Velindre University NHS Trust

Head of Quality, Safety and Assurance

Annual Quality and Safety Report

2024/2025

Velindre University NHS Trust is responsible for the delivery of a wide range of specialist NHS Wales services including the Velindre Cancer Service and the Welsh Blood Service and we host Health Technology Wales, and NHS Wales Shared Services Partnership.

Caring

We are always kind, supportive, approachable and show compassion to all.

Respectful

We seek to understand other people's perspectives. We are always open and transparent.

Accountable

We always take personal responsibility for what we do and how we do it.

The Velindre Cancer Service is a specialist treatment, teaching, research and development service for non-surgical tertiary oncology services to patients from across south east Wales and further afield.

The Welsh Blood Service provides essential and highly specialised national services including the collection and production of blood and blood components, specialist diagnostic services and antenatal screening, as well as supporting transplant services for solid organs and stem cells across Wales and internationally.

Health Technology Wales assesses non-medicine health and care technologies and produces national guidance on their use in Wales.

NHS Wales Shared Services Partnership delivers a wide range of professional, technical and administrative services to NHS Wales.

What is quality?

The Health & Social Care (Quality Engagement) (Wales) Act 2020 was implemented from 1st April 2023. This law includes the Duty of Quality and defines quality as the following:

'Continuously, reliably and sustainably meeting the needs of the population we serve'.

This is not limited to the effectiveness of health services; the safety of health services; and positive experience of service users.

The 12 Quality Standards are used across the trust which help deliver against the six quality domains:

- Leadership
- Workforce
- Culture
- Information
- Learning, Improvement & Research
- Whole System Approach

Trust approach

The Trust has a network for all teams to communicate, which is mainly made up of staff from across the Trust. These included our Divisional Quality Hubs, Integrated Quality & Safety Group, Quality, Safety & Performance and Executive Management Board providing assurance to the Trust Board and the population of Wales on the Trust's commitment to the Duty of Quality.

The Trust infrastructure is supported by a range of digital tools and systems to assist with monitoring, collaborating and reporting on the services the Trust supplies across Wales.

With this infrastructure, quality information can be shared effectively and timely. This can also help identify best practices, risks, areas of improvement or just for reporting purposes.

1. Introduction

The Trust's annual integrated quality & safety report provides analysis of key outcomes, activity, learning and improvement during the past year and, where possible, provides themes, trends and comparative data. The report provides assurance in relation to key legislative requirements including Putting Things Right Regulations (2011) & Health and Social Care (Quality and Engagement) (Wales) Act (2020), and maintain a strong focus upon learning and improvement, to ensure the continued provision of Safe, Timely, Effective, Efficient, Equitable and Person-Centred Care.

Quality & Safety Indicators Overview

	2024/25	2023/24
Putting Things Right Formal Complaints	38	55
Putting Things Right Compliance	75%	93%
Early Resolution Complaints	106	147
Re-Opened Complaints	7	4
New Inquests	12	11
Ombudsman Cases	0	4
Incidents	2085	2059
Duty of Candour Incidents	10	8
Nationally Reportable Incidents	2	4
New Redress	6	5
Written Compliments on Datix	471	355
Welsh Blood Service Satisfaction	98%	98%
Velindre Cancer Service Satisfaction	96%	96%
Incident Open Over 30 Days	352	682
Safeguarding Duty Of Report	13	16

The triangulation of data in this annual report has identified a theme of continued concerns and incidents relating to communication with Velindre Cancer Service. These concerns are continuing to have an impact on Patient satisfaction and confidence in our service. Although the incidents are not attributed to harm, they are causing a significant impact on patient's cancer journey.

Overall satisfaction scores for both Welsh Blood Service and Velindre Cancer Service remain positive.

Compliance with Putting Things Right timescales for complaints response has decreased since last year to 75%. This is still within the national PTR target of 75%. This has been due to capacity issues within the Velindre Cancer Service Concerns team and the complexity of concerns.

Ten incidents in the Trust triggered the Duty of Candour. Two incidents met the criteria for National Reportable incidents across the Trust.

The Trust continues to comply with legislative safeguarding responsibilities and reporting.

Hospital Associated Infection rates remain low.

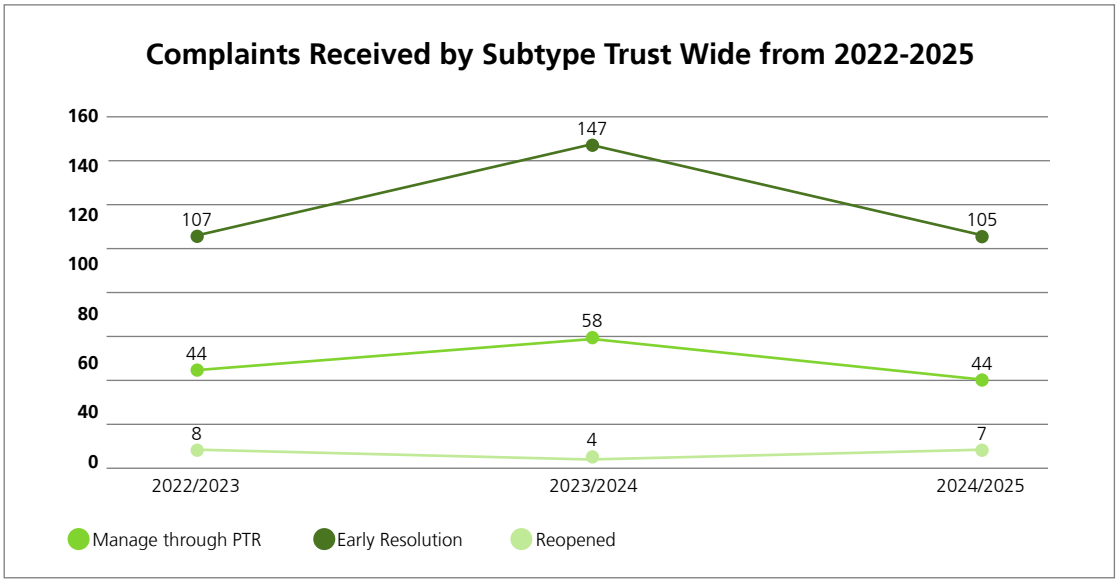
Work has been undertaken to explore further opportunities to gather patient and donor feedback for learning and improvement. A Trust wide Patient and Donor Experience working group has developed and an improvement plan with staff across WBS and VCS.

2. Complaints

2.1 Complaints - Trust overview

Analysis

As shown in graph 1, the Trust has seen a decrease in complaints managed through Putting Things Right (formal) from last year and the year prior. The number managed through Early Resolution has also decreased, this can indicate that the Trust has had less complaints overall and has been successful at managing complaints without the complaint becoming formal.



Although compliance has decreased since last year. The Trust is still within the national PTR target, which is 75%. 2 complaints remain open; one is still within the PTR timescales. The complexity of the complaints received has increased.

	Total complaints raised	% Compliance with 30 day resolution targets
2022 / 2023	159	86.4%
2023 / 2024	209	93%
2024 / 2025	153	75%

2.2 Complaints - Ombudsman

The Public Services Ombudsman Wales investigates complaints about unfair treatments by Welsh Public Service and works to improve standards. The Ombudsman can consider complaints made to her within one year of the matters complained about or within one year of when you became aware. All Trust complaints letters and correspondence informs the public of how to contact the Ombudsman if they are unhappy with our complaints handling.

Analysis

There were no open Public Services Ombudsman cases in the year 24/25. This provides a positive assurance regarding our concerns management and comprehensive responses provided to our service users or their families.

	Ombudsman cases opened against the Trust
2022 / 2023	4
2023 / 2024	0
2024 / 2025	0

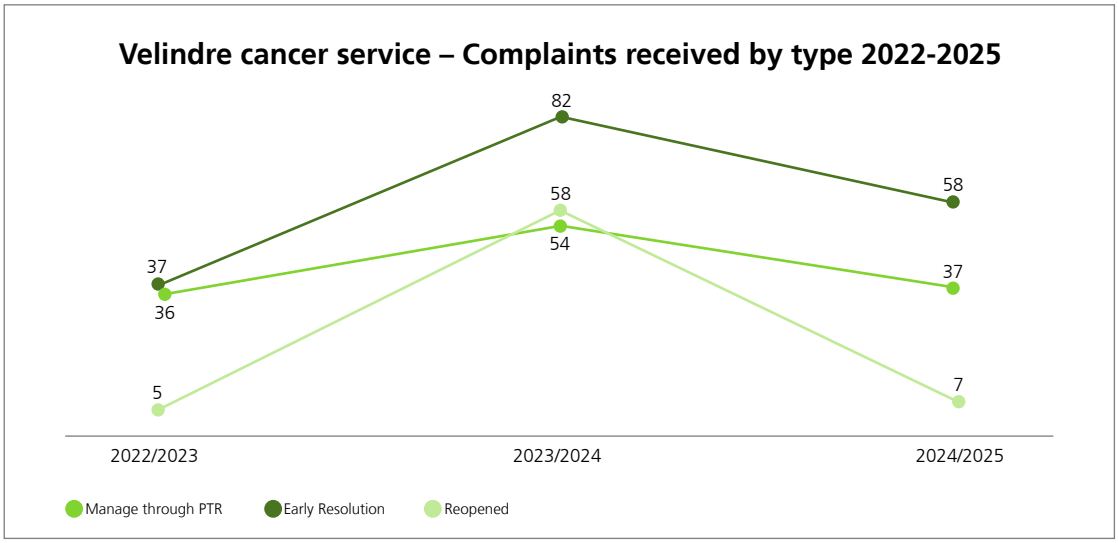
2.3 Complaints - Velindre Cancer Service

There has been an overall decrease in the number of complaints received in the past year compared to 2023/2024. The most common reason for complaints was related to communication of appointments and difficulty contacting departments. The Trust conducted a Pain Point Review into these concerns and work is underway to address the issues.

95 complaints were received in total (0.04% of patient attendances)

7 complaints were reopened complaints where complainants were not satisfied with their final response. In person meetings have been offered and concerns reviewed. All template letters have been reviewed and amended to improve the quality of the content and layout ensuring they meet the requirements of accessibility.

2 concerns identified a breach of duty of care which resulted in potential harm.

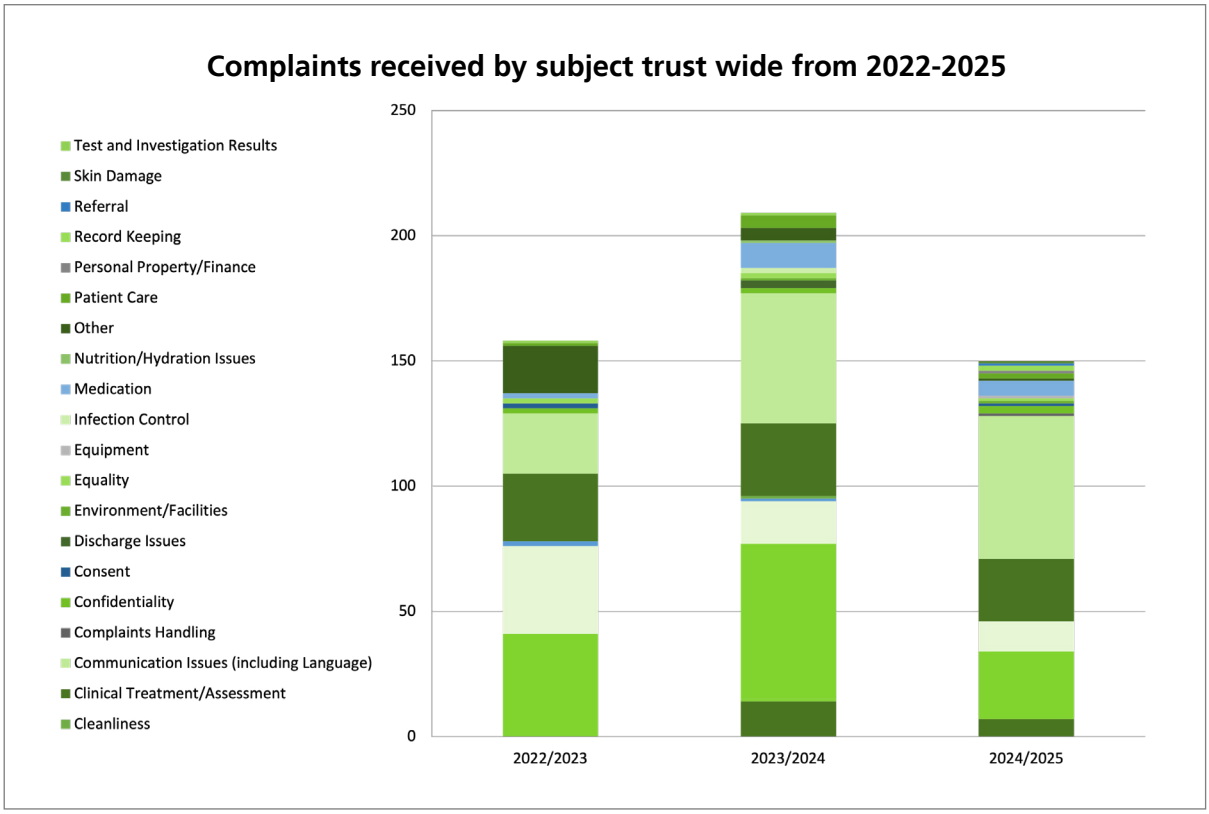


Total Complaints raised	Number managed as Early Resolution	Number managed under Putting Things Right	Number Reopened
95	58	37	7

Analysis

As shown in graph 4, communication issues continue to be the main theme of the Cancer Service complaints in 2024/2025, specifically around outpatient and SACT appointments.

Concerns were raised regarding information being given in consultations around treatment plans and prognosis is also identified as a communication theme, as well as patients concerned that they have not seen their named consultant since their first appointment.



Learning and improvements identified from velindre cancer service complaints

- A review of processes around managing telephony in medical secretaries' team was undertaken, and the importance of always ensuring professionalism when speaking to patient or families was emphasised.

- Two new outpatient clinic rooms have been made available, and the clinic templates have been reviewed to ensure that clinic time and space is being optimised, with the goal of reducing clinic waiting times.
- Feedback was provided to consultants regarding the importance of Advanced Care Planning and Do Not Attempt Cardiopulmonary Resuscitation at the earliest opportunity, and information to support medical colleagues surrounding discussion is available on the intranet.
- The processes around communicating appointment information to ensure the patient is notified in a timely manner have been re-emphasised to staff.
- Reinforcing the opportunity to discuss unexpected scan reports with radiologist before discussing with the patient.
- A number of improvements have been made to PICC line care in the Cancer Service.
- Closer working and earlier referral/discussion with the Trust Safeguarding Lead has been achieved, leading to strengthened collaborative working.
- Theme identified around patients' expectation of seeing consultant each time in clinic. Improved communication to be shared with patients around the role of the multi-disciplinary team especially in outpatient clinics – working with patient engagement team and communications team to utilise the screens and include information about MDT in patients first clinic letters.

2.3 Complaints - Welsh Blood Service

Learning and outcomes

Further learning and improvement areas following concerns have led to:

Collections Team working in collaboration with Planning Department to look at alternative venues across the Service, particularly in North Wales.

Staff reminded of the importance of always wearing a name badges and complying with Trust Values and Behaviours.

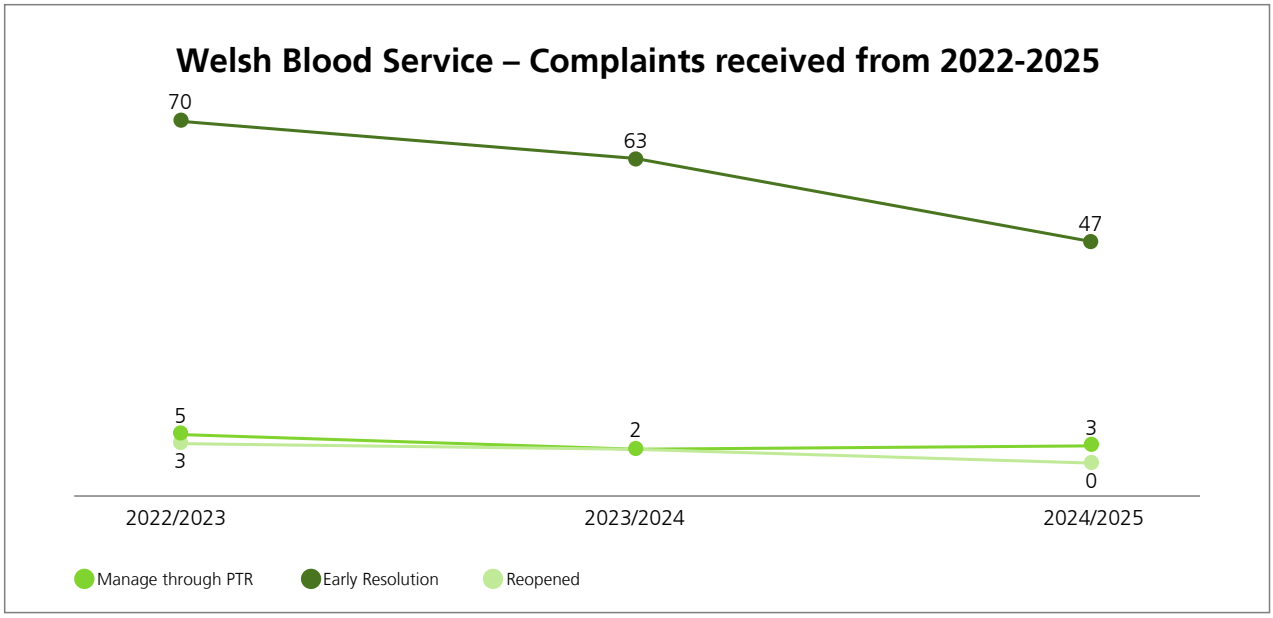
Operational Managers ensuring that where the start of a donation session is delayed, where possible, donors booked later in the day are contacted to reschedule their appointments to reduce donor inconvenience.

The Welsh Blood Service Futures Programme is focused on looking at how WBS can implement new technological advancements to help provide our Donors with the best experience possible.

The Interim Head of Nursing has undertaken an international review of the policies for accepting children at donation clinics. An SBAR outlining the proposal to update the current guidance has been developed. This was an action taken following areas of concern raised by both staff and donors.

Operational Managers reminding staff of the importance of:

- Professional conduct
- Being open and honest with effective communication with our donors at the time that errors occur.



Analysis

47 concerns raised (0.05% of donors), all managed through early resolution.

3 formal concerns were raised; all were closed within the required timeframe.

No complaints were reopened.

The main themes and opportunities for improvement related to attitude & behaviour, communication, appointments, clinical assessment & treatment/procedure mainly within donor collection teams.

These concerns continue to be spread across a variety of teams and locations.

	Managed through PTR	Early Resolution	Reopened
2022 / 2023	5	70	3
2023 / 2024	2	63	2
2024 / 2025	3	2	0

3. Velindre Cancer Service – Patient Experience

Two national surveys are used, 'Your Velindre Experience', consisting of **24** questions, and 'VCC Friends & Family', consisting of **8** questions. The findings below are from both surveys, including the satisfaction score. **2124** patients provided feedback during **2024/2025** financial year (an increase from 1434 in **2023/2024**)

978 patients completed the 'Your Velindre Experience' and 1146 completed the 'VCC Friends & Family'.

Velindre Cancer Service is undertaking work to increase patient feedback numbers by using SMS messaging.

Analysis and learning

96% of patients stated they were overall satisfied with their care. However, **2%** of respondents did not feel well cared for or felt they did not receive assistance when needed, and 3% said they did not understand what was happening in their care. **11%** of patients felt their waiting time was either **'a bit too long'** or **'much too long'.**

There has been a consistency in patient ratings throughout each quarter – with waiting times remaining an area in need of improvement in outpatients. Much work has been undertaken in outpatients to manage the waiting times, including **2 new clinic rooms** and improved signage and information re. current waiting times. Velindre Cancer Service will continue to monitor feedback to assess the efficacy of these changes.

Feedback about your Experience

Satisfaction score	Being well cared for	Receiving assistance when needed	Patients felt they were being listened to	Waiting time on the day
96%	98%	98%	97%	86%

		Question 1	Question 3	Question 4	Question 5	Question 6
		Overall, how was your experience of our service?	**Did you feel that you were listened to?**	**Were you able to speak Welsh to staff if you needed to?**	**How did you find the waiting time in your recent visit?**	**Did you feel well cared for?**
		VCC - Friends and Family	Your Velindre Experience 23/24	Your Velindre Experience 23/24	Your Velindre Experience 23/24	Your Velindre Experience 23/24
Integrated care	444	99	100	92	90	100
Operational services	657	97	92	90	80	92
Pharmacy	53	100	83	83	67	100
Radiation services	433	100	100	94	95	99
SACT	462	100	96	90	89	99
Overall		**99**	**97**	**91**	**88**	**98**
Benchmark		85	85	85	85	85

		Question 7	Question 8	Question 9	Question 10	Question 11	
		If you asked for assistance did you get it when you needed it?	**Did you feel you understood what was happening in your care?**	**Were things explained to you in a way that you could understand?**	**Were you as involved as you wanted to be in decisions about your care?**	**How would you rate your overall experience?** **0 is very bad and 10 is excellent.**	**Overall**
		Your Velindre Experience 23/24	VCC - Friends and Family	Your Velindre Experience 23/24	Your Velindre Experience 23/24	Your Velindre Experience 23/24	
Integrated care	444	99	99	100	99	96	**97**
Operational services	657	92	92	91	92	89	**91**
Pharmacy	53	100	100	100	100	93	**97**
Radiation services	433	99	100	99	100	99	**99**
SACT	462	98	97	98	98	93	**96**
Overall		**98**	**97**	**98**	**97**	**94**	**96**
Benchmark		85	85	85	85	85	92

A breakdown of question 5 identified only 3 surveys completed, and only 1 person felt wait in pharmacy was too long.

Question 5: During your most recent visit to Velindre Cancer Centre, how did you find the waiting time?

Available answers	Responses	Score (%)
Shorter than expected	0	0.00%
About right	2	66.67%
A bit too long	0	0.00%
Much too long	1	33.33%
Total	**3**	**100%**

We asked **You said** **Together we**

You said	We did
"It would be nice to be able to buy snacks while waiting for Clinic"	New coffee shop has now opened in the outpatient's waiting area.
"Unclear signage indicating baby-changing facilities"	We have added baby-changing signs to the toilet doors.
"Waits for blood tests in Outpatients"	Another phlebotomy chair has been added to increase capacity and reduce waiting times.
"The food could be improved (First Floor Ward). More vegan options on the menu"	New menus have been introduced following consultations with patients and staff.
"Bookings sometimes get confused wrong appointment times"	A root and branch review of all administrative processes has been undertaken, and an improvement plan is in progress.
"More patient toilets in new hospital"	New hospital plans have now taken this into account.
"Need early access to leaflets & more info about the process & how it works"	We have undertaken a full review of all information leaflets and made these available to patients at all stages of their cancer journey.
"Waiting times are ridiculous long beyond appointment time"	We have undertaken a wholesale review of outpatient clinics and made a number of improvements including introducing more clinic rooms to help ease the pressure.
"Later appointments for the Therapies Clinics"	Following feedback from patients we have introduced an evening clinic.

3.1 Velindre Cancer Service – Patient Engagement

During 2024 the Trust has continued to embed its patient engagement culture offering a wide range of opportunities through its Velindre Voices structure, Volunteers Service, Patient and Carer Partnership Board (PCPB) and through formal consultation opportunities.

Highlights

The Patient and Carer Partnership Board (PCPB) has strengthened.

A recruitment campaign in the Spring/Summer of 2024, the PCPB held their first formal meeting in November 2024. PCPB has engaged in the following:

- Llais Living with Cancer Report
- Value Based Healthcare Project
- Development of Trust's Integrated Medium-Term Plan (IMTP)
- Velindre Oncology Academy course development
- Serenity trial implemented in research areas such as Cardiff University

3.2 Welsh Blood Service – Donor Experience

The Welsh Blood Service values all donor feedback received in helping understanding both successes and further opportunities to improve. We capture, analyse and trend our donor experience feedback, and share it, along with actions taken in response, with our donors, their families and staff in line with the requirements of the Duty of Quality. These are the results of the Civica Surveys and digital on-session feedback forms.

11,000 (12%) donors provided feedback during this period with an overall satisfaction score of 98%.

Feedback about your Experience

Satisfaction score	Friendly & Welcoming	Helpful & Knowledgeable	Compassionate & caring	11,000 donors provided feedback
98%	100%	100%	100%	

	Question 1	Question 2	Question 3	Question 4	Question 5	Question 6
	On a scale of 1-5 how satisfied are you with your overall experience within the collection clinic	**Based on today's visit did you find staff welcoming & friendly?**	**Based on today's visit did you find staff helpful & knowledgeable?**	**Based on today's visit did you find staff professional, compassionate & caring?**	**Based on today's visit did you feel you were treated with dignity & respect?**	**Based on today's visit were you provided with enough info about the donation process?**
	Compliments and Concerns. West Team.	Compliments and Concerns. West Team.	Compliments and Concerns. West Team.	Compliments and Concerns. West Team.	Compliments and Concerns. West Team.	Compliments and Concerns. West Team.
WBS	98	100	100	100	100	100
Overall	**98**	**100**	**100**	**100**	**100**	**100**
Benchmark	95	95	95	95	95	95

	Question 7	Question 8	Question 9	Question 10	Question 11	Question 12
	Based on today's visit did you received adequate emotional & physical support?	**Based on today's visit did you find a good standard of hygiene & cleanliness?**	**Based on today's visit did you feel safe?**	**Based on today's visit do you feel you were offered quality of care?**	**Based on today's visit are you satisfied with the venue & facilities?**	**Based on today's visit were you satisfied with the snacks and beverages available to you?**
	Compliments and Concerns. West Team.	Compliments and Concerns. West Team.	Compliments and Concerns. West Team.	Compliments and Concerns. West Team.	Compliments and Concerns. West Team.	Compliments and Concerns. West Team.
WBS	100	100	100	100	99	100
Overall	**100**	**100**	**100**	**100**	**99**	**100**
Benchmark	95	95	95	95	95	95

We asked **You said** **Together we**

Based on feedback received, operational managers have:

- Reviewed the cleanliness of Mobile Donor Units (MDU) to ensure a high standard of cleanliness is always maintained.
  - The MDU's receive a deep clean weekly when the vehicle is available to facilities. The team clean the surfaces and equipment every day and between donors as appropriate.
- Supported staff to undertake Welsh language learning.
  - All staff who have expressed an interest in progressing their language skills have been supported with either study leave or fixed working days to allow them to attend.
- Provided mobile heaters for Collections Teams.
  - New Dysons purchased and sent out to both Trailers.
- Undertaken a full review of venues to identify and address issues that would affect donor experience.

Welsh Blood Service undertakes a monthly email survey to evaluate donor satisfaction from initial contact to post-donation experience. The goal is to improve donor retention. Survey results are reviewed, and the overall satisfaction score is reported to the Welsh Government.

Satisfaction Statistics

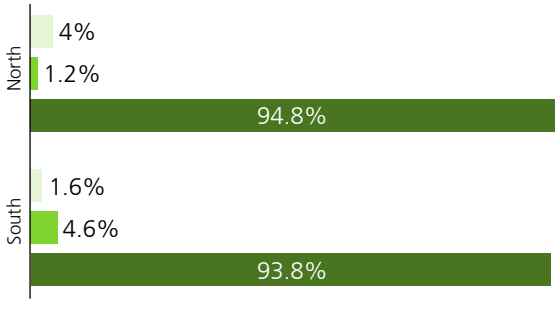
As part of our questionnaire, we ask respondents a number of questions about the service we provide. Respondents are asked to score these services, with six being totally satisfied and one being totally dissatisfied.

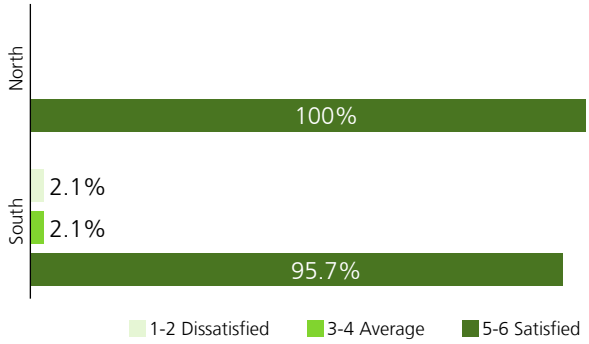
Donor satisfaction for those who had successfully donated was 97.1%

Overall (734)	97.1%
N.Wales (157)	99.4%
S.Wales (577)	96.5%

Donor satisfaction for every respondent, including incomplete donations

Overall (802)	94.0%
N.Wales (173)	94.8%
S.Wales (629)	93.8%





Donation day

Donation day experience	Process comfort	Process duration
96.2%	96.2%	97.1%
85.1% scoring 6/6	87.4% scoring 6/6	90.8% scoring 6/6

Donor engagement and sentiment

Contact centre experience	Feeling valued	Eligibility info. Available
96.1%	95.7%	93.3%
76.4% scoring 6/6	83.8% scoring 6/6	80.3% scoring 6/6

Venues

Cleanliness	Accessibility
97.4%	94.2%
84.8% scoring 6/6	81.1% scoring 6/6

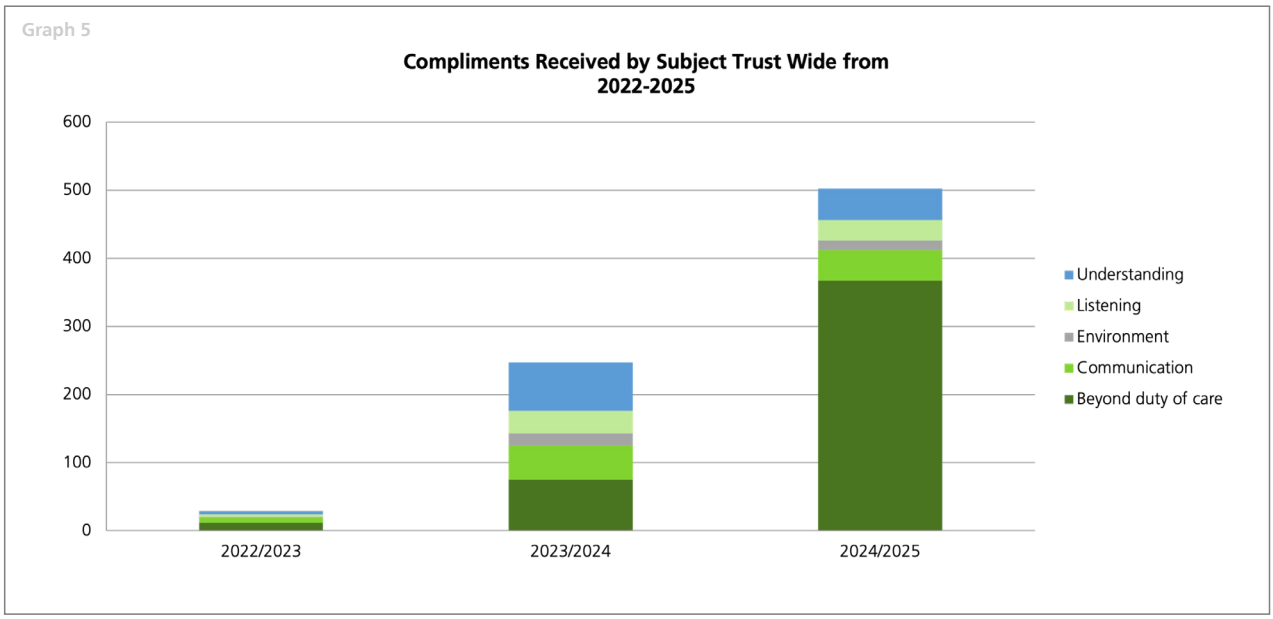
4. Trust Overview – Compliments

For 2024/25 a total of 423 compliments were recorded on Datix. This is an increase from the previous year (365) following work to improve recording of compliments on Datix.

374 compliments were received by Velindre Cancer Service and 49 compliments were added to Datix by Welsh Blood Service.

Work is being undertaken in WBS regarding recording compliments on Datix as other systems within the division are used for this gathering this information.

Graph 5



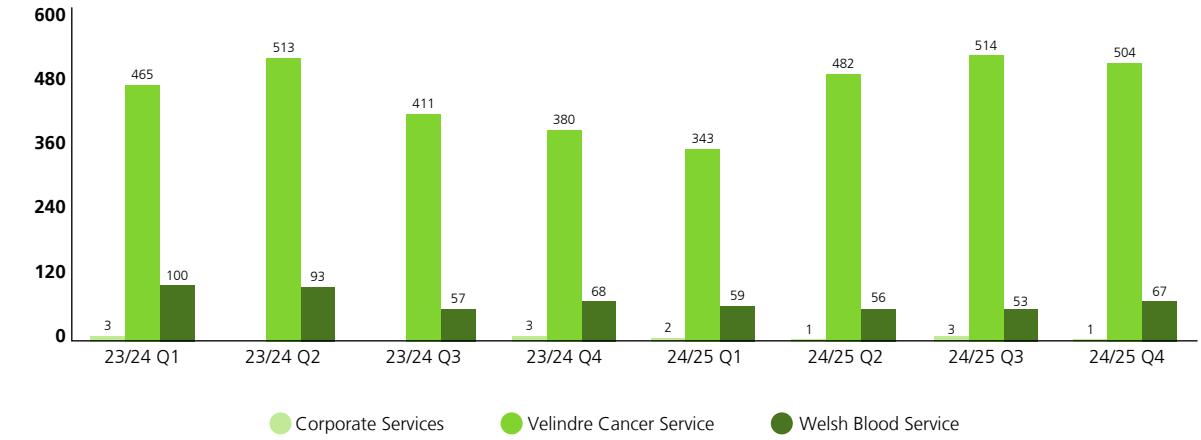
4.1 Incidents – Trust-Wide Overview

Patient and donor safety incidents are any unintended or unexpected incidents, which could have, or did, lead to harm for one or more patients/donors receiving healthcare. Incidents are all reported and reviewed at service level, through Quality and Safety leads and the Quality and Safety Hubs.

2024-25 Trust Incident Summary

Total incidents reported	Corporate services	Velindre Cancer Service	Welsh Blood Service
565	7	1843	235

Graph 6



Analysis of incidents is provided per Division later.

5. National Reportable Incidents (NRI)

Analysis

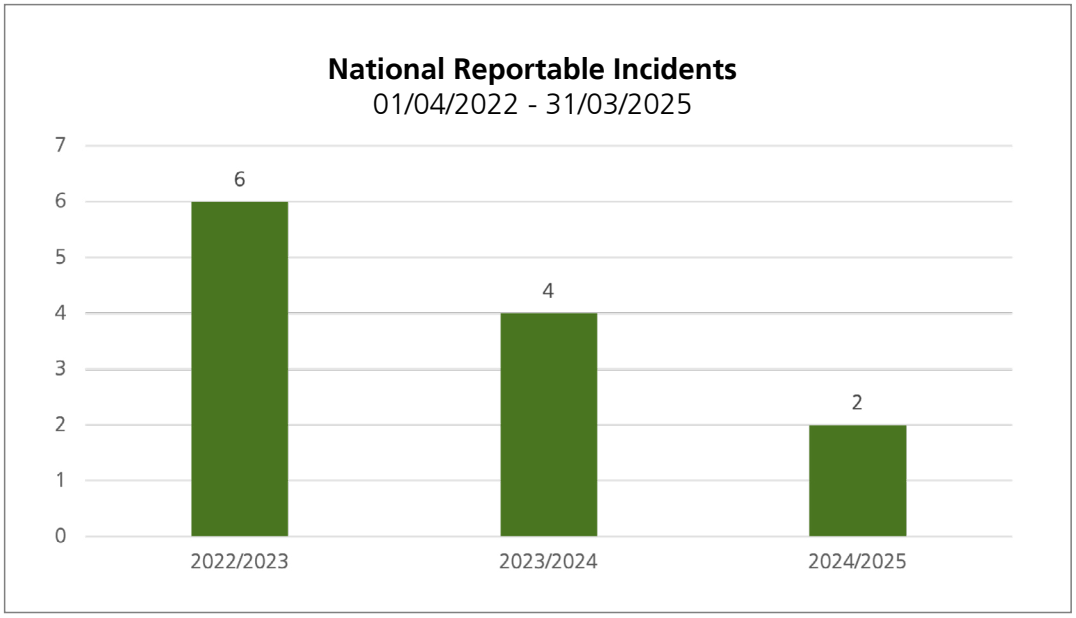
There have been 2 Nationally Reportable Incidents in 2024/25, both occurring in January 2025. This is a reduction in comparison to 2023/24, which had 3 national reportable incidents.

Both incidents met the criteria for severe harm and were reported to the NHS Executive in line with national policy requirements. One investigation remains ongoing, and one investigation closed within the 30-day agreed timescale.

Learning Identified

- Improved communication between multidisciplinary teams.
- Ensuring Clinical staff utilise multiple systems to obtain patient clinical information.

Following the NRI incidents, the Trust undertook in-depth investigations, and developed improvement plans to prevent similar events from occurring.



Severe Harm:

A service user experiences a permanent disability or loss of function and the NHS care did or may have contributed.

Death:

A service user dies and the NHS care did or may have contributed to the death

5.1 Incidents – Duty of Candour

Since the Duty of Candour was enacted in April 2023 there has been an increase in incidents reported as our processes have become embedded into incident management.

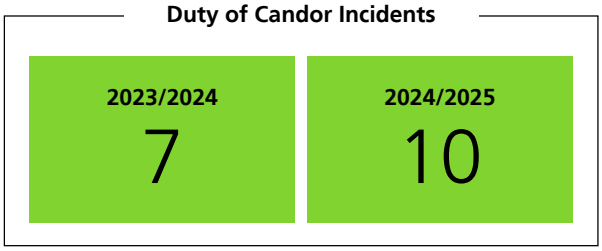
In NHS Wales, the Duty of Candour is a legal requirement for organisations to be open and honest with service users when something goes wrong during their care or treatment, potentially causing harm. This duty stems from the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

In March 2025, an internal audit commenced, field work to provide assurance that the Trust was compliant with the requirements of the Duty of Candour.

The findings of the audit will be reported in quarter 2 of 2025/2026 reports.

Analysis

10 incidents during 2024-25 have been managed under Duty of Candour meaning they potentially caused moderate harm or above, with 2 of the incidents also being reported as a National Reportable Incident meaning they potentially caused severe harm. 6 investigations were closed, and 4 Duty of Candour incidents are currently under investigation, at the end of 2024-25.



Themes noted

1 | Use of email for communicating urgent medical information. The risk has been recorded on the risk register and a task and finish group established and work ongoing to develop new processes and ways of working.

2 | Lack of robust process for ensuring all blood test results are reviewed in a timely manner. There is a risk in place on the register and a task and finish group established and work is ongoing to develop new processes and ways of working to ensure that all blood results are reviewed in a timely manner.

3 | Use of electronic clinical systems – numerous issues identified including multiple systems in use that do not interface with each other; multiple clinical systems in use by different professional groups in isolation causing information to be missed; and issue surrounding important clinical information being missed on Welsh Clinical Portal due to the number of non-clinical annotations.

4 | Staff knowledge and education around Granulocyte Colony Stimulating Factor medications. Training and education being provided by the Education Team.

5 | Transferring of acutely unwell patients between departments.

6 | Contact with SACT Treatment Helpline and management of patients.

7 | High clinic workloads and environmental interruptions increase the risk of errors during the prescribing and verification processes.

Improvement Actions

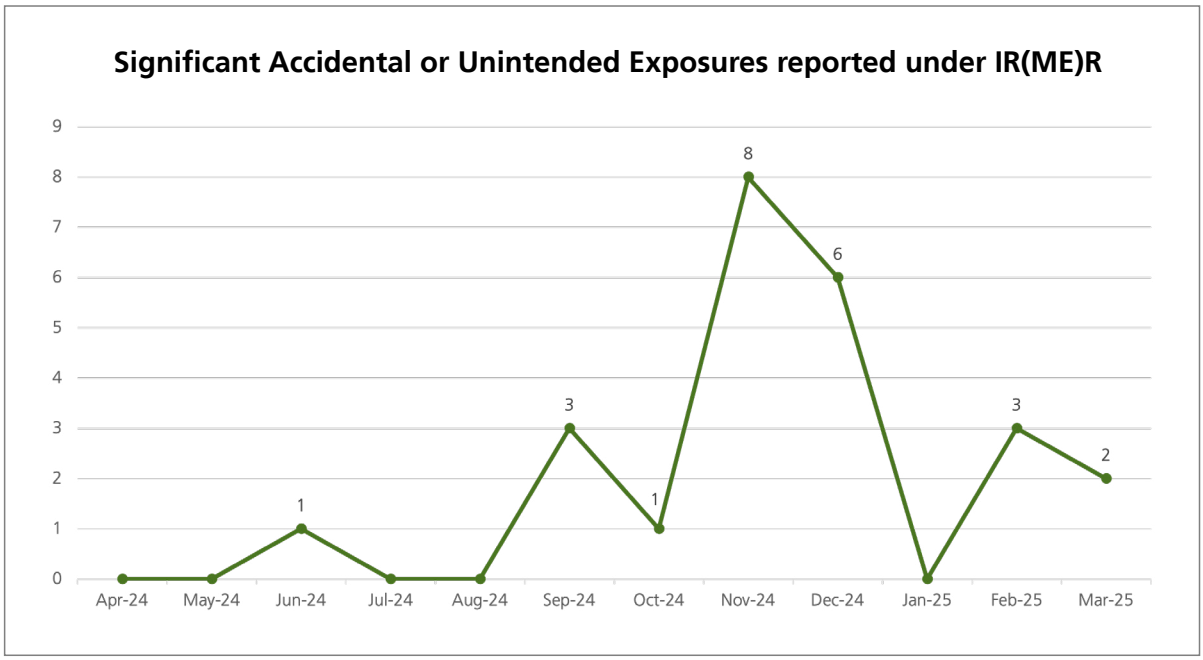
Improvement plans have been developed based on the investigation recommendations. These will be monitored via the Trust Regulatory Tracker and Quality & Safety governance processes. The findings and learning for these investigations will be reported in the future quarterly reports.

5.2 Ionising Radiation (Medical Exposure) Regulations (Ir(Me)R) Reportable Incidents

24 Significant Accidental or Unintended Exposures (SAUE) under the Ionising Radiation (Medical Exposure) Regulations IR(ME)R were reported to Health Inspectorate Wales (HIW)

On August 21st 2024, there was a change to HIW IRMER notification criteria guidance resulting in an increase in the number of incidents meeting reporting requirements. The change in guidance (reverting back to reporting 3 failed images in a fraction) has resulted in a significant increase in reportable incidents in Radiotherapy Physics due to CBCT technical faults.

RT Physics have long standing mitigations to deal with the Elekta imaging fault, which have been discussed in depth with the UK Health Security Agency (UKHSA). This will improve when the Linacs are replaced.



Radiotherapy Physics lead investigations:

- Two due to issues with the imaging system on the Elekta treatment machine.
- One due to repeat imaging due to an image reconstruction issue on the Varian treatment machines.

Radiotherapy Service lead investigations:

- Planning scan needed to be repeated twice to obtain an appropriate dataset (3 scans in total, including the intended scan)

5.3 Sharing Learning From Incidents & Improving Culture

The ethical duty of openness applies to all incidents, and any failure in care that has occurred whilst being treated through the healthcare that we provide.

The Duty of Candour applies to incidents whereby moderate and greater harm has occurred.

Our clinical colleagues and support teams have enabled the Trust MAKE IT SAFE reviews to effectively identify improvements by raising and reviewing incidents in line with the Trust Incident Framework. All staff involved in the Make it Safe process have commended the supportive Just Culture collaborative approach.

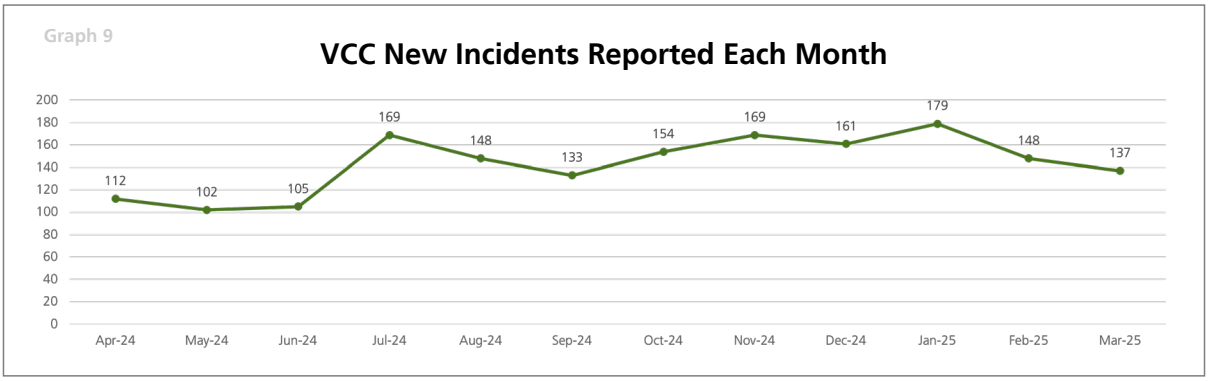
On completion of the full investigation process, a Learning from Review event is held, and feedback is provided to all those involved, plus the wider teams, to share the investigation outcome and learning.

A speedy cascade is one mechanism used to share key learning and messages identified through patient safety incidents and follows rapid action implementation after an incident has occurred.

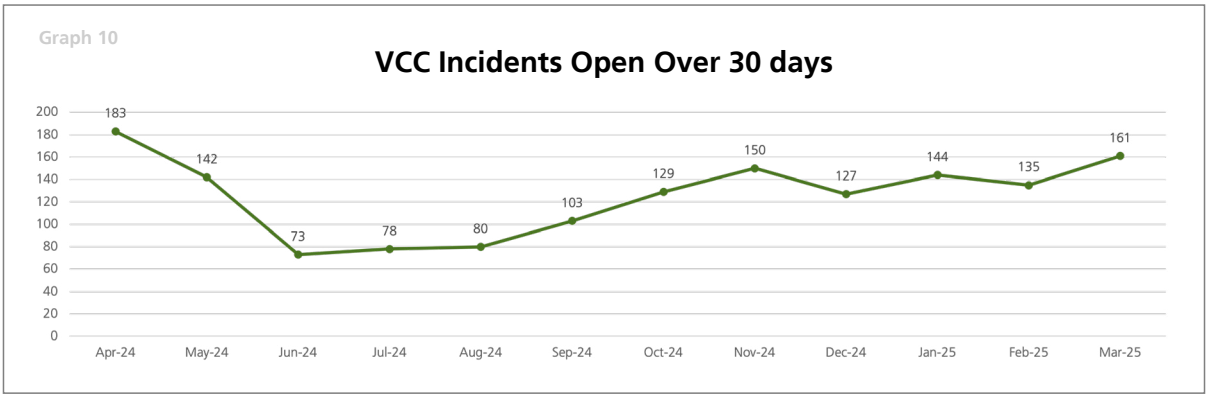
Make it safe meetings	Learning from review events	Speedy cascades
16	4	37

5.4 Velindre Cancer Service – Incidents

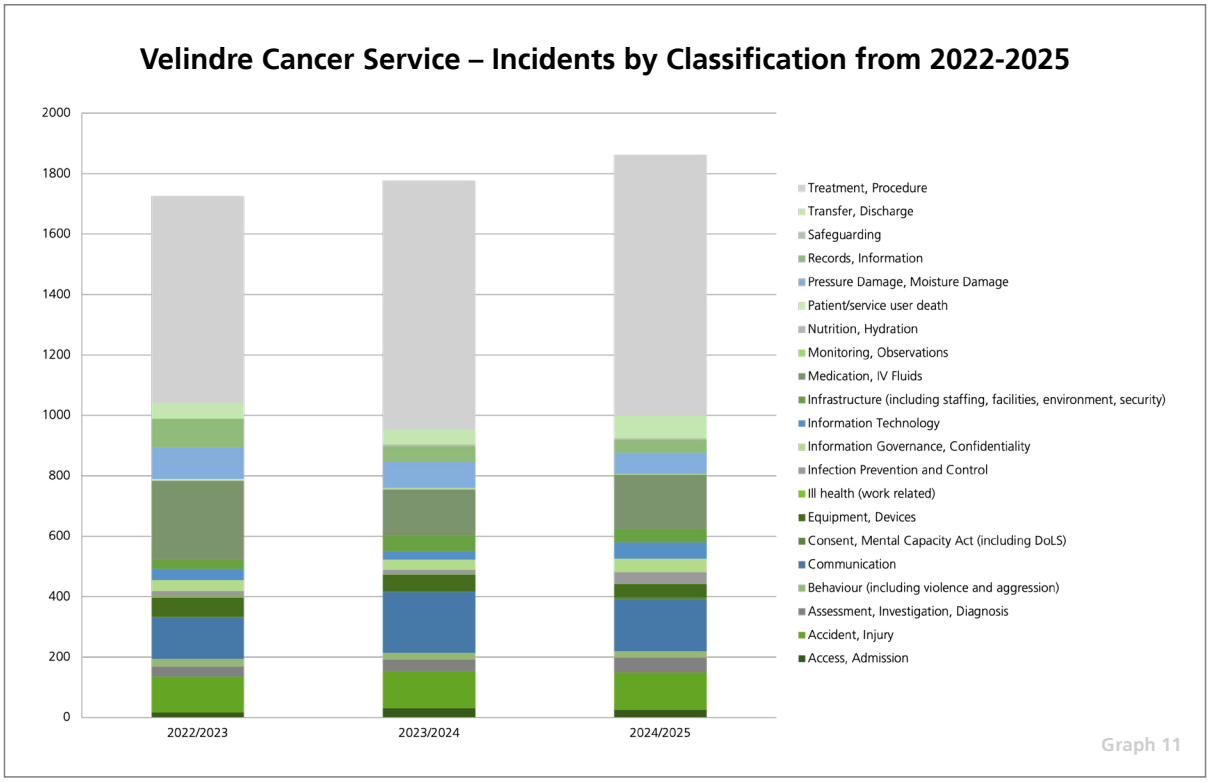
Graph 9



Graph 10



Graph 10 following a successful push to reduce the number of incident open over 30 days across the cancer services during the 1st quarter, we are seeing a gradual increase once again. Work is ongoing with departments to manage this, including regular reports and training and education.



The graph identifies that the highest number of incidents related to treatment and procedure which is in keeping with previous reporting periods.

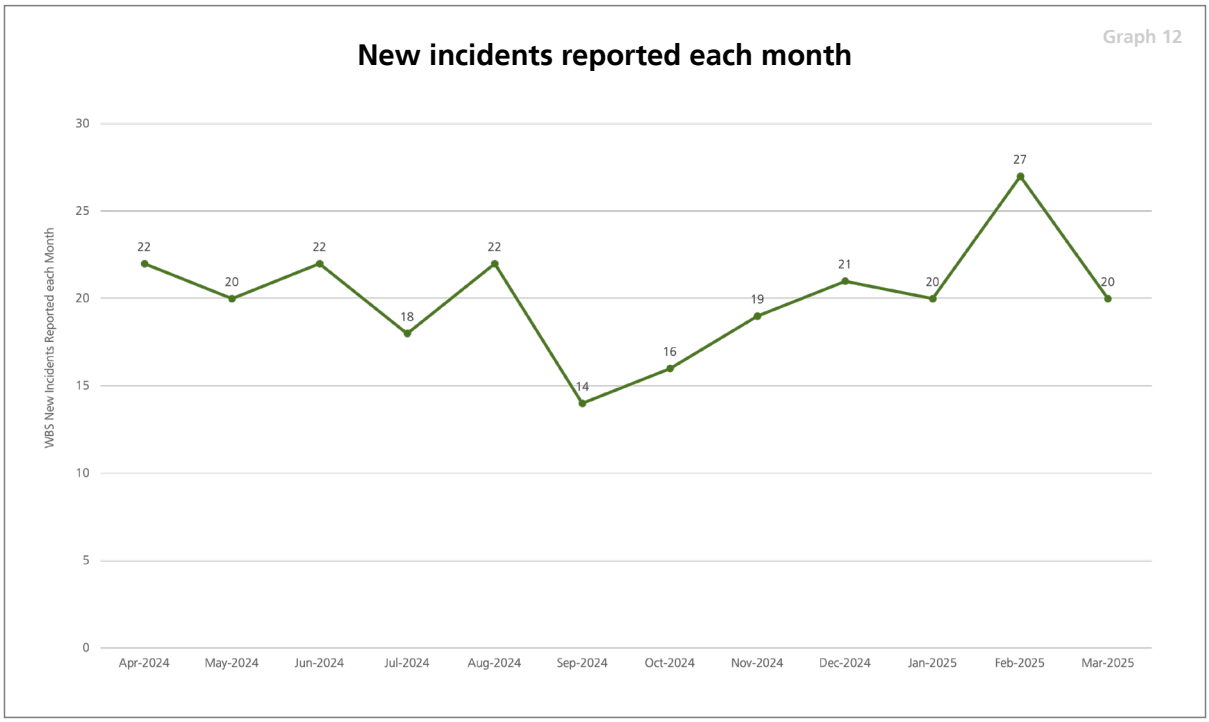
Themes, Learning And Improvements

- Medication Incident deep dive review: Undertaken in January 2025 due to an increase in medication administration errors at VCS SACT Units between September & December 2024 (10 incidents). This identified that these incidents were occurring in the "unplanned activity" work such as where there is an unwell patient, delay in treatment on unit, transport delays etc.
- Themes identified related to inpatient areas through incidents, concerns, and mortality reviews surrounding communication of care, and roles and responsibilities of inpatient staff such as management of fluid balance charts.
- Themes emerging (VCS & Community related) from incidents and concerns related to end connectors not being attached to PICC lines. This necessitates removal and reinsertion of the PICC line. Measures have been taken to address these issues through education and 'speedy cascades' both with VCS and community teams & shared with Once for Wales learning and advisory group for national learning. There have been no incidents or concerns related to this in January to March 2025.
- A theme was identified around the telephone helpline management of patient symptoms when they are unwell (with a high temperature). Management of specific symptoms have been clarified and processes updated and shared with the treatment helpline staff. A speedy cascade has been shared with all VCS staff. Referral routes into Health Boards SDEC (Same Day Emergency Care) has been strengthened resulting in patients not always needing to self-present in the Emergency Department.

- Theme continues within incidents around the use of emails, particularly high-volume email traffic, and use of emails for clinical communication. An email working group has been established and met to identify solutions and improved ways of working.
- Learning and improvement has been made in relation to transcribing information and the importance of documenting patient information directly on to their electronic casefile (Welsh Clinical Portal) including SACT toxicities and prescribing intent. Learning has been shared via speedy cascade to all clinical staff regarding updating a patient's weight when prescribing chemotherapy.
- Improvement actions include education and clinical audits.

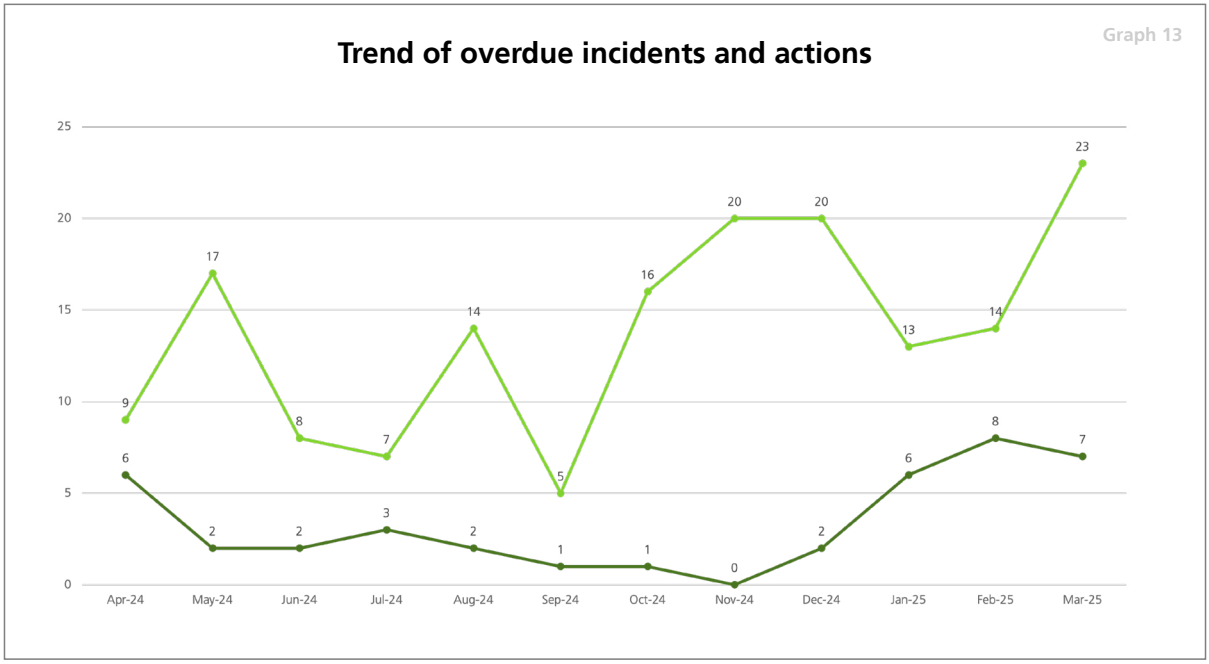
5.5 Welsh Blood Service – Incidents

Incidents which may result in harm to donors, patients, or staff are reported in Datix Cymru for consistency across the Trust.



Analysis

Graph 12: Incident reporting via Datix shows variation across the past 12 months, with a peak in February (27 events). The main category for Datix reports is accident and injury. Overall, the number of reports is low, with no significant trends identified. Monitoring of reports for trends is continuous.



Overdue Activity Performance Trends

Graph 13: The number of incidents exceeding the target date for closure (30 days) has remained low throughout the year.

The rise experienced from December onwards is potentially due to staffing pressures within the Clinical Services team.

Overdue actions fluctuate from month to month and often reflect a high workload versus staff availability; occasionally a single event may result in one person managing several actions to address root cause.

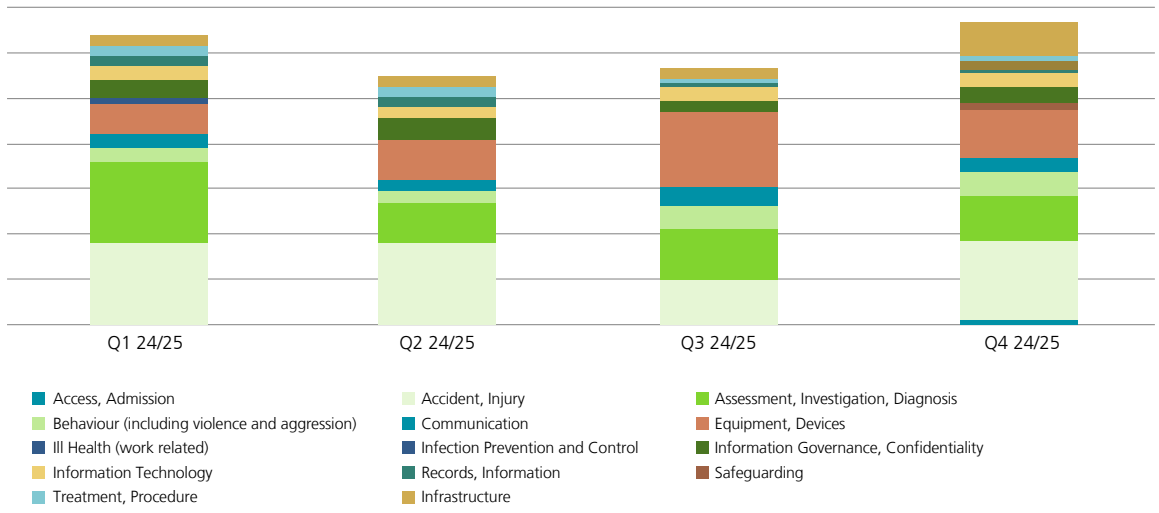
Learning and Outcomes

Senior Leadership Team are advised of these statistics monthly and are responsible for following up with their teams.

Reasons for delays are explored, and where necessary workloads and actions are reassigned to support timely incident management.

Managers must assess risk and submit a formal extension request where actions have been open longer than expected.

Graph 14



Analysis

Graph 14: The most frequently reported themes across the year are:

Accidental injury (red): Information on accidental injury reports can be found in the Health and Safety section of the report.

Equipment & Devices (orange): These errors are often isolated to a piece of equipment (no trend). Where operator error is involved, these events are trended against individuals to ensure there are no competency/training issues.

Assessment, investigation, diagnosis (green): These usually related to 'late donor information', which is subjective to each donor, and occasionally to donor acceptance errors.

Learning and Outcomes

All events have been investigated, with no significant trends identified.

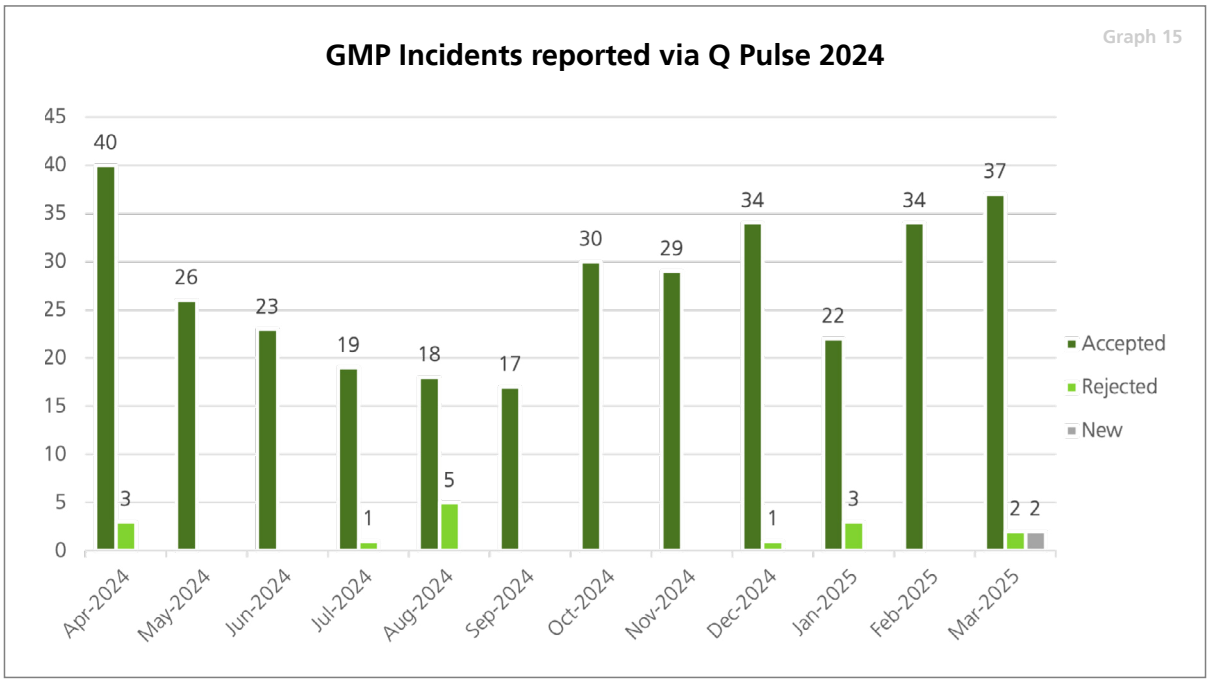
Where 'late' (post-donation) donor information has been received the decision to accept the donor was usually correct, based on information available at the time of donation. Where a donor acceptance error has been made these have been fully investigated:

The process for assessment of travel related risk relies on individuals making assessment using the Donor Selection Guidelines (DSG) and Geographical Disease Risk Index (GDRI)

The DSG and GSRI can be complex, therefore assessing donor travel risk and whether a donor is eligible based on any medication they are taking is not always straightforward.

WBS is working with an external company to develop an automated digital tool that reduces complexity by analysing answers to donor eligibility questions then advising on whether to defer to accept or defer the donor.

Good Manufacturing Practice (GMP) Incidents are reported into the Q-pulse electronic Quality Management System and monitored as a critical part of the overall Quality Management System (QMS), in line with regulatory standards.



Analysis

The number of GMP incidents reported across the year is subject to variation.

The decline to September 2024 was attributed to the decision by WBS IQSH to report events such as 'clip errors' only when there is an identified trend with an individual. The process for managing clip errors is proceduralised and therefore no process deviation has occurred.

The sharp increase from January relates to manual transcription errors within antibody screening reports; this has been subject to a holistic root cause analysis investigation and barrier analysis.

Learning and Outcomes

Transcription errors are not unexpected where manual processes are involved, however the complexity of manual reporting processes, combined with an ageing and underdeveloped IT system, and an inadequate verification process have been identified as the main causes of these errors. Contributory factors include high workload and operational pressures, working environment, senior staff changes and skill gaps (caused by absence of experienced staff).

A designated quiet area for report writing and authorisation has been implemented. Additional actions to reduce recurrences include implementation of a temporary digital solution, adoption of a two-person writing and authorisation process, and reallocation of workload. New staff are also being recruited to support the operational workload within this laboratory

5.6 Welsh Blood Service – Externally Reported Incidents (SABRE/MHRA)

Analysis

18 adverse events were reported externally to MHRA via the SABRE portal this year.

All events were risk assessed and made safe prior to full root cause analysis investigation; where necessary this involved a multi-disciplinary team of subject matter experts and members of the Clinical and/or Quality teams.

Corrective and preventive actions were reviewed by relevant members of the Divisional Integrated Quality and Safety Hub before submission to the Regulatory body.

Theme	Outcome / Improvement
Donor travel risk not assessed correctly	• Exploration of implementing a digital tool that allows donors to verify their travel history; this will reduce reliance on memory and verbal communication. • Travel assessment complexities are being discussed at national level, to try to address the challenges of travel related queries and explore ways to empower staff with the tools and guidance necessary to make accurate assessments.
Transcription errors on manually generated patient reports issued to customer hospitals	• Implementation of a temporary digital solution that pre-populates reports. • Utilising a dedicated quiet space for report authorisation. • Development and delivery of a learning session. • Recruitment of additional staff to support laboratory workload.
Communication issues	• Updated guidance for staff regarding cross-functional activities. • Implementation of a discussion forum to ensure mutual understanding of systems/processes. • Pre-briefing discussions with auditors from other Divisions to outline, expectations, roles and escalation procedures.

Analysis

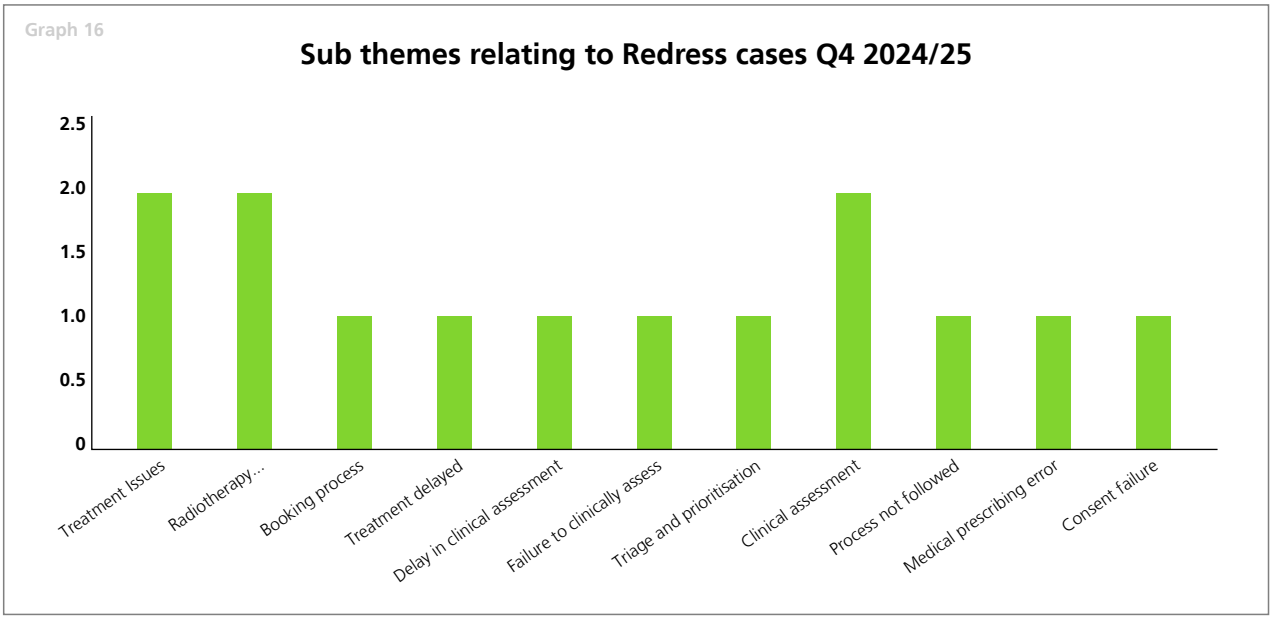
3 adverse events reported to the Human Tissues Authority (HTA) involved collection of stem cells by a 3rd party. These were reviewed and investigated, and root cause analyses and corrective actions have been reviewed by relevant members of the WBS Integrated Quality and Safety Hub.

Theme	Outcome / Improvement
One of three bags harvested was positive for skin bacterium. Risk to patient safety is low; these bacteria very rarely cause post- transplant complications, but this could not be ruled out.	• No patient harm. • Bone marrow harvest incurs such incidents as the needle being pushed through the skin may take skin into the needle which then can be transferred to the collection bag. • The centre that undertake stem cell collection on behalf of WBS are HTA and JACIE accredited centre; their contamination rate of 11% is in line with global rates for this procedure. The WBMDR will continue to monitor and report similar events to the relevant bodies.

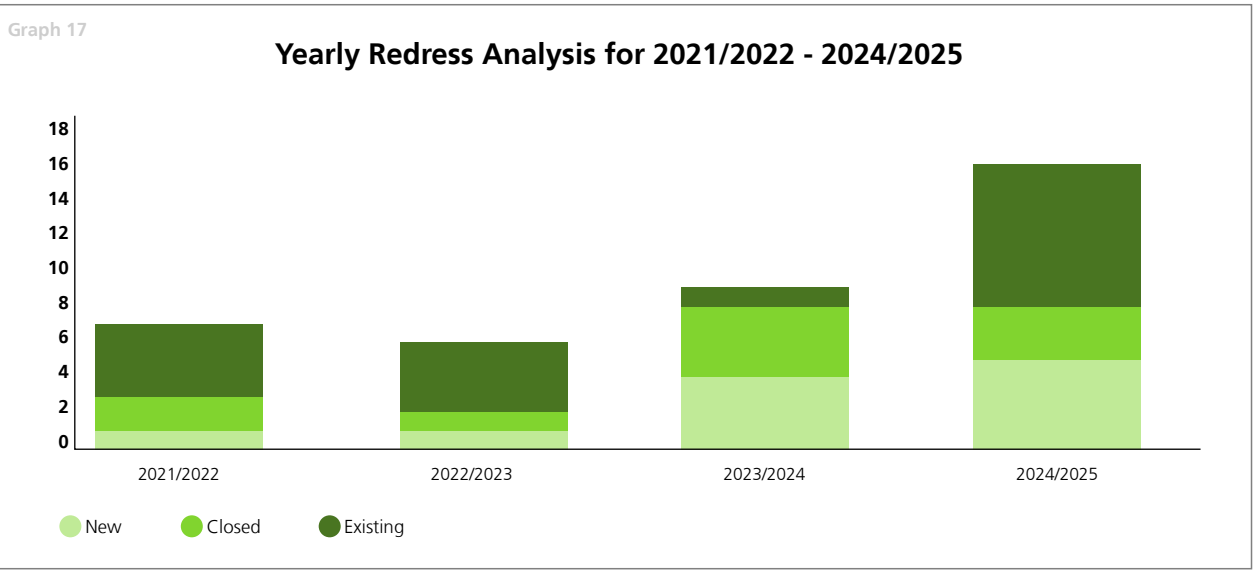
6 Redress

The Redress analysis for the reporting period illustrates an overall rise in Redress matters compared to previous years, following the introduction of Duty of Candour.

Graph 16



Graph 17



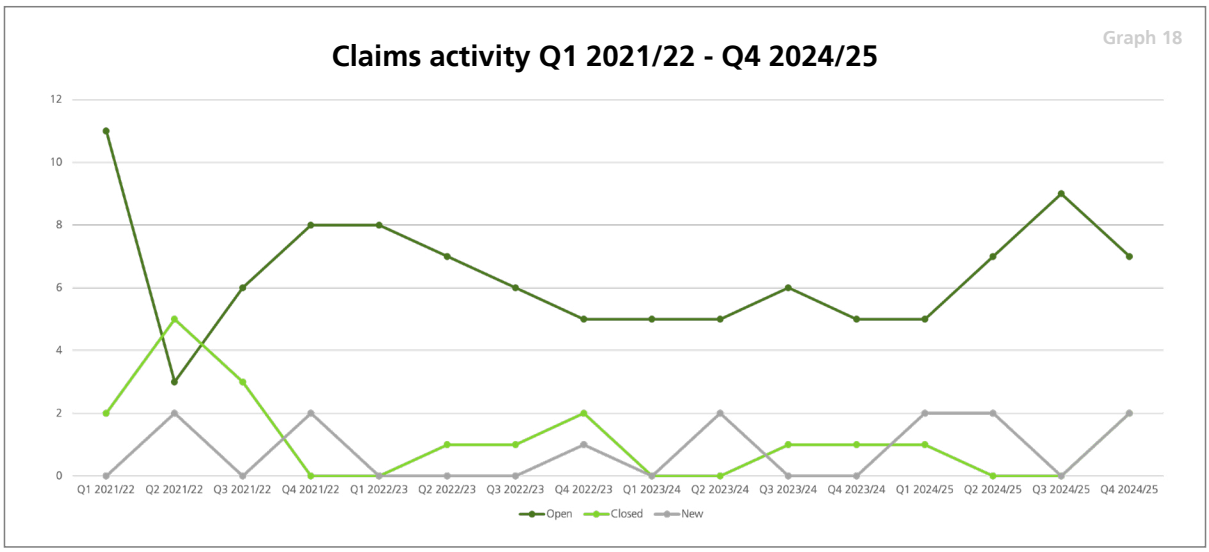
Quality Improvements made following Redress investigations

Development of an escalation pathway for urgent medical reviews	Enhanced Systemic Anti-Cancer Therapy training including assessing and completing the UK Oncology Nurses Society triage tool	Reduction on the reliance on emails to manage referrals with increased communication to escalate/ urgent clinical information
Introducing SpR and Junior Doctor handbooks	Strengthening the induction process for clinicians	Strengthening the referral processes
Implementing the patient discharge checklist	Implementing the Velindre Cancer Service Discharge Policy	Enhanced sepsis training and reflective practice learning
Implementing a SHO practical guide	SACT telephone review and audit	Improving training for secretarial staff

Redress Review

8 cases remain under investigation over 12 months from the date when the incident/complaint was reported. This exceeds the Welsh Government target to complete Putting Things Right matters within a 12 month period. There are a number of reasons for breaching the target, including:

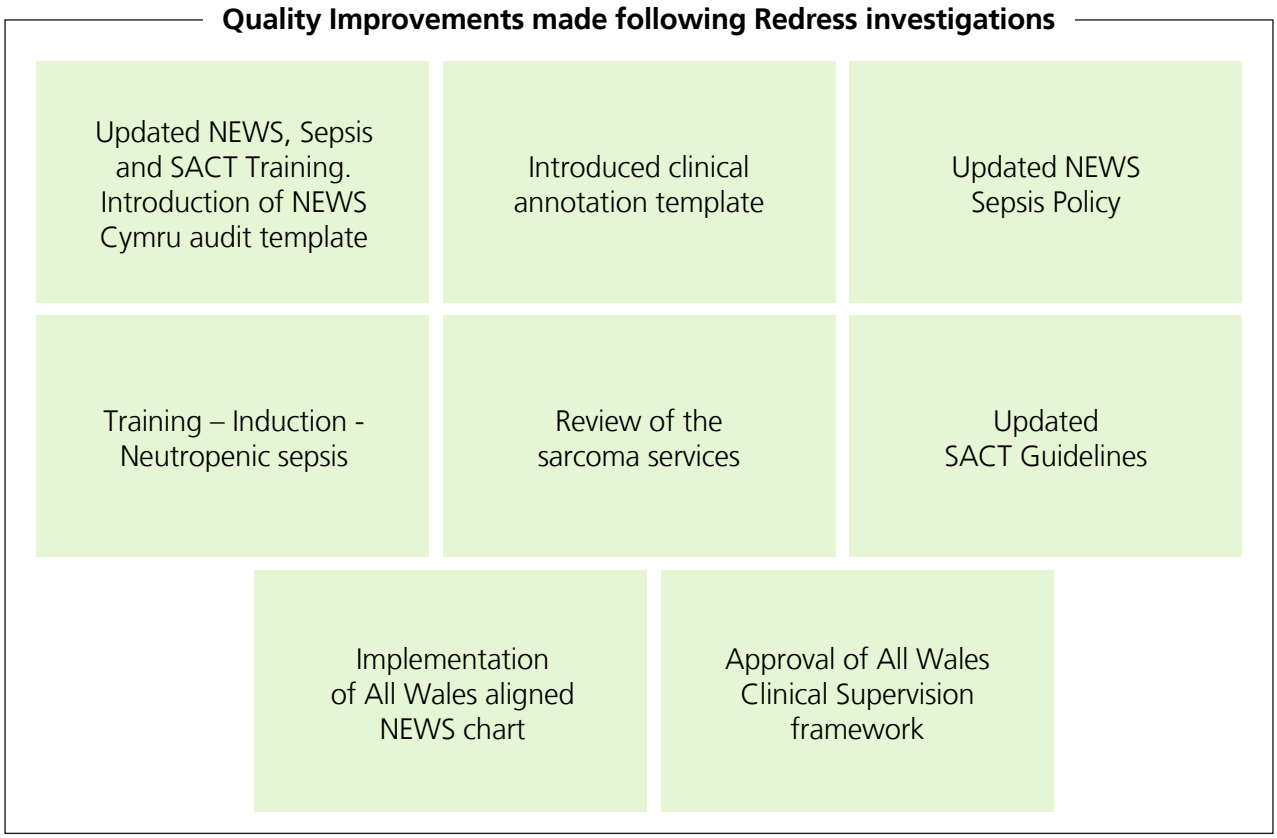
- Delays experienced in receiving Compensation Recovery Unit Certificates issued by the Department of Works and Pension due to misdirection. Without a valid CRU Certificate the case cannot proceed to settlement. Efforts are being made to identify the reasons to prevent undue delay in quantifying cases.
- Several PTR investigations have exceeded the target of 30, 60 or 90 days, due to complexity.
- Failure to follow PTR process and identify correct recipient / personal representative of deceased patient, culminating in delay in proceeding with Redress. A process has since been introduced addressing Next of Kin issues.
- Delay in receiving medical records from NHS providers.
- Instruction of independent expert - additional time is needed to identify suitability of expert and instruct on joint basis and await findings.
- Increase in workload of cases involving Redress, inquests and claims. The team has recently expanded to 2 part time Claims, Redress & Inquest Managers.



Graph 18 shows claims activity during 2024/2025:

- The Trust has 9 claims open at the end of the reporting period, which includes claims for clinical negligence and personal injury.
- During 2024/2025, 6 new claims were received.
- 3 claims were closed.
- There were no themes noted.

7.1 Claims Improvements



Key claims developments

- **Recruitment** of additional part time Claims, Inquests and Redress Manager.
- **Implementation of Lawtel** – an online platform providing access to case law, legislation, articles, and press coverage. It also provides the means to assist in quantify claims by reference to specific cases that act as a guide in reaching suitable offers of financial compensation.
- **Claims Audit** – Introduced during 2024/25, which now forms part of the governance arrangements in place. Carried out bi-monthly.

8 Inquests

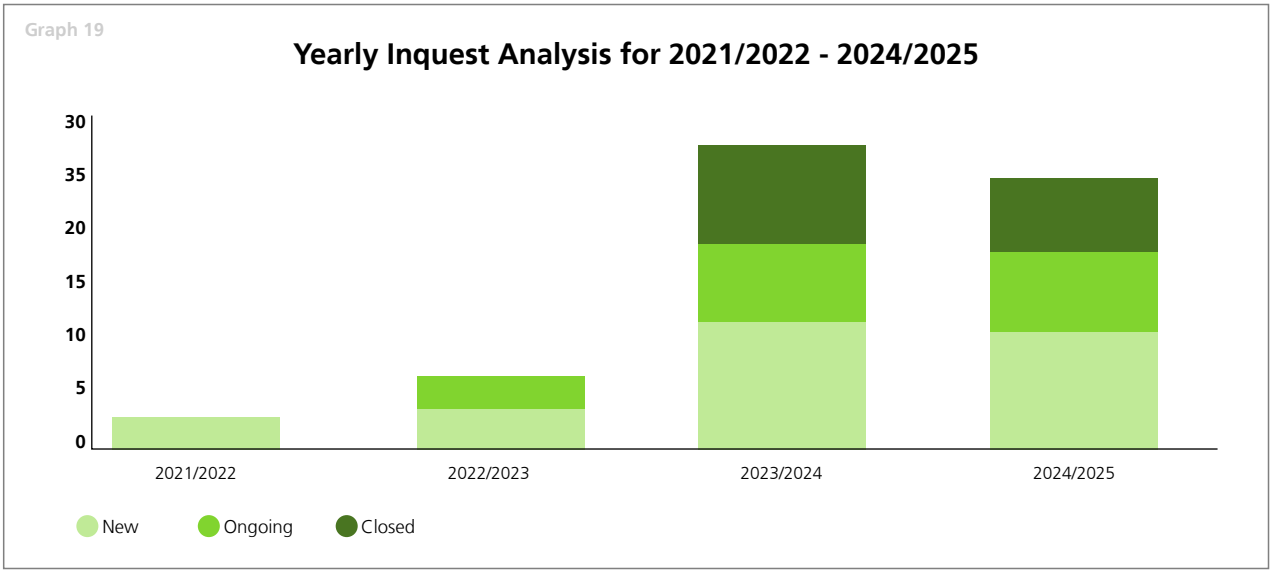
Analysis

Whilst there has been a rise in inquests being opened during the financial year, no trends, themes, risks or issues have been identified in relation to the Trust. Following one inquest, the family wished to highlight that they **"couldn't fault all the care and treatment … received. All the staff were brilliant".** This positive feedback demonstrates the level of care and treatment that is provided to our service users.

Activity during 2024/2025

- 12 new inquests were opened
- 8 inquests were closed - no issues were identified affecting the Trust

Graph 19



9 Mortality

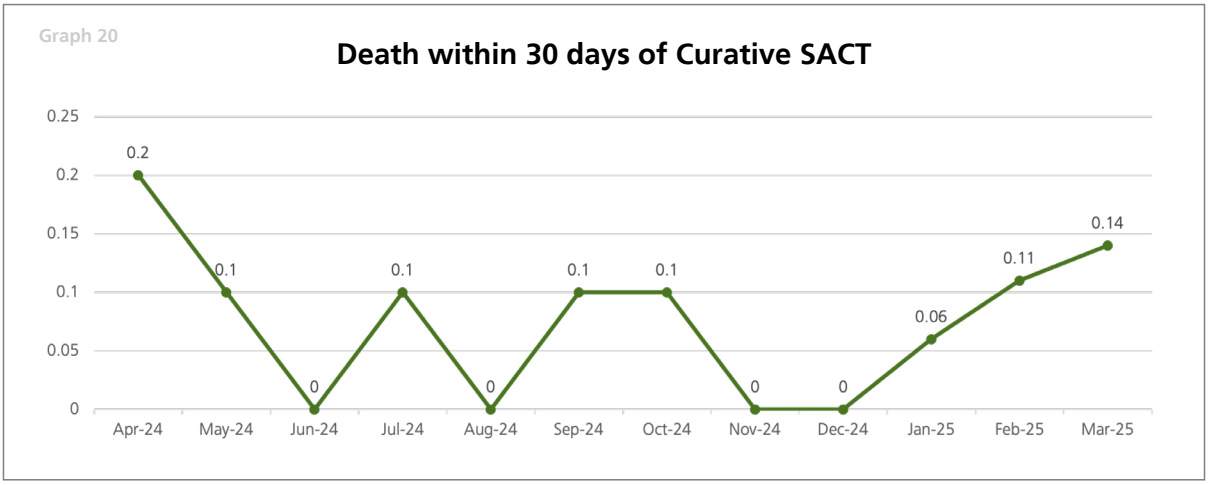
Analysis

SACT mortality data is collected and reported monthly. Although there is no benchmark for curative or palliative SACT, a 2% 30-day mortality rate from the 2008 NCEPOD report is commonly used for SACT overall, and VCS remains below it.

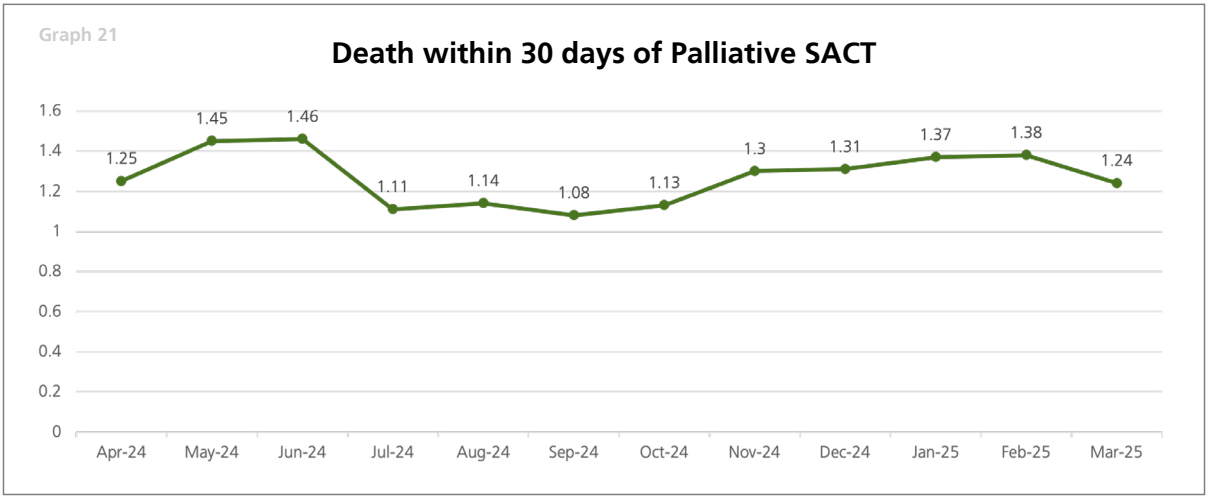
All SSTs now review deaths within 30 days of SACT, 30 days of palliative radiotherapy, and 90 days of radical radiotherapy. Each SST hold these meetings quarterly, are well attended with good engagement. Feedback from the SSTs is positive of the learning and reflection opportunities the meetings provide.

Radiotherapy data validity issues prevent full reporting through to PMF, but the Data and Insight team aims to resolve this by quarter 1 2025/26. However, 30- and 90-day radiotherapy mortality data continues to be captured and reviewed by the mortality team and SSTs.

Graph 20



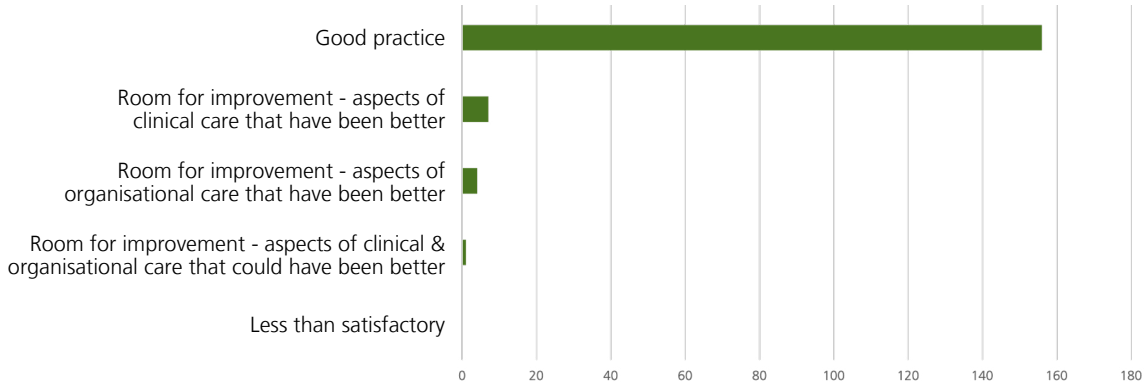
Graph 21



Themes for Learning and Improvement

- Develop SOP for patients within specific SST who can be referred to Virtual Assessment Pathway clinic, this will increase capacity within SST outpatients' clinics.
- Consideration of the performance score and frailty state of patients: this needs to be included in radiotherapy requests from DGH's, and practitioners and prescribers need to be more mindful when considering and prescribing SACT.
- Communication with health care partners: improvements required related to oncology communication with Primary Care and Health Boards and the need to communicate important information in letters as opposed to documenting on Welsh Clinical Portal only.
- Management of raised blood glucose: education and guidelines updated for treatment helpline staff.
- Sarcoma service: Delay in patients being referred to VCS (due to delays in biopsy and delays in MDT process). VCS involved in work with Health Boards to review the pathway.

Graph 22



Analysis

Velindre Cancer Service (VCS) is compliant with all aspects of the Medical Examiner Service (MES) – reviewing cases referred to VCS and feeding back findings and identifying learning.

All inpatient deaths are reviewed independently by the MES and internally at VCS at the monthly Inpatient Mortality Review Meeting.

No clinical concerns were identified from MES or within the VCS mortality reviews.

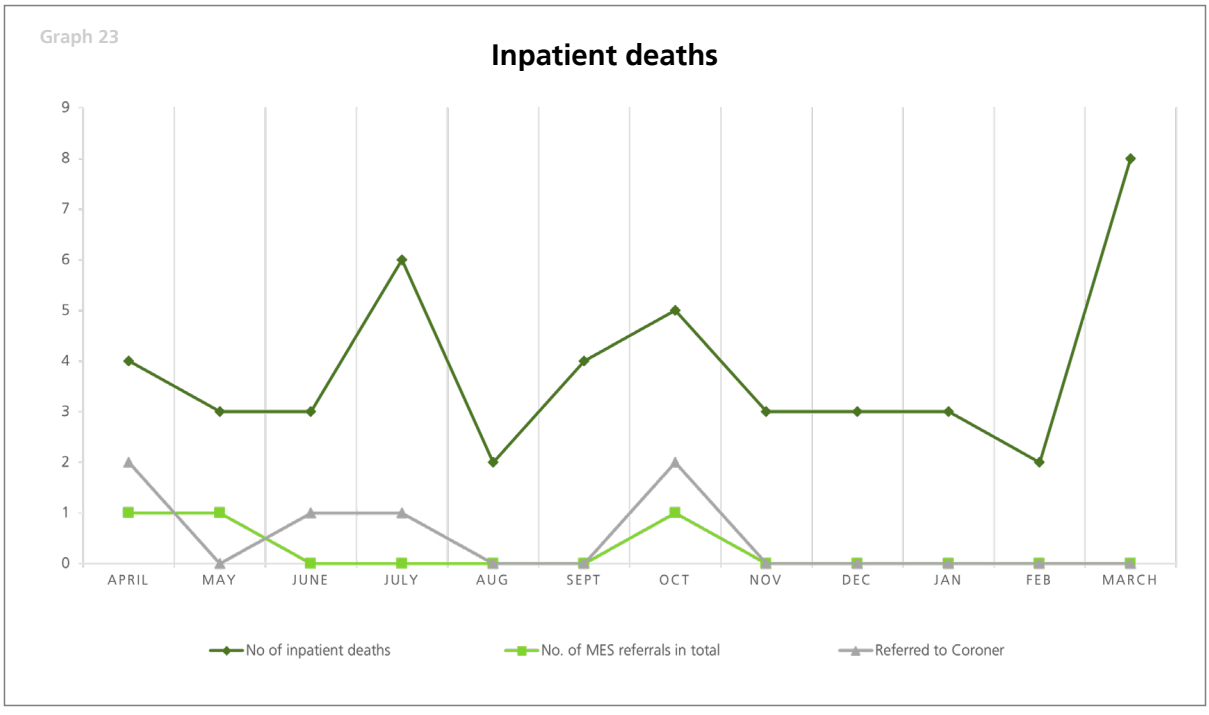
There was an increased number of patients who died in July 2024 and March 2025, but no concerning themes or clinical concerns identified.

Cases referred to the Coroner were not related to care and treatment received in VCS.

Themes for Learning and Improvement

Although no clinical concerns were identified from the MES, opportunities for learning were identified from the inpatient mortality review meeting:

- Ensuring assessment proforma is completed if a patient is admitted to the ward directly (i.e. not via assessment unit).
- Unwell patients should not be transferred between departments if procedure / treatment required can be undertaken at the bedside.
- Improvement needed in the communication between hospitals and VCS when transferring patients for emergency treatment, to ensure decision making regarding the appropriateness for treatment before the patients is moved.
- Development of stoma care education for VCS nursing staff by ANP with extensive surgical experience and Tissue Viability Nurse leading.
- Improvements made in the safety and storage of oxygen procedures on the ward.



10 Clinical Audit – AMaT Clinical Audit Projects

The Clinical Audit department ensures the Cancer Centre can demonstrate, sustain and improve high quality of care throughout all its departments. The Audit team seek to support and facilitate all aspects of audit work within the cancer centre. Key performance indicators are defined through NICE and Royal College guidelines, national audits, safety parameters and patient experience. Throughout the year 2024/2025 a total of 100 projects have been submitted via AMaT, 36 active, 58 completed, and 6 discontinued.

2024/25 : 148 Audits

Complete	Active	Ongoing	Discontinued
58	36	48	6

There are an additional 48 ongoing continuous monitoring projects not registered via AMaT and are reported via Tendable or the PMF. The majority of clinical audit projects are captured via the AMaT system with the exception of the frequency of audits and the radiation services regulatory audits. However, the frequency of audits are in the process of being transferred from Tendable to AMaT and will be captured in the Ward and Area module.

Project type	Count
Clinical Audit	63
Patient/Staff Survey	15
Service Evaluation	16

Forward plan	Additional Activity	Quality and Safety related Audits
124	24	63

10.1 Clinical Audit – Key Successes

An audit of patient outcomes (with regards to survival and toxicity) after treatment with Sotorasib for KRAS G12C mutated non-small cell lung cancer at Velindre Cancer Centre

- Sotorasib appeared to be generally well-tolerated given that the majority of treatment discontinuation was due to disease progression as opposed to inability to tolerate toxicities. Sotorasib was also shown to have some effect on disease regression or at least stabilising disease for a period of time.

A Service Evaluation Looking at the Non-Surgical Management of Relapsed Prostate Cancer Following PSMA PET-CT Evaluation

- PSMA PET CT scans have revolutionized the way that BCR is investigated and therefore managed. More sites of disease are being picked up and at earlier stages than previously, meanwhile newer methods of treatment have gained prevalence such as SABR, resulting in increased intervention

An evaluation of the Immunotherapy Toxicity Service at Velindre

- 100% of Staff found the IO service a valuable service, with advice from the team seen as a useful resource

An Audit of DPYD Testing in Velindre Cancer Centre

- Velindre Cancer Centre have implemented a quick and efficient DPYD testing process.

A Review of Pre-Treatment FDG PET-CT Imaging for High-Risk, Locally Advanced Head and Neck Malignancies

- The results of this audit highlight that HNC patients across South East Wales are being investigated appropriately according to NWJCC guidelines as 88.6% of patients who required PET-CT for initial staging pre-treatment, did receive one.

A Service Evaluation of the Liquid Biopsy Service for Lung Cancer Diagnostics in Wales

- Overall, liquid biopsy ctDNA tests have a quicker turnaround time than tissue genomic biopsies and with correct usage they can be a helpful tool in meeting the new 49-day lung cancer pathway target.

Is the information in patient treatment escalation plans (TEPs) useful in the ongoing care of patients in the community and in future admissions? To what extent is the information within a patient's TEP communicated to other healthcare professionals in different care settings?

- Despite significant gaps in TEP completion and subsequent documentation on EDALs, results suggest that patients with Advance Care Planning on EDALs informed by TEPs experience fewer hospital readmissions and ambulance calls, and arguably, a better quality of life.

10.2 Clinical Audit – AMaT Key Concerns

A Service Evaluation Of The Referral and Diagnostic pathway of Oesophago-Gastric Cancer

- Health Boards in South Wales are having difficulty meeting the optimal treatment and investigation timelines
- Action: Recommendations are outside Velindre remit, however, we are constantly trying to achieve activity that corresponds to optimal pathways

An evaluation of the Immunotherapy Toxicity Service at Velindre

Lack of awareness of the wider activities of the service beyond purely 'support' managing IO toxicities. Three quarters of respondents were unaware of the adrenal education workshop. Half the respondents were unaware of the endocrine MDT

Actions: Expansion of the service required, therefore a business case for band 7 CNS was submitted. Training plan developed in order to upskilling/training of current staff to keep up with new developments. Pathways developed to provide clarity on who should be referred to the service? The IO service was presented at the consultants meeting in order to Increase awareness of what the service is currently offering.

Is the information in patient treatment escalation plans (TEPs) useful in the ongoing care of patients in the community and in future admissions? To what extent is the information within a patient's TEP communicated to other healthcare professionals in different care settings?

EP not being appropriately completed. Appropriate Information regarding the patients cancer status contained within a TEP is not being cascaded appropriately onto the eDAL and therefore shared with primary care and unscheduled care colleagues. There is scope to improve the information pertinent to patients disease status and advanced care planning within the eDAL.

Action: Further data collection to take place to look at current recordings within an eDAL, this will establish if the correct/relevant information is being made available to appropriate working partners and providing the best outcome for patients. The prevalence of incomplete TEPs and EDALs lacking ACP emphasises the need for ongoing QI initiatives to enhance outcomes.

10.3 Clinical Audit – Post Project Impact

Evaluation of the benefits of the Day 8 Callback for patients receiving SACT capecitabine

A decision was made based on the evidence provided from the project that day 8 call backs are no longer required and therefore have been stopped. This frees up staff time/resource. The project finding were discussed at the ICOG and the SST leads meeting. This will also be present for information at the medicines management group.

A service evaluation of symptom control for palliative inpatients at Velindre Cancer Centre

Patients have been offered additional therapies and pharmaceutical drugs to help alleviate symptoms. The team will continue to monitor and look at alternative therapies and medication in the future to enhance the patient experience.

DNACPR FORMS – 2024 Audit Data Collection Results and Analysis Velindre University NHS Trust

Velindre is in the process of switching to electronic note writing in the new Specialist Palliative Care Module in Welsh Clinical Portal. This is already having a demonstrable impact on how other teams are viewing and reviewing information on Future Care Planning preferences, for instance preferred place of care, performance status and also whether DNACPR has been discussed. Further discussions are taking place to extend the current ACP Flag system online into FCP Flag with a document uploader, where forms such as the All Wales DNACPR form, but also patient held Advance Decisions to Refuse Treatment (ADRT) can be stored and shared.

Less patients hold these, but we are seeing more people bring them in. We now have a process in place where any such form can be uploaded to Welsh Clinical Portal, so that the wider team is aware of its existence. We will audit the use of the Future Care Planning Flag on the front page on WCP records (in the Adverse Reaction box).

Implementation of the 'Antibiotic Review Kit (ARK) Project' into VCC

Overall it was a success and virtual microbiology ward rounds have now been implemented.

A Retrospective audit of admissions to first floor and assessment unit at Velindre Cancer Centre during May 2023

Aspects of certain audits require longer term actions and will be included in larger pieces of work following the structure changes currently taking place.

Nurse Led Post Radiotherapy Clinic for Gynaecological patients

Post project impact is that due to the success of the clinic and 100% patient satisfaction, the clinic is being continued and the team are looking to expand this service to the vaginal and vulva patients.

Physio-led Prehab Clinic for gynae-oncology patients – Staff Questionnaire

This project highlighted that some staff felt there was a huge benefit with having a dedicated Physio-led Prehab clinic for gynae oncology patients, other staff members felt there was a lack of communication and several improvements could be made. Unfortunately changes are unable to be carried out due to the physio staff member leaving the trust so is no longer being in post.

10.3 Clinical Audit – Improvements achieved

- Developed a robust governance process for the approval and escalation of issues.
- IPCT audits have been moved from MEG to AMaT.
- Enhanced collaboration on the clinical audit plan with the quality and safety team to incorporate audits from incidents, complaints and patient safety issues. This has been supported by clinical audit department becoming part of the quality and safety team.
- Frequency audits are in the process of being moved from Tendable to AMaT, so the majority of audit activity is captured in one system.

Areas of development for VCC

- Identify a clinical lead for audit.
- Strengthen the quality hubs to ensure projects are reviewed to ensure alignment with SST/ IMTP/ QI objectives.
- Strengthen the quality hubs to ensure learning from audit projects are disseminated and any identified improvements undertaken.
- Annual Trust Clinical Audit and Quality Improvement events to share learning and foster a culture of clinical effectiveness and improvement through the VCS Grand Round events.
- Development of Quality & Safety Dashboard to include clinical audit activity and will be available for each SST.

11 Safety Alerts

Analysis

210 safety alerts were received in 24/25; this is a decrease from 23/24 (225).

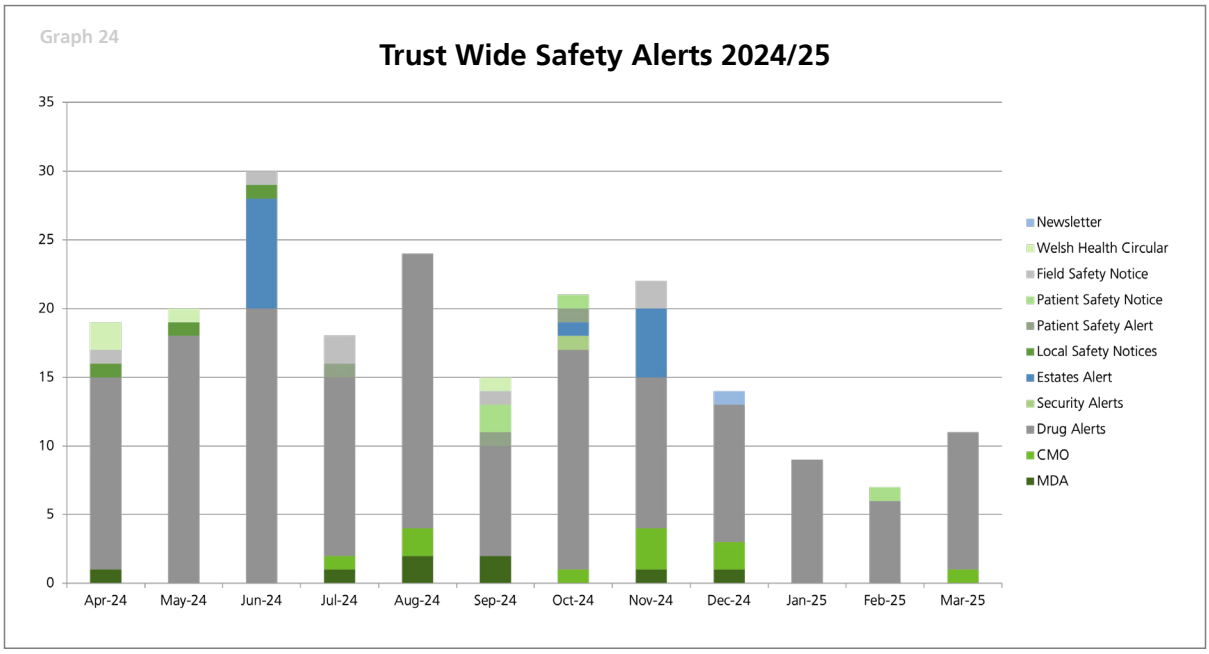
Drug/pharmaceutical alerts continue to be the highest number of alerts received, 155. The drug alerts relate to medicine recalls and stock issue notifications from suppliers. Drug alerts assessed as being applicable to the Trust were further shared, with pharmacists to take appropriate actions.

Themes and Outcomes

The most common theme for Safety Alerts were medication shortages. Any alerts that were applicable to the Trust were addressed, e.g. stock checking and using the recommended alternatives. There are numerous types of Safety Alerts, these are all shared to the appropriate teams across the Trust and dealt with accordingly.

Positive Assurance

Each of the alerts received have been reviewed by subject matter leads and appropriate actions taken. From 1st April 2025, the Safety Alerts will be recorded in a module on Datix Cymru.



12 Information Governance

Annual Report 2024-25 (1st April 2024 - 31st March 2025) – Information Governance

Introduction

Information Governance can be considered as the way in which an organisation manages the information processes and procedures and forms a key component of integrated governance and assurance arrangements along with Clinical Governance, Risk Management, Research Governance, Financial Governance and Corporate Governance. It formally links data quality management, records management, information management, information sharing, information security (including ICT security), risk management, ethics, openness and transparency into an integrated approach and covers a wide spectrum of requirements including procedures and processes to ensure data integrity, availability,security and confidentiality and the collection, storage and dissemination of information.

- **Incidents and Investigations** – total number of incidents for the quarter plus a 2 year run graph displaying the themes and trends.
- **Root Cause Analysis** – where the cause of the incident is not immediately clear, the Head of IG will conduct a more indepth investigation.
- **Reported to the ICO** – it is a legal requirement to report certain types of incident to the ICO (where a personal data breach is likely to result in a high risk to the rights and freedoms of individuals). RCA will also be conducted as a matter of course.
- **Subject Access Requests** – the legal right for a data subject to request their own data, the Trust must respond within 1 month of the date of request, unless the request is complex or technical in its nature, in which case a further 2 months may be granted.
- **Data Protection Impact Assessments** – it is a requirement to report activity to Senior Trust Management via established governance routes so that Assurance is gained that the Trust is complying with its statutory legal obligations. The IG Toolkit assesses annual compliance with this requirement
- **Training Attainment** – the minimum standard for compliance in NHS Wales is 85%, the compliance (%) is reported as of 1st January annually and may affect CAG status.

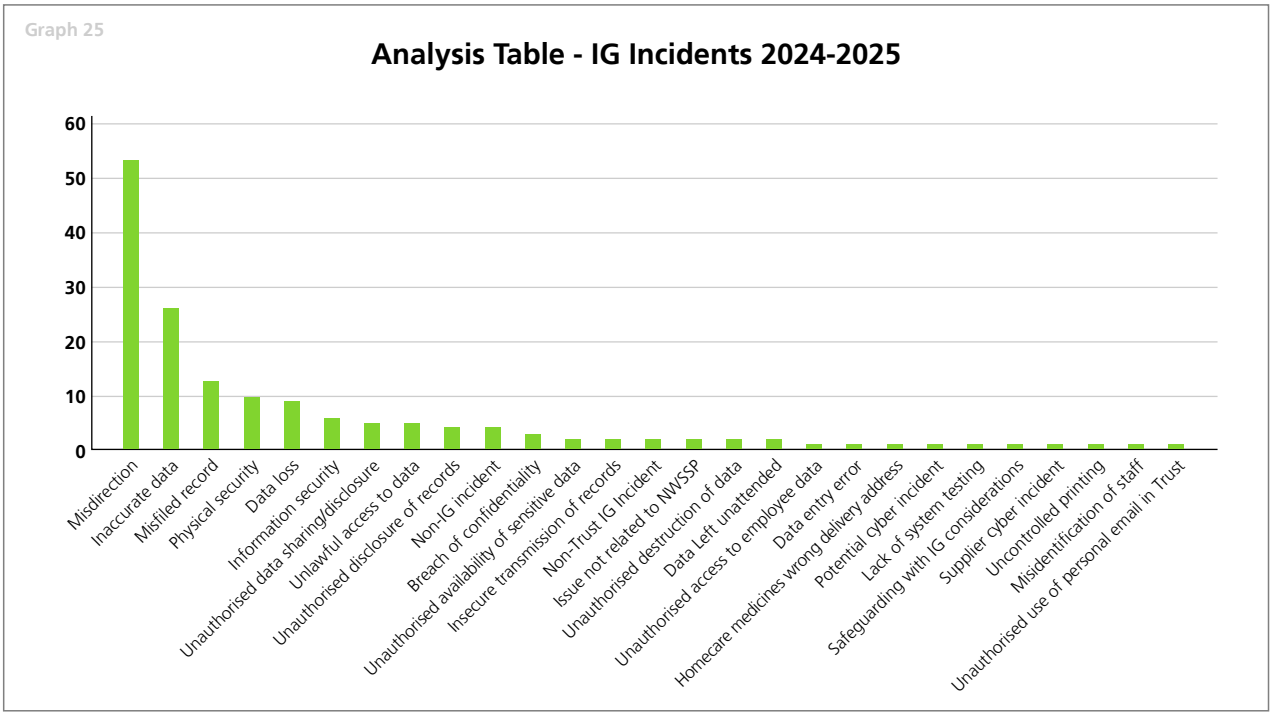
Incidents – 1st April 2024 to 31st March 2025

	DATIX Incident	Incident reported to the ICO	Total	Low Risk / No harm	Root Cause Analysis	Total
Quarter 1 2024-2025						
Corporate Service	0	0	0	0	0	0
Velindre Cancer Service	23	3	23	20	3	23
Digital	0	0	0	0	0	0
Welsh Blood Service	7	1	7	6	1	7
TCS/NVCC	0	0	0	0	0	0
NWSSP	12	0	12	12	0	12
Total for Q1 2024-2025	**42**	**4**	**42**	**38**	**4**	**42**
Quarter 2 2024-2025						
Corporate Service	1	0	1	1	0	1
Velindre Cancer Service	23	0	23	23	0	23
Digital	0	0	0	0	0	0
Welsh Blood Service	6	0	6	6	0	6
TCS/NVCC	0	0	0	0	0	0
NWSSP	17	0	17	17	0	17
Total for Q2 2024-2025	**47**	**0**	**47**	**47**	**0**	**47**
Quarter 3 2024-2025						
Corporate Service	4	0	4	4	0	4
Velindre Cancer Service	14	0	14	14	0	14
Digital	0	0	0	0	0	0
Welsh Blood Service	5	0	5	5	0	5
TCS/NVCC	0	0	0	0	0	0
NWSSP	6	0	6	6	0	6
Total for Q3 2024-2025	**29**	**0**	**29**	**29**	**0**	**29**
Quarter 4 2024-2025						
Corporate Service	0	0	0	0	0	0
Velindre Cancer Service	22	0	22	22	0	22
Digital	0	0	0	0	0	0
Welsh Blood Service	9	0	9	9	0	9
TCS/NVCC	0	0	0	0	0	0
NWSSP	14	0	14	14	0	14
Total for Q4 2024-2025	**45**	**0**	**45**	**45**	**0**	**45**
Total for 2024-2025	**163**	**4**	**163**	**159**	**4**	**163**

Analysis table for Incidents – 1st April 2024 to 31st March 2025

Reason	Number of Incidents	Corporate	VCS	WBS	Digital	TCS/ NVCC	HTW	NWSSP
Misdirection	55	3	14	7	0	0	0	31
Inaccurate data	27	1	21	1	0	0	0	4
Misfiled record	13	0	12	1	0	0	0	0
Physical security	10	0	9	1	0	0	0	0
Data loss	9	0	2	6	0	0	0	1
Information security	6	0	5	1	0	0	0	0
Unauthorised data sharing / disclosure	5	0	1	3	0	0	0	1
Unlawful access to data	5	0	5	0	0	0	0	0
Unauthorised disclosure of records	4	0	1	1	0	0	0	2
Non-IG incident	4	0	1	1	0	0	0	2
Breach of confidentiality	3	1	1	1	0	0	0	0
Unauthorised availability of sensitive data	2	0	1	1	0	0	0	0
Insecure transmission of records	2	0	2	0	0	0	0	0
Non-Trust IG incident	2	0	1	0	0	0	0	1
Issue not related to NWSSP	2	0	0	0	0	0	0	2
Data left unattended	2	0	0	1	0	0	0	1
Unauthorised destruction of data	2	0	0	0	0	0	0	2
Unauthorised access to employee data	1	0	1	0	0	0	0	0
Data entry error	1	0	1	0	0	0	0	0
Homecare medicines delivered to incorrect address	1	0	1	0	0	0	0	0
Potential cyber incident	1	0	1	0	0	0	0	0
Lack of system testing	1	0	0	1	0	0	0	0
Safeguarding with UG considerations	1	0	1	0	0	0	0	0
Supplier cyber incident	1	0	1	0	0	0	0	0
Uncontrolled printing	1	0	0	1	0	0	0	0
Misidentification of staff	1	0	0	0	0	0	0	1
Unauthorised use of personal email in Trust email system	1	0	0	0	0	0	0	1
Total for 2024/2025	**163**	**5**	**82**	**27**	**0**	**0**	**0**	**49**

Graph 25



VCS (Medical Records) Subject Access Requests – 1st April 2024 to 31st March 2025

Month	Number of requests	Number of requests completed within statutory timeframe	Request breached	Percentage compliance
April	18	13	5	72.22%
May	20	16	4	80%
June	15	15	0	100%
July	16	14	2	87.5%
August	27	27	0	100%
September	15	15	0	100%
October	22	22	0	100%
November	14	13	1	92.85%
December	21	21	0	100%
January	24	24	0	100%
February	16	16	0	100%
March	19	19	0	100%
Total	**227**	**215**	**12**	**94.71%**

Corporate (Non-Medical Records) Subject Access Requests – 1st April 2024 to 31st March 2025

Month	Number of requests	Number of requests completed within statutory timeframe	Request breached	Percentage compliance
April	2	2	0	100%
May	1	1	0	100%
June	1	1	0	100%
July	3	3	0	100%
August	1	1	0	100%
September	0	0	0	100%
October	0	0	0	100%
November	3	3	0	100%
December	0	0	0	100%
January	0	0	0	100%
February	0	0	0	100%
March	1	1	0	100%
Total	**12**	**12**	**0**	**100%**

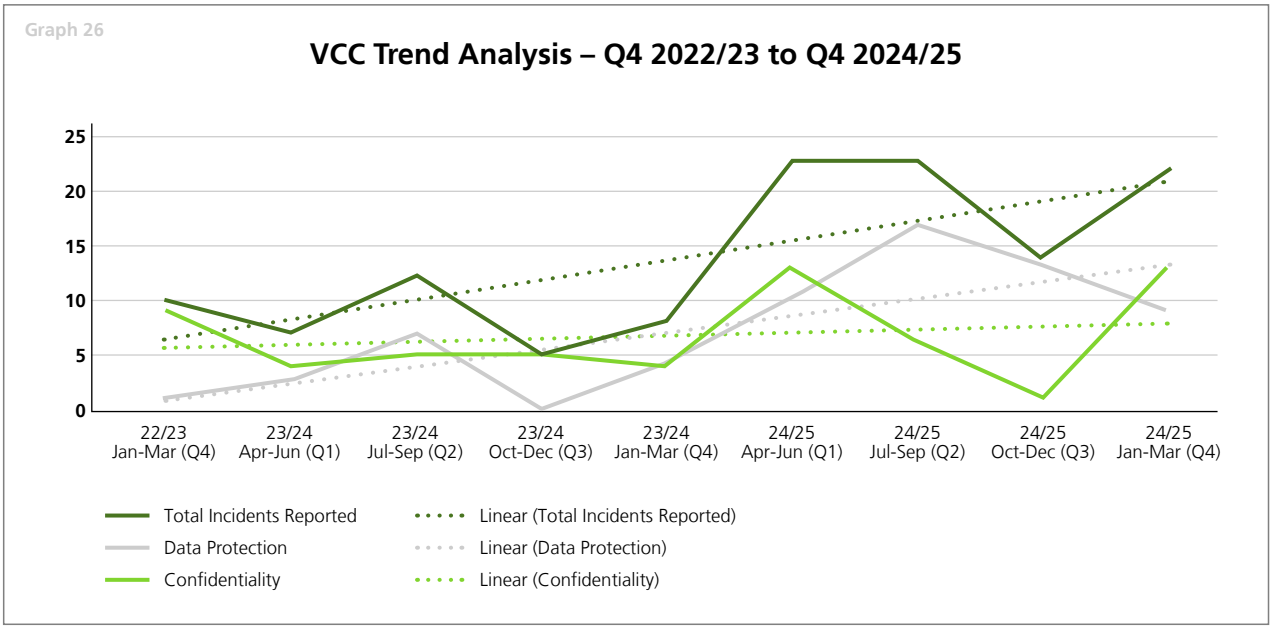
WBS (Donor Records) Subject Access Requests – 1st April 2024 to 31st March 2025

Month	Number of requests	Number of requests completed within statutory timeframe	Request breached	Percentage compliance
April	18	18	0	100%
May	8	8	0	100%
June	11	11	0	100%
July	14	14	0	100%
August	11	11	0	100%
September	6	6	0	100%
October	6	6	0	100%
November	5	5	0	100%
December	7	7	0	100%
January	11	11	0	100%
February	12	12	0	100%
March	16	16	0	100%
Total	**125**	**125**	**0**	**100%**

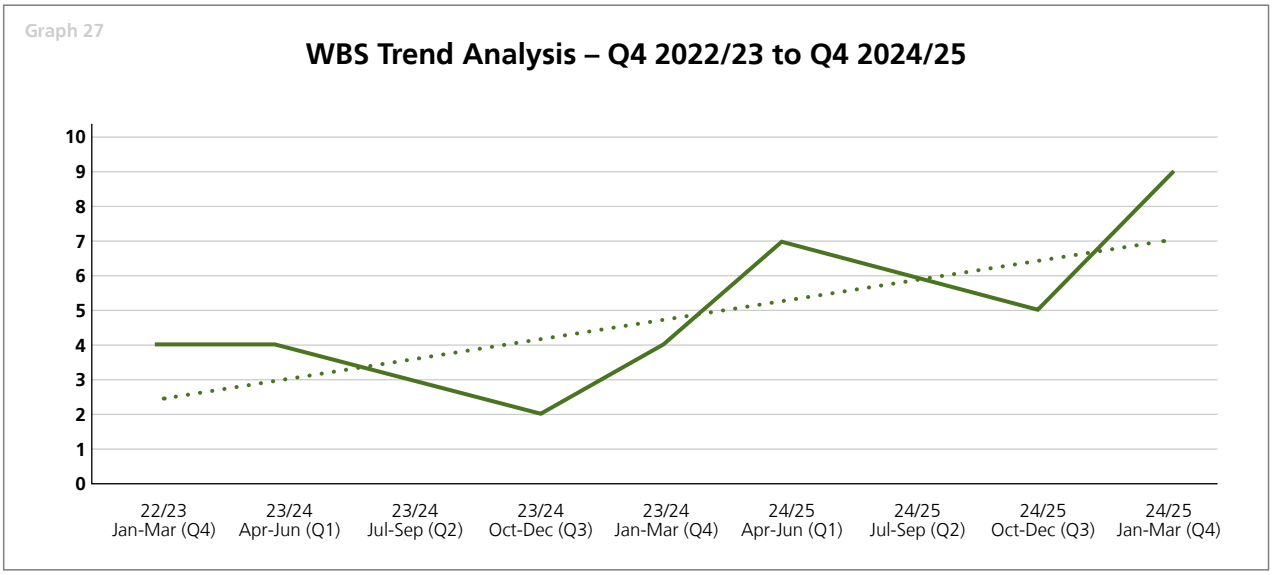
NWSSP Subject Access Requests – 1st April 2024 to 31st March 2025

Month	Number of requests	Number of requests completed within statutory timeframe	Request breached	Percentage compliance
April	2	2	0	100%
May	0	0	0	100%
June	0	0	0	100%
July	0	0	0	100%
August	0	0	0	100%
September	0	0	0	100%
October	1	1	0	100%
November	1	1	0	100%
December	0	0	0	100%
January	1*	0	0	100%
February	0	0	0	100%
March	0	0	0	100%
Total	**5**	**4**	**0**	**100%**

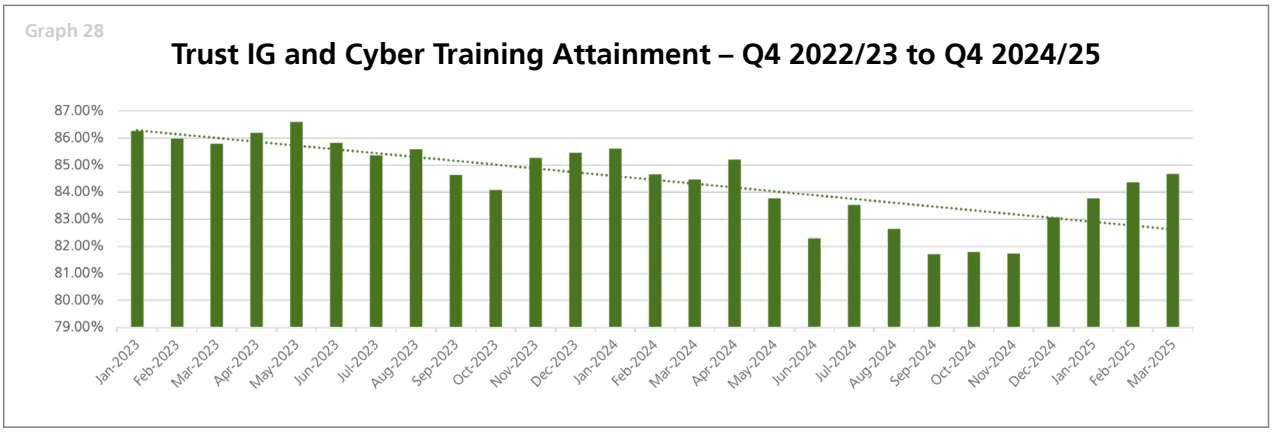
Graph 26



Graph 27



Graph 28



Positive Assurance

1 | **Training**

- Training throughout 2024/25 was delivered in multiple ways, including via ESR, inductions and specific workshops. It will continue to be delivered in the same format for 2025/26. It is planned to deliver training in Welsh in North Wales to WBS Collections teams in June 2025, a first for NHS Wales.
- IG Training compliance on 31st March 2025 for the Trust is 84.67% (minimum standard is 85%), 88.18% for NWSSP and 73.91% for HTW. 280 VUNHST Staff are out of date for IG/Cyber as of 31st March 2025 which equates to 15.33% of the workforce.
- From 1st April 2025, HTW will be included in core Trust compliance figures.

2 | **Email** – Updated All-Wales IG Policies reviewed by HBs in March 2025. Due to disestablishment of WIGB, DPO/SIRO/CG in discussion in peer groups for an all-Wales route to approval via a DDAT.

3 | **SAR Compliance** – Steady across the Trust, 100%

4 | **DPIAs** – 45 DPIAs, 6 LIA's and 18 DPA's were approved across the Trust in 2024/25.

5 | **IG Toolkit** – IG toolkit submitted on time, 28th March 2025 for 2024/25 timeframe – compliance observations and resultant IG workplan is included in main IG Annual Report

Risks to compliance with legislation, policies, procedures and standards and mitigation activity

1 | **Compliance Risk** – Risk of non-compliance with minimum M&S standards for IG and Cyber Security training on ESR is an issue, not a risk for 2024/25. VCS has increased compliance from 82.23% to 83.22% within Quarter 4 of FY 2024/25. NVCC has dropped compliance from 82.61% to 78.26% and Corporate has dropped compliance from 84.15% to 82%. HTW has highest non-compliance at 73%, DPO contacted HTW in early April 2025 stating that non-compliance requires addressing as soon as possible.

2 | **Incidents** – The Misdirection whilst aligning with UK statistics (17% of all IG incidents are misdirection) is far too high in incidence. This represents high risk to the Trust, the impact often far outweighs the act of misdirection itself.

3 | **DPIAs** – Trust DPO along with other DPOs in HBs noted last minute projects have resulted in increased IG Risk, one HB has had to approve DPA at risk due to timeframe of procurement. This has had a wider impact and DPO is working with NWSSP L&R in order to produce an aligned approach across NHS Wales.

4 | **TAF Risk** – DPO continues to review TAF 05 with CDO. Cyber Resilience exercise was conducted on 24 Mar 25 in VCS, second exercise is planned for 7 Apr 25. UK Blood Forum exercise planned for June 2025.

5 | **Overall IG Risk** – Cyber risk remains overriding risk in line with the current threat environment, risk level is such that SIRO/CG will meet on All-Wales basis on 11 Apr 25 with support of DPO if required.

6 | **Training Risk Mitigation** – The provision of workshops and sessions throughout the Trust in 2024/25 whilst offered have not seen as large a take up as was expected, but this is most likely due to Service Pressures. 477 Staff received face to face IG training during 2024/25. Divisional Directors continue to support the approach taken by DPO.

Analysis, themes and learning

1 | **Incidents** – Overriding theme in 2024/25 remains constant; misdirection, inaccurate data and misfiling of records remain a constant in each quarter of reporting to QS. It is avoidable, how to avoid it is taught by the DPO in all face to face sessions. IG Team will explore further resources online in 2025/26.

2 | **ICO Reported Incidents** – 3 incidents were reported to the ICO in 2024/25, all of which resulted in NO REGULATORY IMPACT on the Trust. Training provision was updated to reflect lessons learned, further analysis is in the IG Annual Report.

3 | **Training** – Training compliance in 2024/25 dipped mid-year. 2024/25 Q4 (84.67%) whilst much improved on Q3, still requires further time investment by Corporate, VCS, WBS and HTW in Q1 2025/26 to continue to progress the upward trend and achieve the minimum standard of 85%.

4 | **DPIA** – Remains the main methodology to assess compliance with data protection by design and default and address risk and information rights. It should be noted that Service Areas are responsible for the completion of the DPIAs (and related Cyber Risk Assessments where appropriate) to ensure timely delivery of projects.

5 | **Triangulation** – Training compliance correlates with incidents. Points 1&3 above demonstrates that increased training and awareness can reduce incidents.

13 Infection Prevention and Control

Key Highlights:

- Sustained zero incidence of Pseudomonas aeruginosa bacteraemia for second year
- International Infection Prevention Week 2024 – Escape Room - The team developed a unique, innovative learning experience
- Benchmarking – creating links with peers in transfusion services/cancer units
- Significant increase in uptake of Influenza vaccine
- IPCT members successfully completed Decontamination and Water Safety courses giving greater resilience and knowledge base.

Healthcare Associated Infection

Healthcare acquired infection is a patient harm indicator and we need to do all we can to prevent patients acquiring such infections. During 2024-2025 the following occurred:

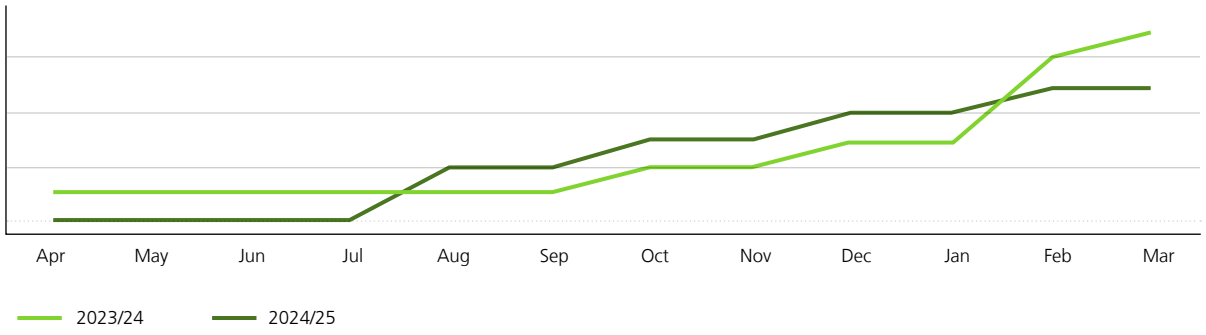
Healthcare Associated Infection

Healthcare acquired infection is a patient harm indicator and we need to do all we can to prevent patients acquiring such infections. During 2024-2025 the following occurred:

Graph 29

Clostridioidies difficile

Cumlative monthly count of C. difficile in Velindre NHST, 2024/25 compared to previous FY



During the **2024/25** reporting period, **5 cases** of healthcare-associated Clostridioides difficile infection (CDI) were reported. This marks a reduction of **2 cases (29%)** compared to the previous year, reflecting a positive trend in infection prevention efforts.

Root cause analysis determined that three of the reported cases were attributable to acquisition within Velindre. Investigations into each case have informed ongoing quality improvement initiatives aimed at further reducing the incidence of healthcare-associated infections. Learning included improved communication between multi-disciplinary teams and correct use of anti-microbial therapy.

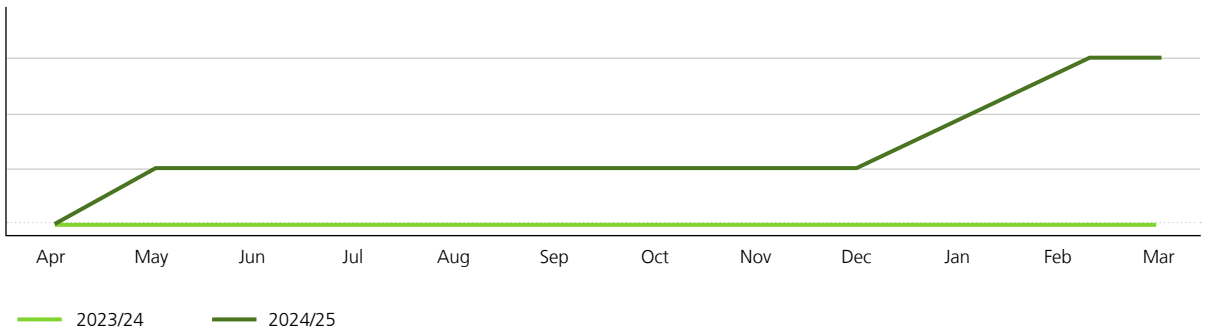
MRSA Bacteraemia

One case of Meticillin-Resistant Staphylococcus aureus (MRSA) bacteraemia was reported in the 2024/25 period, consistent with the number recorded in the previous year. Following investigation, the case was determined not to be acquired at Velindre as the patient was colonised on admission. The review of this infection resulted in education regarding admission screening, compliance with MRSA screening subsequently improved.

Graph 30

MSSA Bacteraemia

Cumlative monthly count of MSSA Bacterarmia in Velindre NHST, 2024/25 compared to previous FY

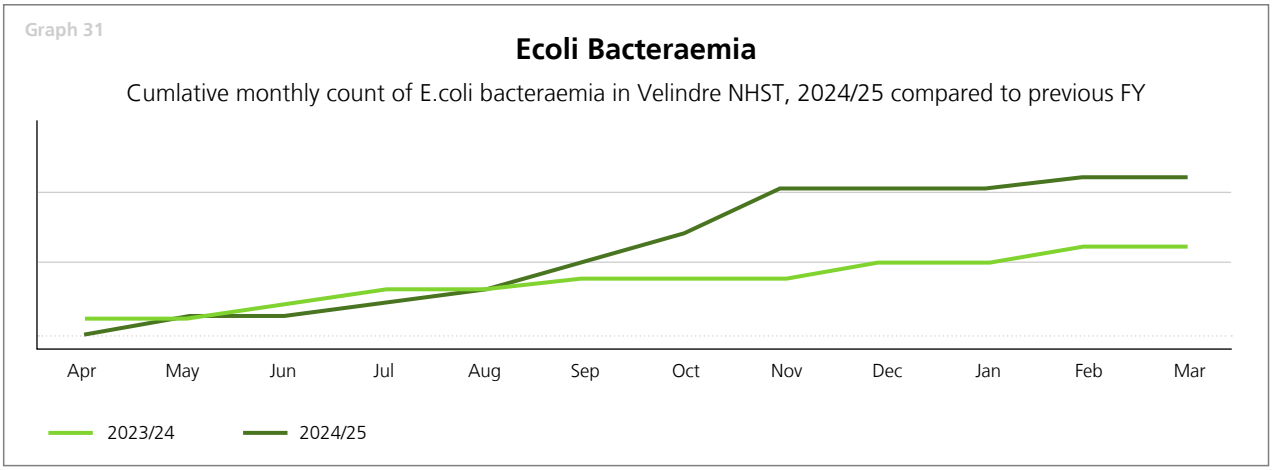


In the **2024/25** reporting period, there were **3 cases** of healthcare-associated Meticillin-Sensitive Staphylococcus aureus (MSSA) infection. This represents no change from the previous year's total. Following an investigation, none of these cases were identified as having been acquired at Velindre.

Ecoli Bacteraemia

In the 2024/25 reporting year, there were 11 recorded cases of healthcare-associated E. coli bacteraemia. This represents an increase of five cases compared to the previous year. Following investigation, only one case was identified as having been acquired within Velindre.

Graph 31



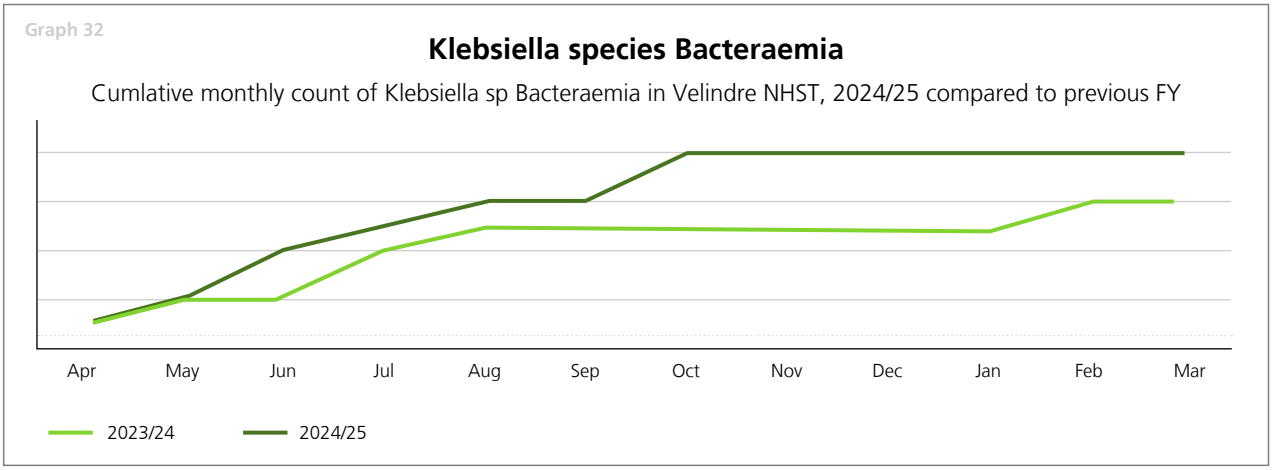
Pseudomonas aeruginosa Bacteraemia

There were no reported cases of Pseudomonas aeruginosa bacteraemia in the 2024/25 period, maintaining the zero-incidence level achieved in the previous year.

Klebsiella species Bacteraemia

During 2024/25, eight cases of healthcare-associated Klebsiella species bacteraemia were reported, representing an increase of three cases from the previous year. Detailed investigation found that only one of the eight cases was likely acquired within Velindre.

Graph 32



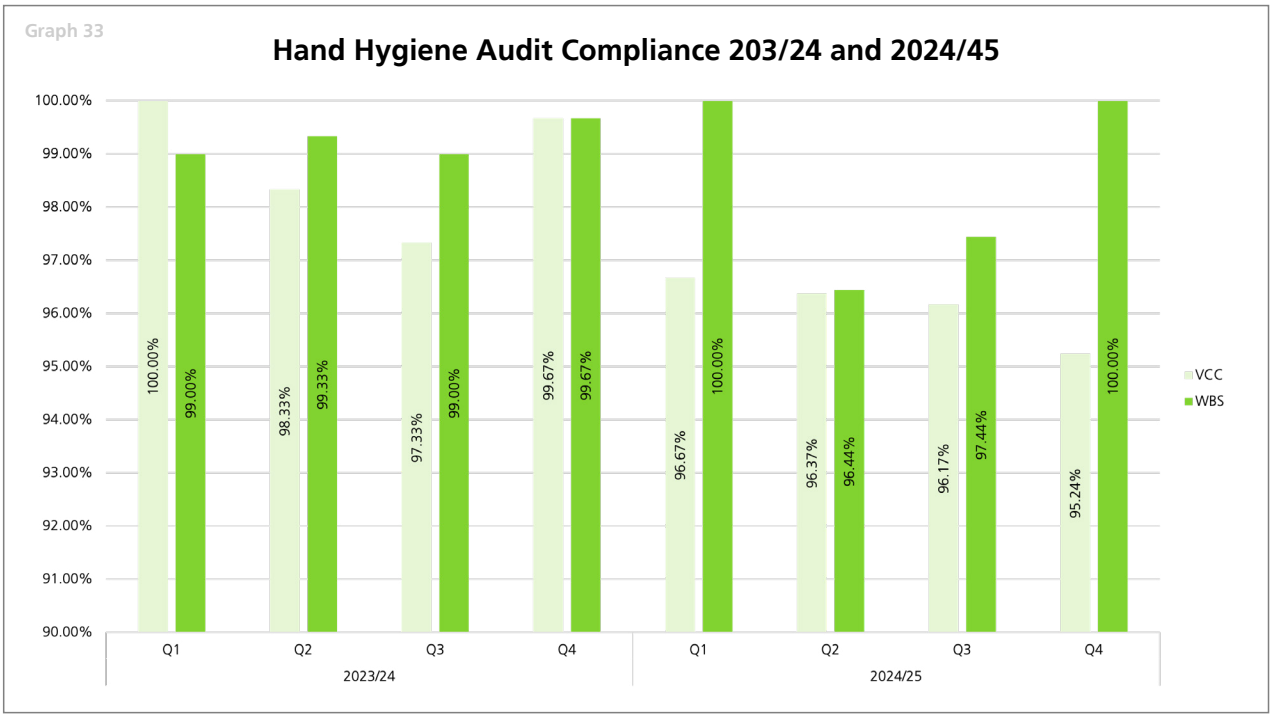
Audits Clinical Practice Audits

Clinical practice audits are necessary elements of healthcare as they ensure delivery of high quality and safe patient care. Throughout the clinical areas of VCC, the audits serve as systematic evaluations of practices, processes, and outcomes, aiming to identify areas of improvement and adherence to standards and guidelines and areas of excellence. Clinical practice audits undertaken include compliance with urinary catheter bundles, ANTT, central venous catheter maintenance, and peripheral cannula care bundles. This high compliance is reflected in the sustained low infection rates.

Hand Hygiene

Observational audits were conducted throughout the year in alignment with the World Health Organisations '5 Moments for Hand Hygiene' framework, which emphasises critical points of patient care where hand hygiene is essential to prevent healthcare-associated infections. Audits were conducted by both departmental hand hygiene champions and the IPCT, providing valuable insights into compliance and serving as a proactive measure to reinforce best practices. Observers identified several missed opportunities — most commonly before patient contact and after patient environment — which are promptly addressed through immediate, constructive feedback and on-the-spot education. This real-time approach not only supports individual accountability but also fosters a culture of continuous improvement and patient safety across clinical teams.

Graph 33



Innovation & Sustainability

Infection prevention and control measures contribute to NHS sustainability by reducing healthcare-associated infections, thereby decreasing the demand for intensive treatments and prolonged hospital stays. This not only improves patient outcomes but also supports environmental goals through more efficient use of resources, including time, more ethically produced gloves and reduced waste.

The IPC team has worked in close collaboration with the Surgical Materials Testing Laboratory (SMTL), Welsh Blood Service, and the Trust Sustainability Lead to advance several key projects aimed at improving both infection control practices and environmental responsibility.

Current initiatives include

FFP3 Mask Streaming

Exploring transitioning to a UK-manufactured FFP3 mask that not only supports local production but is expected to deliver cost savings and significantly reduce staff fit-testing time from approximately one hour to just 20 minutes.

Sustainable Hand Hygiene Solutions

Exploring alternatives to traditional alcohol-based hand sanitisers to reduce environmental impact while maintaining high standards of hand hygiene.

Optimising Use of Blue Couch Roll

Reviewing usage practices to ensure blue couch paper is used appropriately and sustainably. Minimising unnecessary waste.

Ethically Sourced Gloves

Assessing options for gloves that are ethically produced and responsibly manufactured, supporting fair labour practices and reducing environmental impact.

14 Safeguarding and Vulnerable Groups

The Trust's achievements in Safeguarding is driven by a strong organisational culture, which embeds the Trust's values, fosters professional curiosity, encourages scrutiny and supports the actions required to protect those at risk of abuse or in need of care and support.

This section of the Quality and Safety Annual Report provides the Trust with assurances that the organisation is meeting the statutory duties under the Children Act 2004, The Social Services & Wellbeing (Wales) Act 2014, the Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015, the Domestic Abuse Act 2021 and Wales Safeguarding Procedures.

Key Achievements 2024/25

- 10% Increase in safeguarding training compliance when comparing end of year figures with 2023-2024.
- Increase in safeguarding Duty to Reports submitted during this reporting period.
- The completion of an Audit reviewing the quality of documentation of Deprivation of Liberty Safeguards (DoLS) applications.
- 5 new Dementia champions who have completed inhouse dementia training at influencer level.
- 2 Kings Fund Environmental assessments completed in Outpatient Department and Radiotherapy.
- 2 Carefit for VIPS self-assessment completed.
- Safeguarding information stands and Welsh Blood Service and Velindre Cancer Centre during National Safeguarding Week.

Key Challenges 2024/25

- Progressing the workplan in relation to people who are living with a Learning Disability.
- The completion of a pathway to facilitate contact between victims of domestic abuse/sexual violence.
- Dissemination of health specific recommendations made following Practice Reviews undertaken in Wales and evidencing how staff learn and improve practice from accessing these resources. **The Head of Safeguarding & Vulnerable Persons lead will participate in the Learning Framework workstream which is part of the Strengthening Safeguarding in Health Delivery Group.**
- Operational demands continue to impact on staff attending training.

Safeguarding and Public Protection Activity

Analysis

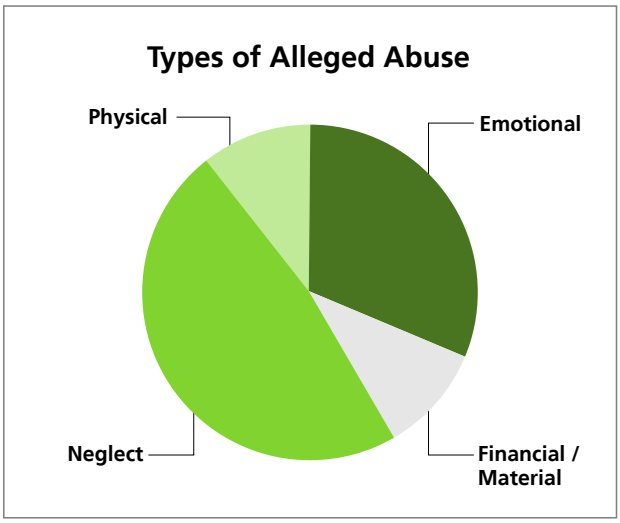
15 Duty to Reports were submitted during 2024-25, this is a slight increase on the previous reporting years.

The number of adult at risk reports submitted this year is lower than previous years. This may be a consequence of signposting/referring adults experiencing domestic abuse to specific support services rather than through the Adult at Risk process. However, there has been an increase in the number of child reports submitted. The 43% increase in Level 3 Safeguarding Children training compliance, could be a contributing factor to an improvement in staff recognising and responding to safeguarding issues related to children.

Report type	2022/23	2023/24	2024/25
Adult at Risk	11	13	9
Child at Risk	3	1	6
Total	**14**	**14**	**15**

The chart on the right illustrates the type of alleged abuse cited in the safeguarding reports submitted during this reporting year. This reflects the same categories as the previous year, however, during 2024-25 the number of reports highlighting Neglect as a concern has overtaken Emotional/Psychological.

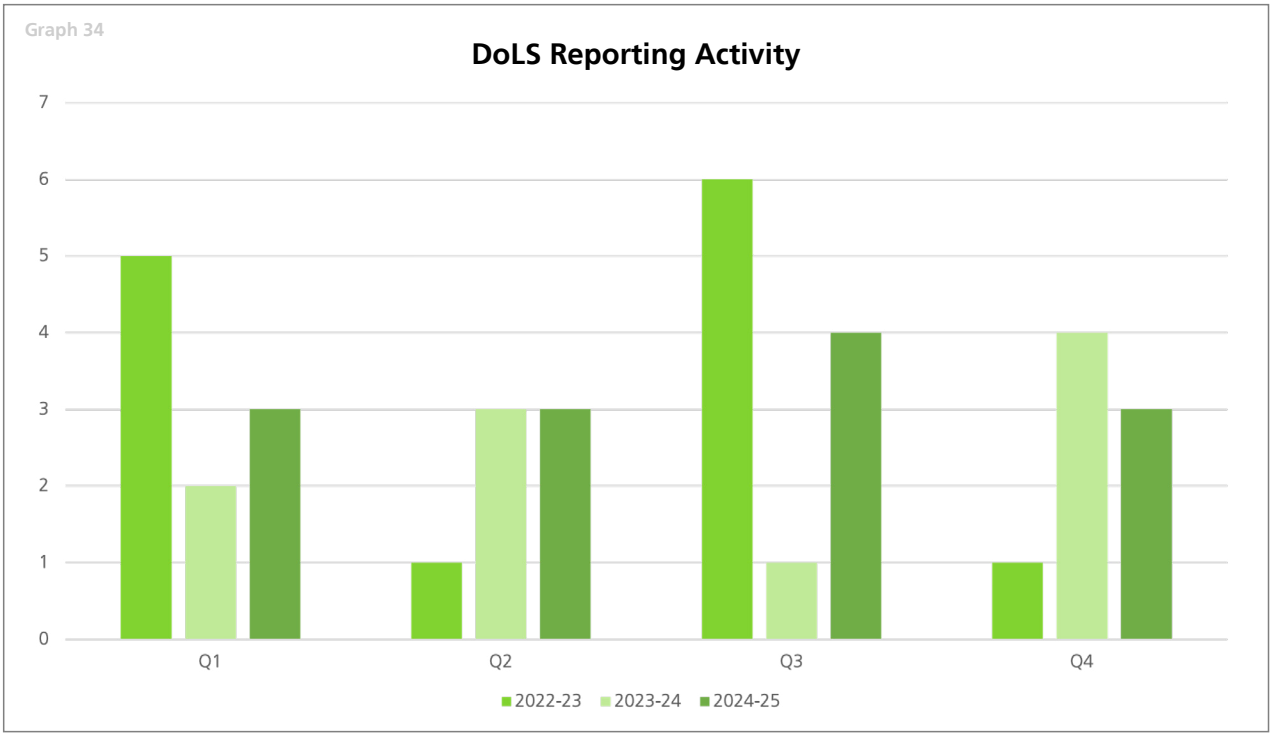
All reports were raised by staff in Velindre Cancer Centre with an even distribution of reports submitted to Local Authority areas across South- East Wales. One exception was a report which was submitted out of area to the Hereford locality.



Deprivation Of Liberty Safeguards (DoLS) activity

At the end of this reporting year, we said a fond farewell to our Practice/Educator for MCA/ DoLS. I would like to take the opportunity to say a big Thank-You to them, for their dedication, professionalism, support and guidance. It is through their hard work that our position in MCA/ DoLS training, staff knowledge and access to resources has been strengthened.

Graph 34



Analysis

13 applications for Deprivation of Liberty Safeguards (DoLs) were made during this reporting period. This is an increase on the number (10) submitted during 2023-24, and equal to the number submitted 2022-23.

Mental Capacity Act (MCA)/DoLS training compliance has increased by 22% when compared with the end of year total for 2023-24. Equipping Staff with confidence and competence in supporting patients, families and caregivers where there are concerns related to mental capacity.

Training materials were updated to include information related Mental Capacity and Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR). This was in response to the recommendations related to training found in the Health Inspectorate Wales (HIW) report Review of DNACPR Decisions for Adults in Wales 2024.

Infographic on the DoLS process developed.

Following patient feedback, staff working within VCC Outpatient Dept have resources enabling them to support patients to access Advocacy Services.

Violence Against Women, Domestic Abuse & Sexual Violence

Domestic abuse causes long-lasting physical and mental health harm. It can impact on cancer care, treatment, recovery and a person's ability to attend and donate in donor sessions. Working in the Cancer Centre and Welsh Blood Service provides a unique window to **'Ask & Act'.**

This year the Trust supported victims/survivors who experience these forms of abuse by:

- Displaying the Live Fear Free Helpline in public areas. Empowering victims/survivors to access this specialist service.
- Providing training to staff at all levels to recognise and respond to issues related to VAWDASV. There has been a 14% increase in training compliance when compared with the end of year total for 2023-24.
- Clinical Nurse Specialists for Gynaecological Cancer have included signposting services on a newly developed patient information leaflet and padlet.
- Promotion of the Cancer and Domestic Abuse: A toolkit for professionals during Ask & Act training, staff can also access this resource through the safeguarding hub.
- Staff have successfully supported victims to access community or health based Independent Domestic Violence Advisers (IDVAS).
- Ensuring Safeguarding processes are triggered where an adult or child at risk is affected by these issues.

Live Fear Free Helpline
Llinell Gymorth Byw Heb Ofn
0808 80 10 800

Key Priorities for 2025-2026

01

Work with senior leadership team within WBS to explore whether a routine enquiry question related to Violence Against Women, Domestic Abuse & Sexual Violence (VAWDASV) could be included on the questionnaire completed by donors when they attend sessions. Work with the senior leadership teams across VCC and WBS to develop a 'targeted enquiry' pathway which will support staff to facilitate contact between victims/ survivors of VAWDASV and the Live Fear Free Helpline.

02

We will continue to monitor and review the Trust's position against Dementia Care Pathway of Standards.

Audit the use of the cognitive impairment symbol on First Floor Ward and implement a person-centred assessment (PORT).

03

We will implement a reasonable adjustment checklist for patients who are living with a Learning Disability, Cognitive Impairment, Physical or Sensory Disability, ensuring that there is equitable access to services delivered by the Trust.

15 Health and Safety

VUNHST Health & Safety Annual Update

VUNHST H&S	RIDDOR Events	Incidents
2024/25	5	91

Outcome

Overall, the Trust has made clear improvements in key areas such as infrastructure, equipment safety, and behavioural incidents. The reduction in accident/injury numbers in 2024-25 is encouraging, although still the most common category.

The is RIDDOR incidents highlights the need for continued vigilance and follow-up action. The data provides a solid platform for ongoing improvement, learning and prioritisation of safety efforts.

Themes

Violence and Aggression (V&A) Incident Overview: The Trust has seen a positive reduction in Violence and Aggression (V&A) incidents over the last financial year:

- WBS reported a 18.75% decrease, with incidents dropping from 16 to 13.
- VCS achieved a 5% reduction, which is particularly encouraging given the ongoing efforts to improve incident reporting as part of the Anti-Violence Collaborative Forum.
- In support of these efforts, VCS held drop-in workshops in partnership with the Cardiff Hospital Liaison Police Officer, promoting personal safety and security. These initiatives reflect the Trust's commitment to reducing violence and aggression while supporting staff wellbeing and a safer working environment.

Focus – Summary of Focus Area Outcomes:

Over the past year, the Trust made meaningful progress across all three health and safety focus areas. A new Health and Safety Technician was successfully recruited, strengthening the team's capacity and enabling greater coverage and responsiveness across key areas. The development of a structured Health and Safety Management System began, with Principle 1 (Leadership and Accountability) in active implementation through monthly audits and executive-led Safety Tours. Although the Welsh Government's 85% compliance target for statutory and mandatory training was not yet fully achieved, the Trust significantly improved performance from 81% to 84%. Efforts to enhance accessibility and accountability have brought the organisation within 1% of the target, reflecting a strong and ongoing commitment to safety, leadership, and staff development across the Trust.

Trends – Combined Incident Theme Summary – WBS & VCS (2021-2025):

An analysis of incident themes across WBS and VCS over the past three financial years highlights three key themes of concern across the Trust:

1 | **Slip, Trip or Fall**

- This theme has been the most consistent across both divisions, with incidents reported each year in both WBS and VCS.
- These types of incidents point to ongoing environmental and procedural risks, such as flooring hazards, cluttered walkways, and slippery surfaces. Continued focus on workplace safety and preventative measures is essential.

2 | **Contact with Object or Animal**

- This theme has emerged consistently over the years from both divisions, suggesting that patient care and clinical handling may be contributing factors, particularly in high-risk areas.
- It points to the need for enhanced training and ergonomic risk assessments in environments where staff are regularly interacting with patients or equipment.

3 | **Exposure to Hazardous Substances & Sharps/Needles**

- WBS has reported exposure incidents involving hazardous substances consistently, while VCS has seen sharps/needle-related incidents re-emerge in 2024-2025.
- These incidents highlight the critical need for rigorous protocols, safe handling training, and proper waste disposal practices.

16 Regulatory Quality and Safety Tracker Compliance

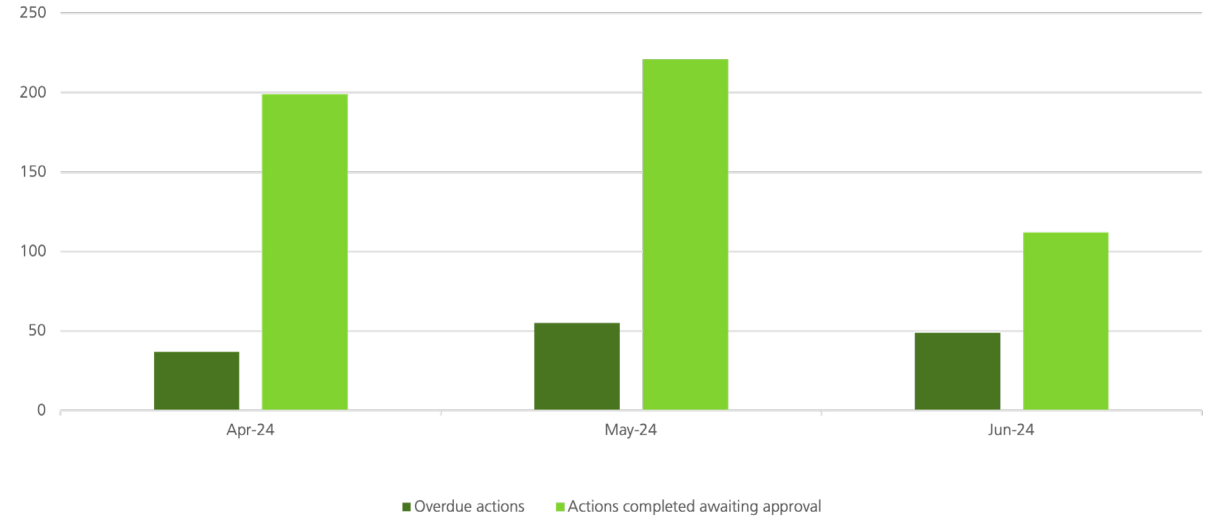
During Q1, 2 new improvement plans were added to the Tracker.

- The HIW DNA CPR review improvement plan
- A moderate incident (Duty of Candour) improvement plan (following a missed referral at VCC)

The Tracker contained 13 improvement plans related to the following:

Moderate Incidents (Duty of Candour)	Nationally Reportable Incidents	Health Inspectorate Wales Inspections	Internal Reviews	External Peer Review
3	4	2	2	2

Graph 35



Significant progress was made during both Quarters in:

- Completing actions contained in the Regulatory Tracker
- Achieving final sign off for completed actions

This is due to concerted efforts by Divisional teams to address actions and engage with senior leadership to provide evidence of completion.

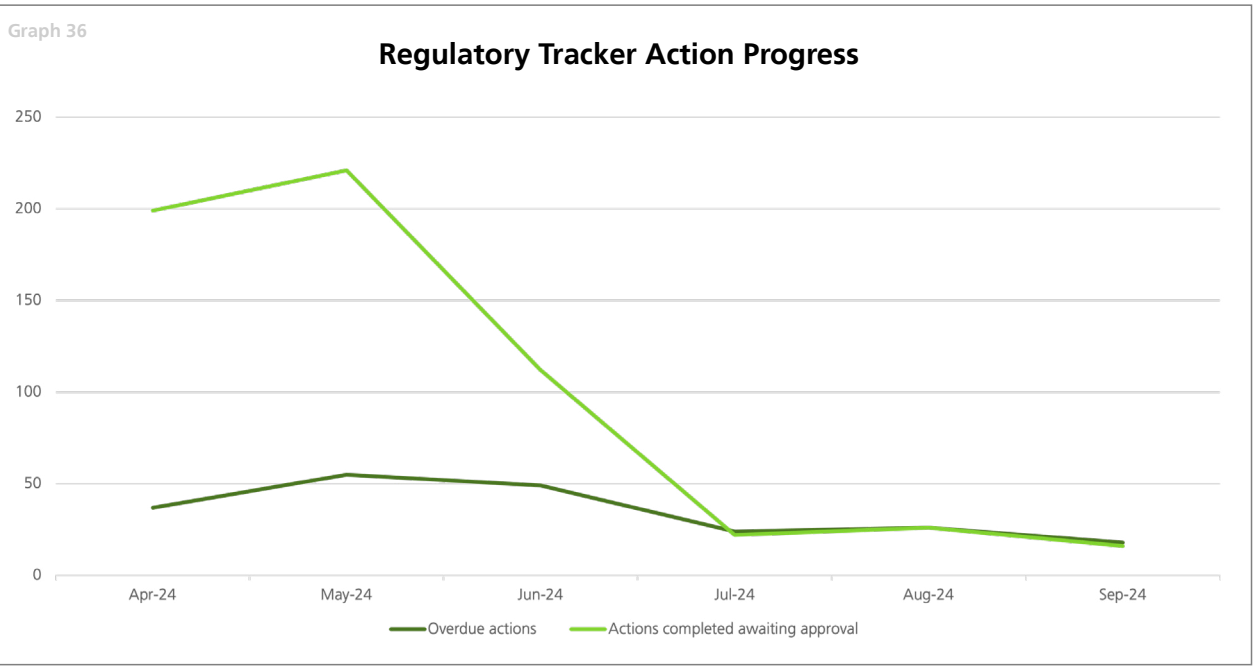
During Q2, 6 new improvement plans were added to the Tracker.

- 3 Duty of Candour incidents related to Total Parenteral Nutrition (TPN) feeding, delay in treating Metastatic Spinal Cord Compression (MSCC) & missed opportunity for chemotherapy dose reduction
- Medicines Management Internal Audit Report Aug 2024
- United Kingdom Accreditation Service (UKAS) inspection (Welsh Blood Service laboratories)
- Natural Resources Wales (NRW) High Activity Sealed Sources (HASS) inspection (Velindre Cancer Service Radiation Services)

The Tracker contained **17 improvement plans** related to the following:

Moderate Incidents (Duty of Candour)	Nationally Reportable Incidents	External Inspections	Internal Reviews	External Peer Review
5	4	3	3	2

Graph 36



During Q3, 7 new improvement plans were added to the Tracker.

- 15 Step Visit of VCC Pharmacy
- Implementation of Quinolone Prescribing and Counselling Aids
- IR(ME)R (Amendment) 2024 - compliance of Radiotherapy Service
- IRMER CAS-INVES-11653
- MARRS Action Plan (October 2024)
- Pharmacy 15 Step Challenge
- WMDA Inspection 18th - 20th November 2024

The Tracker contained **17 improvement plans** related to the following:

The Quarter showed:

- 50 actions in progress
- 4 actions partially complete
- 1 action partially complete and overdue
- 7 actions overdue
- 19 actions awaiting approval
- 0 rejections
- 6 actions approved unable to complete

Divisions were reminded to approve/sign off the completed actions within their services.

During Q3, 4 new improvement plans were added to the Tracker.

- 15 Step Visit - Radiology Department
- IR(ME)R (Amendment) 2024 – Compliance of Radiotherapy Service
- MARRS Action Plan (October 2024)
- WMDA Inspections 18th-20th November 2024

The Tracker contained **25 improvement plans** related to the following:

The Quarter showed:

- 32 actions in progress
- 0 actions partially complete
- 2 actions partially complete and overdue
- 5 actions overdue
- 4 actions awaiting approval
- 0 actions rejected
- 37 actions approved
- 0 unable to complete

17 Priorities for quarter 2025-26

Quality Priorities For 2025-2026

1 | Improve patient and donor communications
2 | Strengthen Quality & Safety infrastructure
3 | Improve patient & donor safety
4 | Improve opportunities together and learn from people's feedback

The Trust quality priorities have been co-produced by the quality hubs, across the Trust. The priorities have been developed based on learning from incidents, concern and reviews.
The 4 main priority themes are:

- Improve Patient & Donor Communications
- Strengthen Quality & Safety infrastructure
- Improve Patient & Donor Safety
- Improve Opportunities to gather and learn from people's feedback.

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