Control	All Wales IPC 19	Infection Prevention and Control within Building Development, Change and Adaptation Policy	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting	Sep-22	N/A	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Infection, Prevention and Control	All Wales IPC 03	Aseptic Non Touch Techniques (ANTT)	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting	Jul-22	N/A	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Infection, Prevention and Control	IPC 00	Framework Policy for Infection Prevention and Control	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsing QSP - Approval Trust Board - Policy Update Noting	Nov-25		Policy in date	Policy in date with no risk assessment required
Infection, Prevention and Control	IPC 10	Hand Hygiene Policy	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting	Nov-25		Policy in date	Policy in date with no risk assessment required
Infection, Prevention and Control	IPC 21	Infection Prevention and Control Policy for the Management of Respiratory Infections and Addendum	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting	Nov-25		Policy in date	Policy in date with no risk assessment required
Infection, Prevention and Control	IPC 07	Meticillin Resistant Staphylococcus Aureus (MRSA)	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting	May-25		Policy in date	Policy in date with no risk assessment required
Infection, Prevention and Control	IPC 04	Decontamination Policy	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting	Mar-25		Policy in date	Policy in date with no risk assessment required
Infection, Prevention and Control	IPC 01	Viral Gastro Enteritis (including Norovirus) Policy & Addendum	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting	Mar-25		Policy in date	Policy in date with no risk assessment required
Infection, Prevention and Control	IPC 18	Tuberculosis Management	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting	Nov-24		Policy in date	Policy in date with no risk assessment required
Infection, Prevention and Control	IPC 15	Control and Management of Multi Drug Resistant Bacteria	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting	Jun-24		Policy in date	Policy in date with no risk assessment required
Infection, Prevention and Control	IPC 11	Specimen Collection, Handling and Transport Policy	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting	Dec-22	EMB: April 2023 QSPC: May 2023 TB: June 2023	Policy review date passed – action underway/required	Policy review date passed with low risk
Infection, Prevention and Control	IPC 06	Policy for the Management of Occupational Exposure to Blood and High Risk Body Fluids	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting	Sep-22	Dec 2022 Review April 2023 Approving Body	Policy review date passed – action underway/required	Policy review date passed with moderate risk
Infection, Prevention and Control	IPC 13	Policy for the Prevention and Control of Transmissible Spongiform	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting	Sep-22	Dec 2022 Review April 2023 Approving Body	Policy review date passed – action underway/required	Policy review date passed with moderate risk
Infection, Prevention and Control	IPC 12	Guidelines on Single Use Medical Devices	Executive Medical Director	EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting	Jul-22	Dec 2022 Review April 2023 Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Infection, Prevention and Control	IPC 09	Sharps Safety Policy & Addendum	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting	Jul-22	Dec 2022 Review April 2023 Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Infection, Prevention and Control	All Wales IPC 22	~~Management and Control of the Environment **(Cleaning)**~~ Cleaning Manual	Chief Operations Officer	EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting	May-10	Dec 2022 Consultation April Approving Body	Policy review date passed – action underway/required	Policy review date passed with moderate risk

APPENDIX 4: INFORMATION GOVERNANCE POLICY REGISTER

Directorate/ Department	Policy Reference	Policy Title	Accountable Executive Lead(s)	Approving Body	Policy Review Date (3 year cycle)	Updated Policy Approval Status	Policy status	Policy Risk assessment
Imformation Governance	All Wales	Information Governance Policy	Executive Director of Finance	EMB - Endorsing for Trust Adoption QSP - Approval for Adoption Trust Board - Policy update report	Jan-23		All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Imformation Governance	All Wales	Information Security Policy	Executive Director of Finance	EMB - Endorsing for Trust Adoption QSP - Approval for Adoption Trust Board - Policy update report	Jan-23		All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Information Governance	IG 08	Freedom of Information Act Policy	Director Corporate Governance and Chief of Staff	EMB - Endorsement QSP - Noting	Jul-25		Policy in date	Policy in date with no risk assessment required
Information Governance	IG 01	Records Management Policy	Executive Director of Finance	EMB - Endorsement QSP - Approval	Jul-25		Policy in date	Policy in date with no risk assessment required
Information Governance	IG 02	Data Protection & Confidentiality Policy	Executive Director of Finance	EMB - Endorsement QSP - Approval	Jul-25		Policy in date	Policy in date with no risk assessment required
Information Governance	IG 13	Confidentiality Breach Reporting Policy	Executive Director of Finance	EMB - Endorsement QSP - Approval	Jul-25		Policy in date	Policy in date with no risk assessment required
Information Governance	IG 08a	FOI Standard Operating Procedure	Director Corporate Governance and Chief of Staff	EMB - Endorsement QSP - Noting	Apr-22	EMB April 2023 QSPC May 2023	Policy review date passed – action underway/required	Policy review date passed with low risk

APPENDIX 5: CORPORATE COMMUNICATIONS POLICY REGISTER

Directorate/ Department	Policy Reference	Policy Title	Policy Lead(s)	Accountable Executive Lead(s)	Approving Body	Policy Review Date (3 year cycle)	Updated Policy Approval Status	Policy status	Policy Risk assessment
Corporate Communications	All Wales	Social Media Policy	All Wales Policy	Director Corporate Governance and Chief of Staff	EMB - Endorsing for Trust Adoption QSP - Approval for Adoption Trust Board - Policy update report	Jan-18	N/A	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk

APPENDIX 6: ESTATES, PLANNING AND PERFORMANCE POLICY REGISTER

Directorate/ Department	Policy Reference	Policy Title	Accountable Executive Lead	Approving Body	Policy Review Date (3 year cycle)	Is the policy on the Internet	Updated Policy Approval Status	Policy status	Policy Risk assessment
Estates, Planning & Performance	PP 04	Asbestos Policy	Director of Strategic Transformation, Planning & Digital	Quality, Safety & Performance Committee	Nov-25			Policy in date	Policy in date with no risk assessment required
Estates, Planning & Performance	PP 05	Control of Contractors	Director of Strategic Transformation, Planning & Digital	Quality, Safety & Performance Committee	Nov-25			Policy in date	Policy in date with no risk assessment required
Estates, Planning & Performance	PP 09	Water Safety Policy	Director of Strategic Transformation, Planning & Digital	Quality, Safety & Performance Committee	Nov-25			Policy in date	Policy in date with no risk assessment required
Estates, Planning & Performance	PP 03	Environmental Policy	Director of Strategic Transformation, Planning & Digital	Quality, Safety & Performance Committee	May-25			Policy in date	Policy in date with no risk assessment required
Estates, Planning & Performance	PP 13	Electrical Low Voltage Policy	Director of Strategic Transformation, Planning & Digital	Quality, Safety & Performance Committee	Sep-23			Policy in date	Policy in date with no risk assessment required
Estates, Planning & Performance	PP 01	Fire Safety Policy	Director of Strategic Transformation, Planning & Digital	Quality, Safety & Performance Committee	Sep-23			Policy in date	Policy in date with no risk assessment required
Estates, Planning & Performance	PP 10	Medical Gas Piped Systems Policy	Director of Strategic Transformation, Planning & Digital	Quality, Safety & Performance Committee	Aug-23			Policy in date	Policy in date with no risk assessment required
Estates, Planning & Performance	PP 12	Operational Policy for High Voltage Electricity Supply Systems	Director of Strategic Transformation, Planning & Digital	Quality, Safety & Performance Committee	Aug-23			Policy in date	Policy in date with no risk assessment required
Estates, Planning & Performance	PP 11	Operational Policy for High Voltage Electricity Supply Systems using a contractor as the Authorised Person (HV)	Director of Strategic Transformation, Planning & Digital	Quality, Safety & Performance Committee	Aug-23			Policy in date	Policy in date with no risk assessment required
Estates, Planning & Performance	PP 14	Ventilation Policy	Director of Strategic Transformation, Planning & Digital	Quality, Safety & Performance Committee	Aug-23			Policy in date	Policy in date with no risk assessment required
Estates, Planning & Performance	PP 02	Security Policy	Director of Strategic Transformation, Planning & Digital	Quality, Safety & Performance Committee	Nov-21		EMB April 2023 QSPC May 2023	Policy review date passed – action underway/required	Policy review date passed with low risk
Estates, Planning & Performance	PP 07	Protocol for dealing with suspect packages and bomb threats	Director of Strategic Transformation, Planning & Digital	Quality, Safety & Performance Committee	Jul-21		EMB April 2023 QSPC May 2023	Policy review date passed – action underway/required	Policy review date passed with low risk
Estates, Planning & Performance	PP 06	Business Continuity Policy	Chief Operating Officer	Quality, Safety & Performance Committee	Apr-21		EMB April 2023 QSPC May 2023	Policy review date passed – action underway/required	Policy review date passed with low risk
Estates, Planning & Performance	PP 08	Waste Management Policy	Director of Strategic Transformation, Planning & Digital	Quality, Safety & Performance Committee	Mar-21		EMB April 2023 QSPC May 2023	Policy review date passed – action underway/required	Policy review date passed with low risk
Estates, Planning & Performance	PP 01a	Safety and Protocol Prevention of Fire and Arson	Director of Strategic Transformation, Planning & Digital	Quality, Safety & Performance Committee	Feb-21		EMB April 2023 QSPC May 2023	Policy review date passed – action underway/required	Policy review date passed with low risk

APPENDIX 7: DIGITAL POLICY REGISTER

Directorate/ Department	Policy Reference	Policy Title	Accountable Executive Lead	Approving Body	Policy Review Date (3 year cycle)	Policy status	Policy Risk assessment
DIGITAL	All Wales	Email Use Policy	Director of Strategic Transformation, Planning & Digital		Jun-18	All Wales Policy review date passed – awaiting national review	Policy review date passed with moderate risk
DIGITAL	All Wales	Internet Use Policy	Director of Strategic Transformation, Planning & Digital		31 July 2025	Policy in date	Policy in date with no risk assessment required
DIGITAL	IG 05	Software Policy	Director of Strategic Transformation, Planning & Digital		31 July 2025	Policy in date	Policy in date with no risk assessment required
DIGITAL	IG 06	Anti Virus Policy	Director of Strategic Transformation, Planning & Digital		31 July 2025	Policy in date	Policy in date with no risk assessment required
DIGITAL	IG 11	Data Quality Policy	Director of Strategic Transformation, Planning & Digital		31 July 2025	Policy in date	Policy in date with no risk assessment required
DIGITAL		Information Asset Policy	Director of Strategic Transformation, Planning & Digital		31 July 2025	Policy in date	Policy in date with no risk assessment required
DIGITAL	IG 10	Staff Mobile Phone Policy	Director of Strategic Transformation, Planning & Digital	Endorsed-EMB Approval-Audit Committee	Mar-12	Policy review date passed – action underway/required	Policy review date passed with low risk

APPENDIX 8a: WORKFORCE AND ORGANISATIONAL DEVELOPMENT POLICY REGISTER

Directorate/ Department	Policy Reference	Policy Title	Accountable Executive Lead	Approving Body	Review Due (3 year cycle)	Updated Policy Approval Status	Policy Status	Policy Risk Assessment
Workforce & OD	All Wales Velindre adopted	Employment Break Scheme	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	Jan-23		All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Workforce & OD	All Wales Velindre adopted	Menopause Guidance	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Endorsement Trust Board - Adopt	Dec-21	April 2023 Submission to Approving Body	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Workforce & OD	All Wales Velindre adopted	Managing Attendance at Work Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Endorsement Trust Board - Adopt	Oct-21	N/A	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Workforce & OD	All Wales	Capability Policy and Procedure	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	Jun-21	N/A	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Workforce & OD	All Wales	Disciplinary Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	Mar-20	Review on hold NHS Employers to focus on implementation of Respect & Resolution policy	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Workforce & OD	All Wales Velindre adopted	Organisational Change Redeployment Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	Mar-20	N/A	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Workforce & OD	All Wales Velindre adopted	All Wales Lease Car Policy	Sarah Morley, Executive Director of Workforce and OD	Endorsed-EMB Approval-Audit Committee	Jun-19		All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Workforce & OD	All Wales Velindre adopted	Upholding Professional Standards in Wales (Medical Staff Only)	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	Oct-18	N/A	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Workforce & OD	All Wales (WF 10)	Accessing NHS Pension and Retirement Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	Mar-18	N/A	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Workforce & OD	All Wales Velindre adopted	Dress Code and Uniform Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	Feb-18	N/A	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Workforce & OD	All Wales Velindre adopted	Protocol on Collective Consultation of Proposed Radiance	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Endorsement Trust Board - Adopt	Sep-17	To EMB only (protocol)	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Workforce & OD	All Wales Velindre adopted	Flexible Working Policy and Procedure	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	May-17	N/A	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Workforce & OD	All Wales Velindre adopted	Exit Policy & Procedure	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	Jun-16	N/A	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk

APPENDIX 8b: WORKFORCE AND ORGANISATIONAL DEVELOPMENT POLICY REGISTER

Directorate/ Department	Policy Reference	Policy Title	Accountable Executive Lead	Approving Body	Review Due (3 year cycle)	Updated Policy Approval Status	Policy Status	Policy Risk Assessment
Workforce & OD	All Wales Velindre adopted	Pay Progression Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	Sep-25		Policy in date	Policy in date with no risk assessment required
Workforce & OD	All Wales Velindre adopted	Procedure for NHS Staff to Raise Concerns (Whistleblowing)	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Endorsement Trust Board - Adopt	Sep-25		Policy in date	Policy in date with no risk assessment required
Workforce & OD	All Wales Velindre adopted	Special Leave Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	Sep-25		Policy in date	Policy in date with no risk assessment required
Workforce & OD	All Wales Velindre adopted	Secondment Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Endorsement Trust Board - Adopt	Jul-24		Policy in date	Policy in date with no risk assessment required
Workforce & OD	All Wales Velindre adopted	Respect and Resolution Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	Apr-24		Policy in date	Policy in date with no risk assessment required
Workforce & OD	All Wales Velindre adopted	Reserve Forces Training and Mobilisation Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	Mar-24		Policy in date	Policy in date with no risk assessment required
Workforce & OD	WF 54	Violence, Domestic Abuse & Sexual Violence Workplace Policy & Procedure	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	Jul-23		Policy in date	Policy in date with no risk assessment required
Workforce & OD	WF 05	Equality & Diversity Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	Sep-25		Policy in date	Policy in date with no risk assessment required
Workforce & OD	WF 44	Working Time Regulations	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	Sep-25		Policy in date	Policy in date with no risk assessment required
Workforce & OD	GC 03	Standards of Behaviour Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	Nov-22	Policy review and updates underway Taken through governance process March 2023	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 18	Alcohol, Drugs & Sustance Misuse Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	Jun-22	Policy review and updates underway Taken through governance process March 2023	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 21	Professional Registration Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	Jun-22	Policy review and updates underway Taken through governance process March 2023	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 56	Smoke Free Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	Jun-22	Policy review and updates underway Taken through governance process March 2023	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 16	Welsh Language Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	May-22	Policy review and updates underway Taken through governance process March 2023	Policy review date passed – action underway/required	Policy review date passed with low risk

APPENDIX 8c: WORKFORCE AND ORGANISATIONAL DEVELOPMENT POLICY REGISTER

Directorate/ Department	Policy Reference	Policy Title	Accountable Executive Lead	Approving Body	Review Due (3 year cycle)	Updated Policy Approval Status	Policy Status	Policy Risk Assessment
Workforce & OD	WF 40	Supporting Staff who are Carers	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	Dec-21	Sept 2022 Review & updates March 2023 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 48	Dealing with Anonymous Communication Policy	Director of Corporate Governance and Chief of Staff	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	Oct-21	Sept 2022 Review & updates March 2023 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 46	Supporting Transgender Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	Aug-21	Sept 2022 Review & updates March 2023 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 17	Policy on Reimbursement of Removal and Associated Expenses	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	Jun-21	Sep 2022 Review & updates March 2023 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 34	Applying for Incremental Credit for Staff starting or rejoining the NHS	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	Jun-21	Currently reviewing, updating & formatting policy March 2023 take through governance process	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 45	Homeworking Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	Apr-21	Sep 2022 Review & updates March2023 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 52	Redeployment Policy (Exc OCP Redeployments)	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	Apr-21	Sep 2022 Review & updates March 2023 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 53	Redundancy and Security of Employment Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	Apr-21	Dec 2022 Review and updates March 2023 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 13	Adverse Weather Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	Mar-21	Sep 2022 Review & updates March 2023 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	Black 50/ WF19	Policy for Employing Ex Offenders and people with a criminal record	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	Jan-21	Sep 2022 Review & updates March 2023 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 31	Sabbatical Leave Policy for Consultant Medical Staff	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	Jan-21	Sept 2022 Review and updates March 2023 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 43	Mental Health, Wellbeing & Stress Management Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	Jan-21	Sep 2022 Review & updates March 2023 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 30	PADR Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	May-20	Review completed March 2023 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 35	Annual Leave and Bank Holiday Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	Mar-20	June 2022 Review & updates Dec 2022Consultation April 2023: Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 28	Recruitment of Locum Doctor Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	Apr-17	Dec 2022 Review and updates March 2023 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 29	Maternity, Paternity, Adoption and Parental Leave Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	Aug-16	Sep 2022 Review & updates March 2023 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	missing	Voluntary Early Release Scheme	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	Jun-15	Sept 2022 Review and updates March 2023 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	Black 38/ WF12	Study Leave Policy, Procedure & Guidelines	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	Nov-13	Sept 2022 Review and updates March 2023 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk

QUALITY, SAFETY & PERFORMANCE COMMITTEE

JANUARY 2023 COMMITTEE EFFECTIVENESS: REFLECTIVE EVALUATION FEEDBACK REPORT

DATE OF MEETING	16th March 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Emma Stephens, Head of Corporate Governance
PRESENTED BY	Emma Stephens, Head of Corporate Governance
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, AHPs & Health Science

REPORT PURPOSE	FOR DISCUSSION / REVIEW

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

1.   SITUATION

This report provides the Quality, Safety & Performance Committee with the results of the **January 2023 Committee Effectiveness: Reflective Evaluation Feedback**, (included at *Appendix 1)*.

The Committee is asked to:

    a. **DISCUSS** and **REVIEW** the feedback received**.**
    b. **DISCUSS** the 27% (4 out of 15) response rate.
    c. **APPROVE** the proposed actions included within *Appendix 1*.

2.   BACKGROUND

The Quality, Safety & Performance Committee reported the results of its Annual Effectiveness Survey in November 2022 and agreed to re-issue the fully survey in March 2023. Following which it was also agreed that a mechanism be identified that supported the ongoing continuous review of the Committee's effectiveness, that also enabled the reporting and monitoring of any variance throughout the year.

As a result, in **January 2023** the Committee instigated a **Reflective Evaluation Feedback Survey** comprising of 6 focused questions to be issued directly following each meeting to all attendees. It was agreed that the feedback results would be formally reported at each subsequent meeting with any highlights of good practice and proposed changes as a result of the feedback received. To ensure this newly established mechanism develops and matures effectively across the organisation, over and above the Committee's Annual Effectiveness Survey, the Annual Survey will not be brought forward to March 2023 as initially considered at the November 2022 meeting, instead it will remain as part of the Annual reporting cycle and next undertaken in March 2024 as this is the agreed refreshed annual review and reporting cycle.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 January 2023 Reflective Evaluation Feedback - Methodology

The **January 2023** survey consisted of 6 carefully selected and focused questions agreed with the Chair and Executive Lead of the Quality, Safety & Performance Committee. The questions were designed and selected to gain valuable feedback and harness the opinion

of all attendees who were present at the meeting, to ascertain their views with respect to the Committee effectiveness. The questions were posed in a structured format with survey respondents invited to provide a reason / supporting comments for each question. No personal data was collected in the completion of the survey questionnaire; hence, all responses are anonymised.

The questions were emailed to attendees immediately after the meeting.

3.2 Findings

15 people were asked to complete the survey and 4 responses were received, giving an overall response rate of **27%**. The full survey results are attached in *Appendix 1.*

Due to the low response rate no significant key themes can be accurately identified following the **January 2023** meeting. However, a short number of proposed actions in response to the feedback received are provided within *Appendix 1* for discussion and review, the majority of which have already been fully enacted as detailed below:

- **Risk & Trust Assurance Framework (TAF) -** have been placed higher on the March 2023 Public QSP Committee Agenda. Accountable Executives have also been requested to identify which papers contain information that require full discussion and advise on time required.
- **Revised reporting template –** has been developed through significant discussion and engagement across the Trust with an agreed trial implementation in the March 2023 governance reporting cycle. The trial period will follow a Plan Do Study Act (PDSA) methodology reviewed on a quarterly basis. A 'how to guide' will also sit alongside the revised reporting template to support implementation.
- **Further refining of meeting papers –** will be supported through the newly established Integrated Quality & Safety Group that will play a key role in supporting the development, maturing and embedding of streamlined, triangulated reporting to the Committee.
- **Full implementation of the 7 levels of assurance –** will begin in parallel with the revised reporting template through the March 2023 governance reporting cycle.

3.3 Proposed Next Steps

Committee attendees are asked to prioritise completion of the post meeting effectiveness questionnaire / reflective feedback so that the true effectiveness of each meeting can be ascertained.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The effectiveness of the Committee is a critical element of the Trusts ability to effectively execute its Quality & Safety responsibilities.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
	Not required for this exercise
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

5. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to:

    a. **DISCUSS** and **REVIEW** the **January 2023** feedback results**.**

    b. **DISCUSS** the 27% (4 out of 15) response rate and agree to prioritise evaluation completion moving forward.

    c. **AGREE** the proposed actions attached in *Appendix 1*.

Appendix 1:

Quality, Safety & Performance Committee January 2023 REFLECTIVE EVALUATION FEEDBACK

Response Rate: 27% response rate (4 out of 15)

Questions Asked	Response 1	Response 2	Response 3	Response 4	Proposed Action	Action Owner
Was sufficient time allocated to enable focused discussion for the items of business received at today's Committee?	Yes	Provided members have had sufficient time to read papers, there was sufficient time to scrutinise and allow for focused discussion at today's Committee	Unplanned questions raised on consent items detracted from time for main agenda items, however, there was sufficient time to discuss the main agenda. The Risk Register and TAF need to be earlier in the agenda	No, the meeting overran	**Risk & TAF to be placed higher on agenda for future meetings** **Responsible Executives to identify which papers contain information that require full discussion and advise on time required**	Secretariat / Chair Executive Leads / Secretariat
Were papers concise and relevant, containing the	In the main, some were too long and not assurance focused	Papers were relevant. There is opportunity to be more concise. We may need to adapt or change the reporting template and	Papers require refining further; however this will be achieved via the Integrated	No, but this has improved significantly over the past few meetings	**Revised reporting template to be introduced**	Director of Corporate Governance & Chief of Staff

Questions Asked	Response 1	Response 2	Response 3	Response 4	Proposed Action	Action Owner
appropriate level of detail?		it may not be easy in setting the context for public consumption	Quality & Safety Group			
Was open and productive debate achieved within a supportive environment?	Yes	Yes, the Chair is constructive and appreciative in their questions and observations, as are the Board members		Yes	N/A	
Was it possible to identify cross-cutting themes to support effective triangulation?	In the main but enhanced papers will help with this further	Yes, however the organisation is on a journey. The Integrated Quality work should help us on this path	Proactive triangulation discussion progressed well	Not always		
Was sufficient assurance provided to Committee members in relation to each item of business received?	There was some verbal assurance rather than papers being written through an assurance lens		Assurance is still not at the required level but with the assistance of the Integrated Quality & Safety Group, papers will be received that propose a	Yes	**Further refining of meeting papers** **Full implementation of the 7 levels of assurance**	Director of Corporate Governance & Chief of Staff

Questions Asked	Response 1	Response 2	Response 3	Response 4	Proposed Action	Action Owner
			level of assurance and the committee will be able to discuss this and agree or propose a level of assurance based on outcomes			