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Summary report

About this report

1 Quality should be at the 'heart' of all aspects of healthcare and putting quality and service user safety first more than anything else is one of the core values underpinning the NHS in Wales. Poor quality care can also be costly in terms of harm, waste, and variation. NHS organisations and the individuals who work in them need to have a sound governance framework in place to help ensure the delivery of safe, effective, and high-quality healthcare. A key purpose of 'quality governance' arrangements is to help organisations and their staff monitor and where necessary, improve standards of care.

2 The drive to improve quality has been reinforced in successive health and social care strategies and policies over the last two decades. In June 2020, the Health and Social Care (Quality and Engagement) (Wales) Act became law. The Act strengthens the duty to secure system-wide quality improvements, as well as placing a duty of candour on NHS bodies, requiring them to be open and honest when things go wrong to enable learning. The Act indicates that quality includes, but is not limited to, the effectiveness and safety of health services and the experience of service users. Statutory guidance in relation to the Duty of Quality and the Duty of Candour are yet to be consulted upon but expected in autumn 2022. The date for enactment of both duties is yet to be determined but anticipated to be part way through 2023-24.

3 Quality and safety must run through all aspects of service planning and provision and be explicit within NHS bodies' integrated medium-term plans. NHS bodies are expected to monitor quality and safety at board level and throughout the entirety of services, partnerships, and care settings. In recent years, our annual Structured Assessment work across Wales has pointed to various challenges, including the need to improve the flows of assurance around quality and safety, the oversight of clinical audit, and the tracking of regulation and inspection findings and recommendations. There have also been high profile concerns around quality of care and associated governance mechanisms in individual NHS bodies.

4 Given this context, it is important that NHS boards, the public and key stakeholders are assured that quality governance arrangements are effective and that NHS bodies are maintaining an adequate focus on quality whilst responding to the COVID-19 pandemic. The current NHS Wales planning framework reflects the need to consider the direct and indirect harm associated with COVID-19. It is important that NHS bodies ensure their quality governance arrangements support good organisational oversight of these harms as part of their wider approach to ensuring safe and effective services.

5 Our audit examined whether the organisation's governance arrangements support delivery of high quality, safe and effective services. We focused on both the operational and corporate approaches to quality governance, organisational culture and behaviours, strategy, structures and processes, information flows and reporting. This report summarises the findings from our work at Velindre University

NHS Trust (the Trust) carried out between June 2021 and May 2022[1]. To test arrangements from 'floor to board', we examined the arrangements in both the Velindre Cancer Centre (VCC) and the Welsh Blood Service (WBS).

Key messages

6 Overall, we found **that significant progress has been made to improve the Trust's quality governance arrangements.**

7 The Trust has approved a new Quality and Safety Framework. It sets out the arrangements through which the Trust will meet its quality and safety responsibilities from floor to Board, clarifies roles and responsibilities and sets out the ambition to ensure learning and improvement are embedded. The Trust has set out ambitious quality priorities and has appropriate arrangements to monitor delivery. However, quality priorities are not specific or time-bound, and thus do not easily allow assessment of whether they have been achieved. Good progress has been made to improve risk management arrangements, but there is scope to make improvements to enhance scrutiny of risk registers and strategic priorities.

8 The Trust has an open and learning culture and is committed to learning from service users and staff. There are good arrangements to collect service user and staff feedback and experiences and to share these. Some staff perceive that the Trust may not act in response to concerns or take action to deal with bullying or harassment. Work to understand views expressed in the NHS Staff Survey is in motion.

9 The new Quality and Safety Framework and planned work to operationalise the Quality Hubs have articulated the operational quality and safety governance structures and flows of assurance to support quality governance. There are appropriate identified resources for quality governance and plans to address gaps in resources.

10 The agendas of Quality, Safety and Performance Committee meetings are becoming more manageable and focussing on key matters. However, the timeliness of some data and information is a challenge to effective scrutiny.

Recommendations

11 Recommendations arising from this audit are detailed in **Exhibit 1**. The Trust's management response to these recommendations is summarised in **Appendix 1**.

Exhibit 1: recommendations

[1] At varying points in the review, we paused our work, to allow the Trust to respond to the pandemic.

Recommendations

Quality priorities

R1 At the time of writing, the Trust had recently developed ten new Quality Improvement Goals; however, they are not specific or time-bound, and thus do not easily allow assessment of whether they have been achieved on time. Going forward, the Trust should ensure that Quality Improvement Goals are underpinned with specific, time-bound actions.

Board Assurance Framework

R2 To date, Board committees' scrutiny of the Board Assurance Framework has focused on its development and format. As soon as possible, the Trust should ensure that each committee incorporates a review of the strategic risks assigned to them within their cycles of business and:

a) provide appropriate consideration of each of the controls and sources of assurance, and
b) scrutinise progress to address gaps in controls and assurances.

Risk information for scrutiny

R3 Risk registers presented to meetings do not always include enough information to allow good scrutiny. The Trust should:

a) determine what information is needed in risk registers (including the Corporate Risk Register) to enable good scrutiny and challenge (such as including opening, current and target risk scores, and sufficient clarity on existing controls and mitigating action);
b) if risks appearing in the Trust Risk Register have been discussed in other agenda items, provide suitable cross references in the cover report; and
c) executive risk owners should lead discussions on risks within their areas of responsibility.

Action to address staff survey results

R4 Progress to develop a Trust-wide action plan to address findings from the NHS Staff Survey slowed due to the impact of the pandemic. The Trust should progress work to develop the action plan as soon as possible and:

a) undertake work to understand why some staff feel that the Trust does not take effective action to deal with bullying, harassment or abuse; and
b) undertake work to understand why some staff may feel that the Trust does not act adequately to address concerns.

Recommendations

Quality and safety flows of assurance

R5 Some of the attendees of meetings that consider quality and safety matters in VCC felt that there is duplication of coverage, and that not all meetings had appropriate representation. When operationalising the Quality Hubs, the Trust should for VCC and WBS and Trust-wide:

a) ensure that the group structures and meeting remits avoid unnecessary duplication of coverage;
b) ensure that attendees of each meeting are appropriate and provide adequate representation of relevant disciplines; and
c) ensure that the Trust has clearly articulated which meetings consider quality and safety matters and their reporting lines.

Quality and safety information

R6 Information in reports and performance data are sometimes out of date. The Trust should ensure that as far as possible, data and information presented to the Quality, Safety and Performance Committee meeting is as up to date as possible, covering agreed time periods.

Detailed report

Organisational strategy for quality and service user safety

12 Our work considered the extent to which there are clearly defined priorities for quality and service user safety and effective mitigation of the risks to achieving them.

13 We found that **the new Quality and Safety Framework sets out clear quality and safety arrangements and responsibilities. There are ambitious quality priorities with appropriate arrangements to monitor delivery, however, they do not easily allow assessment of whether they have been achieved. Good progress has been made to improve risk management arrangements, but there is scope to make improvements to enhance scrutiny of risk registers and risks to achieving strategic priorities.**

Quality and safety framework

14 We found that **progress to review and finalise the Trust's Quality and Safety Framework was adversely impacted by the pandemic. However, the new Quality and Safety Framework sets out clear quality and safety arrangements and responsibilities**.

15 The Trust has long recognised that the Quality and Safety Framework (the Q&S Framework) needed a significant overhaul. In 2019, work commenced to develop a new Q&S Framework, with the intention to complete the work in 2020. However, work did not proceed as planned due to significant adverse operational pressures resulting from the pandemic.

16 Early in 2021, the Trust consulted with executives, senior leaders, and health care standard leads, and a Trust-wide staff consultation took place in June 2021. An early draft was issued at this time to stimulate further comment.

17 Work to progress the Q&S Framework was adversely impacted by a further peak of COVID-19. The Trust intended to take the Q&S Framework to the January 2022 meeting, However, a committee paper indicated that it would be postponed to the March meeting due to pressures caused by the pandemic. However, there was no challenge when it was excluded from the March meeting agendas. Similarly, the Board Assurance Framework shared at the May 2022 committee meeting stated that the Q&S Framework would be tabled at that same meeting, but there was no challenge when it was excluded from the agenda.

18 In 2022, several changes were made to the draft Q&S Framework, as a result of the consultation undertaken in 2021. In July 2022, following endorsement from the Quality, Safety and Performance Committee, the Board approved the Q&S Framework and supporting Implementation Plan.

19 Completing the Q&S Framework was an important and necessary priority for the Trust. The new Q&S Framework sets out the arrangements through which the Trust will meet its quality and safety responsibilities from floor to Board, clarifies

roles and responsibilities and sets out the ambition to ensure learning and improvement are embedded. There is clear alignment between the Q&S Framework and the new Trust Strategy and supporting enabling strategies.

20 The supporting Implementation Plan sets out the actions needed to ensure arrangements set out in the Q&S Framework are fully operationalised. For each action there is an identified lead and delivery timescale. The Trust recognises that fully implementing the Q&S Framework will take time. However, the Trust told us that work undertaken over the previous three years has laid the foundations, both organisationally and culturally. The Trust has set an ambitious, but achievable timescale for the actions in the Implementation Plan to be embedded and fully operational.

21 Progress against the Implementation Plan will be monitored quarterly by the Executive Management Board and twice a year by the Quality, Safety and Performance Committee.

22 The Trust has committed to reviewing the Q&S Framework in 2023 once the duties set out in the Health and Social Care (Quality and Engagement) (Wales) Act (see **paragraph 2)** are enacted.

Quality and service user safety priorities

23 We found that the **Trust sets out ambitious quality priorities and has appropriate arrangements to monitor delivery. However, quality priorities are not specific or time-bound, and thus do not easily allow assessment of whether they have been achieved**.

24 The Trust included 12 quality priorities in the 2019-2022 Integrated Medium Term Plan (IMTP). Since then, the 2020-2021 quarterly plans and the 2021-2022 Annual Plan included high level quality priorities focused on quality arrangements during the pandemic[2]. However, no reports have been received by the Quality, Safety and Performance Committee to indicate how the Trust did in delivering against these quality priorities.

25 Within the 2022-25 IMTP, the Trust set out a programme of work to progress clinical quality and safety arrangements and ensure delivery of Health and Social Care (Quality and Engagement) (Wales) Act 2020. The IMTP sets out 11 key priorities supported by specific actions with timescales for delivery. The priorities are focused on setting up the arrangements and infrastructure through which the Trust will meet its quality and safety responsibilities, and include;

- implementing the Q&S Framework;
- developing Quality Hubs (VCC, WBS and Trust);

[2] Including optimising infection prevention and control measures; strengthening service user engagement and the capture of service user experiences; and implementing digital initiatives to ensure continued patient engagement throughout the pandemic.

- establishing a Quality and Safety team fit to deliver new legislation;
- implementing Duty of Quality and Candour requirements;
- planning for and implementing new Quality Standards;
- ensuring there are clear service delivery to Board quality metrics;
- implementing a Trust Quality Management system;
- ensuring robust mechanisms for capturing service user experiences, with learning and improvement mechanisms;
- ensuring robust clinical leadership, and establishing a Clinical and Strategy Board; and
- optimising working at top of license and optimising advanced practice working.

26 It is our understanding that the Quality, Safety and Performance Committee will monitor delivery of these priorities as part of its quarterly review of monitoring delivery of priorities set out in the IMTP.

27 In conjunction with the new Q&S Framework, the Trust developed ten new Quality Improvement Goals for 2022-23. These are in addition to the 11 priorities set out in the 2022-25 IMTP (see **paragraph 25**). The focus of the ten new Quality Improvement Goals is service redesign to meet increasing predicted demand and to deliver further service improvements. Going forward, the Trust should ensure that the Quality Improvement Goals are SMART. They should indicate what specific actions will be taken, by when, and what the intended outcome is, and thereby allow assessment of whether they have been fully achieved. The Trust should also reflect on including more service user reported outcome measures/experience measures as well as pure quality indicators (**Recommendation 1**).

28 The Trust told us it intends to consult with staff to develop annual Quality Improvement Goals by 31 January each year for inclusion in the IMTP. Each Quality Improvement Goal will have a defined outcome and delivery plan and will be managed by an identified operational lead and executive director sponsor. Delivery will be monitored through relevant quality teams, and by exception through to Executive Management Board and quarterly to the Quality, Safety and Performance Committee.

Risk management

29 We found that the **Trust has made good progress to improve risk management arrangements. However, the Board and its committees need to ensure they scrutinise progress to address gaps in controls and assurances of strategic risks. There are opportunities to improve scrutiny of risks appearing in risk registers both operationally and by the Board's committees**.

30 In 2020, the Trust produced a Board Assurance Framework which identifies ten principal risks to achieving strategic priorities. During 2021 and 2022, work progressed to populate each principal risk with key controls and sources of assurance and identify any gaps. Each risk is assigned to a responsible executive lead, and an appropriate Board committee for monitoring purposes.

31 Whilst the Board Assurance Framework was developing and maturing, it has been considered by the Board, the Strategic Development Committee and the Audit Committee to ensure the direction of travel is right, more so than considering the controls and assurance in place or yet to be developed. However, to achieve the next level of maturity, Board committees need to begin to review their assigned strategic risks more methodically, receive and monitor progress against associated action plans and ensure that Board committee cycles of business provide appropriate consideration of each of the controls and sources of assurance.

32 The Board Assurance Framework contains a strategic risk specific to quality and safety[3]. At the time of writing, the Quality, Safety and Performance Committee had not received the Board Assurance Framework or any paper specifically on the quality and safety strategic risk. As set out in **paragraph 31,** we expect to see the Quality, Safety and Performance Committee's cycle of business to be updated to include the Board Assurance Framework for regular review and ensure regular consideration of the sources of assurance (**Recommendations 2a and 2b**).

33 The Trust has a limited dedicated corporate risk management team. Previously, it consisted of a 0.2 WTE working to the Director of Corporate Governance. The Trust are trialling a new Risk and Compliance and Assurance Officer role to increase capacity in the team. VCC and WBS both have risk management leads, and there is a risk management lead for the Transforming Cancer Services

[3] The strategic risk is 'the Trust does not currently have cohesive and fully integrated Quality and Safety mechanisms, systems, processes and datasets including ability to on mass learn from patient feedback (patient/donor feedback/outcomes/complaints/claims, incidents) and the 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 (The Health and Social Care (Quality and Engagement) (Wales) Act, 2020) and a reduction in public/patient/donor, external agency, regulator and commissioner confidence in the quality of care the Trust provides.'

programme[4] team. The risk management leads in VCC and WBS are not dedicated risk management resources, and they both have wider portfolios of work.

34 In September 2020, the Board approved the Trust's new risk management framework, risk appetite statement and associated risk management procedures and user guides. In our 2021 Structured Assessment, we reported that the Trust had made good progress to develop new risk management arrangements.

35 The Trust undertook a significant review of all open risks on operational risk registers during 2021. The review was necessary to ensure risk information was current and complete prior to the migration of all risks to a new version of Datix[5] and to ensure information was recorded consistently with the new requirements in the new risk management framework. The review of open risks took longer than anticipated and at the time of our fieldwork there remained some work to complete, including:

- migrating WBS risks to the new version of Datix;
- updating procedures within the Risk Management Framework as a result of refinement following implementation;
- delivering training to operational and corporate staff; and
- ensuring consistency and clarity in the way that both existing controls and planned additional controls are recorded.

36 Since our fieldwork, rollout of risk management training has largely been completed and each of the other areas of outstanding work have been finished.

37 The divisional risk leads meet weekly with the Director of Corporate Governance to manage any risk management issues and ensure that risk scoring is appropriate and consistent across the Trust.

38 We observed the scrutiny of divisional risk registers at a number of VCC Quality and Safety Group meetings and WBS Regulatory Assurance and Governance Group meetings between June 2021 and February 2022. Whilst there was reasonably good scrutiny of the risks on registers (particularly at the WBS meetings), the ability to scrutinise was hampered by the way risk information was presented. Our observations took place during the time the risk registers were being reviewed and updated, this led to omissions in the data provided. For example, in the February 2022 VCC Quality and Safety Committee meetings, only the current risk score was provided (but not the initial or target scores) and the mitigating control information was unclear (and in some cases omitted) meaning it

[4] Transforming Cancer Services is a programme of work to keep pace with the increasing demand and complexity of cancer care and to deliver more care closer to home. The programme comprises several projects. These include the construction of a new cancer centre, the development of a new radiotherapy satellite centre, procurement of clinical and digital equipment, delivery of more outreach services, and clinical service transformation.

[5] Datix is a web-based incident reporting and risk management system used by healthcare organisations.

was impossible to determine whether there was any progress to reduce risk scores, or what further action was required. The Trust should ensure that risk reports provided for monitoring and scrutiny at all levels include the necessary detail to enable good scrutiny and challenge. There should be agreement on the level of detail provided on risks, but this should include opening, current and target risk scores, and ensure sufficient clarity on existing controls and mitigating action (**Recommendation 3a**).

39 The respective divisional senior management teams review and scrutinise divisional risks. The Trust Executive Management Board reviews risk registers at its monthly meetings. Any risks meeting the risk score of 12 or more are added to the Corporate Risk Register. The Corporate Risk Register is reported to the Board's committees (the Audit Committee, the Quality, Safety and Performance Committee, and the Strategic Development Committee). Risks scored 16 and over are scrutinised by the Board.

40 Our observations of the Quality, Performance and Safety Committee found that when the Corporate Risk Register is tabled, there appears to be little discussion or scrutiny on the risks within the register assigned to the Committee. We believe there are a number of reasons for this:

- currently, the narrative on controls is unclear in the risk registers. It is difficult to differentiate between controls already in place, and those which are intended to be put in place and by when. Therefore, it is impossible to see if any intended mitigating action has been implemented on time, and whether it has had the intended impact (such as a reduction in the risk score) (**Recommendation 3a**).
- for many risks, there are separate agenda items which provided detailed information, and thus the discussion had already occurred. When discussing the Corporate Risk Register, it would be beneficial for the Trust to draw attention to any risks that have previously been discussed within a different agenda item (**Recommendation 3b**).
- discussions have focused on the progress to update and the risk registers, rather than the risks themselves. Whilst the executive risk owners are present, they do not lead discussion on risks within their areas of responsibility (**Recommendation 3c**).

41 Going forward, discussions in Board and committee meetings need to scrutinise the appropriateness of existing controls, ensuring that intended actions to increase and improve controls are timely and having the desired impact.

Organisational culture

42 NHS organisations need to focus on continually improving the quality of their care whilst using finite resources to achieve better outcomes and experiences for service users. Our work considered the extent to which the Trust is promoting a quality and service-user, safety-focused culture. We considered: compliance with

statutory and mandatory training, participation in quality improvement processes integral with wider governance structures, listening and acting upon feedback from staff and service users, and learning lessons.

43 We found that **the Trust has an open and learning culture and is committed to learning from service users and staff. There are good arrangements to collect service user and staff feedback and to share these. However, some staff perceive that the Trust may not act in response to concerns or take action to deal with bullying or harassment.**

Quality improvement

44 We found that **reporting of clinical audit has improved, although opportunities remain to demonstrate how learning from clinical audit is embedded. Good progress has been made to implement the requirements of the Medical Examiner Service**.

Quality cycle

45 The Trust plans to develop an organisation-wide quality management (assurance) system. It is intended that the system will align with the Board Assurance Framework and incorporate the management of risk, internal and external assurance mechanisms, mechanisms for regulatory and legislative monitoring, and quality, safety, outcome and experience oversight.

Clinical Audit

46 Clinical audit is an important way of providing assurance about the quality and safety of services. Each year, VCC participates in relevant clinical audits within the national programme of clinical audits and reviews; while WBS is subject to routine external audits to ensure compliance with regulatory requirements. The Trust also agrees a programme of local clinical audit in both divisions to provide assurance about the quality and safety of services and compliance with expected standards of care.

47 The Trust told us they have no corporate central resources for Clinical Audit. However, the Executive Medical Director is responsible for clinical audit and ensuring that the Trust makes adequate provision to support clinicians and managers undertaking clinical audits. Both VCC and WBS division have designated clinical leads for clinical audit.

48 In VCC, local clinical audit plans are determined and prioritised by the cancer site teams. Local clinical audit plans are linked to national standards set by the National Institute for Health and Care Excellence, findings arising from the review of significant incidents and complaints and to assess the introduction of new technologies. VCC has a dedicated clinical audit team led by the Clinical Audit Manager.

49 VCC and WBS report progress against the clinical and other audits within their respective quarterly divisional reports, which are received by the Quality, Safety and Performance Committee.

50 The Trust introduced its first Trust-wide Clinical Audit Plan in 2020 (previous plans covered just VCC). The Quality, Safety and Performance Committee approved the 2022-23 Clinical Audit Plan in July 2022.The development of the Q&S Framework should strengthen alignment between clinical audit and the quality and safety agenda across the Trust and ensure there is alignment between the co-ordination, oversight, and triangulation of outcomes.

51 The first Trust-wide Clinical Audit Report in 2020-21 was received by the Quality, Safety and Performance Committee in July 2021[6]. In previous years our Structured Assessment reviews have found that the Trust's clinical audit reports have not adequately and clearly identified key actions for improvement, making it difficult to track progress against implementing identified actions. Our view is that whilst the Clinical Audit Report 2020-21 highlights areas for improvement, the report does not set out what action will be taken, or by when. We remain of the opinion that there needs to be a more robust reporting of findings, learning and resulting actions to allow demonstration of how learning has been shared and implemented[7].

Mortality and morbidity reviews

52 Mortality and morbidity review meetings provide a systematic approach for peer review of adverse events, complications, or mortality, to reflect, learn, and improve patient care. The Medical Examiner Service was rolled out across Wales, and became a statutory independent review mechanism for patient deaths from April 2022.

53 VCC already had a specific process to review mortality and morbidity. All inpatient deaths are reviewed by a consultant nurse and input provided by consultants and the ward team that provided treatment. Any issues raised were escalated to the VCC Significant Clinical Incident Forum which has multi-disciplinary membership to conduct reviews and disseminate learning across the Trust.

54 To support the introduction of the new requirements of the Medical Examiner Service, VCC identified a consultant lead for the Significant Clinical Incident Forum and Mortality reviews. In October 2021, VCC commenced a pilot to ensure that requirements for reporting patient deaths to the Medical Examiner Service were complied with. VCC established a Mortality Project Group to lead this work. Training has been provided to appropriate staff. Since the pilot, the Mortality Project Group has been developing a standard operating procedure for the process.

[6] In previous years the Clinical Audit Report contained VCC audits only.

[7] The Clinical Audit Report 2021-22 had not been tabled at a Quality, Safety and Performance Committee by the time of reporting.

55 VCC reported to the March 2022 Quality, Safety and Performance Committee that it is meeting the requirements of the Medical Examiner Service. VCC will present a Medical Examiners Service and Mortality Framework Report to the Quality, Safety and Performance Committee twice a year.

Values and behaviour

56 We found that the **Trust has a well-established Values and Behaviour Framework which encourages an open and learning culture. Compliance with statutory and mandatory training is good but has been impacted by the pandemic**.

57 The Trust's Values and Behaviours Framework was launched in 2018 and supports a quality and service-user focused culture with emphasis on continuous improvement, openness, transparency and learning when things go wrong. When launched, the Trust took steps to publicise the values and behaviours. There have been no recent refresher initiatives. However, we were told that the Trust's Independent Members have requested a refresh for staff and there are plans in place to refresh organisational awareness of the Values and Behaviours Framework to ensure that values are at the forefront of everything that staff do. The Trust's Values and Behaviours are integral to Personal Appraisal and Development Reviews (PADRs), and form part of interview assessments and induction training.

58 Our work revealed a positive picture in relation to the culture of reporting errors, near misses, incidents and raising concerns. Of the staff who completed our survey[8], 53 out of 61 staff agreed or strongly agreed that the Trust encourages staff to report errors, near misses or incidents. Two-thirds of staff (39 out of 61 staff) agreed or strongly agreed that staff involved in an error, near miss or incident are treated fairly by the organisation. Most staff (48 out of 61 staff) agreed or strongly agreed that the organisation acts to ensure that errors, near misses or incidents do not happen again.

59 In the NHS Wales Staff Survey undertaken in November 2020, a proportion of Trust staff indicated they had experienced bullying, harassment, or abuse by another colleague, member of the public or line manager over the previous year (15%, 8%, 6% respectively). Disappointingly, fewer than half (42%) agreed or strongly agreed that the organisation takes effective action (**Recommendation 4a**). The Trust reviewed the NHS Staff Survey Findings results and key messages at their Board in February 2021. It was agreed that the results would be discussed within teams and that a Trust-wide action plan would be developed. Pressures

[8] We invited operational staff working across the VCC and WBS to take part in our online attitude survey about quality and patient safety arrangements. The Trust publicised the survey on our behalf. The estimated response rate is 2.9%. Although the findings are unlikely to be representative of the views of all staff across VCC and WBS, we have used them to illustrate particular issues.

arising from the pandemic led to delays, but at the time of writing, the Trust were planning to restart the work.

60 Undertaking annual PADRs is important for identifying training needs. The Welsh Government target for PADR compliance is 85%, WBS were reported to be just below this target at 78.4% and VCC lower at 66.0% (March 2022)[9]. Compliance with undertaking annual PADRs was impacted by the pandemic, and at the time of writing, action to improve compliance included targeting hotspot areas.

61 Statutory and mandatory training is important for ensuring staff and patient safety and wellbeing. The Trust is required to report compliance to the Welsh Government each month, and the target for compliance is 85%. Figures reported at the May 2022 Quality, Safety and Performance Committee show in March 2022, WBS achieved 92.3% compliance and VCC 84.8%. The pandemic has inevitably impacted the ability for staff to attend training. Therefore, it is not surprising that less than half (26 out of 61) of staff responding to our survey agreed or strongly agreed that they have enough time at work to complete any statutory and mandatory training. Whilst performance in both divisions is near to or above the target, the Education and Development Team continue to work closely with VCC to improve compliance and a training plan is being developed.

Listening and learning from feedback

62 We found that the **Trust demonstrates a strong commitment to learn from service user and staff experiences. There are good arrangements to collect service user feedback, and these have been enhanced by an electronic system to collect real time feedback and a new patient engagement strategy for cancer services. There is a culture of staff feeling able to raise concerns, however, some staff are concerned that the Trust will not act in response to concerns**.

Service user experience

63 Both divisions have designated leads for patient/donor experience with protected time to carry out this role. The Trust have worked with a range of patients, staff and wider stakeholders to develop a Patient Engagement Strategy for cancer services, which was approved by the Board in May 2022. The Patient Engagement Strategy covers a wide range of interactions with patients, including future planning, service design, service delivery and individual care. It sets out a series of goals and underlying principles for VCC to ensure patient engagement is integral to how VCC works.

[9] As reported in the May 2022 Quality, Safety and Performance Committee.

64 The Patient Engagement Strategy sets out plans to create a Patient Engagement Hub in VCC which will be a focal point for patients, staff and stakeholders to contact VCC and to co-ordinate engagement activities.

65 VCC currently has a range of mechanisms to collect patient feedback, including the All-Wales Patient Questionnaire, social media, the Patient Leadership Group and specific surveys developed for Clinical Audits. Whilst some patient experience activities ceased during the height of the pandemic, they recommenced in 2021. The pandemic led to a greater emphasis for digital capture of patient feedback, including social media. VCC are now using a digital platform, Civica, to collect patience experience, which allows the collection of real time data to enable immediate identification of issues and a quicker response.

66 VCC has a well-established Patient Liaison Group. Designated patient 'leaders' from this group are active in helping staff understand things from a patient or carer's perspective. The Trust has adopted a 'You said, we did' approach to demonstrating learning and responding to patient feedback.

67 Learning from patient experience is discussed in the VCC Quality and Safety Management Group and the Trust's Putting Things Right Panel.

68 WBS invites all donors to give feedback via paper, online or SMS surveys. Compliment and concerns cards are available in all donation clinics and social media channels offer further opportunities to provide feedback. Feedback is reviewed each month and key learning is discussed at the WBS Regulatory Assurance and Governance Group meeting. WBS is also using Civica to capture donor experience.

69 The Quality, Safety and Performance Committee receives a range of service user experience, including summaries of each division's survey results. The Trust also produces an annual patient and donor experience report. Service user feedback continues to be very positive.

70 Despite the range of mechanisms to collect data, only half (29 out of 61) of Trust staff responding to our survey agreed or strongly agreed that they receive regular updates on service user feedback for their work area,

71 The Trust produces an annual Putting Things Right Report, and quarterly updates are presented to the Quality, Safety and Performance Committee. The most recent update, Quarter 4 2021-22, was presented to the Quality, Safety and Performance Committee in May 2022. Most concerns were rated as low level, and similarly nearly all incidents were graded as no harm/low harm. Across the Trust, the main themes of concerns were associated with communication, attitudes, and behaviours. The more highly graded concerns related to communication about clinical care, such as perceived miscommunication regarding treatment plans. Lower graded complaints relating to attitude centring on scheduling of appointments. Reports include a summary of the learning captured from reviews of concerns and incidents, and examples of actions taken in response.

72 The Welsh Government target for timely response to complaints is 75% within the 30-day target. The Trust reported in the May 2022 Quality, Safety and

Performance Committee that the Trust's performance for quarter 4 2021-22 was 100% compliance, exceeding the Welsh Government target.

Service user stories

73 Quality, Safety and Performance Committee meetings commence with either a patient or a donor story, which usefully sets the tone for the remainder of the meeting. Service user stories allow a deep dive into events that have not gone so well as well as positive experiences. Stories lead to discussion and challenge to ensure that lessons have been identified and shared. Podcasts are produced and staff are encouraged to consider the stories.

74 Patient Safety WalkRounds provide Board members with an understanding of the experiences of staff, patients and donors and help to make data more meaningful. In 2022, the Trust restarted their programme of 15 step challenge following the cessation during the height of the pandemic. The 15 step challenge visits help to reassure senior staff and independent members that services are welcoming, caring, well organised and safe. They also provide an opportunity for staff to raise concerns and ask questions. The recommendations and actions from visits are taken to a subsequent Quality, Performance and Safety Committee for discussion and a follow-up visit scheduled to ensure recommendations are addressed.

Listening to staff feedback and concerns

75 The Trust is committed to listening and learning from staff experiences and concerns. Quality, Safety and Performance Committee meetings hear staff stories.

76 Staff can report their concerns through the Work in Confidence virtual platform. Comments are reviewed and investigated by staff from the Workforce and Organisational Development team. The Workforce Report for February 2022, presented to the May 2022 Quality, Safety and Performance Committee noted that as a result of low usage of the Work in Confidence Service, they were unable to provide information without it being potentially identifiable.

77 Our interviewees were confident that they and other staff members would feel comfortable raising concerns directly via their manager or more senior managers. However, our survey found that only half (30 out of 61) staff members agreed or strongly agreed that the Trust acts on concerns raised by staff. A similar theme was identified in the NHS Staff Survey 2020. The Trust should set out in their NHS Staff Survey action plan how it intends to explore the reasons why some staff may not feel the Trust adequately acts on concerns (**Recommendation 4b**).

78 VCC staff have daily handover meetings where staff are encouraged to raise any concerns and use the opportunity to share learning. WBS donor collection teams hold a daily de-brief after each donation session where they can raise any concerns. Executive and senior clinicians within the Trust and both divisions are operationally visible, to help them understand the staff experience and be more accessible to staff.

79 Just under half (27 out of 61) of staff agreed or strongly agreed that communication between senior management and staff is effective. This may be a result of the opportunities to meet being more limited during the pandemic. We note that during the pandemic, the Trust stepped up opportunities to communicate with staff via social media, digital and video conferencing. However, the Trust should consider how it may re-stimulate staff engagement.

80 Whilst not universal views, our fieldwork identified that some divisional staff feel remote from the Trust executive team, and consequently distant from strategic decision making. The Trust told us of plans to re-establish the Clinical Advisory Group on a permanent basis (in summer 2022) and to develop a Clinical and Scientific Strategy Board. These fora will provide clinicians from both divisions with the opportunity to inform decision making.

Governance structures and processes

81 Our work considered the extent to which organisational structures and processes at and below board level support the delivery of high-quality, safe, and effective services.

82 We found that the **new Quality and Safety Framework and planned work to operationalise the Quality Hubs have articulated the operational governance structures and flows of assurance to support quality governance.**

Resources and expertise for quality governance

83 We found that **there are appropriate identified resources for quality governance, and the Trust, in operationalising its new Quality Hubs has plans to address gaps in resources**.

VCC quality governance resources

84 The Director of Velindre Cancer Services holds ultimate responsibility for quality and safety in VCC. Whilst the VCC senior management team has collective responsibility for quality and safety, the VCC Head of Nursing Quality, Patient Experience and Integrated Services is the identified lead. The VCC Clinical Director is responsible for providing leadership for the VCC medical directorate. There are appropriate leads for services such as mortality reviews, quality and safety, radiology quality and safety, complaints, and patient experience.

85 VCC told us they receive support from the corporate quality and safety team and the corporate governance team as required.

86 At the time of our fieldwork, VCC told us that they felt they needed additional quality and safety resources to fully implement new requirements arising from the new Q&S Framework, the Medical Examiner Service requirements and to implement the Duty of Candour, and to improve reporting between VCC and the Trust.

87 As set out in the Q&S Framework, the Trust intends to create a VCC Quality Hub, led by a nominated divisional lead. The intention is for the VCC Quality Hub to support the VCC Senior Management Team in executing quality, safety, regulatory and assurance responsibilities by ensuring effective oversight, co-ordination, learning, assurance and triangulation and effective functioning of Divisional Quality and Safety Group. There are plans to develop and operationalise the VCC Quality Hub during the remainder of 2022, including identifying and filling resource needs.

WBS quality governance resources

88 The Director of the Welsh Blood Service holds ultimate responsibility for quality assurance and safety in the division. Whilst the senior management team has collective responsibility for quality assurance and safety, the Head of Quality Assurance and Regulatory Compliance leads the strategic development, delivery and management of the quality systems throughout the division. The WBS Head of Nursing is responsible for clinical governance, managing concerns and donor engagement. There are designated leads for, infection prevention and control, clinical audit, quality improvement, risk management, Datix, health and safety and data analytics. Some leads do not have protected time to fulfil their role, including the leads for clinical audit and infection, prevention and control.

89 At the time of our fieldwork, WBS told us that resources to support quality assurance and safety were inadequate with a number of vacant posts. Staff told us that there was a pending (overdue) review of WBS quality staff requirements, which was necessary, because staffing needs had changed over time.

90 The Q&S Framework sets out that there will be a WBS Quality Hub with the same purpose as the VCC Quality Hub (see **paragraph 87**). There are plans to develop and operationalise the WBS Quality Hub during the remainder of 2022, including identifying and filling resource needs.

Trust leadership for quality governance

91 There is collective responsibility for quality and safety amongst the Executive Management Board, senior managers and leads within the divisions to ensure the quality and safety of services. However, it is the Director of Nursing, Allied Health Professionals and Health Science (Director of Nursing) who is the executive lead for quality and safety across the Trust.

92 The Director of Nursing has delegated responsibility for ensuring the necessary infrastructure is in place to deliver quality and safe services and is the professional lead for Putting Things Right, Infection Prevention and Control, decontamination, safeguarding, managing incidents and service user experience. The Director of Nursing chairs the Trust's Infection Prevention and Control Group and the Safeguarding and Vulnerable Adults Group and also co-chairs the Clinical Strategy Group with the Trust's Executive Medical Director.

93 The Director of Nursing is supported by the Deputy Director of Nursing, Quality and Patient/Donor Experience, however, at the time of our fieldwork, there were a number of unfilled vacancies within the corporate quality and safety support team. In 2020, the Trust identified the need to strengthen the central quality and safety function. A review of the corporate quality resources was delayed due to the pandemic. More recently, a more integrated structure has been identified to pull together all elements of quality and safety regardless of executive portfolio, with additional funding identified to create new roles within a Corporate Quality Hub. The Trust began a process to populate posts after our fieldwork was completed.

94 The Q&S Framework sets out that the Corporate Quality Hub will be a virtual hub of all quality and safety activity covering the span across a number of executive/director responsibilities and not just those managed through the Corporate Quality Team. The Corporate Quality Hub is planned to interface significantly with national work programmes and bodies, as well as professionally support the two divisional quality hubs. The three Quality Hubs are intended to be accountable for co-ordination, oversight and triangulation rather than delivery of the quality and safety agenda for respective services as this lies with responsible managers.

95 The Director of Nursing works closely with the Trust's Medical Director. The Medical Director is responsible for the quality of medical care, clinical audit and effectiveness and mortality reviews. The Medical Director is supported by five Assistant Medical Directors, each with a lead Trust-wide role (including clinical audit, education and training, and quality and safety). At the time of our fieldwork, there was very little support capacity for the Medical Director and the Assistant Medical Directors. However, since our fieldwork, the Trust has created a senior support role to help support these Trust-wide functions.

96 The Director of Corporate Governance has responsibility for governance, risk, assurance, legal and compliance frameworks and also communications and engagement and Freedom of Information.

Governance structures to support quality governance

97 We found that **the Trust in developing a new Quality and Safety Framework and operationalising in Quality Hubs has articulated the operational governance structures and flows of assurance to support quality governance**.

VCC quality and safety meetings

98 VCC's main forum for discussing quality and safety is the VCC Quality and Safety Management Group (VCC Q&SMG). It meets each month, and is chaired by VCC's Head of Nursing, Quality, Safety and Integrated Care. Meetings cover a range of critical quality and safety information and arrangements. Coverage includes new policies and guidelines, the divisional risk register, incident management and

compliance with health care standards, patient experience, infection, prevention and control, clinical audit, digital, outpatients, radiotherapy and therapies. The VCC Q&SMG reports to the VCC Senior Management Team and the reports are also tabled at Quality, Safety and Performance Committee meetings.

99 We observed the VCC Q&SMG on three occasions in 2021 and early in 2022. We found that meetings were well-structured and well-chaired, and coverage was appropriate. We did observe that on numerous occasions, agenda items were presented, which stimulated very little discussion or questions. VCC Q&SMG attendees told us that some members suggested there was significant duplication of information considered in other fora (**Recommendation 8a**). In addition, historically the VCC Q&SMG has had no or little medical representative attendees, which has limited the ability for multidisciplinary discussions (**Recommendation 8b**). We also noted that some papers would have benefited from the inclusion of a cover paper, providing a summary of the main issues being presented.

100 Whilst we anticipate that once the VCC Quality Hub is fully operationalised, work will be undertaken to address our **Recommendations 8a and b**. However, until the Trust's quality hubs are fully operational, we are unable to make an assessment, and thus our recommendations remain in place.

101 Whilst undertaking our fieldwork we were aware of a number of groups in VCC that cover quality and safety matters, for instance, the Medical Gases Committee, the Medicines Management Group, the Safety Alerts Group, the Controlled Drugs Group, the Radiation Protection Group and the VCC Infection, Prevention and Control Group. We were unable to ascertain where the reporting of quality and safety information and assurance rising from these groups fed. However, the new Q&S Framework sets out the topics which the VCC Q&SMG will consider in its meetings.

WBS quality and safety meetings

102 WBS's main forum for discussing quality and safety is the WBS Regulatory Assurance and Governance Group (WBS RAGG). Meetings are monthly and chaired by WBS's Head of Quality Assurance and Regulatory Compliance. Meetings cover a range of key quality management arrangements.

103 The agenda for the WSB RAGG contains good coverage of quality and safety issues via monthly update reports. There is a good balance of looking at performance issues triangulated with patient and donor feedback.

104 The structure of fora covering quality and safety matters in WBS is straightforward. There are two main groups that report to the WBS RAGG, the Donor Clinical Governance Group and the Patient Clinical Governance Group.

105 Our observations of the WBS RAGG found the meeting to be well structured, and well chaired. We observed good debates and constructive challenges on agenda items. The WBS RAGG reports to the WBS Senior Management Team, and the reports are also tabled at Quality, Safety and Performance Committee meetings.

Trust-wide quality and safety meetings

106 There are a small number of Trust-wide meetings which cover quality and safety, such as the Infection, Prevention and Control Group and the Safeguarding and Vulnerable Adults Groups. Significant work had been undertaken during the 12 months prior to our fieldwork to strengthen and enhance the workplans of the Trust-wide groups.

107 During our fieldwork, we asked the Trust to provide us with a diagram setting out the groups/fora at a Trust level and within both divisions that consider any quality and safety matters, and associated flows of assurance. At the time of our fieldwork, the Trust was unable to provide us with a comprehensive diagram. Whilst there is more clarity in the new Q&S Framework, we are still of the view it would be beneficial to set out all, rather than just some, of the meetings that consider quality and safety matters across the Trust (**Recommendation 8c**).

108 The new Corporate Quality Hub and Divisional Quality Hub leads will formally meet bi-monthly (from October 2022) as a newly created Quality and Safety Governance Group (Q&S Governance Group). The purpose of the Q&S Governance Group will be to ensure effective triangulated assurance and/or exceptions reporting to the Executive Management Board and the Quality and Safety Performance Committee.

Trust Quality, Safety and Performance Committee

109 The Trust's Quality, Safety and Performance Committee is responsible for providing assurance and advice to the Board in respect of quality and safety. The Quality, Safety and Performance Committee meets on a bi-monthly basis. During the pandemic the Committee increased the frequency of meetings as and when deemed appropriate. We observed the Committee on several occasions and found that there was good challenge and scrutiny from independent members.

Arrangements for monitoring and reporting

110 Our work considered whether arrangements for performance monitoring and reporting at both an operational and strategic level provide an adequate focus on quality and patient safety.

111 We found that **the agendas of Quality, Safety and Performance Committee meetings are becoming more manageable and focussing on key matters. However, the timeliness of some data and information is a challenge to effective scrutiny.**

Coverage of quality and patient safety matters

112 We found that the **agendas of Quality, Safety and Performance Committee meetings are becoming more manageable, with less duplication of coverage,**

and cover papers are now focusing on key matters. However, some information is not timely.

113 The remit of the Quality, Performance and Safety Committee is vast. In our Structured Assessment 2021, we found that the amount of detail provided to the committee on many items was too great, and that further work was needed to agree the amount and level of detail needed to provide necessary assurance to the committee. We said consideration was needed on how to best summarise and synthesise information to help provide focus on key matters. During 2022, we have seen improvements, meetings are generally running to time, there is less duplication of coverage within committee papers, and papers and verbal presentations are providing better focus on key matters.

114 We understand that once operationalised, the Q&S Governance Group will play a critical role in ensuring effective triangulated assurance and/or exception reporting to the Quality, Safety and Performance Committee, and thus ensure that the detail of committee papers is pitched correctly.

115 Every four months, VCC and WBS separately produce divisional Quality and Safety Performance Reports providing a summary of performance information against key quality and safety metrics. The reports are structured around the six domains of quality and safety (Safe Care, Effective Care, Efficient Care, Patient Centred Care, Timely Care and Equitable Care). The reports are comprehensive covering incidents, complaints, risks, claims, clinical audit plan updates, service user experience, external/interview audit findings and training compliance. VCC and WBS present their reports alternatively at Quality, Safety and Performance Committee meetings. Each report provides the most recent month of validated data available. For instance, the May 2022 Committee meeting received the VCC Quality and Safety Performance Report which included February 2022 data. Whilst the report provides useful information on many areas of quality and safety, scrutiny is not completely effective if the data and information presented are not as up to date as possible (**Recommendation 6**).

116 A highlight report of the discussion from the most recent Quality, Safety and Performance Committee is presented by the Chair to the Board meeting. The Committee has a cycle of business which sets out what it intends to cover across the year in its meetings.

Performance information for scrutiny and assurance

117 We found that the **Trust produces lots of information for scrutiny and assurance, but data analytics support is limited. The introduction of quality dashboards would improve the timeliness of data and thus strengthen oversight and monitoring**.

118 The Chief Operating Officer presents a cover paper of the Trust-wide Performance Management Framework to each Quality, Safety and Performance Committee meeting. The cover paper draws attention to key performance metrics across VCC,

WBS, and Workforce. Where performance is off track, the cover paper summarises actions to address performance. There are separate performance reports for VCC, WBS and Workforce.

119 The performance reports provided to the May 2022 Quality, Safety and Performance Committee, contained data from March 2022 (VCC and WBS) and February 2022 (Workforce). Therefore, the data is not as timely as it could be (**Recommendation 6**).

120 The Trust has long intended to make significant improvements to the Performance Management Framework report. Progress has been delayed due to the pandemic. However, following an initial tranche of work, a summary dashboard is now included, and improvements made to explanations of performance and intended actions. Further work is planned in 2022, to fully revise the report and use business intelligence reporting. Plans also include developing more outcome-based measures, adding benchmarking comparisons, and aligning performance reporting to strategic priorities. During 2022, the Trust intends to develop specific performance scorecards for the Board, the Quality, Safety and Performance Committee, Executive Management Board and the divisional senior management teams. The proposed approach is a hierarchy of performance measurements appropriate to the remit and scrutiny requirements at each level and the Board will take assurance from the detailed review and challenge undertaken by each level below.

121 The Trust does not currently have a dedicated data analytics team which means, operationally, there is limited data analytics support available to help divisions manage their data. However, the Trust is seeking funding to increase its data analytics functions. The Trust does not have a live dashboard of key performance data.

Appendix 1

Management response to audit recommendations

Exhibit 2: management response This table will be completed once the report and detailed management response have been considered by the relevant committee(s).

Recommendation	Management response	Completion date	Responsible officer
Recommendation 1 At the time of writing, the Trust had recently developed 10 new Quality Improvement Goals; however, they are not specific or time-bound, and thus do not easily allow assessment of whether they have been achieved on time. Going forward, the Trust should ensure that Quality Improvement Goals are underpinned with specific, time-bound actions.	Trust will ensure 2023-24 and future years quality Goals are specific (SMART) and timebound.	March 2023	Executive Director Nursing, AHP and Health Science

Recommendation	Management response	Completion date	Responsible officer
Recommendation 2 To date, Board committees' scrutiny of the Board Assurance Framework has focused on its development and format. As soon as possible, the Trust should ensure that each committee incorporates a review of the strategic risks assigned to them within their cycles of business and: a) Provide appropriate consideration of each of the controls and sources of assurance, and b) Scrutinise progress to address gaps in controls and assurances.	a) Agreement of Committee mapping to Trust Assurance Framework risks complete and endorsed by Strategic Development Committee in October 2022 for implementation through next governance cycles, starting from November 2022. (Cross-reference to the Governance, Assurance and Risk work under the Building Our Future Together Programme (BOFT) - Project Trust Assurance Framework 4.0). b) Further scrutiny and evidence of this, in line with the comments made in the report, will be actioned as part of the next governance cycle review of the Trust Assurance Framework.	a) January 2023 b) January 2023	Director Corporate Governance and Chief of Staff
Recommendation 3 Risk registers presented to meetings do not always include enough information to allow good scrutiny. The Trust should: a) Determine what information is needed in risk registers (including the Corporate Risk Register) to enable good scrutiny and challenge (such as including opening, current	a) Quality of data and consistency of reporting is a focus of the current risk work. (Cross-reference to Governance, Assurance and Risk work under BOFT - Project Risk 4.0 & Risk 5.0). b) To be included in new Cover Paper Template and Risk Register report (Cross-reference to Governance, Assurance and Risk work under BOFT - Project GOV 2.0). c) Implement from next governance cycle.	a) March 2023 b) January 2023 c) January 2023	Director Corporate Governance and Chief of Staff

Recommendation	Management response	Completion date	Responsible officer
and target risk scores, and sufficient clarity on existing controls and mitigating action). b) If risks appearing in the Trust Risk Register have been discussed in other agenda items, provide suitable cross references in the cover report. c) Executive risk owners should lead discussions on risks within their areas of responsibility.			
Recommendation 4 Progress to develop a Trust-wide action plan to address findings from the NHS Staff Survey slowed due to the impact of the pandemic. The Trust should progress work to develop the action plan as soon as possible and: a) Undertake work to understand why some staff feel that the Trust does not take effective action to deal with bullying, harassment or abuse.	a) Trust-wide conversations are underway regarding the way staff feel about working in the organisation. The outputs of this work will give a picture of the culture of the organisation and enable the next iteration of the Trust Values. Part of this engagement work will also be extended to address particular feedback on dealing with bullying, harassment or abuse. b) The work described at a) will also address the issue of dealing with concerns raised in the workplace.	a) January 2023 b) January 2023	Executive Director of Organisational Development and Workforce

Recommendation	Management response	Completion date	Responsible officer
b) Undertake work to understand why some staff may feel that the Trust does not act adequately to address concerns.			
Recommendation 5 Some of the attendees of meetings that consider quality and safety matters in VCC felt that there is duplication of coverage, and that not all meetings had appropriate representation. When operationalising the Quality Hubs, the Trust should for VCC and WBS and Trust-wide. a) Ensure that the group structures and meeting remits avoid unnecessary duplication of coverage. b) Ensure that attendees of each meeting are appropriate and provide adequate representation of relevant disciplines. c) Ensure that the Trust has clearly articulated which meetings consider quality and safety matters and their reporting lines.	Integrated Quality and Safety Group to be established (19th October 2022). The Group will take responsibility for reviewing Trust-wide quality and safety related meeting structures, including required representation. Output to be approved by Executive Management Board and the Quality, Safety and Performance Committee. It is noted however, that this will require ongoing review as the Trust and Integrated Quality and Safety Group matures.	March 2023	• Executive Director Nursing, AHP and Health Science; • Director Corporate Governance & Chief of Staff; • Head of Corporate Governance

Recommendation	Management response	Completion date	Responsible officer
Recommendation 6 Information in reports and performance data are sometimes out of date. The Trust should ensure that as far as possible, data and information presented to the Quality, Safety and Performance Committee meeting is as up to date as possible, covering agreed time periods.	Reporting cover periods to be made explicit as part of Committee agenda setting and work plan.	From January 2023 Quality, Safety and Performance Committee	• Executive Director Nursing, AHP and Health Science; • Director Corporate Governance & Chief of Staff; • Head of Corporate Governance

Appendix 2

Staff survey findings

Exhibit 3: staff survey findings

Attitude statements	Number of staff agreeing or disagreeing with statements						Total respondents
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know	
Delivering safe and effective care							
1. Care of patients is my organisation's top priority	35	18	5	3	0	0	61
2. I am satisfied with the quality of care I give to patients	28	25	8	0	0	0	61
3. There are enough staff within my work area/department to support the delivery of safe and effective care	7	20	7	21	6	0	61
4. My working environment supports safe and effective care	18	24	10	6	3	0	61

Attitude statements	Number of staff agreeing or disagreeing with statements						Total respondents
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know	
5. I receive regular updates on patient feedback for my work area/department	12	17	11	14	4	3	61
Managing patient and staff concerns							
6. My organisation acts on concerns raised by patients	21	23	9	1	0	7	61
7. My organisation acts on concerns raised by staff	10	20	19	8	3	1	61
8. My organisation encourages staff to report errors, near misses or incidents	30	23	5	0	2	0	60
9. Staff who are involved in an error, near miss or incident are treated fairly by the organisation	21	18	15	2	1	4	61

Attitude statements	Number of staff agreeing or disagreeing with statements						Total respondents
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know	
10. When errors, near misses or patient safety incidents are reported, my organisation acts to ensure that they do not happen again	17	31	8	3	2	0	61
11. We are given feedback about changes made in response to reported errors, near misses and incidents	13	29	7	8	4	0	61
12. I would feel confident raising concerns about unsafe clinical practice	22	29	3	2	3	2	61
13. I am confident that my organisation acts on concerns about unsafe clinical practice	16	28	10	4	2	1	61
Managing patient and staff concerns							
14. When errors, near misses or patient safety incidents are reported, my organisation acts to ensure that they do not happen again	17	31	8	3	2	0	61

Attitude statements	Number of staff agreeing or disagreeing with statements						Total respondents
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know	
15. We are given feedback about changes made in response to reported errors, near misses and incidents	13	29	7	8	4	0	61
16. I would feel confident raising concerns about unsafe clinical practice	22	29	3	2	3	2	61
17. I am confident that my organisation acts on concerns about unsafe clinical practice	16	28	10	4	2	1	61

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