TRUST BOARD
Velindre University NHS Trust Putting Things Right 2021-2022 Annual Report

DATE OF MEETING	28th July 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Non-Applicable

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

REPORT PURPOSE	APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME
Executive Management Board	01/07/2022	Endorsed
Quality, Safety & Performance Committee	14/07/2022	Endorsed

1. SITUATION

The 2021-2022 Velindre University NHS Trust Putting Things Right Annual Report is provided to the Trust Board for **APPROVAL.**

2. BACKGROUND

All NHS bodies in Wales must ensure that they have effective processes for managing concerns raised by patients and staff in accordance with the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.

Velindre University NHS Trust is committed to ensuring the provision of an effective and timely process for responding to concerns, which ensures concerns are thoroughly and appropriately investigated and enables the Trust to improve its services based on lessons learned.

The Putting Things Right Annual Report includes information about the Trust's concerns profile, and performance against concerns (complaints and serious incidents) management standards during the reporting period of the 1st April 2021 – 31st March 2022.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The Velindre University NHS Trust Putting Things Right Annual Report 2021-2022 covers the period 1st April 2021 and 31st March 2022 and contains the following key messages:

- ➢ The Trust received 190 concerns; 150 managed as 'early resolution' and 40 managed under Putting Things Right. This is a 32% increase in the concerns managed as early resolution demonstrating quicker responses to those raising concerns.
- ➢ 44% of concerns were raised to the Trust via e-mail and 41% via telephone.
- ➢ The Trust responded to 70% (28 of 40) of Putting Things Right concerns within 30 working days during the year which is 5% below the Welsh Government target of 75%. Compliance did improve during quarters 3 and 4 due to enhanced divisional ownership and enhanced systems and processes with 100% of Putting Things Right concerns responded to within 30 working days.
- ➢ Two concerns were re-opened as the complainant was dissatisfied with the original response.
- ➢ Four concerns were raised (all relating to the Welsh Blood Service) in relating to Welsh Language provision.
- ➢ 12 COVID related concerns were raised, 5 received in quarter 3 and none in quarter 4.
- ➢ Throughout this year there has been significantly improved ownership, systems and processes for the management and responding to concerns within Velindre Cancer Centre and the pre-existing robust arrangements continued within WBS.
- ➢ Improved ownership of concerns with management overview and onward reporting, lessons learned embedded for service improvement.
- ➢ There were 7 Public Services Ombudsman cases during the year: 2 investigated but not upheld; 2 were not investigated; and 3 were investigated and partially upheld.
- ➢ 5 redress cases were managed: 2 cases did not establish a qualifying liability; 2 cases identified a qualifying liability for which one offer of financial

compensation was made; and one remains under investigation, pending the decision of an independent expert on qualifying liability

3.2 IMPACT ASSESSMENT

RELATED HEALTHCARE STANDARD	Yes
	Safe Care and Individual Care
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	Yes
	The Putting Things Right legislative implications of the management of incidents across the Trust
FINANCIAL IMPLICATIONS / IMPACT	Yes
	Possible financial implications in the event of complaints and claims as a result of an incident and where errors have occurred or system failures are evident.

4. RECOMMENDATION

The Trust Board is asked to **APPROVE** the 2021-2022 Velindre University NHS Trust Putting Things Right Annual Report.

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

Gwasanaeth Gwaed Cymru
Welsh Blood Service

Canolfan Ganser Felindre
Velindre Cancer Centre

PUTTING THINGS RIGHT

ANNUAL REPORT

2021/2022

Learn it Lead it Live it

LEARN TODAY FOR A BETTER TOMORROW

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1. Introduction

Velindre University NHS Trust is one of the leading providers of specialist cancer, blood and transplantation services within the UK, bringing together expert staff, high quality cancer care, donor and transplantation services, together with excellence in research, development and innovation. We have built a strong reputation across the United Kingdom, Europe and internationally for the services we provide.

We have two main divisions: Velindre Cancer Centre (which provides specialist tertiary non-surgical cancer care) and the Welsh Blood Service (which is responsible for the provision of blood and blood products to NHS Wales.

The Trust places a high value on ensuring that we always keep our patients and donors at the heart of everything that we do, and we are grateful for the continued levels of assistance, encouragement and positive feedback that we get from our patients, donors, staff, partners and supporters. Whilst we pride ourselves in delivering high quality and safe services, there are occasions when things go wrong. When this happens, we are committed to resolving all complaints and incidents in accordance with the NHS (Concerns, Complaints and Redress Arrangements) (Wales), which apply to all Welsh NHS bodies, providing NHS funded care, commonly known as **Putting Things Right** (PTR).

The Velindre University NHS Trust Putting Things Right Annual Report 2021-22 summarises how the Trust and its two divisions has managed concerns (complaints and serious incidents) during the period of the 1st April 2021 to the 31st March 2022.

This includes: how the Trust has developed its systems and process for the effective investigation and management of concerns; engaged with and responded to patients/donors and their families during these processes; and assured that changes have been made and lessons learnt and disseminated following investigations.

2. Putting Things Right – Definitions

The Putting Things Right Regulations refer to the term "concern" which means any complaint, claim or reported patient safety incident (about NHS treatment or services). For the purpose of this report, the following definitions will be used when describing our concerns activity.

3. Trust arrangements for managing concerns

The Trust's Chief Executive has ultimate overall responsibility for all concerns (complaints, redress, claims and serious incidents). However, he has delegated this responsibility to the Executive Director of Nursing, Allied Health Professionals and Health Science who is accountable for setting the systems and processes to ensure that the Trust meets its Putting Things Right Regulatory requirements.

As identified within the Regulations, the Trust has identified an Independent Member who is responsible for maintaining an overview of how the Trust is implementing the Putting Things Right procedures.

The Trust's Deputy Director of Nursing, Quality and Patient Experience is responsible for overseeing the handling and consideration of all concerns across the Trust, and is further supported by a Concerns Team comprising of a Corporate Quality and Safety Officer, a Claims Manager and by Quality and Safety leads within the two divisions.

The way in which we manage concerns (complaints, redress, claims and serious incidents) is based upon a number of key principles; we:

- Have a consistent approach for investigating concerns which is proportionate to the issue raised.

- Ensure that the person raising the concern is properly and appropriately supported, for example, through access to advocacy support at all stages of the process, both from Community Health Council (CHC) advocates and more specialist advocacy services where needed.

- Provide an acknowledgement within 2 working days of the concern being raised, and will aim to respond to all concerns within 30 working days.

- Deal with all concerns openly and honestly.

- Provide a detailed response including clarity about next steps, and an offer to meet to discuss the findings of our investigation.

- Ensure decisions relating to Redress are clearly explained.

- Demonstrate that learning and improvements have resulted from the process

4. Complaints received

Raising a concern will be easy and information will be widely accessible.
Put the complainant at the centre of the process and provide support for individual requirements.
*Listen to concerns and treat everyone with dignity and respect.*

Acknowledge all concerns within 2 working days.
Aim to resolve concerns at source, or by the end of the next working day.
Responses required under PTR will be provided within the legislative timescales.

Complaints are received via a number of routes including verbal, email, social media, formally in writing and through our websites. When a complaint does not require a comprehensive investigation, we aim to resolve these complaints by the end of the following working day. These complaints are called 'Early Resolutions' and do not need to be formally considered under the Putting Things Right Regulations (PTR).

Where it has not been possible to resolve a complaint within this timescale, or where an in-depth investigation is required, the complaint is managed under the Putting Things Right Regulations.

Complaints received between the 1st April 2021 and the 31st March 2022:
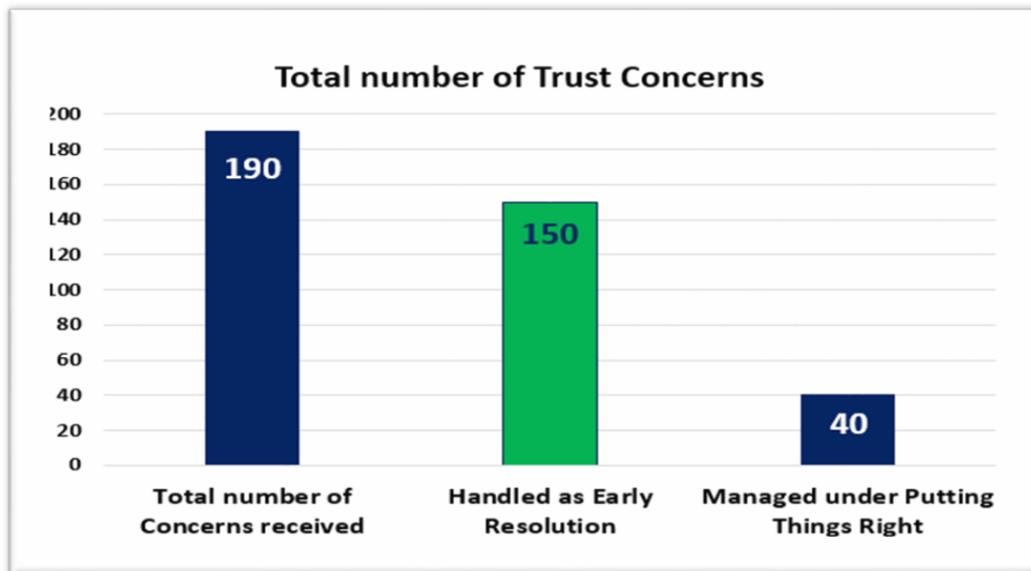
Where a complaint is investigated under Putting Things Right, an acknowledgment should be provided to the complainant within 2 working days of the concern being raised. Welsh Government requires Health Bodies within Wales to thoroughly investigate all complaints received and, that 75% of all complaints be resolved, ensuring a formal response is produced within 30 working days of receipt. Where this cannot be achieved, a response should be provided within 6 months.

The 30-day response timescales for Putting Things Right concerns for the year was 70% which is 5% below the required Welsh Government standard of 75%. However, significant improvements have been made during quarters 3 and 4 with **100% compliance** being achieved for Quarter 4.

Compliance rate (percentage)
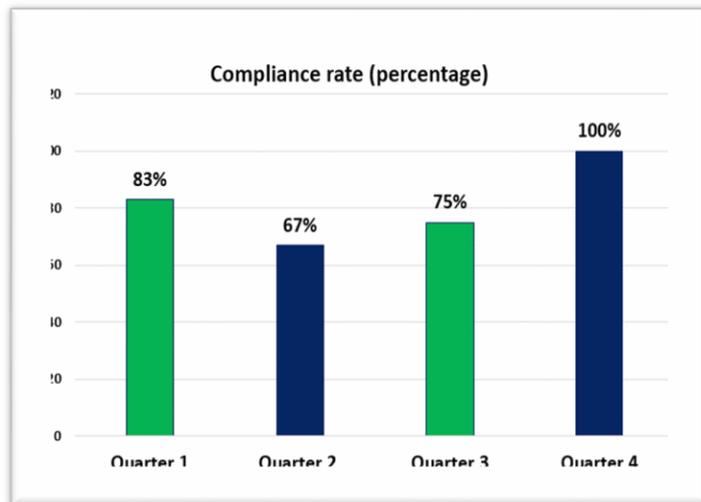
During 2021/22 the Trust investigated and responded to **40** complaints managed through the Putting Things Right Regulations. This is a **32% increase** in comparison to the year before, indicating that as a Trust we are handling more Concerns as Early Resolutions.

28 out of the 40 Putting Things Right Concerns that were investigated, were successfully closed within 30 days, in line with the Regulations. **12** concerns investigated under the Putting Things Right Regulations did not produce a formal response within 30 days and the below pie chart displays the rate of closure.

Concerns managed under Putting Things Right: Closure rate
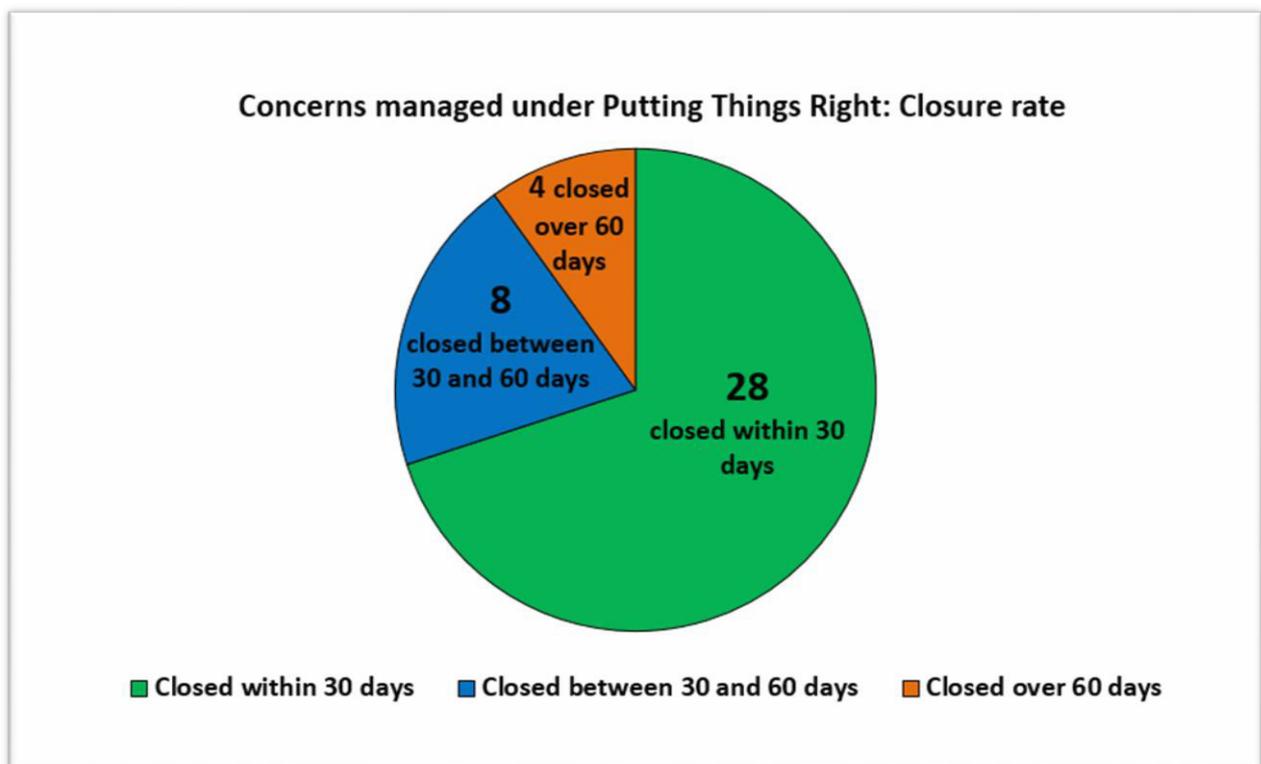
It is important to note that the **12** concerns investigated that did not meet the 30 day closure requirement fell within the Q2 and Q3 2021/22 period, which correlates with the lower compliance rate during these two quarters.

At this time there were significant changes to the complaints management personnel and process, with several complex complaints spanning a number of Health Boards.

Targeted action was taken to increase compliance ensuring that the Trust improved and maintained the position in excess of the 75% compliance requirement.

For those investigations that required longer than 30 working days to investigate, our concerns team contacted the person raising the complaint, prior to the 30 day timescale, to explain the reason for the delay and to agree a revised date.

Method of Communication

It is evident that Email communication remains the preferred method of contacting the Velindre University NHS Trust, with **44%** of complaints being received in this way.
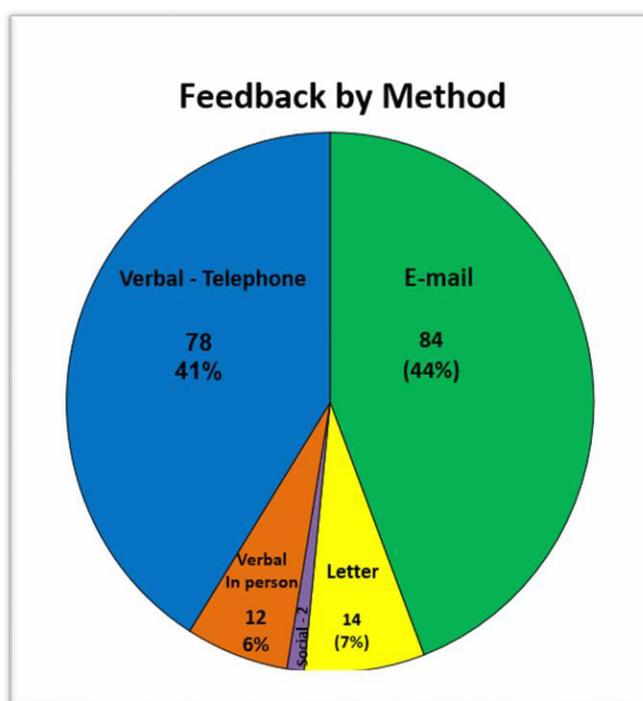
The Trust has observed a rise in the number of concerns received via telephone during the year, highlighting a switch in the preferred contact method being used during quarter 4 2021/22. Throughout the Covid pandemic, the adopted method for reporting Concerns has mainly been via email

Re-opened Complaints

During 2021/22, two complaints that had been previously investigated were re-opened. In both cases, the further concerns raised were swiftly investigated and managed, through to final closure. As part of our complaint response improvement work, we have focused on ensuring the provision of a comprehensive initial response to complainants, and to date, have not had any further re-opened complaints.

Complaints relating to the Welsh Language

The Trust received four complaints during the reporting period in relation to the provision of services in the medium of Welsh. Three of these complaints were investigated under the Putting Things Right Regulations and one resolved as an Early Resolution. All four complaints were raised by the Welsh Blood Service and were investigated with support from our Welsh Language Officer.

Covid related complaints

Trust Covid Concerns
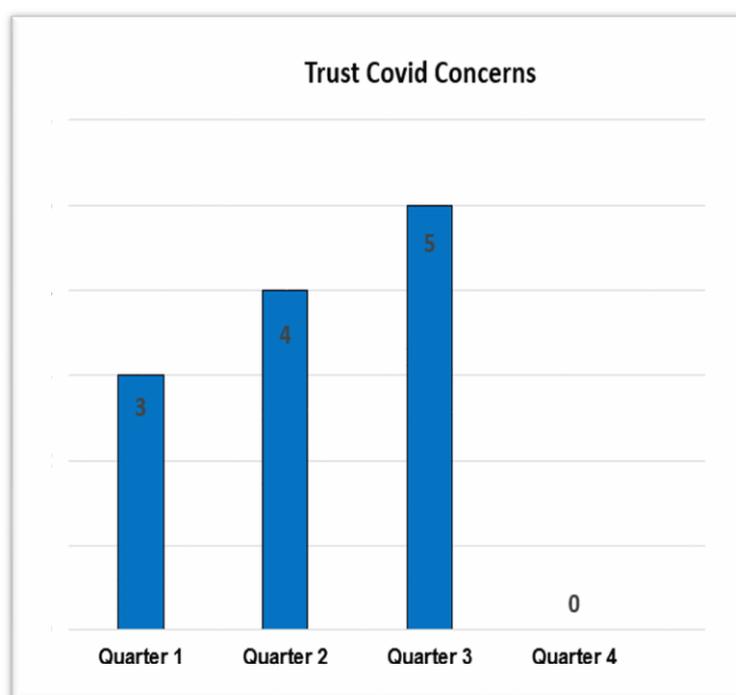
12 Covid related concerns were received during 2021/22. The highest number of Covid concerns were reported in Quarter 3. It was apparent in the steady increase of concerns reported that Trust process and services continued to be impacted by the various Covid waves of the pandemic. This led to an increase in the Trust Covid concern rate during the year. Quarter 4 saw the first time during 2021/22 that no Covid concerns were raised.

> *Concerns will be assessed to determine the level of investigation required*
> *Undertake robust investigations by trained staff*
> *Being open and transparent throughout the investigation*

Grading Concerns

All concerns graded level 2 – 5 undergo an assessment of harm to determine whether the Trust has breached its duty of care, whether a qualifying liability in tort exists and to ensure that the appropriate level of investigation is undertaken. Relevant cases are discussed at the Trust's Putting Things Right Panel.

All concerns are graded upon receipt and the Complaints grading table is included as **Appendix 1** in this report. During the year **89%** of all concerns were graded as level 1, and **10%** as grade 2. There was **one** concern graded at a level 3 and **one** concern graded as level 4.

- The one level 3 concern was received during Quarter 2 and related to a patient complaining about potential harm that occurred from their cancer treatment. However, following initial contact made, the complainant subsequently withdrew their concern and consent was not obtained to proceed with an investigation.

- The one level 4 concern was received during Quarter 3 and was an extremely complex case which was investigated and managed by the Trust Corporate Team. The complaint related to the cancer management of a patient, where concerns were raised over delays in the patient's treatment care plans and decision making. This concern also accounted for one of the re-opened concerns during the year.

Wherever possible, all Trust concerns graded as level 1 should be resolved as an Early Resolution. During the year **169** concerns were graded as level 1 and **150** of those concerns were resolved as an Early Resolution, suggesting **89%** of grade 1 concerns were resolved within 2 working days via the Early Resolution process.
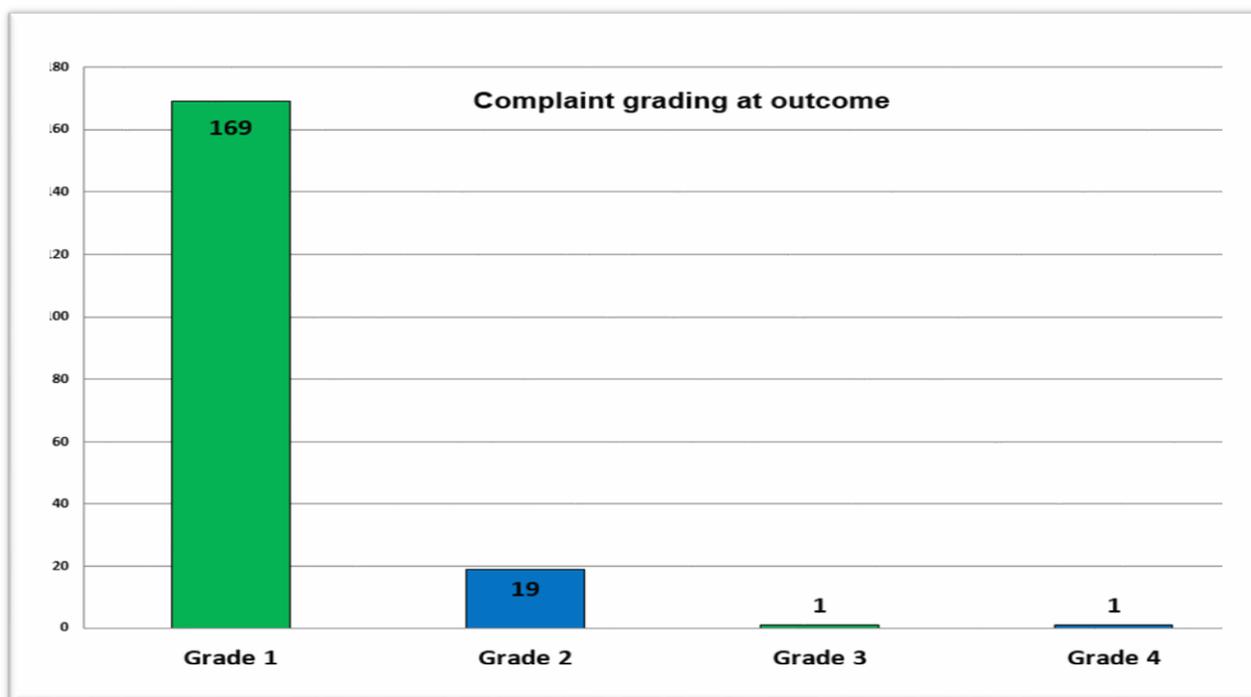
During 2021/22 the Velindre University NHS Trust Handling Concerns and Incident Policies underwent a robust review and were amended to reflect current Trust procedures and practices when handling Concerns. Both the Concerns Handling and Incident Policies were approved at the March 2022 Quality, Safety and Performance Committee and form the basis for Trust conduct when handling all types of concerns raised.

Provide an apology where required and confirm what has been done to Put Things Right
Redress will be considered where appropriate
Offer concerns meetings and details of the Public Services Ombudsman Wales

5. Public Service Ombudsman for Wales

When a complaint cannot be resolved to the satisfaction of the person raising the complaint, the matter can be referred to the Public Service Ombudsman for Wales (PSOW). During the 2021/22 reporting period, **seven** complaints were referred to the Public Service Ombudsman for Wales for investigation, an increase from four cases the year before.

The pie chart below displays the outcome for each case that was referred to the Public Service Ombudsman for Wales during the year:

Concerns referred to the Public Services Ombudsman Wales
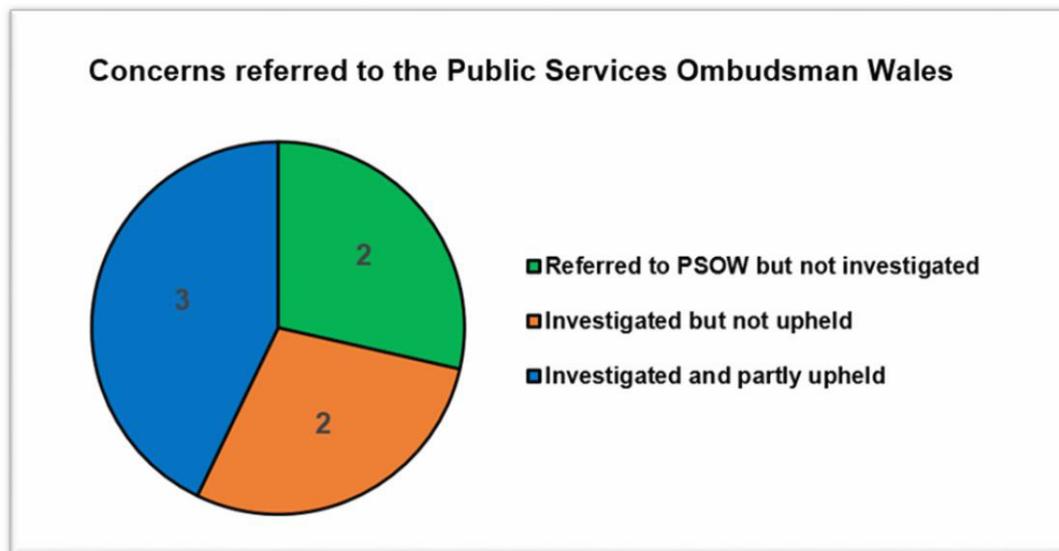
6. Redress

Under the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 (section 25-33), there is a requirement for an NHS organisation to consider Redress in situations where a patient may have been harmed, and that harm was caused by an NHS provider in Wales.

When a breach of duty and harm has been caused, a qualifying liability will be established. This means that the Trust is liable and will be responsible for taking steps to put things right by offering a remedial resolution under the Putting Things Right processes.

The Redress remedies are as follows:

- An explanation
- A written apology
- A report on the action(s) which has, or will be taken to prevent similar cases occurring
- An offer to provide care or treatment
- An offer of financial compensation - maximum threshold for damages settlement of £25,000
- Or an offer of both treatment and financial compensation

The offer of redress is subject to the individual forgoing the right to pursue civil proceedings.

Where the investigation of a concern concludes there has been a breach of duty, the case is presented to the Trust Putting Things Right Redress Panel. The Panel are required to consider whether redress applies in situations where a patient may have been harmed, and whether the harm was caused during / by care provided by the Trust.

During the reporting period (1st April 2021-31st March 2022), 5 Redress cases were investigated under the Putting Things Right Regulations (PTR):

- 2 cases did not establish a qualifying liability. These cases were subsequently closed during the reporting period.
- 2 cases identified a qualifying liability for which one offer of financial compensation has been made.
- 1 case remains under investigation, pending the decision of an independent expert on qualifying liability.
- 2 Case Management Records were submitted to the Welsh Risk Pool for reimbursable expenses paid out (in the sum of £8,160.74). The monies were successfully recouped.

	Identify and implement learning from concerns raised *Updating patients and donors as to how learning has improved services*

Learning from complaints

We continue to work in partnership with other organisations across Wales to investigate and resolve complaints. Where a complaint is investigated that also relates to the services provided by other health bodies, the Trust Concerns Team work collaboratively with the relevant health body to ensure a single, co-ordinated complaint response.

The Trust work closely with the Community Health Council in Wales as part of the advocacy services they provide for people who want to raise a concern about NHS care and/or treatment and all of our complaint acknowledgement letters provide information on the advocacy support available from the Community Health Council and include a Putting Things Right leaflet which details useful information on the PTR process for individuals raising concerns.

Concern Themes

Our complaints are recorded in accordance with the All Wales categories that have been determined by the Welsh Government. This ensures that themes and trends can be identified across NHS Wales and learning can be shared on a National basis. The below graph displays the Trust top 5 areas that recorded the highest number of complaint themes investigated during the reporting period,

Concern themes during 2021/22

Attitude and Behaviour	Appointments	Clinical	Communication Issues	Other
48	41	34	24	16
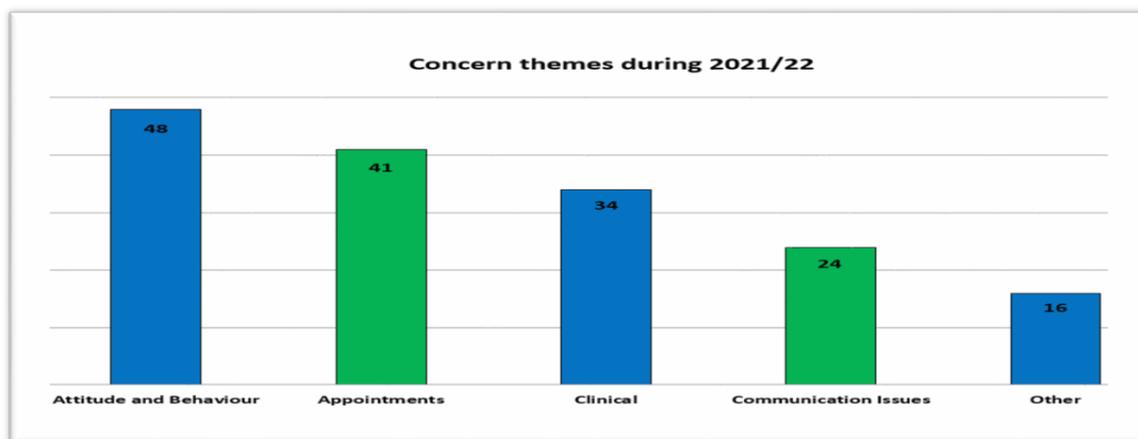
Attitude and behaviour

It was noted during the reporting period that attitude and behaviour were recurring themes. **48** concerns were recorded in this area during 2021/22, doubling in comparison to the previous year and therefore requiring a further review to better understand the root cause of the concerns raised.

Following a deep dive analysis that was carried out in Quarter 3 it was clear, there was still much pressure on the operational teams from the repercussions of various Covid strains which continued to impact Trust operations and services.

The outcomes following the deep dive were shared with both Divisions who have reviewed and received the findings and are working with the Quality and Safety leads to develop local action plans to support the reduction of complaints in this area. The data shared has been used to inform work streams such as the treatment helpline and transport service. This work has continued to be managed through departmental work plans and assurance provided to Senior Management and Leadership teams.

Appointments

The Trust noted a large increase in the number of appointment related concerns during the year for both Divisions:

Velindre Cancer Centre recognised that appointment related concerns were closely linked to the communication aspect of patient care, with some patients raising concerns regarding appointment delays and lack of communication for follow up appointments, including why appointments had been cancelled or re-scheduled at short notice. An outpatient improvement programme was introduced during Quarter 3 and was led by the clinical transformation lead which reviewed processes around clinical appointments and has significantly improved the service in this area.

The Welsh Blood Service witnessed a rise in appointment related concerns mainly around the unavailability of walk in Donor appointments, this change in service was implicated by the Covid pandemic. As a result of the increase in appointment related concerns, Welsh Blood Service swiftly enhanced its communications via all channels to Donors explaining the original reasons for the change and future improvements to utilise and manage the flow of clinics and optimising efficiency.

Clinical treatment

Clinical treatment concerns mainly related to treatment provided by the Velindre Cancer Centre. The clinical treatment field on the Once for Wales system which captures the themes of concerns is very broad and can be difficult to capture specific occurrences.

The Cancer Centre have identified and understand that Radiotherapy and SACT remain the highest number of reported occurrences within the system and these are routinely reviewed at the Velindre Cancer Centre Quality and Safety Management Group meeting. The UK Health Security Agency require all SACT, hypersensitivity and extravasation occurrences have to be recorded and reported which in turn displays high reported figures within the Once for Wales system even though they are not concerns as such.

Trust complaint process - Improvement highlights

The below detail displays areas of process improvement following complaint themes and trends identified during the year:

Learning from concerns raised

An important part of the management of complaints is to ensure that lessons are learnt from identified failings and that actions are taken to reduce the likelihood of reoccurrence. The Trust have a range of processes in place to share learning from complaints, including: direct feedback to staff members involved, team meetings, newsletters and clinical audits.

The following spotlight on learning provides examples of how we improved and developed our services following concerns raised during 2021/22:

Velindre Cancer Centre

SACT Appointments	Following an increase in appointment related concerns, an improvement project has been implemented and is chaired by the Interim Velindre Cancer Centre Director to deep dive into SACT capacity issues including, pharmacy, nursing and booking centre processes. Furthermore, a SACT deferrals task and finish group has been established to identify a clear process for managing deferrals.
Communication	A number of complaints were received relating to the difficulties in communication around virtual clinics and lack of face to face appointments. As a result patients are now offered a choice of in video or telephone virtual clinics and the offer of face to face clinic appointments when there is a clinical need and Covid guidelines allow.
New Velindre Cancer Centre (nVCC)	The Trust has witnessed a significant increase in concerns relating to the New Velindre Cancer Centre site since ground work commenced in Quarter 4 2021/22. In partnership with Cardiff Council, the Trust established a process to manage the issues raised, introducing a dedicated nVCC concerns email address alongside a lead point of contact from Transforming Cancer Services.

Welsh Blood Service

Attitude and behaviour	Following a consistent trend of high concerns in relation to attitude and behaviour, Clinic Lead Registered Nurses are now available to support staff members and identify areas of concern. All senior staff members have been made aware of the situation and Clinic Lead Registered Nurses are advised to address all actions with team members and monitor situations as they arise.
Covid	Covid related concerns were apparent during the year and consisted of concerns raised around the wearing of face masks, appointment and social distancing requirements. As such, a clinic lead registered nurse is available to offer support and provide full explanations on current Joint Professional Advisory Committee (JPAC) guidelines for assisting donors in relation to social distancing measures whilst attending sessions.
Donor Online Appointments	Welsh Blood Service concern themes identified that blood donors were able to schedule their next donation via an online appointment system without any suggestion they were booking too soon following their previous donation. This resulted in donors arriving to give blood, only to be turned away. A new process was implemented to identify all donors who attempt to prematurely schedule their next donation appointment online.

Compliments

Patients, donors, relatives and carers regularly contact the Trust to let us know about the good care and service they have received. Compliments are received via many different routes including, verbally or via social media, by letter and messages in thank you cards. The Trust received **122** compliments during the reporting period, **58** compliments were received for the Velindre Cancer Centre and **64** compliments were recorded for the Welsh Blood Service.

We appreciate the time taken by patients, donors, relatives and carers to let us know how good their experience of our service and care has been. The individuals and teams involved in the care and service provided are pleased and encouraged by such feedback.

A snapshot of compliments received during 2021/22 have been included below:

Velindre Cancer Centre

Welsh Blood Service
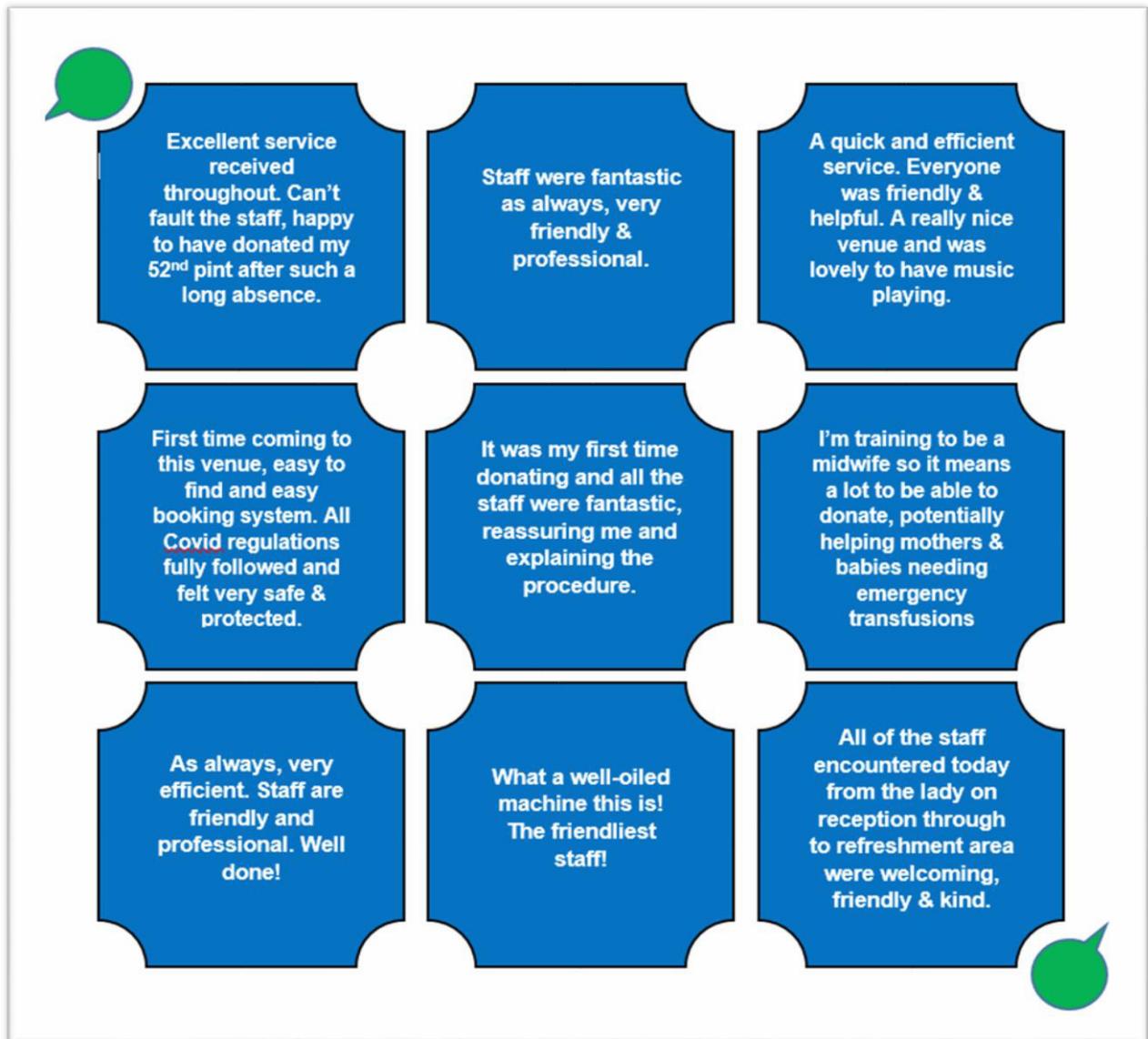
6. Incidents

The Velindre University NHS Trust record all Incidents and National reportable incidents *(replaced Serious Incidents in June 2021)* within the Once for Wales reporting system. Welsh NHS bodies are required to report all serious patient safety incidents to the Welsh Government.

1925 Incidents were reported across the Trust throughout 2021/22. The graph below displays the number of incidents per quarter that were reported and investigated with the severity confirmed at closure.

Trust Incident Severity per Quarter 2021/22

	21/22 Q1	21/22 Q2	21/22 Q3	21/22 Q4
No harm	161	162	110	111
Low harm	150	196	218	174
Moderate	12	19	22	10
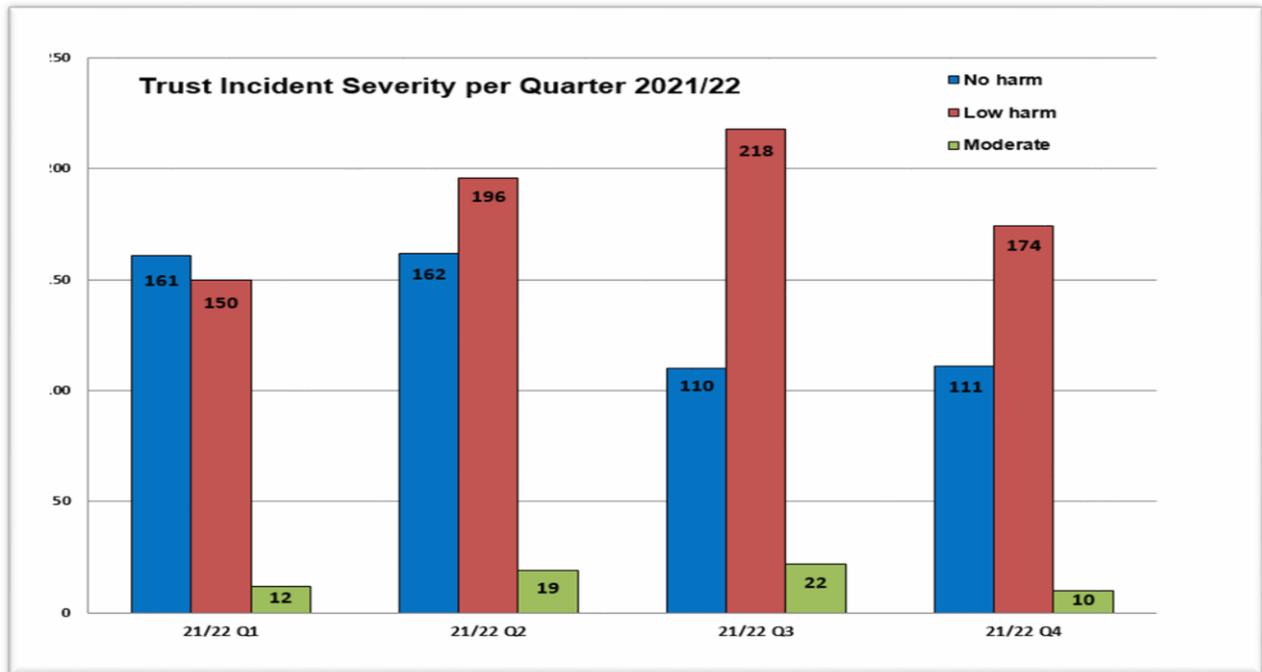
A number of incidents recorded within the Once for Wales system did not determine a severity rating at the point the incident was raised. This has been recognised as a Once for Wales Incident training need throughout the Trust and will form part of the extended training programme that is being rolled out for staff members in order to strengthen our ability to objectively and comprehensively raise, investigate and learn from all incidents.

During the year, the majority of incidents reported were recorded as no or low harm accounting for **97%** of the incidents raised and investigated.

7. National Reportable Incidents (replaced Serious Incidents in June 2021)

National reportable incidents will occur when care has not been delivered to the required standard, and has resulted in serious harm. National reportable Incidents should be fully investigated within 60 working days, and learning needs to be identified to avoid a similar situation occurring.

The Trust recorded a total of **12** National reportable incidents throughout 2021/22 which is a small reduction from 15, in comparison to the year before. The below information provides a further breakdown per quarter of the National reportable incidents raised and subsequently shared with the required Welsh Regulatory Body; *Welsh Government, NHS Wales Delivery Unit, Healthcare Inspectorate Wales.*

There were no National Reportable Incidents reported during the 1st Quarter. During Quarter 2 the Velindre Cancer Centre reported **1** National reportable incident to Welsh Government. The incident was reportable following it being identified on the 7th July 2021 that between March 2020 and July 2021, during a routine medical records audit that a Band 4 Medical Secretary undertook telephone follow up consultations with 348 prostate cancer patients in place of a clinician/nurse.

- Immediate action was taken to stop the Medical Secretary from undertaking this role.
- A review of all medical secretaries and consultants was undertaken to ensure this was not being undertaken by anyone else.
- Widespread communication was provided to all medical secretaries detailing their roles and that they are not to undertake any clinical assessments/reviews ensuring that the escalation processes are followed, redirecting calls to a nominated clinician.
- A comprehensive medical review of all 348 patients was commissioned – including a harm review.
- An investigation into the circumstances leading up to these events was commissioned.

There were no National Reportable Incidents reported to Welsh Government during quarter 3. Quarter 4 saw 10 IR(ME)R related incidents reported to Healthcare Inspectorate Wales. All were no or low harm but met the reporting classifications. There had been a delay in a number of these being identified as reaching the threshold for reporting which is why it indicates a significant increase. The radiation services department subsequently undertook a full review of its incident and reporting arrangements in order to ensure that all reportable incidents are identified and reported within the required timescales.

- A number of these incidents were in relation to a known manufacturer fault with the radiotherapy system. A full review was conducted looking at how/if other cancer centres using the same equipment are mitigating for this known fault as the company cannot resolve the issues.

- There was one National reportable incident recorded during the quarter relating to an offsite storage contractor suffering major damage to one of its storage sites and that hard copy Trust medical and non-medical records may have been adversely affected.

- The investigation and remedial actions continue to be worked through.

7. Looking Forward to 2022/2023

During 2022-23, the Trust will strive to maintain the good work that has been implemented during 2021/22 in improving the Complaint handling framework. The Trust Concerns Handling Team will continue to strengthen its processes for learning from concerns ensuring practical changes are introduced where needed.

- During 2022/2023 a large cohort of staff members will complete an in-depth Investigation training course run by a highly recommended third party company. Individuals have been identified to complete the training in order to undertake detailed and objective investigations. The investigation training commenced in April 2022.

- The Corporate Quality and Safety Team will further develop the Once for Wales system that captures concerns, by setting up additional reporting functionalities and dashboards within the system.

- Report writing training commenced in May 2022 for Executive colleagues and key individuals across the Trust.

- A training plan will be delivered and implemented to ensure that all staff receive training in the management of complaints. The Trust induction programme will also be expanded to ensure that all new staff receive training on the management of concerns within the first few weeks of joining the organisation.

- The Trust will further embed the improved Welsh language support service for the handling of complaints: We are committed to providing an equal service for our Welsh speaking population, and our email address for reporting a complaint will be provided bilingually. Our concerns team will work with the Trust Welsh Language Officer to identify ways of improving our Welsh language provision for the management of complaints.

- Establish a robust process to ensure that all learning from concerns received is fully embedded, and that the Trust Board receives assurance in this area.

- We will continue to strengthen the Quality and Safety culture throughout the Trust.

8. Further Information

This report will be published on the Velindre University NHS Trust Internet Site and can be accessed via the following link: https://velindre.nhs.wales/

Appendix 1: Grading Framework

GRADING FRAMEWORK FOR DEALING WITH ALL CONCERNS

The All Wales grading framework is based on a risk matrix developed by the National Patient Safety Agency [2] and has been used to assess and manage risks and incidents. This approach has been built on to develop a framework for determining the level of investigation required in dealing with all types of concerns in order to promote a consistent approach across NHS Wales. The impact or harm experienced by the patient is always the overriding factor for grading concerns. The harm grading is dynamic in nature and must be considered throughout the investigation. Due consideration should also be given to the potential for litigation, regardless of the harm grading. However there may be situations where the grading of harm is low i.e. a grade 2, but there is indication there they will be pursuing a claim. **The examples listed are meant only to be a guide and not an exhaustive list.**

Grade	Harm	Examples of concerns	Consider potential for qualifying liability / Redress
1	None	a) Concerns which normally involve issues that can be easily / speedily addressed; b) Potential to cause harm but impact resulted in no harm having arisen; c) Outpatient appointment delayed, but no consequences in terms of health;, d) Difficulty in car parking; e) Patient fall – no harm or time of work; f) Concerns which have impacted on a positive patient experience.	Highly unlikely
2	Low	a) Concerns regarding care and treatment which span a number of different aspects/specialities; b) Increase in length of stay by 1 - 3 days; c) Patient fall - requiring treatment; d) Requiring time off work - 3 days; e) Concern involves a single failure to meet internal standards but with minor implications for patient safety; f) Return for minor treatment, e.g. local anaesthetic or extra investigations.	Unlikely
3	Moderate	a) Clinical / process issues that have resulted in avoidable, semi permanent injury or impairment of health or damage that require intervention; b) Additional interventions required or treatment / appointments needed to be cancelled; c) Readmission or return to surgery, e.g. general anaesthetic; d) Necessity for transfer to another centre for treatment / care; e) Increase in length of stay by 4 -15 days; f) RIDDOR Reportable Incident; g) Requiring time off work 4 -14 days; h) Concerns that outline more than one failure to meet internal standards; i) Moderate patient safety implications; j) Concerns that involve more than one organisation;	Possible in some cases
4	Severe	a) Clinical process issues that have resulted in avoidable, permanent harm or impairment of health or damage leading to incapacity or disability; b) Additional interventions required or treatment needed to be cancelled; c) Unexpected readmission or unplanned return to surgery; d) Increase in length of stay by >15 days; e) Necessity for transfer to another centre for treatment / care; f) Requiring time of work >14 days; g) A concern, outlining non compliance with national standards with significant risk to patient safety; h) RIDDOR Reportable Incident;	Likely in many cases
5	Death	a) Concern leading to unexpected death, multiple harm or irreversible health effects; b) Concern outlining gross failure to meet national standards; c) Normally clinical/process issues that have resulted in avoidable, irrecoverable injury or impairment of health, having a lifelong adverse effect on lifestyle, quality of life, physical and mental well-being; d) Clinical or process issues that have resulted in avoidable loss of life; e) RIDDOR Reportable Incident;	Very likely

Appendix 2: Concerns Pledges

Valuing Concerns - Our Pledge

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

Concerns will be valued.

- We will ensure information on raising a concern is widely accessible.
- We will provide support to raise concerns, taking account of individual requirements.
- We will listen to your concerns and review our services to Put Things Right.

Concerns will be dealt with quickly and efficiently.

- We will acknowledge concerns within 2 working days.
- We will aim to resolve concerns at source, or by the end of the next working day.
- Where a concern cannot be resolved at source, we will aim to provide a full response within 30 working days.

Investigations will be proportionate and robust.

- We will assess all concerns and determine the level of investigation required.
- We will undertake robust investigations by trained staff with the required skills and knowledge.
- We will be open and transparent throughout the investigation of the concern.

Responses will be easy to read and will address all of the issues.

- We will provide an apology where appropriate.
- We will consider forms of Redress where we have not met our highest standards of care.
- We will advise you of next steps, offer a meeting with key staff and provide details of the Public Services Ombudsman Wales

Learning will be identified to improve our services.

- We will identify and implement learning from concerns raised with us.
- We will let our patients and donors know how their experience has changed the way we deliver services.

<table>
<tr><td colspan="2" align="center">TRUST BOARD</td></tr>
<tr><td colspan="2" align="center">Velindre University NHS Trust Patient and Donor Experience 2021/2022 annual   Report</td></tr>
</table>

DATE OF MEETING	28th July 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Non-applicable

PREPARED BY	Jade Coleman, Quality and Safety Officer
PRESENTED BY	Jade Coleman, Quality and Safety Officer & Nigel Downes, Interim Deputy
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	01/07/2022	Endorsed for submission to Quality, Safety & Performance Committee
Quality, Safety & Performance Committee	14/07/2022	Discussed and Endorsed for submission to Trust Board

ACRONYMS	
N/A	

1. SITUATION

The 2021-2022 Velindre University NHS Trust Patient and Donor Experience Annual Report reflects the period between the 1st April 2021 and the 31st March 2022 and is provided to the Trust Board for **APPROVAL** prior to publication on the Trusts website following Welsh language translation.

2. BACKGROUND

The Trust strives to ensure that patients and donors are at the heart of everything we do. A critical element of this is to receive meaningful feedback on-mas from our patients and donors. We must also ensure our staff receives this feedback and, at all levels, that it is used to celebrate and spread good and exemplar practice and ensure that it is used to drive improvements to further improve our care and services and further enhance the experiences of our patients and donors. It is only through openly listening to our patients and donors that we can ensure that our services are truly patient / donor centred, and that continued improvements are made.

The 2021 – 2022 Velindre University NHS Trust Annual Patient and Donor Experience Report provides an overview of how the Trust has engaged with patients and donors to obtain their feedback, and also how we have learnt from what we have been told, and how we have made changes to our services as a result.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

Despite the continued challenges of the COVID-19 Pandemic during 2021 – 2022, the teams at the Velindre Cancer Centre and the Welsh Blood Service have actively sought to engage with our patients and donors to seek their feedback on the services that we have provided during this time.

The Trust have continued to encourage and obtain patient and donor feedback when traditional feedback mechanisms were not as accessible as they had previously been (in particular due to reduced face to face attendances at the Cancer Centre as part of the COVID-19 risk reduction measures in place nationally). Nonetheless, this also provided the Trust with the opportunity to explore 'doing things differently', and in particular, seeking greater donor and patient feedback digitally.

The report was endorsed at the Quality, Safety & Performance Committee on the 14th July 2022. The Committee requested that national benchmarking be undertaken in respect of Patient Experience standards. The 2021/22 Patient Experienced reports from NHS bodies across Wales is being sourced so that this benchmarking can be undertaken.

3.1 Patient and Donor Highlights

The satisfaction responses received from our patients and donors remained overall positive, but also highlighted some areas where improvement work is required. The highlights are:

Velindre Cancer Centre:

- 70% of patients scored their experience as excellent (9 out of 10)
- 91% of patients stated that they always felt cared for
- 90% of patients said that they always felt listened to
- 75% of patients always understood what was happening regarding their care and treatment

Welsh Blood Service:

- 10,438 (80.4%) of donors rated their care as 6 out of 6 (i.e. excellent)

- Total appointments booked from calls: 17,553 (13,751 inbound appointments & 3,802 outbound appointments).

- Community Partnership Officer continues to make strong strategic relationships with key partners across Wales, for example, the Football Association of Wales for the JD Cymru Leagues and the Orchard Welsh Premier Women's League for the 2021-2022 football seasons.

4. IMPACT ASSESSMENT

RELATED HEALTHCARE STANDARD	Yes
	Safe Care and Individual Care
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	Yes
	The Putting Things Right legislative implications of the management of incidents across the Trust
FINANCIAL IMPLICATIONS / IMPACT	Yes
	Possible financial implications in the event of complaints and claims as a result of an incident and where errors have occurred or system failures are evident.

5. RECOMMENDATION

The Trust Board is asked to **CONSIDER** the 2021-2022 Trust Patient and Donor Experience Annual Report and **APPROVE** the report prior to publication on the Trusts website following Welsh language translation.

VELINDRE UNIVERSITY NHS TRUST

Annual Patient and Donor Experience Report

2021 – 2022

Gwasanaeth Gwaed Cymru
Welsh Blood Service

Canolfan Ganser Felindre
Velindre Cancer Centre

GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre

Velindre University
NHS Trust

CONTENTS

1.0 EXECUTIVE SUMMARY

Velindre University NHS Trust is committed to ensuring that patients and donors are at the heart of everything we do, striving to ensure that all of our patients and donors receive positive care and service experiences.

This report covers the period from the 1st April 2021 to the 31st March 2022 and details how we have engaged with patients and donors to seek their feedback, what their feedback has shown us, and how we have utilised the feedback to shape and improve our services.

During the reporting period, we continued to witness the effects of the worst global pandemic in modern times with COVID-19 radically changing the traditional ways in which the Trust delivered care to our patients and donors. The COVID-19 Pandemic also provided us with the added challenge of continuing to encourage and obtain patient and donor feedback when traditional feedback mechanisms were not as accessible as they had previously been (in particular due to reduced face to face attendances at the Cancer Centre as part of the COVID-19 risk reduction measures in place nationally). Nonetheless, this also provided the Trust with the opportunity to explore 'doing things differently', and in particular, seeking greater donor and patient feedback digitally. We have during this year continued to implement the 'Once for Wales' Patient Feedback system: 'CIVICA' so that we can capture real time experience feedback on mass.

The Trust strives to ensure that patients and donors are at the heart of everything that it does, and is grateful for the continued levels of assistance, encouragement and feedback that is received from our patients, donors, staff, partners and supporters.

2.0 INTRODUCTION

Velindre University NHS Trust is one of the leading providers of specialist cancer, and blood and transplantation services within the UK, bringing together expert staff, high quality cancer care, donor and transplantation services, together with excellence in research, development and innovation. The Trust provides a wide range of specialist services at local, regional and all Wales levels provided through two core delivery services:

Providing blood, bone marrow, haematopoietic stem cell and transplant laboratory services, and immunogenetics services across Wales.

Providing non-surgical tertiary oncology and palliative care services to the population of south-east Wales, and highly specialist cancer services for patients from other regions of Wales

2021 – 2022 Context

The activity and number of patients and donors treated and cared for by our services continued to increase during 2021 – 2022 (as anticipated). The added challenge over the past year was to work to ensure that our patients and donors continued to have a good experience of their care, despite the frequent and rapid changes in services that needed to be made to ensure patient and donor safety during the COVID-19 Pandemic.

During 2021 – 2022, the Trust remained as committed as ever to ensuring that every patient and donor had an excellent experience, and that feedback was actively sought. However, the COVID-19 pandemic necessitated the need to adopt different pathways and mechanisms to engage, encourage and obtain feedback from our patients and donors. Adopting more digital ways of receiving feedback provided us with ability to continue to monitor patient and donor experiences during the COVID-19 pandemic, and enabled us to continue to learn and adapt our services following the feedback received.

The greater digital feedback received during this time also afforded us with the opportunity to receive more 'real time' supportive messages from our patients and

donors. The ability to receive and share such positive and caring feedback amongst our staff in 'real time' was enormously beneficial in boosting the morale of our staff during what was a very challenging period for them.

The Trust remains indebted to its patients and donors for their support during this time.

The Trust continues to have a strong governance framework regarding the monitoring of our patient and donor feedback, including a review of qualitative and quantitative data (including patient / donor stories) at the following forums:

- *Divisional Quality Groups*
- *Divisional Senior Leadership Groups*
- *Quality, Safety and Performance Committee*
- *Executive Management Board*
- *Trust Board*

This is being further strengthened with the phased implementation of the CIVICA digital patient and donor feedback system. The use of various feedback surveys at the Velindre Cancer Centre is well underway with many departments utilising the CIVIC system to its full potential. The Welsh Blood Service continued to utilise the Snap Survey tool whilst the initial phase of implementation was completed at the Cancer Centre. The Welsh Blood Service continue to focus on implementing CIVICA within various departments throughout the Division.

This report provides an overview of how we seek and monitor patient / donor experience, our patient / donor satisfaction scores, the actions that we have undertaken as a result of patient / donor feedback, and how we engage with our patients /donors.

3.0 CAPTURING PATIENT AND DONOR FEEDBACK

The Trust continues to have a number of different mechanisms to encourage and obtain patient and donor feedback. This has been further enhanced with a greater emphasis on Digital feedback mechanisms. This has been a particularly important shift, as our more traditional method of hard paper copies of patient surveys was removed due to Infection Prevention and Control reasons during the Pandemic.

3.1 Velindre Cancer Centre: patient and carer feedback mechanisms in place:

✈ Online digital surveys linked to social media messaging

✈ Social media channels were a valuable source of feedback including comments, stories and check-ins

✈ Provision of a snapshot survey to enable a faster way for patients to share their thoughts, containing just three of the core validated questions

✈ 'How Did We Do' business cards that patients could pick up and take away as a reminder about how and where to complete the online surveys

✈ Quickly identifying issues and concerns raised to enable learning to be captured and changes to be made

To listen to, learn from, share with, and involve patients and their families in the work of Velindre Cancer Centre.

Canolfan Ganser Felindre
Velindre Cancer Centre

3.2 Welsh Blood Service: Donor feedback mechanisms in place:

Feedback	Format	Detail
On session	Paper feedback forms	At each donation session, sealable English and Welsh paper feedback forms are made available. Every response is read by the Donor Experience Manager and escalated if necessary.
On session and post-donation	Donor adverse events	Occasionally donors can experience an adverse event as a result of donating blood, i.e. bruising, discomfort or feeling light headed. A report is completed on session and followed up by the Clinic Nurse or for more complex incidents the Specialist Nurse for Donor Care/Medical Consultant.
Post-donation	Concerns procedure	An easily accessible process for our donors to report when things go wrong, these are handled in line with 'Putting Things Right' guidelines. Concerns are forwarded to the relevant departments who discuss the concern with donors to identify possible improvements.
	Contact centre and social media	Donors can provide feedback through our social media channels which are operated during typical office hours or call 0800 252 266. Feedback is forwarded to the relevant teams or escalated if necessary.
	Donor awards	Each year we host around 12 award evenings where senior management sit amongst donors and gather qualitative feedback.
	Digital survey	Each donor session attendee is invited to complete a digital survey via email based on their experience at session. A monthly report is generated and shared at a monthly departmental meeting.

3.3 Recent and Future developments in strengthening Feedback Mechanisms

Our key focus is to ensure that patients and donors can provide feedback in an easy, simple and straightforward way. The implementation of the new feedback system (called CIVICA) has provided patients and donors with a wider choice of channels to use to provide their feedback. This will include: including online, paper, phone, SMS and email.
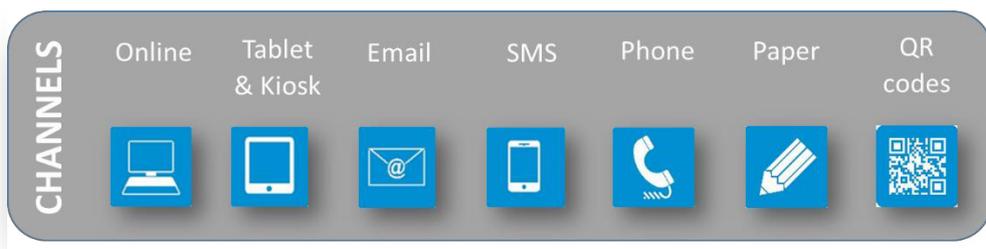
The diagram below demonstrates how the CIVICA system can be used in order that 'real time' insights into patient and donor feedback can be received and reviewed. This will enable rapid actions to be taken to address any areas of concern.

Typical workflow – survey distribution and completion
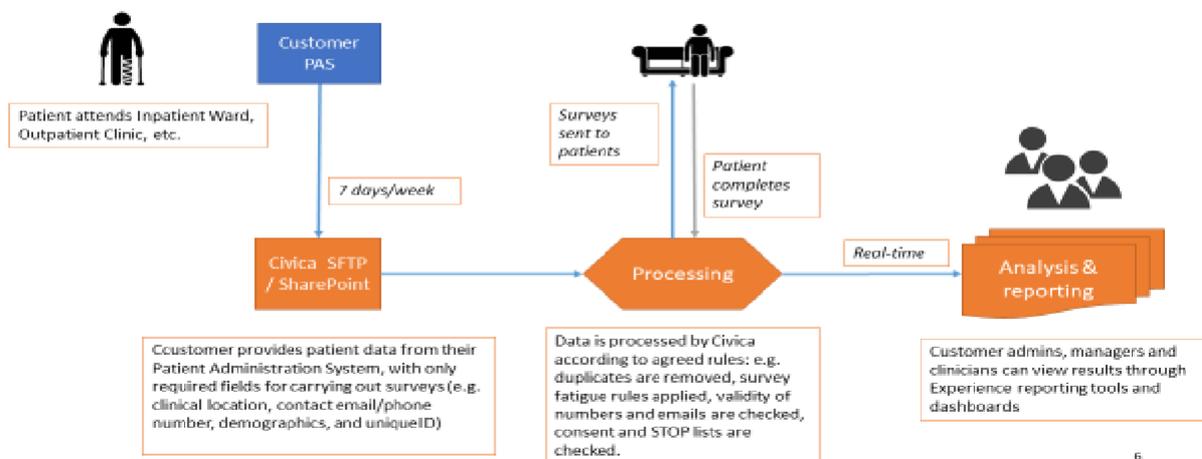
CIVICA has been further rolled out across the Cancer during 2021 – 2022.

4.0 VELINDRE CANCER CENTRE PATIENT SATISFACTION RESULTS

Due to the global COVID pandemic, all the formal patient experience surveys were undertaken and feedback captured via Digital mechanisms.

4.1 Patient and Carer Satisfaction Results

Survey themes

1st April 2021 – 31st March 2022

70% scored their experience as 'Excellent' (>9 out of 10)

82% indicated their experience was within the last 6 months

91% stated they always felt cared for

90% felt they were always listened to

38% said their time spent waiting was shorted than expected

54% said their waiting time was about right

72% felt they always had assistance when they needed it

75% always understood what was happening with their care

80% said explanations were given in a way they could understand

83% felt they were involved as much as they wanted to be in decisions about their care

The Trust continued to work in line with national COVID risk reduction measures, with many of our routine outpatient appointments still managed through 'virtual clinics'. This was an initial challenge for the Cancer Centre and for our patients however patient experience improved throughout the year.

A selection of survey results completed throughout the year are shown below:

1. Did you feel well cared for?

Available Answers	Responses	Score (%)
Always	544	90.82%
Usually	49	8.18%
Sometimes	5	0.83%
Never	1	0.17%
Total	599	100%
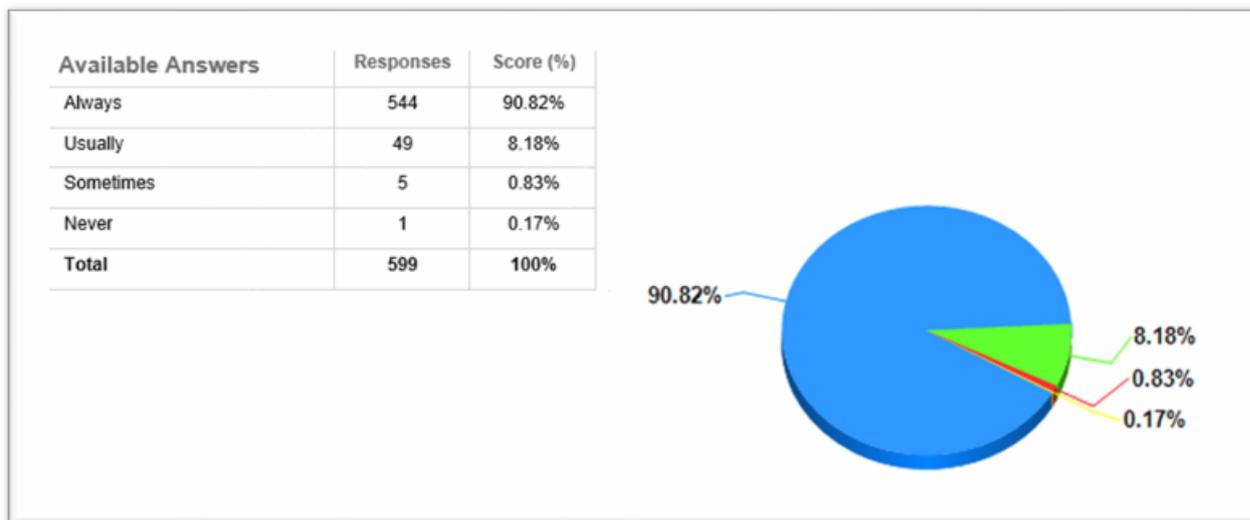
2. Did you feel that you were listened to?

Available Answers	Responses	Score (%)
Always	537	89.65%
Usually	54	9.02%
Sometimes	7	1.17%
Never	1	0.17%
Total	599	100%
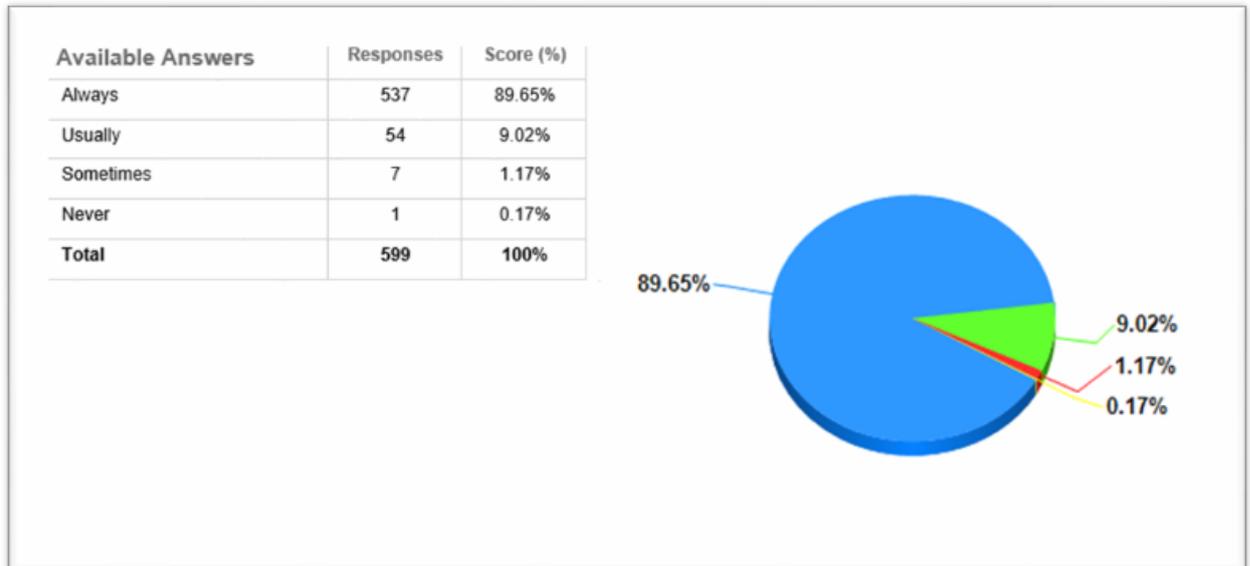
3. Were things explained to you in a way that you could understand?

Available Answers	Responses	Score (%)
Always	481	80.30%
Usually	102	17.03%
Sometimes	11	1.84%
Never	5	0.83%
Total	599	100%

80.30%
17.03%
1.84%
0.83%
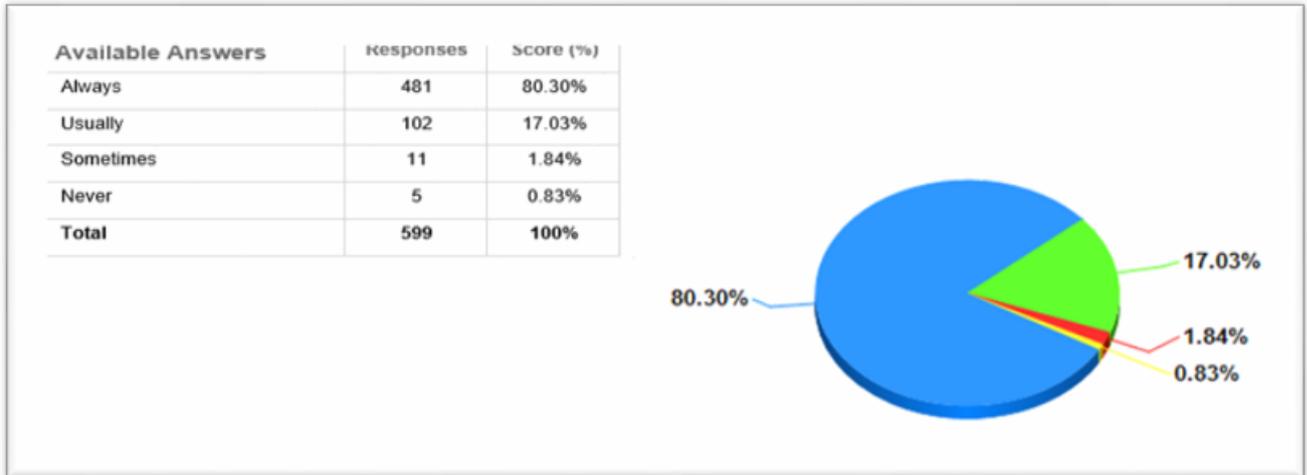
4. Were you able to speak Welsh to staff if you needed to?

Available Answers	Responses	Score (%)
Always	13	2.20%
Usually	3	0.51%
Sometimes	6	1.01%
Never	30	5.07%
Not applicable	540	91.22%
Total	592	100%

91.22%
2.20%
0.51%
1.01%
5.07%
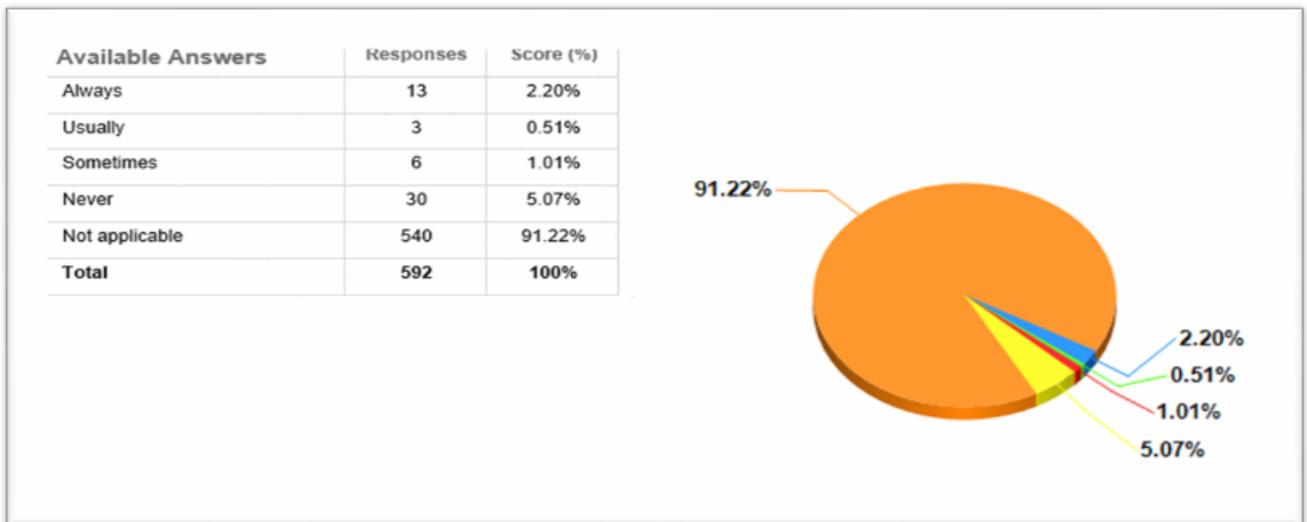
5. From the time you realised you needed our service, how long did you wait for an appointment?

Available Answers	Responses	Score (%)
Shorter than expected	217	38.34%
About right	307	54.24%
A bit too long	39	6.89%
Much too long	3	0.53%
Total	566	100%

54.24%
6.89%
0.53%
38.34%
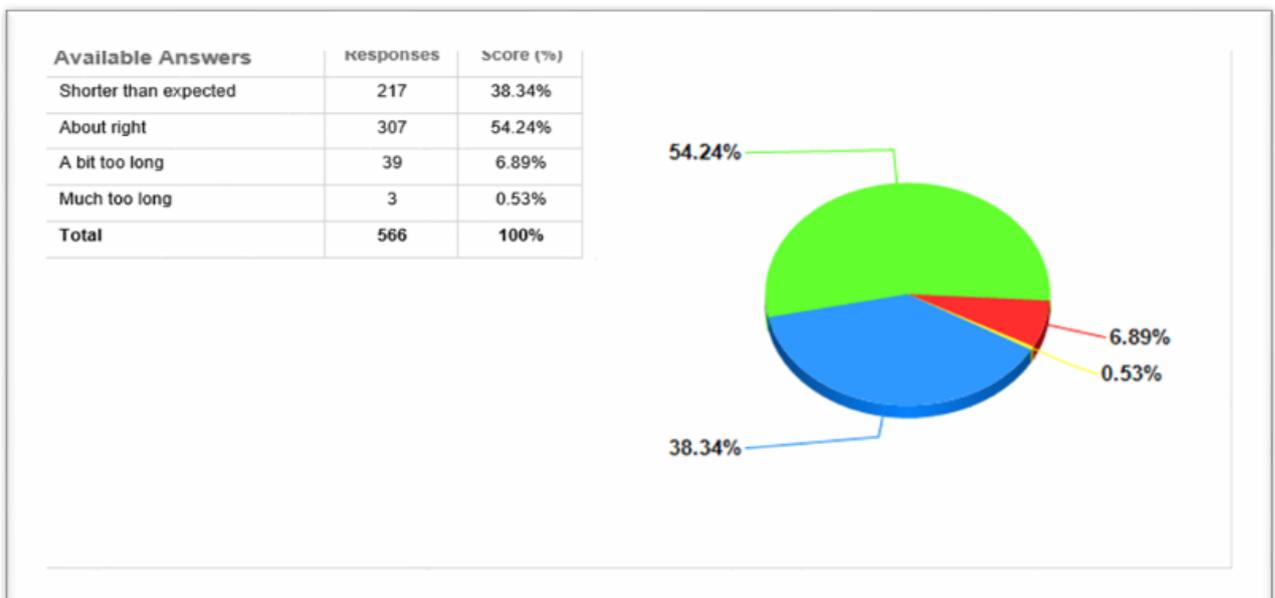
6. Did you feel you understood what was happening in your care?

Available Answers	Responses	Score (%)
Always	451	75.42%
Usually	126	21.07%
Sometimes	19	3.18%
Never	2	0.33%
Total	598	100%
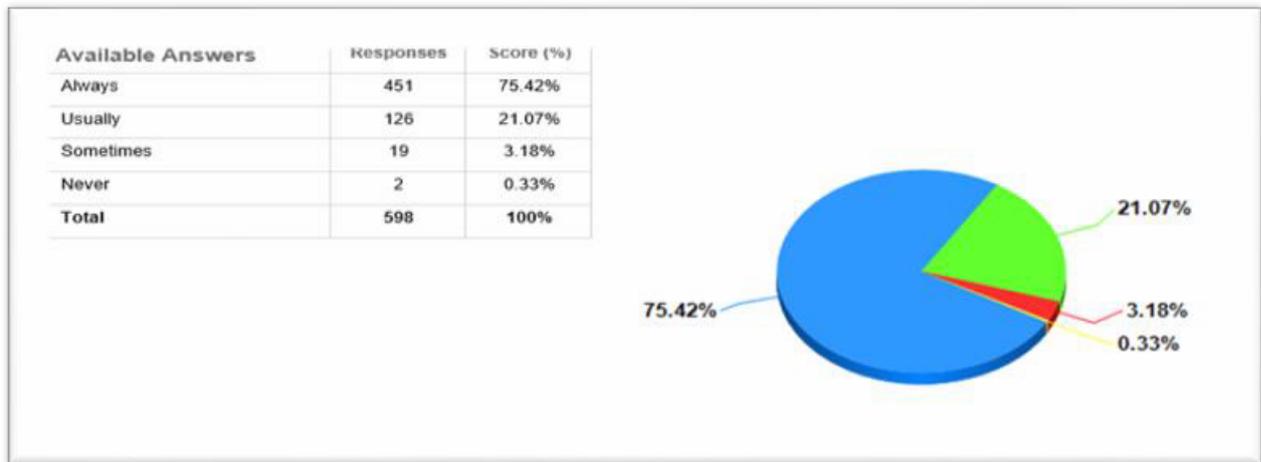
7. Were you involved as much as you wanted to be in decisions about your care?

Available Answers	Responses	Score (%)
Always	494	82.75%
Usually	83	13.90%
Sometimes	15	2.51%
Never	5	0.84%
Total	597	100%
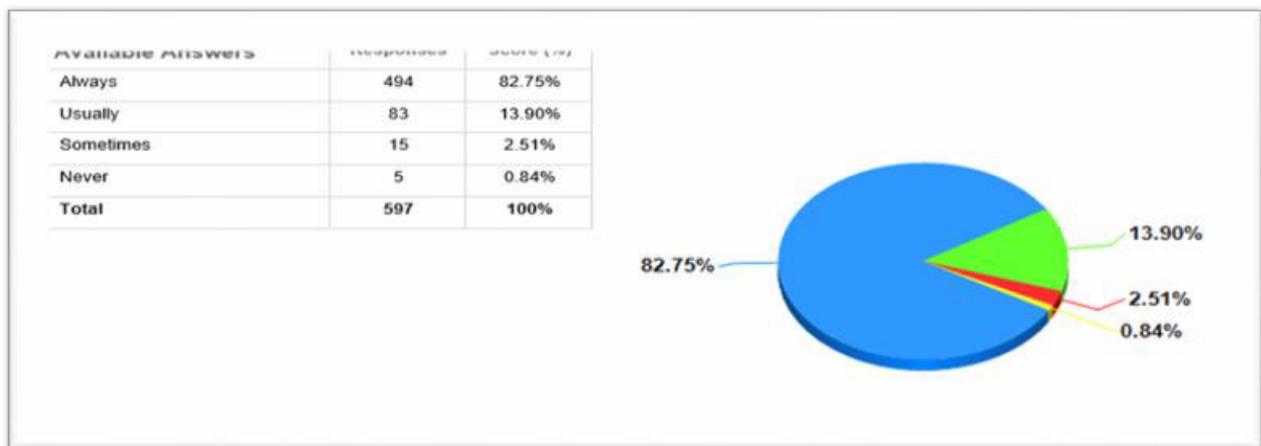
8. Using a scale of 0 to 10 where 0 is very bad and 10 is excellent, how would you rate 'your overall experience?

Available Answers	Responses	Score (%)
10	415	69.63%
9	110	18.46%
8	48	8.05%
7	7	1.17%
6	4	0.67%
5	4	0.67%
4	1	0.17%
3	3	0.50%
2	3	0.50%
1	0	0.00%
0	1	0.17%
Total	596	100%
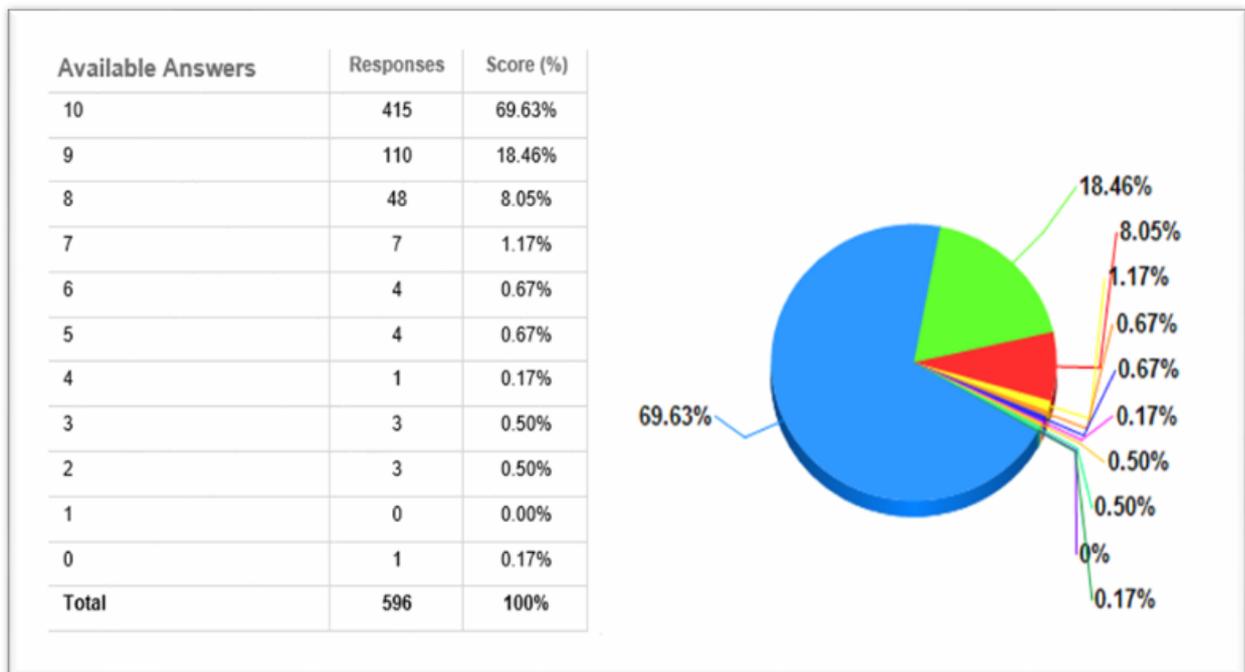
The results from the satisfaction surveys were generally positive and we continue to undertake both face to face and virtual clinics for some patients. We will continue to use the survey results to improve the experience of our patients who attend them.

The risk of contracting COVID-19 was of great concern to our patients who were receiving chemotherapy treatments. Their concern was justifiable given the known increased risks to immuno-compromised patients.

4.2 Velindre Cancer Centre – You said, we did

Theme	Response
The new speed bumps that were introduced as you drive around to the radiotherapy entrance caused issues for Prostate Cancer patients.	As a result of this feedback the speed bumps have been widened reducing impact on patients having to drive over the speed bumps.
Delays in, and cancelled appointments	An improvement project has been introduced to look at SACT booking centre processes and will ensure patients are offered a choice in video or telephone virtual clinic. Offering face to face clinic appointment when there is a clinical need and Covid guidelines allow.
Patient Involvement in Care Decisions	Identified patients at need of increased support from key workers.

4.3 Positive comments received from Patients and their Carers

The comments below provide a snapshot overview about what patients and carers have told us about their experience at the Cancer Centre.

During 2021 – 2022, the qualitative feedback was mainly very positive, and many supportive messages were received from our patients during this time. However, a number of formal concerns were also raised around communication, staff attitude and behavior, appointments and treatment.

The concerns raised regarding appointments and treatment included reasons related to the changes in our services due to the COVID Pandemic. Following a deep dive analysis it was clear, there was still much pressure on the operational teams from the repercussions of various Covid strains which continued to impact Trust operations and services.

The outcomes following the deep dive were shared with both Divisions who have reviewed and received the findings and are working with the Quality and Safety leads to develop local action plans to support the reduction of complaints in this area. The data shared has been used to inform work streams such as the treatment helpline and transport service. This work has continued to be managed through departmental work plans and assurance provided to Senior Management and Leadership teams.

Our patients and carers have been very generous in providing us with their feedback, and for their suggestions for improvement. We will continue to ensure that we learn from what they have told us, and that we improve our services as a result.

The below detail displays areas of process improvement following complaint themes and trends identified during the year:

Established Framework

A concerns investigation framework has improved the structure of investigations, identifying potential delays earlier in the process.

Efficient Complaints Process

The Trust complaints process was reviewed. Clear roles and responsibilities were identified and an improved complaints management procedure has been implemented and delivered.

Improved Response Timescales

Improvements were made in the 30 day response timescales, with 100% of complainants receiving a response within 30 working in Quarter 4 2021/22.

Robust Investigations

All complainants were contacted by the concerns team to offer an apology and to fully discuss the nature of their concerns.

Monitoring performance

Weekly Trust Concern review meetings ensure that all active complaints, serious incidents and claims are monitored through to closure.

Roles and Responsibilities

An appointed Velindre Cancer Centre Quality and Safety Manager now leads on undertaking quality investigations.

Acknowledge Complaints Promptly

During the period 100% of complaints were acknowledged within 2 working days.

Improved Technology

The Once for Wales system is now firmly embedded within the Concerns framework since being launched in April 2021, enhancing functionality to identify themes, trends and

Established Donor Experience Manager

Manages concerns relating to the Welsh Blood Service with a view to improving the services provided to the donor.

5.0 WELSH BLOOD SERVICE DONOR SATISFACTION RESULTS

5.1 Donor Satisfaction Results

The Welsh Blood Service continues to actively seek and obtain Donor feedback. As part of our questionnaire, we ask respondents questions about the service we provide. The chart below shows National satisfaction scores and the North and South Wales regions' scores over the previous 13 months. The data in the table below shows data from March 2021 to March 2022.

Positive satisfaction (%) — Overall | North Wales | South Wales | Target

Months: Mar-21, Apr-21, May-21, Jun-21, Jul-21, Aug-21, Sep-21, Oct-21, Nov-21, Dec-21, Jan-22, Feb-22, Mar-22

Donor satisfaction for those who had successfully donated remained above target at 95.9 per cent.

Overall (10901)	95.9%
S. Wales (8858)	95.7%
N. Wales (2043)	96.9%

Respondent satisfaction for clinic attendees, including those who did not make a full donation, was slightly lower.

Overall (11804)	93.6%
S. Wales (9579)	93.3%
N. Wales (2225)	94.9%

In total, 10,438 (80.4%) donors rated the service six out of six. Here is a selection of the comments received from these respondents.

Qualitative response

I am always extremely impressed by the kindness and professionalism of the blood transfusion staff. Over all these years of donating I have never met a miserable one. The staff on the telephone ar3 also extremely pleasant and helpful. I prefer the mobile units that go to the supermarkets but understand they cannot be used at the moment. I would like to return to using the mobile units once we are able. Thank you for all that you do and the way that you do it.

Team are always amazing and could give some fancy restaurants some tips on service excellence. I've been looked after by trainees on my past two visits who were a credit to you

Although I am now retired and will be 74 this year I see no reason why as long as I have good health I can't continue to donate. I think it is very important to donate and only wish more people did it - as I said previously my husband's life was saved by the generosity of people and I always hope that someone will benefit from my contribution too. I have to say that the nursing staff are always pleasant and caring and I was particularly impressed on my last visit with the nurse who attended to me. She had changed jobs as due to the covid outbreak her previous job wasn't viable and she is a credit to your organisation.

It has been a long time since my last donation and I'm astounded by the service improvement including tablets instead of forms. Very efficient. Staff were so polite, encouraging and helpful. Would deffo start donating more frequently.

Whenever I leave the donation centre I am impressed at how smooth and easy the process is, how well run it is and how friendly and professional the staff are .

My son gave for the first time aged 17 and the staff were amazing with him and made him feel valued.

Thank you so much for being so kind to me. I was so disappointed not to be able to donate but I am really thankful for everyone being so kind. I hope I can donate next year.

I think you have coped magnificently in these difficult times, thank you

Respondents' overall satisfaction is grouped below by the point at which the donation process concluded. Evidence shows that donor satisfaction is closely linked to a donor's ability to achieve their goal (a completed donation) on a session.


	Arrived at clinic	Health questionnaire	Screening	Started donation	Completed donation
n	40	34	319	347	11,990
Pos %	92.5%	67.6	71.2	40.6	95.9
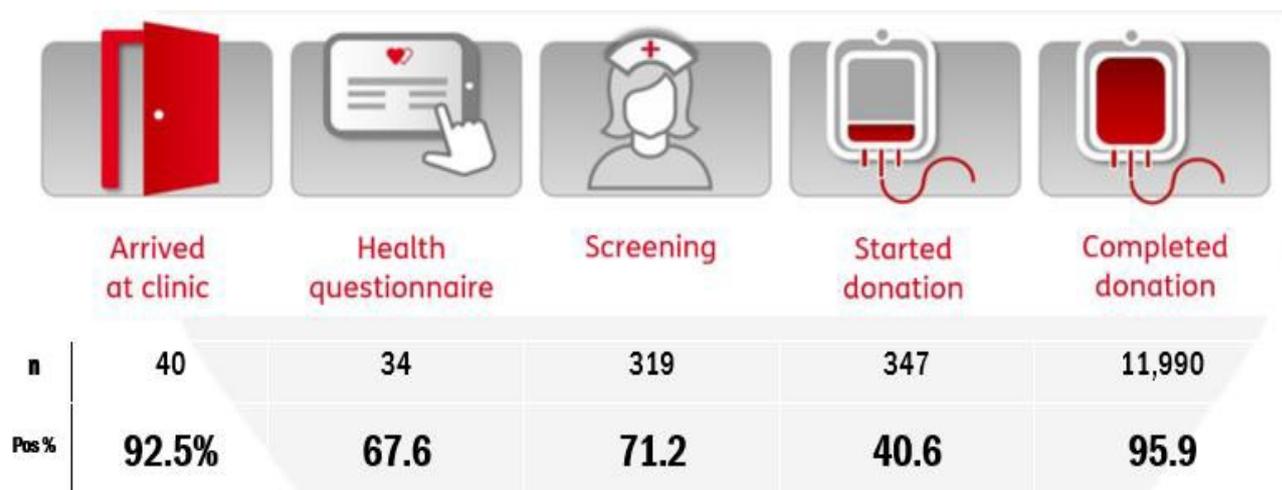
On certain occasions, and for a number of reasons, Donors may not actually progress to being able to donate blood when they attend the Donation clinic. Each respondent who had not successfully donated was asked if they were happy with the explanation that they received regarding why they were unable to proceed to donate blood. The results are shown overleaf:

76.8% said 'yes'

There were 570 respondents (76.8%) who were happy and 126 (17.0%) who were not satisfied with the explanation provided, 46 (6.2%) selected 'N/A'.
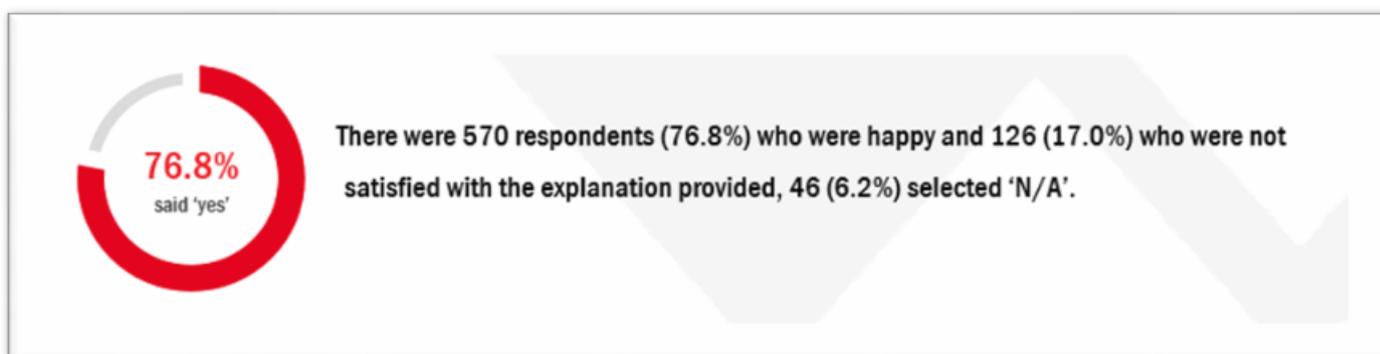
There were 570 respondents to this specific survey which is a reduction in comparison to the previous year. 76.8% were happy with the explanation they received, and 17% were not satisfied with the explanation provided, 46 (6.2%) selected 'N/A'.

The Team is currently working to review and improve our communications as to why progressing to donating blood was not possible, and we will continue to monitor the feedback received regarding this issue

5.2 Venues

Respondents were asked to provide feedback regarding their satisfaction with the Donation Clinic venues.

Eight questions were posed which were rated on a scale of one to six, with six being totally satisfied and one being totally dissatisfied. Any respondent selecting one or two were

provided with the opportunity to add a qualitative response. The results are shown   below:

Venue matrix response	n	1	2	3	4	5	6	Mean
Overall	90,309	384	670	2,163	5,346	13,265	68,481	5.61
The frequency of our visits to your area	12,928	145	216	693	1,463	2,345	8,066	5.31
The availability of information to check your eligibility to give blood	12,883	36	73	212	554	1,787	10,221	5.69
The location of the clinic	12,925	71	117	434	1,080	1,939	9,284	5.52
The accessibility of the clinic	12,915	41	66	228	561	1,675	10,344	5.69
The cleanliness of the venue	12,919	7	7	68	242	1,595	11,000	5.82
The opening times of the clinic	12,860	62	152	391	977	2,039	9,239	5.53
The facilities of the clinic (i.e. parking and restrooms)	12,879	22	39	137	469	1,885	10,327	5.73

Respondents were asked how satisfied they were with the frequency with which they were contacted by our donor contact centre. Three questions were asked on a scale of one to six, with six being totally satisfied and one being totally dissatisfied. The results are shown below:

	n	1	2	3	4	5	6	N/A	Mean
Post	13,021	353	171	384	646	957	4,431	6,079	4.94
SMS	13,752	231	148	342	686	1,523	9,388	1,434	5.59
Telephone	12,837	284	132	295	468	704	3,340	7,614	5.07
Overall Contact Centre Experience	11,617	32	24	103	268	1,271	8,738	1,181	5.77

5.3 Welsh Blood Service - You said, We did

Theme	Response
Donors booked too soon	Donors who book before their 12 or 16-week eligibility date are now identified and contacted. Our Donor Contact Centre educates the donor and, where possible, rebooks the donor into an eligible slot.
Donating after reaching 70 years of age.	Donors aged 70 or over who will 'lapse' if they do not donate within two years are now contacted manually before lapsing, where possible, the donor is then booked onto an upcoming slot.
Changes to the letter invites	Several donors outlined they could not donate due to booking an appointment within seven days of having dental treatment. Whilst reference to dental treatment has always been a part of the digital eligibility quiz. It has now been included in the invitation letters. Note, letters are being sent out less frequently following Covid-19.
Website refresh will help first time donors with 'what to expect'	The Service has been working hard to introduce a refreshed website, making it easier for donors to explore the site and find information useful to them. For example, 'what to expect' for those who have never donated before or, how to be a WBS 'supporter' for those who do not wish to, or cannot, donate. The website refresh aligns with the new donor engagement mission: 'To empower the people of Wales to continuously donate, advocate and inform service provision.'
New video explaining current changes to donation clinics.	During the initial weeks of the pandemic, an 'explainer' video was created to help explain to donors how our operations were changing to support the blood supply chain and maintain our high, safety standards. This video was modernised to meet the latest WBS requirements and help donors understand how best to support the Service during covid-19.
Venue changes	During the pandemic, the number of invites sent to nearby regional hubs to donors was increasing. The Service closely reviewed the venues against donors' willingness to travel to donate blood. Changes have been made on a local and regional basis to improve the geographical footprint of the Service during C19.

5.4 Comments received from our Donors

Below is a selection of the positive comments that we have received from our Donors:

> Excellent service received throughout. Can't fault the staff, happy to have donated my 52nd pint after such a long absence.

> Staff were fantastic as always, very friendly & professional.

> A quick and efficient service. Everyone was friendly & helpful. A really nice venue and was lovely to have music playing.

> First time coming to this venue, easy to find and easy booking system. All Covid regulations fully followed and felt very safe & protected.

> It was my first time donating and all the staff were fantastic, reassuring me and explaining the procedure.

> I'm training to be a midwife so it means a lot to be able to donate, potentially helping mothers & babies needing emergency transfusions

> As always, very efficient. Staff are friendly and professional. Well done!

> What a well-oiled machine this is! The friendliest staff!

> All of the staff encountered today from the lady on reception through to refreshment area were welcoming, friendly & kind.

Overall, the feedback received from our Donors over the past year has been very positive, this is despite the many rapid changes (for example alterations in clinic venues) that needed to be made to our services due to the COVID Pandemic.

As always, the Welsh Blood Service remains committed to learning from the feedback provided, and improvement work remains ongoing in certain areas, for example communication.

We will continue to actively seek Donor feedback over the next year.

6.0 LEARNING FROM FEEDBACK RECEIVED FROM DONORS AND PATIENTS

Patient and donor feedback is vitally important to us. It is only through their feedback that we can make meaningful improvements to our services.

6.1 Velindre Cancer Centre Learning

The following spotlight on learning provides examples of how we developed our services during 2021-2022 using learning from the feedback received.

Velindre Cancer Centre

SACT Appointments	Following an increase in appointment related concerns, an improvement project has been implemented and is chaired by the Interim Velindre Cancer Centre Director to deep dive into SACT capacity issues including, pharmacy, nursing and booking centre processes. Furthermore, a SACT deferrals task and finish group has been established to identify a clear process for managing deferrals.
Communication	A number of complaints were received relating to the difficulties in communication around virtual clinics and lack of face to face appointments. As a result patients are now offered a choice of in video or telephone virtual clinics and the offer of face to face clinic appointments when there is a clinical need and Covid guidelines allow.
New Velindre Cancer Centre (nVCC)	The Trust has witnessed a significant increase in concerns relating to the New Velindre Cancer Centre site since ground work commenced in Quarter 4 2021/22. In partnership with Cardiff Council, the Trust established a process to manage the issues raised, introducing a dedicated nVCC concerns email address alongside a lead point of contact from Transforming Cancer Services.

6.2 Welsh Blood Service Learning

Welsh Blood Service

Attitude and behaviour	Following a consistent trend of high concerns in relation to attitude and behaviour, Clinic Lead Registered Nurses are now available to support staff members and identify areas of concern. All senior staff members have been made aware of the situation and Clinic Lead Registered Nurses are advised to address all actions with team members and monitor situations as they arise.
Covid	Covid related concerns were apparent during the year and consisted of concerns raised around the wearing of face masks, appointment and social distancing requirements. As such, a clinic lead registered nurse is available to offer support and provide full explanations on current Joint Professional Advisory Committee (JPAC) guidelines for assisting donors in relation to social distancing measures whilst attending sessions.
Donor Online Appointments	Welsh Blood Service concern themes identified that blood donors were able to schedule their next donation via an online appointment system without any suggestion they were booking too soon following their previous donation. This resulted in donors arriving to give blood, only to be turned away. A new process was implemented to identify all donors who attempt to prematurely schedule their next donation appointment online.

The Trust has a robust mechanism in place to ensure that we learn from all the complaints received, and that we work to improve our services as a result.

7.0 Patient and Donor Engagement

The Trust is committed to engaging and working in partnership with our patients and donors, as it is only through co-design that we can ensure that our services truly meet the needs of our patients and donors.

7.1 Patient engagement at Velindre Cancer Centre

Efforts have been made to continue to engage with our patients and their carers during the past year, although traditional methods of doing this were challenging due to the COVID Pandemic. Therefore, a switch was made to greater digital engagement methods, including online focus groups.

The Patient Liaison Group meetings continued to be held using video conferencing. This enabled the continuance of the group to engage, inform and advise.

At the Velindre Cancer Centre, a Patient Liaison Group (PLG) is well established, and the designated patient 'leaders' from this group actively participate in the running of the cancer centre. Below is a statement from the group which provides an overview of their role and purpose:

"We are a group of enthusiastic and passionate people who have experienced the work of Velindre, either as a patient or as a carer. We come from all over the region and help Velindre to understand things from a patient or carer's perspective.

Our role is varied and valued. One day we might be commenting on documents, co designing new services or giving presentations. Another day we could be offering our ideas for improvement. Each member has their own strengths and interests and Velindre works closely with us so that we can all make the most of our wide range of skills and networks."

7.2 Donor engagement at the Welsh Blood Service

Within the Welsh Blood Service, Donor Engagement is hugely important, not only to ensure that the Donor experience is optimised, but also to ensure that people engage with the service and that they chose to donate their blood.

The Service has two distinct teams: the Donor Contact Centre team and the Communications, Marketing and Engagement team. The two areas are responsible for six areas within the Welsh Blood Service as shown below.

Donor interactions
To manage donor admin and inspire current donors to donate again.

Research
Gather and share donor feedback to improve service provided.

Communications
Using local and national media to educate and inspire people in Wales to donate or advocate for the Service.

Partnerships
Create relationships with national organisations that can be used in local communities, across Wales.

Celebrating donors
Support donors through the donation lifecycle including donor award ceremonies.

Local engagement
Promote upcoming donor sessions within local communities, using key advocates and influencers to maxmise publicity.

Donor Contact Centre

The key purpose of the Donor Contact Centre is to be the first point of contact for blood donors in Wales, with main functions including: booking appointments, answering queries, seeking feedback and keeping consistent lines of communication with our donors.

The Donor Contact Centre's key aim is to deliver an exceptional standard of service and care for our donors, whilst ensuring that hospital blood stocks are consistently at the optimum levels.

✓ During 2021-2022, the team adapted to the COVID restrictions by:
✓ *Making contact with donors to advise on last-minute changes with clinics.*
✓ *Moved to SMS invites instead of letters to allow for greater agility with clinic changes and collection requirements.*
✓ *Contacting donors around the change to regional hubs giving them an alternative option to their regular donation clinic.*
✓ *Proactive contact of over 70s regarding clinic attendance following shielding.*
✓ *Maintained appointment bookings.*
✓ *Total calls handled by Contact Centre were 107,646 (44,201 inbound calls & 63,445 outbound calls)*
✓ *Total appointments booked from calls: 17,553 (13,751 inbound appointments & 3,802 outbound appointments).*

8.0 COMMUNITY PARTNERSHIPS

8.1 Community Health Council

The Community Health Council is the independent voice of people in Wales who use NHS services. The South Glamorgan Community Health Council Officers & Members have continued to provide support and advice to the Trust,and are very much valued partners of the Velindre University NHS Trust.

The Community Health Council are members of a number of the Trust's committees and advocate for patient and service user centered healthcare and engagement. They have actively worked with the Trust throughout 2021-2022.

8.2 Community Partnerships within the Welsh Blood Service

The Welsh Blood Service's Community Partnerships Officer is responsible for creating strategic relationships with key partners across Wales. The Officer aims to work with socially engaged groups on a national level to create a suite of engagement material that our donor engagement coordinators can share locally as they visit the towns and villages of Wales to promote our donation sessions.

The Community Partnership Officer works with a wide range of socially engaged groups that are present across Wales, from football, cricket, rugby and other leisure clubs to choirs, churches or community groups.

One such example is the recent partnership with the Football Association of Wales for the JD Cymru Leagues and the Orchard Welsh Premier Women's League for the 2021-2022 football seasons.

9.0 PRIORITIES FOR PATIENT & DONOR EXPERIENCE IN 2022-23

The Trust will continue to actively seek feedback from patients and donors to help strengthen and improve our services.

We will continue with the rollout out of our new electronic feedback system that will enable participants to provide feedback through a channel of choice. This will provide real-time insights that will enable us to immediately identify any issues, thus enabling a quicker response to undertaking any required remedial action.

We will continue to strengthen our processes for responding to and learning from concerns. This includes a continued focus on seeking to set up additional reports and dashboards in complaint management to improve current reporting requirements and continue to implement and train staff in the use of the Once for Wales reporting system. A training plan will be implemented to ensure that all staff receive training in the management of complaints.

We will also work to improve our Welsh language service to ensure an equal service is available for our Welsh speaking population.

10.0 CONCLUSION

Ensuring good patient and donor experience is at the heart of everything that we do. The constructive patient and donor feedback from 2021-2022 highlights this. It would be fair to say that the past year has continued to be challenging for everyone, bringing changes and adaptions required to keep staff, patients and donors safe during the Pandemic. Whilst at times, it has been testing for all involved, it has also provided us with opportunities to do things differently.

We have learnt so very much from what our patients and donors have told us over the past year, and have made improvements to our services as a result. We remain committed to ongoing improvements in patient and donor experience, and to truly working in partnership with the people we serve.

TRUST BOARD
NURSE STAFFING LEVELS (WALES) ACT 2021/2022 ANNUAL REPORT

DATE OF MEETING	28th July 2022

PREPARED BY	Anna Harries, Senior Nurse Professional Standards & Digital
PRESENTED BY	Anna Harries, Senior Nurse Professional Standards & Digital
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science

REPORT PURPOSE	FOR ASSURANCE

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME
Executive Management Board	30/05/22	Endorsed for submission to Quality, Safety & Performance Committee
Quality, Safety & Performance Committee	14/07/2022	Endorsed for submission to Trust Board

1. **SITUATION**

    This paper is provided to the Trust Board to **REVIEW** and **APPROVE** the content of the Nurse Staffing Act (Wales) 2021/2022 Annual Report.

2. **BACKGROUND**

    The Nurse Staffing Levels (Wales) Act 2016 requires health service bodies to make provision for safe nurse staffing levels, and to ensure that nurses are deployed in sufficient numbers. The Act is intended to:

    ☐ Enable the provision of safe nursing care to patients at all times;
    ☐ Improve working conditions for nursing and other staff; and
    ☐ Strengthen accountability for the safety, quality and efficacy of workforce planning and management.

    Health Boards / Trusts are required to demonstrate compliance with sections 25A, 25B, and 25C of the Act and formerly report this information to their Board. For the first three years of the Act Velindre University NHS Trust had been identified as only being required to comply with section 25A - the overarching responsibility to have regard to providing sufficient nurses in all settings. This decision had been made using a purest definition of a medical / surgical ward.

    Section 25B (Duty to calculate and take steps to maintain nurse staffing levels) - applies to adult acute medical inpatient wards and adult acute surgical inpatient wards and places a duty for Local Health Boards and NHS Trusts in Wales (where applicable) to calculate and take all reasonable steps to maintain nurse staffing levels and inform patients of the level. The nurse staffing level is the number of nurses appropriate to provide care to patients that meets all reasonable requirements in the relevant situation. The number of nurses means the number of registered nurses (this being those with a live registration on Sub Parts 1 or 2 of the Nursing and Midwifery Council register). In calculating the nurse staffing level, account can also be taken of nursing duties that are undertaken under the supervision of, or delegated to another person by, a registered nurse.

    Section 25B - sets out that where a Local Health Board ("LHB") or NHS Trust in Wales ("Trust") provides nursing services in a clinical setting to which that section applies, it must designate a person or a description of a person, known as the "designated person" to calculate the nurse staffing level for that setting. The designated person must act within the LHBs (or Trusts) governance framework authorising that person to undertake this calculation on behalf of the Chief Executive Officer of the LHB (or Trust). In view of the requirement to exercise nursing professional judgement when calculating nurse staffing levels, the designated person should be registered with the Nursing and Midwifery Council.

    The Executive Management Board and the Trust Board agreed that the inpatient Ward at Velindre Cancer Centre (First Floor Ward) does fit within the wider definition of a medical ward (non-surgical oncology wards in other parts of Wales, and therefore has been reported as a 25b report ward from the 1st April 2021.

3.   ASSESSMENT / SUMMARY OF MATTERS FORCONSIDERATION

3.1   Nurse Staffing Act Reporting

A reporting template has been further developed by the All Wales Nurse Staffing Group to enable Health Boards / Trusts to report compliance with the Nurse Staffing Levels (Wales) Act 2016 in a standardised way. Therefore, there are changes to the annual report presented 2020-2021. Health Boards and Trusts are required to demonstrate compliance with sections 25A, 25B, and 25C of the Act, and formerly report this information to their Board.

Up until March 2021 the inpatient Ward (First Floor) at Velindre Cancer Center was only required to comply with section 25A - the overarching responsibility to have regard to providing sufficient nurses in all settings to provide sensitive care to patients. The standardised reporting template has been used to capture the Trust's compliance with relevant sections of the Act, and sections that are not applicable have been marked N/A. This is attached in ***Appendix 1***.

This report details that there were no incidents that occurred within the First Floor Ward as a result of Nurse Staffing levels and the details that the 5 complaints related to care are not in linked to staffing levels. In addition, ***this year's report provides detail into the maintenance of the planned roster and appropriate management.***

3.2   Plans to Further Enhance monitoring & compliance with Nurse Staffing Act Requirements

The following actions are being taken by Velindre University NHS Trust to further enhance its ability to robustly evidence that it is meeting the Nurse Staffing Act Requirements:

- ***Implementation of electronic nurse rostering (six Nursing units in VCC) – Health Roster (ALLOCATE)*** – Allocate has been fully implemented within six nursing areas (including First Floor Ward) at Velindre Cancer Centre. The Safe Care module (reporting module) implementation is currently being planned.

- ***Acuity Reviews*** – it is critically important to understand acuity levels across services if we are going to appropriately deploy staff and set appropriate staffing levels. There is a 6 monthly national benchmarked acuity review undertaken at present (June & January each year, although moved to July 2020 due to COVID). Inpatient areas in Velindre Cancer Centre have moved to daily acuity capture and there are plans to increase the frequency to at least twice daily and to be extended to other areas such as the Assessment Unit.

- ***Establishment Reviews –*** Following each audit and availability of national benchmarked data is available the Executive Director of Nursing, AHP & Health Science and Head of Nursing will undertake a formal establishment review across all nursing areas within Velindre Cancer Centre. The last review was undertaken in June 2022 based on the January 2022 Acuity data (there was a

delay with the availability of the national benchmarking acuity report).

3.3 **COVID-19 Response Phase Surge Nursing Staffing Contingency Plan**

As part of the COVID-19 response phase emergency planning for unprecedented surge significant work was done to develop robust nurse staffing plan to safely meet patient needs. These were very detailed and actively involved the Research Nurse Team, Nurses from all areas across the Cancer Centre and Nurses from Welsh Blood Service. A plan for 'ideal' staffing levels as well as minimal levels in the event of worse-case scenario staffing deficits that should never ever be worked below were agreed. It was identified that the minimal levels were not ideal and would have reduced the quality of care patients received but this was an unprecedented emergency. As patient numbers did not increase and in fact have been lower than normal staffing levels to date the Trust has not needed to go below agreed 'ideal' establishment levels. Despite there being on some occasions high absenteeism related to COVID there has continued to be sufficient nursing staff in place to care sensitively for patients given the reduced patient numbers within the ward. When possible, and without affecting staff / patient ratios, First Floor Ward staff have, when patient numbers / acuity allow, been able to support SACT delivery to ensure that cancer patients to receive their vital treatment.

4.   IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	There is a strong evidence base that links nurse staffing levels with patient experience and outcomes.
RELATED HEALTHCARE	Safe Care
STANDARD	Individual care, Timely care, Dignified Care, Staff & resources
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	Compliance with the relevant sections of the Nurse Staffing Levels (Wales) Act 2016 is a statutory obligation and will be subject to scrutiny.
FINANCIAL IMPLICATIONS / IMPACT	Given the duty of the act, in the event of patient acuity and / or numbers increasing the staffing levels will need to be increased accordingly. This will have a financial impact.

5. RECOMMENDATION

The Trust Board is asked to **APPROVE** the 2021/22 Nurse Staffing Levels Act (Wales) Annual Report.

Annual Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act: Report for Board/Delegated Committee			
Health board	Velindre University NHS Trust		
Date annual assurance report is presented to Board	May 2022 Data from April 6th 2021- April 5th 2022		
	Adult acute medical inpatient wards	**Adult acute surgical inpatient wards**	**Paediatric inpatient wards**
During the last year the lowest and highest number of wards	1	0	0
During the last year the number of occasions (for section 25B wards) where the nurse staffing level has been reviewed/ recalculated outside the bi-annual calculation periods	0	NA	NA
The process and methodology used to calculate the nurse staffing level. 	Within Velindre Cancer Centre a process of review and calculation of nurse staffing levels has been formally introduced in line with Act, using the evidence based methodology. The Welsh Levels of Care document provides an evidence based workforce tool that is mandated for use as part of the triangulated method of calculating nurse staffing levels. Using the Welsh Levels of Care, patient's nursing needs / activities of daily living are assessed. This includes taking into consideration the holistic needs of the patient, including social, psychological, spiritual and physical requirements. When calculating nurse staffing levels, quality indicators including the extent to which patients' well-being is known to be sensitive to the provision of care by a nurse is taken into consideration including: medication administration errors, patient falls resulting in harm and hospital acquired pressure ulcers. To aid this, an updated incident reporting DATIX system has been adopted within Velindre University NHS Trust, allowing this data to be easily accessible and reportable. Professional judgement is exercised; considering the qualifications, competencies, skills and experience of the nurses providing care to patients. Including consideration for continuing professional development and the effect on the nurse staffing level, including consideration of the use of temporary staff. In addition to this Velindre Cancer Centre have implemented an electronic nurse roster (HealthRoster), this provides an evidence base of key performance indicators and allows review of rosters and temporary staff instantly through digital technology. Patient acuity data is routinely collected (daily) on inpatient wards using the Welsh Levels of Care tool, however moving forward the safe care module within the HealthRoster system will be used following all Wales implementation. Tendable (was Perfect Ward) nursing assurance tool application has also been implemented on the inpatient ward since Nov 2021 with full monthly data covering 9 differing Audits based upon Health care standards.		

	There has been no primary change to the ward structure in the last year. In 2020-2021 bed numbers were reduced to accommodate social distancing, this remained for 2021-2022 reporting period. However this will be reviewed for 2022-2023. The ward sister/charge nurse remains in a supervisory capacity to the planned roster and the current whole time equivalent establishment includes the uplift of 26.9%.
Informing patients	Information regarding the nurse staffing levels is displayed at the entrance to the ward informing patients and relatives about the nurse staffing level. There is also an opportunity now for patients to provide feedback anonymously through a digital feedback system called CIVICA. This ensures patients can provide real time feedback to concerns or compliments for action. Prior to 2022 feedback was provided verbally or on paper, which limited responses and timely action.

Section 25E (2a) Extent to which the nurse staffing level has been maintained

As the nurse staffing level is defined under the NSLWA as comprising both the planned roster *and* the required establishment, this section should provide assurance of the extent to which the planned roster has been maintained *and* how the required establishments for Section 25B wards have been achieved/maintained over the reporting period.

Extent to which the required establishment has been maintained within <u>adult acute medical and surgical wards.</u>		Period Covered …………		
		Number of Wards:	RN (WTE)	HCSW (WTE)
	Required establishment (WTE) of <u>adult acute medical and surgical wards</u> calculated during first cycle (May)	1	**23.68**	**23.68**
	WTE of required establishment of <u>adult acute medical and surgical wards</u> funded following first (May) calculation cycle	1	**23.68**	**23.68**
	Required establishment (WTE) of <u>adult acute medical and surgical wards</u> calculated during second calculation cycle (Nov)	1	**23.68**	**23.68**
	WTE of required establishment of <u>adult acute medical and surgical wards</u> funded following second (Nov) calculation cycle	1	**23.68**	**23.68**

Extent to which the planned roster has been maintained within **both adult medical and surgical wards and paediatric inpatient wards**		Total number of shifts	Shifts where planned roster met and appropriate	Shifts where planned roster met but not appropriate	Shifts where planned roster not met but appropriate	Shifts where planned roster not met and not appropriate	Data completeness
	TOTAL	4,745	3,773 (80%)	0 Number and (%)	972 Number and (20 %)	0 Number and (%)	100 (%)

Extent to which the planned roster has been maintained within **adult acute medical and surgical wards**		Total number of shifts	Shifts where planned roster met and appropriate	Shifts where planned roster met but not appropriate	Shifts where planned roster not met but appropriate	Shifts where planned roster not met and not appropriate	Data completeness
	TOTAL	4,745	3,773 (80%)	0 Number and (%)	972 Number and (20 %)	0 Number and (%)	100 (%)

Accompanying narrative:

In October 2020 VUNHST implemented health Roster which can now capture real-time recording and reviewing the nurse staffing levels and variations from the planned roster for six nursing areas within the Cancer Centre. This records wider than the inpatient ward and supports safe staffing to patient areas wider than the Act.

Accuracy of data is high for VUNHST as there is one area to report on with lower patient numbers.

Health care monitoring system is currently used to record daily acuity with Allocate's *Safecare* system expected to be implemented in 2022-2023 reporting period.

While the planned roster was not met on occasions this was deemed safe and compliant due to reduced bed numbers and with patient numbers consistently below capacity. Through the Heath roster system this approved at each stage. Escalation for intervention is through the Senior Nurse on site and is responsible for ensuring safe deployment of staff in line with the Act requirements on a day by day basis.

When the second duty of the Nurse Staffing Levels (Wales) Act 2016 (the Act) came into force in April 2018, there was no consistent solution to extracting all of the data explicitly required under section 25E of the 2016 Act, and health boards/trust were

	using a variety of e-rostering and reporting systems. During the first reporting period health boards/trusts in Wales worked as part of the All Wales Nurse Staffing Programme, to enhance the Health Care Monitoring system (in lieu of a single ICT solution) to enable each organisation to demonstrate the extent to which the nurse staffing levels across the health board/trust. NHS Wales is committed to utilising a national informatics system that can be used as a central repository for collating data to evidence the extent to which the nurse staffing levels have been maintained and to provide assurance that all reasonable steps have been taken to maintain the nurse staffing levels required.
	Over the last 3 years extensive work has been undertaken to inform the development of the Safecare system that continues to be implemented within health boards and trusts within Wales through a phased approach. Each health board/trust is at different stages of implementation and Velindre University NHS Trust is due to implement following testing by two other health boards (this is expected to be in the summer of 2022) The implementation of this national IT system will ensure consistency in recording and reporting data across organisations and support the 'Once for Wales' approach'.
	For the first reporting period (April 2018-April 2021) this Trust - together with all other health boards/trusts in Wales, provided narrative to describe the extent to which the nurse staffing levels have been maintained in order to meet its statutory reporting requirement under Section 25E of the Act. During the latter part of the second reporting period (April 2021-April 2024) because of a robust national IT system being implemented, it is anticipated that health boards/trusts can collate, review and report more information relating to the extent that nurse staffing levels have been maintained. In addition, health boards/trusts will be able to demonstrate the extent to which the planned roster has been maintained and whether the deployment of nurse staffing was appropriate to meet the needs of patients sensitively.
	During year 1 of the current reporting period (April 2021-April 2022) heath boards/trusts have utilised 2 system to enable the capture and analysis of data – the HealthCare Monitoring system and Safecare. Due to the COVID-19 pandemic health boards/trusts have experienced extreme operational pressures which has impacted on the organisations ability to implement Safecare within the desired timeframe and data capture has not been consistent throughout that period. During April 2021 to April 2022 Velindre University NHS Trust has recorded acuity daily within the HealthCare monitoring system and will continue to record within this system until transition over to Safecare.
Process for maintaining the Nurse staffing level	There are various processes in place to maintain the nurse staffing level within the Cancer Centre and the inpatient ward, which includes: • Monitoring nurse staffing levels within the Cancer Centre, with oversight by the Deputy/Head of Nursing, through the Health Roster System (this provides a dash board view of nurse staffing within the wider Cancer Centre. • Formal escalation to the Deputy/Head of Nursing. • Establishment review will be undertaken upon receipt of all Wales Acuity Benchmarking data. This occurred following June 2021 Acuity data and is due to be completed following January 2022 data. • Datix records are all reviewed daily and staffing levels are covered during site handover twice daily meetings.

- The Senior Nurse on site is responsible for ensuring safe deployment of staff in line with the Act requirements on a day by day basis.

Rostering is now electronic through HealthRoster (ALLOCATE) allowing easy real-time access/review to all rosters

From April 2021 Velindre first floor ward has be reclassified as an adult acute Medical inpatient ward and a section 25B reporting ward.

Section 25E (2b) Impact on care due to not maintaining the nurse staffing levels in adult acute medical & surgical inpatients wards						
Incidents of patient harm with reference to quality indicators and any complaints about care provided by nurses	Total number of incidents/ complaints during last year	Number of closed incidents/ complaints during current year	Total number of incidents/ complaints **not closed** and to be reported on/during the **next** year	Increase (decrease) in number of closed incidents/ complaints between previous year and current year	Number of incidents/ complaints when the nurse staffing level (planned roster) was not maintained	Number of incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor
Hospital acquired pressure damage (grade 3, 4 and unstageable)	0	NA	0	Remaining at 0	0	0
Falls resulting in serious harm or death (i.e. level 4 and 5 incidents).	0	NA	0	Remaining at 0	0	0
Medication errors never events	0	NA	0	Remaining at 0	0	0
Any complaints about nursing care	5	5	0	Increase (new method of reporting)	0	0

Section 25E (2b) Impact on care due to not maintaining the nurse staffing levels in Paediatric inpatient wards						
Incidents of patient harm with reference to quality indicators and any complaints about care provided by nurses	Total number of incidents/ complaints during last year	Number of closed incidents/ complaints during current year	Total number of incidents/ complaints **not closed** and to be reported on/during the **next** year	Increase (decrease) in number of closed incidents/ complaints between previous year and current year	Number of incidents/ complaints when the nurse staffing level (planned roster) was not maintained	Number of incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor
Hospital acquired pressure damage (grade 3, 4 and unstageable)	NA	NA	NA	NA	NA	NA
Medication errors never events	NA	NA	NA	NA	NA	NA
Infiltration/ extravasation injuries	NA	NA	NA	NA	NA	NA
Falls resulting in serious harm or death (i.e. level 4 and 5 incidents).	NA	NA	NA	NA	NA	NA
Any complaints about nursing care	NA	NA	NA	NA	NA	NA

NOTE: Complaints refers to those complaints made under NHS Wales complaints regulations (Putting Things Right (PTR)

	Section 25E (2c) Actions taken if the nurse staffing level is not maintained
Actions taken when the nurse staffing level <u>was not</u> maintained in section 25B wards	• No additional actions were taken or required during 2020-2021 within Velindre Cancer Centre as there were no datix incident investigations that demonstrated that nurse staffing levels were a contributing factor. • All incidents related to inpatient falls and pressure ulcers are reviewed by a scrutiny panel on a monthly basis and nurse staffing is considered as a possible contributing factor as part of the investigations carried out. • The medication safety group meets monthly to discuss all incidents related to medication errors and to share good practice and any relevant learning. No new significant errors reported within this reporting period related to nurse staffing. • Weekly Trust wide complaints meetings are held to discuss complaints/concerns and compliance with the Putting Things Right process is monitored through this forum which includes nursing and first floor inpatient ward, learning logs are shared at the Quality and Safety management meeting, during the reporting period there have been no serious complaints reported that are directly related to first floor nursing
Conclusion & Recommendations	• This is the first report for Velindre University NHS Trust in relation to section 25b (previously the ward was reporting on section 25a only) • Previous reports have been submitted in line with the requirements of the Act • Please note there are no Paediatric wards to report on for Velindre University NHS Trust • While planned roster was not met on occasions this was deemed safe and compliant due to reduced bed numbers and with patient numbers consistently below capacity.

TRUST BOARD

Safeguarding and Vulnerable Adults 2022-2023 Annual Report

DATE OF MEETING	28th July 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Non-applicable

PREPARED BY	Tina Jenkins, Senior Nurse Safeguarding & Public Protection
PRESENTED BY	Tina Jenkins, Senior Nurse Safeguarding & Public Protection & Nicola Williams, Executive Director Nursing, AHP & Health Science
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, AHPs and Health Science

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME
Safeguarding & Vulnerable Adults Group	13/06/22	Endorsed for submission to EMB
Executive Management Board	30/06/22	Endorsed for submission to Quality, Safety & Performance Committee
Quality, Safety & Performance Committee	14/07/22	Endorsed for submission to Trust Board

1. SITUATION

This paper is to provide the Trust Board with the Trust's 2021-2022 Safeguarding and Vulnerable Adults Annual Report.

The Trust Board is asked to **APPROVE** the Safeguarding and Vulnerable Adults 2021/2022 Annual Report prior to translation and publication on the Trust's website.

2. BACKGROUND

The Safeguarding and Vulnerable Adult agenda is underpinned by increasingly complex statutory and national frameworks and standards. These agendas are broad, diverse and is ever evolving.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

This is the first combined Safeguarding and Vulnerable Adults Annual Report following the Vulnerable Adults agenda being incorporated into the Business of the previous Safeguarding & Public Protection Committee during 2021. The report summarises safeguarding activity and developments within the Trust for the period 1st April 2021 to 31st March 2022 and is intended to provide assurance to the Trust Board in relation to compliance with statutory and requirements and obligations. The five key highlights from the report are:

- The Trust has established a Supporting Vulnerable Groups Forum and is developing a workplan to ensure that the Trust is making adjustments for patients/donors with additional needs for support.
- The Trust is making progress to prepare for the Liberty Protection Safeguards.
- The Trust has developed safeguarding resources, to support staff to comply with legislative responsibilities.

- Multiagency working has continued and the Trust has shared information to protect adults and children from abuse and neglect, in line with the Wales Safeguarding Procedures.
- Staff across the Trust have had access to safeguarding supervision and support.

4.   IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Standard 2.7 of the Health and Care Standards (Safeguarding Children and Safeguarding Adults at Risk) requires health services to promote and protect the welfare and safety of children and adults who become vulnerable or at risk at any time.
RELATED HEALTHCARE STANDARD	Safe Care
	2.7 Safeguarding adults and children at risk 7.1 Workforce.
EQUALITY IMPACT ASSESSMENT COMPLETED	No (Include further detail below)
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The Trust has a statutory obligation to comply with safeguarding legislation
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

5. RECOMMENDATION

The Trust Board is asked to **APPROVE** the Safeguarding and Vulnerable Adults 2021/2022 Annual Report prior to translation and publication on the Trust's website.

SAFEGUARDING AND VULNERABLE ADULTS ANNUAL REPORT 2021 -2022

Table of Contents

1. INTRODUCTION

This is the Safeguarding and Vulnerable Adults Annual Report of Velindre University NHS Trust (hereafter 'the Trust'). It summarises safeguarding activity and developments within the Trust through the year April 2021 to March 2022 and is intended to provide assurance to the Trust Board in relation to compliance with statutory requirements and obligations.

Throughout this time, the Trust's Safeguarding and Public Protection Management Group meetings have continued to ensure the Trust continued to meet its safeguarding and public protection responsibilities. The group reviewed and amended their terms of reference, and increased the scope of the Group to include supporting the vulnerable groups agenda. This includes supporting people with dementia and a learning disability. The Group's name was also amended to the Trust's Safeguarding and Vulnerable Adults Group, which is the name referenced throughout this Annual Report.

The Trust is committed to supporting staff to ensure that safeguarding remains everybody's business and this remained whilst services continued to cope with the COVID-19 pandemic, and the further pressure brought about by the omicron variant. During this time employees continued to report if they had cause to suspect that an adult or child was at risk of abuse of neglect.

Key Achievements 2021-2022:

The following are the key achievements for the Trust during 2021/2022:
- The scope of the role and function of the Trusts Safeguarding & Vulnerable Adults Group extended to include the Vulnerable Adults agenda including cognitive impairment, dementia, older persons and learning disability
- Continued full compliance with its statutory responsibilities by reporting safeguarding concerns and working with multiagency partners.
- Safeguarding supervision and advice was accessed from both the Cancer Centre and Welsh Blood Service.
- Safeguarding training continued to be delivered virtually and via eLearning.
- Continued regional partnership training for domestic abuse.
- Continued supporting the national safeguarding work and regional board responsibilities
- The divisions improved their processes for reporting safeguarding activity and assurances to the senior management teams.
- Safeguarding newsletters were developed and disseminated across the Trust with key messages. Screens in patient facing areas were utilised to communicate messages to service users and staff.
- Audits completed utilising the Welsh Nursing Care Record.

Challenges:

The COVID-19 pandemic created significant challenges across the Trust. In relation to safeguarding this included:

- Changes to working arrangements and contacts.
- Reduced accessible opportunities for safeguarding peer support and supervision.
- Fewer opportunities to release staff to engage in training or new initiatives.
- Fewer opportunities to see patients and families face to face which potentially impacts on the ability to identify safeguarding concerns.

2. GOVERNANCE ARRANGEMENTS

2.1 Responsibility for Safeguarding and Vulnerable Adults within the Trust

Executive Responsibility	• The Chief Executive Officer has overall responsibility for safeguarding and public protection. • The Executive Portfolio is delegated to the Executive Director of Nursing, Allied Health Professionals and Health Science. • Supported by: The Deputy Director of Nursing, Quality & Patient Experience. • Named independent member

Operational Responsibility	• Director, Velindre Cancer Centre.
	  • Supported by: The Head of Nursing, Quality and Patient Experience.
	• Director, Welsh Blood Service.
	  • Supported by: The Head of Nursing.

Named Safeguarding Lead	• Senior Nurse Safeguarding and Public Protection. The Senior Nurse for Safeguarding and Public Protection, or the The Deputy Director of Nursing, Quality & Patient Experience will provide advice, guidance, and support for any safeguarding or public protection concerns disclosed, witnessed or suspected within the Trust.

2.2 Internal Governance & Assurance

2.2.1 Compliance with the Health and Care Standards (2015)

The Health and Care Standards were published in April 2015. The Standards comprise seven core themes, developed through engagement with patients, clinicians and stakeholders: staying healthy; safe care; effective care; dignified care; timely care; individual care; and staff and resources.

Standard 2.7 *Safeguarding Children and Safeguarding Adults at Risk*, focuses on how the Trust promotes and protects the welfare and safety of children and adults who become vulnerable or are at risk of abuse and neglect.

The evidence against each standard criteria was reviewed. This supports an overall assessment rating of 4 ''***We have well developed plans and processes can demonstrate sustainable improvement throughout the organisation / business''***.

Assessment Level	1	2	3	4	5
	We do not yet have a clear, agreed understanding of where we are (or how we are doing) and what / where we need to improve	We are aware of the improvements that need to be made and have prioritised them, but are not yet able to demonstrate meaningful action.	We are developing plans and processes and can demonstrate progress with some of our key areas for improvement	We have well developed plans and processes can demonstrate sustainable improvement throughout the organisation / business	We can demonstrate sustained good practice and innovation that is shared throughout the organisations / business, and which others can learn from

The following has been achieved in relation to delivery of the 2021/22 improvement actions in relation to this standard:

Health and Care Standard 2.7 - priorities and aims for 2021/2022		Achieved
To provide a clear mechanism to provide all staff with the required mandatory Mental Capacity Act training.	Senior Nurse Safeguarding & Public Protection	✓
Ensure the Trust has robust plans in place to fully meet the requirements of the new Liberty Protection Safeguards as outlined in the Liberty Protection Safeguards Code of Practice (awaited).	Senior Nurse Safeguarding & Public Protection	✓
To undertake a Safeguarding Training needs analysis to ensure allocated training is appropriate to the specific role.	Workforce Development Manager, Education & Development and Senior Nurse Safeguarding & Public Protection	✓
To improve compliance with safeguarding training to achieve compliance of 95% or above across all relevant areas.	Head of Nursing & Directors VCC& WBS	A safeguarding dashboard has been developed. The results of the training needs and analysis will be reviewed and areas with low compliance targeted for support to improve. Revised date for completion is September 2022.
Develop the role of the safeguarding champion across the Trust to support and maintain the safeguarding standards and embedding good practice and support the implementation of the safeguarding action plan.	Senior Nurse Safeguarding & Public Protection Head of Nursing VCC& WBS	✓

To implement the Once for Wales Concerns Datix safeguarding module in the Trust to improve safeguarding record keeping and reporting.	Senior Nurse Safeguarding & Public Protection	This is a national work programme that has been delayed due to omicron pressures. A pilot is currently underway in Hywel Dda University Health Board
To Review the delivery of a Level 3 safeguarding adults and children training package for the Trust.	Senior Nurse Safeguarding and Public Protection	✓

3. Compliance with the Safeguarding Maturity Matrix

The NHS Safeguarding Network developed the Safeguarding Maturity Matrix, as a tool to enable services within the NHS in Wales to self-assess the organisational safeguarding arrangements to identify the strengths, and also areas for development and improvement. The Trust's Safeguarding Maturity Matrix self-assessment process is undertaken by gathering evidence against each standard. The standards include several example indicators to assist the organization in establishing their self-assessment score. The score is then agreed by meeting with key professionals across the Trust.

Over the year, the Trust's Matrix score reduced from 24 out of 25 to 21 out of 25. It was identified that work was required to improve the Trust DBS position. The Trust identified 7 areas for improvement, detailed below. All of which have been incorporated into the work plan of the Safeguarding and Vulnerable Adults Management Group. The safeguarding maturity matrix improvement plan was and submitted to the NHS Safeguarding Network in November 2022 to collaboratively record the overall themes from NHS Wales improvement plans.

Safeguarding Maturity Matrix Improvement Plan 2022 -2022

Standard	Maturity Score	Current Position Where an improvement need has been identified	Proposed Action to Improve	How did we do?
1. Governance and Rights Based Approach	4	There is no identified person to liaise with the older person and children commissioner within the Trust.	Identify a person to act as a liaison with the commissioners to ensure the Trust is aware of emerging issues or initiatives.	Completed
2. Safe Care	3	To agree a multiagency Level 3 training package for adults and children.	Ensure that an accurate training needs analysis is undertaken, and that staff have access to multiagency level 3 training, required for their specific role.	Completed
		Safeguarding training is below the identified mandatory compliance target.	Quarterly meeting to be held with both divisions and performance reports developed. The subject's being monitored for improved compliance include: • Safeguarding adults and children • VAWDASV Group 1 & 2	

			• Equality and diversity • Mental Capacity Act	
		It has been identified that some staff did not have the required DBS check and the Trust does not have a DBS policy.	A multidisciplinary group has been established and an action plan developed to improve the Trust DBS position. To ensure that all staff have an appropriate DBS check across the Trust and consider next steps regarding renewal.	
		To provide a clear mechanism to provide all staff with the required mandatory Mental Capacity Act training.	To develop and deliver a training package for professionals with specific responsibilities under the mental capacity act.	
		Currently safeguarding supervision is provided following safeguarding concerns and reports.	Trust's approach to safeguarding supervision and support for vicarious trauma this remains difficult due to ongoing restrictions.	

3. ACE Informed	5			
4. Learning Culture	4	Due to the pandemic the learning log was not updated during 2019 – 2020.	To establish the Trust learning from reviews log 2020 – 2021.	All learning is included in the Safeguarding and Vulnerable Adults Workplan through the year instead of a separate learning log.
5. Multiagency Partnership Working	5			

Bwrdd Diogelu Caerdydd a'r Fro
Cardiff & Vale Safeguarding Board

4.1 Regional Safeguarding Boards

The work of the Safeguarding Board's subgroups was suspended due to the COVID 19 pressures. During this period, the opportunity was taken to review the subgroups and the structure, with the agreed structure noted below. The requirements of Safeguarding Children Boards and Safeguarding Adults Boards in Wales have been established under section 134 of the Social Services and Well-being (Wales) Act 2014. The Trust is a member of the Cardiff and Vale Regional Safeguarding Board and the following subgroups:
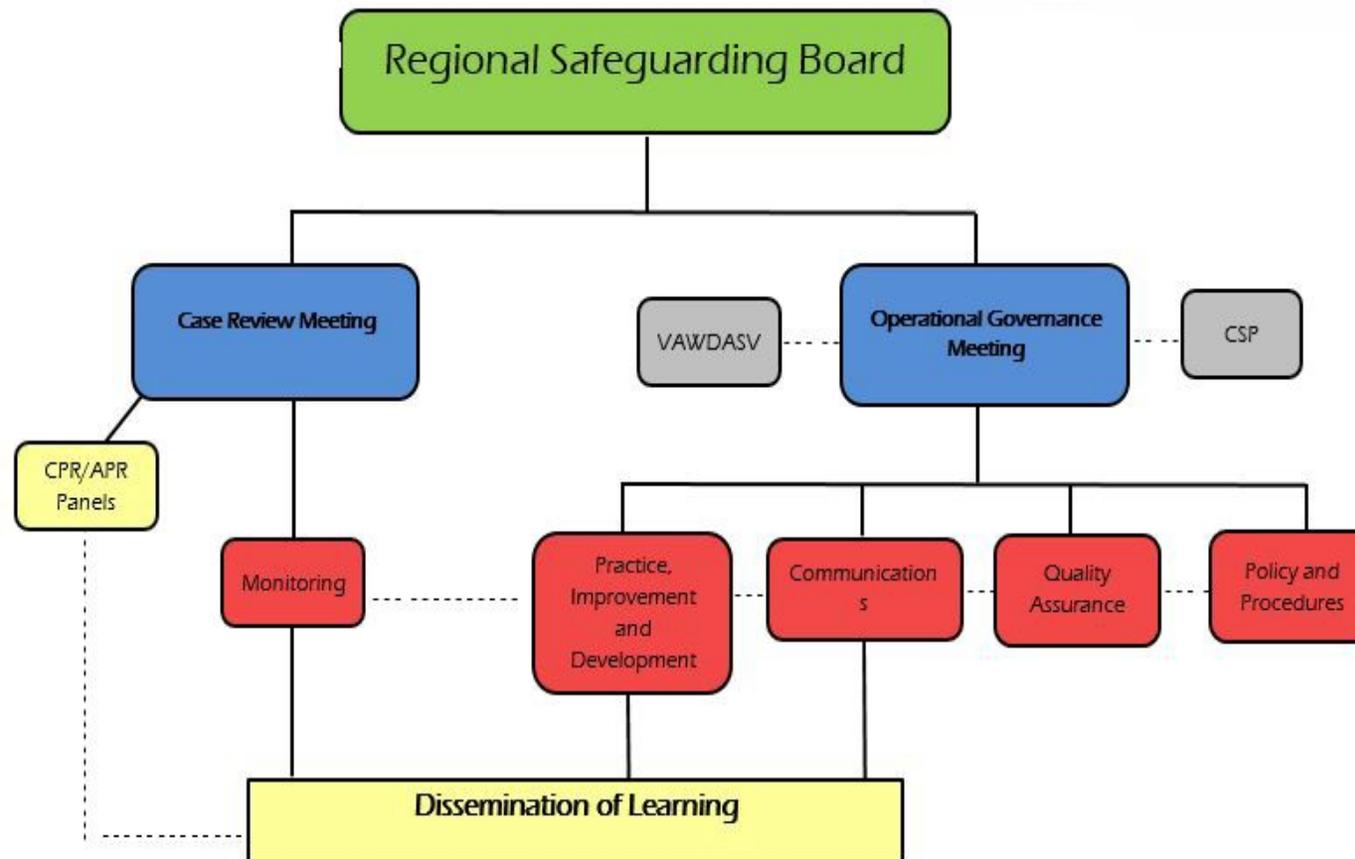
4.2 National Safeguarding Week 15th-19th November 2022
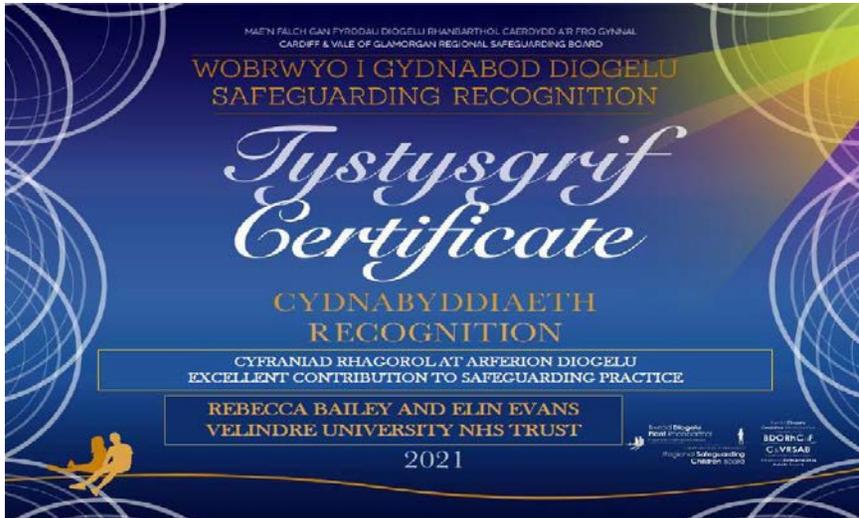
The aim of the National Safeguarding week is to raise awareness about safeguarding issues and to reinforce the message that '*safeguarding is everyone's responsibility*'.

The National Safeguarding Week virtual events were promoted across the Trust. The week ended with a safeguarding recognition award ceremony. The Trust nominated 2 employees. Elin Evans Consultant, Oncologist and Rebecca Bailey, Clinical Nurse Specialist who were both recognised for their Excellent Contribution to Safeguarding Practice.

5. SAFEGUARDING AND PUBLIC PROTECTION POLICY


Wales Safeguarding Procedures are the first universal national safeguarding procedures for Wales. The Wales Safeguarding Procedures aim to translate legislation such as the Social Service and Wellbeing (Wales) Act and any accompanying duties into practice. All Trust Safeguarding Policies and Procedures were reviewed and all policies are up to date on the intranet pages.

5.1 Referral Process and Multi-Agency Arrangements

Allegations of abuse that occurred in Velindre Cancer Centre are referred into the Cardiff Multi Agency Safeguarding Hub (MASH). Any other allegation or disclosure of abuse is referred to the local authority safeguarding team linked to the geographical location of the individual's usual residence.

The Senior Nurse Safeguarding and Public Protection supports Trust staff to comply with reporting processes and collates information on behalf of the Trust. This is to ensure accurate reporting and identification of themes and/or trends across the portfolio. The Trust has worked in collaboration with the MASH, reported concerns, and made enquiries on behalf of the local authority in line with legislation and policy during 2021/22. Below are the regional safeguarding board areas across Wales that the Trust may report to.

5.2 Safeguarding and Public Protection Activity

Most areas across Wales have seen the safeguarding referral rate return to pre-covid levels. The Table below details the activity across the Trust:

Safeguarding Activity	Reports Made Apr 2019-Mar 2020	Reports Made Apr 2020-Mar 2021	Reports Made Apr-21-Mar 2022
Child care and support referrals	1	0	0
Child at risk referrals	7	1	3
Adult at risk referrals	16	7	5
Reported incidents of adult abuse/neglect at VCC	5	0	1
MARAC referrals	1	1	3
Ask and Act Pathway	Data not collected	7	5

MAPPA Information Shared	Data not collected	3	1
Prevent	Data not collected	0	0
Safeguarding allegations/concerns about practitioners and those in a position of trust	Data not collected	1	3
High Risk Multi-Agency information shared	Data not collected	6	7
126 SSWA Enquiries (Adult at risk)	Data not collected	5	2
Section 47 Enquiries (Child at risk)	Data not collected	0	0

Adults and Children at risk have been reported to relevant local authority areas in line with legislation and the Wales Safeguarding Procedures. The Trust has also supported safeguarding enquiries by sharing and gathering information and attending strategy meetings as required.

5.3 Information Sharing

Trust employees must share information in accordance with the Data Protection Act 1998 and the common law duty of confidentiality. Both allow for the sharing of information and should not be automatically used as a reason for not doing so. In exceptional circumstances, personal information can be lawfully shared without consent where there is a legal requirement, or the professional deems it to be in the public interest.

5.4 Female Genital Mutilation (FGM)

Although the Trust does not provide women's health services it is still required to comply with Section 5B of the Female Genital Mutilation Act 2003, as amended by the Serious Crime Act 2015, which includes a statutory duty for health professionals to report known (either identified or disclosed) cases of FGM among girls under the age of 18 years, directly to the police within one month of identification. This duty applies to the healthcare professional directly and not the employer. No incidents of FGM were identified in the Trust during the reporting period. The Trust includes FGM awareness in its safeguarding children training programme. In addition, details of the All-Wales Clinical Pathway for responding to cases of FGM has been updated during the reporting period and is available on the Trust's safeguarding and public protection intranet pages.

5.5 Multi-Agency Public Protection Arrangements (MAPPA)

The Trust is required to discharge its duties as a Multi-Agency Public Protection Arrangement (MAPPA), Duty to Co-operate Agency, under s325 Criminal Justice Act 2003. MAPPA is the process through which the police, probation and the prison services (Responsible Authority) work together, with other Duty to Co-operate Agencies, to manage the risks posed by violent and sexual offenders living in the community, in order to protect the public. MAPPA offenders are managed on a multi-agency basis through multi-agency public protection meetings.

Although the Trust does not attend MAPPA meeting routinely, information is shared with the safeguarding lead as appropriate if a high-risk offender is planning to access treatment in the cancer centre. Information will be shared on a strictly need to know basis, dependent on identified offender risk. Ensuring the dignity of the patient involved is not compromised through the risk assessment process is paramount.

5.6 PREVENT

The Trust is required to discharge its duties under the Counter Terrorism and Security Act 2015. 'PREVENT' is the part of the Government's counter-terrorism strategy that aims to stop people who might be vulnerable or susceptible to radicalisation from becoming terrorists or supporting terrorist activities.

While the Trust does not provide the key service areas for PREVENT e.g. mental health, primary care and accident and emergency, it does cover a wide geographical area including an all Wales Blood Service, so it is important that staff are aware and know how to identify and escalate concerns. The Senior Nurse for Safeguarding and Public Protection acts as the Trust's point of contact for PREVENT. Raising Awareness of Radicalisation e-Learning training is included as a mandatory subject for all staff and included in the compliance matrix across the Trust. No reports have been identified during the reporting period.

5.7 Violence against Women, Domestic Abuse & Sexual Violence

The Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 places legislative duties on public bodies. The Trust remains committed to raising awareness and providing guidance for employees and managers to address the effects of all domestic abuse and intimate and sexual violence, involving staff, volunteers, service users and the general public.   The Trust is represented at the NHS Wales Safeguarding Network Violence against Women, Domestic Abuse,

Sexual Violence (VAWDASV) Subgroup by the Senior Nurse, Safeguarding and Public Protection. The group meets quarterly with the aim of sharing good practice and standardising the approach across Health Boards and Trusts in Wales.

6. MENTAL CAPACITY ACT AND DEPRIVATION OF LIBERTY SAFEGUARDS

The Deprivation of Liberty Safeguards (DoLS) were introduced in April 2009 as the formal procedures to protect people who, for their own safety and in their own best interests, need care and treatment that may deprive them of their liberty but who lack the capacity to consent, and where detention under the Mental Health Act 1983 is not appropriate at that time. If a deprivation of liberty is identified within the Cancer Centre, the Trust, as the managing authority, must contact the relevant supervisory body to assess and, if appropriate authorise the deprivation.

6.1 Trust DoLS activity is summarised in the table below:

DoLS 2019-2020	Total
Applications made	9
DoLS 2020-2021	**Total**
Applications made	8
DoLS 2020-2021	**Total**
Applications made	13

There has been an increase in applications for DoLS in the Cancer Centre during the reporting period compared to the previous year. Several applications were withdrawn prior to assessment by the Supervisory Body as either patients' regained capacity, were discharged, or sadly passed away prior to the assessment. No breaches were identified.

6.2 Liberty Protection Safeguards

Liberty Protection Safeguards (LPS) were introduced in the Mental Capacity (Amendment) Act 2019 and will replace the Deprivation of Liberty Safeguards (DoLS) system. (The planned implementation date was April 2022 but was not met. A revised date has not yet been announced.) The safeguards will provide protection for people aged 16 and above who are, or who need to be, deprived of their liberty to enable their care or treatment, and who lack the mental capacity to consent to the arrangements.

Preparation for the implementation of the Liberty Protection safeguards has commenced across the Trust during 2021/2022.

Liberty Protection Safeguards Implementation Plan

STANDARD	ACTION	ACTION STATUS
1. Ensure that Mental Capacity Act NHS Wales e-Learning is Mandatory for all staff with direct patient/ donor contact.	To ensure that staff are trained at an appropriate level.	COMPLETED
2. Level 2 Classroom training Mental Capacity Act and Deprivation of Liberty Safeguards	Identify all registered professional that delivers direct patient care.	Planned date for completion – Sept 2022
3. Establish a multidisciplinary task group to provide a consultation response on publication of the draft code of practice.	To fully consider the implications for the Trust.	COMPLETED
4. Develop the role of the safeguarding champion to clearly understand the principles of the MCA and support staff to embed in the clinical area.	Recruit safeguarding champions and provide appropriate skills and training.	Planned date for completion – March 2023
5. Welsh Government Funding Government funding accessed for training provision for regulated professionals	Training accessed and 60 spaces purchased for the Trust. Well evaluated sessions.	COMPLETED

6. Assessment of Capacity pocket guides developed and purchased	Pocket guides distributed and well received.	COMPLETED

6.3 Liberty Protection Safeguards Consultation

The UK government is consulting on six sets of draft regulations which will underpin the new system. When enacted, four regulations would apply in England only (Welsh Government has published four different regulations for Wales) and the remaining two will apply to both England and Wales. The consultation period is between the 17ᵗʰ March 2022 and the 7ᵗʰ July 2022. Welsh Government is **consulting** on draft **Regulations for Wales** which will support the implementation of the LPS. At the same time, UK Government is consulting on the **Code of Practice** for the LPS (as well as on LPS Regulations for England). Both Consultations are now live and will close on the same day.

The Trust successfully bid for funding from Welsh Government to support the preparation for the liberty protection safeguards. The funds were used to purchase bespoke training for registrants in Mental Capacity Act Training. Pocket guides were also developed, purchased, and distributed to clinical staff. The guide contains practical advice, on how to undertake a capacity assessment. Assessment of capacity is a key clinical skill for registered practitioners.

7. SUPPORTING VULNERABLE GROUPS

Work has continued to support patients and donors with additional needs and ensure reasonable adjustments are made to enable vulnerable groups to receive the best possible experience of our service. A new group has been established and the terms of reference for the Trust supporting vulnerable groups forum has been approved.
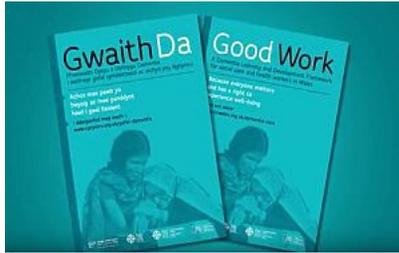
1. A revised training needs analysis was disseminated for dementia training online with the levels specified in the Good Working dementia learning and development framework. This will ensure that staff have access to training that is relevant to their role in the Trust. Dementia training has been sourced from Cardiff & Vale University Health Board and is available for staff requiring skilled level training.
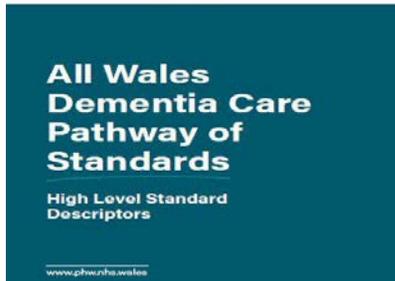
2. The twenty standards sit within four themes: Accessible, Responsive, Journey, Partnerships & Relationships underpinned by Kindness & Understanding. Scoping has been undertaken with the Trust to ensure we are compliant with the standards and that we provide the best possible care to patients with Dementia.

3. The Health Profile has been developed to provide you with key information you need to help you to provide safe, and person-centred healthcare for people with learning disabilities. This has **been distributed across** the Cancer Centre.

Dementia Friendly
Hospital Charter for Wales
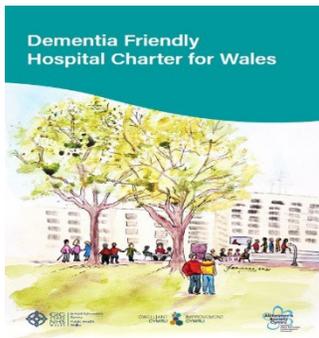
4. The all Wales Dementia Friendly Hospital Charter is part of the dementia aspect of improvement Cymru work plan. The aim of the charter is to support and drive quality improvement across hospitals to support better experiences for people living with dementia and their carers /partners. This will be launched in April 2022, dates have been circulated for Cancer Centre staff to join the launch. Any action required will be included in the work plan of the supporting vulnerable groups forum.

8. SAFEGUARDING TRAINING AND LEARNING

8.1 Safeguarding Adults and Children at Risk

Compliance is monitored by departmental managers and relevant divisions and overseen by the Safeguarding and Vulnerable Adults Management Group. A training needs analysis that includes all safeguarding and public protection training was circulated across the Trust during the reporting period. This identifies accurate information to input into ESR to improve compliance reporting in 2022/23. The below table includes Trust mandatory training compliance as of 31st March 2021.

Subject	Trust-wide Compliance as of 31/03/21	Trust-wide Compliance as of 31/03/22
Safeguarding adults level 1	84.1%	84.6%
Safeguarding adults level 2	81.3%	79.2%
Safeguarding children level 1	82.9%	82.9%
Safeguarding children level 2	76.4%	76.4%

In addition, numerous virtual training and safeguarding conferences were circulated across the Trust for staff to access, including multiagency workshops on domestic abuse and exploitation.

8.2 Level 3 Safeguarding and Children

Level 3: Registered health care staff who engage in assessing, planning, intervening and evaluating the needs of adults where there are safeguarding concerns (as appropriate to role).

Historically, Trust employees have accessed Level 3 Safeguarding training with an agreement from C&V UHB. This provided staff with a more varied audience. However, this is more difficult to access and monitor compliance. Cardiff & Vale Regional Safeguarding Board commissioned new pathways in 2021 to develop Level 3 multiagency packages for safeguarding board use. The training was developed as a full day's training and to be delivered to a multiagency audience. There is currently no capacity in the business unit of the Regional Safeguarding Board to coordinate multiagency training.

With the profile of our services, the most crucial safeguarding training is Level 2 recognition and responding to abuse. This gives staff the knowledge of how to recognize signs of abuse and clearly explains the statutory duty to report. Level 3 training clearly explains the safeguarding process following a report and the possible scenarios and outcomes that could support safeguarding an adult or child at risk.

Given this the Trust has agreed the following training:
- Level 3 safeguarding adults training to be provided to all Registrants with patient contact in VCC and staff in WBS identified as a safeguarding champion or safeguarding lead.
- Level 3 safeguarding children training will be provided to staff whose role involves working with children in the Cancer Centre and Champions or safeguarding leads across the Trust.
- The Cardiff & Vale RSB Level 3 training packages will be delivered to Trust staff in a 2-hour session. The training will be tailored to give relevant information to our services and involvement in the safeguarding process.

8.3 Violence against Women, Domestic Abuse and Sexual Violence

Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 places a statutory duty on the Trust to train all staff in line with the requirements of the National Training Framework.

The National Training Framework on violence against women, domestic abuse and sexual violence:
Statutory guidance under section 15 of the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 and section 60 of the Government of Wales Act 2006

17 March 2016

Cymorth i Ferched Cymru
Welsh Women's Aid
Rhoi Merched a Phlant yn Gyntaf
Putting Women & Children First

The Framework is made up of six groups. All professions within the Public Service will fall into one of these groups and a minimum training requirement is outlined per group.

- *Group 1 (all staff): Awareness raising and practical guidance - This is available to all staff as an e-learning training programme.*

- *Group 2 (public service staff who are most likely to be making contact with those experiencing domestic abuse): 'Ask and Act' – Delivered as face to face training in the Trust.* In April 2019 the Executive Management Board approved the implementation of the NHS Group 2 Ask and Act Training within the Trust. A review of the training needs analysis has been undertaken and it a competency aligned to individuals' compliance matrix in ESR. It was identified that 748 Trust employees were required to undertake Group 2 training. Nominations were sent to the region and the first session of Ask and Act Group 2 train the trainer was completed. Multiagency group 2 training via teams was accessible for Trust staff from November 2020. This training replaced the NHS Group 2 Ask and Act training.

- *Group 3 (professionals with a lead responsibility for VAWDASV e.g. those required to fulfil a champion role within the Trust): Enhanced training for non-specialist practitioners with a pivotal role in client support – this will be developed by a consortia and will be provided on a regional basis -* Pharmacy, nursing, medicine, therapies, radiotherapy and WBS will each have at least one group 3 champion. This roll out of the safeguarding champion training will be included in the 2022/2023 work plan.

Subject	Trust-wide 20/21	Trust-wide 21/22
VAWDASV Group 1 2020 NHS Wales ELearning	71.4%	72.5%
VAWDASV Group 2 2021 Ask & Act	26.17%	43.1%

8.4 Trust Board Safeguarding Training

In December 2021 a safeguarding training update was delivered to the executive management board and future sessions planned on specific topics.

9. LEARNING FROM CONCERNS AND INCIDENTS

'Putting Things Right' states that staff dealing with concerns must be aware of the potential for any safeguarding or protection issues to apply, in relation to a child or a vulnerable adult. The Senior Nurse for Safeguarding and Public Protection has worked closely with the corporate and divisional quality and safety teams and any potential safeguarding concerns have been considered with the team. No Trust safeguarding concerns have been received. The Datix system has a safeguarding field, and all safeguarding incidents are reviewed by the safeguarding lead to ensure appropriate action is taken.

9.1 All Wales Pressure Ulcer Investigation

Following review using the All-Wales Pressure Ulcer Guidance, no incidents of Velindre acquired pressure damage required reporting to safeguarding. In order to ensure there is learning from all incidences of pressure ulcers acquired within Velindre Cancer Centre, a Pressure Ulcer Scrutiny Panel meets monthly and is chaired by the Head of Nursing. The Panel scrutinises compliance against the All-Wales Pressure Ulcer Reporting and Investigation. It achieves this by:

- Scrutinising each incident report and completed All Wales Pressure Ulcer Reporting Investigation Tool for accuracy, completeness, timeliness, and effectiveness.
- Approving outcome of the investigation or requesting further work.
- Ascertaining if the acquisition of the pressure ulcer was avoidable.
- Agreeing feedback processes of all outcomes and learning to the clinical staff and, where required, to the patient, carer, or family.
- Monitor the implementation of any proposed actions/recommendations.
- Review whether VCC met the agreed timescales set for safeguarding screening arrangements.

9.2 Falls scrutiny panel

The Patient Falls Scrutiny Panel is designed to take all reasonable steps to ensure the safety and independence of its patients and respects the rights of patients to make their own decisions about their care. No falls were referred to safeguarding during the reporting period. All inpatient falls are referred to the scrutiny panel who:

- Scrutinises each fall as identified through the incident reporting system Datix.
- Will review all associated documentation for accuracy and whether they were completed in a timely, effective and robust manner in line with the falls policy.
- Feedback to the clinical staff / patient / carer / family the outcome and identified learning.
- Monitor and track the implementation of any proposed actions / recommendations.
- Review whether VCC met the agreed timescales set for safeguarding screening arrangements.

9.3 Child Practice Reviews (CPR) and Adult Practice Reviews (APR)

A Practice Review is undertaken if a child or adult dies or is seriously injured and abuse or neglect is suspected. The Senior Nurse for Safeguarding and Public Protection represents the Trust at the Cardiff and Vale of Glamorgan Regional Safeguarding Board's Child and Adult Practice Regional Subgroup and brings back learning for discussion and if appropriate through the Trust's Safeguarding and Vulnerable Adults Management Group. During the reporting period the Safeguarding Public Protection Management Group reviewed one published Child Practice Review from Cardiff and Vale Regional Safeguarding Board for transferable learning. The Trust was not an agency involved with the child or family in the review.

9.4 Thematic Review of Adult Practice Reviews

The findings from a thematic analysis of Adult Practice Reviews in Wales identified 5 themes and 15 recommendations in the report. This was reviewed and one theme was identified that was pertinent to the Trust: self-neglect. An additional tab was included on the safeguarding intranet and guidance distributed in the Trust wide communications and the Trust is providing membership to support the Regional Safeguard Board to develop a self-neglect tool kit.

10. STAFF GUIDANCE AND INFORMATION

The Safeguarding and Public Protection Intranet pages have been updated during the reporting period. Each safeguarding and public protection theme has a separate tab, and the page and contents are regularly updated with recent guidance and information. Key information has been circulated in the Trust wide communication newsletters.

A safeguarding newsletter has been developed and circulated across the Trust. The screens at the Cancer centre have been utilised to promote messages to staff and the public. Including Welsh Government Resources on the abolition of reasonable punishment in March 2022.

Safeguarding supervision is available for staff as required and following any safeguarding concerns. Safeguarding supervision has been provided to staff following events and reports.

Pocket guides have been developed for Welsh blood collection teams who may be unable to access the safeguarding intranet pages for advice and guidance. The pocket guides include key safeguarding information on how to report abuse and also resources for wellbeing.

11. LOOKING AHEAD

Exciting Safeguarding and Vulnerable adults' developments for 2022/20

Trust priorities and aims for 2022/2023		
Ensure the Trust has robust plans in place to fully meet the requirements of the new Liberty Protection Safeguards as outlined in the Liberty Protection Safeguards Code of Practice (awaited).	Senior Nurse Safeguarding & Public Protection	October 2022
To review the completed safeguarding training needs analysis to and support areas to improve training compliance.	Workforce Development Manager, Education & Development and Senior Nurse Safeguarding & Public Protection	July 2022
Embed the role of the safeguarding champion across the Trust to Support and maintain the safeguarding standards and embedding good practice and support the implementation of the safeguarding action plan.	Senior Nurse Safeguarding & Public Protection Head of Nursing VCC& WBS	July 2022
To develop a workplan against the dementia standards to ensure Trust compliance against relevant standards.	Supporting Vulnerable Groups Forum	June 2022
To access learning disability training for Trust staff in line with the Learning Disability Framework for Healthcare Staff in Wales.	Workforce Development Manager, Education & Development and Senior Nurse Safeguarding & Public Protection	July 2022
To Develop a workplan to make required improvements in line with the Dementia Friendly Hospital Charter.	Supporting Vulnerable Groups Forum	June 2022

TRUST BOARD

INFECTION PREVENTION & CONTROL 2021-2022 ANNUAL REPORT

DATE OF MEETING	28th July 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Muhammad Yaseen- Head of Infection Prevention & Control
PRESENTED BY	Muhammad Yaseen- Head of Infection Prevention & Control & Nicola Williams, Executive Director of Nursing, AHPs & Health Science
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, AHPs & Health Science

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME
Infection Prevention & Control Management Group	19/05/2022	Endorsed
Executive Management Board	01/07/2022	Endorsed
Quality, Safety & Performance Committee	14/07/2022	Endorsed

1. SITUATION

The 2021 / 2022 Trust Infection Prevention & Control Annual Report is provided to the Trust Board for **APPROVAL** prior to publishing once translated on the Trusts website.

2. BACKGROUND

Each year the Trust produces an annual Infection Prevention & Control report that outlines the progress, activities and achievements in relation to Infection Prevention and Control.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The 2021/22 Infection Prevention & Control Annual Report covers the period 1st April 2021 to 31st March 2022. The report is attached in *Appendix 1*.

The following are the key messages emerging from the report:

- Throughout the COVID-19 pandemic the Infection Prevention and Control Team (IPCT), clinical leaders and divisional teams have worked to devise and continually review pathways and safe systems to ensure the Trust provides safe treatments, care and services to its patients and donors.
- There have been no cases of inpatient Healthcare acquired bacteraemia.
- No cases of Catheter Associated Urinary Tract Infections.
- 50% decrease in healthcare associated Clostridioides *difficile* infection.
- Trust has had positive COVID and influenza staff vaccination programme.
- Above 90% average compliance to "Start Smart Then Focus" antimicrobials audit.
- There was an outbreak of COVID-19 in Inpatient Ward (First Floor ward) in March 2022 which was identified early and managed well.
- All outdated infection Prevention and Control policies were reviewed, approved, and uploaded to the intranet page.

4.   IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Healthcare Associated Infections (HCAI) remain a key patient safety issue and result in a significant burden of disease. The burden of HCAI is broader than the indicator organisms
RELATED HEALTHCARE STANDARD	Safe Care
	Standard 2.4 (Infection Prevention and Control and Decontamination): Effective infection prevention and control needs to be everybody's business and must be part of everyday healthcare practice and based on the best available evidence so that people are protected from preventable healthcare
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
	Nil of note to bring to the attention of the Executive Management Board.
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Redress will need to be considered if significant harm has occurred to a patient as a consequence of a healthcare associated infection related to inadequate decontamination. Implications of COVID-19 yet to be realised.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	HCAI/AMR is a key patient safety issue and results in significant burden of disease and financial cost to the NHS.

5. RECOMMENDATION

The Trust Board is asked to **APPROVE** the 2021/2022 Trust Infection Prevention & Control Annual Report prior to publishing following translation on the Trust's website.

Infection Prevention and Control Annual Report 2021/2022

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1. INTRODUCTION

Velindre University NHS Trust (VUNHST) provides specialist services to the people of Wales. The Trust has two core clinical services Velindre Cancer Centre and the Welsh Blood Service.

Welsh Blood Service (WBS)

The Welsh Blood Service plays a fundamental role in the delivery of healthcare in Wales. It works to ensure that the donor's gift of blood is transformed into safe and effective blood components, which allow NHS Wales to improve quality of life and save the lives of many thousands of people in Wales every year. The Welsh Blood Service provides blood, bone marrow, haematopoietic stem cell and transplant laboratory services, and immunogenetics services across Wales.

Within the Welsh Blood Service, ensuring exemplary infection prevention standards is vital in maintaining the safety of donors, products and recipients. As such, the Welsh Blood Service operates a robust infection prevention programme which is designed to maintain the high standards of care and services required to meet regulatory frameworks.

Velindre Cancer Centre (VCC)

Velindre University NHS Trust delivers specialist cancer services for Southeast Wales using a hub and spoke model. The hub of our specialist cancer services is Velindre Cancer Centre. The Velindre Cancer Centre: provides non-surgical tertiary oncology services to the population of south-east Wales, and highly specialist cancer services for patients from other regions of Wales. VCC is a specialist treatment, teaching, research and development centre for non-surgical oncology. Patients are treated with chemotherapy, Systemic Anti-Cancer Treatments (SACTs), radiotherapy and related treatments, together with caring for patients with specialist palliative care needs.

Velindre Cancer Centre also strives to ensure that high infection control standards are maintained. This is especially important given the vulnerability of our immuno-compromised patient group.

Infection Prevention and Control Team

The Trust's Infection Prevention and Control Team leads on ensuring the continued safety of the Trust's services, by working with the clinical and operational staff to mitigate the risk of patients and donors acquiring infection through contact with our services.

This report provides a summary of the progress, activities and achievements in Infection Prevention and Control for the Velindre University NHS Trust during the period 1st April 2021 to 31st March 2022.

2. <u>KEY ACHIEVEMENTS</u>

Despite the advent of the COVID-19 pandemic that has disrupted much of the normal working of the Trust, the Infection Prevention and Control Team (IPCT) in coordination with the other key stakeholders has been instrumental to devising pathways and safe systems to allow the Trust to provide services to its patients and donors. In addition to the workload generated by Covid-19 pandemic, the IPCT has continued to oversee education, guidelines, and practice to ensure the risk of all infection is minimised in the trust. Overall, 2021-22 was an extra-ordinary year: The Infection Prevention and Control Team was instrumental in the Trust's response to the COVID-19 pandemic, and in ensuring that core services were maintained throughout. Below are the key achievements for the Trust from April 2021 to March 2022:

- There have been no cases of inpatient Healthcare acquired:
  - MRSA bacteraemia (there have been no cases of MRSA bacteraemia since 2013)
  - Escherichia *coli* bacteraemia
  - Klebsiella Spp. bacteraemia
  - Pseudomonas *aeruginosa* bacteraemia
  - Catheter Associated Urinary Tract Infections
- 50% decrease in healthcare associated Clostridioides *difficile* infection
- 96% of WBS staff were compliant with mandatory IPC level 1 training.
- Above 90% average compliance to "Start Smart Then Focus" antimicrobials audit
- All outdated infection Prevention and Control policies were reviewed, approved, and uploaded to the intranet page.
- Appointment of Band 4 surveillance and audit officer to enhance surveillance and audit capacity
- Refurbishment of decontamination room in operating theatres
- Along with the wider senior team, to deliver the Trust's Vaccination programme, which includes building on the successes of the Influenza staff vaccination campaign and the COVID-19 booster vaccination.
- There were no influenza outbreaks
- Throughout 2021-22, compliance with the required standard of skin cleansing practices remained high, with all the collection teams across Wales achieving 100 % compliance rates of consistently.

3. GOVERNANCE ARRANGEMENTS AND REPORTING FRAMEWORKS

Figure 1. Infection Prevention and Control Governance and Reporting Framework

INFECTION PREVENTION AND CONTROL MEETING STRUCTURE
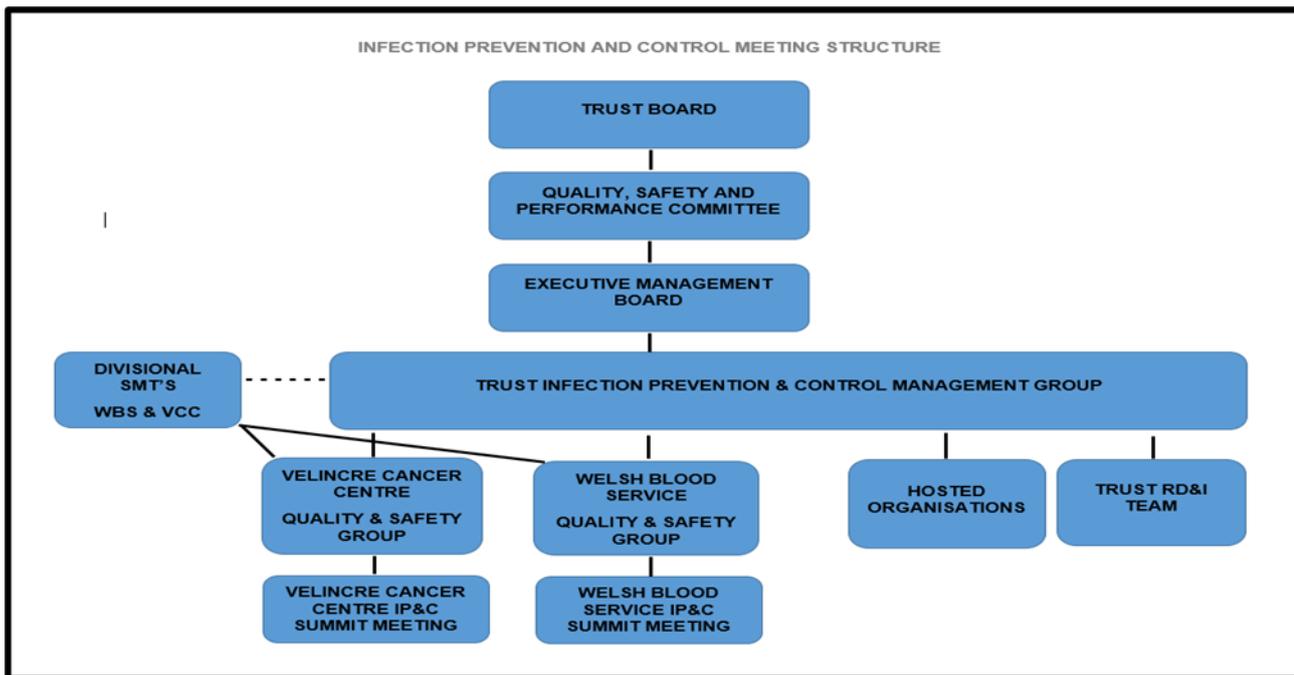
Figure 2. **Infection Prevention & Control Team Organisational structure**
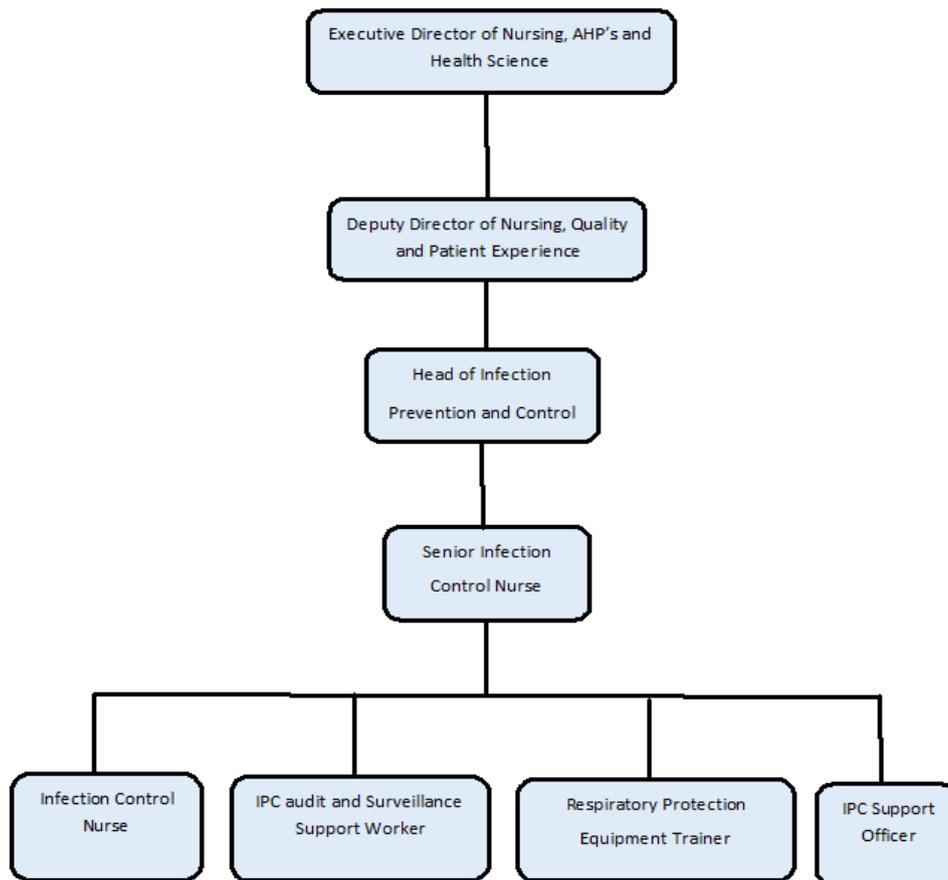
Figure 3. key Infection Prevention and Control leadership roles and responsibilities

Executive Responsibility	• Steve Ham, Chief Executive Officer • Nicola Williams, Executive Director of Nursing AHPs and Health Science • Nigel Downes, Interim Deputy Director of Nursing, Quality & Patient Experience
Operational Responsibility	• Cath O'Brien, Chief Operating Officer • Paul Wilkins, Interim Director, Velindre Cancer Centre • Alan Prosser, Director Welsh Blood Service
Infection Prevention & Control Team	• Dr. Muhammad Yaseen, Head of Infection Prevention and Control • Hayley Harrison Jeffreys, Infection Prevention and Control Nurse • Julianne Golding-Sherman, Infection Prevention and Control Nurse • Lydia Ayres, Respiratory Protection Equipment Trainer • Sarah Parsons, Administrative Support to IPC • Dr Ricky Frazer, Consultant Medical Oncologist and Clinical Lead for IPC
Microbiology & Antimicrobial Stewardship Support	• Dr Rishi Dillon, Microbiology Consultant • Laura Basini-Gazzi, Antimicrobial Pharmacist

4. <u>PERFORMANCE AGAINST THE INFECTION PREVENTION AND CONTROL INDICATORS / STANDARDS</u>

The NHS in Wales set clear goals for Infection prevention and Control in 2021- 2022, namely:

- An integrated "whole system approach" to Antimicrobial Resistance and Healthcare Associated Infections.

- Evidence will be required that an integrated approach is being taken across both community and hospital care settings.

- Ensuring that all antimicrobial prescriptions in hospitals adhere to the principles of "Start Smart then Focus".

- Ensuring that indications for antimicrobial prescriptions are documented in primary care and improving the diagnosis and management of Urinary Tract infections.

- Improving prevention, control and management of infections to deliver significant change in key infections.

- Implementing quality improvement projects to deliver evidence-based interventions to prevent Catheter Associated Urinary Tract Infection, sepsis and Clostridioides difficile disease.

As the Velindre Cancer Centre provides specialist oncological services to surrounding Health Boards, there are only a small number of in-patient beds. As such, it is not possible to directly compare our infection rates with those of the other Health Boards in Wales. This is because

each Health Board calculates its infection rate per 100,000 population, whereas at the Velindre Cancer Centre, the infection rate is calculated per 1,000 patient admissions.

The Trust's actual performance with regards to the Health Care associated infections is shown in Section below:

4.1   <u>Healthcare Associated Infection</u>

Table1. Clostridioides *difficile* (*C.difficile*) infection

	Total numbers	Inpatients	Non-inpatients
2021-22	5	3	2
2020-21	6	6	0
2019-20	3	3	0

5 cases of Clostridioides *difficile* infections were identified during 2021 – 2022, only 3 of which were related to inpatients. This is a decrease of 50% from the last year. All identified cases were investigated thoroughly via a multi-disciplinary approach to establish whether any lapses in care occurred which may have contributed to the patient acquiring Clostridioides *difficile* disease. Opportunities for learning are also identified via this approach with lessons learnt, shared and improvements made.

The investigation revealed that all cases were individual cases without any proven link to each other. All cases had a full root cause analysis completed and a summary of outcomes using a multidisciplinary approach.

Many of the patients at Velindre Cancer Centre are at an increased risk of developing Clostridioides *difficile* disease because they require more than one course of antibiotics to prevent and treat serious infections. Weekly virtual Microbiology ward round has commenced to ensure appropriate and judicious use of antibiotics. The Infection Prevention and Control Team and staff are continuing to work to reduce the incidence of Clostridioides *difficile* disease. Examples include:

- Working closely with staff to increase awareness, and to re-iterate the need for timely sampling to check for Clostridioides *difficile* disease.

- Promoting the need for vigilance in infection prevention and control precautions and hand hygiene.

- Closely monitoring and reviewing all antibiotics prescribed, including the undertaking of antimicrobial ward rounds.

- Enhancing the cleaning of the clinical area with specific disinfectants/sporicidal and utilise ultraviolet disinfection technology.

- Ensuring effective communication between the Infection Prevention and Control Team and clinical staff to share 'lessons learnt' and to ensure the delivery of safe and effective treatment and care.

Table 2. Methicillin Resistant Staphylococcus Aureus(MRSA) Bacteraema

	Total numbers	Inpatients	Non-inpatients
2021-22	0	0	0
2020-21	0	0	0
2019-20	0	0	0

There have been no cases of Methicillin Resistant Staphylococcus Aureus acquired bacteraemia (bloodstream infections) in Velindre University NHS Trust since 22nd November 2013.

At Velindre University NHS Trust, there have been many interventions that have helped to reduce and sustain the zero Methicillin Resistant Staphylococcus Aureus infection rates, including:

- Continued use of ChloraPrep™ for cleaning the skin prior to insertion of any intravenous devices. ChloraPrep also used during the maintenance of Central Venous Catheters.

- Standardised dressing and cannulation packs.

- Utilising 'Securacath' to secure Peripherally Inserted Central Catheter lines, and employing Biopatch dressings to reduce the risk of infection by releasing chlorhexidine gluconate for our higher risk patients.

- Undertaking a regular review of best practice processes and procedures regarding Peripherally Inserted Central Catheter line insertion, and ensuring that these are implemented.

- Undertaking Methicillin Resistant Staphylococcus Aureus screening at important points of the patient care pathway including:

  - On first admission to Velindre Cancer Centre

  - If admitted from another hospital/healthcare establishment

  - If the patient has had Methicillin Resistant Staphylococcus Aureus infection previously

  - Before any surgical procedures

  - Before a Central Venous Catheter is inserted

Table 3. Methicillin Sensitive Staphylococcus Aureus Bacteraemia (MSSA)

	Total numbers	Inpatients	Non-inpatients
2021-22	3	1	2
2020-21	2	1	1
2019-20	2	1	1

Methicillin Sensitive Staphylococcus aureus is a bloodstream infection caused by a common skin bacteria called Staphylococcus *aureus*.

Two cases of Methicillin Sensitive Staphylococcus aureus bacteraemia were identified in the year 2021-22 and only one was identified in inpatient.

Table 4. Escherichia coli (E. *coli*) Bacteraemia

	Total numbers	Inpatients	Non-inpatients
2021-22	5	0	5
2020-21	6	3	3
2019-20	9	8	1

The surveillance of Escherichia coli bacteraemia began in April 2017, and there has been considerable progress since then with a continuous reduction. Five cases of E. *coli* bacteraemia were identified in 2021-22 but none of them was identified in inpatients.

Table 5. Klebsiella Species Bacteraemia

	Total numbers	Inpatients	Non-inpatients
2021-22	4	0	4
2020-21	2	1	1
2019-20	3	2	1

Four cases of Klebsiella bacteraemia were identified in 2021-22 but none of them was identified in inpatients.

Table 6. Pseudomonas aeruginosa (P. *aeruginosa*) Bacteraemia

	Total numbers	Inpatients	Non-inpatients
2021-22	1	0	1
2020-21	0	0	0
2019-20	1	1	0

Only one case of P. *aeruginosa* bacteraemia was identified in 2021-22 and it was identified in non-inpatient.

- **Central Venous Catheter Infection**

Central Line Associated Blood Stream Infections (CLABSI) are serious infections which typically cause a prolongation of a patient's hospital stay, an increase in a patient's care costs, and a greater risk of mortality. Due to low incidence CLABSI in the last two years (*0.12 per 1000 catheter days)*, active surveillance of CLABSI events was not carried out in the year 2021-22. However, work continued to maintain high quality, standardised care for the insertion and maintenance of Peripheral Vascular Cannula and central venous catheter. Previous quality improvements with insertion packs, Aseptic Non Touch Technique and care bundles continue.

- **Multi drug-resistant Organisms**

Multidrug-resistant organisms are increasingly recognised as a growing public threat, both within the health care system and in the community.

A clinical risk assessment has been produced which is completed on admission to establish whether a patient has risk factors for carriage/ infection with Multidrug-resistant organism, and the Infection Prevention and Control team will continue to monitor this.

4.2   Infection Prevention and Control Audits

4.2.1 Welsh Blood Service Pre-Venepuncture Skin Cleansing Audit

Figure 4. Pre- Venipuncture Skin Cleansing Audit

Pre- venepuncture skin cleansing audit April 2021- March 2022
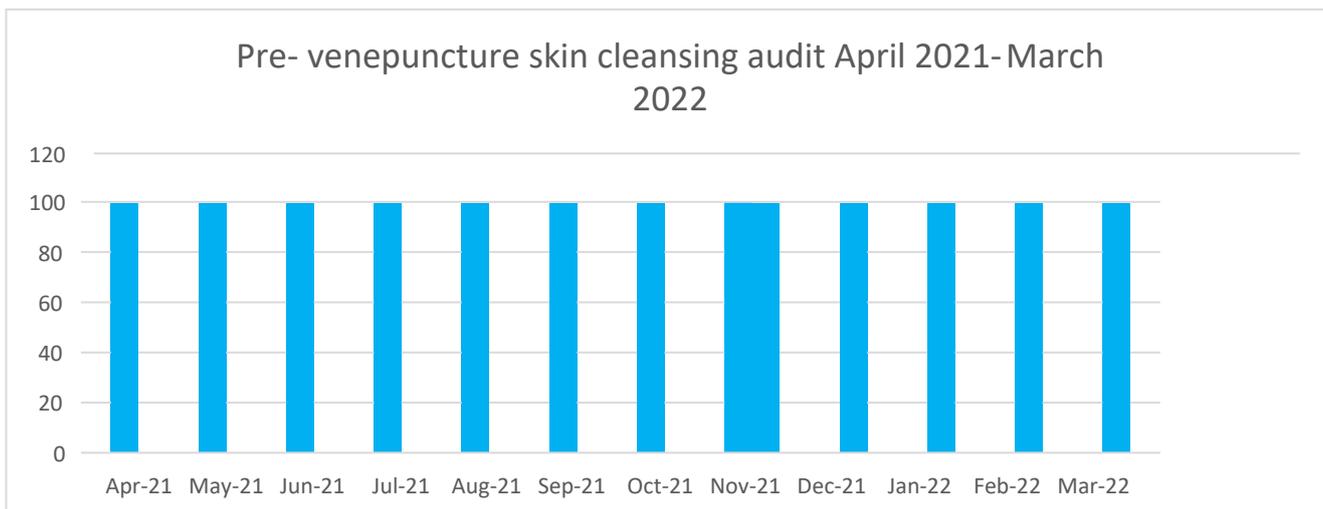
Robust and effective skin cleansing prior to venepuncture is vital in ensuring the safety of the donor, the product, and the recipient. To ensure this key requirement is completed to a high standard, the Welsh Blood Service has developed and implemented a pre venepuncture arm cleansing monthly observational audit programme.

Any areas of non-compliance identified are documented and addressed at the time of audit. All audit results are then scrutinised by the Clinical Education Team and improvement/ lesson learnt action plans developed and addressed.

Throughout 2021-22, compliance with the required standard of skin cleansing practices remained high, with all the collection teams across Wales achieving 100 % compliance rates of consistently.

4..2.2 Welsh Blood Service Bacteriological Confirmed Positive Platelet Donations (Apheresis and Pooled)

Figure 5. Confirmed Bacteriological positive Platelets

Confirmed Bacteriological Positive Platelets 2021/22
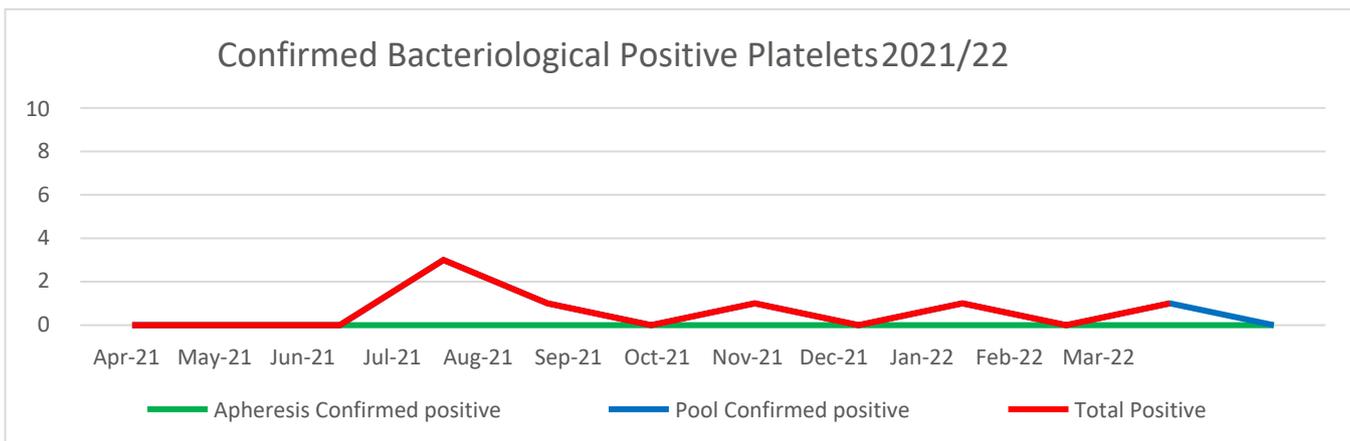
Stored platelet products provide an ideal environment for bacterial growth, being held at 22 degrees Celsius. It is also possible that this could be further influenced by inadequate arm cleansing practices prior to venepuncture and IPC practices in laboratory areas. Bacterial contamination of platelet products would significantly impact upon recipient safety if transfused.

Therefore, the Welsh Blood Service has a robust system in place to test and identify bacterial contamination of platelets to ensure recipient safety is maximised.

The number of bacteriological confirmed positive platelet donations identified at the Welsh Blood Service (WBS) are monitored on an ongoing basis.
During this reporting period incidences of confirmed Bacteriological positive platelets remain stable.

4.2.3 Cleanliness Audit of Identification lanyards & badges at WBS

There are several problems associated with the wearing of lanyards, including deep-seated contamination with nosocomial pathogens within the fabric; an inability to eradicate with surface disinfection techniques; transfer of contaminating pathogens from lanyards to other worn items in contact with the lanyard; the transfer of pathogens from lanyard to patient; the transfer of pathogens to the hands of the HCW wearing the lanyard, after performing adequate hand hygiene. In May 2019 Public Health Wales released a safety brief to all NHS staff advising the removal of lanyards before driving/travelling, due to a risk of injury if an airbag is activated.

In the summer and autumn of 2021, a small study was undertaken by IPCN Julianne Golding-Sherman to ascertain the cleanliness of lanyards, reel pulls, and ID badges worn by the HCWs within Welsh Blood Apheresis unit, using an Adenosine triphosphate (ATP) monitoring system. Following the initial ATP sampling of lanyards and ID badges in July 2021, ID clip pull reels were issued for use. It has been proven that clipping ID badges at a higher level means they are less likely to be touched or become contaminated, are easier to decontaminate, and are less likely to be in contact a patient or donor. However, staff were more comfortable clipping them to the uniform pocket at waist level. PPE (masks, gowns and gloves are worn during clinical interventions).

The study demonstrated that the clip pull reels were slightly less contaminated than lanyards. It also indicated that ID badges are most contaminated when attached to a lanyard rather than when housed by the clip reel pull. Increased decontamination frequencies are required for both the housing and the ID badges.

Figure 6. Identification lanyards & badges screening results
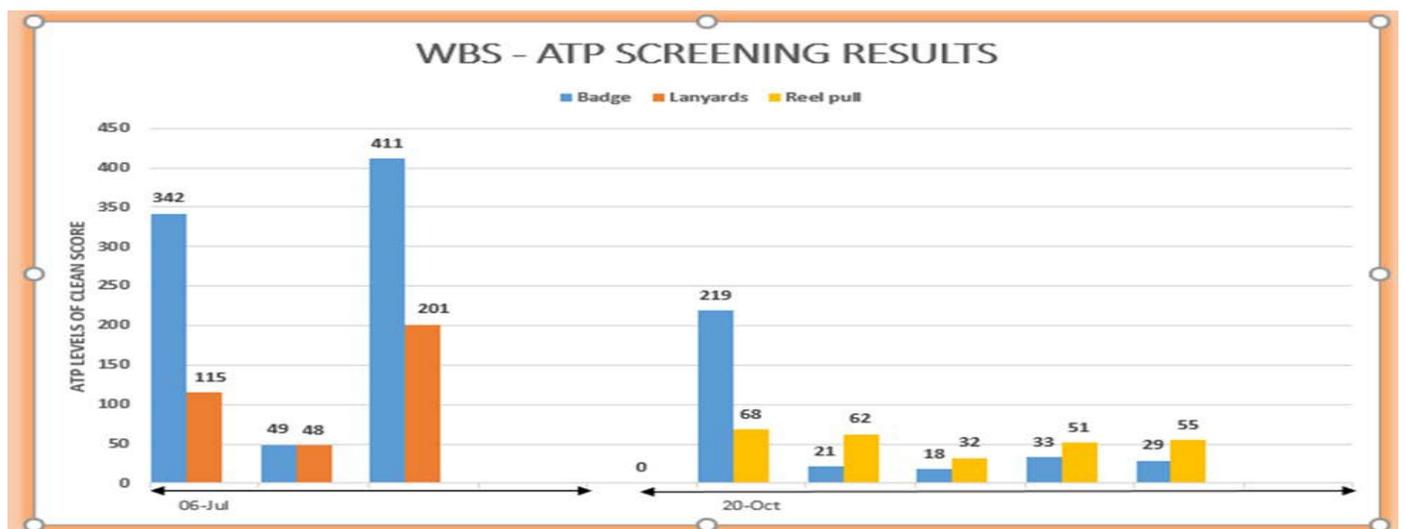
The data provides strong evidence to suggest that lanyard, clip reel pull, and ID badge hygiene is poor. This represented a clear risk of transmission to donors and suggests that recommendations of regular lanyard laundry are unlikely to achieve good compliance to mitigate this risk.

Following the study, the recommendation was to replace lanyards with universal introduction of ID clip pull reels across Welsh Blood Service staff.

4.2.3 Hand Hygiene Audits

During 2021 – 2022, hand hygiene compliance has been variable across the Trust, and improvement work has been undertaken to improve compliance. Completed hand hygiene training and assessment is now recorded through the NHS Electronic Staff Record. The Infection Prevention and Control Team continue to support the department Hand Hygiene champions, and compliance is reported through both the divisional Infection Prevention and Control Summit meetings and the Infection Prevention and Control Management Group.

As outlined in Figure 7 below, throughout the year overall compliance at WBS has been between 94% and 98% and that across the Trust hand hygiene audit compliance has remained above 90% throughout the year and peaked at 100% in March 2022.

Figure 7. Hand Hygiene Audit Compliance
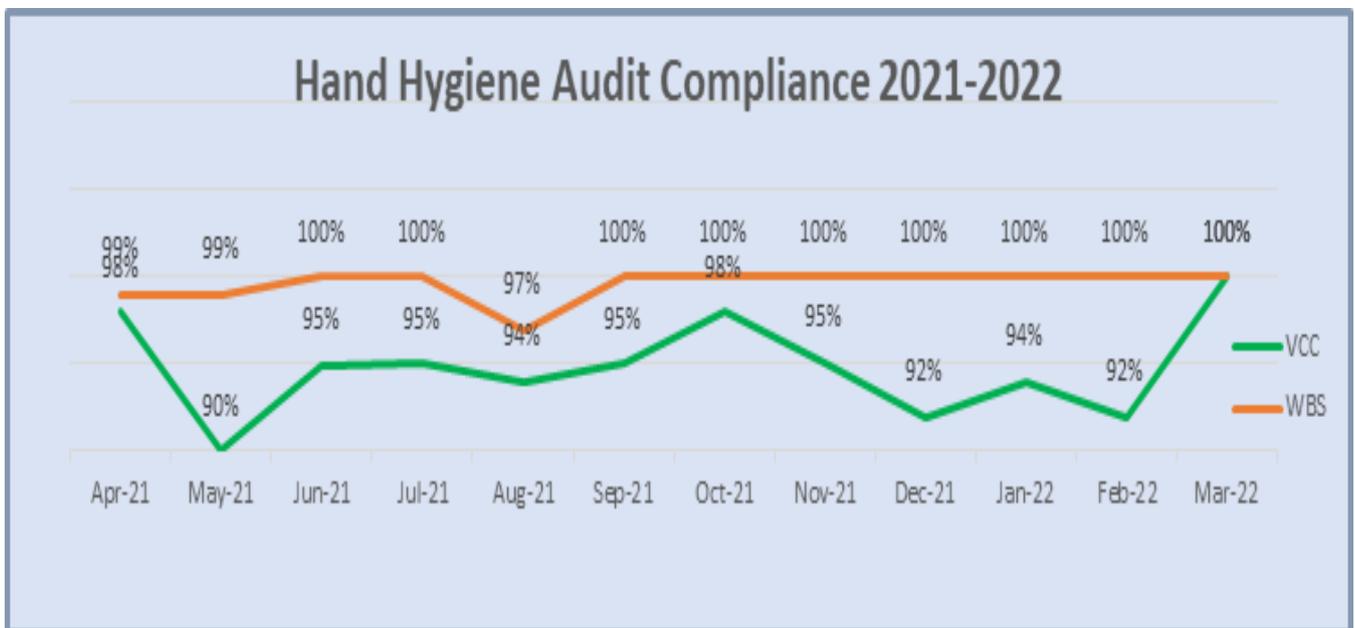
4.2.4 Environmental Audits

Velindre University NHS Trust utilises an electronic quality improvement system, MEG Environmental Audit tool, to help to reduce transmission of healthcare associated infections through audit, feedback and timely reporting, specifically addressing the EPIC 3 Guidelines alongside the Code of Practice Guidance. The audit tools are available on mobile devices, and this provides real time results for auditors and the management teams.

The annual audit programmes have been expanded to include the Welsh Blood service, and more audits will be undertaken throughout the Welsh Blood Service after an initial pilot has been completed and the staff have undergone training. The audit results were comparable to previous years audits, and highlighted the continued age of the Cancer Centre building which is in need of repair and refurbishment. The main themes arising were wear and tear on the environment and carpet in some clinical areas and a rolling programme to address issues underway by estates team. Other issues included lack of visible cleaning schedules which has since been addressed.

Figure 8. Environmental Audit scores

Audit scores 2021 - 2022

| Marie Curie Hospice | VCC Female Changing room | VCC - Commodes | VCC - First Floor Ward | WBS Collection Team East B | Collections Team West |
| 88% | 84% | 100% | 99% | 98% | 100% |
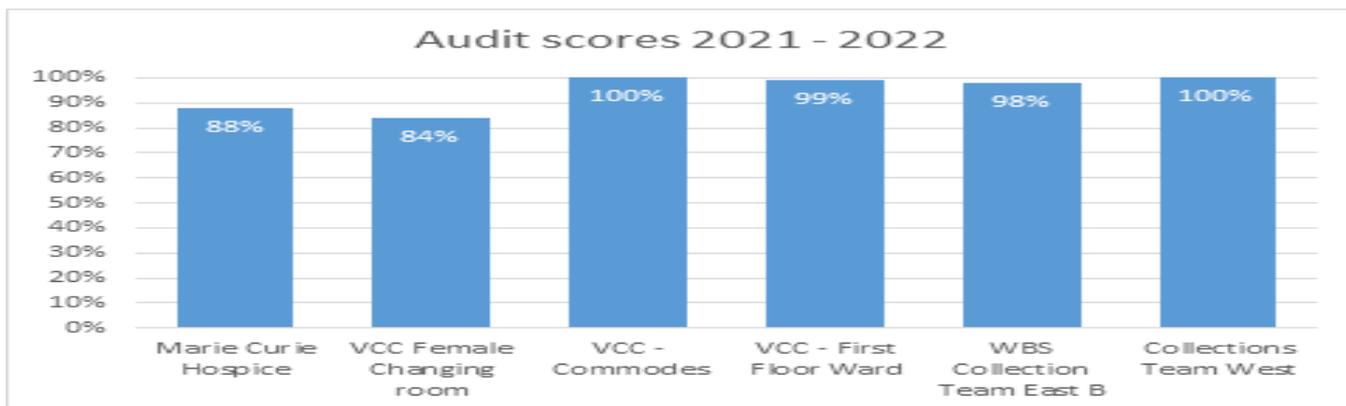
4.2.5 Clinical Practice Audits

The clinical practice audits have been undertaken again this year. These cover insertion and the maintenance of invasive devices. No concerns have been raised regarding any of the clinical practice audits undertaken. This is reflected in the sustained low infection rates at the Cancer Centre and in the Welsh Blood Service.

4.3 Infection Prevention and Control Training Compliance

Infection Prevention and Control Training has continued throughout the COVID-19 pandemic. However, the mechanism through which training has been provided has reflected the required social distancing restrictions.

Level 1 and level 2 training has been predominantly provided through the e-learning platform. In addition, the Infection Prevention and Control team continued to be proactive and available to advise and assist as required. A training needs analysis was undertaken across the Trust to assist in identifying who requires specific training such as FIT-testing, donning and doffing training and hand hygiene.

Figure 9. Infection Prevention and Control Level 1&2 Training Compliance

2021 - 22 IP&C Training compliance

	Corporate	RD&I	TCS	VCC	WBS
IP&C level 1	73%	84%	77%	81%	96%
IP&C level 2	75%	71%		73%	90%
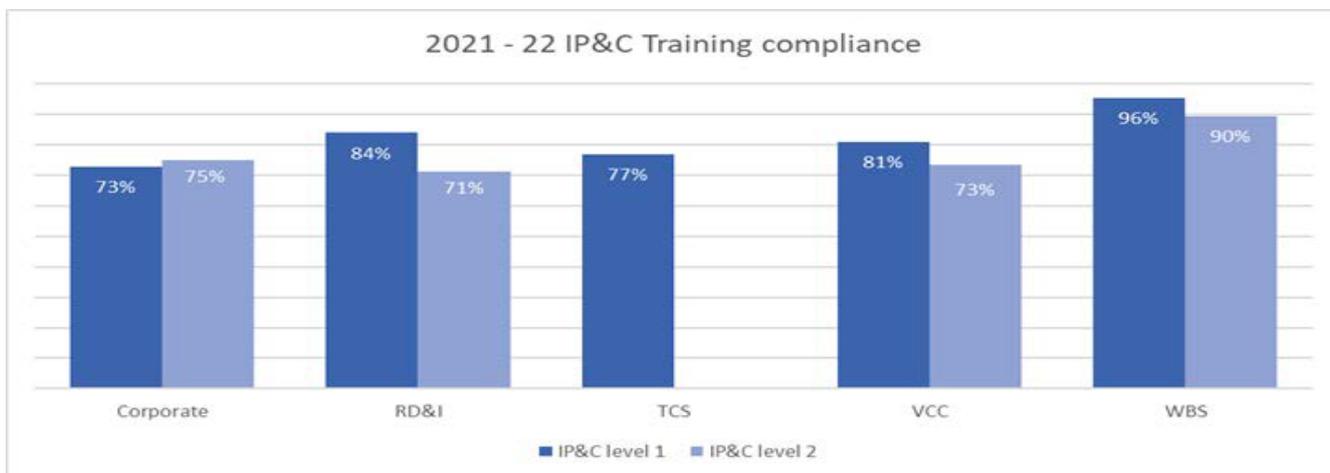
One of the causes in the reduction in hand hygiene training compliance is due to some of the hand hygiene champions leaving their roles. Figure 10 highlights the number of staff out of compliance. In order to address this, new champions have been identified and trained by the IPCT, and action plans to improve compliance rates submitted by service areas to the divisional IPC summit groups.

Figure 10. Hand Hygiene Training Compliance

Row Labels	Achieved	Lapsed	Not Achieved	Total Required to complete assessment	Compliance %
120 Corporate Division					
120|LOCAL|120 Velindre Annual Hand Hygiene|Core	6		2	8	75.0%
120 Research, Development and Innovation Division					
120|LOCAL|120 Velindre Annual Hand Hygiene|Core	5	1	15	21	23.8%
120 Velindre Cancer Centre					
120|LOCAL|120 Velindre Annual Hand Hygiene|Core	362	88	159	609	59.4%
120 Welsh Blood Service					
120|LOCAL|120 Velindre Annual Hand Hygiene|Core	265	15	19	299	88.6%
Grand Total	638	104	195	937	

Figure 11. PPE donning and Doffing Training Compliance

Row Labels	Achieved	Lapsed	Not Achieved	Total required to complete the assessment	Compliance %
120 Corporate Division					
120|LOCAL|120 Velindre Donning and Doffing - 1 year|Core	6		3	9	66.7%
120|LOCAL|120 Velindre Donning and Doffing ASSESSMENT - 1 year|Core	6		2	8	75.0%
120 Research, Development and Innovation Division					
120|LOCAL|120 Velindre Donning and Doffing - 1 year|Core	18	2	1	21	85.7%
120|LOCAL|120 Velindre Donning and Doffing ASSESSMENT - 1 year|Core	15	1	5	21	71.4%
120 Velindre Cancer Centre	746	127	166	1039	
120|LOCAL|120 Velindre Donning and Doffing - 1 year|Core	380	54	92	526	72.2%
120|LOCAL|120 Velindre Donning and Doffing ASSESSMENT - 1 year|Core	366	73	74	513	71.3%
120 Welsh Blood Service	539	18	46	603	
120|LOCAL|120 Velindre Donning and Doffing - 1 year|Core	271	9	23	303	89.4%
120|LOCAL|120 Velindre Donning and Doffing ASSESSMENT - 1 year|Core	268	9	23	300	89.3%
Grand Total	1330	148	223	1701	

Figure 12. ANTT Training Compliance

	Achieved	Lapsed	Not Achieved	Total number required	Compliance %
120 Corporate Division					
120|MAND|Aseptic Non-Touch Technique (ANTT)|Core	1			1	100.0%
120 Velindre Cancer Centre					
120|LOCAL|120 Velindre ANTT - ASSESSMENT General	95	72	28	195	48.7%
120|MAND|Aseptic Non-Touch Technique (ANTT)|Core	175	20	3	198	88.4%
120 Welsh Blood Service					
120|LOCAL|120 WBS ANTT Practical/Theoretical Assessment (CS 083) |Core	133	6		139	95.7%
120|MAND|Aseptic Non-Touch Technique (ANTT)|Core	127	3	6	136	93.4%
Grand Total	531	101	37	669	

In addition, the following developments have also taken place throughout the year:

- The Respiratory Personal Equipment Trainer gained accreditation for 'Fit to Fit' Accreditation. This will enable the Trust to provide robust in-house FIT testing training for Velindre University NHS Trust staff and possibly offer a service nationally.

The Welsh Blood Service developed and delivered a robust training programme that included Hand Hygiene and Donning and Doffing that was delivered within donor facing and laboratory services across Wales to maximise staff education and training opportunities

4.4 <u>Vaccination Programmes</u>

4.4.1 COVID-19 Vaccination programme

The COVID -19 Vaccination Programme was established as part of the All-Wales response to the roll out of vaccinations to frontline NHS staff and the wider population of Wales as the initial ask. However, since the start of 2022 Velindre University NHS Trusts' responsibility to the National Programme remains with staff vaccination.

In line with the national vaccination priorities, the following priority groups were vaccinated by the Velindre University NHS Trust.

- Frontline VUNHST employees

- Frontline Welsh Ambulance Service Trust (WAST) employees

- Other frontline staff groups providing services to NHS Wales patients, including Cardiff and Vale University Health Board staff, third sector and private hospital providers

- Patients of the Cancer Centre who were eligible for the vaccine due to immuno-suppression or because they were included in the 'Clinically Extremely Vulnerable' category.

To support the running of the vaccination clinics, and in line with the approach taken across Wales, it was necessary to establish a workforce to support the whole vaccination pathway. This included the following roles: Clinical Support Assistants, Clinical Supervisors – Immunisations, Immunisation Nurses, Clinical Nurse Educator, Administration Manager, Administration Officer, Application Services Manager, and IT Support Officers.

In total, 233 individuals took part in delivering the COVID-19 vaccination Programme at VUNHST. Multiple departments were also instrumental in contributing to the success of the programme, these included Business Intelligence, Digital Facilities, Estates, Finance, Pharmacy, Stores, Transport and Workforce & OD. Many of these staff offered to assist either by fitting it into their working week or by supporting weekend clinics.

4.4.2 Staff Influenza Vaccination Campaign

The national influenza vaccination programme for the 'at risk' population and front-line health care professionals has been in place for many years. In view of the additional challenges during the winter of 2021, due to a combination of the Influenza and Covid-19 viruses, the Welsh Government advised of the need to increase frontline staff uptake of the Influenza vaccination. Despite this, the national target compliance for frontline staff remained at 60%.

The Influenza vaccine campaign in 2021 involved greater divisional leadership and ownership of the campaign, whilst the Infection Prevention and Control team continued to provide strategic support.

Figure 13. VUNHST Staff Flu vaccination uptake
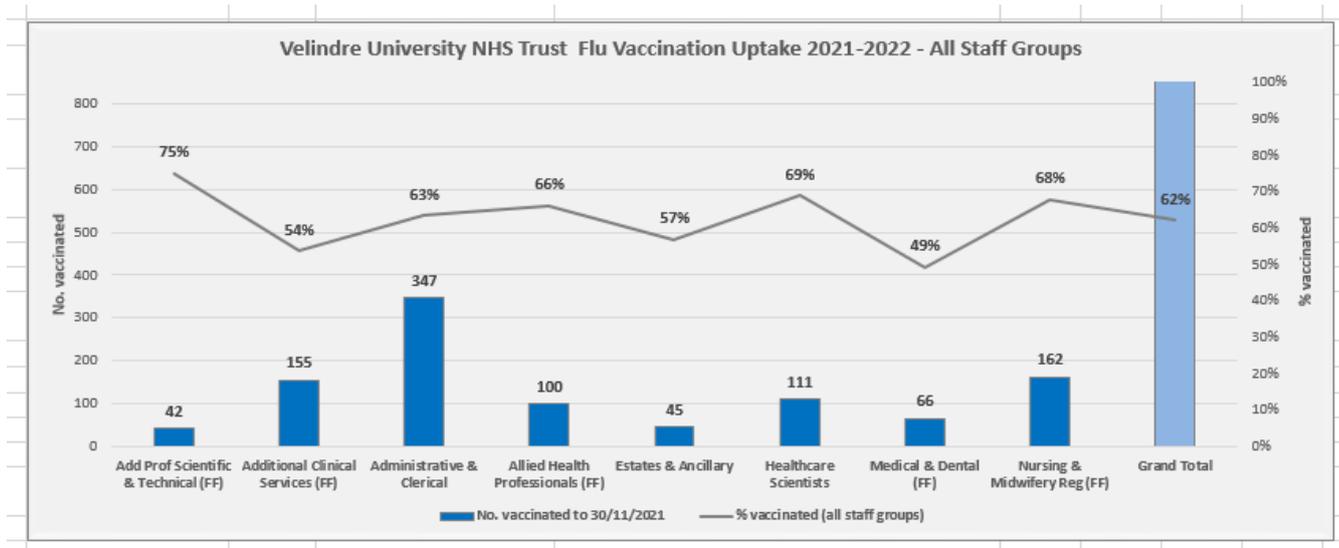
4.5 Antimicrobial Stewardship

The term 'Antimicrobial Stewardship' is defined as 'an organisational or healthcare-system-wide approach to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness' - NICE Guidelines [NG15] - Aug 2015

In particular, Antimicrobial Stewardship aims to:

- Promote the appropriate use of antimicrobial agents

- Improve patient outcomes

- Reduce healthcare associated infections such as Methicillin Resistant Staphylococcus aureus and Clostridioides difficile and

- Prevent antimicrobial resistance

Antimicrobial Stewardship is essential within the Velindre Cancer Centre given the vulnerability of our patient population, especially those on cytotoxic chemotherapy who have a compromised immune system.

One of the practices undertaken across Wales to ensure that good Antimicrobial Stewardship processes are in place is the nationally approved 'Start Smart Then Focus' (SSTF) audit. This is a point prevalence audit that is undertaken in all NHS hospitals across Wales on a monthly basis. It is an audit of the inpatient prescribing of antimicrobial agents, the aim of which is to ensure that prescribing is appropriate, evidence basis, regularly reviewed and does not continue for longer the necessary. The SSTF audit looks at the following measures (*the audit target of 100% compliance for all measures*):

1. Whether the indication for treatment was documented

2. Whether the prescribed treatment was compliant with either local guidelines, based on the results of cultures and sensitives or based on microbiology advise

3. Whether there was a documented review date / stop date on initiation of treatment

4. Whether there was a documented senior review at 72 hours

In Velindre Cancer Centre (VCC), this data is collected by the ward pharmacy team as 'point prevalence' data on a monthly basis. This data is then uploaded onto the Trust Performance

Framework, and reported to both Velindre Cancer Centre Quality and Safety Committees and the Infection Prevention and Control Management Group. The data is also fed into a national database so that benchmarking can be undertaken against other NHS health boards within Wales.

In March 2021, VCC implemented the all-Wales Antimicrobial Review Kit (ARK) Chart as the standard inpatient medication chart across all clinical areas within the cancer centre. This chart encourages these 4 SSTF measures to be completed when antimicrobial agents are prescribed and reviewed. Over the 2021/22 financial year, compliance against these 4 measures has significantly improved when compared to the previous year, and compliance is favourable within VCC when compared to the national average.

The table below identifies current average compliance of SSTF over the year 2021/22.

Table 7. Average compliance of "Start Smart Then Focus"

	VCC average compliance April 2020 – March 2021	VCC average compliance April 2021 – March 2022	National average compliance April 2021 – March 2022
Documented indication for treatment	91.8%	90.2%	91%
Compliant with guidelines / C&S or microbiology advice	92.4%	95.8%	91.5%
Documented review / stop date	72.5%	97.7%	86.7%
Documented senior review at 72hours (if applicable)	65.9%	93.2%	90.8%

Going forward, the pharmacy will continue to collect data, take action when required and feedback to the appropriate medication and infection prevention governance committee's

5. COVID-19 PANDEMIC

The emergence of Omicron (new variant of SARS-CoV2) had a major impact on the services as increased number of staff were reported absent due to either being positive or having close contact with a positive case. Guidance from the Welsh Government kept changing rapidly especially affecting staff dealing with immunocompromised or extremely clinically vulnerable patient population. The IPC and Workforce teams tried their best to keep the staff informed of the changes in national and local guidance to keep them updated. A simple but concise flowchart for staff guidance who are either COVID-19 positive or and contacts of positive cases was created and disseminated through trust intranet page and screensaver.

Regular meetings of COVID response cell as well as Silver and Gold command were held in response to Omicron with representation from IPC team members. COVID-19 surgery continued to be held by Infection Prevention and Control team along with a workforce representative to discuss any issues faced by the trust staff, this service is available for all departmental managers across the Trust.

5.1 Infection Prevention and Control (IPC) Assurance for Velindre

- IPC Board Assurance Framework- Gap Analysis was revised in August 2021 to include updated guidance
- Management Checklist for Welsh Blood Service (WBS) and Velindre Cancer Centre (VCC)
- Champions for donning and doffing, hand hygiene and fit testing rolling out competency assessments which is linked in to ESR for accurate reporting
- Use of MEG audit tool to monitor compliance with Personal Protective Equipment (PPE)
- Webpages refreshed and updated monthly and includes latest 4 Nation Infection Prevention and Control Guidance
- Reviewing the contact tracing assessment pathway for staff contacts to support Regional Test Trace & Protect Service & Velindre Contact Tracing Hub as required.
- Reviewing the pathways for staff who are a confirmed contact of a positive COVID-19 case.
- Continuance of the IPC Newsletter
- Exploring new cleaning technologies

6. OUTBREAKS / INCIDENCES

Although incidental clusters of cases were observed on different occasions they did not meeting the outbreak definition, they were not considered as outbreaks except one COVID-19 outbreak in the First Floor Ward.

6.1 First Floor Ward COVID-19 Outbreak

6.1.1 Outbreak Summary

Between 20th and 30th March 2022, five patients were linked to an outbreak on First Floor Ward at Velindre Cancer Centre. However, following robust review, it was determined that, given timelines: three patients on the balance of probability acquired COVID-19 whilst an inpatient at Velindre (one had parents staying for extended periods due to cognitive ability) and two patients (who were asymptomatic) were likely to have acquired COVID-19 in the community.

Table 8. Criteria for determining if a Covid-19 infection is healthcare-associated

HCAI category	Criteria
Community onset	Positive specimen date ≤2 days after admission to Trust
Indeterminate healthcare-associated	Positive specimen date 3-7 days after admission to Trust
Probable healthcare-associated	Positive specimen date 8-14 days after admission to Trust
Definite healthcare-associated	Positive specimen date 15 or more days after admission to Trust

In addition, between 20th and 27th March 2022, three staff tested positive for COVID-19, all three staff were symptomatic and tested positive on Lateral Flow Test (LFT). One of the three positive staff members had known external factors that could have led to their positive result. COVID samples were not sent for genotyping due to the Omicron transmissibility being the dominant variant.

6.1.2 Control Measures

The following control measures were in place at the time of the outbreak:

- Appropriate environmental cleaning in line with Public Health Wales (PHW) guidance. The nature and frequency of the cleaning regime in place exceeded the Welsh Government guidelines. Regular audits were undertaken by a multi-disciplinary team and no non-compliances were noted.

- Inpatient visiting was in line with PHW / government guidance which was to allow compassionate visiting permitted with prior agreement with the ward/department manager.

- All patients and any relatives were triaged at the entrances to the Cancer Centre. All staff were required to self-test using LFT prior to attending work twice a week. However, for those staff who were working in the outbreak environment, daily LFT tests were introduced for the duration of the outbreak.

- Use of Personal Protective Equipment (PPE) was in line with Welsh Government COVID-19 guidance.

- Monthly hand hygiene audits were completed by departments and daily spot checks undertaken by the Infection Control and Prevention Team and Service Managers. The Infection Control and Prevention Team carried out weekly validation audits during the outbreak, the results of which were fed back at the scheduled outbreak meetings, Infection Prevention and Control summit meetings and the Infection Prevention and Control Management Group.

- Screening of all staff who had contact with patients or attended the ward area within a defined period by testing proactively.

- All patients were tested upon admission (day 1 screen) and isolated in cubicles until a negative result was received and patient not exhibiting any symptoms of COVID-19. A day 5 test was performed to give additional reassurance of the patient's negative COVID-19 status before moving the patient to an open area of the ward.

- Where possible, staff were segregated to minimise cross-contamination, and where this was not possible, there were clear infection control guidance on how to safely manage such situations.

6.1.3 Outbreak Conclusion

In conclusion, the Outbreak Control Group determined that there was a high community prevalence of COVID at the time of the incident. There was robust patient management in place with admissions into a single room only and good compliance with all relevant Infection Prevention & Control measures including hand hygiene and donning and doffing. The training compliance had dipped to below required levels due to high number of new starters but there was no evidence through regular audits that this translated into compliance issues with required standards. There

was good compliance with cleaning standards. The situation was managed well and contained quickly.

On 28th April 2022, the Outbreak Group confirmed that the outbreak had ended in line with national Outbreak Management timescales.

7. <u>SAFE WATER SYSTEM MANAGEMENT, BUILDING ENVIRONMENTAL IMPROVEMENTS.</u>

The Infection Prevention and Control Team and Estates Department have continued to work very closely to maintain high standards of water safety throughout the past year. The Estates Team manage the major water infrastructure services. Both the Welsh Blood Service and Velindre Cancer Centre Trust Water Safety Group meets regularly to discuss progress against the annual water safety plan and any actions in response to positive water samples. Recently the Trust has revised the water safety plans for both sites to ensure that the process and training requirements and relevant appointments for Responsible persons are achieved. Assurance of water safety is reported through the divisional Infection Prevention and Control summit meetings and the Infection Prevention and Control Management Group.

There is an increased risk to patients if the water systems are not managed appropriately i.e. through inconsistent flushing/contamination of outlets, as they are immunocompromised. The Infection Prevention and Control Team have continued to provide clinical advice where required on water sampling regimes/water results and monitoring outlet cleanliness.

Following an increase in positive pseudomonas water samples, work was undertaken with the Operational Services Department to develop an outlet cleaning standard operating procedure, and to train and assess housekeeping staff in its use. Further work has been undertaken to hold an annual refresher training for staff to ensure the standard of cleaning is maintained. Moreover, this has resulted in a significant improvements in water sampling results relating to Pseudomonas.
The Infection Prevention and Control Team have worked closely with the Estates department on several refurbishment projects including
- Pharmacy dispensary refurbishment
- Temporary ward ventilation First Floor ward
- Water services site schematics
- OPD Flooring works
- Decoration to improve environmental improvements.

Furthermore, there will be a IPAC - Estates budget ring fenced this financial year to address environmental recommendations along with a four-year operational plan to target areas within the hospital. Estates are also working closely with specialist estates services to undertake annual verifications of critical air handling plant onsite at VCC. All aspects of compliance are being looked at on AHU's and recommendations made by SES will be addressed under this year's estates discretionary budget allocation.

8. <u>DECONTAMINATION</u>

Healthcare organisations have a duty of care to patients, their workforce, and the public to ensure that a safe and appropriate environment for healthcare is provided.

The Welsh Government Welsh Health Circular (WHC/2015/050) issued a Decontamination Improvement Plan for organisations across Wales in order to ensure that re-usable medical

devices are safe for use on a patient and for staff to handle without presenting an infection risk. The planned Endoscope Decontamination audit assessing compliance for decontamination of flexible endoscopes and non-lumen probes has been postponed due to the COVID-19 pandemic and will be arranged for 2021-2022.

In 2019, the Welsh Government Peer audit of Decontamination of medical devices audit team recommended the implementation of automated technology systems for the decontamination of the ultrasound probes in order to increase and ensure compliance against the decontamination standards specified in the Welsh Health Technical Memorandum 01-06, (Decontamination of flexible endoscopes). These, gold standard, systems are now in place in in the Cancer Centre and the processes are embedded.

The Service Level Agreement with Cwm Taff Bro Morgannwg Health Board continues for the Welsh Blood Service whereby sterile items are decontaminated at Royal Glamorgan hospital.

Members of the Infection Prevention and Control Team will be undertaking Decontamination training during 2022, to provide additional resilience within the team on this aspect of the Infection Prevention and Control work.

9. <u>POLICY DEVELOPMENT</u>

Infection Prevention and Control policies that were required to be revised, have been revised and reviewed during 2021-22, in line with the Trust's Policy Management programme. The following policies were revised during the year 2021-22 and uploaded to the intranet after completing the governance process and approval by relevant groups/committees:

- IPC 01 Viral Gastro-Enteritis (Including Norovirus) policy
- IPC 04 Decontamination of Equipment policy
- IPC 07 Prevention and Control of Methicillin Resistant Staphylococcus Aureus (MRSA)

10. <u>ICNet PDATE</u>

ICNet is an electronic surveillance software product that connects clinical data systems in healthcare facilities to provide a unified solution for infection prevention and surveillance staff and was awarded the contract for implementation across Wales.

A Project Implementation Group has been established and a risk assessment undertaken to address concerns of duplication of data entry as unfortunately ICNet doesn't interface with the Cancer Network Information System Cymru. The transition of the Cancer Network Information System Cymru (CANISC) with the Welsh Clinical Portal has been delayed however once this has been completed, the ICNet interface risk will resolve.

11. INFECTION PREVENTION AND CONTROL AWARENESS CAMPAIGNS

11.1 Infection Prevention and Control Newsletter for staff

The frequency of the Infection Prevention & Control newsletter was increased to daily, then weekly during the height of the second wave of the COVID-19 Pandemic, but it has now returned to monthly.

The aim of the newsletter is to raise awareness and reinforce the importance of infection prevention and control, and to raise awareness on a variety of key topics, during 2021 – 2022, this was primarily focussed on COVID-19 and the recommendations from national guidance.

The newsletter has been well received by staff with suggestions for topics for future issues.

11.2 Celebration of Global Hygine Day: 5th May 2021

Global Hygiene Day serves as a yearly reminder that hand hygiene is one of the best steps, we can take to avoid getting sick and spreading germs to others, and the COVID-19 virus has highlighted the importance of hand hygiene. On 5th May each year the World Health Organization (WHO) celebrates the SAVE LIVES: Clean Your Hands campaign and aims to maintain a global profile on the importance of hand hygiene in health care and to 'bring people together' in support of hand hygiene improvement globally.

This year the focus is on achieving appropriate hand hygiene action at the point of care. This has been at the core of the WHO infection prevention and control and patient safety strategies for many years but is now more critical than ever. This means to practice hand hygiene when it is needed (at 5 specific moments) and in the most effective way (by using the right technique with readily available products) to prevent transmission of infectious microorganisms (germs) during the sequence of health care delivery. In 2021, the Infection Prevention and Control team built upon the existing hand hygiene promotion initiatives in the context of COVID-19, while maintaining the focus on staff and patients.

11.3 International Infection Prevention Control week: 17th – 23rd October 2021

In October 2021, we celebrated International Infection Prevention Control Week to highlight the importance of Infection Prevention and the vital work that we are part of to prevent and control healthcare associated infection, including COVID-19.

The theme this year is to raise awareness and celebrate infection preventionists and all they do to prevent healthcare-associated infection, and for Velindre University NHS Trust that means protecting patient, donor and staff health. You may be wondering: what is infection prevention? Who are infection perfectionists? And what do they do? Well, hopefully I can answer some of these questions. The IPC team worked with our company representatives to be able to give staff a bag with pens, 'post it' notes, sweets, and alcohol hand gel as a thank you for their hard work and their continued commitment.

12. CONCLUSION

The data contained within this report demonstrates that despite the challenges posed by the ongoing COVID-19 pandemic, over the past year, there have been continued and sustained improvements in the reduction of healthcare associated infections at the Trust.

There has been strong leadership shown by all, including the Infection Prevention and Control Team, Divisional Management Teams and staff at all levels, who have risen to the numerous daily challenges as the COVID-19 pandemic developed and progressed. There has been excellent collaboration across all teams, with great examples of cross divisional working.

Despite the considerable challenge of the past year, there have also been many positives elements. The most striking is that it is now widely accepted that infection prevention is "everyone's business", and everyone's responsibility, not just the Infection Control Team. We will work to ensure that this ethos continues into 2022 – 2023 and beyond.

13.   PRIORITES FOR 2022-2023

Despite the COVID-19 Pandemic, the Trust's Infection prevention team have worked with the Clinical Teams to maintain good levels of compliance with all the national infection control quality standards and metrics. However, the team remains committed to ensuring that further progress is made. The Team's priorities for the year ahead includes the following:

- IPC has a role in the Nosocomial Scrutiny Panel which is a part of the national investigation/inquiry work

- Continue to be proactive in the COVID-19 Pandemic response, and to prepare for potential further waves, whilst ensuing that learning from previous waves is embedded

- Along with the wider senior team, to support the Trust's Vaccination programme; which includes building on the successes of the Influenza staff vaccination campaign and the COVID-19 booster vaccination.

- Review and update the Gap Analysis against the Public Health England Infection Prevention and Control Board Assurance Framework, and to undertake any required actions

- Further enhance the Trust's Infection Prevention & Control Assurance / Accountability framework

- Continue to increase engagement and collaboration with Infection prevention and control agenda within all divisions of the trust

- Continue to roll out Environmental audits at the Welsh Blood Service

- Work with Public Health Wales to enhance the level of support from the Consultant Microbiologist

- Lead on the sustained reductions in healthcare associated infections within the Trust

- Continue to utilise ICNet and plan to fully transition to the Wales Patient Access Scheme

- Continue to support the Antimicrobial Pharmacist with implementing strategies to further promote Antimicrobial Stewardship
- Work collaboratively to support the Sepsis agenda across the Trust

- Explore ways to improve levels of training across the organisation

- Effectively contribute to refurbishment projects and water management and safety across the Trust, including supporting the design process of the new Velindre Cancer Centre. As well as working in-line with HTM (Health Technical Memoranda) specifications, the work will involve refreshing clinical specifications to reflect the impact of the COVID-19 Pandemic. Work with Digital Nursing team to develop Tendable audit tool for environmental audits.

- Implement the Massive Open Online Course (MOOC) IPC Level 3 training and the national work on how IPC teams should look anywhere?

- Support the de-escalation plans and to remove restrictions that have been in place.

TRUST BOARD

ANNUAL REPORT 2021-2022

DATE OF MEETING	28.07.2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Sarah Morley, Exec Director of OD and Workforce
PRESENTED BY	Sarah Morley, Exec Director of OD and Workforce
EXECUTIVE SPONSOR APPROVED	Sarah Morley, Executive Organisational Development & Workforce

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME
Local Partnership Forum	05/07/2022	Endorsed for approval
Quality, Safety and Performance Committee	14/07/2022	Approved

ACRONYMS	
LPF	Local Partnership Forum

1.   SITUATION/BACKGROUND

1.1 In accordance with Standing Orders and the Trust's Scheme of Delegation, the Board requires the LPF to provide an Annual Report.

1.2 The LPF Annual Report reflects the fora's role and functions and summarises the key areas of trade union partnership activity, undertaken by Velindre NHS Trust between April 2021 and March 2022.

1.3 The Report also highlights the key issues which the LPF intends to give further consideration to over the next 12 months.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The Annual Report has been produced to ensure compliance with the fora's requirement to report retrospectively on its activities during the previous financial year and to highlight key areas for its work programme, for the forthcoming financial year.

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

4. RECOMMENDATION

4.1   The Trust Board is asked to **CONSIDER** and **APPROVE** the content of the 2021 – 2022 LPF Annual Report.

LOCAL PARTNERSHIP FORUM

ANNUAL REPORT

APRIL 2021 – MARCH 2022

1. **Introduction**

   This report reflects the Local Partnership Forum's (LPF) role and functions and summarises the key areas of trade union partnership activity, undertaken by Velindre University NHS Trust between April 2021 and March 2022. It highlights some of the key issues which the Local Partnership Forum intends to give further consideration to over the next 12 months.

2. **Role and Responsibilities of the Local Partnership Forum**

   The LPF is the formal mechanism within the Trust where trade unions work together with the management of the Trust, to engage, inform, debate and agree local priorities, in respect of workforce and Trust related issues. The broad term used to describe this is "partnership working". All members of the LPF are full and equal members and collectively share responsibility for the decisions made by the forum.

   The LPF provides the formal mechanism for consultation, negotiation and communication between the staff representatives and management. The Trust involves staff representatives in policy formulation, implementation and evaluation at a strategic and operational level and in service decisions, problem solving, service planning, local management meetings and communications. At the earliest opportunity, the organisation engages with staff representatives in all key discussions and decision making processes. The LPF adheres to the principles and best practice of partnership working, as derived from '*Partnership Agreement. An agreement between Department of Health, NHS Employers and NHS Trades Unions*'.

3. **Purpose of the Local Partnership Forum**

   The purpose of the LPF is to:

   - engage staff, through their representatives, in the key discussions and decisions taking place at senior levels and to provide Trade Union representatives with an opportunity to contribute to decisions of the Trust;
   - enable management and staff representatives to propose and discuss issues which affect the workforce;
   - provide opportunities for unions to contribute to the Trust's service delivery plans at an early stage and to consider implications for staff of service reviews and/or organisational change;
   - discuss and to appraise in partnership, the Trust's services and activities against performance targets and to discuss proposals to address resultant issues;
   - appraise the trade unions of the financial performance of the Trust;
   - inform of any intention by the Trust to begin formal consultation on any issue affecting individual departments or services.

4. **Duties of the Local Partnership Forum**

   The LPF provides the formal mechanism for consultation, negotiation and communication between the recognised trade unions, their members and management of the Trust.

   The scope of the LPF is limited to staff and service issues, under the scope of the Trust.

5. **Local Partnership Forum Agenda Planning Process**

The LPF Management Chair (in the absence of a Joint Chair) draws up the final agenda, in partnership. The venues, locations and other administrative arrangements are organised a year in advance by the Workforce and OD Department.

The secretariat for the meeting is provided by the Business Support Officer to the Executive Director of OD and Workforce.

The agenda and papers are disseminated to LPF members at least seven days before the date of the meeting. Where appropriate all papers are accompanied by a cover sheet, which provides an executive summary and guidance to the LPF on the action(s) required.

6. **Local Partnership Forum Operating Arrangements**

The LPF has in place agreed terms of reference and operating arrangements. These were reviewed and approved in September 2021. In accordance with Trust governance arrangements the terms of reference and operating arrangements for the LPF will be reviewed on an annual basis.

7. **Local Partnership Forum Membership, Frequency and Attendance**

All members of the LPF are full and equal members and share responsibility for decisions made by the forum. Unions represented at the Local Partnership Forum are; Unison, Unite, RCN, GMB, SOR and MIP, acting as the coordinators of representative views within the Trust.

Trade union representation at the LPF allows for representatives from each recognised trade union, from each division of the Trust, to represent the interests of their members. Representation should reflect the distribution and staff groups employed within the Trust's workforce. None of the Trust's hosted organisation's trade union representatives attend the Velindre University NHS Trust LPF. It should be noted that NHS Wales Shared Services Partnership has an active and engaged local LPF.

All Trust trade union representatives are nominated via their trade union, from the membership in their Division. Union representatives must be employed by Velindre University NHS Trust, and be accredited by their respective trade union organisation. If a representative ceases to be employed by the Trust, then they automatically cease to be a member of the LPF. Full time officers of trade unions may attend Local Partnership Forum meetings.

The management representatives are drawn from members of the Executive Management Board, Velindre Cancer Centre and Welsh Blood Service Senior Leadership Teams and the Workforce & OD function.

Meetings are held on a quarterly basis or as and when the group determines necessary. Every effort is made by all parties to maintain a stable membership of the LPF. There should be at least three management and three trade union representatives for the meeting to be

quorate. If the meeting is not quorate, information may be exchanged but decisions cannot be made.

During this time period the LPF met on the following 4 occasions.

> ➢ 2nd June 2021
> ➢ 1st September 2021
> ➢ 1st December 2021
> ➢ 2nd March 2022

8. **Review of Local Partnership Forum Activity**
The LPF fulfilled its work plan for the reporting period 2021 / 2022, covering a wide range of activity and focussing on Trust Strategic and Operational issues. Examples of some of the work undertaken in partnership are summarised below:

- **Health and Wellbeing**
The LPF received regular updates on the Health and Wellbeing activity across the Trust along with engagement work that has taken place to ensure this met the needs of staff.

- **Agile Working Programme**
The LPF received regular updates on the progress the Trust was making in developing its approach to agile / hybrid working through its Agile Working Programme.

- **Gender Pay Gap Report**
The LPF received, discussed and noted the content of the Trust's updated Gender Pay Gap Report.

- **IMTP General and WOD Specific 2022 / 2025 Updates**
The LPF received regular updates on the IMTP submitted to the Welsh Government and the planning process and development of the 2022 IMTP. The LPF discussed how the Trust should share this information with staff representatives. Staff representatives were encouraged to engage in this process, particularly in the development of the Workforce and OD IMTP elements, to offer further suggestions on the best methods to engage with them in these important discussions.

- **People Strategy**

The LPF received details of the Trust People Strategy at different stages of its development and had the opportunity to comment on proposed content of the strategy.

- **Violence and Aggression**
The LPF received a presentation on the Anti Violence Collaborative and the subsequent Obligatory Responses to Violence and Aggression paper. At the subsequent meeting of the LPF in March 2022 the LPF received an update on the Trusts response to the actions outlined in the paper by the Trust Health and Safety Manager.

- **NHS Wales and Velindre University NHS Trust Workforce Policies**

The LPF were encouraged to comment on new and revised Trust workforce policies and note their approval via this group. This group were also informed of NHS Wales Workforce policies which were approved for implementation via the Quality, Safety and Performance Committee.

- **Divisional Updates**

The LPF were provided with regular updates in respect to workforce activity and data from both operational Divisions. This supplemented the discussions held at both Divisional Partnership Fora.

- **Disclosure and Barring Project Update**

The LPF received details of a Trust project to ensure appropriate DBS checks had been carried out across the organisation. LPF was updated on details of the project as it progressed.

- **Trade Union Updates**

The LPF informed the Trust that it was concerned about the way in which partnership working was being undertaken by some senior managers in the organisation. Concern was also expressed about the way in which certain concerns that had been raised by Trade Union colleagues had been dealt with by the organisation. Updates were also received from Trades Union colleagues on national issues as they emerged.

- **Industrial Relations and Partnership Working**

At the June 2021 LPF a decision was made to investigate the opportunity to undertake formal development of partnership working relationships via the Involvement and Participation Association that had recently delivered workshops to support national partnership working arrangements. This followed a conversation that took place at March 2021 LPF around the partnership working relationship; highlighting pinch points as well as identifying ways forward to ensure the positive working relationships already established continue. These workshops were subsequently held in October 2021, were well received and culminated with a Partnership Working Action Plan being developed.

- **Living Wage**

Discussions were ongoing in LPF around the contracted staff and the assurance of living wage remuneration. This work requires changes to contractual arrangements for contracts held by NWSSP. LPF was updated that work is continuing with procurement colleagues and the Trust.

9.   **Engagement with LPF members**

LPF has provided the opportunity to inform, discuss and appraise trade union representatives on the following issues over the past 12 months:

- progress being made against the VCC Transforming Cancer Services Programme;

- updates and briefings on the Trust's IMTP and the Workforce and OD element of the IMTP;
- updates on the implementation of the Education Strategy;
- updates on Welsh Language standards implementations;
- discussions on Trust's Workforce Metrics, in relation to sickness absence, PADR and statutory and mandatory training compliance;
- updates on the Trust's financial performance; and
- updates on the Trust's work in developing Velindre Futures.

10. Reporting and Communication

The LPF's papers, including the minutes from all the meetings are routinely available for LPF members to view.   A highlight report from the LPF is submitted to the Trust Board for information / noting etc. as appropriate.

11. Conclusions and Way Forward

The Executive Management Board and the Senior Management Teams are very grateful for the engagement and participation of trade union representatives, in the activities of the LPF and other Trust meetings and activities. The positive and constructive way in which they have contributed has enabled the Trust to meet and deliver on its organisational objectives.

The next 12 months again provides an opportunity for the LPF to continue to build on this year's successes, in addressing new and emerging workforce and service priorities.

12. Future Proposed Activity

The LPF has agreed to undertake the following key actions, as identified in the Working in Partnership Action Plan, over the course of the next 12 months:

- To work to the agreed cycle of business work plan in year. This approach will ensure that the LPF monitors progress against the identified work areas. It will also ensure that there is clarity for LPF members in respect of who is required to contribute to the agenda and what is expected of them and when

- To collaborate with Velindre University NHS Trust management and local and national trade union representatives and officers, to organise recruitment days (with management support), to attract new representatives on a regular basis;

- To collaborate with Velindre University NHS Trust Healthy and Engaged Steering Group to support the Trust's Health and Wellbeing Plan

- To work in partnership with the Trust via the Hybrid Working Group to shape news ways of working following the COVID pandemic, to support the safety and wellbeing of all staff

- To actively encourage Trade Union representatives to provide regular updates during the LPF meetings and actively engage them to participate in the agenda discussions, to ensure that their member's voice is heard in this fora.

TRUST BOARD

TRUST QUALITY & SAFETY FRAMEWORK

DATE OF MEETING	28th July 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Jade Coleman, Quality & Safety Officer Nicola Williams, Executive Director Nursing, AHP & Health Science
PRESENTED BY	Nicola Williams, Executive Director Nursing, AHP & Health Science
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director Nursing, AHP & Health Science

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME
Executive Management Board	22/05/2022	Endorsed for submission to Quality, Safety & Performance Committee
Quality, Safety & Performance Committee	14/07/2022	Endorsed for submission for Board approval

1. SITUATION

The Trust 2022-2024 Quality & Safety Framework is provided to the Trust Board for **APPROVAL.** Once approved an easy read version will be produced, the framework will be translated into Welsh and published on the Trust website.

2. BACKGROUND

The Trust has been developing its Quality & Safety framework over the past two years. The development of the framework was significantly impeded by the pandemic. Significant consultation took place prior to commencing framework development and during 2021 on the draft framework. A number of changes were made to the framework as a direct result of this consultation.

In September 2021 Welsh Government published the National Quality Framework. The Trust Quality & Safety Framework has been developed in line with the national framework requirements. In addition, the framework has been based on the requirements of the Wales Health & Social Care, Quality & Engagement Act (2020).

3. ASSESSMENT

3.1 Trust Quality & Safety Framework

The Trust proposed Quality & Safety Framework is attached in *Appendix 1*.

The statutory documents for the Duty of Quality & Duty of Candour are being consulted on from August 2022. This framework will need to be reviewed once these are finalised. In addition, the Trust has engaged with the IHI who are undertaking a foundation safety visit on the 20th & 21st July 2022. The outcome of this visit will also be fed into a future framework review. It is therefore proposed that this review is undertaken during 2023 to ensure the framework remains live and relevant.

The framework was endorsed by the Quality, Safety and Performance Committee. Following this some additional Welsh Blood Service examples have been included in section 6.

3.2 Quality Improvement Goals 2022/2023

As outlined in the Trust's Quality & Safety Framework each year the Trust will by the 31st January agree the Quality Improvement Goals for the forthcoming year. These will be

determined following detailed triangulated analysis and consultation with staff annual quality improvement goals approved at the start of each financial year. The Improvement Goals will be determined through the Quality & Safety Governance Group, Clinical & Scientific Strategic Board and the Executive Management Board and approved through the Quality, Safety & Performance Committee. These will form part of the organisational priorities within the IMTP.

The Quality Improvement Goals will be reviewed each year and will be included as part of the IMTP process. The 2022/23 Quality improvement Goals have been determined through Executive level prioritisation pending the Quality Framework being finalised and are a feature of the post pandemic recovery priorities facing the organisation in addition to the quality & safety framework critical infrastructure work that is required. For 2022 /2023 the proposed Quality Improvement Goals are:

- Revised brachytherapy service delivery specification that meets predicted demand, is resilient and benchmarks favourably in terms of outcomes and experience with other brachytherapy providers across the UK.
- SACT service redesigned to meet predicted demands ensuring all SACT delivered within clinical required timescales and benchmarks favorably with other international SACT services.
- Radiotherapy service redesigned to meet predicted demands ensuring Radiotherapy is delivered within clinical required timescales and benchmarks favourably with other international Radiotherapy services.
- VCC Telephone helpline review to ensure patient needs are being met, national standards delivered and the previous improvement plan fully implemented (unless superseded).
- Implement SaBTO recommendations for detection of Occult Hepatitis B Infection in donors to further reduce risk of Hepatitis B transmission through blood transfusion.
- Blood collection delivery post pandemic redesign (including staffing model redesign) ensuring service can meet demand predicted demand for blood & blood products.
- Velindre Cancer Centre meeting the national consent standards 100% of the time.
- Ensuring the Cancer Service is able to respond appropriately & timely to the deteriorating patient (adult & child).
- Fully functioning Quality Governance Group that provides triangulated quality, safety, outcome, experience and governance assurance & exceptions to Executive Management Board and Quality, Safety & Performance Committee.
- Fully established and functioning Corporate and Divisional Quality Hubs.

Each Quality Improvement goal will be managed through a defined project with an identified operational lead and Executive Director Sponsor. The Outcomes to be achieved by year end will be agreed and a delivery plan developed. It is proposed that these will

be monitored through relevant Quality Hubs and by exception through to Executive Management Board and quarterly to Quality, Safety & Performance Committee.

3.3 Quality & Safety Framework Implementation plan

It is recognised that implementing this Quality Framework will take time. Work undertaken over the last three years has laid some of the foundations for this work both culturally and organisationally but significantly more development is required. This work is crucial if the Trust is to meet the legislative requirements set by the Wales Quality & Engagement Act (2020) and National Quality Framework (2021). It is also recognised that this framework will needed to be both formally evaluated and reviewed in 2023 upon publication of the final Duty of Quality & Duty of Candour statutory guidance. Funding has been secured for a one Year Quality Framework Implementation lead to support the organisation in the work required to make this framework a reality.

The Implementation plan is attached in *appendix 2*.

3.4 Quality & Safety Framework Evaluation

The Quality Framework implementation approach will be evaluated by Internal Audit during 2022/23 Quarters 3 & 4 and through an externally commissioned peer review in 2023. The 2022/23 Internal Review will guide any refinements to the implementation plan and approach.

The 2023 Peer Review will be used as part of the Framework implementation assurance mechanisms as well as be used to inform the review of the framework that will need to be completed by 2024.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
RELATED HEALTHCARE STANDARD	Safe Care
	Applicable to all Health & Care standards
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	There will be adverse legal implications in the event of Trust not meeting its quality & safety responsibilities
FINANCIAL IMPLICATIONS /	Yes (Include further detail below)

IMPACT	There will be resource requirements to meet this framework responsibilities within divisions and corporately. Resources agreed re restructuring of corporate Quality & Safety Team. Resource requirements within VCC require quantifying

5.   RECOMMENDATION

The Trust Board is asked to **APPROVE** the 2022-2024 Trust Quality & Safety Framework.

Velindre University NHS Trust Quality and Safety Framework 2022 - 2024
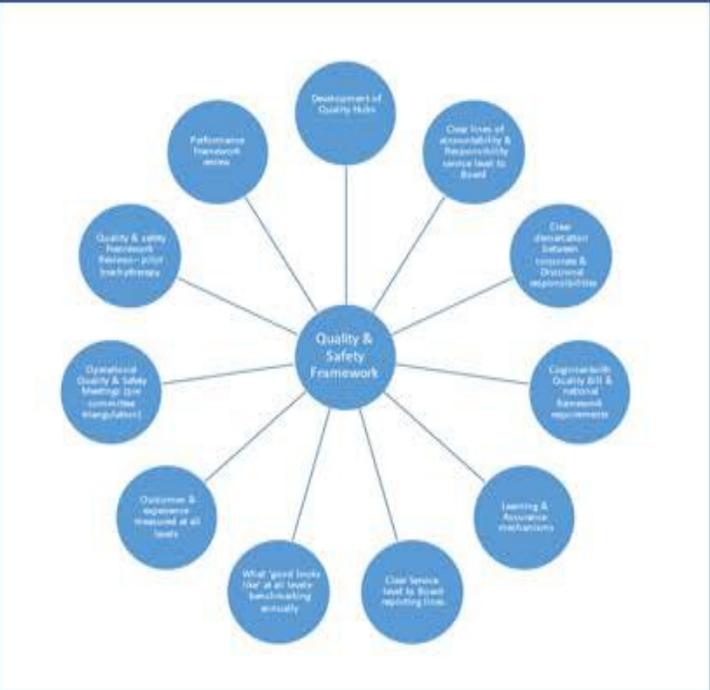
"Putting quality, patient / donor safety and experience firmly at the heart of everything we do, and all decisions made, that enables the active involvement of both the people who receive care / services and those who provide it, and a relentless focus on learning and improvement"

FOREWORD

Velindre University NHS Trust ("the Trust") provides specialist non-surgical cancer and blood services (Velindre Cancer Service) and Blood, Blood and transplantation products (Welsh Blood Service). In addition, the Trust Hosts Health Technology Wales and NHS Wales Shared Services Partnership. Our staff are highly motivated, and work tirelessly to provide high quality, responsive services to patients and donors. Our research is world class, and many of our clinicians and scientists are leaders in their field with international reputations.

Velindre University NHS Trust Quality and Safety Framework (2022 – 2024) provides the framework and mechanism through which the Trust will meet its Quality and Safety responsibilities as outlined in the Health & Social Care (Quality and Engagement) Wales Act 2020 and NHS Wales Quality and Safety Framework – Learning & Improving (2021). The framework has been developed in line with the Institute of Medicines (1999) six domains of quality: safe, effective, person-centred, timely, efficient and equitable and sets the structure for embedding quality, safety, outcomes, experiences and learning from service level to Board across all areas of the Trust. *This framework will be further refined during 2023, to reflect the requirements of the Duty of Quality statutory guidance that will be published later this year.*

Velindre University NHS Trust Quality & Safety Vision: 'All Velindre University NHS Trust staff put quality, patient / donor safety and experience firmly at the heart of everything they do, and all decisions made, that enables the active involvement of both the people who receive care / services and those who provide it, and a relentless focus on learning and improvement.'

The Trust is also committed to achieving the vision clearly articulated in 'A Healthier Wales' (Welsh Government 2018) the Welsh Government's long-term plan for health and social services in Wales. It sets out the vision of a 'whole system approach to health and social care' which is focused on health and wellbeing, and on preventing physical and mental illness.

Every day more than a million people are treated safely and successfully in the NHS. However the advances in technology and knowledge in recent decades have created an immensely complex healthcare system. This complexity brings risks, and evidence shows that things will and do go wrong in the NHS; that patients and donors are sometimes harmed no matter how dedicated   and

professional the staff. The effects of harming a patient are widespread. There can be devastating emotional and physical consequences for patients and their families. For the staff involved too, incidents can be distressing, while members of their clinical teams can become demoralised and disaffected. Safety incidents also incur costs through litigation and extra treatment. Patient safety concerns everyone in the NHS, whether you work in a clinical or a non-clinical role.

Understanding 'what good looks like', measuring progress in delivering it, together with systematic benchmarking and robust systems for learning and improvement will form the basis of our approach. Using staff, donor and patient experience as indicators to ensure good quality outcomes for our patients / donors. Continuous improvement in quality is key to making the Trust fit for the future and one which achieves value.

The Trust has long standing values that are at the core of this framework. The other critical element is delivering through a compassionate leadership style. The COVID pandemic has given us both challenges and opportunities as an organisation and has had a considerable impact on our staff. Staff wellbeing and support is imperative, as our staff are our most important asset.

The Velindre University NHS Trust Strategy 'Destination 2032' sets out the Trusts' five strategic goals. Although all 5 strategic goals align to this framework this framework is a key enabler for the delivery of Goals 1 and 2.
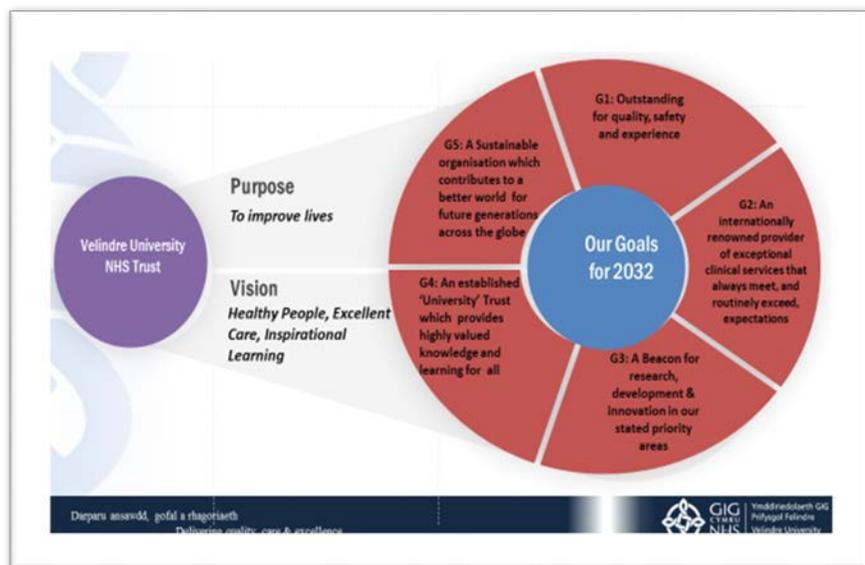
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"Velindre University NHS Trust staff put quality, patient / donor safety and experience firmly at the heart of everything they do, and all decisions made, that enables the active involvement of both the people who receive care / services and those who provide it, and a relentless focus on learning and improvement"

Strategic Goal One:
Outstanding for quality, safety & experience

Our objectives are to:
- provide harm free care, the best outcomes and a great patient and donor experience
- listen to, and learn from, patients and donors experiences of our care to drive continuous improvement
- be an organisation which consistently demonstrates Compassionate Leadership in everything we do
- be recognised as 'outstanding' by Health Inspectorate Wales, the Medicines and Healthcare products Regulatory Authority and by UK and international peers for the services we provide

We will achieve these by:
- implementing the requirements within the Health and Social Care Quality and Engagement Act
- implementing a quality and safety management framework which will drive every action we take and decision we make
- delivering the national programme for Compassionate Leadership across the organisation.
- continuing the development of a quality led culture which drives the highest standards of care and safety and ensures all staff live the ethos that 'the standard you walk past is the standard we set'.
- getting the basics right by improving access and transport to our services; reducing the need for journeys for care and improving car parking and public transport if you have to visit us
- continuing to develop an open, transparent, just and learning culture which allows excellence to flourish
- Developing a value based healthcare programme which supports us in reducing unwarranted clinical variation and inefficiencies, using best practice as our benchmark.
- providing staff with education, training and support to develop improvement skills and knowledge which drive quality and safety standards
- developing our performance management framework to report our performance on quality, safety and experience in an uncomplicated way which everyone can easily understand and see how we are doing
- benchmarking the quality, safety and experience of our services nationally and internationally to identify learning and improvement

Strategic Goal Two:
An internationally renowned provider of exceptional clinical services that always meet, & routinely exceed expectations

Our objectives are to:
- achieve national and internationally recognised standards of care which keep pace with emerging evidence
- be a trusted and influential partner across Wales to deliver great local health services which meet need
- become a 'centre for excellence' and leading provider across the UK for the highly specialist services we deliver
- become a system leader in our areas of expertise, nationally and internationally
- identify a range of new services that the Trust could deliver to improve quality, experience and outcomes across Wales

We will achieve these by:
- applying the National Clinical Framework to the services we provide to improve their quality and the outcomes of them
- implementing our patient/donor/citizen engagement strategy which improves our ability to have conversations with people to understand their needs
- co-designing models of care in partnership with people from all parts of the communities we serve with the aim of providing care at home or close to home wherever appropriate and desired
- delivering services which comply with all statutory legislation and reduce inequalities in healthcare
- rapidly adopting evidence-based research outcomes which improve patient and donors quality, safety and experience of care
- developing and implementing our clinical and scientific strategies which will set out what services we will deliver over the next ten years; focusing our offer on delivering services that we believe we can truly become leading experts in
- agreeing with our Local Health Board partners and the Welsh Government the system leadership roles we will undertake to maximise the value we can add for our patients, donors and partners
- Working with the Welsh Government and other partners to plan, fund and deliver world class buildings, facilities and technology for patients, donors and staff
- benchmarking our performance nationally and internationally to see how we perform against our peers and to identify learning and improvement

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Velindre University NHS Trust staff put quality, patient / donor safety and experience firmly at the heart of everything they do, and all decisions made, that enables the active involvement of both the people who receive care / services and those who provide it, and a relentless focus on learning and improvement.

1. FRAMEWORK AIMS

This framework is developed to support the Trust in delivering its Quality and Safety vision and to meet its responsibilities in relation to the Health and Social Care (Quality and Engagement) (Wales) Act 2020 and the NHS Wales Quality & Safety Framework: Learning & Improving (Welsh Government 2021).   In order to achieve this, the framework will:

- Articulate the expectations of the Board in relation to quality and patient / donor safety
- Improve the provision of safe care through clear lines of communication and reporting from service level to Board and Board to service level
- Provide clarity of roles, responsibilities and lines of reporting in respect of Quality, Safety and Experience
- Provide a structure within which Corporate Services, Divisions, Departments and teams can:
  - Engage and actively listen to donors, patients, their families, staff and other key stakeholders to improve experience, outcomes and therefore efficiency
  - Empower everyone to put quality and patient safety at the heart of everything they do, ensuring quality drives delivery of care to improve experience and outcomes
  - Promote a quality and patient / donor safety focused culture in all aspects of care delivery they are responsible for and beyond
  - Clearly articulate a common understanding and ownership in relation to their individual and collective role, responsibility and accountability related to quality and patient / donor safety
  - Be sufficiently aware of potential risks to quality in delivery of safe and effective care
  - Demonstrate effective processes for escalating, investigating, managing and reporting on concerns about quality and patient / donor safety
  - Use triangulated data to drive quality improvement, ensuring issues of equity are also identified and where appropriate addressed

This framework will use the six domains of Quality as defined by the Institute of Medicine (1999) as its core delivery mechanism:

Safe: Avoiding harm to patients / donors from the care / services intended to help them

Effective: Providing services based on scientific and evidence based knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively)

Patient / donor centred: Providing care that is respectful of and responsive to individual patient / donor preferences, needs, and values and ensuring that patient values guide all clinical decisions

Timely: Reducing waits and sometimes harmful delays for both those who receive and those who give care / services

Efficient: Avoiding waste, including waste of equipment, supplies, ideas, and energy

Equitable: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status

2. NATIONAL STRATEGIC BACKGROUND

There is a considerable amount of legislation, national frameworks and best practice guidance documents that have supported the development of this Framework. These are set out in *Appendix 1*. There are two recently published documents that have set the direction for this framework:

- *The Health and Social Care (Quality and Engagement) (Wales) Act 2020 –* Aims to improve the quality of health services and ensure the citizens of Wales are kept at the heart of ever-improving health and social care services. The Act requires NHS Wales heath bodies to secure quality in health services and to exercise their functions with a view to securing improvement in the quality of health services, encompassing reference to service quality improvement and outcomes in its decision-making. The Act has four main objectives:

  - Greatly **strengthen the existing duty of quality** on NHS bodies and extend this to Welsh Ministers (in relation to their health service functions). The Trust must exercise its functions with a view to securing improvement in the quality of health services. Quality is described as:
    - ➤ The effectiveness of health services
    - ➤ The safety of health services
    - ➤ The experience of individuals to whom health services are provided;

  - **Institute a duty of candour** - requiring NHS bodies to be open and honest with patients and service users (including donors) as soon as they are aware that things have gone wrong, or may have gone wrong, with their care or treatment.

7

- Strengthen the voice of citizens, by replacing Community Health Councils with a new, **all-Wales Citizen Voice Body** to represent the views and interests of people across health *and* social care; and,

- Enable the ***appointment of vice chairs for NHS Trusts***.

3. ROLES & RESPONSIBILITIES

3.1 Employee Responsibilities

Enabling clinical leadership at every level is key to safe, quality care (Kings Fund, 2015) and ensures activities that promote positive cultures in order to enhance outcomes. It is essential that individual and collective roles and responsibilities related to quality and patient safety are explicit, in order to ensure that quality and patient safety are maintained at the heart of all of the Trust activities, wherever they are undertaken. Trust leadership style required to deliver safe and effective care is that of kindness and compassion so that staff undertake their roles feeling empowered, engaged and psychologically safe. Every employee from service level to Board has a pivotal role in ensuring patient / donor quality and safety, learning and improvement and we therefore require that:

Individual members of staff
At all times, put quality, patient /donor safety and experience, learning and improvement at the heart of everything you do and all decisions made, working within the Trusts values and behaviours, regulatory Codes of Conduct and legislation i.e. Putting Things Right, Wales Quality Bill, working within relevant policies, procedures and guidelines, practicing within known evidence base, reporting any incidents, near misses, issues or concerns, auditing and reviewing practices and services and taking every opportunity to learn and improve both individually and within the team you work.

Managers & Clinical Leaders
Creating a positive patient / donor centred quality and safety culture within areas of responsibility where staff feel safe to report errors and issues and are nurtured to grow, develop, learn and improve. This includes ensuring: Trusts values and behaviours are met by all; sufficient fully trained and competent staff; quality and safety is owned by all; ensuring that 'what good looks like' within areas of responsibility is described, known by all and regularly reviewed in line with evidence based / best practice; that quality metrics including outcomes and experience data is captured and used to improve services; regulatory and legislative requirements are met; compliance with policies, procedures and guidelines; a positive reporting and comprehensive investigation culture where lessons are learnt and service improvement is at the centre of service developments; the quality of data and record keeping; and escalating any areas of concern or non-compliance with agreed standards and practices.

Divisional Senior Leadership Teams

Securing senior management commitment to quality and patient / donor safety, learning and improvement expressed through planning, resource allocation and the establishment of a robust local quality and patient / donor safety governance framework delivery structure. This includes: ensuring via clinical / non-clinical teams the delivery of high quality, safe service; ensuring service delivery areas commit the resources (staff, time, knowledge, skills, expertise, services, data, and equipment) necessary to meet its obligations; robust workforce planning; continuous quality improvement based on triangulated data; ensuring the support and interventions offered through education, training, learning and organisational development initiatives are readily available to individuals and teams to support improvement and build resilience. Divisional Directors and their teams are fully expected to fulfil the requirements of Putting Things Right, in relation to being open, transparent and embracing the duty of candour.

Executive Directors / Corporate Directors

Are collectively responsible for the Trust delivering its objectives safely, effectively and efficiently in line with national and legislative requirements that includes setting the strategic direction for areas of responsibilities and ensuring appropriate policies, procedures and guidelines are in place. Specific leadership roles include:

- o Chief Executive Officer: is the Accountable officer for the Trust and has overall responsibility for all areas of the Trust and its services. The Chief Executive has delegated the following responsibilities in respect of this framework to the following Executive Directors / Trust Officers:
- o Executive Director of Nursing, Allied Health Professionals and Healthcare Science: responsibility for the overall strategic direction and policy implementation in relation to Putting Things Right, Wales Quality & Engagement Act, Patient and Donor Experience, Infection Prevention & Control, safeguarding and ensuring professional and regulatory standards for Nurses, AHP's & Healthcare Scientists are in place;
- o Executive Medical Director: responsibility for clinical effectiveness, audit, Research and Development, Medicines Regulations and Safety, IRMER, and ensuring professional and regulatory standards for Pharmacists and Medical Staff are in place;
- o Executive Director of Finance: responsibility for Value Based Health Care and to ensure that resources are used to best effect to enable compliance with legislative requirements e.g. the Nurse Staffing Levels (Wales) Act 2016, along with the resource allocation for the provision of safe care, services and treatment to all cared for by the Trust;
- o Executive Director of Organisational Development and Workforce: responsibility for workforce planning and development, developing a sustainable workforce to deliver quality and patient safety;
- o Director of Strategic Transformation, Planning & Digital: responsibility for ensuring strategic planning is predicated upon quality and patient & donor safety and that the measurement of performance is based on quality, safety, experience and outcomes and that the Trust is fully digitally optimised.
- o Director of Corporate Governance: responsibility for effective governance arrangements including the development and delivery of the Trust Assurance Framework, effective Trust Communications and ensuring effective and agile service to Board risk management systems and processes are in place; and,
- o Chief Operating Officer; responsibility for the delivery of safe and effective operational delivery across the Trusts two service Divisions i.e. Velindre Cancer Service and the Welsh Blood Service.

Trust Board Members

The Trust Board is responsible for Strategy, culture and assurance. The Board therefore are responsible for creating the quality and safety culture for the organisation and ensuring there is a robust infrastructure in place to ensure that quality, safety, experience, learning and improvement is embedded across the whole Trust and that all staff understand their role in respect of this. Independent Members of the Board are required to scrutinise performance and outcomes related to quality and patient safety. The Board has 'a crucial' role in overseeing the aggregated risk accumulated across the organisation. The Board is required to make all decisions through a quality lens and ensure Trust is meeting its statutory responsibilities. There is an identified Independent Member with an active leadership role in overseeing the quality and safety work of the Board, but overall responsibility and accountability is that of the Board's via the Board Chair and Chief Executive.

Corporate / Divisional Quality, Safety & Regulatory Teams

- Assist in identifying organisation / division wide themes and trends generated through hard (performance data) and soft intelligence, listening to patients / donors, staff and other stakeholders, triangulating with exception reporting and other datasets to enable the Trust to adopt an integrated risk management approach to cross cutting issues and concerns
- Focus on being open, ensuring there is learning and improvement and using duty of candour to support local and organisation wide learning for quality improvement
- Constructively challenge and support to ensure that quality and safety are embedded in all decision making and at all points of the patient and donor pathway, including through the provision of data that is meaningful, can be triangulated and focusses on the metrics most useful to the services being provided
- Proactively support and enable clinical teams to conduct robust investigations and identify the root causes when things go wrong and to articulate the learning and quality improvements that can result
- Lead and support the management of complex issues related to Putting Things Right including serious incidents, redress, clinical negligence; the interface with HM Coroner and the Public Services Ombudsman for Wales, MHRA, Healthcare Inspectorate Wales and other external regulators.
- Support organisation wide reporting to Senior Leadership Teams, Board and its Committees and subgroups related to all quality and patient & donor safety.
- Use the findings and recommendations of external review to shape the way in which teams can be supported to deliver high quality, safe care.

4. QUALITY & SAFETY ASSURANCE / MEETING STRUCTURE

4.1 Meeting structure at a glance:
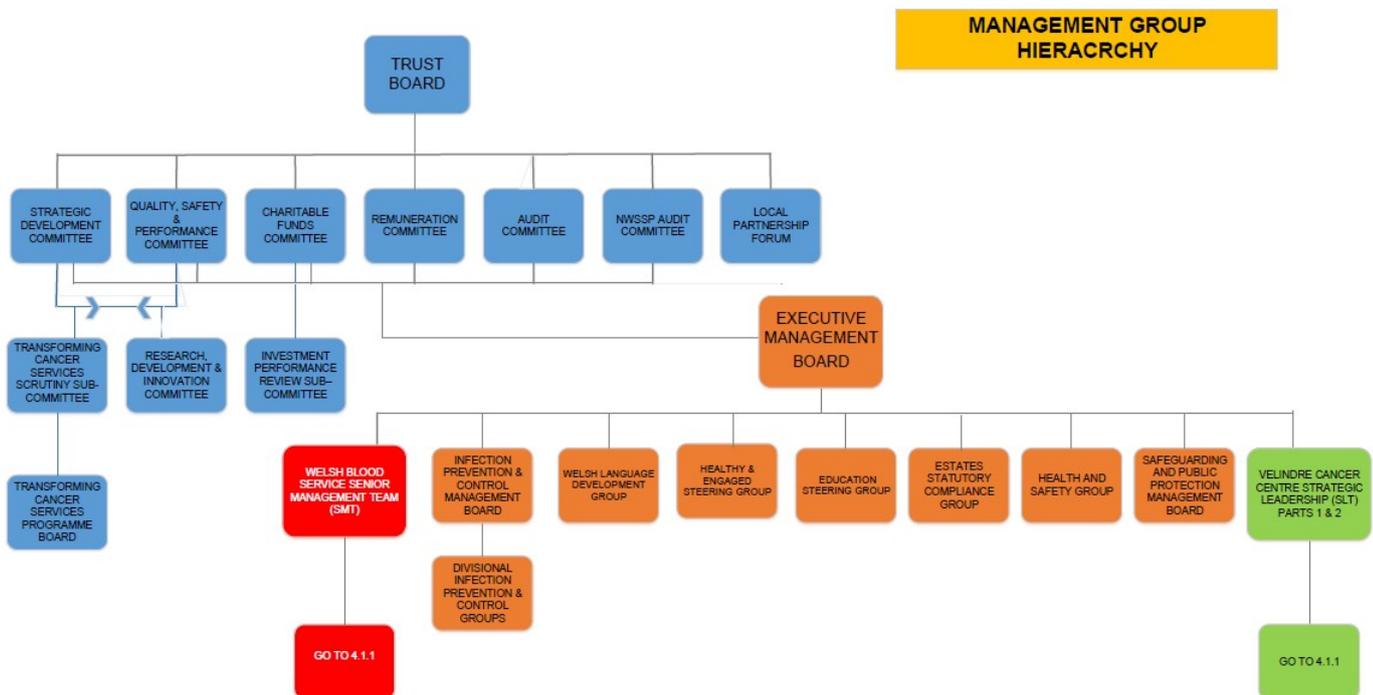
4.2 Meeting Requirements

> **Team Meetings**
>
> Individual team meetings involving as many staff as possible should be held at least monthly. A mechanism for communicating to those who could not attend to be put in place. The team meetings need to consider all elements detailed for departmental meetings but at a team level and feed the outputs from these discussions into the departmental meetings. Items discussed need to include: quality metrics, patient / donor outcomes; audit findings; patient / donor experience feedback; summary of compliments, concerns and incidents and ideas & suggestions from improvement.

Departmental Meetings

Departmental / Service Managers should be organising at least monthly formal meetings to review performance, outcomes, standards, experience, learning and improvement. All areas of the service should be represented. These representatives are responsible for two way communication between their teams and wider department / service. Minimal areas of focus at these meetings need to include:

- Determining what good looks like for department linked to services responsible for including overseeing new standards / best practice
- Agreeing and monitoring relevant metrics / performance data – including process, patient / donor outcomes, Datix reports (concerns, compliments, incidents, claims etc), experiential feedback (patient/donor/staff) & benchmarking
- Receiving any 'harm' investigation reports
- Determining departmental audit plan / priorities aligned to data analysis and review audit outcomes and agree any improvement actions
- Ensuring learning is identified, disseminated and translated into improvement action
- Agreeing areas for improvement and development and determining priorities.
- Oversight of relevant workforce metrics such as mandatory, statutory and clinical training, PDAR compliance etc
- Agree and review quality & performance priorities.
- This section can go in pretty infographics as well

Divisional Quality & Safety Meetings

Each Division will have a Quality & Safety Meeting that is responsible for overseeing Quality, safety, experience and governance on behalf of the Division. Minimal responsibilities will include oversight of:

- Quality, safety and experiential outcomes, learning and improvement across all services & Divison as a whole
- Monitoring of quality, audit and improvement standards
- Undertaking triangulation
- Infection Prevention & Control standards
- Health & Safety Standards
- Safeguarding and legislative / regulatory standards and compliance
- External / peer / internal reviews / audits and tracking completion of actions
- Ensuring learning
- Overseeing implementation of this Quality & Safety Framework and the Duty of Quality and Duty of Candour.

Divisional Senior Management Team (SMT) Meetings

At Least monthly Divisional Senior Management Team meetings will be held that is attended by all members of the Senior Management Team ensuring that all Departments are represented. The aim of the SMT meetings is to oversee the strategic planning and operational management of the Division, ensuring the delivery of safe, effective and high quality services and the Divisional aspects of the Trust's strategic objectives. The outputs from departmental and Divisional Quality Meetings will feed into the Senior Management Team Meeting.

Quality, Safety & Performance Committee

The Trusts Quality, Safety and Performance Committee provides:
- Evidence based and timely advice to the Board to assist it in discharging its functions and meeting its responsibilities with regard to the:
- quality, safety and performance of healthcare;
- all aspects of workforce;
- digital delivery and information governance; and

- Assurance to the Board in relation to the Trust's arrangements for safeguarding and improving the quality, safety and performance of patient and service user centred healthcare, workforce matters, digital delivery and information governance in accordance with its stated objectives, legislative responsibilities and the requirements and standards determined for the NHS in Wales. The Divisions formally report into the Quality & Safety Committee at least three times a year.

Corporate and Divisional Responsibilities

Corporate	Divisions
• Defining 'what good looks like' for the organisation	• Defining 'what good looks like' for division and its services and agreed metrics
• Ensuring Trust is fully meeting its Quality and Safety responsibilities & legal duties through: Trust wide systems, processes, policies, procedures, strategies, frameworks, infrastructure, training, support and direction in place.	• Ensure Division is fully executing its quality, safety and regulatory compliance responsibilities, robust learning assurance, reporting & improvement systems and mechanisms in place.
• Internal and external reporting and assurance mechanisms	• Management and oversight of local assurance / regulatory reviews / inspections e.g. MHRA
• Ensuring and assuring that learning and improvement actually takes place	• Implementation of Health and Care Standards
• Coordination and oversight external inspections / reviews e.g. Audit Wales, HIW, WRP, HCS reviews etc.	• Divisional culture
• Ensuring Board can execute its responsibilities incl. committee management, work plans and level information.	• Ensuring staff are appropriately trained
• Identification of external learning and translating into actions	• Ensuring staff are aware of and work within agreed quality & safety policies, procedures and framework
• Putting Things Right and Duty of Candour legally executed	• Ensuring incidents, serious incidents and complaints are recorded and robustly investigated and managed
• Serious Incident management	• Robust divisional mechanisms for quality, safety, learning and improvement
• IPC, SG, Clinical Audit management & delivery arrangements	• Robust meeting and reporting infrastructure
• Corporate triangulated assurance of divisional activity	• Timely escalation of issues / concerns
• Provision of triangulated organisation wide assurance to QSP Committee	• Local workforce planning
• Performance framework development and oversight	• Provisional triangulated divisional assurance to EMB and QSP Committee.
• Assurance professional workforce plans meet required standards	
• Setting organisational culture	

5. QUALITY CYCLE

5.1 Quality Assurance / Quality Management System

During 2021/2022 the Trust will develop its organisation wide quality management (assurance) system, building on the system that is in place within the Welsh Blood Service (WBS). This aligns with the Trust overarching assurance framework (TAF) and incorporates the management of risk, internal and external assurance mechanisms and will require mechanisms for regulatory and legislative monitoring, in addition to quality, safety, outcome and experience oversight. This will be developed with support from Improvement Cymru. Work is commencing with strengthening the overall Board and Committee assurance processes. The Trust Quality management (assurance system) will incorporate all elements of the quality cycle summarised below:

- **Quality Planning:** The Trust will ensure that all planning and service development is undertaken through a quality and clinical lens including the development of its Integrated Medium Term Plan (IMTP). To achieve this, service level to Board quality metrics will be developed using a quality dashboard, based on robust data analysis, including outcome and experience data. A Clinical & Scientific Strategic Board will be developed to strengthen the clinical strategic oversight of planning and prioritisation.
- **Quality Improvement**: The Trust and Divisional Quality improvement priorities will be developed annually and managed through a project management infrastructure. The Trust will further strengthen its clinical effectiveness arrangements i.e. Clinical Audit, Patient Reported Experience Measures (PREMS) & Patient reported Outcome Measures (PROMS) mechanisms, NICE & Clinical standards assurance processes and through improvement priorities identified through the Clinical & Scientific Strategy Board. The Trusts Quality Improvement (QI) infrastructure will be reviewed to ensure an effective QI delivery infrastructure at local, divisional and Trust level. This will include agreement of the QI methodology.
- **Quality Control:** Trust will develop an infrastructure so that quality control occurs at all levels of the organisation i.e. Service level to Board. Service, Divisions and the Trust will determine 'what good looks like', agreed outcome and experience measures to monitor this so that there are robust arrangements for monitoring the desired quality of the services provided, facilitating early detection and response when there is variation from the desired quality. Mechanisms will be implemented using values based healthcare principles to, as far as possible, standardise clinical practices, aligned with standards and eliminated unwarranted clinical variation.

Quality is more than just meeting service standards; it is a system-wide way of working to provide safe, effective, person-centred, timely, efficient and equitable health care in the context of a learning culture.

5.2 Quality Hubs

The Trust will establish quality hubs to support the delivery of this framework and the Duty of Quality legislative requirements. There will be a Corporate Quality Hub that will be the virtual hub of all quality &safety activity covering the broader elements that span across a number of executive / director responsibilities and not just those that are managed through the Corporate Quality Team. The Hubs are intended to be a centre of activity and co-ordination – accountable for co-ordination, oversight and triangulation and not for delivery of the whole quality and safety agenda for respective services as this, at outlined above, lies with responsible managers. There will be three Quality Hubs:

- **The Corporate Quality Hub** will have a central co-ordinating role pulling together all elements of Quality & Safety (that sit under Executive Director of Nursing, Executive Medical Director, Director of Governance and Director of Strategic Transformation, Planning and Digital), will interface significantly with national work and bodies, as well as professionally supporting the Divisional Quality Hubs. The Corporate Quality Hub & Divisional Quality Hub Leads will formally meet at least monthly in the Quality & Safety Governance Group, that will provide analysis of all outputs / outcomes and ensure effective assurance reporting through the provision of triangulated assurance or exceptions reporting through to the Executive Management Board and Quality, Safety & Performance Committee. The responsibility for the Corporate Hub and Quality & Safety Governance Group will lie with the new Head of Quality & Safety, when appointed.

- **Welsh Blood Service (WBS) Quality Hub** & **Velindre Cancer Centre (VCC) Quality Hub**: These will be led by a nominated divisional senior leader and will support the Divisional Senior Management Teams in executing their Quality, Safety, regulatory and assurance responsibilities by ensuring effective oversight, co-ordination, learning, assurance and triangulation of 'the whole' & effective functioning of Divisional Quality & Safety Group. It is essential that Departmental & Directorate Managers retain full accountability and responsibility for all aspects of quality, safety and regulation within their areas of responsibility.

Quality Hubs at a glance
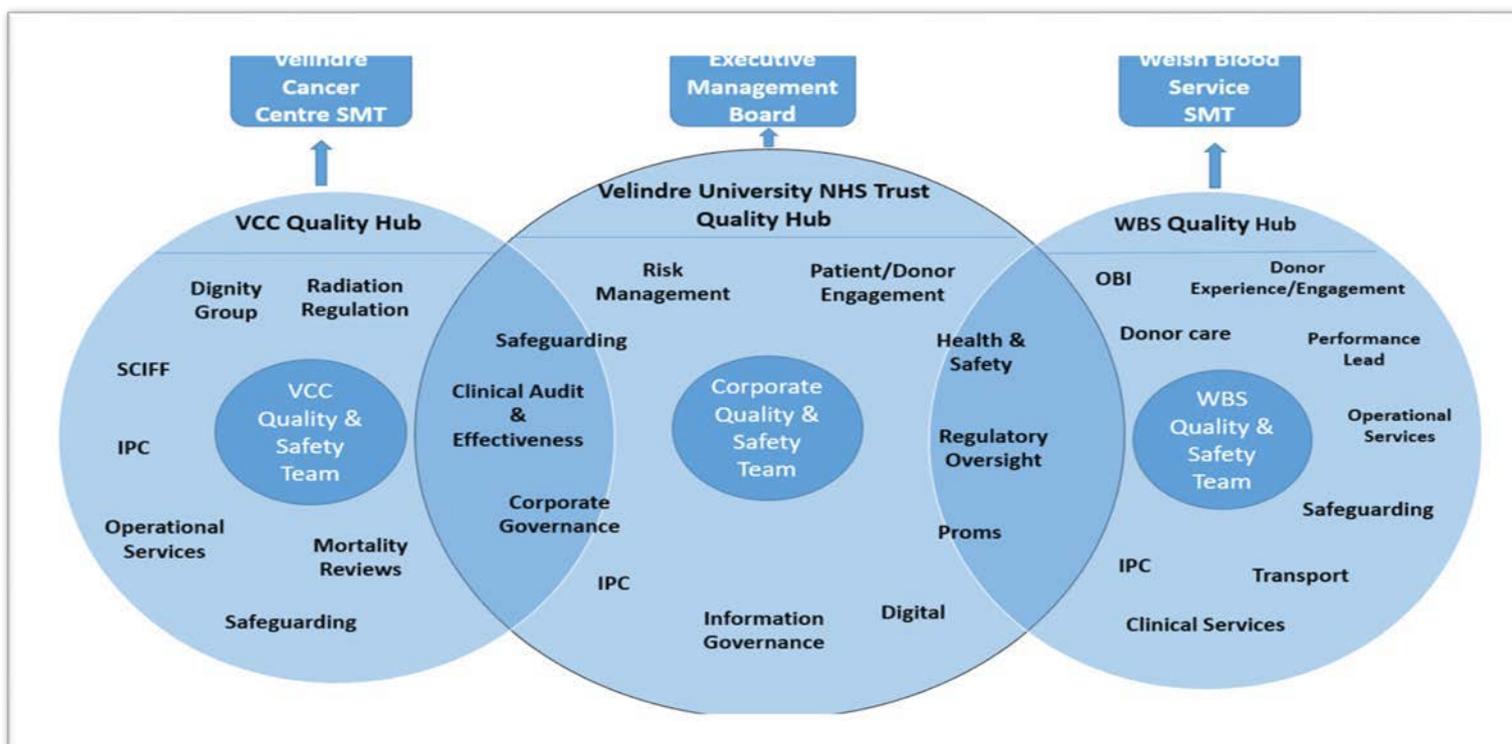
The Divisional Hubs will have oversight of the quality infrastructure within all areas of their division, as detailed below:
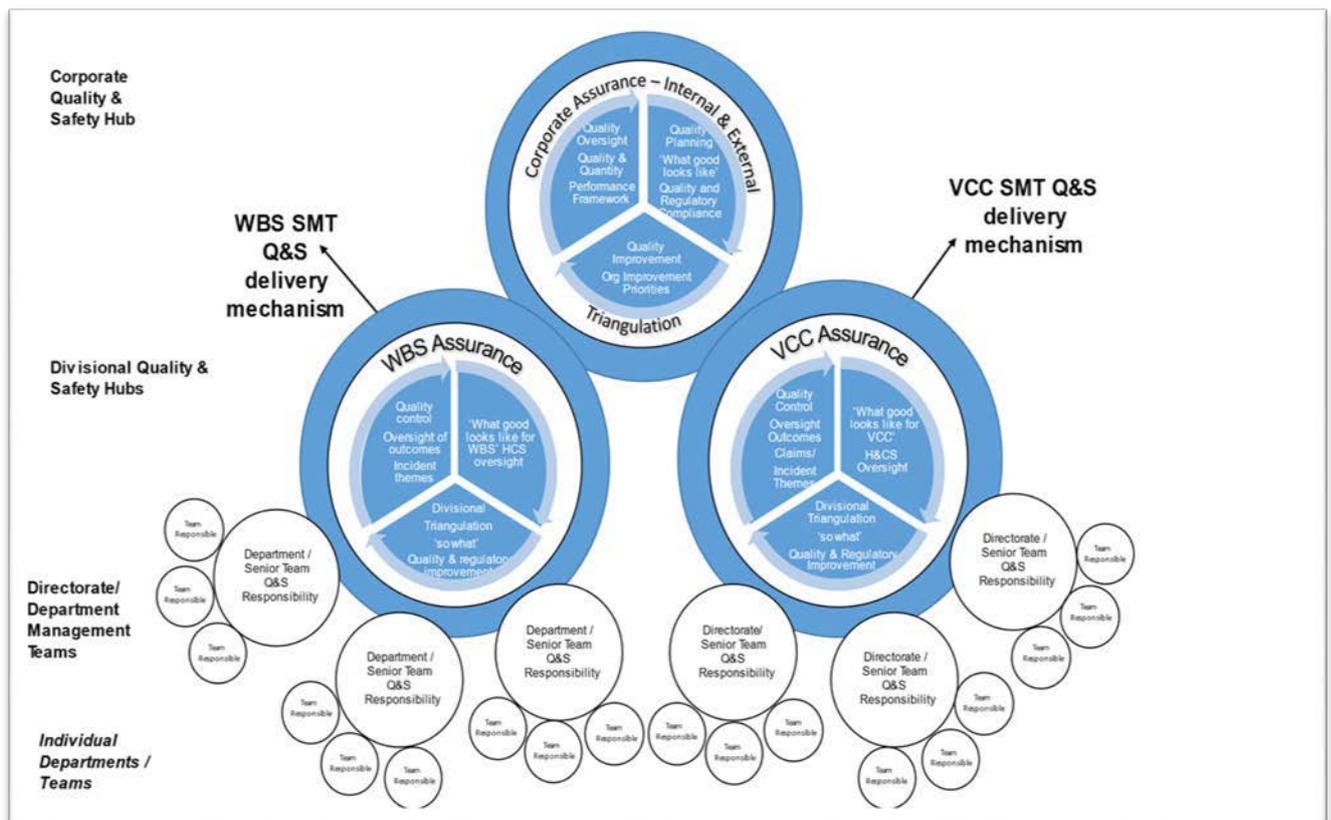
5.3 Quality & Safety 5 step framework (keeping it simple)

The 5 step framework detailed below is designed to support managers at all levels to assess where there are in respect of quality requirements and to identify areas that may require strengthening. Support in this will be available from both the Corporate and relevant Divisional Quality Hubs.

Velindre University NHS Trust Quality and Safety 5 Step Framework

Graduated Service Level to Board Approach

ASSURANCE
- Data / Data / Data
- Meaningful dashboard which tells you how you are doing
- Reporting / escalating in a meaningful way
- Robust Quality based service level Board Performance Framework
-

Board Assurance
SMT Assurance
Departmental Assurance
Team/Service Assurance

- Action based assurance
- Includes the "why" and "so what"

IMPROVING WHAT YOU DO
- Triangulate (assess) what your "know how you are doing" measures are telling you / your department
- Celebrate success widely – What has gone well and areas of improvement
- Identify root cause of areas that are not where they need to be (i.e. why)
- Agree improvement actions for team
  - identify lead/action owner
  - seek help if need be
  - how have others tackled this?
- Put mechanisms in place to identify if improvement is in place/worked
- Review impact over time e.g. have metrics improved?
- Are Standards now in place
- PDSA cycle

Plan
Do
Study
Act

- Innovation

Know HOW YOU ARE DOING?
- Continual experience feedback Patients / Donors (aim 40% contacts)
- Review concerns and compliments – Culture survey
- Regularly review Quality measures – at least monthly
- Formally assess against Standards
  - Self-assessment
  - Review audit findings
  - Peer review
  - External review
- Review you workforce metrics
  - Sickness
  - Turnover
  - Mandatory training
  - Staff compliance
  - Clinical skills training
  - PDAR
- Robust, meaningful, fair investigations when timings go wrong – identify all root causes and contributing factors
- Monthly analysis of complaints, incidents, claims and events
- Research outcomes
  Re-review what you are measuring at lease annually

MAKING YOUR SERVICE GOOD
- Systems for regularly reviewing evidence base
- Agree priorities and plan to meet Standards and what is important to Patients/Donors
- Research evidence / activity
- Determine quality measures and systems for collecting ensuring data quality
  - Process outcome and experience measures / including mortality
- Agree your audit plan
- Align to standards
- Right staff, right skills, right place, right time
- Fully engage the whole team
- Champion roles
- Positive reporting culture

KNOW WHAT GOOD LOOKS LIKE
- Trust Standards
- Service Standards
  - Evidence base e.g. NICE, Professional Guidelines
  - Best practice e.g. Benchmarking Indicators
  - Research Findings
- Regulatory / Legislative Standards
- National Standards e.g. Health & Care Standards
- Identify what is important to Patients / Donors

Review at least annually

17

Velindre University NHS Trust staff put quality, patient / donor safety and experience firmly at the heart of everything they do, and all decisions made, that enables the active involvement of both the people who receive care / services and those who provide it, and a relentless focus on learning and improvement.

6 MONITORING AND MEASURING

6.1 Safety monitoring framework

One of the recommendations made by Don Berwick in his 2013 review into patient safety was that all NHS organisations should:

'……*routinely collect, analyse and respond to local measures that serve as early warning signals of quality and safety problems such as the voice of the patients and the staff, staffing levels, the reliability of critical processes and other quality metrics. These can be 'smoke detectors' as much as mortality rates are, and they can signal problems earlier than mortality rates do'.*

By using the Framework and considering these questions, the Trust and its staff will be able to understand and discuss more clearly what it means to be safe. The framework shifts the emphasis away from focusing solely on past cases of harm, and more on real-time performance and measures that relate to future risks and the resilience of organisations. The Trust will have a safety foundation visit from the Institute of Healthcare Improvement (IHI) in July 2022, which will assess the Trust in respect of its safety culture and infrastructure and inform the development of the Trust Safety Monitoring framework.

A Framework for measuring and monitoring safely: The Health Foundation 2013:

Has patient care been safe in the past?
Ways to monitor harm include:
· Mortality statistics
· Record review (including case note review harm review)
· Staff reporting (including incident report and 'Never Events')
· Routine databases

Are we responding and improving?
Sources of information to learn from include:
· Automated information management systems highlighting key data at a clinical unit level (e.g. medication errors and hand hygiene compliance rates)
· At a Board level, using dashboards and reports with indicators, set alongside financial and access targets.

Are our clinical system and processes reliable?
Ways to monitor reliability include:
· Percentage of all inpatient admissions screened for MRSA
· Percentage compliance with all elements of the pressure ulcer care bundle

Will care be safe in the future?
Possible approaches for achieving anticipation and preparedness include:
· Risk registers
· Safety culture analysis and safety climate analysis
· Safety training rates
· Sickness absence rates
· Frequency of sharps injuries per month
· Human reliability analysis (e.g. FMEA) safety cases

Is care safe today?
Ways to monitor sensitivity to operations include:
· Safety WalkRounds™
· Using designated patient safety officers
· Meetings, handovers and ward rounds
· Day-to-day conversations
· Staffing levels
· Patient interviews to identify threats to safety

Past harm — Reliability — Safety measurement and monitoring — Integration and learning — Anticipation and preparedness — Sensitivity to operations

Based on the work of Vincent C, Burnett S, Carthey J. The measurement of monitoring of safety. The Health Foundations, 2013

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6.2 Harm

The reduction or elimination of harm is one of the overarching aims of this framework. It is therefore critical that the Trust understands and tracks the harm that can / does occur through its functions. Understanding past harm is important i.e. has patient / donor care been safe in the past? There are many ways in which it can go wrong. Therefore, the Trust needs to understand the different types and causes of Patient / Donor harm, which can be caused by:

- *Delayed or inadequate diagnosis* **–** e.g**.** misdiagnosis of cancer or diagnosis, treatment for cancer being delayed, inaccurate blood test results from transplantation and immunogenetics.
- *Failure to provide appropriate treatment* – e.g. rapid thrombolytic treatment for stroke, donors being over bled or prophylactic antibiotics before surgery, failure to discontinue a donation during an adverse event.
- *Treatment* –*e.g.* the adverse effects of chemotherapy, citrate reactions.
- *Over-treatment* –e.g. painful / toxic treatments of no benefit to those at end of life.
- *General harm* – e.g. incorrect pre blood-donation screening outcomes, harm to recipients caused by blood borne infection/virus, or post donation cannulation nerve damage, inappropriate donor selection.
- *Psychological harm* – e.g. depression following diagnosis.

Multiple types of harm require more than just a single measure. A range of measures may include: mortality statistics, systematic record review, selective case note review, reporting systems and existing data sources.

6.3 Safety Culture

Studies have shown that the safety culture and climate of an organisation have a direct correlation with patient outcomes and staff injuries. Staff indicators of safety, such as sickness absence rates and staffing levels, can help to forecast an organisation's ability to safely provide care in the future. Identifying and extending good practice in their organisation, with actions at strategic and operational levels, Trust Officers need to embed the need to look for good practice when making decisions at relevant meetings, such as the Senior Management Team meetings, Executive Management Board, Committees and Trust Board with clear flows and good practice lessons learnt logs, accountability laying with the Executive Team and Divisional Directors / Senior Management Teams. All decisions should be made through a Quality lens supported by robust triangulated quality information. This will be supported by the development of a Trust wide monthly Quality and Safety Governance Group (spanning Corporate and Divisional Quality Hub senior members, risk, health & safety, corporate governance, clinical audit & effectiveness, mortality leads, information governance & digital) that will formally report into the Executive Management Board and Quality, Safety & Performance Committee. Trust Board and senior trust officers will require strategic safety and improvement training.

It is important that all staff, patient / donor facing & leadership teams think of all aspects & factors (the big picture) impacting patient / donor care and see all aspects as offering an opportunity for improvement. Teams should focus on providing excellent care and services, ensuring staff have the resources they require and are able to eliminate distractions before they become problematic or result in preventable error or an adverse event. Mechanism for supporting this include:

- Safety walk arounds, which enable operational staff to discuss safety issues with senior managers / senior Trust Officers directly
- Forums, such as operational meetings, handovers and patient/donor/carer representative meetings, to act as sources of intelligence on the safety of services
- Day-to-day conversations between teams and managers
- Patient safety officers actively seeking out, identifying and resolving patient safety issues in their clinical departments / divisions. The Trust has three trained patient safety officers (details in appendix 2)
- Briefings and debriefings, such as at the start / end of a theatre list / SCAT / Collections clinic, to reflect on learning
- Patient / donor experience feedback and stories to identify good practice, and any threats to safety
- Staff experience feedback

6.4 Triangulated Incident Analysis

Incident analysis should go further than explaining the nature of the event, to help to identify wider problems in the system. *Feedback, action and improvements* are vital to making systems safer in the future. There are many different types of local feedback mechanisms in use, ranging from individual discussions to safety newsletters and web based feedback. The challenge at Senior Management Team, Executive Management Board, Committee and Board level is to integrate the information available to draw wider lessons and to spread learning right across the organisation where appropriate, without losing the granularity that makes information real for individuals. The Quality and Safety Governance Group will be responsible for the triangulation, analysis and assurance collation and exception identification in addition to tracking harm and implementation of quality improvement priorities.

6.5 Integration and Learning

There are many different sources of safety information available, however these must be integrated and weighted if risks and hazards are to be effectively understood and prioritised at all levels so that effective action can be taken. This must also be undertaken in different ways at different levels. For example, the level of detail and specificity required by a team / department would be different to the summarised, high level information that the Trust Board requires, to receive an overview of the safety across the organisation. An effective system for incident reporting would be made up of information, analysis, learning, feedback and action.

A Trust wide Quality & Safety learning portal will be developed for cross-sector sharing of good practice and include Welsh Government.

6.6 Trust Monitoring, Reporting & Assurance Arrangements

There must be robust monitoring and reporting systems in place, from service level through to the Board, to ensure we are continually reviewing if we are meeting our quality standards and goals and assessing if our improvement activities are having a positive impact on our patients and donors. These need to include:

Quantitative
- Defined metrics to measure against agreed 'What Good Looks Like' standards
- National quality indicators
- Clinical Incident / harm metrics
- Mortality indicators
- Clinical Outcome measures
- Harm Measures
- Patient Reported Outcome Measures (PROMS)
- Percentage recommending rates (from patients / donors/ carers & staff)
- Patient and donor experience metrics
- Donor adverse events
- Donor deferral statistics
- Part bag and failed venipuncture data

Qualitative
- Voice of Patient / Donor, patient / donor stories, experience comments, concerns and compliments
- Day in the life of (staff's lived experience)
- 15 step challenge: Board to floor walkabouts which enable discussion with staff and patient / donors about their experience of giving and receiving care with an appreciative enquiry approach focussed on quality and safety of care.
- Mechanisms for internal (across Trust) and external proactive peer reviews across all our services.
- External Assessment reports e.g. HIW, MHRA HTA ISO15189/17043

6.7 Triangulated evidence

Along with a minimum dataset informed by national quality and performance indicators, managers and clinical / senior leaders must have access to a bespoke dataset meaningful to the service it applies to, that enables analysis, triangulation and intelligent interpretation so that learning, quality improvement and service development are evidenced. The voice of the patient/donor, whether expressed through compliment, concern, face to face, in writing or by a third party, at any stage in the care pathway, must be a central consideration to all decision making in terms of quality and patient/donor safety.

Soft intelligence is invaluable as an early quality trigger where something is potentially of concern. Therefore, it is essential that staff feel empowered to voice and escalate concerns, and that patient / donor experience, both real-time and retrospective, is

central to quality and service improvement. Soft intelligence can also be attained through leadership walkabouts and other internal assurance activities (detailed in section 3), and further enables well informed assessment. Experience has shown that where these does not exist, risk is increased and the opportunity to provide safe care is reduced. The Quality and Safety Governance Group will take on this function, of triangulating evidence, for the Trust on a monthly basis.

7. IMPROVEMENT

7.1 What quality improvement means within Velindre University NHS Trust

Our approach to quality improvement will mean consistent and well understood use of methods and tools to continuously improve the way we do things. Studies have shown that board commitment and a leadership focus on quality improvement is linked to higher quality care. The Kings Fund (2017) provides a starting point for NHS leaders to embed Quality Improvement:

- Make quality improvement a leadership priority for board.
- Share responsibility for quality improvement with leaders at all levels.
- Don't look for magic bullets or quick fixes.
- Develop the skills and capabilities for improvement.
- Have a consistent and coherent approach to quality improvement.
- Use data effectively.
- Focus on relationships and culture.
- Enable and support frontline staff to engage in quality improvement.
- Involve patients, service users and carers.
- Work as system.

The Trust will undertake a review of its quality improvement infrastructure and mechanisms.

It is vitally important that all clinical improvements are made through a value based and prudent healthcare lens. Growing demand on NHS services and increased complexity is putting a huge strain on the money available to deliver services. By ensuring that the right care is delivered first, each and every time, to all our patients and donors, we will see improvements in quality, efficiency and effectiveness and therefore achieve better value from the services we provide.

The 4 principles of prudent healthcare

Public and professionals are EQUAL PARTNERS through CO-PRODUCTION

CARE FOR those with the greatest health need FIRST

Do only WHAT IS NEEDED and do NO HARM

Reduce INAPPROPRIATE VARIATION through EVIDENCE-BASED approaches

For further information visit www.prudenthealthcare.org.uk

Understanding the outcome of each intervention or treatment, its cost and what it means to patients /donors is fundamental to value-based health care. This will mean that we will ensure that we take every opportunity to improve value by tackling variations in care across our services, reducing waste and implementing known best practice. We believe that this approach will benefit our patients, donors, our staff and all healthcare services. The Trust has identified a number of value-based healthcare priorities for 2022/24.

- Culture, Socialisation and Education

- Measurement of Outcomes & Cost in a meaningful way

- Prudent Healthcare and Service Prioritisation

A number of value based healthcare key deliverables and action with timescales to enable delivery of these strategic priorities have been agreed for 2022 - 25.

7.2   Quality Improvement Goals

The Trust will determine, following detailed triangulated analysis and consultation with staff, annual quality improvement goals. The Quality Improvement Goals will be reviewed and approved at the start of each financial year and will be included as part of the IMTP process.

Each Quality Improvement goal will be managed through a defined project with an identified operational lead and Executive Director sponsor. The Outcomes to be achieved by year end will be agreed and a delivery plan developed. These will be monitored through relevant Quality Hubs and by exception through to Executive Management Board and quarterly to Quality, Safety & Performance Committee.

8. CULTURE & VALUES

8.1 Trust Values

Velindre University NHS Trust is ambitious to deliver our vision 'Healthy People, Great Care, Inspirational Learning'. Focusing on 'Healthy People', Our People Strategy coupled with our Education Strategy have been developed from feedback from staff surveys and broader engagement with staff - it is grounded in our values. Be Accountable, Be Bold, Be Caring, Be Dynamic, these values are supported by the Trust Behaviours Framework.

The People strategy can be found add link once uploaded to Intranet. In support of a positive culture our overall aim is to develop our staff, given clear career pathways, provide them with leadership, skills and knowledge they need to deliver the care our patients and donors need now and in the future to support their wellbeing and to recognise and value their diversity in a bi-lingual culture. Examples of turning the Trusts values into behaviours is attached in *Appendix 3*.

When something fails or goes wrong staff must feel safe, supported and able to speak up, having confidence that they will be listened to. If concerns are raised about the quality of care, they need to be listened to, acknowledged and acted upon (psychological safety). The staff of Velindre University NHS Trust need to know   that concerns are taken seriously, and that they are welcomed, will be listened to and acted upon. When an organisation is open and honest, staff feel able to raise concerns and to implement improvement actions. No health service is perfect and this must be acknowledged in order to feel confident in a continually improving service. The implementation of the duty of candour will support this as an approach.

When errors do occur, they need to be fully and robustly investigated to understand how the system failed, with rapid action taken to prevent the risk being repeated. This approach needs to not apportion blame. Even if the key action was an individual error, there will have been multiple steps that contributed and must be understood. Adequate support needs to be provided both to the patient / donor and their loved ones but also to the members of staff involved, to know that they remain valued and supported throughout any investigation. A punitive environment is a powerful barrier to fair and authentic reflection. A just and learning culture balances fairness, justice and learning with responsibility and accountability.

Patients and donors also need to be encouraged to speak up when things go wrong and know that their concerns and experiences are listened to and not dismissed. This is crucial in a truly learning system.

The whole workforce needs to be engaged fully in the need to improve. Personal wellbeing is a fundamental requirement for this to take place. If members of staff are suffering from burnout or feeling disengaged from the organisation, service improvement will inevitably drop off, but if wellbeing is prioritised, patient / donor care will be safer and of higher quality and continual service improvement will occur.

8.2 Leadership

The Trust People and Education Strategies sets out how Velindre University NHS Trust will support and develop competent and capable leadership possessing the skills and competencies required to deliver excellence. Add link once uploaded to Intranet.

Leading with Compassion

The Trust supports the NHS Wales Compassionate Leadership Principles and has embedded these in its Leadership development approach. This provides the foundation of the Trust People Strategy.

8.3 Equality, Diversity & Inclusion

As part of our everyday work we aim to build a culture within the organisation that both recognises and embraces inclusion, equality and human rights. We are committed to strengthening leadership, governance and accountability via our strategies, policies, practices and processes. By improving engagement with staff, patients, donors, carers and visitors so that everyone is empowered and able to participate in the development of meaningful services and support.

The Trust is committed to embedding the principles of the Anti-Racist Wales Action Plan and other national action plans to ensure that all patients, donors and staff are empowered to have their voice heard and are not subject to discrimination in any part of their interaction with the Trust.

The Trust is committed to capturing the voice of the public in the design, planning and delivery of services, to ensure that the services we provide are meeting the needs of the communities that we serve. To do this the Trust uses a number of engagement methods, which include:
- Patient Liaison group
- Patient and carer representation on Trust Wide strategic groups, such as Patient Dignity group, Equality Impact Assessment group, Quality and Safety committee
- Public events such as BME Health Fair, Pride, National Eisteddfod
- Public engagement forums – Welsh Blood stakeholder sessions
- Staff newsletter, surveys and feedback sessions
- Monthly Patient surveys at Velindre Cancer Centre
- Monthly donor surveys at Welsh Blood Service
- Community, stakeholder and partnership engagement

8.4 Staff Wellbeing

The Trust recognises the commitment of our dedicated staff and the vital role they play in the delivery of quality, care and excellence. As an employer, we encourage a culture of fairness, dignity and respect. Over the past year the mental health and wellbeing of staff as a result of the pandemic has been even more crucial and will continue to be for many years as the long term impact is realised.

Supporting staff with their health and wellbeing through initiatives such as;
- *Stress assessments*
- *Mindfulness programs - including the use of apps*
- *Respite care funding*
- *Childcare School Holiday funding*
- *Complementary Treatments*
- *Provision of an Employee Assistance Programme*
- *Managerial and self-referral services to Occupational Health services*
- *Access to free counselling*
- *Mentoring and coaching services*

The Trust has had a number of staff networks in place, which play a pivotal role in raising awareness and understanding of protected characteristics.

9.0 Quality and Safety Implementation Plan

This Framework will be delivered through an implementation plan. It is recognised that implementing this Quality Framework will take time. Work undertaken over the last three years has laid some of the foundations for this work, both culturally and organisationally, however further development is required. This work is crucial if the Trust is to meet the legislative requirements set by the Health and Social Care (Quality and Engagement) (Wales) Act 2020 and the NHS Wales Quality & Safety Framework: Learning & Improving (Welsh Government 2021). It is also recognised that this framework will need to be both formally evaluated and reviewed in 2023, upon publication of the final Duty of Quality & Duty of Candour statutory guidance. Funding has been secured for a one Year Quality Framework Implementation Lead to support the organisation in the work required to make this framework a reality.

APPENDICIES

Appendix 1: National Strategic Background & Links

- ***The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 -*** Also known as ' Putting Things Right Regulations were first introduced in 2011 and remain the legislative framework under which incidents and concerns are received, investigated, managed and responded to in addition to how organisations learn and improve: http://www.wales.nhs.uk/sitesplus/documents/861/Healthcare%20Quality%20-%20Guidance%20-%20Dealing%20with%20concerns%20about%20the%20NHS%20-%20Version%203%20-%20CLEAN%20VERSION%20%20-%2020140122.pdf.

- ***NHS Wales Health & Care Standards (2015)*** http://www.wales.nhs.uk/sitesplus/documents/1064/24729_health%20standards%20framework_2015_e1.pdf – were designed to support the NHS and partner organisations in providing quality services across all healthcare settings and describe what the people of Wales can expect when they access health services. The framework has seven "themes", each of which are supported by a set of standards (22 in all), along with criteria linked to the individual standards and underpinned by a further "standard" of "Governance, Leadership and Accountability", with four linked criteria (encompassing strategy setting, leadership, people development and health service innovation.)

- ***The Organisation for Economic Co-operation and Development (OECD) Review of Health Care Quality (2016)*** https://www.oecd.org/unitedkingdom/oecd-reviews-of-health-care-quality-united-kingdom-2016-9789264239487-en.htm - commented that quality is at the heart of the healthcare system in Wales and made recommendations to strengthen what has already been built. These included a stronger relationship between health organisations and Welsh Government, more visible accountability within health organisation, with the technical, managerial and leadership capacity to drive up standards.

- ***A Healthier Wales Our Plan for Health and Social Care (2018)*** https://gov.wales/sites/default/files/publications/2019-10/a-healthier-wales-action-plan.pdf - Welsh Government's long-term plan for health and social care in Wales and sets out a long-term vision that everyone in Wales should have longer, healthier and happier lives. It proposes a whole-system approach to health and social care which is equitable, and where services are designed around individuals and groups based on their unique needs and what matters to them, as well as quality and safety outcomes. The first NHS Wales core value described in A Healthier Wales is "Putting quality and safety above all else – providing high-value evidence-based care for our patients at all times."

- ***The Health and Social Care (Quality and Engagement) (Wales) Bill 2020 -*** Published on 1st June 2020 and will come into fully into effect by April 2023 and is, in part, a lever to achieve the vision of "A Healthier Wales". https://gov.wales/health-and-social-care-quality-and-engagement-wales-act-summary. The Bill aims to improve the quality of health services and ensure the citizens of Wales are kept at the heart of ever-improving health and social care services and requires NHS Wales heath bodies to secure quality in health services and to exercise their functions with a view to securing improvement in the quality of health services, encompassing reference to service quality improvement and outcomes in its decision-making.

- ***The NHS Wales National Clinical Framework (2021)*** https://gov.wales/sites/default/files/publications/2021-05/national-clinical-framework-a-learning-health-and-care-system_0.pdf - Published in parallel to the NHS Wales Quality Framework is document, setting out how clinical services need to evolve in the decade ahead and the importance of clinical pathways, data and quality improvement. It describes how to deliver prudent in practice behaviours and quality management systems can play their part in a learning healthcare system.

- ***NHS Wales Quality & Safety* Framework (Welsh Government 2021)** https://gov.wales/sites/default/files/publications/2021-09/quality-and-safety-framework-learning-and-improving_0.pdf This document replaces the Welsh Government '*Quality Delivery Plan*' (2012) and '*Delivering Safe Care, Compassionate Care' (2013) and* represents a way forward, learning from recent system failures in Wales, as well as the coronavirus pandemic and its associated potential for harm. The document outlines that everyone has a role in improving quality and outlines what needs to be in place to ensure how everyone's voice can be heard and provides a planning bridge to the new duties of quality and candour required in 2023.

- **MHRA ISO Standards:**

    o **BS EN ISO9001: 2015 Quality Management Systems – Velindre Cancer Centre - held since 2014**

    o **ISO 15189:2012 Medical laboratories - Requirements for quality and competence** https://www.iso.org/standard/56115.html the internationally recognised standard that specifies requirements for competence and quality that are particular to medical laboratories. The standard specifies criteria for the development and assessment of management systems and laboratory technical controls that provide confidence in the results obtained.

    o **ISO 17043:2010 Conformity assessment - General requirements for proficiency testing** https://www.iso.org/standard/29366.html the internationally recognised standard that specifies general requirements for the competence of providers of proficiency testing schemes and for the

development and operation of proficiency testing schemes. The standard applies to quality assessments schemes run by WBS, these are Histocompatibility & Immunogenetics National External Quality Assessment Scheme and Welsh Assessment of Serological Proficiency Scheme.

☐ **Welsh Blood Service Regulatory Framework**

The MHRA has awarded a Blood Establishment Authorisation under the Blood Safety & Quality Regulations 2005, and a Wholesale Dealer's Licence under the Human Medicines Regulations which allows WBS to operate as a Blood Establishment for collection and processing of blood, and as a Wholesale Dealer for commercial blood products and more recently for vaccines.

o Blood Safety & Quality Regulations 2005, Statutory Instrument 50, and amendments -
https://www.legislation.gov.uk/uksi/2005/50/pdfs/uksi_20050050_en.pdf

o Human Tissue Act 2004 -
https://www.legislation.gov.uk/ukpga/2004/30/pdfs/ukpga_20040030_en.pdf

o Human Tissue (Quality and Safety for Human Application) Regulations 2007 - https://www.hta.gov.uk/policies/licensing-under-human-tissue-quality-and-safety-human-application-regulations-2007-amended

o Human Medicines Regulations 2012 -
https://www.legislation.gov.uk/uksi/2012/1916/pdfs/uksi_20121916_en.pdf

o Medicines and Medical Devices Act 2021 -
https://www.legislation.gov.uk/ukpga/2021/3/contents

o Good Practice Guidelines for blood establishments (Council of Europe) -
https://www.edqm.eu/en/good-practice-guidelines-blood-establishments

o Guide to the quality and safety of tissues and cells for human application (Council of Europe) - https://www.edqm.eu/en/news/new-guide-quality-and-safety-tissues-and-cells-human-application

o European Federation for Immunogenetics (EFI) - *EFI: Standards for Histocompatibility & Immunogenetics testing. The European Federation for Immunogenetics (EFI) awards the EFI certificate to laboratories that meet the quality requirements set by EFI (Standards). EFI is a European organisation that focuses on immunogenetics, tissue typing and transplantation. The EFI certificate is required by a number of organisations operating in the field of stem cell and solid organ transplantation including JACIE, NMDP and the Eurotransplant foundation.*

- o World Marrow Donor Association (WMDA) - *WMDA: World Marrow Donor Association WMDA International Standards for Unrelated Hematopoietic Stem Cell donor registries.*

- ☐ **Quality Statement Cancer (2021)** https://gov.wales/quality-statement-cancer-html - Builds on the work of the 2012 and 2016 Cancer Delivery Plans Developed to ensure there is a long-term and consistent approach to improving outcomes. The statement details a number of quality attributes and outlines the role of the NHS Executive, Wales Cancer Network Board and the clinical network in setting out a rolling, three-year implementation plan that identifies and prioritises national cancer service developments based on the quality attributes.

- ☐ The recently-published National Clinical Framework (prudent in practice) provides a clinical interpretation of A Healthier Wales and describes a learning health and care system, centred on clinical pathways that focus on the patient, grounded in a life-course approach. In recent years, major health condition delivery plans set out policy expectations for high priority clinical services. These plans came to an end in December 2020 and as described in the National Clinical Framework, will gradually be replaced by Quality Statements. These successor arrangements will help to set out what stakeholders think are important quality attributes of high priority clinical areas, such as cancer, heart disease and stroke services; as well as services such as critical care and end of life care.

Appendix 2: Trust Patient Safety Advisers

The Trust has three trained patient Safety Advisers:

- ☐ Annie Evans, Clinical Transformation Lead: annie.evans5@wales.nhs.uk
- ☐ Nigel Downes, Interim Deputy Director Nursing, Quality & Patient experience: nigel.downes@wales.nhs.uk
- ☐ Dr Jillian MacLean: jillian.Maclean@wales.nhs.uk

Appendix 3: Values into behaviours

TRANSLATING VELINDRE NHS TRUST'S ORGANISATIONAL VALUES INTO BEHAVIOURS

These four Values were approved in 2015 following analysis of significant feedback from staff who worked for all Divisions, professions and staff groups in the Trust. They describe the aspects of Velindre NHS Trust which we already have, and must respect and protect; and also what we must become in order to achieve our organisational ambitions in a modern NHS.

To help us understand the reality of them in our day-to-day roles we've worked with a wide range of staff from across the organisation to create this list of behaviours which clearly describe 'how' we should...and shouldn't be behaving if we are to be true to our organisational Values.

Ein gwerthoedd...

- BYDD Atebol
- BYDD Feiddgar
- BYDD Garedig
- BYDD Ddynamig

Our values...

- BE Accountable
- BE Bold
- BE Caring
- BE Dynamic

Being ACCOUNTABLE means…

We will:

1. Complete all assigned tasks on time and with minimal supervision
2. Fulfil all commitments made to peers, co-workers, supervisors, and customers
3. Admit mistakes, misjudgements, or errors; immediately inform others when unable to meet a commitment
4. Take personal responsibility for seeing efforts through to completion and/or tough decisions, etc
5. Accept full responsibility for our contribution as a team member
6. Display honesty and truthfulness
7. Follow through and meet personal commitments to others on time
8. Take our responsibilities seriously and consistently
9. Present ourselves with professionalism and credibility
10. Express concern for doing things better and producing quality work
11. Acknowledge responsibility for failures and mistakes
12. Set and maintains high performance standards for self and others that support the Trust's strategic plan
13. Manage our time well in order to complete tasks on time and with high quality
14. Assume responsibility for results of own actions and their impact on the work group/department
15. Complete assignments without the need for prompting from our supervisor or others
16. Successfully complete most tasks independently but ask for additional support, as appropriate, when faced with unfamiliar tasks or situations

It does not mean that we can:

1. Use our position to delay decisions
2. Ignore the contributions of colleagues
3. Disempower colleagues

Velindre University NHS Trust staff put quality, patient / donor safety and experience firmly at the heart of everything they do, and all decisions made, that enables the active involvement of both the people who receive care / services and those who provide it, and a relentless focus on learning and improvement.

We will:

1. Take calculated risks to achieve goals

2. Challenge ourselves and others to consistently improve and achieve "stretch" goals

3. Push forward with important initiatives in the face of uncertainty

4. Move ahead without always requiring a consensus

5. Make recommendations that challenge the status-quo

6. Step forward with a position of principle even when there is ambiguity regarding the facts

7. Give people the feedback they need even in difficult situations

8. Support others who take calculated risks to achieve Velindre NHS Trust goals

9. Take responsibility and stays focused on problems until an effective solution can be found

10. Make decisions through weighing up the cost-benefit and risk implications

11. Take decisions as necessary on the basis of the information available

12. Make decisions without unnecessarily referring to others

13. Involve and consult with internal and external stakeholders early in decisions that impact them

14. Identify potential barriers to decision making and initiates action to move a situation forward

15. Be aware of the Trust's decision making processes and how to use them

16. Propose options for solutions to presented problems

17. Demonstrate resilience against challenges and obstacles

We will not:

1. Be impulsive or rash

2. Ignore the facts

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3. Pass responsibility for decisions inappropriately to others

4. Make decisions without discussing them with those they will affect, or without clear rationale or consideration of their impact

5. Take an unimaginative or narrow approach to solving problems

We will:

1. Be dedicated to meeting the expectations and requirements of internal colleagues and external donors/patients

2. Take pride in delivering a high quality service

3. Treat all people, both colleagues and service users, with dignity and respect

4. Avoid making statements that may offend or hurt others

5. Consistently communicate even the most difficult messages in a sensitive and supportive manner without compromising on the meaning of the message

6. Consider and respects different opinions, styles, and ways of working

7. Ask questions to identify the needs or expectations of others

8. Consider the impact on colleagues, donors and patients when carrying out our own job

9. Work to remove barriers that get in the way of providing a high quality service

10. Seek feedback from others to assess satisfaction with service being provided

11. Continuously monitor service delivery and act promptly to resolve any problems

12. Endeavour to respond to phone calls and emails promptly; update voice messages and email notification when we're going to be absent from the workplace for more than one half day, advising alternative contact where possible

13. Be punctual and fully prepared for meetings

Velindre University NHS Trust staff put quality, patient / donor safety and experience firmly at the heart of everything they do, and all decisions made, that enables the active involvement of both the people who receive care / services and those who provide it, and a relentless focus on learning and improvement.

It does not mean we that we are allowed to:

1. Not deliver the task

2. Avoid difficult decisions

We will:

Being **DYNAMIC** means...

1. Be adaptable and able work effectively with a variety of situations, individuals and groups.

2. Demonstrate flexibility and agility, and not be unduly delayed or stopped by the unexpected

3. Open to new ideas and listen to other people's points of view

4. Demonstrate willingness to change our ideas or perceptions based on new information or contrary evidence

5. Remain focused on strategic priorities when faced with competing demands

6. Make pragmatic reasonable adjustments to ensure maximum effectiveness and motivation of ourselves and others

7. Change our overall plan, goal or project to fit the situation

8. Create and support dynamism by ensuring our processes and procedures don't block quick turnaround and flexibility

9. Weigh up costs and benefits impartially

10. Think laterally, creatively and collaboratively to resolve problems

11. Be willing to investigate options in depth, even when they are the ideas of others

12. Adjust schedules, tasks, and priorities when necessary

13. Anticipate and change strategy before the current method proves to be ineffective

14. Proactively identify and take action to achieve standards of excellence

15. Look for ways to improve services, add value and contribute new ideas

16. Plan ahead for upcoming problems or opportunities and takes appropriate action

17. Recognise and act upon opportunities

18. Exhibit a strong sense of urgency about solving problems and accomplishing work

19. Respond flexibly to changing circumstances

20. Demonstrate openness to changing work priorities and deadlines

21. Use change as an opportunity to improve ways of working, encouraging others' buy-in

It does not mean that we can:

1. Ignore our colleagues views

2. Be unrealistic in our goals

3. Be unaware of the impact of change on others

4. Be resistant to change and trying new things

5. Rush change or change for change sake

6. Do it all ourselves

Appendix 2

Quality and Safety Implementation Plan

The implementation plan will be monitored quarterly through the Executive Management Board and six monthly through the Quality, Safety & Performance Committee.

Required Outcome	Implementation Action	Action Lead	Delivery Timescale	December 2023 required status
Dedicated implementation support available to support establishment of Quality Hubs and work with services and teams to determine what good looks like and required measures – Trust meeting Duty of Quality requirements	Recruitment of agreed / resourced one year framework implementation lead	Executive Director Nursing, AHP & Health Science	Recruitment completed by 30th August 2022	75% of clinical teams agreed 'what good looks like', agreed metrics to assess status
Staff across the Trust aware of the framework and what this means for them and their teams	Quality Framework in action animated video to be produced aimed at teams and departments	Executive Director Nursing, AHP & Health Science	30th September 2022	Fully completed
	Quality Framework roadshows to be held within clinical areas and pre-arranged team meetings	Executive Director Nursing, AHP & Health Science	Completed by 30th September 2022	Fully completed

Quality, Safety, outcome and experience measures routinely monitored and used to inform decision making, prioritisation and improvements	Service level to Board quality, outcome & experience measures identified and captured across all services as part of routine monitoring arrangements	Divisional Quality Leads, Head of Quality & Safety & Quality & Safety implementation manager	December 2023	100% of clinical teams agreed 'what good looks like', agreed metrics to assess status
	Quality & Safety Governance Group to be established	Deputy Director Nursing, AHP & Health Science, Head of Quality & Safety	30th September 2022	Fully embedded in how organisation functions
Corporate & Divisional Quality Hubs fully operationalised, undertaking triangulated analysis and supporting the creation of the required quality & safety culture	Quality Hub Lead role specification to be developed	Deputy Director of nursing, Quality & Patient Experience	31st July 2022	Fully completed
	Quality Hub Leads to be identified / appointed	Divisional Directors & Director of Nursing, AHP & Health Science	30th August 2022	Fully completed
	Corporate & Divisional Quality Hubs to be fully operational	Divisional Directors & Deputy Director of Nursing, Quality & Patient Experience	30th September 2022	Quality Hubs fully embedded in how organisation functions
Quality and Quality Improvement is embedded at the centre of all decisions made across the Trust	Trust Quality Management System to be designed and implemented with support from Improvement Cymru	Director of Nursing, AHP & Health Science, Medical Director & Director	30th September 2023	Fully completed

		Corporate Governance		
	The Trust will undertake a review of its quality improvement infrastructure and mechanisms supported by Improvement Cymru	Director of Nursing, AHP & Health Science, Medical Director & COO	March 2023	Fully completed
	2022/23 Quality Improvement Goals met	Executive Directors	March 2023	Fully completed
	2023/2024 Trust Quality Improvement Goals agreed	Executive Directors	31st March 2023	Priorities on trajectory for delivery
Trust safety Monitoring Framework developed and in place	IHI Foundation safety & improvement assessment to be undertaken and any further improvement actions quantified	Director of Nursing, AHP & Health Science, Medical Director & COO	30th July 2022	Fully completed
	Trust Safety Advisors to undertake staff safety survey and repeat annually	Trust Safety Advisers	Initial by 30th September 2022	Two staff surveys completed and analysed to assess culture changes
	Trust Safety Monitoring Framework to be established and implemented across both divisions	Trust Safety Advisers	30th March 2023	Fully operational

	Harm to be defined across all services both potential and actual and harm reduction goals determined	Trust Safety Advisers	July 2023	Defined across all clinical services
	A programme of SLT and Board Safety Walkabouts to be implemented	Trust Safety Advisers	December 2022	Fully established as part of how Trust & Divisions operate
	A Trust wide Quality & Safety learning portal to be developed for cross-sector sharing of good practice and include Welsh Government.	Deputy Director Nursing, Quality & Patient Experience & Chief Digital Officer	March 2023	Fully completed
	Senior Trust Officers & Board Members all trained in strategic safety and improvement	Director of Corporate Governance	December 2022	100% Board members and Divisional SLT members received training
Well-developed Quality & Safety assurance mechanisms in place	Trust Board level Assurance infrastructure and reporting requirements to be clearly defined	Director of Corporate Governance	31st October 2022	Fully Completed
	Trust assurance and performance frameworks aligned with 6 domains of Quality	Director of Corporate Governance & Director of Strategic Transformation, Planning & Digital	31st December 2022	Fully Completed
	Trust meeting Structure to be reviewed to ensure transparency of reporting and removal of any	Executive Directors /	March 2023	Fully completed

	duplication post implementation of the Quality & Safety Governance Group	Divisional Directors		
Clinical Leaders setting Trust clinical quality priorities for future IMTPs	Clinical & Scientific Strategic Board Established	Medical Director, Director of Nursing, AHP & Health Science	30th September 2022	Fully completed
	Trust wide Clinical & Scientific Strategy developed	Medical Director, Director of Nursing, AHP & Health Science	March 2023	Fully completed
Robust and clearly defined clinical effectiveness arrangements across whole organisation	A formal review of Clinical effectiveness and clinical audit infrastructure to be undertaken	Head of Quality & Safety	June 2023	Fully Completed
Values based healthcare principles embedded across organisation	The Trust has identified a number of values based healthcare priorities for 2022/24 – these will be implemented through a project management approach.	Medical Director	December 2023	Top five VBHC priorities delivered

Review date: January 2023 & July 2023

Trust Board

MAY 2022 Performance Management Framework
COVER PAPER

DATE OF MEETING	28/07/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Anna-Marie Jones, Business Support Manager Wayne Jenkins, Head of Planning and Performance Alan Prosser, Director WBS Sue Thomas, Assistant Director 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	8.6.22	Reviewed and Noted
VCC SLT	30.6.22	Reviewed and Noted
WBS PERFORMANCE REVIEW	20.6.22	Reviewed and Noted
VCC PERFORMANCE REVIEW	24.6.22	Reviewed and Noted
EMB RUN	1.7.22	Reviewed and Noted

QSP	14.7.22	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

1.1 The attached Trust performance reports provide an update to the Trust Board with respect to Trust-wide performance against key performance metrics through to the end of May

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**.** 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:

The first two months of 2022/23 have seen increased pressure on radiotherapy and SACT services as a result of additional activity commencing in Health Boards. In addition to the projected growth, referrals will continue to increase as Health boards undertake further 'waiting list initiative' activity. Due to the unpredictable nature of this work, it is recognised there will be significant variability in the timing of referrals to VUNHST.

Based on forecasting work for 2022/23 undertaken as part of the IMTP, it is anticipated that referrals will increase further by 8% for radiotherapy and by 12% for SACT by March 2023. The referral prediction for 2022/23 are based on 2021/22 outturn plus a further increase of 8% and 12%. The identified increase in growth based on where organisations were in 2021/22 are national predictions from Cancer Research UK and Wales Cancer Network and are the figures being used across Health Boards.

Whilst the data sets established in 20/21 provide a track of patients in the referral pathways within Health Boards and inform the VUNHST planning, the myriad of operational decisions within each clinical team within each Health Board are creating wide variation in our referrals which are challenging to predict and respond to. Operational meetings with each Health Board have bene initiated to identify these factors and incorporate into planning where possible.

Radiotherapy Waiting Times

Overall referrals to radiotherapy for May (391) exceeded predications (309). Overall attendances for May (3031) significantly exceed predictions, with 3405 actual attendances.

With the exception of urology, referrals across all tumour sites has seen an increase in the monthly average number of referrals for that site when compared to 2020/21 and 2021/22.

We have already seen higher than anticipated and planned referrals for breast cancer patients as Health Boards are commencing a range of activity to target their waiting lists and clear backlogs for breast patients. There is also some anecdotal evidence that more patients are presenting with greater burden of disease burden at a later stage, which are unsuitable for hypo-fractionation, which adds to capacity challenges. These patients may require more scans and appointments to enable their treatment.

Patient receiving radical radiotherapy within 28 day

Of the 213 patients referred for radical radiotherapy, 17 did not begin treatment within the 28 day target; 12 of these being treated by day 35. Delays with treatment related to constraints with LINAC capacity and planning capacity

There are a range of factors impacting on radiotherapy capacity. Firstly LINAC capacity is subject to ongoing additional requirements that increase time between patients for cleaning. The further aging of the fleet is impacting through additional quality assurance and breakdowns. For planning, the increase in the complexity of the planning and need for 3D plans is creating additional work and the cycle of plan production constrains capacity increases. Work is being undertaken to introduce the planned expansion in capacity through the year. This is heavily reliant on the workforce and the qualification of this year's cohort of new registrants who will join us in Q3.

Additional activity was delivered through the RCC for radiotherapy treatment during this period, although this has now ceased creating additional service pressure.

There are a number of focused immediate actions that are underway as part of the ongoing service capacity review. This includes incremental release of capacity through review of variations in practice by each SST as well as identifying options for increasing planning capacity.   Brachytherapy capacity increase is planned and a business case is in process with WHSSC.

SACT Waiting Times

We have continued to see increased pressures on the capacity available to deliver SACT treatment as a result of increased referrals, sickness, maternity and vacancies continue to be significant in nursing and booking workforce.

Sickness levels for nursing were at 11.8% and administration and clerical staff at 8%. Workforce and Organisational Development are working with the Directorate to

appropriately manage sickness. Internal mutual aid is being provided from nursing within other departments to support maintaining activity.

Referrals for SACT treatment in May (415) significantly exceeded predictions (376).

As part of managing the forecast demand in referrals for SACT services, a Taskforce has been established to develop a plan to identify additional capacity.

In order to deliver the required additional activity, nursing, pharmacy and workforce resource need to align alongside the estate plan for number of SACT chairs..

To address the nursing vacancies, we will be recruiting additional Band 3,5,6 SACT nurses with interviews scheduled for early July. A rolling recruitment programme is be implemented going forward.

There are a range of activities underway to expand capacity including temporary reassignment of staff to SACT delivery, using other service areas such as Assessment Unit to deliver some treatments that do not require SACT specialist trained staff.

Pharmacy are currently going through an Organisational Change Process (OCP), due to conclude in September, which will provide additional pharmacy resource as a result of change in working patterns.

Adverts are currently out for the booking team to address staffing levels and increase capacity.

Further work will take place through the Taskforce to identify opportunities to provide additional activity. This will include weekend working and re-instating pre-covid levels of activity at Prince Charles hospital.

All new patients and urgent patients are prioritised using Welsh Cancer Network guidance and available clinical best practice information.

Plans were underway in April and May to supplement capacity for SACT provision through circa 50 patients being treated through the Rutherford Cancer Centre in June, however the removal of this option creates ongoing pressure in the system. Plans to maximise SACT delivery at Prince Charles Hospital are underway, including the outsourcing of medication compounding.

Outpatients

Data collection relating to the 30 minute target, was paused in December 2021 due to operational pressures and staff absence as manual collection of individual patient attendances is required. We are reviewing a number of new outpatient KPIs that will enable review of the service in this area. These will form part of the new PMF development.

Therapies

All patients were seen within target in May.

Other areas

Falls

During May 2022, 1 fall was reported on first floor ward, involving a patient in an isolation cubicle.   The patient had fluctuating capacity and was COVID positive and was being nursed in an isolation cubicle. While the door of cubicle was closed, in line with infection control requirements, the patient mobilised.

The incident was investigated by the VCC Falls scrutiny panel and was deemed to be avoidable. All standards were followed but an enhanced supervision policy will be implemented in June and there will be increased collaboration with infection control staff on decisions regarding Covid positive patients.

Pressure Ulcers

No pressure ulcers reported for this month.

Healthcare Acquired Infections

There were no reported infections in May 2022.

SEPSIS bundle NEWS score

15 patients initially met the criteria for administration of the sepsis treatment bundle in May 2022. 13 patients received all elements of the bundle within 1 hour, on further review of clinical notes 2 did not satisfy the criteria.

10 patients received a diagnosis of sepsis, 9 of these patients had received all elements of the bundle within 1 hour. The 10th patient did not satisfy the criteria for the administration of the bundle therefore compliance is 100%. There were some gaps in documentation noted which have been highlighted to the team and reminders of the importance of completing all elements of the sepsis pathway documentation will be

added to the 'message of the day' morning safety briefing for the acute assessment unit nursing staff.

Delayed Transfers of Care (DTOC's)

There was no Delayed Transfer of Care was reported in May 2022.

Further detailed performance data is provided in Appendix 1

2.2   Welsh Blood Service

Supply Chain Performance

Whilst Covid related sickness continues to be challenging in collecting blood, during May the service continued to meet demand. The Blue Alert to hospitals has continued into May and has been extended to include additional blood groups. A total of 100 units of red cells were provided by NHSBT as part of our mutual aid support to help maintain stocks. Blood banks across Wales continue to work with the service in terms of a reduced stock holding to support our position. It should be noted the extended Jubilee bank holiday in early June will continue to place additional pressure on stock levels.

2.3.1   Recruitment of new bone marrow volunteers

The number of new bone marrow volunteers added to the Welsh Bone Marrow Donor Registry (WBMDR) reached 163 in May compared to 141 in the previous month. The ongoing action plan for increasing bone marrow donors includes donor recruitment promotion at universities and colleges, and engagement team visits will take place in June in a bid to further drive recruitment at the start of the academic year in September. An external marketing campaign has also been commissioned to support additional recruitment for the time.

2.3.2   Reference Serology

The turnaround times continue to be impacted significantly by unavoidable key staff absences, high levels of referrals and remains at 70% as it was last month. Work continues to be prioritised based on clinical need, and all compatibility testing is completed to the required time/date.

Staffing pressures have delayed the validation of the new automated analyser, which will improve efficiency, and work will now begin in June 2022. The testing strategy for patient samples suitable for automated testing has been completed and the findings of the recent Out of Hours Referrals Audit have been reviewed for implementation. A paper regarding service pressures and outlining solutions for maintaining service delivery will be reviewed by WBS Senior Management team in June, with a view to overseeing and improving performance in the short, medium and longer term.

2.3.2 Quality

Incidents reported to Regulator/Licensing

There were no Serious Adverse Events (SAE) reported to regulators during May

Incidents closed within 30 days

This measure has not met target (90%) for the period January to May, however the number of incidents not closed in the required timeframe decreased from 21 to 20 (14 QPulse and 6 Datix). All QPulse incidents have been risk assessed, investigated and closed. Only 1 Datix incident remains open but with preventative action applied.

Whole Blood Collection Productivity

The collection productivity rate has improved, due to efficiencies from donor sessions operating at 1m instead of 2m social distancing, but remain below target. The collections team are actively preparing a recovery plan over the summer to bolster stock in light of the lifting of Covid restrictions and operations returning to pre Covid supply levels. The mobile collection units will be incorporated into donor sessions in late summer to enable the service to extend its community reach.

Number of Concerns Received

Initial responses to 7 of the 8 concerns in May were managed within 2 working days as required by the Putting Things Right (PTR) regulations. There was a delay in responding to 1 concern, due to the failure to utilise the correct reporting pathway as a result of the complexity of the concern, which has resulted in exceeding the 2 day reporting timeline.

Donor Satisfaction

Continues to perform strongly at a national level despite the COVID restrictions in place.

3.   WORKFORCE

3.1   PADR

Trust Wide 69.73%, slight increase on previous month (Target 85%)
WBS 79.26%, compliance rates slightly increased compared to last month.
VCC 68.62%, rates slightly decreased compared to last month

Sickness Absence

Trust wide 6.37%, sickness increased on last month. (Target 3.54%)
WBS 7.04%, sickness rates decreased compared to last month
VCC 6.28%, sickness increased compared to last month.

3.2 Statutory & Mandatory Compliance

Trust Wide 86.09%, above target (Target 85%)
WBS 92.44%, well above target
VCC 85.46%, tracking above target

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   Trust Board is asked to **NOTE** the contents of the attached performance reports.

Appendices

1. VCC May PMF Report
2. WBS May PMF Report
3. Workforce PMF Report

Velindre Cancer Centre Monthly Performance Report Summary Dashboard (May 2022)

			Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Radiotherapy	Patients Beginning Radical Radiotherapy Within 28-Days (page 7)	Actual	94%	97%	96%	97%	96%	92%	78%	92%	92%	92%	87%	92%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Patients Beginning Palliative Radiotherapy Within 14-Days (page 9)	Actual	85%	82%	82%	82%	82%	74%	84%	90%	90%	81%	79%	81%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Patients Beginning Emergency Radiotherapy Within 2-Days (page 11)	Actual	100%	97%	100%	97%	100%	85%	89%	100%	93%	88%	84%	88%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
SACT	Patients Beginning Non-Emergency SACT Within 21-Days (page 12)	Actual	98%	99%	99%	98%	99%	99%	99%	94%	91%	71%	69%	61%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Patients Beginning Emergency SACT Within 2-Days (page 14)	Actual	100%	100%	100%	100%	100%	86%	100%	100%	100%	83%	100%	100%
		Target	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 30 minutes of the Scheduled Appointment Times (National Target) (page 19)	Actual	76%	76%	53%	53%	65%	65%						
		Target	100%	100%	100%	100%	100%	100%	In December 2021 data collection paused.					

			Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Therapies	Did Not Attend (DNA) Rates	Actual	4%	5%	5%	5%	5%	5%	3%	3%	3%	3%	3%	3%
		Target	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%
	Therapies Inpatients Seen Within 2 Working Days (page 17)	Actual (Dietetics)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Physiotherapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Occupational Therapy)	100%	100%	100%	100%	95%	100%	100%	100%	100%	100%	100%	100%
		Actual (Speech and Language Therapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	67%	100%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	%
	Therapies Outpatient Referrals Seen Within 2 Weeks (page 17)	Actual (Dietetics)	84%	94%	94%	98%	97%	100%	95%	98%	100%	98%	100%	100%
		Actual (Physiotherapy)	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%
		Actual (Speech and Language Therapy)	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%

			Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
	Routine Therapies Outpatients Seen Within 6 Weeks (page 17)	Actual (Dietetics)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Physiotherapy)	100%	100%	100%	100%	100%	100%	100%	86%	100%	100%	100%	100%
		Actual (Occupational Therapy)	100%	100%	96%	33%	78%	100%	100%	100%	100%	100%	100%	100%
		Actual (Speech and Language Therapy)	100%	96%	100%	100%	96%	100%	100%	100%	100%	100%	100%	100%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Safe and Reliable Care	Number of VCC Acquired, Avoidable Pressure Ulcers (page 19)	Actual	0	0	2	1	1	0	1	0	1	1	0	0
		Target	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
		Target	0	0	0	0	0	0	0	0	0	0	0	0
	Number of VCC Inpatient Falls (page 21)	Actual (Total)	1	3	4	2	3	1	4	3	2	9	4	1
		Unavoidable	1	3	4	1	3	1	4	2	2	9	3	0
		Avoidable	0	0	0	1	0	0	0	1	0	0	1	1
		Target	0	0	0	0	0	0	0	0	0	0	0	0
	Number of Delayed Transfers of Care (DToCs)	Actual	0	0	1	0	4	0	0	1	4	1	1	0

			Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
		Target	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
		Target	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 (page 24)	Actual	100%	80%	100%	75%	100%	100%	100%	100%	100%	100%	88%	100%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Healthcare Acquired Infections (page 25)	Actual	0	1 (*C.diff*)	0	0	0	0	0	1 (*C.diff*)	0	0	0	0
		Target	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%	%
		Target	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.

Radiotherapy Referral Trends – Overall

Monthly Average (2020-21)	Monthly Average (2021-22)	Total New Patient Referrals (May 2022)
315	343	397

Total New Patient Referrals by Month to May 2022
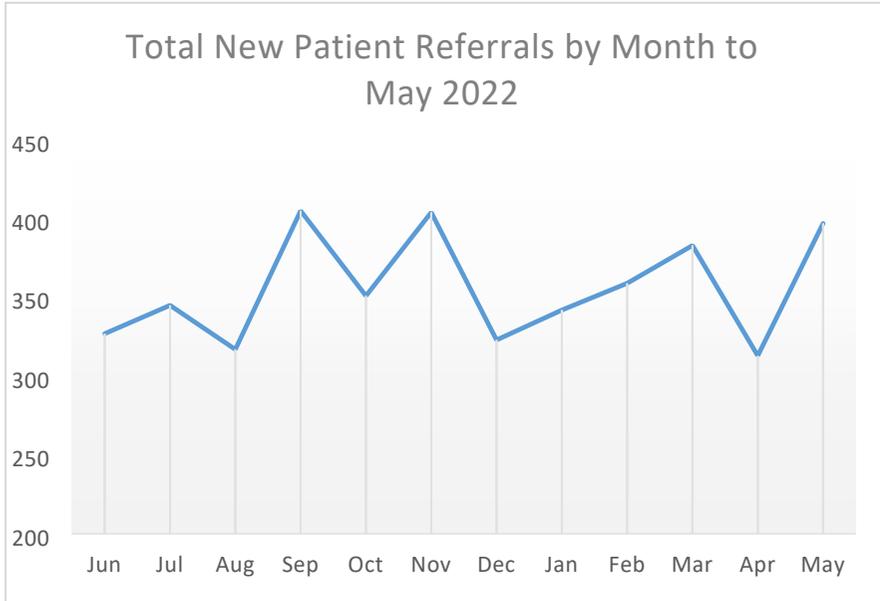
The total number of referrals received in May 2022 (397) was markedly higher than those received in April 2022 (313). The number of referrals was also higher than the average number received in any month, on average, during 2020-21.

Areas of risk:

Brachytherapy surge due in May 2022. Capacity to meet demand remains limited. This is under active surveillance and subject to a business case to WHSSC for increased capacity

Referral Trends - Tumour Site
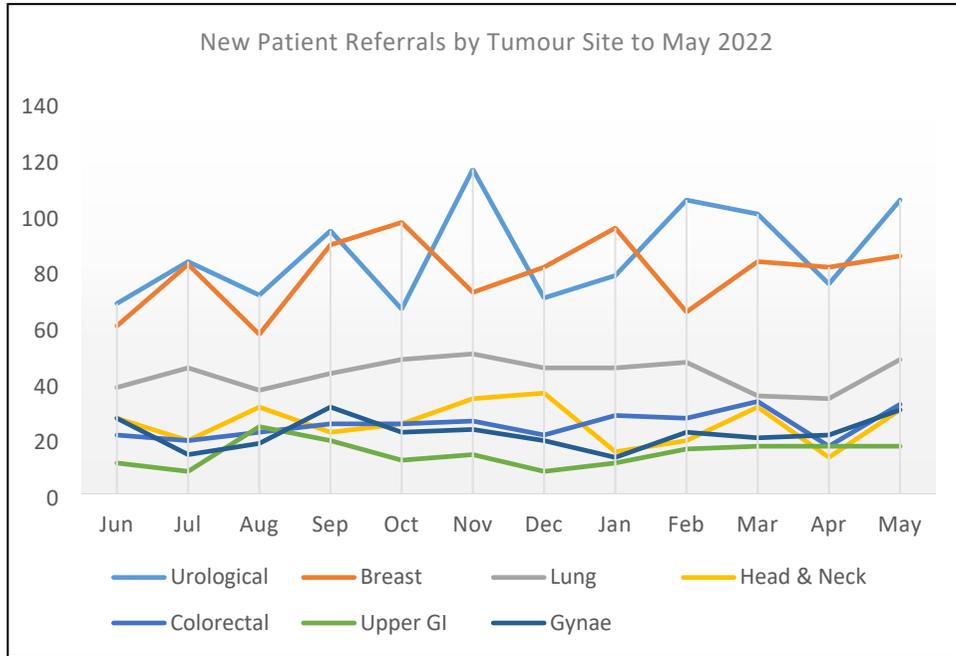
New Patient Referrals by Tumour Site to May 2022

Site	Monthly Average (2020-21)	Monthly Average (2020-21)	Monthly Average (2021-22)	2021-22 Average Relative to 2020-21 Average	New Patients (May 2022)
Breast	88	60	81	+35%	85
Urology	82	82	78	-5%	105
Lung	47	38	40	+5%	48
Colorectal	20	22	24	+9%	32
Head and Neck	23	23	25	+9%	30
Gynaecological	18	18	20	+11%	30
Upper Gastrointestinal	16	13	14	+8%	17
Top 7 Tumour Sites by Number of Referrals as Percentage of Total Referrals	82%	81%	82%		87%

The graph and table show the number of patients scheduled to begin treatment in May by the tumour sites most commonly referred for radiotherapy treatment.

- Referrals overall and across some tumour sites now returning to pre-covid levels.
- Referrals in the tumour sites most commonly referred for radiotherapy is up from 82% to 84% against the 2019/20 baseline.
- Weekly variation in referrals from health boards, across individual tumour sites, is impacting on our ability to meet demand in a timely fashion as our LINACs are configured to individual or groups of tumour sites, so limits flexibility. We are reviewing configuration to explore all options to flex to demand. Engagement with health boards ongoing to understand their backlog clearance plans.
- All options being explored by Site Specialist Teams (SST's) to meet short term surges and to respond to health board backlog clearance.

Patients Receiving Radical Radiotherapy Within 28-Days	
Target: 98%	**SLT Lead: Radiotherapy Services Manager**
Trend	Current Performance

Patients Receiving Radical Radiotherapy Within 28 Days

The number of patients scheduled to begin radical radiotherapy treatment in May 2022 (213) was significantly more than the monthly average observed in 2021-22 (170), but was larger than the number scheduled to begin treatment in the previous month (188).

Intent	Monthly Average (2020-21)	Monthly Average (2021-22)	Patients Scheduled to Begin Treatment (May 2022)
Radical	150	170	213
	Patients Scheduled to Begin Treatment (May 2020)	Patients Scheduled to Begin Treatment (May 2021)	
	168	159	

Current Performance

17 of the 213 patients referred for radical radiotherapy did not begin treatment within the 28 day target constituting an overall performance rate of 92**%.** 12 of these were treated by day 35.

Breaches were due to capacity constraints and followed an approved clinical prioritisation process to ensure risk to patients and outcomes is minimised.

Capacity secured at the Rutherford centre which has been utilised in the last few months and planned to be used for the next 6 months is now unavailable which will increase the capacity challenge.

There were a number of places in the care pathway where capacity constraints caused the target time to treat to be breached and these are listed below. A number of breaches (5) were due to constrained treatment machine (linac) capacity. 3 breaches were the result of the requirement to undertake a re-scan. Delays associated with planning processes also accounted for a number of delays (4). Limited brachytherapy capacity resulted in 1 breach and 1 was due to a lack of MRi capacity. All patients were subject to clinical prioritisation.

A comprehensive review of service capacity for each element of the service is underway which includes maximising capacity at all stages and scoping options to manage variation in referral patterns and all options for increasing capacity are explored and secured. These are being formally monitored through a weekly capacity and demand meeting.

Breakdown of breach length of waits:

Treatment Intent	< 35 days	≥ 35 days	≥ 40 days
Radical (28-day target)	12	2	3

Short term actions:
- Escalation processes continue to monitor predicted breaches and prevent breaches where possible through weekly capacity meetings. Delays and cancellations are monitored weekly and reported back to Radiotherapy Management Group and the pathway sub-group (see below)
- Recognising breaches resultant from pressure other than LINAC capacity, the Medical Directorate has identified a pathway lead to review all breaches with the SSTs responsible and to target the areas where there are process variation. This took effect from March 2022.

Medium Term Actions

- We are working with each SST to develop a tailored capacity delivery plan based on demand projections and treatment options e.g. Brachytherapy, molecular radiotherapy.
- Recruitment and appointments in progress for additional front-line resources but will rely on the newly qualified staff who register in the autumn. However, this will not create capacity increases until Q3/4 of 2022 due to lead in time, but we will be maximising capacity from September-December 2022.
- Brachytherapy expansion business case has been written and is currently going through internal governance implementation timescales pending approval to begin June 2022.

Patients Receiving Palliative Radiotherapy Within 14-Days	
Target: 98%	**SLT Lead: Radiotherapy Services Manager**
Trend	Current Performance

Patients Receiving Palliative Radiotherapy Treated Within 14 Days

The number of patients scheduled to begin palliative radiotherapy treatment in May 2022 (84) was above the monthly average observed in 2021-22 (71) and was higher than the number scheduled to begin treatment in April (76).

Intent	Monthly Average (2020-21)	Monthly Average (2021-22)	Patients Scheduled to Begin Treatment (May 2022)
Palliative	75	71	84
	Patients Scheduled to Begin Treatment (May 2020)	Patients Scheduled to Begin Treatment (May 2021)	
	78	67	

Of the 84 patients referred for radiotherapy treatment with palliative intent scheduled to begin treatment in May 2022, 16 did not begin treatment within the 14-day target constituting an overall performance rate of **81%.**

Breakdown of breach length of waits:

Treatment Intent	< 21 days	≥ 21 days	45 days
Palliative (14-day target)	7	5	4

The requirement of 3D planning resulted in 4 breaches (medical physics processes are designed to deliver this in 21 days). 2 further breaches were attributed to limited linac capacity. 1 breach resulted from a change in treatment intent and 1 was attributed to a referral being accepted before all necessary clinical investigations had been completed.

As a result of breaches primarily reflecting issues in areas of pathway not necessarily linac capacity, the Medical Directorate has identified a pathway lead to review all breaches with the SSTs responsible and to target the areas where there are process variation. This process took effect in March 2022.

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

Patients Receiving Emergency Radiotherapy Treated Within 2 Days

Target % in 2 days
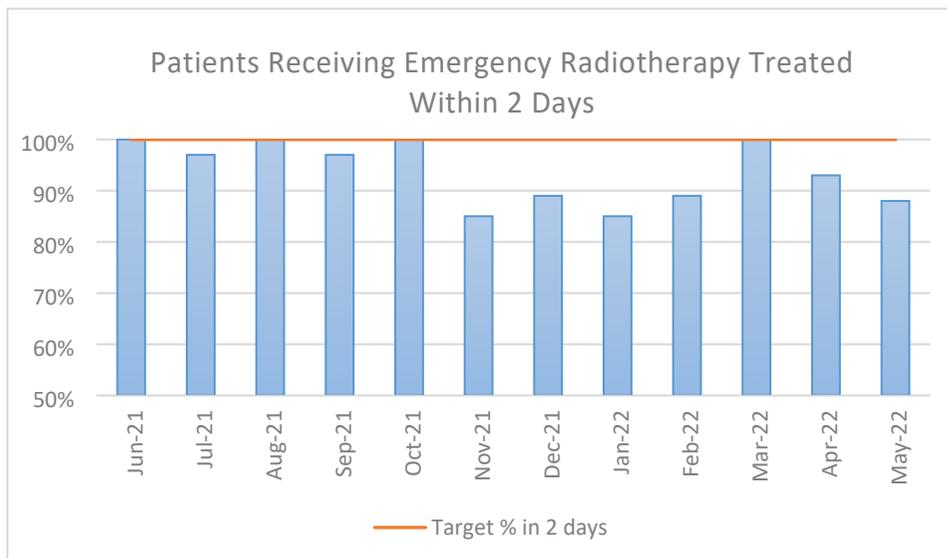
17 patients referred for radiotherapy treatment with emergency intent were scheduled to begin treatment in May 2022. Of these 2 and did not begin treatment within the 2 day target constituting an overall performance rate of **88%.**

1 patient was treated on day 3 and the second on day 5. One delay was attributed to restricted LINAC capacity and the second to a change of treatment intent.

Wider Actions as above for 28 and 14 day targets

The number of patients scheduled to begin emergency radiotherapy treatment in May 2022 (17) was fewer than the number scheduled to begin treatment in the previous month (19).

Intent	Monthly Average (2020-21)	Monthly Average (2021-22)	Patients Scheduled to Begin Treatment (May 2022)
Emergency	27	24	17
	Patients Scheduled to Begin Treatment (May 2020)	Patients Scheduled to Begin Treatment (May 2021)	
	21	17	

Non-Emergency SACT Patients Treated Within 21-Days	
Target: 98%	**SLT Lead: Chief Pharmacist**
Current Performance	Trend

SACT Referrals Actual v Projected by Month Excludes Oral SACT

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
SACT Referrals Actual 2019/20	315	334	309	387	310	284	359	295	317	394	276	379
SACT Referrals Actual 2020/21	242	211	300	303	275	327	312	313	309	298	330	375
SACT Referrals Actual 2021/22	376	336	349	342	306	295	341	364	343	335	350	396
SACT Referrals Actual 2022/23	345	415										
SACT Referrals Projections 2022/23	421.12	376.32	390.88	383.04	342.72	330.4	381.92	407.68	384.16	375.2	392	443.52

Trend

401 patients were referred for non-emergency SACT treatment scheduled to begin treatment in May 2022. Of this total, 158 patients did not begin treatment within the 21 day target, constituting an overall performance rate of 61%.

Of the 158 patients who did not begin treatment within 21-days:

Treatment Intent	≥ 28 days	29 - 35 days	36- 42 days	> 42 days
Non-emergency (21-day target)	32	49	54	23

All patients within a Clinical Trial are booked within the trial timeframes to ensure compliance with the trial protocols.

Due to current capacity constraints within SACT, all new patients and urgent patients are prioritised using Welsh Cancer Network guidance and available clinical information. Patient escalation due to clinical priority is reviewed daily.

SACT Attendances Actual v Projected by Month
Excludes Oral SACT
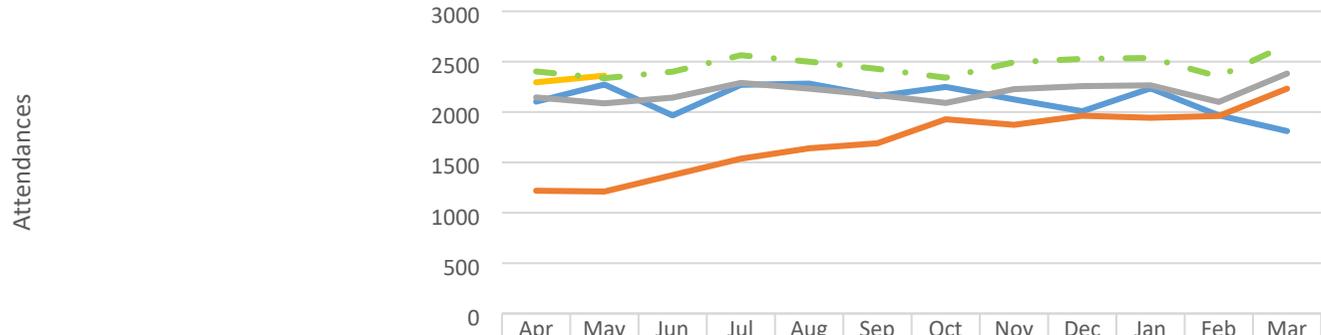
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
SACT Attendances Actual 2019/20	2103	2273	1966	2270	2282	2158	2249	2125	2008	2235	1967	1811
SACT Attendances Actual 2020/21	1219	1211	1374	1537	1640	1690	1928	1873	1963	1943	1961	2232
SACT Attendances Actual 2021/22	2145	2086	2143	2289	2232	2168	2090	2227	2257	2265	2100	2382
SACT Attendances Actual 2022/23	2295	2361										
SACT Attendances Projections 2022/23	2402	2336	2400	2564	2500	2428	2341	2494	2528	2537	2352	2668

Daily SACT Escalation meetings continue to be held with senior clinical SACT team leads who actively manage this prioritisation process and endeavour to ensure that all patients are treated in as timely a manner as possible according to their clinical prioritisation category and date of referral to the service.

There was an expectation that additional provision from Rutherford Cancer Centre would commence in June to provide parenteral SACT for 50 patients per week as an interim measure while the longer term sustainable plan to move to Prince Charles Hospital and eventually Neville Hall Hospital was delivered. The Rutherford option is no longer available and has increased the challenge in providing capacity requirements.

A comprehensive review of capacity covering all elements of the SACT service including physical space, clinical review of patients and pharmacy drug compounding has been undertaken and phased plans are in development to increase capacity and all options for increasing capacity are explored and secured.

	All treatments that can be safely delivered outside of the SACT clinic have now been moved to other areas of the service.
	Actions
	- Mutual aid arrangements from other parts of the service have been recommenced. - Weekend clinics are planned to commence in August. - Treatment regimens which can be delivered in other clinical areas have been actioned and further are being explored to release capacity in the SACT clinic area. - A SACT Taskforce has been established to identify solutions to support the service in increasing capacity, productivity, and sustainability. Commenced June 2022 and ongoing. - Discussions with Aneurin Bevan UHB regarding the reintroduction of services at Nevill Hall Hospital (NHH) as an interim solution have taken place. NHH colleagues are considering options. - A plan to maximise service delivery at Prince Charles Hospital is being enacted.

Emergency SACT Patients Treated Within 5-Days	
Target: 98%	**SLT Lead: Chief Pharmacist**
Current Performance	Trend

Emergency SACT Patients Treated Within 5 Days

The number of patients scheduled to begin emergency SACT treatment in May 2022 (12) was higher than in April (10).
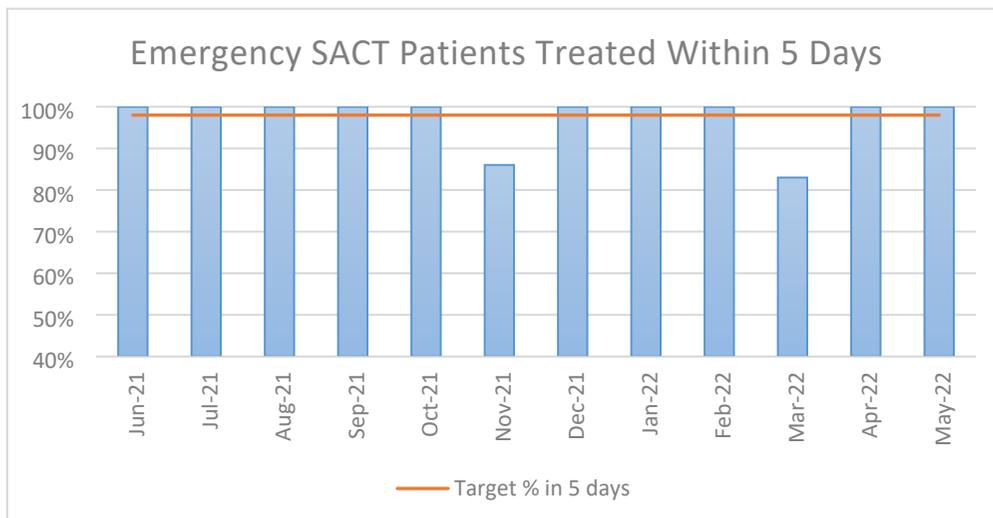
12 patients referred for emergency SACT treatment were scheduled to begin treatment in May 2022. All patients began treatment within target.

- Ring fencing of emergency chair capacity has allowed us to improve the compliance in this area. This took a number of months until the correct balance between ring fencing and chair utilisation was achieved.

Actions

- Continue to balance demand and ring fencing with capacity.

Intent	Monthly Average (2020-21)	Monthly Average (2021-22)	Patients Scheduled to Begin Treatment (May 2022)
Emergency	4	7	12
	Patients Scheduled to Begin Treatment (May 2020)	Patients Scheduled to Begin Treatment (May 2021)	
	5	14	

SACT – Operational Context			

Current Performance Consolidated

Measure	Target	May-22	The table shown here sets-out performance relative to the extant time to SACT targets.
Non-emergency (21-day target)	98%	**61%**	
Emergency (5-day target)	98%	**100%**	

Referral Trends - Overall

Total New Patient Referrals by Month to May 2022
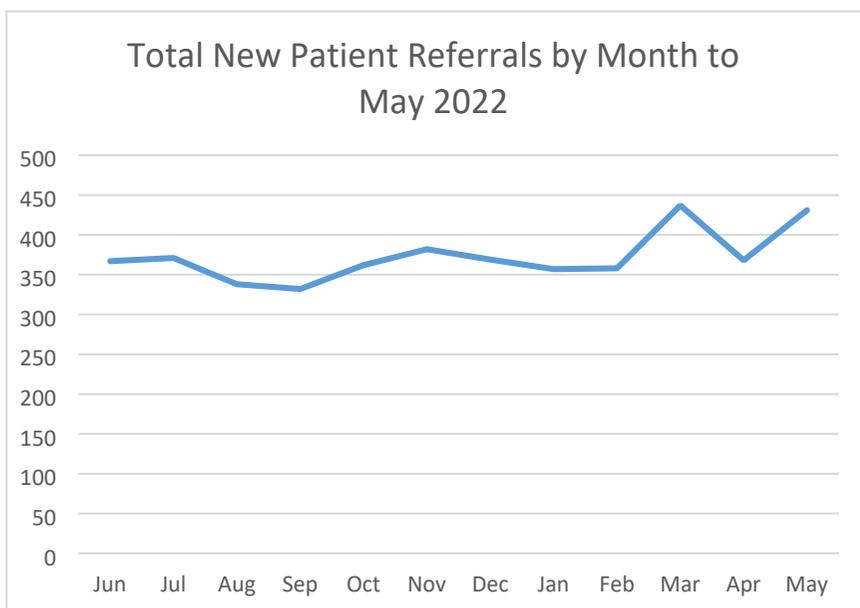
Monthly Average (2020-21)	Monthly Average (2021-22)	Total New Patient Referrals (May 2022)
301	346	431

The total number of referrals received in May 2022 (431) was greater than the average number received in any given month during 2021-22 (346) and was greater than the total received in April 2022 (368).

Referrals fell dramatically following the first national lock-down in March 2020. Subsequently, referrals have returned to pre-pandemic levels.

Referrals include new patients for 1st definitive treatment and repeat treatments for patients mid cycle or on a revised treatment cycle.

Referral Trends - Tumour Site

New Patient Referrals by Tumour Site to May 2022

Legend: Breast, Colorectal, Lung, Gynae, Urological, Upper GI, Head & Neck

Site	Monthly Average (2019-20)	Monthly Average (2020-21)	Monthly Average (2021-22)	2021-22 Average Relative to 2020-21 Average	New Patient Referrals (May 2022)
Breast	**92**	**76**	**101**	**+33%**	74
Colorectal	**54**	**55**	**55**	**0%**	28
Lung	**33**	**32**	**37**	**+16%**	22
Gynaecological	**31**	**31**	**34**	**+10%**	29
Urological	**36**	**26**	**30**	**+15%**	22
Upper Gastrointestinal	**18**	**26**	**30**	**+15%**	14
Head and Neck	**16**	**14**	**16**	**+14%**	11
Top 7 Tumour Sites by Number of Referrals as Percentage of Total Referrals	**86%**	**87%**	88%		46%

The graph and table show referrals for the tumour sites most commonly referred for SACT treatment.

SACT referrals are being driven by a high level of internal demand as a result of new/combination regimens, increasing patient treatment cycles etc.

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

	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Dietetics	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Physiotherapy	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
OT	100%	100%	100%	100%	95%	100%	100%	100%	100%	100%	100%	100%
SLT	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	67%	100%

Percentage of Urgent Therapies Referrals (Outpatients) Seen Within 2 Weeks

	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Dietetics	84%	94%	94%	98%	97%	100%	95%	98%	100%	98%	100%	100%
Physiotherapy	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
OT	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
SLT	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Percentage of Routine Therapies (Outpatients) Seen Within 6 Weeks

	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Dietetics	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Physiotherapy	100%	100%	100%	100%	100%	100%	100%	86%	100%	100%	100%	100%
OT	100%	100%	96%	33%	78%	100%	100%	100%	100%	100%	100%	100%
SLT	100%	96%	100%	100%	96%	100%	100%	100%	100%	100%	100%	100%

All patients were seen within target during May.	No specific action required.

Velindre Acquired Pressure Ulcers	
Target: 0	SLT Lead: Head of Nursing
Current Performance	

Total Number of Velindre Acquired Pressure Ulcers

Velindre Acquired Pressure Ulcers (Total) — Mean ----- Process Limit
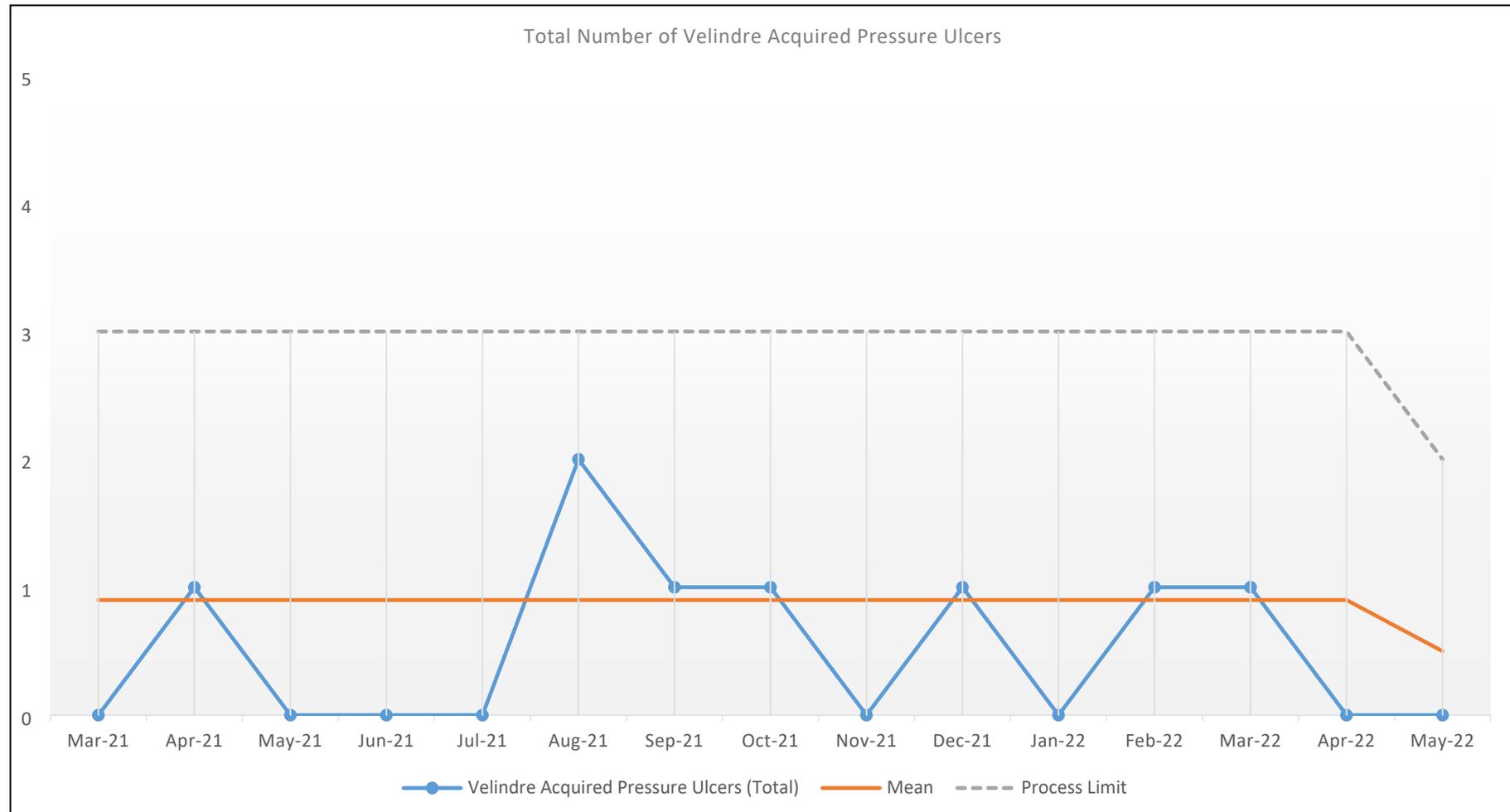
	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Velindre Acquired Pressure Ulcers (Total)	0	0	1	0	0	0	2	1	1	0	1	0	1	1	0
Potentially Avoidable Velindre Acquired Pressure Ulcers	0	0	1	0	0	0	0	0	0	0	0	0	1	0	0

Trend	Action
No pressure ulcers were reported in May 2022. No Velindre acquired ulcers were reported to Welsh Government as a Serious Incident (SI).	No further action required.

Velindre Inpatient Falls	
Target: 0	**SLT Lead: Head of Nursing**
Current Performance	
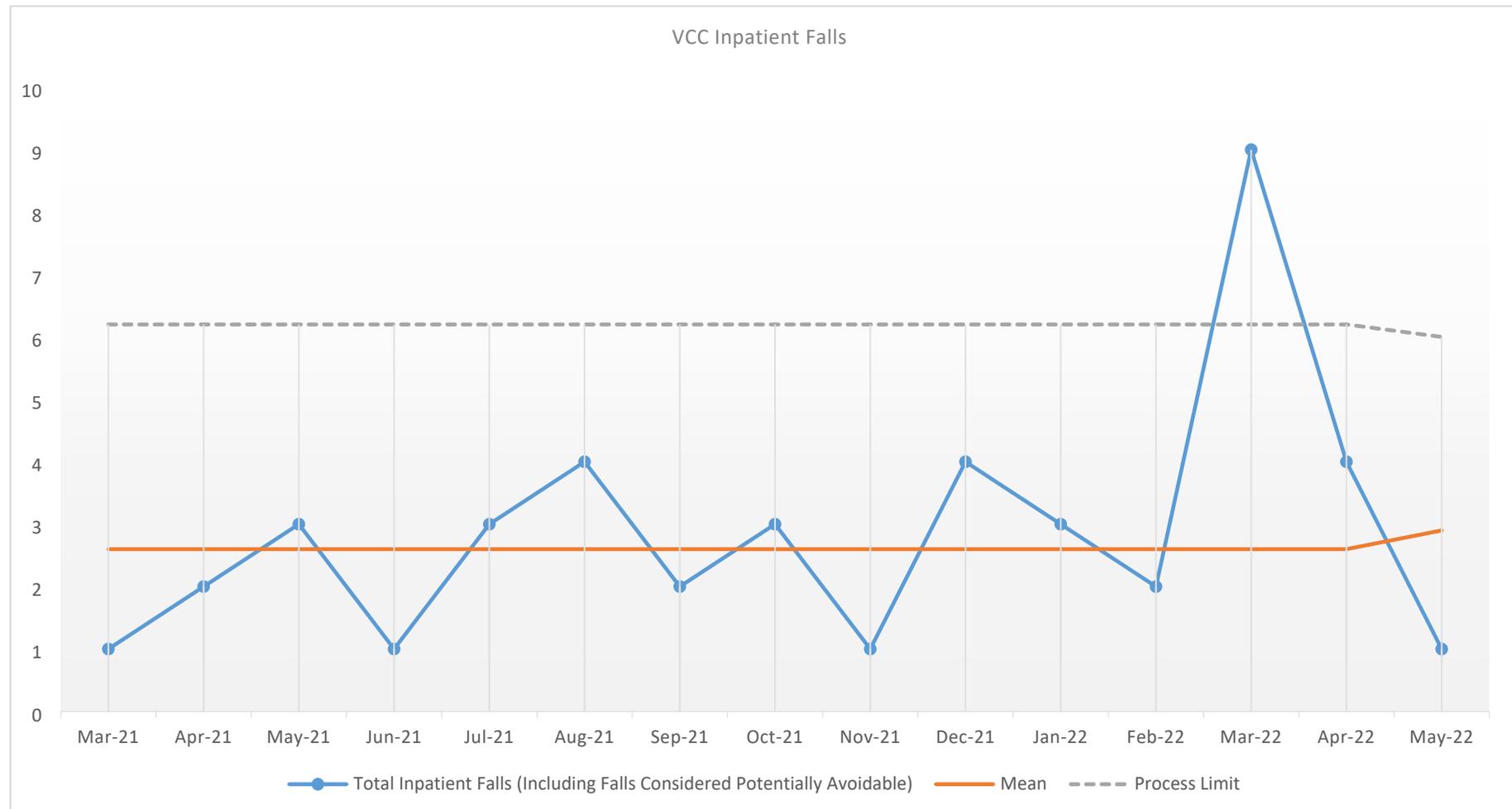
VCC Inpatient Falls

Total Inpatient Falls (Including Falls Considered Potentially Avoidable) — Mean — Process Limit

	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Total Inpatient Falls	1	2	3	1	3	4	2	3	1	4	3	2	9	4	1
Potentially Avoidable Inpatient Falls	0	1	0	0	0	0	1	0	0	0	1	0	0	1	1

Trend	Action
During May 2022, 1 fall was reported on First Floor Ward. The incident has been fully investigated by the VCC Falls Scrutiny Panel which has a wide range of membership with independence provided via a member of the Corporate Nursing. The fall was deemed avoidable. The patient was COVID positive and was being nursed in an isolation cubicle. While the door of cubicle was closed, in line with infection control requirements, the patient mobilised. All assessments were completed in line with standards and appropriate post fall care adjustments made and medical review undertaken.	Although all standards were followed there was some additional learning was identified by the Scrutiny Panel that could further improve standards: • Enhanced supervision policy to be developed and implemented (June 2022). • Involve infection control colleagues in management decisions in the case of patients who are assessed to be at risk of a fall and who are COVID positive (June 2022).

Delayed Transfer of Care	
Target: 0	**SLT Lead: Head of Nursing**
Current Performance	

No Delayed Transfer of Care (DToC) was reported in May 2022.

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

Proportion of Patients with a NEWS Score Greater Than or Equal to Three Who Received All Six Elements in Required Timeframe

Trend

15 patients met the criteria for administration of the sepsis treatment bundle in May 2022. 13 patients received all elements of the bundle within 1 hour. 10 patients received a diagnosis of sepsis, 9 of these patients had received all elements of the bundle within 1 hour.

On review, the patients who did not receive all elements of the bundle within 1 hour did not satisfy the criteria for the administration of the bundle. As such, performance was deemed to be 100%.

Actions

Staff to be reminded of the importance of completing all elements of the sepsis pathway documentation (June 2022).

Healthcare Acquired Infections (HAIs)

Target: 0	SLT Lead: Clinical Director

Current Performance

	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
C.diff	0	0	1	0	0	0	0	1	0	1	0	0
MRSA	0	0	0	0	0	0	0	0	0	0	0	0
MSSA	0	0	0	0	0	0	0	0	0	0	0	0
E.coli	0	0	0	0	0	0	0	0	0	0	0	0
Klebsiella	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

Trend	Action
There were no reported infections in May 2022.	No specific action required.

Gwasanaeth Gwaed Cymru
Welsh Blood Service

- The Welsh Blood Service continuously monitors the availability of blood for transfusion through its daily resilience group meetings and plans its collection model to meet demand. Whilst Covid related sickness continues to be challenging in collecting blood, during May the service continued to meet demand for red cells with demand for O, A and B positive groups maintained above 3 days. The Blue Alert issued on 21/03/2022 remains in place however the service has extended the alert to also include O and D negative red cells as well. The extended Jubilee bank holiday will place additional pressure on stock levels due to reduced collection opportunities and 100 red cells were provided by Mutual Aid support to help maintain stock. It should be noted that all UK services are experiencing similar issues. WBS continues to work closely with blood banks across Wales and they have reduced their stockholding, which in turn, provides WBS with flexibility in managing the current situation. Demand in May averaged at 1497 units per week, increasing slowly towards pre coved levels.

- The number of new bone marrow volunteers added to the Welsh Bone Marrow Donor Registry (WBMDR) reached 163 in May compared to 141 in April, but is still below target. The service is taking a two-pronged approach to increase the number of bone marrow volunteers which includes promoting 'SWAB' kits and increasing the number of younger donors donating blood. The ongoing action plan for increasing bone marrow volunteers includes donor recruitment promotion at universities and colleges, profiling on social media as well as improving content and visibility on the WBS website. In June, staff will visit local colleges to discuss the recruitment of volunteer bone marrow donors and plan to attend collection sessions at colleges and universities upon the start of the academic year. In addition, the service is commissioning an external marketing campaign to further drive the recruitment of volunteers. Following these actions, increases in bone marrow donors are anticipated from September onwards.

- Stem cell collections in Wales continue to be affected by the COVID pandemic which has impacted on unrelated donor stem cell transplants globally, resulting in lower stem cell collection requests. The service has also seen a higher cancellation rate (30%) compared to that pre pandemic (15%). This is due to patient fitness and the requirement for collection centres to 'work up' two donors simultaneously in order to ensure sufficient number of donors available at the required point of a patient's treatment. The move to apheresis stem cell collection at Velindre Cancer Centre (VCC) has provided additional capacity and has enabled 6 stem cell collections to be planned in June. In addition, the five year strategy currently under development will reappraise the existing collection model and its ambition.

- Against a target of 80%, Red Cell Immunology turn around performance remains at 70% for May and continues to be impacted significantly by key staff absences and a repeated high level of referrals (233). Work continues to prioritise clinical need, and all compatibility testing is completed to the required time/date. Whilst the complexity of referrals continues to impact performance in May, staff absence remains the most significant factor in this. Staffing pressures have delayed validation of the new automated analyser, which will improve efficiency, and work will now begin in June 2022. The testing strategy for patient samples suitable for automated testing has been completed and the findings of the recent Out of Hours Referrals Audit have been reviewed for implementation. A paper regarding service pressures and outlining solutions for maintaining service delivery will be reviewed by WBS SMT in June, with a view to overseeing and improving the performance of the department in the short, medium and long term.

- The collection productivity rate has improved, due to efficiencies from donor sessions operating at 1m instead of 2m social distancing, but remains below target of 1.25. The collections team are actively preparing a recovery plan over the summer to bolster stock in light of the lifting of Covid restrictions and operations returning to pre Covid supply levels. In May, work commenced to ensure adequate ventilation in mobile donor collection vehicles to meet Covid requirements. It is anticipated that a mobile unit will be incorporated into donor sessions in the summer to enable the service to extend its community reach. Collections are looking to maximise efficiency of larger clinics which is expected to positively support performance against this measure.

- At 86%, performance against the 'Incidents closed within 30 days' measure has not met the target of 90% for the 3 month rolling period to May. The number of incidents not closed within the timeframe decreased from 21 to 20 in May with performance via QPulse at 83% and Datix at 90%. All QPulse incidents have been risk assessed, investigated and closed. All Datix incidents were low or no harm events. 5 were closed but exceeded the 31-day closure limit whilst the remaining Datix incidents remain open with preventive action applied. There were no external audits undertaken or any Serious Adverse Events (SAE) reported to regulators during May. It should be noted that an MHRA inspection is planned to take place between the 8-10 June at the WBS Site in North Wales.

- In May, 7,487 donors were registered at donation clinics. 8 concerns (0.11%) were reported within this period. No formal concerns were due to be completed in May and whilst 2 formal concerns were received in May, both are due to be completed in July under 'Putting Things Right' (PTR) guidelines. Initial responses to 7 of the 8 concerns in May were managed within 2 working days as required by PTR regulations. There was a delay in responding to 1 concern, due to the failure to utilise the correct reporting pathway as a result of the complexity of the concern, which has resulted in exceeding the 2 day reporting timeline. 476 new donors completed a donation in May, 6.68% of the total donations received. During the pandemic, appointment slots have been reduced to match hospital demand resulting in fewer available opportunities for new donors to donate. Detailed planning for the return to universities and colleges will take place from June onwards, whilst school venues (used prior to Covid) are being contacted to reintroduce the sessions once schools return in September and should produce results post September. At 96% donor satisfaction continued to be above target for May. In total there were 1,216 respondents to the donor survey.

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

May-22

BMV Donors
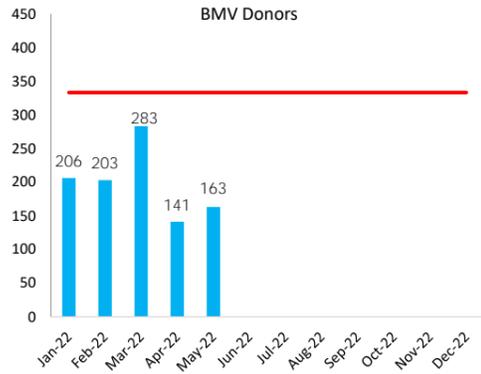
Annual Target: 4000 (ave 333 per month)	SMT Lead: Jayne Davey / Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
The number of new bone marrow volunteers added to the Welsh Bone Marrow Donor Registry (WBMDR) reached 163 in May compared to 141 in April, but is still below target.

There were no university or college collection sessions due to the end of the academic year. Coupled with a lower number of eligible (17-30 year old) bone marrow volunteers at community collection sessions, this has contributed to only a small increase in bone marrow volunteers in May. | The Service is taking a two-pronged approach to increase the number of bone marrow volunteers which includes promoting 'SWAB' kits and increasing the number of younger donors donating blood.

The ongoing action plan for increasing bone marrow volunteers includes donor recruitment promotion at universities and colleges, profiling on social media as well as improving content and visibility on the WBS website. In June, staff will visit local colleges to discuss the recruitment of volunteer bone marrow donors and plan to attend collection sessions at colleges and universities upon the start of the academic year. In addition, the service is commissioning an external marketing campaign to further drive the recruitment of volunteers.

Following these actions, increases in bone marrow donors are anticipated from September 2022 onwards. | Rolling Action Plan |

May-22

Number of days red cell stock level is below 3 days for groups O, A & B-
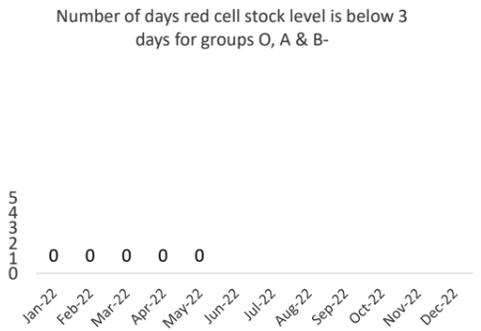
Monthly Target: 0	SMT Lead: Jayne Davey / Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
O, A and B positive blood groups continued to be maintained above 3 days.

This is core business and is reviewed on a daily basis at resilience meetings and any concerns are escalated via WBS Senior Management Team (SMT) leads for immediate action.

The Blue Alert issued on 21/03/2022 remains in place but the service has extended the alert to also include O and D negative red cells as well due to continued low stock levels in these groups. | The Welsh Blood Service constantly monitors the availability of blood for transfusion through its daily 'Resilience Group' meetings which include representatives from all departments supporting the blood supply chain and includes the collections, manufacturing, distribution and blood health team.

At the meetings business intelligence data is also reviewed and facilitates operational responses to the challenges identified at each daily review. Appropriate operational adjustments are made to maintain adequate stock levels and minimise blood shortages.

In addition regular demand planning meetings take place to consider the more strategic aspects of blood supply. | Business as Usual, reviewed daily |

May-22

% Red Cell Demand Met

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 hospital demand for red cells was met.

Given the significant weekly variation in demand, collections and issues were effectively balanced resulting in a steady overall stock position for the month of May.

The Jubilee bank holiday will place considerable pressure on stock levels, due to reduced collection opportunities and 100 red cells were provided by Mutual Aid support to help maintain stock levels.

Stock management continues to be closely monitored and discussed at daily resilience meetings with immediate escalation to SMT if required.

Demand in May (full weeks) averaged at 1497 units per week increasing slowly towards pre coved levels. | The Welsh Blood Service constantly monitors the availability of blood for transfusion through its daily 'Resilience Group' meetings which include representatives from all departments supporting the blood supply chain and includes the collections, manufacturing, distribution and blood health team.

At the meetings business intelligence data is also reviewed and facilitates operational responses to the challenges identified at each daily review. Appropriate operational adjustments are made to maintain adequate stock levels and minimise blood shortages.

WBS continues to work closely with blood banks across Wales and they have reduced their stockholding, which in turn, provides WBS with flexibility in managing the current situation.

In addition, regular demand planning meetings take place to consider the more strategic aspects of blood supply.

The collections team are actively preparing a recovery plan over the summer to bolster stock in light of the lifting of Covid restrictions and returning operations to pre Covid supply levels | Business as Usual, reviewed daily to support responses to changes in demand |

% Platelets Demand Met

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. Platelets are produced by two different methods: Donor Apheresis and Manufactured Pools from whole blood. In combination, they provide the total number of units available each month. 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. For May, platelet demand was 216 units per week on average, higher than pre coved levels. 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.		The Ambient Overnight Hold (AONH) production process continues to allow flexibility in the production plan for platelets. Adjustments (i.e. increased production) on the weekly targets can to be made to align with increased demand. The service is undertaking a review of platelet production to assess where improvement opportunities lie. Identification and implementation of quick wins will be completed by end of July and development of a longer term strategy to address issues will be completed by end of September.	Reviewed daily

Stem Cell Collections
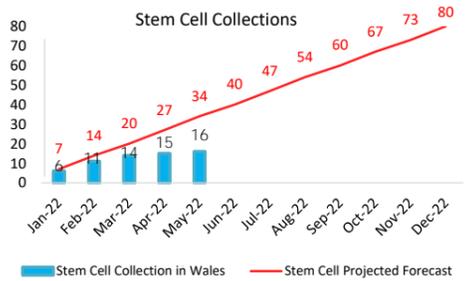
Annual Target: 80 (ave 7 per month)	SMT Lead: Tracey Rees	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Stem cell collections in Wales continue to be affected by the COVID pandemic which has impacted on unrelated donor stem cell transplants globally, resulting in lower stem cell collection requests. The service has also seen a higher cancellation rate (30%) compared to that pre pandemic (15%). This is due to patient fitness and the requirement for collection centres to 'work up' two donors simultaneously in order to ensure sufficient number of donors available at the required point of a patient's treatment.	The move to apheresis stem cell collection at Velindre Cancer Centre (VCC) has provided additional capacity and has enabled 6 stem cell collections to be planned in June 2022. In addition, the five year strategy currently under development will reappraise the existing collection model and its ambitions.	31/09/2022

Antenatal Turnaround Times
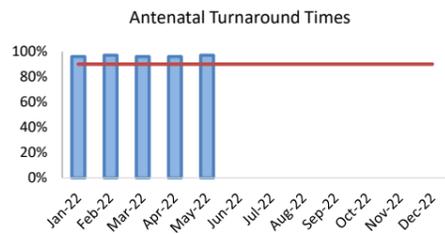
Monthly Target: 90%	SMT Lead: Tracey Rees	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
At 97%, the turnaround time for routine Antenatal tests in May remains above the target of 90% Continued monitoring and active management remains in place.	Efficient and embedded testing systems are in place. Continuation of existing processes are maintaining high performance against current target.	Business as Usual, reviewed daily

Reference Serology
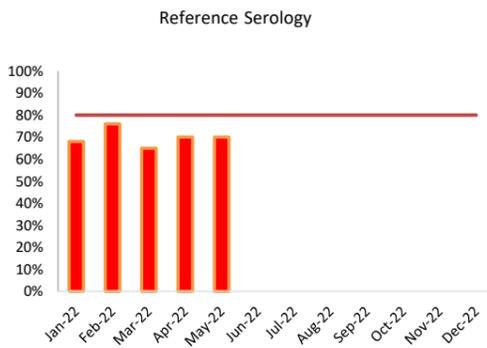
Monthly Target: 80%	SMT Lead: Tracey Rees	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
At 70% turn around times for May continued to be significantly impacted by key staff absences and a repeated high level of referrals (the number of samples referred reached 233 in May compared to the average of hospital patient referrals at 226/month for 2021 and 181/month in 2020). Staffing pressures have delayed the validation the new automated analyser, which will improve efficiency, and work will now begin in June 2022. Whilst the complexity of referrals continues to impact performance in May, the more significant impact continues to be due to unavoidable staff absences.	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 and all compatibility testing is completed to the required time/date. These requests are time critical and require provision of blood for transfusion, the tests are prioritised and patient care was not affected. Work to validate the new automated analyse will now begin in June and this will support improved efficiency. The testing strategy for patient samples suitable for automated testing has been completed and the findings of the recent Out of Hours Referrals Audit have been reviewed for implementation. A paper regarding service pressures and outlining solutions for maintaining service delivery will be reviewed by WBS SMT in June, with a view to overseeing and improving the performance of the department in the short, medium and long term.	30/06/2022

Quality Incidents closed within 30 days (rolling 3 months)

Monthly Target: 90%	SMT Lead: Peter Richardson	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
At 86%, performance has not met the target of 90% for the 3 month rolling period to May. The number of incidents not closed within the timeframe decreased from 21 to 20 (14 in QPulse and 6 in Datix) in May with performance via QPulse at 83% and Datix at 90%. All QPulse incidents have been risk assessed, investigated and closed. QPulse does not permit closure of the report until all CAPA (Corrective and Preventative Actions) are completed. The reasons for late closure is due to incomplete CAPA and not delayed investigation. Of the 6 Datix incidents, all were low or no harm events. 5 were closed but exceeded the 31-day closure requirement. The remaining Datix incidents remain open but with preventive action applied.	The revised process for managing low-impact incidents within QPulse was implemented on 1st June, new reports are reviewed and risk assessed daily and the majority of incidents are fully closed within a few days of reporting. The QA team send weekly updates alerting owners of incidents recorded within QPulse that are likely to breach close-out deadlines and close attention is paid to the progression of these incidents. The QA triage team also run bi-weekly Datix reports to ensure early recognition of any reports requiring attention. Details regarding the specific incidents that need to be progressed shall be reported to the relevant managers and SMT Leads.	Continue with close monitoring and early recognition of potential timeline breaches.

Critical Findings

Target: 0	SMT Lead: Peter Richardson	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
There were no external audits undertaken during May. However, it should be noted that an MHRA inspection is planned to take place between the 8-10 June at the WBS Site in North Wales.	No action required at this time.	Completion of existing action plans for previous external audits is monitored via the monthly RAGG meeting.

Incidents Reported to Regulator/Licensing
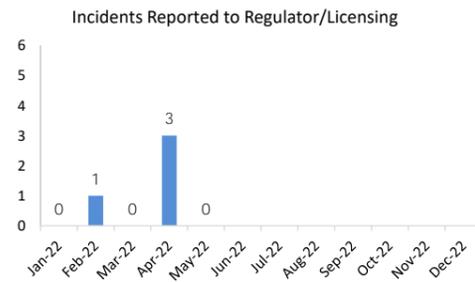
Annual Target: 0	SMT Lead: Peter Richardson	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
There were no Serious Adverse Events (SAE) reported to regulators during May.	For the previous three reports submitted to SABRE in April, all three investigations are completed. SABRE 99 is closed and the investigation reports for SABRE 100 and 101 are circulating for review and agreement of preventive actions.	The confirmatory report for SABRE 100 was due for submission by 06/05/22, and SABRE 101 by 27/05/22. Both investigations were delayed due to operational challenges and the complexity of the events being investigated. MHRA were notified of delayed submission in advance and have acknowledged the delay. Footnotes on progress have been added within the SABRE reports, to ensure MHRA are kept informed of progress.

% Part Bags

■ Total % Part Bags

Monthly Target: Maximum 3%	SMT Lead: Janet Birchall	May-22
What are the reasons for performance?	Action(s) being taken to improve performance	By When
The combined 'Part Bag' rate remains within the required tolerance level (3%) at 2.30% during May. All teams were below required tolerance levels, with the exception of the South West team which is at the threshold (3.0%). Further analysis, monitoring and investigation of the part bag rate continue to ensure no practice issues are evident. However, 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 Venepunctures (FVPs).	Performance analysis of the South West team is taking place and any emerging performance trend details passed to the Collections, Operational and Training teams to address.	Continued close monitoring and intervention where required

% Unsuccessful Venepuncture
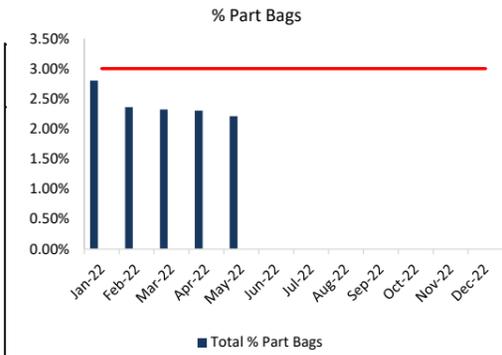
Monthly Target: Maximum 2%	SMT Lead: Janet Birchall	May-22
What are the reasons for performance?	Action(s) being taken to improve performance	By When
The combined Failed Venepuncture (FVP) rate for all whole blood teams for May remains within the required tolerance (2%) at 1.23%.	Scrutiny of tolerance levels will continue.	Continue with close monitoring and intervention where required

Whole Blood Collection Productivity
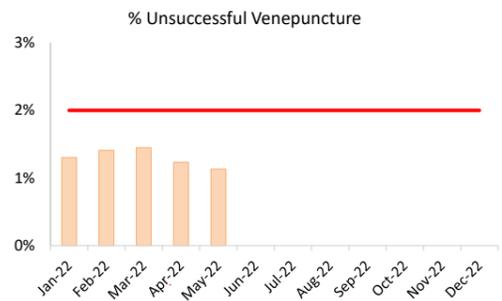
Monthly Target: 1.25	SMT Lead: Jayne Davey	May-22
What are the reasons for performance?	Action(s) being taken to improve performance	By When
The collection productivity rate has improved, due to efficiencies from donor sessions operating at 1m instead of 2m social distancing, but remains below target of 1.25. To ensure blood supply is aligned with the demands of hospitals, collection clinics continue to operate on an appointment only basis, which removes the ability to backfill 'non attendance' on the day with walk in donors.	The reduction in social distancing has improved the economy of scale for all clinics and regional variation has improved. The collections team are actively preparing a recovery plan over the summer to bolster stock in light of the lifting of Covid restrictions and operations returning to pre Covid supply levels. In May, work commenced to ensure adequate ventilation in mobile donor vehicles to meet Covid requirements. It is anticipated that a mobile unit will be incorporated into donor sessions in the summer to enable the service to extend its community reach. Collections are looking to maximise efficiency of larger clinics which is expected to positively support performance against this measure.	31/08/2022

Manufacturing Productivity
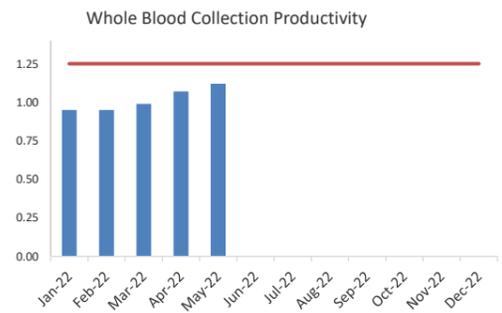
Monthly Target 392	SMT Lead: Tracey Rees	
What are the reasons for performance?	Actions(s) bring taken to improve performance	By When
At 385.90 the manufacturing efficiency performance for May was close to the target level of 400. Manufacturing efficiency, which is a European Blood Alliance (EBA) measure, is calculated by dividing working time available by the amount of work completed. The work completed relates to clinical components and does not include other work (such as commercial plasma sales) performed by the department..	This target is based on the pre Covid operating model and is due to be reviewed as part of the ongoing reporting framework.	Ongoing review

Time Expired Platelets
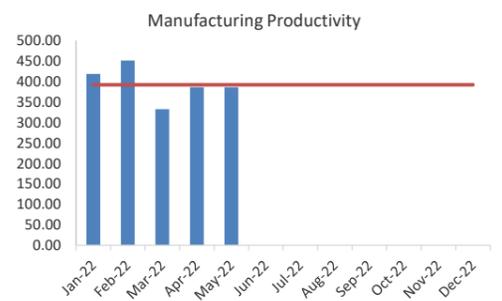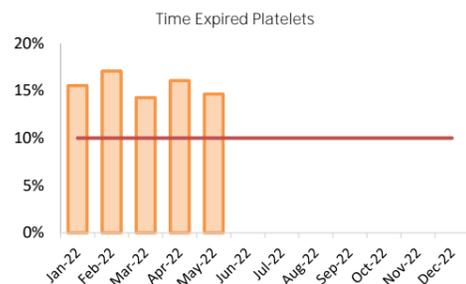
Monthly Target: Maximum 10%	SMT Lead: Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
Platelet production is increased during the period leading up to Bank Holidays due to increased uncertainty around demand and decreased opportunity to make. Platelet expiry occurred in high numbers the week following the Bank Holiday but were generally low otherwise throughout the month. NB: All demand continues to be met without the need to rely on any Mutual Aid support.	Platelets are being produced by two different methods: Donor Apheresis and Manufactured Pools from whole blood. In combination, the methods provide the total number of units available each month. The introduction of Ambient Overnight Hold process for the manufacturing of blood components has increased flexibility in production of pooled platelets. Daily communications between the Collections and Laboratory teams enables agile responses to variations of stock levels and service needs. Adjustments to the platelet manufacturing targets are made in the laboratory to better align with demand, and take into account the apheresis appointments and donor attendance. Although it should be noted that demand can fluctuate significantly on a daily basis. Given the variability of expired platelets over the past 12 months, initial analysis to understand the current situation has been completed and work is now underway to engage with stakeholders to implement quick wins (completed by end of July) and develop a longer term strategy to address the issues (completed by end of September).	Ongoing and reviewed daily

Controllable Manufacturing Losses
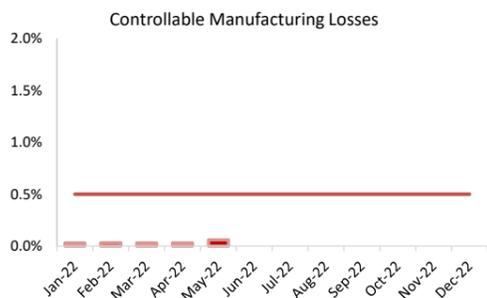
Monthly Target: Maximum 0.5%	SMT Lead: Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
Controllable losses were extremely low at 0.06% and remain within tolerance of below 0.5%. The losses were (units): M&D Operator - Heat Seal Failure: 3 units M&D Operator - Incorrect storage: 1 unit These levels are well within tolerance and represent good performance. The monthly controllable losses should be considered against total production of approx. 1500 units per week.	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
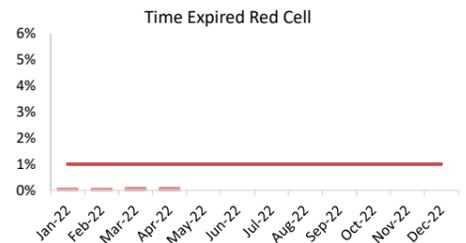
Monthly Target: Maximum 1%	SMT Lead: Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
Red cell expiry was 0.00%. The Covid challenges continue to affect the blood collection numbers resulting in faster stock turnover preventing red cells stocks from ageing in storage. This metric remains 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 Satisfactions

■ Scored 5_6 out of 6 SW   ■ Scored 5_6 out of 6 NW
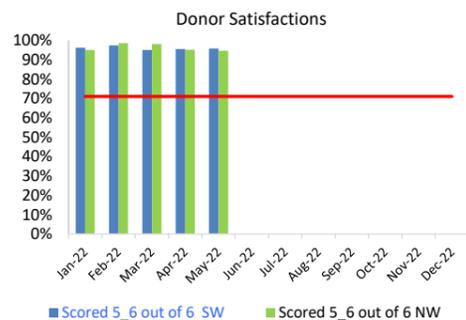
Monthly Target: Minimum 71%	SMT Lead: Jayne Davey	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
At 96% Donor Satisfaction continued to be above target for May. In total there were 1,216 respondents to the donor survey (some of which are non attributable).	Findings are reported at Collections Meeting to address any actions for individual teams.	Business as usual, reviewed monthly

Number of Concerns Received

15
10
5
0
Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22

■ Formal ■ Informal

Target: N/A	SMT Lead: Alan Prosser	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
In May 2022, 7,487 donors were registered at donation clinics. 8 concerns (0.11%) were reported within this period. 2 concerns are being managed under 30 day 'Putting things Right' (PTR) Regulations timeline, meaning that they are due to be resolved by the end of July. 6 concerns were managed within timeline as 'early resolution' and are detailed below: 1. Formal Concern - The complainant raised concerns about the level of Welsh language detail on the WBS website. 2. Formal Concern - A Donor raised concern regarding the conduct of a member of staff. 3. Three donors expressed disappointment at not being able to book a more convenient appointment. 4. 1 donor was unhappy receiving text reminders when no longer wishing to donate. 5. 1 donor was unhappy with the nature of the dialogue with a member of staff due to the donor's needle phobia. 6. 1 donor was unhappy, perceiving that booking on-line was the only option to make donation appointments.	All individual concerns have been addressed by Heads of Departments and / or Operational Managers. Following an identified trend in concerns relating to communication and staff attitude during recent months, a focus is being placed upon donor experience, satisfaction and staff communication/interactions. This trend will continue to be monitored going forward and appropriate interventions undertaken. Apart from the complaint detailed in No.3 below where there has been no response to WBS communications, all early resolution concerns have been closed to donor satisfaction within the required timescales. 1. The Communications Manager has reviewed issues raised by complainant relating to the level of bilingual content on the WBS website which has now been has updated accordingly. Welsh language considerations are to be reviewed prior to future website updates or re-launch. Changes to the new WBS website content include: • Website amended to ensure all donor eligibility 'quiz' questions are bi-lingual. • Welsh and English versions of video content now available on the website. • Welsh and English language guidance content now available on the website. 2. Observations of practice are due to commence across the collection teams in June. 3. 2 donors were happy with explanation given with both booking future appointments, whilst there has been no response to WBS communications from the third donor. 4. The explanation was accepted with the donor now categorised as 'non-notifiable' by SMS by request. 5. The Clinic Lead Nurse has discussed the donor's concerns with the staff member and will continue to monitor and provide support. WBS staff have also been reminded of the importance of retaining donors. 6. The donor has been informed that bookings can also be made via telephone and is happy with outcome and has booked their next appointment.	Business as usual, reviewed daily

% Responses to Concerns within 30 Working Days

100%
80%
60%
40%
20%
0%
100%
N/A N/A N/A N/A
Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22

Monthly Target: 100%	SMT Lead: Alan Prosser	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
No formal concerns were due to be completed in May and whilst two formal concerns were received in May, both are due to be completed in July 2022 under 'Putting Things Right' (PTR) guidelines. * 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 formal complaint response progress and 30 day target compliance. Timescale requirements communicated to all involved in concerns management.	Ongoing reviewed daily

% Concerns Acknowledged within 2 Working Days

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22

Monthly Target: 100%	SMT Lead: Alan Prosser	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
Initial responses to 7 of the 8 concerns in May 2022 were managed within 2 working days as required by PTR regulations. There was a delay in responding to 1 concern, due to the failure to utilise the correct reporting pathway as a result of the complexity of the concern, which has resulted in exceeding the 2 day reporting timeline.	Continue to monitor this measure against the 'two working day' target compliance. Timescale requirements communicated to all involved in concerns management.	ongoing, reviewed daily

Workforce Monthly Report

May 2022

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
	May-22	**Apr-22**	
PADR	**69.73%**	**69.49%**	**85%**
Sickness	**6.37%**	**6.31%**	**3.54%**
S&M Compliance	**86.09%**	**85.59%**	**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	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Corporate	49.58	47.01	48.33	50.43	45.69	46.58	44.59	45.64	44.08	50.33	53.02	51.01	53.38
Research, Development & Innovation	64.58	62.50	61.70	65.96	66.67	72.09	90.91	88.37	84.09	80.00	60.87	60.98	64.29
Transforming Cancer Services	68.75	71.43	66.67	60.00	56.25	43.75	62.50	75.00	63.16	57.89	57.14	57.89	55.00
Velindre Cancer Centre	78.88	76.52	74.31	75.17	76.40	73.77	70.90	67.61	65.16	65.25	63.56	68.69	68.62
Welsh Blood Service	82.41	81.74	79.78	78.27	77.93	77.52	82.19	83.06	83.73	81..75	78.44	78.16	79.26
Velindre Organisations	76.77	75.09	73.28	73.58	73.67	71.69	72.11	70.83	69.21	69.75	66.86	69.24	69.81
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)	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Corporate	70.08	69.08	69.26	70.45	71.36	74.54	72.32	74.40	72.17	73.64	74.51	73.48	74.31
Research, Development & Innovation	83.08	85.69	86.00	85.80	86.25	84.89	84.58	85.83	84.26	80.42	80.21	80.23	79.56
Transforming Cancer Services	70.00	76.00	76.84	85.26	82.50	82.86	83.33	81.43	77.86	77.39	77.39	78.64	80.91
Velindre Cancer Centre	81.77	82.45	82.70	83.16	82.89	83.11	84.91	84.93	84.73	84.18	84.88	85.17	85.46
Welsh Blood Service	92.23	92.39	93.38	92.66	92.21	92.54	93.36	93.56	93.78	92.02	92.30	92.19	92.44
Velindre Organisations	84.09	84.59	84.97	85.24	84.95	85.10	86.06	86.40	85.97	85.26	85.77	85.76	85.08

Key	0% - 3.54%		3.55% - 4.49%		4.5 % & Above								

Sickness Rolling %	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Corporate	4.70	4.68	4.64	4.49	4.58	4.67	5.01	5.33	5.47	5.52	5.54	5.61	5.58
Research, Development & Innovation	3.46	3.16	3.34	3.55	3.96	4.29	4.41	4.31	4.51	4.81	5.41	6.27	6.73
Transforming Cancer Services	0.88	0.41	0.32	0.33	0.40	0.86	1.27	0.99	0.95	1.02	1.07	1.20	1.20
Velindre Cancer Centre	5.38	5.41	5.47	5.47	5.52	5.57	5.63	5.52	5.56	5.64	5.92	6.18	6.28
Welsh Blood Service	4.37	4.58	4.82	5.11	5.42	5.72	5.99	6.26	6.44	6.53	6.80	7.05	7.04
Velindre Organisations	4.87	4.94	5.05	5.13	5.28	5.43	5.58	5.63	5.73	5.81	6.06	6.31	6.37
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

Monthly Sickness Rolling Covid Only Absence %		0.01% - 0.49%		0.50 % & Above									
Sickness Leave Covid Related	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Corporate	0.78	0.88	0.99	1.16	1.34	1.46	1.57	1.64	1.70	1.73	1.69	1.65	1.62
Research, Development & Innovation	0.44	0.45	0.45	0.43	0.43	0.43	0.53	0.66	0.87	1.08	1.33	1.65	1.74
Transforming Cancer Services	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Velindre Cancer Centre	0.89	0.86	0.87	0.88	0.85	0.86	0.84	0.73	0.82	0.89	1.05	1.18	1.21
Welsh Blood Service	0.29	0.28	0.29	0.29	0.36	0.39	0.38	0.36	0.38	0.42	0.60	0.79	0.85
Velindre Organisations	0.67	0.66	0.67	0.69	0.72	0.75	0.74	0.69	0.76	0.83	0.98	1.11	1.14

Monthly Special Leave Absence Rolling %		0.01% - 0.49%		0.50 % & Above									
Special Leave Non Covid Related	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Corporate	0.05	0.04	0.06	0.05	0.03	0.09	0.09	0.09	0.09	0.09	0.10	0.12	0.13
Research, Development & Innovation	0.42	0.51	0.60	0.74	0.92	1.08	1.25	1.37	1.57	1.62	1.70	1.90	1.89
Transforming Cancer Services	0.51	0.51	0.53	0.56	0.55	0.54	0.40	0.24	0.07	0.07	0.07	0.07	0.06
Velindre Cancer Centre	0.41	0.41	0.43	0.46	0.48	0.53	0.57	0.61	0.66	0.67	0.73	0.80	0.81
Welsh Blood Service	0.59	0.56	0.57	0.58	0.59	0.59	0.58	0.56	0.53	0.51	0.49	0.50	0.48
Velindre Organisations	0.43	0.43	0.45	0.47	0.49	0.53	0.55	0.56	0.58	0.59	0.61	0.66	0.66

Monthly Special Leave Absence Rolling %		0.01% - 0.49%		0.50 % & Above									
Special Leave Covid Related	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Corporate	0.25	0.18	0.11	0.03	0.01	0.00	0.00	0.00	0.00	0.00	0.02	0.02	0.04
Research, Development & Innovation	0.76	0.49	0.21	0.13	0.13	0.15	0.10	0.15	0.20	0.20	0.20	0.20	0.20
Transforming Cancer Services	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Velindre Cancer Centre	1.35	1.08	0.90	0.78	0.77	0.79	0.73	0.73	0.78	0.77	0.84	0.94	0.98
Welsh Blood Service	1.06	0.82	0.68	0.62	0.67	0.67	0.68	0.65	0.63	0.61	0.59	0.63	0.66
Velindre Organisations	1.12	0.88	0.72	0.63	0.63	0.64	0.61	0.60	0.62	0.61	0.64	0.70	0.74

PADR – The Figures

PADR Status - last 12 Months by Division

	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Corporate	49.58	47.01	48.33	50.43	45.69	46.58	44.59	45.64	44.08	50.33	53.02	51.01	53.38
Research, Development & Innovation	64.58	62.50	61.70	65.96	66.67	72.09	90.91	88.37	84.09	80.00	60.87	60.98	64.29
Transforming Cancer Services	68.75	71.43	66.67	60.00	56.25	43.75	62.50	75.00	63.16	57.89	57.14	57.89	55.00
Velindre Cancer Centre	78.88	76.52	74.31	75.17	76.40	73.77	70.90	67.61	65.16	65.25	63.56	68.69	68.62
Welsh Blood Service	82.41	81.74	79.78	78.27	77.93	77.52	82.19	83.06	83.73	0.00	78.44	78.16	79.26
Velindre Organisations	76.77	75.09	73.28	73.58	73.67	71.69	72.11	70.83	69.21	69.75	66.86	69.24	69.81
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85

Sickness Data – The Figures

Sickness - Last 12 Months by Division

	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Corporate	4.70	4.68	4.64	4.49	4.58	4.67	5.01	5.33	5.47	5.52	5.54	5.61	5.58
Research, Development & Innovation	3.46	3.16	3.34	3.55	3.96	4.29	4.41	4.31	4.51	4.81	5.41	6.27	6.73
Transforming Cancer Services	0.88	0.41	0.32	0.33	0.40	0.86	1.27	0.99	0.95	1.02	1.07	1.20	1.20
Velindre Cancer Centre	5.38	5.41	5.47	5.47	5.52	5.57	5.63	5.52	5.56	5.64	5.92	6.18	6.28
Welsh Blood Service	4.37	4.58	4.82	5.11	5.42	5.72	5.99	6.26	6.44	6.53	6.80	7.05	7.04
Velindre Organisations	4.87	4.94	5.05	5.13	5.28	5.43	5.58	5.63	5.73	5.81	6.06	6.31	6.37
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

4

Sickness – The Narrative

Performance Indicator	RAG/ Change from previous month	April Figure	Hotspot	%	Comment to include reasons for change / rates high or low
Sickness absence (3.42%)	**6.37%** ↑	6.31%	**Welsh Blood Service (5.70%)**		
			Collection Services	7.12%	Decrease this month from 10.94%. Resolution of some short-term sickness has resulted in slight reduction in sickness absence.
			Laboratory Services	9.20%	Decrease this month from 10.05%
			Quality Assurance	2.73%	Decrease this month from 4.71%
			**Velindre Cancer Centre (6.25%)**		
			Outpatients	16.86%	Significant decrease from 24.90% last month. Newly appointed manager into the service, who is working with the HR Operational Team to manage team sickness absence.
			Radiotherapy	8.29%	Decrease this month from 10.06%. Some staff who were on LTS have returned, however there are a few now approaching LTS, these are being closely monitored. Positive covid cases have dropped.
			Pharmacy	6.07%	Decrease this month from 9.00%
			Operational Services	11.13%	Increase this month from 9.75%
			Clinical Audit	16.78%	Increase this month from 12.51%
			**Corporate Areas (4.24%)**		

		Corporate Management Section	4.33%	Increase this month from 0.42%
		Fundraising	9.76%	Decrease this month from 13.16%

Action/ initiatives:

Velindre University NHS Trust

Stress and mental health related absence continue to be the highest impactor of absence across the Trust at 33.2% in month and 31.4% rolling.

The newly appointed staff psychologist will take up position in August 2022 and the WOD Department will continue to work closely with EAP, Canopi and our occupational health providers to ensure support for staff. As part of the development in the people management training package there will be practical support for managers on managing stress in the workplace and completing stress risk assessments.

WBS
Following a slight increase in sickness absence recently, due to Covid infections, short-term sickness has again decreased as staff have tested negative and have been well enough to return to work again. WBS is continuing to track Covid absence cases following information that Covid infections are on the rise throughout the general population. WBS will implement any recommended measures to ensure Covid Risk Assessments are followed and staff are able to limit their exposure to Covid infections in the workplace.

VCC
In month sickness has decreased this month and is reported at 6.25%, with both short- and long-term sickness absence decreasing this month, 1.54% and 4.71% respectively.

A number of areas across the Cancer Centre are reporting decreased sickness absence this month, managers continue to manage absences, in line with policy and with the support of the HR Team. Monthly KPI meetings with HR Advisors to

support sickness absence management continue to take place. Some concerns have been raised re: Occupational Health report quality, which will be further explored.

Corporate Areas (including RD&I & TCS)
Continuing to follow the trend of low short-term sickness absence with slightly higher long-term sickness absence. Stress and anxiety remain as main reason for LTS absence. Workforce continue to have monthly KPI meetings to support managers in effectively managing short-term and long-term sickness absence.

Statutory and Mandatory Figures – The Figures

Statatory & Mandatory Compliance (10x CSTF) last 12 months by Division
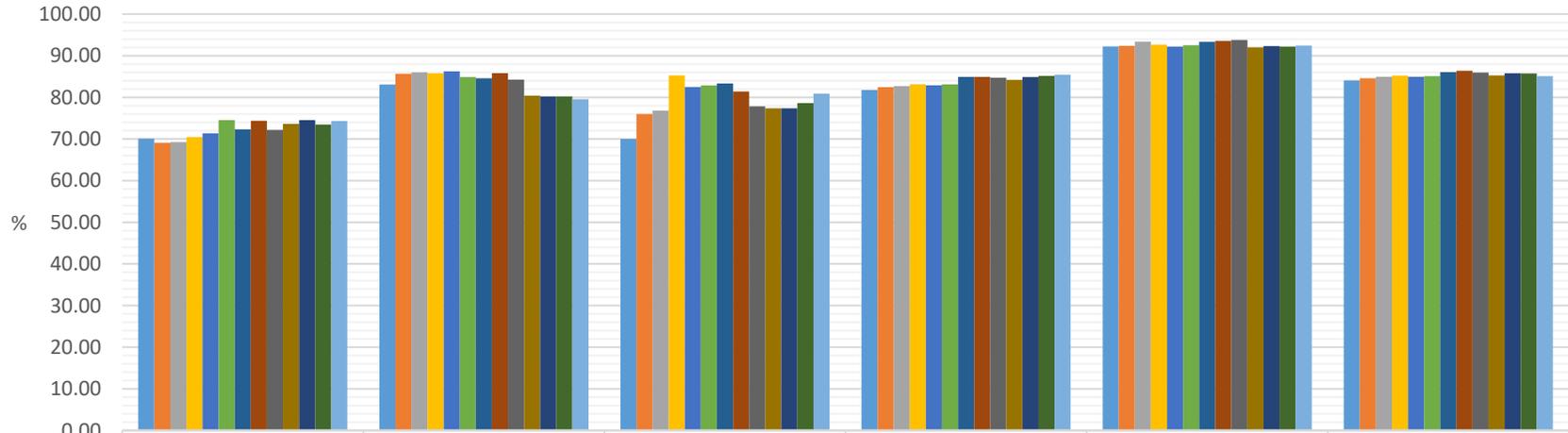
	Corporate	Research, Development & Innovation	Transforming Cancer Services	Velindre Cancer Centre	Welsh Blood Service	Velindre Organisations
May-21	70.08	83.08	70.00	81.77	92.23	84.09
Jun-21	69.08	85.69	76.00	82.45	92.39	84.59
Jul-21	69.26	86.00	76.84	82.70	93.38	84.97
Aug-21	70.45	85.80	85.26	83.16	92.66	85.24
Sep-21	71.36	86.25	82.50	82.89	92.21	84.95
Oct-21	74.54	84.89	82.86	83.11	92.54	85.10
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

Work In Confidence (WIC)

No detail has been provided this month in terms of the number of staff who have accessed the WIC platform, or categorisation of the type of conversations that have taken place; this is primarily the result of low usage of the platform over the last month and therefore the potential to identify those who have made contact.

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. The WOD Team have also been previously involved in facilitating discussions between the Manager and member of staff.

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

TRUST BOARD

FINANCE REPORT FOR THE PERIOD ENDED 30TH JUNE 2022 (M3)

DATE OF MEETING	28/07/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Steve Coliandris – Financial Planning & Reporting Manager / 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

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 June 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	0.004	0.007	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	0.723	3.134	24.535
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	96.0%	95.2%	95.0%

2.2 Revenue Budget

At this stage of the financial year the overall revenue budget (excl Covid) 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 June 22 is an underspend of **£0.007m**, with an underachievement against income offset by an underspend within both Pay and Non Pay.

A large element of the underachievement on planned income relates to WBS WTAIL and Blood Components due to the impact of Covid, for which the Trust is expecting to receive

WG funding to cover during the first 6 months of the year, with strategic plans being put in place to mitigate the risk exposure during the latter part of the year.

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

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

The Trust is reporting a year end forecast breakeven position; however, this assumes that all additional Covid-19 costs are fully reimbursed by WG, all planned additional income is received and the savings targets achieved.

2.3 PSPP Performance

PSSP performance for the whole Trust (inc. NWSSP) is currently 95.47% against a target of 95%, with the performance against the Core Trust (exc. NWSSP) being 95.22%

Measures have recently been put in place to target key areas which have been causing 'bottlenecks' in the PSPP process which has been reflected recent performance figures.

2.4 Covid Expenditure

Covid-19 Revenue Spend/ Funding		
	YTD Actual £m	Forecast Spend 2022/23 £m
Mass Covid Vaccination	0.096	0.373
PPE	0.042	0.293
Cleaning Standards	0.073	0.420
Covid Recovery	1.186	3.762
Covid Response	0.364	0.833
Total Covid Spend /Funding Requirement 2022/23	**1.761**	**5.680**
WG Funding		1.328
Commissioner Funding		4.352
Balance of Funding Requirement		**5.680**

The overall gross funding requirement related to Covid is £5.680m, with £1.328m being recognised although not confirmed for funding from WG, and the balance of £4.352m being sought from our Commissioners.

The £5.680m represents a significant reduction in outsourcing costs from the Trust IMTP plan as of 31st March, 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.

At this stage only unavoidable costs pressures are being considered for funding against the Trust reserves, with any new investment decisions being put on hold until the Trust receives confirmation that all Covid related expenditure will be funded by WG and / or Commissioners.

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 £4.352m, 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.

The expectation at this stage is that Covid response costs will be funded from WG, however the Trust has not yet received formal confirmation. Following further de-escalation guidance operational costs of circa £0.200m are no longer considered to be Covid response and will need to be borne from the Trust.

Savings

Due to the ongoing pandemic and the potential inability to enact several savings schemes there is a risk that some of the savings that are RAG rated amber may not be fully achieved. Those schemes with risk of delivery are being reviewed at divisional level with a view to ensure delivery, or to find replacement schemes as the year progresses.

TCS

A non-recurrent revenue funding request of £0.104m has been made by the TCS Programme relating to shortfalls in funding on the PMO and nVCC project. This was presented to EMB Run on 1st July and agreed. Latest forecast requirement currently stands at £0.133m which reflects additional Judicial fees of £0.029m (total to date £0.043m.

The revenue financial information provided within the main body of the report and the TCS Programme Board paper differ slighlty which is due to both a timing difference, and the authorisation of budget virements from the Core Trust to the TCS Programme.

Other Exceptional National Cost Pressures

The Trust is anticipating full funding for the Employers NI increase (£0.550m) and the incremental increase in Energy prices (£1.669m). The anticipated funding for the Energy price increase reflects the latest forecast provided by NWSSP during July, which indicates a significant rise from the £0.912m included in the prior month forecast.

All other financial risks are expected to be mitigated at divisional level, however there is a risk that operational cost pressures may materialise during the year which is beyond divisional control or the ability to be managed through the overall Trust funding envelope.

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.

Other Major Schemes in development that will be considered during 2022/23 and beyond in conjunction with WG include, Integrated Radiotherapy Solution (IRS), WBS HQ, WBS Hemoflows, Scalp Coolers, VCC Outpatients & Ventilation and Plasma Fractionation.

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 discretionary allocation has ringfenced £0.434m to support the Integrated Radiotherapy Solution (IRS). However, discussions are currently taking place with WG colleagues in order to try and secure All Wales capital funding for the costs via the IRS business case.

The Trust Discretionary Programme for 2022/23 has recently been agreed by the Capital Planning and Delivery Group for 2022/23 with a paper going to EMB in August for approval.

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 June 2022 is an underspend of £0.007m with a year-end forecast break-even position in accordance with the approved IMTP

4. RECOMMENDATION

Trust Board is asked to **NOTE:**

4.1   the contents of the June 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 June 2022 attached as **Appendix 1**.

FINANCIAL PERFORMANCE REPORT

FOR THE PERIOD ENDED JUNE 2022/23

TRUST BOARD
28/07/2022

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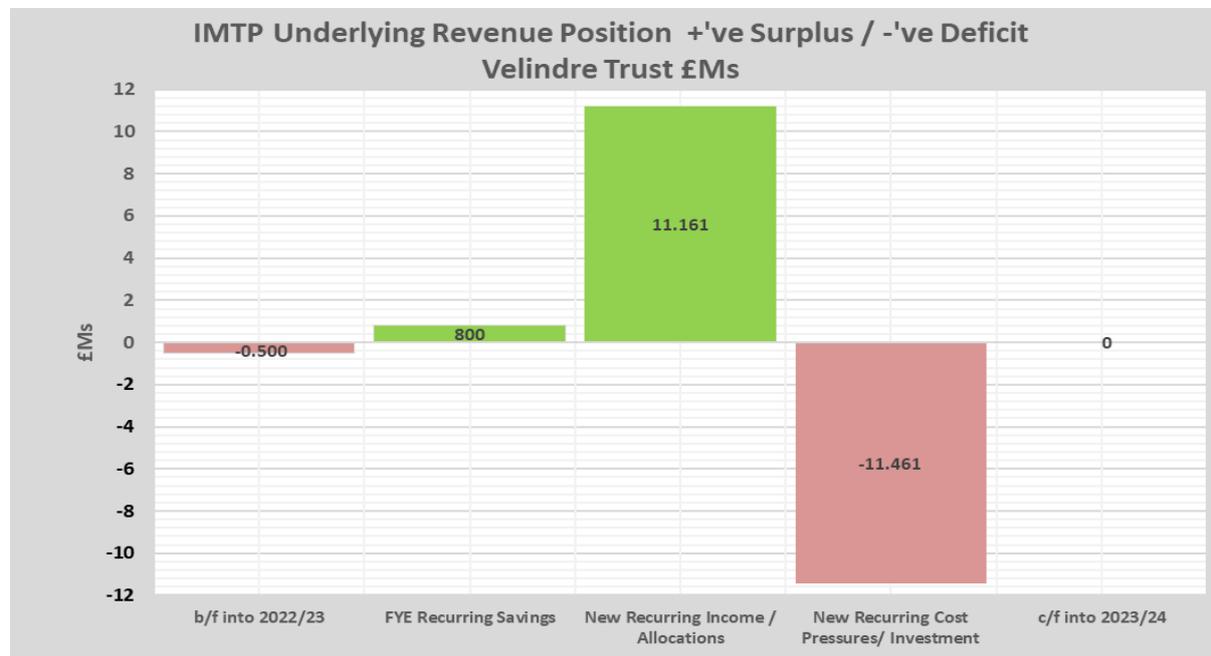
Underlying Position +Deficit/(-Surplus) £Ms	b/f into 2022/23	Recurring Savings	New Recurring Income / Allocations	FYE New Cost Pressures/ Investment	c/f into 2023/24
Velindre NHS Trust	-0.500	0.800	11.161	-11.461	0

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	0.004	0.007	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	0.723	3.134	24.535
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	96.0%	95.2%	95.0%

Performance against Planned Savings Target

Efficiency Savings	Variance	0	0	0

Revenue

The Trust has reported a £0.004min-month underspend position for June '22, with a cumulative position of £0.007munderspent, and an outturn forecast of **Breakeven**.

Capital

The approved Capital Expenditure Limit (CEL) as at June 2022 is **£24.535m**. This represents all Wales Capital funding of **£23.081m**, and Discretionary funding of **£1.454m.** The Trust reported Capital spend to June'22 of £3.134m and is forecasting to remain within its CEL of £24.535m.

The Trust's CEL is broken down as follows:

	£m Opening	£m Movement	£M June 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	-1.900	22.002
Total CEL	**25.856**	**-1.321**	**24.535**

Funding for the CANISC Cancer Project was allocated by WG in June, totalling £0.579m.
Slippage on the TCS Programme has led to £1.900m Capital funding being pushed back to 2023/24 financial year, reducing the WG Capital allocation to £22.002m this financial year.

PSPP

During May '22 the Trust (core) achieved a compliance level of **95.97%** (May 22: 96.07%) of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **95.22%** as at the end of month 3, and a Trust position (including hosted) of **95.47%** compared to the target of 95%.

PSPP has been significantly impacted by the ongoing pandemic and reduced levels of receipting on orders which is due to the high levels of sickness being experienced in the Trust over the past year. The finance team has been working with NWSSP colleagues with a view to help improve performance, which has included a full review the approval hierarchy which has been reflected in recent performance figures.

Efficiency / Savings
At this stage the Trust is currently planning to fully achieve the savings target during 2022-23.

Revenue Position

Cumulative					Forecast		
£0.007m Underspent					Breakeven		
Type	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)		Full Year Budget (£m)	Full Year Forecast (£m)	Forecast Variance (£m)
Income	(43.066)	(42.785)	(0.282)		(179.290)	(179.290)	0.000
Pay	18.039	17.872	0.167		71.655	71.655	0.000
Non Pay	25.027	24.905	0.122		107.635	107.635	0.000
Total	(0.000)	(0.007)	0.007		0.000	0.000	0.000

The overall position against the profiled revenue budget to the end of June 2022 is an underspend of **£0.007m**, with a Pay and Non Pay underspend offsetting an Income under achievement.

The Trust is reporting a year end forecast breakeven position, however this is based on the assumption that all additional Covid-19 costs are fully reimbursed by both WG and the Trust commissioners, that all planned additional income is received, and the planned savings targets are achieved during 2022-23.

4.1 Revenue Position Key Issues

Income Key Issues
Income underachievement to May and is largely where activity is lower than planned on Bone Marrow and Plasma Sales in WBS, with plans being put in place to support recovery in the latter part of the year.

Pay Key Issues
The total Trust vacancies as at June 2022 is 153WTE, VCC (77WTE), WBS (40WTE), Corporate (10WTE), R&D (17WTE), TCS (2WTE) and HTW (7WTE).

Increase in Employers NI rates (1.25%) is currently being offset by divisional reserves, however funding is expected to be secured from WG through the recognition of exceptional national cost pressures.

Vacancies throughout the Trust remain high however a number of 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 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.

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 circa (£1.669m) June (£0.912m), has been recognised as an exceptional national cost pressures by WG with the Trust expectation that these costs will be fully funded during 2022/23, although this is yet to be confirmed.

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 for 2022/23.

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

4.2 Pay Spend Trends (Run Rate)

The pay award for 2022/23 is yet to be agreed so these costs are not yet reflected in the pay spend. It is hopeful that agency costs will decrease during 2022/23 largely from the reduction of agency staff that has been used over the past year in response to Covid and through the recruitment into filling vacancies.
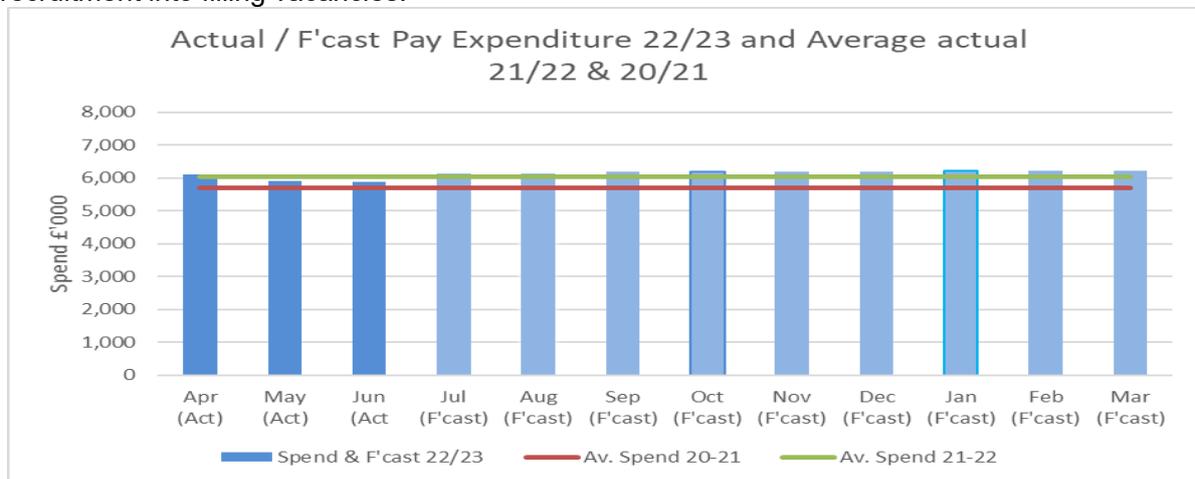
The spend on agency for June'22 was £0.129m (May £0.125m), which gives a cumulative year to date spend of **£0.358m** and a current forecast outturn spend of circa **£1.376m** (£1.906m 2021/22). Of these totals the year to date spend on agency directly relating to Covid as at the end of June is £0.101m and forecast spend is circa £0.399m (£0.826m 2021/22).

Changes in Total WTE 2021-22 to 2022-23
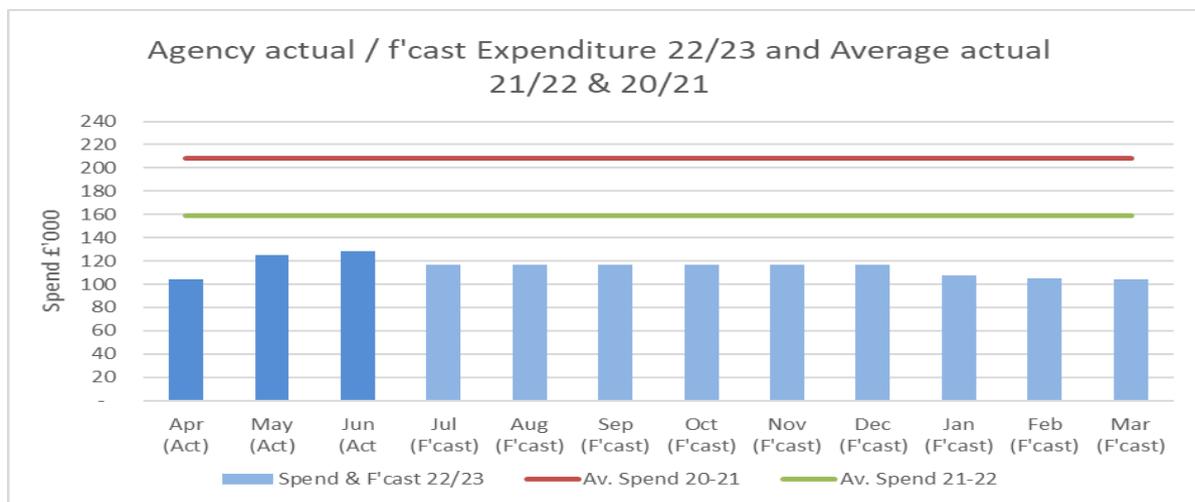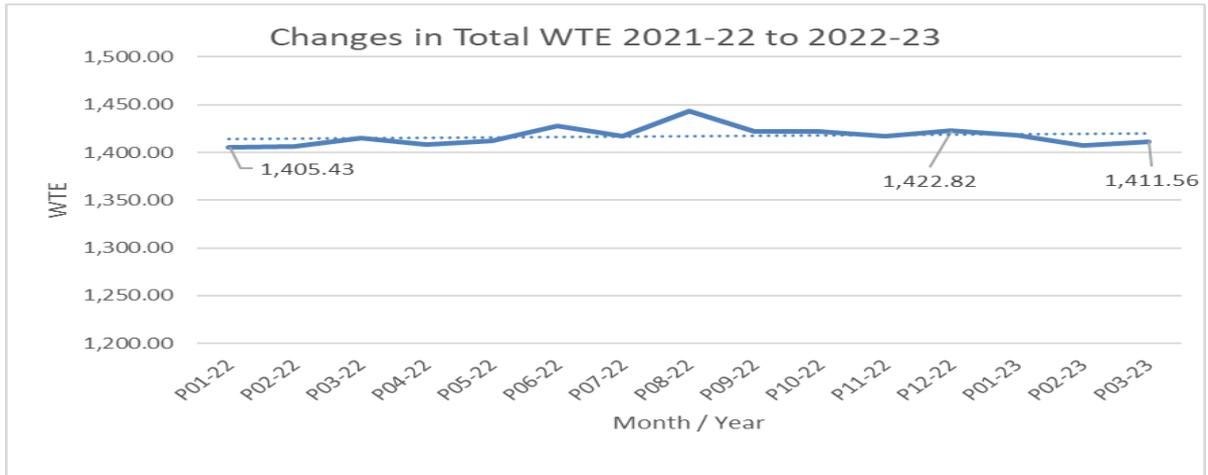
* Reduction in WTE since March 22 is largely due the instruction to cease Covid related staff.

Changes in WTE 2021-22 to 2022-23 By Division
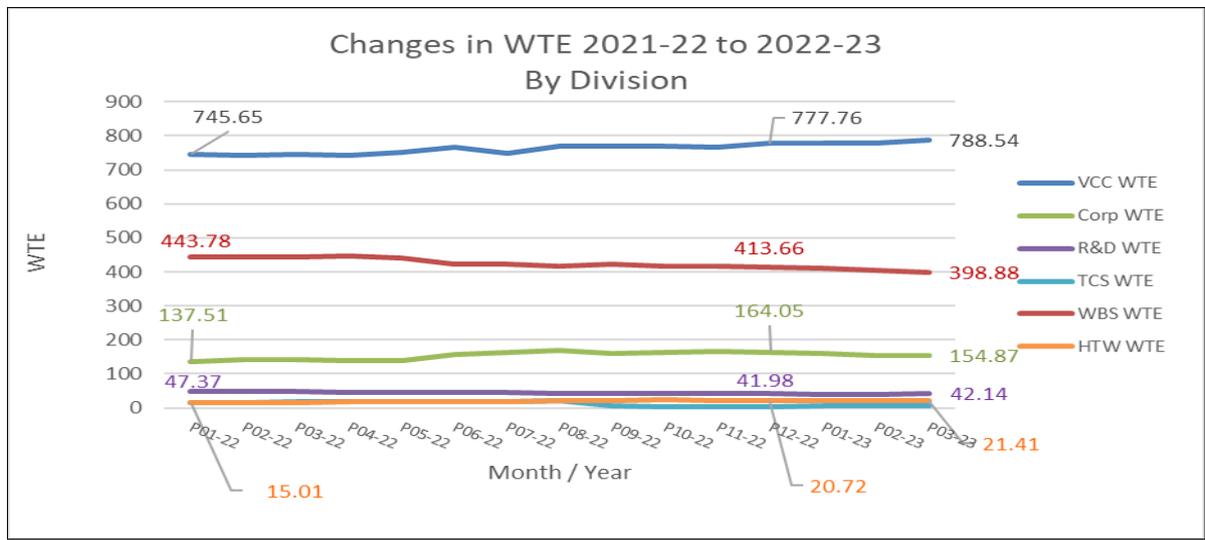
4.3 Non Pay

Non-pay 21/22 (c£96m) av. 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 increase in WBS wholesaling (circa £0.3m). The average monthly spend for 22-23 is currently £8.3m (3.8%) more than 21/22, which again largely relates to the increase in both NICE / High-Cost drug usage and WBS Wholesaling in response to increased activity.

Monthly Non Pay Spend 2022-23 compared to Average 21-22 & 20-21
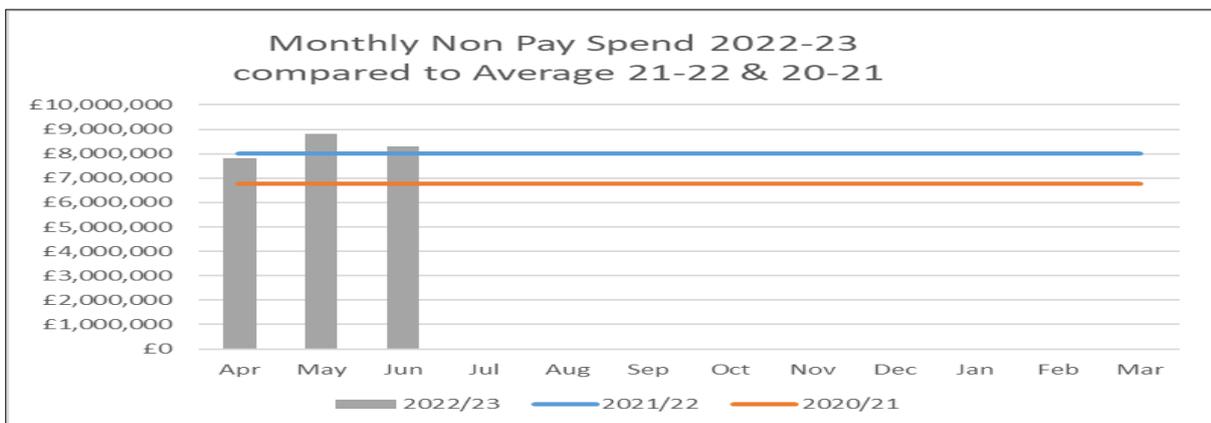
4.4 Covid-19

Covid-19 Funding 2022/23			
	WG £m	Commissioners £m	Total £m
Mass Vaccination	0.373		0.373
PPE	0.293		0.293
Cleaning	0.420		0.420
Other Covid Response	0.243	0.590	0.833
Covid Recovery - Internal Capacity		2.943	2.943
Covid Recovery - Outsourcing and Outreach		0.819	0.819
Total	**1.328**	**4.352**	**5.680**

The latest forecast funding requirement in relation to Covid for 2022-23 has been revised down further to £5.680m (May £6.025m) which is a significant reduction from the £12.310m that was submitted as part of the Trust IMTP. Of the £5.680m total Covid requirement £1.328m (IMTP plans £2.104m) is being requested directly from WG, and the balance of £4.352m (IMTP plans £10.206m) being sought from our commissioners.

Following further Covid de-escalation related activity and a review of operational costs in line with the updated guidance, the latest forecast spend and funding requirement from WG has reduced by a further £0.345m from £1.673m reported in June to £1.328m. A large element circa £0.200m of the reduction relates to operational costs such as the leasing of additional office space, and IT licensing requirement which were enacted in response to Covid and will now need be borne by the Trust.

WG funding has been assumed for programme related Covid costs of £0.665m (Mass Vaccination and PPE), along with other Covid response funding of £0.663m in relation to ongoing cleaning, increase in workforce costs, and capacity and facility costs per letter received from Judith Paget dated 14th March 2022.

Covid-19 Revenue Spend/ Funding 2022/23		
	YTD Actual £m	Forecast Spend 2022/23 £m
Mass Covid Vaccination	0.096	0.373
PPE	0.042	0.293
Cleaning Standards	0.073	0.420
Covid Recovery	1.186	3.762
Covid Response	0.364	0.833
Total Covid Revenue Spend	**1.761**	**5.680**
Source of Funding:		
WG Funding		1.328
Commissioner Funding		4.352
Total Source of Funding Requirement		**5.680**

The Trust Covid expenditure is based on activity demand forecast modelling which commenced in 2021/22 and has been updated regularly since. The Trust has already invested £2.943m in additional capacity. Following news that The Rutherford has gone into liquidation, the funding previously required for outsourcing has significantly reduced (by £3.650m). In response the Trust

is looking to establish additional outreach Capacity at Prince Charles Hospital for SACT with forecast additional cost above that already invested in Covid capacity of circa £0.320m and is currently developing plans for Radiotherapy capacity internally looking to weekend working which will require waiting list initiatives (WLI)and enhanced pay rates. The cost of this additional capacity is 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 risk to the Trust.

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%).

Currently several of the schemes are still RAG rated amber which in large relates to those schemes that are either expected to still be impacted by Covid during 2022-23 or affected by current market conditions where there has been a significant rise in prices.

Service redesign and supportive structures is a key area for the Trust which is about focusing on finding efficiencies in the ways that we are working. Due to the pandemic the savings scheme start date has been pushed back further to September, with work ongoing but proving to be difficult under the current workforce situation, particularly with the high number of vacancies and the high level of sickness currently being experienced throughout the core Trust.

It is extremely important that divisions review their current savings schemes, and where delivery may not be achieved alternative schemes are implemented to ensure that the Savings target is met for 2022-23.

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	25	25	0	100	0
Laboratory & Collection Model (WBS)	Green	50	13	13	0	50	0
Laboratory & Collection Model (WBS)	Green	50	13	13	0	50	0
Stock Management (WBS)	Green	100	25	25	0	100	0
Stock Management (WBS)	Green	150	38	38	0	150	0
Procurement - Supply Chain (WBS)	Amber	50	13	13	0	50	0
Service Redesign (VCC)	Amber	100	0	0	0	100	0
Supportive Stuctures (VCC)	Amber	100	0	0	0	100	0
Procurement - Supply Chain (VCC)	Amber	50	13	13	0	50	0
Total Saving Schemes		750	138	138	0	750	0
Income Generation							
Maximinsing Income Opportunities - Income Attraction (WBS)	Green	50	13	13	0	50	0
Maximinsing Income Opportunities - Income Attraction (WBS)	Geen	50	13	13	0	50	0
Maximinsing Income Opportunities - Private Patients (VCC)	Amber	150	17	17	0	150	0
Maximinsing Income Opportunities - Private Patients (VCC)	Green	100	25	25	0	100	0
Maximinsing Income Opportunities - Income Attraction (VCC)	Green	200	50	50	0	200	0
Total Income Generation		550	117	117	0	550	0
TRUST TOTAL SAVINGS		1,300	254	254	0	1,300	0
				100%		100%	
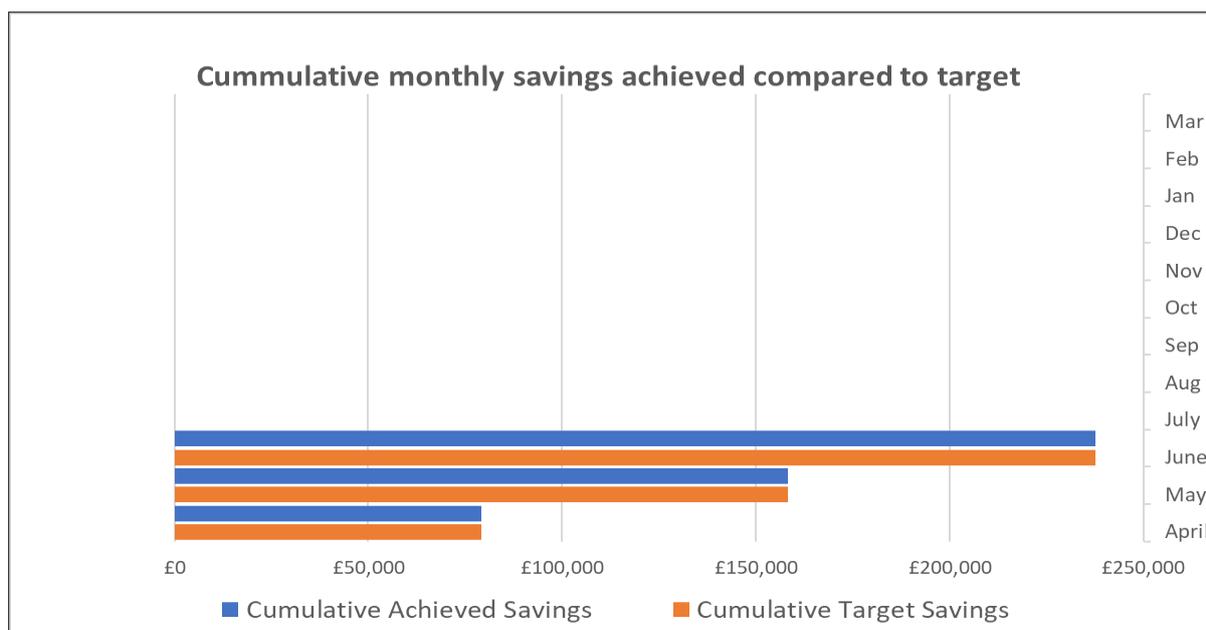
Cummulative monthly savings achieved compared to target

Legend: ■ Cumulative Achieved Savings ■ Cumulative Target Savings

5. Reserves

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

Summary of Total Recurrent Reserves Remaining Available in 2022/23	£m
Recurrent Reserves Available for investment	1.190
Previously Committed Reserves Bfwd 2021-22	(0.137)
Previously agreed Exec Investment	(0.973)
New Commitments	(0.080)
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	1.404
Previously Committed Reserves Bfwd 2021-22	(0.102)
Previously Agreed Exec Investment	(1.302)
Emergence of Slippage against Non-Recurrent Commitments	
Remaining Balance	**0**

At this stage only unavoidable costs pressures should be considered for funding against the Trust reserves, with any new investment decisions being put on hold until the Trust receives confirmation that all Covid related expenditure 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 number of risks which are being managed and closely monitored. The table below summarises the key financial risks & opportunities highlighted to Welsh Government.

Non-Delivery of Savings - Risk £0.100m, Likelihood - Medium

The Trust as part of the IMTP identified £1.300m of Savings and Income Generation to be achieved during 2022/23. Due to the ongoing pandemic and the potential inability to enact service redesign and supportive structures there is a risk that these amber savings target may not be fully achieved. Those schemes with risk of delivery are being reviewed at Divisional level with a view to ensure delivery, or to find replacement schemes as the year progresses.

The conclusion of the Microsoft 365 National Deal led to a £0.157m (incl. VAT) in-year cost pressure, which will be assigned as a Cost Improvement Programme to the Digital Services Team. This includes the standing down of legacy IT infrastructure which is not required due to the MS 365 deal.

Covid Funding via Commissioners – Risk TBC, Likelihood - High

The Trust continues to have discussions with our commissioners who recognise our Covid funding requirement, however they have not committed to providing the full funding ask of £3.852m £3,852k (£4.352m less £0.500m outsourcing treatments completed). Commissioners have all stated that any funding required to cover additional Covid recovery costs will only flow through the LTA under the national funds flow mechanism. This mechanism whilst providing enhanced income protection over the normal LTA does not cover the additional costs of premium rates incurred through outsourcing, enhanced internal 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 will remain a risk for the Trust.

Covid Outsourcing- Risk £0.500m, Likelihood - High

The Covid outsourcing relates to the cost-of-service delivery for activity demand which is beyond Trust internal planned capacity volumes. The Trust had planned to outsource services to the Rutherford Cancer Centre to deal with the Planned Care backlog. There is a risk that £0.500m of cost incurred by the Trust prior to the liquidation of RCC will not be recoverable from Commissioners as a result of the national funding flows agreement not including an agreed mechanism for outsourced service cost recovery. The Trust is in negotiations with both RCC and Commissioners to mitigate the impact of this risk.

Other C-19 Response Costs – Risk £1.328m, Likelihood - Medium

Following further Covid de-escalation related activity and a review of operational costs in line with the updated guidance, the latest forecast spend and funding requirement from WG has reduced by £0.345m from £1.673m reported in May-22 to £1.328m in June-22. A large element of the reduction circa £0.200m relates to operational costs such as the leasing of additional office space, and IT licensing requirement which were enacted in response to Covid and will now be borne by the Trust.

Other Exceptional National Cost Pressures – Risk £2.219m - Medium

The Trust is still anticipating full funding for the Employers NI increase (£0.550m) and the incremental increase in Energy prices (£1.669m). The anticipated funding for the Energy price increase reflects the latest forecast provided by NWSSP during July, which indicates a significant rise from the £0.912m included in the prior month forecast .

__Management of Operational Cost Pressures – Risk £0.250m, Likelihood - Low__

Cost pressures that have / will surface through the year are expected to be managed in line with normal budgetary control procedures or through utilisation of the Trust reserve. However, due to the current demands on the service there is a small risk that pressures may materialise beyond divisional control or be able to be managed through the overall Trust funding envelope.

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 @ M3 £m	Full Year Actual Spend £m	Year End Variance £m
All Wales Capital Programme						
nVCC - project costs	2.089	0.894	0.000	1.195	2.539	-0.450
nVCC - Enabling Works	19.913	1.696	0.000	18.217	19.463	0.450
Canisc Cancer Project	0.579	0.188	0.000	0.391	0.579	0.000
Fire Safety	0.500	0.110	0.000	0.390	0.500	0.000
			0.000			
Total All Wales Capital Programme	23.081	2.888	0.000	20.193	23.081	0.000
Discretionary Capital	1.454	0.246	0.000	1.208	1.454	0.000
Total	24.535	3.134	0.000	21.401	24.535	0.000

The approved 2022/23 Capital Expenditure Limit (CEL) as at June 2022 was £24.535m. This includes All Wales Capital funding of £23.081m, and discretionary funding of £1.454m. The approved CEL has been reduced by £1.900m to reflect the latest forecast requirement on the nVCC Enabling works project for 2022/23. Following agreement with WG the £1.900m will be re-provided to the programme during 2023/24.

In addition, WG colleagues have been notified of an additional request to move £0.450m from the nVCC enabling works to support the additional costs associated with the nVCC project fees and advisory activities.

In January 2022 WG informed the Trust that the discretionary allocation with 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 has recently been agreed for 2022/23 via the Capital Planning and Delivery Group with a paper going to EMB in August for approval.

The discretionary allocation has ringfenced £0.434m to support the Integrated Radiotherapy Solution (IRS). Discussions are currently taking place with WG colleagues with the ambition that the Trust may be reimbursed for the costs incurred in supporting the procurement phase of the scheme.

Whilst there is a reduction in availability of Capital funding this year, WG colleagues have indicated that they are keen for organisation to continue to develop capital proposals should additional funding become available later in the financial year.

Whilst the financial position is challenging it is expected that capital requirements will be managed through the Trust discretionary allocation during 2022/23 or additional funding will be agreed and secured from WG.

Performance to date

The actual cumulative expenditure to June 2022 on the All-Wales Capital Programme schemes was £2.888m, this is broken down between spend on the nVCC enabling works £1.696m, nVCC project costs of £0.894m, Canisc Cancer Project £0.188m, and fire safety £0.110m.

Spend to date on Discretionary Capital is currently £0.246m.

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 being developed	1.016	12.808	9.996	4.434	5.215	0.608	0.048
2	IRS	46.921*	OBC & PBC approved by WG, FBC under development	7.453	9.533	22.832	7.103	0.000	0.000	0.000
3	Hemoflows	0.224	SBAR being Completed	0.224	0.000	0.000	0.000	0.000	0.000	0.000
4	Scalp Coolers	0.250	SBAR being Completed	0.250	0.000	0.000	0.000	0.000	0.000	0.000

*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 Jun-22	Movement from 1st April Jun-22	Forecast Closing Balance End of Mar 23
Non-Current Assets	£'000	£'000	£'000	£'000
Property, plant and equipment	143,136	147,375	4,239	139,375
Intangible assets	8,667	7,803	(864)	5,869
Trade and other receivables	1,092,008	1,296,479	204,471	1,296,479
Other financial assets	0	0	0	0
Non-Current Assets sub total	1,243,811	1,451,657	207,846	1,441,723
Current Assets				
Inventories	65,207	55,789	(9,418)	55,789
Trade and other receivables	540,227	279,511	(260,716)	291,836
Other financial assets			0	
Cash and cash equivalents	30,404	20,891	(9,513)	18,500
Non-current assets classified as held for sale	0	0	0	0
Current Assets sub total	635,838	356,191	(279,647)	366,125
TOTAL ASSETS	1,879,649	1,807,848	(71,801)	1,807,848
Current Liabilities				
Trade and other payables	(277,601)	(207,003)	70,598	(207,003)
Borrowings	0	0	0	0
Other financial liabilities	0	0	0	0
Provisions	(341,123)	(342,519)	(1,396)	(342,519)
Current Liabilities sub total	(618,724)	(549,522)	69,202	(549,522)
NET ASSETS LESS CURRENT LIABILITIES	1,260,925	1,258,326	(2,599)	1,258,326
Non-Current Liabilities				
Trade and other payables	(7,336)	(7,336)	0	(7,336)
Borrowings	0	0	0	0
Other financial liabilities	0	0	0	0
Provisions	(1,094,206)	(1,091,599)	2,607	(1,091,599)
Non-Current Liabilities sub total	(1,101,542)	(1,098,935)	2,607	(1,098,935)
TOTAL ASSETS EMPLOYED	159,383	159,391	8	159,391
FINANCED BY:				
Taxpayers' Equity				
General Fund	0	0	0	0
Revaluation reserve	30,935	30,934	(1)	30,934
PDC	112,982	112,983	1	112,983
Retained earnings	15,466	15,474	8	15,474
Other reserve	0	0	0	0
Total Taxpayers' Equity	159,383	159,391	8	159,391

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 this 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 will be drawn down in July from WG to reimburse the Trust ensuring that there is 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 £'000	May £'000	Jun £'000	Jul £'000	Aug £'000	Sep £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £'000	Totals £'000
	RECEIPTS													
1	LHB / WHSSC income	33,083	40,208	40,042	40,230	41,250	40,200	41,352	40,038	39,900	39,850	39,536	35,218	470,907
2	WG Income	20,937	24,551	17,010	20,100	22,450	24,145	24,620	24,155	24,188	24,158	24,037	24,182	274,532
3	Short Term Loans													0
4	PDC												13,839	13,839
5	Interest Receivable	19	27	30	10	10	10	10	10	10	10	10	10	166
6	Sale of Assets													0
7	Other	7,106	7,289	4,321	4,214	3,623	3,848	3,623	3,590	3,671	3,920	3,583	4,347	53,136
8	TOTAL RECEIPTS	61,145	72,074	61,403	64,554	67,333	68,203	69,605	67,793	67,769	67,938	67,166	77,596	812,579
	PAYMENTS													
9	Salaries and Wages	21,735	29,243	29,483	29,991	29,999	30,067	30,101	30,108	30,116	30,183	30,132	30,212	351,369
10	Non pay items	30,543	33,079	54,139	37,561	35,423	34,850	37,400	35,525	33,238	31,890	36,696	38,322	438,666
11	Short Term Loan Repayment												7,000	7,000
12	PDC Repayment													0
14	Capital Payment	1,926	2,567	1,420	2,626	2,280	2,453	1,587	1,660	3,289	1,383	1,849	4,409	27,448
15	Other items													0
16	TOTAL PAYMENTS	54,205	64,889	85,042	70,177	67,702	67,370	69,087	67,293	66,643	63,456	68,677	79,943	824,483
17	Net cash inflow/outflow	6,941	7,185	(23,639)	(5,623)	(369)	833	517	500	1,126	4,482	(1,511)	(2,347)	
18	Balance b/f	30,404	37,345	44,530	20,891	15,267	14,898	15,732	16,249	16,749	17,875	22,357	20,847	
19	Balance c/f	37,345	44,530	20,891	15,267	14,898	15,732	16,249	16,749	17,875	22,357	20,847	18,500	

Monthly Cash Flow Forecast
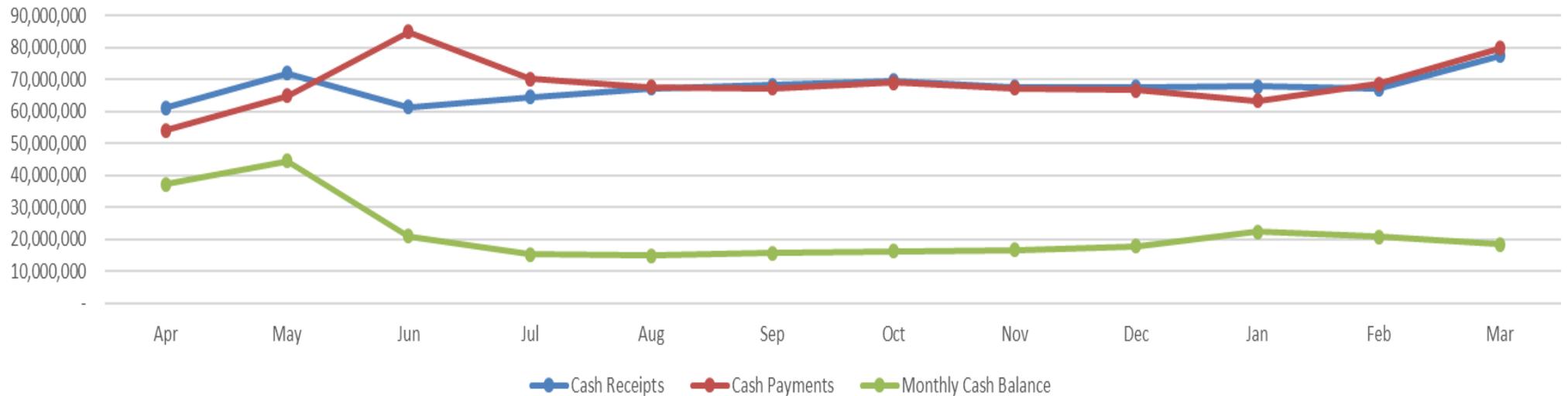
DIVISIONAL ANALYSIS

(Figures in parenthesis signify an adverse variance against plan)

Core Trust

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
VCC	(8.987)	(8.989)	0.003	(36.398)	(36.398)	0.000
RD&I	(0.227)	(0.227)	(0.000)	0.365	0.365	0.000
WBS	(4.785)	(4.820)	0.035	(19.882)	(19.882)	0.000
Sub-Total Divisions	**(13.999)**	**(14.036)**	**0.037**	**(55.915)**	**(55.915)**	**0.000**
Corporate Services Directorates	**(2.540)**	**(2.495)**	**(0.045)**	**(10.108)**	**(10.108)**	**0.000**
Delegated Budget Position	**(16.539)**	**(16.531)**	**(0.008)**	**(66.023)**	**(66.023)**	**0.000**
TCS	(0.138)	(0.138)	0.000	(0.551)	(0.551)	0.000
Health Technology Wales	(0.007)	(0.007)	(0.000)	(0.028)	(0.028)	0.000
Trust Income / Reserves	16.684	16.681	0.002	66.602	66.602	0.000
Trust Position	0.000	0.007	(0.007)	0.000	0.000	0.000

VCC

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**17.190**	**17.204**	**0.014**	**75.305**	**75.305**	**0.000**
Expenditure						
Staff	**10.749**	**10.684**	**0.065**	**43.453**	**43.453**	**0.000**
Non Staff	**15.428**	**15.509**	**(0.081)**	**68.251**	**68.251**	**0.000**
Sub Total	**26.177**	**26.193**	**(0.017)**	**111.704**	**111.704**	**0.000**
Total	**(8.987)**	**(8.989)**	**0.003**	**(36.398)**	**(36.398)**	**0.000**

VCC Key Issues:

The reported financial position for the Velindre Cancer Centre as at the end of June 2022 was a small overspend of **£(0.003)m**, and an expected outturn position of **breakeven**.

Income at Month 3 represents a small overachievement of **£0.014m**. This is largely from an increase in activity from providing SACT Homecare and the additional VAT savings, an over achievement on private patient income due to drug performance which is above general private patient performance and a one off drug rebate. This is offsetting the divisional income savings target and the loss of income from the now permanent closure of gift shop, which was initially closed due to Covid, and will now be transformed to make additional space at the Cancer Centre.

VCC have reported a year to date underspend of **£0.065m** against staff. The division continues to have a high level of vacancies, sickness, and maternity leave predominantly within Inpatients, Pharmacy and Radiotherapy which is above the divisional vacancy factor target and is offsetting

the cost of agency (£0.253m to end of June) although £0.087m is directly related to Covid. Inpatients underspend relates to the holding off on recruitment due to reduced bed capacity from social distancing measures, however with social distancing measures reducing a review of service model is being undertaken which considers both recruitment requirement, but also additional ambulatory care to help reduce inpatient flow.

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 is currently still being covered by Jnr Dr's with expectation that the transition to nursing starts to take place from august.

Non-Staff Expenditure at Month 3 was **£(0.081)m** overspent. The overspend largely relates to the maintenance and repairs of the Linacs, transport SLA overspend, and unexpected prior year invoices being received from Virgin Media. The affect from the increase in price for utilities is included as an exceptional national costs pressure with the expectation that the costs will be funded by WG.

WBS

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**6.503**	**6.237**	**(0.266)**	**21.950**	**21.444**	**(0.506)**
Expenditure						
Staff	**4.072**	**4.108**	**(0.035)**	**15.181**	**15.247**	**(0.065)**
Non Staff	**7.216**	**6.950**	**0.266**	**26.650**	**26.079**	**0.571**
Sub Total	**11.289**	**11.057**	**0.231**	**41.831**	**41.326**	**0.506**
Total	(4.785)	(4.820)	0.035	(19.882)	(19.882)	(0.000)

WBS Key Issues:

The reported financial position for the Welsh Blood Service at the end of June 2022 was an **£(0.035)m overspend** with an outturn forecast position of **breakeven** currently expected.

Income underachievement to date is **£(0.266)m**, where activity is lower than planned on Bone Marrow and Plasma Sales. Plasma sales recovery is still being impacted and expected to continue in the short term, but now expected to return to business as usual levels after the summer following attraction of new income. Transitional operating sites for Bone Marrow and increasingly curtailed procedures is resulting in activity being considerably lower than target. Covid funding will be utilised during the first 6 months to offset reduce activity impacted by the pandemic, with the division developing a strategy to increase the panel to help mitigate the risk during the latter part of the year.

Staff reported a year-to-date overspend of **£(0.035)m** to June. Overspend from posts supported without identified funding source which includes advanced recruitment and service developments have been incurred as a divisional cost pressure particularly in relation to Plasma Fractionation where no WHSSC funding has been secured.

Work is 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 **£0.266m** is largely due to reduced costs from suppressed activity (currently running at 80%), underspend on Collections Services, Laboratory Services, WTAIL, and General Services which is primarily timing of proactive and reactive building maintenance.

Corporate

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected £m
Income	0.156	0.239	0.082	0.628	0.745	0.117
Expenditure						
Staff	2.108	2.079	0.029	8.435	8.395	0.040
Non Staff	0.588	0.654	(0.067)	2.300	2.457	(0.157)
Sub Total	2.696	2.734	(0.037)	10.736	10.853	(0.117)
Total	(2.540)	(2.495)	(0.045)	(10.108)	(10.108)	0.000

Corporate Key Issues:

The reported financial position for the Corporate Services division at the end of June 2022 was an underspend of **£0.045m**. 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 is being reflected in the overachievement on income within the Corporate Division.

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

Non pay overspend is **£(0.067)m** as at month 3 largely relates to upfront payment in relation to contracts which is offset by income, and year to date impact of the divisional savings target £(0.026)m 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.

RD&I

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	0.403	0.369	(0.034)	3.107	3.107	0.000
Expenditure						
Staff	0.608	0.564	0.044	2.578	2.578	0.000
Non Staff	0.022	0.032	(0.010)	0.164	0.164	0.000
Sub Total	0.630	0.596	0.034	2.742	2.742	0.000
Total	(0.227)	(0.227)	(0.000)	0.365	0.365	0.000

RD&I Key Issues

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

Reduced income expectations is offsetting staff vacancies.

TCS – (Revenue)

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**0.000**	**0.000**	**0.000**	**0.000**	**0.000**	**0.000**
Expenditure						
Staff	**0.138**	**0.138**	**0.000**	**0.551**	**0.551**	**0.000**
Non Staff	**0.000**	**0.000**	**0.000**	**0.000**	**0.000**	**0.000**
Sub Total	**0.138**	**0.138**	**0.000**	**0.551**	**0.551**	**0.000**
Total	**(0.138)**	**(0.138)**	0.000	**(0.551)**	**(0.551)**	**0.000**

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

TCS will achieve breakeven on the assumption that the Trust reserves again supports the forecasted non-pay costs of £0.030m, along with associated costs of the judicial review which is currently £0.043m.

HTW (Hosted Other)

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**0.416**	**0.338**	**(0.078)**	**1.664**	**1.664**	**0.000**
Expenditure						
Staff	**0.364**	**0.299**	**0.065**	**1.456**	**1.456**	**0.000**
Non Staff	**0.059**	**0.046**	**0.013**	**0.235**	**0.235**	**0.000**
Sub Total	**0.423**	**0.344**	**0.079**	**1.692**	**1.692**	**0.000**
Total	**(0.007)**	**(0.007)**	(0.000)	**(0.028)**	**(0.028)**	**0.000**

HTW Key Issues

The reported financial position for Health Technology Wales at the end of June 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 Finance Report
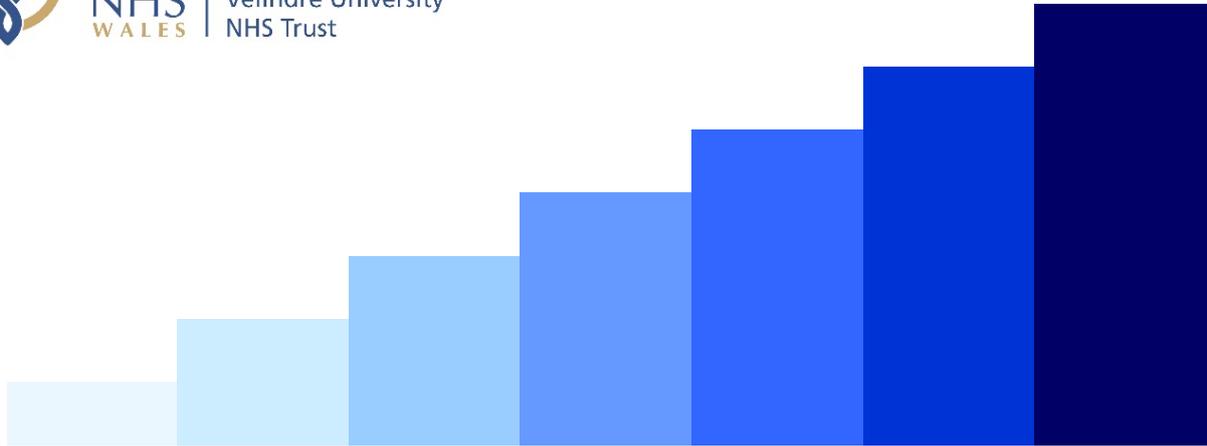
TCS PROGRAMME

FINANCE REPORT 2022/23

Period Ending June 2022

Presented to the

TCS Programme Delivery Board on

13th July 2022

Contents   Page

1. INTRODUCTION

1.1   The purpose of this report is to provide a financial update for the Transforming Cancer Services (TCS) Programme for the financial year 2022-23, outlining spend to date against budget as at Month 03 and current forecast.

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

1.3   Please note that this report is still in development and will be fully updated for July 2022.

2. EXECUTIVE SUMMARY

2.1   The summary financial position for the TCS Programme for the year 2022-23 as at 30th June 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	£2.676m	£22.436m	£22.436m	£0m
Revenue	£0.176m	£0.684m	£0.684m	£0m
Total	**£2.853m**	**£23.120m**	**£23.120m**	**£0m**

2.2   The Programme is currently forecasting an overall breakeven position for capital and revenue expenditure.

2.3   There are currently three key risks for the Programme: an Enabling Works underspend due to delays; increased New Velindre Cancer Centre (nVCC) advisory fees; and increased Judicial Review Matter legal fees. Plans to mitigate these risks are 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, 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   To date, £22.436m capital and £0.684m revenue funding has been provided to the Trust to support the TCS Programme in 2022-23, as outlined in Appendix 2.

4. CAPITAL POSITION

4.1   WG has issued a Capital Expenditure Limit (CEL) of £19.463m for the Enabling Works Project and £2.089m to support the nVCC Project in 2022/23.

4.2   WG funding for the Integrated Radiotherapy Solution Procurement (IRS) Project was utilised in full during 2021/22, therefore no CEL has been issued for this Project. The capital funding requirement of £0.434m will be provided from the Trust's discretionary capital allocation.

4.3   The capital position as at 30th June 2022 is outlined below, with a forecast breakeven outturn for 2022/23 against an overall budget of £22.436m.

Capital Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Enabling Works Project	£1.697m	£19.913m	£19.463m	£0.450m
nVCC Project	£0.894m	£2.089m	£2.539m	-£0.450m
IRS Project	£0.086m	£0.434m	£0.434m	£0m
Total	**£2.676m**	**£22.436m**	**£22.436m**	**£0.000m**

4.4   The forecast overspend of £0.450m for the nVCC Project will be supported by the Enabling Works Project underspend of the same. This reflects the support provided by the nVCC project to the Enabling Works Project in 2021/22.

5. REVENUE POSITION

5.1   Revenue funding for the Programme Management Office (PMO) and the Service Development & Transformation (SDT) Project continues to be provided by the Trust and the NHS Commissioners.

5.2   To date, the Trust has ring-fenced £0.073m revenue funding for the nVCC Project, as no revenue funding has been provided by WG this year. Formal delegation of this budget is pending. The Commissioner's funding for 2022/23 is £0.420m.

5.3   The revenue position as at 30th June 2022 is outlined below, with a forecast breakeven outturn for 2022/23 against a budget of £0.684m.

Revenue Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
PMO	£0.053m	£0.300m	£0.300m	£0m
nVCC Project	£0.051m	£0.073m	£0.073m	£0m
SDT Project	£0.073m	£0.311m	£0.311m	£0m
Total	**£0.176m**	**£0.684m**	**£0.684m**	**£0m**

6. CASH FLOW

6.1   This update is currently being develop and will be provided in the next financial report.

7.   PROJECT FINANCE UPDATES

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

Programme Management Office (PMO)

7.2   In November 2021, the Trust EMB approve phased funding of £250m for the Strategic Transformation Programme. The first year's allocation of £0.060m was provided to the TCS Programme in 2022-23 as part of the transition between Programmes. This additional funding was released in May 2022, increasing the total revenue funding to £0.300m for 2022/23.

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 June 2022 is shown below.

PMO Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Pay	£0.053m	£0.283m	£0.283m	£0m
Non Pay	£0m	£0.017m	£0.017m	£0m
Total	**£0.053m**	**£0.300m**	**£0.300m**	**£0m**

7.5   There are currently no financial risks relating to the PMO.

Enabling Works Project

7.6   In February 2022, the Minister for Health and Social Services approved the Enabling Works FBC, along with a total capital funding of £28.089m. £19.913m of this funding has been allocated in the financial year 2022/23.

7.7   The Enabling Works financial position for June 2022 is shown below, with a further breakdown provided in Appendix 3. The forecast position reflects an underspend of £0.450m, which will be used to support the nVCC Project as agreed by WG. This reflects the support that was provided by the nVCC Project in 2021/22.

Enabling Works Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Pay	£0.054m	£0.220m	£0.218m	£0.002m
Non Pay	£1.643m	£19.693m	£19.245m	£0.448m
Total	**£1.697m**	**£19.913m**	**£19.463m**	**£0.450m**

7.8   There is a financial risk related to a significant underspend as a result of the delay in key project activities. The Project will make an assessment for the virement of funding into 2023-24 as per agreement with WG.

New Velindre Cancer Centre (nVCC) Project
Capital

7.9   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 of £2.089m in 2022/23.

7.10   The capital financial position for the nVCC Project for June 2022 is shown below, with a further breakdown provided in Appendix 4. The forecast position reflects an over-spend of £0.450m, which will be supported from the Enabling Works Project as agreed by WG. This reflects the support that was provided to the Enabling Works Project in 2021/22.

nVCC Capital Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Pay	£0.321m	£1.413m	£1.427m	-£0.015m
Non Pay	£0.573m	£0.676m	£1.112m	-£0.435m
Total	**£0.894m**	**£2.089m**	**£2.539m**	**-£0.450m**

7.11   There is a financial risk relating to advisory fees to conclude the tender evaluation stage, and Successful Participant to Financial Close stage.   The Project will track the progress of these fees and develop a mitigation plan if required.

Revenue

7.12   No revenue funding has been provided for this project by WG, therefore the Trust has ring-fenced £0.030m for nVCC Project Delivery, and a further £0.043m for the Judicial Review Matter. This is an increase from the funding of £0.044m reported in May 2022 due to the increased fees for the Judicial Review Matter. Formal delegation for both budgets is pending.

7.13   The capital financial position for the nVCC Project for June 2022 is shown below, reflecting a forecast breakeven position against a budget of £0.073m.

nVCC Revenue Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Project Delivery	£0.007m	£0.030m	£0.030m	£0m
Judicial Review	£0.043m	£0.043m	£0.043m	£0m
Total	**£0.051m**	**£0.073m**	**£0.073m**	**£0m**

7.14   There is a revenue financial risk relating to Judicial Review matter, which is it dependent on the outcome of court proceedings. It is difficult to quantify this risk, therefore the Project will track the progress of this matter and request further revenue funding from the Trust if required.

Integrated Radiotherapy Solution Procurement (IRS) Project

7.15   Due to a delay in the procurement process, the IRS Project has been extended to September 2022. This has resulted in an additional capital requirement of £0.434m in 2022/23, which is assumed to be provided by the Trust from its discretionary capital allocation.

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

7.17   The capital position for the IRS Project 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	£0.049m	£0.0.71m	£0.0.71m	£0m
Non Pay	£0.036m	£0.363m	£0.363m	£0m
Total	**£0.086m**	**£0.434m**	**£0.434m**	**£0m**

7.18   A review in May 2022 of the resource requirement for the Project has resulted in a decrease in pay costs. The released funds will be used to cover advisory additional fees for the Project.

7.19   There are currently no financial risks relating to the IRS Procurement Project.

Service Delivery and Transformation (SDT) Project

7.20   The SDT Project has received revenue funding of £0.131m from the Trust and £0.180m funding from the NHS Commissioners' contribution to support pay and non-pay costs in 2022/23.

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

7.22   The SDT Project revenue position as at 30th June 2022 is shown below.

SDT Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Pay	£0.073m	£0.288m	£0.288m	£0m
Non Pay	£0m	£0.023m	£0.023m	£0m
Total	**£0.073m**	**£0.311m**	**£0.311m**	**£0m**

7.23   There are currently no financial risks relating to the SDT Project.

8.   KEY RISKS AND MITIGATING ACTIONS

8.1   There are currently three key financial risks for the TCS Programme:

- An underspend by the Enabling Works Project as a result of the delay in key project activities;

- Increased advisory fees required to conclude the nVCC tender evaluation stage, and Successful Participant to Financial Close stage; and

- Increased legal fees for the Judicial Review matter.

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

9.   SPEND REPORT SUMMARY FOR QUARTER 1 2022-23

9.1   This update is currently being develop and will be provided in the next financial report.

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

CAPITAL	Year to Date			Full Financial Year		
	Budget	Spend	Variance	Budget	Forecast	Variance
	£	£	£	£	£	£
PAY						
Project Leadership	52,194	53,183	-989	208,776	212,667	-3,891
Project 1b – Enabling Works FBC	54,936	53,637	1,299	219,744	217,838	1,906
Project 2a – New Velindre Cancer Centre OBC	271,634	268,154	3,480	1,203,913	1,214,671	-10,758
Project 3a – Radiotherapy Procurement Solution	47,653	49,495	-1,842	70,601	70,601	0
Capital Pay Total	**426,417**	**424,469**	**1,948**	**1,703,034**	**1,715,777**	**-12,743**
NON-PAY						
nVCC Project Delivery	28,985	22,010	6,975	84,000	84,000	0
Project 1b – Enabling Works FBC	1,740,748	1,642,899	97,849	19,693,260	19,244,951	448,309
Project 2a – New Velindre Cancer Centre OBC	441,300	550,761	-109,461	592,311	1,027,561	-435,250
Project 3a – Radiotherapy Procurement Solution	39,000	36,345	2,655	363,399	363,399	0
Capital Non-Pay Total	**2,250,033**	**2,252,015**	**-1,983**	**20,732,970**	**20,719,911**	**13,058**
CAPITAL TOTAL	**2,676,450**	**2,676,484**	**-34**	**22,436,004**	**22,435,688**	**315**

REVENUE	Year to Date			Full Financial Year		
	Budget	Spend	Variance	Budget	Forecast	Variance
	£	£	£	£	£	£
PAY						
Programme Management Office	49,979	52,632	-2,653	282,993	282,993	0
Project 6 – Service Change Team	72,098	73,047	-950	288,390	288,390	0
Revenue Pay total	**122,077**	**125,679**	**-3,602**	**571,383**	**571,383**	**0**
NON-PAY						
nVCC Project Delivery	8,169	7,263	906	30,000	30,000	0
nVCC Judicial Review	43,417	43,417	0	43,417	43,417	0
Programme Management Office	1,500	0	1,500	17,007	17,007	0
Project 6 – Service Change Team	5,652	67	5,586	22,610	22,610	0
Revenue Non-Pay Total	**58,738**	**50,747**	**7,992**	**113,034**	**113,034**	**0**
REVENUE TOTAL	**180,815**	**176,426**	**4,389**	**684,417**	**684,417**	**0**

APPENDIX 2: TCS Programme Funding for 2022/23

Description	Funding Type	
	Capital	Revenue
Programme Management Office	**£0m**	**£0.300m**
Commissioner's funding (April 2022)		£0.240m
Trust Funding (date)		£0.060m
Enabling Works OBC	**£19.913m**	**£0m**
2022/23 CEL from Welsh Government funding for Enabling Works FBC approved in February 2022	£19.913m	£0m
New Velindre Cancer Centre OBC	**£2.089m**	**£0.073m**
2022/23 CEL from Welsh Government funding for nVCC OBC in March 2021	£2.089m	
Trust revenue funding for nVCC Project Delivery (May 2022)		£0.030m
Trust revenue funding for the Judicial Review Matter (May 2022)		£0.014m
Additioal Trust revenue funding for the Judicial Review Matter (June 2022)		£0.029m
Radiotherapy Procurement Solution	**£0.434m**	**£0m**
Trust Discretionary Capital Allocation (date)	£0.434m	
Radiotherapy Satellite Centre	**£0m**	**£0m**
No funding requested or provided for this project to date		
SACT and Outreach	**£0m**	**£0m**
No funding requested or provided for this project to date		
Service Delivery, Transformation and Transition	**£0m**	**£0.311m**
Commissioner's funding (April 2022)		£0.180m
Trust Funding (April 2022)		£0.131m
VCC Decommissioning	**£0m**	**£0m**
No funding requested or provided for this project to date		
Total	**£22.436m**	**£0.684m**

APPENDIX 3: Enabling Works Project Budget and Spend 2022/23 as at 30th June 2022

Description	Year to Date			Full Financial Year		
	Budget £	Spend £	Variance £	Budget £	Forecast £	Variance £
PAY						
Project 1b - Enabling Works FBC	54,936	53,637	1,299	219,744	217,838	1,906
Pay Capital Total	**54,936**	**53,637**	**1,299**	**219,744**	**217,838**	**1,906**
NON-PAY - PROJECTS						
EF01 Construction Costs	0	28,800	-28,800	0	28,800	-28,800
EF02 Utility Costs	0	0	0	1,850,895	1,850,895	0
EF03 Supply Chain Fees	108,563	111,638	-3,075	596,047	786,345	-190,298
EF04 Non Works Costs	13,886	14,788	-902	553,200	553,872	-672
EF05 ASDA Works	225,600	221,409	4,191	5,928,137	5,928,137	0
EF06 Walters D&B	1,148,679	1,148,679	0	8,735,418	8,735,418	0
EF07 Other (Decant Works, Surveys & Investigations, IM&T etc.)	0	0	0	234,000	234,000	0
EFQR Quantified Risk	244,020	0	244,020	1,351,828	599,919	751,909
EFQS QRA - SCP	0	0	0	454,080	454,080	0
EFRS Enabling Works FBC Reserves	0	117,586	-117,586	-10,345	73,486	-83,831
Enabling Works Project Capital Total	**1,740,748**	**1,642,899**	**97,849**	**19,693,260**	**19,244,951**	**448,309**
TOTAL ENABLING WORKS FBC CAPITAL EXPENDITURE	**1,795,684**	**1,696,536**	**99,148**	**19,913,004**	**19,462,789**	**450,214**

APPENDIX 4: nVCC Project Budget and Spend 2022/23 as at 30th June 2022

Description	Year to Date Budget £	Spend £	Variance £	Full Financial Year Budget £	Forecast £	Variance £
PAY						
Project Leadership	52,194	53,183	-989	208,776	212,667	-3,891
Project 2a - New Velindre Cancer Centre OBC	271,634	268,154	3,480	1,203,913	1,214,671	-10,758
Pay Capital Total	**323,828**	**321,337**	**2,491**	**1,412,689**	**1,427,337**	**-14,649**
NON-PAY						
nVCC Project Delivery	**28,985**	**22,010**	**6,975**	**84,000**	**84,000**	**0**
Work Packages						
VC08 Competitive Dialogue - Dialogue & SP to FC	441,300	479,979	-38,679	554,500	978,879	-424,379
VC10 Legal Advice	0	1,407	-1,407	0	1,407	-1,407
VC11 S73 Planning	0	59,548	-59,548	0	59,548	-59,548
VCRS nVCC Reserves	0	9,828	-9,828	37,811	-12,272	50,083
nVCC Project Capital Total	**441,300**	**550,761**	**-109,461**	**592,311**	**1,027,561**	**-435,250**
TOTAL nVCC fbc CAPITAL EXPENDITURE	**794,113**	**894,108**	**-99,995**	**2,089,000**	**2,538,899**	**-449,899**

TRUST BOARD

TRUST RISK REGISTER

DATE OF MEETING	28.07.2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	This is a public document

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

REPORT PURPOSE	FOR NOTING

Committee/Group who have received or considered this paper PRIOR TO THIS MEETING		
Committee or Group	DATE	OUTCOME
EMB Run	01.07.2022	Discussed and Noted by EMB
Quality, Safety & Performance Committee	14.07.2022	Discussed out of Committee by IMs
Audit Committee	19.07.2022	Discussed however Policy not endorsed for approval, as set out in this Paper

ACRONYMS	
VCC	Velindre Cancer Centre
WBS	Welsh Blood Service
TCS	Transforming Cancer Services
SLT/SMT	Divisional Senior Leadership Teams / Senior Management Teams
EMB	Executive Management Board

1. SITUATION AND BACKGROUND

The purpose of this report is to:

- Share the May extract of risk registers to allow the Board to have effective oversight and assurance of the way in which risks are currently being managed across the Trust.
- Summarise the feedback, and progress against that to date, on the process from the previous cycle of Committees and Trust Board.
- Summarise the final phase in implementing the Risk Framework.

2 ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

Key Points for the Committee:

1. There has been good progress on completing the final phase of the risk framework implementation, as outlined in section 3.

2. There were two key points following oversight at Executive Management Board during this period:

   a. There were two risks areas that were requested to be assessed and reflected in the next reporting period as appropriate: firstly regarding service SACT capacity risks; and secondly ensuring the workforce and finance triangulated identified risks are appropriately reflected in DATIX.

   b. In terms of the formatting of this report, the focus over the previous period has been the completion of the risk framework implementation. It is recognised that this cover paper is not currently in most effective format as the clarity on SMART action plans is not being demonstrated in the way in which the data is being

pulled from DATIX. In other cases the Action plans section on DATIX is not being effectively used, this is being addressed in the training but an exercise to ensure all clear action plans for 16 and above as priority will be completed during the next reporting period.

3. **In addition, the summary from Quality, Safety & Performance and Audit Committee included:**

   a. Both Committees requested further detail required on management response to risks 2200 and 2529. This will be discussed in the Board meeting and reflected in the DATIX extract for following reporting period.

   b. In terms of point 2.b above, the Quality, Safety and Performance Committee Members were not assured on the risk register due to there not being clear action plans.

   c. It was also discussed by Quality, Safety and Performance Committee Members that the risk register extract from DATIX is not presented consistently across the Committees. This is being addressed by the risk working Group and a consistent approach will be taken from the next reporting period.

   d. It was noted in Audit Committee that the risks relating to projects on hold in the Transforming Cancer Services Programme included in the commentary that – "No changes made to current risk ratings as no review & confirmation undertaken by Risk Owner whilst Project remains On Hold." It is important to ensure the principle of course system reporting remains however, given these risks were in DATIX during the reporting period.

   e. Before endorsing the new Risk Policy for Board approval, the Committee also wanted sight of the Trust Risk Appetite Strategy document again. This will be circulated and the request for endorsement was agreed could take place out of Committee.

2.1 THE TRUST RISK REGISTER

2.1.1 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 included.

3
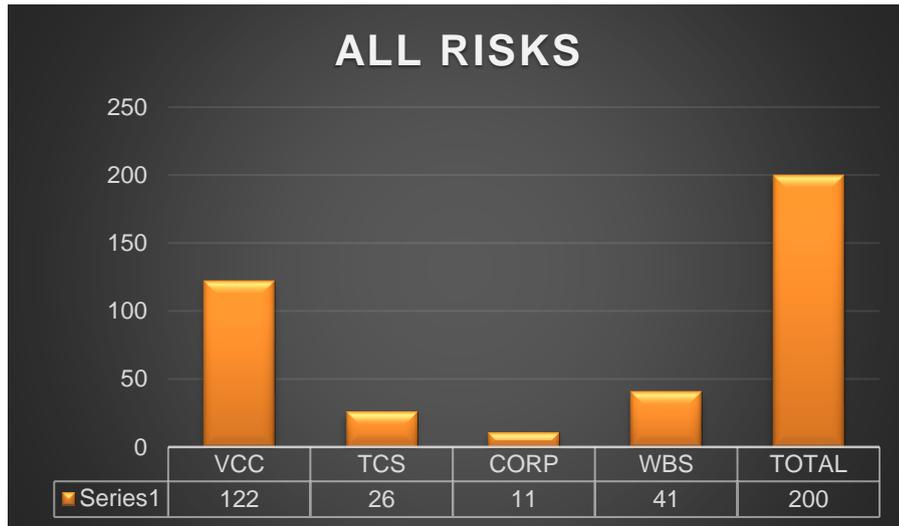
2.1.3 Analysis of risks

An analysis of risks by level is provided below. Tables provide detail of each risk including risk type, risk ID, review date and title of the risk.

Risks level 25

There remain no level 25 risks up to 31st May 2022.

Risks level 20

ID	Division	Review date	Title	Risk (in brief)	Rating (current)	Rating (Target)	RR - Current Controls
2400	Transforming Cancer Services	01/08/2022	Risk that there is lack of project support	There is a risk that the lack of appropriate project support from the programme will lead to delays in developing the solutions required for the project success.	20	6	No changes made to current risk ratings as no review & confirmation undertaken by Risk Owner whilst Project remains On Hold. 1) Project Manager role currently going through recruitment process – September 2) Outcomes of Programme Stocktake (July) will inform governance structure of TCS & VF Programmes - September
2529	Velindre Cancer Centre	01/08/2022	There is a risk that the e-film service operated in xray within VCC may fail as a result of unsupported hardware and software.	The device is used when importing images from Oncology and from outside of NHS Wales. In addition, it's also used to push images back to the Oncology service. It is the only way staff can import images off Radiology CT /MRI/ scanners that fall outside of Fuji PACS. There is no resilience, backup, business continuity or disaster recovery plans in place should the device and/or e-film software fail. Merge, the company who produce e-film software are no longer supporting ANY version of the software from 30 June 2022, therefore a new solution will need to be sought.Any migration to a supported solution will need to be done in advance of the aforementioned date, which needs to be considered.	20	1	Operationally, no controls are in place to prevent the risk from happening.

ID	Division	Opened	Review date	Risk (in brief)	Rating (current)	Rating (Target)	RR - Current Controls
2200	Velindre Cancer Centre	30/08/2022	01/08/2022	Availability of sufficient radiotherapy capacity within available financial resource affects achievement against national cancer standards. Patients may not be treated to optimum treatment timescales, which may affect the overall patient experience and lead to poorer outcomes.	16	6	13/6/2022 Update - Ongoing monitoring of capacity, demand breaches and waiting times targets. Development of breach escalation process to ensure, where needed patients are prioritised effectively. - Extended working hours are in place on the treatment machines and in many other areas of service. - Agency Radiographers are in place to support additional hours. Assessment of potential Agency staff experience at point of hire to ensure that Agency staff are able to rotate around more than one work area / linac type / OMS type within department. - Changes made to RT Booking processes, and staff flexibility used to maximise use of resources. - Understand and prioritise activities that promote wellbeing in the team. Diverse training sessions held to enhance mindfulness, wellbeing, and resilience. - Review of dose & fractionation, plan complexity and recruitment at clinical trials is being reviewed by SST's and Clinical Director. - Revisit maximising capacity document. - Reassess potential to outsource patients.
2211	Velindre Cancer Centre		01/08/2022	Digital Health & Care Record (DH&CR - Canisc Replacement) programme. DHCR004(R) - Requirements for standardisation, process redesign and agreed Ways of Working - Business Change The scope of the deliverables for the workstreams will change after being signed off and planned and may cause delays. There is a risk that without an element of standardisation; process redesign and agreed ways of working; system configuration, testing and training becomes very complicated and time consuming.	16	12	Ways of Working sessions to be held. Key advocates for change, standardisation and process redesign to be involved in the project Project Governance - Workstreams will be established to ensure key decisions are made with all involved in a timely manner required by the project. SMT and Clinical Lead support on standardisation of Ways of Working

2326	Velindre Cancer Centre			01/08/2022	There is a risk that the Service will be unable to significantly reduce the capacity of clinics over the Digital Health & Care Record go-live.A Minimal amount of outpatient activities can be paused due to the nature of the service provision. Some non-cancer and follow-up clinics can be reduced however. Clinics will be running at normal capacity - ideal situation on a large go-live would be for reduced clinics for a few days after go-live to allow users a little additional time to get used to the new system.	16	9	1. Service managers and teams to be available on site. 2. Training champions/super users to support on site during the Go-Live period. 3. Minimise annual leave as much as possible.
2402	Transforming Cancer Services			01/08/2022	Project 5 – Outreach - There is a risk that time-consuming infrastructure work i.e. the refurbishment of a current site or identification of a new build is required to deliver the agreed outreach model of care. This could lead to delays in outreach services not being established or operational ahead of the new VCC as agreed within Programme objectives	16	9	No changes made to current risk ratings as no review & confirmation undertaken from Risk Owner whilst Project remains On Hold.
2454	Corporate Services			01/08/2022	There is a risk that the Digital Services team are unable to support agreed Divisional and/or Trust strategic and operational objectives as a result of limited capacity within the team, which may lead to a delay in the delivery of new / updated digital services.	16	8	Head of Digital Delivery and Head of Digital Programmes developing resource and financial strategy, to present to DoF and EMB in Q1 2022/23. Regular review of IT work plan, to ensure delivery is aligned to Trust / Divisional priorities. VCC and WBS IT work plans regularly reviewed, to be shared via relevant channels (BPG, SMT/SLT etc.). 'Agile' utilisation of Digital Services resource, to ensure focus on prioritised work.

3   Development of Risk Framework

Policy & Procedure

The new Risk Management Policy has been completed and been out for consultation. The policy has been endorsed by the Executive Management Board and was received by the Audit Committee for endorsement for Trust Board approval. However, as noted above, before endorsing the new Risk Policy for Board approval, the Committee also wanted sight of the Trust Risk Appetite Strategy document again. This will be circulated and the request for endorsement was agreed could take place out of Committee

.

In addition, a new Corporate Risk Management Procedure has been finalised and will be distributed in line with approved Policy.

Training

Management Level 2 Training module is being rolled out. Over 100 staff trained to date over 7 sessions. Remainder are being scheduled. Most to complete by August however there will be an opportunity for final wash up sessions in early September, to reflect the holiday period for staff.

Management Level 1 training has been finalised and will be rolled out on ESR from late August, following the completion of the bulk of the level 2 training. This sequencing is important to ensure that managers are clear on the processes and their roles prior to all their teams being trained.

Leadership Level 3 is near complete, with Trust Board, Executive Management Board and Velindre Cancer Centre Senior Leadership Team having received their training. Transforming Cancer Services Leadership Team session is confirmed for August and Welsh Blood Service Senior Management Team slot is being confirmed for the same period.

DATIX 14

Welsh Blood Service has completed transition to DATIX 14 for all new risk activity and risks will be reporting at Board appetite levels from DATI 14 for the next reporting period.

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
	Completed for individual risks as appropriate
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.

5   RECOMMENDATION

The Board is asked to:

- **NOTE** the risks level 20 and 16 reported in the Trust Risk Register and highlighted in this paper.
- **NOTE** the on-going developments of the Trust's risk framework.

9

TRUST BOARD

TRUST ASSURANCE FRAMEWORK

DATE OF MEETING	28/07/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable – Public Report

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
Executive Management Board	01.07.2022	Discussed and reviewed
Strategic Development Committee	09.07.2022	Discussed and reviewed
Audit Committee	19.07.2022	Discussed and reviewed

1. SITUATION / BACKGROUND

1.1   The purpose of this paper is to provide the Trust Board with an update on:

- The status of the Principal Risks identified in the Trust Assurance Framework (TAF) included at **Appendix 1,** which may affect the achievement of the Trust's Strategic Objectives, and the level of assurances in place to evidence the effectiveness of the management of those risks.

- The ongoing work to support the continued development, articulation and operationalisation of the Trust Assurance Framework across the organisation, since the May 2022 meeting of the Trust Board.

- Provide an overview of the scrutiny undertaken at each level of the Trust's Governance and Accountability Framework, aligned with the respective roles of each of the various parts of the Trust Board Governance Structure. This summary view is for the **July 2022** governance reporting cycle.

2.   ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1   **Key developments previously noted to the Trust Board and planned up to end September 2022, for discussion and review through each of the respective Board Committee's October 2022, governance reporting cycle:**

2.1.1 **Link to Risk Register, Performance Framework and Quality Framework**

An important step in the development of the Trust Assurance Framework will be to develop the link between the Trust Risk Management Framework, Performance Management Framework and Quality & Safety Management Framework. The connections between these four key frameworks is important to the ability of the Board to more effectively triangulate and assure going forwards.

The first step is to link the Trust Risk Management Framework and Trust Assurance Framework – and this work will be completed over the summer for October 2022 Strategic Development and Audit Committee reporting.

Following the development of the Trust Performance Management and Quality Management Frameworks, key metrics relating to the strategic risks will also be linked during Q3.

2.1.2 **Reverse Stress Testing**

Reverse stress testing is the identification of a pre-defined adverse outcome, for instance the point at which an organisation may be considered as failing, and severe, but plausible, risks materialising that might result in this outcome are then explored. This is an important development in the organisation's risk maturity and capability.

This work will be underway and plans progressed to secure external support to facilitate a taregtted workshop at the next Trust Board Development Session. The outcome of which will be reported in the October 2022 Committee governance cycle. This work will progress in parallel with the review of the overall risk profile, as approaching the macro level risk questions in this way will be a useful tool and input into the annual review.

2.1.3 **Link to Strategy Development**

In reviewing the profile, in addition to the reserve stress testing exercise described above, there are two further key suggested inputs:

- Using research and insight on global organisational and health care trends to challenge and support our thinking on macro strategic risks.
- Frame the review in the Trust approved Strategy and Enabling Strategies.

The work will then also culminate into the October 2022 Committee governance reporting cycle.

2.1.4 **Revised reporting mechanism - Integration of Trust Assurance Framework into Datix.**

Following discussion and engagement with risk colleagues in other Health Boards across Wales and the identification and assessment of increased automation of the Trust

Assurance Framework colleagues in the Datix team are liaising with the Hywel Dda Datix team regarding the development of principal risks within Datix Version 14.

Initial scoping work has taken place and a gap analysis and mapping exercise will take place in August 2022 in order to further progress this work.

Furthermore, at the July 2022 Audit Committee, the application of Power Business Intelligence for reporting against the Trust Assurance Framework was also discussed and the benefits this can deliver. It was recognised that currently the availability of such resource within the Trust is extremely limited. Options to explore availability of external resource and support across NHS Wales was discussed. It was agreed that colleagues in Audit Wales will assist in exploring any opportunities that may be available for the Trust to access and tap into the Data Analytics Team within Audit Wales.

2.2 **Further developments discussed and agreed through June – July 2022:**

In the July 2022 Executive Management Board discussion, the following actions were discussed and agreed:

2.2.1 **Actions on specific strategic risks**

The scoring of the Strategic Workforce Planning **TAF 03** needed to be reviewed, as consensus was the assessment was likely to result in an increased score. This view was further reinforced at the July 2022 Quality, Safety & Performance Committee where workforce planning was discussed. This was triangulated following further scrutiny of **TAF 03** at the July 2022 Trust Audit Committee. As a result, this strategic risk has since been re-assessed and the residual risk score has been revised and increased from **9** to **12.** The corresponding action plan has also 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. A more detailed review of this risk and the existing gaps in assurance will be undertaken by the end of August for reporting to the September 2022 Trust Board.

Secondly that the organisational culture **risk TAF 04** needed to be linked more specifically to the development of the organisational design programme of work.

2.2.2 **Mapping Trust Assurance Framework to governance cycle**

In line with Board development discussions with Internal Audit and Audit Wales during this period, there should be a clearer link between the Trust Assurance Framework. This will be progressed during the next reporting period. Work will include:

- Ensuring that cycles of business provide appropriate consideration of each of the TAF controls and sources of assurance.
- Mapping the relevant actions into governance cycles.
- Ensure each committee scrutinise progress to address gaps in controls and Assurances within its scope.

2.2.3 **Link to Audit tracker**

Executive Management Board also agreed to map the Audit tracker to the third line of defence mapping in the Trust Assurance Framework in order to provide assurance that all current insight, including the impact of open actions on the effectiveness of the control framework, are taken into account.

2.3 **Trust Assurance Framework Dashboard**

2.3.1 The updated Trust Assurance Framework Dashboard Report is included at *Appendix 1.*

2.3.2 Overall the Trust Assurance Framework Dashboard is showing that progress updates have been received since the May 2022 Trust Board in respect of the following Principal Risks.

2.3.3 To also note that in the July Strategic Development Committee and Audit Committee, the summary of each strategic risk was discussed and reviewed, in line with the scope of that Committee to ensure that the Principal Risks are being managed in an effective way in order to enable the realisation of the Trust's strategic objectives.

			Legend
	🟥 RED		NO REVIEW TAKEN PLACE
	🟧 ORANGE		REVIEWED NO CHANGES
	🟩 GREEN		REVIEWED AND UPDATED

No.	Risk	Owner	MAR	APR	MAY	JUN
01	Demand and Capacity	COB	Orange	Green	Green	Green
02	Partnership Working / Stakeholder Engagement	CJ	Green	Green	Green	Green
03	Workforce Planning	SFM	Orange	Green	Green	Green
04	Organisational Culture	SFM	Orange	Green	Green	Green
05	Organisational Change / 'strategic execution risk'	CJ	Green	Green	Green	Green
06	Quality & Safety	NW	Green	Green	Green	Green
07	Digital Transformation – failure to embrace new technology	CJ	Green	Green	Green	Green
08	Trust Financial Investment Risk	MB	Green	Orange	Green	Green
09	Future Direction of Travel	CJ	Green	Green	Green	Green
10	Governance	LF	Green	Orange	Green	Green

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 Trust Board is asked to:

    a. **DISCUSS AND REVIEW** the progress made and next steps in supporting the continued development and operationalisation of the Trust Assurance Framework, as outlined in section 2.

    b. **DISCUSS AND REVIEW** the update to the Trust Assurance Framework Dashboard, included at *Appendix 1.*

TAF DASHBOARD

DEMAND AND CAPACITY

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	Jun-22	1 - Outstanding for quality, safety and experience
NEXT REVIEW	Aug-22	

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**	4	4	**16**	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		

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	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

TAF DASHBOARD

DEMAND AND CAPACITY

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
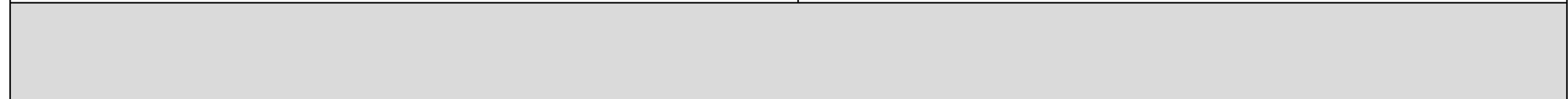
TAF DASHBOARD

DEMAND AND CAPACITY

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-22
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	Email sent via COO to each HB requesting further meetings to discuss data	Aug-22
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

PARTNERSHIP WORKING AND STAKEHOLDER ENGAGEMENT

RISK ID:	TAF 02	**PARTNERSHIP WORKING AND STAKEHOLDER ENGAGEMENT:** Failure to establish and maintain effective relationships with internal and external stakeholders, and/or align our operational actions or strategic approach with system partners, resulting in confusion, duplication or omissions; threatening collaborative working initiatives; and/or an inability to deliver required change to achieve our medium to long term objectives.								
LAST REVIEW	Jun-22	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations									
NEXT REVIEW	Aug-22										

RISK SCORE (See definitions tab)

EXECUTIVE LEAD	Carl James	INHERENT RISK			RESIDUAL RISK			TARGET RISK		
		Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
		3	4	12	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		

GAP IN CONTROLS						GAPS IN 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
1.1	System structures – core cancer services commissioning arrangements		X			PE	Commissioning contracting reporting	IA	Strategic Development Committee/Quality Safety and Performance Committeee	PA	Wales Audit Office/Welsh Government	PA
1.2	Strategic partnerships which support effective delivery of working/ work programmes			X		PE	Supply and demand reporting	IA	Strategic Development Committee/Quality Safety and Performance Committeee	IA	Wales Audit Office/Welsh Government	PA

PARTNERSHIP WORKING AND STAKEHOLDER ENGAGEMENT

1.3	Performance data and measures to clearly track progress against objectives				X	PE	Linked through performance framework insight	PA	Strategic Development Committee/Quality Safety and Performance Committeee	PA	Wales Audit Office/Welsh Government	PA
2.1	Blood - core blood services commissioning arrangements			X		PE	Commissioning contracting reporting	IA	Strategic Development Committee/Quality Safety and Performance Committeee	IA	Regulatory scope re MHRA tbc	PA
3.1	Local Partnership Forum		X	X		PE	Feedback from LPF	PA	Strategic Development Committee/Quality Safety and Performance Committeee	PA	Wales Audit Office	PA
4.1	South Wales Collaborative Cancer Leadership Group system model to provide leadership across region		X			PE	Agreed to model for next phase	PA	Strategic Development Committee/Quality Safety and Performance Committeee	PA	Wales Audit Office/Welsh Government	PA
5.1	Partnership Board arrangements with partner Health Boards model;		X			PE	Agreed to model for each organisation	IA				

GAP IN CONTROLS	GAPS IN ASSURANCE
Across the models of working in strategic partnerships, there are common themes of control effectiveness – with the models largely in place, further development required on the ways of working/work programmes and even further development required on the reporting mechanisms	First line and second lines of defence assurance are in place to a certain extent
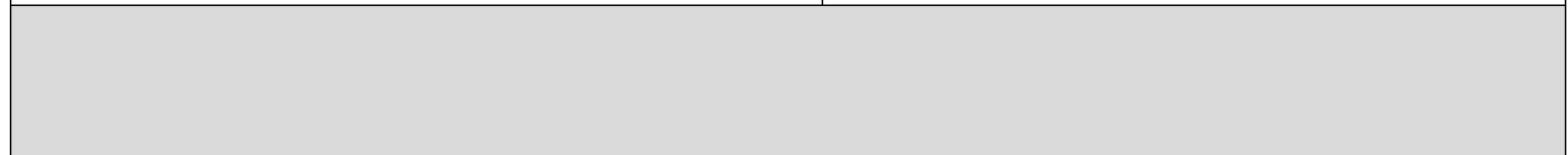
TAF DASHBOARD

PARTNERSHIP WORKING AND STAKEHOLDER ENGAGEMENT

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE				
	Action Plan	**Owner**	**Progress Update**	**Due Date**
1.1	Although each of these mechanisms and controls are reported through various mechanisms – a specific action plan against these controls will be developed and reported through governance to support this strategic risk	Carl James	Linked to developments in ways of working for the Trust, the actions to enhance the effectiveness of the controls will be specifically developed and reported on.	Complete
1.2	Consideration of second and third line opportunities for further assurance to be incorporated into action plan as per action 1.1	Carl James		Complete
1.3	Development of CCLG leadership and goverancne arrangements: towards Alliance System: agree next steps with CEOs	Carl James		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	Jun-22	1 - Outstanding for quality, safety and experience							
NEXT REVIEW	Aug-22								

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	3	12	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
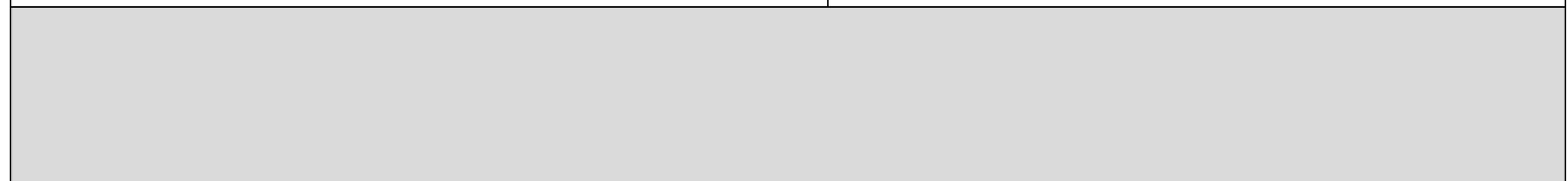
TAF DASHBOARD

WORKFORCE PLANNING

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE				
	Action Plan	Owner	Progress Update	Due Date
1.1	Attraction, Retention and Recruitment Programme established to deliver outputs to support the supply and shape of the workforce	Sarah Morley	The Programme Group has been established and a range of outputs defined to deliver between September 2022 and 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   ORGANISATIONAL CULTURE

RISK ID:	TAF 04	**ORGANISATIONAL DESIGN: Failure to establish effective systems and structures built around shared values and behaviours.**							
LAST REVIEW	Jun-22	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations							
NEXT REVIEW	Aug-22								

EXECUTIVE LEAD	Sarah Morley	**RISK SCORE** (See definitions tab)							
		INHERENT RISK			**RESIDUAL RISK**			**TARGET RISK**		
		Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
		3	3	9	3	3	9	2	2	4

Overall Level of Control Effectiveness: Rating and Rag (see definitions tab)	RATING	Overall Trend in Assurance	THIS WILL INCLUDE A TREND GRAPH
	PE		

KEY CONTROLS — SOURCES OF ASSURANCE

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Trust Strategies and enabling strategies (including people, RD&I and Digital) to be agreed to provide clarity and alignment on strategic intent of the Organisation	Carl James	X			PE	Working group led by CJ	PA	Trust Board reporting on strategy and controls via cycle of business	PA	To be completed as per compliance/ reg tracker update	PA
C2	Developing Capacity of the Organisation – set out in the Education Strategy and implementation plan to support the educational development of the Organisation to support the Trust direction	Susan Thomas	X			PE	Education and training Steering Group	PA	Trust Board reporting on strategy and controls via cycle of business	PA	To be completed as per compliance/ reg tracker update	PA

TAF DASHBOARD

ORGANISATIONAL CULTURE

C3	Management and Leadership development in place to provide a infrastructure to develop compassionate leadership and managers established via the creation of the Inspire Programme with development from foundations stages in management to Board development	Susan Thomas	X			PE	Education and training Steering Group	PA			
C4	Values to be reviewed and Behaviour framework to be considered Values of the Organisation used in induction, recruitment and via PADR processes	Susan Thomas	X			PE	Healthy and Engaged Steering Group Education and Training Steering Group	PA			
C5	Communication infrastructure in place to support the communication of leadership messages and engagement of staff	Lauren Fear	X			PE	Healthy and Engaged Steering Group	PA			
C6	Health and Wellbeing of the Organisation to be managed –with a clear plan to support the physical and psychological wellbeing of staff	Susan Thomas	X			PE	Health & Wellbeing Steering Group	PA			
C7	Governance arrangements in place to monitor and evaluate the implementation of plans	Lauren Fear	X			PE	Executive Management Board	PA			
C8	Performance Management Framework in place to monitor the finance, workforce and performance of the Organisation	Carl James	X			PE	PMF Working Group	PA			

TAF DASHBOARD   ORGANISATIONAL CULTURE

C9	Service models in place to provide clarity of service expectations moving forward	Susan Thomas	X			PE	SLT Meetings	PA				
C10	Aligned workforce plans to service model to ensure the right workforce is in place	Cath O'Brien	X			PE	SLT Meetings	PA				
							Education and Training Steering Group	PA				
C11	Development and implementation of a Management Framework that supports cohesive work across the organisation	Carl James	X			PE	To be determined	PA				

GAP IN CONTROLS	GAPS IN ASSURANCE
Each of the controls requires further development and progression, the plans for which are at varying levels of maturity	Development of 3rd Line of defence assurance to be completed
Requires a cohesive and holistic Organisation alignment between performance management, service improvement, leadership behaviours and people practices to deliver the desired culture	Mapping of relevant sources of assurance and development of that assurance will sit alongside the development of the key controls

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Development of Organisationa Design approach for the Trust to encapsulate both process and cultural elements that need to be inplace to allow the organisation to achieve its strategic goals	Sarah Morley	Stakeholder engagement has taken place on the rationale for this work and an overview of some of the elements of work that may sit within it with the Executive Team, Divisional Senior Leadership Teams and the Board. Work has taken place to identify a Quality management System for the Trust. The scope of the programme and governance arrangements will be developed and agreed by September 2022, during which the timelines associated with the main elemtns will be determined.	Sep-22
1.2	A staff engagement project to understand levels of staff engement and also review the Trust Values	Sarah Morley	It has been decided that the Trust Values Project will fulfill a wider brief under the Organisational Design Approach. Interviews are being put in place with Board members as first round of engagement activity.	Dec-22

TAF DASHBOARD — ORGANISATIONAL CHANGE/STRATEGIC EXECUTION RISK

RISK ID:	TAF 05	Risk that aggregate levels of organisational change underway across the Trust creates uncertainty and complexity, leading to a disruption to business as usual (BAU) operations; an adverse impact on our people/culture; deterioration or an unacceptable variation in patient/donor outcomes; and/or a failure to deliver on our strategic objectives and goals.
LAST REVIEW	Jun-22	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations
NEXT REVIEW	Aug-22	

RISK SCORE (See definitions tab)

EXECUTIVE LEAD	Carl James	INHERENT RISK			RESIDUAL RISK			TARGET RISK		
		Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
		3	4	16	3	4	12	2	2	4

Overall Level of Control Effectiveness: Rating and Rag (see definitions tab)	RATING	Overall Trend in Assurance	THIS WILL INCLUDE A TREND GRAPH

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
1.1	Trust strategy to provide clear set of goals, aims and priorities	Carl James	x				Executive Management Board review	PA	Strategy Committee/QSP/Internal Audt Review / CHC	PA	Audit Wales	PA
1.2	Integrated Medium Term Plan to translate strategy into clear delivery plans	Carl James	x				Executive Management Board review	PA	Strategy Committee/QSP/Internal Audt Review / CHC	PA	Audit Wales	PA
1.3	Performance reporting in place to ensure delivery of required quality/performance in core service	Carl James	x		x		Executive Management Board review/ patient and donor feedback	PA	Strategy Committee/QSP/Internal Audt Review / CHC	PA	Audit Wales	PA

TAF DASHBOARD   ORGANISATIONAL CHANGE/STRATEGIC EXECUTION RISK

			x										
1.4	Risk management framework / arrangements in place to identify/monitor/manage risks at corporate and service level	Lauren Fear		x			Executive Management Board review	PA	Strategy Committee/QSP/Internal Audt Review / CHC	PA	Audit Wales		PA
1.5	Well defined change programmes at a local level to manage change effectively (WBS Change programme & Velindre Futures)	Cath O'Brien	x				Executive Management Board review / staff feedback	IA	Strategy Committee/QSP/Internal Audt Review / CHC	IA	Audit Wales		IA
1.6	Effective leadership and management of change at Executive Management Board	Steve Ham	x					IA	Internal Audt Review	PA	Audit Wales/HIW		PA

GAP IN CONTROLS	GAPS IN ASSURANCE
Currently gap in ability to measure all desired outcomes	
Lack of capacity in business intelligence to develop range of information and automate it	
Revised performance management framework not fully implemented	
Not all supporting strategies approved by the Board	

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

Action Plan	Owner	Progress Update	Due Date
Finalise all strategies and plans	Carl James	Drafts well developed with final engagement exercise ongoing - Board approval in May 2022 (on track for May 26th 2022). Trust strategy and enabkers developed and approved (with launch in Sept 2022)	Complete
Develop IMTP to provide priority for action and application of resource	Carl James	Final draft going to Board for approval March 2022	Complete
Information requirements being scoped	Cath O'Brien	First phase to support new performance measures (on track for September 2022)	Sep-22
Implement revised performance management framework	Carl James	New scorecards being finalised for implementation (on track for September 2022)	Sep-22

QUALITY AND SAFETY

RISK ID:	TAF 06	Trust does not currently have cohesive and fully integrated Quality & Safety mechanisms, systems, processes and datasets including ability to on mass learn from patient feedback i.e. patient / donor feedback / outcomes / complaints / claims, incidents and ability to gain insight from robust triangulated datasets and to systematically demonstrate the learning, improvement and that preventative action has taken place to prevent future donor / patient harm. This could result in the Trust not meeting its national and legislative responsibilities (Quality & Engagement Bill (2020)) and a reduction in public/patient/donor, external agency, regulator and commissioner confidence in the quality of care the Trust provides.
LAST REVIEW	Jun-22	1 - Outstanding for quality, safety and experience
NEXT REVIEW	Aug-22	Goal 1

RISK SCORE (See definitions tab)

EXECUTIVE LEAD	Nicola Willams	INHERENT RISK			RESIDUAL RISK			TARGET RISK		
		Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
		5	5	25	3	5	15	2	5	10

Overall Level of Control Effectiveness: Rating and Rag (see definitions tab)	RATING	Overall Trend in Assurance	THIS WILL INCLUDE A TREND GRAPH
	PE		

KEY CONTROLS / SOURCES OF ASSURANCE

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Once for Wales Datix System implemented	Nicola Williams			X	PE	Staff feedback	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

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 not finalized due to pandemic	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 & Candour guidance still under development	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 Trusts performance framework does not currently adequately monitor service level to board quality, safety, outcome and experiential measures
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 establishment - to operationally pull together all stands and feed into EMB & QSP

QUALITY AND SAFETY

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	Trust wide consultation on the Quality & Safety Framework completed. Executive engagement session held. Final version being drafted.	Jul-22
1.2 Corporate & Divisional Quality Hubs to be established	Nicola Williams Paul Wilkins Alan Prosser	Constitution of Corporate Quality & Safety Hub agreed & resourcing determined- awaiting confirmation of funding – aligned with restructuring of corporate Quality & Safety Team. OCP Process has 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	Aug-22
1.3 Trust Quality & Safety Framework implementation plan to be completed in line with agreed timescales	Exec Team Divisional Directors	Will be developed once Framework finalised	Jun-22
1.4 Instigate a Quality & Safety monthly operational meeting where cross cutting outcome review & triangulation takes place	Nicola Williams	Will be established once OCP completed	Jun-22
1.5 Ensure the Action & learning sections within the Once for Wales Datix System are robustly implemented & audited	Nicola Williams	Training arranged for March - delayed due to Omicron	Jun-22
1.6 Implement a robust compassionate leadership programme	Sarah Morley		
1.7 Ensure all responsible officers receive Investigation Training	Nicola Williams Cath O'Brien	Planned for March 2022	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	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	Jun-22

TAF DASHBOARD   QUALITY AND SAFETY

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.	Jun-22

TAF DASHBOARD

DIGITAL TRANSFORMATION

RISK ID:	TAF 07	Risk that the Trust fails to sufficiently consider, exploit and adopt new and existing technologies (i.e. assess the benefits, feasibility and challenges of implementing new technology; implement digital transformation at scale and pace; consider the requirement to upskill/reskill existing employees and/or we underestimate the impact of existing and new technology and the willingness of patients to embrace it/ their increasing expectation that their care be supported by it) compromising our ability to keep pace and be seen as a Centre of Excellence.
LAST REVIEW	Jun-22	5 - A sustainable organisation that plays it part in creating a better future for people across the globe
NEXT REVIEW	Aug-22	

RISK SCORE (See definitions tab)

EXECUTIVE LEAD	Carl James	INHERENT RISK			RESIDUAL RISK			TARGET RISK		
		Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
		3	4	12	3	4	12	3	4	12

Overall Level of Control Effectiveness: Rating and Rag (see definitions tab)	RATING	Overall Trend in Assurance	THIS WILL INCLUDE A TREND GRAPH
	PE		

KEY CONTROLS

SOURCES OF ASSURANCE

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Trust Digital Strategy, target approval at Trust Board in May 2022	Carl James	X			PE	Tracking key outcomes and benefits map – aligned to Trust Digital Strategy	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA	Wales Audit Office	PA
C2	Active work ongoing to leverage existing and deliver on new technologies – e.g. LIMS, IRS, BECS	Chief Digital officer		X		E	Trust digital governance reporting	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA	Wales Audit Office	PA

TAF DASHBOARD

DIGITAL TRANSFORMATION

C3	Training & Education packages to develop internal capabilities – including for exec and Board	Chief Digital officer	X			PE	Staff feedback	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA	Wales Audit Office	PA
C4	Training & Education packages for donors, patients	Chief Digital officer	X			PE	Patient and donor feedback	IA	Feedback and progress of working with Universities	IA	Wales Audit Office	PA
C5	Ring-fencing digital advancement in Trust budget – benchmark 4%	Chief Digital officer	X			PE	Review of proposals via EMB / Trust Board	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	IA	Wales Audit Office	PA
C6	Specifically development of digital resources capacity and capability	Chief Digital officer	X			PE	Review of proposals via EMB / Trust Board	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	IA	Wales Audit Office/Centre for Digital Public Services	PA
C7	Digital inclusion – in wider community	Chief Digital officer	X			PE	Tracking key outcomes and benefits map – aligned to Trust Digital Strategy	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA	Wales Audit Office	PA
C8	Opportunities for digital career paths	Chief Digital officer	X			PE	Tracking key outcomes and benefits map – aligned to Trust Digital Strategy	PA	Trust digital governance reporting	PA	Wales Audit Office	PE

C9	Prioritisation and change framework to manage service requests	Chief Digital officer	X			PE	Trust digital governance reporting	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	IA	Wales Audit Office	PE
C10	Levels of unsupported applications/ legacy systems	Chief Digital officer		X		PE	Trust digital governance reporting	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	IA	Wales Audit Office	PE
C11	Trust digital governance	Carl James		X		PE	Trust digital governance reporting	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA	Wales Audit Office	PA
C12	Framework of lead and lag indicator reporting into Trust digital governance structure, integrated into wider performance framework	Chief Digital officer		X		PE	Review via Divisional SMT / SLT	PA	Review via EMB / Trust Board	PA	Wales Audit Office	PE

GAP IN CONTROLS	GAPS IN ASSURANCE
Each of the controls (with exception of c2) requires further development and progression, the plans for which are at varying levels of maturity – see action 1.1	Development of 3rd Line of defence assurance to be completed in line with the development of the compliance and regulatory tracker see action 1.2
	Mapping of relevant sources of assurance and development of that assurance will be also alongside the development of the key controls, as per action 1.1

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Chief Digital Officer to bring a paper to next Strategic Development Committee with further detail on the plans to develop each of the key controls to an "effective" level	Chief Digital officer	Action carried forward following departure of Chief Digital Officer in December 2021. Aim to bring paper to July meeting of SDC (on track for July 2022) (new CDO commences on 1st July - will pick up on appointment)	Jul-22
1.2	December Strategic Development Committee	Chief Digital officer	Action carried forward following departure of Chief Digital Officer in December 2021. Aim to bring paper to July meeting of SDC (new CDO commences on 1st July - will pick up on appointment)	Oct-22

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	Jun-22	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations
NEXT REVIEW	Aug-22	Goal 2

EXECUTIVE LEAD	Matthew Bunce	RISK SCORE (See definitions tab)								
		INHERENT RISK			RESIDUAL RISK			TARGET RISK		
		Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
		3	4	12	4	4	16	3	4	12

Overall Level of Control Effectiveness: Rating and Rag (see definitions tab)	RATING	Overall Trend in Assurance	GOING FORWARD THIS WILL INCLUDE A TREND GRAPH
	PE		

KEY CONTROLS / SOURCES OF ASSURANCE

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Trust Financial Strategy	Matthew Bunce	X			PA	Tracking forecast delivery against financial strategy via Performance Committees and Trust Board	PA	Monthly Performance Review with Executives and Senior Management Teams	PA	Internal Audit cycle of assurance on financial strategy	PA
C2	Active engagement with Commissioners and Welsh Government to ensure inclusion of Velindre requirements within their Financial Planning	Matthew Bunce		X		PE	Inclusion in Health Board IMTP Financial Plans	IA	Monthly Commissioner Meetings held to confirm financial planning requirements	IA		

TAF DASHBOARD

TRUST FINANCIAL INVESTMENT RISK

	KEY CONTROLS						SOURCES OF ASSURANCE					
ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C3	Active engagement with Trust & Divisions to ensure investment does not exceed available funding	David Osborne	X			PA	Monthly Financial Performance Review Reported to Execs and Senior Management Teams	PA	Quarterly Directorate financial reviews established across both Divisions	PA	Monthly Budget Holder Meetings with Business Partners	PA
C4	Continuous review of contracting currencies and direct WHSCC funding to ensure reflective of efficient cost of delivery	Matthew Bunce		X		PE	Frequent formal Reviews to be established, combined with routine contract reporting	IA	Routine meetings with Depts to support business cases and any impacts on currencies	IA	Annual Review of Contracting Model (focus on pandemic legacy impact)	IA
C5	Benchmarking with appropriate services to ensure value	Matthew Bunce			X	PE	Non Surgical Benchmarking Group with Welsh Cancer Centres	PA	National Costing Cycle	PA		
C6	Routine contracting reporting and discussion with Commissioners to review activity and early identify income volatilities	David Osborne			X	PE	Monthly Financial Performance Review Reported to Commissioners with Monthly Meetings	PA	Annual Review of Contracting Model (focus on pandemic legacy impact)	IA	Introduction of Service Line Reporting	IA

TAF DASHBOARD

TRUST FINANCIAL INVESTMENT RISK

| C7 | Establish Investment Prioritisation Framework at a Trust and Divisional level to ensure no investment creep and strategic priority alignment | Matthew Bunce | X | | | PE | Chief Executive Consideration of Investment at a Trust Level | IA | Divisional Senior Management Team investment review | IA | | |

GAP IN CONTROLS	GAPS IN ASSURANCE
C3 – Governance of investment at Velindre Cancer Centre is being enhanced through the embedding of resource authorization, prioritization and allocation process, linked to Velindre Futures. Framework not fully embedded at present.	Inclusion of Velindre funding requirements with respective Commissioner financial planning requires formal clarification from Commissioners. Whilst requirements may be acknowledged, the financial challenges that Commissioners are prioritizing may not align with Velindre intents, consequently, assurance cannot be given that Velindre requirements will be met.
C4 – Whilst the contracting model has been continuously reviewed, the impact of COVID related measures has had a potential significant shift in cost base. This requires further understanding to identify mitigations.	The impact of COVID on current performance and cost base remains volatile, with recurrent funding also unclear. Capacity and demand modelling being undertaken in key risk areas. Welsh Government and Commissioners engaged on current and future consequences.
C7 – Trust Investment Prioritisation Framework to be established.	Investment is limited in it's prioritisation to the Executive Team and Senior Management Teams discretion and not formally supported by a framework for decision making.

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Support the embedding of investment framework within Divisions	David Osborne	Process continues to be embedded, terms of reference and process established. Communications throughout Division and "live" operation to follow.	Jul-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.	Jul-22
1.3	Establish Trust Investment Prioritisation Framework	Matthew Bunce	Initial proposals prepared, Executive discussions to shape and take forward	Jul-22

TAF DASHBOARD

FUTURE DIRECTION OF TRAVEL

RISK ID:	TAF 09	Risk that the Trust's ability to develop new services and failure to take up and create opportunities to apply expertise and capabilities elsewhere in the healthcare system.							
LAST REVIEW	Jun-22	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations							
NEXT REVIEW	Aug-22	Goal 2							

EXECUTIVE LEAD	Carl James	RISK SCORE (See definitions tab)							
		INHERENT RISK			RESIDUAL RISK			TARGET RISK		
		Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
		3	4	12	3	4	12	3	4	12

Overall Level of Control Effectiveness: Rating and Rag (see definitions tab)	RATING	Overall Trend in Assurance	THIS WILL INCLUDE A TREND GRAPH
	PE		

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
	KEY CONTROLS						SOURCES OF ASSURANCE					
C1	Development of a Trust strategy and other related strategies (R, D& I; digital etc) which articulate strategic areas of priority	Carl James	x			PE	Executive Management Board review	PA	Strategic Development Committee	PA	Audit Wales Reviews	PA
C2	Trust Clinical and Scientific Strategy	Nicola Williams	X			PE	Executive Management Board review	NA	Strategic Development Committee	IA	Audit Wales Reviews	PA
C3	Development of a Clinical and Scientific Board to lead clinical direction of travel	Jacinta Abraham				PE	Executive Management Board review	NA	Strategic Development Committee	IA	Audit Wales Reviews	PA
C4	Development of improved local, regional and national clinical commissioning arrangements	Matthew Bunce	x			PE	Executive Management Board review	IA	Strategic Development Committeen and performance management framework	IA	Audit Wales Reviews	PA

TAF DASHBOARD   FUTURE DIRECTION OF TRAVEL

C5	Agreement of system leadership roles for primary services: 1. Blood Services 2. Cancer Services	Cath O'Brien	x			PE	Executive Management Board review/ patient and donor feedback	IA	Strategic Development Committee	IA	Audit Wales/MHRA & HIW/ regulators	PA
C6	Change in strategic workforce plan to recognize/address any new leadership/clinical/management skills related to strategic growth	Sarah Morley	x			PE	Executive Management Board review	IA	Strategic Development Committee	IA	Audit Wales/MHRA & HIW/ regulators	PA
C7	Refresh of Investment and Funding Strategy	Jacinta Abraham	x			PE	Executive Management Board review	IA	R< D & I Sub-Committee and Performance Management	IA	Audit Wales/External Research organisations & Welsh	PA
C8	Development of commercial strategy	Matthew Bunce	x			PE	Executive Management Board review	IA	R< D & I Sub-Committee and Performance Management Framework	IA	Audit Wales/External Research organisations & Welsh Government	PA
C9	Attraction of additional commercial and business skills	Matthew Bunce		x		PE	Executive Management Board review	IA		IA	Audit Wales/External Research organisations & Welsh Government	PA

TAF DASHBOARD   FUTURE DIRECTION OF TRAVEL

GAP IN CONTROLS	GAPS IN ASSURANCE
Lack of clinical and scientific strategy	
Commercial expertise within the Trust	
Robust commissioning arrangements across Wales	
Clear understanding of strategic direction/system design with partner LHBs	
Ability to identify and secure funding	
Lack of clarity about future services and required skills, capacity and capability to leverage the strategic oppor	

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Develop full suite of strategic documents to provide clarity on future direction of travel	Carl James	On track for May 2022. The overarching Trust Strategy "Destination 2032" was approved in the January Trust Board. The Enabling Strategies were subsequently approved, as outlined below, in the May 2022 Trust Board.	COMPLETE
1.2	Board decision on strategic areas of focus/to pursue	Board	Final enabling strategies on track for may 2022 - allowing prioritisation to occur in future IMTPs. Trust Enabling Strategies were approved by the Trust Board in May 2022.	COMPLETE
1.3	Discussion with partner(s) to determine whether opportunity viable	Execs		tbc (dependent on Board decisions)
1.5	development of clinical and scientific strategy	Jacinta Abraham		tbc

TAF DASHBOARD   FUTURE DIRECTION OF TRAVEL

1.4	Identify capability required and funding solution/source	Execs		tbc (dependent on Board decisions)

TAF DASHBOARD

GOVERNANCE

RISK ID:	TAF 10	There is a risk that the organisation's governance arrangements do not provide appropriate mechanisms for the Board to sufficiently fulfil its role and the organisation to then be effectively empowered to deliver on the shaping strategy, culture and providing assurance, particularly through a quality and safety lens.									
LAST REVIEW	Jun-22	1 - Outstanding for quality, safety and experience									
NEXT REVIEW	Aug-22	Goal 1									

EXECUTIVE LEAD	Lauren Fear	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
	E			

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	Annual Assessment of Board Effectiveness	Emma Stephens			X	E	Annual Board Effectiveness Survey Annual Self- Assessment against the Corporate Governance in Central Governance Departments: **Code of Good Practice 2017**	PA	Audit Committee Trust Board	PA	Internal Audit Reports Audit Wales Structured Assessment Programme / Reports Joint Escalation & Intervention Arrangements	PA
C2	Board Committee Effectiveness Arrangements	Lauren Fear	X			E	Internal Annual Review	PA	Audit Committee Trust Board	PA	Internal Audit of Board Committee Effectiveness Audit Wales Structured Assessment	PA

						Audit Wales Review of Quality Governance Arrangements	

	KEY CONTROLS						SOURCES OF ASSURANCE					

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C3	Health & Care Standards Self-Assessment Arrangements: Standard 1.0 - Governance, Leadership and Accountability	Lauren Fear			X	E	Divisional Management Arrangements for overseeing effective implementation and monitoring	PA	The Trust has an established framework through which self-assessment are undertaken and action taken to implement improvements and changes required – reported on a quarterly basis to EMB Run, Quality, Safety & Performance Committee and Board as required	PA	Annual Internal Audit Report against the Health & Care Standards for Wales (20/21 assessment provided substantial assurance) Audit Wales review outcomes of report as part of Annual Report - Accountability Report	PA
C4	Board Development Programme	Lauren Fear	X			PE	Programme established PA	IA	Independent Member Group repurposed and second meeting now held. Further embedding through 2022/23	IA		
C5	All-Wales Self-Assessment of Quality Governance Arrangements	Lauren Fear		X		E	Action plan developed in response to self-assessment exercise. All actions complete /on track to complete by end of this financial year.	PA		PA	Audit Wales review of Quality Governance Arrangements	PA

TAF DASHBOARD   GOVERNANCE

| C6 | Quality of assurance provided to the Board | Lauren Fear | | X | | E | Quality of Board papers and supporting information effectively enabling the Board to fulfil its assurance role. IA | IA | Trust Board assessment via formal annual and additional effectiveness review exercises.   IA | IA | Internal Audit Reports. Audit Wales Structured Assessment Programme/Reports | PA |

GAP IN CONTROLS		GAPS IN ASSURANCE
None		Third line of defence in respect of C4 – Board Development Programme: no course of action is proposed

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

Action Plan	Owner	Progress Update	Due Date
C4 • Development of a more structured needs based approach to inform a longer terms plan for the Board Development Programme.		Supported by the development priorities identified through an externally facilitated programme of Board development underway.	Complete
Ongoing input from the Independent Members via the repurposed Integrated Governance Group		Terms of Reference and supporting refreshed standard agenda has been agreed by Independent Members for the Independent members Group.	Complete

TRUST BOARD

AUDIT COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	03/05/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Alison Hedges, Business Support Officer
PRESENTED BY	Martin Veale, Chair
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR NOTING

ACRONYMS	
~	~

1.   **PURPOSE**

This paper has been prepared to provide the Trust Board with details of the key issues and items considered by the Audit Committee at its meeting held on the 3 May 2022.

Key highlights from the meeting are reported in Section 2.

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

2. **HIGHLIGHT REPORT**

The following areas were highlighted for reporting to the Trust Board from the meeting of the Audit Committee held on the 3 May 2022:

ALERT / ESCALATE	**AUDIT ACTION TRACKER – OVERDUE RECOMMENDATIONS** The Audit Committee noted 41 overdue red recommendations. Of these, some had revised dates, but not all. Some has no updates on progress. The Audit Committee noted this is not a satisfactory situation. The Audit Committee expressed the need to make sure each audit and each action has Executive ownership with responsibility for the responses of individuals within their teams. The Audit Committee stressed that if responses for recommendations are not received then individuals will be asked to attend Audit Committee to explain overdue actions. All extensions requested within the Audit Action Tracker were agreed. For actions that don't have extensions specified, the Audit Committee agreed target date end June 2022.
ADVISE	**EXTERNAL AUDIT** The Audit Committee **REVIEWED** the following Audit Wales reports: • Audit Plan 2022 • Audit Position Update • Taking Care of the Carers
ASSURE	**TRUST RISK REGISTER** The Audit Committee **REVIEWED** the risk report, and **NOTED:** • The Committee's role in the overall governance of the framework. • That progress against the management of the risks has moved on considerably, which will be further demonstrated through the next Cycle of Governance. • The 3 levels of DATIX training which would all be complete by end June 2022. **TRUST ASSURANCE FRAMEWORK** The Audit Committee **REVIEWED** the further development of the Trust Assurance Framework (TAF), together with the ongoing work to support its continued development, articulation, and embedding within the Trust. The Audit Committee **NOTED** the complete assurance Framework in its first iteration and that there is still work to do on demand, capacity, resource, and assurance. **CHARITY ANNUAL ACCOUNTS 2020/21 LESSONS LEARNED** The Audit Committee discussed and reviewed the lessons learned and the proposed Finance Function improvements that will help facilitate timely completion for 2021/22 and future accounts. This paper will now be taken to the May 2022 Charitable Funds Committee for noting. **PRIVATE PATIENT SERVICE REVIEW** The Audit Committee **NOTED**:

	• EMB will be considering further paper around the strategic direction, and the operational, commercial and governance arrangements. • Report setting out the oversight arrangements of the process going forward will be brought to the July 2022 Audit Committee. • The procurement of external specialist support to review the income base and identify opportunity for additional income. • Possible procurement of external expert management, training, and development expertise to support the VCC Private Patient Team.
INFORM	**INTERNAL AUDIT REPORTS** The Committee received the following internal audit reports: • nVCC MIM Governance　　　　　Substantial assurance • nVCC Contract Management　　　Reasonable assurance • Financial Systems　　　　　　　Reasonable assurance • Scrutiny of Expenditure　　　　　Reasonable assurance • DBS Checks　　　　　　　　　　Reasonable assurance • Charitable Funds　　　　　　　　Reasonable assurance **OTHER BUSINESS:** The Committee also received written or verbal reports under the following agenda items: • Losses and Special Payments • 2021/22 Internal Audit Progress Update • Draft 2021/22 Internal Audit Opinion • Draft 2022/23 Internal Audit Plan • Counter fraud progress report • Counter fraud annual plan • Private patient debts • Procurement Compliance Report • Audit Committee effectiveness survey • Declaration of Interests, Gifts, Sponsorship, Hospitality & Honoraria • ISO Paper - The recertification audit of the ISO14001:2015 audit.
APPENDICES	**NONE**

3. RECOMMENDATION

The Trust Board is asked to **NOTE** the contents of this report.

TRUST BOARD

PUBLIC QUALITY, SAFETY & PERFORMANCE COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	28th July 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Kyle Page, Business Support Officer
PRESENTED BY	Vicky Morris, Chair of the Quality, Safety & Performance Committee
EXECUTIVE SPONSOR APPROVED	Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience *(Deputising for Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science)*

REPORT PURPOSE	FOR NOTING

ACRONYMS	
SACT	Systemic Anti-Cancer Therapy
SAE	Serious Adverse Event
MHRA	Medicines and Healthcare Products Regulatory Agency
HEIW	Health Education & Improvement Wales
SST	Site Specific Team
IHI	Institute of Healthcare Improvement
DBS	Disclosure and Barring Service
KPI	Key Performance Indicator

1. PURPOSE

This paper has been prepared to provide the Trust Board with details of the key issues and items considered by the Quality, Safety & Performance Committee at its meeting held on the 14th July 2022.

2. BACKGROUND

The Quality, Safety and Performance Committee meets on a bi-monthly basis and provides an opportunity to triangulate information and data in respect of quality, safety, finance, workforce, performance and digital. The Committee is continuing to embed and mature, actively seeking opportunities for continuous improvement together with the ongoing development of reporting formats, additional assurance mechanisms, including additional COVID-19 related matters as required.

3. HIGHLIGHT REPORT: 14th July 2022

3.1 Triangulated Theme

The Committee had previously identified that the triangulated core theme arising across a number of the reports received was workforce, impacting on finance and operational delivery. Due to a number of factors, it was concluded that workforce remains the Trust's biggest risk.

The increasing workforce risk is currently being addressed and plans are underway to undertake a comprehensive review of the current workforce, development of a robust 5-year Workforce and Recruitment plan to facilitate active and timely recruitment into hotspot areas and a number of continued support mechanisms and interventions to protect the wellbeing of staff. A plan to increase capacity in areas of immediate concern has also been developed to accommodate ongoing and predicted increasing service demands.

3.2 Summary of Committee Highlights

The following areas were highlighted for reporting to the Trust Board from the meeting:

ALERT / ESCALATE	**Velindre Quality & Safety Committee for NHS Wales Shared Services** The CIVAS@IP5 Service Performance Report was received, which set out the current levels of performance against Good Manufacturing

Practice Standards. In addition, the Committee received an update on the findings and CIVAS@IP5 risk status assigned by the Medicines and Healthcare products Regulatory Agency (MHRA) following its recent inspection, and resulting action plan.

The following was discussed:

- *Process for the development and sign off of new products* - The Committee requested greater understanding of the governance process in relation to the manufacture of new products and sign off by Health Boards, in order to receive oversight and assurance that appropriate processes are being followed before new products arrive on stream. This will be discussed, and a clear process presented, at the September 2022 Committee.
- *Cytotoxic Medications* – Due to facilities restrictions and risk of cross-contamination, the service does not offer cytotoxic medications (toxic to living cells). It was agreed that further clarity is required in relation to the categorisation / distinction of cytotoxic / immunotherapy medicines to allow the wider public a better understanding of products manufactured by the service.

Workforce & Organisational Development Performance Report / Financial Report
The workforce and associated finance risks report was received, highlighting the key workforce and associated financial risks currently faced by the Trust and their impact on the ability to deliver core services. The following was discussed:

- Risks associated with how the Trust is delivering services and current utilisation of the workforce remain in terms of the provision of adequate financial support / workforce for 'at risk' services. Work to secure additional funding to support posts already appointed to and potential migration of staff into vacancies within areas of concern is underway in both divisions to mitigate incurring premium agency costs where possible.
- Absence levels continue to present challenges. A variety of wellbeing interventions have been introduced with the aim to reduce absence levels as stress / anxiety remain the leading causes.
- A recruitment and retention project is currently under development to attract colleagues to hotspot areas within the organisation and support their development once appointed. Clarity relating to dates for delivery will be required in future papers.

 (red cell)	• **Income Risk** - A holistic analysis of the organisation has been undertaken in relation to current vacancies, absence rates, substantive workforce and investment for additional capacity to support the COVID-19 backlog. Despite current sickness levels, operational workforce numbers remain at pre-COVID levels. However, a risk is posed to income flow, should services not maintain pre-COVID-19 levels of activity. Additional income risk is also detailed under the Financial Report item in the ASSURE section of this report.
ADVISE	**Welsh Blood Service – Staff Story** The Committee had received in advance a video outlining the critical role of staff in the performance of the manufacturing and distribution of blood and blood products within the Welsh Blood Service. The video outlined the importance of recruitment, development and retention of staff due to the unique skillset of the department and detailed examples of opportunities to facilitate this. The video focused on the journey of a staff member from initial recruitment to the position of a Medical Laboratory Assistant and progression to Registered Biomedical Scientist and their anticipated continued further development to Specialist Biomedical Scientist and beyond. It was noted that the passion and commitment of staff was clear, and a result of the training and support provided. The Committee commended the Welsh Blood Service for their commitment to supporting the development of staff and acknowledged that this is a vital component in the effective retention of a niche skillset to maintain the quality of work undertaken by the Service. • **Velindre Cancer Service Performance Report** The Velindre Cancer Service report provided an update on performance against key metrics for the period until the end of May 2022. The following areas were highlighted: o Evidence of an increase in referrals over and above projected numbers due to an increase in activity within Health Boards (a national increase of 8% for Radiotherapy and 12% for Systemic Anti-Cancer Therapy (SACT) referrals is expected by year end). o All areas within Radiotherapy have seen improvement and plans are in place to facilitate increased capacity within the service by quarter 3 to accommodate ongoing increasing demand. o A plan is in place to enable gradual improvement within SACT,

via weekend clinics and additional outreach capacity to accommodate ongoing increasing demand.
- o Challenges remain in relation to staff sickness absence within SACT, in addition to a number of areas still operating within a COVID-19 environment.

- **Welsh Blood Service Quality, Safety & Performance Divisional Report**

The Welsh Blood Service report provided an update on performance against key metrics for the period until the end of May 2022. The following areas were highlighted:

- o Clinical demand continues to be met; however the Service remains under blue alert status (a mutual support agreement with other UK blood services) for both O blood groups. Work is currently underway to agree a collections recovery plan and to facilitate appropriate use of blood and blood products across Wales.
- o High sickness absence and a number of staff in training continue to present challenges in terms of team capacity. An improvement plan is currently under development.
- o Some improvement has been evidenced within Reference Serology, due to staff returning to work and a further bone marrow recruitment campaign will target 17-20 year olds and ethnic minorities from September 2022.
- o A review of Apheresis production is underway to enable analysis of platelet supply and demand in order to manage waste.
- o 3 Serious Adverse blood related Events (SAEs) were reported to the MHRA. Proposed corrective actions have been accepted by the MHRA and an action plan is in place.
- o An MHRA inspection of the North Wales sites had identified one 'major' and three 'other' findings. Processes have since been amended and a proposed plan is awaiting sign off. The findings are not considered to pose a high risk.

Medical Workforce Update
The 2021-2022 Annual Medical Workforce Revalidation Progress Report was received the following was highlighted:
- The report demonstrated that the Trust is compliant with the Medical Profession (Responsible Officers) Regulations 2010, and it was advised that systems and processes are in place to support and inform the appraisal and revalidation for medical staff.
- Of the 78 'prescribed connections' for the Trust, 88.5% of

	appraisals (69) have been completed during the last year. • 27 of the 29 domains outlined in the update are currently reporting as green in terms of assurance. Two recent areas proposed by Health Education & Improvement Wales (HEIW) require further development and are awaiting formal HEIW guidance ((1) considering public and patient views regarding revalidation processes (2) encouraging lay involvement in quality assurance processes to provide independent scrutiny and challenge). **Trust Clinical Audit Plan** The Trust Clinical Audit Plan was received, representing an overview of the Trust-wide Clinical Audit Strategic approach and programme of work for 2022-2023. The following was highlighted: • A wide-ranging programme of work with a systematic process for the prioritisation and delivery of clinical audit across the Trust has been developed (in conjunction with Site Specific Teams (SSTs)) in line with the organisational strategic direction and is reflective of the services provided. • It is anticipated that the programme will be strengthened over the coming year through the Trust's Quality & Safety Framework, establishment of Quality Hubs across the Trust and developments within Clinical Strategy. **Local Partnership Forum Annual Report** The Local Partnership Forum Annual Report for the period 1st April 2021 to 31st March 2022 was received, reflecting the activity undertaken by the Forum during this period.
ASSURE	**Financial Report** The financial report was received, outlining the financial position and performance to the end of May 2022. The following was highlighted: • *Revenue* – A balanced position is forecast in line with expectations with a projected year-end position of breakeven. • *Capital* – It is anticipated that the Trust will remain within the capital limit. • *Public Sector Payment Performance* – The administrative target of payment of 95% of non NHS invoices within 30 days has returned to an on target position. • *Risk* – Discussions are ongoing with the Trust's Commissioners in relation to the COVID-19 funding requirement for 2022-2023, as this poses a significant risk to the Trust should this not be met.

Putting Things Right 2021/22 Annual Report
The Annual Putting Things Right Report, providing a summary of concerns, complaints and incidents received during the period 1st April 2021 and 31st March 2022, was discussed.

It was noted that it would be of benefit to understand the Trust's position in comparison to other organisations and this will be included within the next quarterly Putting Things Right report. The Committee also welcomed the inclusion of a snapshot of compliments received from patients, donors and carers.

Patient & Donor Experience Annual Report
The Annual Patient & Donor Experience Report reflected the period 1st April 2021 to 31st March 2022.

Infection Prevention & Control Annual Report
The Annual Infection Prevention & Control Report was received, providing an outline of progress, activities and achievements for the period 1st April 2021 to 31st March 2022. The following key items were highlighted:

- There have been no cases of inpatient Healthcare Acquired Bacteraemia.
- There have been no cases of catheter associated Urinary Tract Infections.
- There has been a 50% decrease in Healthcare Associated Clostridioides Difficile infection.

Safeguarding Annual Report
The Safeguarding 2021-2022 Annual Report reflecting the period 1st April 2021 to 31st March 2022 was received.

Trust-wide The Nurse Staffing Levels (Wales) Act **Annual Report**
The The Nurse Staffing Levels (Wales) Act Annual Report provided the Committee with ASSURANCE in relation to the provision of safe staffing levels and that no incidents had occurred on First Floor Ward as a result of Nurse Staffing levels.

Health & Care Standards Annual Report
The Health and Care Standards Annual Report provided the outcome of the 2021-2022 Health and Care Standards Assessment process, and details of the plans to further revise the assessment process for the Trust for 2022-2023.

INFORM	**Quality & Safety Framework** The Trust Quality & Safety Framework 2022-2024 was received, and the following was discussed: • Following significant consultation, the Quality & Safety Framework has been developed in line with national requirements to ensure that foundations, infrastructure and ways of working are in place to allow the Trust to meet current requirements and work through current Quality priorities. • The Committee was advised that due to the rapidly changing environment of the Quality agenda within NHS Wales and the current work in relation to organisational development and design, the Trust Quality & Safety Framework would undergo a further review, with agreement of Quality Improvement Goals during 2023. Additionally, statutory documents for the Duty of Quality and Duty of Candour will be consulted on from August 2022, and the Framework will require review once these are finalised. **Infection Prevention & Control Management Group Highlight Report** The Infection Prevention & Control Management Group Highlight Report provided the Committee with details of the key issues considered at its meeting held on 19th May 2022. **Safeguarding & Vulnerable Adults Group Highlight Report** Two Highlight Reports were received from the Safeguarding & Vulnerable Adults Management Group, providing details of key issues considered at its meetings on 8th March and 13th June 2022. **Patient Safety Alerts Group Highlight Report** The Highlight Report from the Trust Safety Alerts Management Group was received, providing key outputs for the period 1st January to 31st May 2022. The following was highlighted: • Following review, it was confirmed that the ligature and ligature point risk alert only applies to organisations providing mental health services and is therefore not applicable to the Trust. Notwithstanding, a robust multi-disciplinary risk reduction plan has been developed, in addition to completion of ligament audit tools for the First Floor Ward and the identification of an observation / treatment area for potentially mentally vulnerable patients. Training in the cutting of ligatures will also be provided. Actions undertaken will be comprehensively referenced within future reporting.

	Workforce The following Workforce KPIs for the Trust were noted: • Personal Appraisal Development Review (PADR) – 69.73% (Trust-wide). • Sickness Absence – 6.37% (year to May 2022). • Statutory & Mandatory Compliance – 86.09% (trust-wide). **National Imaging Academy - Hosting Agreement** The Committee **ENDORSED** the NHS Wales National Imaging Academy Hosting Agreement for Trust Board **APPROVAL**. The Committee **APPROVED** the following revised policies: • QS03 - Handling Concerns Policy. • QS18 - Health, Safety & Welfare Policy. • IG01 – Records Management Policy. • IG02 – Data Protection and Confidentiality Policy. • IG05 – Software Policy. • IG06 – Anti-virus Policy. • IG08 – FOIA Policy. • IG11 – Data Quality Policy. • IG13 – Confidentiality Breach Reporting Policy. • IG14 – Information Asset Policy.
APPENDICES	N/A.

4. RECOMMENDATION

The Trust Board is asked to **NOTE** the key deliberations and highlights from the meeting of the Quality, Safety & Performance Committee held on the 14th July 2022.