Public Quality, Safety & Performance Committee

Tue 17 January 2023, 10:00 - 13:00

Via Microsoft Teams

Agenda

10:00 - 10:15
15 min

1. PRESENTATIONS

1.1. Velindre Cancer Centre - Patient Story

Michele Pengelly, Specialist Nurse

1.1.0 QSP presentation January 2023.pdf (5 pages)

10:15 - 10:40
25 min

2. STANDARD BUSINESS

2.1. Apologies received from

Led by Vicky Morris, Quality, Safety & Performance Committee Chair

2.2. In Attendance

Led by Vicky Morris, Quality, Safety & Performance Committee Chair

2.3. Declarations of Interest

Led by Vicky Morris, Quality, Safety & Performance Committee Chair

2.4. Review of Action Log

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

2.4.0 Public QSP Action Log January 2023.pdf (8 pages)

2.5. Matters Arising

Led by Vicky Morris, Quality, Safety & Performance Committee Chair

2.5.1. Committee Effectiveness Survey - Updated Action Plan

Led by Emma Stephens, Head of Corporate Governance

2.5.1 Updated Committee Effectiveness Survey Action Plan_November 2022.pdf (2 pages)

2.5.2. Updated Private Patient Improvement Plan

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

2.5.2 Private Patient Improvement Plan Update Report.pdf (3 pages)

10:40 - 10:50
10 min

3. CONSENT ITEMS

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

3.1. ITEMS FOR APPROVAL

3.1.1. Draft minutes from the meeting of the Public Quality, Safety & Performance Committee held on 10th November 2022

Led by Vicky Morris, Quality, Safety & Performance Committee Chair

3.1.1 Public Quality Safety Performance Committee Minutes 10.11.22 (v4approved).pdf (24 pages)

3.1.2. Trust Policies for Approval

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

3.1.2 QS02 MGT of Safety Alerts and Important Notifications Policy v1 (002).pdf (12 pages)

3.2. ITEMS FOR ENDORSEMENT

There are no items for endorsement.

3.3. ITEMS FOR NOTING

3.3.1. Draft Summary of the unapproved minutes from the meeting of the Private Quality, Safety & Performance Committee held on 10th November 2022

Led by Vicky Morris, Quality, Safety & Performance Committee Chair

3.3.1 Private Quality Safety and Performance Committee Summary Minutes 10.11.2022(v3approved).pdf (4 pages)

3.3.2. RD&I Sub Committee Highlight Report (15th November 2022)

Led by Jacinta Abraham, Executive Medical Director

3.3.2 RDI Highlight Report 151122 to QSPC FINAL.pdf (4 pages)

3.3.3. Transforming Cancer Services (TCS) Programme Scrutiny Sub Committee Highlight Report (17th November 2022)

Led by Stephen Harries, Vice Chair and Chair of the TCS Programme Scrutiny Sub Committee

3.3.3 Highlight Report - PUBLIC TCS 17.11.2022.pdf (4 pages)

3.3.4. Datix Project Report

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

3.3.4 DATIX Project Board Highlight Report 1.pdf (6 pages)

3.3.5. Medical Devices Report

Led by Cath O'Brien, Chief Operating Officer

3.3.5 QSP Medical Devices Paper. 17.01.2023.pdf (9 pages)

3.3.6. Information Governance Assurance Report

Led by Matthew Bunce, Executive Finance Director

3.3.6 QSP IG Assurance Report Quarter 3 2022-23-FINAL.pdf (9 pages)

3.3.7. Vaccination Programme Board Update

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

3.3.7 Vaccination Programme Board.pdf (3 pages)

3.3.8. Safe Care Collaborative

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

3.3.8 Safe Care Collaborative.pdf (16 pages)

3.3.9. Hepatitis E Virus Testing of Apheresis Platelet Donors

Led by Alan Prosser, Director of Welsh Blood Service

3.3.9 HEV Testing of Apheresis Platelet DonorsAP2.pdf (4 pages)

10:50 - 12:45
115 min

4. MAIN AGENDA

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

4.1. Trust Integrated Quality & Safety Group

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

4.1.0 Integrated Quality Safety Group.pdf (11 pages)

4.2. Duty of Quality Gap Analysis

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

4.2.0 Duty of Quality - Gap Analysis Paper.pdf (15 pages)

4.3. Workforce & Organisational Development Performance Report / Finance Report

Led by Sarah Morley, Executive Director of Workforce & Organisational Development and Matthew Bunce, Executive Finance Director

4.3.0 QSP Finance Workforce Key Risks Paper -Jan 2023 final_.pdf (15 pages)

4.3.1. Finance Report

Led by Matthew Bunce, Executive Finance Director

4.3.1 M8 Finance Report.pdf (28 pages)
4.3.1a Appendix 1 - TCS Programme Board Finance Report (November 2022) - Main Report.pdf (14 pages)

4.3.2. Workforce Report

Led by Sarah Morley, Executive Director of Workforce & Organisational Development

4.3.2 Trust-wide WOD Performance Report - Nov 2022.pdf (13 pages)

4.3.3. Gender Pay Gap Report

Led by Sarah Morley, Executive Director of Workforce & Organisational Development

4.3.3 QSP Gender Pay Gap Report 2022.pdf (17 pages)

4.4. Quality, Safety & Performance Reporting

Led by Cath O'Brien, Chief Operating Officer

4.4.0 VUNHST NOVEMBER PERFORMANCE COVER PAPER FOR JANUARY QSP v1_.pdf (9 pages)

4.4.1. Velindre Cancer Service Quality, Safety & Performance Divisional Report

Led by Rachel Hennessy, Interim Director of Velindre Cancer Service

4.4.1 Updated FInal Draft 05.01.2023 - Divisional QSP Report for Jul-Oct 2022-2023 (002) (004).pdf (32 pages)
4.4.1a VCC Performance Report - Nov 2022 v3.pdf (19 pages)

4.4.2. Welsh Blood Service Divisional Report

Led by Alan Prosser, Director of Welsh Blood Service

4.4.2 Nov2022 WBS PMF Report FINAL (003).pdf (10 pages)

4.5. Annual Equality, Diversity & Inclusion Report 2021-22

Led by Sarah Morley, Executive Director of Organisational Development & Workforce

4.5.0 QSP Annual Equality Report 2022 17.1.23.pdf (16 pages)

4.6. Business Continuity & Emergency Planning

Led by Cath O'Brien, Chief Operating Officer

4.6.0 VUNHST Business Continuity and Emergency Preparedness Work Programme.docxAPCOB.pdf (12 pages)

4.7. Sustainability Report 2021-22 (including Decarbonisation)

Led by Carl James, Director of Strategic Transformation, Planning and Digital

4.7.0 ANNUAL SUSTAINABILITY REPORT 2021-22.pdf (26 pages)

4.8. Trust Risk Register / Trust Assurance Framework

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

4.8.0 QSP - Trust Risk Register Paper - 17.01.20223 - Vfinal.pdf (20 pages)
4.8.0a Appendix 1 - RISK-AUDIT- 12.01.2023 - REPORT DATA-final.pdf (7 pages)
4.8.0b Appendix 2 - Risk Appetite Statements.pdf (5 pages)
4.8.0c TAF Review Paper - QSP - 17.01.2023 -Vfinal.pdf (4 pages)
4.8.0d QSP V23 - TAF DASHBOARD - 10.01.2023.pdf (13 pages)

12:45 - 12:55
10 min

5. INTEGRATED GOVERNANCE

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

5.1. January Analysis of Triangulated meeting themes

Led by Vicky Morris, Quality, Safety & Performance Committee Chair

5.2. January Analysis of Quality, Safety & Performance Committee Effectiveness

Led by Vicky Morris, Quality, Safety & Performance Committee Chair

- 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?

12:55 - 12:55
0 min

6. HIGHLIGHT REPORT TO TRUST BOARD

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

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

12:55 - 13:00
5 min

7. ANY OTHER BUSINESS

Led by Vicky Morris, Quality, Safety & Performance Committee Chair

7.1. Infected Blood Inquiry

Led by Cath O'Brien, Chief Operating Officer

7.1.0 Infected Blood Inquiry.pdf (6 pages)

What matters to me - Gaynor's story

Quality, Safety and Performance Committee 17th January 2023

Michele Pengelly
Supportive care Lead nurse

Background

- 48 year old lady
- Married, lived with husband, two adult children and daughter-in-law
- Diagnosed Ca endometrium 2011 treated with chemotherapy and radiotherapy, found to have metastatic disease July 2022
- Commenced palliative chemotherapy
- Emergency admission to first floor ward November 2022
- Discussion with Gaynor and her family with Specialist Registrar about disease progression, very poor prognosis and future plans
- 25th wedding anniversary blessing planned spring 2023, this blessing was extremely important to Gaynor
- 28th November 2022 Staff arranged wedding blessing at the hospital
- Discharged home 30th November 2022 in the care of her family, district nurses and community palliative care
- Died 5th December at home with the family

The team and services around the blessing

Sue Sheppard-Murphy
Carol O'Mahoney
Matt Weale
VCC Cancer services
Palliative care
Stefan Dale
First Floor staff
Operational services
Integrated services
VCC Fundraising
Ruth Stone
Leigh Porter
Tracey Langford
Quality and safety
Medical team
Rev Jason Tugwell
Pharmacy
Amy Penketh
Lucesca Walters
TCS
Benjamin Tugwell
Supportive care
Alex James

Challenges/Learning

Challenges

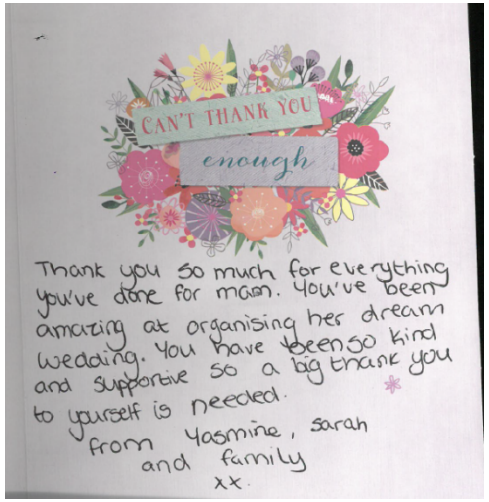
- Visiting restrictions – when should “compassionate visiting” start?
- Family felt that a lot of care was needed at home, which they did. However, this may have resulted in hospice admission if they hadn’t been able to manage - when Gaynor had expressed a wish to die at home. Could we have communicated more about care needs prior to discharge?

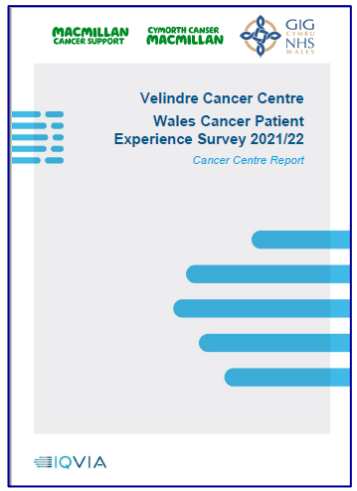
Good Practice

- Evidence of patient centred discussion and decision/plan – “what matters to you and how can we help?”
- Staff throughout VCC going the extra mile and working as a team to help organise an important memory.
- Displaying Trust values - ABCD
- Excellent support from Community nursing team
- Ongoing meetings with family members to help facilitate bereavement support

Learning

- Importance of asking patients “what matters to you”
- Remember it is what the patient wants not what we think they want
- Sharing our learning both within and beyond VCC:
  Guidelines written for staff and guidance for patients/families
  Patient dignity training
  Publication of VCC guidelines in the British Journal of Medicine
  Velindre wedding featured in 2022 Iris film festival
- Importance of care and support centred around both the patient and family
- Communication of needs prior to discharge





Special thanks to David, Sarah, Yasmine and Josh for generously giving their permission and time to share their story and for the very kind donation to the hospital in Gaynor's memory

It has been a complete privilege for VCC to be a small part of your story

QUALITY, SAFETY AND PERFORMANCE - PART A					
Minute ref	**Action**	**Action Owner**	**Progress to Date**	**Target Date**	**Status (Open/Closed)**
Actions agreed at the 14th July 2022 Committee					
4.4.0	ND to confirm Trust position re Putting Things Right in comparison to other organisations in the next quarterly PTR report.	Nigel Downes	**Update 10/01/2023** - A further update will be provided at the January 2023 Committee. Update 11/10/2022 - Benchmarking against other Health Boards' reporting in relation to Putting Things Right / Patient Experience is ongoing and will be concluded as soon as possible. NW advised that information made available by NHS Wales Health Boards would be presented at a future Committee. Update 08/09/2022 - A comparison to other organisations will be included in a future quarterly PTR report.	TBC	OPEN
Actions agreed at the 15th September 2022 Committee					
0.0.1	RH/VCS team to explore options for improved access to ambulance transport for Radiotherapy daycase patients.	Rachel Hennessy	**Update 10/01/2023** - The Trust has an arrangement with WAST to transport Radiotherapy patients - commonly used to transport MSCC patients from secondary care settings for emergency Radiotherapy treatment (typically 3-4 per week). The ambulance crew is based at VCC and begin their shift at midday. Affording sufficient time for transporting the patient, scanning, planning and treatment delivery before the crew's shift ends can be problematic. An earlier start has been previously trialled and	10/11/2022 now 17/01/2022	OPEN

			apparently worked well. However, at that point WAST were unable to institute a permanent change to its working pattern, but is open to discussion. A discussion around the Radiotherapy transport has been planned. It is now scheduled to take place Feb/March, having been delayed due to industrial action. This discussion will explore the SLA requirement and the details included, our service need, financial impact etc. Update 10/11/2022 - Discussion is ongoing and it was agreed to revise the completion date to January 2023. SA requested further discussion in relation to issues around accessing ambulance transportation for daycare patients to enable further progress with the Welsh Ambulance Service. Update 03/11/2022 - This will be addressed at the November Committee.		
Actions agreed at the 10th November 2022 Committee					
17.02.2022 (superseded)	Supersedes action closed at the November 2022 Committee in relation to invitation of a Public Health Wales representative to a future Board Development Session to facilitate a discussion in relation to the	Lauren Fear	**Update 10/01/2023** - A further update will be provided at the January 2023 Committee.	17/01/2023	OPEN

	Trust's role / requirements & public health. This will require an alternative approach.				
0.0.1	AP to contact Stephen Allen (South Glamorgan CHC) in relation to recruitment activity within schools / hard to reach communities to secure support in raising awareness on behalf of the Trust within local communities.	Alan Prosser	**Update 07/12/2022** - This has been actioned and an update to the national CHC is planned for 11/01/2023.	17/01/2023	CLOSED
0.0.1	Explore use of CIVICA at blood collection sessions to post targeted questions in relation to students involving the wider community in blood donations.	Alan Prosser	**Update 07/12/2022** - AP has requested that use of CIVICA is placed on the work programme for student collection sessions going forward in 2023.	17/01/2023	CLOSED
1.5.0	Information available to patients in relation to Oral SACT Education to be sighted by Committee members (IM request).	Cath O'Brien	**Update 16/01/2023 -** A number of patient leaflets are available in hard copy and on the website: https://velindre.nhs.wales/velindrecc/patient-information/chemotherapy-immunotherapy-information-leaflets The recent review of patient leaflets did not involve patients, but was a desktop professional assessment / evaluation comparison of other organisations' leaflets.	17/01/2023	CLOSED

			Going forward, patient enangement will be a key element.		
1.5.0	CJ to review reporting of risks presented in areas of limited assurance against potential clinical issues and escalation of these to the Quality, Safety & Assurance Committee going forward (Estates Assurance item).	Carl James	**Update 10/01/2023** - Risk reporting arrangements have been reviewed regarding areas of limited assurance. They are contained within the existing risk reporting arrangements and escalated as appropriate.	17/01/2023	CLOSED
2.1.3	GAP analysis/updated implementation plan to be sighted at January 2023 Committee following the Duty of Quality Consultation.	Nicola Williams	**Update 09/01/2023** - This document is included on the January 2023 agenda.	17/01/2023	CLOSED
2.3.4	SA/NW to discuss VUNHST's Nosocomial process.	Nicola Williams	**Update 02/12/2022** - A meeting has been scheduled for 11/01/23.	17/01/2023	CLOSED
3.0.0	Review of NWSSP cover paper to be undertaken and reference to appendix 1 (included erroneously) to be removed.	Gareth Tyrrell		16/03/2023	OPEN
3.0.0	Further explanation of acronyms to be provided to ensure clarity for public audience.	Gareth Tyrrell		16/03/2023	OPEN
3.0.0	Signed off actions identified following the self assessment of Health and Care	Peter Stephenson		16/03/2023	OPEN

	Standards to be sighted at the March QSP Committee.				
3.0.0	Discussion re reporting requirements to QSP Committee to be undertaken with NWSSP in relation to reporting requirements.	Vicky Morris/Nicola Williams/Emma Stephens/Lauren Fear/Secretariat	**Update 16/12/2022** - Meeting scheduled for 18/01/2023.	16/03/2023	OPEN
3.0.0	Cross check of Trust policies applicable to NWSSP to be undertaken, in addition to ensuring up to date copies are in use and reference to these on the Trust's policy template.	Emma Stephens/Lauren Fear	**Update 09/01/2023** - Cross reference mapping completed in line with Trust Standing Orders. Addendum drafted for inclusion with overarching Trust Policy Template.	17/01/2023	CLOSED
4.1.0	Discussion required in relation to how an appropriate level of detail regarding objectives and target dates which support the IMTP progress report can be included.	Carl James/Hilary Jones	**Update 10/01/2023** – A meeting will be arranged to discuss this.	17/01/2023	OPEN
4.1.0	A review of narrative around Radiotherapy and SACT performance (within IMTP report) to be reviewed to align with VCS performance report.	Carl James	**Update 10/01/2023** - A further update will be provided at the January 2023 Committee.	17/01/2023	OPEN
4.2.0	Updated recommended action plan following Committee Effectiveness	Emma Stephens	**Update 09/01/2023** - This document is included on the January 2023 agenda.	17/01/2023	CLOSED

	Survey to be sighted at January 2023 Committee.				
4.2.2	Re-instate Highlight Report from the TCS Scrutiny Sub Committee on the Committee Cycle of Business.	Secretariat	**Update 11/11/2022** - This has been actioned.	17/01/2023	CLOSED
4.4.1	Recommendations from the Human Tissue Authority (HTA) inspection of WBS to be sighted at the January 2023 Committee.	Alan Prosser/Peter Richardson	**Update 07/12/2022** - A paper will be brought to the January 2023 Committee following January EMB.	17/01/2023	CLOSED
4.4.2	Further narrative in relation to Radiotherapy / SACT breaches detailing when patients not managed within National timescales received treatment to be circulated to Committee members.	Cath O'Brien/Rachel Hennessy	**Update 10/01/2023** - A further update will be provided at the January 2023 Committee.	17/01/2023	OPEN
4.4.2	Investigate the extent of impact on SHOs required to provide services traditionally undertaken by Health Boards (i.e. prescribing medication).	Hilary Williams	**Update 09/01/2023** - Following further investigation, it was confirmed that this does not present a significant problem and no further action is required.	17/01/2023	CLOSED
4.6.0	Updated Private Patient Improvement Plan to be sighted at the January 2023 Committee under Matters Arising.	Nicola Williams	**Update 09/01/2023** - This document is included on the January 2023 agenda. Update 02/12/2022 - NW to meet with External Company during December.	17/01/2023	CLOSED

4.7.0	Wording within Estates Annual Report to be reviewed to remove reference to years outside the reporting period, in addition to providing further clarity around completed recommendations and timescales.	Carl James	**Update 10/01/2023** - Estates Annual Report 2021-22 reviewed and amended.	17/01/2023	CLOSED
4.10.0	An update in relation to non-compliance with Storage of Safe Medicines alert to be received at January 2023 Committee.	Rachel Hennessy	**Update 07/12/2022** - Capital funding has been allocated (end of November 2022). We will be working to end of March delivery date due to the procurement process required.	17/01/2023	CLOSED
4.14.0	Additional policies required (in particular DBS policy) to be included on policy compliance list.	Lauren Fear	**Update 09/01/2023** - Additional policies incorporated into Trust register via Policy Audit Programme.	17/01/2023	CLOSED
4.16.0	Review wording of risk 2709 (on risk register) to avoid potential queries from the public.	Lauren Fear	**Update 23/11/2022** - The wording of risk 2709 was updated prior to the VUNHST Risk Register being sighted at Trust Board.	17/01/2023	CLOSED
4.16.0	Further comments regarding the Trust Risk Register and Trust Assurance Framework to be provided by the Chair of the Committee to LF outside the Committee via email.	Vicky Morris	**Update 05/12/2022** - Comments provided by Chair to LF by email.	17/01/2023	CLOSED
5.1.0	Identify mechanism to facilitate feedback from all members following each	Emma Stephens/Vicky Morris	**Update 09/01/2023** - Limited selection of questions identified and agreed for use following each Committee.	17/01/2023	CLOSED

	Committee in relation to Committee effectiveness and encourage continued improvement.				

Quality, Safety & Performance Committee Annual Effectiveness Survey: Recommendations Action Plan

(*Text in Red additional actions requested at November 2022 QSP Committee – ref. Page 2*)

Required Outcome	Required Action	Action Lead	Delivery Timescale
Committee Cycle of Business aligned to National, legislative and Trust risk based priorities.	Continual review of Committee Cycle of Business via ongoing regular engagement with Executive & Service Leads	Executive Director of Nursing, AHPs & Health Science, Head of Corporate Governance, QSP Business Support Officer	March 2023 *(minimum annual basis thereafter)*
Committee receives robust, succinct and appropriate data and information	Effective automated electronic Business Intelligence system to be in place to feed Committee through robust triangulated dashboards PMF reports.	Chief Operating Officer	March 2023
Clear and effective presentation of reports at Committee.	Establish clear protocol and guidelines on how reports should be presented during Committee meetings.	Corporate Governance Manager	January 2023
100% compliance with paper deadlines to achieve 7-day pre-Committee papers publication.	Zero Tolerance to late papers except new papers not predicted in response to situations that arise.	Corporate Governance Team	January 2023 *(every meeting thereafter)*
Clear, high quality papers / reports provided for Committee	7 steps of assurance work,	Director of Corporate Governance & Chief of Staff	March 2023

	Next steps to report writing training Revised committee paper template		
Effective utilisation of the Consent Agenda.	Full review of use of Consent Agenda with supporting Procedure.	Director of Corporate Governance & Chief of Staff	March 2023
Frequency of meetings aligned to support effective delivery of Committee Cycle of Business.	Frequency of Committee meetings to be reviewed March 2023 - following establishment and operationalisation of the Integrated Quality & Safety Group that will support effective triangulation and streamline reporting.	Executive Director of Nursing, AHPs & Health Science, Head of Corporate Governance, QSP Business Support Officer	March 2023 *(minimum annual basis thereafter)*
Constructive scrutiny and challenge at Committee meetings to support pursuit of excellence and continuous improvement.	Review support arrangements in place to review what is considered 'effective scrutiny' and 'effective challenge'.	Director of Corporate Governance & Chief of Staff	March 2023
Effective tracking and continual review of Committee effectiveness.	Implement short and focused questionnaire to track and support continual review of Committee effectiveness following each meeting.	Head of Corporate Governance, QSP Business Support Officer	January 2023

QUALITY, SAFETY & PERFORMANCE COMMITTEE	
Updated Private Patient Service Improvement Plan	
DATE OF MEETING	17th January 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Nicola Williams, Executive Director Nursing, AHP and Health Sciences
PRESENTED BY	Nicola Williams, Executive Director Nursing, AHP and Health Sciences
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director Nursing, AHP and Health Sciences
REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Private Patient Improvement Group	22/12/2022	Approved
Executive Management Board	03/01/2023	Endorsed

ACRONYMS	

1. PURPOSE

This slightly amended Private Patient Improvement Plan was endorsed by the Executive Management Board on the 3rd January 2023 and is provided to the Quality, Safety & Performance Committee for **APPROVAL**.

2. BACKGROUND

The Executive Management Board and Quality, Safety & Performance Committee previously received and approved the revised Private Patient Improvement Plan. It was recognized that a further review of delivery timescales may be required once the procured external support (Liaison) had reviewed the plan.

3. PRIVATE PATIENT IMPROVEMENT PLAN CHANGES

The External Private Patient experts commenced supporting the Trust from the 3rd December 2022. The elements of the Improvement Plan that were for delivery by the company have been reviewed and it was confirmed that all actions assigned to Liaison could be delivered within the identified timescale with the exception of one. Improvement action 17: 'Renegotiate the contracts with large insurers' was identified as for completion by the 31st March 2023. Liaison have advised that all the preparatory work would be completed by March 2023 but more time is required for the re-negotiation of the contracts and that a more achievable timescale for this is the 30th June 2023.

The amended improvement plan is attached in ***Appendix 1.***

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Organisational learning identified through external report- significant enhanced governance re PP service required
RELATED HEALTHCARE STANDARD	Safe Care
	All
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	There are adverse legal implications if there is insufficient governance in relation to PP service
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Significant financial implications is respect of current provision as identified in external report

5. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **APPROVE** the change made to the Private Patient Improvement Plan.

Improvement Plan - Private Patient Service

Date Updated: 22/12/2023

Ref No.	Status	Date	Recommendation/Issue to be addressed	Action Progress	Action Owner	Target Date	Revised Target Date
STRATEGIC BUSINESS MANAGEMENT							
PP1	**IN PROGRESS**	28.01.22	Review and update Private Patient Service Specification	21/11/22 - Draft Policy circulated to Improvement Group members on 12th and 19th November 2022. Awaiting feedback. **22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan.**	Head of Operational Services and Delivery	30/06/2022	31/03/2023
PP16	**IN PROGRESS**	28.01.22	Develop marketing plan/commercial strategy	**22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan.**	COB/MB / External Provider	31/07/2022	31/03/2023
PP19	**IN PROGRESS**	28.01.22	Develop a new private patient pack, brochure, and stationery to be sent to all private patients prior to their admission/outpatient appointment and for marketing purposes.	Links to Strategy. **22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan.**	External provider	30/09/2022	31/03/2023
PP26	**IN PROGRESS**	28.01.22	Develop and implement a marketing plan and processes for both traditional and on-line digital	This will follow the agreement of a Strategy.			31/03/2023
PP17	**IN PROGRESS**	28.01.22	Renegotiate the contracts with large insurers	21/11/2022- This is the first priority of the procured support. All contracts have been shared with them prior to their visit on 5th December 2022. **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.**	COB/MB / External Provider	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.	**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	31/05/2022	31/03/2023
PP20	**IN PROGRESS**	28.01.22	Develop new professional fee arrangements which provide consistency across disciplines. Set fees at commercial levels.	21/11/2022 - Tarrif will be updated in line with contract discussions as in PP17. **22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan.**	External provider	31/07/2022	31/03/2023
MEDICAL GOVERNANCE							
PP7	**IN PROGRESS**	28.01.22	Evaluate and review all clinical professionals undertaking private practice, and privilege rights, as well as appropriate indemnity insurance.	Discussions underway with regard to process requriements.	Clinical Director	30/04/2022	30/09/2022
PP8	**NOT STARTED**	28.01.22	Establish Clinical Advisory Committee	Private Patient Consultant Engagement Meeting took place on the 14th December 2022 and the establishment of a Clinical Advisory Committee was discussed. Terms of Reference to be shared and Clinical Lead (who will Chair the COmmittee) to be appointed.	Clinical Director	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	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	31/03/2023
PP22	**IN PROGRESS**	28.01.22	Develop a new charge capture process and procedure and billing methodology and implement reflecting the new tariff structure.	**22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan.**	External provider	31/07/2022	31/03/2023
PP25	**IN PROGRESS**	28.01.22	Develop a new process to produce cost estimates with prescribed methodology which ensures that the Trust complies with the Unfair Trading Practices Act.	Cost estimates provided for those that self pay. Work progressing for private patients and insurance companies. **22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan.**	External provider	31/07/2022	31/03/2023
PP27	**IN PROGRESS**	28.01.22	Increase private income through exploiting opportunities to expand the clinical scope of the private patient service.	increased income by ensuring all activity is billed in line with process. Now charging for some element of care previously not charged for. Currently discussing expansion of radiology service. Any significant changes are closely linked to Strategy. **22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan.**	Clinical Lead	31/07/2022	31/03/2023
OPERATIONAL							
PP10	**OPEN**	28.01.22	Review patient pathway for private patients to ensure there is equity of service provision (MDT, CNS, psychology etc)	Discussions have commenced SLT leads on the current gaps in service provision within the PP pathway. The approval of the overarching policy will be integral to this action. 21/11/2022 - Refer to narrative in PP1.	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.**	COB / External Provider	30/04/2022	31/03/2023
PP15	**IN PROGRESS**	28.01.22	Review patient management arrangements by creating a Senior PP Manager role reporting to the COO	**22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan.**	COB / External Provider	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.	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
PP43	**IN PROGRESS**	28.01.22	Undertake a commercial review of the HCaH contract and consider the creation establishment of a Trust peripatetic home chemotherapy service.	Given current constraints and pressures within SACT and wider services it is suggested this is consider during 2023/24 .**22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan.**	PW	31/07/2022	31/03/2023

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Minutes

Public Quality, Safety & Performance

Committee Velindre University NHS Trust

Date: 10th November 2022
Time: 10:00 – 13:00
Location: Microsoft Teams
Chair: Vicky Morris, Independent Member

ATTENDANCE		
Prof Donna Mead OBE	Velindre University NHS Trust Chair	DM
Stephen Harries	Vice Chair and Independent Member	SH
Hilary Jones	Independent Member	HJ
Nicola Williams	Executive Director of Nursing, Allied Health Professionals and Health Science	NW
Cath O'Brien	Chief Operating Officer	COB
Lauren Fear	Director of Corporate Governance and Chief of Staff	LF
Carl James	Director of Strategic Transformation, Planning and Digital	CJ
Matthew Bunce	Executive Director of Finance	MB
Sarah Morley	Executive Director of Organisational Development & Workforce	SfM
Alan Prosser	Director of Welsh Blood Service	AP
Rachel Hennessy	Interim Director of Velindre Cancer Service	RH
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

0.0.0	PRESENTATIONS	Action Lead
0.0.1	**Welsh Blood Service – Donor Story** Led by Julie Farrup, Community Partnerships Officer, Donor Recruitment and Rachael Hutchings, Communication and Engagement Coordinator, Welsh Bone Marrow Registry Prior to the meeting, the Committee had received an uplifting donor (video) story, relating to the re-commencement of blood collections for aged 17 and older pupils within a secondary school as such collections had ceased during the pandemic. The video featured sixth form pupils talking about how proud they were of donating and their understanding of its importance. As well as donating blood on the day, a significant number of the young people who donated blood (71%) also signed up to the bone marrow register.	

	The Committee commended the passion and commitment of the team in relation to the rollout of the schools' education programmes and identifying methods of wider recruitment of bone marrow donors during difficult times. The Committee was advised of the 'school education pack' that will target all schools across Wales, aiming to instigate wider impact on the community and encourage school students to continue to donate during College, University and beyond. SA asked that WBS link in with the Community Health Council in respect of this work as they can support with further raising awareness on behalf of the Trust within local communities. AP agreed to contact SA. CJ queried whether further provision could be made by the Trust to encourage students to involve the wider community and AP suggested the use of CIVICA at donation sessions to pose targeted questions in this regard. In addition, further work will be undertaken going forward to engage ethnic minorities and hard to reach communities.	**AP** **AP**
1.0.0	**STANDARD BUSINESS**	
1.1.0	**Apologies** had been received from: • Steve Ham, Chief Executive Officer • Dr Jacinta Abraham, Executive Medical Director • Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience	**SHa** **JA** **ND**
1.2.0	**Additional Attendees:** • Dr Hilary Williams, Consultant and Associate Medical Director for Health & Safety *(deputising for Jacinta Abraham, Executive Medical Director)* • Julie Farrup, Donor Recruitment and Rachael Hutchings, Welsh Bone Marrow Registry *(for item 0.0.1)* • Katrina Febry, Audit Lead, Audit Wales • Heledd Thomas, Senior Auditor, Audit Wales *(in part)* • Stephen Allen, Chief Officer (South Glamorgan Community Health Council) • Emma Rees, Deputy Head of Internal Audit (NWSSP) • Gareth Tyrrell, Head of Technical Services (NWSSP) *(for item 3.0.0)* • Peter Stephenson, Head of Technical Services (NWSSP) *(for item 3.0.0)* • Bethan Tranter, Head of SACT and Medicines Management (*for item 4.13.0)* • Carl Taylor, Chief Digital Officer *(for item 2.3.2)* • Jason Hoskins, Assistant Director Estates *(for item 1.5.0)* • Melanie Findlay, Business Support Officer and Bethan Lewis, TCS Programme Planner and Risk Advisor *(to observe item 4.16.0)*	**HW** **JF/RH** **KF** **HT** **SA** **ER** **GT** **PS** **BT** **CT** **JH** **MF/BL**
1.3.0	**Declarations of Interest** Led by Vicky Morris, Quality, Safety & Performance Committee Chair	

	No declarations of interest were raised.	
1.4.0	**Review of Action Log** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science The action log was discussed in detail. 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. The 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) – Public Health Wales (PHW) Representative to be invited to a future Board development session to discuss the Trust's role / requirements and public health*** – LF advised that conversations continue in relation to establishing a Board Development Session around the wider Public Health agenda. The best way of achieving this following some PHW personnel changes is being considered. **4.4.0 (14/07/2022) –** ***Confirm Trust position in relation to Putting Things Right in comparison to other organisations in the next quarterly report*** – NW advised that benchmarking against other Health Boards' reporting in relation to Putting Things Right / Patient Experience had commenced following a review of what is published on their websites. The level of information is extremely variable. ***0.0.1 (15/09/2022) – VCS team to explore options for improved access to ambulance transport for Radiotherapy daycase patients*** – RH advised that discussions in respect of this are underway. A revised completion date of January 2023 was agreed. SA requested further discussion in relation to issues around accessing ambulance transportation for daycare patients to enable further progress with the Welsh Ambulance Service. ***4.7.0 – Investigate potential for reporting against protected characteristics (PTR) at national forums*** – NW advised that contact has been made with the Once for Wales Datix Team and national work in relation to the coding of the Datix system is underway. It was agreed to close the action and amend reporting once this work has been completed.	**Secretariat** **LF** **NW** **RH** **Secretariat**
1.5.0	**Matters Arising** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science • ***Health Inspectorate Wales Report*** *(DBS issues and recommendations following action 4.8.0 from 14th July 2022 Committee)* - The Committee noted that this would be addressed under item 4.8.0 on the main agenda.	

	• ***Receipt of briefing on oral SACT patient education*** *(following action 2.8.8 from July 2021 Committee)* - Led by Cath O'Brien, Chief Operating Officer The paper provided the current position in relation to oral SACT education within Velindre Cancer Centre, in addition to an update on current work to ensure that patient need for oral SACT education is met. COB advised that a programme of ongoing development of oral SACT education resources is in place to enable an improved offer of this to all patients going forward. Benchmarking undertaken against other Health Boards indicated that the Trust offers level of service equal to other Cancer Centres in Wales and improvements to this will continue. DM noted that no reference had been made to equality issues / equality impact assessment requirement and queried the provision of an equal standard of care to visually impaired, non-English speaking patients etc. It was **agreed** that an equality impact assessment should be undertaken and the Committee was advised that this had been included in the work programme. HW indicated that a significant amount of clinical time could be saved if patients receive Oral Sact Education prior to attending consent appointments and suggested that more resource is required to support patients experiencing difficulty accessing education. SH queried whether patient feedback had been received as part of the evaluation exercise and COB agreed to explore this. SH also requested sight of the information made available to patients. The Committee **NOTED** the evaluation of the Oral SACT Education Service and the amendments required before publication on the Trust website. • **Estates Assurance** *(following action 4.5.0 from 15th September 2022 Committee)* - Led by Jason Hoskins, Assistant Director Estates The paper provided the current position in relation to the Trust's compliance against the main elements of statutory estates compliance, in addition to management of responsibilities and actions to achieve a sustainable position across Estates Management (via KPIs underpinned by both internal and external audits). JH advised that an action plan had been developed around a prioritised list of areas of non-conformity, management and delivery of which is reported via the appropriate governance process. VM suggested triangulation of risks presented in areas of limited assurance against potential clinical issues, and escalation and reporting of these to the Quality, Safety & Performance Committee going forward. CJ agreed to review this following the Committee.	**COB** **CJ**

	The Committee **NOTED** the content of the Estates Assurance Report, the current position with regard to the Trust's compliance against the main Estates elements and the actions being taken to achieve and sustain compliance. The Committee also commended the succinct and informative manner in which the data had been provided.	
2.0.0	**CONSENT ITEMS** (The consent part of the agenda considers routine Committee business as a single agenda item. Members may ask for items to be moved to the main agenda if a fuller discussion is required).	
2.1.0	**ITEMS FOR APPROVAL**	
2.1.1	**Draft Minutes from the meeting of the Public Quality & Safety Committee held on the 15th September 2022** Led by Vicky Morris, Quality, Safety and Performance Committee Chair The Committee **APPROVED** the minutes from the 15th September 2022 Public Quality, Safety & Performance Committee.	
2.1.2	**Trust-wide Policies and Procedures for Approval** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science and Carl James, Director of Strategic Transformation The following updated policies were discussed: • QS25 – Preceptorship Policy • IPC00 – Infection Prevention & Control Framework – The Accountabilities and Responsibilities • IPC10 – Hand Hygiene Policy & Procedure • IPC21 – Policy for the Management of Respiratory Infections • PP04 – Asbestos Policy • PP05 – Control of Contractors Policy • PP09 – Water Safety Policy The Committee was advised that all policies / procedures for **APPROVAL** listed above had previously been **ENDORSED** by the Executive Management Board. The Committee **APPROVED** all the above revised policies / procedures for publication on the Trust website and circulation to the policy distribution list based on the updates within the cover papers. The Committee **AGREED** to a one-year extension to the following three policies, due to national reviews currently being undertaken. It is anticipated that the reviews will conclude in the next 12 months: • IPC03 – Aseptic Non Touch Technique (ANTT). • IPC05 – National Infection Prevention and Control Manual. • IPC15 – Control and Management of Multi Drug Resistant Bacteria.	

	The review dates on the published policies will be amended.	
2.1.3	**Duties of Quality & Candour Report** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science The Committee received the report, which provided an overview of the development of the national statutory guidance and regulations, the outcome of a gap analysis in respect of the Duty of Candour regulations (following consultation) and a draft implementation plan (including the establishment of a Trust implementation Group). It was noted that both a Regulatory and an Equality Impact Assessment is required for both Duties prior to implementation. This is currently being undertaken at a National level and will be supported and taken forward on behalf of the Trust by the Quality & Safety Implementation Group. A significant amount of associated literature will be produced nationally, covering a number formats, (braille, multiple languages) providing maximum inclusion. The Committee was advised that the Duty of Quality consultation had recently commenced and that an updated implementation plan and GAP analysis would be provided at the next Committee. DM commended NW's position as chair of the National Group and for progressing this significant piece of work on behalf of the Trust. The Committee **NOTED** the position in relation to the two Duties and **APPROVED** the implementation measures detailed in bold on pages and 3 and 4 and the interim implementation plan.	**NW**
2.2.0	**ITEMS FOR ENDORSEMENT**	
2.2.1	**Nurse Staffing Levels (Wales) Act 2016 Report** To be led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science The Committee received the mid-year Nurse Staffing Act report, which provided an update on the Trust's position in relation to compliance with the Nurse Staffing Act and a summary and analysis of the status of staffing levels in relation to legislative requirements. The overall conclusion was that there had been no impact on patient care as a result of not maintaining nurse staffing levels during the period in respect of the ward. The Committee **ENDORSED** the Nurse Staffing Act Report prior to submission to Trust Board.	
2.3.0	**ITEMS FOR NOTING**	
2.3.1	**Draft Summary of the unapproved Minutes from the meeting of the**	

	Private Quality, Safety & Performance Committee held on 15th September 2022 Led by Vicky Morris, Quality, Safety and Performance Committee Chair The Committee **APPROVED** the summary minutes from the Private Quality, Safety & Performance Committee held on 15th September 2022.	
2.3.2	**Digital Service Operational Report** Led by Carl Taylor, Chief Digital Officer CJ advised the Committee that following a number of delays, the Prometheus application is now live. The Committee **NOTED** the Digital Service Operational report.	
2.3.3	**Highlight Report from the RD&I Sub Committee** Led by Hilary Williams, Consultant and Associate Medical Director for Health & Safety The Committee **NOTED** the key deliberations and highlights from the public meeting of the Research, Development & Innovation Sub Committee held on 21st July 2022.	
2.3.4	**Highlight Report from the Infection Prevention & Control Management Group** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science SA requested discussion outside the Committee in relation to the Trust's Nosocomial process. The Committee **NOTED** the Infection Prevention & Control Management Group Highlight Report.	**SA/NW**
2.3.5	**Freedom of Information Requests** Led by Lauren Fear, Director of Corporate Governance & Chief of Staff The Committee **NOTED** the Freedom of Information report.	
2.3.6	**Transforming Cancer Services Programme Scrutiny Sub Committee Highlight Report** Led by Stephen Harries, Vice Chair and Chair of the Transforming Cancer Services Scrutiny Sub Committee The Committee **NOTED** the Transforming Cancer Services Programme Scrutiny Sub Committee report of 18th October 2022 and the actions being taken.	
2.3.7	**Health Inspectorate Wales (Annual Report)** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science	

	The Committee **NOTED** the Healthcare Inspectorate Wales 2021-2022 Annual Report and its key findings in relation to Velindre University NHS Trust.	
2.3.8	**Health & Care Standards Report** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science The Committee **NOTED** for Quarter 2 position, the: • Current status and progress in respect of the Health and Care Standards; • Status in respect of the Health & Care Standard Improvement Plan; • The overarching Trust compliance scoring table for the Health and Care Standards; and, • The planned National move to Quality Standards from 1st April 2023.	
2.3.9	**Radiation Protection and Medical Exposure Strategic Group Highlight Report** Led by Hilary Williams, Consultant and Associate Medical Director for Health & Safety The Committee **NOTED** the key deliberations and highlights from the Radiation Protection and Medical Exposures Strategic Committee, held on 6th October 2022.	
2.3.10	**Wales Infected Blood Support Scheme (WIBBS) Annual Report 2021-22** Led by Lauren Fear, Director of Corporate Governance and Chief of Staff The Committee **NOTED** the Wales Infected Blood Support Scheme 2021-22 Annual Report.	
2.3.11	**Covid-19 Inquiry Preparation Group Highlight Report** **Led by Lauren Fear, Director of Corporate Governance and Chief of Staff** The Committee **NOTED** the key deliberations and highlights from the meeting of the COVID-19 Inquiry Preparation Group meeting held on 21st October 2022.	
4.8.0	**Audit Wales Quality Governance Review** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science, Lauren Fear, Director of Corporate Governance and Chief of Staff and Katrina Febry, Audit Lead, Audit Wales The Committee received the Audit Wales review of Quality Governance Arrangements (that concluded in June 2022) and the Trust's management response. The Committee was advised that although significant progress has been made in relation to improvements to Trust Quality Governance arrangements, further work is required as detailed in the recommendations.	

	The Trust welcomed the review and its findings and had accepted all recommendations. A further review of the effectiveness of the new arrangements that are currently being put in place, including the Quality Hubs and Integrated Quality & Safety Group, will be undertaken in early 2023 / 24 by Internal Audit. HJ queried the feasibility of the completion dates contained within the management response and NW advised that despite the challenging winter anticipated, the dates were considered achievable as completion of actions will also be required by the Duty of Quality.	
3.0.0	**Velindre Quality & Safety Committee for NHS Wales Shared Services**	
	Led by Gareth Tyrrell, Head of Technical Services, NHS Wales Shared Partnership The CIVAS@IP5 Service Performance Report was received, setting out current levels of performance against Good Manufacturing Practice Standards. • There were no significant service performance updates to service performance since the last Committee. • The completion dates for both outstanding actions detailed on the MHRA action plan have been extended until end of November 2022 due to difficulties implementing the required software. The following was noted: • Reference to appendix 1 in the cover paper had been included in error and it was **agreed** to review the cover paper prior to the next submission. • Further explanation of acronyms contained in the paper will be provided going forward to enable clarity for public audience. • It was agreed that the Quality, Safety & Performance Committee is to receive notification of any new products prior to formal introduction. • Key strategic Quality & Safety issues and risks are to be reported to the Committee going forward. The Committee **NOTED** the current levels of service performance against the framework of standards set out in EU GMP and with which they are legally required to comply as an MHRA "Specials" and Wholesale Dealer licence holder and progress of actions taken to date.	**GT** **GT**
	NWSSP Health and Care Standards Report Led by Peter Stephenson, Head of Finance and Business Development, NHS Wales Shared Services Partnership (NWSSP) The Committee received the report, which provided an update in relation to the NWSSP Health and Care Standards Self-Assessment for 2021-2022. The following was noted:	

	• An increase in the diversity of services provided by NWSSP (and associated risks) has been evidenced over the reporting period. • The requirement for a different approach to the self-assessment process and associated reporting is anticipated going forward, due to the commencement of the Health and Social Care (Quality and Engagement) (Wales) Act 2020. • Actions identified following the self-assessment have been signed off by the NWSSP Senior Leadership Group (October 2022) and will be sighted at the March 2023 Partnership Committee. NW advised that following discussions between herself and NWSSP in relation to the Duty of Quality and proposed Quality Standards (to replace Health and Care Standards from 01/04/2023), further discussion would be undertaken to review NWSSP governance and reporting requirements to the Trust. PS advised the Committee that evidence to support statements within the report and appropriate governance was in place. Use of the Information Governance Toolkit to support the self-assessment was also confirmed, despite no reference to this in the report. VM queried NWSSP's understanding of VUNHST policies applicable to hosted organisations, those identified as out of date and ongoing review / amendments to these. It was **agreed** that a cross-check would be undertaken to ensure clarity in relation to policies applicable to NWSSP (and provision of up to date copies where relevant). Reference to this will also be included within the Trust's policy template. The Committee **ENDORSED** the NWSSP Health and Care Standards Self-Assessment for 2021-22, pending minor amendments to dates contained in the cover paper (2021-22 to replace 2022-23).	**PS** **LF/ES**
4.0.0	**MAIN AGENDA** (This section supports the discussion items for review, scrutiny and assurance).	
4.1.0	**IMTP – Quality Issues arising requiring Committee Assurance** Led by Carl James, Director of Strategic Transformation, Planning & Digital The Committee received the report, which provided an overview of the Trust Accountability Conditions Letter Monitoring Document and quarterly progress in relation to the actions within the agreed 2022-2025 IMTP. The following was noted: • The Accountability Conditions Monitoring Document was developed following receipt of Accountability Conditions set out by the Director General and NHS Wales Chief Executive, to ensure full compliance with both general and Trust-specific accountability conditions, including specific actions relating to cancer. The document detailed the current position at Quarter 2.	

	• The Quarter 2 progress report on IMTP actions for 2022-2023 indicated good progress in the majority of areas, while also highlighting areas experiencing delays or challenges. VM queried the frequency of reporting to Quality, Safety & Performance Committee to date and intended frequency going forward and also outlined that wording in the quarterly updates to both internal committees and WG would need to be evidenced and tracked for audit purposes. CJ advised that the report would be sighted at the Committee on a quarterly basis and that information relating to both Quarter 1 and 2 had been included in the November report due to misaligned timescales preventing timely reporting of Quarter 1 progress. HJ noted that although an update on new projects had been included under 'five ways of working and sustainable development,' there was no update in relation to existing services. CJ noted that the purpose of the report is to provide a composite review of progress on significant areas of work to Welsh Government; however it would be possible to provide an update on other current developments across the organisation if required. HJ also noted the requirement of target dates to facilitate effective monitoring of the IMTP. Although it was advised that a series of objectives and associated timelines are contained within a further (more detailed) report and monitored on a monthly basis, it was agreed that HJ and CJ would discuss outside the Committee a method of presenting an appropriate level of detail in relation to this within the IMTP progress report. VM noted that the narrative in relation to Radiotherapy and SACT performance did not align with the VCS performance report and it was agreed to review the wording of this section. The Committee **ENDORSED** the paper, which sets out the progress made in delivering the requirements set out in the Accountability Conditions and the IMTP 2022-2025.	**CJ/HJ** **CJ**
4.2.0	**Committee Effectiveness Survey Report** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science, supported by Emma Stephens, Head of Corporate Governance The Committee received the results of the Committee's Annual Effectiveness Survey and proposed recommended actions, areas of priority and delivery timescales. The following was discussed: • A potential increase in the frequency of Committee meetings to accommodate the significant volume of information was discussed. It was noted that the review of the Committee cycle of business had intended to reduce and refine information reported to the Committee (supported by the Integrated Quality & Safety Group) and a further effectiveness survey would follow in March 2023. This is to be included	

	in the recommended actions. • The need to address feedback indicating where there was a perception of potential over-challenging at Committee meetings. It was noted that it may be of benefit to address this separately outside Committee, to identify what is considered 'effective challenge' and mechanisms to engage with individuals outside Committee. • A review of question response options; little change to survey results from the previous year may be the result of a limited range of responses. Enabling tracking of progress will be discussed further outside Committee. DM suggested that identification and triangulation of key messages and interdependencies across areas covered by the Committee (Finance, Workforce, Quality) could be explored by the Integrated Quality & Safety Group. NW advised that following discussion, triangulation of data will be undertaken by the Group in addition to integration with the value-based Healthcare bid. The Committee: • **DISCUSSED** and **REVIEWED** the results of the Quality, Safety & Performance Committee Annual Effectiveness Survey (November 2021-October 2022) outlined in Appendix 1; • **AGREED** what actions should be taken, including areas of prioritisation and timescales for delivery outlined in Appendix 2. It was **AGREED** that an updated action plan would be sighted at the January Committee under matters arising.	**VM/DM** **ES**
4.2.1	**Committee Terms of Reference and Operating Arrangements** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science, supported by Emma Stephens, Head of Corporate Governance The Committee received the report and revised Committee Terms of Reference, which provided a summary of amendments to the Committee Terms of Reference and Operating Arrangements, following engagement with the Executive Team and review by the Committee Chair. It was advised that a further formal review would be undertaken in March 2023 in conjunction with the Committee Effectiveness Survey and Cycle of Business, also allowing inclusion of Duty of Quality requirements. The Committee **ENDORSED** the amendments to the Trust Board Standing Orders – Schedule 3, as outlined in section 3 of the report and included in Appendices 1 and 2. Following this, the revised Terms of Reference will be received at the next meeting of the Trust Board Audit Committee for formal **ENDORSEMENT** and recommendation to the Trust Board for **APPROVAL**.	
4.2.2	**Quality, Safety & Performance Committee Cycle of Business** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science, supported by Emma Stephens, Head of	

	Corporate Governance The Committee received the revised Quality, Safety & Performance Committee Cycle of Business that contained a number of proposed revisions. These changes had been made following discussions with Executive Directors and review of the Committee's Terms of Reference. It was noted that a further formal review would be undertaken during March 2023 to allow revision of annual reporting in line with the financial reporting year, inclusion of reviewed hosted organisations' and Duties of Quality and Candour reporting requirements, in addition to outputs from the Trust's newly established Integrated Quality & Safety Group. HJ queried whether the results of the staff survey would continue to be reported to the Committee. SfM advised that this will be reported following the next staff survey in Spring 2023. It was also noted that the Highlight Report from the TCS Scrutiny Sub-Committee had been removed in error and that this would be re-instated on the cycle of business. The Committee **ENDORSED** the proposed revisions to the Quality, Safety & Performance Committee Cycle of Business outlined in section 3.2 and **NOTED** the additional work to be undertaken outlined in section 3.3 to support and underpin further review as part of the commitment to continuous improvement.	**Secretariat**
4.3.0	**Workforce and Organisational Development Performance Report / Financial Report** Led by Sarah Morley, Executive Director of Workforce and Organisational Development and Matthew Bunce, Executive Director of Finance The report was received, which outlined the current position in relation to key people strategy themes reflecting the complex Workforce picture within the organisation. It was acknowledged that a number of factors impact development of the Workforce required to effectively deliver services. SfM advised that: • A number of projects are currently in progress, (using the nationally agreed Workforce Planning Principles) to address the requirement for a different Workforce model. • A Recruitment, Attraction and Retention Group has been established to address ways of improving the offer across the employment journey in its entirety. The intention is to align this with national work to simplify the recruitment process. It was also noted that Student Streamlining will be stood down next year for the Trust. • Key financial risks continue in relation to use of agency staff and associated costs incurred. This is significantly impacted by sickness absence rates, maternity leave, annual and special leave and is therefore a crucial factor in plans to deliver the service in the short term. A	

reduction in sickness absence rates has a direct impact on reducing the variable pay bill.

- Additional risk remains in relation to recruitment of permanent staff in response to COVID-19 where funding from Welsh Government is no longer guaranteed and is now directly linked to activity delivered. SACT service activity has returned to pre-COVID levels, with further increase still required within Radiotherapy in order to generate further income.
- A number of posts have been appointed 'at risk' within both divisions in response to COVID and work is underway to secure additional financial support for these posts / migrating staff into vacancies where appropriate.
- Despite a reduction in agency costs due to recruitment of a number of permanent staff, fewer staff are entering Radiotherapy via the Streamlining process and due to the absence of anticipated posts for the service, use of agency staff has been required to maintain capacity.

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

Finance Report

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

- KPIs are on target in terms of forecast year end, with a projected year-end position of break-even.
- An increase in the deficit for NHS Wales from £100m to £140m indicated that Welsh Government may not be in a position to support COVID response costs for the 2022-23 period; however, an internal budget review indicated that this had been resolved.
- Implementation of the two planned recurrent service savings schemes involving Workforce redesign has not been possible due to the impact of the pandemic on reduced availability of staffing resource, particularly higher levels of sickness. Non-recurrent savings schemes have been implemented this year to replace these recurrent schemes, to ensure the savings target for this financial year would be met.

The Committee **NOTED**:

- The contents of the September 2022 Financial Report and in particular the financial performance to date and the year-end forecast to achieve financial break-even and key risk in relation to income to cover COVID backlog additional capacity costs;
- The TCS Programme financial report for September 2022 attached as 4.3.0c.

Workforce Report

The following Workforce KPIs for the Trust were discussed by SfM:

- Personal Appraisal Development Review (PADR) – 71.24% (Trust-wide). Corporate PADR has shown an increase of 10% (to 62%).
- Sickness Absence – 6.31%. A number of measures have been taken to address financial wellbeing of staff due to the cost of living crisis.

	• Statutory & Mandatory Compliance – 85.49% (Trust-wide). In addition, SfM advised the Committee that notification that the Trust will be subject to Industrial Strike action had been received from the Royal College of Nursing. The Trust has established mechanisms an Industrial Action Cell and will focus on patient / donor safety and staff wellbeing. The Committee **NOTED** the content of the report and commended the level of statutory and mandatory training compliance.	
4.4.0	**Quality, Safety & Performance Reporting** Led by Cath O'Brien, Chief Operating Officer The Quality, Safety & Performance Update was received by the Committee and is discussed in further detail under items 4.4.1 and 4.4.2. The following key points were raised by COB: • Significant progress continues across both divisions, supported by a high volume of work. • Noteable improvements have been evidenced within the Cancer Service and significant work has been undertaken to explore re-aligning service delivery in terms of both long and short term measures, with SACT delivery on target by the end of the year. • The Integrated Radiotherapy Solution (IRS) Implementation Programme has commenced and an update will be shared early next year. • DHCR (Digital Health Care Record, replacing the CANISC system) will be implemented over the coming weekend. • WBS has returned to a position where it is able to support other UK services due to the tenacity and work of the team. • Schools donor recruitment – WBS is now focusing on a post COVID (age 17-30) donor recruitment plan, to include both blood and bone marrow donor recruitment. The Committee **NOTED** the content of the WBS and VCS performance reports.	
4.4.1	**Welsh Blood Service Quality Safety & Performance Divisional Report** Led by Alan Prosser, Director of Welsh Blood Service The Welsh Blood Service report provided an update on performance against key metrics for the period until the end of September 2022. The following areas were highlighted: • Following the amber alert declared for all blood groups by NHSBT during October 2022, WBS was able to support the services unable to recover and maintain stock. National publicity resulted in 2,000 additional donors registering with WBS, allowing expansion of the December 2022 clinic schedule. Amber alert was rescinded on 9th November 2022. This was commended by the Committee and it was noted that this had also been recognised nationally.	

	• An inspection by the Human Tissue Authority (HTA) of the Service and new VCS stem cell collection facility during October had identified no major observations and both sites were reaccredited. An FE inspection is also currently assessing Transplantation Services. In response to a query from VM, recommendations from the HTA will be sighted at the January 2023 Committee. • Challenges remain in relation to Welsh Bone Marrow Donor Register (WBMDR) recruitment which is critical to income generation and stem cell collection. Detailed plans are currently being worked through and engagement with the academic programme will be vital to recruitment of 17-30 year olds (and the wider community). • Closure of incidents remains on target and the Service continues to sustain good donor satisfaction throughout. • Both high scoring actions resulting from the Medicines and Healthcare products Regulatory Agency (MHRA) inspection are now complete and closed. • Areas of immediate focus are continued maintenance of blood stocks throughout the winter and ongoing implementation of recommendations in relation to Occult Hepatitis B infection testing. Two 15 step visit closure reports had been included (*Laboratories visit, May 2022 and Wrexham Collections Team, August 2022*), detailing the current position and areas where actions remain outstanding. The professionalism and care of the Collections staff was commended. HJ queried how emerging themes across reports would be identified and managed. AP advised that emerging themes across 15 step visit reports will be triangulated and managed appropriately across the service to ensure repeated issues are avoided. The Committee **NOTED** the content of the report.	**AP/PA**
4.4.2	**Velindre Cancer Service Performance Report** Led by Rachel Hennessy, Interim Director of Velindre Cancer Service The Velindre Cancer Service report provided an update on performance against key metrics for the period until the end of September 2022. The following areas were highlighted: • Improvements within SACT continue, with referrals above pre-COVID levels. • Radiotherapy referrals have returned to pre-COVID levels, although challenges remain (in particular due to the new LINAC programme). • Management of recovery continues, supported my regular operational meetings between VCS and local Health Boards to ascertain potential demand on services from VCS. • A reduction in the number of breaches in patients receiving Radiotherapy within 28 days (50% reduction in breaches from August 2022). • A continued decrease in SACT breaches is anticipated over the next reporting period, reflecting improvements implemented to date.	

	VM requested the inclusion of further narrative in relation to Radiotherapy and SACT breaches, detailing when patients who had not been managed within the national timescale received treatment. It was noted that this had previously been requested. CoB assured the Committee that this would be included going forward and that the relevant information relating to this report would be provided outside the Committee to all members. HW reported the impact of lack of services elsewhere on SHOs, who are often required to provide a number of other services traditionally undertaken by Health Boards (such as prescribing medication). Reportable evidence of this will be required if this is to be broached with Health Boards from a Clinical standpoint and HW agreed to investigate the extent of the issue. It was noted that agreeing national treatment pathways could potentially mitigate this. DM queried whether a communications had been planned for, once the specifics of industrial action were known, in order to reassure patients. CJ advised that contingency plans continue and that communications will require the inclusion of staff, patients and the wider public. Derogations are currently being identified both Nationally and locally in conjunction with Trade Unions, and changes to services will ensure minimal disruption and maintain patient safety. The Committee **NOTED** the content of the report.	**COB/RH** **HW**
4.5.0	**Putting Things Right Report – Quarter 2** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science The Quarter 2 Putting Things Right Report, providing a summary of concerns (complaints) and incidents received during the period 01/07/2022 to the 30/09/2022, was discussed and the following was highlighted: During the quarter: • 2 National Reportable **Incidents** were submitted to Welsh Government. • 4 Ionising Radiation (Medical Exposure) Regulations **incidents** were reported to Healthcare Inspectorate Wales. • 34 **concerns** were raised (6 relating to COVID-19), 84% of which were graded at level 1 (low). • 100% of **formal concerns** were investigated and responded to within the required 30-working day timeframe. Trends continue to be appointments, communication & clinical treatment. • 510 **incidents** were raised, 98% graded at low or no harm. • Formal investigation training has concluded for all key staff. The Committee **NOTED** the 2022-2023 Quarter 2 Putting Things Right Report and commended the 100% compliance with responding to formal concerns within 30 working days.	
4.6.0	**Private Patient Improvement Plan**	

	Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science The Committee received the report, which included a highlight report from the Private Patient Improvement Group, revised Private Patient Improvement Plan and group Terms of Reference. The following was highlighted: • NW advised that the Improvement Group had met three times to date and the Improvement Plan had been developed following an external review into the Service. • The Improvement Plan had been revised to include realistic target dates and targeted actions to best meet the recommendations. • It was not possible to provide full assurance that delivery dates are achievable as feedback from external expertise procured to support delivery of actions is still awaited. A revised plan will be sighted at the January 2023 Committee. • Attempts to have an NHS Private Patient Service Critical friend specialist support on the Group had been unsuccessful. It was noted that the revised Improvement Plan will also be sighted at Audit Committee to facilitate progress of key financial and commercial actions. The Committee: • **NOTED** the highlights from the Private Patient Improvement Group meetings held during August and September 2022; • **APPROVED** the amended Private Patient Improvement Plan (with the caveat that a number of delivery timescales may require amending); • **NOTED** the commissioning of external expert support for the areas identified in the Improvement Plan; • **APPROVED** the Private Patient Improvement Group Terms of Reference; • **ENDORSED** the Executive Management Board preferred option regarding the future provision of Private Patient Services prior to consideration at Trust Board.	**NW**
4.7.0	**Annual Estates Report** Led by Carl James, Director of Strategic Transformation, Planning & Digital The Committee received the Estates 2021-2022 Annual Report, which provided an overview of Estates, Performance and Delivery during the financial year 2021-2022. The following was noted: • Reference to two appendices had been included in error as these were not necessary. • Various narratives within the main report referred to years prior to the reporting period. • Further clarity is required in terms of completed recommendations and timescales. The Committee **ENDORSED** the Annual Estates Report for Board Approval	

	and it was agreed that a review of wording would be undertaken.	**CJ**
4.8.0	**Audit Wales Quality Governance Review** This item was addressed following the consent for noting section of the agenda.	
4.9.0	**Healthcare Inspectorate Wales (HIW) Inspection Reports** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science (as COB & RH had left the meeting) The Committee received Two Healthcare Inspectorate Wales (HIW) reports and subsequent improvement plans following HIW Inspections to Velindre Cancer Centre Nuclear Medicine Service in June 2022 and Velindre Cancer Centre First Floor Ward in July 2022. NW advised the following: • No immediate actions for improvement are required and no immediate concerns were raised following the reviews. • The new Integrated Quality & Safety Group has commissioned external support to facilitate improved tracking of actions at a strategic level, aligned with quality and safety. An assurance rating will be applied to both improvement plans (in addition to the Audit Wales Governance Review action plan) and sighted by the Quality, Safety & Performance Committee as appropriate. The Committee **NOTED** the Healthcare Inspectorate Wales Reports, Improvement Plans and implementation of agreed actions to date.	
4.10.0	**Highlight Report from the Patient Safety Alerts Group** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science The Committee received the Highlight Report, which provided details of key outputs from the Trust's Safety Alerts Management Group for the period 01/06/2022 – 30/09/2022, in addition to an update regarding one safety alert where the Trust currently remains non-compliant (safe storage of medicines (original compliance date 30/09/2021)). The Committee was advised that the majority of the alert requirements had been met and four areas remained outstanding. Following significant discussion at Executive Management Board, implementation requirements are currently being worked through and a risk / cost analysis being undertaken considering the new hospital build. Work will be completed by December 2022 in the following four specific areas of non-compliance related to medicines storage: • Further roll out of DigiTRAC. • Air conditioning. • Improved lighting.	

	• Appropriate locks. The Committee **DISCUSSED** and **NOTED** the report and actions being taken by Velindre Cancer Service to achieve compliance with the Safe Storage of Medicines Alert. It was **NOTED** that an update would be received under matters arising at the January 2023 Committee in respect of the Medicines Storage compliance.	**RH**
4.11.0	**Quality & Safety Framework and Priorities Update** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science The Committee received an update, detailing the current position in relation to the implementation of the Trust's Quality & Safety Framework and Quality Priorities. NW advised the Committee that following review of the Trust's position against set priorities, some delays have occurred to the completion of a number of the framework requirements; however, all are on target to be delivered by March 2023 and the proposed revised completion dates were included within the report. The Committee **NOTED** the status in relation to the implementation of the Quality & Safety Framework and the 2022/23 Quality Improvement Goals.	
4.12.0	**Highlight Report from the Safeguarding & Vulnerable Adults Group** *(including DBS item noted under matters arising)* - Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science The Committee received the highlight report, which provided details of the key issues considered by the Safeguarding & Vulnerable Adults Group at its meeting on 09/09/2022, in addition to a comprehensive GAP Analysis against the January 2019 Healthcare Inspectorate Wales report into Abertawe Bro Morgannwg University Health Board's management of the employment and allegations against an Employee. The following was highlighted: • *Safeguarding Training* - Significant work has been undertaken by the Trust's Head of Safeguarding and Workforce Colleagues to cleanse Safeguarding & Vulnerable Adult Mandatory & Statutory Training compliance data with ESR, including a repeat of the Training Needs Analysis. This will be followed by further scrutiny and cross-check of records across both divisions and will be revisited at the December Safeguarding & Vulnerable Adults Group meeting. *GAP Analysis against HIW Recommendations (2019)* – A number of areas of work are currently underway. It was also noted that a number of recommendations in the report are not applicable to the Trust. An internal audit in relation to DBS checks and review of the process was successfully undertaken over the course of the year. A Trust policy for DBS checks is still outstanding; this is also addressed under item 4.14.0 and will be included on the out of date / required policies list.	

	The Committee **NOTED** the training compliance status and actions being taken to address the training data accuracy and **APPROVED** the GAP Analysis against the 2019 HIW report into Abertawe Bro Morgannwg University Health Board's handling of the employment and allegations made against Mr W.	
4.13.0	**Highlight Report from the Medicines Management Group** Led by Hilary Williams, Consultant and Associate Medical Director for Health and Safety, supported by Bethan Tranter, Head of SACT and Medicines Management The Committee received the Highlight Report (following item 4.9.0), which provided details of the key issues considered by the Medicines Management Group. The Committee was alerted to the following: • A number of out of date Clinical Guidelines and related Medicines Management Procedures have undergone a high level review and no significant amendments are required, therefore presenting minimal risk to patient safety. • 77% of Clinical Guidelines are currently in date; those outstanding are to be addressed by Pharmacy and will be resolved by the end of December 2022. • Remaining outstanding Guidelines requiring multi-disciplinary / multi-site input are currently being addressed in conjunction with site leads / site specific teams to progress these. • It was **agreed** that the use of national documentation where feasible would be explored. The Committee **NOTED** the key deliberations and highlights from the Medicines Management Group.	
4.14.0	**Quality, Safety & Performance Committee - Policy Compliance Report** Led by Lauren Fear, Director of Corporate Governance and Chief of Staff The Committee received the Trust Policy Compliance Report, which provided assurance on the progress made on the policy review programme during the Sept/Oct 2022 governance reporting cycle. The following was noted: VM noted that despite previous discussions, only out of date policies are included on the list; therefore the absence of the DBS policy and any other additional policies required remains. LF advised that the DBS policy would be included. The Committee **NOTED** the Quality, Safety & Performance Committee Policies Extract Compliance Report as at 20th October 2022 included at Appendices 1-8 and received **ASSURANCE** that progress is being managed via the Executive Management Board.	**LF**
4.15.0	**Highlight Report from the Trust Estates Assurance Group** Led by Carl James, Director of Strategic Transformation, Planning & Digital	

	The Committee received the Highlight Report, which provided the Quality, Safety & Performance Committee with details of key issues considered by the Trust Estates Assurance Group, including Health and Safety, Fire Safety, Environment and Statutory Compliance. The Committee was alerted to the following: • Mandatory Training levels require further improvement (currently standing at 70-80%) and action has been taken to address this in collaboration with Education & Development, ensuring managerial awareness of available training and via the appointment of a new trainer to support the Trust. KPIs in relation to training are detailed in the Performance Management Report. • An Asbestos Personal Injury Claim was received by the Trust a number of months ago and is being actively managed with support from NHS Wales Shared Services. • A review of the current fire safety training strategy is underway, including implementation of plans to support departmental requirements. • Further fire safety assurance will be achieved via compartmentation / renewal of fire safety doors within the Cancer Centre, due to complete imminently. The Committee **NOTED** the content of the report and actions being taken.	
4.16.0	**Trust Risk Register** Led by Lauren Fear, Director of Corporate Governance and Chief of Staff The Committee received the current extract of risk registers, which provided oversight and assurance of the management of risks across the Trust and outlining the current risks scoring 15 and above. • LF advised that further work is being undertaken within Velindre Cancer Service in respect of its risk profile, ensuring clearer presentation of risks, actions, ownership, mitigations and risk reduction timescales. Further development will ensue over the next reporting period. • CJ indicated that there is a likelihood that a reduction in risk 2709, relating to funding of the nVCC Full Business Case, leading to delay, would be evidenced over the next reporting period, following planned engagement sessions with local Health Board Commissioners. • Due to the public nature of the document, it was **AGREED** to review the wording of risk 2709, as this may prompt queries from the public around funding. The Committee **NOTED** the risks level 20, 16 and 15 reported in the Trust Risk Register and highlighted in the paper, and NOTED the ongoing developments of the Trust's Risk Framework. **Trust Assurance Framework** Led by Lauren Fear, Director of Corporate Governance and Chief of Staff	**LF**

	The report provided the current position in relation to principal risks which fall within the remit of the Quality, Safety & Performance Committee and management thereof. Development of the approach to strategic risks continues and, following agreement at Audit Committee, strategic risks within the Framework specific to Demand and Capacity, Workforce Planning, Finance and Quality & Safety are to be separately scrutinised by the Quality, Safety & Performance Committee from November 2022 onwards. The Committee: • **DISCUSSED** and **REVIEWED** the update to the Trust Assurance Framework for the Principal Risks that fall within the remit of the Quality, Safety & Performance Committee, included at Appendix 1; • **NOTED** the progress made and next steps in supporting the continued development and operationalisation of the Trust Assurance Framework as outlined in section 2. VM advised that further comments in relation both items in this section would be provided to LF following the meeting via email.	**VM**
5.0.0	**INTEGRATED GOVERNANCE** (The integrated governance part of the agenda will capture and discuss the Trust's approach to mapping assurance against key strategic and operational risks)	
5.1.0	**Analysis of triangulated meeting themes** Led by Vicky Morris, Quality, Safety and Performance Committee Chair, supported by all Committee members This was discussed at various points during the meeting. **Analysis of committee effectiveness** Led by Vicky Morris, Quality, Safety and Performance Committee Chair, supported by all Committee members VM suggested identifying a mechanism to evaluate each Committee meeting between now and the further formal review to be undertaken in March 2023, to allow attendees the opportunity to raise concerns in relation to allocating sufficient time to discussions and facilitate ongoing improvements. This will be applied from the January 2023 Committee.	**VM/ES**
6.0.0	**HIGHLIGHT REPORT TO TRUST BOARD**	
	Members were asked to identify items to include in the Highlight Report to the Trust Board: • For Alert / Escalation • For Assurance • For Advising • For Information	

	Items to be agreed by the Committee Chair, Executive Director of Nursing and Committee Secretariat following the meeting.	
7.0.0	**ANY OTHER BUSINESS**	
	No other business was raised.	
8.0.0	**DATE AND TIME OF THE NEXT MEETING**	
	The Quality, Safety & Performance Committee will next meet on the: **17th January 2023 from 10:00 – 13:00 via Microsoft Teams**	
CLOSE		
The Committee is asked to adopt the following resolution: That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).		

QUALITY SAFETY & PERFORMANCE COMMITTEE

MANAGEMENT OF SAFETY ALERTS AND IMPORTANT NOTIFICATION POLICY (Reference QS02)

DATE OF MEETING	17th January 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Quality, Safety and Performance Committee is a public meeting

PREPARED BY	Jade Coleman, Quality Safety and Assurance Manager
PRESENTED BY	Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Trust Safety Alerts Group	4th October 2022	Endorsed
Executive management Board	3rd January 2023	Endorsed

1. SITUATION

The revised Trust Management of Safety Alerts and Important Notifications Policy (Reference QS02) is provided to the Quality, Safety and Performance Committee for **APPROVAL** following endorsement at the 3rd January 2023 Executive Management Board.

2. BACKGROUND

The Management of Safety Alerts and Important Notifications policy is in place to ensure the robust management of Patient Safety Solutions and that the Trust is meeting its legislative and national requirements and is a long-standing Trust policy.

The purpose of this policy is to ensure that Velindre University NHS Trust fulfils the requirements for the robust management of Safety Alerts and Important Notifications and to set out and ensure an effective internal management system within Velindre University NHS Trust for the distribution, monitoring and compliance of all Safety Alerts and Important Notifications received throughout the Trust. The Trust must be able to demonstrate that it has responded appropriately to alert information that is received, and evidence that robust audit trails are in place which confirm that appropriate actions have been taken within a reasonable time period.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

This policy has been updated to reflect enhanced arrangements in line with Welsh Government's authorisation for the NHS Wales Delivery Unit to lead on adapting existing Patient Safety Solutions so they are applicable in Wales. The Policy will require a further review in April 2023 to ensure additional updates are captured in line with the introduction of the Once for Wales Safety Alerts module reporting system and the additional functionality provided.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The policy is critical to effective Quality & Safety arrangements within the Trust.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	This policy can span across all the Health & Care Standards domains
	Yes

EQUALITY IMPACT ASSESSMENT COMPLETED	As this policy is only a revision to an existing policy, therefore a new EQIA is not required.
LEGAL IMPLICATIONS / IMPACT	The Trust has a legal duty to ensure the robust management and timely review of each Safety Alert and Important Notification that is received.
FINANCIAL IMPLICATIONS / IMPACT	There are direct impacts on resources as a result of the activity outlined in this report.

5. RECOMMENDATION

The Quality, Safety and Performance Committee is asked to **APPROVE** the Trust Management of Safety Alerts and Important Notifications Policy.

QS02
Management of Safety Alerts and Important Notifications Policy

Executive Sponsor &Function:	Executive Director Nursing, Allied Health Professionals and Health Science
Document Author:	Quality, Safety and Assurance Manager
Approved by:	Quality, Safety & Performance Committee
Approval Date:	*17.1.2023 (TBA)*
Date of Equality Impact Assessment:	NA
Equality Impact Assessment Outcome:	NA
Review Date:	*January 2024*
Version:	1

TABLE OF CONTENTS **PAGE NUMBER**

APPENDICES

1. Policy Statement

Safety Alerts and Important Notifications are developed and distributed to Velindre University NHS Trust, to support and direct solutions required to improve patient safety. The NHS Wales Delivery Unit has been given the authority by Welsh Government to lead on the vital role of adapting existing Patient Safety Solutions, so that they are applicable for Wales. Key safety risks, concerns and solutions are identified and developed at a national level, and where appropriate are adopted in Wales through a collaborative approach. The Delivery Unit is responsible for distributing Patient Safety Solutions at an all-Wales level to help manage risks identified and monitor compliance with NHS Wales's organisations.

The purpose of this procedure is to set out and ensure an effective internal management system within Velindre University NHS Trust for the distribution, monitoring and compliance of all Safety Alerts and Important Notifications received throughout the Trust. The Trust must be able to demonstrate that it has responded appropriately to alert information that is received, and evidence that robust audit trails are in place which confirm that appropriate actions have been taken within a reasonable time period.

It does not replace the duty and professional accountability of staff to report any adverse incidents with a medical device, hazardous product or unsafe procedure.

Working to a defined standard will reduce variations, so that solutions are relevant and useful to Velindre University NHS Trust and should avoid unnecessary overload of solutions work.

2. Responsibilities

The Chief Executive has overall responsibility for the management and oversight of all alerts and notifications management process, alert compliance, implementation and sign off within the Trust. For the practical operation of the system the Chief Executive has delegated this responsibility to the Corporate Quality and Safety Department (Quality, Safety and Assurance Manager's) who have a central role in ensuring that key personnel receive the solutions for actions, as considered appropriate by Velindre University NHS Trust. The role requires responsibility for acknowledging, disseminating, closing off safety alerts and providing feedback to relevant service divisions within designated timescales

The Divisional Directors have responsibilities to ensure arrangements are in place locally for the dissemination, action, and review of alerts within their area(s) of activity and responsibilities. This includes the nomination of an assigned nominated lead for the alerts and notification process and is set out in **APPENDIX 1** within this policy.

If, following the implementation of alert, information needs to be shared to identified staff, this will be done so via the most appropriate method of communication. All staff who receive information are responsible for ensuring they understand and apply to their practice.

2.1 The nominated Trust lead/deputy is responsible for:

- The onward distribution within the Trust to the Velindre Cancer Service and Welsh Blood Service Divisional leads.
- Consulting with the Divisional leads nominated to review the alert.
- Monitoring progression of solutions against set deadlines.
- Liaising with the Delivery Unit, updating the Datix Alerts Module, to ensure up to date and robust compliance recording.
- Confirming to the Delivery Unit the Trust compliance status by the deadline set out within the alert.
- Attending the All-Wales Patient Safety Solutions Reference Group contributing to the development and oversight of solutions compliance.

2.2 The service leads are responsible for:

- Receiving alerts via the Corporate Quality & Safety Department on behalf of their Division and speciality area.
- Acknowledging all alerts and to confirm if the alert is applicable within 48 hours of receipt.
- Ensuring the review of alerts and identifying appropriateness for the service.
- Undertaking a baseline assessment against Divisional compliance, risk assessing the issues involved and adding to the Risk Register if appropriate.
- Ensuring actions are identified and implemented within the area of responsibility to enable compliance with the alert.
- Leading on completing the actions held within the action plans and return compliance status to the Corporate Quality and Safety Department.

3. The various types of Safety Alerts and Important Notifications include:

- Patient Safety Alerts
- Patient Safety Notices
- Ministerial Letters
- Pharmaceutical Alerts
- Product Recalls and Manufacturer/Field Safety Notices
- Estates and Facilities Alerts
- Medical Device Alerts
- Security Alerts
- Healthcare Inspectorate Wales Reports
- Regulatory agency reports e.g., Health and Safety Executive, Fire authority, Human Tissue authority
- Accreditation visit reports
- Internal Safety Notices (Health and Safety)
- Internal Safety Notices (Patient Safety)
- Professional Regulatory Alerts

This list is not exhaustive and from time-to-time other important notifications may be received which require an equivalent response by the Trust. NHS organisations are required to submit responses on the action they have taken and are monitored on their compliance with completing such alerts within agreed deadlines when required.

4. Velindre University NHS Trust Patient Safety Alert Management Group

The Trust Patient Safety Alert Management Group meet on a quarterly basis and are responsible for overseeing the alerts and notification process, ensuring actions are implemented as per the appropriate action plans. Areas of non-compliance are reviewed and referred to an appropriate management group for further review and to determine mitigation actions. The group will approve all action plans and will agree when alerts can be closed. The Group, through its chair, will seek assurance that all alerts are appropriately managed in an effective and timely manner.

As well as managing externally created alerts, the Trust has developed its own system for sharing internal safety alerts to make staff aware of particular issues arising from concern and incidents learning outcomes.

5. Record Keeping

The Corporate Quality and Safety department is responsible for maintaining a register of all publications received and monitoring follow-up action status for reporting to the Trust Quality, Safety and Performance Committee.

To ensure the Trust is operating a robust system for managing alerts regular monitoring will be carried out. Quarterly reports outlining performance will be reported to the Trust Quality, Safety and Performance Committee.

6. Audit and Review

An annual audit will be undertaken by the Trust Corporate Quality and Safety Department to assess ongoing compliance with actions and timeframes and will include a review against compliance of twenty percent of Safety Alerts and Important Notifications received within each financial year.

The audit outcome will be reported to the March Trust Quality, Safety and Performance Committee.

Appendix 1

Nominated assigned leads

Type of safety alert / notification	Divisional nominated leads	Department	Responsible group / committee
Patient safety alerts	**Velindre Cancer Service:** Head of Nursing Quality and Safety Manager	Quality and Safety Department	Patient Safety Alert Management Group/Quality, Safety and Performance Committee
Patient safety notices	**Velindre Cancer Service:** Head of Nursing Quality and Safety Manager	Quality and Safety Department	Patient Safety Alert Management Group/Quality, Safety and Performance Committee
Ministerial Letters	Board Secretary	Quality and Safety/Governance Department	Executive Board & Quality, Safety and Performance Committee
Pharmaceutical Alerts	**Velindre Cancer Service:** Head of Pharmacy/deputy	Pharmacy Department	Medicine Management Group
Product Recalls and Manufacturer/Field Safety Notices	Head of Estates Health, Safety & Environment Officer (WBS)	Estates Department / Health and Safety	Planning & Performance Committee/Trust Health & Safety Management Group
Estates and Facilities Alerts	Head of Estates (VCS) Health, Safety & Environment Officer (WBS)	Estates Department /Health and Safety	Planning & Performance Committee/Trust Health &Safety Management Group
Medical Device Alerts	Medical Physics lead	Medical physics	Infection Prevention and Control Management Group/Trust Health and Safety Management Group
Security Alerts	Head of Estates	Estates Department	Planning & Performance Committee/Trust Health & Safety Management Group

Healthcare Inspectorate Wales Reports	Head of Quality and Safety Department	Quality and Safety Department	Quality, Safety and Performance Committee
Regulatory agency reports e.g., Health and Safety Executive, Fire authority, Human Tissue authority	Head of Quality and Safety Department	Quality and Safety Department	Quality, Safety and Performance Committee
Accreditation visit reports	Head of Corporate Governance	Corporate Governance Department	Quality, Safety and Performance Committee
Internal Safety Notices (Health and Safety)	Health and Safety Manager	Health and Safety Department	Trust Health & Safety Management Group/Local Groups
Internal Safety Notices (Patient Safety)	**Velindre Cancer Service:** Head of Nursing Quality and Safety Manager	Quality and Safety Department	Quality and Safety Committee
Professional Regulatory Alerts	HR Officers Medical/Clinical Directors	VCS/WBS Divisions/Hosted Organisations	Workforce & Organisational Development Committee

Appendix 2

Patient Safety Management Group Terms of Reference

Name of Group:	Trust Safety Alerts Management Group
Summary of Role:	To ensure the Trust has robust systems for the receipt and implementation of safety alerts. To improve safety by complying with best practice as detailed in the alerts
Remit:	To act as a forum for the receipt and analysis of all safety alerts. To co-ordinate and oversee the implementation of alerts across the Trust – this includes Patient Safety Alerts, Medical Devices, Pharmaceutical Alerts, Dangerous Incident Notification Alerts and Hazard Notices and Welsh health Circulars. Identify and facilitate the referral of safety alerts to appropriate groups/committees. This will ensure wider engagement of appropriate staff and managers (clinical and non-clinical) Identify and monitor risks associated with the implementation of alerts. Ensure processes exist so risks are treated or mitigated to their lowest level and where relevant, referred to the divisional/Trust risk register To ensure a multi-disciplinary approach to the assessment of safety alerts. This includes the need to consider sustainability for the future. Monitor the on-going implementation of alerts and progress against related action plans. Identify lessons learnt from alerts and share learning across the organisation. To facilitate the link between alerts and audit. Ensure a reporting procedure to provide assurance to the Division/Trust. Consider and share best practice and identify alternative solutions to risks identified in alerts.
Reporting to:	Executive Management Board Trust Quality, Safety and Performance Committee

Communicates with:	Velindre Cancer Centre Medicines Management Group Medical Devices Group	
Chaired by:	Interim – Head of Nursing, Quality, Patient Experience and Integrated Care (previously the Trust Quality & Safety Manager)	
Membership:	Velindre Cancer Centre, Head of Nursing Quality, Patient Experience and Integrated Care (deputy chair) Velindre Cancer Centre Quality & Safety Manager Trust Medical Devices Officer (Medical Devices) Head of Medical Physics (Velindre Cancer Centre) Senior Infection Control Nurse (Corporate) Principal Pharmacist Clinical Services (Velindre Cancer Centre) Medication Safety & Governance Pharmacist (Velindre Cancer Centre) Radio Diagnostic Imaging Services Manager (Velindre Cancer Centre) Consultant Representative (Velindre Cancer Centre) Education and Training Representative (Trust) Estates Manager (Velindre Cancer Centre) Therapies Manager (Velindre Cancer Centre) Quality and Assurance Manager (Welsh Blood Service)	
Meeting Frequency:	Quarterly. Additional meetings will be held if urgent matters arise. Six members would be required to achieve a Quorum out of which representative from Nursing, Patient Safety, Pharmacy, Medical and Corporate to be present.	
Documentation Required/Submitted From:	**Documentation**	**Submitted From**
	Alerts Alerts register Alerts action plans Highlight Reports	Trust Q&S department Trust Q&S department Alert lead Alert Lead
Outputs	Minutes, Alerts action plans, risk assessments.	
Contact: Trust Quality and Safety Coordinator	**Date ToR last revised:** January 2022	**Next review due:** January 2023

Summary Minutes

Private Quality, Safety & Performance Committee

Velindre University NHS Trust

Date: 10th November 2022
Time: 13:15-13:45
Location: Microsoft Teams
Chair: Mrs Vicky Morris, Independent Member

ATTENDANCE		
Vicky Morris	Independent Member and Quality, Safety & Performance Committee Chair	VM
Stephen Harries	Vice Chair and Independent Member	SH
Hilary Jones	Independent Member	HJ
Nicola Williams	Executive Director of Nursing, Allied Health Professionals & Health Science	NW
Lauren Fear	Director of Corporate Governance and Chief of Staff	LF
Matthew Bunce	Executive Director of Finance	MB
Carl James	Director of Strategic Transformation, Planning & Digital	CJ
Sarah Morley	Executive Director of Organisational Development & Workforce	SfM
Cath O'Brien	Chief Operating Officer	COB
Alan Prosser	Director, Welsh Blood Service	AP
Emma Stephens	Head of Corporate Governance	ES
Kyle Page	Business Support Officer (Secretariat)	KP

1.0.0	**STANDARD BUSINESS**	
1.1.0	**Apologies:** • Prof. Donna Mead, Velindre University NHS Trust Chair • Jacinta Abraham, Executive Medical Director	
1.2.0	**In Attendance:** • No additional attendees.	
1.3.0	**Declarations of Interest** Led by Vicky Morris, Quality, Safety & Performance Committee Chair No declarations of interest were raised.	
1.4.0	**Review of Action Log** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science	

	The action log was reviewed and the following was agreed: The action log was reviewed in detail. The Secretariat is to make all required amendments / updates and circulate to members following the meeting.	**Secretariat**
2.0.0	**CONSENT ITEMS** (The consent part of the agenda considers routine Committee business as a single agenda item. Members may ask for items to be moved to the main agenda if a fuller discussion is required).	
2.1.0	**ITEMS FOR APPROVAL**	
2.1.1	**Draft Minutes from the meeting of the Private Quality, Safety and Performance Committee held on the 15th September 2022** Led by Vicky Morris, Quality, Safety & Performance Committee Chair The draft minutes of the Private Quality, Safety & Performance Committee held on the 15th September 2022 were **APPROVED** as an accurate reflection of proceedings.	
2.2.0	**ITEMS FOR NOTING**	
2.2.1	**Transforming Cancer Services (TCS) Programe Scrutiny Sub Committee Highlight Report** Led by Stephen Harries, Vice Chair and Chair of the Transforming Cancer Services Scrutiny Sub Committee The Committee **NOTED** the contents of the Private TCS Scrutiny Sub-Committee highlight report and actions being taken.	
3.0.0	**MAIN AGENDA**	
3.1.0	**Trust Claims Report – Quarter 2** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science The Committee received the Quarter 2 Trust Claims Report. This provided an analysis of the claims being managed by the Trust as of the 30th September 2022, an update on redress cases and summary of inquest activity. The Committee **DISCUSSED** and **NOTED** the Quarter 2 Claims, Redress and Inquest Report. It was noted that across Wales there had been a backlog of inquests as a result of the pandemic which has increased the numbers of open inquests within the Trust and across Wales.	
3.2.0	**Infected Blood Inquiry (IBI)** Led by Cath O'Brien, Chief Operating Officer	

	The Committee received the Infected Blood Inquiry Report, providing an update in relation to the involvement of the Welsh Blood Service (WBS) as a core participant of the Inquiry and approach taken to the submission of a final response. It was noted that the Inquiry is approaching closure and that a statement will be submitted by the Trust to the Inquiry on the 15th December 2022. The Committee **NOTED** the update and **AGREED** the approach to inform the Board of the matters for inclusion in the Board briefing and the outline for the final Written Statement to the IBI by the December 16th 2022 deadline.	
4.0.0	**Analysis of meeting outputs** Led by Vicky Morris, Quality, Safety & Performance Committee Chair	
	No themes emerged from the Part B Quality, Safety & Performance Committee.	
5.0.0	**HIGHLIGHT REPORT TO TRUST BOARD**	
	Members were asked to identify items for inclusion in the Highlight Report to the Trust Board: • For Escalation • For Advising • For Assurance • For Information	
6.0.0	**ANY OTHER BUSINESS**	
6.0.0a	**Offsite Storage Incident Update *(Datix Ref: 4411)*** Led by Matthew Bunce, Executive Finance Director The Committee received the Offsite Storage Incident Update, providing an update on the management of the consequences of the flooding incident during February 2022, resulting in the damage / loss of archived medical records. A number of key areas were highlighted, including correspondence received in relation to the current position of the parties involved and plans to apply the Dispute Resolution Procedure to discuss resolution of the claims. The Committee **NOTED** the content of the paper for **ASSURANCE**.	

6.0.0b	**National Reportable Incidents** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science The Committee received a report that summarised two National Reportable Incidents (and associated investigation plans) that had been identified and reported during October 2022. One related to the SACT Telephone Helpline and the other to a patient not beng placed on the SACT booking list. Both incidents are currently under investigation. The Committee **NOTED** the two incidents that have occurred, the action taken to date and further planned actions ***and will receive an update at the next meeting.***	**NW/RH**
7.0.0	**DATE AND TIME OF THE NEXT MEETING**	
	The Quality, Safety & Performance Committee will next meet on **17th January 2023 from 13:15 – 13:45 via Microsoft Teams.**	
CLOSE		

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

PUBLIC RESEARCH, DEVELOPMENT & INNOVATION SUB-COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	17/01/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Sarah Townsend, Head of Research & Development
PRESENTED BY	Professor Andrew Westwell, Chair of the Research, Development & Innovation Sub-Committee
EXECUTIVE SPONSOR APPROVED	Dr Jacinta Abraham, Executive Medical Director

REPORT PURPOSE	FOR NOTING

ACRONYMS	
CVUHB	Cardiff and Vale University Health Board
ELISA	Enzyme-Linked Immunosorbent Assay
H&CRW	Health and Care Research Wales
HLA	Human Leukocyte Antigen
RD&I	Research, Development and Innovation
QSP	Quality, Safety and Performance Committee
NWSSP	NHS Wales Shared Services Partnership

WBS	Welsh Blood Service
WTAIL	Welsh Transplantation and Immunogenetics Laboratory

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 15/11/2022. Key highlights from the meeting are reported in Section 2.

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

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for **ALERT** or **ESCALATION** to the Quality, Safety & Performance Committee.
ADVISE	**Head of Innovation** The Head of Innovation has now been re-advertised and an update will be given at the next meeting. Existing arrangements continue to support the Trust's ambitious Innovation agenda. **RD&I Terms of Reference and Operating Arrangements** The Research, Development & Innovation Sub- Committee endorsed the revised Terms of Reference which will now be received at the next meeting of the Trust Board Audit Committee for formal endorsement and recommendation to the Trust Board for approval. **Radiotherapy Research** Delivery of Radiotherapy and combination Drug/Radiotherapy research continues to be challenging due to limited capacity across the Radiotherapy service. In October 2022, a meeting took place to discuss the issues and identify possible mitigation strategies. Work is underway to identify and implement mitigation strategies to improve the Radiotherapy service's capacity in terms of research studies and the wider service. The findings and outcomes will be fed back to the RD&I Operational Management Group and RD&I Strategic Leadership Group. A report will be made to the RD&I Sub-Committee in February 2023.
ASSURE	**Trust RD&I Sub-Committee Risk Register Extract** At the last Sub-Committee meeting, it was requested to make this a standard agenda item to formally note, if any, items that are required to be escalated to the

Sub-Committee, in line with the Trust Board Risk Appetite. It was reported that there were no open risks recorded on Datix for escalation to November's RD&I Sub-Committee.

TRUST Research, Development, and Innovation Performance Report 2021/2022

The RD&I Integrated Performance Report summarised activities of the Trust's Research, Development, & Innovation function during quarter 2 of financial year 2022/23 as follows :

- **Welsh Blood Service (WBS) : COVID-19 Serosurveillance Scheme**

The Welsh Blood Service RD&I Facilitation Team were recent finalists in the NHS Wales Awards. This cross-department work, in tandem with the partnership between Public Health Wales, Cwm Taf Morgannwg University Health Board and Swansea Bay University Health Board, has been recognised for its efforts by the award nomination. The scheme updates Welsh Government on the changes in infection and vaccine-mediated immunity to the COVID-19 virus in the adult Welsh population, month-on-month. The project, which began during the first wave in 2020, has processed over 66,000 samples to date. The scheme supports effective decision-making about Wales's vaccination programmes and public health measures.

- **Audit of Research & Development by NHS Wales Shared Services Partnership**

NHS Wales Shared Services Partnership (NWSSP) undertook an audit of Research & Development (R&D) as part of the 2022/23 internal Audit Plan. The review sought to provide the Trust with assurance regarding the effective management of R&D within the Trust. The Trust's R&D function received a "substantial" assurance classification following this audit.

- **Oncacare**

Wales Cancer Research Centre introduced Oncacare to the Trust, and also to Cardiff and Vale University Health Board (CVUHB), in early 2021 and a Letter of Intent was signed by the Trust in July 2021 followed by a confidentiality agreement in November 2021. The Letter of Intent contained offerings to the Trust in the context of the NHS and its well-established four nations systems and processes specifically in the set-up of commercial clinical trials. The Trust can expect to be offered interesting studies with a guarantee of acceptance as a site if we decided our patients would benefit from the trial on offer. The Trust will continue to maintain and develop its current relationships with sponsors and other CROs and to manage delivery of its portfolio of commercial studies independently of Oncacare. The Trust R&D office is working with the Joint Research Office at CVUHB to ensure that the terms of the collaboration are the same for both parties.

INFORM	**PROD Study Update** The Sub-Committee received a presentation on Predictive biomarkers response to desensitisation by Felicity May, Clinical Specialist Histocompatibility & Immunogenetics Digital Lead of the Welsh Blood Service. **WBS RD&I Strategy Update** Dr Sian James, RD&I Facilitation Lead presented an update on the development of a new WBS RD&I Strategy. **EXECUTIVE SUMMARY HIGHLIGHTS** The Executive Medical Director briefing reported high-level activities relating to Research, Development and Innovation that took place during Quarter (Q) 2 of Financial Year (FY) 2022/23. The following key highlights were reported : Welsh Blood Service ➢ COVID-19 Serosurveillance Scheme ➢ Welsh Bone Marrow Donor Registry Research & Development ➢ FAKTION and CAPItello-291 ➢ Research & Development Internal Audit ➢ Charitable Funds Committee Integrated Bid ➢ Oncacare ➢ Head of Innovation ➢ Radiotherapy Research
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 15/11/2022.

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

HIGHLIGHT REPORT FROM THE CHAIR OF THE TCS PROGRAMME SCRUTINY SUB-COMMITTEE

DATE OF MEETING	17th January 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Liane Webber, Business Support Officer
PRESENTED BY	Stephen Harries, Vice-Chair and Chair of the TCS Programme Scrutiny Sub-Committee
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning & Digital
REPORT PURPOSE	FOR NOTING

ACRONYMS	
WG	Welsh Government
LHB	Local Health Board
nVCC	New Velindre Cancer Centre
IRS	Integrated Radiotherapy Solution

1. PURPOSE

1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the TCS Programme Scrutiny Sub-Committee held on 17th November 2022.

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

1.3 The Board is requested to **NOTE** the contents of the report and actions being taken.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for Alert/Escalation to the Trust Board.
ADVISE	There were no items identified to Advise the Trust Board.
ASSURE	**TCS Programme Finance Report** The Sub-Committee received the TCS Programme Finance Report and the following queries were raised: • It was noted that the Sub-Committee are keen to gain a clear understanding of the potential impact on the Trust's finances. This was to be fed back to the author in order to further develop this detail in the report. • The Sub-Committee noted that the £0.434m sum to support the IRS programme has now been returned to the Trust Discretionary fund upon approval of the FBC. • Clarity was sought with regards to potential further underspend this year over and above the current underspend and whether this would mean a shortfall in the enabling works project next year due to delays in utilising the funds. It was explained that due diligence had been conducted in terms of reviewing and assessing the contracts in order to produce an accurate forecast and that there are processes by which this can be managed with Welsh Government, although it is understood that revising the planned spending generally becomes more difficult. • The potential impact of the annual NHS pay award referenced at para 7.28 was queried and it was confirmed that this had been factored into the revenue position. The Sub-Committee **noted** the TCS Programme Finance Report.

	Programme Director's Report The Sub-Committee received the Programme Director's Report, noting that the Programme Tranche Review has now received an initial review by the Independent Members. Noted also that the IRS is now ready to be signed and is awaiting ministerial approval. The "new" status of Risk R394 was queried. It was clarified that this is not a new risk but is a long-standing risk being presented in a different way. It was agreed that this was misleading and the words "new risk" would be removed. It was noted that a number of the risks had review dates which had passed. It was explained that these risks related to the outreach project which is currently still on hold. The accuracy of the description of Risk R2418 was queried. It was agreed that this risk in indeed due for review and that this would be carried out shortly with an update to follow. Concerns were raised over the current hard campaign against the TCS clinical model and the potential effect, if any, this was having on Welsh Government decisions. It was noted that on the balance of evidence, there was sufficient confidence that the objectives can and will be achieved. The Sub-Committee noted the Programme Director's Report. **Nuffield Recommendations Update** The Sub-Committee received the Nuffield Recommendations update and noted that good progress continues to be made. It was noted that the Heads of Terms had been agreed and that branding work is underway but clarity was sought as to what extent Velindre has been incorporated in either the nomenclature or the branding. The Sub-Committee were advised that the Heads of Terms, which have been written by a member of Velindre staff, are currently in draft and will be taken through EMB for sign-off, and that Velindre are very much in control of both pieces of work. It was queried whether legal input had been given and this was confirmed. The Sub-Committee **noted** the Nuffield Recommendations Update.

	The Sub-Committee received a brief update of the **FBC and Planning** progress, and **noted** that the FBC has been approved by Health Boards and is complete and that planning is imminent.
INFORM	**Communications & Engagement** The Sub-Committee received and **noted** the Communications and Engagement update.
APPENDICES	None.

QUALITY, SAFETY & PERFORMANCE COMMITTEE

DATIX PROJECT BOARD HIGHLIGHT REPORT

DATE OF MEETING	17th January 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable – Public Meeting

PREPARED BY	Sharon Wilson, Quality, Safety and Assurance Manager
PRESENTED BY	Sharon Wilson, Quality, Safety and Assurance Manager
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, Allied Healthcare Professionals, & Health Scientists

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Datix Project Board	19/10/2022 & 21/12/2022	AGREED ITEMS FOR HIGHLIGHT REPORT
Executive Management Board	3rd January 2023	NOTED & APPROVED

1. SITUATION

This paper provides the Quality, Safety & Performance Committee with a summary of the key developments reported at the Datix Project Board meetings held on the 19th October 2022 and 21st December 2022 and to advise of Executive Management Board approval to close down the Datix Project Board meetings after January 2023 and move to a quarterly Datix Operational Group.

2. BACKGROUND

The Datix Project Board was established in 2019 to oversee the implementation of Datixweb Version 14 and subsequently the National Once for Wales Datix system and is chaired by the Executive Director of Nursing, Allied Health Professionals and Health Scientists. Meeting were initially held monthly however frequency has reduced as the implementation has progressed.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 *Datix Version 12 Archiving / WBS Risk Migration*

The Velindre version 12 Datix is now hosted on a cloud-based platform, operated by the software provider-RLDatix. This is in archive format in all areas apart from risk where access is set up on a 'read only' basis to all legacy files. In addition, there are an agreed number of users within the WBS who have extended access to the legacy risk module in Read/Write mode for the period 1st June 2022 to 31st March 2023, to assist with migrating all WBS risks from Datix version 12. This additional access has been arranged until 31st March 2023. WBS provided assurance at the Project Board that all risks will be migrated by the end of January 2023, this is a slight slippage from the planned completion by 31st December 2023.

Venue Risk assessments were historically managed via Datix V12, for which there are the licensing restrictions to the end of March 2023. The Once for Wales Team have facilitated the development of a new form and process for capturing and the management of Venue Risk Assessments within DatixWeb v14 and is currently being reviewed at an operational level within WBS prior to being rolled out for use. All current and in use Venue Risk Assessments have been migrated onto Datix Version 14, and these will be followed by legacy Venue Risk Assessments by mid-January 2023.

3.2 Migration of Datix Version 14 to new server environment

The Velindre instance of DatixWeb V14 was being held on an on-premise server hosted by DHCW which was at the end of life and required to be moved to a migrated to a new server environment. This migration activity was undertaken on the 26th October 2022 in collaboration with DHCW, Digital Services and the OFW Central Team followed by a period of testing and validation by the Datix Local Service Lead and the WBS Validation team. This has been successful and did not have impact on operational services other than a window of downtime which was scheduled in advance and agreed via the Datix Project Board members. Version 14 is currently in use as the live operational system for the reporting and management of Risks and Safety Alerts and a Read Only archive system for Incidents, Claims and Complaints prior to April 2021.

3.3 Mortality Module

The new Datix Mortality Module is available in the system and a project group within Velindre Cancer Centre (VCC) is ongoing to implement the new All Wales Mortality Framework within VCC. This Framework will utilise the Datix module as a support tool. Meetings have been taking place which scope the use of the module to support the Mortality review process within VCC and deliver the project plan in conjunction with the All Wales Mortality Review Framework Working Group and Mortality Workstream.

3.4 Datix on the Go

NWSSP have launched a new initiative in the use of a QR code to be able to login to Datix Cymru and report incidents remotely. This has been advertised on posters and cards issued in the form of a wallet sized card with the QR code and login information to all staff who don't routinely use computers on a daily basis. This will mean that they are able to scan the QR code and securely login and report incidents via their mobile phones. Reporting 'On the Go'.

The Project Board agreed that this would a valuable tool across the Trust and has agreed a plan to roll this out Trustwide. It will be especially beneficial for outreach & WBS collection teams who can input live into the Datix System.

3.5 Once for Wales Update

3.5.1 Overall Once for Wales System Update: The Trust has been live since May 2021 on the Wales (once for Wales) Datix system for the Incident, Complaint, Compliment, Claim, and Redress modules with all new cases being reported and managed on this system. The Once for Wales system has been described by staff as being "intuitive" to use, and no significant problems have been reported or experienced.

3.5.2 Service and Location Limiting Combo Linking: Divisions have reported issues whereby staff can inadvertently choose locations and services within the OFW Datix system that are outside of their Division, once these are submitted into the system the appropriate notifications to managers are not being activated and there is the risk that Incidents may not be picked up and actioned or investigated. There is a defect under investigation by RLDatix, with no current fix available. To overcome this issue staff education has been ongoing to ensure staff are aware of the available reporting requirements and further guides have been made available. A further solution has been discussed with RLDatix and the OfW team are awaiting a proposal of testing to see if this is a viable option.

The situation is ongoing and is being monitored by the Datix Project Board via the Issues Log and is also an ongoing action at the All Wales Datix Local Service Leads meeting as the effect is being experienced by other organisations in Wales.

3.5.3 Future Once for Wales Modules:

- ***Safeguarding Module***: This module is currently being piloted in Hywel Dda UHB and is going well. A general release date will be determined once the results of the pilot have been addressed. Velindre University NHS Trust have volunteered be the next adaptor organization and implementation will commence in January 2023.

- ***Risk Module***: Is currently being developed by the All Wales Risk Workstream, which has representation from VCC and WBS to ensure consideration is being given to the specific requirements of the Trust. The pilot version of the module is scheduled for release in December 2022 followed by a period of review. Following this roll out will be implemented across across Wales in 2023 and migration plan for legacy risks will be established.

- ***Safety Alerts Module***: This module is in testing mode and it is anticipated that a staged approach to the roll out will be undertaken during 2023.

- ***Investigations Module***: No specific release date agreed. Development work on this module remains underway by RLDatix and the OFW team.

- ***Yellowfin Business Intelligence Tool***: Development is almost complete and training will commence in early 2023. The Trust will be required to send system leads and informatic staff to receive the training.

The Datix Project Board is not anticipating any significant issues relating to the implementation of any of the above modules.

3.5.4 Datix National Audit Plan: An All Wales audit plan is currently being scoped and developed by the OFW Central Team following engagement with NHS bodies. The focus will be on auditing the usage of the Datix system, and compliance with the agreed national key performance indicators initially focusing on the Incidents and Feedback modules. The draft plan will be presented at the next Project Board for implementation from February 2023.

3.6 Future of Datix Project Board

The Board felt that it had achieved its core aims and therefore could be closed down in its current format. It was proposed therefore, that the final Datix Project Board meeting will be held on the 18th January 2023. Following which, a Datix Operational Group would be established to manage the ongoing system, upgrade requests and implementation of any new features/modules and have oversight of any issues. It is proposed that the Operational Group will meet at least quarterly and report into the Trust Integrated Quality and Safety Governance Group.

It was noted that all identified risks as part of the implementation project have now been closed and resolved with the exception of one issue ongoing which is beyond the control of the Trust and is being monitored by the Once for Wales national team. An ongoing action relating to the timely closure of Incidents within the designated 30 day period is still of concern but actions are ongoing to address this and will be transferred to be monitored through the Integrated Quality & Safety Group.

A Formal Close Down report will be prepared against the Terms of Reference to ensure these have been achieved and submitted to this meeting. In addition, the proposed Terms of Reference for the new Datix Operational Group will be presented for approval to the group together with a Governance Process around the management of any future upgrades/system downtime.
The Executive Management Board on the 3rd January approved the Datix Project Board close down plans.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The DATIX project will improve the reporting and management of concerns and risks across the Trust and will support the on-going development of the Trust safety culture.
RELATED HEALTHCARE STANDARD	Safe Care
	The management of concerns will support the provision of safe care for patients and donors.
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
	Concerns considered to have an impact on equality will be identified during the review of each concern.
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

5. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to NOTE the key outcomes from the October and December 2022 Datix Project Board meetings and the Executive Management Boards approval to close the Datix Project Board down after the January 2023 meeting and initiate a quarterly Datix Operational Group.

QUALITY, SAFETY & PERFORMANCE COMMITTEE

MEDICAL DEVICES

DATE OF MEETING	17th January 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	N/A
PREPARED BY	Tim Register, Head of Engineering, Radiotherapy Physics, VCC Jignesh Raiyani, Medical Devices Officer, VCC
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**
Executive Management Board	03/01/2023	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. SITUATION

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 & Performance Committee is requested to NOTE the contents of the report and actions being taken.

2. 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

3.1 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 have not been enacted into UK law. The Medicines and Healthcare Products Regulatory Agency, recognising the need for updated legislation has recently consulted on the matter and updated regulations are expected to come in to force in July 2024.

It is expected that new, draft legislation (MDR), will be laid before the UK parliament in the near future and VUNHST must remain alert to the potential impacts of this. Whilst the legislation and advice from MHRA has yet to be published, it is anticipated that there will be a high level of alignment with existing (new) EU legislation, and this may impact across the Trust, For VCC, in particular around inhouse manufacturing of medical devices and the development of software as a medical device and for WBS in the use of certain reagents and software.

Both WBS and VCS have undertaken a review of the potential impact if the UK adopted the same standard as EU regulations. This is still in draft, but areas of additional cost are being identified. For WBS in particular, the use of certain reagents will be impacted. This has been part of an ongoing discussion with WHSSC who have committed to funding these costs.

VUNHST is also actively engaged with Welsh Government through the Deputy Chief Medical Officer and the Chief Scientific Adviser, on the current state of preparation for the new UK MDR in every Trust and Health board within Wales.
The VUNHST preparedness is a standing item on the VUNHST Medical Devices Group and is also informed through active engagement with the Wales 'Medical Device Regulations Group' which provides an information sharing forum for NHS Wales in respect of current and future Medical Device Regulations as they apply to preparedness of NHS Health Boards and Trusts in response to those regulations and reports key items to the Welsh Scientific Advisory Committee (WSAC) and Welsh Therapies Advisory Committee (WTAC) on a quarterly basis.

The wider impact of these regulations are being assessed and incorporated into work plans and the procurement of new devices. The digital system impact is also being considered.

VCC Linac Engineering department will continue to work to establish a QMS (ISO 13485) for in-house manufacturing of medical devices within Medical Physics.

Further detail on progress in relation to the impending regulatory changes will be provided in the annual report.

3.1.1 The VUNHST Medical Device Group

The Trust has a Medical Devices Group (MDG), the purpose of which is to ensure that risks of all types associated with the lifecycle of medical devices (including acquisition, in-house manufacture or development, decontamination, use, maintenance and disposal) are controlled and minimised. It includes responsibility for formulating appropriate policies for the identification and management of any issues with medical devices in use or being maintained. This includes responding to any relevant MHRA or manufacturer alerts and keeping the Chief Operating Officer informed of specific issues that require their attention.

The group meets quarterly. It ensures that all MHRA and Manufacturer Medical Device Safety Alerts/Notices have been addressed. The group receives periodic reports from the Medical Gases Committee and Electrical Safety User Group for note of any medical device specific issues or actions to ensure areas of mutual interest are covered. Any urgent operational issues are dealt with in real time.

The governance route for assurance and escalation is via highlight reports to EMB and via discussions with the Chief Operating Officer.

3.1.2 VCS Update

There is a full cycle of maintenance for Medical Devices. Maintenance of the majority of VCC's portable powered medical equipment (including wall mounted oxygen flow meters and suction) are maintained by C&V Clinical engineering. The governance arrangement for the SLA with C&V Point of care testing services for POCT service is in place.

Various maintenance and service contracts with manufacturers, suppliers or external service providers are in place to support and maintain various medical devices and equipment. We currently have more than 100 different types of devices which equates to in excess of 1200 individual portable medical devices within VCC (see Appendix A for details), of these, 672 devices are supported and maintained within an SLA with C&V, over 368 devices are maintained by VUNHST and 224 devices are maintained by manufacture or contractually with another 3rd party supplier.

Various medical devices are used within the VCC and Outreach Clinics to support day to day activities. An inventory of equipment (medical devices) is available, however, to improve the management of this inventory, VCC has procured and populated a dedicated commercial software database, the work to complete and activate this database in awaiting final testing and is imminent. Once complete VCC will have an active comprehensive database for managing medical devices.

To comply with forthcoming new MDR, VCC Linac engineering department is working to establish a QMS (ISO 13485) for in-house manufacturing of medical devices within Medical Physics. Please note that the development of the new QMS (ISO 13485) is challenging due to the amount of documentation required, however this resource intensive task is on track for the anticipated MDR Q4 2024 implementation date.

In the last six months, there have been 248 Medical Device Alerts, Medical Device Safety Bulletin, Field Change Order, and Field Safety Notices. Nine of these were applicable to VCS and have all been actioned.

The equipment work stream of the nVCC project includes the procurement and commissioning of the medical devices for the new hospital. Work is underway to scope the detail of the work plan and the associated requirements for meeting the regulatory requirements. This will also be an opportunity to develop new approaches. The consensus of experts in this field recommends that the future direction of travel should be to procure and commission an asset tracking system for medical devices (e.g. RFID tracking), particularly for the new hospital. This will enable hospital wide visibility of all portable powered medical devices and can be useful when locating critical equipment. It will help to increase clinical and medical staff productivity by eliminating time spent searching for devices, hence providing prompt patient care. It will also help to maximise device utilisation. Overall, it will be an effective part of the Medical Device management system.

Implementation of the IRS programme is also part of the wider work plan.

3.1.3 WBS Update

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.
- Planning and delivery of nVCC and IRS

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	No (Include further detail below)

ASSESSMENT COMPLETED	This is part of the procurement process, however other aspects are currently being considered where necessary
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.

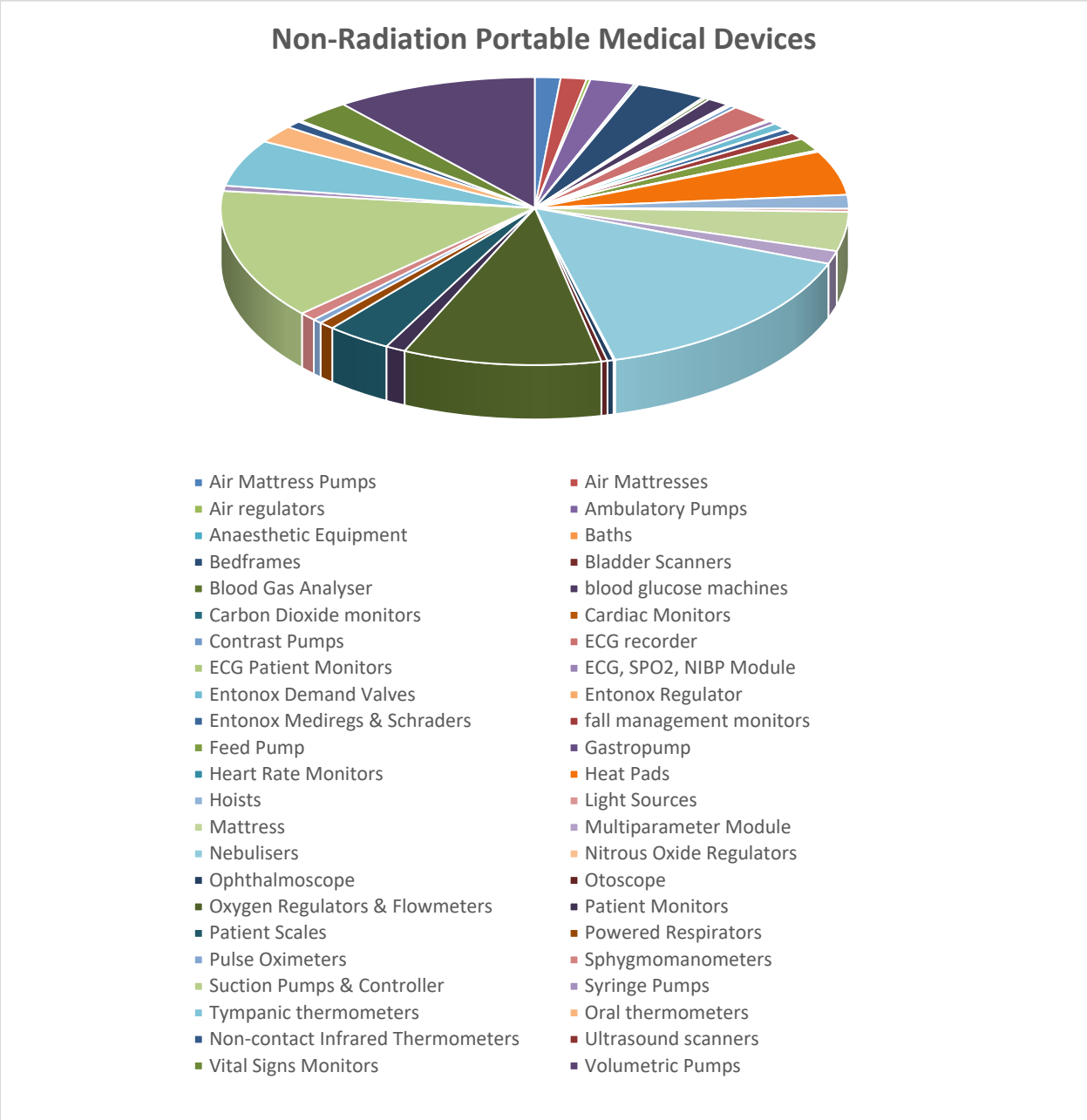
5. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **NOTE** the **(Medical Devices Annual 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
2022 / 2023 QUARTER 2 (1st July 2022 to 30th September 2022) and QUARTER 3 (1st October to 30th November 2022) INFORMATION GOVERNANCE ASSURANCE REPORT

DATE OF MEETING	17th January 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	

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	26th October 2022	**ENDORSED** for **NOTING** and **ASSURANCE** by the Committee, and;
Executive Management Board	3rd January 2023	**ENDORSED** for **NOTING** and **ASSURANCE** by the Committee

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		

1. SITUATION

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

The report outlines key **ASSURANCE** activities, (1) Data Protection, (2) Information Management (3) Trust Assurance (Risk). The report also includes data security incidents & investigations for the reporting periods of 1st July 2022 to 30th September 2022 and 1st October 2022 to 30th November 2022.

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

2. BACKGROUND

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

VUNHST is committed to ensuring the provision of an effective IG Assurance Framework. This ensures that the Trust meets its statutory obligations and other standards. Meeting the obligations and standards means that incidents are appropriately investigated, and that learning takes place

in order that the Trust can improve the quality and safety of its services, and the patient and donor experience.

3. ASSESSMENT/SUMMARY OF MATTERS FOR CONSIDERATION

The following are the key highlights as detailed within the quarter 3 report for the period 1st October 2022 to 30th November 2022:

- The three IG Assurance Framework areas being focused on are: (1) Data Protection (2) Information Management (3) Trust Assurance (Risk). 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.

The detailed report has been presented to EMB and is available for further information.

(1) Data Protection

This provides assurance that the Trust is processing personal data in line with data protection legislation. Due to the amount of personal data processed, it is sub-split into differing areas. In this report QSP are requested to note:

- HR Breach – Impact of the report of the unauthorized sharing of an investigation report by the Trust to individuals who are not the data subjects.

  Actions:

  - In depth data protection training for all Trust Workforce and OD Officers in relation to UK GDPR (Article 5) the ICO employment practice code and ACAS guidance.
  - Separate reports into single investigations, it will remove complexity and reduce risk of inadvertent data disclosure and data breach
  - Workforce and OD Officers to seek IG advice prior to any sharing of personal data in respect of post-investigation reports if in case of doubt.

- Considerations around the correct methodology and processes for research activity utilizing personal data in whichever form the personal data takes

  Action: HOIG to diarise a workshop as agreed with the Caldicott Guardian and SIRO to facilitate research activity in line with current legislation and guidance.

- Consideration of the impact of pseudonymization on research, development and innovation activity across all divisions of the Trust.

Actions:

- HoIG to prepare a paper and presentation on pseudonymisation measures for presentation at EMB Run and the RD&I Sub-Committee respectively
- HoIG to conduct a workshop approach to pseudonymisation security measures anonymisation definitions to understand processes, risk and impact.

(2) Information Management

Provides assurance in relation to Information management processes and activity, which has included:

- COVID 19 inquiry, whilst the majority of this activity sits within the Goverance area of the Trust under the Director of Corporate Goverance and Chief of Staff, the support function in terms of Information and Records Management has now come to the fore, this is in part due to the fact that the Inquiry began on 4th August 2022 with Modules 1 and 2 following in quick succession. Module 3 is now imminent.

  Action: Continue to fully support the needs of the COVID 19 Public Inquiry to ensure that the Trust responds in accordance with the Inquiries Act 2005

- Records Task and Finish Group – Post DHCR go live this work will begin in early Jan 23, this is to permit the DHCR Medical Records team to bed in new ways of working and take stock to ensure that there are no operational issue in that area before looking back implementing the lessons learned from the ongoing incident.

  Action: HOIG to support the Working Group's aim of driving delivery by 31st March 2023

- DHCR Go-live – during the Quarter the CANISC replacement system went live, supported by IG, there was specific risk mitigating action undertaken in terms of processes and assessments to ensure that go live was as smooth as possible from an IG perspective.

  Actions:

  - Continue to support DHCR activity
  - Review the DPIA for SAR's no later than 6th Jan 23 (DHCW mailed on 4th Jan 23, requesting project update)
  - Continue to support risk management in relation to project delivery

(3) Trust Assurance (Risk)

Assurance that the Trust is undertaking activity and has processes in place to ensure that risk is regularly assessed and reported in line with Trust Policy and Standards, in particular in the following areas:

- Internal Audit – Work has begun on preparing for an internal audit on IG systems and processes, using the IG Toolkit as the yardstick by which to measure assurance. This approach was agreed nationally between NWSSP Audit and DHCW.

  Action: Teams channel set up on 4th January 2023 to share documentation to facilitate and support audit activity.

- Offsite Storage Risk – regular reviews of current risk in relation to this incident with DATIX updated monthly to reflect risk reviews.

  Action: HOIG continues to fully support the Trust response to the incident, monitor risk, latest information on 4th January 2023 is that 640 boxes moved to Maltings from Oasis, deliveries of approximately 1280 boxes per week expected.

- Caldicott/SIRO/HOIG meetings – This supports the quarterly meeting between SIRO/Board IG Champion and the HOIG so that clinical risk is clearly understood as well as finance and IG Risk in relation to projects and activity that is processing patient data. This work will feed into the annual IG report.

  Action: Agenda setting meeting held on 9th December 2022, further Caldicott/SIRO/HOIG meetings (including the Chief Digital Officer) planned for January 2023 and quarterly thereafter.

SARs, DPIAs, Data security incidents & investigations.

clinical information	**Quarter 2:1st Jul – 30th Sep**	**Quarter 3:1st Oct - 30th Nov**
Requests for access to health records	34	36
No. Breaches against one calendar month response timeframe	3	1
% Breaches against one calendar month response timeframe	9%	2.7%

non-clinical information	Quarter 2:1st Jul – 30th Sep	Quarter 3:1st Oct - 30th Nov
Requests to provide information held on an individual	1	0
No. Breaches against one calendar month response timeframe	0	0
% Breaches against one calendar month response timeframe	0%	0%

DPIAs

- 68 DPIA's were commenced since Oct 21, 65 of which are Trust DPIA's, 3 are NHS Wales national DPIA's
- 11 Trust DPIA's have been approved during quarter 2 (July – Sep 22) 2022-23
- 7 Trust DPIA's have been approved during quarter 3 (Oct – Nov 22) 2022-23
- No NHS Wales DPIA's have been approved.

Actions:

- Work ongoing to identify all existing Trust systems to assess whether a DPIA has been completed. A risk-based approach is being followed to prioritise assessments, the IG and Digital are involved in this work, identifying instances which come to the fore, e.g. contract renewal work, systems where data migration is identified
- DPIA's and Data Processing Agreements remain unaligned with Contract activity, Procurement and IG Team to undertake contract alignment work during quarter 4 2022-23

Data security incidents & investigations

- There have not been any digital incidents of note since the last report:.

Incidents & Investigations for the period 1st July 2022 to 30th September 2022 (Quarter 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	18	0	18	0	18	0	18	8	10	18
WBS	2	0	2	0	2	0	2	0	2	2
NWSSP	19	0	19	0	17	2	19	2	17	19
Total Trust	**39**	**0**	**39**	**0**	**37**	**2**	**39**	**10**	**29**	**39**

Incidents & Investigations for the period 1st October 2022 to 30th November 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	1	0	1	0	1	0	1	0	1	1
Velindre Cancer Services	6	0	6	0	6	0	6	2	4	6
TCS	0	0	0	0	0	0	0	0	0	0
WBS	3	0	3	0	3	0	3	1	2	3
NWSSP	11	0	11	0	11	0	11	3	8	11
Total Trust	**21**	**0**	**21**	**0**	**21**	**0**	**21**	**6**	**15**	**21**

- The top three themes of incidents continue to be confidentiality breaches; 1. patient records/information sent to wrong recipient (x8). 2. staff records/information sent to wrong recipient (x4). 3. Staff records/information sent to wrong recipient (x4).
- The remaining 5 are split between other (x4) and patient records/information inappropriately divulged (x1)
- Most incidents still 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**
- VCC has two open incidents, the first is not IG but related to a physical security issue (ID badge collected by someone who was not a member of Staff), this has been reassigned to VCC Operational Services. The remaining incident is under investigation by the Service (Medical Records) and relates to misdirection of an email.
- WBS has one open incident which relates to Apheresis, it does not constitute a data breach and is awaiting closure. The HoIG has been in communication with area leads to ensure that the DATIX is investigated and closed properly.
- Due to improved DATIX reporting functionality, granular data in relation to Corporate and TCS divisions is available from 1st October 2022.
  - Corporate division has no incidents under investigation.
  - TCS division has no incidents reported, nor under investigation.
- NWSSP has three incidents under investigation, these are:
    - Awaiting CCTV footage from Velindre to establish the circumstances leading to the alleged incident, HOIG has intervened to support NWSSP;

- Awaiting an update from the Director of the service; and
- Incident that took place in November 2022 but reported on the 12th December 2022 is undergoing review and discussion to consider the next steps in order to locate the information.

- HoIG has written an SOP to enable Service Areas to investigate incidents appropriately after discussion at the Integrated Quality and Safety Group meeting on 22nd November 2022. The SOP is with the Trust DATIX lead for initial review. HofIG will continue to investigate IG incidents of a serious nature and provide advice, guidance and support to those investigating simple incidents.
- 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.

Action:

- Individual(s) who have caused incident are required to re-take ESR IG awareness training
- Enhanced IG training delivered by HoIG to teams and/or individuals using a risk-based assessment i.e., no. of incidents from each team balanced against impact
- If an incident is assessed as potentially having a serious impact on the patient/donor or the family of a patient/donor a Root Cause Analysis investigation is undertaken in addition to the investigation template within DATIX

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	Effective Care
	Standard 3.4 Information Governance and Communications Technology
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 2 (1st July 2022 to 30th September 2022) and 2022/23 Quarter 3 (1st October 2022 to 30th November 2022) Information Governance Report for **ASSURANCE**.

Quality, Safety & Performance Committee

VACCINATION PROGRAMME BOARD UPDATE

DATE OF MEETING	17/01/2023

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	08/11/2022	Items for discussion agreed
Executive Management Board	05/12/2022	NOTED

ACRONYMS	
JCVI	Joint Committee on Vaccination and Immunisation
DHCW	Digital Health & Care Wales
WIS	Welsh Immunisation System
WBS	Welsh Blood Service
VCS	Velindre Cancer Service

1. SITUATION

This paper is to provide the Quality, Safety & Performance Committee with an update in relation to the Trust's Autumn 2022 Influenza vaccination plans and current position in relation to COVID-19 booster vaccinations, as discussed and agreed at the Trust's Vaccination Programme Board held on the 8th November 2022.

The Quality, Safety & Performance Committee is asked to **NOTE** completion of the Autumn 2022 Influenza vaccination programme and proposed action to ascertain COVID-19 booster vaccination status of Trust staff.

2. BACKGROUND

The purpose of the Trust-wide Vaccination Programme Board is to assume responsibility for planning and safely delivering the Public Health Wales Vaccination Programmes for the Trust, to include vaccines for Influenza and the COVID-19 virus, in line with Joint Committee on Vaccination and Immunisation (JCVI) guidelines, frontline categories and age groups on an ongoing basis as dictated.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Autumn 2022 programme

Due to failure by Digital Health & Care Wales (DHCW) to maintain / upgrade the Velindre instance of the Welsh Immunisation System (WIS) since May 2021, Velindre University NHS Trust was unable to administer COVID-19 booster vaccinations to staff during Autumn 2022 and these were received via their respective Health Boards.

The Trust continued to provide the opportunity for all staff to access and receive Influenza vaccinations, and surplus vaccines were transferred to Cardiff & Vale University Health Board to help maintain national contingency vaccination stocks.

3.2 Influenza Vaccinations

To date (during the Autumn 2022 programme), 905 (54%) of staff have received their Influenza vaccination via Velindre University NHS Trust (at organised clinics within both Divisions during the last week of September and first week of October 2022 and subsequent ad hoc 'mop up' appointments). The overall percentage of staff having received an Influenza vaccination during the Autumn 2021 Programme was 61%, exceeding the Government target of 60%.

DIVISION	STAFF VACCINATED	STAFF EMPLOYED	% OF STAFF VACCINATED
Corporate	94	179	52%
WBS	267	460	58%
VCS	544	1019	53%
TOTAL	**905**	**1658**	**54%**

***** Students, non-ESR and bank staff not included in the figures detailed above.***

The number of Influenza vaccinations received elsewhere (outside the Trust) is currently being analysed, supported by completion of online forms by staff having received vaccinations via their Health Boards / GP surgeries.

3.3 COVID-19 Booster Vaccinations

The Trust Business Intelligence Team is undertaking an anonymised data search of Health Board WIS information, to ascertain if the Trust COVID-19 Vaccination numbers can be ascertained for this booster programme. It is unlikely that a Trust vaccination percentage will be possible.

3.4 Communications

Regular communications regarding the plans for Influenza vaccinations were posted on the Trust intranet and circulated in divisional newsletters.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	No
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	No

5. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **NOTE** completion of the Trust's Autumn 2022 Influenza vaccination programme and proposed action to ascertain, if at all possible, the COVID-19 booster vaccination compliance for the Trust**.**

QUALITY, SAFETY & PERFORMANCE COMMITTEE

SAFE CARE COLLABORATIVE

Date of meeting	17th January 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Non-Applicable Public Report
Prepared by	Nicola Williams, Executive Director of Nursing, Allied Healthcare Professionals, & Health Science
PRESENTED BY	Nicola Williams, Executive Director of Nursing, Allied Healthcare Professionals, & Health Science
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, Allied Healthcare Professionals, & Health Science

REPORT PURPOSE	FOR NOTING

Committee/Group who have received or considered this paper prior to this meeting		
Committee or Group	DATE	OUTCOME
National Patient Safety Collaborative	29/11/2022 30/11/2022	PLAN AGREED
Executive Management Board	03/01/2023	APPROVED

ACRONYMS	
IHI	Institute of Healthcare Improvement

1. SITUATION

This paper is to provide the Quality, Safety & Performance Committee with an overview of the National Safe Care Collaborative that was launched in November 2022 and the Trusts plans in respect of the establishment of a Trust Safe Care Collaborative.

2. BACKGROUND

Improvement Cymru has re-launched the support being given to NHS Wales bodies through a Safe Care Collaborative. The Safe Care Collaborative was launched nationally on the 29th and 30th November 2022 and 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. Full details of the national Collaborative is attached in ***Appendix 1***.

At organisational level the aim of this work is to achieve a locally owned and managed safety programme with the infrastructure to support a sustainable learning system that will work towards achieving results at scale.

Four national priority areas have been identified following the diagnostic Safer Care Foundation Visits held earlier this year (Trusts report previously provided).

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 National Safe Care Collaborative

An Improvement Collaborative is a systematic approach to health care, quality and improvement. Organisations and providers of care will test, measure and practice innovations and share their experiences. This will accelerate learning and achieve widespread implementation of best practice. The Safe Care Collaborative will aim

to demonstrate significant improvements and performance by focusing on the following four work stream areas:

1. Leadership for patient safety improvement
2. Safe and effective community care
3. Safe and effective ambulatory care
4. Safe and effective acute care.

This results-focused safety collaborative will be co-designed and co-delivered by Improvement Cymru and IHI, bringing together teams, coaches, executive and senior leaders for safety from across all health boards and trusts. It will align the work of the safety leadership network with teams and coaches engaged in improvement work on identified safety priorities. Demonstrating what is possible through content specific prototyping and delivery of early results, preparation, and planning for spread and scale can be executed beyond the initial phase of the work.

This initial phase of collaborative learning is intended to establish learning systems locally and nationally. Building relationships and networks that will ensure an all-Wales approach to improvement and achieve safe reliable and effective health care. Leaders and teams who participate will support the delivery of local leadership plans for the infrastructure to achieve a reliable system for safety and quality.

The collaborative offers in-person learning sessions and action period coaching which has proven to be a foundational tool to creating long-term success. This method can help care settings accelerate work that is already underway and plan for meaningful progress over time. However, it is important to note that the work of genuinely transforming patient experience is a multi-year process.
The two day launch provided the background and learning from across the globe of such a collaborative including Scotland. The outcomes from hospitals / teams who have taken this approach had overwhelmingly had a significant positive impact on reduction in harm events, safety issues and improved patient experience.
The event was opened by the Health Minister and the Chief Nursing Officer for Wales, Deputy Chief Medical Officer for Wales, and Deputy Chief Executive for Wales were all present and set out the requirement for NHS bodies to deliver this requirement in order to improve patient safety and reduce harm.
Time was afforded during the second day for the Trust to consider its plans to launch this work.

3.2 Trust Safe Care Collaborative

3.2.1 Trust attendees

The Trust had a small team of staff who attended the two-day launch although there was no direct Divisional SLT / SMT representation. The Executive Director of Nursing, AHP & Health Science (Exec Lead) and Executive Medical Director attended (supporting Exec) and the following additional Trust representation:

- Nigel Downes, Interim Deputy Director Nursing, Quality & Patient Experience – Trust Safety Coach
- Annie Evans, Interim Clinical Transformation Lead – Trust Safety Coach
- Victoria Mills Evans, Service Improvement Manager - Trust Improvement Coach
- Carys Jones, Senior Programme Delivery & Assurance Manager - Trust Improvement Coach
- Phillipa Blackford, Operations Manager, WBS
- Abbey Griffiths, Training Lead, WBS
- Hayley Jeffries, Head of Infection Prevention & Control
- Tina Jenkins, Head of Safeguarding & Vulnerable Adults

3.2.2 Improvement Cymru Trust Support

Two Improvement Cymru advisers have been allocated to support the Trust in the delivery of its requirements: Andrew Ware and Sarah Patmore.

3.2.3 Trust Plans

The Trust Team identified that three of the four workstreams applied to the Trust and should be taken forward. It was agreed that the 'Safe and effective community care' did not apply to the Trust as it related to community response and escalation particularly in the care home setting. It was identified that areas of work and priorities needed to be aligned under the remaining three areas.

It was agreed that a Trust Safer Care Collaborative is required, it would be a sub-group of the Integrated Quality & Safety Group and would be attended by the two Improvement Cymru Advisers. Membership must include Divisional SLT/SMT Officers, Senior Improvement Leads from across the Trust, Communications, all Trust Safety Coaches and Improvement Coaches, as well as relevant Corporate Staff. The inaugural meeting is arranged for the 9th January 2023.

The following was identified as the priority areas for discussion / consideration of the 9th January 2023 in order to achieve a clinically driven Trust Safety Collaborative:

- Identification of all staff trained to date in improvement methodology – identify need for any refresher training – national team will provide
- Identification of all staff in Improvement roles
- Champion roll out of a single improvement methodology across the Trust – proposed this is the PDSA methodology being endorsed by Improvement Cymru and the Institute of Healthcare Improvement.
- Conduct a Trust wide safety survey to assess current safety culture
- Completion of Driver diagrams for all three areas of work – using the national driver diagrams as the basis
- Significant focus on Leadership work to engender a safety first, improvement and psychological safety culture across
- Align current 'burning platform work' e.g. Unwell Patient work to this collaborative
- A mechanism for engendering local ownership of small-scale safety / harm reduction change measures to be developed aligned with value based healthcare work e.g. Dragons Den type events attaching front line staff with Improvement / Safety Coach support.
- Identification of Safety and Harm Measures
- Ongoing safety focused communications with a theme of the month
- Develop a team progress reporting mechanism aligned with 7 levels of assurance

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Significant positive impact on Quality, safety, outcome & experience
RELATED HEALTHCARE STANDARD	Safe Care
	The management of concerns will support the provision of safe care for patients and donors.
EQUALITY IMPACT ASSESSMENT COMPLETED	No (Include further detail below)
	An equality Impact assessment will be completed for each area of work
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

5. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **NOTE** the National Safe Care Collaborative plans and the Trust plans as detailed in section 3.2.3.

Safe Care Collaborative - NHS Wales

improvement.cymru

Contents

The Safe Care Collaborative 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.

At organisational level an aim of this work is to achieve a locally owned and managed safety programme with the infrastructure to support a sustainable learning system that will work towards achieving results at scale.

Project Information

In partnership, Improvement Cymru and IHI will implement a program that builds on Improvement Cymru's bold commitment to improve patient safety and achieve the following objectives:

- Support the creation and progress of patient safety improvement projects across all health boards and trusts in Wales.
- Demonstrate improvement in key safety metrics and/or reduction in patient safety harms in health boards or trusts.
- Strengthen improvement capability within the teams being supported by the collaborative.
- Provide a once for Wales approach that seeks to create the culture and conditions for patient safety and to reduce avoidable harm and unnecessary variation across the whole system.
- Share good practice and accelerate knowledge mobilisation to enable improvements in quality and safety at pace and scale across NHS Wales.

With the overall aim of achieving and sustaining safer care for patients and populations in a range of care settings across NHS Wales, the Safe Care Collaborative will support health boards and trusts between November 2022 and February 2024.

The Improvement Cymru Safe Care Collaborative

What is the structure of an Improvement Collaborative?

An Improvement Collaborative is a systematic approach to health care, quality and improvement. Organisations and providers of care will test, measure and practice innovations and share their experiences. This will accelerate learning and achieve widespread implementation of best practice.

The Safe Care Collaborative will aim to demonstrate significant improvements and performance by focusing on the following four work stream areas:

1. **Leadership for patient safety improvement**
2. **Safe and effective community care**
3. **Safe and effective ambulatory care**
4. **Safe and effective acute care.**

This results-focused safety collaborative will be co-designed and co-delivered by Improvement Cymru and IHI, bringing together teams, coaches, executive and senior leaders for safety from across all health boards and trusts. It will align the work of the safety leadership network with teams and coaches engaged in improvement work on identified safety priorities. Demonstrating what is possible through content specific prototyping and delivery of early results, preparation, and planning for spread and scale can be executed beyond the initial phase of the work.

This initial phase of collaborative learning is intended to establish learning systems locally and nationally. Building relationships and networks that will ensure an all-Wales approach to improvement and achieve safe reliable and effective health care. Leaders and teams who participate will support the delivery of local leadership plans for the infrastructure to achieve a reliable system for safety and quality.

The collaborative offers in-person learning sessions and action period coaching which has proven to be an exceptional foundational tool to creating long-term success. This method can help care settings accelerate work that is already underway and plan for meaningful progress over time. However, it is important to note that the work of genuinely transforming patient experience is a multi-year process.

Recruiting Teams

Teams and individuals who have an interest in one of the four work streams should be encouraged to join the Safe Care Collaborative. They should be willing to prototype and deliver results orientated work that requires the application of improvement science methods in practice.

Work stream 1: Leadership for patient safety improvement

- Executive leadership with responsibility for safety as a senior sponsor.
- Leading Patient Safety graduates who have an understanding of the core components of the Safe Reliable and Effective Care Framework: Leadership, Culture and Learning System.

Work stream 2: Safe and effective community care

- The Coaching for Patient Safety graduates who have been assigned to the organisational projects for this work stream
- Teams should be working in an area of practice outside of the acute hospital setting.
- Teams who join this work stream will work to test and deliver core safety practices that aim to prevent deterioration.
- They provide appropriate care for patients based on their wishes, with the aim of preventing hospital admissions where appropriate.
- We would expect to see multidisciplinary teams in this work stream including care home staff, GPs, GP practice staff, wider community wrap-around services and partner organisation staff such as WAST who lead on preventative intervention work.

Work stream 3: Safe and effective ambulatory care

- The Coaching for Patient Safety graduates who have been assigned to the organisational projects for this work stream
- Teams should be working in an area of practice that cares for patients outside of the hospital and provides acute oversight and management of care. i.e., Virtual Ward, Hospital at Home, MDEC or SDEC units, Frailty or falls management that does not require hospital admission.

Work stream 4: Safe and effective acute care

- The Coaching for Patient Safety graduates who have been assigned to the organisational projects for this work stream
- Teams of acute multidisciplinary staff who work in in-patient areas and are ready to commit to learning as one of the test sites for the organisation.
- Typical units to consider are surgical ward, medical ward, specialist unit / ward.
- The work of teams in this work stream will involve core safety practices including prevention of deterioration, recognition, escalation of concern and response and treatment of acute deterioration.

Participation and Commitment

There will be an expectation that teams recruited to participate in the Safe Care Collaborative will be consistent in their attendance in learning events and coaching calls. The team membership may alter following the first learning session and as the team get organised. However once it is decided who is best placed to contribute it is an expectation for the team to remain consistent.
This will ensure that teams have the best chance of success in the work they take forward. Participating teams will need review the dates for all events and meetings to ensure they have the capacity to attend all sessions.

Learning Sessions

Learning sessions are designed to achieve a number of objectives:

- Learning how to apply the scientific method for improvement to achieve results in safe reliable and effective care.
- Collaboration and learning alongside teams working on similar subject matter with a shared aim.
- Engagement of health boards and trusts staff with leaders in partnership to deliver on a shared purpose.
- Learning for the work stream team and their organisation in preparing the ground for scalable work that will achieve whole system learning and impact.
- Evidence what is possible and build the spread plan for results at scale.

Action Periods and Coaching Improvement

Action periods are made up of the weeks in-between learning sessions, usually around 10-12 weeks. During the action period, teams will be expected to attend virtual monthly calls to share learning and progression of work in preparation for the next learning session. Work stream calls will be provided to combine shared learning about interventions and the application of quality improvement methods and tools to support progress.

Coaching support will be provided by the Improvement Cymru regional teams, connecting with Improvement Hubs and Coaching for Patient Safety graduates who will provide coaching support within the work streams. The IC regional leads will support the momentum of the work, build a network of learning and support the design of spread and scale plans to ensure the successful work can be achieved with rigor.

Collaborative Schedule

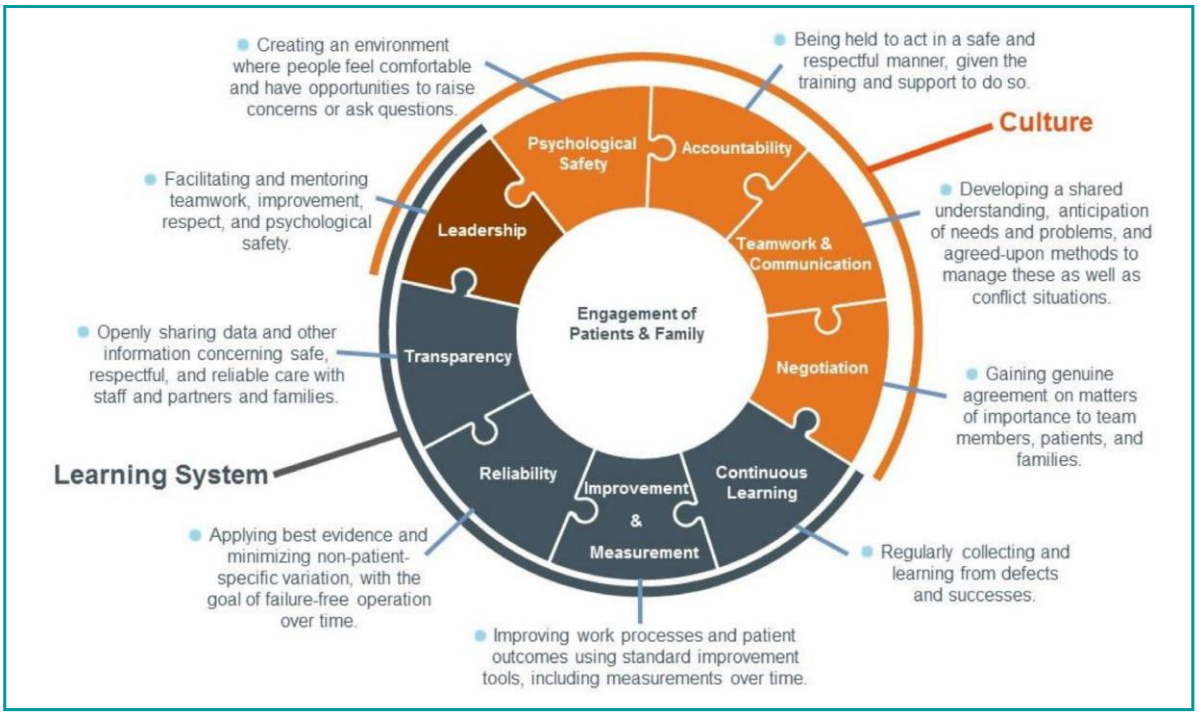
Monthly collaborative MS Teams calls will be conducted during each Action Period. The dates and time of these calls will be shared on registration.

- **Pre-Work Call:** 9 November, virtual - MS Teams call
- **Learning Session 1:** 29-30 November 2022, Cardiff
- **Action Period 1:** December 2022 – March 2023, virtual - MS Teams monthly calls in January and February
- **Learning Session 2:** 7-8 March 2023, Cardiff
- **Action Period 2:** March – June 2023, virtual - MS Teams monthly calls in April and May
- **Learning Session 3:** 13-14 June 2023, Cardiff
- **Action Period 3:** June – September 2023, virtual - MS Teams monthly calls in July and August
- **Learning Session 4:** 19-20 September 2023, Cardiff
- **Action Period 4:** September – November 2023, virtual - MS Teams monthly calls in October
- **Learning Session 5:** 28-29 November 2023, Cardiff
- **Action Period 5:** November 2023 – February 2024, virtual - MS Teams monthly calls December
- **Celebration:** 21 February 2024, Cardiff

Getting Started Checklist

- [ ] **Confirm health board / trust Executive Sponsor**
- [ ] **Confirm Leading for Patient Safety Sponsors for work stream teams**
- [ ] **Confirm Coaching for Patient Safety Coaches for work stream teams**
- [ ] **Confirm Project Team day-to-day leads (up to two to three people)**
- [ ] **Confirm point of contact within the organisation who the Improvement Cymru leads will link with**
- [ ] **Select work stream teams (include patients or residents)**
- [ ] **Confirm data lead to support work stream teams**
- [ ] **Confirm administrative provisions to support work stream teams**
- [ ] **Complete Safe Care Collaborative registration (ensure the correct project teams are registered under the correct work stream)**
- [ ] **Share Model for Improvement information with work stream team**
- [ ] **Prepare for Learning Session 1**

Framework for Safe Reliable Effective Health Care



https://www.ihi.org/resources/Pages/IHIWhitePapers/Framework-Safe-Reliable-Effective-Care.aspx

GWELLIANT CYMRU IMPROVEMENT CYMRU

Institute for Healthcare Improvement

QUALITY, SAFETY & PERFORMANCE COMMITTEE

HEV Testing of Apheresis Platelet Donations

DATE OF MEETING	17/01/2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Peter Richardson, Head of Quality Assurance and Regulatory Compliance
PRESENTED BY	Alan Prosser, Director, Welsh Blood Service
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**
Executive Management Board	03/01/2023	NOTED

ACRONYMS	
WBS	The Welsh Blood Service
HTA	Human Tissue Authority
WBMDR	Welsh Bone Marrow Donor Registry
SaBTO	Advisory Committee on the Safety of Blood, Tissues and Organs

HEV	Hepatitis E Virus
NHSBT	NHS Blood and Transplant
SABRE	Serious Adverse Blood Related Events Scheme

1. SITUATION

An apheresis platelet component donated on 17/11/2022 tested positive for Hepatitis E Virus (HEV) during routine screening – this donation was discarded. This finding prompted the Welsh Blood Service (WBS) team to re-test the previous donation from this individual which also proved to be positive despite passing screening at the time of donation.

Fortunately, although the previous month's donation had been split into 8 neonatal doses, none of these had been issued to hospitals and had been discarded. Had any of these units been administered to a neonate with an immature immune system the risk of harm would have been significant. The incident was initially reported as a process issue in Q-pulse, but due to the potential for harm and the need to report externally it has now been entered into Datix (Ref 8964).

2. BACKGROUND

The Welsh Blood Service (WBS) introduced HEV testing using pooled donations in July 2017 following guidance issued by the Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO).

The WBS screening test for HEV involves pooling 16 samples into a single test sample. If this pool tests positive for HEV then each individual sample is separately tested for the presence of the virus. This incident arose because the 16x dilution effect of the pooled samples meant that the viral load was below the cut off for detectability. In other UK services the pool used can be up to 24 samples, giving an even greater dilution factor.

There have been previous similar incidents including one at WBS in 2019 and at NHS Blood and Transplant (NHSBT) in England. As a result, SaBTO set up the HEV Working Group in October 2020 to re-examine the effectiveness of pooled HEV screening of blood and platelet (apheresis) donors, and to advise on whether it provides sufficient mitigation of transmission risk.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

As a result of this incident, a decision was taken at the WBS Regulatory Assurance and Governance Group in November 2022 to stop pooled screening of apheresis platelet donations with immediate effect and to start testing each sample individually pending the recommendations of the SaBTO HEV working group.

Details of the incident have now been shared with other UK blood services and with regulators as a near-miss under the Serious Adverse Blood Related Events (SABRE) scheme.

Other UK services have requested more details from WBS to inform their own local responses, and the SaBTO HEV Working group has been reconvened to study the latest evidence and make recommendations on the continued use of pooled screening by March 2023.

WBS will continue to test individual apheresis platelet donations until this work is completed and the SaBTO guidance is confirmed.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	This incident has identified a potential risk to patient safety if the root cause is not addressed.
RELATED HEALTHCARE STANDARD	Safe Care
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
	Neutral Impact
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)

	There could be legal implications if a patient came to harm as a result of a transfusion transmitted infection
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	There is a small increase in the cost of testing individual samples vs pooled screening, this is estimated at £6,000 per annum.

5. RECOMMENDATION

The Committee are asked to:

NOTE the incident and the requirement to report it to regulators, and
NOTE the decision to test individual apheresis platelet donations until the SaBTO guidance is confirmed.

QUALITY, SAFETY & PERFORMANCE COMMITTEE

Integrated Quality & Safety Group

DATE OF MEETING	17th January 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Non-applicable Public Paper
PREPARED BY	Nicola Williams, Executive Director Nursing, AHP & Health Science
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 NOTING & APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Integrated Quality & Safety Group	06/12/2022	Approved
Executive Management Board	03/01/2023	Endorsed

ACRONYMS	

1. SITUATION

This paper is to provide the Quality, Safety & Performance Committee with an overview of the key deliberations and outcomes of the first three Integrated Quality & Safety Group Meetings held between October and December 2022 and to provide the Terms of Reference for **APPROVAL.** The Quality, Safety & Performance Committee is asked to:

- **DISCUSS** this paper
- **NOTE** the urgent work required in respect of the development of Quality, Harm and Safety metrics and an integrated business intelligence system in order to electronically capture the required information to support effective triangulation and analysis
- **APPROVE** the Integrated Quality & Safety Group Terms of Reference that were endorsed by the Executive Management Board on the 3rd January 2023.
- **APPROVE** the proposal to incorporate the work of the Safety Alerts Group into the Integrated Quality & Safety Group and to close down the Datix Project Board (separate paper on the Committee agenda).

2. BACKGROUND

The Integrated Quality & Safety Group was established in October 2022 in order to provide oversight to support the Board, Executive Team and Divisional Senior Leadership Teams in meeting their Quality and Safety Responsibilities. This includes meeting legislative and national requirements in particular the 'Duty of Quality' responsibilities to help to ensure quality is at the centre of all decision making across the Trust.

The Group is the coming together of the Corporate and Divisional Quality & Safety Hubs to provide integrated analysis and assurance / escalation to the Executive Team and Quality, Safety & Performance Committee on behalf of the Board in respect of the Trust meeting its Quality and Safety responsibilities in line with legislative and national requirements and ensuring the Trust is learning from internal and external events, and always improving.

3. SITUATION

3.1 Integrated Quality & Safety Group Terms of Reference

The Integrated Quality & Safety Group Terms of Reference are attached in ***Appendix 1*** for approval. These will be reviewed in 6 months' time once the Group is fully established.

3.2 Key Outcomes and Deliberations

3.2.1 7 levels of assurance: The Group received a 7 levels of assurance presentation and has agreed that this will be of significant benefit to enhance assurance mechanisms. It was successfully tested for open Infection Prevention & Control & Health & Safety actions. All areas agreed to use this mechanism.

3.2.2 Quarter 2 data analysis: The Group attempted to undertake analysis of quarter 2 quality & safety data from across a range of functions. There was no succinct way of presenting this data to the group and many, detailed papers were produced. It was identified that urgent critical work was required to not only determine and agree the quality, harm and safety metrics for the Trust but to provide electronic, automated, business intelligence and dashboard so that meaningful analysis can take place and the priority focus areas identified.

It was identified that interim support can be brought in using Value Based Health Care monies but no clear plan as yet developed to achieve this.

In the interim, a basic SCP training programme for responsible officers has been arranged although access to Power BI across the Trust as the platform is required.

3.2.3 2023/24 Quality Priorities: These are currently under consideration by the Group so that they can feed into the IMTP process.

3.2.4 Development of Quality & Safety Hubs: Corporate Hub development is delayed due to the senior Quality & Safety Team structure not being in place. Confirmation is awaited from both Divisions in respect of the establishment of their hubs.

3.2.5 Future Reporting: It was agreed that future reporting through to Executive Management Board and Quality & Safety Group will be via the Integrated Quality & Safety Group and as far as possible aggregated and succinct reports will be provided. It was recognised that these will take time to mature and will be optimised once the business intelligence system is addressed.

3.2.6 Quality & Safety Meetings: A full mapping of all current quality and safety meetings across the Trust has been undertaken. This requires further refinement and will be finalised by January's meeting. The following proposals have been made to date:

- Incorporate the work of the Safety Alerts Group into the Integrated Quality & Safety Group work from March 2023
- Close down the bi-monthly Datix Project Board from January 2023 and replace with a quarterly Datix Operational Group.

It is expected that further adjustments will be suggested post completion of the mapping.

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:

- **DISCUSS** this paper
- **NOTE** the urgent work required in respect of the development of Quality, Harm and Safety metrics and an integrated business intelligence system in order to electronically capture the required information to support effective triangulation and analysis
- **APPROVE** the Integrated Quality & Safety Group Terms of Reference that were endorsed by the Executive Management Board on the 3rd January 2023.
- **APPROVE** the proposal to incorporate the work of the Safety Alerts Group into the Integrated Quality & Safety Group and to close down the Datix Project Board (separate paper on the Committee agenda).

TRUST INTEGRATED QUALITY & SAFETY GROUP
Terms of Reference and Operating Arrangements

Version: 5.0
Date Reviewed: January 2023
Review Date: July 2023
Agreed by: Nicola Williams, Executive Director or Nursing, Allied Health Professionals and Health Sciences
Endorsed by: Executive Management Board: 03/01/2023
Approved by: Quality, Safety and Performance Committee

1. CORE FUNCTION

The Integrated Quality and Safety Group ("the Group") will provide the oversight to support the Board, Executive Team and Divisional Senior Leadership Teams in meeting their Quality and Safety Responsibilities. This includes meeting legislative and national requirements in particular the 'Duty of Quality' responsibilities to help to ensure quality is at the centre of all decision making across the Trust.

The Group is the coming together of the Corporate and Divisional Quality & Safety Hubs to provide integrated analysis and assurance / escalation to the Executive Team and Quality, Safety & Performance Committee on behalf of the Board in respect of the Trust meeting its Quality and Safety responsibilities in line with legislative and national requirements and ensuring the Trust is learning from internal and external events, and always improving.

To achieve this the Group will be responsible for reviewing, analysing and triangulating information, outcomes and metrics from across a broad range of quality, safety and experience functions to identify themes, trends, areas for improvement, audit and escalation.

The Group will enhance cohesive and collaborative working in respect of quality, safety, improvement and outcomes across the Trust.

2. PURPOSE

The Trust Quality and Safety Governance Group will:

- Oversee the operational implementation of the Quality & Safety Framework
- Oversee the operational implementation of the Trust Quality Priorities
- Oversee the operational implementation of the Duty of Quality and Duty of Candour
- Oversee the implementation of the new Wales Quality Standards (from 2023)
- Oversee effective embedding of the Trusts CIVICA Patient / Donor Experience system.

- Agree and ensure regular review of Trust Quality, Safety & Experience metrics including robust data definitions, collection methods, and delivery targets

- Oversee the high level delivery of agreed quality, safety & experience improvement / action plans

- Identify themes, trends, areas for action, improvement priorities, general prioritisation, assurance and escalation through detailed analysis of outcomes from across all broad functions including:

-
    - Compliment themes
    - Claims
    - Concerns / complaints themes
    - Patient-reported outcome measures (PROMs)
    - Patient / Donor reported experience measures (PREMs)
    - Staff satisfaction / engagement scores
    - Safety culture
    - Inquests
    - Peer Reviews
    - Inspectorate reviews (also learning from high profile reviews external to Trust)
    - Health & Safety
    - Information Governance
    - Mortality data
    - Infection Prevention & Control
    - Safeguarding & Vulnerable Adults
    - Workforce
    - Regulatory requirements *(to be listed?)*
    - Delivery against core standards (e.g. Red Book (WBS), Cancer Standards & Cancer Quality Statement)
    - Safety Culture
    - Clinical Audit
    - Financial control

This will require detailed analysis of the outputs across these areas to identify 'the so what' in relation to what this information / data is telling us. Ensuring that these are adequately and in 'real time' represented within the Risk register, Trust Assurance Framework, IMTP Planning priorities and audit / clinical audit plans.

- Identification of the annual Trust quality & safety priorities (need to be sophistically developed)

- Identification of Values Based Healthcare opportunities

- Oversee the implementation of the metrics and dashboards to monitor quality and safety at different levels of the organisation and across all sub groups in terms of clinical outcomes, patient safety, effectiveness and experience, and expected levels of performance

- Be responsible for overseeing the development of the Duty of Quality reporting requirements

- Oversee implementation of Duty of Candour regulations and reporting requirements

- Explore macro level data to ensure data outputs are useful and effective to improve performance and compliance areas.

- Ensuring Risk registers reflect outcomes determined through the group from its analysis

- Oversee the development of the Trust wide Clinical Audit Plan ensuring the Clinical Audit Plan is informed by quality, safety and experience outcomes

- To review and evaluate relevant reports in respect of relevant organisations to identify lessons learnt for the Trust

- Identify good practice and learning for sharing.

3. DELEGATED POWERS AND AUTHORITY

The Quality & Safety Governance Group formally reports into the Trusts Executive Management Board, following which to the Trusts Quality, Safety & Performance Committee. A triangulated assurance report will be provided following each meeting that will be supplemented by any papers identified as being required at the meeting. All such reports will be approved by the meeting chair prior to submission.

The Quality and Safety Governance Group will receive requested reports from **both Divisions** and will include unified information from:

- Senior Leadership Teams
- Divisional Quality and Safety Groups
- SCIF
- Mortality Review
- Regulatory Compliance
- Finance
- Digital
- Risk management
- Infection, Prevention and Control
- Safety Alerts Management Group
- Workforce and Organisational Development
- Health and Care Standards / Quality Standards
- Putting Things Right, Claims and Inquests
- Audit
- Datix
- Information Governance
- Health and Safety
- Business Intelligence

The group will commission any work required to undertake further reviews, investigations or analysis that assists it in meeting its core function and purpose this may include establishment of task and finish groups, commissioning surveys, external reviews / support or further detailed specialist analysis.

4. OUTCOMES

The core outcomes will be:

- Reduced duplication
- Enhanced assurance
- Streamlining of meetings and reporting
- Enhanced learning & improvement
- SMART Quality Improvement Goals 2023/34
- Enhanced communications
- All Wales Audit Review

It is anticipated that in the event of the above being achieved this will reduce harm and improve quality and experience of patients and donors.

5. MEMBERSHIP

The core membership of the Group is:

Co-Chairs: Executive Director of Nursing, Allied Health Professional and Health Science / Executive Medical Director

Vice Chair: Assistant Medical Director Quality & Safety

Co-Option: Additional members maybe co-opted onto a meeting as relevant to the agenda with prior agreement of at least one of the Co-Chairs

Secretariat: Administrator for Corporate Quality & Safety Team

Membership: *All members are expected to attend each meeting. In the event of being unable to attend it is the member's responsibility to arrange for a deputy to attend who has full authority to act and make decisions on behalf of the member.*

Table 1: MEMBERS

NAME	TITLE	DEPUTY	MEETING ROLE & RESPONSIBILITY
Nicola Williams & Dr Jacinta Abraham	Executive Director of Nursing, AHP & HS / Executive Medical Director	Co-chair arrangement	Co- Chairs: ensuring meetings are effective and achieving the required outcomes
Dr Hilary Williams	Assistant Medical Director Quality & Safety		Vice Chair
Helen Jones	Health & Safety Manager	Ceri Pell,VCC Health and Safety Advisor	Health and Safety
Carl Taylor	Chief Digital Officer	David Mason-Hawes (Head of Digital Delivery) / Suzanne Rogers (Head of Digital Programmes)	Digital & Informatics
Dr Jillian McLean	Consultant Oncologist	NA	Mortality oversight
Nigel Downes	Deputy Director Nursing, Quality & Patient Experience	Head of Quality, Safety & Assurance	Responsible for Effective Oversight and reporting of / from the group
TBC	Head of Quality, Safety & Assurance	Deputy Head of Quality, Safety & Assurance	Effective Management of the Group
TBC	Deputy Head of Quality, Safety & Assurance	Quality, Safety and Assurance Managers	
Ian Bevan	Head of Information Governance	Debbie Evans - Trust Archivist	Information Governance

Lauren Fear	Director of Corporate Governance	Emma Stephens, Head of Corporate Governance	Corporate Governance & Risk Triangulation
Tina Jenkins	Head of Safeguarding & Vulnerable Groups	NA	Safeguarding & Vulnerable Groups
Hayley Jeffries	Head of Infection Prevention & Control	Julianne Golding-Sherman, Infection Control Nurse	Infection Prevention & Control Aspects
Matthew Bunce	Executive Director of Finance	Chris Moreton Deputy Director of Finance	Value – Resources and outcome triangulation
Sharon Wilson Jade Coleman	Quality, Safety and Assurance Managers	Quality, Safety and Assurance Managers	To provide updates for Safety Alerts, PTR, Claims, Inquests, Health and Care Standards
Jayne Rabaiotti	Claims, Redress & Inquest Manager	Quality, Safety and Assurance Managers	Claims, inquests, redress, ombudsman
Viv Cooper	Head of Nursing	Sarah Owen Quality and Safety Manager (VCC)	VCC Divisional Lead
Sarah Owen	VCS Quality and Safety Manager	NA	
Peter Richardson	Head of Quality Assurance	Maria Cheadle, Quality Improvement Manager	WBS Divisional Lead
Zoe Gibson, Head of Nursing WBS	Donor engagement	Sharon Porter – Quality & Service Development Nurse	
Susan Thomas	Deputy Director of Workforce and OD	Amanda Jenkins – Head of Workforce	
Philip Hodson	Deputy Director of Planning & Performance	Peter Gorin Head of Corporate Planning	IMTP planning lead - Integrated links between meeting triangulated outcomes / identified priorities and IMTP planning & performance framework development
Sara Walters	Clinical Audit Manager	No deputy at present – currently recruiting into the vacant Band 5 role.	Ensuring Clinical Audit planning is aligned with Quality & Safety Outcomes
Catherine Pembroke	Clinical Audit lead / Consultant Oncologist	NA	

6. MODUS OPERANDI

6.1 Attendance

- Core members are required to attend at least 75% of meetings. Members of the Group shall appoint suitably qualified deputies to represent them at meetings when they are unable to attend personally.

- With the approval of the Chair, other persons may be asked to attend meetings from time to time for a specific purpose.

- The Chair of the Group may require the attendance of specialist advisors or other attendees to attend meetings either in full, or for specific agenda items.

- Other managers may be required to attend at the discretion of the Chair of the Group.

6.2 Quorum

In order for a meeting to go ahead the following members are required:

- Chair or Vice Chair
- At least two members of the Corporate Quality & Safety Team
- Each Division represented
- Corporate Governance / Risk
- Health & Safety
- Claims manager

6.3 Frequency of meetings

Meetings shall be held bi-monthly.

6.4 Meeting Arrangements

Meetings will be held 'in person' unless otherwise required due to the pandemic when a 'Teams' meeting will be arranged. A clear work plan will be developed to support delivery of core business.

6.5 **Meeting support**

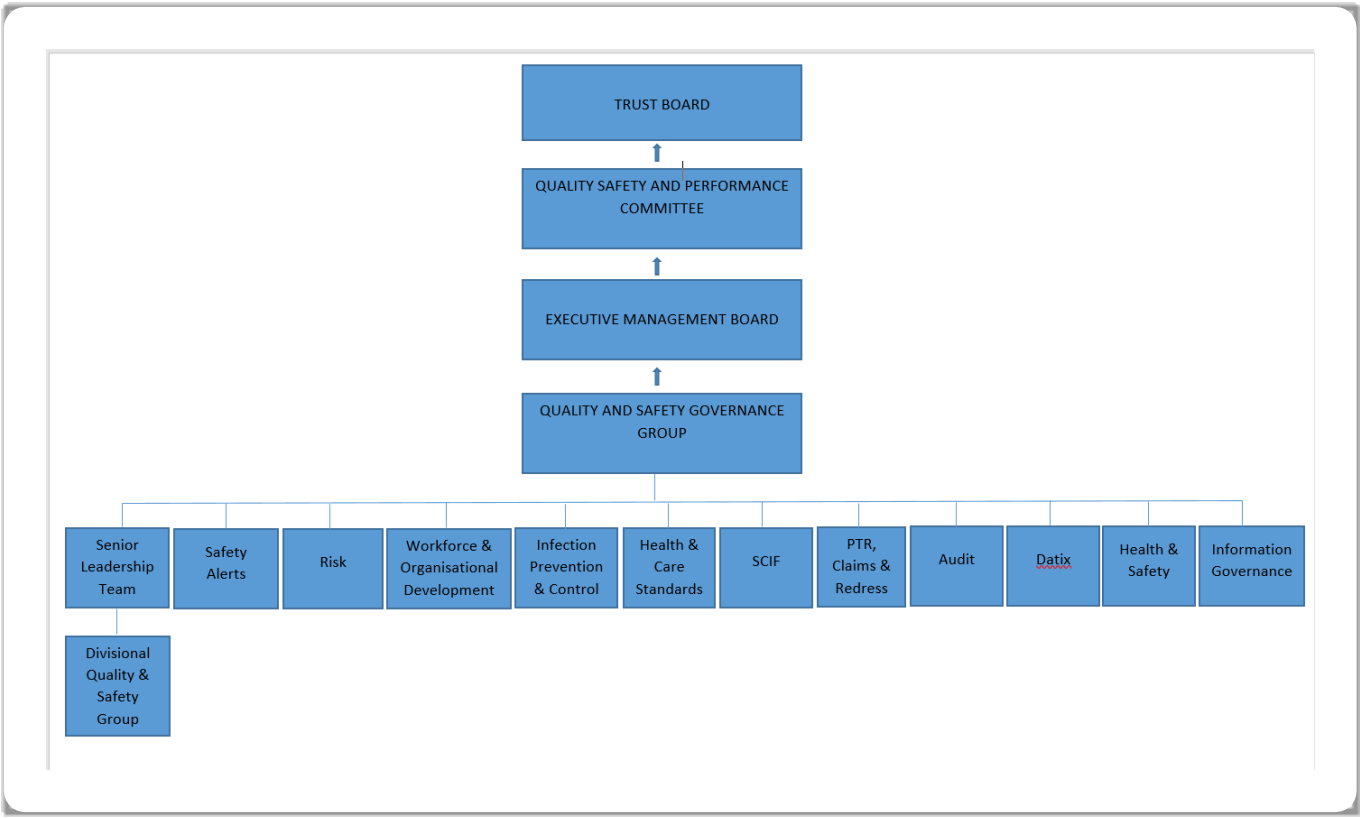
The Corporate Quality & Safety Team will be responsible for the effective functioning and organisation of the group including all secretarial duties, minute taking and administrative support. Duties shall include:

- Agreement of the meeting agendas with the Group Chair;
- Providing draft meeting notes and action log to all members within 7 days of a meeting taking place;
- All papers are to be provided to the meeting Secretariat at least 7 days prior to the meeting; and,
- The agenda and papers will be circulated at least 5 days in advance of the meeting.
- A quarterly learning focussed quality & safety newsletter will be produced by the Group.
- No tabled or verbal reports will be accepted. If an event occurs that requires reporting after papers have been circulated a late paper is to be submitted after agreement with the meeting chair.

7. REPORTING AND ASSURANCE ARRANGEMENTS

The Quality & Safety Governance Group will formally report (escalation & assurance) into the Trust Executive Management Board and Quality, Safety & Performance Committee.

In addition, the Group will provide escalation reports into the Divisional Quality & Safety Groups / SLT/SMTs as deemed appropriate by the Group (in event of unresolved matters or new triangulation / matters identified that have not been previously reported to Divisions). It is the responsibility of the Divisional representatives on this Group to ensure the escalation reports are formally considered within the Division and to provide action targeted outcomes to the next meeting.



Sub Groups

The Group will establish sub-groups / Task and Finish Groups to support the delivery of its responsibilities. At the outset these will include:

- Duty of Quality & Duty of Candour Implementation Group
- Safety Collaborative

8. REVIEW

These terms of reference and operating arrangements shall be reviewed in 6-months.

9. IMTP DEVELOPMENT

Points to consider under IMTP:

- Looking forward over 3 years.
- Areas to be prioritised, to be determined.
  - high priority for Quality and Safety Governance Group to demonstrate the pathway from identifying risk to fix.
- Consider Welsh Government dictation.
- How do we evidence that Trust can identify improvement in quality.

QUALITY, SAFETY & PERFORMANCE COMMITTEE

DUTY OF QUALITY GAP ANALYSIS REPORT

DATE OF MEETING	17th January 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Non-applicable public report

PREPARED BY	Nigel Downes, Interim Deputy Director of Nursing, Quality & Patient Experience and Nicola Williams, Executive Director Nursing, AHP & Health Science
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**
Executive Management Board	03/01/2023	Paper discussed & Implementation Plan approved (pending availability of delivery resources)

ACRONYMS	
"The Trust"	Velindre University NHS Trust

1. SITUATION

This paper is to provide the Quality, Safety & Performance Committee with an initial gap analysis and draft implementation plan against the Duty of Quality (element of Wales Quality & Engagement Act 2020) draft Statutory Guidance that is out for consultation.

This paper is provided for **DISCUSSION** and **NOTING.**

2. BACKGROUND

As previously reported, the Health and Social Care (Quality and Engagement) (Wales) Act was passed in 2020. A national Steering Group supported the development of the regulatory and statutory guidance documents for the Duties of Quality and Candour. The enactment of these duties had been delayed due to the pandemic. However, enactment will now be required for both duties from 1st April 2023. The national Steering Group has now been superseded by a Duty of Quality & Duty of Candour Implementation Board.

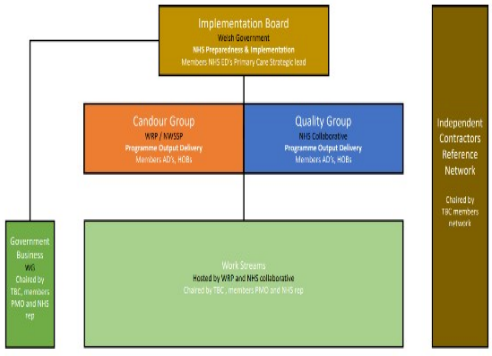
The Duty of Candour consultation closed on the 13th December 2022. The Duty of Quality consultation commenced on the 25th October and closes on the 17th January 2023.

Both duties will require changes in local policies, procedures, working practices and local and national reporting requirements. In addition, there will be a requirement for organisation-wide awareness of the new duties, as well as education and training for clinical staff, leaders and Quality & Safety Teams. Given the collective responsibilities Boards will have in meeting the requirements of these Duties, Board level training will also be required.

3. SITUATION

3.1 Trust representation at National Meetings

The newly established Implementation Board is being chaired by the Trust's Executive Director of Nursing, AHPs & Health Science. This is a monthly strategic assurance board, providing assurance to the Welsh Government that the implementation programme is progressing appropriately across NHS bodies.



In addition to the Implementation Board, two operational groups have established: a Candour Group coordinated by the WRP, and a Quality Group coordinated by the NHS Collaborative to lead and oversee successful implementation across the NHS. These groups are intended to provide senior support for the operationalisation of the Duties. It is envisaged that these Groups may, in time, develop into Candour and Quality Networks to enable national coordination and learning for the Duties across Wales.

Nigel Downes, Deputy Director Nursing, Quality & Patient Experience & Dr Hillary Williams, AMD Quality & Safety represent the Trust at the Quality Group and that Dr Jillian McLean, Consultant Oncologist and Jayne Rabaiotti, Claims & Redress Manager represent the Trust on the Duty of Candour Group.

3.2 Trust Implementation Leads

The following implementation leads have been agreed:

- Executive Lead: Nicola Williams, Executive Director Nursing, AHPs & Health Science.
- Operational Lead: Nigel Downes, Deputy Director Nursing, Quality & Patient Experience.
- Independent Member Lead: Duty of Quality – Vicky Morris, Independent Member (Quality & Safety Champion).

3.3 Duty of Quality

3.3.1 Duty of Quality Requirements

Due to the level of wide engagement across the NHS in Wales through the drafting process it is not anticipated to be substantial changes to the Duty of Candour Statutory Guidance post consultation, although this is not a given. . Therefore, NHS bodies have been asked by WG to plan for implementation from the 1st April 2023, based on the consultation documents.

Ultimately, the purpose of the duty of quality is to ensure that Welsh Ministers and NHS bodies secure improvements in the quality of services they provide. The duty represents an ambition of achieving ever-higher standards of person-centred health services in Wales. Quality is more than just meeting service standards. It needs to be a system-wide way of working. Quality covers 6 domains: safe, timely, effective, efficient, equitable and person-centred health care which is embedded within a culture of continuous learning and improvement. The duty requires Welsh Ministers and NHS bodies to actively consider these domains of quality when making decisions about health services so that improved outcomes are secured. This supports the five ways of working (long term, integration, involvement, collaboration and prevention) within the Well-being of Future Generations (Wales) Act 2015 2 as well as promoting the well-being goal of A Healthier Wales 3.

The Implementation Board has developed a document that details the requirements of the Duty and what needs to be in place by the 1st April 2023. This is attached in ***Appendix 1***.

3.3.2 *Duty of Quality Draft Implementation Plan*

A gap analysis against the consultation documents has been undertaken and a draft implementation plan is detailed in ***Appendix 2***. This was discussed in detail at the Executive Management Board and although the timescales were approved and there is a full commitment to support the delivery of these requirements as a priority it was identified that there is a moderate risk of time slippage due to ongoing senior gaps within the corporate quality and safety team, pending departure of the interim Deputy Director of Nursing, Quality & Patient Experience and the additionally required implementation resources detailed below.

3.3.3 *Required Implementation Resources*

An initial review of required implementation resources has been undertaken and submitted to Welsh Government. This requires further review by the Implementation Group. To date the Trust has been advised by WG officers that national resources to support NHS bodies implement this Act are not available.

Given the small infrastructure within Velindre early indications following analysis of the consultation documents are that the following will be required that cannot be absorbed into

current available infrastructure:

- Business Intelligence Officer – 1WTE (both duties)
- Patient Liaison Officer – 1WTE (duty Candour)
- Quality & Safety Manager (both duties)
- Electronic PROMS system across all cancer SST's (duty Quality)
- Quality Management System costs & any running costs (yet to be determined)

In addition, it is recognised that the volume of redress cases are likely to increase and therefore this places additional redress related Legal & Risk costs resource requirements. The Executive Management Board agreed to include this requirement within the IMTP that is under development.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
RELATED HEALTHCARE STANDARD	Safe Care
	If more than one Healthcare Standard applies please list below: 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 **DISCUSS** the paper, **NOTE** the implementation resource requirements and the draft Duty of Quality implementation plan.

Appendix 1:

Duty of Quality implementation in the NHS

Themes *(and related Q&S Programme actions)*	**NHS organisation – *implementation task* and Business As Usual. Taken directly from draft Statutory Guidance**	**NHS organisation - minimum requirements to be completed BY APRIL 2023**	**NHS organisation – subsequent actions AND TIMESCALES**
Leadership and culture *(Q&SP Action 12b – Board development; Q&SP Action 14 – Workforce engagement to create quality-led system)*	• *Designate appropriate senior leads to hold responsibility for strategic implementation and oversight of duty (an officer member of Board)* • *Designate operational lead to support implementation of duty is also suggested* • *Provide willingness and financial support to develop skills and infrastructure to implement DoQ* • *Consider psychological readiness as well as the infrastructure, governance, system understanding and leadership in place for change* • *Create compelling vision for improved quality (that is recognised and intrinsically motivates staff at all levels)* • Create a culture of quality within organisations – demonstrate responsibility for delivering DoQ in actions and behaviours • Think and act differently by applying the concept of quality across all functions • Ensure health services are organised and delivered in such a way that system-wide continuous improvement in the quality of health services is achieved • Encourage system-wide shared learning and expertise • Ensure "system" has resources, capacity, time and autonomy needed to develop approaches to improving quality • Exercise functions in a way that considers how quality and outcomes will be improved on an ongoing basis • All staff (clinical and non-clinical) have responsibility for complying with the duty in their role • Give staff at all levels the permission, opportunity and confidence to test new ideas to test quality that are aligned to organisation's vision • Embed Welsh language considerations in the culture of quality	**Implementation ownership** • Designate an [officer] member of Board to hold responsibility for strategic implementation and oversight of duty • Designate operational lead to support implementation of duty **Outcome: Senior responsible leadership in place and driving implementation work** **Vision and cascade / engagement** • Create compelling vision for improved quality (that is recognised and intrinsically motivates staff at all levels) • Determine Quality roles and responsibilities for all staff **Outcome: All staff recognise and understand the organisation's Quality vision, and their roles within it** **Infrastructure** • Provide willingness and financial support to develop skills and infrastructure to implement DoQ • Consider infrastructure, governance, system understanding and leadership in place for change • Create appropriate infrastructure for Quality • Provide support for implementing Duty **Outcome: Commitment, resources and infrastructure in place to implement Duty effectively**	• Ongoing work to achieve Business As Usual position
Decision-making	• Ensure that all strategic decisions are made through the lens of improving the quality of health services and outcomes for the population • Actively consider whether decisions made will improve service quality and secure improvement in outcomes for the population • Involve people in decisions that affect them	**Board decision making** • Develop processes and systems for informing and structuring Board decision-making to demonstrate consideration of quality (i.e. improved services and outcomes; Quality Standards 2023) • Develop processes and systems for capturing and recording decisions made by Board to provide evidence of quality considerations (for future reporting) **Outcome: Processes and systems in place to provide demonstrable evidence that Board decisions have been made through Quality lens**	**All strategic decision-making – BY SEPTEMBER 2023** • Develop processes and systems for informing and structuring all strategic decision-making (to include organisational planning) to demonstrate consideration of quality (i.e. improved services and outcomes; Quality Standards 2023) • Develop processes and systems for capturing and recording all strategic decisions to provide evidence of quality considerations (for future reporting)

Themes *(and related Q&S Programme actions)*	NHS organisation – *implementation task* and Business As Usual. Taken directly from draft Statutory Guidance	NHS organisation - minimum requirements to be completed BY APRIL 2023	NHS organisation – subsequent actions AND TIMESCALES
			Outcome: Demonstrable evidence that all strategic decisions and plans have been made through Quality lens • Ongoing work to achieve Business as Usual position
Governance and accountability structures *(Q&SP Action 10a – Quality Assurance Framework; Q&SP Action 11 – Quality indicators and measures; Q&SP Action 12b – Board development)*	• *Integrate effective implementation and monitoring of DoQ into existing corporate governance frameworks, processes and procedures – including existing performance and quality reports* • Accountability for compliance rests with Chief Executive of NHS bodies • Responsibility to ensure due consideration to the duty applies to all officer and non-officer board members • Ensure internal governance and assurance arrangements are structured within a robust quality management system • Embed DoQ when designing or introducing new structures and processes • All committees must report to the Board on DoQ – not just Q&SC so that Board can seek assurance that DoQ is being discharged across system • Committees will need to ensure sustainable quality improvements are being maintained • Board Assurance Framework and strategic risk register must have due regard to meeting DoQ • Take account of DoQ when reviewing processes and assurance mechanisms e.g. planning of audit programmes	**Board reporting** • Ensure agendas of, and reports to Board from, all sub-committees and structures include Duty of Quality considerations (i.e. improved services and outcomes; Quality Standards 2023) **Outcome: Board are assured that DoQ is being considered across system** **Governance documentation** • Review [Board / Trust / SHA] Assurance Frameworks to ensure they support Duty of Quality • Review Risk Registers to ensure they support Duty of Quality • Review existing performance and quality reports to ensure they support Duty of Quality • Review any other existing standard governance documentation to ensure it supports Duty of Quality **Outcome: Routine governance documentation is DoQ-ready**	• Ongoing work to achieve Business As Usual position
Reporting and information (data to knowledge) *(Q&SP Action 11 – Quality indicators and measures)*	• Demonstrate [with evidence] how they exercised their functions and improved the quality of services in accordance with duty • Actively monitor progress on the improvement of quality services and outcomes and routinely share this information with their population • Report annually on the steps taken to comply with the duty of quality and assess the extent of improvements in outcomes • Annual report – describe progress and challenges on quality journey. Focus on information that will demonstrate the DoQ in decision-making, action taken following learning, quality improvement and improved outcomes. Signpost readers to “always on” reporting. Look back and look forward – ensuring continuity between years. Align annual report to Annual Report and Accounts process • Quality reporting must reflect the breadth of domains of quality, quality enablers and QMS • Develop “always on” reporting • Collate, monitor, and make information available within and outside of organisation – across QMS – recognition	**External reporting / information** • Identify / develop appropriate channel (web presence / infrastructure) for reporting DoQ progress externally • Develop and share roll-out plan for the publication of routine “always on” qualitative and quantitative information to include for example: ○ Patient experience information / PREMS ○ Progress against quality priorities ○ Infections and mortality rates etc ○ “You said, we did” **Outcome: Mechanism and publication schedule / plan in place for sharing DoQ progress information externally** **Internal reporting / information** • Ensure processes in place for escalating quality-related information by exception (outside tolerances) through internal structures • Ensure Boards and sub-committees understand their roles in considering escalated quality-related information	**Annual narrative report – POST MARCH 2024** • Draft content and structure for annual report to describe steps taken to comply with the duty of quality and assess the extent of improvements in outcomes • Finalise and publish report **Outcome: First DoQ Annual report published** • Ongoing work to achieve Business As Usual position

Themes *(and related Q&S Programme actions)*	**NHS organisation – *implementation task* and Business As Usual. Taken directly from draft Statutory Guidance**	**NHS organisation - minimum requirements to be completed BY APRIL 2023**	**NHS organisation – subsequent actions AND TIMESCALES**
	and sharing of good practice and early escalation and intervention in response to signals • Develop suite of measures and processes / systems that collect, analyse and feedbacks impact of improvement • Make use of information and reporting mechanisms already in place wherever possible • Adopt agile approach to mature quality reporting • Welsh language considerations must be embedded quality reports	**Outcome: Quality-related information escalation mechanisms in place, with plans for review and consideration at appropriate level**	
Commissioning	• The duty is always the responsibility of the commissioning body • Ensure that services delivered by alternative providers (including primary care contractors and non-NHS organisations) will secure improvement in quality and outcomes	**Commissioning arrangements** • Review existing commissioning arrangements to identify where changes will be required to support DoQ (existing definitions in contracts, roles and responsibilities and DoQ reporting requirements) **Outcome: A clear and corporately agreed understanding of changes required to incorporate DoQ requirements into all commissioning arrangements**	**Commissioning arrangements – BY SEPTEMBER 2023** • Amend commissioning arrangements to support DoQ **Outcome: All commissioning arrangements incorporate DoQ requirements** • Ongoing work to achieve Business As Usual position
Hosting	• The DoQ remains the responsibility of host organisations	**Hosting arrangements** • Review existing commissioning arrangements to identify where changes will be required to support DoQ (existing definitions in contracts, roles and responsibilities and DoQ reporting requirements) **Outcome: A clear and corporately agreed understanding of changes required to incorporate DoQ requirements into hosting arrangements**	**Hosting arrangements – BY SEPTEMBER 2023** • Amend hosting arrangements to support DoQ **Outcome: All hosting arrangements incorporate DoQ requirements** • Ongoing work to achieve Business As Usual position
Quality Standards *(Q&SP Action 2 – Health and Care Standards)*	• *Create system-wide understanding of what good quality looks like for the broad range of services* • Take [new] quality standards into account for the purpose of discharging the duty • Need to ensure health services are safe, timely, effective, efficient, equitable and person-centred • Understand and have regard to the six domains and five enablers of quality within DoQ	**Quality infrastructure** • Review existing quality tools, processes, systems and improvement activity to identify current alignment with Health and Care Standards 2015, and therefore required realignment with Quality Standards 2023 • Develop a plan to align existing quality tools, processes, systems and improvement activity to Quality Standards 2023 **Outcome: A clear understanding of changes required to existing quality infrastructure and agreed programme of work to align with Quality Standards 2023**	**Quality infrastructure – BY SEPTEMBER 2023** • Migrate quality infrastructure from Health and Care Standards 2015 to Quality Standards 2023 **Outcome: Quality infrastructure clearly aligned to Quality Standards 2023** **Local Quality Statements – FROM DECEMBER 2023** • Create local statements of what good looks like against the Quality Standards 2023 informed by Quality Statements from WG, NICE guidelines, professional standards etc with plan to regularly review / refresh. • Create processes to monitor progress and compliance with local quality statements **Outcome: Routinely monitored, system-wide understanding of what good quality looks like for the broad range of services.** • Ongoing work to achieve Business As Usual position

Themes *(and related Q&S Programme actions)*	**NHS organisation – *implementation task* and Business As Usual. Taken directly from draft Statutory Guidance**	**NHS organisation - minimum requirements to be completed BY APRIL 2023**	**NHS organisation – subsequent actions AND TIMESCALES**
Quality management system – general *(Q&SP Action 12a – Local development of QMS; Q&SP Action 13 – Toolkit for assurance of QMS)*	• Strengthen quality management systems with quality-driven decision making and planning • Ensure that NHS organisations develop 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	**QMS – General** • Provide commitment to develop a quality management system in line with Duty of Quality and Quality and safety Framework 2021. • Start to review and consider what needs to be in place to develop a fully-functioning quality management system **Outcome: A clear understanding of, and commitment to, a quality management system, with plans in place to identify requirements and current gaps**	**QMS – General – BY SEPTEMBER 2023** • Develop a roadmap for establishing quality management system • Implement roadmap **Outcome: Quality Management System road map agreed and implemented** • Ongoing work to achieve Business As Usual position
Quality management system – Planning *(Q&SP Action 8 – Planning for Quality)*	• *Understand readiness for change – identify capability gaps and have plan to address them* • Continually seek to understand the needs of their population to inform their decision-making and secure improvement in outcomes • Demonstrate long-term commitment (and investment) to improving quality when setting strategic direction • Prioritise national and regional initiatives and recommendations that fit the organisation's way of working • Ensure initiatives to improve quality are consistent with their overall strategy, and identify and unlock barriers • Plan to deliver the outcomes that matter to people with the resources available in a way that is sustainable	Development area – no specific minimum requirements by April 2023	• Ongoing work to achieve Business As Usual position
Quality management system – Improvement *(Q&SP Action 9 – Capacity and capability for improvement; Q&SP Action 14 – Workforce engagement to create quality-led system)*	• Leaders champion improvements in quality that are strategically aligned, driven and owned by teams • Develop systematic approach to managing quality that includes building improvement capability – general and specialist improvement skills • Ensure learning from success and failures (weaker areas)	Development area – no specific minimum requirements by April 2023	• Ongoing work to achieve Business As Usual position
Quality management system – Control *(Q&SP Action 11 – Quality indicators and measures; Q&SP Action 14 – Workforce engagement to create quality-led system)*	• Use regular assessments, investigations and measurement over time to identify areas to improve quality • Develop operating models to standardise core processes and activities to address variations in quality • Collate, monitor, and make information available within organisation – across QMS – recognition and sharing of good practice and early escalation and intervention in response to signals	Development area – no specific minimum requirements by April 2023	• Ongoing work to achieve Business As Usual position
Quality management system – Assurance *(Q&SP Action 10a – Quality Assurance Framework*; *Q&SP*	• Satisfy themselves that they are complying with the duty • Demonstrate long-term commitment to improving quality when seeking assurance of delivery • Seek assurance that quality improvement activities are sustainable	Development area – no specific minimum requirements by April 2023	• Ongoing work to achieve Business As Usual position

Themes *(and related Q&S Programme actions)*	**NHS organisation – *implementation task* and Business As Usual. Taken directly from draft Statutory Guidance**	**NHS organisation - minimum requirements to be completed BY APRIL 2023**	**NHS organisation – subsequent actions AND TIMESCALES**
Action 11 – Quality indicators and measures; Q&SP Action 13 – Toolkit for assurance of QMS)	• NHS bodies will conduct an assessment of the extent of any improvement in outcomes achieved, through e.g. self-assessment, peer review, clinical audit etc (quality assurance)		
Communication and engagement *(Q&SP Action 14 – Workforce engagement to create quality-led system)*	Not in Statutory Guidance but enabling activity	**Communication and engagement** • Develop local comms and engagement plan • Develop local comms and engagement material, building on national comms • Cascade DoQ messages throughout organisation **Outcome: All staff are aware of key DoQ messages tailored to their organisation**	Ongoing communication and engagement
Training and education *(Q&SP Action 12b – Board development; Q&SP Action 14 – Workforce engagement to create quality-led system)*	Not in Statutory Guidance but enabling activity	**Training and education** • Ensure at least nominated individuals at Board level have undergone training **Outcome: At least one member of Board trained, knowledgeable and able to influence Board in relation to DoQ**	**Training and education – BY JUNE 2023** • Undertake organisational training needs analysis • Develop training plan • Ensure full Board has undergone training **Outcome: Board trained, knowledgeable and operationalising DoQ requirements** **Training and education – BY DECEMBER 2023** • Train remining staff in line with training needs analysis and training plan. **Outcome: All staff trained to determined appropriate level**
Tools and methodologies *(Q&SP Action 13 – Toolkit for assurance of QMS)*	Not in Statutory Guidance but enabling activity	Development area – no specific minimum requirements by April 2023	

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Appendix 2

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	Achieved: Executive Lead: Executive Director of Nursing, AHP & Health Science identified
	Independent Member to be allocated as IM Lead	CEO/ Director Corporate Governance	January 2023	Achieved: Identified as Quality & Safety IM Champion
	Divisional Implementation Leads to be identified	Divisional Directors	January 2023	Awaiting names
	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	Achieved: 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	Inaugural meeting arranged for 10/01/23
	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 will improve 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	
	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	
	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	

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	Initial awareness provided Dec 22
	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	National Training not yet available
	Trust wide Duty of Quality Training to be rolled out to all responsible officers	Trust Training Department	31/03/2023	National Training Programme not yet available
	Trust wide awareness campaign to be undertaken through ongoing communications	Head of Communications	Commence January 2023 – complete by 30/04/2023	National Communications awaited
	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	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	
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	Initial training being arranged
	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	Consultation period is not yet completed
Securing wider organisational buy-in and co-creating a vision				
NHS bodies should create a compelling vision for improved quality that is recognised and intrinsically motivates staff at each level of the Trust	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	
	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,	Initial survey to be completed by 31/01/2023	

		Quality & Patient Experience		
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	
	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	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	

barriers are identified and unlocked.	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 – inaugural meeting arranged for 09/01/2023
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. • Requirements that leaders champion improvements in quality that are strategically aligned, driven and owned by the teams responsible for delivering health services.	Chief Operating Officer / Executive Medical Director / Executive Director Nursing	30/09/2023	

QUALITY SAFETY AND PERFORMANCE COMMITTEE

WORKFORCE & ASSOCIATED FINANCE RISKS

DATE OF MEETING	17th January 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

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

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
N/A		

ACRONYMS	
IMTP	Integrated Medium Term Plan
ED&I	Equality, Diversity & Inclusion
HB	Health Board
LTA	Long Term Agreement
TOIL	Time off in Lieu

WBS	Welsh Blood Service
WTAIL	Welsh Transplantation and Immunogenetics Laboratory
WG	Welsh Government
VCC	Velindre Cancer Centre

1. SITUATION/BACKGROUND

1.1 The purpose of this report is to highlight the key workforce and associated financial risks that the Trust is currently facing and that might crystalise in 2022-23, together with the required management action to ensure risk mitigation and performance improvement.

1.2 The paper is structured under the risks identified within the key People strategy themes of Workforce Supply and Shape; Wellbeing; Attraction and Retention. Each theme and section of the report will be structured as follows:

1.2.1 Key Workforce and Associated Financial Risks

1.2.2 Actions to be taken to address WOD and Financial Risks

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Workforce Supply and Shape

Key issues currently and expected to continue through 2022-23 are:

2.1.1 Key Workforce and Associated Financial Risks

Key workforce risk: In response to service demand, traditional staffing models cannot deliver service need, the **shape** of the workforce has to change. This may require finance to be allocated across different teams and different staff groups. The Trust has key hotspot areas in diagnostic radiation services, nuclear medicine, SACT Nursing and medical oncology. However based on the current pressures in the NHS and the volatile labor market we dynamically review workforce shape and supply to ensure significant changes are being measured, and emerging hotspot areas are considered. The implication of the Gender Pay Gap report will also be considered in the context of the shape of the workforce. Current issues impacting on the **supply** of the workforce is relation to the ongoing strike action will also be considered.

Financial risk: The financial risk associated with workforce planning will be monitored and managed through the pay budget monitoring process. This includes staff who were permanently recruited in response to Covid where guaranteed funding from Welsh Government is no longer available. This funding is now linked to activity delivered compared to 2019-20 levels as part of the Long-Term Agreements with Commissioners. Finance are working with the operations and performance teams to understand the impact of funding these posts at risk, including an evaluation of the activity levels. This analysis will support the development of the Medium-Term Financial Plan and budget for 2023/24.

The full year pay budget as at end of November is £76,493m based on 1563 WTE.

As at November 2022, the current staff in post is 1462WTE. The number of vacancies is 101 WTE, which represents a .6.5% vacancy rate. The vacancy gap is largely being met by the use of agency staff and overtime, which is reported on further in section 3, Attraction and Retention.

Vacancies throughout the Trust remain high, however significant improvement has been made due to the targeted recruitment interventions in SACT (in VCC and outreach), reducing the Nursing and HCSW vacancies by 20WTE. This improvement has given the service opportuntiy to explore workforce and service redesign and to take forward some fundemental changes that will enable a more efficient and productive service.

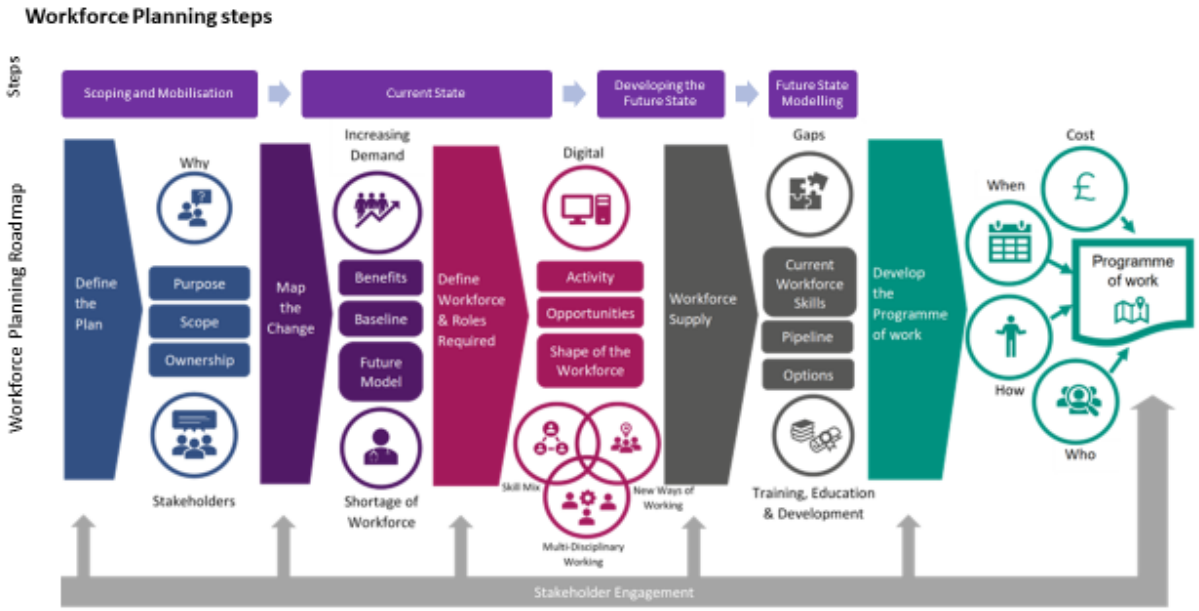
In addition, a number of posts in both VCC and WBS have been appointed at risk in response to Covid. There has also been further recruitment on service developments without agreed funding pending activity undertaken or FBC approval by WG and Commissioners. Work is underway in both divisions to either secure additional funding to support these posts or looking at options to migrate staff into vacancies to help mitigate the current risk exposure.

The Trust has reported a cumulative year-to-date spend of £50.651m on pay against a budget of £51.012m resulting in an underspend position of £0.359m as at November 22. The pay costs include the costs of agency staff, on-call and overtime.

2.1.2 *Actions taken to mitigate WOD and Finance Risks related to Workforce Supply and Shape*

Using the nationally agreed Workforce Planning (WP) Principles (Appendix A), the Trust are taking forward a number of projects, focused on hotspot areas, to address the need to change the workforce model. The planning principles have been adopted into a Work plan, utilizing the Workforce Repository and Planning Tool with actions and timescales as noted below.

Workforce planning steps based on the Workforce planning principles



- In the interim the finance team are working with W&OD to support departments to implement alternatives to agency where possible, such as establishment of Bank staffing and agreeing overtime.
- The W&OD and Finance Team conducts Quarterly performance reviews with each Directorate within WBS and VCC. The focus of these meetings has been on understanding the workforce challenges and associated financial considerations, supported by quantitative analysis. This analysis targets the gaps between

budgeted workforce and the available operating workforce factoring the impact of investments, vacancies, sickness, maternity, facilitating targeted recruitment and management action. Action plans are in place to address gaps relating to sickness. The Workforce Performance report notes the actions taken to address sickness hotspots. The vacancy gaps are addressed via the Attraction, Recruitment and Retention group. .

2.1.3 Impact of Strike action to date

Strike Action Update

As part of the ongoing strike action the Trust has established an Industrial Action Cell and Gold Command infrastructure. This provides the management infrastructure to manage ongoing service delivery during strikes, address communication to staff and provides a conduit to update on national strike activities affecting the Trust. The following gives an overview of strike action to date and impact on the Trust.

Royal College of Nursing – Strike action – 15th and 20th December

As of December 2022, industrial action by RCN was anticipated to have significant service delivery impact, with concerns that blood stocks would be impacted and appointments for patients would need to be cancelled. Through detailed business continuity planning at both divisions and from the agreements made for derogations with the RCN Dispute Committee, the Trust was able to remain in a safe position during the strike action. Derogations for full and partial workforce numbers to ensure service delivery and safety were agreed in the following areas:

- Chemotherapy Services (nationally agreed)
- Brachytherapy
- Integrated Care
- Treatment Helpline
- Assessment Unit
- Ambulatory Care
- First Floor Ward
- Palliative Care
- PiCC Clinic
- SACT Nurse Lead Assessment Clinics

- Apheresis Platelet Clinic
- Whole Blood Clinic
- Welsh Bone Marrow Donor Registry

The strike at the Trust did not impact on service delivery to patients. All clinics ran as normal.

Welsh Ambulance Service Strike – 21st December

Impact on the Cancer Centre proved to be minimal and no major impact on patient transportation.

The planned WAST strike for the 28th was postponed until the New Year when a more co-ordinated and sustained plan of strike action is anticipated across the Welsh Ambulance system.

Other Union actions

The Society of Physiotherapist have confirmed a successful ballot for industrial action for the Trust. It is not known yet the dates or type of action to be taken. Ongoing communication is being undertaken with the Welsh regional officer.

The Unite ballot has now closed but they did not receive a majority mandate to take strike action in the Trust.

2.1.4 Gender Pay Gap Considerations

Equalities Reporting

The Gender Pay Gap and Annual Equalities Reports for 2021-22 have been undertaken earlier in the year than for 2020-21 and are presented as separate reports. The timetable will accelerate further next year with the 2022-23 reports being presented in July 2023 with other Trust Annual reports. There has been very little change in our headline figures between 2021 and 2022. The Mean Gender Pay Gap stayed at 4% overall with a Mean Bonus Gap remaining at 43%. The Median figures have improved with the Median Pay Gap falling from 7% to 2% and the Median Bonus Gap going from 22% to 9% in the year. However, the gender split in the workforce has become slightly more polarised, going from 58% women in 2021 to 60% women in 2022. This reflects the picture for Velindre University NHS Trust, including NHS Wales Shared Services Partnership.

Actions arising from the Gender Pay Gap analysis are:

1. **Listening to women.** We will offer options for staff, male and female, to share their experiences and ideas relating to improving gender equality in the workplace. This will include options such as setting up an internal Gender Equality Network, joining other external Equality Networks and/or the introduction of Allyship in support of women.

2. **Implementing our Education Strategy in an equal and fair way**, supporting all staff in their personal and professional development. During the year we will develop a Talent Management approach based on principles of inclusion. This will be demonstrated through the range of leadership development and coaching and mentoring opportunities that are taken up by women and men. This will be offered in a way that does not unintentionally exclude any groups of staff, including on basis of gender or race. The allocation of funding for Study Leave will be reviewed to ensure fairness across the Trust.

3. **Utilising our development projects such as nVCC to create development opportunities for people at all levels of the organisation.** Where necessary, additional encouragement will be offered to offset any gender disparity in uptake. Project roles and responsibilities will be offered as development opportunities to existing staff, either as a secondment or as an addition to their current role.

4. **To deliver an Attraction, Recruitment and Retention project** to achieve effective and inclusive approaches to bringing people into our organisation and encouraging them to remain with us. This includes improving the recruitment processes to ensure that we use gender-sensitive language in adverts and use gender-neutral pronouns and clean language to prevent us from potentially putting women off from applying for positions. This will include highlighting all Agile working and family-friendly benefits and ensuring all new staff understand how and when they can apply for incremental credit on appointment. This will benefit all genders of applicants and offer an environment for more women to put themselves forward for employment.

5. **To promote inclusive language within education and development training inside our organisation, to keep raising awareness and continue to develop a culture of inclusivity**. Develop and deliver unconscious bias training that can firstly be delivered to managers so they can role model expected behaviours creating a peer-learning environment that models the values of the organisation.

6. **Monitoring of engagement with initiatives by gender.** The proportion of male and female staff taking up education programmes and development opportunities will be monitored to highlight if positive action is required. Analysis of recruitment will show whether job applications receive equal outcomes for men and women, from application, shortlisting and appointment.

2.2 Wellbeing

2.2.1 Key Workforce and Associated Financial Risks

Key workforce risk: The COVID pandemic has driven in generally higher levels of sickness absence compared to pre-Covid. The main reason for absence remains stress and anxiety. The Trust, throughout COVID, has provided a raft of wellbeing interventions

to support staff with the Workforce teamwork supporting hotspot areas to ensure targeted interventions are provided – Please refer to September Workforce Monthly Performance.

Financial risk: The cost of sickness is reflected as an indicative productivity/ efficiency loss. The indicative productivity loss and cost for the last 12 months related to sickness is £2.114m, which is 24,274 days. High levels of sickness may also increase the need to use more staff through agencies and to therefore incur the associated costs. This risk is reported under the Attraction and Retention section below. Reduction in sickness absences rates has a direct impact on reducing the variable pay bill.

*2.2.2 **Actions taken to mitigate Workforce ad OD and Finance Risks related to Wellbeing***

In addition to the range of physical and mental wellbeing resources available to staff the following actions are being undertaken, monitored via the Healthy and Engaged Steering group:

- Work-related stress has been added to the Trust's risk register to highlight the risk of harm to staff and to service delivery. This entry also sets out the controls, which are in place and being implemented across the Trust.
- The Clinical Psychologist for Staff and Teams came into post in September 2022 and is developing a model for the psychology service for staff.
- The contract for an Employee Assistance Programme with Workplace Options was renewed from April 2022 and now runs until March 2024. This gives staff access to information and support in relation to managing money.
- Salary Finance provide a service to all NHS Organisations in Wales including help and support with budgeting and the ability to provide a loan repaid through salary deductions. Links to their services are available on the intranet.
- A series of weekly Drop-in Sessions ran from 14 November 2022 to 19 December 2022 to offer information and a space for discussion on wellbeing issues
- Contact has been made with the government's independent Money and Pensions Service and their resources, branded Money Helper, have been added to the intranet
- The Trust has cited Financial Wellbeing as one of their top three wellbeing issues in the HEIW Health and Wellbeing Network. A session on Pension and the Menopause was held on 18 October 2022 for all NHS Organisations in Wales.

- The Trust advertised the NHS Pension webinars in July 2022, which gave information about the scheme and how to access the Annual Benefit Statements.
- The Trust ran the childcare subsidy scheme over the summer holidays and it was accessed by 35 staff with a total of £7,750 paid out to support childcare costs in 2022
- Complementary Therapies are available to staff to help alleviate physical and psychological problems.

3. Attraction and Retention

3.1.1 Key Workforce and Associated Financial Risks

Key workforce risk: The Trust is currently carrying 101 WTE vacancies as at the end of November 2022. An Attraction and Retention plan has been developed with targeted specific interventions in hotspot areas together with work ongoing with regional partners to develop regional interventions. For further details refer to the Trust Attraction and Retention Plan in Appendix C.

Financial risk: The cost is reflected in the pay costs through use of agency and overtime and provision of TOIL.

The cumulative spend year-to-date as at November 2022 on measures to bridge the vacancy gap include:

- Agency spend £1,149k (£221k directly related to Covid)
- Overtime spend £379k

The 2022/23 full year forecast outturn for Agency spend is circa £1,600k (£315k Covid related) compared to £1,906k 2021/22, which is a £306k (16%) expected year-on-year reduction

Based on the full year 2022/23 cost forecast, £480k is estimated to be premium cost that could be saved if the Trust were able to recruit permanently rather than utilise Agency.

3.1.2 Actions taken to mitigate Workforce and OD and Finance Risks related to Attraction and Retention

The Trust has established a Recruitment, Attraction and Retention group to address the issues related to its key recruitment and retention hotspots. Three Action Groups related to improving marketing for hotspot areas, streamlining the process around recruitment

and working with national colleagues to ensure a better user experience and turnaround time for recruitment have been established. These are particularly aligned to hotspot areas.

Marketing

The marketing sub group have completed and sent over the final storyboard idea for the Trust wide attraction video called 'This is Velindre'. Additionally, SACT, Medical Physics and Collections Nursing have developed more bespoke storyboards for their area's having been supported by the Velindre Fundraising team to develop their brand. Filming of these videos is now required.

Process:

- A recruiting manager's toolkit is in development on the new Intranet, making it easier for managers to find information they need to prepare for recruitment.
- The Recruitment Modernisation processes are now live across the Trust with early indicators that the programme and changes have been successful. In July 2022 the Velindre average time to hire was 123.2 days (from advertising to start date) however in November 2022 the figure is now 70.6 days. VUNHST is one of only 4 NHS Wales's organisations within the target time to hire of 71 days.
- A new Recruitment Policy and supporting procedures and supporting manager guides (DBS and Scrutiny etc.) are currently within the Trusts governance approval process and expected to be live in early February 2023.

Retention:

- A more detailed consideration is required of organisational culture and the impact on retention given the qualitative information gathered from hotspot areas. Work is currently being scoped by the WOD team.

In addition, the first draft of a recruitment policy is being reviewed by partnership colleagues currently for progress through the policy work being undertaken across the Trust.

4. Measures to Monitor Improvement

To address improvement the following Key Performance Indicators are being reviewed monthly:

WOD Risk	Hotspot Risk Areas – Reviewed and Updated monthly via Service and Workforce Performance reports	Key Performance Indicator
Supply and Shape	Monthly Performance reports to address and monitor improvement trajectories	Fixed term contracts reviewed
Wellbeing		Sickness Absence Rates Indicative productivity loss (Hrs.) and cost (£)
Attraction and Retention		Vacancy Rate Vacancy turnover rate Agency spend

5. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	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	Yes
	Impact of individual elements of the interventions described in this report are carried out as necessary.
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Covid staff costs that may not be fully covered by WG or Commissioner income Ongoing premium cost of agency

5. RECOMMENDATION

a. The Quality, Safety and Performance Committee is asked to **NOTE and CONSIDER** the workforce risks, opportunities and associated financial impacts as outlined within the contents of the report.

Appendix A

Workforce Planning Principles

Agile, workforce will work flexibly and across traditional professional, physical, psychological, Organisational and geographical boundaries

Transformative, embrace opportunities for workforce transformation because of changes within digital, technological and medical advances

Intelligence Led, information and analysis that will support intelligence-based decision making.

Health and Wellbeing focus, ensuring the psychological wellbeing of staff and that staff are only required to work within their level of competence

ED&I Focus, reflective of the population and that workforce demographics are considered including ageing workforce, gender balance, flexible and part-time working and inclusivity

Welsh Language Considerations, Welsh language legislation will be considered as part of all workforce plans

Sustainable, appropriately skilled and competent multi-disciplinary team members are enabled to undertake tasks rather than traditional roles. Plans to be resilient and workforce deployed effectively

MDT Focus, workforce plans will have a clear scope and assumptions will be clearly stated. This will ensure that the outcomes of the planning are robust, feasible, affordable and that they will be supported

Whole System, Safety, quality and affordability will be equal key cornerstones of workforce planning.

Co-Produced, strong engagement and collaboration with key stakeholders to ensure that all plans are co-produced and that any actions are owned and agreed at the outset.

Consistent Approach, the development of a workforce plan will be based on the Six Step Methodology adopted across NHS Wales

Clearly Defined, workforce plans will have a clear scope and assumptions will be clearly stated.

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

FINANCE REPORT FOR THE PERIOD ENDED 30 NOVEMBER 2022 (M8)

DATE OF MEETING	17/01/2023

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	03/01/2023	NOTED

ACRONYMS	
IMTP	Integrated Medium Term Plan
WBS	Welsh Blood Service
WTAIL	Welsh Transplantation and Immunogenetics Laboratory
WG	Welsh Government
VCC	Velindre Cancer Centre
MMR	Monthly Monitoring Returns
HTW	Health Technology Wales

1. SITUATION/BACKGROUND

1.1 The attached report outlines the financial position and performance for the period to the end of November 2022.

1.2 This financial information included within this report relates to the Core Trust (Including HTW). The financial position reported does not include NWSSP as they are directly accountable to WG for their financial performance. Only the balance sheet (SoFP) and cash flow provides the full Trust position as this is reported in line with the WG monthly monitoring returns (MMR).

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Performance against Key Financial Targets:

	Unit	Current Month £m	Year to date £m	Year End Forecast £m
Revenue	Variance	(0.002)	0.003	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	2.149	10.010	28.312
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	96.0%	95.7%	95.0%

2.2 Revenue Budget

At this stage of the financial year the overall revenue budget (excl. Covid and the exceptional cost pressures) remains broadly in line with expectations as planned within the IMTP, with a projected forecast outturn position of breakeven.

The overall position against the profiled revenue budget to the end of November 22 is an underspend of **£0.003m**, with an outturn forecast position of **Breakeven**.

The Trust has now received funding towards both the pay award and the temporary increase in Employers NI.

The pay award funding received for 2022-23 was £3.065 leaving a funding risk of circa £0.450m. This year the gap will be mitigated through non recurrent measures with divisions calculating the recurrent impact into future years as part of the IMTP budget setting process.

The Trust is yet to receive full funding from WG for both Covid response and the incremental increase in Energy costs, however confirmation has been received that funding will be provided based on a maximum of the outturn forecast as at September leaving minimal risk to the Trust.

It is expected that any potential cost pressures are managed by budget holders to ensure the delegated expenditure control limits are not exceeded in line with budgetary control procedures.

Two saving schemes relating to service redesign and supportive structures have turned red with contingency plans have been put in place to ensure that the saving target is met for this financial year.

The Trust continues to report a year end forecast breakeven position which is following confirmation from WG that the Exceptional National cost pressures and Covid response costs will be funded based on the month 6 forecast position. Covid funding towards recovery from commissioners remains a risk, however, will be mitigated on a non-recurrent basis during 2022-23.

2.3 PSPP Performance

During November ’22 the Trust (core) achieved a compliance level of **96%** of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **95.72%** as at the end of month 8.

2.4 Covid Expenditure

Covid-19 Revenue Spend / Funding 2022/23					
	WG £m	Commissioners £m	Total £m	IMTP Plans £m	Cost Reduction £m
Mass Vaccination	0.225		0.225	0.375	0.150
PPE	0.070		0.070	0.335	0.265
Cleaning	0.293		0.293	0.427	0.134
Other Covid Response	0.304		0.304	0.967	0.663
Covid Recovery - Internal Capacity		3.645	3.645	6.056	2.411
Covid Recovery - Outreach		0.261	0.261	4.150	3.889
	0.893	**3.906**	**4.799**	**12.310**	**7.511**

The overall gross funding requirement related to Covid has reduced further and currently stands at £4.799m, with £0.893m being recognised for funding from WG, and the balance of £3.906m being sought from our Commissioners.

The £4.799m represents a significant reduction in outsourcing costs from the Trust IMTP plan as of 31st March, largely due to the liquidation of the Rutherford Cancer Centre (RCC).

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

2.5 Reserves

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

A review of the reserves position is currently underway which is following confirmation from WG that both Covid and the Exceptional National Costs will be funded.

2.6 Financial Risks

Covid

The Trust continues to be in dialogue with Commissioners with regards to the costs of additional capacity required to meet the demands placed on our Planned Care services. To date, the full requirement of £3.906m, which has been invested in securing additional capacity, has not been agreed by Commissioners.

The Trust has received signed Long Term Agreements (LTA's) from our Commissioners. However, the funding for Planned care & Covid backlog capacity remains a risk as the marginal income that the Trust is forecast to receive will not cover the additional costs being incurred.

2.7 Capital

a) All Wales Programme

Performance against the current agreed All Wales Programme budget allocations are at this stage expected to deliver to budget. Slippage on the nVCC Enabling works has resulted in the Trust returning £6.393m of funding to WG during 2022/23 which will be re-provided next financial year.

The Trust (during November) received the funding award letter from WG in relation to IRS. The total funding allocated is £41.602m for the period April 22 to March 2026 with £7.9m of the total to be provided during 2022/23.

Also, in November the Trust received an additional £0.370m of funding from WG yearend slippage money which will go towards priority schemes approved by EMB on the 26th October.

The Trust CEL was fixed on the 31st October. At this point WG expect any further slippage to be managed internally by the Trust.

Due to the timing of meetings the CEL reported in the TCS finance report does not include the requested changes to the nVCC enabling and project costs. This will be updated to align with the main finance report from next month.

b) Discretionary Programme

The Trust discretionary capital allocation for 2022/23 is £1.454m. This represents a 24% reduction in capital allocation compared to £1.911m in 2021/22 and is reflective of the reduced overall NHS capital budget position.

The Trust Discretionary Programme for 2022/23 was approved by EMB in August and is expected to deliver and remain within the CEL.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The Trust financial position at the end of November 2022 is an underspend of £0.003m with a year-end forecast break-even position in accordance with the approved IMTP

4. RECOMMENDATION

QSP is asked to **NOTE**

4.1 the contents of the November 2022 financial report and in particular the financial performance to date, and the year-end forecast to achieve financial break-even and key risk in relation to income to cover Covid backlog additional capacity costs.

4.2 the TCS Programme financial report for November 2022 attached as **Appendix 1**.

FINANCIAL PERFORMANCE REPORT

FOR THE PERIOD ENDED NOVEMBER 2022/23

QUALITY SAFETY & PERFORMANCE COMMITTEE 17/01/2023

1. Introduction

The purpose of this report is to outline the financial position and performance for the year to date, performance against financial savings targets, highlights the financial risks, and forecast for the financial year, outlining the actions required to deliver the IMTP Financial Plan for 2022-23.

2. Background / Context

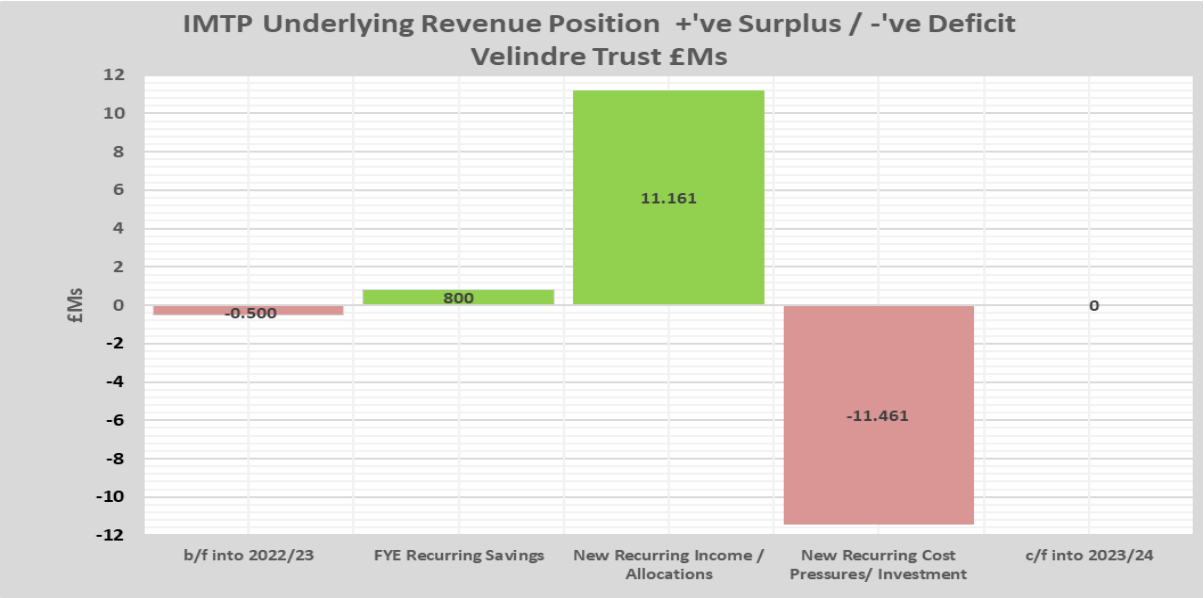
The Trust IMTP Financial Plan for the period 2022-2025 was set within the following context.

- The Trust submitted a balanced three year IMTP, covering the period 2022-23 to 2024-25 to Welsh Government on the 31 March 2022.

- For 2022-23 the Plan (excl Covid) included;
  - an underlying **deficit of -£0.5m** brought forward from 2021-22,
  - FYE **of new cost pressures / Investment** of -**£11.461m,**
  - offset by **new recurring Income** of **£11.161m,**
  - and Recurring FYE **savings schemes** of **£0.8m,**
  - Allowing **a balanced position** to be carried into 2023-24.

- The underlying deficit is expected to be eliminated during 2022/23 through the discretionary uplift in funding, enabling a balanced position to be carried into 2023/24.

- **To eliminate the brought forward underlying deficit, the savings target set for 2022-23 must be achieved, all anticipated income is received, and any new emerging costs pressures are either mitigated at Divisional level or managed through the Trust reserves.**



Underlying Position +Deficit/(-Surplus) £Ms	b/f into 2022/23	Recurring Savings	New Recurring Income / Allocations	FYE New Cost Pressures/ Investment	c/f into 2023/24
Velindre NHS Trust	-0.500	0.800	11.161	-11.461	0

3. Executive Summary

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

(Figures in parenthesis signify an adverse variance against plan)

Table 1 - Key Targets

	Unit	Current Month £m	Year to date £m	Year End Forecast £m
Revenue	Variance	(0.002)	0.003	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	2.149	10.010	28.312
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	96.0%	95.7%	95.0%

Performance against Planned Savings Target

Efficiency / Savings	Variance	0	0	0

Revenue

The Trust has reported a £(0.002)m overspend for November '22, with a cumulative position of £0.003m underspent, and an outturn forecast position of **Breakeven**.

Capital

The approved Capital Expenditure Limit (CEL) as at November '22 is **£28.312m**. This represents all Wales Capital funding of **£26.858m**, and Discretionary funding of **£1.454m.** The Trust reported Capital spend to November'22 of £10.010m and is forecasting to remain within its CEL of £28.312m for 2022-23.

The Trust's CEL is broken down as follows:

	£m Opening	£m Movement	£m November 2022
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	-6.393	17.509
IRS		7.900	7.900
Priority Year end Spend		0.370	0.370
Total CEL	**25.856**	**2.456**	**28.312**

With WG agreement, slippage on the TCS Programme has led to £6.393m Capital funding being pushed back into 2023/24.

The Trust has now received approval from WG for the Integrated Radiotherapy Solution (IRS) capital expenditure with £7.900m being provided during 2022-23 and has also been awarded £0.370m as part of the request for year-end priority schemes which gives a revised Trust CEL of £28.312m for 2022-23.

PSPP

During November '22 the Trust (core) achieved a compliance level of **96%** (October 22: 97.29%) of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **95.72%** as at the end of month 8, and a Trust position (including hosted) of **95.73%** compared to the target of 95%.

Efficiency / Savings

At this stage the Trust is currently planning to fully achieve the savings target during 2022-23. Replacement schemes have been put in place to support under delivery on two schemes that have turned RAG rated red and will not be achieved during this financial year.

Revenue Position

Cumulative				Forecast		
£0.003m Underspent				Breakeven		
Type	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)	Full Year Budget (£m)	Full Year Forecast (£m)	Forecast Variance (£m)
Income	(118.305)	(118.110)	(0.196)	(182.187)	(182.023)	(0.165)
Pay	51.012	50.652	0.359	76.493	76.365	0.128
Non Pay	67.294	67.454	(0.160)	105.694	105.658	0.036
Total	**(0.000)**	**(0.003)**	**0.003**	**(0.000)**	**(0.000)**	**0.000**

The overall position against the profiled revenue budget to the end of November 2022 is an underspend of **£0.003m**, along with an overall outturn forecast position of **Breakeven**.

The Trust continues to report a year end forecast breakeven position which is following confirmation from WG that the Exceptional National cost pressures and Covid response costs will be funded based on the month 6 forecast position. Covid funding towards recovery from commissioners remains a risk, however, will be mitigated on a non-recurrent basis during 2022-23.

4.1 Revenue Position Key Issues

Income Key Issues

Income underachievement to November is largely where activity is lower than planned on Bone Marrow and Plasma Sales in WBS, with plans having already been put in place to support recovery in the latter part of the year particularly around plasma sales which has seen a significant overachievement during November.

The WBS underachievement (£0.595k) to date is being partly offset by VCC income generated through increase in activity from providing SACT homecare and the additional VAT savings, along with the over achievement on private patient income due to drug performance.

Pay Key Issues

The total Trust vacancies as at November 2022 is 101wte, VCC (49wte), WBS (31wte), Corporate (5wte), R&D (9wte), TCS (0wte) and HTW (7wte).

The Trust has now received the pay award funding of £3.065m from WG relating to 2022/23. The funding provided leaves a funding risk of circa £0.450m, with £3.510m being the total funding required to cover the core Trust full establishment including vacancies and increments. The divisions are currently reviewing the impact on the position however any funding gap for this year will be met through the high level of vacancies that has been carried through the Trust across the period, along with the release of the additional annual leave provision carried forward from last year. The recurrent financial impact into future years will need to be considered as part of the IMTP process which is currently underway.

The Trust has now received the full funding of £0.339m from WG towards the temporary increase in Employers NI rates (1.25%).

Vacancies throughout the Trust although reducing remain high, however several posts in both VCC and WBS have been appointed at risk in response to Covid activity backlog and additional capacity required for forward recruitment on service developments without agreed funding pending activity undertaken or FBC approval by WG and Commissioners. In addition, work continues to be underway in both divisions to either secure additional funding to support these posts or looking at options to migrate staff into vacancies to help mitigate the current risk exposure.

Both VCC and WBS hold a £0.450m vacancy factor target, which will need to be achieved during 2022/23 in order to balance the overall Trust financial position.

Non Pay Key Issues

The expected increase in energy prices has reduced further during November to £0.671m (October £0.845m) following the introduction of the price cap and review of volume consumption. The stepped increase of £0.671m has been recognised as an Exceptional National cost pressures by WG with confirmation that funding will be provided based on the month 6 forecast (£0.898m) as a maximum.

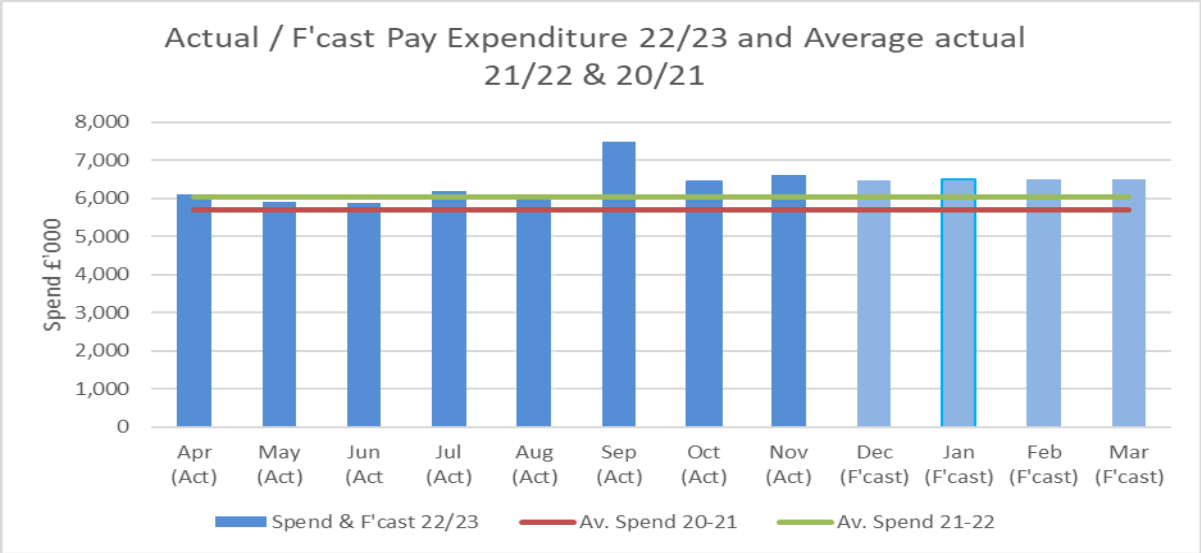
Each Division holds both a general reserve to meet unforeseen costs and a savings target / Cost improvement Plan (CIP). The savings target for each division was set as VCC £0.700m, WBS £0.500m and Corporate £0.100m as part of the IMTP for 2022/23.

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

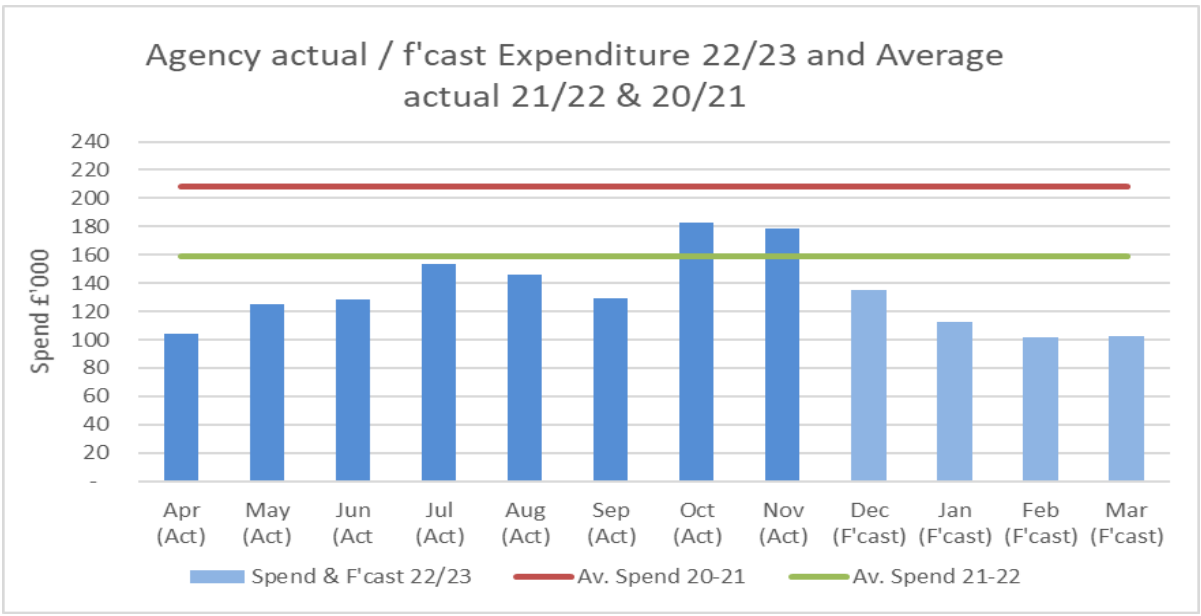
4.2 Pay Spend Trends (Run Rate)

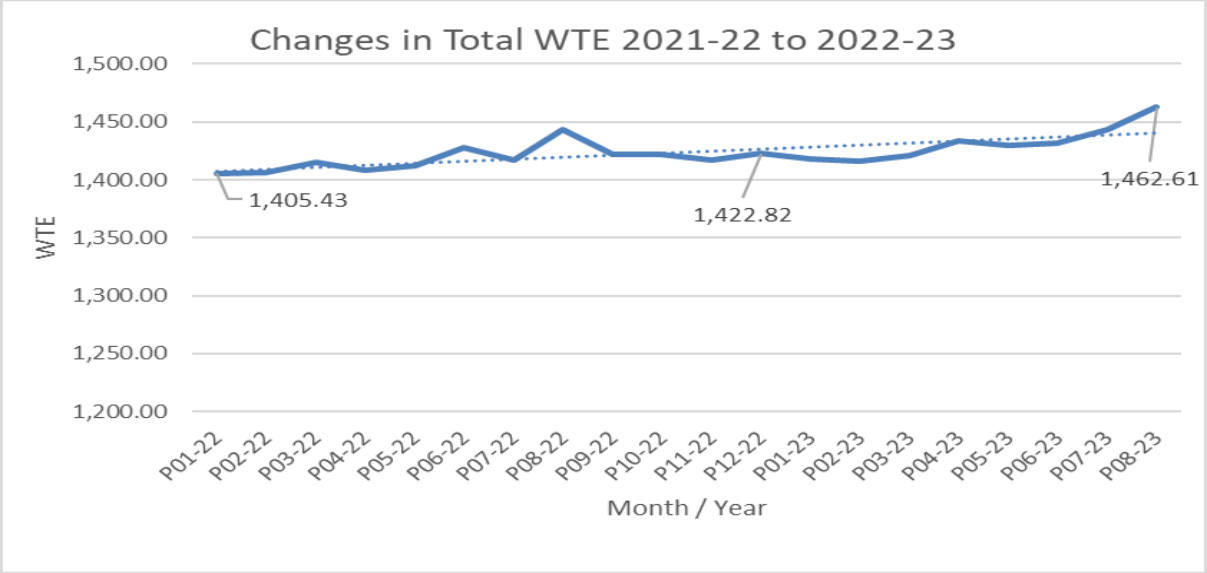
The pay award for 2022/23 was paid in September (back dated to April) as demonstrated in the spike in pay spend shown in the graph below. Agency costs have decreased this year from the 2021/22 levels largely due to the reduction of agency staff previously recruited to support Covid response. Further reductions in the use of agency were expected in 2022/23 by recruiting staff required on a permanent basis. However, more agency staff have been required recently in

particular to support the running of estates in VCC in order to deliver ongoing maintenance and statutory compliance duties. The service are actively trying to recruit into current vacancies in order to reduce the need of agency support.

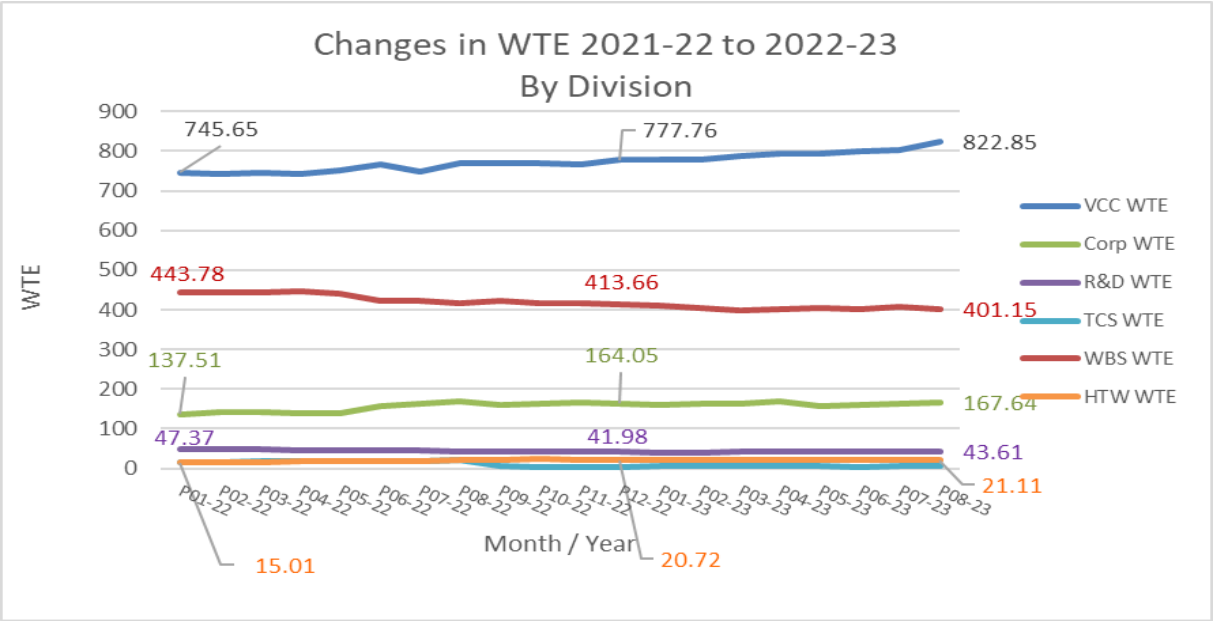


The spend on agency for November 22 was £0.179m (September £0.183m), which gives a cumulative year to date spend of **£0.149m** and a current forecast outturn spend of circa **£1.600m** (£1.906m 2021/22). Of these totals the year to date spend on agency directly relating to Covid as at the end of November is £0.221m and forecast spend is circa £0.315m (£0.826m 2021/22).



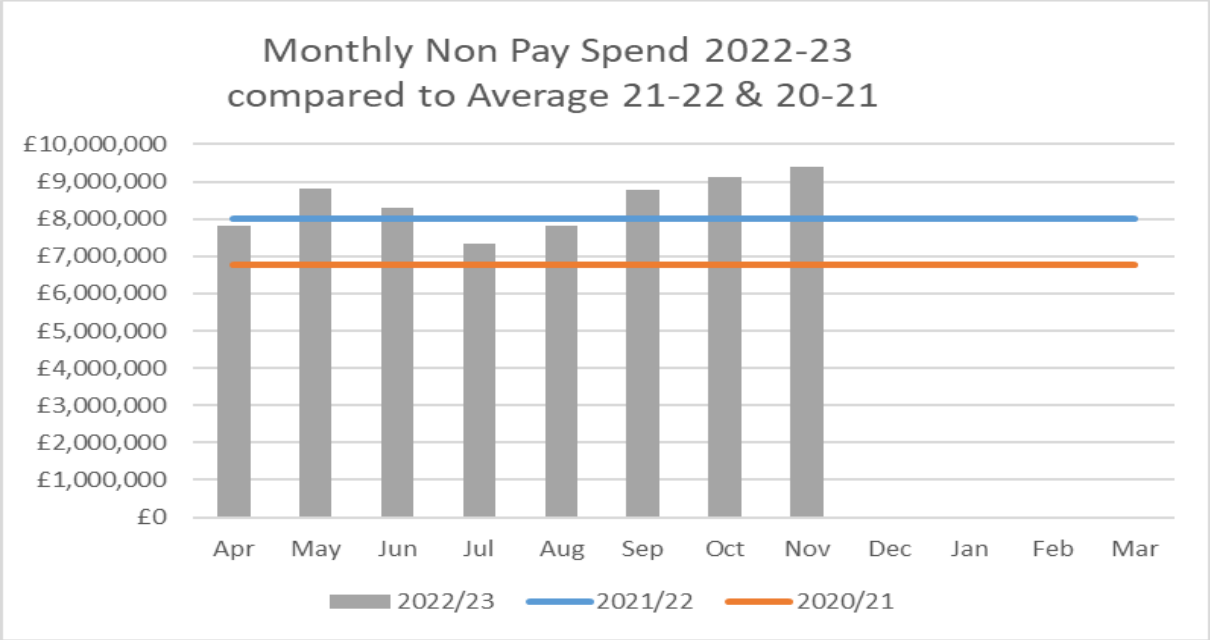


The increase in WTE (20) during November is largelywithin VCC and relates to the recruitment of Nurses and HCSW into service area's such as inpatients, Chemotherapy and Prince Charles.



4.3 Non Pay

Non-pay 21/22 (c£96m) average monthly spend of £8m was £1.2m higher than the reported monthly average spend for 20/21 (£6.8m). Most of the monthly average increase (circa £0.9m) related to the growth in NICE / High Cost drug usage following the recovery and associated surge related to Covid and an increase in WBS wholesaling (circa £0.3m). The average monthly spend for 22-23 is currently £8.4m which is an average increase of circa £0.4m against 21/22 expenditure and is mainly due to the increase in NICE / High Cost drugs.



4.4 Covid-19

The latest forecast funding requirement as at 30th November in relation to Covid for 2022-23 has been further revised down to £4.799m (October £4.856m) which is a significant reduction from the £12.310m that was submitted as part of the Trust IMTP. Of the £4.799m total Covid requirement £0.893m (IMTP plans £2.104m) is being requested directly from WG, and the balance of £3.906m (IMTP plans £10.206m) being sought from our commissioners.

Covid-19 Revenue Spend / Funding 2022/23					
	WG £m	Commissioners £m	Total £m	IMTP Plans £m	Cost Reduction £m
Mass Vaccination	0.225		0.225	0.375	0.150
PPE	0.070		0.070	0.335	0.265
Cleaning	0.293		0.293	0.427	0.134
Other Covid Response	0.304		0.304	0.967	0.663
Covid Recovery - Internal Capacity		3.645	3.645	6.056	2.411
Covid Recovery - Outreach		0.261	0.261	4.150	3.889
	0.893	**3.906**	**4.799**	**12.310**	**7.511**

The latest forecast spend and funding requirement from WG has decreased by a further £0.057m from £0.950m reported in October to £0.893m. A further de-escalation of required cleaning is reducing both cost and funding requirements.

Following DoF's meeting on the 2nd November the Trust is now assuming that full funding for Covid response costs will be provided by WG. The Trust has already invoiced and received funding for costs in relation to Mass Vaccination and PPE, for the first quarter of the year from April to June 2022.

The Trust Covid expenditure is based on activity demand forecast modelling which commenced in 2021/22 and has been updated regularly working with Health Board operational teams. The Trust

has already invested £2.943m in additional capacity. The anticipated funding requirement of £4.150m for outsourcing has been removed as the Rutherford went into liquidation earlier this year. The Trust had also been working up plans to expand internal capacity which it has now established in its outreach Centre at Prince Charles Hospital (from October) for SACT, with forecast additional cost above that already invested in Covid capacity of circa £0.261m. In addition, the Trust has developed plans for expanding Radiotherapy capacity internally through use of weekend working which will require existing staff to work additional hours as WLIs with enhanced pay rates. The full cost and operational deliverability of this additional capacity is still being worked up. These additional investments in capacity to meet the activity demand from Health Boards will not be fully covered through LTA marginal income leading to an additional financial pressure to the Trust which it is managing through use of non-recurrent measures in 2022-23. However, with the anticipated removal of the LTA income protection in 2023-24 there will be a significant financial risk of £1.5m – £2m which the Trust may not be able to cover depending on demand and its ability to deliver activity within the current capacity.

Other cost reduction from IMTP plans reflects financial control measures and review of service delivery models to reflect latest WG Covid de-escalation guidance.

4. Savings

The Trust established as part of the IMTP a savings requirement of £1.300m for 2022-23, £0.800m recurrent and £0.500m non-recurrent, with £0.750m being categorised as actual saving schemes and £0.550m being income generation.

The divisional share of the overall Trust savings target has been allocated to VCC £0.700m (54%), WBS £0.500m (38%), and Corporate £0.100m (8%).

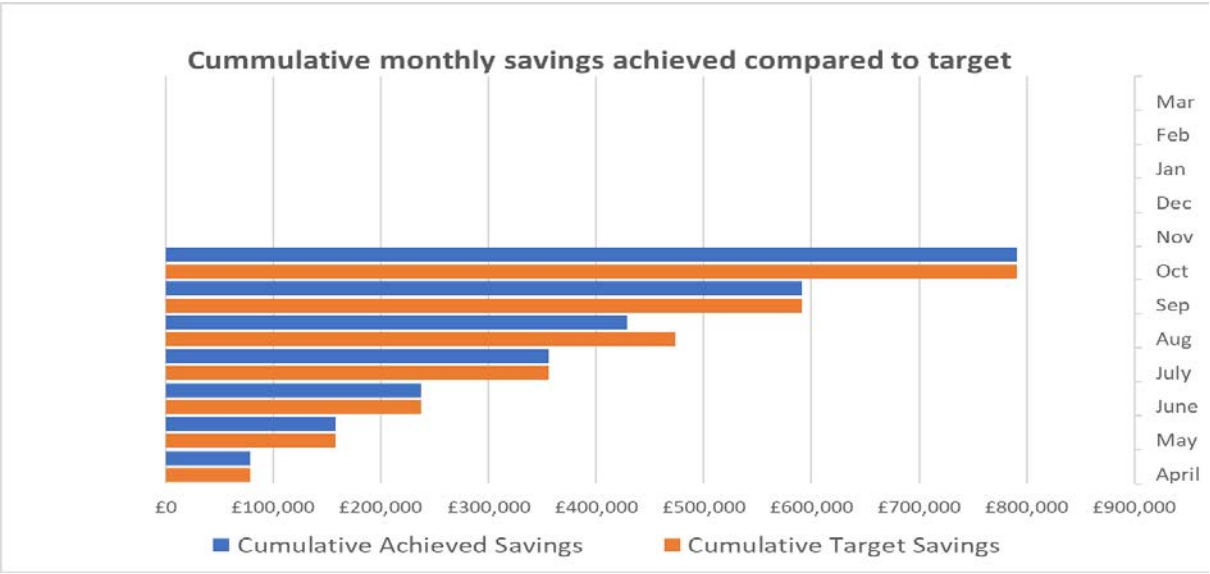
Two schemes continue to be impacted by Covid during 2022-23 have now turned red which relate to service redesign and supportive structures.

Service redesign and supportive structures is a key area of savings for the Trust which are focused on removing inefficiencies in the ways the Trust are working. These plans are aligned to a number of the Trust VBHC bids that sought funding for new posts to support medical workforce redesign but were unsuccessful. The ability to enact these saving schemes is proving to be difficult due to the legacy of the pandemic and current workforce situation, particularly the high number of vacancies along with the high level of sickness that is currently being experienced throughout the Trust. Plans are still being developed by the Trust divisions however, it is recognised due to the current challenges that these saving schemes will not be achieved in the short term and therefore delivery has been removed from this financial year.

Contingency measures have been put in place on the basis that these savings schemes will not achieved this year, however these replacement schemes are both recurrent and non-recurrent in nature. **It is extremely important that divisions continue to review their current savings schemes, and where delivery is not going to be achieved this year consider the impact on next year's financial position especially where those schemes were classified as recurrent.**

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	360	272	(88)	500	(200)
			76%		71%	
WBS TOTAL SAVINGS	500	292	292	0	500	0
			100%		100%	
CORPORATE TOTAL SAVINGS	100	58	58	0	100	0
			100%		100%	
TRUST LEVEL TOTAL SAVINGS			88	88	200	200
TRUST TOTAL SAVINGS IDENTIFIED	1,300	710	710	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	58	58	0	100	0
Laboratory & Collection Model (WBS)	Green	50	29	29	0	50	0
Laboratory & Collection Model (WBS)	Green	50	29	29	0	50	0
Stock Management (WBS)	Green	100	58	58	0	100	0
Stock Management (WBS)	Green	150	88	88	0	150	0
Procurement - Supply Chain (WBS)	Green	50	29	29	0	50	0
Service Redesign (VCC)	Red	100	44	0	(44)	0	(100)
Supportive Stuctures (VCC)	Red	100	44	0	(44)	0	(100)
Procurement - Supply Chain (VCC)	Green	50	29	29	0	50	0
Bank Interest (Trust - In Year)	Green		0	55	55	167	167
Vacancy Factor (Trust - In Year)	Green		0	33	33	33	33
Total Saving Schemes		**750**	409	409	0	750	0
Income Generation							
Maximinsing Income Opportunities - Income Attraction (WBS)	Green	50	29	29	0	50	0
Maximinsing Income Opportunities - Income Attraction (WBS)	Green	50	29	29	0	50	0
Maximinsing Income Opportunities - Private Patients (VCC)	Green	150	67	67	0	150	0
Maximinsing Income Opportunities - Private Patients (VCC)	Green	100	58	58	0	100	0
Maximinsing Income Opportunities - Income Attraction (VCC)	Green	200	117	117	0	200	0
Total Income Generation		**550**	300	300	0	550	0
TRUST TOTAL SAVINGS		**1,300**	**709**	**709**	**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.

Summary of Total Recurrent Reserves Remaining Available in 2022/23	£m
Recurrent Reserves Available for investment	1.241
Previously Committed Reserves Bfwd 2021-22	(0.137)
Previously agreed Exec Investment	(0.973)
New Commitments	(0.131)
Emergence of Slippage against Recurrent Reserves Commitments	
Remaining Balance	**0**

Summary of Total Non-Recurrent Reserves Remaining Available in 2022/23	£m
Non-Recurrent Reserves Available for investment	1.471
Previously Committed Reserves Bfwd 2021-22	(0.102)
Previously Agreed Exec Investment	(1.302)
New Commitments	(0.067)
Emergence of Slippage against Non-Recurrent Commitments	
Remaining Balance	**0**

A review of the reserves position is currently being undertaken which is following confirmation from WG that both Covid and the Exceptional National Costs will be funded.

6. End of Year Forecast / Risk Assessment

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

Covid Funding via Commissioners – *Risk £500k, Likelihood - Medium*

Commissioners have not committed to providing the full funding ask of £3.906m as a block funding arrangement but have all stated that any funding required to cover additional Covid recovery costs will flow through the LTA under the national funds flow mechanism. This mechanism, whilst providing enhanced income protection over the normal LTA arrangements, does not cover the additional costs of enhanced pay rates for WLI's or additional costs above marginal when establishing new capacity. The Trust has received signed LTA's back from our commissioners, however the funding for planned care & Covid backlog capacity remains a risk for the Trust.

Other C-19 Response Costs – *Risk £0.755m (total £0.893m less income received £0.138m), Likelihood - Low*

Following further Covid de-escalation related activity and a review of operational costs in line with the updated WG guidance, the latest forecast spend and funding requirement from WG has reduced further by £0.057m from £0.950m reported in October to £0.893m. The risk level has been reduced to low given the message delivered by Steve Elliot Interim Director of Finance for Health and Social Care, Welsh Government at DoFs on the 2nd November that Covid response funding will be provided based on the year-end forecast provided in month 6.

Exceptional National Cost Pressures – *Risk £0.671m - Low*

Following DoF's meeting on the 2nd November the Trust is now assuming to receive full funding for Energy prices based on the month 6 year end forecast and so this risk has been reduced to low but will remain flagged as a risk until the funding flows through to the Trust. The incremental increase in Energy prices has reduced slightly from £0.845m in October to £0.671m which reflects the latest forecast provided by NWSSP Colleagues during November.

7. CAPITAL EXPENDITURE

Administrative Target

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

	Approved CEL £m	YTD Spend £m	Committed Orders Outstanding £m	Budget Remaining @ M8 £m	Full Year Actual Spend £m	Year End Variance £m
All Wales Capital Programme						
nVCC - project costs	2.394	2.073	0.000	0.321	2.894	-0.500
nVCC - Enabling Works	15.115	6.048	0.000	9.067	14.615	0.500
Canisc Cancer Project	0.579	0.579	0.000	0.000	0.579	0.000
Fire Safety	0.500	0.172	0.000	0.328	0.500	0.000
Integrated Radiotherapy Solutions (IRS)	7.900	0.809	0.000	6.831	7.640	0.260
WG Priority Year end Spend	0.370	0.000	0.000	0.370	0.370	0.000
Total All Wales Capital Programme	26.858	9.681	0.000	16.917	26.598	0.260
Discretionary Capital	1.454	0.329	0.000	1.125	1.714	-0.260
Total	28.312	10.010	0.000	18.042	27.942	0.000

The approved 2022/23 Capital Expenditure Limit (CEL) as at November 2022 was £28.312m. This includes All Wales Capital funding of £26.858m, and discretionary funding of £1.454m. The approved CEL has increased in year by £2.456m which reflects approval of the Canisc Cancer Project (0.579m), IRS (7.900m), and Velindre's share of the WG yearend spend request (0.370m). This is offset by a reduction of 6.393m on the nVCC Enabling works project to reflect the latest forecast requirement for 2022/23. Following agreement with WG the £6.393m will be re-provided to the programme during 2023/24.

WG colleagues have agreed a further movement of £0.500m between the nVCC enabling and project costs which is reflected in the table above but represented as a variance rather than a CEL adjustment.

In January 2022 WG informed the Trust that the discretionary allocation will be significantly reduced during 2022/23 (previously £1.911m), which is reflective of the reduced overall NHS capital budget position.

Allocation of the discretionary programme was approved by EMB Shape on the 27th August.

Following a request from WG a list of prioritised bids was approved by EMB on 26th October for submission to WG should any Capital funding become available. The Trust has received confirmation during November that £0.370m of additional funding will be provided to support delivery of the priority one schemes which includes replacement Hemoflows in WBS £0.238m, Patient Monitors in VCC £0.062m and £0.070m towards Digital priorities.

On the 22nd November the Trust received the award funding letter from WG in relation to IRS. The total funding allocated is £41.602m for the period April 22 to March 2026 with £7.900m of the total to be provided during 2022/23 with future years funding cash flow to be agreed with WG.

Within the £7.900m of IRS funding, £0.694m has been released back into the discretionary programme which was previously either spent or ringfenced to support the procurement stage of the IRS project. Of the £0.694m, £0.434m was ringfenced from discretionary in 2022/23 and £0.260m will be reimbursed from the WG funding allocation as the spend was incurred last financial year.

The £0.694m will be utilised to support the remaining priority one schemes that were submitted to EMB on the 26th October but not supported by WG.

The Trust CEL was fixed on the 31st October. At this point WG expect any further slippage to be managed internally by the Trust.

On the 16th December the Trust was awarded funding of £11.400m in respect of the Integrated Radiotherapy Solution for the Satellite Centre at Nevil Hall. The funding will be drawn down from 2023/24 and beyond to match the profiled spend.

Performance to date

The actual cumulative expenditure to November 2022 on the All-Wales Capital Programme schemes was £9.681m, this is broken down between spend on the nVCC enabling works £6.048m, nVCC project costs of £2.073m, Canisc Cancer Project £0.579m, fire safety £0.172m, and IRS £7.900m.

Spend to date on Discretionary Capital is currently £0.329m leaving a remaining balance of £1.125m as at the 30th November.

Year-end Forecast Spend

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

Major Schemes in Development

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

Major Schemes in development that will be considered during 2022/23 and beyond in conjunction with WG include:

	Scheme	Scheme Total	Stage (i.e. OBC development, FBC development, scoping etc.)	22/23 £m	23/24 £m	24/25 £m	25/26 £m	26/27 £m	27/28 £m	28/29 £M
1	WBS HQ	34.125*	FBC under development	0.150	13.674	9.996	4.434	5.215	0.608	0.048

*Cash flow of these schemes is still under review alongside WG.

Other Major schemes which are under discussion internally and WG are sighted on include VCC outpatients, ventilation, and plasma fractionation.

8. BALANCE SHEET (Including Hosted Organisations)

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

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

	Opening Balance Beginning of Apr 22	Closing Balance End of Nov-22	Movement from 1st April Nov-22	Forecast Closing Balance End of Mar 23
Non-Current Assets	**£'m**	**£'m**	**£'m**	**£'m**
Property, plant and equipment	143.136	155.186	12.050	149.550
Intangible assets	8.667	7.803	(0.864)	8.200
Trade and other receivables	1,092.008	1,403.114	311.106	1,403.114
Other financial assets	0.000	0.000	0.000	0.000
Non-Current Assets sub total	1,243.811	1,566.103	322.292	1,560.864
Current Assets				
Inventories	65.207	50.298	(14.909)	50.298
Trade and other receivables	540.227	178.530	(361.697)	212.888
Other financial assets	0.000	0.000	0.000	0.000
Cash and cash equivalents	30.404	52.858	22.454	18.500
Non-current assets classified as held for sale	0.000	0.000	0.000	0.000
Current Assets sub total	635.838	281.686	(354.152)	281.686
TOTAL ASSETS	1,879.649	1,847.789	(31.860)	1,842.550
Current Liabilities				
Trade and other payables	(277.601)	(240.708)	36.893	(235.469)
Borrowings	0.00	0.00	0.000	0.00
Other financial liabilities	0.00	0.00	0.000	0.00
Provisions	(341.123)	(342.831)	(1.708)	(342.831)
Current Liabilities sub total	(618.724)	(583.539)	35.185	(578.300)
NET ASSETS LESS CURRENT LIABILITIES	1,260.925	1,264.250	3.325	1,264.250
Non-Current Liabilities				
Trade and other payables	(7.336)	(7.336)	0.000	(7.336)
Borrowings	0.00	0.00	0.000	0.00
Other financial liabilities	0.00	0.00	0.000	0.00
Provisions	(1,094.206)	(1,091.599)	2.607	(1,091.599)
Non-Current Liabilities sub total	(1,101.542)	(1,098.935)	2.61	(1,098.935)
TOTAL ASSETS EMPLOYED	159.383	165.315	5.932	165.315
FINANCED BY: **Taxpayers' Equity**				
General Fund	0.000	0.000	0.000	0.000
Revaluation reserve	30.935	30.934	(0.001)	30.934
PDC	112.982	118.911	5.929	118.911
Retained earnings	15.466	15.470	0.004	15.470
Other reserve	0.000	0.000	0.000	0.000
Total Taxpayers' Equity	159.383	165.315	5.932	165.315

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 £5m of stock had been purchased by NWSSP and an additional £2m of commercial blood products were purchased by WBS, to provide resilience for NHS Wales due to the uncertainty around supply chain reliability because of Brexit.

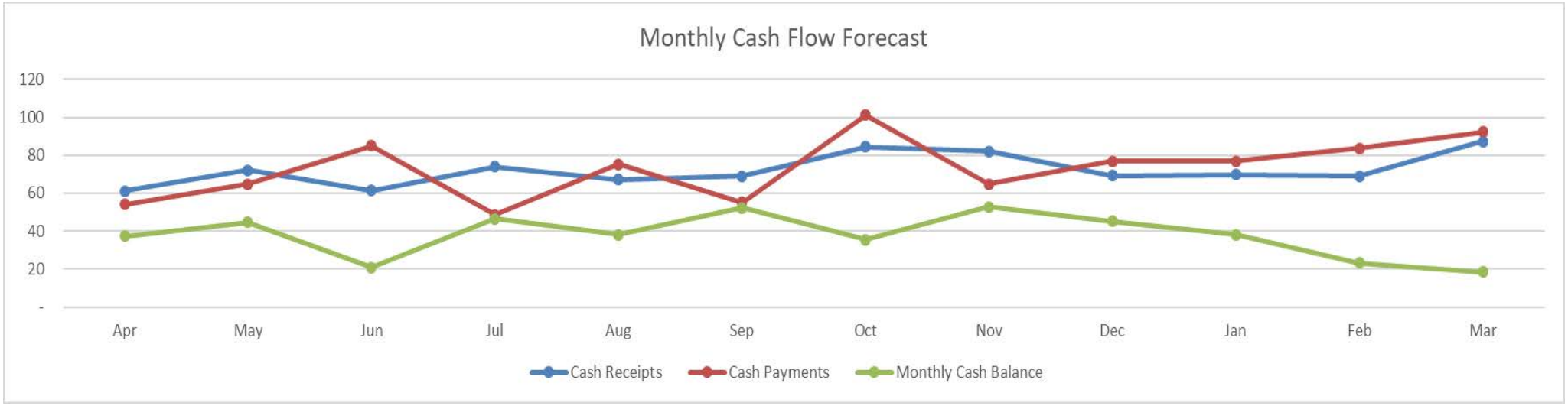
To aid the Trust's cash flow while the additional stock was being held for Brexit, Welsh Government provided the Trust with additional cash of £7m during 2019/20. WBS did intend to run down the commercial blood stock, however given the uncertain situation with Covid and potential impact on supply chains the Trust continues to hold this stock with assessments ongoing. NWSSP are continuing to liaise with WG regarding the level of Brexit stock to maintain but it is anticipated that the repayment of the additional cash will take place later this year but will be dependent on the stock being released.

Due to the high levels of purchases relating to Covid within NWSSP, the cash levels over the past year or so have been significantly higher than usual, however by the end of this financial year expectation is that cash balances should return to pre-Covid levels.

Following a request from WG the Trust transferred £5.9m of cash into the Escrow holding account during May for the nVCC programme. These funds were consequently drawn down in July from WG to reimburse the Trust ensuring that there was no cash risk to the organisation.

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

		Apr £'m	May £'m	Jun £'m	Jul £'m	Aug £'m	Sep £'m	Oct £'m	Nov £'m	Dec £'m	Jan £'m	Feb £'m	Mar £'m	Totals £'m
	RECEIPTS													
1	LHB / WHSSC income	33.135	40.208	40.042	37.491	47.836	36.522	43.649	41.695	40.900	41.380	41.870	40.718	485.446
2	WG Income	20.937	24.551	17.010	24.552	15.002	26.148	32.585	33.410	23.568	24.458	23.687	24.982	290.889
3	Short Term Loans													0.000
4	PDC				5.928								17.124	23.052
5	Interest Receivable	0.019	0.027	0.030	0.025	0.037	0.062	0.075	0.105	0.050	0.050	0.050	0.050	0.580
6	Sale of Assets													0.000
7	Other	7.106	7.289	4.321	6.094	4.246	6.395	8.220	6.982	4.771	3.820	3.283	4.547	67.075
8	TOTAL RECEIPTS	**61.197**	**72.074**	**61.403**	**74.090**	**67.121**	**69.127**	**84.529**	**82.192**	**69.289**	**69.708**	**68.890**	**87.421**	**867.042**
	PAYMENTS													
9	Salaries and Wages	21.735	29.243	29.483	29.705	29.549	34.417	36.535	33.118	33.026	33.014	33.056	33.531	376.412
10	Non pay items	30.543	33.079	54.139	17.703	44.384	20.200	63.158	29.085	40.438	38.260	44.654	44.006	459.649
11	Short Term Loan Repayment												7.000	7.000
12	PDC Repayment													0.000
14	Capital Payment	1.926	2.567	1.420	1.215	1.428	0.446	1.469	2.732	3.454	5.630	5.927	7.671	35.885
15	Other items													0.000
16	TOTAL PAYMENTS	**54.205**	**64.889**	**85.042**	**48.623**	**75.361**	**55.063**	**101.162**	**64.935**	**76.918**	**76.904**	**83.637**	**92.208**	**878.946**
		1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
17	Net cash inflow/outflow	6.993	7.185	(23.639)	25.467	(8.240)	14.064	(16.633)	17.257	(7.629)	(7.196)	(14.747)	(4.786)	
18	Balance b/f	30.404	37.397	44.582	20.943	46.410	38.170	52.234	35.601	52.858	45.229	38.033	23.287	
19	Balance c/f	37.397	44.582	20.943	46.410	38.170	52.234	35.601	52.858	45.229	38.033	23.287	18.500	



DIVISIONAL ANALYSIS

(Figures in parenthesis signify an adverse variance against plan)

Core Trust

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Variance £000
VCC	(24,706)	(24,706)	0	(38,364)	(38,364)	0
RD&I	(383)	(383)	(0)	240	240	0
WBS	(13,826)	(13,826)	(0)	(20,797)	(20,797)	0
Sub-Total Divisions	**(38,915)**	**(38,915)**	**(0)**	**(58,922)**	**(58,922)**	**0**
Corporate Services Directorates	(7,303)	(7,300)	(3)	(11,279)	(11,279)	0
Delegated Budget Position	**(46,218)**	**(46,215)**	**(3)**	**(70,201)**	**(70,201)**	**0**
TCS	(433)	(433)	0	(797)	(797)	0
Health Technology Wales	(39)	(38)	0	(48)	(48)	0
Trust Income / Reserves	46,689	46,689	0	71,046	71,046	0
Trust Position	**0**	**3**	(3)	**0**	**0**	**0**

VCC

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**46.178**	**46.589**	**0.410**	**71.698**	**72.139**	**0.441**
Expenditure						
Staff	**30.207**	**30.188**	**0.019**	**45.366**	**45.195**	**0.171**
Non Staff	**40.677**	**41.107**	**(0.430)**	**64.697**	**65.309**	**(0.612)**
Sub Total	**70.884**	**71.295**	**(0.410)**	**110.063**	**110.504**	**(0.441)**
Total	**(24.706)**	**(24.706)**	0.000	**(38.364)**	**(38.364)**	**0.000**

VCC Key Issues:

The reported financial position for the Velindre Cancer Centre as at the end of November 2022 was **breakeven**, and an expected outturn position of **breakeven**.

Income at Month 8 represents a surplus of **£0.410m** and a forecast outturn overachievement of **£0.441m**. This is largely from an increase in activity from providing SACT homecare and the additional VAT savings, and over achievement on private patient income due to drug performance, which is above general private patient performance, along with a one-off drug rebate. This is offsetting the divisional income savings target of £0.541m as at the end of November.

VCC have reported a year-to-date underspend of **£0.019m** against staff, and a forecast of **£0.171m** underspent. The level of vacancies within VCC reduced by circa 20wte during November following recruitment of Nurses and HCSW into service areas such as inpatients, Chemotherapy and Prince Charles. As at month 8 the Division is still carrying 49wte vacancies with the savings being above the divisional vacancy factor target and offsetting the cost of agency (£0.807)m to end of November, £0.193m being directly related to Covid). In additions the savings from vacancies are also supporting the costs of advanced recruitment into IRS.

Medical costs have increased due to additional temporary staff recruited at risk to ensure that all Jnr Dr rotation placements are filled, and to provide additional resilience against pressured consultants. Additionally, enhanced out of hours service, for advanced life support which will be nursing led continues at this stage covered by Jnr Dr's with transition to nursing having begun but being phased.

Early recruitment to the delayed Integrated Radiotherapy Solution (IRS) has led to year to date committed cost of £0.353m.

Non-Staff Expenditure at Month 8 was **£(0.430)m** overspent, forecast **£(0.612)m** overspend. The overspend largely relates to the facilities management office pressures which were previously supported by Covid, maintenance and repair of the Linacs, transport SLA overspend, consumable spend from increased activity, and unexpected prior year invoices being received from Virgin Media, which are being partly offset by an underspend on general drugs.

WBS

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	**17,519**	**16,924**	**(595)**	**24,718**	**23,930**	**(788)**
Expenditure						
Staff	11,438	11,443	(4)	16,878	17,302	**(424)**
Non Staff	19,906	19,308	599	28,637	27,425	**1,212**
Sub Total	**31,345**	**30,750**	**595**	**45,515**	**44,727**	**788**
Total	**(13,826)**	**(13,826)**	**0**	**(20,797)**	**(20,797)**	**0**

WBS Key Issues:

The reported financial position for the Welsh Blood Service at the end of November 2022 was **breakeven** with an outturn forecast position of **breakeven** currently expected.

Income underachievement to date is **£(0.595)m** forecast **£(0.788)m**, where activity is lower than planned on Bone Marrow and Plasma Sales. Targeted income generation YTD from plasma sales to research is not achieving desired levels, however contract one of two awarded for new supplier in October which includes increased selling price. Benefits of new contract reflected with significant overachievement during November and expectation that the underachievement will be recovered by the year end for plasma sales to breakeven. Transitional operating sites for Bone Marrow and increasingly curtailed procedures is resulting in activity being considerably lower than target.

Assumed WHSSC income for supressed income is reflected as an underspend within the non-pay position, however WHSSC income support for the underachievement has now been fully utilised.

Staff reported a small year-to-date overspend of **£(0.004)m** to November, forecast **£(0.434)m**. Outturn overspend expected from posts supported without identified funding source which includes advanced recruitment and service developments which have been incurred as a divisional cost pressure particularly in relation to Component development where no WHSSC funding has been secured. WG bid has been submitted to support Plasma Fractionation staffing costs.

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

Non-Staff underspend of **£0.599m,** forecast **£1.212m** is largely due to reduced costs from suppressed activity underspends within Laboratory Services and WTAIL. WTAIL underspend is inclusive of £0.217m relating to Bone Marrow reflected to contra income underachievement as described above.

Corporate

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected £000
Income	**697**	**969**	**272**	**1,226**	**1,619**	**393**
Expenditure						
Staff	6,219	6,106	112	9,659	9,546	**113**
Non Staff	1,782	2,163	(381)	2,845	3,352	**(507)**
Sub Total	**8,000**	**8,269**	**(268)**	**12,505**	**12,898**	**(393)**
Total	**(7,303)**	**(7,300)**	**3**	**(11,279)**	**(11,279)**	**0**

Corporate Key Issues:

The reported financial position for the Corporate Services division at the end of November 2022 was an underspend of **£0.003m**. The Corporate division is currently expecting to achieve an outturn position of **breakeven**.

The Trust is currently benefiting from receiving greater returns on cash being held in the bank due to the rise in interest rates which will be partly utilised to support the WRP contribution on the expectation this cost will become recurrent in nature.

Staff expectation is that vacancies within the division, will help offset use of agency and achieve the £0.100m divisional savings target.

Non pay overspend is **£(0.381)m,** forecast **£(0.507m)** as at month 8 largely relates to the divisional savings target £(0.0104)m as at end of November which is expected to be met in year via staff vacancies and the additional income being received in response to the increase in interest rates. Other large pressures include the increased running costs for the hospital Estate.

RD&I

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	**1,542**	**1,420**	**(123)**	**3,238**	**3,027**	**(211)**
Expenditure						
Staff	1,785	1,656	129	2,766	2,498	**268**
Non Staff	140	146	(6)	232	289	**(57)**
Sub Total	**1,925**	**1,803**	**123**	**2,998**	**2,787**	**211**
Total	**(383)**	**(383)**	**0**	**240**	**240**	**0**

RD&I Key Issues

The reported financial position for the RD&I Division at the end of November 2022 was **breakeven** with a current forecast outturn position of **breakeven**.

Staff vacancies which are relatively high at the moment within R&D are offsetting the innovation income target with the stretched target for this year and not expected to be met.

TCS – (Revenue)

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	**0**	**0**	**0**	**0**	**0**	**0**
Expenditure						
Staff	372	372	0	598	598	**0**
Non Staff	61	61	0	76	76	**0**
Sub Total	**433**	**433**	**0**	**674**	**674**	**0**
Total	**(433)**	**(433)**	**0**	**(674)**	**(674)**	**0**

TCS Key Issues

The reported financial position for the TCS Programme at the end of November 2022 is **Breakeven** with a forecasted outturn position of **Breakeven.**

Preapproved reserves budget for strategic transformation £0.060m, non-pay costs of £0.030m, along with the total associated costs of the judicial review £0.033m has now been transferred into the TCS budget for 2022-23.

HTW (Hosted Other)

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	**1,109**	**949**	**(161)**	**1,664**	**1,664**	**0**
Expenditure						
Staff	991	887	104	1,476	1,476	**0**
Non Staff	157	99	57	235	235	**0**
Sub Total	**1,148**	**987**	**161**	**1,712**	**1,712**	**0**
Total	**(39)**	**(38)**	**0**	**(48)**	**(48)**	**0**

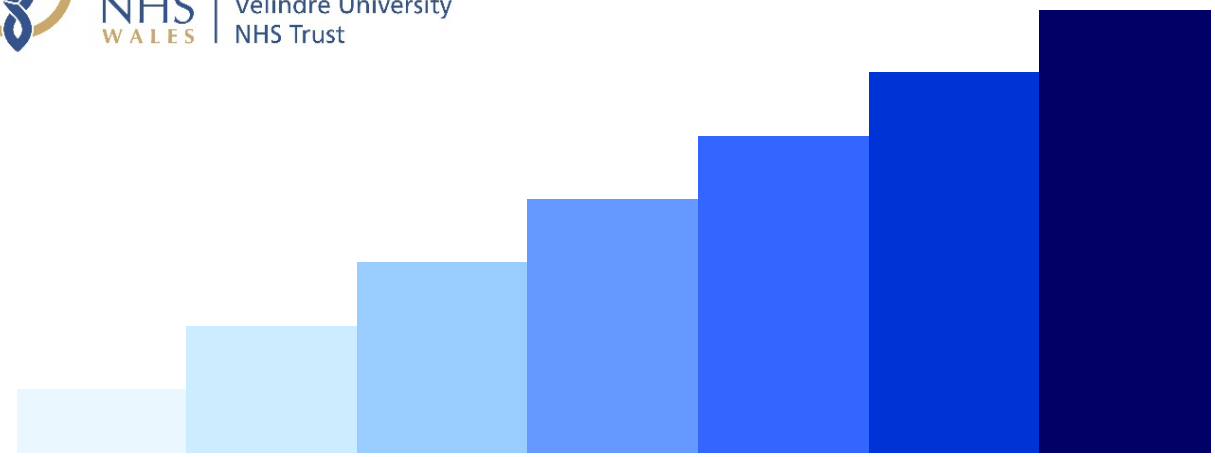
HTW Key Issues

The reported financial position for Health Technology Wales at the end of November 2022 was **breakeven,** with a forecasted outturn position of **breakeven** on the basis that any potential slippage will be handed back to WG**.**

Appendix 1 – TCS Programme Board Finance Report

TCS Programme Board Finance Repo

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust



TCS PROGRAMME FINANCE REPORT 2022/23

Period Ending November 2022

Presented to the
TCS Programme Delivery Board on
14th December 2022

Contents

1. INTRODUCTION

1.1 The purpose of this report is to provide a financial update for the Transforming Cancer Services (TCS) Programme for the financial year 2022/23, outlining spend to date against budget as at November 2022 and the current year-end forecast.

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

2. EXECUTIVE SUMMARY

2.1 The summary financial position for the TCS Programme for the year 2022/23 as at 30th November 2022 is provided below. A detailed table of budget, spend and variance for the capital and revenue expenditure is provided in Appendix 1.

Expenditure Type	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Capital	£8.297m	£17.687m	£17.677m	£0.010m
Revenue	£0.433m	£0.674m	£0.674m	£0
Total	**£8.730m**	**£18.361m**	**£18.351m**	**£0.010m**

2.2 The Programme is currently forecasting an overall underspend of £0.010m against a budget of £18.361m for the financial year 2022/23.

2.3 The Enabling Works forecast position reflects an under-spend of £0.805m, which will support the nVCC Project. This will be provided from the Enabling Works QRA and poses a low financial risk for the Enabling Works Project. The approach has been agreed with WG and we are awaiting formal approval.

2.4 A review of the Enabling Works Project in October 2022 has resulted in a further virement of £3.021m from 2022/23 into 2023/24, as agreed with WG. This reduces the overall **capital** funding for 2022/23 to **£17.687m**. To date the EW Project has undertaken the following adjustments into 2023/24:

- Adjustment of £1.9m in May 22 – delay in Enabling Works Project
- Adjustment of £1.472m in August 22 – delay in the Asda works
- Adjustment of £3.021m in October 22 – delay in the Asda works; utilities and Added Value works

2.5 The Welsh Government position is that the funding allocations shown on CRL / CEL schedules at the end of October 2022 will be considered fixed. Therefore, following the above reviews, the EW Project has confirmed its funding requirements to deliver the EW FBC in 2022-23. The project will need to manage its financial position, and any further 'slippage' will need to be managed by the Trust's Capital Programme or returned to WG without reprovision.

2.6 Following Ministerial approval of the IRS Final Business Case during November 2022, the IRS Procurement Project will now close. The final costs for this Project are

£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 will be drawn down by the Project. However, as there is provision to fund these costs in the FBC, this amount will reimbursed back to the discretionary programme for utilisation elsewhere within the Trust.

2.7 Provisional revenue funding of £0.020m towards pay award costs was provided to the Programme in September 2022 from the WG allocation to the Trust. However, following a review of the Programme's revenue budget and forecast expenditure for the year, there is sufficient resource from within the Programme to cover its increased pay costs. Therefore, this additional funding will not be drawn down in 2022/23. These increased costs will however be take into account when forecasting future pay costs.

2.8 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 paragraph 7.16 below). The **revenue** budget has now reverted to **£0.674m** for 2022/23.

2.9 There are currently three key financial risks to the Programme:

- A further underspend within the Enabling Works Project as a result of the delay in key project activities;
- Increased advisory fees to conclude the tender evaluation stage and Successful Participant to Financial Close stage; and
- Further legal fees relating to the Judicial Review matter.

2.10 These risks have mitigation plans in place or being developed by the relevant Project Teams.

3. BACKGROUND

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

3.2 By 31st March 2022, the Welsh Government (WG) had provided a total of £25.904m funding (£23.283m capital, £2,261m revenue) to support the TCS Programme. In addition, the Trust provided £0.264m from its discretionary capital allocation and £0.111m from non-recurrent revenue funding.

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

3.4 The current funding provided to support the TCS Programme in 2022/23 is £17.943m capital and £0.704m revenue, as outlined in Appendix 2.

4. CAPITAL POSITION

4.1 The current capital funding is outlined below:

• EW Project	£15.420m	Capital Expenditure Limit (CEL)
• nVCC Project	£2.089m	Capital Expenditure Limit (CEL)
• IRS Project	£0.178m	Trust's discretionary capital allocation
Total	**£17.687m**	

4.2 The capital position as at 30th November 2022 is outlined below, with a forecast underspend for 2022/23 of £0.010m.

Capital Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Enabling Works Project	£6.046m	£15.420m	£14.615m	£0.805m
nVCC Project	£2.073m	£2.089m	£2.885m	-£0.796m
IRS Procurement Project	£0.178m	£0.178m	£0.178m	£0
Total	**£8.297m**	**£17.687m**	**£17.677m**	**£0.010m**

4.3 The forecast overspend of £0.796m for the nVCC Project will be supported by the Enabling Works Project underspend of £0.805. This will be provided from the Enabling Works QRA and poses a low financial risk for the Enabling Works Project. The approach has been agreed with WG and we are awaiting formal approval.

4.4 Following Ministerial approval of the IRS Final Business Case during November 2022, the IRS Procurement Project will now close. The final costs for this Project are £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 will be drawn down by the Project. However, as there is provision to fund these costs in the FBC, this amount will reimbursed back to the discretionary programme for utilisation elsewhere within the Trust. Further details are provided in Section 7.

5. REVENUE POSITION

5.1 The current revenue funding is outlined below:

• PMO	£0.300m	NHS Commissioners & Trust Reserves
• nVCC Project	£0.063m	Trust Reserves
• SDT Project	£0.311m	NHS Commissioners & Trust Reserves
Total	**£0.674m**	

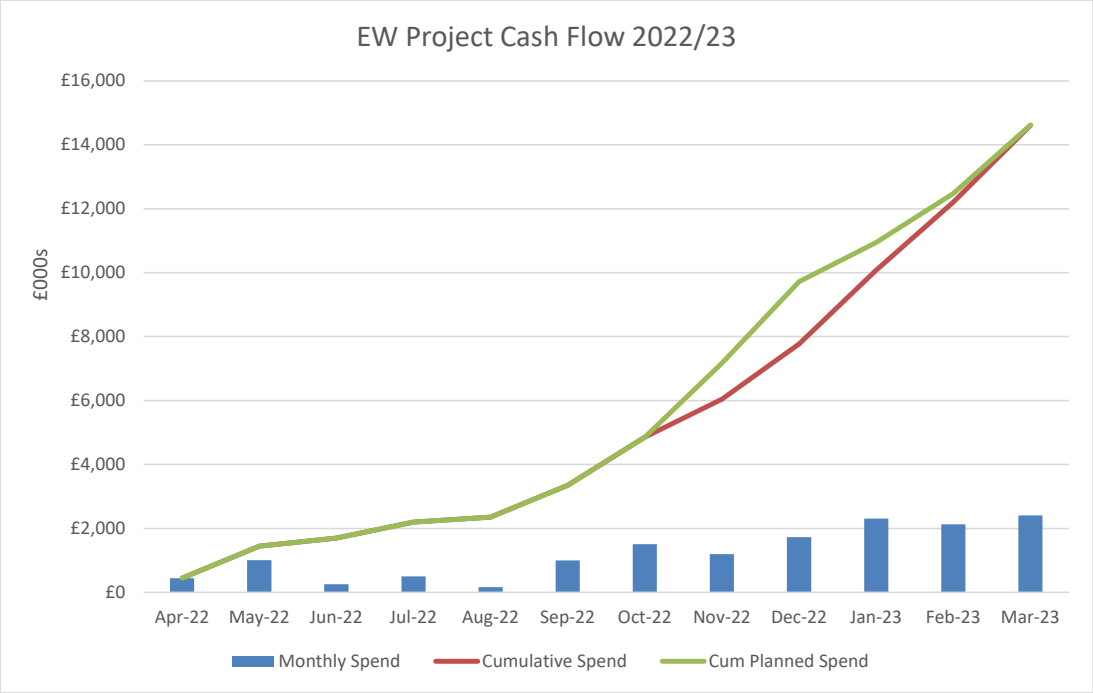
5.2 Following the implementation of the annual NHS pay award in September 2022, a review of the forecast revenue pay for 2022/23 has taken place in November 2022. Adjustments has been made in to the relevant pay and non-pay budgets, allowing increased revenue pay costs in 2022/23 to the covered from within the Programme.

5.3 The revenue position as at 30th November 2022 is outlined below, with a forecast breakeven outturn for 2022/23 against a revised budget **of £0.674m**.

Revenue Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
PMO	£0.171m	£0.300m	£0.300m	£0
nVCC Project	£0.054m	£0.063m	£0.063m	£0
SDT Project	£0.207m	£0.311m	£0.311m	£0
Total	**£0.433m**	**£0.674m**	**£0.674m**	**£0**

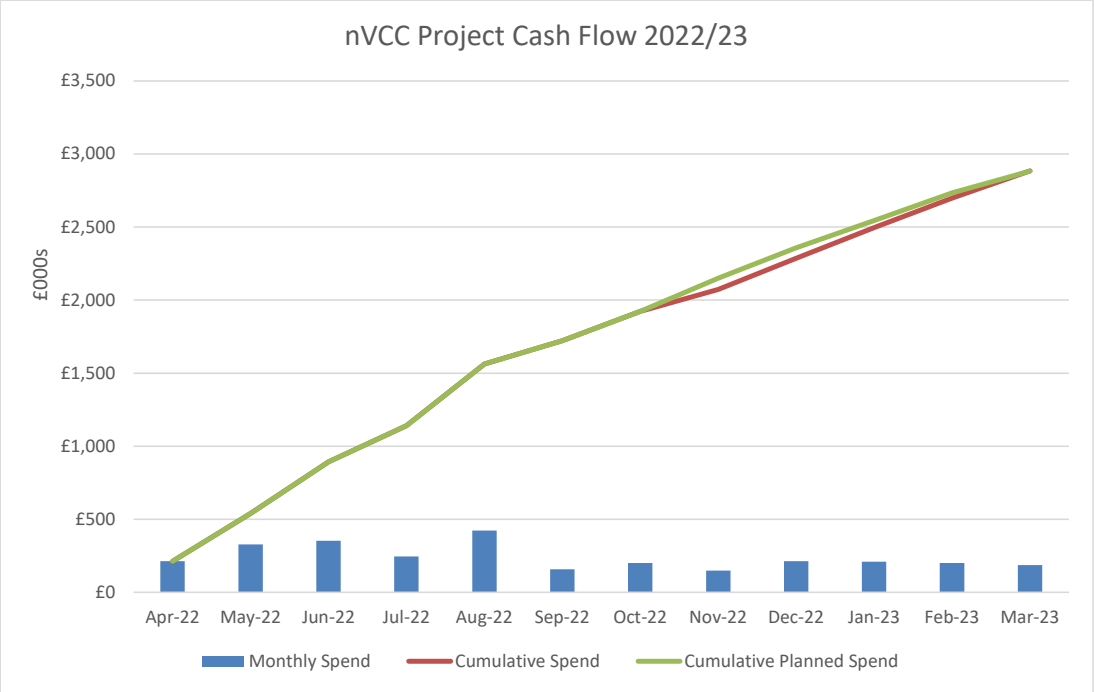
6. CASH FLOW

6.1 The projected capital cash flow for the **EW Project** is outlined below:



6.2 The run rate indicates that around 80% of the costs will be incurred in the second half of the financial year. This is due to the delay in the start of the works.

6.3 The projected capital cash flow for the **nVCC Project** is outlined below:



6.4 The run rate for the nVCC Project is relatively 'flat' and reflects planned activities in respect of the successful participant stage.

6.5 The capital cash flow for the **IRS Project** and the **Revenue** cash flow are not reported as these are not of a material nature.

7. PROJECT FINANCE UPDATES

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

Programme Management Office

7.2 The total revenue funding for 2022/23 is **£0.300m**. £0.0240m of this is from NHS Commissioners' funding, and the remaining £0.060m from the Trust Reserves. The provisional pay award funding of £0.010m in 2022/23 previously reported will not be drawn down as the increased costs will be covered from within the PMO financial year.

7.3 There is no capital funding requirement for the PMO in 2022/23.

7.4 The revenue position for the PMO as at 30th November 2022 is shown below.

PMO Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Pay	£0.165m	£0.287m	£0.287m	£0
Non Pay	£0.006m	£0.013m	£0.013m	£0
Total	**£0.171m**	**£0.300m**	**£0.300m**	**£0**

7.5 The forecast spend review in November 2022 has resulted in an adjustment to the pay and non-pay budgets to align them with the new forecasts.

7.6 There is a low financial risk of an underspend due to a delay in project and support work carried out by the PMO. However, plans will be developed during December to mitigate this risk.

Enabling Works Project

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

7.8 For 2022/23 the EW Project initially received a CEL for £21.813m but after several reviews the final CEL is **£15.420m.** It should be noted that the Welsh Government position, is that the funding allocations shown on CRL / CEL schedules at the end of October 2022 will be considered fixed. Therefore, following the above reviews, the EW Project has confirmed its funding requirements to deliver the EW FBC in 2022-23. The project will need to financially manage its position, and any further 'slippage' will need to be managed by the Trust's Capital Programme or returned to WG without reprovision.

7.9 The Project's financial position for 30th November 2022 is shown below. The forecast position reflects an underspend of £0.805m due to a delay in key activities, which will be used to support the nVCC Project as agreed by WG.

Enabling Works Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Pay	£0.224m	£0.220m	£0.335m	-£0.115m
Non Pay	£5.822m	£15.200m	£14.280m	£0.920m
Total	**£6.046m**	**£15.420m**	**£14.615m**	**£0.805m**

7.10 The spend relates to the following activities:

Enabling Works Project Capital Budget & Spend Summary 2022-23

Description		Year to Date Budget Nov-22 £	Year to Date Spend Nov-22 £	Year to Date Variance Nov-22 £	Financial Year Annual Budget £	Financial Year Annual Forecast £	Financial Year Annual Variance £
PAY							
Project 1b - Enabling Works FBC		146,496	224,227	-77,731	219,744	334,878	-115,134
Pay Capital Total		**146,496**	**224,227**	**-77,731**	**219,744**	**334,878**	**-115,134**
NON-PAY - PROJECTS							
EF01	Construction Costs	0	40,981	-40,981	0	40,981	-40,981
EF02	Utility Costs	62,576	62,576	0	979,771	979,771	0
EF03	Supply Chain Fees	373,231	371,731	1,500	527,481	527,481	0
EF04	Non Works Costs	175,914	273,001	-97,087	225,603	343,690	-118,087
EF05	ASDA Works	485,706	446,652	39,054	3,022,743	2,961,798	60,945
EF06	Walters D&B	4,150,714	4,150,714	0	8,735,418	8,735,418	0
EF07	Other (Decant Works, Surveys & Investigations, IM&T etc.)	0	0	0	174,000	0	174,000
EFQR	Quantified Risk	826,863	195,878	630,986	1,227,798	410,078	817,720
EFQS	QRA - SCP	307,200	316,895	-9,695	307,200	316,895	-9,695
EFRS	Enabling Works FBC Reserves	0	-36,375	36,375	0	-36,375	36,375
Enabling Works Project Capital Total		**6,382,205**	**5,822,053**	**560,152**	**15,200,014**	**14,279,737**	**920,278**
TOTAL ENABLING WORKS FBC CAPITAL EXPENDITURE		**6,528,701**	**6,046,280**	**482,421**	**15,419,758**	**14,614,615**	**805,143**

7.11 There is a risk of a further underspend within the Enabling Works Project as a result of the delay in key project activities.

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 is **£2.089m**.

7.13 The capital financial position for the nVCC Project for 30th November 2022 is shown below, with a further breakdown provided in Appendix 4. The forecast position reflects an overspend of £0.796m, which will be supported from the Enabling Works Project as agreed by WG.

nVCC Capital Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Pay	£0.770m	£1.274m	£1.175m	£0.099m
Non Pay	£1.303m	£0.815m	£1.709m	-£0.894m
Total	**£2.073m**	**£2.089m**	**£2.885m**	**-£0.796m**

7.14 The spend relates to the following activities:

nVCC Project Capital Budget & Spend Summary 2022-23

Description	Year to Date Budget Nov-22	Year to Date Spend Nov-22	Year to Date Variance Nov-22	Financial Year Annual Budget	Financial Year Annual Forecast	Financial Year Annual Variance
	£	£	£	£	£	£
PAY						
Project Leadership	139,184	138,922	262	208,776	207,909	867
Project 2a - New Velindre Cancer Centre OBC	723,023	630,971	92,052	1,065,097	967,269	97,828
Pay Capital Total	**862,207**	**769,893**	**92,313**	**1,273,873**	**1,175,177**	**98,695**
NON-PAY						
nVCC Project Delivery	**44,790**	**41,078**	**3,712**	**84,000**	**81,518**	**2,482**
Work Packages						
VC08 Competitive Dialogue - Dialogue & SP to FC	627,015	1,184,634	-557,619	731,127	1,500,634	-769,507
VC10 Legal Advice	0	10,630	-10,630	0	10,630	-10,630
VC11 S73 Planning	0	88,681	-88,681	0	88,681	-88,681
VC12 nVCC FBC	0	43,500	-43,500	0	82,000	-82,000
VCRS nVCC Reserves	0	-65,460	65,460	0	-54,050	54,050
nVCC Project Capital Total	**627,015**	**1,261,984**	**-634,969**	**731,127**	**1,627,894**	**-896,767**
TOTAL nVCC fbc CAPITAL EXPENDITURE	**1,534,012**	**2,072,955**	**-538,944**	**2,089,000**	**2,884,589**	**-795,589**

7.15 There is a financial risk relating to increased advisory fees in the range of £0.100m to £0.200m required to conclude the tender evaluation stage and Successful Participant to Financial Close stage. The Project's financial position will be monitored closely over the remaining months of the financial year.

Revenue

7.16 No revenue funding has been provided for the nVCC Project by WG in 2022/23. Therefore, the Trust has provided **revenue** budget of **£0.063m** from the Trust reserves. This is £0.010m less than was previously reported due to a budget of £0.033m provided for the Judicial Review matter as opposed to the original ring fenced budget of £0.043m. this revised budget was based on a revised forecast spend for the year.

7.17 The revenue financial position for the nVCC Project for 30th November 2022 is shown below, reflecting a forecast breakeven spend against a budget of **£0.063m**.

nVCC Revenue Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Project Delivery	£0.021m	£0.030m	£0.030m	£0
Judicial Review	£0.033m	£0.033m	£0.033m	£0
Total	**£0.054m**	**£0.063m**	**£0.063m**	**£0**

7.18 The legal team has provided an estimated final cost for this matter of £0.134m. £0.084m of this was expended in 2021/2022, and the remaining £0.050m is expected during 2022/23. Therefore there is a risk of an overspend of £0.017m in this financial year. The action to mitigate this risk is to request additional funding from the Trust Reserves during December 2022.

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, has instigated the closure of the IRS Procurement Project by 30th November 2022. Continuation of the overall project will continue with the IRS Implementation Project, managed by Velindre Cancer Centre.

7.20 The final costs for the IRS Procurement Project are £0.178m, as outlined below:

Pay	£0.083m
Legal Advisors	£0.092m
Other Costs	£0.003m
Total costs	**£0.178m**

7.21 Estimated costs of £0.127m in 2022/23 for bunker refurbishment LA5 previously reported by the Project will now be covered directly by funding provided directly from the FBC and have been removed from the final Project costs.

7.22 Of the £0.434m funding ring fenced from the core Trust discretionary programme for the project in lieu of FBC approval, only the final requirement of £0.178m will be drawn down. However, as there is provision to fund these costs from the FBC funding letter provided by WG, this will reimbursed back to the discretionary programme for utilisation elsewhere within the Trust.

7.23 There is no revenue requirement for the Project in 2022/23.

7.24 The capital position for the IRS Project for 30th November 2022 is outlined below, with a breakeven position forecast for the year.

IRS Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Pay	£0.083m	£0.083m	£0.083m	£0
Non Pay	£0.095m	£0.095m	£0.095m	£0
Total	**£0.178m**	**£0.178m**	**£0.178m**	**£0**

7.25 There is a risk of the final legal fee being higher than expected. However, it is not anticipated that this will be a significant amount. There are no financial risks relating to the IRS Procurement Project.

Service Delivery and Transformation Project

7.26 The total revenue funding for 2022/23 is £0.180m from NHS Commissioners' funding and £0.131 from Trust reserves. The provisional pay award funding of £0.010m in 2022/23 previously reported will not be drawn down as the increased costs will be covered from within the SDT project for this financial year. The resulting budget is **£0.311m** for this financial year.

7.27 There is no capital funding requirement for the Project in 2022/23.

7.28 The SDT Project revenue position as at 30th November 2022 is shown below.

SDT Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Pay	£0.207m	£0.288m	£0.288m	£0
Non Pay	£0.000m	£0.023m	£0.023m	£0
Total	**£0.207m**	**£0.311m**	**£0.311m**	**£0**

7.29 The forecast spend review in November 2022 has resulted in an adjustment to the pay and non-pay budgets to align them with the new forecasts.

7.30 There is a low financial risk of an underspend due to a delay in project and support work carried out by the SDT Project. However, plans are being developed to mitigate this risk.

8. KEY RISKS AND MITIGATING ACTIONS

8.1 There are currently three key financial risks to the Programme:

- A further underspend within the Enabling Works Project as a result of the delay in key project activities;
- Increased advisory fees to conclude the tender evaluation stage and Successful Participant to Financial Close stage; and
- Further legal fees relating to the Judicial Review matter.

8.2 These risks have mitigation plans in place or being developed by the relevant Project Teams.

9. TCS SPEND REPORT SUMMARY

9.1 This update is currently being developed.

APPENDIX 1: TCS Programme Budget and Spend 2022/23 as at 30th November 2022

CAPITAL	Year to Date			Financial Year		
	Budget Nov-22	Spend Nov-22	Variance Nov-22	Annual Budget	Annual Forecast	Annual Variance
	£	£	£	£	£	£
PAY						
Project Leadership	139,184	138,922	262	208,776	207,909	867
Project 1b - Enabling Works FBC	146,496	224,227	-77,731	219,744	334,878	-115,134
Project 2a - New Velindre Cancer Centre OBC	723,023	630,971	92,052	1,065,097	967,269	97,828
Project 3a - Radiotherapy Procurement Solution	82,882	82,882	0	82,882	82,882	0
Capital Pay Total	**1,091,584**	**1,077,002**	**14,582**	**1,576,498**	**1,592,937**	**-16,439**
NON-PAY						
nVCC Project Delivery	44,790	41,078	3,712	84,000	81,518	2,482
Project 1b - Enabling Works FBC	6,382,205	5,822,053	560,152	15,200,014	14,279,737	920,278
Project 2a - New Velindre Cancer Centre OBC	627,015	1,261,984	-634,969	731,127	1,627,894	-896,767
Project 3a - Radiotherapy Procurement Solution	95,119	95,119	0	95,119	95,119	0
Capital Non-Pay Total	**7,149,128**	**7,220,233**	**-71,105**	**16,110,260**	**16,084,267**	**25,993**
CAPITAL TOTAL	**8,240,713**	**8,297,235**	**-56,523**	**17,686,758**	**17,677,204**	**9,554**

REVENUE	Year to Date			Financial Year		
	Budget Nov-22	Spend Nov-22	Variance Nov-22	Annual Budget	Annual Forecast	Annual Variance
	£	£	£	£	£	£
PAY						
Programme Management Office	164,559	164,559	0	286,809	286,809	0
Project 6 - Service Change Team	207,150	207,328	-178	288,000	288,000	0
Revenue Pay total	**371,709**	**371,887**	**-178**	**574,809**	**574,809**	**0**
NON-PAY						
nVCC Project Delivery	21,332	21,332	0	30,000	30,000	0
nVCC Judicial Review	33,000	33,000	0	33,000	33,000	0
Programme Management Office	6,300	6,300	0	13,191	13,191	0
Project 6 - Service Change Team	178	0	178	23,000	23,000	0
Revenue Non-Pay Total	**60,810**	**60,632**	**178**	**99,191**	**99,191**	**0**
REVENUE TOTAL	**432,519**	**432,519**	**0**	**674,000**	**674,000**	**0**

APPENDIX 2: TCS Programme Funding for 2022/23

Description	Funding Type	
	Capital	Revenue
Programme Management Office	**£0m**	**£0.300m**
Commissioner's funding		£0.300m
Pay Award Funding – assumed (September 2022)		£0.010m
Pay Award Funding – reversed (November 2022)		-£0.010m
Enabling Works OBC	**£15.420m**	**£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	
New Velindre Cancer Centre OBC	**£2.089m**	**£0.073m**
2022/23 CEL from Welsh Government funding for nVCC OBC (March 2021	£2.089m	
Trust revenue funding from reserves		£0.063m
Integrated Radiotherapy Procurement Solution	**£0.178m**	**£0m**
Trust Discretionary Capital Allocation	£0.434m	
Reduction in requirement of capital funding	-£0.256m	
Radiotherapy Satellite Centre	**£0m**	**£0m**
No funding requested or provided for this project to date		
SACT and Outreach	**£0m**	**£0m**
No funding requested or provided for this project to date		
Service Delivery, Transformation and Transition	**£0m**	**£0.311m**

Description	Funding Type	
	Capital	Revenue
Commissioner's funding Trust revenue funding from reserves Pay Award Funding – assumed (September 2022) Pay Award Funding – reversed (November 2022)		£0.120m £0.191m £0.010m -£0.010m
VCC Decommissioning No funding requested or provided for this project to date	**£0m**	**£0m**
Total	**£17.687m**	**£0.684m**

Canolfan Ganser Felindre
Velindre Cancer Centre

Workforce Monthly Report

November 2022

Gwasanaeth Gwaed Cymru
Welsh Blood Service

Workforce Report provides the following:

- Overview of Key Performance Indictors for Sickness, PADR, Statutory and Mandatory training in all Divisions of the Trust, including Corporate Divisions, TCS and Research and Development (excluding hosted);
- Corporate Divisions include Finance, Workforce and OD, Corporate Estates and Planning, Corporate IT, Clinical Governance, Infection Control, Fundraising and Trust Management and Board;
- The report provides a 12 monthly trend report for Sickness, PADR, Statutory and Mandatory training;
- Hotspots identified, with in month actions to explain improvement trajectory work. Hotspots defined as areas where KPIs are not met and there has been a downward trend over the last three months;
- In month Job Planning figures with narrative to notify areas of improvement;
- Usage of Work in Confidence platform.

At a Glance for Velindre (Excluding Hosted)

Velindre (Excluding Hosted	Current Month	Previous Month	Target
	Nov-22	Oct-22	
PADR	75.40	71.24	85%
Sickness	6.19	6.30	3.54%
S&M Compliance	86.79	85.69	85%

Workforce Dashboard

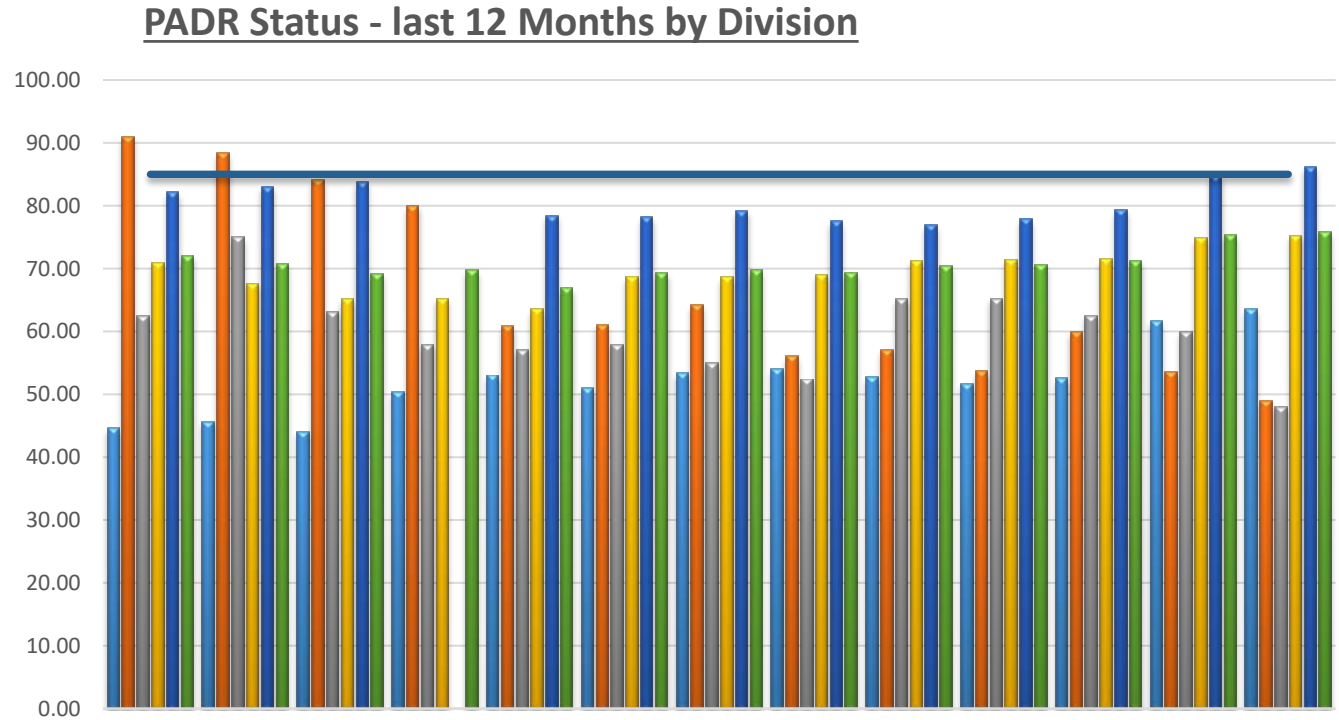
Data below highlights rolling figures for workforce KPI's. This provides a running total of the values of the last 12 months of an indicator providing trend data for the indicators. Granular monthly data is generated for divisions as separate reports. Data RAG rated for ease of reading.

Key	85%-100%		50% - 84.99%		0% - 49.99%								
These figures exclude Trainee Doctors, those on Maternity, Starters within first 6 Months, those currently off on sickness absence.													
PADR	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Corporate	44.59	45.64	44.08	50.33	53.02	51.01	53.38	54.05	52.74	51.72	52.63	61.69	63.64
Research, Development & Innovation	90.91	88.37	84.09	80.00	60.87	60.98	64.29	56.10	57.14	53.66	60.00	53.49	48.89
Transforming Cancer Services	62.50	75.00	63.16	57.89	57.14	57.89	55.00	52.38	65.22	65.22	62.50	60.00	48.00
Velindre Cancer Centre	70.90	67.61	65.16	65.25	63.56	68.69	68.62	69.04	71.30	71.47	71.50	74.90	75.23
Welsh Blood Service	82.19	83.06	83.73	81..75	78.44	78.16	79.26	77.53	76.90	77.86	79.27	84.67	86.17
Velindre Organisations	72.11	70.83	69.21	69.75	66.86	69.24	69.81	69.29	70.45	70.61	71.24	75.40	75.80
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85

Key	85%-100%		50% - 84.99%		0% - 49.99%								
These figures exclude those on Maternity and those currently off with sickness absence													
Stat and Mand Compliance (10x CSTF)	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Corporate	72.32	74.40	72.17	73.64	74.51	73.48	74.31	74.41	73.06	71.95	73.84	76.12	77.14
Research, Development & Innovation	84.58	85.83	84.26	80.42	80.21	80.23	79.56	82.95	81.09	80.22	84.77	87.45	87.23
Transforming Cancer Services	83.33	81.43	77.86	77.39	77.39	78.64	80.91	76.96	75.65	75.42	77.20	79.23	80.38
Velindre Cancer Centre	84.91	84.93	84.73	84.18	84.88	85.17	85.46	85.22	84.68	84.39	85.01	84.92	85.31
Welsh Blood Service	93.36	93.56	93.78	92.02	92.30	92.19	92.44	93.17	91.72	92.19	91.33	90.96	93.75
Velindre Organisations	86.06	86.40	85.97	85.26	85.77	85.76	85.08	86.20	85.27	85.10	85.49	85.69	86.79

Key	0% - 3.54%		3.55% - 4.49%		4.5 % & Above								
Sickness Rolling %	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Corporate	5.01	5.34	5.48	5.53	5.57	5.63	5.59	5.37	5.19	4.99	4.72	4.49	4.21
Research, Development & Innovation	4.41	4.31	4.51	4.81	5.41	6.21	6.84	7.29	7.32	7.42	7.36	7.38	7.53
Transforming Cancer Services	1.29	1.01	0.98	1.05	1.10	1.24	1.27	1.24	1.21	1.15	1.07	1.10	0.90
Velindre Cancer Centre	5.63	5.51	5.56	5.63	5.92	6.15	6.24	6.32	6.44	6.47	6.35	6.32	6.24
Welsh Blood Service	5.99	6.27	6.45	6.53	6.80	7.04	7.04	7.18	7.40	7.32	7.20	7.19	7.06
Velindre Organisations	5.58	5.63	5.73	5.81	6.07	6.30	6.36	6.42	6.53	6.50	6.36	6.30	6.19
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

PADR – The Figures



	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Corporate	44.59	45.64	44.08	50.33	53.02	51.01	53.38	54.05	52.74	51.72	52.63	61.69	63.64
Research, Development & Innovation	90.91	88.37	84.09	80.00	60.87	60.98	64.29	56.10	57.14	53.66	60.00	53.49	48.89
Transforming Cancer Services	62.50	75.00	63.16	57.89	57.14	57.89	55.00	52.38	65.22	65.22	62.50	60.00	48.00
Velindre Cancer Centre	70.90	67.61	65.16	65.25	63.56	68.69	68.62	69.04	71.30	71.47	71.50	74.90	75.23
Welsh Blood Service	82.19	83.06	83.73	0.00	78.44	78.16	79.26	77.53	76.90	77.86	79.27	84.67	86.17
Velindre Organisations	72.11	70.83	69.21	69.75	66.86	69.24	69.81	69.29	70.45	70.61	71.24	75.40	75.80
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85

PADR – The Narrative

Performance Indicator	RAG / change from previous month	Oct Figure	Hotspot Areas	%	Comment
PADR Compliance (85%)	**76%** ↑	75%	**Welsh Blood Service (86%)**		
			Directors	50%	*Same as previous month* Identified issue with manager accuracy imputing PADRS dates into the system. This issue has now been rectified and data should be updated from December onwards.
			Velindre Cancer Centre (%)		
			CSMO	54%	Increase from previous month (44%) Targeted interventions being undertaken with SBP and monitored in monthly performance meetings with SLT.
			Clinical Audit	33%	*Decrease on previous month (50%)* Due to the low headcount in this department (3 total) the outstanding PADR is due to absence.
			Outpatients	48%	*Decrease on previous month (52%)*
			Corporate Areas (53%)		
			RD&I	49%	*Decrease on previous month (53%)* TCS compliance has declined month on month for the past 3 months and is therefore now considered a hotspot area. WOD continue to support managers in completing PADR's in an accurate and timely manner.
			TCS	48%	*Decrease on previous month (60%)* TCS compliance has declined month on month for the past 3 months and is therefore now considered a hotspot area. Senior Managers have noted the compliance dip and a targeted

					review is taking place during January to improve compliance with support from SBP.

Action/reasons/initiatives:

Velindre University NHS Trust

PADRs across the Trust continue to steadily increase (4% increase in comparison to November 2021 compliance) and the new Pay Progression Policy is now fully live and operational across the organisation.

WBS

PADR Compliance has increased again this month, after a sustained effort from the teams to increase compliance following pay progression discussions. Compliance is reporting above the target of 85%.

VCC

PADR rates continue to increase month on month (4% since Nov 21) however they remain below Trust target level of 85%

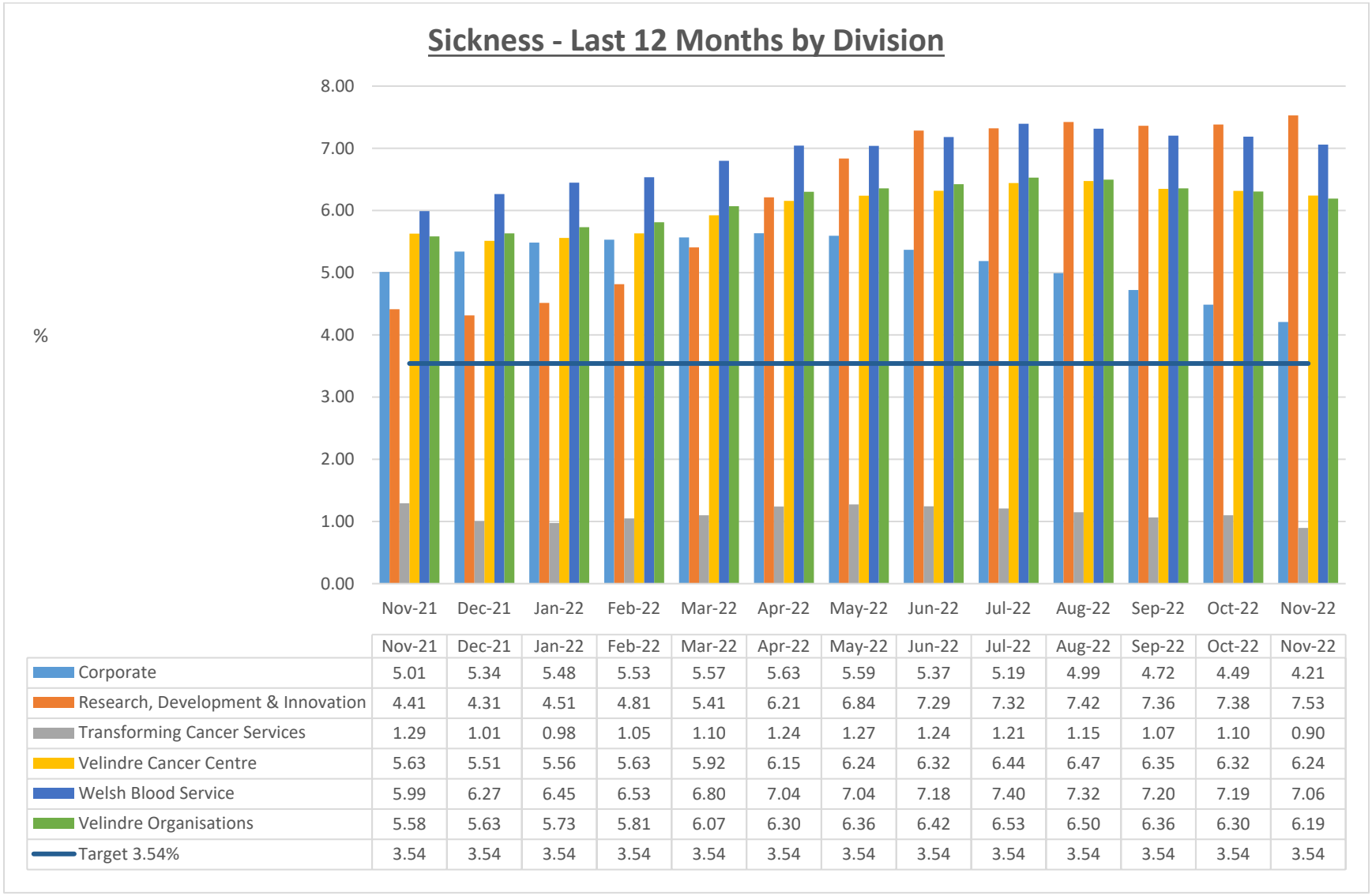
Targeted intervention has taken place in CMSO with the significant improvement of 10% on last month's figures as demonstrated in the hotspot table above.

Corporate Services

Two areas identified as new hotspots, TCS and RD&I after 3 consecutive months of PADR decline. Senior Managers will work with WOD colleagues to improve compliance and identify issues of concern in January 2023.

Corporate PADR compliance continues to rise month on month with a significant growth of 19% since November 2021. WOD Senior BP will continue to support managers in ensuring PADRs are completely in a timely and accurate manner.

Sickness Data – The Figures



	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Corporate	5.01	5.34	5.48	5.53	5.57	5.63	5.59	5.37	5.19	4.99	4.72	4.49	4.21
Research, Development & Innovation	4.41	4.31	4.51	4.81	5.41	6.21	6.84	7.29	7.32	7.42	7.36	7.38	7.53
Transforming Cancer Services	1.29	1.01	0.98	1.05	1.10	1.24	1.27	1.24	1.21	1.15	1.07	1.10	0.90
Velindre Cancer Centre	5.63	5.51	5.56	5.63	5.92	6.15	6.24	6.32	6.44	6.47	6.35	6.32	6.24
Welsh Blood Service	5.99	6.27	6.45	6.53	6.80	7.04	7.04	7.18	7.40	7.32	7.20	7.19	7.06
Velindre Organisations	5.58	5.63	5.73	5.81	6.07	6.30	6.36	6.42	6.53	6.50	6.36	6.30	6.19
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

Sickness – The Narrative

Performance Indicator	RAG/ Change from previous month	Oct Figure	Hotspot	%	Comment
Sickness absence (3.42%)	**6%** →	6%	**Welsh Blood Service (7%)**		
			Collections	10%	*Same as previous month (10%)* The People and Relationships team continue to support managers in the application of MAWW policy. Sickness audits underway with expected outcomes in late January 2022.
			Laboratory	8%	*Increase on previous month (7%)* Outcome of targeted Respect and Resolution interventions to be collated for SMT and further action will be required.
			Velindre Cancer Centre (6%)		
			Clinical Audit	12%	*Decrease on previous month (14%)* Due to the smaller nature of the department one absence has had significant impact on the overall sickness compliance of the team.
			Outpatients	14%	*Decrease on previous month (15%)* The People and Relationships team continue to support managers in the application of MAWW policy.
			Private Patients	9%	*Same as previous month (9%)* In month absence has declined and it is expected the rolling absence compliance will decline as the year progresses.
			Information Section	9%	*Increase on previous month (7%)* New hotspot areas due to increasing compliance month on month. Detailed analysis required by services leads and WOD Business Partner.

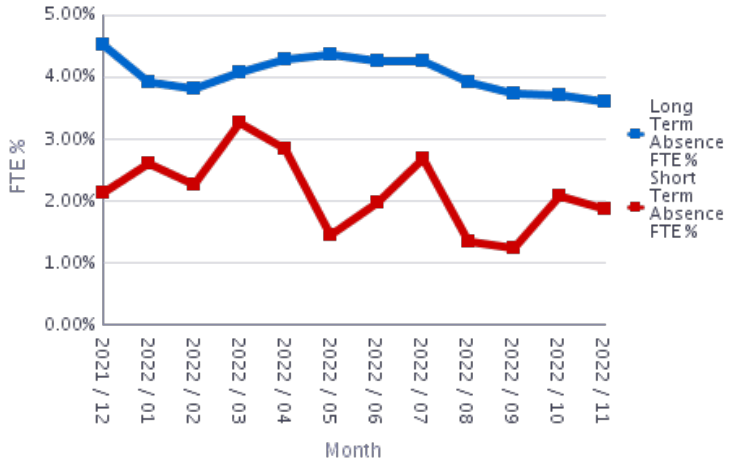
		Operational Services	9%	*Increase on previous month (8%)* New hotspot areas. Operational services were removed from the hotspot category after significant improvement in absence earlier in the year however they now have 3 consecutive months of absence growth which is a cause for concerns to be further analysed by Senior BP and service leads.
		Corporate Areas (4%)		
		Clinical Corporate Governance	12%	*Same as previous month (12%)* Highly complex long-term sickness cases remain the primary concern for the department and these cases are being managed in line with the MAWW policy.
		RD&I	7%	*Same as previous month (7%)* Long-term absence cases remains to be the primary concern in RD&I and cases are being managed in line with the MAWW policy.
		TCS	0%	The spike in short-term absence in the month of October has ended and TCS absence has returned to its normal position. This will be removed as a hotspot.

Velindre University NHS Trust

Long Term Sickness (in month) **1.87%**
Short Term Sickness (in month) **3.59%**

The graph opposite shows the changing position of long and short term sickens (rolling 12 months) absence. There is an overall decline in long-term and short-term sickness as the People and Relationship Team continue to support managers in the application of the MAWW policy.

Anxiety/stress/depression/other psychiatric illnesses remains the highest reason for absence across the Trust at 31% and wellbeing drop in



session have been scheduled to support staff and glean useful qualitative data for improving this figure.

WBS

Long Term Sickness (in month) **2.18%**
Short Term Sickness (in month) **4.72%**

Stress/Anxiety related absence continues to be the highest reason of all absences over the last 12 months, at a slightly increased rate this month, of 36.8% coupled with a turnover rate (12 month) is reported at 17.26% there has been a need for targeted intervention within WBS to understand any correlation and provide analysis to this quantitative day.

Ongoing interventions and collation of qualitative data from within hotspot areas and this information is being prepared for SMT in January 2022 which will also become part of ongoing OD interventions regarding culture and values within the organisation.

VCC

Long Term Sickness (in month) **3.14%**
Short Term Sickness (in month) **2.04%**

In month sickness has increased slightly once more in November 5.18% and managers continue to manage cases in line with the MAWW policy. Sickness Audits undertaken in departments across VCC have shown no cause for concern in relation to the application of the MAWW policy.

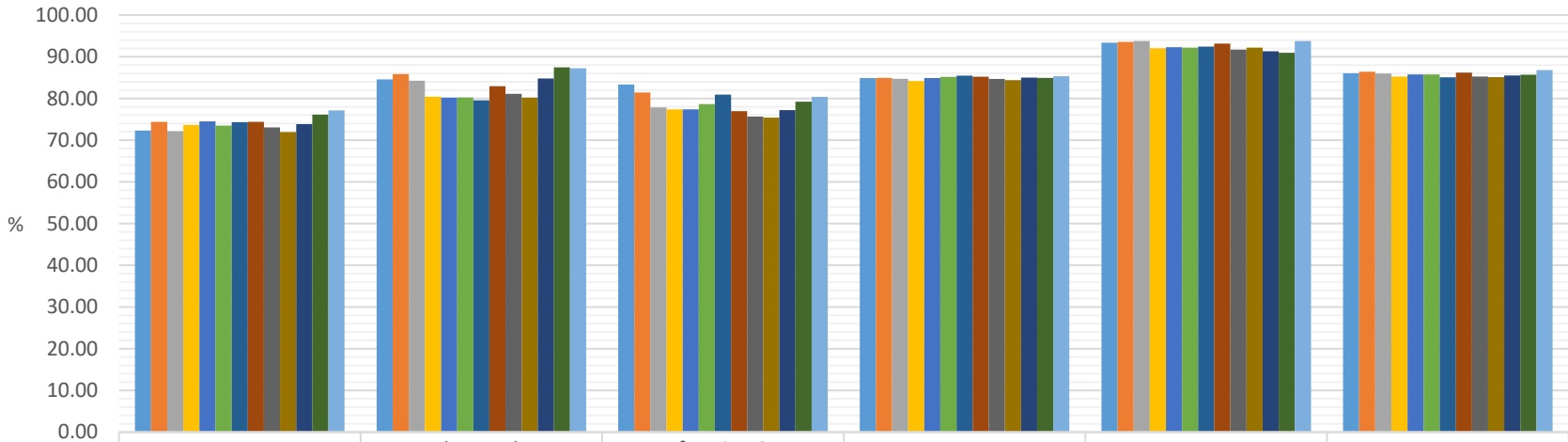
Corporate Areas (including RD&T, HTW & TCS)

Long Term Sickness (in month) **3.43%**
Short Term Sickness (in month) **0.71%**

The significant increase in short–term absence seen in October 2022 has returned to normal in the month of November.

There are several ongoing complex long-term absence cases in Corporate and RD&I that are being managed sensitively and in line with the MAWW policy.

Statutory and Mandatory Figures – The Figures



	Corporate	Research, Development & Innovation	Transforming Cancer Services	Velindre Cancer Centre	Welsh Blood Service	Velindre Organisations
Nov-21	72.32	84.58	83.33	84.91	93.36	86.06
Dec-21	74.40	85.83	81.43	84.93	93.56	86.40
Jan-22	72.17	84.26	77.86	84.73	93.78	85.97
Feb-22	73.64	80.42	77.39	84.18	92.02	85.26
Mar-22	74.51	80.21	77.39	84.88	92.30	85.77
Apr-22	73.48	80.23	78.64	85.17	92.19	85.76
May-22	74.31	79.56	80.91	85.46	92.44	85.08
Jun-22	74.41	82.95	76.96	85.22	93.17	86.20
Jul-22	73.06	81.09	75.65	84.68	91.72	85.27
Aug-22	71.95	80.22	75.42	84.39	92.19	85.10
Sep-22	73.84	84.77	77.20	85.01	91.33	85.49
Oct-22	76.12	87.45	79.23	84.92	90.96	85.69
Nov-22	77.14	87.23	80.38	85.31	93.75	86.79

Statutory and Mandatory Figures – The Narrative

Performance Indicator	RAG/ Change from previous month	Oct Figure	Hotspot	%	Comment to include reasons for change / rates high or low
Stat & Mand Training (85%)	**87%** ↑	85%	**Welsh Blood Service (94%)**		
			Continuously above target for over 12 months		
			Velindre Cancer Centre (85%)		
			Continuously at or above target for 8 months		
			Corporate Areas (81%)		
			Corporate Management Section	64%	Same as previous month 64%
			Fundraising	57%	Same as previous month 57%

Action/ initiatives:

Velindre University NHS Trust

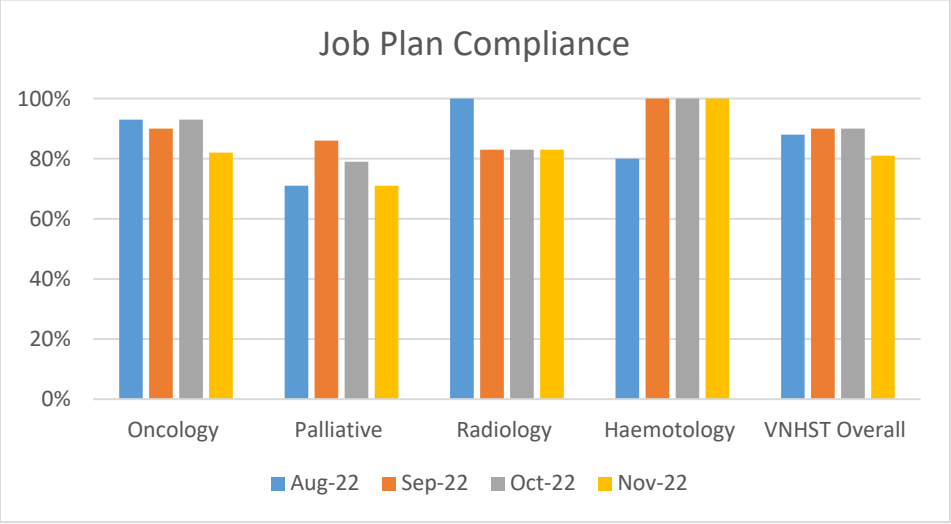
Statutory and Mandatory compliance remains within target across the Trust for the year (December 21 – November 22) and in comparison to this time last year (Nov 21) compliance is up by 1% overall.

The Education and Development team are currently working on developing a new virtual reality training programme for fire safety that will immerse the learner into an exact replica of their work environment providing different fire scenarios they may face and allowing them to virtually decide on the appropriate action to be taken.

Job Planning

Job planning data as of 24th November 2022, not including new starters, maternity leave or long-term sickness

Directorate	Role	Assignment Count	Job Plans Completed	Percentage of Job Plans completed
Oncology	Overall	45	37	82.22%
	Clinical Oncologists Consultan	36	28	77.78%
	Medical Oncologist Consultant	8	8	100.00%
	Specialty Doctors	1	1	100.00%
Palliative	Overall	14	10	71.43%
	Palliative Care Consultants	13	9	69.23%
	Specialty Doctors	1	1	100.00%
Radiology	Overall	6	5	83.33%
	Radiology Consultants	6	5	83.33%
	Specialty Doctors	1	1	100.00%
Haemotology	Overall	5	5	100.00%
	WBS Consultants	4	4	100.00%
	Specialty Doctors	1	1	100.00%
NWSSP	Overall	0	0	#DIV/0!
	Medical Examiners	0	0	#DIV/0!
VNHST	Overall	70	57	81.43%



Work In Confidence (WIC)

No new concerns have been raised via the Work in Confidence platform in relation to behaviour of colleagues.

In all contacts with staff, staff are encouraged, where appropriate, to share their concerns with their Line Manager (or next appropriate Manager), in order to achieve an early, informal resolution.

Quality, Safety and Performance Committee

Gender Pay Gap Report 2022

DATE OF MEETING	17 January 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Claire Budgen: Head of Organisational Development,
PRESENTED BY	Sarah Morley, Executive Organisational Development & Workforce
EXECUTIVE SPONSOR APPROVED	Sarah Morley, Executive Organisational Development & Workforce
REPORT PURPOSE	ENDORSE FOR BOARD APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	5.12.22	ENDORSED FOR APPROVAL

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 apply to a list of 'specified public authorities' in relation to the publication of their gender pay gap data, which came into force on 31 March 2017. These regulations underpin the Public-Sector Equality Duty and require relevant organisations to publish their gender pay gap by 30 March each year. This includes the mean and median gender pay gaps; the mean and median gender bonus gaps; the proportion of men and women who received bonuses; and the proportions of male and female employees in each pay quartile.

1.2 It is important for the Trust to analyse its pay data, to gain an understanding of any gaps, what this means for its workforce and as appropriate, use this information and data to develop an action plan that will respond to bridging any identified gender pay gaps.

1.3 The analysis of pay data as of 30 March 2022 was conducted earlier in the year than usual to allow the Trust to understand its current situation before developing the actions included in this report. The deadline for reporting these figures remains 30 March 2023.

1.4 The report attached therefore provides the Executive Management Board with the information to endorse for Board Approval the publication of the Trust Annual Gender Pay Gap Report.

2. ASSESMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The attached report provides data and narrative of activities for the mean and median gender pay gaps; the mean and median gender bonus gaps; the proportion of men and women who received bonuses; and the proportions of male and female employees in each pay quartile to ensure the Trust meets its legal requirements.

2.2 The report shows information of the summary of statistics below that are being detailed in the Gender Pay Gap Report.

<table>
<tr>
<td rowspan="2">The Mean Gender Pay Gap is £0.88 an hour. Women are paid 4% less than men. The mean average hourly rate is £19.83 for women and £20.72 for men.</td>
<td rowspan="2">The Median Gender Pay Gap is £0.44 an hour. Women are paid 2% less than men. The median average hourly rate is £17.94 for women and £18.38 for men.</td>
<td>Men's mean bonus payment is £3,113 more than women's, a Mean Bonus Pay Gap of 43%</td>
</tr>
<tr>
<td>Men's median bonus payment is £307 more than women's, a Median Bonus Pay Gap of 9%</td>
</tr>
</table>

2.3 This report also analyses the situation for Velindre core services, when NHS Shared Services Partnership data is excluded. This level of detail has shown a different picture than that for the legal entity as a whole. In particular:

- The Mean Gender Pay Gap is 14%, not 4%. This is shown in context of Welsh Health Boards who have reported Gender Pay Gaps of 21%, 28% and 32% over the past two years.

- The Mean Bonus Gap is 47%, not 43%. However, the Median Bonus Gap falls from 9% for the combined figure to -7% for Velindre only, which means when looking at the median of bonus payments made to all staff, women are paid more than men. Thirty-four staff received a bonus in 2021-22, 20 women and 14 men, all within the Medical staff group.

- There is variation in the Gender Pay Gap depending on Staff Group. There is a gap for Medical and Dental of 3.2%, Estates and Ancillary of 4.5% and Nursing and Midwifery of 5.3%, all of which should be addressed. However, the key determinant of the 14% Gender Pay Gap is the 26.2% Gender Pay Gap for Administrative and Clerical where male staff are disproportionately represented in the higher pay bands.

2.4 Five actions were agreed in March 2022 linked to the previous Gender Pay Gap report. Progress with these actions over the past three months is listed below.

Actions set in March 2022	**Progress as at November 2022**
Pursue the Strategic Equality Objectives including eliminating pay gaps by 2024	All actions below support the elimination of gender pay gaps by 2024. This will be supplemented by consideration of the pay gaps for other groups, such as the Race Pay Gap, during 2022-23.
Undertake a programme of work offering opportunities for women to develop their leadership skills, build career aspirations and take on more senior roles. There will be a particular focus on female Medical staff in light of the bonus pay implication of the Clinical Excellence Award scheme.	Two delegates completed the HEIW Talent Management Practitioner programme to allow the Trust to move forward with building career pathways to more senior roles, including supporting under-represented groups such as women. This work is being led by the Executive Director of OD and Workforce and will benefit from the sponsorship from the Executive Ambassador for Gender.

	Nationally, the Clinical Excellence Award Scheme has been changed to the National Clinical Impact Award Scheme specifically to counteract the Gender Pay Gap that resulted from the previous scheme.
Improve recruitment processes and to ensure gender-sensitive language in adverts, gender-blind shortlisting and decision making and unconscious bias training for recruiting managers. Ensure all new staff understand how and when to apply for incremental credit on appointments.	The Attraction, Reward and Recognition project has been initiated to improve our approach to attracting and retaining talent. This includes reducing bias and promoting inclusivity. The process for applying for incremental credit on appointment has been revised and is now an integral part of the recruitment process.
To promote inclusive language when working externally in schools, colleges and within education and development training inside our organisation. To keep raising awareness and continue creating a culture of inclusivity.	The Trust has a Widening Access Coordinator who works with schools and colleges to improve access to NHS jobs and careers. The Inspire Leadership Development programme includes a module on Equality, Diversity and Inclusion which is supporting the development of an inclusive culture.
Supporting all staff equally in developing, through leadership, coaching and mentoring.	Leadership is one element within the Building our Future Together portfolio. During 2022-23 the Trust will be building resources for staff to access leadership development, coaching and mentoring. This will allow women, or other people who are currently underrepresented at more senior levels, to progress their professional development and their careers.

2.5 The actions for 2022-23 have been refined, taking into account the findings from the Gender Pay Gap as at March 2022 and these fall into six areas:

1. **Listening to women.** We will offer options for staff, male and female, to share their experiences and ideas relating to improving gender equality in the workplace. This will include options such as setting up an internal Gender Equality Network, joining other external Equality Networks and/or the introduction of Allyship in support of women.

2. **Implementing our Education Strategy in an equal and fair way**, supporting all staff in their personal and professional development. During the year we will develop a Talent Management approach based on principles of inclusion. This will be demonstrated through the range of leadership development and coaching and mentoring opportunities that are taken up by women and men. This will be offered in a way that does not unintentionally exclude any groups of staff, including on basis of gender or race. The allocation of funding for Study Leave will be reviewed to ensure fairness across the Trust.

3. **Utilising our development projects such as nVCC to create development opportunities for people at all levels of the organisation.** Where necessary, additional encouragement will be offered to offset any gender disparity in uptake. Project roles and responsibilities will be offered as development opportunities to existing staff, either as a secondment or as an addition to their current role.

4. **To deliver an Attraction, Recruitment and Retention project** to achieve effective and inclusive approaches to bringing people into our organisation and encouraging them to remain with us. This includes improving the recruitment processes to ensure that we use gender-sensitive language in adverts and use gender-neutral pronouns and clean language to prevent us from potentially putting women off from applying for positions. This will include highlighting all Agile working and family-friendly benefits and ensuring all new staff understand how and when they can apply for incremental credit on appointment. This will benefit all genders of applicants and offer an environment for more women to put themselves forward for employment.

5. **To promote inclusive language within education and development training inside our organisation, to keep raising awareness and continue to develop a culture of inclusivity**. Develop and deliver unconscious bias training that can firstly be delivered to managers so they can role model expected behaviours creating a peer-learning environment that models the values of the organisation.

6. **Monitoring of engagement with initiatives by gender.** The proportion of male and female staff taking up education programmes and development opportunities will be monitored to highlight if positive action is required. Analysis of recruitment will show whether job applications receive equal outcomes for men and women, from application, shortlisting and appointment.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
	The work described in the response to the gender pay gap analysis will benefit people on the basis of gender and also other protected characteristics
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Legal requirement to publish by 30 March 2023
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

The Quality, Safety and Performance Committee is asked to **ENDORSE** the report for Trust Board approval.

GIG CYMRU NHS WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

GENDER PAY GAP

2022 REPORT

FORWARD

Velindre University NHS Trust aims to ensure that people are treated fairly and equally at work. Our focus ensures that staff has the same access and opportunities to reward, recognition, and career development.

The Trust believes that it is important to analyse its pay data, to gain an understanding of any gaps, what this means for our workforce, and as appropriate, to use this information and data to develop an action plan that will respond to any identified gender pay gaps.

WHAT IS THE GENDER PAY GAP

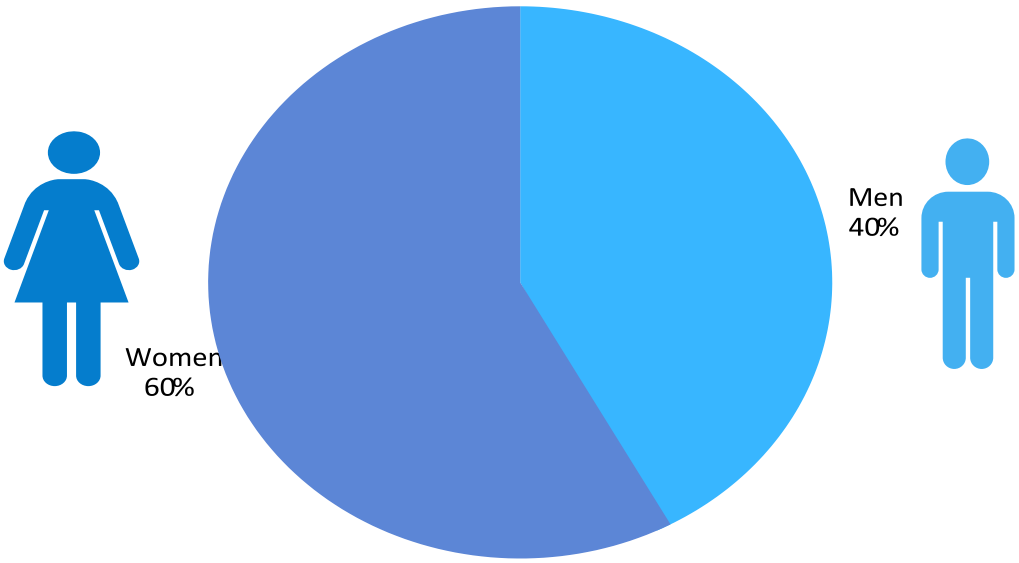
The gender pay gap shows the difference between the average (mean or median) earnings of male and female employees. It should be noted that gender pay gap analysis differs from that of equal pay issues, which deal with the pay differences between male and female employees who carry out the same jobs, or similar jobs, or work of equal value. It is unlawful to pay employees unequally because of their gender.

When gender pay reporting is used to its full potential, it provides a valuable tool to assist an organisation to assess levels of equality in the workplace, male and female participation, and how effectively talent is being maximised. A high gender pay gap can be an indication that there may be a number of issues that the organisation may need to deal with as a matter of priority. The individual gender pay calculations may help the organisation to identify what those issues are.

This document reports pay data on 31 March 2022. It represents Velindre University NHS Trust as a legal entity that also includes hosted organisations, NHS Wales Shared Services Partnership and Health Technology Wales. To better understand our pay gap, we have drilled down to some of the Divisions within the organisation and created actions to address issues which were not evident in the data for the composite organisation.

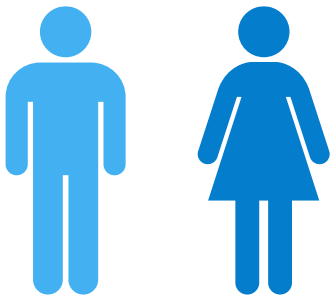
OUR GENDER PAY PROFILE 2022

On 31 March 2022 VUNHST employed 6,420 people, 40% male 60% female.



Mean and Median Pay

The **Mean Gender Pay Gap** is £0.88 an hour. Women are paid 4% less than men. The mean average hourly rate is £19.83 for women and £20.72 for men.



The **Median Gender Pay Gap** is £0.44 an hour. Women are paid 2% less than men. The median average hourly rate is £17.94 for women and £18.38 for men.

Bonus Pay

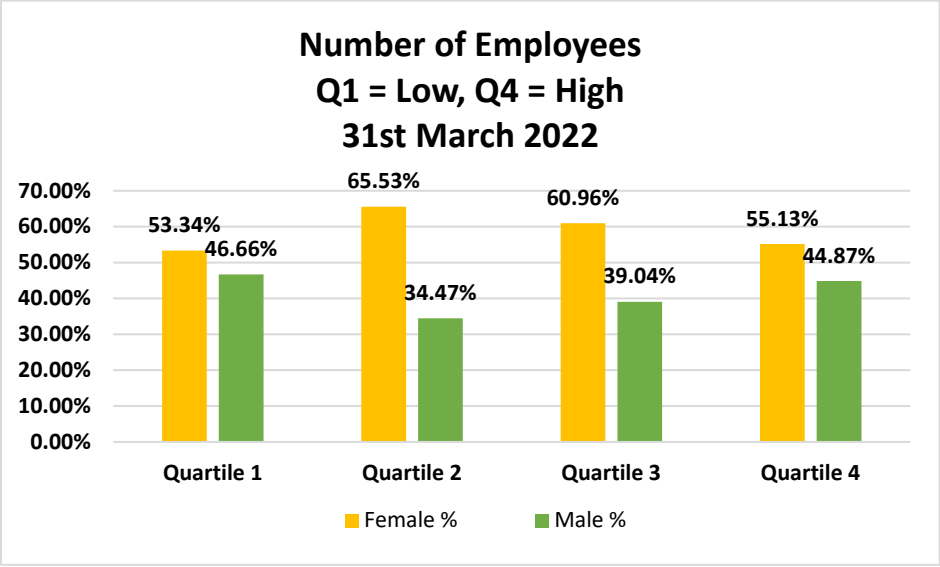
0.93% of men receive a bonus
1.53% of women receive a bonus

Men's mean bonus payment is £3,113 more than women's, a **Mean Bonus Pay Gap** of 43%

Men's median bonus payment is £307 more than women's, a **Median Bonus Pay Gap** of 9%

Quartile Range

When dividing the female workforce and the male workforce into four equal parts, men's pay and women's pay show different patterns with women being clustered in the middle quartiles and men more concentrated in the lowest and highest quartiles.

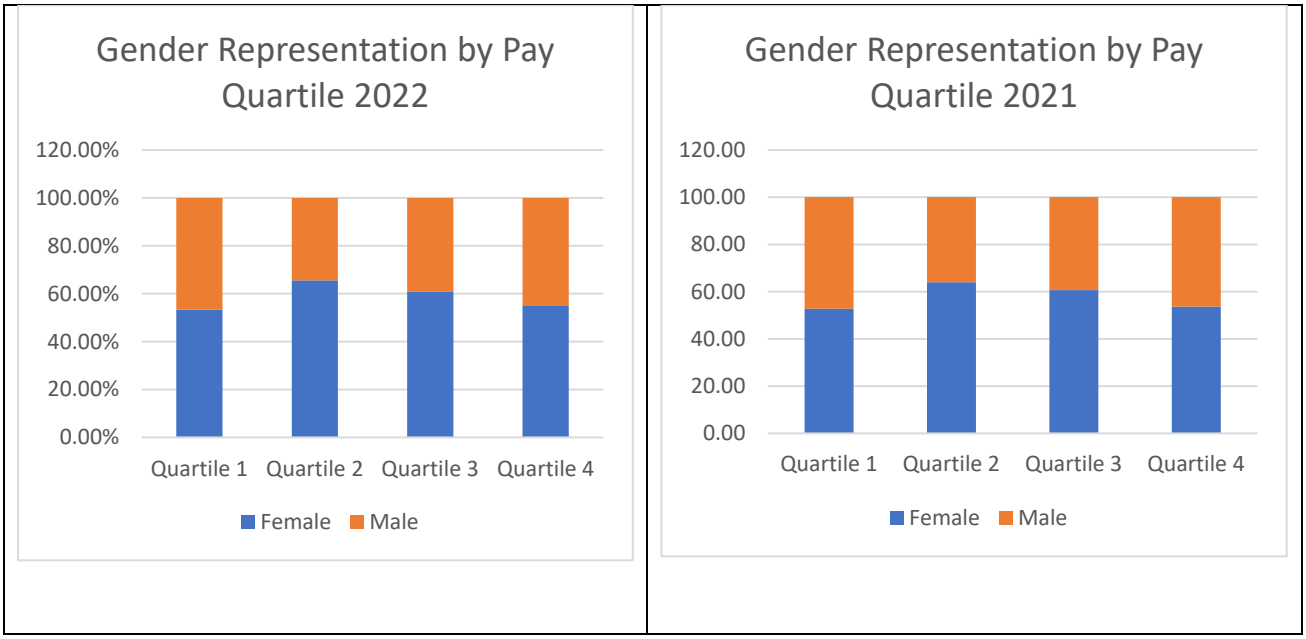


MOVEMENT BETWEEN 2021 AND 2022

The Mean Gender Pay Gap has stayed the same, at 4%. However, the Median Gap has decreased from 7% in 2021 to 2% in 2022.

The Mean Bonus Gap stayed the same at 43% whereas the Median Bonus Gap decreased from 22% to 9%.

The spread between the Quartiles for each gender is also very similar between 2021 and 2022 where we see Women clustered in Quartile 2 and 3 and Men tending to fall more towards either Quartile 1 or 4.



LOOKING BENEATH THE ORGANISATIONAL LEVEL DATA

The above report is based on the legal entity of 6,420 employees, 76% of whom work for NHS Wales Shared Services Partnership. If these people are taken out of the analysis, there are 1,567 employees in Velindre Cancer Centre, Welsh Blood Service and Corporate and other functions.

These 1,567 employees are spread between two Divisions and a combination of Corporate and other functions, as follows:

	Women	Men	Percentage Women	Percentage Men	Total Employees
Velindre Cancer Centre	595	176	77%	23%	771
Welsh Blood Service	315	116	73%	27%	431
Corporate and Other Functions	253	112	69%	30%	365
TOTAL	1,163	404	**74%**	**26%**	**1,567**

This shows that all three groupings are female dominated, with 77% of the Velindre Cancer Centre workforce, 73% of Welsh Blood Service and 69% of Corporate staff being Female.

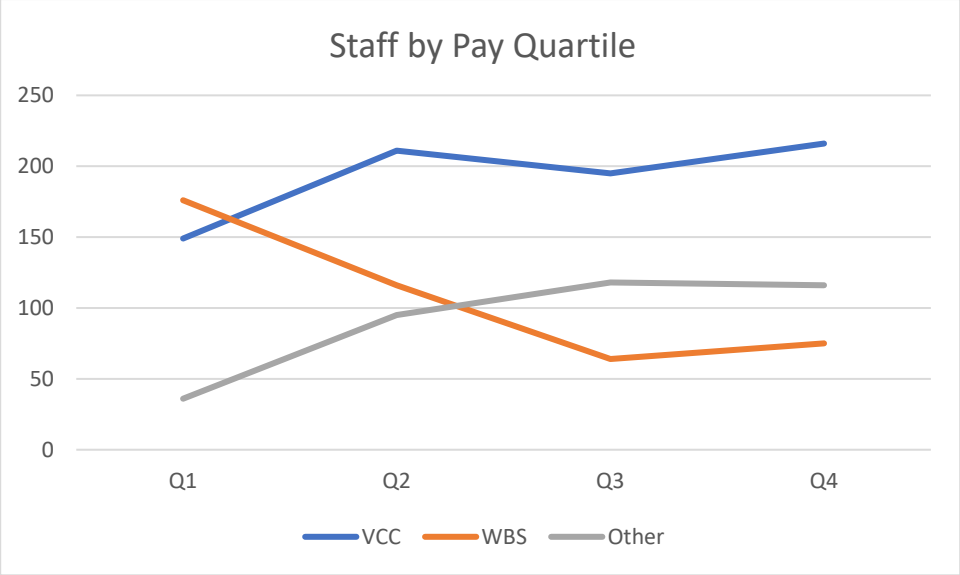
Similarly, all staff groups are predominantly Female, however this becomes particularly pronounced with Allied Health Professionals and Nursing and Midwifery. The Staff Groups are ranked in order of gender diversity below.

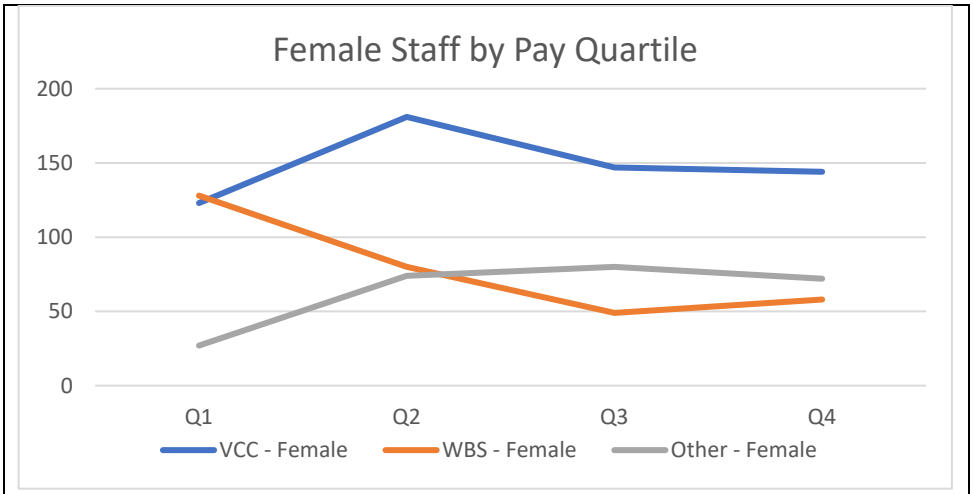
Staff Group	Female to Male Ratio
Estates and Ancillary	53:47
Medical and Dental	58:42
Healthcare Scientists	59:41
Additional Professional, Scientific and Technical	71:29
Administrative and Clerical	75:25
Allied Health Professions	82:18
Nursing and Midwifery	93:7

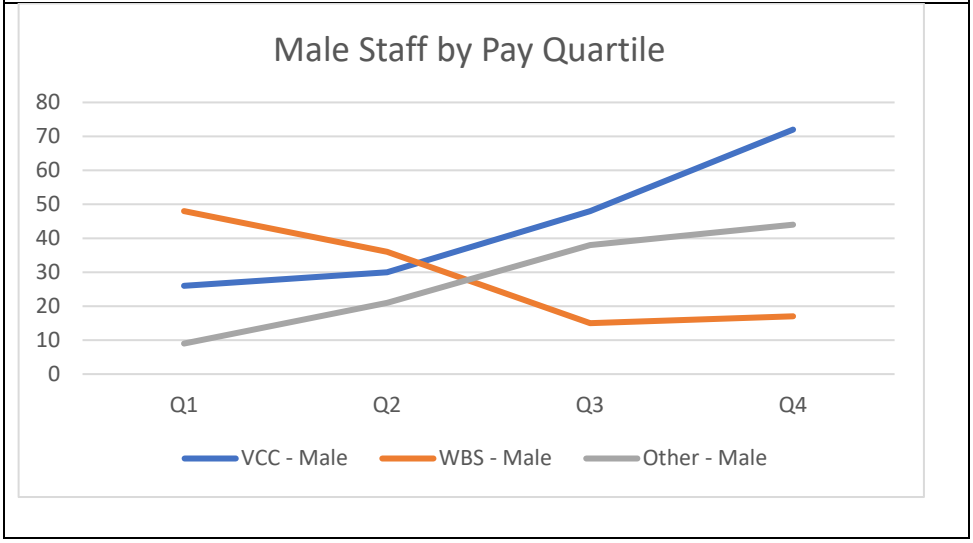
The key statistics for Gender Pay Gap reporting are shown below. This shows a marked difference between the Trust position as a whole and that for Velindre. The Mean Gender Pay Gap increases from 4% to 14% and the Median Bonus Gap changes from 9% to -7% (meaning Women are paid more than Men).

	2022	2022	2022
	Velindre	NWSSP	Combined
Mean Gap	£2.95 an hour	3p an hour	88p an hour
Mean Gap	14%	<1%	4%
Median Gap	65p an hour	0	44p an hour
Median Gap	4%	0	2%
Mean Bonus Gap	£6,648	£813	£3,113
Mean Bonus Gap	47%	25%	43%
Median Bonus Gap	-£434	£1,319	£307
Median Bonus Gap	-7%	37%	9%

When looking into the detail of the spread of pay for all employees we see a difference between Welsh Blood Service and Velindre Cancer Centre and Corporate/Other functions with a higher proportion of staff being with Quartile 1. This difference is not linked to gender, as the graphs below show a similar line for Female and Male staff in Welsh Blood Service.


Staff by Pay Quartile
250
200
150
100
50
0
Q1
Q2
Q3
Q4
VCC
WBS
Other


Female Staff by Pay Quartile
200
150
100
50
0
Q1
Q2
Q3
Q4
VCC - Female
WBS - Female
Other - Female


Male Staff by Pay Quartile
80
70
60
50
40
30
20
10
0
Q1
Q2
Q3
Q4
VCC - Male
WBS - Male
Other - Male

However, what is clear from these graphs is that there is a peak in Females in Velindre Cancer Centre in Pay Quartile 2, which is feeding into the overall pay structure within the Gender Pay Gap analysis.

CONCLUSIONS

- There has been very little change in our headline figures between 2021 and 2022. The Mean Gender Pay Gap stayed at 4% overall with a Mean Bonus Gap remaining at 43%. The Median figures have improved with the Median Pay Gap falling from 7% to 2% and the Median Bonus Gap going from 22% to 9% in the year. However, the gender split in the workforce has become slightly more polarised, going from 58% women in 2021 to 60% women in 2022. This reflects the picture for Velindre University NHS Trust, including NHS Wales Shared Services Partnership.

- When we drill down, we see that although the Mean Pay Gap for the Velindre University NHS Trust is 4%, when Shared Services are discounted it changes to 14%. This shows that specific actions are need in the clinical and corporate areas of the Trust.

- The Bonus Pay Gap reflects a small number of payments which tends to produce larger percentages. Despite there being an overall pay gap for the Trust, there is actually a negative Median Bonus Pay Gap in Velindre meaning that Women's median bonus payment is £434 higher than men's.

- All staff groups are female dominated and this is markedly so in Allied Health Professionals and Nursing and Midwifery. This does not necessarily cause a gender pay gap – it would depend on salaries earned being comparable to those in other staff groups. However, a more even gender balance would be desirable to create more diverse and inclusive teams and help reduce career-based gender stereotypes.

- Welsh Blood Service shows a different spread of people within the four Pay Quartiles, with an over-representation in Quartile 1 and a low representation in Quartiles 3 and 4 but this does not affect either gender specifically. Initiatives to improve career progression within the Welsh Blood Service can improve this trajectory so that the service has a more even distribution of pay.

- When comparing pay for men and women the key issue seen is a disproportionate representation of Women from Velindre Cancer Centre in Pay Quartile 2. This covers hourly salaries between £11.53 an hour and £16.18 an hour (base pay plus enhancements paid during the period) and includes people from all staff groups.

ACTIONS MOVING FORWARD FOR 2022 - 2023

The Trust is committed to its Strategic Equality Objectives including eliminating pay gaps by 2024. The action to achieve this over the next period are:

1. **Listening to women.** We will offer options for staff, male and female, to share their experiences and ideas relating to improving gender equality in the workplace. This will include options such as setting up an internal Gender Equality Network, joining other external Equality Networks and/or the introduction of Allyship in support of women.

2. **Implementing our Education Strategy in an equal and fair way**, supporting all staff in their personal and professional development. During the year we will develop a Talent Management approach based on principles of inclusion. This will be demonstrated through the range of leadership development and coaching and mentoring opportunities that are taken up by women and men. This will be offered in a way that does not unintentionally exclude any groups of staff, including on basis of gender or race. The allocation of funding for Study Leave will be reviewed to ensure fairness across the Trust.

3. **Utilising our development projects such as nVCC to create development opportunities for people at all levels of the organisation.** Where necessary, additional encouragement will be offered to offset any gender disparity in uptake. Project roles and responsibilities will be offered as development opportunities to existing staff, either as a secondment or as an addition to their current role.

4. **To deliver an Attraction, Recruitment and Retention project** to achieve effective and inclusive approaches to bringing people into our organisation and encouraging them to remain with us. This includes improving the recruitment processes to ensure that we use gender-sensitive language in adverts and use gender-neutral pronouns and clean language to prevent us from potentially putting women off from applying for positions. This will include highlighting all Agile working and family-friendly benefits and ensuring all new staff understand how and when they can apply for incremental credit on appointment. This will benefit all genders of applicants and offer an environment for more women to put themselves forward for employment.

5. **To promote inclusive language within education and development training inside our organisation, to keep raising awareness and continue to develop a culture of inclusivity.** Develop and deliver unconscious bias training that can firstly be delivered to managers so they can role model expected behaviours creating a peer-learning environment that models the values of the organisation.

6. **Monitoring of engagement with initiatives by gender.** The proportion of male and female staff taking up education programmes and development opportunities will be monitored to highlight if positive action is required. Analysis of recruitment will

show whether job applications receive equal outcomes for men and women, from application, shortlisting and appointment.

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

NOVEMBER 2022 Performance Management Framework COVER PAPER

DATE OF MEETING	17/01/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Wayne Jenkins, Head of Planning and Performance Velindre Cancer Centre Alan Prosser, Director WBS Amanda Jenkins, Head of WOD
PRESENTED BY	Cath O'Brien, Chief Operating Officer Sarah Morley, Director WOD
EXECUTIVE SPONSOR APPROVED	Cath O'Brien, Chief Operating Officer

REPORT PURPOSE	FOR DISCUSSION / REVIEW

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
WBS SMT MEETING	13.12.2022	Reviewed and Noted
VCC SLT	19.12.2022	Reviewed and Noted
WBS PERFORMANCE REVIEW	21.12.2022	Reviewed and Noted
VCC PERFORMANCE REVIEW	21.12.2022	Reviewed and Noted

EXECUTIVE MANAGEMENT BOARD	06.01.2023	Reviewed and Noted

ACRONYMS	
VUNHST	Velindre University NHS Trust
UHB	University Health Board
VCC SLT	Velindre Cancer Centre Senior Leadership Team
WBS SMT	Welsh Blood Service Senior Management Team
QSP	Quality, Safety & Performance Committee
RCR	Royal College of Radiologists
JCCO	Joint Council for Clinical Oncology
PADR	Performance Appraisal and Development Review
KPIs	Key Performance Indicators
SACT	Systemic Anti-Cancer Therapy
WTE	Whole Time Equivalent (staff)
EMB	Executive Management Board
COSC	Clinical Oncology Sub-Committee
IPC	Infection Prevention Control
RCC	Rutherford Cancer Centre

1. SITUATION/BACKGROUND

The attached Trust performance reports provide an update to the Quality, Safety and Performance Committee with respect to Trust-wide performance against key performance metrics

through to the end of November 2022 for the Velindre Cancer Centre, the Welsh Blood Service and for VUNHST Corporate Services respectively.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The reports set-out performance at Velindre Cancer Centre **(*appendix 1*),** the Welsh Blood Service **(*appendix 2*)** and the Workforce **(*appendix 3).*** Each report is prefaced by an '*at a glance*' section which is intended to draw attention to key areas of performance. A number of areas from the reports are highlighted below.

2.1 Velindre Cancer Centre:

Due to the implementation of the new digital patient system DH & CR, there is a requirement to fully remap and rebuild the extraction of data from this system into our data warehouse and rebuild all of the reports. This is a known and planned stage of the replacements of such systems and has previously been highlighted in relation to the DHCR programme. This extensive work programme is still ongoing and being delivered according to the delivery plan. The impact of this is mainly for the radiotherapy treatment times and outpatient attendances that this system provides. The data system work is due to be completed in late January/early February and will then be operationally validated. This will then enable the retrospective data for November, December and January to be compiled for review. Data will be shared as it becomes available.

VCC continues to experience challenge in providing capacity to meet the overall demand for services within SACT and Radiotherapy, with referrals increasing as health boards undertake additional activity to address their longest waiting patients. There continues to be variation in demand and tumour sites.

Regular operational meetings continue to take place between VCC and the local Health Boards, which help to provide a more detailed picture of the expected number of referrals to VCC from Health Boards and changes to specialist teams and practice that are likely to impact on demand for services from VCC. There are planned activities in Health Boards to significantly reduce their waiting lists which will have a likely impact upon VCC services through quarter 4 of 2022-23. There is detailed analysis of the Health Board data to ensure this is fed into the VCC demand data to allow services to plan for the likely surge.

Alongside better intelligence on demand to support planning, there is a comprehensive programme of work supported by activity plans to maximise efficiency and productivity to demonstrate the most effective use of resources. However, it should be noted that

variation in referral patterns occurring continues to be a challenge as health boards undertake focused activity within specific specialist areas.

Whilst the forecast increase in referrals to SACT and RT of 12% and 8% respectively has yet to be seen, information from within individual health board cancer trackers suggests that this level of increase in referrals is still potentially to be realised by 31st March 2023.

A number of immediate actions have been implemented as part of the ongoing capacity task force groups established in radiotherapy and SACT. The improvement programmes have led to an ongoing improvement in waiting times in both radiotherapy and SACT.

2.1.2 Radiotherapy Waiting Times

As explained above, due to the implementation of DH & CR in the cancer centre, we are unable to report the November waiting times position yet as the reports are still being written which could not be done in advance of the implementation. We are expecting to report at the end of February when we will report November's position alongside December.

A gradual increase in LINAC capacity has been underway to increase the number of planned hours, which is being supported through a temporary increase in staffing hours and reallocation of roles. This has helped support the improving position.

In addition, a change in software has increased the number of Linacs on which breast patients may be receive treatment, which has resulted in increased flexibility to manage these patients.

Work is also being undertaken through a taskforce to understand principal reported causes for delays and breaches. Three main areas have been identified: delays in planning for those patients waiting for radial RT, requirement for 3D conformal Plans for palliative radiotherapy patients, change of intent/transport delays for emergency patient.

There will now be some focused work to address these issues, which include:

- Implementation of holistic pathway improvement project, which will require a more granular analysis of the breaches to determine a way forward.
- Complex palliative treatments will be re-categorised as 'scheduled' (January 2023) in conjunction with new COSC guidelines and clinical leads.
- Work with WAST on revised transport arrangements and a clear action in relation to transport delays for emergency patients.

Attendances show significantly less than 2019/20 baseline. However, this is as a result of change in the management of patients i.e. introduction of hypofractionation.

Challenges in radiotherapy remain aligned to the fragility of the equipment associated with its age, resulting in a greater risk of breakdown, as we increase usage and capacity issues in brachytherapy and medical physics as a result of staffing issues.

The IRS implementation programme has commenced and its delivery will create resilience and medium term system improvements.

2.1.3 SACT Waiting Times

Performance against the non-emergency time-to-treatment target has continued to improve and has resulted in full compliance with waiting times targets in November. Breach numbers have also reduced from 14 in October to 6 in November. The 6 patients who breached were all treated within 28 days, which is also a considerable improvement from recent months. We are continuing to monitor delivery against demand.

Other areas

2.1.4 Falls

During November 2022, there were 4 Velindre falls on first floor ward. All falls were discussed at the Scrutiny Panel and two were deemed avoidable. Appropriate actions have been identified.

2.1.5 Pressure Ulcers

During November 2022, there was 1 Velindre acquired pressure ulcer on first floor ward. This was deemed as unavoidable by the Scrutiny Panel and all learning and actions to reduce the risk of pressure ulcers occurring was undertaken.

2.1.6 Healthcare Acquired Infections

No Healthcare Acquired Infections (HAIs) were reported in November 2022.

2.1.7 SEPSIS bundle NEWS score

6 patients met the criteria for response to sepsis and all 6 received antibiotics within 1 hour where appropriate = 100% compliance.
5 of the 6 patients went on to receive a diagnosis of sepsis and all 5 patients received all 6 elements of the SEPSIS bundle within 1 hour = 100% compliance.

2.1.8 Delayed Transfers of Care (DTOC's)

There was 1 delayed transfers of care reported in November 2022. The delay was due to lack of bed availability at the District General Hospital.

Further detailed performance data is provided in Appendix 1

2.2 Welsh Blood Service

Demand for red blood cells averaged at 1371 units per week, and all clinical demand was met in November placing the service in good and stable position. During November the red cell stock holding did not drop below 3 days for priority blood groups, and stock levels were satisfactory across all groups. Due to this, the service was in a position to export 120 units to Northern Ireland. The role of the daily Demand Planning Group meeting, which includes representatives from all departments supporting the supply chain, has been critical to steering the service through extremely challenging times.

2.2.1 Quality

At 96% quality incident investigations completed continues to exceed the target of 90% closed within 30 days. There were no critical or major non-conformances recorded from audits in November, no adverse event reports submitted to the MHRA and no adverse event reports were submitted to the HTA. In addition, no Serious Hazards of Transfusion (SHOT) incidents were reported during the month.

At 96% donor satisfaction continues to remain above target.

In November 2022, 7,904 donors were registered at donation clinics with 8 concerns (0.1%) reported within this period. The one formal concern recorded in November is expected to be completed before the 30 day target of 05/01/23, whilst the remaining concerns were managed as 'early resolution' within the required timescales.

2.2.2 Recruitment of new Bone Marrow Volunteers

In November, 315 new donors were recruited to the Welsh Bone Marrow Donor Registry (WBMDR) against a target of 333, the highest number recruited this year. The Recovery Plan continues to focus on recruitment of donors at schools, colleges and universities, and in November ensured that a 'Bone Marrow Champion' was present at every school, college and university blood collection session. The service continues to work proactively to understand the optimum programme for recruitment of donors via buccal swab, including utilising digital solutions to improve ways of generating an increase in numbers.

The total stem cells collected in November was 1 (1 collection was cancelled during November for patient reasons). The total stem cell provision for the service was 6 (1 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.

2.2.3 Part Bags & Failed Venepuncture

Performance for both % part bags and failed venepuncture are within tolerance, however, there is an upward trend in monthly figures that is currently being explored.

2.2.4 Collection Efficiency

Collection efficiency performance failed to meet target in November. This drop in performance is a short-term consequence of managing low hospital demand. The number of donor slots was reduced to avoid over collection, however the time was utilised to support staff to complete mandatory training and PADRs.

2.2.5 Reference Serology

Reference Serology turnaround performance failed to meet the 80% target in November at 65%. Recent performance is due to continued staff absences, high levels of testing requests and planned annual leave. An additional Band 6 Specialist Biomedical Scientist resource to increase complex testing is being recruited. Validation the new automated analyser has been completed and this will start to support an improvement in performance. Further validation of red cell phenotyping is expected to be completed by the end of January 2023 further improving efficiency.

2.2.6 Time Expired Platelets

All clinical demand for platelets was met averaging 161 units per week, representing a strong performance against this metric in November. However, platelet wastage is still above target at 15%. Creation of a forecasting tool to inform decisions around pooled platelet manufacture will support a reduction in this figure. This is due to be completed in quarter 4.

3 WORKFORCE

3.1 PADR (Target 85%)

Trust Wide 75.40%, increase on previous month
WBS 84.67%, increased compared to last month

VCC 74.90%, increased compared to last month

3.2 Sickness Absence (Target 3.54%)

Trust wide 6.23%, very slight increase on previous month
WBS 7.17%, sickness rates decreased compared to last month
VCC 6.20%, sickness decreased compared to last month.

3.3 Statutory & Mandatory Compliance (Target 85%)

Trust Wide 85.69%, above target increase on previous month.
WBS 90.96%, above target but decrease on previous month
VCC 84.92% decrease on previous month.

4.0 IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The current performance reporting and monitoring system is predicated upon identifying performance issues and supporting effective decision making at service and operational levels to drive forward continuous improvement in quality, safety and the overall experience of patients and donors.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below: • Staff and Resources • Safe Care • Timely Care • Effective Care.
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Delivery against the performance metrics presented in the attached reports and the work associated with delivering improved performance supports sound financial governance across the Trust.

5.0 RECOMMENDATION

5.1 QS&P is asked to **NOTE** the contents of the attached performance reports.

Appendices

1. VCC October PMF Report
2. WBS October PMF Report
3. Workforce Monthly October PMF Report

VELINDRE UNIVERSITY NHS TRUST
QUALITY, SAFETY, PERFORMANCE COMMITTEE

VCC DIVISIONAL QSP REPORT
(JULY, AUGUST, SEPTEMBER, OCTOBER 2022)

DATE OF MEETING	17 January 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	Circulated out of meeting	Approved by COO 03/01/2023

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 July to October 2022.

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 July to October 2022.

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 report provides 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 (July to October 2022):

- All clinical services were under significant pressure during the reporting period following an increase in referrals 'covid surge' and an increase in complexity of patient clinical presentation.
- The SACT service set up a task and finish group which was established in April, to manage a surge in patient numbers and a lack of capacity to manage the demand. The waiting times have reduced and the SACT team continue to be supported by VCC SLT and Executive team to manage the increased demand. A review of SACT delivery nursing capacity has also been completed with an action plan set to deliver objectives to enhance SACT nursing delivery by

the end of February 2023. Further details of the treatment time target compliance will be presented in the VCC performance report for this period.

- The Radiotherapy service experienced a number of challenges due to fragility of the equipment and inability to treat site specific cases on different machines. Further details will be presented in the VCC performance report for this period.
- 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 from the outcomes and a NRI relating to a patient fall that was reported during the period.
- The Sepsis Bundle compliance continues at 100%
- The compliance with the PTR regulations related to concerns/complaints continues at 100%
- Closure of quality incidents within the required 30 days remains a challenge but has improved since the previous reporting period by 30%
- In response to patient feedback we have implemented several service improvements reflected in further detail in this report
- Overall patient satisfaction continues to exceed target at 96.5%.

3.2 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 with any challenges and issues 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 and Performance Committee are asked to **NOTE** the information in this 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 July, August, September, October 2022 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 points were escalated to SLT.

- Revised membership, refreshed terms of reference SLT asked to: Ensure Directorates are represented and engaged with VCC QSMG meetings.
- SLT are asked to consider that the radiation sources currently within the CRW area are now removed under the HASS Regulation

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 performancereports)
- 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 inplace.

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-fundedcare
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 July, August, September and October 2022 and how they were initially categorised by the incidentreporter.

	No of incidents	None	Low	Moderate	Severe	Catastrophic
July 2022	169	111	51	4	1	2
Aug 2022	149	90	51	7	0	1
Sept 2022	137	78	55	4	0	0

Oct 2022	141	90	44	6	0	1

4.1.1 Severe and Catastrophic Incidents

- 1 incident was categorised as severe but following initial review has been downgraded to low.
- 4 incidents were categorised as catastrophic. 2 have been downgraded to low and none. 2 remain categorised as catastrophic following investigations.
- There were 2 separate cases where there was a missed opportunities for the treatment helpline to refer 2 patients for an earlier medical review. Both incidents have been reported as National Reportable Incidents. Immediate learning and improvements have been identified:
- All treatment helpline staff reminded about following the UKONS triage tool recommendations, and to escalate all calls to appropriate senior nurse, ANP, or SpR if any queries about the escalation plan.
- Regular handovers between the treatment helpline and the senior Operational nurse to discuss calls received. A full review of the treatment helpline is currently underway with several optional models being considered by the SACT and medicines management service to ensure a robust MDT management approach.
- Facilities to record treatment helpline calls have been prioritised and will be delivered as part of Digital Services plans for deployment of new SIP service into VCC in 2023. There will be a focus on the SACT Improvement work including; nurse staffing model review, audit of escalation process and harm review process included in the next VCC QSP report.

4.1.2 Moderate Incidents

21 incidents were categorised as moderate harm when first reported.

Following an investigation of all 21 incidents, 2 remain categorised as moderate:

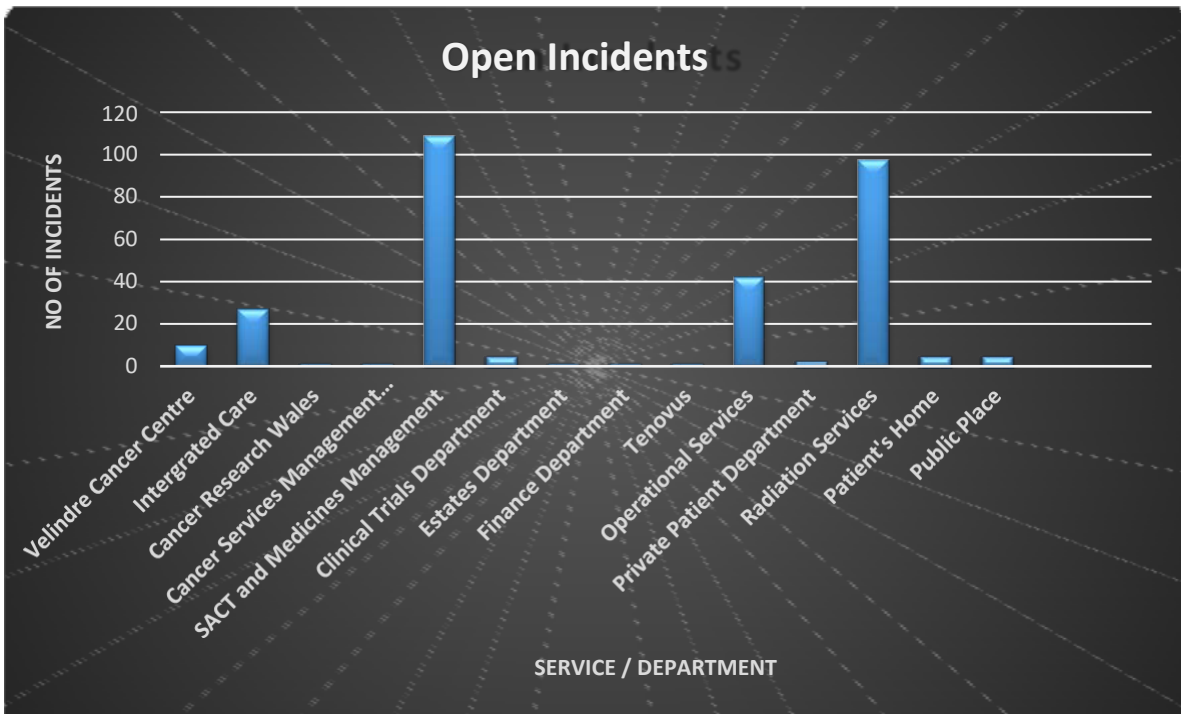
- inanimate load manual handling incident involving a member of staff. Investigation concluded that competency training is required.
- 1 unavoidable patient fall in the car park. Learning identified review of equipment available in outside areas to mobilise patients needed, an action plan following this incident is being led by the health and safety team.

There are a further 5 incidents where the investigation is in progress on Datix and therefore remain categorised as moderate;

- delay in starting SACT treatment,
- pain following a procedure,
- potential delay in patient being reviewed in A+E following transfer by VCC,
- pain following flu vaccine at injection site,
- a medication omission.

4.1.3 Open Incidents

There are 305 incidents open over 30 days. This is an improvement from the previous VCC QSP report which showed 399 incidents open over 30 days. The Q&S team will continue to work closely with all services areas to ensure timely management of Datix reports within the required timeframes.



4.2 Falls Scrutiny Panel

During this reporting period there were 14 falls during the reporting period affecting 11 patients, 3 of which were avoidable falls on First Floor ward. All falls were investigated and discussed in the monthly fall's scrutiny panel. Identified learning below.

- First Floor ward staff reminded that the physiotherapy team are available on weekends to accept referrals,
- to establish a process for testing sensor mats prior to use and per shift,
- to expedite the roll out of the Enhanced Supervision policy for patients identified at risk of falls.

Following the October 2022 scrutiny panel, a national reportable incident has been submitted as a patient suffered a fractured neck of femur following a fall. Appropriate nursing assessment and care planning was evident however there was a missed opportunity for referral to out of hours physiotherapy therefore the scrutiny panel categorised the fall as avoidable.

4.2.1 Pressure Ulcer Scrutiny Panel

There was 1 avoidable VCC acquired pressure ulcer during July – October 2022. Feedback has been provided to the ward on the importance of ensuring staff document fully their intervention and care plans for timely pressure relief.

4.2.2 National Reportable Incidents

There have been 4 National Reportable Incidents for July – October 2022.

- 1 related to a fall on First Floor ward as a patient suffered a fractured neck of femur. Appropriate care was provided however there was a missed opportunity for referral to out of hours

physiotherapy. Learning has been shared with the ward staff through their 'Big 4' communication tool to remind First Floor ward staff that the physiotherapy team are available on weekends to accept referrals. The physiotherapy team are reviewing and updating their referral criteria and will share with the First-Floor staff through their Big 4 communication tool, and the ward meeting.

- 2 reports relate to 2 patients where there were missed opportunities for the treatment helpline to refer patients for an earlier medical review. Immediate learning and improvements have been identified as described in 4.2.2. Action Plan attached (**Appendix 1**)

- A NRI was submitted due to a delay in scheduling a patient to start SACT. Initial investigation identified processes within the electronic systems used for prescribing and booking SACT may have contributed to the delay. Action plan attached. **(Appendix 2**)

4.2.3 IR(ME)R HIW Reportable Incidents

- There were 9 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.

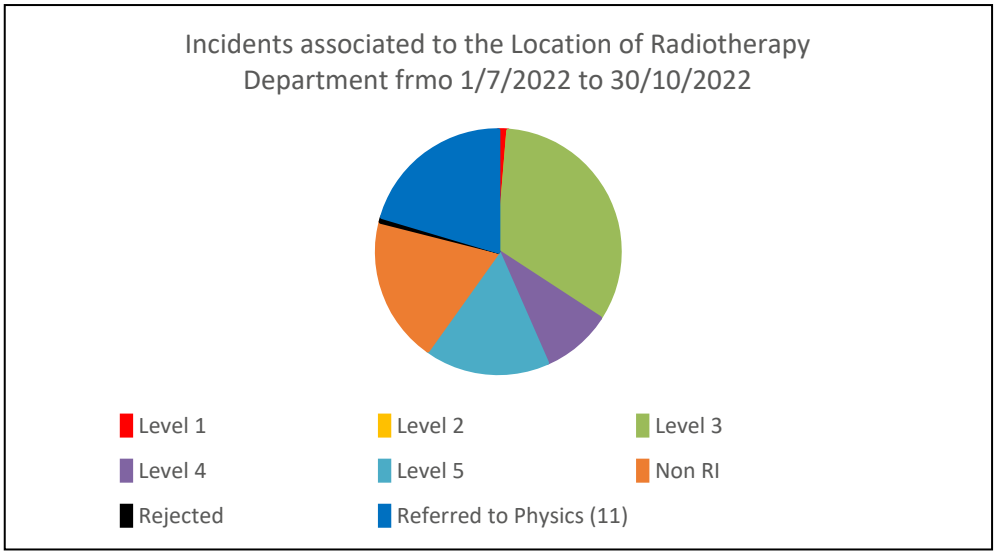
4.2.4 Early Warning Notifications

There are no Early Warning Notifications for this reporting period.

4.3. IRMER Compliance/ Issues/ Incidents

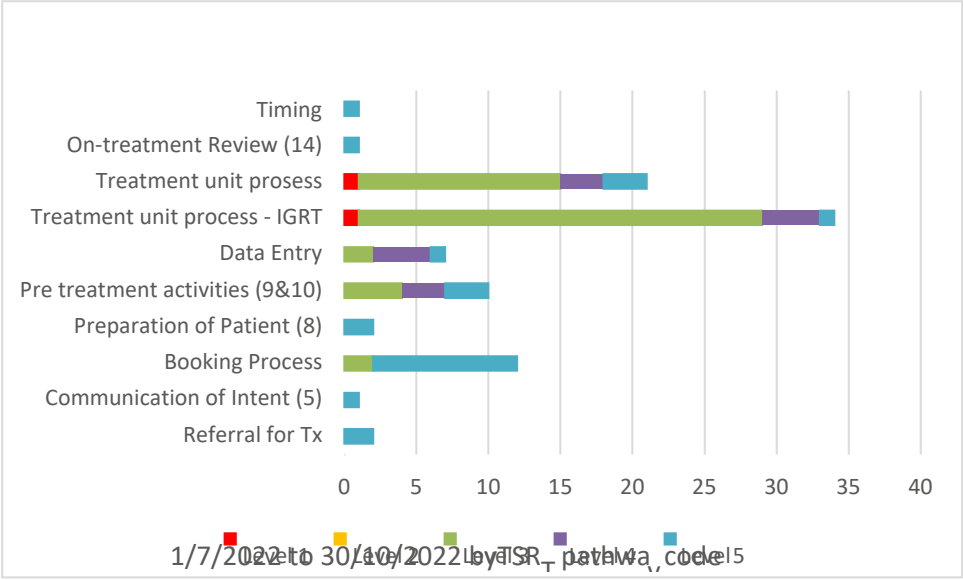
Between 1st July and 30th October 2022, 152 incidents were reported in the Once for Wales Datix Incident module and associated to the Location of Radiotherapy Department. Of the 152 incidents reported, 122 were classed as radiotherapy errors / radiation incidents. 91 of which have been or are under investigation by the radiotherapy department and have been coded in line with Towards Safer (TSRT) pathway coding and 31 have been referred to Radiotherapy Physics for investigation.

Unintended Exposures (SAUE) under IR(ME)R guidance.
98% of radiation incidents were classed as minor radiation incidents (Level 3), near misses (Level 4), or other



2% of radiation incidents were classed as Level 1 and were reportable to HIW as per Significant Accidental and non-conformances (Level 5) for the 4-month period 1/7/2022 to 30/102022 which benchmarks well with the National report of 98.0%, reported in the UK Health Security Agency Safer Radiotherapy e-Bulletin #8 September 2022.

The most frequent Radiotherapy Error Code (RTE) was 'on-set imaging: production process' being attributed to 20% (n=18) of Radiation Incidents which is slightly higher than the national average which is 12.9%. 16/18 incidents were attributed to Human Error with 2 attributed to machine/IT failure. 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.



4.4 Mortality

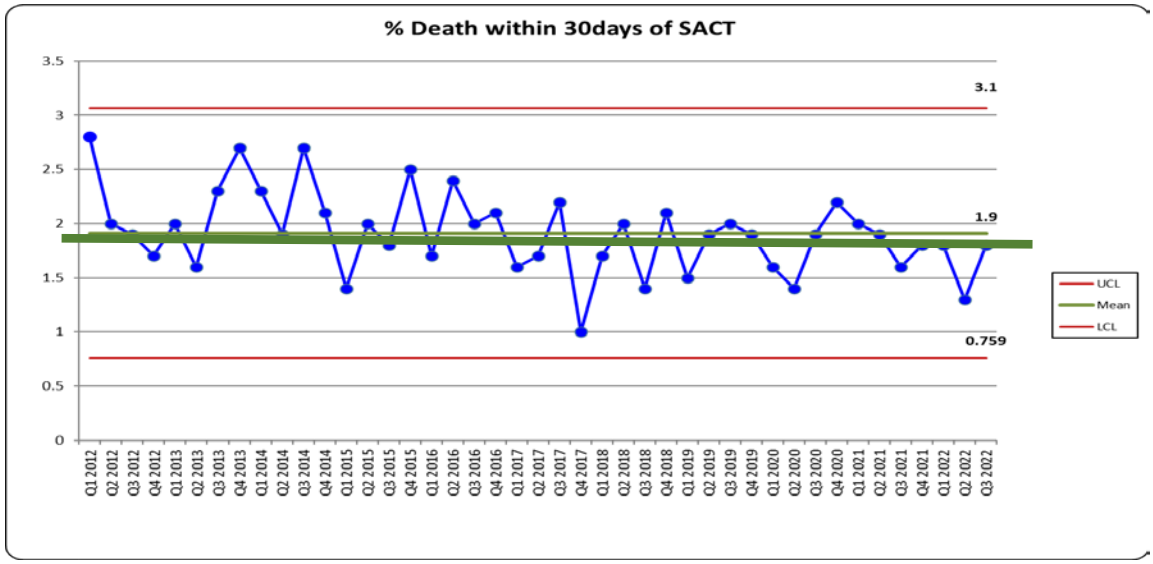
It was identified as part of the SACT peer review February 2020 that a more robust approach to death within 30 days of SACT was required. A small group was established to work through the best approach and after benchmarking it was decided to pilot mortality and morbidity meetings in line with other health boards. The colorectal SST agreed to be the pilot site. For the purposes of the study, the definition of chemotherapy treatment includes cytotoxic drugs and biological agents, such as interferon and monoclonal antibody therapies.

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

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

Percentage deaths 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 202	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



4.4.1 NCEPOD Benchmark

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. The pilot identified issues that needed addressing before the roll out to other sites. This includes the need for a standalone meeting, a digital form and identifying who is responsible for completing the forms. The pilot will be extended and reviewed again.

4.4.2 MES requests and processes

There have been 2 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 questioned the decision making around the patients discharge. An in-depth investigation has identified that the discharge was well planned and documented, but also provided opportunities for learning, namely around families understanding of the support that will be provided by the care agencies and home and what the family may be expected to contribute to a care package when caring for their relatives at home.

4.5 Divisional Risks

During the reporting period July, August, September October 2022, there were 9 (12 and above) risks open and 10 (12 and above) risks closed during the months of July, August, September and October 2022.

The departments with open risks for that period are Radiotherapy, SACT, Therapies, Medical, and Operational Services and are related to DHCR, Q-Pulse, workforce challenges, and private patient services.

4.6. Significant Clinical Incident Forum (SCIF)

3 cases were discussed in SCIF during this period, all resulted in no or low harm and learning was identified and disseminated.

- Availability of medical staff on the ward. Ward based clinical requirements fed back to the junior doctors and has been incorporated into their induction.
- The management of a medical emergency in the out of hours setting. Task and Finish group established to review the processes for alerting the team to a medical emergency and the response that follows in the out of hours setting.
- Management of capecitabine toxicity. This topic has been included in the junior doctor induction and fed back to the registrars and nursing staff. This will be incorporated into Acute Oncology Service study sessions.

4.7 COVID 19

Outbreak on First Floor ward

An outbreak of COVID-19 was confirmed on First Floor Ward in July 2022. Ten patients and eight staff were affected, although it is important to note that prevalence was high in the community at that time. The outbreak was managed in accordance with Public Health Wales (PHW) guidelines and regular outbreak meetings took place, chaired by the Deputy Director of Nursing and Quality. All patients were managed using the Nosocomial Toolkits and it was confirmed that no patients suffered harm as a result of contracting COVID-19. A closure report has been completed as per the PHW requirements.

5.0	Effective Care Descriptor: evidence based and appropriate

5.1. Complaints

Type of concern	No.	KPI Achieved
Early resolution	9	100%
Putting Things Right (PTR) (formal concern)	13	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 22 concerns between July and October 2022. 9 were managed as early resolutions, and 13 were managed through Putting Things Right. 1 concern is now being managed under the Redress process (see 4.2.2). The concerns can be grouped into the following themes

- Medical staff communication and attitude with patients
- communication between departments
- appointments
- processes around treatments
- symptom management
- communication between VCC and GP/ HB's

Learning and improvements identified – processes to improve communication with GP surgeries being undertaken by Health Records Manager, clinicians continue to undertake reflective practice, departments to ensure timely communication with patients regarding changes with their appointments, clinicians to ensure all samples that are requested by them are reviewed by them.

5.1.1 Claims

For the reporting period between 1st July-31st October 2022, the Trust handled 7 active claims as follows:-

Personal Injury Total 2		Clinical Negligence Total 5	
Velindre Cancer Centre		**Velindre Cancer Centre**	
Slip, Trip, Fall	1	Missed diagnosis	2
Defective Equipment	1	Misreporting	1
		Treatment complications	2

.

6.0	**Efficient Care Descriptor; avoid waste**

6.1. `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.

There are currently 156 audits on the programme for 2022/2023; 33 have been completed 113 are in progress, 43 of which are continuous monitoring projects, 3 are on hold and 2 have been discontinued. 5 have yet been started as are planned SSC project for March 2023.

Projects in progress are at various stages, for example data collection, data entry or analysis.

6.2 Chaperone audit

During this reporting period an audit of the active offer of a chaperone was undertaken in both gynaecology oncology and breast SSTs, it should be noted that an active offer of a chaperone is required for an intimate examination. A total number of 275 patients' records were reviewed of which 149 had an intimate examination documented in Canisc. On review of the notes there was no documentation regarding an offer or acceptance of a chaperone in any of the notes reviewed, however there was mention of a chaperone being present, their job title and patients consent to being examined in some cases.

Of the 31 (21%) patients that had a chaperone present, the name and designation of the chaperone was present in 81% (25/31) of cases. The audit demonstrates areas for improvement in all the key elements within the good working principles.

An action plan was developed as a result of the audit and a number of the recommendations have already been implemented. Posters have been designed and posted around the VCC outpatients department. SST leads and CNS's have been made aware if the guidelines through attendance at various meetings. The Quality team are working with the DHCR to establish whether this a 'drop down' option to confirm an active offer of a chaperone in the new WPAS and WCP systems to enable reporting of this important requirement going forward. A re-audit has been planned for the next financial year.

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 withing VCC. There is a choice for patients of completing 2 surveys – the quick "VCC Friends and Family Test", and the longer "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

Heat Map

Showing : Survey results for chosen service, broken down by ward/clinic and displayed as a heat map.
For the date period specified in filters.

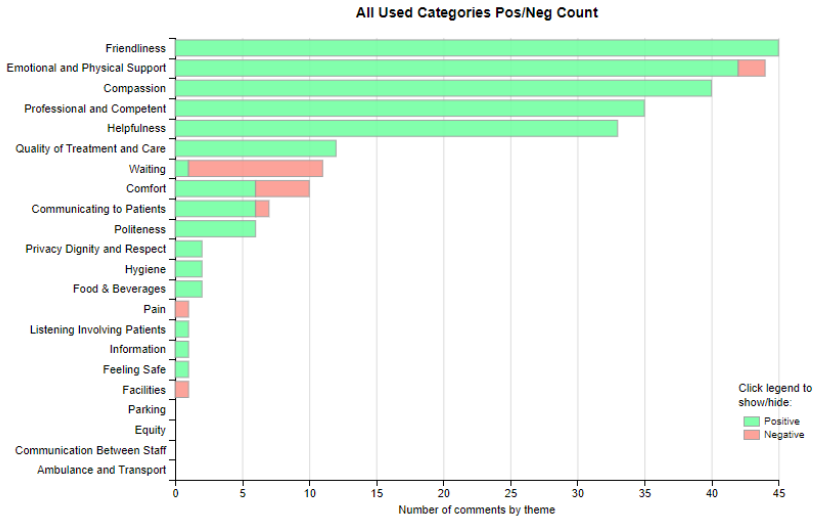
Benchmark Met
1 - 5 points below the Benchmark
More than 5 points below the Benchmark

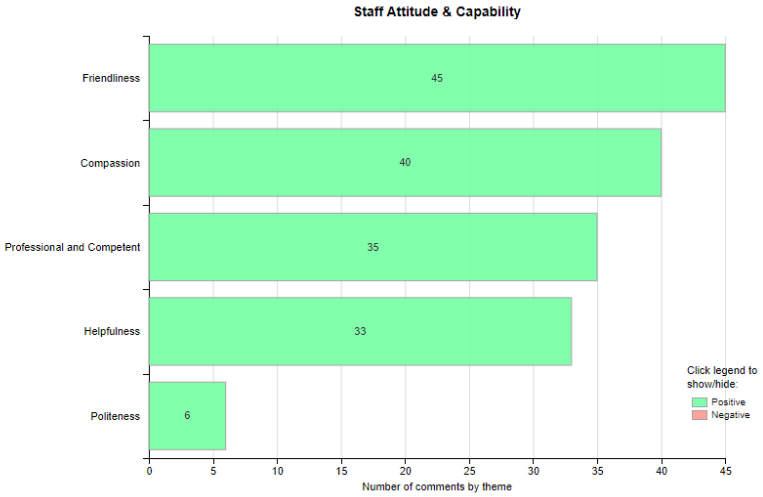
Start Date: 01/07/2022 12:00:00 AM End Date: 31/10/2022 11:59:59 PM

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	-	73	100	75	100	100	100	90	92
Clinical Psychology	1	-	100	-	73	100	100	100	100	100	100	97
Clinical Trials	8	-	100	-	74	96	100	100	100	100	100	96
Nuclear Medicine	8	100	-	-	-	-	-	-	-	-	-	100
Nursing	110	100	95	60	82	99	99	96	94	95	96	95
Outpatients	27	95	100	33	73	100	100	100	100	100	100	94
Palliative care	7	-	100	100	89	100	92	89	89	86	94	92
Pharmacy	2	100	66	33	100	-	-	-	-	-	-	75
Radiology	1	-	100	-	100	100	-	75	100	100	100	96
Radiotherapy	18	100	90	100	78	95	91	94	97	94	97	93
SACT	37	100	-	-	-	-	-	-	-	-	-	100
	Overall	99	96	63	81	98	98	96	95	95	96	95
	Benchmarks	85	85	85	85	85	85	85	85	85	85	92

The ability to speak Welsh is often receiving a low score. Patient feedback about ability to speak Welsh if desired has been added to the VCC Welsh Language Working Group agenda

We know that during the reporting period 2 of our main services were experiencing significant pressures and waiting times, both department action plans included patient communications to explain the waits and our actions to address the service pressures.



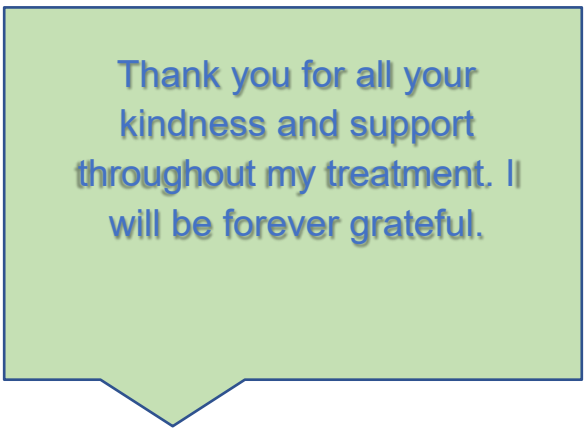


Feedback received:

About the Ambulatory Care Service:		About the Assessment Unit:
The staff are so personable kind and sympathetic. It opened my eyes and I became so overwhelmed by the genuine kindness and warmth they showed. Thank You all I owe you my life. And you all deserve a holiday		I cannot express how highly I rate the quality of staff and treatment at Velindre Cancer Centr I was triaged by the treatment help desk who asked me to come into the assessment unit. Once assessed I needed inpatient admission while they undertook various tests. I have been seen by various staff and everyone has shown compassion and understanding of my illness and concerns.I cannot praise the staff highly enough as they continue to help me during this most difficult time in my life.
About First Floor Ward:		About Radiology
I cannot find fault with any aspect of treatment or care I have received as the staff are all highly skilled and are very compassionate and caring. They always ask if there is anything more they can do which makes you feel important especially as they are so busy but always find time to have a chat about how your feeling and what outcome you expect from this visit. Keep doing exactly what you do as I feel the Velindre team are simply the best.		At the breast MDT this morning, when the Medical Director was in attendance, the Consultant wanted specifically to single out one of our radiographers, for her help with a breast patient who last week was diagnosed with a brain met, the lady said she would never have gone into the scanner without the caring nature of the MRI staff and the Consultant said that she went out of her way to facilitate the scan. I happened to be in MRI when the scan was finishing, I felt the nurse who attended with the lady was also wonderful so I fed that back too.

		To my MRI Guardian Angel. Thank you for always making lot easier for me you really are an Angel. Sending lots of thank you hugs

Compliments received are added to the Datix system and shared with staff via feedback boards in the clinical areas. During July, August, September, October 2022, 44 compliments were captured on the OfW Datix system. Some of the complimentsinclude:



7.2 WHAT OUR REGULATORS / EXTERNAL / INTERNAL AUDIT ARE SAYING

Health Inspectorate Wales (HIW) Unannounced Visit

Healthcare Inspectorate Wales undertook an inspection of the inpatient ward in Velindre Cancer Centre on 12 and 13 July 2022. The Trust was provided with a 24-hour notice period owing to the nature of the ward with the intention of allowing sufficient time for the COVID-19 safe arrangements to be put in place for the inspection. At the time of the inspection, the inpatient ward was experiencing an outbreak of COVID-19.

The inspection report details all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients.

Overall, the findings were positive; however, there were some recommendations for service improvements which are detailed in the report. These recommendations have been reviewed by the VCC senior nursing team who have developed an Improvement Action Plan to address the areas highlighted for improvement by the inspection team. Overall findings were as noted below:

Quality of Patient Experience - Overall, it was noted that patients were provided with a positive experience.

Safe and Effective Care - Overall, it was noted that the ward and wider Trust was committed to maintaining patient safety, which was evident through its audit and governance processes. Some of the improvements that were identified, such as falls prevention, had already been recognised by the Trust and the team saw evidence that work is underway in these areas.

Quality of Management and Leadership – The team found good management and leadership on the ward with staff commenting positively on the support that they receive from the ward manager.

A number of actions have already been completed, including:

- Ensuring the cleaning room on the ward remains locked at all times
- Regular Falls Scrutiny Panels taking place
- Improved ward communication through daily huddles and the implementation of the 'Big 4' to aid communication of key messages
- Formal COVID-19 risk assessments implemented

Ongoing work includes working with the Trust Safeguarding Nurse to arrange dementia training for staff, embedding of the Enhanced Supervision Policy and introducing a process for spot-checks of medical devices on the ward.

HIW IRMER Inspection

HIW completed an announced Ionising Radiation (Medical Exposure) Regulation's inspection of the Nuclear Medicine Department on 14 and 15 June 2022. The findings of the inspection were reported in September 2022.

Overall, from the evidence examined, HIW found that compliance with IR(ME)R 2017 was good. Policies and written procedures required under IR(ME)R 2017 were available and up to date. These helped the department to comply with the requirements of the regulations as they applied to the department. Patients who completed the survey were very positive about their experiences whilst in the department. Discussions with managers and department staff throughout our inspection provided assurance that arrangements were in place to ensure examinations were being undertaken safely in line with IR(ME)R. Some areas for improvement were identified, and HIW accepted the improvement plan submitted by VCC with a number of improvements already completed.

15 Step Challenge – Radiotherapy

The 15-Step Challenge led by the Executive Director of Nursing, AHPs and Health Scientists took place on 26th July 2022 and received positive feedback from patients. Some areas to consider include:

- General Estates, i.e., painting, carpeting, de-clutter
- Improve patient information and signage
- Uniform review
- Drinks provision.

15 Step Challenge – First Floor Ward

The 15-Step Challenge led by the Executive Director of Nursing, AHPs and Health Scientists took place on 8 September 2022 and generally positive feedback received from staff and wholly positive feedback received from patients. Some areas to consider include:

- Dedicated discharge support to manage the repatriation and complex discharge of patients
- More support and leadership required
- Consider weekly remuneration for bank staff would facilitate current staff working extra shifts on ward on bank rather than agency shifts elsewhere
- A full action plan has been developed and is being monitored via the VCC QSMG.

Audit of pre-booked admissions to the Assessment Unit

An audit of pre-booked admission to the Assessment Unit was undertaken by one of the Advanced Nurse Practitioners to better understand the reasons for pre-booking patients onto the Assessment Unit.

The Unscheduled care Acute Oncology Assessment Unit opened 4 years ago with aim of treating:

- Same day referrals from the Treatment Helpline
- Patients presenting 'sick on site'
- Day case radiotherapy

In 2022, up to 60% of admissions are pre-booked onto the assessment unit and are not same day referrals. This is potentially reducing capacity for unscheduled admissions.
The audit showed that there were many reasons for pre-booking patients to attend the Assessment Unit, some of which could be seen in an alternative setting, such as via:

- The new immunotherapy toxicity service
- By creating an ANP led acute oncology virtual ward.
- Ensuring patients' post discharge bloods to be managed by patient teams.
- Ensuring existing pathways are being followed

- IV access service
- Alternative bed spaces for palliative RT review clinic

The Assessment Unit team are working with clinical teams to ensure that all patients are seen and treated in the most appropriate setting so that they receive timely and efficient care at all times.

8.0	Timely Care

8.1 Service improvements or projects undertaken

Same Day Emergency Care (SDEC)

Ambulatory Care Service

Work to embed the expanded Ambulatory Care service has progressed well. In July 2022, the Ambulatory Care Service extended its opening hours Monday – Friday until 8pm and to include Sundays and the unit has been open for patients needing supportive care interventions and treatments. The recruitment of the additional nursing and therapies staff funded by the bid is now complete and activity on the unit has increased.

A dedicated page on the Intranet has been set up to give staff information on the service and an Ambulatory Care Internet page will be published and be available to patients that will include resources, guidelines, education & general information to help them with treatments.

Immunotherapy Toxicity Service

The formal launch of the Immunotherapy Toxicity Service took place in early September 2022 following a successful pilot in August. Significant work has been undertaken to document key policies and procedures,

guidelines and to establish Service Level Agreements with LHBs for specialist consultant input from endocrine and gastroenterology teams. A bespoke database has been developed to capture activity and for use as a patient assessment tool.

An immunotherapy toxicity Intranet and Internet page have been set up and is being populated with guidance in line with service developments.

A meeting with the Welsh Government SDEC Team took place with VCC service leads in August to review progress with the implementation of the projects. The following quote was received from WG SDEC team.

"Thank you so much for taking the time yesterday to go through your SDEC development. We were truly impressed with the amount you have achieved and also the enthusiasm from the whole team."

Psychology and Occupational Therapy Screening Project

A joint Psychology and Occupational Therapy screening project has been undertaken on First Floor Ward to increase awareness of both services, to identify potential referrals in a timely manner and to highlight the emotional and occupational therapy needs of patients on the ward.

Altered airways Bleep Service

A joint working initiative between the Speech & Language Therapy Team and the Advanced Nurse Practitioner in Head & Neck Cancer have led to the establishment of a patient safety improvement project and they have set up an Altered Airway Service within VCC.

The aim of the service is to ensure safe, equitable and quality care for all patients with a Tracheostomy or Laryngectomy irrespective of their location within VCC. It is planned that successful implementation will facilitate a strategic approach to the delivery of care and management of patients with a Tracheostomy or Laryngectomy in order to improve patient safety and reduce risks associated with having patients with altered airways on site at VCC.

Although the numbers of patients with altered airways attending VCC are low, it is often the case that these patients attend a number of departments within VCC and would previously attend without any of their equipment which could posed a safety risk.

One element of the Altered Airways patient safety project is the implementation of an Altered Airways Bleep System. When a patient with an altered airway presents in any department in VCC, a member of staff bleeps the Altered Airway service and lets them know the patient is on site. This will help to capture the flow and demand of altered airways through VCC, ensure correct information is provided and ensure that we are proactive in our decision making. It will also ensure that the correct equipment is available should an altered airway emergency occur. The Altered Airway Bleep Service will also aim to accommodate ad hoc teaching sessions, expedite Speech & Language reviews, avert admissions and develop a more confident workforce to manage Altered Airways.

It is planned that establishing the Altered Airways Service will help to address any concerns regarding altered airway patients and reassure all staff that there is a point of contact for these patients. The long-term aim is to ensure that all members of staff have a level of confidence to help support these patients so that their experience is as smooth and efficient whilst going through treatment at VCC.

In the last 3 months, 59 staff have attended training for management of altered airways.

CNS Review Project

A project aimed to explore and define the role of a CNS / Advanced Specialist Nurse Practitioner aligned with required standards and needs of cancer patients has been established in VCC. It will include scoping current working practices by Site Specific Team and identifying the current key difference between the band 7 and band 6 roles.

In addition, it will define top of license working and look at identifying tasks that may be safely undertaken by non-registrants through a scheme of delegation, developing core competencies, and developing CNS care delivery standards. The project will establish CNS key performance indicators and deliver a robust framework for the CNS / Advanced practice service in VCC involving key stake holders from other services around Wales.

A Project Steering Group has been established and the work is being planned alongside a capacity and demand exercise with support from the Workforce Planning team.

Staff Psychology Service and the Management of Staff Stress

A new Staff Psychology Service has been established in VCC to support staff with dealing with the stress that can result from working in the oncology specialty also to ensure a resilient workforce post Covid. Within the remit of the staff Psychology Service, attention will be given to the determinants of workplace psychological safety and relationships (including peers, supervisors/managers and senior leaders). For long-term benefits to be felt and cultural shift to occur, the management of stress needs attention at all levels of the organisation. Therefore, moving forward, the Psychology Service will aim to raise awareness of stress determinants and management practices at an organisational as well as 'ground' level.

The staff Psychologist team is working closely with Workforce and Development to consult and influence policy and procedures where appropriate, to enhance the assessment and formulation of staff psychological and emotional needs when necessary, and encourage psychologically informed, personalised interventions.

The team will develop a continuous programme of training, ongoing supervision and reflective practice sessions for staff, designed to prevent future stress and down-regulate stress already experienced; and ad hoc group sessions, designed to help staff manage the distress of crises. The work of the staff psychologist also involves developing KPIs so that the service can be properly evaluated during the three-year funding period.

Brachytherapy Improvement Group

In May/June 2022 a peer review of the Brachytherapy service was undertaken by Clatterbridge Cancer Centre (CCC) and a set of recommendations was received in July 2022. 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. The report acknowledged multiple areas of good practice, and the Clatterbridge team also subsequently reported implementation of some of the good practices and procedures observed in VCC..

The recommendations were categorized into immediate action of which could be actioned and closed, those requiring further information, consideration and analysis and an action plan to support their implementation. Some actions were aspirations that would be delivered within future programmes such

as IRS. The prioritisation of recommendations had to be aligned with IRS and DHCR work.

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 opportunities for nVCC. The range of recommendations included those wider consideration and aspirations for future service delivery that will be delivered over time, such as longer term workforce capacity and including advanced practice and succession planning.

In terms of the recommendations, all have been considered and reviewed and will be formally signed off at the Operational Board in January 2023. There are a number of recommendations where further work is ongoing to scope options and actions the remaining work to fully inform the final set of actions will be complete by 31st July 2023.

The current positions stands at:

Actions and Closed:	51
Target completion date 31st Jan 2023 :	48
Target completion for further action planning 31st July 2023:	35

Further exploration of Brachytherapy workforce has been undertaken in response to the report.
A series of workshops were held within VCC, which looked at the pathways within gynaecology and urology service and challenges linked to the workforce. A particular focus was on examining all aspect of staff are training, outlining competencies for the service and a service wide training plan and succession planning.

A number of proposals and suggestions were made covering: workforce; training; line management and reporting structures; efficiency and pathway redesign; digital and artificial intelligence developments; equipment; patient reported outcomes and patient reported experience. This work is being used to underpin the action plans.

A new operating model is being scoped that will enable additional capacity to be delivered and frm which a workforce model is being planned that will ensure staff are working at the top of their licence, that advanced practice is embraced and that the demand from increasing patient volume frm demographic changes and growth in indication for treatment.

A summary of the full action plan will be provided in the next QSP following its sign off by the Brachytherapy Improvement Group, SLT and EMB.

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

9.1.1 Healthcare Standards

The Q2 Health & Care Standards were approved at SLT meeting in October and sent to Trust for inclusion in the September QSP Committee 2022.

9.1.2 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 July, August, September, October 2022**

Please see **appendix 3**

11.0	Celebration and Exception

11.1 Celebrations

Our **Neuro-Oncology AHP & CNS Led Clinic** have won the Macmillan Professional Excellence Award.

The win came in the *Whatever It Takes* Category in which the team beat nine other nominees shortlisted.

The winners were announced during the Awards Ceremony on Tuesday 8 November 2022 and we're hugely proud of them.

Kate Baker, Macmillan Head of Therapies at VCC, said *"The team go above and beyond to deliver the highest quality care for our patients, everyone should be so proud of themselves.*

"It was a pleasure to be at the awards to recognise this fantastic work which helps support patients and their families and carers during what can be a very tough time."

Cathryn Lewis, Macmillan Clinical Lead Occupational Therapist, said: *"It was wonderful to be considered amongst the outstanding range of services across the UK that made up this year's finalists, all of whom do so much for the patients we put at the heart of our services.*

This award belongs to the whole team, whose collaboration and commitment has made this such a special service. This in turn means we can offer the personalised care that every individual cancer patient needs, at a time when they need it the most."

What an amazing evening and true recognition of collaborative MDT working", said **Rhian Burke, Clinical Nurse Specialist**. *"This clinic is an additional opportunity for patients and their families to discuss individualised patient centred care, discussing what is really important to them. On to the next phase of service improvement!"*

VCC staff shortlisted for two Advancing Healthcare Awards Wales

Two Velindre Cancer Centre staff have been shortlisted for their work to advance healthcare.

Lucy Wills, Principal Treatment Planning Healthcare Scientist, and Deborah Mullan, Macmillan Speech and Language Therapy Assistant, have been shortlisted for awards at the Advancing Healthcare Awards Wales 2022. The Advancing Healthcare Awards were introduced to recognise and celebrate the work of allied health professionals, healthcare scientists and those who work alongside them in support roles, leading innovative healthcare practice in the UK.

Award for New Ways of Working

This award celebrates those who introduce innovative new ways of working. Lucy Wills, our Principal Treatment Planning Healthcare Scientist, was nominated for the 'Radiotherapy Target Definition by Clinical Technologists' project. The project developed a quicker, lower-cost training route to address oncologist shortfalls and bottlenecks in radiotherapy preparation. It means that clinical technologists are now able to perform radiotherapy target definition in place of an oncologist.

The new way of working has created more clinical capacity for newly referred non-surgical oncology patients to be seen and reduced waiting times with better outcomes in line with new national radiotherapy treatment targets. The collaborative approach has enhanced professional education, increased skills and resilience to respond to current and future challenges in radiotherapy.

Award for Outstanding Achievement by an AHP or Healthcare Science Apprentice, Support Worker, Assistant or Associate

This award recognises the positive contributions to patient outcomes made by individuals in high performing teams. Deborah Mullan, Macmillan Speech and Language Therapy Assistant was nominated for her tireless commitment. Unfortunately, Deborah did not win the award, but feels privileged to be shortlisted.

12.0	Conclusions

12.1 This period has been a very busy period clinically with services seeing an increase in pre- Covid-19 demand and some restrictions remain in place in order to manage as per the post Covid guidelines. Despite this, there have been a number of excellent service developments and individual staff and team achievements across VCC referenced in this paper.

There is evidence that incidents/concerns/compliments are now 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. 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 proposed development of the VCC Quality Hub.

Velindre Cancer Centre Monthly Performance Report Summary Dashboard (November 2022)

			Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Radiotherapy	Patients Beginning Radical Radiotherapy Within 28-Days (page xx)	Actual	92%	78%	92%	92%	92%	87%	92%	83%	72%	77%	82%	91%	Not Available
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Patients Beginning Palliative Radiotherapy Within 14-Days (page xx)	Actual	74%	84%	90%	90%	81%	79%	81%	83%	83%	85%	84%	84%	Not Available
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Patients Beginning Emergency Radiotherapy Within 2-Days (page xx)	Actual	85%	89%	100%	93%	88%	84%	88%	100%	100%	94%	93%	95%	Not Available
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
SACT	Patients Beginning Non-Emergency SACT Within 21-Days (page xx)	Actual	99%	99%	94%	91%	71%	69%	61%	58%	66%	77%	89%	96%	98%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Patients Beginning Emergency SACT Within 2-Days (page xx)	Actual	86%	100%	100%	100%	83%	100%	100%	86%	100%	100%	100%	100%	100%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
Outpatients	New Patient, other Outpatient and Chemotherapy Assessment Appointments Where Patients Were Seen Within	Actual	65%	Data Collection (Paused)	Data Collection (Paused)	Data Collection (Paused)-	Data Collection (Paused)-	Data Collection (Paused)-	Data Collection (Paused)-	Data Collection (Paused)	70%	47%	57%	Data Collection (Paused)	Data Collection (Paused)

			Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
	30 minutes of the Scheduled Appointment Times (National Target) (page xx)	Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Did Not Attend (DNA) Rates	Actual	5%	3%	3%	3%	3%	3%	3%	3%	5%	5%	5%	4%	Not Available
		Target	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%
Therapies	Therapies Inpatients Seen Within 2 Working Days (page xx)	Actual (Dietetics)	100%	100%	100%	100%	100%	100%	100%	100%	100%	96%	95%	100%	100%
		Actual (Physiotherapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Occupational Therapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Speech and Language Therapy)	100%	100%	100%	100%	100%	67%	100%	100%	100%	100%	100%	100%	100%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Therapies Outpatient Referrals Seen Within 2 Weeks (page xx)	Actual (Dietetics)	100%	95%	98%	100%	98%	100%	100%	100%	100%	100%	100%	100%	98%
		Actual (Physiotherapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Occupational Therapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	50%	100%	100%

			Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
		Actual (Speech and Language Therapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Routine Therapies Outpatients Seen Within 6 Weeks (page xx)	Actual (Dietetics)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Physiotherapy)	100%	100%	86%	100%	100%	100%	100%	100%	100%	100%	78%	100%	100%
		Actual (Occupational Therapy)	100%	100%	100%	100%	100%	100%	100%	100%	97%	100%	100%	100%	100%
		Actual (Speech and Language Therapy)	100%	100%	100%	100%	100%	100%	100%	100%	96%	100%	100%	100%	100%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Safe and Reliable Care	Number of VCC Acquired, Avoidable Pressure Ulcers (page xx)	Actual	0	1	0	1	1	0	0	1	0	0	0	1	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0
	Number of Pressure Ulcers Reported to Welsh Government as Serious Incidents	Actual	0	0	0	0	0	0	0	0	0	0	0	0	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0
	Number of VCC Inpatient Falls (page xx)	Actual (Total)	1	4	3	2	9	4	1	1	2	1	3	4	4
		Unavoidable	1	4	2	2	9	3	0	1	2	1	2	0	2

			Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
		Avoidable	0	0	1	0	0	1	1	0	0	0	1	0	2
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0
	Number of Delayed Transfers of Care (DToCs)	Actual	0	0	1	4	1	1	0	0	0	0	1	2	1
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0
	Number of Potentially Avoidable Hospital Acquired Thromboses (HAT)	Actual	0	0	0	0	0	0	0	0	0	0	0	0	Not Available
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0
	Patients with a NEWS Score Greater than or Equal to Three Who Receive all 6 Elements in Required Timeframe	Actual	100%	100%	100%	100%	100%	88%	100%	100%	100%	100%	100%	100%	90%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	0
	Healthcare Acquired Infections	Actual	0	0	1 (*C.diff*)	0	0	0	0	0	1 (E.Coli bacteremia)	0	0	0	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0
Percentage of Episodes Clinically Coded Within 1 Month Post Episode End Date		Actual	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
		Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

RAG rating above indicates: Green - Target was achieved. Amber - 85% Compliance or above. Red - Target not achieved.

KEY NOTE:

Due to the implementation of the new digital patient system DH & CR, there is a requirement to fully remap and rebuild the extraction of data from this system into our data warehouse and rebuild all of the reports. This is a known and planned stage of the replacements of such systems and has previously been highlighted in relation to the DHCR programme. This extensive work programme is still ongoing and being delivered according to the delivery plan. The impact of this is mainly for the radiotherapy treatment times and outpatient attendances that this system provides. The data system work is due to be completed in late January/early February and will then be operationally validated. This will then enable the retrospective data for November, December and January to be compiled for review. Data will be shared as it becomes available.

Patients Receiving Radical Radiotherapy Within 28-Days	
Target: 98%	**SLT Lead: Radiotherapy Services Manager**
Trend	Current Performance
	Medium Term Actions **Actions: what we are doing to improve** • 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 73.5planned hours in June to 76.5 hours delivered in October. • 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. • Fleet configuration changes to support Breast patient treatment options have been implemented. • Treatment planning taskforce established to identify opportunities to release non-medical treatment planning. • Escalation processes continue to monitor predicted failures to meet time to treatment metrics and prioritise patients to

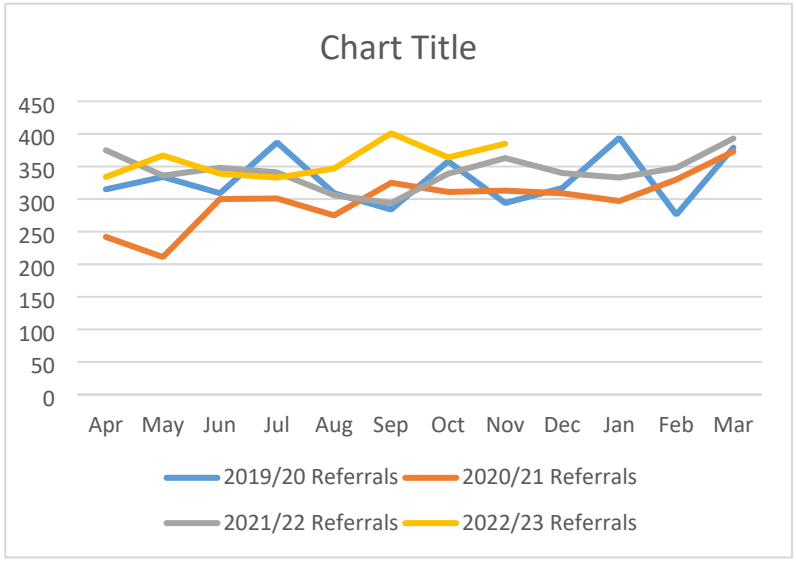
	commence treatment and minimise delay where possible, undertaken through weekly capacity meetings. Delays and cancellations are monitored weekly and reported back to Radiotherapy Management Group and the pathway sub-group.

Patients Receiving Palliative Radiotherapy Within 14-Days	
Target: 98%	**SLT Lead: Radiotherapy Services Manager**
Trend	Current Performance
	Medium Term Actions
	Refer to 28 day medium term actions.

Patients Receiving Emergency Radiotherapy Within 2-Days	
Target: 98%	**SLT Lead: Radiotherapy Services Manager**
Trend	Current Performance

	Actions: Refer to short and medium term actions above:

SACT Referral Trends - Overall



All SACT Referrals

Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019/20 Actual	315	334	309	387	309	284	359	294	317	394	276	379
2020/21 Actual	242	211	300	301	275	326	311	313	309	298	330	374
2021/22 Actual	375	336	348	342	306	294	339	364	341	333	349	395
2022/23 Actual	332	366	338	330	344	392	374	385				

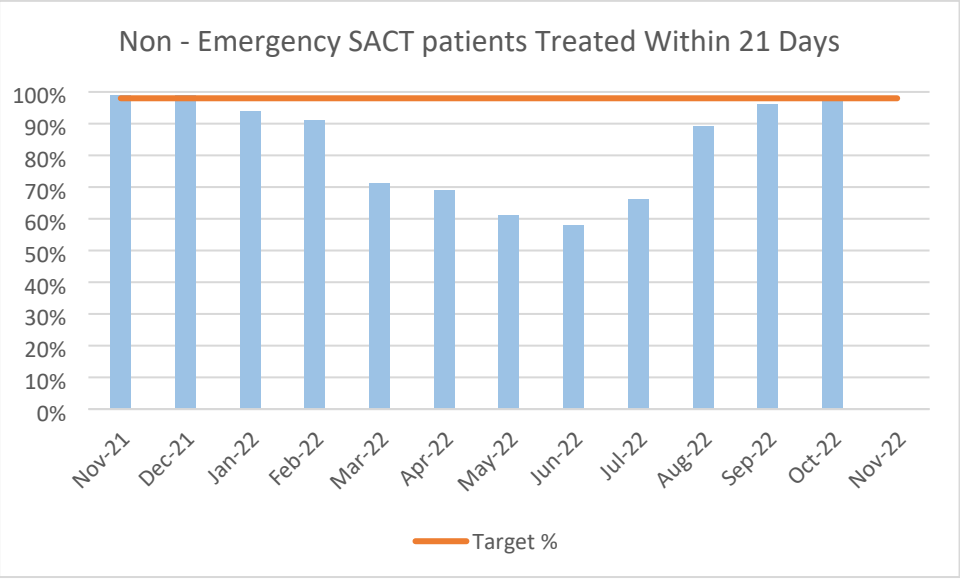
Another month of high referrals into the SACT service, with November 2022 being the 3rd highest ever recorded.

Non-Emergency SACT Patients Treated Within 21-Days

Target: 98%

SLT Lead: Chief Pharmacist

Current Performance



Intent	Monthly Average (2020-21)	Monthly Average (2021-22)	Patients Scheduled to Begin Treatment (Nov 2022)
Non - emergency	Patients Scheduled to Begin Treatment (Nov 2020)	321 Patients Scheduled to Begin Treatment (Nov 2021)	354
		325	

Trend

Of 354 patients treated, 6 patients waited over 21 days = performance of 98%. This is the first time the performance target has been achieved since December 2021.

Intent /Days -	22-28
Non-emergency (21-day target)	6

This is the 6th month where performance has improved from the previous month, arresting a 7-month decline. Breach numbers have also reduced to 6 in November from 14 in October.

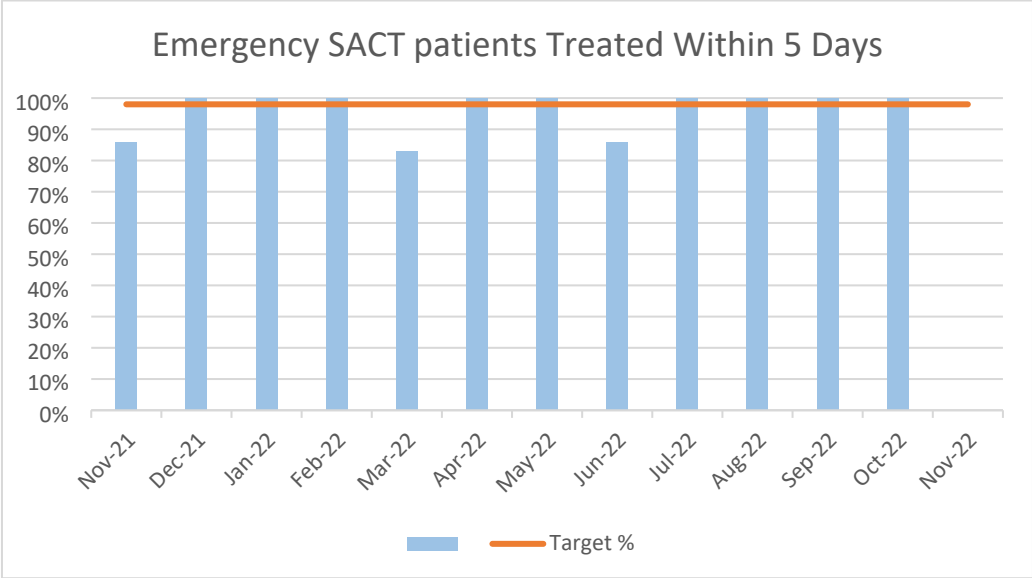
No patient waited longer than 28 days for treatment, which is also a significant improvement as we have been regularly treating patients waiting 50 days in recent months.

Short Term Actions

Incremental gains in pharmacy capacity are being delivered through reviews of working practices and the focus on maximising SACT provision.

Discussions with Aneurin Bevan UHB regarding the reintroduction of services at Nevill Hall Hospital (NHH) as an interim solution taking place.

Emergency SACT Patients Treated Within 5-Days	
Target: 98%	**SLT Lead: Chief Pharmacist**
Current Performance	Trend



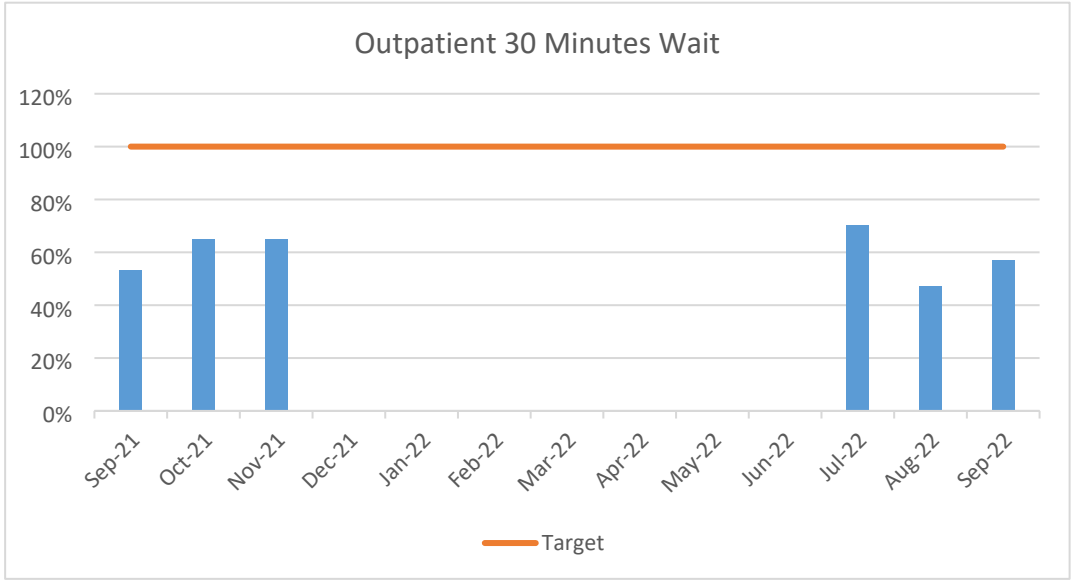
The number of patients scheduled to begin emergency SACT treatment in October 2022 (5) was lower than in September (9).

Intent	Monthly Average (2020-21)	Monthly Average (2021-22)	Patients Scheduled to Begin Treatment (Nov 2022)
Emergency		6	6
	Patients Scheduled to Begin Treatment (Nov 2020)	Patients Scheduled to Begin Treatment (Nov 2021)	
		6	

6 patients referred for emergency SACT treatment were scheduled to begin treatment in November 2022. All were treated in target with 100% performance.

Actions

- Continue to balance demand and ring fencing with capacity.

Outpatient 30 minute wait	
Target: 100%	**SLT Lead: Outpatient Manager**
Current Performance	Trend
	Monitoring of indicator reinstated between July and September, but remained limited as only a snapshot of clinics at particular times. Currently paused due to DHCR implementation.
	Actions
	Focus Groups to be established with patient involvement to define performance measures reflecting the entire patient experience at outpatients. as part of the Trust wide PMF review.

Equitable and Timely Access to Services - Therapies	
Target: 100%	**SLT Lead: Head of Nursing**

Current Performance

Percentage of Therapies Referrals (Inpatients) Seen Within 2 Working Days

	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Dietetics	100%	100%	100%	100%	100%	100%	100%	100%	100%	96%	95%	100%	100%
Physiotherapy	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
OT	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
SLT	100%	100%	100%	100%	100%	67%	100%	100%	100%	100%	100%	100%	100%

Percentage of Urgent Therapies Referrals (Outpatients) Seen Within 2 Weeks

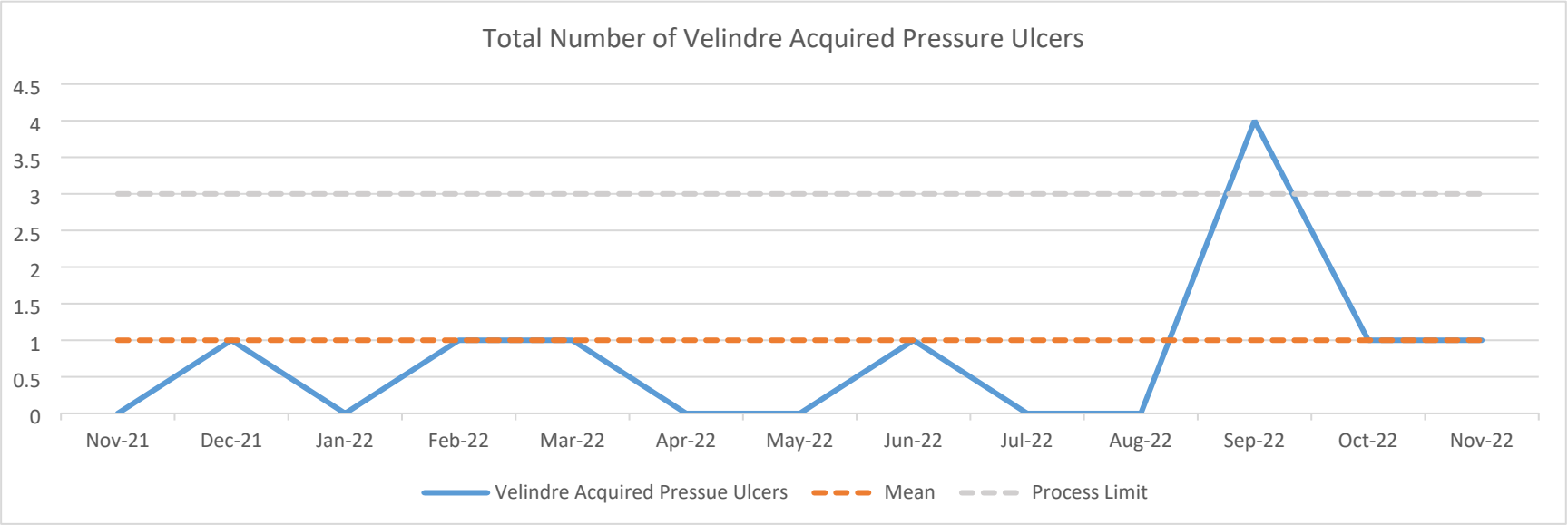
	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Dietetics	100%	95%	98%	100%	98%	100%	100%	100%	100%	100%	100%	100%	98%
Physiotherapy	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
OT	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
SLT	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	50%	100%	100%

Percentage of Routine Therapies (Outpatients) Seen Within 6 Weeks

	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Dietetics	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Physiotherapy	100%	100%	86%	100%	100%	100%	100%	100%	100%	100%	78%	100%	100%
OT	100%	100%	100%	100%	100%	100%	100%	100%	97%	100%	100%	100%	100%
SLT	100%	100%	100%	100%	100%	100%	100%	100%	96%	100%	100%	100%	100%

OP's (urgent) **DT = 98 %** (x 1 breach. The referral was received on 3/11. The patient had an appointment in clinic on 15/11 but Dietitian covering the clinic was on annual leave. Dietitians made contact with him 18/11 - hence the breach.	Actions: Review cross cover arrangements. Small team makes cross cover a challenge. The breach was due to annual leave. There are x2 part time locums. Recruitment has proved difficult to date and a current risk is still open regarding this. Cover is prioritised cover on a daily basis and recruitment for the vacancies are still underway. Posts are being redesigned where appropriate.

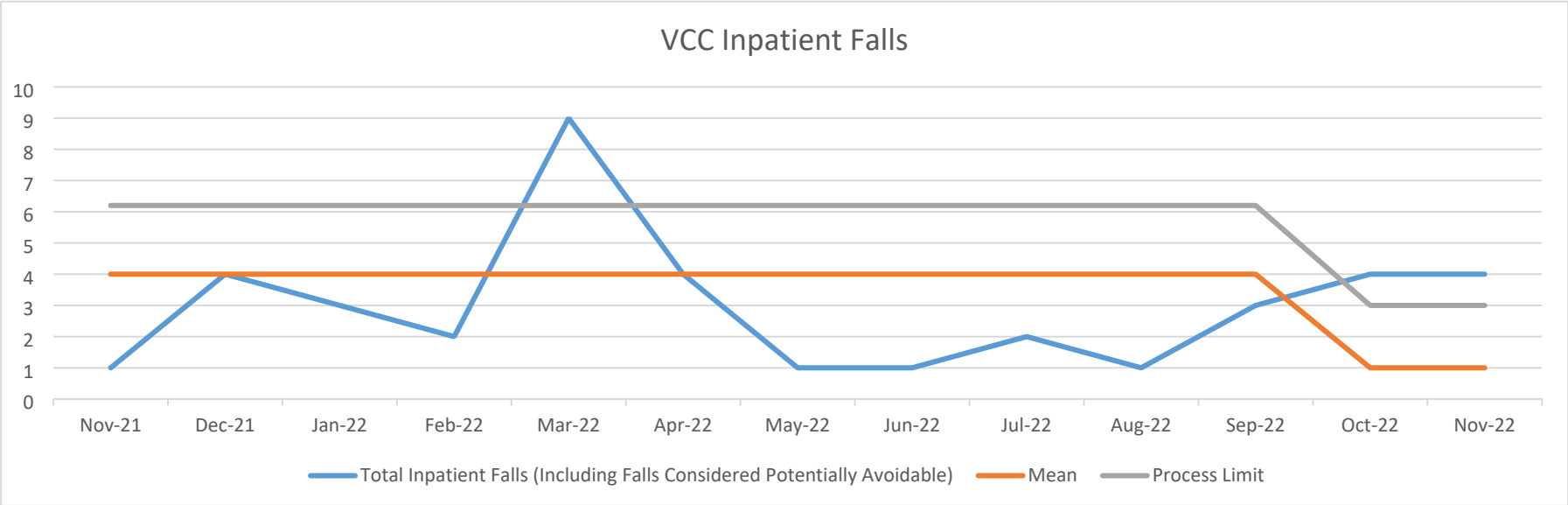
Velindre Acquired Pressure Ulcers	
Target: 0	**SLT Lead: Head of Nursing**
Current Performance	



	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Velindre Acquired Pressure Ulcers (Total)	1	0	1	0	1	1	0	1	0	0	4	1	1
Potentially Avoidable Velindre Acquired Pressure Ulcers	0	0	0	0	1	0	0	1	0	0	0	0	0

Trend	Action
During November 2022 1 VCC acquired pressure ulcer was reported. The patient's family attempted to move the patient with the bed sheet, a grade 2 pressure ulcer was subsequently identified on the patients back. The scrutiny panel deemed this unavoidable.	**Actions: what we are doing to improve** Information was provided to the patients family members regarding repositioning and advised to call for staff if patient requires repositioning.

Velindre Inpatient Falls	
Target: 0	**SLT Lead: Head of Nursing**
Current Performance	



	Nov -21	Dec -21	Jan -22	Feb -22	Mar -22	Apr -22	May -22	Jun -22	Jul -22	Aug-22	Sep-22	Oct-22	Nov-22
Total Inpatient Falls	1	4	3	2	9	4	1	1	2	1	3	4	4
Potentially Avoidable Inpatient Falls	0	0	1	0	0	1	1	0	2	0	1	0	2

Trend	Action
There were 4 falls during November 2022, 2 of which were deemed avoidable after a multi-disciplinary review. Fall 1 –The patient was deemed at risk of falls. All relevant care plans and equipment were in place. Patient had full capacity and did not use the call bell before mobilising and fell. All post fall care completed, and **no harm** identified. Fall 2 – The patient was deemed at risk of falls. All relevant care plans and equipment were in place. Patients second fall during admission. Patient had full capacity and did not use the call bell before mobilising and fell. All post fall care completed, and **no harm** identified. Fall 3 - The patient was deemed at risk of falls due to previous falls at home. All relevant care plans and equipment were in place. The patient was admitted out of hours on the weekend. There was a missed opportunity for referral to out of hours physiotherapy which may have resulted in supply of a walking aid. This fall is therefore deemed avoidable. All post fall care completed, and **no harm** identified. Fall 4 - The patient was deemed at risk of falls due to confusion and agitation and required 1:1 nursing. During a busy night shift, another patient required urgent support from a number of staff. During this period the nurse undertaking the 1:1 supervision was asked to assist. The patient was asleep at the time of the decision, however the patient subsequently woke up and attempted to mobilise and fell. All post fall care completed, and **no harm** identified. Due to the unexpected increase in acuity on the night shift this fall was deemed avoidable.	**Actions: what we are doing to improve** Revise investigation tool. Feedback the outcomes of scrutiny panel back to ward staff. To remind staff about the services provided by physiotherapy on the weekend – this will be discussed with the staff daily during w/c 12/12/22 at the staff huddle. Implement a checking system to check sensor mat equipment. Physiotherapy to develop a referral criteria and attend ward huddles and staff meetings to discuss. This is not currently done at weekends.

Delayed Transfer of Care	
Target: 0	**SLT Lead: Head of Nursing**
Current Performance	

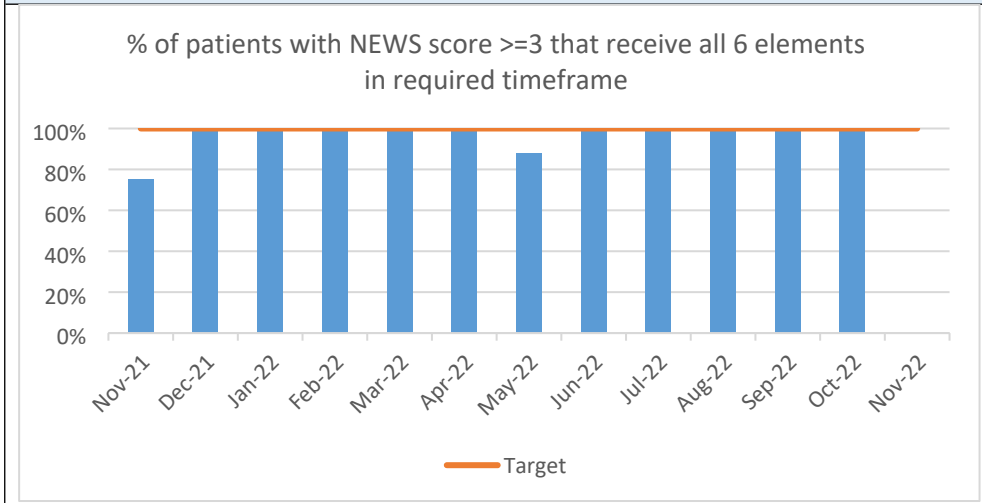
There was 1 DTOC in November 2022.

Patient admitted to FF ward and had a prolonged admission requiring physiotherapy and occupational therapy input to support discharge home and ongoing rehabilitation. Patient was referred for repatriation to local DGH for rehabilitation. There was a delay in repatriation due to lack of bed capacity at accepting DGH. A social work referral and therapies input to support discharge were ongoing during admission and the patient was safely discharged home from VCC, resulting in a delay of 21 days.

Actions:

Monthly operational meetings are now in place between VCC senior team and Health Board teams. We will add DTOC to that agenda to ensure that these cases are understood by the HBs and to consider joint improvements to manage these issues.

In addition, we will join the daily patient flow meetings with HBs, WAST and Welsh Government to ensure that issues impacting on us are shared with the health community for awareness and resolution.

Patients with a NEWS Score Greater Than or Equal to Three Who Receive All 6 Elements in Required Timeframe	
Target: 100%	**SMT Lead: Clinical Director**
Current Performance	Trend
	**Assessment of current performance, set out key points:** • 7 patient episodes met criteria for response to sepsis - 7 received antibiotics within 1 hour where appropriate = 100% • In total 5 patient episodes received diagnosis of sepsis - 5 received all 6 elements within 1 hour = 100%
	Actions
	No improvement actions required.

Healthcare Acquired Infections (HAIs)	
Target: 0	**SLT Lead: Clinical Director**

Current Performance

	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
C.diff	0	0	1	0	1	0	0	0	0	0	0	0	0
MRSA	0	0	0	0	0	0	0	0	0	0	0	0	0
MSSA	0	0	0	0	0	0	0	0	0	0	0	0	0
E.coli bacteremia	0	0	0	0	0	0	0	0	1	0	0	0	0
Klebsiella	0	0	0	0	0	0	0	0	0	0	0	0	0
Pseudomonas Aeruginosa	0	0	0	0	0	0	0	0	0	0	0	0	0

Trend	Action
There were no reported infections in November 2022.	No specific action required.

Welsh Blood Service Monthly Report
November 2022

Gwasanaeth Gwaed Cymru
Welsh Blood Service

Demand for red blood cells (full weeks) averaged at 1371 units per week, and all clinical demand was met in November placing the service in good and stable position. During November the red cell stock holding did not drop below 3 days for priority blood groups (O, A and B+), and stock levels were satisfactory across all groups. Due to this, the service was in a position to export 120 units to Northern Ireland. The role of the daily Demand Planning Group meeting, which includes representatives from all departments supporting the supply chain, has been critical to steering the service through extremely challenging times.

At 96% quality incident investigations completed continues to exceed the target of 90% closed within 30 days. There were no critical or major non-conformances recorded from audits in November, no adverse event reports submitted to the MHRA and no adverse event reports were submitted to the HTA. In addition, no Serious Hazards of Transfusion (SHOT) incidents were reported during the month.

At 96% donor satisfaction continues to remain above target.

In November 2022, 7,904 donors were registered at donation clinics with 8 concerns (0.1%) reported within this period. The one formal concern recorded in November is expected to be completed before the 30 day target of 05/01/23, whilst the remaining concerns were managed as 'early resolution' within the required timescales.

Performance for both % part bags and failed venepuncture are within tolerance, however there is an upward trend in monthly figures that is currently being explored.

Collection efficiency performance failed to meet target in November. This drop in performance is a short term consequence of managing low hospital demand. The number of donor slots was reduced to avoid over collection, however the time was utilised to support staff to complete mandatory training and PADRs.

At 96% the turnaround time for routine Antenatal tests in November remains above the target of 90%, however, Reference Serology turnaround performance failed to meet the 80% target in November at 65%. Recent performance is due to continued staff absences, high levels of testing requests and planned annual leave. An additional Band 6 Specialist Biomedical Scientist resource to increase complex testing is being recruited. Validation of the new automated analyser has been completed and this will start to support an improvement in performance. Further validation of red cell phenotyping equipment is expected to be completed by the end of January 2023 further improving efficiency.

All clinical demand for platelets was met averaging 161 units per week, representing a strong performance against this metric in November. However, platelet wastage is still above target at 15%. Creation of a forecasting tool to inform decisions around pooled platelet manufacture will support a reduction in this figure. This is due to be completed in quarter 4.

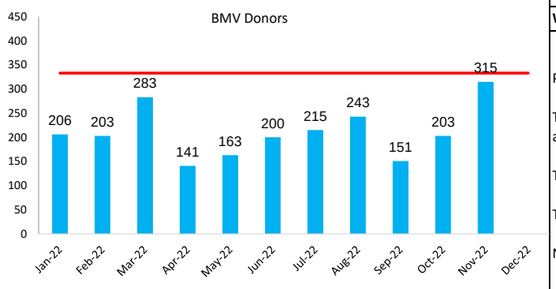
In November, 315 new donors were recruited to the Welsh Bone Marrow Donor Registry (WBMDR) against a target of 333, the highest number recruited this year. The Recovery Plan continues to focus on recruitment of donors at schools, colleges and universities, and in November ensured that a 'Bone Marrow Champion' was present at every school, college and university blood collection session. The service continues to work proactively to understand the optimum programme for recruitment of donors via buccal swab, including utilising digital solutions to improve ways of generating an increase in numbers.

The total stem cells collected in November was 1 (1 collection was cancelled during November for patient reasons). The total stem cell provision for the service was 6 (1 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.

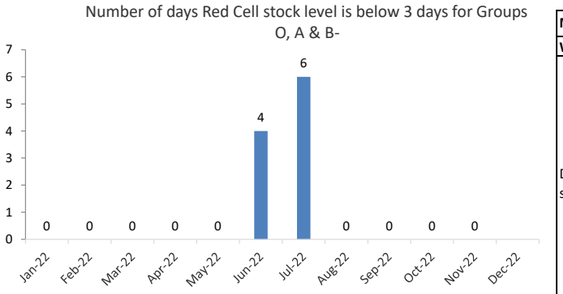
Reference Table

Measure	Target	Timeframe	National / Local
Number of new bone marrow donors aged 18-30 recruited to the Welsh Bone Marrow Donor Registry (WBMDR)	4,000	Annual	Local
Number of days when the Red Blood Cell (RBC) stockholding for O, A & B- fell below 3 days cover	0 days	Monthly	Local
Number of bags of RBCs manufactured as a % of the number of issues to hospitals **(% Red Cell Demand Met)**	100%	Monthly	Local
Number of bags of platelets manufactured as a % of the number of issues to hospitals **(% Platelet Demand Met)**	100%	Monthly	Local
Number of Confirmatory Tests (CTs) requested and bled as a % of the total CTs requested **(Confirmatory Tests Bled)**	65%	Monthly	Local
Number of Stem Cell Collections	80	Annual	Local
Number of antenatal patient results provided to customer hospitals within 3 working days from receipt of sample **(Antenatal Turnaround Times)**	90%	Monthly	Local
Number of samples referred for red cell reference serology work ups provided to customer hospitals within 2 working days. **(Reference Serology Turnaround Times)**	80%	Monthly	Local
% of Quality Incident Records (recorded in DATIX), closed within 30 days over a rolling 3 month period	90%	Rolling	Local
Number of critical non-conformances through external audits or inspections	0	Annual	Local
Number of Serious Adverse Blood Reactions & Events (SABRE) reported to the Medicines and Healthcare products Regulatory Agency (MHRA)	0	Annual	Local
Number of whole blood donations that are collected on session which are below the minimum viable volume, as a % of the total number of whole blood donations collected **(% Part Bags)**	3%	Monthly	Local
Number of donors where venepuncture is attempted to be performed on but no blood enters the bag, as a % of the number of donors who have reached the donation chair **(% Unsuccessful Venepuncture)**	2%	Monthly	Local
The number of blood components (weighted) collected per Standardised FTE (**Blood Collection Efficiency)**	1.25 WTE	Monthly	Local
Number of components manufactured per Standardised FTE. **(Manufacturing Efficiency)**	392	Monthly	Local
Number of platelets which have time expired as a % of the total number of platelets manufactured **(Time Expired Platelets)**	10%	Monthly	Local
Number of RBC units which become non-viable during the manufacturing process which could have been avoided, as a % of the number of complete whole blood donations **(Controllable Manufacturing Losses)**	0.5%	Monthly	Local
Number of bags of RBC, including Paediatric bags, which have time expired as a % of the total number of RBC bags manufactured **(Time Expired Red Cells)**	1%	Monthly	Local
Number of donors that scored 5 or 6 out of 6 (6 being totally satisfied and 1 being totally dissatisfied with their overall donation experience after they have been registered on clinic to donate **(Donor Satisfaction)**	71%	Monthly	Local
Number of 'formal' and 'informal' concerns received from blood donors	~	~	~
% of 'formal' concerns received and treated under 'Putting things Right Regulations within 30 working days	100%	Monthly	National
% of all concerns (formal and informal) acknowledged within 2 working days as required by the 'Putting things Right' Regulations	100%	Monthly	National
Number of new Whole Blood Donors recruited to the donor panel	2,750	Quarterly	Local
Number of new Apheresis Donors recruited to the donor panel	14	Quarterly	Local
Number of Deceased Donor Typing / Cross Matching reported within given period	80%	Quarterly	Local
Number of Anti D & -c Quantitation patient results provided to customer hospitals within 5 working days	90%	Quarterly	Local

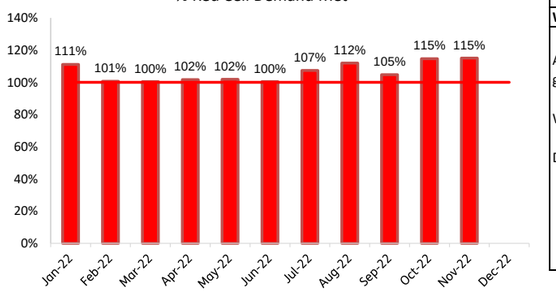
Monthly Reporting



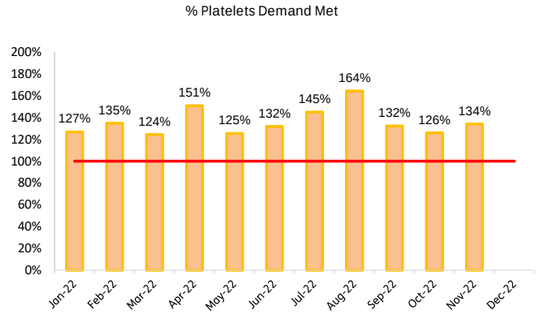
Annual Target: 4000 (ave 333 per month)	SMT Lead: Jayne Davey / Tracey Rees	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Performance has started to improve as the Recovery Plan is implemented but has still not met target in November. The service continues to focus on recruitment of donors at schools, colleges and universities, with a bone marrow champion present at every school, college and University blood session. The number of eligible donors increased in November to 951 versus 700 in October. The service continues to work proactively to understand the optimum programme for recruitment of donors via buccal swabs. NB: there is a delay between timelines of registration and receiving the swabs back from donors of up to six weeks.	A Recovery Plan has been developed to explore new ways to increase recruitment of bone marrow volunteers. A project group has been established to drive implementation and is meeting weekly. A review is being carried out in December and the plan will be adapted accordingly to focus on areas where results are being seen. As part of that plan, targeted bone marrow donor recruitment on social media commenced in November. A 'Roadshow' marketing campaign, which aims to actively recruit donors aged between 17-30 across Wales, is being piloted between December 2022 and May 2023. Digital solutions are being explored to support recruitment. 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.	Ongoing May 2023 Qtr 4



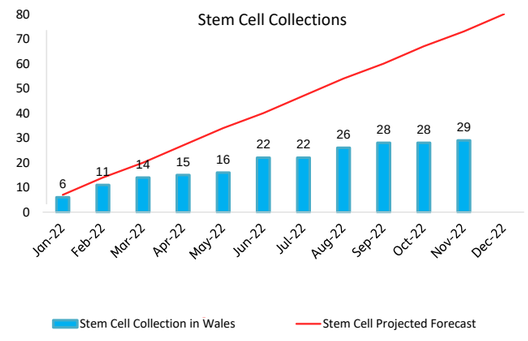
Monthly Target: 0	SMT Lead: Jayne Davey / Tracey Rees	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
During November, the red cell stock holding did not drop below 3 days for priority blood groups (O, A and B+). Stock levels are satisfactory across all groups.	The service constantly monitors the availability of blood for transfusion through its daily Demand Planning 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. Appropriate operational adjustments are made to maintain adequate stock levels and minimise blood shortages.	Reviewed daily to support responses to changes in demand.



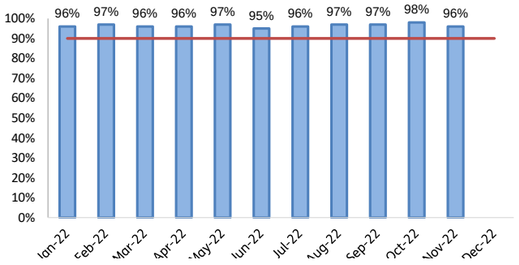
Monthly Target: 100%	SMT Lead: Jayne Davey/ Tracey Rees	
What are the reasons for performance?	**Actions(s) being taken to improve performance**	**By When**
All clinical demand was met in November with the service in good and stable position, with healthy stock levels across all priority groups. Due to this, 120 O+ units were able to be exported to Northern Ireland in November. Washed red cells received due to specialist requirements. Demand in November (full weeks) averaged at 1371 units per week.	The service constantly monitors the availability of blood for transfusion through its daily Demand Planning 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. Appropriate operational adjustments are made to maintain adequate stock levels and minimise blood shortages.	Reviewed daily to support responses to changes in demand.



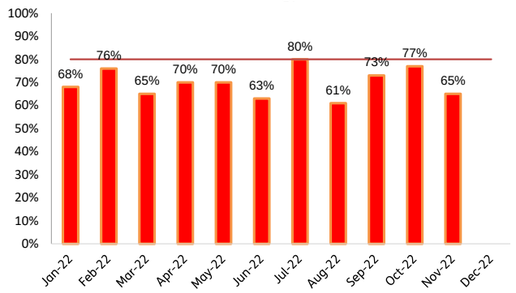
Monthly Target: 100%	SMT Lead: Jayne Davey / Tracey Rees	
What are the reasons for performance?	**Actions(s) being taken to improve performance**	**By When**
All clinical demand for platelets was met representing a strong performance against this metric in November. Platelet demand was 161 units per week on average. Note: A value over 100% indicates sufficiency in supply over the month, whilst a value less than 100% would indicate shortage of platelets. High values will also increase time expiry of platelets.	Due to their short shelf life (7 days), platelet stocks are monitored on a daily basis to ensure adequate response time to any 'spikes' in demand. Daily communications between the Collections and Laboratory teams enables agile responses to variations of stock levels and service needs. The service carried out a review to better understand current demand trends in order to improve production/distribution efficiency performance. Task & Finish Groups were established in Q3 to implement the recommendations. They cover optimising the clinic collection plan for Apheresis and creation of a forecasting tool to inform decisions around pooled platelet manufacture.	Reviewed daily 12 months Qtr 4



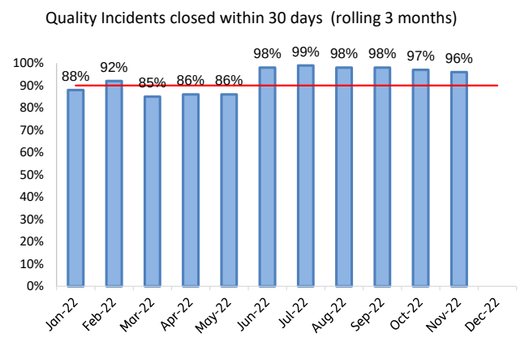
Annual Target: 80 (ave 7 per month)	SMT Lead: Tracey Rees	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
The total stem cells collected was 1 (1 collection was cancelled during November for patient reasons). The total stem cell provision for the service was 6 (1 collected and 5 imported for Welsh patients). In addition, 2 Peripheral Blood Lymphocytes were collected. 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. Currently, 4 stem cell products are due for collection in December.	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.	Quarter 4



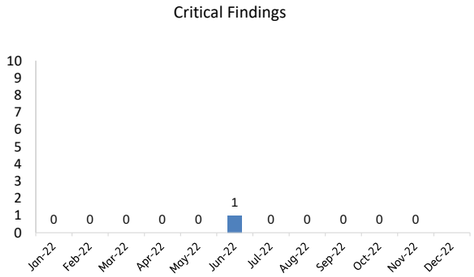
Monthly Target: 90%	SMT Lead: Tracey Rees	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
At 96% the turnaround time for routine Antenatal tests in November remains above the target of 90%.	Efficient and embedded testing systems are in place. Continued monitoring and active management remains in place, maintaining high performance against current target.	Business as Usual, reviewed daily



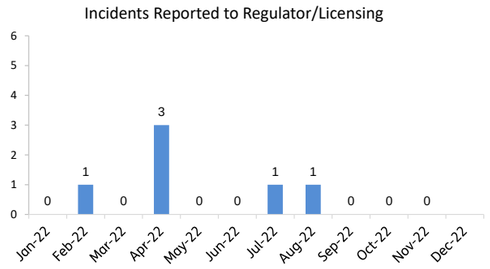
Monthly Target: 80%	SMT Lead: Tracey Rees	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Reference Serology 'turnaround' performance failed to meet the 80% target in November 2022. Recent performance is due to continued staff absences, continued high levels of testing requests and planned annual leave. Compatibility testing (43% of referrals) continues to meet clinical target and all time-critical tests are being completed on time, whilst the volume of testing requests has increased slightly to 228 per month compared to Average 226/month for 2021.	The service conducts specialist tests to confirm hospital results that are difficult to interpret or will undertake additional testing which is not performed in the hospital blood banks. These tests must be performed within 7 days of the sample being taken and are prioritised appropriately to ensure the fastest turnaround possible. The service continues to prioritise compatibility referrals and safe provision of red cells for transfusion. All referrals are prioritised based on clinical need. An additional Band 6 Specialist Biomedical Scientist resource to increase complex testing is being recruited. Validation the new automated analyser has been completed and this will start to support an improvement in performance through efficiency. Further validation of red cell phenotyping equipment is expected to be completed by the end of January 2023 further improving analytical efficiency.	Quarter 4 January 2023



Monthly Target: 90%	SMT Lead: Peter Richardson	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
At 96% Quality incident investigations closed within 30 days continues to exceed the target of 90% . A 1% reduction in month is within expected variation for this measure.	Continue to closely monitor performance. Each incident report is reviewed within a working day of being reported to ensure all information needed for effective risk assessment and investigation is captured. The review identifies complex investigations that may need multi-disciplinary support to establish a root cause. We expect the multidisciplinary approach to investigating complex incidents to enable faster identification of root cause and more effective preventative action to be put in place. The progress of actions to address incidents is closely monitored. The QA team continue to send weekly updates alerting owners/managers of actions recorded within QPulse that are likely to breach close-out deadlines.	Every incident report is reviewed within a working day of being reported

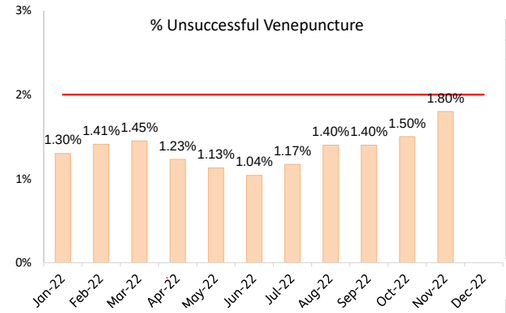


Target: 0	SMT Lead: Peter Richardson	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
There were no critical or major non-conformances in November.	Where they occur, the work to assign root causes of non conformances will be completed.	

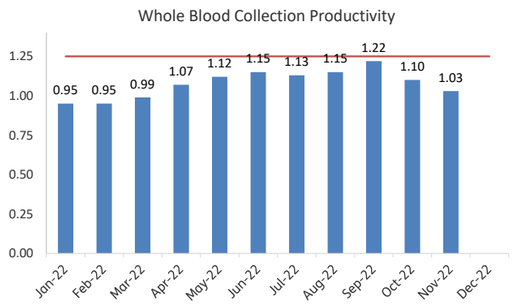


Annual Target: 0	SMT Lead: Peter Richardson	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
There were no Serious Averse Blood-Related Event (SABRE) reports submitted to the Medicines and Healthcare Product Regulatory Agency (MHRA) in November. No adverse event reports were submitted to the Human Tissue Authority (HTA), and no Serious Hazards of Transfusion (SHOT) incidents were reported during the month.	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.

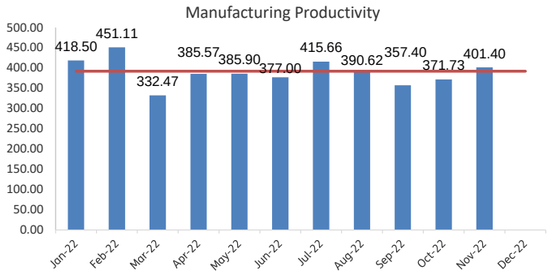
Monthly Target: Maximum 3%	SMT Lead: Janet Birchall	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Performance remains within the required tolerance level of 3% at 2.92% for November, however there is an upward trend in monthly figures that is being explored. NB: Causes of Part Bags are various (needle placement, clinical risk, donor is unwell, donor request to stop donation, late donor information and equipment failure) and at times cessation of donation resulting in a part bag is clinically appropriate. This is a separate factor to Failed Venepuncture (FVPs).	Work is underway with Clinical Services and the Training Team to understand rationale for upward trend. Findings shared with operational managers and further training/support provided where required. Continue with close monitoring and intervention where required.	Ongoing



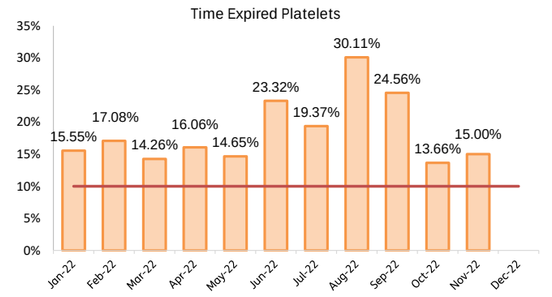
Monthly Target: Maximum 2%	SMT Lead: Janet Birchall	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
At 1.8%, overall performance is within the required tolerance (2%), however there is an upward trend in monthly figures that is being explored.	Work is underway with Clinical Services and the Training Team to understand rationale for upward trend. Findings shared with operational managers and further training/support provided where required. Continue with close monitoring and intervention where required.	Ongoing



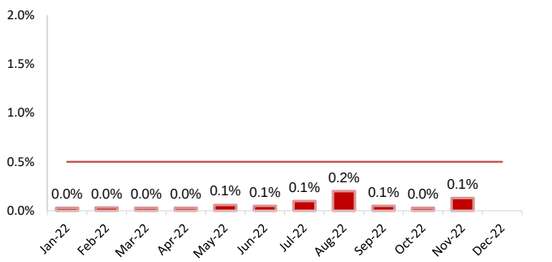
Monthly Target: 1.25	SMT Lead: Jayne Davey	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Collection efficiency performance failed to meet target in November. This drop in performance is a short term consequence of managing low hospital demand. The number of donor slots was reduced to avoid over collection, however the time was utilised to support staff to complete mandatory training and PADRs. NB. Current resource reporting does not allow for recording of non-donor facing hours which also has had a direct impact on performance reporting.	Daily review of stock levels in conjunction with the wider service to support correct available 'days of blood' by blood group stock levels. Supporting staff to complete mandatory training and PADRs when capacity allows. Daily monitoring of hospital demand to support flexible increases in capacity if required. Update the current efficiency reporting tool to incorporate the capture of non-donor facing hours, this will lead to a more accurate reporting efficiency.	December 2022



Monthly Target 392	SMT Lead: Tracey Rees	
What are the reasons for performance?	**Actions(s) being taken to improve performance**	**By When**
At 401 manufacturing efficiency performance exceeds the target of 392. NB. This target measures the manufacturing productivity by assessing the staffing levels against the number of blood components being manufactured.	Continue to monitor and review as part of development of new suite of KPIs.	

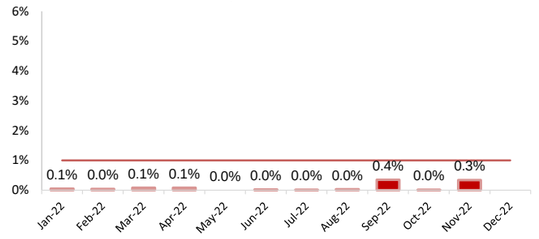


Monthly Target: Maximum 10%	SMT Lead: Tracey Rees	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Platelet wastage is still above target at 15% due to difficulty in understanding production/distribution efficiency performance. Demand continues to be met without the need for Mutual Aid support.	Given the variability of expired platelets over the past 12 months, the service has carried out a review to better understand current demand trends in order to improve production/distribution efficiency performance. Task & Finish groups have been established in November to implement the recommendations. They cover optimising the clinic collection plan for Apheresis and creation of a forecasting tool to inform decisions around pooled platelet manufacture. Regular highlight reports are being submitted to the SMT. More sustained resolution will arise through the work exploring cold platelet storage which the Component Development Laboratory are facilitating.	12 months Qtr 4



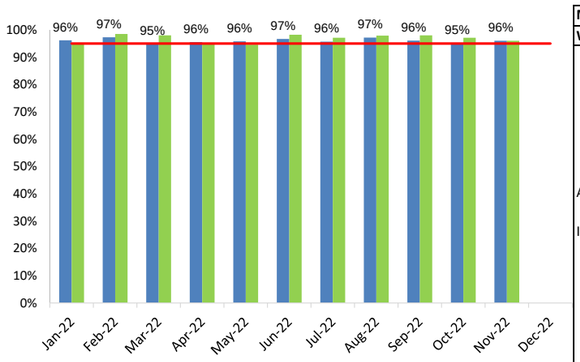
Monthly Target: Maximum 0.5%	SMT Lead: Tracey Rees	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Controllable losses were low at 0.13% and remain within tolerance of below 0.5%. These levels are well within tolerance and represent good performance.	Active management of the controllable losses in place, including vigilance and reporting of all units lost. Ongoing monitoring of losses when occurring in order to understand the reasons and consider appropriate preventative measures thus continuously improving practice through lessons learned and analysis.	Business as Usual, reviewed monthly

Time Expired Red Cell



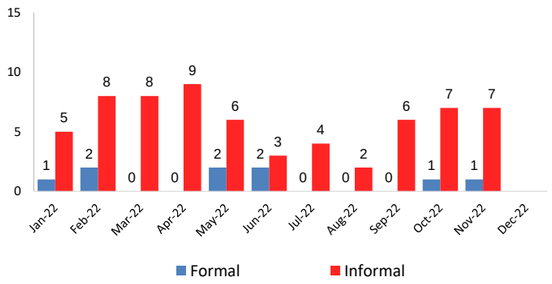
Monthly Target: Maximum 1%	SMT Lead: Tracey Rees	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
This metric remains well within the target and there are no concerns around expiry of red cells.	Daily monitoring of age of stock as part of the resilience meetings. Red Cell shelf life is 35 days, with all blood stocks stored in blood group and expiry date order and issued accordingly. Continued effective management of blood stocks to minimise the number of wasted units.	Business as usual, reviewed daily

Donor Satisfaction



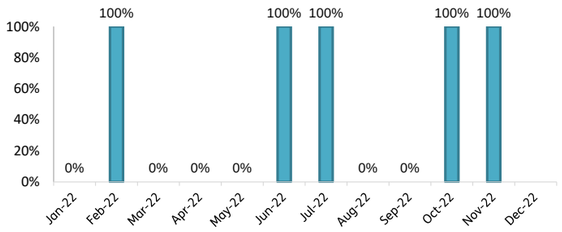
Monthly Target: Minimum 71%	SMT Lead: Jayne Davey	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
At 96.1% donor satisfaction continues to be above target for November. In total there were 1,100 respondents to the donor survey.	Findings are reported to the Senior Management Team (SMT) at the Collections meeting to address any actions for individual teams. WBS has now fully implemented the Civica tool at post donation care on donor sessions. Feedback will be incorporated into future quarterly divisional highlight reports.	Business as usual, reviewed monthly

Number of Concerns Received



Target: N/A	SMT Lead: Alan Prosser	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
In November 2022, 7,904 donors were registered at donation clinics with 8 concerns (0.1%) reported within this period. The one formal concern recorded in November is being managed under 'Putting Things Right' (PTR) regulations and is expected to be completed before the 30 day target of 05/01/23. The formal concern recorded in October was completed on 21/10/22, ahead of the 30 day target. The remaining concerns were managed as 'early resolution' within the required timescales. Formal Concern: A Donor raised a number of concerns around donation experience. Early Resolutions: 1. A donor felt rushed, was disappointed with RN's behaviour. 2. 2 Donors were unhappy to be turned away from session when attending with children. 3. 2 Donors were unhappy to be turned away from session for being late. 4. A donor was unhappy with the lack of available venues in postcode area. 5. A donor was unhappy that a staff member made comment about existing bruise on arm.	Formal Concern: A full Investigation underway to establish if there was a breach of duty. Early Resolution: 1. An apology was made to the donor regarding their donation experience, caused by the failure of the RN to explain the need to wash hands following a blood spillage. The RN has been reminded of the importance of effective communication. 2. The Clinical Lead RN in question has been reminded to discuss attendance at collections session with donors who bring children, emphasising that accepting children at donation centres will be at their discretion and based on clinical safety and venue capacity. 3. Reception staff have been reminded to inform the Clinical Lead RN of donors who arrive late for their appointment, in order to be able to assess clinic capacity and safety and the potential to accept late donors. 4. Following appropriate risk assessments as part of the aim to restore collections to pre COVID levels, plans to re-introduce Mobile Donation Units (MDU) to support the availability of collections made in the community are now in place. 5. Collections team staff have been reminded of the importance of effective and sensitive use of their communication skills with donors.	

% Responses to Concerns within 30 Working Days



Monthly Target: 100%	SMT Lead: Alan Prosser	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
All concerns due to be completed in November were dealt with in October ahead of timeline. The Service is on target to conclude the formal concern received in November within the 30-working day timeframe. All concerns continue to be monitored and actioned as appropriate. * 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.	Continue to monitor this measure against the '30 working day' target compliance. Continued emphasis of the 'Concern' timescale needs to all involved in concerns management reporting. Review Standard Operating Procedure (SOP) relating to children attending session with donors. - Training Awareness of Effective Documentation Skills is taking place. - Ongoing individualised staff assessments.	December 2022

% Concerns Acknowledged within 2 Working Days

Monthly Target: 100%	SMT Lead: Alan Prosser	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Performance met target in November 2022, with all concerns managed within required timelines.	Continued daily monitoring of this measure against the 'two working day' compliance target. Remind all staff involved in concerns management of the importance of the 2-day response timescale Review the Standard Operating Procedure (SOP) relating to children attending donation sessions Training Awareness of Effective Documentation Skills is taking place. Ongoing individualised staff assessments	

Quality, Safety and Performance Committee

Annual Equality Report 31 March 2022

DATE OF MEETING	17 January 2023

PUBLIC OR PRIVATE REPORT	Private

IF PRIVATE PLEASE INDICATE REASON	Draft Status - Final Version will be Published in Public Domain

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

REPORT PURPOSE	ENDORSE FOR BOARD APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
EMB	**5.12.22**	**Endorsed for Committee approval**

ACRONYMS	
VCC	Velindre Cancer Centre
WBS	Welsh Blood Service

1. SITUATION/BACKGROUND

1.1 This report provides the equality monitoring data in line with the Equality Act 2010 and the Public Sector Equality Duty (2011). The equality duty was created under the Equality Act 2010. The equality duty replaced the race, disability and gender equality duties. The workforce statistics relating to protected characteristics as at 31 March 2022 can be seen in appendices 1 and 2. The data presented at Appendix 1 covers the full legal entity, including NHS Wales Shared Services, and the data presented at Appendix 2 is Velindre only, covering Velindre Cancer Centre, Welsh Blood Service and Corporate Services.

1.2 The Public Sector Equality Duty (PSED) requires that all public authorities covered under the specific duties in Wales should produce an annual equality report by 31st March each year. The essential purpose of the specific duties under the Equality Act, in relation to monitoring, is to help authorities to have better due regard to the need to achieve the three aims of the general duty, which are to:

- eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Act;
- advance equality of opportunity between people who share a protected characteristic and people who do not share it;
- foster good relations between people who share a protected characteristic and people who do not share it.

Therefore, as a specific duty itself, the role of annual reporting is to support the Trust in meeting the general duty. It also has a role in setting out achievements and progress towards meeting the other specific duties. In particular, the annual report supports the Trust to have a better due regard to the duties by providing an opportunity to;

- Monitor and review progress;
- Monitor and review the effectiveness and appropriateness of arrangements;
- Review objectives and processes in light of new legislation and other new developments;
- Engage with stakeholders around these issues, providing partners and the public with transparency.

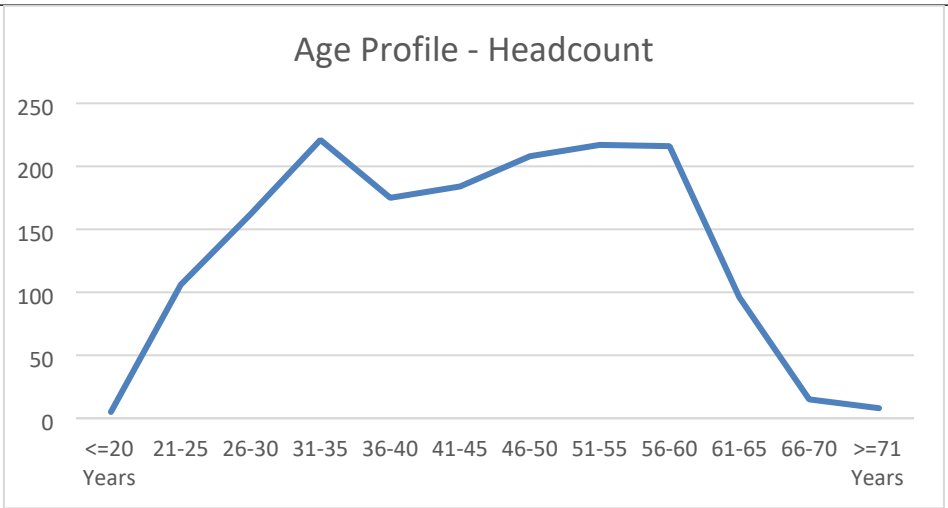
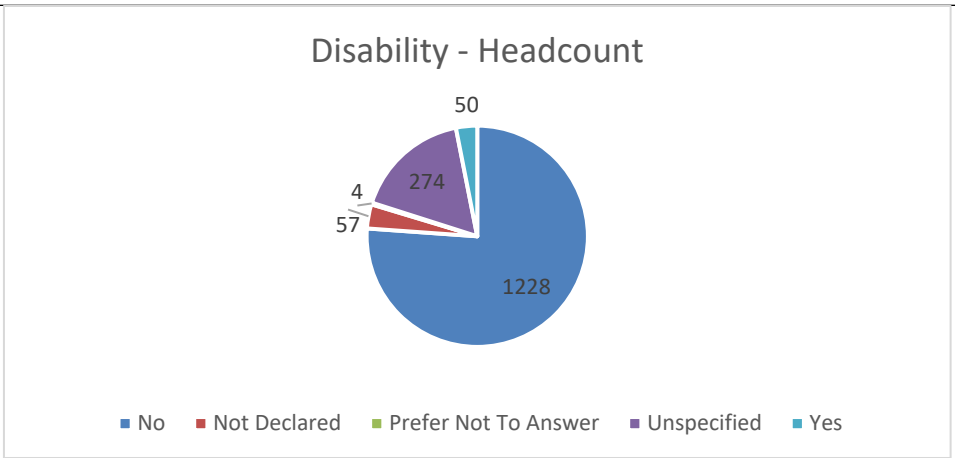
1.3 As well as meeting the Trust's obligations under the Public Sector Equality Duty, this data will inform the Trust's Workforce and OD actions, in the areas of recruitment, training and policy.

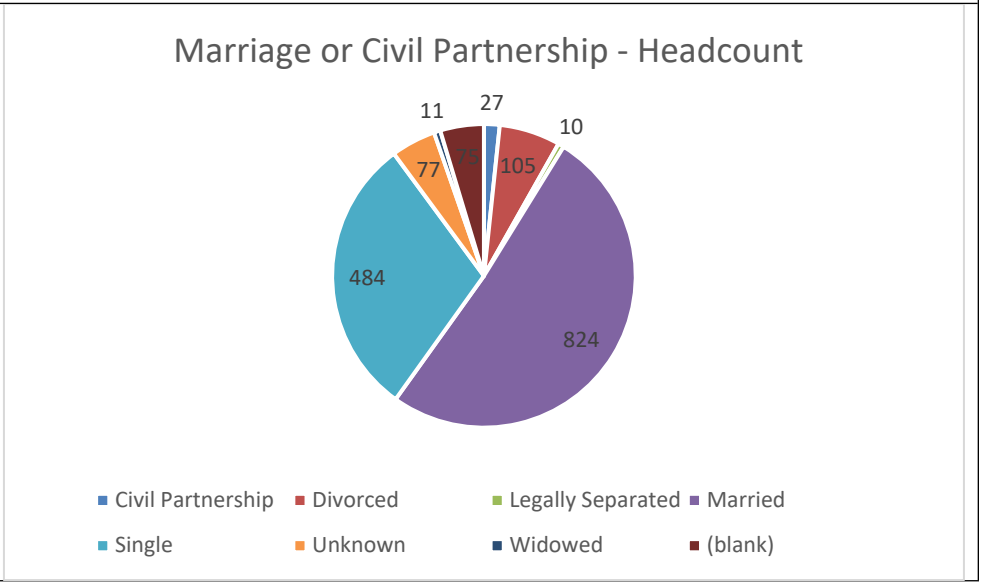
1.4 The report also includes a synopsis of progress made against the Trust's Strategic Equality Plan objectives, which run from 2020 to 2024.

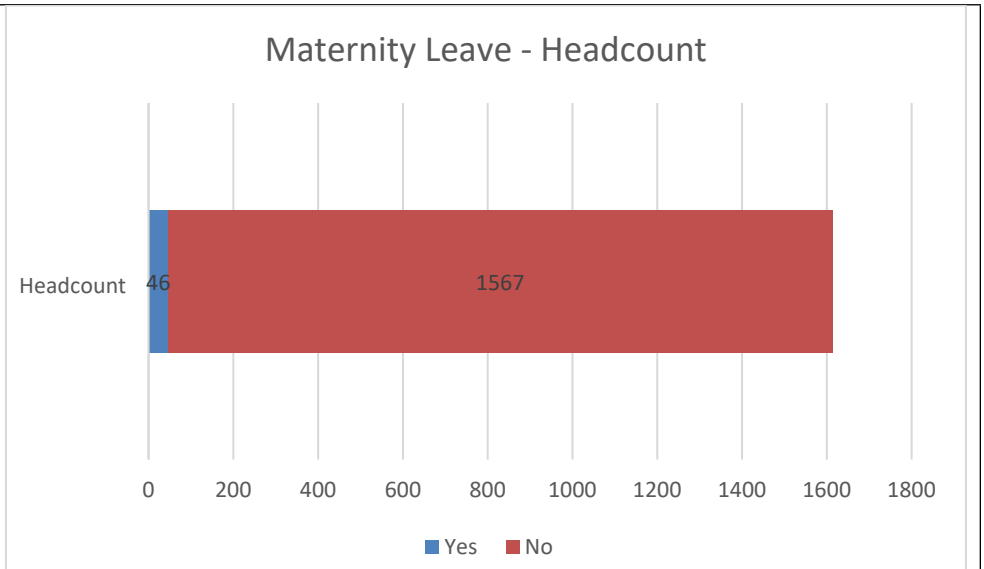
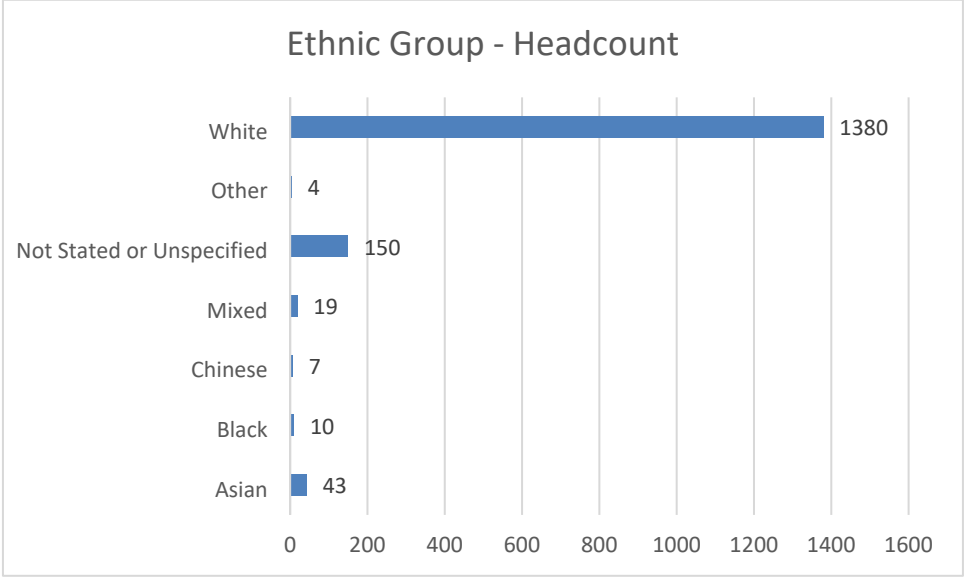
2. ASSESMENT / SUMMARY OF MATTERS FOR CONSIDERATION

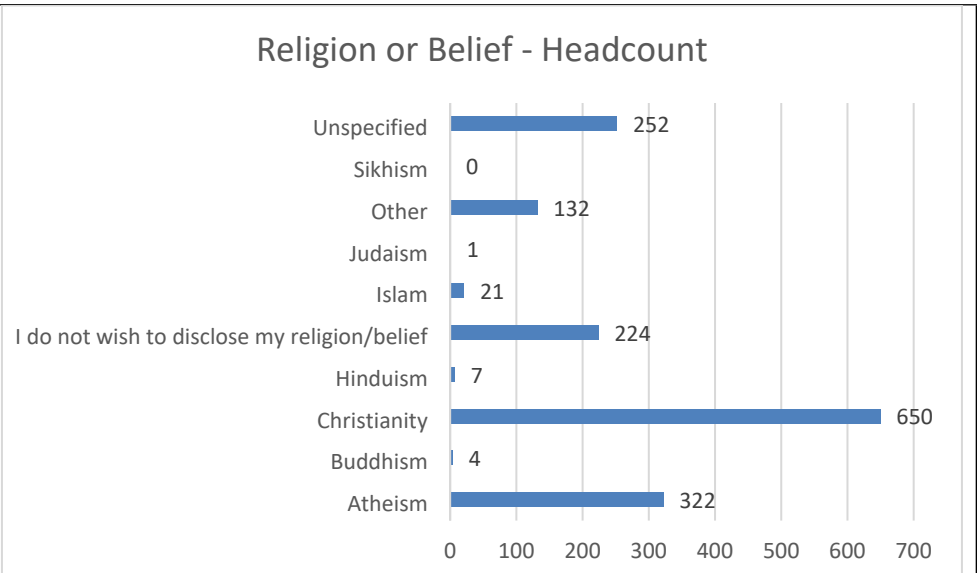
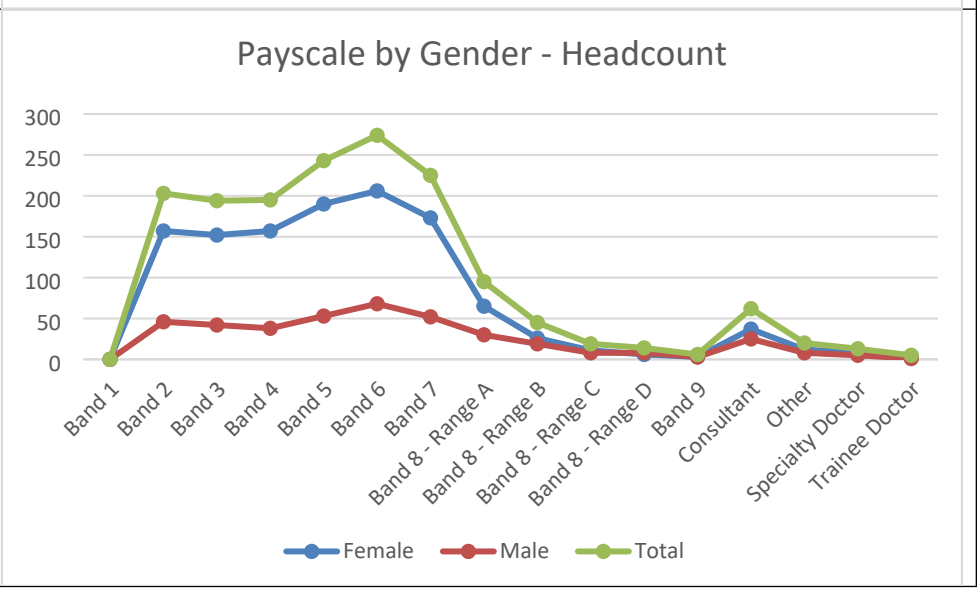
There are nine protected characteristics under the Equality Act 2010 which all public sector organisation report on annually. Statistics are neutral; it is the picture they paint that can help us understand difference in experience of employees from different backgrounds.

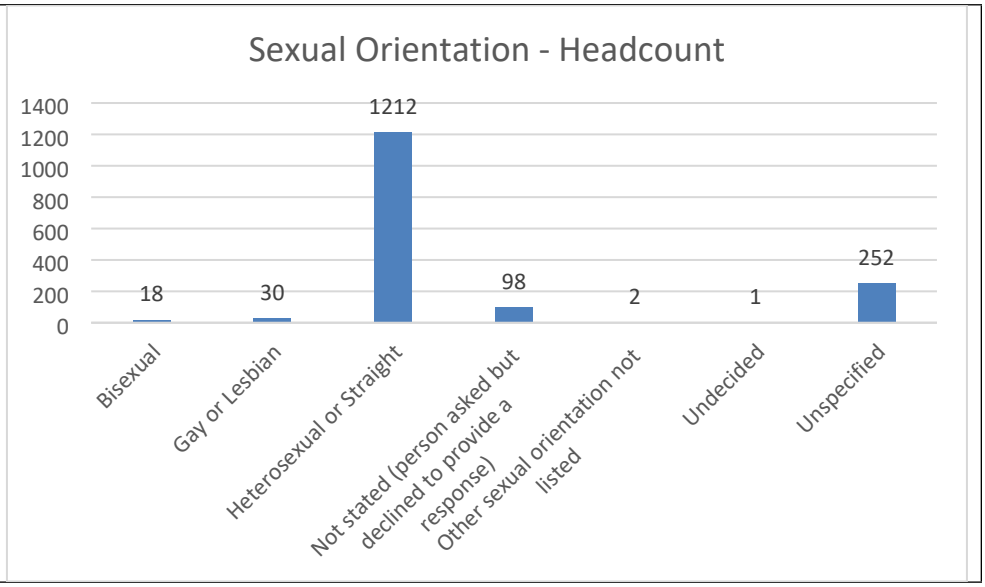
The data for the combined organisation of 6,505 people is available at Appendix 1. The analysis below focuses on the 1,613 people at Velindre (excluding hosted) only, shown at Appendix 2.

1	**Age** Spread between age 31 and 60, with a dip between 36 and 46. Lower numbers below the age of 30. This profile informs the Trust's Recruitment strategy with age profile data being used to identify future shortfalls in different professions as a result of retirements.	
2	**Disability** 3% of the workforce have declared a disability compared with around 16% of the working population. However, 21% are listed as Not Declared/ Prefer not to Answer/ Unspecified which needs to be reviewed.	

	The Trust is registered as a Disability Confident Employer Level 2 and is working towards Level 3.	
3	**Gender Reassignment**	ESR does not record Gender Reassignment and therefore we do not hold statistics on this characteristic. Whilst we cannot present statistics on Gender Reassignment the Trust has a Supporting Transgender Staff Policy which provides a framework for staff who have transitioned or who are in the process of transitioning their gender.
4	**Marriage or Civil Partnership** Half the workforce is married and almost a third are single. Other categories make up the remaining 20%.	

5	**Pregnancy or Maternity** 2.85% of the workforce were on Maternity Leave on 31 March 2022 which reflects the public sector norm.	
6	**Race** 86% are recorded as White, with the second largest group being Asian at 3%. Attention needs to be given to updating the 9% of records which are currently Not Stated or Unspecified. The Trust is developing an Anti-Racist Plan including implementation of the Workforce Race Equality Standard which will give a more detailed picture of the experience of Black and Minority Ethnic staff.	

7	**Religion or Belief** 40% Christian, 20% Atheist, 14% Do Not wish to Disclose. 16% unspecified needs to be followed up. The Trust has set up a Multi Faith Room at the VCC and is designing one for WBS at Talbot Green.	
8	**Sex (Gender)** 75:25 split Female to Male. 58% of women have full time roles compared with 84% of men. Payscales for Men make a up a smaller proportion of jobs at Bands 7 and below than for Bands 8 and above. This area is dealt with more fully within the Gender Pay Gap report.	

9	**Sexual Orientation** 75% straight, 6% Not Stated and 15% Unspecified. This data gap needs to be followed up.	

2.1 Progress with the five objectives in the Strategic Equality Plan is outlined below.

2.1.1 Increase workforce diversity and inclusion

A Widening Access Coordinator postholder has been working with local colleges and the community to offer a wider variety of routes into working in healthcare. The Trust has provided Internships and Apprenticeships to local people to support their education and employment experience. The Trust is working with HEIW on national careers initiatives, for clinical and non-clinical roles.

The Trust is accredited at Level 2 of Disability Confident and is working towards Level 3.

Staff Networks have been operational from time to time although participation was hampered due to COVID and related restrictions. A new phase of work started in 2022 to establish the networks and engagement opportunities that staff are looking for.

The focus on individual staff needs and risks that was required during COVID has left a positive legacy in terms of how people's needs are considered at work. This has informed the Trust's approach to hybrid working where instead of rigid policies regarding working location being applied to all staff, there are fundamental principles in place showing that service needs determine what work needs to be done and then there can be flexibility about how or where that is done to reflect individual preferences.

2.1.2 Eliminate pay gaps

The focus has been on the Gender Pay Gap with the Trust reporting in line with national requirements. The reporting cycle for this has been brought forward in 2022 to allow the Trust earlier identification of issues and opportunities to reduce the pay gap. This will be

supplemented by calculating the Race Pay Gap in 2023 in line with the Anti-Racism Wales plan and the Trust will also implement the policy on pay gaps in relation to Disability once the details have been issued.

All new posts are evaluated through the All Wales Job Evaluation process to counteract bias relating to preconceptions of the value of different work. Recent improvements to the recruitment process have made it easier for new staff to apply for incremental credit on appointment which will reduce disparity in starting salaries between people with a protected characteristic and those without.

2.1.3 Engage with the community

Patient feedback is gathered in VCC in relation to the provision of cancer services and to understand people's views and experience. Similarly, Donor feedback is used by WBS to refine their processes. A specific example is the work done to increase the diversity of the Bone Marrow donor panel. Approximately 2% of the Welsh Bone Marrow Donor Registry (WBMDR) panel is identified as minority ethnic and this is reflected in the blood donor panel. In recognition of this under-representation and to encourage ethnic diversity on the stem cell donor panel, the WBMDR have introduced registration for non-blood donors using mouth swabs instead of blood samples. Consequently, the service can recruit from communities not actively giving blood strengthening the ability of the WBMDR to recruit donors from all communities.

The WBMDR is actively engaging ethnic minority communities to understand the barriers to joining the stem cell donor panel. This includes the Welsh Race Forum and the National Black Asian and Minority Ethnic Transplant Alliance.

Velindre University NHS Trust uses an integrated assessment process for equality, wellbeing and socio-economic impact. This rounded approach means that all issues are raised and reviewed at the early stage of any project. For example, a recent EQIA on the inclusive design of our new VCC hospital in Cardiff examined the impact on people from a wide range of perspectives. This aims to ensure that everyone is able to participate and relax and have equal access to treatment. This would be achieved through making the building accessible from the beginning, giving clear signposting and communication and providing an on-site car parking and bus stop and future public transport links. This has the potential to reduce health inequalities

2.1.4 We communicate with people in ways that meet their needs

The Trust has implemented the Active Offer in relation to the Welsh language in VCC and WBS. Improvements have been achieved in the range of ways patients and donors can access service through the medium of Welsh.

The Trust uses the Wales Interpretation and Translation service which provides 24/7 translation support in 135 languages including BSL. Staff can access this when it will assist in

communicating with patients who do not communicate effectively in English.

2.1.5 Ensure service delivery reflects individual need.

Equality Impact Assessments are used to support any service development or change. These are comprehensive assessments covering the protected characteristics, socio-economic duty and sustainability. They are a systematic approach to ensure service delivery reflects individual needs.

In addition to Equality Impact Assessments, work has been in hand in VCC and WBS to tailor services. One specific example of this relates to lifting the ban on Gay men from blood donation in 2021.

On 14 June 2021 the UK rules around blood donation changed, allowing more people than ever before to be eligible to donate including people from the Men who have Sex with Men (MSM) community. Dr Stuart Blackmore from WBS played a leading role in the research that led to this change.

Prior to the change in donation rules we announced the changes through media releases distributed to national and local outlets, including Welsh Government and LGBT+ groups. The announcement was shared through national news outlets such as ITV, BBC and S4C. Detailed information was also provided through the WBS channels such as dedicated webpages, FAQs and social media posts.

On the day of launch a donation session was arranged featuring a gay male couple, a gay male and regular blood donor and the First Minister of Wales. ITV and BBC both filmed on the day and media releases were sent publicly, including Welsh Government, Wales247 and more. Announcements were made on the day via WBS social channels featuring quotes from the donors including the First Minister.

After the launch, the WBS continued to promote the introduction of the new rule over a 16-week period (one full cycle for donors) via SMS and social media updates. WBS' Dr Stuart Blackmore also represented the Service at a live Q&A held by Pride Cymru for the LGBT+ community. A full review was carried out to analyse the success of the campaign during National Blood Donor Week. Over 235,000 accounts were reached during the week.

As a result of this change we no longer ask donors about their sexuality, this makes it difficult to quantify the number of previously excluded individuals who have now become donors. Anecdotal feedback immediately after the change was extremely positive and continues to be so.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
	The work described in this report supports the organisation in its achievements of its duties under Equality legislation which benefits people across all protected characteristics
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The Trust is required to publish its Equality Monitoring Information of 31 March 2022 by 31 March 2023.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

The Quality, Safety and Performance Committee is asked to **ENDORSE** this report for onwards submission to the Trust Board.

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Appendix 1

Equality Monitoring Data Velindre University NHS Trust

(including NHS Wales Shared Services Partnership)

Employment Category	Headcount	%
Full Time	5028	77.29
Part Time	1477	22.71
Grand Total	**6505**	**100.00**

Gender	Headcount	%
Female	3920	60.26
Male	2585	39.74
Grand Total	**6505**	**100.00**

Age Band	Headcount	%
<=20 Years	23	0.35
21-25	744	11.44
26-30	1287	19.78
31-35	1241	19.08
36-40	700	10.76
41-45	549	8.44
46-50	537	8.26
51-55	554	8.52
56-60	525	8.07
61-65	266	4.09
66-70	53	0.81
>=71 Years	26	0.40
Grand Total	**6505**	**100.00**

Sexuality	Headcount	%
Bisexual	67	1.03
Gay or Lesbian	91	1.40
Heterosexual or Straight	3979	61.17
Not stated (person asked but declined to provide a response)	355	5.46
Other sexual orientation not listed	4	0.06
Undecided	1	0.02
Unspecified	2008	30.87
Grand Total	**6505**	**100.00**

Religious Belief	Headcount	%
Atheism	1116	17.16
Buddhism	45	0.69
Christianity	2064	31.73

Staff Group	Headcount	%
Add Prof Scientific and Technic	79	1.21
Additional Clinical Services	403	6.20
Administrative and Clerical	2181	33.53
Allied Health Professionals	153	2.35
Estates and Ancillary	605	9.30
Healthcare Scientists	165	2.54
Medical and Dental	2675	41.12
Nursing and Midwifery Registered	241	3.70
Students	3	0.05
Grand Total	**6505**	**100.00**

Employment Category By Gender	Headcount Female	Headcount Male	Grand Total
Full Time	2713	2315	5028
Part Time	1207	270	1477
Grand Total	**3920**	**2585**	**6505**

Pay Grade By Gender	Female	Male	Total
Band 1	1	1	2
Band 2	303	422	725
Band 3	486	233	719
Band 4	414	158	572
Band 5	369	153	522
Band 6	334	137	471
Band 7	267	120	387
Band 8 - Range A	114	62	176

Hinduism	97	1.49
I do not wish to disclose my religion/belief	661	10.16
Islam	342	5.26
Judaism	4	0.06
Other	393	6.04
Sikhism	15	0.00
Unspecified	1768	27.18
Grand Total	**6505**	**100.00**

Ethnic Origin	Headcount	%
Asian	446	6.86
Black	146	2.24
Chinese	31	0.48
Mixed	89	1.37
Not Stated or Unspecified	1491	22.92
Other	48	0.74
White	4254	65.40
Grand Total	**6505**	**100.00**

Disability	Headcount	%
No	5056	77.72
Not Declared	246	3.78
Prefer Not To Answer	5	0.08
Unspecified	1035	15.91
Yes	163	2.51
Grand Total	**6505**	**100.00**

Marital Status	Headcount	%

Band 8 - Range B	65	42	107
Band 8 - Range C	32	34	66
Band 8 - Range D	12	17	29
Band 9	5	10	15
Consultant	51	42	93
Other	23	21	44
Specialty Doctor	8	5	13
Trainee Doctor	1436	1128	2564
Grand Total	**3920**	**2585**	**6505**

Civil Partnership	72	1.11
Divorced	231	3.55
Legally Separated	30	0.46
Married	2294	35.27
Single	1762	27.09
Unknown	1389	21.35
Widowed	28	0.43
(blank)	699	10.75
Grand Total	**6505**	**100.00**

Profession by Gender	Female	Male	Total
Add Prof Scientific and Technic	54	25	79
Additional Clinical Services	291	112	403
Administrative and Clerical	1475	706	2181
Allied Health Professionals	129	24	153
Estates and Ancillary	146	459	605
Healthcare Scientists	100	65	165
Medical and Dental	1499	1176	2675
Nursing and Midwifery Registered	223	18	241
Students	3	0	3
Grand Total	**3920**	**2585.00**	**6505**

On Maternity	Headcount	%
Yes	160	2.46
No	6345	97.54
Grand Total	**6505**	**100.00**

Contract Type by Gender	Female	Male	Total
Fixed Term Temp	1731	1381	3112
Permanent	2189	1204	3393
Grand Total	**3920**	**2585.00**	**6505**

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Appendix 2

Equality Monitoring Data Velindre University NHS Trust

(excluding NHS Wales Shared Services)

Employment Category	Headcount	%
Full Time	1045	64.79
Part Time	568	35.21
Grand Total	**1613**	**100.00**

Gender	Headcount	%
Female	1207	74.83
Male	406	25.17
Grand Total	**1613**	**100.00**

Age Band	Headcount	%
<=20 Years	5	0.31
21-25	106	6.57
26-30	162	10.04
31-35	221	13.70
36-40	175	10.85
41-45	184	11.41
46-50	208	12.90
51-55	217	13.45
56-60	216	13.39
61-65	96	5.95
66-70	15	0.93
>=71 Years	8	0.50
Grand Total	**1613**	**100.00**

Sexuality	Headcount	%
Bisexual	18	1.12
Gay or Lesbian	30	1.86
Heterosexual or Straight	1212	75.14
Not stated (person asked but declined to provide a response)	98	6.08
Other sexual orientation not listed	2	0.12
Undecided	1	0.06
Unspecified	252	15.62
Grand Total	**1613**	**100.00**

Staff Group	Headcount	%
Add Prof Scientific and Technic	54	3.35
Additional Clinical Services	275	17.05

Religious Belief	Headcount	%
Atheism	322	19.96
Buddhism	4	0.25
Christianity	650	40.30
Hinduism	7	0.43
I do not wish to disclose my religion/belief	224	13.89
Islam	21	1.30
Judaism	1	0.06

Administrative and Clerical	567	35.15
Allied Health Professionals	152	9.42
Estates and Ancillary	76	4.71
Healthcare Scientists	165	10.23
Medical and Dental	83	5.15
Nursing and Midwifery Registered	238	14.76
Students	3	0.19
Grand Total	**1613**	**100.00**

Employment Category By Gender	Headcount Female	Headcount Male	Grand Total
Full Time	703	342	1045
Part Time	504	64	568
Grand Total	**1207**	**406**	**1613**

Pay Grade By Gender	Female	Male	Total
Band 1	0	0	0
Band 2	157	46	203
Band 3	152	42	194
Band 4	157	38	195
Band 5	190	53	243
Band 6	206	68	274
Band 7	173	52	225
Band 8 - Range A	65	30	95
Band 8 - Range B	26	19	45
Band 8 - Range C	11	8	19
Band 8 - Range D	6	8	14
Band 9	3	3	6

Other	132	8.18
Sikhism	0	0.00
Unspecified	252	15.62
Grand Total	**1613**	**100.00**

Ethnic Origin	Headcount	%
Asian	43	2.67
Black	10	0.62
Chinese	7	0.43
Mixed	19	1.18
Not Stated or Unspecified	150	9.30
Other	4	0.25
White	1380	85.55
Grand Total	**1613**	**100.00**

Disability	Headcount	%
No	1228	76.13
Not Declared	57	3.53
Prefer Not To Answer	4	0.25
Unspecified	274	16.99
Yes	50	3.10
Grand Total	**1613**	**100.00**

Marital Status	Headcount	%
Civil Partnership	27	1.67
Divorced	105	6.51
Legally Separated	10	0.62
Married	824	51.08

Consultant	37	25	62	Single	484	30.01
Other	12	8	20	Unknown	77	4.77
Specialty Doctor	8	5	13	Widowed	11	0.68
Trainee Doctor	4	1	5	(blank)	75	4.65
Grand Total	**1207**	**406**	**1613**	**Grand Total**	**1613**	**100.00**

Profession by Gender	Female	Male	Total
Add Prof Scientific and Technic	39	15	54
Additional Clinical Services	208	67	275
Administrative and Clerical	417	150	567
Allied Health Professionals	128	24	152
Estates and Ancillary	38	38	76
Healthcare Scientists	100	65	165
Medical and Dental	52	31	83
Nursing and Midwifery Registered	222	16	238
Students	3		3
Grand Total	**1207**	**406**	**1613**

On Maternity	Headcount	%
Yes	46	2.85
No	1567	97.15
Grand Total	**1613**	**100.00**

Contract Type by Gender	Female	Male	Total
Fixed Term Temp	109	53	162
Permanent	1098	353	1451
Grand Total	**1207**	**406**	**1613**

QUALITY, SAFETY & PERFORMANCE COMMITTEE

VUNHST Business Continuity & Emergency Preparedness

DATE OF MEETING	17/01/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Laurie Thomas, Head of Validation & Risk Management
PRESENTED BY	Alan Prosser, Director, WBS
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**
Executive Management Board	03/01/2023	IN SUPPORT

ACRONYMS	
VUNHST	Velindre University NHS Trust
BC	Business Continuity
EP	Emergency Preparedness
EMB	Executive Management Board

WBS	Welsh Blood Service
VCC	Velindre Cancer Centre
EPC	Emergency Planning College
BIA	Business Impact Analysis
EPRR	Emergency Planning Resilience and Response

1. SITUATION

The report aims to provide the Quality, Safety & Performance Committee with a high-level overview of the VUNHST Business Continuity & Emergency Preparedness work programme and outlines priorities planned for 2023-2024.

2. BACKGROUND

The Trust continues to make significant progress for Business Continuity and Emergency Preparedness ensuring the Trust continues to meet its obligations to Emergency Planning Resilience and Response (EPRR) and relevant statutory duties. The VUNHST Business Continuity & Emergency Preparedness Steering Group supports the framework and governance within the Trust. The group has regained meeting frequency following a pause due to a Trust wide response to Covid19.

The focus of the Trust for 2020 through to the early part of 2022 remained on the planning and response to the Covid19 global pandemic, and ensuring the Trust continued to deliver core service provision throughout this exceptional time. Robust incident management structures were put in place across the Trust to manage the Covid19 response.

During 2022 both Welsh Blood Service (WBS) and Velindre Cancer Centre (VCC) have focused on reviewing their Business Impact Analysis (BIA) and Major Incident Plans alongside a review of key operational Business Continuity Plans to ensure the learning from Covid19 was captured and mitigated where possible.

The VUNHST Business Continuity Leads have focused attention on the review of business continuity risk assessments and impacts on existing Business Continuity Plans. The changing environment of risk has resulted in the strategies and plans being reviewed regularly and in line

with the National and Wales Community Risk Registers. These plans are commensurate with the level of risk the Trust anticipates exposure to.

Emerging risks and threats such as the Geo-Political tensions in Ukraine, Industrial Action, and power disruption have been considered in the development and enhancement of risk mitigation and response strategies.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 VUNHST Business Continuity Trust Wide Work Programme Progress

Section 2.2 below outlines the work objectives identified for the VUNHST Business Continuity Trust Wide work programme.

The objectives were identified through the Trust Business Continuity Action Plan and recommendations identified from the Strategic training delivered by the Emergency Planning College in October 2021.

It should be noted that the timeframes are subject to the availability of services/ departmental staffing resources whilst under pressures to deliver front line services and manage back log issues. As such, the work programme will need regular review and amending if timescales slip or new actions as identified.

WBS and VCC BC teams continue to meet on a weekly basis to monitor progress and report into VUNHST Business Continuity & Emergency Preparedness Steering Group.

It is anticipated the Executive Management Board will receive updates against this plan on a quarterly basis.

3.2 VUNHST Business Continuity Trust Wide Work Programme Objectives 2023/2024

(Status, Red- Not on target for completion by agreed/revised date, Amber– On target for completion by agreed/ revised date, Green– Complete).

Recommendation/ Summary of Key Actions	Quarter 2023/ 2024	Key Milestones / Objectives	Status	Comments	Responsible Executive Lead/ Management Lead
VUNHST Work Programme					
Formalise a clearly defined VUNHST Business Continuity Management System that covers organisational as well as divisional responsibilities.	Q1-Q4, 2023	Consistent formal Plan, Do, Check Act framework across VUNHST which includes:- - Alignment of divisional Business Impact Assessments process to incorporate good practice - Formalise consistent VUNHST wide Business Continuity and Emergency Planning templates - Agreement on management and centralised storage of live VUNHST Business Continuity plans i.e. electronic Quality Management System for document control, review and management. (Include accessibility to Live versions through Trust intranet)		Work progress in some areas throughout 2022, remaining outstanding actions to be ratified Q1-Q2 2023.	Cath O'Brien/Alan Prosser/Paul Wilkins Lauren Fear
Establish a VUNSHT Task and Finish group to review Trust Business Continuity & Emergency Planning Policy.	Q1, 2023	Maintain a revised Policy		Policy circulated for review and comments. Plan to table for approval at VUNHST BC meeting Q4, 2022-2023.	Cath O'Brien

Develop and approve a VUNHST Incident Response Plan.	Q4, 2023	Formalising the VUNHST Incident Response structure to be implemented in the event of a disruptive event. Consisting of a single VUNHST overarching response plan and discrete response plans for each division.		Incident Plan currently drafted for review and consideration at the VUNHST BC meeting Q4, 2022-2023.	Cath O'Brien
Develop and approve terms of reference for VUNHST Command Structure i.e. Gold, Silver, Bronze meetings.	Q1, 2023	Develop and maintain a terms of reference for each group establishment.			Cath O'Brien Lauren Fear
Develop and approve an on-call pack to support Executive Management team.	Q1, 2023	Finalise on-call pack to support Executive Management team whilst on call.		Executive pack ready to be rolled out into preferred location. (Note, Data Protection Impact Assessment (DPIA) signed off 23/11/2022))	Cath O'Brien
Establish a VUNHST Wide Task & Finish group to review all existing security policies and plans.	Q2-Q4, 2023	Security Task and Finish Group established		Security Task and Finish Group established within WBS to develop lockdown arrangements, VUNHST Task and Finish Group to follow for collective gap analysis and review of learning from testing arrangements. Review of site WBS & VCC site wide security assessment – complete.	Cath O'Brien

Develop and approve site lockdown plans.	Q1-Q3, 2023	Test site lockdown plans and exercise following approval.		Yet to be arranged (Plan to exercise Q4)	Cath O'Brien
Review VUNHST Communications Plan for incident management.	Q1–Q2, 2023	Review VUNHST Communications Plan for consideration to incident management.		Obtain revised Communications Plan.	Cath O'Brien Lauren Fear
Develop and approve a VUNHST National Fuel Plan.	Q1-Q2, 2023	Develop Trust National Fuel Plan		WBS Plan live, requires adaptation into VUNHST wide plan once templates standardised and accepted.	Cath O'Brien
Procure supplementary Loggist training across VUNHST.	Q1, 2023	Source and procure supplementary Loggist training to ensure a bank of individuals are trained as Loggist across VUNHST		Available dates planned for February 2023, collated list of volunteers for the Trust.	Cath O'Brien
Review and implement the EPC Strategic & Tactical Emergency Management Action Plan.	Q1-Q2, 2023	Address and incorporate identified actions.		Partial completion of work identified for WBS and Execs. Action plan for VCC to be addressed following subsequent training and incorporated into one VUNHST action plan.	Cath O'Brien
Continued multi agency working and engagement with Welsh Government Emergency Planning Advisor around key strategies for workload, training, and exercises.	On-going	Active participation.		On-going attendance at meetings.	Cath O'Brien
Follow up with PHW to revisit National Pandemic Plan.	Q4, 2023	Review the revised Pandemic Plan for Wales and adopt for VUNHST, incorporating learning from Covid-19		To be drafted into standardised VUNSHT template.	Cath O'Brien

		Pandemic.			
Review and consider UK and Wales Risk Registers and impact to VUNHST.	On-going	Consideration of VUNHST impact of risks captured on UK and Wales Risk Registers for impact to Trust.		On-going review and development.	Cath O'Brien
Review VUNHST existing plans in line with HM Government CONTEST strategy.	Q1-Q2, 2023	Develop and maintain plans to ensure the Trust assurance to key objectives of CONTEST, pursue, prevent, protect, and prepare.		Ensure all existing plans for all VUNHST sites are reviewed and aligned to requirements of CONTEST.	Cath O'Brien
Develop and maintain a VUNHST Exercise Testing and Training Programme.	Q2-Q4, 2023-2024	Develop and maintain exercise, testing and training programme to include role specific training packages for Tactical, Strategic on calls and requirements for BC.		WBS drafted – to be shared at VUNHST BC meeting Q4 2022-2023 for consideration and applicability at VCC.	Cath O'Brien
VUNHST Cyber Attack Assessment and Plans.	Q2-Q3, 2023-2024	Understand thoroughly VUNHST position.		Plans for VUNHST Digital Response to loss of Digital Services tabled at VUNHST BC meeting September 2022. Finalised BIAs across divisions to prompt operational BC plans review and development for disruptions to Digital Services.	Cath O'Brien Carl Taylor
VUNHST BC & EP Review / Gap Analysis.	Q4, 2023-2024	External review of VUNHST Business Continuity Management System, cost to be factored in to VUNHST budget.		Not yet explored – to be agreed / carried out once programme complete to identify further recommendations or	Cath O'Brien

				improvements.	
Establish Business Impact Analysis for Executive Corporate Services.	Q2, 2023-2024	Business Impact Analysis forms to be completed for Executive Corporate Services.		Not yet started.	Cath O'Brien
Establish/review Trust HQ Business Continuity Plan.	Q2, 2023-2024	Establish/review Business Continuity Plan.		Review previous Business Continuity Plan.	Lauren Fear
VCC Work Programme					
Review Business Impact Analysis within VCC.	Q1, 2023	Incorporate Business Impact Analysis close out report recommendations.		Work ongoing, many of the recommendations align/mirror actions within VCC work programme.	Paul Wilkins
Strategic and Tactical Emergency Management training identified for VCC Senior Leadership Team on call and VCC BC Lead.	Q1, 2023	Key individuals trained as required.		Due to be concluded Q4, on target. Proposed training w/c 04/02/2023).	Paul Wilkins
Review and approve VCC Business Continuity Plans.	Q1-Q2, 2023	Revised to include Digital thread.		Relevant clinical Business Continuity Plans updated through Digital Health Care Record readiness, further enhancements required to include all Digital elements within all Business Continuity Plans.	Paul Wilkins
Review and approve VCC Evacuation Strategy.	Q1-Q2, 2023	Revised Strategy.		Work commenced/ being reviewed post	Paul Wilkins

				incident/lesson learnt from actual event.	
Review and approve Evacuation Departmental Plans.	Q1-Q2, 2023	Revised Departmental Plans.		Work commenced/ being reviewed post incident/lesson learnt etc.	Paul Wilkins
Review BC Risk Assessments.	On-going	Review impact for VCC and log onto risk register.		Risk Assessments drafted for; Adverse Weather, Flood, Site Security. Full interrogation of risks within the system underway.	Paul Wilkins
Review and approve Major Incident Plan.	Q1-Q2, 2023	Revised Major Incident Plan.		On-going review and development. On target.	Paul Wilkins
Maintain an exercise, test and training programme to ensure plans can be tested.	On-going	Maintain a log capturing Business Continuity tests, training and exercises.		Under development, aligning templates etc. with WBS.	Paul Wilkins
Identify lessons from exercises and incidents and develop action plans to implement improvements.	On-going	Maintain a lessons identified log for continuous improvement.		On-going.	Paul Wilkins
Exercise Clinical Emergency Communication tests.	On-going	Undertake communication tests.		Working closely with WBS colleagues on plan.	Paul Wilkins
Establish a VCC Business Continuity Group, cycle of business and reporting schedule into Senior Leadership Team.	Q1, 2023	To implement a divisional specific BC group and meeting frequency.		First meeting planned for early Q4.	Paul Wilkins

WBS Work Programme					
Exercise and test Major Incident Plan.	Q3, 2023	Current Business Continuity Plan for WBS Major Incident exercised.		Complete - Major Incident exercise run in Q2 2022. Included on Exercise, Testing and Training Programme for future (Q2-Q3, 2023).	Alan Prosser
Exercise and test WBS Mass Casualty Response Plan.	Q1-Q2, 2023	Current Business Continuity Plan for WBS Mass Casualty Response Plan exercised.		National exercise for larger scale mass casualty incident postponed 2022 due to NHS Wales pressures. Re-planned for 2023.	Alan Prosser
Roll out new Business Impact Analysis (BIA) within WBS.	Q1, 2023	Refreshed Business Impact Analysis process across WBS and consider implementation of Business Continuity Plans for any identified gaps.		Final Business Impact Analysis awaiting approval.	Alan Prosser
Review Business Continuity Risk Assessments.	On-going	Review impact for WBS and log onto VUNHST Risk Register.		Risk Assessments drafted for; Adverse, Weather, Flood, Major Incident & Mass Casualty, National Fuel Shortage, Pandemic Outbreak, Site Security.	Alan Prosser
Continued engagement with UK Blood Services on alignment and Business Continuity planning.	On-going	Regular engagement on alignment.		Meetings currently held weekly.	Alan Prosser
WAST Major Incident Communications. Test.	On-going	Participate as required.		On-going.	Alan Prosser

Develop and approve a loss of Communications Plan.	Q1, 2023	Plan to be developed and exercised.		Plan developed. Aim to exercise by Q1 2023.	Alan Prosser
Develop and approve a loss of Power Plan.	Q1, 2023	Plan to be developed and exercised.		Draft plan being finalised with proposal to run Exercise in coming months as part of Exercise, Test & Training Programme.	Alan Prosser
Develop and approve WBS Lockdown and Evacuation Strategy/ Plan.	Q1-Q2 2023	Revised Strategy/ Plan		Task and Finish Group established to enhance and develop arrangements with aim to test by Q4 2022-2023.	Alan Prosser
Exercise and test WBS Blood Shortage Plan.	Q1, 2023	Current Business Continuity Plan for WBS Blood Shortage Plan exercised. Engagement with review of UK Blood Shortage Trigger Levels.		Blood Shortage exercise held with all Health Boards to test response to activation, collated de-brief and lessons to be circulated early 2023. Blood Shortage trigger levels under review.	Alan Prosser
Maintain an exercise, test and training programme to ensure plans can be tested.	On-going	Maintain a log capturing Business Continuity tests, training and exercises.		On-going.	Alan Prosser
Identify lessons from exercises and incidents and develop action plans to implement improvements.	On-going	Maintain a lessons identified log for continuous improvement.		On-going.	Alan Prosser

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Robust Business Continuity plans essential to providing safe services for patients and donors.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	For noting with regards to possible public inquiry involvement.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

5. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **NOTE** the work programme outlined in this report.

QUALITY, SAFETY & PERFORMANCE COMMITTEE

VUNHST INTERNAL ANNUAL SUSTAINABILITY REPORT

DATE OF MEETING	17/01/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Rhiannon Freshney, Environmental Development Officer
PRESENTED BY	Rhiannon Freshney, Environmental Development Officer
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning and Digital

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
EMB	26/10/2022	Noted

ACRONYMS	
EMS	Environmental Management System

1. SITUATION/BACKGROUND

1.1 The attached report provides a summary of the Sustainability works from April 2021 – March 2022 within the Sustainability Team.

2. ASSESSMENT/SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The purpose of the annual report is to provide an overview of the progress against key performance indicators, service improvement initiatives and approved relevant documentation throughout the year.

2.2 Throughout the year there has been significant progress in sustainability, both operationally and strategically. A few key achievements are highlighted in the report -

ISO14001:2015 – Recertification

A new Trust Travel Plan has been developed to inform and enact change in the everyday lives of our staff, in and outside the workplace. The plan will be in place from 2022-2027.

Trust Travel Plan

A new, free service has been introduced for anyone affected by cancer. The weekly sessions connect attendees with nature and embed the principles of the circular economy by using found and natural materials.

Green Social Prescribing

A new, free service has been introduced for anyone affected by cancer. The weekly sessions connect attendees with nature and embed the principles of the circular economy by using found and natural materials.
Industrial Placement Student

A first in NHS Wales, the Trust launched an Industrial Placement scheme, employing an Sustainability Placement student. The student working within the Sustainability team and worked closely with the Transforming Cancer Services team.

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	Yes (Include further detail below)
	Compliance with Environment (Wales) Act 2016 Contribution to Well-being of Future Generations (Wales) Act 2015
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	There is an annual fee for accreditation.

4. RECOMMENDATION

4.1 The Quality, Safety & Performance Committee are asked to **NOTE** the recertification audit of the Internal Annual Sustainability Report.

GIG CYMRU NHS WALES

Ymddiriedolaeth GIG
Prifysgol Felindre

Velindre University
NHS Trust

SUSTAINABILITY ANNUAL REPORT

2021 - 22

TABLE OF CONTENTS

INTRODUCTION

Human activity has caused rapid and widespread changes to Earth's systems, driven by increased concentrations of greenhouse gases. The NHS is responsible for 2.6% of the total carbon footprint in Wales. It has fallen behind other sectors when it comes to response and reducing environmental impact, when these responses are more important than ever.

At COP26, it was agreed we as global citizens must now move forward together and deliver on the expectations set out in the Glasgow Climate Pact. It is up to all of us to sustain our model of keeping 1.5 degrees within reach and to continue our efforts to get finance flowing and boost adaptation.

The consumption of resources is necessary for the provision of healthcare services and to provide a comfortable environment for patients, donors, staff and visitors. We also have a responsibility to be transition to a new, sustainable world which minimises the use of resources and creates wider value. The last two years have posed unprecedented challenges for the Trust and NHS Wales, which has had a significant impact on our consumption, most notably use of single use items such as masks.

Despite this, the Trust has continued to be ambitious with our sustainability aims. We have developed strategic & operational goals and initiatives to ensure we are mitigating our impact and consumption to ensure we act today, for a more sustainable tomorrow.

SUSTAINABILITY STRATEGY

The Trust has created a suite of enabling strategies to outline the future of the organisation. This includes a Sustainability Strategy, which embeds the Well-being of Future Generations Act at its core. The strategy outlines our sustainability aims and enables real action to create positive and significant change.

To align with the NHS Wales Decarbonisation Plan, we have used 2018/2019 as our baseline data which we will monitor our progress against.

Our Trust Strategy 'Destination 2032' outlines a clear ambition for the organisation over the coming years; the delivery of high quality, sustainable health care services which reduce our impact on the environment and provides wider value to our communities. This is an exciting challenge for us which will require us to continue to pursue excellence in our clinical services whilst also making a contribution to the wealth, health and prosperity of across the country.

To develop the Trust Sustainability Strategy we have engaged with our staff, aligned with key legislation, and benchmarked against other NHS and private organisations. The strategy creates a roadmap for us to contribute to our communities and mitigate our impact on the planet whilst continuing to deliver world class services for our donors, patients and carers. This will only be possible if we enhance our existing infrastructure, and educate and empower our workforce. Every individual and team should have the ability to act sustainably and have the knowledge and confidence to make environmentally conscious decisions.

SUSTAINABILITY STRATEGY

To achieve this vision, we set out what we want to achieve together with ten themes which we will focus on to deliver our ambitions. These are driven by the United Nations Sustainable Development Goals and the Well-Being of Future Generations Act, which together ensure we achieve the our Trust Well-being Objectives.

Theme 1: Creating Wider Value: Our Organisational Approach

Theme 2: Sustainable Care Models

Theme 3: Eliminating Carbon

Theme 4: Sustainable Infrastructure

Theme 5: Transition to a Future of Renewables

Theme 6: Sustainable Use of Resources

Theme 7: Connecting with Nature

Theme 8: Greening our Travel and Transport

Theme 9: Adapting to Climate Change

Theme 10: Our People as Agents of Change

KEY ACHIEVEMENTS

Throughout the year there has been significant progress in sustainability, both operationally and strategically. A few key achievements have been highlighted below -

ISO14001:2015 - Recertification

Following a five day re-certification, the Trust successfully maintained the ISO14001:2015 Environmental Management System, with no non conformities identified.

Trust Travel Plan

A new Trust Travel Plan has been developed to inform and enact change in the every day lives of our staff, in and outside the workplace. The plan will be in place from 2022-2027.

Green Social Prescribing

A new, free service has been introduced for anyone affected by cancer. The weekly sessions connect attendees with nature and embed the principles of the circular economy by using found and natural materials.

Industrial Placement Scheme

A first in NHS Wales, the Trust launched an Industrial Placement scheme, employing an Sustainability Placement student. The student working within the Sustainability team and worked closely with the Transforming Cancer Services team.

ISO14001:2015

Welsh Government sets a requirement for all NHS bodies to be accredited by the ISO14001:2015 standard, an Environmental Management System (EMS). The Trust has successfully obtained the ISO 14001:2015 standard for the last five years for all sites.

At the end of 2021, the Trust was due a recertification audit, a more in depth review of the EMS. Each year, a different selection of sites are chosen to be reviewed. As the audit was a recertification rather than a surveillance audit, more sites were under the scope of audit.

The following sites were under review -

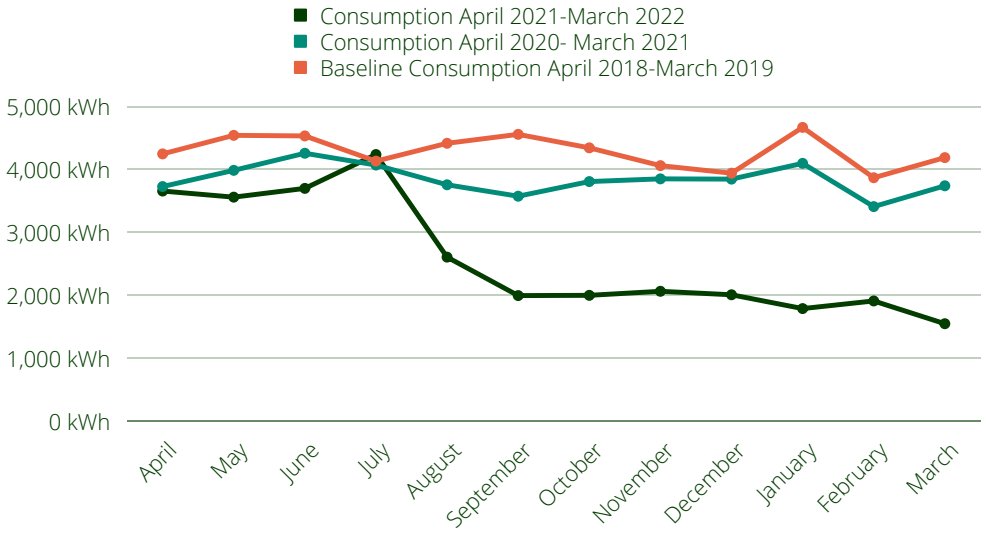
- Velindre NHS Trust Headquarters (1 day)
- Velindre Cancer Centre (2 days)
- Welsh Blood Service Talbot Green (1 day)
- Welsh Blood Service, Pembroke House (half a day)
- Welsh Blood Service, Unit 30, Llandegai Industrial Estate (half a day)

The Trust successfully obtained recertification and received zero non conformities. The external auditor noted, "The organisation have continued to maintain an effective Environmental Management System which is proactive in maintaining compliance with evolving processes to meet and exceed requirements set by regulators and governmental requirement. A plethora of information was discussed and evidenced by functional levels of the Management Team which was wholly delivered by an enthusiastic and competent personnel."

To continue the positive progress, an ISO14001:2015 Management Group has been formed to oversee all elements of the EMS. The group consists of key divisional colleagues who input into the Trust Environment Management System. The purpose of the group is to ensure sufficient and effective monitoring of the EMS. Members meet once a month and the agenda aligning with the Management Review timetable.

ELECTRICITY CONSUMPTION

TRUST HEADQUARTERS

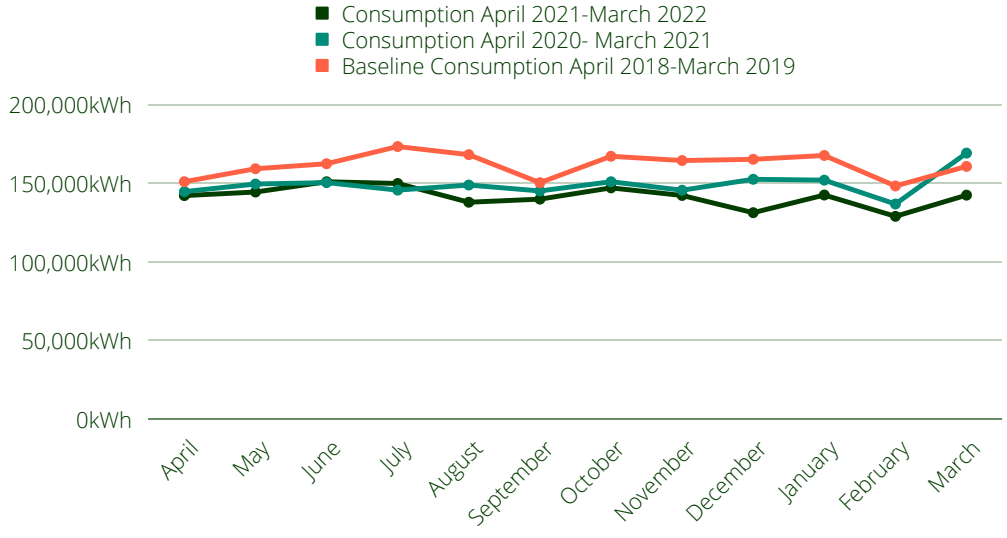


OUR ELECTRICITY CONSUMPTION HAS REDUCED BY

39.5%

AGAINST BASELINE OF 2018/19

WELSH BLOOD SERVICE

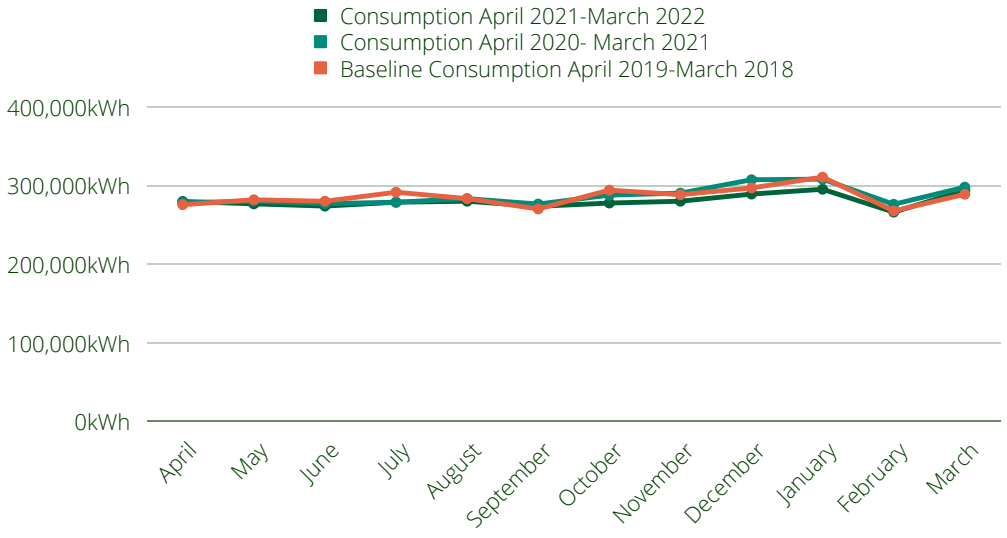


OUR ELECTRICITY CONSUMPTION HAS REDUCED BY

12.29%

AGAINST BASELINE OF 2018/19

VELINDRE CANCER CENTRE



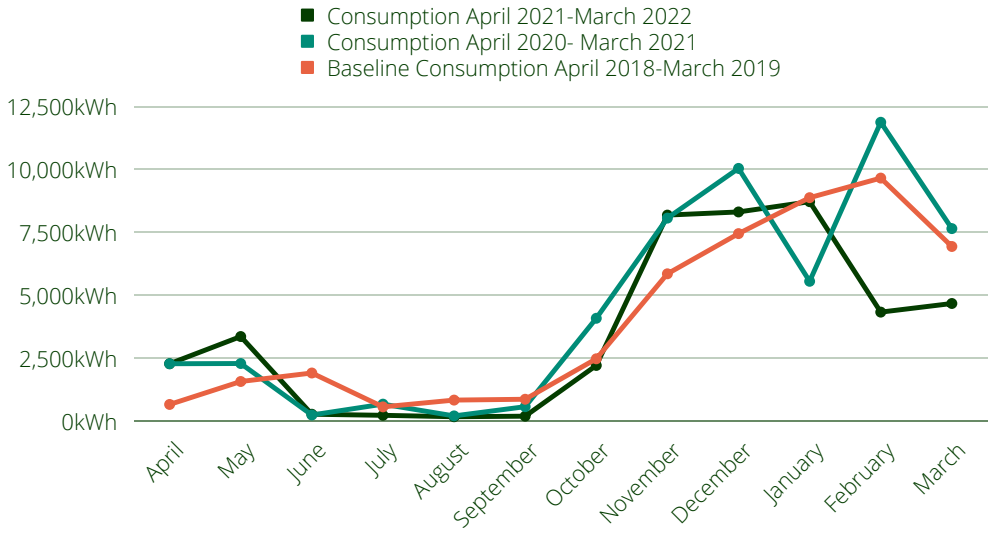
OUR ELECTRICITY CONSUMPTION HAS REDUCED BY

1.89%

AGAINST BASELINE OF 2018/19

GAS CONSUMPTION

TRUST HEADQUARTERS

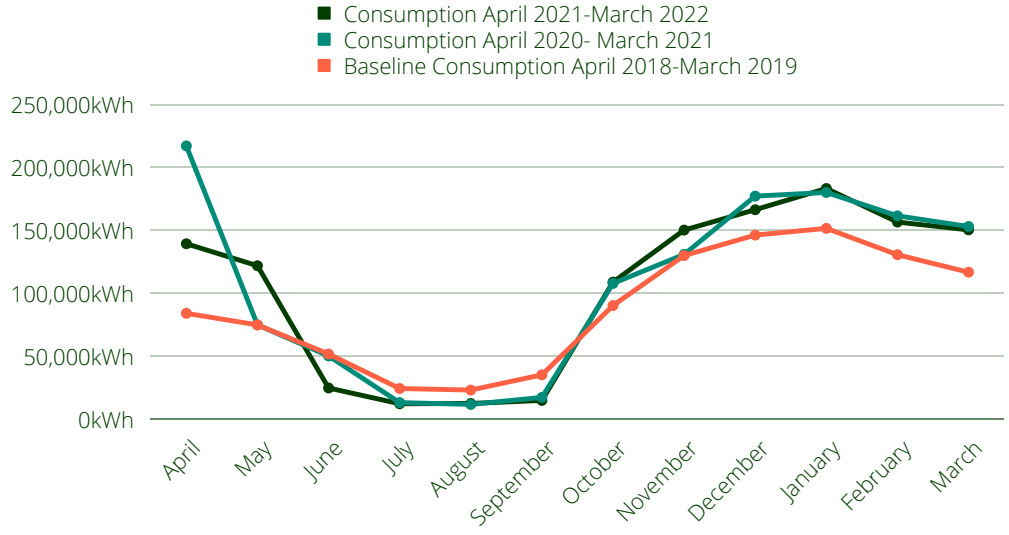


OUR GAS CONSUMPTION HAS REDUCED BY

19.63%

COMPARED TO 2020/21

WELSH BLOOD SERVICE

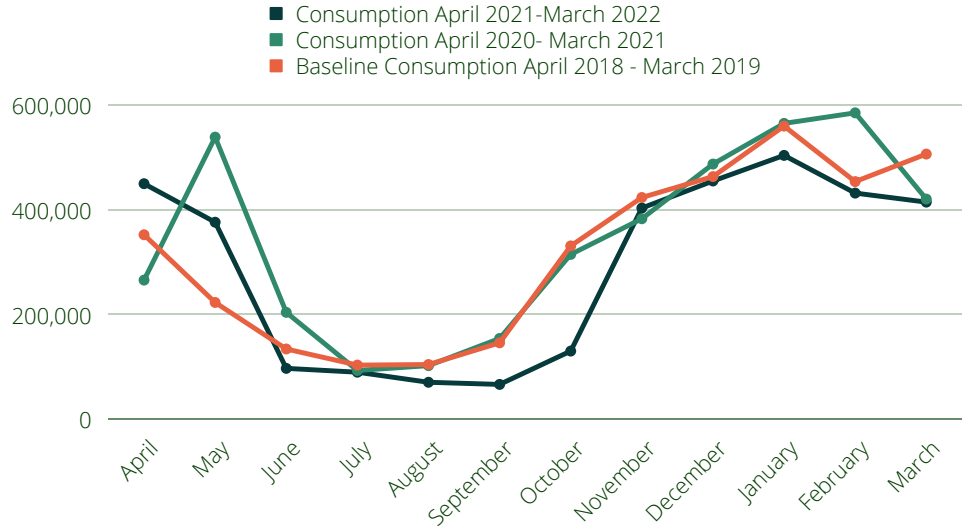


OUR GAS CONSUMPTION HAS REDUCED BY

4.15%

COMPARED TO 2020/21

VELINDRE CANCER CENTRE



OUR GAS CONSUMPTION HAS REDUCED BY

13.52%

COMPARED TO 2020/21

DECARBONISATION

The Trust was successful in obtaining bids in Welsh Governments Decarbonisation grant funds. The Trust has successfully obtained funding for the following –

- Velindre Cancer Centre Building Management System Upgrade
- Trust Headquarters LED Lighting Upgrade

Work was completed within the financial year 2021-2022 and monthly progress reports are submitted to Welsh Government via an EFAB tracker.

The LED lighting upgrades have continued across all sites, and where possible motion sensors and daylight sensors have been installed.

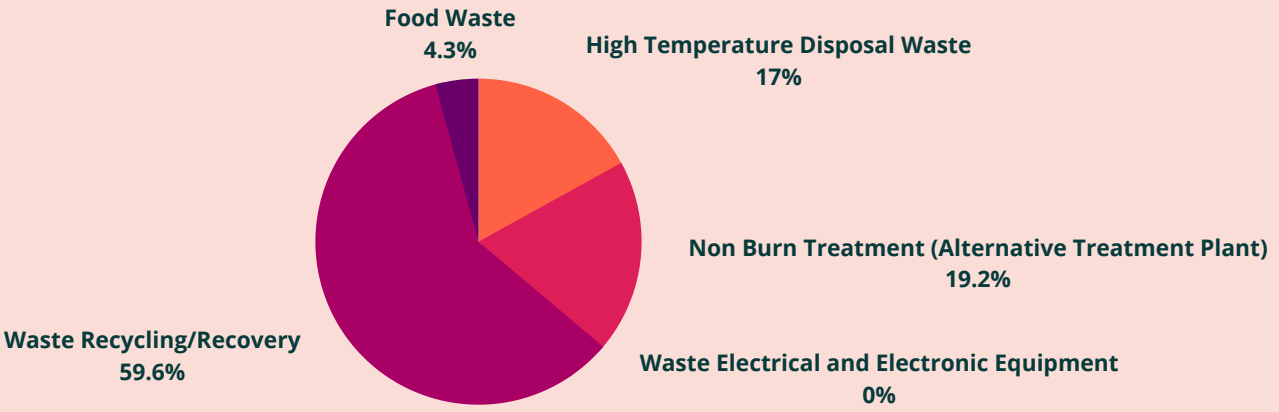
An in depth decarbonisation action plan as been developed which covers all aspects of our carbon footprint, ranging from transport to procurement. Aligning with the NHS Wales Decarbonisation Strategy, the detailed plan is an ambitious document which provides the Trust with a roadmap to be Net Zero by 2030.

Throughout the Trust, major capital programmes are being undertaken which will contribute significantly to our decarbonisation agenda. The Talbot Green Infrastructure upgrade project & new Velindre Cancer Centre will be large contributors. Throughout the year, the Sustainability team have provide sustainability advice & were directly involved in the Community Benefit workstreams to these capital programmes.

Our consumption reduction through projects and initiatives contributes to the Trust Well-being Objective, ***"Deliver bold solutions to the environmental challenges posed by our activities"***

WASTE

VELINDRE CANCER CENTRE



ZERO WASTE to landfill

OUR WASTE HAS INCREASED BY

8.17%

COMPARED TO 2020/21

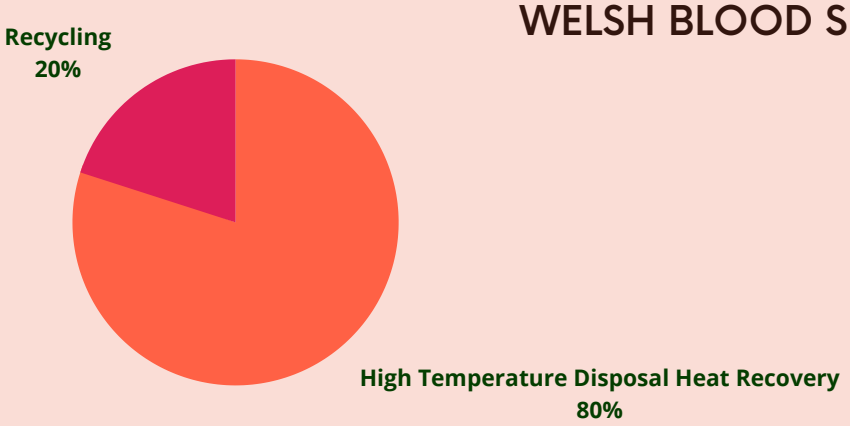
TOTAL WASTE WEIGHT WAS

171

TONNES

Waste has increased in the last financial year due to the impact of the pandemic. There has been a significant increase in PPE. Single use items had to be reintroduced on site due to adhere to necessary Infection, Prevention & Control measures implemented throughout the pandemic.

WELSH BLOOD SERVICE



OUR WASTE HAS INCREASED BY

3.54%

COMPARED TO 2020/21

TOTAL WASTE WEIGHT WAS

132

TONNES

ZERO WASTE to landfill

WASTE

VELINDRE CANCER CENTRE

As the pandemic entered a new phase, and with IP & C approval, there have been either new waste campaigns, or reintroduction of previous ones employed pre-pandemic. At the Cancer Centre, extensive work has been undertaken to reduce single use plastic where possible.

The following is just some of the successful campaign;

- new bins in the Velindre Café, clearly signposted to for correct waste segregation
- Eco to Go cups & water bottles were relaunched, any profits made were given to fundraising.
- VegeWare (compostable material) have replaced single use plastic containers
- biodegradable aprons, trialled on First Floor ward. The aprons were cheaper, better for the environment, and the quality was the same as the plastic ones!


WELSH BLOOD SERVICE

Across all of the Welsh Blood Service sites, waste initiatives have been introduced to tackle our waste consumption, both in offices & with our donors.

The following has been introduced;

- new bins with clear signposted across all sites
- reusable water bottle, coffee cup & bag were provided to all staff members across WBS to encourage reusing
- plastic stirrers & straws have been removed from donor clinics and wooden replacements have been introduced
- biodegradable cup have been successfully trialled on West Collections team

WATER CONSUMPTION

WELSH BLOOD SERVICE

OURWATER CONSUMPTION HAS REDUCED BY

16.20%

COMPARED TO 2020-21

TRUST HEADQUARTERS

OURWATER CONSUMPTION HAS REDUCED BY

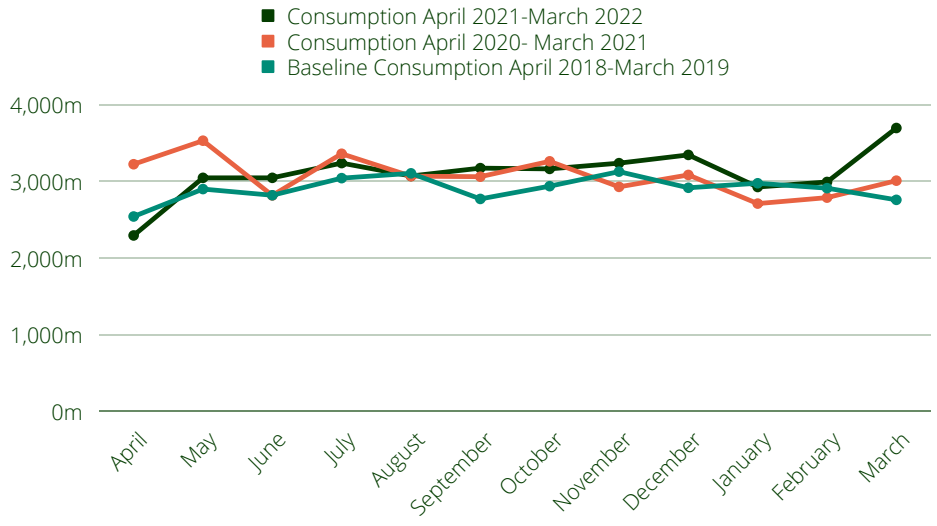
48.71%

COMPARED TO 2020-2021

There has been a reduction of water consumption at all Welsh Blood Service sites and Trust Headquarters.

WBS has recently reduced water tank storage capacity due to a compliance recommendation. Robust flushing regimes are now agreed with building users and agile working is still taking place in various departments, however flushing will still be required in these parts of the building to maintain a safe water practices. Furthermore, Trust Headquarters & WBS staff have, where possible, been encouraged to work from home during the pandemic, which has contributed to the reduction in consumption.

VELINDRE CANCER CENTRE



OUR WATER CONSUMPTION HAS INCREASED BY

2.95%

COMPARED TO 2020/21

The water consumption increase is due to an enhanced flushing regime in line with Water Safety guidelines & Infection, Prevention & Control measures.

BIODIVERSITY

As part of our compliance to the Environment (Wales) Act & specifically Section 6, we are enhancing biodiversity across all of our estate. To date we have had an external biodiversity audit undertaken and received recommendations which we are working towards to enhance ecosystems & local flora and fauna. There has been huge progress in this area in the past year, and a few highlights are listed below!

Biodiversity Enhancement Plans

Working in partnership with Crown Gardens, an action plan has been created to ensure we are enhancing biodiversity. Actions include reduction of mowing ('No Mow May' & 'Let it Bloom June'), sewing wildflowers and removal of invasive species.

Collaboration with South Wales Fire Service & Rescue

To celebrate NHS Sustainability Day for Action, run by NHS Sustainability Partnerships, and celebrated World Environment Day the SWFSR cleared the rubbish & debris by the river at Talbot Green - following assessment to ensure there is not nesting birds – to create a viewing area to the river. The team removed debris & rubbish. This area is fully accessible for staff and have recycled benches placed there for staff to have lunch or a break.

Nature Notices

To help give your audience an overview, this section can include a brief description of the goal, its relevance to your sector or industry, and the specific sub-targets your organization is addressing.

Alongside enhancing biodiversity, we aim to educate our community about its importance. Within the Environmental Awareness training a new biodiversity section has been introduced and infographics have been developed which are now included in the staff induction. Furthermore, the Trust has formed a partnership with Ray of Light, a South Wales-based charity who deliver weekly green social prescribing sessions., which contribute to our Well-being Objectives.

Improve the health and well-being of families across Wales by striving to care for the needs of the whole person

Reduce health inequalities, make it easier to access the best possible healthcare when it is needed and help prevent ill health by collaborating with the people of Wales in novel ways

Bring communities and generations together through involvement in the planning and delivery of our services

Nature Based Support

Ray of Light host free green social prescribing sessions designed for those affected by cancer. The sessions are always based around the therapeutic properties of nature, and are centred around the core principles of finding a use for everything, with nothing being wasted.

Leadership Support

Following endorsement from PLG, Dignity Group and approval from the Senior Leadership Team, the Sustainability Team organised a pilot event with staff. Following helpful feedback, weekly sessions began every Tuesday.

Well Attended

Each session consists of a main activity followed by a mindfulness session. The feedback from attendees has been overwhelmingly positive, with regulars & newcomers every week.

TRAVEL & TRANSPORT

Trust Travel Plan 2022- 2027

Travel Plans are the Government's recommended method to widen travel choice, to promote more sustainable travel choices and to reduce single-occupancy car travel. The newly published Travel Plan aims to inform, and enact change in the everyday lives of our staff, in and outside of the workplace.

With all staff engaged in the plan, and publicising your behavioural changes with friends and family, we can enact cultural changes towards decarbonisation of the public sector by 2030 in Wales. An imperative in the context of the climate emergency. Following extensive engagement, the Travel Plan was drafted in 2021, to run from 2022 - 2027.

The Travel Plan aligns with the following Trust Well-being Objectives:

Reduce health inequalities, make it easier to access the best possible healthcare when it is needed and help prevent ill health by collaborating with the people of Wales in novel ways.

Improve the health and well-being of families across Wales by striving to care for the needs of the whole person.

Deliver bold solutions to the environmental challenges posed by our activities.

Bring communities and generations together through involvement in the planning and delivery of our services.

The Staff Travel Survey was undertaken over the summer period in 2021 and accrued 438 responses. This enabled us to identify key trends across a number of different themes. Staff Travel Survey was conducted to establish a baseline in order to set targets and monitor progress, quantify how staff currently travel to work. It also helped us to understand the barriers preventing staff from travelling by more sustainable means.

Travel Plan Launch

The Travel Plan launch events were held in Velindre Cancer Centre & Talbot Green. There was spin bike challenges, Pin the Lock on the Bike & freebies to encourage more sustainable travel.

Next Bike

After being temporarily removed from Cardiff, Next Bike has returned and the Velindre Cancer Centre spot has been more popular than ever! To assist staff, a 'How To' guide & YouTube video has been created.

Cycle Confidence

Within the survey results many staff members noted they were not confident when cycling. In response, the Sustainability team worked with Cardiff Council to offer free Cycle Confidence training.

Electric Vehicle Fleet

At Welsh Blood Service, the first electric fleet vehicle is being trialled. The vehicle is part of a pilot and following review, will hopefully be rolled out across all of our Welsh Blood sites.

COMMUNICATION & ENGAGEMENT

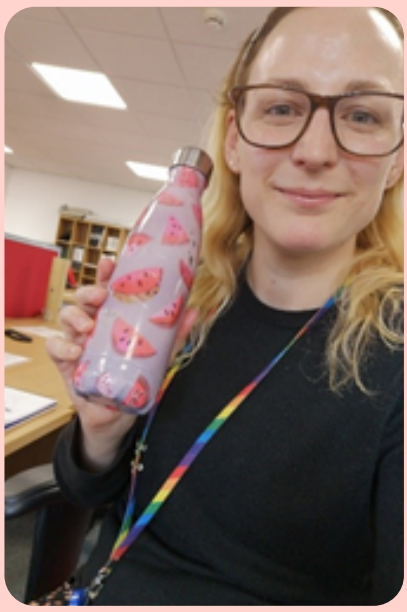
To keep staff motivated and engaged in sustainability, there are continuous communications via global email, divisional newsletters, events & more! The below highlights the most successful communication campaigns over the past year! A sustainability email address has been created for staff to ask questions, propose ideas or feedback on initiatives.

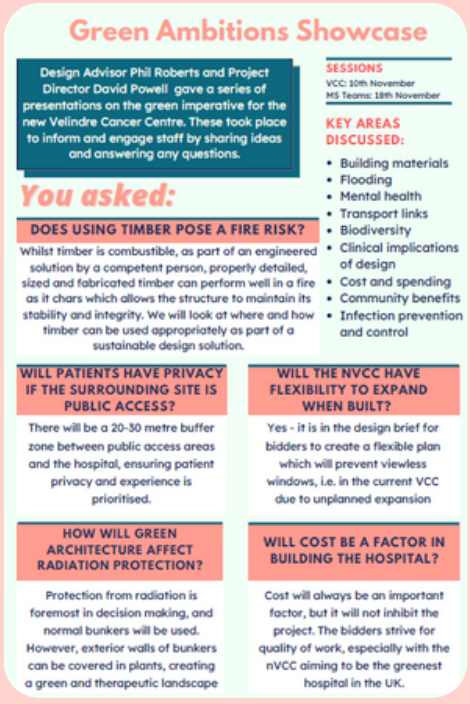
Events

Green Ambitions Showcase
Spring Clean Cymru
Pride Cymru - Sustainability
Travel Plan Launch
Litter Picks
Sustainability Day for Action

Communications

Recycle Week
Eat Seasonally
No Mow May
Plastic Free July
Secondhand September
All I Want for Christmas is...





ARTS IN HEALTH

To achieve the ambitions outlined in the Sustainability Strategy & to become an exemplar in the Future Generations Act, the Trust considers the wider opportunities available to it us as a healthcare provider, to enhance the performance of our primary functions and to increase the societal value it adds from discharging those functions. Arts and Culture have a material contribution to make to both of these opportunities.

ARTS MULTI DISCINPLINARY TEAM

The Arts Multidisciplinary Team (MDT) was created in autumn 2021, united by a passion for the arts, and a curiosity of how they can be beneficial in a healthcare setting. The MDT has grown to include members representing Oncology, Innovation, Sustainability, and more, leading to a communal varied and diverse skillset. Motivated by the Transforming Cancer Services programme, the MDT has been a fast paced, collaborative project.

SENIOR LEADERSHIP ENGAGEMENT

During a presentation to the Trust Board, at its development session in April, the breadth of the opportunities to improve patient experience and outcomes, and also to create to a higher quality working environment and experience for our workforce, from Art in Health activities. The presentation also highlighted the regional collaborative opportunities to work with our Health Board partners to integrate art in health across the cancer pathway and establish a research programme with academic partners.

RESOURCE & PARTNERSHIPS

The arts programme hsd begun to form partnerships on behalf of the Trust. There is a wealth of organisations within Wales, ranging from visual and performing arts groups and centres, to educational and research institutions, sporting groups, community wellbeing initiatives, and other healthcare organisations. A Regional Arts Board has been created with the Trust Commissioners. The Arts MDT has met with industry leads across to understand the opportunities and potential of the programme, which has been invaluable learnings.

The Trust has employed an Arts Consultant for the Transforming Cancer Services programme, drafted a job description for an Arts Coordinator & started an Arts in Health internship programme.

Cyngor Celfyddydau Cymru
Arts Council of Wales

Reduce health inequalities, make it easier to access the best possible healthcare when it is needed and help prevent ill health by collaborating with the people of Wales in novel ways.

Improve the health and well-being of families across Wales by striving to care for the needs of the whole person.

Strengthen the international reputation of the Trust as acentre of excellence for teaching, research and technicalinnovation whilst also making a lasting contribution toglobal well-being

Bring communities and generations together through involvement in the planning and delivery of our services.

Demonstrate respect for the diverse cultural heritage of modern Wales

EDUCATION & DEVELOPMENT

SSC STUDENTS

A number of Student Selected Component (SSC) medical students have worked with the Sustainability team to review & analyse different areas of the Trust. The projects ranged from single use plastic to carbon footprint of patient meals.

INDSUTRIAL PLACEMENT STUDENT

The Trust employed a student studying Geography with Sustainabilty during their Industrial Placement year. The placement student was based in the Sustainability department and the Transforming Cancer Services team. They will be undertaking their dissertation on the new hospital project.

ENVIRONMENTAL AWARENESS COMPLIANCE

81.33%

TRUSTWIDE COMPLIANCE

The overall compliance Environmental Awareness compliance is at 81.33% at the end of the financial year. When the Sustainability team began delivering training, compliance was below 30%.

This improvement is despite in person training being paused due to the pandemic. Teams training sessions & e-learning have been available to staff. To further support this area, infographics on the KPIs have been developed are included within the Trust staff induction.

CONCLUSION

The Trust has made significant improvements which we will continue to build on. Our Trust Strategy 'Destination 2032' outlines a clear ambition for the organisation over the coming years; the delivery of high quality, sustainable health care services which reduce our impact on the environment and provides wider value to our communities. This is an exciting challenge for us which will require us to continue to pursue excellence in our clinical services whilst also making a contribution to the wealth, health and prosperity of across the country.

The importance of environmental interventions, sustainable solutions and working with our communities to deliver safe, high quality services and our long-term goals cannot be overstated.

ENSURING WE CONTRIBUTE TO A BETTER WORLD FOR FUTURE GENERATIONS IN OUR COMMUNITY AND ACROSS THE GLOBE…

…acting today, for a more sustainable tomorrow

Questions? Contact us.

sustainability.velindre@wales.nhs.uk

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

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

TRUST RISK REGISTER

DATE OF MEETING	17.01.2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	
PREPARED BY	MEL FINDLAY, BUSINESS SUPPORT OFFICER
PRESENTED BY	Lauren Fear, Director of Corporate Governance and Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance and Chief of Staff
REPORT PURPOSE	FOR DISCUSSION / REVIEW

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
BOARD DEVELOPMENT DISCUSSION ON RISK APPETITE	**08.11.22**	**Discussed**
EMB RUN	**03.02.23**	**Discussed**

Acronyms

VCC	Velindre Cancer Centre	SLT	Senior Leadership Team
WBS	Welsh Blood Service	SMT	Senior Management Team
TCS	Transforming Cancer Services	EMB	Executive Management Board
ELT	Extended Leadership Team		

1. BACKGROUND

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.
- Inform of the approach to the refresh of the Trust's risk appetite.

2. ASSESSMENT OF MATTERS FOR CONSIDERATION

Key points for the Quality, Safety and Performance Committee:

1. Work has taken place on VCC risk, including information to manage risk. The work undertaken is reflected in the data cut included in this paper. Work continues with the VCC SLT to move forward the work around risk.
2. Following discussion at EMB a review of risks recorded for the Welsh Blood Service was carried out, the amended risk record can be seen in 2.2.3 of the risk register.
3. Executive Management Board have endorsed the conclusions of risk appetite refresh for Trust Board approval in January, if further endorsed in January Audit Committee. This matter is dealt with first in 2.1 below.

2.1 Risk Appetite Refresh

Two matters to conclude on:

1. Agree refresh level of risk appetite for each risk category
2. Agree refresh of escalation levels according to risk appetite levels into governance layers of the Trust.

2.1.1 Level of Risk Appetite for Each Risk Category

Domain	Current Risk Appetite Level	Proposed refreshed level- following Board development discussion (Highlighted changes in yellow)
Quality	2 – Cautious	2 – Cautious
Safety	1 – Minimal	1 – Minimal
Compliance	2 – Cautious	2 – Cautious
Research and development	3 - Open	3 - Open
Reputation	2 – Cautious	2 – Cautious
Performance and service sustainability	2 – Cautious	2 – Cautious
Financial sustainability	2 - Cautious	2 - Cautious
Workforce	**2 - Cautious**	**3 - Open**
Partnerships & innovation	4 - Seek	4 - Seek
Information Governance	2 – Cautious *Working approach – to be agreed in Trust Board in Jan 2023	2 – Cautious
Enviromental	**2 – Cautious** ***Working approach – to be agreed in Trust Board in Jan 2023**	**3 - Open**

The discussion at Board Development for both workforce and environment was given the scale of the organisation's and wider industry challenges in these respects

that an Open level to Board risk appetite is most appropriate to meet these challenges.

Following the agreement of the levels, the updated statements for those with any change, in addition to IG and Environmental to be agreed by Executive Lead and included in the Trust Board papers. All Executive Leads to confirm wording for current statements also – change will be required to reflect Duty and Quality for instance.

2.1.2 Escalation Levels According to Risk Appetite Levels into Governance Layers of the Trust

Risk Appetite Levels	Escalation level to Trust Board if risk at level Score below – according to the 5x5 matrix	Proposed refreshed level- following Board development discussion (Highlighted changes in yellow)
0 – Avoid	9	9
1 – Minimal	12	12
2 – Cautious	12	15
3 – Open	12	15
4 – Seek	15	16
5 – Mature	15	16

There was a suggestion that for levels 2 and 3, these should also be level 16. However the consensus was as above. This could then be refreshed for 2023/24, based on a further year of maturity of the risk framework.

2.1.3 Risk Appetite Next Steps in Engagement and Embedding

- Policy agreed and all in clear in one place for staff on intranet and external stakeholders on intranet
- Part of level 2 training already included the concept and importance of risk appetite. This cohort will also receive specific regular risk briefings – including on Risk Appetite refresh outcome
- Update to Divisional Leadership Teams and the Extended Leadership Team on Risk Appetite refresh outcome
- Embedded into new cover paper format in risk section to encourage active consideration
- All challenging each other in strategic decision making to active and relevant

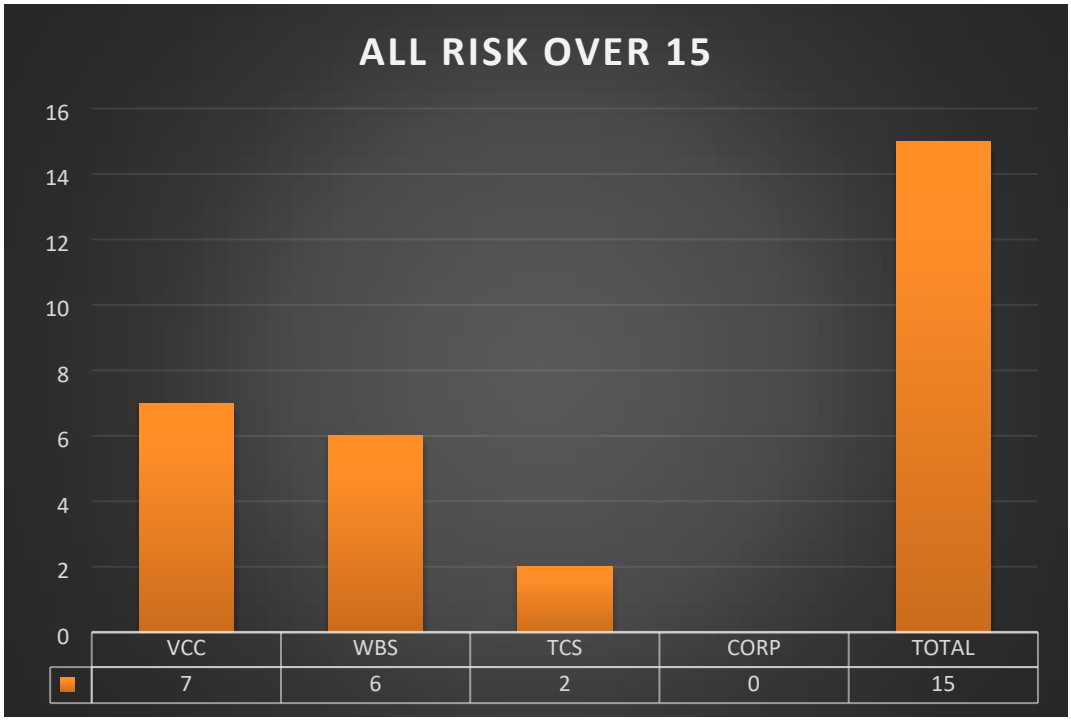
2.2 Trust Risk Register

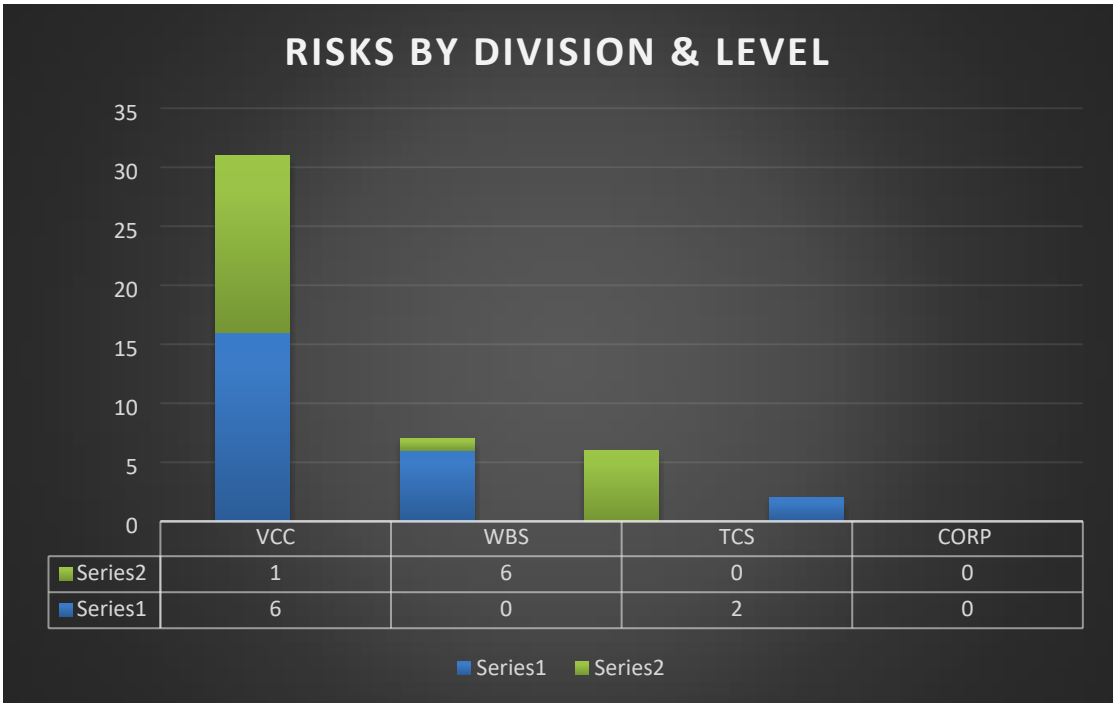
2.2.1 Total Risks

There are a total of 15 risks with a current risk level over 15 recorded on Datix 14.

2.2.2 Risks by Level

The graph below provides a breakdown of risks by level across the Trust. A further breakdown of risks by level and division is also include.


ALL RISK OVER 15
16
14
12
10
8
6
4
2
0
VCC
WBS
TCS
CORP
TOTAL
7
6
2
0
15


RISKS BY DIVISION & LEVEL
35
30
25
20
15
10
5
0
VCC
WBS
TCS
CORP
Series2
1
6
0
0
Series1
6
0
2
0
Series1
Series2

2.2.3 **Analysis of risks**

An analysis of risks by level is provided below. Tables provide detail of each risk including risk type, risk ID, review date, date risk opened on Datix, amount of days risk open and title of the risk.

Of the 15 risks recorded there are 7 risks for Velindre Cancer Centre, 6 risks for Welsh Blood service, 2 risks for Transforming Cancer Services and no risks over 15 for the Corporate function.

Risks level 16

The work undertaken to further review risks have also resulted in a change in the number of level 16 risks.

ID	Risk Title - New	Risk Type	Opened	Approval status	Division	RR - Current Controls	Risk (in brief)	Rating (current)	Review date	Length of time risk open
2769	There is a risk to quality /complaints /audit /GxP as a result of limited access to FoxPro expertise and use of outdated systems, leading to increased risk of incorrect test results and clinical advice.	Quality	26/10/2022	New Risk	Welsh Blood Service	vDOS emulation to allow running of applications on latest version of Windows. Where possible, seek to ensure integration with 3rd party systems and services can be supported as part of future procurements. Patient results are verified prior to issue.	(This refers to line reference number 1.0 on FMEA) WHAIS in-house developed IT applications are built using legacy FoxPro and DOS based technology that is no longer supported. There is only one FoxPro developer within WBS Digital Services team and there is limited ability to access agency resource with required level of FoxPro expertise. This may lead to inability to enhance WHAIS services to meet business needs and/or other factors such as changes to external regulatory requirements. Increased risk of data entry/transcription errors could lead to incorrect test results and clinical advice, potentially impacting patient safety. This could also lead to reputational damage as unable to update systems in line with stakeholders' requests.	16	14/04/2023	72

2774	There is a risk to quality/complaints/audit/GxP as a result of use of outdated legacy systems, leading to increased risk of incorrect test results and clinical advice.	Quality	27/10/2022	Accepted	Welsh Blood Service	Middleware has been developed in house to support interfacing to transfer data from a single laboratory software (HLA Fusion) to WHAIS IT. Minimal updates progressed within constraint of system and available IT SME resource. Patient results are verified prior to issue.	(This refers to line reference number 2.0 on FMEA) WHAIS in-house developed IT applications are built using legacy FoxPro and DOS based technology that is no longer supported. There is only one FoxPro developer within WBS Digital Services team and there is limited ability to access agency resource with required level of FoxPro expertise. Staff are required to print results from analysers and manually enter complex, scientific results into IT systems that require either double entry or verification by a 2nd scientist. Increased risk of data entry/transcription errors could potentially lead to incorrect test results and clinical advice which could impact patient safety.	16	14/04/2023	71
2775	There is a risk to quality/complaints/audit/GxP as a result othe use of outdated, legacy systems, leading increased risk of incorrect results and clinical advice	Quality	27/10/2022	New Risk	Welsh Blood Service	Working group to manage prioritisation of a 'back-log' 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 use.	(This refers to line reference number 3.0 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. There is a resulting increased risk of data entry/transcription errors leading to incorrect test results and clinical advice, potentially impacting patient safety. As there are increased manual, and resource heavy workarounds, staff morale may be reduced and there is a potential that staff may not be able to be released to focus on service-enhancing projects.There is an increased reliance on specialist staff and therefore, an increased pressure on workforcce.	16	14/04/2023	71

2776	There is a risk to performance and service sustainability as a result of the ongoing use of outdated, legacy systems, leading to the inability to enhance services to meet business needs.	Performance and Service Sustainability	27/10/2022	Accepted	Welsh Blood Service	Working group to manage prioritisation of a 'backlog' of urgent development work, shore up the system, and prevent critical failure. Minimal updates progressed within constraint of system and available IT SME resource. Patient results are verified prior to issue.	(This refers to line reference number 6.0 on FMEA) WHAIS in-house developed IT applications are built using legacy FoxPro and DOS based technology that is no longer supported. There is only one FoxPro developer within WBS Digital Services team and there is limited ability to access agency resource with required level of FoxPro expertise. This may lead to inability to enhance WHAIS services to meet business needs and/or other factors such as changes to external regulatory requirements. Increased risk of data entry/transcription errors could lead to incorrect test results and clinical advice, potentially impacting patient safety. This could also lead to reputational damage as unable to update systems in line with stakeholders requests.	16	14/04/2023	71
2779	There is a risk to financial sustainability as a result of ongoing use of obsolete/end of life systems, leading to requirement of increased staffing resource.	Financial Sustainability	27/10/2022	New Risk	Welsh Blood Service	None identified	(This refers to line reference number 12.0 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. There is increased staffing resource required due to ongoing use of obsolete/end of life systems	16	14/04/2023	71
2800	Newly discovered services at Asda	Performance and Service Sustainability	02/11/2022	Accepted	Transforming Cancer Services	1. Secure site investigation from Welsh Water	There is a risk that the high-pressure water main at Asda, which have recently been discovered, will need to be moved, which may lead to a delay of several months to Asda's works.	16	16/01/2023	65

2689	There is a risk to performance and service sustainability as a result of limited access to FoxPro expertise, leading to IT system failures and inability to provide one or more WHAIS services.	Performance and Service Sustainability	01/09/2022	New Risk	Welsh Blood Service	Business continuity using 3rd party (high cost) agency resource. Potential to transfer some operational responsibilities to NHSBT and/or other 3rd parties.	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 provide one or more WTAIL services, if unable to respond to urgent IT incidents or system failures and inability to develop existing WTAIL IT systems due to lack of availability of appropriate FoxPro expertise within Digital Services team.	16	14/04/2023	127
2714	Interest Rates There is a risk that increased rates of interest before financial close lead to the costs of the project exceeding the affordability envelope.	Financial Sustainability	09/09/2022	Accepted	Transforming Cancer Services	1. Discuss with Welsh Government. CAPEX was increased during CD. Complete 2. Monitor interest in line with the financial index. Monitor inflation, maintain the contingency buffer within budget. NB this risk will be the responsibility of the participant after financial close. Ongoing	Interest Rates There is a risk that increased rates of interest before financial close lead to the costs of the project exceeding the affordability envelope.	16	22/12/2022	119

2465	Number of emails medics are receiving, especially those related to clinical tasks.	Safety	05/11/2021	Accepted	Velindre Cancer Centre	No current controls - emails come in daily (including over the weekend) from within Velindre and outside (AOS teams, HB teams, primary care teams).An audit has been proposed to be undertaken on clinical emails, this will identify how many emails per day, time spent on clinical queries, where the emails originate from, how clinicians communicate that this is not the best route to forward clinical queries. Task and finish group to be established with key staff members in attendance.	The volume of emails received by medical staff is unmanageable. There is a risk of missing critical emails especially critical clinical questions. Clinical questions may not be responded to in a timely way or responses may not be accurate due to the pressure of responding to the number of emails received. This may lead to impact on patient care and staff wellbeing through stress, working additional hours to catch-up and potential for medical error due to distraction from other critical tasks. There is a secondary risk when colleagues are away so emails are not being actioned, and when they return, there is a huge backlog of messages to catch up on.	16	30/11/2022	427

Risks level 15
Summary of level 15 risks are detailed in the table below.

ID	Risk Title - New	Risk Type	Opened	Approval status	Division	RR - Current Controls	Risk (in brief)	Rating (current)	Review date	Length of time risk open
2187	Radiotherapy Physics Staffing There is a risk of the radiotherapy physics team being unable to complete core and developmental tasks due to inadequate staffing. This staff group is key in ensuring quality and safety of radiotherapy treatments. This may result in - patient treatment delay - Radiotherapy treatment errors. - key projects not keeping to time e.g. commissioning of essential systems - suboptimal treatment - either due to lack of planning time or lack of developmental time	Safety	14/09/2020	Accepted	Velindre Cancer Centre	Radiotherapy Physics workforce remains below recommended (IPEM) levels. Additional surge funding has been utilised alongside IRS funding to increase recruitment in the short term. The service head has developed an outline workforce plan, looking at roles and responsibilities and demands on the service, mapping out the essential BAU activity, critical projects and programmes of service development to implement a prioritisation if activity and resource utilisation. Whilst the situation to establish a full complement of staff in the service remains a challenge, development of a medium term workforce planning, and long term workforce strategy, with HEIW and W&OD colleagues continues alongside recruitment there will need to be support to focus on service critical projects. These have been determined as DHCR replacement, IRS and nVCC. Recruitment is underway to mitigate this risk, currently at 15, as this resource will cover the business critical programmes. This is subject to dynamic risk assessment due to the anticipated shortage of appropriate candidates.	There is a risk of the radiotherapy physics team being unable to complete core and developmental tasks due to inadequate staffing. This staff group is key in ensuring quality and safety of radiotherapy treatments. This may result in - patient treatment delay - Radiotherapy treatment errors. - key projects not keeping to time e.g. commissioning of essential systems - suboptimal treatment - either due to lack of planning time or lack of developmental time Example of areas of the service currently considered as routine that are detrimentally impacted by the lack of resource include i. Completion of incident investigations, reports and learning, essential to prevent future radiotherapy errors and incidents and improve local practice ii. Inability to provide engineering cover during weekend quality control activities iii. MPE advice on, and review of, treatment protocols to ensure they are in line with national guidelines whilst also appropriate for local practice iv. Development of workflow processes to increase efficiency v. Delays to the commissioning of new treatment techniques / service developments e.g., Partial Breast Irradiation (PBI) and Internal Mammary Node Irradiation (IMN)	15	30/12/2022	844

							vi. Delays in performing local RTQA slowing opening of new trials and thus reducing recruitment of Velindre patients to trials compared with other centres (e.g. PACE C) vii. MPE support for imaging activities providing imaging to the radiotherapy service inside and outside VCC. Background The ATTAIN report highlighted that in comparison to the Institute of Physics and Engineering in Medicine (IPEM) guidance, Radiotherapy Physics were under resourced by approximately 25%. The IPEM recommendations for the provision of a physics service to radiotherapy are recognised as a benchmark for minimum staffing guidance. The Engineering Section in particular is identified as an area of risk to the radiotherapy service. Not only are staffing numbers significantly under those recommended by IPEM but the age profile of this team is of concern, with up to 6 engineers planning to retire within 5 years. Linac engineering is a specialist area requiring in depth knowledge of complex machines and requires training to work at high voltages in a radiation environment. This is particularly critical with the age profile of our current linac fleet. The effects of incorrect repairs and / or maintenance can be significant on the patient and it is vital that this area is sufficiently resourced. Skill mix within physics enables most staff to be redirected to physics planning in order to meet fluctuating demand in the pre-treatment pathway and minimise patient delays and breaches.			

							However, this negatively impacts on other essential core duties.			
2612	Acute Oncology Service (AOS) Workforce Gaps	Workforce and OD	28/07/2022	Accepted	Velindre Cancer Centre	Consultant on call is made aware of the AOS gap and will take responsibility for the 24 hour period that they are on call. AOS sessions have been put into consultant job plans going forward.	There is a risk that the AOS service at Velindre Hospital is not sufficiently resourced. As a result this could result in periods of time in which the service is not sufficiently covered and other medic's providing a limited service. This may lead to medic's becoming overworked and stretched due to their responsibilities and a full AOS gap specification not being delivered.	15	31/01/2023	162
2433	DHCR037(R) - There is a risk that patient records will be incomplete, caused by data held in Canisc not being migrated to DHCR while interfaces are switched off during the dry run period. The impact will be the inability access up to date information.	Performance and Service Sustainability	09/06/2021	Accepted	Velindre Cancer Centre	Although treatment data will not update over go-live weekend, radiotherapy would have up to date record on paper & in Aria/ Mosaiq. Treatment helpline/ on call staff to be made aware of this.Radiation Services will only be treating emergency patients over the go-live weekend.Action point to be recorded on go-live weekend plan to ensure treatment helpline/ on call staff aware of this issue	Please note this risk has been raised as part of the Digital Health & Care Record (DH&CR - Canisc Replacement) programme and is ratified and managed via the DH&CR Project Board.DHCR037(R) - Risk that RT treatment will not update over go-live weekend. Patient record will not be fully complete - may affect advice given	15	30/12/2022	576

2630	Digital Health & Care Record DHCR062(R) - There is a risk that patients will still be live in Canisc at the end of the 12-week dual running period, caused by an increased number of patient treatment delays/suspensions. There will be a negative impact on service capacity with the additional need to manually migrate IRMER forms that are nearly complete or fully complete. This may further negatively impact BAU activities, such as the Mosaiq upgrade.	Performance and Service Sustainability	12/08/2022	Accepted	Velindre Cancer Centre	Working group has been established to consider all options and discuss potential measures and mitigations. An impact assessment and project plan is being written, requiring further review. Following the dual running period, may have to consider manual input of admissions and increased number of manually migrated IRMERs at the end of the duel running period. This would require a significant increase in resource.	Please note this risk has been raised as part of the Digital Health & Care Record (DH&CR - Canisc Replacement) programme and is ratified and managed via the DH&CR Project Board. Dual running initially estimated to be 6-8 weeks post go-live, in meeting 20/06/22 it was established it's now likely to be 12 weeks minimum - 6 weeks + 6 weeks of fractions - finish W/c 6th Feb - finish Friday 10th. Risk is that there are still patients in Canisc who haven't finished treatment at the end of dual running period. Following decision to run dual entry up to 12 weeks, there will be a resource requirement, which is planned for and now in place, but there are further specialist resource interdependencies beyond 12 weeks for which there is currently no mitigation, which will impact on other project timescales.	15	30/12/2022	147

2515	There is a risk that staffing levels within Brachytherapy services are below those required for a safe resilient service. This may result in a lack of resource to develop the service, investigate incidents and cover for absences.This may impact on the quality of care due to a reduction in resilience and development of the service	Performance and Service Sustainability	09/02/2022	Accepted	Velindre Cancer Centre	Capacity is managed by careful examination of rotas, refusing leave and redeployment of staff from other areas.A programme of training sufficient staff to cover all areas and a review of staff numbers is taking place	"Brachytherapy Staffing Levels at Velindre are low and recruitment and retainment of staff is not at the level required.There are a number of staff nearing retirement. There are also staff on maternity leave, sick leave, sabaticals etc. affecting staffing levels day to day.""There are a number of single points of failure within the service with a lack of cross cover, loss of single members of key staff could interupt patient treatment. Loss of trained staff leaves the service with a number of additional single points of failure. Training times are often long and impact on staff's current role. Staff can be sought from university cohorts but these are limited and the time required to train them to work within the Velindre service means they are not direct replacement for lost staff"	15	17/01/2022	331
2579	There is a risk to performance and service sustainability as a result of training curriculum changing to include acute oncology leading to inability to secure the required number of Palliative Care Trainees	Performance and Service Sustainability	10/06/2022	Accepted	Velindre Cancer Centre	Due to the change in the content of the training position to include acute oncology, VCC has be unsuccessful in securing trainees. this is leading to significant gaps in the training rota. There is a national shortage for these roles	Due to not recruiting through the national training programme, we are out to advert to fill the gaps by recruiting speciality doctors in their place. Where we are unable to cover gaps, we are temporarily providing support via oncology. this is a short term solutions as there is an impact on the ability to cover rota within the cancer centre. Where necessary the consultant will act down to cover the specialist registrar gap.	15	30/06/2023	210

3. Development of Risk Framework

3.1 Three levels of training to be delivered:

- All staff Level - training covering: why is risk management important, what is my role, first form of Datix 14, which is the simple input from which all staff in the organisation have access to in order to raise a risk. This training will be delivered via online learning on ESR. This training is in the later stages of the process with Shared Services and is anticipated to be live on the online learning portal by the end of February 2023.
- Management level – covering the Policy and Corporate Management Level Procedure and second form on Datix 14, which requires scoring, articulation of controls, setting actions and assigning ownership. It is following this step that a risk is confirmed onto the risk register. The Manager level then has the on-going responsibility for the overall management of that risk. Level 2 training has been completed. Additional sessions will be run for all divisions for those who have not yet accessed level 2 training.
- Leadership level – covering the Policy and oversight roles - Divisional Leadership Teams, Executive Management Board and Trust Board. Training has been completed for Board members and Executive Management Board members, including Divisional leadership.

3.3 The review of risk appetite was discussed with the Board in the development session on 8th November 2022. Risk appetite discussions commenced taking account of approaches in other organisations for reference. Discussions were around the risk appetite level of 15 for the Trust. Additionally, an exercise regarding reverse stress testing was considered with a scenario around special measures being agreed upon as appropriate to test, ensuring appropriate approaches are taken for both the Welsh Blood Service and The Velindre Cancer Service. This work will be continued with progress updates being provided in the March 2023 reporting cycle.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Is considered to have an impact on quality, safety and patient experience
RELATED HEALTHCARE STANDARD	Safe Care
	If more than one Healthcare Standard applies please list below.
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Risks open for extended periods of time without indication that work is being undertaken could expose the Trust that may have legal implications.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	If risks aren't managed / mitigated it could have financial implications.

4. RECOMMENDATIONS

The Quality, Safety and Performance Committee is asked to:

- **NOTE** the revised Risk Appetite level, following initial discussions at the Board Development session on 8th November 2022 and the outcome of the January Audit Committee, prior to January Trust Board.
- **NOTE** the risks level 16 and 15 reported in the Trust Risk Register and highlighted in this paper.
- **NOTE** the on-going developments of the Trust's risk framework.

ID	Risk Title - New	Risk Type	Opened	Approval status	Division	RR - Current Controls	Risk (in brief)	Rating (current)	Review date	Length of time risk open
2769	There is a risk to quality/complaints/audit/GxP as a result of limited access to FoxPro expertise and use of outdated systems, leading to increased risk of incorrect test results and clinical advice.	Quality	26/10/2022	New risk	Welsh Blood Service	vDOS emulation to allow running of applications on latest version of Windows. Where possible, seek to ensure integration with 3rd party systems and services can be supported as part of future procurements. Patient results are verified prior to issue.	(This refers to line reference number 1.0 on FMEA) WHAIS in-house developed IT applications are built using legacy FoxPro and DOS based technology that is no longer supported. There is only one FoxPro developer within WBS Digital Services team and there is limited ability to access agency resource with required level of FoxPro expertise. This may lead to inability to enhance WHAIS services to meet business needs and/or other factors such as changes to external regulatory requirements. Increased risk of data entry/transcription errors could lead to incorrect test results and clinical advice, potentially impacting patient safety. This could also lead to reputational damage as unable to update systems in line with stakeholders' requests.	16	14/04/2023	75
2774	There is a risk to quality/complaints/audit/GxP as a result of use of outdated legacy systems, leading to increased risk of incorrect test results and clinical advice.	Quality	27/10/2022	Accepted	Welsh Blood Service	Middleware has been developed in house to support interfacing to transfer data from a single laboratory software (HLA Fusion) to WHAIS IT. Minimal updates progressed within constraint of system and available IT SME resource. Patient results are verified prior to issue.	(This refers to line reference number 2.0 on FMEA) WHAIS in-house developed IT applications are built using legacy FoxPro and DOS based technology that is no longer supported. There is only one FoxPro developer within WBS Digital Services team and there is limited ability to access agency resource with required level of FoxPro expertise. Staff are required to print results from analysers and manually enter complex, scientific results into IT systems that require either double entry or verification by a 2nd scientist. Increased risk of data entry/transcription errors could potentially lead to incorrect test results and clinical advice which could impact patient safety.	16	14/04/2023	74

2775	There is a risk to quality/complaints/audit/GxP as a result othe use of outdated, legacy systems, leading increased risk of incorrect results and clinical advice	Quality	27/10/2022	New risk	Welsh Blood Service	Working group to manage prioritisation of a 'back-log' 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 use.	(This refers to line reference number 3.0 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. There is a resulting increased risk of data entry/transcription errors leading to incorrect test results and clinical advice, potentially impacting patient safety. As there are increased manual, and resource heavy workarounds, staff morale may be reduced and there is a potential that staff may not be able to be released to focus on service-enhancing projects. There is an increased reliance on specialist staff and therefore, an increased pressure on workforce.	16	14/04/2023	74

2776	There is a risk to performance and service sustainability as a result of the ongoing use of outdated, legacy systems, leading to the inability to enhance services to meet business needs.	Performance and Service Sustainability	27/10/2022	Accepted	Welsh Blood Service	Working group to manage prioritisation of a 'backlog' of urgent development work, shore up the system, and prevent critical failure. Minimal updates progressed within constraint of system and available IT SME resource. Patient results are verified prior to issue.	(This refers to line reference number 6.0 on FMEA) WHAIS in-house developed IT applications are built using legacy FoxPro and DOS based technology that is no longer supported. There is only one FoxPro developer within WBS Digital Services team and there is limited ability to access agency resource with required level of FoxPro expertise. This may lead to inability to enhance WHAIS services to meet business needs and/or other factors such as changes to external regulatory requirements. Increased risk of data entry/transcription errors could lead to incorrect test results and clinical advice, potentially impacting patient safety. This could also lead to reputational damage as unable to update systems in line with stakeholders requests.	16	14/04/2023	74
2779	There is a risk to financial sustainability as a result of ongoing use of obsolete/end of life systems, leading to requirement of increased staffing resource.	Financial Sustainability	27/10/2022	New risk	Welsh Blood Service	None identified	(This refers to line reference number 12.0 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. There is increased staffing resource required due to ongoing use of obsolete/end of life systems	16	14/04/2023	74
2800	Newly discovered services at Asda	Performance and Service Sustainability	02/11/2022	Accepted	Transforming Cancer Services	1. Secure site investigation from Welsh Water	There is a risk that the high-pressure water main at Asda, which have recently been discovered, will need to be moved, which may lead to a delay of several months to Asda's works.	16	16/01/2023	68

2689	There is a risk to performance and service sustainability as a result of limited access to FoxPro expertise, leading to IT system failures and inability to provide one or more WHAIS services.	Performance and Service Sustainability	01/09/2022	New risk	Welsh Blood Service	Business continuity using 3rd party (high cost) agency resource. Potential to transfer some operational responsibilities to NHSBT and/or other 3rd parties.	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 provide one or more WTAIL services, if unable to respond to urgent IT incidents or system failures and inability to develop existing WTAIL IT systems due to lack of availability of appropriate FoxPro expertise within Digital Services team.	16	14/04/2023	130
2714	Interest Rates There is a risk that increased rates of interest before financial close lead to the costs of the project exceeding the affordability envelope.	Financial Sustainability	09/09/2022	Accepted	Transforming Cancer Services	1. Discuss with Welsh Government. CAPEX was increased during CD. Complete 2. Monitor interest in line with the financial index. Monitor inflation, maintain the contingency buffer within budget. NB this risk will be the responsibility of the participant after financial close. Ongoing	Interest Rates There is a risk that increased rates of interest before financial close lead to the costs of the project exceeding the affordability envelope.	16	22/12/2022	122

2187	Radiotherapy Physics Staffing There is a risk of the radiotherapy physics team being unable to complete core and developmental tasks due to inadequate staffing. This staff group is key in ensuring quality and safety of radiotherapy treatments. This may result in - patient treatment delay - Radiotherapy treatment errors. - key projects not keeping to time e.g. commissioning of essential systems - suboptimal treatment - either due to lack of planning time or lack of developmental time	Safety	14/09/2020	Accepted	Velindre Cancer Centre	Radiotherapy Physics workforce remains below recommended (IPEM) levels. Additional surge funding has been utilised alongside IRS funding to increase recruitment in the short term. The service head has developed an outline workforce plan, looking at roles and responsibilities and demands on the service, mapping out the essential BAU activity, critical projects and programmes of service development to implement a prioritisation if activity and resource utilisation. Whilst the situation to establish a full complement of staff in the service remains a challenge, development of a medium term workforce planning, and long term workforce strategy, with HEIW and W&OD colleagues continues alongside recruitment there will need to be support to focus on service critical projects. These have been determined as DHCR replacement, IRS and nVCC. Recruitment is underway to mitigate this risk, currently at 15, as this resource will cover the business critical programmes. This	There is a risk of the radiotherapy physics team being unable to complete core and developmental tasks due to inadequate staffing. This staff group is key in ensuring quality and safety of radiotherapy treatments. This may result in - patient treatment delay - Radiotherapy treatment errors. - key projects not keeping to time e.g. commissioning of essential systems - suboptimal treatment - either due to lack of planning time or lack of developmental time Example of areas of the service currently considered as routine that are detrimentally impacted by the lack of resource include i. Completion of incident investigations, reports and learning, essential to prevent future radiotherapy errors and incidents and improve local practice ii. Inability to provide engineering cover during weekend quality control activities iii. MRE advice on, and review of,	15	30/12/2022	847
2612	Acute Oncology Service (AOS) Workforce Gaps	Workforce and OD	28/07/2022	Accepted	Velindre Cancer Centre	Consultant on call is made aware of the AOS gap and will take responsibility for the 24 hour period that they are on call. AOS sessions have been put into consultant job plans going forward.	There is a risk that the AOS service at Velindre Hospital is not sufficiently resourced. As a result this could result in periods of time in which the service is not sufficiently covered and other medic's providing a limited service. This may lead to medic's becoming overworked and stretched due to their responsibilities and a full AOS gap specification not being delivered.	15	31/01/2023	165

2433	DHCR037(R) - There is a risk that patient records will be incomplete, caused by data held in Canisc not being migrated to DHCR while interfaces are switched off during the dry run period. The impact will be the inability access up to date information.	Performance and Service Sustainability	09/06/2021	Accepted	Velindre Cancer Centre	Although treatment data will not update over go-live weekend, radiotherapy would have up to date record on paper & in Aria/ Mosaiq. Treatment helpline/ on call staff to be made aware of this. Radiation Services will only be treating emergency patients over the go-live weekend. Action point to be recorded on go-live weekend plan to ensure treatment helpline/ on call staff aware of this issue	Please note this risk has been raised as part of the Digital Health & Care Record (DH&CR - Canisc Replacement) programme and is ratified and managed via the DH&CR Project Board. DHCR037(R) - Risk that RT treatment will not update over go-live weekend. Patient record will not be fully complete - may affect advice given	15	30/12/2022	579
2630	Digital Health & Care Record DHCR062(R) - There is a risk that patients will still be live in Canisc at the end of the 12-week dual running period, caused by an increased number of patient treatment delays/suspensions. There will be a negative impact on service capacity with the additional need to manually migrate IRMER forms that are nearly complete or fully complete. This may further negatively impact BAU activities, such as the Mosaiq upgrade.	Performance and Service Sustainability	12/08/2022	Accepted	Velindre Cancer Centre	Working group has been established to consider all options and discuss potential measures and mitigations. An impact assessment and project plan is being written, requiring further review. Following the dual running period, may have to consider manual input of admissions and increased number of manually migrated IRMERs at the end of the duel running period. This would require a significant increase in resource.	Please note this risk has been raised as part of the Digital Health & Care Record (DH&CR - Canisc Replacement) programme and is ratified and managed via the DH&CR Project Board. Dual running initially estimated to be 6-8 weeks post go-live, in meeting 20/06/22 it was established it's now likely to be 12 weeks minimum - 6 weeks + 6 weeks of fractions - finish W/c 6th Feb - finish Friday 10th. Risk is that there are still patients in Canisc who haven't finished treatment at the end of dual running period. Following decision to run dual entry up to 12 weeks, there will be a resource requirement, which is planned for and now in place, but there are further specialist resource interdependencies beyond 12 weeks for which there is currently no mitigation, which will impact on other project timescales.	15	30/12/2022	150

2465	Number of emails medics are receiving, especially those related to clinical tasks.	Safety	05/11/2021	Accepted	Velindre Cancer Centre	No current controls - emails come in daily (including over the weekend) from within Velindre and outside (AOS teams, HB teams, primary care teams). An audit has been proposed to be undertaken on clinical emails, this will identify how many emails per day, time spent on clinical queries, where the emails originate from, how clinicians communicate that this is not the best route to forward clinical queries. Task and finish group to be established with key staff members in attendance.	The volume of emails received by medical staff is unmanageable. There is a risk of missing critical emails especially critical clinical questions. Clinical questions may not be responded to in a timely way or responses may not be accurate due to the pressure of responding to the number of emails received. This may lead to impact on patient care and staff wellbeing through stress, working additional hours to catch-up and potential for medical error due to distraction from other critical tasks. There is a secondary risk when colleagues are away so emails are not being actioned, and when they return, there is a huge backlog of messages to catch up on.	16	30/11/2022	430
2579	There is a risk to performance and service sustainability as a result of training curriculum changing to include acute oncology leading to inability to secure the required number of Palliative Care Trainees	Performance and Service Sustainability	10/06/2022	Accepted	Velindre Cancer Centre	Due to the change in the content of the training position to include acute oncology, VCC has be unsuccessful in securing trainees. this is leading to significant gaps in the training rota. There is a national shortage for these roles	Due to not recruiting through the national training programme, we are out to advert to fill the gaps by recruiting speciality doctors in their place. Where we are unable to cover gaps, we are temporarily providing support via oncology. this is a short term solutions as there is an impact on the ability to cover rota within the cancer centre. Where necessary the consultant will act down to cover the specialist registrar gap.	15	30.06.2023	213
2515	There is a risk that staffing levels within Brachytherapy services are below those required for a safe resilient service. This may result in a lack of resource to develop the service, investigate incidents and cover for absences. This may impact on the quality of care due to a reduction in resilience and development of the service	Performance and Service Sustainability	09/02/2022	Accepted	Velindre Cancer Centre	Capacity is managed by careful examination of rotas, refusing leave and redeployment of staff from other areas. A programme of training sufficient staff to cover all areas and a review of staff numbers is taking place	"Brachytherapy Staffing Levels at Velindre are low and recruitment and retainment of staff is not at the level required. There are a number of staff nearing retirement. There are also staff on maternity leave, sick leave, sabaticals etc. affecting staffing levels day to day." "There are a number of single points of failure within the service with a lack of cross cover, loss of single members of key staff could interupt patient treatment. Loss of trained staff leaves the service with a number of additional single points of failure. Training times are often long and impact on staff's current role. Staff can be sought from university cohorts but these are limited and the time required to train them to work within the Velindre service means they are not direct replacement for lost staff"	15	17/01/2022	334

RISK APPETITE SCORING MATRIX

AGREED BY THE BOARD AS PART OF THE AGREED 2020 FRAMEWORK THAT RISK APPETITE MATRIX SCORING WOULD BE REVIEWED FOR 2020 FOLLOWING THE GOOD GOVERNANCE INSTITUTE (GGI) AS EITHER **AVOID, MINIMAL, CAUTIOUS, OPEN, SEEK** OR **MATURE** RISK APPETITE.

Risk levels ▶ / Key elements ▼	0 **Avoid** Avoidance of risk and uncertainty is a Key Organisational objective	1 **Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	2 **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	3 **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	4 **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	5 **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Financial/VFM	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach.	Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself.
Compliance/ regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances.	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation.
Innovation/ Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation.	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.
APPETITE	NONE	LOW	MODERATE	HIGH	SIGNIFICANT	

RISK APPETITE STATEMENTS AGREED IN 2020

	Domain / Risk Category	Risk Appetite (GGI Level)
1	Quality The provision of high-quality services is of the utmost importance for Velindre University NHS Trust. The Trust acknowledges that in order to achieve individual patient care, treatment and therapeutic goals there may be occasions when a low level of risk must be accepted. Where such occasions arise, we will support our staff to work in collaboration with those who use our services, to develop appropriate and safe care plans. We therefore have a 'LOW' appetite for risks which my compromise the quality of the care we deliver / could result in poor quality care, non-compliance with standards of clinical or professional practice or poor clinical interventions. Our service is underpinned by clinical and professional excellence and any risks which impact quality, could have catastrophic consequences for our patients.	2 - Cautious
2	Safety Velindre University NHS Trust hold patient, donor and staff safety in the highest regard. We have a 'NONE – LOW' appetite for risks which may compromise safety, however recognising that individual risk tolerance may on some occasions go above this if it is in the best interests of patients to accept some risk in order to achieve the best outcomes from individual patient care, treatment and therapeutic goals. We accept this and support our staff to work in collaboration with people who use our services to develop appropriate and safe care plans based on assessment of need and clinical risk. N.B., Key to keeping patients, donors and staff safe is the condition of the estate. We are committed to ensuring that our services are provided in buildings that are fit for purpose, are compliant with legislation and do not represent a health and safety risk.	1 - Minimal

RISK APPETITE STATEMENTS AGREED IN 2020

	Domain/Risk Category	Risk Appetite (GGI Level)
3	Compliance We are cautious when it comes to compliance and regulatory requirements. Where the laws, regulations and standards are about the delivery of safe, high quality care, or the health and safety of the staff and public, we will make every effort to meet regulator expectations and comply with laws, regulations and standards that those regulators have set, unless there is strong evidence or argument to challenge them.	2 – Cautious
4	Research and development We have a HIGH risk appetite for Clinical Innovation that does not compromise quality of care and patient safety / the Trust has a HIGH appetite for risks associated with innovation, research and development in order to take forward our vision in relation to the new treatments, developments of new models of care and improvements in clinical practice that support the delivery of our person centred values and approach. The Trust will only take risks when it has the capacity to manage them and is confident that there will be no adverse impact on the safety and quality of the services provided.	3 – Open
5	Reputation The Trust will maintain high standards of conduct, ethics and professionalism at all times. We have a LOW risk appetite for actions and decisions taken in the interest of ensuring quality and sustainability which may affect the reputation of the organisation.	2 – Cautious

RISK APPETITE STATEMENTS AGREED IN 2020

	Domain/Risk Category	Risk Appetite (GGI Level)
6	Performance and service sustainability We have a LOW- MODERATE risk appetite for risks which may affect our performance and service sustainability. And are prepared to accept managed risks to our portfolio of services if they are consistent with the achievement of patient/donor safety and quality improvements as long as patient/donor safety, quality care and effective outcomes are maintained. Whilst these will both be at the fore of our operations; we recognise there may be unprecedented challenges (such as Covid-19) which may result in lower performance levels and unsustainable service delivery for a short period of time.	2 – Cautious
7	Financial sustainability Velindre University NHS Trust is entrusted with public funds and must remain financially viable while safeguarding the public purse. The Trust has no appetite for accepting or pursuing risks that would leave the organisation open to fraud or breaches of Standing Financial Instruction. We strive to deliver our services within the budgets our financial plans and will only consider accepting or taking financial risks where this is required to mitigate risks to patient safety or quality of care according to a LOW- MODERATE risk appetite. We will ensure that all such financial responses deliver optimal value for money.	2 – Cautious

RISK APPETITE STATEMENTS AGREED IN 2020

	Domain/Risk Category	Risk Appetite (GGI Level)
8	Workforce Velindre University NHS Trust is committed to recruit and retain staff that meet the high-quality standards of the organisation and will provide on-going development to ensure all staff reach their full potential. This key driver supports our values and objectives to maximize the potential of our staff to implement initiatives and procedures that seek to inspire staff and support transformational change whilst ensuring it remains a safe place to work. We have a MODERATE risk appetite for decisions taken in relation to workforce but given the recognised workforce shortages we may tolerate a HIGH level of risk on some occasions to support patients. N.B., We will not accept risks, nor any incidents or circumstances which may compromise the safety of any staff members and patients or contradict our Trust Values i.e., unprofessional conduct, underperformance, bullying or an individual's competence to perform roles or tasks safely nor any incident or circumstances which may compromise the safety of any staff members or group.	2 – Cautious
9	Partnerships The Trust is committed to working with its stakeholder organisations to bring value and opportunity across current and future services through system-wide partnership. We are open to developing partnerships with organisations that are responsible and have the right set of values, maintaining the required level of compliance with our statutory duties. We therefore have a HIGH risk appetite for partnerships which may support and benefit the patients in our care. For example, the Trust has a high appetite for risks associated with innovation and partnership with industry and academia in order to realise the provision of new models of care, new service delivery options, new technologies, efficiency gains and improvements in clinical practice. However, the Trust will balance the opportunities with the capacity and capability to deliver such opportunities and is confident that there will be no adverse impact on the safety and quality of the services provided.	4 - Seek

QUALITY, SAFETY AND PERFORMANCE COMMITTEE	
TRUST ASSURANCE FRAMEWORK	
DATE OF MEETING	17.01.2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	N/A

PREPARED BY	Emma Stephens, Head of Corporate Governance and Mel Findlay, Business Support Officer
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance & Chief of Staff
REPORT PURPOSE	FOR DISCUSSION / REVIEW

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
STRATEGIC DEVELOPMENT COMMITTEE	**08.12.2022**	**Discussed**
AUDIT COMMITTEE	**12.01.2023**	**Discussed**

1. SITUATION / BACKGROUND

1.1 The purpose of this paper is to provide the Quality, Safety & Performance (QSP) Committee with a report on the Principal Risks identified in the Trust Assurance Framework that fall within the remit of this Committee (***ref. Appendix1***), which may affect the achievement of the Trust's Strategic Objectives, and the level of

assurances in place to evidence the effectiveness of the management of those risks.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

TAF 01: Demand and Capacity

- **Residual Risk Score –** 12. This remains unchanged since the previous review and there is no specific evident trend emerging in the data.
- **Overall Level of Control Effectiveness –** This remains as Partially Met (PE)
- **Sources of Assurance –** There have been no changes to the sources of assurance.
- **Action Plan for Gaps Identified –** The action plan has been updated is largely progressing on target.

TAF 03: Workforce Planning

- **Residual Risk Score – 12.** The residual risk increased from 9 to 12 in the September 2022 governance reporting cycle and has remained at this level since that time.
- **Overall Level of Control Effectiveness –** This remains as Partially Met (PE)
- Sources of Assurance – There have been no changes or additions to the sources of assurance since the previous review
- **Action Plan for Gaps Identified –** The action plan has been updated to provide a further level of detail and assurance on the planned timetable for delivery of the associated programme of work to mitigate this risk.

TAF 06: Quality and Safety

- **Residual Risk Score – 15**. This remains unchanged since the previous review with no trend emerging since March 2022.
- **Overall Level of Control Effectiveness** – This remains as Partially Effective (PE), unchanged since the last review.
- **Sources of Assurance** – Gaps in controls and assurance have been amended following review;
    - Following approval of the Quality and Safety Framework approved in July 2022, implementation commenced.
    - Quality and Safety Operational Group Planning meeting held, inaugural meeting arranged in October 2022.

- An additional gap in assurance has been identified:
- The current mapped meeting reporting structure does not cover floor to board at divisional level.

- **Action Plan for Gaps Identified** – Amendments have been made to the action plan to address the gaps identified and target dates reviewed.

TAF 08: Trust Financial Investment

- **Residual Risk Score – 12.** The residual risk decreased from 16 to 12 in the July 2022 governance reporting cycle and has remained at this level since that time.
- **Overall Level of Control Effectiveness -** This remains as Partially Met (PE)

Sources of Assurance – The reviewed sources of assurance have resulted in some additions:

- Key objectives of investment framework and relationship to contract performance and value identified.
- Investment framework to be articulated and agreed by Divisions and Executive Team.
- Investment framework to be applied within IMTP process.

- **Action Plan for Gaps Identified** – There has been extensive review of the action plan resulting in the addition of new actions being added, detail below the main actions can be seen in Appendix 1:
  - Review of contracting model for impact of COVID related measures.
  - Establish Trust Investment Prioritisation Framework.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes
	Please refer to ***Appendix 1*** for relevant details.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

The Quality, Safety and Performance Committee is asked to:

DISCUSS AND REVIEW the update to the Trust Assurance Framework Dashboard, included at Appendix 1.

RISK ID:	TAF 01	We fail to deliver sufficient capacity leading to deterioration in service quality, performance or financial control as a result of capacity or demand planning or the operational service challenges											
LAST REVIEW	Sep-22	1 - Outstanding for quality, safety and experience											
NEXT REVIEW	Oct-22	RISK DOMAIN						Performance and Sustainability					
EXECUTIVE LEAD	Cath O'Brien	**RISK SCORE (See definitions tab)**											
		INHERENT RISK			**RESIDUAL RISK**						**TARGET RISK**		
		Likelihood	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**				**Likelihood**	**Impact**	**TOTAL**
		4	4	**16**	3	4	**12**				2	4	**8**

Overall Level of Control Effectiveness: **Rating and Rag** (see definitions tab)	**RATING**	**Overall Trend in Assurance**	**THIS WILL INCLUDE A TREND GRAPH**
	PE		

KEY CONTROLS							**SOURCES OF ASSURANCE**					
ID	**Key Control**	**Owner**	**Preventativ**	**Mitigating**	**Detective**	**Control Effectiveness Rating**	**1st Line of Defence**	**Assurance Rating**	**2nd Line of Defence**	**Assurance Rating**	**3rd Line of Defence**	**Assurance Rating**
C1	Blood stock planning and management function WBS and Health Boards. This includes active engagement with Health Boards in Service Planning including the established annual Service Level agreement,. The overall annual collection plan based on this demand and the active delivery of blood stocks management through the Blood Health Plan for NHS Wales and monthly laboratory manager meetings.	Director WBS	X			E	Annual SLA meetings with Health Boards to review supply. Benchmarking against national and international standards. Annual Blood Health Team review of Health Board supply and prudent use of blood Annual Integrated Medium Term Plan (IMTP) review of previous 3 year demand trend to build resilience and inform and predict any surge demand.	PA	Senior Management Team, COO review and EMB Review, QSP committee and Board.	PA	Welsh Government Quality, Planning and Delivery Review.	PA

C2	Operational Blood stock planning and management function in WBS. Delivered through annual, monthly and daily resilience planning meetings. Underpinned by the UK Forum Mutual Aid arrangement	Director WBS	X			E	Department Head review with escalation to Director	PA	Performance Report Senior Management Team and EMB Review, QSP committee and Board	PA	Welsh Government Quality, Planning and Delivery Review	PA
C3	SEW- VUNHST cancer demand modelling programme with HBs and WGDU in place, continues to provide high level assurance on demand projections.	Director VCC (VCS)	X	X		PE	SE Wales Group	IA	Performance Report - SLT, EMB, QSP and Board	IA	Welsh Government Quality, Planning and Delivery Review	IA
C4	Demand and Capacity Plan for each service area	Heads of Service - Each Area	X	X		PE	Service area operational planning meeting	IA	Performance Report - SLT, EMB, QSP and Board	IA	Welsh Government Quality, Planning and Delivery Review	IA
C5	Active operation engagement with health boards on demand	Director VCC (VCS)	X	X	X	PE	SLT	IA	Performance Report - SLT, EMB, QSP and Board	IA	Welsh Government Quality, Planning and Delivery Review	IA

GAP IN CONTROLS	GAPS IN ASSURANCE
Lack of real time data on fating of blood to allow business intelligence data set that links Health Board and activity changes to demand. Addressing this gap would need digital systems to be in place which are out of WBS control. Projects are progressing externally.	
The demand management for blood still varies across Health Boards and within clinical teams. The Blood Health National Oversight Group work programme continues to address inapproprite use if blood, which impacts demand.	
Lack of visibility of granular level planning data and Health Board activity plans to clear backlog at VCC.	
Lack of a formal oversight of capacity and demand management at a divisional level to recognise the complexity of interdependencies of various functions and services at VCC.	Executive Team oversight of the more detailed capacity and demand plans

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

Action Plan	Owner	Progress Update	Due Date
Exploratory pilot project with Cardiff and Vale Health Board to scope real time digital solution to develop blood fate data set.	Lee Wong	Project is underway in Cardiff and Vale, supported by WBS. Funding options are being sought	Dec-23
Blood Health National Oversight Group project is underway identifying inappropriate use of blood.	Lee Wong	Gap anaylysis is underway across Health Boards. The IBI lens will be used on this project	Dec-23
Engaging with Health Boards to seek further information on recovery and wider operational plans; such as waiting time initiatives and to formalise a route for planning and managing demand variation, including clinical choices.	Lisa Miller	Contact has been made with HBs and work has been done on data sets and will continue to be reviewed in regular VCS/HB meetings	Complete
A formal demand and capcity review meeting has been established at VCC	Lisa Miller	The group has been established and is currently meeting weekly to address the impact on capacity due failure of third party provision. Currently expericencing above usual demand for SACT	Complete
There is a weekly meeting between the Executive Team and Senior Leadership Team established to provide an opportunity for collaboration and oversight for addressing the immediate challenge at VCC	Steve Ham	This meeting is a short term focused meeting pending revised capacity plans	Complete

TAF DASHBOARD

WORKFORCE PLANNING

RISK ID:	TAF 03	**WORKFORCE PLANNING:** Risk of not having the right staff in right place at right time with right capability, as a result of not having appropriate and effective workforce plan owned in the right place, resulting in deterioration of operational performance, decline in the safety/quality of service provision, threatening financial sustainability and/or impacting our transformation ambitions.
LAST REVIEW	Oct-22	1 - Outstanding for quality, safety and experience
NEXT REVIEW	Nov-22	RISK DOMAIN Workforce and Organisational Development
EXECUTIVE LEAD	Sarah Morley	

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
4	4	16	4	3	12	2	3	6

Overall Level of Control Effectiveness: Rating and Rag (see definitions tab)	RATING	Overall Trend in Assurance	THIS WILL INCLUDE A TREND GRAPH
	PE		

KEY CONTROLS

SOURCES OF ASSURANCE

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Draft Trust People Strategy clearly noting the strategic intent of Workforce Planning - 'Planned and Sustained Workforce'	Sarah Morley	X			PE	Tracking key outcomes and benefits map – aligned to Trust People Strategy	PA	Internal Audit Reports	PA	To be completed as per compliance/ reg tracker update	PA
C2	Workforce Planning Methodology approved by Executive Management Board	Susan Thomas	X			PE	Staff Feedback	PA	Trust Board reporting against Trust People Strategy	PA	To be completed as per compliance/ reg tracker update	PA
C3	Workforce Planning – Skills Development – Training and Development Package in Place	Susan Thomas	X			PE	reports via divisional and committee structures	PA				
C4	Workforce Planning embedded into our Inspire Programme to develop Mangers and leaders in WP skills	Susan Thomas	X			PE	Evaluation Sheets	PA				

TAF DASHBOARD

WORKFORCE PLANNING

C5	Additional workforce planning resources recruitment to support development of workforce planning approach and facilitate the utilisation of workforce planning methodology	Susan Thomas	X			PE	Staff meeting to feedback on implementation plan	PA				
C6	Educational pathways in place for hard to fill roles in the Trust to support the recruitment of new skills and development of new roles	Susan Thomas	X			PE	Recruitment and retention repots via Board	PA				
C7	Widening access Programme in train to support development of new skills and roles	Susan Thomas	X			PE	Reports via Trust Committee cycle on updates	PA				
C8	Workforce analysis available via ESR and Business Intelligence support	Susan Thomas	X			PE	Performance reports via divisional and committee structures	PA				
C9	Hybrid Workforce Programme established to assess implications for planning a workforce following COVID and learning lessons will include technology impact assessments.	Sarah Morley			X	PE	Agile Project and Programme Board	PA				

GAP IN CONTROLS	GAPS IN ASSURANCE
Gaps are evident in understanding agreed service models – both internally and regionally	Development of 3rd Line of defence assurance to be completed
Each of the controls requires further development and progression, the plans for which are at varying levels of maturity	Mapping of relevant sources of assurance and development of that assurance will be also alongside the development of the key controls

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

TAF DASHBOARD

WORKFORCE PLANNING

Action Plan		Owner	Progress Update	Due Date
1.1	Attraction, Retention and Recruitment Programme established to deliver outputs to support the supply and shape of the workforce	Sarah Morley	The Programme Group has been established and a range of outputs defined to deliver between September 2022 and February 2023.	Feb-23
1.2	The Healthy and engaged workplan to be implemented to support worforce capacity within the Trust	Sarah Morley	The Trust has appointed a staff psychologist to support mental health and wellbeing. In addition all elements of the Trust wellbeing offer have been added to the national GWELLA platform allowing them to be more easily accessible for staff.	Dec-22
1.3	Establish Hybrid working arrangements as a core way in which the Trust undertakes some of its work.	Sarah Morley	The Trust has approved a set of Hybrid working principles. There are now task and finish groups working under the Hybrid working project to develop the operational systems and toolkits that will allow the Trust to fully relaise the benefits of hybrid working arrangements.	Dec-22

TAF DASHBOARD

QUALITY AND SAFETY

RISK ID:	TAF 06	Trust has just approved (July 2022) its integrated Quality & Safety Framework and is in the process of setting up the required mechanisms, systems, processes and datasets. This includes the ability to on mass learn from patient feedback i.e. patient / donor feedback / outcomes / complaints / claims, incidents and ability to gain insight from robust triangulated datasets and to systematically demonstrate the learning, improvement and that preventative action has taken place to prevent future donor / patient harm. These are not currently in place and could result in the Trust not meeting its national and legislative responsibilities (Quality & Engagement Bill (2020)) and a reduction in public/patient/donor, external agency, regulator and commissioner confidence in the quality of care the Trust provides.		
LAST REVIEW	Oct-22	1 - Outstanding for quality, safety and experience		
NEXT REVIEW	Nov-22	Goal 1	RISK DOMAIN	Quality and Safety/ Comliance and Regulatory

		RISK SCORE (See definitions tab)								
		INHERENT RISK			**RESIDUAL RISK**			**TARGET RISK**		
EXECUTIVE LEAD	Nicola Willams	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**
		5	5	**25**	3	5	**15**	2	5	**10**

Overall Level of Control Effectiveness: **Rating and Rag** (see definitions tab)	**RATING**	**Overall Trend in Assurance**	**THIS WILL INCLUDE A TREND GRAPH**
	PE		

KEY CONTROLS							**SOURCES OF ASSURANCE**					
ID	**Key Control**	**Owner**	**Preventative**	**Mitigating**	**Detective**	**Control Effectiveness Rating**	**1st Line of Defence**	**Assurance Rating**	**2nd Line of Defence**	**Assurance Rating**	**3rd Line of Defence**	**Assurance Rating**
C1	Once for Wales Datix System implemented	Nicola Williams			X	PE	Staff feedback	IA	Internal Audit Reviews	Not Assessed	Audit Wales Reviews	Not Assessed
C2	CIVICA pt/donor feedback system being implemented	Nicola Williams			X	PE	Patient/Donor Feedback	IA	Quality, Safety & Performance Committee	IA	HIW Inspect	Not Assessed
C3	Trust wide Divisional to Board level Quality & Safety meeting structure in place	EXECS	X	X	X	PE	15 Step challenge	IA	Peer reviews	Not Assessed	MHRA	Not Assessed
							EMB	IA			Professional bodies	Not Assessed
C4	Quality & Safety Teams in place corporately & in each Division	NW, AP, PW	X	X	X	PE	Divisional Q&S Groups	IA			Delivery Unit	Not Assessed
							PMF	IA				Not Assessed

TAF DASHBOARD

QUALITY AND SAFETY

C5	PMF in place & under review to include experience & outcomes	Carl James			X	NE	Perfect Ward audits	IA				
							PMD	IA				
C6	Trust Risk Register in place	Lauren Fear	X	X	X	PE	Mortality reviews	IA				
C7	Regular Staff Feedback sought	Sarah Morley			X	PE						
C8	Staff Q&S training & Education	Nicola Williams	X			PE		IA	Internal Audit Reviews	Not Assessed		

GAP IN CONTROLS	GAPS IN ASSURANCE
National standards / best practice standards (including benchmarkable outcome & experience measures) are not explicit across all departments of the Trust & /or regularly reviewed	Currently mechanisms to automatically & systematically review and triangulate & integrate quality & safety information at corporate and VCC Divisional level are insufficiently robust due to lack of cohesive infrastructure
Data / information infrastructure currently insufficient and unable to provide triangulation	Currently the mechanisms to evidence learning and improvement service level to Board remains under development
Quality & Safety Framework approved in July 2022, implementation commenced. Quality & Safety Operational Group Planning meeting held, inagural meeting arranged in October 2022.	There are gaps in the Quality & Safety reporting mechanisms from service level to Board in respect of meeting structures and reporting lines
National Duty of Quality statutory guidance 12 week consulation due in October 2022 & Duty of Candour regulation changes 12 week consultation commenced on 20th September 2022.	Trust Quality, Safety & Performance Committee needs to further refine its work plan, quality of papers and triangulation methodologies
Work required to ensure consistent and recognized Floor to Board lines accountability & responsibility for Quality & Safety	The current mapped meeting reporting structure does not cover floor to board at divisional level
Work required to ensure robust links between incidents, feedback, complaints, mortality review outcomes clinical audit and improvement plans and to be able to demonstrate improvement	Quality & Safety assurance infrastructure for hosted organisations is unclear
Trust wide and VCC Quality & Safety Teams have insufficient capacity and capability to currently be able to fully execute responsibilities	Quality & Safety Operational Group requires full establishment - to operationally pull together all stands and feed into EMB & QSP

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Trust Quality & Safety Framework to be finalized and implementation plan developed.	Nicola Williams	Framework finalised and approved by Board in July 2022	COMPLETE

TAF DASHBOARD

QUALITY AND SAFETY

1.2	Corporate & Divisional Quality Hubs to be established	Nicola Williams Alan Prosser Paul Wilkins	Corporate OCP completed and recruitment commenced. WBS Quality Hub requirements determined – minor changes required from existing arrangements VCC Quality Hub high level requirements determined - additional / realignment of resources maybe required. Detail needs to be worked through	Oct-22
1.3	Trust Quality & Safety Framework implementation plan to be completed in line with agreed timescales	Exec Team Divisional Directors	Implementation plan developed and approved	Mar-23
1.4	Instigate a Quality & Safety operational meeting where cross cutting outcome review & triangulation takes place	Nicola Williams	Planning meeting held, draft terms of reference developed and membership agreed. Inagural meeting planned for October 2022	Oct-22
1.5	Ensure the Action & learning sections within the Once for Wales Datix System are robustly implemented & audited	Nicola Williams	Being picked up through the Datix project Board	Dec-22
1.6	Implement a robust compassionate leadership programme	Sarah Morley	Compassionate Leadership is woven through the Trust 'Inspire' Leadership Programme. A broader Trust wide programme is being developed for all leaders and managers which forms part of the 'Building our Future Together' Portfolio.	Apr-23
1.7	Ensure all responsible officers receive Investigation Training	Nicola Williams Cath O'Brien	Investigation training provided to officers within corporate quality & safety team and both divisions	Jun-22
1.8	Implement National Duty of Candour guidelines / requirements	Jacinta Abraham	Awaiting National statutory Guidance. Nicola Williams Chairing national Duty Quality / Duty Candour Steering group. Consultations planned for Autumn 2022.	Apr-23
1.9	Implement National Duty of Quality guidelines / requirements	Nicola Williams		Apr-23
1.10	Explicitly define the required Quality, Safety & Governance assurance mechanisms for Hosted Organisations	Lauren Fear	Governance and Assurance mechanisms have been agreed and established for Shared Services, reporting through to the Quality, Safety and Performance Committee, Shared Services Audit Committee and Shared Services Partnership Committee. A review is underway of Health Technology Wales and required Governance and Assurance mechanisms. This will be progressed in quarter 1 2022/23. Update 06.10.2022 - Defined project as part of the Building Our Future Together work programme.	Jan-22
1.11	Complete Risk Register Review, transmission onto Datix v14 (04W when available) & ensure regular reviews at all levels in line with Quality and Safety outcomes	Lauren Fear	Regular reviews are taking place and work is ongoing to transfer of all risks to Datix V14, followed by Once for Wales when available.	COMPLETE

TAF DASHBOARD

TRUST FINANCIAL INVESTMENT RISK

RISK ID:	TAF 08	There is a risk that the contracting arrangements between Velindre and its Commissioners do not adequately acknowledge future service developments and changes in clinical & scientific practices and thus ensure appropriate funding mechanisms are in place and agreed.		
LAST REVIEW	Oct-22	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations		
NEXT REVIEW	Nov-22	**Goal 2**	**RISK DOMAIN**	**Financial Sustainability**

EXECUTIVE LEAD	Matthew Bunce	**RISK SCORE (See definitions tab)**								
		INHERENT RISK			**RESIDUAL RISK**			**TARGET RISK**		
		Likelihood	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**
		4	4	**16**	3	4	**12**	2	4	**8**

Overall Level of Control Effectiveness: **Rating and Rag** (see definitions tab)	**RATING**	**Overall Trend in Assurance**	**GOING FORWARD THIS WILL INCLUDE A TREND GRAPH**
	PE		

KEY CONTROLS							**SOURCES OF ASSURANCE**					
ID	**Key Control**	**Owner**	**Preventative**	**Mitigating**	**Detective**	**Control Effectiveness Rating**	**1st Line of Defence**	**Assurance Rating**	**2nd Line of Defence**	**Assurance Rating**	**3rd Line of Defence**	**Assurance Rating**
C1	Trust Financial Strategy	Matthew Bunce	X			PA	Tracking forecast delivery against financial strategy via Performance Committees and Trust Board	PA	Monthly Performance Review with Executives and Senior Management Teams	PA	Internal Audit cycle of assurance on financial strategy	PA
C2	Active engagement with Commissioners and Welsh Government to ensure inclusion of Velindre requirements within their Financial Planning	Matthew Bunce		X		PE	Inclusion in Health Board IMTP Financial Plans	IA	Monthly Commissioner Meetings held to confirm financial planning requirements	IA		

TAF DASHBOARD

TRUST FINANCIAL INVESTMENT RISK

C3	Active engagement with Trust & Divisions to ensure investment does not exceed available funding	David Osborne	X			PA	Monthly Financial Performance Review Reported to Execs and Senior Management Teams	PA	Quarterly Directorate financial reviews established across both Divisions	PA	Monthly Budget Holder Meetings with Business Partners	PA
C4	Continuous review of contracting currencies and direct WHSCC funding to ensure reflective of efficient cost of delivery	Matthew Bunce		X		PE	Frequent formal Reviews to be established, combined with routine contract reporting	IA	Routine meetings with Depts to support business cases and any impacts on currencies	IA	Annual Review of Contracting Model (focus on pandemic legacy impact)	IA
C5	Benchmarking with appropriate services to ensure value	Matthew Bunce			X	PE	Non Surgical Benchmarking Group with Welsh Cancer Centres	PA	National Costing Cycle	PA		
C6	Routine contracting reporting and discussion with Commissioners to review activity and early identify income volatilities	David Osborne			X	PE	Monthly Financial Performance Review Reported to Commissioners with Monthly Meetings	PA	Annual Review of Contracting Model (focus on pandemic legacy impact)	IA	Introduction of Service Line Reporting	IA
C7	Establish Investment Prioritisation Framework at a Trust and Divisional level to ensure no investment creep and strategic priority alignment	Matthew Bunce	X			PE	Chief Executive Consideration of Investment at a Trust Level	IA	Divisional Senior Management Team investment review	IA		
GAP IN CONTROLS							**GAPS IN ASSURANCE**					

TRUST FINANCIAL INVESTMENT RISK

C3 – Governance of investment at Velindre Cancer Centre is being enhanced through the embedding of resource authorization, prioritization and allocation process, linked to Velindre Futures. Framework not fully embedded at present.	Inclusion of Velindre funding requirements with respective Commissioner financial planning requires formal clarification from Commissioners. Whilst requirements may be acknowledged, the financial challenges that Commissioners are prioritizing may not align with Velindre intents, consequently, assurance cannot be given that Velindre requirements will be met.
C4 – Whilst the contracting model has been continuously reviewed, the impact of COVID related measures has had a potential significant shift in cost base. This requires further understanding to identify mitigations.	The impact of COVID on current performance and cost base remains volatile, with recurrent funding also unclear. Capacity and demand modelling being undertaken in key risk areas. Welsh Government and Commissioners engaged on current and future consequences.
C7 – Trust Investment Prioritisation Framework to be established.	Investment is limited in it's prioritisation to the Executive Team and Senior Management Teams discretion and not formally supported by a framework for decision making.

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	**Support the embedding of investment framework within Divisions**	**David Osborne**	**Process continues to be embedded, terms of reference and process established. Communications throughout Division and "live" operation to follow.**	**Dec-22**
	Investment scrutiny with services against commitments made and intended.	David Osborne	Completed and subject to continuous review	Completed
	Key objectives of investment framework and relationship to contract performance and value identified	David Osborne	Completed	Completed
	Investment framework to be articulated and agreed by Divisions and Exec	David Osborne	Due through Q3	Dec-22
	Investment framework to be applied within IMTP process	David Osborne	Due through Q3	Dec-22
1.2	**Review of contracting model for impact of COVID related measures**	**David Osborne**	**Areas of concern identified, discussions to inform are underway with Services. Board to be advised of present volatility and Commissioners engaged.**	**Dec-22**
	Protected Enhanced rates secured for 22-23	David Osborne	Completed	Completed
	Contract currencies of concern identified and impact assessed	David Osborne	Impact of hyperfractionation reviewed	Completed
	Business Cases completed for Brachytherapy	David Osborne	Business case prepared and agreed	Completed

	Engage with National Funding Flows Group for contract agreements for future financial years	David Osborne	Ongoing, due November	Dec-22
1.3	**Establish Trust Investment Prioritisation Framework**	**Matthew Bunce**	**Initial proposals prepared, Executive discussions to shape and take forward**	**Dec-22**

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

INFECTED BLOOD INQUIRY

DATE OF MEETING	17/01/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	N/A

PREPARED BY	Suzanne Jones, Project Support Officer
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**

ACRONYMS	
IBI	Infected Blood Inquiry
NHSBT	National Health Service Blood and Transplant (England)
NIBTS	Northern Ireland Blood Transfusion Service

SNBTS	Scottish National Blood Transfusion Service
WBS	Welsh Blood Service

1. SITUATION/BACKGROUND

1.1 The Infected Blood Inquiry is the independent public statutory inquiry into the use of infected blood particularly since the 1970's.

1.2 The Inquiry has been established to examine why men, women and children in the United Kingdom were given infected blood and / or infected blood products; the impact on their families; how the authorities (including government) responded; the nature of any support provided following infection; question of consent; and whether there was a cover-up.

1.3 The Welsh Blood Service (WBS), VUNHST has core participant status in the Inquiry.

1.4 The Inquiry has been in operation for over 4 years and has been taking evidence from those affected and infected together with a number of individuals representing relevant organisations. The activity of the IBI has continued during the COVID 19 pandemic. We are now approaching the stage of the inquiry that will enable Core Participants to submit a written statement in response to the evidence that has been heard.

1.5 During the majority of the period under review, WBS was legally an entity within a number of Welsh NHS organisations and operated in effect as a regional center under a collaborative working arrangement across England and Wales. As such, the evidence given by NHSBT has in the main covered England and Wales.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Written submissions to IBI

VUNHST submitted a Final Written Statement, as agreed to the Inquiry by the deadline of 16th December 2022 (Appendix 1).

This statement was written by the Lead Counsel representing the Trust and stated that WBS agreed with and endorsed the comprehensive submissions and recommendations advanced to the Inquiry by NHSBT. This was in the main due to the fact there was no neat separation between the blood services in England and Wales for the periods the Inquiry has been considering. For much of it, the Welsh service was in effect a constituent centre of the English service

The statement did not seek to duplicate what had been submitted but did observe that, in Wales, headway is already being made in areas which overlap some of the recommended actions.

An apology was included which recognised the utterly devastating impact upon the Infected and Affected of what had occurred, and apologised for the actions or inactions of its predecessor organisations.

It was recognised that there have been substantial changes in science, technology and medicine over the more than 50 years under consideration by the Inquiry.

The statement confirmed that in Wales, headway is already being made in areas which overlap some of the recommendations, however WBS would consider whatever recommendations the Inquiry makes and would work in collaboration with the other UK blood services through the Blood Services UK Forum.

2.2 Hearings

The Oral Hearings are due to resume on the week commencing 16th January 2023, where the Inquiry will hear closing oral statements from those Core Participants who have requested to do so. Lead Counsel for the Trust will be making the final Oral Statement on Thursday 26th January 2022 at approximately 14:00. This can be viewed live via the YouTube link on the IBI website.

Following the conclusion of the Oral Statements the Chair will retire to consider the conclusions and recommendations he may wish to consider. As a Core Participant the Trust will have access to the final report prior to publication.

3 IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
	The Inquiry relates to historic timelines.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	Standard 2.8 Blood Management
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required

	The Inquiry relates to historic timelines.
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The Inquiry will identify in relation to its' Terms of Reference, any individual responsibilities as well as organisational and systematic failures.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Funding for this work was confirmed with the Welsh Government to continue for the duration of the Inquiry

4. RECOMMENDATION

The QS&P members are asked to NOTE the update.

INFECTED BLOOD INQUIRY

WRITTEN SUBMISSION OF THE WELSH BLOOD SERVICE, VELINDRE UNIVERSITY NHS TRUST ("WBS") TO THE INQUIRY FOLLOWING THE CLOSE OF EVIDENCE

1. This submission from WBS is made following careful consideration of the comprehensive submissions and recommendations that are to be provided to the Inquiry by NHSBT.

2. Today, WBS is a distinct service covering Wales. However, as traversed in the evidence received by the Inquiry, there was no such neat separation between the blood services in England and Wales for the periods the Inquiry has been considering. For much of it, the Welsh service was in effect a constituent centre of the English service. The history and relationship between the services has been set out in the following documents: the rule 9 response of Gail Miflin **[WITN0672006]**; the brief history of the establishment and management of the Welsh blood service **[WITN6876002]**; the Updated NHSBT Family Tree **[WITN0672007]**; the Counsel to the Inquiry presentation on the history of the blood services in the UK **[INQY0000307]**; the first rule 9 response of Catherine O'Brien **[WITN6876001]**; and the rule 9 response of Tony Napier **[WTN6915001]**.

3. As those documents demonstrate, a large part of Wales was served by the NHSBT through a regional transfusion centre in Liverpool up until 2016, and the south of Wales was served by a single regional transfusion centre under NBTS (Wales), which ultimately answered to the Welsh Office within the UK government until 1999.[1]

[1] The historically idiosyncratic nature of the blood service as described means that at times over the course of the Inquiry, the meaning of the phrase 'England and Wales' has been used where at times more appropriately it would have been 'England with North Wales', and where at other times it would have been 'England with North Wales, and additionally South Wales'.

4. Although WBS has accordingly been a smaller presence during the Inquiry compared to NHSBT, it has endeavoured to support the Inquiry to the best of its ability, including in respect of the sourcing and disclosure of historic documents, its provision of Rule 9 statements, and the giving of live evidence. WBS is a signatory to the Charter for Families Bereaved by Public Tragedy[2] and has endeavoured at all times to assist the Inquiry with openness, honesty and transparency.

5. At this closing stage, WBS agrees and endorses the comprehensive submissions and recommendations now advanced to the Inquiry by NHSBT. It does not seek to duplicate what has there been said, though observes that, in Wales, headway is already being made in areas which overlap some of the recommended actions, as a result of the Welsh-specific 'NHS Wales Blood Health Plan'[3], initially launched in 2017. WBS will consider with care whatever recommendations the Inquiry makes, with a view to building on those improvements which have already started. In doing so it will work in collaboration with the other UK blood services through the Blood Services UK Forum, which is the vehicle for co-ordination and promotion of consistency and collaboration between UK services.

6. WBS wishes to offer its own apology to the Infected and Affected before concluding this brief submission. WBS recognises the utterly devastating impact upon the Infected and Affected of what has occurred, and apologises, without reservation, for the actions or inactions of its predecessor organisations which have contributed to bringing about what occurred.

Debra Powell KC
Susanna Rickard
15 December 2022

[2] An Operational Division of Velindre University NHS Trust.
[3] https://bhnog.wales.nhs.uk/wp-content/uploads/2021/11/Welsh-Health-Circular-NHS-Wales-Blood-Health-Plan-2021-English.pdf - the first (2017) iteration of the plan is at https://bhnog.wales.nhs.uk/wp-content/uploads/2022/12/Welsh-Health-Circular-2017-028-NHS-Wales-Blood-Health-Plan-English.pdf