Public Quality, Safety & Performance Committee

Tue 16 May 2023, 10:00 - 13:00

via Microsoft Teams

Agenda

10:00 - 10:30
30 min

1. PRESENTATIONS

1.1. Velindre Cancer Service - Patient Story

To be led by Vivienne Cooper, Head of Nursing, Quality, Patient Experience and Integrated Care and Matthew Walters, Operational Senior Nurse

Patient Story QSP presentation May 2023 2.pdf (5 pages)

1.2. Clinical Governance and a Just Culture - Making it a reality

To be led by Zoe Gibson, Head of Nursing, Welsh Blood Service

WBS Clinical Governance and Just Culture FINAL.pdf (6 pages)

10:30 - 10:45
15 min

2. STANDARD BUSINESS

2.1. Apologies

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

2.2. In Attendance

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

2.3. Declarations of Interest

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

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

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

Public Quality Safety and Performance Committee 16th March 2023 MINUTES (v4)approved.pdf (18 pages)

2.5. Review of Action Log

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

Action Log.pdf (2 pages)

2.6. Matters Arising

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

2.6.1. Medical Devices Update

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

QSP Medical Devices Interim Report v0.1 May 23.pdf (7 pages)

10:45 - 12:30
105 min

3. MAIN AGENDA

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

3.1. Trust Risk Register

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

RISK REGISTER - QSP- 16.05.2023 - V02.pdf (8 pages)
Appendix 1 - Trust Risk Register - 05.05.2023.pdf (5 pages)
Appendix 2 -Risk Level Data - QSP - 16.05.2023.pdf (2 pages)

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

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

QSP Workforce Supply and Shape Paper May 2023.pdf (10 pages)

3.2.1. Finance Report

Matthew Bunce

Finance Report.pdf (77 pages)

3.2.2. Anti-Racist Wales Action Plan

Sarah Morley

QSP Anti-racist Action Plan16.5.23.docx.pdf (9 pages)

3.3. Velindre Cancer Service Quality & Safety Divisional Report

To be led by Paul Wilkins, Interim Director of Velindre Cancer Service

Including:
Brachytherapy Review and Action Plan

VCC Divisional Report - QSP Committee 16 May 2023 (v2).pdf (109 pages)

3.4. Quality, Safety & Performance Report

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

QSP Cttee 16.05.23 MARCH PMF Performance Report WJ FINAL version 002.pdf (65 pages)

3.5. Integrated Medium Term Plan Q4 2022-2023 Progress Report

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

QSP CTTEE Quarter 4 VCC WBS Update against IMTP Actions version 002.pdf (49 pages)

3.6. Integrated Quality & Safety Group Report

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

Including:

- Safe Care Collaborative Group
- Duty of Quality & Duty of Candour Implementation

Integrated Quality Safety Group - final.pdf (24 pages)

3.7. Quality & Safety Quarter 4 Report

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

Quality and Safety 2022-23 Quarter 4 report - final.pdf (16 pages)

3.8. Quality & Safety Improvement Tracker

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

Quality Safety Improvement Tracker (2) - final.pdf (4 pages)
App 1. Quality & Safety Assurance Tracker.pdf (6 pages)

3.9. Trust Clinical Audit Plan 2023-2024

To be led by Jacinta Abraham, Executive Medical Director

Trust Clinical Audit Plan 2023-24.pdf (32 pages)

3.10. Information Governance Assurance Report

To be led by Matthew Bunce, Executive Director of Finance

20230420-QSP IG Assurance Report -Quarter 3 and 4 2022-23-FINALV2.pdf (10 pages)

12:30 - 12:40
10 min

4. CONSENT ITEMS FOR APPROVAL

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

4.1. Trust Policies for Approval

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

Safeguarding Policies.pdf (44 pages)

4.2. Health and Care Standards 2022-2023

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

Health Care Standards Annual Report - final.pdf (20 pages)

12:40 - 12:40
0 min

5. ITEMS FOR ENDORSEMENT

There are currently no items for endorsement.

12:40 - 12:50
10 min

6. CONSENT ITEMS FOR NOTING

6.1. Vaccination Programme Board Update

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

Vaccination Programme Board QSP final paper.pdf (3 pages)

6.2. Patient Nosocomial COVID-19 Update

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

Nosocomial Update.pdf (21 pages)

6.3. Private Patient Improvement Plan

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

Private Patient Service Imp Group Highlight Report April 2023-final.pdf (6 pages)

6.4. Safeguarding & Vulnerable Adults Group Highlight Report

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

Safeguarding and Vulnerable Adults Highlight Report April 2023 - final.pdf (4 pages)

6.5. Transforming Cancer Services (TCS) Programme Scrutiny Sub Committee Highlight Report (23/03/2023)

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

**Paper not received.*

6.6. RD&I Sub Committee Highlight Report (20/02/2023)

To be led by Jacinta Abraham, Executive Medical Director

RDI Highlight Report to 16.05.23 QS&PC.pdf (3 pages)

6.7. Radiation Protection & Medical Exposures Strategic Group Highlight Report

To be led by Jacinta Abraham, Executive Medical Director

RPMESC Highlight Report 16.05.23 QS&PC.pdf (4 pages)

6.8. Body Storage Review and Recommendations (November 2022)

To be led by Rachel Hennessy, Interim Head of Operational Services

Body Storage 21042023.pdf (8 pages)

6.9. Freedom of Information Requests

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

**Paper not received.*

6.10. Nurse Staffing Levels (Wales) Act 2016 Annual Report

To be led by Anna Harries, Head of Nursing, Professional Standards & Digital

Nurse Staffing Levels - final.pdf (13 pages)

6.11. Digital Plan Update

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

Digital Services Quarterly Report.pdf (19 pages)

12:50 - 13:00
10 min

7. INTEGRATED GOVERNANCE

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

7.1. May 2023 Analysis of triangulated meeting themes

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

7.2. May 2023 Analysis of Quality, Safety & Performance Committee Effectiveness

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

- Was sufficient time allocated to enable focused discussion for the items of business received at today's Committee?
- Were papers concise and relevant, containing the appropriate level of detail?

- Was open and productive debate achieved within a supportive environment?
- Was it possible to identify cross-cutting themes to support effective triangulation?
- Was sufficient assurance provided to Committee members in relation to each item of business received?

7.3. Committee Effectiveness Survey Report - Reflective Feedback from March 2023 Committee

To be led by Emma Stephens, Head of Corporate Governance

QSP Mar survey feedback for May Committee(v1).pdf (2 pages)

13:00 - 13:00
0 min

8. HIGHLIGHT REPORT TO TRUST BOARD

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

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

13:00 - 13:00
0 min

9. ANY OTHER BUSINESS

Prior approval by the Chair required.

13:00 - 13:00
0 min

10. DATE AND TIME OF THE NEXT MEETING

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

Jenny's story

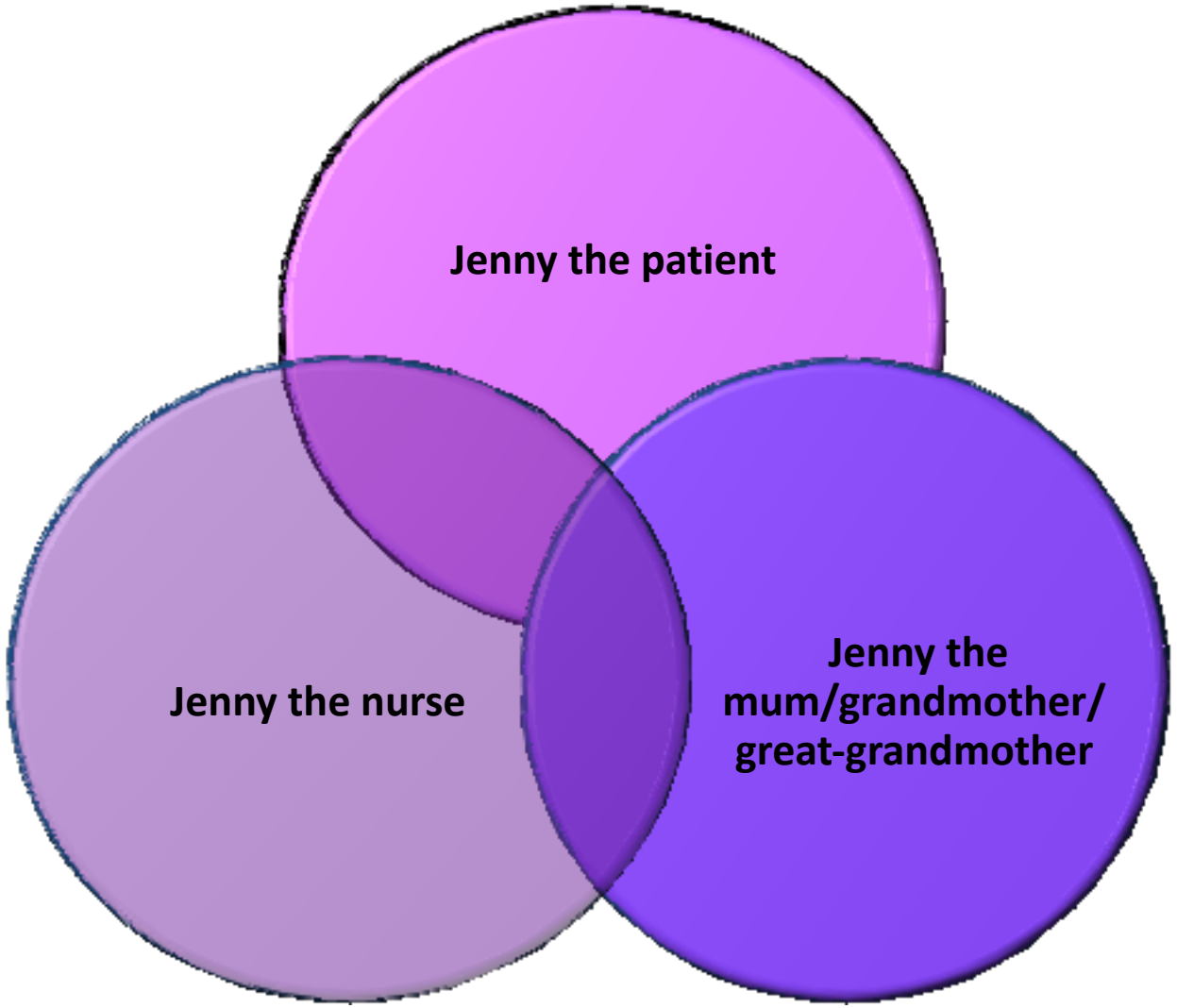
Quality, Safety and Performance Committee May 2023

Viv Cooper: Head of Nursing, Quality, Patient Experience and Integrated Care
Matthew Walters: Operational Senior Nurse

Background

- Permission to share Jenny's story ✓
- Nursing career began in 1977 as a student
- Short period working Caerphilly Miners Hospital
- 40 years + working at Velindre Cancer Centre 'a real character ☺'
- Skilled and valuable SACT nurse
- Recent short illness = palliative diagnosis
- Referred to Velindre from local DGH for inpatient palliative radiotherapy
- Consideration of other treatment options

Caring for Jenny



Jenny’s memories of Velindre

Challenges/Learning

Challenges

- Maintaining dignity and privacy when a colleague is a patient receiving palliative care
- Supporting staff particularly those who are both colleagues, friends and now caregivers – knowing limitations, being supported with our limitations
- Only one inpatient ward at VCC

Identified from literature review:

- Maintaining boundaries between relationships with colleagues or between roles as physician/colleague/friend,
- Avoiding assumptions about patient knowledge and health behaviours

Good Practice

- Protecting confidentiality. Information governance – accessing medical records. Asking Jenny her wishes
- Person-centred and holistic care
- Awareness of staff needs – respecting limitations
- Staff well-being services offered. Clinical psychology offered immediate support and support following Jen's discharge home

Learning

- Literature review of HCP as patients in palliative setting

13 studies, mostly qualitative, only one study focussed on nurse as patient, majority of studies were physicians as patients – are the issues identified in this research comparable to when a nurse is the patient?

- Is there a need for further research in this area?
- is this something we should consider as a potential study for VUNHST nursing research agenda?

Gwasanaeth Gwaed Cymru
Welsh Blood Service

Clinical Governance and a Just Culture- 'Making it a Reality.'

Zoe Gibson,

Head of Nursing.

Introduction

Gwasanaeth Gwaed Cymru
Welsh Blood Service

Successfully implementing Clinical Governance in practice is recognised as challenging, and requires staff at all levels of the organisation to understand and support :

- The concept of Clinical Governance
- Its application in practice
- Organisational Aims and Objectives

- The need to embed Clinical Governance in practice
- Benefits in ensuring Quality and Safe Care
- The need to support and engage Clinical Governance

How Do We Achieve This?

Gwasanaeth Gwaed Cymru
Welsh Blood Service

- Structured approach to clinical Governance e.g. strategies, frameworks and processes
- Robust approaches to Engagement, Involvement and Communication
- Assess and address knowledge base
- Leadership
- Culture

Culture.

Gwasanaeth Gwaed Cymru
Welsh Blood Service

Organisational Culture is key to successful embedment of Clinical Governance required to ensure high quality and safe service provision. Cultural requirements are considered to be based upon five cultural foundations, (Nicholls et al, 2000):

As organisational leaders with responsibility and accountability for quality and safe care provision, it is important that we ensure, support and enable these foundations to be in place.

A Just Culture

Gwasanaeth Gwaed Cymru
Welsh Blood Service

A culture of fairness, openness and learning by making individuals feel confident to speak up when things go wrong, rather than fearing blame.

Supporting staff to be open about mistakes allows valuable lessons to be learnt so the same errors can be prevented from being repeated, with a positive impact upon quality and safety of care provision through continuous improvement.

Such an approach was taken by Mersey Care, a N.H.S Trust providing Mental Health Services to a large population in the North of England, and utilisation of such positive stories can really help to describe the benefits of such an approach for staff and patients resulting in increased understanding and engagement:

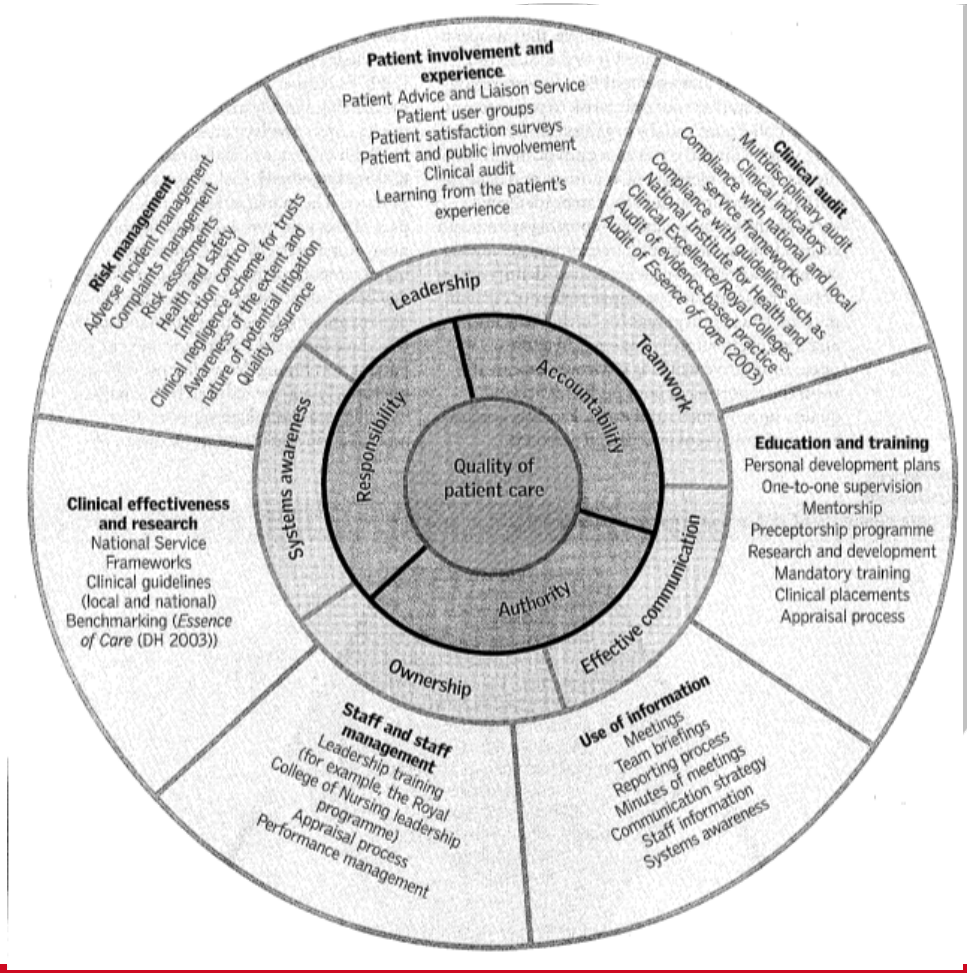
Here's their story:

https://vimeo.com/267727392?embedded=true&source=video_title&owner=4155497

How Can We Embed Clinical Governance? (1)

Gwasanaeth Gwaed Cymru
Welsh Blood Service

Through considering the 7 pillars of Clinical Governance we are able to identify opportunities that enhance staff engagement and enable clinical governance to be embedded in practice, (Braine, 2006):



Minutes

Public Quality, Safety & Performance Committee

Velindre University NHS Trust

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

ATTENDANCE		
Stephen Harries	Vice Chair and Independent Member	SH
Hilary Jones	Independent Member	HJ
Nicola Williams	Executive Director of Nursing, Allied Health Professionals & Health Science	NW
Carl James	Director of Strategic Transformation, Planning & Digital	CJ
Jacinta Abraham	Executive Medical Director	JA
Lauren Fear	Director of Corporate Governance & Chief of Staff	LF
Matthew Bunce	Executive Director of Finance	MB
Alan Prosser	Director of Welsh Blood Service	AP
Paul Wilkins	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	**Welsh Blood Service (WBS) – Donor Story** Led by Alan Prosser, Director of Welsh Blood Service A video donor story had been shared with Committee members in advance of the meeting, describing the establishment of a donation pathway by WBS for people with Genetic Haemochromatosis. AP introduced Julie Curry (Deputy Head of Nursing WBS) and Ashley Bowen-Jones (Donor Contact Centre Team Leader) who had been integral in the development of this new pathway. The pathway development involved a review of the frequency of donations for the population of Wales with haemochromatosis, that facilitates people with hereditary haemochromatosis to donate blood more frequently, provided that eligibility criteria are met. This not only supports effective management of the donor's condition, but reduces impact on Health Boards, reduces travelling time for donors and also provides additional blood / blood products for NHS Wales; the blood prior to these changes would have been discarded. The video included a Donor with haemochromatosis, describing the positive impact this change has had, giving a positive feeling of being able to provide additional blood to the population of Wales and avoids him	

	having to make frequent hospital visits. The Committee provided extremely positive feedback to the team as this development has resulted in increasing the stock of blood and blood products. The Committee was advised that the National Oversight Group will be informed of this work, in addition to exploring engagement with GPs, the wider health community and Haemochromatosis Society. As increasing the number of diverse donors is a key element of the 5 year strategy, CJ queried whether potential donors may exist within other areas, but are currently unable to do so. AP advised that the strategy will continue to focus on reaching Black And Ethnic Minorities (BAME) and hard to reach communities, as a shortage of such donors is recognised. The outcomes of this work will be showcased. The Committee thanked the team and the donor for providing this story.	
2.0.0	**STANDARD BUSINESS**	
2.1.0	**Apologies** received from: • Steve Ham, Chief Executive Officer • Professor Donna Mead, Velindre University NHS Trust Committee Chair • Sarah Morley, Executive Director of Organisational Development & Workforce • Cath O'Brien, Chief Operating Officer	
2.2.0	**In Attendance** • Nigel Downes, Interim Deputy Director of Nursing, Quality & Patient Experience (ND) • Susan Thomas, Deputy Director of Organisational Development and Workforce (deputising for Sarah Morley) (ST) • Zoe Gibson (observing) - Head of Nursing, Welsh Blood Service (ZG) • Emma Rees, Deputy Head of Internal Audit (NWSSP) (ER) • Katrina Febry, Audit Lead, Audit Wales (KF) • Gareth Tyrrell, Head of Technical Services, CIVAS@IP5 (NWSSP) (GT) • Ruth Alcolado - Medical Director, Corporate Services (NWSSP) (RA) • Ashley Bowen-Jones – Donor Contact Centre Team Leader (for item 1.1.0) (ABJ) • Julie Curry – Deputy Head of Nursing (for item 1.1.0) (JC) • Peter Gorin, Head of Corporate Planning (to observe item 6.3.0) (PG) • Viv Cooper, Head of Nursing, Quality, Patient Experience and Integrated Care (for item 6.6.0) (VC) • Sarah Owen, Health and Safety Manager (for item 6.6.0) (SO) • Bethan Tranter, Chief Pharmacist (for item 7.6.0) (BT)	
2.3.0	**Declarations of Interest** To be led by Vicky Morris, Quality, Safety and Performance Committee Chair There were no declarations of interest.	
2.4.0	**Review of Action Log** To be led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science	

	The action log was discussed in detail and Committee members confirmed that they were assured that all actions identified as closed on the action log had been fully instigated and could therefore be closed. Items not yet due for completion were not discussed and will remain open. The remaining action log was reviewed and the following was agreed: ***(17/02/2022 – superseded action now for 2023/24) – Invitation of a Public Health Wales (PHW) representative to a future Board development session to discuss the Trust's role / requirements and public health –*** LF confirmed that Public Health matters would be included on the agenda for the October 2023 Board Development Session, closing the action. ***4.1.0 (10/11/2022) - A review of narrative around Radiotherapy and SACT performance (within IMTP quarterly progress report) to be reviewed to align with VCS performance report –*** PW advised that that a cross-check of narratives of both reports would ensure consistency going forward, closing the action. ***3.1.1 (17/01/2023) – LF to address governance process for new products prior to coming onstream with NWSSP –*** LF indicated that this requires addressing further due to the potential 'approval role' required by the Committee and advised that further discussion would be undertaken with the Medical Director (NWSSP Corporate Services). Outcomes will be circulated to all members ahead of the May 2023 Committee. ***4.3.0 (17/01/2023) – NW/DM to discuss cessation of streamlining process for Radiotherapists and impact on recruitment –*** NW advised that this would be discussed at the next 1:1, planned for April 2023. The Committee NOTED that the action log would be amended as appropriate.	**Secretariat** **Secretariat** **LF** **NW/DM**
2.5.0	**Matters Arising** To be led by Vicky Morris, Quality, Safety and Performance Committee Chair • **Medical Devices Report – Oral Update** Led by Paul Wilkins, Director of Velindre Cancer Service and Peter Richardson, Head of Quality Assurance and Regulatory Compliance (WBS) PR / PW provided the following assurances that appropriate governance processes and structures are in place: • A review of the current corporate Medical Devices Policy and references to standards (which have now been superseded) will be undertaken. • A gap analysis is underway to analyse whether current Trust processes are in line with the current recommendations and guidelines in relation to management of medical devices within a healthcare environment; no concerns have been identified to date. • Re-establishment of the Medical Devices Group (to cover both divisions), including assurance focus as well as technical. • A documented assurance structure will be sighted at May 2023 Committee. • Resource issues within the department are currently being worked through; partial resolution of this is anticipated by sharing of resources between divisions. • A device tracking system has now been purchased and training is currently underway.	

	• A recovery plan is in place following the pause of the routine maintenance work plan during the COVID-19 pandemic, in conjunction with the current Service Level Agreement.	
3.0.0	**CONSENT ITEMS FOR APPROVAL** (The consent part of the agenda considers routine Committee business as a single agenda item. Members may ask for items to be moved to the main agenda if a fuller discussion is required).	
3.1.0	**Draft Minutes from the meeting of the Public Quality, Safety & Performance Committee held on the 17th January 2023** Led by Vicky Morris, Quality, Safety and Performance Committee Chair The Committee **APPROVED** the minutes from the 17th January 2023 Public Quality, Safety & Performance Committee and no further comments were raised.	
3.2.0 **3.2.1** **3.2.2**	**Trust Policies for approval** Led by Jacinta Abraham, Executive Medical Director and Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science **QS19 – Ionising Radiation Safety Policy** VM had raised a small number of minor formatting issues prior to the Committee and JA advised that these had now been clarified and would be included subject to APPROVAL of the policy. **IPC13 – Policy for the prevention and control of transmissible spongiform encephalopathies (Creutzfeldt-Jakob Disease (CJD)) minimising the risk of transmission** NW advised the Committee that the following changes would be made to the policy prior to sighting at Trust Board: ○ Review date to be revised; ○ Inclusion of rationale around requirement of an Equality Impact Assessment (not required as only minor amendments have been made to the policy since the last formal review) on the cover paper. PR noted that the policy may require a shorter review period due to the current high level of activity in relation to blood and blood transfusions and the likelihood of further changes over the next 6-12 months. Following discussion, it was agreed to retain the standard 3 year review period, with the caveat that the policy will undergo earlier review (via the Quality, Safety & Performance Committee) should this be required. WBS will notify the Infection Prevention & Control Team if earlier changes are required. The Committee **APPROVED** both policies subject to the amendments detailed above.	
4.0.0	**CONSENT ITEMS FOR ENDORSEMENT**	
4.1.0	**Committee Terms of Reference and Operating Arrangements** Led by Emma Stephens, Head of Corporate Governance The proposed revised Terms of Reference were provided to the Committee for ENDORSEMENT and the following key amendments were highlighted:	

	• The addition of the Trust Integrated Quality & Safety Group to the relationships and accountabilities within the Board, its Committees and groups, and; • The reflection of this in the wider governance and accountability framework. It was acknowledged that further amendments will be made to the accountability framework as the Integrated Quality & Safety Group and associated meeting structure matures and the work on the overall Quality & Safety meeting structure concludes. It was noted that subject to ENDORSEMENT at today's Committee, the Terms of Reference would also be received at the April 2023 Audit Committee for ENDORSEMENT of the required revision to Schedule 3 of the Trust Standing Orders to include the revised Terms of Reference, prior to onward approval at Trust Board. HJ noted that there had been no mention of outputs following programming work undertaken by the Velindre Futures Group. CJ informed the Committee that a Strategic Capital Board will commence from April 2023, to finalise Velindre Futures arrangements (including the move of a number of elements currently included in the programme to business as usual and taking forward more important matters within the programme such as Acute Oncology, SACT & Outreach Services, IRS implementation). This, together with the Velindre Futures outputs, will be reported as the overall cancer strategy to the TCS Scrutiny Sub-Committee. Notwithstanding the above, it was confirmed that no further changes were required to the Committee Terms of Reference. SH queried the phrasing of the Quorum section of the report and suggested reworking the grammar of this section. LF responded that this would be considered; however this is based on Welsh Govenrment's Model Standing Orders. The Committee **ENDORSED** the amendments to the Committee Terms of Reference and Operating Arrangements.	
4.2.0	**Committee Cycle of Business** Led by Emma Stephens, Head of Corporate Governance The updated Committee Cycle of Business was provided to the Committee, following formal review undertaken during February 2023 in collaboration with the accountable Executive Leads and Committee Chair. The following was highlighted: • The addition of items currently reported through the Committee but not captured on the Cycle of Business; • The addition of new items of business for assurance purposes; • Review of frequency of reports with a view to streamlining the business of the Committee; • Further areas identified where reporting is currently being progressed. NW identified two further changes identified on the cycle of business since publication of papers: HTW Quality Report to be included on cycle for November; and the omission of the Quality & Safety Improvement Tracker to be brought to each Committee from May 2023 onwards. KP will make the required changes.	**KP**

	VM queried how outcomes of regulatory inspections are included in the Cycle of Business and sighted by the Committee (receipt of reports, recommendations and follow up action plans). It was agreed that a retrospective update would be brought to the May Committee via the refreshed Quality and Safety Improvement Tracker, clarifying the position in relation to improvements identified from previous reviews in addition to reviews to be undertaken. HJ queried the absence of staff survey results, noting that previous conversations had indicated the inclusion of this item on the cycle of business. ES agreed to liaise with Workforce and Organisational Development to clarify the capture and reflection of this, as this will potentially be included within the Workforce report. ES acknowledged the support of the Executive team in the accurate update of the Cycle of Business and the Committee **APPROVED** the revised Cycle of Business pending the additional changes being made.	**ES**
5.0.0	**NHS Wales Shared Services Partnership (NWSSP)**	
5.1.0	**Transforming Access to Medicine / Clinical Pharmacy Technical Services Update** Led by Gareth Tyrrell, Head of Technical Services, CIVAS@IP5 The CIVAS@IP5 Service Performance Report was received, outlining current levels of performance. GT highlighted the following: • The report will include the Transforming Access to Medicines (TRAMS) and Pharmacy Technical Services Division of Shared Services within the report going forward, in addition to the CIVAS@IP5 Medicines Unit service performance. • The Service continues to meet all regulatory requirements. • Completion of the Medicines and Healthcare Products Regulatory Agency (MHRA) action plan. • Two service complaints had been received from Health Boards in relation to antibiotics for the treatment of Strep A, both of which had been fully investigated and closed. The following points were noted: • Reference to a vacant post had been included in error, as the team is now fully staffed. • Further explanation of the acronyms in Appendix 1 were requested (in particular GMP and GDP). GT advised that these were in relation to 'Good Manufacturing Practice' and 'Good Distribution Practice'. • The absence of headings in Appendix 1, in addition to this being written in the past tense. GT advised that a holistic review of the report would be undertaken prior to the next submission and the Committee **NOTED** the report and performance indicators.	
5.2.0	**Implementation of Duty of Quality Update** Led by Ruth Alcolado, Medical Director, Corporate Services (NWSSP) The Committee received the current position and an assessment of NHS Wales Shared Services' readiness to comply with the requirements of the Duty of Quality and RA advised that further updates to the readiness assessment will follow	

	today's discussions at the Senior Leadership Group, before sighting at Partnership Board later this week. NW also advised the Committee that the (still awaited) final Statutory Guidance documentation would cement responsibilities applicable to hosted organisations (and therefore reporting arrangements) going forward. The Committee was informed that reporting requirements for both NWSSP and Health Technology Wales (as the Trust's other hosted organisation) had now been included within the Committee Cycle of Business going forward. The Committee **NOTED** the Duty of Quality NWSSP readiness.	
5.3.0	**Update – NWSSP Self-Assessment of Health and Care Standards** Led by Ruth Alcolado, Medical Director, Corporate Services (NWSSP) The Committee received a summary of the final iteration of NWSSP Health and Care Standards action plan and acknowledgement of the new approach to reporting required from 1st April 2023 (as a result of the commencement of the Duty of Quality and the new Health & Care Quality Standards). The Committee **NOTED** the progress made in relation to the NWSSP Health and Care Standards Action Plan.	
6.0.0	**MAIN AGENDA** (This section supports the discussion of items for review, scrutiny and assurance).	
6.1.0 **6.1.1**	**Trust Risk Register / Trust Assurance Framework** Led by Lauren Fear, Director of Corporate Governance and Chief of Staff **Trust Risk Register** The Trust risk register update was provided using the newly formatted report template with the 7 levels of assurance. The report provided the status of the current extract of risks (scoring 12 and above) reportable to Trust Board, in line with the renewed risk appetite levels. LF highlighted the following: • Further strengthening of action plans for each risk is required (resulting in an assurance rating of 1). • Reference to actions taken in relation to the two specific risks discussed at the January 2023 Quality, Safety & Performance Committee. • Level 1 mandatory framework training for all staff is now complete and loaded onto ESR; this is to be completed every two years. • Emerging trends and themes are to be included in the cover report going forward for ease. VM noted that there were no associated action plans against a number of risks scoring level 20, which may present concerns due to the public nature of the document. LF agreed to address this. VM also requested that all fields within the Risk Register are to be completed in consistent and appropriate order prior to sighting at committee, to facilitate more focused discussion in relation to the risks in hand.	**LF** **LF** **LF**

	In terms of overall formatting, inconsistencies in relation to risk titles, descriptions and actions were recognised and it was agreed to re-order columns for improved clarity. LF advised that detailed training had been undertaken in conjunction with departmental leads across the Trust in terms of consistent data input and that risk entries were appropriately worded in the main. LF also advised that a review of the Risk Register (those scoring 15 or greater) is undertaken at Executive Management Board prior to being provided to the Committee and that work will continue to improve the presentation. The Committee **NOTED** the risks level 20,16 and 15, as well as risks in the safety domain with a level of 12 reported in the Trust Risk Register and **NOTED** the ongoing developments of the Trust's risk framework.	
6.1.2	**Trust Assurance Framework** The Committee received an update in relation to the status of the Principal Risks identified in the Trust Assurance Framework and assurances in place to support managment of these. LF highlighted the following: • Following Committee / Trust Board feedback during January 2023, substantial work has been undertaken in relation to the format of the template. It is anticipated that this will be completed and the refreshed template sighted at the May 2023 Quality, Safety & Performance Committee and Trust Board. • A refresh of Strategic Risks is currently being undertaken in conjunction with divisional Senior Management Teams / Senior Leadership Teams, to be included in the next (May 2023) cycle. VM suggested a 'deep dive' exercise into two of the risks identified for oversight of the Quality, Safety & Performance Committee, to identify gaps in assurance and receive associated action plans; this is also to be captured in the Trust Assurance Framework section of the Committee Cycle of Business. HJ requested further explanation around the establishment of a programme group and range of outputs defined in relation to the Workforce Planning risk, in addition to triangulation of this with the main Workforce / Finance report. It was agreed that the information in the Trust Assurance Framework would be updated to reflect current activity around Workforce Planning to mitigate vacancies within the Trust. The Committee **DISCUSSED** and **NOTED** the update to the Trust Assurance Framework Dashboard and the planned further development.	**ES** **ST**
6.2.0	**Triangulated Workforce & Organisational Development Performance Report / Finance Report** Led by Susan Thomas, Director of Workforce and Organisational Development and Matthew Bunce, Executive Director of Finance The trianglated Workforce / Finance report highlighted the key workforce and associated financial risks currently faced by the Trust, in addition to the required management actions to ensure mitigation was discussed. The following key points were highlighted: The ability to deliver service requirements through the current workforce model remains the main risk, with transformation of the multi-professional workforce across the Trust (and associated re-allocation of finance) required.	

- A number of projects are currently in progress, focusing on hotspot areas, in addition to addressing changes required to the workforce model as a whole.
- Significant work is currently being undertaken to develop a holistic 'supply and shape' framework around workforce planning, addressing workforce trends, challenges and risks. This will be achieved by using the following mechanisms:
  - *Recruitment and development of appropriate roles* – The established Recruitment, Attraction and Retention group will address recruitment issues and streamlining of the recruitment process. Additionally, a range of marketing materials and promotional videos have been developed by staff within the Welsh Blood Service Collections Teams; these interventions will be evaluated by new starter feedback and website footfall.
  - *Boost existing workforce resource via improvements to ways of working* – Work is currently being undertaken around demand and capacity skill mixing, with short term recruitment in place to address gaps within the service. A number of joint appointments with Cardiff & Vale University Health Board have also been made. It is the intention to expand to a 7 day service.
  - *Retain the current workforce via provision of opportunities and optimisation of skillsets* – Sickness absence has shown some improvement, but remains at 6.3%. An extensive list of wellbeing interventions are in place, in addition to a programme of work to develop flexible working to support Velindre as an employer of choice.
  - *Manage workforce performance and absence, ensuring appropriate standards of staff behaviour across the Trust* – Staff will be utilised across multiple departments to support effective service delivery.
  - *Develop the capacity of existing staff, expanding competencies through learning programmes* – A number of education and leadership programmes are in place, in addition to the development of the School of Oncology and Centre for Learning.
  - *Use of agency staff to temporarily address gaps in service provision* – Agency spend is currently supporting resolution of the 7.8% vacancy gap, alongside the interventions mentioned above.

VM queried whether KPIs relating to recruitment and retention had moved forward in areas outside of SACT. ST advised that improvements are minor and 6 monthly monitoring (as opposed to quarterly) of such KPIs would be more appropriate to evidence improvements more easily.

NW advised that discussions at the Integrated Quality & Safety Group in relation to a number of metrics identified the need to consider the overlay of KPIs, quality metrics and associated outcomes and the urgent need to develop a quality dashboard will be critial to achieving this.

SH queried whether the agency spend noted in the report covered both the current vacancy gap and sickness. MB confirmed that this is the case, however it was noted that high cost Locums are not utilised by the Trust to cover medical staff.

JA noted that Velindre (in comparison with other health bodies) does not incur significant spend on medical Locums, partly due to the challenge in obtaining expertise at the required level. However, an alternative solution is required to ease the pressure on internal staff currently used for this purpose.

	HJ queried why only 70 of 120 vacancies had been advertised (and the outcome of the 50 positions that had not been). ST advised that this was due to misalignment between the current workforce and required future workforce; upon a review of vacancies, it had been identified that a number of these were not actually required. CJ commented that simply maintaining the same position in terms of staff retention and stabilising sickness levels could be deemed an improvement, considering the current climate (COVID-19 burnout, industrial action regarding pay and conditions and the like). A realistic approach to improving staff engagement, wellbeing and therefore ensuring their return to work would allow the development of plans to align with services the Trust wishes to provide. It was recognised that staff needs are changing and improved leadership and understanding of reasons for the current level of vacancies is critical. The Committee **NOTED** and **CONSIDERED** the workforce risks, opportunities and associated financial impacts outlined within the content of the report.	
6.2.1	**Finance Report** Led by Matthew Bunce, Executive Director of Finance The Committee received the Financial Report, outlining the Trust position and performance for the period to end of January 2023. The following was highlighted: • Public Sector Payment Performance had seen a reduction in compliance during January (to 90%) as a direct result of vacancies within Shared Services' payment teams. It is anticipated, however, that the compliance target (95%) will be achieved by year end. • Confirmation that funding will be provided by Welsh Government for the significant increase in energy prices, in addition to COVID-19 response costs. • Capital schemes remain on track, despite challenges presented by slippage on major schemes. • Commissioners have not yet committed to providing the full COVID-19 funding request for 2023-24 and this will flow through the national funds flow mechanism. This remains a risk for the Trust. • All financial KPIs remain on target. • It is anticipated that the Trust will achieve financial break-even for the year 2022-23 at year end. The Committee **NOTED**: • The content of the January 2023 financial report, performance to date and year end forecast to achieve financial break-even. • Key risk in relation to income to cover COVID-19 backlog additional capacity costs. • The TCS Programme financial report for January 2023.	
6.3.0	**Performance Management Framework Report** Led by Carl James, Director of Strategic Transformation, Planning & Digital The first iteration of the new Trust Performance Report was received for the period April 2022-January 2023. The report seeks to provide an enhanced view of the Trust performance for the period, using a dashboard approach to triangulate interaction between operational delivery, service quality and safety, workforce and finance to represent an uncomplicated, holistic representation.	

	VM queried whether the Duty of Quality would be adequately met in terms of Quality Performance Indicators. NW advised that the Duty of Quality requires the urgent development of a Quality dashboard, agreeing required quality, safety, harm, outcome and experience measures and throughout this year the development of a Trust wide Quality Management System. A number of measures are already in place, however a significant amount of work is still required. The Executive Management Board had agreed to include the required resources in the IMTP. Two errors were identified within the document provided that will be amended for February's data: the omission of Hand Hygiene and the listing of the patient experience target at 85%, to be amended to 95%. • **Velindre Cancer Service Performance** Led by Paul Wilkins, Director of Velindre Cancer Service PW advised the following: • Comprehensive programmes of work are in place to manage continued challenges in terms of providing capacity meet overall Systemic Anti-Cancer Therapy (SACT) and Radiotherapy demand. 100% compliance was achieved in relation to emergency SACT and 97% in relation to non-emergency SACT. Significant variations within referral patterns are also being addressed with Health Boards. • There is currently no availability of validated data in relation to Radiotherapy performance. • Significant manual monitoring of all waiting lists is currently in place across all areas until the availability of electronic data (following the introduction of the new Digital Health Care Record (DHCR) system). Manual validation of Radiotherapy data is also currently being undertaken for this reason. There is currently no date for when this data may be available electronically and it is anticipated that resource issues will continue over the immediate weeks / months. • Analysis of a slight increase in healthcare associated infections over the period had identified no trends or themes. An increase has been seen across Wales in recent years which had not been felt to date in the Trust. • All targets continue to be met in terms of pressure ulcers, falls, sepsis and Delayed Transfers of Care. VM queried when Radiotherapy performance data would be electronically available via the new system and whether additional resource was required to support current manual validation (to ensure patients do not miss out on treatment). PW advised that no date had been confirmed and that implementing additional resource to support with manual validation would be challenging due to the specialist nature of the data. However, a specialist task force is being established to work on specific areas of data in the interim. CJ indicated that the current reporting of KPIs against (The Royal College of Radiologists) RCR targets will be stood down (as required by the national policy) with a move to reporting against (Clinical Oncology Sub-Committee) COSC targets. It would be of benefit to run both reports alongside one another to explain potential variations in performance, resulting due to changes in the reporting mechanism.	**PG**

	SH noted that the 93% of patients that rate experience at Velindre at 9 out of 10 or above had been based on the 'friends and family survey', as opposed to the 'Your Velindre Experience' survey (completed by patients and currently reporting at 85%). NW advised that 'friends and family' is the national title and a one question, UK-wide patient satisfaction measure asking if you would recommend service to your freinds and family, whereas the patient survey is longer, seeking more in-depth information. While both figures are currently reflected, the Trust is procuring a patient voice body to develop an improved patient survey. • **Welsh Blood Service Performance** Led by Alan Prosser, Director of Welsh Blood Service AP advised the following: • 98% of quality incident investigations were closed within 30 days during January, with no adverse events reported. • O negative supplies were recovered without the requirement to import, despite the difficult collections season. • Collections exceeded demand for the month, with minimal wastage, indicating alignment with supply and demand in this area. • Platelet wastage remains above target, to be addressed by a platelet task and finish group. • An increase in bone marrow and stem cell collection activity with encouraging figures reported in both areas. • Continued very high level of Donor satisfaction. The Committee **NOTED** the Performance Management Framework.	
6.3.1	**Welsh Blood Service Quality Safety & Performance Divisional Report** Led by Alan Prosser, Director of Welsh Blood Service Key quality, safety and performance outcomes and metrics for the period October 2022 to January 2023 were discussed under item 6.3.0. The Committee **NOTED** the content of the report.	
6.4.0	**IMTP 2022/23 Quarterly Actions Progress Report (Q3)** Led by Carl James, Director of Strategic Transformation, Planning & Digital The Committee received the 2022/23 Quarter 3 IMTP position. CJ noted that although progress remains broadly on track, more precise analysis of the impact on current performance and future plans is required. Committee members agreed that a more enhanced understanding of key deliverables for the Quality, Safety & Performance component of the IMTP is required, in addition to analysis of targets, accurate associated narrative and high level assurance that targets will be met. The Committee was assured that work would be undertaken across both divisions to achieve this. The Committee **NOTED** the progress made as of Quarter 3 (2022-2023) in delivery of the key Trust actions included within the approved IMTP for 2022-2025, subject to discussions noted above.	**CJ**

6.5.0	**Value Based Healthcare** Led by Matthew Bunce, Executive Finance Director The Committee received its first Value Based Healthcare report, which outlined progress made in relation to the Value Based Healthcare programme of work and associated bid submitted to Welsh Government (during August 2022). MB advised that funding had been received for 2 of 5 projects submitted to WG (WBS Preoperative Anaemia Pathway and Value Intelligence Centre) to support progress of the work programme. External BI support has been sought to progress a number of elements of the programme, to be followed by the recruitment of Value Intelligence Centre staff and the establishment of the Value Based Healthcare Delivery Group / sign off of associated Terms of Reference. No comments or questions were raised and the Committee **NOTED** the progress of the Value-Based Healthcare Programme.	
6.6.0	**Medical Examiner Service & Mortality Framework Report** Led by Viv Cooper, Head of Nursing, Quality, Patient Experience and Integrated Care and Sarah Owen, Health and Safety Manager The Committee received an update regarding the progress to date and actions being taken to implement the Medical Examiner Service requirements within the Trust. The following was highlighted: • The Trust currently continues to meet the minimum statutory requirements and good relationships have been forged with Medical Examiner Service colleagues. • Positive progress has been made and a dedicated resource has recently been committed to support the establishment of a robust mortality framework for the Trust. • There is a significant Business Intelligence challenge in relation to the reporting requirements for mortality data (coming into force on the 1st April 2023). • A Once for Wales (OfW) Datix Mortality Module is now available for use and training is currently being scheduled for relevant staff, to facilitate consistent reporting across multiple areas. • Additional resource for a Mortality Review and Improvement Facilitator has been approved by the Executive Management Board and the appointment process has commenced. This will also enable the re-establishment of an overarching Mortality Group to support the collation and analysis of all mortality data. • New data standards approved by the Welsh Government, Welsh Cancer Network and Welsh Information Standards Board require comprehensive radiotherapy and Systemic Anti-Cancer Therapy datasets including 30 day mortality metrics. This is currently undertaken manually and for these new requirements to be met from 1st April 2023, significant clinical validation automated data capture through a quality metric / business intelligence mechanism is required. Although this is a Business Intelligence priority, the Trust may potentially be unable to start providing this information from 01/04/2023. This is to be resolved at Executive level as a matter of urgency. *Next steps:* • Appoint a Mortality Review and Improvement Facilitator as a matter of urgency.	

	• Continue to with the Medical Examiner Service to address the national reporting requirements outlined in the report. • Address the identified data standards / reporting issue. JA thanked the team and acknowledged the significant amount of work undertaken to date and current position in terms of compliance. The Committee **NOTED** the developments to date and next steps being taken to ensure the Trust is fully meeting its Medical Examiner Service Statutory responsibilities, in addition to establishing a robust Mortality and Morbidity process for the Trust.	
6.7.0	**Quality & Safety Quarter 3 report** Led by Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience The Quality & Safety Quarter 3 report provided an overview of Trust responsibilities in relation to key elements of Quality & Safety, including claims, inquests, safety alerts and Putting Things Right for the period 01/10/2022-31/12/2022. ND highlighted the following: • Implementation of the Duty of Candour (statutory compliance required by 1st April 2023) remains a priority. • Preparation for Welsh Risk Pool Q4 assessment and analysis of compliance with learning from claims and redress cases is currently underway. • A recent validation audit of Putting Things Right (PTR) by the Welsh Risk Pool (WRP) had identified an anomaly in the classification of the Trust's reporting of compliance with 30-working day concerns response. The WRP advised that changes are taking place nationally regarding classifications, but day one is currently classed as the day a concern is received; the Trust had been recording this as day 0. This had resulted in the completion of only 4 of 9 PTR concerns within 30 days during quarter, however all 9 had been responded to within 31 working days. The Trust has now made the necessary system changes to rectify this moving forward. VM requested improved visibility of graphs included in the report and this will be addressed for future reporting. VM noted that this would be ND's final attendance at the Quality, Safety & Performance Committee due to his departure from the Trust at the end of March 2023 and Committee members wished him well. The Committee **DISCUSSED** and **APPROVED** the report.	
6.8.0	**Palliative and End of Life Care Quality Statement** Led by Helen Way, ANP / Lead Nurse Palliative Care A detailed Gap Analysis was provided to the Committee and discussed. The document outlined the Trust's position in respect of meeting the All Wales Palliative Quality Standards (published October 2022). HW highlighted the following: • The Trust is currently transitioning from the previous Palliative Implementation Board to the new National Clinical Framework for Palliative and End of Life Care. • The Trust is represented in all relevant workstreams and projects currently being developed.	

	• The development of an All Wales Palliative and End of Life Care dashboard is currently in discussion, which will facilitate improved (electronic) data collection and national access to data. • Patient experience is currently captured via CIVICA; however a new palliative patient experience survey is nearing completion, which will be piloted by the Velindre Palliative Care Team. • A national review of 7 day Palliative Care working is to be undertaken; however a holistic review of the Palliative structure, including weekend availability of hospice care, other associated services and competencies of staff will be required to manage increasingly complex patient needs. NW thanked HW for her leadership and commitment to the service and it was acknowledged that critical metrics are to be embedded as part of the Performance Management Framework. The Committee **REVIEWED** and **NOTED** the Palliative Quality Standards Gap Analysis.	
7.0.0	**CONSENT ITEMS FOR NOTING**	
7.1.0	**Draft minutes from the meeting of the Private Quality, Safety & Performance Committee held on 17th January 2023** Led by Vicky Morris, Quality, Safety and Performance Committee Chair The Committee **NOTED** the minutes from the Private Quality, Safety & Performance Committee held on 17th January 2023.	
7.2.0	**Highlight Report from the Infection Prevention & Control Management Group** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science The Committee **NOTED** the Infection Prevention & Control Management Group 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.	
7.3.0	**Professional Nursing Update Report** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science The Committee **NOTED** the Professional Nursing update for the period October 2022 to February 2023, including the Nursing Strategy agreed themes and principles.	
7.4.0	**Transforming Cancer Services (TCS) Programme Scrutiny Sub Committee Highlight Report** Led by Stephen Harries, Vice Chair and Chair of the TCS Programme Scrutiny Sub-Committee The Committee **NOTED** the content of the report and actions being taken.	

7.5.0	**Highlight Report from the Trust Estates Assurance Group –** Led by Carl James, Director of Strategic Transformation, Planning & Digital – *(this item was removed from the consent agenda to allow further discussion)* CJ provided the Committee with assurances following queries raised by HJ regarding areas for escalation to the Committee, in terms of risk to the organisation and mitigating measures: • Despite remaining below required compliance levels, some improvement has been evidenced in relation to Health and Safety / Fire Safety Mandatory Training levels and take up will be further encouraged among staff. • Estates and Statutory Compliance – Staffing remains an issue for the department; however, recruitment is underway and a full team is anticipated by the end of May 2023, in order to more effectively support the delivery of Estates services. • Limited assurance was received on the Low Voltage Audit as a result of recruitment issues and training of 'Competent and Authorised Persons'; however, full resolution of this is expected by the end of July 2023. The Committee **NOTED** the content of the report and actions being taken.	
7.6.0	**Assurance Report Medicines Management Group** Led by Bethan Tranter, Chief Pharmacist - *(this item was removed from the consent agenda to allow further discussion)* BT provided the Committee with assurances following queries raised by VM in the following areas: • Assurance that all outstanding areas of compliance with the Patient Safety Notice (PSN 055 – Safe Storage of Medicines) will be completed by the end of March 2023 and from this time the Trust will be fully compliant. • The management of clinical guidelines where there have been changes in practice or new treatment options identified has been prioritised following streamlining of the review process. • A revised policy procedure framework is in place to support medication requests for unlicensed and 'off label' medications by the Medicines Management Group. The Committee **NOTED** the activity of the Medicines Management Group.	
7.7.0	**Nosocomial COVID-19 Transmission Update** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science The Committee **NOTED** the Trust position in relation to patient nosocomial COVID-19 reviews.	
7.8.0 **7.8.1**	**Internal Audit Reports** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science and Jacinta Abraham, Executive Medical Director **Patient / Donor Experience** The Committee **NOTED** the findings of the Patient and Donor Experience Internal Audit Report (January 2023) and resulting Management Action Plan.	

7.8.2	**Clinical Audit Final Internal Audit Report** The Committee **NOTED** the findings of the Clinical Audit Internal Audit Report (January 2023) and resulting Management Action Plan.	
7.9.0	**Trust-wide Policies and Procedures Compliance Report** Led by Lauren Fear, Director of Corporate Governance and Chief of Staff The Committee: • **NOTED** 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; • **NOTED** the Quality, Safety and Performance Committee Policy Extract Compliance Report as of **February 2023**, included in ***Appendices 1 to 8,*** and; • Received **ASSURANCE** that progress is being managed via the Executive Management Board.	
8.0.0	**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).	
8.1.0	**March 2023 Analysis of triangulated meeting themes** Led by Vicky Morris, Quality, Safety and Performance Committee Chair supported by all Committee members It was agreed that an emerging theme of today's discussions related to the current challenge in meeting the Duty of Quality requirements in a timely manner, as the main mechanism for data capture currently is manual and there is no quality dashboard in place and no delivery timescale. It was recognised that the current data capture mechanisms are an onerous process, requiring a considerable amount of clinical validation and staff time, removing staff from their role in delivery of care and treatment. In order to achieve effective and efficient capture of all quality information across the Trust, it was agreed that a quality dashboard / robust business intelligence structure is required as a matter of urgency, to facilitate automated processing and effective triangulation of this information. The Committee to receive a high level delivery plan and timescale at the next meeting.	
8.2.0	**March 2023 Analysis of Quality, Safety & Performance Committee Effectiveness** To be led by Vicky Morris, Quality, Safety and Performance Committee Chair supported by all Committee members It was agreed that the Secretariat would circulate the questions below to all attendees following today's Committee: • *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?*	**KP**

8.3.0	• *Was sufficient assurance provided to Committee members in relation to each item of business received?* **Committee Effectiveness Survey Report – Reflective Feedback from January 2023 Committee** Led by Emma Stephens, Head of Corporate Governance The Committee received the results of the January 2023 Committee Effectiveness reflective evaluation feedback, noting the 27% response rate (4 out of 15 attendees) to the targeted feedback questions circulated following the January 2023 Committee. ES encouraged the provision of robust feedback from all in attendance to allow continued improvements. The Committee **AGREED** the resulting proposed actions detailed in Appendix 1.	**All attendees**
9.0.0	**HIGHLIGHT REPORT TO TRUST BOARD**	
	VM advised that items for inclusion in the Highlight Report to the Trust Board for Escalation, Assurance, Advising and Information would be agreed following the Committee.	
10.0.0	**ANY OTHER BUSINESS**	
	No other business was raised.	
11.0.0	**DATE AND TIME OF THE NEXT MEETING**	
	The Quality, Safety & Performance Committee will next meet on the **16th May 2023 from 10:00 – 13:00**	
CLOSE		

QUALITY, SAFETY AND PERFORMANCE - PART A					
Minute ref	**Action**	**Action Owner**	**Progress to Date**	**Target Date**	**Status (Open/Closed)**
Actions agreed at the 17th January 2023 Committee					
3.1.1	LF to address governance process for new products prior to coming onstream with NWSSP.	Lauren Fear	**Update 04/05/2023** - Meeting arranged with NWSSP Colleagues for 09/05/2023.	16/03/2023 now 16/05/2023	OPEN
3.3.5	Medical Devices Report update to be sighted by QSP Committee prior to July 2023.	Cath O'Brien	**Update 20/04/2023** - Paper to be included under matters arising at May QSP Committee.	16/05/2023	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	Not yet due.	13/07/2023	OPEN
4.3.0	NW/DM to discuss cessation of streamlining process for Radiotherapists and impact on recruitment.	Nicola Williams/Donna Mead	**Update 19/04/2023** - This item was discussed at April 1:1	16/03/2023 now 16/05/2023	CLOSED
Actions agreed at the 16th March 2023 Committee					
4.2.0	ES to liaise with Workforce & Organisational Development to clarify reporting mechanism for **staff survey information** to QSP Committee and potential inclusion as an item on the Committee Cycle of Business.	Emma Stephens	**Update 14/04/2023** – Email sent to Workforce colleagues requesting confirmation of plans for reporting information to QS&P Committee, in addition to how this should be captured on the Committee cycle of business.	16/05/2023	CLOSED
6.1.1	Emerging trends / themes to be included in the Trust Risk Register cover paper from May 2023 Committee.	Lauren Fear	**Update 27/04/2023** - This has been included on the Register for May 2023 Committee.	16/05/2023	CLOSED
6.1.1	LF to address absence of action plans for risks scoring level 20.	Lauren Fear	**Update 27/04/2023** - This has been addressed and included on the Register for May 2023 Committee.	16/05/2023	CLOSED

6.1.1	Ensure all fields within Trust Risk Register are ordered appropriately and complete prior to each Committee.	All Risk Owners	**Update 04/05/2023** - Regular reminders issued to all risk owners to update key areas.	16/05/2023	CLOSED
6.1.2	Capture of 'deep dive' exercise into two of the risks identified on the Trust Assurance Framework for oversight of the QSP Committee in the TAF section of the QSP Cycle of Business.	Emma Stephens	**Update 19/04/2023** – Deep dive information to be captured within the Trust Risk Register and Trust Assurance Framework reports for discussion at QS&P Committee via relevant Executive Lead.	16/05/2023	CLOSED
6.1.2	ST to update information within the Trust Assurance Framework regarding workforce planning, to ensure triangulation with the main Workforce / Finance QSP report.	Susan Thomas	**Update 26/03/2023** - This has been actioned.	16/05/2023	CLOSED
6.3.0	Amendments to be made to the PMF to include (1) Hand Hygiene and (2) Amendment of patient experience target from 85% to 95%.	Peter Gorin	**Update 04/04/2023** - 1) Hand Hygiene KPI Scorecard line added plus Supporting Data Template. Awaiting information from HCI Lead to populate with data. 2) VCC Patient Experience targets amended to 95%. Plus now showing two survey measures, namely a) “Would you recommend us?” and b) “Your Velindre Experience.	16/05/2023	CLOSED
6.4.0	CJ to facilitate inclusion of more precise information within the IMTP Quarterly Actions Progress Report, in particular in relation to key deliverables for the QS&P Committee component.	Carl James	Not yet due.	13/07/2023	OPEN

QUALITY SAFETY AND PERFORMANCE COMMITTEE

MEDICAL DEVICES UPDATE

DATE OF MEETING	16/05/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Tim Register, Head of Engineering, Radiotherapy Physics, VCC Jignesh Raiyani, Medical Devices Officer, VCC Kathy Ikin, Head of Radiation Services, VCC Peter Richardson, Head of QA, WBS
PRESENTED BY	Cath O'Brien, Chief Operating Officer
EXECUTIVE SPONSOR APPROVED	Cath O'Brien, Chief Operating Officer

REPORT PURPOSE	FOR NOTING

Committee/Group who have received or considered this paper PRIOR TO THIS MEETING		
Committee or Group	**DATE**	**OUTCOME**
VCC SLT	19.04.2023	The paper was noted

ACRONYMS	
VUNHST	Velindre University NHS Trust
VCC	Velindre Cancer Centre
C&V	Cardiff and Vale

POCT	Point of Care Testing
MDG	Medical Devices Group (VUNHST)
MHRA	Medicines and Healthcare Product Regulatory Agency
MDR	Medical Device Regulations
MDD	Medical Devices Directive
AIMDD	Active Implantable Medical Devices
IVDD	In Vitro Diagnostic Medical Devices
The Sharps Regulations	The Health and Safety (Sharp Instruments in Healthcare) Regulations 2013
SLA	Service Level Agreement
RFID	Radio-Frequency Identification
QA	Quality Assurance
CE	EU conformity mark
UKCA	UK conformity Assessment mark

1. PURPOSE

1.1 This paper has been prepared to provide the Quality, Safety & Performance Committee with an update on medical devices and compliance with the medical devices regulations across operation in Velindre University NHS Trust (VUNHST). A full annual report will be provided for 2022/23 in the July meeting.

1.2 The Quality, Safety and Performance Committee is requested to **NOTE** the contents of the report and actions being taken.

2. SITUATION/BACKGROUND

'Medical device' means any instrument, apparatus, appliance, software, implant, reagent, material or other article intended by the manufacturer to be used, alone or in combination, for human beings for a range of specific medical purposes including diagnosis, investigation or treatment. An 'accessory for a medical device' is also defined and accessories are regulated as if they are a medical device.

It is of note that 'software' can be a medical device if it is intended to have one of the specific medical purposes, therefore mobile apps and spreadsheets can be considered a medical device, as well as complex software such as treatment planning systems.

Medical Devices are regulated under The Medical Devices Regulations (MDR) 2002 (SI 2002 No 618, as amended) (UK MDR 2002). These regulations are intended to improve the safety and performance of medical devices and intend to provide a high level of protection for the health of patients and uses of these medical devices are based on 3 EU directives.

The Health and Safety (Sharp Instruments in Healthcare) Regulations 2013, known as 'The Sharps Regulations', build on existing health and safety law and provide specific detail on requirements that must be undertaken by healthcare employers and their contractors.

The Trust is subjected to or can be inspected by regulatory authorities including Healthcare Inspectorate Wales (HIW), Medicines and Healthcare Product Regulatory Agency (MHRA), the Health and Safety Executive (HSE) and Wales Audit Office (WAO).

The VUNHST has responsibility for implementing the requirements of the regulations governing work involving MDR and The Sharps Regulations throughout all Services managed by the Trust. The Chief Operating Officer has been delegated responsibility at Trust Board level for the management of medical devices and equipment. Roles and responsibilities are defined in the Trust Medical Devices and Equipment Management Policy (QS24).

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

Regulation changes

The EU introduced updated medical devices regulations in 2017, but the regulations did not come fully into force until 2021. The UK decision to leave the EU means that the latest EU regulations were not enacted into UK law. The Medicines and Healthcare Products Regulatory Agency, recognising the need for updated legislation has recently consulted on the matter and updated regulations are expected to come in to force 1st July 2024.

The MHRA are yet to release any guidance notes and the details of the planned legislation. Planning for the regulations is a standing item on the VUNHST Medical Devices Group and is represented and actively engaged in the Wales ‘Medical Device Regulations Group’. This group provides an information-sharing forum for NHS Wales in respect of current and future Medical Device Regulations as they apply to preparedness of NHS Health Boards and Trusts. The VUNHST planning is consistent with the all Wales approach, in working towards the EU regulations that were not enacted; in anticipation and until formal guidance is provided by the MHRA.

Governance and reporting of preparedness towards the new regulations are also monitored through the Welsh Scientific Advisory Committee (WSAC) and Welsh Therapies Advisory Committee (WTAC) on a quarterly basis.

Expected Requirement and Status of Actions

Velindre Cancer Centre - Current position

1. There will be a new quality standard to replace CE marking which all commercial suppliers will need to meet
2. We expected all NHS produced / manufacture of Medical Devices will have a healthcare institution exemption from the full Medical Device Regulations, so long as the device remains within the legal entity of the organisation. Anything transferred to another organisation would be deemed as 'commercial supply' and full quality marking standards would apply.
3. We expect general safety and performance standards to be implemented and for all manufacture of medical devices need to be done under a suitable Quality Management System, with ISO13485 being recommended.
4. We are developing service delivery towards compliance with the ISO13485, which will support the evidence of design and quality standards and performance. This work is on target for completion towards the current expected Q4 2024 timeline.

It is important to reiterate all of these plans are subject to change as the MHRA have yet to issue any guidance notes. However, the service planning and monitoring of the regulations is robust and ready to respond to any future proposed changes.

A baselining exercise has been completed at VCC; to confirm there are no other departments that would be directly impacted by the new regulations. This exercise will be repeated once the full guidance is available to assess and assure against any change in service provision.

At VCC, the 'Mold room' do 'custom make' medical devices for patients undergoing radiotherapy. Any external adaptations in manufacture, such as the addition of additional shielding, is managed through the engineering workshop, so will be included within the IS013486 being implemented in engineering.

WBS – Current Position

In preparation for the new UK MDR the WBS has conducted a series of classification meetings to identify in-house developed medical devices, medical device software and reagents that would be classified as medical devices under the new regulations, should those regulations align with the EU MDR/IVDR in terms of classification. From these meetings it was identified that several in-house developed software packages and some reagent kits would fall under the definitions of medical device software and in-vitro medical devices respectively.

Strategic decisions now need to be made as to whether in-house development of software and reagent kits is to continue within the WBS or whether these are to be purchased from the marketplace. From the

classification meetings it has been identified that it is unlikely that certain reagent kits can be purchased. Work is ongoing to address these issues and make the appropriate decisions.

The WBS Quality Management System (QMS) is unique to the WBS and is based on the EU Good Practice Guidelines for Blood Establishments. A review of the system and the ongoing use of an in house system is being reviewed and a proposal will be made based on the final regulatory requirements. A further update on this will be provided in the annual report.

3.2 Key Actions / Areas of focus during next period

- Ongoing development of the requirements for new regulatory changes together with associated impact including cost.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Compliance with the latest regulatory standards is a significant element of the overall system which assures the safety of patients.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies, please list below: • Staff and Resources • Safe Care • Effective Care • Health and Care Standard 2.9 - Medical Devices, Equipment and Diagnostic Systems
EQUALITY IMPACT ASSESSMENT COMPLETED	No (Include further detail below)
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Potential failure to meet compliance with the Regulations once new UK legislation is introduced may have an impact.

FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Compliance with the Regulations may require investment however the potential financial impact has not been assessed at present.

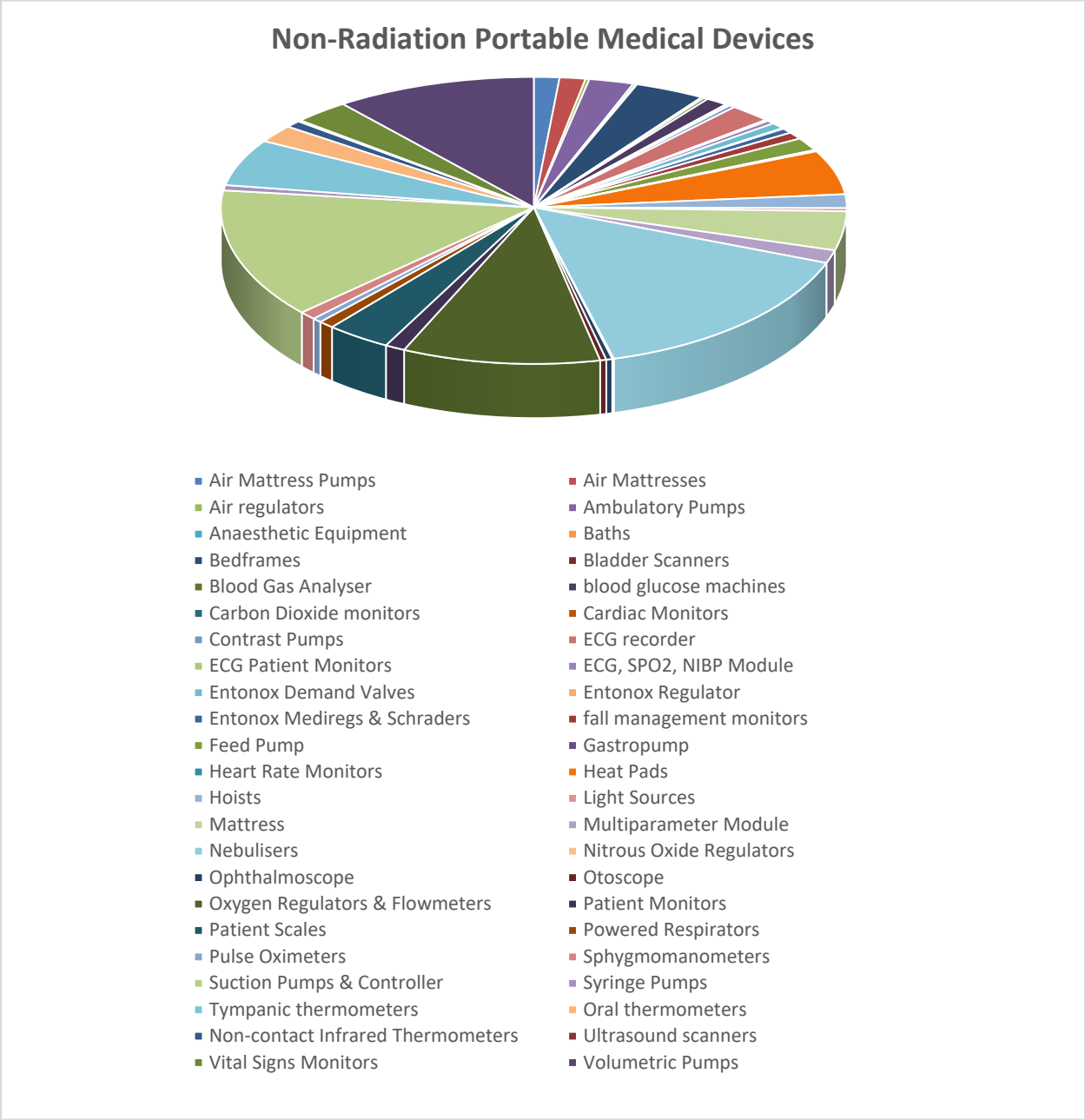
4. RECOMMENDATIONS

The Quality Safety and Performance Committee is asked to **NOTE** the information in this report.

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

Appendix A

Non-Radiation Portable Medical Devices



Please note: Many of the categories above will have multiple subcategories of types of devices within them.

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

TRUST RISK REGISTER

DATE OF MEETING	16.05.2023

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	02.05.2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS THE PAPER WAS DISCUSSED AT THE MEETING; FURTHER REVIEW OF RISK WAS TO BE CARRIED OUT AHEAD OF QSP.	

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.						

APPENDICES	
1	Current risk register data.
2	Risk data graphs

1. SITUATION

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

2. BACKGROUND

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

3. ASSESSMENT

3.1 Trust Risk Register

There are a total of 11 risks to report to Board and Committee on Datix 14, this includes 10 risks with a current score over 15 and 1 risk with a current score of 12, reported in the 'Safety' domain. The information is pulled from Datix 14.

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 The Risk Register

- The risk register detail in Appendix 1 is for consideration by the Quality, Safety and Performance Committee.
- Action plans for risks are continually under review in divisions with transition to SMART actions underway.
- 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 SMART actions during the previous reporting period resulted in agreement for the need for a more specific guidance section to be added into the Datix How To Guide, this has now been updated and uploaded to the risk area of the intranet DATIX - How To Guide.
- Following discussion with Independent Members the following was agreed as part of the development work in respect of risk management:
  - A Deep Dive will be timetabled into the Risk programme of work; two risks will have an in depth review at the next Quality, Safety and Performance Committee in May.
  - A meeting has been arranged for VCS and WBS colleagues to meet in order to share good practice.
  - An analysis of risk appetite versus target levels, as a starting point the risk appetite has been included for level 1 risk appetite risks in respect of safety risks; this information has been included in Appendix 1.

4.2 Risk In Depth Review

Following discussion with Independent Members and at the last Quality, Safety and Performance Committee an in depth review has been timetabled for this meeting of the Quality, Safety and Performance Committee. Given the balance of risks it has been decided to focus the first in depth review on Velindre Cancer Service highest level risks.

4.3 Next Steps in Engagement and Embedding

- The approved Policy and Procedure are now on the intranet, with links on both divisional intranet pages.
- Level 1 mandatory training for all staff is complete and is now live in individual ESR Learning Matrixes, as of 17th April 2023. Initial management of completion of training will be tracked via the Trust risk weekly meeting and reported into Executive Management Board; as of 26th April 2023 272 staff have completed the level 1 training via ESR. The on-going requirement will be to complete the training every two years.

5. IMPACT ASSESSMENT

RELATED TRUST STRATEGIC GOAL(S)	Please indicate whether or not any of the matters outlined in this report impact the Trust's strategic goals. Please indicate here
Please tick all relevant goals: . Outstanding for quality, safety and experience ☒ . An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ . A beacon for research, development and innovation in our stated areas of priority ☐ . An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ . A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC TRUST ASSURANCE FRAMEWORK RISK	06 - QUALITY & SAFETY
QUALITY AND SAFETY	Tick all relevant domains.

IMPLICATIONS / IMPACT	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Cantered ☒
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). The risk register and associated risk framework are imperative to quality and safety in the organisation.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED	Not required
	There are no socio economic impacts linked directly to the current risks in paper.
TRUST WELL-BEING GOAL IMPLICATIONS/IMPACT	Choose an item.
	There are no direct well-being goal implications or impact in the current risks in this paper.
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	This section should outline the financial resource requirements in terms of revenue and / or capital implications that will result from the Matters for Consideration and any associated Business Case.

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

6. RISKS

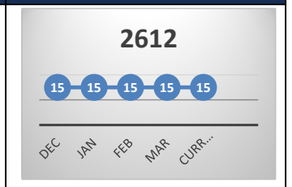
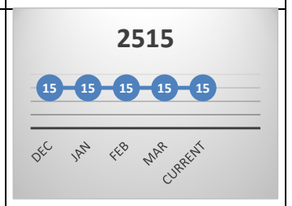
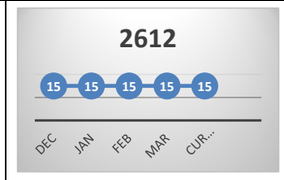
ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	The risk register is detailed in Appendix 1 and throughout the paper.
WHAT IS THE CURRENT RISK SCORE	NA

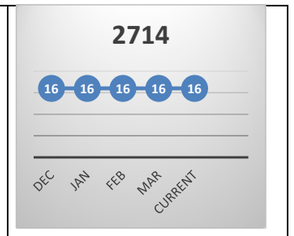
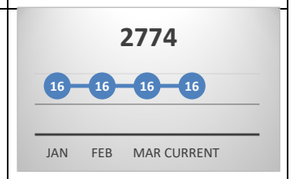
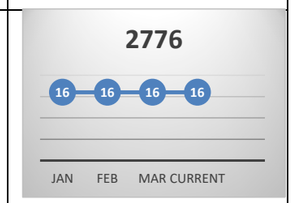
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	Actions plans for individual risk require further work.
BY WHEN?	
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix	

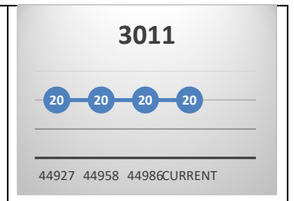
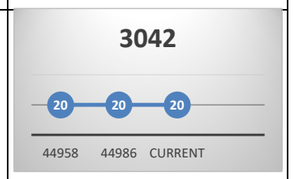
APPENDIX 1

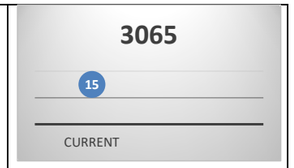
Detailed Definitions of 7 Levels of Evaluation to Determine RAG Rating / Operational Assurance and Summary Statements of 7 Levels

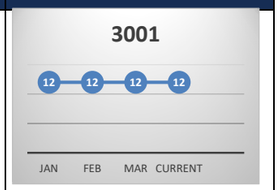
RAG rating	ACTIONS	OUTCOMES	RAG rating	SUMMARY STATEMENTS OF 7 LEVELS
Level 7	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions,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

ID	Risk Title - New	Risk Type	Opened	Division	Risk (in brief)	RR - Current Controls	Rating (current)	Rating (Target)	Review date	Action Plan	Number of Days Open	Risk Trend
2465	Number of emails medics are receiving, especially those related to clinical tasks.	Safety	05/11/2021	Velindre Cancer Centre	There is a risk of missing critical emails especially critical clinical questions due to the volume of emails. Clinical questions may not be responded to in a timely way or responses may not be accurate due to the pressure of responding to the number of emails received. This may lead to impact on patient care and staff wellbeing through stress, working additional hours to catch-up and potential for medical error due to distraction from other critical tasks. There is a secondary risk when colleagues are away so emails are not being actioned, and when they return, there is a huge backlog of messages to catch up on.	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.	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 by June 30th 2023 email etiquette to be developed as part of hybrid working tool kit and shared widely. By June 30th 2023	546	
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	Velindre Cancer Centre	"Brachytherapy Staffing Levels at Velindre are low and recruitment and retainment of staff is not at the level required. There are a number of staff nearing retirement. There are also staff on maternity leave, sick leave, sabaticals etc. affecting staffing levels day to day." "There are a number of single points of failure within the service with a lack of cross cover, loss of single members of key staff could interupt patient treatment. Loss of trained staff leaves the service with a number of additional single points of failure. Training times are often long and impact on staff's current role. Staff can be sought from university cohorts but these are limited and the time required to train them to work within the Velindre service means they are not direct replacement for lost staff"	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.	15	5	30/09/2023	workforce review in Q1/2 2023 to look at demand for next 5 years. By September 2023	450	
2612	Acute Oncology Service (AOS) Workforce Gaps	Workforce	28/07/2022	Velindre Cancer Centre	There is a risk that the AOS service at Velindre Hospital is not sufficiently resourced. As a result this could result in periods of time in which the service is not sufficiently covered and other medic's providing a limited service. This may lead to medic's becoming overworked and stretched due to their responsibilities and a full AOS gap specification not being delivered.	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.	15	6	30/09/2023	reset' of local and national AOS programme or work to be undertaken, via Velindre Futures by 30.09.2023	281	

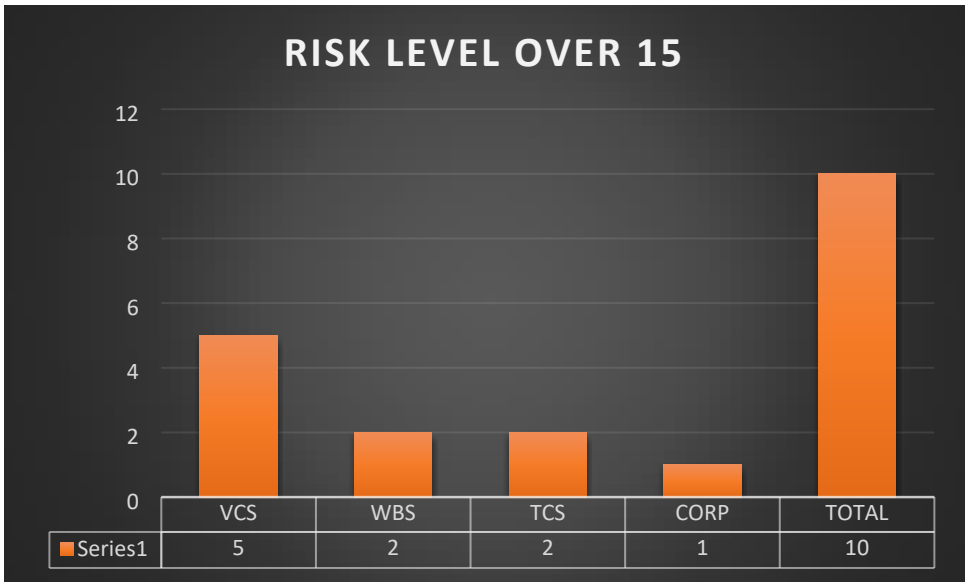
2714	Interest Rates There is a risk that increased rates of interest before financial close lead to the costs of the project exceeding the affordability envelope.	Financial Sustainability	09/09/2022	Transforming Cancer Services	Interest Rates There is a risk that increased rates of interest before financial close lead to the costs of the project exceeding the affordability envelope.	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	16	12	24/05/2023	Continue to monitor interest in line with the financial index. Due date: 24.05.2023 Progress: Monitoring of the interest rates, maintain the contingency buffer within budget. NB this risk will be the responsibility of the participant after financial close. Ongoing	238	
2774	There is a risk to quality/complaints/audit/GxP as a result of use of outdated legacy systems, leading to increased risk of incorrect test results and clinical advice.	Quality	27/10/2022	Welsh Blood Service	(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.	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.	16	4	01/09/2023	Individual Actions recorded in risk 2776: Secure Funding by 28/04/2023 Tender for replacement LIMS by 31/05/2023 Implement replacement LIMS by 31/07/2024 WHAISIT Project Group to manage. WHAISIT Business case on agenda for DPIF Scrutiny Panel on 08/03/2023 Tender documentation in progress.	190	
2776	There is a risk to performance and service sustainability as a result of the ongoing use of outdated, legacy systems, leading to the inability to enhance services to meet business needs.	Performance and Service Sustainability	27/10/2022	Welsh Blood Service	(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.	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.	16	4	01/09/2023	Tender for Replacement LIMS. Procurement Brief, URS and supporting documnetation in progress. Due date 31.05.2023. Managed by the WHAISIT Project Group	190	

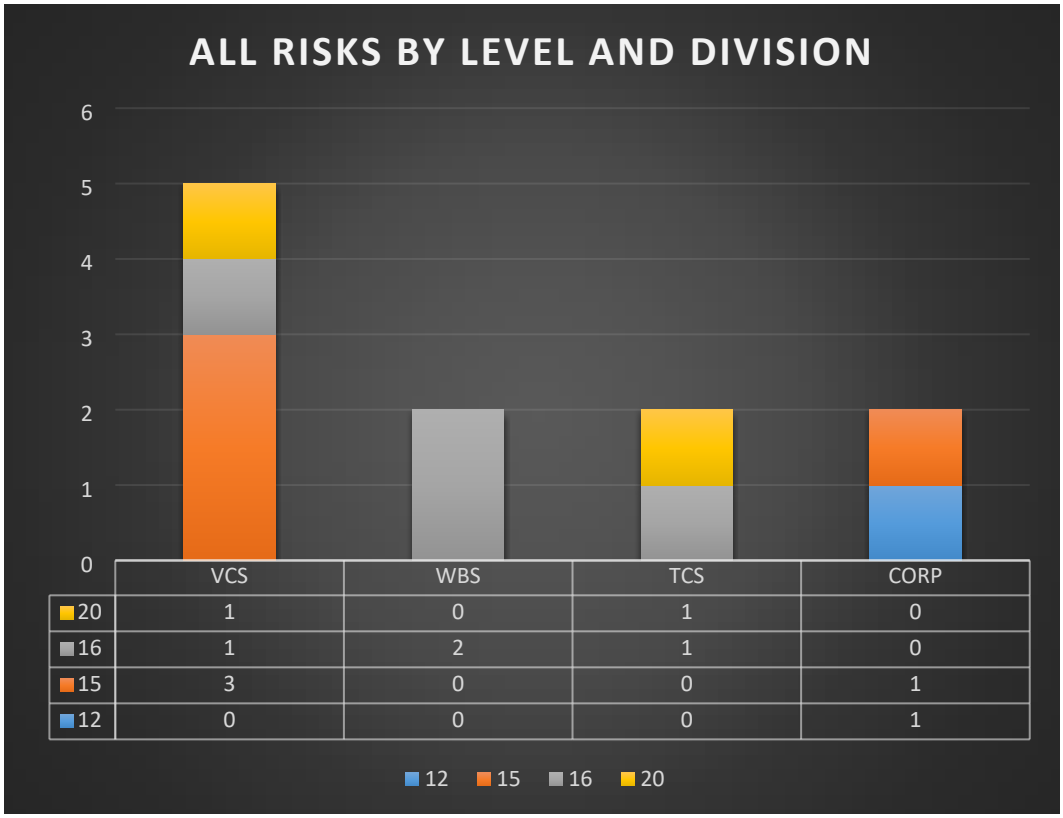
3011	There is a risk that the continuation of safe patient care may be adversely affected resulting in harm as a result of delays in scheduling patient appointments due to a technical error in the processing of Outpatient Oncology Note Outcomes.	Safety	22/12/2022	Velindre Cancer Centre	Technical failure 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.	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)	15	5	30/06/2023	1. 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)	134	
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	Velindre Cancer Centre	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.	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.	20	5	07/08/2023	Actions to ensure appropriate delivery of LINC into VCC or mitigations if LINC delayed - due date 30.06.2025 Active ongoing engagement in national programme. Confirmation of internal governance and escalation process across the Trust.	87	

3065	There is a risk to COMPLIANCE as a result of the permanent deletion of email mailboxes for VUNHST staff who have fully left the NHS since September 2021, leading to a potential issue should those emails be required by a 3rd party investigation - e.g. COVID enquiry.	Compliance	10/03/2023	Corporate Services	NHS Wales deployed O365 in July 2019. The national tenancy was established with the intention of ensuring emails / mailboxes for staff who left the NHS (i.e. there O365 account was closed) would be retained for a 7ear year retention period, as per the national NHS Wales Email Policy. Investigations prompted by an enquiry by C&V UHB in February 2023 confirmed that this policy was not what was configured on the NHS Wales tenancy. As such, any emails / mailboxes for staff who have left the NHS will have been deleted after 30 days of account closure, unless another form of manual 'hold' was in place on the account. In VUNHST, 'litigation hold' was in place by default on all accounts up to 22/09/2021, when a national change was made to remove litigation hold for VUNHST O365 accounts. As such, the risk for VUNHST is that staff who have left NHS Wales in the period 23/09/2021 - 17/02/2023 will be that emails for those staff will not be retrievable for (e.g.) FoI, evidence for COVID-19 enquiry etc.	Upon identification of the incident, DHCW have put in place temporary measures - effective from 17/02/2023 - to prevent further deletion of mailboxes for staff leaving the NHS Wales. DHCW are also engaging with Microsoft to explore what, if any, opportunity there is to retrieve the deleted emails/mailboxes.	15	3	01/08/2023	List of impacted mailboxes has been produced by Digital Services - to be reviewed by Head of IG & Head of Digital Delivery to assess overall impact of deletion.	56	
3087	TCAR 2 - EW and MIM Contractor Usage There is a risk that if the EW and MIM contractors are required to make use of TCAR 2 simultaneously that the volume of traffic may exceed what is allowed by the planning approval, leading to a delay to one or both sets of works.	Quality	24/04/2023	Transforming Cancer Services	TCAR 2 - EW and MIM Contractor Usage There is a risk that if the EW and MIM contractors are required to make use of TCAR 2 simultaneously that the volume of traffic may exceed what is allowed by the planning approval, leading to a delay to one or both sets of works.	1) Volumes of traffic during contractor crossover period are likely to be accommodated by the volume of traffic allowed by planning. 2) Trust to facilitate dialogue between both contractors to manage construction plans to allow simultaneous access if required. 3) There is an opportunity to achieve earlier access via the Asda access road and the Northern access bridge, but this would require and acceleration on both contracts.	20	4	22/05/2023	Trust to facilitate dialogue between both contractors to manage construction plans to allow simultaneous access if required. Due date: 22.05.2023 Progress: It has become apparent as Acorn have redeveloped their construction programme that they require exclusive access. As the enabling works has been delayed it may be that Walters need to amend their work plans so that they can work without access to the TCAR, or a compensation event may be required Ongoing	11	NEW RISK - NOT ENOUGH DATA FOR TREND

ID	Risk Title - New	Risk Type	Opened	Division	Risk (in brief)	RR - Current Controls	Rating (current)	Rating (Target)	Risk Appertite Level	Review date	Amount of Days Open	ACTION PLAN	Risk Trend
3001	There is a risk to safety as a result of work related stress leading to harm to staff and to service delivery.	Safety	09/12/2022	Corporate Services	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	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	12	9	1	31/05/2023	147	Healthy and Engaged steering Group to communicate with Divisions and Departments about stress risk assessments by 30 June 2023.	

Risk Level Data




ALL RISKS BY LEVEL AND DIVISION
6
5
4
3
2
1
0
VCS WBS TCS CORP
20 1 0 1 0
16 1 2 1 0
15 3 0 0 1
12 0 0 0 1
12 15 16 20

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

WORKFORCE SUPPLY AND SHAPE UPDATE

DATE OF MEETING	16th May 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Susan Thomas, Deputy Director of W&OD Chris Moreton, Deputy Director of Finance
PRESENTED BY	Sarah Morley, Executive Director of Organisational Development and Workforce Matthew Bunce, Executive Director of Finance
EXECUTIVE SPONSOR APPROVED	Sarah Morley, Executive Direcor of Organisational Development and Workforce 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**
N/A		

ACRONYMS	
IMTP	Integrated Medium Term Plan
HB	Health Board
TOIL	Time off in Lieu
WBS	Welsh Blood Service
WG	Welsh Government

VCC	Velindre Cancer Centre

1. SITUATION/BACKGROUND

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

The key to ensuring a robust plan around workforce supply and shape is to strengthen our current workforce planning approach. A workforce development framework has been approved by the Trust. The framework is aligned to the the all Wales Workforce planning strategy and training for managers within the Trust has been given to implement this approach. The framework will provide a structure to enable the strategic and local development of our workforce and associated plans.

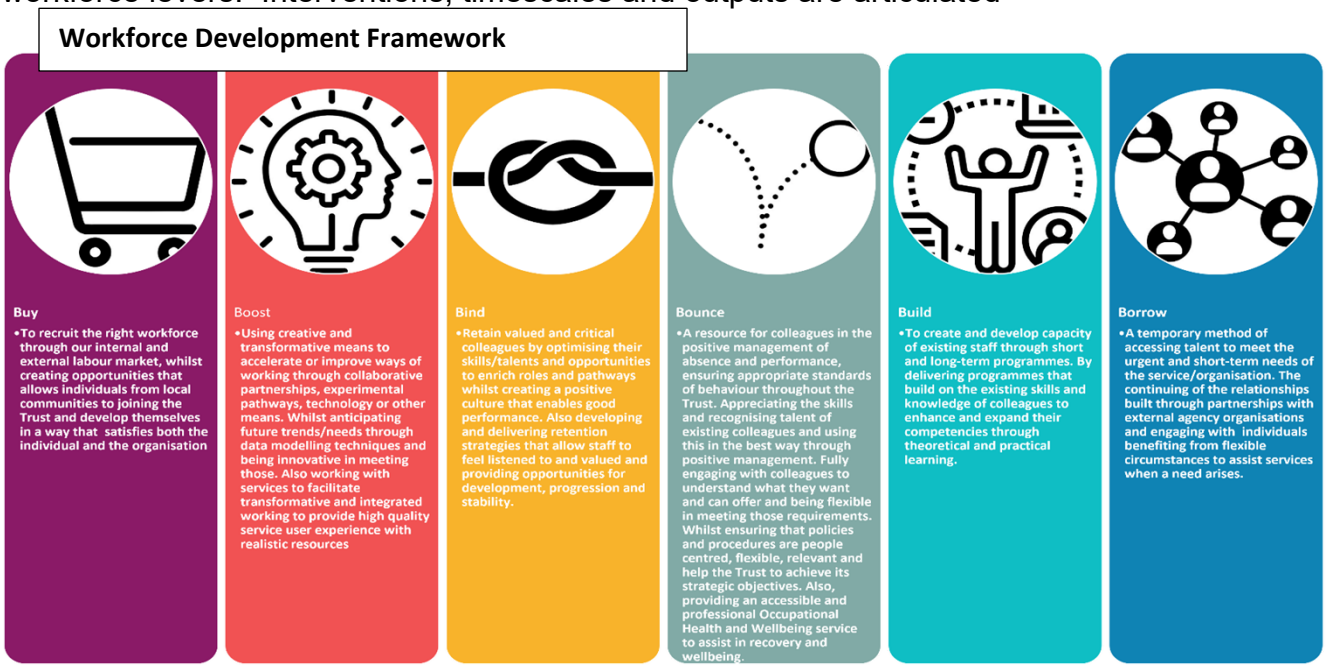
Figure 1

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

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Quarterly update: Workforce Development Framework Actions and Outputs

Using the workforce development framework that incorporates all workforce actions the table below highlights the workforce hotspot areas against the workforce levers. Interventions, timescales and outputs are articulated



WP Activity	Hotspot areas	Actions	Timelines	Outputs
Buy	**Recruitment**	A streamlined vacancy authorization process across the Trust	*May 2023*	• New Trust wide Recruitment Policy • Supporting management guidance and documents • Approval of streamlined establishment

WP Activity	Hotspot areas	Actions	Timelines	Outputs
				control and scrutiny process • One consistent approach to the Trust's three scrutiny processes
	Recruitment	Develop a customer focused approach to recruitment planning	*Completed*	• Managers guides and videos now live • Regular training available to all supervisor / managers by POD team • SOP for WOD in supporting recruitment requests
	Recruitment	Develop marketing / brand attraction campaign for Trust Welsh language focus	*WBS Completed* *June 2023*	• WBS careers page / targets job videos • Recruiter presence on LinkedIn • VCC careers page / targets job videos • Trust wide marketing campaign video showcasing the strategy and values of the Trust
	Widening access	Widening Access Programme	*Up to December 2023*	• Engagement with local schools/collages on career options within the Trust • Signed the agreement to take Nursing Cadets on placement

WP Activity	Hotspot areas	Actions	Timelines	Outputs
				• Disability Confident Level 2 renewed to set benchmark for how to support people with disabilities to join our workforce • Signed the agreement to support Army veterans coming into the workplace
Boost	**Work plans: Radiotherapy Satellite Unit at NHH** **Neville Hall Cancer Unit – SACT** **TrAMS**	Focus on building, construction and contract. Discussions ongoing between Trust and HB All Wales service provisions	*November 2024* *TBC* *TBC*	Providing outreach patient services, closer for patients' homes, collaboration with HBs As above All Wales service for pharmacy technical services
Bind	**Retention**	All Wales Nurse Retention Work stream	*September 2023*	• Develop standard retention toolkit for NHS Wales • Understand the retention issues though exit process analysis • Implement 'pre-exit' interview process

WP Activity	Hotspot areas	Actions	Timelines	Outputs
		Corporate Induction Review	*August 2023*	Induction Programme upgrade
		Agile / hybrid working	*Completed*	• Hybrid Working toolkit published to allow new ways of working to become embedded • Working with the nVCC team to establish the right conditions within the built environment and also develop new approach to working with cancer
Bounce	**Employee Relations**	ER process review	*May 2023*	• Improve potential for avoidable employee harm • Regular case management reviews • Recruitment of bank IO • Policy and Procedure reviews
	Wellbeing	Occupational Health and EAP	*Health and Engaged work plan to September 2023*	• Fatigue and Facilities Charter for Medical Staff has been adopted and all arrangements put in place to meet the criteria.

WP Activity	Hotspot areas	Actions	Timelines	Outputs
				• Healthshield payment plan introduced to support staff with health costs • Complementary Therapies provided to staff via Cardiff Met • Menopause cafes established
		Staff Engagement		• Review of feedback on staff experience and values and culture shared with EMB • Black History Month ad British Sign Language Week celebrated • Equality Impact Assessment process updated and Toolkit published on intranet
Borrow	See below financial information on agency spend- page 7			

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

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

The financial risk associated with workforce supply and shape will be monitored and managed through the pay budget monitoring process. This includes staff who were permanently recruited in response to Covid where guaranteed funding from Welsh Government is no longer available 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 March is £83,108m based on 1,588 WTE. This includes pay award funding of £5.500m from WG relating to 2022-23. In March 2023, the Trust accounted for the 1.5% non-consolidated pay award (£0.900m), the 1.5% consolidated pay award (£1.200m) and the 6.3% additional pension requirement associated with the pay award (£3.400m). Full funding was provided from WG to support the non-consolidated 1.5% pay award that was received in March 23. At this stage the Trust is expecting to receive full funding for the 1.5% consolidated pay award, which will be processed during May 23 and back dated to April 22. Whilst still in negotiations, any further pay award associated with 2022-23 is expected to be fully funded by WG.

As at March 2023, the current staff in post is 1,463WTE. The number of vacancies is 125 WTE, which represents a 7.8% vacancy rate. The vacancy gap is largely being met by the use of agency staff and overtime

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 opportunity to explore workforce and service redesign and to take forward some fundemental changes that will enable a more efficient and productive service (as noted in the QSP paper March 2023).

In addition, a number of posts in both VCC and WBS have been appointed at risk in response to Covid which poses a significant financial risk for the Trust. There has also been some forward recruitment on service developments without agreed funding pending activity undertaken or FBC approval by WG and Commissioners. 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.

The Trust has reported a total spend of £82.118m on pay against a budget of £83.108m resulting in a underspend position of £0.990m for 2022-23. The pay costs include the costs of agency staff, on-call and overtime.

3. 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 supply and shape updates and associated financial impacts as outlined within the contents of the report.

QUALITY SAFETY & PERFORMANCE COMMITTEE

FINANCE REPORT FOR THE PERIOD ENDED 31ST MARCH (M12)

DATE OF MEETING	16/05/2023

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	02/05/2023	Noted

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

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

1. SITUATION/BACKGROUND

1.1 The attached report outlines the final financial position and performance for 2022-23.

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

1.3 The figures in this report are currently in draft subject to audit review and sign off.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Performance against Key Financial Targets:

	Unit	Current Month £m	Total Actual 2022-23	Year End Forecast £m
Revenue	Variance	0.061	0.064	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	10.155	27.758	0.000
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	95.0%	95.0%	95.0%

2.2 Revenue Budget

The overall position against the profiled revenue budget for 2022-23 was an underspend of **£0.064m**.

Revenue budget Key highlights

During the period the Trust has received full funding towards the temporary increase in Employers NI, the increased energy costs above baseline due to energy price inflation and Covid response costs.

The Trust also received funding towards the 2022-23 pay award that was provided to the Trust in September which left a gap of £0.045m relating to unfunded incremental drift. Whilst the gap will be met this year it will impact on the financial position in future years which will need to be met by Divisions.

Full funding has been provided from WG to support the non-consolidated 1.5% pay award that was received in March 23.

At this stage the Trust is expecting to receive full funding for the 1.5% consolidated pay award which will be processed during May 23 and back dated to April 22.

Whilst still in negotiations any further pay award associated with 2022-23 is expected to be fully funded by WG.

The Trust fully achieved the savings target during 2022-23 with replacement schemes being implemented to support under delivery on two schemes that turned RAG rated red due to the inability to deliver during the period.

The Board were previously made aware of and approved that the recharge to the Charity will be reduced by £1.5m during 2022-23 to offset c£1.5m of non-recurrent income that the Trust accumulated from a number of sources. This was transacted in March 2023.

2.3 PSPP Performance (draft)

Draft PSSP performance for the whole Trust was **95%** against a target of 95%, with the Core Trust excluding NWSSP also recording 95%.

PSPP improved in Feb & Mar ‘23 following a dip of performance in the preceding few months which enabled the overall Trust to achieve the 95% target. Work between the finance team, NWSSP accounts payable team and the service will need to continue in order to both improve and maintain performance going into 2023/24.

2.4 Covid Expenditure

Covid-19 Revenue Spend 2022/23					
	WG £m	Commissioners £m	Total £m	IMTP Plans £m	Cost Reduction £m
Mass Vaccination	0.224		0.224	0.375	0.151
PPE	0.070		0.070	0.335	0.265
Cleaning	0.289		0.289	0.427	0.138
Other Covid Response	0.290		0.290	0.967	0.677
Covid Recovery - Internal Capacity		3.167	3.167	6.056	2.889
Covid Recovery - Outreach		0.261	0.261	4.150	3.889
	0.873	**3.428**	**4.301**	**12.310**	**8.009**

The overall gross funding requirement related to Covid for 2022-23 was £4.301m, with £0.873m being funded directly from WG, and the balance of £3.428m largely funded by the Trust Commissioners via LTA as additional income where activity is above 2019-20 baseline, with financial protection from the National Funds Flow framework. T

The £4.301m represents a significant reduction in activity outsourcing costs included in the Trust IMTP plan as of 31st March '22, due to the liquidation of the outsourcing provider Rutherford Cancer Centre (RCC). The lost outsourcing capacity was replaced through creating additional internal capacity and productivity improvements.

Other funding / cost reduction reflects control measures and review of service delivery models during the period to reflect WG Covid de-escalation guidance.

2.5 Reserves

The Trust reserves position delivered a surplus during 2022-23 due to slippage on previously approved commitments. Further, the Trust did not receive confirmation until November '22 that WG would fund exceptional cost pressures relating to Covid and energy costs in particular. In addition, release of recurrent reserves for new investment was not considered possible in 2022/23 as they have been ringfenced to support the 2023/24 expected financial pressures on both energy and Covid recovery staff capacity.

The underspend on reserves was utilised to support the suspension of recharges to the charity during 2022-23.

2.6 Financial Risks

All risks were mitigated during the period to ensure delivery of the financial position.

2.7 Capital

The overall Capital programme achieved the Trust CEL by reporting a spend of £27.758m against a CEL allocation of £27.760m.

An underspend from last minute slippage on the discretionary programme was utilised against the IRS programme under the All Wales Capital programme.

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 the IRS. The total funding allocated is £41.602m for the period April 2022 to March 2026 with £7.900m of the total being provided during 2022-23.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The Trust reported a financial position of **£0.064m** for 2022-23 which is in line with the IMTP

4. RECOMMENDATION

QSP is asked to:

4.1 **NOTE** the contents of the March 2023 financial report and in particular the yearend financial performance which reported a £0.064m underspend.

4.2 **NOTE** the TCS Programme financial report for 2022-23 which is attached as **Appendix 1** and in particular the reported breakeven position on and the reported £0.131m underspend on the revenue budget.

4.2 **NOTE** the core Trust WG Monthly Monitoring Return (MMR) for month 12 **Appendix 2.**

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FINANCIAL PERFORMANCE REPORT

FOR THE PERIOD ENDED MARCH 2022/23

QUALITY, SAFETY & PERFORMANCE COMMITTEE 16/05/2023

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

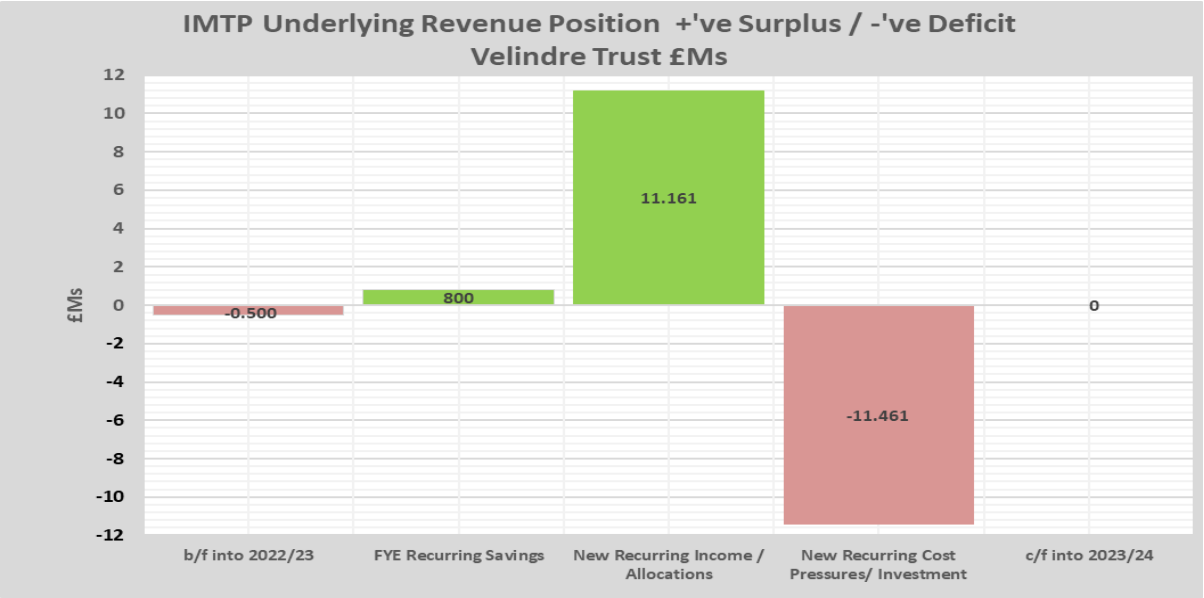
The Trust IMTP Financial Plan for the period 2022-2025 was set within the following context.

- 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 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

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	Total Actual 2022-23	Year End Forecast £m
Revenue	Variance	0.061	0.064	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	10.155	27.758	0.000
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	95.0%	95.0%	95.0%

Performance against Planned Savings Target

Efficiency / Savings	Variance	0	0

Revenue

The core Trust reported a **£0.061m** in-month underspend position for March '23, with a cumulative final reported underspend position of **£0.064m** for 2022-23.

Capital

The final approved Capital Expenditure Limit (CEL) for 2022-23 was **£27.760m**. This represents all Wales Capital funding of £26.306m, and Discretionary funding of £1.454m. The Trust reported actual spend of **£27.758m** ensuring the Trust CEL target was achieved for 2022-23.

The Trust's CEL for 2022-23 was broken down as follows:

	£m Opening	£m Movement	£m March 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 schemes 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**

With WG agreement, slippage on the TCS Programme led to a further £0.709m being handed back during January '23, in total £7.102m was provided back to WG during 2022-23. This funding will be re-provided to the programme during 2023-24.

During the period the Trust received approval from WG for the Integrated Radiotherapy Solution (IRS) capital expenditure with £7.900m being provided during 2022-23. The Trust was also awarded £0.370m as part of the request for year-end priority schemes, along with £0.157m, towards the OBC fees for the WBS infrastructure case which gave a revised Trust CEL of £27.760m for 2022-23.

PSPP

During March '23 the Trust (core) achieved a draft compliance level of **95%** (February 23: 95%) of non-NHS supplier invoices paid within the 30-day target, which resulted in a cumulative core Trust compliance figure of **95%** (draft) for 2022-23 and a final Trust position (including hosted bodies) of **95%** (draft) which will result Trust as a whole met its statutory target of 95%.

PSPP improved in Feb & Mar '23 following a dip of performance in the preceding few months which enabled the overall Trust to achieve the 95% target. Work between the finance team, NWSSP accounts payable team and the service will need to continue in order to both improve and maintain performance going into 2023/24.

Efficiency / Savings

The Trust fully achieved the savings target during 2022-23 with replacement schemes being implemented to support under delivery on two schemes that turned RAG rated red due to the inability to deliver during the period.

Revenue Position

2022/23 Financial Position			
£0.064m Underspent			
Type	Full Year Budget (£m)	Full Year Actual (£m)	Full Year Variance (£m)
Income	(185.404)	(184.518)	(0.886)
Pay	83.108	82.118	0.990
Non Pay	102.296	102.335	(0.040)
Total	**(0.000)**	**(0.064)**	**0.064**

The overall final position against the profiled revenue budget for 2022-23 was an underspend of **£0.064m**

4.1 Revenue Position Key Issues

Suspension of expenditure recharges to Charity 2022/23

During 2022/23 the Trust has accumulated c£1.5m of non-recurrent income from a number of sources including significantly higher levels of bank interest income than normal, non-commitment

of all its recurrent discretionary funding, unused recurrent emergency reserve and non-recurrent accountancy gains.

The Trust receives funding from the Charity which supports the supplementation of cancer services, the administration of the funds and investment in research and development. Given the c£1.5m of extraordinary non-recurrent income generated the level of Trust expenditure funded by the Charity in 2022-23 was reduced by £1.5m.

Income Key Highlights

Income in WBS is lower than planned on Bone Marrow where the annual target was not achieved for 2022-23.

VCC and Corporate over achievement on private patient, SACT homecare and bank interest.

nVCC overachievement on interest received from the Escrow bank account.

Overall income overachievement reduced by £1.5m due to the suspension of expenditure recharges to the Charity.

Pay Key Highlights

The total core Trust vacancies as at March 2023 is 125wte, VCC (70wte), WBS (28wte), Corporate (11Wte), R&D (10wte), TCS (0wte) and HTW (6wte).

The Trust received the pay award funding of £3.065m from WG relating to 2022-23. Following review by Divisions the funding gap was £450k which relates to unfunded incremental drift. The funding gap in year was met through the high level of vacancies that have been carried throughout the Trust, along with the release of the additional annual leave provision carried forward from last year. The recurrent financial impact into future years has been considered as part of the IMTP process however the requirement will be that each Division will need to manage this pressure internally.

Full funding was provided from WG to support the non-consolidated 1.5% pay award that was received in March 23.

At this stage the Trust is expecting to receive full funding for the 1.5% consolidated pay award which will be processed during May 23 and back dated to April 22.

Whilst still in negotiations any further pay award associated with 2022-23 is expected to be fully funded by WG.

The Trust 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 remained high during 2022-23. A large number of posts in VCC and WBS were recruited at risk to create additional capacity required to respond to the Covid activity backlog and service developments without certainty around LTA income pending activity undertaken or FBC funding approval by WG and Commissioners. Work is continuing in both Divisions to understand the likely cancer activity demand and associated income, secure additional funding to support these posts and assessing options to migrate staff into vacancies to help mitigate the financial risk exposure.

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 Highlights

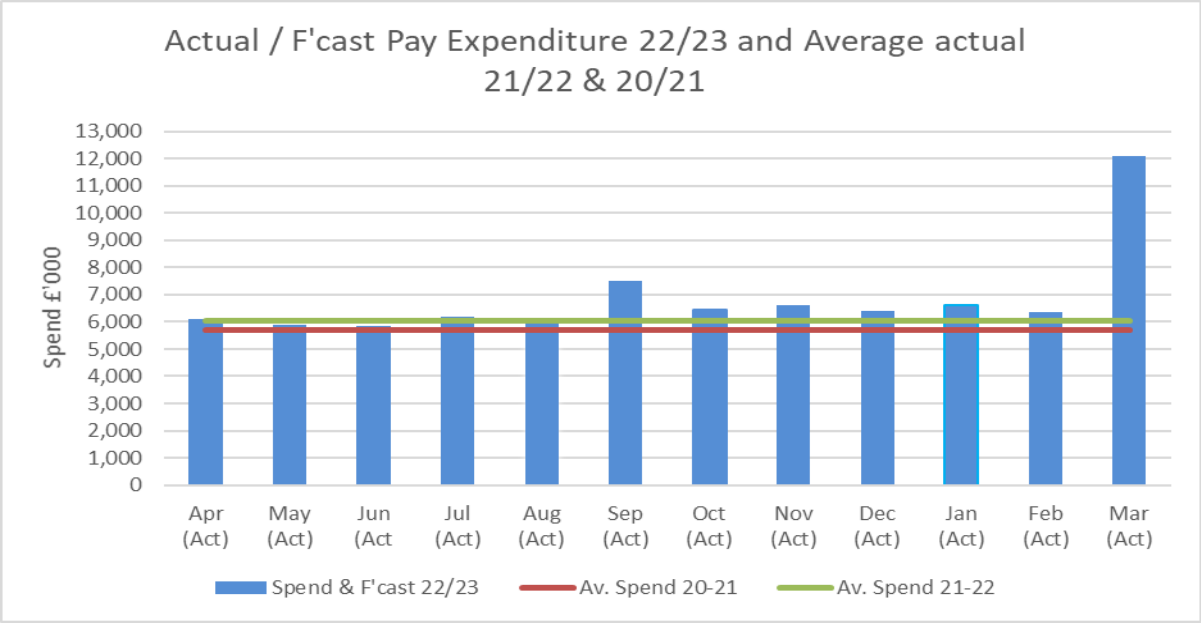
WG provided funding of £0.671m to support the increase in energy costs above the 2021-22 baseline.

Each Division holds both a general reserve to meet unforeseen costs and a savings target / Cost improvement Plan (CIP). The Trust 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 which were fully delivered, although two VCC workforce schemes for service redesign and support structures could not be delivered due to the high level of gaps due of sickness and vacancies. Replacement schemes were implemented to deliver the savings target.

The Trust reserves and previously agreed unallocated investment funding was distributed out in month 12 to support the divisional income targets that were reduced following the suspension of recharges to the charity.

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. The 1.5% Consolidated pay award and additional 6.3% pension both funded via WG explains the surge in the pay during March.

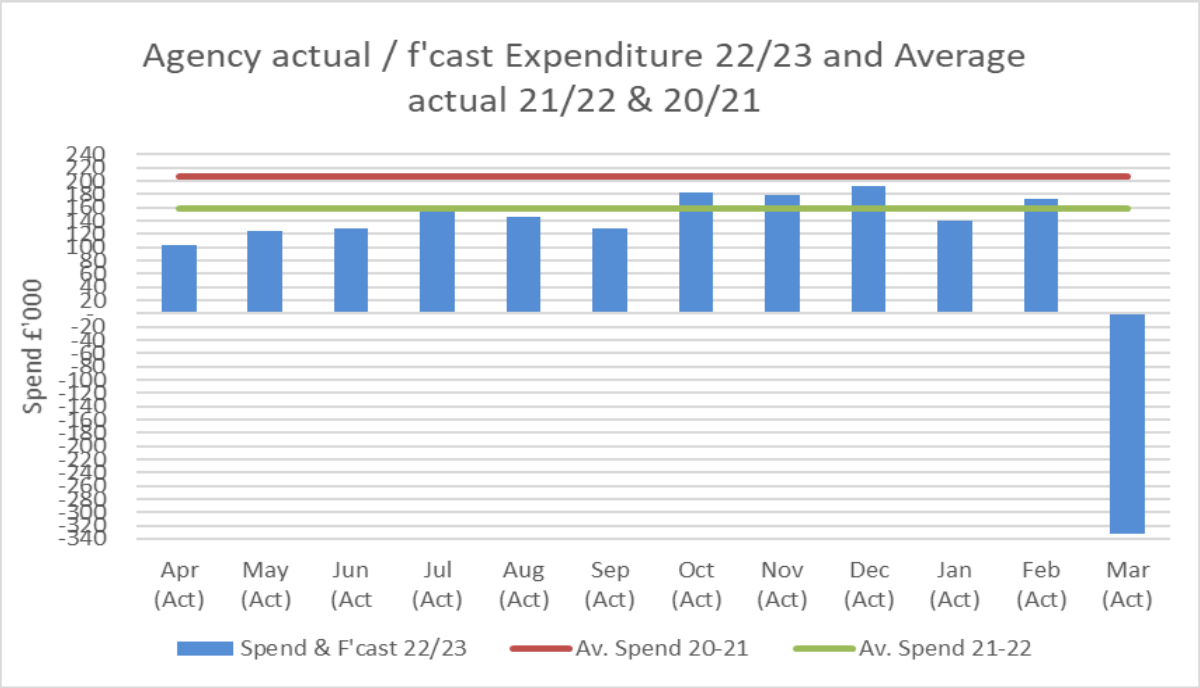


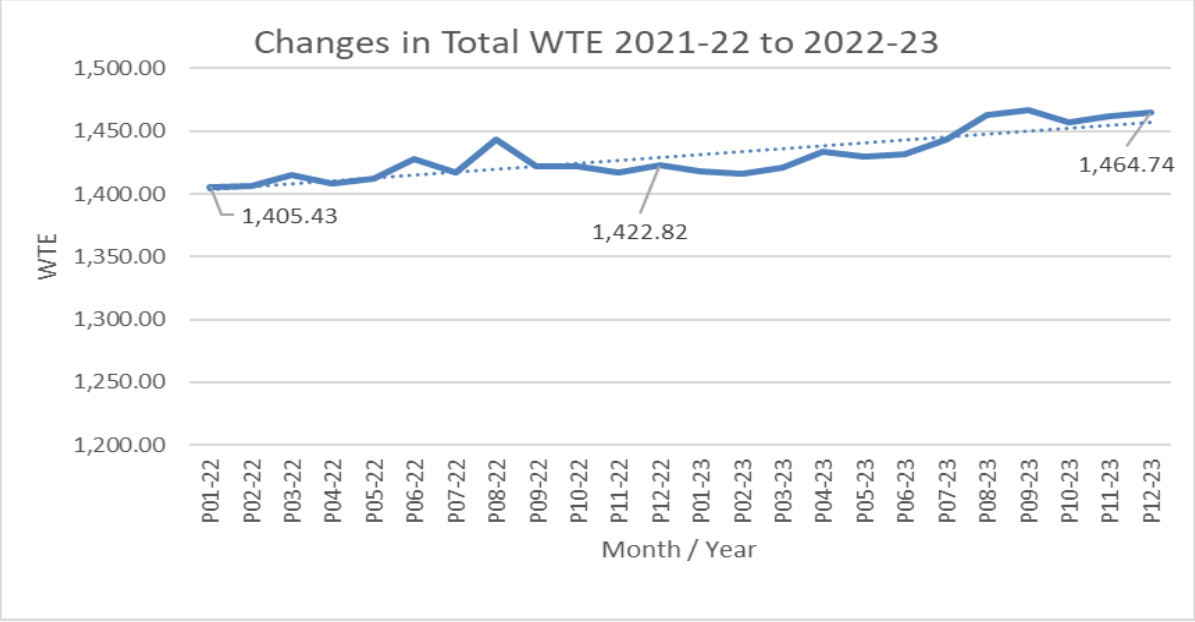
The spend on agency for March '23 was £(0.332)m (February £0.173m), which gives a cumulative full year spend of **£1.323m** for 2022-23 (£1.906m 2021/22). Of these totals the total spent on agency directly relating to Covid was £0.314m (£0.826m 2021-22).

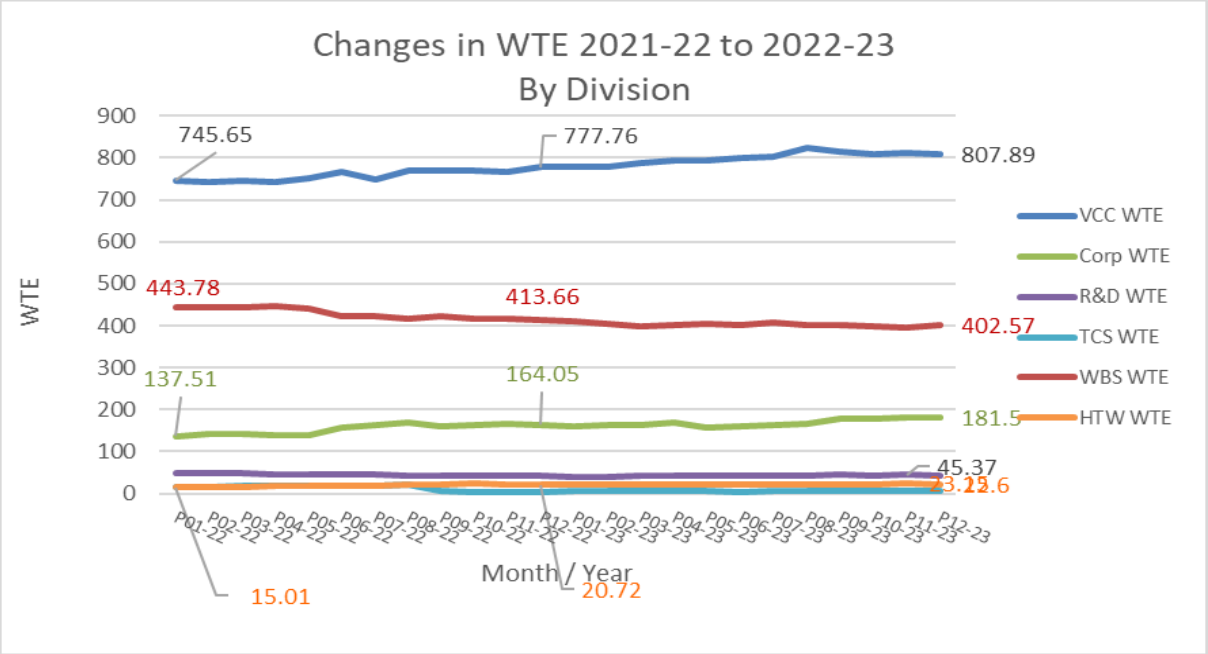
Agency costs have decreased this year from the 2021-22 levels which is due to the reduction of agency staff previously recruited to support Covid response. Further reductions in the use of agency were expected in 2022-23 by recruiting staff required on a permanent basis. However, more agency staff were required at the back end of the year in particular to support the running of estates in VCC to ensure delivery of ongoing maintenance and statutory compliance duties. The

service has been actively recruiting into this area, so agency costs are expected to be replaced by the use of appointing permanent staff during 2023-24.

During March a review of agency requirement within VCC was undertaken which resulted in the release of a bfwd provision from 2021-22. In addition, a review of system committed orders was undertaken which resulted in several receipted orders being identified as no longer being required. This generally occurs when agency staff leave before their agreed term and the orders need to be closed, consequently a credit is released back into the revenue position.



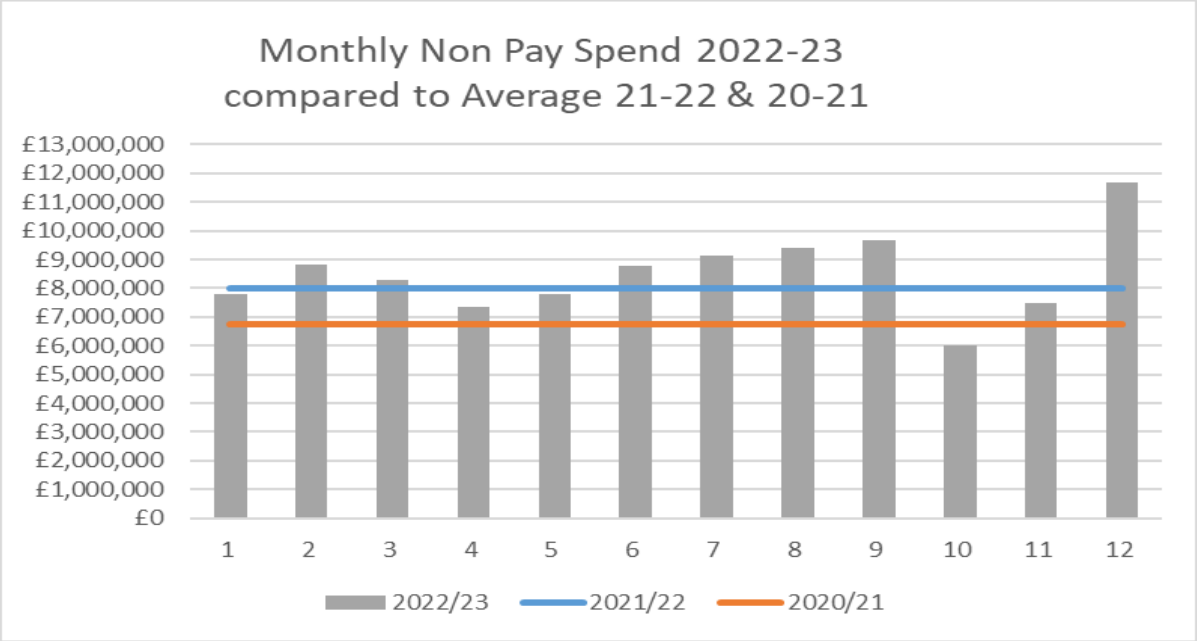




The increase of 20 WTE during November (P08-23) is largely within VCC and relates to the recruitment of Nurses and HCSW into service area's such as inpatients, Chemotherapy and Prince Charles.

4.3 Non Pay

Non-pay 2021-22 (c£96m) average monthly spend of £8m was £1.2m higher than the reported monthly average spend for 2020-21 (£6.8m). The majority 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 was £8.5m which is an average increase of circa £0.5m, a large element of this increase relates to the WBS wholesaling costs, along with the growth in energy costs and general inflation.



The non-pay spend reduction in January is due to NICE / High Cost Drugs spend being offset by receipt of rebates on a significantly higher scale than anticipated which was 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.

During March a provision of £1.5m was made under nVCC for FBC bidder reimbursement costs, which are expected to be funded by WG.

4.4 Covid-19

The total funding requirement for 2022-23 in relation to Covid was £4.301m. This was a significant reduction from the £12.310m that was submitted as part of the Trust IMTP. Of the £4.301m total Covid requirement £0.873m (IMTP plans £2.104m) was funded directly from WG, and the balance of £3.428m (IMTP plans £10.206mwas largely provided by our commissioners via LTA as additional income where activity is above 2019-20 baseline, with financial protection from the National Funds Flow framework.

Covid-19 Revenue Spend 2022/23					
	WG £m	Commissioners £m	Total £m	IMTP Plans £m	Cost Reduction £m
Mass Vaccination	0.224		0.224	0.375	0.151
PPE	0.070		0.070	0.335	0.265
Cleaning	0.289		0.289	0.427	0.138
Other Covid Response	0.290		0.290	0.967	0.677
Covid Recovery - Internal Capacity		3.167	3.167	6.056	2.889
Covid Recovery - Outreach		0.261	0.261	4.150	3.889
	0.873	**3.428**	**4.301**	**12.310**	**8.009**

The Trust received £0.873m funding from WG which supported all associated Covid response costs.

The Trust Covid recovery expenditure for 2022-23 of £3.428m was a result of investment in additional capacity based on activity demand forecast modelling which commenced in 2021-22 and has been updated regularly working with Health Board operational teams. The initial anticipated funding requirement of £4.150m for outsourcing was removed as the Rutherford Cancer Centre (RCC) went into liquidation during the period. The Trust expanded internal capacity at its outreach Centre at Prince Charles Hospital (from October '22) for SACT, with additional cost of £0.261m above that already invested in Covid capacity. In addition, the Trust had developed plans for expanding Radiotherapy capacity internally through use of weekend working which has required existing staff to work additional hours as Waiting List Initiatives (WLIs) with enhanced pay rates. These additional investments in capacity to meet the activity demand from Health Boards was not fully covered through LTA marginal income, despite the National funds flow protection, leading to an additional financial pressure of c£0.500m to the Trust which it managed 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 financial risk of c£1.5m which the Trust will need to cover through inflation growth funding and / or savings depending on demand growth and the Trust ability to deliver activity within the current capacity.

Other cost reduction from IMTP plans reflected financial control measures and review of service delivery models to reflect the 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 cost reduction 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%).

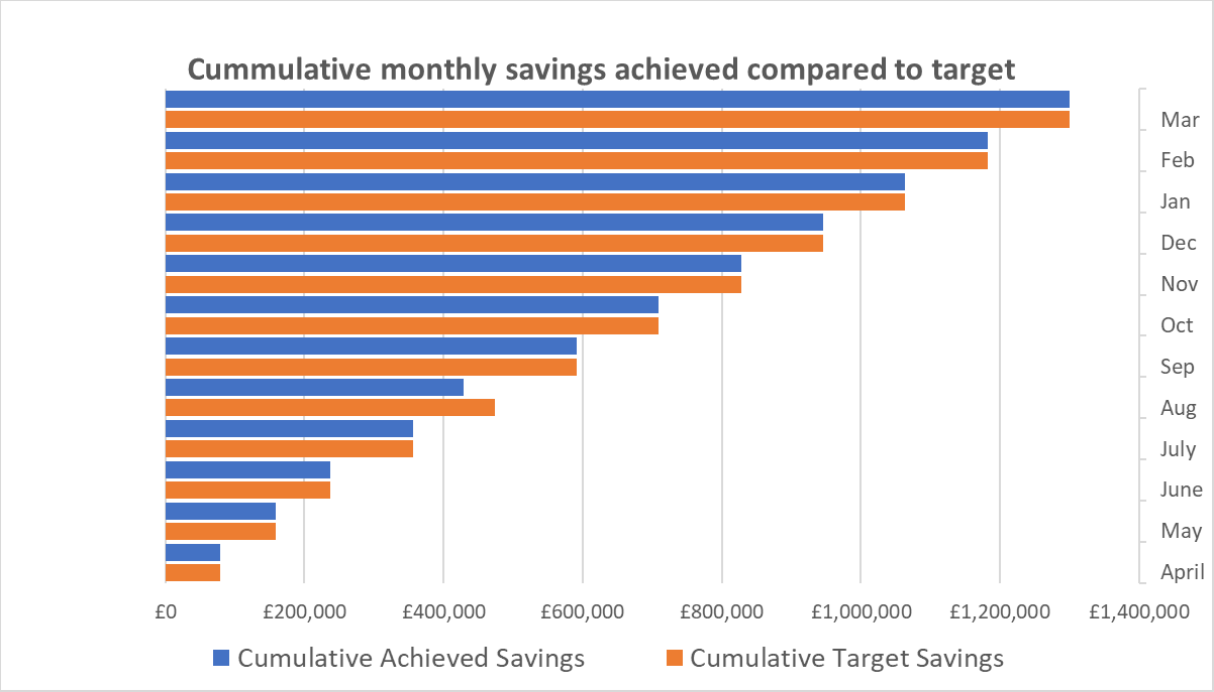
Two VCC workforce schemes which relate to service redesign and support structures continued to be impacted by the Covid legacy of higher than normal sickness levels and significant activity demand pressures during 2022-23 and therefore were turned from RAG rated amber to red due to the inability to deliver.

Service redesign and support structures is a key area of savings for the Trust which are focused on removing inefficiencies in the ways the Trust are working. 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 VCC Division however, it was recognised due to the current challenges that these saving schemes were not going to be achieved during the financial year.

Contingency measures were put in place during 2022-23 on the realisation that these savings schemes were not going to achieved. **It is important as we move into 2023/24 that divisions take ownership of their respective saving schemes to ensure that they are full delivered during the period.**

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**	**700**	**500**	**(200)**	**500**	**(200)**
			71%		**71%**	
WBS TOTAL SAVINGS	**500**	**500**	**500**	**0**	**500**	**0**
			100%		**100%**	
CORPORATE TOTAL SAVINGS	**100**	**100**	**100**	**0**	**100**	**0**
			100%		**100%**	
TRUST LEVEL TOTAL SAVINGS			**200**	**200**	**200**	**200**
TRUST TOTAL SAVINGS IDENTIFIED	**1,300**	**1,300**	**1,300**	**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	100	100	0	100	0
Laboratory & Collection Model (WBS)	Green	50	50	50	0	50	0
Laboratory & Collection Model (WBS)	Green	50	50	50	0	50	0
Stock Management (WBS)	Green	100	100	100	0	100	0
Stock Management (WBS)	Green	150	150	150	0	150	0
Procurement - Supply Chain (WBS)	Green	50	50	50	0	50	0
Service Redesign (VCC)	Red	100	100	0	(100)	0	(100)
Supportive Stuctures (VCC)	Red	100	100	0	(100)	0	(100)
Procurement - Supply Chain (VCC)	Green	50	50	50	0	50	0
Bank Interest (Trust - In Year)	Green		0	167	167	167	167
Vacancy Factor (Trust - In Year)	Green		0	33	33	33	33
Total Saving Schemes		**750**	750	750	0	750	0
Income Generation							
Maximinsing Income Opportunities - Income Attraction (WBS)	Green	50	50	50	0	50	0
Maximinsing Income Opportunities - Income Attraction (WBS)	Green	50	50	50	0	50	0
Maximinsing Income Opportunities - Private Patients (VCC)	Green	150	150	150	0	150	0
Maximinsing Income Opportunities - Private Patients (VCC)	Green	100	100	100	0	100	0
Maximinsing Income Opportunities - Income Attraction (VCC)	Green	200	200	200	0	200	0
Total Income Generation		**550**	550	550	0	550	0
TRUST TOTAL SAVINGS		**1,300**	**1,300**	**1,300**	**0**	**1,300**	**0**
				100%		**100%**	



5. Reserves

The financial strategy for 2022-23 facilitated the development of a recurrent and non-recurrent reserve in support of the Trust transformation and delivery agenda. These reserves could only be accommodated on the basis that all income expectations are received, planned savings schemes delivered and new emerging cost pressures managed. In addition, the Trust holds an emergency reserve of £0.522m.

The Trust reserves position delivered a surplus during 2022-23 due to slippage on previously approved commitments. Further, the Trust did not receive confirmation until November '22 that WG would fund exceptional cost pressures relating to Covid and energy costs in particular. In addition, release of recurrent reserves for new investment was not considered possible in 2022/23 as they have been ringfenced to support the 2023/24 expected financial pressures on both energy and Covid recovery staff capacity.

The underspend on reserves was utilised to support the suspension of recharges to the charity during 2022-23.

6. End of Year Forecast / Risk Assessment

The Trust reported a small yearend underspend position of £0.064m against its revenue budget for 2022-23. All risks were mitigated during the period to ensure delivery of the financial position.

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	Full Year Actual Spend £m	Year End Variance £m
All Wales Capital Programme			
nVCC - Project costs	2.394	2.994	-0.600
nVCC - Enabling Works	14.406	13.806	0.600
Canisc Cancer Project	0.579	0.582	-0.003
Fire Safety	0.500	0.500	0.000
Integrated Radiotherapy Solutions (IRS)	7.900	8.004	-0.104
WG Priority Year end Spend	0.370	0.370	0.000
WBS Infrastructure OBC Fees	0.157	0.139	0.018
Total All Wales Capital Programme	26.306	26.395	-0.089
Discretionary Capital	1.454	1.363	0.091
Total	27.760	27.758	0.002

The approved 2022-23 Capital Expenditure Limit (CEL) for 2023 was £27.760m. This includes All Wales Capital funding of £26.306m, and discretionary funding of £1.454m. The approved CEL increased during the year by a total of £1.904m. This 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). The increased capital allocation was offset by a reduction of £7.102m on the nVCC Enabling Works project to reflect the cash flow requirement for 2022-23. Following agreement with WG the £7.102m will be re-provided to the programme during 2023-24.

WG colleagues agreed a further movement of £0.600m 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 would be significantly reduced during 2022-23 (previously £1.911m), which was 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 would 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 (IRS) for the Satellite Centre at Nevil Hall. The funding will be drawn down from 2023-24 and beyond to match the profiled spend.

Yearend performance

The total spend on the All-Wales Capital Programme schemes for 2022-23 was £26.395m which resulted in a small overspend of £0.089m against the approved CEL of £26.306m. Following last minute slippage on the discretionary programme of £0.091m, along with cost savings on the WBS Infrastructure OBC costs (£0.018m) a decision was made to utilise the underspend by bringing forward the purchase of licenses required for the IRS programme.

The Trust discretionary actual spend for 2022-23 was £1.377m against an approved CEL of £1.454m leaving a balance of £0.002m on the overall Capital programme resulting in the Trust achieving its CEL target for 2022-23.

Major Schemes in Development

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

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

The capital investment required over the period of the IMTP are schemes that have or will be submitted to Welsh Government as cases for consideration against the All-Wales Capital Fund. These include:

All Wales Approved and Unapproved Capital Schemes	2023-24 £m	2024-25 £m	2025-26 £m	2026-27 £m	Further Years £m	Total All Wales Schemes £m
All Wales Approved Schemes						
TCS nVCC enabling works	7.979	0.000	1.547			9.526
Integrated Radiotherapy Solution (IRS)	10.326	15.813	5.634			31.773
IRS Satellite Centre	1.347	10.065				11.412
Total Approved Capital Schemes	**19.652**	**25.878**	**7.181**	**0.000**	**0.000**	**52.711**
All Wales Unapproved Schemes						
TCS nVCC	7.168	34.132	7.147			48.447
TCS nVCC Enabling works	1.000					1.000
WBS HQ	0.120	1.016	12.808	9.996	10.961	34.901
Plasma Fractionation (under development)						0.000
WBS Fleet Replacement		1.400				1.400
WTAIL Lims Case	0.826	0.066				0.892
WBS Blood Establishment Computer System (BECS) (under development)						0.000
WBS Blood Group Analyser Replacement		0.480				0.480
WBS Asset Replacement		0.300	0.400	0.500		1.200
VCC Replacement Brachytherapy Applicators			0.300			0.300
Digital Services	0.650	0.400	0.400	0.400		1.850
Digital Scannining infrastructure	2.536	0.536				3.072
Total Unapproved Capital Schemes	**12.300**	**38.330**	**21.055**	**10.896**	**10.961**	**93.542**
Total All Wales Capital Plans	31.952	64.208	28.236	10.896	10.961	146.253

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.

Due to the financial year end the balance sheet is currently not ready to be presented to EMB.

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

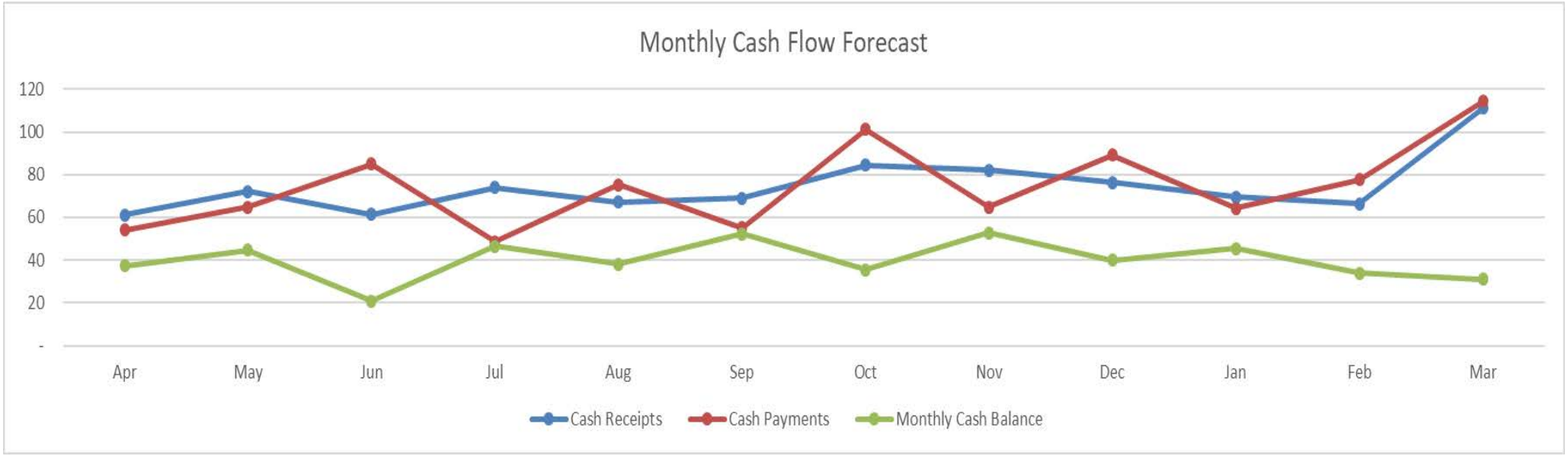
provide resilience for NHS Wales due to the uncertainty around supply chain reliability because of Brexit.

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 continued uncertain situation with Covid and potential impact on supply chains the Trust continues to hold this stock with assessments ongoing. NWSSP however have now issued the additional stock and the £4.5m was repaid to WG during February '23.

Following a request from WG the Trust transferred £5.9m of cash into the Escrow holding bank account during May '22 for the nVCC programme. These funds were consequently drawn down in July '22 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 pay its creditors and meet anticipated commitments.

	Apr £'000	May £'000	Jun £'000	Jul £'000	Aug £'000	Sep £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £'000	Totals £'000
RECEIPTS													
LHB / WHSSC income	33,135	40,208	40,042	37,491	47,836	36,522	43,649	41,695	38,513	45,628	44,298	44,698	493,714
WG Income	20,937	24,551	17,010	24,552	15,002	26,148	32,585	33,410	26,654	16,898	15,890	45,123	298,760
Short Term Loans													0
PDC				5,928								12,551	18,479
Interest Receivable	19	27	30	25	37	62	75	105	103	174	157	163	977
Sale of Assets													0
Other	7,106	7,289	4,321	6,094	4,246	6,395	8,220	6,982	11,052	6,891	6,119	8,726	83,442
TOTAL RECEIPTS	**61,197**	**72,074**	**61,403**	**74,090**	**67,121**	**69,127**	**84,529**	**82,192**	**76,323**	**69,591**	**66,464**	**111,262**	**895,373**
PAYMENTS													
Salaries and Wages	21,735	29,243	29,483	29,705	29,549	34,417	36,535	33,118	32,231	32,387	31,821	34,197	374,422
Non pay items	30,543	33,079	54,139	17,703	44,384	20,200	63,158	29,085	55,738	30,845	38,992	71,723	489,589
Short Term Loan Repayment											4,500		4,500
PDC Repayment													0
Capital Payment	1,926	2,567	1,420	1,215	1,428	446	1,469	2,732	1,152	1,105	2,455	8,237	26,152
Other items													0
TOTAL PAYMENTS	**54,205**	**64,889**	**85,042**	**48,623**	**75,361**	**55,063**	**101,162**	**64,935**	**89,121**	**64,337**	**77,768**	**114,157**	**894,663**
Net cash inflow/outflow	6,993	7,185	(23,639)	25,467	(8,240)	14,064	(16,633)	17,257	(12,798)	5,254	(11,304)	(2,896)	
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	34,009	
Balance c/f	37,397	44,582	20,943	46,410	38,170	52,234	35,601	52,858	40,060	45,313	34,009	31,114	



DIVISIONAL ANALYSIS

(Figures in parenthesis signify an adverse variance against plan)

Core Trust

	Full Year Budget £m	Full Year Actual £m	Closing Variance £m
VCC	**(39.905)**	**(39.892)**	**0.014**
RD&I	**0.149**	**0.153**	**0.004**
WBS	**(21.405)**	**(21.406)**	**(0.001)**
Sub-Total Divisions	**(61.162)**	**(61.145)**	**0.017**
Corporate Services Directorates	**(12.123)**	**(12.231)**	**(0.108)**
Delegated Budget Position	**(73.285)**	**(73.376)**	**(0.091)**
TCS	**(0.695)**	**(0.564)**	**0.131**
Health Technology Wales	0.000	0.025	0.025
Trust Income / Reserves	**73.980**	**73.980**	**(0.000)**
Trust Position	0.000	0.064	0.064

VCC

	Full Year Budget £m	Full Year Actual £m	Closing Variance £m
Income	**64.501**	**64.441**	**(0.060)**
Expenditure			
Staff	**46.069**	**46.038**	**0.031**
Non Staff	**58.338**	**58.295**	**0.042**
Sub Total	**104.407**	**104.333**	**0.074**
Total	**(39.905)**	**(39.892)**	**0.014**

VCC Key Issues:

The reported final financial position for the Velindre Cancer Centre during 2022-23 was a small underspend of **£0.014m.**

Income for 2022-23 represented an underachievement of **£(0.060)m**. The divisional savings target offset the additional income received from the VAT savings made from providing SACT homecare,

and the surplus on private patient income due to drug performance, along with several other small overachievements.

VCC reported a **£0.031m** underspend against staff for 2022-23. The Division continues to carry a large number of vacancies with the savings generated being above the divisional vacancy factor target and offsetting the cost of agency (£0.875m) for 2022-23, £0.276m being directly related to Covid). In addition, the savings from vacancies are also supporting the costs of advanced recruitment for implementation staff into the IRS project.

Medical staff 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, an enhanced out of hours service for advanced life support, which will be nursing led, currently continues to be covered by Jnr Dr's with transition to nursing having begun being phased in.

Non-Staff Expenditure reported a **£(0.042)m** underspend for 2022-23. Overspends in the period largely related to the facilities management office pressures which were previously supported by Covid, maintenance and repair of the Linacs, and consumable spend from increased activity. The overspends were offset by utilisation of the Divisional reserves, and drug rebate income.

WBS

	Full Year Budget £m	Full Year Actual £m	Closing Variance £m
Income	**26.759**	**26.315**	**(0.444)**
Expenditure			
Staff	**17.274**	**17.299**	**(0.024)**
Non Staff	**30.889**	**30.422**	**0.467**
Sub Total	**48.164**	**47.721**	**0.443**
Total	**(21.405)**	**(21.406)**	(0.001)

WBS Key Issues:

The reported final financial position for the Welsh Blood Service during 2022-23 was **breakeven**.

WBS reported an income underachievement of **£(0.444)m** where activity was significantly lower than planned on Bone Marrow. Transitional operating sites for Bone Marrow and increasingly curtailed procedures is resulted in activity being considerably lower than target. There has been a lack of growth in the bone marrow registry largely due to the legacy impact of Covid and inability to grow the panel in sites such as schools and universities, which is currently being addressed through campaigns. The WHSSC income for supressed activity for the first 6 months is reflected as an underspend within the non-pay position which is due to the mechanics of WHSSC allocation and a requirement to set a non-pay budget within the WBS reserves. The WHSSC income support for the underachievement was fully utilised during the first 6 months.

Targeted income generation from plasma sales has recovered following the contract award for a new supplier in October which included an increased selling price. Benefits of new contract reflected with significant upturn in the latter part of the year which resulted in an overachievement being reflected for 2022-23.

Staff reported a **£(0.024)m** overspend for 2022-23. Overspend was a result of posts being 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. The Trust has now received confirmation of funding from WG to support the Plasma programme (previously fractionation) staffing costs so this pressure has been removed.

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

Non-Staff reported an underspend of **£0.467m** is largely due to reduced costs from suppressed activity underspends within Laboratory Services and WTAIL. WTAIL underspend is inclusive of WHSSC allocation relating to Bone Marrow reflected to contra income underachievement as described above.

Corporate

	Full Year Budget £m	Full Year Actual £m	Closing Variance £m
Income	**5.799**	**5.534**	**(0.264)**
Expenditure			
Staff	**14.853**	**14.250**	**0.603**
Non Staff	**3.068**	**3.515**	**(0.447)**
Sub Total	**17.922**	**17.765**	**0.156**
Total	**(12.123)**	**(12.231)**	(0.108)

Corporate Key Issues:

The final reported financial position for the Corporate Services division for 2022-23 was an overspend of **£(0.108)m**.

Reported Income underachievement is a result of the suspension of recharges to the Charity which is offsetting the benefits that the Trust is currently receiving from the Bank interest following rate rises.

Significant number of vacancies were bring carried in Corporate over the year (circa 8% of the total divisional workforce) which will led to a large underspend against staff. This also offset use of agency and ensure achievement the divisional savings target.

Non pay reported overspend is **£(0.447)m,** 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

	Full Year Budget £m	Full Year Actual £m	Closing Variance £m
Income	**3.713**	**3.556**	**(0.157)**
Expenditure			
Staff	**2.865**	**2.576**	**0.288**
Non Staff	**0.700**	**0.827**	**(0.127)**
Sub Total	**3.565**	**3.404**	**0.161**
Total	**0.149**	**0.153**	0.004

RD&I Key Issues

The final reported financial position for the RD&I Division for 2022-23 was a small **£0.004m** underspend.

Staff vacancies remained relatively high although active recruitment slowly reduced vacancy levels across the period, however several posts are not going be filled before the year end. The underspend on staff is offsetting the innovation income target which has not been met this year due to a vacancy in a key position.

Non staff overspend is a combination of multiple small pressures across several cost centres.

TCS – (Revenue)

	Full Year Budget £m	Full Year Actual £m	Closing Variance £m
Income	**1.897**	**2.004**	**0.107**
Expenditure			
Staff	**0.619**	**0.588**	**0.031**
Non Staff	**1.974**	**1.981**	**(0.007)**
Sub Total	**2.593**	**2.569**	**0.024**
Total	**(0.695)**	**(0.564)**	0.131

TCS Key Issues

The final reported financial position for the TCS Programme for 2022-23 was an underspend of **£0.131m.**

Income overachievement is a result of interest being received on the Escrow account.

During March a provision of £1.5m was made under nVCC for FBC bidder reimbursement costs which is fully funded by WG.

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.

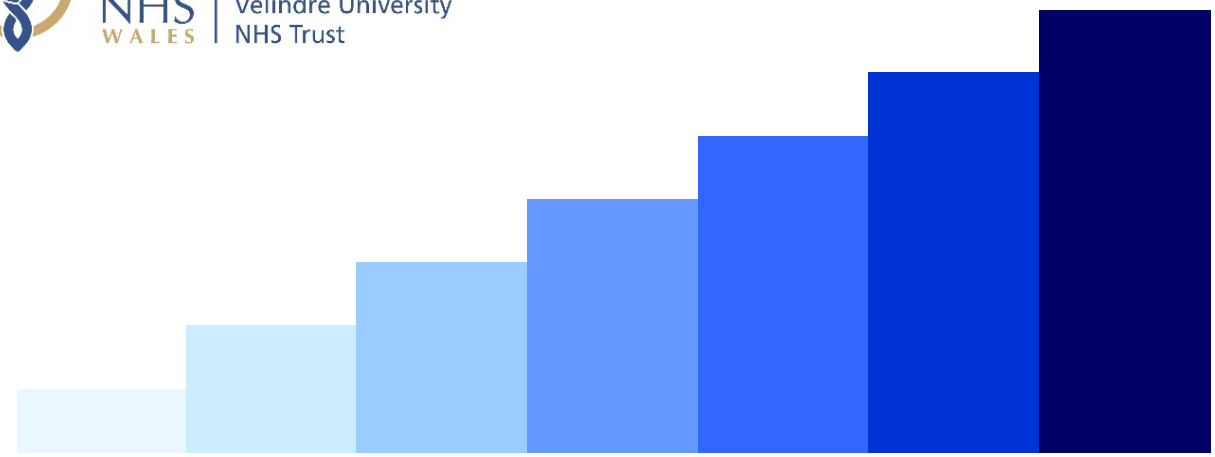
HTW (Hosted Other)

	Full Year Budget £m	Full Year Actual £m	Closing Variance £m
Income	**1.664**	**1.596**	**(0.068)**
Expenditure			
Staff	**1.428**	**1.367**	**0.062**
Non Staff	**0.235**	**0.204**	**0.031**
Sub Total	**1.664**	**1.571**	**0.093**
Total	**0.000**	**0.025**	0.025

HTW Key Issues

The final reported financial position for Health Technology Wales was an underspend of **£0.025m**.

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



TCS PROGRAMME
FINANCE REPORT 2022-23

Period Ending March 2023

Presented to the
EMB Shape Transformation Board on
17th April 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 against budget.

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 is provided below. A detailed table of budget, spend and variance for the capital and revenue expenditure is provided in Appendix 1.

Expenditure Type	2022-23 Full Year		
	Budget	Outturn	Variance
Capital	£16.801m	£16.801m	£0.000m
Revenue	£0.695m	£0.564m	£0.131m
Total	**£17.497m**	**£17.365m**	**£0.131m**

2.2 The overall outturn for the Programme is an underspend of £0.131m for the financial year 2022-23 against a budget of £17.497m.

2.3 The Enabling Works final position reflects an underspend of £0.600m, which has supported the nVCC Project. This has been provided from the Enabling Works QRA. The approach has been agreed with WG.

2.4 A review of the Enabling Works Project funding requirements during the year has resulted in a total virement of £7.102m from 2022-23 into 2023-24, and £0.305m to the nVCC Project, as agreed with WG. This, along with the change in the IRS Procurement Project funding, reduces the overall **capital** funding for 2022-23 to **£16.801m**. The adjustments undertaken by the Enabling Works during 2022-23 are as follows:

- Adjustment of £1.900m in May 2022 – delay in Enabling Works 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;
- Adjustment of £0.709m in January 2023 – further delay in the Asda works; utilities and Added Value works; and
- Virement of £0.305m to the nVCC Project.

2.5 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 Procurement Project for 2022-23 will therefore be not be reported by the TCS Programme.

2.6 A provisional revenue funding of £0.020m towards annual 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 are sufficient resources from within the Programme to cover these costs. Therefore, this additional funding has not been drawn down in 2022-23. These increased costs will however be take into account when forecasting future pay costs.

2.7 In February 2023, a non-consolidated pay enhancement of 1½% was awarded to NHS staff in Wales for 2022-23. Revenue funding of £0.021m was provided to the Programme from the WG allocation to the Trust to cover the additional costs. A consolidate pay enhancement of 1½% has also been award in 2022-23.This has been accounted for centrally by the Core Trust for 2022-23 with expectation that the pay award will be fully funded by WG. The pay date for processing the consolidated pay award has been confirmed as May 2023. .

2.8 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 overall **revenue** budget is now to **£0.695m** for 2022-23.

2.9 The Escrow bank account for the Enabling Works Project has yielded interest of £0.107m during 2022-23. This has been treated as revenue income to the Enabling Works Project in March 2023.

2.10 Welsh Government has provided revenue funding of £1.560m to cover nVCC bidder reimbursements costs incurred during March 2023. The resulting income and expenditure transactions will have a nil effect in 2022-23.

2.11 There are no outstanding financial risks for the financial year 2022-23.

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, increased to £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 March 2023)

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	WG Pay Award	Total Funding
PMO	£0.240m	£0m	£0m	£0.240m
nVCC Project	£0m	£0.073m	£0m	£0.073m
SDT Project	£0.180m	£0.131m	£0m	£0.311m
Total	**£0.420m**	**£0.204m**	**£0m**	**£0.624m**

Overall Change to Allocation

Project	LHB Commissioners	Trust Reserves	WG Pay Award	Total Funding
PMO	£0m	£0.060m	£0.005m	£0.065m
nVCC Project	£0m	-£0.010m	£0.015m	£0.005m
SDT Project	£0m	£0m	£0.001m	£0.001m
Total	**£0m**	**£0.065m**	**£0.021m**	**£0.071m**

Current Allocation (as at March 2023)

Project	LHB Commissioners	Trust Reserves	WG Pay Award	Total Funding
PMO	£0.240m	£0.060m	£0.005m	£0.305m
nVCC Project	£0m	£0.063m	£0.015m	£0.078m
SDT Project	£0.180m	£0.131m	£0.001m	£0.312m
Total	**£0.420m**	**£0.269m**	**£0.021m**	**£0.695m**

4. CAPITAL POSITION

4.1 The capital funding for 2022-23 is outlined below:

- Enabling Works 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 for 2022-23 is outlined below, with an overall breakeven position.

Capital Expenditure	2022-23 Full Year		
	Budget	Outturn	Variance
Enabling Works Project	£14.407m	£13.807m	£0.600m
nVCC Project	£2.394m	£2.994m	-£0.600m
IRS Procurement Project	£0m	£0m	£0.000m
Total	**£16.801m**	**£16.801m**	**£0m**

4.3 The overspend of £0.600m for the nVCC Project has been supported by the Enabling Works Project underspend of the same. This has been provided from the Enabling Works QRA. The approach has been agreed with WG and we are awaiting formal approval.

4.4 Following Ministerial approval of the IRS Final Business Case (IRS FBC) during November 2022, the IRS Procurement Project was closed on 30th November 2022. There was final cost of £0.182m for the Project against a budget of £0.178m, with funding ring fenced from the core Trust discretionary programme. However the IRS FBC included provision to fund these costs, therefore the funding was reimbursed back to the discretionary programme, and both the budget and costs for 2022-23 were

transferred to the IRS Implementation Project. Therefore the final budget and outturn for the IRS Procurement Project for 2022-23 is nil.

5. REVENUE POSITION

5.1 The revenue funding for 2022-23 is outlined below:

• PMO	£0.305m	NHS Commissioners & Trust Reserves
• nVCC Project	£0.078m	Trust Reserves
• SDT Project	£0.312m	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 In March 2023, a non-consolidated pay enhancement was awarded to NHS Wales staff for 2022-23, resulting in WG funding of £0.021m allocated to the TCS Programme.

5.4 The revenue position for 2022-23 is outlined below, with an overall underspend of £0.131m against a budget **of £0.695m**.

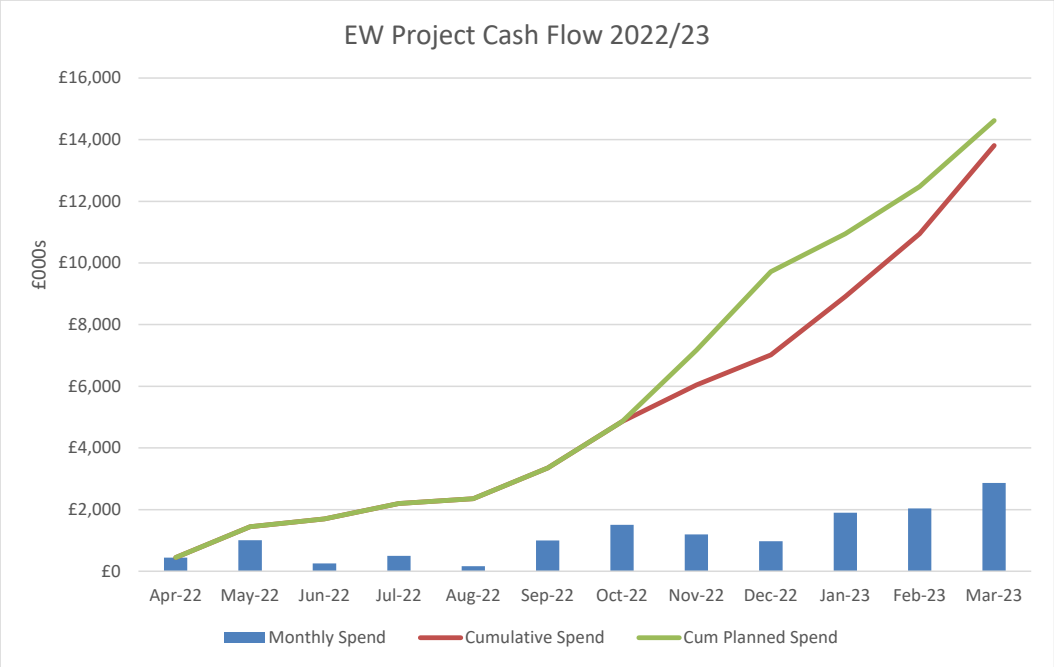
Revenue Expenditure	2022-23 Full Year		
	Budget	Outturn	Variance
PMO	£0.305m	£0.288m	£0.016m
Enabling Works	£0m	-£0.107m	£0.107m
nVCC Project	£0.078m	£0.088m	-£0.010m
SDT Project	£0.312m	£0.295m	£0.017m
Total	**£0.695m**	**£0.564m**	**£0.131m**

5.5 There are increased costs for the nVCC Judicial Review, which has resulted in an overspend of £0.010m. However, this has been offset by an underspend elsewhere in the TCS Programme.

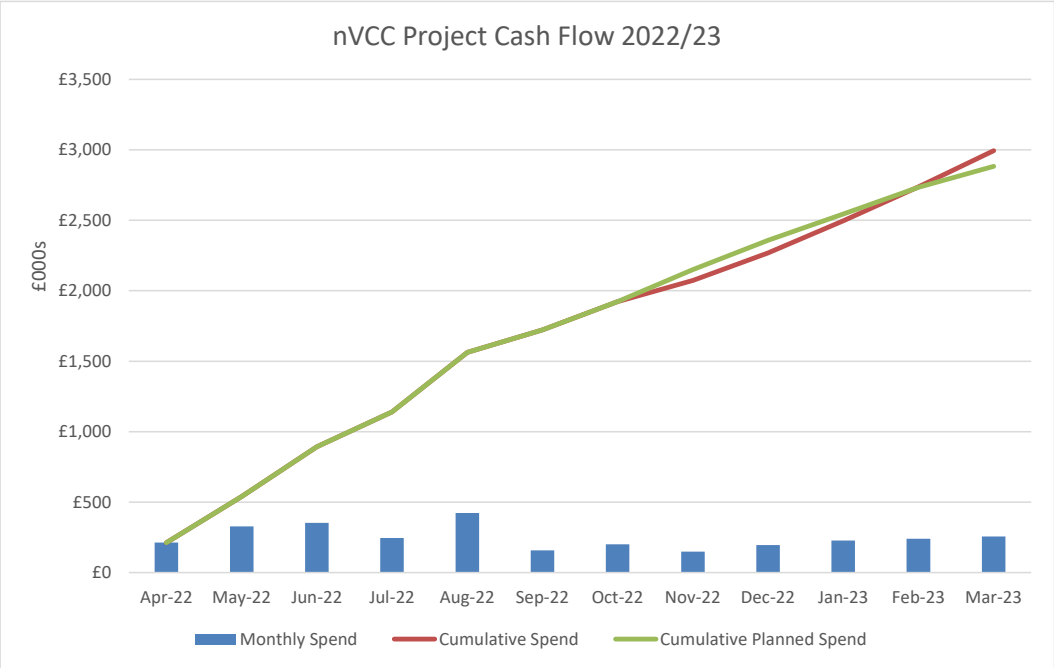
5.6 The Escrow bank account for the Enabling Works Project has yielded interest of £0.107m during 2022-23. This has been treated as revenue income to the Enabling Works Project in March 2023, increasing the expected revenue underspend for the Programme from £0.024m to £0.131m.

6. CASH FLOW

6.1 The capital cash flow for the **Enabling Works Project** is outlined below. The run rate indicates that, following the capital funding adjustment in January 2023, around 75% of the costs have been incurred in the second half of the financial year. This is due to the delay in the start of the works.



6.2 The 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.



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 the PMO for 2022-23 is **£0.305m**. £0.0240m of this has been provide from NHS Commissioners' funding, £0.060m from the Trust Reserves, and £0.005m from non-consolidated enhanced pay award funding. The provisional funding of £0.010m for the annual pay award has not been drawn down as the increased costs have been covered from within the PMO financial year.

7.3 There has been no capital funding requirement for the PMO in 2022-23.

7.4 The revenue position for the PMO for 2022-23 is shown below.

PMO Expenditure	2022-23 Full Year		
	Budget	Outturn	Variance
Pay	£0.291m	£0.280m	£0.011m
Non Pay	£0.013m	£0.008m	£0.005m
Total	**£0.305m**	**£0.288m**	**£0.016m**

7.5 There is an overall underspend of £0.016m for the year due to a delay in project and support work carried out by the PMO. This underspend has been utilised part to offset increased costs incurred by the nVCC Judicial Review.

Enabling Works Project

Capital

7.6 In February 2022, the Minister for Health and Social Services approved the EW FBC. This has provided capital funding of £28.089m in total.

7.7 For 2022-23 the Enabling Works 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.

7.8 The Project's capital position for 2022-23. The final position reflects an underspend of £0.600m due to a delay in key activities, which has been used to support the nVCC Project as agreed by WG.

Enabling Works Expenditure	2022-23 Full Year		
	Budget	Outturn	Variance
Pay	£0.220m	£0.334m	-£0.115m
Non Pay	£14.187m	£13.473m	£0.715m
Total	**£14.407m**	**£13.807m**	**£0.600m**

7.9 The spend relates to the following activities:

Description		Financial Year Annual Budget £	Annual Forecast £	Annual Variance £
PAY				
Project 1b - Enabling Works FBC		219,744	334,432	-114,688
Pay Capital Total		**219,744**	**334,432**	**-114,688**
NON-PAY - PROJECTS				
EF01	Construction Costs	0	40,981	-40,981
EF02	Utility Costs	710,613	47,616	662,997
EF03	Supply Chain Fees	527,481	538,615	-11,133
EF04	Non Works Costs	225,603	369,160	-143,556
EF05	ASDA Works	2,584,385	2,958,907	-374,522
EF06	Walters D&B	8,735,418	8,897,618	-162,200
EF07	Other (Decant Works, Surveys & Investigations, IM&T etc.)	174,000	0	174,000
EFQR	Quantified Risk	922,798	206,258	716,540
EFQS	QRA - SCP	307,200	437,156	-129,956
EFRS	Enabling Works FBC Reserves	0	-23,359	23,359
Enabling Works Project Capital Total		**14,187,499**	**13,472,951**	**714,548**
TOTAL ENABLING WORKS FBC CAPITAL EXPENDITURE		**14,407,243**	**13,807,383**	**599,860**

Revenue

7.10 The Escrow bank account for the Enabling Works Project has yielded interest of £0.107m during 2022-23. This has been treated as revenue income to the Enabling Works Project in March 2023.

7.11 The Project's revenue position for the full financial year is shown below. The final position reflects an underspend of £0.131m.

Enabling Works Revenue Expenditure	2022-23 Full Year		
	Budget	Outturn	Variance
EW Escrow Interest	£0m	-£0.107m	£0.107m
Total	**£0m**	**-£0.107m**	**£0.107m**

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 2022-23 is shown below, with a further breakdown provided in Appendix 4. The final position reflects an overspend of £0.600m, which has been supported from the Enabling Works Project as agreed by WG.

nVCC Capital Expenditure	2022-23 Full Year		
	Budget	Outturn	Variance
Pay	£1.274m	£1.159m	£0.115m
Non Pay	£1.120m	£1.768m	-£0.648m
Total	**£2.394m**	**£2.927m**	**-£0.533m**

7.14 The spend relates to the following activities:

Description	Financial Year Annual Budget £	Annual Forecast £	Annual Variance £
PAY			
Project Leadership	208,776	199,632	9,144
Project 2a - New Velindre Cancer Centre OBC	1,065,097	951,897	113,200
Pay Capital Total	**1,273,873**	**1,151,529**	**122,344**
NON-PAY			
nVCC Project Delivery	**84,000**	**86,804**	**-2,804**
Work Packages			
VC08 Competitive Dialogue - Dialogue & SP to FC	731,127	1,560,859	-829,732
VC10 Legal Advice	0	49,272	-49,272
VC11 S73 Planning	0	101,582	-101,582
VC12 nVCC FBC	106,453	102,757	3,697
VCRS nVCC Reserves	198,547	-59,287	257,834
nVCC Project Capital Total	**1,036,127**	**1,755,183**	**-719,056**
TOTAL nVCC OBC CAPITAL EXPENDITURE	**2,394,000**	**2,993,516**	**-599,517**

Revenue

7.15 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.

7.16 Further funding of £0.015m has been allocated from the WG funding for the non-consolidated pay award for 2022-23. The final **revenue** budget for the nVCC Project is now **£0.078m**.

7.17 The revenue financial position for the nVCC Project for 2022-23 is shown below, reflecting a forecast overspend of £0.010m against a budget of **£0.078m**.

nVCC Revenue Expenditure	2022-23 Full Year		
	Budget	Outturn	Variance
nVCC Pay Award	£0.015m	£0.015m	£0m
Project Delivery	£0.030m	£0.029m	£0.001m
Judicial Review	£0.033m	£0.043m	-£0.010m
Total	**£0.078m**	**£0.088m**	**-£0.010m**

7.18 The overall overspend of £0.010m for the Judicial Review matter has been offset by the overall underspend by the Programme.

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. The overall IRS 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 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.

7.22 The CEL for the IRS FBC has been allocated to the IRS Implementation Project. This includes provision to fund the IRS Procurement Project in 2022-23, therefore the full budget and costs for 2022-23 in full this Project have been transferred to the IRS Implementation Project. The ring fenced funding has been released back to the core Trust discretionary programme for use elsewhere within the Trust.

7.23 The final capital position for the IRS Project for the financial year 2022-23 is **£0m**, with no funding, budget or spend to report for both pay and non pay.

7.24 There is no revenue requirement for the Project in 2022-23.

Service Delivery and Transformation Project

7.25 The total revenue funding for 2022-23 is £0.180m from NHS Commissioners' funding, £0.131 from Trust reserves, and £0.001m from non-consolidated pay award funding. 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 **£0.312m** for this financial year.

7.26 There is no capital funding requirement for the Project in 2022-23.

7.27 The SDT Project revenue position for 2022-23 is shown below.

SDT Expenditure	2022-23 Full Year		
	Budget	Outturn	Variance
Pay	£0.293m	£0.293m	-£0.000m
Non Pay	£0.020m	£0.002m	£0.017m
Total	**£0.312m**	**£0.295m**	**£0.017m**

7.28 There is an overall underspend of £0.017m due to a delay in project and support work carried out by the Project. This has be utilised to offset increased costs incurred by the nVCC Judicial Review.

8. KEY RISKS AND MITIGATING ACTIONS

8.1 There are no outstanding financial risks for the financial year 2022-23.

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 for 2022-23

CAPITAL	Financial Year Annual Budget	Annual Forecast	Annual Variance
	£	£	£
PAY			
Project Leadership	208,776	199,632	9,144
Project 1b - Enabling Works FBC	219,744	334,432	-114,688
Project 2a - New Velindre Cancer Centre OBC	1,065,097	951,897	113,200
Project 3a - Radiotherapy Procurement Solution	0	0	0
Capital Pay Total	**1,493,617**	**1,485,961**	**7,655**
NON-PAY			
nVCC Project Delivery	84,000	86,804	-2,804
Project 1b - Enabling Works FBC	14,187,499	13,472,951	714,548
Project 2a - New Velindre Cancer Centre OBC	1,036,127	1,755,183	-719,056
Project 3a - Radiotherapy Procurement Solution	0	0	0
Capital Non-Pay Total	**15,307,626**	**15,314,938**	**-7,312**
CAPITAL TOTAL	**16,801,243**	**16,800,899**	**343**

REVENUE	Financial Year Annual Budget	Annual Forecast	Annual Variance
	£	£	£
PAY			
nVCC Pay Award	15,327	15,327	0
Programme Management Office	291,322	279,827	11,495
Project 6 - Service Change Team	292,832	292,862	-30
Revenue Pay total	**599,481**	**588,016**	**11,465**
NON-PAY			
EW Escrow Interest	0	-106,807	106,807
nVCC Project Delivery	30,000	29,417	583
nVCC Judicial Review	33,000	43,380	-10,380
Programme Management Office	13,191	8,313	4,878
Project 6 - Service Change Team	19,624	2,131	17,493
Revenue Non-Pay Total	**95,815**	**-23,566**	**119,381**
REVENUE TOTAL	**695,297**	**564,450**	**130,846**

APPENDIX 2: TCS Programme Funding for 2022-23

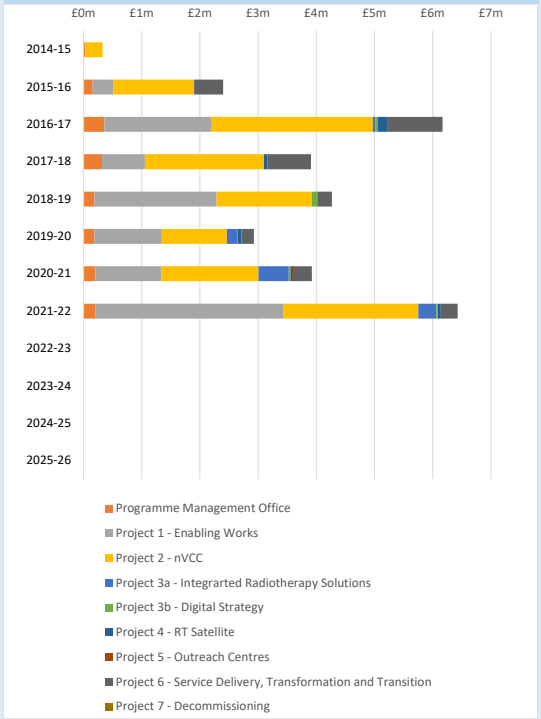
Description	Funding Type	
	Capital	Revenue
Programme Management Office	**£0m**	**£0.305m**
Commissioner's funding		£0.240m
Trust Revenue Funding		£0.060m
Pay Award Funding – assumed (September 2022)		£0.010m
Pay Award Funding – reversed (November 2022)		-£0.010m
Non-Consolidated 2022/23 Pay Award Funding		£0.005m
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**	**£0.078m**
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
Non-Consolidated 2022/23 Pay Award Funding		£0.015m
Integrated Radiotherapy Procurement Solution	**£0m**	**£0m**
Trust Discretionary Capital Allocation	£0.434m	
Reduction in requirement of capital funding	-£0.256m	

Description	Funding Type	
	Capital	Revenue
Reimbursement of funds back to the Trust discretionary programme	-£0.178m	
Radiotherapy Satellite Centre No funding requested or provided for this project to date	**£0m**	**£0m**
SACT and Outreach No funding requested or provided for this project to date	**£0m**	**£0m**
Service Delivery, Transformation and Transition Commissioner's funding Trust revenue funding from reserves Pay Award Funding – assumed (September 2022) Pay Award Funding – reversed (November 2022) Non-Consolidated 2022/23 Pay Award Funding	**£0m**	**£0.312m** £0.180m £0.131m £0.010m -£0.010m £0.001m
VCC Decommissioning No funding requested or provided for this project to date	**£0m**	**£0m**
Total	**£16.801m**	**£0.695m**

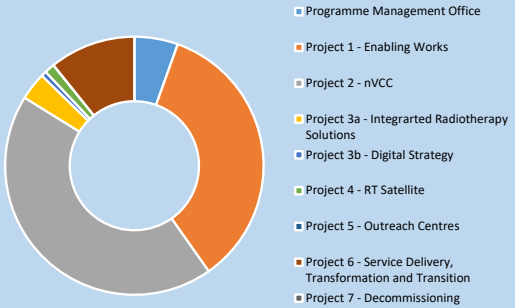
APPENDIX 3: TCS Cumulative Spend Report to 31st March 2022

SUMMARY OF CUMULATIVE TCS SPEND
TO 31 MARCH 2022

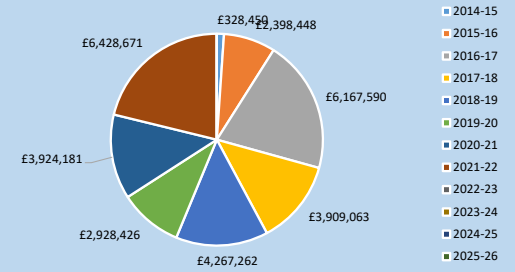
SPEND PER PROJECT PER YEAR



SPEND FOR EACH PROJECT ACROSS ALL YEARS



SPEND FOR EACH YEAR ACROSS ALL PROJECTS



TOTAL SPEND BY PROJECT TO DATE	£30,352,092
Programme Management Office	£1,655,897
Project 1 - Enabling Works	£10,559,242
Project 2 - nVCC	£13,234,264
Project 3a - 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

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

VALIDATION SUMMARY 2022-23

Your organisation is showing as :	VELINDRE TRUST
Period is showing :	MAR 23
TABLE A : MOVEMENT	VELINDRE TRUST IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE A1 : UNDERLYING POSITION	VELINDRE TRUST IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE A2: RISKS	VELINDRE TRUST IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE B : MONTHLY POSITIONS	VELINDRE TRUST IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE B2 : PAY & AGENCY/LOCUM	VELINDRE TRUST IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE B3 : COVID-19	VELINDRE TRUST IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE C, C1 & C2 : SAVINGS SCHEMES	VELINDRE TRUST IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE C3 : TRACKER	VELINDRE TRUST IS CURRENTLY SHOWING 4 ERRORS FOR THIS TABLE
TABLE E : RESOURCE LIMITS	VELINDRE TRUST IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE E1 : INVOICED INCOME	VELINDRE TRUST IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE F : STATEMENT OF FINANCIAL POSITION	VELINDRE TRUST IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE G : MONTHLY CASHFLOW	VELINDRE TRUST IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE I : CAPITAL RESOURCE / EXPENDITURE LIMIT	VELINDRE TRUST IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE J: CAPITAL IN YEAR SCHEMES	VELINDRE TRUST IS CURRENTLY SHOWING 1 ERRORS FOR THIS TABLE
TABLE K : CAPITAL DISPOSALS	VELINDRE TRUST IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE L : EFL	VELINDRE TRUST IS CURRENTLY SHOWING 2 ERRORS FOR THIS TABLE
TABLE N : GENERAL MEDICAL SERVICES	VELINDRE TRUST IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE O : GENERAL DENTAL SERVICES	VELINDRE TRUST IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TOTAL ERRORS FOR YOUR MAR 23 RETURN IS	**5 ERRORS ON 2 DIFFERENT TABLE/S**

Velindre Trust

Period : **Mar 23**

Summary Of Main Financial Performance

Revenue Performance

		Actual YTD £'000	Annual Forecast £'000
1	Under / (Over) Performance	64	64

Velindre Trust **Period : Mar 23**

Table A - Movement of Opening Financial Plan to Forecast Outturn

This Table is currently showing 0 errors

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

		In Year Effect	Non Recurring	Recurring	FYE of Recurring		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	In Year Effect
		£'000	£'000	£'000	£'000		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
1	Underlying Position b/fwd from Previous Year - must agree to M12 MMR (Deficit - Negative Value)	-500	0	-500	-500	1	-42	-42	-42	-42	-42	-42	-42	-42	-42	-42	-42	-42	-500	-500
2	Planned New Expenditure (Non Covid-19) (Negative Value)	-23,256	-1,100	-22,156	-22,156	2	-1,678	-1,681	-1,681	-1,719	-1,719	-1,719	-1,719	-1,719	-1,719	-1,719	-1,719	-4,462	-23,256	-23,256
3	Planned Expenditure For Covid-19 (Negative Value)	-2,104	-1,407	-697	-697	3	-168	-168	-168	-168	-171	-201	-171	-171	-171	-171	-171	-202	-2,104	-2,104
4	Planned Welsh Government Funding (Non Covid-19) (Positive Value)	6,345	600	5,745	5,745	4	300	300	300	300	300	300	300	300	300	300	300	3,043	6,345	6,345
5	Planned Welsh Government Funding for Covid-19 (Positive Value)	2,104	1,407	697	697	5	166	169	169	169	172	201	172	172	172	172	172	202	2,104	2,104
6	Planned Provider Income (Positive Value)	16,111	0	16,111	16,111	6	1,343	1,343	1,343	1,343	1,343	1,343	1,343	1,343	1,343	1,343	1,343	1,343	16,111	16,111
7	RRL Profile - phasing only (In Year Effect / Column C must be nil)	0	0	0	0	7												0	0	0
8	Planned (Finalised) Savings Plan	750	150	600	600	8	46	46	46	68	68	68	68	68	68	68	68	68	750	750
9	Planned (Finalised) Net Income Generation	550	350	200	200	9	33	33	33	50	50	50	50	50	50	50	50	50	550	550
10	Planned Profit / (Loss) on Disposal of Assets	0	0	0	0	10													0	0
11	Planned Release of Uncommitted Contingencies & Reserves (Positive Value)	0	0			11													0	0
12		0	0			12													0	0
13	Planning Assumptions still to be finalised at Month 1	0	0			13													0	0
14	**Opening IMTP / Annual Operating Plan**	**0**	**0**	**0**	**0**	14	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
15	Reversal of Planning Assumptions still to be finalised at Month 1	0	0	0	0	15	0	0	0	0	0	0	0	0	0	0	0	0	0	0
16	Additional In Year & Movement from Planned Release of Previously Committed Contingencies & Reserves (Positive Value)	0	0			16													0	0
17	Additional In Year & Movement from Planned Profit / (Loss) on Disposal of Assets	0	0			17													0	0
18	Other Movement in Month 1 Planned & In Year Net Income Generation	167	0	167	200	18	0	0	0	0	0	33	22	22	22	22	22	22	167	167
19	Other Movement in Month 1 Planned Savings - (Underachievement) / Overachievement	-200	0	-200	-200	19	0	0	0	-22	-22	-22	-22	-22	-22	-22	-22	-22	-200	-200
20	Additional In Year Identified Savings - Forecast	33	33	0	0	20	0	0	0	0	0	33	0	0	0	0	0	0	33	33
21	Variance to Planned RRL & Other Income	-4,150	-4,150			21			-365	-421	-421	-421	-421	-421	-421	-421	-421	-421	-4,150	-4,150
22	Additional In Year & Movement in Planned Welsh Government Funding for Covid-19 (Positive Value - additional)	-1,231	-1,231			22	0	-85	-138	-65	-84	-132	-116	-118	-112	-117	-131	-132	-1,231	-1,231
23	Additional In Year & Movement in Planned Welsh Government Funding (Non Covid) (Positive Value - additional)	4,491	4,491			23	-52	-51	0	-30	-1	25	-59	36	0	4	-7	4,625	4,491	4,491
24	Additional In Year & Movement Expenditure for Covid-19 (Negative Value - additional/Postive Value - reduction)	1,230	1,230			24	2	84	138	65	84	132	115	118	112	117	130	132	1,230	1,230
25	In Year Accountancy Gains (Positive Value)	395	395	0	0	25	0	0	0	0	0	0	0	0	200	0	0	195	395	395
26	Net In Year Operational Variance to IMTP/AOP (material gross amounts to be listed separately)	64	64			26	-1	2	4	23	20	-47	4	-2	3	-4	2	60	64	64
27	Reduction in outsourcing spend (RCC)	4,150	4,150			27			365	421	421	421	421	421	421	421	421	421	4,150	4,150
28	In year increase in Energy Forecast (£671 - £600 IMTP Plan) (based on latest NWSSP Schedule)	-71	-71			28	52	51	0	30	1	-17	60	-73	-46	-50	-39	-39	-71	-71
29	In year reduction in NI (£551IMTP Plan-£339)	212	212			29						-8	-1	37	46	46	46	46	212	212
30	Unfunded Pay Award / incremental Drift	-200	-200			30									-200				-200	-200
31	1.5% Consolidated Pay Award	-1,178	-1,178			31												-1,178	-1,178	-1,178
32	6.3% Pension Contributions	-3,454	-3,454			32												-3,454	-3,454	-3,454
33	Support towards shortfall in marginal LTA	-195	-195			33												-195	-195	-195
34		0	0			34													0	0
35		0	0			35													0	0
36	**Forecast Outturn (- Deficit / + Surplus)**	**64**	**97**	**-33**	**0**	36	**1**	**2**	**3**	**1**	**-2**	**-3**	**4**	**-2**	**3**	**-4**	**2**	**60**	**64**	**64**
37	**Covid-19 - Forecast Outturn (- Deficit / + Surplus)**	**0**				37	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Velindre Trust

Period : Mar 23

Table A1 - Underlying Position

This table needs completing monthly from Month: 1

This Table is currently showing 0 errors

	Section A - By Spend Area	IMTP	Full Year Effect of Actions			New, Recurring, Full Year Effect of Unmitigated Pressures (-ve)	IMTP
		Underlying Position b/f	Recurring Savings (+ve)	Recurring Allocations / Income (+ve)	Subtotal		Underlying Position c/f
		£'000	£'000	£'000	£'000	£'000	£'000
1	Pay - Administrative, Clerical & Board Members				0		0
2	Pay - Medical & Dental	(47)		47	0		0
3	Pay - Nursing & Midwifery Registered	(50)		50	0		0
4	Pay - Prof Scientific & Technical	(195)		195	0		0
5	Pay - Additional Clinical Services				0		0
6	Pay - Allied Health Professionals				0		0
7	Pay - Healthcare Scientists				0		0
8	Pay - Estates & Ancillary				0		0
9	Pay - Students				0		0
10	Non Pay - Supplies and services - clinical				0		0
11	Non Pay - Supplies and services - general	(208)		208	0		0
12	Non Pay - Consultancy Services				0		0
13	Non Pay - Establishment				0		0
14	Non Pay - Transport				0		0
15	Non Pay - Premises				0		0
16	Non Pay - External Contractors				0		0
17	Health Care Provided by other Orgs – Welsh LHBs				0		0
18	Health Care Provided by other Orgs – Welsh Trusts				0		0
19	Health Care Provided by other Orgs – WHSSC				0		0
20	Health Care Provided by other Orgs – English				0		0
21	Health Care Provided by other Orgs – Private / Other				0		0
22	**Total**	**(500)**	**0**	**500**	**0**	**0**	**0**

	Section B - By Directorate	IMTP	Full Year Effect of Actions			New, Recurring, Full Year Effect of Unmitigated Pressures (-ve)	IMTP
		Underlying Position b/f	Recurring Savings (+ve)	Recurring Allocations / Income (+ve)	Subtotal		Underlying Position c/f
		£'000	£'000	£'000	£'000	£'000	£'000
1	Primary Care				0		0
2	Mental Health				0		0
3	Continuing HealthCare				0		0
4	Commissioned Services				0		0
5	Scheduled Care				0		0
6	Unscheduled Care				0		0
7	Children & Women's				0		0
8	Community Services				0		0
9	Specialised Services	(292)		292	0		0
10	Executive / Corporate Areas				0		0
11	Support Services (inc. Estates & Facilities)	(208)		208	0		0
12	**Total**	**(500)**	**0**	**500**	**0**	**0**	**0**

Velindre Trust

Period : **Mar 23**

This Table is currently showing 0 errors

	Table A2 - Overview Of Key Risks & Opportunities	FORECAST YEAR END	
		£'000	Likelihood
	Opportunities to achieve IMTP/AOP (positive values)		
1	**Red Pipeline schemes (inc AG & IG)**		
2	**Potential Cost Reduction**		
3	**Total Opportunities to achieve IMTP/AOP**	0	
	Risks (negative values)		
4	Under delivery of Amber Schemes included in Outturn via Tracker		Low
5	Continuing Healthcare		
6	Prescribing		
7	Pharmacy Contract		
8	WHSSC Performance		
9	Other Contract Performance		
10	GMS Ring Fenced Allocation Underspend Potential Claw back		
11	Dental Ring Fenced Allocation Underspend Potential Claw back		
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			
26	**Total Risks**	0	
	Further Opportunities (positive values)		
27			
28			
29			
30			
31			
32			
33			
34	**Total Further Opportunities**	0	
35	**Current Reported Forecast Outturn**	64	
36	**IMTP / AOP Outturn Scenario**	64	
37	**Worst Case Outturn Scenario**	64	
38	**Best Case Outturn Scenario**	64	

Velindre Trust

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

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

This Table is currently showing 0 errors

	A. Monthly Summarised Statement of Comprehensive Net Expenditure / Statement of Comprehensive Net Income		1 Apr £'000	2 May £'000	3 Jun £'000	4 Jul £'000	5 Aug £'000	6 Sep £'000	7 Oct £'000	8 Nov £'000	9 Dec £'000	10 Jan £'000	11 Feb £'000	12 Mar £'000	Total YTD £'000	Forecast year-end position £'000
1	Revenue Resource Limit	Actual/F'cast													0	0
2	Capital Donation / Government Grant Income (Health Board only)	Actual/F'cast													0	0
3	Welsh NHS Local Health Boards & Trusts Income	Actual/F'cast	7,827	8,495	8,345	7,982	7,612	7,950	8,913	9,291	9,405	5,667	8,089	10,791	100,366	100,366
4	WHSSC Income	Actual/F'cast	4,696	4,456	4,209	3,888	4,655	4,502	4,991	4,222	4,594	3,472	4,882	4,391	52,958	52,958
5	Welsh Government Income (Non RRL)	Actual/F'cast	606	698	479	679	597	2,935	381	1,344	888	1,781	32	9,355	19,775	19,775
6	Other Income	Actual/F'cast	785	1,052	1,062	943	981	809	1,210	1,136	1,087	1,520	684	(841)	10,429	10,429
7	**Income Total**		**13,914**	**14,700**	**14,094**	**13,492**	**13,845**	**16,196**	**15,495**	**15,993**	**15,974**	**12,440**	**13,688**	**23,697**	**183,529**	**183,529**
8	Primary Care Contractor (excluding drugs, including non resource limited expenditure)	Actual/F'cast													0	0
9	Primary Care - Drugs & Appliances	Actual/F'cast													0	0
10	Provided Services - Pay	Actual/F'cast	6,099	5,896	5,865	6,186	6,076	7,485	6,438	6,606	6,389	6,623	6,338	12,116	82,118	82,118
11	Provider Services - Non Pay (excluding drugs & depreciation)	Actual/F'cast	2,657	3,525	4,351	3,233	3,586	3,752	4,012	3,985	4,242	4,074	3,308	7,815	48,538	48,538
12	Secondary Care - Drugs	Actual/F'cast	4,265	4,570	3,381	4,036	3,659	4,461	4,553	5,028	4,963	1,449	3,725	3,329	47,419	47,419
13	Healthcare Services Provided by Other NHS Bodies	Actual/F'cast													0	0
14	Non Healthcare Services Provided by Other NHS Bodies	Actual/F'cast													0	0
15	Continuing Care and Funded Nursing Care	Actual/F'cast													0	0
16	Other Private & Voluntary Sector	Actual/F'cast	346	156	0	(502)	0	0	0	0	0	0	0	0	0	0
17	Joint Financing and Other	Actual/F'cast													0	0
18	Losses, Special Payments and Irrecoverable Debts	Actual/F'cast													0	0
19	Exceptional (Income) / Costs - (Trust Only)	Actual/F'cast													0	0
20	Total Interest Receivable - (Trust Only)	Actual/F'cast			(76)	(25)	(37)	(62)	(75)	(105)	(103)	(174)	(157)	(175)	(989)	(989)
21	Total Interest Payable - (Trust Only)	Actual/F'cast													0	0
22	DEL Depreciation\Accelerated Depreciation\Impairments	Actual/F'cast	530	534	552	546	546	546	546	464	464	455	455	527	6,168	6,168
23	AME Donated Depreciation\Impairments	Actual/F'cast	17	17	17	17	17	17	17	17	17	17	17	25	211	211
24	Uncommitted Reserves & Contingencies	Actual/F'cast												0	0	0
25	Profit\Loss Disposal of Assets	Actual/F'cast													0	0
26	**Cost - Total**	Actual/F'cast	**13,913**	**14,698**	**14,091**	**13,491**	**13,847**	**16,199**	**15,492**	**15,995**	**15,972**	**12,444**	**13,686**	**23,637**	**183,464**	**183,464**
27	**Net surplus/ (deficit)**	Actual/F'cast	**1**	**2**	**4**	**0**	**(2)**	**(3)**	**3**	**(2)**	**3**	**(4)**	**2**	**60**	**64**	**64**

	B. Cost Total by Directorate		1 Apr £'000	2 May £'000	3 Jun £'000	4 Jul £'000	5 Aug £'000	6 Sep £'000	7 Oct £'000	8 Nov £'000	9 Dec £'000	10 Jan £'000	11 Feb £'000	12 Mar £'000	Total YTD £'000	Forecast year-end position £'000
28	Primary Care	Actual/F'cast													0	0
29	Mental Health	Actual/F'cast													0	0
30	Continuing HealthCare	Actual/F'cast													0	0
31	Commissioned Services	Actual/F'cast													0	0
32	Scheduled Care	Actual/F'cast													0	0
33	Unscheduled Care	Actual/F'cast													0	0
34	Children & Women's	Actual/F'cast													0	0
35	Community Services	Actual/F'cast													0	0
36	Specialised Services	Actual/F'cast	12,157	12,886	12,269	11,639	11,937	14,094	13,243	13,805	13,559	10,253	11,736	20,767	158,345	158,345
37	Executive / Corporate Areas	Actual/F'cast	813	832	759	798	824	944	1,052	1,144	1,249	1,130	865	1,668	12,078	12,078
38	Support Services (inc. Estates & Facilities)	Actual/F'cast	397	429	494	491	522	598	633	565	682	589	613	650	6,663	6,663
39	Reserves	Actual/F'cast	0											0	0	0
40	**Cost - Total (Excluding DEL & AME Non-Cash Charges)**	Actual/F'cast	**13,367**	**14,148**	**13,521**	**12,928**	**13,283**	**15,636**	**14,928**	**15,514**	**15,490**	**11,972**	**13,214**	**23,085**	**177,086**	**177,086**

C. Assessment of Financial Forecast Positions

Year-to-date (YTD)	£'000	
28 . Actual YTD surplus/ (deficit)	64	
29. Actual YTD surplus/ (deficit) last month	4	
30. Current month actual surplus/ (deficit)	60	
		Trend
31. Average monthly surplus/ (deficit) YTD	5	▲
32. YTD /remaining months	#DIV/0!	

Full-year surplus/ (deficit) scenarios	£'000
33. Extrapolated Scenario	64
34. Year to Date Trend Scenario	64

D. DEL/AME Depreciation & Impairments

			1	2	3	4	5	6	7	8	9	10	11	12		
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	Forecast year-end position
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000		
	DEL															
41	Baseline Provider Depreciation	Actual/F'cast	433	433	341	341	341	341	341	286	286	276	276	276	3,968	3,968
42	Strategic Depreciation	Actual/F'cast	84	84	195	195	195	195	195	169	169	164	164	236	2,047	2,047
43	Accelerated Depreciation	Actual/F'cast													0	0
44	Impairments	Actual/F'cast													0	0
45	IFRS 16 Leases	Actual/F'cast	12	17	16	10	10	10	10	10	10	15	15	15	153	153
46	**Total**		**530**	**534**	**552**	**546**	**546**	**546**	**546**	**464**	**464**	**455**	**455**	**527**	**6,168**	**6,168**
	AME															
47	Donated Asset Depreciation	Actual/F'cast	17	17	17	17	17	17	17	17	17	17	17	25	211	211
48	Impairments (including Reversals)	Actual/F'cast													0	0
49	IFRS 16 Leases (Peppercorn)	Actual/F'cast													0	0
50	**Total**		**17**	**17**	**17**	**17**	**17**	**17**	**17**	**17**	**17**	**17**	**17**	**25**	**211**	**211**

E. Accountancy Gains

			1	2	3	4	5	6	7	8	9	10	11	12		
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	Forecast year-end position
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000		
51	Accountancy Gains	Actual/F'cast	0	0	0	0	0	0	0	0	200	0	0	195	**395**	**395**

F. Committed Reserves & Contingencies

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

Velindre Trust

Period : Mar 23

YTD Months to be completed from Month: 1

This Table is currently showing 0 errors

Forecast Months to be completed from Month: 1

Table B2 - Pay Expenditure Analysis

A - Pay Expenditure

REF	TYPE	1 Apr £'000	2 May £'000	3 Jun £'000	4 Jul £'000	5 Aug £'000	6 Sep £'000	7 Oct £'000	8 Nov £'000	9 Dec £'000	10 Jan £'000	11 Feb £'000	12 Mar £'000	Total YTD £'000	Forecast year-end position £'000
1	Administrative, Clerical & Board Members	1,793	1,727	1,708	1,832	1,758	2,145	1,905	1,897	1,972	2,051	1,899	3,951	**24,639**	**24,639**
2	Medical & Dental	1,114	1,049	1,066	1,140	1,102	1,394	1,160	1,267	1,127	1,298	1,345	2,170	**15,233**	**15,233**
3	Nursing & Midwifery Registered	875	833	832	869	871	1,064	930	913	884	873	889	1,591	**11,423**	**11,423**
4	Prof Scientific & Technical	214	216	211	220	223	282	230	258	246	237	244	468	**3,049**	**3,049**
5	Additional Clinical Services	580	580	555	561	567	756	592	606	555	578	581	1,135	**7,645**	**7,645**
6	Allied Health Professionals	601	600	595	633	621	748	648	647	641	626	530	846	**7,736**	**7,736**
7	Healthcare Scientists	722	706	724	748	745	924	770	782	775	778	671	1,555	**9,900**	**9,900**
8	Estates & Ancillary	189	178	167	176	181	160	195	232	182	175	170	384	**2,388**	**2,388**
9	Students	11	8	8	8	8	11	8	5	7	7	10	15	**105**	**105**
10	**TOTAL PAY EXPENDITURE**	**6,099**	**5,896**	**5,866**	**6,187**	**6,076**	**7,484**	**6,438**	**6,607**	**6,389**	**6,623**	**6,339**	**12,115**	**82,118**	**82,118**

Analysis of Pay Expenditure

11	**LHB Provided Services - Pay**	6,099	5,896	5,865	6,186	6,076	7,485	6,438	6,606	6,389	6,623	6,338	12,116	**82,118**	**82,118**
12	**Other Services (incl. Primary Care) - Pay**													**0**	**0**
13	**Total - Pay**	**6,099**	**5,896**	**5,865**	**6,186**	**6,076**	**7,485**	**6,438**	**6,606**	**6,389**	**6,623**	**6,338**	**12,116**	**82,118**	**82,118**
		0	0	0	0	0	0	0	0	0	0	0	0		

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

REF	TYPE	1 Apr £'000	2 May £'000	3 Jun £'000	4 Jul £'000	5 Aug £'000	6 Sep £'000	7 Oct £'000	8 Nov £'000	9 Dec £'000	10 Jan £'000	11 Feb £'000	12 Mar £'000	Total YTD £'000	Forecast year-end position £'000
1	Administrative, Clerical & Board Members	23	26	36	43	29	7	17	26	49	30	(3)	(15)	**268**	**268**
2	Medical & Dental	5	3	5	3	5	4	3	7	1	4	(4)	0	**36**	**36**
3	Nursing & Midwifery Registered	0	0	0	0	0	0	0	0	(0)	0	0	(11)	**(11)**	**(11)**
4	Prof Scientific & Technical	2	3	2	2	3	4	4	4	3	3	(1)	4	**32**	**32**
5	Additional Clinical Services	5	0	10	0	1	5	3	9	23	3	17	2	**77**	**77**
6	Allied Health Professionals	39	48	50	73	84	89	71	92	81	70	91	(309)	**478**	**478**
7	Healthcare Scientists	0	0	0	0	0	0	0	0	9	0	3	2	**14**	**14**
8	Estates & Ancillary	30	44	27	32	25	21	86	40	28	30	71	(5)	**430**	**430**
9	Students	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**
10	**TOTAL AGENCY/LOCUM (PREMIUM) EXPENDITURE**	**104**	**125**	**129**	**154**	**146**	**129**	**183**	**179**	**193**	**140**	**173**	**(332)**	**1,323**	**1,323**
11	**Agency/Locum (premium) % of pay**	**1.7%**	**2.1%**	**2.2%**	**2.5%**	**2.4%**	**1.7%**	**2.8%**	**2.7%**	**3.0%**	**2.1%**	**2.7%**	**(2.7%)**	**1.6%**	**1.6%**

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

REF	REASON	1 Apr £'000	2 May £'000	3 Jun £'000	4 Jul £'000	5 Aug £'000	6 Sep £'000	7 Oct £'000	8 Nov £'000	9 Dec £'000	10 Jan £'000	11 Feb £'000	12 Mar £'000	Total YTD £'000	Forecast year-end position £'000
1	Vacancy	25	33	39	50	29	12	93	73	55	46	56	(43)	**469**	**469**
2	Maternity/Paternity/Adoption Leave													**0**	**0**
3	Special Leave (Paid) – inc. compassionate leave, interview													**0**	**0**
4	Special Leave (Unpaid)													**0**	**0**
5	Study Leave/Examinations													**0**	**0**
6	Additional Activity (Winter Pressures/Site Pressures)	49	51	64	72	89	88	79	80	117	73	91	(313)	**541**	**541**
7	Annual Leave													**0**	**0**
8	Sickness													**0**	**0**
9	Restricted Duties													**0**	**0**
10	Jury Service													**0**	**0**
11	WLI													**0**	**0**
12	Exclusion (Suspension)													**0**	**0**
13	COVID-19	29	41	26	32	28	29	11	25	22	21	26	24	**314**	**314**
14	**TOTAL AGENCY/LOCUM (PREMIUM) EXPENDITURE**	**104**	**125**	**129**	**154**	**146**	**129**	**183**	**179**	**193**	**140**	**173**	**(332)**	**1,323**	**1,323**
		0	0	0	0	0	0	0	0	0	0	0	0		

Velindre Trust

Period : Mar 23

This Table is currently showing 0 errors

Table B3 - COVID-19 Analysis

A - Additional Expenditure

		1	2	3	4	5	6	7	8	9	10	11	12		
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	Forecast year-end position
A1	***Enter as positive values***	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
1	**Testing (Additional costs due to C19) enter as positive values - actual/forecast**														
2	**Provider Pay (Establishment, Temp & Agency)**														
3	Administrative, Clerical & Board Members													0	0
4	Medical & Dental													0	0
5	Nursing & Midwifery Registered													0	0
6	Prof Scientific & Technical													0	0
7	Additional Clinical Services													0	0
8	Allied Health Professionals													0	0
9	Healthcare Scientists													0	0
10	Estates & Ancillary													0	0
11	Students													0	0
12	**Sub total Testing Provider Pay**	0	0	0	0	0	0	0	0	0	0	0	0	0	0
13	Primary Care Contractor (excluding drugs)													0	0
14	Primary Care - Drugs													0	0
15	Secondary Care - Drugs													0	0
16	Provider - Non Pay (Clinical & General Supplies, Rent, Rates, Equipment etc) **Exclude PPE - see A6**													0	0
17	Healthcare Services Provided by Other NHS Bodies													0	0
18	Non Healthcare Services Provided by Other NHS Bodies													0	0
19	Continuing Care and Funded Nursing Care													0	0
20	Other Private & Voluntary Sector													0	0
21	Joint Financing and Other (includes Local Authority)													0	0
22	Other (only use with WG agreement & state SoCNE/I line ref)													0	0
23														0	0
24														0	0
25														0	0
26	**Sub total Testing Non Pay**	0	0	0	0	0	0	0	0	0	0	0	0	0	0
27	**TOTAL TESTING EXPENDITURE**	0	0	0	0	0	0	0	0	0	0	0	0	0	0
28	**PLANNED TESTING EXPENDITURE (In Opening Plan)**													0	0
29	**MOVEMENT FROM OPENING PLANNED TESTING EXPENDITURE**	0	0	0	0	0	0	0	0	0	0	0	0	0	0
A2	***Tracing (Additional costs due to C19) enter as positive values - actual/forecast***														
30	**Provider Pay (Establishment, Temp & Agency)**														
31	Administrative, Clerical & Board Members													0	0
32	Medical & Dental													0	0
33	Nursing & Midwifery Registered													0	0
34	Prof Scientific & Technical													0	0
35	Additional Clinical Services													0	0
36	Allied Health Professionals													0	0
37	Healthcare Scientists													0	0
38	Estates & Ancillary													0	0
39	Students													0	0
40	**Sub total Tracing Provider Pay**	0	0	0	0	0	0	0	0	0	0	0	0	0	0
41	Primary Care Contractor (excluding drugs)													0	0
42	Primary Care - Drugs													0	0
43	Secondary Care - Drugs													0	0
44	Provider - Non Pay (Clinical & General Supplies, Rent, Rates, Equipment etc) **Exclude PPE - see A6**													0	0
45	Healthcare Services Provided by Other NHS Bodies													0	0
46	Non Healthcare Services Provided by Other NHS Bodies													0	0
47	Continuing Care and Funded Nursing Care													0	0
48	Other Private & Voluntary Sector													0	0
49	Joint Financing and Other (includes Local Authority)													0	0
50	Other (only use with WG agreement & state SoCNE/I line ref)													0	0
51														0	0
52														0	0
53														0	0
54	**Sub total Tracing Non Pay**	0	0	0	0	0	0	0	0	0	0	0	0	0	0
55	**TOTAL TRACING EXPENDITURE**	0	0	0	0	0	0	0	0	0	0	0	0	0	0
56	**PLANNED TRACING EXPENDITURE (In Opening Plan)**													0	0
57	**MOVEMENT FROM OPENING PLANNED TRACING EXPENDITURE**	0	0	0	0	0	0	0	0	0	0	0	0	0	0

A3	***Mass COVID-19 Vaccination (Additional costs due to C19) enter as positive values - actual/forecast***															
58	**Provider Pay (Establishment, Temp & Agency)**															
59	Administrative, Clerical & Board Members														**0**	**0**
60	Medical & Dental														**0**	**0**
61	Nursing & Midwifery Registered														**0**	**0**
62	Prof Scientific & Technical														**0**	**0**
63	Additional Clinical Services														**0**	**0**
64	Allied Health Professionals	7	11	29	7	10	12	8	10	14	8	0	0		**116**	**116**
65	Healthcare Scientists												25		**25**	**25**
66	Estates & Ancillary														**0**	**0**
67	Students														**0**	**0**
68	**Sub total Mass COVID-19 Vaccination Provider Pay**	**7**	**11**	**29**	**7**	**10**	**12**	**8**	**10**	**14**	**8**	**0**	**25**		**141**	**141**
69	Primary Care Contractor (excluding drugs)														**0**	**0**
70	Primary Care - Drugs														**0**	**0**
71	Secondary Care - Drugs														**0**	**0**
72	Provider - Non Pay (Clinical & General Supplies, Rent, Rates, Equipment etc) **Exclude PPE - see A6**	15	19	15	11	(0)	5	4	4	6	5	0	0		**83**	**83**
73	Healthcare Services Provided by Other NHS Bodies														**0**	**0**
74	Non Healthcare Services Provided by Other NHS Bodies														**0**	**0**
75	Continuing Care and Funded Nursing Care														**0**	**0**
76	Other Private & Voluntary Sector														**0**	**0**
77	Joint Financing and Other (includes Local Authority)														**0**	**0**
78	Other (only use with WG agreement & state SoCNE/I line ref)														**0**	**0**
79															**0**	**0**
80															**0**	**0**
81															**0**	**0**
82	**Sub total Mass COVID-19 Vaccination Non Pay**	**15**	**19**	**15**	**11**	**(0)**	**5**	**4**	**4**	**6**	**5**	**0**	**0**		**83**	**83**
83	**TOTAL MASS COVID-19 VACC EXPENDITURE**	**22**	**30**	**45**	**18**	**9**	**17**	**12**	**15**	**19**	**13**	**0**	**25**		**224**	**224**
84	**PLANNED MASS COVID-19 VACC EXPENDITURE (In Opening Plan)**	24	24	24	24	27	57	27	27	27	27	27	57		**375**	**375**
85	**MOVEMENT FROM OPENING PLANNED MASS COVID-19 VACC EXPENDITURE**	**2**	**(5)**	**(20)**	**6**	**18**	**40**	**15**	**13**	**8**	**15**	**27**	**32**		**151**	**151**

A4	***Extended Flu Vaccination (Additional costs due to C19) enter as positive values - actual/forecast***															
86	**Provider Pay (Establishment, Temp & Agency)**															
87	Administrative, Clerical & Board Members														**0**	**0**
88	Medical & Dental														**0**	**0**
89	Nursing & Midwifery Registered														**0**	**0**
90	Prof Scientific & Technical														**0**	**0**
91	Additional Clinical Services														**0**	**0**
92	Allied Health Professionals														**0**	**0**
93	Healthcare Scientists														**0**	**0**
94	Estates & Ancillary														**0**	**0**
95	Students														**0**	**0**
96	**Sub total Extended Flu Vaccination Provider Pay**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**		**0**	**0**
97	Primary Care Contractor (excluding drugs)														**0**	**0**
98	Primary Care - Drugs														**0**	**0**
99	Secondary Care - Drugs														**0**	**0**
100	Provider - Non Pay (Clinical & General Supplies, Rent, Rates, Equipment etc) **Exclude PPE - see A6**														**0**	**0**
101	Healthcare Services Provided by Other NHS Bodies														**0**	**0**
102	Non Healthcare Services Provided by Other NHS Bodies														**0**	**0**
103	Continuing Care and Funded Nursing Care														**0**	**0**
104	Other Private & Voluntary Sector														**0**	**0**
105	Joint Financing and Other (includes Local Authority)														**0**	**0**
106	Other (only use with WG agreement & state SoCNE/I line ref)														**0**	**0**
107															**0**	**0**
108															**0**	**0**
109															**0**	**0**
110	**Sub total Extended Flu Vaccination Non Pay**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**		**0**	**0**
111	**TOTAL EXTENDED FLU VACC EXPENDITURE**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**		**0**	**0**
112	**PLANNED EXTENDED FLU VACC EXPENDITURE (In Opening Plan)**														**0**	**0**
113	**MOVEMENT FROM OPENING PLANNED EXTENDED FLU VACC EXPENDITURE**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**		**0**	**0**

A5	**Cleaning Standards (Additional costs due to C19) enter as positive values - actual/forecast**															
114	**Provider Pay (Establishment, Temp & Agency)**															
115	Administrative, Clerical & Board Members													**0**	**0**	
116	Medical & Dental													**0**	**0**	
117	Nursing & Midwifery Registered													**0**	**0**	
118	Prof Scientific & Technical													**0**	**0**	
119	Additional Clinical Services													**0**	**0**	
120	Allied Health Professionals													**0**	**0**	
121	Healthcare Scientists													**0**	**0**	
122	Estates & Ancillary	46	19	0	35	35	35	12	18	19	21	20	20	**280**	**280**	
123	Students													**0**	**0**	
124	**Sub total Cleaning Standards Provider Pay**	**46**	**19**	**0**	**35**	**35**	**35**	**12**	**18**	**19**	**21**	**20**	**20**	**280**	**280**	
125	Primary Care Contractor (excluding drugs)													**0**	**0**	
126	Primary Care - Drugs													**0**	**0**	
127	Secondary Care - Drugs													**0**	**0**	
128	Provider - Non Pay (Clinical & General Supplies, Rent, Rates, Equipment etc) **Exclude PPE - see A6**	5	1	3	1	4	1	(6)	0	0	0	0	0	**9**	**9**	
129	Healthcare Services Provided by Other NHS Bodies													**0**	**0**	
130	Non Healthcare Services Provided by Other NHS Bodies													**0**	**0**	
131	Continuing Care and Funded Nursing Care													**0**	**0**	
132	Other Private & Voluntary Sector													**0**	**0**	
133	Joint Financing and Other (includes Local Authority)													**0**	**0**	
134	Other (only use with WG agreement & state SoCNE/I line ref)													**0**	**0**	
135														**0**	**0**	
136														**0**	**0**	
137														**0**	**0**	
138	**Sub total Cleaning Standards Non Pay**	**5**	**1**	**3**	**1**	**4**	**1**	**(6)**	**0**	**0**	**0**	**0**	**0**	**9**	**9**	
139	**TOTAL CLEANING STANDARDS EXPENDITURE**	**51**	**20**	**3**	**36**	**39**	**36**	**6**	**18**	**19**	**21**	**20**	**20**	**289**	**289**	
140	**PLANNED CLEANING STANDARDS EXPENDITURE (In Opening Plan)**	51	51	51	51	51	51	51	51	51	51	51	51	**607**	**607**	
141	**MOVEMENT FROM OPENING PLANNED CLEANING STANDARDS EXPENDITURE**	**(0)**	**31**	**47**	**14**	**11**	**15**	**45**	**32**	**31**	**30**	**30**	**31**	**317**	**317**	

A6	**PPE, Long Covid & Other (Additional costs due to C19)** ***enter as positive value - actual/forecast***															
142	**Provider Pay (Establishment, Temp & Agency)**															
143	Administrative, Clerical & Board Members														**0**	**0**
144	Medical & Dental	21	12	24	25	25	25	42	21	21	21	21	21		**277**	**277**
145	Nursing & Midwifery Registered														**0**	**0**
146	Prof Scientific & Technical														**0**	**0**
147	Additional Clinical Services														**0**	**0**
148	Allied Health Professionals														**0**	**0**
149	Healthcare Scientists														**0**	**0**
150	Estates & Ancillary	25	(20)												**5**	**5**
151	Students														**0**	**0**
152	Movement of Annual Leave Accrual														**0**	**0**
153	Other (only use with WG Agreement & state SoCNE/I line ref)														**0**	**0**
154	Nosocomial C19 costs													4	**4**	**4**
155															**0**	**0**
156	**Sub total Other C-19 Provider Pay**	**46**	**(8)**	**24**	**25**	**25**	**25**	**42**	**21**	**21**	**21**	**21**	**25**		**286**	**286**
157	Primary Care Contractor (excluding drugs)														**0**	**0**
158	Primary Care Contractor (excluding drugs) - Costs as a result of lost GDS Income														**0**	**0**
159	Primary Care - Drugs														**0**	**0**
160	Secondary Care - Drugs														**0**	**0**
161	Provider - Non Pay (Clinical & General Supplies, Rent, Rates, Equipment etc) **Exclude PPE - see separate line**	20	24	(37)	1	1	0	(5)	0	0	0	0	0		**4**	**4**
162	Provider - Non Pay - PPE	28	18	(4)	24	13	(8)	0	0	0	0	0	0		**70**	**70**
163	Healthcare Services Provided by Other NHS Bodies														**0**	**0**
164	Non Healthcare Services Provided by Other NHS Bodies														**0**	**0**
165	Continuing Care and Funded Nursing Care														**0**	**0**
166	Other Private & Voluntary Sector														**0**	**0**
167	Joint Financing and Other (includes Local Authority)														**0**	**0**
168	Other (only use with WG Agreement & state SoCNE/I line ref)														**0**	**0**
169															**0**	**0**
170															**0**	**0**
171															**0**	**0**
172															**0**	**0**
173															**0**	**0**
174															**0**	**0**
175															**0**	**0**
176	**Sub total Other C-19 Non Pay**	**48**	**42**	**(41)**	**24**	**14**	**(8)**	**(5)**	**0**	**0**	**0**	**0**	**0**		**75**	**75**
177	**TOTAL OTHER C-19 EXPENDITURE**	**94**	**35**	**(17)**	**49**	**39**	**16**	**38**	**21**	**21**	**21**	**21**	**25**		**361**	**361**
178	**PLANNED OTHER C-19 EXPENDITURE (In Opening Plan)**	94	94	94	94	94	94	94	94	94	94	94	94		**1,122**	**1,122**
179	**MOVEMENT FROM OPENING PLANNED OTHER C-19 EXPENDITURE**	**0**	**59**	**111**	**44**	**55**	**77**	**56**	**73**	**73**	**73**	**73**	**69**		**761**	**761**
180	**TOTAL ADDITIONAL EXPENDITURE DUE TO COVID**	**166**	**84**	**31**	**103**	**87**	**69**	**56**	**53**	**59**	**54**	**41**	**70**		**874**	**874**
181	**PLANNED ADDITIONAL EXPENDITURE DUE TO COVID (In Opening Plan)**	**168**	**168**	**168**	**168**	**171**	**201**	**171**	**171**	**171**	**171**	**171**	**202**		**2,104**	**2,104**
182	**MOVEMENT FROM OPENING PLANNED ADDITIONAL COVID EXPENDITURE**	**2**	**84**	**138**	**65**	**84**	**132**	**115**	**118**	**112**	**117**	**130**	**132**		**1,230**	**1,230**

B - Additional Welsh Government Funding for C19

		1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**		
		Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total YTD**	**Forecast year-end position**
	Enter as Positive values	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
183	**PLANNED WG FUNDING FOR COVID-19**	166	169	169	169	172	201	172	172	172	172	172	202	**2,104**	**2,104**
184	**MOVEMENTS FROM OPENING PLANNED WG FUNDING FOR COVID-19**	**0**	**(85)**	**(138)**	**(65)**	**(84)**	**(132)**	**(116)**	**(118)**	**(112)**	**(117)**	**(131)**	**(132)**	**(1,231)**	**(1,231)**
185	**TOTAL ACTUAL / FORECAST WG FUNDING FOR COVID-19**	166	84	31	103	87	69	56	53	59	54	41	70	**873**	**873**
186	**ACTUAL / FORECAST NET IMPACT ON OVERALL FINANCIAL POSITION DUE TO COVID-19**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(0)**	**0**	**(0)**	**(0)**

Velindre Trust

Period : Mar 23

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

This Table is currently showing 0 errors

			1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Full-year forecast	YTD as %age of FY	Assessment		Full In-Year forecast		Full-Year Effect of Recurring Savings
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			*YTD variance as %age of YTD*	Green	Amber	non recurring	recurring	
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000				£'000	£'000	£'000	£'000	£'000
1	CHC and Funded Nursing Care	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
2		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
3		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
4	Commissioned Services	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
5		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
6		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
7	Medicines Management (Primary & Secondary Care)	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
8		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
9		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
10	Non Pay	Budget/Plan	33	33	33	33	33	33	33	33	33	33	33	33	400	400		400	0			
11		Actual/F'cast	33	33	33	33	33	33	33	33	33	33	33	33	400	400	100.00%	400	0	150	250	250
12		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	*0.00%*	0	0			
13	Pay	Budget/Plan	13	13	13	35	35	35	35	35	35	35	35	35	350	350		150	200			
14		Actual/F'cast	13	13	13	13	13	46	13	13	13	13	13	13	183	183	100.00%	183	0	33	150	150
15		Variance	0	0	0	(22)	(22)	11	(22)	(22)	(22)	(22)	(22)	(22)	(167)	(167)	*(47.71%)*	33	(200)			
16	Primary Care	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
17		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
18		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
19	Total	Budget/Plan	46	46	46	68	68	68	68	68	68	68	68	68	750	750		550	200			
20		Actual/F'cast	46	46	46	46	46	79	46	46	46	46	46	46	583	583	100.00%	583	0	183	400	400
21		Variance	0	0	0	(22)	(22)	11	(22)	(22)	(22)	(22)	(22)	(22)	(167)	(167)	*(22.27%)*	33	(200)			
22		Variance in month	0.00%	0.00%	0.00%	(32.65%)	(32.65%)	15.84%	(32.65%)	(32.65%)	(32.65%)	(32.65%)	(32.65%)	(32.65%)	(22.27%)							
23		In month achievement against FY forecast	7.86%	7.86%	7.86%	7.86%	7.86%	13.52%	7.86%	7.86%	7.86%	7.86%	7.86%	7.86%								

Velindre Trust **Period : Mar 23**

Table C1- Savings Schemes Pay Analysis

			Month	1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Full-year forecast	YTD as %age of FY	Assessment		Full In-Year forecast		Full-Year Effect of Recurring Savings
				Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			*YTD variance as %age of YTD Budget/Plan*	Green	Amber	non recurring	recurring	
				£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000				£'000	£'000	£'000	£'000	£'000
1	Changes in Staffing Establishment	Budget/Plan		13	13	13	35	35	35	35	35	35	35	35	35	350	350		150	200			
2		Actual/F'cast		13	13	13	13	13	13	13	13	13	13	13	13	150	150	100.00%	150	0	0	150	150
3		Variance		0	0	0	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(200)	(200)	*(57.14%)*	0	(200)			
4	Variable Pay	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
5		Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
6		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
7	Locum	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
8		Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
9		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
10	Agency / Locum paid at a premium	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
11		Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
12		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
13	Changes in Bank Staff	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
14		Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
15		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
16	Other (Please Specify)	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
17		Actual/F'cast		0	0	0	0	0	33	0	0	0	0	0	0	33	33	100.00%	33	0	33	0	0
18		Variance		0	0	0	0	0	33	0	0	0	0	0	0	33	33		33	0			
19	Total	Budget/Plan		13	13	13	35	35	35	35	35	35	35	35	35	350	350		150	200			
20		Actual/F'cast		13	13	13	13	13	46	13	13	13	13	13	13	183	183	100.00%	183	0	33	150	150
21		Variance		0	0	0	(22)	(22)	11	(22)	(22)	(22)	(22)	(22)	(22)	(167)	(167)	*(47.71%)*	33	(200)			

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

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

Velindre Trust

Mar 23

This Table is currently showing 4 errors

Table C3 - Tracker

	£'000	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	Full-year forecast	Non Recurring	Recurring	FYE Adjustment	Full-year Effect
Savings (Cash Releasing & Cost Avoidance)	Month 1 - Plan	46	46	46	68	68	68	68	68	68	68	68	68	750	750	150	600	0	600
	Month 1 - Actual/Forecast	46	46	46	46	46	46	46	46	46	46	46	46	550	550	150	400	0	400
	Variance	0	0	0	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(200)	(200)	0	(200)	0	(200)
	In Year - Plan	0	0	0	0	0	33	0	0	0	0	0	0	33	33	33	0	0	0
	In Year - Actual/Forecast	0	0	0	0	0	33	0	0	0	0	0	0	33	33	33	0	0	0
	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Total Plan	46	46	46	68	68	101	68	68	68	68	68	68	783	783	183	600	0	600
	Total Actual/Forecast	46	46	46	46	46	79	46	46	46	46	46	46	583	583	183	400	0	400
	Total Variance	0	0	0	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(200)	(200)	0	(200)	0	(200)
Net Income Generation	Month 1 - Plan	33	33	33	50	50	50	50	50	50	50	50	50	550	550	350	200	0	200
	Month 1 - Actual/Forecast	33	33	33	50	50	50	50	50	50	50	50	50	550	550	350	200	0	200
	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	In Year - Plan	0	0	0	0	0	33	22	22	22	22	22	22	167	167	0	167	0	167
	In Year - Actual/Forecast	0	0	0	0	0	33	22	22	22	22	22	22	167	167	0	167	33	200
	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	33	33
	Total Plan	33	33	33	50	50	83	72	72	72	72	72	72	717	717	350	367	0	367
	Total Actual/Forecast	33	33	33	50	50	83	72	72	72	72	72	72	717	717	350	367	33	400
	Total Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	33	33
Accountancy Gains	In Year - Plan	0	0	0	0	0	0	0	0	200	0	0	0	200	200	200	0	0	0
	In Year - Actual/Forecast	0	0	0	0	0	0	0	0	200	0	0	195	395	395	395	0	0	0
	Variance	0	0	0	0	0	0	0	0	0	0	0	195	195	195	195	0	0	0
Total	Month 1 - Plan	79	79	79	118	118	118	118	118	118	118	118	118	1,300	1,300	500	800	0	800
	Month 1 - Actual/Forecast	79	79	79	96	96	96	96	96	96	96	96	96	1,100	1,100	500	600	0	600
	Variance	0	0	0	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(200)	(200)	0	(200)	0	(200)
	In Year - Plan	0	0	0	0	0	66	22	22	222	22	22	22	400	400	233	167	0	167
	In Year - Actual/Forecast	0	0	0	0	0	66	22	22	222	22	22	217	595	595	428	167	33	200
	Variance	0	0	0	0	0	0	0	0	0	0	0	195	195	195	195	0	33	33
	Total Plan	79	79	79	118	118	184	140	140	340	140	140	140	1,700	1,700	733	967	0	967
	Total Actual/Forecast	79	79	79	96	96	162	118	118	318	118	118	313	1,695	1,695	928	767	33	800
	Total Variance	0	0	0	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)	173	(5)	(5)	195	(200)	33	(167)

Velindre Trust

Period : Mar 23

Table D - Income/Expenditure Assumptions

Annual Forecast

	LHB/Trust	Contracted Income	Non Contracted Income	Total Income	Contracted Expenditure	Non Contracted Expenditure	Total Expenditure
		£'000	£'000	£'000	£'000	£'000	£'000
1	Swansea Bay University			0			0
2	Aneurin Bevan University			0			0
3	Betsi Cadwaladr University			0			0
4	Cardiff & Vale University			0			0
5	Cwm Taf Morgannwg University			0			0
6	Hywel Dda University			0			0
7	Powys			0			0
8	Public Health Wales			0			0
9	Velindre			0			0
10	NWSSP			0			0
11	DHCW			0			0
12	Wales Ambulance Services			0			0
13	WHSSC			0			0
14	EASC			0			0
15	HEIW			0			0
16	NHS Wales Executive			0			0
17	**Total**	0	0	0	0	0	0

Velindre Trust

This Table is currently showing 0 errors **Period : Mar 23**

Table E - Resource Limits

1. BASE ALLOCATION

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

2. ANTICIPATED ALLOCATIONS

3	DEL Non Cash Depreciation - Baseline Surplus / Shortfall					0					
4	DEL Non Cash Depreciation - Strategic					0					
5	DEL Non Cash Depreciation - Accelerated					0					
6	DEL Non Cash Depreciation - Impairment					0					
7	DEL Non Cash Depreciation - IFRS 16 Leases					0					
8	AME Non Cash Depreciation - IFRS 16 Leases (Peppercorn)					0					
9	AME Non Cash Depreciation - Donated Assets					0					
10	AME Non Cash Depreciation - Impairment					0					
11	AME Non Cash Depreciation - Impairment Reversals					0					
12	Removal of Donated Assets / Government Grant Receipts					0					
13	Total COVID-19 (see below analysis)	0	0	0	0	0					See below analysis
14	Removal of IFRS-16 Leases (Revenue)					0					
15	Energy (Price Increase)					0					
16	Employers NI Increase (1.25%)					0					
17	Real Living Wage					0					
18						0					
19						0					
20						0					
21						0					
22						0					
23						0					
24						0					
25						0					
26						0					
27						0					
28						0					
29						0					
30						0					
31						0					
32						0					
33						0					
34						0					
35						0					
36						0					
37						0					
38						0					
39						0					
40						0					
41						0					
42						0					
43						0					
44						0					
45						0					
46						0					
47						0					
48						0					
49						0					
50						0					
51						0					
52						0					
53						0					
54						0					
55						0					
56						0					
57						0					
58	Total Anticipated Funding	0	0	0	0	0		0	0	0	

3. TOTAL RESOURCES & BUDGET RECONCILIATION

59	Confirmed Resources Per 1. above	0	0	0	0	0		0	0	0
60	Anticipated Resources Per 2. above	0	0	0	0	0		0	0	0
61	**Total Resources**	**0**	**0**	**0**	**0**	**0**		**0**	**0**	**0**

ANALYSIS OF WG FUNDING FOR COVID-19 INCLUDED ABOVE		Allocated Total £'000	Anticipated HCHS £'000	Anticipated Pharmacy £'000	Anticipated Dental £'000	Anticipated GMS £'000	Total RRL £'000	WG Contact and date item first entered into table.
62	Testing (inc Community Testing)						0	
63	Tracing						0	
64	Mass COVID-19 Vaccination						0	
65	PPE						0	
66	Extended Flu						0	
67	Cleaning Standards						0	
68	Long Covid						0	
69							0	
70							0	
71							0	
72							0	
73							0	
74							0	
75							0	
76							0	
77							0	
78							0	
79							0	
80							0	
81							0	
82							0	
83							0	
84							0	
85							0	
86							0	
87							0	
88							0	
89							0	
90							0	
91							0	
92	**Total Funding**	**0**	**0**	**0**	**0**	**0**	**0**	

Velindre Trust

Period : **Mar 23**

This Table is currently showing 0 errors

Table E1 - Invoiced Income Streams - TRUSTS ONLY

Ref		Swansea Bay ULHB	Aneurin Bevan ULHB	Betsi Cadwaladr ULHB	Cardiff & Vale ULHB	Cwm Taf Morgannwg ULHB	Hywel Dda ULHB	Powys LHB	Public Health Wales NHS Trust	Welsh Ambulance NHS Trust	Velindre NHS Trust	NWSSP	DHCW	HEIW	WG	EASC	WHSSC	Other (please specify)	Total	WG Contact, date item first entered into table and whether any invoice has been raised.
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	
1	**Agreed full year income**	5,210	30,887	3,048	30,745	21,548	3,470	1,485	1,795	30	0	0	731	1,418	19,775	0	52,958	10,429	**183,529**	
	Details of Anticipated Income																			
2	DEL Non Cash Depreciation - Baseline Surplus / Shortfall																		0	Gary Young M1
3	DEL Non Cash Depreciation - Strategic																		0	Gary Young M1
4	DEL Non Cash Depreciation - Accelerated																		0	
5	DEL Non Cash Depreciation - Impairment																		0	
6	DEL Non Cash Depreciation - IFRS 16 Leases																		0	Jackie Salmon M1
7	AME Non Cash Depreciation - IFRS 16 Leases (Peppercorn)																		0	
8	AME Non Cash Depreciation - Donated Assets																		0	Gary Young M1
9	AME Non Cash Depreciation - Impairment																		0	
10	AME Non Cash Depreciation - Impairment Reversals																		0	
11	Total COVID-19 (see below analysis)														0				0	See below analysis
12	Removal of IFRS-16 Leases (Revenue)																		0	Jackie Salmon M1
13	Energy (Price Increase)																		0	
14	Employers NI Increase (1.25%)																		0	
15	Real Living Wage																		0	
16																			0	
17																			0	
18																			0	
19																			0	
20																			0	
21																			0	
22																			0	
23																			0	
24																			0	
25																			0	
26																			0	
27																			0	
28																			0	
29																			0	
30																			0	
31																			0	
32																			0	
33																			0	
34																			0	
35																			0	
36																			0	
37	**Total Income**	**5,210**	**30,887**	**3,048**	**30,745**	**21,548**	**3,470**	**1,485**	**1,795**	**30**	**0**	**0**	**731**	**1,418**	**19,775**	**0**	**52,958**	**10,429**	**183,529**	

	ANALYSIS OF WG FUNDING DUE FOR COVID-19 INCLUDED ABOVE	Allocated £'000	Anticipated £'000	Total £'000	WG Contact, date item first entered into table and whether any invoice has been raised.
38	Testing (inc Community Testing)			0	
39	Tracing			0	
40	Mass COVID-19 Vaccination	224		224	Richard Dudley M1 Raised
41	PPE	70		70	Richard Dudley M1 Raised
42	Extended Flu			0	
43	Cleaning Standards	289		289	Richard Dudley M1 Raised
44	Long Covid			0	
45	A2. Increased bed capacity specifically related to COVID-19			0	Richard Dudley M1 Raised
46	A3. Other Capacity & facilities costs (exclude contract cleaning)			0	Richard Dudley M2 Rasied
47	B1. Prescribing charges directly related to COVID symptoms			0	
48	C1. Increased workforce costs as a direct result of the COVID response and IP	282		282	Richard Dudley M2 Rasied
49	D1. Discharge Support			0	
50	D4. Support for National Programmes through Shared Service			0	
51	D5. Other Services that support the ongoing COVID response	8		8	Richard Dudley M3 Rasied
52	E1. Primary Care Contractor (excluding drugs) - Costs as a result of lost GDS Income			0	
53				0	
54				0	
55				0	
56				0	
57				0	
58				0	
59				0	
60				0	
61				0	
62				0	
63				0	
64				0	
65				0	
66				0	
67				0	
68	**Total Funding**	873	0	873	

Velindre Trust **Period :** **Mar 23**

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

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

	EXPLANATION OF ALL PROVISIONS	Opening Balance Beginning of Apr 22	Closing Balance End of Mar 23	Closing Balance End of Mar 23
31				
32				
33				
34				
35				
36				
37				
38				
39				
40	**Total Provisions**	0	0	0

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

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

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

Velindre Trust

Period : **Mar 23**

This Table is currently showing 0 errors **This table needs completing monthly from Month: 2**

Table G - Monthly Cashflow Forecast

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

Velindre Trust

Period : Mar 23

Table H - PSPP

This table needs completing on a quarterly basis
NOTE: Data to 1 decimal place

30 DAY COMPLIANCE

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

10 DAY COMPLIANCE

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

Velindre Trust

Period : **Mar 23**

This Table is currently showing 0 errors

Table I - 2022-23 Capital Resource / Expenditure Limit Management

£'000	
Approved CRL / CEL issued at :	

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

	Other (Including IFRS 16 Leases) Schemes:						
49				0			0
50				0			0
51				0			0
52				0			0
53				0			0
54				0			0
55				0			0
56				0			0
57				0			0
58				0			0
59				0			0
60				0			0
61				0			0
62				0			0
63				0			0
64				0			0
65				0			0
66				0			0
67				0			0
68				0			0
69	**Sub Total**	**0**	**0**	**0**	**0**	**0**	**0**

70	**Total Expenditure**	**0**	**0**	**0**	**0**	**0**	**0**

	Less: **Capital grants:**						
71				0			0
72				0			0
73				0			0
74				0			0
75				0			0
76	**Sub Total**	**0**	**0**	**0**	**0**	**0**	**0**

	Donations:						
77				0			0
78	**Sub Total**	**0**	**0**	**0**	**0**	**0**	**0**

	Asset Disposals:						
79				0			0
80				0			0
81				0			0
82				0			0
83				0			0
84				0			0
85				0			0
86				0			0
87				0			0
88				0			0
89				0			0
90	**Sub Total**	**0**	**0**	**0**	**0**	**0**	**0**

91	***Technical Adjustments***			**0**			**0**

92	**CHARGE AGAINST CRL / CEL**	**0**	**0**	**0**	**0**	**0**	**0**

93	**PERFORMANCE AGAINST CRL / CEL (Under)/Over**		**0**			**0**	

Velindre Trust

Period : Mar 23

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

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

Table J - In Year Capital Scheme Profiles

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

Velindre Trust

Period : Mar 23

Table K - Capital Disposals

This Table is currently showing 0 errors

A: In Year Disposal of Assets

	Description	Date of Ministerial Approval to Dispose (Land & Buildings only)	Date of Ministerial Approval to Retain Proceeds > £0.5m	Date of Disposal	NBV	Sales Receipts	Cost of Disposals	Gain/ (Loss)	Comments
		MM/YY (text format, e.g. Apr 22)	MM/YY (text format, e.g. Apr 22)	MM/YY (text format, e.g. Feb 23)	£'000	£'000	£'000	£'000	
1								0	
2								0	
3								0	
4								0	
5								0	
6								0	
7								0	
8								0	
9								0	
10								0	
11								0	
12								0	
13								0	
14								0	
15								0	
16								0	
17								0	
18								0	
19								0	
	Total for in-year				0	0	0	0	

B: Future Years Disposal of Assets

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

Velindre Trust

Period : Mar 23

This Table is currently showing 2 errors
This table needs completing monthly from Month: 3

Table L: EXTERNAL FINANCING LIMIT

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

Velindre Trust

Table M - Debtors Schedule

Period:	**Mar 23**
11 weeks before end of Mar 23 =	13 January 2023
17 weeks before end of Mar 23 =	02 December 2022

Debtor	Inv #	Inv Date	Orig Inv £	Outstand. Inv £	Valid Entry	>11 weeks but <17 weeks	Over 17 weeks	Arbitration Due Date	Comments
Betsi Cadwaladr Uni LHB-East	1119034	22/12/22	£507.40	£507.40	Yes, valid entry for period	507.40		20 April 2023	PO have been approved and copy invoice sent /Payment imminant
Betsi Cadwaladr Uni LHB-East	1119137	09/01/23	£71,803.50	£71,803.50	Yes, valid entry for period	71,803.50		08 May 2023	PO have been approved and copy invoice sent /Payment imminant
Betsi Cadwaladr Uni LHB-East	1119140	09/01/23	£8,398.10	£8,398.10	Yes, valid entry for period	8,398.10		08 May 2023	PO have been approved and copy invoice sent /Payment imminant
Betsi Cadwaladr Uni LHB-East	1119141	09/01/23	£775.20	£775.20	Yes, valid entry for period	775.20		08 May 2023	PO have been approved and copy invoice sent /Payment imminant
Betsi Cadwaladr Uni LHB-East	1119143	09/01/23	£13,453.36	£13,453.36	Yes, valid entry for period	13,453.36		08 May 2023	PO have been approved and copy invoice sent /Payment imminant
Betsi Cadwaladr Uni LHB-East	2016724	10/01/23	(£46.01)	(£46.01)	Yes, valid entry for period	-46.01		09 May 2023	PO have been approved and copy invoice sent /Payment imminant
Betsi Cadwaladr Uni LHB-East	1119236	13/01/23	£239.52	£239.52	Yes, valid entry for period	239.52		12 May 2023	PO have been approved and copy invoice sent /Payment imminant
			95,131.07	**95,131.07**		**95,131.07**	**0.00**		

Invoices paid since the end of the month		
Total outstanding as per MR submission date	**95,131.07**	**0.00**

Velindre Trust

Period : **Mar 23**

Table N - General Medical Services
Table to be completed from Q2 / Month: **6**

This Table is currently showing 0 errors

Operating Expenditure - ring fenced GMS budget

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

SUPPLEMENTARY INFORMATION

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

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

Local Enhanced Services *A (iii)*	LINE NO.	£000's	£000's	£000's	£000's	£000's
ADHD	42				0	
Asylum Seekers & Refugees	43				0	
Cardiology	44				0	
Care Homes	45				0	
Care of Diabetes	46				0	
Chiropody	47				0	
Counselling	48				0	
Depo - Provera (including Implanon & Nexplanon)	49				0	
Dermatology	50				0	
Dietetics	51				0	
DOAC/NOAC	52				0	
Drugs Misuse	53				0	
Extended Minor Surgery	54				0	
Gonaderlins	55				0	
Homeless	56				0	
HPV Vaccinations	57				0	
Immunisations (inc Pertussis excluding DES - Childhood Imm & Influenza & Pneumococcal Im	58				0	
Learning Disabilities	59				0	
Lithium / INR Monitoring	60				0	
Local Development Schemes	61				0	
Mental Health	62				0	
Minor Injuries	63				0	
MMR	64				0	
Multiple Sclerosis	65				0	
Muscular Skeletal	66				0	
Nursing Homes	67				0	
Orthopaedic (Upper Limb GPwSi/Clinical Assessments)	68				0	
Osteopathy	69				0	
Phlebotomy	70				0	
Physiotherapy (inc MT3)	71				0	
Referral Management	72				0	
Respiratory (inc COPD)	73				0	
Ring Pessaries	74				0	
Sexual Health Services	75				0	
Shared Care	76				0	
Smoking Cessation	77				0	
Substance Misuse	78				0	
Suturing	79				0	
Swine Flu	80				0	
Transport/Ambulance costs	81				0	
Vasectomy	82				0	
Weight Loss Clinic (inc Exercise Referral)	83				0	
Wound Care	84				0	
Zoladex	85				0	
	86				0	
	87				0	
	88				0	
	89				0	
	90				0	
	91				0	
	92				0	
	93				0	
TOTAL Local Enhanced Services (must equal line 10)	94		0	0	0	0

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

GENERAL MEDICAL SERVICES
Operating Expenditure

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

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

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

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

Memorandum item

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

GENERAL MEDICAL SERVICES
Dispensing

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

Velindre Trust

Period : **Mar 23**

Table O - General Dental Services

This Table is currently showing 0 errors

Table to be completed from Q2 / Month: 6

Operating Expenditure from the revenue allocation for the dental contract

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

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

RECEIPTS

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

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Anti-racist Action Plan Progress Report

DATE OF MEETING	16 May 2023

PUBLIC OR PRIVATE REPORT	Private

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Claire Budgen: Head of Organisational Development,
PRESENTED BY	Sarah Morley, Executive Organisational Development & Workforce
EXECUTIVE SPONSOR APPROVED	Sarah Morley, Executive Organisational Development & Workforce

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	2.5.23	Noted

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 The Trust agreed an Anti-racist Action Plan in December 2022. Progress with the plan is captured in Appendix 1.

2. ASSESMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Progress has been made in several areas, initially with actions at Board level with the agreement of personal objectives and development sessions. This has provided a robust starting point for the next phase of development.

2.2 There are several areas where the Trust is waiting materials from external sources, including the training packages and the Workplace Race Equality Scheme.

2.3 Alongside the specific actions in the plan, the Trust has reviewed and re-launched its approach to Equality Impact Assessments which will be supported by training for managers. This is a fundamental process which will enable aspects of the Anti-racist action plan to be developed.

2.4 The Trust Anti-Racist Wales Action plan will be mapped against the 7 levels of assurance in preparation for future updates.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Staff and Resources
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes

	The work described in this documents directly contributes to the Trust duties in relation to Equality Impact Assessment.
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)

4. RECOMMENDATION

The Quality, Safety and Performance Committee is asked to **NOTE** the progress.

Velindre University NHS Trust

Anti-Racist Action Plan 2022-23- Progress Update 16 May 2023

Aim

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

The Trust has five objectives within its Strategic Equality Plan 2023-24, all of which touch on elements of this Anti-Racist Action Plan. They are:

1. Increase workforce diversity and inclusion
2. Eliminate Pay Gaps
3. Engage with the community
4. Communicate with people in ways which meet their needs
5. Ensure service delivery reflets individual need

Ref	National Actions	Date	Trust Actions	Progress – May 2023
1	Trust Chair's objective to be set in support of this anti-racism work, to be discussed by relevant stakeholder groups and agreed by Ministers or Welsh Government Senior officials.	September 2023	• Share the Chair's objectives with all Board members to highlight Anti-racism commitments	• Chair and Independent Members share the objective of *To attend and participate in a Board Anti-Racist Development Programme*

2	Trust to develop anti-racism action plans; for both employment and service delivery as a specific part of their wider approach to equality, inclusion and diversity.	December 2022 December 2022 March 2023 March 2023 December 2022 and ongoing	• Map Anti-racist goals against the goals of the Strategic Equality Plan and set out how the two work together • Include Anti-racism within the IMTP process using the Equality Impact Assessment. • Consult with staff, patients and donors to test what their experience is and what needs to change • Establish a current baseline set of data relating to staff, patients and donors in respect of race. Compare this data with local demographic data relating to racial diversity. • Develop, implement and monitor the plan through the Healthy and Engaged Steering Group.	• Strategic Equality Plan objectives have been added to this document as reference for anti-racist actions • An EQIA was developed for the 2023-24 IMTP which covers anti-racism • This plan will embedded into the 2023-24 workplan for the Healthy and Engaged Steering Group and reviewed at its Quarterly meetings
3	All NHS Board members will begin anti-racist development in 2022 and undertake an anti-racist education programme	Summer 2023 December 2023	• Deliver Board Development awareness session on importance of cultural competence • Deliver Board development programme during 2023	• Session delivered by Dr Charles Willie on 27.10.22. Will be followed up by using the Culture Competence Audit tool. • Awaiting publication of programme

			commissioned by Public Bodies Unit, WG	
4	All NHS Board members will have and report progress against personal objectives to meet vision of an anti-racist Wales.	December 2022 December 2022 and ongoing December 2023	• Establish personal objective in support of Anti-racist Wales for each Board member • Board members will role model anti-racist practices by challenging discrimination, listening to lived experiences and considering racial perspectives when making decisions. • Anti-racist objectives to be cascaded through every level of the organisation and made relevant to each job role.	• Chair and Independent Members share the objective of *To attend and participate in a Board Anti-Racist Development Programme* • Patient and Staff stories are regular feature in Board meeting. Will use this model to share experience around race
5	Staff, volunteers and students to complete redesigned anti-racist education programmes to bring enhanced awareness of race, racism, micro behaviours, microagressions at all levels of the organisation.	December 2023 June 2023 June 2023 June 2023	• Implement programme when available • Embed anti-racism into management and leadership development activities • Offer coaching to support leaders implement and enhance practice in supporting their Black, Asian and racially minoritised colleagues • Embed anti-racism into staff induction by developing a welcome programme of activities for staff joining the organisation via international recruitment activities. This may involve establishing a buddying / support	• Awaiting publication of national programme • Will be included in review of Inspire, Q1 and Q2 2023-24 • To be addressed as part of any international recruitment campaign

			network for staff and drawing on experience of other Health organisations who have established such an approach.	
6	Appointing 'Executive Equality Champions' and 'Cultural Ambassadors	September 2023 September 2023	• Build on existing role of Executive Equality Ambassador • Develop Cultural Ambassador role once role profile is available	• Equality Champion for Race nominated and has presented at Board on Race. • Awaiting details of Cultural Ambassador role
7	Implementing a leadership and progression pipeline plan for Black, Asian and Minority Ethnic staff	September 2023 September 2023	• Establish a pipeline for Black, Asian and Minority Ethnic staff as part of Trust talent management approach • Review promotion and development process to ensure there is no bias or bias is mitigated	• Will be part of the Trust's Talent Management approach when developed in 2023-24
8	Review People policies to ensure they fully support all employees	December 2023 December 2023 December 2023	• Support All Wales programme of review of national policies • Review Trust level policies through active use of an Equality Impact Assessment for each policy • Examine all Trust recruitment processes through an anti-racist lens	• Worked with Diverse Cymru to offer focus groups to Black and Minority ethnic Staff. Contributed to the ED&I specialist focus group discussions. • Will use Diverse Cymru's advice in reviewing Trust policies, including recruitment.
9	Implement an anti-racist communication plan and create forums for Black, Asian and Minority Ethnic	September 2023	• Re-Establish Black and Ethnic Minority staff group. Terms of Reference to set out how they have access to the Board and that	• Initial discussions have taken place on establish Staff Networks. Offer being launched during Equality Week in May 2023. Staff networks are cited in the

	staff to communicate their experiences and ideas. Providing Ethnic Minority Networks appropriate levels of resource and access to the Board.	September 2023	they are a resource for consultation and communication. • Standardise the consideration of staff, patient and donor stories setting out the lived experience of people from different racial backgrounds.	EQIA toolkit as a source of feedback the impact of changes.
10	Improve workforce data quality and introduce a Workforce Race Equality Standard (WRES)	September 2023 September 2023 September 2023 September 2023	• Request all staff to update their demographic information on ESR • Work with NHS colleagues in adopting the WRES, ensuring ESR is able to produce the reports • Use WRES to understand the experience of ethnic minority staff in relation to pay and treatment • Ensure monitoring is in place and includes Leavers, Promotions, Training Opportunities, Grievances, Complaints, recruitment applications v shortlisted v successful and staff engagement surveys	• Automatic requests come through ESR • Awaiting arrangements for WRES
11	Implement systemic monitoring of concerns of workforce discrimination and bullying raised by staff through the Joint Executive Team process.	December 2023 December 2023	• Capture and include discrimination and bullying data within Workforce Reports. • Develop clear robust processes and provide sufficient channels for staff to record and report racial	• Included in Workforce report

	Review and scrutinise reporting processes for reporting racism, discrimination, inappropriate behaviours.	December 2022 and ongoing December 2023	discrimination and for the Trust to take action • Issue regular communications regarding zero tolerance of inappropriate behaviour • Work with Trades Unions to find ways for lower paid workers from ethnic minorities to raise concerns such as Speak Up initiatives, surveys and networks. Monitor uptake and remove barriers to access.	
12	Ensure our COVID-19 recovery plans are fully inclusive and targeted to address known health inequalities in access to care and service provision.	September 2023	• Apply Equality Impact Assessment to COVID 19 recovery plans and link to known health inequalities.	•

VELINDRE UNIVERSITY NHS TRUST
QUALITY, SAFETY, PERFORMANCE COMMITTEE

VCC DIVISIONAL QSP REPORT
(November 2022 to March 2023)

DATE OF MEETING	16 May 2023

PUBLIC OR PRIVATE REPORT	PUBLIC

IF PRIVATE PLEASE INDICATE REASON	Not Applicable

PREPARED BY	VIV COOPER, HEAD OF NURSING, QUALITY, SAFETY AND PATIENT EXPERIENCE SARAH OWEN, QUALITY AND SAFETY MANAGER TRACEY LANGFORD, QUALITY & SAFETY OFFICER
PRESENTED BY	PAUL WILKINS, DIRECTOR OF CANCER SERVICES
EXECUTIVE SPONSOR APPROVED	CATH O'BRIEN, CHIEF OPERATING OFFICER

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Senior Leadership Team Executive Management Board	19.04.2023 02.05.2023	Approved Approved

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

1. SITUATION

This purpose of this paper is to provide the Trust Quality, Safety & Performance Committee with an update on the key quality, safety and performance outcomes and metrics for the Velindre Cancer Centre for the period November 2022 to March 2023.

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

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

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

2. BACKGROUND

This report is a summary of key operational, quality, safety and performance related matters being considered by the Velindre Cancer Centre for the period November 2022 to March 2023.

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 Patients and our responses to it.
- Regulator and Audit Feedback, assurance and learning themes
- An outline of key service developments in VCC

3.1 Triangulated Analysis

The purpose of this report is to provide assurance to the Quality, Safety and Performance Committee that VCC is continuing to meet its Quality, Safety and Performance standards. To summarise for the reporting period (November 2022 to March 2023).

All clinical services were under significant pressure during the reporting period following an increase in demand and an increase in complexity of patient clinical presentation.

- VCC have identified and begun work on 2 Safe Care Collaborative Projects, Malignant Spinal Cord Compression Pathway and The SACT Treatment Helpline
- VCC continue to meet all of the minimum requirements related to the MES

- Falls and Pressure Ulcer scrutiny panels continue to meet monthly and examine the documentation, evidence and learning around each individual incident. The falls scrutiny panel have revised their investigation tool to reflect learning.
- The Sepsis Bundle compliance continues at 100%
- The compliance with the PTR regulations related to concerns/complaints continues at 100%
- Closure of quality and safety incidents within the required 30 days remains a challenge
- Overall patient satisfaction continues to exceed target at 92%.

3.2 The top five matters arising for this period are;

- Positive report following unannounced CHC visit to First Floor ward February 2023.
- There were 0 avoidable VCC acquired pressure ulcers for the reporting period
- A number of patients reporting they are "waiting longer than they would like" on CIVICA feedback surveys. The newly appointed Patient Experience and Concerns Manager will start to work closely with departments to identify root causes and corrective actions.
- Number of Datix incidents open over the 30 days remain high and is higher than the last reporting period. An improvement plan has been identified by Q+S team commencing in April 2023.
- NRI submitted due to a patient being lost to follow up which remains under investigation. Immediate learning identified and actioned while a joint investigation is being undertaken between VCC and the relevant HB.

3.3 Key Actions / Areas of focus during next period

Quality and safety and patient experience remains at the heart of our service during this period in all aspects of service delivery as does the well-being of our staff. During this period the staff psychologist has joined the Trust and is available to help/support individual staff and teams following any incidents/concern/challenging clinical scenario they may be facing.

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

RECOMMENDATIONS

The Quality, Safety & Performance Committee is asked to **NOTE** the content of the report.

CONTENTS PAGE

1.0	Introduction

INTRODUCTION

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

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

2.0	Impact Assessment

2.1 This report covers the period of November, December 2022, January, February, March 2023 and therefore retrospectively provides VCC service, quality and safety data and narrative, the purpose of which is to provide assurance. The report is structured around the 6 domains of quality and safety.

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

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

- SLT members to reiterate within the Directorates that more consistent engagement and attendance at QSMG is required.
- A commercial medical equipment database has been recommended following a Wales Audit Office review
- New risks need to be actioned when reported to meet reporting and risk management requirements
- Incidents need to be investigated and closed in a more timely way by Directorate leads and their teams

4.0	Safe Care Descriptor; avoid harm

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

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

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

4.1 Incidents

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

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

The table below provides the numbers of incidents that were reported during November, December 2022, January, February and March 2023 and how they were initially categorised by the incident reporter.

	None	Low	Moderate	Severe	Total
Nov 2022	59	31	9	0	99
Dec 2022	100	44	5	0	149
Jan 2023	119	39	9	0	167
Feb 2023	123	37	6	2	168
Mar 2023	83	51	10	0	144
Total	484	202	39	2	727

4.1.1 Severe and Catastrophic Incidents

- 2 incidents were categorised as severe at the time of reporting. One of the incidents has been downgraded as low following the investigation. The second incident categorised as severe remains under investigation, a joint investigation is being undertaken by VCC and the relevant Health Board regarding this patient who was lost to follow up. This incident has been reported as a NRI and more detail is provided elsewhere in the report.

4.1.2 Moderate Incidents

40 incidents were categorised as moderate harm when first reported.

28 of these incident have been investigated and closed on Datix. Following the investigations, 2 incidents remain categorised as moderate:

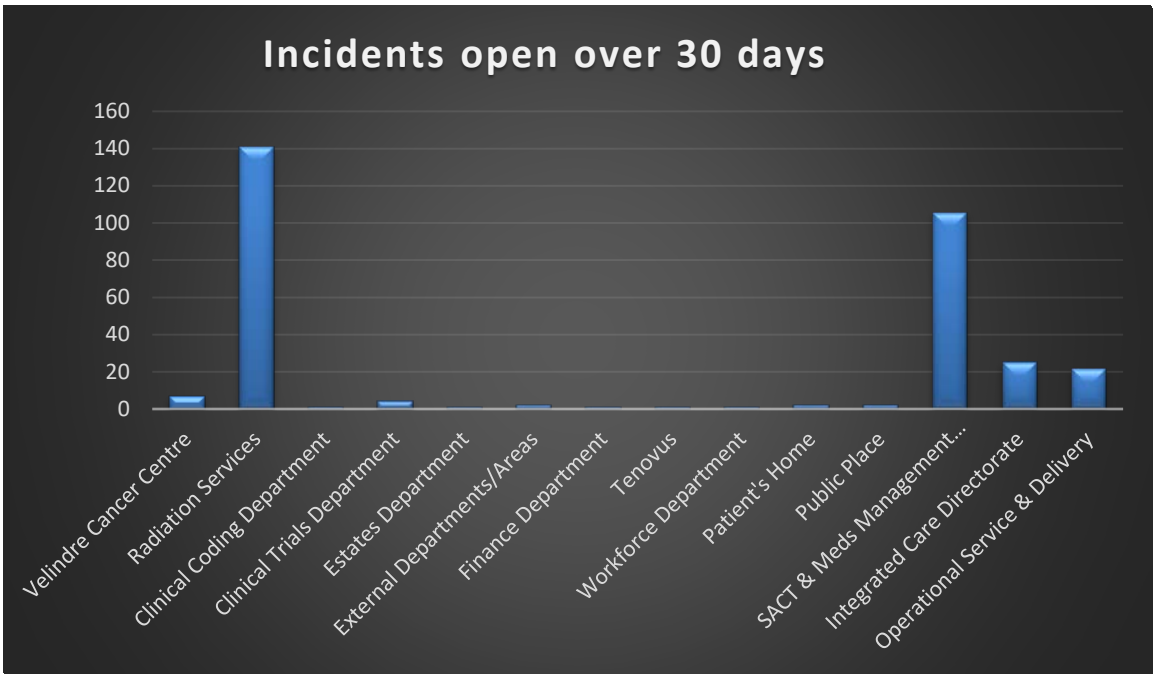
- Staff member fall resulting in a broken arm, the fall invoved a piece of equipment, the incident has been reported and managed appropriately.
- Patient suffered a fractured neck of femur following a fall on First Floor. Following March 2023 scrutiny panel, the fall was deemed to be unavoidable as appropriate nursing assessment and care planning was evident and the patient, who did had full capacity and no cognitive impairment, did not comply with the mobility and fall reduction plan put in place. Learning was identified around the storage of equipment which has been disseminated to the ward staffas part of the daily 'Big 4' speedy cascade of learning/information.

There are a further 12 incidents where the investigation is in progress on Datix and therefore remain categorised as moderate. This has been escalated to directorate leads and SLT;

One of the moderate incidents that remain open is being investigated by a neighbouring Health Board as it is related to care provided by the Health Board which was reported by a VCC consultant, the investigation is in progress

4.1.3 Open Incidents

There are 358 incidents open over 30 day but due to different regulatory reporting system and investigation process within radiotherapy 42 of these incidents require 90 days to investigate. There is a slight increase from the previous VCC QSP report which showed 310 incidents open over 30 days. The Q&S team has recruited extra resource with an objective to prioritise and focus on working with departments and directorates to improve their compliance of investigating and closing incidents within 30 days focusing on the areas with the highest number of open incidents initially. This work includes provision of regular reports to the departments, establishing an incident management working group with representation from each deprtament, and regular meeting with department leads and managers to imprve compliance and identifying learning. Regular highlight reports to SLT will continue.



4.2 Falls Scrutiny Panel

During this reporting period there were 15 falls affecting 14 patients, 2 of which were **avoidable** falls on First Floor ward and resulted in no harm to the patients. All falls were investigated and discussed in the monthly fall's scrutiny panel. Identified learning from the scrutiny discussion is detailed below;

- First Floor ward staff reminded that the physiotherapy team are available for half a day on each day of the weekend to accept new referrals
- Phsiotherapy lead to develop a referral criteria to physiotherapy for patients admitted to FF with a prior history of falls

As mentioned previously, a patient suffered a fractured neck of femur following a fall. Following March 2023 scrutiny panel, the fall was deemed to be unavoidable as appropriate nursing assessment and care planning was evident and the patient, who did had full capacity and no cognitive impairment, did not comply with the mobility and fall reduction plan put in place. Learning was identified around the storage of equipment which has been disseminated to the ward staff as part of the daily 'Big 4' speedy cascade of learning/information.

4.2.1 Pressure Ulcer Scrutiny Panel

There was 0 avoidable VCC acquired pressure ulcer during this reporting period.

4.2.2 National Reportable Incidents

There have been 2 National Reportable Incidents for November 2022 – March 2023.

- A national reportable incident has been submitted as a patient suffered a fractured neck of femur following a fall. Following March 2023 scrutiny panel, the fall was deemed to be unavoidable as appropriate nursing assessment and care planning was evident and the patient, who did had full capacity and no cognitive impairment, did not comply with the mobility and fall reduction plan put in place. Learning was identified around the storage of equipment which has been disseminated to the ward staff as part of the daily 'Big 4' speedy cascade of learning/information.

- An NRI was submitted due to a patient being lost to VCC follow up. A joint investigation is currently being undertaken by VCC and the relevant HB. Immediate learning and improvements have been identified including updating the nursing discharge checklist, consideration of a medical discharge checklist, case presentation and teaching session to the multi-disciplinary team, and speedy cascade sent out to all staff with the identified learning.

4 NRI investigations were closed during this period, related to the treatment helpline, SACT booking centre, and a patient fall. Details of learning and actions for these were provided in the last reporting period. The key findings and improvements from these investigation are:

- Physiotherapy referral criteria and awareness of weekend availability
- SACT booking centre to operate one list of patients requiring their SACT to be scheduled, as opposed to two lists.
- Importance of clear communication between SACT booking centre and clinical teams.
- An evident increased demand and increased complexity of the patients contacting the SACT treatment helpline for support and changes in cancer treatments. A full review of the SACT Treatment Helpline is required, which is being undertaken as a Safe Care Collaborative improvement project.

4.2.3 IR(ME)R HIW Reportable Incidents

- There were 7 IR(ME)R related incidents reported to Health Inspectorate Wales (HIW) during the period. All were no or low harm but met the HIW reporting classifications. A number of these incidents are in relation to a known manufacturer fault with the radiotherapy system.
- A full review of these incidents has been undertaken by an external expert from the UKHSA (UK

Health Security Agency). This review included discussing local management of on-treatment radiotherapy imaging incidents related to equipment failure. Each one of the types of incidents discussed, would not constitute a reportable notification to HIW in their own right, but do become reportable once the repeat imaging thresholds are met or once multiple patients are affected by a similar incident. It was recognised that the Trust was reporting these incidents in line with current HIW guidance, and some advice was provided in relation to strengthening the Trusts Risk Assessment Processes.

- The UKHSA *Safer Radiotherapy* publication series identified that onset imaging processes account for a significant proportion of all error and near miss events shared with UKHSA for analysis. Of these, failure of imaging devices is a recurring theme nationally. UKHSA is in dialogue with the MHRA on how these incidents might be better addressed. The review also identified some ambiguity surrounding the radiotherapy imaging notification criteria nationally with the UK IR(ME)R enforcing authorities are addressing this with HIW.

4.2.4 Early Warning Notifications

There are no Early Warning Notifications for this reporting period.

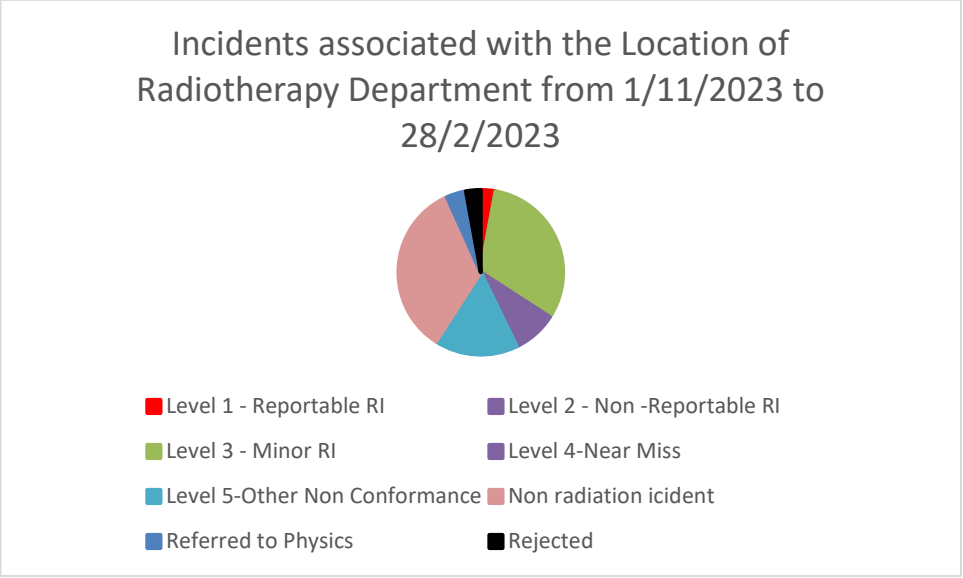
4.3. IRMER Compliance/ Issues/ Incidents

Between 1st November 2022 and 28th February 2023, 208 incidents were reported in the Once for Wales Datix Incident module and associated to the Location of Radiotherapy Department. Of the 208 incidents reported, 131 were classed as radiotherapy errors / radiation incidents. 123 of which have been or are under investigation by the radiotherapy department and have been coded in line with Towards Safer (TSRT) pathway coding and 8 have been referred to Radiotherapy Physics for investigation.

95% of radiation incidents were classed as minor radiation incidents (Level 3), near misses (Level 4), or other and non-conformances (Level 5) for the 4-month period 1/11/2022 to 28/2/2023 which benchmarks with the National report of 97.8.%, reported in the UK Health Security Agency Safer Radiotherapy e-Bulletin #9 January 2023.

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

5% of radiation incidents were classed as Level 1 and were reportable to HIW as per Significant Accidental Unintended Exposures (SAUE) under IR(ME)R guidance.



4.4 Mortality

The Welsh Clinical Quality Performance Indicators for SACT and Radiotherapy requires the collection and reporting of data regarding 30 day mortality following radical SACT, palliative SACT, palliative radiotherapy and 90 day mortality following radical radiotherapy. This data should be used to enable learning and influence practice to ensure the development of high quality services. It is a clinical indicator of transparency in outcomes and protecting patients from avoidable harm.

The Trust has collected and reported on death within 30 days of SACT since 2012, however It was identified as part of the SACT peer review February 2020 that a more robust approach to death within 30 days of SACT was required. A small group was established to work through the best approach and after benchmarking it was decided to pilot mortality and morbidity meetings in line with other health boards. The colorectal SST agreed to be the pilot site and the first stage of the pilot has been completed. The next stage of the pilot is due to commence in April 2023.

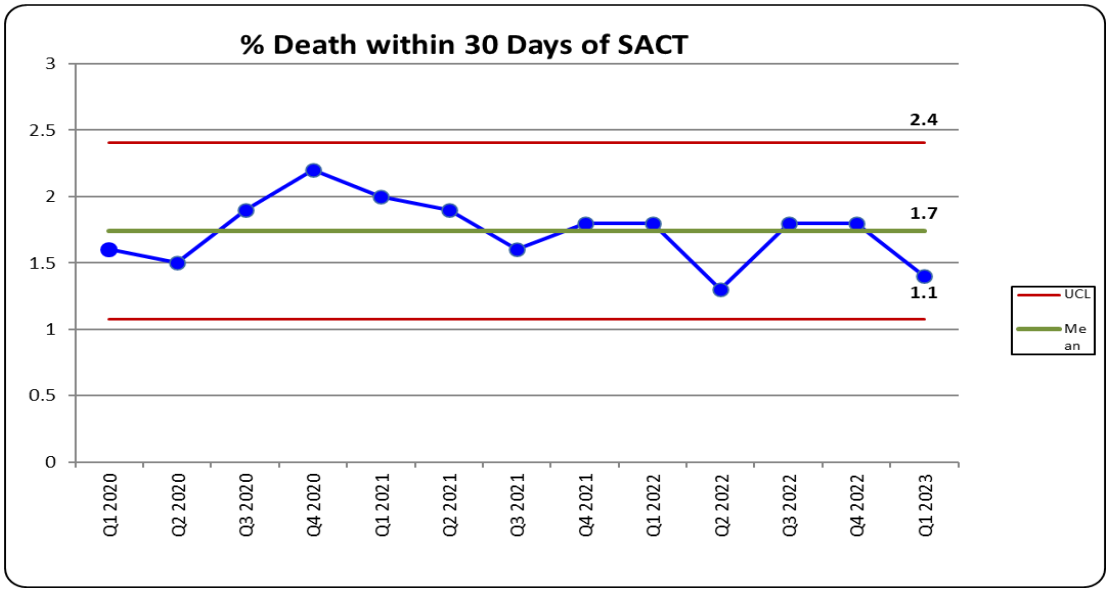
% Deaths within 30 days is calculated using the formula:-

$$\frac{\text{Total N}^{o}\text{ deaths within 30 days of SACT cycle per quarter}}{\text{Total N}^{o}\text{ patients starting SACT cycle per quarter}} \times 100$$

Death 30 days Quarter 1 – January 2023- March 2023

Percentage deaths within 30 days of SACT by quarter

Quarter	Months	VCC Deaths	SACT	%
Q1 2020	January-March 2020	40	2453	1.6
Q2 2020	April-June 2020	25	1689	1.5
Q3 2020	July-September 2020	40	2072	1.9
Q4 2020	October-December 2020	48	2163	2.2
Q1 2021	January-March 2021	47	2347	2.0
Q2 2021	April-June 2021	46	2388	1.9
Q3 2021	July-September 2021	37	2337	1.6
Q4 2021	October-December 2021	44	2416	1.8
Q1 2022	January-March 2022	43	2457	1.8
Q2 2022	April-June 2022	34	2525	1.3
Q3 2022	July-September 2022	47	2613	1.8
Q4 2022	October-December 2022	48	2671	1.8
Q1 2023	January-March 2023	36	2609	1.4



Additional resources have been provided to the Quality and Safety team for a Mortality Review and Improvement Facilitator, with a job advertisment imminent. The role will support the processes around MES, VCC mortality reviews, death within 30 days of SACT and death within 30/90 days of radiotherapy reviews with an emphasis on learning, improvements and dissemination of the information and data.
A mortality review team is established and a meeting has been held there is a plan to set draft standards and a framework for managing this set of quality indicators once the resource is in place.

4.4.1 MES requests and processes

There have been 3 referrals from the Medical Examiners Service in this time period for consideration of a further review.

- 1 case was referred as the patient died with covid, this case has been referred to our Nosocomial Scrutiny Panel.

- 1 case was referred as the family raised concerns about communication and care from the consultant, this was raised and investigated as a concern, the outcomes and learning are being managed by the Clinical Director.
- 1 case was referred as family unhappy with communication around scan results by DGH medical team. The scan was not requested by VCC and VCC medical team unaware the scan had been requested and taken place. The consultant has discussed this further with the family. This has also been fed back to the involved Health Board

4.5 Divisional Risks

The risk register currently holds 194 records, 36 of which have been scored 12 and above. During the reporting period November 2022 to March 2023, there were 6 (12 and above) new risks opened and 10 (12 and above) risks closed during the reporting period.

The departments with open risks for that period are Operational Services, Integrated care, Digital Services and Medical and are related to DHCR, Q-Pulse, workforce challenges, and funding. The need to ensure the risks are updated and managed regularly has been escalated to SLT.

4.6. Significant Clinical Incident Forum (SCIF)

1 case was discussed in SCIF during this period, the incident resulted in no harm and learning was identified and disseminated.

- Process for management of referrals and admissions to the assessment unit

5.0	Effective Care Descriptor: evidence based and appropriate

5.1. Complaints

Type of concern	No.	KPI Achieved
Early resolution	6	100%
Putting Things Right (PTR) (formal concern)	19	100%
Ombudsman	1	100%

A summary of the key themes is highlighted below. Improvement plans and lessons learnt are being captured and shared where appropriate to demonstrate the learning undertaken.

VCC received 25 concerns between November 2022 and March 2023. 6 were managed as early resolutions, and 19 were managed through Putting Things Right. 3 of these concerns were re-opened

concerns. A breach of duty was identified with 1 concern which is now being managed under the Redress process related to a BI data breach. We have received 1 referral from the Ombudsman which has been actioned appropriately. The themes from the concerns for this quarter can be grouped as follows;

- Medical staff communication and attitude
- Appointments related to DHCR
- Processes around treatments
- Management of enteral feeding in the community
- Communication between VCC and GP/ HB's
- Data breach

Learning and improvements identified –

- processes to improve communication with GP surgeries being undertaken by medical directorate and Macmillan GP. Focus on linking with GP colleagues to identify the information they require and the frequency. Education sessions are also being provided for GP colleagues which include VCC structure and processes.
- clinicians continue to undertake reflective practice where communication issues have been raised. This action is owned by the medical directorate ,
- DHCR issues are being managed through a care working group and sub groups across the whole service where it is clear that ways of working and new processes have been identified as a challenge
- improvements to BI processes when sharing data.

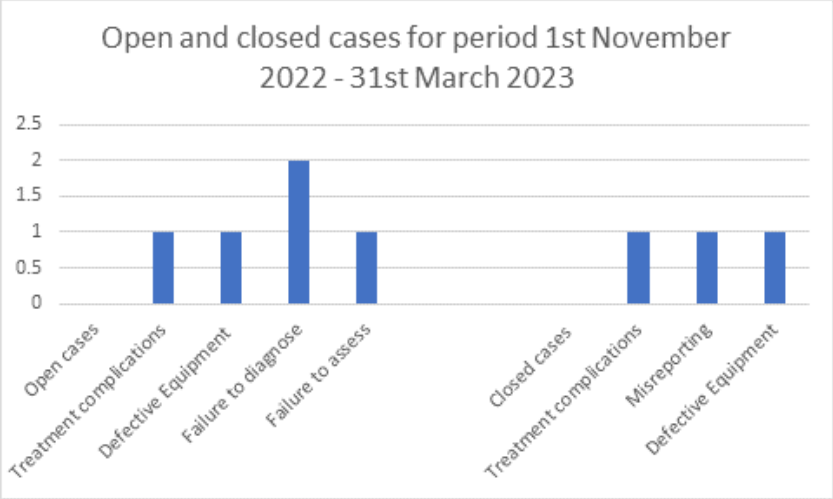
5.1.1 Claims

For the reporting period between 1st November 2022 – 31st March 2023, the Trust handled 1 new claim re: failure to recognise complications of treatment (included in the table below)

Personal Injury **Total 1** **Velindre Cancer Centre**		**Clinical Negligence** **Total 4** **Velindre Cancer Centre**	
Defective Equipment	1	Missed diagnosis / failure to diagnose	2
		Failure to assess	1
		Failure to recognise treatment	1

Closed cases between 1st November – 31st March 2023 – 3 in total. 2 in relation to Clinical Negligence and 1 in relation to personal injury. Themes below:

- Treatment complications
- Misreporting
- Defective Equipment



6.0	**Efficient Care Descriptor; avoid waste**

6.1. **Clinical audit Update:**

The Planned Clinical Audit Programme is linked to the Health Care Standards (HCS) and in addition to planned audits it also includes continuous monitoring projects and those rolled over from the previous year. Project progress is monitored throughout the year and is reported to all SST's.
The completed projects include a summary of results, areas of good practice or areas for improvement identified and any recommendations. These recommendations are then followed up at the SST meetings quarterly where progress against them is recorded. An annual summary will be included in the report for all national audits and continuous monitoring projects. It is worth noting that any projects submitted throughout the year are added to the programme and their progress will be monitored.

The 2023/24 clinical audit plan is due for approval via QSMG in April 2023. There are 93 audits on the programme. 43 of which are continuous monitoring projects such as infection control audits, and medication safety audits.

7.0	**Patient Centred Care** **Descriptor: respectful and responsive to the individuals needs and wishes**

7.1 CIVICA has now been implemented in the majority of departments within VCC. There is a choice for patients of completing 2 surveys – the quick 7 question "VCC Friends and Family Test", and the longer 28 question "Your Velindre Experience".

There are “You Said, We Did” boards in all departments for patients, visitors, and staff to see how each department is utilising the feedback they are receiving, the updating of these boards is the responsibility of department leads.

Service	Responses	1 - Overall, how was your experience of our service?	2 - Did you feel that you were listened to?	3 - Were you able to speak Welsh to staff if you needed to?	4 - From the time you realised you needed to use the service, was the time you waited:	5 - Did you feel well cared for?	6 - If you asked for assistance did you get it when you needed it?	7 - Did you feel you understood what was happening in your care?	8 - Were things explained to you in a way that you could understand?	9 - Were you involved as much as you wanted to be in decisions about your care?	10 - Using a scale of 0 to 10 where 0 is very bad and 10 is excellent, how would you rate your overall e	Overall
		VCC - Friends and Family	Your Velindre Experience	Your Velindre Experience	Your Velindre Experience	Your Velindre Experience	Your Velindre Experience	Your Velindre Experience	Your Velindre Experience	Your Velindre Experience	Your Velindre Experience	
Catering services	1	-	100	-	100	100	100	100	100	100	100	100
Clinical Trials	27	-	99	50	75	99	100	95	98	99	96	95
Nuclear Medicine	15	100	-	-	-	-	-	-	-	-	-	100
Nursing	93	100	91	72	81	96	96	92	94	93	92	93
Outpatients	161	95	89	61	71	93	91	86	88	87	89	87
Palliative care	9	-	100	83	89	100	100	89	94	100	96	96
Pharmacy	20	95	-	-	-	-	-	-	-	-	-	95
Radiology	67	89	95	67	80	94	95	95	95	96	94	92
Radiotherapy	36	95	97	-	70	98	100	94	96	92	97	93
SACT	290	100	100	0	89	100	100	100	100	100	100	100
	Overall	98	93	63	75	95	95	91	92	92	92	92
	Benchmarks	85	85	85	85	85	85	85	85	85	85	92

There has been an improvement in the number of CIVICA reponses within the cancer centre overall, and particularly in outpatients department following the use of CIVICA QR code being included in the patients appointment letter. SACT continue to receive an increased number of feedback surveys also.

The responses related to “waiting times for the service” are low overall. Further analysis of the feedback identifies 15% of respondents felt they waited too long, the majority being reported from outpatients. The quality and safety team are working with departments and directorates to explore the feedback, to investigate further and support the departments to identify improvements and actions. This data is not comparable with the previous report as the number of CIVICA responses have increased significantly however a comparison can be provided in the next report and an update on actions assuming that the increased numbers of responses continues.

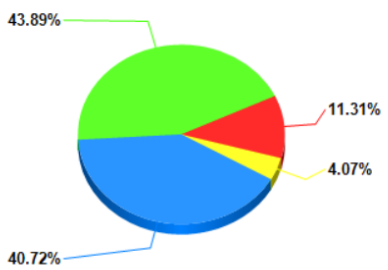
Question 4: From the time you realised you needed to use the service, was the time you waited:

Survey: Your Velindre Experience

Available Answers	Responses	Score (%)
Shorter than expected	90	40.72%
About right	97	43.89%
A bit too long	25	11.31%
Much too long	9	4.07%
Total	221	100%

View Demographic Report

Create new action



The responses for ‘ability to speak Welsh’ also remains low overall, and remains on the VCC Language

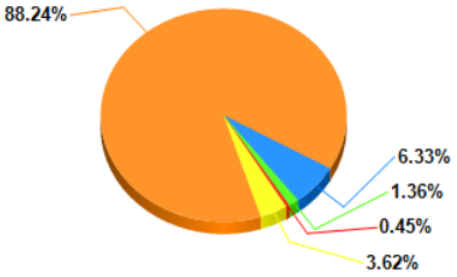
Working Group agenda. Again a deeper review of this data shows that 8 patients reported to never be able to speak Welsh to staff if they needed to, and 17 responding they always or usually could. The question was not applicable for 195 of the responders.

Question 3: Were you able to speak Welsh to staff if you needed to?

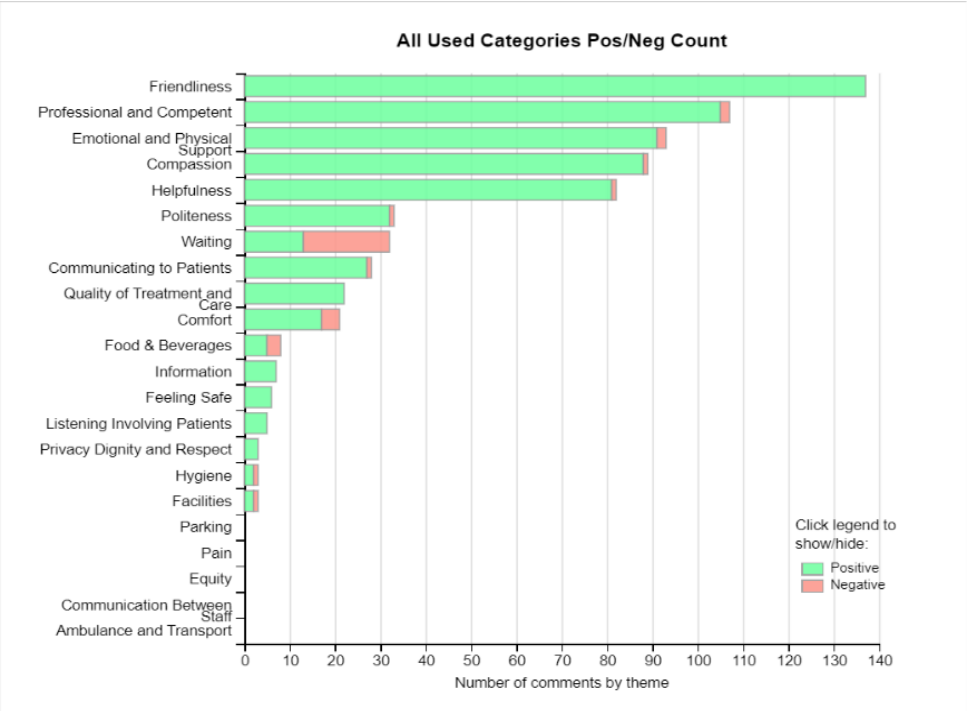
Available Answers	Responses	Score (%)
Always	14	6.33%
Usually	3	1.36%
Sometimes	1	0.45%
Never	8	3.62%
Not applicable	195	88.24%
Total	**221**	**100%**

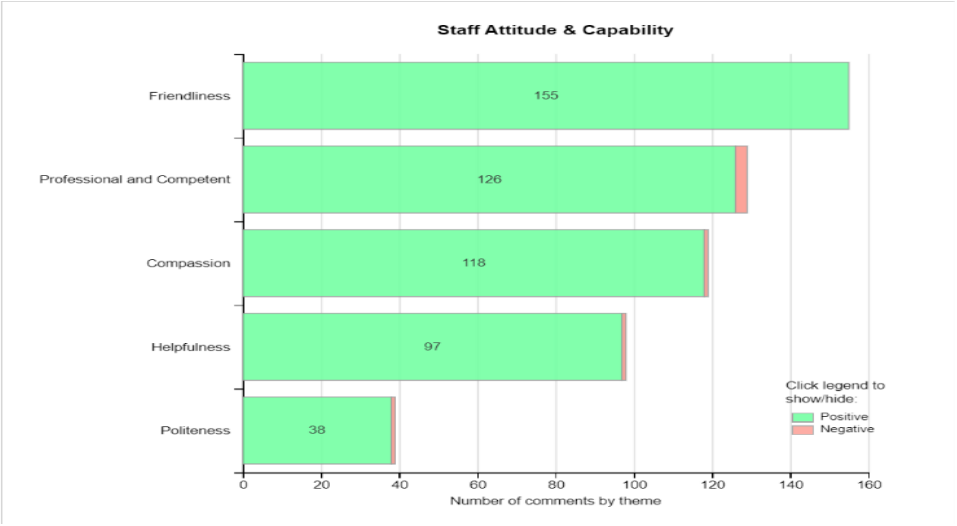
View Demographic Report

Create new action



An analysis of the comments provided in the surveys by the patients identified the following information





Feedback received:

Clinical Trials	Radiotherapy	Chemotherapy Day Unit
The staff are amazing, they treat me with respect and their professionalism is outstanding. They are truly the "Rolls Royce" of nursing.	The Radiotherapy experience was very good and I was put at ease on each session	All staff were very friendly and very reassuring and there was a relaxed but professional atmosphere in the unit

Outpatients	Assessment Unit	Inpatient Ward
First rate service from reception to treatment. All personnel friendly efficient and well trained. Detailed, fast, efficient, friendly & caring. It took away a lot of the anxiety around the appointment	You are never felt rushed staff always have the time to listen and answer any questions in a way you understand	Outstanding care and support that have been shown from all members of staff on the ward. This included absolutely all staff from the nurses and doctors to the catering staff and the cleaners. The atmosphere was really positive and kind and made a huge difference to a very difficult time that the patient and her family were experiencing. The nurses were all amazing. One of the patients daughters works as a DN and has been in multiple hospitals but says that this is my far the cleanest hospital/ ward that she has ever seen. She was very impressed by the dedication of the cleaning staff. They also said the food was really lovely and the family very much appreciated the cups of tea that they were given when they were staying for prolonged periods.

Compliments are recorded on the Datix system. From 1st November 2022 until 31st March 2023 there were 72 compliments recorded.

On behalf of the family we would like to thank you and your wonderful staff for caring, compassion and expertise with the treatment administered to our Mother during her illness

Thank you for your dedication and hard work, you treat everyone with respect.
You cheer everyone up when they are down.
Thank you so much

7.2 WHAT OUR REGULATORS / EXTERNAL / INTERNAL AUDIT ARE SAYING

Patient and Donor Experience Internal Audit

An internal audit was conducted across the trust on patient and donor experience. We received the final report in January 2023 and VCC received reasonable assurance. An action plan has been produced following the recommendations and is being managed through QSMG (**see appendix A**). The appointment of a Patient Experience and Concerns Manager in VCC who joined full time from 1st April 2023 will drive this work forward.

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

Clinical Audit Internal Audit

A recent internal 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 (**see appendix B**). Overall, a 'Reasonable' assurance rating was reported across all 5 objectives (strategy, plans, action plans, monitoring and learning)

The findings demonstrated that the Trust has an approved clinical audit approach, however 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

It was acknowledged that the implementation of AMaT, which has now been implemented, would

provide the foundation for standardisation and aide with some of the areas identified for improvement.

National Review of Consent to Examination and Treatment Standards in Wales

A review was conducted across all Health Boards and Trusts in Wales by the Welsh Risk Pool in 2022 and the results provided in January 2023.

VCC received Reasonable Assurance that arrangements to secure governance, risk management and internal control in relation to Consent to Treatment are suitably planned and applied effectively. An action plan has been devised from the recommendations and is being managed through QSMG (**see appendix C**)

CHC Unannounced Visit First Floor

First Floor ward received an unannounced CHC visit on 24th February 2023 (**see Appendix D**). The findings were overall very positive, noting the positive feedback they had received form patients about their care and the attitude of staff on the ward. CHC identified areas for improvement around the availability of storage for equipment, and the availability of medication for patients on discharge (not always available from one pharmacy).

The CHC provided the following recommendations.

1. The Managers pass on the thanks of the patients to the staff for the excellent level of service and care on the Ward, and for the initiatives to improve the welfare of patients.
2. Ensure that the design of the Ward in the new hospital has sufficient storage space for equipment and space between the beds for privacy.
3. Ensure that prescriptions are available in one location for the patients on their discharge from hospital.

To note - HIW IRMER Inspection to be undertaken in radiotherapy department in May 2023 and an update will be provided in the next report.

15 Steps

The VCS has adopted a coordinated approach to managing the 15 Step challenges, those which have been undertaken and those which are planned going forward. The challenge and action plans are centralized via cancer services management offce with a Teams channel set up for updating actions. This should ensure that duplication of effort is avoided and that a prioirtised list of actions where there is a cost associated with them will be overseen by by SLT. There were no 15 step challenges undertaken during this reporting period. The majority of actions for the 15 step challenges previously undertaken have been completed.

Actions identified through the 15 step challenge undergo a health and safety risk assessment as part of a cost benefit analysis in the context of the current financial challenge and forthcoming move to nVCC.

The outstanding actions are as below:

Radiotherapy

There are 4 actions left open for Radiotherapy which include the uneven floor outside L5. A risk assessment has been completed of the floor area and a review by estates. The other 3 action have contuining improvements recorded.

Outpatients
The two outstanding actions for Outpatients are the reclocation of the Reception Desk which is being planned, and pursuing an alternative phlebotomy location. A review of the phlebotomy service is being undertaken as part of the Divisions pathway programme in order to determine the most appropriate service delivery model. This will determine the utilization requirement for phlembotomy. Both actions are owned by the Directorate Lead.

First Floor
Out of 32 actions, there are currently two actions outstanding in relation to the flooring and a door entry system.

Therapies
Of the outstanding actions, four are due to be closed in either April or May 2023. The remaining two are behind schedule but the service has actions to complete these.

Brachytherapy Peer Review

A peer review of the Brachytherapy Service at Velindre Cancer Centre by Clatterbridge Cancer Centre (CCC) was commissioned in 2021 and took place in May and June 2022. The initial (draft) report was received on 25th July 2022 and following accuracy checks a final version was received by the Velindre Cancer Centre on 2nd September 2022.

The peer review report made 134 recommendations for the Brachytherapy Service to consider as service improvements. On review of the CCC report, there were a number of themes identified as follows: Workforce; Safety and Quality Management (Policy / Procedures; Training / Resilience & Professional Development; Capacity & Efficiency; Communication; the estate and nVCC. The report acknowledged multiple areas of good practice, and the Clatterbridge team also reported implementation of some of the good practices and procedures observed in VCC. The peer review did not suggest any fundamental changes to the treatment techniques provided by the Cancer Centre as it was recognised that these are already in line with national recommendations

Of the 134 recommmedations, 77 have now been closed. There were initial 7 recommendations categorised as strongly needing to be implemented. There remain 2 outstanding, one which is due for closure by end of May 2023. The other outstanding recommendation relates to the development of a clinical skills training package for ultrasound brachytherapy. Discussions have taken place with HEIW who will need to lead this work as there is currently no training programme in Wales. However, there is a 2-year timeframe allocated to this work. A conversation has also taken place with CCC in relation to their ability to providing this training. Unfortunately they have indicated due to their own resources issues they will not be able to provide this (**see appendix E**)

Private Patients Improvement

Following receipt of an External Private Patient review report identifying critical areas for improvement with the Velindre Cancer Centre's Private Patient service it was agreed by both the Executive Management Board and

Audit Committee that a Private Patient Improvement Group would be established to drive through and oversee the required improvements. A consultancy firm 'Liaison' have been appointed to work with the Trust. Key work ongoing includes the review of existing pathways and contracts, development of a policy for the management of Private patients and management of aged debt. Aged debt continues to be monitored through the audit committee.

8.0	Timely Care

8.1 Service improvements or projects undertaken

Safe Care Collaborative
VCC have identified 2 Safe Care Collaborative Projects,

- Malignant Spinal Cord Compression Pathway –
  - Aim: The project will aim to improve the Metastatic Cord Compression Pathway and prevent delays in treatment and improve patient experience.
  - Patients diagnosed with MSCC who are treated with Radiotherapy at VCS are treated with emergency intent (typically, 3-4 patients per week). Currently, this requires active treatment to begin within 24-hours of referral for treatment with Radiotherapy. Patients treated at VCS are typically already admitted as inpatients in secondary care settings elsewhere and are transported to the Centre by (non-emergency) ambulance in anticipation of treatment. Transport is provided by the Welsh Ambulance Service Trust (WAST) and the service is delivered principally by the 'dedicated' ambulance and crew based at VCS. The treatment of these patients with External Beam Radiotherapy requires them to undergo a planning scan (CT/MR) at VCS. The scan is used to develop a treatment plan prior to treatment commencing. Current practice assumes that any such patient, on the same day, should be transferred to VCS, undergo a scan to facilitate the production of a plan and receive treatment before being returned to the setting in which they are undergoing on-going care. Delays in any area of the process can mean a delay in the patient receiving their radiotherapy treatment.
  - Project status: Early stages; a VCS working group has been established, dialogue with which was on a revised operating model commenced in February 2023. A revised service level agreement is being drafted and the aim is that by the end of May 23, there will be a revised service model.

- SACT Telephone Helpline
  - Aim: To improve the treatment helpline and ensure that there are clear pathways for escalation of deteriorating patients and eliminate helpline related patient harm.
  - The Velindre Cancer Service SACT & Medicine Management Directorate has reviewed the data that has been captured by the team within the UKONS triage tool and has identified that approximately 50% of the calls being directed to the SACT Treatment Helpline (STH) are not appropriate or within the remit of the STH.
  - Project status: Early stages; a VCS working group has been established.

<u>The Unwell Patient Project</u>
The Unwell Patient Project is beginning in May 2023 with the aim to explore collaborative and efficient ways to improve scheduled and unscheduled acute oncology services at VCC ensuring that sustainability, innovation and the patient-centred approach is optimised. Numerous workstreams have been identified including VCC clinical

model, leadership, workforce model, resuscitation standards, patient transfers, regional AOS work, and patient experience and outcomes. An update on the proect will be provided in the next report.

9.0	**Equitable Care** **Descriptor; an equal chance of the same outcome regardless of geography, socioeconomic status**

9.1.1 Healthcare Standards

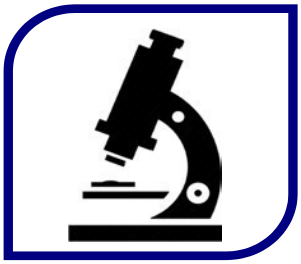
The Q3 Health & Care Standards were approved at SLT meeting in February 2023 and the scores were as follows. To note there were no changes to the scores in this quarter 3 updates:

	Score 2021/22	Score Q1	Score Q2	Score Q3
Safe care				
Std 2.1 Managing Risk and H&S (VC&LM)	Partial	4	4	4
Std 2.2 Preventing Pressure Damage	Partial	4	4	4
Std 2.3 Falls Prevention	Partial	4	4	4
Std 2.4 Infection Prevention and Control	Partial	4	4	4
Std 2.5 Nutrition and Hydration	Partial	4	4	4
Std 2.6 Medicines Management	Full	5	5	5
Std 2.7 Safeguarding	Partial	4	4	4
Std 2.8 Blood Management	Full	5	5	5
Std 2.9 Medical Devices, Equipment and Systems	Partial	4	4	4
Effective care				
Std 3.1 Safe and clinically Effective Care	Full	**4**	**4**	**4**
Std 3.2 Communicating Effectively	Partial	4	4	4
Std 3.3 Quality Improvement, Research and Innovation	Full	5	5	5
Std 3.4 IG and Technology	Full	4	4	4
Std 3.5 Record Keeping	Full	4	4	4
Dignified care				
Std 4.1 Dignified Care	Partial	4	4	4
Std 4.2 Patient Information	Partial	4	4	4
Timely care				
Standard 5.1 Timely Access	Full	**3**	**3**	**3**
Individual care				
Std 6.1 Promote Independence	Partial	3	3	3
Std 6.2 Peoples Rights	Full	4	4	4
Std 6.3 Learning from Feedback	Full	3	3	3

Learning Infographics

The learning infographics below show the themes from incidents, claims and are where Directorate leads are being asked to focus their efforts on learning, retraining and intervention. There are many improvement plans in place in all of the Directorates to address some of the themes. These improvement plans are monitored through the Velindre Futures Board and through the IMTP for each Directorate.

Velindre Cancer Centre themes from incidents and feedback

Appointments 	Staff Attitude / Behaviour 	Clinical Services/Assessments 
Communications issues (Including Language) 	Infection Control 	Monitoring and Observations 
Access to Services and Resources 	Test and Investigation 	Patient Care 

10.0	Performance

10.1 VCC Performance Summary upto an including March 2023 data.

(see appendix F)

11.0	Celebration and Exception

11.1 Celebrations

In celebration of 40 Years of Nursing, Michele Pengelly has teamed up with Velindre Cancer Charity and our communications team to deliver an exciting campaign and charity challenge.

Congratulations to Dr Hilary Williams who has been elected as the Royal College of Physicians' (RCP) next Vice President for Wales.

Professor Mark Taubert was nominated in the Critical Worker (Key Worker) category for the St Davids award, which recognises an individual, team or group in Wales working in health and social care, the third sector, the emergency services, local government, education or childcare.

12.0	Conclusions

There is evidence that incidents/concerns/compliments continue to be consistently managed appropriately and compliant with the PTR regulations, the VCC team have worked hard to achieve 100% compliance with the national KPIs. Lessons learned and actions are implemented and monitored by Directorate leads and their teams, the Q&S Team recognise there is more improvement work needed and additional resources within the team will allow this work to be taken forward. The team recognise the Cancer Centre wide quality culture shift that is required is starting to have a positive effect and this will be further enhanced by the development of the VCC Quality Hub.

Following review the Quality and Safety team have set out the VCC quality priorities for 24/25 these are;

- Compliance with the Duty of Quality & Duty of Candour,
- SACT treatment helpline improvement,
- MSCC treatment pathway,
- improvement in timely incident management,
- work towards organisation culture that "quality is everybody's responsibility", clear improvement plans to be established and owned by departments following concern investigation.

Patient and Donor Experience
Final Internal Audit Report

January 2023

Velindre University NHS Trust

Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Contents

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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.

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

[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.

[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.

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		

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		

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

[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.

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.

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Clinical Audit (Velindre Cancer Centre)

Final Internal Audit Report

January 2023

Velindre University NHS Trust

Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Contents

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Executive sign-off:	Jacinta Abraham, Medical Director
Distribution:	Nicola Hughes, Acting Medical Directorate Manager Sara Walters, Clinical Audit Manager 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.

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

[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.

[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.

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

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)

	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

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

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

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

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.

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.

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Cronfa Risg Cymru
Shared Services Partnership
Welsh Risk Pool Services

A National Review of Consent to Examination & Treatment Standards in NHS Wales

A Report by the Welsh Risk Pool Safety and Learning Team

Velindre NHS Trust

Draft Report January 2023

Rhaglen Cydsynio i Driniaeth Cymru Gyfan

All Wales Consent to Treatment Programme

Gwella Diogelwch Cleifion Trwy Ddysgu
Improving Patient Safety Through Learning

A National Review of Consent to Examination & Treatment Standards in NHS Wales

A Report by the Welsh Risk Pool Safety and Learning Team

January 2023

About this Report

This report is intended for health bodies within NHS Wales, with the aim to improve patient safety and compliance in relation to the process for sharing information and obtaining informed consent to examination and treatment.

The report follows an evidence-gathering exercise against the published Welsh Risk Pool Standard. Each health body was invited to provide evidence and populate a structured template against each Area of Assessment.

This report provides draft findings for each health body and is circulated for comments and factual accuracy considerations.

The report identifies a number of proposed recommendations. These are shared to enable each organisation to develop an action plan which addresses the findings and supports the prioritisation of improvement activity in this topic area.

Once factual accuracy comments have been considered, a final copy of the report will be shared with organisations, with the relevant action plan included to assist with future reviews.

Evidence Gathering	May 2021 – Sep 2021
Pause due to pandemic	Oct 2021 – Sep 2022
Evidence Gathering Update	Oct 2022 – Dec 2022
Draft Findings shared	January 2023
Action Plans Received	AWAITED
Final Report Published	ANTICIPATED MARCH 2023

Version
VUNHST Report VDraft1

CONTENTS

1 Purpose of Review

1.1 A number of significant clinical negligence claims submitted to the Welsh Risk Pool Committee (WRP) relate to failures to provide patients with information and failures to document what information was provided.

1.2 In particular, the discussions that took place regarding the benefits and risks (including material risks) of the proposed treatment and the benefits and risks of any available alternative treatments (including no treatment).

1.3 The WRP committee has requested that the Welsh Risk Pool Safety & Learning Team undertake a review of the organisations policies and their clinical application, for obtaining informed consent to examination or treatment with a particular focus on the areas identified above.

1.4 Outputs from the assessment will be an All-Wales summary report and individual reports for each of the organisations assessed. The reports will provide recommendations to enable organisations to develop an improvement plan to address areas for development.

2 Scope of Review

2.1 The aim is to assess the policies and their clinical application in Health Body against the All-Wales Consent to Examination or Treatment Model policy. The WRP has produced an assessment tool that outlines the areas for assessment. This was circulated to the organisation's executive and operational leads for consent to assist organisations in identifying the evidence required to be submitted as part of the assessment.

2.2 The assessments commenced in May 2021 starting with the collection by the organisations of the evidence outlined in the assessment tool. The terms of reference included the opportunity for site visits and staff interviews to consolidate evidence.

2.3 By completing the assessments, organisations were required to scrutinise and interrogate their consent processes. This enabled local teams to familiarise with the WRP Standard and identify source evidence which demonstrated compliance or achievement against each area for assessment.

2.4 The evidence submitted by all organisations was comprehensive and covered the topics required in the standard. Audits on consent provided an honest reflection of each organisations' own current position. This meant that further site visits were not required.

2.5 The clinical areas selected for the focus of the assessment in acute organisations were:

- Unscheduled Orthopaedics
- Elective Endoscopy
- Elective Gynaecology

2.6 The review was disrupted due to the impact of the pandemic and the WRP Committee agreed to recommence the work in this area on 21st September 2022. The Welsh Risk Pool Consent Assessment Team subsequently reviewed the information supplied by each organisation and provided the assessment material back to designated contacts for their further analysis, augmentation where required and final submission. The team did not apply an overall outcome for each standard at that time, as the process was intended to be formative. Several comments were made from the team making suggestions for change or alternative sources of evidence.

2.7 A number of organisations have managed to improve their compliance with the areas of assessment since the original evidence was submitted in 2021 and it is clear that all organisations have been working on improving consent to examination and treatment processes.

3 Assessment Team

3.1 The Welsh Risk Pool assembled a team of specialist practitioners with experience in the topic area:

Sponsor:	Jonathan Webb, Head of Safety & Learning
Field Work:	Susan Derbyshire, Clinical Assessor
	Isobel Smith, Clinical Assessor
Clinical Lead:	Ben Thomas
	National Lead - Consent to Examination & Treatment
Legal Advice:	Sarah Watt, Solicitor
	Gavin Knox, Solicitor
Oversight:	Manon Gwilym, Principal Safety & Learning Advisor
	Eleri Wright, Safety & Learning Advisor

4 Review Findings

4.1 Policy Content

The organisation has adopted the All-Wales Model Policy for consent to examination or treatment and adapted it into organisational policy format. The organisation's policy is currently due for review with a completion date of January 2023 to enable the policy to be approved through the relevant governance processes.

The policy for consent for systemic anti-cancer therapy (SACT) follows the appropriate sections of the model policy and has been adapted for the specific role that Velindre Cancer centre plays.

The organisation has a Consent Working Group. This is seen as good practice.

Compliance with Standard: COMPLIANT

4.2 Consent Forms

The organisation has a Procedure for the Production, Use and Management of Procedure Specific Consent Forms (PSCF's). Following organisational restructure resulting in a number of groups changing, this procedure is currently being reviewed. The new guidance will include the organisation's governance process in relation to the development of local PSCF's.

The organisation has officially implemented the CRUK consent forms for SACT and RCR consent forms for radiotherapy. The CRUK and RCR consent forms are developed externally and are UK national. These PSCF's are comprehensive and informative for patients and include risks and benefits plus side effects. The use of CRUK, RCR and All Wales consent forms is highlighted on the organisation's consent intranet page.

There is no legislative requirement for CRUK and RCR PSCF's forms to be made available bilingually (although RCR consent forms are bilingual). Where used, Consent forms 1, 2 and 4 are bilingual. The 'SACT consent: using the national consents forms at Velindre' guidance adopts the National SACT Consent Forms Process. Locally produced PSCF's need to be compliant with Welsh Language Standards.

Compliance with Standard: PARTIAL

4.3 Training in Consent

The Montgomery Law video is viewed as part of the junior doctor induction. A link to the video is also included in their Handbooks.

The availability of the All-Wales training module on consent - Decision Making and Consent in Wales has been publicised to all health professionals undertaking consent – junior doctors, consultants, Non-Medical Prescribers, Clinical Nurse Specialists, Advanced Nurse Practitioner, and Radiographers via e.g. the organisation's Consent intranet page and e-mail

The ESR module is in the process of being added to all relevant staff's ESR Matrix and finalisation of the frequency of training.

Compliance with Standard: COMPLIANT

4.4 Consent Process for Adults

The organisation has adopted the All-Wales Model Policy for consent to examination or treatment and adapted it into organisational format. The specific guidance for obtaining consent involving adult patients noted in Area for assessment 2 is included the organisation's policy.

During the COVID 19 pandemic, there was a rapid introduction of virtual technology to assist consultations. An Implementation of Remote Consent for SACT & RT & MRT operating procedure was developed to support this new way of working.

The guidance for remote consent was issued in 2020 as part of the SACT documentation. This has been adopted by the organisation and gives a clear flowchart and guidance on the subject. The required categories, given the specialised nature of the service, is covered in this and the organisation's Consent policy.

Compliance with Standard: COMPLIANT

4.5 Consent Process for Children & Young People

The organisation has adopted the All-Wales Model Policy for consent to examination or treatment and adapted it into organisational format. The specific guidance for obtaining consent involving children and young people adult patients noted in Area for assessment 3 is included in the organisations policy.

Safeguarding policies and procedures are available on the intranet.

Compliance with Standard: COMPLIANT

4.6 Patient Information

The organisation's intranet includes multiple and appropriate leaflets for the services offered. The organisation also has an extensive library of information resources for both patients and carers. Patients are able to visit the information resource centre that is open every day of the week – night and day. There is no evidence that the organisation has a database of patient information leaflets used within the consent process.

Although the organisation has provided evidence of how local patient information is developed and approved there is no formally approved document setting out the governance process for the development and approval of local patient information leaflets. Locally developed patient information leaflets must be compliant with Welsh Language Standards.

The organisation's consent audit confirms that provision of patient leaflets needs improvement. It is a requirement to tick in the appropriate box on the consent forms that additional information has been provided to the patient (53% at February 2021 and 41% at November 2021). Although these results do not in the organisations opinion reflect true practice, the results of the audit have been fed back to the medical directorate meeting. A consent update is also being provided to junior doctors, consultant and CNS' in their team meetings, and will include the importance of fully completing the consent forms. This will also be included in the next consent audit due to be undertaken in May/June 2023.

Compliance with Standard: PARTIAL

4.7 Monitoring of the Consent Process

It is appreciated that work is ongoing to strengthen the consent processes and this includes audit and monitoring.

The organisation has provided evidence that audits on consent continue to take place. Consent is part of the organisation's Clinical Audit Plan 2022-2023 for ongoing annual consent audit to be undertaken and the organisation has provided evidence of a recent Consent for Audit Report published in June 2022.

This audit re-enforces the need to look at the current process for how consent forms are stored. There was an increase in the number of patients who had no consent form in their paper or electronic notes and therefore no evidence of written consent.

The audit also highlight other areas for improvement such as documentation around treatment intent and responsible healthcare professional.

The organisation reports the highlights of the Consent Audit and Improvement Action Plan at various levels e.g. VCCQSMG, the consent T&F group and at board level at QSP.

The results of the consent audit were fed back within the medical directorate weekly meeting. A consent update is also provided to junior doctors, consultant and CNS' in their team meetings, and will include the importance of fully completing the consent forms.

The organisation has developed a further consent action plan building on the improvement. This provides evidence that shortfalls identified continue to be addressed and progress is being made in relation to the consent action plan.

Compliance with Standard: PARTIAL

5 Assurance Rating

5.1 Having considered the evidence submitted against each Area for Assessment, the Review Team have determined an overall assurance rating. This utilises the NHS Wales Internal Audit Framework outlined in Appendix 1.

REASONABLE ASSURANCE		The organisation can take **reasonable assurance** that arrangements to secure governance, risk management and internal control in relation to Consent to Treatment are suitably planned and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.

6 Main Themes

6.1 The organisation's policy on consent is in place and covers the required topics. Procedure specific examples for consent were provided and show compliance with requirements.

6.2 A clear training programme is in place and consent is part of the organisation's Clinical Audit Plan 2022-2023 for ongoing annual consent audit to be undertaken.

6.3 Audits have identified that there is a lack of evidence that patients have been provided with relevant procedure specific information leaflets, there was also evidence that not all consent forms were available in the patient records. The organisation is working to strengthen the consent processes through audit and monitoring.

7 Recommendations

It is recommended that the organisation:

7.1 Completes the policy review and approval through the relevant governance processes.

7.2 Finalises the review of the organisation's Procedure for the Production, Use and Management of Procedure Specific Consent Forms and ensures that it includes the organisation's governance process in relation to the development and approval of local Procedure Specific Consent Forms. This guidance should take into consideration the All-Wales Principles and framework for the development and approval of PSCF's and All Wales Model PSCF Template.

7.3 Implements the requirement for all clinicians who take consent from patients to complete a recognised training programme. It is recommended that the frequency of this training should be at least once per revalidation cycle for the relevant professional group, it being accepted that such training is more relevant to some groups than others. This could be either via the national e-learning consent training package or an approved in-house face to face training session.

7.4 Develops a database of patient information leaflets used within the consent process.

7.5 Develops a formally approved document setting out the governance process for the development and approval of local patient information leaflets.

7.6 Puts a process in place to comply with the 'Criteria for use of Procedure-specific Patient Information Leaflets following publication of RMA2020-01' namely - Where an organisation wishes to deviate from the use of an EIDO patient information leaflet, or where no EIDO leaflet or compliant alternative is available, this will need to be notified via email to consenttreatment@wales.nhs.uk

7.7 Undertakes a peer review of the organisation's consent process using the peer review tool developed on an All-Wales basis. In addition to monitoring the organisation's consent process it will enable the organisation to comply with requirement number 6 of the WRP RMA 2020-01 Consent to Treatment - monitoring of compliance with the requirements of consent to treatment documentation (which may be in patient records or on a consent form) of the provision of procedure specific patient information leaflets.

7.8 Continues to monitor and address any shortfalls in the use, provision of and documentation of patient information leaflets and addresses any shortfalls.

7.9 Continues to monitor and address any shortfalls in consent form storage by developing an improvement plan so that consent to treatment documentation is available to confirm that the patient was correctly informed to make the relevant choice in a 100% of occasions.

8 Conclusion

8.1 Velindre NHS Trust can take reasonable assurance in respect of the processes relating to Consent to Examination & Treatment.

8.2 The organisation is aware of the shortfalls identified in the consent and governance processes.

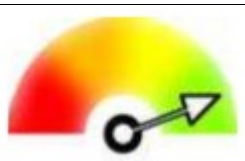
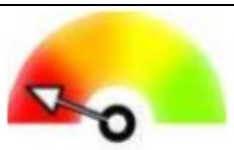
8.3 The Welsh Risk Pool wish to thank the NHS organisation and the staff who were involved in this assessment. The effort involved for those who participated is much appreciated.

9 Appendices

Appendix 1 NHS Wales Assurance Framework

Appendix 1

NHS Wales Assurance Framework

SUBSTANTIAL ASSURANCE		The organisation can take **substantial assurance** that arrangements to secure governance, risk management and internal control in relation to Consent to Treatment are suitably planned and applied effectively. Few matters require attention and are compliance or advisory in nature with low impact on residual risk exposure.
REASONABLE ASSURANCE		The organisation can take **reasonable assurance** that arrangements to secure governance, risk management and internal control in relation to Consent to Treatment are suitably planned and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.
LIMITED ASSURANCE		The organisation can take **limited assurance** that arrangements to secure governance, risk management and internal control in relation to Consent to Treatment are suitably planned and applied effectively. More significant matters require management attention with moderate impact on residual risk exposure until resolved.
NO ASSURANCE		The organisation has **no assurance** that arrangements to secure governance, risk management and internal control in relation to Consent to Treatment are suitably planned and applied effectively. Action is required to address the whole control framework in this area with high impact on residual risk exposure until resolved.

CYNGOR IECHYD CYMUNED
COMMUNITY HEALTH COUNCIL

DE MORGANNWG | SOUTH GLAMORGAN

CHC Visit Report
(Unannounced)

1st Floor Ward,
Velindre Cancer Centre

24th February 2023

Accessible formats

If you would like this publication in an alternative format and/or language, please contact us.

You can download it from our website or ask for a copy by contacting our office.

Contact Information

South Glamorgan Community Health Council
Pro Copy Business Centre (Rear)
Parc Ty Glas
Llanishen
Cardiff
CF14 5DU

Telephone: 02920 750 112
Email: SouthGlam.Chiefofficer@waleschc.org.uk

Contents

Your Community Health Council

Community Health Councils (CHCs) are the independent watch-dog of NHS services within Wales and we seek to encourage and enable members of the public to be actively involved in decisions affecting the design, development and delivery of healthcare for their families and local communities.

CHCs seek to work with the NHS and inspection and regulatory bodies to provide the crucial link between those who plan and deliver the National Health Service in Wales, those who inspect and regulate it, and those who use it.

CHCs maintain a continuous dialogue with the public through: a wide range of community networks, direct contact with patients, families and carers through enquires, our Complaints Advocacy Service, visiting activities and through public and patient surveys, with the CHC acting as the "Public & Patient Voice" within Cardiff and Vale of Glamorgan.

Visit Overview

Two members of the CHC visited 1st Floor Ward, Velindre Cancer Centre on 24th February 2023 at 10:00am. This visit was originally intended to be an announced visit and agreed between the CHC and Velindre Cancer Centre, but due to an administrative error in the visit schedule, staff were not aware CHC Members would be visiting this month and, therefore, would now be classed as an unannounced visit.

The purpose of the visit was for the visiting team to observe the environment, quality of service provision being provided on the Ward and to gather the views and experiences of the patients, carers and visitors whilst on the ward and wider site.

As part of the visit, members of the CHC were able to speak with the following NHS Staff:

- Ward Manager

Briefing Information

Management Arrangements

The 1st floor Ward, Velindre Cancer Centre is a part of the Velindre Cancer Centre Nursing Clinical Board and sits within the Integrated Care Directorate. The area is managed by a Ward Manager.

Introduction

The 1st floor ward provides specialist inpatient Oncology care. The ward has 30 beds and 2 isotope cubicles (currently 20 and 2 isotope cubicles available due to social distancing requirements in response to the COVID Pandemic), there are 8 cubicles and 2 additional cubicles off the ward that safely accommodate isotope patients. The ward is split with a female and male side.

Patients are admitted to the 1st floor ward for clinical management of an array of specialist Oncological interventions examples are described below:

- Metastatic Spinal Cord Compression (MSCC treatment and management).
- Specialist Radiotherapy treatment.
- Head and Neck cancer management and support to patients who are experiencing toxicity of radiotherapy treatment where the treatment is often curative but radical and where the patient is not able to be managed on an ambulatory care basis.
- Neutropenic Sepsis management.
- Elective inpatient Systemic Anti-Cancer Treatment [SACT] where the regime requires it.

Capacity

The 1st floor ward has a commissioned capacity of 30 beds and 2 isotope cubicles. Throughout the pandemic, the beds were reduced to 20 to comply with social distancing, due to recent changes in the guidance the bed spaces have been reviewed and the ward can now admit up to their 30 plus 2 bed capacity. There are 8 cubicles, 5 with en-suite facilities

which support isolation of patients with infection and also provide dignity to patients and a place for families to be present in the patients' last days of life.
Additionally, there are 2 cubicles situated off the ward that safely accommodate patients receiving radioactive isotope treatment.

The social distancing requirements have prevented 1st floor ward from opening beyond 20 inpatient beds throughout each wave of the pandemic but have recently reverted to their full capacity of 30 plus 2.

There are no concerns in relation to capacity and current demand but an important development has been the expansion in ambulatory care capacity to enable the ward to continue to manage patients who require Oncology treatment and can be managed as a day case.

Over the preceding 3 months, admission numbers have been:
Oct 2022 = 32
Nov 2022 = 49
Dec 2022 = 47
Total admissions= 128

The ward provides the following Tertiary services:

- Systemic Anti-Cancer Treatment,
- Radiotherapy,
- Brachytherapy

These services are provided for:

- Cardiff and Vale UHB
- Cwm Taf Morgannwg UHB
- Aneurin Bevan UHB
- Powys UHB
- Hywel Dda UHB
- Swansea Bay UHB

There are issues with repatriation to local UHB's due to bed capacity which has been exacerbated by the COVID-19 pandemic. Patients often are discharged home or to a Hospice from 1st floor ward and all of the social and community support referrals are performed by the Nursing staff on 1st floor ward to support safe discharge home. On occasions, the response to these referrals is delayed due to external capacity, patients can be waiting a considerable time to be discharged home or repatriated.

Delayed transfer of care data is submitted every month as part of the cancer centre tier 1 target submission.

Staffing

Velindre Nurse staffing levels are set by the requirement to comply with The All Wales Nurse Staffing Act. They participate in the required twice-yearly acuity data submissions and monitor Datix for any non-compliances with the required staffing levels – there are no Datix reports in relation to non-compliance with the required staffing levels.

The 1st Floor Inpatient Ward Nurse staffing levels are:-

- 1 Ward Manager
- 7:00 - 19:30
    - 1 Nurse Co-ordinator,
    - 4 Registered Nurses
    - 3 Health Care Support Workers
- 19:00 – 7:30
    - 1 night sister who is also site manager and triage of patients calling the treatment helpline,
    - 4 Registered Nurses
    - 2 Health Care Support Workers

Per shift requires Registered Nurse (RN) ratio of 1 RN to 6 patients.

The wards' medical cover is:

- Consultant on call
- Registrar on call
- SHO team – normally at least 3 on site during the day, and 1 resident overnight. There is also a second ALS trained staff member resident in the 'hospital house' opposite the main entrance should they need to be called to assist with the deteriorating patient.

In addition to the above core staffing, the Ward is also supported by by the multidisciplinary team to meet the needs of the patient as required.

The ward is currently running with a number of vacancies for Registered Nurses, which are currently being recruited into.

The centre is currently recruiting Registered Nurses at present and don't have any issues to report with regard to recruitment, there are a small number of Band 5 vacancies currently out to recruitment.

There are no vacancies of junior Doctors, one is on maternity leave. The Centre is due another rotation in August. Their numbers currently are:
10 SHO's
14 SPR's

This situation is alleviated as some staff have worked extra shifts as overtime, occasionally HCSW are used via agency to support 1-1 patient supervision otherwise agency staff are rarely used and no agency registered nurses are used.

The ward does not currently have input from volunteers due to the COVID-19 pandemic. During the first wave, based on national guidance, the centre made a decision to limit the footfall into the centre and therefore ceased using volunteers on site.

Opening/Operating Arrangements

The wards' opening/operating arrangements are as follows:

- The ward operates 24 hours a day, 7 days a week.
- The ward operates protected mealtimes.
    - Breakfast 7:00/7:30
    - Lunch 12:00/13:00
    - Tea 17:00/18:00

Visiting is currently on compassionate grounds only due to the COVID-19 Pandemic. This visiting is assessed and authorised by the nurse in charge of the ward and is under continuous review.

Velindre Cancer Centre have devised a COVID passport for patient's carer to be allowed on site in support of their loved ones when performing personal care or feeding for example.

Visitors are triaged/ screened at the main entrance in relation to COVID-19 symptoms.

There are times where access to patients/carers may be difficult due to the additional pressures because of the COVID-19 pandemic, however patients and families are encouraged to use virtual calls as a way of keeping in touch.

Environmental Improvements

The ward last had work undertaken on 31/01/2022. The ward environment was assessed and performed exceptionally well achieving overall average of 99.9%. The identified actions for improvement were:

- Painting of walls, door frames and wall bunding along all the main corridors & reception area.
- Renewing the reception desk as it is chipped in several areas.
- In most toilets/showers and storerooms both sides of the ward, the wall bunding requires attention.

Quotes have been obtained for these works however funding is currently being sourced.

The following work is required to be completed:

- Painting of walls, doorframes and wall bunding along all the main corridors & reception area.
- Renewing the reception desk as it is chipped in several areas.
- In most toilets/showers and store rooms both sides of the ward, the wall bunding requires attention.

The ward currently has no outstanding requests for work that could be considered urgent.

Initiatives

Therapies are currently implementing an Enhanced Discharge Service to support patients being safely discharged as soon as they are medically fit.

The Ward Manager has implemented a system of employee of the month to support staff morale.

Patient Engagement

The visiting team spoke to 8 of the patients from both the men's and women's sides of the ward.

Staff Care: The patients were all very complimentary about the level of care and support from the ward staff. The words used included: *`amazing standard of care', so impressed`, `nothing too much trouble, welcoming and wonderful`, `very good with difficult patients'.* They commented that cancer is not a nasty word and can de discussed with staff comfortably. There is a pleasant, positive and happy atmosphere with staff showing a sense of humor.

Communication: All the patients felt that they had been properly informed about their treatment plans and medication needed by the doctors. There were call bells by each bed, and the majority of patients said that the staff responded to a call very quickly.

Food: On the whole, the food was felt to be good, with a variety of choice and appetising and good quality meals. There was plenty of access to drinks.

Visiting times: The amount of time allowed to individual patients for family and friends to visit varied according to their individual circumstances and if they were receiving end of life care. Some patients could only have one visitor booked for an hour each day, while others could have more people for longer periods of time. One patient commented that there was an arrangement for his wife to visit to help with the feeding procedure so that she could learn how to manage when he returned home.

Ventilation: With the patients able to control their own windows, they did not regard the heat on the ward as a problem.

Noise levels: some patients commented that they were unhappy with the level of noise on the ward. One cause was from the sound of the trolleys as they were pushed, sometimes at speed, through the ward. A patient suggested that rubber wheels may help. The noise of blaring TV sets was also mentioned. During the pandemic, headphones were no longer used and are sometimes left blaring in the evenings.

Prescriptions: The visiting team were advised that there was a problem with a hospital issued prescription. It contained both hospital and community pharmacy items, so the patient could not be issued with the prescription items from either the hospital or the community pharmacy. The patient had to go to another hospital to obtain all the medication, which caused stress and anxiety.

Environment

A Ward Environment Audit was undertaken by the hospital on 31.01.22. It found that the areas for improvement were some painting of walls and door frames, renewing the reception desk and attention to the wall bunding in the toilets/showers. The visiting team observed that some decoration had taken place in the reception and changing areas, and some areas of flooring had been improved but that the reception desk had not been replaced, and the showers are still in need of improvement.

Funding is being sought for the further works, although it may not be a priority with the planned move to a new site in due course.

There were interesting and informative notice boards on the ward walls detailing: the staff on the ward with the colour of their uniforms, guidelines on infection control, feedback from patients with responses from staff, and information about assessment and care records. There was no CHC poster on the wall.

The ward was calm and well organized, however some of the corridors were cluttered with equipment as the ward has insufficient storage facilities.

In the previous CHC report dated July 2021, many patients were complaining about the level of heat on the ward. In response, a Ventilation Group was established by the hospital. Patients can now open the window next to their bed and reflective screens have been installed on the windows. The Group continues to look for ways of improving the ventilation for patients.

Each bed has a TV close to it and access to call bells. Sometimes, a patient falls asleep and the TV is left blaring on the ward. The beds are fairly close to each other, separated only by a curtain. A couple of patients commented on how they are able to hear everything going on with their neighbours.

On the ward, a room called the Barbara Lewis room has been created which can accommodate relatives staying overnight when a patient is very poorly.

The ward was clean and tidy, apart from one toilet on the women`s side of the ward. When informed, the Ward Manager sent a member of staff to clean it and to check all the toilets.

Interaction with Staff

The visiting team spoke to the Ward Manager.

The Manager said that there is a capacity for 30 beds and 2 Isotope cubicles on the ward. However, they had 20 patients on that day. The staffing availability was 4 qualified nurses and 3 Health Care assistants during the day, and 3 qualified nurses and 2 Health Care assistants in the night. This is less than the establishment recommended. However, they do not employ agency staff as it is specialised work and the existing staff pick up any slack from week to week with extra shifts. In the event of a patient requiring a lot of time and attention, the Co-ordinator will step in as a back up for staff.

There is a Ward meeting each morning involving the nurses, dieticians, physios, OTs, clinic staff etc to discuss referrals, patient plans, and the use of beds. It was noted that a Social Worker is not allocated to the Ward. The doctors have a separate meeting.

The hospital is specialist and covers a wide area across South Wales and beyond. Repatriation back to the patients` areas continues to be difficult when there is a need for a package of care or a bed in a hospice. Patients often have complex needs. They remain on the Ward for rehabilitation after treatment or until local arrangements are made. The OTs make home visits and liaise with the local services.

There is a new system for patients to give feedback on the service they are receiving called Civicas. Patients were given ipads on which they can register their compliments and complaints. There is also a Bounce pad on the wall which relatives/carers can use for their comments. Feedback from this system is put on to the notice board.

The move to the new site of the hospital is being planned and the foundations being created. Staff are being consulted on the layout and details of Ward care by Acorn meetings. The Manager is hoping that the Ward storage shortage will be resolved in the new building.

A new initiative is being created and set up by the physiotherapists using a MacMillan Grant. It is a Wellness Channel on a large TV with an application giving nutritional advice, a falls video and pressure relieving actions amongst other information. It will be installed in one cubicle, initially as a trial. If it is successful, it will be rolled out to all the patients.

The rules for visiting by family and friends vary according to individual needs. This can be difficult for patients to understand without divulging personal information about a patient`s condition.

The Infection Control on the Ward was excellent with all staff wearing masks, bare below the elbow and hand gels were available with appropriate signage to them nearby. The arrangements for cleanliness are being controlled by a Central Group of the hospital following Covid advice. The Ward Manager is hoping that they will be able to revert to pre-Covid arrangements in the near future.

Summary of Visit

Positive Findings

1. The majority of patients were very positive about the care they were receiving on the Ward. They commented on the professional and caring attitude of staff, the high level of comfort and the supportive and efficient way the Ward looks after them, particularly when they have been very poorly.
2. The Hospital has established new initiatives to improve the comfort of the patients; for example, the Ventilation Group; the Civicas feedback system; and the Wellness Channel.
3. There is a good atmosphere on the Ward. Staff spend time with patients when needed and work together well, particularly in a crisis.
4. There is good communication from the doctors about the treatment planned and what patients can expect.
5. There is a high level of comfort with the food and drink being provided.

Negative Findings

1. There was clutter on the corridors with equipment and trolleys along the corridors.
2. The arrangement for issuing a patient`s medication can be difficult with items only being available from different pharmacies.
3. The level of noise on the Ward can be uncomfortable for a few patients with blaring TVs and the proximity of beds which are separated only by a curtain.
4. The décor of the Ward could be improved if the funding can be sourced.

Recommendations

1. The Managers pass on the thanks of the patients to the staff for the excellent level of service and care on the Ward, and for the initiatives to improve the welfare of patients.
2. Ensure that the design of the Ward in the new hospital has sufficient storage space for equipment and space between the beds for privacy.
3. Ensure that prescriptions are available in one location for the patients on their discharge from hospital.

The visiting team would like to thank the family members and carers who gave their time to speak with them during the visit. Thank you also to the staff for their time and assistance in an interesting and informative visit.

theme	ID	Recommendation	Status	Target completion date	Delivery Group	Evidence	Actions Completed	date closed	Actions Remaining	Governance - DM group	Owner	Strong Recommendation
HASS Regulations and Afterload Security	5	Review access route from the HDR room and control area to any adjacent public areas and consider whether any additional access control (e.g. swipe access or fixed partitioning) is appropriate.	open	30/04/2023	BOG	compliance with CCTV and security audit	Daytime access is under key operated control by radiographers and documented within procedures		Investigate with VCC Estates suitable solutions to increase security via physical barriers to area. Compare site security levels (CCTV surveillance, 24/7security response and on call physics	SLT	Service planning manager Business Continuity Head of Brachytherapy	
Radiation Safety and Contingency Rehearsal	9	All staff groups involved in the care of HDR patients should be trained against documented emergency procedures and be clear on their roles and responsibilities	open	30/04/2023	BOG	Operational Procedure Training logs and schedule monitored by BOG	Transferred to BOG 01-02-23. Staff training logged and schedule monitored by BOG		BOG to identify remaining emergencies and training/schedules required. Time to be identified for all staff involved to train in required procedures Induction training pack under construction (BOG Action BOG 24)	BOG	Head of Brachytherapy	
Radiation Safety and Contingency Rehearsal	10	All staff should be given time to periodically rehearse contingencies, including the removal of applicators as described in the SOP, and this practice regularly audited	open	31/05/2023	BOG	Operational procedure and BOG minutes/audits	Periodic rehearsals commenced for source stick emergencies. Time identified for all staff involved to train in required procedure. RT Brachy Advanced Practioner removal training schedule monitored by BOG.		Remaining contingency reheasals to be identified (BOG Action log BOG 23b) and scheduled	BOG	Head of Brachytherapy	
Radiation Safety and Contingency Rehearsal	12	Purchase additional electronic personal dosimeters that can be worn during contingency procedure including spares in the event of a malfunction	open	30/04/2023	BOG	Transferred to BOG 22-03-23 BOG Agenda/minutes/action log	Loan EPDs from RPS until pruchased		Purchase of monitors and return of loan monitors - quotes under review RT BAPs Action Log BOG 44	BOG	Head of Brachytherapy	
Document Control and Quality Management System	13	A full review should be carried out of the policies and procedures available within the quality system and gap analysis performed across the service to identify missing areas of documentation	open	30/04/2023	BOG	BOG Agenda/minutes Mar 23/ action log/ list to be compiled	Current theatre policies under review. RT: current reviewed, bar 1 outstanding. 3US WI under constructions Physics list under construction.		Develop list of all relevant policies and procedures . Review and gap analysis for all area. schedule for policy review to be completed at next BOG -April 23 BOG Action 25 &26	BOG	Head of Brachytherapy	
Document Control and Quality Management System	14	Outstanding draft policies and procedures should be approved in a timely manner, and staff engaged with updates and process changes as part of business as usual	open	31/12/2023	BOG	Qpulse	Reviewed exiting processes and procures		ensures process in place for all specialties prior to new Qpulse being implemented	BOG	Head of Brachytherapy	
Document Control and Quality Management System	15	Investment should be made and a robust system implemented to anticipate quality system updates rather than to be reactive to overdue deadlines	open	31/03/2024	Trustwide Adoption Group	Secure Document Store	Consenus Trust QMS / document mangement system to be extended and utilised in Brachytherapy. JP to escalte through RT physics		Trust procurement process for Qpulse replacement ongoing	SLT	Head of Brachytherapy	
Document Control and Quality Management System	16	Consider a single electronic source for storage of policies and procedures, such as Q-Pulse, which can automate review reminders, track change requests and capture distribution and acknowledgement of new or updated protocols and work instructions	open	31/03/2024	Trustwide Adoption Group	Secure Document Store	Consenus Trust QMS / document mangement system to be extended and utilised in Brachytherapy. JP to escalte through RT physics		Trust procurement process for Qpulse replacement ongoing	SLT	Head of Brachytherapy	
Document Control and Quality Management System	17	Consider consistent evidencing of clinician (practitioner) authorisation for clinical protocols	open	31/03/2024	Trustwide Adoption Group	Secure Document Store	Consenus Trust QMS / document mangement system to be extended and utilised in Brachytherapy. JP to escalte through RT physics		Trust procurement process for Qpulse replacement ongoing	SLT	Head of Brachytherapy	
Line Management / Reporting Structure	23	Review the staff reporting structure, consider redesign and provide clarity over reporting lines	open	30/09/2023	Project Board	BOG minutes	Recommendation considered. Clarity exist for line management reporting as per contracts. Professional accountability remains as per professional group.		A consensus needs to be reached on service model, giving consideration to alternative models.	SLT	Head of Brachytherapy	

Efficiency & Workflow	26	Perform a comprehensive review of the way the service is delivered to ensure the principle of having the right staff with the right training for the right task at the right time is embedded across the service	open	30/06/2023	BOG/BPG	D&C plan BOG minutes and IMTP reporting	Workforce and patient pathway planning workshops underway		D&C plan and forecasting to be developed service delivery model to be reviewed in light of D&C plans	SLT	Head of Planning and Performance Head of Brachytherapy	
Efficiency & Workflow	27	Perform a comprehensive review of all processes and pathways to identify barriers and bottlenecks. Translate this into Project & action plans initally looking for quick wins and small improvements that can be delivered easily. In turn, this will create the momentum and engagement for larger scale improvements that may be required, plus efficiency release from within the team to support larger improvements	open	30/06/2023	BOG/BPG	D&C plan BOG minutes and IMTP reporting	Workforce and patient pathway planning workshops underway		linked to #6	SLT	Head of Planning and Performance Head of Brachytherapy	
Efficiency & Workflow	31	Review checking processes to ensure both radiographer checks are completely independent and both radiographers cross check the same data sources	open	31/03/2024	BOG	Clinical Audit Schedule & BOG minutes	checking processes reviewed by Head of Service		audit to be undertaken of new practice	Heads of RT Treatment and RT Clinical Governance lead	Head of Brachytherapy	
Workforce	38	Explore and implement medical succession planning options including developing own talent in current medical workforce	open	30/09/2023	BOG	Documented succession plan available	Email correspondece with Clinical Director		Discussion required regarding option for extended medical roles	Clinical Director	Head of Brachytherapy	
Workforce	39	Consider the role of consultant radiographers to support both urology and gynae services	open	30/09/2023	BOG	Consultant radiographer Role for Urology and Brachytherapy are included in longer term workforce plan for radiotherapy	reviewed role of consultant radiographers		Consensus between medics and non-medical workforce on extended roles	SLT	Head of RT / RSM	
Workforce	40	Consider adopting prescription protocol for MPEs to authorise Brachytherapy exposures in accordance with written practitioner guidelines	open	30/09/2023	BOG	Email agreement	recommendation reviewed. Decision to consider as part of next round of IMTP planning 2023/24	24/04/2023		Section Managers Assurance Meeting	Head of Brachytherapy	
Workforce	41	Continue to train physics staff on a regular basis, in particular with a view to expanding MPE support	open	30/09/2023	BOG	Agreed model and training plan.	recommendation reviewed. Decision to consider as part of next round of IMTP planning 2023/25	24/04/2023		Section Managers Assurance Meeting	Head of Brachytherapy	
Workforce	42	Develop a clear plan of workforce requirements; this should be robust, have in-built succession planning, and should include a training and development framework	open	30/09/2023	BOG/BPG	Workforce plan available and rppoert through VCC IMTP meetings	Workforce and patient pathway planning workshops currently underway to review the staff currently within the pathway.		Succession plans will be developed in all areas where required including review of possible options including Consultant Radiographer	SLT	Head of Brachytherapy	
Workforce	45	Review staffing allocation against guidelines	open	30/09/2023	BOG	D&C plan			linked to #26	SLT	Head of Planning and Performance Head of Brachytherapy	
Workforce	46	Explore service redesign within current staffing model to explore release of theatre capacity	open	30/09/2023	BOG	D&C plan	VCC service improvement staff tasked to review theatre utiisation and develop expansion options		linked to #26	SLT	Head of Planning and Performance Head of Brachytherapy	
Nursing & Theatre	50	Regular independent peer audit to include observation and documentation of the full five-step process	open	30/04/2023	BOG	Transferred to BOG 01-02-2023 BOG agenda/minutes/audit schedule	Incorporated into clinical audit plan for service . Clinical audit on BOG agenda (BOG action log 48)	30/04/2023		Head of Integrated Care	Theatre Nurse Lead	
Patient Pathway Management	51	Create additional planned gynae capacity via service redesign with the existing workforce and equipment or via a business case for additional resource	open	30/06/2023	BOG/BPG	D&C plans			as #26	SLT	Head of Planning and performance Head of Brachytherapy	
Patient Pathway Management	52	Take a collaborative approach to scheduling based on an agreed set of priorities that consider the whole MDT	open	30/06/2023	BOG/BPG	Collaborative working evidenced via emails and BOG minutes D&C plans	Collaborative approach to working in place. Prioritisation linked to D&C planning	01/02/2023	as #26	SLT	Head of Planning and performance Head of Brachytherapy	
Medicines Management	61	COSHH risk assessments to be developed, if not already in place	open	30/04/2023	BOG	current risk assessments			Review current COSHH risk assessments in conjunction with Operational Services - H&S lead	BOG	Service Planning Manager Business Continuty Theatre Lead	

Training & Professional Development	63	Develop competency documents for all staff groups and method for ongoing competency updates	open	30/09/2023	BOG	Competenciy documents	Physics: Competencies for operators are reviewd March 23. Training packs redesigned.		Theatres: Competency framework will be developed RT: All training documentation and competency assessments provided to KF to incorporate into exempplar training plans Physics Checker/MPE training for review April 23	BOG	Service leads	
Training & Professional Development	66	Full multidisciplinary team to be involved in regular scenario based contingency practices for removal of applicators, resus, local toxicity, bleed, fire evacuation. Attendance should be documented	open	30/09/2023	BOG	Competency documents			review business continuity plan	BOG	Service Planning Business continuty Head of Brachytherapy	
Miscellaneous	70	Sterile probe cover cut with non-sterile scissors, non sterile gloves used to perform scan. Risk assessment to be in place if this is acceptable practice, or do not cut the probe cover and scrub in and use sterile gloves instead	open	01/05/2023	BOG	Risk assessment or BOG minutes (BOG Action log 51)	Staff training and awareness of fields in place . Added to BOG Agenda and action log 51		Risk assessment - brachy APs sonography & JW for issue	BOG	Sonographer Brachy AP/ THeatre Lead	
Miscellaneous	72	Staff to work in another area when not directly involved in the procedure	closed	31/03/2023	BOG/BPG	Establishment review	Recommendation reviewed. Review of nurse establishment complete and addtional posts recruited. On the rare occasion there are no patient treatments planned the agreed business process is for staff to report to their line manager for	31/03/2023		Head of Nursing	Theatre Lead	
Miscellaneous	75	Visitor risk assessment should be in place and available in accordance with the Health and Safety at Work Act and the Management of Health and Safety at Work Regulations	open	Transferred to BOG Apr-2023	BOG	RA and SOP BOG Action 70	The SOP and risk assessment are current and up to date We have a 'Visitors to Theatre policy' clearly displayed at the Theatre entrance and can be found on			BOG	Theatre Lead	
Miscellaneous	76	Ensure the Trust's medical devices policy is fit-for-purpose and implemented	open	BOG April 2023	BOG	Policy. goverance,BOG Mar 23 agenda/minutes/audit schedule	JR and JMcC contacted and advise given. Theatre/ RT/ Physics med devices inventory created		JR/JP to review on 20th April 2023	Quality and Safety	Medical Devices Lead	
Miscellaneous	77	Perform monthly out medical devices checks and audits	open	Transferred to BOG 01-02-23	BOG	Transferred to BOG 01-02-2023 BOG agenda/minutes/audit schedule	All anaesthetic medical devices are controlled by 'RAS' Respiratory and Anaesthetic support. Daily documented checks in theatres supported by C&V medical devices who undertake audits All HDR equipment is quality assured within the RT Physics ISO9000 system		JR to assist audit set up	Meadical Devices Lead	Head of Brachytherapy	
Patient Management Pathway- Radiotherapy (VVBT / Skins)	78	Review both services from operational perspective; how they work together, resource requirements, and map clinician availability and job plan to treatment sessions	open	31/12/2023	BOG	Service delivery model Workforce plan job plans	Initial mapping of resources and staff availability in progress.		Mapping of resources and staff required to meet sustainable service delivery model. Job planning for medical staff required Further review of A4C staff due to staff changes	SLT	Eve Gallop- Evans RSM	
Patient Management Pathway- Radiotherapy (VVBT / Skins)	79	Perform capacity and demand review then work out appropriate staffing allocation across the working week	open	30/06/2023	BPG	Demand and Capacity Plan Workforce plan	Mapping of treatment sessions and capacity completed		Demand and capacity plan to be developed	SLT	Head of Planning and Performance RSM	
Patient Management Pathway- Radiotherapy (VVBT / Skins)	81	Perform regular and ongoing reviews of staffing levels and workforce plans and submit business cases to reflect the staffing requirements for the workload	open	n/a	BPG/BOG	demand tracked via elekta system		n/a	service delivery model to be developed in response to D&C planning	SLT	Head of Planning and Performance Head of Radiotherapy physics	
Patient Management Pathway- Radiotherapy (VVBT / Skins)	82	Consider electronic rostering and rosters being shared among teams so teams can see when other staff will be available	open	30/09/2023	BOG Medical Directorate	Annual leave rota in TEAMS	Annual leave rota for radiation services in Teams and updated weekly	31/08/2023	annual leave for medics to be shared with Radiation services	SLT	Directorate Manager Medics RSM	
Demand & Capacity Modelling	83	Ring fence adequate resource to review activity over the last five years and use modelling tools to predict demand for next five years	open	30/06/2023	BPG/BOG	D&C plan			service delivery model to be developed in response to D&C planning and forecasting	SLT	Head of Planning and Performance Head of Brachytherapy	

Demand & Capacity Modelling	84	Revisit modelling annually to ensure it is reflective of service provision	open	31/12/2023	BPG/BOG	D&C plan	BOG meeting monthly to discuss demand BPG monthly performance meetings		Annual review as part of IMTP forecasting informed through monthly trends	SLT	Head of Planning and Performance Head of Brachytherapy	
Demand & Capacity Modelling	85	Run automated reports (if possible) prospectively and retrospectively and use this to inform ongoing service provision and redesign	open	31/03/2024	IRS/Brachy implementation group	IRS data resports			IRS/Brachy implementation group to be established Analysis system and reporting to be IRS output	SLT	Head of Brachytherapy	
Demand & Capacity Modelling	86	Embed capacity and demand modelling and workforce planning as they are dependent on each other	open	30/06/2023	BPG/BOG	D&C plan	manual data set available D&C discussion at monthly brachy meeting		D&C plan and forecasting	SLT	Head of Planning and Performance Head of Brachytherapy	
Communication & Collaboration	87	Radiographer involvement with the full patient journey should be promoted including presence within theatre and involvement in the insertion procedure	open	31/12/2023	BPG/BOG	Fully trained radiographers and training protocol completed			Develop agreed training plan for radiographers Identify trainers undertake training	SLT	Clinical Director RSM	
Communication & Collaboration	88	Regular contingency rehersal should be carried out involving all members of the MDT as described in section 3.3	open	31/05/2023	BOG	Duplicate of #10	Duplicate of #10, 66,68		see #10			
Training & Professional Development	93	Protect time for training and writing and updating SOPs should be allocated by factoring this into the workforce plans and job plans for the radiographers	open	31/12/2023	BOG Medical Directorate	Job plans	draft job plan for radiographers with enhanced SPA requirements is complete		to be reviewed alongside medical job plans	SLT	Eve Gallop- Evans RSM	
Training & Professional Development	94	Radiographers should not only be trained to check and deliver treatment but should also be educated, have understanding, and be involved in the insertion, planning process	open	31/12/2023	duplicate #87	duplicate #87	duplicate #87	duplicate #87	duplicate #87	duplicate #87	duplicate #87	
Training & Professional Development	95	Radiographers should be integrated further into the Brachytherapy MDT: they have a wealth of knowledge and skill and are versatile, and this will cement their underpinning knowledge	open	30/09/2023	BOG Medical Directorate	job plans to include MDT			Discussions with Medical Directorate required to agree consensus on service delivery model	RT Clinical Governance	Eve Gallop- Evans RSM	
Training & Professional Development	96	A Brachytherapy training and competency package should be developed to include background knowledge of Brachytherapy Principles, planning of procedures, and pre-treatment pathway. Formal Brachytherapy training is limited to a small number of M level modules and the ESTRO teaching course.	open	Transferred to BOG	BOG	RT Line Management development and training records,	Requirements were reviewed Oct 2022.	31/05/2023	Knowledge of planning to be addressed. Emailed HP and CT for closure response	RT Clinical Governance	RSM	
Training & Professional Development	98	Consider further role development and role extension for rotational Band 6 Brachytherapy radiographers to help support the service to be more robust. This could include HDR contingency training, insertion of vault applicators, gynae ultrasound, and dilator counselling with appropriate underpinning policy	open	30/09/2023	BOG/ BPG	qualified ultrasonographer	Rotational rads currently have the opportunity to complete competency in Vault and IGBT removals and dilator counselling. There is now a subsequent insertions training package also available for VVBT which the APs have now completed.		Discussion on intended direction of travel for Trust Ultrasound training: need to identify training delivery resource and agree timeframe	SLT	RSM	
Training & Professional Development	100	When implementing further advanced practice responsibilities ensure there is more than one member of staff trained to cover planned/unplanned absenses	open	30/09/2023	BOG/BPG	Line Management development and training records,	Staff now recruited into AP posts within Radiotherapy Training is funded and backfill supported through appointment of Locum Radiographer with Sonography skills (in place until all relevant competencies achieved)		Discussion to take place regarding Trust intention and resilience planning single handed practitioner in physics - need to determine appropriate service model single handed medic gynae - need to determine service model	RT Clinical Governance	Eve Gallop- Evans RSM	

Ultrasound	102	Urgently develop an in-house clinical skills training package for ultrasound Brachytherapy to expedite training in a timelier manner and to train more staff to cover the service. Consider then supplementing it with M level module when service is more robust	open	31/08/2024	BOG	training package developed training records	Currently no training programme in Wales Discussion with Clatterbridge re: providing training, unable to do so due to capacity issues Discussion taken place with HEIW (August 2022) as no ability to provide in-house training		HEIW develop training package and robust QA processes and will need to deliver the training - anticipated timeframe 2years	RT Clinical Governance	RSM	1
Ultrasound	103	Within advanced practice frameworks, policies, and training, ensure that services have more than one trained member of staff before the service can operate. This will prevent future single points of failure	open	30/09/2023	duplicate #98 #102	duplicate #98 #102	duplicate #98 #102	duplicate #98 #102	duplicate #98 #102	duplicate #98 #102	duplicate #98 #102	
Digital Security & Best Practice	109	Consider individual log-ins designed to minimise the opportunity for unauthorised access	open	30/05/2023	Section Managers Assurance Meeting	workstations closed when unattended Access to patient planning restricted to Nadax log-on All Oncentra Brachy users have individual, password protected accounts. All operators (planners and checkers) involved in the plan production are recorded for	requriement for indiviudal log-in reviewed in line with recommendation		Risk assessment needs to be completed to document decision	Section Managers Assurance Meeting	Lead Brachytherapy MPE	1
Treatment Planning (Prostate)	117	The calibration measurement should be checked independently by a second person	open	30/05/2023	Section Managers Assurance Meeting	Robust system in place to confirm calibration via independent method. checkers notified to request second check. Operators trained risk assessment in place	review of practice undertaken to confirm compliance with recommendation		to be included in WIs	Section Managers Assurance Meeting	Lead Brachytherapy MPE	
Treatment Planning (Prostate)	123	Free lengths - Consider this check being done independently by a pair of scrubbed radiographers, one to the initial measure and one to check. Any discrepancies can be resolved prior to the plan being produced or indeed delivered. Needle measurements are also then independent to those planning the treatment	open	30/05/2023	Section Managers Assurance Meeting	RA on BOG agenda	way of working reviewed and confirmed in light of the recommendation.		Risk assessment to be completed to confirm management of variation - to be signed off at next BOG	Section Managers Assurance Meeting	Lead Brachytherapy MPE/ CCO	
Treatment Planning (Prostate)	124	Needle positions should be checked against the underlying ultrasound image and adjusted as necessary so final planned distribution matches delivered distribution as closely as possible. The team would need to ensure that the superior end of the needle is included in scan to achieve this	open	30/04/2023	Section Managers Assurance Meeting	Risk assessment confirm our position and decision to reject recommendaiton	Reviewed recommendation locally in discussion with Clatterbridge Clatterbridge to adopt our process.	30/04/2023		Section Managers Assurance Meeting	Lead Brachytherapy MPE/ CCO	
Treatment Planning (Cervix)	131	Review employers scope of entitlement procedure for duty holders under IRMER and consider whether current practice with respect to operator roles is represented adequately	open	10/05/2023	Section Managers Assurance Meeting	Qpulse record	review of entitlement procedures underway and reported to RPSG		response to outcome from HIW revew	Section Managers Assurance Meeting	Lead Brachytherapy MPE	
Treatment Planning (Cervix)	132	Consider introducing Venezia vaginal caps to provide additional rectal dose sparing in cases where they may be clinically suitable	open	31/12/2023	Section Managers Assurance Meeting	Qpulse record and SOP	Applicator project established		Consider as part of applicator replacement project. Pt comfort & emergency procedure impact will need to be considered.	Section Managers Assurance Meeting	Lead Brachytherapy MPE/CCO	
Treatment Planning (Cervix)	133	Consider aligning prescribing practice to ICRU89 recommendations, in particular the use of HR CTV D90%	open	31/03/2023	Section Managers Assurance Meeting/BOG	outcome from audit			Audit to be undertaken of current practice - paused due to resource issues	Quality and Safety	Lead Brachytherapy MPE/CCO	
Treatment Planning (Cervix)	134	Consider implementing EMBRACE II optimal contraints for targets and OARs to guide dose optimisation and alert the clinicians where a particular structure maybe outside the optimal range	open	30/04/2023	BOG	Wis SOP	Project ongoing to adapt to VCC requirements, ensure necessary QA in place and implement in to clinical workflow		Consensus between medics and non-medical workforce on implementation of trial findings required.	Quality and Safety	Lead Brachytherapy MPE/CCO	

total= 7

Cancer Services Scorecard as at March (Month 12) 2022/23.

QSF Domain	Cancer Services Safety Scorecard			Performance as at Month 12 (March)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline April '22	Target	Actual	In Month Position	Cumulative data trend	
Safety	Number of Velindre Cancer Centre acquired (avoidable) patient pressure ulcers	National	Monthly	1	0	0	✗	➔	KPV.01
	Number of VCC Inpatient (avoidable) falls	National	Monthly	4	0	0	✗	➔	KPV.02
	% Patients with a Sepsis NEWS score >or= 3 receiving all 6 treatment elements within 1 hour	National	Monthly	90%	100%	100%	✓	➔	KPV.03
	Number of Potentially (avoidable) Hospital Acquired Thromboses (HAT)	National	Monthly	0	0	2	✗	➔	KPV.07
	Number Healthcare acquired Infections (HAIs) MRSA	National	Monthly	0	0	0	✓	➔	KPV.04
	Number Healthcare acquired Infections (HAIs) MSSA	National	Monthly	0	0	0	✓	➔	KPV.04
	Number Healthcare acquired Infections (HAIs) P. aeruginosa cumulative	National	Monthly	0	0	0	✓	➔	KPV.04

	Number Healthcare acquired Infections (HAIs) Klebsiella spp	**National**	**Monthly**	**0**	**0**	**0**	✓	➔	KPV.04
	Number Healthcare acquired Infections (HAIs) C Difficile	**National**	**Monthly**	**0**	**0**	**0**	✓	➔	KPV.04
	Number Healthcare acquired Infections (HAIs) E Coli	**National**	**Monthly**	**0**	**0**	0	✓	➔	KPV.04
	Number Healthcare acquired Infections (HAIs) Gram negative bacteraemia	**National**	**Monthly**	**0**	**0**	0	✓	➔	KPV.04
	Hand Hygiene	**National**	**Monthly**	**TBA**	**TBA**	**TBA**	✓	➔	KPV.08
	Number of Health and Safety Incidents recorded	**Local**	**Monthly**	**1**	**0**	**9**	✗	➔	KPV.56
	% compliance for staff who have completed the Core Skills and Training Framework Level 1	**National**	**Monthly**	**85%**	**85%**	**85%**	✓	➔	KPV.59
	Number of Staff RIDDOR Incidents, Injuries and Work Related Accidents	**Local**	**Monthly**	**0**	**0**	**0**	✓	➔	KPV.54

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

QSF Domain	Cancer Services Effectiveness Scorecard			Performance as at Month 12 (March)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline April '22	Target	Actual	In Month Position	Cumulative data trend	
Effectiveness	Number of Delayed Transfers of Care (DToCs)	National	Monthly	0	0	1	✗	➔	KPV.05
	% Personal Appraisal Development Reviews (PADR) Compliance	National	Monthly	69%	85%	72%	✗	🡻	KPV.56
	% Rolling average Staff sickness levels	National	Monthly	6.18%	3.54	6.43%	✗	🡻	KPV.57
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving 🡹 stable ➔ fluctuating 🡹🡻 deteriorating 🡻									

QSF Domain	Cancer Services Experience Scorecard			Performance as at Month 12 (March)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline April '22	Target	Actual	In Month Position	Cumulative data trend	

Patient/ Staff Experience	% of Patients Who Rate Experience at VCC as very good or excellent	**Prof. Std.**	**Monthly**	**N/A**	**95%**	**95**	✓	➔	KPV.11
	% of 'formal' concerns responded to within 30 working days	**Local**	**Monthly**	**100%**	**85%**	**100**	✓	➔	KPV.12
	% staff who rate VCC as a good employer	**National**	**Annually**	**TBA**	**TBA**	**TBA**	N/A	N/A	KPV.13
	Number of Incidents of violence and aggression to staff	**Local**	**Monthly**	**1**	**0**	**7**	✗	↑↓	KPV.53
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving ↑ stable ➔ fluctuating ↑↓ deteriorating ↓									

QSF Domain	**Cancer Services Timeliness Scorecard**			**Performance as at Month 12 (March)**			**Compliance against Target or Standard**		**Data Link**
	Key Performance Indicator (KPI)	**Target**	**Reported**	**Baseline April '22**	**Target**	**Actual**	**In Month Position**	**Cumulative data trend**	

Timeliness	Scheduled Radiotherapy Patients Treated 80% within 14 Days and 100% within 21 Days (COSC)	**National**	**Monthly**	**N/A**	**80%** **100%**	**29%** **47%**	✗	➔	KPV.14
	Urgent Symptom Control Radiotherapy Patients Treated 80% within 2 Days and 100% within 7 days (COSC)	**National**	**Monthly**	**N/A**	**80%** **100%**	**6%** **48%**	✗	➔	KPV.15
	Emergency Radiotherapy Patients Treated 100% within 1 Day (COSC)	**National**	**Monthly**	**N/A**	**100%**	**94%**	✗	➔	KPV.16
	Elective delay Radiotherapy Patients Treated 80% within 14 Days and 100% within 21 Days (COSC)	**National**	**Monthly**	**N/A**	**80%** **100%**	**27%** **32%**	N/A	N/A	KPV.17
	% Patients Beginning Non-Emergency SACT within 21 days	**National**	**Monthly**	**69%**	**98%**	**98%**	✓	↑↓	KPV.20
	% Patients Beginning Emergency SACT within 5 days	**National**	**Monthly**	**100%**	**98%**	**98%**	✗	↑	KPV.21
	% Outpatients seen within 30 minutes of scheduled time	**Local**	**Monthly**	**65%**	**100%**	**paused**	✗	➔	KPV.22
	% Patients receiving equitable and timely access to Therapy Services	**Local**	**Monthly**	**97%**	**100%**	**100%**	✓	➔	KPV.23

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

QSF Domain	Cancer Services Efficient Scorecard			Performance as at Month 12 (March)			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	% Outpatient Did Not Attend (DNA) rates	National	Monthly	3%	5%	NDA	✓	➔	KPV.24
	Electricity performance in kilowatt hours (kWh)against target consumption budget profile	National	Monthly	N/A	289k Jan	295k Jan	✓	↑↓	KPV.62
	Gas performance in kilowatt hours (kWh) against target consumption budget profile	National	Monthly	N/A	396k Nov	352k Nov	✓	↑↓	KPV.62
	Water performance usage in cubic metres against target consumption	Local	Monthly	N/A	1500m3	1750m3	✗	↑	KPV.67
	Financial Balance – achievement of VCC forecast (£k) in line with revenue expenditure profile	National	Monthly	£0k	£0k	£0k	✓	➔	KPV.71
	VCC expenditure (£k) on Bank and Agency staff against target budget profile	National	Annually	£88k	£88k	£113k	✗	↓	KPV.72
	Cost Improvement Programme – VCC achievement of savings (£k) in line with profile	National	Monthly	N/A	£632k	£455k	✗	↓	KPV.74

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

QSF Domain	Cancer Services Equitable Scorecard			Performance as at Month 12 (March)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline April '22	Target	Actual	In Month Position	Cumulative data trend	
Equitable	Diversity of Workforce – % of women in senior leadership positions (defined as Band 8 and above)	Local	Quarterly	TBA	TBA	TBA	✓	➔	KPV.78
	Diversity of Workforce – % Black, Asian and Minority Ethnic people (based on Wales version of WRES)	Local	Quarterly	TBA	TBA	TBA	✓	➔	KPV.79
	Diversity of Workforce – % People with a Disability	Local	Quarterly	TBA	TBA	TBA	✓	➔	KPV.80
	% of Workforce declared Welsh Speakers at Level 1	National	Quarterly	TBA	TBA	TBA	✓	➔	KPV.81

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

QUALITY SAFETY AND PERFORMANCE COMMITTEE

VELINDRE UNIVERSITY NHS TRUST PERFORMANCE MANAGEMENT FRAMEWORK REPORT AND SUPPORTING ANALYSIS FOR THE PERIOD TO MARCH 2023

DATE OF MEETING	16/05/23

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Peter Gorin, Head of Corporate Strategic Planning and Performance Wayne Jenkins, Assistant Director, Sarah Richards, Interim General Services Manager
PRESENTED BY	Cath O'Brien, Chief Operating Officer
EXECUTIVE SPONSOR APPROVED	Carl James, Executive Director of Strategic Transformation, Planning and Digital

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 / Performance Review VCC SLT / Performance Review EMB	19th April 2023 20th April 2023 2ND May 2023	**NOTED** **NOTED** **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 MANAGEMENT FRAMEWORK (PMF) FOR THE PERIOD APRIL TO MARCH 2023

1.1 This paper reports on the yearend performance of our Trust for the period April to March 2023, against a range of national targets, best practice standards and locally identified outcome measures for our cancer and blood and transplant services, as well as incorporating measures of patient and donor satisfaction, staff wellbeing, support functions and financial balance.

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

1.3 Navigating our PMF Performance Report

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

Each KPI is supported by data that explains the current performance, using wherever possible, Statistical Process Control (SPC) Charts or other relevant information to allow the distinction to be made between 'natural variations' in activity, trends or performance requiring investigation. The scorecards incorporate hyperlinks to supporting KPI data, enabling switching from the high-level position to detailed analysis and back.

1.4 Individual VCC and WBS PMF reports were presented initially to the respective VCC and WBS Senior Leadership Teams (SLT), followed by the Chief Operating Officer Divisional Performance Review meetings.

1.5 During 2023/24, the PMF Development Project Group will look to evaluate potential Business Intelligence solutions that automate KPI collection, analysis and reporting, and approach potential benchmarking partners for both tertiary cancer and blood services.

2. VELINDRE NHST PERFORMANCE REPORT EXECUTIVE SUMMARY TO MARCH 2023

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

2.1 Cancer Centre Services Overview

Targets were met for Pressure Ulcers, Falls, SEPSIS, Healthcare Associated Infections and both SACT waiting times. Targets not met for Radiotherapy and Therapies waiting times, Hospital Acquired Thrombosis and Delayed Transfers of Care.

Due to data system changes which have occurred because of the transition to the new data warehouse (following implementation of the Digital Health and Care Record - DHCR) and a requirement for a full rebuild of the data warehouse to accommodate reporting functionality for the new Radiotherapy Time to Treatment targets (RRTT) (previously known as COSC), data remains unavailable for the period November to January 2023. This is because the simultaneous new warehouse provision and move to the new metrics mean that the system is unable to produce either standard JCCO (previous reporting metrics) or RRTT patient lists for the transition period. This means that there is no data available that could be usefully validated to produce a comparative performance metrics. This does not mean however that patients are not being tracked and monitored as they progress through the treatment pathway. Safeguards remain 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 further warehouse developments and changes to address reporting issues within the system are delivered and ensures that patients are not missed. Patients are also continuing to be prioritised in line with national guidance.

The new categorisation of treatment times are a major change that is being adopted by colleagues and work is ongoing to fully embed the changes alongside the new digital system brought in through DHCR. We are still experiencing some data quality issues that are being worked through and are resultant from adoption of new treatment date options and some operational errors in choices being made. However training is ongoing to improve understanding of the new categories and how to use the system and work is taking place at a national level to more clearly define the new categories and how they can be delivered.

The new categories are outlined below:

The revised NHS Wales Radiotherapy Priority Definitions are as follows:

- Emergency – will include patients with Spinal Cord Compression, Superior Vena Cava Obstruction, severe haemorrhage/haemoptysis and stridor
- Urgent – Symptom Control – will include patients with pain and bleeding. These treatments are expected to be delivered with simple treatment fields.
- Scheduled – will include all non-urgent palliative patients and all patients treated with radical intent without an elective delay.

- Elective Delay - patients should be reported separately from ‘Scheduled’ patients and have an Earliest Clinically Appropriate Date (ECAD) to start Radiotherapy.

  Comparison of JCCO and COSC

	JCCO Good Practice	Maximum acceptable	COSC 80% optimal	100% mandatory
Emergency	24hours	48hours	24hours	48hours
Urgent symptom control	-	-	48 hours	7 days
Palliative	48 hours	14 days	-	-
Scheduled	-	-	14 days	21 days
Radical	14 days	28 days	-	-
Elective delay	-	-	7 days	14 days

The radiotherapy data for February within the PMF remains only partially-validated data due to additional system changes that had to be put in place. These are now complete, and the March data is fully validated.

Since January 2023, all radiotherapy bookings have been made with the intent of meeting the new target times to treatment. This change seeks to shorten the time to treatment from the previous targets, changes the categories of treatment and introduces a new target for patients who have to have other interventions prior to their radiotherapy (Elective Delay). Work is being undertaken across the entire patient pathway to streamline the working processes and shorten the pathway. This will continue to be progressed, making incremental changes to improve performance against the new targets. The implementation of the new integrated radiotherapy system (IRS) and the new machines and systems that brings will also contribute to our ability to streamline our pathways.

A Radiotherapy Capacity Management group has been established. A clear activity plan is being developed to address the ongoing requirements for additional capacity and address the increasing need for more complex planning for patients. The action plans will address the pathway within the radiation services teams and also across other services that play a role in the pathway. This group will report through Velindre Cancer Services Business Planning Group and on to the Senior Leadership Team.

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.

A series of 'deep dives' with the Directorates has conclude and operational action plans by Directorate have been developed. The DHCR Project Structure has been revised and a new Operational Delivery Group has been established to ensure delivery of the operational action plans. Key themes arising from the 'deep dives' include: data quality relating to human error, training needs; additional resource requirements. Timelines have been identified for delivery against key actions and a number of proposals are scheduled for presentation at the DHCR Project Board in May 2023.

2.2 Welsh Blood Service Overview

2022/23 has been another challenging year for WBS, however, the service has continued to successfully maintain the supply of blood and blood products to the patients of Wales throughout. Whilst we have had to rely on minimal support from other UK blood services, this has been outweighed by the mutual aid we have provided. In particular, assistance has been provided to Northern Ireland in terms of both red cells and ongoing advice around collection planning and donor engagement techniques.

WBS have continued to perform extremely well across the board throughout 2022/23, despite difficult operational conditions, including but not limited to strike action, COVID restrictions, extreme weather and additional bank holidays. We have ended the year in a stable and strengthening position, which has left us well placed as we enter the 2023/24 financial year.

All clinical demand was met in March. At 96% quality incident investigations closed within 30 days continues to exceed target (90%). There were no reportable events submitted to regulators and no Serious Hazards of Transfusion (SHOT) incidents reported during the month.

At 95% donor satisfaction continues to remain above target. In March, 7,465 donors were registered at donation clinics with 9 concerns (0.01%) reported within this period. No formal concerns were raised and the 9 informal concerns were managed within timelines as 'early resolution'.

Collection efficiency failed to meet target in March. Contributory factors include the cancellation of clinics due to issues at clinic venues and reduction in venue capacity due to short term staff sickness.

Reference Serology turnaround performance failed to meet the 80% target in March at 70%. All time critical requests were prioritised and completed on time maintaining safety of clinical care. Current performance is due to continued staff sickness, vacancies combined with continued high levels of testing requests from health boards. Additional workforce is now in place and sickness levels are starting to improve, however, the training programme for new recruits will take time to embed.

Antenatal –D & -C quantitation was also just below the 90% target at 83% for the quarter. This was due to a failure to meet target for one month attributed to multiple staff absences. Team resilience is being reviewed to ensure reporting timescales can be met going forward.

All clinical demand for platelets was met representing a strong performance against this metric, however, platelet wastage continues to be above target at 20% (target 10%). Despite not meeting target, the overall number of time expired platelets reduced to the lowest numbers this quarter. The main contributory factor is high variability in demand over the month. A Platelet Strategy project will be established in April 2023 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 related work programmes in Clinical Services.

The service has over performed against the annual recruitment target for apheresis platelet donors which is testament to the efforts of the collections and recruitment team throughout the year. The number of new blood donors recruited in the financial year did not meet annual target (6,478 against a target of 11,000) by the end of March. This was due in the main to requirements to intensify the appointment management by donor blood type throughout a prolonged O positive and O negative blood shortage blue alert, lasting from March 2022 to August 2022 and delays in returning to educational settings.

Whilst we were not able to meet the annual target for new bone marrow volunteers, performance has been increasing month on month since January 2023, with swab kit returns at a record high at the end of March and conversion rates on donor session showing an upward trend. The number of new donors recruited to the Welsh Bone Marrow Donor Registry (WBMDR) was 320 in March, just below the target of 333, and the highest number this financial year. The conversion rate of eligible blood donors increased again to 30% and swab kits returns were at a record high of 87 (an increase of 30 from February). The Recovery Plan continues to focus on Schools/College/University engagement programme, marketing campaigns aimed at existing donors and engagement with external marketing companies to explore wider recruitment opportunities.

The total stem cells collected in March was 6 (6 additional collections were cancelled in March due to patient reasons). The total stem cell provision for the service was 11 (6 collected and 5 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.

2.3 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 6.22% to March 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 is at 73% 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 87% and has been consecutively on target for the whole year to March 2023.

2.4 Nursing and Quality

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

2.5 Patient and Donor Experience

Velindre Cancer Centre uses two patient satisfaction surveys: 'Would you recommend us?' (95%) and 'Your Velindre experience?' (82%) both set against a 95% target. The Welsh Blood and Transplant service has maintained a high level of donor satisfaction at 95% that continues to meet the target.

2.6 Digital Services

No further significant IT business continuity incidents (SI's) in February or March. However, rolling 12 month performance still remains an ongoing area of concern; however, as noted in previous reports the Digital Services team continue to implement improvements to address the legacy IT estate in VCC, which is where the majority of the incidents are occurring. This work will continue into 2023/24.

Performance in respect of the timescales for resolving service requests and incidents improved slightly down on February 2023.. Team capacity remains a contributory factor – various recruitment ongoing, covering roles in both 1st and 2nd line IT support roles. Performance expected to improve in Q1 2023/24.

Reporting arrangements for two remaining (2) indicators are still being developed, aim is to to establish routine reporting in April 2023 (for March 2023 data) for the following indicators:

- Digital Cyber Security % of employees clicking on internal phishing campaigns/exercises – campaigns to be re-started following recruitment into the Cyber Security Manager role.
- % uptime of critical digital systems which may have direct clinical or business implications – a number of critical systems have been identified as 'in scope' of this indicator. Initial reporting has been developed for WBS Appointments System (>99.9% uptime) – however, these reports are still undergoing validation to ensure accuracy of the reported data.

2.7 Estates Infrastructure and Sustainability

The period through to March has seen consolidation of compliance levels, PPM and reactive tasks are currently listed as green. Although the department is under resourced (recruitment underway job offers made and accepted) the Team are becoming focussed on management through the availability of data which is now evident through the consolidation of compliance figures.

Energy management is intrinsically linked to Estates resourcing and will be improved with recruitment in the Estates Department, and implementation of the decarbonisation plan. Recent events have hindered the availability of utility data which is largely due to the introduction of Energy Bill Relief Scheme (EBRS) which continues to be an issue with reporting data.

Fire Safety and Health & Safety KPIs are at acceptable levels with the exception of training, which is a constant challenge. New initiatives have been rolled out working closely with Education and Development Colleagues which is having a positive impact on performance, there is now sufficient training capacity to meet the needs of the organisation. Module C training (Violence and Aggression) is currently listed as red, due to this being new course which is currently being rolled out to relevant areas. It is anticipated that this figure will rise with availability of training moving forward.

Divisions have reinvigorated H&S meeting which will support improvement of training, by approaching issues at operational level, working with trainers and departments to tailor a package that meets departmental requirements, this is underpinned by support from SLT.

2.8 Finance

The overall position against the profiled revenue budget for 2022-23 was £0.064m underspent. During the period the Trust received full funding towards the temporary increase in Employers NI, the increased energy costs above baseline due to energy price inflation and Covid response costs.
The overall Capital programme achieved the Trust CEL for 2022-23 by reporting a spending of £27.758m against a CEL allocation of £27.760m.
Draft PSSP performance for the Trust was 95.33% against a target of 95%, with the Core Trust excluding NWSSP also achieving 95%.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes (Please see detail below)
	Quality and Safety considerations form an integral part of IMTP 2022/23 to 2025/26 plans and PMF to monitor and report on progress against our strategic objectives

RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below: • Staff and Resources • Safe Care • Timely Care • Effective Care • Staying Healthy
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	VUNHST IMTP 2022/23 to 2025/26 plans must be delivered within the Trust's financial envelope

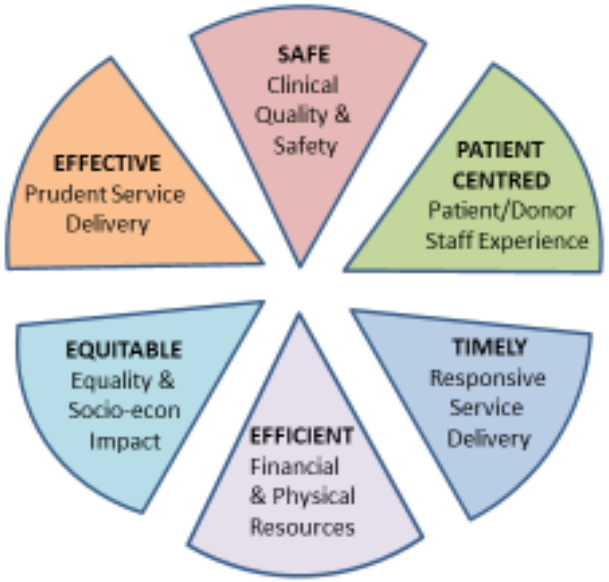
4. RECOMMENDATIONS

4.1 The 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 3.

4.2 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.

Canolfan Ganser Felindre
Velindre Cancer Centre

Consolidated Performance Management Framework



Welsh Blood Service

Quality Safety & Performance (QSP) Committee Scorecard as at March (Month 12) 2022/23

QSF Domain	QSP Committee Performance Scorecard			Performance as at Month 12 (March 2023)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline April '22	Target	Actual	In Month Position	Cumulative data trend	
Safety	% compliance for staff who have completed the Core Skills and Training Framework Level 1 competencies	National	Monthly	85%	85%	87%	✓	↑	WOD.19
	Number of VCC Inpatient (avoidable) falls	National	Monthly	1	0	0	✓	→	KPV.02
	Number of Potentially (avoidable) Hospital Acquired Thromboses (HAT)	National	Monthly	0	0	2	✗	↓	KPV.07
	Number Healthcare acquired Infections (HAIs) MRSA	National	Monthly	0	0	0	✓	→	KPV.04
	Number Healthcare acquired Infections (HAIs) MSSA	National	Monthly	0	0	0	✓	→	KPV.04
	Number Healthcare acquired Infections (HAIs) P. aeruginosa cumulative	National	Monthly	0	0	0	✓	→	KPV.04
	Number Healthcare acquired Infections (HAIs) Klebsiella spp	National	Monthly	0	0	0	✓	→	KPV.04
	Number Healthcare acquired Infections (HAIs) C Difficile	National	Monthly	0	0	0	✓	→	KPV.04
	Number Healthcare acquired Infections (HAIs) E Coli	National	Monthly	0	0	0	✓	→	KPV.04
	Number Healthcare acquired Infections (HAIs) Gram negative bacteraemia	National	Monthly	0	0	0	✓	→	KPV.04
	Number of Velindre Cancer Centre acquired (avoidable) patient pressure ulcers	National	Monthly	0	0	0	✓	→	KPV.01
	Number of Incidents reported to Regulator / Licensing Authority	Local	Monthly	3	0	0	✓	↓	KPI.30
	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	1	✗	→	KPV.05
	% Demand for Red Blood Cells Met	Best practice	Monthly	102%	100%	104%	✓	↑	KPI.04
	% Time Expired Red Blood Cells (adult)	Local	Monthly	0.08%	Max 1%	0.02%	✓	↑	KPI.26

QSF Domain	QSP Committee Performance Scorecard			Performance as at Month 12 (March 2023)			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%	20%	✗	↑↓	KPI.25
	Number of Stem Cell Collections per month	Local	Monthly	1	7	6	✗	↑	KPI.13
	% Rolling average Staff sickness levels	National	Monthly	6.31%	3.54%	6.22%	✗	↓	WOD.37
	% Personal Appraisal Development Reviews (PADR) compliance staff appraisal carried out by managers	Prof. Std.	Monthly	69%	85%	73%	✗	↑↓	WOD.36
Patient/Donor/ Staff Experience	% of Patients Who Rate Experience at VCC as very good or excellent	Prof. Std.	Monthly	N/A	85%	95	✓	→	KPV.11
	% Donor Satisfaction	Local	Monthly	96%	95%	95%	✓	↑	KPI.09
	% of 'formal' VCC concerns responded within 30 working days	Local	Monthly	100%	85%	100	✓	→	KPV.12
	% Responses to Formal WBS Concerns within 30 Working Days	Local	Monthly	100%	90%	100%	✓	→	KPI.03
Timeliness	% Patients Beginning Radical Radiotherapy Within 28 days (JCCO)	National	Monthly	87%	98%	86%	✗	↑↓	KPV.27
	% Patients Beginning Palliative Radiotherapy Within 14 days (JCCO)	National	Monthly	79%	98%	86%	✗	→	KPV.18
	% Patients Beginning Emergency Radiotherapy Within 2 days (JCCO)	National	Monthly	84%	98%	100%	✓	↑↓	KPV.19
	Scheduled Radiotherapy Patients Treated 80% within 14 Days and 100% within 21 Days (COSC)	National	Monthly	N/A	80% 100%	29% 47%	✗	→	KPV.14
	Urgent Symptom Control Radiotherapy Patients Treated 80% within 2 Days and 100% within 7 days (COSC)	National	Monthly	N/A	80% 100%	6% 50%	✗	→	KPV.15
	Emergency Radiotherapy Patients Treated 100% within 1 Day (COSC)	National	Monthly	N/A	100%	94%	✗	→	KPV.16
	Elective delay Radiotherapy Patients Treated 80% within 14 Days and 100% within 21 Days (COSC)	National	Monthly	N/A	80% 100%	27% 32%	✗	→	KPV.17
	% Patients Beginning Non-Emergency SACT within 21 days	National	Monthly	69%	98%	98%	✓	↑↓	KPV.20

QSF Domain	QSP Committee Performance Scorecard			Performance as at Month 12 (March 2023)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline April '22	Target	Actual	In Month Position	Cumulative data trend	
	% Patients Beginning Emergency SACT within 5 days	National	Monthly	100%	98%	100%	✓	🡅	KPV.21
	% Antenatal Turnaround Times (within 3 working days)	Best practice	Monthly	96%	90%	96%	✓	→	KPI.18
	% Turnaround Times (Antenatal -D & -c quantitation) within 5 working days	Best practice	Quarterly	97%	90%	83%	✗	🡇	KPI.17
Efficient	Financial Balance – achievement of Trust forecast (£k) in line with revenue expenditure profile	National	Monthly	0	0	(£0.064m)	✓	→	FIN.71
	Financial Capital spend (£m) position against forecast expenditure profile	National	Monthly	0	£27,760 M	£27,758M	✓	→	FIN.73
	Trust expenditure (£k) on Bank and Agency staff against target budget profile	National	Monthly	N/A	£0.128m	£0.140m	✗	→	FIN.72
	Cost Improvement Programme £1.3M achievement of savings (£k) in line with profile	National	Monthly	N/A	£1.300m	£1.300m	✓	🡅	FIN.74
	Public Sector Payment Performance (% invoices paid within 30 days)	National	Monthly	95%	95%	95%	✓	→	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

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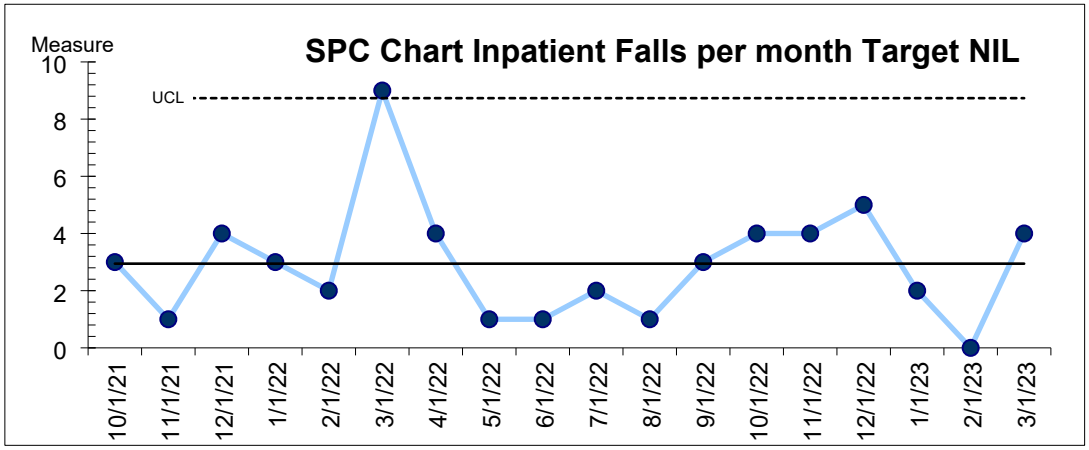
Number of VCC Inpatient Falls per month

Target: 0 Avoidable

SLT Lead: Head of Nursing

Current Performance against Target or Standard

VCC	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	Feb 23	Mar 23
Actual Number	3	2	9	4	1	1	2	1	3	4	4	5	2	0	4
Avoidable Falls	1	0	0	1	1	0	2	0	1	2	2	0	0	0	0
Target NIL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0



SPC Chart Analysis

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

Performance

There were no avoidable falls in March 2023. Target Achieved.

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

-

KPI Indicator KPV.01

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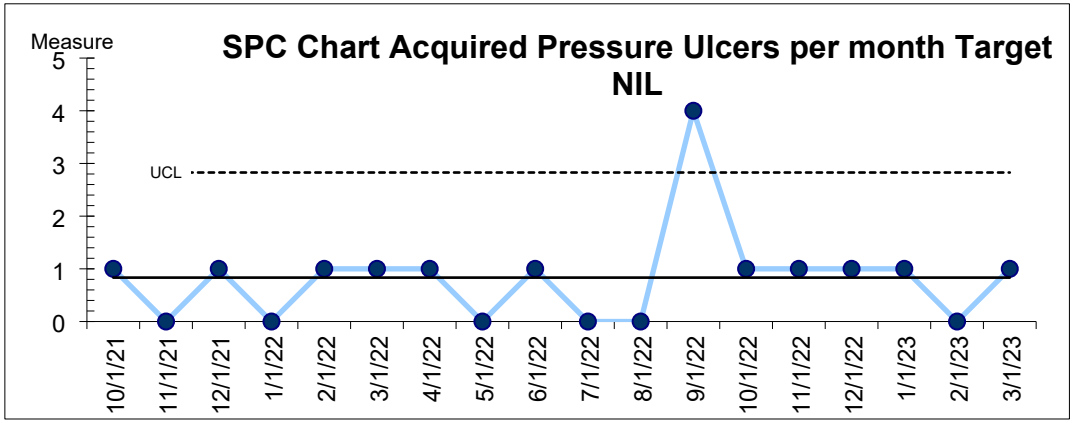
Number of VCC Acquired Pressure Ulcers per month (Inpatients)

Target: 0 Avoidable

SLT Lead: Head of Nursing

Current Performance against Target or Standard

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



SPC Chart Analysis

The SPC chart shows common cause or normal variation over the last 15 months.

Performance

No avoidable Pressure Ulcers in March 2023. Target Achieved.

Service Improvement Actions – Immediate (0 to 3 months)

	Timescale:	Lead:

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

KPI Indicator WOD.19

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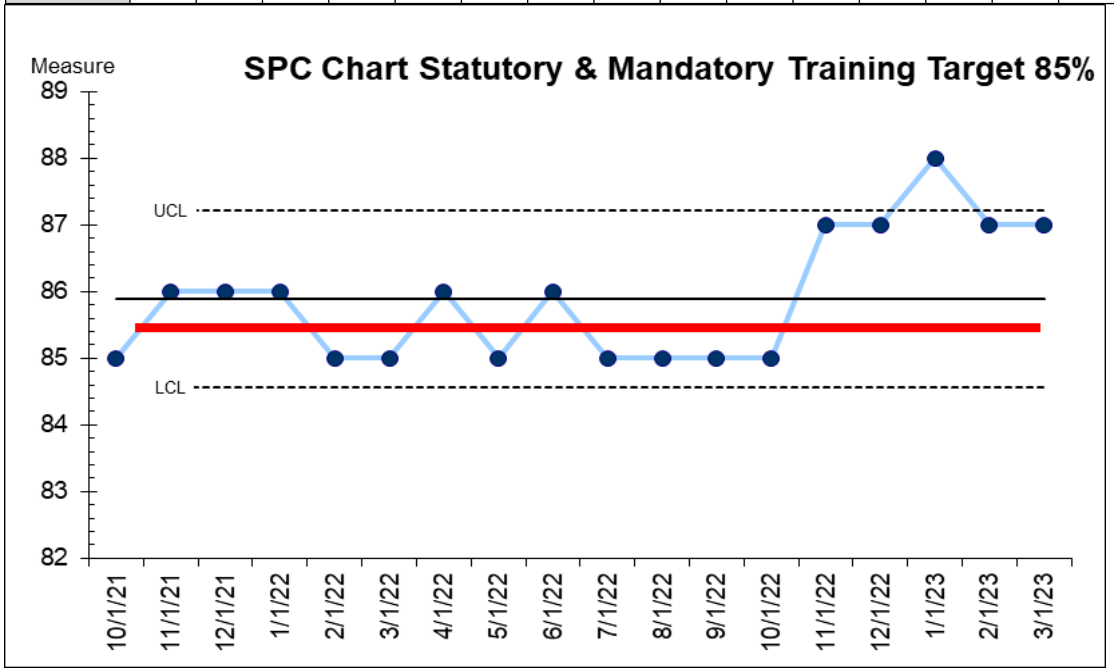
Statutory and Mandatory (S and M) Training Compliance

Target: 85%

SLT Lead: WOD Business Partner

Current Performance against Target or Standard

Trust Position	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 %	86	85	85	86	85	86	85	85	85	85	87	87	88	87	87
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85



SPC Chart Analysis

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

Performance

Assessment of current performance, set out key points:

- Compliance target is being met
- VCC at 85%
- WBS at 95%
- Corporate Services at 88%

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 preformance with all areas across the Trust above the target level.

Service Improvement Actions – tactical (12 months +)

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

KPI Indicator KPV.07

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

Target: NIL

SLT Lead: Clinical Director

Current Performance against Target or Standard

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

VCC	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	Feb 23	mar 23
Hospital Acquired Thromboses	1	0	1	0	0	0	1	0	0	0	0	0	0	0	2
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:

In March there were 2 potentially avoidable HATs identified via root cause analysis.

1 was due to the VTE section of the chart not being completed on admission and therefore no dalteparin prescribed for a medical admission.

The second was a missed dose of dalteparin (blank box on the chart).

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Identify the root cause and feedback to the stakeholders, this include always ensuring that a risk assessment is conducted and always ensure that doses are never un-intentionally missed.	1 month	VCC CHAT Group

Expected Performance gain - immediate

Ideally should see an immediate effect, and will be able to assess in 1 month time.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Revise the clerking proforma to include a HAT risk assessment into the proforma	1 month	CHAT group (Jolene Lewis)
Ensure ward nursing staff know that 'critical medications' including thromboprophylaxis cannot be missed (in ward 'big 4')	1-2 months	CHAT group – Rhian Hathaway
Ensure that the important of VTE prophylaxis is covered at induction and potential teaching sessions	3-6 monthly	Pharmacy induction
Implement ESR training for all staff	To start in 3-6 months and repeat every 2 years	Workforce and OD

	Expected Performance gain – longer-term Consistent monthly performance of no potentially avoidable HATs each month
	Risks to future performance
	Set out risks which could affect future performance • Change in ward medical staff

KPI Indicator KPV.04

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Healthcare Acquired Infections (Inpatients)

Target: NIL

SLT Lead: Head of Nursing

Current Performance against Target or Standard

Incidence of Healthcare Acquired Infections for the period December 2022 to March 2023

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

Performance

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

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	1	4	1	0

Risks to future performance

Set out risks which could affect future performance

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

KPI Indicator KPI.30

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

Target: NIL

SLT Lead: Peter Richardson

Current Performance against Target or Standard

	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	Feb 23	Mar 23
Actual	0	1	0	3	0	0	1	1	0	0	0	2	0	2	0
Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Performance

Assessment of current performance, set out key points:
There were no reportable events submitted to regulators in March. There were no Serious Hazards of Transfusion (SHOT) incidents reported during the month.

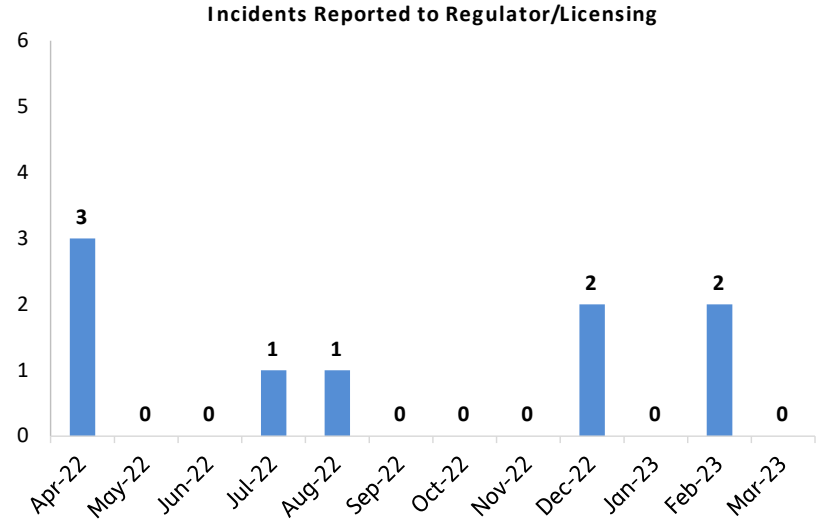
Service Improvement Actions – Immediate (0 to 3 months)

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

KPI Indicator EST.06

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% 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

Trust Position	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 Number															
Target -16%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%

[Graph and data to be inserted under development]

Performance

Assessment of current performance, set out key points:

- insert text
- insert text
- insert text

Service Improvement Actions – Immediate (0 to 3 months)

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

	Expected Performance gain - immediate
	Service Improvement Actions – tactical (12 months +)

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

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Number of Delayed Transfers of Care (DToC)

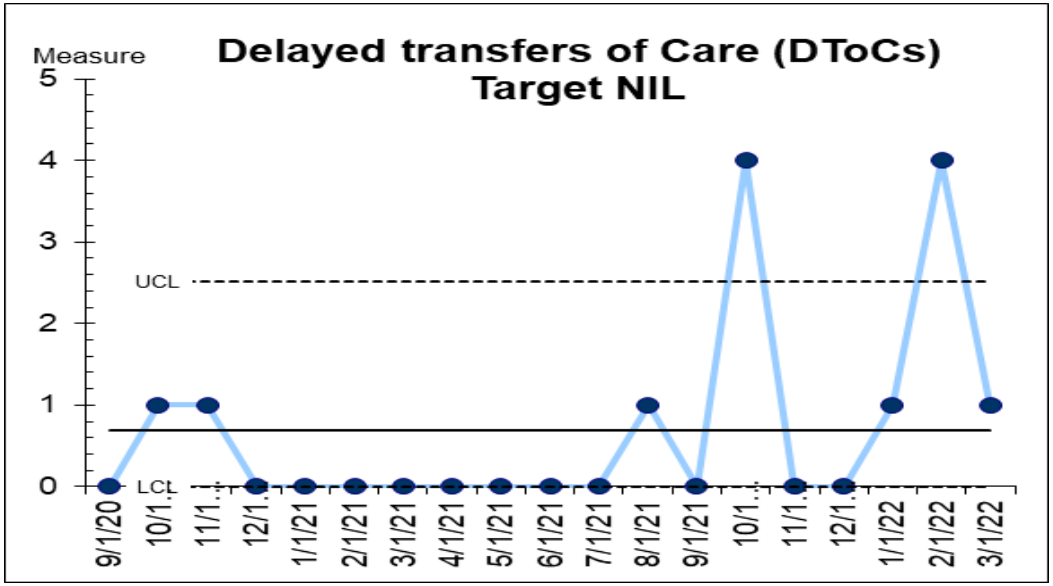
Target: NIL | **SLT Lead: Head of Nursing**

Current Performance against Target or Standard | **Performance**

VCC	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	Feb 23	Mar 23
Actual %	1	4	1	0	0	0	0	0	0	2	1	0	0	1	1
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:
There was 1 DTOC in March 2023, patient referred for repatriation to the host HB for rehabilitation and discharge planning – delayed by 15 days due to bed availability and service pressures in host HB.

Service Improvement Actions – Immediate (0 to 3 months)



SPC Chart Analysis

The SPC Chart shows two 'special cause' or exceptional variations in October 2021 and February 2022.

Actions: what we are doing to improve	**Timescale:**	**Lead:**
VCC Nurse leads now have membership of the new Pathways of Care Delays National Group system access has been granted and training has been provided by the DU, BI working with senior nurses to agree data source currently manual collection.	**End of June 2023**	**Matthew Walters Senior Operational Nurse**

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	**Timescale:**	**Lead:**
Membership of all Wales POCD group, opportunity to discuss with HB colleagues and review national data including VUNHST data identifying themes and patterns.	**March 2023**	**Matthew Walters Senior Operational Nurse**

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

-

KPI Indicator KPI.04

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

Target: 100%

SLT Lead: Jayne Davey / Tracey Rees

Current Performance against Target or Standard

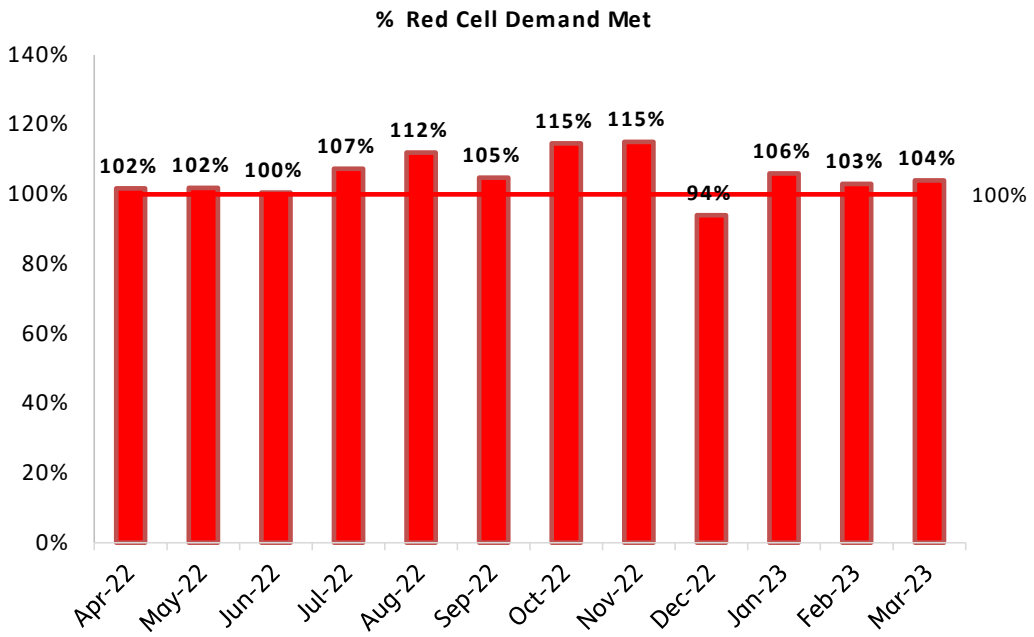
	Jan 22	Feb 22	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Actual %	110	100	100	102	102	100	107	112	105	115	115	94	106	103	104
Target 100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Performance

All clinical demand was met during this period with a good blood group distribution.

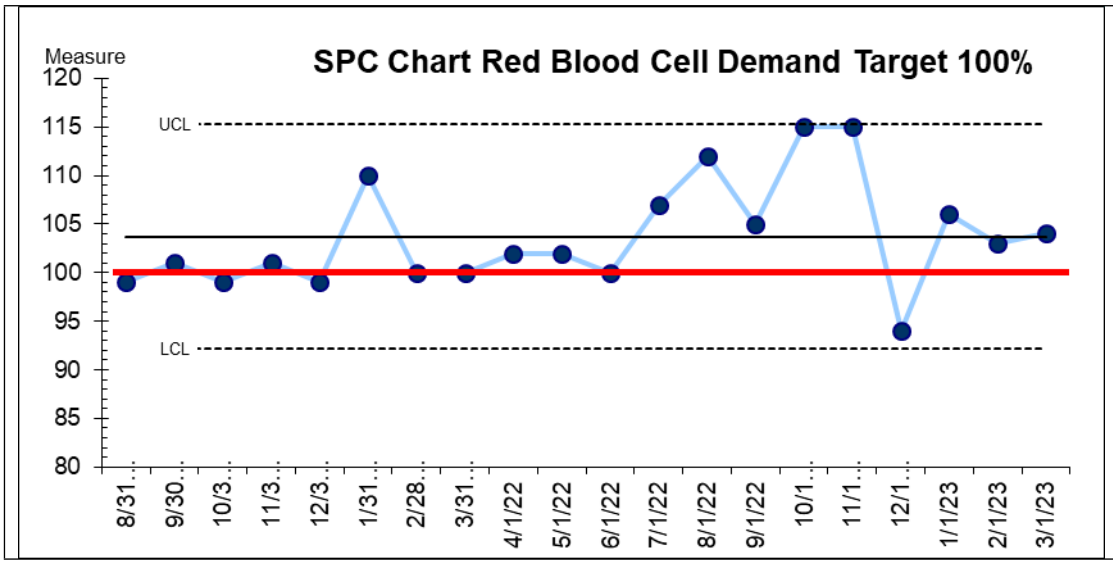
Demand (full weeks) averaged at 1351 units per week which is lower than the February period.

Service Improvement Actions – Immediate (0 to 3 months)



Actions: what we are doing to improve 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.	**Timescale:** Daily **Lead:** Jayne Davey / Tracey Rees
Expected Performance gain - immediate. Reviewed daily to support responses to changes in demand.	
Service Improvement Actions – tactical (12 months +)	
Actions: what we are doing to improve N/A	**Timescale:** N/A **Lead:** Jayne Davey / Tracey Rees
Expected Performance gain – longer-term	N/A
Risks to future performance	
Set out risks which could affect future performance. Impact of industrial action on ability to collect sufficient blood donations (ongoing).	

	SPC Chart Analysis



The SPC chart shows common cause or normal variation over the 15-month period. The average performance of 104% consistently exceeding the 100% target.

KPI Indicator KPI.26

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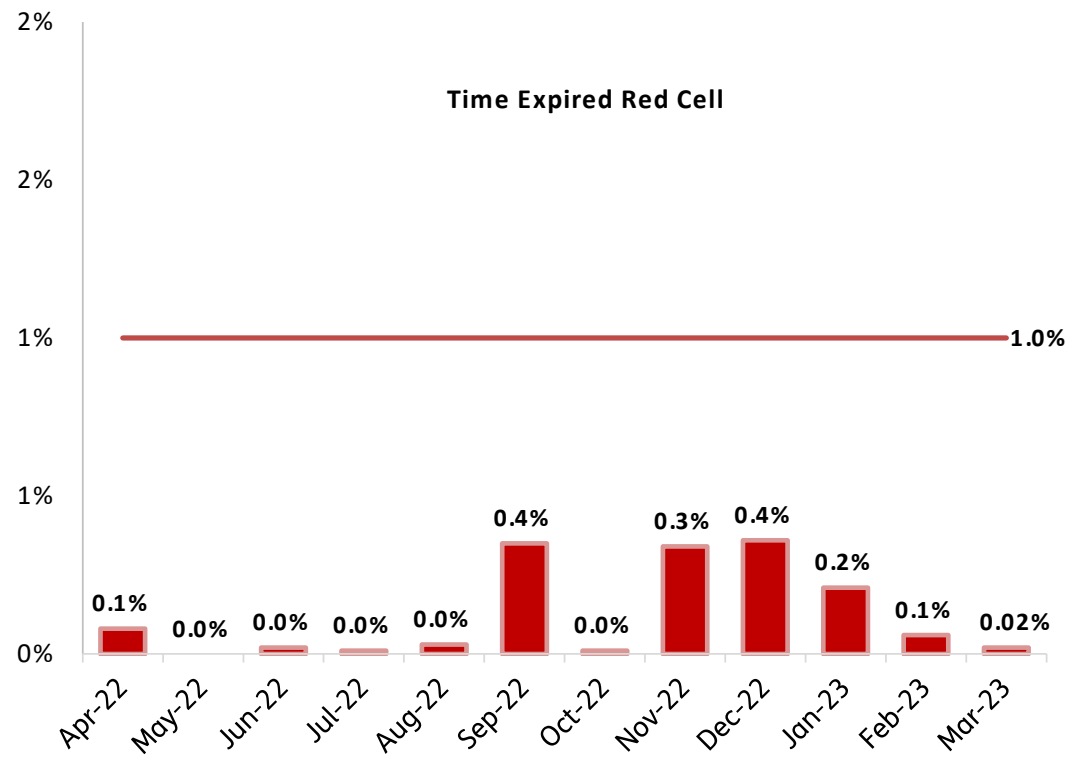
Time Expired Red Blood Cells - number of red blood cells, excluding paediatric bags, which have a time expired, as % of the total number of red blood cell bags	
Target: Maximum Wastage 1%	**SLT Lead: Tracey Rees**
Current Performance against Target or Standard	**Performance**

	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Actual %	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	0.06	0.02
Target Max 1%	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0



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

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

Service Improvement Actions – Immediate (0 to 3 months)

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

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

Service Improvement Actions – tactical (12 months +)

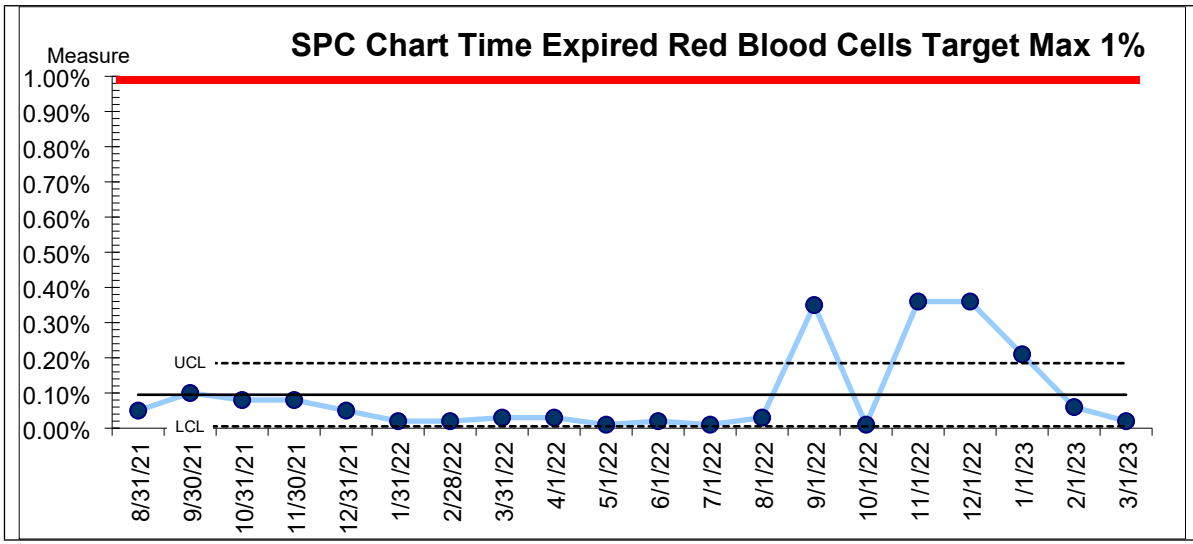
Actions: what we are doing to improve	Timescale:	Lead:
N/A		

Expected Performance gain – longer-term
N/A

Risks to future performance

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

SPC Chart Analysis



The SPC chart shows 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

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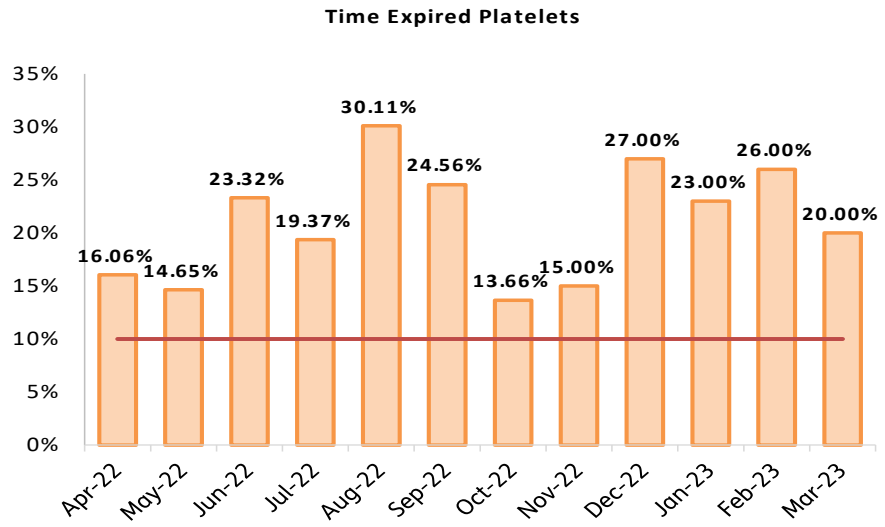
Time Expired Platelets – number of platelets which have time expired as a % of the total number of platelets manufactured

Target: Maximum Wastage 10%

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	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 %	15	17	14	16	15	23	19	30	25	14	15	27	23	26	20
Target Max 10%	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10



NB: Platelet production takes account of the average expected issues and is a balance to ensure sufficiency of supply where production occurs 2.5 days before they are available for issue. This means in shortage there tends to be over production. Decreasing production would reduce waste but increase the probability of shortage, which in turn may create a need to rely on mutual aid support.

Performance

Assessment of current performance, set out key points:
Platelet production was reduced during March in accordance with the production plan and whilst target was not achieved, overall number of time expired platelets reduced to the lowest numbers this quarter.

(NB Platelet expiry is based on a % of production, as platelet production reduces, the % contribution to expiry for each individual platelet increases)

33% of March platelet expiry occurred in the first week, prior to the impact of the reduced production. The week of the 13th of March also saw the lowest platelet issuing figure for several years.

Excess expiry also occurred on Wednesdays (from platelets collected on the previous Wednesday). Production cannot be reduced on these days as these are apheresis platelets.

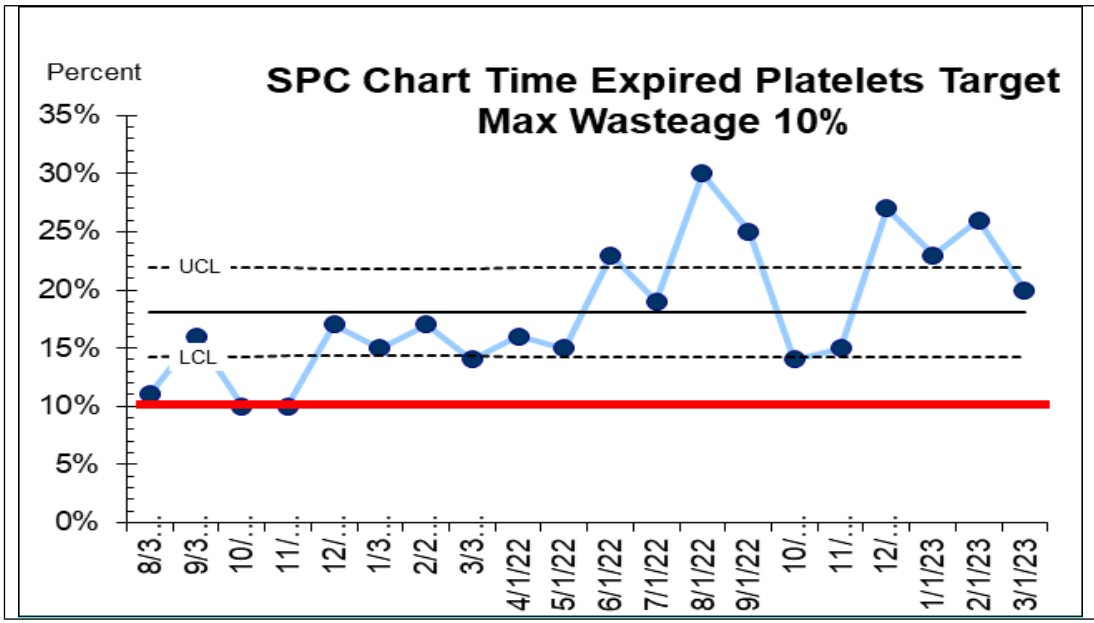
NB

- Production set at 165 per week on the basis that the average demand was impacted by a single exceptional week.
- April will have significant challenges in wastage rates due increased production in readiness for the bank holidays which impact on usual production schedules.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Lead:**
• Daily monitoring of the 'age of stock' as part of the 'Resilience' meetings. • Pooled platelet reductions have been implemented and reviewed for March	Tracey Rees / Peter Richardson **Timescale:**

	as a measured approach to the declining demand trend. • A Platelet Strategy Board will be established to co-ordinate the work of the two Task and Finish Groups convened following the November 2022 platelet review and other ongoing work streams in Clinical Services. • Develop a forecasting tool to inform decisions around pooled platelet manufacture (Task & Finish Group 1).	Daily (BAU) Qtr 4 Proof of Concept trial - March 23 onwards
	Expected Performance gain – immediate. Controlled platelet production leading to reduced wastage	
	Service Improvement Actions – tactical (12 months +)	
	Actions: what we are doing to improve Reviewing the clinic collection pan for Apheresis (Task & Finish Group 2) to ensure the clinic times are optimised, given to additional 2-day shelf life of platelets.	**Timescale:** Qtr 1, 2 & 3 onwards **Lead:** Jayne Davey
	Expected Performance gain – longer-term Platelet expiry reduction using a risk-based approach balancing platelet expiry against ability to supply platelets for clinical needs.	
	Risks to future performance	
	Set out risks which could affect future performance Unexpected increases in clinical need Industrial Action Adverse weather	



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%.

KPI Indicator KPI.13

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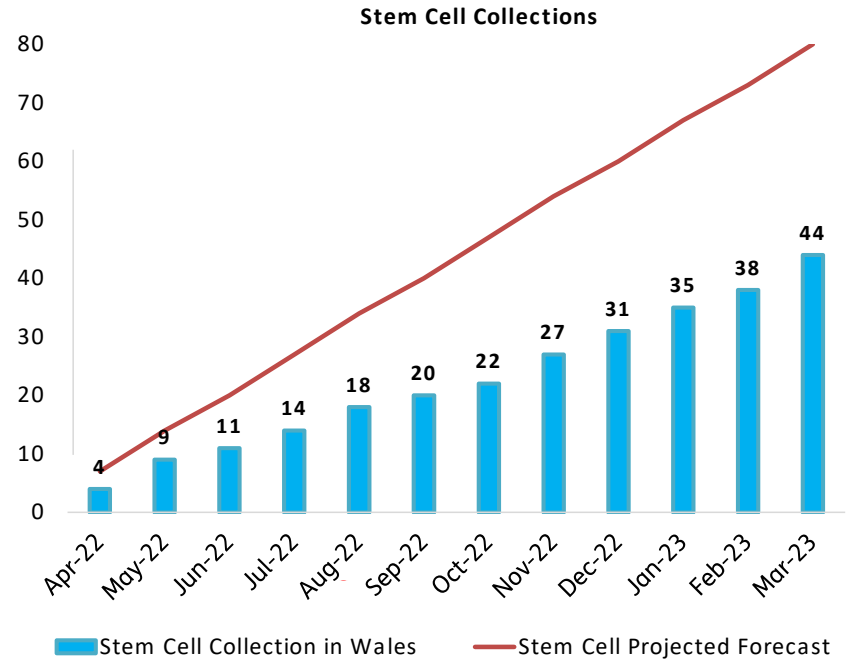
Number of stem cell collections supported year to date. Annual figure 80 per annum reported against cumulative monthly target

Target: 80 per annum

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	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	Feb 23	Mar 23
Cumulative Actual	39	44	47	4	9	11	14	18	20	22	27	31	35	38	44
Cumulative Target p/a	67	73	80	7	14	20	27	34	40	47	54	60	67	71	80



Performance

Whilst performance for March did not meet target, it was still the busiest month of the 22-23 financial year. 5 collections were cancelled during March for patient reasons and 1 cancelled due to a donor failing a medical examination.
The total stem cell provision for the Service was 11, made up of 6 collections and 5 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.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:**
The WBMDR five-year strategy, re-appraising the existing collection model and its ambition, is being finalised to support the ongoing development of the WBMDR. A recovery plan has been implemented to improve recruitment of new donors to the Register which over time will increase the number of collections see KPI.20	Qtr 4 **Lead:** Tracey Rees

	Expected Performance gain - immediate. As above
	Service Improvement Actions – tactical (12 months +)
	Implementation of the five-year strategy. — **Timescale:** Qtr 1 2023 onwards **Lead:** Tracey Rees
	Expected Performance gain – longer-term. Improved recruitment of new donors to the Register which over time will increase the number of collections
	Risks to future performance
	Set out risks which could affect future performance. Identified risks are being managed.

KPI Indicator WOD.37

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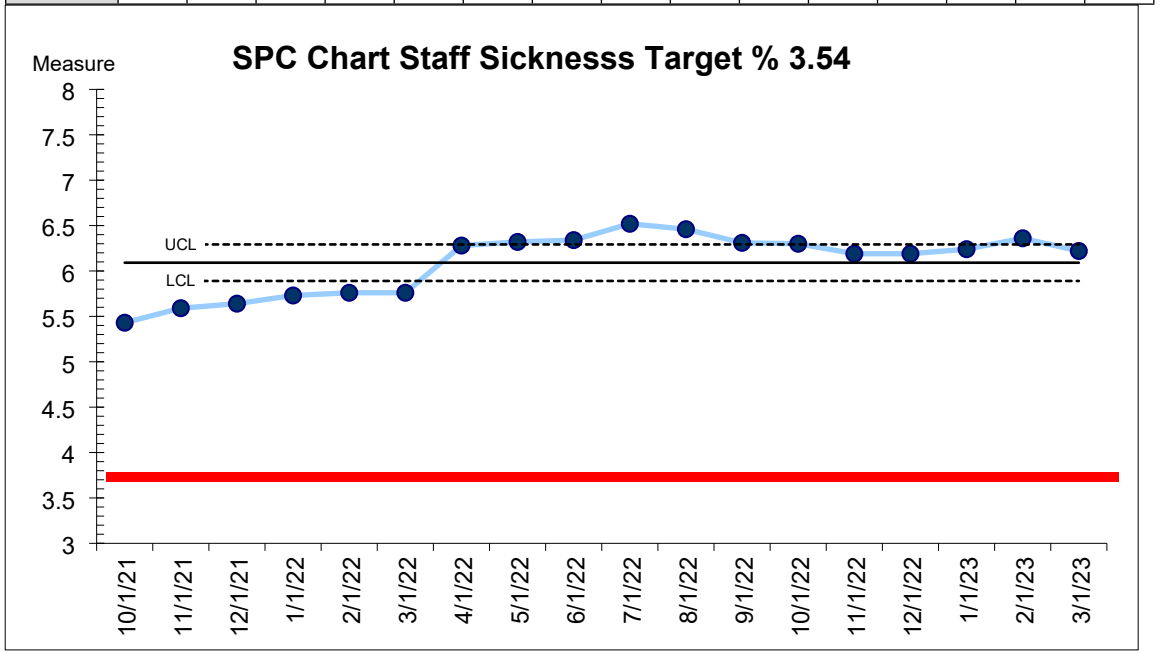
Staff Sickness levels against Target

Target: 3.54%

SLT Lead: WOD Director

Current Performance against Target or Standard

Trust Position	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 %	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	6.36	6.22
Target 3.54%	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54



SPC Chart Analysis

The SPC chart shows a deteriorating trend over the last 15 months with the overall average 5.6% sickness level remains higher than the 3.54% target

Performance

Assessment of current performance, set out key points:

There is a slight decline in sickness 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

KPI Indicator WOD.36

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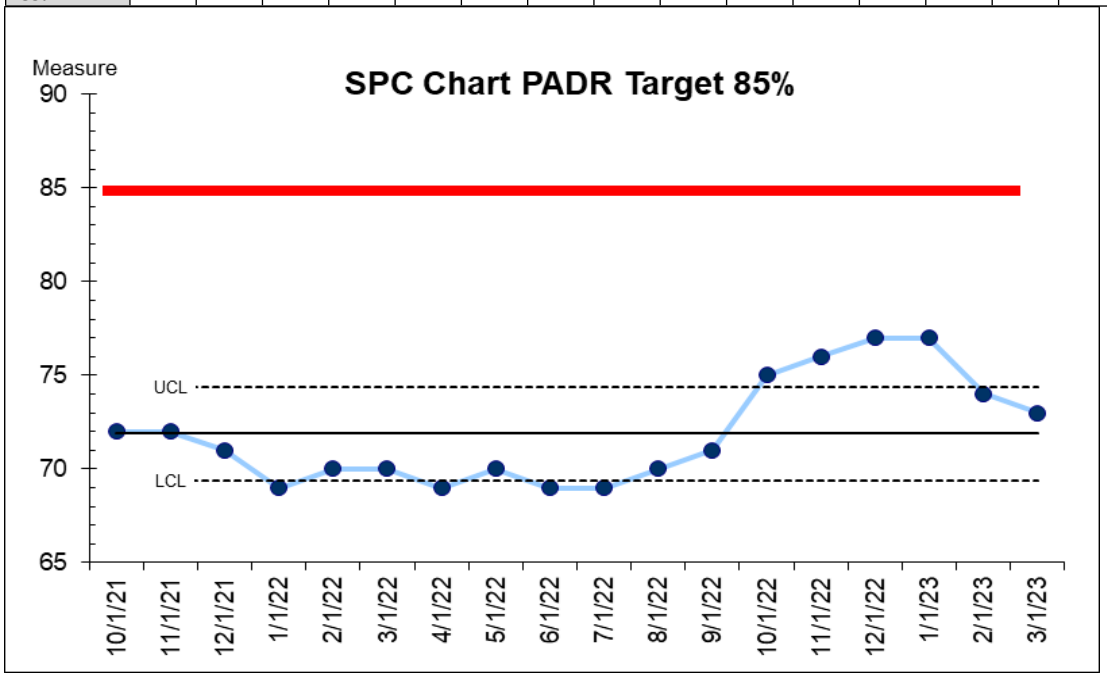
Performance and Development Reviews (PADR) % Compliance

Target: 85%

SLT Lead: WOD Director

Current Performance against Target or Standard

Trust Position	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 %	69	70	70	69	70	69	69	70	71	75	76	77	77	74	73
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85



SPC Chart Analysis

The SPC chart shows a special cause deteriorating trend over the last 15months months, averaging 72%, and consistently falling short of the 85% target.

Performance

Assessment of current performance, set out key points:

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)

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

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% of Patients that Rate Experience at Velindre at 9/10 or above

Target: 85%

SLT Lead: Head of Nursing

Current Performance against Target or Standard

VCC	Jan 22	Feb 22	Ma 22	Apr 22	My 22	Jun 22	Jul22	Aug22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Would you recommend us? %								89	89	88	nda	nda	93	96	95
Your Velindre Experience? %											nda	nda	84	86	82
Target 85%	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95

Performance

Assessment of current performance, set out key points:

There are 2 surveys used in VCC – 'Would you recommend us?' and 'Your Velindre Experience' The Your Velindre experience uses 0-10 in the question about rating VCC, whereas 'Would you recommend us?' used Very good, good etc. The majority of surveys completed in VCC is the 'Would you recommend us?' one.

The 95% in March was due to 118 survey responses to the VCC 'Would you recommend us? CIVICA survey.

56 patients responded to "Your Velindre Experience" CIVICA survey. Of these 56 responses, 38 responded 9/10 and 10/10. 13 patients responded 7 and 8 out of 10, with 5 patients scoring 5 and below.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Outcomes from CIVICA are reviewed monthly and form part of QSP report	Ongoing	Head of Nursing/SLT
• Directorate Reports are provided monthly to enable detailed review and 'You Said We Did' feedback	Ongoing	SLT
• Directorates to develop plans to increase response rate.	Ongoing	SLT
• Q+S team to work with each directorate to provide further analysis on responses		

Expected Performance gain – immediate

Patient Experience and Concerns manager in post since February 2023.

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text

KPI Indicator KPI.09

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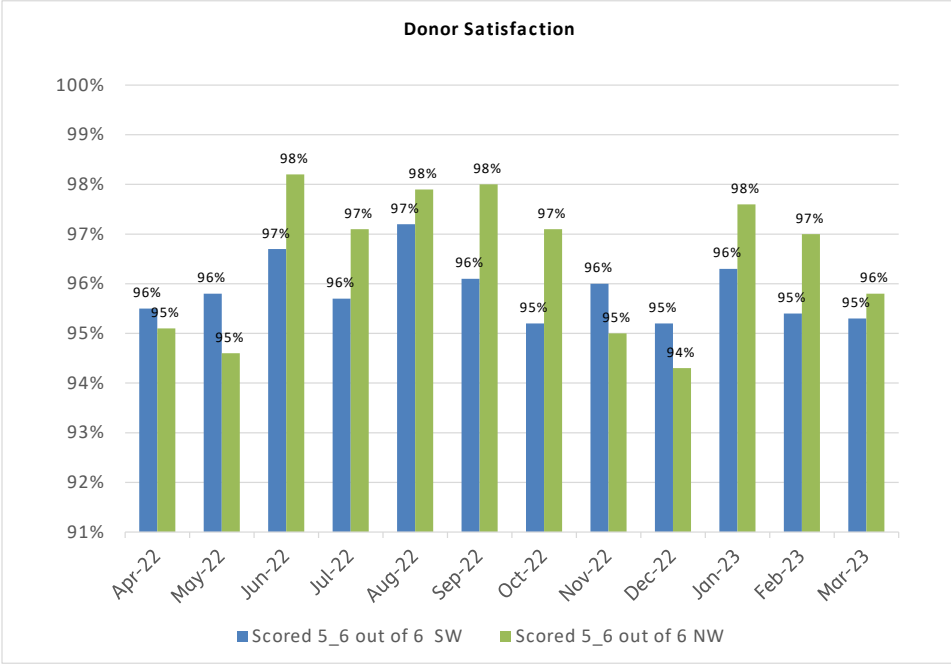
% Donor Satisfaction - donors that scored 5 or 6 out of 6 with their "overall" donation experience after they have been registered on clinic

Target: 95%

SLT Lead: Jayne Davey

Current Performance against Target or Standard

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



Performance

Assessment of current performance, set out key points:

At 95.4% donor satisfaction exceeded target for March.

In total there were 1,064 respondents to the donor survey, 177 from North Wales (scoring satisfaction at 95.8%), and 877 from South or West Wales (scoring satisfaction at 95.3%).

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Findings are reported on at Collections Services Monthly Performance Meetings (OSG) to address any actions for individual teams. 'You Said, We Did' actions are taken from the report.	Business as usual, reviewed monthly	Jayne Davey

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Following analysis of the donor satisfaction survey from the Service Improvement team, there are nine metrics statistically linked to the donor satisfaction score. These nine metrics are now being explored to evaluate where improvements can be made in these areas	**Q4 2023/24**	Andrew Harris

Expected Performance gain – longer-term

N/A

Risks to future performance

Set out risks which could affect future performance

N/A

KPI Indicator KPV.12

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

Target: 85%

SLT Lead: Head of Nursing

Current Performance against Target or Standard

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

Performance

Assessment of current performance, set out key points:

- Target deadline has been achieved

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Patient Experience and Concerns manager in post since February 2023

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

KPI Indicator KPI.03

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% Formal Concerns responded to under "Putting Things Right" (PTR) within required 30-day Timescale

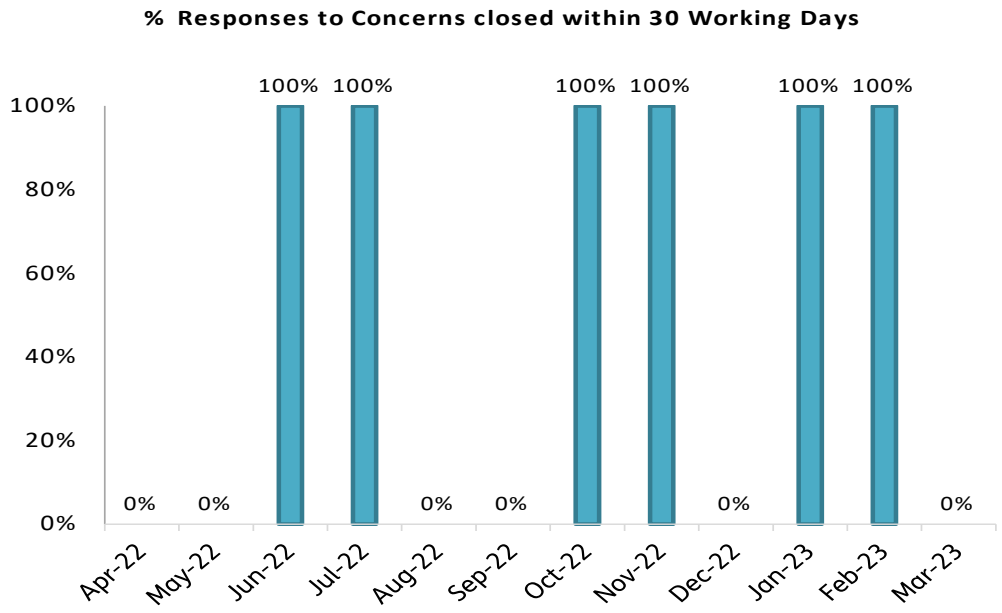
Target: 90%

SLT Lead: Edwin Massey

Current Performance against Target or Standard

WBS	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 %	n/a	100	n/a	n/a	n/a	100	100	n/a	n/a	100	100	N/A	100	100	N/A
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



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:
There were no formal concerns raised or due to be closed in March 2023.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:
• Continue to monitor this measure against the '30 working day' target compliance. • Continued emphasis of concerns reporting timescale to all staff involved in concerns management reporting	Ongoing **Lead:** Edwin Massey

Expected Performance gain – immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:
Continue to monitor and have oversight of concerns management in line with PTR.	Ongoing **Lead:** Julie Reynish

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

TIMELINESS

KPI Indicator KPV.27

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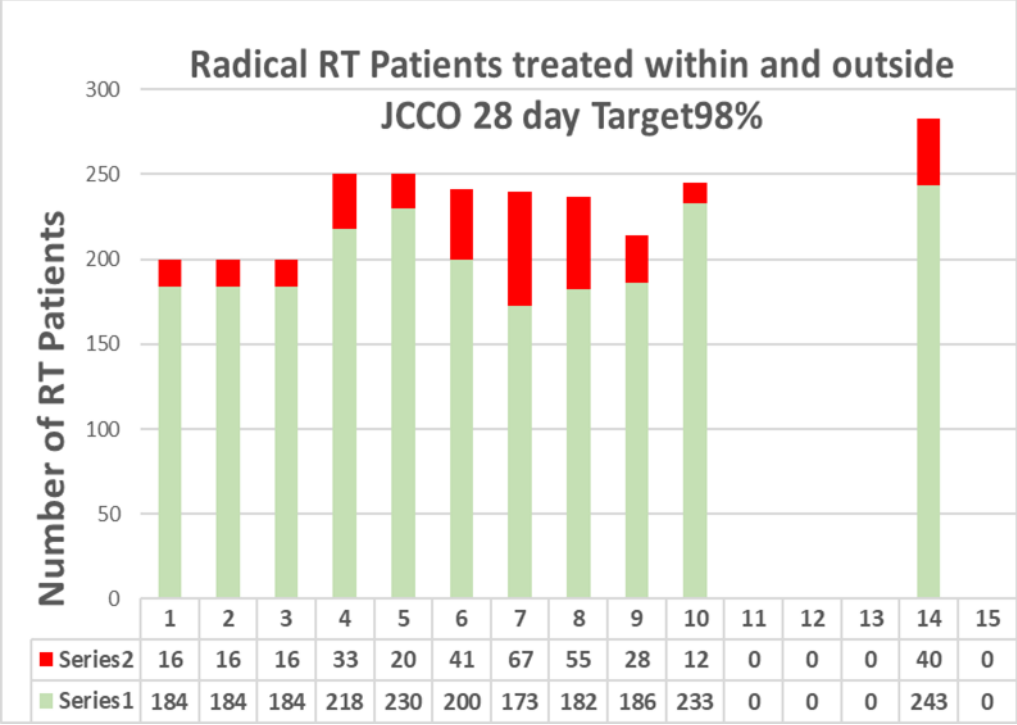
Radical Radiotherapy Patients Treated Within 28 Days (JCCO)	
Target: 98%	**SLT Lead: Head of Radiation Services / Clinical Director**
Current Performance against Target or Standard	**Performance**



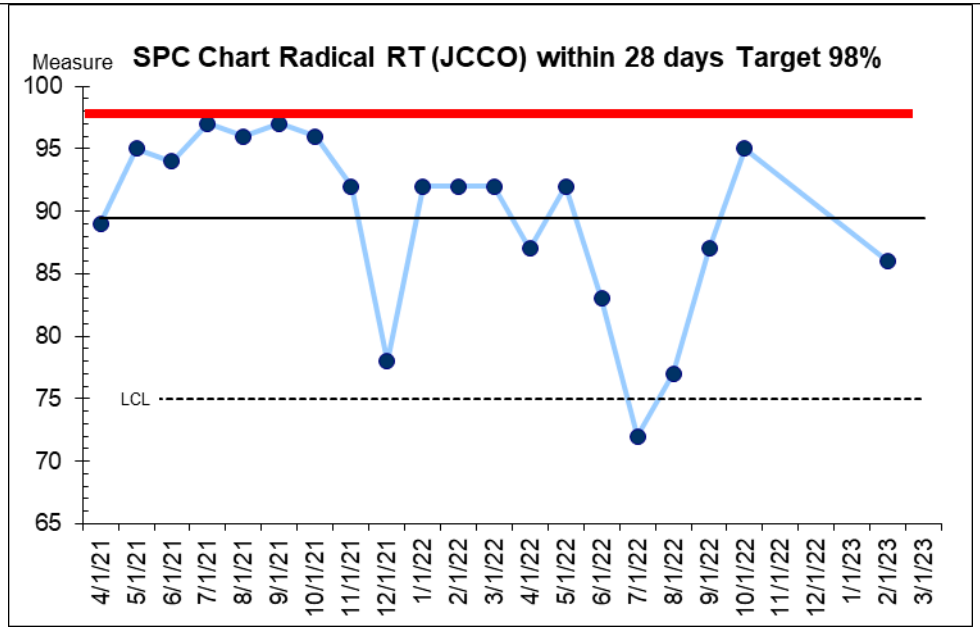
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Series2	16	16	16	33	20	41	67	55	28	12	0	0	0	40	0
Series1	184	184	184	218	230	200	173	182	186	233	0	0	0	243	0

Assessment of current performance, set out key points:

Due to the implementation of DH & CR, there were no waiting list reports available to accurately report Radiotherapy performance for a period. 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 early February. These will be tested and will be followed by a validation of the waiting list reports for November and December, followed by the January position. There will not be a reported position available until the January report is produced. 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	
• Delays and cancellations are monitored weekly and reported back to Radiotherapy Management Group and the pathway sub-group.	January 2023	



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.

• Review of patients who were not ready for treatment to assess whether treatment planned too soon. Collate lessons learnt and review pathway. • The Prostate HDR business case was approved by Senior Leadership Team at the Velindre Futures Programme Board in June 2022. The preferred option of extended days will be the model utilised in the expansion.		SI Manager Radiation Services Manager
Expected Performance gain - immediate		
Service Improvement Actions – tactical (12 months +)		
Actions: what we are doing to improve • 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.	**Timescale:** Q3/4	**Lead:** 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.		

KPI Indicator KPV.18

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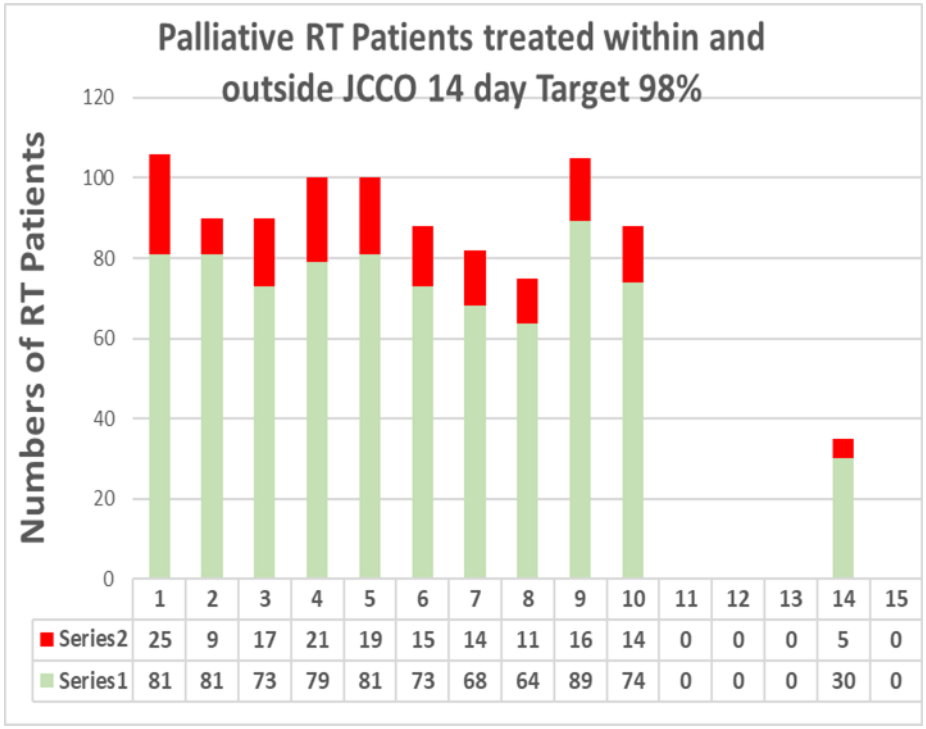
Palliative Radiotherapy Patients Treated Within 14 Days (JCCO)	
Target: 98%	**SLT Lead: Head of Radiation Services / Clinical Director**
Current Performance against Target or Standard	**Performance**



	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Series2	25	9	17	21	19	15	14	11	16	14	0	0	0	5	0
Series1	81	81	73	79	81	73	68	64	89	74	0	0	0	30	0

Due to the implementation of DH & CR, there were no waiting list reports available to accurately report Radiotherapy performance for a period. 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 early February. These will be tested and will be followed by a validation of the waiting list reports for November and December, followed by the January position. There will not be a reported position available until the January report is produced. The targets affected by this are the 3 Radiotherapy waiting time targets.

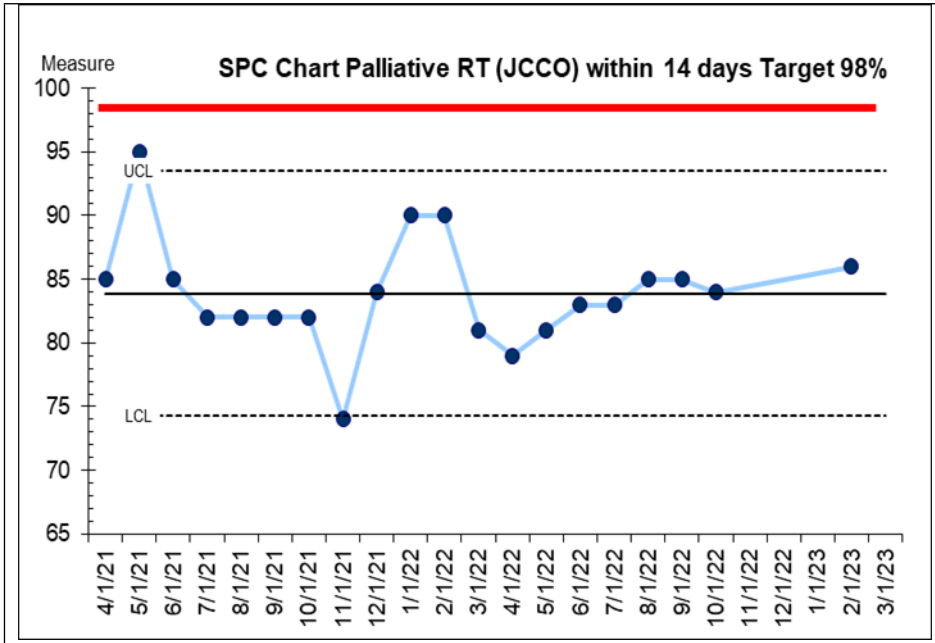
Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Review of 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		Heads of Service / Medical Lead

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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



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.

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

KPI Indicator KPV.19

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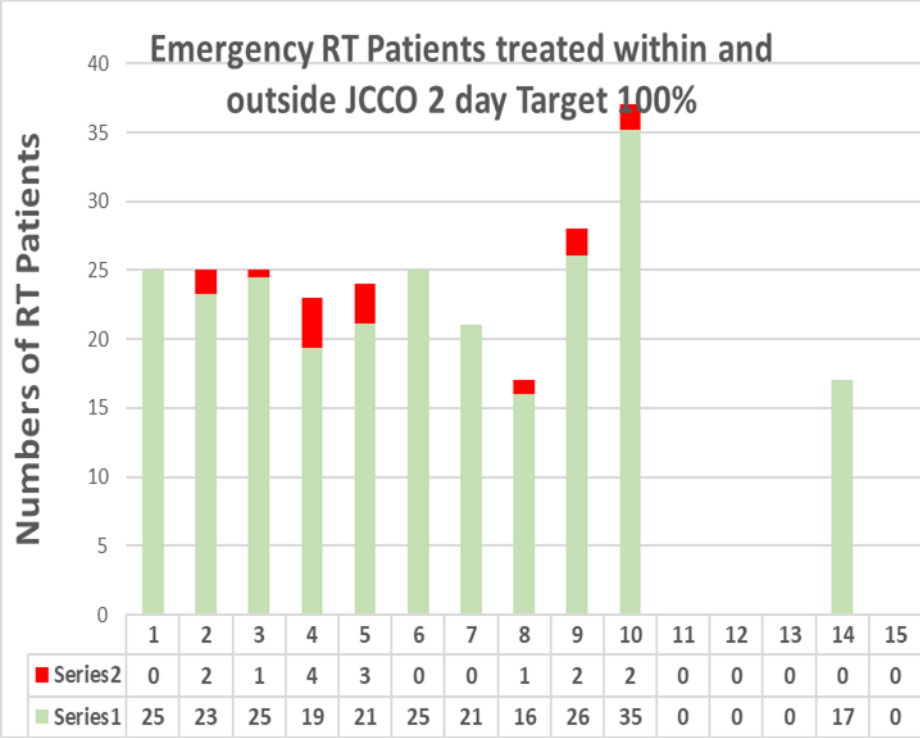
Emergency Radiotherapy Patients Treated Within 2 Days (JCCO)	
Target: 98%	**SLT Lead: Head of Radiation Services / Clinical Director**
Current Performance against Target or Standard	**Performance**



Due to the implementation of DH & CR, there were no waiting list reports available to accurately report Radiotherapy performance for a period. 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 early February. These will be tested and will be followed by a validation of the waiting list reports for November and December, followed by the January position. There will not be a reported position available until the January report is produced. 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

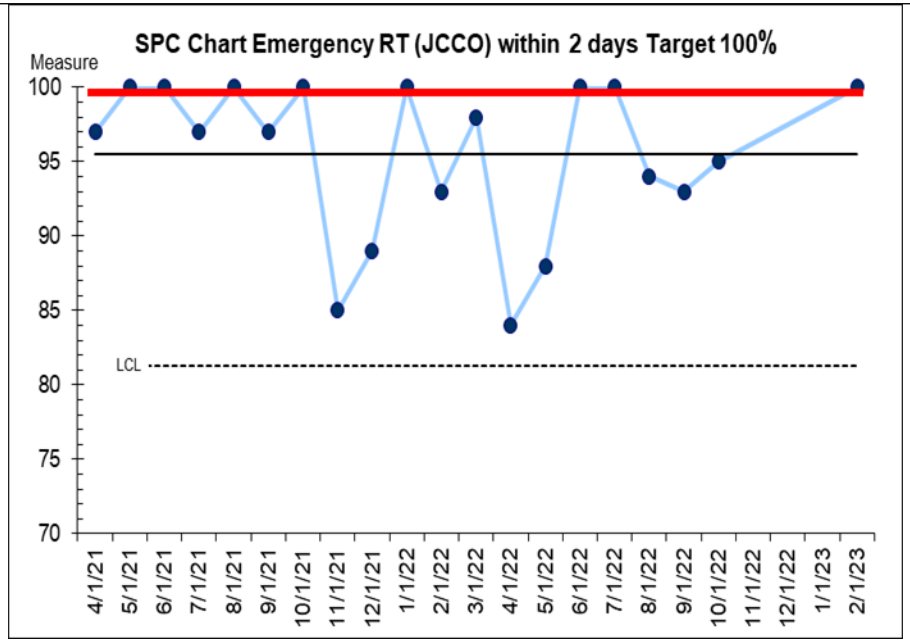
Expected Performance gain – immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance



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.

Set out risks which could affect future performance

-

KPI Indicator KPV.14

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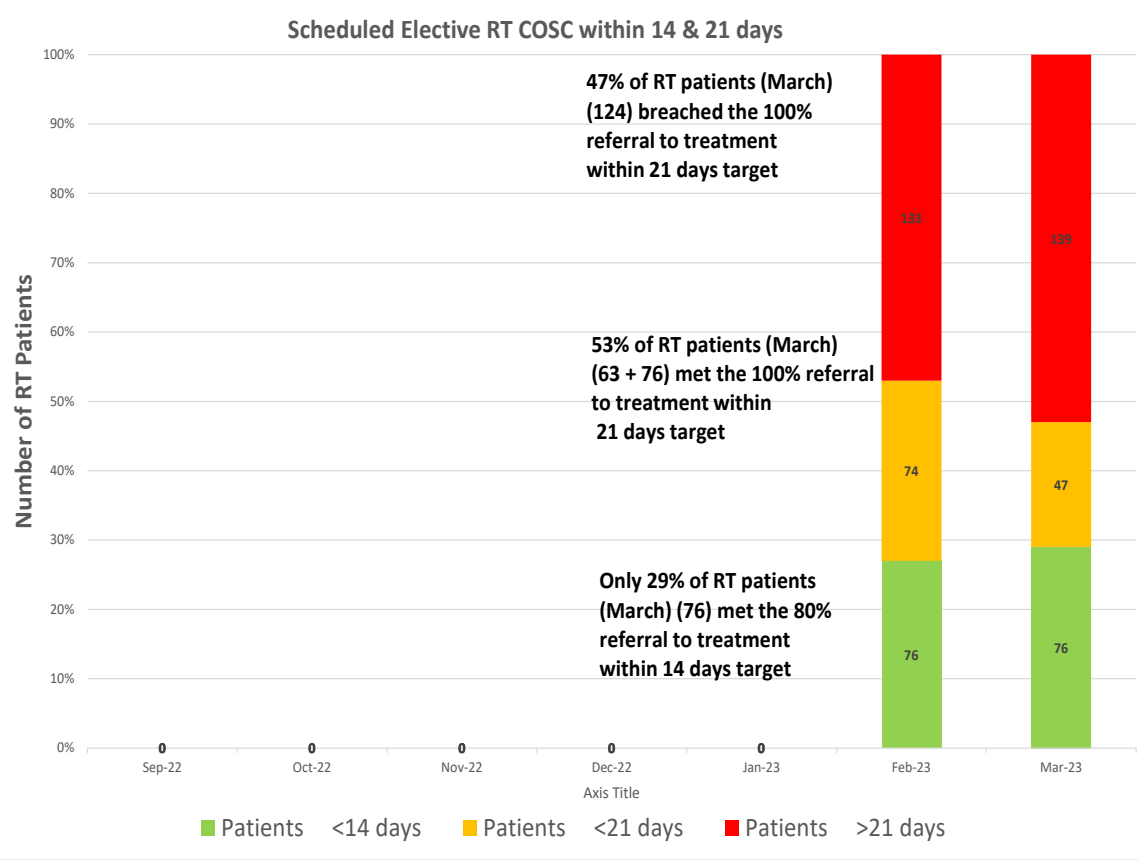
Scheduled Radiotherapy Patients Treated 80% within 14 Days and 100% within 21 Days (COSC)

Target: 80%

SLT Lead: Head of Radiation Services / Clinical Director

Current Performance against Target or Standard



SPC Chart Analysis

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

Performance

Assessment of current performance, set out key points:

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

Number of referrals	263	
treated within 14 days of referral (80% target)	76	29%
treated within 21 days of referral (100% target)	124	47%

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Fully validated position and improvement in performance.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Pathway change group in place to address changes in process to meet revised patient journey timings with SST leads.	6 months	Tom Rackley

Expected Performance gain – longer-term

Changes to patient pathway in line with cosc timings

Risks to future performance

Set out risks which could affect future performance

Linac replacement programme which has already commenced

KPI Indicator KPV.15

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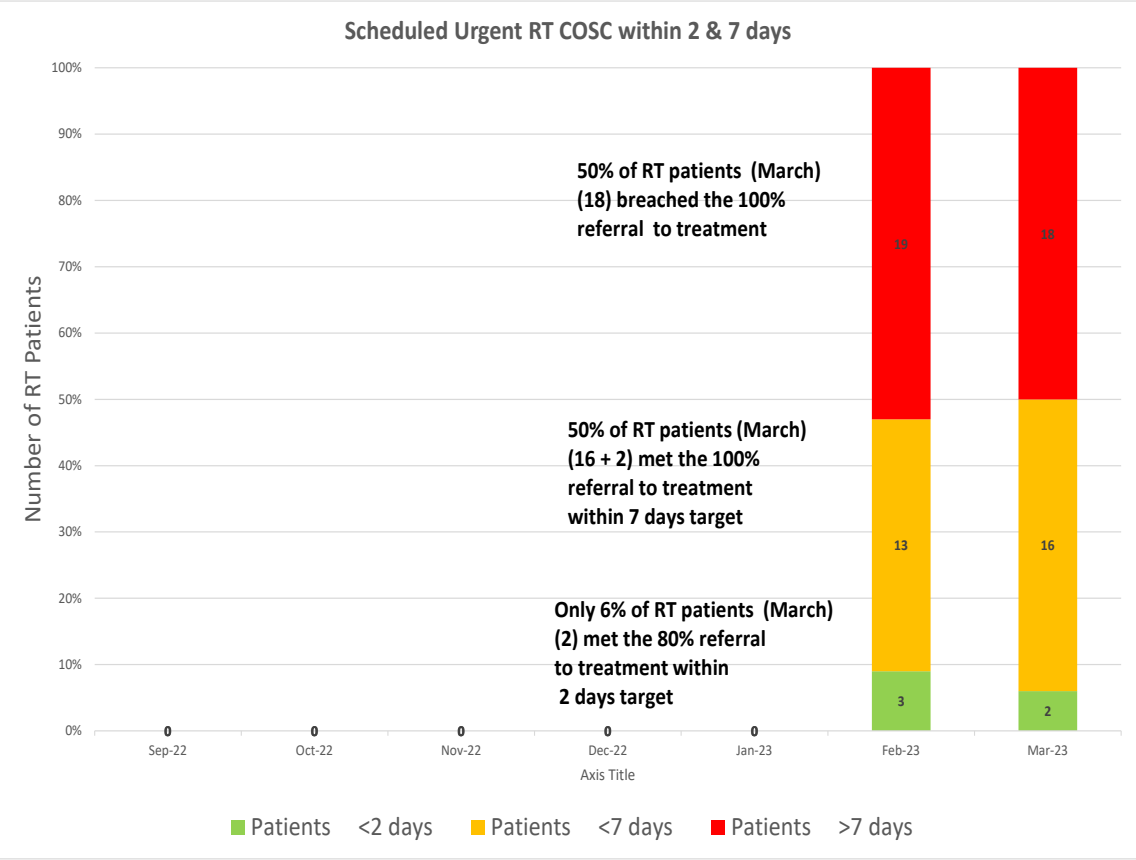
Urgent Scheduled Radiotherapy Patients Treated 80% within 2 Days and 100% within 7 days (COSC)

Target: 80%

SLT Lead: Head of Radiation Services / Clinical Director

Current Performance against Target or Standard



SPC Chart Analysis

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

Performance

Assessment of current performance, set out key points:

Issues as Scheduled elective patients above

Number of referrals	36	
treated within 2 days of referral (80% target)	2	6%
treated within 7 days of referral (100% target)	18	50%

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

KPI Indicator KPV.16

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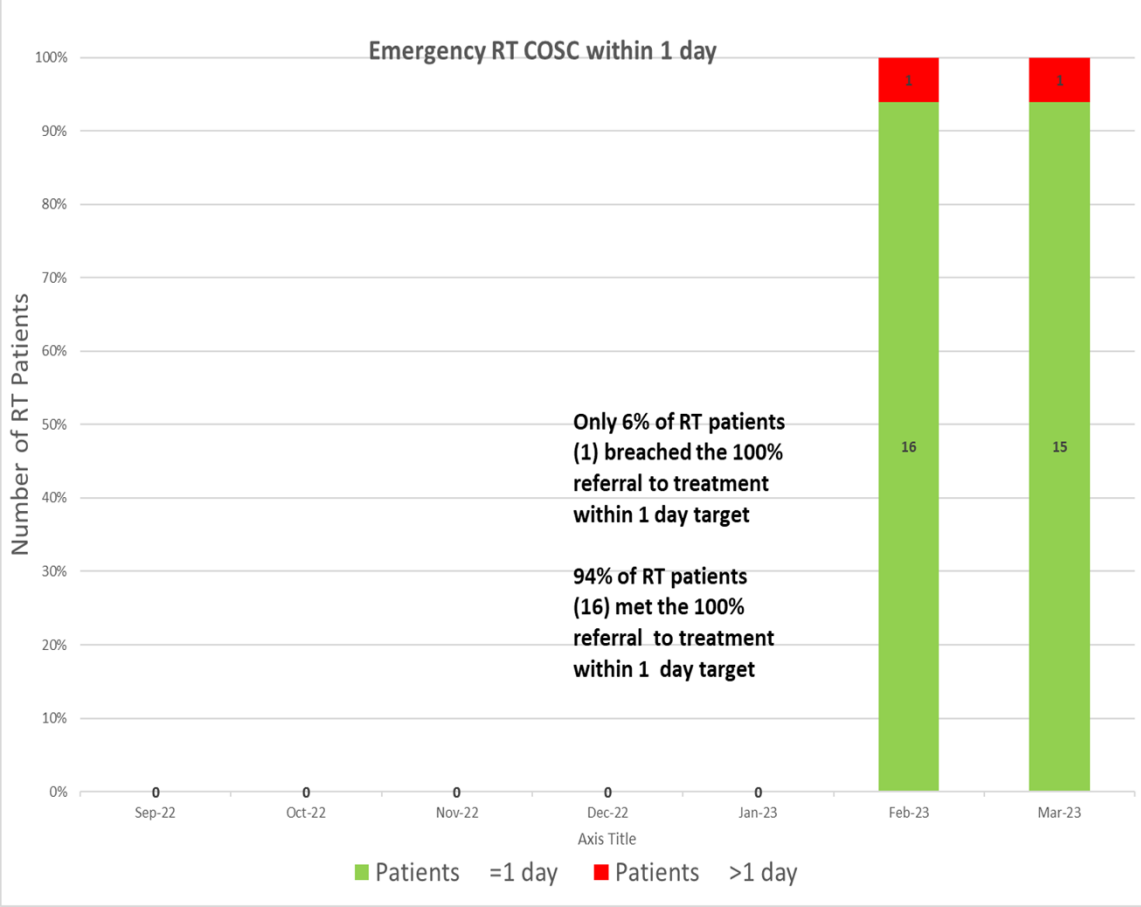
Emergency Radiotherapy Patients Treated Within 1 Day (COSC)

Target: 80%

SLT Lead: Head of Radiation Services / Clinical Director

Current Performance against Target or Standard



SPC Chart Analysis

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

Performance

Assessment of current performance, set out key points:

Issues as Scheduled elective patients above

Number of referrals	16	
% treated within 1 day of referral	15	94%
% treated within 2 days of referral	16	100%

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
As for scheduled above		

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

KPI Indicator KPV.17

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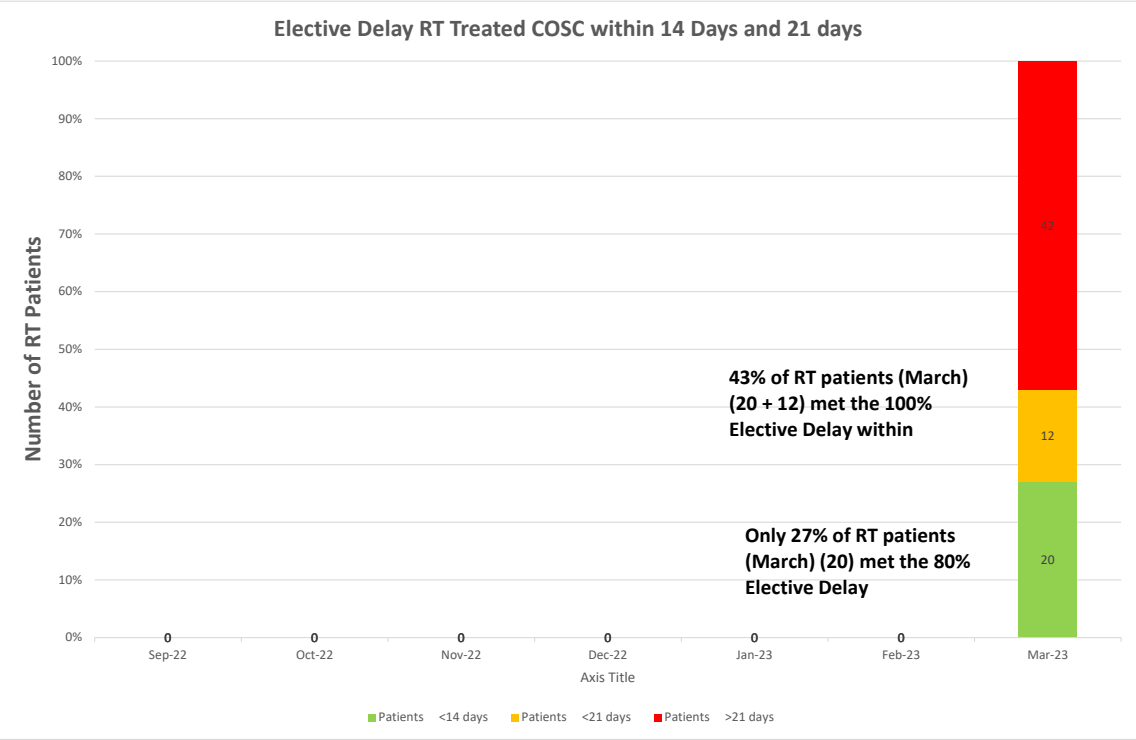
Elective delay Radiotherapy Patients Treated 80% within 14 Days and 100% within 21 Days (COSC)	
Target: 80%	**SLT Lead: Head of Radiation Services / Clinical Director**
Current Performance against Target or Standard	**Performance**

Elective delay is a new recording category and differentiates between scheduled patients referred in to commence treatment as soon as possible, and those referred whilst on another form of treatment



SPC Chart Analysis

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

Assessment of current performance, set out key points:

Issues as Scheduled elective patients above

Number of referrals	74	
treated within 14 days of referral (80% target)	20	27%
treated within 21 days of referral (100% target)	32	43%

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
As for Scheduled Above		

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

KPI Indicator KPV.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

	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	Feb 23	Mar 23
Actual %	94	91	71	69	61	59	66	77	89	96	98	96	97	98	98
Target 98%	**98**	**98**	**98**	**98**	**98**	**98**	**98**	**98**	**98**	**98**	**98**	**98**	**98**	**98**	**98**
More than 21 days	**21**	**32**	**118**	**116**	**146**	**147**				**14**	**6**	**12**	**9**	**9**	**8**
Within 21 days	**329**	**319**	**400**	**375**	**375**	**355**				**341**	**354**	**322**	**336**	**388**	**409**

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	2,558							

Performance

Of 409 patients treated, 8 patients waited over 21 days = performance of 98%. Target Achieved

Intent /Days -	22-28	29-35	36-42	43 days +
Non-emergency (21-day target)	6	1	1	0

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• The reintroduction of services at Nevill Hall Hospital (NHH) interim facility from April 2023.	In Place April 2023	BT

Expected Performance gain – immediate

Maintain current delivery of targets

Service Improvement Actions – tactical (12 months +)

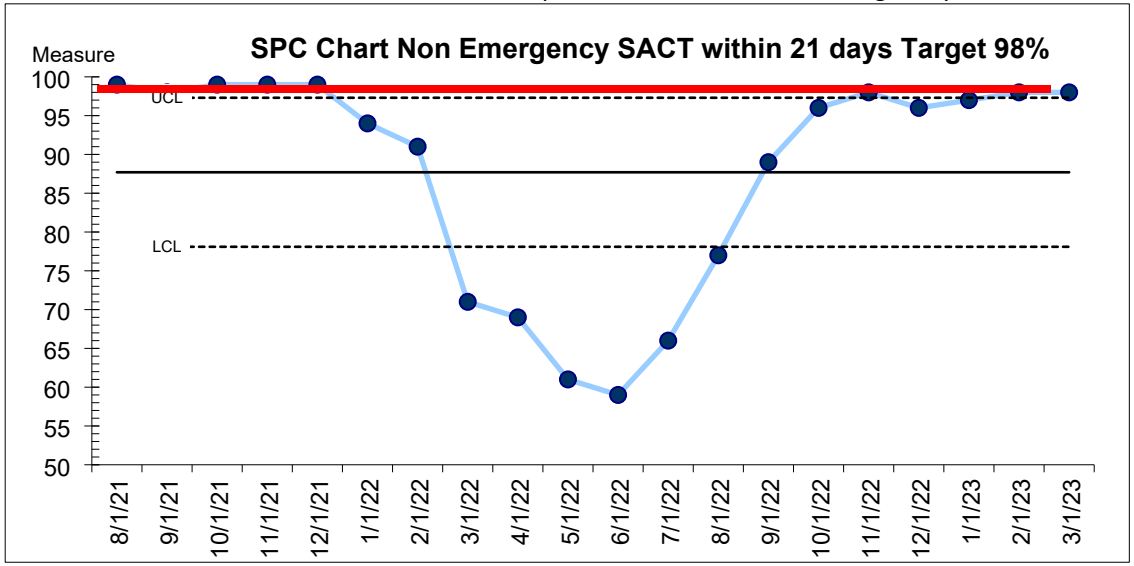
Actions: what we are doing to improve	Timescale:	Lead:
SACT Delivery Group commenced to deliver balanced capacity plan and implement service improvement plans for Nursing, SACT booking and pharmacy.	In place and implementation over next 12 months	Bethan Tranter

Expected Performance gain – longer-term

Improved productivity, balance of capacity and staffing, preparedness for future challenges.

Risks to future performance

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.



SPC Chart Analysis

The system improvements were maintained for the period May to Dec 2021, but a significant fall and 'special cause' variation trend during the summer with recent recovery.

Set out risks which could affect future performance

KPI Indicator KPV.21

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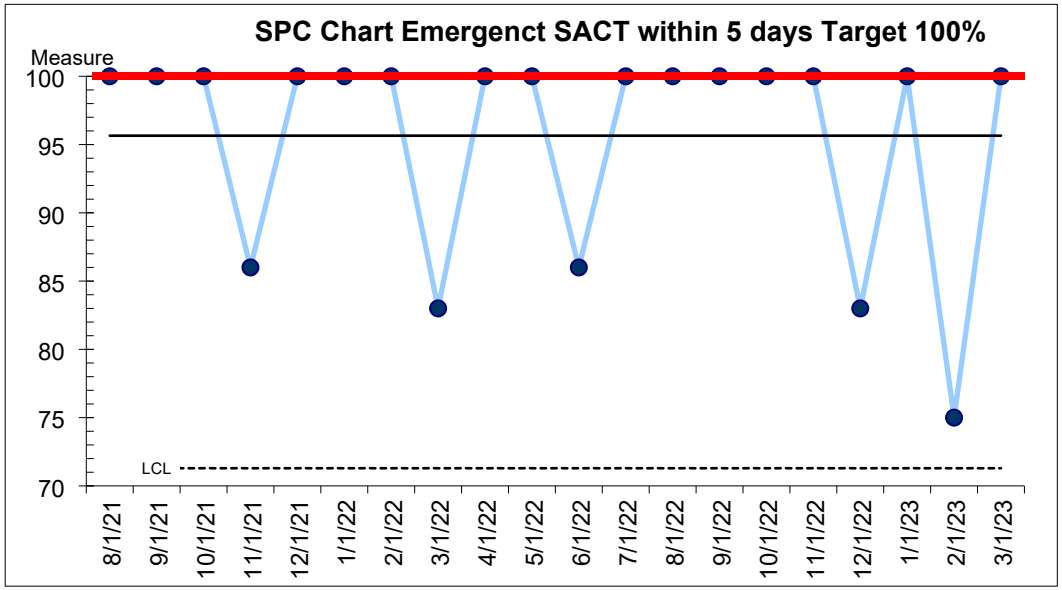
Emergency SACT Patients Treated Within 5 Days

Target: 100%

SLT Lead: Head of Medicines Management and SACT

Current Performance against Target or Standard

VCC	Jan 22	Feb 22	Ma 22	Apr 22	My 22	Jun 22	Jul22	Au22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Actual %	100	100	83	100	100	86	100	100	100	100	100	83	100	75	100
Target 100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
More than 5 days	0	0	1	0	0	2	0	0	0	0	0	1	0	1	0
Within 5 days	10	9	6	7	9	7			0	5	6	5	8	3	



SPC Chart Analysis

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

Performance

7 patients referred for emergency SACT treatment were scheduled to begin treatment in March 2023. All were treated in target = 100% performance.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Continue to balance demand and ring fencing with capacity. Other actions as set out in non emergency above.	Ongoing	BT

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

-

KPI Indicator KPI.18

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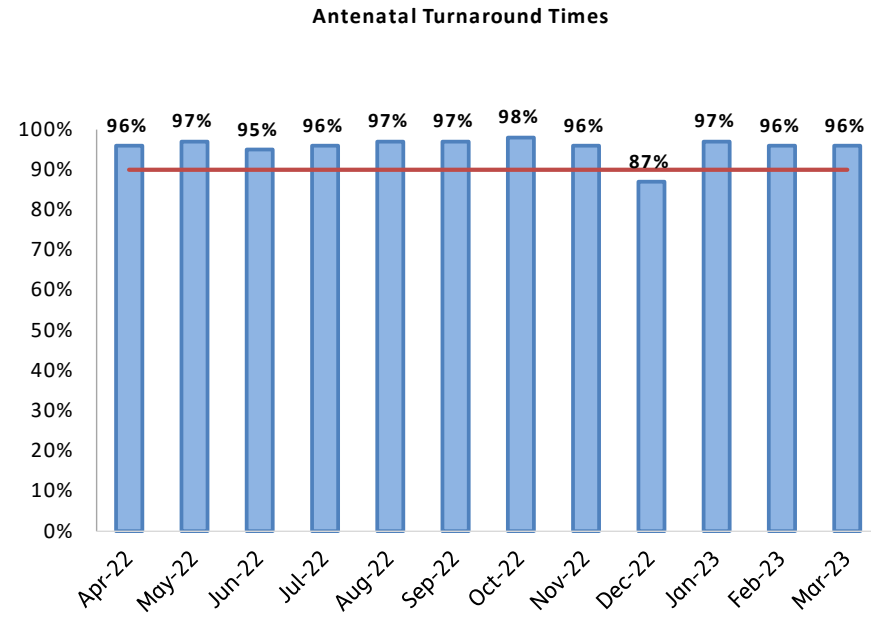
Antenatal Turnaround Times - Patient Results provided to customer Hospitals within 3 working days of receipt of sample

Target: 90%

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Actual %	96	96	96	95	96	95	96	97	97	98	96	87	97	96	96
Target 90%	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90



Performance

Assessment of current performance, set out key points:
At 96% the turnaround time performance for routine Antenatal tests continued to exceed target in March 2023.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Efficient and embedded testing systems are in place. Continuation of existing processes are maintaining high performance against current target.	Ongoing	Tracey Rees

Expected Performance gain - immediate.
Business as usual, reviewed daily.

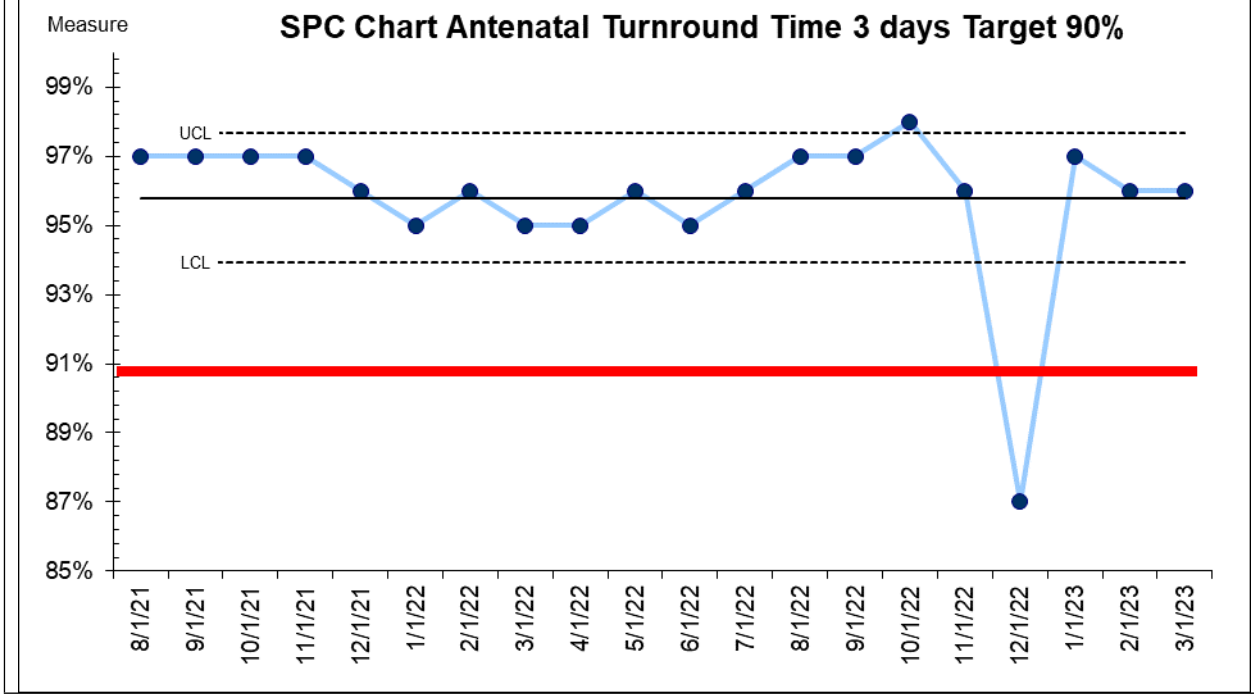
Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term.
N/A

Risks to future performance

Set out risks which could affect future performance



SPC Chart Analysis

The SPC chart shows common cause or normal variation over the 15-month period. However, a special cause variation has occurred in December (as discussed above). The average performance of 96% exceeds the 90% target.

KPI Indicator KPI.17

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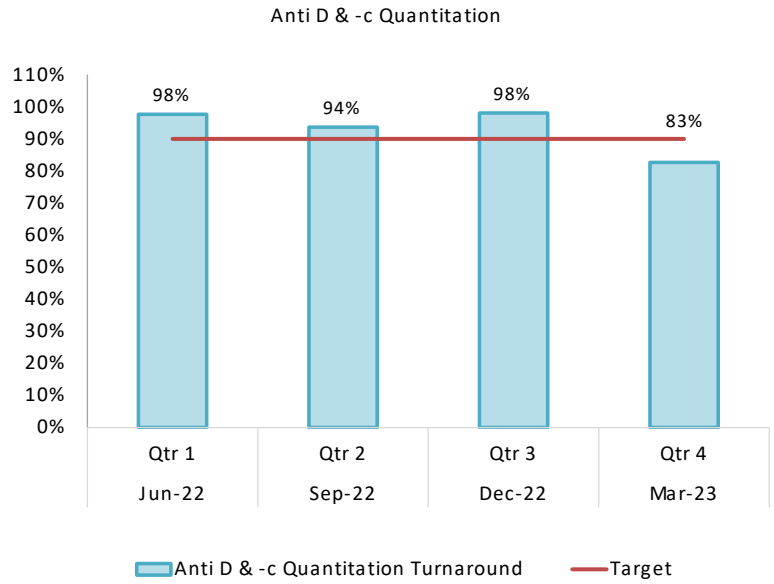
% Antenatal -D & -C quantitation results provided to customer hospitals within 5 working days

Target: 90% per quarter

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	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	96	60	92
Target 90%	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90



Performance

Performance against this quarterly metric was below target this quarter and is attributed to absence of key staff in February.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Review the resilience of the reporting team within the dept to ensure that reporting function is maintained and completed on time.	Q1	Tracey Rees

Expected Performance gain - immediate.

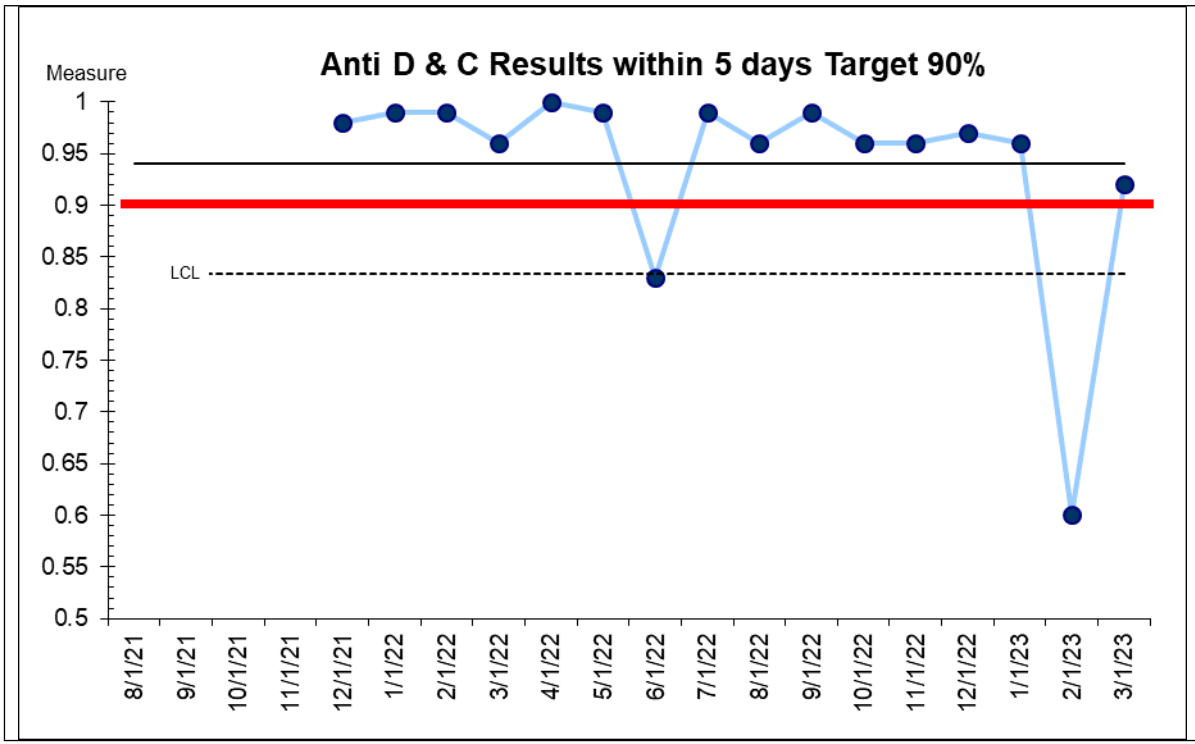
Service Improvement Actions – tactical (12 months +)

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.



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

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Financial Balance – Revenue Position

Target: Net Zero Trajectory

SLT Lead: Director of Finance

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	4	64
Target Net Zero													NIL

Trust-wide Revenue Position for 2022/23

	Full Year Budget £m	Full Year Actual £m	Closing Variance £m
VCC	(39.905)	(39.892)	0.014
RD&I	0.149	0.153	0.004
WBS	(21.405)	(21.406)	(0.001)
Sub-Total Divisions	(61.162)	(61.145)	0.017
Corporate Services Directorates	(12.123)	(12.231)	(0.108)
Delegated Budget Position	(73.285)	(73.376)	(0.091)
TCS	(0.695)	(0.564)	0.131
Health Technology Wales	0.000	0.025	0.025
Trust Income / Reserves	73.980	73.980	(0.000)
Trust Position	0.000	0.064	0.064

Assessment of current performance, set out key points:

The overall position against the profiled revenue budget for 2022-23 was an underspend of £0.064m.

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

•

KPI Indicator FIN.73

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Financial Balance – Capital Expenditure Position

Target: Expenditure in line with Capital Forecast

SLT Lead: Finance Director

Current Performance against Target or Standard

Trust Position	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	19.495	27,758
Target £27.760M CEL		1.0	1.411	3.134	3.989	4.615	5.954	7.884	9.681	11.796	14.346	19.495	27.760

Trust-wide Capital Position for 2022/23

	Approved CEL £m	Full Year Actual Spend £m	Year End Variance £m
All Wales Capital Programme			
nVCC - Project costs	2.394	2.994	-0.600
nVCC - Enabling Works	14.406	13.806	0.600
Canisc Cancer Project	0.579	0.581	-0.002
Fire Safety	0.500	0.500	0.000
Integrated Radiotherapy Solutions (IRS)	7.900	8.004	-0.104
WG Priority Year end Spend	0.370	0.361	0.009
WBS Infrastructure OBC Fees	0.157	0.135	0.022
Total All Wales Capital Programme	26.306	26.381	-0.075
Discretionary Capital	1.454	1.377	0.077
Total	27.760	27.758	0.002

Performance

The overall Capital programme achieved the Trust CEL by reporting a spend of £27.758m against a CEL allocation of £27.760m.

An underspend from last minute slippage on the discretionary programme was utilised against the IRS programme under the All Wales Capital programme.

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 the IRS. The total funding allocated is £41.602m for the period April

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

•

KPI Indicator FIN.72

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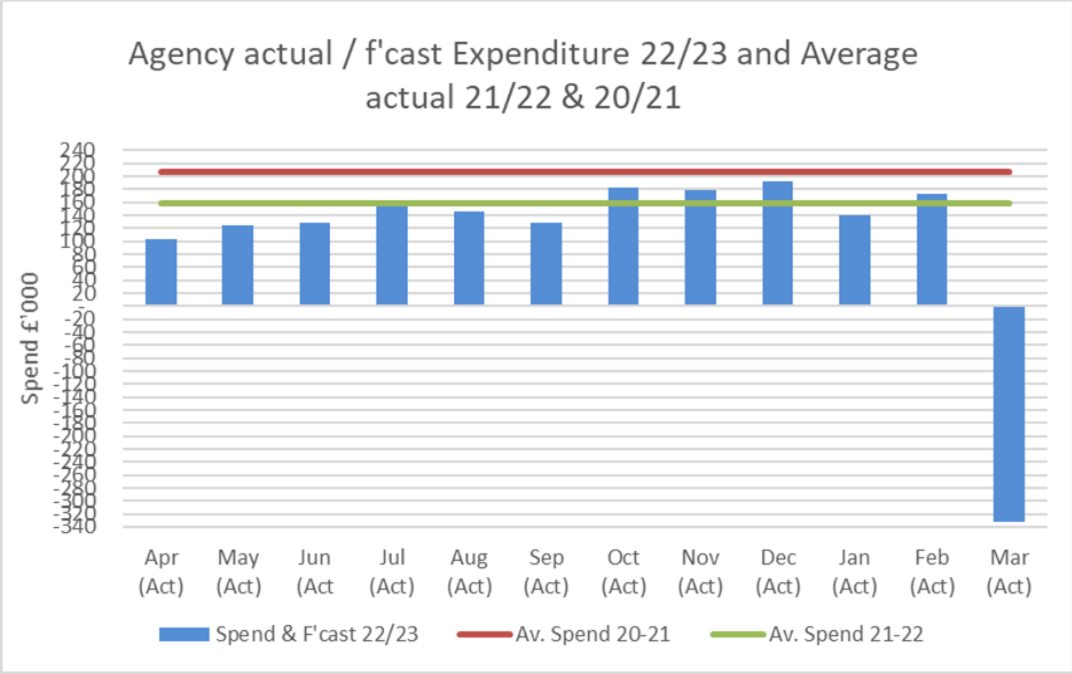
Usage of Overtime Bank and Agency Staff within Budget

Target: Spending within budget

SLT Lead: Finance Director

Current Performance against Target or Standard

Trust Position	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	173	(332)
Target £1.533M Forecast		128	128	128	128	128	128	128	128	128	128	128	128



Performance

The spend on agency for March '23 was £(0.332)m (February £0.173m), which gives a cumulative full year spend of **£1.323m** for 2022-23 (£1.906m 2021/22). Of these totals the total spent on agency directly relating to Covid was £0.314m (£0.826m 2021-22). 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 were required at the back end of the year in particular to support the running of estates in VCC to ensure delivery of ongoing maintenance and statutory compliance duties. The service has been actively recruiting into this area, so agency costs are expected to be replaced by the use of appointing permanent staff during 2023-24.

During March a review of agency requirement within VCC was undertaken which resulted in the release of a bfwd provision from 2021-22. In addition, a review of system committed orders was undertaken which resulted in several receipted orders being identified as no longer being required. This generally occurs when agency staff leave before their agreed term and the orders need to be closed, consequently a credit is released back into the revenue position

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Actions addressed via Divisional action plans		Matthew Bunce

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

•

KPI Indicator FIN.74

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Cost Improvement Programme delivery against plan

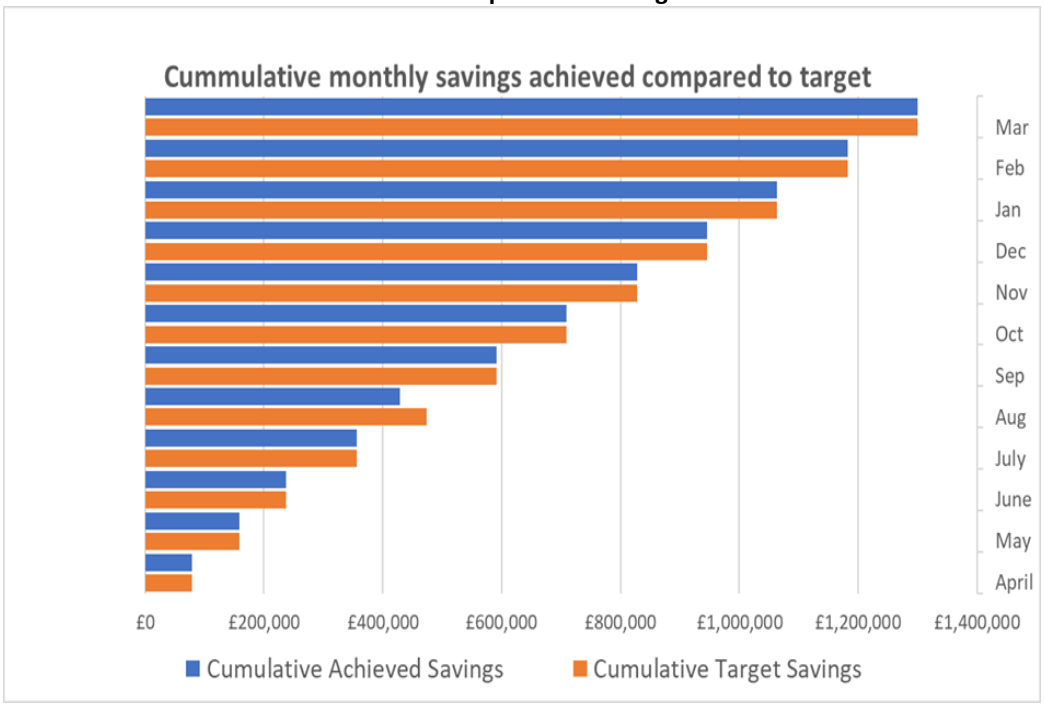
Target: Savings in line with Forecast CIP

SLT Lead: Finance Director

Current Performance against Target or Standard

Trust Position	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	.0160	0.254	**0.355**	0.429	0.592	0.709	0.795	0.945	1.064	1.182	1.300
Target £1.3M Forecast		0.75	0.160	0.254	0.355	0.474	0.592	0.709	0.795	0.945	1.064	1.182	1.300

Overall VUNHST Cost Improvement Programme £1.3M



Performance

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 cost reduction 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 VCC workforce schemes which relate to service redesign and support structures continued to be impacted by the Covid legacy of higher than normal sickness levels and significant activity demand pressures during 2022-23 and therefore were turned from RAG rated amber to red due to the inability to deliver.

Service redesign and support structures is a key area of savings for the Trust which are focused on removing inefficiencies in the ways the Trust are working. 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 VCC Division however, it was recognised due to the current challenges that these saving schemes were not going to be achieved during the financial year.

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

•

KPI Indicator FIN.60

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Public Sector Payment Performance Target Non NHS Invoices paid within 30 days

Target: 95%

SLT Lead: Finance Director

Current Performance against Target or Standard

	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	Feb 23	Mar 23
Trust Position															
Capital & Revenue Invoices				95	95	96	96	96	96	96	96	95	94	95	95
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 March '23 the Trust (core) achieved a draft compliance level of **95%** (February 23: 95%) of non-NHS supplier invoices paid within the 30-day target, which resulted in a cumulative core Trust compliance figure of **95%** (draft) for 2022-23 and a final Trust position (including hosted bodies) of **95%** (draft) which will result Trust as a whole met its statutory target of 95%.

PSPP has shown signs of recovery over the last couple of months which is following a dip of performance in the preceding few months and this has resulted in the overall Trust achieving the 95% target. Work between the finance team, NWSSP accounts payable team and the service will need to continue in order to both improve and maintain performance going into 2023/24.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
	31/03/2023	M Bunce

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Work between Finance, NWSSP and the service will continue into 2023-24 in order to both improve and maintain performance.	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

KPI Indicator WOD.81

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% Workforce declared Welsh Speakers in Trust at Level 1

Target: TBA%

SLT Lead: Director of Workforce and OD

Current Performance against Target or Standard

Trust Position	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]

Total VUNHST headcount 1624

People with a Disability 70 (4%)

SPC Chart Analysis

The SPC chart shows

Performance

Assessment of current performance, set out key points:

- insert text
-

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
- insert text

KPI Indicator WOD.78

Return to Top

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

Target: TBA%

SLT Lead: Director of Workforce and OD

Current Performance against Target or Standard

Trust Position	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]

Total VUNHST headcount 1624
Male 405 (25%)
Female 1219 (75%)
Senior positions (Band 8 +)
Male 94 (37%)
Female 159 (63%)

SPC Chart Analysis
The SPC chart shows

Performance

Assessment of current performance, set out key points:

- insert text
-

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
-

KPI Indicator WOD.79

Return to Top

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

Target: TBA%

SLT Lead: Director of Workforce and OD

Current Performance against Target or Standard

Trust Position	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]

Total VUNHST headcount 1624

White 1424 (88%)

Black, Asian and Minority Ethnic people 200 (12%)

SPC Chart Analysis

The SPC chart shows

Performance

Assessment of current performance, set out key points:

- insert text
-

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
-

KPI Indicator WOD.80

Return to Top

Diversity of Workforce – People with a Disability

Target: TBA%

SLT Lead: Director of Workforce and OD

Current Performance against Target or Standard

Trust Position	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]

Total VUNHST headcount 1624

People with a Disability 70 (4%)

SPC Chart Analysis

The SPC chart shows

Performance

Assessment of current performance, set out key points:

- insert text
-

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
-

QUALITY SAFETY AND PERFORMANCE COMMITTEE

TRUST INTEGRATED MEDIUM TERM PLAN – PROGRESS AGAINST QUARTERLY ACTIONS FOR 2022 / 2023

DATE OF MEETING	16/05/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	N/A

PREPARED BY	Peter Gorin, Head of Strategic Planning & Performance
PRESENTED BY	Philip Hodson, Assistant Director Planning & Performance
EXECUTIVE SPONSOR APPROVED	Carl James, Executive Director of Strategic Transformation, Planning & Digital

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
VCC Senior Leadership Team	April 2023	Noted
WBS Senior Management Team	April 2023	Noted
Executive Management Board	2nd May 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 (IMTP) 2022-2025 was approved by the Minister for Health and Social Service in July 2022. Integral to the IMTP was a range of Action Plans to support the delivery of the Trust's Strategic Aims, across our range of cancer services and blood and transplant services.

1.2 Following approval of our IMTP a letter was issued from the Director General and NHS Wales Chief Executive to the Chief Executive of Velindre University NHS Trust. This letter set a number of IMTP Accountability Conditions, including the requirement to report progress against key IMTP action plans.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 This report provides progress against the Quarterly Actions identified in the IMTP for 2022/23 in the form of the monitoring templates for WBS and VCC, included within **Appendices A and B**.

2.2 Due to the timing of the end of Quarter 4 (January to March 2023), this final year end position for 2022/23 has been prepared for the next QSP Committee meeting to be held on 16th May 2023.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:

EQUALITY IMPACT ASSESSMENT COMPLETED	Not required (Note: the IMTP will be subject to a EQIA assessment as will all relevant service developments proposals detailed within the IMTP)
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

4.1 The Quality Safety and Performance Committee is asked to **NOTE** the yearend position in delivering against the key Trust actions included within the approved IMTP for 2022 – 2025.

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

APPENDIX A

Welsh Blood Service IMTP Quarterly Progress Report 2022/23 for Quarter 4 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 Q4 (yearend)**	**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.	With agreement from Policy Leads at Welsh Government, WBS has formally expressed an interest in joining the UK Plasma Fractionation contract to supply recovered plasma from whole blood donations. The outcome of the contract negotiations is expected by June 2023. In the meantime, the WBS project plan is underway to enable plasma supply for fractionation to start from April 2025. WBS is now a member of the UK Plasma Programme Board and has contributed to a safety assessment of UK plasma which was published recently. This is likely to play a significant part in addressing regulatory concerns from the EU and reduce the overall risks to the programme.	
	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.	Development of the Donor Strategy continues with engagement planned with donors/stakeholders/public via facilitated focus groups.	

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 Q4 (yearend)**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
	3. Develop and implement WBMDR strategy.	Scope service need project structure established draft strategy produced.	Consultation on strategy.	Implementation plan developed.	Implementation commence.	Reappraising the existing collection model and the development of the new 5 year strategy for WBMDR continues under the WBS Futures initiative. UK Stem Cell Strategic Forum recommendations are also being taken forward as part of this work. The Recovery Plan is being implemented to increase recruitment of bone marrow volunteers.	
	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.	The first phase of the OCP has been completed. The second phase and agreement of the new clinical model will be taken up under the Collection Services Modernisation Programme a part of WBS Futures initiative.	

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 Q4 (yearend)**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
SP2: Meet the patient demand for blood and blood products through faciltiating 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.	Governance for the Vein to Vein (V2V) project has been transferred to Digital Healthcare Wales (DHCW) to provide further alignment with the LINC programme.	
SP3: Provide safe, high quality and the most advanced manufacturing, distrbution and testing laboratory services	**6.** Assess and implement SaBTO (guidelines 2021 release date) recommendations on blood donor testing to reduce the risk of transmission of Hepatitis B infection as required.	Confirm role of WBS with Welsh Government establish project structure.	Complete OCP process in relation to service mode.	Establish workforce model.	Implementation.	Stock swap out completed, all blood components in WBS and Health Boards now Hep B core negative. This element of the Hep B Core project is completed. There have been 3 confirmed lookbacks identified to date. Completion of lookback documentation by Health Boards is ongoing and actively monitored for compliance by the WBS Blood Health Team.	

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 Q4 (yearend)**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
						Quarterly progress reports continue to be submitted to the WG Oversight Board. SaBTO is currently reviewing the pathway for notification of relatives of deceased recipient patients and updated guidance is expected. WBS continues to attend the OBI UK Forum Implementation Group and work collaboratively across the UK Blood Services to ensure successful completion of this project.	
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 has been transferred to Digital Healthcare Wales (DHCW) for management and implementation. A new National Steering Group for WLIMS implementation has been set up, the first meeting took place on 30/01/2023. The Local Deployment Board meeting took place on 06/03/2023, whilst the WBS deployment planning workshop with Citadel took place on the 21/03/2023.	

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 Q4 (yearend)**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
	8. Implementation of Foetal DNA typing.	Engage with Antenatal Screening services to develop implementation plan.	Agree implementation plan.	Take forward implementation.	Take forward implementation.	Procurement for a commercial kit solution will begin in April 2023. The project is expected to go live in as planned January 2024.	
SP5: Provide, services that are environmentally sustainable and benefit our local communities and Wales	**9.** Establish a quality assurance modernisation programme to develop and implement strategy which support more efficient and effective management of regulatory compliance and maximising digital technology.	Project to be scoped. Project structure established. Phased work plan.	Develop implementation plan.	Take forward implementation.		Reconfiguration of RAGG Quality Hub remains under review, and progress reported and monitored via the Trusts' Integrated Quality & Safety Group. The Electronic Signatures (DocuSign) system is being used successfully to date in Phase 1. The eQMS (Quality Management system) user specification (URS) is now complete. Confirmation of an alternative eQMS on the NHS framework has been received. A comparison with a non-WBS system URS has been	

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 Q4 (yearend)**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
						completed and a further meeting is due to take place 14th April to consider the results of the analysis. The redesign of the document hierarchy is scheduled for Q3.	
	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.	Work underway to understand phasing of this programme in light of the Laboratory Modernisation Programme and the Plasma for Medicines programme and the interdependencies with this programme. This work is due to be completed in May 2023.	
SP6: Be a great organisation with great people dedicated to improving outcomes for patients and donors.	**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.	WBS senior management consultation begins in April 2023 and is due to end May 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 Q4 (yearend)**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
	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 under WBS Futures initiative. Work underway to understand phasing of this programme in light of the Talbot Green Infrastructure Programme and the interdependencies. This work is due to be completed in May 2023.	
	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.	The Apheresis Status report is progressing with final report expected in August 2023. A vacant “clean room” cell manufacturing facility option has recently become available at a Cardiff location and is currently being explored by key stakeholder organisations for potential usage.	

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 Q4 (yearend)**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
						A new ATW programme lead has now been appointed with an expected start date of June 2023. An event is planned for June 2023 in collaboration with the Life Science Hub. The focus of the meeting is planning and delivering advanced therapies, with NHS CEOs, Planners, Clinical leads, Research leads, academia, stakeholder organisations as the target audience. An invitation for public representative to join the ATW Programme Board is in the process of being advertised. The clinical trial sector continues to expand, and ATW are providing support, sign posting, and working group facilitation with NHS organisations across a range of projects and research activity.	

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 Q4 (yearend)**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
	14. Support UK Infected Blood Inquiry and delivery of its Terms of Reference.	IBI continues	IBI continues	IBI continues	IBI continues	The hearings have now been completed and the Chair has retired to consider the conclusions. Recommendations are expected in the Autumn of 2023. A 2nd Interim Report was published by the Chair on 5th April 2023 that addressed the issues of compensation. Further recommendations were made in relation to additional eligibility for interim payments and the setting up of a body to address future compensation payments. Compensation payments are expected to be met by the UK Government as health had not been devolved when the harm took place. The Trust is continuing to receive documents from the IBI Team requesting permission to share with other core participants.	

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 Q4 (yearend)**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
						The Chair is in the process of compiling the final report and part of this process involves the sending of "Warning Letters" to individuals or organisations that may be criticised in the final report. This gives individuals or organisations the opportunity to respond to these criticisms prior to the publication of the final report. Should the Trust receive any, they will respond accordingly.	

KEY:

BLUE	Action successfully completed with benefits being realised
GREEN	Satisfactory progress being made against action in line with agreed timescale
YELLOW	Issues with delivery identified and being resolved with remedial actions in place
AMBER	Delays in implementation / action paused due to external issues beyond our control
RED	Challenges causing problems requiring recovery actions to be identified

APPENDIX B

Velindre Cancer Service IMTP Quarterly Progress Report 2022/23 for Quarter 4 as at 20/01/2023.

IMTP Strategic Priorities VCC Service Delivery Framework							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/ Objectives**	**Key Quarterly Actions 2022/23 and Progress**					
		2022/23				**Quarterly Progress Update for Q4 (yearend)**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
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.	Performance relative to time to treatment measures for new referrals maintained at above target levels throughout quarter 4. Level of chair utilization at VCS and at the Macmillan Unit at the Prince Charles Hospital, Merthyr Tydfil maintained.	
		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	Service specification finalised and agreement on total delivery capacity reached. Treatment of patients scheduled to commence in first week of April.	

IMTP Strategic Priorities VCC Service Delivery Framework							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/ Objectives**	**Key Quarterly Actions 2022/23 and Progress**					
		2022/23				**Quarterly Progress Update for Q4 (yearend)**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
		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.		Objective discontinued when identified third-party partner went into receivership in June 2022.	
		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	Action plan developed. Progress against plan will be overseen by new SACT and Medicines Management demand and capacity working group. Group will formally begin work in April 2023 and will report into novel VCS business planning structure.	

IMTP Strategic Priorities VCC Service Delivery Framework							
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		Q1	**Q2**	**Q3**	**Q4**		
	2. Radiation Services Capacity Plan	Maximise Rutherford contract – revised service	MRI refurbishment in radiology	Streamline plan complexity for certain palliative scenarios.		Objective discontinued when identified third-party partner went into receivership in June 2022.	
		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	Linac capacity periodically reduced as various upgrades carried out on TrueBeam machines as part of IRS implementation. Anticipated that 78-hours of capacity will typically be available from March 2023. Radiotherapy specific pathway improvement project to be included as workstream within Centre-wide pathway improvement programme. Programme steering group and radiotherapy workstream to formally begin work in April 2023 (objective fully defined in IMTP for 2023-24).	

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		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			Workforce recruitment to support prostate service expansion underway. Implementation and staff training ongoing alongside review to inform future service model.	

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		Review demand and capacity for clinical trials	Explore dose and fractionation schedules and alternative treatment approaches			Review of overall treatment capacity to be undertaken as part of radiotherapy specific pathway improvement work (objective fully defined in IMTP for 2023-24).	
		Review the Linac transition capacity for IRS implementation.	Agree the position on temporary/mobile/ fully commissioned leased bunkers while IRS process takes down fleet.			Recruitment to identified medical physics roles complete.	
	3. Radiotherapy Pathway/COSC target achievement and radiotherapy clinical	Programme to review efficiency of existing pathways continues including reduction in variation in ways	Develop standard operating procedures for pathway management, building on those developed in Lung Pathways and	Evaluate roles for advanced practice particularly Non-Medical Outliners in optimal pathways with SST leads.	Implement agreed pathway and workforce models developed to meet COSC target requirements.	Pathway improvement improvement workstream scheduled to formally commence work in early April. Draft Terms of Reference and draft work plan developed, group members identified.	

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	treatment developments	of working /action plan developed.	emerging themes/challenges with SST leads.				
		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	Response to formal WHSSC appraisal developed in readiness for submission in April 2023. Appraisal panel visit to Velindre site scheduled for April.	

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		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	Clinical lead(s) to be identified to support prioritisation work of new VCS business planning structure. Engagement with health boards on introduction of novel radiotherapy treatments of breast cancers (including IMN) scheduled to begin in May 2023.	

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	4. Outpatient Services/Medical Directorate	SST and Outpatient Transformation programmes to commence building on pre-pandemic work. (interdependent with radiotherapy projects) 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 multidisciplinary workforce model.	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	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 Reference to be developed (objective fully defined in IMTP for 2023-24). Project to relocate reception desk and introduce outpatient ambulance (non-emergency patient transport) discharge lounge initiated.	

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		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 ways of working				Workforce capacity modelling in Outpatients undertaken for CNSs.	

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		Maximise use of virtual consultations and embed into 'business as usual'. (50% at present).				Virtual consultations continue to be utilised as standard. Rates of utilisation continue to be actively monitored.	

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		Establish optimum levels of Phlebotomy provision and notify HBs of changes in access.				Outpatient nursing team and reception staff have implemented extended working hours to provide support to meet increased demand. Opportunities to increase activity have been explored with further SACT injectable treatment delivered within the Department.	
		Provide increased capacity incl. at evenings/weekends to meet demand initially while the more fundamental pathway changes and ways of working are introduced					

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		pending service improvement efficiency delivery.					
		Work to reduce demand within the Outpatient setting, including: review and streamlining of patient pathways and the implementation of the 'supported self-management' model				Review of workforce and physical capacity utilisation and patient pathways undertaken in Outpatients. Improvement Cymru facilitated lean-style review of Breast-specific pathway undertaken by external consultants. Output of review to inform pathway improvement work from quarter 1 2023-24.	

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		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		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 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	Operational oversight group created to support development of directorate level action plans focused on optimisation of ways of working / administrative processes.	

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		Functional testing	Operational Go Live planning	Dry run weekend planned Complete Go Live review impact on service delivery and lessons learned	Plan phase 2		
		User Acceptance Testing	Go Live readiness assessment				
			Go Live run through				
		Data Migration	SOP development				
		Operational service change planning					
		Training sign off					
	6. Integrated Radiotherapy Solution	Complete Tender Evaluation and Identify Winning Bidder, issue standstill letter.	Complete hybrid OBC/FBC and submit to WG and await approval.	LA6 Bunker Decommissioning commences	LA6 Bunker Refurb complete.	First replacement linac delivered to site. Commissioning work begun. Anticipated that linac will be available for clinical use in early July 2023.	

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			Award IRS contract once approval of capital and revenue funding.		Service plans for second machine replacement confirmed.	Actions on track managed through IRS implementation programme board.	
			Receive vendors detailed implementation plans				
					Initial scoping works on TPS/OIS replacement and Phase 1 additional functionality.	Actions on track managed through IRS implementation programme board.	
					Plans for Satellite and nVCC confirmed	Actions on track managed through IRS implementation programme board.	

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		Appoint Radiation Services Programme Manager to lead implementation and commence design of 1st bunker.	Prepare recruitment of IRS implementation posts.	Recruit to IRS implementation posts		Actions on track managed through IRS 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.	

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	7. Acute Oncology Service- local delivery	Recruit ANPs and other staff	Pathway design with region	Pathway implementation	Pathway implementation	2 new trainee ANPs recruited (quarter 3). ANPs continue 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 VCC element of AOS.			Work undertaken to develop suite of measures / indicators to support monitoring of activity locally. MSCC pathway identified as eligible for service improvement input as part of the national Safe Care Collaborative initiative. Working group identified and scope of work 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	Updated plan for optimal SDEC model developed.	

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		(SDEC) Ambulatory Care – finalise staff recruitment	Ambulatory Care- increase weekday opening	Ambulatory Care- weekend opening		Extended hours of operation sustained. Work commenced to develop appropriate suite of performance indicators to support ongoing monitoring of activity and to allow reporting to national structures. Formal reporting of activity via NHS Wales Delivery Unit initiated.	

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			Deliver requirements of national projects e.g. Immuno Oncology				
	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)	Cancer and Hospital Acquired Thrombosis Group re-established. Terms of Reference. Group overseeing response to All Wales HAT audit. Audit response to include review of the CAT clinic.	

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	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.	Response to formal WHSSC appraisal of potential Velindre PRRT service developed in readiness for submission in April 2023. Appraisal panel visit to Velindre site scheduled for April. Engagement with health boards on introduction of novel radiotherapy treatments of breast cancers (including IMN) scheduled to begin in May 2023.	
	Clinical team priorities – gaps in service therapies access to trials research					New VCS business planning structure in place from April 2023 will support prioritisation and implementation of service developments (support to include project management	

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	MDT attendance/cover arrangements					and business case development advise).	
		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		New business planning function to prioritise service developments and allocate appropriate support. New business planning structure in place form April 2023.	
		Finalise the	Begin development	Continue the		Clinical lead(s) to be identified	

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		priority of clinical team priorities.	of implementation plans for clinical team priorities requiring support/wider discussions.	development of implementation plans for clinical team priorities requiring support/wider discussions.		to inform prioritisation work of new VCS business planning structure.	
	11. Radiotherapy Satellite Centre	Support Strategic case development and review of FBC. Workforce Plan. Finance case. IRS alignment and FBC. FBC scrutiny and approval by	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	Operational model delivery plan preparation	Managed through IRS Implementation Board.	

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		service lead and through Boards					
	12. Radiology	Commission reconditioned MRI scanner. Phase 1 capacity delivery	Review Radiology demand and align to capacity plan		Full additional capacity plan is delivered	Introduction of DHCW and associated disruption to routine activity reporting restricted ability to undertake demand and capacity planning. Software upgrade procured which will improve efficiency and throughput of reconditioned MR scanner.	

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	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	Future model of treatment helpline provision to be considered by the VCS Senior Leadership Team. Work to stabilise platform will continue. Digital work to enable recording of calls scoped and completed. Service Improvement work, as part of national Safe Care Collaborative initiative, to continue whilst future model determined.	

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		Commence review of service functionality and fitness for purpose. Engage with digital team to explore system capability and options for future.	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		
	14. Implementation of patient engagement strategy to strengthen our conversations with patients, families and	Commence Patient panel Implement patient panel management	Commence establishment of Patient Engagement Hub and Patient Leadership Group Establish initial Patient Engagement	Patient Leadership Group recruitment and training	Continue to develop Group, staff team and patient engagement delivery. Includes underpinning nVCC.	Individual appointed to work within the Trust's Communications team and focus on developing patient engagement hub pilot. Hub pilot to be launched quarter 1 2023-24 (objective fully defined in IMTP for 2023-24).	

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	wider partners	software programme	activity for Velindre Futures projects				
	15. Establish Primary Care project under Velindre Futures					Opportunities for the Centre for Collaborative Learning (CfCL) to support primary care education and development programmes to be scoped. Initial workshop to be held in April 2023 (objective fully defined in IMTP for 2023-24).	

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Strategic Priority 4: To be an international leader in research, development, innovation and education	**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.	The Velindre R,D&I 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. Engagement with Prehab2Rehab collaborative and with the Wales Cancer Network National Prehabilitation Group continued. Active contribution to work to define the remit and scope of both groups.	

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	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.	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.	

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	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	Engagement with Prehab2Rehab collaborative and with the Wales Cancer Network National Prehabilitation Group continued. Active contribution to work to define 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' the workforce Advanced Practice Radiographers and Therapeutic Radiographers	Implement Physicians Associate posts. Prepare plan for advanced practice and non-medical Consultant level roles.	Workforce modernisation programme continues	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 be undertaken to demonstrate benefits and to identify alternative means of supporting the innovation being actively explored.	

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	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.	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 programme. Draft ToRs developed and members of working group identified (objective fully defined in IMTP for 2023-24).	
		Aims to Standardise patient referrals to VCC.		Mapping of Breast Pathway from patient referral to service to treatment commenced.		Engagement with Wales Cancer Network continued. Discussions on recruitment of project resource by the WCN to support activity at VCS advanced. Recruitment to new position to be undertaken in quarter 1 2023-24.	
		Timely receipt of all diagnostic test results and treatment pre-		Identify touch points along pathway and			

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		requisites prior to MDT.		potential bottlenecks			
		Improve patient outcomes by early genomic testing where indicated. Develop training plans		Measure how currently delivering against the National Optimal Pathways (NOP)			
Strategic Priority 5: To work in partnership with stakeholders to improve	**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.			Meetings continued with a more developed focus on key operational issues (this includes the review and	

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prevention and early detection of cancer		Commence meetings to deliver on these priorities.	Agree outreach plans for outpatients and SACT with all HBs.			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 & PERFORMANCE COMMITTEE

Integrated Quality and Safety Group Update

DATE OF MEETING	16th May 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	N/A
PREPARED BY	Tina Jenkins, Interim Deputy Director of Nursing and Patient Experience
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	FOR DISCUSSION

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
TRUST INTEGRATED QUALITY AND SAFETY GROUP	25/04/23	Items agreed
EXECUTIVE MANAGEMENT BOARD	02/05/23	Discussed and noted

1. SITUATION

This paper is to provide the Quality, Safety & Performance Committee with an overview of the key deliberations and outcomes of the Trust Integrated Quality & Safety Group meetings held between 14th March 2023 and the 25th of April 2023. The paper includes an overview of the Safe Care Collaborative and Duty of Quality & Duty of Candour Implementation Group as these now report into the Integrated Quality & Safety Group. The Quality, Safety & Performance Committee is asked to:

- **NOTE** the discussions that took place and outputs from these meetings
- **NOTE** the plans for the Trust to develop its Quality Management System
- **DISCUSS** the further work required to develop a robust automated electronic integrated quality dashboard containing required quality, harm and safety metrics so that the Group can undertake its role in effectively triangulating relevant quality metrics from across the Trust.

2. BACKGROUND

The Trust Integrated Quality and Safety Group was established in October 2022 in order to provide oversight to support the Board, Quality, Safety & Performance Committee. 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 ensure quality is at the centre of all decision making across the Trust.

The Group brings together the Corporate and Divisional Quality and Safety Hubs to provide integrated analysis and assurance / escalation to the Executive Team and Quality, Safety & Performance Committee on behalf of the Board in respect of the Trust meeting its Quality and Safety responsibilities in line with legislative and national requirements and ensuring the Trust is learning from internal and external events, and always improving.

It was identified at the outset that the Group would take time to mature and develop before it reached its full potential.

3. KEY OUTCOMES / DELIBERATIONS

3.1 ***Quarter 4, Trust Quality and Safety Reports:*** the Group considered and endorsed the Trust's quarter 4 Health and Care Standards report and the quarter 4 Trust Quality & Safety reports. The Group will oversee the development of the translation of the revised Health & Care Quality Standards (2023) into an implementation and embedding plan for the Trust. The group also agreed to further enhance the Quality and Safety quarterly reports by including enhanced learning evidence, translation of outcomes into clinical audit plans, and inclusion of key

outcomes in relation to Health & Safety, Safeguarding & Vulnerable Adults, Infection Prevention & Control, and Information Governance.

From May 2023 the Duty of Quality requires public facing (website) reporting of 'Always on Measures'. It was agreed that the first measure would be experience using CIVICA outcomes for both Velindre Cancer Service and the Welsh Blood Service followed by concerns (will include 'you said…we did...' information).

3.2 ***Trust Quality Dashboard:*** Significant discussions have taken place across each meeting held as to have access to all quality relate information in a single dashboard (as well as being included as part of the Trusts Performance Management Framework) is essential for the success of this group and the Trust's ability to meet its Duty of Quality responsibilities. Initial scoping has been completed by the Business Intelligence Team and significant cleansing / refinement is planned to take place prior to the next Group. The group agreed 4 principles in respect of the Quality Dashboard metric work:

- There will be one quality fully automated quality & safety dashboard
- Unless service critical and justified, no new manual measures to be reported outside of the automated dashboard development
- Relevant quality & safety measures will also be incorporated into the Trusts Performance Management framework so that quality is at the centre of what we do

3.3 ***Velindre Cancer Service Mortality Measures:*** Significant discussions took place in relation to the required mortality measures (30 days radical SACT, 30 days post palliative SACT, 30 palliative radiotherapy, 90 days post radical radiotherapy) around the difficulty in robustly reporting these measures. Inpatient deaths are reported through the Medical Examiner Service. Having robust mortality outcomes across these three areas was identified as the most critical metric required for the Quality Dashboard and this needs to be automated. 30 days post SACT data is now available and will be reported through to the next meeting.

3.4 ***Trust Quality Management System:*** The Group received the new National Quality Management System Principles and endorsed the plan to have an Executive Led (with Divisional representation) discussion on what the Trusts Quality Management system should look like in May 2023, followed by an Integrated Quality & Safety group discussion at the next meeting. This would develop the framework for the Board Development session planned for the 27th June 2023 where there will be Board level discussion in relation to what the Trusts Quality Management System will look like.

3.5 ***Quality Hubs:*** The Group has had oversight of the development of the three Quality Hubs. The Welsh Blood Service Hub is now established and is in the early stage of operation. Multi-professional development discussions have taken place in relation to the Velindre Cancer Service Hub and the appointment to a Head of Post

has commenced. The development of the Corporate Hub was delayed and can now commence following the appointment of the Trust Head of Quality & Safety.

3.6 ***Quality & Safety Tracker:*** The Group received and discussed the Quality and Safety tracker. Further work is required to ensure that all information is included. A plan will then be developed by agreed leads in an appropriate update and reporting process. The Group will have operational ownership of this tracker once its development is completed.

3.7 ***Clinical audit report*** – The Groups role in respect of overseeing and influencing the Trusts Clinical audit plans and outcomes have been discussed over the meetings. The Group agreed the following areas needed to be included in 2023/24 clinical audit plan following review of outcomes from 2022/23:

- Treatment Helpline
- Intravenous access
- SACT bookings
- Consent
- Chaperone Audits

3.8 ***National Reportable Incidents:*** Discussions took place in relation to an update received from the NHS Executive for National Reportable Incidents process and forms. A single investigation outcomes form has been developed and from the 1st of May 2023 all learning will submitted using this method. The forms were released to coincide with the newest version of the National Policy on Patient Safety Incident Reporting that the NHS Executive is developing. This will be incorporated into the revision the Trust is making to the Incident Reporting Policy.

3.9 ***Learning from published Public Service Ombudsman report***s in relation to poor patient care (and investigation / concerns processes / outcome) experienced by a patient at Betsi Cadwaladr University Health Board and Cardiff & Vale University Health Board.. The following transferable learning was identified for the Trust: effective complaints handing; It was also suggested that the report was reviewed in VCC as they had identified a number of failing in fundamental practices in the in-patient area.

3.10 ***Trust Quality & Safety Related Meeting Reporting Review:*** The Trust meeting structure were submitted to the group. Further work is required to that this work is condensed into an organogram of a quality meeting structure within the divisions.

3.11 ***Safe Care Collaborative:*** The Group received the Safe Care Collaborative highlight report (attached in ***Appendix 1***). It was agreed that once the Collaborative is mature the work of the Safe Care Collaborative Group will be incorporated into the Integrated Quality & Safety Group and the separate group disbanded.

3.12 ***Duty of Quality & Duty of Candour Implementation Group:*** The Group received the Duty of Quality & Duty of Candour highlight report (attached in ***Appendix 2***). It was agreed that once most of the required deliverables from the Duty of Quality & Duty of Candour Group the ongoing compliance will be incorporated into the Integrated Quality & Safety Group and the separate group disbanded.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Critical to the effective delivery of Trusts Quality & Safety responsibilities
RELATED HEALTHCARE STANDARD	Safe Care
	If more than one Healthcare Standard applies please list below: Individual Care Governance Leadership and Accountability
EQUALITY IMPACT ASSESSMENT COMPLETED	A full equality impact assessment of the duty is being undertaken nationally – once completed will be reviewed locally
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Meeting the Duty of Quality is a statutory requirement
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	There will be expenditure requirements to ensure the Trust meets its legal responsibilities. There will also be financial implications if the Trust does not meet its Duty of Quality responsibilities.

5. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to:

- **NOTE** the discussions that took place and outputs from these meetings
- **NOTE** the plans for the Trust to develop its Quality Management System
- **DISCUSS** the further work required to develop a robust automated electronic integrated quality dashboard containing required quality, harm and safety metrics so that the Group can undertake its role in effectively triangulating relevant quality metrics from across the Trust.

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Appendix 1: Safe Care Collaborative Highlight Report

1. SITUATION

This paper is to provide an overview of the key deliberations and outcomes of the Trust Safe Care Collaborative Meeting held on the 7th of March 2023 and the 11th of April 2023.

2. BACKGROUND

Improvement Cymru re-launched the support being given to NHS Wales bodies through a Safe Care Collaborative on the 29th and 30th November 2022. This is part of the Safe Care Partnership, which is between NHS Wales Health Boards and Trusts, Improvement Cymru and the Institute for Healthcare Improvement (IHI). The partnership's aim is to coach and support Health Boards and Trusts to improve the quality and safety of care across their systems.

The Safe Care Collaborative creates a learning system where organisations test and measure practice innovations and share their experiences to accelerate learning and widespread implementation of best practices for safe care. It brings together teams, coaches, executives and senior leaders for safety from across all the Health Boards and Trusts in Wales to focus on a common aim. Four national priority areas have been identified following the diagnostic Safer Care Foundation Visits held earlier this year:

1. Leadership for patient safety improvement.
2. Safe and effective community care.
3. Safe and effective ambulatory care.
4. Safe and effective acute care.

3. ASSESSMENT

3.1 Outcome from Second National Collaborative Event held on 7th & 8th March 2023

The second Safe Care Collaborative National Event hosted by Improvement Cymru took place on 7th & 8th March 2023 and a good multi-professional team attended from Velindre University NHS Trust including Executive, Corporate and Clinical Staff. The key outcomes from the collaborative were opportunities for organisations to share their ideas for projects. There was also protected time for individual organisations to work in their chosen workstream group with the support of Improvement Cymru coaches to consider how to progress with the projects. At the leadership breakout on day one, the focus was on the role of leaders in shaping culture and psychological safety.

3.2 Trust Safe Care Collaborative Status

3.3.1 Safety Culture Survey

Members of the Trust Board, Divisional Senior Leadership Teams and the Trust Collaborative Group were asked to complete the IHI safety culture (covering safe, reliable and effective care) self-assessment tool. There were 14 responses. The high-level results are summarised below:

Total Responses	Numerical Value
Psychological Safety	28
Accountability	28
Teamwork & Communication	30
Negotiation	27
Continuous Learning	29
Improvement	28
Measurement	22
Reliability	24
Transparency	23
Leadership	29

Measurement was the lowest score followed by Transparency, Reliability, Negotiation.

Detailed 'so what' analysis of these results are now required and Improvement Cymru have been requested to support this. A meeting is being arranged with IHI colleagues to undertake this. Once this is completed the Trusts Leadership collaborative actions will be proposed and brought back to Executive Management Board for approval. The overall improvement would be to increase scores across a number of these areas when survey repeated in 12 months' time.

In addition, support is being provided from Improvement Cymru in relation to how a version of this survey can be provided to staff at all levels of the Trust.

3.3.2 Trust Safe Care Collaborative Projects

The Trust has identified 5 Safe Care Collaborative Projects (one Trust wide, two Velindre Cancer Service (VCS) & two Welsh Blood Service (WBS)).

- Leadership (Trust wide) - Enhance the safety culture and psychological safety environment across the Trust – the specifics will be determined once Improvement Cymru has supported the analysis of the initial senior safety culture assessment (early April 2023).
- *Donor Adverse Event Reporting* (WBS) – ***Project Status: Early development*** - Aim: To optimise the Donor Adverse Event Management Pathway by producing a robust system of reporting Donor Adverse Events that improves the quality and timeliness of care and information to the donor / patient and enhances the investigation capabilities of the organisation.

Due to the clinical nature of blood and component collection donors at times may experience adverse effects, such as bruising, pain, fainting, arterial punctures and nerve injuries. When such events occur it is imperative that as an organisation, we have processes and procedures in place that enable timely and high-quality donor care provision to optimise donor safety, experience, clinical outcomes and continued donor wish to donate in the future. Additionally, it is imperative that robust risk management systems are in place to ensure that all such incidences are reported, reviewed and investigated, that learning and improvement opportunities are identified to optimise the provision of safe and effective donor care services.

- *Haemochromatosis* (WBS) – ***Project Status: Early stages*** - Aim: The project will develop a referral pathway covering all Welsh Health Boards for haemochromatosis patients to access venesection through the WBS and donate the blood that is normally discarded.

Currently WBS collects approximately 110,000 units of blood per annum. A regular donor can donate blood once every 12 to 16 weeks to allow for sufficient recovery. Patients with Haemochromatosis store excess iron in their blood which when in excess can result in organ damage. They are therefore required to attend venesection sessions in the hospital setting to take blood out of their blood stream more frequently than once every 12 weeks (this blood is discarded).

- *Malignant Spinal Cord Compression Pathway (VCS)* - ***Project status: Early stages***; a VCS working group has been established, dialogue with which was on a revised operating model commenced in February 2023. A revised service level agreement is being drafted and the aim is that by the end of May 23, there will be a revised service model

Aim: The project will aim to improve the Metastatic Cord Compression Pathway and prevent delays in treatment and improve patient experience.

Patients diagnosed with MSCC who are treated with Radiotherapy at VCS are treated with emergency intent (typically, 3-4 patients per week). Currently, this requires active treatment to begin within 24-hours of referral for treatment with Radiotherapy. Patients treated at VCS are typically already admitted as inpatients in secondary care settings elsewhere and are transported to the Centre by (non- emergency) ambulance in anticipation of treatment. Transport is provided by the Welsh Ambulance Service Trust (WAST) and the service is delivered principally by the 'dedicated' ambulance and crew based at VCS. The treatment of these patients with External Beam Radiotherapy requires them to undergo a planning scan (CT/MR) at VCS. The scan is used to develop a treatment plan prior to treatment commencing. Current practice assumes that any such patient, on the same day, should be transferred to VCS, undergo a scan to facilitate the production of a plan and receive treatment before being returned to the setting in which they are undergoing ongoing care.

- *SACT Telephone Helpline* (VCS) – ***Project status: Early stages;*** a VCS working group has been established. An options paper has been presented to the Senior Leadership Team and an option selected for change Aim: To improve the treatment helpline and ensure that there are clear pathways for escalation of deteriorating patients and eliminate helpline related patient harm.

The Velindre Cancer Service SACT & Medicine Management Directorate has reviewed the data that has been captured by the team within the UKONS triage tool and has identified that approximately 50% of the calls being directed to the SACT Treatment Helpline (STH) are not appropriate or within the remit of the STH.

3.3.4 Progress reports

Improvement Cymru require monthly status reporting for all projects commencing on the 12th April 2023 (scoring attached in ***Appendix a***). The project progress scoring for each is detailed below, these scores were scrutinsed by the Group prior to submission and a number of changes were made:

- *Donor Adverse Event Reporting: Progress score 1.5*
- *Haemochromatosis*: Progress score 2.0
- *Malignant Spinal Cord Compression Pathway: Report score 1.0*
- *SACT Telephone Helpline: Report Score: 1.0*

Scoring criteria:

Score	***Assessment / Description***	
1.0	Forming a team	Team has been formed, target population identified; aim determined, and baseline measurement begun.
1.5	Planning for the project has begun	Team is meeting, discussion is occurring. Plans for the project have been made.

2.0	Activity, but no changes	Team actively engaged in development, research, discussion but no changes have been tested.
2.5	Changes tested, but no improvement	Components of the model being tested but no improvement in measures. Data on key measures are reported.
3.0	Modest improvement	Initial test cycles have been completed and implementation began for several components. Evidence of moderate improvement in process measures.
3.5	Improvement	Some improvement in outcome measures, process measures continuing to improve, PDSA test cycles on all components of the Change Package, changes implemented for many components of the Change Package.
4.0	Significant improvement	Most components of the Change Package are implemented for the population of focus. Evidence of sustained improvement in outcome measures, halfway toward accomplishing all of the goals. Plans for spread and scale improvement are inplace.
4.5	Sustained improvement	Sustained improvement in most outcomes' measures, 75% of goals achieved, spread to a larger population.
5.0	Outstanding sustained results	All components of the Change Package implemented, all goals of the aim have been accomplished, outcome measures at national benchmark levels, and spread to another facility is underway.

4. TERMS OF REFERENCE

The terms of Reference for the group were endorsed by the Integrated Quality & Safety Group and approved by the Executive Management Board.

5. NEXT STEPS

- Determine the Trust Improvement Coach support for Welsh Blood Service as all support to date allocated to VCS
- Ongoing support and coaching calls with improvement Cymru.
- To commence/progress projects and ensure that there is a clear plan and regular local working groups with roles identified.
- Additional Trust Improvement coaches trained / established to support the project teams (to include WBS and corporate staff).
- Project teams to bring project data and documents and updates to each Safe Care Collaborative Group meeting for review and monitoring of project progress.
- To offer ongoing support from the corporate team to the divisions with identified projects.
- Arrange a meeting with Improvement Cymru and identify a key person for support.

Appendix 2: Duty of Candour & Duty of Quality Implementation Group Report

1. SITUATION

This paper is to provide an update in respect to status of the Trust in relation to the Implementation of the Duty of Candour and Duty of Quality (elements of Wales Quality & Engagement Act 2020) that were enacted on 1st April 2023.

2. BACKGROUND

The Health and Social Care (Quality and Engagement) (Wales) Act was passed in 2020. The enactment of the Duty of Candour and Duty of Quality have been delayed due to the pandemic but both duties come into force from the 1st April 2023.

The Duty of Candour statutory guidance and revised Putting Things Right Regulations were published early March and the Duty of Quality statutory guidance published on the 29th March 2023.

3. SITUATION

3.1 Overall preparedness

The overall preparedness of the Trust in respect of the duties were impeded by the late publication of the final statutory guidance and that some national documents are yet to be published e.g revised National Putting Things Right policy and duty of quality training package. Despite this, there is a high degree of confidence in the Trust's preparedness to meet the requirements of the Duty of Candour but the Trust is only partially complaint at present with Duty of Quality requirements.

Divisions have pursued managing incidents on a live basis, reviewing moderate and greater harm events as they arise and that would trigger the duty. The policy revisions are being worked through and the reviewed policies will be submitted for approval at the July 2023 Executive Management Board.

A Duty of Quality and Duty of Candour - staff briefing and Question and Answer session was offered to all staff members on the 5th April 2023 and was reported to be the highest attended staff briefing session to date with 172 attendees. In addition, positive feedback was received following the session. The Group identified that significant work is required for cultural change to fully meet all the requirements of the Duty of Quality. In addition, there is a need for the Trust to have a Quality Dashboard and Quality Management System in place.

3.2 Duty of Candour

The Duty of Candour implementation plan is attached in ***Appendix a.*** 10 implementation actions have been fully completed. The implementation plan was reviewed during the meeting and confirmation received that awareness training for all employees has been made available via the Trust Internet and Intranet sites. The education and development team will continue to work to allocate specific, more in depth Duty of Candour training for patient and donor facing employees. The Duty of Candour Impact Assessment was approved.

The group approved a Trust template letter for duty of candour that will also need to be personalized based on the outcome from the 'in-person notification'.

3.3 Duty of Quality

The Duty of Quality implementation plan is attached in Appendix b. 10 of the implementation actions have been delivered.

The national training for the Duty of Quality is due to be published in July 2023. The Trust are currently working through developing the Trust Quality Management System aligning agreed quality metrics. An Executive discussion is planned in May 2023 followed by a Board Development Session on the 27th June 2023 to scope out the Trusts Quality Management System. The newly agreed national Quality Management principles were received.

Metrics and "always on" key measures are expected to be agreed by the end of April 2023. It was agreed that the first Always on public facing report will be patient and donor experience. To work in collaboration with the communication team to consider development and distribution of a CIVICA survey.

It was agreed that engagement with the two Trust engagement teams to ascertain from our patients / donors what they want to see in respect of the quality of Velindre's services.

The Trust Board / Committee paper template that incorporates consideration in respect of the Duty of Quality (quality standards) is going through the final approval process.

The national quality impact assessment tool is still under development.

Appendix a

Velindre University NHS Trust Duty of Candour Implementation Plan

Required Outcome	Implementation Action	Lead	Timescale	Status
Trust Requirements				
Roles and responsibilities Strategic accountability required for oversight and operation of Duty of Candour procedures & regulations Responsibility for overseeing the management of duty of candour and adverse outcomes, including those directly involved with the investigation management and/or notification of adverse outcomes and any staff dealing with concerns.	Executive Lead to be appointed	CEO	31st October 2022	**Achieved** - Executive Lead: Executive Director of Nursing, AHP & Health Science identified
	Independent Member to be allocated as IM Lead	CEO/ Director Corporate Governance	31st October 2022	**Achieved** - Independent Member for Putting Things Right identified as lead for Duty of Candour
	Divisional Implementation Leads to be identified	Divisional Directors	31st October 2022	**Achieved** - WBS: Peter Richardson/Zoe Gibson VCS: Viv Cooper/Sarah Owen
	Operational responsible officer to be identified – responsible for overall day-to-day responsibility and operation of Candour Regulations, must form links between candour and PTR.	Executive Director Nursing, AHP & Health Science	31st October 2022	**Achieved** - Operational Lead: Deputy Director Nursing, Quality & Patient Experience
Accountability To adopt a constructive and non-punitive approach to patient safety incidents. To provide training and awareness on the Duty of Candour and support staff in understanding their legal responsibility and accountability. Focus on learning, with a view to improving quality in care and provision.	Measures taken to remove blame culture and barriers. Supporting staff through education, empowerment, mentoring and encouragement, to achieve cultural shift and break down in barriers.	Chief Executive/ Executive Directors/ Service Leads People and OD Directorate	1st April 2023 Revised date 31st May 2023	**In progress** - PTR policy and Incident reporting policy currently under review to include Duty of Candour. National training video made available March 2023 and staff are being encouraged to view video although action awaited from shared services to link with ESR competencies.

Supporting Staff & Service Users				
Supporting Staff To have readily available support from senior nominated staff, including access to counselling, Employee Wellbeing, Trade Union Representatives and Occupational Health.	Nominated senior staff member, with relevant attributes outlined in the Duty of Candour Guidance, to be identified within the Trust and each Division to act as a contact or advocate for support to staff when the Duty of Candour is triggered.	Deputy Director Nursing, Quality & Patient Experience Divisional Directors	30th November 2022	**Achieved** - Duty of Candour leads identified in each service division and the corporate team. Clinical Lead also identified to provide peer support. Staff Health and Wellbeing intranet page in place for all staff. Additional support services will be included in the revised PTR policy.
	An inventory of wellbeing, mental health and support services to be provided and made available to Senior Candour Leads so can be provided to staff involved when the Duty of Candour is triggered	Deputy Director of Workforce & Organisational Development	1st April 2023 Revised date 31st May 2023	**In progress** -Information will be included in the revised PTR policy. Duty of Candour intranet page set up which will include links to Health and Wellbeing and Trust Leads
Supporting service users and advocates Explanation leaflets, information and materials to be prepared and circulated to support service users, advocates and support groups.	A range of Duty of Candour bilingual materials to be made available across the Trust and on intranet / internet sites to include video's, easy read leaflets and materials to empower service users or advocates to seek answers regarding the care and services received.	Deputy Director Nursing, Quality & Patient Experience	1st April 2023	**Achieved:** intranet page set up and bilingual material available on the site. Internet page to be updated by 1st April with information
	Duty of Candour contact details to be provided bilingually on the Trusts website.	Head of Communication	1st April 2023	**Achieved**
Training Requirements				
Duty of Candour Training	A full Duty of Candour Training needs analysis to be undertaken identifying which staff require what level of training	Deputy Director Nursing, Quality	31st December 2022	**Achieved** – Trust TNA undertaken in compliance with all Wales recommendations

All relevant staff to understand and apply Duty of Candour. Staff who are involved in performing or exercising functions in connection with the Duty of Candour procedures must undergo appropriate training. Training must be tailored to reflect banding, status and seniority of staff, consisting of basic training for lower graded staff, to more in-depth training for senior members of staff.	A clear training plan to be developed and delivered to relevant staff. To include: Requirements and legal responsibilities of Duty of Candour Understanding the legal framework and levels of harm Understanding terminology and meaning of when duty of Candour is triggered Investigating or managing notifiable adverse outcomes General Data Protection Rules (GDPR) principles Systems recording (please see above separate Datix training requirements) Apologising and saying sorry	& Patient Experience Claims and Redress Manager	1st April 2023 Revised date 31st May 2023	**Partially Completed** – TNA in place. Level 1 training for all staff has commenced. An awareness video has been launched and is available to view on the Trust intranet (level 1). Level 2 e-learning training package was received 16/3/23 and is accessible via ESR. A technical issue with the capturing of staff who have completed the e-learning has delayed roll out. This will now be prioritised
Once for Wales (OfW) Datix Reporting Concerns triggering the Duty of Candour to be captured and monitored on the OfW Datix modules to comply with compliance, assurance and reporting requirements.	Datix Duty of Candour training guide to be developed to include: The need to understand how and when to report Duty of Candour on Datix How to use the prompt field that trigger the duty How to document and record conversations and progress notes.	Quality, Safety & Assurance Manager	31st December 2022	**Achieved** – Datix fields have been created by the Once for Wales team for use from 1st April 2023. User guide and training material has been developed and available for staff.
	How to audit and track incidents on the Once for Wales Datix modules. How to open and how & when to close Datix record. Any further individual Datix training required to ensure compliance with the Duty of Candour.			

Communication and written outcomes To address the effects of harm and the physical consequences for service users, their families, carers and advocates as soon as possible, once the Duty of Candour is triggered.	Trust Duty of Candour procedures to be developed aligned with regulatory requirements to cover all operational requirements	Deputy Director Nursing, Quality & Patient Experience Claims and Redress Manager	1st April 2023 Revised date 31st May 2023	**In progress** – PTR policy and Incident Reporting policy currently under review for submission to EMB April 2023. Duty of Candour procedures and flow diagrams are under development for inclusion in the revised policies.
Putting Things Right Guidance 2023				
Putting Things Right Guidance 2023 - Update Awareness of the timescales and changes to the PTR guidance regarding the handling of concerns. When the duty of candour is triggered the timeframe will now run from the time the "in person" notification to the service user is made.	Trust Putting Things Right policy to be revised in line with revised national putting things right guidance and Duty of Candour requirements, including the required timescales. .	Deputy Director Nursing, Quality & Patient Experience Claims and Redress Manager	1st April 2023 Revised date 31st May 2023	**In progress** – As above; PTR policy and Incident Reporting policy currently under review for submission to EMB April 2023. Duty of Candour procedures and flow diagrams are under development for inclusion in the revised policies.
Responses should be issued within 30 working days or within 6 months from the date notification of a concern is received, or the date on which the duty of candour comes into effect, whichever is the later.				
Monitoring, Assurance, Effectiveness, Compliance and Review				
Monitoring Assurance, Effectiveness & Compliance	A review of service level to Board monitoring arrangements to be undertaken to incorporate required monitoring of the Duty of Candour.	Deputy Director Nursing, Quality & Patient Experience	1st April 2023	**Achieved** – Duty of Candour will be incorporated into the reporting arrangements for PTR
	Duty of Candour reporting to be integrated into PTR reporting through to QSP Committee. Annual PTR report containing Duty of Candour data to be published on intra / internat site	Deputy Director Nursing, Quality & Patient Experience	1st June 2023	**On track** – PTR reporting templates will be amended to incorporate Duty of Candour. The templates have been piloted and the steering group meeting on Thursday 27th April 2023 is expected to approve the template for a phased roll out.

Review Review of processes	A formal Duty of candour audit programme to be introduced that includes: identification of themes and trends and evidencing that learning and improvements have taken place within the required timescale	Deputy Director Nursing, Quality & Patient Experice	1st June 2023	To be developed

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Appendix b

Quality and Safety "Duty of Quality" Gap Analysis / Implementation Plan

Required Outcome	Implementation Action	Action Lead	Delivery Timescale	Status
Trust Requirements				
Roles and responsibilities Strategic accountability required for oversight and operationalisation of Duty of Quality procedures & regulations.	Executive Lead to be appointed	CEO	October 2022	***Completed:*** Executive Lead: Executive Director of Nursing, AHP & Health Science identified
	Independent Member to be allocated as IM Lead	CEO/ Director Corporate Governance	January 2023	***Completed:*** Identified as Quality & Safety IM Champion
	Divisional Implementation Leads to be identified	Divisional Directors	January 2023	***Completed:*** WBS Head Quality/Head of Nursing /VCS Q&S Manager/ Head of Nursing
	Trust wide Operational responsible officer to be identified – responsible for overall day-to-day responsibility and operation of Duty of Quality Regulations	Executive Director Nursing, AHP & Health Science	October 2022	***Completed:*** Operational Lead: Deputy Director Nursing, Quality & Patient Experience

Accountability: Responsibility for overseeing the implementation of the management of the duty of quality, including for the Trust to exercise its function of securing improvement in the quality of health services	Develop a Duty of Quality & Duty of Candour Implementation Group as a sub- group to the Integrated Quality & Safety Group	Executive Director Nursing, AHP & Health Science	January 2023	***Completed:*** Established
.	Meeting the duty of quality: The Trust meeting template to be reviewed to ensure the following elements of the duty can be evidenced: Ensuring that all strategic decisions are made through the lens of improving the quality of health services and outcomes for the population. Exercises its functions in a way that considers how it willimprove quality and outcomes on an ongoing basis. Actively monitoring progress on the improvement of quality services and outcomes	Executive Director Nursing, AHP & Health Science & Director of Corporate Governance	30th March 2023 Revised date 31st May 2023	"How to guide" circulated to key individuals for comment awaiting approval. Template being piloted
	Process for Trust website monthly 'Always On' of key quality & experience measures and annual reporting to be determined and implemented (including assessment of the extent of improvements in outcomes).	Director of Corporate Governance, Director of planning & clinical transformation & Executive Director Nursing, AHP & Health Science	30th April 2023	In progress: Key "always on" measures are being developed through the Trust Duty Implementation and Integrated meetings.

	Trust to develop a quality management system, with appropriate focus on quality control, quality planning, quality improvement and quality assurance, with the aim of achieving a learning and improving environment; and creating a culture of quality	Executive Team (collective)	Agree system & implementation plan by 30th March 2023 Fully implement by March 2024	Quality management system to be developed. Request made for national support for a solution from the DoQ implementation board.
Securing Board Support				
The Trust Board has collective responsibility for ensuring the duty of quality is delivered and they must demonstrate this in their actions and behaviours. They must demonstrate their long-term commitment to improving quality when setting the strategic direction and seeking assurance of delivery	Trust Board members to receive training in executing their Duty of Quality Responsibilities	Director Corporate Governance	Completed by 30/06/2023	***Completed:*** Initial awareness provided Dec 22. Complete March
	IM & Executive Lead to receive Nationally provided Duty of Quality Training so that they can effectively execute their responsibilities	Executive Director Nursing, AHP & Health Science	31/03/2023	***Completed:*** X2 IMs received training March 2023
	Trust wide Duty of Quality Training to be rolled out to all responsible officers	Trust Training Department	July 2023	National Training Programme not yet available and expected to be received in July 2023.
	Trust wide awareness campaign to be undertaken through ongoing communications	Head of Communications	Commence January 2023 – complete by 30/04/2023	***Completed:*** Trust Internet and Intranet live and updated with current national Communications and will be maintained as legislation and guidance is published.
	A Trust wide review of Improvement Infrastructure to be undertaken including identification of improvement coaches and those trained bronze to gold level	Chief Operating Officer / Executive Director Nursing, AHP & Health Science	31/03/2023 Revised date 31st May 2023	Commenced as part of safety collaborative

	A Trust wide Improvement methodology to be agreed (aligned with NHS Wales safety collaborative methodology) & all staff involved with improvement to receive refresher training	Chief Operating Officer / Executive Director Nursing, AHP & Health Science	31/06/2023	Some safety & improvement coach training undertaken
	A mechanism for the Board to ensure they adhere to the duty of quality in their decision-making and seek assurance with regard to decisions made by others to be developed and fully implemented	Director of Corporate Governance	31/03/2023	***Completed:*** Revised paper template agreed covering quality
Assessing Readiness				
System-wide understanding of what good quality looks like for the broad range of the Trust's services.	Develop a programme to ensure all leaders are able to use basic improvement measures & SPC charts to start measuring for improvement and safety	Trust Education Department	Commence Jan 23 and complete 31/03/2023	***Completed:*** Completed – positively evaluated
	A full review to be undertaken once final (post consultation) statutory guidance is published to review Trust implementation plans	Head of Quality & Safety	31/03/2023 Revised date 31st May 2023	Statutory Guidance published 29/3/23 – guidance being worked through to execute at Trust level.
Securing wider organisational buy-in and co-creating a vision				
NHS bodies should create a compelling vision for improved quality that is recognised and	Develop a mechanism that supports a culture of distributed leadership, which gives staff at all levels the permission, opportunity and confidence to test new ideas to improve quality that are aligned to the Trust's vision – to included targeted work on enhancing psychological safety	Executive Director of Workforce & Organisational Development	1st April 2023	Trust wide accessible sessions arranged for 5th April 2023 and were well received.
intrinsically motivates staff at each level of the Trust	Undertaken an annual safety survey to assess the safety culture across the Trust – use survey outcomes to target cultural and infrastructure priorities in order that the Trust's psychological readiness including the infrastructure, governance, system understanding and leadership in place for change can be assessed.	Deputy Director of Workforce & Organisational Development & Deputy Director of Nursing, Quality & Patient Experience	Initial survey to be completed by 31/01/2023 Revised date 31st May 2023	Strategic survey completed – analysis awaited – staff level survey tool requires development

Developing improvement skills and infrastructure				
The Trust needs a systematic approach to managing quality that includes building improvement capability to ensure teams at each level of the Trust have the general and specialist improvement skills needed.	Using the Trust Value Based Health Care infrastructure standard operating models to standardise core processes and activities should also be developed to address variations in quality across the Trust	Executive Director of Finance / Divisional Head of Nursing, CD, MD, Chief Scientific Officer	Commence January 2023 – complete March 2024	
	Development of a suite of Quality, safety & harm measures service level to Board	Quality & Safety Divisional leads & Head of Quality, Safety & Regulation	Initial suite by 30th March 2023 Comprehensive suite by 30th June 2023	Quality management system to be developed. The Trust Integrated Quality and Safety Group exploring options of Quality measures.
	Development of a system that collects, analyses and feeds back quality, safety & harm measures and on the impact of the improvements.	Head of Informatics	30th June 2023	
Aligning and coordinating activity				
The Trust needs to ensure that initiatives to improve quality are consistent with the Trust's overall strategy and mission and barriers are identified and unlocked.	All the Trust's activity should ensure that all strands of activity align over time.	Chief Operating Officer / Divisional Directors	Fully in place by 31/03.2023	
	The Trust should ensure that learning from success and weaker areas continue to shape the improvements in quality that are required.	Chief Operating Officer / Executive Medical Director / Executive Director Nursing	Commence January 2023 – infrastructure well established and fully embedded by 31/03.2023	Safety Collaborative being established – work ongoing with identified improvement projects in each area.

Sustaining an organization-wide approach				
The Trust must invest in maintaining the momentum for improvements in quality and recognise that this is a longer-term journey.	Trust Quality Improvement strategy to be developed as a sub-strategy to the Quality & Safety Framework detailing how quality improvement priorities will be determined and outcomes monitored service level to board. To include: The ongoing focus on early wins to challenge and maintain success to engage staff and stakeholders. Supporting front line staff to maintain a focus on local improvements aligned to the Trust's purpose / strategy. The provision of Board assurance that quality improvement activities are sustainable with appropriate assurance mechanisms to maintain the improvements. Commitment to improving quality underpinned by a willingness and financial support to develop the skills and infrastructure for implementation. Prioritising supporting national and regional initiatives along with recommendations that fit the Trust's way of working.	Chief Operating Officer / Executive Medical Director / Executive Director Nursing	30/09/2023	
	Requirements that leaders champion improvements in quality that are strategically aligned, driven and owned by the teams responsible for delivering health services.			

QUALITY, SAFETY & PERFORMANCE COMMITTEE		
2022 / 2023 QUARTER 4 TRUST QUALITY AND SAFETY REPORT		
DATE OF MEETING	16th May 2023	
PUBLIC OR PRIVATE REPORT	Public	
IF PRIVATE PLEASE INDICATE REASON	N/A	
PREPARED BY	Jayne Rabaiotti, Trust Claims Manager Jade Coleman, Quality, Safety & Assurance Manager	
PRESENTED BY	Tina Jenkins, Interim Deputy Director of Nursing, Quality & Patient Experience	
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science	
REPORT PURPOSE	FOR ASSURANCE	
COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Trust Integrated Quality and Safety Group	25th April 2023	CONTENT APPROVED
Executive Management Board	2nd May 2023	DISCUSSED

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 position and execution of its responsibilities in respect of key elements of Quality and Safety for quarter 4: 1st January – 31st March 2023. The report covers the following areas:

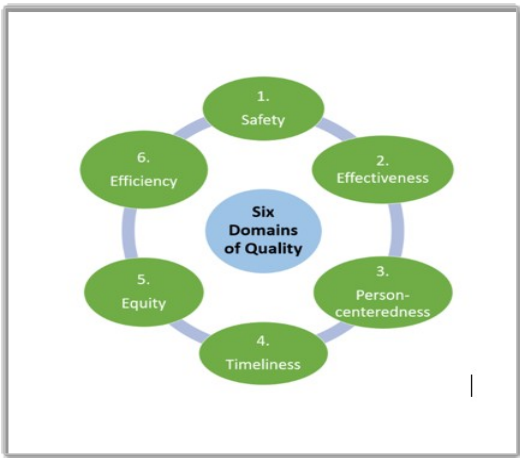
- NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.
- Management of Claims, Inquests and Ombudsman cases.
- Management of Safety Alerts.

The Quality, Safety & Performance Committee is asked to **DISCUSS** the Quarter 4 Trust Quality & Safety 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 Trust Integrated Quality & Safety Group and will continue to develop further in forthcoming months.



3. ASSESSMENT/SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Quarter 4 report highlights

- There has been a decrease in the numbers of new Ombudsman cases opened
- The Trust is displaying a trend in a reduction of concerns received across the 4 quarters 2022/23.
- During the quarter the achieved 100% compliance in relation to the 2-day formal acknowledgement and 30-day PTR investigation and formal response in respect of concerns.
- Further work required at VCS to complete incident investigations and close in Datix within 30 days. 332 remained open longer than 30 days at the end of the quarter

(although each month since Jan 2023 significantly more incident investigation are being completed and the incidents closed).

- Safety alerts are well managed through the Datix system, with timely reviews completed by Trust wide specific area safety leads.

3.2 The following were the three main areas of risk that required attention 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 provided documentation and training materials, including patient and staff leaflets for the implementation of the Duty of Candour to take immediate effect from the 1st April 2023. **Impact**: The delay in receiving national training materials and ESR configuration challenges have impacted on delivery of this training across the Trust. **Assurance**: Staff are updated through communication on the importance of the Duty of the Candour and their obligation in triggering the duty if moderate harm or above occurs. Staff are required to undergo the national 4-minute Duty of Candour awareness training, to enhance their understanding and meaning of the duty coming into effect to comply with regulatory training requirements. **Mitigation:** • Training Needs Analysis has been developed, identifying groups of staff throughout the Trust that will require basic up to advanced training, to comply with the Duty of Candour requirements. • Small harm incident numbers facilitate robust corporate Team oversight of all possible Duty of Candour incidents and concerns triggering early clinical review and consideration of triggering of 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. • The Duty of Candour trigger fields have been captured on the OfW Datix Cymru to report incidents when it is considered that moderate harm or above has occurred.
2.	**Priority:** ***successful completion of Welsh Risk Pool audit into analysis of compliance with the learning from concerns, claims and redress cases.*** **Risk:** Anomalies had previously been identified during Quarter 3 in respect of compliance with 30 working day target. Despite a range of improvement actions taken date anomalies continue to be identified with the OfW Datix Cymru Wales concerns module. **Impact:** Potential for low assurance rating.

	Assurance: No immediate escalation matters raised. It is anticipated that the Welsh Risk Pool will issue its findings by June 2023. Any recommendations or actions will be addressed, as required. **Impact from actions and emerging outcomes:** Addressing systemic issues to improve the data inputting on Datix OfW Cymru Wales modules continues. Training on OfW Datix Cymru has been provided by the Welsh Risk Pool during the reporting period and has consisted of training delivered to the Quality and Safety Team, and investigators from the VCS and WBS. It is envisaged that this training will improve the efficiency of data inputting on the OfW Datix Cymru modules and provide greater assurance to the Board that improvements are continuously being made to develop and enhance the data inputting on OfW Datix Cymru modules.
3.	**Priority: VCS *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:** Trust has a significant number of incidents open after the 30-day standard. This reduces the possibility of rapid learning from incident investigation, and may create Trust reputational damage as incident closure was a feature of the WRP audit. **Impact:** Possibility of repeated themes emerging due to delayed learning and may impact negatively on WRP assurance rating. **Assurance:** In recent months there has been VCS Senior Leadership engagement to resolve the large number of incidents open for longer than 30 days at VCS and this is resulting in an increasing number each month since January 2023 being investigated and closed on Datix.

3.3 Outcome of Integrated Quality & Safety Group Discussion

It was agreed that the 2023/24 quarter one report will also include key outcomes from Health & Safety, Information Governance, Infection Prevention & Control and Safeguarding.

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 & Performance Committee is asked to **DISCUSS and NOTE** the Quarter 4 Trust Quality & Safety report.

Velindre University NHS Trust 2022/23 Quarter 4 Quality & Safety Report

1. INTRODUCTION

The Trust Quality and Safety Quarter 4 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)

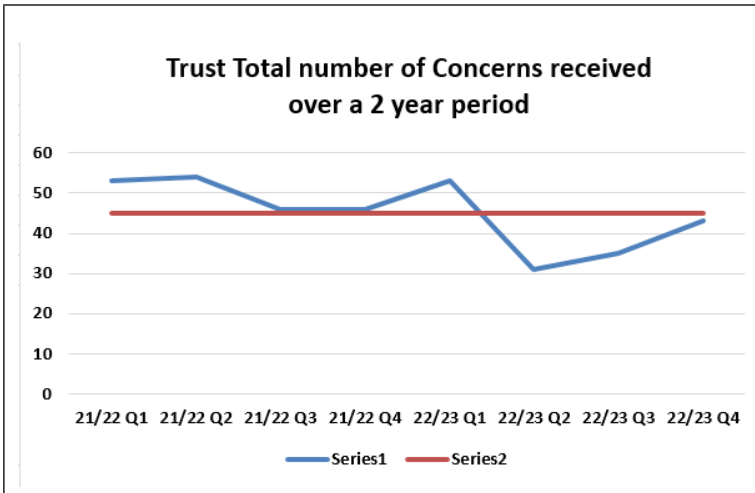
VELINDRE UNIVERSITY NHS TRUST QUARTERLY INDICATORS 2022/23					
	Q1	**Q2**	**Q3**	**Q4**	**YTD Total**
CONCERNS					
Trust Early Resolution (ER) (resolved within 48 hours**)**					
ER opened	***40***	***20***	***24***	***24***	***108***
Trust Putting Things Right (PTR) (formal**)**					
Trust wide PTR opened	***13***	***12***	***9***	***11***	***45***

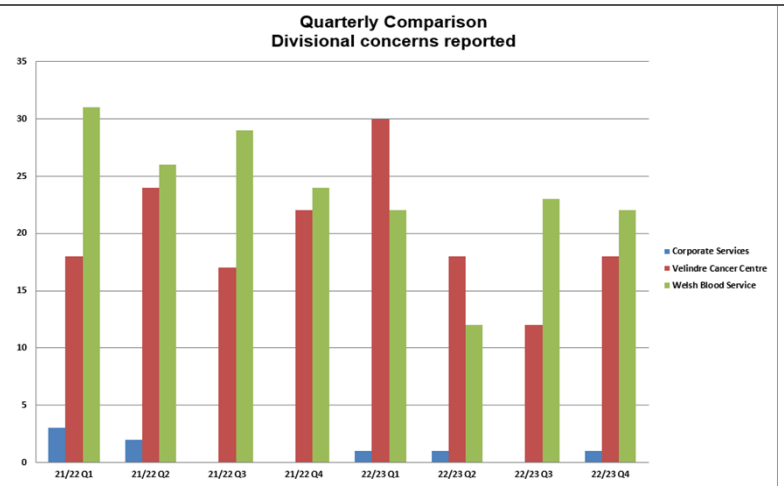
Acknowledged within 48 hours	**13**	**12**	**9**	**11**	**45**
PTR closed within 30 days	**13**	**12**	**4**	**11**	**40**
PTR closed after 30 days	**0**	**0**	**5**	**0**	**5**
Concerns raised through Welsh language	**1**	**0**	**0**	**1**	**2**
Total number of concerns (PTR/ER) received per	***53***	***32***	***33***	***35***	**-**
OMBUDSMAN (OMBS)					
OMBS cases opened	**0**	**3**	**0**	**1**	**4**
Open OMBS cases	**3**	**6**	**3**	**3**	**-**
OMBS cases closed	**0**	**0**	**3**	**1**	**4**
Total number of Ombudsman cases received	**0**	**3**	**0**	**1**	**-**
REDRESS					
Redress cases opened	**1**	**0**	**1**	**2**	**4**
Open redress cases	**3**	**4**	**3**	**4**	**2**
Redress cases closed	**0**	**0**	**1**	**0**	**1**
Total opened during quarter	**1**	**0**	**1**	**2**	**-**
CLAIMS					
Claims opened	**0**	**0**	**0**	**1**	**1**
Open claims	**8**	**7**	**6**	**5**	**3**
Closed claims	**0**	**1**	**1**	**2**	**4**
Total opened during quarter	**0**	**0**	**0**	**1**	**-**
INQUESTS					
Inquests opened	**1**	**1**	**1**	**0**	**0**
Open inquests	**4**	**5**	**5**	**6**	**5**
Closed inquests	**0**	**0**	**1**	**1**	**0**
Total opened during quarter	**1**	**1**	**1**	**0**	**-**
INCIDENTS REPORTED					
Corporate incidents	**6**	**7**	**2**	**2**	**17**
Velindre Cancer Service	**388**	**444**	**385**	**501**	**1718**
Welsh Blood Service incidents	**82**	**73**	**67**	**74**	**296**
National Reportable Incidents	**0**	**1**	**3**	**2**	**6**
IR(ME)R reported incidents	**3**	**4**	**5**	**7**	**19**
Total opened during quarter	**479**	**529**	**462**	**586**	**2056**
SAFETY ALERTS RECEIVED					
Pharmaceutical alerts	**29**	**25**	**31**	**37**	**122**
Patient safety alert	**0**	**0**	**2**	**1**	**3**
Patient safety notice	**2**	**1**	**2**	**1**	**6**
Medical Device	**4**	**2**	**0**	**3**	**9**

Estates and facilities alerts	**1**	**0**	**3**	**14**	**18**
Welsh Health Circulars	**3**	**1**	**7**	**3**	**14**
Total received during quarter	**39**	**29**	**45**	**59**	**-**

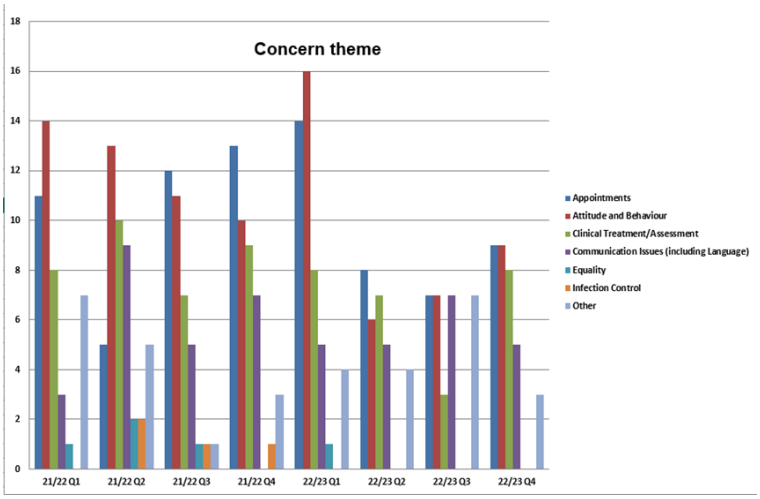
3. QUARTER 4 IN MORE DETAIL

3.1 CONCERNS EARLY RESOLUTION and PUTTING THINGS RIGHT	
***Velindre Cancer Service*:** **5** early resolution and **11** Putting Things Right concerns were raised, which is an increase in comparison to the previous quarter. There were **2** concerns reopened during the quarter. The **48-hour acknowledgement** and **30-day** investigation through to closure targets were **achieved** meaning that Velindre Cancer Service gained 100% compliance with the Putting Things Right regulatory requirements. **Email** remains the preferred method of contact. There were no **Covid related concerns** raised. **Top concern themes** related to clinical treatment & assessment, communication issues and attitude & behaviour. The outpatients department received the **highest numbers of concerns** raised, with patients and family members reporting communication issues, dissatisfaction with treatment plans and difficulty in obtaining timely appointments. There were no concerns graded higher than grade 1.	***Welsh Blood Service*:** **21** early resolution and **0** Putting Things Right concerns were raised, this is a consistent with previous quarters. The **48-hour acknowledgement** and **30-day** investigation through to closure targets were **achieved** meaning that Welsh Blood service gained 100% compliance with the Putting Things Right regulatory requirements. **Telephone** was recorded as the preferred method of contact. There were no **Covid related concerns** raised. **Top concern themes** continued to relate to appointments, attitude and behaviour issues. The community blood donation clinics received the **highest numbers of concerns** raised, totalling 18 out of the 21 that were recorded and related to appointments being cancelled, being turned away because of lateness or having children in attendance and not enough parking spaces (including disabled parking allocation). These are all issues WBS have seen raised before. There were no concerns graded higher than grade 1. All complainants were contacted to discuss their concerns raised and were happy with the outcomes of conversations and actions.
How many concerns were reported:	**Where** was the concern reported**:**

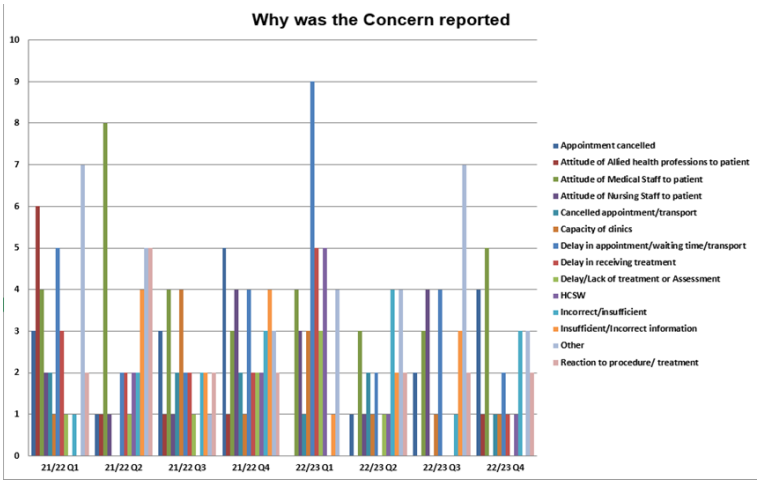




What was the concern related to**:**



Why was the concern reported:



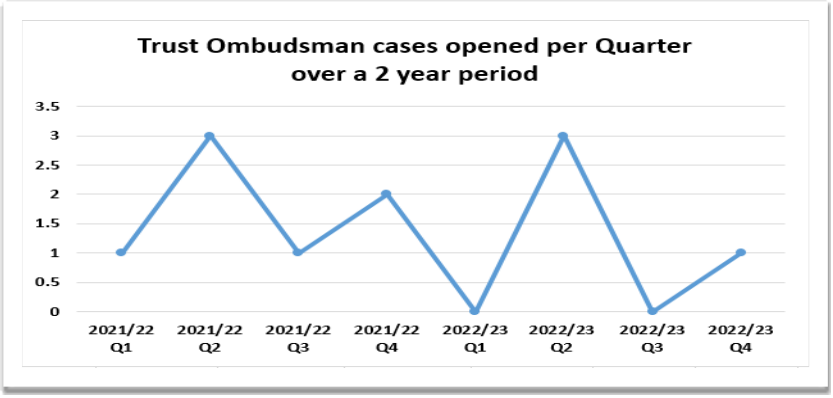
EXAMPLE OF LEARNING:

During the quarter significant learning was recorded in relation to the management of patient information, where a chronic pain management patient was incorrectly advised they were on a cancer patient distribution list. The investigation covered three organisations: Cardiff and Vale University Health Board; Digital Health Care Wales; and Velindre University NHS Trust. A number of changes in practices have been made as a result of the learning from this case. These include: enhanced controls to ensure that any data shared with other organisations has a second quality assurance check; placing an identifier within the database to clearly identify “cancer and non-cancer patient’s”, Velindre Cancer Service receives a detailed written specification for every request and that quality assurance documentation is complete before any data is shared; Information Governance training has been repeated for the Business Intelligence (BI) team; formal quality assurance training has provided to BI team members; and the standard operating procedure has been updated to guide individuals when handling requests for data. This case is now being concluded under NHS Redress.

3.2 OMBUDSMAN

The run graph below displays Ombudsman cases opened within the last 2 years:

There was **one new** Ombudsman case opened during the quarter. **1** Ombudsman case was closed, leaving 3 remaining cases under investigation at the end of Quarter 4. These relate to: Delays in diagnosis and poor communication; delays in referral and appointment and; delay in treatment.

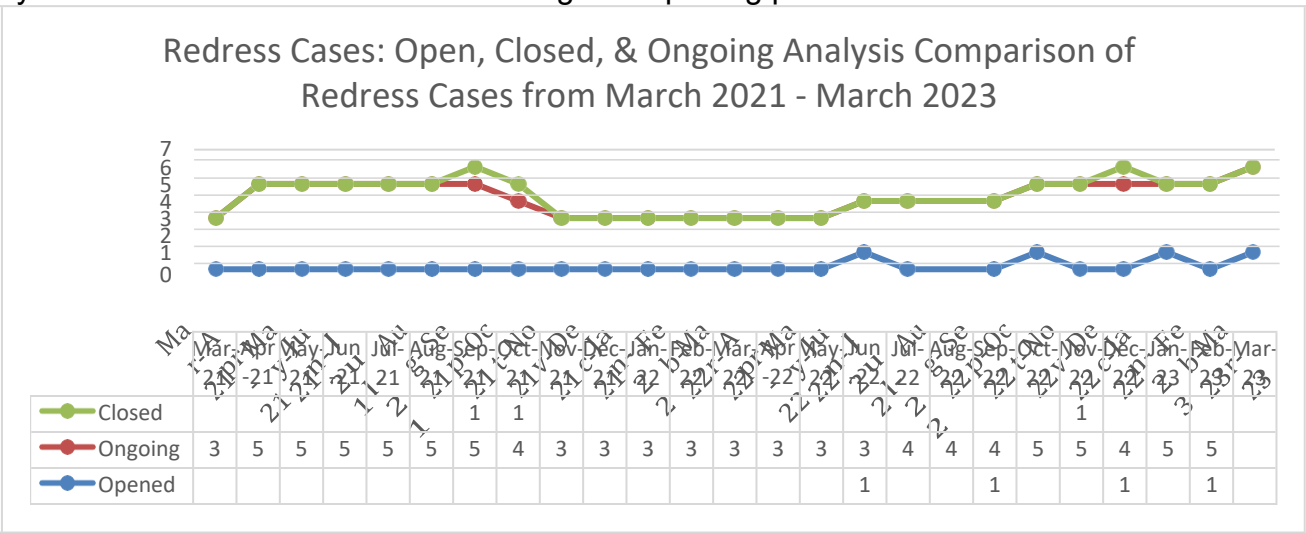


POSITION:

The Trust continue to receive very 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, which could be due to the significant work undertaken to improve how investigations are undertaken and ensuring these are concluded in a timely manner. The concern teams 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

2 matters were referred onto Redress during the quarter, in addition to the 3 existing Redress cases. All are being managed in accordance with the Putting Things Right process. Although active management is underway no Redress cases were closed during the reporting period.



3.4 CLAIMS

Current performance: The Trust continues to drive down litigation and the costs associated with it. The reduction in litigation has not, however, been at the expense of a less rigorous approach to investigations, as the Trust continues to respond to the responsibilities and challenges in relation to claims and legal change. The number of cases resolved continue to slowly increase. This has allowed flexibly to respond to new priorities without significantly affecting progress towards the Trust's strategic aims to ensure continued relevance. Negligence claims form a very small proportion of both the number of incidents and complaints reported in comparison to the many individual episodes of care that are delivered by the Trust on a daily basis.

Compliance/Assurance –Substantial

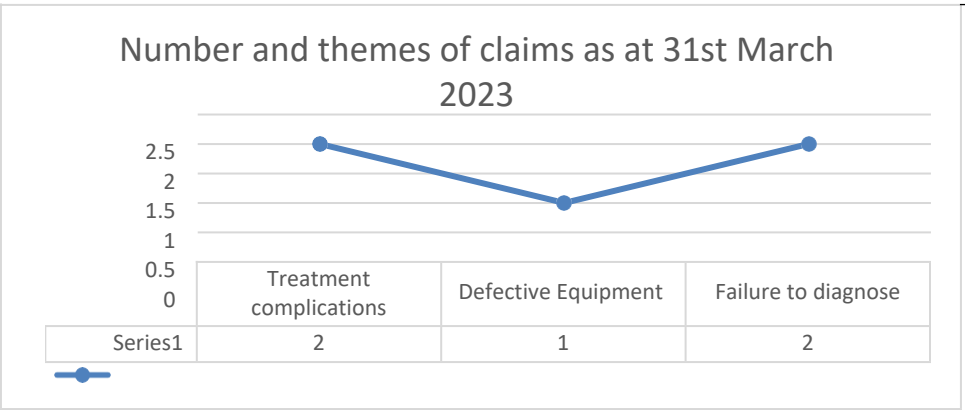
There was a reduction in the number of claims litigated against the Trust in comparison to the same quarter during 21/22.

Trust Liability: The Trust's liability is the best estimate of the expenditure required to settle the present obligation for predicated claims to be settled. The figure is updated quarterly and is an informed estimate that depends on assumptions about future developments and therefore lies within a range of possible results. The Trust is responsible for paying the first £25,000 of a negligence claim and thereafter seeks recoupment from the Welsh Risk Pool (who are the Trust's indemnifiers). There are no outstanding requests for reimbursement for the quarter.

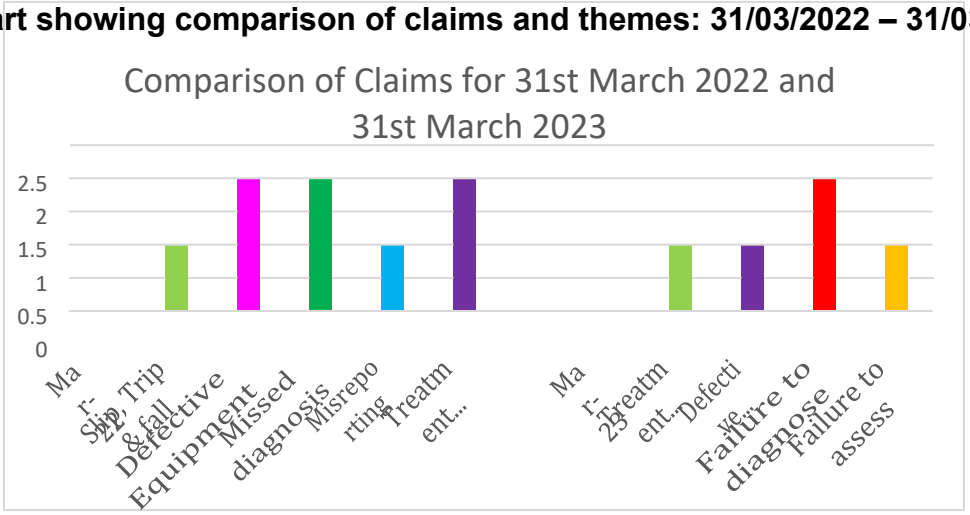
Trust Liability: £924,576.23

Anticipated Trust Liability: £100,000

Learning: There is a continuous focus on learning and improvements across the Trust, especially from contemporaneous feedback, which encourages staff to support service users and families better through the Putting Things Right process, where many concerns are resolved through the remedies available via the Redress scheme. The new legal requirement of the Duty of Candour is also expected to see a rise in learning when things go wrong, and the need to offer the most practical resolution available, where possible, under the Putting Things Right process. When the Duty of Candour is triggered that identifies harm that is more than minimal (i.e. moderate and above), the Trust's obligation will be to offer immediate action by providing a sincere apology, investigate the circumstances that gave rise to the event and learn from the experience. It is anticipated that when harm is identified, the Trust will continue to learn and share outcomes that ultimately will enhance service user experience. Overall, it is envisaged that the new duty will help to prevent future recurrences of harm and in turn, see both a reduction in claims and the litigated costs associated with them.



Combined run chart showing comparison of claims and themes: 31/03/2022 – 31/03/2023



Learning from settled Clinical Negligence Claim: Closed February 2023

A clinical negligence claim relating to a radiological reporting (CT Scan) error in February 2015, resulted in the Claimant requiring extensive surgery, which, on balance of probabilities, could have been prevented. The case proceeded against Aneurin Bevan and Swansea Bay University Health Boards (UHBs), in addition to the claim proceeding against Velindre University NHS Trust. A damages payment was agreed on an apportionment basis with Aneurin Bevan and Swansea Bay UHBs, in an out of court settlement in April 2022. Velindre UNHST's apportionment of damages amounted to £57,550.83, Claimant's costs totalled £13,950, and defence costs amounted to £1,740 on an apportionment basis.

In July 2021, a Learning from Events Report (LfER) was submitted to the Welsh Risk Pool. The following learning actions were undertaken:

- Learning has been shared in departmental radiology events and learning meetings (known as REALM), where cases and adverse events are recorded and discussed
- Introduction of regular audit meetings to discuss CT scan findings
- Introduction of peer reviews
- Introduction of mentoring to support and discuss opinions

- The sharing of learning from this case, at the multi-disciplinary team meeting and Morbidity and Mortality (M&M) Sarcoma meeting
- Introduction of time factored into the job plan for radiologists to review imaging.
- Sourcing of a governance lead to support radiology resource.
- Radiologist appointees made to strengthen clinical governance and provide further monitoring and assurance.

The above learning actions were approved by the Welsh Risk Pool Learning Advisory Committee in November 2021. On 21st September 2022, the Welsh Risk Pool approved the Trust's request for reimbursement in the sum of £43,635.38, thereby concluding all financial matters.

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.

NWSSP Legal and Risk Services Update - Change in the Costs Rules (CPR 44) on the 6 April 2023

The Civil Procedure rules will change for cases issued at Court post the 6th April 2023. The changes have costs consequences and mean that Defendants will be able to claim their costs from Claimants and Defendant Part 36 offers.

Solicitors acting on behalf of claimants are seeking waivers to protect their costs in respect to cases which have not yet been issued at Court. However, Legal and Risk has advised that Welsh NHS organisations should not agree to any waivers and seek advice when required.

Waivers that are being sought by Claimant solicitors are being escalated to Legal and Risk and are not being approved to protect the Trust in relation to costs consequences, in accordance with the legal advice.

WRP update – The Welsh Risk Pool Committee has agreed to apply a penalty of £25,000 to cases where approval of learning has been deferred for over twelve months from May 2023. Alternative penalties will be proposed for cases where learning is deferred longer than six months.

There are no immediate concerns affecting the Trust as it has complied with requests for evidence of learning within the required timeframes. However, the action taken by the Welsh Risk Pool serves as a reminder to submit further learning, as requested, within the timeframe, to prevent adverse serious financial repercussions.

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.

1 inquest was closed during the reporting period.

3.6 INCIDENTS / NATIONAL REPORTABLE INCIDENTS

During the quarter Velindre Cancer Service reported **497** incidents, Welsh Blood Service reported **73** incidents and Corporately **1** incident was reported. All incidents were graded as no or low harm.

At the end of the quarter WBS had 28 incidents that had been open longer than 30 days.

At the end of the quarter VCS had 332 incidents open longer than 30-days. Although more than double the number of incidents had investigations were completed and closed in VCS in March (104) compared with the previous two months (14 Jan 23 and 51 Feb 23).

2 incidents met the threshold for reporting as national reportable incidents during the quarter 4: a patient fall that resulted in an inpatient on the First Floor ward (FFW) at Velindre Cancer Service trying to mobilise herself to use the commode, lost balance and fell to the floor and, delay in a patient's referral and treatment whereby no referral from inpatient urology was sent leading to a significant delay in treatment for the patient. Both investigations are underway and conclusion is expected by the end of June 2023.

Two National Reportable Incident investigations were concluded during the quarter:

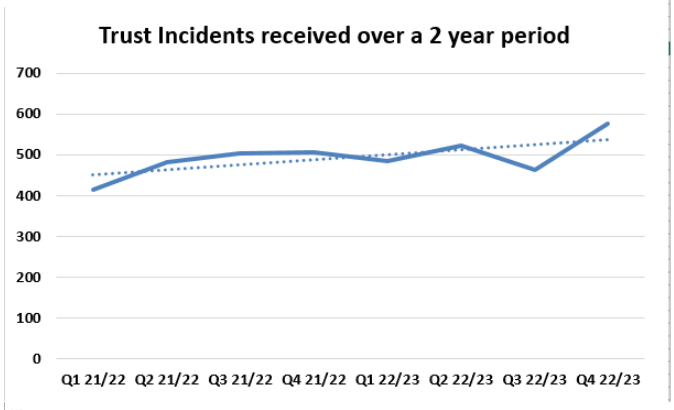
1) Possible avoidable death following a call made to the VCS Treatment Helpline. escalation resulting in. A full investigation was undertaken and the following has / is being undertaken as a result:
   - Changes to working practice has been agreed through a formal governance and assurance process
   - Staff now have protected time for supervision and debriefs
   - Work has been undertaken to revisit how the UKONS Triage assessment tool is adhered too
   - Escalation processes reviewed to ensure real time appropriate clinical escalation
   - A full review of the Trust Treatment helpline is underway as a Safe Care Collaborative project.

2) An inpatient slipped and sustained a fracture. A full investigation has been undertaken and the following improvements made:
   - Clearer referral criteria for referring patients with a history of falls to the physiotherapy team developed
   - Clarity gained about the availability and role of the physiotherapy team on weekends.

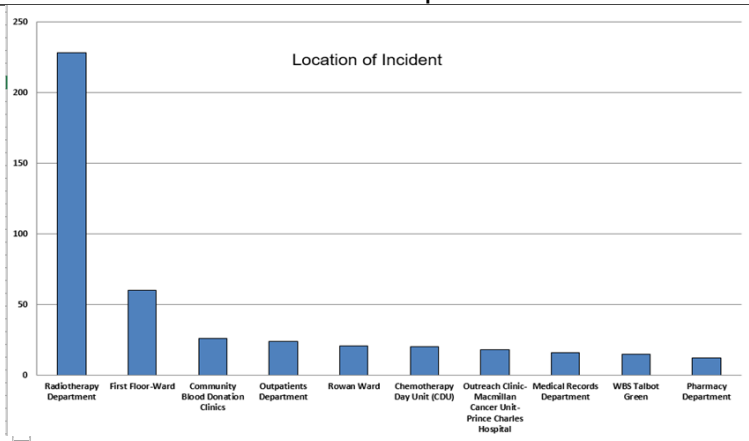
Radiotherapy remains the area recording the highest number of incidents, a number of these incidents are in relation to a known manufacturer fault with the radiotherapy system. The Executive Management Board is fully aware of this situation. The Radiation Service is continuously look to new ways of mitigating this known fault as the company cannot resolve the issues. The Trust reported **7** ionising radiation (medical exposure) regulation IR(ME)R incidents to Health Inspectorate Wales, investigations are underway.

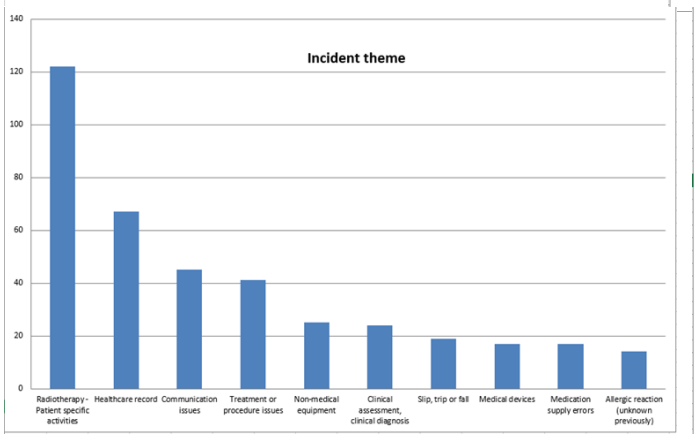
Incident graphs

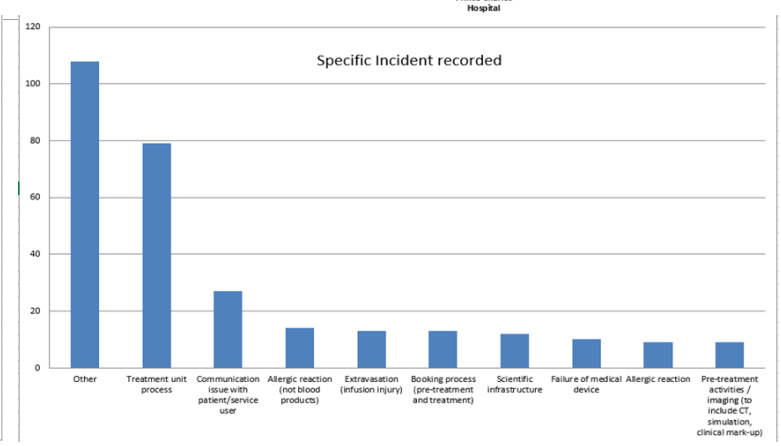
How many incidents were reported:



Where was the incident reported:







LEARNING:

Although incident figures have seen a rise during this reporting period, this is an indication that staff are reporting and capturing more incidents than seen previously. This enables the Trust to undertake an in-depth analysis of incidents, identifying where the incident was reported, the reasons giving rise to it and an evaluation of key themes.

By identifying these three core aspects, this allows the Trust to bring together key parties to determine what improvements can be made to address the findings and how best this will support the Trust's governance and assurance.

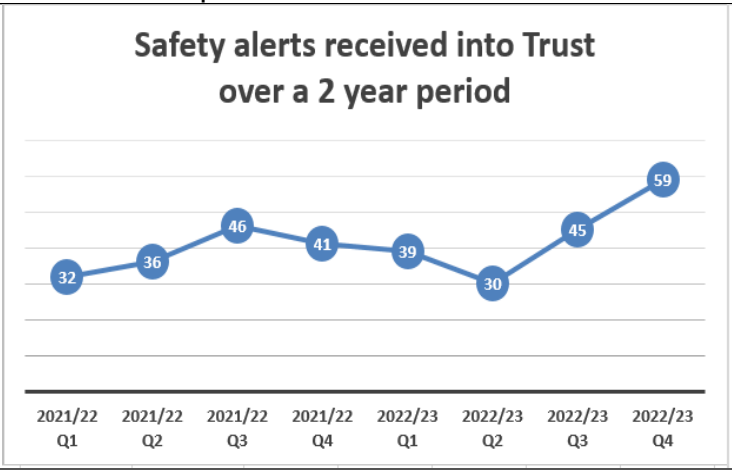
By identifying key incidents, the Trust has an opportunity for learning by developing staff, its systems and services to deliver safe, quality care to all our service users, which in turn, helps to mitigate against risk.

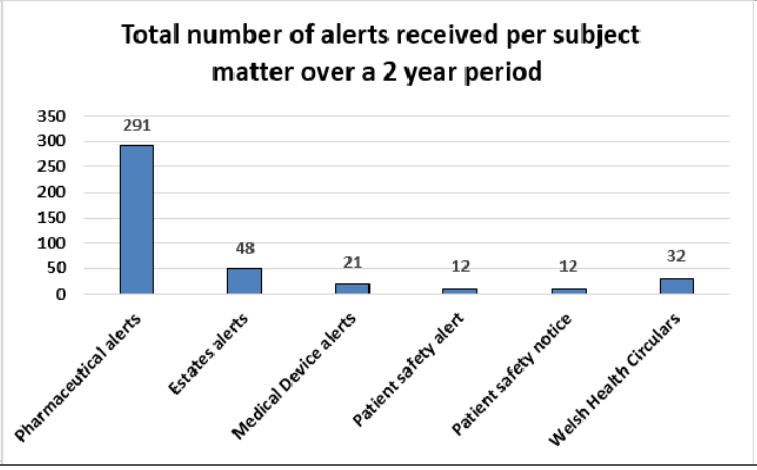
As part of continuous learning, divisions will be required to look at timely intervention to develop actions to address incidents. This will include review at the monthly Senior Leadership Team meetings whereby managers and staff will be supported to understand their risk profile, target safety activity and ensure that learning is shared across the system to improve service user care.

4. SAFETY ALERTS

59 Safety alerts were received into Trust during the quarter: **1** patient safety alert; **1** patient safety notice; **14** estates alerts; **3** Welsh Health Circulars; and **37** pharmaceutical alerts. Following review, only **7 of the 59 alerts were deemed applicable** to Trust, **6** were pharmaceutical alerts and **1** was Patient Safety. The patient safety alert was received on the 20th January 2023 and related to the Safe use of oxygen cylinders in areas without medical gas pipeline systems. The Trust's Chief Pharmacist has provided assurance that the required risk assessment has been completed and the Trust is fully compliant with the alert. Ongoing monitoring of this alert will be undertaken through the medicines management and medical gas meetings.

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 5th May 2023 which is slightly passed the previously identified completion date of the 31st March 2023.





6. PRIORITIES FOR QUARTER 1 2023-24

The following are the agreed priorities for Quarter 1 2023-24:

- Further development of the Trust Integrated Quality and Safety Group to facilitate more effective triangulation.
- Continued establishment of the Trust's Safe Care Collaborative.
- 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 strengthen investigations and to effectively capture learning and outcomes from new concerns and incidents reported during Quarter 1 2023-24.

- Implementation of a process for post incident (moderate or>) reflection event for all staff involved to received closure, understand investigation findings and be part of the improvement assurance process (be staff themselves assessing if they think the actions that have been put in place to prevent a re-occurrence would be effective)
- Implement any actions arising from the Welsh Risk Pool audit.

QUALITY, SAFETY & PERFORMANCE COMMITTEE

QUALITY & SAFETY ASSURANCE TRACKER

DATE OF MEETING	16th May 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 and Health Science
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, AHPs and 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**
Integrated Quality & Safety Group	25/04/2023	Matter discussed and further work identified
Executive Management Board	02/05/2023	Identified that further work is required

1. SITUATION

The paper is to provide the Quality, Safety & Performance Committee with the position in relation to the re-development of the Trust's Quality and Safety Assurance Tracker.

2. BACKGROUND

Following the 2018 Structured Assessment, the Wales Audit Office recommended that an external audit / inspection recommendation and action log be developed and received by the Quality, Safety & Performance Committee, the purpose of which is to enable the Committee to review progress against recommended actions that are not being monitored by other Board Committees. This was developed and put in place. However, the Audit Wales Structured Assessment 2022 report identified that the Quality & Safety Improvement Tracker had not been provided to the Quality, Safety & Performance Committee since June 2020. This had been accidentally omitted from the Committee cycle of business.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Revised Quality & Safety

Work on the revised Quality and Safety Improvement Tracker has commenced using the 7 levels of assurance template. The draft tracker has been received and discussed in length in both the Integrated Quality & Safety Group and the Executive Management Board. The proposed content for the tracker was agreed and it was identified that significant further development work is required.

To prevent duplication, the tracker will not cover areas that the Audit Committee receives assurance on e.g. Audit Wales recommendations, Internal Audit recommendations and legislative and regulatory compliance.

The proposed areas for inclusion are:

- 'Other' recommendations outside of the areas noted above;
- Externally commissioned Quality related reports e.g Private patients;
- Peer review recommendations;
- CHC / Llais visits;
- 15 step visits;
- Details of pending inspections; and,
- Gap analysis recommendations following receipt of external reports containing learning relevant to the Trust.

The tracker re-development is taking time and is being actively worked on at present and overseen by the Integrated Quality & Safety Group. Currently the inspection, regulatory and learning reports from Estates, Environment & Capital and Pharmacy are being added in.

In addition, a further review will be undertaken to source information regarding additional inspections and audits undertaken during the elapsed reporting time period to ensure a comprehensive record of information in a central location across the remit of the Quality, Safety & Performance Committee.

The tracker template is available through this link:
https://nhswales365.sharepoint.com/:f:/r/sites/VEL_QualitySafetyAssuranceTracker/Shared%20Documents/General?csf=1&web=1&e=KXbhPa

An overview of the Inspectorate page of the tracker developed thus far is attached in ***appendix 1***. This includes the historical as well more recent recommendations and status updates are currently being sourced. It is anticipated that the majority of actions have been delivered and oversight has been undertaken via different mechanisms e.g. the decontamination inspection actions through the Infection, Prevention & Control Group.

3.2 Tracker oversight

The Integrated Quality & Safety Group will maintain operational oversight for the tracker supported by the Trust's Quality and Safety Team. The full tracker will have Executive oversight at the Executive Management Board.

It is envisaged that the Quality, Safety & Performance Committee will receive high level oversight of the tracker. This will include receiving all such inspection and regulatory reports and improvement plans, and subsequent high-level summary of levels of completion and detail of areas of non-compliance / exceptions. This will be one of the mechanisms by which the Trust will enhance its quality & safety assurance mechanisms.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Compliance with recommendations from external audits / inspections will impact the quality and safety of services provided.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required for the tracker development and oversight
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	There is the potential for legal implications if regulatory requirements are not met.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	However, there is the potential for financial implications through delivery / non-delivery of

	the required recommendations arising from reports

5. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to:

- **NOTE** the Quality & Safety Assurance tracker re-development work undertaken to date and the plans for further development
- **APPROVE** the proposed areas for inclusion
- **APPROVE** the 7 levels of assurance format
- **AGREE** to receive the further amended tracker detailing all open actions at the July Committee.

Definitions of 7 Levels Framework for Evaluating Delivery of Improvement Plans

DETAILED DEFINITIONS OF 7 LEVELS OF EVALUATION TO DETERMINE RAG RATING / OPERATIONAL ASSURANCE

RAG rating	ACTIONS	OUTCOMES
Level 7	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes over a defined period of time i.e., 3 months.
Level 6	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement also of desired outcomes.
Level 5	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with little or no evidence of the achievement of desired outcomes.
Level 4	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of several agreed actions being delivered, with little or no evidence of the achievement of desired outcomes.
Level 3	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Some measurable impact evident from actions initially taken AND an emerging clarity of outcomes sought to determine sustainability, with agreed measures to evidence improvement.
Level 2	Comprehensive actions identified and agreed upon to address specific performance concerns.	Some measurable impact evident from actions initially taken.
Level 1	Initial actions agreed upon, these focused upon directly addressing specific performance concerns.	Outcomes sought being defined. No improvements yet evident.
Level 0	Emerging actions not yet agreed with all relevant parties.	No improvements evident.

SUMMARY STATEMENTS OF 7 LEVELS

RAG rating	SUMMARY
7	Improvements sustained over time - BAU
6	Outcomes realised in full
5	Majority of actions implemented; outcomes not realised as intended
4	Increased extent of impact from actions
3	Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes
2	Symptomatic issues being addressed
1	Actions for symptomatic issues, no defined outcomes
0	Enthusiasm, no robust plan

Quality & Safety Tracker - Version 0.01 - RECOMMENDATIONS / OPEN ACTIONS
Date 17 - 04 - 2023

7	Improvements sustained over time - BAU
6	Outcomes realised in full
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4	Increased extent of impact from actions
3	Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes
2	Symptomatic issues being addressed
1	Actions for symptomatic issues, no defined outcomes
0	Enthusiasm, no robust plan

Ref No	Service	Recommendation	Outcomes Required	Suggested SMART Actions	Operational Lead	Executive Lead	Operational Oversight	Strategic Oversight	Delivery Date	Summary of Progress	Level of Assurance	Outstanding management Action	Report Received
All Wales Endoscope Decontamination Survey 2018													
REF001	Infection Prevention & Control	It is recommended the Trust holds a workshop to raise awareness of decontamination within the organisation. It is proposed that the day covers items such as the principles of decontamination, manual cleaning, infection control and trace-ability. The idea is to enhance awareness but not replace dedicated training supplied by individual manufacturers. NWSSP/SES will endeavour to assist the Trust on this venture.		A workshop will be arranged post implementation of the high level disinfection systems & ultraviolet light environmental decontamination system.	Head of Infection Prevention & Control	Executive Director of Nursing, AHPs and Health Science	Infection Prevention & Control Management Group	Quality, Safety & Performance Committee	Mar-20				
REF002	Infection Prevention & Control	Upon inspection it was clear a number of policy documents, specific to endoscope use, are undergoing revision, it is recommended such are reviewed at periodic intervals in response to changes at local/national level.	Audit of decontamination processes will be undertaken to assess compliance within 6 months of implementation.		Infection Prevention and Control Team	Executive Director of Nursing, AHPs and Health Science	Infection Prevention & Control Management Group	Quality, Safety & Performance Committee	Dec-19				
HIW unannounced inspection VCS 19th / 20th March 2019 (report published June 2019)													
REF003	VCC Inpatient Wards	Reflect on the less favourable staff responses to some of the questions in the HIW questionnaire, as noted in the Quality of Management and Leadership section of this report, and take action to address the issues highlighted.	The nursing team, the senior management team and the executive team have received a copy of the draft report and will reflect and act on the less favourable responses. The final report will be formally presented at Trust meetings and committees. Work is being undertaken in relation to the All Wales Staff Survey and some of the issues raised are captured in work that is already planned.		Head of Nursing, Quality, Patient Experience and Integrated Care	Executive Director of Nursing, AHPs and Health Science		Quality, Safety & Performance Committee	Mar-20				
Welsh Risk Pool Safety & Learning Team National Review of Venous Thromboembolisms (VTE) October - December 2020													
REF004		Re-establish a VCC Thrombosis Working Group with multidisciplinary representation.	The main focus of the group is to have oversight of all thrombosis-related practices within VCC including guidelines development and updates, audit, education, Root Cause Analysis on all patient diagnosed with hospital acquired thrombosis and sharing good practices both within VCC and nationally. The working group can also develop links with other hospitals / health boards to ensure patients diagnosed with VTE elsewhere are appropriately and safety managed.	Identify key individuals to make up Working Group. Appoint Chair and Vice Chair	SACT and Medicines Management Lead / Chief Pharmacist		VCS Medicines Management Group / VCS Q&S Group	Quality, Safety & Performance Committee	Aug-22				Welsh Risk Pool VTE Report
REF005		Implement a formal VTE Risk Assessment Tool for use in all patients admitted to VCC that is fully in line with the All-Wales Thromboprophylaxis Policy.	This should be incorporated within all inpatient clerking proforma's and be audited for compliance on a 3 month basis. These results should then be fed back to VCC Quality and Safety Committee for scrutiny and recommendation.	Once working group established (action point 1), to review current national Risk Assessment Tools (RAT) in use (including recommended DoH RAT). Agree RAT to be used in VCC, along with frequency of audit and feedback.	Principal Pharmacist, Clinical Services		VCS Medicines Management Group / VCS Q&S Group	Quality, Safety & Performance Committee	Dec-22				
REF006		Ensure all relevant front line clinical staff have formal training, awareness and understanding of Venous Thromboembolisms.	Training to be included as part of VCC clinical staff training requirements	Adopt the 2 national modules that have been developed on the recognition of symptoms and prevention of HAT into VCC. Include as part of Mandatory and Statutory training for all clinical staffs; or set completion targets (e.g. 50% of all relevant clinical staff by year 1 and 80% by year 2) Re-validation of training every 3-4 years.	Head of Nursing, Quality, Patient Experience and Integrated Care . W&OD Lead / Chief Pharmacist		VCS Q&S Group	Quality, Safety & Performance Committee	Training plan and requirement to be agreed and in place by Sep-22				
REF007		Continue to develop the CAT service.	Acknowledging that the CAT service accepts referrals from outside VCC, to include Cwm Taf Morgannwg UHB, Hywel Dda UHB and Powys UHB.	Work with Dr Pease CAT service lead and haematology colleagues as part of the work of the VCC Thrombosis Working Group.	Clinical Director		VCS Thrombosis Working Group	Quality, Safety & Performance Committee	Plan to be developed by Dec-22				
REF008		All All-Wales checklist for the investigation of HAT is developed in order to maintain a uniform investigative approach across NHS Wales.		All Wales checklist when agreed to be used to investigate all incidences of VCC related HAT and checklist included as part of the Datix investigation field.	SACT and Medicines Management Lead/Chief Pharmacist		VCS Medicines Management Group / VCS Q&S Group	Quality, Safety & Performance Committee	Once All Wales checklist agreed				
REF009		VTE risk assessment compliance and all HAT data is shared at appropriate health body governance meetings.		VCC VTE risk assessment compliance to be incorporated into VCC Performance Management Framework and reported through to SLT	Assistant Director of Planning VCS		VCS SLT		Sep-22				

Lloyds Register Quality Assurance (ISO 9001:2008) External Auditors (Radiology) - February 2022													
REF010	VCC Radiology	The process for maintaining documented informatino was not found to be fully effective.	To the extent necessary, the Trust shall maintain documented information to support the operation of its processes and retain documented information to have confidence that the processes are being carried out as planned.	A draft document with updated guidance was drafted immediately and at conclusion of the audit, was awaiting appropriate review and approval by the Lead Radiologist prior to issuing.	Radiology Manager	Chief Operating Officer		Quality, Safety & Performance Committee					Radiology ISO visit report Feb 23
All Wales Quality Assurance Pharmacist (on behalf of WG) 26th / 27th April 2022													
REF011	VCC Pharmacy	Outcome was as follows: Red deficiencies - 0 Amber Deficiences -12 Yellow Deficiencies - 47 Green Compliance - 412	Action plans for all of the deficiencies has been added to the iQAAPS website, a high number of deficiencies are linked and they have been linked into the relevant action plans and is overseen by Martin Rees-Milton, who submits 6 monthly progress reports on line via the iQAAPS website. Action plan resolution times and reminder alerts have been set up, as the action plans are resolved they will be closed on iQAAPS.	AWAITING REPORT WITH RECOMMENDATIONS	Chief Pharmacist	Medical Director	Progress monitored via Medicines Management Group	Quality, Safety & Performance Committee					Requested
HIW visit to VCC First Floor Ward 12th / 13th July 2022													
REF012	VCC Inpatient Wards	The Trust must ensure that there is a close focus on the dementia provision on the ward. This may include implementing a patient identification system on the ward and a review of the current non-mandatory approach to training.	The Enhanced Supervision Policy to be fully implemented. The policy will identify the requirements of patients with confusion or cognitive impairment e.g. closer supervision, open visiting.		Operational Senior Nurse and First Floor Ward Manager	Head of Nursing, Quality, Patient Experience and Integrated Care			Oct-22				HIW FFW Visit July 2022
REF013	VCC Inpatient Wards	See above (line 13)	Compliance with the Enhanced Supervision Policy to be reviewed quarterly for the first year to assess effectiveness.		First Floor Ward Manager	Head of Nursing, Quality, Patient Experience and Integrated Care			From 3 months post implementation - Jan 23				
REF014	VCC Inpatient Wards	See above	First Floor ward to implement “This is me” booklet for patients with dementia and cognitive impairment		Operational Senior Nurse and First Floor Ward Manager	Head of Nursing, Quality, Patient Experience and Integrated Care			Nov-22				
REF015	VCC Inpatient Wards	See above	The implementation of “This is Me” booklet will be audited quarterly for the first year to assess effectiveness.		First Floor Ward Manager	Head of Nursing, Quality, Patient Experience and Integrated Care			From 3 months post implementation - Feb 23				
REF016	VCC Inpatient Wards	See above	A dementia awareness/ update session to be provided to all staff within a ward meeting		First Floor Ward Manager	Head of Nursing, Quality, Patient Experience and Integrated Care			Nov-22				
REF017	VCC Inpatient Wards	See above	All staff to receive formal dementia training via the arrangement with Cardiff and Vale Heath Board		First Floor Ward Manager	Head of Nursing, Quality, Patient Experience and Integrated Care			Mar-23				
REF018	VCC Inpatient Wards	See above	Ward to develop as part of patient status at a glance board, above beds & handover process a visual mechanism for all patients with cognitive impairment that’s a visual reminder to all personnel.		First Floor Ward Manager	Head of Nursing, Quality, Patient Experience and Integrated Care			Nov-22				
REF019	VCC Inpatient Wards	The Trust must continue to carefully monitor falls incidents on the ward to ensure that the anticipated improvements are realised in a timely and effective manner.	All actions from the recent corporate nursing falls audit to be fully implemented.		Operational Senior Nurse and First Floor Ward Manager	Head of Nursing, Quality, Patient Experience and Integrated Care			Nov-22				
REF020	VCC Inpatient Wards	The Trust may wish to consider implementing intentional (safe) rounding as an additional proactive measure.	The Ward Manager and Operational Senior to formally consider implementing intentional rounding.		Operational Senior Nurse and First Floor Ward Manager	Head of Nursing, Quality, Patient Experience and Integrated Care			Oct-22				
REF021	VCC Inpatient Wards	See above (line 21)	Enhanced Supervision Policy to be fully implemented which identifies the level of supervision a patient requires dependent on risk of falls, confusion, risk of patient becoming lost/ wandering.		Operational Senior Nurse and Quality & Safety Manager	Head of Nursing, Quality, Patient Experience and Integrated Care			Oct-22				
REF022	VCC Inpatient Wards	See above (line 21)	Compliance with the Enhanced Supervision Policy to be reviewed quarterly for the first year to assess effectiveness.		First Floor Ward Manager	Head of Nursing, Quality, Patient Experience and Integrated Care			3 months post-implementation - Jan-23				
REF023	VCC Inpatient Wards	The Trust must ensure that COVID-19 risk assessments continue to be completed and evidenced within patient records.	All patients receive a COVID PCR test on admission. Information risk assessments are currently being done on all admissions (history of cough, temperature, close contact). Clerking proforma to be updated to include a formal COVID risk assessment to document and evidence the action taken.		Acute Oncology Lead Nurse	Head of Nursing, Quality, Patient Experience and Integrated Care			Oct-22				
REF024	VCC Inpatient Wards	The Trust must ensure that, following completion of risk assessments, patients are followed up at the required intervals and that these checks are evidenced within patient notes. This includes evidencing a plan of care or referrals to specialist services (e.g. dieticians) where required.	The Trust is implementing the WNCR and is aware that there are 2 systems both digital and paper in place at ward level at present, this is an All Wales position. Many of the WNCR nursing assessment include a care plan e.g. skin bundle. The ward manager, senior operational nurse, ward clinical educator, and digital CNS are meeting to formulate and roll out an improvement plan for documentation.		Operational Senior Nurse and First Floor Ward Manager	Head of Nursing, Quality, Patient Experience and Integrated Care			Dec-22				
REF025	VCC Inpatient Wards	See above (line 24)	Documentation, including risk assessments and care plans will be audited on a quarterly basis to ensure compliance and high standard of documentation evident.		Operational Senior Nurse and First Floor Ward Manager	Head of Nursing, Quality, Patient Experience and Integrated Care			Dec-22				

REF026	VCC Inpatient Wards	The Trust must ensure that Patient Names / IDs are recorded on all pages.	All staff (doctors, nurses, AHPs) reminded to include patient ID on all pages. Included in Big 4, emailed to all doctors, emailed to all AHP, put on nurses Whatsapp work group. This information to be included in future documentation audits.		Operational Senior Nurse and First Floor Ward Manager	Head of Nursing, Quality, Patient Experience and Integrated Care			Sep-22				
REF027	VCC Inpatient Wards	The Trust must ensure that oxygen is prescribed.	All staff (nurses and doctors) reminded that oxygen must be prescribed – included in Big 4, emailed to all doctors, put on nurses Whatsapp work group. Audit to be taken quarterly and fed back to ward and medical gases group.		Operational Senior Nurse and First Floor Ward Manager	Head of Nursing, Quality, Patient Experience and Integrated Care			Sep-22				
REF028	VCC Inpatient Wards	The Trust must ensure that medication fridges are locked when not in use.	All staff (nurses and pharmacy) reminded of safe storage of medication. Emailed to all pharmacy staff, included in Big 4, put on nurses Whatsapp work group, and emailed to Medicines Safety Group chair. Spot checks to be undertaken by ward manager / Senior Nurse regularly and fed back to ward Medicines Safety Group.		Chief Pharmacist / Head of Therapies / Clinical Director	Head of Nursing, Quality, Patient Experience and Integrated Care			Sep-22				
REF029	VCC Inpatient Wards	The Trust must ensure that medical devices / equipment on the ward are serviced at the required intervals.	Ward manager and medical physics to undertake a spot check of all medical devices on the ward to identify devices/ equipment that need immediate servicing.		First Floor Ward Manager / Medical Physicist	Head of Nursing, Quality, Patient Experience and Integrated Care			Sep-22				
REF030	VCC Inpatient Wards	See above (line 29)	Ward manager and medical physics to ensure a robust system in place for regularly checking the service date for medical devices/ equipment		First Floor Ward Manager / Medical Physicist	Head of Nursing, Quality, Patient Experience and Integrated Care			Oct-22				
REF031	VCC Inpatient Wards	See above (line 29)	Trust to consider implementing a Medical Devices electronic tracking system that recalls devices requiring service		Medical Physicist	Head of Nursing, Quality, Patient Experience and Integrated Care			Mar-23				
REF032	VCC Inpatient Wards	The Trust must ensure that sepsis training is delivered on a consistent basis and that evidence of attendance is maintained.	Sepsis training is delivered to all registered nursing staff as a core part of the Acute Oncology Study day.		First Floor Ward Manager / Acute Oncology Lead Nurse	Head of Nursing, Quality, Patient Experience and Integrated Care			Oct-22				
REF033	VCC Inpatient Wards	See above (line 33)	Training compliance to be reviewed and be further rolled out as part of the implementation of NEWS Cymru. Training plan will be developed to be delivered over 6 months.		First Floor Ward Manager / Acute Oncology Lead Nurse	Head of Nursing, Quality, Patient Experience and Integrated Care			Mar-23				
REF034	VCC Inpatient Wards	The Trust must ensure that where DNACPR discussions or forms of escalation are not considered necessary that details of the decision making are recorded within the patient notes to evidence an appropriate audit trail.	Spot checks to be undertaken by ward manager / Senior Nurse regularly and fed back to clinical team. Ward daily midday safety huddle to include question regarding treatment escalation plan to ensure in place for all patients.		Operational Senior Nurse and First Floor Ward Manager	Head of Nursing, Quality, Patient Experience and Integrated Care			?				
REF035	VCC Inpatient Wards	The Trust must consider how care plans are completed and reviewed to ensure that individualised patient care can be captured and demonstrated within patient notes.	The Trust is implementing the WNCR and is aware that there are 2 systems both digital and paper in place at ward level at present, this is an All Wales position. Many of the WNCR nursing assessment include a care plan e.g. skin bundle.	The ward manager, senior operational nurse, ward clinical educator, and digital CNS to formulate and roll out an improvement plan for documentation.	Operational Senior Nurse and First Floor Ward Manager	Head of Nursing, Quality, Patient Experience and Integrated Care			Dec-22				
REF036	VCC Inpatient Wards	See above (line 36)	Documentation, including risk assessments and care plans will be audited on a quarterly basis to ensure compliance and high standard of documentation evident.		Operational Senior Nurse and First Floor Ward Manager	Head of Nursing, Quality, Patient Experience and Integrated Care			From Sep-22				
REF037	VCC Inpatient Wards	The Trust should consider how its patient record systems align (or otherwise) to ensure that there is a unified and streamlined approach to the access and review of patient notes by all staff groups		The Trust is implementing the WNCR and is aware that there are 2 systems both digital and paper in place at ward level at present, this is an All Wales position. The Velindre Cancer Centre (VCC) is implementing WPAS in November 2022 and full use of WCP as the clinical record as part of its Canisc replacement, this will improve the current situation where there are multiple sources of documentation in relation to a patients care at VCC.	Operational Senior Nurse	Head of Nursing, Quality, Patient Experience and Integrated Care			Dec-22				
REF038	VCC Inpatient Wards	Given the improvements identified above, the Trust should increase its record keeping audit activity.	Following improvements being made to documentation overall, regular audits will be undertaken quarterly to monitor risk assessments, care plans, referrals, and patient identification.		Operational Senior Nurse and First Floor Ward Manager	Head of Nursing, Quality, Patient Experience and Integrated Care			Dec-22				
REF039	VCC Inpatient Wards	The Trust may wish to reflect on the staff findings to determine if any further actions or forms of staff engagement are required.	The team have reflected on the staff feedback, there are in place multiple ways of receiving staff feedback, in relation to the specific feedback in this report the senior nurses will include themes from the feedback in the ward and team meetings agendas and in the daily Big 4 communications.		Operational Senior Nurse and First Floor Ward Manager	Head of Nursing, Quality, Patient Experience and Integrated Care			Oct-22				
REF040	VCC Inpatient Wards	See above (line 40)	Explore the use of Civica for regular staff feedback, pulse surveys, implement and monitor feedback from themes.		Operational Senior Nurse and First Floor Ward Manager	Head of Nursing, Quality, Patient Experience and Integrated Care			Oct-22				

MHRA (Medicines and Healthcare Products Regulatory Agency) inspection of WBS North Wales 8th / 9th June 2022													
REF041	WBS (North Wales)	Suitable premises, equipment and trained personnel had not been maintained to support the authorised activity of collecting plasma by apheresis at the Wrexham site, following suspension of the convalescent plasma programme in March 2021. There had been no change control or other quality	A retrospective change control will be raised to record those actions already undertaken to remove the facility from use. This change control will also cover the suspension of other WBS plasma collection centres at the Welsh Wound Innovation Centre and Dafen, along with any associated risk(s). The BEA licence will be updated accordingly. The target date for submitting the BEA variation is 13/08/2022; the inspectors shall be copied in as requested.						Aug-22				MHRA North Wales Inspection June 2022
HIW visit to VCS Nuclear Medicine 14th / 15th June 2022													
REF042	Nuclear Medicine Department	The Trust is required to ensure that action is taken to promote the availability of Welsh speaking staff or support within the department to help deliver the 'Active Offer'		A Trust wide audit of 'Active Offer' to be undertaken across all patient / donor facing clinical areas and local action taken to ensure any 'Active Offer' deficits are addressed .	Trust Welsh Language Manager				Mar-23				HIW IRMER Visit June 2022
REF043	Nuclear Medicine Department	The employer must ensure that the entitlement matrix is updated to include dates, as opposed to ticks, so that management are aware of when the documents need to be reviewed. The documentation must also be in a consistent format as part of the document quality system.	This and other documents will be transitioned to an electronic document management system to ensure a robust document management and review system is in place for all documentation. This will include either the purchase of additional licenses for an existing document management system in radiation services or the purchase of a new system.		Head of Operations / Head of Nuclear Medicine				Feb-23				
REF044	Nuclear Medicine Department	The employer must ensure that a consistent system of document control is introduced into employer's procedures. This must include the document review timescale, review dates, who is involved in establishing or reviewing procedures and how they are agreed by the employer.	Documents will be transitioned to an electronic document management system to ensure a robust document management and review system is in place for all documentation. This will include either the purchase of additional licenses for an existing document management system in radiation services or the purchase of a new system.		Head of Operations / Head of Nuclear Medicine				Feb-23				
Patient Discharge from Hospital to General Practice (HIW)													
REF045		NHS Wales healthcare organisations should ensure there is clarity in relation to the roles staff play in the discharge process, and to communicate this across their respective organisations therefore helping to increase staff and patient understanding of the discharge process, and improve consistency.	Develop an inpatient VCC Discharge Policy to define the discharge process at VCC (Velindre Cancer Centre) with clear staff roles and responsibilities around safe discharge. Include in the policy the following: •Provide advice to patients regarding the discharge process. •Provide medication advice at discharge. •Explain the process of ongoing medication supply via the GP and local pharmacy. •CIVICA platform will evaluate the discharge process feedback from patients and staff.		Operational Senior Nurse / Lead Pharmacist				Oct-22				Patient Discharge Action Plan
REF046		NHS Wales healthcare organisations need to audit and monitor compliance with their own policy timeframes and Health and Care Standard 2.6 regarding the provision of to take out (TTO) medication.	An annual audit in respect of Healthcare Standard 2.6 regarding take out medication to be undertaken (more frequently if significant issues identified) and reported through to the Medicines Management Group & VCC Quality Group		Lead Pharmacist				Oct-22				
REF047		NHS Wales healthcare organisations need to ensure that patients are provided with appropriate information about the medication they have been prescribed in a timely manner prior to discharge. Compliance against this should be audited and monitored.	An annual audit in respect of medication information to be undertaken to be undertaken (more frequently if significant issues identified) and reported through to the Medicines Management Group & VCC Quality Group						Oct-22				
REF048		NHS Wales should ensure that any potential benefits identified as part of PKB pilot studies, are shared across healthcare organisations.	PKB is currently not being utilised by the Trust.	This will be reviewed by the Trust to ensure the learning and benefits of the study are shared across the trust.	Operational Senior Nurse				Sep-22				
REF049		Measures should be taken to improve inpatient, family and carer engagement to ensure people are fully consulted about their care and treatment NHS Wales healthcare organisations. This is in line with Health and Care Standard 4.2 Patient Information and Standard 5.1 Timely Access.	Develop an inpatient VCC Discharge Policy to define the discharge process at VCC (Velindre Cancer Centre) with clear staff roles and responsibilities around safe discharge. Include in the policy the following: •Provide advice to patients regarding the discharge process. •Provide medication advice at discharge. •Explain the process of ongoing medication supply via the GP and local pharmacy. •CIVICA platform will evaluate the discharge process feedback from patients and staff.										

Human Tissue Authority (HTA) WBS Inspection 3rd / 4th October 2022													
REF050	Welsh Blood Service	The establishment's systems and procedures for the oversight of one of the procurement satellites are not sufficiently robust to provide assurance that requirements for temperature monitoring and raw data retention will be met, or that any deviations or serious adverse events and reactions (SAEARs) would be appropriately communicated for establishment assessment.	An investigation has been undertaken of the VCC Pharmacy temperature monitoring system and a CAPA plan agreed.	A review of the process for alerting VCC and WBMDR staff to temperature excursions has been completed and a new SOP put in place to cover this process (SOP 057, v1.0). Permanent temperature monitors have been placed in each of the 3 rooms used by the WBMDR at the VCC and WBDMR staff have been added as users to TempTrak software to enable monitoring of temperature profile and alarms (this will be in addition to VCC staff who will also be performing monitoring as per SOP 057). Stand-alone data loggers have also been placed in each room as back up for any system downtime due to connectivity issues. The SOP also requires VCC monitoring staff to contact WBMDR staff to inform of any temperature excursions on all occasions and the VCC ward nursing staff to manage the out of hours monitoring of the rooms.					31/03/2023				HTA October 2022
CHC visit to VCC Outpatients Department 8th February 2023													
REF051	VCC Outpatients Department	The Trust should explore the possibility of having easy access to wheelchairs for patients parking in the car park at the rear of the Cance Centre.	There are wheelchairs available at the start of the day for patients entering from the rear car park but these are used and left in various other departments. The trust is looking to purchase more wheelchairs.										CHC Outpatients Visit 8.2.23
REF052	VCC Outpatients Department	Introducing signage requesting visitors to park in the Whitchurch site rather than in the streets nearby would lessen the reliance on the parking staff directing people to this facility.	Patients are not expected to park in the Whitchurch site, this is for staff only.										
REF053	VCC Outpatients Department	The Trust should consider improving the current system of calling patients ensuring the system meets the needs of patients with hearing and sight loss.	The electronic calling system is being repaired but the trust is also looking at an alternative calling system which would provide a visual system for those hard of hearing.										
REF054	VCC Outpatients Department	While there is drinking water available in the department, it is not well signposted and improving this would help patients.	Signs have been put up in the department directing patients.										
CHC visit to VCC First Floor Ward 24th February 2023													
REF055	VCC First Floor Ward	The Managers pass on the thanks of the patients to the staff for the excellent level of service and care on the ward and for the initiatives to improve the welfare of patients.	ACTION PLAN AWAITED	ACTION PLAN AWAITED									CHC First Floor Ward Visit 24.2.23
REF056	VCC First Floor Ward	Ensure that the design of the ward in the new hospital has sufficient storage space for equipment and space between the beds for privacy.	ACTION PLAN AWAITED	ACTION PLAN AWAITED									
REF057	VCC First Floor Ward	Ensure that prescriptions are available in one location for the patients on their discharge from hospital.	ACTION PLAN AWAITED	ACTION PLAN AWAITED									

QUALITY, SAFETY & PERFORMANCE COMMITTEE

VUNHST CLINICAL AUDIT PLAN 2023-24

DATE OF MEETING	16/05/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Sara Walters, Clinical Audit Manager VCC Zoe Gibson, Clinical Services WBS
PRESENTED BY	Dr Hilary Williams, AMD for Quality & Safety
EXECUTIVE SPONSOR APPROVED	Jacinta Abraham, Executive Medical Director

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
EMB	02/05/2023	APPROVED

ACRONYMS	
WBS	Welsh Blood Services
VCC	Velindre Cancer Centre

1. SITUATION / BACKGROUND

The purpose of this paper is to provide the Quality, Safety and Performance Committee with the Trust Clinical Audit Plan and seek approval of the plan. This Annual Trust Clinical Audit plan will represent an overview of the Velindre Cancer Centre and Welsh Blood Service Clinical Audit Strategic approach and Programme of work for 2023/24.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 NHS Organisations delivering clinical activity are required to develop a clinical audit Programme which needs to be reflective of the service provided and aligned with the Organisational strategic direction. See WBS / VCC Clinical Audit Programme 2023/24 Appendix 1 & 2.

2.2 In order to ensure that these clinical audits contribute to the overall priorities of the organisation, and clearly improve patient and donor care, there needs to be a process of strategic planning and prioritisation. The resources for clinical audit are finite so the projects that have been proposed need to be reviewed and prioritised in a systematic way.

2.3 In line with national guidance (NHS Wales National Clinical Audit and Outcome Review Plan for 2023/24, Appendix 3), VUNHST should provide the resources to enable their staff to participate in all audits, reviews and national registers of relevance to the service, included in the annual plan.

3. IMPACT ASSESSMENT

RELATED HEALTHCARE STANDARD	Effective Care
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

The Quality, Safety and Performance Committee are requested to **APPROVE** the contents of the report which seeks to provide assurance that there is a systematic process for prioritising and delivering clinical audit across Velindre Cancer Centre and the Welsh Blood Service.

Velindre NHS Trust

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

CLINICAL AUDIT PLAN 2023/2024

VELINDRE UNIVERSITY NHS TRUST CLINICAL AUDIT PLAN 2023/2024

1. INTRODUCTION

Clinical Audit is a core component of the Quality and Safety Framework for the Trust. It ensures that as an organisation we can provide Safe, Timely, Effective, Efficient, Equitable and Person-centred care through learning and continuous service improvement, to meet the requirements of The Health and Social Care (Quality and Engagement) (Wales) Act 2020.

It is vital that the organisation develops a robust and structured approach to Clinical Audit for 2023/24 through the provision of a Clinical Audit plan that describes both the strategic approach and intended annual clinical audit cycle.

The purpose of this document is to provide the Quality and Safety Committee with the proposed Trust Clinical Audit Plan for Velindre Cancer Service and the Welsh Blood Service 2023/24 for consideration and approval.

2. BACKGROUND

2.1 NHS organisations delivering clinical activity are required to develop a clinical audit programme which needs to be reflective of the service provided and aligned with the organisational strategic direction.

2.2 VUNHST is committed to delivering effective clinical audit in all the clinical services it provides. This is essential to continually evolve, develop and maintain high quality patient and donor centred services. The resources for clinical audit are finite, so the projects that have been proposed are continuously reviewed and prioritised in a systematic way.

2.3 In line with national guidance (NHS Wales National Clinical Audit and Outcome Review Plan 2022/23), VUNHST should provide the resources to enable their staff to participate in all audits, reviews and national registers of relevance to the service, and ensure these are included in the annual plan. The details of the NHS Wales National Clinical Audit Plan can be found in Appendix 3

3. KEY REQUIREMENTS TO ACHIEVE A TRUST CLINICAL AUDIT PLAN

3.1 The necessary structures should be in place to support and complete engagement included in the Trust Clinical Audit plan.

3.2 A Clinical Lead for each of the divisions is required to provide clinical leadership and act as a local champion and point of contact for national audits and external relationships.

3.3 The full audit cycle should be completed and findings and recommendations from audit should link directly into a quality improvement programme.

3.4 The learning from clinical audit should be shared across the organisation, and communicated to staff and patients, and be used to improve the quality of care.

4. GOVERNANCE and REPORTING

4.1 The Executive Medical Director has overall responsibility for the development of a Trust Clinical Audit Plan and ensuring that this is aligned to the Trust strategic priorities.

4.2 The overall responsibility to complete the annual clinical audit programme for each division is delegated to the Divisional Directors.

4.3 Within each division there is a Clinical Audit or Quality Improvement manager with responsibility for the following:

- Ensuring that all Clinical Audit Activity within their division is registered
- Ensuring there is full participation in national clinical audits as required.
- Ensuring the clinical audit programme meets all clinical, statutory and commissioning requirements e.g. implementation of National Institute for Health and Care Excellence (NICE) guidance.

4.4 Reporting and monitoring of Clinical Audit activity to the Senior Leadership Team within each division should occur at quarterly intervals.

4.5 A highlight report of Clinical Audit activity from each division should be presented to the Trust Quality Safety Committee at quarterly intervals.

4.6 The outputs of this Clinical Audit plan will feature within the Trust Annual Clinical Audit Report, which is endorsed by both the Trust Quality and Safety Committee, and the Trust Audit Committee and then finally approved by Trust Board. This ensures that there are clear lines of communication with full board engagement in the consideration of audit, the review of its findings and the necessary quality improvements to follow.

4.6 Any national audit that provides benchmarking information should be highlighted.

4.7 An escalation process should exist for any areas of risk identified through participation of local or national audit e.g. using the risk registers within each division to assess, document and mitigate risk as appropriate.

5.0 IMPACT OF KEY STRATEGIC AREAS of DEVELOPMENT on the TRUST CLINICAL AUDIT PROGRAMME 2022-23

5.1 Positioning of Clinical Audit within the Trust Quality and Safety Framework

The Trust Quality and Safety Framework has strengthened the position of clinical audit and ensures that there is alignment strategically with the quality and safety agenda across the Trust. The establishment of Quality Hubs has been instrumental in linking in key individuals and pieces of work, to ensure there is coordination, oversight and triangulation of outcomes. As part of the development of a Quality cycle, there will be a project management infrastructure to strengthen its clinical effectiveness arrangements including Clinical Audit.

5.2 Positioning of Clinical Audit within the National Clinical Framework (NCF)

The National Clinical framework has Quality Statements for a number of Clinical Networks and disease areas including Cancer and End of Life. This will be a set of clinical priorities that can be used to benchmark against, using Clinical Audit and Quality Improvement to drive change. The NCF also promotes the principles of prudent health and use of quality management systems, in line with our Trust QSF and Trust Value Based Healthcare principles

5.3 Trust Integrated Quality and Safety Group

The establishment of this Trust group has helped to centrally position Clinical Audit to ensure that all Clinical Audit Activity is captured and that it is informed and influenced by the triangulation of all available sources of Quality data. The Business Intelligence system to support this triangulation is in its early stages but aims to eventually have a live dashboard that can be interrogated.

High level incidents and themes from complaints that have been identified by the group for inclusion in the planned programme include communication, the treatment helpline, SACT

bookings and the offer of a chaperone. Work on developing projects around some of these issues are underway and will be added to the plan in due course.

In addition, the group provides a feedback mechanism so that learning can be shared and issues identified can be escalated.

5.4 Trust Clinical Scientific and Strategic Board

The future establishment of the CSSB will provide a strong focus for prioritisation of Clinical Audit, learning from Clinical Audit Outcomes and the benchmarking of Clinical Audit findings, in line with the development of a Clinical and Scientific Strategy.

5.5 Trust Value Based Healthcare Programme

The embedding of Value in Health principles across the Trust will shape the focus for Clinical Audit in reducing harm and variation in clinical pathways and also considering the equity of care across the system.

6.0 Internal Audit of Trust Clinical Audit Process and Governance

A recent internal audit (January 2023) sought to provide the Trust with assurance that Velindre University NHS Trust has effective processes in place to embed a culture of clinical audit best practice and continuous quality improvement in all services. Overall, a ***'Reasonable'*** assurance rating was reported across all 5 objectives (Strategy, Plans, action plans, monitoring and learning)

The following areas of improvement were identified and relevant actions are now being taken which will be fully realised in this 2023/34 Clinical Audit plan.:

- Particular focus will now be given to ensure that the Clinical Audit Actions are SMART and regularly reviewed
- Discussions are underway to with regards to the feasibility of a centralised clinical audit team or exploring how WBS and VCC can work together ensuring processes are aligned across the organisation
- Annual audit engagement with each SST with robust documented discussion including annual plan, progress, learning and actions.
- Review of SST meetings to establish how discussions are documented with progress of clinical audits.
- The full implementation of a Digital Clinical Audit platform AMaT will be achieved by March 2024 Across Trust, which will provide the foundation for standardisation of approach and systematic reporting.

SUMMARY

The Trust Clinical Audit Plan seeks to provide assurance that there is a systematic process for prioritising and delivering clinical audit across Velindre Cancer Centre and the Welsh Blood Service. The clinical audit programme is well established within Velindre Cancer Centre given its patient facing role and is largely focused to date on the activity of the Site Specific teams as well as full compliance on national audits. The Welsh Blood Service continues to develop its plan for Clinical Audit and this will be shaped further over the next 12 months. The developments across the divisions and Trust in the areas of Quality, Safety, and Clinical Strategy will undoubtedly shape the next iteration of this plan and broaden its future priorities.

7.0 **VELINDRE CANCER CENTRE CLINICAL AUDIT PROGRAMME**

7.1 Definition of Clinical Audit at Velindre Cancer Centre (VCC)

The universally accepted definition for both national and local clinical audit as defined by the National Institute for Health and Clinical Excellence (NICE) in their 'Principles for Best Practice in Clinical Audit' is:

"a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes, and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in healthcare delivery." NICE, 2002

7.2 Principles of the Clinical Audit Process at VCC

7.2.1 Within Velindre Cancer Centre (VCC) there is a comprehensive and wide ranging audit programme that has been developed in conjunction with Site Specialist Teams (SST's), Directorate managers and the Quality & Safety/Improvement Team.

7.2.2 In line with best practice highlighted in a number of key documents including *Clinical Audit: A simple guide for NHS Boards & Partners (Healthcare Quality Improvement Partnership)* and *NHS Wales National Clinical Audit and Outcome Review Plan 2022/23* the VCC programme covers the following areas;

- ✓ Involvement in National Audits and Outcome Reviews
- ✓ Quality and Safety – Audits undertaken in response to serious incidents/adverse incidents/near-misses/complaints, to ensure corrective actions taken to prevent a recurrence have been implemented
- ✓ Cancer Peer Review Outcomes
- ✓ Professionally led and/or SST lead audits - to ensure healthcare professionals are enabled to participate in clinical audit in order to satisfy the demands of their relevant professional bodies (for example, for revalidation and professional development)
- ✓ Internal 'Must Do' Audits based on high risk/high profile/tier one target areas etc.

7.2.3 The VCC audit programme is signed off by the VCC Quality and Safety Management Group (QSMG) and the Senior Leadership Team.

7.2.4 The VCC programme for 2023/24 is shown in appendix 1.

7.3 National Audits

A new national centre of excellence to strengthen NHS cancer services by looking at treatments and patient outcomes right across the country has been established. The National Cancer Audit Collaborating Centre will deliver five new national cancer audits in breast cancer (primary and metastatic), ovarian, pancreatic, non-Hodgkin lymphoma and kidney cancer. These will be added to the planned programme once established.

The Welsh Cancer Network supports NHS Wales' participation in National Cancer Audit and have published A Cancer Improvement Plan for NHS Wales 2023-2026 which sets out the ambition for Wales to improve cancer patient outcomes and reduce health inequalities.

7..4 Dissemination of audit results and learning from audit outcomes.

7.4.1 The Multidisciplinary Site Specific Teams take ownership for the internal audit results and discuss and report these at the regular team meetings. All this data feeds into the VCC Clinical Audit Annual Report which is validated by the Quality Senior Management Team and reported to the Trust Quality and Safety Committee,

7.4.2 The development of a hospital-wide Audit/QI afternoon is underway in order to display the successful audit work taking place within the cancer centre. All professional groups will be invited to present completed projects either in oral or poster formats. A quarterly newsletter highlighting success stories would supplement this.

7.4.3 A full summary of the impact of these audits and outcomes is reported following the meeting and action plans are developed. Any areas of concern identified are escalated through the Site Specific Team appraisal process and plans to re-audit areas or assess the impact of interventions, is also agreed here.

7.5 Areas of development for VCC

- Integration of Clinical Audit and other quality and safety teams to create a **Quality Improvement Hub**. Members would include Clinical Audit, QI, Morbidity and Mortality, Quality and Safety and Patient Experience.
- In conjunction with HEIW, we would like to deliver a Velindre-specific 'Train the Trainer and QI Fundamentals to the professional groups. Prioritising a Training and development programme in QI and safety to ensure staff delivering the services are involved and aware of underlying principles of Audit/QI/patient safety and are actively involved in delivery & completion of audit cycles.
- The Quality Improvement Hub would aim for biannual meetings with SST leads starting at the beginning of the academic year (September 2023). Key SST priorities, benchmarking and focused projects predefined
- The QI Hub would aim for monthly meetings where each project is reviewed to ensure alignment with SST/ IMTP/ QI objectives. A framework to encourage mentorship, completion and dissemination of information will be predefined.
- Annual Trust Clinical Audit and QI events to share learning and foster a culture of clinical effectiveness and improvement.
- Implementation of AMat, which is a web-based Audit Management and Tracking tool to streamline all of auditing requirements into one simple, easy-to-use system. It provides control over audit activity and provides real-time insight and reporting for clinicians, wards, audit departments and healthcare trusts.
- Ensure all audit activities are brought together maximising the systems we have in place for example, Tendable, MEG and AMaT.

8. WELSH BLOOD SERVICE (WBS) CLINICAL AUDIT PROGRAMME

8.1 Clinical audit at the WBS is fundamental in ensuring the provision of safe, timely, effective, efficient and person-centred care and interventions

8.2 When carried out in accordance with best practice standards, clinical audit:
- Identifies and celebrates areas of best practice and service excellence
- Identifies areas of learning and improvement
- Provides assurance of compliance with clinical standards

8.3 A number of clinical audit activities are already embedded into WBS processes which demonstrate a commitment to sustain and improve safe and high quality of care for all of our donors and ensures the safety of the blood supply chain and recipients.

8.4 At the Welsh Blood Service the clinical audit function is lead by the Medical Director and supported by the wider clinical service team.

8.5 Clinical Audit findings, learning and improvements are reported and reviewed through both the WBS and Trust Quality, Safety and Clinical Governance Structures. Audits are reported to the relevant clinical governance group and hence to the Regulatory Assurance and Governance Group. However, this structure is currently under review and is being realigned to ensure the requirements of the Duty of Quality (2023) are achieved.

8.6 The Welsh Blood Service is committed to clinical audit and continues to embed and expand both electronic systems and programmes of clinical audit across the division to enable the provision of high quality, safe, timely, effective, efficient and person-centred care with a strong lens upon continuous improvement and learning.

8.7 Participation in External Audits

The Blood Health Team (BHT) at WBS contributes to the prioritisation, design and coordination of national audits relating to transfusion medicine across Wales on behalf of the Blood Health National Oversight Group (BHNOG) The BHT completes all-Wales analysis and contributes to the action plans from specific audits and from the ongoing monthly performance indicator data for individual hospitals to ensure provision of safe and high quality transfusion interventions.

8.8 Participation in U.K/ European Audit and Benchmarking Activities

The Blood Health Team undertake sub analyses of UK wide National Comparative Audits in the field of blood transfusion and work with the BHNOG individual Health Boards and if the audit is relevant to patients with cancer the VCC. The National Comparative Audit program is supported by the four nations of the UK and typically has a high uptake in Wales.

The WBS also participates in international audits of practice, initiating surveys and audits that are priorities for Wales. We are members of the European Blood Alliance (EBA) and the worldwide Biomedical Excellence for Safer Transfusion (BEST) Collaborative.

9.0 Please see the Appendix for full details on the Clinical Audit Programme 2022/23:

Welsh Blood Service Clinical Audit Programme 2023/24 Appendix 1
Velindre Cancer Centre Clinical Audit Programme 2023/24 Appendix 2
NHS Wales National Clinical Audit and Outcome Review Plan 2022/23 Appendix 3

APPENDIX 1

Welsh Blood Service Clinical Audit Overview

Welsh Blood Service Clinical Audit Plan 2023/24

Clinical Audit Plan

During 2023/24, a significant proportion of the Welsh Blood Service clinical audit activity will be related to reviewing and enhancing clinical audit approaches, structures, systems, processes and standards to ensure the provision of safe, timely, effective, efficient, equitable and person centred care through continuous learning and improvement, ensuring the alignment with the Duty of Quality (2023), Health and Care Quality Standards (2023) and to address learning identified through the recent VUNHST clinical audit internal audit report (2023).

Clinical Audit Programme 23/24

Audit	Aim	Frequency
Pre- venepuncture Skin Decontamination	- To prevent bacterial contamination of blood and blood products effective pre-venepuncture skin cleansing is of paramount importance. - To ensure that the arm cleansing techniques are in line with both evidence based practice and regulatory requirements.	Monthly Quarterly Validation Audits
Points of Care	- To ensure compliance with points of care UK evidenced based donation care principles to maximise donor outcomes.	Quarterly & Annual Validation
Hand Hygiene	- To ensure compliance with W.H.O 5 moments of hand hygiene to maintain donor, staff and recipient safety.	Monthly with Quarterly Validation
Donor Adverse Event Report Management Audit	To ensure the provision of safe, effective, efficient and equitable donor care provision in the event of a donor adverse event occurrence.	Quarterly

Donation Clinical Standards	A suite of clinical audits will be developed and introduced within the Tendable Clinical Audit System across the Division to ensure that donor care provision aligns with evidence-based practice standards.	Quarterly
• **UK National Comparative Audits x 4**	a) Audit of acute upper gastrointestinal bleeding (AUGIB – May 2022) b) Audit of patient blood management in paediatric surgery (June 2022) c) Audit of blood sample collection & labelling (Sept 2022) d) Audit of NICE Quality Standards for Blood Transfusion (date TBC) These are audits of practice undertaken by Health Boards and Trusts in the UK against national guidance. The Blood Health Team facilitates these audits and provides a national report for Wales from the findings. Results are therefore provided for individual Health Boards benchmarked against peers in Wales and across the United Kingdom. The Blood Health Team will be facilitating a re-run of the 4th audit in the list (compliance with NICE quality standards) in 2022 to enable all Health Boards to participate as to date only half have.	3 Specific point audits commencing on the dates stated
Major Haemorrhage Protocol Activations in Health Boards	To promote appropriate use of blood and alternatives to blood. Including monitoring use of O D positive red cells in emergencies before the blood group of the recipient is known, preserving stocks of O D Neg for the patients who need them (females of childbearing potential).	Quarterly
Blood Health National Oversight Group (BHNOG) Performance Indicators	To provide an ongoing measure of practice from each of the Health Boards (HBs) in Wales for the use of O D negative red cells (ODneg) as a percentage of all red cells ordered (target <12%), wastage of ODneg as a percentage of total ODneg (<10%). Wastage of platelets as a percentage of total issues (<15%)	Monthly

APPENDIX 2

Velindre Cancer Centre Clinical Audit Programme 2023/24

Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
Medical Directorate					
National Audits					
National Audit of Breast Cancer in Older People	National audit to assess the management of all symptomatic and screen detected breast cancers.	Clinical Audit Dept.	National Audit	Ongoing (Annual)	Ongoing (Annual)
National audit of lung cancer	The National Audit focuses on four main areas relating to lung cancer; the number of lung cancer cases within the UK, the range of treatments used, regional variations in these treatments and variations in outcomes	Clinical Audit Dept.	National Audit	Ongoing (Annual)	Ongoing (Annual)
National Prostate Cancer Audit	Looking at diagnosis, management and treatment of every patient newly diagnosed with prostate cancer in England and Wales, and their outcomes.	Clinical Audit Dept.	National Audit	Ongoing (Annual)	Ongoing (Annual)
NOGCA - National Oesophago-gastric Cancer Audit	To evaluates the process of care and the outcomes of treatment for all OG cancer patients, both curative and palliative.	Clinical Audit Dept.	National Audit	Ongoing (Annual)	Ongoing (Annual)
National Bowel Cancer Audit	The Audit's main aim is to improve the quality of care and survival of patients with bowel cancer.	Clinical Audit Dept.	National Audit	Ongoing (Annual)	Ongoing (Annual)

Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
RCR Curative & N/A RT for Lung	To provide confirmation that there has been progress and allow a re-assessment of where further pieces of work need to be directed	Clinical Audit Dept. Consultant	National Audit	January 2023	June 2023
Continuous Monitoring – Quality and Safety and Must Do's					
Death within 30 days SACT	Review patients who die within 30 days of SACT	Clinical Audit Dept. SST's	Patient safety	Ongoing (Monthly)	Ongoing (Monthly)
Mortality reviews	Review inpatients who die at Velindre.	SCIF Clinical Audit Dept.	Patient safety	Ongoing (Weekly)	Ongoing (Weekly)
Re- audit Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Audit	To ensure the patient's wishes are respected, decisions reflect the best interest of the individual and benefits are not outweighed by burdens. A DNACPR decision is clearly recorded and communicated between health professionals.	Consultant	National guidance	Ongoing 2 yearly (next audit due 2024)	Ongoing 2 yearly
Consent Audit (Including Audit of all Wales consent form 4 (best interests)	To identify if consent forms are available to view and to ascertain completeness of the information	Clinical Audit Dept.	Clinical risk	Ongoing (Annual)	Ongoing (Annual)
Breast Malignancies SST					
Audit of adjuvant bevicumcilib blood monitoring	Discussed at SST Once drug approved	NMP	TBC	TBC	TBC

Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
Primrose a national prospective observational study in breast cancer patients with central nervous system involvement in the UK	To report the survival of patients diagnosed with Central Nervous System (CNS) disease secondary to Breast cancer (BC).	SPR	NICE Guidelines/ National project	February 2020	April 2023
Gynaecological Malignancies SST					
A service evaluation of the management of cervical cancer during the COVID-19 pandemic	To analyse and compare data from February 2019 to February 2020 and March 2021 to March 2022 in Velindre and potentially Swansea to see how COVID-19 has affected the usual cervical cancer diagnosis and treatment. The data will be sourced from CANISC, WCP and Chemocare.	SSC Student SPR	Key indicator of practice Clinical effectiveness SSC project	March 2023	June 2023
Late Effects of Radiotherapy Gynae-oncology – Survey	To evaluate patient's experience of the Gynae-oncology Late Effects Clinic.	Consultant	Users views	September 2020	Ongoing
Head & Neck SST					
A retrospective review of Head and Neck neuroendocrine carcinomas treated in Velindre cancer centre over the past 10 years	We aim to look at the management and the outcomes of the neuroendocrine head and neck cancers that were treated in VCC over the past 10 years. These are a rare type of head and neck cancers that were not included in many studies before	SPR Consultant	Key Indicators of Practice Clinical Effectiveness VCC Guidelines	January 2023	December 2023

Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
Retrospective review of the recurrent, progressive, or metastatic head and neck cancers (with positive PDL, CPS >1) treated by first line of systemic treatment (Pembrolizumab/ chemotherapy) in VCC over the past 5 years	We aim to look at the management of and compare the outcomes of the recurrent, progressive, or metastatic head and neck cancers(with positivePDL, CPS >1) treated by PEMBROLIZUMAB or chemotherapy as first line of systemic treatment in VCC over the past 5 year**s**. Pembrolizumab was approved by FDA for the use in this entity of patients in 2016. We need to compare our outcome in VCC to the international data	SPR Consultant	Key Indicators of Practice Clinical Effectiveness VCC Guidelines	January 2023	December 2023
Audit of Surveillance after Treatment of Differentiated Thyroid Cancers.	PET-CT for multiple tumour sites and types, ongoing projects examining Radiomics for the automated analysis of data that may be present in scans but not yet perceived by Radiologists. Discussions about when and how to use expensive scans means that any project reviewing outcomes is of immediate and wide interest	Medical Student Consultant	SSC	March 2023	June 2023
Lung Malignancies SST					
Metastatic non-small cell lung cancer: exploring the role of whole brain radiotherapy in patients with brain metastases in the era of immunotherapy.	TBC	Medical Student (SSC) Consultant	TBC	March 2023	June 2023
Audit of outcomes of patients having radical radiotherapy for NSCLC at Velindre Cancer Centre	Compare VCC outcomes to established best practice (as defined by international clinical trials) – overall survival and progression free survival	SPR	Key indicator of practice	April 2021	December 2023

Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
Retrospective Data Collection for Lung Cancer Radiotherapy FDG PET Relapse Prediction in NSC Lung Cancer	To update data to date, looking at outcomes and other factors such as genetics and PETS	Consultant	Key indicator Clinical Effectiveness Innovation	July 2020	March 2023
Radical approach in selected patients Stage IV disease	Audit looking at outcomes for patients with limited stage IV disease in whom we've adopted a radical approach, incorporating neurosurgery or adrenal excision, brain SRS or SBRT during their treatment course.	SPR Consultant	TBC	April 2023	March 2024
Urology SST					
Treatment options in Kidney Cancer.	We currently use immunotherapy to treat renal cancer. This project will involve understanding the outcomes of patients receiving immunotherapy both in terms of toxicity and survival.	Medical Student (SSC) Consultant	Key indicator of practice	May 2022	June 2022
Prospective data collection HDR PROMS and outcome (first 18 months)	To collect patients related outcome measures	Consultant	PROMS	June 2021	January 2024
SABR / SPACER programme data (first 18 months)	To collect patients related outcome measures	Consultant	PROMS	June 2021	January 2024

Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
Multi centre audit of treatment and survival outcomes in Renal cancer	To ascertain overall survival and grade of toxicities	Consultant CAD	Key indicator of practice	May 2021	Ongoing
PSMA PET-CT use in prostate cancer	PETIC – Changes to management	Consultant Medical Student SSC	SSC	May 2023	July 2023
Standard Radiotherapy prostate 60gy/20# PROMS and outcome	Prospective data collection for Standard Prostate radiotherapy 60gy/20# PROMS and outcome.	Elizabeth Jenkins		March 2023	March 2024
Audit Evaluating combination immunotherapy toxicities and their role in renal cancer	TBC	Medical Student (SSC) Consultant	SSC Project	March 2023	June 2023
Palliative Care SST					
Symptom Control QI Project including POS-S	Evaluation of the use the POS-S within palliative care team	Medical Student SSC Consultant	Clinical effectiveness	May 2022	July 2022
Cancer Associated Thrombosis (CAT) MDT	This audit seeks to better understand the CAT MDT patient population and know how and where the CAT guidelines are applied.	Consultant	NICE Guidelines	November 2022	November 223

Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
Colorectal SST					
Investigating the impact of covid 19 on the management of radiotherapy treatment of locally advanced colorectal cancer	Compare the clinical effectiveness of short course Radiotherapy with long course radiotherapy. to see if there was an additional benefit of a combination of giving chemotherapy before and after short course radiotherapy	Medical Student SSC SPR Consultant	Key indicator of practice Clinical Effectiveness	May 2023	July 2023
Rectal contact Radiotherapy	To Evaluate the selection criteria, and outcomes for patients who are treated with contact radiotherapy for rectal cancer	SPR Consultant	NICE	April 2021	September 2022
A single-centre audit of the neo-adjuvant treatment of localised rectal cancer	To evaluate the treatment of rectal cancer within a single centre located in Wales. To identify which of the various neo-adjuvant treatments patients received and identify what the future standard of care may be.	Medical Student (SSC) Consultant	NICE Guidelines VCC Guidelines SSC Project	March 2023	July 2023
A retrospective study of the impact of perioperative oncological treatment on clinical outcomes in locally advanced rectal cancer patients	To review outcome data for locally advanced rectal cancer	Medical Student (SSC) Consultant	SSC Project	March 2023	July 2023
Rectal cancer: ADVANCE Participant Survey	To evaluate the Point of Care test for neutropenic sepsis	Medical Student (SSC) Consultant	Users views SSC project	March 2023	July 2023

Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
UGI SST					
Re-Audit: Immune checkpoint inhibitor immunotherapy related toxicity monitoring and management	To identification and management of Immunotherapy-related toxicities in the treatment of upper GI and HPB cancers in VCC in comparison to the guidelines.	Medical Student (SSC) Consultant	SSC Project	March 2023	June 2023
The use of new systematic and/or radiotherapy-based treatments in the treatment of Upper oesophageal cancers.	TBC	Medical Student (SSC) Consultant	SSC Project	May 2023	July 2023
Immune checkpoint inhibitor induced liver injury: a multi-centre experience	We aim to determine epidemiology of immune checkpoint inhibitor induced liver injury (CPILI), immune-related adverse events (IRAE) and to study management options and outcomes across different UK centres	SPR Consultant	Multi centred project	April 2021	December 2023
Neuro-oncology SST					
Re-audit of local guidelines for glycaemic control and bone protection in neuro-oncology patients taking glucocorticoids at Velindre Cancer Centre	To assess current practice against local guidelines for the use of glucocorticoids, such as dexamethasone in the neuro oncology outpatient department (OPD) at Velindre Cancer Centre (VCC).	Medical Student (SSC) Consultant	SSC Project	Mary 2023	July 2022

Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
Outcomes in patients undergoing surgery for recurrent/progressive glioblastoma in South and Mid Wales	Second-line surgery is a considerable undertaking for patients with limited life expectancies and a consideration for surgical resources. To date, our local practice has not been reviewed and doing so will allow us to better define the patient population most likely to benefit and inform our discussions with patients.	Medical Student (SSC) Consultant	Clinical effectiveness	May 2023	July 2023
Sarcoma SST					
Sarcoma Pathway	Working with the Welsh Cancer Network to develop and assess the pathway.	CNS	Key indicator of practice	Ongoing	Ongoing
Other Sites/Services					
Evaluating the role of the immunotherapy toxicity service and its interplay with clinical teams	Understanding the role of an immunotherapy toxicity service. Audit the value of the National IO Education Forum. Understanding the educational needs of the wider clinical teams regarding immunotherapy toxicity.	Medical Student (SSC) Consultant		May 2023	July 2023
Lynch Testing in Colorectal Cancer - An Audit of the Cardiff and Vale University Health Board Pathway	To audit the current Lynch Testing Pathway for colorectal cancer patients in Cardiff and Vale University Health Board	Medical Student (SSC) Consultant	NICE Guidelines SSC project	May 2023	July 2023

Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
Combination immunotherapy (IO) with Ipilimumab and Nivolumab for stage 4 advanced melanoma	To assess long term survival and morbidity/mortality including hospitalisations and death related to treatment in a non trial cohort of patients treated at Velindre Cancer Centre and see how it compares with the Checkmate 067 Trial.	Satish Kumar Mia Sahar SSC Project	SSC Project	May 2023	July 2023
Integrated Care Directorate					
National Audit					
UK NACEL Audit	NHS Benchmarking project	SPCT	National Audit	Ongoing (Annual)	Ongoing (Annual)
Continuous Monitoring – Quality and Safety and Must Do's					
All Wales Patient experience framework	To evaluate patients experience at VCC to identify areas from improvement	Patient experience Manager	Users views	Ongoing (Monthly)	Ongoing (Monthly)
CIVICA	Independent service to allow patients to feedback their experiences.	Palliative Care	Users views	Ongoing	Ongoing
Staff Survey: Safeguarding	To establish if staff are aware of the relevant guidelines and support regarding safeguarding within the trust	Safeguarding Lead	Users views	TBC	TBC
Safeguarding documentation audit	To provide measure compliance with the All Wales Safeguarding Procedures.	Safeguarding Lead	All Wales guidelines	TBC	TBC

Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
Metastatic spinal cord compression (MSCC)	To measure compliance with the standard for referral and assessment for metastatic spinal cord	Physiotherapy	Local & National Guidelines	Ongoing (6 monthly)	Ongoing (6 Monthly)
Pressure Sores	Tier 1 target - To provide evidence to support safe effective care in relation to the health care standards	Nursing Ward Manager	Quality assurance	Ongoing (Monthly)	Ongoing (Monthly)
Slips/Trips/Falls	Tier 1 target - To provide evidence to support safe effective care in relation to the health care standards	Nursing Ward Manager	Quality assurance	Ongoing (Monthly)	Ongoing (Monthly)
Nutritional Screening including Protected Meal times & fluid balance compliance	To provide evidence to support safe effective care in relation to the health care standards	Nursing Ward Manager	Quality assurance	Ongoing (Monthly)	Ongoing (Monthly)
Mouth care bundles	Ensure compliance with good practice and all Wales standards	Nursing Ward Manager	Quality assurance	Ongoing (Monthly)	Ongoing (Monthly)
Sepsis Six compliance	Tier 1 target - To provide evidence to support safe effective care in relation to the health care standards	Acute Oncology ANP	Quality assurance	Ongoing (Monthly)	Ongoing (Monthly)
Rapid Response to Acute Illness (RRAILS) – National Early Warning Score (NEWS) compliance	Tier 1 target - To provide evidence to support safe effective care in relation to the health care standards	Acute Oncology ANP	Quality assurance	Ongoing (Monthly)	Ongoing (Monthly)
Oxygen spot-check	To measure compliance with local/national guidelines	Nursing Ward Manager	Quality assurance	Ongoing (Monthly)	Ongoing (Monthly)

Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
Catheter associated Urinary Tract Infections (CAUTI)	To measure compliance with all elements for insertion and maintenance of bundles for urinary catheters	IPCT with support from dept. champions	Local & National Guidelines	Ongoing (Weekly)	Ongoing (Weekly)
Visual Infusion Phlebitis (VIP) Score – Chemotherapy Inpatient Unit (CIU)	To measure compliance with all elements for insertion and maintenance of bundles for peripheral vascular cannula	Ward Manager	Local & National Guidelines	Ongoing (Daily)	Ongoing (Daily)
Patient data for MRSA/ MSSA/ C diff/ E Coli/ CAUTI/ Bacteremia	Tier 1 target - To monitor infection rates for all Healthcare Associated Infections (HCAIs)	Nursing Ward Manager & IPC Team	Local & National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
Methicillin Resistant Staphylococcus Aureus (MRSA) Screening	Tier 1 target - To measure compliance with screening for MRSA	Nursing Ward Manager & IPC Team	Local & National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
Hand hygiene	Tier 1 target - To measure hand hygiene compliance against World Health Organisation (WHO) 5 Moments of Hand Hygiene	IPCT with support from dept. champions	Local & National Guidelines	Ongoing (Weekly)	Ongoing (Weekly)
Personal Protection Equipment (PPE)/Isolation	To monitor compliance with PPE (donning and doffing)	IPCT with support from dept. champions	Local & National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
Environment/ commodes/ sharps/ waste/ linen	To monitor against National Standards for IPC (inclusive of key audits- environmental, commodes/ sharps / clinical practice audits	Infection Prevention & Control	Local & National Guidelines	Ongoing (Annual)	Ongoing (Annual)
Delayed Transfer of Care (DTOC)	Tier 1 target	Nursing Ward Manager	Local & National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)

Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
Chaperone audit	To ascertain current practice of documentation regarding the offer of a chaperone	Viv Cooper CAD	SI/VCC Guidelines	TBC	TBC
Record Keeping Audit	Record keeping audit every 6 months to look at compliance to our record keeping guidelines. To then feedback to team and make adjustments/give further education as indicated.	AHP	National guidelines	February 2022	6 monthly
WAASP Quality Audit	To highlight any inaccuracies in WAASP scoring by comparing WAASP tools completed by nursing staff against how they should be scored based on information from medical notes, nursing documents and patient reports.	AHP	NICE Guidelines Patient Safety VCC Guidelines	November 2022	Ongoing (Annually)
Key worker Audit	To review compliance of patients with document key worker	CNS Manager CAD	Key performance indictor	January 2022	Monthly
Breast SST					
Audit of the Pathway for Adjuvant Bisphosphonates in Early Breast Cancer	To ensure all adjuvant breast cancer patients eligible to receive adjuvant bisphosphonate with zoledronic acid are managed safely and equally within the treatment pathway	CNS CAD	NICE Guidelines	January 20219	October 2024
Gynaecological SST					
Patient Survey :Prehab	To obtain patients views with regards to the prehab service	AHP CAD	Users views	March 2021	Ongoing

Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
Colorectal SST					
The incidence of acute onset nausea and vomiting during oxaliplatin infusions	To identify how frequently this is occurring and if we can identify if there are any factors such as dose or number of cycles administered which can help us anticipate which patients are more at risk.	SACT Lead Nurse CAD	Clinical Risk	April 2021	September 2021
Patient support group	support for the CRC cancer patients	CNS	Users views	April 2021	Ongoing
Recovery package and treatment summaries	To ensure all adjuvant patients receive rehab recovery package to enable rehab following completion of treatment. Treatment summary to communicate with patients and primary care – treatment given	CNS	User views Clinical effectiveness	April 2021	Ongoing
Other Sites/Services					
Cancer Unknown Primary (CUP) Patient Survey	To capture patients experience of the CUP service	CNS	Users views	February 2023	December 2023
Cancer Unknown Primary (CUP) Staff Survey	To capture staff experience of the CUP service	CNS	Users views	February 2023	December 2023

Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
Single Cancer Pathway – Treatment Pathway Review	Review the treatment pathways for all SST's for patients who receive first definitive treatment at VCC. This will include a retrospective look at what the processes were and how long they took and what the impact of the new pathways will be on service capacity and demand.	Service Improvement	National guidelines	Ongoing	Ongoing
Radiation Services Care Directorate					
Local Safety Standard for Invasive Procedure (LOCSSIP)	To evidence of compliance with the WHO Surgical Safety checklist and VCC/NICE guidelines	Radiation services	NICE Guidance WHO	Ongoing (Annual)	Ongoing (Annual)
Is the occurrence of Radiotherapy Human Error related to Group Affective processes within the Radiotherapy team?	To explore affect and group affect processes within the specific Radiotherapy team following a human error	Radiotherapy	Patient safety	May 2020	October 2023
CT PA requests	To create a robust pathway for suspected PE	Radiographer		April 2021	On going
SACT & Medicines Management					
Medication safety thermometer	To measure compliance of the completion of the 'drug allergy section' on the medication chart against national standards.	Pharmacy	National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)

Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
Medication safety thermometer	To measure compliance of the completion of the VTE risk assessment on the medication chart against national standards.	Pharmacy	National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
Medication safety thermometer	To measure compliance of the completion of 'medicines reconciliation within 24 hours of admission against national standards.	Pharmacy	National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
Medication safety thermometer	To measure the number of unintentional missed/ omitted medication doses within a 24 hour period against national standards.	Pharmacy	National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
Medication safety thermometer	To measure the number of missed doses for 'high risk medications' against national standards. *High-risk medication includes antimicrobials, anticoagulants, opioids, anticonvulsants and oral SACT.*	Pharmacy	National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
Antimicrobial Stewardship – Start Smart Then Focus (SSTF)	To determine whether the indication for treatment is documented either on the medication chart / in medical notes	Pharmacy	National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
Antimicrobial Stewardship – Start Smart Then Focus (SSTF)	To determine whether the duration of treatment is recorded either on the medication chart / in medical notes	Pharmacy	National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)

Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
Antimicrobial Stewardship – Start Smart Then Focus (SSTF)	To determine whether the antimicrobial is prescribed in accordance with the trust guidelines / C&S or following microbiology advice	Pharmacy	National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
Antimicrobial Stewardship – Start Smart Then Focus (SSTF)	To determine whether a senior review was carried out at 48 / 72 hours, and documented on the medication chart / medical notes (including outcome of review).	Pharmacy	National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
Hospital Acquired Thrombosis	WG Tier 1 target – To identify the number of potentially avoidable Hospital Acquired Thrombosis (HATs)	Pharmacy	National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
Snapshot audit of the use of DPYD in clinical decision making.	To inform the future delivery of this important service	Pharmacy	National audit	April 2022	December 2022

Appendix 3

NHS Wales National Clinical Audit and Outcome Review Plan 2022/23 Appendix 3

NCAORP Plan 2022/23

QUALITY, SAFETY AND PERFORMANCE COMMITTEE
INFORMATION GOVERNANCE ASSURANCE REPORT **2022 / 2023 QUARTER 3 (1st Oct '22 to 31st Dec '22) and QUARTER 4 (1st Jan '23 to 31st Mar '23)**

DATE OF MEETING	16th May 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	N/A
PREPARED BY	Ian Bevan, Head of Information Governance Matthew Bunce, Executive Director of Finance
PRESENTED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance
REPORT PURPOSE	FOR ASSURANCE

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	2nd May 2023	**NOTED**

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

DHCW	Digital Health and Care Wales	M&S	Mandatory and Statutory
HoIG	Head of Information Governance	DPIAs	Data Protection Impact Assessments
GDPR	General Data Protection Regulation	DHCR	Digital Health and Care Record
MHRA	Medicines and Healthcare products Regulatory Agency	SAR	Subject Access Requests
AHRA	Access to Health Record Act 1990	IGMAG	Information Governance Management Advisory Group
SIRO	Senior Information Responsible Officer	DPO	Data Protection Officer
FOIA	Freedom of Information Act	EIR	Environmental Information Regulation
VUNHST	Velindre University NHS Trust	VCC QSMG	VCC Quality Safety Management Group
IM	Independent Member	IBI	Infected Blood Enquiry

1. SITUATION

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

The report outlines key activities, (1) Patient Records, (2) Freedom of Information Act (3) Information Governance Internal Audit. The report also includes data security incidents & investigations for the reporting periods of 1st October 2022 to 31st December and 1st January 2023 to 31st March 2023.

The full report was provided to and **NOTED** by EMB on 2nd May 2023.

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

2. BACKGROUND

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

VUNHST is committed to ensuring the provision of an effective IG Assurance Framework. This ensures that the Trust meets its statutory obligations and other standards. Meeting the obligations and standards means that incidents are appropriately investigated, and that learning takes place

in order that the Trust can improve the quality and safety of its services, and the patient and donor experience.

3. ASSESSMENT/SUMMARY OF MATTERS FOR CONSIDERATION

The following are the key highlights as detailed within the Quarter 3 and Quarter 4 report for the periods of 1st October 2022 to 31st December 2022 and 1st January 2023 to 31st March 2023:

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

  (1) Patient Records

  (2) Freedom of Information Act

  (3) Information Governance Internal Audit

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

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

(1) Patient Records

This provides assurance that the Trust is processing Patient Records in accordance with Data Protection Legislation, the Common Law Duty of Confidentiality and Caldicott Principles. In this report the Committee is asked to consider:

- DHCR Project Board continues to meet, whilst challenges continue in relation to management of patient records, no further IG risks have been identified.
- The DPIA for the SAR process has been extended to the 31st May 2023 as it has transpired that the solution proposed by DHCW to permit simplified access to records will not be available until 15th May at the earliest. The DPIA extension has been discussed and agreed with the Associate Director for Information Governance and Patient Safety within DHCW.
- In relation to the Offsite Records Storage Incident, it is confirmed that on 15th March 2023 the Maltings has received all outstanding boxes to the facility in Wentloog. The risk profiles within DATIX have been updated to reflect the closure of risks where they are no longer relevant or a review of mitigating actions to ensure that they are clearly understood and recorded.
- Procurement has commenced work on extension of the Contract with Maltings to December 2023 as the records transfer did not begin until December 2022.

- Harwell continue to store damaged records from the incident at a cost of £43k p.a. Originally 479 boxes were transferred to Harwell's which has reduced to 359 following transfers back to Velindre of 120 dry record boxes. To fully restore all records, it would cost c£142k. EMB need to consider the options for managing these records going forward.
- The IBI has stated that where records have a full digital backup that paper records may now be destroyed. The Trust is assessing whether damaged records can be reconstructed from digital records, to enable a decision to be made to destroy paper records of patients deceased for at least eight years.
- Records Task and Finish Group – the initial meeting is planned for 11th May 2023.

(2) Freedom of Information Act

Provides assurance that the Trust is meeting its statutory obligations in relation to compliance with the Freedom of Information Act (FOIA). FOI does not sit within the DoF portfolio; however the IG Team is temporarily supporting Corporate Governance until an FOI Officer is recruited into the vacancy.

The data below shows the compliance level for Quarter 4, information for the financial year is contained within the detailed report.

Requests received	requests completed	Request paused awaiting clarification	Requests ongoing and not in breach	breach of statutory deadline	% Compliance
58	54	0	0	4	93.10%

The following provides more information for the four FOIs that are in breach of timelines:

- Delay within information owning department in responding to request and reminders – delay 10 working days beyond 20 working day statutory deadline
- Delay due to need to align response with Welsh Ambulance Service Trust (WAST) prior to issue as the requestor had contacted both organisations requesting identical information – delay 6 working days beyond 20 working day statutory deadline
- Delay due to request incorrectly sent to VCC which had to be redirected to Finance, requestor contacted to keep them up to date – delay 4 working days beyond 20 working day statutory deadline
- Delay within information owning department in responding to request and reminders – delay 2 working days beyond 20 working day statutory deadline

(3) Information Governance Internal Audit February 2023

Provides Assurance that the Trust is compliant with legislation, codes of practice, Trust Policies and the NHS Wales IG Framework. The key focus of the audit was the Trust 2021/22 IG Self-Assessment Toolkit. The final report overall assurance is "Reasonable." The Trust SIRO/HoIG had identified the assessed areas within their self-assessment when completing the IG Toolkit in Feb to April 2022.

The Audit assurance assessment against the four objectives is:

Assurance Objectives	Assurance
Handling of Sensitive Information	Reasonable
Information Governance Training	Reasonable
Recording of Data Breaches	Substantial
Governance and Oversight	Substantial

- Handling Sensitive Information (reasonable assurance) - whilst the Trust has a Record of Processing Activity (ROPA), which is a legal requirement, it has not reviewed it regularly and it is not using Information Asset Registers (IAR's) to support the ROPA. The audit recommended the introduction of IAR's and training for Information Asset Owners (IAO's).
- Information Governance Training (reasonable assurance) - the auditor observed that whilst all clinical staff receive IG induction training, provision needs to be expanded to all Staff. In addition, training compliance levels were less than the 75% target in certain areas of the Trust.
- Recording of Data Breaches (substantial assurance) - the Trust has a robust data breach management system in place using DATIX as its basis.
- Governance and oversight (substantial assurance) - reporting to Board level via QSP is assessed as robust and consistent.

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

Clinical SAR's

Quarter	Number of requests	Number of requests completed within statutory timeframe	Percentage compliance
3	45	39	86.60%
4	45	45	100%

Non-Clinical SAR's

Quarter	Number of requests	Number of requests completed within statutory timeframe	Percentage compliance
3	0	0	100%
4	1	0	0%

The SAR which has not yet been completed for Q4 2022/23 is deemed an unreasonable request due to the lack of detail to define the data requested to a manageable level. Dialogue with the requestor has taken place on three occasions to attempt to reduce the request to a manageable level but has so far been unsuccessful.

Data Protection Impact Assessments

Full Register for Calendar Year 2022 (up to end of Q3 2022/23 – 31st December 2022)

Division	On register	Completed	Not Started	Ongoing	Cancelled	Total
Corporate	14	9	3	1	1	**14**
VCC	34	17	4	12	1	**34**
WBS	22	11	1	8	2	**22**
TCS	3	1	0	0	2	**3**
Total	**73**	**38**	**8**	**21**	**6**	**73**

- 8 Trust DPIA's have been approved during Quarter 3 2022-23
- No NHS Wales DPIA's have been approved
- Work ongoing to identify all existing Trust systems to assess whether a DPIA has been completed. A risk-based approach is followed to prioritise assessment. IG and Digital teams participate in this work, identifying systems where a DPIA has not been completed, for example when contracts are renewed and when system data migration is required. The HoIG reports progress by the 5th of each month following previous month's activity.
- During Quarter 3 DPIA's and Data Processing Agreements remained unaligned with Contract activity, Procurement and IG Team to undertook contract alignment work during Quarter 4 2022-23. This will be maintained by re-establishing the procurement register for contracts valued between £5k – £25k and monthly meetings between HoIG and the new Procurement Manager to align Contract and IG registers.

Quarter 4 2022-23 (1st January 2023 to 31st March 2023)

Division	On register	Completed	Not Started	Ongoing	Paused	Cancelled	Total
Corporate	7	2	5	0	0	0	7
VCC	18	4	9	4	1	0	18
WBS	8	2	1	4	0	1	8
TCS	0	0	0	0	0	0	0
HTW	1	0	0	1	0	0	1
Total	**34**	**8**	**15**	**9**	**1**	**1**	**34**

- 8 Trust DPIA's have been approved during Quarter 4 2022-23.
- No NHS Wales DPIA's have been approved.
- 1 VCC DPIA is paused, as the project has not yet been approved by VCC SLT within the IMTP process.
- 1 WBS DPIA is cancelled as this is no longer required.

Data security incidents & investigations

There has been one digital incident of note since the last report. Data within the Master Patient Index (MPI) was discovered to be inaccurate as a result of testing activity within DHCW. The incident is still evolving nationally, IG and Digital Teams are connected to the national response across Wales. The position at time of writing remains that there is no requirement for formal reporting to the ICO by DHCW (the Data Controller). This was confirmed in a call between DHCW and the ICO on 5th April 2023.

Clinical Risk remains under continual assessment by DHCW's Patient Safety Team. Further updates will be provided to relevant Executive Directors as the situation develops. The incident was briefed in full to EMB on 17th April 2023.

Incidents & Investigations for the period 1st October 2022 to 31st December 2022 (Quarter 3)

Service	DATIX Incidents	Incidents Reported outside DATIX	Total Incidents	Reported to ICO	Investigation			Investigation		
					Low Risk / No Harm	Root Cause Analysis	Total	Open	Closed	Total
Corporate Services	2	0	2	0	2	0	**2**	0	2	**2**

Service	DATIX Incidents	Incidents Reported outside DATIX	Total Incidents	Reported to ICO	Investigation			Investigation		
					Low Risk / No Harm	Root Cause Analysis	Total	Open	Closed	Total
Velindre Cancer Services	11	0	11	0	11	0	**11**	4	7	**11**
TCS	0	0	0	0	0	0	**0**	0	0	**0**
WBS	4	0	4	0	4	0	**4**	1	3	**4**
NWSSP	14	0	14	0	14	0	**14**	4	10	**14**
Total Trust	**31**	**0**	**31**	**0**	**31**	**0**	**31**	**9**	**22**	**31**

Incidents & Investigations for the period 1st January 2023 to 31st March 2023 (Quarter 4)

Service	DATIX Incidents	Incidents Reported outside DATIX	Total Incidents	Reported to ICO	Investigation			Investigation		
					Low Risk / No Harm	RCA	Total	Open	Closed	Total
Corporate Services	0	0	0	0	0	0	**0**	0	0	**0**
Velindre Cancer Services	10	0	10	0	10	0	**10**	7	3	**10**
TCS	0	0	0	0	0	0	**0**	0	0	**0**
WBS	4	0	4	0	4	0	**4**	3	1	**4**
IT incidents with IG implications	4	0	4	0*	4*	0	**4**	2	2	**4**
NWSSP	22	0	22	1^	21	1^	**22**	2	20	**22**
Total Trust	**40**	**0**	**40**	**1**	**39**	**1**	**40**	**14**	**26**	**40**

* Refers to the MPI incident which was briefed to EMB on 17th April 2023 by the Chief Digital Officer. Incident owned by the Digital Team but has potential IG implications.

^ Refers to inappropriate access to personal data by an employee in NWSSP Primary Care Services which was subsequently shared unlawfully. Incident took place in March 2023, reported to IG Manager NWSSP on 8th April 2023. Subsequently reported to the ICO and remains under investigation with possible disciplinary action.

- The top three themes of incidents continue to be confidentiality breaches;

- patient records/information sent to wrong recipient (misdirection).
- staff records/information sent to wrong recipient.
  staff records/information inappropriately accessed.

- The remaining areas are split between
  - other
  - patient records/information inappropriately divulged
  - patient information/records lost
- Most incidents could be avoided with improved IG awareness & training of staff as human error remains the common factor
- **100% of the incidents closed were graded as no harm to the continuity of patient care, donor services or to staff**
- Corporate division has no incidents reported, nor under investigation.
- TCS division has no incidents reported, nor under investigation.
- IT incidents with IG implications added to reporting; Effective Q4 2022/23.
- Quarterly IG assurance meetings between Stephen Harries (IM champion for IG), Matthew Bunce (SIRO), Ian Bevan (Head of IG) and Carl Taylor (Chief Digital Officer) continue to take place to provide additional assurance to the committee.
- The first Caldicott Meeting took place in February 2023, in which the Caldicott Guardians, SIRO, HoIG, CDO, and Chief Clinical Information Officer met and discussed incidents, in particular any incidents of inappropriate access to clinical systems by Staff.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The loss or disclosure of personal information should be an important consideration for all staff on a day-to-day basis as it can seriously damage the Trust's reputation and undermine patients, donors and/or service user's trust.
RELATED HEALTHCARE STANDARD	Health and Social Care (Community Health and Standards) Act 2003, Sections 7 and 8 of the Duty of Quality Statutory Guidance 2023.
	Information - as described in Section 8 of the Duty of Quality Statutory Guidance 2023.
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)

	The accidental or unlawful destruction, loss, alteration, unauthorized disclosure of, or access to, all personally identifiable data may lead to a breach of security and the noncompliance with Data Protection Legislation. Where there is an impact on the rights and freedoms to the Data Subject, this may be reportable to the ICO within 72 hours of the discovery of the breach. unauthorised access to systems may also lead to further legal ramifications (Computer Misuse Act 1990)
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The Information Commissioners Office has the power to impose financial penalties (fine of up to 20 million euros (approx. £17.5m) and issue enforcement action.

5. RECOMMENDATION

The Committee is asked to **NOTE** the 2022/2023 Quarter 3 and 4 Information Governance Report.

QUALITY, SAFETY & PERFORMANCE COMMITTEE

SAFEGUARDING & PUBLIC PROTECTION POLICY & POLICY FOR THE MANAGEMENT OF SAFEGUARDING ALLEGATIONS /CONCERNS ABOUT PRACTITIONERS AND THOSE IN A POSTION OF TRUST

DATE OF MEETING	16th of May 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	N/A

PREPARED BY	TINA JENKINS, DEPUTY DIRECTOR OF NURSING, QUALITY AND PATIENT EXPERIENCE
PRESENTED BY	Nicola Williams, Executive Director of Nursing, AHPs & Health Scientists
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, AHPs & Health Scientists

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Safeguarding and Vulnerable Adults Group	11/04/23	ENDORSED FOR APPROVAL
Executive Management Board	02/05/23	ENDORSED FOR APPROVAL

1. SITUATION

The Safeguarding and Public Protection Policy and the Policy for the Management of Safeguarding Allegations/Concerns About a Practitioner and Those In a Position of Trust is paper are provided to the Quality, Safety and Performance Committee for **APPROVAL.**

2. BACKGROUND

Both policies were due for review in March 2023. The revised policies have been endorsed by the Safeguarding and Public Protection Group and the Executive Management Board.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 *Safeguarding and Public Protection Policy Review (Appendix 1)*

Only minor changes were required which are highlighted in yellow for ease of reference. These changes include:

- The Trust will commence using the NHS Wales reporting form from April the 1st 2023. The report forms for adults and children are included in the policy.
- Duty of Candour has been included in the relevant guidance/legislation section.

An Equality Impact Assessment was undertaken on the 04/02/2020, the outcome of the assessment found that any impact from the procedure would have a positive effect to the equality groups mentioned. Where appropriate, the Trust will make plans for the necessary actions required to minimise any stated impact to ensure that it meets its responsibilities under the equalities and human rights legislation. A revised equality impact assessment was not required as minimal changes included.

3.2 Policy for the Management of Safeguarding Allegations/Concerns About A Practitioner And Those In A Position of Trust (Appendix 2)

The only changes required was to include reference to the Duty of Candour (highlighted in yellow in the policy).

An Equality Impact Assessment was undertaken on the 04/02/2020, the outcome of the assessment found that any impact from the procedure would have a positive effect to the equality groups mentioned. Where appropriate the Trust will make plans for the necessary actions required to minimise any stated impact to ensure that it meets its responsibilities under the equalities and human rights legislation. A revised equality impact assessment was not required as minimal changes included.

3 IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
RELATED HEALTHCARE STANDARD	Safe Care
	Standard 2.7 of the Health and Care Standards (Safeguarding Children and Safeguarding Adults at Risk) requires health services to promote and protect the welfare and safety of children and adults who become vulnerable or at risk at any time
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	A statutory framework for safeguarding public protection
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 are asked to **APPROVE** the following policies:

- Safeguarding and Public Protection.
- Policy for the Management of Safeguarding Allegations/Concerns about a Practitioner and those in a position of trust.

QS12

SAFEGUARDING AND PUBLIC PROTECTION POLICY

Executive Sponsor & Function	Executive Director of Nursing, AHPs and Health Science
Document Author:	Head of Safeguarding and Vulnerable Groups
Approved by:	Quality & Safety Committee
Approval Date: 29th April 2020	**Date of Equality Impact Assessment:** 2nd February 2020
Equality Impact Assessment Outcome:	This policy has been screened for relevance to equality. No potential negative impact has been identified.
Review Date:	March 2023
Version	Version 2

1. POLICY STATEMENT

Velindre University NHS Trust (hereafter 'the Trust') has statutory duties to comply with legislation in relation to safeguarding and public protection. It discharges these duties by working within regional partnership arrangements and complying with both UK Government and Welsh Government Codes of Practice and national safeguarding procedures.

2. SCOPE OF POLICY

This Policy applies to all staff employed by or working within the Trust, regardless of whether or not their employment brings them into direct contact with adults or children at risk. The principles set out in this Policy will also apply to other individuals and groups, including bank staff and agency workers, students, contractors, honorary contract holders, volunteers and trainees. In every incident of alleged abuse of a child or adult at risk, staff must comply with the Wales Safeguarding Procedures.

3. AIMS AND OBJECTIVES

To ensure that all staff who work within the Trust understand their responsibilities in relation to safeguarding children and adults at risk, and in relation to public protection.

This document will ensure that staff are clear about their statutory duties and about action they must take in response to safeguarding and/or public protection concerns.

To enable the Trust to fulfil its statutory duties safely and competently it must:

- Ensure effective measures are in place to safeguard people and protect children and adults at risk; and,

- Ensure appropriate systems and processes are in place, including those to support sharing of information, to enable staff to work effectively and in partnership with other agencies with regard to safeguarding and public protection.

4. RESPONSIBILITIES

Governance & Reporting Arrangements

The Trust's governance and reporting structure is set out below.

Executive Responsibility	• The Chief Executive Officer has overall responsibility for safeguarding and public protection. • The Executive Portfolio is delegated to: Executive Director of Nursing, Allied Health Professionals and Health Science. • Supported by: The Deputy Director of Nursing, Quality & Patient Experience.
Operational Responsibility	• Director, Velindre Cancer Centre • Supported by: The Director of Operations, Velindre Cancer Centre • Director, Welsh Blood Service • Supported by: The Head of Nursing
Named Lead	Head of Safeguarding & Vulnerable Groups, or the Deputy Director of Nursing, Quality & Patient Experience will provide advice, guidance, and support for any safeguarding or public protection concerns disclosed, witnessed or suspected within the Trust.

The Trust has a legal obligation to ensure that the protection and safeguarding of children and adults at risk is of paramount importance. Situations may arise where the privacy rights of others may have to be balanced against the needs of the child / adult at risk.

Employee Responsibilities

The Social Services and Wellbeing (Wales) Act (2014) states that everyone has a duty to report all incidents of alleged abuse of children and adults at risk.

All employees must take positive and decisive action when witnessing incidents, experiencing concerns or receiving information alleging abuse or inappropriate care of a child or adult at risk. Employees can obtain advice and support about concerns they may have with their line manager or the Safeguarding Lead.

Employees also have a responsibility to comply with their relevant professional Code of Conduct which will include the standards of behaviour expected outside of work.

All employees must comply with their statutory and mandatory training requirements, including Safeguarding Adults and Safeguarding Children training.

5. DEFINITIONS

Safeguarding involves working with partner agencies to protect children and adults at risk of abuse, neglect or other kinds of harm, and involves activities to actively prevent individuals from becoming at risk of abuse, neglect or other kinds of harm.

Public Protection includes actions taken to protect, promote and improve the health, safety and well-being of the population.

Safeguarding Children
A child is defined by the Children Act 1989 as anyone less than 18 years of age.

A 'child at risk' is defined in the Social Services & Wellbeing (Wales) Act 2014 as a child who:

a) Is experiencing or is at risk of abuse, neglect or other kinds of harm; and
b) Has needs for care and support (whether or not the Local Authority is meeting any of those needs).

Safeguarding children is the responsibility of everyone working in the Trust. This responsibility extends to children who are patients, children who are visitors to the Trust, children of any adults who are patients or donors of the Trust, and children of staff members.

Adults at Risk An 'adult at risk' is defined in the Social Services & Wellbeing (Wales) Act 2014 as an adult who:

a) Is experiencing or is at risk of abuse or neglect;
b) Has needs for care and support (whether or not the Local Authority is meeting any of those needs); and
c) As a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

Statutory Duty to Report
From April 2016 the Social Services & Wellbeing (Wales) Act 2014 introduced the statutory duty for all who work for the Trust to report to the Local Authority any concerns that a child or an adult is at risk. See Appendix 1

Deprivation of Liberty Safeguards (DoLS)
The process to protect people who, for their own safety and in their own best interests, need care and treatment that may deprive them of their liberty, but who lack the capacity to consent to that care and/or treatment, and where detention under the Mental Health Act 1983 is not appropriate.

Multi Agency Public Protection Arrangements (MAPPA)
The Trust is required to discharge its duties as a Multi-Agency Public Protection Arrangement (MAPPA) Duty to Co-operate Agency under s325 Criminal Justice Act 2003.

MAPPA is the process through which the police, probation and the prison services (Responsible Authority) work together with other agencies that have a duty to cooperate to manage the risks posed by violent and sexual offenders living in the community, in order to protect the public.

A MAPPA Strategic Management Board (SMB) covering the South Wales Police Force area is responsible for overseeing MAPPA related activity, including agreeing the role and representation of different agencies within the SMB, and developing protocols and memoranda of understanding which formalise these. The Trust is not represented on the MAPPA Strategic Management Board.

MAPPA offenders are managed on a multi-agency basis through Multi-Agency Public Protection meetings at Level 2 and 3:

- MAPPA 2: High risk of harm – monthly meetings
- MAPPA 3: Very high risk of harm – on a basis of need

Violence against Women, Domestic Abuse and Sexual Violence (VAWDASV)

The Violence against Women Domestic Abuse and Sexual Violence (Wales) Act 2015 definitions are:

Gender Based Violence–

a) Violence, threats of violence or harassment arising directly or indirectly from values, beliefs or customs relating to gender or sexual orientation.
b) Female genital mutilation.
c) Forcing a person (whether by physical force or coercion by threats or other psychological means) to enter into a religious or civil ceremony of marriage (whether or not legally binding);

Domestic Abuse is abuse where the victim of it is or has been associated with the abuser.

Sexual Violence includes sexual exploitation, sexual harassment, or threats of violence of a sexual nature.

6. IMPLEMENTATION

6.1 Safeguarding Children and Adults at Risk:

The Wales Safeguarding Procedures describe in detail actions to be taken at all stages of the child and adult safeguarding process.

They are available via the Trust's policies page and on the Trust's safeguarding & public protection intranet pages. The procedures must be adhered to in all safeguarding matters.

http://www.myguideapps.com/projects/wales_safeguarding_procedures/default/

6.2 Cardiff and Vale Regional Safeguarding Board Polices & Procedures All multi-agency safeguarding policies and procedures are approved by the Cardiff and

Vale Regional Safeguarding Board, of which the Trust is a member agency. They are available via their website at www.cardiffandvalersb.co.uk

6.3 Individual Roles & Responsibilities to Safeguard Children & Adults at Risk

All staff must know who to contact to express concerns and how to report those concerns to the Local Authority

- If it is believed the child or adult **is or may be at risk** this must be **reported immediately by telephone** to the relevant Local Authority.

- The **reporting** of concerns should be **discussed with** the child's **parents** and the child as appropriate to their age and understanding. Or with the **adult at risk** or their family/representative if they lack mental capacity to make decisions for themselves.

- The **exception** to this is if such a discussion would place the child/adult at greater risk of harm.

- The telephone report must be **confirmed in writing** within **24 hours** using the referral Forms (available on the Safeguarding and Public Protection website).

- If, having made the initial report in writing the report maker has not received an acknowledgement from social services **within 7 working days**, they must contact social services.

- Referrers who are **not satisfied** with the response from the Local Authority must discuss this with the Trust's Safeguarding Lead.

- All staff must discuss any **uncertainty** about concerns or **differences of opinion** with the Trust's Safeguarding Lead.

- If the Trust's Safeguarding Lead is **unavailable** the concern must be discussed with the relevant Local Authority Social Worker.

- After this discussion a **decision** must be made as to whether or not the child or adult meets the definitions of a child or adult at risk.

- If it is believed that the child or adult is **not at risk** consider if they would benefit from additional services and with their **consent** make the appropriate referrals.

See Trust Adult at Risk and Child Risk Reporting forms. APPENDIX2&3

6.5 Concerns about the behaviour of a member of staff

If the behaviour of a member of the Trust staff, in or out of work, causes concern and may pose a risk to children or adults at risk, staff are instructed:

- Do not dismiss concerns;

- Do escalate your concerns
- To discuss concerns with the Trust's Safeguarding Lead or if not available a senior member of the Workforce and OD Team.
- The Trust Safeguarding Lead or the Workforce Business Partner will act in accordance with the Trust Policy for the Management of Safeguarding Allegations/Concerns about Practitioners and those in a Position of Trust.

6.6 Deprivation of Liberty Safeguards Procedures [DoLS]

The Trust flowchart describes the actions to be taken in the Cancer Centre with regards to the Deprivation of Liberty Safeguards process.

They are available via the Trust's Policies Page and on the Trust's Safeguarding & Public Protection intranet pages.

6.7 Multi Agency Public Protection Arrangements [MAPPA]

The Trust has a flowchart for when high risk offenders or prisoners are admitted to hospital.
They are available via the Trust's Policies Page and on the Trust's Safeguarding & Public Protection intranet pages.

6.8 Violence Against Women Domestic Abuse Sexual Violence Procedures [VAWDASV]

The Trust has Policy and Guidance to support victims of violence against women, domestic abuse and sexual violence. The policy and guidance is designed to promote the safety of victims of domestic and sexual violence who are receiving services provided by the Trust, and explains the processes and procedures that staff will use to identify and respond to violence against women, domestic abuse & sexual violence.
They are available via the Trust's Policies Page and on the Trust's Safeguarding & Public Protection intranet pages.

6.9 Information Sharing

Information must be shared in accordance with the Data Protection Regulations 2018 and the common law duty of confidentiality. Both allow for the sharing of information and should not be automatically used as a reason for not doing so.

In exceptional circumstances, personal information can be lawfully shared without consent where there is a legal requirement or the practitioner deems it to be in the public interest. One of the exceptional circumstances is in order to prevent abuse or serious harm to others. It is not possible to give guidance to cover every circumstance in which sharing of confidential information without consent will be justified. You **must** make a judgement on the facts of the individual case. Where there is a clear risk of significant harm to a child or serious harm to an adult, the public interest test will almost certainly be satisfied. There will be other cases where you will be justified in sharing limited confidential information in order to make decisions on sharing further information or taking action – the information shared should be necessary for the purpose and be proportionate.
Safeguarding information will be retained in line with Trust information governance related policy.

https://gov.wales/information-sharing-safeguard-children-and-adults-leaflet

You should seek advice from the Information Governance Lead and Safeguarding Lead if you are unsure

6 EQUALITY IMPACT ASSESSMENT

The Trust is committed to ensuring that as far as is reasonably practicable, the way it provides services to the public and the way it treats its employees reflects their individual needs and does not discriminate against individuals or groups.

The Trust has undertaken an Equality Impact Assessment and received feedback on this policy and the way it operates. The Trust wanted to know of any possible or actual impact that this procedure may have on any groups in respect of gender (including maternity and pregnancy as well as marriage or civil partnership issues) race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics.

The assessment found that any impact from the policy would have a positive effect to the equality groups mentioned.
Where appropriate the Trust will make plans for the necessary actions required to minimise any stated impact to ensure that it meets its responsibilities under the equalities and human rights legislation

7 GETTING HELP

Contact Senior Nurse Safeguarding and Public Protection

[See Safeguarding and Public Protection Guidance Booklet for referral process flowcharts]

8 RELATED POLICIES

- Data Protection and Confidentiality Policy (2017)
- Disciplinary Policy (2017)
- Disclosure and Barring Checks on Trust Post Guidance
- NHS Wales Procedure for NHS Staff to Raise Concerns
- Wales Safeguarding Procedures (2019)
- Violence, Domestic Abuse and Sexual Violence Workplace Policy and Procedure (2018)
- Records Management Policy (2018)
- Policy for the Management of Safeguarding Allegations/Concerns about Practitioners and those in a Position of Trust

9 TRAINING AND EDUCATION

Safeguarding and Public Protection training is vital in protecting our patients and donors, their families and our communities from harm.

Safeguarding training is available both on a single agency and a multi-agency basis in line with the NHS Safeguarding Training Framework.

10 LEGISLATION AND NHS REQUIREMENTS

The Trust has to comply with relevant legislation, external standards and good practice guidance including:

- Social Services & Well-being (Wales) Act 2014 and the related Codes of Practice; Part 6 [Looked After Children] & Part 7 [Safeguarding Children & Adults at Risk]
- Children Act 1989, section 47 [child protection investigations]
- Children Act 2004 sections 25, 27 and 28 [duty to cooperate to safeguard & promote welfare of children]
- Mental Capacity Act 2005 as amended in the Mental Health Act 2007 [Supervisory Body and Managing Authority requirements for the Deprivation of Liberty Safeguards]
- s325 Criminal Justice Act 2003 [Multi-Agency Public Protection Arrangement (MAPPA) Duty to Co-operate Agency]
- Violence Against Women, Domestic Abuse, Sexual Violence (Wales) Act 2015 [develop and implement a local strategy with the Local Authority]
- s5B of the Female Genital Mutilation Act 2003 (amended by Serious Crime Act 2015) [mandatory reporting of FGM in under 18s to the police]
- Counter Terrorism & Security Act 2015 [to address those drawn into, or at risk of being drawn into terrorist and extremist behaviour]
- Safe Care Standard 2.7 of Health & Care Standards in Wales
- Duty of Candour 2023 (To be open and honest with people they are caring for if things go wrong and harm has occurred.)

11 REVIEW AND AUDIT

Review of this policy will be undertaken no later than three years after the date of approval. The policy may be subject to audit and will be assessed in line with normal audit planning processes, the outcome of any audits undertaken will be reported to the Trust Safeguarding and Public Protection Management Group.

12 ACKNOWLEDGEMENTS

This policy has been informed by a similar policy: Cwm Taf UHB Safeguarding and Public Protection Policy (2018)

Appendix 1

An overview of the duty to report process

I am aware of a child or adult that may be at risk of harm? of a child or adult that may be at risk of harm? What evidence do I have: disclosure; observation; information?

↓

I am aware of a child or adult that may be at risk of harm? of a child or adult that may be at risk of harm? What evidence do I have: disclosure; observation; information?

↓

I am aware of a child or adult that may be at risk of harm? of a child or adult that may be at risk of harm? What evidence do I have: disclosure; observation; information?

↓

I am aware of a child or adult that may be at risk of harm? of a child or adult that may be at risk of harm? What evidence do I have: disclosure; observation; information?

↓

I am aware of a child or adult that may be at risk of harm? of a child or adult that may be at risk of harm? What evidence do I have: disclosure; observation; information?

↓

I am aware of a child or adult that may be at risk of harm? of a child or adult that may be at risk of harm? What evidence do I have: disclosure; observation; information?

Appendix 2

Details of the person making the report	
Name	
Designation	
Contact Telephone Number	
Email Address	
Date of Report	

Reason for report	
Report in relation to:	
Type of Abuse	
Does this involve a professional concern?	
Reason for the report / nature of concerns	
Did you discuss the views and wishes with the victim	
What are their views and wishes and what would they like the outcome to be?	
If not discussed, why not?	
Does the adult at risk have/need an advocate?	
Adult at risk advocate details	
Is the adult at risk subject to legislative powers, such as DoLS, MHA or Power of Attorney?	
If yes, please provide details	
Is the adult at risk aware of the report?	
If No, please explain why	
Is there any evidence to suggest that the adult at risk lacks mental capacity to consent to this report?	
Do they consent to their information being shared with other agencies?	

Is there an overriding reason to share this concern without consent?	

Where the abuse occurred		
Where did the alleged Abuse occur?		
Address if not Home / Hospital		
If this occurred in an NHS Service, if so, please state which service and where		
Service		**Location**
Other - Please State:		

Details of the person affected	
Who has been affected by the alleged abuse?	
What type of person is affected	
NHS Number	
Subtype of Person Affected	
Forename	
Surname	
Gender	
Date of Birth	
Address Line 1	
Address Line 2	
Address Line 3	
Email	
Primary Contact Number	
Secondary Contact Number	
Preferred Language	
Is interpreter required	
Ethnicity	
Are there Other Adults or Children at the Property?	
If Yes, are they also at risk	
Please give details of this risk	
Are there any disability considerations?	
Persons Circumstances	
Disabilities	
Any other relevant information:	
Was the person injured in the incident?	
Injury – Check Merge code	
Body Part Check Merge code	
Treatment Check Merge code	

Care and Support	
Does the individual have care and support needs and as a result of those needs are they unable to protect themselves against the abuse, neglect or harm or the risk of it?	
What are those care needs and how are they met?	
Why are they not able to protect themselves?	
Is the individual experiencing or is at risk of abuse, neglect or other kinds of harm?	
What action has been taken to safeguard the individual?	

Other Person(s) Affected	
Are there adults or children at the property?	
Are they also considered at risk?	
If yes - what is the risk?	

Associated Persons	
Is the associated person a member of the same household?	
Are they a Service User/Relative/ Member of the Public/Employee or member of staff?	
Title	
Forenames	
Surname	
Address	
Telephone Number	
Language	
Disabilities (if any)	
Relevant Risk Factors *(including Substance Misuse, Mental ill-health, Physical ill-health, Domestic Abuse, History of violent behaviour)*	

Employees	
Contact Role	
Contact Type	
Subtype	
Relationship to Individual at Risk	

Title	
Forenames	
Surname	
Email	
Address Line 1	
Address Line 2	
Address Line 3	
Telephone Number	
Other Employer Details	
Does the alleged person of concern have any **contact with children** in any employment role?	
Does the alleged person of concern have any **contact with adults** in any employment role?	
Is the alleged person of concern aware of the report?	
Any other relevant information about this individual Put N/A if there is no other information	

Witnesses	
Type (Service User/ Relative/ Public/ Employee/ Other)	
Forenames	
Surname	
Address	
Postcode	
Telephone	
Relationship to victim:	
Is witness a child?	
Is witness aware of report?	

Agency Involvement	
Agency Role	
Contact Number	
Contact Email	

Local Authority Reporting to	

Appendix 3

Details of the person making the report	
Name	
Designation	
Contact Telephone Number	
Email Address	
Date of Report	

Reason for Report	
Report in relation to:	
Type of Abuse	
Does this involve a professional concern?	
Reason for the report / nature of concerns	
Did you discuss the views and wishes with the victim	
What are their views and wishes and what would they like the outcome to be?	
If not discussed, why not?	
Has consent for report been obtained from the person with the parental responsibility?	
Has consent been obtained from the child/young person?	
Is there an overriding reason to share this concern without consent?	
If yes, please explain why	
Views of the person with the parental responsibility about making this report	
Views of the Child / Young Person about making this report:	

Where the abuse occurred	
Where did the alleged Abuse occur?	
Other Please state:	

Address if not Home/Hospital	
If this occurred in an NHS Service, if so, please state which service and where	
Location	
Secondary Location	
Service Submitting report	
Service Responsible for Individual at Risk	

Details of the person affected	
Who has been affected by the alleged abuse?	
What type of person is affected	
NHS Number	
Forename	
Surname	
Gender	
Date of Birth	
Address Line 1	
Address Line 2	
Address Line 3	
Email	
Primary Contact Number	
Secondary Contact Number	
Has the family resided in another area	
If yes, why and where?	
Has the Child / Young Person arrived from overseas?	
Immigration Status:	
If yes, Date of Arrival?	
Home Office Registration Number:	
Preferred Language	
Is interpreter required	
Communication Needs	
Cultural Needs:	
Ethnicity	
CP Register	
Are there any disability considerations?	
Persons Circumstances	
Disabilities	
Any other relevant information:	
Looked after?	
Injuries	
Injury	
Body Part	

Treatment	

Care and Support	
Does the individual have care and support needs and as a result of those needs are they unable to protect themselves against the abuse, neglect or harm or the risk of it?	
What are those care needs and how are they met?	
Why are they not able to protect themselves?	
Is the individual experiencing or is at risk of abuse, neglect or other kinds of harm?	
What action has been taken to safeguard the individual?	

Other persons involved

Are there Other Adults or Children at the Property?	
If Yes, are they also at risk	
Please give details of this risk	

Associated Persons	
Is the associated person a member of the same household?	
Relationship	
Are they a Service User/Relative/ Member of the Public/Employee or member of staff?	
Contact Subtype	
Title	
Forenames	
Surname	
ID Number Type	
ID Number	
Gender	
Date of Birth	
Date of Death	
Email	
Address	
Postcode	
Primary Telephone Number	
Secondary Telephone Number	
Language	
Disabilities (if any)	
Relevant Risk Factors *(including Substance Misuse, Mental ill-health, Physical ill-health, Domestic Abuse, History of violent behaviour)*	

Witnesses	
Type (Service User/ Relative/ Public/ Employee/ Other)	
Forenames	
Surname	
Address	
Postcode	
Telephone	
Relationship to victim:	
Is witness a child?	
Is witness aware of report?	

Agency Involvement	
Agency Role	
Contact Number	
Contact Email	

Local Authority Reporting to	

QS 08

POLICY FOR THE MANAGEMENT OF SAFEGUARDING ALLEGATIONS /CONCERNS ABOUT PRACTITIONERS AND THOSE IN A POSITION OF TRUST

Executive Sponsor & Function	Executive Director of Nursing, AHPs and Health Science
Document Author:	Head of Safeguarding and Vulnerable Groups
Approved by:	Quality & Safety Committee
Approval Date: 29th April 2020	**Date of Equality Impact Assessment:** 2nd February 2020
Equality Impact Assessment Outcome:	This policy has been screened for relevance to equality. No potential negative impact has been identified.
Documents to read alongside this policy:	There is a link to al of the appropriate forms and additional reading material within the appendices to the policy.
Review Date:	March 2023
Version	Version 2

Contents

1. Policy Statement

As an employer and provider of services, Velindre University NHS Trust has a duty to protect individuals in our care from abuse. This policy relates to the management of allegations of abuse made against an employee of the Trust and will enable the organisation to ensure that all instances of concerns or alleged abuse or neglect of children and adults are risk assessed, to ensure patient / donor safety.

Where a concern or abuse is alleged to have occurred in the employee's private capacity (i.e. outside of their Trust employment) careful consideration will need to be given to whether the employee presents any risk to patient's / donors within their working environment in the Trust, and if they may be in breach of their professional code of practice (regulated employees).

2. Scope of Policy

This Policy applies to all Velindre University NHS Trust employees, bank, locum and agency, students, contractors, honorary contracts holders, volunteers, trainees and Trust staff undertaking duties overseas as part of a Trust supported health link staff, regardless of role or whether or not their employment brings them into direct contact with vulnerable adults or children.

This Policy applies in all cases of alleged abuse of a child or adult by an employee of the Trust regardless of whether the abuse is alleged to have taken place in work or in their private lives. In every incident of alleged abuse of a child or adult staff must comply with the Wales Safeguarding Procedures.

http://www.myguideapps.com/projects/wales_safeguarding_procedures/default/

3. Aims and Objectives

This policy has been developed to ensure that employees of Velindre University NHS Trust are aware of their responsibilities and the processes for identifying and reporting professional abuse of children and adults at risk either within the workplace or in the employee's home / external environment. The policy has been developed to ensure a robust and consistent approach in responding to allegations of actual or potential abuse.

- To ensure that all incidents of abuse and neglect of a child or adult at risk are dealt with within the appropriate framework.
- To safeguard children and adults at risk from abuse and avoidable neglect by Trust employees.

- To ensure an equitable, fair and consistent response when concerns are raised.
- To support employees who have made a referral or who have had a referral made against them; and
- To raise awareness of all Trust employees of the possibility of abuse of children and adults at risk, by professionals and other healthcare workers.

4. Responsibilities

Velindre University NHS Trust has a legal obligation to ensure that the protection and safeguarding of children and adults at risk is of paramount importance. Situations may arise where the privacy rights of others may have to be balanced against the needs of the child / adult at risk.

The Trust has a responsibility to notify the police when concerns are raised, if it is in the public interest, even if the individual concerned does not wish the police to be involved.

• Executive Director of Nursing, Allied Health Professionals and Health Science

The Executive Director of Nursing, Allied Health Professionals and Health Science has delegated responsibility for ensuring the safeguarding of children in accordance with Section 28 of the Children Act (2004) and for safeguarding under the Social Service and Wellbeing (Wales) Act (2014).

• Employee Responsibilities

In line with the Social Services and Wellbeing (Wales) Act (2014), all staff have a duty to report all incidents of alleged abuse of children and adults at risk.

All employees must take positive and decisive action when witnessing incidents, experiencing concerns or receiving information alleging abuse or inappropriate care of a child or adult at risk. Employees can obtain advice and support about concerns they may have with their line manager, the Trust Safeguarding Lead or via the processes set out in NHS Wales Trust Procedure for NHS Staff to Raise Concerns.

Employees also have a responsibility to comply with their relevant professional Code of Conduct which will include the standards of behaviour expected outside of work.

All employees must comply with their statutory and mandatory training requirements, including Safeguarding Adults and Safeguarding Children training.

- **Managers**

Line managers are responsible for complying with this Policy and, in all circumstances should notify the Trust Senior Nurse for Safeguarding & Public Protection or the Deputy Director of Nursing, Quality & Patient Experience in order to gain the required support / advice / multi agency involvement.

In some cases, the line manager may feel it appropriate to make a referral to the Occupational Health Service to provide appropriate support for any employee concerned or involved in the process. This must be done with their consent. A management or self-referral to the Occupational Health Service / Employee Assistance Programme should be in addition to and not instead of the processes set out in this Policy.

Managers should ensure that employees who find themselves overstretched in their caring responsibilities outside of work are made aware of support available to them (e.g. Occupational Health Service, Employee Assistance Programme, Flexible Working Policy, third sector organisations).

- **Trust Senior Nurse Safeguarding & Public Protection**

The Trust Senior Nurse for Safeguarding and Public Protection must provide support, oversight and direction to line managers when managing situations in line with this policy and ensure that the Executive Director of Nursing, Allied Health Professionals & Healthcare Scientists is notified and kept updated.

5. Definitions

5.1 Abuse: This describes physical, sexual, psychological, emotional or financial abuse (and includes abuse taking place in any setting, whether in a private dwelling, institution or any other place).
(Wales Safeguarding Producers 2019)

5.2 A child is defined as “any person under the age of 18” *(UN Convention on the Rights of the Child 1989).*

5.2 Section 130 (4) defines a “child at risk” as a child who;
(a) Is experiencing or is at risk of abuse or neglect; and
(b) Has needs for care and support (whether or not the authority is meeting any of those needs)

5.3 Section 126(1) defines an adult at risk;
An “adult at risk”, for the purposes of this Part, is an adult who:- (c) Is experiencing or is at risk of abuse or neglect;

(d) Has needs for care and support (whether or not the authority is meeting any of those needs); and
(e) As a result of those needs is unable to protect himself or herself against the abuse or neglect of the risk of it.

6. Implementation / Policy Compliance

6.1 The Trust needs to be able to recognise and respond appropriately to allegations raised against an employee. Allegations could be identified in a number of ways, including (but not limited to) the following:

- by the Police;
- by Social Services;
- from an adverse incident and/or completed DATIX report that may identify a potential allegation;
- a concern made by a patient / donor or carer;
- a concern made by another employee;
- by adults disclosing historical abuse which they experienced as a child; or
- a professional or regulatory body.
- an individual involved in a Trust supported international health partnership link.

6.2 During weekday working hours

Allegations of abuse by an employee must be reported without delay to the appropriate line manager who will take any remedial action and have an initial discussion with the Trust Senior Nurse, Safeguarding & Public Protection / Deputy Director of Nursing, Quality & Patient Experience.

A decision will be made at this initial discussion to confirm if this policy needs to be evoked and, who will inform Local Authority or the Police.

Out of hours

Allegations of abuse by an employee must be reported immediately to the On-Site Manager who may refer the matter to the On-Call Manager for advice / support. The on Site and On Call Managers can be contacted via switchboard.

The immediate priority is the protection and safety of a child or adult at risk and managing any associated staff issues. Any immediate risks must be considered, and action taken to mitigate that risk where appropriate. However, under no circumstances should internal enquires into the allegation be commenced until advice has been received from the on-call Managers.

If it is felt that the alleged abuse may be criminal, there must be no delay in reporting the matter to the Police, who will advise on preserving the scene for evidence**.**

All actions taken should be clearly recorded. It is essential that all records are written clearly, accurately, legibly and contemporaneously with all details recorded, to provide as full a picture of the account as possible throughout this process. All records should be signed and dated if not written contemporaneously then the date they were written should be made clear, as well as the date of the contact.

6.3 On being informed of the allegation of abuse, the Trust Risk Assessment form attached as ***Appendix 2*** must be completed to inform Trust action. The Workforce and OD Department will provide advice and support to the relevant line manager in determining if the employee can continue in work, should be moved temporarily to another role or if they should be suspended. Any decision taken to suspend an employee must be taken in line with the relevant Disciplinary Policy.

6.4 When determining the appropriate action to be taken, consideration must be given to:

- how the person's protection is to be ensured.
- whether there are other children or adults who might be at risk.
- what support the employee may require;
- the right of the employee who has had an allegation made against them in respect of their privacy and confidentiality.

In addition, Trust employees who have an allegation made against them need to:

- understand the concerns expressed;
- know the procedures/processes being operated;
- know the timescale set for the process;
- be told what support is available to them;
- be clearly informed on the outcome of any investigation and the implications for disciplinary/capability processes;

Procedures need to be applied with common sense and judgement, and full decision-making documentation.

6.5 The Professional Strategy Discussion

The professional strategy meeting will be convened when safeguarding allegations have been raised about a practitioner/person in positions of trust. A Professional Strategy discussion will take place with the Police;

any other appropriate partners and employers. The focus of the Strategy discussion is as follows:

- Whether the matter meets the threshold for progressing to a formal Professional Strategy meeting
- Identification of any activities or caring responsibilities for children or adults that the subject of the allegation is involved in outside of their paid employment
- Consideration of interim safeguards whilst further enquiries are made
- Decision about what information can be shared with the subject of the allegation, the child or adult at risk and their parent/carer
- Decision about employer involvement with the process
- Review adequacy of safeguards in place
- Agree any actions to be taken or any further information needed prior to the Professional Strategy meeting
- Decide whether immediate briefings to senior managers are required

6.6 Professional Strategy Meeting

The professional strategy meeting will be convened by the Local Authority Designated Officer for Safeguarding when safeguarding allegations/concerns have been raised about a practitioner/person in positions of trust. This can either be in a personal or professional capacity, where the individual has wider contact with children or with adults at risk.

The main functions of the strategy meeting are to:

- Ensure the proper co-ordination of child, adult protection, criminal and employment procedures
- Share all relevant information about the allegation/concern in question
- Consider what action may be required to protect the child or adult at risk in question
- Consider the likelihood of harm to other children or adults at risk with whom the person has contact at work or other activities, and agree any actions that are required
- Consider and evaluate the risk of harm to the subject's own children or adults they may have caring responsibilities for, and agree any actions that are required
- Discuss any previous allegations or other concerns.
- Plan any enquiries needed and allocate tasks and set timescales
- Decide who is to be interviewed and lead agency
- Identify a lead contact manager within each agency
- Decide what information can be shared with whom, when and who will do this

- Agree timescales for actions and/or dates for further meetings
- Consider the employees suitability to continue working with children or adults at risk in his or her current position has been called into question
- Consider whether there are disciplinary issues to be followed up
- Agree at what stage in the process the disciplinary issues should be followed up
- Consider any other factors that may affect the management of the case e.g. consideration of the need for a media strategy where there is likely to be press interest.
- Confirm arrangements regarding who will communicate with the person about whom there are concerns and ensure appropriate support is provided
- Ensure that the appropriate referrals are made to the Disclosure and Barring Service and registering bodies of the professional involved (this can be completed at any point throughout the process
- The employer/voluntary organisation or registering body may need to consider suspending the employee without prejudice.

The immediate priorities of the Professional Strategy Meeting are to ensure the protection and safety of the child/children or adult's at risk, and to also discuss whether the allegation may have a bearing on the individual's employment. The Trust should not decide in isolation to progress the matter through the relevant Disciplinary Policy. Discussion must take place with the police and social services prior to commencement of proceedings.

6.7 Who will be invited to the Professional Strategy Meeting?

The Professional Strategy Meeting will be chaired by the Local Authority Designated Officer for Safeguarding for children or adults, who will also identify who will attend.

Where the allegations involve concerns or alleged abuse of a child or adult at risk by a Trust employee the employee's line manager, a senior Workforce and OD representative and the Safeguarding Lead, as a minimum must be in attendance at the Professional Strategy Meetings.

6.8 Informing the individual

The person who is the subject of the allegation should generally be informed that they are subject of an allegation at the earliest opportunity. This should be done by the line manager. However, specific details of the allegation cannot be provided until the timings for doing so have been agreed with Children's or Adults Services/Police. This will be considered during the interim safeguarding arrangements discussed and agreed by the Police and the Designated Officer for Safeguarding. In determining when to inform the individual, consideration should be given to any potential risks to the child or adult involved in the allegations, or to any other children or adults connected to the individual's home, work or community life.

When informing the individual careful consideration should be given to the following:

- The person subject to the allegation should be given appropriate support by their employer or nominated individual;
- The person who is the subject of the allegation should be treated fairly and honestly and helped to understand the concerns expressed and processes involved;
- Information about the adult, child or family should not be shared with the individual against whom the allegation was made or anyone representing them;
- Consideration should also be given to the potential for the individual to impede any investigation, remove or interfere with evidence or to intimidate or coerce potential witnesses;
- If suspended, the individual will be kept up to date about events in the workplace by a named contact;
- As soon as possible after an allegation has been received, the accused member of staff should be advised to contact their Trade Union or professional association;
- Workforce &OD should be consulted at the earliest opportunity in order that appropriate support can be provided via the organisation's occupational health, employee welfare arrangements, or individual agency's own safeguarding arrangements;

6.9 Informing parents / carers, children, adults at risk or their representatives

- The general principle is that the parents or carers of the adult or children involved and the adult or children where appropriate, should be informed about the allegation as soon as possible but only following discussion with the Designated Officer for Safeguarding responsible for safeguarding allegations/concerns against practitioners and those in positions of trust.
- Parents/carers of the adult or children involved and the adult or children where appropriate, must be informed of the outcome of the strategy discussion/meeting and should, when necessary, be helped to understand the decisions reached. It will be agreed in the Strategy Discussion or Strategy meeting who will undertake this.
- Examples where it may not be appropriate to inform parents, carers, adults or children or their representative immediately could include where the allegation made is against a family member, or if the Police investigation could be hampered by informing the parent/carer, child, adult at risk or their representative. In these cases the timings for the parents or carers being told must be confirmed with the relevant social services and Police.

6.10 Concluding the process

An Outcome Professional Strategy Meeting should be held to decide, whether on the balance of probabilities the concerns are substantiated. If the concerns are not deemed to be substantiated, then the outcome should be recorded as unsubstantiated, unfounded or deliberately invented or malicious. The following definitions will guide strategy meetings in determining which outcome applies; Allegations will have outcomes within the following four categories:

Substantiated – a substantiated allegation is one which is established by evidence or proof.

Unsubstantiated – an unsubstantiated allegation is not the same as an allegation that is later proved to be false. It simply means that there is insufficient identifiable evidence to prove or disprove the allegation. The term, therefore, does not imply guilt or innocence.

Unfounded – this indicates that the person making the allegation misinterpreted the incident or was mistaken about what they witness. Alternatively, they may not have been aware of all the circumstances. For an allegation to be classified as unfounded, it will be necessary to have evidence to disprove the allegation.

Deliberately invented or malicious – this means there is clear evidence to prove there has been a deliberate act to deceive and the allegation is entirely false.

The outcomes discussion would normally precede any decision by the employer to invoke disciplinary procedures. Where the concerns are substantiated, employing or volunteer agencies should consult if not already done so with the Disclosure and Barring Service and other relevant professional bodies about the requirement for a referral. (Further information and guidance from the DBS can be obtained from their website at www.homeoffice.gov.uk/dbs).

If the Professional Strategy Meeting concludes there is to be no further action from a multi-agency perspective then the appropriate Trust manager will need to determine whether there are disciplinary issues in relation to the member of staff concerned that need to be addressed in accordance with the relevant Disciplinary Policy. Consideration also needs to be given as to whether the Professional Registered Body of the member of staff needs to be informed.

Where a criminal investigation results in no further action but it is determined that a disciplinary investigation is to take place subsequently, a request can be made to the police for permission to use the information gained from the criminal investigation in the disciplinary investigation. The police will consider any request on a case by case basis.

6.11 Cross boundary issues

This is an area of work that is best supported by sound inter-authority working. Where child or adult protection enquiries have been made in one area, but the

alleged perpetrator lives or works within other areas, there will be need for information to be shared between the two areas. The Delegated Officer for Safeguarding must ensure that they share all information with their counterpart in the other Local authority. Due regard is to be had to the relevant data protection principles which allow sharing of personal information, as provided for in the Data Protection Act 2018 and the General Data Protection Regulation (GDPR). It is usually the responsibility of the Local authority where the alleged abuse took place /concern arose to hold the Professional Strategy Meeting. After discussion between the Designated Officers for Safeguarding it will be decided and recorded which authority will be responsible for convening the Professional Strategy Meeting and the reasons why.

7. Confidentiality and Record of the Professional Strategy Meeting

In view of the potential sensitivity of the information and the lessons of the Bichard Inquiry (2004), (www.police.homeoffice.gov.uk/publications/bichard-inquiryreport) care should be taken in recording the concern and the outcome of the process.
A record of the meeting will be made and retained by the local authority in accordance with their record, retention and disposal policy. Attendees representing the employer should receive a copy of the summary and recommendations of the meeting with the child's or adult at risk's name removed. All other attendees will receive a copy of the summary and recommendations.

The Designated Officer for Safeguarding will consider any request for a full record of the meeting and ensure that in the event of disclosure, an appropriately redacted version of the record is disclosed.

Where the person makes a data subject access request for the record of the Professional Strategy Meeting, this will be considered, and the nominated Designated Officer for Safeguarding will ensure redaction the document prior to disclosure. Other meeting attendees will be made aware of the request and can be sent a copy of the redacted document where requested

8. Referral to Disclosure and Barring Service (DBS) and Professional Bodies

The Trust, like all employers have a legal duty to refer information to the DBS if an employee has harmed or poses a risk of harm to vulnerable groups and where they have dismissed them or are considering dismissal. Employers also have a duty to refer where an individual has resigned before a formal decision to dismiss them has been made. **Failure to refer such matters to the DBS is a criminal offence.**

Please refer to the Disclosure and Barring Checks on Trust Post Guidance

Further information about the referral process is also available on the DBS website at www.homeoffice.gov.uk/agencies-public-bodies/dbs/services/dbsreferrals/

The Trust may also have a duty to report an employee to other relevant Professional Bodies such as the General Medical Council, Nursing Midwifery Council and the Health and Care Professions Council.

9. Equality Impact Assessment Statement

The Trust is committed to ensuring that as far as is reasonably practicable, the way it provides services to the public and the way it treats its employees reflects their individual needs and does not discriminate against individuals or groups.

The Trust has undertaken an Equality Impact Assessment and received feedback on this policy and the way it operates. The Trust wanted to know of any possible or actual impact that this procedure may have on any groups in respect of gender (including maternity and pregnancy as well as marriage or civil partnership issues) race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics.

The assessment found that any impact from the policy would have a positive effect to the equality groups mentioned.
Where appropriate the Trust will make plans for the necessary actions required to minimise any stated impact to ensure that it meets its responsibilities under the equalities and human rights legislation

10. References

- Adapted from ABMU Policy for the Management of Allegations of Abuse of Children or Adults by Professionals and Members of Staff (2016);
- Children's Act (2004);
- General Data Protection Regulations (2018);
- Social Service and Wellbeing (Wales) Act (2014);
- Wales Safeguarding Procedures (2019)

11. Getting Help

Contact the Safeguarding Lead for Velindre University NHS Trust: Senior Nurse Safeguarding and Public Protection.

12. Related Policies

- Data Protection and Confidentiality Policy (2017)
- Disciplinary Policy (2017)
- Disclosure and Barring Checks on Trust Post Guidance

- NHS Wales Procedure for NHS Staff to Raise Concerns
- Wales Safeguarding Procedures (2019)
- Violence, Domestic Abuse and Sexual Violence Workplace Policy and Procedure (2018)
- Safeguarding and Public Protection Policy (2019)
- Records Management Policy (2018)
- Serious Crime Act (2015)
- Duty of Candour (2023)

13. Information, Instruction and Training

13.1 Training

Employee awareness of safeguarding issues and responsibilities will be undertaken through both safeguarding children and adults at risk mandatory training. All Trust staff who have direct contact with patients are required to complete Level 2 Safeguarding Adults and Children training. Certain groups of staff will require extra training in accordance with the NHS Safeguarding Training Framework. It is the responsibility of the line manager to ensure that employees are made aware of these requirements.

13.2 Audit

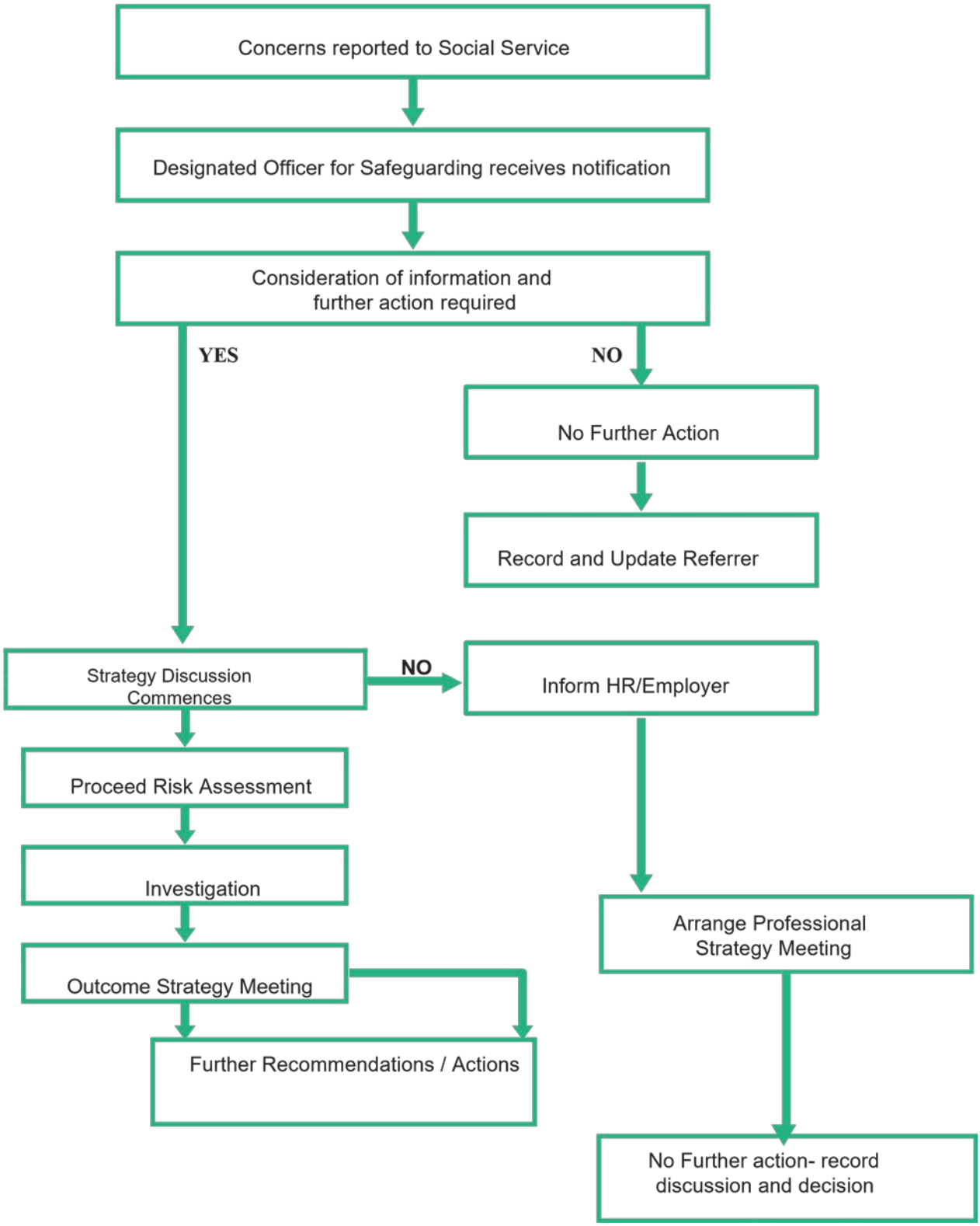
This policy may be subject to audit and will be assessed in line with normal audit planning processes. The outcomes of any audits undertaken will be reported to the Safeguarding & Public Protection Management Group.

14. Main Relevant Legislation

General Data Protection Regulations (2018)
Children's Act (2004)
Safeguarding Vulnerable Groups Act (2006)
Social Service and Wellbeing (Wales) Act (2014)
Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act (2015)
Serious Crime Act (2015)

Appendix 1

Flowchart: Referrals about people whose work brings them into contact with children or adults at risk



Appendix 2

Safeguarding Children and Adults

Guidance Notes on the Completion of a Risk Assessment Form following Allegations Against an Employee

RISK is a combination of the likelihood and severity of a specified event (incident).

This form is used to undertake a detailed risk assessment when potential risks have been identified at a Professional Strategy Meeting and Wales Safeguarding Procedures 2019 and/or when a member of staff is considered to be a risk.

All sections of this form should be completed by the employee's line manager, with support from the appropriate Safeguarding Lead and Workforce and OD as part of the Professional Strategy Meeting proceedings. The objective of this form is to establish whether the individual poses a risk to children/adults at risk, and if so, to establish what appropriate, additional controls can be put in place to ensure that the risks are reduced to an acceptable level. The completed form must be kept in the employees' confidential file.

NATURE OF ALLEGATIONS

TYPE OF ABUSE ALLEGED Select the type of abuse that is being alleged.

SEVERITY OF THE ABUSE ALLEGED

Select severity of abuse alleged as appropriate. If unsure, please contact the Safeguarding Lead

HOW MANY TIMES HAS THE ABUSE OCCURRED

Select whether the abuse has occurred on one occasion or more than one occasion. This information will be shared at the Professional Strategy Meeting.

EXPLANATIONS GIVEN

Select whether no explanation provided, or if explanation provided, whether the explanation is inconsistent or consistent. This information will be shared at the Professional Strategy Meeting.

PERSONS PRESENT AT TIME OF INCIDENT

Select whether the employee was the sole carer at the time of the incident, or whether there were other people present. This information will be shared at the Professional Strategy Meeting.

LEGAL PROCEEDINGS

Select whether care proceedings or criminal proceedings are in place. This information will be shared at the Professional Strategy Meeting.

EMPLOYMENT ISSUES

ROLE WITHIN TRUST Select whether administrative, academic, clinical or other. If other, please give details

ACCESS TO CHILDREN

If employee has access to children or young people under the ages of 18 years, in any capacity whilst in his role in the Trust select yes. If employee only has access to people aged 18 years and above, then select no

UNSUPERVISED ACCESS TO CHILDREN

If the employee does have access to children or young people under the age of 18 years, select how often this access is unsupervised/employee sole staff member present

ACCESS TO ADULTS AT RISK

If the employee has access to adults at risk, select how often this access is unsupervised/employee sole staff member present

RISK ASSESSMENT MATRIX

1. PROBABLE LIKELIHOOD RATING (PLR)

Taking account of the controls in place and their adequacy, how likely is it the individual will harm a patient or visitor during the course of their work for the Trust? Score according to the following scale:

Score	Descriptor	Description
5	Almost Certain	Likely to occur on many occasions
4	Likely	Will probably occur but is not a persistent issue
3	Possible	May occur occasionally
2	Unlikely	Do not expect it to happen but it is possible
1	Rare	Can't believe that this will ever happen

2. PROBABLE CONSEQUENCE RATING (PCR)

Taking account of the controls in place and their adequacy, how severe would the consequence be of such an incident if it were to occur? Apply a score according to the following scale:

Level	Descriptor	Actual or potential impact on individual	Actual or potential impact on organisation
5	Catastrophic	Death or national adverse publicity	National adverse publicity, possible investigation
4	Major	Permanent physical / psychological injury	Service closure Local adverse publicity, possible investigation
3	Moderate	Semi-permanent injury or harm	Needs careful PR
2	Minor	Short term injury or harm	Risk to organisation
1	Insignificant	No injury or adverse outcome	No risk at all to the organisation

RISK LEVEL ESTIMATOR/ RISK RATING (RR)

LIKELIHOOD of Adverse Event Occurring X SEVERITY of Outcome = Risk Rating

Likelihood (PLR) / Severity (PCR)	Almost Certain 5	Likely 4	Possible 3	Unlikely 2	Rare 1
Catastrophic 5	25	20	15	10	5
Major 4	20	16	12	8	4
Moderate 3	15	12	9	6	3
Minor 2	10	8	6	4	2
Insignificant 1	5	4	3	2	1

RR Score	RISK LEVEL	ACTION AND TIMESCALE
1 - 5	LOW	Provide support for the individual. Continue normal working activity with close monitoring

6 - 10	MODERATE	Provide support for the individual. Consider redeployment to low risk area or work with continuous supervision whist enquiries undertaken
11 - 25	UNACCEPTABLE	Provide support for the individual Suspension pending further enquiries

SAFEGUARDING CHILDREN / ADULTS – EMPLOYEE RISK ASSESSMENT FORM

Name of Individual ☐ Designation ☐ Unit/ Department ☐

Nature of Allegations

Type of abuse alleged: *(please tick)*

Neglect ☐ Emotional Abuse ☐ Sexual Abuse ☐ Physical Injury ☐ Domestic Abuse ☐

Financial ☐

Severity of alleged abuse *(please tick)*

Mild ☐ Moderate ☐ Severe ☐

Has the abuse occurred on: *(please tick)*

One occasion ☐ More than one occasion ☐

Explanations given: *(please tick)*

None ☐ Inconsistent explanation ☐ Consistent explanation ☐

Persons present at time of incident: *(please tick)*

Individual - sole care ☐ Individual and another – shared care ☐

Legal Proceedings: *(please tick)* ☐

None ☐ Care Proceedings ☐ Criminal Proceedings

Employment Issues

Role within Trust: *(please tick)* ☐ ☐

Administrative ☐ Academic ☐ Clinical Other *(please state)*

Access to children/adults at risk: Yes ☐ No ☐
(please tick)

Unsupervised Access to children/adults at risk: Never ☐ Occasional ☐ Regular ☐
(please tick))

Initial Risk Rating

Given the information above, what level of risk does the employee pose to the organisation and its service users? *(see page 2)*

Probable Likelihood Rating (PLR) ☐ X Potential Consequence Rating (PCR) ☐ = Initial Risk Rating (IRR) ☐

Risk Level (*please delete*): LOW / MODERATE / UNACCEPTABLE

Safeguards to minimise risk

Safeguards needed to minimise/eliminate risk: *(see page 2 for suggested actions)*

Feasibility of implementing safeguards:

Revised Risk Rating

With the above action implemented the risk rating figure would be reduced to: = Revised Risk Rating (RRR) ☐

Probable Likelihood Rating (PLR) ☐ X Potential Consequence Rating (PSR) ☐

Revised Risk Level (*please delete*): LOW / MODERATE / UNACCEPTABLE

Recommendations

Joint Assessment made by:

Name	Signature	Position

Date of Assessment		Review Period		Dates of Review			

Further information on review:	Risk Rating	*Date & Signature*

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

QUALITY, SAFETY & PERFORMANCE COMMITTEE

HEALTH AND CARE STANDARDS ANNUAL REVIEW REPORT

DATE OF MEETING	16th May 2023

PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	N/A
PREPARED BY	Jade Coleman, Quality, Safety and Assurance Manager
PRESENTED BY	Nicola Williams, Executive Director Nursing, Allied Healthcare
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director Nursing, Allied Healthcare Professionals and Health Science

REPORT PURPOSE	APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Integrated Quality & Safety Group	25/04/2023	Endorsed
Executive Management Board	02/05/2023	APPROVED

ACRONYMS	
HCS	Health and Care Standards
VCS	Velindre Cancer Service
WBS	Welsh Blood Service

1. SITUATION

This report is to provide the Quality, Safety & Performance Committee with the outcome of the 2022/23 Health and Care Standards Assessment process and the action that will be taken to consider how the new Health & Care Quality Standards (2023) will be implemented and embedded across the Trust moving forward.

The Quality, Safety & Performance Committee is asked to:

- **APPROVE** the overarching 2022/23 Healthcare Standards Trust status as a level 4;
- **NOTE** the Divisional Assurance Highlight Reports;
- **NOTE** the plans to consider how the Health and Care Quality Standards (2023) will be implemented and embedded across the Trust and the legacy improvements that will be considered as part of this process.

2. BACKGROUND

The current Health and Care Standards have been in place across NHS Wales since 2015 and since this time the Trust have developed a process to help more firmly embed the Standards in the core business of Divisions and corporate teams. For the past two years there has been enhanced reporting, monitoring and accountability arrangements in relation to the standards. The assessments have been reviewed on a quarterly basis by divisions and corporate leads and improvement plan updated. The assessment scoring criteria included: compliant; partial compliance or non-compliance to the national scoring criteria detailed below:

Self-Assessment Rating					
Assessment Level	1 We do not yet have a clear, agreed understandin g of where we are (or how we are doing) and what / where we need to improve	2 We are aware of the improvement s that need to be made and have prioritised them, but are not yet able to demonstrate meaningful action.	3 We are developing plans and processes and can demonstrate progress with some of our key areas for improvement	4 We have well developed plans and processes can demonstrate sustainable improvement throughout the organisation / business	5 We can demonstrate sustained good practice and innovation that is shared throughout the organisations / business, and which others can learn from

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 2022/2023 Health and Care Standards Self-Assessment Outcomes

3.1.1 Delivery against revised self-assessment process: At the start of 2022/23 all standards were reviewed and a new improvement plan drafted. These were reviewed each quarter by each Division and corporate leads. The outcomes were reported after 6 months to the

Divisional Senior Leadership Teams and Executive Management Board.

3.1.2 Stage 1 – Divisional assessment against the Health and Care Standards: The divisional self-assessments have been completed and approved through the responsible Senior Management Teams. The Standard/s Operational Lead/s have undertaken an independent quality check of the Divisional self-assessment and some of this did result in re-scoring. The Divisional Health and Care Standards highlight reports are attached in ***Appendix 1a & 1b****.*

3.1.3 Stage 2-Assessment: In addition to the Operational Lead oversight of the Divisional self-assessments the Operational lead/s also complete an assessment of overarching Trust position in respect of the standards that they are accountable for and assign a Trust wide assessment score for each. The summary of this is detailed in ***Appendix 2***. Standards scored between a level 3 (Trust is 'developing plans and processes and can demonstrate progress with some of our key areas for improvement') and a level 5 (Trust 'can demonstrate sustained good practice and innovation that is shared throughout the organisations/business, and which others can learn from').

The overarching Trust score in respect of the Healthcare Standards for the year 2022/23 is identified as a ***level 4***. The Trust have reported a level 4 status for the past 2 years meaning "we have well developed plans and processes can demonstrate sustainable improvement throughout the organization/business".

3.1.3 Delivery against the 2022/23 Health and Care Standards Improvement plan

The Health Care Standards Improvement Plan details the actions that are required per Standard in order to improve compliance, and to ultimately improve the quality of care provided within the organisation. The Improvement plan was reviewed and updated throughout the year and 11 (22%) of improvement actions were fully completed. 38 (78%) of actions are more complex requiring a longer time period for completion. These outstanding actions will continue to be worked through and have been transferred to a draft legacy 2023/24 Healthcare Standards Improvement Plan (attached in ***Appendix 3***). This will be considered as part of the 2023/24 Health & Care Quality standards delivery plan.

3.2 New Health & Care Quality Standards (2023)

The Duty of Quality Statutory Guidance details revised Health and Care Quality Standards that replace the previous Health & Care Standards. The Health and Care Quality Standards provide a structure on which to implement the Duty of Quality, allowing the standards to integrate with wider Trust health systems and consist of 6 quality standards (6 domains of quality) and 6 enablers as detailed below.

The Duty of Quality & Duty of Candour Implementation group are considering the new quality standards to develop a proposal for how they will be implemented and embedded across the Trust. This proposal will be considered in the May 2023 meeting. Following the proposal, work will be further developed through the Integrated Quality

& Safety group and a proposal brought to Quality, Safety & Performance Committee for consideration.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	The areas considered to have an impact on quality and safety are identified in the Health and Care Standards
RELATED HEALTHCARE STANDARD	All related to the Health and Care Standards.
EQUALITY IMPACT ASSESSMENT	All areas considered to have an impact on equality are identified in the Standards.
LEGAL IMPLICATIONS / IMPACT	There would be potential legal implications of non-delivery of these core standards.
FINANCIAL IMPLICATIONS / IMPACT	There would be financial implications aligned to both delivery and non-delivery of the Health and Care Standards. The non-delivery will be in relation to possible litigation due to non-compliance. Delivery of financial requirements will be worked through as part of local implementation/delivery plans.

5. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to**:**

- **APPROVE** the overarching 2022/23 Health and Care Standards end of year status as a level 4:
- **NOTE** the Divisional Assurance Highlight Reports;
- **NOTE** the draft 2023/24 legacy Healthcare Standards Improvement Plan
- **APPROVE** the approach to determine the implementation and embedding plans for the new Health and Care Quality Standards (2023).

APPENDIX 1a

HEALTH & CARE STANDARDS WALES SELF ASSESSEMENT 2022/23
DIVISIONAL HIGHLIGHT REPORT QUARTER 4

3.1.1 Standard 1 - Staying Healthy

Staying healthy	Score 2022/23	Score Q1	Score Q2	Score Q3	Score Q4	Corporate Score	SLT Lead
	Partial	4	4	4	4		Amanda Jenkins
Standard 1.1 Health Promotion							

3.1.2 Standard 2 - Safe Care

Safe care	Score 2022/23	Score Q1	Score Q2	Score Q3	Score Q4	Corporate Score	SLT Lead
Std 2.1 Managing Risk and H&S (VC&LM)	Partial	4	4	4	4		Lisa Miller/Viv Cooper
Std 2.2 Preventing Pressure Damage	Partial	4	4	4	4		Viv Cooper
Std 2.3 Falls Prevention	Partial	4	4	4	4		Viv Cooper
Std 2.4 Infection Prevention and Control	Partial	4	4	4	4		Viv Cooper
Std 2.5 Nutrition and Hydration	Partial	4	4	4	4		Viv Cooper
Std 2.6 Medicines Management	Full	5	5	5	5		Bethan Tranter
Std 2.7 Safeguarding	Partial	4	4	4	4		Viv Cooper
Std 2.8 Blood Management	Full	5	5	5	5		Viv Cooper
Std 2.9 Medical Devices, Equipment and Systems	Partial	4	4	4	4		Kathy Ikin

3.1.3 Standard 3 – Effective Care

Effective care	Score 2022/23	Score Q1	Score Q2	Score Q3	Score Q4	Corporate Score	SLT Lead
Std 3.1 Safe and clinically Effective Care	Partial	4	4	4	4		Viv Cooper
Std 3.2 Communicating Effectively	Partial	4	4	4	4		Viv Cooper
Std 3.3 Quality Improvement, Research and Innovation	Full	5	5	5	5		Christopher Cotterill-Jones
Std 3.4 IG and Technology	Partial	4	4	4	4		David Mason-Hawes
Std 3.5 Record Keeping	Partial	4	4	4	4		Rachel Hennessey

3.1.4 Standard 4 – Dignified Care

Dignified care	Score 2022/23	Score Q1	Score Q2	Score Q3	Score Q4	Corporate Score	SLT Lead
Std 4.1 Dignified Care	Partial	4	4	4	4		Viv Cooper
Std 4.2 Patient Information	Partial	4	4	4	4		Viv Cooper

3.1.5 Standard 5 – Timely Care

Timely care	Score 2022/23	Score Q1	Score Q2	Score Q3	Score Q4	Corporate Score	SLT Lead
Standard 5.1 Timely Access	Partial	3	3	3	3		Wayne Jenkins

3.1.6 Standard 6 – Individual Care

Individual care	Score 2022/23	Score Q1	Score Q2	Score Q3	Score Q4	Corporate Score	SLT Lead
Std 6.1 Promote Independence	Partial	3	3	3	3		Eve Gallop-Evans
Std 6.2 Peoples Rights	Partial	4	4	4	4		Rachel Hennessey
Std 6.3 Learning from Feedback	Partial	3	3	3	3		Viv Cooper

3.1.7 Standard 7 – Our Staff

Our staff	Score 2022/23	Score Q1	Score Q2	Score Q3	Score Q4	Corporate Score	SLT Lead
	Full	5	5	5	5		Rachel Hennessey
Standard 7.1 Workforce							

- The Trust provides a wide range of Education and Development opportunities in house and via external agencies.
- Velindre NHS Trust has University Status and is accredited with awarding bodies.

APPENDIX 1b

HEALTH & CARE STANDARDS WALES SELF ASSESSEMENT 2021/22
WBS DIVISIONAL HIGHLIGHT REPORT

3.1.1 Standard 1 - Staying Healthy

Staying healthy	Score 2022/23	Score Q1	Score Q2	Score Q3	Score Q4	Corporate Score
	Partial	4	4	4	4	
Std 1.1 Health Promotion						
Many of the standards are not relevant to WBS, but the division is able to demonstrate compliance with standards 8, 10 and 11						

3.1.2 Standard 2 - Safe Care

Safe care	Score 2022/23	Score Q1	Score Q2	Score Q3	Score Q4	Corporate Score
Std 2.1 Managing Risk and H&S	Partial	4	4	4	4	
Std 2.2 Preventing Pressure Damage	N/A	N/A	N/A	N/A	N/A	
Std 2.3 Falls Prevention	N/A	N/A	N/A	N/A	N/A	
Std 2.4 Infection Prevention and Control	Partial	4	4	4	4	
Std 2.5 Nutrition and Hydration	N/A	N/A	N/A	N/A	N/A	
Std 2.6 Medicines Management	N/A	N/A	N/A	N/A	N/A	
Std 2.7 Safeguarding	Partial	4	4	4	4	
Std 2.8 Blood Management	Partial	4	4	4	4	
Std 2.9 Medical Devices, Equipment and Systems	Full	5	5	5	5	

WBS has completed the implementation of the revised corporate Risk Management project and cutover to the new system and data migration is complete.

Standard 2.8:

- The project to introduce Haemoglobin S testing for red cells issued for neonatal use is proving challenging delivery was paused for review but is now estimated to complete in Q3 2022/23
- The project to address non-compliance to advise monitoring of antenatal patients with anti-D is ongoing, delivery is now estimated to complete in Q3 2022/23.

Standard 2.9

- WBS is awaiting publication of the final draft of the UK Medical Devices legislation.

3.1.3 Standard 3 – Effective Care

Effective care	Score 2022/23	Score Q1	Score Q2	Score Q3	Score Q4	Corporate Score
	Full	5	5	5	5	

Std 3.1 Safe and clinically Effective Care	Partial	4	4	4	4	
Std 3.2 Communicating Effectively	Full	5	5	3	3	
Std 3.3 Quality Improvement, Research and Innovation	Partial	4	4	4	4	
Std 3.4 Information Governance and Technology	Full	5	5	5	5	
Std 3.5 Record Keeping						

Care, treatment and decision making reflects best practice based on evidence to ensure that donors receive the right care and recipient safety is maintained. Robust governance processes are in place to ensure that research activities follow the highest ethical and scientific standards, including controls on the sharing of tissue samples and confidential data.
Recent communication improvements include the introduction of aids for people who are hard of hearing. Access to welsh-speaking members of collections teams remains a key challenge

Updated guidance on the use of pseudonymised data relating to donated samples, and new guidance on the need for Data Protection Impact Assessments in these instances was issued by the Head of Information Governance during Q1. This has resulted in delays in approving some collaborative research with third parties and has led to reputational damage.

Robust information governance and technology systems and processes, to support delivery of donor and patient services; however, work ongoing to establish a resilient business intelligence platform to support organisational information and reporting needs. As the amount of IG incidents has been noted by QSP, the emphasis is to reduce incidents via the increased delivery of training, identifying issues via gap analysis and addressing training needs via a risk-based approach, where risks have been reported via DATIX.

3.1.4 Standard 4 – Dignified Care

Dignified care	Score 2022/23	Score Q1	Score Q2	Score Q3	Score Q4	Corporate Score
Std 4.1 Dignified Care	Partial	4	4	4	4	
Std 4.2 Patient Information	Full	5	5	5	5	

During Q3 WBS implemented Phase 2 of CIVICA, A digitally enabled feedback system which will enable the WBS to seek and capture comprehensive ‘real time’ donor feedback.

Introduction of Translation on Wheels, A digital system that enables the WBS staff to call on a face-to-face British Sign Language Interpreter was completed in Q4 2022/23.

3.1.5 Standard 5 – Timely Care

Timely care	Score 2022/23	Score Q1	Score Q2	Score Q3	Score Q4	Corporate Score
Std 5.1 Timely Access	N/A	N/A	N/A	N/A	N/A	

Whilst the individual standards do not directly apply to WBS as the division deals predominantly with healthy donors, robust clinical governance arrangements are in place to monitor the quality and timeliness of donor care, and the support WBS provides for recipients of our products and services.

3.1.6 Standard 6 – Individual Care

Individual care	Score 2022/23	Score Q1	Score Q2	Score Q3	Score Q4	Corporate Score
Std 6.1 Promote Independence	N/A	N/A	N/A	N/A	N/A	
Std 6.2 Peoples Rights	Full	5	5	5	5	
Std 6.3 Learning from Feedback	Partial	4	4	4	4	

Implementation of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 is a key priority for 2023/24

3.1.7 Standard 7 – Our Staff

Our staff	Score 2022/23	Score Q1	Score Q2	Score Q3	Score Q4	Corporate Score
	Full	5	5	5	5	
Std 7.1 Workforce						

- WBS staff continue to be enrolled on courses run across the trust to support Welsh language skills, mental health and wellbeing and leadership skills. The Clinical Services team is currently working with HEIW and OD to create a bespoke HCSW framework for Collection Teams.
- Collaboration between WBS and colleagues in the hospital clinical transfusion setting has allowed us to improve services for patients by developing All Wales policies and guidance ensuring safer transfusion practice and appropriate use of blood. These initiatives have been particularly important during Q1 2022-23 and have helped Wales recover from low blood stocks over the summer and ahead of the rest the UK.

APPENDIX 2

OVERARCHING TRUST COMPLIANCE WITH THE HEALTH & CARE STANDARDS FOR 2022/23

	HCS Standard	VCC self-assessment rating	WBS self-assessment rating	Overarching Trust assessment rating post Executive Review	Comment 2022/23
Governance, Leadership and Accountability	Effective governance, leadership and accountability in keeping with the size and complexity of the health service are essential for the sustainable delivery of safe, effective person centred care.	**4**	**4**	**4**	**Working towards 5**
STANDARD 1 Staying Healthy	**Standard 1.1 Health Promotion, Protection and Improvement** People are empowered and supported to take responsibility for their own health and wellbeing and carers of individuals who are unable to manage their own health and wellbeing are supported. Health services work in partnership with others to protect and improve the health and wellbeing of people and reduce health inequalities.	**4**	**4**	**4**	**Working towards 5**
STANDARD 2 Safe Care	**Standard 2.1 Managing Risk and Promoting Health and Safety** People's health, safety and welfare are actively promoted and protected. Risks are identified, monitored and where possible, reduced or prevented.	**4**	**4**	**4**	**Working towards 5**
	Standard 2.2 Preventing Pressure and Tissue Damage People are helped to look after their skin and every effort is made to prevent people from developing pressure and tissue damage.	**4**	**NA**	**4**	**Overarching score increased to 5 following Exec review**
	Standard 2.3 Falls Prevention People are assessed for risks of falling and every effort is made to prevent falls and reduce avoidable harm and disability.	**4**	**NA**	**4**	**Working towards 5**

	Standard 2.4 Infection Prevention and Control (IPC) and Decontamination Effective infection prevention and control needs to be everybody's business and must be part of everyday healthcare practice and based on the best available evidence so that people are protected from preventable healthcare associated infections.	**4**	**4**	**4**	**Working towards 5**
	Standard 2.5 Nutrition and Hydration People are supported to meet their nutritional and hydration needs, to maximise recovery from illness or injury.	**4**	**NA**	**4**	**Working towards 5**
	Standard 2.6 Medicines Management People receive medication for the correct reason, the right medication at the right dose and at the right time.	**5**	**NA**	**4**	**Working towards 5**
	Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk Health services promote and protect the welfare and safety of children and adults who become vulnerable or at risk at any time.	**4**	**4**	**4**	**Working towards 5**
	Standard 2.8 Blood Management People have timely access to a safe and sufficient supply of blood, blood products and blood components when needed.	**5**	**4**	**4**	**Working towards 5**
	Standard 2.9 Medical Devices, Equipment and Diagnostic Systems Health services ensure the safe and effective procurement, use and disposal of medical equipment, devices and diagnostic systems.	**4**	**5**	**4**	**Working towards 5**
STANDARD 3 Effective Care	**Standard 3.1 Safe and Clinically Effective Care** Care, treatment and decision making should reflect best practice based on evidence to ensure that people receive the right care and support to meet their individual needs.	**4**	**5**	**4**	**Working towards 5**
	Standard 3.2 Communicating Effectively In communicating with people health services proactively meet individual language and communication needs.	**4**	**4**	**4**	**Working towards 4**
	Standard 3.3 Quality Improvement, Research and Innovation Services engage in activities to continuously improve by developing and implementing innovative ways of delivering care. This includes supporting research and ensuring that it enhances the efficiency and	**5**	**3**	**4**	**Working towards 5**

	effectiveness of services.				
	Standard 3.4 Information Governance and Communications Technology Health services ensure all information is accurate, valid, reliable, timely, relevant, comprehensible and complete in delivering, managing, planning and monitoring high quality, safe services. Health services have systems in place, including information and communications technology, to ensure the effective collection, sharing and reporting of high quality data and information within a sound information governance framework.	**4**	**4**	**4**	**Change to overall score following CDO review** **Needs review** **Working towards 5**
	Standard 3.5 Record Keeping Good record keeping is essential to ensure that people receive effective and safe care. Health services must ensure that all records are maintained in accordance with legislation and clinical standards guidance.	**4**	**5**	**4**	**Working towards 5**
STANDARD 4 Dignified Care	**Standard 4.1 Dignified Care** People's experience of health care is one where everyone is treated with dignity, respect, compassion and kindness and which recognises and addresses individual physical, psychological, social, and cultural, language and spiritual needs.	**4**	**4**	**5**	**Work towards maintaining 5**
	Standard 4.2 Patient Information People must receive full information about their care which is accessible, understandable and in a language and manner sensitive to their needs to enable and support them to make an informed decision about their care as an equal partner.	**4**	**5**	**4**	**Change to overall score following Exec review** **Working towards 4**
STANDARD 5 Timely Care	**Standard 5.1 Timely Access** All aspects of care are provided in a timely way ensuring that people are treated and cared for in the right way, at the right time, in the right place and with the right staff.	**3**	**NA**	**4**	**Working towards 4**

STANDARD 6 Individual Care	**Standard 6.1 Planning Care to Promote Independence** Care provision must respect people's choices in how they care for themselves as maintaining independence improves quality of life and maximises physical and emotional wellbeing.	**3**	**NA**	**3**	**Changed to 3 at VCC following consultation with Exec Lead**
	Standard 6.2 Peoples Rights Health services embed equality and human rights across the functions and delivery of health services in line with statutory requirement recognising the diversity of the population and rights of individuals under equality, diversity and human rights legislation.	**4**	**5**	**4**	**Changed to 3 following Exec review** **Working towards 4**
	Standard 6.3 Listening and Learning from Feedback People who receive care, and their families, must be empowered to describe their experiences to those who provided their care so there is a clear understanding of what is working well and what is not, and they must receive an open and honest response. Health services should be shaped by and meet the needs of the people served and demonstrate that they act on and learn from feedback	**3**	**4**	**4**	**Working towards 4**
STANDARD 7 Staff and Resources	**Standard 7.1 Workforce** Health services should ensure there are enough staff with the right knowledge and skills available at the right time to meet need.	**5**	**4**	**4**	**Working towards 4**

APPENDIX 3 Self-Assessment Rating					
Assessment Level	1 We do not yet have a clear, agreed understanding of where we are (or how we are doing) and what / where we need to improve	2 We are aware of the improvements that need to be made and have prioritised them, but are not yet able to demonstrate meaningful action.	3 We are developing plans and processes and can demonstrate progress with some of our key areas for improvement	4 We have well developed plans and processes can demonstrate sustainable improvement throughout the organisation / business	5 We can demonstrate sustained good practice and innovation that is shared throughout the organisation / business, and which others can learn from

LEGACY

HEALTH AND CARE STANDARD IMPROVEMENT PLAN 2023-24

Key RAG Rating		
At risk of not being achieved	On target to be achieved	Complete

Improvement Identified	Action Lead	Executive Lead	Priority	Completion Date	Progress	Completion update	
			High/Medium/ Low			RAG	If action at risk of not being completed by target date please provide reason
Governance Standard **Working towards self-assessment Score 5**							
Clinical Audit – review process for capturing learning and any associated improvement action ensuring there is a robust process for reporting both internally and externally	Clinical Audit Medical Lead	Director of Corporate Governance and Chief of Staff	High	Q4	On track – good progress being made with the Consent Audit process.		
Standard 1 Staying Healthy **Working towards self-assessment Score 4**							
Achieve Disability Confident accreditation	WOD SMTs	Executive Director of OD & Workforce	Medium	Q2	Trust has achieved level 2 Level 3 requires more work and alignment with the ED&I agenda Plan to progress to Level 3 2023/24		
Standard 2.1 Risk **Working towards self-assessment Score 4**							
Complete the implementation of revised incident and risk management processes.	Director of Corporate Governance & Chief of Staff	Director of Corporate Governance & Chief of Staff	Medium	Q4	Once for Wales Risk Management module to commence 2022/23. Update OfW Enterprise Risk Module is scheduled for release by April 2024 work is ongoing to pilot this in other organisations		
Review health and safety monitoring systems to ensure measures are in place to identify proactive and reactive indicators of compliance.	Assistant Director of Estates	Executive Director of Corporate Governance	Medium	Q4	H&S Board established to support management of H&S matters across the Trust.		
Standard: 2.2 Preventing Pressure and Tissue Damage – VCC ONLY **Working towards self-assessment Score 5**							

Improvement Identified	Action Lead	Executive Lead	Priority	Completion Date	Progress	Completion update	
			High/Medium/ Low			RAG	If action at risk of not being completed by target date please provide reason
Undertake a full review of all HCSW staff at Velindre Cancer Centre in relation to sign off and competency against HCSW Clinical Competency 18: Prevention & Management of Pressure Ulcers & ensure any competency / training deficits are addressed	Deputy Head of Nursing	Executive Director of Nursing, AHP's and Medical Scientists	Medium	Q4	Prevention & Management of Pressure Ulcers checked locally and through the all Wales group.		
Standard: 2.3 Falls Prevention – VCC ONLY Working towards self-assessment Score 5							
Fully transition from current paper version of Falls risk assessment documentation and care planning documentation to the electronic risk assessment and Care Planning in line with the Wales Nursing Care Record.	Deputy Head of Nursing	Executive Director of Nursing, AHP's and Medical Scientists	TBC	Q4	All Wales Falls care plan is not available digitally on WNC yet – once it is available we will move over to the digital format		
Undertake a call bell audit that includes call bell availability and time taken to respond	Deputy Head of Nursing	Executive Director of Nursing, AHP's and Medical Scientists	High	Q3	Monthly call bell audits are being undertaken. The Ward Manager reviews this information.		
Standard 2.4 Infection Prevention & Control & Decontamination Working towards self-assessment Score 5							
Review the Service Level Agreement with Public Health Wales Microbiology to formalise dedicated time for Consultant Microbiology ward rounds, and appoint to the 2 additional sessions which were funded during 2020	Senior Infection Control Nurse	Executive Director of Nursing, AHP's and Medical Scientists	High	Q3	Plan to meet with PHW again.		
Standard 2.5 Nutrition and Hydration – VCC ONLY Working towards self-assessment Score 5							
To ensure continued involvement in the National implementation for the pictorial menu and implement when approved	Head of dietetics and Deputy Operational Services Manager	Executive Director of Nursing, AHP's and Medical Scientists	Medium	Q4	Pictorial menus have been approved nationally but we are still in the implementation phase at VCC.		
Standard 2.6 Medicines Management – VCC ONLY Working towards self-assessment Score 5							
Review of the SACT prescribing passport and compliance of completion for new staff/new prescribers.	SACT SG	Medical Director	Low	Q4	The SACT Management of Prescribers procedure, which includes the requirement for new SACT prescribers to work according the SACT Prescribing Passport framework.		
Implementation of Q Pulse within the clinical pharmacy services.	Pharmacy	Medical Director	Low	Q3	Pharmacy considering whether to progress in light of new All Wales Technical Services business case for similar system being considered.		

Improvement Identified	Action Lead	Executive Lead	Priority	Completion Date	Progress	Completion update	
			High/Medium/ Low			RAG	If action at risk of not being completed by target date please provide reason
Formalise a process for the monitoring of SACT 'death's in 30 days'.	Clinical Director, Medical Lead for Mortality with support from Quality and Safety Manager	Medical Director	High	Q3	Pilot due to begin in the colorectal SST on the new process of reviewing death within 30 days SACT and rolled out to other SST's. This will be fed up via QSMG and QSP.		
Implement ChemoCare version 6 worksheet and labels module	Pharmacy	Medical Director	Low	Q4	The worksheet module is live and we're working towards switching all of the worksheets to the new module.		
Standard 2.7 Safeguarding Children and Adults at Risk Working towards self-assessment Score 5							
Ensure the Trust has robust plans in place to fully meet the requirements of the new Liberty Protection Safeguards as outlined in the Liberty Protection Safeguards Code of Practice (awaited)	Senior Nurse Safeguarding & Public Protection	Executive Director of Nursing, AHP's and Medical Scientists	Medium	Q4	Funding received and MCA training commissioned for registered practitioners until April 2023.		
To improve compliance with safeguarding training to achieve compliance of 95% or above across all relevant areas	Senior Nurse Safeguarding & Public Protection	Executive Director of Nursing, AHP's and Medical Scientists	Low	Q3	Work ongoing to improve training compliance in the divisions. Safeguarding dashboards developed to improve compliance monitoring		
Standard 2.8 Blood Management Working towards self-assessment Score 5							
VCC to purchase a Blood Trak system.	Head of WTAIL WBS/ VCC Head of Nursing WBS Chief Scientific Officer/ WBS Head of Collections	Chief Operating Officer	High	2022/23	Work remains ongoing as part of the Velindre Futures work stream.		
Introduce Haemoglobin S testing for units issued for neonatal use Consider introduction of Haemoglobin S testing for exchange transfusions and 'top up' transfusions for sickle cell patients	Kalinga Perera/ Georgia Stephens	Chief Operating Officer	Low	2022/23	Implementation was re-evaluated and procurement paused. Project timelines being reviewed alongside ongoing and upcoming priorities. Estimated procurement exercise in Q3 2023/24.		
Standard 2.9 Medical Devices, Equipment and Diagnostic Systems Working towards self-assessment Score 5							
Implement a robust divisional procedure for the procurement of medical devices and medical equipment, that underpins the Trust policy and ensure that department processes are implemented to support these. This element is not specified within the criteria for the standard but is a fundamental part of the overall standard statement, we have developed	Medical Devices Officer	Chief Operating Officer	Medium	Q3	Awaiting Procurement feedback.		

procedure and flowcharts and once feedback is provided by procurement we will be in a position to fully develop the divisional procedure							
Working towards implementation QMS and procedures put in place to meet in-house manufacturing and its use requirements as will be defined by MHRA going forward.	Head of Medical Physics	Chief Operating Officer	Medium	Q4 2023	Development of the new QMS system (ISO 13485) for in house manufacturing of Medical Devices. Resource intensive but on track for the anticipated MDR Q4 2023.		
Continue implementing the equipment database, ensuring its consistency and then the rollout to department leads and other divisions.	Medical Devices Officer	Chief Operating Officer	Medium	Q3	VPN token for remote access will be in place soon.		
Standard 3.1 Safe and Clinically Effective Care Working towards self-assessment Score 4							
Trust to develop clear systems and processes for assessing, monitoring and providing assurance reporting from divisional level to Board in respect of new / revised guidelines e.g NICE as part of its Quality & Safety Framework	Executive Medical Director & Executive Director Nursing, AHP and HCS	Executive Director Nursing, AHP & HCS	Medium	Q2	Work delayed due to pandemic.		
Both Divisions to ensure there are robust mechanisms in place for monitoring compliance of and escalation of non-compliance in respect of national clinical and benchmarked standards	Medical Director WBS (Edwin Massey) and Clinical Director VCC	Executive Director Nursing, AHP & HCS	Medium	Dec 2022	WBS status- complete Non-compliance is identified, reported and monitored as previously stated.	WBS complete VCC status to be confirmed	
All clinical services to define 'what good looks like' in respect of their services, and agree clear outcome KPIs aligned to these and agree benchmarking / peer review opportunities	Medical Director WBS (Edwin Massey) and Clinical Director VCC	Executive Director Nursing, AHP & HCS	Medium	Q3	WBS - Non-compliance is identified, reported and monitored as previously stated	VCC status to be confirmed	
Trusts audit plan to contain assurance audits in relation to agreed actions arising from critical incidents and complaints as assurance that agreed actions / improvement work has taken place	Medical Director WBS (Edwin Massey) and Clinical Director VCC	Executive Director Nursing, AHP & HCS	Medium	Nov 2022	Local assurance monitoring will be via the WBS Quality Hub (currently RAGG). WBS audit plan covers incidents and complaints management.	WBS complete VCC status to be confirmed	
Standard: 3.2 Effective Communication Working towards self-assessment Score 4							
Approve a new VUNHST communications and engagement strategy	Assistant Director Communications	Executive Director of Corporate Governance Executive Director of OD & Workforce	Medium	Q2	The Comms and Engagement strategy, whilst having been approved by the EMB and SLTs wasn't considered by strategy committee or the Trust Board.		
Continuous rollout of Interpreter on Wheels service for interpreter needs. Currently have 3 mobile units but ability to download service to additional devices. Currently used throughout VCC, but to be expanded to satellite sites and WBS clinics. Training on using the systems to be provided by Equality manager.	Equality & Diversity Manager	Executive Director of Nursing, AHP's and Medical Scientists	Medium	Q4	The interpreter on wheels device is a stand- alone device used throughout the Cancer centre.		

Looking at IT systems across the Trust, ensure staff are collecting language choice and recording it as part of the need to provide the 'Active offer' – secure KPI's around collection of Welsh language and new WPAS system (VCC) as an example.	Welsh Language Manager	Executive Director of Corporate Governance Executive Director of OD & Workforce	Medium	Q4	The system is taking a long time to embed therefore this action is still live.		
Standard 3.3 Quality Improvement, Research and Innovation Working towards self-assessment Score 5							
Subsequent to the review of current Trust R&D processes with a view to integration of Innovation requirements, develop and incorporate identified improvements into Trust RD&I, e.g. introduce a quality manual. **Carried forward from 2020/21**	RD&I (VCC)	Medical Director	Low	Q4	This work is an ongoing improvement of the RD&I Division's service.		
Develop a RD&I training programme for Trust staff members, and work with other organisations to provide training opportunities, so that staff: - Understand the role of Trust RD&I in the organisation and the context of NHS research - Understand what managing NHS research entails, including roles and responsibilities, capacity and capability, safety, finance and contracts - Understand how quality research is developed, designed, set-up and carried out - Understand the oversight required for NHS research	RD&I (VCC)	Medical Director	Low	Q4	Continue the work to develop and implement a R&D/Trials training programme.		
Review the administrative structure, roles and responsibilities of the research delivery team and make recommendations for improvement	RD&I (VCC)	Medical Director	Low	Q4	This work is an ongoing improvement of the RD&I Division's service.		
Develop business intelligence to support the expression of interest/feasibility and set-up and delivery processes	RD&I (VCC)	Medical Director	Low	Q4	This work is an ongoing improvement of the RD&I Division's service.		
Standard 3.4 Information Governance & Communications Technology Working towards self-assessment Score 5							
Trust / WBS / VCC: New Digital Strategy 2020 – 2025	Chief Digital Officer	Director of Strategic Transformation Planning & Digital	Medium	Q4	Under development		
Standard 3.5 Record Keeping Working towards self-assessment Score 4							
Implementation of the Digital Health Record and the Welsh Patient Administration System.	Chief Digital Officer	Director of Strategic Transform ation, Planning and Digital	Medium	Q1 2022/23	Project in place to progress delivery of the DH&CR and WPAS.		

Strategy for the management of the paper medical record.	Health Records Manager	Executive Director of Finance	Medium	Q4	On target for strategy development.		
Standard 4.1 Dignified Care Working towards self-assessment Score 4							
Standard 4.2 Patient Information Working towards self-assessment Score 4							
Standard: 5.1 Timely Care Working towards self-assessment Score 4							
Develop plans for increasing ambulatory care provision	Dr Hilary Williams Consultant Oncologist	Chief Operating Officer	High	Q3	Welsh Government, to improve and extend the ambulatory care provision at VCC is progressing well and on track to deliver all Civica objectives.		
Implement VCC specific measures in support of the systemic implementation of the Single Cancer Pathway	Wayne Jenkins Head of Planning and Performance	Chief Operating Officer	Low	Q2	Being taken forward by Velindre Futures.		
Standard 6.1: Planning Care to Promote Independence Working towards self-assessment Score 4							
Standard 6.2: People Rights Working towards self-assessment Score 4							
Standard 6.3: Listening and Learning from Feedback Working towards self-assessment Score 4							
Standard 7 Staff and Resources Working towards self-assessment Score 4							
Focused action plan for PADR completion – focus on areas of poor PADR completion	Workforce team	Executive Director of OD & Workforce	High	2022/23	Hotspot work ongoing to improve PADR compliance. This will be ongoing to 23/34		
Planned and Sustained Workforce							
Utilising the delegation framework commence a project in VCC to develop the HCSW role maximising opportunities for this role	Workforce team	Executive Director of OD & Workforce	Medium	Q4	Development of HCSW roles in VCC to enhance skills in training. Working with MDT teams to understand how the role can be utilising and extended in workforce plans		

Quality, Safety & Performance Committee

VELINDRE UNIVERSITY NHS TRUST VACCINATION PROGRAMME BOARD UPDATE

DATE OF MEETING	16th May 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, Allied Health Professionals and Health Science
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science

REPORT PURPOSE	For Noting

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Trust Vaccination Programme Board	24/01/2023	Items for discussion agreed
Executive Management Board	02/03/2023	APPROVED

ACRONYMS	
WIS	Welsh Immunisation System
JCVI	Joint Committee on Vaccination & Immunisation
DHCW	Digital Health & Care Wales

1. SITUATION

This paper is to provide the Quality, Safety & Performance Committee with an update in relation to the Trust's Autumn 2022 Influenza and COVID vaccination programmes and to advise of the Executive Management Boards decision to cease providing COVID booster vaccines for the 2023 COVID-19 booster programme.

2. BACKGROUND

Prior to the pandemic the Trust provided annual influenza vaccines to eligible staff. As part of the national public health agenda Velindre University NHS Trust provided COVID-19 vaccinations / boosters to its staff in line with JCVI eligibility criteria. During Autumn 2021:

- 1,418 staff (83%) received a COVID-19 vaccination, 1,250 of which were via the Trust.
- 1,214 staff (71%) received an Influenza vaccination via the Trust.

During Autumn 2022 due to the Velindre instance of the Welsh Immunisation System (WIS) not being updated, the Trust was unable to administer COVID-19 booster vaccinations to its eligible staff. These were provided in line with the rest of the population through employees respective Health Boards in line with eligibility criteria and timescales. During Autumn 2022:

- 955 staff (58%) received a COVID-19 vaccination; however it is important to note that this figure is potentially inaccurate, as this relates to staff members in WIS with an employing organisation of Velindre and is therefore reliant on up to date / complete information.
- 917 staff (56%) Trust-wide received an Influenza vaccination via the Trust. This does not include students and non-ESR / bank staff.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Resolution of Velindre instance of the Welsh Immunisation System (WIS)

There is currently no resolution anticipated for the Velindre instance of WIS, however the development of a single instance for Wales continues, with management of the Autumn 2023 booster campaign expected through the NHS Wales Delivery Unit (not DHCW).

3.2 Funding

It has been advised that ongoing national funding for the provision of COVID-19 vaccinations by the Trust will not continue.

3.3 Proposal re future COVID Booster Programmes

Following initial discussions with staff involved in the delivery of the Autumn 2021 (dual) campaign, it has been recognised that the operational management of a vaccination programme is adding significant burden to staff in areas where there are already capacity and demand gaps and is therefore very onerous, adding a significant amount of additional work to an already overstretched service. Additionally, ongoing vaccination funding will not be available to cover staff costs, as there is no dedicated vaccine team and a direct response is still awaited relating to the Trust's readiness to support the administration of

COVID-19 vaccinations from a digital point of view (WIS system access). If COVID-19 Boosters were to be continued at Velindre University NHS Trust for its employees, weekend vaccine clinics would be required, expecting many staff to come into Velindre during their days off and it is anticipated that uptake would be low given the stage we are at with the pandemic.

A proposal was presented to the Executive Management Board in April 2023 that due to the above reasons (Smooth Health Board COVID-19 vaccination process for staff, resource & logistical constraints, digital showstoppers and no onward COVID vaccination funding) that staff should continue to receive future COVID-19 booster vaccinations via their respective Health Boards. Health Boards are anticipating providing these to Velindre employees. It was also proposed that as Health Boards are not responsible for providing Velindre employees with their influenza vaccinations that these will continue to be offered by the Trust as previously, as this can be delivered quickly and swiftly as part of the working week (small vaccine trained staff input will be required over a two-week window). This proposal was approved by the Executive Management Board.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes
	The vaccination programme has a positive impact on Quality & Safety
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 – if Velindre to recommence administering COVID Booster vaccinations

3 RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **NOTE** the outcome of the Trust's Autumn 2022 Influenza vaccination programme and the Autumn 2022 COVID-19 vaccination status of Trust staff and that moving forward Velindre University NHS Trust employees will receive their COVID-19 vaccinations via their local Health Boards.

QUALITY, SAFETY & PERFORMANCE COMMITTEE

PATIENT NOSOCOMIAL COVID-19 UPDATE

DATE OF MEETING	16th May 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	N/A
PREPARED BY	Nigel Downes, Interim 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	30/06/22 - 17/03/2023	Cases discussed and next steps agreed
Executive Management Board	03/04/2023	POSITION NOTED

1. SITUATION

This paper is to provide the Quality, Safety & Performance Committee with progress in respect of patient nosocomial COVID-19 reviews. The Quality, Safety & Performance Committee is asked to **NOTE** the position in relation to patient nosocomial COVID-19 reviews and next steps in relation to this and the NHS Wales National Nosocomial COVID-19 Programme Interim Learning Report.

2. BACKGROUND

The Trust is part of the National Nosocomial Programme Board and is implementing the national requirements in relation to patient Nosocomial COVID-19 reviews in line with the NHS Wales National Framework for the Management of Patient Safety Incidents following Nosocomial Transmission of COVID-19, published in March 2021.

The following is the agreed Trust wide nosocomial investigation / review process.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Current position in relation to patient Nosocomial COVID-19 reviews:

As of 17th March 2023, there have been 49 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. 27 incidents occurred up to the 30th April 2022 and the remaining 21 incidents (49 in total) occurred between the 1st May 2022 and 17th March 2023.

The Peer Review Panel has held 13 meetings and the Executive Nosocomial Panel has met on 7 occasions.

48 of the 49 cases have been reviewed. There is one new case which is going through the review process.

A summary of the status of all patient COVID-19 nosocomial investigations, as of 17th March 2023:

	No Harm	Low Harm	Moderate Harm	Severe Harm	Death	TOTAL
Indeterminate 3-7 days of admission	**10**	**3**	**0**	**0**	**2**	**15**
Probable 8-14 days of admission	**12**	**0**	**1**	**0**	**5**	**18**
Actual > 14 days of admission	**10**	**2**	**1**	**0**	**2**	**15**
TOTAL	**32**	**5**	**2**	**0**	**9**	**48**

The specific outcomes of nineteen cases have been previously reported. A summary of the remaining twenty-nine more recently approved cases was provided to the Executive Management Board in April 2023 and are available from the Interim Deputy Director of Nursing, Quality and Patient experience if required.

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 referral to Legal and Risk Services for consideration under Putting Things Right.
11 of the cases are being referred to Legal and Risk Services for Putting Things Right advice as per agreed national requirements.

3.2 Patient / Family Contact

Patient and family contact will take place on a case-by-case basis. The Executive Nosocomial Panel has considered patient / family contact for each case and has used 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. Contact will be made for all probable and actual involving moderate harm or greater.

The patients / families of all cases of nosocomial COVID acquired in the last year 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, Quality and Patient Experience and a follow up letter sent within a few days of the call from the Executive Director Nursing, AHP & Health Science using agreed template that will also be personalised.

4. NEXT STEPS

The plan outlined in the last Nosocomial Programme Board paper, reviewed in Executive Management Board on 2nd March 2023, was for the 48 nosocomial COVID-19 cases to be reviewed and completed by the Scrutiny Panel and Executive Nosocomial Panel, and that has been successfully completed. A further nosocomial case has occurred over recent weeks, which will need to be reviewed by the Scrutiny Panel and the Executive Nosocomial Panel.

As previously reported, in all likelihood, further nosocomial COVID-19 cases will continue to occur at the Trust, and these cases will be reviewed using the same methodology and process in the future.

The next steps are for the Trust to await the advice from Legal & Risk and take forward the required action and to make all the required patient / family contacts.

5. NHS WALES – INTERIM LEARNING REPORT: NATIONAL NOSOCOMIAL COVID-19 PROGRAMME (MARCH 2023)

The NHS Wales – Interim Learning Report: National Nosocomial COVID-19 Programme (March 2023) document is for noting in Appendix 1.

Thus far, the learning themes (Section 5 of the document) from the Nosocomial COVID- 19 investigation process include:

- Bereavement support and care-after-death services
- Supporting service users during an investigation process
- Visiting restrictions
- Identification, reporting and investigation of Health Care Acquired Infections (HCAIs) as a Patient safety incident
- The application of Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) decisions
- Infection Prevention & Control – roll out of guidance
- Infection Prevention & Control – Outbreak management.

6. 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	Equality will be considered as part of the patient / family follow up
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.

7. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to NOTE the position in relation to patient nosocomial COVID-19 reviews, the next steps and the NHS Wales – Interim Learning Report: National Nosocomial COVID-19 Programme (March 2023).

Interim Learning Report

National Nosocomial COVID-19 Programme

March 2023

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Bwrdd Iechyd Prifysgol Cardiff and Vale University Health Board

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Bwrdd Iechyd Prifysgol Bae Abertawe Swansea Bay University Health Board

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Bwrdd Iechyd Addysgu Powys Powys Teaching Health Board

Ymddiriedolaeth GIG Prifysgol Felindre Velindre University NHS Trust

Contents

The glossary of terms in section 8.2 provides more information on some of the terms used.

1. Introduction

The National Nosocomial COVID-19 Programme (NNCP) wishes to extend its sincere condolences to those who lost loved ones after acquiring COVID-19 in healthcare settings. It has without a doubt been an extremely difficult time for many families, carers and staff alike and the impact cannot be underestimated.

The purpose of the Interim Learning Report is to outline the early learning that has emerged as a result of the nosocomial investigations and the wider programme of work.

It is important to recognise that the programme is not a nationally led investigation into nosocomial (hospital-acquired) COVID-19 in Wales, nor does it seek to detract from the role of the UK COVID-19 Inquiry. The NNCP has been established to support NHS Wales organisations undertake their duty to investigate patient safety incidents in a proportionate way - whilst reflecting the complexities of COVID-19 which caused unusually high numbers of incidents.

2. Background

In response to the pandemic, NHS Wales rapidly adapted and altered its operational focus to minimise the harmful impact of COVID-19 as far as possible, at a time of high levels of uncertainty and anxiety. It is widely acknowledged that NHS staff worked tirelessly through the most challenging period in the history of the NHS to maintain high standards of clinical care and minimise risk to patients. Despite best efforts, the requirement for the NHS to shift operational focus to respond to the pandemic severely disrupted routine healthcare activity.

On an international level, COVID-19 was a new and unpredictable infection of which little was known, beyond the fact it posed a serious threat to global population health. Whilst infection prevention and control (IP&C) measures are routine practice for the NHS, the spread of COVID-19 in healthcare settings proved challenging, particularly at times when community prevalence was high, and hospitals had significantly high levels of patient complexity, demand and occupancy.

The scale of the pandemic meant that, despite being in a healthcare environment, patients in hospitals and other in-patient settings inevitably faced an increased risk of contracting nosocomial COVID-19. Whilst Health Care Acquired Infections (HCAIs) - now including COVID-19 - are a recognised risk in healthcare settings, learning and developing our understanding of how to investigate such matters of patient safety is important to help inform IP&C design and implementation.

3. What is the National Nosocomial COVID-19 Programme?

The NNCP was established in April 2022 to support NHS Wales organisations to conduct proportionate investigations into patient safety incidents of nosocomial COVID-19, which occurred between March 2020 and April 2022. It is a collective membership of all NHS organisations across Wales, working together to implement as consistent an approach as feasible, to investigate nosocomial patient safety incidents.

Beyond the commitment by NHS Wales to investigate and answer as many questions as possible, the programme also provides a timely opportunity to consider how NHS Wales manages and undertakes patient safety investigations; particularly how service users, families and carers are supported and engaged in the process.

All NHS Wales organisations have a duty to manage and proportionately investigate patient safety incidents in line with the NHS Wales The Duty of Candour Procedure (Wales) Regulations 2023 (the Regulations).

Patient safety incidents are any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS-funded care. HCAIs, including COVID-19, will in certain circumstances be considered a patient safety incident, depending on how and when the infection was acquired.

To assist NHS organisations investigating patient safety incidents of nosocomial COVID-19, a National Framework for the *Management of Patient Safety Incidents following Nosocomial Transmission of COVID-19* was developed, to ensure as consistent an approach as feasible was followed and investigations were done once and done well. To date, the framework has supported NHS Wales organisations to assess and investigate over 5,000 cases of nosocomial COVID-19 where they met the definition of a patient safety incident.

Acknowledging the impact of COVID-19 on service users, families, carers and NHS Wales staff, the programme has adopted a learning approach that seeks not to place blame but maximise the opportunity for learning and improvement.

4. How has learning been identified?

As organisations work hard to progress the completion of their patient safety investigations at pace, learning is identified through various quantitative and qualitative methods including investigation findings, the experiences of people (service users, families, carers and NHS Wales staff), incidental findings, and through collaboration with internal and external partners. Learning has also emerged through organisational scrutiny panels, which are conducted independently of investigations.

Combined learning from across organisations is collated into national themes to further support the identification of areas for improvement in the quality and safety of services, enhancing provision and people experience.

Learning sources include:

- Set-up of the programme including preparatory work
- Test sample audit and subsequent impact assessment
- Investigations
- People's experiences (Service users, families, carers and NHS staff)
- Wider feedback and stakeholder engagement

Acknowledging that listening to and learning from people's experiences is integral to learning for the programme, a *Capturing Experience Through the National Nosocomial COVID-19 Programme* plan has been developed to further support and enhance people's voices in the process, particularly during the second year of the programme.

5. What are the learning themes so far?

The below sections identify the learning themes which have emerged through the first year of the programme and have been categorised as follows:

People's experiences

- Bereavement support and care-after-death services
- Supporting the service user during the investigation process
- Visiting restrictions

Patient safety incidents and concerns

- Patient safety incidents outside of NHS Wales hospitals
- Identification, reporting and investigation of Health Care Acquired Infections (HCAIs) as a patient safety incident
- Application of Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) decisions

National infection prevention and control guidance

- Roll out of guidance
- Outbreak management

5.1 People's experiences

5.1.1 Bereavement support and care-after-death services

Access to high-quality bereavement and care-after-death support services can be extremely helpful in managing grief. When the NNCP programme was established, consideration was made about how service users - particularly the bereaved - would be supported. It has been identified that there is a differentiation in pathways for signposting, referring and accessing bereavement support services across NHS organisations. Some NHS Wales organisations did not have dedicated services that offered support following a bereavement.

To help reduce variation in accessing bereavement support, a *National Framework for the Delivery of Bereavement Care* was launched in 2021. The framework highlighted the need for a consistent and equitable approach across Wales for accessing bereavement support. This has resulted in organisations now having a dedicated bereavement support service.

NHS Wales recognised that support should be available for all families contacted as part of the programme and worked collaboratively with Health Boards and Trusts to ensure bereavement support arrangements were in place for bereaved families when contacted. Learning has identified that this came too late for some families connected with the programme, and that the bereavement process for some families has been adversely impacted.

Good practice
The Development of the *National Framework for the Delivery of Bereavement Care* launched in 2021 has assisted in setting a standard of expectation to be implemented within all organisations for the provision of a bereavement support service. Organisations have worked hard to implement this requirement.

Key learning
Bereavement support services should be proactively made available to all families, particularly for those where there may be a link with an associated patient safety incident.

Families should be proactively signposted to information about bereavement services at the earliest opportunity.

5.1.2 Supporting service users during an investigation process

Navigating and understanding the concerns process and knowing who to contact when people have a question is sometimes the difference between understanding and trusting the process, or dissatisfaction and lack of trust. In equal measure, listening to the experience of service users, families and carers is a fundamental principle of good concerns management, and key to ensuring learning opportunities are maximised.

Through contacting patients and their families impacted by the patient safety investigations, feedback emerged that patients and families found it confusing knowing how and who to contact to discuss a concern or seek clarification on the progress of their case.

To improve this experience, organisations established a dedicated five-day single point of access for service users, families and carers, when managing a concern.

Good practice
To ensure this principle was facilitated for service users, families and carers, a set of minimum standards were established by the NNCP for how services should engage the public. The provision supports a coordinated approach to handling queries about nosocomial COVID-19, with ease of access to address additional queries or broader concerns regarding nosocomial COVID-19.

Key learning
Every service user, family and carer should have timely access to a dedicated and easy-to-access single point of contact to provide feedback, and raise questions, concerns or queries. This is particularly key for patients and families involved in the concerns process.

Supporting information should be available and easily accessible to assist families in understanding the sometimes-complicated language linked to the concerns process.

5.1.3 Visiting restrictions

Visitors play an important part in a patient's recovery, with evidence continually highlighting the role visitors have on positive outcomes such as shorter stays and faster recovery times for patients. It is recognised that families and carers are often best placed to observe deterioration and identify a loved one's needs.

Visiting restrictions can be a tool used in response to infectious outbreaks in healthcare settings. Restrictions during COVID-19 were introduced to help reduce transmission from community settings into hospital environments, and particularly to minimise the risk for vulnerable patient groups.

The programme identified, through service user, family and carer feedback, that visiting restrictions had many adverse effects on the physical and mental health of patients - especially those in the vulnerable groups that the restrictions were intended to safeguard, many of whom were not able to fully understand the decisions made. The limited alternative opportunities for making contact and communicating with loved ones, also negatively impacted the experience for many other service users, families and carers.

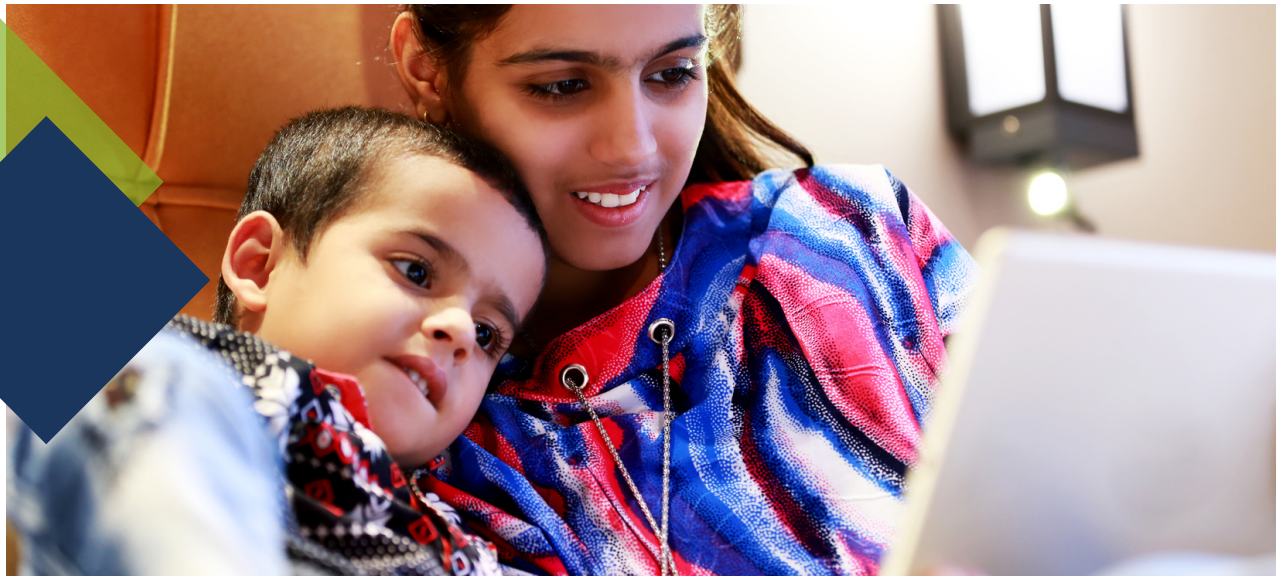
Investigations highlighted that families often relied on clinical teams and ward staff to connect with their loved ones. Whilst this communication in the main has been highlighted as positive, there are instances where communication was below the expected standards, especially the inability to make contact during busy periods.

Good practice
Organisations developed many innovative ways to minimise the impact of the visiting restrictions. These included examples such as virtual visiting via tablet devices, outdoor visiting and utilising ward-based patient support teams to bridge the gap.

Volunteers also played a key role in bridging the gap, particularly later in the pandemic. Many organisations have continued to strengthen these services and enhanced staff training.

Key learning
All services and wards should have named dedicated patient support teams and volunteers to support service users, families and carers who may be finding it difficult to visit a loved one in hospital.

Future visiting guidance should pay particular reference to the role carers have as an important part of a patient's care team.



5.2 Patient safety incidents and concerns

5.2.1 Patient safety incidents outside of NHS Wales hospitals

Patients often receive NHS-funded care in other settings, for example, their own homes, care homes, and facilities outside of Wales. Whilst NHS Wales organisations, under the duty of candour, have a responsibility to ensure any patient safety incidents that occur to their local population are reported to them, the requirement to undertake investigations can alter.

In applying the *National Framework for the Management of Patient Safety Incidents Following Nosocomial Transmission of COVID-19*, it has been identified that how the Regulations are applied in different parts of the health and social care system, as well as other sectors such as independent providers (private and public service), is variable and confusing.

Learning has identified that whilst the Regulations require an investigation for concerns relating to the transmission of COVID-19 during NHS-funded healthcare, there are a number of differences when care has been provided by a non-NHS organisation. For example, who undertakes the investigation, how the investigation is progressed, the requirement to compensate and how NHS Wales organisations who fund the care are notified.

The programme identified that the Regulations create variability and inequity for service users, families and carers who receive NHS-funded healthcare via another provider when a concern is raised. On this basis of the Regulations, the current programme does not extend to investigating all instances of nosocomial COVID-19 which occurred through an independent provider setting under NHS-funded care, including care homes.

Evidence from the experience of service users, families and carers connected to the programme to date, suggests they are not routinely informed of these differences.

Good practice
The learning from applying the *National Framework for the Management of Patient Safety Incidents following Nosocomial Transmission of COVID-19* has been shared with social care colleagues. A good practice guide is being developed for non-NHS support services in other sectors to apply a more consistent and standardised approach to concerns in social care and care home settings.

Key learning
All policies and procedures relating to the management of patient safety incidents which occur during NHS-funded care should set expectations of the standards required across all care settings to minimise confusion for service users, families and carers who may be receiving care across multiple complex care pathways.

5.2.2 Identification, reporting and investigation of Health Care Acquired Infections (HCAIs) as a patient safety incident

Learning from patient safety incidents is an important element to improve quality of care, and continually learn how to minimise the impact of HCAIs and the impact on patients.

Beyond the management of nosocomial COVID-19 as a patient safety incident, learning has identified that current arrangements within NHS Wales for the identification, reporting and investigation of all HCAIs that meet the definition of a patient safety incident are variable.

The programme also identified inconsistent approaches to the management and reporting of HCAIs across Wales and variations in the methodology used to investigate such incidents. It has also been established that the use of surveillance definitions in NHS Wales does not automatically indicate that a patient safety incident has occurred.

Good practice
As a result of this learning, the National Policy on patient safety incident reporting has been updated to reflect new national reporting requirements for HCAIs, including the reporting of nosocomial COVID-19.

Key learning
All health-acquired infections need to be assessed against the requirement to report as a patient safety incident, in line with national incident policy, and a proportionate patient safety investigation needs to be initiated.

5.2.3 The application of Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) decisions

DNACPR is designed to protect people from unnecessary suffering by receiving resuscitation that they do not want, that will not work, or where the harm outweighs the benefits. It is a key enabler in the promotion of a dignified death.

A common theme in the concerns raised by families and carers during the early part of the programme was the application of DNACPR decisions for patients who acquired COVID-19. Some of the themes in the concerns related to a view that there was a 'blanket approach' to applying the decision when somebody was diagnosed with COVID-19, and a lack of knowledge or consultation in the process of applying the decision.

Findings from investigations and other sources such as the Medical Examiners Service and mortality reviews have identified that there was a:

- Need to improve the description of patient's co-morbidities and their impact on the reason for a DNACPR being enacted
- Need to improve communication, especially around the rationale for DNACPR implementation and discussions with patients, families and carers
- Need to improve documentation related to discussions with patients, families and carers
- Need to improve the DNACPR document, particularly whether a decision should be reviewed if a patient's condition improves

Whilst a DNACPR decision does not strictly require consent from a next of kin or carer before application, unless the patient lacks capacity, learning from the investigations has recognised the importance of such communication, and the impact the management of this sensitive subject can have when managed well, and in these instances, not so well.

The analysis did not identify evidence or trends that DNACPR decisions had been placed inappropriately, or not in keeping with the current All Wales DNACPR Policy.

Good practice
There is an NHS Wales Strategic Advance & Future Care Planning group that includes representatives from NHS organisations. The group has agreed to strengthen the section in the policy relating to appropriate and timely communication with patients and families. This is seen as an important step to support clinicians to move beyond the formal process of DNACPR, providing helpful guidance and support in how, when and with whom to communicate to ensure understanding, and minimise upset.

Key learning
Service users, families and carers place great value on good communication around the DNACPR process and need to be involved as much as possible in the decision-making process.

Continued development and roll-out of an electronic advanced care planning document, is also seen as key to improvements which would support clinicians during the process and alleviate some of the potential issues around DNACPR documentation and broader communication.

5.3 Infection Prevention and Control

5.3.1 Roll out of guidance

National policy and guidance on IP&C are essential elements in supporting healthcare organisations to develop and implement local strategies which help to reduce the risk of infections. In response to the pandemic, the UK infection prevention and control guidance was co-produced across the UK's four nations and was published by the UK Health Security Agency (previously Public Health England).

Due to the need to respond rapidly to the significant population health risk that COVID-19 posed, guidance updates were published frequently, at short notice and often out of normal business hours. The rapid increase in the prevalence of COVID-19 and the high demand on health and social care, in addition to the emergence of new evidence, made it necessary to update guidance on an almost weekly basis, sometimes more frequently.

NHS Wales staff experience has shown that the frequency in which the guidance was updated, created challenges for already stretched IP&C teams, who are responsible for leading the necessary changes for all HCAIs across often large and complex organisations. Naturally, it can take time to assess and disseminate guidance which requires organisations to make significant adjustments to care delivery. For example, changes to care pathways, guidance on PPE (personal protective equipment), and testing processes.

The expectation that guidance should be implemented immediately, once published, was a significant challenge during the pandemic, particularly given the level of resources required to ensure training, communication and application across large workforce numbers and settings. It is worth noting that IP&C workforces responsible for COVID-19, also retained existing duties relating to other IP&C issues which continued throughout the pandemic. The implementation impacted staff who worked shifts and or were off sick, making it difficult to keep pace with changes in guidance that related to their practice.

Whilst acknowledging updates to IP&C policy are critical, the NHS in Wales should consider how updates are distributed and communicated when an evidence base is rapidly evolving in a future major incident scenario.

Good practice
Organisations developed extraordinary systems to respond to the rapid increase in the prevalence of COVID-19 and the high demand on health and social care. In addition, due to the emergence of new evidence, they also had systems in place to respond at pace to updating the necessary guidance on an almost weekly basis.

Key learning
NHS Wales organisations are encouraged to continue exploring and implementing digital communication methods that support timely and engaging communication with colleagues on updates to guidance.

5.3.2 Outbreak management

Testing can be an important mechanism in the identification and prevention of infectious diseases, including COVID-19. Access to appropriate testing and the timely turnaround of test results are crucial to mitigating and preventing the onward spread of infectious diseases.

Increased demand for COVID-19 testing during the pandemic posed a significant challenge to the existing testing infrastructure, which still had to manage routine provisions such as blood tests for in-patients. Demand exceeding capacity and the inability to test rapidly for COVID-19 during periods of 2020, meant that testing was somewhat ineffective as a mechanism for reducing infections, until the supply of consumables met demand and testing capacity increased.

Due to the testing capacity challenges early in the pandemic, service users were discharged into other care settings or their own homes without the ability to rapidly test for COVID-19. This was in line with national guidance at the time, which did not advise that negative tests were required before transfer/admission into residential settings.

Further UK guidance, especially early in the pandemic, actively encouraged the discharge of patients from hospitals into care home settings, to free up hospital capacity in order to manage the anticipated demand for services.

Whilst a testing strategy produced by Welsh Government was launched on 15th July 2020, significant challenges in applying the policy existed due to limited access to the volume of consumable items required to undertake tests, and laboratory capacity to manage the extreme demand. Additional capacity beyond the existing infrastructure was achieved with the launch of the lighthouse laboratory (IP5), towards the end of August 2020, this meant it became easier and quicker to test patients and staff for COVID-19.

As well as testing, isolation plays an important part in preventing and controlling the spread of infections, especially in healthcare settings. Timely testing, along with the ability to isolate suspected or positive patients can aid in preventing onward transmission. It is important to note that isolation is one of several control measures and must be used in conjunction with other measures to be effective.

It should also be noted that isolation for infection purposes brings additional risks to service users with other care needs, particularly for older and vulnerable people, such as falls. Decisions to isolate patients for infectious purposes, even when isolation is available, should be considered in a holistic risk-balanced way that does not introduce the risk of additional harm.

An aged estate and limited isolation facilities (such as access to single rooms) meant that patients were often unable to be isolated in single rooms, and co-horting was established to maintain operational flow through hospitals during extreme demand. The inability to isolate patients often meant that, in an attempt to reduce spread of infections, service users were subjected to multiple ward movements.

In line with UK guidance, the introduction of designated care pathways, which tried to prevent onward transmission (as far as reasonably practicable), played a significant part in multiple ward movements - especially in older estates.

Experience from families and carers found that they were often not informed of these movements, which resulted in additional communication difficulties when seeking updates.

Good practice
Organisations rapidly implemented increased point-of-care testing (POCT) to support clinical care delivery and assist in more timely diagnosis and clinical decision-making. This supported improved daily epidemic control by reducing patient movements and achieving early detection for treatment plans to be put in place which assisted in the safe timely transfer and discharge of patients into alternative care settings where necessary.

Key learning
Policies and procedures should reflect mechanisms that result in limiting the number of patient moves, ensuring patients are in the right place at the right time.

Where patients are moved, families should receive proactive and timely communication on the location and rationale for the move.

6. Looking forward

The NNCP will be working with NHS Wales organisations to further share and embed learning in the second year of the programme.

In addition to progressing the learning on the subjects listed in this report, the programme will continue to identify and explore new and emerging topics. The below list represents topics which are currently emerging and will be reported upon further in the final report:

- Staff experience to help further inform learning themes
- Service user experience of the NNCP to date
- Healthcare environments (estates and ventilation in relation to IP&C)
- Consideration of safeguarding in the emergency response to COVID-19
- Discharge planning

7. Closing remarks

Thank you to the NHS Wales staff who are delivering the programme, and for the valuable feedback from service users, families and carers, through whom we are identifying many areas for improvement. The wealth of positive feedback and areas of good practice are equally as valuable in demonstrating positions we should continue to take and develop.

Some of the content in this report may be upsetting for many. However, it is imperative that this programme offers transparent insights that will lead to meaningful change. Please be conscious of NHS Wales staff, service users, families and carers who are involved in this programme when discussing findings.

The extent of the work that still lies ahead should not be underestimated. The NNCP will continue to identify learning in the second year of the programme, with a view to sharing findings in Spring 2024.

8. Additional information

8.1 Accessing support

People involved in the programme are encouraged to reach out to their designated Health Board/Trust contact if they feel like they need a conversation about some of the findings. Mental health and wellbeing support can be accessed 24/7 via the CALL Mental Health Listening Line, call 0800132737 or text “help” to 81066.

A number of organisations that provide bereavement support can be found on the Health Education and Improvement Wales website.

Access to mental health and wellbeing support for NHS Wales staff is available through wellbeing services and occupational health in each Health Board/Trust in the first instance. Additional mental health and wellbeing support can be accessed through the CALL Mental Health Listening Line.

Media requests should be directed via the typical channels.

Aneurin Bevan University Health Board	Call: 0300 373 0652 Email: abb.covidinvestigationteam@wales.nhs.uk
Betsi Cadwaladr University Health Board	Call: 03000 846992 Email: BCU.HCAICovid19@wales.nhs.uk
Cwm Taf Morgannwg University Health Board	Call: 01443 443084 Email: CTM.NosocomialCV19@wales.nhs.uk
Cardiff and Vale University Health Board	Call: 02921 836407 Email: Cav.Covidsupport@wales.nhs.uk
Hywel Dda University Health Board	Call: 0300 303 8322 Email: covidenquiries.hdd@wales.nhs.uk
Swansea Bay University Health Board	Call: 01639 684440 Email: SBU.NosocomialReviewTeam@wales.nhs.uk
Powys Teaching Health Board	Call: 01874 442918 Email: PTHBNosocomialReviewTeam@wales.nhs.uk
Velindre University NHS Trust	Call: 02920 196161 Email: HandlingConcernsVelindre@wales.nhs.uk

8.2 Glossary of terms

Co-horting	Defines groups of people with shared characteristics from health data being placed together where demand exceeds capacity. In the context of this report, co-horting relates to suspected COVID-19 diagnosis and other health related issues.
Concern	A concern is any patient safety incident, or any expression of dissatisfaction raised by a member of the public and can be verbal or written.
Consumable items	Goods used by individuals and businesses that must be replaced regularly such as needles / swabs etc. In the context of this report, 'consumables' refers to items used for COVID-19 testing.
DNACPR	This refers to a specific process of discussion and documentation NOT to initiate future CPR (Cardio-Pulmonary Resuscitation) in the event of a future cardiac arrest and natural and anticipated dying event. A DNACPR decision does not have repercussions on any other element of treatment and care.
Independent providers	Services delivered by organisations that are not NHS Health Board/ Trust services. Examples include independent care providers such as care homes, local authority social services, charities and Third Sector organisations.
Nosocomial infections	Nosocomial infections, also referred to as 'healthcare-associated infections' (HAI), are infection(s) caught during the process of receiving health care, and where that infection was not present during the time of a person's admission to hospital or healthcare setting. They may occur in different areas of healthcare delivery, such as in hospitals, long-term care facilities, and ambulatory settings. The infection may also appear after discharge from a healthcare setting but are attributed to the time a person was in contact with the healthcare setting.
Patient safety incident	An unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS-funded care.
PPE (Personal protective equipment)	Protective face coverings, clothing, helmets, goggles, or other garments, designed to protect the wearer from injury or infection.
Service users	Anybody using NHS Wales healthcare funded services.
Surveillance definitions	Surveillance of Health Care Acquired Infections refers to the monitoring and reporting of these events. Surveillance definitions are used to categorise these events as part of investigations.

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

QUALITY, SAFETY & PERFORMANCE COMMITTEE

Private Patient Service Improvement Group Highlight Report & Improvement Plan update

DATE OF MEETING	16th May 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	N/A
PREPARED BY	GARETH MITCHELL, DIRECTORATE SUPPORT OFFICER, CSMO
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	FOR ASSURANCE

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

COMMITTEE OR GROUP	DATE	OUTCOME
Executive Management Board	02/05/2023	NOTED

ACRONYMS

VUNHST	Velindre University NHS Trust
EMB	Executive Management Board
VCC	Velindre Cancer Centre
SLT	Senior Leadership Team
PPS	Private Patient Services

1. PURPOSE

This paper is to advise the Quality, Safety & Performance Committee of the highlights from the Private Patient Improvement Group held on the 21st April 2023 and the position in relation to the Private Patient Improvement Plan.

2. BACKGROUND

Following receipt of an External Private Patient review report identifying critical areas for improvement with the Velindre Cancer Centre's Private Patient service it was agreed by both the Executive Management Board and Audit Committee that a Private Patient Improvement Group would be established to drive through and oversee the required improvements.

The Executive Director of Nursing, AHPs and Health Science was identified as the Senior Responsible Officer (SRO) and external delivery support was commissioned from Liaison.

The Private Patient Improvement Group meets monthly. However, the March 2023 meeting did not go ahead due to the number of apologies.

3. PRIVATE PATIENT IMPROVEMENT PLAN

In total, 29 improvement actions have been completed, 10 of which were between February and April 2023. However, 7 improvement actions had not been achieved by the originally identified completion date (March 2023). It was agreed that most would be completed by June 2023.

The improvement plan detailing all open actions is attached in ***Appendix 1***. Revised completion dates are in red ink. The action completed log is available from Gareth Mitchell if required.

4. HIGHLIGHT REPORT

The following are additional highlights from the meeting:

ALERT / ESCALATE	There were no items to alert or escalate
ADVISE	***Contractual resource mapping work*:** Although significant work has been undertaken alongside Liasion colleagues in relation to contractual resource mapping the work had taken longer than anticipated to complete. It is anticipated that this will be completed by the end of June 2023. ***Revised Private Patient Policy***: The revision of the revised Private Patient Policy has taken longer than anticipated. Following national benchmarking the revised policy consultation has commenced and the policy will be brought for endorsement approval to the next meeting.
ASSURE	***Private Patient Key Performance Indicators (KPI's)***: A draft Private Patient KPI dataset has been formulated and presented. Minor changes are needed in relation to the wording being used to ensure that they are in-line with national standards, including detailing numerator, denominator, data standards and sources. The availability of Business Intelligence resources to meet the required KPI reporting was highlighted as a high risk. The importance of capturing Patient Experience feedback for private patients via CIVICA was stressed.
INFORM	***Trust Private Patient Brochure:*** A first-draft of the Private Patients brochure was presented and a number of areas identified for the brochure to be further enhanced. In particular, it was identified that further work will be needed to make sure that the brochure adequately differentiates the Private Patients offer from the NHS service in order to manage expectations.

5. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **NOTE** the highlights from the Private Patient Improvement Group held on the 21st June 2023 and the delivery to date of the Private Patient Improvement actions, the slippage in the delivery of a number of these actions and the revised delivery dates.

Improvement Plan - Private Patient Service

Date Updated: 18/04/2023

Ref No.	Status	Date	ommendation/Issue to be addres	Assurance Committee	Action Progress	Action Owner	Target Date	Revised Target Date	Outcome	Evidence for Closure
STRATEGIC BUSINESS MANAGEMENT										
PP3	IN PROGRESS	28.01.22	Integrate business planning into Trust IMTP process	Strategic Development	The service management group feeds into the wider Operational Services and Delivery Directorate where such business planning takes place. This feeds into the IMTP process. Content for 2023/24 IMTP will be based on outcome of strategy discussions and direction.	AMS	31/07/2022	N/A	Agreed private patient strategy will feed into Trust IMTP proess which concludes at end of March	
PP19	IN PROGRESS	28.01.22	Develop a new private patient pack, brochure, and stationery to be sent to all private patients prior to their admission/outpatient appointment and for marketing purposes.	Links to Strategy. 22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan. 18/04/23 - existing materials being refreshed based on retention of current service offer	Links to Strategy. 22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan. **18/04/23 - existing materials being refreshed based on retention of current service offer.**	External provider	30/09/2022	30/06/2023		
PP5	IN PROGRESS	28.01.22	Develop/procure and implement patient management and information system	Quality, Safety & Performance	Electronic patient record in place. The Digital Health and Care Record will be implemented across the Private Patient Service. Standard reports agreed with the Business Intelligence Team.	AMS	31/07/2022	N/A		
PP26	IN PROGRESS	28.01.22	Develop and implement a marketing plan and processes for both traditional and on-line digital	Strategic Development	This will follow the agreement of a Strategy.			31/03/2023	Refer to Action PP19	
PP8	IN PROGRESS	28.01.22	Produce job planning guidance to define NHS and private patient work within Consultant job plans	Quality, Safety & Performance	National template used which is incorporated into job planning discussions.	EGE/NH	30/04/2022	N/A		
PP9	IN PROGRESS	28.01.22	Implement changes to the existing clinical governance arrangements which provide assurance that private patient work is subject, as a minimum, to the same scrutiny and level of service for NHS patients.	Quality, Safety & Performance	Common systems, policies and procedures used for NHS and private patients to collect clinical information, risks, incidents, complaints and claims. Patients can be idenfied by certain fields.These are monitored at a monthly management group. Information is included in indivdiaul apprasials as part of the standard process.	JA	30/04/2022	N/A		
PP10	IN PROGRESS	28.01.22	Review patient pathway for private patients to ensure there is equity of service provision (MDT, CNS, psychology etc)	Quality, Safety & Performance	Discussions have commenced SLT leads on the current gaps in service provision within the PP pathway. The approval of the overarching policy will be integral to this action.	EGE/AMS	30/06/2022	31/12/2022		
PP12	IN PROGRESS	28.01.22	Introduce private patient contract/agreement to be signed by all staff undertaking PP practice.	Quality, Safety & Performance	Process in place for Consultants who undertake private practice	EGE/AMS	31/07/2022	N/A		
PP13	IN PROGRESS	28.01.22	Ensure rolling programme in place to ensure workforce agreements are reviewed in a timely manner	Quality, Safety & Performance	Cycle of business in place for the service and under development for management group.	AMS	30/04/2022	N/A		
PP17	IN PROGRESS	28.01.22	Renegotiate the contracts with large insurers	Audit Committee	21/11/2022- This is the first priority of the procured support. All contracts have been shared with them prior to their visit on 5th December2022. 21/12/2022 - Target date revised to reflect discusions with Liaison Services who are supporting the renegotiation. A target of 31/03/2023 will remain for the preparation work of reviewing current contracts, tarrifs and ensuring Trust billing is up to date. DPIA's will be completed. **18/04/23 - Finance and LIAISON working together on financial resource mapping**	MB / External Pr	30/09/2022	30/06/2023		

PP18	**IN PROGRESS**	28.01.22	Develop a new process to produce estimates with prescribed verbiage which ensures that the Trust complies with the Unfair Trading Practices Act.	Audit Committee	22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan.**18/04/23 - Finance and LIAISON working together on financial resoruce mapping**	External provide	31/05/2022	30/06/2023		
PP20	**IN PROGRESS**	28.01.22	Develop new professional fee arrangements which provide consistency across disciplines. Set fees at commercial levels.	Audit Committee	21/11/2022 - Tarrif will be updated in line with contract discussions as in PP17. 22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan. **18/04/23 - Finance and LIAISON working together on financial resource mapping**	External provide	31/07/2022	30/06/2023		
STRATEGIC BUSINESS MANAGEMENT										
PP8	**IN PROGRESS**	28.01.22	Establish Clinical Advisory Committee		Private Patient Consultant Engagement Meeting took place on the 14th December 2022 and the establishment of a Clinical Advisory Committee was discussed. Terms of Reference to be shared and Clinical Lead (who will Chair the COmmittee) to be appointed.	Clinical Director	30/04/2022	31/03/2023		
COMMERCIAL										
PP21	**IN PROGRESS**	28.01.22	Develop a private patient tariff for both self-pay and insured private patients	Audit Committee	21/11/2022 - Refer to narrative in PP17. **22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan.**	External provider	31/07/2022	30/06/2023		
PP22	**IN PROGRESS**	28.01.22	Develop a new charge capture process and procedure and billing methodology and implement reflecting the new tariff structure.	Audit Committee	22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan. **18/04/23 - Revised processes have been established and are being rolled out.**	External provider	31/07/2022	30/06/2023		
PP23	**CLOSED**	28.01.22	Update the Undertaking to Pay form to include all the necessary legal and GDPR rules	Audit Committee	Form up-dated, which included input from the Information Governance Manager. Completed 23.06.21.	AMS	30/09/2022	N/A		
PP25	**IN PROGRESS**	28.01.22	Develop a new process to produce cost estimates with prescribed methodology which ensures that the Trust complies with the Unfair Trading Practices Act.	Refer to narrative in PP17.	External provider	External provider	31/07/2022	30/06/2023		
PP28	**CLOSED**	28.01.22	Develop new professional fee arrangements which provide consistency across disciplines. Set fees at commercial levels.	Audit Committee	REPEAT PP20	External provider	31/07/2022	N/A		
OPERATIONAL										
PP30	**CLOSED**	28.01.22	Develop training plan for PP staff	Quality, Safety & Performance	Training plans in place for all staff members. There has been a delay in securing the services of an external specialist provider therefore this has not been progressed.	AMS	31/07/2022	N/A		
PP31	**CLOSED**	28.01.22	Integrate Medical Secretary into Health Records department	Quality, Safety & Performance	The Medical Secretary has been integrated in to the Medical Records Department, specifically in terms of attending monthly meetings and inclusion in regular and adhoc communications/up-dates. The ability to physically co-locate as has been delayed due to space limitations in light of covid restrictions.	TB	28/02/2022	N/A		
PP10	**OPEN**	28.01.22	Review patient pathway for private patients to ensure there is equity of service provision (MDT, CNS, psychology etc)	Quality, Safety & Performance	Discussions have commenced SLT leads on the current gaps in service provision within the PP pathway. The approval of the overarching policy will be integral to this action. **21/11/2022 - Refer to narrative in PP1.**	EGE/AMS	30/06/2022	31/03/2023		
PP14	**IN PROGRESS**	28.01.22	Review management structure and reporting arrangements	22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan. **18/04/23 - Revised operating stuctures under review and being recruited to**	22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan. **18/04/23 - Revised operating stuctures under review and being recruited to**	COB / External Provider	30/04/2022	31/05/2023		

PP15	**IN PROGRESS**	28.01.22	Review patient management arrangements by creating a Senior PP Manager role reporting to the COO	Quality, Safety & Performance	**22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan.**	B / External Prov	30/04/2022	31/03/2023		
PP37	**OPEN**	28.01.22	Procure or develop a private patient management system that will enable production of regular management information including a private patient activity report.	Audit Committee	The CANISC Patient Administration System is the primarily solution for this information. Therefore an additional system is not required. Three standard reports have been established:- Report 1 - General overview of private patient activity for both inpatient and outpatients Report 2 - Private inpatient activity for a current day Report 3 - Radiology attendances, including exam type Patient KPI report (activity and phlebo) established (to be reviewed and signed off) Requirements provided to provide a single report that captures all activity at a patient level (which can be filter, including attendance month, year, department, activity type etc). This is dependent upon BI resources and prioritisation. BI resource currently focussed on implementation of DHCR. Dedicated finance resource required to produce monthly report for Senior Leadership Team. WPAS has now been deployed. There is ongoing work to ensure SOPs etc are aligned to ensure PPs are correctly recorded in the system to support ongoing activity reporting. **22/12/22 - Issues with the change in patient infomation systems are currently being worked through.**	WJ	30/05/2022	31/03/2023	PPMG agreed that current systems appropriate to capture information.	
PP41	**OPEN**	28.01.22	Consult with clinicians and realign payment arrangements for their fees to ensure the credit risk from non-payment is shared between the Trust and clinicians rather than the current arrangement where the Trust bears all the risk.	Audit Committee	No update provided	DO	30/05/2022	N/A		
PP43	**IN PROGRESS**	28.01.22	Undertake a commercial review of the HCaH contract and consider the creation establishment of a Trust peripatetic home chemotherapy service.	Audit Committee	Given current constraints and pressures within SACT and wider services it is suggested this is consider during 2023/24 .22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan. **18/04/23 - HCaH contract reviewed and maximised for Blood Testing, but not the wider Chemo service - all contract negotiations aligned to Q1 delivery.**	PW	31/07/2022	31/03/2023		

QUALITY, SAFETY & PERFORMANCE COMMITTEE

SAFEGUARDING & VULNERABLE ADULTS GROUP HIGHLIGHT REPORT

DATE OF MEETING	16th May 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	N/A
PREPARED BY	Dave Harris, Interim Senior Professional Safeguarding & Public Protection
PRESENTED BY	Tina Jenkins, Interim Deputy Director Nursing, Quality & Patient Experience
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, AHPs and Health Science
REPORT PURPOSE	**ASSURANCE**

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
SAFEGUARDING & VULNERABLE ADULTS MANAGEMENT GROUP	11/04/23	Areas for inclusion agreed
EXECUTIVE MANAGEMENT BOARD	02/05/23	NOTED

1. PURPOSE

This paper has been prepared to provide the Quality, Safety & Performance Committee with details of the key issues considered by the Trust's Safeguarding and Vulnerable

Adults Group at the meeting held on the 11th April 2023.

2. SAFEGUARDING & PUBLIC PROTECTION MANAGEMENT GROUP HIGHLIGHT REPORT

The following are the agreed highlights from the Safeguarding & Vulnerable Adults Group held on the 11th April 2023:

ALERT / ESCALATE	No areas to Alert / Escalate
ADVISE	• The Group reviewed the ***workplan*** for April 2022 to March 2023. 9 actions had been fully completed. 2 actions had not been fully completed and have been included in the April 2023 to March 2024 workplan. The two not fully completed were: ○ To improve compliance with safeguarding training to achieve compliance of 85% or above across all relevant areas. ○ To include section 5 of the Wales Safeguarding Procedures in mangers' training across the Trust. • The Group received the ***Safeguarding training compliance*** dashboard and acknowledged the amount of work undertaken this year to cleanse the data. This program of work ensures all training requirements are correctly assigned and enable a targeted focus in strengthening compliance figures across the Trust. A number of areas remain below the agreed compliance target of 85%. For the VCS Level 3 courses for 'Safeguarding Children' and 'Safeguarding Adults'. Improved compliance on both Level 3 packages is a key action to be completed and reported back to the next group, with continued focus on improving all training compliance within the 2023 to 2024 workplan. An accurate training compliance matrix will support in monitoring training compliance and plan required improvements across the divisions. • A paper outlining how ***safeguarding supervision*** is delivered across the trust was presented to the group. Whilst recognising various mechanisms of providing supervision in the Trust was in accordance with 'All Wales Safeguarding Best Practice Supervision Guidance', it was recognised this national guidance was due for review in 2018. The group agreed a further piece of work to create a Trust guidance document advising local arrangements and staff access supervision. This will be presented at the next meeting.

ASSURE	• Two revised ***Safeguarding policies*** (due for renewal in March 2023) were approved by the group: 'Safeguarding and Public Protection Policy' and 'Policy for the Management of Safeguarding Allegations / Concerns About Practitioners in a Position of Trust'. • Welsh Government have requested submission by 26th May 2023 of the 2023-2024 training plan and 2022-2023 annual progress report in relation to ***Violence Against Women, Domestic Abuse and Sexual Violence training*** in the Trust. Key measurables are training Groups 1,2,3 and 6 as per requirements of the National Training Framework. Current compliance figures for each group were presented to the group for information and work is ongoing to complete the training plan and progress report for submission. Plans to be improve compliance for group 2 and to identify key individuals to undertake group 3 training will be added to next year's work plan. • The ***standard operating procedure for Virtual Assessment Pathway*** developed by Velindre Cancer Service was presented to the Group for information. The Group were assured by the inclusion of guidance on responding to concerns of domestic abuse and / or safeguarding matters to further support the Trust in meeting its legislative responsibilities and promote the safety and wellbeing of our patients and service users.
INFORM	• The Deputy Minister for Mental Health and Wellbeing recently issued a written statement providing an update on the implementation of the ***Liberty Protection Safeguards (LPS)***. This follows recent confirmation from the UK Government that they are not progressing the implementation of the Mental Capacity (Amendment) Act 2019 and the transition from DOLs to LPS within this Parliament. A stakeholder engagement event is being planned and further information will be reported back to the group • Consultation has commenced on the ***Single Unified Safeguarding Review (SUSR)***, Welsh Government's initiative to change the approach of practice reviews in Wales, including child practice, adult

	practice, domestic homicide, mental health, offensive weapons homicide reviews. These will now all come under one framework to try and prevent families from going through multiple reviews at a time. The draft Guidance is being reviewed within the consultation phase and work has commenced in formulating comments on the document, subject to Trust approval.
APPENDICES	**N/A**

3. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **NOTE** the key deliberations that took place at the Safeguarding and Vulnerable Adult Group held 11th April 2023.

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

PUBLIC RESEARCH, DEVELOPMENT & INNOVATION SUB-COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	16/05/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Sarah Townsend, Head of Research & Development
PRESENTED BY	Professor Andrew Westwell, Chair of the Research, Development & Innovation Sub-Committee
EXECUTIVE SPONSOR APPROVED	Dr Jacinta Abraham, Executive Medical Director

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
		Choose an item.

ACRONYMS	
IP	Intellectual Property
nVCC	New Velindre Cancer Centre

RD&I	Research, Development and Innovation
QS&P	Quality, Safety and Performance Committee
VCC	Velindre Cancer Centre
WBS	Welsh Blood Service

1. PURPOSE

This paper has been prepared to provide the Quality, Safety and Performance Committee with details of the key issues and items considered by the **Public** Meeting of the Research, Development and Innovation Sub-Committee on the 28/02/2023. Key highlights from the meeting are reported in Section 2. The Quality, Safety and Performance Committee is requested to **NOTE** the contents of the report and actions being taken.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for **ALERT** or **ESCALATION** to the Quality, Safety & Performance Committee.
ADVISE	• **RADIOTHERAPY RESEARCH** Several groups have been established to ensure Radiotherapy Research continues to be a core function within Velindre with focused objectives and clear aims. The Radiotherapy Research Working Group has been set up to bring representatives from the three departments in Radiotherapy together, along with representatives from TCS. This collaborative group will share information with oversight of the Research Bunker in nVCC as well as relevant bids going into Charitable Funds and Advancing Radiotherapy Funds. From this group, a subgroup has been formed to identify the preferred type of machine to go into the bunker that will would facilitate and enhance the status of the nVCC/VCC/Trust as a UK/International research leader. Alongside this, the task and finish group looking at capacity issues within the core Radiotherapy service continues to work together to identify solutions and next steps to collectively best address this topic. • **HEAD OF INNOVATION (occurred following the RDI Sub-Committee)** Jennet Holmes has now been appointed as Head of Innovation and takes up post end of June / early July 2023.
ASSURE	• **TRUST RD&I SUB-COMMITTEE RISK REGISTER EXTRACT** No open risks were recorded on Datix for escalation to February's 2023 RD&I Sub-Committee, in line with the Trust Board Risk Appetite.

	• **TRUST RESEARCH, DEVELOPMENT AND INNOVATION PERFORMANCE REPORT 2022/23** The RD&I Integrated Performance Report summarised activities of the Trust's Research, Development, & Innovation function during Quarter 3 of financial year 2022/23. • **INTELLECTUAL PROPERTY (IP) POLICY** The Research, Development & Innovation Sub-Committee approved the revised Intellectual Property Policy following minor amendments. The IP policy will be on the Trust Board agenda on the 30th March 2023 and will be reviewed in three years from the date of approval.
INFORM	• **PALLIATIVE AND SUPPORTIVE CARE RESEARCH, BUILDING ON SUCCESS PRESENTATION** Dr Anthony Byrne, Consultant in Palliative Medicine provided a short presentation on Palliative and Supportive Care Research, Building on Success and the contribution this will make to the Velindre Cancer Strategy. The Presentation was well received from the RD&I Sub-Committee. • **EXECUTIVE SUMMARY HIGHLIGHTS** The RD&I Sub-Committee received a presentation and briefing from Dr Jacinta Abraham, Executive Medical Director reporting on high-level activities relating to Research, Development and Innovation that took place during Quarter 3 of Financial Year (FY) 2022/23. The following key highlights were reported : **Welsh Blood Service** ➢ The RD&I Sub-Committee congratulated Chloe George, Head of Component Development at WBS who has been awarded 'Healthcare Scientist of the Year' at the Advancing Healthcare Awards Cymru. ➢ Welsh Blood Service would like to congratulate the Vaccine Distribution Project Team, who were deservedly shortlisted for the 'Improving Public Health Outcomes' Award. **Research & Development** ➢ Charitable Funds Committee Integrated Bid ➢ Cardiff Cancer Research Hub – Update on Branding and Heads of Terms ➢ Oncacare – Progress with Collaboration and Contract ➢ Research Study Data & Performance Metrics
APPENDICES	**NOT APPLICABLE**

3. RECOMMENDATION

The Quality, Safety & Performance Committee are asked to **NOTE** the key deliberations and highlights from the **Public** Meeting of the Research, Development & Innovation Sub-Committee held on the 28/02/2023.

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

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

DATE OF MEETING	16/05/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Matthew Talboys, Head of Nuclear Medicine & Kathy Ikin, Head of Radiation Services
PRESENTED BY	Dr Hilary Williams, AMD for Quality & Safety
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	02/05/2023	NOTED

ACRONYMS	
HSE	Health and Safety Executive
VCC	Velindre Cancer Centre

UKHSA	United Kingdom Health Security Agency
EBRT	External Beam Radiotherapy
IRR17	Ionising Radiation Regulations 2017
CTSA	Counter Terrorism Security Advisor

1. PURPOSE

This paper has been prepared to provide the Quality, Safety & Performance Committee with an assurance that the Trust responsibilities in respect of both staff and patient safety related to radiation management and medical exposures are being effectively discharged. The governance arrangement for this responsibility is delegated to Dr Jacinta Abraham as Chair of the Radiation Protection Medical Exposures Strategic Committee (RPMESC).

A summary of the current issues and plans from the last meeting held on 16/03/2023 are provided within this report.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for **ALERT** or **ESCALATION** to the Quality Safety and Performance Committee.
ADVISE	**Staff Safety** **Classification of Workers** The regulatory risk assessments completed in 2022 highlighted the requirement to formally 'classify operators' within Brachytherapy. The service managers have completed all possible actions to date. The only remaining action is for the staff to complete a medical assessment. Due to scarcity of local qualified doctors to undertake the medicals, advice and referral information has been sought from the UKHSA (who maintain the register of qualified medics). **Classification of Nuclear Medicine workers** Following review of the 2022 risk assessments in Nuclear Medicine and in keeping with the HSE expectations, the Radiation Protection Service have recommended that, Nuclear Medicine workers

	become Classified Workers. There will be a small financial implication to the Nuclear Medicine department to undertake classification in addition to the issues identified above. This is anticipated to be less than £1000, and the service lead has advised to proceed within this budget. **Site Safety** **Radon Monitoring** Following the VCC site wide Radon survey, and subsequently obtained professional advice, enhanced airflow in one room within the workshop area has been recommended. The Radiation Protection Service has been working with estates and facilities to provide guidance to staff on effective short-term mitigation, while the air exchange is installed. The target completion date is May 2023.
ASSURE	**External Beam Radiotherapy Risk Assessments** A focus group chaired by Kathy Ikin, has been convened to revise the existing EBRT risk assessments to ensure they are IRR17 compliant and fit for purpose for the anticipated new HSE consent process. The new process is expected in late Autumn and there are no issues or concerns to report in meeting this new compliance standard. Lack of completion could result in a risk of failing the safety assessment process if the risk assessments are not fit for purpose. **IRR17 Audit Program** A review of governance arrangements for the management of IRR17 audits for VCC is underway. An option appraisal for decision will be taken at the next RPMESC.
INFORM	The Trust application to HSE for the regulatory licences and consent to operate are due for completion in June 2023. The application process is underway for timely submission to HSE. The TRUST is required to dispose and remove a historic Highly Active Sealed Source from VCC. On request from the Counter Terrorism Adviser, this disposal was delayed, as there was an initial Home Office programme to dispose of such items. However, since the inception of the Ukraine Conflict this programme has been

	suspended due to the associated security risks. The CTSA has subsequently advised VCC should continue with local arrangements for disposal. The budgetary provision has been confirmed and the disposal development plan is underway and on track.
APPENDICES	**NOT APPLICABLE**

3. RECOMMENDATION

The Quality, Safety & Performance Committee are asked to **NOTE** the key deliberations and highlights from the Radiation Protection and Medical Exposures Strategic Committee on the 16/03/2023.

QUALITY SAFETY AND PERFORMANCE COMMITTEE

BODY STORAGE REVIEW

DATE OF MEETING	16.05.2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Rachel Hennessy, Interim head of operational Services and Delivery
PRESENTED BY	Paul Wilkins, Director
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**
SLT VCC	04/05/2023	NOTED
Executive Management Board	02/05/2023	NOTED

ACRONYMS	

1. **SITUATION**

This paper provides an outline of the response from Velindre Cancer Services (VCS) to the Welsh Government, Wales–wide review for body storage and the subsequent recommendations received in November 2022.

The Quality, Safety and Performance Committee are asked to note the content of this report.

2. **BACKGROUND**

In November 2021, Welsh Government asked all health boards to supply information on body storage facilities which fall outside the current Human Tissue Authority (HTA) licensing and regulatory oversight of premises where post mortem examinations take place.

Returns showed significant variation across a number of areas.

Attached is the document from Welsh Government describing the review and the recommendations (Appendix 1).

3. **ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION**

The Division has considered the recommendations and completed a self-assessment against them. The action plan is attached (Appendix 2).

It should be noted that there are two the actions relating to access and security, which have been assessed by the Division as scoring 1. This is due to the close alignment to the outcomes from a recent CCTV audit, which has been received in draft for comment before a final version will be considered by SLT and an appropriate action plan developed to manage any recommendations. Once timelines have been agreed for this audit, it will be possible to finalise the timelines for delivery of actions 4.9 and 4.10.

The remaining action scoring 1 (4.15), is due to the requirement to put in plan a SLA.

The Division will monitor delivery of the outstanding actions in the body storage action plan, through the Operational Services Directorate. Progress will be monitored and reported via the Division Business Planning Group and into the Senior Leadership Team (SLT) meetings.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
RELATED HEALTHCARE STANDARD	Dignified Care
	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 and Performance Committee is asked to **NOTE** the content of this report.

Appendix 1

Body Storage review and recommendations (November 2022)

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

Health board returns showed there is significant variation in relation to:

• Access and security arrangements

• Quantity and capacity of body storage within health boards

• Use of standard operating procedures

• Alignment with mortuary policies and management arrangements

The Human Tissue Authority provided initial advice to the UK Government in December 2021. It has amended and recently published its updated Post Mortem sector licensing standards and guidance. NHS England has also taken forward work reviewing its Health Service Building note relating to facilities for mortuary and post-mortem.

The Fuller Inquiry has been established to investigate how David Fuller was able to carry out inappropriate and unlawful actions in the mortuary of Maidstone and Tunbridge Wells NHS Trust and why they went apparently unnoticed. It will also consider if procedures and practices in other hospital and non-hospital settings, where bodies of the deceased are kept, safeguard the security and dignity of the deceased. The Inquiry will publish its initial report on matters relating to David Fuller's activities at Maidstone and Tunbridge Wells NHS Trust in first half of 2023 (this has been delayed due to the volume of evidence the Inquiry has and continues to receive, and the number of witnesses to interview, is far greater than anticipated) and its final report, looking at the broader national picture and the wider lessons for the NHS and other settings in either late 2023 or during 2024. The Inquiry did publish a progress update in May 2022, which highlighted a number of areas of concern escalated to NHS England.

Given the above findings, the work undertaken by the HTA and the length of time it is likely to take for the Fuller Inquiry to conclude, Welsh Government have produced interim recommendations for health boards/trusts to implement in areas where bodies of the deceased are kept, to safeguard the security and dignity of the deceased.

In relation to building safety notices, it would appear that we have not updated these in Wales for some time and did not issue the last update which was sent out in England and Scotland. Shared services colleagues have seen a copy of the latest proposed revisions and circulated

these to NHS Wales colleagues and received multiple comments. NHS Wales shared services have committed to clarifying with NHS England their timescales for publication and issuing the English version as an interim measure in Wales as swiftly as possible once it has been published.

Interim recommendations

The interim recommendations below are consistent with revised guidance issued from the HTA in relation to mortuaries/post-mortem rooms and the draft building safety notice. It is proposed that the same standards of security and oversight should apply to all NHS premises where bodies are stored.

Health boards/trusts should:

- Identify and appoint a single accountable officer for body storage facilities who can oversee implementation of the recommendations and provide updates to your board/Welsh Government
- Review and consolidate where possible their body storage arrangements, especially in community hospital settings
- Consolidate the management of body stores and where possible align them to mortuary and post-mortem services
- Apply relevant HTA post-mortem sector licensing standards and guidance to body storage areas including: o Documented standard operating procedures (SOP) should take account of standard and out of hours arrangements and cover for storage of bodies, record keeping, receipt and release of bodies, lone working, access and where applicable viewing of bodies, transfer of bodies.
    - Access to bodies storage facilities should be strictly controlled with clear policies and procedures which protect bodies from harm and breaches of confidentiality.
    - Policies and SOPs should be reviewed regularly
    - All staff who may access body storage facilities should be appropriately trained, for example, portering staff, site managers
    - Contractors, visiting and temporary staff should be made aware of policies and SOPs
    - Records must include records of access to the body storage (by whom and for what purpose)

- Staff know how to identify and report incidents with i Information about incidents is shared with all staff to avoid repeat errors.
- Risk assessments should be undertaken and reviewed on a regular basis and cover risks to the security, dignity and integrity of bodies and stored tissue.
- Systems to track each body from admission to the body storage facility to release for burial or cremation e.g. body receipt and release details should be logged, including the date and name of the person who received/released the body and, in the case of release, to whom it was released.
- Bodies should be identified using a minimum of three identifiers attached to the body that can be used to check the identification of the deceased. (eg. name, date of birth/death)
- Premises are secure (for example there is controlled access to the body storage area(s) and the use of CCTV to monitor access). Security arrangements should be robust, with effective mechanisms to strictly control access. Security arrangements must protect against unauthorized access and ensure oversight of visitors and contractors who have a legitimate right of access.
- Entry to body storage facilities should include swipe card access with lists reviewed and updated regularly. Records of access (electronic and paper-based) and CCTV footage should be regularly audited to ensure adherence to relevant policies and procedures. Anyone entering should have a legitimate right of access and audits should scrutinise the purpose, frequency and duration of access and be particularly alert to unusual patterns, times of entry or other unexplained or suspicious activity which must be investigated immediately.
- Staff and authorised visitors and contractors should be aware of the establishment's security arrangements. Authorised visitors and contractors should also be supervised while in the body storage areas.
- Bodies should be shrouded or in body bags whilst in storage.
- Establishments should have documented agreements with any funeral services that they may use for contingency storage.

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Appendix 2.

Cold Room Body Store, VCC Divisonal Wide Improvement Plan - Version 0.2
Date 28/03/2023

Service	Source	Outcomes Required	Actions	Operational Lead	Executive Lead	Management Oversight	Evidence of Delivery	Delivery Date	Summary of Progress	RAG	Outstanding management Action
Operational services	Welsh Government review and recommendations	**Identify and appoint a single accountable officer for body storage facilities who can oversee implementation of the recommendations and provide updates to your board/Welsh Government**	To appoint accountable officer within Velindre cancer Centre	Deputy Operational Services Manager	Executive Director of Nursing, Quality & Research	Interim Head of Operations & Delivery. SLT	Deputy Operational Services Manager is Operational Lead, single accountable officer for Velindre cancer centre is Interim Head of Operations & Delivery.	01/03/2023	outcome realised in full	7	
Operational services	Welsh Government review and recommendations	**Review and consolidate where possible their body storage arrangements, especially in community hospital settings**	The Cancer Centre is the only Directorate within the Velindre University NHS Trust to hold a cold room body store facility, we therefore have no requirement to align with community or other divisions within the Trust, as not applicable	Deputy Operational Services Manager	Executive Director of Nursing, Quality & Research	Interim Head of Operations & Delivery. SLT		31/03/2023	outcome realised in full	7	
Operational services	Welsh Government review and recommendations	**Consolidate the management of body stores and where possible align them to mortuary and post-mortem services**	The Cancer centre is the only Directorate within the Velindre University NHS Trust to hold a cold room body store facility, we therefore have no requirement to align to the mortuary and post mortem services, as not applicable	Deputy Operational Services Manager	Executive Director of Nursing, Quality & Research	Interim Head of Operations & Delivery. SLT		31/03/2023	outcome realised in full	7	
Operational services	Welsh Government review and recommendations	**Apply relevant HTA post-mortem sector licensing standards and guidance to body storage areas including:**									
Operational services	Welsh Government review and recommendations	SOP in place	Documented standard operating procedures (SOP) should take account of standard and out of hours arrangements and cover for storage of bodies, record keeping, receipt and release of bodies, lone working, access and where applicable viewing of bodies, transfer of bodies.	Deputy Operational Services Manager	Director of Nursing AHP's and Medical Scientists	Interim Head of Operations & Delivery. SLT	Documented standard operating procedures (SOP), have been completed and are implimented to take into account access requirement s for contractors, vistors, under escort	30/09/2023	outcome realised in full	6	review SOP to ensure meets requriements
Operational services	Welsh Government review and recommendations	control procedures in place	Access to bodies storage facilities should be strictly controlled with clear policies and procedures which protect bodies from harm and breaches of confidentiality.	Deputy Operational Services Manager	Director of Nursing AHP's and Medical Scientists	Interim Head of Operations & Delivery. SLT	Procedure (SOP) are in place to control access to body store facilities	30/06/2023	Majority of actions implimented; outcomes not realised as intended	5	Need to confirm divisional nursing policy completes this action
Operational services	Welsh Government review and recommendations	SOPs and policy in place and up to date	Policies and SOPs should be reviewed regularly	Deputy Operational Services Manager	Director of Nursing AHP's and Medical Scientists	Interim Head of Operations & Delivery. SLT	Documentation to be reviewed annually in line with the Operational Services Audit Programme	latest review 27/01/2023	outcome realised in full	6	
Operational services	Welsh Government review and recommendations	all staff appropriately trained	All staff who may access body storage facilities should be appropriately trained, for example, portering staff, site managers	Deputy Operational Services Manager	Director of Nursing AHP's and Medical Scientists	Interim Head of Operations & Delivery. SLT	All relevant staff are trained in IP&C, All Wales Manual Handling passport, and local procedure for access to the Cold room body store	30/04/2023	outcome realised in full	6	clarify training log in place and up to date
Operational services	Welsh Government review and recommendations	Processes in place for external visitors	Contractors, visiting and temporary staff should be made aware of policies and SOPs	Deputy Operational Services Manager	Director of Nursing AHP's and Medical Scientists	Interim Head of Operations & Delivery. SLT	Contractors,complete induction, temp staff visiting site are made aware of procedure and escorted at all times whilst entering the cold room body strore	Ongoing	outcome realised in full	7	
Operational services	Welsh Government review and recommendations	records in place and maintained	Records must include records of access to the body storage (by whom and for what purpose)	Deputy Operational Services Manager	Director of Nursing AHP's and Medical Scientists	Interim Head of Operations & Delivery. SLT	Physical record kept of two persons signing out cold room keys, Secure door access reports are held digitally	30/04/2023	outcome realised in full	6	confirm record log in place and location

Operational services	Welsh Government review and recommendations	staff trained in datix	Staff know how to identify and report incidents with Information about incidents is shared with all staff to avoid repeat errors.	Deputy Operational Services Manager	Director of Nursing AHP's and Medical Scientists	Interim Head of Operations & Delivery. SLT	All relevant staff are aware of how to report incidents or concerns. Staff are also aware of the datix procedure. Lessons learnt are shared with relevant divisional management groups.	31/05/2023	Majority of actions implimented; outcomes not realised as intended	3	All staff to undertake datix refresher training
Operational services	Welsh Government review and recommendations	risk assessments completed and logged	Risk assessments should be undertaken and reviewed on a regular basis and cover risks to the security, dignity and integrity of bodies and stored tissue.	Deputy Operational Services Manager	Director of Nursing AHP's and Medical Scientists	Interim Head of Operations & Delivery. SLT	Risk assessments are completed on the security elements of cold room body store. Current SOP addresses the dignity and integrity of bodies whilst stored..	30/04/2023	outcome realised in full	6	confirm frequency and record of risk assessments
Operational services	Welsh Government review and recommendations	SOP in place logs available	Systems to track each body from admission to the body storage facility to release for burial or cremation e.g. body receipt and release details should be logged, including the date and name of the person who received/released the body and, in the case of release, to whom it was released.	Deputy Operational Services Manager	Director of Nursing AHP's and Medical Scientists	Interim Head of Operations & Delivery. SLT	Systems are in place to track from admission to release. Measures in place include Authorised body release book in operation, which list undertaker, patient, inclusive of undertakers registration number	30/04/2023	outcome realised in full	6	confirm location of body release book and that it is maintained
Operational services	Welsh Government review and recommendations	SOP in place	Bodies should be identified using a minimum of three identifiers attached to the body that can be used to check the identification of the deceased. (eg. name, date of birth/death)	tbc	Director of Nursing AHP's and Medical Scientists	Interim Head of Operations & Delivery. SLT	Deceased are prepped at ward level with identification bracelet, Velindre notification of death which includes time of death next of kin jewellery etc	31/05/2023	outcome realised in full	6	SOP to be developed for notification of death tbc: nursing/med records
Operational services	Welsh Government review and recommendations	robust security arrangements in place	Premises are secure (for example there is controlled access to the body storage area(s) and the use of CCTV to monitor access). Security arrangements should be robust, with effective mechanisms to strictly control access. Security arrangements must protect against unauthorized access and ensure oversight of visitors and contractors who have a legitimate right of access.	Deputy Operational Services Manager	Director of Nursing AHP's and Medical Scientists	Interim Head of Operations & Delivery. SLT	CCTV has coverage of the front door only, not including the access corridor. We have security processes in place.	date tbc	Majority of actions implimented; outcomes not realised as intended audit of CCTV udnertaken April 2023	1	receive CCTV audit consider action required in response to CCTV audit
Operational services	Welsh Government review and recommendations	robust security arrangements in place	Entry to body storage facilities should include swipe card access with lists reviewed and updated regularly. Records of access (electronic and paper-based) and CCTV footage should be regularly audited to ensure adherence to relevant policies and procedures. Anyone entering should have a legitimate right of access and audits should scrutinise the purpose, frequency and duration of access and be particularly alert to unusual patterns, times of entry or other unexplained or suspicious activity which must be investigated immediately.	Deputy Operational Services Manager	Director of Nursing AHP's and Medical Scientists	Interim Head of Operations & Delivery. SLT	Secure door access was installed with double tap facillity, enabling access by 2 s authorised member of staff, CCTV audit has been undertaken across the site, awaiting report	date tbc	Actions for symtomatic, contributory route causes. Impact from actions and imerging outcomes. Audit of CCTV undertaken April 2023	1	receive CCTV audit consider action required in response to CCTV audit
Operational services	Welsh Government review and recommendations	robust security arrangements in place	Staff and authorised visitors and contractors should be aware of the establishment's security arrangements. Authorised visitors and contractors should also be supervised while in the body storage areas.	Deputy Operational Services Manager	Director of Nursing AHP's and Medical Scientists	Interim Head of Operations & Delivery. SLT	Documented standard operating procedures (SOP) takes in to account access requirement s for contractors, vistors, under escort, they are supervised at all times	31/05/2023	outcome realised in full	6	SOP to be reviewed security signage to be addressed in line with CCTV audit
Operational services	Welsh Government review and recommendations	appropriate management of bodies	Bodies should be shrouded or in body bags whilst in storage.	Deputy Operational Services Manager	Director of Nursing AHP's and Medical Scientists	Interim Head of Operations & Delivery. SLT	Deceased are shrouded and placed in a body bags at ward level	Ongoing	outcome realised in full	7	
Operational services	Welsh Government review and recommendations	Formal agreements in place with funeral services	Establishments should have documented agreements with any funeral services that they may use for contingency storage.	Deputy Operational Services Manager	Director of Nursing AHP's and Medical Scientists	Interim Head of Operations & Delivery. SLT	We have verbal agreement with local undertakers, Within the division we would introduce established and agreed contingency measures.	30/06/2023	Majority of actions implimented; outcomes not realised as intended	1	clarify position develop SLA in conjunction with business planning

QUALITY, SAFETY & PERFORMANCE COMMITTEE

NURSE STAFFING LEVELS (WALES) ACT 2016

DATE OF MEETING	16th May 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Non-Applicable
PREPARED BY	Rhian Wright, Nurse Staffing Programme Lead
PRESENTED BY	Anna Harries, Head of Nursing, Professional Standards & Digital
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, AHP & Health Science
REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Professional Nurse Forum	6th April 2023	Content agreed
Executive Management Board	2nd May 2023	NOTED

1. SITUATION

This paper is to provide the Quality, Safety & Performance Committee with the annual assurance that all statutory requirements of the Nurse Staffing Levels (Wales) Act 2016 are being met. This report provides the position from the 6th of April 2022 to the 5th of April 2023.

The Quality, Safety & Performance Committee is asked to **NOTE** the position in respect of the Trust's compliance with the Nurse Staffing Levels (Wales) Act 2016 for the period 6th April 2022 – 5th April 2023.

2. BACKGROUND

The Nurse Staffing Levels (Wales) Act 2016 requires health service bodies to make provision for safe nurse staffing levels, and to ensure that nurses are deployed in sufficient numbers. The Act is intended to:

- Enable the provision of safe nursing care to patients at all times;
- Improve working conditions for nursing and other staff; and;
- Strengthen accountability for the safety, quality and efficacy of workforce planning and management.

Since the 1st April 2021 the Velindre Cancer Service First Floor Ward was re-classified as meeting the wider definition of a 'medical ward' as it is a specialist oncology medical ward and therefore, the ward and Trust are now required to meet the full Act reporting requirements. Through establishment reviews of all nursing areas, a triangulated approach to each area has been considered despite not requiring national reporting this information is vital to quality indicators. The full detailed report will follow however part of this is considered in the assessment/summary below.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Nurse Staffing Act Reporting

To facilitate the preparation of the statutory three yearly report to Welsh Government, there is an agreed All Wales requirement that an annual assurance report be prepared to provide assurance to the Board that all statutory requirements are being met. The Nurse Staffing Levels (Wales) Act 2016 Annual Assurance Report has been completed and the report (using the national reporting template) is attached in ***Appendix 1***. This report highlights:

- Nurse staffing levels have been calculated using the triangulated approach bi-annually.
- ***No impact on patient care relating to the quality indicators reported due to not maintaining staffing levels***
- There have been no incidents of harm relating to the quality indicator of pressure damage, no medication never events aligned with staffing and there has been one fall resulting in harm. The investigation into this is yet to be concluded and will be reported on in next year's Annual Assurance Report.
- There has been one complaint concerning nursing care managed through the

Putting Things Right complaints regulations. This complaint was not solely related to nursing care and was not attributable to the nurse staffing level on the ward. Learning has been shared in relation to this complaint and a task and finish group was set up to improve quality and safety in relation to enteral feeding.

- There have been occasions when the required roster has not been met mainly due to sickness absence and increased acuity. Every effort (reasonable steps) has been made to fill any gaps in the roster. ***There have been no incidences relating to quality indicators reported where staffing levels have impacted adversely of the First Floor Ward to provide the required care or treatment to patients.***
- The implementation of SafeCare on first floor in March 2023 has enabled us to bring together the elements of nurse staffing and acuity to help deliver safe and effective care for inpatients being cared for at Velindre Cancer Centre (SafeCare is the national system that is being implemented within Wales to enable boards/trusts to meet the requirements of the Nurse Staffing Levels (Wales) Act 2016. It allows for real time visibility of staffing levels taking into account patient numbers and acuity, thus helping to ensure an awareness of whether we have the correct staffing levels to care for patients safely and sensitively). SafeCare will be utilised for data retrieval for the next Annual Assurance Report, this report has been compiled using the existing Health Care Monitoring System.
- Currently, the nursing establishment is sufficiently funded and appropriate to provide the planned roster for first floor. There are no financial concerns in relation to the staffing of first floor.

3.2 Establishment Reviews

Following each national benchmarked acuity review (twice yearly) an establishment review is undertaken across all areas of the Trust that require registered nurses in front line care / treatment delivery (both Divisions) chaired by the Executive Director of Nursing, AHP & Health Science and relevant Head of Nursing. The establishment reviews are reported on a template for agreement at each level. Each establishment review includes an overview of:

- Current funded establishments
- Vacancies and staff in post
- Datix Incidents – related to service delivery and staffing
- Complaints relevant to establishment or staffing
- Training compliance
- PADR compliance
- Review of Roster
- Patient Feedback (CIVICA)
- Audits (Tendable)
- Acuity that may be formally assessed i.e. First floor or discussion of area for understanding
- KPI review
- Service plans or Clinic Templates as applicable (not all areas)

In summary, there were no incidents relating to the quality indicators or complaints effecting care linked to nurse staffing levels for the reporting period. PADR compliance overall was good (100% in some areas) First Floor PADR compliance was reported at

93.02% during the last establishment review in October 2022. There was a plan to undertake all outstanding PDAR's where 100% was not achieved. Training compliance was overall good. Discussions were held around achieving top of license working and the implementation of Band 4 Associate Practitioners based on NHS Wales agreed standards.

3.3 Electronic Rostering

Health roster is fully utilised in six nursing areas and for the nurse bank. Rostering Key Performance Indicators (KPI's) are produced electronically which are scrutinised locally to assess rostering efficiency and effectiveness. An overview of these KPI's are also taken as part of establishment reviews. Health Roster also facilitates rapid and robust assurance that staffing levels are safe across all nursing areas. These rosters are legible, auditable and viewed in one centralised location for visibility of responsible staff.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	There is a strong evidence base that links nurse staffing levels with patient experience and outcomes
RELATED HEALTHCARE STANDARD	Safe Care
	Individual care, Timely care, Dignified Care, Staff & resources
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
	However, a wider nurse workforce equality review is required
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Compliance with the relevant sections of the Nurse Staffing Levels (Wales) Act 2016 is a statutory obligation and will be subject to scrutiny
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Given the duty of the act, in the event of patient acuity and / or numbers increasing the staffing levels will need to be increased accordingly. This will have a financial impact

5. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **NOTE** the Annual Assurance Report for 2022/2023 as assurance that the necessary processes and reviews have taken place for Velindre NHS Trust to remain compliant with its duties under the Nurse Staffing Levels (Wales) 2016 Act.

Annual Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act: Report for Board/Delegated Committee			
Health board	Velindre University NHS Trust		
Date annual assurance report is presented toBoard	4th May 2023 Reporting period 6th April 2022 to the 5th April 2023		
	Adult acute medical inpatient wards	**Adult acute surgical inpatient wards**	**Paediatric inpatient wards**
During the last year the lowest and highest number of wards	1		
During the last year the number of occasions (for section 25B wards)where the nurse staffing level has been reviewed/ recalculated outside the bi-annual calculation periods	0		
The process and methodology used to calculate the nurse staffing level.	Velindre University NHS Trust has one medical inpatient ward that falls under Section 25B of the Nurse Staffing Levels (Wales) Act 2016 which is the First Floor Ward, Velindre Cancer Centre. The triangulated methodology prescribed in section 25C of the Nurse Staffing Levels (Wales) Act 2016 and documented in the Welsh Levels of Care Toolkit has been utilised to inform the calculation of the nurse staffing levels. A quality improvement approach is central to the bi-annual establishment review process. When calculating the nurse staffing levels, quality indicators including patient falls, pressure damage, medication errors and patient complaints are taken into consideration to inform the calculation of safe nurse staffing levels. Patient acuity data and patient flow is discussed and bed occupancy rates are also considered. Key performance indicators are analysed during the review process. Following the bi-annual acuity audit process, establishment reviews take place with the senior nursing team and the ward management team and include detailed professional discussions on whether the current establishment is appropriate to deliver safe and effective care. In accordance with statutory guidance, the ward manager has remained supernumerary throughout the reporting period. In addition to the ward manager a band 6 nurse coordinator is also additional to the planned roster, however, they do assist with patient care and on occasions are included in the planned roster if the need arises. The current whole time equivalent establishment includes the required 26.9% uplift as mandated by the Nurse Staffing Levels (Wales) Act 2016.		

The ward has not changed its 'primary purpose' during the reporting period. At the start of the reporting period, First Floor had 22 beds open to patients (to account for social distancing and COVID 19 restrictions). Due to the relaxation of national COVID 19 guidance and increasing demand, the ward increased back to full capacity of 32 beds in September 2022.

During the reporting period acuity data was recorded once a day. Since March 2023 acuity has been scored twice a day using the SafeCare module which will facilitate richer data and real time data capture. Acuity levels have remained fairly consistent over the last two years with an increase in patients scoring level 3 and 4 acuity levels and a slight decrease in Level 5 acuity.

Level 5	**One to One Care** - the patient requires at least one to one continuous nursing supervision and observation for 24 hours a day
Level 4	**Urgent Care** - The patient is in a highly unstable, unpredictable condition either related to their primary problem or an exacerbation of other related factors.
Level 3	**Complex Care** - The patient may have a number of identified problems, some of which interact, making it difficult to predict the outcome of individual treatment
Level 2	**Care Pathways** - The patient has a clearly defined problem but there may be a small number of additional factors that affect how treatment is provided.
Level 1	**Routine Care** - The patient has a clearly identified problem, with minimal other complicating factors.

The percentage of patients assigned to each level as a proportion of the total data captured

WLOC Level	2021-2022	2022-2023	Trend
Level 5	9.8%	6.5%	↓
Level 4	39.9%	46.7%	↑
Level 3	41.1%	43.8%	↑
Level 2	9.1%	3.1%	↓
Level 1	0.2%	0.02%	↓

Informing patients

Bilingual All Wales 'Informing Patients Posters' are displayed at the entrance of the ward informing patients and relatives of the nurse staffing numbers calculated for the identified period and the date that the calculation was undertaken and signed off by the designated person. The posters are updated following each bi-annual re-calculation. In addition, copies of the All Wales FAQ's on Nurse Staffing Levels are available for patients and visitors to the ward.

Patients can provide anonymous feedback through a digital feedback system called CIVICA. This helps to ensure that patients can provide real time feedback for any concerns relating to patient care.

Section 25E (2a) Extent to which the nurse staffing level has been maintained

As the nurse staffing level is defined under the NSLWA as comprising both the planned roster *and* the required establishment, this section should provideassurance of the extent to which the planned roster has been maintained *and* how the required establishments for Section 25B wards have been achieved/maintained over the reporting period.

Extent to which the required establishment has been maintained within <u>adult acute medical and surgical wards.</u> NB: First cycle: spring 2022 following January audit Second cycle: autumn 2022: following June audit		**Period Covered – April 2022 – April 2023**		
		Number of Wards:	**RN (Wte)**	**HCSW (Wte)**
	Required establishment (WTE) of <u>adult acute medical and surgical wards</u> calculated during first cycle (May)	1	23.68	23.68
	WTE of required establishment of <u>adult acute medical and surgical wards</u> funded following first (May) calculation cycle	1	23.68	23.68
	Required establishment (WTE) of <u>adult acute medical and surgical wards</u> calculated during second calculation cycle (Nov)	1	28.42	14.21
	WTE of required establishment of <u>adult acute medical and surgical wards</u> funded following second (Nov) calculation cycle	1	28.42	14.21
	The nursing establishment is sufficiently funded and appropriate to provide the planned roster for First Floor. There are no financial concerns in relation to the staffing of First Floor. In-patient bed capacity was reduced 22 beds during the pandemic. After undertaking a review of the current funded nursing establishment against the required establishment for First Floor Ward, the Integrated Care Directorate is of the opinion that the current establishment is sufficient to manage and deliver care sensitively to 32 beds from September 2022.			

Extent to which the planned roster has been maintained within<u>adult acute medical and surgical wards</u>

	Total number of shifts	Shifts where planned roster met and appropriate	Shifts where planned roster met but not appropriate	Shifts where planned roster not met but appropriate	Shifts where planned roster not met and not Appropriate	Data completeness
TOTAL	*652*	*414* *64%*	*36* *5%*	*72* *11%*	*130* *20%*	*89% (due to spanning two data capture systems)*

The data shows that 64% of shifts were reported where the planned roster was met and it was deemed appropriate. There is a slight variation in the data showing that the night shifts displayed better compliance with the planned roster. 5% of shifts that reported the planned roster was met but not appropriate, the accompanying narrative in relation to these shifts predominantly highlighted increased patient acuity. The planned roster was not met but was appropriate in 11% of shifts. It was reported that the planned roster was not met and not appropriate in 20% of shifts. On such occasions temporary staffing is considered and requested, however, it is not always available especially if staff sickness is reported near shift commencement or during a shift. Analysing the data and accompanying narrative it is important to note that the planned roster is not met on many occasions due to vacant beds on the ward. Analysis of the Health Care Monitoring System (HCMS) data indicates that the average bed occupancy from September 2022 to April 2022 was 61%, hence the planned roster is not always deployed. To ensure consistency of approach Welsh Levels of Care acuity scoring and reporting training continues to be delivered to ward staff.

Implementation of SafeCare to First Floor in Velindre was complete in March 2023. Health Care Monitoring System (HCMS) has been utilised for data capture for the current reporting period. SafeCare data will be utilised for future reporting periods. SafeCare system, is now the national system that is being implemented within Health Boards/Trusts to enable organisations to meet the requirements of the Nurse Staffing Levels (Wales) Act 2016.

During April 2022 to April 2023 Velindre University NHS Trust has recorded acuity daily using the Health Care Monitory System and commenced acuity recording in the pilot phase of SafeCare implementation from March 2023.

When the second duty of the Nurse Staffing Levels (Wales) Act 2016 (the Act) came into force in April 2018, there was no consistent solution to extracting all of the data explicitly required under section 25E of the 2016 Act, and health boards/trust were using a variety of e-rostering and reporting systems. During the first reporting period health boards/trusts in Wales worked as part of the All Wales Nurse Staffing Programme, to enhance the Health Care Monitoring system (in lieu of a single ICT solution) to enable each

	organisation to demonstrate the extent to which the nurse staffing levels across the health board/trust. Over the last 3 years extensive work has been undertaken to inform the development of the Safecare system that continues to be implemented within health boards and trusts within Wales through a phased approach. Velindre implemented Safecare on First Floor Ward from March 2023. The national implementation of Safecare will ensure consistency in recording and reporting data across organisations in Wales. During year 1 of the current reporting period (April 2021-April 2022) heath boards/trusts have utilised 2 systems to enable the capture and analysis of data – the HealthCare Monitoring System and Safecare. Due to the COVID-19 pandemic health boards/trusts have experienced extreme operational pressures which has impacted on the organisations ability to implement Safecare within the desired timeframe and data capture has not been consistent throughout that period During April 2022 to April 2023 Velindre University NHS Trust has recorded acuity daily using the Health Care Monitory System and commenced acuity recording in the pilot phase of SafeCare implementation from March 2023.
Process for maintaining the Nurse staffing level	There are risk escalation processes in place to enable real time nurse staffing levels risk escalation. Concerns regarding nurse staffing levels in Velindre Cancer Centre are escalated to the senior nursing team via a bleep system. Operational teams are taking "all reasonable steps" to maintain the nurse staffing level as per the requirements of the Act. Reasonable steps are considered and staff redeployment from other areas as well as bank and agency are utilised if staffing levels are deemed insufficient. SafeCare is used to help determine whether staffing levels are appropriate for the acuity of the patients. Operational steps to maintain the nurse staffing level include: • There are clearly defined mechanisms in place to ensure deployment of staff to ensure appropriate clinical and/or leadership skills. • Deployment of staff deemed as supernumerary or non-rostered for example, ward manager, nurse co-ordinator and practice educator to provide direct patient care. • Utilising bank and agency. • Incentivised pay for substantive staff during the reporting period has contributed to additional staffing capacity.

Section 25E (2b) Impact on care due to not maintaining the nurse staffing levels in adult acute medical & surgical inpatients wards						
Incidents of patient harm with reference to quality indicators and any complaints about care provided by nurses	**Total number of incidents/ complaints during last year**	**Number of closed incidents/ complaints during current year**	**Total number of incidents/ complaints not closed and to be reported on/during the next year**	**Increase (decrease) in number of closed incidents/ complaints between previous year and current year**	**Number of incidents/ complaints when the nurse staffing level (planned roster) was not maintained**	**Number of incidents/complaintswhere failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor**
Hospital acquired pressure damage (grade 3, 4 and unstageable)	0	0	0	No change	0	0
Falls resulting in serious harm or death (i.e. level 4 and 5 incidents).	1	0	1	No change	0	0
Medication errors never events	0	0	0	No change	0	0
Any complaints about nursing care	1	1	0	Increase of 1	0	0

NOTE: *Complaints refers to those complaints made under NHS Wales complaints regulations (Putting Things Right (PTR)*

There have been no incidents of harm relating to the quality indicator of pressure damage. No medication never events have occurred during the reporting period. There has been one fall resulting in harm which is yet to be concluded and will be reported on in next years Annual Assurance Report. There has been one complaint concerning nursing care managed through the Putting Things Right complaints regulations. This complaint was not solely related to nursing care and was not attributable to the nurse staffing level on the ward. Learning has been shared in relation to this complaint and a task and finish group was set up to improve quality and safety in relation to enteral feeding.

	Section 25E (2c) Actions taken if the nurse staffing level is not maintained
Actions taken when the nurse staffing level <u>was not</u> maintained in section 25B wards	When nurse staffing levels have not been able to be maintained, there is evidence that operational teams are taking 'all reasonable steps' to maintain the nurse staffing levels e.g. the utilisation of temporary workforce, using a risk based approach to move staff. In addition: • All incidents related to inpatient falls and pressure damage are reviewed by a monthly scrutiny panel, nurse staffing is considered as a possible contributing factor of the investigations carried out. • The medication safety group meets monthly to discuss all incidents relating to medication errors, to share good practice and plan any relevant learning. • Regular Trust wide complaints meetings are held to discuss complaints, concerns and compliance with the Putting Things Right process. • During the COVID 19 pandemic bed capacity was reduced to 22 beds on the ward to aid social distancing.
Conclusion & Recommendations	• The planned roster and ward establishment has not changed during the reporting period. • The nursing establishment is sufficiently funded and appropriate to provide the planned roster for First Floor. There are no financial concerns in relation to the staffing of First Floor. • Due to the unprecedented challenges of the COVID 19 pandemic, beds on First Floor were reduced to 22, they are now open to the full capacity of 32 beds. • There have been reported shifts where the planned roster was not met and not appropriate mainly due to staff sickness and/or increased acuity. Bed occupancy figures reveal that the ward usually has empty beds so the planned roster would not necessarily have been appropriate on all occasions. It is evident that all 'reasonable steps' were taken to maintain the nurse staffing levels. • An upward trend in the level of acuity is apparent for levels 3 and 4, however there has been a decrease in level 5 patients during the reporting period. • There have been no instances of pressure damage in relation to the reportable quality indicators and no medication never events. • There has been one fall which is yet to be concluded and will be reported on in subsequent reports. • One complaint in relation to nursing care has been received for First Floor. This was not as a result of staffing, key learning has been shared and plans to improve quality and safety in this area have been enacted. • SafeCare is now established on First Floor ward and will be utilised for future reporting. • Welsh Levels of Care training continues to be delivered to ward staff with the aim of improving consistency of recording and reporting.

Annual Assurance Report Appendix: Summary of Required Establishment

Health board/trust:	Velindre University NHS Trust		
Period reviewed:	Start Date: 6th April 2022	End Date: 5th April 2023	
Number of wards where section 25B applies:	**Medical:**	**Surgical:**	**Paediatric:**
	1	0	0

To be completed for EVERY ward where section 25B applies

Adult Acute Medical inpatient wards

Ward	**Required Establishment at the start of the reporting period (as at April 6th 2022)**		**Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?***	**Required Establishment at the end of the reporting period (as of April 5th 2023)**		**Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?***	**Biannual calculation cycle reviews, and reasons for any changes made**			**Any reviews outside of biannualcalculation, if yes, reasons for any changes made**		
	RN WTE	**HCSW WTE**		**RN WTE**	**HCSW WTE**		**Completed**	**Changed**	**Rationale**	**Completed**	**Changed**	**Rationale**
First Floor	23.68	23.68	Yes	28.42	14.21	Yes.	Yes	No	Figures differ due to previous miscalculation	No	NA	NA

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Digital Services Quality Report

DATE OF MEETING	16/05/2023
PUBLIC OR PRIVATE REPORT	Private
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	INFORMATION / NOTING
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	David Mason-Hawes – Head of Digital Delivery
PRESENTED BY	Carl Taylor – Chief Digital Officer
APPROVED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital
EXECUTIVE SUMMARY	The attached report sets out the latest position in respect of Digital Services delivery, for the period January 2023 – March 2023 inclusive.
RECOMMENDATION / ACTIONS	No actions required – QSP are asked to **NOTE** the report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
EMB (via Email)	**02/05/2023**
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Report has been updated to reflect recent recommendations of the structured assessment, which included an action to further develop this report to better reflect anticipated benefits that were expected to be realised via the various digital projects and programmes across the Trust. This information has been included in the IMTP update.	

7 LEVELS OF ASSURANCE	
n/a – report for **NOTING** only.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	n/a

APPENDICES	
Appendix 1	Digital Services Quality Report (Jan – March 2023)

1. SITUATION / BACKGROUND

The Digital Services Quality Report, attached as Appendix 1, sets out progress against the digital objectives set out in the Trust Integration Medium Term Plan, key risks and a summary update of recent Significant IT Business Continuity incidents at the Trust for the period Jan-Mar 23.

It is presented to the Quality, Safety and Performance Committee for **NOTING**.

2. ASSESSMENT

Appendix 1 shows an updated view of the Digital IMTP for 23/24 and we have started to introduce the benefits that should arise from the work programme so that this can be tracked in future updates. The programme is largely on track with access to resources continuing to be a challenge, particularly in the Cyber Security area where we have yet to appoint the new Cyber Security lead. Phase 1 of DHCR continues to progress as a Project, although the end date for Phase 1 was March '23, this is to support the continued bedding in of the system into VCC. In the plan there are 0 items in Red, 11 items reporting Amber and 31 Green.

A new 'high' risk was raised in the last reporting period – namely, the risk to operational / clinical services should the new Laboratory Information Management System (LIMS) service not be fully deployed before the contract for the current national LIMS contract expires in June 2025. 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. In April it was confirmed that the proposed Citadel Health solution was not to be progressed so alternative arrangements need to be established.

There was only 1 significant IT business continuity incident in the period January 2023 to March 2023 inclusive. This was a loss of a network node room on 11th Jan 2023 which impacted VCC services, including telephony and lasted from 09am-10:15am. Work remains ongoing to remove legacy IT infrastructure in use across the Welsh Blood Service and the Velindre Cancer Centre and this is often at the root cause of the significant IT business continuity incidents.

3. SUMMARY OF MATTERS FOR CONSIDERATION

No immediate matters for consideration / action.

The Quality, Safety and Performance Committee are asked to **NOTE** the report.

4. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☒ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☒ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: Trust Assurance Framework*	07 - Digital Transformation - Failure to Embrace New Technology
QUALITY AND SAFETY IMPLICATIONS / IMPACT	
	Safe ☒ Timely ☐ Effective ☒ Equitable ☐ Efficient ☒ Patient Centred ☐
	High performing and resilient digital services are key to maintain the safe, effective and efficient delivery of all Trust clinical and operational services.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	If more than one Well-being Goal applies please list below:
	If more than one wellbeing goal applies please list below:

	Click or tap here to enter text
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	Two new risks associated with the financial risks associated with "digital inflation" and the increasing move towards the provision of commercial digital services via a revenue model have been reflected in this latest report. The digital services IMTP includes objectives to set a clear plan for recruitment of staff into the team and the enhancement of Trust IT infrastructure and networking services. The financial implications for these are yet to be fully assessed.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	This paper provides and update on progress in terms of the delivery of the Trust digital programme and associated objectives. There are no aspects of the update that relate to or impact upon equality and/or patient identifiable information.

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

5. RISKS

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

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	
WHAT IS THE CURRENT RISK SCORE	
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	
All risks must be evidenced and consistent with those recorded in Datix	

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Digital Services Quarterly Report

(January 2023 – March 2023)

1. Introduction

1.1 The update covers the period January 2023 to March 2023.

1.2 The paper provides a summary update on the following key areas:

1.2.1 Digital Programme Update – an update on progress against the digital services objectives in the 2023/24 Trust Integrated Medium Term Plan (IMTP).

1.2.2 A summary of key digital risks within the organisation.

1.2.3 Summary descriptions of any significant IT business continuity incidents during the period January 2023 to March 2023.

2. Digital Programme Update

The table below outlines the key digital objectives deliverables within the Trust 2023/24 Integrated Medium Term Plan (IMTP):

Objective	Target Completion Date	Benefits	RAG Status	Update
Ensuring Our Foundations (Digital Strategy – Theme 1)				
VCC Digital Health & Care Record Phases 1b & 2	Q1 – Q4	Improved patient experience. Increased clinical and operational efficiency.		Work ongoing to remediate data quality / operational challenges from initial deployment in November 2022. Draft scope for phase 1b and 2 has been agreed.
Blood Establishment Computer System (BECS). - Procure new contract & commence implementation	Q1 – Q4	Improved donor experience. Increased operational efficiency.		Prior Information Notice (PIN) issued; 3 suppliers invited to engagement days taking place in early May 2023. Formal procurement to take place through late-Q1/Q2 2023/24.
Electronic Prescribing (ePMA) - Procurement / Contract Award (Q3) - Commence Go-Live (Q4)	Q1 – Q4	Improved patient experience. Improved clinical and operational efficiency.		Digital Priorities Investment Funding (DPIF) approved via Welsh Government Digital Scrutiny Panel – recruitment of project team to commence. Initial scoping work underway. Formal procurement to take place through Q3/Q4 2023/24.
WHAIS IT System for WTAIL. - Procure new contract & commence implementation	Q1 – Q4	Increased WBMDR activity & income. Improved operational efficiency. Improved staff recruitment & retention.		Digital Priorities Investment Funding (DPIF) approved via Welsh Government Digital Scrutiny Panel. User Requirements Specification agreed; procurement due to be formally issued in Q1 2023/24.

Objective	Target Completion Date	Benefits	RAG Status	Update
Radiotherapy Satellite Centre - Procurement / Readiness	Q1 – Q4	Improved patient experience. Delivery of SACT and radiotherapy treatment closer to home.		Digital requirements established. Scoping work ongoing, supported by Digital Services team.
Integrated Radiotherapy Solution (IRS). - Offside Data Centre - Workflow Redesign	Q1 – Q4	Improved patient experience. Improved operational and clinical efficiency.		Mosaiq upgrade completed in Q4 2022/23. Work ongoing to establish offside data centre, to support future IRS requirements. Digital Services supporting wider work programme as required.
Radiology Informatics System Procurement (RISP) – local implementation.	Q1 – Q4	Improved patient experience. Improved operational and clinical efficiency.		National Full Business Case in process of being reviewed via relevant Trust committees and Board to complete in May 2023. Project team established, to work with national RISP team in DHCW. Current provisional implementation date for VCC – Jan to March 2025.
Replace digital solution for the Welsh Bone Marrow Donor Registry (WBMDR). - User research (Q2) - Commence implementation (Q3)	Q1 – Q4	Increased operational efficiency.		Initial scoping underway, formal project delivery arrangements yet to be established.
Chemocare v6 Upgrade			COMPLETED	Upgrade delivered in March 2023, v5 switched off April 2023.

Objective	Target Completion Date	Benefits	RAG Status	Update
Printer Management Establish new management arrangement and governance for VUNHST printer estate	Q1 2023/24	Improved operational efficiency. Reduced costs.		Legacy invoicing issue now resolved. Digital Services team now actively managing all printer ordering / invoicing for VCC. New print management solution due to be delivered in VCC in Q1 2023/24. Longer-term aim is to procure new pan-Trust printer management contract – target late-2023/24.
Telephony Procure and implement new / replacement Trust-wide telephony solution	Q1 – Q4	Reduced operational costs. Increased IT support / infrastructure resilience. Improved support for hybrid working.		New SIP licencing in place for VCC – significant financial savings anticipated, to be delivered from 1st July 2023. Pilot of Teams Voice platform underway, plans to adopt through 2023/24. Staff engagement to take place through Q1 2023/24.
IT Infrastructure Establish Digital Infrastructure Strategy and delivery programme, including 'cloud first' strategy	Q3	Fully costed IT infrastructure roadmap and delivery plan.		Initial scoping underway.
IT Service Management Tool Implement new IT Service Management (ITSM) / Digital Service Desk management tool.	Q3	Reduced response timelines through Increased automation. Improved operational efficiency. Improved staff satisfaction with Digital Service Desk (PMF)		Awaiting publication of Outline Business Case via All Wales Infrastructure Programme – delayed from end of March 2023. DHCW to lead procurement of new national ITSM tool. VUNHST to undertake options appraisal on next steps in Q1 2023/24.

Objective	Target Completion Date	Benefits	RAG Status	Update
Pilot new end user device performance monitoring tool → full implementation subject to business case	Q3	Improved IT infrastructure resilience. Quicker remediation of IT support issues through early identification & automation.		Pilot commenced April 2023 – due to report findings in June 2023.
Digital Inclusion (Digital Strategy – Theme 2)				
Digital Platform Establish technical capability and baseline current capabilities.	Q3	Identification of opportunities and challenges in respect of delivery of Trust digital programme.		Work due to commence in Q1.
Increase rates of virtual consultations (VCC). - Pilot new service delivery model (Q2) - Implement new service delivery model (Q4)	Q4	Improved patient experience – choice of appointment types. Improved operational efficiency.		Scoping of new implementation project underway, potential for national funding – subject to approval via national programme board. Initial engagement with clinical groups commenced April 2023; further scoping ongoing.
Insight Driven Services (Digital Strategy – Theme 3)				
Transfer of Business Intelligence teams into to Digital Services.	Q4	Improved operational efficiency. Improved resilience, reduced turnaround time for BI request. Ability to fully utilise BI toolset, development of self-service portals etc.		Proposal re: scope / approach agreed via EMB in April 2023. Aim for approval of changes via relevant Trust governance in Q2. New Head of Data and Analytics role to be created to lead the service.

Objective	Target Completion Date	Benefits	RAG Status	Update
Implement PSA Tracker	Q3	Improved patient experience. Reduction in volume of in-person follow-up attendances in Urology.		Pilot deployment went live in March 2023; further scoping underway to determine approach for proposed delivery of the national (fully-integrated) version of the platform in Q3. Administrative resource is not currently funded through SLT.
PROMS / PREMS – scoping / implementation.	Q3	Improved patient experience.		Consultancy support established; scoping work underway. Wider recruitment plans yet to be finalised – e.g. recruitment into digital services and BI roles.
Safe & Secure Services (Digital Strategy – Theme 4)				
Cyber Security Recruit additional cyber technical expertise	Q1	Increased protection for Trust digital systems and services. Increased cyber security resilience.		Significant challenges in recruitment for cyber security roles. Previous band 6 Cyber Security Officer role reviewed, following failure to appoint. New band 7 Cyber Security Manager role created – interviews scheduled for May 2023.
Cyber Security Enhance network infrastructure and end user monitoring capabilities.	Q2	Increased protection for Trust digital systems and services. Increased cyber security resilience.		Some progress continues to be made, as presented in Cyber Security Strategic Plan mid-year update (May 2023). However, significant improvements delayed whilst Cyber Security Manager role has remained unfilled.
Cyber Security Review data backup and recovery arrangements.	Q2	Increased protection for Trust digital systems and services. Increased cyber security resilience.		Progress made to standardise arrangements across WBS and VCC in 2023/24. A further review of the overall backup strategy is planned for 2023/24.

Objective	Target Completion Date	Benefits	RAG Status	Update
Cyber Security Pilot new tools to support monitoring capability.	Q3	Increased protection for Trust digital systems and services. Increased cyber security resilience.		Pilot commenced April 2023 – due to report findings in June 2023.
A Digital Organisation (Digital Strategy – Theme 5)				
Digital Programme Establish Digital Programme.	Q1 – Q4	Clear delivery roadmap and delivery programme for VUNHST digital services. Clearly established governance arrangements for delivery of VUNHST digital transformation programme.		External consultancy – Perago – brought in to review current arrangements, commenced April 2023 for 12 weeks engagement.
Digital Services Capacity & Capability Build the capacity and capability of Digital Services team. - Take forward Phase 2 of the Digital Services Recruitment Strategy. - Develop and implement new Target Operating Model	Q1	Increased capacity to deliver Digital Programme to agreed timescales. Clear delivery model for execution of digital projects, delivery of industry-standard approach for digital transformation.		Additional fixed-term funding in process of being released from national projects / programmes (e.g. ePMA, TEC Cymru). A review of 2023/24 recruitment requirements is in progress.
Implement Electronic Radiology Test Requesting	Q2	Reduced errors. Increased operational and clinical efficiency.		Testing / training underway.
Digitising Medical Records – develop business case.	Q1 – Q4	nVCC readiness. Increased operational and clinical efficiency.		Programme yet to be formally established; project scope yet to be defined.

Objective	Target Completion Date	Benefits	RAG Status	Update
Robotic Process Automation Scoping Establish funding route to support RPA Recruit RPA Lead	Q1 – Q4	Increased operational efficiency Significant staff time savings through automation of routine / high volume tasks. Potential cost (financial) savings.		Funding for RPA Lead yet to be identified. Potential funding route via NDR identified.
Robotic Process Automation Establishment of PoCs / pilots. Establish RPA service (non-clinical workflows only).	Q1 – Q4	Increased operational efficiency. Significant staff time savings through automation of routine / high volume tasks. Potential cost (financial) savings.		Initial scoping of proof of concept opportunities undertaken with supplier and VUNHST Finance – aim to commence activity in Q1 2023/24.
Office 365 Re-establish Office 365 project.	Q1	Increased staff productivity and operational efficiency.		Project structure yet to be defined.
Implement Digital Inclusion Charter.	Q3	Strategic intent to ensure digital inclusion at heart of Trust digital initiatives.		Digital Inclusion Charter signed. Work due to commence in Q1 on action plan
Initiate 'Digital Enabled Workforce' Programme (Induction/Access/ Skills), including establishment of Digital Champions.	Q2	Establish capacity to further develop and improve Trust digital maturity.		Work due to commence in Q1.
Baseline assessment of current digital workforce capability.	Q2	Identification of opportunities and challenges in respect of delivery of Trust digital programme.		Work due to commence in Q1.
Deliver Desk / Room booking IT platform, to support delivery of VUNHST Hybrid Working.	Q4	Improved operational efficiency. Improved estate management. Improved staff morale.		Current on hold, pending further review of Trust hybrid working approach.

Objective	Target Completion Date	Benefits	RAG Status	Update
Establish 'Live' connectivity for WBS Collection Teams – PoC → Full Implementation.	Q3	Reduction in manual / paper-based processes. Improved compliance with risk / incident reporting. Live view of WBS donation activity for reporting, demand management etc.		IT equipment to support pilot purchased; aim to progress with initial PoC in Q1 2023/24.
WBS Laboratory Device Integration / Automation. - Agree interface development strategy & delivery plan (Q4)	Q4	Improved operational efficiency. Reduction in data quality errors.		Work due to commence in Q1.
Software Development Re-platform WBS Appts. System.	Q3	Improved stability of IT service. Ability to integrate Appts. System into national IT services (e.g. NHS Wales app) via API.		Initial scoping underway, user feedback obtained. Development plan to be established in Q1 2023/24.
Software Development Re-platform VCC Treatment Helpline.	Q1	Increased stability of IT service. Improved usability of VCC Treatment Helpline software. Future proofing.		Due to be completed in May 2023.
Working In Partnership (Digital Strategy – Theme 6)				
BAU support for externally deployed solutions (WIBSS, Appts. System etc.)	Q1 – Q4	Reputational management. Income streams.		BAU support being maintained and managed via formal SLA agreements.
Explore commercial opportunities for in-house developed systems	Q3	Potential income streams.		Scoping work underway.

Objective	Target Completion Date	Benefits	RAG Status	Update
Digital Services staff to join Intensive Learning Academy (USW).	Q2	Staff recruitment & retention. Access to emerging digital talent.		Already engaged with USW ILA – further relationship building anticipated in Q1 2023/24.
Grow Digital Apprenticeship capacity in Digital Services.	Q1	Improved resilience. Staff motivation / recruitment & retention.		Two IT Undergraduate Trainees already in the team. Targeting the introduction of further formal apprenticeships into the team.
HIMSS EMRAM Digital Maturity Assessment.	Q2	Identification of digital priorities for improvement / investment. National assessment of Trust digital services.		Assessment completed in March 2023. Final report being produced by HIMSS, expected to report in Q1 2023/24. A national usability survey is being conducted to go alongside the maturity assessment. Survey closes early May 2023.

3. Digital Services Risks

A new 'high' risk was raised in the last reporting period – namely, the risk to operational / clinical services should the new Laboratory Information Management System (LIMS) service not be fully deployed before the contract for the current national LIMS contract expires in June 2025. 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. Velindre University NHS Trust operational and clinical staff are supporting its ongoing delivery.

The following two risks were also raised in last reporting period:

- Risks of increased costs to the Trust associated with "digital inflation" – may impact on future digital and/or operational budgets.
- Risk of increased costs / financial challenges associated with the increasing transition of digital costs from capital → revenue – may impact on future digital and/or operational budgets.

The risk treatment plan for both risks is 'TOLERATE' – both risks have therefore been closed as not for active monitoring / action.

Various other risks (max score = 12) relating to ongoing use of 'end of life' IT infrastructure – e.g. ongoing use of legacy operating systems in some areas of VCC. Removal of unsupported services remains ongoing.

Recruitment remains a challenge for Digital Services; in particular, recruitment to specialist roles (e.g. cyber, IT infrastructure, software development). Agency support to be explored for difficult to fill roles.

4. Significant IT Business Continuity Incidents

There was only 1 significant IT business continuity incident in the period January 2023 to March 2023 inclusive. There were no issues classified as significant IT Business Continuity incidents in February or March 2023.

Date	Description	Harm	Notes
11/01/2023	VCC Node Room M network unavailable	None	VCC services, including telephony, disrupted from approx. 9am – 10.15am.

Whilst performance was somewhat improved in Q4 2023/24; however, the rolling 12-month trend (12 as at March 2023) requires further work to improve the overall Trust position. Work remains ongoing to remove legacy IT infrastructure in use across the Welsh Blood Service and the Velindre Cancer Centre. The ongoing use of such 'end of life' services is often one of the challenges in maintaining a stable and resilience IT platform. The Digital Services team remain committed to addressing this legacy estate, with plans to further remove relevant equipment built into the 2023/24 work programme, with early progress expected to be delivered in quarter 1 2023/24.

QUALITY, SAFETY & PERFORMANCE COMMITTEE – MARCH 2023 REFLECTIVE EVALUATION FEEDBACK

Response Rate: 19% response rate (4 out of 21)

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, worked well with change of agenda format.	No, the meeting overran (again).	Yes.	I believe the committee is improving in the way in which it is able to focus / time on the key issues. It still remains challenging to really focus on key areas given the size of the agenda; volume of information etc. We still have too many papers to really allow a focus on some of the key issues – although it has / continues to improve i.e. better information/insight; better triangulation of information to allow key risk / issues to be identified and discussed.	**Responsible Executives to identify which papers contain information that require full discussion and advise on time required**	Executive Leads / Secretariat
Were papers concise and relevant, containing the appropriate level of detail?	Work still required to make papers more concise but much improved overall.	Whilst improving, papers still tend to be extremely long and rich in narrative, with too much detail for this level of Committee.	Yes.	The papers are still a bit variable in their conciseness, although there are clear and constant improvements. Papers using a shorter / sharper approach would improve the discussion i.e. focus on the risks / issues and what we are doing.	**Executive leads to ensure papers are concise and contain focused detail targeted for the audience. Further refining of meeting papers will be supported through the Integrated Quality & Safety Group as this matures in its development and role supporting effective Committee reporting**	Executive Leads/Integrated Quality & Safety Group
Was open and productive debate achieved within a supportive environment?	Yes.	Yes.	Yes, although discussions can run on / deviate due to the complexity of operational delivery, coupled with an extensive change programme for an organisation of our size. This in itself creates ambiguity. More targeted site visits may alleviate some of the necessity of scene setting, enabling productive debate at the right level.	Yes, the committee discussion is open, transparent with challenge as appropriate.	**N/A**	
Was it possible to identify cross-cutting themes to support effective triangulation?	Yes.	Not always, although the discussions helped.	In part, although we are still in our infancy in achieving this.	Yes, this has improved significantly and continues to progress; it will be further enhanced with better business intelligence and other information (e.g. clinical audit; other audits etc).	**This will naturally continue to improve supported by the role of the Integrated Quality & Safety Group**	

Was sufficient assurance provided to Committee members in relation to each item of business received?	Mainly further assurance required regarding workforce transformation plans and risk registers.	Yes, but this could have been achieved with much less detail in the documents.	Things have unquestionably improved with the Chair's experience and guiding a clear direction. There remain opportunities to improve and fully embed a meaningful way of working together to provide not only assurance, but create an environment to flourish and succeed.	Yes. The officers provided insight and grip of the issues in their responses and also provide information requested before/after the meeting to the committee.	**Further refining of meeting papers** **Full implementation of the 7 levels of assurance**	Executive Leads & Director of Corporate Governance & Chief of Staff