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Ffôn/Phone : (029) 20196161
https://velindre.nhs.wales

Date: 6th March 2024
Ref: CORP 2024 - 027

Dear xxxx

Freedom of Information request: Unscheduled Transfers (CORP 2024 – 027)

Thank you for your request for information which the Trust received on 01/02/2024.

Your Request:

1) *How many unscheduled transfers have taken place from Velindre to acute services in UHW (or other acute sites) between 01/02/2023 to 01/02/2024?*
2) *How many of these patients were initially due to be transferred by ambulance but were subsequently retrieved by EMRTS due to WAST service constraints?*
3) *What strategies have been implemented for capturing, recording and analysing this data seeing as it was not formally captured in recent years.*
4) *What governance process exists within VUNHST/CAV to address transfer delays that may result in harm? This is with regards to the new 'Duty of Candour' legislation (where a patient passes away in another hospital after an unscheduled transfer from Velindre). Do these cases trigger within either VUNHST or CAV (or any other health board to which to patient is transferred)?*
5) *What formal follow up process exists within Velindre to capture and record data regarding outcomes for patients undergoing an unscheduled transfer to an acute site? Can you confirm that each patient undergoing an emergency transfer out of Velindre triggers discussion at a formal mortality and morbidity meeting?*

Please find the Trust's response below:

1) How many unscheduled transfers have taken place from Velindre to acute services in UHW (or other acute sites) between 01/02/2023 and 01/02/2024?

During his period, there were 124 unscheduled transfers from Velindre to other acute sites.

2) How many of these patients were initially due to be transferred by ambulance but were subsequently retrieved by EMRTS due to WAST service constraints?

There were less than 6 patients retrieved by EMRTs, as such we are applying an exemption under Section 40(2) (personal data) of the Freedom of Information Act

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2000. This is because the Trust believes there is a potential risk of individuals being able to be identified if the figures were disclosed.

3) What strategies have been implemented for capturing, recording and analysing this data seeing as it was not formally captured in recent years.

Whilst we previously relied on Ambulance intel/recording, the following have now been implemented within the Trust:

- For the Assessment Unit (AU), a daily log is in use of all patient attendances and outcomes including patient transfers which is then uploaded onto the AU spreadsheet.
- There is also an Acute Oncology Service (AOS) database for information on patients who are admitted out of hours.
- In addition to this, a Senior Nurse handover document is in place which asks for this information to be recorded.

4) What governance process exists within VUNHST/CAV to address transfer delays that may result in harm? This is with regards to the new 'Duty of Candour' legislation (where a patient passes away in another hospital after an unscheduled transfer from Velindre). Do these cases trigger within either VUNHST or CAV (or any other health board to which to patient is transferred)?

As per NHS Wales guidance, all incidents should be reported on the Risk Data Collection system called Datix as soon as possible. Any member of staff can raise an incident on this system.

Following the reporting on Datix an investigation is instigated and an initial harm review would be undertaken by the investigator. If they suspect harm has occurred this will be discussed with senior clinical colleagues (patient's consultant, Clinical Director) and the Quality and Safety Team. If it is agreed the patient has suffered moderate harm or above, the duty of candour will be initiated, and the incident will be managed under that detailed process. Further details can be found using the below link:
https://velindre.nhs.wales/about-us/quality-safety-performance/feedback/duty-of-candour/duty-of-candour-service-user-guide/

If the patient has suffered severe harm or above, according to National Guidance on criteria - the incident will also be reported to NHS Executive as a Nationally Reportable Incident. Incidents and themes and trends are reviewed through directorate management meetings, Velindre Cancer Centre Quality and Safety Management Group and Senior Leadership Team.

5) What formal follow up process exists within Velindre to capture and record data regarding outcomes for patients undergoing an unscheduled transfer to an acute site? Can you confirm that each patient undergoing an emergency transfer out of Velindre triggers discussion at a formal mortality and morbidity meeting?

All patients that die in a hospital or hospice in Wales have a mortality review undertaken by the Medical Examiners Service (MES). If the MES identify any concerns related to their last admission (or the patient's Next of Kin raise any concerns with the MES), the case is referred back to the related Health Board/Trust to undertake a review. Any cases referred to Velindre Cancer Centre (VCC) from the MES are reviewed by the VCC Mortality Team (Consultant, Senior Nurse and Quality and Safety Manager).

If an incident related to delayed transfer is identified through any mortality review, a harm review would be completed as part of the mortality review. If moderate harm or above has occurred, an incident will be raised on Datix and the Duty of Candour process initiated.

I trust this answers your request for information, however, should you not be satisfied with the information supplied or the process of supplying it, you have a right to complain and request a review. Please note that you must submit a request for a review within 40 days of the date of this letter.

You should forward your complaint to:

Mr Ian Bevan via FOI.VUNHST@wales.nhs.uk
Head of Information Governance
Velindre University NHS Trust
2, Charnwood Court
Heol Billingsley
Parc Nantgarw
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Should you wish to take your complaint further, if you are still unhappy with the decision after review, you can contact the:

Information Commissioner's Office - Wales
2nd Floor,
Churchill House,
Churchill Way,
Cardiff, CF10 2HH
Telephone: 0330 414 6421, email: wales@ico.org.uk

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Velindre University NHS Trust

Gwasanaeth Gwaed Cymru
Welsh Blood Service

Canolfan Ganser Felindre
Velindre Cancer Centre

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Yours sincerely

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