# Bundle Public Quality, Safety and Performance Committee 12 May 2022

| 2.3.6 | Annual Equalities Report (deferred from March 2022 Committee) |
| | *Led by Sarah Morley, Executive Director of Workforce and Organisational Development* |
| | 2.3.6 QSP Cover Paper Equality Monitoring Report 31.3.21.docx |
| | 2.3.6a VUNHST Equality Monitoring Report 31.3.21.docx |
| 2.3.7 | Annual Report from the Controlled Drugs Accountable Officer |
| | *Led by Jacinta Abraham, Executive Medical Director* |
| | 2.3.7 QS&P 120522 Annual Report - CD Oversight Group Mar22 FINAL.docx |
| 2.3.8 | Annual Assurance Report from the Medical Gas Group |
| | *Led by Jacinta Abraham, Executive Medical Director* |
| | 2.3.8 QS&P 120522 Medical Gas Group Annual Report 2021 FINAL.docx |
| 2.3.9 | Trust Annual Performance Report 2021-2022 |
| | *Led by Carl James, Director of Strategic Transformation Planning & Digital* |
| | 2.3.9 Trust Annual Performance Report.pdf |
| | 2.3.9a Appendix 1_Extract Annual Performance WG Guid.docx |
| 2.3.10 | Infected Blood Inquiry Update (brought forward from July 2022 Committee) |
| | *Led by Cath O'Brien, Chief Operating Officer* |
| | 2.3.10 IBI_QSP Update_ 12.05.2022 FINAL PUBLIC-LF.docx |
| 3.0.0 | 10:40 - Velindre Quality & Safety Committee for NHS Wales Shared Services |
| | *Led by Gareth Tyrrell, Head of Technical Services, NHS Wales Shared Partnership* |
| | 3.0.0 Quality Safety  Performance Committee  - CIVAS@IP5 May 2022.docx |
| | 3.0.0a Service Board.pptx |
| | 3.0.0b CIVAS@IP5 Inspection Action Plan (003) .docx |
| | 3.0.0c QSP MHRA Action Plan.pptx |
| 4.0.0 | MAIN AGENDA |
| 4.1.0 | 10:50 - Gold Command Report |
| | *Led by Lauren Fear, Director of Corporate Governance and Chief of Staff, supported by:*<br>*Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science, Cath O'Brien,*<br>*Chief Operating Officer and Dr Jacinta Abraham, Executive Medical Director.* |
| | 4.1.0 GOLD COMMAND_ QSP Highlight Report May 2022_FINAL.docx |
| 4.2.0 | 11:00 - Workforce and Organisational Development Report / Financial Report |
| | *Led by Sarah Morley, Executive Director of Workforce and Organisational Development and Matthew Bunce,*<br>*Executive Director of Finance* |
| | 4.2.0 QSP - Workforce and Finance Key Risks_May 2022 (002).docx |
| | 4.2.0b Month 12 Finance Report Cover Paper - QSP 12.05.22.docx |
| | 4.2.0c M12 VELINDRE NHS TRUST FINANCIAL POSITION TO MARCH 2022.docx |
| | 4.2.0d Trust-wide WOD Performance Report - Feb 2022.pdf |
| 4.3.0 | 11:10 - Quality, Safety & Performance Reporting |
| | *Led by Cath O'Brien, Chief Operating Officer* |
| | 4.3.0 VUNHST MARCH PERFORMANCE COVER PAPER FOR APRIL QSP FINAL  3.5.22.docx |
| 4.3.1 | 11:20 - Velindre Cancer Service Quality, Safety & Performance Divisional Report |
| | *Led by Rachel Hennessy, Interim Director of Velindre Cancer Service* |
| | 4.3.1 VCC Performance Report (March 2022) FINAL 3.5.22.docx |
| | 4.3.1a Final Draft VCC QSP report sent SLT Approval 19.04.2022.pdf |
| 4.3.2 | 11:30 - Welsh Blood Service Performance Report |
| | *Led by Alan Prosser, Director of Welsh Blood Service* |
| | 4.3.2 SMT March 2022 PMF WBS.pdf |
| 4.4.0 | 11:45 - Trust Risk Report |
| | *Led by Lauren Fear, Director of Corporate Governance and Chief of Staff* |
| | QSP Risk Paper April 2022- Public-LF (002).pdf |
| 4.5.0 | 11:55 - Review of Information Governance Toolkit |
| | *Led by Matthew Bunce, Executive Director of Finance* |
| | 4.5.0 IG Assurance Report - Cover Paper Final.docx |
| | 4.5.0a QSP IG Assurance Report Q4 21-22 FINAL.docx |

| 4.6.0 | 12:05 - Putting Things Right Report - Quarter 4 |
| | *Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science* |
| | 4.6.0 Quarter 4 2021-22 PTR Report.pdf |
| 4.7.0 | 12:15 - Digital Service Incident Response Plans |
| | *Led by David Mason-Hawes, Head of Digital Delivery* |
| | 4.7.0 20220512 QSPP Digital Services Incident Response Plans (Cover Paper).docx |
| | 4.7.0a VUNHST Cyber Incident Response Plan v0.5.docx |
| | 4.7.0b VUNHST IT Business Continuity Incident Response Plan v0.1.docx |
| 5.0.0 | INTEGRATED GOVERNANCE |
| 5.1.0 | 12:25 - Quality Safety & Performance Committee - Policy Compliance Report |
| | *Led by Lauren Fear, Director of Corporate Governance and Chief of Staff* |
| | 5.1.0 QSP April 2022_Policy Compliance Report_v7.docx |
| | 5.1.0a Appendices.docx |
| 5.2.0 | Analysis of Triangulated Meeting Themes |
| | *To be led by Vicky Morris, Quality, Safety and Performance Committee Chair supported by all Committee members* |
| | *Analysis of Quality, Safety & Performance Committee effectiveness* |
| | *To be led by Vicky Morris, Quality, Safety and Performance Committee Chair supported by all Committee members* |
| 6.0.0 | HIGHLIGHT REPORT TO TRUST BOARD |
| | *Members to identify items to include in the Highlight Report to the Trust Board:* |
| | *• For Escalation* |
| | *• For Assurance* |
| | *• For Advising* |
| | *• For Information* |
| 7.0.0 | ANY OTHER BUSINESS |
| | *Prior approval by the Chair required.* |
| 8.0.0 | DATE AND TIME OF NEXT MEETING |
| | *The Quality, Safety & Performance Committee will next meet on the 14th July 2022 from 10:00 – 12:30 via Microsoft Teams* |

| Minute ref | Action | Action Owner | Progress to Date | Target Date | Status (Open/Closed) |
|---|---|---|---|---|---|
| **Actions agreed at the 17th February 2022 Committee** |
| | A Public Health Wales representative to be invited to a future Board Development Session to facilitate a discussion in relation to the Trust's role / requirements & public health. A summary paper will be presented to the July 2022 Committee. | Lauren Fear | **Update 16/03/2022** - As referenced, a summary paper is to be reported to the July Committee. | 14/07/2022 | OPEN |
| 3.4.0 | NW to investigate whether colour scheme within the CIVICA report can be amended to avoid confusion. | Nicola Williams | **Update 03/05/2022** - Confirmation received that the colours on the CIVICA reporting module are pre-set and therefore cannot be locally changed. | 24/03/2022 | CLOSED |
| **Actions agreed at the 24th March 2022 Committee** |
| Action Log | Following action 2.2.8 (15th July 2021 Committee), a paper was appended to the March 2022 Committee action log, providing the current position in relation to oral SACT education for patients. Further work will be facilitated to transform how oral SACT education is provided to all patients via the Task Force. An update will be provided at the July Committee at the earliest. | Cath O'Brien | **Update 24/03/2022** - An update will be provided at the July QS&P Committee at the earliest. | 14/07/2022 | OPEN |
| 2.1.2 | A review of Trust policies adhered to by hosted organisations to be undertaken and documented within the overarching Trust Policy for Policies. | Lauren Fear | **Update 05/05/2022** - A verbal update will be provided at the May QS&P Committee. | 12/05/2022 | OPEN |
| 2.3.2 | 2x Written statements by COB in relation to the Infected Blood Inquiry to be circulated following the March Committee. | Cath O'Brien | **Update 05/05/2022** - A verbal update will be provided at the May QS&P Committee. | 12/05/2022 | OPEN |

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| 2.3.5 | Details of plan / timeline for improving mandatory Health & Safety Training to be provided to Committee members. | Carl James | **Update 05/05/2022** - Improvement Plan has been developed for May 2022 in key areas: Manual Handling Level 1&2 and Violence & Aggression A&B to secure improvement in June 2022. | 12/05/2022 | OPEN |
| 4.2.0 | Further detail relating to agency staff and potential outsourcing to be included in the combined Workforce & OD / Financial Report at the May Committee. | Matthew Bunce/Sarah Morley | **Update 29/04/2022** - The main finance report includes information regarding agency spend.  However, this doesn't include an analysis of the spend by reason for use i.e. sickness cover, annual leave, additional capacity etc. Whilst the Healthroster system would provide this analysis it has only been implemented in nursing areas currently so not available in Radiotherapy & Medical Physics, the two main clinical areas of agency use. The Healthroster system would provide information around gaps in workforce and where being covered through agency. Until the system is rolled out into these areas workforce and finance are exploring how best to capture this info for reporting. This will be part of a Finance and workforce senior leadership team workshop to identify the priority areas of workforce and financial risk, understand the challenges and opportunities to improve finance and workforce reporting for 2022/23. | 12/05/2022 | OPEN |
| 4.4.0 | AP to provide an update in relation to the cross-matching error to the Chair of the Committee. | Alan Prosser | **Update 27/04/2022** - RCA report shared with the Chair of the Committee and Executive Director of Nursing on March 28th. Additional questions about the report are expected to be answered before May 12th Committee. | 12/05/2022 | CLOSED |

| 4.5.0 | Detailed breakdown of breaches of waiting time targets to be included in the Velindre Cancer Service Performance Report going forward. | Cath O'Brien | **Update 29/04/2022** - This detail was included in the March PMF which has since been presented to EMB and will be presented to the May QS&P Committee. | 12/05/2022 | CLOSED |
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| 4.9.0 | Quarterly meetings to be arranged between Stephen Harries, Matthew Bunce and Chief Digital Officer to discuss Information Governance processes to allow for higher level reporting to Committee and communication of relevant assurance among Independent Members. | Stephen Harries | **Update 29/04/2022** - Quarterly Information Governance Assurance meetings have been arranged between Stephen Harries, Matthew Bunce (SIRO) and the Chief Digital Officer. | 12/05/2022 | CLOSED |
| 5.1.0 | NW to ascertain if the Health Care Standards self-assessments from other Trusts / Health Boards are available publicly for benchmarking. | Nicola Williams | **Update 03/05/2022** - These are not collated nationally. Information would only be available by requesting from each organisation as Annual Quality statements have not been produced for the last two years. | 12/05/2022 | CLOSED |

**Minutes**

**Public Quality, Safety & Performance Committee**

**Velindre University NHS Trust**

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| **Date:** | 24th March 2022 |
| **Time:** | 10:00 – 13:00 |
| **Location:** | Microsoft Teams |
| **Chair:** | Vicky Morris, Independent Member |

| ATTENDANCE | | |
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| Prof Donna Mead OBE | Velindre University NHS Trust Chair (in part) | DM |
| Hilary Jones | Independent Member | HJ |
| Stephen Harries | Interim Vice Chair and Independent Member | SH |
| Cath O'Brien | Chief Operating Officer | COB |
| Lauren Fear | Director of Corporate Governance and Chief of Staff | LF |
| Carl James | Director of Strategic Transformation, Planning and Digital | CJ |
| Nicola Williams | Executive Director of Nursing, Allied Health Professionals & Health Science | NW |
| Matthew Bunce | Executive Director of Finance | MB |
| Sarah Morley | Executive Director of Organisational Development & Workforce | SfM |
| Alan Prosser | Interim Director of Welsh Blood Service | AP |
| Nigel Downes | Interim Deputy Director of Nursing, Quality & Patient Experience | ND |
| Emma Stephens | Head of Corporate Governance | ES |
| Kyle Page | Business Support Officer (Secretariat) | KP |

| 0.0.0 | PRESENTATIONS | Action Lead |
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| 0.0.1 | **Welsh Blood Service (WBS)– Donor Story**<br>Led by Alan Prosser, Interim Director, Welsh Blood Service, supported by Andrew Harris, Interim Head of Donor Engagement<br><br>The video recording of the donor story had been received and viewed by members in advance of the meeting. The story detailed how the learning from feedback received during a 15 step challenge visit to a donation clinic led to two donors assisting the WBS to make a number of changes to the appointment and donation experience for people with a learning disability. The story outlined the challenges a young lady with learning difficulties had been experiencing when booking into and attending donor sessions and the subsequent co-production that occurred with her and her father to make both the booking system and screening process at donation clinic easier for donors with a learning | |

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| | disability.<br><br>AH provided the Committee with additional context. AH advised that although donor satisfaction survey generally produces high scores, individual conversations with donors provide an opportunity for a much more comprehensive level of information to support service improvements. It was recognized that such face-to-face conversations had proved challenging to maintain during the pandemic, however the WBS is looking at how these will now be re-introduced.<br><br>The Committee commended the WBS for their approach and how they had actively listened and made a number of improvements with the help of donors that will benefit many more people.<br><br>DM advised that an application had been received from WBS staff via the Trust Small Grants Scheme, suggesting research in relation to the needs of donors with disabilities. The application, although approved, had not been progressed due to capacity issues within the service during the pandemic. DM requested that this be revisited and progressed if possible and AP confirmed that this will now be progressed.<br><br>The Committee thanked the WBS team for the actions taken and implementation of improvements following the donor story and for sharing this excellent work. | **AP** |
| **1.0.0** | **STANDARD BUSINESS** | |
| **1.1.0** | **Apologies** had been received from:<br><br>• Paul Wilkins, Interim Director of Velindre Cancer Service<br>• Steve Ham, Chief Executive Officer<br>• Dr. Jacinta Abraham, Executive Medical Director<br>• Stephen Allen (SA) – Chief Officer, South Glamorgan Community Health Council (CHC)<br>• Peter Richardson (PR) – Head of Quality Assurance, Welsh Blood Service | |
| | The Committee **NOTED** that Donna Mead would leave the meeting at 12:15pm due to other prior commitments. | |
| **1.2.0** | **Additional Attendees:**<br><br>• Andrew Harris (AH) – Interim Head of Donor Engagement *(for item 0.0.1)*<br>• Gareth Tyrell (GT) – Head of Technical Services, NHS Wales Shared Services Partnership *(for item 3.0.0)*<br>• David Mason-Hawes (DMH) Head of Digital Delivery *(for item 4.6.0)*<br>• Dr. Hilary Williams (HW), Assistant Medical Director for Quality & | |

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| | Safety (deputising for Dr. Jacinta Abraham) <br> • Emma Rees (ER) – Audit Manager, NWSSP Audit & Assurance Services *(in part)* <br> • Krisztina Kozlovszky (KK) - Audit Manager, NWSSP Audit & Assurance Services *(in part)* <br> • Sarah Thomas (ST) – Healthcare Inspectorate Wales <br> • Katrina Febry (KF) – Audit Lead, Audit Wales <br> • Delyth Brushett (DB) – Senior Auditor, Audit Wales <br> • Daniel Price (DP) – Deputy Chief Officer, South Glamorgan CHC *(deputising for Stephen Allen)* | |
| **1.3.0** | **Declarations of Interest** <br> Led by Vicky Morris, Quality, Safety & Performance Committee Chair <br><br> No declarations of interest were raised. | |
| **1.4.0** | **Review of Action Log** <br> Led by Nicola Williams, Executive Director of Nursing, AHPs and Health Science <br><br> Committee members advised that they were assured that all seven actions identified as closed on the action log had been fully instigated and could therefore be closed. <br><br> Items not yet due for completion were not discussed and will remain open. <br><br> The remaining Action Log was reviewed and the following amendments were agreed: <br><br> • ***5.4.0 (20/01/2022) – Workforce to outline timescales in relation to job planning and areas of concern*** – SfM confirmed that a validation exercise had been undertaken and information would follow in due course. It was agreed to close the action. <br> • ***6.1.0 (20/01/2022) – Presentation of an overview of wider development in a number of areas*** – COB confirmed that following discussion, a list is currently being drafted and it was agreed to close the action. <br> • ***3.2.0 (17/02/2022) – February Financial Report to be amended to reflect that the Committee NOTED but was unable to APPROVE the report*** – MB confirmed that this had been actioned and it was agreed to close the action. <br> • ***3.4.0 (17/02/2022) – Amend colour scheme within CIVICA reports to avoid confusion*** – NW advised that this discussion is underway with CIVICA. The action will remain open until a response is recieved. <br> • ***4.1.0 (17/02/2022) – Communicate positive feedback from Extra-ordinary February QS&P Committee to Trust staff, in particular the staff experience story*** – LF confirmed that | **Secretariat** <br><br><br><br> **Secretariat** <br><br><br><br> **Secretariat** <br><br><br><br> **NW** |

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| | communication had been agreed and issued the previous day and it was agreed to close the action.<br><br>• **_2.2.8 (15/07/2021) – Update to be provided on status of patients' education in relation to oral SACT -_** NW advised the Committee of the inclusion of an additional paper, closing the action. It was suggested that a new action be instigated to facilitate further work to transform how oral SACT education is provided to <u>all</u> patients due to the complexity of the task. COB indicated that the Task Force plan would include this work and that an update would follow later in the year due to current considerable operational pressures. | **Secretariat**<br><br><br><br><br>**COB/ Secretariat** |
| **2.0.0** | **CONSENT ITEMS**<br>(The consent part of the agenda considers routine Committee business as a single agenda item. Members may ask for items to be moved to the main agenda if a fuller discussion is required). | |
| **2.1.0** | **ITEMS FOR APPROVAL** | |
| **2.1.1** | **Draft Minutes from the meeting of the Public Quality & Safety Committee held on the 17th February 2022**<br>Led by Vicky Morris, Quality, Safety & Performance Committee Chair<br><br>Following the Chair's approval prior to the meeting, the minutes of the Public Quality & Safety Committee held on the 17th February 2022 were **APPROVED** as a true reflection of the meeting. | |
| **2.1.2** | **Trust Policies**<br>Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science | |
| **2.1.2a** | **_Infection Control Policies_**<br>The Committee received two revised Infection Prevention and Control policies for approval: IPC01 – Gastro-Enteritis and IPC04 – Decontamination. NW advised the following:<br><br>• A further IPC policy (IPC07 – MRSA) remains under review and will be presented to the May 2022 Committee for final approval. NW requested agreement from the Committee that use of this policy could continue in the interim.<br><br>The Committee **APPROVED** IPC01 and IPC04 and **AGREED** the continued use of IPC07 in its current format until final approval at the May Committee. | |
| **2.1.2b** | **_Incident Reporting & Investigation and Handling Concerns Policies_**<br><br>The Committee received two revised Quality & Safety Policies: QS01-Incident Reporting and Investigation Policy and QS03-Handling | |

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| | Concerns Policy. NW advised that both policies would need to be further reviewed towards the end of 2022 and be approved by April 2023 to ensure they were consistent with the requirements of the new Wales Health & Social Care Quality & Engagement Act (2020) that comes into force in April 2023. The national Putting Things Right Policy is under review aligned with the Act requirements.<br><br>The Committee identified that there was varying referencing made to hosted organisations in relation to the policies. It was identified that some of the policies would not necessarily apply to both hosted organisations given their different roles. However, it was agreed that the policy position in relation to hosted organisations needed to be clarified.<br><br>The Committee **APPROVED** The Handling Concerns Policy (QS03) and Incident Reporting & Investigation Policy (QS01). | **LF** |
| 2.1.3 | **Wales Quality Bill Preparedness**<br>To be led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science<br><br>The Wales Quality Bill Preparedness paper provided the Committee with an overview of timelines for NHS Wales relating to the Wales Health & Social Care Quality Engagement Act (2020) and Trust's ability to meet the Act requirements, in particular two elements: the Duty of Quality and Duty of Candour.<br><br>NW advised that the draft Statutory Guidance for The Duty of Quality and Duty of Candour is due to be published for consultation in May /June 2022.<br><br>A Trust response to this in relation to how the Statutory Guidance requirements will be met will be included as a standalone item on the July Committee agenda for discussion, to ensure enactment of this by the deadline of April 2023.<br><br>DM commended NW for undertaking the role of Chair of the National Duty of Quality and Duty of Candour Steering Group.<br><br>The Committee **NOTED** the current national plans and timescales in respect of the Act and **APPROVED** the Trust preparedness plans. | |
| **2.2.0** | **ITEMS FOR ENDORSEMENT** | |
| **2.2.1** | **Radiation Protection Committee Highlight Report (deferred from January 2022 Committee)**<br>Led by Dr. Hilary Williams, Assistant Medical Director for Quality & Safety<br><br>The Committee **ENDORSED** the new Radiation Protection governance structure. | |

| 2.2.0 | ITEMS FOR NOTING | |
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| 2.3.1 | **Trust Vaccination Programme Board Highlight Report**<br>Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science<br><br>DM commended the Trust's achievement of vaccinating 71% of staff, exceeding the 60% national influenza vaccine target for 2021/22.<br><br>The committee **NOTED** the progress to date and potential plans for 2022. | |
| 2.3.2 | **Infected Blood Inquiry Update**<br>Led by Cath O'Brien, Chief Operating Officer<br><br>COB confirmed that a further meeting with the Infected Blood Inquiry team scheduled for the 6th April 2022 would facilitate a clearer overview of next steps in the Inquiry for inclusion in the next report for the Committee. Additional written statements by COB in relation to the Infected Blood Inquiry will be circulated following the March 2022 Committee.<br><br>The Committee **NOTED** the content of the report. | **COB** |
| 2.3.3 | **Highlight Report from the Trust-wide Patient Safety Alerts Group**<br>Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science & Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience<br><br>NW indicated that a deep dive assurance audit of Trust compliance with 11 of the 21 safety alerts had been the first such audit undertaken. The remaining 10 areas will be audited using the same methodology by the end of May 2022. In addition, areas where insufficient assurance had been achieved will be re-audited.<br><br>It was noted that the nationally set completion dates in two of the three open safety alerts had passed. NW advised that the Trust is working towards improving compliance in all three areas and revised completion dates had been identified. A number of these were awaiting outcomes of national work.<br><br>The Chair supported the suggestion of the Committee receiving the Trust-wide Patient Safety Alerts Report quarterly given the current levels of assurance.<br><br>The Committee **NOTED** the assurance report and next steps. | |
| 2.3.4 | **RD&I Sub Committee Highlight Report**<br>Led by Professor Andrew Westwell, Chair of the RD&I Sub Committee | |

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| | The Committee **NOTED** the key deliberations and highlights from the Public meeting of the Research, Development & Innovation Sub-Committee held on the 13th January 2022. | |
| 2.3.5 | **Highlight Report from the Trust Estates Assurance Group**<br>Led by Carl James, Director of Strategic Transformation, Planning and Digital<br><br>HJ queried potential plans (including timelines) to improve the level of mandatory Health & Safety training. CJ advised that a plan is in place, the details of which would be provided of this outside of the Committee.<br><br>The Committee **NOTED** the content of the report and actions being taken. | **CJ** |
| 2.3.6 | **Transforming Cancer Services Programme Scrutiny Sub Committee Highlight Reports**<br>Led by Stephen Harries, Interim Vice Chair and Chair of the Transforming Cancer Services Scrutiny Sub-Committee<br><br>The Committee **NOTED** the content of the reports and actions being taken. | |
| 2.3.7 | **Medical Devices Report (deferred from January 2022 Committee)**<br>Led by Cath O'Brien, Chief Operating Officer<br><br>The Committee **NOTED** the content of the report. | |
| 2.3.8 | **Trust Operational Annual Plan 2021/2022 – Q3 Progress Report (deferred from January 2022 Committee)**<br>Led by Carl James, Director of Strategic Transformation, Planning and Digital<br><br>In response to a question from the Chair, CJ confirmed that WBS objectives reporting as red do not relate to service critical or safety risks and that the end of year position would form the basis of the three-year Integrated Medium Term Plan (IMTP).<br><br>The Committee **NOTED** the content of the report. | |
| 2.3.9 | **Medical Examiner's and Mortality Report (deferred from January 2022 Committee)**<br>Led by Dr. Hilary Williams, Assistant Medical Director for Quality & Safety<br><br>• NW advised the Committee that the IT issue detailed in the report relating to the sharing of large files has now been resolved and that a secure file portal had now been implemented.<br>• HW noted that additional work is required to gain better | |

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| | understanding of deaths (within 30 days of Chemotherapy) occurring outside the Velindre environment to facilitate learning and improve Quality & Safety as a whole.<br><br>SH noted that the section of the report relating to the death of patients 'outside Velindre' requires clearer wording for clarification to support the public audience.<br><br>The Committee **NOTED** the content of the report. | |
| **3.0.0** | **Velindre Quality & Safety Committee for NHS Wales Shared Services** | |
| | Led by Gareth Tyrrell, Head of Technical Services, NHS Wales Shared Partnership<br><br>The NHS Wales Shared Services Quality & Safety Governance Report was received and discussed and the following was highlighted:<br><br>• Performance against agreed metrics had seen a reduction in output over the last two months, resulting from commercial supplier issues and the presence of new staff within the production process.<br>• Health Boards continue to order consistent amounts of products and no issues with facilities had been reported. Service remains 100% compliant with internal audit requirements.<br>• Only one critical deviation had been reported, resulting in the rejection of one batch of product and one service complaint from a Health Board relating to an incorrect expiry date on a vaccination packdown. The Committee requested further detail in future reports to demonstrate learning and improvement after such deviations and complaints.<br>• The full MHRA (Medicines and Healthcare Products Regulatory Agency) inspection report will be presented at the next Committee and resulting actions worked through in detail.<br>• Discussions are underway to explore how reporting can evolve going forward to include additional areas of Shared Services activity.<br><br>The Committee requested further evidence of a reduction in incidents and events as a result of learning and improvements, in addition to a more detailed level of narrative where issues had been identified.<br><br>DM requested formal oversight of the internal decision process in relation to the inclusion of new service developments within the CIVAS@IP5 programme of work. GT advised that the process is evolving and discussions with Clinicians have been instigated to gain improved understanding of national requirements and products to facilitate maximum national impact. GT indicated that appropriate | |

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| | internal processes are followed to ensure strict GMP (Good Manufacturing Practice) criteria are met before considering the manufacture of new products.<br><br>It was acknowledged that this remains a work in progress and a cycle of business for the Quality Safety & Performance agenda will be developed to include the wider, longer term scope of the Service, in addition to accountability for the Quality & Safety issues raised above.<br><br>The Committee **NOTED** current levels of service performance against the framework of standards set out in EU GMP and with which CIVAS@IP5 are legally required to comply as an MHRA 'Specials' and Wholesale Dealer licence holder. | |
| **4.0.0** | **MAIN AGENDA**<br>(This section supports the discussion items for review, scrutiny and assurance). | |
| **4.1.0** | **Gold Command Report**<br>Led by Lauren Fear, Director of Corporate Governance and Chief of Staff, supported by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science and Cath O'Brien, Chief Operating Officer<br><br>The Gold Command Highlight Report provided details of the key issues considered at Gold Command (COVID) at its meetings held between 16th February 2022 and 16th March 2022. COB highlighted the following:<br><br>• COVID related staff absence is currently at the highest level since the beginning of the pandemic and is affecting both Divisions. Daily staffing / service delivery meetings have been implemented at Velindre Cancer Service to ensure sustained delivery of operational services and monitor impact on other additional priorities. Staff within both Divisions continue to go over and above to maintain services, care and treatment.<br>• Blood stocks at the Welsh Blood Service have reduced in recent weeks due to increasing numbers of donors not attending booked appointments deemed to be COVID related. This is being monitored and managed daily by the Collections team which is working closely with partners and Health Boards to offer additional clinics and actively recruit additional donors.<br>• Due to the staff COVID absence situation Gold Command will continue at present to meet weekly.<br><br>The Committee **NOTED** the content of the report and actions being taken. | |
| **4.2.0** | **Workforce and Organisational Development Performance Report / Financial Report** | |

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

The Committee received its first combined Workforce & Associated Finance Risks Report which outlined the risks currently faced by the Trust in respect of workforce and finance and the mitigation actions. The following areas were highlighted:

- A significant amount of work is currently focusing on the development of holistic 'on the ground' workforce plans to ensure current and future demand requirements are met, in particular Radiotherapy and medical staff which are key areas of risk.
- Work is underway to review all fixed term contracts, with a view to managing down the potential risk of associated redundancy costs, or financial risks associated with recruiting permanent staff as an alternative.
- It was noted that agency costs will continue to be incurred as a direct result of difficulties in recruiting appropriate staff into permanent positions in addition to current levels of staff absence. There is also a lack of specialist agency staff e.g. SACT trained staff which may result in the need to outsource some activity to the private sector, involving further significant financial outlay.
- Options in relation to the agency position will be provided in the next paper to provide additional assurance on actions being taken to reduce agency costs.
- It was advised that more specific Workforce plans and progress against these would be provided via quarterly updates to Committee.

COB outlined the complexity of the workforce planning that this required (and related financial impact) to sustain the next 12-18 months, advising that the Clinical Transformation Lead is currently working alongside Workforce colleagues to analyse:

- skill mix
- use of Advanced Practice
- sustainment and effective utilisation of current Workforce
- investment in and development of new roles
- a review of outreach resources
- changes to current core services
- potential staffing requirements to allow the transition to the new hospital.

HW suggested that investment into possible external training of newly recruited overseas staff (from outside the NHS) would mitigate pressure on Consultants, as this poses a potential risk for the organisation.

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| | SH suggested that a summary of challenges posed by staffing requirements / agency costs, opportunities and plans to manage this going forward would allow a more informed conversation in terms of the extent the Trust would be willing to recruit at risk. This was welcomed.<br><br>The Committee **NOTED:**<br>• The content of the Finance Workforce key risks paper;<br>• The content of the January 2022 Financial report, in particular the financial performance to date and year end forecast to achieve financial break-even; and,<br>• The content of the January 2022 Workforce report. | |
| 4.3.0 | **January Quality, Safety & Performance Update**<br>Led by Cath O'Brien, Chief Operating Officer<br><br>The overarching Trust Performance report was discussed and the following key items were highlighted:<br><br>• There continues to be a two month 'lag' in data reported to the Committee due to the data validation requirements and business intelligence system constraints within the reporting cycle. The Committee was assured that work is ongoing to reduce this timescale as far as possible and that future reports will incorporate new data as it becomes available during the reporting cycle to ensure documentation remains as live as possible.<br>• Work continues in relation to the reporting of COSC (Clinical Oncology Sub-Committee) targets and clarity has been requested from Welsh Government in relation to the position of the COSC targets in Wales. The current working premise is that until such a time as they are considered national targets, they will not be included on the new Trust scorecard. However, reporting data will be retained for use in the event that they are mandated as a formal requirement in the future.<br><br>The Committee **NOTED** the content of the report. | |
| 4.4.0 | **Welsh Blood Service Quality Safety & Performance Divisional Report**<br>Led by Alan Prosser, Interim Director of Welsh Blood Service<br><br>The Welsh Blood Service report provided an update on performance against key metrics for the period until the end of February 2022. The report had been re-configured and was presented for the first time under the headings of the 'six domains of quality'. The following areas were highlighted:<br><br>• Two safety incidents had been reported; one 'near miss event' involving a cross-matching error not identified during the WBS checking procedure but at the bedside check. The Committee was | |

assured that a report had been submitted to the Medicines and Healthcare products Regulatory Agency (MHRA). The second related to a patient death following transfusion where there was a possibility of an infected blood product. A full investigation had been undertaken in conjunction with the relevant Health Board. This concluded that the cause of death was most likely unrelated to the transfusion and following robust sample testing, there was no evidence of any bacterial infection within the product supplied. The Committee acknowledged the robust and swift investigation undertaken by WBS in relation to both matters.

- Due to COVID pressures, not all planned WBS audits had been completed. Six had been delayed. AP indicated that one audit had concluded within the required timeframe and a further three would remain within the current ISO (Internal Organisation for Standardisation) audit cycle. The remaining two will be undertaken during Quarter 1 of 2022/23.
- Donor satisfaction remains high and a summary of 'you said, we did…' was also detailed in the report.

The Committee commended the revised reporting template and **NOTED** that an update in relation to the cross-matching error would be provided by AP to the Chair of the Committee.

**AP**

| 4.5.0 | **Velindre Cancer Service Performance Report** |
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Led by Cath O'Brien, Chief Operating Officer
The Velindre Cancer Service Performance report provided an update on outcomes and performance against key metrics for the period to the end of January 2022. The following was highlighted:

- *Radiotherapy* continues to operate under considerable pressure, due to Linear Accelerator capacity, COVID related staff absence, and an increased volume of patients. Demand and capacity modelling is underway which includes an assessment on patient waiting times.

- *SACT (Systemic Anti-Cancer Treatment Therapy)* – A SACT Task Force has been established to review delivery and staffing plans to ensure optimum efficiency in the delivery of SACT. All short term actions are due to be completed by the end of May 2022. Daily SACT delivery meetings are currently being held to manage the service closely, additional clinics are being held when possible and active staff recruitment is underway. There remains a high volume of both COVID and non-COVID related SACT nurse staff absence.

- *Falls* – One avoidable fall had been reported and the Committee was assured that lessons learnt had been enacted. The Senior Nurse Professional Standards & Practice has undertaken a comprehensive review of falls management on First Floor Ward and the report is awaited.

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| | • *Healthcare Acquired Infections* – One infection (Clostridium Difficile) had been reported and an investigation concluded this had potentially been acquired through Radiotherapy or antibiotic use.<br><br>Further assurance in relation to Radiotherapy patient waiting times was requested due to the potential for claims to be brought against the Trust and the impact of patient complaints on staff. It was also noted that a more detailed breakdown of breaches of waiting time targets is required to provide further public assurance. COB confirmed that a technical issue had prevented access to breach data for this reporting cycle; however this would be included going forward.<br><br>The Committee **NOTED** the content of the report and the inclusion of additional information relating to Radiotherapy referrals to Rutherford Cancer Centre. | **COB** |
| **4.6.0** | **Digital Service Operational Report**<br>Led by Carl James, Director of Strategic Transformation, Planning and Digital and David Mason-Hawes, Head of Digital Delivery<br><br>The comprehensive Digital Services report that provided an update of all operational Digital Services activity for the period October 2021 to February 2022 was discussed. The following was highlighted:<br><br>• A number of elements have been delayed due to significant operational pressures, resulting in deferral to next year's IMTP (Integrated Medium Term Plan).<br>• GovRoam has now been fully implemented, allowing Trust staff seamless connection with the network when working at other local sites / organisations. Positive feedback has been received from clinical staff.<br>• The go live of Prometheus has been delayed due to IT issues and application structure. DMH advised that ongoing engagement will resolve issues identified and provide assurance in terms of managing the infrastructure. A potential revised go live date of June 2022 has been suggested.<br>• Work is ongoing to improve compliance against the NCSC (National Cyber Security Centre) framework for Cyber Security and a full progress report will be received at Quality, Safety & Performance Committee twice yearly.<br>• The Business Continuity Team has confirmed no significant impact on patient and donor care, with resolution of a number of issues achieved via a hardware upgrade.<br><br>The Committee **DISCUSSED** and **REVIEWED** the content of the report and **NOTED** the significant work being undertaken in respect of digital. | |
| **4.7.0** | **Trust Risk Report**<br>Led by Lauren Fear, Director of Corporate Governance and Chief of | |

Staff

The report provided assurance in relation to management of risks across the Trust as identified on the Datix system during February 2022. The following was highlighted:

- There are 170 current risks recorded on Datix.
- The February 2022 extract provided a breakdown of the: 9 level 20 risks (5 for Velindre Cancer Service and 4 for Transforming Cancer Services); and 18 level 16 risks (1 for Transforming Cancer Services, 1 for Corporate and 16 for Velindre Cancer Service). There were no level 25 risks for reporting to the March 2022 cycle.
- The immediate focus for the coming period will be the management of risks and related actions in a prioritised manner.
- Following discussion at Executive Management Board, a further review of the Digital Health and Care Record project risks would be undertaken due to the significant number of risks scoring at 20 and 16. The Committee will be advised of the outcome in the next report.
- Geo-political risks relating to the current war in the Ukraine and their articulation into Datix are currently being worked through by the Business Continuity Group, in particular around potential supply chain disruption and Cyber risks. Updates will continue outside of the reporting Cycle if required.

The Committee **NOTED** the risks level 20 and 16 reported in the Trust Risk Register and highlighted in the cover paper and **NOTED** the ongoing developments of the Trust's Risk Framework.

| 4.8.0 | **Quarter 3 Putting Things Right Report** |
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**Quarter 3 Putting Things Right Report**
Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science & Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience

The Trust Quarter 3 Putting Things Right Report provided a summary of concerns, complaints and incidents received during the period 1st September 2021 and 31st December 2021. The following was highlighted:

- 44 concerns were raised during the Quarter, 89% of which were graded at level 1 (no harm and likely to be speedily addressed). 73% of the concerns raised were managed via the Early Resolution process (within 2 working days) and 27% managed via the Putting Things Right process.
- Concerns relating to the COVID-19 Pandemic were significantly reduced.
- 75% of formal concerns raised were closed within the 30 working day timeframe, which is an increase from the previous quarter and

equate to the Welsh Government target of 75%.

- The top three themes from concerns were: appointments, attitude and behaviour, and Clinical Treatment.
- 468 incidents were raised during the Quarter (367 from the Cancer Service and 101 from the Welsh Blood Service), 85% of which were graded as no harm or low harm.
- There was one National Reportable Incident reported relating to the nature of clinical consultations within a specialty during the pandemic (reported due to volume rather than level of harm).
- The outcome of the 'deep dive' undertaken into incidents and concerns from quarters 1 and 2 was received and discussed. Actions are being taken by Divisions to address the issues identified and a further deep dive will be undertaken during September 2022.
- A significant amount of work has been undertaken within the Cancer Service during the last three months to improve how it investigates and responds to concerns raised.

The Committee **DISCUSSED** and **NOTED** the content of the report and associated appendices.

| 4.9.0 | **Review of Information Governance Incidents & Trends**<br>Led by Matthew Bunce, Executive Director of Finance<br><br>The Information Governance report provided **ASSURANCE** in relation to how the Trust manages patient, donor, service user and staff information in accordance with Information Governance legislation and standards and the eight domains of information governance. The following was highlighted:<br><br>- Application of the Information Governance Toolkit (as is required by all NHS organisations) has facilitated effective assessment of the Trust against all key aspects of Information Governance and the development of a robust work / action plan. This will conclude by the end of March 2022 and will be followed by a self-assessment exercise and shared learning with other organisations to inform the remaining Information Governance Assurance Framework.<br>- All systems, irrespective of age and manual /electronic setup, should undergo a DPIA (Data Protection Impact Assessment) to minimise risks associated with handling and storage of data. The Trust currently does not have completed DPIAs for all systems, so as well as completing DPIAs for new systems, this will require retrospective assessments of some existing systems.<br>- No breaches of the one month calendar response timeframe had been reported during the period 1st December 2021 - 28th February 2022 for the total of 47 information requests.<br>- Aside from Cyber threat, human error remains the largest element of risk and bespoke training is underway to mitigate this in addition to the standard training. | |

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| | MB requested agreement from the Committee for the continued application of those Information Governance policies that had passed their scheduled review date while a review is undertaken. It is anticipated that the review will conclude by end of April 2022.<br><br>The Committee supported the suggestion of removing the standard section explaining Information Governance processes from future reports and should instead focus on more specific aspects of IG assurance work and this would be based on the improvement areas identified through the annual self-assessment National toolkit. This would enable the Committee to take assurance from the evidence used to support each aspect of the IG requirements set nationally. The report would continue to include data security incidents, investigations, associated actions and learning as well as performance against legislative response timescales for data protection DPA information requests.  It was also suggested that quarterly meetings between SH, MB and Chief Digital Officer to enable detailed discussions on IG assurance would allow a higher level of reporting to Committee. SH agreed to communicate relevant assurance among Independent Members and this was welcomed.<br><br>The Committee **DISCUSSED** and **REVIEWED** the content of the report and **AGREED** the continued use of Information Governance Policies that had passed their review date until the review has been completed by end of April 2022. | |
| **4.10.0** | **Freedom of Information Requests Report (deferred from January 2022 Committee)**<br>Led by Lauren Fear, Director of Corporate Governance and Chief of Staff<br><br>A comprehensive Freedom of Information Act Report was received, detailing how the Trust has complied with requirements during the calendar year 2021. The following was highlighted:<br><br>• The Trust had received 151 requests during the year. The three most significant areas of requests continue to be: renewal dates of digital contracts (19); drug treatment data (12); and matters relating to the building of the new hospital (12).<br>• Overall compliance with completion timescales was 52%; this was due to the pandemic affecting the Trust's ability to respond to requests within the required FOI timescales. It had been recognised by the Information Commissioner's Office that, during the pandemic, organisations' ability to meet timescales would be impeded and the Trust website indicated that while the Trust would comply with timescales wherever possible, these may be affected by new priorities resulting from the pandemic.<br>• Improvement plans have been developed to ensure a minimum of 80% compliance throughout 2022. | |

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| | The Committee **NOTED** the content of the report. | |
| **5.0.0** | **INTEGRATED GOVERNANCE**<br>(The integrated governance part of the agenda will capture and discuss the Trust's approach to mapping assurance against key strategic and operational risks) | |
| **5.1.0** | **Health Care Standards Self-Assessment Action Plan / Improvement Plan**<br>Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science & Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience<br><br>The Health & Care Standards report provided the current position in relation to Trust compliance with the Health and Care Standards for Wales (2015) and progress against the 2021/2022 Trust Improvement Plan for the period ending December 2021 (Quarter 3). The following was highlighted:<br>• An Executive review of scores had identified an increase in a number of scores and a reduction in others, indicating that a sufficient level of scrutiny is being applied during the decision making process.<br>• Areas reporting lower scores will undergo improvements with a view to demonstrating adequate evidence of this.<br>• Three Workforce related actions within the Improvement Plan were delayed: Disability Confident Accreditation, the Virtual Reality Learning Project and Development of the HealthCare Support Worker role at Velindre Cancer Service, due to the pandemic and team capacity issues. Revised delivery timeframes had been identified.<br>• A new set of Quality Standards in line with the Wales Quality & Engagement Act are currently under development for use across all departments post-April 2023.<br>• A review of target scores and timeframes for these will be undertaken and included in future reporting.<br><br>VM requested a comparison of how the Trust self-assessment compares with other Health Boards in addition to how the new Quality Standards may affect key areas for improvement. NW advised that this information may not be available but a review would be undertaken to ascertain if this is possible.<br><br>Boards will be provided subject to availability of this information.<br><br>The Committee **NOTED**:<br><br>• The current status and progress being made year to date in respect of the Health and Care Standards;<br>• The status in respect of the Health and Care Standard Improvement Plan; | **NW** |

| | | |
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| | • The overarching Trust compliance scoring table for Health and Care Standards. | |
| **5.2.0** | **Trust-wide Policies and Procedures Report**<br>Led by Lauren Fear, Director of Corporate Governance & Chief of Staff<br><br>The Trust-wide Policies and Procedures Report provided a high level overview of the comprehensive review that had been undertaken in relation to policy management arrangements across the Trust, including details and early outcomes of an audit of all Trust-wide policies that fall within the remit of the Quality, Safety & Performance Committee. The following was highlighted:<br><br>• The revised Trust Policy and Procedure for the Management of Trust Wide Policies that had been approved by the Executive Management Board was received. This policy review had incorporated the findings of a pan Wales' benchmarking exercise to establish best practice and incorporate key changes to statutory requirements. The revised policy also includes the development of a fully integrated impact assessment to support the review of any existing and development of new Trust-wide policies going forward.<br>• Due to the number of Trust wide policies (circa 157), the audit has been phased to ensure a robust review. Workforce and Organisational Development policies will be audited through April 2022 and the results will be reported to the May 2022 Committee, at which time the Committee will have a full and clear audit status of all Trust- wide policies that fall within the remit of the Committee.<br>• Two policies that were audited had long standing review dates (2010 & 2016); the Incident Policy had been reviewed and was approved at the Committee; the ownership of the Cleaning Policy had been amended and a review has commenced.<br>• Further work is required in respect of the position in relation to Trust Policies and Procedures for hosted organisations. This will be included as a separate appendix to the overarching policy once the governance in relation to this has been clarified and agreed.<br><br>The Committee:<br><br>• **NOTED** the revised Policy and Procedure for the management of Trust-wide policies and other Trust-wide written control documents (GC01) following **APPROVAL** at the Executive Management Board (Run) on 7th March 2022;<br>• **DISCUSSED** and **REVIEWED** the findings of the Policy Management Review and compliance status for those policies that fall within the remit of the Quality, Safety & Performance Committee;<br>• **NOTED** the Quality, Safety and Performance Committee Policies | |

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| | Extract Compliance Report as at 1st March 2022.<br><br>The Committee commended the significant amount of work undertaken and progress to date and **NOTED** the planned additional steps. LF agreed to provide confirmation to VM outside the Committee of the required approving authority for the revised Policy and Procedure for Trust Wide Policies. | |
| 5.3.0 | **Analysis of triangulated meeting themes**<br>Led by Vicky Morris, Quality, Safety and Performance Committee Chair, supported by all Committee members<br><br>NW recognised the Trust's current position in line with meeting the new Quality & Engagement Act requirements, including the reconfiguration of the WBS report under the six domains of quality to align with the reporting format of Velindre Cancer Service.<br><br>Additionally, the impact of the COVID pandemic over the past two years on the organisation continues, in particular the impact on the Freedom of Information Act, compliance and Policy reviews. Despite ongoing staffing challenges, the Trust's ability to adapt to continue to deliver core services has been exemplary; however it will be some time before Business as Usual is achieved.<br><br>**Analysis of Quality, Safety & Performance Committee effectiveness**<br>Led by Vicky Morris, Quality, Safety and Performance Committee Chair supported by all Committee members<br><br>VM ensured that the Committee was satisfied that all areas of the agenda had been afforded adequate time for discussion. | |
| 6.0.0 | **HIGHLIGHT REPORT TO TRUST BOARD** | |
| | **Members were asked to identify items to include in the Highlight Report to the Trust Board:**<br><br>It was agreed that VM and the Committee Secretariat would agree items for inclusion in the Board highlight report for the purposes of Alerting / Escalation, Advising, Assurance and Information. | |
| 7.0.0 | **ANY OTHER BUSINESS** | |
| | **Annual Quality Statement**<br>Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science<br><br>NW advised that prior to 2020, it was a requirement of the Trust to publish an Annual Quality Statement. The Trust had received recent notification that consistent with the previous reporting year, there would be no requirement for an Annual Quality Statement for 2022. Therefore, the Trust Annual Report will include a robust Quality | |

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| | Improvement and Learning element.<br><br>Additionally, there is no requirement to publish an Annual Putting Things Right report for 2022; this will however be produced for Trust assurance purposes. | |
| **6.0.0** | **DATE AND TIME OF THE NEXT MEETING** | |
| | The Quality, Safety & Performance Committee will next meet on the:<br>**12th May 2022 from 10:00 – 12:30 via Microsoft Teams.** | |

| CLOSE |
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| **The Committee is asked to adopt the following resolution:**<br><br>That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67). |

# QUALITY, SAFETY & PERFORMANCE COMMITTEE

## Ref: IPC 07: Policy for the Prevention and Control of Methicillin Resistant Staphylococcus Aureus (MRSA)

| DATE OF MEETING | 12th May 2022 |
|---|---|

| PUBLIC OR PRIVATE REPORT | Private |
|---|---|

| IF PRIVATE PLEASE INDICATE REASON | The Executive Management Board is a private meeting |
|---|---|

| PREPARED BY | Julianne Golding-Sherman, Infection Prevention & Control Nurse |
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| PRESENTED BY | Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science |
| EXECUTIVE SPONSOR APPROVED | Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science |

| REPORT PURPOSE | ENDORSE FOR COMMITTEE APPROVAL |
|---|---|

| COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING | | |
|---|---|---|
| COMMITTEE OR GROUP | DATE | OUTCOME |
| Infection Prevention and Control Divisional Group – Velindre Cancer Centre | 09/03/2022 | ENDORSED FOR APPROVAL |
| Trust Infection Prevention and Control Management Group | 23/03/2022 | ENDORSED FOR APPROVAL |
| Executive Management Board | 27/04/2022 | ENDORSED FOR APPROVAL |

| ACRONYMS | |
|---|---|
| CANISC | Cancer Network Information System Cymru |
| CMO | Chief Medical Officer |
| CNO | Chief Nursing Officer |
| CP's | Contact Precautions |
| CRA | Clinical Risk Assessment |
| HCW | Health Care Workers |
| HICK | Broviac Implants |
| ICNet | ICNet Clinical Surveillance Software |
| IPCT | Infection Prevention and Control Team |
| IV | Intravenous |
| MRSA | Methicillin Resistant *Staphylococcus Aureus* |
| MSSA | Methicillin Sensitive *Staphylococcus Aureus* |
| OCCH | Occupational Health |
| PGD | The Patient Group Direction |
| PICC | Peripherally inserted central catheter |
| PPE | Personal protective clothing |
| UHB | University Health Board |
| VCC | Velindre Cancer Centre |

**1.    SITUATION**

The Policy for the Prevention and Control of Methicillin Resistant Staphylococcus Aureus (MRSA) is provided to the Quality, Safety & Performance Committee for **APPROVAL.**

**2.  BACKGROUND**

This policy is a long standing policy for the Trust that has been reviewed in line with changing national guidance.

The aim of this policy is to prevent, as far as possible, the transmission of MRSA between patients and staff and to prevent contamination of the clinical environments with MRSA. The policy is aimed at all Trust employees / contractors, but particularly those in the clinical setting.

The review of this policy was impacted on by the pandemic and Infection Prevention and Control staff constraints. The previous policy remained extant during the time taken to amend this policy.

**3.    ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION**

3.1    Wide engagement has taken place in respect of this policy revision including Public Health Wales colleagues, members of divisional and Trust Infection Control groups.

3.2    A summary of the key changes are outlined below:

- The Policy statement has been expanded slightly.

- The clinical risk assessment tool has been added (this CRA is also included within IPC Policy number 15: Control & Management of Multi Drug Resistant Bacteria).

- Removal of the PGD MRSA decolonisation

- Further additional paragraphs to policy include:

  - Domestic/Housekeeping responsibilities
  - Panton Valentine Leukocidin information
  - Cohort nursing MRSA positive patients

- References reviewed and refreshed.

3.3.   An Equality Impact Assessment was undertaken in January 2020. *No potential negative impact was been identified.* Therefore this does not need repeating as minimal changes have been made.


## 4.   IMPACT ASSESSMENT

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| QUALITY AND SAFETY IMPLICATIONS/IMPACT | There are no specific quality and safety implications related to the activity outined in this report. |
| RELATED HEALTHCARE STANDARD | Safe Care |
| | If more than one Healthcare Standard applies please list below: |
| EQUALITY IMPACT ASSESSMENT COMPLETED | Yes |
| | As this is only revision to the existing policy, a new EQIA has not been requested. |
| LEGAL  IMPLICATIONS / IMPACT | There are no specific legal implications related to the activity outlined in this report. |
| FINANCIAL IMPLICATIONS / IMPACT | There is no direct impact on resources as a result of the activity outlined in this report. |


## 5.  RECOMMENDATION

The Quality, Safety & Performance Committee are asked to **APPROVE** the revised Policy for the Prevention and Control of Methicillin Resistant Staphylococcus Aureus (MRSA). Once approved the revised policy will be published on the Trust Intranet site and circulated to the policy distribution list.

**Ref: IPC 07**

# Policy for the Prevention and Control of Methicillin Resistant Staphylococcus Aureus (MRSA)

| Executive Sponsor & Function | Executive Director of Nursing, AHPs and Health Science |
|---|---|
| **Document Author:** | Infection Prevention & Control Team |
| **Approved by:** | Trust Quality, Safety & Performance Committee |
| **Approval Date:** | |
| **Date of Equality Impact Assessment:** | *January 2020* |
| **Equality Impact Assessment Outcome:** | *This policy has been screened for relevance to equality. No potential negative impact has been identified.* |
| **Review Date:** | Three years: May 2025 |
| **Version:** | 4 |

# CONTENTS

**ABBREVIATIONS**

| | |
|---|---|
| CANISC | Cancer Network Information System Cymru |
| CMO | Chief Medical Officer |
| CNO | Chief Nursing Officer |
| CP's | Contact Precautions |
| CRA | Clinical Risk Assessment |
| HCW | Health Care Workers |
| HICK | Broviac Implants |
| ICNet | ICNet Clinical Surveillance Software |
| IPCT | Infection Prevention and Control Team |
| IV | Intravenous |
| MRSA | Methicillin Resistant *Staphylococcus Aureus* |
| MSSA | Methicillin Sensitive *Staphylococcus Aureus* |
| OCCH | Occupational Health |
| PICC | Peripherally inserted central catheter |
| PPE | Personal protective clothing |
| UHB | University Health Board |
| VCC | Velindre Cancer Centre |
| VUNHST | Velindre University NHS Trust |

## 1. POLICY STATEMENT

### *Staphylococcus aureus* and Methicillin Resistant *Staphylococcus Aureus*

Approximately 30% of the population is colonised by *Staphylococcus aureus* (methicillin sensitive *Staphylococcus aureus*), which is usually present on the nose and/or skin. *S.aureus* infections acquired outside a healthcare setting typically involve the skin and soft tissue (e.g., impetigo, folliculitis, boils, and infected minor breaks of skin) and more rarely the bone and joints.

Healthcare associated *S.aureus* may infect the skin and soft tissue, usually as surgical wound infection, but also colonise the foreign bodies frequently used in patient care causing infections (e.g. intravascular line infection, prosthetic-related infections, urinary catheter-associated infections, ventilator-associated pneumonia). Infections can sometimes be severe and spread to the bloodstream.

Methicillin Resistant *Staphylococcus aureus* (MRSA) is resistant to antibiotics such as Flucloxacillin, an initial option for treating some infections. Some MRSA strains may also be resistant to a wider range of antibiotics leaving a limited choice of antibiotics to treat infections.

Methicillin Sensitive *Staphylococcus aureus* (MSSA) and MRSA are mainly transmitted by direct and indirect physical contact e.g. through the contaminated hands of health care workers (HCW) and / or re-useable equipment if not decontaminated correctly after use on another MSSA / MRSA colonised patient.

This policy sets out appropriate controls and clinical procedures in place to minimise the risk of transmission of MRSA between service users, patient's visitors and staff. The policy has been reviewed and updated.

## 2. SCOPE OF POLICY

The policy applies to all staff, in all locations of Velindre University NHS Trust ("the Trust") including those with honorary contracts and students placement.

## 3. AIMS AND OBJECTIVES

Provide the Trust with structured and appropriate guidance to staff for the prevention and management of MRSA colonisation/infection.

- Set out the requirements for all HCWs involved in the care and management of patients with MRSA.

- Ensure best practice and high quality of care.

- Provide staff with the screening process for admission to hospital.

- Ensure that patients with MRSA have effective and appropriate care wherever that care is delivered.

- Reduce the risk of transmission, acquisition, colonisation and infection with MRSA.

## 4. RESPONSIBILITIES

### 4.1 The Chief Executive

The Chief Executive has overall responsibility for implementation, monitoring and review of this policy.

### 4.2 Clinical and Operational Managers

Clinical and Operational Managers have responsibility to ensure that:
- Staff are informed of the policy.
- Practice complies with this policy.
- Equipment and training is available to facilitate compliance with policy.

### 4.3 Clinical staff working directly with patients and the public

Clinical staff working directly with patients and the public have responsibility to ensure that they:
- Familiarise themselves with the policy.
- When appropriate clinically risk assess patients for MRSA on every admission.
- Manage patients at risk of, or diagnosed with MRSA in a way that will reduce the risk of transmission from patient to patient or patient to staff.
- Report cases transferred in from other hospitals.

### 4.4 Infection Prevention & Control Team (IPCT)

The IPCT is responsible for:
- Providing advice on appropriate placement of patients with MRSA in hospital.
- Producing timely feedback on surveillance of MRSA acquisition for wards/units, departments and Trust.
- Ensuring that patients with first time isolates of MRSA have an Infection Prevention & Control alert placed currently on Cancer Network Information System Cymru (Canisc).
- Ensuring that clinical teams are informed about their patients following identification of MRSA either in pre-admission assessment clinics/outpatient department or when the patient has been an in-patient.
- Producing reports to relevant committees and groups and for the Trust Board on MRSA.
- Ensuring that all MRSA bacteraemias are reported to Public Health Wales via ICNet
- Supporting the investigation of and learning from any MRSA bacteraemia post infection reviews.
- Investigating suspected incidents of cross infection.

### 4.5 Domestic/Housekeeping Staff

Housekeeping **staff** are responsible for:

- Ensuring that they comply with the infection control management of MRSA patients as detailed and that they challenge or report any poor practice.
- Ensuring that enhanced cleaning is carried out for all MRSA patients in their area.
- Terminal cleans on discharge / negative results.

## 4.6.   Distribution

The policy will be available via the Trust intranet site and from the IPCT. Where the staff do not have access to the intranet their line manager must ensure that they have access to a copy of this policy.

## 5.  DEFINITIONS

### 5.1   *Staphylococcus Aureus*

Is a Gram positive bacterium often found on the skin or in the nose of individuals. It colonises the skin or anterior nares (nose) of approximately 20 - 30% of healthy individuals but this percentage can rise in hospitalised patients. The organism can cause abscesses, wound infections and septicaemia. One strain of *S. aureus* known as MRSA is resistant to an antibiotic called methicillin and other antibiotics used to treat infection. This strain accounts for 2 – 3% of all *S.aureus* strains but is no more virulent or more readily spread than MSSA.

### 5.2   Methicillin Resistant *Staphylococcus Aureus* (MRSA)

Methicillin resistant *Staphylococcus aureus* is a significant cause of healthcare associated infection. It can result in blood stream infection (bacteraemia) that can be life threatening. MRSA can also cause skin and wound infections, urinary tract infections and pneumonia. These infections require treatment with antibiotics**.**

It can be easily transmitted by direct skin contact or by indirect contact via equipment and fomites. It has the capacity to survive in the environment for prolonged periods and is resistant to a wide range of antibiotics.

### 5.3   Carriage

A person who harbours MRSA with no overt signs or symptoms of clinical disease, but who is a potential source of infection. Recognised carrier sites for MRSA include the nose and throat and certain skin sites, such as perineum, groin, axilla and buttock. The carriage of MRSA can be transient, intermittent or of long duration (chronic).

#### Transient carriage

Occurs when MRSA is present on the hands, arms, face or inside the nose for a short period of time, i.e. a few hours. Staff often become transient carriers when caring for patients with MRSA**.**

### 5.4   Colonisation

Colonisation by MRSA is harmless and asymptomatic to the patient but in a small number of cases it can cause infection ranging from minor skin infections to BSI's. MRSA colonisation can only be identified by taking swabs from the following sites: nose, groin, wounds, sputum (if the patient has a productive cough) and urine sample (if the patient has a catheter in situ).

Patients colonised with MRSA can be a significant issue in healthcare settings because:
- Patients colonised with MRSA who undergo invasive procedures are at risk of developing an MRSA infection.

- The presence of patients colonised with MRSA in hospitals is a potential source of infection for other patients.
- Should MRSA infections develop they are harder to treat as the antibiotics they are susceptible to are more limited.

## 5.5 Infection

With MRSA occurs when the presence of MRSA causes clinical consequences, e.g. inflammation, swelling and pus formation. MRSA infection can occur in the skin and soft tissues, lungs, bones and joints or in the blood stream i.e. MRSA bacteraemia.

## 5.6 Panton Valentine Leukocidin

Panton Valentine Leukocidin (PVL) is a toxic substance produced by some strains of *S.aureus*, which is associated with an increased ability to cause disease. The incidence is low at present.

PVL can be produced by both methicillin sensitive and methicillin resistant strains of *S. aureus.* At present in the UK the majority of isolates are methicillin sensitive.

The infection control measures used to prevent the spread of PVL-positive MRSA are the same as for any type of MRSA infection; this includes screening and the decolonisation regime.

PVL MRSA affects healthy children and young adults and is usually community acquired. Staff should wear face masks during intubation and chest physiotherapy. Closed suction should be used.

Patients identified on screening as having a PVL producing strain of MRSA may need specific screening and treatment. In this instance advice should be sought from the IPCT as family members may require screening.

## 6. IMPLEMENTATION/POLICY COMPLIANCE

## 6.1 Background

Patients may be carriers of MRSA or contract it through transmission from another affected person. MRSA can cause wound, respiratory, urinary or blood stream infections. The Clinical Risk Assessment (CRA), (Appendix 7) in this policy ensures staff screen patients that are at a higher risk of infection from MRSA (for example, previous MRSA history or admission).

The 'Implementation of modified admission MRSA screening guidance for NHS' from the Department of Health in 2014 required MRSA screens for acute and elective admissions in England to be streamlined to the following:

- All patients admitted to high risk units.
- All patients previously identified as colonised with or infected by MRSA.

Routine MRSA screening has been shown to detect MRSA colonisation early and provides the opportunity to eradicate carriage to prevent transmission and/or infection. Following an evaluation of the Health Protection Scotland's Pathfinder Programme, the Chief Medical Officer (CMO)/Chief Nursing Officer (CNO) Wales implemented targeted MRSA screening across Wales. CMO/CNO letter stipulates the introduction of routine MRSA screening for all patients in the following patient groups, as a minimum and includes:

A requirement to use CRA to assess each admission as to whether the patient:
- Has a past history of colonisation/infection with MRSA at any time
- Is resident in a care home, other institutional setting or is a transfer from another hospital
- Has a wound or in-dwelling device (e.g. gastrostomy, urinary catheter, long term intravascular device) present on admission

A requirement to swab screen any patient who answers yes to any of the above questions using a minimum of 2 swab sites (nasal/perineum or nasal/throat if perineum/ groin is deemed difficult or unacceptable).
- A record of the assessment and results of the swab.
- Prioritisation (within existing schemes of prioritisation) for pre-emptive isolation/cohorting pending swab results.

## 6.2 Risk Factors for MRSA carriage
Patients who are risk from colonisation or infection from MRSA are those who;
- Are known to be carrying MRSA, or to have done so previously.
- Are admitted from care homes.
- Have been in hospital within the past 12 months.
- Are transferred from other hospitals or from abroad.
- Have received repeated course of antibiotics.
- Have renal disease or diabetes.
- Have skin breaks for example for pressure sores, leg ulcers, central/peripheral venous catheter, percutaneous endoscopic gastrostomy tubes and any other indwelling devices.
- Have certain active dermatological conditions, for example psoriasis or eczema.
- Oncology patients with head and neck cancer (based on local data).

## 6.3 Diagnosis of Infection
Any patient found to be a carrier of MRSA should be assessed for evidence of infection, for example sepsis syndrome, skin and soft tissue infection, pneumonia, bone/joint infection, device related infection, endocarditis. The need for in dwelling catheters and intravascular devices should be reviewed and they should be removed when possible to minimise risk of subsequent infection.

MRSA isolated from sputum or from urine, usually represents colonisation but patients should be carefully assessed for active infection.

Eradication of MRSA from catheterised patients usually requires catheter removal or at least change, with or without systemic antibiotic therapy. Advice should be sought from the microbiologist.

MRSA isolated from non-inflamed skin or ulcers, or from other sites where there are no overt signs of infection implies colonisation rather than infection and should be managed as such without oral or parenteral antibiotics. MRSA isolated from a clinically infected wound, or inflamed ulcer, should be interpreted according to the clinical picture.

## 6.4 Screening
Screening should be carried out according to the guidance below or as directed by the IPCT. A patient screen should only include:
- Nasal swab.

- Perineal swab (or groin if perineum not accessible).
- Swabs of any breaks in skin, including wounds, vascular access devices and drain exit sites (see appendix 1).

*Charcoal (black) swabs should be moistened with sterile saline or sterile water prior to use.

The MRSA screen is requested via the Welsh Clinical Portal. Give additional information if submitting additional swabs of any indwelling devices/ and or wounds and provide the relevant clinical information.

### 6.5 Who should be screened?

All patients who will have planned admissions for long courses of daily radiotherapy or inpatient chemotherapy should be screened for MRSA on their first appointment with the Oncologist, or at the time the treatment plan is devised. This will ensure that screen results are returned before admission and that no patient colonised or infected with MRSA is placed on an open ward.

### 6.5.1 Patients requiring peripherally inserted central catheters (PICC) and Broviac Implants (Hickman Line)

All patients scheduled to receive a PICC or a Hickman line must be screened where possible, two weeks before insertion of the device. This will allow time for turnaround of results and decolonisation if necessary. If the PICC or Hickman line is an emergency, a screen for MRSA should be taken as soon as possible. (See appendix 3).
The same principles apply to patients for whom a Hickman line is planned.

### 6.5.2 Patients undergoing radiotherapy as inpatients

All planned admissions to the inpatient wards, for example those undergoing prolonged courses of radiotherapy, should be screened no later than one week prior to admission or at their first appointment at VCC.

### 6.5.3 Patients undergoing chemotherapy as an inpatient

All planned admission to the inpatient chemotherapy ward should be screened for MRSA no later than one week prior to admission or at the first outpatient appointment in VCC.

### 6.5.4 Patients with head and neck cancers.

Patients with a head and neck cancer should be screened for MRSA at least one week prior to admission or at their first appointment in VCC.

Historical data shows that some patients with head or neck cancers are positive for MRSA in the throat and on that basis, throat screens may in special circumstances be requested by the IPCT but should not be included as part of a routine screen.

### 6.5.5 Outreach patients.

A number of patients do not attend VCC, instead they attend "Outreach" clinics hosted by surrounding Health Boards. These patients are attended by Velindre oncologists and Velindre specialist nurses. For those patients for whom an admission to VCC is planned, the specialist nurse or oncologist must screen or arrange for the patient to be screened for MRSA. Staff who place the PICC, or admit the patient must then access the results of the MRSA screen from the relevant UHB microbiology department. Please seek help from the IPCT if difficulties are experienced.

### 6.5.6 GP screening

It may on occasion be more convenient for patients to be screened for MRSA by their own GP. If this is the case the fact should be documented and the responsible clinician

should obtain the results of the screen from the patients GP. A written record from the GP handed to the patient is acceptable.

### 6.5.7 Unplanned emergency admissions
In the case of unplanned or emergency admissions patients should be screened for MRSA within 48 hours/ 2 days of admission. Use CRA when deciding which patients to isolate. For example where possible isolate patients with head and neck cancers who have not been screened. Contact the IPCT for advice.

### 6.5.8 Patients known or suspected to be MRSA positive
Any patient known to be or suspected to be MRSA positive should be isolated and screened with contact precautions (CP's) continuing until the MRSA screen results are returned.

### 6.5.9 Isolation of patient with MRSA
Separation of patients with MRSA (in an individual room) from others in order to prevent or limit the direct or indirect transmission of MRSA to other people who are susceptible.

### 6.5.10 Cohort nursing of patients with MRSA
A group of patients with MRSA who are separated from patients who do not harbour MRSA in a geographically distinct area or with physical separation in the same room. Isolation in separate rooms is preferable to cohort nursing. Ideally, the same nursing staff should provide daily care for the same cohort for the duration of the isolation.

### 6.5.11 Previously decolonised patients
Patients for whom there is documented evidence of a successful decolonisation programme can be nursed on the main ward but should be screened on each further inpatient admission.

### 6.5.12 Patients who have been hospitalised elsewhere since screening
Patients who have previously screened negative for MRSA should be rescreened if they have been admitted to another hospital, hospice or care home since their last admission to VCC e.g. patients who are admitted on a 3 weekly cycle of chemotherapy.


## 7.     DECOLONISATION

Decolonisation should be prescribed to treat a patient who has tested positive for MRSA. An assessment of previous history must be taken prior to starting treatment to identify previous colonisation/ or any decolonisation treatment already received.

The IPCT will direct decolonisation and rescreening, maintain records, and enter Information into the patient electronic record and alert system. The prescription chart for MRSA Decolonisation should be completed by doctors or nurse prescribers.


### 7.1.1 Treatment
Mupirocin nasal ointment and Octenisan body wash are the agents used for decolonisation. A prescription chart for MRSA only Mupirocin nasal ointment 2% should be applied to the inner surface of each nostril, (anterior nares) three times daily for 5 days. The patient should be able to taste the Mupirocin at the back of the throat after application (See appendix 2).

### 7.1.2 Using Octenisan wash lotion

Octenisan is a mild and gentle antimicrobial wash lotion for whole body cleansing including the hair. It is suitable for all skin types with a skin-neutral pH value and is free of artificial colours and perfumes. Daily showers or baths should be taken using Octenisan wash lotion for five days. The skin should be moistened and the Octenisan applied thoroughly (without dilution) to all areas before rinsing in the bath or shower. Special attention should be paid to known carriage sites such as the axilla, groin and perineal area. The Octenisan should also be used for all other washing procedures and for bed bathing (See appendix 2).

The hair should be washed with Octenisan twice in the five days then washed with normal shampoo. Clean clothing, bedding and towels should be provided after each application of Octenisan.

### 7.1.3 Failure to decolonise

Patients should normally receive only two attempts at decolonisation as more are thought likely to promote resistance to the products used. Patients who still test positive for MRSA after two attempts are regarded as chronically colonised and should be managed with contact precautions (CP's) thereafter. Further courses of decolonisation treatment may be recommended if the patient is to have surgery or other invasive procedure. If a third attempt is required Neomycin nasal ointment may replace Mupirocin nasal ointment on advice from the IPCT or microbiologist only.

### 7.1.4 Throat colonisation

In cases where throat colonisation is proved the IPCT may advise that patients gargle with 0.2% chlorhexidine gluconate mouthwash (e.g. Corsodyl®) mouthwash twice a day. If the patient has dentures or other dental prostheses, these should be soaked daily in 0.2% chlorhexidine gluconate mouthwash.

### 7.2 Rescreening

Three negative screens are required to prove decolonisation has been effective. The first screen should be collected at least 48 hours after the completion of decolonisation and parenteral antibiotics. Rescreens two and three must only be collected after the results from the previous test have been received.

### 7.2.1 Staff screening and management

Do not routinely screen staff for MRSA unless there is a clear epidemiological reason for doing so.

If staff are identified as MRSA positive, consider excluding staff from work, reducing their Interaction with patients, and offering decolonisation therapy as deemed appropriate.

## 8 CLINICAL MANAGEMENT & INFECTION CONTROL PROCEDURES / CONTROL MEASURES

Control measures include:
- Hand hygiene.
- Appropriate use of protective equipment.
- Maintenance of appropriate cleaning procedures (and correct use of appropriate cleaning products).

- Rational use of antibiotics.
- Appropriate disposal of waste.
- If a patient is colonised with MRSA, a single room is preferred. Decisions on individual cases should be risk assessed by clinicians/patient access with the support of IPCT.

### 8.1.2 Standard Infection Control Precautions

Standard infection control precautions include the use of gloves and aprons (personal protective clothing – PPE) when handling body fluids, decontaminating the clinical environment and medical equipment, and the disposal of sharps, linen and waste**.** Hand hygiene is the foundation of standard precautions and the prevention of infection.

### 8.1.3 Isolation of the patient

Please see appendix 5 & 6 for additional information on precautions & decontamination.

Patients known to be MRSA positive must be isolated ideally in an ensuite room. A Contact Precaution (CP's) Isolation sign (see appendix 4) must be fixed to the cubicle door. If ensuite is not available a commode must be placed in the isolation cubicle. Where possible the cubicle door must remain closed. Monitoring equipment, for example blood pressure cuffs and stethoscope must be dedicated to the isolated patient.

Staff who will have direct contact with the isolated patient or the patients' environment must don personal protective equipment (PPE) before entering an isolation cubicle. Gloves and aprons must be changed between care procedures and hand hygiene must be performed after glove removal. The PPE must be removed before leaving the cubicle and disposed of into the infectious waste stream (orange) located inside the cubicle. Hands must be washed after removal of gloves and before leaving the isolation cubicle. Once outside the cubicle staff must apply alcohol hand rub to the hands. All staff must employ CP's if they are to have direct contact with the patient, or the patients' environment.

Prior to transferring the patient to a single room, the implications of MRSA colonisation, infection and treatment should be clearly explained to the patient or relative. Leaflets which provide information on MRSA should be available on all wards.

- Isolate patients for as short a time as possible to minimise feelings of stigma, loneliness, and low mood.
- Provide clear information to patients about the need for the use of protective equipment to reduce feelings of stigma.
- Be consistent in the use of protective equipment to ensure that patients have confidence in the decision to place them in isolation.

### 8.1.4 Rehabilitation

For rehabilitation purposes, for example mobilising and practising the stairs patients can leave the cubicle. Therapy staff must use CP's and decontaminate any equipment before use on the next patient. Patients must decontaminate their hands before leaving the cubicle.

### 8.1.5 Patients who wish to leave their room

Patients who wish to see visitors in the hospital gardens or merely wish to sit in the garden can do so provided they:
- Decontaminate their hands before leaving the cubicle **and**

- Do not have direct contact with other patients **and**
- Do not go into the bed areas of other patients.

**8.1.6** Transfer of patients who are colonised or infected with MRSA between wards/ other care settings.

- Do not transfer patients between wards, units, hospitals, or other clinical settings unless it is clinically necessary.
- Inform the receiving ward/unit and the ambulance/transport service that the patient is colonised/ infected with MRSA.

**8.1.7 Visitors and relatives**

Visitors and members of staff from other departments must report to the nurse-in-charge before entering the room.

There is no restriction on the number or type of visitors to the patient. Visitors do not need to wear gloves and aprons unless giving direct care to the patient. Relatives must decontaminate their hands with soap and water before entering and leaving the cubicle or apply alcohol foam/gel to the hands. Visitors should not visit other patients after visiting a patient with MRSA.

**8.1.8 After death**
Use standard infection control measures. Lesions and puncture sites should be covered. In VCC a body bag is used for all diseased patients. Relatives, friends and carers may view the body without restriction.

**8.1.9 Using the public washrooms and toilets**
Whenever possible patients with MRSA should be last to use the showers or bath which should be decontaminated using detergent and disinfectant after that use. If for any reason a patient needs to use the shower ahead of the other patients the shower/bath should be decontaminated immediately after use.

**8.1.10 Outbreaks**
In the case of outbreaks the Infection Prevention & Control Team will investigate the source of the outbreak and manage accordingly. Where there are not enough cubicles the affected patients will be cohorted, (nursed together in the same bay with access to restricted bathroom and toilet facilities). Only rarely has carriage by healthcare workers (HCW's) been implicated in an outbreak, however, carriage of MRSA by HCW's must be considered in when there has been failure to control outbreaks.

**8.2 Communication**

**Clinical Staff** must
- Check the patients' Cancer Network Information System Cymru (CANISC) record and front sheet/page for "alerts" which will indicate that patient has MRSA.
- Inform portering staff of the patient's status and the infection control precautions required when requesting movement of the patient.
- Inform the receiving ward / department that the patient is MRSA positive.
- Inform the receiving healthcare establishment of the patient's status.
- Inform ambulance control when requesting transport.

Where possible confirmed MRSA cases should attend at the end of the treatment list to reduce contact time with fellow patients.

Patient information which advises on MRSA is available from the IPCT on request.

## 8.3 Healthcare Personnel

- Routine screening of staff is not recommended but may be considered in an outbreak situation or if transmission continues on a unit despite active control measures.
- It must be emphasised that MRSA colonisation poses a little to no risk to healthy individuals. If a staff member does become colonised and shares accommodation with other healthcare workers or other vulnerable individuals (e.g. immunocompromised), they should contact the IPCT for further advice.
- Decolonisation of known MRSA positive staff members is attempted to prevent transmission of MRSA to vulnerable patients.
- All decolonisation and follow-up screening is undertaken by the Occupational Health Department (OCCH) and not done at ward level. OCCH should be informed immediately when a staff member is known to be MRSA positive.

### 8.3.1 Nasal Carriage

Nasal carriers should be given 2% Mupirocin which is part of the decolonisation pack obtainable via OCCH on prescription. If the staff member works in a non-high risk area they can continue to work once treatment has started. If they work in a high-risk area the IPCT, in conjunction with OCCH will review their work status on an individual basis.

## 8.4 Decontamination of the patient environment and medical equipment

Please refer to Appendix 6 for further detail.

## 9 REFERENCES / BIBLIOGRAPHY

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Guidelines for the control and prevention of meticillin-resistant Staphylococcus aureus (MRSA) in healthcare facilities by the Joint BSAC/HIS/ICNA Working Party on MRSA. Journal of Hospital Infection 2006; 63S: S1 – S44
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## 10   GETTING HELP

### 10.1   Further information and support:

Velindre IPCT: 02920196129, internal extension 6129.

## 11   RELATED POLICIES
This policy should be read in conjunction with:

- IPC 04 Decontamination Policy
- IPC05 National Infection Prevention and Control Manual
- IPC 10 Hand Hygiene
- IPC 15 Control & Management of Multi Drug Resistant Bacteria
- IPC 21 Management of Respiratory Infections
- Cleaning Standards Manual 2015 https://phw.nhs.wales/topics/latest-information-on-novel-coronavirus-covid-19/information-for-health-and-social-care/addendum-key-standards-for-environmental-cleanliness/

## 12   INFORMATION, INSTRUCTION AND TRAINING

### 12.1   Training
Whilst there are no formal training programmes in place to ensure implementation of this policy, each Executive Director, Divisional Director, Clinical Director, Divisional General Manager, Divisional Nurse, Departmental Manager, Head of Nursing and Head of Departments must ensure that managers and all staff, clinical and non-clinical, are made aware of the policy provisions and that they are adhered to at all times.

## 12.2    Key guidance

- National Infection Control Policies for Wales
- NHS Wales. Healthcare Associated Infection Wales. Commitment to Purpose; Elimination preventable healthcare associated infections (HCAIs) 2011
- Healthcare Associated Infection (HCAI): Guidance Set. Healthcare Associated Infection and Antimicrobial Resistance and Prescribing Programme (HARP) 2019.
- Joint Healthcare Infection Society (HIS) and Infection Prevention Society (IPS) guidelines for the prevention and control of Methicillin-resistant *Staphylococcus aureus* (MRSA) in healthcare facilities. September 2021
- National Infection Prevention & Control Manual (NIPCM)

## 13   MAIN RELEVANT LEGISLATION

- Health and safety act at Work Act 1974
- The Control of Substances Hazardous to Health Regulations (COSHH) 2002
- Personal Protective Equipment at Work Regulation (2002)

**Appendix 1 – Screening for MRSA**

All inpatients should be screened prior to admission. For unplanned admission screening for MRSA must be carried out within the first 48 hours of admission. Please inform IPCT when a patient known to be MRSA positive is admitted. Ext. 6129.

Use standard wound swabs in charcoal medium.

**Swabs Should Include**
Nose (anterior nares)
Perineum (or groin if perineum inaccessible)
Any wounds
Any invasive device

**If possible soak the swab in normal saline (it improves pick up)**
- Swab left and right anterior nostril with five strokes, using the same swab.

- Swab the perineum/groin with five strokes, one swab.

- All swabs should be identified, labelled and put into **one** microbiology clini-pac.

- The nature of the specimen should read "nose and perineum swabs".

- The investigation requested should read "MRSA screen".

**Wound screening.**

Any wounds the patient may have at the time of screening should also be swabbed.

Each wound swab should be identified, labelled and have a separate form requesting for Culture & Sensitivity (not MRSA screen). Wounds swabs and screens should not be taken until at least forty eight hours after the course of decolonisation is completed.

**Three negative screens are required before contact precautions can be discontinued.**

**Infection Control Precautions**

The aim of decolonisation is to eradicate the carriage of MRSA and/or treat localised infection. Staff must adhere to standard precautions for infection control and isolation when caring for MRSA positive patients. Hand decontamination and the use of protective clothing (gloves and apron) are essential in prevention of cross infection of other patients.

1. **Mupirocin (Bactroban) Nasal Ointment 2% - Administer three times daily**

   Instruct the patient to wash his/her hands and then apply the preparation with a fingertip to inner surface of each nostril covering the posterior and anterior nares then wash hands afterwards. If the patient is unable to do this then the nurse is to apply the preparation to a cotton bud/swab and gently apply to inside of each nostril. **Duration of treatment – 5 days.**

2. **Octenisan – Daily Wash**

   If there is a pre-existing skin condition a dermatological opinion should be sought. If skin irritation occurs discontinue treatment and seek advice from the infection control nurse.

   Use a washing agent instead of soap.  Preferably the patient should bath or shower. If a blanket bath is performed apply solution to a wet disposable flannel or sponge and wash all parts of the body, thoroughly, making lather. Rinse off with clean warm water. Shampoo hair with Octenisan twice during the course of the treatment (suggest day 2 and 5). Apply to wet hair, lather and rinse off with warm water. Can use shampoo or shower gel after rinsing off Octenisan. **Duration of treatment – 5 days.**

**Patient Screening**

After 5 days decolonisation wait 48 hours before screening patient. Screening sites:

➢ Nose
➢ Perineum or Groin
➢ Any wounds, cuts, broken skin
➢ IV sites

> *Send for C&S rather than part of the* MRSA screen

Await result, if positive recommence decolonisation for a further 5 days, if negative rescreen and await result. Continue until 3 negative screens obtained. Seek advice from the IPCT if eradication has not been achieved after two treatments.

**Appendix 3 – Screening for MRSA pre-implantation of a PICC**



Flowchart:

**Has the patient had a MRSA screen in the last 4 weeks?**

- **No**
  - **Is the PICC an emergency, ie treatment to start within the week?**
    - **No** → Defer PICC, screen patient and wait for the result.
    - **Yes** → **Is patient to start treatment on the day?**
      - **No** → Screen patient and commence Octanisan for at least 2 days prior to placing PICC.
        - Screen comes back negative- stop octanisan.
        - screen comes back positve, commence 5 days of bactroban, stop for 2 days and rescreen
      - **Yes** → Contact medical team to obtain permission to place PICC without a screen
- **Yes**
  - **Positive result**
    - **Has the patient been treated with Octanisan for a minimum of 5 days?** → Stop Octanisan for 2 days, rescreen patient and wait for results prior to PICC placement.
  - **Negative result**
    - **Has the patient been an inpatient in another hospital since screening, is in long term care or is an ENT patient?**
      - **Yes** → Rescreen patient and wait for the results
        - Positive result, - commence Octanisan/Bactroban treatement for 5 days.
        - Negative result- place PICC.
      - **No** → Place PICC

**Appendix 4 – Isolation nursing door sign.**



Canolfan Ganser Felindre
Velindre Cancer Centre

GIG
CYMRU
NHS
WALES

# Contact Precautions

**STOP**

**Visitors:**
Report to nurse in charge before entering this room.

**Staff members:**

| | | |
|---|---|---|
| | **Hands** | Decontaminate hands before entering this room. |
| | **Personal Protective Equipment** | Wear disposable apron and gloves before entering this room. |
| | **Door** Keep door closed | Risk assessed ☐ Door required to remain open. Initials: ☐ Date: ☐ |
| | **Before leaving** | Decontaminate equipment prior to removal from room. Discard gloves and apron in healthcare waste bin. Decontaminate hands. |

Developed by the infection control team 2018

**Appendix 5 – Contact Precautions:**

**Personal Protective Equipment (PPE)**
- Gloves should be worn if there is any risk of contact with blood and body fluids. If gloves have been worn they should be removed and hands decontaminated before leaving the room/area.
- Plastic aprons must be worn when direct contact with the patient or the patient's equipment is anticipated.
- Face protection e.g. masks, visors/goggles must be worn if there is a risk of aerosol production or splashing from blood or body fluids and secretions. Face protection e.g. masks, visors/goggles must be worn if there is a risk of aerosol production or splashing from blood or body fluids and secretions.
- All PPE should be disposed of before leaving the room and hand decontamination performed.

**Disposal of Waste**
- All infected waste should be disposed of into the appropriate clinical waste bag (HTM 07-01 Safe Management of Healthcare Waste 2006).

**Linen**
- All linen should be placed in the appropriate bag for infected linen and returned to the laundry.
- Curtains, including window curtains, adjacent to MRSA positive patients should be changed when a patient has been transferred/discharged or when visibly soiled.

**Instruments or Equipment**
Whenever possible instruments and equipment such as writing materials, sphygmomanometers and stethoscopes should be designated for MRSA positive patients.

If this is not possible, such items should be cleaned and disinfected before use on another patient. For more information, see IPC 04 Decontamination Policy.

**Cleaning**

**Daily Cleaning**
If the patient is in a single room, the nurse-in-charge must ensure that the appropriate cleaning is carried out by liaising with Operational Services teams.

If the patient is not in a cubicle, the bed space where the patient is present should be cleaned twice a day with a hyper chloride releasing disinfectant, (e.g. Oxivir).

**Cleaning On Discharge**
The patient's room must be cleaned thoroughly with hyper chloride releasing disinfectant. Curtains will also need to be changed.

All hospital furniture (e.g. bed frame, tables) and any dust collecting ledges should also be wiped with hyper chloride releasing disinfectant.

The mattress should be decontaminated with hyper chloride releasing disinfectant and the mattress checked for strike through damages.

Ultraviolet light clean should then be carried out in accordance to instructions.

## Management of spillages of blood and body fluids

Body fluids should be mopped up using a mop with an absorbent washable mop heads or wiped up with an absorbent disposable material and the surface then cleaned and disinfected using hyper chloride releasing disinfectant.

- Protective clothing (gloves, aprons and goggles) should be worn.
- The spillage must be covered with absorbent disposable pad to remove excess fluid.
- Absorbent granules can be applied to larger spillages.
- Hyper chloride releasing disinfectant should be applied to the spillage.
- Disposable cloths/mops should be used to remove spillage.
- Finally wash affected area with detergent and water.

## Disposal of sharps waste

No special precautions required dispose of as per normal routine.

## Collection and transportation of biological specimens.

No special precautions or labelling required. Other Clinical Specimens for histology or cytology investigations do not require special precautions

**Appendix 6 – Decontamination of the patient environment and medical equipment**

**Decontamination of the patient environment and medical equipment**

**Domestic staff.** Cubicles should be cleaned and disinfected daily using yellow coded cleaning materials. The isolation cubicle should be cleaned last to avoid cross contamination during the cleaning process. All waste clinical and domestic should be disposed of into the infectious waste stream.

**Nursing staff.** All medical equipment should be cleaned and disinfected following discharge of the patient. Patients should be encouraged to keep possessions to a minimum to aid cleaning**.** Medical/surgical supplies not used by the patient should be disposed of into the infectious clinical waste stream (orange bag) and not returned to stock. In order to minimise waste and facilitate cleaning supplies of medical/surgical stock kept in the patients' room must be kept to a minimum.

.

**Long stay patients (over one week).** Domestic staff must clean and disinfect isolation cubicles daily. Nursing staff must clean and disinfect all medical equipment including the bed and wall mounted equipment once weekly.

**Portering staff.** Gloves and aprons should be donned before entering the cubicle. After assisting the patient into the wheelchair or onto the trolley porters should dispose of gloves and aprons into the orange infectious waste stream before leaving the cubicle. Hands should be decontaminated outside the cubicle using alcohol foam before touching the wheelchair or trolley. On reaching the receiving department the porter should don gloves and aprons before assisting with the patient. The areas of the wheelchair or trolley which have come into direct contact with the patient should be decontaminated using disposable wipes, gloves and aprons should then be disposed of on the spot and hands decontaminated.

**Radiotherapy staff.** Gloves and aprons should be worn by staff attending the patient. Following treatment the areas with which the patient has had direct contact for example treatment couches should be cleaned and disinfected with Chlorclean after use by the patient (NB: This will change to hyper chloride releasing disinfectant in the future).

**Radiology staff.** Gloves and aprons should be worn by staff attending the patient. Treatment chairs, beds, couches and wheelchairs with which the patient has had direct contact should be cleaned and disinfected using hyper chloride releasing disinfectant after use by the patient

Outpatient staff (including phlebotomy and chemotherapy). Gloves and aprons should be worn by staff attending the patient. Treatment chairs, beds, couches and wheelchairs with which the patient has had direct contact should be cleaned and disinfected using hyper chloride releasing disinfectant after use by the patient.

**Appendix 7 – IPC Clinical Risk Assessment.** Adapted with permission from Cardiff & Vale University Health Boards' MDRO procedure (Updated November 2017)

| Infection Prevention and Control (IP&C) Admission Risk Assessment | NO | YES | If 'YES' to any question action the following immediately | Initial |
|---|---|---|---|---|
| **Carbapenemase Producing Organism (CPO)** | | | | |
| In the last 12 months has the patient had any healthcare contact outside of the U.K.? Healthcare abroad includes the whole range of in-patient care, also dental care, cosmetic surgery, elective surgery (including day surgery) and fertility treatments | | | Isolate (High priority) and contact precautions. Seek advice from IP&C / Microbiology out of hours. Screen for CRO & MRSA | |
| In the last 12 months has the patient been an in-patient or transferred from a hospital /healthcare setting in the UK in known high prevalence areas? | | | Screen for CRO & MRSA. Discuss with IP&C | |
| Does the patient have any IP&C flags (on CANISC/ ICNet) for any multi-drug resistant organisms? | | | | |
| **Does the patient have a history of MDRO infection/colonisation (Inc. *Candida auris*)?** | | | Discuss with IP&C | |
| **MRSA** | | | | |
| Is patient screened for MRSA routinely on admission? | | | Screen for MRSA: | |
| Does the patient have a previous history of MRSA? | | | Nose Groin | |
| On admission does the patient have a wound or invasive device? | | | Invasive device site(s) Wound(s) | |
| Has the patient been transferred from a hospital outside of the Health Board/Trust? | | | ............/............../........ (Screen sent date / time / initial) | |
| Has the patient been admitted from a Nursing Home or Long-term care facility? | | | Refer to local MRSA Procedure / Clinical Risk Assessment | |
| **Diarrhoea and Vomiting** | | | | |
| Does the patient have a history of diarrhoea / vomiting within the last 48 hours that may be infectious? | | | Isolate / cohort (High priority) Contact Precautions. Send two separate diarrhoea samples for Microbiology and Virology. Refer to local Viral Gastroenteritis Procedure | |

**Summary Minutes**

**Private Quality, Safety & Performance Committee**

**Velindre University NHS Trust**

| | |
|---|---|
| **Date:** | 24th March 2022 |
| **Time:** | 13:15-13:45 |
| **Location:** | Microsoft Teams |
| **Chair:** | Mrs Vicky Morris, Independent Member |

| ATTENDANCE | | |
|---|---|---|
| Vicky Morris | Independent Member and Quality, Safety & Performance Committee Chair | VM |
| Stephen Harries | Interim Vice Chair and Independent Member | SH |
| Hilary Jones | Independent Member | HJ |
| | | |
| Lauren Fear | Director of Corporate Governance and Chief of Staff | LF |
| Matthew Bunce | Executive Director of Finance | MB |
| Sarah Morley | Executive Director of Organisational Development & Workforce | SfM |
| Alan Prosser | Interim Director, Welsh Blood Service | AP |
| Nicola Williams | Executive Director of Nursing, Allied Health Professionals & Health Science | NW |
| Nigel Downes | Interim Director of Nursing, Quality & Patient Experience | ND |
| Ian Bevan | Head of Information Governance | IB |
| David Mason-Hawes | Head of Digital Delivery (in part) | DMH |
| Emma Stephens | Head of Corporate Governance | ES |
| Kyle Page | Business Support Officer (Secretariat) | KP |

| 1.0.0 | **STANDARD BUSINESS** | |
|---|---|---|
| 1.1.0 | **Apologies:**<br><br>• Steve Ham, Chief Executive Officer<br>• Cath O'Brien, Chief Operating Officer<br>• Carl James, Director of Strategic Transformation, Planning & Digital<br>• Professor Donna Mead OBE, Velindre University NHS Trust Chair<br>• Dr. Jacinta Abraham, Executive Medical Director<br>• Paul Wilkins, Interim Director of Velindre Cancer Service | |
| 1.2.0 | **In Attendance:** | |
| 1.3.0 | **Declarations of Interest**<br>Led by Vicky Morris, Quality, Safety & Performance Committee Chair<br><br>No declarations of interest were raised. | |

| | | |
|---|---|---|
| **1.4.0** | **Review of Action Log**<br>Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science<br><br>The action log was reviewed in detail. The Secretariat is to make all required amendments / updates and circulate to members following the meeting. | **Secretariat** |
| **2.0.0** | **CONSENT ITEMS**<br>(The consent part of the agenda considers routine Committee business as a single agenda item.  Members may ask for items to be moved to the main agenda if a fuller discussion is required). | |
| **2.1.0** | **ITEMS FOR APPROVAL** | |
| **2.1.1** | **Draft Minutes from the meeting of the Private Quality, Safety and Performance Committee held on the 20th January 2022**<br>Led by Vicky Morris, Quality, Safety & Performance Committee Chair<br><br>The Committee **REVIEWED** and **APPROVED** the minutes of hte meeting held on the 20th January 2021 as an accurate reflection of proceedings. | |
| **2.2.0** | **ITEMS FOR NOTING** | |
| **2.2.1** | **Disciplinary Suspension Review**<br>Led by Sarah Morley, Executive Director of Organisational Development and Workforce<br><br>The Disciplinary Suspension Review update paper that provided assurance on the correct application of the NHS Wales Disciplinary Policy in relation to the two employees suspended from the workplace was received and discussed.<br><br>The Committee **NOTED** the status of the disciplinary suspensions and completion timescales. | |
| **2.2.2** | **Patient Nosocomial Transmission Review Update**<br>Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science<br><br>The Patient Nosocomial Transmission Review paper that provided the current position in relation to the review / investigation of all patient nosocomial COVID-19 acquisitions within Velindre Cancer Service was discussed.<br><br>It was noted that weekly meetings are currently in place to ensure progression and oversight of the Trust investigation progress in line with National guidance and the outcomes would be reported at a future public Quality, Safety & Performance Committee. | |

| | | |
|---|---|---|
| | The Committee **NOTED** the content of the report and the work being undertaken to fulfil the Trust's responsibilities in relation to patient nosocomial transmissions. | |
| 2.2.3 | **Transforming Cancer Services Programme Private Scrutiny Sub Committee Highlight Report** <br> Led by Stephen Harries, Independent Member and Chair of the Transforming Cancer Services Scrutiny Sub Committee <br><br> The Highlight Reports from the two Transforming Cancer Services (TCS) Programme Private Scrutiny Sub-Committees held on the 21st December 2021 and 19th January 2022 were received and **NOTED**. <br><br> The Committee requested a review of the infrastructure by which the status of all TCS projects is reported. | **LF** |
| 3.0.0 | **MAIN AGENDA** | |
| 3.1.0 | **Trust Private Risk Register** <br> Led by Lauren Fear, Director of Corporate Governance & Chief of Staff <br><br> The Trust Private Risk Register was received, providing the February 2022 extract of risk. <br><br> It was noted that a review of the articulation of risks within the private Committee will be completed during the next reporting cycle. <br><br> The Committee **NOTED** the level 20 private risks reported in the Private Trust Risk Register and highlighted in the cover paper. | |
| 3.2.0 | **Quarter 3 Claims Report** <br> Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science <br><br> The 2021/22 Quarter 3 Claims Report was received, providing an overview of claims and redress activity and outcomes for the period 1st September 2021 to 31st December 2021. <br><br> A reduction in the overall number of open claims within the Trust has been evidenced for the last two Quarters, in addition to a significant reduction in the Trust claims potential financial value following withdrawal of a historic claim. <br><br> The Committee **DISCUSSED** and **NOTED** the content of the report. | |
| 3.3.0 | **Offsite Records Storage Incident** <br> Led by Ian Bevan, Head of Information Governance <br><br> The Offsite Records Storage Incident paper was received and discussed at length. It was noted that, at the request of the Trust Chair, Stephen | |

| | | |
|---|---|---|
| | Harries in his role as Independent Member for Digital had received a detailed briefing on the matter by the Head of Information Governance. The paper provided to the Committee contained additional areas of assurance as an outcome of this discussion. The paper provided an update on the patient records incident which occurred during February 2022 as a result of serious flooding of one of the storage facilities used by the Trust for patient medical / clinical records.<br><br>It was acknowledged that the incident had been reported to the Information Commissioner and to Welsh Government as a Nationally Reportable Incident and that the situation is evolving rapidly and that following further action, recommendations would be considered at the next Executive Management Board and Quality, Safety and Performance Committee.<br><br>The Next Offsite Records Storage Incident report for QSP will consider the issues, risks and cost in relation to this matter.<br><br>The Committee **DISCUSSED** and **REVIEWED** the content of the report. | |
| **4.0.0** | **Analysis of meeting outputs**<br>Led by Vicky Morris, Quality, Safety & Performance Committee Chair | |
| | | |
| **5.0.0** | **HIGHLIGHT REPORT TO TRUST BOARD** | |
| | Members were asked to identify items for inclusion in the Highlight Report to the Trust Board:<br><br>• **For Escalation –** Offsite Records Storage Incident<br>• **For Advising**<br>• **For Assurance**<br>• **For Information**<br><br>It was agreed that the matters identified above would be included. | **Secretariat** |
| **6.0.0** | **ANY OTHER BUSINESS** | |
| | Led by Vicky Morris, Quality, Safety & Performance Committee Chair<br><br>No other business was raised. | |
| **7.0.0** | **DATE AND TIME OF THE NEXT MEETING** | |
| | The Quality, Safety & Performance Committee will next meet on **Thursday 12th May 2022 via Microsoft Teams.** | |
| **CLOSE** | | |

# QUALITY, SAFETY & PERFORMANCE COMMITTEE

## VCC MEDICINES MANAGEMENT GROUP – HIGHLIGHT REPORT
## July – Dec 2021

| DATE OF MEETING | 12/05/2022 |
|---|---|

| PUBLIC OR PRIVATE REPORT | Public |
|---|---|

| IF PRIVATE PLEASE INDICATE REASON | Not Applicable - Public Report |
|---|---|

| PREPARED BY | Usman Malik, Principal Pharmacist |
|---|---|
| PRESENTED BY | Usman Malik, Principal Pharmacist |
| DIRECTOR SPONSOR APPROVED | Jacinta Abraham, Executive Medical Director |

| REPORT PURPOSE | FOR NOTING |
|---|---|

| COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING | | |
|---|---|---|
| **COMMITTEE OR GROUP** | **DATE** | **OUTCOME** |
| VCC Medicines Management Group

EMB | March 2022 out of meeting 27/04/2022 | ENDORSED FOR APPROVAL |

| ACRONYMS | |
|---|---|
| MMG | Medicines Management Group |

**1.     SITUATION/BACKGROUND**

1.1    The main function of the Medicines Management Group (MMG) is to have strategic and operational oversight of all medicines management practices within VCC, and to ensure that medicines are used safely, cost effectively and in line with accepted current best practices.

1.2    Several medication related sub-groups report into MMG, which subsequently reports to VCC Quality, Safety and Performance Group and onwards to Trust Quality, Safety and Performance Committee (see Appendix 1, Terms of Reference).

1.3    As part of its remit, MMG receive standing agenda items that are reported on a rolling basis. (See Appendix 2, Timetable for rolling agenda items)

1.4    The report highlight work undertaken by the MMG over the six-month period from July – December 2021.

**2.     ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION**

2.1    There are no matters that MMG wish to highlight as a concern

2.2    MMG held meetings in late June, September and November. During this time, the group has continued to perform all its medication governance responsibilities.

2.3    One of the functions of the MMG is to ensure that clinical guidelines are regularly reviewed, updated, approved and are accessible to all healthcare professionals via the VCC intranet site.

2.3.1  The process involves several healthcare staff including medical, nursing, pharmacy and often other allied healthcare professionals (depending on the nature of the guideline) to read, review and update all clinical guidelines; these are then approved by either the Medical Chair of MMG or the Clinical Director. There are currently over 100 documents uploaded onto the clinical guidelines page, all of which require a review every 3 yearly.

2.3.2  In the November 2021, MMG approved a more streamline process so that clinical guidelines can be reviewed and approved more efficiently. This new process has resulted in 12 clinical guidelines being reviewed and approved between the November and the end of December.

2.4    The various work-streams of the MMG over this period are highlighted below:

2.4.1  Review, approve and continue to have governance oversight of all unlicensed and 'off-label' medications. From July – December 2021, there have been 14

medication requests that have fall under this category, all of which have been considered appropriate.

2.4.2    Review of national Patient Safety Notices / Alerts to ascertain whether they apply to VCC, along with implementation of recommendations

2.4.3    Monitoring and if required, managing the impact of medication shortages / medication discontinuation. Additionally, oversight of national drug recall alerts and drug shortages, whether they impact on VCC and if necessary, ensuring that any corrective actions required are undertaken including sourcing alternative clinical options when necessary.

2.4.4    Oversight of the Medicines at Home service, including review of all safety and performance KPIs, incidents and financial savings. There is a standard suite of KPIs that have been agreed by both Principal Pharmacist and Patient Safety Nurse that are reviewed each month by the VCC Medicines@Home governance lead and reported back to MMG on a 6 monthly basis. Any areas of concern are discussed at MMG, along with any recommended actions to be taken forward. To date, there have been no concerning trends identified.

2.4.5    Oversight of the Horizon Scanning Group who assess the impact of new treatments on the VCC SACT service.

2.4.6    Continual monitoring of the drug expenditure including the general drugs budget, the high-cost drugs budget and the NICE drugs budget. All drug expenditures are within budget.

2.4.7    Awareness of all IPFR requests that are reviewed via the IPFR Advisory Group. During the 6-month period, there were 14 IPFR requests that were reviewed of which 4 were approved by VCC and 10 sent to the health boards.

2.4.8    Oversight of Antimicrobial Stewardship in relation to the safe and appropriate prescribing of antimicrobial agents. This includes ongoing monitoring of the 'Start Smart Then Focus' (SSTF) measures which form part of the Welsh Government Improvement Goals for 2021/22. Currently VCC are performing above the national average in our compliance against the 4 SSTF measures.

2.4.9    Ownership and responsibility of the 'Medicines Management Health and Care standards (Standard 2.6), to ensure that VCC is compliant against the standards set.  VCC is currently shown to be compliant across all 4 standards that are categorised into the following:

- Compliance with legislation,
- Fitness to practice,
- Access to information and medical advice, and
- Incident reporting and investigation

2.4.10 Updating the oral SACT handbook with all new oral SACT, which is then uploaded to the VCC intranet site. This is to ensure that HCPs, including the treatment helpline, are able to access up to date information in a timely manner.

## 3.     IMPACT ASSESSMENT

| QUALITY AND SAFETY IMPLICATIONS / IMPACT | There are no specific quality and safety implications related to the activity outined in this report. |
|---|---|
| RELATED HEALTHCARE STANDARD | Safe Care |
| | Governance, Leadership and Accountability: |
| EQUALITY IMPACT ASSESSMENT COMPLETED | Not required |
| LEGAL  IMPLICATIONS / IMPACT | There are no specific legal implications related to the activity outlined in this report. |
| FINANCIAL IMPLICATIONS / IMPACT | There is no direct impact on resources as a result of the activity outlined in this report. |

## 4.     RECOMMENDATION

QS&P Committee are asked to **NOTE** the contents of this report.

## QUALITY, SAFETY & PERFORMANCE COMMITTEE

## 2021/22 PROFESSIONAL REGULATION / REVALIDATION ASSURANCE PAPER

| DATE OF MEETING | 12th May 2022 |
| --- | --- |
| PUBLIC OR PRIVATE REPORT | Public |

| IF PRIVATE PLEASE INDICATE REASON | Not Applicable - Public Report |
| --- | --- |

| PREPARED BY | Nicola Williams, Assistant Director Nursing, AHP & Health Science<br>Dr Jacinta Abraham, Executive Medical Director |
| --- | --- |
| PRESENTED BY | Nicola Williams, Assistant Director Nursing, AHP & Health Science<br>Dr Jacinta Abraham, Executive Medical Director |
| EXECUTIVE SPONSOR APPROVED | Nicola Williams, Assistant Director Nursing, AHP & Health Science<br>Dr Jacinta Abraham, Executive Medical Director |

| REPORT PURPOSE | For Assurance |
| --- | --- |

| GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING | | |
| --- | --- | --- |
| COMMITTEE OR GROUP | DATE | OUTCOME |
| Professional Nurse Forum | 2021/22 | REGULATORY COMPLIANCE IMPROVEMENTS AGREED |
| AHP / Health Science Forum | 2021/22 | REGULATORY COMPLIANCE IMPROVEMENTS AGREED |
| Executive Management Board | 27/04/2022 | NOTED |

## 1. SITUATION

This paper is to provide the Quality, Safety & Performance Committee with a high-level summary of any professional registration / revalidation breaches (Nursing & Midwifery Council (NMC), General Medical Council (GMC), Health & Care Professions Council )HCPC), and General Pharmaceutical Council (GPhC) during 2021/22.

This paper is to provide assurance in relation to professional regulation governance.

## 2. BACKGROUND

All healthcare professionals are required to re-register and some revalidate.  There is variation across the professional groups that is detailed below:

### 2.1 Nursing & Midwifery Council (NMC)
Every qualified nurse on the NMC Professional register is required to complete  a process of re-registering yearly and revalidation three yearly.  If a registrant does not re-register or revalidate when due their registration will lapse.  If registration lapses a registrant cannot practice and they will need to apply to the NMC to be re-registered – this can take up to 6 weeks.

There is a legal requirement for any individual using the protected title of registered nurse or registered midwife in the UK to revalidate every three years.  Nurses must evidence that they have met the following requirements in order to revalidate:
- 450 practice hours
- 35 hours of continuing professional development (20 of which must be participatory)
- Five pieces of practice-related feedback
- Five written reflective accounts detailing learning, resultant changes or improvements to practice, and relevance to the Code
- A reflective discussion with another NMC-registered nurse
- Declarations of health and character
- Evidence of appropriate indemnity arrangements.
- Confirmation of adherence with the revalidation process, usually by the employer.

### 2.2  Health & Care Professions Council (HCPC)
The HCPC regulate 15 professions.  These professions have designated titles that are protected by law and professionals must be registered with the HCPC to use them.  These are:
- Arts Therapists
- Biomedical Therapists

- Chiropodists / Podiatrists
- Clinical Scientists
- Dieticians
- Hearing Aid Dispensers
- Occupational Therapists
- Operating Department Practitioners
- Orthoptists
- Paramedics
- Physiotherapists
- Practitioner Psychologists
- Prosthetists / Orthotists
- Radiographers
- Speech and Language Therapists

HCPC Registrants need to re-register every two years. Each profession has a set month during the two-yearly cycle when registration is required to be completed by. Registrants will receive notification of renewal deadlines and needs to complete a professional declaration and pay a renewal fee no later than the deadline to avoid being removed from the register. If removed they cannot practice. A random sample of 2.5 percent of the profession will be selected to submit a continuing professional development (CPD) profile for the renewal period.

There are no revalidation requirements.

### 2.3 General Medical Council (GMC)
Every doctor on the General Medical Council (GMC) register is required to revalidate, normally every five years. To maintain a licence to practice a doctor must demonstrate that they work in line with the principles set out within the GMC's Good Medical Practice Guidance. Medical revalidation, through statutory duties will provide assurance that doctors in the UK are fit to practice.

A Responsible Officer or suitable person is required to make a recommendation to the GMC about whether a doctor connected to them should be revalidated. Following this, the GMC decides whether a doctor can be revalidated based on the recommendation and any other information that they hold. There are three types of revalidation recommendations that can be made:

- Recommendation to revalidate
- Recommendation to defer
- Recommendation of non-engagement

In order to make a recommendation which is consistent, fair and reliable the Responsible Officer requires evidence that a doctor is regularly appraised on their whole practice, ensuring the completeness and quality of supporting information and their reflections on it. Any areas for development in a doctor's practice should be identified and addressed in a targeted way, and concerns about a doctor's fitness to practice referred to the GMC where appropriate.

Connected doctors are required to have annual appraisals where there is evidence of:

- Scope of work
- Review of PDP
- CPD
- Review of complaints and compliments
- Review of Significant events
- Probity and Health declarations
- In every revalidation cycle the doctor additionally is required to provide evidence of Formal patient and colleague feedback.
- Information supporting a quality improvement.

### 2.4 General Pharmaceutical Council (GPhC)
To practise in Great Britain, pharmacists and pharmacy technicians must be registered with the GPhC and have satisfied the council that they meet it's requirements.

Pharmacist and pharmacy technician are protected titles and therefore there is a legal requirement that only registered and re-validated individual can use these titles.

Pharmacies must also be registered with the GPhC (or be a pharmacy department based in a hospital or health centre) to operate in Great Britain and to use the title 'pharmacy'.

Pharmacists, pharmacy technicians and registered pharmacies must renew their registration annually, which involves completing a declaration stating that they meet all professional, fitness to practise and ethical standards.

Annual re-validation for pharmacists and pharmacy technicians includes submission of
- 4 x CPD records,
- a peer review discussion to ensure engagement with others on the individual's learning and practice and
- a reflective account to encourage consideration of how the individual meets professional pharmacy standards.

**3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION**

During the year 1st April 2021 – 31st March 2022 the following registration / revalidation issues / breaches occurred:

### 3.1 NMC

There was one NMC registration lapse this year (July 2021) where a registrant working within Velindre Cancer Centre failed to re-register. The nurse worked 11 shifts without an active registration. It took several weeks for the individual to be re-registered with the NMC during which time the nurse was unable to work. A full investigation was undertaken and the appropriate Workforce policy followed. In addition, to the registrant failing to re-register the Cancer Centre systems for ensuring all staff were actively registered also failed to highlight this breach. As a result of the learning from the investigation the systems and processes for ensuring at the end and the start of each month the registration status of each registrant using the ESR data feed has been strengthened.

There were no NMC revalidation breaches during this period.

A revised NMC standard operating procedure has been approved within the Professional Nurse Forum to ensure robust checking procedures are in place.

### 3.2 HCPC

There were Two Clinical Scientists working within the Welsh Blood Service who failed to renew their HCPC registration by 30th September 2021. This meant they were unable to perform Clinical Scientist duties in the laboratory during the period of lapsed registration.

The HCPC Clinical Scientist registration renewal in 2021 was altered compared to the last time it was conducted in 2019. The previous renewal procedure included correspondence from the HCPC by letter. There were also postal reminders sent out if registration was not renewed. Furthermore, ESR previously informed managers if someone in their hierarchy had not renewed/had lapsed registration. However, in 2021, the renewal process was performed online and all correspondence was via e-mail. An initial notification e-mail was sent out from the HCPC on the 2nd July 2021 to e-mail address held on their system. A single reminder e-mail was sent to those that had not renewed 2 weeks prior to registration lapsing. No postal correspondence was sent from the HCPC.

The employees who failed to renew their registration were sent an e-mail on the 1st October 2021 advising them that they had been removed from the HCPC register. Managers did not receive an ESR lapse notification.

This change in HCPC procedure contributed to two Clinical Scientists failing to renew their HCPC registration:

- The first employee the reminder e-mail from the HCPC went into their 'junk' e-mail folder and therefore did not receive the reminder. The employee then received the notification on the 1st October advising that they had been removed from the HCPC register. At this time, they were off work due to personal circumstances and therefore did not work any shifts whilst unregistered.
- The second employee was only identified as having breached during a professional / management internal audit of Clinical Scientist registration in the service undertaken on the 7th October (instigated due to the first breach being identified). The employee was unaware that their HCPC registration had lapsed. Due to specific personal circumstances this individual no longer had access to the e-mail address registered with the HCPC, so had not received any communication from the HCPC regarding registration renewal. The employee had worked four shifts whilst unregistered.

Both employees were stopped from performing any work that requires HCPC registration. All work undertaken by the second employee whilst un-registered was retrospectively, verified and reports re-issued by a HCPC registered Clinical Scientist.

Appropriate workforce procedures were followed.

There have been no previous lapses in HCPC registration in the service concern and the root cause incidents was attributed to the change in HCPC process combined with specific personal circumstances for the individuals involved.

In addition to communications being sent to the Health Scientist workforce the managers responsibility and checking procedures were reviewed, the standard operating procedure within WBS for registration checks was reviewed and feedback given to the HCPC regarding their new procedures.

### 3.3 GMC

Within Velindre University NHS Trust there have been sixty nine appraisals undertaken, twenty eight recommendations to revalidate and two recommendations to defer during the past twelve months.

- The first deferral occurred due to there being a new connection to the Trust following the doctor's revalidation date and a request for deferral was made due to lack of evidence.
- The second deferral was made due to lack of evidence as the doctor was unable to undertake yearly appraisal's due to personal exemptions.

| Welsh Revalidation and Appraisal Group reporting as at the 31.03.2022 | | | | |
|---|---|---|---|---|
| IMPORTANT: ONLY DOCTORS WITH WHOM THE DESIGNATED BODY HAS A PRESCRIBED CONNECTION SHOULD BE INCLUDED IN THIS SECTION. EACH DOCTOR SHOULD BE INCLUDED IN ONLY ONE CATEGORY | Number of prescribed connections | No of doctors exempt from appraisal due to extenuating circumstances | No of completed appraisals (summary agreed) | No. of Approved Missed appraisals |
| **General Practitioners** | 0 | 0 | 0 | 0 |
| **Consultants** (including honorary contract holders) | 65 | 0 | 60 | 0 |
| **Staff grade, associate specialist, specialty doctor** (including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere) | 8 | 0 | 7 | 0 |
| **Doctors with practising privileges** (for independent healthcare providers only); all doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade) | 0 | 0 | 0 | 0 |
| **Temporary or short-term contract holders** (including trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts) | 4 | 0 | 2 | 0 |
| **Other** (Including some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc.) | 0 | 0 | 0 | 0 |
| **Trainees doctor on national postgraduate training scheme** (for Deaneries only) | | | | |

### 3.4 GPhC

There were no incidences in 2021/22 when a pharmacy professional failed to renew their registration and re-validation.

## 4. IMPACT ASSESSMENT

| | |
|---|---|
| **QUALITY AND SAFETY IMPLICATIONS / IMPACT** | Yes (Please see detail below) |
| | Staff are required to comply and Trust must provide reassurance of monitoring |
| **RELATED HEALTHCARE STANDARD** | Effective Care |
| | If more than one Healthcare Standard applies please list below: <br> **Safe Care** |
| **EQUALITY IMPACT ASSESSMENT COMPLETED** | Yes |
| | All Staff on NMC register |
| **LEGAL IMPLICATIONS / IMPACT** | Yes (Include further detail below) |
| | This is a legal requirement |
| **FINANCIAL IMPLICATIONS / IMPACT** | Yes (Include further detail below) |
| | Financial impact if staff unable to practice due to failure of this process |

## 5. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to:
- **NOTE** 2021/22 position in respect of Professional Registration / Revalidation compliance across all professional groups.
- **NOTE** the action that has been taken forward in respect of breaches that occurred.

| QUALITY SAFETY & PERFORMANCE COMMITTEE |
|---|

| HEALTHCARE INSPECTORATE WALES STRATEGIC PLAN 2022-2025 |
|---|

| DATE OF MEETING | 12th May 2022 |
|---|---|

| PUBLIC OR PRIVATE REPORT | Public |
|---|---|

| IF PRIVATE PLEASE INDICATE REASON | N/A as Public Paper |
|---|---|

| PREPARED BY | Kyle Page, Business Support Officer |
|---|---|
| PRESENTED BY | Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science |
| EXECUTIVE SPONSOR APPROVED | Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science |

| REPORT PURPOSE | FOR NOTING |
|---|---|

| COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING | | |
|---|---|---|
| COMMITTEE OR GROUP | DATE | OUTCOME |
| Executive Management Board | 27/04/2022 | NOTED |

| ACRONYMS | |
|---|---|
| | N/A |

## 1. SITUATION

The paper is to provide the Quality, Safety & Performance Committee with Health Inspectorate Wales' 2022 - 2025 strategic plan.

## 2. BACKGROUND

Alongside the principles set out by the Well-Being of Future Generations (Wales) Act, learning gained over the past few years has formed the basis of the new organisational strategy, ensuring that the Healthcare Inspectorate Wales remains agile and responsive to the emerging risks and required adaptations as healthcare services continue to function alongside COVID-19. The purpose of the plan is to ensure that healthcare services are delivered in a manner to maximise the health and wellbeing of patients.

## 3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

### 3.1 HIW Priorities

Four new priorities will seek to identify whether healthcare meets the need of the community by:

- o Focusing on the quality of healthcare provision within communities while accessing, using and moving between services.

- o Remaining agile in responding to emerging risks to patient safety.

- o Working in collaboration with organisations to maximise system and service improvements to healthcare services.

- o Supporting and developing the workforce to ensure delivery of key priorities.

### 3.2 HIW Immediate Programme

The work plan for 2022-2023 will include a mix of onsite and offsite work, with communication to teams in advance of on-site visits due to the current rate of infection within the community, therefore ensuring safe conduct of inspections (unless severe safety concerns dictate otherwise). A new reporting process following on-site inspections will be implemented from April 2022, involving the publishing of a public summary and full detailed report for each setting.

The 2022-23 programme of work will continue to focus on patient flow in addition to a National review of a number of planned care services, the outcomes of which will be communicated to Trusts and Health Boards via relationship managers.

## 4. IMPACT ASSESSMENT

| | |
|---|---|
| **QUALITY AND SAFETY IMPLICATIONS/IMPACT** | Choose an item. |
| **RELATED HEALTHCARE STANDARD** | Governance, Leadership and Accountability |
| **EQUALITY IMPACT ASSESSMENT COMPLETED** | Not required |
| **LEGAL IMPLICATIONS / IMPACT** | There are no specific legal implications related to the activity outlined in this report. |
| **FINANCIAL IMPLICATIONS / IMPACT** | There is no direct impact on resources as a result of the activity outlined in this report. |

## 5. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **NOTE** the Healthcare Inspectorate Wales 2022-2025 Strategic Plan.

# Healthcare Inspectorate Wales
## Strategic Plan 2022-2025

agic hiw | Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality

Collaboration

Responsive

Workforce

Health

Learning

People and Communities

Improvement

Inclusive

# Foreword

## It gives me great pleasure to introduce our strategic plan for 2022 - 2025

Alun Jones
Interim Chief Executive

Change and flexibility have been key features of life since March 2020 and as an organisation we have learned much about how and where our work can add value to the healthcare improvement agenda. The learning we have done over the past three years, and particularly since the start of the pandemic, has challenged us in positive ways, and has contributed to the foundations of this strategy. It has been developed through consultation with our own staff, with stakeholders and members of the public. Their contributions and feedback are something we place great value on. The opportunity to hear from those at the heart of healthcare in Wales is more important now, than ever, as we learn how to live alongside COVID-19 and navigate the new and ongoing challenges.

In A Healthier Wales: our plan for health and social care, Welsh Government is clear that to achieve longer, healthier and happier lives, health and social care must be designed as a whole-system, delivered in accordance with quality and safety outcomes and the individual needs of people and the communities in which they live. Guided by our strategy we will seek opportunities in our work to promote this whole-system approach to healthcare and will consistently keep quality and safety of people and communities central to our work.
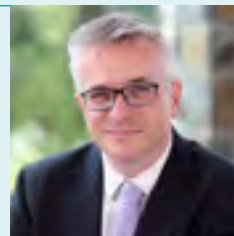
Our vision for the next three years recognises that we must remain an agile organisation, one which is able to adapt our work and use our resources most effectively to deliver our goal: to be a trusted voice which influences and drives improvement in healthcare. We will consider the quality of healthcare as it is delivered to people as they access, use and move between services. We will need to work collaboratively with others, harnessing the insight, understanding and expertise they bring, in order to help us consider a whole-system approach and deliver against our goal. We have a talented team of staff and we will continue to support them and invest in their development to help us achieve our vision. We want to make sure that HIW is an organisation people continue to feel proud to work for.

In order to be agile and responsive to emerging risks in healthcare, we will keep our strategy and priorities under regular review, ensuring that our detailed plans of activity continue to target our resources most effectively. We will describe our progress through our annual reports as we seek to drive improvement and promote quality in healthcare services across Wales.

Alun Jones
Interim Chief Executive
Healthcare Inspectorate Wales

# We are HIW

## We are the regulator of independent healthcare and the inspectorate of NHS healthcare in Wales.

We look at the quality, safety and effectiveness of the services that are being provided to people and communities, drawing attention to good practice where we find it and calling out practice that could cause harm to those who are receiving it.

What matters to people and communities is core to what we do. Healthcare exists for people and communities, and the work we carry out looks at whether it meets the needs of a community and whether it is of a good quality. Where we find inequalities in healthcare provision, where a service is not designed for the needs of the community it serves, we will challenge this. Equality and diversity is embedded in the work we do and we consider how healthcare services reach those who face the greatest barriers to access, and poorest outcomes in health.

We have a specific responsibility to consider the rights of people who are being cared for under the Mental Health Act or the Mental Capacity Act Deprivation of Liberty Safeguards (DoLS) and, once they are introduced to replace DoLS, the Liberty Protection Safeguards.

Our responsibilities in relation to mental health span both the NHS and the independent sector.

HIW also works with other review and inspectorate bodies to consider the quality of healthcare delivered in non-healthcare settings such as prisons.

We inspect NHS services in Wales

We regulate and inspect independent healthcare services in Wales

We undertake a programme of reviews to look in depth at national or more localised issues

We monitor concerns and safeguarding referrals

We recommend improvements, immediate and longer term, to NHS services and independent healthcare services

We take regulatory action to ensure registered independent healthcare services meet legislative requirements

We have a team of 73 staff who work for us, across Wales, supporting our functions and undertaking our assurance work

We have a team of specialist peer reviewers who we continually recruit to provide specialist, up to date knowledge about services and quality standards

We also have specialists in Mental Health Act Administration and a panel of psychiatrists who provide our Second Opinion Appointed Doctor service.

# Our purpose, goal and values

## Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales.

### Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

### Our goal is:

To be a trusted voice which influences and drives improvement in healthcare

### Our values

We place people at the heart of what we do. We are:

- **Independent** – we are impartial, deciding what work we do and where we do it

- **Objective** – we are reasoned, fair and evidence driven

- **Decisive** – we make clear judgements and take action to improve poor standards and highlight the good practice we find

- **Inclusive** – we value and encourage equality and diversity through our work

- **Proportionate** – we are agile and we carry out our work where it matters most

# Achieving our goal

We have set out 4 priorities which will guide us to deliver our goal:

## 01

We will focus on the quality of healthcare provided to people and communities as they access, use and move between services

## 02

We will adapt our approach to ensure we are responsive to emerging risks to patient safety

## 04

We will support and develop our workforce to enable them, and the organisation, to deliver our priorities

## 03

We will work collaboratively to drive system and service improvement within healthcare

# Priority 01

We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.

- We will consider the quality of care given to people during their time on a clinical pathway
- We will seek out opportunities to listen to people about what matters to them on their healthcare journey
- We will build on our approach to exploring care delivered both in and outside of a hospital setting, recognising that many people receive care in the community.

# Priority 01

## How we will do this:

- We will build on our expertise in conducting national reviews, increasing the opportunities we have to structure our other assurance and inspection work around specific clinical pathways so that we are considering the journey of a patient at various points in a healthcare system

- We will harness the skills of our inspection teams and clinical peer reviewers by providing them with the tools to explore the care delivered to a patient at various stages in their healthcare journey

- We will increase the range of options we provide for people to share their views with us, considering how we do this, and looking for further opportunities to collaborate with others in doing so

- We will work with stakeholders to develop better methods for engaging with Black and Minority Ethnic Groups about our work.

## Priority 02

We will adapt our approach to ensure we are responsive to emerging risks to patient safety.

- We will build on the flexible models of assurance and inspection work that we developed during the pandemic, using all tools available to us to help us carry out our work

- We will use our internal intelligence function and our work with others to direct our work at areas of highest risk

- We will build on our engagement methods, so that we can communicate our messages quickly to drive improvement.

# Priority 02

## How we will do this:

- We will continue to build on the range of options we have for seeking assurance about the quality and safety of healthcare, developing new methodologies in response to emerging models of care

- We will build on our internal intelligence expertise, to guide us in our work

- We will embed the use of our new data management system to support our work by providing us with easier access to information about services

- We will align the way in which we describe quality in accordance with the direction of healthcare policy in Wales

- We will develop a strategic communications plan which supports us in delivering our role.

## Priority 03

## We will work collaboratively to drive system and service improvement within healthcare.

- We will work with others to strengthen our understanding of the issues affecting healthcare services and the people and communities who use them

- We will specifically consider the challenges faced by minority groups when using healthcare services, using this understanding to help challenge healthcare inequalities through our work

- We will build on our working relationships with partners so that we increase the impact we can make to the quality of healthcare delivered to the people of Wales

- We will support our staff to make judgements about both service and system level issues.

# Priority 03

## How we will do this:

- We will take a holistic view of our work programme, identifying and drawing in others who can contribute to our understanding of the area

- We will continue to seek out opportunities to involve others in our work, using stakeholder forums and consulting with third sector agencies to support our work

- We will create an equality strategy which underpins the way in which we consider the needs of Black and Minority Ethnic Groups, and other minority groups through our work

- We will undertake equality impact assessments for our inspection and review work, acting on the results of these to improve the way we consider the specific healthcare needs of minority groups and whether healthcare provision is tailored to their needs

- We will build on our methodologies for joint working with Inspection Wales partners – Care Inspectorate Wales, Audit Wales and Estyn

- We will build a strong relationship with the new Citizens Voice Body (CVB), drawing on the effective relationship we have had with the Community Health Councils for Wales and recognising the potential that working closely with this new organisation can have

- We will provide a range of different methods and opportunities for staff of all levels to tell us about their experiences of working in a service

- We will continue to increase opportunities to use peer reviewers in our work, harnessing their expertise to contribute to the work we do.
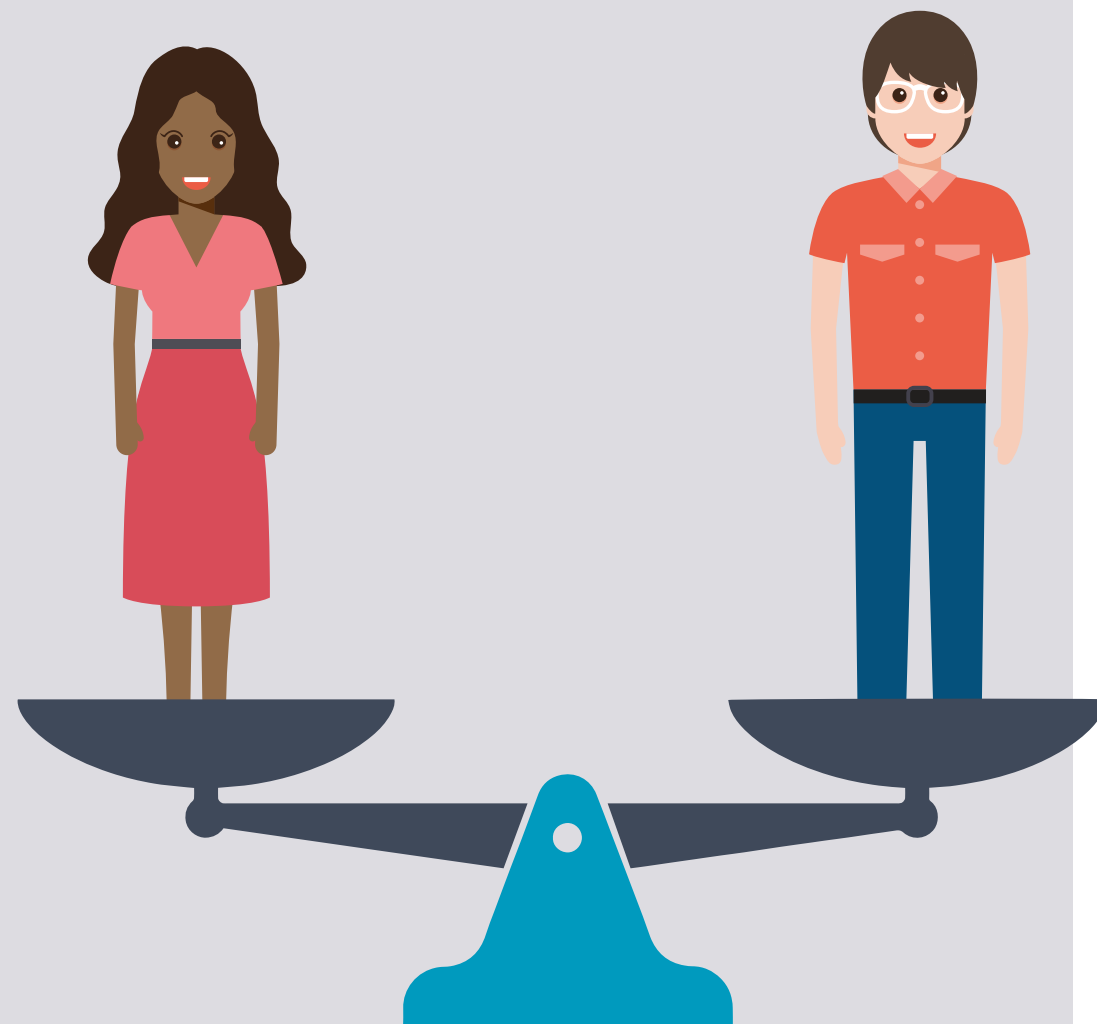
# Priority 04

## We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

- We will continue to invest in developing the skills and knowledge of our staff

- We will build on the learning culture we have put in place, ensuring that evaluation and reflection is a core approach to our work

- We will embed our quality governance strategy so that it is at the heart of everything we do.

# Priority 04
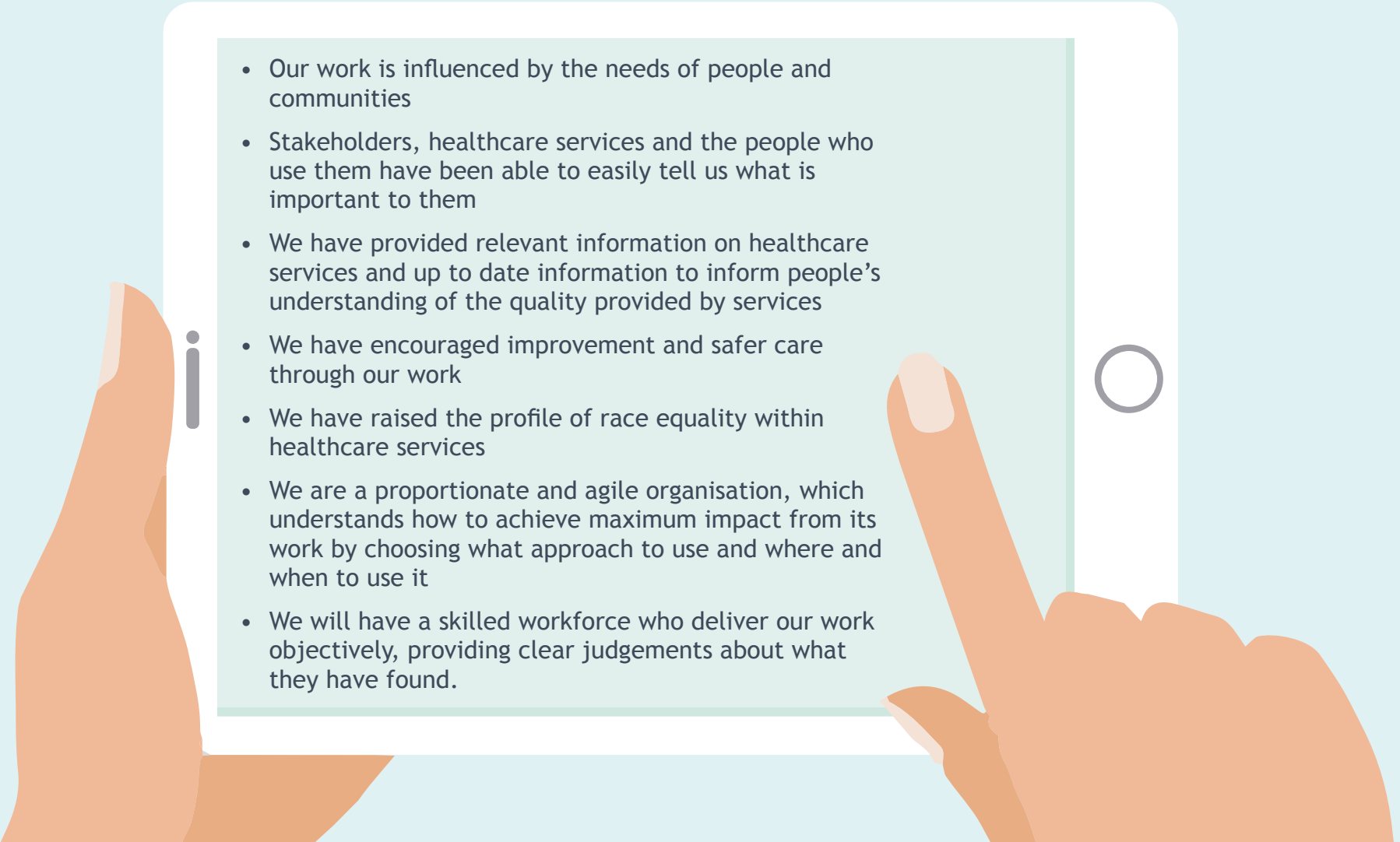
## How we will do this:

- We will develop our staff through training which builds on the skills needed to effectively deliver our role

- We will support the wellbeing and resilience of our staff so that they are able to adapt to dynamic work programmes

- We will develop our leaders so that they can support our staff effectively and work confidently with external partners

- We will build on our listening culture so that staff know they will be heard and that we will respond to them

- We will embed evaluative processes throughout our work so that we are constantly challenging and improving the way we work

- We will keep quality at the heart of all the work we do, we will promote it through our methodologies, and it will be central to the judgements we make.

# Outcomes

## By delivering this strategy we will achieve the following outcomes:

- Our work is influenced by the needs of people and communities

- Stakeholders, healthcare services and the people who use them have been able to easily tell us what is important to them

- We have provided relevant information on healthcare services and up to date information to inform people's understanding of the quality provided by services

- We have encouraged improvement and safer care through our work

- We have raised the profile of race equality within healthcare services

- We are a proportionate and agile organisation, which understands how to achieve maximum impact from its work by choosing what approach to use and where and when to use it

- We will have a skilled workforce who deliver our work objectively, providing clear judgements about what they have found.

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

## Contact us

Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

By email:  hiw@gov.wales
By phone:  0300 062 8163

www.hiw.org.uk

Find us on:

To Chief Executives and Chairs of
NHS Health Boards and Trusts Wales
*Via Email*

31 March 2022

Dear Chief Executive and Chair

**HIW 2022 - 2025 Strategic Plan and Spring Update**

Firstly, I would like to once again extend a thank you for the way in which your staff have continued to engage with our work over the past year through our relationship managers, and our inspectors during onsite and offsite assurance activities. As a result, we have been able to continue to deliver our role effectively during a difficult period and provide you with rapid feedback on relevant areas to support improvement.

**Strategic Plan 2022-2025**

You will be aware from my previous correspondence and other discussions that over the last six months we have been developing our new organisational strategy. The learning we have done as an organisation over the past three years has challenged the way we work and carry out our role, and has contributed to the foundations of our new strategy. Cutting across all of this is the need for us to remain agile and responsive to the emerging risks and models which will continue to arise as society and healthcare services adapt to living alongside COVID-19. I am pleased to be able to enclose a copy of our new three year Strategic plan, which launches today, March 31 2022.

HIW, as a public body organisation, has a responsibility to support the principles set out by the Well-Being of Future Generations (Wales) Act and we have kept these principles, and 'A healthier Wales' at the core of our new strategy. We have refreshed our organisational purpose and developed a new goal underpinned by four new priorities. Our new organisational purpose is *to check that healthcare services are provided in a way which maximises the health and wellbeing of people*.

Our four new priorities are:
- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

**Gwirio bod pobl yng Nghymru yn derbyn gofal da**

**Checking people in Wales are receiving good care**

Llywodraeth Cymru / Welsh Government
Parc Busnes Rhydycar / Rhydycar Business Park
Merthyr Tudful / Merthyr Tydfil
CF48 1UZ
Tel / Ffôn 0300 062 8163
Fax / Ffacs 0300 062 8387
www.hiw.org.uk

These priorities will help us to consider whether healthcare meets the needs of a community and whether it is of a good quality. Equality and diversity will be core to the work we do and our strategy will support us to consider how healthcare services reach those who face the greatest barriers to access, and poorest outcomes in health.

We have set standards for reporting our inspection and assurance findings and will continue to publish our performance in our annual reports.

**Programme Update**

Our work programme for 2022-2023 is now planned, it contains a blended mix of onsite and offsite work for the year. Our position in developing this plan remains unchanged in that we have continued to plan in accordance with risk and our aim to support the response and recovery of healthcare services from the pandemic. Further to the changes introduced as a result of the latest Welsh Government review of COVID-19 restrictions, combined with the current trend in infection rates within the community, we intend to continue providing **around 24 hours' notice for inspections to super green,** green and elective pathways. This notice period ensures our teams have time to communicate with your staff and provides time for arrangements to be put in place for the safe delivery of the inspection. I expect this to be the approach for all inspections that fall into this category, however, we must still reserve the right to operate in a fully unannounced way where we determine there to be an extremely high risk to patient safety as a result of the way a service is operating.

We have recently concluded a project which will mean we will be implementing a new reporting style for onsite inspections. This new approach will be implemented for all onsite inspections which take place from April 2022, and will involve publishing a public summary and a full detailed report for the setting. I will provide further information on these over the next few weeks so that you can share the changes with your staff, they will see these during post inspection factual accuracy checks. The new style reports, however, will not begin to be published to our website until June 2022.

Our programme of review work in 2022-2023 will involve the continuation and conclusion of our national review of patient flow (focus on stroke pathway), the continuation and conclusion of our local review into Swansea Bay University Health Board's governance arrangements of healthcare services to HMP Swansea and thirdly, a local review of discharge arrangements for adult mental health inpatients in Cwm Taf Morgannwg University Health Board. We will also commence a national review of planned care services and when I am in a position to share more information in relation to this work I will ensure that our relationship managers make contact with you.

I look forward once again to further positive and constructive working with your health board/trust in this coming year.

In the meantime, should you wish discuss anything with me directly then please do not hesitate to get in touch.

Yours sincerely

**Alun Jones**
Interim Chief Executive
**Healthcare Inspectorate Wales**
Cc. NHS Medical Directors and Directors of Nursing
Katherine Williams, HIW Director of Clinical Advice and Quality Governance
HIW Relationship Managers

Gwirio bod pobl yng Nghymru
yn derbyn gofal da

Checking people in Wales are
receiving good care

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**QUALITY, SAFETY & PERFORMANCE COMMITTEE**

**LIBERTY PROTECTION SAFEGUARDS**

| DATE OF MEETING | 12th May 2022 |
|---|---|

| PUBLIC OR PRIVATE REPORT | Public |
|---|---|

| IF PRIVATE PLEASE INDICATE REASON | N/A |
|---|---|

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

| REPORT PURPOSE | FOR NOTING |
|---|---|

**COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING**

| COMMITTEE OR GROUP | DATE | OUTCOME |
|---|---|---|
| Safeguarding and Public Protection Management Group | 10/02/21 | NOTED |
| Executive Management Board | 27/04/22 | Discussed & plans endorsed |

| ACRONYMS | |
|---|---|
| LPS | Liberty Protection Safeguards |
| DoLs | Deprivation of Liberty Safeguards |

| MCA | Mental Capacity Act |
|------|---------------------|
| ECHR | European Convention of Human Rights |
| AMCP | Approved Mental Capacity Practitioner |

## 1. SITUATION

This paper is provided to update the Quality, Safety & Performance Committee on the national planned transition from Deprivation Liberty Protection Safeguards (DoLS) to Liberty Protection Safeguards (LPS).

The Quality, Safety & Performance Committee is asked to **NOTE** the implications for the Trust of the new Liberty Protection Safeguards and the plans to facilitate Trust wide engagement in the consultation of the Draft Mental Capacity Act (2005) Code of Practice including the Liberty Protection Safeguards.

## 2. BACKGROUND

The Liberty Protection Safeguards (LPS) will be replacing the Deprivation of Liberty Safeguards (DoLS). The new safeguards will protect people's rights and freedom if they lack the mental capacity to make their own decisions and will apply to 16- and 17-year- olds as well as adults and be applied in all setting including people's own homes. Wales will have its own Regulations about how to put the LPS into practice.

The most recent national Liberty Protection Safeguards newsletter is attached in *appendix 1*.

## 3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

### 3.1 Code of Practice

When the Mental Capacity Act (MCA) came into force a Code of Practice was also published to aid implementation. This national document is being updated to ensure that it meets the new legislative requirements outlined in the Liberty Protection Safeguards (LPS) and in particular the required organisational and terminological changes, and developments in ways of working and good practice.

### 3.2 Liberty Protection Safeguards Consultation

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

The consultation is complex as there are numerous documents to review. The documents included are the draft code consist of 24 chapters (510 pages), there are also draft regulations, easy read documents, impact assessments and training and development plans. It is important that clinical and managerial colleagues alike participate in this consultation as the proposed changes are significant. However, given the sheer volume of documents this is going to be challenging. In order to manage this as best we can the Trust has established a consultation working group (made up of representation from therapies, medicine, nursing, quality, and safety (VCC), corporate nursing and the Welsh Blood Service) that have a planned programme of work spread across the 12-week consultation period. A Trust consultation response will be prepared. Following this a formal impact assessment will be undertaken and be provided to the Executive Management Board for consideration in August 2022.

## 3.3 LPS Changes & Trust Considerations

Under the current DoLS scheme Velindre Cancer Centre is the Managing authority. Where the managing authority thinks, they may need to deprive someone of their liberty they must submit a request to the supervisory body, they decide if a person can be deprived of their liberty. The supervisory body appoints assessors to see if the conditions are met to allow the person to be deprived of their liberty. These assessments include:

- Age assessment
- Is the person suffering a mental disorder
- Capacity assessment
- Best interest assessment
- Eligibility assessment
- No refusals

Currently Cardiff & Vale supervisory body are the agency charged with authorising the arrangements in the Velindre Cancer Centre, that give rise to a deprivation of liberty under the current DoLS scheme.

Under LPS deprivation of Liberty will be authorised by the Responsible body. If the arrangements are carried out mainly in an **NHS hospital**, the responsible body is the "hospital manager" (in most cases, the Trust that manages the hospital in England or the local health board in Wales). When the Liberty Protection Safeguards are in force the Responsible Body will be required to:

I. **Assessment:** This can be carried out by any person considered appropriate by the responsible body. They do not need a specific LPS qualification. E.g. Ward Manager. This is currently undertaken by the supervisory body so would require significant training for health care staff. The types of assessments under LPS are:
    - Mental Capacity Assessment
    - Medical Assessment

- Necessary and Proportionate assessment.

The draft regulation on who can carry out assessments is part of the consultation.

II. **Pre-Authorisation Review:** Carried out on behalf of the responsible body by someone not involved in the day-to-day care of the person or providing treatment to them.

The Trust needs to consider appropriate staff in the Trust to undertake this role or recruit into a specific post this will further explained in the draft code and regulations and will be considered as part of the consultation.

OR

If the person is objecting, an Approved Mental Capacity Practitioner (AMCP).

This role is a new role introduced by the LPS. The draft regulation on AMCP state the role of the AMCP, and training required.

III. **Authorisation:** The authorisation is carried out by the responsible body. How this will apply to Velindre will be considered as part of the consultation.

IV. **Monitoring and Reporting:** The responsible body will also be required to produce performance data. The data set requirements are under review as part of the regulations for consultation.

V. **Education and Training:** A national LPS workforce and training strategy is also included in the LPS consultation.



Liberty Protection Safeguards (LPS) Workforce and Training Triangle

Competency group

Increasing specialisation

Increasing numbers requiring training

F — AMCP (conversion and new)

E — IMCA

D — Pre authorisation review | Authorisation

C — Assessment, determination and consultation

B — Identification and referral

A — Awareness raising – The Liberty Protection Safeguards system (in the context of the Mental Capacity Act)
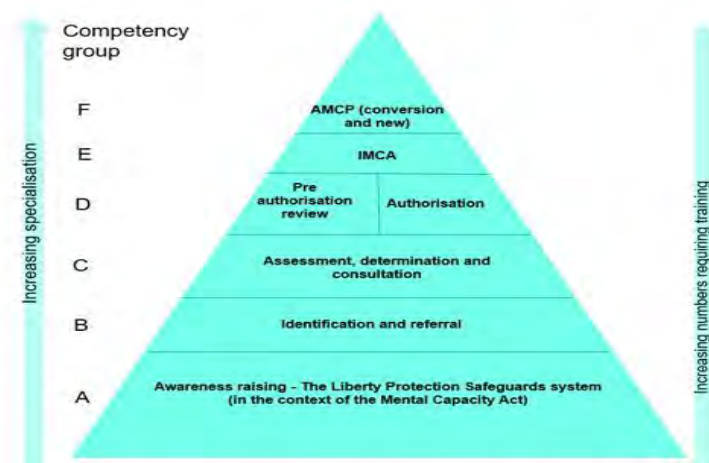
In readiness for LPS, the Trust safeguarding, and vulnerable adults' group had identified improving understanding of the mental capacity act as a priority and a key element to preparing for the liberty protection safeguards.

### 3.4 Trust preparation for the Liberty Protection Safeguards

With the information known to date the Trust has taken as much action as possible to prepare for these changes. These are summarized below:

| | | | |
|---|---|---|---|
| 1. Ensure that Mental Capacity Act training is Mandatory for all staff with direct patient/ donor contact | To ensure that staff are trained at an appropriate level. Training needs analysis developed to identify training required for specific staff groups | Paper approved at educational steering Group and SMT and SLT.<br><br>EMB approved | Completed |
| 2. Level 1 NHS eLearning | Identify All staff with direct patient/donor contact | VCC WBS<br><br>Corporate | Completed |
| 3. Level 2<br><br>Classroom training Mental Capacity Act and Deprivation of Liberty Safeguards | Identify all registered professional that delivers direct patient care. | VCC WBS<br><br>Corporate | In Progress:<br><br>Training needs analysis return deadline May 2022. |
| 4. Establish a multidisciplinary task group to provide a consultation response on publication of the draft code of practice. | To fully consider the implications for the Trust. | VCC | Completed |
| 5. Develop the role of the safeguarding champion to clearly understand the principles of the MCA and support staff to embed in the clinical area. | Recruit safeguarding champions and provide appropriate skills and training. | Champions recruited, champion framework developed.<br><br>Supervision sessions and individual champion meeting in progress. | Completed |

| | | | |
|---|---|---|---|
| 6. WG Government funding accessed for training provision for regulated professionals | Training accessed and 60 spaces purchased for the Trust. Well evaluated sessions. | | Completed |
| 7. Assessment of Capacity pocket guides developed and purchased | Pocket guides distributed and well received. | | Completed |
| 8. Distribute messages across the Trust and engage staff in wider consultation. | Work with the comms team to develop and consultation intranet page and distribute regular updates and messages. | Meeting planned April 2022. | Ongoing |

## 4. IMPACT ASSESSMENT

| | |
|---|---|
| **QUALITY AND SAFETY IMPLICATIONS/IMPACT** | Yes (Please see detail below) |
| **RELATED HEALTHCARE STANDARD** | Dignified Care |
| | If more than one Healthcare Standard applies, please list below:<br><br>Safe Care |
| **EQUALITY IMPACT ASSESSMENT COMPLETED** | Not required |
| | |
| | Yes (Include further detail below) |

| LEGAL  IMPLICATIONS / IMPACT | Changes proposed to current legal system. |
|---|---|
| FINANCIAL IMPLICATIONS / IMPACT | Yes (Include further detail below) |
| | Potential resource implications. |

## 5. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **NOTE** the implications for the Trust of the new Liberty Protection Safeguards and the plans for the consultation of the Draft Mental Capacity Act (2005) Code of Practice including the Liberty Protection Safeguards.

Appendix 1 WG LPS Newsletter

[sgroliwch i lawr am y Gymraeg / scroll down for Welsh]

**Liberty Protection Safeguards**
**NEWSLETTER**

19 April 2022

This newsletter provides you with an update on key milestones in our progress to implement the Liberty Protection Safeguards (LPS) in Wales.

**Consultation**

The Welsh Government consultation on the LPS draft Regulations for Wales was published on the 17 March. The consultation will last for 16 weeks and the deadline for responses is 7 July 2022.

All of the consultation documents and additional resources to help you discuss and respond to the consultation can be found here:

https://www.gov.wales/liberty-protection-safeguards
https://www.llyw.cymru/diogeliadau-amddiffyn-rhyddid

The Minister for Health and Social Services has issued a Written Statement, which can be accessed here:

Written Statement: Welsh Government consultation on Regulations for Wales to support the implementation of the Liberty Protection Safeguards (17 March 2022) | GOV.WALES

Separately, the UK Government is consulting on draft Regulations for England and the draft Code of Practice for England and Wales, for the same 16 week period (ending on 7 July). **STAKEHOLDERS IN WALES WILL ALSO NEED TO RESPOND TO THE UK GOVERNMENT CONSULTATION ON THE DRAFT CODE OF PRACTICE FOR ENGLAND AND WALES.**

Details of how you can do that can be found here:

https://www.gov.uk/government/consultations/changes-to-the-mca-code-of-practice-and-implementation-of-the-lps

https://www.gov.uk/government/consultations/changes-to-the-law-and-guidance-about-making-your-own-decisions-easy-read

**UK Government engagement with people with lived experience**

The UK Government have planned to engage with people with lived experience and members of the public with an interest in the LPS process. These events will focus on people's experiences rather than policy decisions and will cover themes including: how to help people with lived experience understand the LPS process, the role of the Appropriate Person and the IMCA, how to support people with lived experience and how to challenge LPS authorisations.

We would strongly encourage people with lived experience in Wales to attend these UK events. Please share this link within your networks to support people with lived experience to register their interest.

https://consultations.dhsc.gov.uk/625576088edebc5ddd238e23.

**Live Event**

Welsh Government hosted a live online event on 5 April. During this event we covered the details of the consultation including the context, the resources available and our planned stakeholder engagement during the consultation period. The second presentation gave an introduction and key information on each of the four draft Regulations for Wales.

By hosting the live event online we were able to reach a wide audience and over 100 people attended. If you were not able to attend the event, we have provided recordings of both presentations in both Welsh and English which you can find here:

Diogeliadau Amddiffyn Rhyddid (LPS) yng Nghymru/Liberty Protection Safeguards (LPS) in Wales - YouTube

**Engagement**

As stated previously, we are planning to organise more focussed discussion with Responsible Bodies (local authorities and health boards) and other stakeholders in the second half of the consultation period after the elections. These sessions will focus more on the role of the Responsible Bodies, the LPS Journey and what the Regulations will do to support the LPS process.

If colleagues would like to attend these stakeholder engagement meeting, please get in touch with us via our mailbox.

**Consultation Responses**

Since the publication of our consultation a fortnight ago, we have received 7 responses. We will look forward to hear from more people over the coming weeks.

**Here is the link to our FAQs document:**

liberty-protection-safeguards-the-lps-implementation-in-wales-frequently-asked-questions.pdf (gov.wales)

If you have any questions regarding the consultation, please contact the Welsh Government's Mental Health and Vulnerable Groups Mailbox:

[MentalHealthandVulnerableGroups@gov.wales](mailto:MentalHealthandVulnerableGroups@gov.wales)

Best wishes / Cofion gorau,

**Mental Health, Substance Misuse and Vulnerable Groups Division**

**Diogeliadau Amddiffyn Rhyddid
CYLCHLYTHYR**

19 Ebrill 2022

Mae'r cylchlythyr hwn yn rhoi'r wybodaeth ddiweddaraf i chi am y cerrig milltir allweddol yn ein cynnydd at weithredu'r Diogeliadau Amddiffyn Rhyddid (yr LPS) yng Nghymru.

**Ymgynghoriad**

Cafodd ymgynghoriad Llywodraeth Cymru ar reoliadau drafft yr LPS i Gymru ei gyhoeddi ar 17 Mawrth. Bydd yr ymgynghoriad yn parhau am 16 wythnos a'r dyddiad cau ar gyfer ymatebion yw 7 Gorffennaf 2022.

Mae modd canfod yr holl ddogfennau ymgynghori - a'r adnoddau ychwanegol sydd ar gael i'ch helpu chi i drafod ac ymateb i'r ymgynghoriad - yma:

https://www.llyw.cymru/diogeliadau-amddiffyn-rhyddid
https://www.gov.wales/liberty-protection-safeguards

Mae'r Gweinidog Iechyd a Gwasanaethau Cymdeithasol wedi cyhoeddi Datganiad Ysgrifenedig ar yr LPS ac mae ar gael yma:

Datganiad Ysgrifenedig: Ymgynghoriad Llywodraeth Cymru ar y Rheoliadau i Gymru i helpu i weithredu'r Diogeliadau Amddiffyn Rhyddid (17 Mawrth 2022) | LLYW.CYMRU

Ar wahân, mae Llywodraeth y DU yn ymgynghori ar reoliadau drafft ar gyfer Lloegr a'r Cod Ymarfer drafft ar gyfer Cymru a Lloegr. Bydd yr ymgynghoriadau yma yn parhau am yr un cyfnod o 16 wythnos (gan ddod i ben ar 7 Gorffennaf). **BYDD ANGEN I RANDDEILIAID YNG NGHYMRU HEFYD YMATEB I YMGYNGHORIAD LLYWODRAETH Y DU AR Y COD YMARFER DRAFFT AR GYFER**

**CYMRU A LLOEGR**.  Mae'r wybodaeth ar sut i wneud hynny ar gael yma:

https://www.gov.uk/government/consultations/changes-to-the-mca-code-of-practice-and-implementation-of-the-lps

https://www.gov.uk/government/consultations/changes-to-the-law-and-guidance-about-making-your-own-decisions-easy-read

**Ymgysylltu â phobl sydd â phrofiad personol**

Mae Llywodraeth y DU wedi cynllunio digwyddiadau ymgysylltu â phobl sydd â phrofiad personol o'r maes hwn, a phobl sydd â diddordeb ym mhrosesau'r LPS. Bydd y digwyddiadau yma yn canolbwyntio ar brofiadau pobl yn hytrach na phenderfyniadau polisi, a byddant yn ffocysu ar themâu megis: sut i helpu pobl sydd â phrofiad personol ddeall beth yw'r LPS; rôl y Person Priodol a'r IMCA, sut i gefnogi pobl sydd â phrofiad personol a sut i herio awdurdodiadau'r LPS.

Rydym yn cynghori yn gryf y dylai pobl yng Nghymru sydd â phrofiad personol fynychu'r digwyddiadau DU yma. Rhannwch y ddolen hon gyda'ch rhwydweithiau er mwyn cefnogi pobl sydd â phrofiad personol i'w mynychu:

https://consultations.dhsc.gov.uk/625576088edebc5ddd238e23.

**Digwyddiad Byw**

Cynhaliodd Llywodraeth Cymru ddigwyddiad byw ar-lein ar 5 Ebrill. Yn ystod y digwyddiad hwn bu inni rannu manylion yr ymgynghoriad – y cyd-destun, yr adnoddau sydd ar gael a'r digwyddiadau rydym wedi eu cynllunio ar gyfer rhanddeiliaid yn ystod y cyfnod ymgynghori. Roedd ail ran y cyflwyniad yn cyflwyno ac yn manylu ar wybodaeth am y pedwar Rheoliad drafft i Gymru.

Drwy gynnal y digwyddiad hwn ar-lein roedd modd inni gyrraedd cynulleidfa eang, a bu i dros gant o bobl fynychu'r sesiwn. Os nad oedd modd i chi fynychu'r digwyddiad cewch droi at ein recordiad o'r ddau gyflwyniad a gafwyd. Mae'r rhain ar gael yn y Gymraeg a'r Saesneg o'r safle hon:

Diogeliadau Amddiffyn Rhyddid (LPS) yng Nghymru/Liberty Protection Safeguards (LPS) in Wales - YouTube

**Ymatebion i'r Ymgynghoriad**

Ers cyhoeddi ein hymgynghoriad bythefnos yn ôl, rydym wedi derbyn saith ymateb. Edrychwn ymlaen at glywed gan fwy o bobl dros yr wythnosau nesaf.

**Cwestiynau Cyffredin**

Dyma'r ddolen at ein dogfen Cwestiynau Cyffredin:

gweithredur-diogeliadau-amddiffyn-ryddid-lps-yng-nghymru-cwestiynau-cyffredin.pdf (llyw.cymru)

Os oes gennych unrhyw gwestiwn am yr ymgynghoriad, cysylltwch â blwch post Grwpiau Iechyd Meddwl a Grwpiau Agored i Niwed Llywodraeth Cymru:

MentalHealthandVulnerableGroups@gov.wales

Cofion gorau,

**Is-adran Grwpiau Iechyd Meddwl, Polisi Camddefnyddio Sylweddau ac Agored i Niwed**

| **Quality, Safety and Performance Committee** |
|---|

| **Equality Monitoring Report 31 March 2021** |
|---|

| DATE OF MEETING | 12 May 2022 |
|---|---|

| PUBLIC OR PRIVATE REPORT | Private |
|---|---|

| IF PRIVATE PLEASE INDICATE REASON | Draft Status - Final Version will be Published in Public Domain |
|---|---|

| PREPARED BY | Claire Budgen: Head of Organisational Development, Paola Spiteri: Equalities, Diversity, Inclusion and Organisational Development Manager |
|---|---|
| PRESENTED BY | Sarah Morley, Executive Organisational Development & Workforce |
| EXECUTIVE SPONSOR APPROVED | Sarah Morley, Executive Organisational Development & Workforce |

| REPORT PURPOSE | FOR NOTING |
|---|---|

| COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING | | |
|---|---|---|
| **COMMITTEE OR GROUP** | **DATE** | **OUTCOME** |
| **EXECUTIVE MANAGEMENT BOARD** | **27.04.22** | **APPROVED** |

| ACRONYMS | |
|---|---|
|  |  |

## 1.    SITUATION/BACKGROUND

1.1    This report provides the equality monitoring data in line with the Equality Act 2010 and the Public Sector Equality Duty (2011). The equality duty was created under the Equality Act 2010. The equality duty replaced the race, disability and gender equality duties.

1.2    The Public Sector Equality Duty (PSED) requires that all public authorities covered under the specific duties in Wales should produce an annual equality report by 31st March each year. The essential purpose of the specific duties under the Equality Act, in relation to monitoring, is to help authorities to have better due regard to the need to achieve the three aims of the general duty, which are to:
- eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Act;
- advance equality of opportunity between people who share a protected characteristic and people who do not share it;
- foster good relations between people who share a protected characteristic and people who do not share it.

Therefore, as a specific duty itself, the role of annual reporting is to support the Trust in meeting the general duty. It also has a role in setting out achievements and progress towards meeting the other specific duties. In particular, the annual report supports the Trust to have a better due regard to the duties by providing an opportunity to;
- Monitor and review progress;
- Monitor and review the effectiveness and appropriateness of arrangements;
- Review objectives and processes in light of new legislation and other new developments;
- Engage with stakeholders around these issues, providing partners and the public with transparency.

## 2.    ASSESMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1    The workforce statistics relating to protected characteristics as at 31 March 2021 can be seen in the attached report.

2.2    The data includes NHS Wales Information Systems and NHS Wales Shared Services Partnership.  NHS Wales Information Systems ceased to be hosted by Velindre University NHS Trust on 1 April 2021 and are therefore all coded as Leavers within the year.

2.3 The analysis of the current workforce demographics will be presented in the Equality Monitoring Report of 31 March 2022 including a review of progress in advancing equality of opportunity between people with different protected characteristics.

## 3. IMPACT ASSESSMENT

| | |
|---|---|
| **QUALITY AND SAFETY IMPLICATIONS/IMPACT** | There are no specific quality and safety implications related to the activity outined in this report. |
| **RELATED HEALTHCARE STANDARD** | Governance, Leadership and Accountability |
| **EQUALITY IMPACT ASSESSMENT COMPLETED** | Not required |
| **LEGAL IMPLICATIONS / IMPACT** | There are no specific legal implications related to the activity outlined in this report. |
| **FINANCIAL IMPLICATIONS / IMPACT** | There is no direct impact on resources as a result of the activity outlined in this report. |

## 4. RECOMMENDATION

The Quality, Safety and Performance Committee to **NOTE** the attached report as approved by the Executive Management Board on the 27th April 2022.

# Velindre University NHS Trust Equality Monitoring report 31 March 2021

The data includes NHS Wales Information Systems and NHS Wales Shared Services Partnership. NHS Wales Information Systems ceased to be hosted by Velindre University NHS Trust on 1 April 2021 and are therefore all coded as Leavers within the year.

## Ethnic Origin

| Ethnic Origin | Headcount | % |
|---|---|---|
| Asian | 196 | 3.83 |
| Black | 89 | 1.74 |
| Chinese | 15 | 0.29 |
| Mixed | 72 | 1.41 |
| Not Stated or Unspecified | 717 | 14.03 |
| Other | 20 | 0.39 |
| White | 4002 | 78.30 |
| **Grand Total** | **5111** | **100.00** |

## Age Profile

| Age Band | Headcount | % |
|---|---|---|
| <=20 Years | 22 | 0.43 |
| 21-25 | 393 | 7.69 |
| 26-30 | 742 | 14.52 |
| 31-35 | 744 | 14.56 |
| 36-40 | 607 | 11.88 |
| 41-45 | 545 | 10.66 |
| 46-50 | 607 | 11.88 |
| 51-55 | 630 | 12.33 |
| 56-60 | 508 | 9.94 |
| 61-65 | 245 | 4.79 |
| 66-70 | 45 | 0.88 |
| >=71 Years | 23 | 0.45 |
| **Grand Total** | **5111** | **100.00** |

## Religious Beliefs

| Religious Belief | Headcount | % |
|---|---|---|
| Atheism | 853 | 16.69 |
| Buddhism | 12 | 0.23 |
| Christianity | 1883 | 36.84 |
| Hinduism | 35 | 0.68 |
| I do not wish to disclose my religion/ | 671 | 13.13 |
| Islam | 98 | 1.92 |
| Judaism | 2 | 0.04 |
| Other | 389 | 7.61 |
| Sikhism | 6 | 0.12 |
| Unspecified | 1162 | 22.74 |
| **Grand Total** | **5111** | **100.00** |

## Sexual Orientation

| Sexuality | Headcount | % |
|---|---|---|
| Bisexual | 32 | 0.63 |
| Gay or Lesbian | 71 | 1.39 |
| Heterosexual or Straight | 3552 | 69.50 |
| Not stated (person asked but declined to provide a response) | 307 | 6.01 |
| Other sexual orientation not listed | 2 | 0.04 |
| Undecided | 5 | 0.10 |
| Unspecified | 1142 | 22.34 |
| **Grand Total** | **5111** | **100.00** |

## Gender Reassignment or Gender Identity

The ESR system currently does not have the data fields to allow for the collection of data on gender reassignment or gender identity.

## Disability

| Disability | Headcount | % |
|---|---|---|
| No | 3425 | 67.01 |
| Not Declared | 156 | 3.05 |
| Prefer Not To Answer | 4 | 0.08 |
| Unspecified | 1321 | 25.85 |
| Yes | 205 | 4.01 |
| **Grand Total** | **5111** | **100.00** |

## Marital Status

| Marital Status | Headcount | % |
|---|---|---|
| Civil Partnership | 62 | 1.21 |
| Divorced | 266 | 5.20 |
| Legally Separated | 22 | 0.43 |
| Married | 2356 | 46.10 |
| Single | 1613 | 31.56 |
| Unknown | 460 | 9.00 |
| Widowed | 32 | 0.63 |
| (blank) | 300 | 5.87 |
| **Grand Total** | **5111** | **100.00** |

## Pregnancy and Maternity

| On Maternity | Headcount | % |
|---|---|---|
| Yes | 102 | 2.00 |
| No | 5009 | 98.00 |
| **Grand Total** | **5111** | **100.00** |

## Employment Category by Gender

| Employment Category By Gender | Headcount Female | Headcount Male | Grand Total |
|---|---|---|---|
| Full Time | 2013 | 1846 | 3859 |
| Part Time | 1033 | 219 | 1252 |
| **Grand Total** | **3046** | **2065** | **5111** |

## Pay Scales by Gender

| Pay Grade By Gender | Female | Male | Total |
|---|---|---|---|
| Band 2 | 239 | 356 | 595 |
| Band 3 | 501 | 217 | 718 |
| Band 4 | 441 | 184 | 625 |
| Band 5 | 447 | 262 | 709 |
| Band 6 | 406 | 253 | 659 |
| Band 7 | 313 | 201 | 514 |
| Band 8 - Range A | 122 | 130 | 252 |
| Band 8 - Range B | 70 | 66 | 136 |
| Band 8 - Range C | 36 | 58 | 94 |
| Band 8 - Range D | 15 | 16 | 31 |
| Band 9 | 6 | 12 | 18 |
| Consultant | 52 | 37 | 89 |
| Other | 19 | 16 | 35 |
| Specialty Doctor | 5 | 3 | 8 |
| Specialty Registrar | 374 | 254 | 628 |
| **Grand Total** | **3046** | **2065** | **5111** |

## Profession by Gender

| Profession by Gender | Female | Male | Total |
|---|---|---|---|
| Add Prof Scientific and Technic | 50 | 21 | 71 |
| Additional Clinical Services | 300 | 121 | 421 |
| Administrative and Clerical | 1767 | 1169 | 2936 |
| Allied Health Professionals | 118 | 23 | 141 |
| Estates and Ancillary | 68 | 359 | 427 |
| Healthcare Scientists | 91 | 59 | 150 |
| Medical and Dental | 434 | 296 | 730 |
| Nursing and Midwifery Registered | 215 | 17 | 232 |
| Students | 3 | | 3 |
| **Grand Total** | **3046** | **2065** | **5111** |

## Contract Type by Sex

| Contract Type by Gender | Female | Male | Total |
|---|---|---|---|
| Fixed Term Temp | 670 | 429 | 1099 |
| Honorary | 5 | 1 | 6 |
| Non-Exec Director/Chair | 1 | | 1 |
| Permanent | 2370 | 1635 | 4005 |
| **Grand Total** | **3046** | **2065** | **5111** |

## Leavers

| Row Labels | Count of Employee Number |
|---|---|
| 120 Corporate Division | 20 |
| 120 Health Technology Wales Division | 5 |
| 120 NHS Wales Informatics Service Division | 858 |
| 120 NHS Wales Shared Services Partnership Division | 250 |
| 120 Research, Development and Innovation Division | 4 |
| 120 Transforming Cancer Services Division | 4 |
| 120 Velindre Cancer Centre | 94 |
| 120 Welsh Blood Service | 53 |
| **Grand Total** | **1288** |

## Leavers continued

| Employment Category | Headcount | % |
|---|---|---|
| Full Time | 1081 | 83.93 |
| Part Time | 207 | 16.07 |
| **Grand Total** | **1288** | **100.00** |

| Age Band | Headcount | % |
|---|---|---|
| <=20 Years | 4 | 0.31 |
| 21-25 | 96 | 7.45 |
| 26-30 | 206 | 15.99 |
| 31-35 | 198 | 15.37 |
| 36-40 | 169 | 13.12 |
| 41-45 | 153 | 11.88 |
| 46-50 | 143 | 11.10 |
| 51-55 | 130 | 10.09 |
| 56-60 | 101 | 7.84 |
| 61-65 | 66 | 5.12 |
| 66-70 | 19 | 1.48 |
| >=71 Years | 3 | 0.23 |
| **Grand Total** | **1288** | **100.00** |

| Staff Group | Headcount | % |
|---|---|---|
| Add Prof Scientific and Technic | 6 | 0.47 |
| Additional Clinical Services | 34 | 2.64 |
| Administrative and Clerical | 1021 | 79.27 |
| Allied Health Professionals | 8 | 0.62 |
| Estates and Ancillary | 29 | 2.25 |
| Healthcare Scientists | 9 | 0.70 |
| Medical and Dental | 150 | 11.65 |
| Nursing and Midwifery Registered | 29 | 2.25 |
| Students | 2 | 0.16 |
| **Grand Total** | **1288** | **100.00** |

| | Headcount | Headcount | Grand Total |
|---|---|---|---|
| Employment Category By Gender | Female | Male | |
| Full Time | 445 | 636 | 1081 |
| Part Time | 156 | 51 | 207 |
| **Grand Total** | **601** | **687** | **1288** |

| Pay Grade By Gender | Female | Male | Total |
|---|---|---|---|
| A & C Trust Payspine - Grade C | 1 | | 1 |
| Adhoc | 8 | 4 | 12 |
| Band 2 | 30 | 25 | 55 |
| Band 3 | 39 | 22 | 61 |
| Band 4 | 72 | 49 | 121 |
| Band 5 | 108 | 131 | 239 |
| Band 6 | 119 | 146 | 265 |
| Band 7 | 74 | 107 | 181 |
| Band 8 - Range A | 34 | 70 | 104 |
| Band 8 - Range B | 16 | 34 | 50 |
| Band 8 - Range C | 9 | 24 | 33 |
| Band 8 - Range D | 4 | 7 | 11 |
| Band 9 | 1 | 4 | 5 |
| Consultant | 2 | 3 | 5 |
| Local Salaried GP | | 1 | 1 |
| Specialty Doctor | 4 | 2 | 6 |
| Specialty Registrar | 80 | 58 | 138 |
| **Grand Total** | **601** | **687** | **1288** |

| Profession by Gender | Female | Male | Total |
|---|---|---|---|
| Add Prof Scientific and Technic | 6 | | 6 |
| Additional Clinical Services | 23 | 11 | 34 |
| Administrative and Clerical | 443 | 578 | 1021 |
| Allied Health Professionals | 6 | 2 | 8 |
| Estates and Ancillary | 5 | 24 | 29 |
| Healthcare Scientists | 3 | 6 | 9 |
| Medical and Dental | 86 | 64 | 150 |
| Nursing and Midwifery Registered | 27 | 2 | 29 |
| Students | 2 | | 2 |
| **Grand Total** | **601** | **687.00** | **1288** |

| Contract Type by Gender | Female | Male | Total |
|---|---|---|---|
| Fixed Term Temp | 138 | 115 | 253 |
| Permanent | 463 | 572 | 1035 |
| **Grand Total** | **601** | **687** | **1288** |

| Gender | Headcount | % |
|---|---|---|
| Female | 601 | 46.66 |
| Male | 687 | 53.34 |
| **Grand Total** | **1288** | **100.00** |

| Sexuality | Headcount | % |
|---|---|---|
| Bisexual | 9 | 0.70 |
| Gay or Lesbian | 19 | 1.48 |
| Heterosexual or Straight | 942 | 73.14 |
| Not stated (person asked but declined to provide a response) | 93 | 7.22 |
| Undecided | 2 | 0.16 |
| Unspecified | 223 | 17.31 |
| **Grand Total** | **1288** | **100.00** |

| Religious Belief | Headcount | % |
|---|---|---|
| Atheism | 283 | 21.97 |
| Buddhism | 6 | 0.47 |
| Christianity | 438 | 34.01 |
| Hinduism | 12 | 0.93 |
| I do not wish to disclose my religion/belief | 168 | 13.04 |
| Islam | 29 | 2.25 |
| Judaism | 1 | 0.08 |
| Other | 116 | 9.01 |
| Sikhism | 2 | 0.16 |
| Unspecified | 233 | 18.09 |
| **Grand Total** | **1288** | **100.00** |

| Ethnic Origin | Headcount | % |
|---|---|---|
| Asian | 48 | 3.73 |
| Black | 18 | 1.40 |
| Chinese | 1 | 0.08 |
| Mixed | 17 | 1.32 |
| Not Stated or Unspecified | 160 | 12.42 |
| Other | 4 | 0.31 |
| White | 1040 | 80.75 |
| **Grand Total** | **1288** | **100.00** |

| Disability | Headcount | % |
|---|---|---|

| | | | |
|---|---|---:|---:|
| No | | 955 | 74.15 |
| Not Declared | | 52 | 4.04 |
| Prefer Not To Answer | | 1 | 0.08 |
| Unspecified | | 235 | 18.25 |
| Yes | | 45 | 3.49 |
| **Grand Total** | | **1288** | **100.00** |

| Marital Status | Headcount | % |
|---|---:|---:|
| Civil Partnership | 16 | 1.24 |
| Divorced | 66 | 5.12 |
| Legally Separated | 4 | 0.31 |
| Married | 555 | 43.09 |
| Single | 451 | 35.02 |
| Unknown | 136 | 10.56 |
| Widowed | 8 | 0.62 |
| (blank) | 52 | 4.04 |
| **Grand Total** | **1288** | **100.00** |

| On Maternity | Headcount | % |
|---|---:|---:|
| Yes | 12 | 0.93 |
| No | 1276 | 99.07 |
| **Grand Total** | **1288** | **100.00** |

## QUALITY, SAFETY & PERFORMANCE COMMITTEE

## ANNUAL REPORT OF VCC CONTROLLED DRUG OVERSIGHT GROUP 2021

| DATE OF MEETING | 12/05/2022 |
|---|---|

| PUBLIC OR PRIVATE REPORT | Public |
|---|---|

| IF PRIVATE PLEASE INDICATE REASON | Not Applicable - Public Report |
|---|---|

| PREPARED BY | Bethan Tranter, Head of SACT and Medicines Management |
|---|---|
| PRESENTED BY | Usman Malik, Principal Pharmacist, Clinical Services |
| DIRECTOR SPONSOR APPROVED | Jacinta Abraham, Executive Medical Director |

| REPORT PURPOSE | FOR NOTING |
|---|---|

| COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING | | |
|---|---|---|
| COMMITTEE OR GROUP | DATE | OUTCOME |
| VCC CD Oversight Group EMB | 01/03/22 27/04/2022 | ENDORSED FOR APPROVAL |

| ACRONYMS | |
|---|---|
| CD | Controlled Drug |
| LIN | Local Intelligence Network |
| NG | Naso-gastric |

# 1. SITUATION/BACKGROUND

VCC CD Oversight Group meet twice per year chaired by the Director of Service Transformation who is the Accountable Officer for Controlled Drugs at Velindre Cancer Centre.

The role of the group is to maintain oversight of the safe management and use of CDs at VCC

It reports to the Trust Quality, Safety and Performance Committee.

# 2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

**2.1** The following are standing agenda items of the group:

- Review of CDs prescribed on WP10 (HPs) in a preceeding month to the meeting.

  The purpose of this spot check audit is to ensure the use of WP10 (HPs) as a means of furnishing patients with prescriptions of CDs is being appropriately used. This is undertaken by triangulating the information on the prescription with the patient's Canisc clinic record.

  No clinical concerns or queries were identified for the month's audited (June and Dec 2021).

- Review of the compliance of the Pharmacy Service in undertaking patient's own and ward stock CD checks

  Overall compliance is good. Occassional challenges have been experienced during short periods of staff shortages. Completion of these checks is now included with Pharmacy Clinical Services KPIs, in addition to being monitored by the CD Oversight Group.

- Incidents involving CDs
  All incidents involving CDs are investigated and reported to the CD Oversight Group.

  Between Jan 2021 and Dec 2021 there have been 11 incidents in Velindre Cancer Centre. Please see Table 1 for further information.

Key issues to note:

- No incidents resulted in patient harm.
- There have been no trends with regards to the members of staff involved in the administration errors seen on First Floor.
- The use of the medication error policy and the BESS scoring tool has improved governance in the way that the investigation of incidents are undertaken and resolved.
- Feedback is provided to nursing teams to ensure on-going learning and compliance with policies and procedures.
- Summaries of CD related incidents are shared via CD LIN partnership meetings which provides an opportunity for external, independent scrutiny and also shared learning .

**2.2**   During 2021, the group, in partnership with the Medicines Management Group oversaw the following brand switches:

- Discontinuation of MST™ granules by the manufacturer. Change to Zomorph™ capsules.
  The main patient group affected by this switch were those with Head and Neck or Upper Gastro-intestinal Cancers who require NG tubes. This switch was undertaken by a multi-disciplinary Task and Finish Group. It included the production of patient information leaflets and the co-ordination of staff and patient education sessions. No incident has subsequently been reported as a result of this change.

- Change of brand of oxycodone from Oxycontin™/Oxynorm™ to Longtec™/Shortec™.

  This change resulted in a small financial saving by VCC but, importantly ensured that VCC and its neighbouring HBs are utilizing the same branded products to facilitate seamless transfer of care.

  No incident has subsequently been reported.

**2.3**   The VCC CD Newsletter was circulated to all prescribers in Q2 2021. It contained information as to the switches as described above and reminders as to secure storage of WP10 (HP) prescriptions.

**2.4**   The VCC CD Oversight Terms of Reference were updated, reviewed and approved in March 2021. See appendix.

## 3. IMPACT ASSESSMENT

| | |
|---|---|
| **QUALITY AND SAFETY IMPLICATIONS / IMPACT** | There are no specific quality and safety implications related to the activity outined in this report. |
| **RELATED HEALTHCARE STANDARD** | Safe Care |
| | If more than one Healthcare Standard applies please list below: |
| **EQUALITY IMPACT ASSESSMENT COMPLETED** | Not required |
| | |
| **LEGAL IMPLICATIONS / IMPACT** | There are no specific legal implications related to the activity outlined in this report. |
| | |
| **FINANCIAL IMPLICATIONS / IMPACT** | There is no direct impact on resources as a result of the activity outlined in this report. |
| | |

## 4. RECOMMENDATION

QS&P Committee are asked to **NOTE** this paper.

| Reference | Description of concern[1] | Actions taken | Open/Closed |
|---|---|---|---|
| 14/01/2021 | CD delivered to First Floor ward and left on top of worktop in the treatment room unattended. Not placed in the CD cupboard at point of delivery. | Oncall pharmacist contacted, and as discussed CD entered into the book. Policies and procedures followed appropriately with regards to the investigation. Correct medication delivered to the ward. SOP familiarisation by all staff. No further action needed. | Closed |
| 09/02/2021 | Upon doing the daily CD check on First Floor, MST ampule was broken within the packaging. | Two nurse checking the CD balances. Ampule disposed of appropriately and destruction annotated in the CD register. Correct procedures followed. No further concerns, or harm caused. | Closed. |
| 30/04/2021 | Midazolam needed for a patient out of hours and no stock on First Floor ward. | On-call pharmacist contacted and attended to supply. CD stock list reviewed and new updated list implemented. | Closed. |
| 01/05/2021 | Oramorph oral liquid 20mg/1ml discrepancy on the First Floor ward of 14.5ml. | Discrepancy policy used and less than 0.3% therefore accepted as not significant. No further concerns. | Closed. |
| 05/06/2021 | Oramorph oral liquid 20mg/1ml discrepancy found on the First Floor ward of 12.75mls | Discrepancy policy used and less than 0.3% therefore accepted as not significant. No further concerns. | Closed. |
| 23/06/2021 | Patient given double the dose of alfentanil on 2 separate occasions. Patient was given 1.2ml instead of 0.6ml

Checked by 3 nurses and error noticed prior to evening dose. | Team made aware, patient came to no harm. Palliative care team informed and involved. Medication error policy used - BESS tool score 11.

Reflections carried out by all members of nursing staff involved. No further actions needed. | Closed. |

| | | | |
|---|---|---|---|
| 04/07/2021 | Patient's morning medications to be carried out and found medicine pot on table which contained sevredol 10mg. Patient had not taken. | Team made aware and discussed with the palliative care team. BESS tool scoring used and nurses carried out reflections. No further actions needed. | Closed. |
| 05/07/2021 | Patient stated that she took a small blue tablet (presumed MST) in the morning which she forgot to take as her evening dose. | Team made aware and discussed with the palliative care team. BESS tool scoring used and nurses carried out reflections. No further actions needed. | Closed. |
| 03/08/2021 | Staff nurse asked by student nurse to give patient PRN oramorph pre radiotherapy.<br><br>Gave patient 10mg/5ml PRN oramorph at 17:15, previous dose 16.35 therefore too early as prescribed 1-2 hourly. | BESS tool scoring used and reflection carried out by the members of staff involved. Patient came to no harm. No further actions needed. | Closed. |
| 09/09/2021 | Upon checking drug chart, nurse noticed evening dose of longtec hadn't been given to the patient. | Clinical team made aware and additional discussed with the palliative care team. No harm to patient or their pain control by missing a single dose. BESS tool scoring used, and nursing staff involved carried out reflections. No further actions needed. | Closed. |
| 25/11/2021 | Spillage of oxynorm liquid on the first floor ward. Therefore discrepancy in the CD book. | The event was witnessed by a second member of staff, no rubber bung placed on the bottle therefore contributing to the spill. Staff will ensure rubber bung used on liquid medication to ensure spillage limited. SOPs to be followed, no further action. | Closed. |

# QUALITY, SAFETY & PERFORMANCE COMMITTEE

# VCC MEDICAL GAS GROUP ANNUAL REPORT 2021

| DATE OF MEETING | 12/05/2022 |
|---|---|

| PUBLIC OR PRIVATE REPORT | Public |
|---|---|

| IF PRIVATE PLEASE INDICATE REASON | Not Applicable - Public Report |
|---|---|

| PREPARED BY | Bethan Tranter, Head of SACT and Medicines Management, Chair of VCC Medical Gas Group |
|---|---|
| PRESENTED BY | Usman Malik, Principal Pharmacist |
| DIRECTOR SPONSOR APPROVED | Jacinta Abraham, Executive Medical Director |

| REPORT PURPOSE | FOR NOTING |
|---|---|

| COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING | | |
|---|---|---|
| COMMITTEE OR GROUP | DATE | OUTCOME |
| VCC Medical Gas Group<br>EMB | 16/02/22<br>27/04/2022 | ENDORSED FOR APPROVAL |

| ACRONYMS | |
|---|---|
| MGPS | Medical Gas Pipeline Systems |
| NWSSP | National Wales Shared Services Partnership |

## 1. SITUATION/BACKGROUND

1.1 This paper had been prepared to provide assurance of the key issues considered by the Medical Gases Group between January 2021 to December 2021 inclusive.

1.2 Medical Gases are medicinal products. As such the governance of medical gases within a hospital is the responsibility of its Chief Pharmacist.

1.3 HTM 02-01 describes the corporate responsibilities held by various officers within an NHS hospital, including how responsibility for the maintenance and integrity of the MGPS is discharged.

1.4 VCC Medical Gas Group meets twice per year, membership consists of clinical and non-clinical colleagues who are involved in the safe delivery of medical gases to VCC's patients and reflects key personnel as outlined in HTM 02-01.

## 2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Operational management arrangement for MGPS is an annual audit that is undertaken by NWSSP. It's focus is on the MGPS installed at VCC and the processes for it's maintenance to the Trust

2.2 The most recent MGPS Audit Report March 2021 (received Nov 2021) rated VCC as Amber. The previous report also rated VCC as amber.

2.3 The audit report included 17 recommendations. The Estates Dept have developed an action plan to address these recommendations which is monitored via the Estates Compliance Group

2.4 Medical Gas training across all relevant staffing groups progressed through 2021, particularly within Integrated Care and Operational Services. A plan is in place for training to be rolled out within SACT Daycase, Outpatients and Radiotherapy Services during 2022. Departmental managers are engaged.

2.5 Operational Services continue to undertake monthly stock take and expiry checks on medical gas cylinders held within clinical areas.

2.6 Pharmacy and Operational Services undertook the annual inspection in October in all areas where medical gas cylinders are utilized to ensure that medical gases cylinders:

- are securely stored
- are within their expiry date
- have sufficient quantity remaining within each cylinder
- and that appropriate stock levels are held in clinical areas

2.7　No significant issues have been raised through these spot checks and all were addressed with departmental leads at the time.

## 3.　IMPACT ASSESSMENT

| QUALITY AND SAFETY IMPLICATIONS / IMPACT | There are no specific quality and safety implications related to the activity outined in this report. |
|---|---|
| | |
| RELATED HEALTHCARE STANDARD | Safe Care |
| | Governance,Leadership and Accountability: |
| EQUALITY IMPACT ASSESSMENT COMPLETED | Not required |
| | |
| LEGAL  IMPLICATIONS / IMPACT | There are no specific legal implications related to the activity outlined in this report. |
| | |
| FINANCIAL IMPLICATIONS / IMPACT | There is no direct impact on resources as a result of the activity outlined in this report. |
| | |

## 4.　RECOMMENDATION
QS&P Committee are asked to **NOTE** the contents of this report.

| QUALITY, SAFETY & PERFORMANCE COMMITTEE |
|---|

| DRAFT VELINDRE UNIVERSITY NHS TRUST<br>ANNUAL PERFORMANCE REPORT 2021-2022 |
|---|

| DATE OF MEETING | 12/05/2022 |
|---|---|

| PUBLIC OR PRIVATE REPORT | Public |
|---|---|

| IF PRIVATE PLEASE INDICATE REASON | Not Applicable - Public Report |
|---|---|

| PREPARED BY | Peter Gorin, Head of Corporate Strategic Planning and Performance<br>Phil Hodson, Assistant Director of Planning and Performance |
|---|---|
| PRESENTED BY | Peter Gorin, Head of Corporate Strategic Planning and Performance |
| EXECUTIVE SPONSOR APPROVED | Carl James, Director of Strategic Transformation, Planning, & Digital |

| REPORT PURPOSE | FOR NOTING / REVIEW |
|---|---|

| COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING | | |
|---|---|---|
| COMMITTEE OR GROUP | DATE | OUTCOME |
| Executive Management Board | (27/04/2022) | IN SUPPORT |

| ACRONYMS | |
|---|---|
|  |  |

## 1. SITUATION/BACKGROUND

1.1 NHS bodies are required to publish, as a single (unified) document, a three-part Annual Report and Accounts which includes the:

- Performance Report;
- Accountability Report; and
- Financial Statements

The draft Performance Report will form part of the suite of Annual Report Documents and is intended for the Public and provides information in an honest and transparent way about the services provided by Velindre University NHS Trust.

## 2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The timetable for submission of the FINAL DRAFT Annual Performance Report for 2021-22 to Welsh Government and Audit Wales has been confirmed as:

- **FINAL Draft** Submission **mid-day Wednesday 15 June 2022**

2.2 The guidance provided by Welsh Government advises that the Performance Reporting needs to include a breakdown of the Annual Performance Report content requirements as set out in **Chapter 3 of the NHS Manual for Accounts**, *ref. Appendix 1* for the relevant extract.

2.3 The Performance Reporting content also needs to include how the organisation has performed against the **FIVE** harms: https://gov.wales/sites/default/files/publications/2021-07/technical-advisory-group-5-harms-arising-from-covid-19_0.pdf

2.4 Welsh Government has advised that the focus of the guidance is on ensuring that bodies show how they have performed against the **Annual targets set for 2021-22**. It is a similar structure to 2020-21 because the 3-year plan has been suspended and the Trust are operating on an Annual Planning Framework for 2021-22 before reverting to the three-year duty from 2022-23.

The emphasis will be reporting how organisations have performed against the Parameter Letters issued in September and October 2021 and the Delivery Framework. A key metric to report will be NHS waiting list statistics (where relevant to the Trust) and organisations recovery plans to return to the normal operating environment in 2022-23.

2.5 The First Draft has been shared with Executive Management Board for their review ahead of submission to the Quality, Safety & Performance Committee. Engagement with the relevant service leads has also formed part of the development pathway.

## 3. IMPACT ASSESSMENT

| | |
|---|---|
| **QUALITY AND SAFETY IMPLICATIONS/IMPACT** | Yes (Please see detail below) |
| | The draft Performance Report encompasses and details the Trust Performance against a number of key Quality & Safety aspects for the organisation. |
| **RELATED HEALTHCARE STANDARD** | Governance, Leadership and Accountability |
| | If more than one Healthcare Standard applies please list below: |
| **EQUALITY IMPACT ASSESSMENT COMPLETED** | Not required |
| | |
| **LEGAL IMPLICATIONS / IMPACT** | There are no specific legal implications related to the activity outlined in this report. |
| | |
| **FINANCIAL IMPLICATIONS / IMPACT** | Yes (Include further detail below) |
| | The Performance Report forms part of the suite of Annual Report Documents and will be translated in Welsh, which will have a cost implication for translation. |

## 4. RECOMMENDATION

4.1 The Quality, Safety & Performance Committee is asked to **NOTE/REVIEW** and provide any feedback on the First Draft of the Annual Performance Report in readiness for inclusion as part of the Final Draft Submission to Welsh Government and Audit Wales for 2021-2022.

# Velindre University NHS Trust Performance Report 2021-2022

# CONTENTS

# INTRODUCTION AND CEO STATEMENT

This Annual Performance Report, describes how we delivered services from 1st April 2021 to 31st March 2022 in the context of the ongoing COVID-19 pandemic.  It also outlines how we ensured patient, donor and staff safety and demonstrates our total commitment to Quality, Care and Excellence.

During 2021 - 2022 I am proud that our patients, donors and families have continued to benefit from the highest standards of care, innovation and professionalism across the range of services we deliver.  We successfully maintained the supplies of blood and blood products to the whole of NHS Wales, transplant services both solid organ and stem cells, and delivered essential tertiary cancer services to South East Wales. We believe the strong foundations and clinical operating models that we have established will stand us in good stead, as we enter 2022/2023.

The NHS Wales Annual Planning Framework Guidance required the production of a three year Integrated Medium Term Plan (IMTP), covering the period 2022 - 2025. In line with this guidance we submitted our plan to the Welsh Government on 31st March 2022. Our plan builds upon the excellent work undertaken by teams from across the Trust, working with our many partners, to develop a set of ambitious priorities, which build on our strengths and which will result in people who use our services receiving excellent care, service and support.  Our plans are outlined in three distinct areas.

Firstly, the plan sets out our commitment to delivering high quality, safe services which provide an excellent experience and outlines how we deliver this in context of the living with COVID-19.  It describes what services we will provide, where they will be provided from and how we will meet the expected increase in demand for services over the coming years. The foundation of our services will be work we are progressing on our clinical and scientific plans and value-based healthcare.

Secondly, the plan identifies our priorities related to the implementation of enhanced models of care and services for blood and cancer services.  This will see donors and patients being able to access services as close to home as possible, receive a wider range of information services digitally, and have access to a trials and other services provided by our partners which may add value for them.  We will also seek to significantly develop our buildings and upgrade our equipment by 2025 and this, together with our clinical and sustainability plans, will provide us with the opportunity to deliver a carbon Net Zero organisation and a range of wider benefits to support the development of thriving and resilient communities across Wales.

The third area, and related priorities, signal the continued strategic development of the Trust and its transformation into new and potentially exciting areas of work in accordance with the challenge laid down by 'A Healthier Wales'.  This will see us explore opportunities across the health and social care system to identify areas where we can further support our partners in achieving outcomes and benefits for the populations we serve.

The plan we have set out demonstrates the exciting times ahead of Velindre University NHS Trust.  We look forward to working with our staff, patients, donors and partners to deliver the changes set out within the plan and continue our transformation into the future.

## IMTP PROCESS ANNUAL PLANNING FRAMEWORK 2021-2022 AND DELIVERY FRAMEWORK 2021-2022

The Welsh Government NHS Wales Planning Framework for 2022 - 2025 confirmed the re-instatement of three year Integrated Medium Term Plans (IMTP) for the current planning round.

The submission of our IMTP 2022- 2025 was approved by the Trust Board, on 31st March 2022, as part of the Trusts' statutory duty under the Finance (Wales) Act 2014.

The development of the IMTP has been challenging this year, given the level of uncertainty in the operating environment resulting from the ongoing impact of Covid-19 together with the range of challenges faced by the healthcare system and wider public services in Wales.

The IMTP 2022-2025 is framed within the Trusts' ambition for the future, following the Boards' approval of the Trust strategy '*Destination 2032*' and brings together the immediate, medium and long-term ambitions of the organization.

Notwithstanding this, and in accordance with the Welsh Government guidance, the IMTP is particularly focused on 2022 – 2023, to ensure that there are robust plans in place to deliver the required levels of service which achieve the appropriate levels of quality, safety and experience in a Covid-19 operating environment.

The core principle in developing the IMTP has been our commitment to quality and safety.  Our IMTP will ensure that we put our patients and donors at the centre of everything we do; working towards optimum quality, safety and experience; and continual learning and improving.  This is the '*golden thread*' throughout our organization.

Our strategic goals will be achieved by ensuring that all of our services are developed and delivered in collaboration with the patients and donors who use them, continually reviewing outcomes and experience and using these to learn and improve.
These priorities set out within our IMTP have been discussed and agreed with our commissioners and reflects their service needs.

The Trust's IMTP for 2022 - 2025 will be subject to internal performance management arrangements and reporting to various stakeholders, including the Welsh Government

Integrated Quality Planning Delivery (IQPD) progress review meetings and audit/regulatory bodies throughout the year.

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# THE FIVE HARMS 0F COVID-19

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In March 2020, Covid 19 arrived in the United Kingdom and fundamentally changed the lives of our population during the pandemic.

Harm related to COVID-19 can be broadly grouped into 5 key areas; 4 harms have been identified previously, but a fifth cross-cutting harm has been added, explicitly recognising the important impact of inequality on the harm experienced by people.

| |
|---|
| 1. Harm directly arising from SARS-CoV2 infections (COVID-19) |
| 2. Indirect COVID-19 harms due to surge pressures on the health and social care system, such as cancellation or postponement of urgent and non-urgent treatments and delayed management of long-term conditions. |
| 3. Harms arising from population based health protection measures such as, educational, psychological, isolation from shielding and other measures |
| 4. Economic harms such as unemployment and reduced business income arising both from COVID-19 directly and population control measures e.g. lockdowns, social distancing and masks wearing |
| 5. Harms arising from the way COVID-19 has exacerbated existing, or introduced new, inequalities in our society |

The impact on people's health and well-being in Wales has, and will continue to be profound in range of ways:
- People who did/were not able to access services with health concerns and subsequently receive a diagnosis later than would have occurred pre-COVID
- Patients who were waiting for treatment, which was delayed and affected the outcome

Looking ahead, NHS Wales is working with a wide range of partners to move to a position where Covid-19 can be managed as an endemic factor i.e. 'living with COVID' This means that the level of disease is more predictable and therefore planning can be undertaken with greater levels of certainty and confidence.

# IMPACT OF COVID ON DELIVERY OF SERVICES

The pandemic continues to affect our service planning and delivery for both our cancer and blood and transplant services. COVID related absences, capacity reductions due to enhanced Infection Prevention Control (IPC) measures and increasing patient numbers are all having an impact on our service provision and waiting times.

The pressure on our services continues to be intense, as we seek to deal with the complex needs of people using them, ongoing staff illness and a backlog of people's treatments that have been delayed as a result of the measures put in place to manage the health, safety and well-being of society during the pandemic.

However, it is important to note that despite all the challenges we continue to respond in providing excellent care for our cancer patients, by relocating staff from other areas, maximising the use of hypofractionation, reviewing the utilization of our Linac fleet and drawing upon private sector capacity in the short term.

Our blood and transplant services also continue to operate under COVID restrictions which impact upon blood collection and manufacturing capacity. However, work is in hand with the Infection Prevention and Control team to assess removal of triage and reducing social distancing within collections which should help improve this position as Wales begins to lift COVID restrictions.

The total Trust Covid funding requirement for 2022-23 as presented in the tables below is £12,310k. The Trust has received confirmation that the £710k National response programme costs relating to both Mass Vaccination (£375k), PPE (£335k) and Covid IPC (£1394k) will be funded directly by Welsh Government, whilst our Commissioners have included £6,056k within their financial plans for Covid Recovery capacity costs.

| Covid Funding Requirement 2022-23 | Total £000 |
|---|---|
| Mass Vaccination | 375 |
| PPE | 335 |
| **Subtotal Covid Programme Funding** | **710** |
| Covid Recovery & Response Funding<br>- Welsh Government (IPC)<br>- Local Health Boards (capacity) | 1394<br>6056 |
| Covid Additional Outsourcing for SACT & Radiotherapy | 4,150 |
| **Subtotal Covid Recovery and Response Funding** | **11,600** |

| **Total Covid Funding Requirement 2022-23** | **12,310** |
|---|---|

The Trust is also including £4,150k for additional capacity outsourcing requirement in relation to both SACT and Radiotherapy which is based on the anticipated maximum cost, with the current expectation that this will be funded via our Commissioners.

## PLANNING AND DELIVERY OF SAFE, EFFECTIVE AND QUALITY SERVICES FOR COVID CARE

**Clinical safety for our Patients and Donors:**

Velindre University NHS Trust is committed to ensuring the delivery of safe, high quality and effective care to our patients and donors. It is also committed to continuous quality improvement in order to achieve this.

During 2021 – 2022, the Trust was focused on maintaining the safe delivery of its core priority services during the various waves of the COVID pandemic. In the main, Velindre Cancer Centre and the Welsh Blood Service were both able to continue to provide their core clinical services. This required a tremendous effort from all staff who continue to go over and above for the benefit of our patients and donors.

Throughout the COVID pandemic, all relevant national IPC & COVID guidelines and policies were adhered to, and stringent infection prevention and control measures were maintained. This necessitated a reduction in the in-patient bed base at VCC, however, this was mitigated by extending ambulatory care pathways / infrastructure.

As well as responding to the challenge of maintaining service delivery in the pandemic, we have also played a key role in supporting the National Vaccination Programme by not only delivering vaccinations to our own staff and vulnerable patients but by also delivering vaccinations to the wider health and social care staff and some cancer patients.

# PLANNING AND DELIVERY OF SAFE, EFFECTIVE AND QUALITY SERVICES FOR NON-COVID CARE

**Welsh Blood Service:**

The Welsh Blood Service has continued to adapt its blood collection and processing service model and its transplant support services in response to changing public health and IPC guidance. This was vital in ensuring continuity of service during the pandemic and the ongoing need for infection prevention adaptations will create a need for further evolution during 2022/23.

The pattern of change in demand for our services is clearly aligned to that of the Local Health Board services and we have continued to work closely with NHS colleagues through the National Oversight Group for Blood Health and blood bank managers to respond as required.

In addition, as we move through the year, we will be continuing to work through several other major initiatives such as our Blood Supply Chain and Digital programmes as well as commence work to scope the further collection of Plasma for the benefit of patients in Wales.

**Our Priorities Delivered in 2021/22:**

> **Provide an efficient and effective collection Service, facilitating the best experience for the donor, and ensuring blood products and stem cells are safe, high quality and modern –** Our donor engagement strategy has been revised and relaunched for both whole blood and stem cell donors. The newly-established Component Development Research laboratory has worked with the Transfusion laboratories team to review and implement changes to our strategy platelet, plasma and cryoprecipitate strategy. Significant progress has been made on the plans for occult Hepatitis B screening which will be introduced in 2022.

> **Meet the patient demand for blood and blood products through facilitating the most appropriate use across Health organisations -** WBS has sustained supply of blood and blood products for Wales in extremely difficult circumstances and whist it has had to rely on support from other UK blood services on occasion, WBS has also found itself supporting those services at other times during the year. The Blood Health team continue to work with hospitals across Wales, providing training and support to ensure that blood products are used appropriately.

> **Provide safe, high quality and the most advanced manufacturing, distribution and testing laboratory services –** In the last year, Welsh Blood has procured new Blood Group Analysers for whole blood, and a new Bacteriological monitoring and alerting system for platelets. New processes have been developed to support the screening of donors for occult Hepatitis B infections. Screening of platelet donors for HNA antigens has been introduced.

**Provide safe, high quality and the most advanced diagnostic, transplant and transfusion services** – Welsh Blood has implemented state of the art Next Generation Sequencing in the Histo-compatibility and Immuno-genetics labs and has implemented changes to cross-matching tests used to assess compatibility in solid organ transplantation. From April 1st 2022, WBS has introduced a Consultant Clinical Scientist on-call service to support organ transplantation.

**Provide, services that are environmentally sustainable and benefit our local communities and Wales –** The program of work is underway to develop and implement an energy efficient, sustainable, SMART estate at Talbot Green site that will facilitate a future service delivery model. Other projects are working to reduce the use of non-recyclable materials such as water bottles and disposable cups in donation clinics, and to reduce the use of printed documents across the service.

**Be a great organisation with great people dedicated to improving outcomes for patients and donors –** Welsh Blood continues to offer a variety of career development pathways for it's people at all levels. We have maintained support for higher education and vocational training for scientists and health professionals including the national Higher Specialist Scientific Training program for consultant clinical scientists as well as management and leadership development. Trade union engagement continues to be positive with close collaboration as we seek to align terms and conditions across our collection teams. Work is ongoing to design an agile model of working where lessons from the pandemic can be applied to allow our people flexibility in where they work.

## Challenges faced during 2021/22:

Whilst we always will plan to collect enough blood to meet the forecast issuing needs of hospitals across NHS Wales, 2021/22 has continued to present unique challenges as a result of the pandemic, as outlined below:

### Collection of Blood and blood products, processing and distribution:

- Fewer fixed donation sites, incorporating social distancing and infection prevention control measures
- Competition for donation sites from vaccination clinics
- The need to increase stocks of Fresh Frozen Plasma to support stock replacement as part of the occult Hepatitis B screening program.
- Access to timely, up to date demand information to support forward planning

### Wholesale Distribution of Commercial Blood Products:

- Ongoing monitoring of availability of stock and contingency planning
- Pressure to increase and maintain critical stocks in response to forecast global shortages of donated plasma from which these products are made.

**Blood and stem cell donor selection regulations:**

- Continuing to meet stringent and changing donor selection guidelines and regulations for blood and stem cells including the forthcoming introduction of screening for occult Hepatitis B Infections and the potential need to review historical donations from donors who test positive.
- Continuing to meet COVID-19 requirements for facilitation of export and import of stem cell products such as transport from restricted countries and COVID-19 testing of couriers.

**Maintaining an engaged healthy donor panel:**

- Focus on 'targeting' to meet specific and fluctuating requirements for specific groups
- Strategy for bone marrow donor recruitment, where age group differs to whole blood donors

**A healthy and sustainable workforce:**

- Specialist staff shortages
- Recruitment and retention

Work is ongoing through the Blood Health Team and Collections Team to align the collection profile with demand for specific blood groups, but this remains difficult to determine. We are also challenged by lack of certainty from Health Boards regarding activity levels. Furthermore, there is a requirement to ensure the supply of blood by blood group meets the demand, which adds to the risk of supply and issuing alignment being achieved.

We continue to plan to use our donor recruitment plans to flex to meet demand and our donors are responsive. However, in the event of shortage, we will draw on our mutual aid agreement with the UK Blood Services or in extreme circumstances initiate the National Blood Shortage Plan to actively manage stocks with hospitals.

**Velindre Cancer Service:**

The sustained delivery of our services with sufficient capacity in the context of COVID-19 was our primary focus during 2021/22. Our overarching aim has been to safely maintain the delivery of non-surgical cancer services for the population of South East Wales, while ensuring that staff and patients are safe when attending our treatment locations and to minimise the risk of COVID-19 transmission.

In doing this we were required to transfer all outreach SACT and outpatient services from other hospitals to the VCC site and this remains the case for all outreach SACT delivery apart from Prince Charles.  This service is reduced due to nurse staffing challenges, there is a task and finish group in place to address the challenges of establishing a resilient SACT nursing workforce.

We are following Welsh Government Guidance and implementing changes agreed by our Trust Covid cell which continues to meet fortnightly. We are making changes in a measured way due to our clinical extremely vulnerable patient population. We are

reviewing all of our Covid measures and reducing them e.g. removal of 2 metre rule in our inpatient ward to return to our full bed capacity.

The Transforming Cancer Services programme will continue to be a core area of work for us and the recommendations of the Nuffield Review, finalised in March 2021, where we continue to work in partnership with South-East Wales Local Health Boards and the Collaborative Cancer Leadership Group (CCLG). Existing regional projects such as the Acute Oncology Service Project also continue to be key strategic priorities for us and our LHB partners.

In taking account of the above determining factors, the Velindre Cancer Service pursued the following priorities during 2021/22.

**Our Priorities in 2021/22:**

**Priority 1: Ensuring that Staff and Patients are Safe at our Treatment Locations** – we minimised the Risk of COVID-19 transmission through enhanced infection control measures, revised patient and care delivery pathways, vaccination and testing strategies during 2021/22.

**Priority 2: Delivery of appropriate capacity to meet patient demand –** despite the pressures caused by the pandemic we continue to deliver all of our services adapting our clinical model to ensure we are responding to the service pressures brought by the pandemic. An example of this is growing our ambulatory care model to manage same day emergency oncology care which in turn enables patients to continue their treatment without interruption. **Priority 3: Delivery of business critical initiatives** – primarily through Velindre Futures and planning the new Velindre Cancer Centre.

**Priority 4: Engagement with Health Boards and Regional Service Planning** – including developing the regional approach the Acute Oncology Service Project and pre-habilitation.

**Priority 5: Patient Experience and Engagement** – recognising and responding to the impact of COVID-19.

Our patient engagement strategy has been developed working in conjunction with Velindre Cancer Centre patients, our volunteers, our staff, cancer charities and the Community Health Councils. It outlines how we will engage with our patients, their families, and carers in the future to ensure that their voices are at the heart of how we plan and deliver our services.

Velindre Cancer Centre is undergoing a period of unprecedented change. We are undertaking an exciting, ambitious programme of work to improve the cancer services we deliver for our patient population, building on our past achievements and learning from our experiences.

The focus of this strategy are the actions that we will take to achieve a step change in our partnership with our patients to improve what we do today and plan what we need for the future.

We have rolled out the electronic real time patient feedback system CIVICA to capture the feedback from patients, this feedback is shared with department leads and through our quality, safety and performance systems.

**Challenges faced during 2021/22:**

The year 2021/22 provided significant challenges for VCC in responding to the COVID-19 pandemic, and a number these will remain as we move into 2022/23 as we move out of the pandemic and move into business as usual whilst balancing the delivery of critical and time limited treatments and services with COVID risks taking into account the changing COVID risks.

We are preparing to *'flex'* to the changing scenarios that the next phases of the pandemic will bring as we manage the predicted 'surge' of patient activity following the pandemic. Ensuring effective and safe utilisation of the site to accommodate services remains a challenge; particularly in respect of delivery of SACT services as we work with health boards on repatriation of pre pandemic SACT outreach facilities.

The wellbeing of our staff has been a key priority during 2021/22, and the professional and personal impact of the pandemic and the way in which we work will continue to be a key area of focus, particularly as we plan for increases in capacity to meet suppressed demand as referrals increase through the year. The recruitment of additional staff with specialist skills that we require and the most effective use of our staff skill sets and skill mix will be critical. This will require very different ways of working and delivering our services.

In addition, we will continue to operate against the background of the challenges for tertiary cancer services that exist out with those that result from the pandemic. These include increasing cancer rates and health inequalities, a growing gap in the forecast demand between supply and demand, increasingly complicated and personalised treatments and supporting people to live with and beyond cancer.

**Velindre Futures:**

The Velindre Futures programme was established in 2020, and is the vehicle through which we are delivering the transformation needed to meet the aspirations of the South East Wales Transforming Cancer Services programme, the further regional opportunities and the existing ambitious plans for service modernisation.

Over the past year, a number of the transformation programmes have made good progress despite the impact of the COVID pandemic – these have included progress on the Unscheduled and Acute Oncology pathways with our local Health Board partners, the development of a Research and Development Hub at the University of Wales Hospital, the Radiotherapy service change programme and the development of a formal engagement strategy for the Trust.

The outpatient transformation programme (linked with Values Based Health Care), and the replacement of the CANISC system through the delivery of the Digital Health and Care Record system are continuing.

As we move on from the recent wave of the COVID pandemic, we will further drive the transformation agenda at the Cancer Centre via the Velindre Futures Board. Core to these ongoing service changes is ensuring that the voice of the patient, their carers, families and the public are involved in shaping what we do.

**New Velindre Cancer Centre:**

Since Welsh Government's approval in March 2021 for the outline business case for the new Velindre Cancer Centre the Trust has successfully continued to take forward the plans to the next stage. The Trust has been working with two consortia as part of the competitive dialogue process to design, build and operate the new VCC. This work includes working with our patients and staff to develop a hospital design that will deliver our ambition of a world-class facility that will deliver unrivalled care for cancer patients across South-East Wales, be an inspiring workplace for our dedicated staff to thrive and be a focal point for international research. In addition, the Trust and consortia have been actively seeking to ensure the new hospital is a place that benefits the local community.

The Trust has successfully started the enabling works on the new site, which is a key dependency for the opening of the new centre, which is programmed to open in 2025.

We are all continuing to work to develop the new Velindre Cancer Centre to be one we can all be proud of for generations to come.

**Digital Innovation:**

The Trust continues to progress its digital agenda, to improve the delivery of patient / donor care and to improve quality and safety. A new Digital Strategy is being developed, due to be published in May 2022, which will set out the future vision for the delivery of digital services across the Trust over the next 5 – 10 years. Its focus is on using digital services to support key Trust ambitions, such as the delivery of cancer treatment closer to home, automating currently manual, largely paper-based processes to improve efficiency and release capacity for staff to focus on operational and clinical duties, and to deploy new operational and clinical IT systems to further improve the quality of care being delivered to patients and donors.

Over the past 12 months, the primary focus of activity within the Velindre Cancer Centre has remained the Digital Health & Care Record – a programme to replace the existing 'CANISC' IT system with the national Welsh Patient Administration System (WPAS) and an enhanced version of the Welsh Clinical Portal (WCP) – both national (NHS Wales) systems managed and developed by Digital Health & Care Wales (DHCW). In aligning the IT systems used within VCC to the national IT portfolio, this will build on the gains made in recent years and support the further sharing of clinical information, across organisational boundaries in support of the delivery of effective cancer treatment for the patients of southeast Wales.

Activity within the Welsh Blood Service has largely been focussed on the delivery of a number of upgrades to its Blood Establishment Computer System (BECS) and Welsh Transplantation & Immunogenetics Laboratory (WTAIL) IT systems.

Whilst the DHCR programme and the broader challenges associated with the COVID-19 pandemic have been the focus of much of the digital agenda over the last 12 months, progress has been made in a number of areas, where new digital services have been enabled or upgraded in support of the quality, safety and performance agenda, such as:

- The enablement of the 'GovRoam' service, enabling clinicians to connect seamlessly to the local VCC IT services when working remotely at other NHS Wales hospitals across southeast Wales.

- Deployed the Welsh Nursing Care Record (WNCR) service in the Velindre Cancer Centre, to being the transition from the recording of nursing documentation on paper to a fully digitized solution, thus allowing for important nursing notes and information to be routinely shared with other organisations via the Welsh Clinical Portal (WCP).

- Deployed the Welsh Clinical Portal (WCP) within the Welsh Blood Service, to enabling clinical staff to access the medical / clinical history of donors when providing supplementary advice and clinical follow-up to Welsh blood donors. This helps ensure the advice being given takes a donor's full medical history into account, improving both the safety and quality of the clinical / medical advice they are able to offer.

- Continued to enhance the Blood Establishment Computer System (BECS), to ensure the Welsh Blood Service complied with changing regulatory requirements and deliver improvements to service delivery for Welsh donors.

- Deployed the new IT system into the Velindre Cancer Centre pharmacy, moving the VCC off is previous 'end of life' system onto the all-Wales platform, which is used by all other Health Boards in Wales.

- Continued use of the 'AttendAnywhere' virtual consultation service, to allow outpatient consultations to take place without the need for patients to attend on-site – a key aid in supporting the wider Trust response to the COVID-19 pandemic.

- Enhanced the IT systems used by the Welsh Transplantation & Immunogenetics Laboratory (WTAIL), based in the WBS, to enable more effective delivery of the services provided by the Welsh Bone Marrow Donor

Registry (WBMDR) and the work undertaken by the laboratory team who provide support for renal transplantation in Wales.

- Further enhanced our local cyber security systems and procedures, to help secure patient and donor data and protect critical Trust IT services.

Aligned to the aforementioned digital strategy, looking forward to 2022/23 the Trust is developing a digital transformation programme, to develop and deploy new digital capabilities that will enable transformative ways of delivering cancer and blood and transplant services to all stakeholders.

In support of our digital aspirations, we are working with the Centre for Digital Public Services (CDPS) and Digital Communities Wales (DCW), to develop our approach to improve patients', donors' and staff digital accessibility and acceptability and work towards addressing wider digital exclusion.

Lastly, the Digital Services team continue to play a key role in the new Velindre Cancer Centre (nVCC) programme, to ensure digital and 'SMART' capability is built into the design of the new hospital from the outset.

# PUTTING THINGS RIGHT

We are committed to managing, and learning from, concerns in accordance with The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.

During 2021/2022, we received a total of 191 concerns. This was comparable with the volume of concerns raised during 2020 – 2021.  44% of the concerns were raised to the Trust via email, 41% received verbally by telephone, 7% via letter, 6% verbally in person and 1% via social media.

The Trust has continued to achieve above 75% compliance of providing a response to the complainant within 30 days of receipt of their concern. The compliance breakdown per quarter is listed below and demonstrates a continuous compliance improvement over the year:

Q1 – 83% Q2 – 67%, Q3 – 75%, Q4 – 100%

Over 96% of the concerns raised were graded 1 and 2, and 59% were successfully resolved via the 'early resolution' process. The Trust has continued to have a low number of re-opened complaints of less than 2% for the year.

8 complaints have been referred to the Ombudsman during the year. 5 Ombudsman cases remain open and the current decision status for each case referred to the Ombudsman during 2021-22 are below:

- o 2 cases were upheld

- o 1 case was partially upheld

- o 3 cases were not upheld/rejected

The Trust await an Ombudsman decision for 2 cases. Following an evident increase in the number of Covid related concerns reported at Quarter 1 (3 concerns) through to Quarter 3 (5 concerns), there has since been a reduction in the number of concerns raised relating to the impact of Covid resulting in No Covid related concerns raised during the last quarter of 2021-22.

The main theme of the concerns raised throughout the year related to communication, attitude and behaviour. Communication regarding appointments, communication regarding treatment decisions, communication regarding the manner on which patients / donors had felt they had been spoken to / treated.

For the Cancer Centre, the main focus of the communication issues related to concerns around the lack of seamless / 'joined up' care between Health Boards. For the Welsh Blood Service, the communication concerns centred around the booking of appointments and regarding changes in clinic venues.

We remain committed to encouraging patient / carer feedback so that we can learn from this to improve our services. We are continuing to refine our complaints management processes so that we can resolve concerns fully and ensure that any actions required are taken promptly and that learning from complaints is fully embedded. Our concerns policy was approved at the March 2022, Executive Management Board and Quality, Safety and Performance Committee.

## Redress

During the reporting period, the Trust has investigated 5 Redress cases to determine if harm has resulted from breaches of duty in care, which would amount to a qualifying liability.

2 cases involved the instruction of a joint independent medical expert to seek an opinion on whether harm occurred following the breaches of duty identified. In both cases the independent expert did not identify harm, which would amount to a qualifying liability under the Putting Things Right Regulations, and these 2 cases were closed during the reporting period.

2 cases identified harm following further investigation, for which offers of financial compensation have been agreed by the Putting Things Right Panel. During the reporting period, one offer has been put forward to settle the case.

1 case remains under investigation.

The themes have mainly consisted of communication, mis-diagnosis, delay in treatment/referrals and wrong mode of treatment.

Where learning has been identified from these cases, these have been reported to the Welsh Risk Pool in accordance with the governance arrangements in place and learning has been implemented to prevent future occurrence.

We remain committed to encouraging patient / carer feedback so that we can learn from this to improve our services. We are continuing to refine our complaints management processes so that we can resolve concerns fully and ensure that any actions required are taken promptly and that learning from complaints is fully embedded. Our concerns policy was approved at the March 2022, Executive Management Board and Quality, Safety and Performance Committee.

## Claims

Throughout the reporting period, the Trust's role is to handle claims to achieve a fair resolution for all parties. Where claims are valid, the Trust looks to settle these or defend where there is sufficient merit to do so.

Of the 18 claims managed by the Trust during the reporting period;

- 4 new claims were received, comprising of three personal injury claims and one clinical negligence claim.

- 5 claims were withdrawn following denials of liability made by the Trust.

- 5 claims were settled, due to the risk of increased litigation costs and proceeding to trial. These were closed during the reporting period.
- The caseload of claims as at the end of the reporting period is 8. These comprise of 5 clinical negligence cases and 3 personal injury cases against VCC. The themes relate mainly to defective equipment, slip trip and falls, misdiagnosis, misreporting and treatment complications.

The number of new claims against the Trust continues to remain low, however, the clinical negligence claims that are brought against the Trust are often complex and can take a number of years to resolve. Clinicians and staff continue to provide support and witness commentary when required. This includes attending meetings with solicitors and medical experts. Reports on clinical negligence cases are shared with the appropriate Trust Committees and with other key Divisional Groups to highlight learning and improve services to prevent a recurrence.

Decisions taken to settle claims against the Trust are often made as a consequence of lack of evidence. The ability to defend claims relies heavily on the quality of the Trust's documentation, its records and the decisions taken, or not taken, at the time. Where learning is identified from these claims, the Trust continues to play its part in reducing the cost of claims through the actions it takes to improve the standard of care.

As part of learning assurance, the Trust is required to submit a Learning from Events Report (LfER) to the Welsh Risk Pool that demonstrates what lessons are learnt.

When a breach of duty has been identified, the Quality and Safety team will work with directorates and services to identify the learning and actions that are required to satisfy the Welsh Risk Pool criteria and the way in which learning can be implemented to reduce the risk of reoccurrence and future impact. These actions drive down cost in litigation and continues to promote and encourage a culture of learning that benefits both patient, service user and staff.

During the reporting period, 6 learning from Events Reports (1 relates to Redress) were submitted to the Welsh Risk Pool for approval. 4 received approvals during the reporting period. Two are awaiting outcomes from the Learning Advisory Panel.

Recent developments in technology has provided opportunities to adopt an enhanced analytical data that is a feature of the new RL Once for Wales Datix Claims Module. All claims have now been transferred across to the new RL Once for Wales Datix Claims Module from the previous Datix V14 claims model.

The Trust's estimated liability as at the end of the reporting period has seen a considerable reduction from the previously reported period, the figures of which are outlined below:-

- Estimated Claims Value: £957,966.97 (previously £9,519,299.87)
- Anticipated Trust Liability: £125,000.00

# DELIVERING IN PARTNERSHIP

The Trust works with a wide range of partners including health, local authorities, emergency services and the voluntary/charity sector.  Our primary health partners are set out below:

| Organisation | Relationship |
|---|---|
| Aneurin Bevan University Health Board | Commissioner |
| Betsi Cadwaladr University Health Board | Commissioner |
| Cardiff and Vale University Health Board | Commissioner |
| Cwm Taf Morgannwg University Health Board | Commissioner |
| Hywel Dda University Health Board | Commissioner |
| Powys University Health Board | Commissioner |
| Swansea Bay University Health Board | Commissioner |
| Welsh Ambulance Service NHS Trust | Provider |
| Public Health Wales NHS Trust | Provider |
| Health Education and Improvement Wales | Provider |
| NHS Wales Shared Services Partnership | Provider of services |
| Digital Healthcare Wales (DHCW) | Provider of services |
| Welsh Health Specialist Services Committee | Specialist Commissioner |

Effective planning and commissioning of services is fundamental to achieving the best outcomes for the people we serve across Wales and the cultural shift required to reduce health inequalities, improve population health and well-being and achieving excellence across Wales.

The Trust has worked in close partnership with our Local Health Board partners to ensure that our key strategies are aligned, that there are a clear set of shared priorities and to ensure that we can provide sufficient capacity and capability to deliver commissioned services of the highest quality

# Engagement with people who use our services to design them in partnership

Effective and ongoing engagement is vital in the development of our services and we strive to make it as easy as possible for patients and donors to share feedback following their care.

There are a number of ways used to listen, discuss and learn about our services.

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**Cancer Services - Non-surgical Tertiary Oncology**

Our service plans respond to feedback from patients and donors, their families and carers, Velindre staff, Health Boards, third sector and other partners. A range of engagement events and workshops have been undertaken with key stakeholders over the last 12 months.

Social Media continues to offer a productive two-way conversation tool with our online cancer community. This helps us to listen and respond to compliments, queries and concerns. Our Patient Advice and Liaison Service is able to respond in a timely and efficient manner, capturing mini-stories and signposting to wider online surveys.

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**Blood and Transplant Services**

The Blood Service also has daily interactions with members of its community of donors. We are committed to listening to our donors and we do this by circulating a comprehensive survey to every donor that enters a donation session each month.

The service operates a dedicated donor contact centre which exists to inform, educate and assist donors in contributing to the health of the nation by donating their blood, platelets or bone marrow. The service also engages existing and prospective donors through its donor engagement team. This team uses social media, the press, the website and face-to-face interactions to promote blood, platelet and bone marrow donations in Wales.

The engagement department is present in the communities of Wales, building close links and partnerships with community groups, sports teams, businesses, education providers and other socially engaged groups that have an influence in their localities. The engagement team is also committed to having a presence at the high profile national events that occur each year across Wales, such as the National Eisteddfod.

# WORKFORCE AND WELLBEING

**Our overall workforce aims for our people, articulated in our People Strategy, are:**

- To develop a Skilled and Developed Workforce, given clear career pathways, provide them with leadership, skills and knowledge they need to deliver the care our patients and donors need now and in the future.
- To support a Healthy and Engaged Workforce where wellbeing is key, recognizing and valuing their diversity in a bi-lingual culture.
- To have a Planned and Sustained Workforce having the right people with the right values, behaviors, knowledge, skills and confidence to deliver evidence based care and support patient and donor wellbeing.

2021/22 has been a challenging year and one where we have had to deal with ongoing restrictions and challenges caused by the pandemic. Throughout the year the focus has been on supporting the health and wellbeing of our staff who have worked hard to continually provide excellence in the care for our patients and donors.

From the beginning of the pandemic the Trust established a COVID Workforce Operating Framework to manage workforce issues. This framework has been adapted throughout the pandemic to ensure a flexible and agile approach to meet the service need ensuring safe staffing levels.

**Supporting Staff Wellbeing**

2021 has seen the establishment of the Trust's Health and Wellbeing Steering Group and Agile Working Group. The main aim of these groups are to ensure effective provision of the right health and wellbeing interventions across the Trust to deliver timely and effective support to staff whether they are working on Trust sites or working from home. These groups work together in partnership with our Trade Union colleagues and Clinical Advisory groups including a multi-disciplinary membership of Nursing, Allied Health Care professionals and Medical colleagues.

**Wellbeing Developments include:**
- From the start of the pandemic, the Trust developed a daily communications newsletter to all staff from the Executive Management Board, containing latest guidance, key information and wellbeing updates and links.
- The Trust has utilised a universal text messaging service to ensure staff who are unable to access emails on a regular basis, receive important COVID updates and links to wellbeing information.
- The Executive Management Team have established online Q&A sessions to address concerns of staff.
- Staff networks continue, providing a safe space for staff from minority groups to discuss the impact of the pandemic, raise concerns and provide feedback. Networks include LGBT+ Network, BAME Network, Disability Network,

Menopause Café, and a Shielding Network to support staff who are, or have been, shielding.

- Ongoing engagement session have tale place with staff to gain feedback on wellbeing provision ensuring a 'you said, we did' approach
- The Trust's Health and Wellbeing Resources internet area is available for all staff that can be accessed remotely, enabling wider access to self-help resources and toolkits, and additional support.
- The trust has created a physical wellbeing facility, covering the Bobarth Centre, to provide a wellbeing area for staff to access wellbeing support
- Drop in sessions for managers to support and advice effective wellbeing management.
- Thank you card for staff including links to wellbeing services.
- Letter to staff including wellbeing leaflet and signposting information
- Ongoing provision of an Employee Assistance Programme (EAP)– 24/7 support for staff and their families
- Manager Assist – advice for managers available 24/7 via the EAP
- Neyber Financial Wellbeing programme supporting staff with financial hardship
- On-line Aware Mindfulness Stress Reduction Course  - via EAP
- Mediation provision via our EAP
- VCC Mindfulness App has been developed and is available to all staff
- Complimentary Therapy provision accessible for all staff

# WELLBEING OF FUTURE GENERATIONS ACT / CREATING A SUSTAINABLE ORGANISATION

**Our Approach to the Well-Being of Future Generations Act**:

We have a commitment to transform the Trust and to create a sustainable organisation.  We will commence the acceleration of our journey of transformation with the publication of the Trust Strategy together with those for specialist Cancer and Blood and Transplantation Services for 2022 - 2032.  These will set out what good look like in five years' time and the actions we will take over the coming years to achieve the excellence we are committed to.

These strategies have been developed within the context of the Well-Being of Future Generations Act (*the Act*) and we will seek to implement the principles of the Act within the Trust to ensure that they become the central organising principle of each and every action that our staff take on a daily basis.  This will take time but we are committed to ensuring we translate the intentions and spirit of the Act into tangible and sustainable benefits for the people of our region.

The Act requires public-sector organisations in Wales to focus on delivering long-term well-being goals in a sustainable manner. Whilst we have made progress in embedding the *Act* across the organisation we know that we have much more to do. The pioneering Act and the 2016 Environment (Wales) Act 2016 provides Wales with an exciting opportunity to lead the way internationally and outlines our sustainability aims and enables real action to create positive and significant change.

Therefore, we are really excited to be able to set out our journey to sustainability and the benefits it will realise over the coming years. As an anchor organisation in Wales, we are committed to embedding sustainability within our own organisation and become an exemplar for others to come and learn with, and from. We are committed to placing sustainability at the heart of everything we do and to maximise the benefits we can provide for people across Wales.

This Sustainability Strategy will create a roadmap for us to contribute to our communities and mitigate our impact on the planet whilst continuing to deliver world class services for our donors, patients and carers. This will only be possible if we enhance our existing infrastructure, and educate and empower our workforce. Every individual and team should have the ability to act sustainably and have the knowledge and confidence to make environmentally conscious decisions.

This will require an increased focus on sustainability and well-being over the next three years as we attempt to embed the Sustainable Development (SD) principle still further to make it a 'normal' part of everything that we do. The journey we are on will see us implement a new approach to planning and delivery across the Trust and the development of a different organisation that is more involved across the breadth of health, social care and public services. This collaborative way of working will see us working across the region with a range of partners to ensure the five ways of working are embedded within everything we collectively do and that we are actively contributing to the seven well-being goals.

Leadership will be fundamental to effective change. Our Chair is committed to leading the Trust to function as an exemplar Public Sector body in relation to the five ways of working and the embedding of the sustainability principle in all we do as an organisation. We have worked with our Health Board partners to facilitate the establishment of the South East Wales Collaborative Cancer Leadership Group (and this regional collaborative work also embraces the Act as a central principle).

During the next five years we recognise that there are opportunities for us to do more to advance our and the wider community's, well-being and sustainable development agenda. Within our major capital schemes in the new Velindre Cancer Centre and Talbot Green Infrastructure Upgrade Project, are developing ambitious and inclusive community benefits. We will seek to evolve existing partnerships to a much greater extent, and also to develop new relationships within the health sector and beyond in order to maximise our contribution and to support others in doing the same.

**Our Well-Being Objectives**:
The Trust, recognised under the Act as a national body, was required to develop and publish a set of its own well-being objectives.



These objectives were developed following extensive engagement and were designed to focus the Trust's contribution to the realisation of the national well-being goals.

**Delivery Arrangements**:

Our approach is built upon the personal support and leadership from the Chair and our Board. At Executive level, the Director of Transformation, Strategy and Digital holds the responsibility for sustainability within their portfolio and discharges this through a range of Offices which are co-ordinated and led by the Director of Commercial and Strategic Partnerships. The Trust has established a Sustainability Community Group to facilitate and support work across the Trust and the Sustainability Manager plays a key role in this process.

However, it is important to emphasise that our approach is to expect all of our workforce, suppliers and service providers to contribute to the well-being goals and to embody the five ways of working in their day-to-day actions and behaviours. The Act is viewed as adopting a '*way of being*' rather than simply demonstrating compliance to standards. In this regard, at its heart, it is viewed as whole system organisational development and emphasis is being placed on induction, education and training, relationship management, communication and workforce health and well-being.

The workforce, and the processes they utilise to function, will be supported and enhanced respectively so that they: clearly reflect what 'long-term' means, identify the root causes of problems through system wide perspectives, support work across organisational boundaries to maximise value, establish shared processes and ways of working. Importantly, our actions will be framed and facilitated by our strategic approach.

**Progress against Delivery**:

There are a number of actions that we are progressing:

| **Doing things differently to deliver change:** |
| --- |
| • The Trust is considering the Sustainability Development (SD) principle when developing its main strategic programmes, in new Velindre Cancer Centre and the Talbot Green Infrastructure Upgrade Project<br>• The Trust is considering how it can evolve existing partnerships to a greater extent, and develop new relationships within the health sector and beyond, to maximise its contribution to A Healthier Wales and to support others in doing the same. |
| **Developing core arrangements and processes:** |
| • The Trust has developed an ambitious Sustainability Strategy and plans to use it to embed the Sustainable Development principle and utilises the Well-being Goals at its core.<br>• Responsibility for delivering the Act and embedding the Sustainable Development principle sits within the Strategic Transformation, Planning and Digital Division. The Trust is developing current capacity within the team to deliver the requirements of the Act.<br>• The Trust is considering the merging or better alignment of its well-being objectives and strategic goals, ensuring we meaningfully contribute to our set objectives. |

> - The Trust will be developing a strategic planning framework, with the aim of ensuring that the Act genuinely underpins all service development work and the Trust's Integrated Medium Term Plan. All planning activity throughout the Trust will utilise this framework in order to ensure that the Sustainable Development Principle is fully embedded across the organisation. The Trust intends for all investment proposals to demonstrate how they align to the Act.
> - The Trust is currently undertaking work to create a more systematic approach to tracking and monitoring progress.
>
> **Involving citizens and stakeholders:**
> - The Trust is actively identifying ways to improve how it engages with citizens, stakeholders, patients and donors when developing its services.
> - The Trust is exploring possibilities for collaborating with other health bodies to develop a wider regional '*whole system*' Cancer Community and a public health promotion agenda.

Whilst recognising we have much more to do, it is important to acknowledge the achievements of the organisation to date and the strengths it can draw on as we grow together as a sustainable community.

The Welsh Blood Service is currently developing ambitious Business Case to reduce the carbon footprint of the Talbot Green site. A key and ambitious objective of this Programme is to transition to a carbon neutral footprint for the building. This will be achieved through an increased focus on the use of renewable technologies, solar photovoltaic arrays, ground source and air source heat pumps and bio- mass boilers.

We have also focused considerable efforts on ensuring that the TCS Programme has embedded the requirements of the Act. The new Velindre Cancer Centre project is championing sustainable developments, such as integrating sustainable transport into the design of the new VCC, and encouraging the use of sustainable travel. We have identified several proposals for community benefits in the design of the new VCC. In this regard, a number of fundamental deliverables can be evidenced. The project aims to the

We have applied, and continue to apply, the Sustainable Development Principle when designing and developing the TCS Programme clinical service model and supporting infrastructure. The new TCS Programme clinical service model has a clear preventative focus and there are opportunities to educate patients and the wider community on healthier lifestyles to help prevent cancer. The TCS Programme clinical service model and supporting infrastructure also has a strong long-term focus based on a sophisticated understanding of current and future needs.

We have worked in an integrated way to design and develop the TCS Programme and supporting infrastructure and have considered how it can deliver wider benefits as the programme progresses to ensure it has a positive impact on social, economic, environmental and cultural well-being. We are also collaborating with partner organisations across South East Wales to develop and improve cancer services.

In addition, we have a range of strategic and operational examples of good practice in implementing the Act. A number of these are shared below.

## TRUST STRATEGY DEVELOPMENT

The Director of Transformation, Planning and Digital is leading on the development of the Trust Strategy. A comprehensive engagement plan has been created which includes presenting to Patient Liaison Group to ensure members of the community are involved in the strategy development.

## SUSTAINABLE TRAVEL PLAN

The Trust Staff Travel Plan for the 2022-2027 period was launched. The aim of the plan is to inform, and enact change in the everyday lives of staff, in and outside of the workplace, causing a shared behavioural change. The plan was written in response to the Staff Travel Survey, incorporating staff feedback into initiatives to encourage the use of sustainable travel methods, including cycling, walking, using public transport and car-sharing.

## BIODIVERSITY ENHANCEMENTS



As part of our obligations to enhance biodiversity under Section 6 of the Environment Wales Act, the Trust has created an action plan to increase local flora and fauna. This has included 'No Mow May' and 'Let it Bloom June'. To promote the enhancements, a competition with a local schools was undertaken to design 'Nature Notices' which display facts of the benefits of enhancing biodiversity. The CEO & Chair & IM Sustainability Champion picked the final design.

## ISO14001:2015 - REACCREDITATION

Welsh Government sets a requirement for all NHS bodies to be credited by the ISO14001:2015 standard, an environmental management system. We have successfully obtained the ISO 14001:2015 standard for the last five years for all sites. Following the assessment in November 2021, the Trust successfully obtained recertification, with no non-conformities raised.

## GREEN SOCIAL PRESCRIBING

The Trust has collaborated with the charity Ray of Light, to deliver a safe and non-judgemental support group for patients, carers and families affected by a cancer

diagnosis, based at Velindre Cancer Centre. Ray of Light centre their sessions around the well-being benefits of nature, with many activities to choose from, including painting, whittling, forest bathing and many more.

## NEXT BIKE

To encourage active travel, a Next Bike station was reinstalled in the Cancer Centre. Integrating the station into everyday service will contribute to the Travel Plan; encourage active travel, which aligns with the Welsh Government targets of active travel. The Trust aims to join the Healthy Travel Charter, having the bike sharing scheme will contribute to achieving one of the fourteen actions.

## DECARBONISATION GRANTS

The Trust was successful in obtaining bids in Welsh Governments Decarbonisation Grant funds. The Trust has successfully obtained funding for the following Velindre Cancer Centre Building Management System Upgrade and Trust Headquarters LED (light emitting diode) Lighting Upgrade. Alongside the LED lighting upgrade, motion sensors have been installed to reduce consumption and it does not rely on staff remembering to turn off the light. At VCC, the specification for the Building Management System optimisation has been installed to provide increased management of our consumption.

## LITTER PICKS

Within the fortnight celebration by Keep Wales Tidy 'Spring Clean Cymru' [28th May – 15th June] litter picks were held across the Trust with positive engagement with staff with volunteers for the litter pick. Since the success of the campaign, litter picks are held across the Trust.

## CANTEEN

To prevent the production of unnecessary waste, single use plastic cups have been removed from the Parkside dining room at VCC. Beverages are now served in ceramic mugs and staff are encouraged to use re-useable Eco to Go cups made from natural materials and supplied in collaboration with Keep Wales Tidy. The launch in VCC was so successful it has been rolled out to all divisions and hosted organisations. Furthermore, the canteen has introduced Vegeware for all takeaway containers to reduce single use plastic.

# WELSH LANGUAGE REGULATIONS AND COMPLIANCE

**Introduction**

This report will focus on the value the Trust gives to enhancing bilingual provision. It will demonstrate a commitment to the Welsh language standards but also highlight the work we are currently doing on our Welsh language Cultural plan, which is our platform for celebrating and recognising the cultural importance of Wales.

We continue to to provide support for the needs of our bilingual patients and donors. We are keen to ensure the services we provide are even more visible than previously especially at a time where the pandemic has made it difficult to communicate face to face.

We continue to strenthen the Governance around this area and recognise the importance of the Welsh language Standards but are also eager to do more than is required of us. We have began a Trust wide converstation this year on the meaning of Culture and have recognised that our values need to emulate what it means for our staff to provide a bilingual service under continued pressures that the pandemic has brought to us.

We value the work of our staff and at a time of continued change we seek to support them with all that they need to belong to an organisation with true values of Welsh language and Culture. The ethos of our new Cultural plan was accepted by the Executive Board and moving forward we will embace its aims and objectives and seek to further integrate our support for staff, patients and donors who need or chose to use the Welsh language.

**Celebrating Welsh culture**

The Trust continues to actively seek ways in which to engage its staff in the culture of Wales as well as its languages. We recognise the need to comply with its legal obligations but we aim to do more than is needed as this celebrates the diversity of our staff and services.

This reporting year we have drafted a Cultural Plan that aims to strengthen our engagement with staff around the language and Culture of Wales and promote a value of inclusion that encompasses all that we believe. The Executive management board have taken on roles of responsibility for certain aspects of the Equality and Diverstity agenda and this includes an Ambasador role responsible for the Welsh language.

The Trusts draft Cultural plan aims to be as inclusive as possible and the Welsh language Ambasador will drive the ethos of this plan throughout the work of the Executive Board.

**Strengthening the Governance**

**Welsh language Standards Compliance**

As of November 2021 our Trust compliane of the Welsh language Standards stands at over 50%. This evidence is collected through our internal divisional working groups and reported to our Trust wide Welsh language development group. It is our way of ensuring we can build on the regulated compliance year on year and put projects in place to ensure we focus our provision productively.

**Patient and donor correspondence**

We previosuly reported on a systematic approach to ensuring out patient correspondence was bilingual. Since last year this has been put on hold in a number of areas as the old system generating the letters has been put on hold. All development initiatives were ceased due to the pandemic and the roll out of the new new patient system has also been slower than anticipated.

As a Trust we are determined to ensure our bilingual correspondence is accessible and although at the Welsh Blood Service this is a process historically followed we have some way to go to ensure Velindre Cancer Centre are in line with our ambitions.

One of our departments are leading the way in this. Radiotherapy have translated and are using biligual letters as standard and they have also ensured that reception is supported by Welsh speaking triage staff as the number of Welsh speaking reception staff continues to be low. This is a positive way to ensure a department is supported when needed by other members of staff which is the ethos that underpins the 'more than just words' framework.

Monitoring telephone calls to and from the Trust is extremely challenging. At the Welsh Blood Service this is more achievable. In this reporting year, calls to the Donor Collection team was 1004. This is 2% of the overall calls into the donor contact centre.

Our Welsh language Working group at Velindre Cancer Centre will take the monitoring of this on board as a matter of urgency this reporting year.

**Meetings**

In light of the continued change to working arrangements under the pandemic it has been necessary to think of ways in which we can internally support bilingual staff at meetings if they wish to use the Welsh language.

For external meetings we continue to be mindful of the ongoing work underway by Welsh Government with Microsoft and look forward to hearing how this progresses over the coming months. Internally we are piloting a method of language identification within Teams (at the Welsh Blood Service) and will monitor the take up of this. The

process will then be diseminated Trust wide as an option for language identification at internal meetings.

**Recruiting Welsh speakers**

As we stated in last's years report our aim in this reporting year was to finalise our recruitment and language assessment process. We have completed this and are now ensuring that ALL posts going out for recruitment complete a language assessment table that is discussed with the Welsh language manager should questions arise. It has taken some time to integrate this process but we are confident that this will change the way in which we assess the need for language skills, not only as part of the individual post but for the wider teams across the Trust.

The process is in its infancy but will over time give us the data we need to evaluate its success.

As you will see from the figures below the pandemic has placed clinical priorities over language needs and we will be monitoring the increase in the number of 'essential' roles once the recruitment process has embedded.

Moving forward we will also be looking at the translation of our adverts and supporting materials. This will begin in 2022.

| Velindre University NHS Trust 2021-2022 | |
|---|---|

| Total number of vacancies advertised as: | |
|---|---|
| Welsh language skills are essential | 1 |
| Welsh language skills are desirable | 98 |
| Welsh language skills need to be learnt when appointed to the post | 0 |
| Welsh language skills are not necessary | 6 |

| Total Number of vacancies advertised 01/04/2021 to 31/03/2022 | 105 |
|---|---|

| Welsh Blood Service 2021-2022 | |
|---|---|

| Total number of vacancies advertised as: | |
|---|---|
| Welsh language skills are essential | 0 |
| Welsh language skills are desirable | 97 |
| Welsh language skills need to be learnt when appointed to the post | 0 |
| Welsh language skills are not necessary | 1 |

| Total Number of vacancies advertised 01/04/2021 to 31/03/2022 | 98 |
|---|---|

| Velindre Cancer Centre 2021-2022 | |
| --- | --- |

| Total number of vacancies advertised as: | |
| --- | --- |
| Welsh language skills are essential | 0 |
| Welsh language skills are desirable | 269 |
| Welsh language skills need to be learnt when appointed to the post | 0 |
| Welsh language skills are not necessary | 23 |

| Total Number of vacancies advertised 01/04/2021 to 31/03/2022 | 292 |
| --- | --- |

## Communication

### Translation

The Trust has committed additional financial support to translation and we now have two dedicated translators to support our work. We also have a translation agreement with one of our hosted organiations for additional support when needed.

This has meant that we can focus our translation priorities more and has enabled us to begin to translate important documentation such as Job descriptions and build a bank of dedicated bilingual descriptions for future use.

Translation figures continue to demonstrate the commitment given by the Trust to provide bilingual internal and external information and services. This reporting year we have progressed with the purchase of a memory software and are in the process of using this to ensure consistency with translaton and as a time saving of resource. Liaising with our translation colleagues across the NHS we can move this forward again this year and share a productice reasource with other translation teams.

### Websites

Work continues on the Trust Website and the Welsh Blood Service have updated their site in line with priorities and bilingual requirements. This year they have also developed a dedicated Welsh langauge page mirroring that of the Trust's but specific to local requirements. The Promotion of this was extremely successful on St David's day as was the celebration of its dedicated Welsh language working group.

1.12% (3,390) of the Welsh Blood Service website booking portal users (April 2021 to March 2022) have their browsers set in Welsh.

Overall, the Trust main website has received 3,200 Welsh language hits in the reporting year.

**Welsh language Education**

This year we have been actively promoting providing Welsh language training in the workplace. In addition to regularly advertising the opportunities provided by 'Iaith Gwaith' we have been supported by Cardiff University to run two courses for our staff.

Providing in house training is not as simple as ensuring financial support it is crucial that staff are able to attend classes and are supported to do so. Unfortunately within a clinical setting this is not as successful as we would like, however, we are proud to announce that eight of our staff have successfully completed their first year and will be further supported by us to proceed to the next level of training.

Providing continued training and support to a small number of staff is more productive for the them and the needs of the services we provide. Our focus in the coming year is to further promote e-learning opportunities and a stronger in house support for those who wish to pracice and become more confident in the work place.

We are pleased to note that the new Welsh language awareness package supported by the Welsh Government is now completed. The Trust has been eager to recieve this and will now be integrating this as part of its regular training Trust wide initiatives.

**Welsh language Skills**

We have increased our data entry compliance this year and are now showing an 84.5% compliance within ESR.

Collecting the language data is extremely important, however we are aware that even though our recruitment processess use this information to ensure future recruitment needs, we now need to use this data to enable us to strengthen our services further.

Workforce planning and our People Strategy are central to this, being drafted with

*'A Healthy and Engaged workforce, within a culture of true inclusivty, fairness and equality acoss the workforce. A workforce that is reflective of the Welsh population's diversity, Welsh language and Cultural identity'*

The Trust is demonstrating its commitment to ensuring the bilingual needs of its staff and services are central to planning at all levels and will continue this year to integrate these aims across the Trust.

|  | Assignment Count | Required | Achieved | Compliance % |
|---|---|---|---|---|
|  | 1587 | 4761 | 4027 | 84.58% |
| Org L4 | Assignment Count | Required | Achieved | Compliance % |
| 120 Corporate Division | 172 | 516 | 442 | 85.66% |
| 120 Research, Development and Innovation Division | 51 | 153 | 137 | 89.54% |
| 120 Transforming Cancer Services Division | 25 | 75 | 54 | 72.00% |
| 120 Velindre Cancer Centre | 860 | 2580 | 2193 | 85.00% |
| 120 Welsh Blood Service | 479 | 1437 | 1201 | 83.58% |

**Promotion**

Our Trust wide promotion continues with celebrations such as 'Diwrnod Shwmae / Sumae' and St David's day. This year we had an excellent colourfull day at the Cancer Centre with a themed menu at the restaurant and a drop in opportunity for staff.



At the Welsh Blood service the launch of a dedicated Intranet page to assist staff was the main theme and an opportunity once again for staff to hear about the work of the Welsh language working group. It was also a great opportunity to congratulate the Welsh language learners who have completed the first year of their courses.



They will progress this coming year to a second level giving them opportunity to further develop their Welsh language skills.

**Concerns and Complaints**

**The Welsh Blood Service**

Three donor complaints were recieved by the Welsh Blood Service this reporting year.

The first two were relating to text messaging errors and the standard of Welsh sent and the other relating to a website error. Unfortunately an old message had been used and not a professionally translated message but this was rectified.

All three complaints were investigated thoroughly and as a consequence changes have been made to the service and checking processes.

None of the complaints resulted in a formal investigation being undertaken by the Welsh language Commissioner.

**Velindre Cancer Centre**

**Patient Experience**

During this reporting period, we have introduced a new digital feedback system at Velindre Cancer Centre. CIVICA Experience is a cloud-based insights platform which supports multi-channel survey data collection, real-time reporting, smart text analytics, workflow tools, event-driven alerts and push reporting. It was procured in 2021 as part of a Once for Wales exercise to support improvement across NHS Wales.

Capturing feedback from patients and their families in line with the National Framework for Assuring Service User Experience can now be conducted digitally and in real-time, enabling us to capture more data in a timely and responsive system. The CIVICA Experience implementation has seen an increase in survey responses and in particular Question 3 which references the Welsh language.
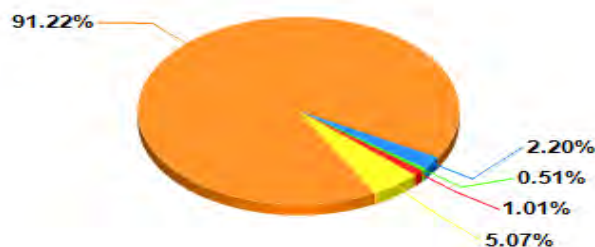


A total of 592 people answered the question "*Were you able to speak Welsh to staff if you needed to?*" with 5% of respondents saying "Never". This equates to 30 patients who feel they were never able to use Welsh in Velindre. This powerful data is now informing our local improvement plans and will be used to continually monitor the impact and progress of service developments.

**Hosted organisations**

The Trust continues to host Health Technology Wales (HTW) and the Shared Services Partnership (NWSSP). Both organisations are committed to ensuring the Welsh language standards are a high priority.

HTW have been actively translating Job descriptions in line with the requirements of the Welsh language standards.

NWSSP have ensured that staff across the NHS can now access the opening page of the Electronis Staff record system in Welsh and in English. This is a really positive step forward as the system has been monolingual since its inception. Being able to access personal employee information in the language of choice demonstrates a commitment to the language needs of the NHS employees and NWSSP have provided this.

Other areas of development have included:

- **Translation Support Services**
  The Welsh Language Unit, in NHS Wales Shared Services Partnership have provided translation services for the following NHS organisations during 2021/22:
  - NHS Wales Shared Services Partnership's divisions and hosted programmes
  - Public Health Wales NHS Trust
  - Digital Health and Care Wales
  - Velindre University NHS Trust
  - Health Education Improvement Wales
  - Wales Ambulance Service Trust in the translation of the 111 Website
  - Welsh Health Specialised Services Committee
  - The All Wales Value in Health Care programme
  - Supported NHS Employers in the translation of Job Descriptions and Person Specifications

  Totalling over 3.7 million words translated during 2021/22.

- **Translation Bank**
  The NHS is facing unprecedented demand for translation services, this is in response to meeting the requirements of the Welsh language standards in the most part, but also to respond to the need/demand amongst patients and the public.
  It is becoming increasingly difficult to recruit qualified and experienced translators to full-time permanent vacancies, and it is also becoming challenging to retain staff, due to the recruitment market being extremely competitive.
  To be able to respond to this situation we've established a bank of translators who can work flexibly for us as we require their services. The bank was established in autumn 2021, and our existing arrangements are working well to

date. Our approach to agile working also means that we can recruit translators from different parts of Wales and beyond to assist us with our ability to respond to the demand for translation services.

- **Student Streamlining**
  NHS Wales Shared Services have improved the customer journey through Student Streamlining Service by ensuring the system provides a Welsh language journey throughout the process.
  We audited and reviewed our processes, automated services and templates to ensure that there is now a seamless Welsh language offer to students engaging with our service.
  As part of this project, we also translated adverts and job descriptions to enable Health Boards to be able to advertise the opportunities through the Student Streamlining programme through both the medium of Welsh and English.

- **All Wales Patient Information Leaflets**
  We undertook a comprehensive audit and review of over 350 Patient Information Leaflets during 2021/22. The leaflets are given to patients as part of the consent process. The audit and review enabled us to make improvements to the language used in the leaflets, to have consistency in terminology as well as making the leaflets wholly bilingual for patients in Wales. Previously Welsh and English versions were available separately. This work will continue in 2022/23 with work being undertaken in partnership with Eido Healthcare to translate easy read versions of the leaflets.

- **ESR Portlets available in Welsh**
  The Welsh Language Unit and the Workforce Information Systems team worked collaboratively with the NHS Business Services Authority and IBM on the development of Welsh Language Portlets on ESR in the autumn of 2021. This now means that the portals on ESR are available to NHS Staff in both Welsh and English to satisfy the requirements of Standard 81 of the Operational Standards.

- **Contact Centre Review Project**
  The purpose of this review project was to audit our existing centre services, establish how our customers currently engage with us, identify improvements, and to increase and improve the self-serve element of the services we provide. As part of this work, the Welsh language provision of services was also scrutinised, and a survey circulated to NHS staff identified that between 10% and 20% of NHS staff wished to engage with us through the medium of Welsh. Further work will be undertaken with contact centres throughout NWSSP over the coming years.

- **TRAC Recruitment system updates**
  We have continued to work with the developers of the TRAC system to ensure that the interface for the system continues to be up-to-date and consistent in both Welsh and English.

**Moving forward**

Over the coming year the Trust will revisit its Values and consult practively with its staff. Culture is central to these values and as we know a positive culture drives better care. We will be considering how we can further integrate our Welsh language and our divisional groups will take forward specific aims and objectives in order to strenghten provision locally.

Nationally we will continue to work with our partners, Local Health Boards and Welsh Government. The language and Culture of Wales belongs to us all and as a Trust we strive to provide the best bilingual care that we can.

# CONCLUSION AND FORWARD LOOK

We have produced our Integrated Medium Term Plan for 2022 – 2025 (insert link) which sets out how we will deliver services from 1st April 2022 to 31st March 2025. It describes what services we will provide, where they will be provided from and how we will continue to ensure patient, donor and staff safety. It also outlines the arrangements we have in place for managing our capacity so that we can meet the expected increase in demand for our services.

The next three years will undoubtedly provide both challenge and opportunity in equal measure. Our intention is to see the challenges as opportunities to support us in taking the learning from the pandemic to place quality, safety and experience at the heart of everything we do. We are committed to working with patients, donors and our health and public service partners to understand, design and deliver services which are truly person focused and deliver the experience and outcomes that people value most.

Whilst this plan sets out our initial view of the 2022 – 2025 period, its primary focus is on the 2022 -2023 period given the level of uncertainty across the globe regarding COVID-19 and its impact. Our focus during this period will be on:

**Delivering the fundamental cornerstones of healthcare provision**
These include:
- Implementing the requirements of the Health and Social Care (Quality and Engagement) (Wales) Act 2021, the National Quality and Safety Framework

and the National Clinical Framework to provide services of the highest possible quality

- Delivering services that meet the national clinical quality and safety standards and provide an excellent experience
- Treating patients as quickly as possible
- Providing blood and blood products to our partner Health Boards to support the provision of treatment and care to people across Wales
- Delivering services which are '*COVID safe*' and reducing / eliminating (as far as is possible) the 5 harms from COVID. This will see us:
  - o Focusing on infection prevention control standards
  - o Responding quickly and robustly to Public Health Wales/Welsh Government guidelines and translating it into safe operational service delivery
  - o Continuing to manage the challenges presented by nosocomial transmission
- Developing agile and flexible capacity plans which allow us to respond quickly to the challenges presented by COVID-19 and its related impacts
- Supporting the health and well-being of our staff who have been working in extremely challenging circumstances for the past two years
- Workforce redesign – optimising multi-professional patient / donor cantered care predicated on co-production and top of licence working

We also have a number of important strategic areas of work. These include:

**Improving population Outcomes and reducing inequalities**
The Trust will work with our Local Health Board and wider partners to identify opportunities where we can support the improvement of public health and population outcomes through primary and primary and secondary prevention. This will focus on a number of areas:

- Improving access to our services to increase uptake and reduce inequalities and ill-health
- Strengthening our decision-making (systems/processes/culture) regarding the Equality Impact Assessment and Socio-Economic Duty to consciously address poor outcomes and inequalities in the communities we serve
- Working with our health partners where it is clear and compelling that we can add value and make a difference
- Developing a range of strategies and plans that enable us to help our staff to improve their health and well-being
- Secondary prevention: making the most of the opportunities of '*every contact counts'* with patients, donors, partners to support them in improving their health and well-being.

ANNEX 7 – PERFORMANCE REPORT OVERVIEW

## 1.      Introduction to include:

*A Statement from the Chief Executive explaining how the organisation has continues respond to the Covid-19 pandemic and the impact this has had on the delivery of services in 2021-22.  This includes describing how the pandemic has affected the quality of health services provided to the public. Reference should also be made to the need for the organisation to account to its public and other stakeholders on the quality of its services. Beyond that, NHS bodies will need to consider how to manage services as we come out of the pandemic, ensuring that quality is never sacrificed and ensuring we learn from the innovative practice and outstanding clinical leadership that we have seen.*

*The statement should provide their perspective on the performance of the organisation over the period. This needs to make clear the position around the paused IMTP process, the extant status of the organisation's IMTP that has been communicated, as well as state how they have performed against the Annual Planning Framework 2021-22 and Delivery Framework 2021-22 outlined in the Parameter letters sent to Chief Executives in September and October 2021. This statement should also include its financial duties under their agreed status in regards to it being an agreed signed plan.*

*In the NHS Wales Planning Framework 2021-22, the Minister for Health and Social Services stated that the "four harms have become our strategic framework and the need to balance the work we do to reduce the harm is critical". Therefore the report should indicate in detail how organisations have performed against the following:*

Harm from COVID itself

Harms from an overwhelmed NHS and social care system

Harm from a reduction in non COVID activity

Harm from wider societal actions/ lockdown

## 2. Areas of Responsibility

•      Information regarding population and scope of responsibility

•      Geographical area

•      Any responsibilities or issues unique to organisation

## 3.      Impact of Covid on delivery of services

*[The key issues and risks that could affect the entity in delivering its objectives - This should be a summary of risk and challenges you identified in your plans and the mitigation you agreed to manage it. You also need to recognise where you are not planning to deliver against national targets the reasons why and what you are doing to improve on this. Detailed analysis of significant organisational risk and mitigation is part of the Governance Statement; this section should not duplicate but concentrate on risks associated with delivery and performance against agreed targets.*

Note: Sections 4 – 9 can be set out in line with the individual themes below. Headings are provided with the aim of ensuring a consistent national approach as far as possible, whilst at the same time providing the opportunity to reflect local priorities. When providing specific examples, it is suggested these are chosen to reflect the local context. **Not all of the areas set out below will be relevant to each organisation, so organisations should draft their response in the spirit of this guidance and adapt their content to suit the services or programmes which they provide.**

Each theme should provide examples of achievements and improvements as well as challenges, including actions in response to any quality triggers or external reviews which may have taken place during the year.  It should show how the organisation has listened to, learnt from and is working with all its partners including social care and the third sector.

**4.      Planning and delivery of safe, effective and quality services for Covid care:**

**Redesigning primary care services to deliver emergency care during acute phase of Covid-** *(evidence of compliance with national clinical guidance).- (primary care remains a ministerial priority – development of new ways of working to deliver both Covid and non-Covid support- examples of joint working with secondary care - movement of therapy services - where relevant provide data for context number of patients reviewed, compared to same period?*

- GP practices
- Pharmacy
- Dentistry
- Optometry
- Community care (District nursing health Visitors)
- Therapy services

**Design and implementation of testing and immunisation for Covid**

- Where relevant provide some context through local data around how many people have been tested- across the HB /LA areas
- Flu vax data - staff and community- provide figures compared to same period if possible?
- Progress against Covid-19 vaccination programme

**Redesign of acute services to provide Covid care:** *(evidence of compliance with national clinical guidance, support narrative with local data to demonstrate delivery of services)*

- Critical care beds - core and additional
- Field hospitals - initial plans then developed plans - change of function second wave
- Emergency care – developments of new measures - new access policy - changes to waiting - use of 111 - WAST developments joint working
- Training and deployment of staff

**5. Planning and delivery of safe, effective and quality services for Non-Covid care:** *(include context of health inequalities how have you managed to do this during Covid)*

**Delivery of infection control measures to deliver both Covid and non-Covid care**

- Management of safe PPE - training and supplies
- Redesign of local estate to deliver safe services during covid (outpatients, theatres, diagnostics)
- Local communication with the community to support them making the right choices
- Summaries the implications from this additional requirement.

**Delivery of essential services (evidence of compliance with national clinical guidance): ensure you acknowledge the ministerial priority of timely access and how it has been used to support new ways of working through essential services**

- Cancer
- Eye care
- Implementing Royal College of Surgeons risk stratification - narrative data on how you have prioritised current waiting list based on clinical risk and timeliness - support with data if you have any i.e.% of list in top priority
- Provide picture of current waiting list - demonstrate what you are actively doing to identify and treat patients based on clinical need
- Give examples of what alternative provision you may be commencing to support people while they wait - self-management tools - rehabilitation role of pre-habilitation
- How you have treated people as individuals - meeting the needs and overall experience of patients with dementia, cognitive impairment or sensory loss
- Managing dignified care, including end of life care, for Covid victims
- Mental health services across all areas primary/community and specialist services = provide some context with data to demonstrate how it is being delivered differently

- Diagnostics - explain what is the current position  is and what you are doing to improve

Outpatients-

- Embracing and implementing new ways of working, (virtual review, consultant connect (other advice services), rolling out SOS and PIFU to reduce follow-up numbers and delays)
- Screening

**Provide summary of capacity constraints lessons learnt throughout the year-**

- Give examples of patient feedback, and recognise constraints
- Changes to visiting - impact and lessons learnt
- Improving safety - Learning from serious incidents, safeguarding issues and independent reviews.

*6 Putting Things Right*

Provide assurance and evidence to the organisation's resident population/stakeholders that you are continuing to deal with and learn from concerns in accordance with The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.  Regulation 51 provides that a responsible body must report on the number of concerns:

- received (including, in the case of Welsh NHS bodies, concerns reported under Part 7 of the Regulations related to cross border services);
- deemed well founded; and
- referred to the Public Services Ombudsman for Wales.

The information should summarise:

- The nature and substance of concerns received;
- Any matters of general importance arising out of these concerns or the way that they were handled including areas of concern within particular departments, staff groups, treatments or services provided, that is reporting on trends; and
- Actions taken to improve services as a result of a concern/s being notified.

It is important that bodies say what they have done about concerns received and lessons acted upon.

**6.     Delivering in Partnership**

*Note: There will have previous mention of partnership working in the above sections. Where organisations think it appropriate a further summary can be provided here.*

- Delivery of trace track and protect locally

- Working with Local Resilience Forums

- Management of plans for excess deaths (during acute phase)

- Supporting social care – ensuring safe discharge

- Working and supporting nursing homes

Reference to role of Stakeholder Reference Group – provide example of role performed during the year and where they have contributed

## 7. Workforce management and Wellbeing

- Ensuring safe staffing levels

- Identifying and training staff to undertake new roles

- Training and use of retired staff

- Wellbeing initiatives for staff

- Risk assessments and shielding of staff

- Review of Covid-19 staff deaths

- Role of Employee/Professional Advisory Groups and any significant activity especially re pandemic

  - Health Professionals Forum
  - Local Partnership Forum

## 8. Conclusion and forward look

*Going forward organisations should also demonstrate that recovery plans continue to optimise delivery and that transformational approaches are being implemented to achieve this. In addition, that plans are in place to re-establish and improve on pre-pandemic levels of activity by March 2022.*

# QUALITY, SAFETY AND PERFORMANCE COMMITTEE

# INFECTED BLOOD INQUIRY

| DATE OF MEETING | 12/05/2022 |
|---|---|

| PUBLIC OR PRIVATE REPORT | Public |
|---|---|

| IF PRIVATE PLEASE INDICATE REASON | |
|---|---|

| PREPARED BY | Suzanne Jones, Project Support Officer |
|---|---|
| PRESENTED BY | Lauren Fear, Director Corporate Governance & Chief of Staff |
| EXECUTIVE SPONSOR APPROVED | Cath O'Brien, Chief Operating Officer |

| REPORT PURPOSE | FOR NOTING |
|---|---|

| COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING | | |
|---|---|---|
| COMMITTEE OR GROUP | DATE | OUTCOME |
| Executive Management Board | 27/04/2022 | The report was noted |

| ACRONYMS | |
|---|---|
| IBI | Infected Blood Inquiry |
| NHSBT | National Health Service Blood and Transplant (England) |
| NIBTS | Northern Ireland Blood Transfusion Service |

| SNBTS | Scottish National Blood Transfusion Service |
|-------|---------------------------------------------|
| WBS   | Welsh Blood Service                         |

## 1.      SITUATION/BACKGROUND

**1.1**      The Infected Blood Inquiry is the independent public statutory inquiry into the use of infected blood.

**1.2**      The Inquiry has been established to examine why men, women and children in the United Kingdom were given infected blood and / or infected blood products; the impact on their families; how the authorities (including government) responded; the nature of any support provided following infection; question of consent; and whether there was a cover-up.

**1.3**      The Inquiry has been in operation for over three years and has been taking evidence from those affected and infected together with a number of individuals representing relevant organisations.

**1.4**      The Trust has Core Participant status in the Inquiry.

**1.5**      The activity of the Inquiry has continued during the COVID 19 pandemic, but ways of working have been adapted.


## 2.      ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

### 2.1      VUNHST Engagement with the Infected Blood Inquiry team

**2.1.1**      The Trust continues to engage with the Infected Blood Inquiry team and held a meeting with the newly appointed lead and deputy solicitors to the Inquiry.  The Inquiry team continues to send documents through giving the Trust the opportunity to request a redaction.  None have been requested to date.

**2.1.2**      At the recent meeting on 6th April, the IBI Team informed the Trust that there are approximately 5000 documents that will be sent which will need approval for release and redactions checked over the coming months.  An estimate is 50-100 documents a week that would require a tight turnaround time and the Infected Blood Inquiry is expecting the Trust to have capacity for this.  This is expected to be over the summer months.

### 2.2 Hearings

The Inquiry has completed taking evidence from the four UK Blood Services. The Hearings will recommence in May when they will be examining the government response and also reporting on the compensation framework study. The Inquiry aims to complete the hearings by the end of 2022.

### 2.3 UK Forum

Meetings have continued to take place with the UK Forum, including NIBTS – Northern Ireland Blood Transfusion Service, SNBTS – Scottish National Blood Transfusion Service and NHSBT – NHS Blood and Transplant on a fortnightly basis to discuss any live issues.

### 2.4 Written submissions to Infected Blood Inquiry

The Trust has been advised that there is an opportunity to provide a written submission, in outline, from recognised legal representatives and unrepresented Core Participants. This is in relation to making recommendations (not related to compensation) to inform the Chair's decision about whether to call additional evidence relevant to recommendations. The 20th June is the deadline for any submissions should any participant wish to. This is in addition to an opportunity to make written submissions in autumn 2022.

Advice has been sought from the legal team representing the Trust, and a formal response is pending on whether the Trust makes an initial submission to the Inquiry in June. This is in addition to engagement on the matter with the other UK Blood Services on this issue.

The intention of Infected Blood Inquiry is to publish any recommendations made by the 20th June deadline to Core Participants once they have been received. The Inquiry will give Core Participants as much time as possible to view all the recommendations and evidence to enable a final submission to be made. There will be the opportunity for challenges to be made following any recommendations in June and there is a further opportunity on 24th October to make a final written submission about the conclusions they think the Chair should reach about factual findings and recommendations.

Submissions in June and October are open to all Core Participants, however there is an expectation that in June there will be more input from the Infected and Affected and the Inquiry Team understands that the UK Blood Services will have already made changes and improvements to the safety of the blood supply chain.

Further consideration of the position for Trust will be made by Trust Officers following the formal advice provided by the legal team.

**2.5    Destruction of Records:**

Core participants are still expected to undertake the commitment that no records will be destroyed, however the Inquiry team understand there are storage costs associated with this and they are looking to provide guidance on this in the near future, but the current position has not changed.

**3       IMPACT ASSESSMENT**

| | |
|---|---|
| **QUALITY AND SAFETY IMPLICATIONS/IMPACT** | There are no specific quality and safety implications related to the activity outined in this report. |
| | The Inquiry relates to historic timelines. |
| **RELATED HEALTHCARE STANDARD** | Governance, Leadership and Accountability |
| | Standard 2.8 Blood Management |
| **EQUALITY IMPACT ASSESSMENT COMPLETED** | Not required |
| | The Inquiry relates to historic timelines. |
| **LEGAL  IMPLICATIONS / IMPACT** | Yes (Include further detail below) |
| | The Inquiry will identify in relation to its' Terms of Reference, any individual responsibilities as well as organisational and systematic failures. |
| **FINANCIAL IMPLICATIONS / IMPACT** | Yes (Include further detail below) |
| | Funding for this work was confirmed with the Welsh Government to continue for the duration of the Inquiry |

**4.      RECOMMENDATION**

The Committee are asked to **NOTE** the content of the report.

# QUALITY, SAFETY & PERFORMANCE COMMITTEE

# (CIVAS@IP5)

| DATE OF MEETING | 12/05/2022 |
|---|---|

| PUBLIC OR PRIVATE REPORT | Public |
|---|---|

| IF PRIVATE PLEASE INDICATE REASON | Choose an item. |
|---|---|

| PREPARED BY | GARETH TYRRELL – HEAD OF TECHNICAL SERVICES - CIVAS@IP5 |
|---|---|
| PRESENTED BY | GARETH TYRRELL |
| EXECUTIVE SPONSOR APPROVED | LAUREN FEAR, DIRECTOR CORPORATE GOVERNANCE & CHIEF OF STAFF |

| REPORT PURPOSE | FOR NOTING |
|---|---|

| COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING | | |
|---|---|---|
| COMMITTEE OR GROUP | DATE | OUTCOME |
| | | Choose an item. |

| ACRONYMS | |
|---|---|
| CIVAS | Centralised Intravenous Additives Service |
| IP5 | Imperial Park Building No.5, Celtic Way, Newport, NP10 8BE |
| TMU | Temporary Medicines Unit |

| GMP | Good manufacturing Practice https://ec.europa.eu/health/documents/eudralex/vol-4_en |
|------|------|
| GDP | Good Distribution Practice https://ec.europa.eu/health/documents/eudralex/vol-4_en |
| MHRA | Medicines and Healthcare products Regulatory Agency |
| MS | MHRA Manufacturers' "Specials" license |
| WDA | MHRA Wholesale Distribution Authorisation |

## 1.     SITUATION/BACKGROUND

1.1     CIVAS@IP5 is an MHRA Licenced "Specials" Manufacturer, Wholesale Dealer and Home Office Licenced holder funded by Welsh Government and Hosted by NHS Wales Shared Services Partnership. The purpose of this service is to provide Licenced "Specials" to Health Boards and Trusts across Wales where there is a clinical need, and local aseptic service capacity does not support local manufacture.

1.2     The initial focus of the service was to provide ready to administer infusions to critical care to alleviate the increased capacity pressures across Wales experienced during the COVID-19 Pandemic.

1.3     Subsequently, CIVAS@IP5 has also expanded services to incorporate other Licenced "Specials" products, COVID-19 Vaccine Packdown and Wholesale Dealer activities

1.4     The CIVAS@IP5 application for General Pharmaceutical Council (GPhC) Premises registration was accepted in March 2021. CIVAS@IP5 has also obtained Home office Domestic Controlled Drugs license, MHRA Manufacturers' "specials" license (MS) and Wholesale Distribution Authorisation (WDA).

1.5     The CIVAS@IP5 service has prepared over 24000 doses of ready to administer intravenous infusions, which have been supplied to each of the health boards to support critical care during the COVID-19 Pandemic CIVAS@IP5 has packed down under the MHRA Specials Licenced just over 200000 vaccine doses to support booster roll out, and assured a drug saving of >£900000 through wholesaling activities.

## 2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 On February 15th-16th 2022 CIVAS@IP5 was subject to a GMP Inspection against the Human Medicines Regulations 2020 (SI 2012/1916). This inspection was undertaken to identify adherence to the principles and guidelines of Good Manufacturing Practice (GMP) and Good Distribution Practice (GDP)

2.2 Within this inspection there were several failures to comply with the principles of GMP/GDP identified relating to three areas, Documentation, Contamination Control and Product Recall.

2.3 The inspectorate provided the findings report and requested an action plan within 28 days which they have been supplied with. This action plan has been accepted by the inspectorate.

2.4 The inspection outcome has therefore assigned the CIVAS@IP5 unit with the **lowest risk rating** and the **longest inspection interval** available. The facility will now be inspected again in February 2024

2.5 Attached to this document is the CIVAS@IP5 Service Board Report for 22/23. This report identifies the following

- Performance metrics for operational output
- Regulatory performance against EU GMP
- Service development progress

2.6 Operational output has fluctuated over Q2-3, largely due to a 68% turnover of staff. It is anticipated that all posts be recruited into by end June 2022.

2.7 Production output remains high, and previous issues with yield output are resolving as more staff are trained and observed. The quality of staff training was a positive noted by the MHRA Inspector during the inspection.

2.8 Current service developments are:

- Standardised Potassium Chloride syringe (50mmol in 50mL)
- Patient safety pilot with CAV UHB providing Emergency Intubation injections. This has potential for all Wales expansion
- Rituximab dose banded infusions provided in ready to use format
- Calcium Folinate infusions provided in ready to use format

- Procurement of semi-automated device for preparation of insulin syringes and OPAT pilot

2.9 As well as the regulatory, compliance and assurance framework for the activity itself, it was also important to consider the wider quality governance framework in which this part of the NWSSP model operates in. To support consideration of this, appendix one was compiled which outlines, from various internal and external sources, key elements which make up an Organisational quality governance framework. The right-hand column then articulates how TMU and NWSSP fulfill these elements. The document has been previously discussed and approved in advance of the Committee with Medical Director NWSSP, Executive Medical Director Velindre University NHS Trust and Executive Director of Nursing, AHPs and Health Science.

## 3. IMPACT ASSESSMENT

| | |
|---|---|
| **QUALITY AND SAFETY IMPLICATIONS/IMPACT** | There are no specific quality and safety implications related to the activity outined in this report. |
| **RELATED HEALTHCARE STANDARD** | Governance, Leadership and Accountability |
| | If more than one Healthcare Standard applies please list below: |
| **EQUALITY IMPACT ASSESSMENT COMPLETED** | Not required |
| | The CIVAS@IP5 was specifically commissioned to ensure equality of access to medicines by supplementing existing aseptic manufacturing capacity. |
| **LEGAL IMPLICATIONS / IMPACT** | There are no specific legal implications related to the activity outlined in this report. |
| | CIVAS@IP5 is operating in compliance with relevant legislation, specifically the Medicines Act (1968), The Human medicines regulations (2012) and the misuse of Drugs act (1971) |
| **FINANCIAL IMPLICATIONS / IMPACT** | There is no direct impact on resources as a result of the activity outlined in this report. |

| | Welsh Government has confirmed continuing funding of revenues for the project to 31/3/23. |
|---|---|

## 4.  RECOMMENDATION

4.1     The Quality, Safety and Performance Committee is asked to **note** current levels of service performance against the framework of standards set out in EU GMP and which we are legally required to comply with as an MHRA "Specials" and Wholesale Dealer license holder. Further update on new products introduced into the CIVAS@IP5 portfolio will be provided in future meetings.

The Quality, Safety and Performance Committee is asked to **note** the findings and CIVAS@IP5 risk status assigned by the MHRA. The action plan and progress update will be provided as part of this agenda item.

**Appendix  - CIVAS@IP5 Governance Arrangements – notes**

| | | | |
|---|---|---|---|
| 1.1 | Quality as drive for organisational strategy | Quality and safety priorities clearly defined, documented and periodically reviewed | CIVAS@IP5 operates in compliance with Good Manufacturing Practice (GMP) and Good Distribution Practice (GDP) these internationally recognised standards designed to ensure safe manufacturing, storage and distribution of medicines are clearly defined: https://ec.europa.eu/health/documents/eudralex/vol-4_en https://ec.europa.eu/health/human-use/good_manufacturing_distribution_practices_en <br><br>The facility and its operation are clearly defined in the CIVAS@IP5 site master file and in standard operating procedures. <br><br>The CIVAS@IP5 was inspected by the MHRA against GMP and GDP on 15-16th December 2020, and for pack down of covid vaccines on the 6TH Sept 2021. All newly licensed manufacturing units are inspected within 12 months of the first inspection. A further inspection in Feb 2022 resulted in a low risk rating applied to the facility. <br><br>The CIVAS@IP5 will be inspected against GMP and GDP on behalf of WG and the Welsh Chief Pharmacists Group by the All Wales QA Pharmacist during 2021. |
| 1.2 | | These priorities are reflected in organisation's IMTP | The CIVAS@IP5 development is fully supported by the Shared Service Partnership Committee and Welsh Government. The Minister has provided funding for the TMU project in response to COVID requirements and |

| | | | | continuity of supply. It is also integral to supporting the COVID vaccination Program.<br><br>Funding is currently assured until March 2023 |
|---|---|---|---|---|
| 1.3 | | | Quality and safety strategic risks are reflected in Board Assurance Framework | The CIVAS@IP5 Board Agenda includes an agenda item on project risk. Any significant quality and safety risks will be also highlighted and discussed at the Shared Service Partnership Committee and the NWSSP Senior Leadership Team as part of the normal operational management and reporting within NWSSP.<br><br>A separate paper outlines the proposed addition of NWSSP business, including CIVAS@IP5, into the Velindre University NHS Trust Quality, Safety & Performance Committee going forwards, the agenda will include a section on associated risks. |
| 1.4 | | | Quality and safety risks central in the risk management strategy and processes of the organisation | Quality and Safety is integral to GMP and GDP quality improvement and quality by design are inherent within the approach to processes within CIVAS@IP5.  As above in terms of reporting risks within NWSSP and to the NWSSP part of the Velindre University NHS Trust Quality, Safety & Performance Committee if approved. |
| | | | | |
| 2.1 | Leadership of quality and safety | | Collective responsibility for quality and patient safety across the executive team and clearly defined roles for professional leads | The CIVAS@IP5 lines of accountability are clearly defined. There are clearly defined professional roles.<br><br>The CIVAS@IP5 Head of Technical Services now reports to the NWSSP Service Director for TrAMS |

| | | | managerially and to the Chief Pharmaceutical Advisor to WG professionally.

The CIVAS@IP5 Head of Technical Services also reports to the Service Board, which in turn reports to the Shared Services Partnership Committee.

The CIVAS@IP5 Head of Technical Services is the Superintendent Pharmacist for the CIVAS@IP5 General Pharmaceutical Council Premises Registration, and the Site lead, and Person Responsible for Security on the Home Office Domestic Controlled Drugs license.

A suitably qualified and experienced individual is employed in the Accountable Pharmacist role. A new accountable pharmacist has been appointed to take over from the incumbent's retirement.

The QA and Production Leads report to the CIVAS@IP5 Head of Technical Services. The QA and Production lead are named on the MHRA Manufacturers' "specials" (MS) license as being responsible for Quality and Production respectively.

The QA lead is the named Responsible Person on the MHRA Wholesale Distribution Authorisation (WDA).

All staff working in the CIVAS@IP5 will be formally engaged to job roles within NWSSP, to ensure accountability for the work undertaken. These engagements will be a mixture of: |
|---|---|---|---|

| | | | |
|---|---|---|---|
| | | | • Honorary Secondments of staff already employed by Health Board or Trust Pharmacy units<br>• Bank Staff engagements<br>• Permanent or where appropriate temporary employment contract<br>All staff have a quality element to their role and an understanding of quality assurance of the operation of the service. |
| 2.2 | | There is sufficient capacity and support, at corporate and directorate level, dedicated to quality and safety | The CIVAS@IP5 board provides scrutiny of safety, quality and performance and of the service. The board also provides strategic and operational support.<br><br>The board has met monthly since the service was envisaged in April 2020. The capacity of the board to carry out the oversight and support roles is evidence by the successful MHRA license applications and service delivery, respectively, within the projected project timescales.<br><br>All health boards through the support of Chief Pharmacists have helped support the creation of the TMU and they are fully supportive and committed to the Unit. NWSSP is about collaboration and support service provision. |
| | | | |
| 3.1 | Organisational scrutiny of quality and patient safety | The roles and function of the Quality and Safety Committee is fit for purpose and reflects the Quality Strategy, Quality and Safety | It is proposed that the following are submitted to the Quality and safety Committee<br>• Annual Quality Statement<br>• Inspection reports (as and when received) |

| | | Governance Framework and key corporate risks for quality and safety | • MHRA Update/Action plan |
|---|---|---|---|
| 3.2 | | Independent/Non-Executive Members are appropriately supported to meet their responsibilities through the provision of an adequate induction programme and ongoing development so they can effectively scrutinise the information presented to them | A separate paper outlines the proposed addition of NWSSP business, including CIVAS@IP5, into the Velindre University NHS Trust Quality, Safety & Performance Committee going forwards.<br><br>Regular updates will be provided as part of the normal course of business to the Shared Service Partnership Committee, which includes representatives from every NHS organisation as the responsible body for shared services. |
| | | | |
| 4.0 | Clinical Audit | There is visibility and oversight of clinical audit and improvement activities across divisions/groups/directorates and at corporate level. This includes identification of outliers and maximising opportunities for sharing good practice and learning | The CIVAS@IP5 service is a professional technical service whereby all clinical decisions are made by health board clinicians and not the CIVAS@IP5 staff. The unit is an accredited production unit which has a self-inspection programme for GMP and GDP.<br><br>The unit is independently inspected by the All Wales QA Pharmacist.<br><br>Best practice is shared through the Welsh Chief Pharmacists Group's pharmacy technical services sub-group (CPTS) and lessons learned from the development of the TMU have been captured. A number of senior health board technical pharmacy staff have been involved in putting in place the quality and operating procedures. |

| | | | |
|---|---|---|---|
| 5.1 | Organisation promotes a quality and safety focused culture | Organisational values and behaviours support a quality and safety focused culture | The organisational structure of CIVAS@IP5 is designed to ensure adequate supervision of all processes. All grades of staff are empowered and supported in identifying process deviations.<br><br>The service will operate in line with the values and culture of NWSSP |
| 5.2 | | Organisation actively participating in quality improvement initiatives | The service has a robust Corrective Action/Preventative Action (CAPA) system built into the Pharmaceutical Quality System (PQS). This ensures lessons are learnt and appropriate actions taken, within an appropriate timescale. The CAPA system also ensure continuous quality improvement. |
| 5.3 | | Organisation takes steps to listen to staff and involve them in monitoring service change/improvement | All grades of staff are empowered and supported in identifying process deviations, during manufacturing process or at daily pre and post manufacturing session meetings. Feedback is provided on issues raised. |
| 5.4 | | Strong culture of learning lessons from staff feedback or concerns | The CAPA system is an essential component of the Pharmaceutical Quality system. Staff training encompasses the PQS and the role of team members in its operation. The management recognize the importance of responding appropriately to staff concerns and providing feedback. |
| 5.5 | | Quality and safety an integral part of workforce management processes | Quality and safety are pre-requisites for compliance with GMP and GDP |
| | | | |

| 6.1 | Organisational structures and processes support delivery of high-quality, safe and effective services | Clear lines of accountability for quality and patient safety across the organisational structure ie 'floor to Board' | Included as point 9 of PQS in Internal Assurance section |
|---|---|---|---|
| 6.2 | | Effective corporate and operational controls to support delivery of high-quality and safe services | Operational controls in PQS in Internal Assurance section<br><br>Current corporate and operational controls have been extended to cover the operation in line with existing processes. Once fully established the Q&S Committee for Shared Services will also provide an additional level of assurance for NWSSP Committee members |
| 6.3 | | The oversight and governance of DATIX and other risk management systems ensures they are used as an effective management and learning tool. This should also include triangulation of information in relation to concerns, at a divisional/group/ directorate or corporate level, and formal mechanisms to identify and share learning | The DATIX is used to report clinical incidents and health and safety incidents. It is recognised that the DATIX system does not have the level of detail in classification of incidents for a CAPA system which meets the expectation of the MHRA. The Q-Pulse system is therefore used in addition to DATIX for management of CAPA and other components of the PQS.<br><br>Complaints will be managed through Q-Pulse, the NWSSP Complaints Management Protocol and if these relate to product quality and or patient safety the MHRA's Defective Medicines Report Centre (DMRC).<br><br>There is a Recall Procedure, the effectiveness of which is tested annually. |
| 6.4 | | Enough resource and expertise to support and improve quality governance arrangements | The CIVAS@IP5 Head of Technical Services is an appropriately qualified and experienced Pharmacist.<br><br>The CIVAS@IP5 Head of Technical Services is supported by QA lead, Production Lead and Production |

| | | | Managers with the necessary qualifications, skills and experience.<br><br>The senior team is supported by a workforce designed, recruited and trained specifically for the operation of the service.<br><br>The team has a clear understanding of their required contribution to the PQS.<br><br>Capacity planning carried out as part of workforce design has ensured that the PQS is appropriately resourced. |
|---|---|---|---|
| 6.5 | | Organisation has comprehensive and timely information for monitoring and reporting on quality and safety | Q-pulse is used to manage the PQS. This system is used to record, monitor and report on information relevant to the PQS: CAPA, facilities and equipment, customer, suppliers, external audit and self-inspection,<br><br>The working environment is monitored by the team. End of batch tryptone soya broth fills are carried out at the end of each manufacturing batch. Public Health Wales provides Microbiological services, including incubation, species level identification and reporting for the environmental monitoring and end of batch testing.<br><br>Finished product is quarantined pending confirmation of satisfactory environmental and end batch testing data. |
| 6.6 | | Quality and patient safety receives effective coverage at both corporate and operational management meetings | The Board receives and reviews a monthly operational report, which includes both quality, safety and operational performance. |

# CIVAS@IP5 Service Board

April 2022

SERVICE PERFORMANCE

# BATCH PRODUCTION



Batches Produced Per Month
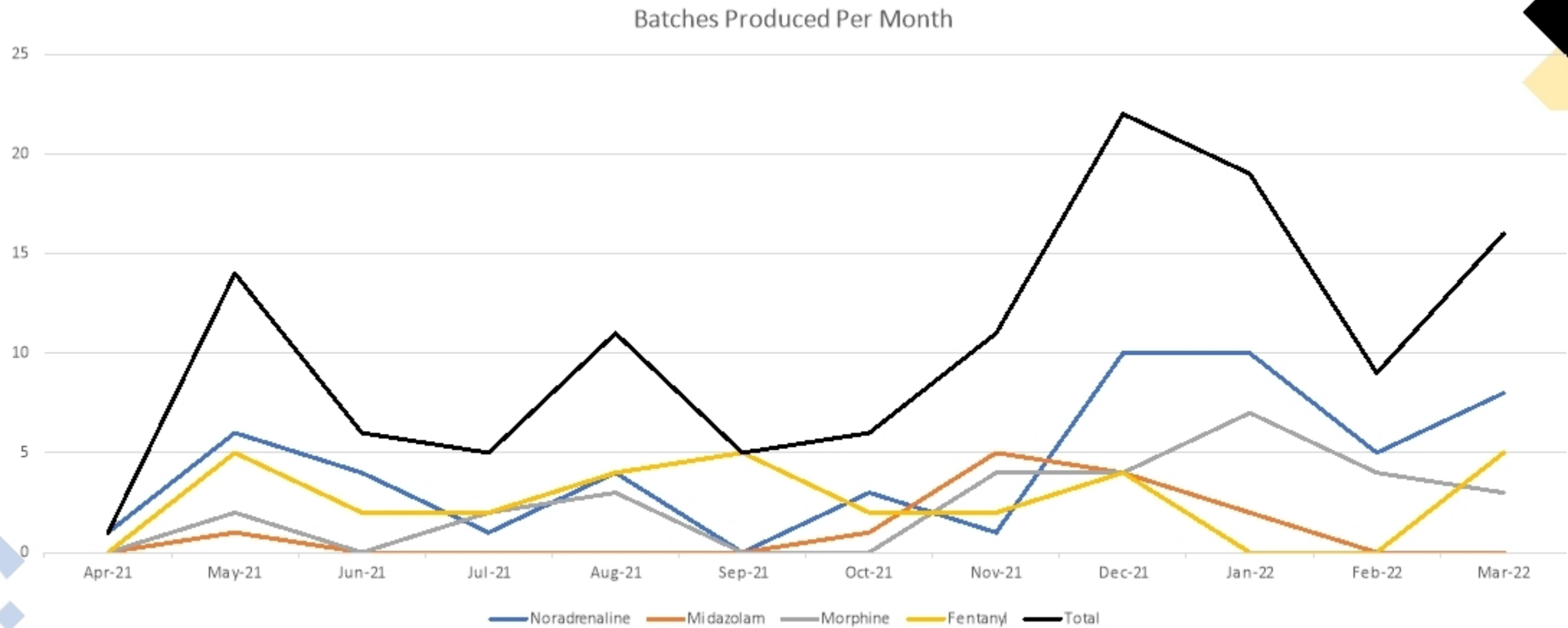
# TOTAL PRODUCTION & % YIELD PERFORMANCE



Monthly Production Numbers and % Yield
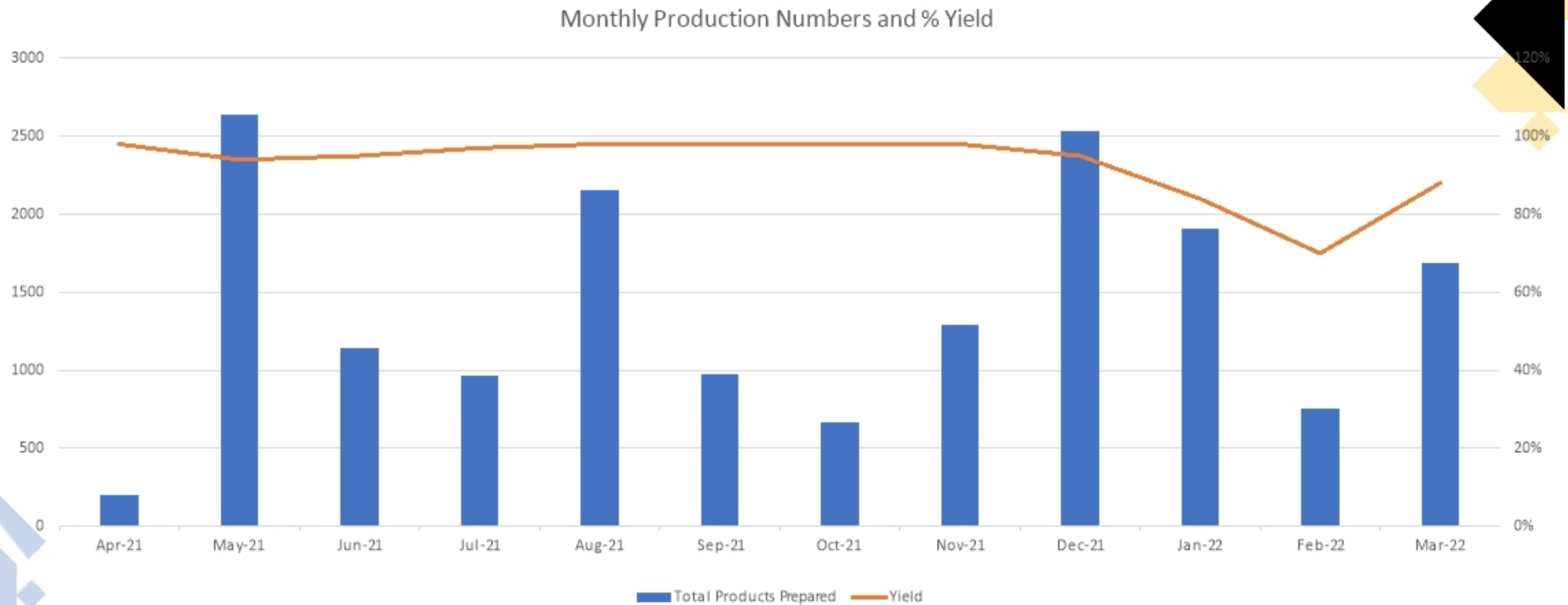
# UHB ORDERS RECEIVED

# RIXATHON WDA SERVICE



Monthly Rixathon Issue Values
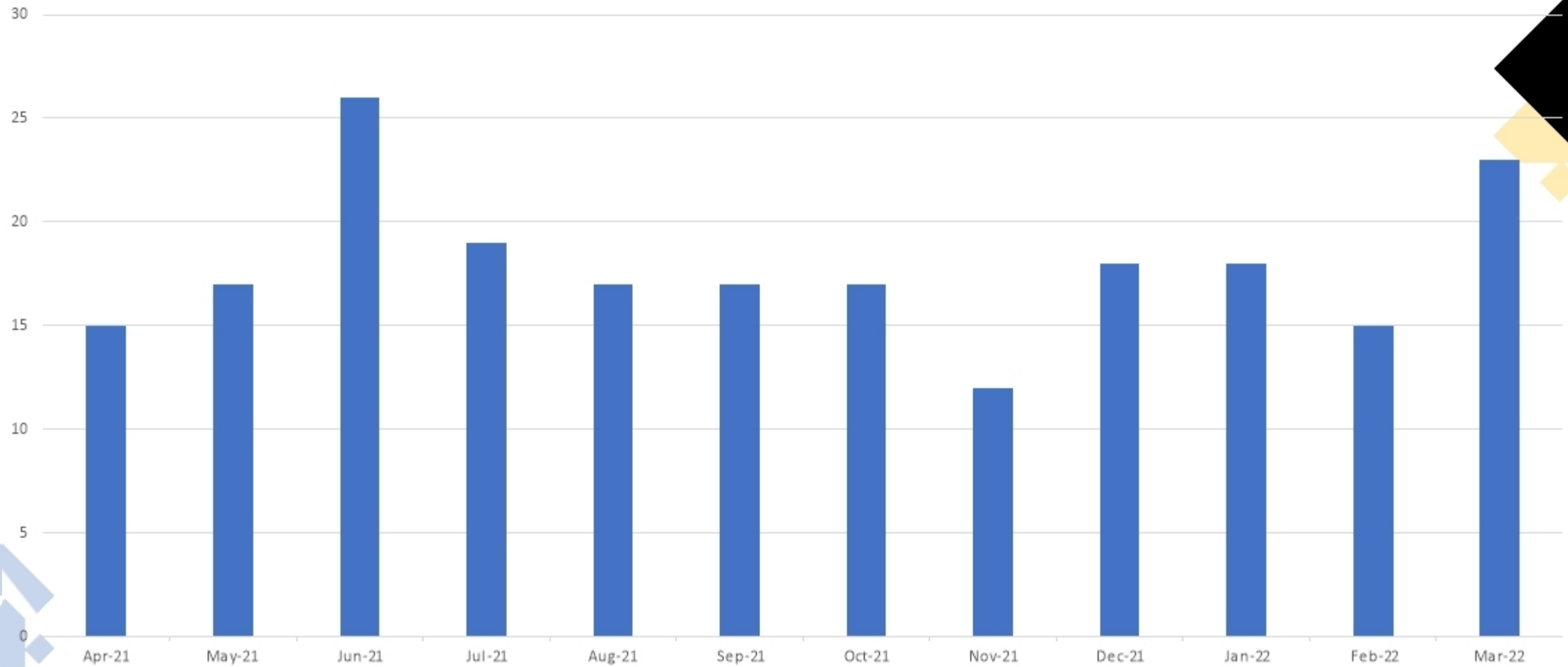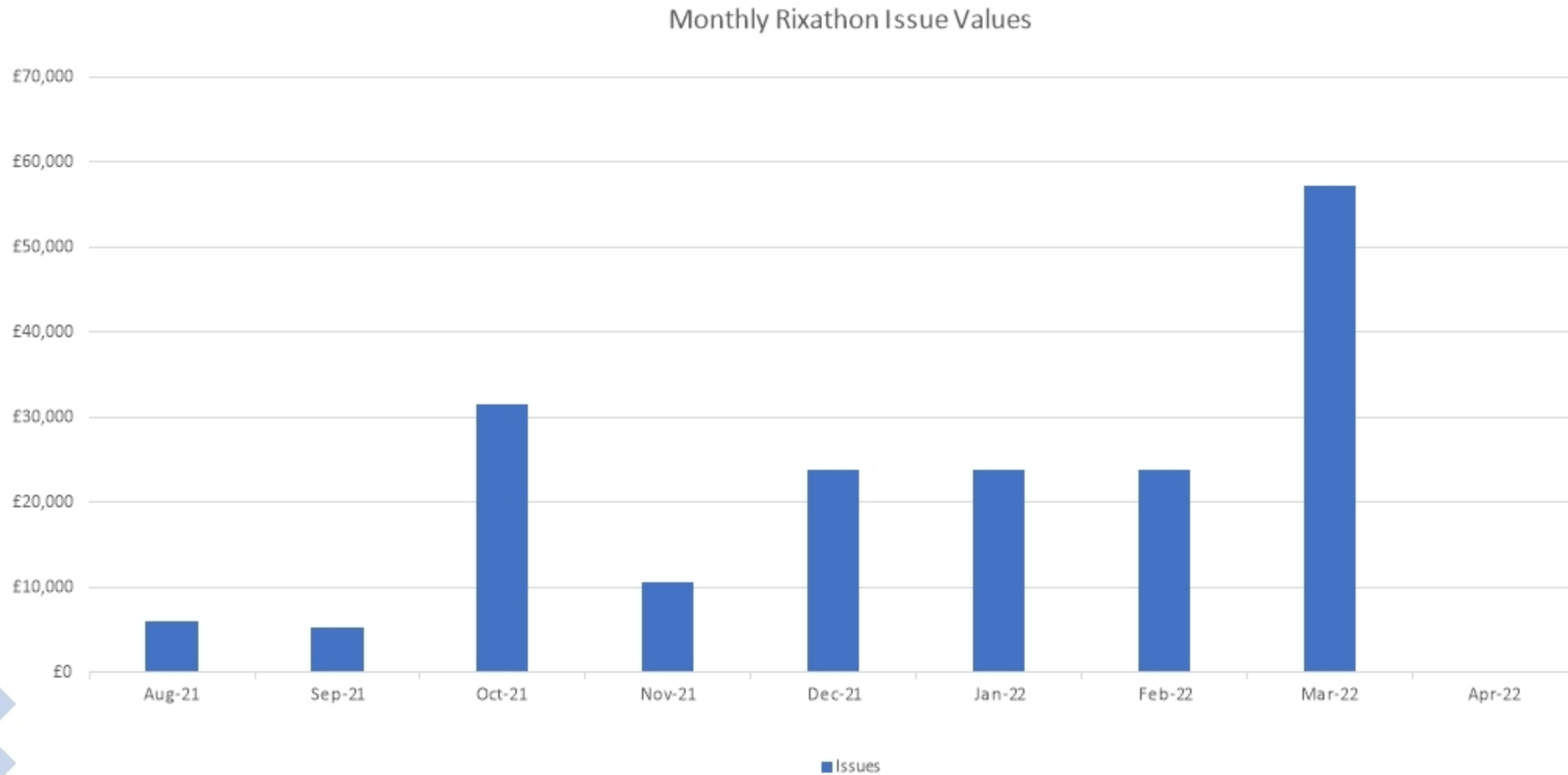
# CUMULATIVE RIXATHON SAVINGS



Monthly Rixathon Issue Values and Savings Impact
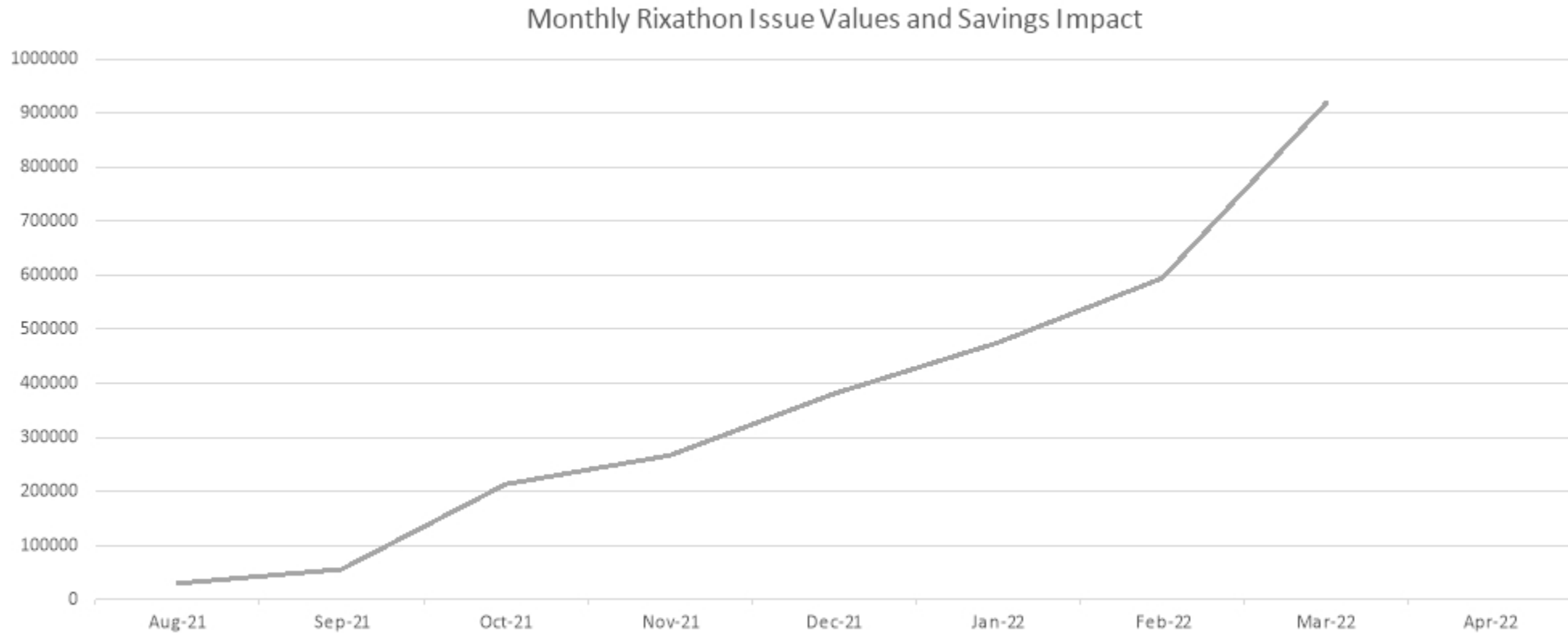
# COVID-19 VACCINE BOOSTER PACK DOWN



203317 Vaccine Doses Packed and Distributed since Sept 2021

Sep-21, 30420
Oct-21, 29250
Nov-21, 35100
Dec-21, 53820
Jan-22, 22075
Feb-22, 7782
Mar-22, 24870

Legend: 44440, 44470, 44501, 44531, 44562, 44593, 44621
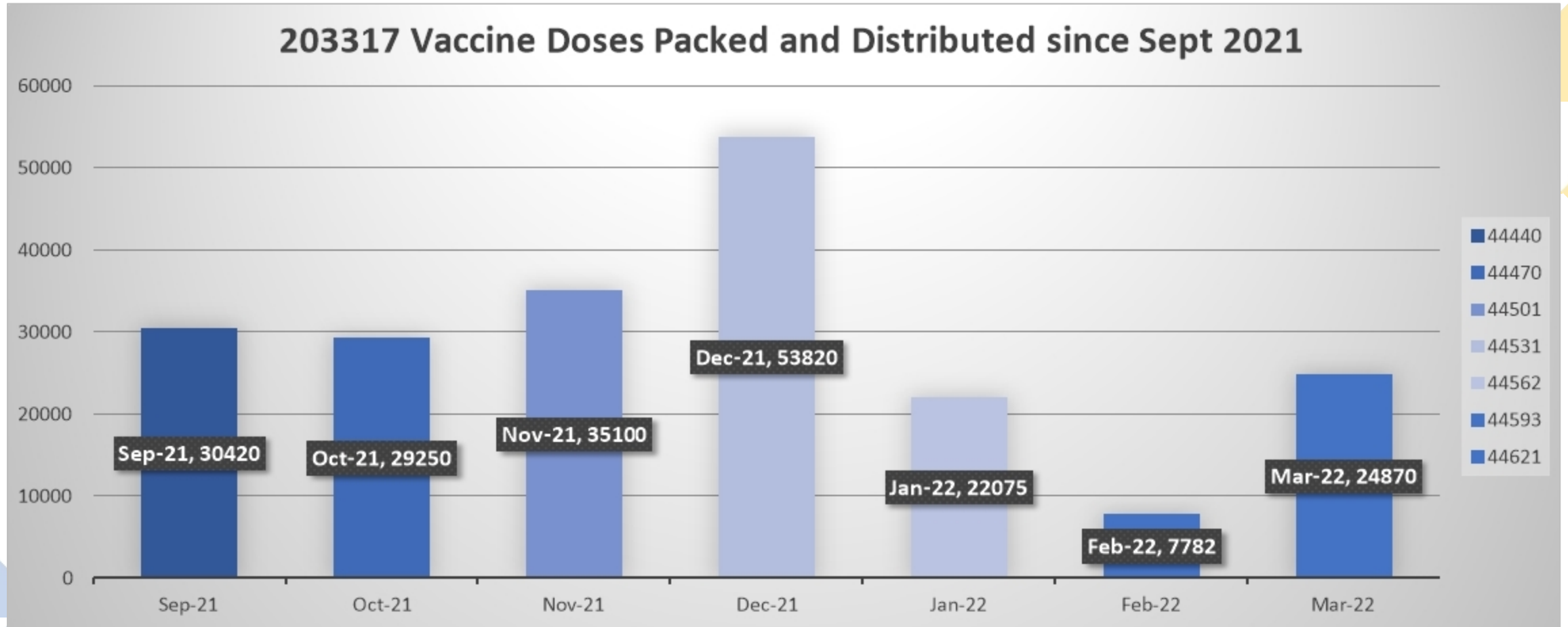
# PHARMACEUTCIAL QUALITY SYSTEM PERFORMANCE

# ERRORS & CRITICAL DEVIATION PROCESS



Errors & Critical Process Deviations
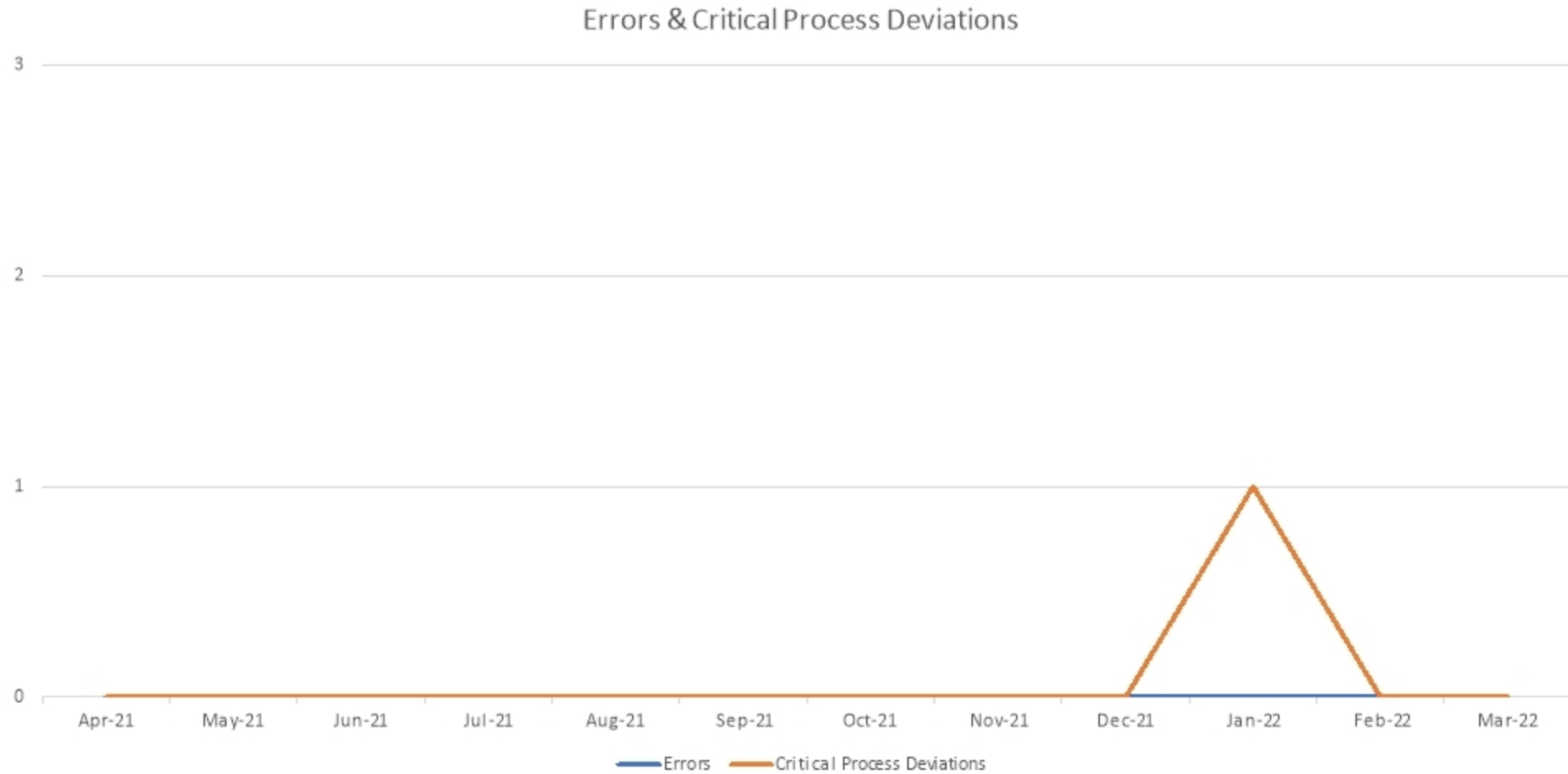
# PRODUCT REJECTION RATE
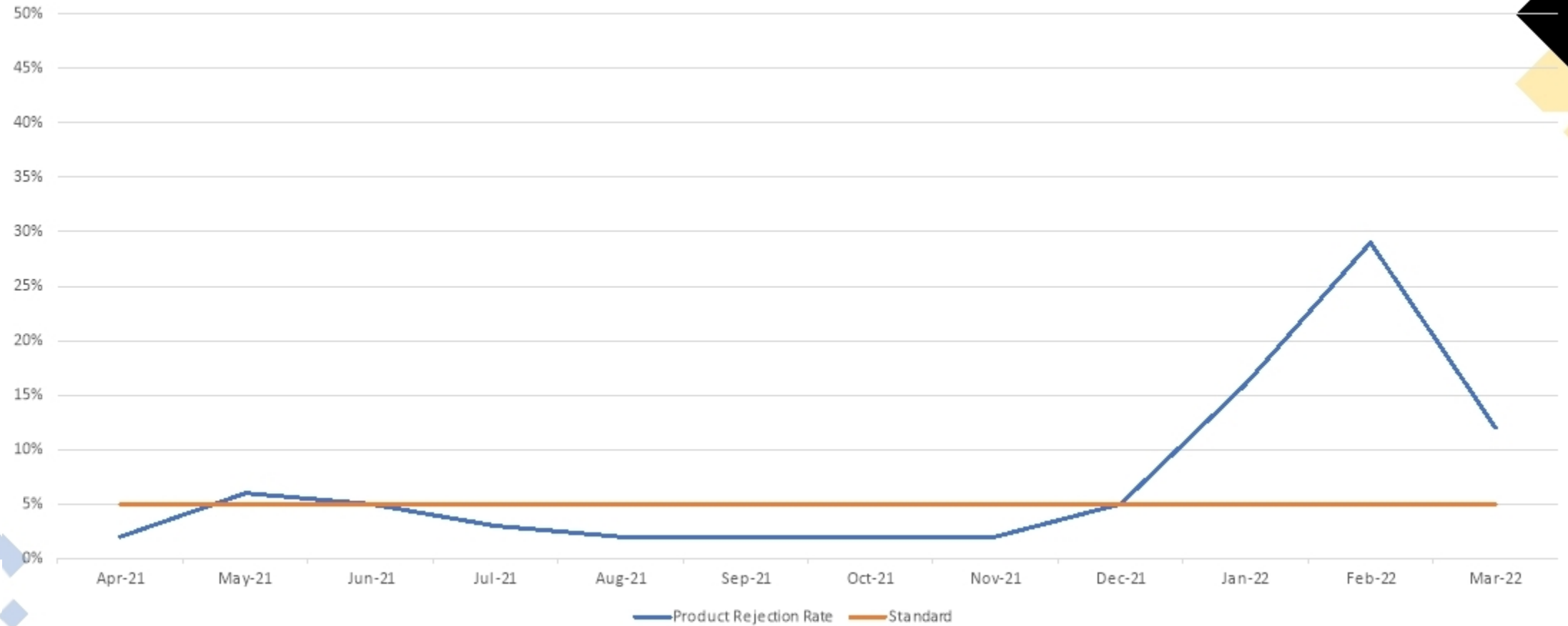
# FACILITIES DEVIATIONS
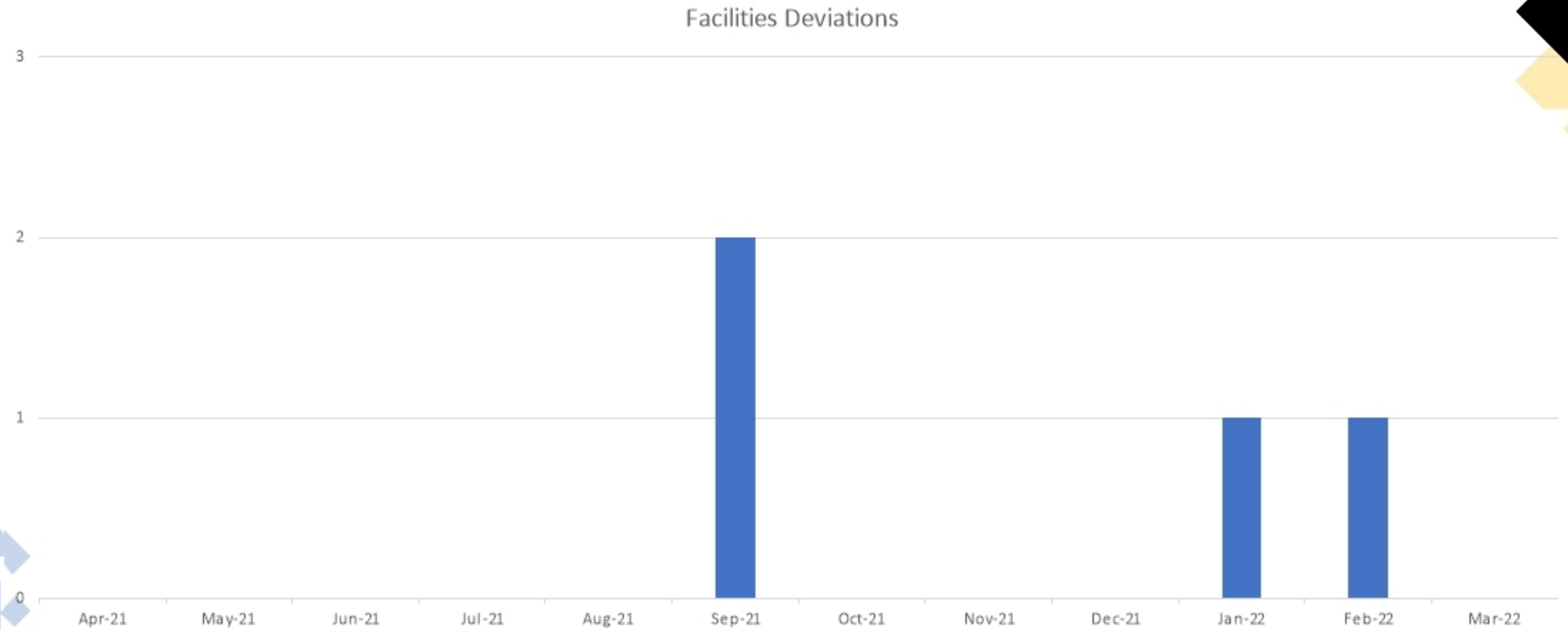
# Other Quality Metrics – Annual Performance 21/22

Internal Audit Compliance – 100%

Documentation review rate – 94% (92% Target)

Critical Zone Environmental Failure rate – 0.5% (5% Target)

Operator Environmental Failure Rate – 0.2% (5% Target)

Service Complaints – 4

# Annual Service Summary 21/22 – Sucess

16000 ready to administer syringes manufactured in 21-22

203317 vaccine doses packed and distributed to >300 locations

Wales first national WDA drug purchase and supply programme – over £900k saved

Low-risk rating achieved during MHRA Inspection

Welsh Pharmacy and Deloitte Innovations Awards

UK's first user of Gri-fill 4.0 Compounding machine

# Annual Service Summary 21/22- Challenges

68% STAFF TURNOVER REQUIRING RESOURCE HEAVY INPUT INTO TRAINING

RECRUITMENT DIFFICULT OWING TO TEMPORARY CONTRACTS OFFERED

STAFF SICKNESS RATES DURING LOW-CAPACITY PERIODS

6-MONTH DELAYS ON EQUIPMENT PROCURED CHALLENGING OUR PRODUCT DEVELOPMENT TIME FRAMES

# 22/23 Programme for CIVAS@IP5

- Gri-fill 4.0 validation and product development of
- Introduction of Smartfiller to increase syringe fill capacity
- Completion of MHRA action plan within time frames
- Identification of further drugs for Once-for-Wales purchase and wholesale dealing
- Introduce MRS Microbiology reporting system
- Replacement of EDS Pharmacy System

**Philip Rose**

**10 South Colonnade**

**Canary Wharf**

**London**

**E14 4PU**


Dear Mr Rose,


Thank you for your letter in relation to our recent inspection against the Human Medicines Regulations 2012, and the detailed deficiencies identified in relation to compliance with the principles of Good Manufacturing and Distribution Practice.

As requested in your letter please find attached a detailed action plan in relation to the deficiencies identified with proposed corrective actions and target dates for completion.

I look forward to your response to this proposed action plan.


Kind Regards


**Gareth Tyrrell**

**Head of Technical Services – CIVAS@IP5**

**CIVAS@IP5 Action Plan**

| Deficiency Number | Deficiency Identified | Corrective Action | Target Date | Comments |
|---|---|---|---|---|
| 2.1 | **Document practices and processes to ensure the integrity of data and traceability of all significant manufacturing activities were deficient in that:** | | | |
| 2.1.1 | The component reconciliation section of the batch record for batch 2601220027 (Noradrenaline) had not been completed despite the section being signed as complete. | Post-inspection the production process has been reviewed and risk assessed to identify areas of weakness in relation to ingredient reconciliation and completion of associated batch documentation.<br><br>The recommendations from the review will be raised as change controls and implemented to strengthen the post-production process. Corrective and preventative actions will be targeted towards separating the post-production ingredient reconciliation and visual inspection process, as well as separate signatures required for completion of each step. | **April 2022** | **Owners AD/ET** |
| | | There will be a resulting requirement to identify an area for post-production ingredient reconciliation prior to visual inspection of final products and a change to the worksheet layout to reflect these changes. These measures will be risk assessed prior to implementation and | **April 2022** | **Owner GT/LL/MJ**<br>**COMPLETED** |

| | | | | |
|---|---|---|---|---|
| | | supportive justification for these actions documented. | | |
| | | All changes will require a re-training of all individuals who are required to complete GMP critical documentation, as well as an updated teaching session on Data Integrity and ALCOA+ principles. | **March 2022** | **Owner LL** COMPLETED |
| | | The production operatives involved in the deficient GMP actions have been identified and a period of re-training will be undertaken. A program of monthly internal self-inspection of all critical GMP -related logs and documentation monthly to identify incidences of incomplete documentation. These will be categorised and trended to identify further corrective process actions. These actions will be supported by the National Quality Assurance Lead | **March 2022** | **Owner AD/ET** COMPLETED |
| 2.1.2 | The label reconciliation section of the batch record for batch 0511210007 (Midazolam) had not been completed despite the batch being released. | A review of the label reconciliation process and associated steps within all process and batch documentation will be undertaken to identify improvements to the documentation and management of label reconciliation actions. Any recommendations identified within this review will be managed via the change control process and will include retraining and competency assessment of all | **April 2022** | **Owner GT/LL** COMPLETED |

| | | individuals required to complete label reconciliation actions.<br><br>Within the updated training sessions relating to Data Integrity and ALCOA+ principles there will be clarification on the requirement to retain, control and deactivate all rejected documentation. | | |
|---|---|---|---|---|
| 2.1.3 | The electronic stock movement section of batch 0511210007 had not been confirmed within the paperwork despite the batch being released and shipped. | SOP QC-1 Product Assessment and Release & DOC6 Batch Release of Comirnaty Vaccine will be updated to state that the final electronic transfer of products must be done by the Releasing Officer or Nominated deputy only.<br><br>This relates to the transfer quarantine to live stock on the Pharmacy Stock Management system "EDS" Production Module.<br><br>QA staff to be provided training on the EDS Production Module to ensure these tasks are carried out contemporaneously and accurately. | **March 2022** | **Owner AD/LL**<br><br>**Q-Pulse Ref: REG78**<br><br>**COMPLETED** |
| 2.1.4 | There was no confirmatory check of "picked" production components within the production facility, prior to use. | The accuracy of the ingredients used within the Laminar Air Flow cabinet is checked by the Production Supervisor at the point of production and is confirmed as correct by a signature only. | **Worksheet Amendments - April 2022** | **Owner GT/LL** |

| | | | | |
|---|---|---|---|---|
| | | The batch documentation will be updated to include steps that document the batch number and expiry of each ingredient and critical component prior to use. This will be signed for immediately prior to use by the Production Supervisor. SOP ASS-WPI3, which is the work-place instruction for syringe filling and in-process checking will be updated to reflect change in practice. Production operators and Supervisors to be re-trained in the additional requirements and competency assessed.<br><br>Supervisors will be provided with additional training and competency assessment for checking and documenting of in-process batch details.<br><br>In the longer term the service plans to introduce barcode scanning of critical ingredients and consumables to provide a digital log of all critical batch information. The manufacturer of the compounding equipment will be approached to provide additional training and design of the in-process batch documentation that can be achieved by the Medimix/Vigo pumps. | **Barcode scanning of critical ingredients – Aug 2022** | |
| 2.1.5 | The receipt log for the vaccines required a "min/max" temperature entry but only the current displayed temperature of the courier's vehicle was recorded. | The receipt log for vaccines (FORM3) has been amended to include separate boxes for the maximum and minimum temperatures to be recorded as well as stating the acceptable temperature range. | **March 2022** | **Owner AD**<br>**Completed** |

| | | This will be assessed as part of the monthly self-inspection of GMP-critical documentation as detailed in 2.1.1 above.<br><br>ALCOA+ and data integrity principles added to the training competencies of all current and future staff to emphasise the importance of accurate documentation practices. This training will also include a review of the understanding of the type and importance of information requested within the batch documentation to ensure complete understanding of the documentation process. | | |
|---|---|---|---|---|
| 2.1.6 | The item layout diagram used to aid component assembly (picking) was not a controlled document within the Pharmaceutical Quality System (PQS). | This identified document has been uploaded to Q-Pulse as a version-controlled training aid document and approved for use.<br><br>A further review of all documentation used within service has been undertaken to identify further uncontrolled documents in use. All documents identified have either been removed or added onto Q-Pulse as a controlled version. | **March 2022** | **Owner AD**<br><br>**PROD-WPI4 created and approved**<br><br>**Completed** |
| 2.2 | **Controls to prevent contamination were deficient in that:** | | | |
| 2.2.1 | Process Validation media fills were not performed every six months at full scale. | Validation master plan (VMP) to be reviewed to ensure appropriate validation intervals as per MHRA Q&A 2015. Validation schedule interval on Q-Pulse to be reduced from the recommended 6 | **March 2022** | **Owner – AD update VMP**<br>**Completed** |

| | | months to a 4 month interval to provide adequate buffer for rescheduling of validations. | | |
|---|---|---|---|---|
| | | Validation of process to be undertaken within February 2022 to reflect full scale manufacturing process. | | **Owner MJ – arrange PV**<br>**Completed** |
| 2.2.2 | Goggles were not worn within the Grade B area posing a risk of shedding. | The production team will approach current clean room and consumable suppliers to identify opportunities to procure sterile goggles. Once an appropriate supply mechanism has been identified this will be introduced immediately into the gowning practices within the Grade B area of the facility.<br><br>A change control will be raised to manage the change process in relation to gowning and will include updated documentation, re-validation of gowning processes and updated training of staff with competency assessments carried out individually. | **April 2022** | **Owner ET**<br><br>**Completed** |
| 2.2.3 | Production surfaces were not smooth, impervious, and unbroken such as the speak-through hatches and gaps between the coving and walls within production footprint. | A monthly visual inspection of the fabric of the facility will be carried out by the production team, against an approved checklist. Identified deficiencies to be recorded on Q-Pulse and provided to clean room contractor Enbloc for resolution during 6 monthly site visits. | **May 2022** | **Owner AD/LL**<br>**Completed** |

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| | | Unit deficiencies identified during this inspection to be documented as a facilities deviation and raised as corrective actions with Clean Room contractor Enbloc for resolution during service visit scheduled for May 2022.<br><br>Melaphone grille to be replaced during visit. | **May 2022** | **Owner AD**<br>**Completed**<br><br>**Owner LL**<br>**In progress** |
| | | Monthly facilities status review will be outlined within an approved SOP and initiated to provide ongoing inspection of fabric of the facility, as well as identification of issues. | **April 2022** | |
| 2.2.4 | Justification was unavailable for particle monitoring not being performed during the critical activities. | Current non-compliance relating to sessional particle monitoring for the closed system processes undertaken within the service will be risk assessed and justification for non-compliance provided. | **May 2022** | **Owner AD**<br>**In progress** |
| 2.2.5 | Environmental Monitoring (EM) trends lacked sufficient detail or magnitude to allow appropriate actions to be taken as they were reported as percent excursions only. | Ongoing trending will be converted to absolute numbers from % failures for all grade areas to ensure changes to data trends are identified and actioned at the earliest opportunity. | **March 2022** | **Owner GT**<br>**Completed** |
| | | The long-term actions include the installation and use of the Microbiological Reporting System (MRS) which allows the automated reporting of environmental deviations and adverse trend patterns. This | **August 2022** | **Owner ET**<br>**Installation to recommence after national agreement of version number to be used** |

| | | will allow early identification of issues that require risk assessment and Corrective and Preventative actions. | | |
|---|---|---|---|---|
| 3.1 | The decision and associated justification to release batches following Grade A recoveries was weak and inadequately documented. For example, the full assessment of risk and mitigations was not documented but often relied on the end of session broth results rather than assessing the associated risk to the product. (This is categorised as an "other" based on the finding primarily being poor justification recorded rather than any adverse risk identified to the products). | A review of all critical Grade A/B Environmental Monitoring excursions be introduced monthly within the existing Monthly Quality Meeting agenda. The aim of the review will be to critically assess the excursion-related data recorded risk assessment of the event, the decision-making process and corrective/preventative actions undertaken with justification for each event. This review will be multidisciplinary in nature with input from the All-Wales QA Pharmacist and Service Director.<br><br>Outcomes and actions from this review will be included in the meeting minutes as well as actions/learning regarding reporting and investigations. | **August 2022** | **Owner AD**<br>**In progress** |
| 3.2 | **The management of recall of potentially defective product was deficient in that:** | | | |
| 3.2.1 | The site had failed to notify the competent authority (Defective Medicines Reporting Centre) of the recall of batch 1001220008 (Morphine). | SOP PQS14 – Recall Process will be updated to provide clarification that once collected by courier (external or internal) then the product is required to be reported to the DMRC where a recall or quality issue is identified. | **March 2022** | **Owner AD**<br>**Q-Pulse Ref: REG 69**<br>**Completed** |

| | | | | | |
|---|---|---|---|---|---|
| | | Senior staff to receive training regarding updated RECALL SOP, with a rotation of staff required to undertake Recall validation to remain competent in identification of the actions required for differing levels of Recall. | | | |
| 3.2.2 | The site had not recorded the reconciliation of the batch following recall within the recall report to ensure that no defective product remained available for use. | SOP PQS14 – Recall Process will be reviewed to identify where the current recall process does not facilitate effective reconciliation and documentation of all products associated with the recall, including where a second check of the reconciliation is required.<br><br>The SOP will be updated to outline the reconciliation process for products received back into stock, those used by the end user and total issued to customers as well as how this data should be presented within the recall documentation.<br><br>The Head of Technical Services, Production and Quality leads and associated deputies will receive training regarding the updated RECALL SOP. These staff will be required to participate in the annual Recall validation to remain competent in identification of the actions required for differing levels of Recall. | **March 2022** | **Owner AD**<br><br>**Q-Pulse Ref: REG79**<br><br>**Completed** | |
| 3.3 | The technical agreement with Health Courier services did not state how quickly the site | As part of annual SLA review with Health Courier Service, the QA team will discuss | **May 2022** | **Owner GT/AD**<br>**Completed** | |

| | | | | |
|---|---|---|---|---|
| | should be notified of a temperature excursion of product during shipment to ensure that appropriate actions could be taken. | and identify the capacity for HCS to report in real time the event of a temperature excursions. This review with HCS will inform an updated Service Level Agreement between CIVAS@IP5 and Health Courier Service Wales to formalise time frames for notification of temperature excursions. The agreed time frame will be risk assessed for suitability.<br><br>This update and requirements for notification will be tested in a dummy recall event to ensure lines of communication and ability to identify temperature excursions do not place product or patient at risk. | | |
| 4.1 | The site should review the available stability data for the product portfolio to ensure that the expiry date of 89 days is reflective of available data and meets the associated requirements. | There will be an internal review of all procedures and documentation in relation to assigning of product shelf life. This will also include a review of all currently assigned shelf lives for live products supplied and detail the recommendations with MHRA Q&A 2015 relating to the assigning of product shelf lives.<br><br>Further sterility and syringe integrity testing will also be reviewed. | **April 2022** | **Owner AD/ET**<br>**Q-Pulse Ref: CC31**<br>**In progress** |

# CIVAS@IP5

Gareth Tyrrell

# MHRA Inspection – February 15th & 16th 2022

- Inspection covered all licenced activity within the facility
  - Licenced "Specials" Manufacturing
  - COVID-19 Vaccination Pack-down
- 2-day forensic inspection of all aspects of Pharmaceutical Manufacturing and Quality Management
- Adherence to Human Medicines Regulations 2012
- Outcome of inspection is a risk rating and associated re-inspection interval – pending completion of action plan.

# POSITIVE OUTCOMES

- Documented feedback during inspection closeout:
  - "very well trained staff and good processes"
  - "No issues with vaccine pack down process"
  - "very good environmental control of the facility"
- 24 month inspection interval – Feb 2024
- Assigned low-risk status
- Learning shared with unit across Wales to drive standards

# MHRA DEFICIENCY CLASSIFICATION

- **Critical:** *a deficiency in pharmacovigilance systems, practices or processes that adversely affects the rights, safety or well-being of patients or that poses a potential risk to public health or that represents a serious violation of applicable legislation and guidelines. – zero identified during inspection.*

- **Major:** *a deficiency in pharmacovigilance systems, practices or processes that could potentially adversely affect the rights, safety or well-being of patients or that could potentially pose a risk to public health or that represents a violation of applicable legislation and guidelines. – two "Major" deficiencies identified.*

- **Other:** *a deficiency in pharmacovigilance systems, practices or processes that would not be expected to adversely affect the rights, safety or well-being of patients. – Three "Other" deficiencies identified.*

- **Comments:** *not an identified deficiency but an identified process that could be refined to be better engineered – One comment identified.*

# MHRA IDENTIFIED DEFICIENCIES

- **MAJOR DEFICIENCY – Documentation**
  - Two examples of incomplete documentation identified.
  - Re-recording of ingredient batch numbers and expiry dates did not re-occur at point of manufacture. This is a new increase in standards not yet published but is the default expected standard.

- **MAJOR DEFICIENCY – Contamination Control**
  - Unit fabric had deteriorated in areas.
  - Single use sterile goggles not used.
  - Lack of detail in investigations of environmental events & no proactive trending of data.
  - Out of date process validation due to operator sickness absence.

- **OTHER – Recall Process Deficient**
  - More detail required during the product recall process within the procedures
  - No time period for reporting temperature deviations by HCSW to CIVAS@IP5 in Technical agreement

- **COMMENT**
  - Requirement to review expiry dates and provide maximum that data will allow

# MHRA ACTION PLAN

| Deficiency | Action Plan | Target Date | Status |
|---|---|---|---|
| Documentation Practice – improve ingredient reconciliation at point of manufacture & avoid occurrence of incomplete documentation | 1. Full review of process to identify suitability of batch documentation layout and process<br>2. Implement barcode scanning of ingredients to improve data integrity and traceability<br>3. Full staff training in data integrity principles and ALCOA+ | April 2022<br><br><br><br>August 2022<br><br><br><br>March 2022 | Completed<br><br><br><br>Ongoing<br><br><br><br>Completed |
| Contamination Control | 1. Ensure single use sterile goggle worn in Grade A areas<br>2. Further justification for investigation outcomes required. Additional training for investigation staff and introduction of MDT process for reviewing events<br>3. Ensure proactive trending using MRS system installation<br>4. Clean room contractor to address fabric issues and also introduce monthly routine unit fabric assessment | April 2022<br><br>August 2022<br><br><br><br><br><br>August 2022<br><br>May 2022 | Completed<br><br>Ongoing<br><br><br><br><br><br>Ongoing<br><br>Completed |
| Management of Recall Procedure | 1. Update procedure to detail chain of custody exchanges<br>2. Update procedure to outline receipt reconciliation after a recall activated<br>3. Outline timeframes for HCSW notification of temperature excursion | March 2022<br><br>March 2022<br><br><br>April 2022 | Completed<br><br>Completed<br><br><br>Completed |

# Summary

- 2 majors – Documentation and Contamination Control

- 3 Others – All related to Recall procedure

- 1 Comment – Product Expiry dates

- Unit assigned the lowest risk rating and longest inspection interval available to the MHRA

- Next inspection in Feb 2024

# QUALITY, SAFETY & PERFORMANCE COMMITTEE

# GOLD COMMAND HIGHLIGHT REPORT

| DATE OF MEETING | 12th May 2022 |
|---|---|

| PUBLIC OR PRIVATE REPORT | Public |
|---|---|

| IF PRIVATE PLEASE INDICATE REASON | Not Applicable - Public Report |
|---|---|

| PREPARED BY | Kay Barrow, Corporate Governance Manager |
|---|---|
| PRESENTED BY | Lauren Fear,<br>Director of Corporate Governance & Chief of Staff<br>Nicola Williams,<br>Executive Director Nursing, AHPs & Health Science<br>Cath O'Brien, Chief Operating Officer<br>Dr Jacinta Abraham, Executive Medical Director |
| EXECUTIVE SPONSOR APPROVED | Lauren Fear,<br>Director of Corporate Governance & Chief of Staff<br>Nicola Williams,<br>Executive Director Nursing, AHPs & Health Science<br>Cath O'Brien, Chief Operating Officer<br>Dr Jacinta Abraham, Executive Medical Director |

| REPORT PURPOSE | FOR ASSURANCE |
|---|---|

| ACRONYMS | |
|---|---|
| COVID | Coronavirus |
| SACT | Systemic Anti-Cancer Treatment |

## 1. PURPOSE

This paper has been prepared to provide the Quality, Safety & Performance Committee with details of the key issues and items considered by **GOLD COMMAND** at its meetings held between the **23/03/2022** to **27/04/2022**.

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

## 2. BACKGROUND

To ensure a combined and coordinated response to the emergence and prevalence of the Omicron variant the Velindre University NHS Trust re-activated its agreed dedicated incident Command and Control structure on the 15/12/2021. The structure provides a formal escalation and de-escalation path and is consistent with the nationally recognised three-tiered Command and Control structure. This has included a strengthened clinical support infrastructure, ensuring effective agile decision making with robust clinical oversight, placing clinicians (Medical, Nursing, AHP's, & Health / Clinical Scientists) firmly at the centre of risk-based decision making.

## 3. HIGHLIGHT REPORT

The following areas were highlighted for reporting to the Quality, Safety & Performance Committee from the GOLD COMMAND meetings held between the **23/03/2022** to **27/04/2022**.

| | |
|---|---|
| **ALERT / ESCALATE** | • **DELIVERY OF SYSTEMIC ANTI-CANCER TREATMENT THERAPY (SACT) WITHIN TARGET TIMESCALES (21 DAYS)**<br><br>Systemic Anti-Cancer Treatment Therapy (SACT) performance is covered in more detail within the Velindre Cancer Service Performance Report however, Gold Command continues to receive regular updates providing a detailed analysis of the current position in relation to the Velindre Cancer Service ability to meet demand for SACT as a result of the impact of COVID and non-COVID related staff absences.<br><br>As at **27/04/2022**, Gold Command was advised that newly referred patients will be provided with a first treatment date in a range from 2 to 7 weeks following initial referral. The longest waits are in the range of 6 to 7 weeks and the longest anticipated wait for any patient scheduled, currently, to begin treatment in May 2022 is 42 days. In addition to the enhanced business continuity measures that are in place to mitigate the risks as far as possible and to ensure service |

| | |
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| <br><br><br><br><br><br><br><br><br><br><br><br><br><br><br> | delivery, the Clinical Prioritisation Framework is being used for clinical patient prioritisation. This involves a daily SACT prioritisation meeting to ensure that patients are prioritised for treatment in line with risk. Due to this increase in the waiting times for commencement of treatment, an assessment of the risk and mapping of the impact of harm, plus projections for the coming months is being undertaken, aligned to the national guidance.<br><br>Patients are advised of potential delays at the point of booking and asked to contact the service if they do not hear from the Velindre Cancer Centre within 3 weeks.<br><br>The SACT Delivery Task Force Group is reviewing and assessing all options available on the SACT treatment pathway, in order to identify and secure the required nurse staffing and also fully consider the wider workforce capacity, to ensure effective optimisation and consideration of all key elements. |
| **ADVISE** | • **GOLD COMMAND**<br><br>The frequency of Gold Command meetings is continually assessed and flexed in line with the needs of the incident and its interface with the Welsh Blood Service and Velindre Cancer Service Silver Commands.<br><br>The requirement for Gold Command to continue to remain in place was reviewed and discussed on **16/03/2022**. At that time, it was agreed that Gold Command and its supporting incident structure arrangements will continue to remain in place. This is due to the continuing number of staff absences and related operational pressure in both of the core divisions, despite the change to the Welsh Government COVID-19 Guidance around isolation. However, following the Gold Command meeting held on **27/04/2022**, the Senior Responsible Officer (SRO) made the decision that due to the core matters being part of performance reports for both Divisions, it was agreed that Gold Command should transition to the next stage of being incorporated into the twice monthly Executive Management Board (EMB) meetings. This will be included as a dedicated section on the EMB agenda to ensure continued specific Command Control governance until a decision is made in future to incorporate back into the usual governance arrangements for the Trust. |

- **GOLD COMMAND TERMS OF REFERENCE**

At its meeting on **20/04/2022**, Gold Command agreed to a revision to its Terms of Reference to include incident management. However, following clarification at its meeting on **27/04/2022**, it was agreed that incident management would remain as part of Business Continuity arrangements.

- **COVID RISKS**

The risk profile associated with the increased prevalence of the Omicron variant continues to reduce and is being carefully monitored. The key risks continue to be associated with staffing levels as a result of the impact of COVID and non-COVID related staff absences presenting continued difficulty within both of the core operating divisions of the Trust. This remains intermittently acute in the Systemic Anti-Cancer Treatment (SACT) service and the Blood Collection Teams and daily monitoring and planning are in place.

Performance reporting for the Velindre Cancer Service and Welsh Blood Service is covered in more detail within the separate Committee reports included on the agenda. The following are the key highlights reported to Gold Command during this reporting period:

- **VELINDRE CANCER SERVICE**

    o *Staff Absence:* Whilst the main impact of COVID Wave 4 for the Velindre Cancer Service remains staff absence and the resulting impact on ability to provide services to all patients within the required timescales.

    o *Activity:* COVID and non-COVID related staff absence is having an impact on activity in the following areas:

        – *SACT:* Longer than normal wait for newly referred patients to begin SACT treatment as outlined above. The SACT Delivery Task Force is reviewing the SACT treatment pathway to address key risks in respect of SACT delivery.

        – *Radiotherapy:* Due to the large number of treatment radiographers' absences in late March 2022 and early April 2022, it is anticipated that the number of time-to-

radiotherapy breaches will increase. The breach position as at the end of March 2022 was 12 patients waiting between 29-35 days and 6 over 35 days after referral to undergo radiotherapy with radical intent treatment. Outliers are unusual and any such delays are typically due to constraints in certain specialist services (e.g. brachytherapy, Stereotactic radiosurgery (SRS), etc.). In such instances, patients are subject to appropriate clinical management.

Radiotherapy patients who may face potential delays are managed on a case by case basis and will be contacted by the Velindre Cancer Centre should an alternative appointment need to be arranged.

- o *Health Boards:* A formal meeting structure with Operational Managers at Health Boards has been established in order to ensure the Velindre Cancer Service have a clear and up to date view of the current COVID position within each of the Health Boards and expected impact on Velindre Cancer Services demand.

- o *COVID Outbreak First Floor Ward:* Gold Command have been receiving updates at each meeting in relation to an outbreak of COVID on First Floor Ward involving 5 patients (2 of which were not acquired at the VCC). All patents had no or low impact from COVID. There was good compliance with all standards and no breaches in practices identified. The Outbreak was formally declared over on the 28th April 2022.

- **WELSH BLOOD SERVICE**

  - o *Blood / Blood Products Stock levels:* Overall Amber status with the Blue Alert revised as at 27th April 2022 to remain at O positive only however, monitoring of the O negative position will continue. Collections are being maintained with targeted blood group collection to reduce the risk to relevant blood stock levels and will continue to be proactively monitored and extra sessions are planned.

    - – Red cell stock levels are continuing on a downward trend and now reporting an Amber position. The position is being closely monitored.

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| | - The change in guidance in relation to physical distancing has provided the opportunity to increase the Donor chair capacity within clinics and additional clinics. However, with the continued staffing pressures this has remained challenging to maintain on an ongoing basis and impacting on Collection Clinic volumes.<br><br>o **Staff Absence:** Increasing staff pressure and prolonged absences due to COVID related reasons within Collections and Clinical Services. However, implementation of local mitigation and contingency arrangements continue. Collections are maintaining full operation with proactive monitoring being undertaken to manage stock levels. Daily resourcing meetings are being conducted and resulting adjustments to clinics are made wherever necessary. Appointment booking is specific blood type focused to refine supply demand alignment. |
| **ASSURE** | On **23/03/2022** Gold Command received and noted the **PPE Stock Level Assurance Report** and agreed that this metric would be included as part of the developing Gold Prototype Dashboard.<br><br>• **GOLD PROTOTYPE DASHBOARD**<br><br>Gold Command continues to refine the datasets for inclusion in the prototype Dashboard that will provide key information drawn from the various Trust systems into an 'at a glance' report. On **27/04/2022** it was agreed that further refinement was required to the definitions and additional information columns for the final version. |
| **INFORM** | On **23/03/2022** Gold Command was informed that the **COVID Enquiry Preparation Group** had restarted and that the Terms of Reference for the national enquiry were being published in draft.<br><br>• **CLOSURE OF THE SHIELDING PATIENT LIST**<br><br>On **23/03/2022** Gold Command received the Deputy Chief Medical Officer (DCMO) letter informing of the closure of the Shielding Patient List from 31 March 2022. Following discussion, it was agreed that a review of staff not currently in their substantive role due to shielding requirements would be undertaken in order to provide appropriate support for returning to normal working in their substantive role. |

- **REMOTE WORKING PRINCIPLES**

Following receipt of the revised Welsh Government COVID Guidance, Gold Command considered on **30/03/2022** the draft Remote Working Principles that have been developed by the Trust's Agile Working Group. The draft Principles are a first step in formalising the Trust's strategic direction of travel as part of the wider work being undertaken in the development of the Trust's Agile Working Policy. The draft Principles provide high level guidance to Line Managers and staff as a first step in moving towards a more flexible and hybrid way of working.

Whilst some roles can be fully remote or a mixture of remote and site based, other roles will require staff to work all their hours at their identified place of work. It is recognised that personal circumstances may impact on the ability for an individual to work remotely or otherwise. Therefore, there will be a requirement for discussions between Line Managers and staff before a formal agile/remote working arrangement is put in place as the model of working will need to be suitable to meet the service delivery needs.

Gold Command agreed that further work was required to refine the draft Principles in preparation for submission to the Executive Management Board on **19/04/2022**.

- **COVID RESPONSE CELL**

As a result of the revised Welsh Government COVID Guidance and the de-escalation of PCR testing for asymptomatic cases and the shift to the use of lateral flow device testing, the Wales Cancer Network reviewed the optimal pre-treatment testing requirements specifically for oncology patients. The recommendations from the review by the Wales Cancer Network were considered by the COVID Response Cell. The following recommendations to revise the Trust's Protocol for Patient Testing made on a risk assessed basis (risk of delivery of critical services balanced with COVID transmission risks) were presented to the Gold Command on **20/04/2022** and approved:

  - **Asymptomatic patient testing pre-treatment/outpatient attendance - Pre-treatment LFD/PCR testing for elective theatre cases and SACT to continue at least until end of June 2022:** Shift to the use of lateral flow testing for SACT,

| | |
|---|---|
| | Radiotherapy and Radio-Iodine treatments and theatre cases to have a PCR test <72 hours in advance of admission; <br> o **Asymptomatic inpatient testing – Asymptomatic elective admissions should continue to have a PCR undertaken <72 hours prior to admission:** Any emergency admissions should continue to be admitted to a side room and have a rapid PCR test undertaken until COVID status known however, the day 5 inpatient COVID testing to cease; <br> o **Asymptomatic Staff Testing:** Asymptomatic staff LFD testing should continue twice a week with a review in early May 2022. <br> o **Asymptomatic External Contractor Testing:** Contractors to continue to be advised to follow the Trust staff testing guidelines, with contractors working in patient areas advised to undergo twice weekly LFD testing. A supply of LFD to be provided to contractors at their Induction to the Trust. <br><br> On **20/04/2022** Gold Command received the revised UK Infection Prevention and Control Guidance for Seasonal Respiratory Infections in Health and Care Settings (including SARS_CoV-2) for winter 2021 to 2022 updated 14/04/2022. Particular attention was drawn to section 6.7.2 – stepping down COVID precautions for exposed patient contacts in hospital settings – no longer need to isolate if asymptomatic. Gold Command requested that the COVID Response Cell undertake a review of the admission criteria and day 5 screenings. <br><br> Gold Command received and noted the revised **Staff COVID Guidance Flowchart** that had been updated in line with the current Welsh Governance COVID Guidance. |
| **APPENDICES** | ~ |

# QUALITY, SAFETY AND PERFORMANCE COMMITTEE

# WORKFORCE & ASSOCIATED FINANCE RISKS

| DATE OF MEETING | 12TH May 2022 |
|---|---|

| PUBLIC OR PRIVATE REPORT | Public |
|---|---|

| IF PRIVATE PLEASE INDICATE REASON | Draft Status - Final Version will be Published in Public Domain |
|---|---|

| PREPARED BY | Susan Thomas, Deputy Director of W&OD & Chris Moreton, Deputy Director of Finance |
|---|---|
| PRESENTED BY | Sarah Morley, Executive Director of OD and Workforce<br>Matthew Bunce, Executive Director of Finance |
| EXECUTIVE SPONSOR APPROVED | Sarah Morley, Executive Director of OD and Workforce<br>Matthew Bunce, Executive Director of Finance |

| REPORT PURPOSE | FOR NOTING |
|---|---|

| COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING | | |
|---|---|---|
| COMMITTEE OR GROUP | DATE | OUTCOME |
| Executive Management Board | 27.04.2022 | NOTED |

| ACRONYMS | |
|---|---|
| IMTP | Integrated Medium Term Plan |
| HB | Long Term Agreement |
| LTA | Health Board |
| WBS | Welsh Blood Service |
| WTAIL | Welsh Transplantation and Immunogenetics Laboratory |

| WG | Welsh Government |
|-----|------------------|
| VCC | Velindre Cancer Centre |

## 1. SITUATION/BACKGROUND

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

## 2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

**2.1 Key Workforce & Associated Financial Risks**

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

**Workforce**

- **Workforce Supply and Shape**.
    - Clear service and workforce plans are required to articulate the skills required to meet both current and future demand. Particular areas of focus are Radiotherapy and Medical staff, Velindre Futures/TCS projects and Laboratory Modernisation in the Welsh Blood Service

    - The supply of staff, due to the funding streams supporting a number of projects over the years the Trust, has resulted in a significant number. of staff (c185) on fixed-term contracts. The Workforce team is currently reviewing all contracts with operational teams to provide a current and updated picture of contractual status in order to quantify risk of any redundancy cost associated with these contracts

- **Wellbeing**
    The COVID pandemic has resulted in a generally higher levels of sickness absence compared to pre-Covid. The main reason for absence remains stress and anxiety. The Trust, throughout COVID, has provided a raft of wellbeing interventions to support staff and the Workforce

teamwork with hotspot areas to ensure targeted interventions are provided

- **Recruitment and Retention**
  - The Trust has 141wte vacancies, 97wte in clinical roles. A Recruitment and Retention plan is being developed with targeted specific intentions in hotspot areas

**Actions:**

- **Workforce Supply and Shape**
  - Robust 5-year workforce plan to enable timely recruitment to fill vacancies reducing agency, TOIL and overtime payments accordingly in the short term and looking at skill mixing and role re-design in the medium term.
    - Workforce models in development - Radiotherapy satellite Centre, All Wales Non-surgical oncology workforce plan, New Cancer Centre Workforce Model
    - Departmental short-term operational plans in place to support workforce development and change
    - Introduction of apprenticeships, advanced practice roles, Physician Associate and HCSW development roles
    - Monitoring the diversity of the workforce to improve and develop via the Equality action plan
    - Number of Welsh language learner to deliver the Welsh language standards

- **Wellbeing**
  - Continue to provide support to teams to manage sickness, with particular focus on hotspot areas. A Trust wide Health and Wellbeing Steering group has been established to provide a holistic overview and assurance to the Executive Board that effective interventions are being undertaken and good practice is shared across the Trust. During COVID staff have often needed to adapt to a hybrid working model. This work will be progressed over the forthcoming months with a focus on supporting staff's wellbeing in different working environments.

- Respectful Resolution toolkit to support managers and staff and develop a positive culture.
- Agile working principles to support a hybrid working environment
- Development of physical wellbeing spaces for staff eg Bobarth
- Recruiting a Staff Psychologist to support in the Development of the Trust's health and wellbeing plan
- Programme of work undertaken to review values
- Aligning hotspot areas of sickness with targeted wellbeing interventions

- **Recruitment and Retention**
  - Work ongoing to:

    - Ensure robust baseline recruitment data in line with effective recruitment processes
    - Deliver effective attraction strategies
    - Develop pilots of new ways of working (in line with effective workforce planning)
    - Create retention strategies to improve retention rates
- Develop one corporate brand; create a social media campaign,
- Recruitment – task and finish group to streamline internal processes
- Task and Finish group to target recruitment hotspots - work with universities for hard to fill roles.
- Development of current induction Programme to ensure effective onboarding
- Development of values-based recruitment Programme – focusing on recruitment the right people for the right roles

**Financial**

- The Trust has reported a cumulative year to date position of £727k (Feb '22) underspent on pay and is forecasting an outturn underspend of circa £711k. However, whilst the Trust pay budgets are underspent due to significant vacancies, the total spend on agency for 2021/22 is £1,906k. **It is estimated that c£500k of the total agency spend of £1,906k relates to premium cost that could be saved if the Trust were able to recruit permanently.**

- The cost of sickness is reflected in the pay costs through use of agency and overtime and provision of TOIL. Reduction in sickness absences rates has a direct impact on reducing the variable pay bill to cover absences.

- Over the past 12 months, the financial value of lost productivity due to sickness in the Trust is estimated to be £2.1m, with 31% of this related to anxiety, stress and depression.

- Covid response & recovery funded posts are the key financial risk for the Trust given the uncertainty regarding the Covid income sum for 2022-23:

  o 72.5wte staff have been recruited permanently to respond and recover from Covid with a cost of £3,600k p.a. A further 38wte staff with a cost of £2,659k p.a. are in the process of being recruited, a total of 110.5wte staff and £6,263k cost p.a.
  o Of the 72.5wte staff, 33wte relate to Covid response which Commissioners have indicated they can't provide funding for amounting to £1,300k.
  o Commissioners have included funding in their IMTPs for the Trust Covid recovery plans, however the risk to the Trust is that funding will flow as marginal income based on activity the Trust treats above its baseline 19-20 levels. The costs are already committed to establish extra capacity which presents a financial risk to the Trust should the activity not flow as forecast. The Chief Exec and DoF are seeking recognition from commissioners to this in terms of the flow of funds.
  o A further risk relates to the outsourced activity for which the Trust must pay a premium cost of x3 times its own marginal rates. Agreement with

commissioners is being sought on the mechanism to enable the premium cost element to be funded.

- o Correspondence on 14.03.22 from Director General for H&SC to Chief Executives has set out that WG will provide funding cover for specific Covid response costs. This is being worked through to assess if there remains any risk around funding of Covid response staff costs.
- o Exceptional and COVID costs for 2022/23 are being reported on a monthly basis to the Finance Delivery Unit as part of a monitoring process to inform Welsh Government of costs at risk.
- o Long Term Agreements for Commissioners have been drafted to reflect the 2022/23 cost profile and have been circulated to Commissioners for review and agreement.

- The W&OD and Finance team will work with departments to manage any associated workforce risk regarding Covid staff recruited permanently where funding is no longer available. This will be through re-deployment into vacancies or redundancy. However, given that the Commissioner funding is recurrently provided to them by WG for Covid recovery and WG has recently confirmed as noted above that they will fund Covid response costs, the Trust is better placed to plan for and manage these risks.

**Actions:**

- Finance and workforce senior leadership teams will convene a workshop to identify the priority areas of workforce and financial risk, understand the challenges and opportunities to improve finance and workforce reporting for 2022/23.
- The output from the workshop will be used as the basis to develop a programme of work that will support reporting improvement in 2022/23.
- As part of continuous improvement, the finance team are working with W&OD to:
  - o Support departments with high use of agency to recruit permanently into substantive vacancies as quickly as possible, subject to market conditions.
  - o Implement alternatives to agency where possible, such as establishment of Bank staffing and agreeing overtime, however these options may be considered unsustainable given the high level of vacancies and sickness levels

This work is ongoing and updates will be provided in future reports, including the potential financial risk around permanently recruited posts and funding.

**3.  IMPACT ASSESSMENT**

| | |
|---|---|
| **QUALITY AND SAFETY IMPLICATIONS/IMPACT** | There are no specific quality and safety implications related to the activity outined in this report. |
| | |
| **RELATED HEALTHCARE STANDARD** | Governance, Leadership and Accountability |
| | If more than one Healthcare Standard applies please list below: |
| **EQUALITY IMPACT ASSESSMENT COMPLETED** | Not required |
| | |
| **LEGAL IMPLICATIONS / IMPACT** | There are no specific legal implications related to the activity outlined in this report. |
| | |
| **FINANCIAL IMPLICATIONS / IMPACT** | Yes (Include further detail below) |
| | Covid staff costs that may not be fully covered by WG or Commissioner income |
| | Ongoing premium cost of agency |

**4.  RECOMMENDATION**

**4.1**  The Quality, Safety and Performance Committee is asked to **NOTE** the contents of the report.

# QUALITY, SAFETY & PERFORMANCE COMMITTEE

# FINANCE REPORT FOR THE PERIOD ENDED
# 31 MARCH 2022 (M12)

| DATE OF MEETING | 12 May 2022 |
|---|---|

| PUBLIC OR PRIVATE REPORT | Public |
|---|---|

| IF PRIVATE PLEASE INDICATE REASON | Not Applicable - Public Report |
|---|---|

| PREPARED BY | Steve Coliandris, Financial Planning & Reporting Manager |
|---|---|
| PRESENTED BY | Matthew Bunce, Executive Director of Finance |
| EXECUTIVE SPONSOR APPROVED | Matthew Bunce, Executive Director of Finance |

| REPORT PURPOSE | FOR NOTING |
|---|---|

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

| ACRONYMS | |
|---|---|
| IMTP | Integrated Medium Term Plan |
| WBS | Welsh Blood Service |
| WTAIL | Welsh Transplantation and Immunogenetics Laboratory |
| WG | Welsh Government |
| VCC | Velindre Cancer Centre |

## 1. SITUATION/BACKGROUND

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

## 2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

**2.1 Performance against Key Financial Targets:**

| | Unit | Current Month £000 | Total Actual 2021-22 £000 |
|---|---|---|---|
| **Revenue** | Variance | 23 | 28 |
| **Capital** (To ensure that costs do not exceed the Capital Expenditure limit) | Actual Spend | 6,020 | 12,426 |
| **Public Sector Payment Performance** (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid). | % | 90.7% | 94.3% |

## 2.2 Revenue Budget

The overall position against the profiled revenue budget for 2021-22 was an underspend of **£28k**, with a large pay underspend due to the Trust carrying a large number of vacancies being throughout the year, which offset a non-pay overspend and underachievement on income.

A large element of the underachievement on planned income relates to WBS WTAIL and Blood Components due to the impact of Covid.

Cost pressures which surfaced during the year, were in line with normal budgetary control procedures, and were managed by budget holders to ensure the delegated expenditure control limits were not exceeded for 2021-22.

The Trust overachieved against the savings target during 2021-22 which is due to increased vacancy factor which was above the target that was held within the divisions.

**All Covid related expenditure requirement was funded by WG during 2021-22**

### 2.3    PSPP Performance

PSSP performance for the whole Trust was 95.7% against a target of 95%, however the performance against the Core Trust excluding NWSSP fell just short at 94.3%.

PSPP compliance levels had significantly recovered following a temporary dip in performance, however since December performance levels have again fallen. Following investigation, it appears to be largely the result of reduced levels of receipting on orders which is most likely due to the high levels of sickness which currently being experienced throughout the Trust. Finance have been working with service colleagues to put measures in place to help rectify this issue.

The finance teams continue to work with the service and NWSSP colleagues with a view to improve performance on the core Trust during 2022-23.

### 2.4    Covid Expenditure

| Covid-19 Revenue Spend/ Funding | | | |
|---|---|---|---|
| | Total Actual 2021/22 £000 | Total Funding Received £000 | Variance to Funding allocated £000 |
| Mass & Booster Covid Vaccination | 392 | 392 | 0 |
| Cleaning Standards | 831 | 769 | 62 |
| PPE | 195 | 226 | (31) |
| Covid Recovery | 3,098 | 3,479 | (381) |
| Other Covid Related Spend & Cost Reduction | 1,624 | 1,274 | 350 |
| BFWD Savings Loss | 700 | 700 | 0 |
| Return of Bonus Payment (over allocated) | (83) | (83) | 0 |
| Annual Leave Provision & Sell Back Scheme | 332 | 187 | 145 |
| SDEC Emergency Care Funding | 77 | 77 | 0 |
| **Total Covid Spend /Funding Requirement 2021/22** | **7,166** | **7,021** | **145** |

The overall gross funding requirement related to Covid for 2021-22 was £7,021k which included £6,217k of directly associated expenditure or cost reduction, £700k in relation to the non-achievement of savings carried forward from 2020/21, the return of surplus NHS bonus payment £(83)k, and the costs associated with the Annual leave sell back scheme £187k.The £145k annual leave provision was met through the Trust savings plans and additional vacancy factor.

**2.5     Reserves**

The financial strategy for 2021-22 facilitated the development of a recurrent and non-recurrent reserve in support of the Trust transformation and delivery agenda. These reserves could only be accommodated on the basis that all income expectations are received, planned savings schemes delivered and new emerging cost pressures managed. In addition, the Trust holds an emergency reserve of 522k.

**2.5.1   Recurrent Reserves (budget unallocated):**

The unspent recurrent reserve balance of £766k will be carried forward for utilisation during 2022-23 against previously agreed commitments.

**2.6     Financial Risks**

All operational financial risks that emerged during the year were mitigated within the overall Trust budget for 2021-22.

**2.7     Capital**

**a)  All Wales Programme**

The total cumulative spend on the All-Wales Capital Programme schemes was £10,525k for 2021-22. As previously highlighted, there were several challenges last financial year which was a combination of procurement capacity constraints, the impact of the pandemic on supplier lead times, and current market conditions where costs have significantly increased. All this resulted in movement and variances being reported in actual spend against approved funding against some of the all Wales schemes, however following discussions with WG this was managed across the whole of the All Wales Programme to ensure that the CEL was achieved for 2021-22.

The Trust discretionary actual spend for 2021-22 was £1,901k against an approved CEL of £1,911k leaving a balance of £10k on the overall Capital Programme.

Other Major Schemes in development that will be considered during the remainder of 2021/22 and in 2022/23 in conjunction with WG include, Integrated Radiotherapy Solution (IRS), WBS HQ, VCC Ventilation & Infrastructure/ Outpatients, and WBS Plasma fractionation (for medicines).

**3.      IMPACT ASSESSMENT**

| | |
|---|---|
| **QUALITY AND SAFETY IMPLICATIONS/IMPACT** | There are no specific quality and safety implications related to the activity outined in this report. |
| | |
| **RELATED HEALTHCARE STANDARD** | Governance, Leadership and Accountability |
| | If more than one Healthcare Standard applies please list below: |
| **EQUALITY IMPACT ASSESSMENT COMPLETED** | Not required |
| | |
| **LEGAL IMPLICATIONS / IMPACT** | There are no specific legal implications related to the activity outlined in this report. |
| | |
| **FINANCIAL IMPLICATIONS / IMPACT** | Yes (Include further detail below) |
| | The Trust reported a financial position of **£28k** for 2021-22 which is in line with the IMTP |

## 4. RECOMMENDATION

**4.1** The Quality, Safety and Performance committee is asked to **NOTE** the contents of the March financial report and in particular the financial performance for 2021-22.

# *FINANCIAL PERFORMANCE REPORT*

## *FOR THE PERIOD ENDED MARCH 2021/22*

## QUALITY,SAFETY & PERFORMANCE COMMITTEE 12/05/2022

## 1. Introduction

The purpose of this report is to outline the financial position and performance for the year to date, performance against financial savings targets, highlights the financial risks, and forecast for the financial year, outlining the actions required to deliver the IMTP Financial Plan for 2021-22.

## 2. Background / Context

The Trust Financial Plan for 2021-22 was set within the following context.

- The Trust submitted a balanced one-year financial plan, covering the period 2021-22 to Welsh Government on the 30 June 2021.

- For 2021-22 the Plan (excl Covid) included;
  - an underlying **deficit of -£700k brought forward from 2020-21,**
  - FYE **of new cost pressures / Investment** of -**£9,307k,**
  - offset by **new recurring Income** of **£8,582k,**
  - and Recurring FYE **savings schemes** of **£925k.**

- Due to the ongoing pandemic and the inability to fully enact savings schemes & cost reduction, the Trust is not expecting to be able to fully eliminate the underlying deficit during 2021-22, however in line with the submitted financial plan the Trust will be aiming to reduce the deficit by £200k to carry forward an underlying position of £500k into 2022-23.

- **To reduce the underlying deficit, the savings target set for 2021-22 must be achieved.**
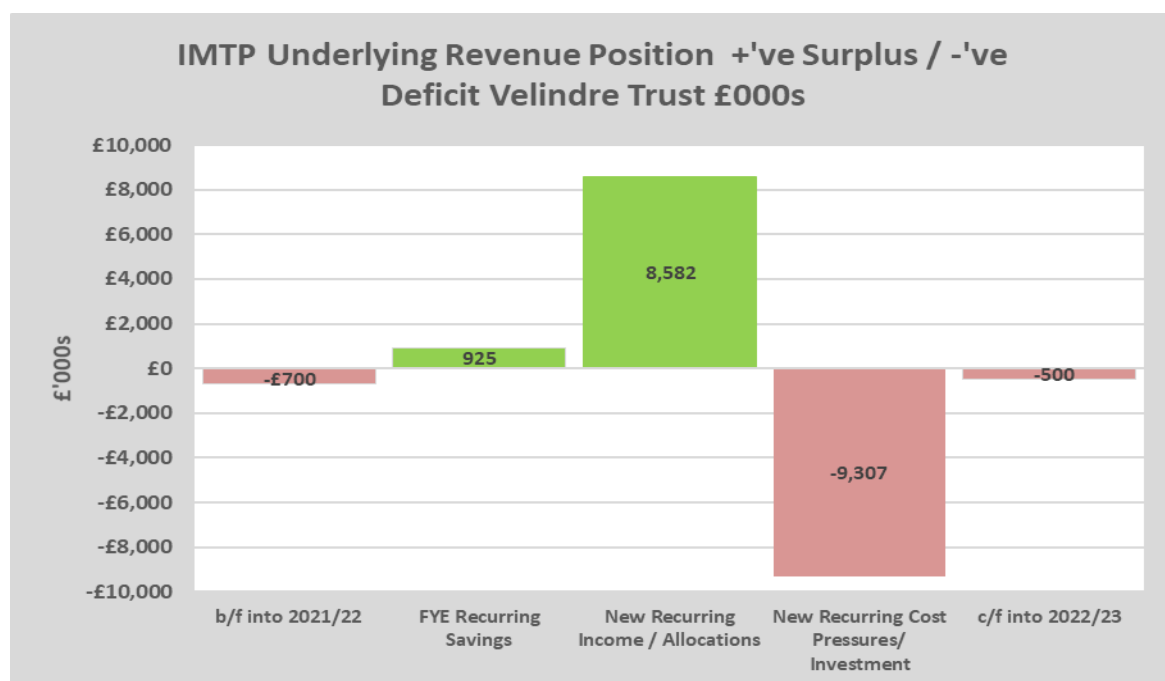


| Underlying Position +Deficit/(-Surplus) £000s | b/f into 2021/22 | Recurring Savings | New Recurring Income / Allocations | FYE New Cost Pressures/ Investment | c/f into 2022/23 |
|---|---|---|---|---|---|
| Velindre NHS Trust | - 700 | 925 | 8,582 | - 9,307 | - 500 |

## 3. Executive Summary

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

*(Figures in parenthesis signify an adverse variance against plan)*

**Table 1 - Key Targets**

|  | Unit | Current Month £000 | Total Actual 2021-22 £000 |
|---|---|---|---|
| **Revenue** | Variance | 23 | 28 |
| **Capital** (To ensure that costs do not exceed the Capital Expenditure limit) | Actual Spend | 6,020 | 12,426 |
| **Public Sector Payment Performance** (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid). | % | 90.7% | 94.3% |

**Performance against Planned Savings Target**

| Efficiency / Savings | Variance | 0 | 145 |
|---|---|---|---|

**Revenue**

The Trust reported a **£23k** in-month underspend position for March '22, with a cumulative final position for the core Trust of **28k** underspent for 2021-22.

**Capital**

The final approved Capital Expenditure Limit (CEL) for 2021-22 was £12,436k. This represented all Wales Capital allocation funding of £10,525k, and Discretionary funding of £1,911k**.** The Trust reported a total capital spend of **£12,426k** for 2021-22 leaving a remaining balance of **£10k**.

**PSPP**

During March '22 the Trust (core) achieved a compliance level of **90.7%** (February 22: 93.7%) of Non-NHS supplier invoices paid within the 30-day target, which gave a cumulative core Trust compliance figure of **94.3 %** for 2021-22, and a final total Trust position (including hosted) of **95.7%** compared to the target of 95%.

Since  December the PSPP compliance levels in have experienced a dip in performance which is following recovery being produced in the previous quarter. Urgent measures are being put in place to improve performance which has been significantly impacted by the ongoing pandemic and reduced levels of receipting on orders which is due to the high levels of sickness which currently being experienced in the Trust. The finance teams continues to work with the service and NWSSP colleagues with a view to improve performance on the core Trust during 2022-23.

**Efficiency / Savings**

The Trust overachieved against the savings target during 2021-22 which is due to increased vacancy factor which is above the target that is held within the divisions.

## Revenue Position

| 2021/22 Financial Position | | | |
|---|---|---|---|
| **£27,695 Underspent** | | | |
| **Type** | **Full Year Budget (£'000)** | **Full Year Actual (£'000)** | **Full Year Variance (£'000)** |
| Income | (172,310) | (171,622) | (688) |
| Pay | 76,945 | 75,592 | 1,353 |
| Non Pay | 95,365 | 96,003 | (637) |
| Total | (0) | (28) | 28 |

The overall final position against the profiled revenue budget for 2021-22 was an underspend of **£28k.**

**4.1 Revenue Position Key Issues**

Income Key Issues

- Income underachievement for 2021-22 largely related to activity being lower than planned on Bone Marrow and Plasma Sales in WBS which resulted in income loss above Covid support received during the period.
- Income underperformance was partly offset within VCC via an increase in VAT savings from providing additional SACT Homecare, and over performance of Private Patient income.

Pay Key Issues

The Trust has reported a final year end underspend of **£1,353k** on Pay for 2021-22.

Significant vacancies carried throughout the year resulted in a large underspend being reported against Pay.

The total Trust vacancies as at 31st March 2022 is 144wte, VCC (79wte), WBS (37wte), Corporate (1wte), R&D (19wte), TCS (1wte) and HTW (7wte).

The WTE by pay category is provided within the table below:

| Pay WTE By Category | | | |
|---|---|---|---|
| **Pay Type** | **WTE Budget** | **WTE Actual** | **WTE Variance** |
| ADD PROF SCIENTIFIC AND TECHNICAL | 58.40 | 51.20 | (7.20) |
| ADDITIONAL CLINICAL SERVICES | 257.04 | 233.83 | (23.21) |
| ADMINISTRATIVE & CLERICAL | 535.63 | 491.64 | (43.99) |
| ALLIED HEALTH PROFESSIONALS | 136.21 | 126.31 | (9.90) |
| ESTATES AND ANCILLIARY | 64.81 | 65.52 | 0.71 |
| HEALTHCARE SCIENTISTS | 165.26 | 155.51 | (9.75) |
| MEDICAL AND DENTAL | 99.49 | 68.94 | (30.55) |
| NURSING AND MIDWIFERY REGISTERED | 226.02 | 204.94 | (21.08) |
| STUDENTS | 2.47 | 2.93 | 0.46 |
| **Total Pay by Category** | **1,545.33** | **1,400.82** | **(144.51)** |

Non Pay Key Issues

The Trust reported a **£(637)k** overspend on Non-Pay for 2021-22.

- Large underspend experienced in WBS due to reduced costs from suppressed activity, underspend on Collections Services, Laboratory Services, WTAIL, and General Services.
- Release in year of dilapidations provision on Wrexham and Bangor sites due to new accounting treatment and introduction of IFRS 16.
- There are underspends on general drugs in VCC from reduced activity and temporary closure of outreach clinics.
- Other underspends within VCC includes release of accountancy measures, and unallocated reserves to fund overall position.
- Overspends in VCC on facilities management, canteen refurbishment and other site improvements, along with a rise in both consumable cost and usage.
- Printing / Stationary & Postage underspend across Trust due to a reduction in office-based activity and paper-based communications given the increased homeworking. A proportion of this underspend is anticipated to be permanent and will be taken as recurrent saving once the Trust has agreed the operating model of future working arrangements.
- The increase in energy prices has resulted in an overspend being reported against utility budgets. The exceptional cost pressures which include energy prices have been included within the Trust IMTP with reassurance form WG that these costs will be funded.
- Significant pressure on the Estates function to maintain and improve Trust sites especially within VCC.
- Divisional Savings targets met through additional Vacancy factor within Pay.

Further details on performance against Income, Pay and Non-Pay is provided within the Divisional analysis later in the paper.

**4.2 Pay Spend Trends (Run Rate)**

The pay spend for 2020/21 was 14.82% above av. pay in 2019-20. 3% was accounted for by the pay award, 1.14% can be accounted for by an increase in use of agency, 2.3% related to the NHS Bonus Payment with the remaining being the additional staff recruited over the course of 2020/21 (c. 126 wte), and the pay costs associated with Covid.

Staff received the 2021/22 pay award of 3% and arrears dated back to April 2021 in their September pay. Excluding the Pay award, spend is still increased throughout the year with the

recruitment of additional posts to meet 'surge' capacity in both VCC and WBS which is in response to Covid recovery. Whilst the plan was to reduce agency costs within the Trust Core staffing structure, due to the difficulty being experienced in recruitment, the agency staff replaced with substantive recruits will now be utilised as part of the Covid recovery.



Actual / F'cast Pay Expenditure 21/22 and Average actual 20/21 & 19/20
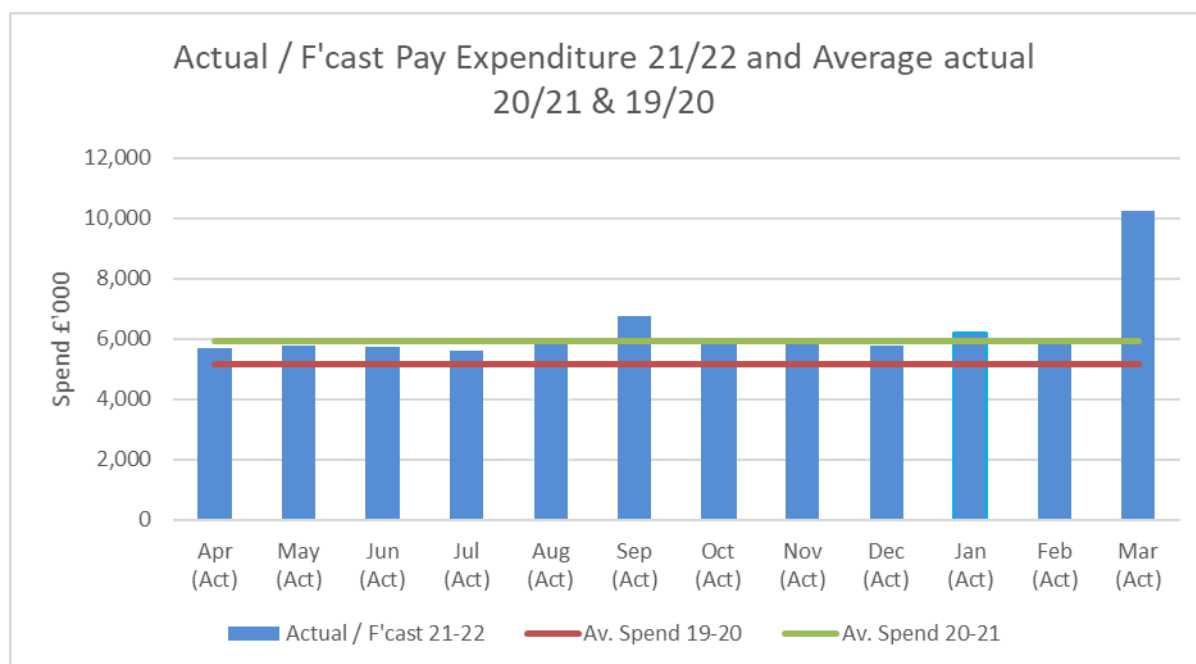
*Sep costs include Pay Award (3%) backdated to April.

*During January Staff who were on bands 1-5 received a 1% non consolidated pay award.

*March pay includes the 6.3% notional pension award funded via WG. and annual leave sell back and carry forward provision.



Changes in Total WTE 2020-21 to 2021-22
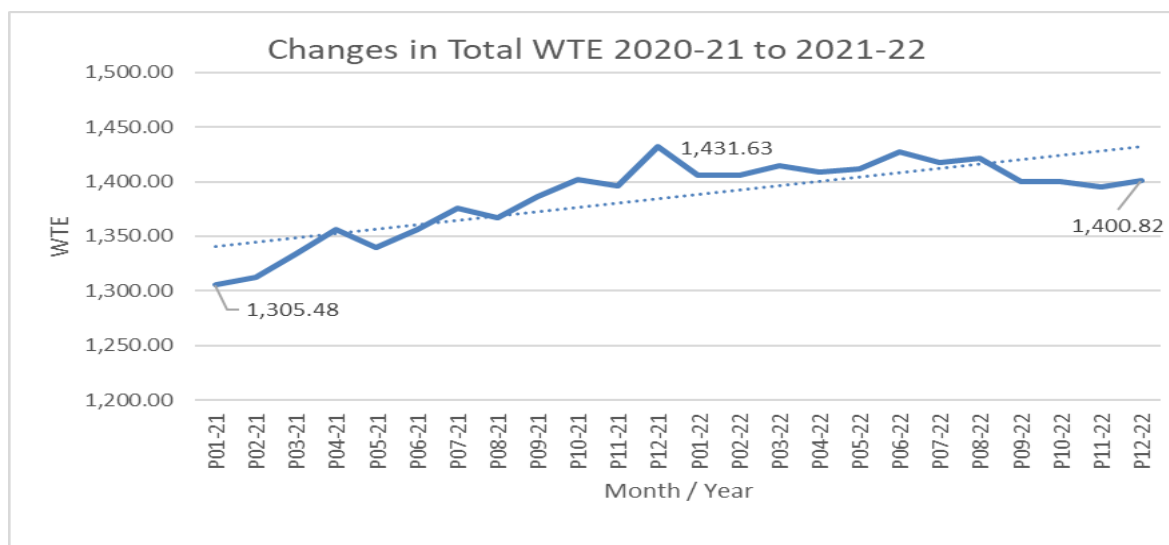
* Reduction in WTE since March 21 is largely due to ceasing of the Patient Vaccination programme.

The spend on agency for March was £196k (February £186k), which gives a cumulative total for the year of **£1,906k.** Of these totals the year to date spend on agency directly relating to Covid was **£826k.**

6

Agency actual / f'cast Expenditure 21/22 and Average actual 20/21 & 19/20
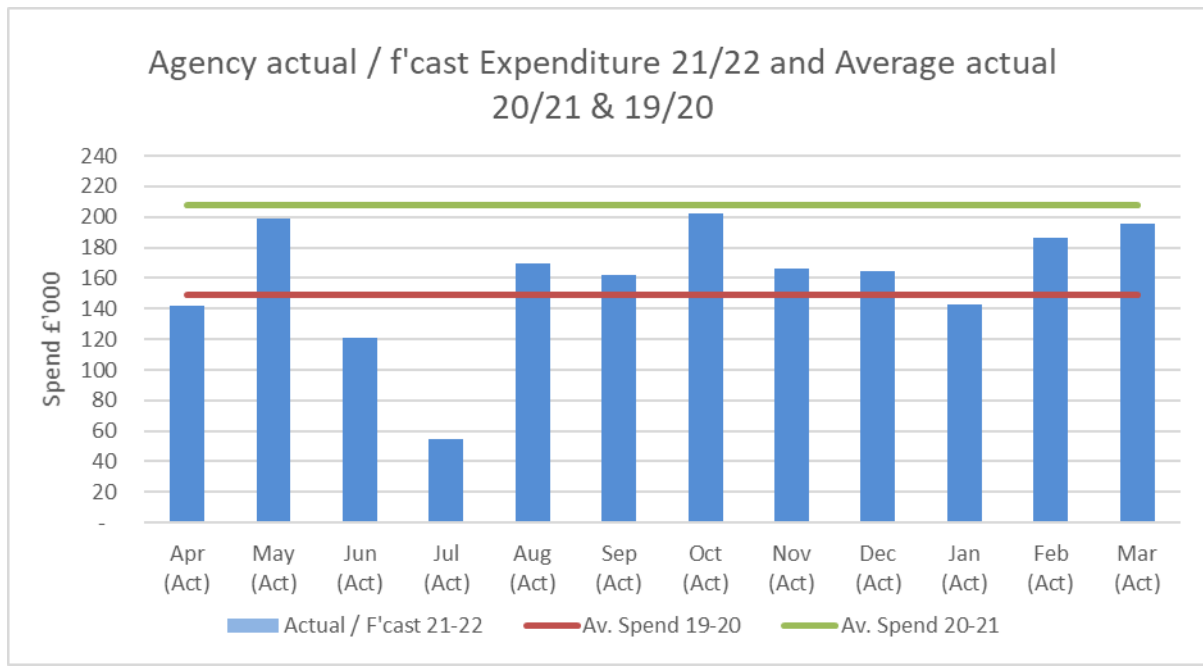
*The increase in May costs has been reviewed and corrected in July following a full review of agency invoices received against orders raised within VCC.

**4.3 Non Pay**

Non-pay 20/21 (c£81.2m) av. monthly spend remained static between 19/20 and 20/21 at £6.8m. The average monthly spend for 21-22 is was £1,200k (15.4%) more than 20/21, which is largely due to the increase NICE / High-Cost drug usage following the recovery and surge related to Covid along with the surge on Blood wholesaling which is demand led.



Monthly Non Pay Spend 2021-22 compared to Average 20-21 & 19-20
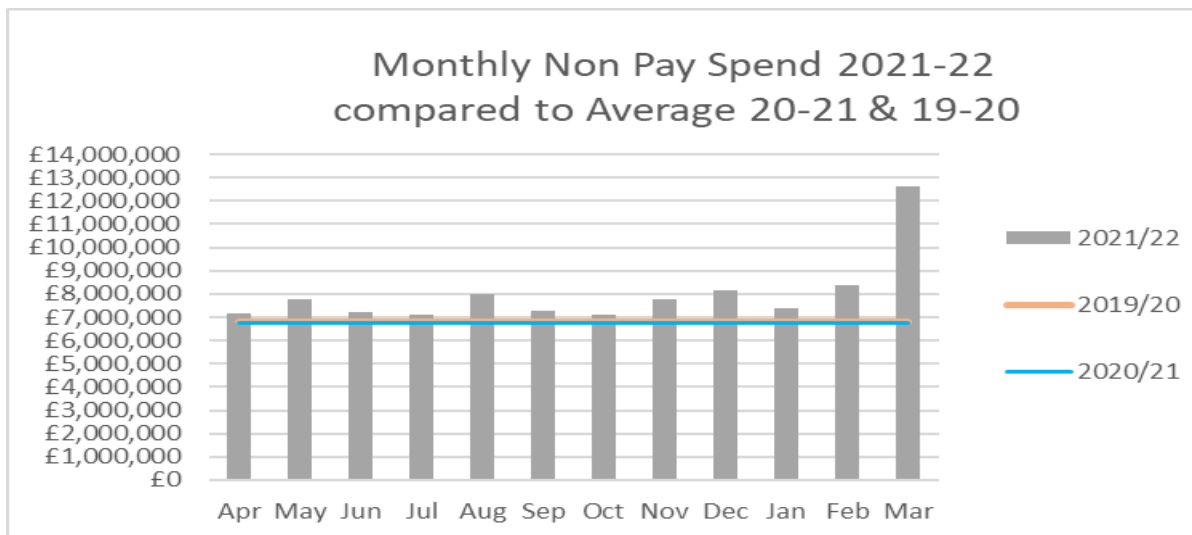
*March spend includes £2m additional drug spend about annual average, £0.7m of WBS blood wholesaling which is demand led, bad debt provision £0.3m, along with spend on investment decisions previously agreed.

**4.4 Covid-19**

| Covid-19 Revenue Spend/ Funding | | | |
|---|---|---|---|
| | Total Actual 2021/22 £000 | Total Funding Received £000 | Variance to Funding allocated £000 |
| Mass & Booster Covid Vaccination | 392 | 392 | 0 |
| Cleaning Standards | 831 | 769 | 62 |
| PPE | 195 | 226 | (31) |
| Covid Recovery | 3,098 | 3,479 | (381) |
| Other Covid Related Spend & Cost Reduction | 1,624 | 1,274 | 350 |
| BFWD Savings Loss | 700 | 700 | 0 |
| Return of Bonus Payment (over allocated) | (83) | (83) | 0 |
| Annual Leave Provision & Sell Back Scheme | 332 | 187 | 145 |
| SDEC Emergency Care Funding | 77 | 77 | 0 |
| **Total Covid Spend /Funding Requirement 2021/22** | **7,166** | **7,021** | **145** |

**All Covid related expenditure requirement was funded by WG during 2021-22**

Covid recovery funding in agreement with WG was flexibly managed with Covid response requirements, whilst delivering the capacity intended by the funding. This maintained the overall funding envelope though recovery has been re-categorised to £3,098k via a reduction in outsourcing.

The Trust received £187k from WG which related to the annual leave sell back scheme, with the remaining £145k provision for untaken leave being managed through the overall Trust position through increased vacancies above the vacancy factor target.

The Trust received £4.5m of Covid funding to support the Hospices during 2021/22. Following discussions with WG and Audit at the last financial year end it was agreed that the Trust should not include the Hospice income and expenditure within the Velindre accounts, and therefore they have also been excluded for reporting purposes from the Trust Financial ledger and the tables above. Following a recent request from WG the figures were included within the Trust monthly financial monitoring returns and the total Covid funding envelope.

**Vaccinations**

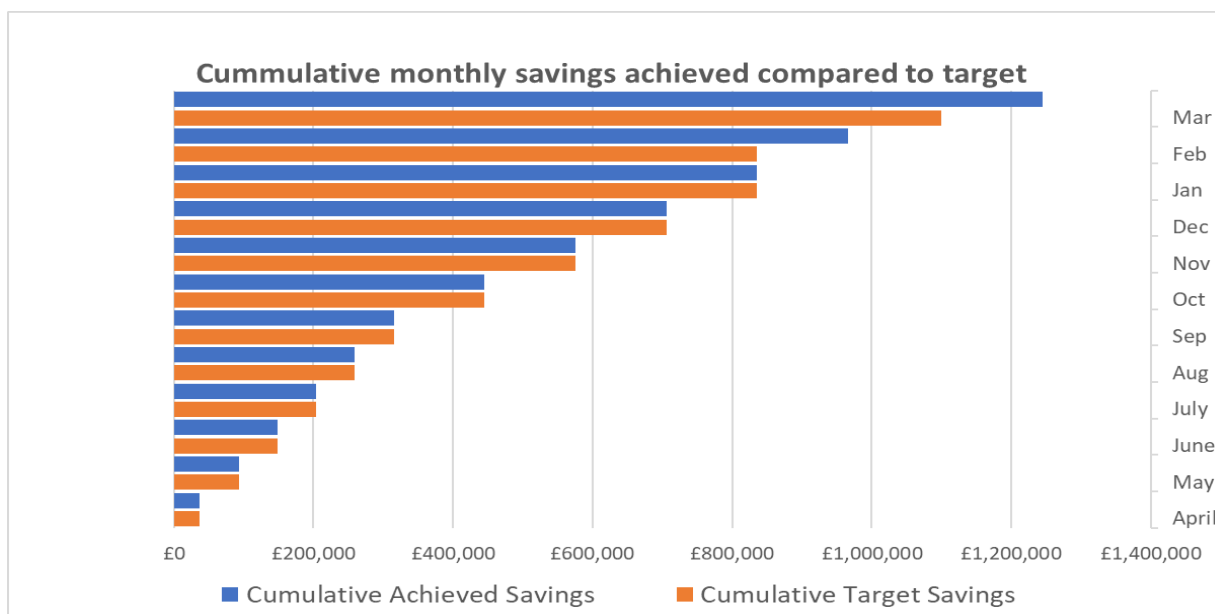The Trust is spent £392k on the Covid Mass & Booster Vaccination programme during 2021/22. The £392k revenue spend requirement largely related to the WBS storage and distribution for NHS Wales (£297k), delivery of vaccinations to front line staff in both Velindre and WAST, and the rollout of the Patient Vaccination programme (£63k), with the balance being spent against the booster programme (£32k).

**4. Savings**

The Trust established as part of the IMTP a savings requirement of £1,100k for 2021-22, £525k recurrent (£925k full year recurrent) and £575k non-recurrent, with £1,050k being categorised as actual saving schemes and £50k being income generating schemes.

The 'Post Covid' Savings of £90k are not reflected in the tables below as they were netted of against Covid Spend during 2021-22, with agreement from WG that the income cannot be drawn down whilst still in the pandemic. The Trust is expected to realise the benefit of these savings post Covid following the new ways of working such as reduced Travel expenses and office consumable spend. These savings were replaced with non-recurrent vacancy factor during 2021-22, which realised a benefit of £145k above the planned target. This was utilised against the annual leave provision which will be carried into 2022/23.

| ORIGINAL PLAN | TOTAL £000 | Planned YTD £000 | Actual YTD £000 | Variance YTD £000 | Full Year Actual £000 | Variance Full Year £000 |
|---|---|---|---|---|---|---|
| VCC TOTAL SAVINGS | 413 | 300 | 300 | 0 | 300 | (113) |
|  |  |  | 100% |  | 73% |  |
| WBS TOTAL SAVINGS | 368 | 300 | 300 | 0 | 300 | (68) |
|  |  |  | 100% |  | 82% |  |
| CORPORATE TOTAL SAVINGS | 119 | 100 | 100 | 0 | 100 | (19) |
|  |  |  | 100% |  | 100% |  |
| TRUST TOTAL SAVINGS IDENTIFIED | 900 | 700 | 700 | 0 | 700 | (200) |
|  |  |  |  |  |  |  |
| TRUST ADDITIONAL NON-RECURRENT SAVINGS | 200 | 400 | 545 | 145 | 545 | 345 |
| TRUST TOTAL SAVINGS | 1,100 | 1,100 | 1,245 | 145 | 1,245 | 145 |
|  |  |  | 113% |  | 113% |  |

| Scheme Type | RAG RATING | TOTAL £000 | Planned YTD £000 | Actual YTD £000 | Variance YTD £000 | F'cast Full Year £000 | Variance Full Year £000 |
|---|---|---|---|---|---|---|---|
| **Savings Schemes** |  |  |  |  |  |  |  |
| Premium of Agency Staffing | Green | 150 | 150 | 150 | 0 | 150 | 0 |
| Premium of Agency Staffing | Green | 100 | 100 | 100 | 0 | 100 | 0 |
| Post Covid Savings (VCC) | Red | 113 | 0 | 0 | 0 | 0 | (113) |
| Blood Supply Chain 2020 | Green | 75 | 75 | 75 | 0 | 75 | 0 |
| Blood Supply Chain 2020 | Green | 25 | 25 | 25 | 0 | 25 | 0 |
| Stock Management | Green | 200 | 200 | 200 | 0 | 200 | 0 |
| Post Covid Savings (WBS) | Red | 68 | 0 | 0 | 0 | 0 | (68) |
| Establishment Control | Green | 100 | 100 | 100 | 0 | 100 | 0 |
| Post Covid Savings (Corporate) | Red | 19 | 0 | 0 | 0 | 0 | (19) |
| **Total Saving Schemes** |  | 850 | 650 | 650 | 0 | 650 | (200) |
|  |  |  |  |  |  |  |  |
| **Income Generation** |  |  |  |  |  |  |  |
| Maximinsing Income Opportunities | Green | 50 | 50 | 50 | 0 | 50 | 0 |
| **Total Income Generation** |  | 50 | 50 | 50 | 0 | 50 | 0 |
|  |  |  |  |  |  |  |  |
| **TRUST ADDITIONAL NON-RECURRENT SAVINGS - VACANY FACTOR** |  | 200 | 400 | 545 | 145 | 545 | 345 |
| **TRUST TOTAL SAVINGS** |  | 1,100 | 1,100 | 1,245 | 145 | 1,245 | 145 |
|  |  |  |  | 113% |  | 113% |  |

**Cummulative monthly savings achieved compared to target**

Legend: Cumulative Achieved Savings (blue), Cumulative Target Savings (orange)

## 5. Reserves

The financial strategy for 2021-22 facilitated the development of a recurrent and non-recurrent reserve in support of the Trust transformation and delivery agenda. These reserves could only be accommodated on the basis that all income expectations are received, planned savings schemes delivered and new emerging cost pressures managed. In addition, the Trust holds an emergency reserve of 522k.

The unspent recurrent reserve balance of £766k will be carried forward for utilisation during 2022/23 against previously agreed commitments.

## 6. End of Year Forecast / Risk Assessment

All operational financial risks that emerged during the year were mitigated within the overall Trust budget for 2021-22.

## 7. CAPITAL EXPENDITURE

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

| | Approved CEL £000s | Full Year Actual Spend £000s | Year End Variance £000s |
|---|---|---|---|
| **All Wales Capital Programme** | | | |
| | | | |
| VCC - Transforming Cancer Services | 3,711 | 3,673 | 38 |
| NVCC - Enabling Works | 1,786 | 1,786 | 0 |
| VCC Radiotherapy Procurement Solution | 312 | 312 | 0 |
| IT - WPAS (CANISC replacement phase 2) | 993 | 1,056 | (63) |
| Fire Safety | 600 | 559 | 41 |
| National Programmes - Decarbonisation | 109 | 111 | (2) |
| National Programmes - Imaging | 1,020 | 1,003 | 17 |
| Covid Recovery | 675 | 699 | (24) |
| DHCW - NDR Funding | 350 | 350 | 0 |
| DHCW - VCC Careflow | 60 | 60 | 0 |
| HTW Capital | 5 | 5 | 0 |
| Linc ETR Funding | 25 | 24 | 1 |
| Additional DPIF Capital Allocations | 41 | 41 | 0 |
| <u>End of Year Capital</u> | | 0 | |
| Multileaf Collimator (MLC) Motor Replacements | 120 | 164 | (44) |
| (CDR) function within the WBS. | 83 | 82 | 1 |
| Patient Specific Quality Assurance (PSQA) Phantom | 100 | 62 | 38 |
| Digital IT Client tech refresh | 450 | 450 | 0 |
| Digital Server Infrastructure Tech refresh | 85 | 89 | (4) |
| **Total All Wales Capital Programme** | 10,525 | 10,525 | (0) |
| | | | |
| **Discretionary Capital** | 1,911 | 1,901 | 10 |
| | | | |
| **Total** | 12,436 | 12,426 | 10 |

The approved Capital Expenditure Limit (CEL) for 2021-22 was £12,436k. This includes All Wales Capital allocation funding of £10,525k, and discretionary funding of £1,911k.

The Trust previously received confirmation of £675k funding from WG towards Capital related Covid recovery. This was used to support additional donor chairs in WBS, urgent ventilation work, and increased capacity in VCC such as improvements to the outpatient area and Bobarth building.

In addition, following a communication from WG of the availability of additional end of year capital monies, the Trust was successful in receiving £838k of funding against the £1,396k of schemes it submitted. The request was based on prioritised divisional bids as provided for in the table above.

**Yearend performance**

The total spend on the All-Wales Capital Programme schemes was £10,525k. As previously highlighted, there were several challenges last financial year which was a combination of procurement capacity constraints, the impact of the pandemic on supplier lead times, and current market conditions where costs have significantly increased. All this resulted in movement and variances being reported in actual spend against approved funding against some of the all Wales

schemes, however following discussions with WG this was manged across the whole of the All Wales Programme to ensure that the CEL was achieved for 2021-22.

The Trust discretionary actual spend for 2021-22 was £1,901k against an approved CEL of £1,911k leaving a balance of £10k on the overall Capital programme.

**Major Schemes in Development**

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

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

| | Scheme | Scheme Total | Stage ( i.e. OBC development, FBC development, scoping etc.) | 22/23 £'000 | 23/24 £'000 | 24/25 £'000 | 25/26 £'000 |
|---|---|---|---|---|---|---|---|
| 1 | VCC Outpatients | 1,250 | Feasibility & design study currently being undertaken although unlikely to gain WG funding to supprt during 2022/23 | 625 | 625 | | |
| 2 | WBS HQ | 22,500 | PBD approved by WG OBC end of February. FBC to be developed 22/23 | 550 | 8,854 | 6,810 | 3,143 |
| 3 | Ventilation | 2,490 | BJC to be submitted (paused during pandemic) | | 1,868 | 623 | |
| 4 | IRS | 37,929 | OBC & PBC approved by WG, FBC under development (Phasing of costs under review) | 8,953 | 8,033 | 22,832 | 7,103 |
| 5 | Plasma Fractionation | TBC | Feasibility study to be developed | | | | |

*Cash flow of these schemes is still under review in conjunction with WG.

## 8. BALANCE SHEET (Including Hosted Organisations)

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

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

The Trust formally removed DHCW from the Trust SoFP during 2021-22, following the transfer of assets and liabilities which took place on the 31 December 2021.

*The SoFP is based at a point in time with the Trust submitting draft accounts to WG on the 29th April so is subject to change.*

**Non-Current Assets**

The balance on PPE and intangible assets will move up and down depended on the agreed purchases from the Trust Capital programme (including hosted), offset against the depreciation charges on owned assets.

Trade debtors and receivables will move up and down each month depending on timing of when invoices are raised and consequently paid by organisations.

**Current Assets**

Discussions between WG and NWSSP have agreed that additional stock to BAU still needs to be maintained. Therefore, cash that is still held for stock held in relation to both Covid and Brexit will be repaid during the next financial year.

The balance on receivables will move up and down each month depending on the timing of when invoices are raised, and when the cash is physically received from debtors. The Trust actively chases its debts to ensure prompt payment.

**Current Liabilities & Non-Current Liabilities**

Liabilities will move up and down each month depending on timing of when commitments are made, and invoices are received and paid.

**Taxpayers Equity**

The movement on PDC and revaluation reserves relates to the transfer of Capital assets relating to DHCW.

| | Opening Balance Beginning of Apr 20 | Closing Balance End of Mar-22 | Movement from 1st April Mar-22 |
|---|---|---|---|
| **Non-Current Assets** | £'000 | £'000 | £'000 |
| Property, plant and equipment | 136,558 | 143,999 | 7,441 |
| Intangible assets | 20,821 | 7,803 | (13,018) |
| Trade and other receivables | 817,142 | 1,087,814 | 270,672 |
| Other financial assets | 0 | 0 | 0 |
| Non-Current Assets sub total | 974,521 | 1,239,616 | 265,095 |
| **Current Assets** | | | |
| Inventories | 95,564 | 65,208 | (30,356) |
| Trade and other receivables | 548,836 | 501,352 | (47,484) |
| Other financial assets | 0 | 0 | 0 |
| Cash and cash equivalents | 43,263 | 30,388 | (12,875) |
| Non-current assets classified as held for sale | 0 | 0 | 0 |
| Current Assets sub total | 687,663 | 596,948 | (90,715) |
| | | | |
| TOTAL ASSETS | 1,662,184 | 1,836,564 | 174,380 |
| | | | |
| **Current Liabilities** | | | |
| Trade and other payables | (353,136) | (240,722) | 112,414 |
| Borrowings | (8) | 0 | 8 |
| Other financial liabilities | 0 | 0 | 0 |
| Provisions | (316,959) | (347,664) | (30,705) |
| Current Liabilities sub total | (670,103) | (588,386) | 81,717 |
| | | | |
| NET ASSETS LESS CURRENT LIABILITIES | 992,081 | 1,248,178 | 256,097 |
| | | | |
| **Non-Current Liabilities** | | | |
| Trade and other payables | (7,301) | 0 | 7,301 |
| Borrowings | 0 | 0 | 0 |
| Other financial liabilities | 0 | 0 | 0 |
| Provisions | (818,782) | (1,088,795) | (270,013) |
| Non-Current Liabilities sub total | (826,083) | (1,088,795) | (262,712) |
| | | | |
| TOTAL ASSETS EMPLOYED | 165,998 | 159,383 | (6,615) |
| | | | |
| **FINANCED BY:** | | | |
| **Taxpayers' Equity** | | | |
| General Fund | 0 | 0 | 0 |
| Revaluation reserve | 27,978 | 30,934 | 2,956 |
| PDC | 122,468 | 112,983 | (9,485) |
| Retained earnings | 15,552 | 15,466 | (86) |
| Other reserve | 0 | 0 | 0 |
| Total Taxpayers' Equity | 165,998 | 159,383 | (6,615) |

## 9. CASH FLOW (Includes Hosted Organisations)

The cash-flow forecast is important to enable the Trust to plan for sufficient cash availability throughout the financial year to pay its debts, such as payroll, services provided by other health bodies and private companies. The cash-flow forecast ensures that the Trust has an early understanding of any cash-flow difficulties.

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

To aid the Trust's cash flow while the additional stock was being held for Brexit, Welsh Government provided the Trust with additional cash of £7m during 2019/20. WBS did intend to run down the commercial blood stock, however given the uncertain situation with Covid and potential impact on supply chains the Trust will continue to hold most of this stock until next financial year. NWSSP are continuing to liaise with WG regarding the level of Brexit with the repayment of the additional cash which is now being carried forward into 2022/23

Due to the high levels of purchases relating to Covid within NWSSP, the cash levels over the past year or so have been higher than usual, however there has been a significant reduction in the balance for the period with the cash balance of £30,388k being held on the 31st March.

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

| | | Apr £'000 | May £'000 | Jun £'000 | Jul £'000 | Aug £'000 | Sep £'000 | Oct £'000 | Nov £'000 | Dec £'000 | Jan £'000 | Feb £'000 | Mar £'000 | Totals £'000 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *RECEIPTS* | | | | | | | | | | | | | |
| 1 | **LHB / WHSSC income** | 23,348 | 22,492 | 30,672 | 34,078 | 32,225 | 28,886 | 33,252 | 33,603 | 30,431 | 31,820 | 36,331 | 33,074 | 370,212 |
| 2 | **WG Income** | 33,807 | 26,132 | 11,582 | 30,431 | 27,512 | 21,398 | 6,388 | 56,520 | 693 | 26,150 | 2,964 | 5,204 | 248,781 |
| 3 | **Short Term Loans** | | | | | | | | | | | | | 0 |
| 4 | **PDC** | | | | | | | | | | | | 27,872 | 27,872 |
| 5 | **Interest Receivable** | | | | | | | | | | 3 | 6 | 6 | 15 |
| 6 | **Sale of Assets** | | | | | | | | | | | 31 | 41 | 72 |
| 7 | **Other** | 7,643 | 3,682 | 4,973 | 5,006 | 4,613 | 5,004 | 4,673 | 2,719 | 9,139 | 2,454 | 9,591 | 1,925 | 61,422 |
| 8 | **TOTAL RECEIPTS** | **64,797** | **52,306** | **47,227** | **69,515** | **64,350** | **55,288** | **44,314** | **92,842** | **40,263** | **60,427** | **48,923** | **68,122** | **708,374** |
| | *PAYMENTS* | | | | | | | | | | | | | |
| 9 | **Salaries and Wages** | 15,189 | 22,734 | 22,015 | 20,181 | 19,284 | 24,383 | 25,582 | 24,544 | 25,089 | 25,614 | 25,419 | 28,288 | 278,322 |
| 10 | **Non pay items** | 52,989 | 43,749 | 25,742 | 35,377 | 45,158 | 42,830 | 18,755 | 19,768 | 49,260 | 7,089 | 48,336 | 27,124 | 416,178 |
| 11 | **Short Term Loan Repayment** | | | | | | | | | | | | 9,486 | 9,486 |
| 12 | **PDC Repayment** | | | | | | | | | | | | | 0 |
| 14 | **Capital Payment** | 2,375 | 277 | 540 | 453 | 225 | 623 | 631 | 499 | 612 | 2,181 | 1,386 | 7,462 | 17,264 |
| 15 | **Other items** | | | | | | | | | | | | | 0 |
| 16 | **TOTAL PAYMENTS** | **70,552** | **66,760** | **48,297** | **56,011** | **64,667** | **67,836** | **44,968** | **44,811** | **74,961** | **34,884** | **75,141** | **72,360** | **721,249** |
| | | | | | | | | | | | | | | |
| 17 | **Net cash inflow/outflow** | (5,755) | (14,454) | (1,070) | 13,504 | (317) | (12,548) | (655) | 48,031 | (34,698) | 25,543 | (26,218) | (4,238) | |
| 18 | **Balance b/f** | 43,263 | 37,508 | 23,054 | 21,984 | 35,488 | 35,171 | 22,623 | 21,968 | 69,999 | 35,301 | 60,844 | 34,626 | |
| 19 | **Balance c/f** | 37,508 | 23,054 | 21,984 | 35,488 | 35,171 | 22,623 | 21,968 | 69,999 | 35,301 | 60,844 | 34,626 | 30,388 | |



Monthly Cash Flow Forecast
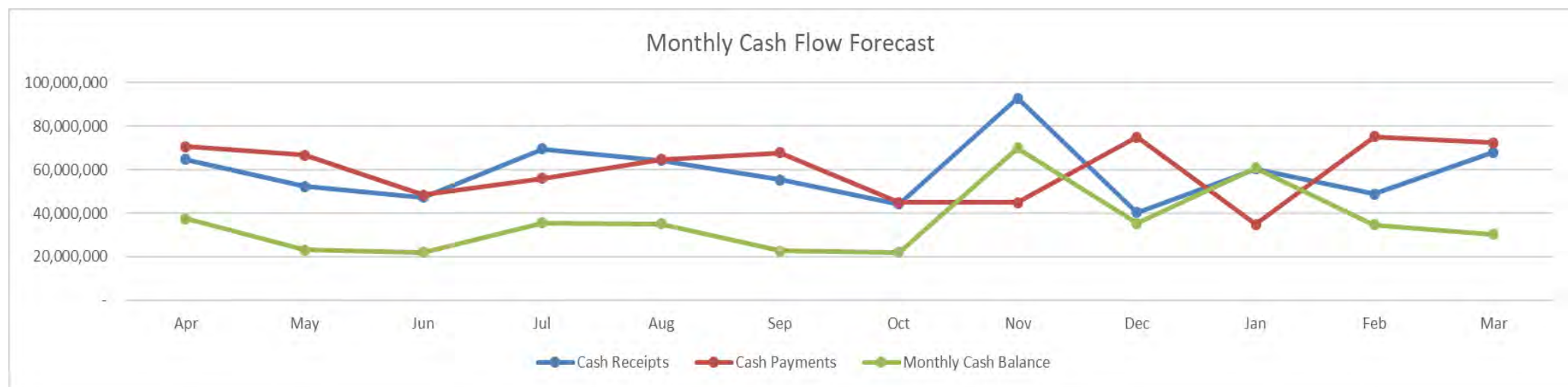
# DIVISIONAL ANALYSIS

*(Figures in parenthesis signify an adverse variance against plan)*

## Core Trust

|  | Full Year Budget £000 | Full Year Actual £000 | Closing Variance £000 |
|---|---|---|---|
| VCC | 37,247 | 37,247 | 0 |
| RD&I | (118) | (118) | (0) |
| WBS | 20,816 | 20,816 | 0 |
| **Sub-Total Divisions** | **57,944** | **57,944** | **0** |
| Corporate Services Directorates | 9,086 | 9,075 | 12 |
| **Delegated Budget Position** | **67,031** | **67,019** | **12** |
| TCS | 669 | 658 | 11 |
| Health Technology Wales | (2) | (7) | 5 |
| **Trust Position** | **67,698** | **67,669** | **28** |

## VCC

|  | Full Year Budget £000 | Full Year Actual £000 | Closing Variance £000 |
|---|---|---|---|
| **Income** | **63,953** | **64,047** | **94** |
| Expenditure |  |  |  |
| Staff | 42,127 | 41,602 | 525 |
| Non Staff | 59,072 | 59,692 | (620) |
| **Sub Total** | **101,199** | **101,294** | **(94)** |
| **Total** | **37,247** | **37,247** | **0** |

## VCC Key Issues:

The reported final financial position for the Velindre Cancer Centre during 2021-22 was **breakeven.**

Income for 2021-22 represented an overachievement of **£94k**. This is largely from an increase in VAT savings from providing additional SACT Homecare, an over achievement on private patient income due to drug performance, which is above general private patient performance,  additional funding for senior medical non-surgical workforce, increased income against the Radiation protection SLA,  and reimbursement of WRP income for Quantum's. This is offsetting the divisional savings target, and the closure of gift shop and volunteer's office in response to Covid.

VCC reported an underspend on staff of **£525k** for 2021-22. The division continues to have a high level of vacancies, sickness, and maternity leave predominantly in Nurse Management, Inpatients, Pharmacy and Radiotherapy which is above the divisional vacancy factor target and is offsetting the premium cost of agency (£1,404k to end of March) although £729k is directly related to Covid and funded via WG. Inpatients underspend relates to the holding off on recruitment due to reduced bed capacity from social distancing measures. Medical costs have increased due to additional temporary staff recruited at risk to ensure that all Jnr Dr rotation placements are filled, and to provide additional resilience against pressured consultants. In addition, enhanced out of hours service, for advanced life support which will be nursing led is currently being covered by Jnr Dr's.

Non-Staff Expenditure reported a total overspend of **£(620)k** for 2021-22. There are underspends on general drugs from reduced activity and temporary closure of outreach clinics, Nuclear medicine warranty savings, along with cost avoidance generated from closure of gift shop and volunteer's office. Other underspends in VCC includes release of accountancy measures, and unallocated reserves to fund overall position. This is in part offsetting the increased spend on consumables within the Division, expenditure on facilities management such as the canteen refurbishment and other site improvements, the legal costs associated with clinical negligence and personal injury, along with reporting fees and oncotype in Senior Medical. The increase in price for utilities is starting to have an impact and is expected to be significant next year, which is being factored into the Trust IMTP, with reassurance from WG that income will be provided to support the increase in energy prices.

## WBS

| | Full Year Budget £000 | Full Year Actual £000 | Closing Variance £000 |
|---|---|---|---|
| **Income** | 23,106 | 22,319 | (787) |
| Expenditure | | | |
| Staff | 17,201 | 16,747 | 454 |
| Non Staff | 26,721 | 26,387 | 333 |
| **Sub Total** | 43,922 | 43,134 | 787 |
| **Total** | 20,816 | 20,816 | 0 |

## WBS Key Issues:

The reported final financial position for the Welsh Blood Service during 2021-22 was **breakeven.**

Income underachievement to date is **£(787)k**, where activity is lower than planned on Bone Marrow and Plasma Sales, due to freezer breakdown and Covid suppressed activity. Plasma sales recovery to business-as-usual levels following hire of freezers, although this has not occurred as anticipated with only partial recovery taken place since December. Transitional operating sites for Bone Marrow and increasingly curtailed procedures is resulting in income loss above Covid support, with assessments as to scale and sustainability strategy still ongoing.

Staff reported an underspend of **£454k** for 2021-22, which is above the division's vacancy factor target. Vacancies remain high at 37 as at end of march. Long standing vacancies in donor contact centre and transport have now been recruited, resulting in reduced vacancy factor. Plasma fractionation staffing costs were supported by division during 2021/22. Component development staffing costs incurred as a divisional cost pressure with no WHSSC funding secured.

Trust approval to appoint a 4th collection team in response to NHS Wales surge capacity and meeting blood demand commenced on 6th September 2021 and continues. These costs were met by WG during 2021-22.

Potential risks due to implications of cessation of CVP Funding where WG initial funding ended 31st March 2021, PYE funding was agreed for 21-22, tenure of RN posts significant as appointed on permanent contracts. SMT approval to partially mitigate the financial risk by transferring CVP permanent posts into team vacancies (where available). This practice is continuing with additional substantive Band 3 posts becoming vacant that has been agreed though Scrutiny to utilise to de-risk the staff group appointed permanently and award to CCA FTC staff to minimise the training required, FTC staff to be recruited to substantive vacancies.

Non-Staff underspend of **£333k** is largely due to reduced costs from suppressed activity, underspend on Collections Services, Laboratory Services, WTAIL, and General Services such as building maintenance and MAK business systems, which is offsetting overspends on utilities, licenses and the Divisions savings target.

## Corporate

|  | Full Year Budget £000 | Full Year Actual £000 | Closing Variance £000 |
|---|---|---|---|
| **Income** | **4,789** | **4,942** | **153** |
| Expenditure |  |  |  |
| Staff | 13,145 | 12,887 | 258 |
| Non Staff | 730 | 1,130 | (400) |
| **Sub Total** | **13,876** | **14,017** | **(142)** |
| **Total** | **9,086** | **9,075** | **12** |

**Corporate Key Issues:**

The reported final financial position for the Corporate division during 2021-22 was **breakeven.**

The Income overachievement for 2021-22 related to non-recurrent income received such as HEIW education funding and DHCW Welsh Nurse Care Record funding which was neutralised through expenditure.

Staff underspend was due to vacancies being held during the period, including the Chief Digital Officer and the Deputy Director of finance which will offset the CIP target and other pressures within non-staff.

The Non pay overspend of **£(400)k** was due to the divisional savings target £(158)k which is expected to be met in year via staff vacancies. Other main cost pressure during 2021-22 £(260)k

relates to the estates budget in VCC which is under immense strain due to the increased repair and maintenance costs of the hospital, recently added costs for statutory compliance and increased material costs, along with general inflation.

## RD&I

| | Full Year Budget £000 | Full Year Actual £000 | Closing Variance £000 |
|---|---|---|---|
| **Income** | **3,874** | **3,750** | **(123)** |
| Expenditure | | | |
| Staff | 2,865 | 2,759 | 107 |
| Non Staff | 890 | 873 | 17 |
| **Sub Total** | **3,756** | **3,632** | **123** |
| **Total** | **(118)** | **(118)** | **(0)** |

### RD&I Key Issues

The reported final financial position for RD&I during 2021-22 was **breakeven.**

Expenditure was below target, mainly due to higher than expected vacancies.

Income was £123k below target through reduction of required planning support for R&D during 2021-22.

## TCS – (Revenue)

| | Full Year Budget £000 | Full Year Actual £000 | Closing Variance £000 |
|---|---|---|---|
| **Income** | **0** | **0** | **0** |
| Expenditure | | | |
| Staff | 525 | 514 | 10 |
| Non Staff | 144 | 143 | 1 |
| **Sub Total** | **669** | **658** | **11** |
| **Total** | **669** | **658** | **11** |

### TCS Key Issues

The small underspend reported through TCS which was due to Vacancy with the programme management office.

## HTW (Hosted Other)

| | Full Year Budget £000 | Full Year Actual £000 | Closing Variance £000 |
|---|---|---|---|
| **Income** | **1,568** | **1,543** | **(25)** |
| Expenditure | | | |
| Staff | 1,082 | 1,082 | 0 |
| Non Staff | 484 | 454 | 30 |
| **Sub Total** | **1,566** | **1,536** | **30** |
| **Total** | **(2)** | **(7)** | **5** |

## HTW Key Issues

HTW reported a small underspend of **£5k** for 2021-22 with the budget fully funded by WG.

# TCS PROGRAMME DELIVERY BOARD

## TCS PROGRAMME FINANCIAL REPORT FOR 2021-22 MARCH 2022

| DATE OF MEETING | 21st April 2022 |
|---|---|

| PUBLIC OR PRIVATE REPORT | Public |
|---|---|

| IF PRIVATE PLEASE INDICATE REASON | Not Applicable - Public Report |
|---|---|

| PREPARED BY | Mark Ash, Assistant Project Director |
|---|---|
| PRESENTED BY | Mark Ash, Assistant Project Director |
| EXECUTIVE SPONSOR APPROVED | Matthew Bunce, Executive Director of Finance |

| REPORT PURPOSE | FOR NOTING |
|---|---|

**COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING**

| COMMITTEE OR GROUP | DATE | OUTCOME |
|---|---|---|
| N/A | | Choose an item. |

**ACRONYMS**

| | |
|---|---|
| TCS | Transforming Cancer Services |
| Trust | Velindre University NHS Trust |
| PBC | Project Business Case |
| PMO | Programme Management Office |
| EW | nVCC Enabling Works |
| nVCC | New Velindre Cancer Centre |
| WG | Welsh Government |
| IRS | Integrated Radiotherapy Solution |
| SDT | Service Delivery and Transformation |

## 1. PURPOSE

1.1 The purpose of this report is to provide a financial update to the TCS Programme Delivery Board for the financial year 2021-22, outlining spend to date against budget as at Month 12.

## 2. BACKGROUND

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

2.2 As at March 2021, the Cabinet Secretary for Health, Well-being and Sport, had approved capital and revenue funding for the TCS Programme and associated Projects of £20.710m and £1.678m respectively.

2.3 Included in this approval was funding for the IRS Procurement Project (Project 3a). The PBC for this project was endorsed by WG in 2019-20, providing capital funding of £1.110m from July 2019 to December 2022. The provision was £0.250m in 2019-20, £0.548m in 2021-22, and £0.312m in 2021-22.

2.4 In addition to WG funding, NHS Commissioners agreed in December 2018 to provide annual revenue funding towards the TCS Programme. £0.400m was provided in the initial year of 2018-19, with £0.420m annually thereafter.

2.5 Further revenue funding was provided by Trust in 2019-20 and 2020-21 from its own baseline revenue budget. Funding of £0.060m and £0.030m respectively was provided for nVCC Project Delivery (previously provided by WG until March 2019). Another £0.039m (2019-20) and £0.166m (2020-21) was provided to cover the costs of staff secondment from Velindre Cancer Centre.

2.6 The total funding and expenditure for the TCS Programme and associated Projects by the end of March 2021 was £23.923m: £20.710m Capital, £3.213m Revenue.

## 3. FUNDING

3.1 Funding provision for the financial year 2021-22 is outlined in the table below.

3.2 In August 2021, the Trust Board approved that the nVCC Project provide interim funding of **c£0.350m** to the EW Project to support the work packages associated with tree and vegetation clearance (c£0.250m) and site management and security (c£0.100m). The EW Project has now secured funding from the approval of its FBC, awarded in January 2022.

3.3 In **JANUARY 2022,** the EW FBC was approved and will cover the costs associated with vegetation and tree clearance works c£0.300m. However, it should be noted that the nVCC Project has provided the EW Project an additional c£0.600m of funding to cover the costs for the following:

- Site Management & Security          c£0.326m
- Legal costs for the injunctions     c£0.274m

3.4    In **MARCH 2022**, the nVCC Project has provided the EW Project an additional c£0.591mm of funding to cover the costs for the following:

- Site Management & Security          c£0.345m
- Legal costs for the injunctions     c£0.246m

**Note: These costs are deemed by WG to be not in the scope of the EW Project.**

3.5    In addition, the EW Project received a further c£0.452m from the nVCC Project to fund pay costs; technical advisors; tree clearance costs; and design costs. The funding needs to be re-provided to the nVCC Project in 2022-23.

3.6    The Trust has provided revenue funding of **£0.110m** to the nVCC Project.

| Description | Funding | |
| --- | --- | --- |
| | **Capital** | **Revenue** |
| **Programme Management Office** Allocation of £0.240m from £0.420m funding provided from Commissioners for 2021-22 to cover direct clinical/management support and Programme Management was provided in April 2021 | **£ nil** | **£0.227m** £0.240m |
| Allocation from WG 2021-22 revenue pay award funding was provided in September 2021 | | £0.006m |
| Forecast underspend in March 2022 allowed for a virement of Commissioners' Funding from the PMO to Project 6 – Service Delivery, Transformation and Transition to cover the latter's overspend | | -£0.019m |
| **Project 1 – Enabling Works for nVCC** Capital funding from WG was provided on 24 March 2021 | **£2.036m** £0.250m | **£ nil** |
| Capital funding of £27.393m awarded by WG on 18 January 2022 for the EW FBC, of which £1.786m has been allocated to the financial year 2021-22 | £1.786m | |
| **Project 2 – New Velindre Cancer Centre** Capital funding from WG was provided on 24 March 2021 | **£3.461m** £3.461m | **£0.110m** |
| The Trust provided revenue funding in September 2021 for Project Delivery | | £0.026m |
| The Trust has provided revenue funding for the Judicial Review costs incurred between August 2021 and December 2021 | | £0.084m |

| Description | Funding | |
|---|---|---|
| | **Capital** | **Revenue** |
| **Project 3a – Radiotherapy Procurement Solution**<br>Final 9 months of a 28 month project, running from 1st August 2019 to 31st December 2021, with a funding allocation of £0.312m for 2021-22 from an overall funding allocation of £1.110m, provided in April 2021 | **£0.312m**<br>£0.312m | **£ nil** |
| Additional funding provided by the Trust for the Project's increased legal and staff costs in November 2021 | £0.264m | |
| Additional funding held by the Trust with the associated spend transferred to Corporate Finance Capital Reserves in March 2022 | -£0.264m | |
| **Project 4 – Radiotherapy Satellite Centre**<br>The project is led and funded by the hosting organisation, Aneurin Bevan University Health Board; no funding requirement is expected from the Trust for 2021-22 | **£ nil** | **£ nil** |
| **Project 5 – SACT and Outreach**<br>A review of all the Trust Programme & Project resources is being undertaken to identify how these are deployed against Trust priorities. This project is on hold pending this review. | **£ nil** | **£ nil** |
| **Project 6 – Service Delivery, Transformation and Transition** | **£ nil** | **£0.332m** |
| Allocation of £0.180m from £0.420m funding provided from Commissioners for 2021-22 to cover direct clinical/management support and Programme Management was provided in April 2021 | | £0.180m |
| Funding provided from the Trust's core revenue budget towards the costs of the Project Director post and the Project Manager post in April 2021 | | £0.116m |
| Allocation from WG 2021-22 revenue pay award funding was provided in September 2021 | | £0.009m |
| Additional funding provided from the Trust's core revenue budget towards the cost of the Project Manager post in November 2021 | | £0.008m |
| Forecast underspend in March 2022 allowed for a virement of Commissioners' Funding from the PMO to Project 6 – Service Delivery, Transformation and Transition to cover the latter's overspend | | £0.019m |
| **Project 7 – VCC Decommissioning**<br>A review of all the Trust Programme & Project resources is being undertaken to identify how these are deployed against Trust priorities. This project is on hold pending this review. | **£ nil** | **£ nil** |
| **Total funding provided to date** | **£5.809m** | **£0.669m** |
| | **£6.478m** | |

## 4. FINANCIAL SUMMARY AS AT 31ST MARCH 2022

4.1 The summary financial position for the TCS Programme for the year 2021-22 as at 31st March 2022 is outlined below:

- **CAPITAL** spend of **£5.711m to M12** and a **variance of £0.038m underspend;** and

- **REVENUE** spend is **£0.658m to M12** and a **variance of £0.011m underspend.**

| TCS Programme Budget & Spend 2021-22 | | | |
|---|---|---|---|
| | | **Financial Year** | |
| **CAPITAL** | **Annual Budget** | **Annual Forecast** | **Annual Variance** |
| | £ | £ | £ |
| **PAY** | | | |
| Project Leadership | 193,000 | 191,707 | 1,293 |
| Project 1 - Enabling Works | 100,000 | 213,521 | -113,521 |
| Project 2 - New Velindre Cancer Centre | 1,008,500 | 773,833 | 234,667 |
| Project 3a - Radiotherapy Procurement Solution | 211,613 | 211,613 | 0 |
| **Capital Pay Total** | **1,513,113** | **1,390,674** | **122,439** |
| | | | |
| **NON-PAY** | | | |
| nVCC Project Delivery | 78,500 | 94,247 | -15,747 |
| Project 1 - Enabling Works | 1,936,000 | 2,274,109 | -338,109 |
| Project 2 - New Velindre Cancer Centre | 2,181,000 | 1,911,794 | 269,206 |
| Project 3a - Radiotherapy Procurement Solution | 100,388 | 100,267 | 120 |
| **Capital Non-Pay Total** | **4,295,888** | **4,380,417** | **-84,530** |
| | | | |
| **CAPITAL TOTAL** | **5,809,000** | **5,771,091** | **37,909** |

| | | | |
|---|---|---|---|
| | | **Financial Year** | |
| **REVENUE** | **Annual Budget** | **Annual Forecast** | **Annual Variance** |
| | £ | £ | £ |
| **PAY** | | | |
| Programme Management Office | 218,833 | 198,329 | 20,503 |
| Project 6 - Service Change Team | 316,633 | 316,095 | 539 |
| **Revenue Pay total** | **535,466** | **514,424** | **21,042** |
| **NON-PAY** | | | |
| nVCC Project Delivery | 26,000 | 24,918 | 1,082 |
| nVCC Judicial Review | 84,000 | 83,709 | 291 |
| Programme Management Office | 8,534 | 19,763 | -11,229 |
| Project 6 - Service Change Team | 15,000 | 14,766 | 234 |
| **Revenue Non-Pay Total** | **133,534** | **143,156** | **-9,622** |
| | | | |
| **REVENUE TOTAL** | **669,000** | **657,580** | **11,420** |

## 5. FINANCIAL POSITION FOR TCS PROGRAMME AND ASSOCIATED PROJECTS AS AT 31ST MARCH 2022

### Project 1 – Enabling Works

5.1    There is a final capital spend for the financial year 2021-22 of **£2.487m** against a budget of **£2.036m, with a variance of £0.452m overspend**.  This overspend has been offset by an underspend by Project 2 – nVCC.

| Work Package | Total Spend for 2021-22 £m |
|---|---|
| **Pay** | **£0.214** |
| Technical Advisers | £0.260 |
| Construction Costs | £0.552 |
| Utility Costs | £0.789 |
| Supply Chain Fees | £0.192 |
| Non Works Costs | £0.400 |
| Asda Works | £0.081 |
| **Non-pay** | **£2.274** |
| **Total** | **£2.488** |

5.2    Many of the EW work packages associated with the EW OBC, for which funding was not provided by WG in 2021-22.  Therefore, these work packages have been funded by the nVCC Project (see section 5.3), with the EW costs for 2021-22 relating to just the EW FBC.

### Project 2 – nVCC

5.3    There is a final capital spend for the financial year 2021-22 of **£2.972m** against a budget of **£3.461m, with a variance of £0.489m underspend**.  This underspend has been utilised to offset an overspend by Project 1 – Enabling Works.2.

| Work package | Total Spend for 2021-22 £m |
|---|---|
| **Pay** | **£0.965** |
| Project Delivery Costs | £0.094 |
| EW Works | £0.451 |
| EW Legal Advice | £0.262 |
| EW Reserves | -£0.195 |
| nVCC Competitive Dialogue – PQQ & Dialogue | £1.291 |
| nVCC Legal Advice | £0.020 |
| nVCC Planning | £0.111 |
| nVCC Reserves | -£0.028 |
| **Non-pay** | **£2.006** |
| **Total** | **£2.972** |

### Project 3a – Integrated Radiotherapy Procurement Solution

5.4    There is a final capital spend for the financial year 2021-22 of **£0.0.312** for the IRS Project against a WG budget of **£0.312 with no variance**. There is an additional spend of £0.248m, which has been offset by Trust capital reserves and transferred accordingly.

| Work package | Total Spend for 2021-22 £m |
|---|---|
| **Pay** | **£0.212** |
| Legal Advisors | £0.100 |
| Financial Advisors | £nil |
| Business Case Advisors | £nil |
| Procurement Advisors | £nil |
| IRS Reserves | £nil |
| **Non-pay** | **£0.100** |
| **Total** | **£0.312** |

*REVENUE SPEND*

*Programme Management Office*

5.5 The PMO spend for 2021-22 is **£0.218m** (£0.198m pay, £0.020m non-pay) against a revised budget of **£0.227mm**.

5.6 There is an underspend in pay costs of £21k due to a delay in recruitment of a Programme Administrator. However, this has been used to offset an overspend of £11k in non-pay costs, and £19k overspend by the Service Change Project, resulting in an overall underspend of £9k.

*Projects 1 and 2 Delivery Costs*

5.7 The full revenue costs in 2021-22 for project delivery are **£0.025m** against a budget of **£0.026m.** This spend relates to office costs and project support.

*nVCC Judicial Review*

5.8 There is a revenue spend of **£0.084m** against a budget of **£0.084m** in 2021-22 for the legal advice to deliver the requirements of the judicial review process as the Trust is an interested party.

*Project 6 – Service Delivery, Transformation and Transition (Service Change)*

5.9 The Service Change spend for 2021-22 is **£0.331m** (£0.316m pay, £0.015m non-pay), against a revised budget of **£0.331m, with no variance**.

**6.    Financial Risks & Issues**

6.1 There are no outstanding financial risks or issues for the financial year 2021-22.

**7.    CONSIDERATIONS FOR BOARD**

7.1 This report is included as an appendix to the Trust Board Finance Report.

**8.    IMPACT ASSESSMENT**

| | |
|---|---|
| **QUALITY AND SAFETY IMPLICATIONS/IMPACT** | There are no specific quality and safety implications related to the activity outined in this report. |
| **RELATED HEALTHCARE STANDARD** | Staff and Resources |

| EQUALITY IMPACT ASSESSMENT COMPLETED | Not required |
|---|---|
| LEGAL  IMPLICATIONS / IMPACT | There are no specific legal implications related to the activity outlined in this report. |
| FINANCIAL IMPLICATIONS / IMPACT | Yes (Include further detail below) |
| | See above. |

## 9.    RECOMMENDATION

9.1    The TCS Programme Board are asked to **NOTE** the financial position for the TCS Programme and Associated Projects for 2021-22 as at 31st March 2022.

**Workforce Monthly Report**

**February 2022**

**Workforce Report provides the following:**

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

## At a Glance for Velindre (Excluding Hosted)

| Velindre (Excluding Hosted | Current Month | Previous Month | Target |
|---|---|---|---|
| | Feb-22 | Jan-22 | |
| PADR | 69.75 | 69.21 | 85% |
| | | | |
| Sickness | 5.76 | 5.73 | 3.54% |
| | | | |
| S&M Compliance | 85.26 | 85.97 | 85% |

## Workforce Dashboard

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

| Key | 85%-100% | | 50% - 84.99% | | 0% - 49.99% | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

These figures exclude Trainee Doctors, those on Maternity, Starters within first 6 Months, those currently off on sickness absence.

| PADR | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Corporate | 41.74 | 43.44 | 45.00 | 49.58 | 47.01 | 48.33 | 50.43 | 45.69 | 46.58 | 44.59 | 45.64 | 44.08 | 50.33 |
| Research, Development & Innovation | 34.04 | 58.33 | 60.00 | 64.58 | 62.50 | 61.70 | 65.96 | 66.67 | 72.09 | 90.91 | 88.37 | 84.09 | 80.00 |
| Transforming Cancer Services | 64.29 | 60.00 | 66.67 | 68.75 | 71.43 | 66.67 | 60.00 | 56.25 | 43.75 | 62.50 | 75.00 | 63.16 | 57.89 |
| Velindre Cancer Centre | 77.53 | 79.78 | 81.07 | 78.88 | 76.52 | 74.31 | 75.17 | 76.40 | 73.77 | 70.90 | 67.61 | 65.16 | 65.25 |
| Welsh Blood Service | 73.19 | 77.25 | 78.65 | 82.41 | 81.74 | 79.78 | 78.27 | 77.93 | 77.52 | 82.19 | 83.06 | 83.73 | 81..75 |
| Velindre Organisations | 71.32 | 74.64 | 76.07 | 76.77 | 75.09 | 73.28 | 73.58 | 73.67 | 71.69 | 72.11 | 70.83 | 69.21 | 69.75 |
| Target 85% | 85 | 85 | 85 | 85 | 85 | 85 | 85 | 85 | 85 | 85 | 85 | 85 | 85 |

| Key | 85%-100% | | 50% - 84.99% | | 0% - 49.99% | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

These figures exclude those on Maternity and those currently off with sickness absence

| Stat and Mand Compliance (10x CSTF) | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Corporate | 70.62 | 69.47 | 69.06 | 70.08 | 69.08 | 69.26 | 70.45 | 71.36 | 74.54 | 72.32 | 74.40 | 72.17 | 73.64 |
| Research, Development & Innovation | 82.50 | 83.73 | 82.59 | 83.08 | 85.69 | 86.00 | 85.80 | 86.25 | 84.89 | 84.58 | 85.83 | 84.26 | 80.42 |
| Transforming Cancer Services | 69.38 | 64.12 | 65.29 | 70.00 | 76.00 | 76.84 | 85.26 | 82.50 | 82.86 | 83.33 | 81.43 | 77.86 | 77.39 |
| Velindre Cancer Centre | 81.53 | 81.57 | 80.98 | 81.77 | 82.45 | 82.70 | 83.16 | 82.89 | 83.11 | 84.91 | 84.93 | 84.73 | 84.18 |
| Welsh Blood Service | 89.54 | 90.90 | 90.43 | 92.23 | 92.39 | 93.38 | 92.66 | 92.21 | 92.54 | 93.36 | 93.56 | 93.78 | 92.02 |
| Velindre Organisations | 83.06 | 83.39 | 82.92 | 84.09 | 84.59 | 84.97 | 85.24 | 84.95 | 85.10 | 86.06 | 86.40 | 85.97 | 85.26 |

| Key | 0% - 3.54% | | 3.55% - 4.49% | | 4.5 % & Above | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

| Sickness Rolling % | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Corporate | 5.13 | 4.94 | 4.74 | 4.70 | 4.68 | 4.64 | 4.49 | 4.58 | 4.67 | 5.00 | 5.32 | 5.40 | 5.36 |
| Research, Development & Innovation | 4.23 | 4.01 | 3.73 | 3.46 | 3.16 | 3.34 | 3.55 | 3.96 | 4.29 | 4.41 | 4.31 | 4.49 | 4.72 |
| Transforming Cancer Services | 2.41 | 2.01 | 1.34 | 0.88 | 0.41 | 0.32 | 0.33 | 0.40 | 0.86 | 1.27 | 0.99 | 0.95 | 1.02 |
| Velindre Cancer Centre | 5.97 | 5.77 | 5.40 | 5.38 | 5.41 | 5.47 | 5.47 | 5.52 | 5.57 | 5.64 | 5.53 | 5.57 | 5.58 |
| Welsh Blood Service | 4.38 | 4.24 | 4.19 | 4.37 | 4.58 | 4.82 | 5.11 | 5.42 | 5.72 | 5.99 | 6.27 | 6.45 | 6.52 |
| Velindre Organisations | 5.29 | 5.11 | 4.85 | 4.87 | 4.94 | 5.05 | 5.13 | 5.28 | 5.43 | 5.59 | 5.64 | 5.73 | 5.76 |
| Target 3.54% | 3.54 | 3.54 | 3.54 | 3.54 | 3.54 | 3.54 | 3.54 | 3.54 | 3.54 | 3.54 | 3.54 | 3.54 | 3.54 |

| Monthly Sickness Rolling Covid Only Absence % | 0% | | 0.01% - 0.49% | | 0.50 % & Above | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Sickness Leave Covid Related | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 |
| Corporate | 0.60 | 0.68 | 0.69 | 0.78 | 0.88 | 0.99 | 1.16 | 1.34 | 1.46 | 1.56 | 1.64 | 1.70 | 1.70 |
| Research, Development & Innovation | 0.46 | 0.42 | 0.35 | 0.44 | 0.45 | 0.45 | 0.43 | 0.43 | 0.43 | 0.42 | 0.37 | 0.40 | 0.39 |
| Transforming Cancer Services | 0.26 | 0.21 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Velindre Cancer Centre | 1.44 | 1.31 | 0.96 | 0.89 | 0.86 | 0.87 | 0.88 | 0.84 | 0.86 | 0.83 | 0.72 | 0.79 | 0.87 |
| Welsh Blood Service | 0.44 | 0.39 | 0.31 | 0.29 | 0.28 | 0.29 | 0.29 | 0.36 | 0.39 | 0.38 | 0.36 | 0.39 | 0.41 |
| Velindre Organisations | 1.00 | 0.92 | 0.70 | 0.67 | 0.66 | 0.67 | 0.69 | 0.71 | 0.75 | 0.74 | 0.68 | 0.74 | 0.79 |

| Monthly Special Leave Absence Rolling % | 0% | | 0.01% - 0.49% | | 0.50 % & Above | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Special Leave Non Covid Related | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 |
| Corporate | 0.23 | 0.17 | 0.11 | 0.05 | 0.04 | 0.06 | 0.05 | 0.03 | 0.09 | 0.09 | 0.09 | 0.09 | 0.09 |
| Research, Development & Innovation | 0.65 | 0.50 | 0.46 | 0.42 | 0.51 | 0.60 | 0.74 | 0.92 | 1.08 | 1.26 | 1.38 | 1.54 | 1.55 |
| Transforming Cancer Services | 0.51 | 0.51 | 0.51 | 0.51 | 0.51 | 0.53 | 0.56 | 0.55 | 0.54 | 0.40 | 0.24 | 0.07 | 0.07 |
| Velindre Cancer Centre | 0.43 | 0.43 | 0.41 | 0.41 | 0.42 | 0.44 | 0.47 | 0.49 | 0.54 | 0.57 | 0.62 | 0.66 | 0.65 |
| Welsh Blood Service | 0.61 | 0.62 | 0.58 | 0.59 | 0.58 | 0.60 | 0.61 | 0.63 | 0.65 | 0.64 | 0.62 | 0.60 | 0.58 |
| Velindre Organisations | 0.48 | 0.47 | 0.44 | 0.43 | 0.44 | 0.46 | 0.49 | 0.51 | 0.55 | 0.57 | 0.59 | 0.60 | 0.59 |

| Monthly Special Leave Absence Rolling % | 0% | | 0.01% - 0.49% | | 0.50 % & Above | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Special Leave Covid Related | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 |
| Corporate | 0.57 | 0.48 | 0.32 | 0.25 | 0.18 | 0.11 | 0.03 | 0.01 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Research, Development & Innovation | 1.95 | 1.45 | 1.04 | 0.76 | 0.49 | 0.21 | 0.13 | 0.13 | 0.15 | 0.10 | 0.15 | 0.23 | 0.23 |
| Transforming Cancer Services | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Velindre Cancer Centre | 2.36 | 2.09 | 1.67 | 1.35 | 1.09 | 0.91 | 0.80 | 0.79 | 0.80 | 0.73 | 0.74 | 0.82 | 0.88 |
| Welsh Blood Service | 1.75 | 1.65 | 1.33 | 1.06 | 0.83 | 0.68 | 0.62 | 0.67 | 0.68 | 0.68 | 0.65 | 0.63 | 0.61 |
| Velindre Organisations | 1.96 | 1.75 | 1.39 | 1.12 | 0.89 | 0.73 | 0.64 | 0.64 | 0.65 | 0.61 | 0.61 | 0.64 | 0.67 |

# PADR – The Figures

## PADR Status - last 12 Months by Division



| | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Corporate | 41.74 | 43.44 | 45.00 | 49.58 | 47.01 | 48.33 | 50.43 | 45.69 | 46.58 | 44.59 | 45.64 | 44.08 | 50.33 |
| Research, Development & Innovation | 34.04 | 58.33 | 60.00 | 64.58 | 62.50 | 61.70 | 65.96 | 66.67 | 72.09 | 90.91 | 88.37 | 84.09 | 80.00 |
| Transforming Cancer Services | 64.29 | 60.00 | 66.67 | 68.75 | 71.43 | 66.67 | 60.00 | 56.25 | 43.75 | 62.50 | 75.00 | 63.16 | 57.89 |
| Velindre Cancer Centre | 77.53 | 79.78 | 81.07 | 78.88 | 76.52 | 74.31 | 75.17 | 76.40 | 73.77 | 70.90 | 67.61 | 65.16 | 65.25 |
| Welsh Blood Service | 73.19 | 77.25 | 78.65 | 82.41 | 81.74 | 79.78 | 78.27 | 77.93 | 77.52 | 82.19 | 83.06 | 83.73 | 0.00 |
| Velindre Organisations | 71.32 | 74.64 | 76.07 | 76.77 | 75.09 | 73.28 | 73.58 | 73.67 | 71.69 | 72.11 | 70.83 | 69.21 | 69.75 |
| Target 85% | 85 | 85 | 85 | 85 | 85 | 85 | 85 | 85 | 85 | 85 | 85 | 85 | 85 |

3

**PADR – The Narrative**

| Performance Indicator | RAG / change from previous month | December Figure | Hotspot Areas | % | Comment to include reasons for change / rates high or low |
|---|---|---|---|---|---|
| PADR Compliance (85%) | 69.75% ↑ | 69.21% | **Welsh Blood Service (81.75%)** | | |
| | | | Directors | 25% | Decrease from previous month (50%) |
| | | | General | 65.52% | Decrease from previous month (85.71%) |
| | | | Clinical Services | 68.18% | No change from previous month (68.18%) |
| | | | **Velindre Cancer Centre (65.25%)** | | |
| | | | Medical Staffing | 49.09% | Increase on previous month 47.27% however, it must be noted that the 'approved missed appraisal' status continues until April 2022 for all medical staff. |
| | | | Radiotherapy | 47.96% | Increase from previous month 44.44%. Significant workforce challenges over absence, recruitment and turnover currently impacting radiotherapy KPI's. |
| | | | Cancer Services Management Office | 53.85% | Targeted interventions have improved figures from 34.48% |
| | | | **Corporate Areas (69.15%)** | | |
| | | | Clinical Governance | 22.5% | Significant increase from previous month (12.50%) |
| | | | Fundraising | 14.29% | Inability to complete due to long-term sickness and complex ER cases ongoing in the department. |
| | | | WOD | 58.82% | Significant increase from previous month (26.32%). Due to significant turnover within the department and appointment of new employees in the past 12 months. Action plan in place to complete by March 2022 (this will be available for May EMB report). |
| **Action/initiatives:** | | | | | |

**Velindre University NHS Trust**

The WOD operational team has a number of vacancies (in progress of being filled) which has meant monthly 1-2-1's on compliance has dipped across the Trust, however it is anticipated that number will improve as the team returns to regular 1-2-1's with service leads.

**Welsh Blood Service**

Overall slight decrease this month in PADR compliance. Compliance rates slightly decreased but still high overall compliance. Some work to do in the hotspot areas.

**VCC**

WOD Business Partner for VCC has worked closely at targeting hotspot areas, and KPI's have improved where this work is able to be supported. The continuation of VCC deep dive and planning of key WOD concerns will continue to improve these figures over the coming months.

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

WOD Business Partner for corporate services has worked closely at targeting hotspot areas, and increases seen in areas where this work is able to be supported. This targeted intervention will continue in March and April.

# Sickness Data – The Figures

## Sickness - Last 12 Months by Division



| | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Corporate | 5.13 | 4.94 | 4.74 | 4.70 | 4.68 | 4.64 | 4.49 | 4.58 | 4.67 | 5.00 | 5.32 | 5.40 | 5.36 |
| Research, Development & Innovation | 4.23 | 4.01 | 3.73 | 3.46 | 3.16 | 3.34 | 3.55 | 3.96 | 4.29 | 4.41 | 4.31 | 4.49 | 4.72 |
| Transforming Cancer Services | 2.41 | 2.01 | 1.34 | 0.88 | 0.41 | 0.32 | 0.33 | 0.40 | 0.86 | 1.27 | 0.99 | 0.95 | 1.02 |
| Velindre Cancer Centre | 5.97 | 5.77 | 5.40 | 5.38 | 5.41 | 5.47 | 5.47 | 5.52 | 5.57 | 5.64 | 5.53 | 5.57 | 5.58 |
| Welsh Blood Service | 4.38 | 4.24 | 4.19 | 4.37 | 4.58 | 4.82 | 5.11 | 5.42 | 5.72 | 5.99 | 6.27 | 6.45 | 6.52 |
| Velindre Organisations | 5.29 | 5.11 | 4.85 | 4.87 | 4.94 | 5.05 | 5.13 | 5.28 | 5.43 | 5.59 | 5.64 | 5.73 | 5.76 |
| Target 3.54% | 3.54 | 3.54 | 3.54 | 3.54 | 3.54 | 3.54 | 3.54 | 3.54 | 3.54 | 3.54 | 3.54 | 3.54 | 3.54 |

6

## Sickness – The Narrative

| Performance Indicator | RAG/ Change from previous month | August Figure | Hotspot | % | Comment to include reasons for change / rates high or low |
|---|---|---|---|---|---|
| **Sickness absence (3.42%)** | **5.76%** ↑ | 5.73% | | **Welsh Blood Service (5.72%)** | |
| | | | Collection Services | 8.5% | Same as previous month |
| | | | Laboratory Services | 7.31% | Same as previous month |
| | | | Quality Assurance | 9.02% | Same as previous month |
| | | | | **Velindre Cancer Centre (5.81%)** | |
| | | | Nuclear Medicine | 7.77% | Decrease from previous month 11.66%. As a small team 1 absence can cause significant rise in absence % |
| | | | Outpatients | 20% | Significant increase from previous month 13.71% with no identified reason for increase. WOD to provide targeted support to managers in March and April. |
| | | | Operational Services | 9.31% | Increase from previous month's 8.44%. WOD to provide targeted support to managers in March and April. |
| | | | | **Corporate Areas (5.4%)** | |
| | | | Corporate Management Section | 8.29% | Increase from previous month 7.44% |
| | | | Fundraising | 27.24% | Increase from previous month 16.3%. Continued targeted intervention from WOD for management facilitate returns alongside management of complex WOD cases. |
| **Action/ initiatives:** <br><br> **Velindre University NHS Trust** | | | | | |

The WOD department sent a Wellbeing letter to all staff at the end of February, to remind colleagues of the wellbeing support we offer as a Trust and to offer thanks and recognition for everyone's effort during the pandemic. This message has been regarded as well-received and appreciated by staff.

An all Wales working group to review the Managing Attendance at Work policy is underway and WOD have representatives to ensure the policy remains fit for managers and staff during the course of this review. The senior BP's are supporting this interaction by feeding back divisions concerns or improvements.

**WBS**

Long-term sickness absence has decreased in February to 3.31%, short term sickness absence has marginally increased to 2.41%. There is a continuing downward trend for long-term sickness absence it is tracking 1% higher than compared with a year ago. The decrease in long-term sickness absences can be attributed to some cases reaching the final absence management stage or being managed out of the business.

Stress Related absence continues to be the highest reason for absence at 30.4% of all absences over the last 12 months, followed again by back problems at a fairly static figure of 8.4%.

**VCC**

Short-term sickness is 2.42% (decrease from last month) and long-term sickness absence is at 3.40% (increase from last month).

WOD senior BP to support SLT in understanding underlying concerns and attributes for these figures through the ongoing VCC deep dives.

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

A significant rise in absence from previous month report of 3.39% has occurred however on analysis of figures it appears not all absence information has been inputted into ESR and therefore the corrected figure for January 2022 is 5.18% for Corporate Services.

# Statutory and Mandatory Figures – The Figures

## Statatory & Mandatory Compliance (10x CSTF) last 12 months by Division



| | Corporate | Research, Development & Innovation | Transforming Cancer Services | Velindre Cancer Centre | Welsh Blood Service | Velindre Organisations |
|---|---|---|---|---|---|---|
| Feb-21 | 70.62 | 82.50 | 69.38 | 81.53 | 89.54 | 83.06 |
| Mar-21 | 69.47 | 83.73 | 64.12 | 81.57 | 90.90 | 83.39 |
| Apr-21 | 69.06 | 82.59 | 65.29 | 80.98 | 90.43 | 82.92 |
| May-21 | 70.08 | 83.08 | 70.00 | 81.77 | 92.23 | 84.09 |
| Jun-21 | 69.08 | 85.69 | 76.00 | 82.45 | 92.39 | 84.59 |
| Jul-21 | 69.26 | 86.00 | 76.84 | 82.70 | 93.38 | 84.97 |
| Aug-21 | 70.45 | 85.80 | 85.26 | 83.16 | 92.66 | 85.24 |
| Sep-21 | 71.36 | 86.25 | 82.50 | 82.89 | 92.21 | 84.95 |
| Oct-21 | 74.54 | 84.89 | 82.86 | 83.11 | 92.54 | 85.10 |
| Nov-21 | 72.32 | 84.58 | 83.33 | 84.91 | 93.36 | 86.06 |
| Dec-21 | 74.40 | 85.83 | 81.43 | 84.93 | 93.56 | 86.40 |
| Jan-22 | 72.17 | 84.26 | 77.86 | 84.73 | 93.78 | 85.97 |
| Feb-22 | 73.64 | 80.42 | 77.39 | 84.18 | 92.02 | 85.26 |

# Statutory and Mandatory Figures – The Narrative

| Performance Indicator | RAG/ Change from previous month | August Figure | Hotspot | % | Comment to include reasons for change / rates high or low |
|---|---|---|---|---|---|
| **Stat & Mand Training (85%)** | **85.26%** ↓ | 86.40% | **Welsh Blood Service (92.25%)** | | |
| | | | *All areas above 90% compliance* | | |
| | | | **Velindre Cancer Centre (84.18%)** | | |
| | | | Palliative/Chronic Pain | 55.42% | Decrease on previous month 61.30% |
| | | | Medical Staffing | 54.92% | Decrease on previous month 60.76% |
| | | | Cancer Services Management Office | 74.83% | Continued slight increase month on month. Previous month 74.70% |
| | | | **Corporate Areas (85.26%)** | | |
| | | | Significant improvement in Stat. and Mandatory training made in all areas of Corporate services bringing compliance back within target from 72.84% in January. | | |

**Action/ initiatives:**

**Velindre University NHS Trust**

Statutory and Mandatory compliance has reported over target for 5 consecutive months within the Trust despite the restrictions on face to face training. Through the COVID pandemic the education and training department have worked on the virtual offering and continue to develop this alongside divisions.

**WBS**

To continue to maintain target compliance across WBS.

**VCC**

Stat and Mandatory training has dipped within VCC with no identified reason for these changes. The WOD senior BP has escalated to SLT in February's divisional performance report for consideration of next steps.

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

Appointment of WOD senior BP has helped support targeted interventions in Corporate Services and the plan is to continue this support to maintain compliance.

## Job Planning Figures – VCC & WBS combined

| Combined | | | | | | | |
|---|---|---|---|---|---|---|---|
| Role | Assignments | With Expired Plan | % With Expired Plan | With Unsigned Plan | % With Unsigned Plan | With Current Plan | % With Current Plan |
| Consultant | 63 | 25 | 39.68% | 13 | 20.63% | 25 | 39.68% |
| Medical Director | 2 | 0 | 0.00% | 0 | 0.00% | 2 | 100.00% |
| Specialty Doctor | 13 | 12 | 92.31% | 0 | 0.00% | 1 | 7.69% |
| Grand Total | 78 | 37 | 47.44% | 13 | 16.67% | 28 | 35.90% |

*NB*

*Data on the job plans associated with other 'medical' posts within the Trust have not been included in the above; this is due to the relatively small numbers involved and therefore the immediately identifiable nature of this information.*

## Narrative

Job plans continue to increase across the Trust (up from 35.90% in January and 20.78% in December) as the process continues to be rolled out with the support of the Medical Directorate at VCC. These figures are expected to continue to rise over the coming months.

The implementation of the new SAS contract has also improved the specialty doctor job plans as these roles develop and are utalised under the new contract.

**Work In Confidence (WIC)**

No detail has been provided this month in terms of the number of staff who have accessed the WIC platform, or categorisation of the type of conversations that have taken place; this is primarily the result of low usage of the platform over the last month and therefore the potential to identify those who have made contact.

In all contacts with staff, staff are encouraged, where appropriate, to share their concerns with their Line Manager (or next appropriate Manager), in order to achieve an early, informal resolution. The WOD Team have also been previously involved in facilitating discussions between the Manager and member of staff.

# QUALITY, SAFETY & PERFORMANCE COMMITTEE

# MARCH PMF COVER PAPER

| | |
|---|---|
| **DATE OF MEETING** | 12/05/2022 |

| | |
|---|---|
| **PUBLIC OR PRIVATE REPORT** | Public |

| | |
|---|---|
| **IF PRIVATE PLEASE INDICATE REASON** | Not Applicable - Public Report |

| | |
|---|---|
| **PREPARED BY** | Wayne Jenkins, Head of Planning and Performance<br>Alan Prosser, Director WBS<br>Sue Thomas Ass Director WOD |
| **PRESENTED BY** | Cath O'Brien, Interim Chief Operating Officer<br>Sarah Morley, Director WOD |
| **EXECUTIVE SPONSOR APPROVED** | Cath O'Brien, Interim Chief Operating Officer |

| | |
|---|---|
| **REPORT PURPOSE** | FOR DISCUSSION / REVIEW |

| COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING | | |
|---|---|---|
| **COMMITTEE OR GROUP** | **DATE** | **OUTCOME** |
| WBS SMT MEETING | 13.4.22 | Reviewed and Noted |
| VCC SLT | 20.4.22 | Reviewed and Noted |
| WBS PERFORMANCE REVIEW | 20.4.22 | Reviewed and Noted |
| VCC PERFORMANCE REVIEW | 21.04.22 | Reviewed and Noted |
| EMB RUN | 27.4.22 | Reviewed and Noted |

| ACRONYMS | |
|---|---|
| VUNHST | Velindre University NHS Trust |
| UHB | University Health Board |
| VCC SLT | Velindre Cancer Centre Senior Leadership Team |
| WBS SMT | Welsh Blood Service Senior Management Team |
| QSP | Quality, Safety & Performance Committee |
| RCR | Royal College of Radiologists |
| JCCO | Joint Council for Clinical Oncology |
| PADR | Performance Appraisal and Development Review |
| KPIs | Key Performance Indicators |
| SACT | Systemic Anti-Cancer Therapy |
| WTE | Whole Time Equivalent (staff) |
| EMB | Executive Management Board |
| COSC | Clinical Oncology Sub-Committee |
| IPC | Infection Prevention Control |
| SPC | Statistical Process Control |

## 1. SITUATION/BACKGROUND

1.1    The attached Trust performance reports provide an update to the Quality, Safety & Performance Committee with respect to Trust-wide performance against key performance metrics through to the end of March 2022 for the Velindre Cancer Centre, the Welsh Blood Service and for VUNHST Corporate Services respectively.

**2.** **ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION**

2.1 The reports set-out performance at Velindre Cancer Centre **(appendix 1),** the Welsh Blood Service **(appendix 2)** and the Workforce **(appendix 3).** Each report is prefaced by an '*at a glance*' section which is intended to draw attention to key areas of performance. A number of areas from the reports are highlighted below.

**2.2** **Velindre Cancer Centre:**

Covid continues to impact our service planning and delivery – positive cases on wards impacts our ability to flexibly use our staff capacity to support SACT and maintain all services.

**Radiotherapy Waiting Times**

Referral volumes were at a high of 383 in March.

As a result of breaches primarily reflecting issues in areas of the patient pathway and not necessarily linac capacity, the Medical directorate has identified a pathway lead to review all breaches with the SSTs responsible and look at where there are process variations that can be resolved to improve the time to treatment. This has commenced with the March data.

Brachytherapy surge due in May- capacity to meet demand remains limited- this is under active surveillance.

**SACT Waiting Times**

We are reporting the lowest performance in the last twelve months due to increasing demand and nurse staffing absences.

A Task and Finish Group was established in late March to create a specific focus on identifying a range of actions to address all aspects of the service that enable patients to receive their SACT treatment. This includes addressing workforce shortage, the physical limitations of capacity for SCAT delivery chairs and increasing capacity in pharmacy and pre-SACT assessment clinics. The EMB received a presentation at their meeting on 27th April to outline the actions taken to date as well as those planned in forthcoming week. A number of actions have been identified and work is currently ongoing to identify the additional capacity that these will create in the forthcoming months. We are still likely to

have to make use of third party provision once contractual arrangements are in place. This work is ongoing and likely to come on line in May.

**Outpatients**

Data collection paused during December to February due to operational pressures and staff absence as manual collection of individual patient attendances is required. We are actively considering new ways of assessing patient experience in clinics as part of the development of the new performance framework.

**Therapies**
Therapy targets primarily being achieved. The one exception being a dietetic patient seen outside of the two week target.

**Other areas**

**Falls**

During March 2022, 9 falls were reported on first floor ward involving 5 patients, 4 of whom fell twice. During this period all patients admitted to the ward were cared for in a single room pending COVID screening results and there was a high patient complexity and acuity. There was no harm or injuries to any patients due to the falls.

All incidents have been fully investigated and been discussed at Scrutiny Panel with independent (Corporate Nursing) scrutiny and all were deemed unavoidable. Although all standards were followed there was some additional learning was identified by the scrutiny panel that could further improve standards. An additional paper on the falls was presented at EMB Run in April.

**Pressure Ulcers**

One Velindre acquired pressure ulcer was reported in March 2022. The patient's mobility was subject to deterioration due to disease progression. The ulcer was deemed unavoidable by the VCC Pressure Ulcer Scrutiny Panel.

No Velindre acquired ulcers were reported to Welsh Government as a Serious Incident (SI).

**Healthcare Acquired Infections**

There was one instance of *C.diff* infection reported in March 2022.

A Root Cause Analysis was undertaken. The infection was deemed to have resulted from extended antibiotic usage and was deemed unavoidable.

**SEPSIS bundle NEWS score**

6 patients met the criteria for administration of the sepsis treatment bundle in March 2022. All patients received all elements of the bundle within one hour. 2 of the patients subsequently received a diagnosis of sepsis or neutropenic sepsis.

**Delayed Transfers of Care (DTOC's)**

One Delayed Transfer of Care was reported in March 2022.

A patient admitted to ensure appropriate nutritional support while undergoing radiotherapy could not be discharged in accordance with the repatriation plan which had been developed because of health board capacity issues.

**Further detailed performance data is provided in Appendix 1**

**2.3 Welsh Blood Service**

**Supply Chain Performance**

WBS continued the monthly trend of meeting demand for red cells with demand for O, A and B groups continuing to be maintained above 3 days in line with the performance for the year.

3 specialist rare patient specific pheno-typed units were requested from NHSBT as part of our mutual aid agreement.

On March 21st the service issued a Blue alert notice to NHS Wales regarding pressure on O group red cells. A number of factors affected this position and included increased demand on common blood groups during the period, high sickness absence rates in collections, vacancy factor and COVID restrictions.

**2.3.1 Recruitment of new bone marrow volunteers**

The number of new bone marrow volunteers added to the Welsh Bone Marrow Donor Registry (WBMDR) improved again in March. It remains below the annual target of 4000 p/a standing at 2,582.

The reduction is due to fewer 17-30 year old blood donor donating red blood, from which bone marrow donors are recruited. This significant reduction can be aligned to COVID 19 Pandemic and the service not being able to target schools, colleges and universities.

The service has recognised this challenge and is in the process of reviewing its approach to recruiting bone marrow donors and identifying how to increase the number of young bone marrow donors. An action plan has been agreed and a business case is being prepared to address this issue. Improvements anticipated Q2 2022.

### 2.3.2 Reference Serology

Turnaround times have reduced to 65% in March and the service is under sustained pressure. Work continues to be prioritised based on clinical need, and all compatibility testing (>55% of referrals) is completed to the required time/date. The complexity of referrals continues to impact performance in March.

The service advised pathology labs across Wales that due to increased staffing pressures all out of hours referrals should be triaged by them to ensure that only those tests that required out of hours provision of results should be sent to WBS for out of hours action.

In addition, following an audit of out of hours referrals these findings are being communicated to Health Board laboratory service leads.

A report on key issues is being prepared which will consider options to improve service provision in the short to long term. In addition, automated analysers are being introduced in Q1 2022 which will enable efficiencies to be realized in some elements of the service.

### 2.3.2 Quality

**Incidents reported to Regulator/Licensing**

There was no Serious Adverse Events (SAE) reported to regulators during March.

**Incidents closed within 30 days**

This measure has not met target (90%) for the period January to March with an increase of incidents not closed within timeframe increasing from 8 to 24.

Of the 16 Datix incidents, 8 were closed in March but exceeded closure timelines. Remaining incidents open in Datix are at the initial reporting stage (4) or remain under investigation (4). Of the remaining incidents, 4 remain open because they are awaiting completion of investigation process which does not permit closure until it has been completed. The remaining 4 incidents were closed late, and the reasons for late closure are currently being compiled.

It should be noted that thirteen of the 16 incidents closed late relate to 'clip failures'. This means that the clip on the donation bag is not fully engaged and as a result the bag has

an amount of blood over the required limit. As a result, the donated unit cannot be used but does not reflect actual or potential harm to the Donor, or risk to patients.

Historically these events were not reported in Datix prior to May 2021 and investigations only completed if an adverse trend outside of normal process variation was detected. Work is nearing completion to revert to monitoring clip failures as a process deviation using Q-pulse, and not to treat them as incidents in Datix.

**Whole Blood Collection Productivity**

The collection productivity for March continues to be below target. This target will not improve under Covid restrictions as the additional resources to operate in this environment are included in the productivity data.

Risk assessments have been undertaken for reducing social distancing to 1m and for the removal of the triage resource at donation clinics from April to support increased capacity at community-based clinics through the reintroduction of additional donation chairs and screening booths and the introduction of self-service triage for donors.

**Number of Concerns Received**

There were 8 concerns received in March and all were managed within timeline as 'Early Resolution'.

**Donor Satisfaction**

Continues to perform strongly at a national level despite the COVID restrictions in place.

3. **WORKFORCE**

3.1 **PADR**

Trust wide performance shows compliance levels at 66.86%

WBS PADR compliance is reported at 78.44% for March 2022.

VCC PADR compliance is reported at 65.96% for March 2022.  This is a slight increase on the previous month.  March has seen an increase across a number or areas within VCC (only 1 area now appearing as 'red'), and Radiotherapy have plans in place to further increase compliance, with the plan looking forward to the next 12 months.

**Sickness Absence**

Rolling absence levels are 6.07%.

WBS sickness absence (in month) has increased, reporting at 7.62%. Short term sickness absence has increased to 4.37%, with long term absence slightly decreasing to 3.25%

VCC sickness absence (in month) has increase in March 2022, reporting at 7.77% from 5.81% in February 2022.  Some areas have reported an increase in Covid related absences, which has resulted in some service pressures.  SACT/Pharmacy have a number of staff on long term sickness absence, these are being managed in line with the managing Attendance at Work Policy.
Both Short- and long term sickness absence has increased this month, 3.24% and 4.53% respectively.

3.2  **Statutory & Mandatory Compliance**

Compliance with the 10 subjects of the Core Statutory Training Framework is at 85.77%.

WBS's Statutory and Mandatory Compliance is 92.30%.

VCC's Statutory and Mandatory Compliance is 84.75% for March 2022, which is a slight increase from the previous month.

4.0  **IMPACT ASSESSMENT**

| | |
|---|---|
| **QUALITY AND SAFETY IMPLICATIONS/IMPACT** | Yes (Please see detail below) |
| | The current performance reporting and monitoring system is predicated upon identifying performance issues and supporting effective decision making at service and operational levels to drive forward continuous improvement in quality, safety and the overall experience of patients and donors. |
| **RELATED HEALTHCARE STANDARD** | Governance, Leadership and Accountability |
| | If more than one Healthcare Standard applies please list below:<br>• Staff and Resources<br>• Safe Care |

| | |
|---|---|
| | • Timely Care<br>• Effective Care. |
| **EQUALITY IMPACT ASSESSMENT COMPLETED** | Yes |
| **LEGAL IMPLICATIONS / IMPACT** | There are no specific legal implications related to the activity outlined in this report. |
| **FINANCIAL IMPLICATIONS / IMPACT** | Yes (Include further detail below) |
| | Delivery against the performance metrics presented in the attached reports and the work associated with delivering improved performance supports sound financial governance across the Trust. |

## 5.0    RECOMMENDATION

5.1    QSP is asked to **NOTE** the contents of the attached performance reports.

*Appendices*

1. VCC December PMF Report
2. WBS December PMF  Report
3. Workforce KPI data

# Velindre Cancer Centre Monthly Performance Report Summary Dashboard (March 2022)

| | | | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Radiotherapy | Patients Beginning Radical Radiotherapy Within 28-Days (page 8) | Actual | 89% | 95% | 94% | 97% | 96% | 97% | 96% | 92% | 78% | 92% | 92% | 92% |
| | | Target | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% |
| | Patients Beginning Palliative Radiotherapy Within 14-Days (page 10) | Actual | 85% | 95% | 85% | 82% | 82% | 82% | 82% | 74% | 84% | 90% | 90% | 81% |
| | | Target | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% |
| | Patients Beginning Emergency Radiotherapy Within 2-Days (page 12) | Actual | 97% | 100% | 100% | 97% | 100% | 97% | 100% | 85% | 89% | 100% | 93% | 88% |
| | | Target | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% |
| SACT | Patients Beginning Non-Emergency SACT Within 21-Days (page 14) | Actual | 98% | 98% | 98% | 99% | 99% | 98% | 99% | 99% | 99% | 94% | 91% | 71% |
| | | Target | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% |
| | Patients Beginning Emergency SACT Within 2-Days (page 15) | Actual | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 86% | 100% | 100% | 100% | 83% |
| | | Target | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% |
| Outpatients | New Patient, other Outpatient and Chemotherapy Assessment Appointments Where Patients Were Seen Within 30 minutes of the Scheduled Appointment Times (National Target) (page 19) | Actual | 66% | 79% | 76% | 76% | 53% | 53% | 65% | 65% | Data collection paused between December and March due to operational pressures. | | | |
| | | Target | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | | | | |

| | | | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Therapies | Did Not Attend (DNA) Rates | Actual | 3% | 4% | 4% | 5% | 5% | 5% | 5% | 5% | 3% | 3% | 3% | 3% |
| | | Target | 5% | 5% | 5% | 5% | 5% | 5% | 5% | 5% | 5% | 5% | 5% | 5% |
| | Therapies Inpatients Seen Within 2 Working Days (page 22) | Actual (Dietetics) | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| | | Actual (Physiotherapy) | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| | | Actual (Occupational Therapy) | 100% | 100% | 100% | 100% | 100% | 100% | 95% | 100% | 100% | 100% | 100% | 100% |
| | | Actual (Speech and Language Therapy) | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| | | Target | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| | Therapies Outpatient Referrals Seen Within 2 Weeks (page 22) | Actual (Dietetics) | 100% | 100% | 84% | 94% | 94% | 98% | 97% | 100% | 95% | 98% | 100% | 98% |
| | | Actual (Physiotherapy) | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| | | Actual (Occupational Therapy) | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| | | Actual (Speech and Language Therapy) | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| | | Target | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |

| | | | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Safe and Reliable Care | Routine Therapies Outpatients Seen Within 6 Weeks (page 22) | Actual (Dietetics) | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| | | Actual (Physiotherapy) | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 86% | 100% | 100% |
| | | Actual (Occupational Therapy) | 100% | 100% | 100% | 100% | 96% | 33% | 78% | 100% | 100% | 100% | 100% | 100% |
| | | Actual (Speech and Language Therapy) | 100% | 100% | 100% | 96% | 100% | 100% | 96% | 100% | 100% | 100% | 100% | 100% |
| | | Target | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| | Number of VCC Acquired, Avoidable Pressure Ulcers (page 24) | Actual | 1 | 0 | 0 | 0 | 2 | 1 | 1 | 0 | 1 | 0 | 1 | 1 |
| | | Target | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Number of Pressure Ulcers Reported to Welsh Government as Serious Incidents | Actual | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | Target | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Number of VCC Inpatient Falls (page 26) | Actual (Total) | 2 | 3 | 1 | 3 | 4 | 2 | 3 | 1 | 4 | 3 | 2 | 9 |
| | | Unavoidable | 1 | 3 | 1 | 3 | 4 | 1 | 3 | 1 | 4 | 2 | 2 | 9 |
| | | Avoidable | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 |
| | | Target | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Number of Delayed Transfers of Care (DToCs) | Actual | 0 | 0 | 0 | 0 | 1 | 0 | 4 | 0 | 0 | 1 | 4 | 1 |

| | | | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Target | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Number of Potentially Avoidable Hospital Acquired Thromboses (HAT) | Actual | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | Target | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Patients with a NEWS Score Greater to or Equal to Three Who Receive all 6 Elements in Required Timeframe (page 28) | Actual | 100% | 100% | 100% | 80% | 100% | 75% | 100% | 100% | 100% | 100% | 100% | 100% |
| | | Target | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| | Healthcare Acquired Infections (page 29) | Actual | 0 | 0 | 0 | 1 (*C.diff*) | 0 | 0 | 0 | 0 | 0 | 1 (*C.diff*) | 0 | 1 (*C.diff*) |
| | | Target | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Percentage of Episodes Clinically Coded Within 1 Month Post Episode End Date | | Actual | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | % |
| | | Target | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% |

RAG rating above indicates: Green - Target was achieved. Amber - 85% Compliance or above.  Red - Target not achieved.

## Radiotherapy Referral Trends - Overall

### Total New Patient Referrals by Month to March 2022



| Monthly Average (2019-20) | Monthly Average (2020-21) | Total New Patient Referrals (March 2022) |
|---|---|---|
| 357 | 315 | 383 |

The total number of referrals received in March 2022 (383) represented an increase on the number received in February 2022 (359). The number of referrals considerably exceeded the average number received in any month, on average, during 2020-21.

Areas of risk:
Brachytherapy surge due in May- capacity to meet demand remains limited- this is under active surveillance and active engagement with WHSSC on increased capacity.

| Radiotherapy – Operational Context |
| --- |
| Referral Trends - Tumour Site |
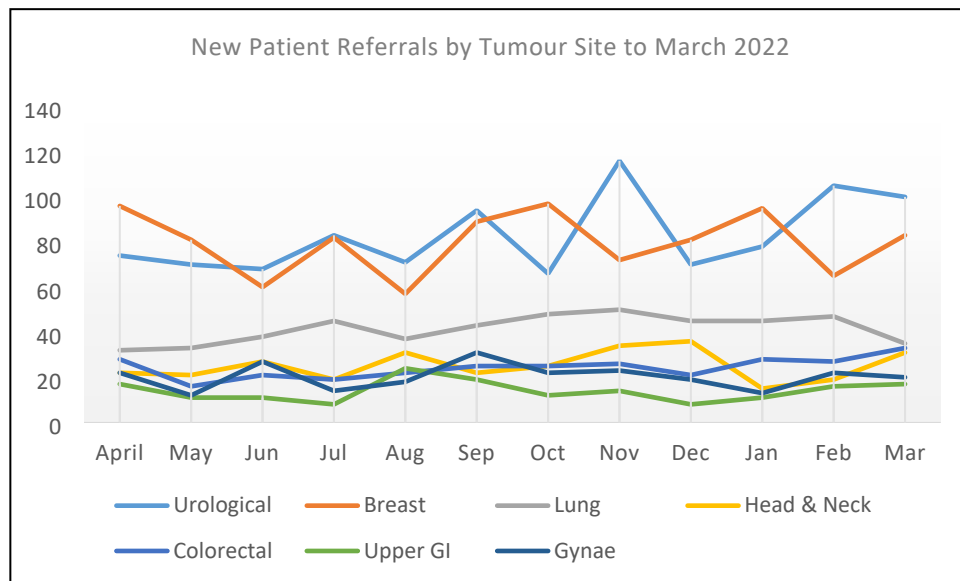


New Patient Referrals by Tumour Site to March 2022

Legend: Urological, Breast, Lung, Head & Neck, Colorectal, Upper GI, Gynae

| Site | Monthly Average (2019-20) | Monthly Average (2020-21) | 2020-21 Average Relative to 2019-20 Average | New Patients (March 2022) |
| --- | --- | --- | --- | --- |
| **Breast** | **88** | **60** | **-32%** | 83 |
| **Urology** | **82** | **82** | **0%** | 100 |
| **Lung** | **47** | **38** | **-19%** | 35 |
| **Colorectal** | **20** | **22** | **+10%** | 33 |
| **Head and Neck** | **23** | **23** | **0%** | 31 |
| **Gynaecological** | **18** | **18** | **0%** | 20 |
| **Upper Gastrointestinal** | **16** | **13** | **- 19%** | 17 |
| **Top 7 Tumour Sites by Number of Referrals as Percentage of Total Referrals** | **82%** | **81%** | | 83% |

*The graph and table show the number of patients scheduled to begin treatment in February by the tumour sites most commonly referred for radiotherapy treatment.*

- Referrals overall and across some tumour sites now returning to pre Covid levels.
- Demand up from 82% to 84% against the 2019/20 baseline (in the tumour sites most commonly referred for radiotherapy, with maximum 80% capacity due to IP&C measures. Prior to staff absences rising during 4th COVID wave.
- Weekly variation in referrals from health boards, across individual tumour sites, is impacting on our ability to meet demand in a timely fashion. Engagement with health boards ongoing to understand their backlog clearance plans.
- All options being explored by SSTs to meet short term surges and to respond to health board backlog clearance.

**Patients Receiving Radical Radiotherapy Within 28-Days**

| Target: 98% | SLT Lead: Radiotherapy Services Manager |
|---|---|
| Trend | Current Performance |



Patients Receiving Radical Radiotherapy Within 28 Days

The number of patients scheduled to begin radical radiotherapy treatment in March 2022 (236) was considerably greater than the monthly average observed in 2020-21 (150) and was larger than the number scheduled to begin treatment in March 2021 (208).

18 patients referred for Radical radiotherapy did not begin treatment within the 28 day target constituting an overall performance rate of 92**%.**

All 18 patients have now commenced treatment and breaches due to capacity constraints followed an approved clinical prioritisation process, to ensure risk to patients and outcomes is minimised.

Breakdown of Breach length of waits:

| Treatment Intent | 29-35 days | Over 35 days |
|---|---|---|
| Radical (28-day target) | 12 | 6 |

Most of the breaches were due to planning/re-planning/re-scanning issues, however the 3 longest waits above were prostate patients (53-75 days) who had their treatment paused during the omicron wave and commenced treatment in month. Everyone now has commenced treatment.

Opportunities for improvement:
Escalation process continues to monitor predicted breaches and prevents breaches where possible through weekly capacity meeting
Delays and cancellations monitored weekly and reported back to Radiotherapy Management Group  and the pathway sub group.
Outsourcing of RT for Breast and prostate patients to RCC continues with 5 prostate and 14 breast patients being referred in March.

| Intent | Monthly Average (2019-20) | Monthly Average (2020-21) | Patients Scheduled to Begin Treatment (March 2022) |
|---|---|---|---|
| Radical | 167 | 150 | 236 |
| | Patients Scheduled to Begin Treatment (March 2020) | Patients Scheduled to Begin Treatment (March 2021) | |
| | 194 | 208 | |

As a result of breaches primarily reflecting issues in areas of pathway not necessarily linac capacity, the Medical directorate has identified a pathway lead to review all breaches with the SSTs responsible and to target the areas where there are process variation. This has commenced with the March data.

## Medium Term Actions

- We are working with each SST to develop a tailored capacity delivery plan based on demand projections and treatment options e.g. Brachytherapy, molecular radiotherapy.
- Recruitment and appointments in progress for additional front line resources, however this will not create capacity increases until 2nd half of 2022 due to lead in time, but we will be maximising capacity from Sept-Dec 2022.
- Peer review with Clatterbridge Trust underway April 2022 to identify options/service models to put service demand and capacity in balance for Brachytherapy.
- Brachytherapy expansion business case being written to obtain support for increased capacity with WHSCC. submission Apr 2022
- Assess the options to escalate some or all of the longer term capacity solutions. April 2022.

| Patients Receiving Palliative Radiotherapy Within 14-Days | |
|---|---|
| **Target: 98%** | **SLT Lead: Radiotherapy Services Manager** |
| Trend | Current Performance |

**Trend**



Patients Receiving Palliative Radiotherapy Treated Within 14 Days

Target % in 14 days

The number of patients scheduled to begin palliative radiotherapy treatment in March 2022 (110) was above the monthly average observed in 2020-21 (74), but was marginally fewer than the number scheduled to begin treatment in March 2021 (112).

| Intent | Monthly Average (2019-20) | Monthly Average (2020-21) | Patients Scheduled to Begin Treatment (March 2022) |
|---|---|---|---|
| Palliative | 82 | 74 | 110 |
| | Patients Scheduled to Begin Treatment (March 2020) | Patients Scheduled to Begin Treatment (March 2021) | |
| | 110 | 112 | |

**Current Performance**

21 patients referred for radiotherapy treatment with palliative intent were scheduled to begin treatment in March and did not begin treatment within the 14 day target constituting an overall performance rate of **81%.**

Additional staffing pressures due to sickness during March as a result of Omicron variant resulted in a reduction of the service.

Breakdown of Breach length of waits:

| Treatment Intent | Under 21 days |
|---|---|
| Palliative (14-day target) | 21 |

3D Planning was the primary cause of breach delays, as it is not possible to produce these within the 14 day targets due to medical physics capacity.

Outsourcing of RT for Breast and prostate patients to RCC continues with 5 prostate and 14 breast patients being referred in March.

As a result of breaches primarily reflecting issues in areas of pathway not necessarily linac capacity, the Medical directorate has identified a pathway lead to review all breaches with the SSTs responsible and to target the areas where there are process variation. This has commenced with the March data.

| | |
|---|---|
| | |
| | Medium Term  Actions |
| | • Refer to 28 day medium term actions. |

| Patients Receiving Emergency Radiotherapy Within 2-Days | |
|---|---|
| **Target: 98%** | **SLT Lead: Radiotherapy Services Manager** |
| Trend | Current Performance |

Patients Receiving Emergency Radiotherapy Treated Within 2 Days



The number of patients scheduled to begin emergency radiotherapy treatment in March 2022 (17) was lower than the monthly average observed in 2020-21 (27) and was lower than the number scheduled to begin treatment in March 2021 (29).

| Intent | Monthly Average (2019-20) | Monthly Average (2020-21) | Patients Scheduled to Begin Treatment (March 2022) |
|---|---|---|---|
| Emergency | 25 | 27 | 17 |
| | Patients Scheduled to Begin Treatment (March 2020) | Patients Scheduled to Begin Treatment (March 2021) | |
| | 33 | 29 | |

**Current Performance**

17 patients referred for radiotherapy treatment with emergency intent were scheduled to begin treatment in March. Of these 2 and did not begin treatment within the 2 day target constituting an overall performance rate of **88%.**

Both patients were treated on day 3. Transport delays at the local health boards in transferring both patients from their local hospitals was the cause of both delays.

Wider Actions as above for 28 and 14 day targets

|  |  |
|---|---|
|  |  |

## Non-Emergency SACT Patients Treated Within 21-Days

| Target: 98% | SLT Lead: Chief Pharmacist |
|---|---|
| Current Performance | Trend |

### Current Performance

Non-Emergency SACT Patients Treated Within 21 Days



The number of patients scheduled to begin non-emergency SACT treatment in March 2022 (400) was considerably larger than both the monthly average observed in 2020-21 (298).

| Intent | Monthly Average (2019-20) | Monthly Average (2020-21) | Patients Scheduled to Begin Treatment (March 2022) |
|---|---|---|---|
| Non - emergency | 328 | 298 | 400 |
|  | Patients Scheduled to Begin Treatment (March 2020) | Patients Scheduled to Begin Treatment (March 2021) |  |

### Trend

400 patients were referred for non-emergency SACT treatment scheduled to begin treatment in March. Of this total, 118 patients did not begin treatment within the 21 day target, constituting an overall performance rate of 71%.

Of the 118 patients who did not begin treatment within 21-days

| Treatment Intent | ≤ 28 days | ≤ 35 days | ≤ 42 days |
|---|---|---|---|
| Non-emergency (21-day target) | 61 | 47 | 10 |

All patients within a Clinical Trial are booked within the trial timeframes.

Due to current capacity constraints within SACT & Medicines Management team, all new patients & urgent patients are prioritised using Welsh Cancer Network guidance and available clinical information. Escalation & capacity needs are continually reviewed and change frequently throughout the day. The Clinical Priority process commenced 20/12/22.

VCC has not reduced social distancing to 1m due to the high community prevalence of COVID. Reduction of social distancing to 1m will enable VCC SACT daycase unit to increase the number of chairs overall by a small margin (yet to be defined). This will aid patient flow. However, the primary capacity challenge of the service is related to staffing resource and thus increase in chair capacity will not facilitate increased capacity without resolution of staffing challenges.
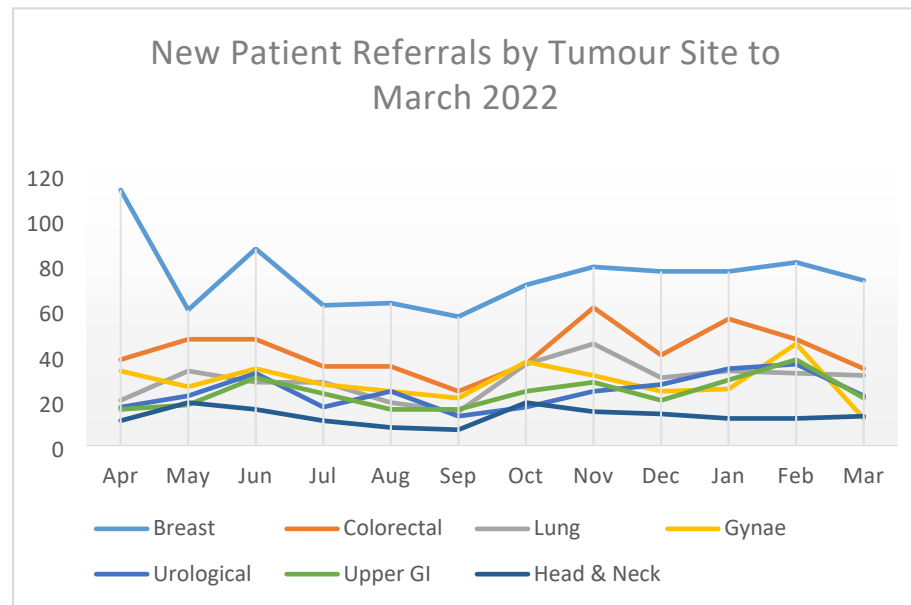
| | 329 | 351 | | All options to address workforce challenges are being considered. <br> Daily SACT Escalation meetings continue to be held with senior clinical SACT team leads who actively manage this prioritisation process and endeavour to ensure that all patients are treated in as timely a manner as possible according to their clinical prioritisation category and date of referral to the service. |
|---|---|---|---|---|
| | | | | **Actions** |
| | | | | <ul><li>Weekend clinics and mutual aid from other parts of the centre are being utilised.</li><li>Additional capacity being secured from Rutherford cancer centre. May 2022 is the predicted commencement, however discussions have commenced to try and bring this forward.</li><li>All treatment regimens that can be delivered in other clinical areas are being explored and actioned to release capacity in the SACT clinic area.</li><li>A task and finish group has been established to identify solutions to support the service in increasing capacity, productivity, sustainability. Commenced March 2022 and ongoing.</li><li>Discussions are being escalated to prioritise the Neville Hall provision, which is the medium term plan for increasing capacity.  We expect a progress report in May.</li></ul> |

| Emergency SACT Patients Treated Within 5-Days | |
|---|---|
| **Target: 98%** | **SLT Lead: Chief Pharmacist** |
| Current Performance | Trend |



Emergency SACT Patients Treated Within 5 Days

Target % in 5 days

The number of patients scheduled to begin emergency SACT treatment in March 2022 (6) was higher than the monthly average observed in 2020-21 (4).

| Intent | Monthly Average (2019-20) | Monthly Average (2020-21) | Patients Scheduled to Begin Treatment (March 2022) |
|---|---|---|---|
| Emergency | 4 | 4 | 6 |
| | Patients Scheduled to Begin Treatment (March 2020) | Patients Scheduled to Begin Treatment (March 2021) | |
| | 3 | 8 | |

**Trend**

6 patients referred for emergency SACT treatment were scheduled to begin treatment in March 2022. 1 patient did not begin treatment within the 5-day target.
The patient was treated on day 10.

- Ring fencing of emergency chair capacity has allowed us to improve the compliance in this area. This took a number of months until the correct balance between ring fencing and chair utilisation was achieved.

**Actions**

- Continue to balance demand and ring fencing with capacity.

| SACT – Operational Context | | |
|---|---|---|
| **Current Performance Consolidated** | | |

| Measure | Target | Mar-22 |
|---|---|---|
| Non-emergency (21-day target) | 98% | **71%** |
| Emergency (5-day target) | 98% | **83%** |

The table shown here sets-out performance relative to the extant time to SACT targets.

**Referral Trends - Overall**



Total New Patient Referrals by Month to March 2022

| Monthly Average (2019-20) | Monthly Average (2020-21) | Total New Patient Referrals (March 2022) |
|---|---|---|
| 325 | 301 | 437 |

The total number of referrals received in March 2022 (437) was markedly greater than the average number received in any given month during 2020-21 (301) and greater than the number received in February 2022 (358). The number of referrals received in March also greatly exceeds the average number received on average, per month in 2019-20.

Referrals fell dramatically following the first national lock-down in March 2020. Subsequently, referrals have returned to pre-pandemic levels.
Referrals include new patients for 1st definitive treatment and repeat treatments for patients mid cycle or on a revised treatment cycle.

| SACT – Operational Context |
| :--- |
| Referral Trends - Tumour Site |

### New Patient Referrals by Tumour Site to March 2022



Legend: Breast, Colorectal, Lung, Gynae, Urological, Upper GI, Head & Neck

| Site | Monthly Average (2019-20) | Monthly Average (2020-21) | 2020-21 Average Relative to 2019-20 Average | New Patient Referrals (March 2022) |
| :--- | :---: | :---: | :---: | :---: |
| **Breast** | **92** | **76** | **-17%** | 73 |
| **Colorectal** | **54** | **55** | **+2%** | 34 |
| **Lung** | **33** | **32** | **-3%** | 31 |
| **Gynaecological** | **31** | **31** | **0** | 12 |
| **Urological** | **36** | **26** | **-28%** | 22 |
| **Upper Gastrointestinal** | **18** | **26** | **+44%** | 21 |
| **Head and Neck** | **16** | **14** | **-12%** | 13 |
| **Top 7 Tumour Sites by Number of Referrals as Percentage of Total Referrals** | **86%** | **87%** | | 47% |

The graph and table show referrals for the tumour sites most commonly referred for SACT treatment.

SACT referrals are being driven by a high level of internal demand as a result of new/combination regimens, increasing patient treatment cycles etc.

## Equitable and Timely Access to Services - Therapies

| Target: 100% | SLT Lead: Head of Nursing |
|---|---|

**Current Performance**

### Percentage of Therapies Referrals (Inpatients) Seen Within 2 Working Days

|  | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Dietetics | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| Physiotherapy | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| OT | 100% | 100% | 100% | 100% | 100% | 100% | 95% | 100% | 100% | 100% | 100% | 100% |
| SLT | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |

### Percentage of Urgent Therapies Referrals (Outpatients) Seen Within 2 Weeks

|  | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Dietetics | 100% | 100% | 84% | 94% | 94% | 98% | 97% | 100% | 95% | 98% | 100% | 98% |
| Physiotherapy | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| OT | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| SLT | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |

### Percentage of Routine Therapies (Outpatients) Seen Within 6 Weeks

|  | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Dietetics | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| Physiotherapy | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 86% | 100% | 100% |
| OT | 100% | 100% | 100% | 100% | 96% | 33% | 78% | 100% | 100% | 100% | 100% | 100% |
| SLT | 100% | 100% | 100% | 96% | 100% | 100% | 96% | 100% | 100% | 100% | 100% | 100% |

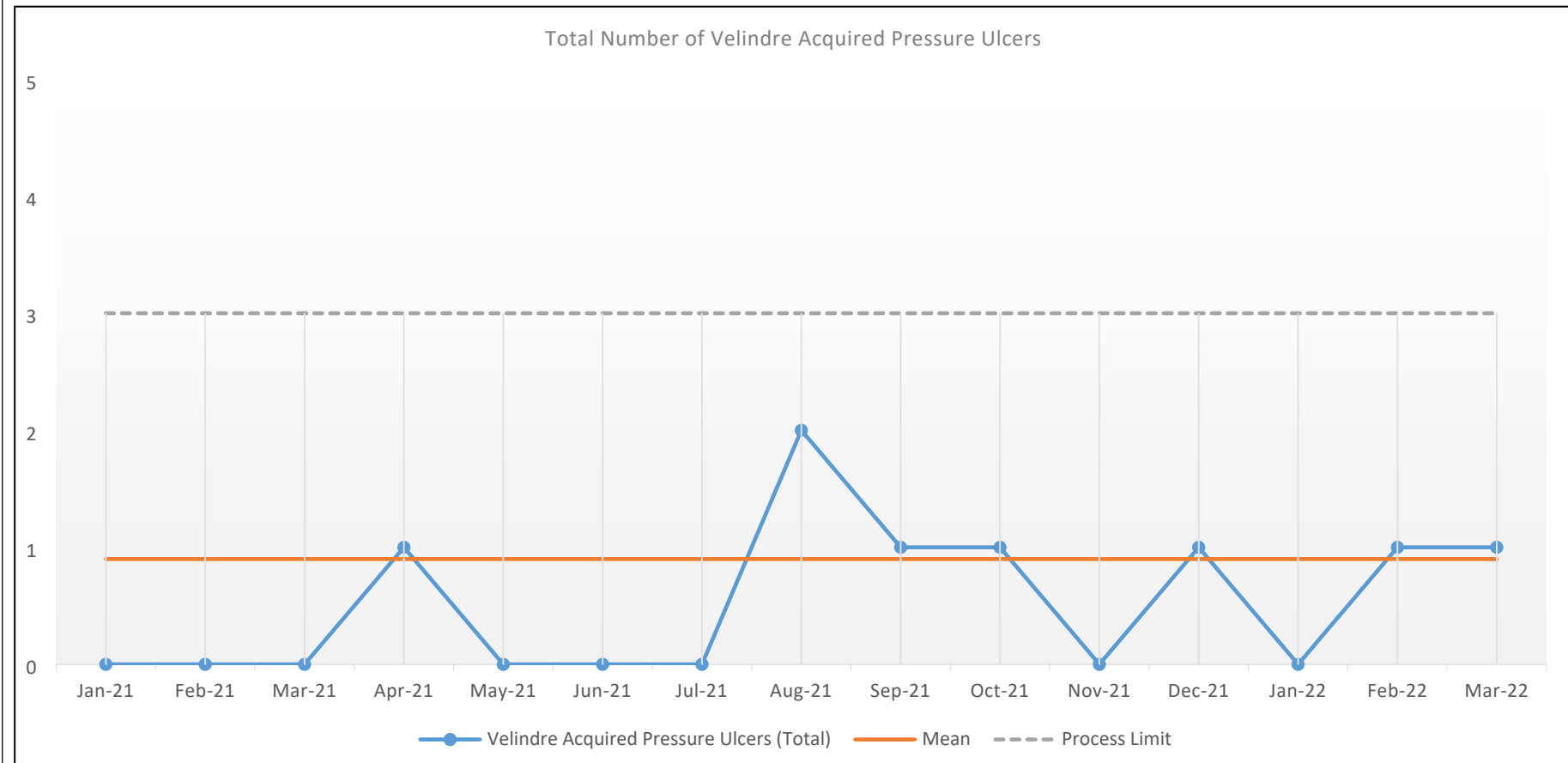| | |
|---|---|
| One dietetic outpatient was not seen within target. The patient was seen one day after the stipulated target. No harm was reported. | No specific actions required. |

| Velindre Acquired Pressure Ulcers | |
|---|---|
| **Target: 0** | **SLT Lead: Head of Nursing** |
| Current Performance | |



Total Number of Velindre Acquired Pressure Ulcers

Legend: Velindre Acquired Pressure Ulcers (Total) — Mean — — — Process Limit

| | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Velindre Acquired Pressure Ulcers (Total) | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 2 | 1 | 1 | 0 | 1 | 0 | 1 | 1 |
| Potentially Avoidable Velindre Acquired Pressure Ulcers | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 |

| Trend | Action |
|---|---|
| 1 Velindre acquired pressure ulcers was reported in March 2022. <br><br>• The patient's mobility was subject to deterioration due to disease progression. The ulcer was deemed unavoidable by the VCC Pressure Ulcer Scrutiny Panel. A risk assessment was undertaken on admission and app <br>• Appropriate interventions put in place. <br><br><br>No Velindre acquired ulcers were reported to Welsh Government as a Serious Incident (SI). | • No further action required. |

| Velindre Inpatient Falls | |
|---|---|
| Target: 0 | SLT Lead: Head of Nursing |
| Current Performance | |
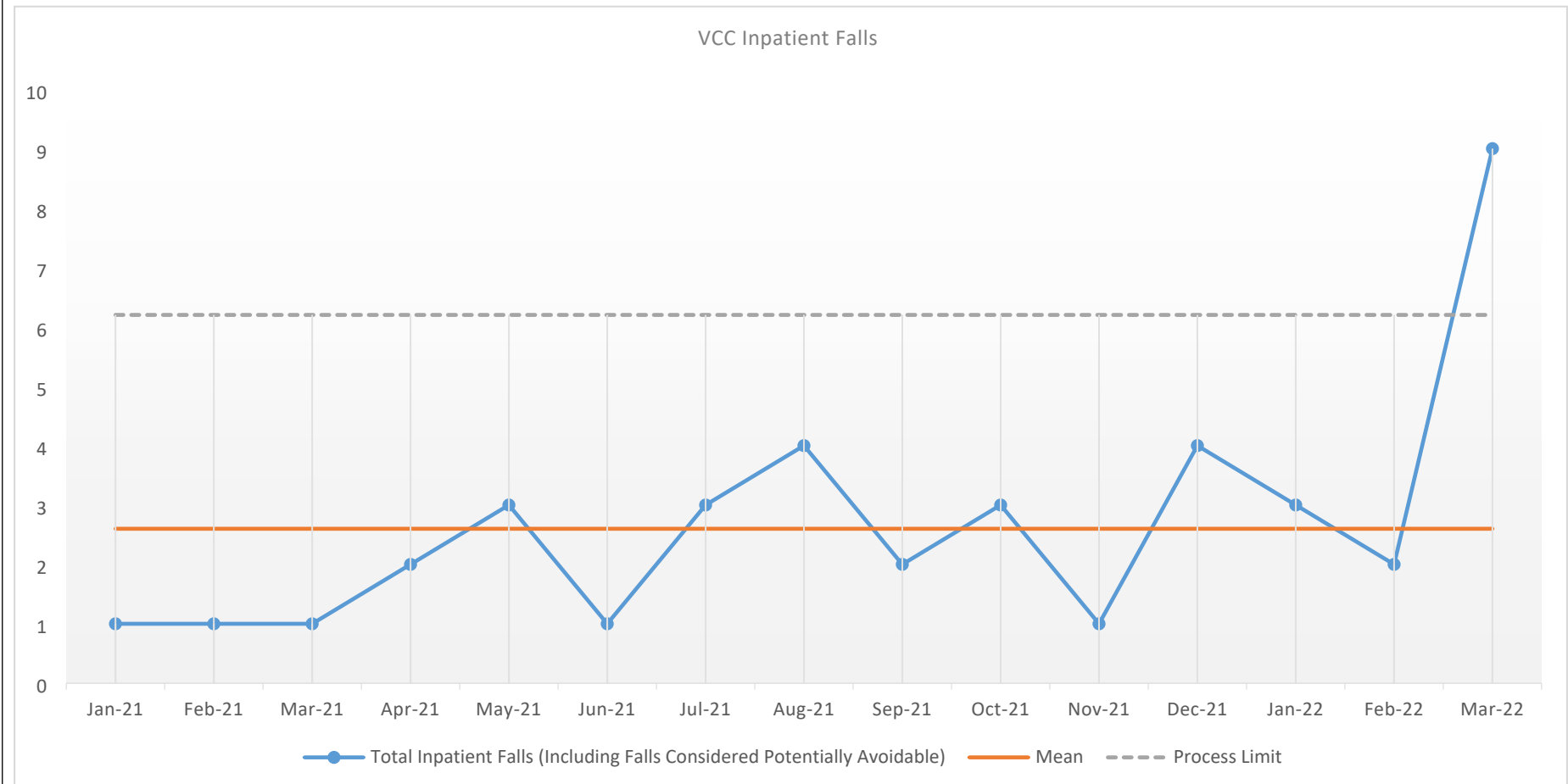


VCC Inpatient Falls

Total Inpatient Falls (Including Falls Considered Potentially Avoidable) — Mean — — — Process Limit

| | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total Inpatient Falls | 1 | 1 | 1 | 2 | 3 | 1 | 3 | 4 | 2 | 3 | 1 | 4 | 3 | 2 | 9 |
| Potentially Avoidable Inpatient Falls | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 |

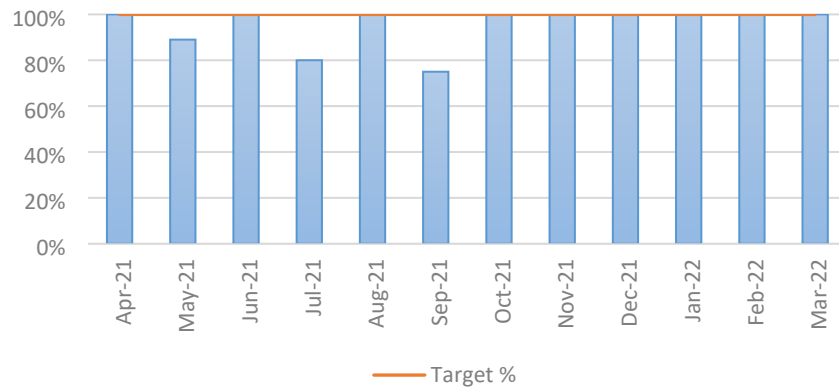| Trend | Action |
|---|---|
| During March 2022, 9 falls were reported on first floor ward involving 5 patients, 4 of whom fell twice. During this period all patients admitted to the ward were cared for in a single room pending COVID screening results and there was a high patient complexity and acuity. There was no harm or injuries to any patients due to the falls.<br><br>All incidents have been fully investigated and been discussed at Scrutiny Panel with independent (Corporate Nursing) scrutiny and all were deemed unavoidable. All assessments were completed in line with standards and appropriate post fall care adjustments made and medical review undertaken. The circumstances and mechanics of each fall varied. Two of the patients were experiencing a degree of cognitive impairment and some of the falls occurred when staff were also present with the patient but could not prevent the descent to the floor. Following one of the patient's second fall 24/7 one to one nursing care was put in place. | Although all standards were followed there was some additional learning was identified by the scrutiny panel that could further improve standards.<br><br>• All patients to have a baseline lying / standing blood pressure reading taken on admission<br>• Staff to liaise with all-Wales Falls Team and local neurological teams at district general hospitals in order to identify specific measures which might be implemented to support patients subject to altered mental capacity. |

| Delayed Transfer of Care | |
|---|---|
| **Target: 0** | **SLT Lead: Head of Nursing** |
| Current Performance | |

1 Delayed Transfers of Care was reported in March 2022.

A patient admitted to ensure appropriate nutritional support while undergoing radiotherapy could not be discharged in accordance with the repatriation plan which had been developed because of health board capacity issues.

| Patients with a NEWS Score Greater Than or Equal to Three Who Receive All 6 Elements in Required Timeframe | |
|---|---|
| **Target: 100%** | **SMT Lead: Clinical Director** |
| Current Performance | Trend |

**Proportion of Patients with a NEWS Score Greater Than or Equal to Three Who Received All Six Elements in Required Timeframe**

| Month | Value |
|-------|-------|
| Apr-21 | 100% |
| May-21 | 90% |
| Jun-21 | 100% |
| Jul-21 | 81% |
| Aug-21 | 100% |
| Sep-21 | 76% |
| Oct-21 | 100% |
| Nov-21 | 100% |
| Dec-21 | 100% |
| Jan-22 | 100% |
| Feb-22 | 100% |
| Mar-22 | 100% |

— Target %

6 patients met the criteria for administration of the sepsis treatment bundle in March 2022. All patients received all elements of the bundle within one hour. 2 of the patients subsequently received a diagnosis of sepsis or neutropenic sepsis.

**Actions**

No specific action required.

| Healthcare Acquired Infections (HAIs) | |
|---|---|
| **Target: 0** | **SLT Lead: Clinical Director** |
| Current Performance | |

| | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| C.diff | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 1 |
| MRSA | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| MSSA | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| E.coli | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Klebsiella | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Pseudomonas Aeruginosa | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

| Trend | Action |
|---|---|
| There was one instance of *C.diff* infection reported in March 2022. | A Root Cause Analysis was undertaken. The infection was deemed to have resulted from extended antibiotic usage and was deemed unavoidable. |

# QUALITY, SAFETY and PERFORMANCE COMMITTEE

## VELINDRE CANCER CENTRE DIVISIONAL REPORT
## FEBRUARY 2022

| DATE OF MEETING | 12 May 2022 |
|---|---|

| PUBLIC OR PRIVATE REPORT | PUBLIC |
|---|---|

| IF PRIVATE PLEASE INDICATE REASON | Not Applicable |
|---|---|

| PREPARED BY | VIV COOPER, HEAD OF NURSING, QUALITY, SAFETY AND PATIENT EXPERIENCE<br>SARAH OWEN, QUALITY AND SAFETY MANAGER<br>TRACEY LANGFORD, QUALITY & SAFETY OFFICER |
|---|---|
| PRESENTED BY | CATH O'BRIEN, CHIEF OPERATING OFFICER |
| EXECUTIVE SPONSOR APPROVED | CATH O'BRIEN, CHIEF OPERATING OFFICER |

| REPORT PURPOSE | FOR NOTING |
|---|---|

| COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING | | |
|---|---|---|
| COMMITTEE OR GROUP | DATE | OUTCOME |
| Senior Leadership Team | | |

| ACRONYMS | |
| --- | --- |
| VCC | Velindre Cancer Centre |
| QSMG | Quality and Safety Management Group |
| QSP | Quality, Safety and Performance |
| WCP | Welsh Clinical Portal |
| NRI | National Reportable Incident |
| WG | Welsh Government |
| RT | Radiotherapy |
| SLT | Senior Leadership Team |
| PTR | Putting Things Right |
| WRP | Welsh Risk Pool |
| OfW | Once for Wales |
| DHCW | Digital Health Care Wales |
| HIW | Health Inspectorate Wales |
| MES | Medical Examiner Service |

| **Overview** |
| :---: |

The purpose of this paper is to provide the QSP Committee with an update on the key quality and safety outcomes and metrics for VCC for February 2022. This report provides the committee with a summary of performance data as comprehensive performance data and narrative is provided and discussed through other reports and committees within the Trust and the Division on a monthly basis. The format of this report is structured around the 6 domains of quality and safety. The Q&S team at VCC are keen to receive feedback/views on the format and content of this paper

| **QUALITY AND SAFETY IMPLICATIONS/IMPACT** | Yes (Please see detail below) |
| :--- | :--- |
| | The current quality, safety and performance reporting and monitoring system is predicated upon identifying issues and supporting effective decision making at service and operational levels to drive forward continuous improvement in quality, safety and improving the overall experience of patients and donors. |
| **RELATED HEALTHCARE STANDARD** | Governance, Leadership and Accountability |
| | If more than one Healthcare Standard applies please list below: Staff and Resources Safe Care Timely Care Effective Care. |
| **EQUALITY IMPACT ASSESSMENT COMPLETED** | Not required |
| **LEGAL IMPLICATIONS / IMPACT** | There are no specific legal implications related to the activity outlined in this report. |
| **FINANCIAL IMPLICATIONS / IMPACT** | Yes (Include further detail below) |

**CONTENTS PAGE**

| 1.0 | **Introduction** |
|-----|------------------|

1.1   The purpose of this paper is to provide the Quality, Safety and Performance Committee with an update on the key quality and safety outcomes and metrics for Velindre Cancer Centre for the period of February 2022.

1.2   The Quality, Safety and Performance Committee are asked to **NOTE**:

- progress against the key priority areas
- issues, corrective actions and monitoring arrangements in place
- identify opportunities for learning and best practice

| 2.0 | **Impact Assessment** |
|-----|------------------------|

2.1 This report covers the period of February 2022 and therefore retrospectively provides VCC service quality and safety data and narrative, the purpose of which is to provide assurance. The report is structured around the 6 domains of quality and safety.

| 3.0 | **Highlight from Velindre Cancer Centre Quality and Safety Management Group** |
|-----|--------------------------------------------------------------------------------|

3.1 There was no urgent matters to escalate to SLT following the VCC QSMG meeting in February 2022.

| 4.0 | **Safe Care**<br>**Descriptor; avoid harm** |
|-----|----------------------------------------------|

4.1   Incidents/near-misses/compliments/feedback are used as indicators of safe care and are captured using the Once for Wales DATIX software system. Assurance regarding the safety of the services provided at Velindre Cancer Centre is provided through various routes/reports and committees including:

- Tier 1 Reportable Indicators (reported via the monthly performance reports)
- Incidents (discussed in each Directorate and reported to the VCC QSMG and Trust QSP)
- Complaints discussed in each Directorate and reported to the VCC QSMG and Trust QSP)
- Claims (reported to the Trust QSP)

- Compliments discussed in each Directorate and reported to the VCC QSMG and Trust QSP). This section will provide assurance that safe care is being delivered in Velindre Cancer Centre and that where there are lessons learned and actions to improve service that there is a monitoring system in place.

## 4.2 **Incidents**

Severity (degree of harm) code descriptors in relation to the Once for Wales System are as follows:

| No harm | No harm (impact not prevented) - Any incident that ran to completion, but no harm occurred to people receiving NHS funded care |
|---------|--------------------------------------------------------------------------------------------------------------------------------|
| Low | Any unexpected or unintended incident that required extra observation or minor treatment and caused minimal harm to one or more persons receiving NHS-funded care |
| Moderate | Any unexpected or unintended incident that resulted in a moderate increase in treatment, possible surgical intervention, cancelling of treatment, or transfer to another area, and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care |
| Severe | Any unexpected or unintended incident that directly resulted in permanent harm to one or more persons |
| Death | Any unexpected or unintended incident that directly resulted in the death of one or more persons |

There were 123 incidents reported in February 2022.

The incidents were initially categorised by the incident reporter as follows:

- 76 no harm
- 40 low harm
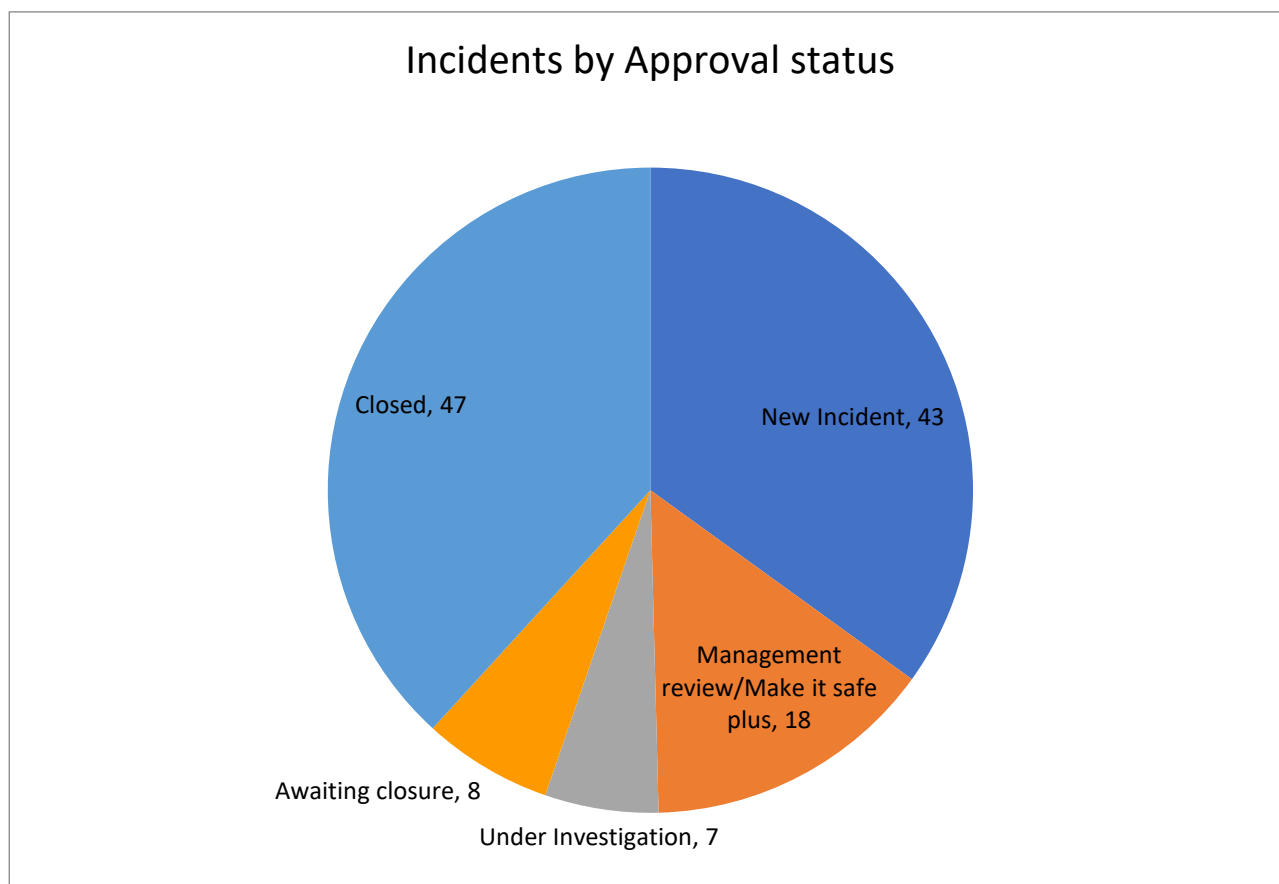- 7 moderate harm
- 0 severe harm

### 4.2.1. **Moderate Incidents**
5 of the 7 moderate incidents have been investigated – 4 have been recategorised to "Low/ No Harm" following the investigation.
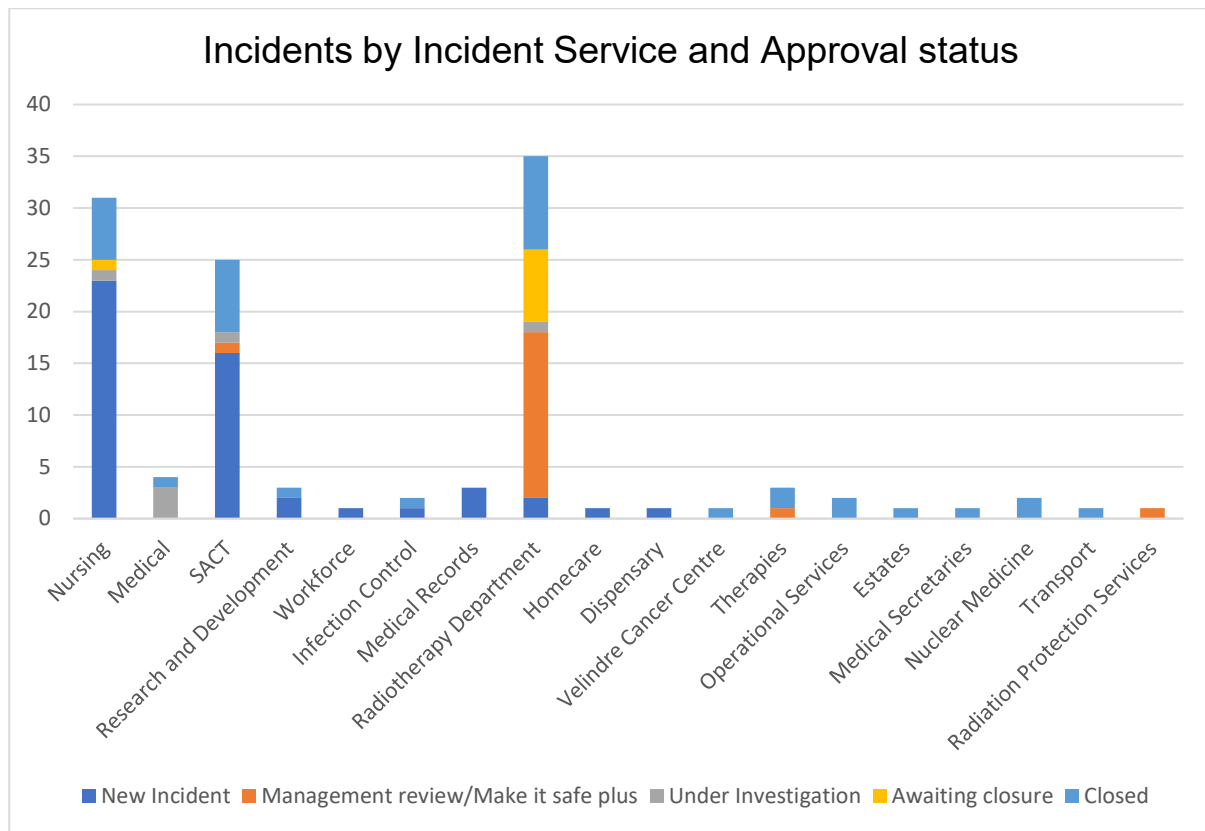
1 remains categorised as "Moderate harm" following investigation. Patient attended for emergency radiotherapy for cauda equina which was treated as per guidelines. However, there were opportunities that could have led to a more optimal treatment for this patient. A suggested measure is that SpR post fellowship grade or a clinical oncology consultant only to review volumes when planned by planning radiographers. To be agreed by medical directorate and forwarded to all relevant departments.

2 incidents categorised as moderate harm have not yet been investigated fully. Both are related to pharmacy – communication with the pharmacy department, prescription not available at pharmacy department.

4.2.2. Open Incidents

## Incidents by Approval status

Closed, 47

New Incident, 43

Management review/Make it safe plus, 18

Awaiting closure, 8

Under Investigation, 7

There are 293 incidents open over 30 days. This is an increase on the last report of 45 incidents. The clinical areas have been under increased pressures throughout March due to increased levels of Covid 19 in the community which has had a knock on effect on staffing levels. This is also demonstrated in the graph below.

**Incidents by Incident Service and Approval status**

Legend: New Incident | Management review/Make it safe plus | Under Investigation | Awaiting closure | Closed

Radiotherapy have seen a decrease in the number of incidents reported in February 2022.

### 4.2.4. Falls Scrutiny Panel
There were 2 inpatient falls in February 2022. Following discussion in the scrutiny panel both were deemed as unavoidable.

### 4.2.5 Pressure Ulcer Scrutiny Panel
During February 2022, there was 1 patient with a hospital acquired pressure ulcer on first floor ward. Contributory factors were that due to pain the patient was unable to lay on side, unable to reposition and constantly lying on his back. This pressure ulcer was deemed avoidable despite compliance with all care and interventions the nursing documentation was incomplete, the pressure ulcer has since healed.

### 4.2.6. National Reportable Incidents

There were 8 incidents that was reportable to HIW.
1 was reported from radiology and 7 from radiotherapy physics.

Radiology NRI

A reportable radiation incident occurred where over a course of treatment, the number of additional imaging exposures a patient received was 20% greater than intended according to local protocol.

1. As a result of the position of the treatment unit on fraction 2 an additional 2 images were taken.
2. As a result of the machine breakdown and position correction error on fraction 4 an additional 3 images were taken.

This meets the criteria as Significant accidental and unintended exposure under IR(ME)R (SAUE) as 3 or more imaging exposures (including the intended image), were taken in a single fraction on two occasions resulting in the number of additional imaging exposures being 20% greater than intended over the course of treatment or than was described in the protocol. This was not considered clinically significant.

Action to reduce the risk of reoccurrence

| Action | Date due | Responsible person | Progress | Staff that require update on changes |
|---|---|---|---|---|
| Standardisation of reference images (isos or treatment fields) for non-planned palliative patients | 31/10/2021 | LAD - IGRT Specialist Radiographer | Completed 31/10/2021 | All Pre-treatment and treatment radiographers |
| Standardisation of Image Guided radiotherapy (IGRT) for non-planned palliative patients | 31/5/2022 | ML - Band 6 Therapy Radiographer /LD - Band 7 Therapy Radiographer | Commenced 04/03/2022 | All Pre-treatment and treatment radiographers |
| Reference Images should be annotated with description of the treatment site and of the image projection | 18/3/2022 | CRD - RT Clinical Governance Manager – email PJ - Operational Superintended Radiographer– Information Meeting | Email 14/3/2022 | All Pre-treatment and treatment radiographers |
| Staff to be reminded that before working on-call or bank holiday to review competence if they have not worked on that specific machine for any length of time | 18/3/2022 | PJ - Operational Superintendent Radiographer – Information Meeting | Radiotherapy Information Meeting 18/3/2022 - minutes | All Pre-treatment and treatment radiographers |

| Professional Standards Document to be reviewed to ensure expectations regarding ensuring competence are included | 31/5/2022 | VP – Band 7 Therapy Radiographer | Commenced 01/03/2022 | All Pre-treatment and treatment radiographers |
|---|---|---|---|---|
| Review of documentation and competency matrix to ensure clear guidance for which competencies are required for working on call | 30/6/2022 | Operational Superintendent | | All Pre-treatment and treatment radiographers |

Radiotherapy Physics NRI

4 of the incidents relate to the CT imaging system attached to the linear accelerator which verify patients are in the correct position before treatment. If the XVI faults during acquisition the patient will receive a small additional imaging dose prior to radiotherapy treatment. These XVI faults are not unique to the systems at Velindre and are known to occur throughout the UK and centres globally. They are reportable under IRMER legislation if 2 scans fail in a single fraction, but are not clinically significant in the context of radiotherapy.

The remaining 3 incidents relate to the planar MV imaging system attached to the Varian linear accelerators, utilised to verify breast patient position. Similar to the XVI faults above the patients received a small additional imaging dose prior to their radiotherapy treatment. None of these planar imaging incidents meet the threshold to be reportable individually; they were reported due to the number of incidents as recommended for best practice. Similar incidents were grouped into type 1, 2 or 3 (hence 3 reports). Type 1 related to a procedural error following a system 'timeout' and type 2 and 3 to machine faults. Training has been provided for type 1 and advice is being sought from the manufacturer regarding type 2 and 3.

4.2.7. **Early Warning Notifications**

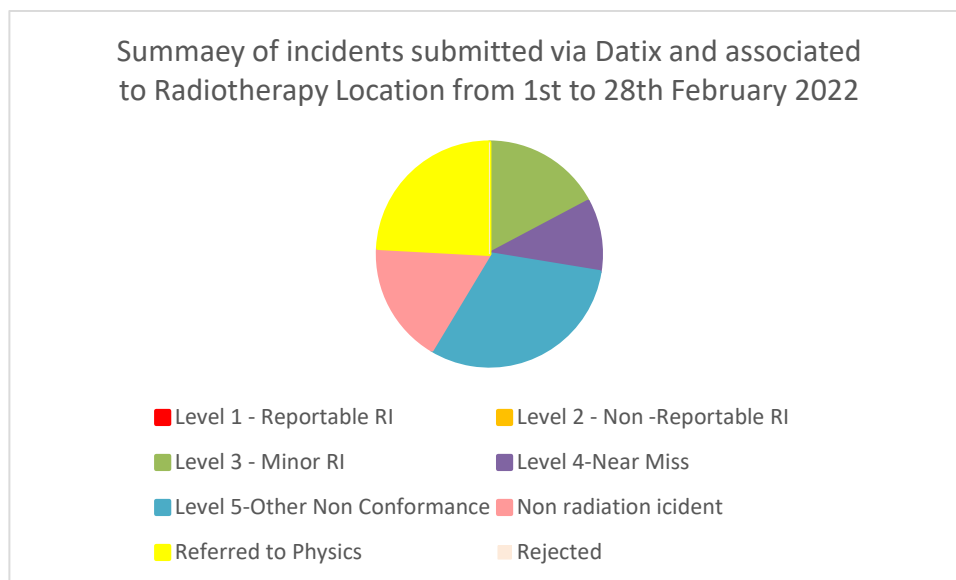There are no Early Warning Notifications for the time period.

4.3. **IRMER Compliance/ Issues/ Incidents**

Please note that this information is for Radiotherapy Department location in Once for Wales Datix Incident module and does not include any incidents assigned to Medical Physics Location.

**February 1st to February 28th 2022**

Between 1st February and 28th February 2022, 29 incidents were reported in the Once for Wales Datix Incident module and associated to the Location of Radiotherapy Department. Of the 29 incidents reported, 24 were classed as radiotherapy errors / radiation incidents. 17 of which are under investigation by the radiotherapy department and have been coded in line with Towards Safer (TSRT) and 7 have been referred to Radiotherapy Physics for investigation.

<u>February 1st to February 28th 2022 (from Once for Wales Datix)</u>



Summaey of incidents submitted via Datix and associated to Radiotherapy Location from 1st to 28th February 2022

- Level 1 - Reportable RI
- Level 2 - Non -Reportable RI
- Level 3 - Minor RI
- Level 4-Near Miss
- Level 5-Other Non Conformance
- Non radiation icident
- Referred to Physics
- Rejected

**Radiotherapy error**[1] – A non-conformance where there is an unintended divergence between a radiotherapy treatments delivered or a radiotherapy process followed and that defined as correct by local protocol.

**Radiation Incident**[1] – a radiotherapy error where the delivery of radiation during a course of radiotherapy is other than that which was intended and which could have resulted or did result in unnecessary harm to the patient.

**Level 1 Reportable radiation incident**[1] – a radiation incident that falls into the category of reportable under any of the statutory instruments (IR(ME)R 2017, IRR 2017 and so on). A reportable radiation incident will generally be clinically significant
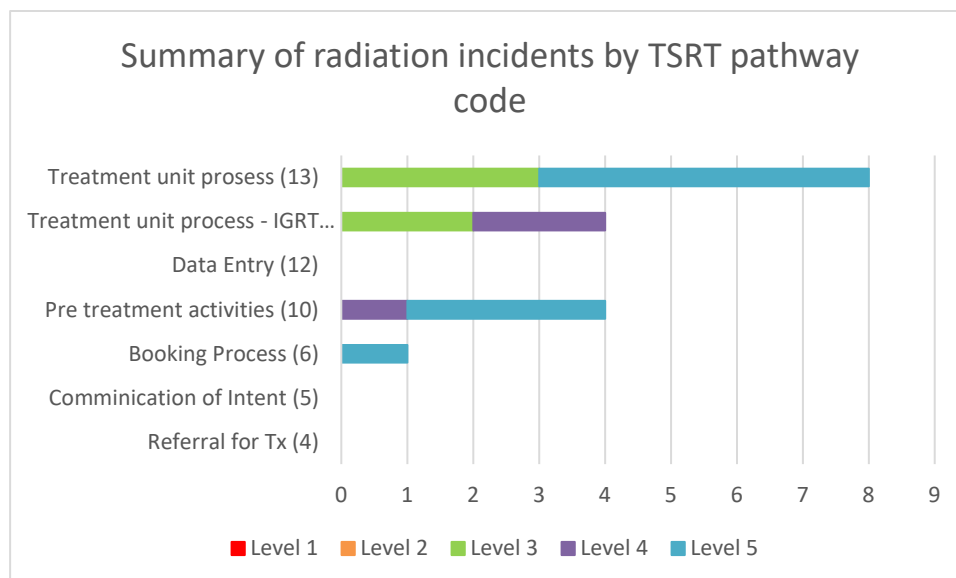
**Level 2 Non-reportable radiation incident**[1] - A radiation incident that does not fulfil the criteria as reportable under any of the statutory instruments (IR(ME)R 2017, IRR 2017 and so on) but is of potential or actual clinical significance. However reporting level 2 radiation incidents to the statutory authority is good clinical governance even though there is no legal requirement to do so.

**Level 3 Minor radiation Incident**[1] – A radiation incident in the technical sense but one of no potential or actual clinical significance.

**Level 4 near miss**[1] – A potential for a radiation incident that was detected and prevented before treatment delivery.

**Level 5 Other non-conformance**[1] – None of the above; that is non-compliance with some other aspect of a documented procedure but not directly affecting radiotherapy delivery.

1. The Royal Collage of Radiologists, Society and Collage of Radiographers, Institute of Physics and Engineering in Medicine, National Patient Safety agency, British Institute of radiology. Towards Safer Radiotherapy. London: The Royal Collage of Radiologists, 2008

Summary of radiation incidents by TSRT pathway code

| Level | Number of errors reported |
|---|---|
| Level 1 - REPORTABLE RADIATION INCIDENTS | 0 |
| Not clinically significant | 0 |
| Level 2 - NON-REPORTABLE RADIATION INCIDENTS | 0 |
| Level 3 - MINOR RADIATION INCIDENTS | 5<br>2 x Imaging process (no action level systematic error correction errors.<br>3 x Treatment unit errors – patient positioning |
| Significant outcome | 0 |
| Level 4 - MINOR RADIATION INCIDENTS | 3 |
| Significant outcome | 0 |
| Level 5 - OTHER NON-CONFORMANCE | 9<br><br>5 x treatment unit errors (not IGRT)<br>3 x pre-treatment errors<br>1 x booking error |
| Significant outcome | 0 |
| Referred to Radiotherapy Physics for investigation -These incidents are linked to on treatment image verification failures for Elexta XVI and DIBH on La5 & LA6 which are long standing issue that are known to the manufacturers and are regularly reviewed by Radiotherapy Physics and the linear accelerator status group. | 7 |

**Routine Audits**

| Action Ref. | Details | Action | Owner/ Lead | Due by | Status | Closed on | Notes/Update |
|---|---|---|---|---|---|---|---|
| 33 | January Audit - Departmental Forms - Unsuccessful | Re-audit in 4 months (June 2022) | Claire R Davies | 31-Jan-22 | Completed | 04-Feb-22 | Forms Archived 8/2/2022 by CRD Re-audit in 4 months (June 2022) to include treatment units |
| 34 | February Audit - Patient ID - Unsuccessful | Re-audit July 2022 | | 28-Feb-22 | Completed | 11-Mar-22 | Audit scheduled after Feb Quality Meeting - to be reported in March's Quality Meeting |
| 35 | Consent | | | 28-Feb-22 | In Progress | | Audit to take place for the whole of February - to be reported in March's Quality Meeting |
| 36 | Hoists - Successful | No Action required | N/A | 25-Feb-22 | Completed | 22-Feb-22 | Hoists & Slings & Serial numbers match up. |

**Training requirements**

The paper which can be found at **appendix 1** identifies the predicted hours required to meet upcoming training requirements of radiotherapy staff and includes Statutory and Mandatory Training and Job Specific Training but excluded anticipated requirements for the move from Canisc to WCP.

The aim is to increase the departments overall compliance in these areas to 100% while also meeting the needs of the service.

## 4.4     Mortality

### 4.4.1   **MES requests and processes**

Mortality Reviews continue to be undertaken on all VCC inpatient deaths in line with WG guidance and Medical Examiner Regulations.

| Month | Number of deaths |
|---|---|
| Mar-21 | 2 |
| Apr-21 | 1 |
| May-21 | 2 |
| Jun-21 | 4 |
| July-21 | 2 |
| Aug-21 | 1 |
| Sep-21 | 2 |
| Oct-21 | 5 |
| Nov-21 | 1 |
| Dec-21 | 4 |
| Jan-22 | 3 |
| Feb-22 | 1 |

Inpatient Deaths

| Cause of Death | Number of patients |
|---|---|
| Malignant disease | 23 |
| Pneumonia, Malignant disease | 2 |
| Candida Septicaemia and Neutropaenia secondary to chemotherapy | 1 |
| Chest Infection & Advanced Rectal Carcinoma with Lung Mets | 1 |
| Renal failure/sepsis | 1 |
| Total | 28 |

| Gender | Number of patients |
|---|---|
| Male | 10 |
| Female | 18 |
| Total | 28 |
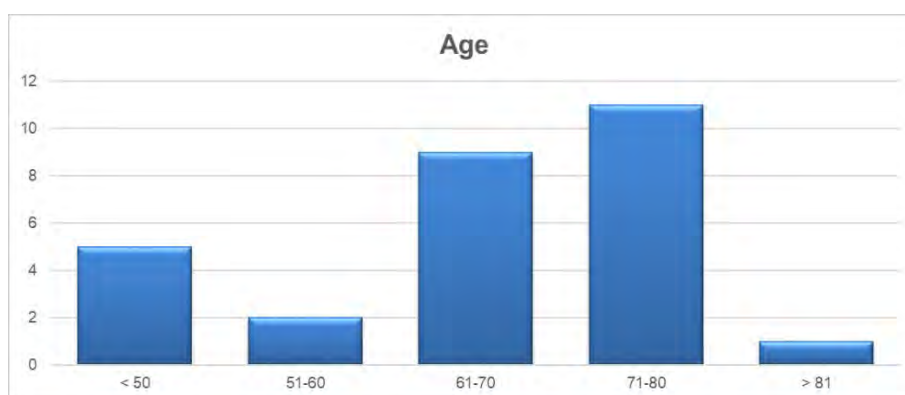
### 4.4.3. Medical Examiner Service Reviews

There were no referrals from the Medical Examiners Service during this reporting period.

### 4.5. Divisional Risks

During February 2022 there were 9 new risks opened.

| ID | Title | Rating (current) | Rating (Target) | Actions | Review date |
|---|---|---|---|---|---|
| 2513 | There are a lack of staff holding a practitioner's licence for prostate Brachytherapy | 20 | 10 | Clinical service is dependent on one consultant - another is in training and about to apply for an ARSAC licence | 01/08/2022 |
| 2514 | There is a risk that Standard Operating Procedures (SOPs) within Brachytherapy are not up to date | 16 | 4 | Following the retirement of the former Head of Brachytherapy Physics, ownership of RT physics documents has transferred to another member of staff who is reviewing SOPs. Similarly a review of documentation is taking place within Radiotherapy | 29/04/2022 |
| 2512 | Digital Health & Care Record DHCR022(R) - Business Continuity Risk following Implementation | 15 | 12 | DHCW to develop a solution as this would have an effect on every HB when they have an Electronic Patient Record | 03/03/2022 |

| ID | Title | Rating (current) | Rating (Target) | Actions | Review date |
|---|---|---|---|---|---|
| 2515 | There is a risk that staffing levels within Brachytherapy services are below those required for a safe resilient service | 15 | 5 | Capacity is managed by careful examination of rotas, refusing leave and redeployment of staff from other areas.<br><br>A programme of training sufficient staff to cover all areas and a review of staff numbers is taking place | 27/05/2022 |
| 2523 | A risk to the delivery of the Physiotherapy Gynae- Oncology service | 12 | 6 | The VCC Gynae team are made aware of the service being put on hold for the time period of 4 weeks with the potential this may increase.<br><br>Any new referrals to the physiotherapy clinic will be received and a waiting list letter sent to the individual patients | 18/03/2022 |
| 2519 | Insufficient radiography trained staff to insert vaginal vault applicators | 9 | 3 | Assistance from gynae consultants is obtained on occasions when a radiographer is not available.<br><br>A training programme / review of staffing levels is underway to identify and provide service resilience, alongside the development of a business case for additional resources. | 01/06/2022 |
| 2518 | The Brachytherapy Service does not have sufficient capacity to meet demand fluctuations in numbers of patients | 9 | 6 | A service review is underway supported by Clatterbridge Cancer Centre to review optimum resource model for the existing service. There is also work underway to develop a business case to reflect service expansion and provide resource to meet fluctuation in demand. In the interim patients are prioritised according to clinical urgency. | 01/09/2022 |
| 2522 | There is a risk to the delivery of the MDT Neuro-oncology clinic due to the cessation of funding | 9 | 4 | Scrutiny cases to be submitted to secure 0.2wte of each profession. Due to a large change of workforce within Therapies there are upcoming opportunities where we can add the 0.2wte of each profession into existing job plans. | 31/03/2022 |

| ID | Title | Rating (current) | Rating (Target) | Actions | Review date |
|---|---|---|---|---|---|
| 2516 | There is a risk that compliant window restrictors may not be fitted which may lead to falls from height of vulnerable patients. | 8 | 4 | Window restrictors in place but not assessed for compliance. Estates report that a key or tool is not required to open the restrictors | 31/03/2022 |

**2 risks were closed during February 2022**

| ID | Title | Risk (in brief) | Manager |
|---|---|---|---|
| 2337 | COVID-SACT-R8 - Delayed delivery of ChemoCare V6 Upgrade | Delayed delivery of ChemoCare V6 Upgrade The Covid-19 Pandemic will adversely affect staff capacity (VCC,NWIS and potentially CIS) to progress project tasks which may result in the overall project timeline / delivery being delayed | Tranter, Bethan |
| 2497 | There is a risk of infection transmission from wearing a medical device wristwatch in a clinical setting | This risk relates to a new member of staff within the Therapies department who works as a Generic Therapies Technician between the occupational therapy & physiotherapy services.<br><br>The staff member's role is a clinical role and her duties involve patient manual handling on the inpatient ward, including; assisting with transfers; mobilising patients; and carrying out functional assessments, such as, washing and dressing assessments.<br><br>The member of staff is diagnosed as a Type 1 diabetic. She has a system that delivers insulin, based on blood sugar levels that are taken from a sensor on her arm. These blood sugar level are shown on a wristwatch and she can also access them on her phone via an app. | Baker, MRS Kate |

| 5.0 | Effective Care<br>Descriptor; evidence based and appropriate |
|---|---|

## 5.1. Complaints

| Type of concern | No. | KPI Achieved |
|---|---|---|
| Early resolution | 9 | 100% |
| Putting Things Right (PTR) (formal concern) | 0 | N/A |
| Re-opened Putting Things Right (formal concerns) | 0 | N/A |
| Redress | 0 | N/A |
| Claims | 1 | N/A |

There is a notable increase in Early Resolutions in February. This is due to a concerted effort by the quality and safety team to try and manage complaints on the day they are raised and resolve if possible. This involves taking a very proactive approach by contacting the complainant by phone on the day they make the complaint and liaising with the appropriate team and department promptly. The Q+S team are encouraging directorates to capture the learning and themes around early resolution as they would for formal concerns.

The Q&S Team have developed a concerns pathway and a process for patients/ relatives that phone VCC or Trust to make a complaint.  These can be found at **Appendix 2.**

5.1.1. A summary of the key themes is highlighted below. Improvement plans and lessons learnt are being captured and shared where appropriate to demonstrate the learning undertaken.

| Early Resolutions | Lessons Learnt/ Improvements |
|---|---|
| Communication Issue – Insufficient Information<br>Lack of Treatment x2<br>Cancelled Appointment<br>Speed bumps x2<br>Patient Involvement in Care Decisions<br> Attitude of Nursing Staff to Patient | Speed bumps widened<br>Identified patient at need of increased support from key workers |

5.2. **Claims**

| Personal Injury<br>Total 3<br>For February 2022 | | Clinical Negligence<br>Total 5<br>For February 2022 | | Service Area |
|---|---|---|---|---|
| **Velindre Cancer Centre** | | **Velindre Cancer Centre** | | |
| Slip, Trip, Fall | 1 operational services | Alleged Missed diagnosis | 2 | Chemo/Nursing<br><br>Medical/Melanoma/Urology |
| Defective Equipment | 2<br>PSU<br>& Radiology | Misreported CT scan | 1 | Radiology |
| | | Treatment complications | 2 | SACT |

**Total number of VCC claims:**
PI – 3
CN - 5

**New Claims**

1 new clinical negligence claim was received during the reporting period. An alleged missed diagnosis following a CT scan.

**Re-opened claims**

No claims were re-opened during the reporting period.

**Potential Claims**
No new potential claims were received during the reporting period.

Total: Three potential claims remain on the Datix OfW Claims Module for the reporting period for VCC:

- Missed referral for a hysterectomy

- A member of staff working at VCC contracted Covid-19
- Missed follow-up following a mastectomy

A potential claim comprises of any communication that is received indicating a potential claim may be pursued against the Trust. When there is such an indication, these are uploaded to the Claims portal by the Claims Manager.

Notification of a claim or potential claim can come from several sources but usually from the following:

- Request for access to records
- Solicitors letter
- Letter/communication direct from claimant
- Incident outcome
- Notification ET1 (Employment Tribunal) (although these are usually done via OD and Workforce)

**Closed claims**

No claims were closed during the reporting period for February 2022.

**Redress**

**New Cases**

No new Redress cases for the reporting period.

**Current Cases**

Currently 3 cases are open for VCC.

- SACT Treatment helpline/nursing.
- Radiotherapy/medical – Wrong choice of treatment modality
- Chemotherapy/medical – Aggressive treatment provided which could have been avoided/lack of informed consent re biopsy

**Closed Redress Cases**

No cases were closed during the reporting period.

**Inquests**

2 notifications have been received regarding inquest proceedings concerning VCC for Feb 2022.

A statement has been requested from the treating consultant oncologist regarding a patient who died by suicide.

A statement has been requested from a charge nurse and treating consultant regarding a patient who passed away due to an infection in a DGH. An initial review has concluded that further investigation of the case is required.

.

| 6 | Efficient Care<br>Descriptor; avoid waste |
|---|---|

### 6.1. Clinical Audit plan update

The Planned Clinical Audit Programme is linked to the Health Care Standards (HCS) and in addition to planned audits it also includes continuous monitoring projects and those rolled over from the previous year.

Project progress is monitored throughout the year and is reported to all SST's. The overall progress is shown in the pie chart below:

**Key**
Red: project has yet to be started
Amber: in progress (excluding continuous monitoring)
Green: completed.

**Planned Clinical Audit programme 2021/2022**

- 4, 3%
- 2, 2%
- 51, 42%
- 65, 53%

- Complete
- Active (excluding continuous monitoring
- On Hold
- Discontinued
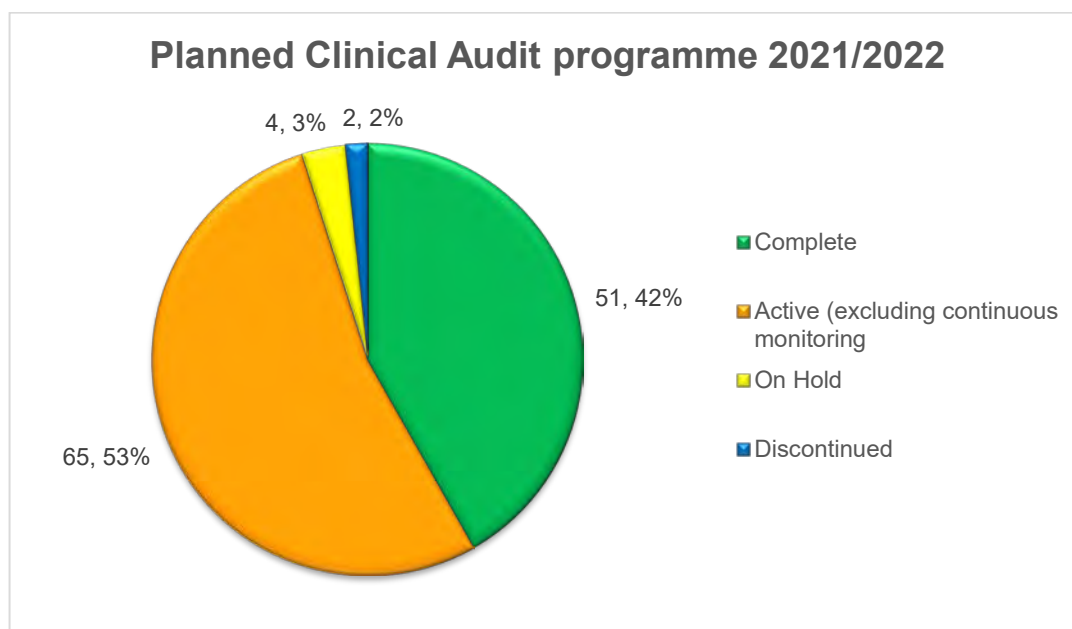
The completed projects include a summary of results, areas of good practice or areas for improvement identified and any recommendations. These recommendations are then followed up at the SST meetings quarterly where progress against them is recorded.

An annual summary will be included in the report for all national audits and continuous monitoring projects. It is worth noting that any projects submitted throughout the year are added to the programme and their progress will be monitored.
There are currently 167 audits on the programme for 2021/2022; 51 have been completed 110 are in progress, 45 of which are continuous monitoring projects, 4 are on hold and 2 have been discontinued.

Projects in progress are at various stages, for example data collection, data entry or analysis.

6.2 **Mortality and Morbidity Pilot**

The NCEPOD report 'For Better, For Worse' (2008) audited deaths within 30 days of systemic anticancer therapy (SACT). The audit revealed good care in 35 % of cases, with room for improvement in 49%. 8% of cases had less than adequate care. Chemotherapy was felt to have caused or hastened death in 27% of cases and 43% experienced grade 3 or 4 toxicity from their treatment. One of the key recommendations from the report was for all deaths within 30 days of SACT should be discussed in a Morbidity and Mortality or clinical governance meeting.

The National Chemotherapy Advisory Group Report, 'Ensuring Quality and Safety of Chemotherapy Services in England' has also made recommendations for each chemotherapy service to develop morbidity and mortality meetings to "review practise, policies and procedures in relation to the safety and quality of chemotherapy practise, policies and procedures in relation to the safety and quality of chemotherapy".

The UK Department for Health report 'Improving Outcomes: A Strategy for Cancer' (2011) recommended 30-day mortality as an indicator of avoidable harm from palliative radiotherapy and 90-day mortality from radical or adjuvant radiotherapy. The Royal College of Radiologists forum and consensus has recommended a 30-day mortality below 20% from palliative radiotherapy.

Morbidity and Mortality meeting (M+M) also provides an appropriate forum for relevant episodes of patient morbidity, "near misses" or patient/ Medical Examiner feedback to be discussed within Site Specific Teams to facilitate learning.

It has been agreed that Velindre will pilot the mortality and morbidity meeting format in the colorectal in the first instance, before rolling out to the sites. There was a process in place previously however it was felt that a more robust format for reviewing these deaths was needed.

The focus of the meeting is primarily educational and to improve patient care.  They will be delivered in a supportive and confidential manner.

The meeting structure will depend on the individual SST some may utilise their existing SST structure and others may require a separate M+M meeting. Other staff involved in the patients care should be invited to participate in discussions and a representation from another SST to provide additional scrutiny. Where learning is identified that could benefit other SSTs or where deficiencies in care are identified, the case should be referred to SCIF. The timetabling of the M+M meeting will be tailored to each SST, but in general these should be every 3 months and timetabled to support attendance.  There will be a virtual option for attendance via Teams.

The pilot will follow the pathway below in the first instance,
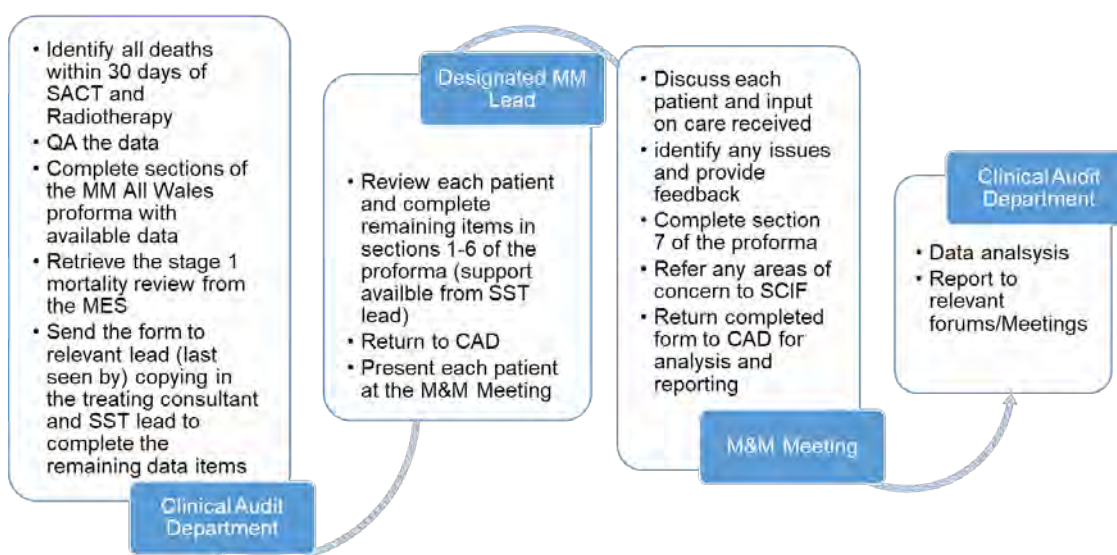


Once the pilot has been completed, the format will be reviewed, and improvements made prior to rolling out across the other site-specific teams. There could be resource implications, and these will be identified within the pilot.

| 7.0 | **Patient Centred Care**<br>**Descriptor; respectful and responsive to the individuals needs and wishes** |
|-----|-----------------------------------------------------------------------------------------------------------|

### 7.1    What are the Patients Saying

Patient feedback has been collected via CIVICA for this reporting period. Please see full CIVICA report at **Appendix 3.**

7.2     Compliments received are added to the Datix system and shared with staff via feedback boards in the clinical areas. During February 2022, 11 compliments were captured on the OfW Datix system. Some of the compliments include:

---

*The Road to Velindre*

*I never thought the time would come*
*When to a peril I would succumb*
*Radiotherapy was the game*
*And Radiation was its name*
*28 games, were prescribed*
*Daily pickups were applied*
*The unknown was some consideration*
*And of course the realisation*

*Incredibly I took the lift*
*Totally unaware of the great gift*
*Off I went on this great step*
*To explore, how, it might help*
*So my journey started with good intent*
*Totally unable to understand what would be sent*
*The hospital staff were all hellbent,*
*And assurance would help the time I spent*

*The 'Taxi' service was supreme*
*It adds a very important effort to 'The Team'*
*Allowing us patients to concentrate on the serious matter in hand*
*And not to worry (too much), about what's to be scanned.*

*What brought us to this super place?*
*Probably it was a timely race*
*To have a treatment, oh so fine*
*To help us to improve our time*
*After the treatment to extend our lease of life*
*In helping some of us reduce our strife*
*If only all the world was so dedicated to others?*
*What would life's challenges be if indeed we were all brothers (and sisters)*

*I never thought the time would come*
*When to a peril I would succumb*
*Radiotherapy was the game*
*And Radiation was its name*
*28 games, were prescribed*
*Daily pickups were applied*
*The unknown was some consideration*
*And of course the realisation*

*Sometimes the worry of wearing the masking*
*My un-comfortability was corrected by asking*
*The team were perfectionists in suiting*
*Personal requirements no disputing*
*So my mask was perfectly fitted*
*As if it had been superbly knitted*
*And after all, it's about the effect*
*All's well that ends well is so correct?*

*A place within, in which to repair*
*Even if you might lose some hair (temporarily that is!)*
*But the wonderful caring workers*
*Amongst which, there are definitely no shirkers*
*Then what a joy behold*
*When patients can be told*
*You now have that chance to even get old!*

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7.2   **WHAT OUR REGULATORS / EXTERNAL / INTERNAL AUDIT ARE SAYING**

There were no regulatory audits undertaken in VCC in February 2022

| 8.0 | **Timely Care** |
|-----|-----------------|

**Re-configuration of the Pharmacy Dispensary**

From 21st March 2022 the pharmacy dispensary is to be refurbished; this will improve the working environment for the staff and improve the workflow within the dispensary. The refurbishment will take approximately 4 weeks, during which time pharmacy will provide its clinical and dispensing services from an interim pharmacy dispensary. In addition to this, pharmacy will not have a dedicated 'patient waiting area' for patients to be able to wait for their prescriptions.

This 4-week refurbishment period will impact on all clinical areas where prescriptions are generated for Velindre Cancer Centre dispensing, the main area of impact being the main outpatient department.

During this interim period, pharmacy will work with all clinical areas including outpatients to aim to ensure that only essential VCC dispensing is undertaken in a safe environment that minimises the impact on patient experience whilst maintaining patient safety. The full SBAR can be found at **Appendix 4.**

# AOS Handover Review Project

## Why?

- A key recommendation from the Rapid Response to Acute Illness learning set (RRAILS) undertaken at VCC was to "*Integrate a set of metrics for review at daily handovers, AOS meeting and ward safety briefings to assure and improve patient safety and generate data on hospital acuity*".
- The key objectives for the handover were to: standardise and improve medical handover to reduce variation in practice, improve communication between teams and highlight any risk to patient and staff safety. This project became one of the six key workstreams of the unscheduled care working group.

## What did we do?

- To meet the key recommendations, from the Peer Review and internal objectives a project was initiated to pilot ideas and introduce a structured AOS handover at the morning sessions at 0900 Monday to Friday
- A safety checklist was produced to support the structuring of the morning AOS handover sessions.
- The safety metrics decided by the project team to be captured during the pilot included, number of 2222 calls, number of emergency transfers, number of Treatment Escalation Plans (TEPs) outstanding and number of patients who had received a review by team.
- The handover checklist was piloted for a 4 week period at the medical 9am handover Monday to Friday
- Pre and post pilot questionnaires were sent to colleagues that attend the handovers to assess if a change had made a difference.

## What were the results and has practice changed as a result of the project ?

- The pilot demonstrated that on the whole the checklist format was followed during the handover and led by the SpR
- Post questionnaire results showed - 41% of respondents felt there was a significant improvement in handovers. Additionally key themes emerging from the questionnaires were that handovers run more succinctly, handovers are more organised/structured, better role designation has evolved,
- Data capture around some of the metrics was a challenge and there are ongoing plans and actions in place to address this aspect.
- Subsequently further work around the handover checklist format, design and content has emerged. A simpler more user friendly form has now been designed in collaboration with the medical staff for ease of use and to avoid note taking
- This form is now in use at the 9am handover and is well received.

| 9.0 | **Equitable Care**<br>**Descriptor; an equal chance of the same outcome regardless of geography, socioeconomic status** |
|---|---|

### 9.1. Assurance/ Learning

There are no learning briefs for this reporting period.

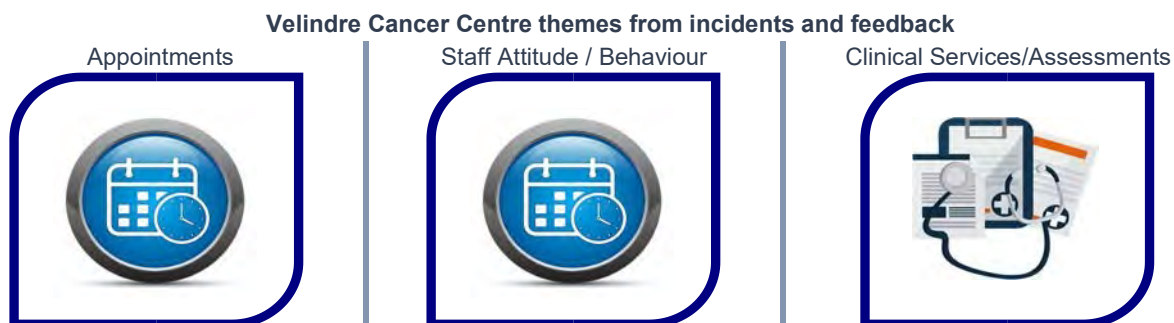### 9.1.1 After Action Review Database

The after-action review database is a central learning database where learning from our complaints are visible and accessible to inform our quality indicators, clinical audits, internal and external audits. The learning database is shared at the VCC Q&SMG meetings with departments being asked to provide an update on their learning.

### 9.1.2 Healthcare Standards

The Q4 Health & Care Standards are due for submission to Trust by 15th April 2022 for inclusion in the July QSP Committee 2022.

### 9.1.3 Learning Infographics

The learning infographics below show the themes from incidents, claims and are where Directorate leads are being asked to focus their efforts on learning, retraining and intervention. There are many improvement plans in place in all of the Directorates to address some of the themes. These improvement plans are monitored through the Velindre Futures Board and through the IMTP for each Directorate.

**Velindre Cancer Centre themes from incidents and feedback**

| Appointments | Staff Attitude / Behaviour | Clinical Services/Assessments |
|---|---|---|

| Communications issues (Including Language) | Infection Control | Monitoring and Observations |
|:---:|:---:|:---:|
|  |  |  |
| Access to Services and Resources | Test and Investigation | Patient Care |
|  |  |  |

| 10.0 | Performance |
|:---:|:---:|

10.1 **VCC Performance Summary February 2022**

The summary of performance in February 2022 can be found on **Appendix 5.**

This shows the overall performance with targets. The continuing restrictions imposed by Covid, absence of staff due to sickness, and increasing patient numbers are continuing to impact on services provided by us at VCC.

There has been an improvement in the radiotherapy targets with 0 reporting red (compared with 5 reporting red in December 2021).

There were 4 delayed transfers of care. Delays were caused by challenges in instituting appropriate care packages and by restricted capacity in the Community Resource Team (CRT).

| 11.0 | Celebration and Exception |
|---|---|

### 11.1   Celebrations

There are no formal celebration items for this reporting period.

| 12.0 | Conclusions |
|---|---|

12.1   This period has been a very busy period clinically with services seeing an increase in pre-Covid-19 demand and restrictions due to the Omicron Covid wave.

There is evidence that incidents/concerns/compliments are now consistently managed appropriately and compliant with the PTR regulations. Lessons learned and actions are implemented and monitored by Directorate leads and their teams but the Q&S Team recognise there is more improvement work needed. The team recognise the Cancer Centre - wide quality culture shift that is required has started and will take time to achieve.

**Training Requirements of Radiotherapy Staffing March- August 2022**

The training requirements of radiotherapy staffing includes Statutory and Mandatory Training and Job Specific Training.

The aim is to increase the departments overall compliance in these areas to 100% while also meeting the needs of the service.

**Statutory and Mandatory Training**

In February 2022, the Radiotherapy department Statutory and mandatory training overall compliance for the 10 core competencies on ESR is 87.2%.

Eight of the core competencies can be completed through Elearning and require 93 man hours
One of the competencies requires in-house training run by BLS assessors and requires 13 man hours for staff training and 26 man hours for radiotherapy BLS assessors totalling 39 man hours.

The Manual Handling Competency has 56.8% compliance.
28 staff are booked onto the manual handling 2 days training between February 2022 and June 2022 totalling 420 man hours.
There are an additional 20 staff that require 2 day training who are not booked. Totalling 300 man hours.
There are 6 staff who require NHS|CSTF|Moving and Handling - Level 1 - 2 Years| eLearning module totalling 6 hours.

To achieve 100% competency in these 10 areas, 858 man hours are needed.

**Job specific Training**

**Datix Training**

Datix Administrator training requires 7 staff to complete, totalling 7 man hours

The completion of Datix Incidents module' One For Wales' requires 2 hours of training for 12 core staff totalling 24 man hours.

The number of Datix Investigators need to increase due to staff absence and requires 18 core staff to complete, totalling 18 man hours.

To achieve the compliance in this area 49 man hours are required

**Donning and Doffing/ Hand Hygiene**

These competencies are completed yearly for all staff and requires 30mins of time each, totalling 125 man l hours.

**120|LOCAL|All Wales COVID-19 Workforce Risk Assessment - 6months|General**

This Risk assessment must be completed every 6months for all staff and requires 15mins of time each, totalling 31.25 man hours.

**BLS Champions**

2 hours of training is required to be competent in-house BLS/AED assessor's, totalling 12 man hours.

**Covid PCR Swab Assessment**

This training must be completed every 12months and requires 15mins, totalling 1.5 man hours.

Samantha Allen and Helen Payne

**Training Requirements of Radiotherapy Staffing March- August 2022**

**Practice Based Learning**

Due to the increase in the number of student radiographers as per WG and assessors leaving the organisation, the radiographer student assessors need to increase which requires 15 man hours per assessor, totalling 30 man hours.

**Overall**

**Total 1155.75 man hours**

**Barriers**
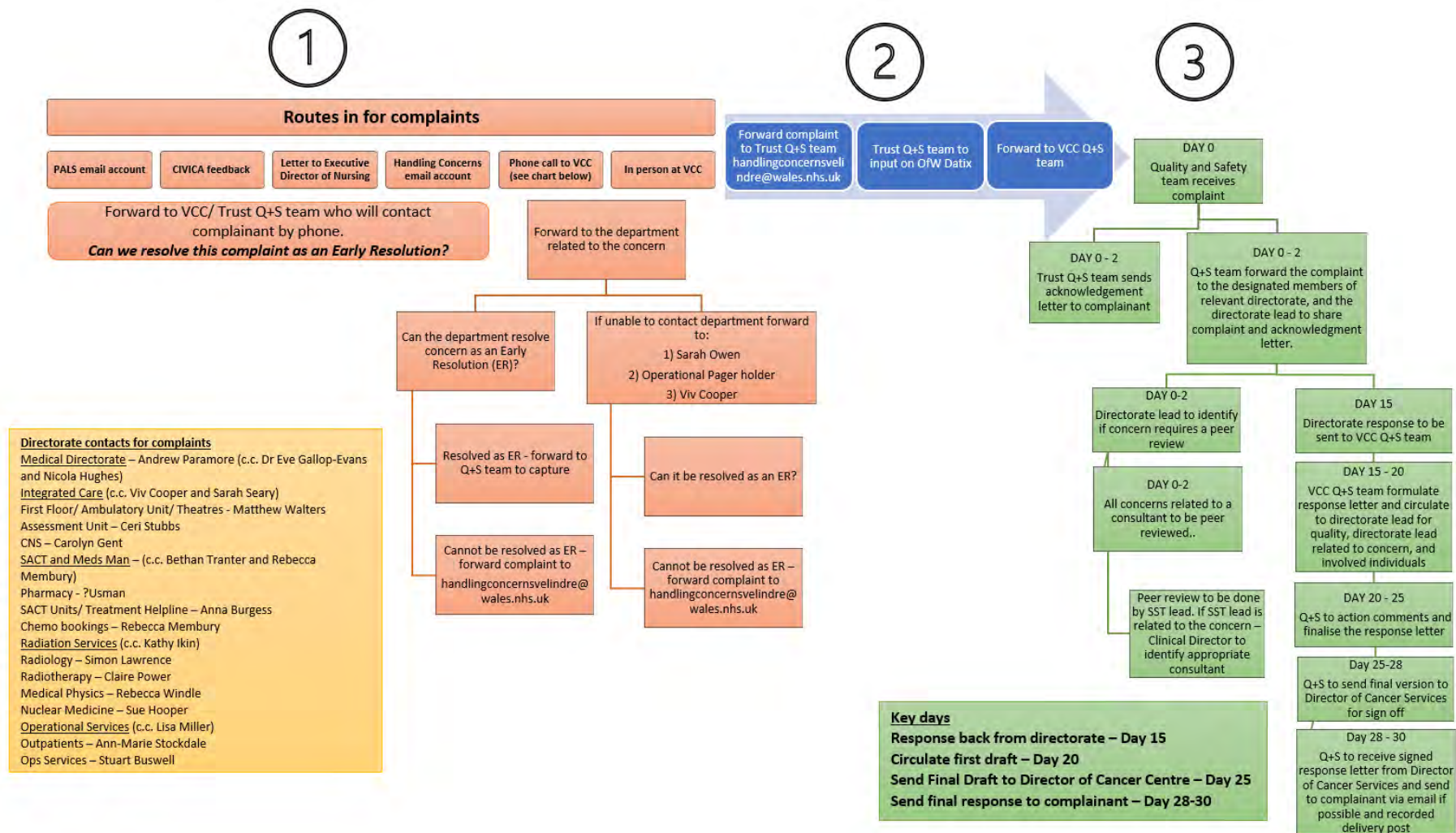
The limiting factors are:

- Availability of IT hardware/software to undertake Elearning
- ELearning via ESR is slow to connect.
- Availability of BLS trainers for in-house training.
- Availability of suitable space for in-house training due to social distancing and general room availability.
- Availability of face to face manual handling training sessions.
- Staff availability for training due to staff sickness short and long term, isolations due to the covid19 close contacts and annual leave.
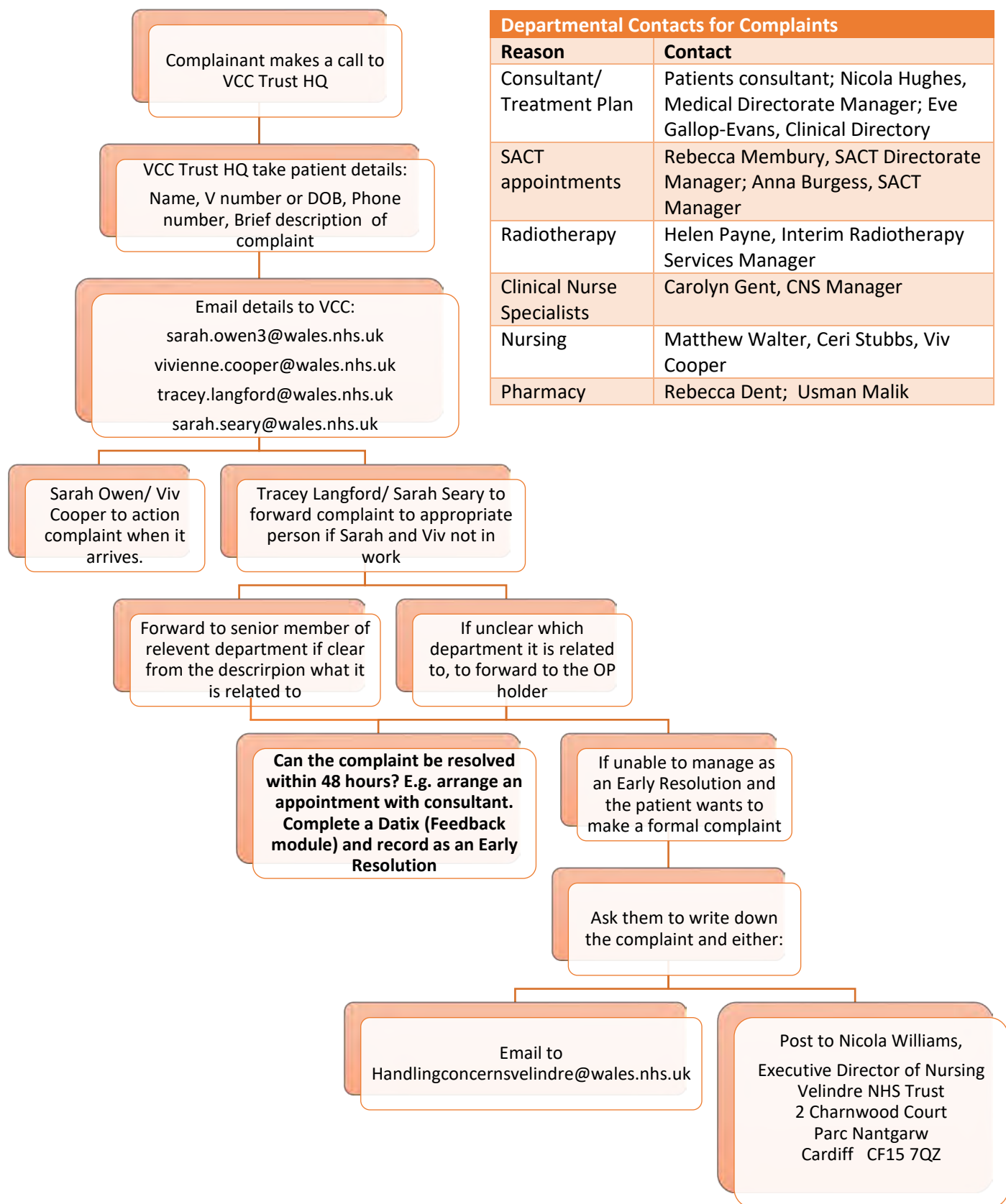
**Action Plan**

- Increase in laptops available to undertake Elearning
- 28 radiographers are booked to undertake manual handling 2 days training between February 2022 and June 2022 totalling 420 hours.
- BLS trainer training is scheduled for February and March.
- If staff are isolating due to a covid19 close contact, staff are encouraged to undertaken Elearning and training as appropriate.

- Increase by 0.6 WTE substantive post at Band 6 to cover the deficit hours.

Appendix 10 core statutory and mandatory Training

Samantha Allen and Helen Payne

**Training Requirements of Radiotherapy Staffing March- August 2022**

| Competence Name | Assignment Count | Length of training | Type of Training | Achieved | Not Achieved | Compliance % | Total man hours needed |
|---|---|---|---|---|---|---|---|
| NHS\|CSTF\|Equality, Diversity and Human Rights - 3 Years\| | 125 | 1 hour | Elearning | 115 | 10 | 92.00% | 10 |
| NHS\|CSTF\|Fire Safety - 2 Years\| | 125 | 1 hour | Elearning | 111 | 14 | 88.80% | 14 |
| NHS\|CSTF\|Health, Safety and Welfare - 3 Years\| | 125 | 1 hour | Elearning | 110 | 15 | 88.00% | 15 |
| NHS\|CSTF\|Infection Prevention and Control - Level 1 - 3 Years\| | 125 | 1 hour | Elearning | 122 | 3 | 97.60% | 3 |
| NHS\|CSTF\|Information Governance (Wales) - 2 Years\| | 125 | 1 hour | Elearning | 102 | 23 | 81.60% | 23 |
| NHS\|CSTF\|Moving and Handling - Level 1 - 2 Years\| However clinical staff require additional training which is either a 1 days update or 2 days | 125 | 2 days/ 1 hours update | In person | 71 | 54 | 56.80% | 28x 15=405 hours not booked<br><br>20 x15=300 hours booked for training between February and June<br><br>6x 1= 6hours for level 1 training |
| NHS\|CSTF\|Resuscitation - Level 1 - 3 Years\| | 125 | 1 hour equates to BLS | In house | 112 | 13 | 89.60% | 13+ 2 trainers needed = 26 hours |
| NHS\|CSTF\|Safeguarding Adults - Level 1 - 3 Years\| 1 | 125 | 1 hour | Elearning | 113 | 12 | 90.40% | 12 |
| NHS\|CSTF\|Safeguarding Children - Level 1 - 3 Years\| | 125 | 1 hour | Elearning | 115 | 10 | 92.00% | 10 |
| NHS\|CSTF\|Violence and Aggression (Wales) - Module A - No Specified Renewal\| | 125 | 1 hour | Elearning | 119 | 6 | 95.20% | 6 |

Samantha Allen and Helen Payne

**①**

**Routes in for complaints**

| PALS email account | CIVICA feedback | Letter to Executive Director of Nursing | Handling Concerns email account | Phone call to VCC (see chart below) | In person at VCC |

Forward to VCC/ Trust Q+S team who will contact complainant by phone.
*Can we resolve this complaint as an Early Resolution?*

Forward to the department related to the concern

Can the department resolve concern as an Early Resolution (ER)?

If unable to contact department forward to:
1) Sarah Owen
2) Operational Pager holder
3) Viv Cooper

Resolved as ER - forward to Q+S team to capture

Can it be resolved as an ER?

Cannot be resolved as ER – forward complaint to handlingconcernsvelindre@wales.nhs.uk

Cannot be resolved as ER – forward complaint to handlingconcernsvelindre@wales.nhs.uk

**Directorate contacts for complaints**
Medical Directorate – Andrew Paramore (c.c. Dr Eve Gallop-Evans and Nicola Hughes)
Integrated Care (c.c. Viv Cooper and Sarah Seary)
First Floor/ Ambulatory Unit/ Theatres - Matthew Walters
Assessment Unit – Ceri Stubbs
CNS – Carolyn Gent
SACT and Meds Man – (c.c. Bethan Tranter and Rebecca Membury)
Pharmacy - ?Usman
SACT Units/ Treatment Helpline – Anna Burgess
Chemo bookings – Rebecca Membury
Radiation Services (c.c. Kathy Ikin)
Radiology – Simon Lawrence
Radiotherapy – Claire Power
Medical Physics – Rebecca Windle
Nuclear Medicine – Sue Hooper
Operational Services (c.c. Lisa Miller)
Outpatients – Ann-Marie Stockdale
Ops Services – Stuart Buswell

**②**

Forward complaint to Trust Q+S team handlingconcernsveli ndre@wales.nhs.uk

Trust Q+S team to input on OfW Datix

Forward to VCC Q+S team

**③**

**DAY 0**
Quality and Safety team receives complaint

**DAY 0 - 2**
Trust Q+S team sends acknowledgement letter to complainant

**DAY 0 - 2**
Q+S team forward the complaint to the designated members of relevant directorate, and the directorate lead to share complaint and acknowledgment letter.

**DAY 0-2**
Directorate lead to identify if concern requires a peer review

**DAY 0-2**
All concerns related to a consultant to be peer reviewed..

Peer review to be done by SST lead. If SST lead is related to the concern – Clinical Director to identify appropriate consultant

**DAY 15**
Directorate response to be sent to VCC Q+S team

**DAY 15 - 20**
VCC Q+S team formulate response letter and circulate to directorate lead for quality, directorate lead related to concern, and involved individuals

**DAY 20 - 25**
Q+S to action comments and finalise the response letter

**Day 25-28**
Q+S to send final version to Director of Cancer Services for sign off

**Day 28 - 30**
Q+S to receive signed response letter from Director of Cancer Services and send to complainant via email if possible and recorded delivery post

**Key days**
**Response back from directorate – Day 15**
**Circulate first draft – Day 20**
**Send Final Draft to Director of Cancer Centre – Day 25**
**Send final response to complainant – Day 28-30**

# VCC Phone Call Complaints Process – Trust HQ

Complainant makes a call to VCC Trust HQ

VCC Trust HQ take patient details:
Name, V number or DOB, Phone number, Brief description of complaint

Email details to VCC:
sarah.owen3@wales.nhs.uk
vivienne.cooper@wales.nhs.uk
tracey.langford@wales.nhs.uk
sarah.seary@wales.nhs.uk

Sarah Owen/ Viv Cooper to action complaint when it arrives.

Tracey Langford/ Sarah Seary to forward complaint to appropriate person if Sarah and Viv not in work

Forward to senior member of relevent department if clear from the descrirpion what it is related to

If unclear which department it is related to, to forward to the OP holder

**Can the complaint be resolved within 48 hours? E.g. arrange an appointment with consultant. Complete a Datix (Feedback module) and record as an Early Resolution**

If unable to manage as an Early Resolution and the patient wants to make a formal complaint

Ask them to write down the complaint and either:

Email to Handlingconcernsvelindre@wales.nhs.uk

Post to Nicola Williams,
Executive Director of Nursing
Velindre NHS Trust
2 Charnwood Court
Parc Nantgarw
Cardiff   CF15 7QZ

| Departmental Contacts for Complaints | |
|---|---|
| **Reason** | **Contact** |
| Consultant/ Treatment Plan | Patients consultant; Nicola Hughes, Medical Directorate Manager; Eve Gallop-Evans, Clinical Directory |
| SACT appointments | Rebecca Membury, SACT Directorate Manager; Anna Burgess, SACT Manager |
| Radiotherapy | Helen Payne, Interim Radiotherapy Services Manager |
| Clinical Nurse Specialists | Carolyn Gent, CNS Manager |
| Nursing | Matthew Walter, Ceri Stubbs, Viv Cooper |
| Pharmacy | Rebecca Dent;  Usman Malik |

# Survey Summary Report

**Showing: Full Breakdown Analysis of Survey Results**

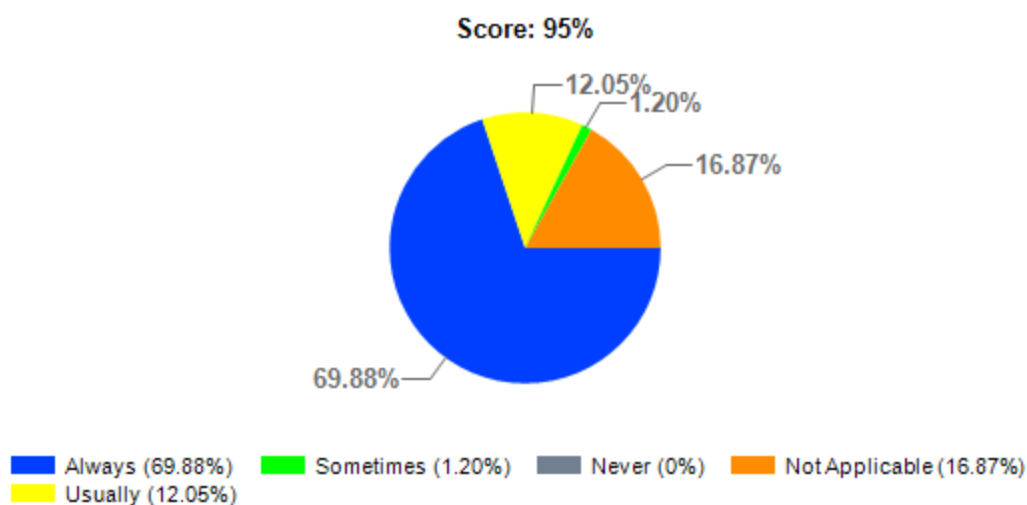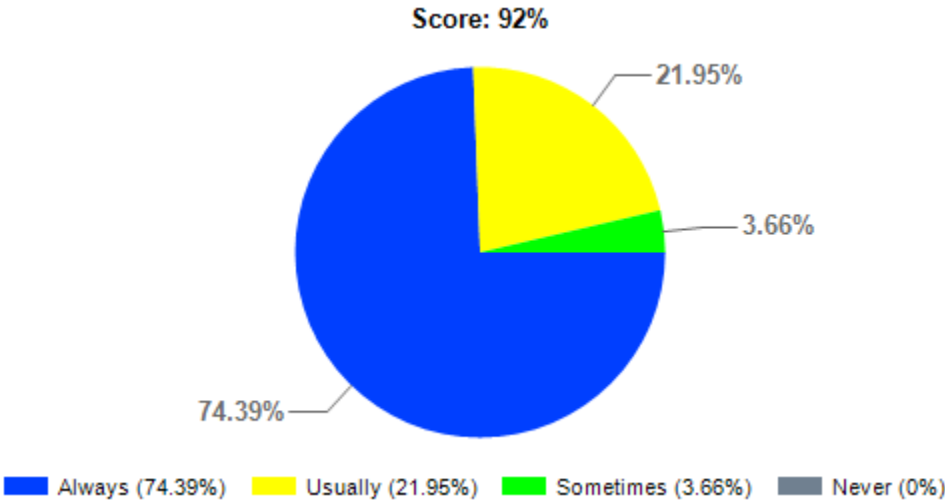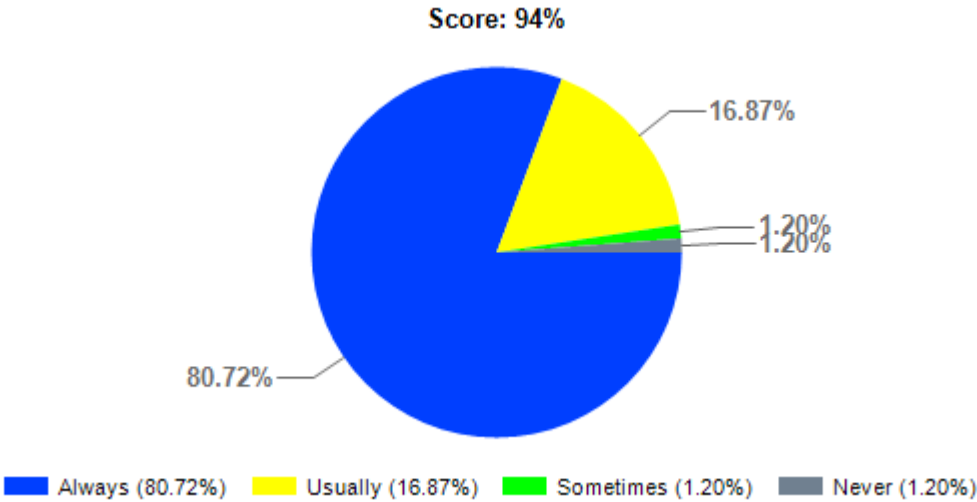Total Respondents: 83

**Survey:** Your Velindre Experience

**Start Date:** 2022-02-01 00:00:00          **End Date:** 2022-02-28 23:59:59

**Results from:** Velindre Cancer Centre

**Question 1:** How recent was the experience you are thinking of?

| Available Answers | Responses | Score (%) |
|---|---|---|
| In the last 6 months | 55 | 74.32% |
| Between 6 months and 1 year ago | 6 | 8.11% |
| Between 1 and 2 years ago | 7 | 9.46% |
| More than 2 years ago | 6 | 8.11% |
| **Total** | **74** | **100%** |
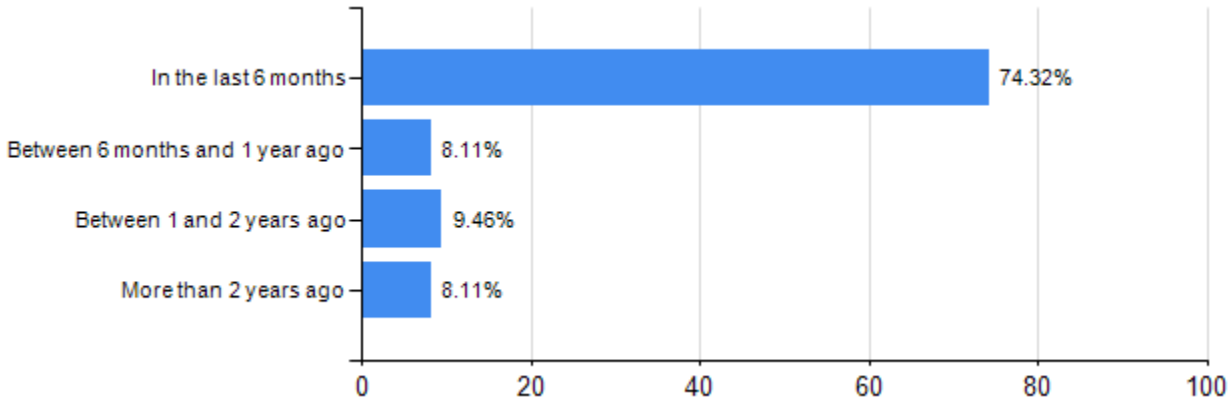
# Survey Summary Report

**Showing: Full Breakdown Analysis of Survey Results**

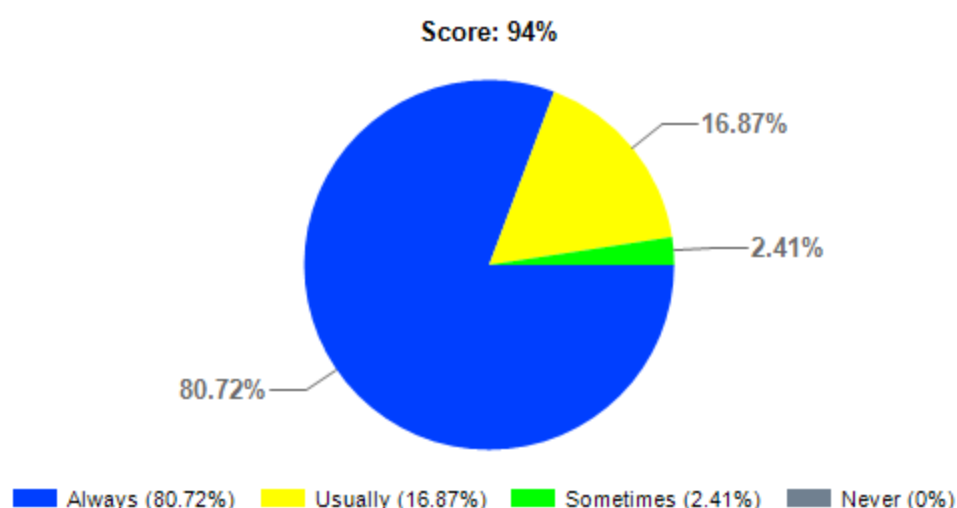Total Respondents: 83

**Survey:** Your Velindre Experience

**Start Date:** 2022-02-01 00:00:00          **End Date:** 2022-02-28 23:59:59

**Question 2:** Did you feel that you were listened to?

| Available Answers | Responses | Score (%) |
|---|---|---|
| Always | 71 | 86.59% |
| Usually | 11 | 13.41% |
| Sometimes | 0 | 0.00% |
| Never | 0 | 0.00% |
| **Total** | **82** | **100%** |

Score: 95%
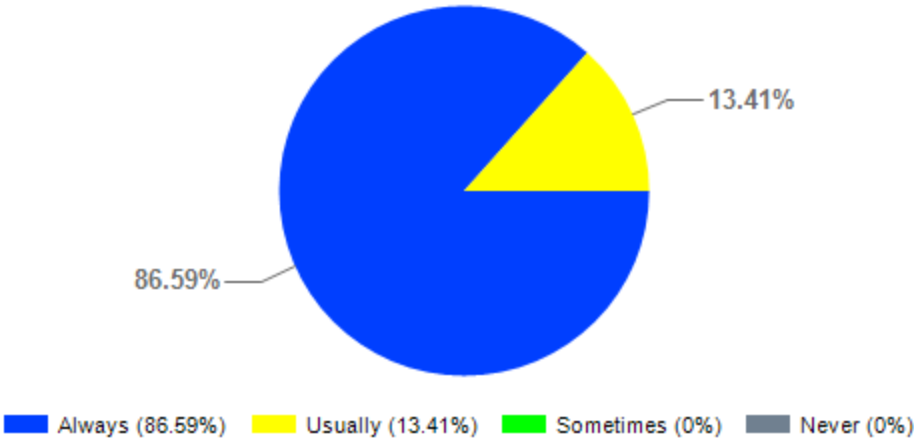


Always (86.59%)   Usually (13.41%)   Sometimes (0%)   Never (0%)

CIVICA

# Survey Summary Report

**Showing: Full Breakdown Analysis of Survey Results**

Total Respondents: 83

**Survey:** Your Velindre Experience

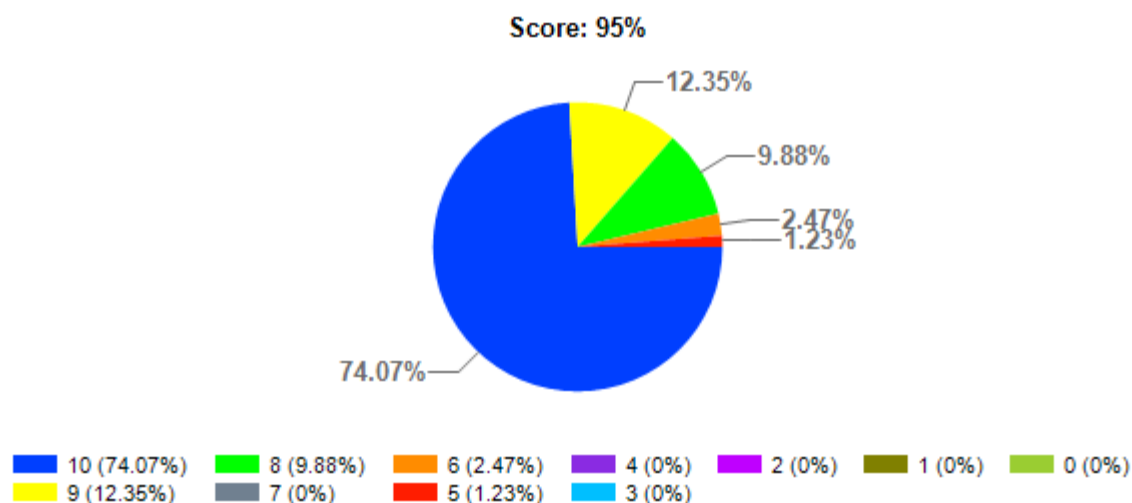**Start Date:** 2022-02-01 00:00:00          **End Date:** 2022-02-28 23:59:59

**Question 3:** Were you able to speak Welsh to staff if you needed to?

| Available Answers | Responses | Score (%) |
|---|---|---|
| Always | 2 | 2.41% |
| Usually | 0 | 0.00% |
| Sometimes | 0 | 0.00% |
| Never | 5 | 6.02% |
| Not applicable | 76 | 91.57% |
| **Total** | **83** | **100%** |

Score: 29%
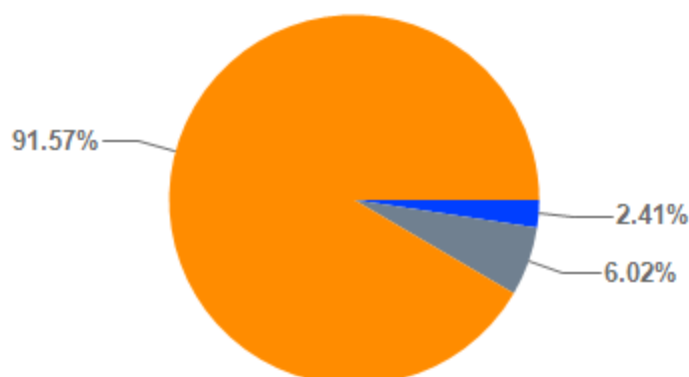


Always (2.41%)  Usually (0%)  Sometimes (0%)  Never (6.02%)  Not applicable (91.57%)

CIVICA

# Survey Summary Report

**Showing: Full Breakdown Analysis of Survey Results**

Total Respondents: 83

**Survey:** Your Velindre Experience

**Start Date:** 2022-02-01 00:00:00          **End Date:** 2022-02-28 23:59:59

**Question 4:** From the time you realised you needed to use the service, was the time you waited:

| Available Answers | Responses | Score (%) |
|---|---|---|
| Shorter than expected | 31 | 37.35% |
| About right | 48 | 57.83% |
| A bit too long | 3 | 3.61% |
| Much too long | 1 | 1.20% |
| **Total** | **83** | **100%** |

Score: 80%
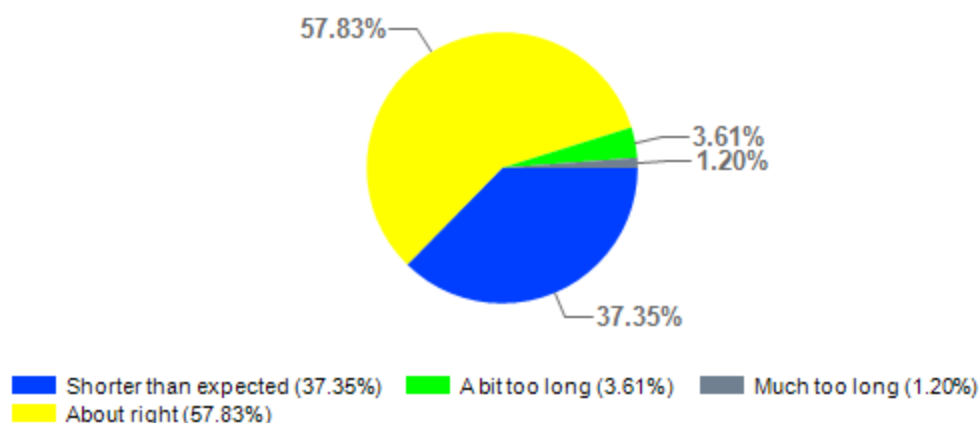
CIVICA

# Survey Summary Report

**Showing: Full Breakdown Analysis of Survey Results**

Total Respondents: 83

**Survey:** Your Velindre Experience

**Start Date:** 2022-02-01 00:00:00          **End Date:** 2022-02-28 23:59:59

**Question 5:** Did you feel well cared for?

| Available Answers | Responses | Score (%) |
|---|---|---|
| Always | 74 | 89.16% |
| Usually | 8 | 9.64% |
| Sometimes | 1 | 1.20% |
| Never | 0 | 0.00% |
| **Total** | **83** | **100%** |
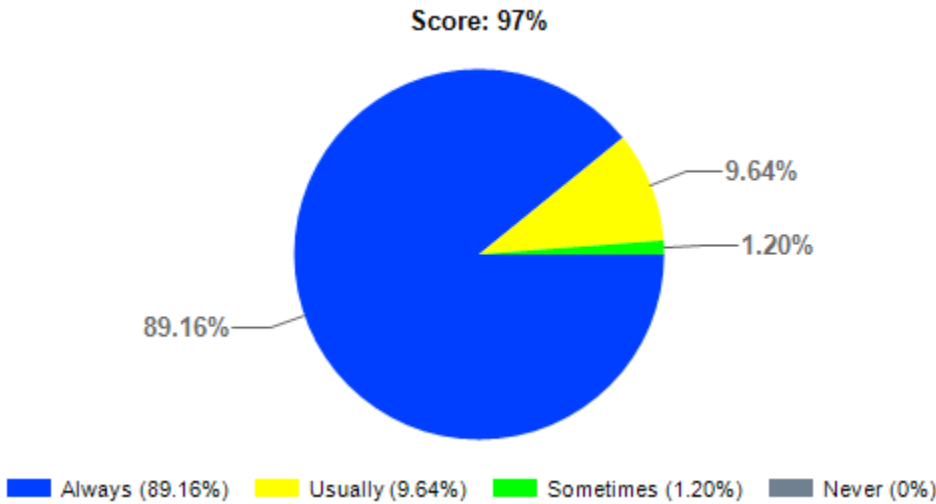
Score: 97%



Always (89.16%)   Usually (9.64%)   Sometimes (1.20%)   Never (0%)

CIVICA

# Survey Summary Report

**Showing: Full Breakdown Analysis of Survey Results**

Total Respondents: 83

**Survey:** Your Velindre Experience

**Start Date:** 2022-02-01 00:00:00        **End Date:** 2022-02-28 23:59:59

**Question 6:** If you asked for assistance did you get it when you needed it?

| Available Answers | Responses | Score (%) |
|---|---|---|
| Always | 58 | 69.88% |
| Usually | 10 | 12.05% |
| Sometimes | 1 | 1.20% |
| Never | 0 | 0.00% |
| Not Applicable | 14 | 16.87% |
| **Total** | **83** | **100%** |

Score: 95%



- Always (69.88%)
- Sometimes (1.20%)
- Never (0%)
- Not Applicable (16.87%)
- Usually (12.05%)

CIVICA

# Survey Summary Report

**Showing: Full Breakdown Analysis of Survey Results**

Total Respondents: 83

**Survey:** Your Velindre Experience

**Start Date:** 2022-02-01 00:00:00          **End Date:** 2022-02-28 23:59:59

**Question 7:** Did you feel you understood what was happening in your care?

| Available Answers | Responses | Score (%) |
|---|---|---|
| Always | 61 | 74.39% |
| Usually | 18 | 21.95% |
| Sometimes | 3 | 3.66% |
| Never | 0 | 0.00% |
| **Total** | **82** | **100%** |

Score: 92%



Always (74.39%)  Usually (21.95%)  Sometimes (3.66%)  Never (0%)

CIVICA

# Survey Summary Report

**Showing: Full Breakdown Analysis of Survey Results**

Total Respondents: 83

**Survey:** Your Velindre Experience

**Start Date:** 2022-02-01 00:00:00          **End Date:** 2022-02-28 23:59:59

**Question 8:** Were things explained to you in a way that you could understand?

| Available Answers | Responses | Score (%) |
|---|---|---|
| Always | 67 | 80.72% |
| Usually | 14 | 16.87% |
| Sometimes | 1 | 1.20% |
| Never | 1 | 1.20% |
| **Total** | **83** | **100%** |

Score: 94%



Always (80.72%)    Usually (16.87%)    Sometimes (1.20%)    Never (1.20%)

CIVICA

# Survey Summary Report

**Showing: Full Breakdown Analysis of Survey Results**

Total Respondents: 83

**Survey:** Your Velindre Experience

**Start Date:** 2022-02-01 00:00:00          **End Date:** 2022-02-28 23:59:59

**Question 9:** Were you involved as much as you wanted to be in decisions about your care?

| Available Answers | Responses | Score (%) |
|---|---|---|
| Always | 67 | 80.72% |
| Usually | 14 | 16.87% |
| Sometimes | 2 | 2.41% |
| Never | 0 | 0.00% |
| **Total** | **83** | **100%** |

Score: 94%

CIVICA

Total Respondents: 83

**Survey:** Your Velindre Experience

**Start Date:** 2022-02-01 00:00:00          **End Date:** 2022-02-28 23:59:59

**Question 10:** Using a scale of 0 to 10 where 0 is very bad and 10 is excellent, how would you rate your overall experience?

| Available Answers | Responses | Score (%) |
|---|---|---|
| 10 | 60 | 74.07% |
| 9 | 10 | 12.35% |
| 8 | 8 | 9.88% |
| 7 | 0 | 0.00% |
| 6 | 2 | 2.47% |
| 5 | 1 | 1.23% |
| 4 | 0 | 0.00% |
| 3 | 0 | 0.00% |
| 2 | 0 | 0.00% |
| 1 | 0 | 0.00% |
| 0 | 0 | 0.00% |
| **Total** | **81** | **100%** |

Score: 95%



- 10 (74.07%)
- 9 (12.35%)
- 8 (9.88%)
- 7 (0%)
- 6 (2.47%)
- 5 (1.23%)
- 4 (0%)
- 3 (0%)
- 2 (0%)
- 1 (0%)
- 0 (0%)

CIVICA

**Question 11:** Was there anything particularly good about your experience that you would like to tell us about?

---

## First and Lasting Impressions

Velindre people care

Friendliness of staff in all departments ( good for my morale)

Nurses on RDU are amazing! So kind and caring but highly professional. They have made my visits an absolute pleasure if that makes sense?

Treated well and not just a number

All staff showed great kindness and consideration at all times. Thank you

The staff are incredibly busy and coping with Covid matters too and yet always cheerful and professional.

Everyone from the "meet and greet" door persons to the consultants were very kind and considerate

Very helpful from all the staff

I found the hospital excellent. Staff nice and very calm. I felt I was in good hands

All very good

On Time

No problems

Help always at hand

No I must admit the service A+++ because it was outstanding

Fantastic service all round from reception to Doctors/Nurses

All members of staff, regardless of role were friendly & reassuring

I am very nervous but everyone made me feel very comfortable and relaxed.

I completely satisfied with the treatment I received and the way the staff made me feel relaxed.

- A check in the waiting area to see how long I had been waiting and was I feeling ok

- offered a free hot drink

I was treated with respect and made comfortable

Wheelchair assistance from porter to scan and nurse took me back to car - Impressed

From the very start my experience at Neville Hall, Merthyr and Velindre has been excellent, whether it's for CT scans, blood tests or treatment the staff are very warm and friendly and I enjoy the telephone consultancies - we have a laugh as well as being serious.

The staff were all excellent from the front desk right through to the radiology department No8


## Receiving care in a safe, supportive healing environment

All staff well knowledgeable and caring

The ward staff were amazing when I had to stay in just before Christmas. Very helpful, informative and took time to speak to me which was important when you are not allowed visitors

I have been care the best

The staff seen able to make the awful situation very bearable and I never feel alone in the search for the right result!

level of caring provided by All staff

The staff are brilliant and well understanding

All staff were very approachable and professional at all times. Made me feel relaxed and cared for

Around 6 months ago I was on the VAP telephone outpatients list and I had a bad back (6th June) 2021.
The team immediately referred me to the Royal Glam hospital AECU where I was examined and over the

next few weeks I was diagnosed with fractures to L5 and L3 of the spine still ongoing treatment but great service from Velindre

I had a telephone appointment with my doctor at Velindre Hospital. It was on time and we discussed my medical issues, the doctor was very sympathetic.

Being able to attend an open evening, it was a good experience to have the treatment explained, see the radiotherapy machine and have the whole procedure fully explained to you in a manner you could understand. So my first visit to have the treatment felt quite relaxed.

When I started reacting to the chemotherapy I was having, the nurses were soon by me helping me feel better and correct what was going wrong. The care is outstanding

CT department was excellent - I arrived 5 mins before my appointment time and was called in immediately for my scan.

I must say that my telephone consultations have been excellent.


## Understanding of and Involvement in my care

I was admitted unexpectedly for a number of complications but the ward staff made me feel at ease and kept me fully informed of what was happening at all times, taking away any worries in what was an uncertain time.

Everything explained and forward planning

Consultant phoned me back explained treatment options and gave me choice

The staff at both Velindre and Merthyr were excellent. I was always treated with professional care and attention. They always took the time to explain everything that was going to happen. I particularly noticed their patience with the elderly. I cannot thank them enough for what can be a very difficult time.

Every member of staff are so professional and any problems you have, they put you at ease and soon rectify and queries you have. The staff create a very relaxed chill-out experience and always put you first

The whole experience was excellent. I found all staff to be helpful and accommodating. Their polite approach putting me at ease and the radiology team were professional and kept me informed at each stage of my treatment calming and reassuring answered all my concerns

Dr always had plenty of time to make sure you understood what was going on with me and reassured that what they decided for my treatment was best for me. Always left up beat not down or sad. They are all doing their best at a lot of stress at the moment.

All the staff were very friendly, helpful and made sure that I was involved in and understood the treatment I received.

All information was given verbally followed up with written information in leaflet form. All staff were able to give explanation when asked questions. Complementary therapy services were offered on the days of treatment. This service I found of value and would recommend to others

# Survey Summary Report

**Showing: Full Breakdown Analysis of Survey Results**

Total Respondents: 83

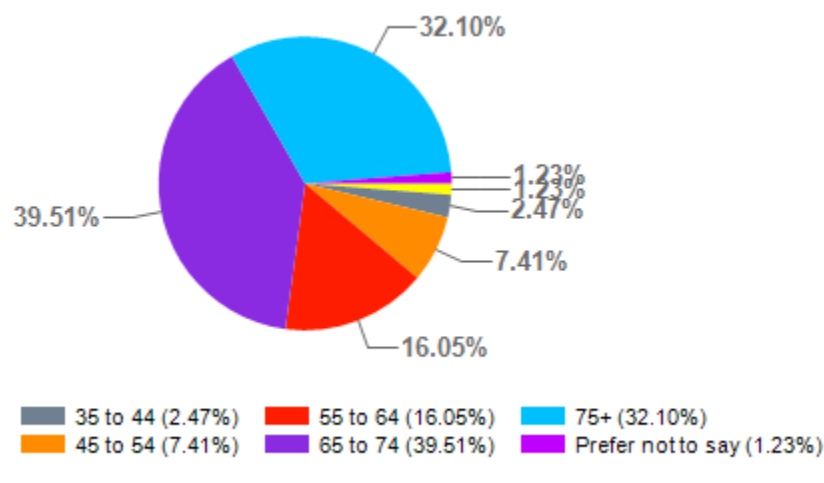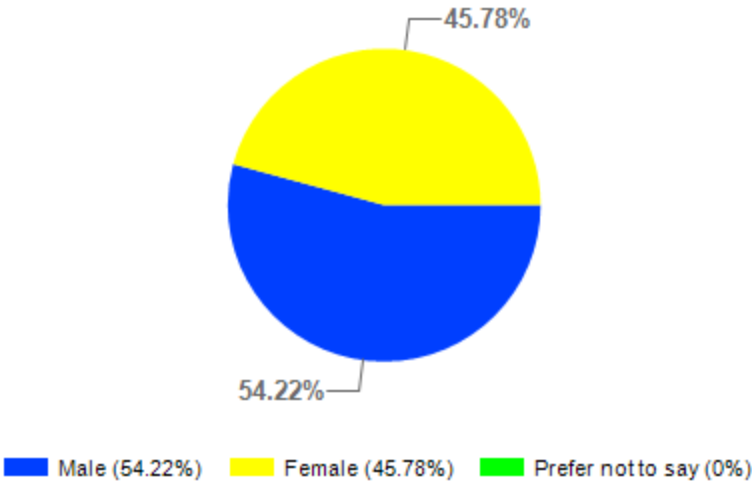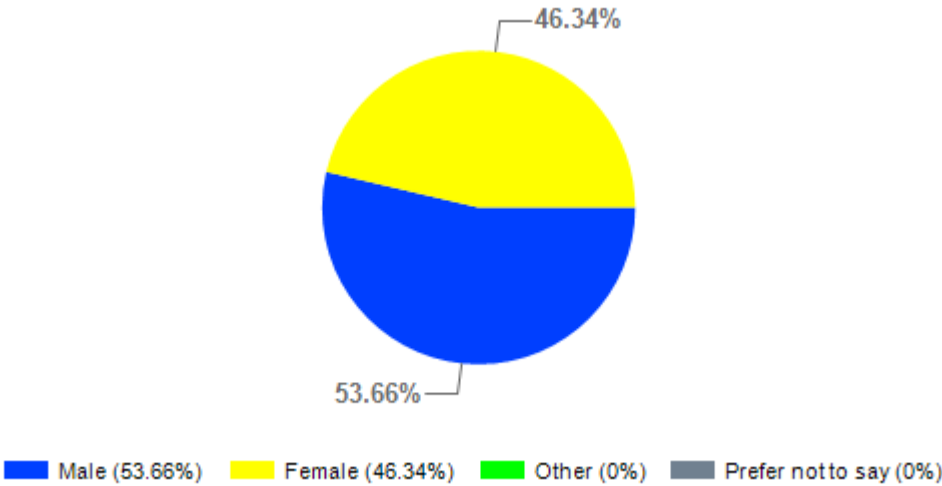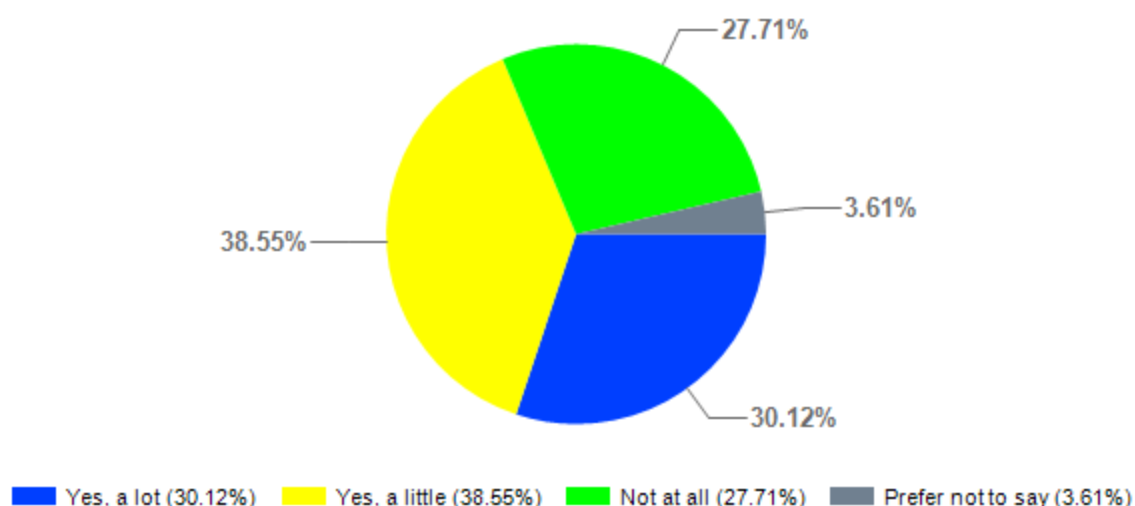**Survey:** Your Velindre Experience

**Start Date:** 2022-02-01 00:00:00          **End Date:** 2022-02-28 23:59:59

**Question 12:** Was there anything that we could change to improve your experience?

## Waiting Times

Waiting times in Friday morning clinic. Last Friday I waited an hour and a half to be seen. Everyone was very nice about it but my whole visit took nearly 3 hours and I was exhausted afterwards

Waiting time for blood tests take too long - never on time

Waiting time, on some occasions I have waited 2 + 3 hours to be seen

Although I arrive 5 minutes before my appointment time I have to wait 40 mins - 50mins to see my consultant (which usually takes 5 mins!) Do you think maybe too may appts are given the same time?

Time of appointments i.e. Allowing treatment time and not causing delays although I appreciate some matters are out of your hands and control.

## Transport / Travel

Too far to travel

People using travel that whole area was difficult to me

## Communication / Information

Although it was good to talk to a medical professional, the only advice I came away with was to contact my local GP with my medical issues. Therefore the phone call was a bit of a waste of time.

I did however feel that my doctor just left me to get on with it. I was never physically examined after my operation. I contacted my specialist nurse but could only leave a message on her answer phone and was never replied to. Overall I felt a bit overlooked with my experience.

## COVID

The situation currently (Covid) is difficult for everyone so I feel everyone is doing their best in the circumstances

Out of your control, family waiting outside  - covid rules

The whole experience of having to be on my own going through this is causing detrimental to my wellbeing and mindset whenever I visit the hospital because of covid restrictions. Maybe my husband could do LFT's the night before to prove Covid free and accompany me in this life crisis

Due to Covid restrictions, all consultant contact is by telephone, which I found rather difficult, and missed the face to face contact

You are all doing your best with coping with Covid. I think everyone has learnt patience and working together to understand that what you are all doing is the best you can do for everyone. I am glad you are here.

## Food & Drink

Tea trolley comes at lunchtime, maybe more frequent would be nice. Other than the above I am more than happy and feel blessed to be receiving the treatment I am.

No! Hope café can open soon

## Environment

Change the red armchair outside LA7 it's stained and lets the overall cleanliness of the facility down.

## Other

My care at Velindre Hospital was excellent, I was could not fault it. My problem was convincing my GP to refer me back to the consultant at UHW when I knew I had a problem again. A quicker referral would have meant a much less invasive surgery and might not have necessitated radiotherapy.

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# Survey Summary Report

**Showing: Full Breakdown Analysis of Survey Results**

Total Respondents: 83

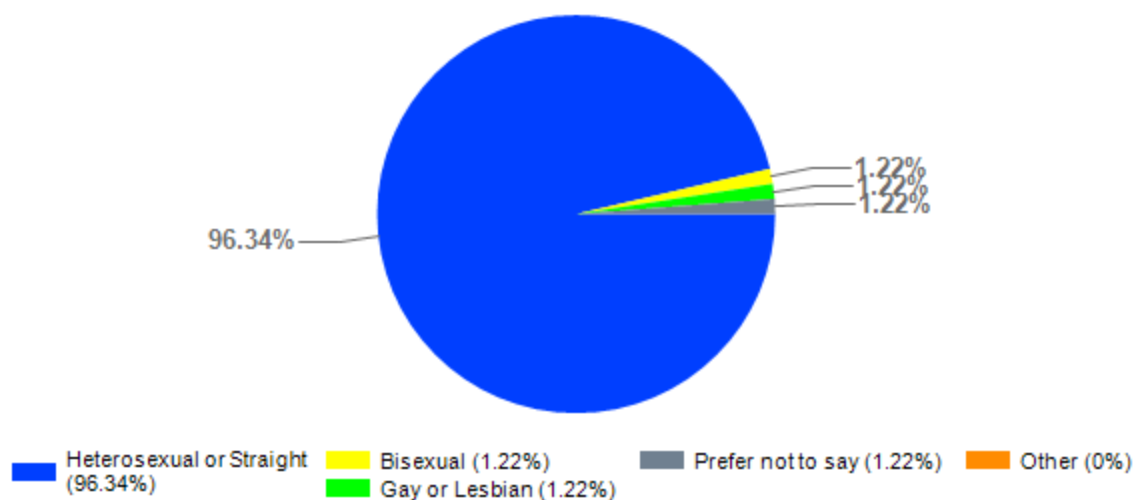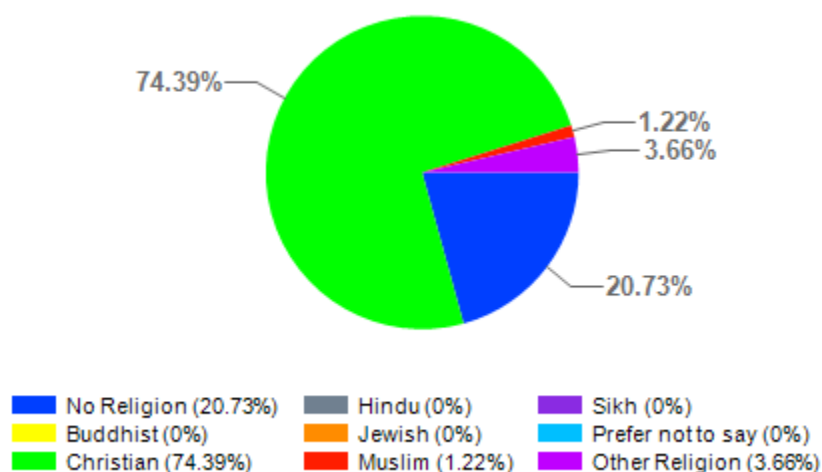**Survey:** Your Velindre Experience

**Start Date:** 2022-02-01 00:00:00          **End Date:** 2022-02-28 23:59:59

**Question 13:** What is your age?

[Create new action](#)

| Available Answers | Responses | Score (%) |
|---|---|---|
| 0 to 15 | 0 | 0.00% |
| 16 to 24 | 1 | 1.23% |
| 25 to 34 | 0 | 0.00% |
| 35 to 44 | 2 | 2.47% |
| 45 to 54 | 6 | 7.41% |
| 55 to 64 | 13 | 16.05% |
| 65 to 74 | 32 | 39.51% |
| 75+ | 26 | 32.10% |
| Prefer not to say | 1 | 1.23% |
| **Total** | **81** | **100%** |



Legend:
- 0 to 15 (0%)
- 16 to 24 (1.23%)
- 25 to 34 (0%)
- 35 to 44 (2.47%)
- 45 to 54 (7.41%)
- 55 to 64 (16.05%)
- 65 to 74 (39.51%)
- 75+ (32.10%)
- Prefer not to say (1.23%)

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# Survey Summary Report

**Showing: Full Breakdown Analysis of Survey Results**

Total Respondents: 83

**Survey:** Your Velindre Experience

**Start Date:** 2022-02-01 00:00:00          **End Date:** 2022-02-28 23:59:59

**Question 14:** What is your Gender?

[Create new action](#)

| Available Answers | Responses | Score (%) |
|---|---|---|
| Male | 45 | 54.22% |
| Female | 38 | 45.78% |
| Prefer not to say | 0 | 0.00% |
| **Total** | **83** | **100%** |



■ Male (54.22%)  ■ Female (45.78%)  ■ Prefer not to say (0%)

CIVICA

# Survey Summary Report

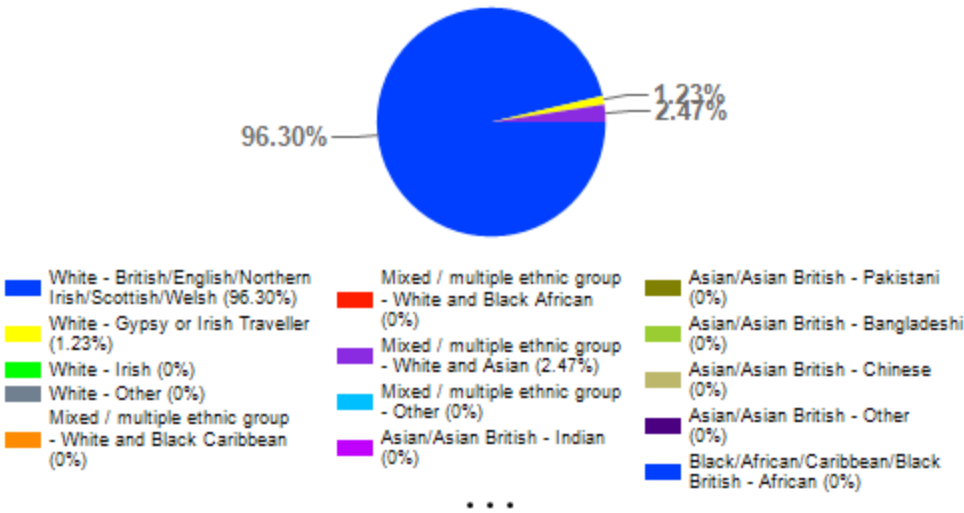**Showing: Full Breakdown Analysis of Survey Results**

Total Respondents: 83

**Survey:** Your Velindre Experience

**Start Date:** 2022-02-01 00:00:00          **End Date:** 2022-02-28 23:59:59

**Question 15:** At birth, were you described as:

[Create  new action](#)

| Available Answers | Responses | Score (%) |
|---|---|---|
| Male | 44 | 53.66% |
| Female | 38 | 46.34% |
| Other | 0 | 0.00% |
| Prefer not to say | 0 | 0.00% |
| **Total** | **82** | **100%** |



Male (53.66%)  Female (46.34%)  Other (0%)  Prefer not to say (0%)

CIVICA

# Survey Summary Report

**Showing: Full Breakdown Analysis of Survey Results**

Total Respondents: 83

**Survey:** Your Velindre Experience

**Start Date:** 2022-02-01 00:00:00          **End Date:** 2022-02-28 23:59:59

**Question 16:** Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?

[Create  new action](#)

| Available Answers | Responses | Score (%) |
|---|---|---|
| Yes, a lot | 25 | 30.12% |
| Yes, a little | 32 | 38.55% |
| Not at all | 23 | 27.71% |
| Prefer not to say | 3 | 3.61% |
| **Total** | **83** | **100%** |

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# Survey Summary Report

**Showing: Full Breakdown Analysis of Survey Results**

Total Respondents: 83

**Survey:** Your Velindre Experience

**Start Date:** 2022-02-01 00:00:00          **End Date:** 2022-02-28 23:59:59

**Question 17:** Which of the following options best describes how you think of yourself?

[Create  new action](#)

| Available Answers | Responses | Score (%) |
|---|---|---|
| Heterosexual or Straight | 79 | 96.34% |
| Bisexual | 1 | 1.22% |
| Gay or Lesbian | 1 | 1.22% |
| Prefer not to say | 1 | 1.22% |
| Other | 0 | 0.00% |
| **Total** | **82** | **100%** |

**Survey:** Your Velindre Experience

**Start Date:** 2022-02-01 00:00:00          **End Date:** 2022-02-28 23:59:59

**Question 18:** What is your religion?

[Create new action](#)

| Available Answers | Responses | Score (%) |
|---|---|---|
| No Religion | 17 | 20.73% |
| Buddhist | 0 | 0.00% |
| Christian | 61 | 74.39% |
| Hindu | 0 | 0.00% |
| Jewish | 0 | 0.00% |
| Muslim | 1 | 1.22% |
| Sikh | 0 | 0.00% |
| Prefer not to say | 0 | 0.00% |
| Other Religion | 3 | 3.66% |
| **Total** | **82** | **100%** |



**Question 19:** Other Religion - please give details in this box:

[Create new action](#)

| Baptist | [631fa4a4 / 2022-02](#) | [Create new action](#) |
|---|---|---|

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# Survey Summary Report

**Showing: Full Breakdown Analysis of Survey Results**

Total Respondents: 83

**Survey:** Your Velindre Experience

**Start Date:** 2022-02-01 00:00:00          **End Date:** 2022-02-28 23:59:59

**Question 20:** What is your ethnic group?

[Create new action](#)

| Available Answers | Responses | Score (%) |
|---|---|---|
| White - British/English/Northern Irish/Scottish/Welsh | 78 | 96.30% |
| White - Gypsy or Irish Traveller | 1 | 1.23% |
| White - Irish | 0 | 0.00% |
| White - Other | 0 | 0.00% |
| Mixed / multiple ethnic group - White and Black Caribbean | 0 | 0.00% |
| Mixed / multiple ethnic group - White and Black African | 0 | 0.00% |
| Mixed / multiple ethnic group - White and Asian | 2 | 2.47% |
| Mixed / multiple ethnic group - Other | 0 | 0.00% |
| Asian/Asian British - Indian | 0 | 0.00% |
| Asian/Asian British - Pakistani | 0 | 0.00% |
| Asian/Asian British - Bangladeshi | 0 | 0.00% |
| Asian/Asian British - Chinese | 0 | 0.00% |
| Asian/Asian British - Other | 0 | 0.00% |
| Black/African/Caribbean/Black British - African | 0 | 0.00% |
| Black/African/Caribbean/Black British - Caribbean | 0 | 0.00% |
| Black/African/Caribbean/Black British - Black British | 0 | 0.00% |
| Black/African/Caribbean/Black - Other | 0 | 0.00% |
| Other Ethnic Group - Arab | 0 | 0.00% |
| Prefer not to say | 0 | 0.00% |
| **Total** | **81** | **100%** |

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# Survey Summary Report

**Showing: Full Breakdown Analysis of Survey Results**

Total Respondents: 83

**Survey:** Your Velindre Experience

**Start Date:** 2022-02-01 00:00:00          **End Date:** 2022-02-28 23:59:59



- White - British/English/Northern Irish/Scottish/Welsh (96.30%)
- White - Gypsy or Irish Traveller (1.23%)
- White - Irish (0%)
- White - Other (0%)
- Mixed / multiple ethnic group - White and Black Caribbean (0%)
- Mixed / multiple ethnic group - White and Black African (0%)
- Mixed / multiple ethnic group - White and Asian (2.47%)
- Mixed / multiple ethnic group - Other (0%)
- Asian/Asian British - Indian (0%)
- Asian/Asian British - Pakistani (0%)
- Asian/Asian British - Bangladeshi (0%)
- Asian/Asian British - Chinese (0%)
- Asian/Asian British - Other (0%)
- Black/African/Caribbean/Black British - African (0%)

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# Survey Summary Report

**Showing: Full Breakdown Analysis of Survey Results**

Total Respondents: 83

**Survey:** Your Velindre Experience

**Start Date:** 2022-02-01 00:00:00         **End Date:** 2022-02-28 23:59:59

**Question 21:** Other Ethnic Group - please give details in this box:

[Create_new action](#)

| Whiter | [9a8dc388 / 2022-02](#) | [Create_new action](#) |
|--------|-------------------------|------------------------|

**Available Filters:**

Note: The available filter selection is dependent on the report that is being generated.

| Filter Option | Selection |
|---------------|-----------|
| Service Group | Velindre Cancer Centre |
| Directorate | Integrated care,Medicine,Operational Services,Operational Services and Delivery,Palliative Medicine,Radiation services,Research, Development & Innovation ,SACT/Medicines Management |
| Service | Catering services,Clinical Psychology,Clinical Trials ,Medicine,Nuclear Medicine,Nursing,Operational Services,Outpatients,Palliative care,Pharmacy,Radiology,Radiotherapy,Radiotherapy/Brachytherapy,SACT,Therapies |
| Location | All Filters Selected |

| | |
|---|---|
| Survey | Your Velindre Experience |
| Question | All Questions Selected |
| Response | All Responses Selected |
| Category | Standard |

| | |
|---|---|
| Start Date | 2022-02-01 00:00:00 |
| End Date | 2022-02-28 23:59:59 |

CIVICA

**Canolfan Ganser Felindre
Velindre Cancer Centre**

| **Re-configuration of the Pharmacy Dispensary** |
|---|

| **Meeting Date:** | 9th February 2022 |
|---|---|
| **Author:** | Usman Malik |
| **Sponsor:** | Bethan Tranter |
| **Report Presented by:** | Usman Malik |
| **Committee/Group who have received or considered this paper:** | Medicines Management Group. |

| **Trust Resolution to:** (please tick) | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Approve:** | | **Endorse:** | | **Discuss:** | | **Note:** | x |
| **Recommendation:** | | To note the information regarding the re-configuration of dispensary and that whilst the re-configuration of the dispensary is being undertaken pharmacy will dispense VCC specific medication only. | | | | | |

| **This report supports the following Trust objectives as set out in the Integrated Medium Term Plan:** (please tick) | |
|---|---|
| Equitable and timely services | **X** |
| Providing evidence based care and research which is clinically effective | |
| Supporting our staff to excel | |
| Safe and reliable services | **X** |
| First class patient /donor experience | **X** |
| Spending every pound well | **X** |

Delivering quality, care & excellence

Darparu ansawdd, gofal a rhagoriaeth

**SITUATION**

From 21st March 2022 the pharmacy dispensary is to be refurbished; this will improve the working environment for the staff and improve the workflow within the dispensary. The refurbishment will take approximately 4 weeks, during which time pharmacy will provide its clinical and dispensing services from an interim pharmacy dispensary. In addition to this, pharmacy will not have a dedicated 'patient waiting area' for patients to be able to wait for their prescriptions.

This 4-week refurbishment period will impact on all clinical areas where prescriptions are generated for Velindre Cancer Centre dispensing, the main area of impact being the main outpatient department.

During this interim period, pharmacy will work with all clinical areas including outpatients to aim to ensure that only essential VCC dispensing is undertaken in a safe environment that minimises the impact on patient experience whilst maintaining patient safety.

**BACKGROUND**

It has been recognised that there is a need to create a safer working environment for the pharmacy dispensary. The need has resulted from an increase in oral SACT prescribing over the past several years and an increased need for better distancing of the dispensary staff resulting from the pandemic. This 'pharmacy refurbishment project' aims to provide a reconfiguration of the current working space within the pharmacy dispensary. This will result in a more efficient workflow and better distancing between staff which will reduce staff anxiety and promote wellbeing.

As part of the project, there will be interim dispensary to provide an ongoing clinical pharmacy service. However, to maintain a good patient experience, it is proposed that VCC pharmacy provide 'VCC essential dispensing' only, and maximize the use of community pharmacy by using WP10 for all non-VCC pharmacy essential dispensing.

For those patients prescribed 'oral only SACT', it is essential that there is good communication between all prescribers and the interim pharmacy dispensary to ensure poor patient experience is minimized.

**ASSESSMENT**

A pharmacy project team has been established, and is finalising several documents to facilitate a safe interim working solution, including:

1. Project Plan Brief
2. Project PID
3. Project plan tracker
4. Project plan risk log


The project team will be able to provide regular feedback to the SACT and Medicines Management Operational Group (SMMOG), departments and service users in the 'run up' period and throughout the 4 week interim period.

On ongoing risk and issues log will be kept, and a summary paper submitted at the end of the project.

---

**RECOMMENDATIONS**

The recommendations are as follows:

1. Over the next 4 weeks, the pharmacy project team will meet with all the main service users to agree safe processes and procedures for work. This will primarily be those clinical areas (day units, wards and departments) that are supplied with a dispensing and medication 'top up' service.

2. It is perceived that Outpatient Department prescribing of oral SACT will be the most challenging service as it is time dependant (e.g., on the day prescribing and dispensing). The pharmacy project team will be working very closely over the 'run in period' before the refurbishment starts with the Outpatient Department to ensure that systems are as robust as possible to minimise any impact on the patient experience.

3. General communication with all staff and patients will be undertaken by the pharmacy project team.

# Velindre Cancer Centre Monthly Performance Report Summary Dashboard (February 2022)

| | | | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Radiotherapy | Patients Beginning Radical Radiotherapy Within 28-Days (page 8) | Actual | 92% | 89% | 95% | 94% | 97% | 96% | 97% | 96% | 92% | 78% | 92% | 92% |
| | | Target | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% |
| | Patients Beginning Palliative Radiotherapy Within 14-Days (page 10) | Actual | 90% | 85% | 95% | 85% | 82% | 82% | 82% | 82% | 74% | 84% | 90% | 90% |
| | | Target | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% |
| | Patients Beginning Emergency Radiotherapy Within 2-Days (page 12) | Actual | 100% | 97% | 100% | 100% | 97% | 100% | 97% | 100% | 85% | 89% | 100% | 93% |
| | | Target | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% |
| SACT | Patients Beginning Non-Emergency SACT Within 21-Days (page 14) | Actual | 88% | 98% | 98% | 98% | 99% | 99% | 98% | 99% | 99% | 99% | 94% | 91% |
| | | Target | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% |
| | Patients Beginning Emergency SACT Within 2-Days (page 15) | Actual | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 86% | 100% | 100% | 100% |
| | | Target | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% |
| Outpatients | New Patient, other Outpatient and Chemotherapy Assessment Appointments Where Patients Were Seen Within 30 minutes of the Scheduled Appointment Times (National Target) (page 19) | Actual | 57% | 66% | 79% | 76% | 76% | 53% | 53% | 65% | 65% | Data collection paused between December and February due to operational pressures. | | |
| | | Target | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | | | |

| | | | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Therapies | Did Not Attend (DNA) Rates | Actual | 3% | 3% | 4% | 4% | 5% | 5% | 5% | 5% | 5% | 3% | 3% | 3% |
| | | Target | 5% | 5% | 5% | 5% | 5% | 5% | 5% | 5% | 5% | 5% | 5% | 5% |
| | Therapies Inpatients Seen Within 2 Working Days (page 22) | Actual (Dietetics) | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| | | Actual (Physiotherapy) | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| | | Actual (Occupational Therapy) | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 95% | 100% | 100% | 100% | 100% |
| | | Actual (Speech and Language Therapy) | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| | | Target | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| | Therapies Outpatient Referrals Seen Within 2 Weeks (page 22) | Actual (Dietetics) | 100% | 100% | 100% | 84% | 94% | 94% | 98% | 97% | 100% | 95% | 98% | 100% |
| | | Actual (Physiotherapy) | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| | | Actual (Occupational Therapy) | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| | | Actual (Speech and Language Therapy) | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| | | Target | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |

| | | | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Routine Therapies Outpatients Seen Within 6 Weeks (page 22) | Actual (Dietetics) | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| | | Actual (Physiotherapy) | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 86% | 100% |
| | | Actual (Occupational Therapy) | 100% | 100% | 100% | 100% | 100% | 96% | 33% | 78% | 100% | 100% | 100% | 100% |
| | | Actual (Speech and Language Therapy) | 100% | 100% | 100% | 100% | 96% | 100% | 100% | 96% | 100% | 100% | 100% | 100% |
| | | Target | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| Safe and Reliable Care | Number of VCC Acquired, Avoidable Pressure Ulcers (page 24) | Actual | 0 | 1 | 0 | 0 | 0 | 2 | 1 | 1 | 0 | 1 | 0 | 1 |
| | | Target | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Number of Pressure Ulcers Reported to Welsh Government as Serious Incidents | Actual | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | Target | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Number of VCC Inpatient Falls (page 26) | Actual (Total) | 1 | 2 | 3 | 1 | 3 | 4 | 2 | 3 | 1 | 4 | 3 | 2 |
| | | Unavoidable | 1 | 1 | 3 | 1 | 3 | 4 | 1 | 3 | 1 | 4 | 2 | 2 |
| | | Avoidable | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 |
| | | Target | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Number of Delayed Transfers of Care (DToCs) | Actual | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 4 | 0 | 0 | 1 | 4 |

| | | | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Target | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Number of Potentially Avoidable Hospital Acquired Thromboses (HAT) | Actual | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | Target | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Patients with a NEWS Score Greater to or Equal to Three Who Receive all 6 Elements in Required Timeframe (page 28) | Actual | 100% | 100% | 100% | 100% | 80% | 100% | 75% | 100% | 100% | 100% | 100% | 100% |
| | | Target | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| | Healthcare Acquired Infections (page 29) | Actual | 0 | 0 | 0 | 0 | 1 (*C.diff*) | 0 | 0 | 0 | 0 | 0 | 1 (*C.diff*) | 0 |
| | | Target | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Percentage of Episodes Clinically Coded Within 1 Month Post Episode End Date | | Actual | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% |
| | | Target | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% |

RAG rating above indicates: Green - Target was achieved. Amber - 85% Compliance or above.  Red - Target not achieved.

## Radiotherapy Referral Trends - Overall

| Monthly Average (2019-20) | Monthly Average (2020-21) | Total New Patient Referrals (February 2022) |
|---|---|---|
| 357 | 315 | 357 |

The total number of referrals received in February 2022 (357) represented an increase on the number received in January 2022 (342). The number of referrals considerably exceeded the average number received in any month, on average, during 2020-21.

### Total New Patient Referrals by Month to February 2022

| Radiotherapy – Operational Context |
| :--- |
| Referral Trends - Tumour Site |



New Patient Referrals by Tumour Site to February 2021

Legend: Urological, Breast, Lung, Head & Neck, Colorectal, Upper GI, Gynae
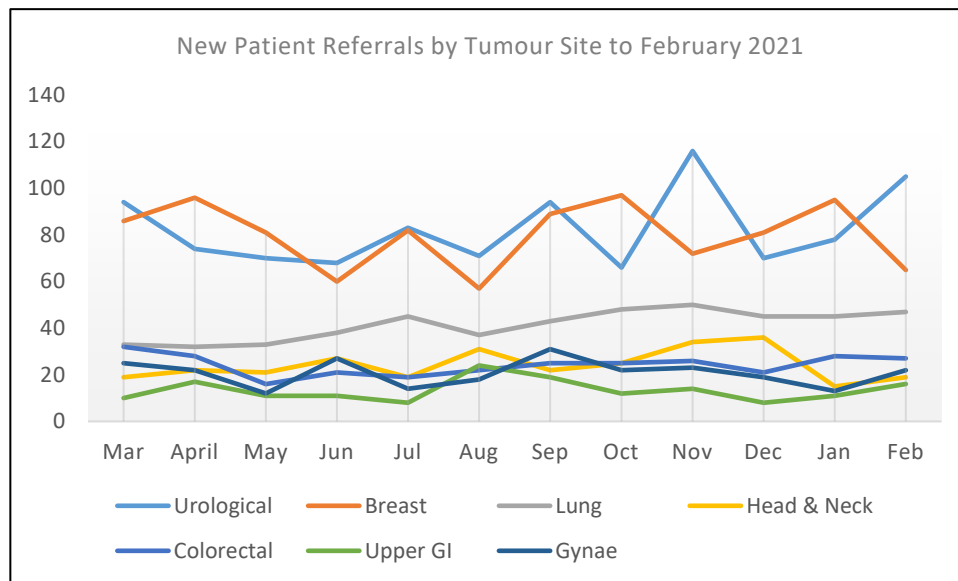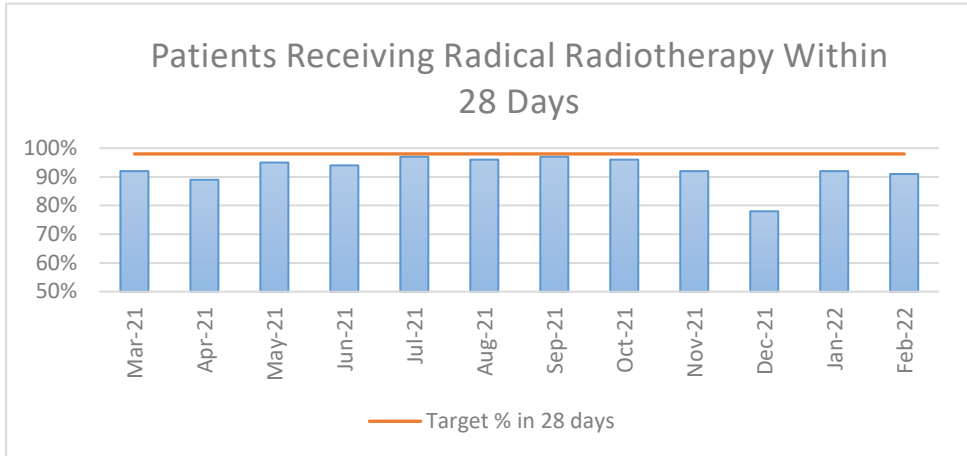
| Site | Monthly Average (2019-20) | Monthly Average (2020-21) | 2020-21 Average Relative to 2019-20 Average | New Patients (February 2022) |
| :--- | :---: | :---: | :---: | :---: |
| **Breast** | **88** | **60** | **-32%** | 65 |
| **Urology** | **82** | **82** | **0%** | 105 |
| **Lung** | **47** | **38** | **-19%** | 47 |
| **Colorectal** | **20** | **22** | **+10%** | 27 |
| **Head and Neck** | **23** | **23** | **0%** | 19 |
| **Gynaecological** | **18** | **18** | **0%** | 22 |
| **Upper Gastrointestinal** | **16** | **13** | **- 19%** | 16 |
| **Top 7 Tumour Sites by Number of Referrals as Percentage of Total Referrals** | **82%** | **81%** | | 84% |

*The graph and table show the number of patients scheduled to begin treatment in February by the tumour sites most commonly referred for radiotherapy treatment.*

- Referrals overall and across some tumour sites now returning to pre Covid levels.
- Demand up from 82% to 84% against the 2019/20 baseline (in the tumour sites most commonly referred for radiotherapy, with maximum 80% capacity due to IP&C measures. Prior to staff absences rising during 4th COVID wave.
- Weekly variation in referrals from health boards, across individual tumour sites, is impacting on our ability to meet demand in a timely fashion. Engagement with health boards ongoing to understand their backlog clearance plans.
- All options being explored by SSTs to meet short term surges and to respond to health board backlog clearance.

| Patients Receiving Radical Radiotherapy Within 28-Days | |
|---|---|
| **Target: 98%** | **SLT Lead: Radiotherapy Services Manager** |
| Trend | Current Performance |



Patients Receiving Radical Radiotherapy Within 28 Days

— Target % in 28 days

The number of patients scheduled to begin radical radiotherapy treatment in February 2022 (137) was below the monthly average observed in 2020-21 (150) and was lower than the number scheduled to begin treatment in January 2021 (156).

13 patients referred for Radical radiotherapy did not begin treatment within the 28 day target constituting an overall performance rate of 92**%.**

All 13 patients have now commenced treatment and breaches due to capacity constraints followed an approved clinical prioritisation process, to ensure risk to patients and outcomes is minimised.

A full breakdown of breach reason and any improvement actions and ongoing assurance can be viewed in the below table.

Breakdown of Breach waits:

| Patient no | Day treatment commenced | Breach reason | Improvement action |
|---|---|---|---|
| 1 | 29 | Planning delay | Discussed with RT physics - working practice and capacity reviewed |
| 1 | 31 | Clinical request | No actions clinical request for optimum patient treatment |
| 1 | 33 | Clinical request | No action - was clinical request for rescan and re-plan on day 27 due to patient change |
| 1 | 34 | Specialist SRS capacity | Medium term action plan underway to address capacity challenges with a focus on specialist areas. |

| Intent | Monthly Average (2019-20) | Monthly Average (2020-21) | Patients Scheduled to Begin Treatment (February 2022) |
|---|---|---|---|
| Radical | 167 | 150 | 137 |
| | Patients Scheduled to Begin Treatment (February 2020) | Patients Scheduled to Begin Treatment (February 2021) | |
| | 162 | 114 | |

| | | | |
|---|---|---|---|
| 2 | 35, 50 | Patient COVID+ and requested to delay chemo, subsequent RT delayed in line | Advise clinician this should be a suspension not a breach |
| 3 | 36, 41, 48 | Linac capacity due to staff COVID absences | Follow clinical prioritisation process to ensure minimal risk to patient. Additionally maximising capacity plan in place and being progressed |
| 1 | 41 | CEDAR trial patient | Clinical request to move due to trial requirements no further risk to patient |
| 1 | 42 | Specialist Space OAR patient | Medium term action plan underway to address capacity challenges with a focus on specialist areas. |
| 1 | 60 | Brachy capacity | Brachy expansion business case in progress with WHSCC funding secured to expand service. Complexity of skills mix for service – timeline 6 months |

As demand of radiotherapy treatment will continue to increase, the following short, medium and longer actions as detailed below will be undertaken. This will ensure breaches in treatment dates above 28 days will be kept to a minimum and always clinically prioritised to ensure patient risk is kept to a minimum. We are aware that growing brachytherapy demand is outweighing capacity and there is an expansion business case in progress.

We have completed the short term actions and are now in the detailed planning stage. All operational intervention in terms of increasing capacity have now been undertaken. We are now moving to medium and longer term actions to sustain our capacity.

| | Medium Term Actions |
|---|---|
| | • We are working with each SST to develop a tailored capacity delivery plan based on demand projections and treatment options eg Brachytherapy, molecular radiotherapy.<br>• Recruitment and appointments in progress for additional front line resources, however capacity increases predicted throughout 2nd half of 2022 due to lead in time, maximising capacity from Sept-Dec 2022.<br>• Peer review with Clatterbridge Trust underway April 2022 to identify options/service models to put service demand and capacity in balance for Brachytherapy.<br>• Brachytherapy expansion business case being written to obtain support for increased capacity with WHSCC. submission Apr 2022<br>• Assess the options to escalate some or all of the longer term capacity solutions. April 2022. |

| | |
|---|---|
| **Patients Receiving Palliative Radiotherapy Within 14-Days** | |
| **Target: 98%** | **SLT Lead: Radiotherapy Services Manager** |
| Trend | Current Performance |

### Trend



Chart: Patients Receiving Palliative Radiotherapy Treated Within 14 Days

Monthly bars Mar-21 through Feb-22 with a "Target % in 14 days" line at ~98%.

The number of patients scheduled to begin palliative radiotherapy treatment in February 2022 (64) was below the monthly average observed in 2020-21 (74), but exceeded the number scheduled to begin treatment in January 2021 (60).

| Intent | Monthly Average (2019-20) | Monthly Average (2020-21) | Patients Scheduled to Begin Treatment (February 2022) |
|---|---|---|---|
| Palliative | 82 | 74 | 64 |
| | Patients Scheduled to Begin Treatment (February 2020) | Patients Scheduled to Begin Treatment (February 2021) | |
| | 83 | 50 | |

### Current Performance

9 patients referred for radiotherapy treatment with palliative intent WHO were scheduled to begin treatment in February, did not begin treatment within the 14 day target constituting an overall performance rate of **90%.**

Additional staffing pressures due to sickness during February as a result of Omicron variant resulted in a reduction of the service.

Breakdown of Breach Waits:

| Treatment Intent | ≥ 20 days | ≥ 30 days | < 35 days |
|---|---|---|---|
| Palliative (14-day target) | 7 | 1 | 1 |

Summary of delays:
Patient waiting up to 35 days was 3D planning and replan. Patient waiting up to 30 days was 3D plan.
Majority of patients in up to 20 day category also 3D Plans.

As demand of radiotherapy treatment will continue to increase, the following short, medium and longer actions as detailed below will be undertaken. This will ensure breaches in treatment dates above 28 days will be kept to a minimum.

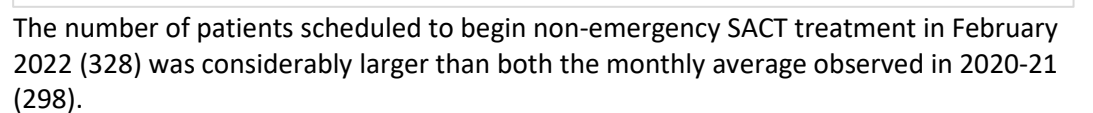| | Medium Term Actions |
|---|---|
| | <ul><li>Recruitment and appointments in progress for additional front line resources, however capacity increases predicted throughout 2<sup>nd</sup> half of 2022 due to lead in time, maximising capacity from Sept-Dec 2022.</li><li>Peer review with Clatterbridge Trust underway to identify options/service models to put service demand and capacity in balance. April 2022</li><li>Brachytherapy expansion business case being written to obtain support for increased capacity with WHSCC. submission Apr 2022</li><li>Assess the options to escalate some or all of the longer term capacity solutions. April 2022.</li></ul> |

| Patients Receiving Emergency Radiotherapy Within 2-Days | |
|---|---|
| **Target: 98%** | **SLT Lead: Radiotherapy Services Manager** |
| Trend | Current Performance |

**Patients Receiving Emergency Radiotherapy Treated Within 2 Days**



The number of patients scheduled to begin emergency radiotherapy treatment in February 2022 (24) was lower than the monthly average observed in 2020-21 (27), but was marginally greater than the number scheduled to begin treatment in January 2021 (22).

| Intent | Monthly Average (2019-20) | Monthly Average (2020-21) | Patients Scheduled to Begin Treatment (February 2022) |
|---|---|---|---|
| Emergency | 25 | 27 | 24 |
| | Patients Scheduled to Begin Treatment (February 2020) | Patients Scheduled to Begin Treatment (February 2021) | |
| | 29 | 18 | |

2 patients referred for emergency radiotherapy treatment which were scheduled to begin treatment in February 2022, did not begin radiotherapy treatment within 2 days of referral constituting an overall performance of **93%.**

Breakdown of Breach Waits:

| Treatment Intent | ≥ 3 days |
|---|---|
| Emergency (2-day target) | 2 |

Summary of delays:
Both patients were treated on day 3, the delay was down to capacity at the time treatment was able to start.

Wider Actions as above for 21 and 14 day targets

| Non-Emergency SACT Patients Treated Within 21-Days | |
|---|---|
| **Target: 98%** | **SLT Lead: Chief Pharmacist** |
| Current Performance | Trend |



**Non-Emergency SACT Patients Treated Within 21 Days**

*(Chart showing monthly bars from Mar-21 to Feb-22 with Target % in 21 days line)*

— Target % in 21 days

The number of patients scheduled to begin non-emergency SACT treatment in February 2022 (328) was considerably larger than both the monthly average observed in 2020-21 (298).

| Intent | Monthly Average (2019-20) | Monthly Average (2020-21) | Patients Scheduled to Begin Treatment (February 2022) |
|---|---|---|---|
| Non - emergency | 328 | 298 | |
| | Patients Scheduled to Begin Treatment (February 2020) | Patients Scheduled to Begin Treatment (February 2021) | 328 |
| | 290 | 318 | |

328 patients were referred for non-emergency SACT treatment scheduled to begin treatment in January. Of this total, 28 patients did not begin treatment within the 21 day target, constituting an overall performance rate of 91%.

Of the 28 patients who did not begin treatment within 21-days, 24 were treated within 28 days and all had begun treatment before day 42:

| Treatment Intent | ≤ 28 days | ≤ 35 days |
|---|---|---|
| Non-emergency (21-day target) | 24 | 4 |

One patient who breached was classified as category 2 waited 24 days. Category 2 is defined for this patient is defined as therapy which adds 20 to 50% chance of cure to surgery or radiotherapy or treatment given at relapse. All other patients were prioritised as categories 3 to 6 and therefore, as 24 patients were treated within 28 days and the remainder within 28 days the risk of harm is considered to be less.

All patients who are referred to the SACT daycase service are clinically prioritised according to the Welsh Cancer Network Clinical Prioritisation Guidelines.

VCC has not reduced social distancing to 1m due to the high community prevalence of COVID. Reduction of social distancing to 1m will enable VCC SACT daycase unit to increase the number of chairs overall by a small margin (yet to be defined). This will aid patient flow. However, the primary capacity challenge of the service is related to staffing
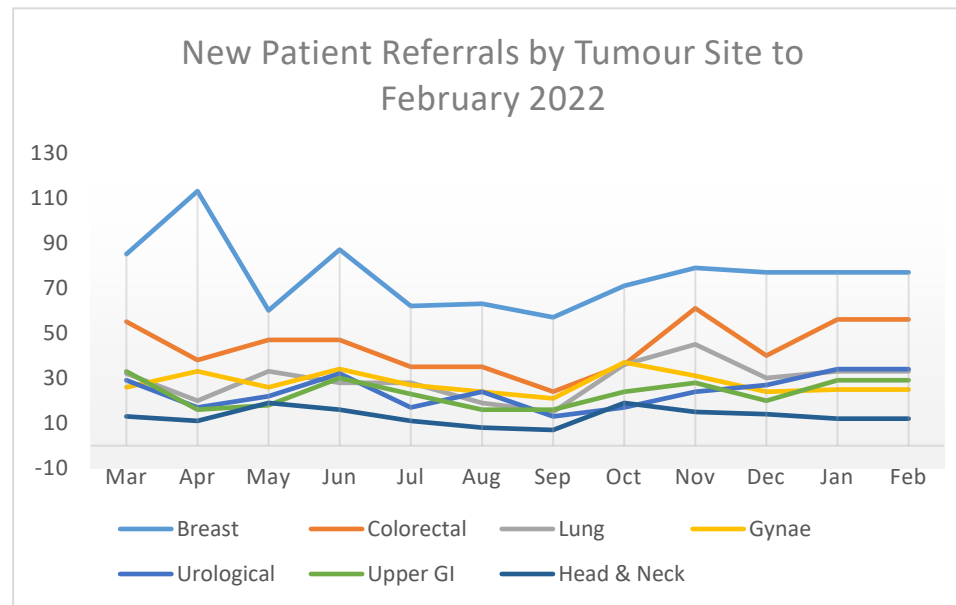
| | resource and thus increase in chair capacity will not facilitate increased capacity without resolution of staffing challenges. Daily SACT Escalation meetings continue to be held with senior clinical SACT team leads who actively manage this prioritisation process and endeavour to ensure that all patients are treated in as timely a manner as possible according to their clinical prioritisation category and date of referral to the service. |
|---|---|
| | **Actions** |
| | • Weekend clinics and mutual aid from other parts of the centre are being utilised.<br>• Additional capacity being secured from Rutherford cancer centre. April 2022 is the predicted commencement, however discussions have commenced to try and bring this forward.<br>• Streamlined management of non-SACT chair activity, e.g. single agent regimens are being moved out of unit to other areas, creating extra capacity. April 2022.<br>• A task and finish group has been established to identify solutions to support the service in increasing capacity, productivity, sustainability. Commenced March 2022 and ongoing.<br>• Discussions are being escalated to prioritise the Neville Hall provision, which is the medium term plan for increasing capacity.  Next update April 2022 |

| Emergency SACT Patients Treated Within 5-Days | |
|---|---|
| **Target: 98%** | **SLT Lead: Chief Pharmacist** |
| Current Performance | Trend |

### Emergency SACT Patients Treated Within 5 Days



— Target % in 5 days

9 patients referred for emergency SACT treatment were scheduled to begin treatment in February 2022. All patients began treatment within the 5-day target. 100% compliance

- Ring fencing of emergency chair capacity has allowed us to improve the compliance in this area. This took a number of months until the correct balance between ring fencing and chair utilisation was achieved.

**Actions**

- Continue to balance demand and ring fencing with capacity.

The number of patients scheduled to begin emergency SACT treatment in February 2022 (9) was higher than the monthly average observed in 2020-21 (4).

| Intent | Monthly Average (2019-20) | Monthly Average (2020-21) | Patients Scheduled to Begin Treatment (February 2022) |
|---|---|---|---|
| Emergency | 4 | 4 | 9 |
| | Patients Scheduled to Begin Treatment (February 2020) | Patients Scheduled to Begin Treatment (February 2021) | |
| | 3 | 6 | |

| SACT – Operational Context | | |
|---|---|---|
| **Current Performance Consolidated** | | |

**Current Performance Consolidated**

| Measure | Target | Feb-22 |
|---|---|---|
| Non-emergency (21-day target) | 98% | **91%** |
| Emergency (5-day target) | 98% | **100%** |

The table shown here sets-out performance relative to the extant time to SACT targets.

**Referral Trends - Overall**

Total New Patient Referrals by Month to February 2022



| Monthly Average (2019-20) | Monthly Average (2020-21) | Total New Patient Referrals (February 2022) |
|---|---|---|
| 325 | 301 | 337 |

The total number of referrals received in February 2022 (3337) was above the average number received in any given month during 2020-21 (301) and marginally below the number received in January 2022 (357). The number of referrals received in January also exceeds the average number received per month in 2019-20.

Referrals fell dramatically following the first national lock-down in March 2020. Subsequently, referrals have returned to pre-pandemic levels.
Referrals include new patients for 1st definitive treatment and repeat treatments for patients mid cycle or on a revised treatment cycle.

| SACT – Operational Context |
| --- |
| Referral Trends - Tumour Site |

## New Patient Referrals by Tumour Site to February 2022



| Site | Monthly Average (2019-20) | Monthly Average (2020-21) | 2020-21 Average Relative to 2019-20 Average | New Patient Referrals (February 2022) |
| --- | --- | --- | --- | --- |
| **Breast** | **92** | **76** | **-17%** | 77 |
| **Colorectal** | **54** | **55** | **+2%** | 56 |
| **Lung** | **33** | **32** | **-3%** | 33 |
| **Gynaecological** | **31** | **31** | **0** | 25 |
| **Urological** | **36** | **26** | **-28%** | 34 |
| **Upper Gastrointestinal** | **18** | **26** | **+44%** | 29 |
| **Head and Neck** | **16** | **14** | **-12%** | 12 |
| **Top 7 Tumour Sites by Number of Referrals as Percentage of Total Referrals** | **86%** | **87%** | | 75% |

The graph and table show referrals for the tumour sites most commonly referred for SACT treatment.

SACT referrals are being driven by a high level of internal demand as a result of new/combination regimens, increasing patient treatment cycles etc.

| Equitable and Timely Access to Services - Therapies | |
|---|---|
| **Target: 100%** | **SLT Lead: Head of Nursing** |
| Current Performance | |

Percentage of Therapies Referrals (Inpatients) Seen Within 2 Working Days

| | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Dietetics | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| Physiotherapy | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| OT | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 95% | 100% | 100% | 100% | 100% |
| SLT | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |

Percentage of Urgent Therapies Referrals (Outpatients) Seen Within 2 Weeks

| | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Dietetics | 100% | 100% | 100% | 84% | 94% | 94% | 98% | 97% | 100% | 95% | 98% | 100% |
| Physiotherapy | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| OT | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| SLT | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |

Percentage of Routine Therapies (Outpatients) Seen Within 6 Weeks

| | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Dietetics | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| Physiotherapy | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 86% | 100% |
| OT | 100% | 100% | 100% | 100% | 100% | 96% | 33% | 78% | 100% | 100% | 100% | 100% |
| SLT | 100% | 100% | 100% | 100% | 96% | 100% | 100% | 96% | 100% | 100% | 100% | 100% |

| All Therapies targets were met in February 2022. | No specific actions required. |
| --- | --- |
| | |

| Velindre Acquired Pressure Ulcers | |
|---|---|
| **Target: 0** | **SLT Lead: Head of Nursing** |
| Current Performance | |



Total Number of Velindre Acquired Pressure Ulcers

Legend: Velindre Acquired Pressure Ulcers (Total) — Mean — Process Limit

| | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Velindre Acquired Pressure Ulcers (Total) | 2 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 2 | 1 | 1 | 0 | 1 | 0 | 1 |
| Potentially Avoidable Velindre Acquired Pressure Ulcers | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |

| Trend | Action |
|---|---|
| 1 Velindre acquired pressure ulcers were reported in February 2022. The patient's mobility was restricted due to pain and they were unable to reposition. Following investigation the ulcer was deemed to have been avoidable by the pressure ulcer scrutiny panel. The reason for this is despite all required care and specialist equipment being provided, there were some gaps in the nursing documentation and therefore it was felt to be incomplete. On admission, the patient had been identified as being at risk of acquiring a pressure ulcer. The pressure ulcer has since completely healed.<br><br>No Velindre acquired ulcers were reported to Welsh Government as a Serious Incident (SI). | <ul><li>A tilt and turn bed and a pressure relieving mattress were hired from a specialist company.</li><li>Nursing staff have been reminded of the need to fully complete necessary monitoring documentation.</li></ul> |

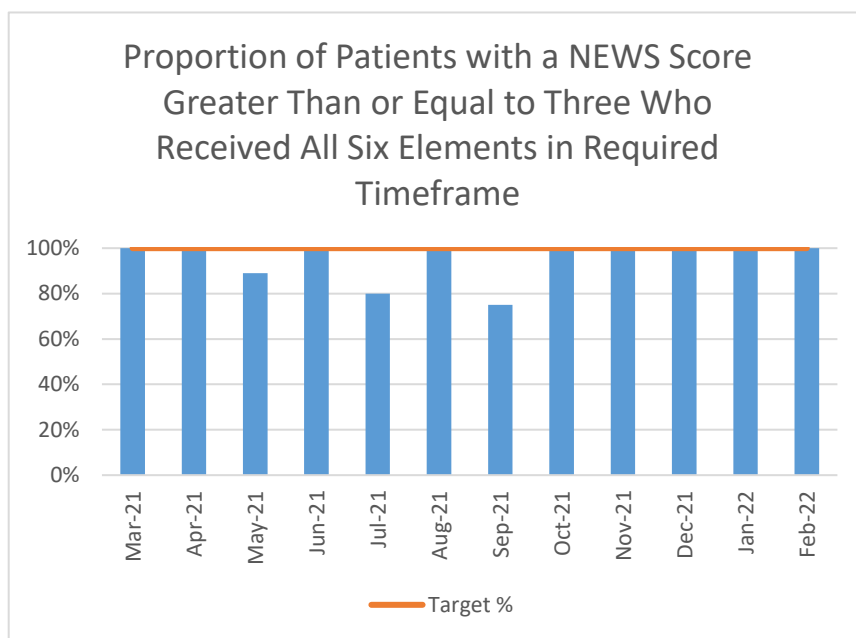| Velindre Inpatient Falls | |
|---|---|
| **Target: 0** | **SLT Lead: Head of Nursing** |
| Current Performance | |
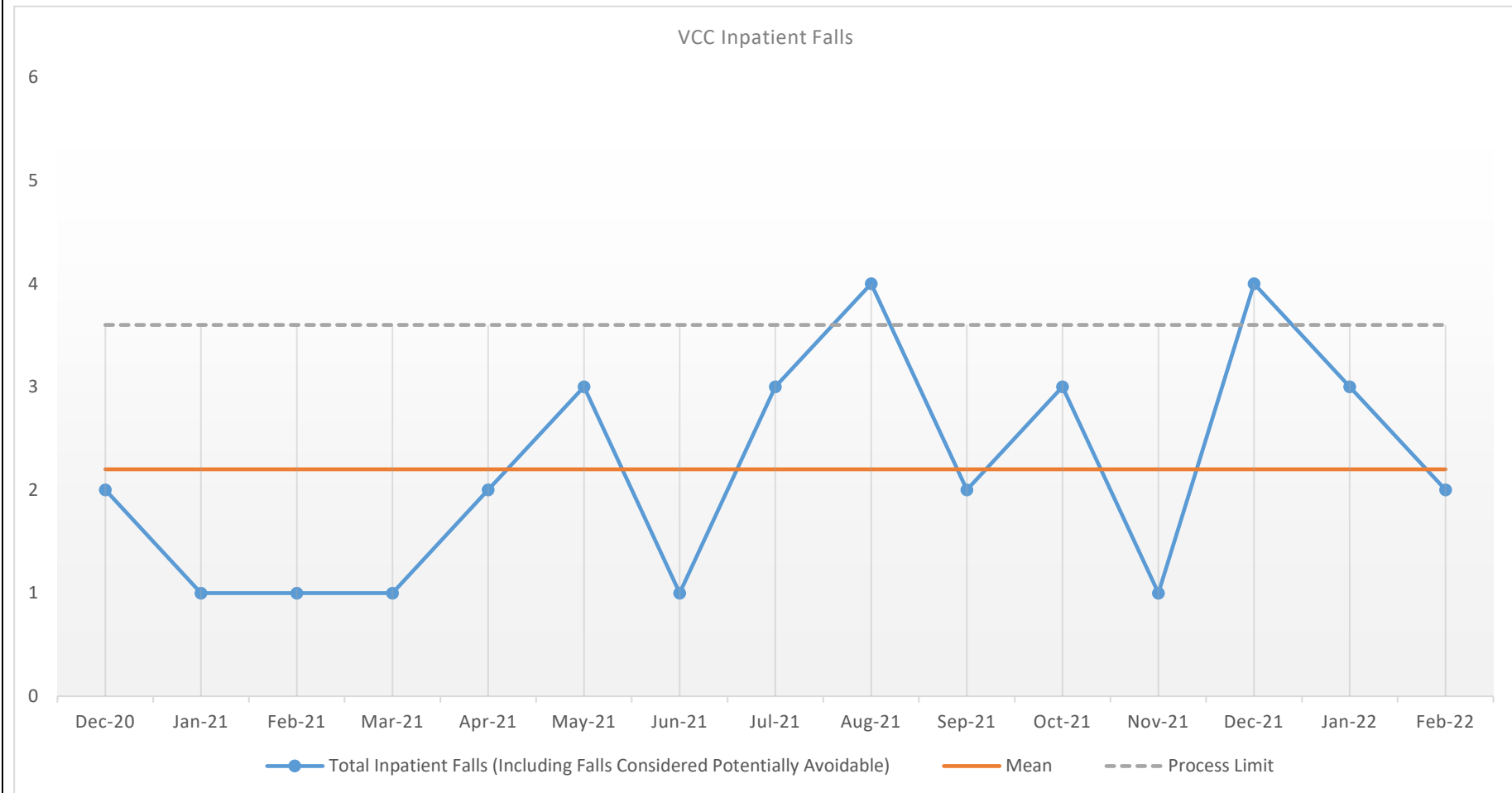


VCC Inpatient Falls

Total Inpatient Falls (Including Falls Considered Potentially Avoidable) — Mean — Process Limit

| | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total Inpatient Falls | 2 | 1 | 1 | 1 | 2 | 3 | 1 | 3 | 4 | 2 | 3 | 1 | 4 | 3 | 2 |
| Potentially Avoidable Inpatient Falls | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 |

| Trend | Action |
|---|---|
| During February 2022, 2 falls were reported on first floor ward.<br><br>Full investigations were undertaken by the VCC Falls Scrutiny Panel. Both falls were deemed to have been unavoidable.<br><br>No injuries were sustained to either patient as a result of these falls. | Falls risk assessments were undertaken, on admission, in each case.<br><br><ul><li>In each case, following the incident the falls pathway was completed and the patient reviewed by a medic.</li><li>In neither case were additional measures required post - fall, other than those identified by the initial risk assessment.</li><li>Both patients were reminded to use the nurse call bell provided for them when mobilising.</li></ul> |

| Delayed Transfer of Care | |
|---|---|
| **Target: 0** | **SLT Lead: Head of Nursing** |
| Current Performance | |

There were 4 Delayed Transfers of Care reported in February 2022.

Delays were caused by challenges in instituting appropriate care packages and by restricted capacity in the Community Resource Team (CRT).

1/ Patient admitted on 28/01/22 for 1# RT to Spinal Cord Compression. Patient was referred for a package of care required for safe discharge. This was discussed with Continuing Health Care 02/02/22. Patient medically fit for discharge on the 08/02/22 but no care package available. The patient was discharged home on 17/02/22. The delay related to waiting for a care package. The family made a decision to bridge the gap between discharge and the care package starting.

2/ Patient admitted on 26th January following a general deterioration. Patient was referred for package of care on 31st January but delays with allocation of social worker and sourcing a care package to provide twice-daily care. Patient -self discharged - on 17/02/22 a delay of 12 days.

3/ Patient was admitted on 27/1/22 for symptom control. Whilst an inpatient received 5# of radiotherapy. Referred to Community Resource Team (CRT) 2/2/22, due to capacity in the CRT the patient was discharged home on 02/3/22. Delay of 28 days.

4/ Patient was transferred from another health board on 12/01/22 to receive 28# of radiotherapy, this completed on 18/02/22. Due to patient condition and known complex discharge patient was referred to social worker. Several discussions and MDTs between social services and continuing health care regarding who should be the care provider on discharge, also challenges with different documentation requirements across the South East Wales area covered by VCC.

| Patients with a NEWS Score Greater Than or Equal to Three Who Receive All 6 Elements in Required Timeframe | |
|---|---|
| **Target: 100%** | **SMT Lead: Clinical Director** |
| Current Performance | Trend |



Proportion of Patients with a NEWS Score Greater Than or Equal to Three Who Received All Six Elements in Required Timeframe

11 patients met the criteria for administration of the sepsis treatment bundle in February 2022. All patients received all elements of the bundle within one hour. 9 of the patients subsequently received a diagnosis of sepsis or neutropenic sepsis.

**Actions**

No specific action required.

| Healthcare Acquired Infections (HAIs) | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Target: 0** | | | | | | **SLT Lead: Clinical Director** | | | | | | |
| Current Performance | | | | | | | | | | | | |

| | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| C.diff | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 |
| MRSA | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| MSSA | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| E.coli | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Klebsiella | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Pseudomonas Aeruginosa | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

| Trend | Action |
|---|---|
| 1 There were no *C.diff* or other infections reported in February 2022. | |

- WBS monitors the availability of blood for transfusion through its daily 'resilience groups' and plans its collection model to meet demand. In March, WBS continued the monthly trend of meeting demand for red cells with demand for O, A and B+ group continuing to be maintained above 3 days in line with the performance for the year. Covid related sickness has been particularly challenging during March within the Collection Teams, which has impacted the Services' ability to collect blood. On 21/03/2022 the service issued a blue alert to NHS Wales highlighting pressure on O blood groups. There were three red cell units imported during March as a result of a request for a rare blood group (phenotype) not available at WBS.

- The number of new bone marrow volunteers added to the Welsh Bone Marrow Donor Registry (WBMDR) remains below the annual target of 4000 p/a at 2582, continuing the upward trend in numbers recruited from December 2021 into March 2022. The reduction is due to fewer 17-30 year old blood donors donating red blood, from which bone marrow donors are recruited. This significant reduction can be aligned to COVID 19 Pandemic. The service is currently reviewing its approach to recruiting bone marrow donors and identifying how to increase the number of young bone marrow donors, which are the preferred demographic of donors due to the fact there is an improved outcome rate. An action plan and a supporting business case has been developed to formally raise awareness of the 'SWAB' test to determine potential bone marrow donors in addition to capturing individuals already donating red blood cells in place. In the meantime two University donor recruitment sessions took place in March which resulted in a higher than average conversion rate for registrations of 17-30 year olds, and the registration of 21 SWAB donors in March.

- There continues to be an upward trend for stem cell collections in Wales. However, the service has seen a higher cancellation rate (30%) compared to that pre pandemic (15%). This is due to patient fitness and the requirement for collection centres to 'workup' two donors simultaneously in order to ensure sufficient number of donors available at the required point of a patient's treatment. The apheresis stem cell collection service commenced in VCC in October 2021 and is providing additional capacity to support stem cell collections. There are plans to open the bone marrow collection service at VCC later in the year.

- Red Cell Immunology staffing related pressures resulted in the Service advising pathology labs across Wales to triage out of hour referrals. At 65% turn around times for March were impacted significantly by key staff absences, with the Service receiving the highest ever number of referrals (272) in March. An audit has been undertaken, and the findings accepted. These recommendations will be introduced with Health Boards and improvements in performance are anticipated.

- At 0.99 the Collection Productivity Rate continues the trend for the year and is below the target of 1.25. Whilst the service continues to operate under COVID19 conditions it is limited in being able to improve the performance which based on a pre Covid19 operating model. For the majority of March, donor sessions operated at 2m distancing, and it is expected that the change to 1m physical distancing from April will help improve this performance figure by increasing the number of donation chairs available at collection sessions.

- At 85% the performance against the 'Incidents closed within 30 days' measure has not met target (90%) for the three month rolling period to March. In this period the number of incidents not closed in the required timeframe increased from eight in the previous reporting period to 24. Thirteen of these relate to clip failures at the end of the donation process leading to collection of an excess quantity of blood, reported as incidents in Datix and granular data has only just been made available. These incidents do not reflect harm to the Donor, or risk to patients, but the blood collected would be discarded as a manufacturing loss. Prior to the introduction of Datix Once for Wales these were not recorded in Datix but were tracked through manufacturing losses. The current number of reports remains within the normal variations and tolerances for blood donation. Reporting of these incidents will be removed to Q-Pulse to reflect the need to monitor trends without an investigation of each individual occurrence.

There were no Serious Adverse Events (SAE) reported to regulators during March.

- In March 2022, 7,415 donors were registered at donation clinics. Eight (8) concerns were reported and managed within the required timeline and 692 new donors completed a donation. Attending University venues has resulted in the increase in new donors whilst donor satisfaction continues to exceed target at 95.7%.
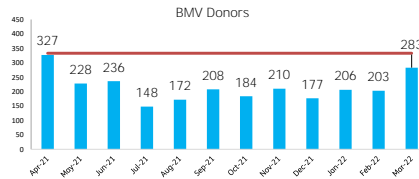
**Reference Table**

| Measure | Target | Timeframe | National / Local |
|---|---|---|---|
| Number of new bone marrow donors aged 18-30 recruited to the Welsh Bone Marrow Donor Registry (WBMDR) | 4,000 | Annual | Local |
| Number of days when the Red Blood Cell (RBC) stockholding for O, A & B- fell below 3 days cover | 0 days | Monthly | Local |
| Number of bags of RBCs manufactured as a % of the number of issues to hospitals **(% Red Cell Demand Met)** | 100% | Monthly | Local |
| Number of bags of platelets manufactured as a % of the number of issues to hospitals **(% Platelet Demand Met)** | 100% | Monthly | Local |
| Number of Confirmatory Tests (CTs) requested and bled as a % of the total CTs requested **(Confirmatory Tests Bled)** | 65% | Monthly | Local |
| Number of Stem Cell Collections | 80 | Annual | Local |
| Number of antenatal patient results provided to customer hospitals within 3 working days from receipt of sample **(Antenatal Turnaround Times)** | 90% | Monthly | Local |
| Number of samples referred for red cell reference serology work ups provided to customer hospitals within 2 working days. **(Reference Serology Turnaround Times)** | 80% | Monthly | Local |
| % of Quality Incident Records (recorded in DATIX), closed within 30 days over a rolling 3 month period | 90% | Rolling | Local |
| Number of critical non-conformances through external audits or inspections | 0 | Annual | Local |
| Number of Serious Adverse Blood Reactions & Events (SABRE) reported to the Medicines and Healthcare products Regulatory Agency (MHRA) | 0 | Annual | Local |
| Number of whole blood donations that are collected on session which are below the minimum viable volume, as a % of the total number of whole blood donations collected **(% Part Bags)** | 3% | Monthly | Local |
| Number of donors where venepuncture is attempted to be performed on but no blood enters the bag, as a % of the number of donors who have reached the donation chair **(% Unsuccessful Venepuncture)** | 2% | Monthly | Local |
| The number of blood components (weighted) collected per Standardised FTE **(Blood Collection Efficiency)** | 1.25 WTE | Monthly | Local |
| Number of components manufactured per Standardised FTE. **(Manufacturing Efficiency)** | 392 | Monthly | Local |
| Number of platelets which have time expired as a % of the total number of platelets manufactured **(Time Expired Platelets)** | 10% | Monthly | Local |
| Number of RBC units which become non-viable during the manufacturing process which could have been avoided, as a % of the number of complete whole blood donations **(Controllable Manufacturing Losses)** | 0.5% | Monthly | Local |
| Number of bags of RBC, including Paediatric bags, which have time expired as a % of the total number of RBC bags manufactured **(Time Expired Red Cells)** | 1% | Monthly | Local |
| Number of donors that scored 5 or 6 out of 6 (6 being totally satisfied and 1 being totally dissatisfied with their overall donation experience after they have been registered on clinic to donate **(Donor Satisfaction)** | 71% | Monthly | Local |
| Number of 'formal' and 'informal' concerns received from blood donors | ~ | ~ | ~ |
| % of 'formal' concerns received and treated under 'Putting things Right Regulations within 30 working days | 100% | Monthly | National |
| % of all concerns (formal and informal) acknowledged within 2 working days as required by the 'Putting things Right' Regulations | 100% | Monthly | National |
| Number of new Whole Blood Donors recruited to the donor panel | 2,750 | Quarterly | Local |
| Number of new Apheresis Donors recruited to the donor panel | 14 | Quarterly | Local |
| Number of Deceased Donor Typing / Cross Matching reported within given period | 80% | Quarterly | Local |
| Number of Anti D & -c Quantitation patient results provided to customer hospitals within 5 working days | 90% | Quarterly | Local |

# Monthly Reporting

## Equitable and Timely Access to Services

Mar-22

### BMV Donors



Chart values: 327, 228, 236, 148, 172, 208, 184, 210, 177, 206, 203, 283 (Apr-21 to Mar-22)

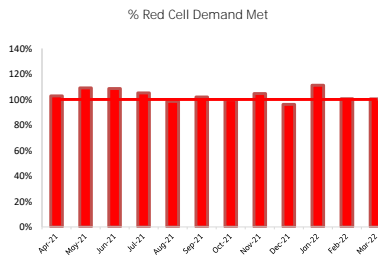| Annual Target: 4000 (ave 333 per month) | | SMT Lead: Jayne Davey / Tracey Rees | |
|---|---|---|---|
| What are the reasons for performance? | | Action (s) being taken to improve performance | By When |
| The number of new bone marrow volunteers added to the Welsh Bone Marrow Donor Registry (WBMDR) reached 283 in March compared to 203 the previous month.<br><br>There were two University sessions in March which were attended by two Subject Matter Experts (SMEs) from the WBMDR to engage with potential donors. This resulted in a higher than average conversion rate for registrations of 17-30 year olds. This coupled with the registration of 21 SWAB donors contributed to the higher number of BMV registrations. | | The Service is taking a two-pronged approach to improve the performance against this measure: 1.) promoting 'SWAB' kits and 2.) supporting the Service to increase the number of younger donors donating blood.<br><br>The proposed action plan will focus on promotion at Universities and Colleges and on social media, as well as improving content and visibility of information on the WBS website. | Reviewed weekly |

## Safe and Reliable Service

Mar-22

### Number of days red cell stock level is below 3 days for groups O, A & B-



Chart values: 0 0 0 0 0 0 0 0 0 0 0 0 (Apr-21 to Mar-22)

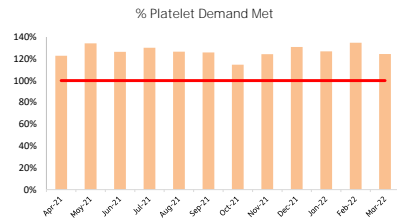| Monthly Target: 0 | | SMT Lead: Jayne Davey / Tracey Rees | |
|---|---|---|---|
| What are the reasons for performance? | | Action(s) being taken to improve performance | By When |
| O, A and B+ blood groups continue to be maintained above 3 days.<br><br>Collections of blood from volunteers are sufficient to maintain stock levels above the 3 day target.<br><br>This is core business and is reviewed on a daily basis at resilience meetings and any concerns are escalated via WBS Senior Management Team (SMT) leads for immediate action. | | The Welsh Blood Service constantly monitors the availability of blood for transfusion through its daily 'Resilience Group' meetings which include representatives from all departments supporting the 'Blood Supply Chain' and include the Collections, Manufacturing, Distribution and Blood Health teams.<br><br>At the meetings business intelligence data is also reviewed and facilitates operational responses to the challenges identified at each daily review. Appropriate operational adjustments are made to maintain adequate stock levels and minimise blood shortages.<br><br>On March 21st the Service issued a Blue Alert for blood group O to NHS Wales and indicated that this will be for a prolonged period.<br><br>In addition regular Demand Planning meetings take place to consider the more strategic aspects of blood supply. | Business as Usual, reviewed daily |

## Safe and Reliable service

Mar-22

### % Red Cell Demand Met



| Monthly Target: 100% | | SMT Lead: Jayne Davey/ Tracey Rees | |
|---|---|---|---|
| What are the reasons for performance? | | Actions(s) being taken to improve performance | By When |
| All hospital demand for red cells was met.<br><br>Collections and Issues were effectively balanced meaning a steady stock position for March, and factors continuing to affect the supply chain include Covid restrictions and staff absence. Stock management is closely monitored and discussed at daily resilience meetings with immediate escalation to SMT if required.<br><br>Demand in March (full weeks) averaged at 1423 units per week, in line with the year average. There was however a considerable weekly variance (1211 - 1632 units per week)<br><br>3 red cells were imported for a specific blood type (phenotype) not available at the Welsh Blood Service was requested and approved by Medical staff. | | The Welsh Blood Service constantly monitors the availability of blood for transfusion through its daily 'Resilience Group' meetings which include representatives from all departments supporting the 'Blood Supply Chain' and include the Collections, Manufacturing, Distribution and Blood Health teams.<br><br>At the meetings business intelligence data is also reviewed and facilitates operational responses to the challenges identified at each daily review. Appropriate operational adjustments are made to maintain adequate stock levels and minimise blood shortages.<br><br>In addition regular Demand Planning meetings take place to consider the more strategic aspects of blood supply. | Business as Usual, reviewed daily |

3

% Platelet Demand Met
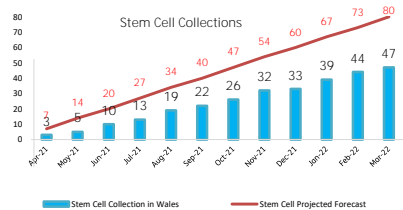
| Monthly Target: 100% | | SMT Lead: Jayne Davey / Tracey Rees | |
|---|---|---|---|
| What are the reasons for performance? | | Actions(s) being taken to improve performance | By When |
| All clinical demand for platelets was met.

Platelets are produced by two different methods: Donor Apheresis and Manufactured Pools from whole blood. In combination, they provide the total number of units available each month.  Due to their short shelf life (7 days), platelet stocks are monitored on a daily basis to ensure adequate response time to any 'spikes' in demand.  Daily communications between the Collections and Laboratory teams enables agile responses to variations of stock levels and service needs.

For March 2022 platelet demand was 197 units per week on average. A value over 100% indicates sufficiency in supply over the month, whilst a value less than 100% would indicate shortage of platelets. | | The Ambient Overnight Hold (AONH) production process allows flexibility in the production plan for platelets. Adjustments on the weekly production continue to be made to align with demand. | Reviewed daily |


Stem Cell Collections

| Annual Target: 80 (ave 7 per month) | | SMT Lead: Tracey Rees | |
|---|---|---|---|
| What are the reasons for performance? | | Action(s) being taken to improve performance | By When |
| The pandemic has impacted on unrelated donor stem cell transplants globally, which has resulted the number of stem cell collection requests.  In addition the Service is experiencing a cancellation rate of around 30% compared to 15% pre COVID pandemic levels.  This is due to patient fitness and the need for collection centres to 'work up' two donors simultaneously due to a reduction of selected donors able to donate at a critical point in patient treatment. | | The move to Velindre Cancer Centre (VCC) has enabled WBS to offer more options for collections, moving to four day availability compared to two previously available at Nuffield.

A five year strategy is being developed which will seek to enhance the Donor Panel and offer potential collaborations with other Donor registry partners. | 30/06/2022 |


Antenatal Turnaround Times

| Monthly Target: 90% | | SMT Lead: Tracey Rees | |
|---|---|---|---|
| What are the reasons for performance? | | Action(s) being taken to improve performance | By When |
| At  96%, the turnaround time for routine Antenatal tests in March remains above the target of 90%

Continued monitoring and active management remains in place. | | Efficient and embedded testing systems are in place.

Continuation of existing processes are maintaining high performance against current target. | Business as Usual, reviewed daily |

4

| Monthly Target: 80% | | SMT Lead: Tracey Rees | |
|---|---|---|---|
| What are the reasons for performance? | | Action(s) being taken to improve performance | By When |



Reference Serology

At 65% turn around times for March were impacted significantly by key staff absences. The number of samples referred in March (272) was the highest number of referrals ever referred to RCI.

Work continues to be prioritised based on clinical need, and all compatibility testing (>54% of referrals) is completed to the required time/date.  Whilst the complexity of referrals continues to impact performance in March the more significant impact has been as a result of unavoidable staff absences.

As previously stated, there were 272 hospital patient referrals in March, with the average number of Hospital Patient referrals at 226/month for 2021,  compared to 181 in 2020.

The Service conducts specialist tests  to confirm hospital results that are difficult to interpret or will undertake additional testing which is not performed in the hospital blood banks. These tests must be performed within 7 days of the sample being taken and are prioritised appropriately to ensure the fastest turnaround possible.

The Service continues to prioritise compatibility referrals and safe provision of red cells for transfusion. All referrals are prioritised based on clinical need and all Compatibility Testing (>52% of referrals) is completed to the required time/date.  These requests are time critical and require provision of blood for transfusion, the tests are prioritised and patient care was not affected. There were 272 hospital patient referrals in March , with the average number of Hospital Patient referrals at 226/month for 2021, compared to 181 in 2020.

Staffing pressures caused by COVID absence have delayed the validation the new automated analyser which will now begin in April. However the testing strategy for patient samples suitable for automated testing has been completed and the findings of the recent Out of Hours Referrals Audit  are being reviewed for implementation.

On 29/03/2022 the Service advised pathology services across Wales on service referral pressures, asking for out of hours cross matching referrals to be triaged.
The service is preparing a paper for May 2022 regarding service pressures and will consider short and long term solutions for maintaining service delivery.
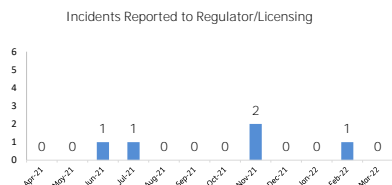
By When: Quarter 1

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| Monthly Target: 90% | | SMT Lead: Peter Richardson | |
|---|---|---|---|
| What are the reasons for performance? | | Action(s) being taken to improve performance | By When |



Quality Incidents closed within 30 days
(rolling 3 months)

At 85% the performance against this metric has not met target (90%) for the three month rolling period to March, with the number of incidents not closed in the required timeframe increasing from eight in the previous reporting period to 24  (8 QPulse and 16 Datix)

All 8 QPulse  incidents  have been risk assessed and investigated. Four QPulse incidents remain open because they are awaiting completion of CAPA (the system does not permit closure of the incident until all CAPA has been completed).  The remaining 4 incidents were closed late, and the reasons for late closure are currently being compiled.

Of the 16 Datix incidents, 8 were closed in March but were late having exceeded the 31 day criteria requirement. Thirteen of these relate to clip failures at the end of the donation process leading to collection of an excess quantity of blood, reported as incidents in Datix and granular data has only just been made available. These incidents do not reflect harm to the Donor, or risk to patients, but the blood collected would be discarded as a manufacturing loss.  Prior to the introduction of Datix Once for Wales these were not recorded in Datix but were tracked through manufacturing losses.

The current number of reports remains within the normal variations and tolerances for blood donation.  Reporting of these incidents will be removed to Q-Pulse to reflect the  need to monitor trends without an investigation of each individual occurrence.

 There remaining 8 incidents open in Datix are either at the initial reporting stage (4) or remain under investigation (4).

All 16 Datix incidents have exceeded the 31 day criteria requirement.

The performance for incidents reported via QPulse is at 94% and 73% for Datix .

The revised process for managing low-impact incidents within QPulse was implemented on 1st June, new reports are reviewed and risk assessed daily and the majority of incidents are fully closed within a few days of reporting.

The QA team send weekly updates alerting owners of incidents recorded within QPulse that are likely to breach close-out deadlines.

Datix User Access for QA Systems Triage team has been granted and allows visibility of progression of incidents through the system and any which are overdue for completion.

Moving forward, close attention will be paid to the progression of these incidents and the QA triage team will run weekly reports to ensure early recognition of those requiring attention.

Details regarding the specific incidents that need to be progressed shall be reported to the relevant managers and SMT Leads.

By When: Continue with close monitoring and early recognition of potential timeline breaches.

**Critical Findings**
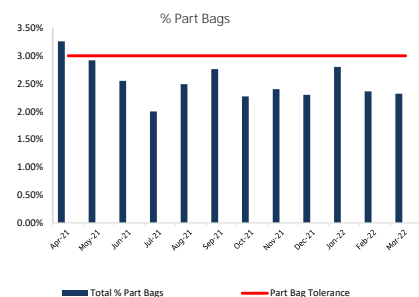


Chart values (Apr-21 to Mar-22): 0 0 0 0 0 0 0 0 0 0 0 0

| What are the reasons for performance? | Action(s) being taken to improve performance | By When |
|---|---|---|
| There was one external audit undertaken in March. UKAS assessment of compliance of WASPS (Welsh Serological Proficiency Scheme) against ISO 17043.<br><br>There were 7 mandatory findings and 2 recommendations. | The UKAS findings are being managed via an action plan and the formal response and submission of evidence (being actioned by Section leader, WASPS) is required by 17/04/2022.<br><br>Actions from previous MHRA inspections are being managed as business as usual via action plans. One action remains open and is within the revised completion date (revised date has been accepted by MHRA) | SABRE 98 completed 11/03/2022 |

**Safe and Reliable service — Mar-22**

**Incidents Reported to Regulator/Licensing**



Chart values (Apr-21 to Mar-22): 0 0 1 1 0 0 0 2 0 0 1 0

| Annual Target: 0 | SMT Lead: Peter Richardson | |
|---|---|---|
| What are the reasons for performance? | Action(s) being taken to improve performance | By When |
| There were no Serious Adverse Events (SAE) reported to regulators during March. | The confirmation report for SABRE 98 (raised and reported February 2022) was submitted to MHRA via the SABRE portal, within the required timescale, and a SHOT near-miss questionnaire was also completed. There are no further actions arising from this.<br><br>Long-term preventive action for SABRE 98 is being managed and monitored via QPulse. | SABRE 98 completed 11/03/2022 |

**Spending Every Pound Well — Mar-22**

**% Part Bags**



| Monthly Target: Maximum 3% | SMT Lead: Janet Birchall | |
|---|---|---|
| What are the reasons for performance? | Action(s) being taken to improve performance | By When |
| The combined 'Part Bag' rate remains within the required tolerance level at 2.32% in March 2022.<br><br>The overall trend on all teams is stable with all teams being under tolerance except the Stock building team (3.4%) -but this associated with low numbers (2 events). East B and East C teams are both close to tolerance at 2.9%.<br><br>Causes of Part Bag are various and include: needle placement, donor is unwell, donor request to stop donation, and equipment failure. This is a separate factor to FVPs. | Analysis of venepuncturist performance on East B and C teams will be undertaken to ensure no repeat venepuncturist issues.<br><br>Operation Managers & the Training Team will be provided with the outcome of the analysis and should it be required further interventions (I.e. Individual Support Plans and or Additional Training /Supervision) can be actioned. | Continued close monitoring and intervention where required |

Legend: Total % Part Bags — Part Bag Tolerance

## % Unsuccessful Venepuncture



| Monthly Target: Maximum 2% | SMT Lead: Janet Birchall | |
|---|---|---|
| What are the reasons for performance? | Action(s) being taken to improve performance | By When |
| The combined Failed Venepuncture (FVP) rate for all whole blood teams for March 2022 remains within the required tolerance at 1.45%.<br><br>The only team to be over tolerance for this factor in March 2022 is Bangor team - but this is associated with low numbers. (2.4% - 9 FVP events).<br><br>East A Team is at the threshold of tolerance (2.0% - 27 events). | A review of the Bangor and East A team venepuncturist performance will be undertaken to determine if there are any trends linked to individual venepuncturists.<br><br>Operation Managers & the Training Team will be provided with the outcome of the analysis and should it be required further interventions (I.e. Individual Support Plans and or Additional Training /Supervision) can be actioned. | Continue with close monitoring and intervention where required |

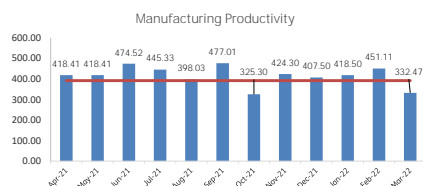## Whole Blood Collection Productivity



| Monthly Target: 1.25 | SMT Lead: Jayne Davey | |
|---|---|---|
| What are the reasons for performance? | Action(s) being taken to improve performance | By When |
| At 0.99, collection productivity for March has improved marginally.<br><br>For the majority of March, donor sessions operated at 2m distancing with Covid and Infection Prevention Control (IPC) measures continuing to limit donation centre capacity. Clinics continue to operate on an appointment only basis, which disables the ability to backfill on the day 'non attendance' with walk in Donors.<br><br>There are regional variations in productivity across collection teams, ranging from 0.68 in Bangor to 1.07 for one of the three East teams which warrant further investigation | A review of donation clinic social distancing (SD) has taken place that has resulted in a reduction of SD from 2metres to 1 metre from April 2022. This will enable an increase in appointment capacity, however this can only be realised if appropriately safe resourcing can be maintained to match increases in donor attendance.<br><br>The Service is reviewing clinic practice, layout, processes and 'capacity to viable donation' data, to understand the regional productivity variation. | Quarter 1 2022 |

## Manufacturing Productivity



| Monthly Target 392 | SMT Lead: Tracey Rees | |
|---|---|---|
| What are the reasons for performance? | Actions(s) bring taken to improve performance | By When |
| The lower Manufacturing Efficiency performance for March is attributed to staff returning from sickness and completing training.<br><br>Manufacturing Efficiency is calculated by dividing working time available by the amount of work completed. The work completed relates to clinical components and does not include other work (such as commercial plasma sales) performed by the department.. | This target measures the manufacturing productivity by assessing the staffing levels against the number of blood components being manufactured.<br><br>This target is based on the Pre COVID operating model and is due to be reviewed as part of the review of this reporting framework. | Quarter 1 2022 |

Mar-22

### Time Expired Platelets
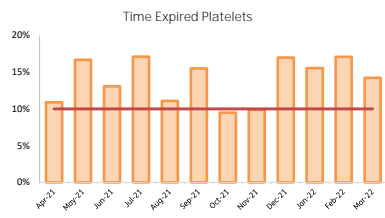
| Monthly Target: Maximum 10% | | SMT Lead: Tracey Rees | |
|---|---|---|---|
| What are the reasons for performance? | | Action(s) being taken to improve performance | By When |
| Platelet expiry was above target for March and a review of expiry against and demand production was undertaken.  Average platelet issue for March was at 197 units per week and production at 215 units per week. On two occasions in March platelet production increased due to expected demand, leading to an excess of approx. 20 units per week.

Planned platelet production does not include apheresis platelets donated for neonatal use. There were 91 units bled for neonatal use of which 5-6 would be used per week leading to an excess of approximately 60 units.  Units not needed for neonatal use would enter general platelet supply. | | Platelets are being produced by two different methods: Donor Apheresis and Manufactured Pools from whole blood. In combination, the methods provide the total number of units available each month.

The introduction of Ambient Overnight Hold process for the manufacturing of blood components has increased flexibility in production of pooled platelets.

Daily communications between the Collections and Laboratory teams enables agile responses to variations of stock levels and service needs.

Adjustments to the platelet manufacturing targets are made in the laboratory to better align with demand, and take into account the apheresis appointments and donor attendance.  Although it should be noted that demand can fluctuate significantly on a daily basis.

Given the variability of expired platelets over the past 12 months the Service is carrying out a review to look at improving wastage rates.

NB: All demand continues to be met without the requirement to import routine stock. | Ongoing and reviewed daily |

Mar-22

### Controllable Manufacturing Losses
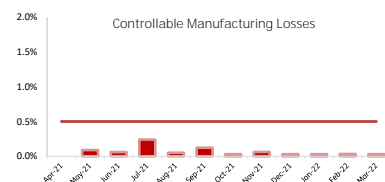
| Monthly Target: Maximum 0.5% | | SMT Lead: Tracey Rees | |
|---|---|---|---|
| What are the reasons for performance? | | Action(s) being taken to improve performance | By When |
| Controllable losses for March were extremely low at 0.03% and remain within tolerance to be below 0.5%.
The losses were (units):
M&D Operator - Operator : 1 unit
M&D Operator - Packing : 1 unit

These levels are well within tolerance and represent good performance. The monthly controllable losses should be considered against total production of approx. 1500 units per week. | | Active management of the controllable losses in place, including vigilance and reporting of all units lost.

Ongoing monitoring of losses when occurring in order to understand the reasons and consider appropriate preventative measures thus continuously improving practice through lessons learned and analysis. | Business as Usual, reviewed monthly |

Mar-22

### Time Expired Red Cell

| Monthly Target: Maximum 1% | | SMT Lead: Tracey Rees | |
|---|---|---|---|
| What are the reasons for performance? | | Action(s) being taken to improve performance | By When |
| Red cell expiry for March remains negligible  at 0.08% and significantly lower than the 1% target.

The Covid 19 challenges continue to affect the blood collection numbers resulting in faster stock turnover preventing red cells stocks from ageing in storage.

This metric is well within the target and there are no concerns around expiry of red cells. | | Daily monitoring of age of stock as part of the resilience meetings.

Red Cell Shelf life is 35 days, with all blood stocks stored in Blood Group and Expiry Date order and issued accordingly.

Continued effective management of blood stocks to minimise the number of wasted units. | Business as usual, reviewed daily |

## Donor Satisfactions



- Scored 5_6 out of 6  SW
- Scored 5_6 out of 6 NW
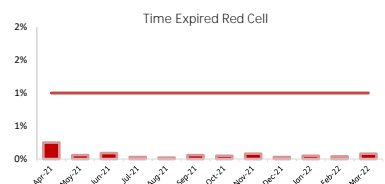- Donor Satisfaction Target

| Monthly Target: Minimum 71% | SMT Lead: Jayne Davey | |
|---|---|---|
| What are the reasons for performance? | Action(s) being taken to improve performance | By When |
| In March overall donor satisfaction continued to exceed target at 95.7%. In total there were 1,199 respondents, who had made a full donation and shared their donation experience (some of which are non attributable), 201 were from North Wales and 974 were from South Wales (where location was able to be defined). | Findings are reported to Management at Collections meeting to address any actions for individual teams. | Business as usual, reviewed monthly |

## Number of Concerns Received



- Formal
- Informal

| Target: N/A | SMT Lead: Alan Prosser | |
|---|---|---|
| What are the reasons for performance? | Action(s) being taken to improve performance | By When |
| In March 2022, 7,415 donors were registered at donation clinics. 8 concerns (0.11%) were reported within this period, all eight concerns were managed within timeline as 'Early Resolution'<br><br>1. 3 x donors raised concerns around staff attitude and behaviour:<br>-Donor late for appointment<br>-Donor unhappy felt venepuncturist was dismissive<br>-Donor felt like he was being told off by staff member<br><br>2. 3 x donors raised concerns around the appointment system<br>-2 x Donors unhappy session had been cancelled<br>-1 x Donor unhappy last appointment had been taken whilst donor was on phone with call handler wanting to book appointment<br><br>3. A Donor raised concern around the amount of plastic/PPE being used on session<br><br>4. A Donor raised concern around being to help her son complete the Self Administered Health History (SAHH) questionnaire and social distancing measures whilst on clinic | Actions taken to address concerns:<br><br>1. Operation Managers have discussed each concern raised with Clinical Lead Registered Nurses (RN) and Supervisors to monitor and support staff members, with an action plan prepared to support staff if necessary.<br><br>2. Apologies and a full explanation have been provided to each donor regarding their concerns with the appointment booking system<br>-2 x donors were unable to be informed of session cancellation prior attendance despite attempts to reach them.<br>- The donor was offered alternative venue/date to donate<br><br>3. A full explanation was provided to the Donor upon Government guidelines for use and disposal of PPE in Health Care settings. The donor was also informed of the WBS work to reduce use of plastic, and of a trial at collections events on the use of biodegradable plastics and waste bags. The trial is due to end in April 2022.<br><br>4. The Clinic Lead Registered Nurse RN provided a full explanation of current guidelines for assisting donors to complete the SAHH questionnaire and explained required social distancing measures whilst attending collections sessions | Business as usual, reviewed daily |

## % Responses to Concerns closed within 30 Working Days



### First Class Donor Experience

| Monthly Target: 100% | | SMT Lead: Alan Prosser | |
|---|---|---|---|
| What are the reasons for performance? | | Action(s) being taken to improve performance | By When |
| During March 2022 there were no formal concerns to report.<br><br>* Under PTR, Organisations have 30 working days to address/ close formal concerns. This can result in concerns being received and subsequently closed within separate reporting periods. | | Continue to monitor Formal complaint response progress, and 30 day target compliance. | Business as Usual, reviewed daily |

### First Class Donor Experience

## % Concerns Acknowledged within 2 Working Days

| Monthly Target: 100% | | SMT Lead: Alan Prosser | |
|---|---|---|---|
| What are the reasons for performance? | | Action(s) being taken to improve performance | By When |
| Initial responses to all eight concerns in March 2022 were managed within timeline. | | Continue to monitor this measure against the 'two working day' target compliance. Monitoring communications e-mail receiving concerns inbox made aware of the importance for such concerns being directly entered into Datix or passed through the usual concerns route to avoid delays in reporting and possible breach of timeline. | ongoing, reviewed daily |

# Quarterly Reporting

## New Whole Blood Donors



New Whole Blood Donors chart with quarterly rolling totals:
- Qtr 1 Jun-21: 1621
- Qtr 2 Sep-21: 2881
- Qtr 3 Dec-21: 4386
- Qtr 4 Mar-22: 5631

Legend: New Whole Blood Donors (Rolling Total); New Whole Blood Donor Annual Target

Mar-22

| Quarterly Target: 2750,  Annual 11000 | SMT Lead: Jayne Davey | |
|---|---|---|
| What are the reasons for performance? | Action(s) being taken to improve performance | By When |
| 692 new donors completed a donation in March, 10.0% of the total donations received in the month. Attending more University venue has resulted in the increase in new donors.<br><br>During Covid-19, appointment slots have been reduced to match hospital demand. The reduction has resulted in fewer available opportunities for new donors to donate. The current demand for blood is being sustained despite the decrease in new donors. Appointment slots have reduced, resulting less available opportunities for new donors to donate.<br><br>As new donors' blood type is unknown, reserving slots for new donors is not prudent as this will increase the number of unknown blood types bookings and decrease the efficiency of blood collection. | The ability to recruit new donors has also been complicated by the reduction of post-5pm donation slots, by the inability to use donation vehicles and the pause on the majority of venues with high numbers of new donors (e.g. Universities). The feasibility of reintroducing universities and school venues is continually reviewed.<br><br>School venues (used prior to Covid 19) are now being contacted to reintroduce the sessions once schools return in Sept 2022.<br><br>The next monthly review is due w/c 14 April 2022. | w/c 14 April 2022. |

## New Apheresis Donors



New Apheresis Donors chart:
- Qtr 1 Jun-21: 20 (rolling), 69 (initial assessments), 14 (projected target)
- Qtr 2 Sep-21: 35, 84, 28
- Qtr 3 Dec-21: 61, 78, 32
- Qtr 4 Mar-22: 77, 75, 56

Legend: New Apheresis Donors (Rolling Total); Apheresis Initial Assessments; Annual Apheresis Projected Target
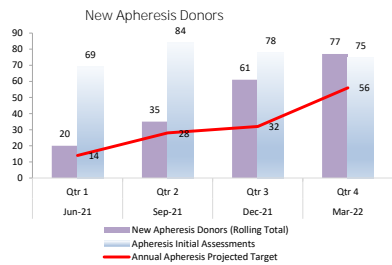
Mar-22

| Quarterly Target: 14 | SMT Lead: Jayne Davey | |
|---|---|---|
| What are the reasons for performance? | Action(s) being taken to improve performance | By When |
| There were 8 new apheresis donors in March 2022, reaching 16 donors for the quarter and exceeding quarterly target of 14, and annual target of 56 | Continue to recruit new apheresis donors. | N/A |

## Turnaround Times (Deceased Donor Typing/Crossmatching)



Chart:
- Qtr 1 Jun-21: 88%
- Qtr 2 Sep-21: 72%
- Qtr 3 Dec-21: 87%
- Qtr 4 Mar-22: 89%
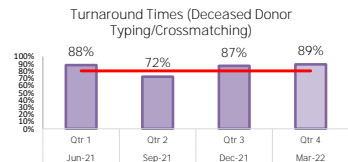
Mar-22

| Quarterly Target: 80% | SMT Lead: Tracey Rees | |
|---|---|---|
| What are the reasons for performance? | Action(s) being taken to improve performance | By When |
| Performance is above the target of 80% | Continue to monitor performance | 30/06/2022 |

## Anti D & -c Quantitation



Chart:
- Qtr 1 Jun-21: 98%
- Qtr 2 Sep-21: 97%
- Qtr 3 Dec-21: 98%
- Qtr 4 Mar-22: 99%

Legend: Anti D & -c Quantitation Turnaround; Target

Mar-22

| Quarterly Target: 90% | SMT Lead: Tracey Rees | |
|---|---|---|
| What are the reasons for performance? | Action(s) being taken to improve performance | By When |
| data for March not yet available | Whilst continued monitoring and active management remains in place, application of the recently introduced  British Society of Haematology guidelines has doubled the workload in the last two months.  The service is preparing a paper for May 2022 regarding service pressures and will consider short and long term solutions for maintaining service delivery. | Quarter 1 |

| QUALITY, SAFETY & PERFORMANCE COMMITTEE |
|:---:|

| TRUST RISK REGISTER |
|:---:|

| DATE OF MEETING | 12.5.22 |
|---|---|

| PUBLIC OR PRIVATE REPORT | Public |
|---|---|

| IF PRIVATE PLEASE INDICATE REASON | |
|---|---|

| PREPARED BY | Mel Findlay, Business Support Officer |
|---|---|
| PRESENTED BY | Lauren Fear, Director of Corporate Governance & Chief of Staff |
| EXECUTIVE SPONSOR APPROVED | Lauren Fear, Director of Corporate Governance & Chief of Staff |

| REPORT PURPOSE | FOR NOTING |
|---|---|

| Committee/Group who have received or considered this paper PRIOR TO THIS MEETING | | |
|---|---|---|
| Committee or Group | DATE | OUTCOME |
| Executive Management Board | 27.3.22 | Noted |

| ACRONYMS | |
|---|---|
| VCC | Velindre Cancer Centre |
| WBS | Welsh Blood Service |
| TCS | Transforming Cancer Services |
| SLT/SMT | Divisional Senior Leadership Teams / Senior Management Teams |
| EMB | Executive Management Board |

## 1. SITUATION AND BACKGROUND

The purpose of this report is to:

- Share the March extract of risk registers to allow the Quality, Safety & Performance Committee to have effective oversight and assurance of the way in which risks are currently being managed across the Trust.
- Summarise the feedback, and progress against that to date, on the process from the previous cycle of Committees and Trust Board.
- Summarise the final phase in implementing the Risk Framework.
- Outline approach to risk appetite review for Summer 2022.

## 2 ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

### Key Points for the Committee:

1. There has been extensive review of the Velindre Cancer Services risks which is reflected in the changes to risk profile at level 20 and 16 in this report.

2. During this next cycle, Executive Management Board will consider whether the overall risk profile reflects assessment for the Trust as a whole and changes made as a result of this assessment as appropriate. Although this is a question considered on each review of the risk profile by the Executive Management Team, it is clearer in this upcoming reporting cycle due to the progress in point 1 above. It also reflects a challenge made by the Trust Board in the March 31st meeting.

3. The remaining elements of the risk framework are on track to complete by end June 2022 and are described in section 3 of this report.

## 2.1 THE TRUST RISK REGISTER

### 2.1.1  Total Risks

There are a total of 165 risks recorded in Datix Trust Risk Registers, 40 in version 12 and 125 in version 14. This compares to 170 risks is the same amount of total risks recorded in the March 2022 reporting cycle, i.e. five have closed – and the rationale are highlighted for the highest scoring risks in this report. The graph below provides a breakdown of the

total number of risks by Division.

## 2.1.2 Risks by level

The graph below provides a breakdown of risks by level across the Trust. A further breakdown of risks by level and Division is also included.

**ALL RISKS**

| | VCC | WBS | TCS | CORP | TOTAL |
|---|---|---|---|---|---|
| | 91 | 40 | 23 | 11 | 165 |

**RISK BY LEVEL V12 & V14**

| | LEVEL 20 | LEVEL 16 | LEVEL15 | LEVEL12 | IMPACT OF 5 |
|---|---|---|---|---|---|
| RISK BY LEVEL V12 & V14 V14 | 9 | 19 | 13 | 55 | 30 |
| RISK BY LEVEL V12 & V14 V12 | 0 | 0 | 0 | 6 | 34 |

RISK BY LEVEL V12 & V14 V12    RISK BY LEVEL V12 & V14 V14

**RISK BY DIVISION AND LEVEL**

| | LEVEL 20 | LEVEL 16 | LEVEL 15 | LEVEL12 | IMPACT OF 5 |
|---|---|---|---|---|---|
| CORP | 0 | 1 | 0 | 10 | 0 |
| TCS | 3 | 2 | 3 | 14 | 1 |
| WBS | 0 | 0 | 0 | 6 | 34 |
| VCC | 6 | 16 | 10 | 30 | 29 |

VCC · WBS · TCS · CORP
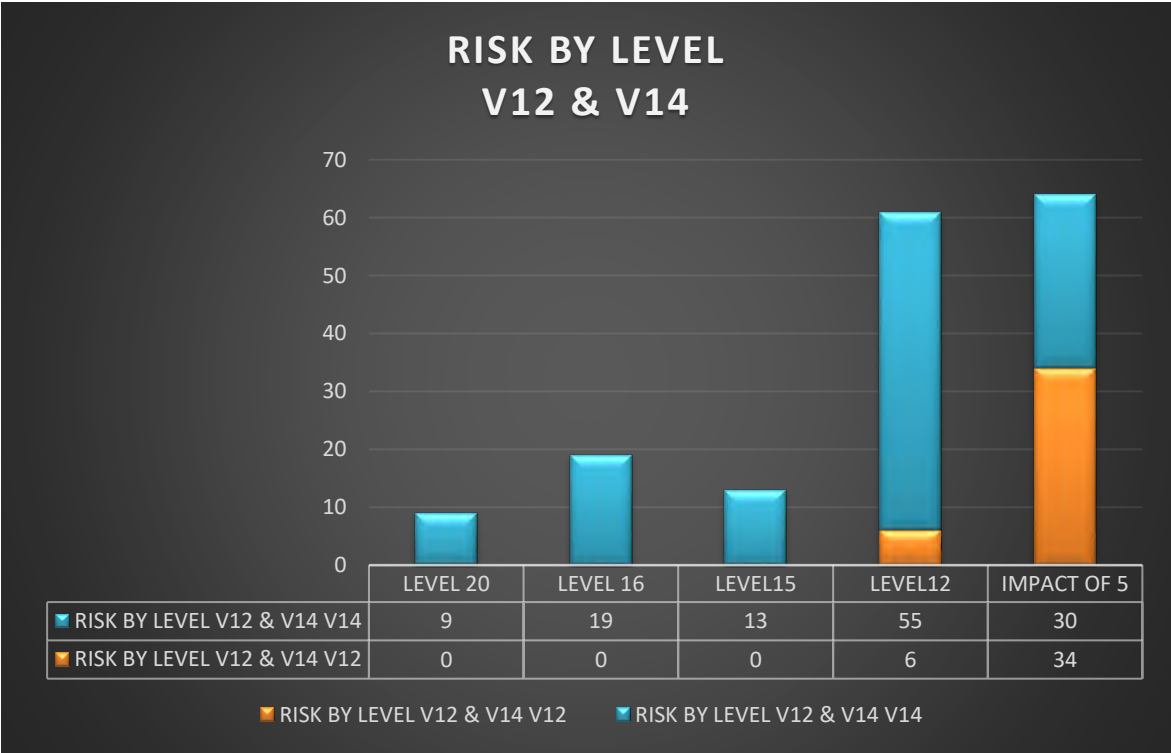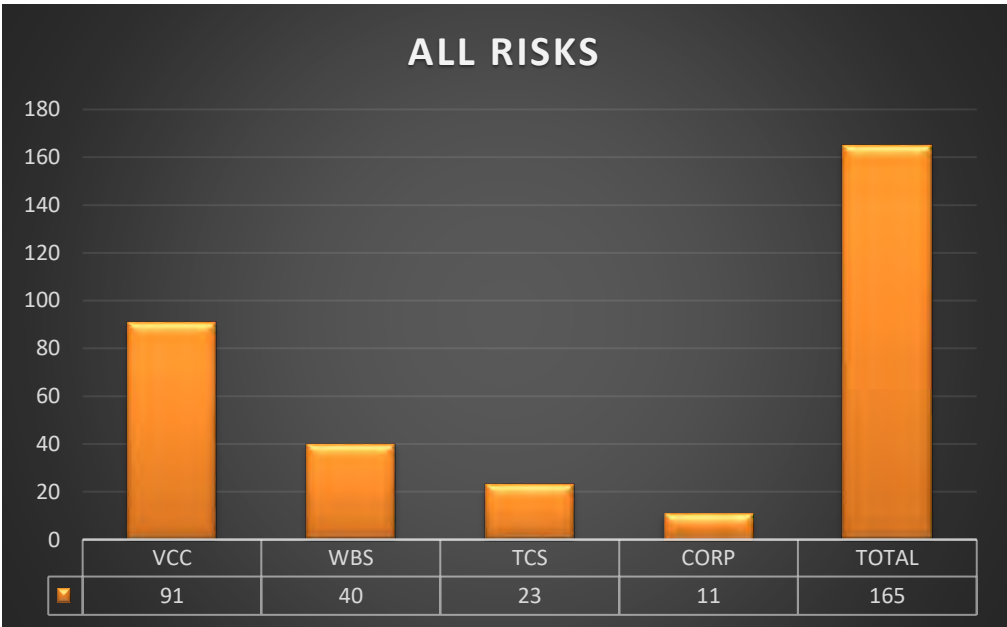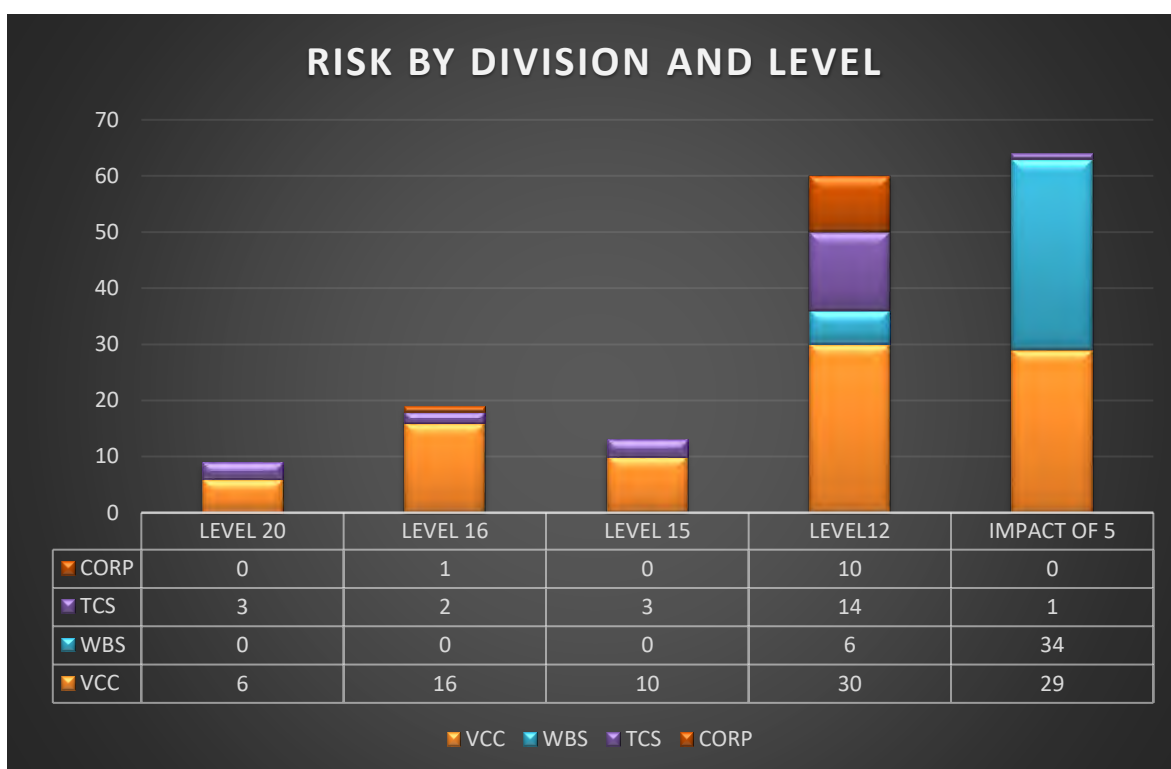
### 2.1.3 Analysis of risks

An analysis of risks by level is provided below. Tables provide detail of each risk including risk type, risk ID, review date and title of the risk.

**Risks level 25**

There remain no level 25 risks up to 30th April 2022.

**Risks level 20**

The table below provides a breakdown of risks level 20. Following the Executive Management Board challenge, which was supported and further challenged by Independent Members in March and April's Quality, Safety and Performance, Audit Committee and Trust Board, Risk Owners across the Trust have further reviewed the highest rated risks. Due required Divisional Governance processes this work remains underway:

This review identified that although VCC SLT had reviewed their risks the Datix system had not been updated. Following review, the following changes have been made:

- Risk 2191 - *Inability to meet COSC / SCP targets* – Has been closed as only shadow

reporting taking place until adopted by Welsh Government as a Tier 1 target.

- Risk 2200 - *There is a risk that patient treatment is delayed due to lack of staffing because of COVID 19 related absence* - has been reduced to a 16, given that sickness levels related to COVID 19 have reduced resulting in increase in capacity to support additional activity.

- Risk 2513 - *There is a risk that patient treatment is delayed as a result of a lack of medical work forward holding a prostate brachytherapy practitioners licence* - has been reduced to a 16 given the actions taken to reduce the risk.

The Digital Health & Care Record Project Team reports into the VCC SLT. The Project Team have asked for further support in reassessing the project risk profile, previously reported as three risks at level 20 and seven at level 16. The matter will be discussed at Project Board on 9th May and the appropriate changes will then be made to the profile. Given the agreement of Executive Management Board that although the overall Project should be reflected as one of the highest risks for the organisation, the current profile has not been included in this report as to not distort the overall picture until an agreed articulation is confirmed.

The VCC SLT will be reviewing their overall profile, following these updates in the next meeting and will specifically discuss the challenge from the Trust Board meeting as to whether the profile reflects accurately the current Velindre Cancer Services risk profile.

The risk at level 20 is detailed in the table below and will be reviewed in the Transforming Cancer Services Sub-Committee. It has been subject to extensive challenge from Independent Members over many months. Further updates discussed in meeting on 4th May and progress on agreed actions for both Risk 2400 and Risk 360 are to be subject to scrutiny in the May and June Committees.

| ID | Risk Type | Division | Review date | Title | Rating (current) | Rating (Target) | RR - Current Controls |
|---|---|---|---|---|---|---|---|
| 2400 | Workforce and OD | Transforming Cancer Services | 30/04/2022 | There is a risk that the lack of appropriate project support for Project 5, Outreach, from the programme will lead to delays in developing the solutions required for the project success. | 20 | 6 | Executive agreement on priority of agreeing final plan and implementation – Complete.<br><br>Project Management recruitment underway.<br><br>Cross-reference to Risk 360, rated 16 – *"There is a risk that Projects remain 'On Hold' and / or incur delays impacting on the key interdependencies with other projects resulting in Programme Master Plan objectives and outcomes being delayed / not being met."* |

**Risks level 16**

The work undertaken to further review risks have also resulted in a change in the number of level 16 risks. As of 30th April there are xx risks scoring a 16 compared with xx on the 31st March 2022. These changes are:

- Risk 2190 - *There is a risk that patient will continue to breach in radiotherapy as a result being unable to address challenging components of the pathway due to limited capacity available within Business Intelligence teams to source the appropriate data sets* – has reduced to 8. The current complexities of the radiotherapy pathways make it difficult for BI to identify the necessary data to reflect the different components. The Business Intelligence team have limited capacity available to undertake the work required to identify the appropriate data set. However, it was judged that there is not a risk of this having a significant impact on radiotherapy performance. The target score has also been reduced to a 4 to reflect SLT's continued management of this risk to green levels.

- Risk 2345 – Radiotherapy Department - *Change to service due to continued response to COVID 19* – has been closed as was describing the current issues in performance, as set out in the performance report, rather than a specific risk to be managed.

- Risk 2502 - *There is a risk that SACT and radiotherapy services may be negatively affected as a result of staff COVID 19 related absences resulting in delay to patient treatment and an increase in waiting times* – has reduced from a 16 to a 12 due to the contingency plans in place to support challenging service areas including redeployment of staff from other service areas, staff working 'down' to cover lower graded posts and the increased utilisation of virtual appointments and changes to patient pathways and exploring external capacity. Although there remains a risk on performance, there has been a reduction in *COVID 19* related sickness which is helping to address some capacity issues. However other factors such as an increase in referrals following release of *COVID 19* restrictions has also had an impact on the waiting times

    o To note that VCC SLT in next meeting will be assessing the risk to delivery risk of SACT and Radiotherapy in general, albeit not as a result of COVID-19 staff absences.

- Risk 2514 - *There is a risk that Standard Operating Procedures (SOPs) within Brachytherapy are not up to date* – reduced to a 8 due to the progress made by new Head of Brachytherapy Physics, now in post. Deputy is to be appointed. Good progress in working through updating of SOPs.

| ID | Risk Type | Division | Review date | Title | Rating (current) | Rating (Target) | RR - Current Controls |
|---|---|---|---|---|---|---|---|
| 2513 | Performance and Service Sustainability | Velindre Cancer Centre | 31/05/2022 | There is a risk that patient treatment is delayed as a result of a lack of medical workforce holding a prostate brachytherapy practitioners licence | 16 | 10 | There is currently a national shortage of clinicians within holding this licence.

Clinical service is dependent on a single handed consultant. A second consultation is undergoing training to obtain his licence. In order to achieve his license there is a requirement to see a number of patients which is taking time due to limited number of patients requiring this treatment. Expected date being confirmed and will be confirmed in next report. |
| 2200 | Performance and Service Sustainability | Velindre Cancer Centre | 31/05/2022 | There is a risk that patient treatment is delayed due to lack of staffing because of COVID 19 related absence | 16 | 6 | Demand and capacity is continuing to be monitored.

Sickness levels related to COVID 19 have reduced resulting in increase in capacity to support additional activity.

Cross-reference to VCC performance report. |
| 2454 | Workforce and OD | Corporate Services | 01/05/2022 | Digital Services Capacity / Skill Mix | 16 | 8 | Regular review of IT work plan, to ensure delivery is aligned to Trust / Divisional priorities.

VCC and WBS IT work plans regularly reviewed, to be shared via relevant channels (BPG, SMT/SLT etc.).

'Agile' utilisation of Digital Services resource, to ensure focus on prioritised work.

Specific actions to reach Target Risk Rating and articulation of the Risk will be considered by WOD Senior Team and confirmed in next report. |
| 2193 | Performance and Service Sustainability | Velindre Cancer Centre | 31/05/2022 | There is a risk that lack of Medical Physics Expert cover impacts on the Molecular Radiotherapy (Nuclear Medicine) services. | 16 | 4 | Currently scoping is taking place of the work required to develop a new service model to ensure appropriate level of Medical Physics Expert cover for nuclear medicine. An initial meeting has been set for May to discuss an outline model.

Following this, specific actions to reach Target Risk Rating will be considered by VCC Senior Leadership Team and confirmed in next report. |
| 2428 | Compliance | Velindre Cancer Centre | 31/05/2022 | There is a risk of increased infection transmission within the cancer centre due to poor ventilation resulting in increased sickness and absence of staff and patients | 16 | 8 | Business case scheduled to VCC SLT in May for approval and consideration of funding from capital allocation. |

| 2198 | Financial Sustainability | Velindre Cancer Centre | 13/12/2021 | VCC may face financial loss, legal action, inadequate service provision as a result of no coordinated system for SLAs, contracts | 16 | 6 | Risk review overdue – therefore specific action to be taken with Finance and VCC teams in order to assess and appropriately rearticulate, score and assign actions as appropriate. |
|---|---|---|---|---|---|---|---|
| 2528 | Performance and Service Sustainability | Transforming Cancer Services | 29/04/2022 | There is a risk that Programme Master Plan objectives / outcomes are delayed and/or not met | 16 | 6 | Stocktake of all Projects and Programme to be undertaken - Work is underway to be completed by end of April '22.<br><br>Refreshed Project Self-Evaluation toolkit - Work to be completed by end of May '22.<br><br>Refresh of Master Programme Plan - Review Programme and Project resources / gaps and make appropriate investments where required.<br><br>Introduce new ways of working - VF & Strategic Infrastructure Board - to be completed by end of June '22. |
| 2501 | Financial Sustainability | Transforming Cancer Services | 04/04/2022 | Risk of Inflation leading to increased costs | 16 | 12 | Paper on affordability submitted to Welsh Government. Ongoing |
| 2517 | Financial Sustainability | Transforming Cancer Services | 04/04/2022 | There is a risk that the competitive dialogue participants tenders exceed the CAPEX limit leading to increase project costs. | 16 | 12 | Paper on affordability submitted to Welsh Government. Ongoing |

## 3  Development of Risk Framework

- Three key steps remain for the development of risk framework by end June:
  - o Re-write of Risk Policy and Corporate Management Level Procedure to reflect the changes in the Framework which has been developed and delivered during this work over the past 18 months.
  - o Three levels of training to be delivered:
    - All Staff – covering: why is risk management important, what is my role, first form of Datix 14, which is the simple input form which all staff in organisation have access to in order to raise a risk.
    - Management level – covering the Policy and Corporate Management Level Procedure and second form of Datix 14, which requires scoring, articulation of controls, setting actions and assigning ownership. It is following this step that a risk is confirmed onto the risk register. The Manager level then has the on-going responsibility for the overall management of that risk.
    - Leadership level – covering the Policy and oversight roles - Divisional Leadership Teams, Executive Management Board and Trust Board. This is scheduled for June, with the Board session scheduled for the Board Development session.
  - o Transition of WBS Risks onto Datix 14.

- Oversight of the development of the risk framework is via the Audit Committee. This includes specific action tracking following Internal Audit's report on the Risk Framework at the end of 2021.

- Initial view on approach to risk appetite review to be discussed in Executive Management Board Shape May meeting:
  - o Consideration as to whether may want recommend to change the risk category thresholds for reporting so more calibrated at 16/15 rather than 12 for reporting residual level of risk to Board level.
  - o Executive leads for risk categories will then discuss with Independent Member leads prior to taking to Board for sign off and approval.

- Following completion of the review of risks previously reported in the private part of the meeting, there are no risks at 16 or above which are now assessed as requiring further reporting due to the changing in commercial risk on these matters. For completeness, there are three risks below 16, all relating to the Integrated Radiotherapy Solution procurement, which have been confirmed as requiring continued reporting in private at present in the TCS Programme Scrutiny Sub-Committee due to the current stage of the competitive dialogue process.

## 4   IMPACT ASSESSMENT

| QUALITY AND SAFETY IMPLICATIONS/IMPACT | Yes (Please see detail below) |
| | Is considered to have an impact on quality, safety and patient experience |
| RELATED HEALTHCARE STANDARD | Safe Care |
| | If more than one Healthcare Standard applies please list below. |
| EQUALITY IMPACT ASSESSMENT COMPLETED | Not required |
| | Completed for individual risks as appropriate |
| LEGAL IMPLICATIONS / IMPACT | Yes (Include further detail below) |
| | Risks open for extended periods of time without indication that work is being undertaken could expose the Trust that may have legal implications. |
| FINANCIAL IMPLICATIONS / IMPACT | Yes (Include further detail below) |
| | If risks aren't managed / mitigated it could have financial implications. |

## 5   RECOMMENDATION

The Quality, Safety & Performance Committee is asked to:

- **NOTE** the risks level 20 and 16 reported in the Trust Risk Register and highlighted in this paper.
- **NOTE** the on-going developments of the Trust's risk framework.

11

**QUALITY, SAFETY AND PERFORMANCE COMMITTEE**

**2021 / 2022 QUARTER 4 INFORMATION GOVERNANCE ASSURANCE REPORT**

| DATE OF MEETING | 12th May 2022 |
|---|---|

| PUBLIC OR PRIVATE REPORT | Public |
|---|---|

| IF PRIVATE PLEASE INDICATE REASON | Not Applicable – Public Report |
|---|---|

| PREPARED BY | Ian Bevan, Head of Information Governance Matthew Bunce, Executive Director of Finance |
|---|---|
| PRESENTED BY | Matthew Bunce, Executive Director of Finance |
| EXECUTIVE SPONSOR APPROVED | Matthew Bunce, Executive Director of Finance |

| REPORT PURPOSE | FOR ASSURANCE |
|---|---|

| COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING | | |
|---|---|---|
| **COMMITTEE OR GROUP** | **DATE** | **OUTCOME** |
| EMB RUN | 27th April 2022 | Amended report in line with recommendations from EMB RUN endorsed for submission to QSP |

| ACRONYMS | | | |
|---|---|---|---|
| IG | Information Governance | NWSSP | NHS Wales Share Service Partnership |
| VCC | Velindre Cancer Centre | ICO | Information Commissioners Office |
| WBS | Welsh Blood Service | NIIAS | National Intelligent Integrated Audit Solution |
| DHCW | Digital Health and Care Wales | M&S | Mandatory and Statutory |

| HoIG | Head of Information Governance | DPIAs | Data Protection Impact Assessments |
|------|-------------------------------|-------|-----------------------------------|
| FOIA | Freedom of Information Act (2000) | EIR | Environmental Information Regulation (2004) |
| GDPR | General Data Protection Regulation | AOS | Acute Oncology Service |
| VUNHST | Velindre University NHS Trust | DPA | Data Protection Act (2018) |
| IM | Independent Member | SIRO | Senior Information Responsible Officer |

## 1. SITUATION

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

The report outlines key **ASSURANCE** activities, (1) IG Toolkit self-assessment, (2) DPIA's and contracts register, (3) DPA requests, data security incidents & investigations for the reporting period of 1st January 2022 to 31st March 2022.

The Quality, Safety and Performance Committee is asked to **NOTE and DISCUSS** the report for **ASSURANCE**.

## 2. BACKGROUND

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

VUNHST is committed to ensuring the provision of an effective IG Assurance Framework. This ensures that the Trust meets its statutory obligations and other standards. Meeting the obligations and standards means that incidents are appropriately investigated, and that learning takes place in order that the Trust can improve the quality and safety of its services, and the patient and donor experience.

## 3. ASSESSMENT/SUMMARY OF MATTERS FOR CONSIDERATION

The following are the key highlights as detailed within the quarter 4 report for the period 1st January to the 31st March 2022:

- The three IG Assurance Framework areas being focused on are: (1) IG Toolkit self-assessment, (2) DPIAs, contract register and associated Data Processing/Sharing Agreements. (3) DPA requests, data security incidents & investigations. Work in these areas will lead to improvements in IG systems & processes.
- Quarterly IG assurance meetings have been established between Mr Stephen Harries (IM champion for IG), Matthew Bunce (SIRO) and newly appointed Director of Digital to provide additional assurance to the committee. The first meeting arranged for May 2022.

**(1) NHS Wales IG Toolkit**
- There are 31 assessment questions, 25 apply to the Trust, with 6 relating to General Practice, community & mental health services. Of the 25 that apply to the Trust, 22 are assessed using the IG Toolkit, the other 3 are Digital (Cyber, Mobile/Remote working, Destruction/Disposal of IT equip) assessed by the National Cyber Resilience Unit (CRU) and Trust Digital Team using the Cyber Assessment Framework developed by the new Cyber Resilience Unit (CRU). replaced the Welsh Cyber Assurance Process (WCAP).
- 16 assessment areas out of a total of 22 areas within the Toolkit have been identified as priority for specific activity. A risk-based approach will be taken to prioritising activity to be undertaken in 2022/23 and that planned for 2023/24.
- The IG Toolkit has three levels (1 to 3) of attainment which have been assessed for the 22 areas. Where assessment is Level 1 is not achieved the assessment has been identified as Level 0.
- The assessment was undertaken by the HoIG, but not yet reviewed fully by the SIRO, which may result in some changes to the assessment Levels which will be highlighted in the next report.

**16 assessment areas out of a total of 24 areas within the Toolkit have been identified as priority for specific activity**

| Section | Expected attainment level | Level achieved 2020/21 | Level achieved 2021/22 | Improvement / No Change / Reduction |
|---|---|---|---|---|
| **Section 2 – Business Responsibilities** | | | | |
| 2.2 – Policies and Procedures | Level 3 | Level 2 | Level 2 | No change |
| 2.3 - Information Sharing | Level 3 | Level 1 | Level 2 | Improvement |
| 2.4 – Contracts and Agreements | Level 3 | Level 1 | Level 0 | No change |
| 2.5 – Data Protection Impact Assessme | Level 3 | Level 2 | Level 2 | No change |
| **Section 3 – Business Management** | | | | |
| 3.2 - IG Risk Register | Level 3 | Not assessed the previous year | Level 0 | N/A |
| 3.3 – Auditing | Level 3 | Not assessed the previous year | Level 0 | N/A |
| **Section 4 – Individual Rights and Obligations** | | | | |
| 4.2 – Right to be Informed | Level 3 | Level 2 | Level 2 | No change |
| 4.5 – Rights related to Automated Decision Making and Profiling | Level 3 | Not assessed the previous year | Level 1 | N/A |
| **Section 5 – Managing and Securing Records (Electronic and Paper Records)** | | | | |
| 5.1 – Management of Records | Level 3 | Level 2 | Level 1 | Reduction |
| 5.2 – Information Asset Register | Level 3 | Level 1 | Level 1 | No change |
| 5.3 – Data Accuracy | Level 3 | Level 2 | Level 1 | Reduction |
| 5.4 – Retention Schedules, Secure Destruction and Disposal | Level 3 | Level 2 | Level 1 | Reduction |
| **Section 6 – Technical, Physical and Organisational Security Measures** | | | | |
| 6.1 – Physical Security Measures | Level 3 | Level 2 | Level 0 | Reduction |
| 6.3 – Organisational Measures (Training and Awareness) | Level 3 | Level 2 | Level 2 | No change |
| 6.6 – Surveillance Systems | Level 3 | Level 1 | Level 0 | Reduction |
| **Section 8 – Breach Management** | | | | |
| 8.1 – Reporting Data Breaches | Level 3 | Not assessed the previous year | Level 3 | N/A |
| | Level 0 | 0 | 5 | |
| | Level 1 | 4 | 5 | |
| | Level 2 | 8 | 5 | |
| | Level 3 | 0 | 1 | |
| | Not assessed | 4 | 0 | |
| | **Total** | **16** | **16** | |

| Sections reviewed and assessment level remains the same but no priority action required |
|---|
| **Section** |
| **Section 2 – Business Responsibilities** |
| 2.1 Information Governance Management Structure |
| 2.6 Freedom of Information Act and Environmental Information Regulation |
| 2.7 Privacy Electronic Communications Regulations |
| **Section 4 – Individual Rights and Obligations** |
| 4.1 Right of Access |
| 4.4 Rights related to profiling and automated decision making that has a significant impact on the data subject |
| **Section 6 – Technical, Physical and Organisational Security Measures** |
| 6.2 Technical Security Measures |

- The IG Workplan has been updated to reflect the requirement to undertake the activity identified in the IG Toolkit in FY 2022/23

**(2) DPIAs, contract register and associated Data Processing/Sharing Agreements**
- 21 DPIA's were commenced since Oct 21, 19 of which are Trust DPIA's, 2 are NHS Wales national DPIA's
- Work is underway to identify all existing Trust systems and where a DPIA has not been completed. A risk-based approach will be taken to prioritising assessments that can be undertaken in 2022/23
- 6 Trust DPIA's have been approved during the quarter, no NHS Wales DPIA's have been approved.
- The Trust does not have a single visible Contracts Register which is highlighted as a risk and is a priority area of work for 2022/23.
- DPIA's and Data Processing Agreements are not all currently aligned with Contract activity. Work is underway to ensure alignment.

**(3) DPA requests, data security incidents & investigations**.
- The top three themes of incidents relate to record confidentiality breaches; failure to secure records (lost), records misfiled, disclosed in error (sent/delivered to wrong recipient, divulged in error)
- Key learning is that most incidents could be avoided with improved IG awareness & training of staff as human error is the common factor
- 100% of the incidents closed were graded as no harm to the continuity of patient care, donor services or to staff

- 15 incidents are in the process of investigation, 13 presenting low risk which is expected to present no harm, the other 2 are subject to Root Cause Analysis (RCA)
- Preliminary results for 1 incident under RCA are the risk of harm may be lower than originally thought. The other RCA relates to the off-site record incident where the initial assessment is there is likely to be low harm
- The backlog of incidents under investigation has increased as significant amount of the HoIG time has been focussed on the off-site record incident.
- There was 1 incident (subject to a separate report) reportable to the ICO relating to the off-site records storage, which was also reported to WG under the Early Warning Notification process.
- 2 Incidents were reported outside of DATIX due to their sensitivity
- A total of 58 requests for access to health records were received with **0% breaches against the one calendar month response timeframe.**
- 3 requests were received for access to information held on an individual. All 3 requests had complex HR elements and as a result had deadlines extended in line with Legislation to enable a full response to be made; all are now complete. **There were 0% breaches against the three-calendar month response timeframe.**

## 4.     IMPACT ASSESSMENT

| QUALITY AND SAFETY IMPLICATIONS/IMPACT | Yes (Please see detail below) |
| --- | --- |
| | The loss or disclosure of personal information should be an important consideration for all staff on a day-to-day basis as it can seriously damage the Trust's reputation and undermine patients, donors and/or service user's trust. |
| **RELATED HEALTHCARE STANDARD** | Effective Care |
| | Standard 3.4 Information Governance and Communications Technology |
| **EQUALITY IMPACT ASSESSMENT COMPLETED** | Not required |
| **LEGAL IMPLICATIONS / IMPACT** | Yes (Include further detail below) |
| | The accidental or unlawful destruction, loss, alteration, unauthorized disclosure of, or access to, all personally |

| | |
|---|---|
| | identifiable data may lead to a breach of security and the noncompliance with Data Protection Legislation. Where there is an impact on the rights and freedoms to the Data Subject, this may be reportable to the ICO within 72 hours of the discovery of the breach. unauthorised access to systems may also lead to further legal ramifications (Computer Misuse Act 1990) |
| **FINANCIAL IMPLICATIONS / IMPACT** | Yes (Include further detail below) |
| | The Information Commissioners Office has the power to impose financial penalties (fine of up to 20 million euros) and issue enforcement action. |

## 5.    RECOMMENDATION

The Quality, Safety and Performance Committee is asked to **DISCUSS** and **NOTE** the 2021 / 2022 Quarter 4 Information Governance Assurance Report.

# 2021 / 2022 QUARTER 4

# INFORMATION GOVERNANCE ASSURANCE REPORT

## Contents

## Acronyms

| IG | Information Governance | NWSSP | NHS Wales Shared Service Partnership |
|----|------------------------|-------|-------------------------------------|
| VCC | Velindre Cancer Centre | ICO | Information Commissioners Office |
| WBS | Welsh Blood Service | NIIAS | National Intelligent Integrated Audit Solution |
| DHCW | Digital Health and Care Wales | M&S | Mandatory and Statutory |
| HoIG | Head of Information Governance | DPIAs | Data Protection Impact Assessments |
| GDPR | General Data Protection Regulation | AOS | Acute Oncology Service |
| MHRA | Medicines and Healthcare products Regulatory Agency | SAR | Subject Access Requests |
| AHRA | Access to Health Record Act 1990 | IGMAG | Information Governance Management Advisory Group |
| SIRO | Senior Information Responsible Officer | DPO | Data Protection Officer |
| FOIA | Freedom of Information Act | EIR | Environmental Information Regulation |
| NCSC | National Cyber Security Council | CISP | Cyber Information Sharing Partnership |
| VUNHST | Velindre University NHS Trust | IMTP | Integrated Medium-Term Plan |
| IM | Independent Member | | |

**Executive Summary**

This is the Trust's Quarterly Information Governance (IG) Assurance Report where the way Velindre University NHS Trust (VUNHST) manages its information in respect of patients, donors, service users and staff highlighting compliance with Information Governance (IG) legislation and standards, actions to improve management of IG risks and report IG incidents and actions from lessons learned are presented in one overarching report. Mr Stephen Harries is the Board champion for IG.

The report sets out how Information Governance supports the delivery of VUNHST's statutory functions and contributes to delivering its Integrated Medium-Term Plan (IMTP) and associated Strategy. It does this through 8 domains of IG:



The report outlines key assurance activities and IG Incidents for the reporting period of 1st January 2022 to 31st March 2022. Relevant updates from this reporting period are provided based on the core responsibilities of the Trust:

Compliance with the IG Toolkit and improvements in managing information risks.

Organisational compliance with legislative and regulatory requirements relating to the handling of information, including compliance with the Data Protection Act (2018) (General Data Protection Regulation (GDPR)), Freedom of Information Act (2000) and Environmental Information Regulations (2004).

Any IG Incidents relating to any losses of personal data or data security breaches within the reporting period.

Any IG work during the reporting period and future work planned to improve IG and data security

The key impacts that the IG assurance Framework aims to mitigate against are:

- rights and freedoms of individuals being breached
- loss of confidence in the Trust, harm or financial impact to patients, donors and staff
- possible impact on safety & quality of clinical care or day-to-day operational functions of the Trust
- Trust reputational damage
- financial impact through ICO fines and cost of recovery of information & systems, legal advice etc.

The key messages/highlights are:

- The three IG Assurance Framework areas being focused on are: (1) IG Toolkit self-assessment, (2) DPIAs, contract register and associated Data Processing/Sharing Agreements. (3) DPA requests, data security incidents & investigations. Work in these areas will lead to improvements in IG systems & processes.
- Quarterly IG assurance meetings have been established between Mr Stephen Harries (IM champion for IG), Matthew Bunce (SIRO) and newly appointed Director of Digital to provide additional assurance to the committee. The first meeting arranged for May 2022.

- **NHS Wales IG Toolkit**
  - There are 31 assessment questions, 25 apply to the Trust, with 6 relating to General Practice, community & mental health services. Of the 25 that apply to the Trust, 22 are assessed using the IG Toolkit, the other 3 are Digital (Cyber, Mobile/Remote working, Destruction/Disposal of IT equip), assessed by the National Cyber Resilience Unit (CRU) and Trust Digital Team using the Cyber Assessment Framework developed by the new Cyber Resilience Unit (CRU). replaced the Welsh Cyber Assurance Process (WCAP).
  - 16 assessment areas out of a total of 22 areas within the Toolkit have been identified as priority for specific activity. A risk-based approach will be taken to prioritising activity to be undertaken in 2022/23 and that planned for 2023/24.
  - The IG Toolkit has three levels (1 to 3) of attainment which have been assessed for the 22 areas. Where assessment is Level 1 is not achieved the assessment has been identified as Level 0.

- o The assessment was undertaken by the HoIG, but not yet reviewed fully by the SIRO, which may result in some changes to the assessment Levels which will be highlighted in the next report.

| 16 assessment areas out of a total of 24 areas within the Toolkit have been identified as priority for specific activity | | | | |
|---|---|---|---|---|
| **Section** | **Expected attainment level** | **Level achieved 2020/21** | **Level achieved 2021/22** | **Improvement / No Change / Reduction** |
| **Section 2 – Business Responsibilities** | | | | |
| 2.2 – Policies and Procedures | Level 3 | Level 2 | Level 2 | No change |
| 2.3 - Information Sharing | Level 3 | Level 1 | Level 2 | Improvement |
| 2.4 – Contracts and Agreements | Level 3 | Level 1 | Level 0 | No change |
| 2.5 – Data Protection Impact Assessment | Level 3 | Level 2 | Level 2 | No change |
| **Section 3 – Business Management** | | | | |
| 3.2 - IG Risk Register | Level 3 | Not assessed the previous year | Level 0 | N/A |
| 3.3 – Auditing | Level 3 | Not assessed the previous year | Level 0 | N/A |
| **Section 4 – Individual Rights and Obligations** | | | | |
| 4.2 – Right to be Informed | Level 3 | Level 2 | Level 2 | No change |
| 4.5 – Rights related to Automated Decision Making and Profiling | Level 3 | Not assessed the previous year | Level 1 | N/A |
| **Section 5 – Managing and Securing Records (Electronic and Paper Records)** | | | | |
| 5.1 – Management of Records | Level 3 | Level 2 | Level 1 | Reduction |
| 5.2 – Information Asset Register | Level 3 | Level 1 | Level 1 | No change |
| 5.3 – Data Accuracy | Level 3 | Level 2 | Level 1 | Reduction |
| 5.4 – Retention Schedules, Secure Destruction and Disposal | Level 3 | Level 2 | Level 1 | Reduction |
| **Section 6 – Technical, Physical and Organisational Security Measures** | | | | |
| 6.1 – Physical Security Measures | Level 3 | Level 2 | Level 0 | Reduction |
| 6.3 – Organisational Measures (Training and Awareness) | Level 3 | Level 2 | Level 2 | No change |
| 6.6 – Surveillance Systems | Level 3 | Level 1 | Level 0 | Reduction |
| **Section 8 – Breach Management** | | | | |
| 8.1 – Reporting Data Breaches | Level 3 | Not assessed the previous year | Level 3 | N/A |
| | Level 0 | 0 | 5 | |
| | Level 1 | 4 | 5 | |
| | Level 2 | 8 | 5 | |
| | Level 3 | 0 | 1 | |
| | Not assessed | 4 | 0 | |
| | **Total** | **16** | **16** | |

| Sections reviewed and assessment level remains the same but no priority action required |
| --- |
| **Section** |
| **Section 2 – Business Responsibilities** |
| 2.1 Information Governance Management Structure |
| 2.6 Freedom of Information Act and Environmental Information Regulation |
| 2.7 Privacy Electronic Communications Regulations |
| **Section 4 – Individual Rights and Obligations** |
| 4.1 Right of Access |
| 4.4 Rights related to profiling and automated decision making that has a significant impact on the data subject |
| **Section 6 – Technical, Physical and Organisational Security Measures** |
| 6.2 Technical Security Measures |

- o The IG Workplan has been updated to reflect the requirement to undertake the activity identified in the IG Toolkit in FY 2022/23

- **DPIAs, contract register and associated Data Processing/Sharing Agreements**
  - o 21 DPIA's were commenced since Oct 21, 19 of which are Trust DPIA's, 2 are NHS Wales national DPIA's
  - o Work is underway to identify all existing Trust systems and where a DPIA has not been completed. A risk-based approach will be taken to prioritising assessments that can be undertaken in 2022/23
  - o 6 Trust DPIA's have been approved during the quarter, no NHS Wales DPIA's have been approved.
  - o The Trust does not have a single visible Contracts Register which is highlighted as a risk and is a priority area of work for 2022/23.
  - o DPIA's and Data Processing Agreements are not all currently aligned with Contract activity. Work is underway to ensure alignment.

- **DPA requests, data security incidents & investigations**

  **Incidents & Investigations for the period 1st January 2022 to 31st March 2022**

| | DATIX Incidents | Incidents Reported outside DATIX | Total Incidents | Reported to ICO | Investigation | | | Investigation | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| | | | | | Low Risk / No Harm | Root Cause Analysis | Total | Open | Closed | Total |
| Velindre Cancer Services | 20 | 2 | 22 | 1 | 16 | 6 | 22 | 15 | 7 | 22 |
| WBS | 2 | 0 | 2 | | 2 | 0 | 2 | 0 | 2 | 2 |
| NWSSP | 8 | 0 | 8 | | 8 | | 8 | 0 | 8 | 8 |
| **Total Trust** | **30** | **2** | **32** | **1** | **26** | **6** | **32** | **15** | **17** | **32** |

- The top three themes of incidents relate to record confidentiality breaches; failure to secure records (lost), records misfiled, disclosed in error (sent/delivered to wrong recipient, divulged in error)
- Key learning is that most incidents could be avoided with improved IG awareness & training of staff as human error is the common factor
- 100% of the incidents closed were graded as no harm to the continuity of patient care, donor services or to staff
- 15 incidents are in the process of investigation, 13 presenting low risk which is expected to present no harm, the other 2 are subject to Root Cause Analysis (RCA)
- Preliminary results for 1 incident under RCA are the risk of harm may be lower than originally thought. The other RCA relates to the off-site record incident where the initial assessment is there is likely to be low harm
- The backlog of incidents under investigation has increased as significant amount of the HoIG time has been focussed on the off-site record incident.
- There was 1 incident (subject to a separate report) reportable to the ICO relating to the off-site records storage, which was also reported to WG under the Early Warning Notification process.
- 2 Incidents were reported outside of DATIX due to their sensitivity

## 1. ASSESSMENT OF MATTERS FOR CONSIDERATION

## 1.1 SPECIFIC MATTERS FOR CONSIDERATION (ASSESSMENT)

The Committee is reminded of the definition of an Information Governance Incident:

> "a breach of security leading to the accidental or unlawful destruction, loss, alteration, unauthorized disclosure of, or access to, all personal data, whether Employee or Patient, Donor, Service User held on computer or held manually and whether communicated verbally, electronically or in writing"

## 1.2 TRUST COMPLIANCE – LEGAL & REGULATORY FRAMEWORK

The following provides an update during the reporting period against the Information Governance (IG) Assurance Framework that ensures the Trust meets its statutory obligations and other standards. There are a number of areas of Risk Management & Assurance in relation to IG that form part of the ongoing IG workplan included at **Appendix 2**.

The three key aspects of assurance that are being brought to the Committee's attention are:

- IG Toolkit – a self-assessment providing an overview of the Trust compliance against national Information Governance (IG) standards and legislation through assessment against the eight domains of IG.

- Data Protection Impact Assessment (DPIA) – this is how we identify processing risk in a privacy by design methodology for electronic and manual systems in operation and also importantly how we continue to review that risk on a regular basis.

- Contract Register and Data Processing/Sharing Agreements – this is how we link procurement of systems to the requirement (via the DPIA process) to ensure that IG is considered at the correct point within the life of the procurement process to ensure compliance with Data Protection Legislation where systems procured may process personal data.

### 1.2.1 Information Governance Toolkit Self-Assessment

The Welsh Information Governance Toolkit (IG Toolkit) is an online self-assessment tool managed by DHCW enabling organizations to measure their level of compliance against national Information Governance (IG) standards and legislation. The tool is completed annually and provides evidence of areas of improvement achieved and identifies actions for the following year.

A short extension was granted to all Health Boards and Trust to 15th April 2022. The Trust submitted its Toolkit to the DHCW site on 13th April 2022. Last year's submission has been used by the HoIG to identify previous areas for improvement and provide background information. However, to ensure that the Trust has a fully updated picture the 2021/22 assessment was completed without incorporation of the previous year's self-assessment.

To provide assurance the 2021/22 assessment has been compared against the previous year's assessment to enable the identification of key priority areas for improvement. These key priority areas will define the workplan for FY 2022/23 by addressing 2-3 areas of risk and the work planned to mitigate that risk. This will be addressed in differing areas in each report building a full picture of risk and assurance across the 12-month reporting period.

The Committee are requested to note that Section 1 of the Toolkit relates to the basic demographic data to enable full identification of the relevant Trust/Health Board, it is therefore not formally assessed and not included in this report.

A comparison table for FY 2020/21 and FY 2021/22 is at **Appendix 1.**

These key priorities have been derived from the comparison table and are articulated below:

**Section 2 – Business Responsibilities**

- Section 2.2 – Policies and Procedures
  - The Polices and Procedures have been reviewed by HoIG and are in their final stages prior to final approval by the Committee.
  - Spot checks will be initiated against the policies and procedures during FY 2022/23.

- Section 2.3 – Information Sharing

  - The Information Asset Register used in FY 2021/22 is unwieldy and not user friendly which affects the ability to use it as an effective tool. It will be simplified during FY 2022/23, once simplified it requires regular review to ensure data sharing/processing agreements are recorded and that these agreements align with Information Assets and Contracts to ensure that the Trust is compliant with Data Protection Legislation.

- Section 2.4 – Contracts and Agreements

  - In 2020/21 a Data Sharing Agreement register was not in place even though Agreements were retained. A register is now in place (FY2022/23) but requires alignment with a procurement contract register to ensure that when contracts are awarded/renewed that IG is considered with an appropriate review process also in place. The Committee is requested to note that this issue is not just VUNHST specific but appears to be an NHS Wales wide issue.

- Section 2.5 – DPIA

  - A DPIA process was always in place, but the use of DPIA's had lapsed in FY2021/22. It has now been revived (FY 2022/23). The Committee is requested to note that this area that is the cornerstone of the management of IG Risk. A large amount of further work is required to review current systems during FY 2022/23 and ensure that the Trust embeds the DPIA process as part of any consideration in relation to the processing of personal data for all new systems within the same timeframe.

**Section 3 – Business Management**

- Section 3.2 – IG Risk Register

  - The Trust does not have an IG Risk Register, this issue was noted by both SIRO and HoIG and highlighted in the Toolkit, a major IG incident has resulted in a Risk Register being created, this Risk Register will be used to form the basis of the Trust IG Risk Register as soon as possible during FY 2022/23.

- Section 3.3 – Auditing

    o The Trust has not been carrying out audits of activity historically, this requires addressing across all Trust areas in FY 2022/23 to ensure that personal data is processed appropriately.

**Section 4 – Individual Rights and Obligations**

- Section 4.2 – Right to be Informed

    o Privacy information in the form of notices, posters and websites all require review during FY 2022/23 to ensure that they reflect the evolving nature of Data Protection Legislation since the UK's transition from the EU in December 2020 (data protection was not in the transition agreement and was eventually agreed on 18th June 2021).

- Section 4.5 – Rights related to Automated Decision Making and Profiling

    o An area that requires further attention in FY 2022/23 especially as systems will be used that use automated decision making (Artificial Intelligence) which require special consideration in relation to the rights and freedoms of data subjects.

**Section 5 – Managing and Securing Records (Electronic and Paper Records)**

- Section 5.1 – Management of Records

    o Records Management is an area that currently carries risk, this requires a full review in FY 2022/23 as already noted by SIRO and HoIG in the management of a serious IG incident.  This applies to Medical Records (all departments) and Corporate Records to ensure alignment with the UK Government Records Management Code of Practice and NHS Wales Records Management Code of Practice for Health and Social Care 2022.

- Section 5.2 – Information Asset register

    o This element links back to Section 2.1 and makes the same observation in that in FY 2022/23 the IAR will require a thorough review to ensure that the current version is no longer unwieldy.  Work has already commenced between WBS/HoIG in Feb/Mar 22 to ensure that the same approach is taken as they also found their IAR was unwieldy and not user friendly.

- Section 5.3 – Data Accuracy

o As with the Audit area, A data accuracy spot check programme will be instigated in FY 2022/23 across all areas.

- Section 5.4 – Retention Schedules, Secure Destruction and Disposal

  o Whilst the retention schedules are published nationally in guidance documentation, further work in ensuring that the Trust destroys information that is no longer required is as important as the collection and processing personal data compliantly, of course this will need to take account of Public Inquiries where destruction of records is not permitted.   This work will require progression in FY 2022/23.

**Section 6 – Technical, Physical and Organisational Security Measures**

- Section 6.1 – Physical Security Measures

  o A risk assessment relating to the risks to the loss or damage of personal data was not observed in the divisions, this will be undertaken by a DPIA, the HoIG will need to lead on this work during FY2022/23.   Areas will also require physical audits to ensure that physical security is compliant with the requirements of Data Protection Legislation.

- Section 6.3 – Organisational Measures (Training and Awareness)

  o The national standard at level 3 of the Toolkit is 85% attainment across organizations, the Trust achieved a rate of 83.05% as at 1 Jan 22 (the date that the assessment was benchmarked to provide parity across NHS Wales). The Trust may need to consider what measures are required to achieve the national standard of 85% attainment in IG training.

- Section 6.6 – Surveillance Systems

  o Work has already commenced to address this area during April 2022 with WBS/VCC in relation to updated ICO Guidance for CCTV in vehicles.  This work will also address CCTV across all static areas (buildings) so that IG is considered wherever CCTV is in use.  A meeting is planned for 28th April 2022.

**Section 7 – Cyber Security**

Cyber Security is assessed by the National Cyber Resilience Unit (CRU) using the Cyber Assessment Framework which has replaced the Welsh Cyber Assurance Process (WCAP). Their overall assessment for the Trust undertaken Oct – Nov '21 and reported findings in mid February 2022.as updated in the Digital Report in March:

Velindre
Overall Compliance

30%
70%

■ Total compliance    ■ Total non-compliance
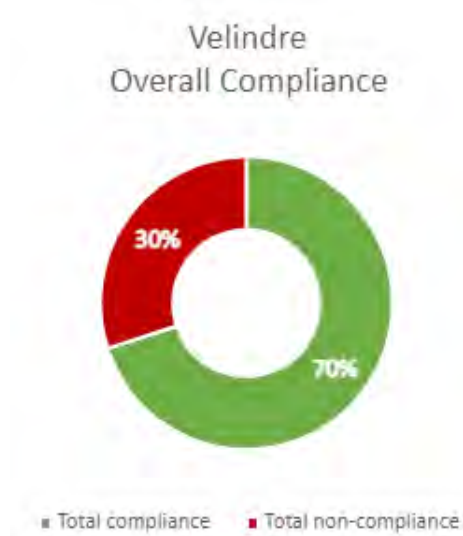
The Digital Team are responsible for the Cyber Response Plan developed to deliver improvements required by the assessment, which is subject to separate activity and reporting.

The Head of IG and Cyber Security Officer meet every two weeks and share information and best practice as required using resources from the National Cyber Security Resilience Unit and ICO.

**Section 8 – Breach Management**

There were not deemed to be any issues in this area. The Committee is requested to note that the Head of IG reports all breaches to SIRO and then to QSP via EMB via a recognized governance process, keeping external authorities updated as required.

The priority areas for improvement will form the basis of the IG workplan for FY 2022/23.

**Action**

- Update of the IG workplan to reflect new areas of improvement required
- Sharing of assessments across Wales to support learning & improvement once all Toolkits are made available by DHCW.

**1.2.2  Data Protection Impact Assessments (DPIAs)**

The IG Toolkit highlighted DPIA's as the cornerstone of risk management in relation to IG Risk.

As a reminder, a DPIA is a process to help analyze, identify and minimize the data protection risks of a system (both electronic and manual records).  Under UK GDPR DPIA's are a legal requirement for processing data that is likely to result in high risk to the rights and freedoms of individuals being breached and good practice hen processing

personal data. A DPIA does not have to eradicate all risk but should help to minimize and determine whether the level of risk is acceptable in the circumstances.

Under UK GDPR, failure to carry out a DPIA when required may leave the Trust open to enforcement notice where the ICO will tell the Trust that it MUST carry out an action and if it does not, the ICO may impose a financial penalty of up to 20 million Euros (£16.52m). There may also be damage to the Trust's reputation should it not protect personal data compliantly.

A review is being undertaken by the HoIG and Head of Digital Delivery of the Trust key systems to assess the status of the DPIA's. An initial finding is that where systems were in place pre-GDPR (25 May 2018) DPIA's were not undertaken for some remains extant.

Due to the volume of systems in use across the Trust work will remain ongoing throughout 2022/23 to obtain a full picture of the DPIA status. The DPIA's will be prioritized and activity planned throughout 2022/23.

The HoIG continues to employ a workshop approach to reviewing new DPIA's with information owners to ensure that understanding is as thorough and detailed as possible. The same approach will be taken with the owners of legacy systems to review and update DPIAs or complete new DPIA where required due to a high risk to the rights and freedoms of individuals being breached. This approach does appear to be delivering some success, the HoIG is prioritizing only those systems that have been approved at the appropriate levels for delivery against authorized Trust delivery plans.

The following sets out the number of new DPIAs commenced since October '21 both for Internal Trust systems and External National systems the Trust uses and whether the DPIA has been approved by the HoIG:

| No. DPIA's | Internal Trust Systems | External NHS Wales National Systems | Commenced by Data Owner / Approved by HoIG |
|------------|------------------------|-------------------------------------|--------------------------------------------|
| 21 | 19 | 2 | Commenced by data Owner |
| 6 | 6 | 0 | Approved by HoIG |

The Information Asset Register (IAR) is another area of substantial work that needs to be progressed, which will record formally DPIA activity and the type of data being processed.

**Action**

- All systems either in use or proposed for adoption across the Trust where personal data is processed and considered a high risk to the rights and freedoms of individuals being breached will undergo a DPIA screening process in line with ICO best practice.

- Work remains ongoing to obtain a clearer picture of existing systems and associated DPIA's across the Trust

- Work ongoing to obtain a full picture of all Trust systems and their DPIA status during 2022-23

- DPIA's will be prioritized and activity planned throughout 2022/23.

### 1.2.3   Contracts Register and Data Sharing/Processing Agreements

The IG Toolkit has highlighted the lack of a visible Contract Register as a risk.  The DPIA process aligns closely with the Contract process and recent experience within the Trust has shown that there is heightened risk where contractual documentation is not supported by correct IG processes and documentation. If the risk becomes an issue, then the impact on the Trust may be financial or reputational or indeed both.

To provide a realistic appraisal, a recent case found that a DPIA was not considered necessary at the time as it was considered that the Terms and Conditions within the Contract addressed IG requirements.  Whilst the Terms and Conditions did address IG requirements, those same Terms and Conditions did not articulate risk to the rights and freedoms of Data Subjects should service delivery not occur as expected.  By not undertaking a due diligence process it would be difficult for the Trust to defend its position should it be required to do so to a regulatory authority.  Analysis also found that guidance within Codes of Practice stated that a DPIA was mandatory as part of the contractual process for the delivery of the service.  Lessons have been learned as a result of the case, and processes put in place to prevent a recurrence at the corporate level.  However, further embedding of processes will be undertaken during FY 2022/23 across all Trust areas so that sharing of learning is as wide as possible.

It was also found that The Terms and Conditions did not have in place a detailed Data Processing Agreement (the relationship for the contract being Controller/Processor).  The ICO Guidance states that when a contract is formed and Personal Data is being processed that a Data Processing Agreement must be in place.  The Data Processing Agreement is a legally enforceable one as it is signed by both parties.  The signed document would have provided the Processor with complete clarity as to their obligations under Data Protection Legislation over and above the already detailed information in the Terms and Conditions Document.

As part of subsequent activity, a Data Processing Agreement will be put in place with a replacement supplier and included as a Schedule within the overall Contract documentation.

To provide clarity, inclusion of the document did not detract from the Terms and Conditions themselves but acted as a legally enforceable supporting document.

The Committee are requested to note that the Trust does not yet have a Data Sharing Agreement (Controller/Controller relationship) in place, however, to address this the HoIG has drafted a document which has been sent for requires review by Legal and Risk within NWSSP.

The HoIG has undertaken a collaborative approach with the Trust's Senior Procurement Manager to review and update procedures so that when systems are being procured that IG is considered at the correct point within the procurement process.

The HoIG has undertaken further work within divisions to ensure that IG is considered as part of any procurement process and is signposting contract managers to the Senior Procurement Manager so that where possible the process is as "joined up" as possible.

The Data Processing Agreements and DPIA's are all recorded in a Data Processing Agreement and DPIA register to allow tracking of activity and facilitate reviews and query resolution.

**Action**

- HoIG to work with the Senior Procurement Manager to identify the methodology to access the contracts register.
- HoIG and the Senior Procurement Manager to ensure that the DPIA process is embedded within the procurement process across all areas of the Trust so that IG is considered at the correct stage in procurement of goods/services.

**2.      REQUESTS, INCIDENTS AND INVESTIGATIONS**

**2.1     DPA requests, Data Security incidents & investigations**

Members of the public are entitled to request information from public authorities, these are known as Subject Access Requests (SAR). Information requested may include information about themselves - Data Protection Act, or information held by public authorities - Freedom of Information (FOI) Act and Environmental Information Regulations (EIR).  The Trust is required to respond to any requests in line with legislation:

- FOI/EIR – 20 Working Days (if received on a bank holiday/Saturday/Sunday – next working day)
- DPA 2018 – 1 calendar month from date of receipt

Note: FOI/EIR requests, incidents and investigations are included in a separate report.

**Data Protection SARs for clinical information and requests from third parties**

During the period of 1st January 2022 – 31st March 2022 a total of 58 requests for access to health records were received with **0% breaches against the one calendar month response timeframe.**

**Data Protection SARs for non-clinical information**

During the period 1st January 2022 – 31st March 2022, 3 requests were received for access to information held on an individual.  All 3 requests had HR elements included within them.  As a result of complexity all 3 had to be extended in line with Data Protection Legislation to enable a full response to be made, all are now complete.  There were **0% breaches against the three-calendar month response timeframe permitted under Data Protection Legislation**

**Data Security Incidents**

**Analysis**
Under GDPR there are 3 types of data breaches:

**Confidentiality breach** – where data or private information is disclosed to 3rd parties without the owner's consent

**Integrity breach (Data protection)** – unauthorized or accidental alteration of personal data

**Availability breach (Data Protection)** – accidental or unauthorized loss of access to, or destruction of, personal data

A number of incidents reported, relate to patient / donor record confidentiality; these incidents include failure to secure records, records misfiled, sent/delivered to the wrong recipient and disclosed in error.

It is a legal obligation under GDPR to notify personal data breaches within 72 hours to the Information Commissioner's Office if the breach is likely to result in a high risk to the rights and freedoms of individuals being breached. Organizations must also inform those individuals without undue delay.

During the reporting period one incident involving personal data breaches (multiple patient records) was assessed as requiring reporting to the Information Commissioner's Office, WG and nationally.  All members of the EMB were informed immediately due to the seriousness of the incident which remains ongoing and is one of the 3 open investigations.

**Velindre Cancer Centre (VCC) Incidents**

**Quarter 4 (1 Jan 22 – 31 Mar 22)**

**Reported via Datix**

There have been 23 Data security incidents reported within Datix this period, however, following review the correct number of incidents is 20. 1 incident has been raised twice in Datix by differing departments. 1 incident relates to an estates/pharmacy issue. 1 incident is not related to IG but rather a non-reply from an addressee to an e mail.

- Of the 20 incidents 11 relate to data protection and 9 to confidentiality.
- 1 incident was reported to the ICO.
- All 20 IG incidents were investigated by the HoIG. And;
  - 6 incidents are closed
  - 14 incidents remain open

All 6 incidents after investigation with the reporter presented no risk of harm to the continuity of patient care from an IG perspective. 14 incidents are still in the process of investigation with 12 of those presenting a low risk which is expected to present no harm to the continuity of patient care, for this reason priority is being given to the investigation of other higher risk incidents. These remaining 2 incidents are subject to Root Cause Analysis. Preliminary results for 1 incident show that the risk of harm may be lower than originally thought, as most information is already recorded within electronic patient systems and evidence is pointing to a series of annotations with no discernible impact on patient records. The remaining incident is under investigation and is the subject of a separate report.

The backlog of incidents has increased as the HoIG has been focusing efforts on resolving a major IG incident. The closure of the Major IG incident it is hoped will permit the HoIG to switch attention to addressing the DATIX backlog.

**Not reported via Datix**

There have been 2 Data security incidents reported directly to the HoIG due to their sensitivity.

- Of the 2 incidents 1 relates to data protection and 1 to confidentiality.
- 1 IG incidents was investigated by the HoIG and closed, the other remains open.

**Incident Trend**

**VCC Trend Anlaysis**
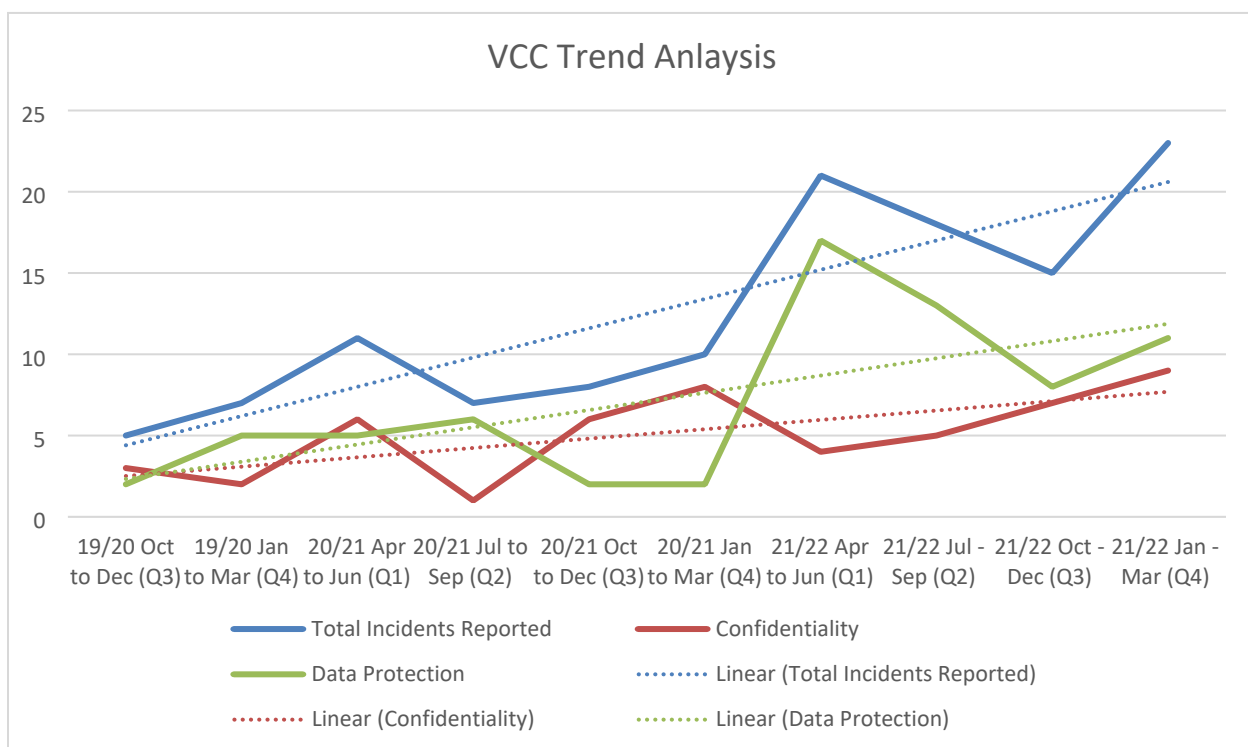
As previously identified since April '21 incidents are across all categories and teams. It appears now that the HoIG has spent longer in post that the core reasons are:

- Incidents that were not primarily identified as IG, but which had an IG aspect not previously being flagged as IG.
- New version of Datix has added functionality of an IG flag, which has increased reporting due to an active campaign by DATIX trainers encouraging individuals to report incidents even if unsure whether the incident requires reporting or not.
- No additional IG training & awareness sessions for 5 months from Jun 21 when the IG Manager departed Velindre, until Dec 21 when HoIG commenced his role.

The Committee are requested to note that outcomes of incidents and lessons learnt are shared at team meetings and IG training awareness sessions.

**Welsh Blood Service (WBS)**

During 21-22 incidents previously only reported on QPulse have also been reported on DATIX so that the Trust has full visibility of all incidents, including IG related.

There were 2 IG incidents reported during the period 1 Jan 22 – 31st Mar 22.  One incident is closed, the other remains open which is expected to present no harm to continuity of patient care, for this reason priority is being given to the investigation of other higher risk incidents within VCC.

**NHS Wales Shared Services Partnership (NWSSP)**

There has been a total of 14 incidents reported in the period 1 Jan 22 – 31 Mar 22. Of this 14, 6 were reported and recorded for information purposes as they were experienced within NWSSP but did not originate within the organization and were therefore not for investigation nor action. This left a balance of 8 incidents which were considered to be breaches.

The 14 incidents have been broken down into the following departments:

| Department | Q4 2021/22 |
| --- | --- |
| Employment Services | 4 |
| Medical Examiner Service | 2 |
| Primary Care | 6 |
| Procurement | 1 |
| People and OD/Digital Workforce | 1 |
| **Total** | **14** |

Of this total the incidents were further broken down into the following identifiers within DATIX:

| No | Type | Q4 2021/22 |
| --- | --- | --- |
| 1 | Information/Records sent to the wrong recipient | 1 |
| 2 | Information inappropriately divulged | 1 |
| 3 | Breach of staff/contractor confidentiality | 4 |
| 4 | Incorrect information documented | 1 |
| 5 | Communication issues between agency/multi agency | 1 |
| 6 | For recording only/concern/Royal Mail | 6 |
|  | **Total** | **14** |

The removal of the 6 incidents that are classified as recording only/concern/Royal Mail leaves the 8 incidents in rows 1-5 above which required further investigation. All incidents are reported as closed. The RCA and lessons learned identify misdirection as the main cause of incidents. This aligns with the analysis seen across the remainder of the Trust.

**IG Root Cause Analysis Investigations**

During the reporting period, 4 incidents reported via DATIX required a Root Cause Analysis Investigation. In addition, 2 incidents were not reported via DATIX due to their sensitivity but reported directly to the HoIG and required a Root Cause Analysis Investigation.

Of the 6 Root Cause Analysis Investigations undertaken, 4 investigations were closed (including those not reported on DATIX) and 2 remain open. The 2 investigations that remain open are recorded on DATIX.

**Action**

- Actions identified through the Root Cause Analysis for each incident are being implemented by the relevant leads

**Lessons Learned / Actions**

Analysis of incidents with the benefit of more time exposure to incidents in general is that most cases could be avoided with improved IG awareness & training of staff as human error appears to be the common factor

Where human error has been assessed as the main contributory factor, the following actions have been taken:

- The person who has made the error required to undertake ESR IG awareness training
- Enhanced IG training delivered by HoIG to teams using a risk-based assessment i.e. no. of incidents from each team balanced against impact
- If an incident is assessed as potentially having a serious impact on the patient/donor or the family of a patient/donor a Root Cause Analysis investigation is undertaken in addition to the investigation template within DATIX

**2.2    Other IG Assurance**

The Comparison Table IG Toolkit 2020/21 and 2021/22 is included at **Appendix 1.**

The updated summary IG workplan is included at **Appendix 2**.

**Appendix 1 – Comparison Table IG Toolkit 2020/21 and 2021/22 – Created 21st April 2022**

| Section | Description of section requirement and expected attainment level | Self-assessment of level achieved 2020/21 | Self-assessment of level achieved 2021/22 |
|---|---|---|---|
| **Section 2 – Business Responsibilities** | | | |
| 2.2 – Policies and Procedures | Level 3 - Compliance with policies and procedures are regularly monitored to ensure they have been adopted in practice throughout the organisation | **Level 2** - There is a review process in place for all policies and procedures and any changes are communicated to staff.  The following was noted:<br><br>Spot check procedure to be undertaken to ensure compliance across all areas of the Trust | **Level 2** - There is a review process in place for all policies and procedures and any changes are communicated to staff.  The following was then noted:<br><br>Review of policies and procedures at final stages and ready to be socialised prior to final approval by the Committee via EMB.<br><br>Spot check procedure to be undertaken to ensure compliance across all areas of the Trust |
| 2.3 - Information Sharing | Level 3 - Compliance with policies and procedures are regularly monitored to ensure they have been adopted in practice throughout the organisation | **Level 1** - Personal information is used and shared lawfully and relevant sharing principles of the Wales Accord on the Sharing of Personal Information (WASPI) and the common standards of the Welsh Control Standard for Electronic Health and Care Records have been adopted. All sharing is carried out in compliance with the General Data Protection Regulation (GDPR) and the Data Protection Act 2018 (DPA), the following was noted:<br><br>Development of an Agreement | **Level 2** - Where appropriate Information Sharing Protocols (ISPs) or Data Disclosure Agreements are recorded in the form of an agreement register. National systems such as NIIAS and AC3 are used to demonstrate the adoption of the Welsh Control Standard for Electronic Health and Care Records.<br><br>The aim is Level 3 - There is a review process in place to ensure agreements are kept up to date. Any changes or updates are reflected in the Information Sharing Register |

| | | Register in order to fully document associated Sharing agreements. | Further information is in amplifying comments. |
|---|---|---|---|
| 2.4 – Contracts and Agreements | Level 3 - A review process is in place to ensure that all contracts and agreements are regularly reviewed and any changes are communicated appropriately | **Level 1** - Data protection and IG contracts and agreements are in place with all suppliers, contractors, third parties and staff, who have access to/process personal data, which include data protection /IG requirements.  The following was noted:<br><br>Development of a Contract Register in order to fully document Data Protection in Procurement activity. | **Level 0** - Assessment is that the Trust has **not achieved Level 1.**<br><br>Whilst the Trust has in place T+C's,  DPIA's and DSA/DPA's are required to ensure that all areas are compliant.<br><br>A contract register is required to be put in place managed by both procurement and IG to ensure that when contracts are formed or expire IG is considered prior to contract award/renewal.<br><br>See amplifying comments and highlight of Risk. |
| 2.5 – Data Protection Impact Assessments | Level 3 - DPIA documentation is regularly reviewed and compliance with the process is reported to the Board/Committee | **Level 2** - A DPIA process is recognised and embedded throughout the organisation for existing processing of personal data and is formally signed off by the organisation's nominated officer | **Level 2** - A DPIA process is recognised and embedded throughout the organisation for existing processing of personal data and is formally signed off by the organisation's nominated officer.<br><br>Reporting of DPIA activity only begun in Mar 22 and is still being embedded, so assess Level 2 for this year. |
| <td colspan="4" align="center">**Section 3 – Business Management**</td> |
| 3.2  - Risk Register | Level 3 - Regular review of processes and the IG risk register are undertaken to ensure they remain up to date, with mitigations regularly | **Not assessed the previous year** | **Level 0** - Assessment is the Trust has **not achieved Level 1** - The organisation analyses IG risks regularly and documents in a formal IG risk register.<br><br>See amplifying comments. |

| | | | |
|---|---|---|---|
| | checked to ensure they remain effective | | |
| 3.3 – Auditing | Level 3 - There is a review process on all the auditing programmes the organisation undertakes to ensure it remains relevant and feedback is acted on | **Not assessed the previous year** | **Level 0** - Assessment is the Trust has **not achieved Level 1** - Organisations have audit processes in place to oversee all aspects of the Information Governance agenda.<br><br>See amplifying comments. |
| <td colspan="4" align="center">**Section 4 – Individual Rights and Obligations**</td> |
| 4.2 – Right to be Informed | Level 3 - All privacy information is regularly reviewed to ensure they remain fit for purpose to reflect the current nature of all the processing undertaken by the organisation Privacy information is approved by the relevant  person with responsibility, IG team/department and documented and linked to the Information Asset Register | **Level 2** - Privacy information accommodates a diversity of individuals and is made available and accessible by varied means e.g. health board website etc.<br><br>The following should be noted:<br><br>Develop linkage/recording of Privacy Notices within the Organisations IAR | **Level 2** - Privacy information accommodates a diversity of individuals and is made available and accessible by varied means e.g. health board website etc.<br><br>Assessment is that as much of the published information dates from 2018 that it requires a full refresh to be able to meet the requirements of Level 3. |
| 4.5 – Rights related to Automated Decision Making and Profiling | Level 3 - Automated decision-making systems are regularly reviewed, including for accuracy and bias.  Identified staff are authorised to undertake reviews, investigate complaints and where necessary change decisions as a result of their findings. The use of all forms of automated decision making is overseen by the appropriate Board / Committee / | **Not assessed the previous year** | Assessment is that this area is one that requires support over the coming year, Project Ritta identified this area as one of concern. The DPIA process paused the project due to automated decision making process issues.<br><br>Therefore **Level 1** achieved on the basis of one project seen so far:  The organisation has identified any solely or partly automated decision making / profiling that has a significant impact on data subjects and has relevant policies and procedures in place to |

| | Management Team, as appropriate | | protect data subject's rights in relation to that processing.

Appropriate lawful bases have been identified and care is taken to ensure the rights of children and vulnerable people are protected. |
|---|---|---|---|
| **Section 5 – Managing and Securing Records (Electronic and Paper Records)** | | | |
| 5.1 – Management of Records | Level 3 - Procedures are regularly reviewed and maintained and spot checks are made to ensure the procedures are enforced across the organisation | **Level 2** - Procedures have been embedded within the organisation and all staff have been informed | The assessment is that there is significant work to be undertake in this area.  The processes and procedures highlighted in **Level 1** - *There are processes and procedures for staff to follow for the creation, management, retention,  and archiving of records* Require refresh. |
| 5.2 – Information Asset Register | Level 3 - The IAR is a working document and the reporting procedure is regularly reviewed to ensure it remains effective and up to date | **Level 1** - The organisation has an extensive Information Asset Register (IAR).  The following should be noted:

Re-establish IAR performance reporting ensuring ongoing and timely review | **Level 1** - The organisation has an extensive Information Asset Register (IAR).

The current IAR is too unwieldy and work is underway to simplify it, tying it to the service catalogue, work ongoing between Digital and IG to complete this.  Aim will be to commence performance reporting during FY 2022/23. |
| 5.3 – Data Accuracy | Level 3 - All procedures are regularly reviewed and where available spot checks are made to ensure the procedures are enforced across the organisation | **Level 2** - System validation processes exist within the organisation; active steps are taken to address any systems lacking validation. The following should be noted:

Carry out spot checks in order to ensure correct procedures are being followed | **Level 1** - The importance of data accuracy is recognised by the organisation and there is supporting guidance and procedures in place to ensure information is updated when necessary.

Gain assurance that system validation does take place in all areas for FY 2022/23.

Spot checks are not currently undertaken - a piece of work that is required for FY2022/23 |

| 5.4 – Retention Schedules, Secure Destruction and Disposal | Level 3 - Such policies and guidance are regularly reviewed and regular audits are conducted  to ensure the organisation is keeping to the retention periods in practice | **Level 2** - Management of organisational records is embedded within the organisation. The following should be noted:<br><br>Establish reporting on Records Management performance to Trust forums | **Level 1** - The organisation holds retention schedules for the processing and disposal of personal data which outline different retention periods dependent on the categories of personal information.<br><br>Embedding retention schedules, destruction and secure disposal is a piece of work for FY 2022/23.  Further work in auditing the areas to achieve level 3 also required for FY 2022/23 |
|---|---|---|---|
| **Section 6 – Technical, Physical and Organisational Security Measures** | | | |
| 6.1 – Physical Security Measures | Level 3 - All reasonable steps have been taken to ensure the premises, equipment, records and other assets are physically secured. Physical security measures are subject to regular risk assessment. Supplementary policies and procedures are regularly reviewed and approved | **Level 2** - Improvements identified by the risk assessment are being made to secure the premises, equipment, records and other assets including staff. Staff are actively made aware of the policies and procedures and any updates made.  The following should be noted:<br><br>Routine audit inspection process established across the respective areas of the Trust | **Level 0** - The assessment is that **Level 1 has not been achieved** (*the Trust has policies and procedures in place addressing security of the premises and has undertaken a risk assessment on its premises to identify privacy and confidentiality risks*) whilst the Trust has policies and procedures in place addressing security of the premises, it has not "*undertaken a risk assessment on its premises to identify privacy and confidentiality risks*".  This is to be achieved via the DPIA process.  It is a task for FY 2022/23. |
| 6.3 – Organisational Measures (Training and Awareness) | Level 3 - Policies and Procedures are regularly reviewed to incorporate any changes and routine checks are made to ensure the organisation remains compliant.  The trust is able to meet 85% compliance in mandatory training  for IG?.  Compliance reports are provided? the IG training | **Level 2** - The Trust is able to meet at least 70% compliance in mandatory training and compliance levels are reported to the organisations Board.  There is a process in place to deliver IG training to temp staff, volunteers and students?.  The following should be noted:<br><br>Training programme of work strengthened in order to improve overall Trust wide training compliance | **Level 2** - The Trust is able to meet at least 70% compliance in mandatory training and compliance levels are reported to the organisations Board.  There is a process in place to deliver IG training to temp staff, volunteers and students?.  The following should be noted<br><br>The Trust achieved  83.05% in all areas. Whilst reporting is taking place accurately. Support may be required at EMB level to |

| | programme is kept under review by DPO? | | improve Trust wide attainment of level 1 mandatory training in IG. |
|---|---|---|---|
| 6.6 – Surveillance Systems | Level 3 - There is an effective review process and audit mechanisms are in place to ensure legal requirements, policies and standards are complied with in practice. Compliance reports and issues of concern are reported to the appropriate forum | The Information Governance Manager was of the opinion that: Review current Fair Processing Notices covering all respective sites as **Level 1** - *The organisation has defined policies and procedures around the use of surveillance systems in use, including CCTV on the premises, body worn recording devices and any other surveillance systems in use within the organisation* was not achieved. | **Level 0** - The assessment is that this requires a full review and that **Level 1 has not been achieved**. A meeting is planned for 28th April 22 with the relevant managers to address the issue further. |
| | | **Section 7 – Cyber Security** | |
| | This should be assessed in the organisation's individual Welsh Cyber Assurance Process (WCAP) | | Regular communication takes place between the Cyber Security Officer and HoIG to ensure that information from ICO/NCSC is shared so that as far as is possible systems are protected against known threats. |
| | | **Section 8 – Breach Management** | |
| 8.1 – Reporting Data Breaches | Level 3 -Improvements are made to reduce the chance of re-occurrence and are reported to the Board. A review process is in place to ensure the notification procedure remains relevant and works in practice | **Not assessed the previous year** | **Level 3** -Improvements are made to reduce the chance of re-occurrence and are reported to the Board. A review process is in place to ensure the notification procedure remains relevant and works in practice.<br><br>This is kept under regular review to ensure that standards are met. |

# Appendix 2 - Workplan Tables – updated 28th Apr 2022

## Table 1 – FY 2022/23 Quarterly Plan Specific Actions

| Item | Q1 2022/23 | Q2 2022/23 | Q3 2022/23 | Q4 2022/23 |
|---|---|---|---|---|
| Review time expired IG Policies/Equality Impact Assessments and republish | X | | | |
| Adapt the Information Asset Register to a more user friendly manageable document to align with the DPIA, Data Sharing Agreement/Processing Register and Contract Register | X | | | |
| Ensure that the new Information Asset Register contains a risk treatment plan presenting the plan annually to the SIRO for review | X | | | |
| Instigate a Data Processing/Sharing Agreement Register and align it with the DPIA , Information Asset and Contract Registers | X | | | |
| Create or access Contract Register and align with DPIA Register, Information Asset and Data Processing/Sharing Agreement Register | X | X | | |
| Instigate a new Data Sharing Agreement template with support from Legal and Risk within NWSSP | X | | | |
| Refresh the Data Protection Impact Assessment (DPIA) Screening Process | X | X | | |
| Review existing DPIA's in relation to legacy systems in operation across VCC to ensure that they are reviewed in line with legislation | | | X | |
| Review legacy systems in operation across VCC to ensure that where required a DPIA is in place | | | X | |
| Review existing DPIA's in relation to legacy systems in operation across WBS to ensure that they are reviewed in line with legislation | | | X | |
| Review legacy systems in operation across WBS to ensure that where required a DPIA is in place | | | X | |
| Review existing DPIA's in relation to legacy systems in place across RD&I, TCS & HTW to ensure that they are reviewed in line with legislation | | | X | |

| Item | Q1 2022/23 | Q2 2022/23 | Q3 2022/23 | Q4 2022/23 |
|---|---|---|---|---|
| Review legacy systems in operation across RD&I, TCS & HTW to ensure that where required a DPIA is in place | | | X | |
| Review existing DPIA's in relation to legacy systems in place across Corporate Departments to ensure that they are reviewed in line with legislation | | | X | |
| Review legacy systems in operation across Corporate departments to ensure that where required a DPIA is in place | | | X | |
| Oversee the creation of a risk assessment (DPIA) that addresses risks to the processing of information in all areas from physical security perspective. This DPIA should then be reviewed annually by the individual responsible for the physical security of the site. | | X | | |
| Undertake a review of all CCTV systems in operations both in vehicles and on sites to ensure that DPIA's where required are in place and kept up to date so that Risks can be identified and where necessary mitigated. | X | | | |
| Review and re-publish the Standard Operating Procedure for FOIA | X | | | |
| Clear backlog of DATIX incidents | X | | | |

**Table 2 – Business as Usual Ongoing Activity – FY 2022/23**

| Item | Financial Year 2022/23 |
|------|:---:|
| Ensure that the DPIA Register is kept maintained and aligns with the Information Asset, Data Sharing/Processing Agreement Register and Contract Register throughout the Financial Year | X |
| Ensure that the Information Asset Register continues to align with the DPIA, Data Sharing/Processing Agreement Register and Contract Register throughout the Financial Year | X |
| Ensure that the Data Processing/Sharing Agreement Register continues to align with the DPIA , Information Asset and Contract Register | X |
| Ensure that the Contract Register continues to align with DPIA Register and Data Processing/Sharing Agreement Register throughout the Financial Year | X |
| Instigate and maintain an annual review process for all DPIA's including those created since 1 Dec 21 | X |
| Instigate and maintain an IG Risk Register and use a manual version to support recording of all IG Risks on DATIX to ensure full corporate visibility throughout the Financial Year | X |
| Instigate and maintain audit of activity on a 12 month rolling basis where IG is a consideration utilsing an audit plan to ensure compliance with Data Protection Legislation | X |
| Review all privacy information (notices, posters, websites etc) within the Trust on a 12 month rolling basis to ensure that the trust is compliant with an individuals right to be informed in line with Data Protection Legislation | X |
| Deliver training, advice and guidance to business areas that may be considering the use of automatic profiling or automated decision making (Artificial Intelligence) (an emerging area of innovation) so that the Trust is compliant with Data Protection Legislation | X |
| Review the Trusts management of records in line with, UK Government and ICO Codes of Practice and NHS Wales Records Management Code of Practice for Health and Social Care 2022.  This work will involve review of the retention of records and ensure adherence to relevant codes of practice | X |
| Undertake spot checks across the Trust to ensure that data processing is accurate and compliant with Data Protection Legislation | X |

| | |
|---|---|
| Continue to deliver bespoke top up training to all staff employed by the Trust and support the attainment of 85% mandatory training in IG by all Trust staff | X |
| Maintain current Record of Processing Activity (ROPA) for all divisions of the Trust, cross referring to DPIA tracker appropropriately | X |
| Create and maintain a central register of Non-Disclosure Agreements throughout the Financial Year | X |
| Review all Subject Access Request (SAR) activity so that the Trust can be assured that it is compliant with Data Protection/FOI/EIR legislation | X |
| Continue to manage Cyber threats working closely with the Cyber Security Officer to maintain a defensive posture so that as far as is possible information processed by the Trust is compliant with the standards set out in Data Protection Legislaiton | X |
| Continue to manage breach activity in accordance with UK GDPR reporting breaches as necessary to the ICO and ensuring that the Committee are kept up to date via SIRO/EMB in respect of any incidents that may damage the Trust in any way, including regulatory, financial and repuational damage | X |
| Conduct reviews and/or investigations of DATIX incidents where IG is a factor – making recommendations and tailoring training proposals as appropriate | X |

| **QUALITY, SAFETY & PERFORMANCE COMMITTEE** |
|---|
| **2021 / 2022 QUARTER 4 PUTTING THINGS RIGHT REPORT** |

| **DATE OF MEETING** | 12th May 2022 |
|---|---|

| **PUBLIC OR PRIVATE REPORT** | Public |
|---|---|

| **IF PRIVATE PLEASE INDICATE REASON** | N/A Public Paper |
|---|---|

| **PREPARED BY** | Jade Coleman, Quality and Safety Facilitator |
|---|---|
| **PRESENTED BY** | Nigel Downes, Deputy Director of Nursing, Quality and Patient Experience |
| **EXECUTIVE SPONSOR APPROVED** | Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science |

| **REPORT PURPOSE** | FOR ASSURANCE |
|---|---|

| **COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING** | | |
|---|---|---|
| **COMMITTEE OR GROUP** | **DATE** | **OUTCOME** |
| Executive Management Board | 27/04/2022 | Discussed & Noted |

| **ACRONYMS** | |
|---|---|
| N/A | |

## 1. SITUATION

The 2021 / 2022 Quarter 4 Putting Things Right report is provided to the Quality, Safety & Performance Committee to provide a summary of concerns (complaints) and incidents received, themes and improvements made during the 1st January 2022 to the 31st March 2022. The paper provides **ASSURANCE** in relation to how the Trust is executing its responsibilities in relation to the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.

## 2. BACKGROUND

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

Velindre University NHS Trust is committed to ensuring the provision of an effective and timely process for responding to concerns. This ensures that concerns (including incidents) are appropriately investigated, and that learning takes place in order that the Trust can improve the quality and safety of its services, and the patient and donor experience.

## 3. ASSESSMENT/SUMMARY OF MATTERS FOR CONSIDERATION

The following are the key highlights as detailed within the quarter 4 report:

- 46 concerns were raised during the Quarter, 91% were graded at level 1 (low level)
- 85% of the concerns raised were managed via the Early Resolution process, with 15% of the concerns raised managed via the Putting Things Right process.
- There were no Concerns raised relating to the COVID Pandemic.
- 100% of the formal concerns raised were closed within the 30 working day timeframe, which is an increase from the previous quarter and exceeds the Welsh Government target of 75%.
- The top three themes of the concerns raised continue to be: Appointments, Communication, and clinical treatment.
- 493 incidents were raised during the Quarter – 403 from the Cancer Centre and 89 from the Welsh Blood Service.
- 97% of incidents raised were graded as no harm or low harm.
- There was 1 National Reportable Incident related to an offsite storage contractor suffering major damage to one of its storage sites and that hard copy Trust medical and non-medical records may have been adversely affected

- There were 10 incidents IRMER incidents reported to Healthcare Inspectorate Wales.
- Formal investigation training has been procured and provided during the quarter.

## 4.    IMPACT ASSESSMENT

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

## 5.    RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **CONSIDER** the 2021 / 2022 Quarter 4 Putting Things Right Report.

# Putting Things Right Report

## Quarter 4 2021/2022

*Learn it Lead it Live it*

LEARN TODAY FOR A BETTER TOMORROW

## Contents

| Section | Topic | Page |
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| 2 | Incidents | 12 |
| 5 | Conclusion | 20 |
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| Appendix 2 | Trust Concerns Pledge | 22 |

## Acronyms

| VCC | Velindre Cancer Centre |
|---|---|
| WBS | Welsh Blood Service |
| SLT | Senior Leadership Team |
| Q&S | Quality and Safety |

**Executive Summary**

This is the Trust's Quarterly Putting Things Right report where the concerns raised and incidents reported during the Quarter are presented within one overarching report. Due to sensitivities, a separate claims and redress report will continue to be presented. This Quarter 4 report reflects the period 1st January 2022 to 31st March 2022. The key messages / highlights are:

- 46 concerns were raised during the Quarter, 91% of which were graded at level 1

- 85% of the concerns raised were managed via the Early Resolution process, with 15% of the concerns raised managed via the Putting Things Right process.

- There were no Concerns relating to the COVID Pandemic reported.

- 100% of the formal concerns raised were closed within the 30 working day timeframe, which is an increase from the previous quarter and exceeds the Welsh Government target of 75%.

- The top three themes of the concerns raised continue to be: Appointments, Communication, and clinical treatment.

- 493 incidents were raised during the Quarter – 403 from the Cancer Centre and 89 from the Welsh Blood Service.

- 97% of incidents raised were graded as no harm or low harm.

- There was 1 National Reportable Incident related to an offsite storage contractor suffering major damage to one of its storage sites and that hard copy Trust medical and non-medical records may have been adversely affected

- There were 10 incidents IRMER incidents reported to Healthcare Inspectorate Wales.


    The report is presented in two parts:

- Part 1: Concerns, which are presented under the heading of the Trust's Concerns Pledge which can be viewed in *Appendix 1*
- Part 2: Incidents for the Velindre Cancer Centre and Welsh Blood Service

# 1. CONCERNS RECEIVED IN QUARTER 4

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

**46** concerns were received by the Trust during Quarter 4. The below pie charts outline where in the Trust the concerns originated, including a further breakdown of Concerns for each location:
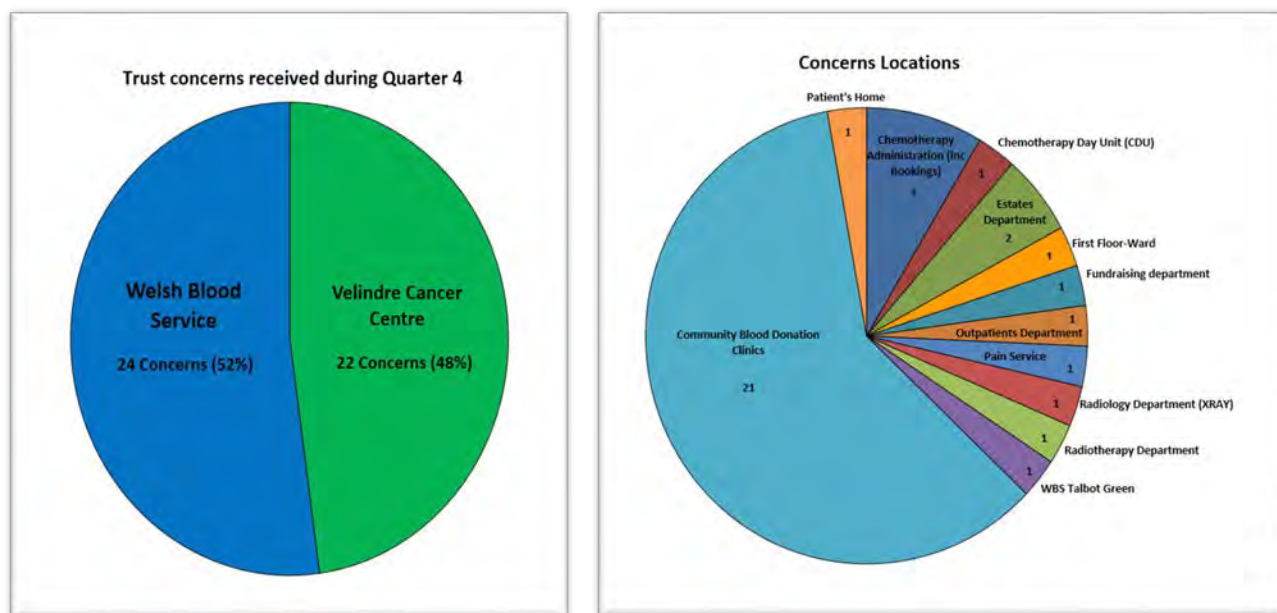


The overall number of concerns raised across the Trust during the quarter was consistent with previous quarters. However, the breakdown across the divisions changed with the Velindre Cancer Centre concerns increasing by 7 and the Welsh Blood Service concerns slightly decreasing by 4. A comparative chart is provided below which displays the Concerns numbers raised within each area of the Trust over each quarter of 2021/2022.
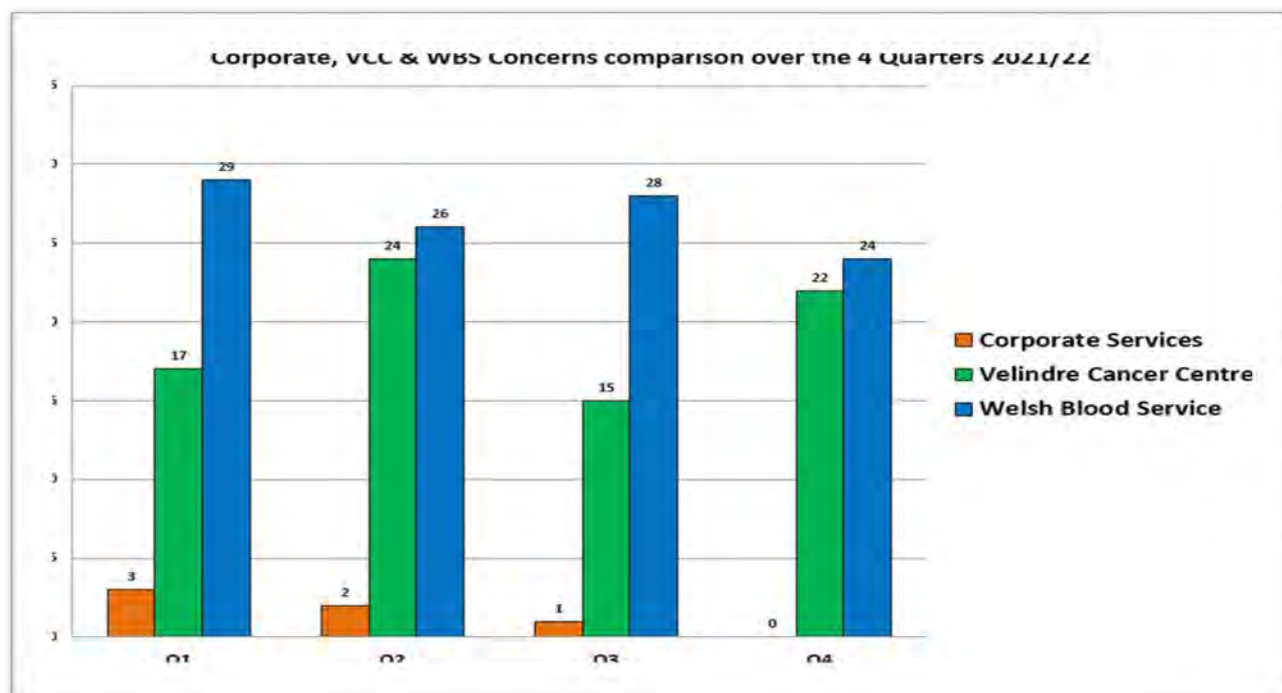
## 1.1 Method of receipt for concerns received in Quarter 4
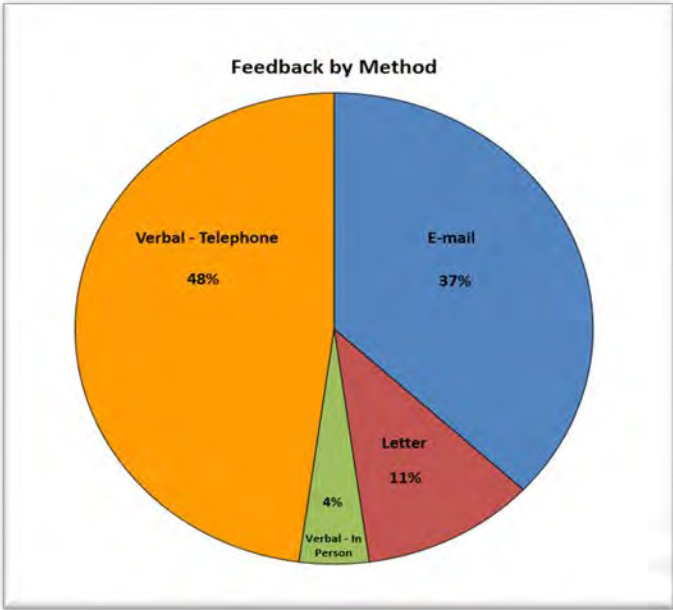


**48%** of Trust concerns were received via Telephone. This has demonstrated a switch in the preferred contact method being used during Quarter 4. Throughout the Covid pandemic, the adopted method for reporting Concerns has mainly been via email, however with Trust employees recently returning to the workplace on a more regular basis following the easing of Covid restrictions, it suggests that staff members are more readily available to take complaints via telephone.

The below bar chart displays the numbers relating to the preferred contact method for Velindre Cancer Centre and the Welsh Blood Service. Whilst the majority of Welsh Blood Service Concerns are received via email, there are equally high numbers for both Divisions via Telephone contact.
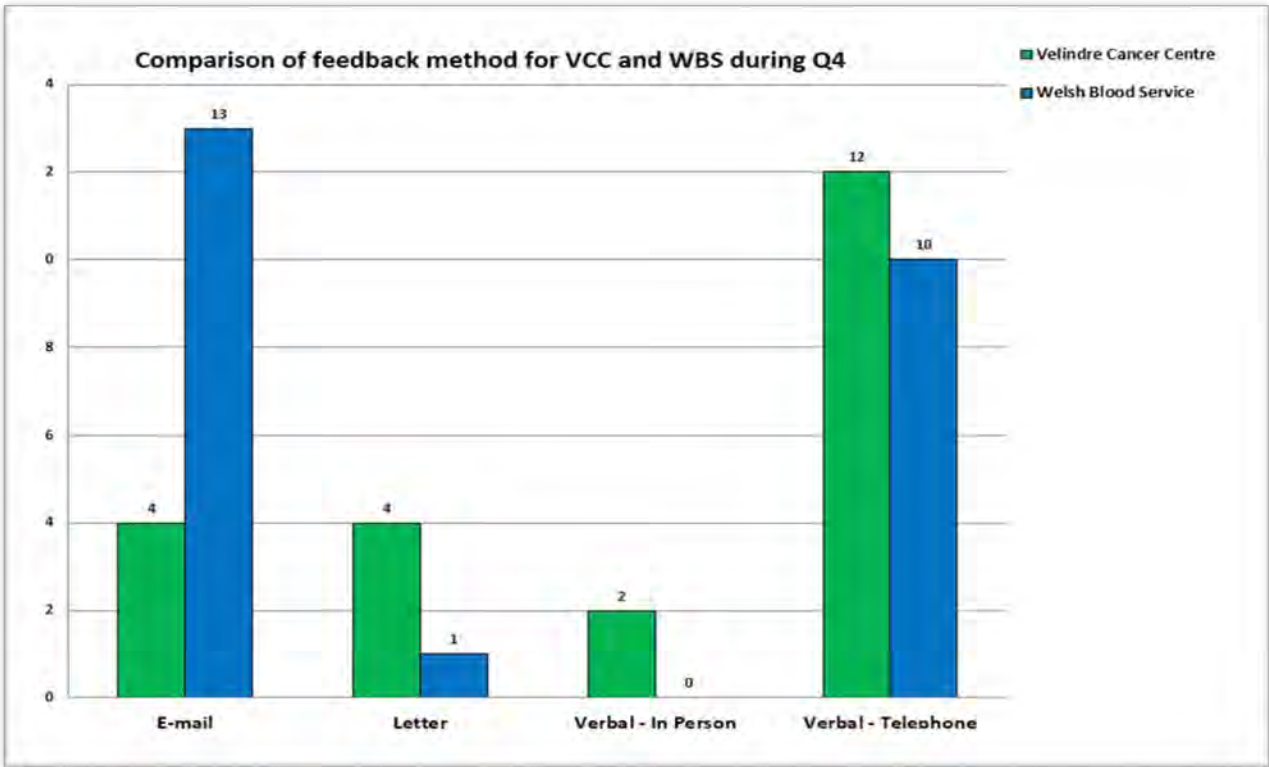


## 1.2. Thematic review of the concerns received in Quarter 4

Of the 46 reported concerns received **22** were received by Velindre Cancer Centre and **24** received by Welsh Blood Service. The below charts display common themes recognised for Concerns received within each Division. Divisional themes have been separated for the purpose of this report:

## 1.2.1 Velindre Cancer Centre



**Velindre Cancer Centre Concern Themes**

| Appointments | Attitude and Behaviour | Clinical Treatment/Assessment | Communication Issues (including Language) | Environment/Facilities | Other |
|---|---|---|---|---|---|
| 8 | 1 | 7 | 3 | 1 | 2 |
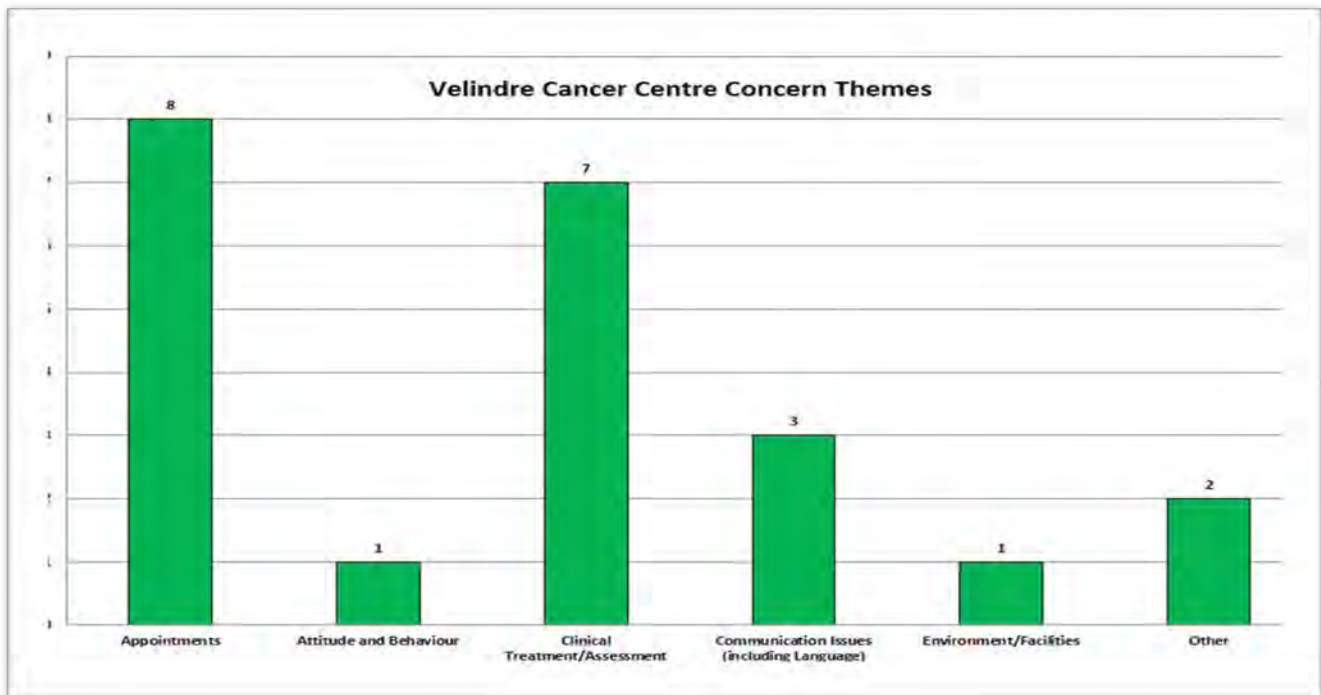
During Quarter 4, appointment related concerns remain one of the highest reported at Velindre Cancer Centre. Velindre Cancer Centre have recognised that these types of concerns are closely linked to the communication aspect of patient care, with some patients raising concerns regarding appointment delays and lack of communication for follow up appointments, including why appointments have been cancelled or re-scheduled at short notice.

During the quarter the number of Velindre Cancer Centre concerns relating to attitude and behaviour has reduced considerably. There was one this quarter compared with five in quarter 3.

Two Velindre Cancer Centre concerns were not recorded under a specific reporting category and catergorised under the title of "other". One related to the attitude of a raffle ticket seller who was fundraising. An immediate apology was offered to the member of public who had politely declined to purchase a raffle ticket and the concern managed as an 'early resolution; the other related to the new speed bumps that have been introduced as you drive around to the radiotherapy entrance at Velindre Cancer Centre which has caused issues for Prostate Cancer patients. As a result of this concern the speed bumps have been widened reducing impact on patients having to drive over the speed bumps.

The below chart provides a breakdown of the top 5 areas of concern raised in relation reported to Velindre Cancer Centre during the quarter. Following a review of these concerns the Cancer Centre have initiated an improvement project to look at the SACT booking centre processes which will ensure patients are offered a choice of video or telephone virtual clinics, and the offer of a face to face clinic appointment when there is a clinical need and Covid guidelines allow this to happen. The Improvement Project is also reviewing the process around booking clinic appointments following MRI and CT scans.

Velindre Cancer Centre Top 5 Concern areas
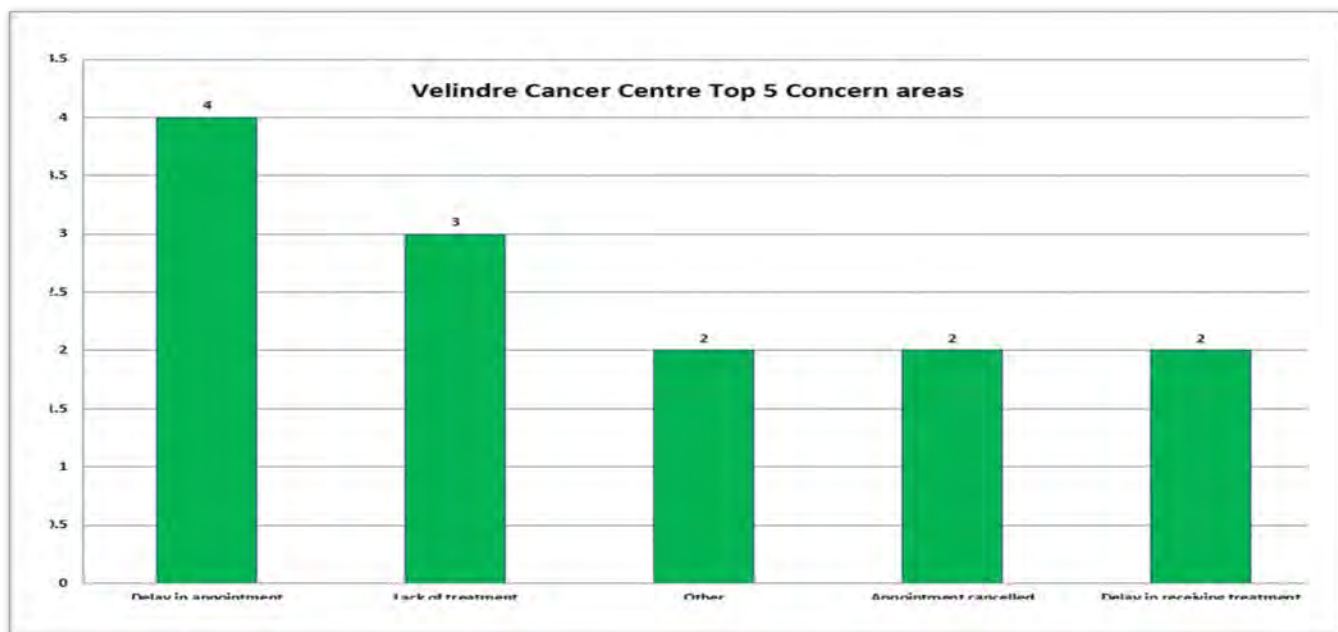
### 1.2.2 Welsh Blood Service

Welsh Blood Service complaints remain low in number considering the service has approximately 6,500 donor contacts. The majority of Welsh Blood concerns were managed as Early Resolutions and overall donor satisfaction continues to exceed target.

Attitude and behaviour is a recurring theme at the Welsh Blood Service and remains the highest reported concern raised during the quarter. The total number of Concerns received relating to attitude and behaviour increased from 6 in Quarter 3 to 9 in quarter 4.



Welsh Blood Service Concern Themes
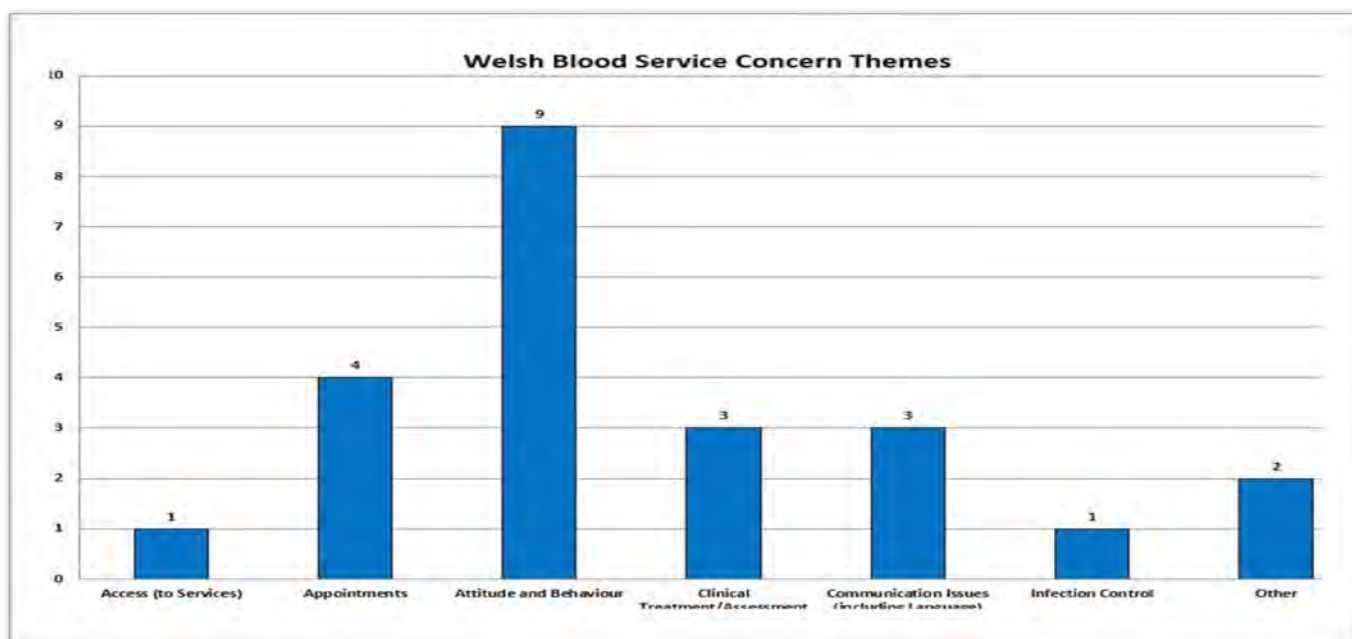
The below chart further displays the breakdown of the top 5 Concern areas that have been reported to Welsh Blood Service during Quarter 4. Following a review of these concerns a number of measures have been put in place to efficiently resolve complaints made relating to attitude and behaviour, including, a Clinic Lead, Registered Nurse being available to support staff members and identify areas of concern. Advising senior staff members of situations as they arise and Clinic Registered Nurses being asked to address all actions following concerns raised with team members and in addition develop action plans that coincide with ongoing monitoring of situations.

7

Welsh Blood Service Top 5 Concern areas
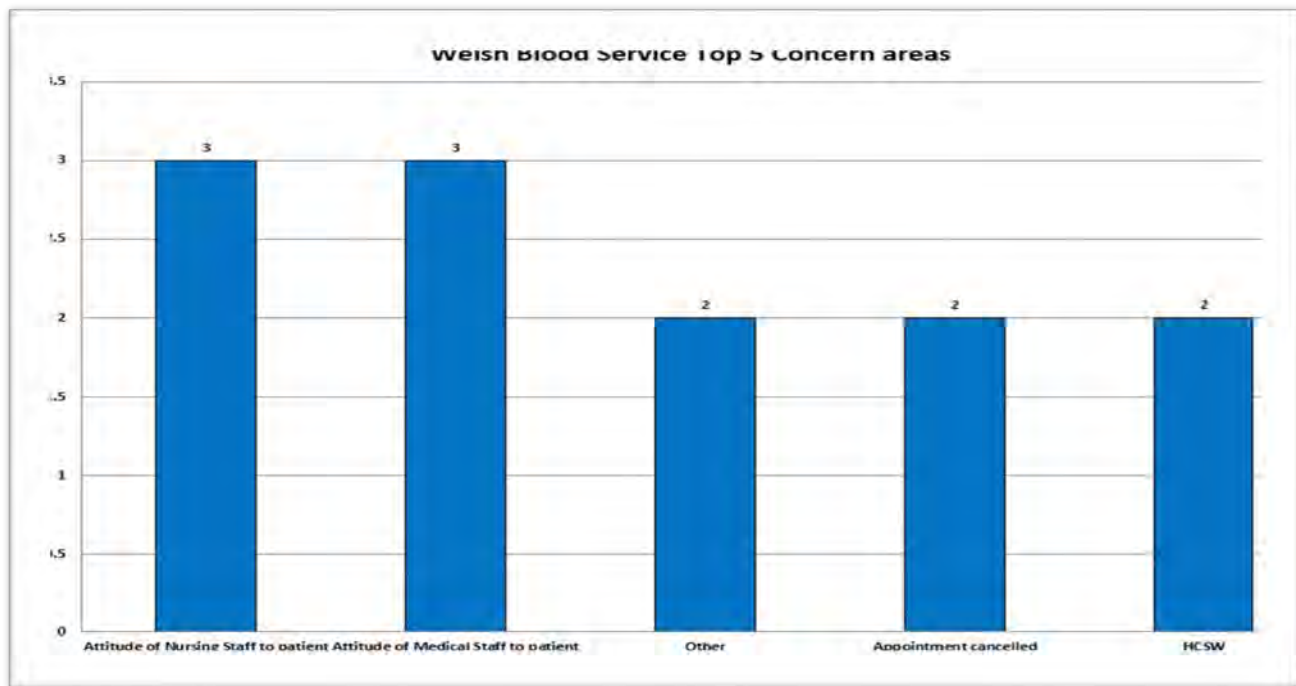
*1.3 COVID related concerns*

There were no Covid related concerns reported during Quarter 4 for the Trust and this is a reduction in numbers following the last two quarters.

## 1.4 Concerns investigated and closed during the Quarter

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

All Trust concerns raised during Quarter 4 were closed during the same Quarter. 85% were closed as an Early Resolution, and 15% under the Putting Things Right regulations.

The percentage of complaints resolved as early resolution increased by 12% from that recorded in Quarter 3. This is partly due to robust handling Concerns processes implemented within each Division and supported by a dedicated complaints managers at the Cancer Centre and Welsh Blood Service. Strong communication channels between Corporate, Velindre Cancer Centre and Welsh Blood Service ensure we continue to drive early resolutions for Concerns at source. Efficient initial reviews of concerns enable each Division to swiftly resolve concerns received and deciding quickly whether a Putting Things Right investigation is required. Clear defined roles and responsibilities have essentially created a strong link between the Corporate Quality & Safety Team, Velindre Cancer Centre and Welsh Blood Service during Quarter 4.

The below pie charts display data captured for Concerns closed during Quarter 4, it is evident that not only all Concerns raised during the quarter were subsequently closed within 30 days, but, a further 4 Concerns which were raised prior to Quarter 4 were also closed down within Datix.

8

**Concerns opened *and* closed during Quarter 4**

6 managed through PTR (15%)

33 resolved as Early Resolution (85%)

**Total Concerns closed during Quarter 4**

8 managed through PTR (19%)

35 resolved as Early Resolution (81%)
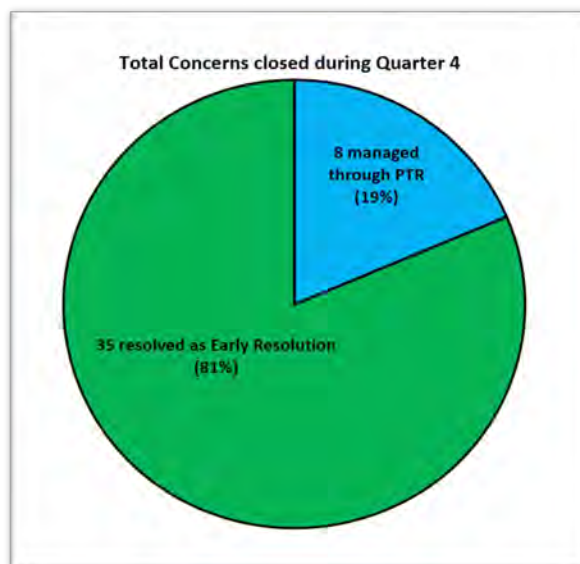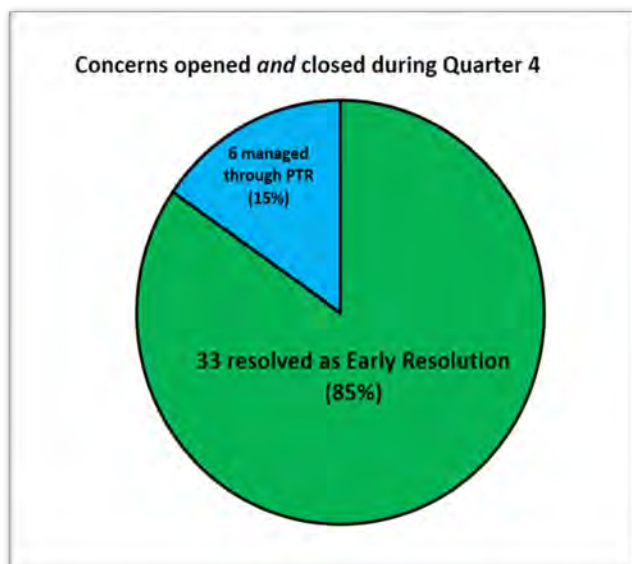
## 1.5 Level of investigations undertaken

<table>
<tr>
<td></td>
<td>*Concerns will be assessed to determine the level of investigation required*<br>*Undertake robust investigations by trained staff*<br>*Being open and transparent throughout the investigation*</td>
</tr>
<tr>
<td></td>
<td>*Provide an apology where required and confirm what has been done to Put Things Right*<br>*Redress will be considered where appropriate*<br>*Offer concerns meetings and details of the Public Services Ombudsman Wales*</td>
</tr>
</table>

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

All concerns are graded upon receipt and the Complaints grading table is included as **Appendix 1** in this report. During the Quarter 83% of all concerns were graded as level 1, 7% as grade 2 and 2 (4%) of concerns were graded at a level 3.

Wherever possible, all Trust concerns graded as level 1 should be resolved as an Early Resolution. During the quarter 38 concerns were graded as level 1 and 35 concerns were resolved as an Early Resolution, suggesting 92% of grade 1 concerns were resolved within 2 working days via the Early Resolution process.

**Initial grading of complaint on receipt**
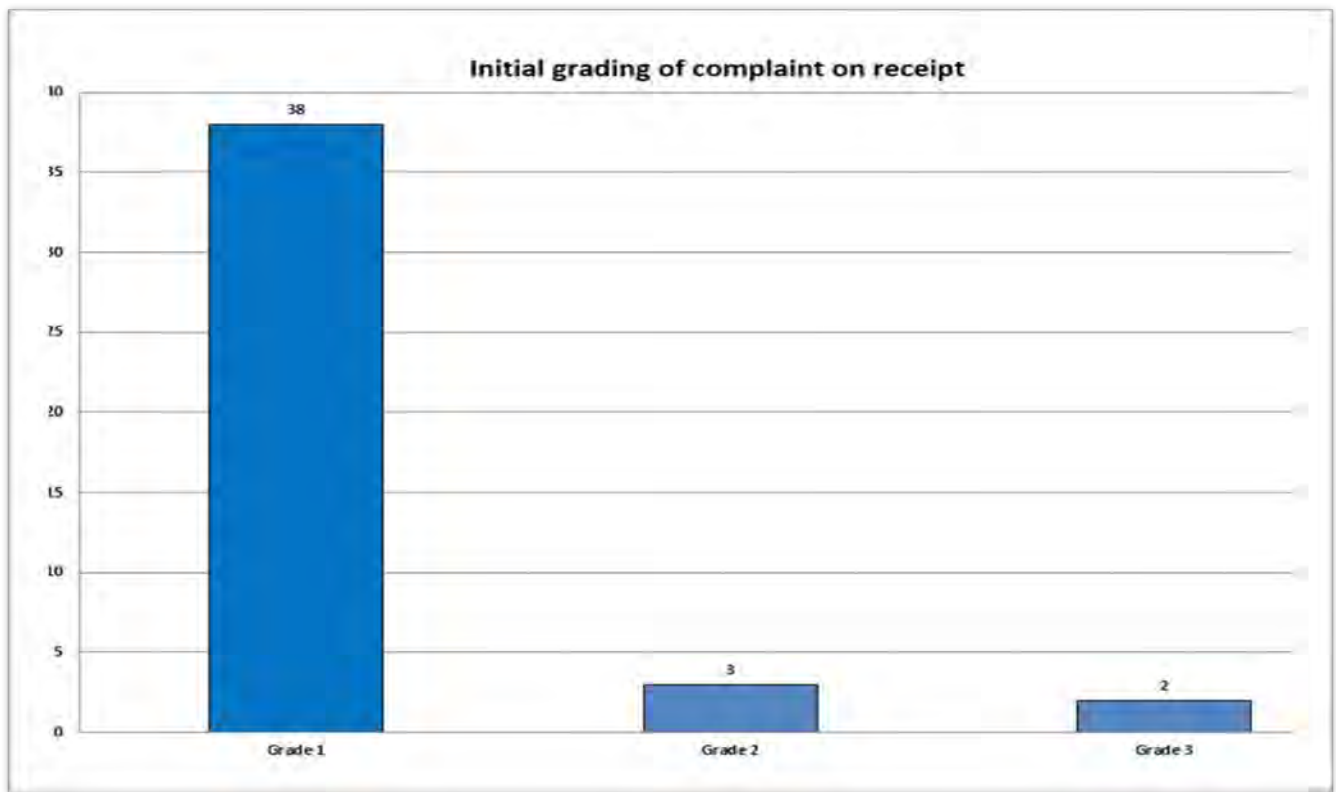


As the below bar charts display, following completion of all Quarter 4 investigations, the Welsh Blood Service recorded only Grade 1 Concerns, and Velindre Cancer Centre reported 19 Grade 1 Concerns, 1 Grade 2 concern with 2 Putting Things Right Grade 3 concerns being downgraded following the investigation outcomes.

**Complaint grading at outcome by Location**
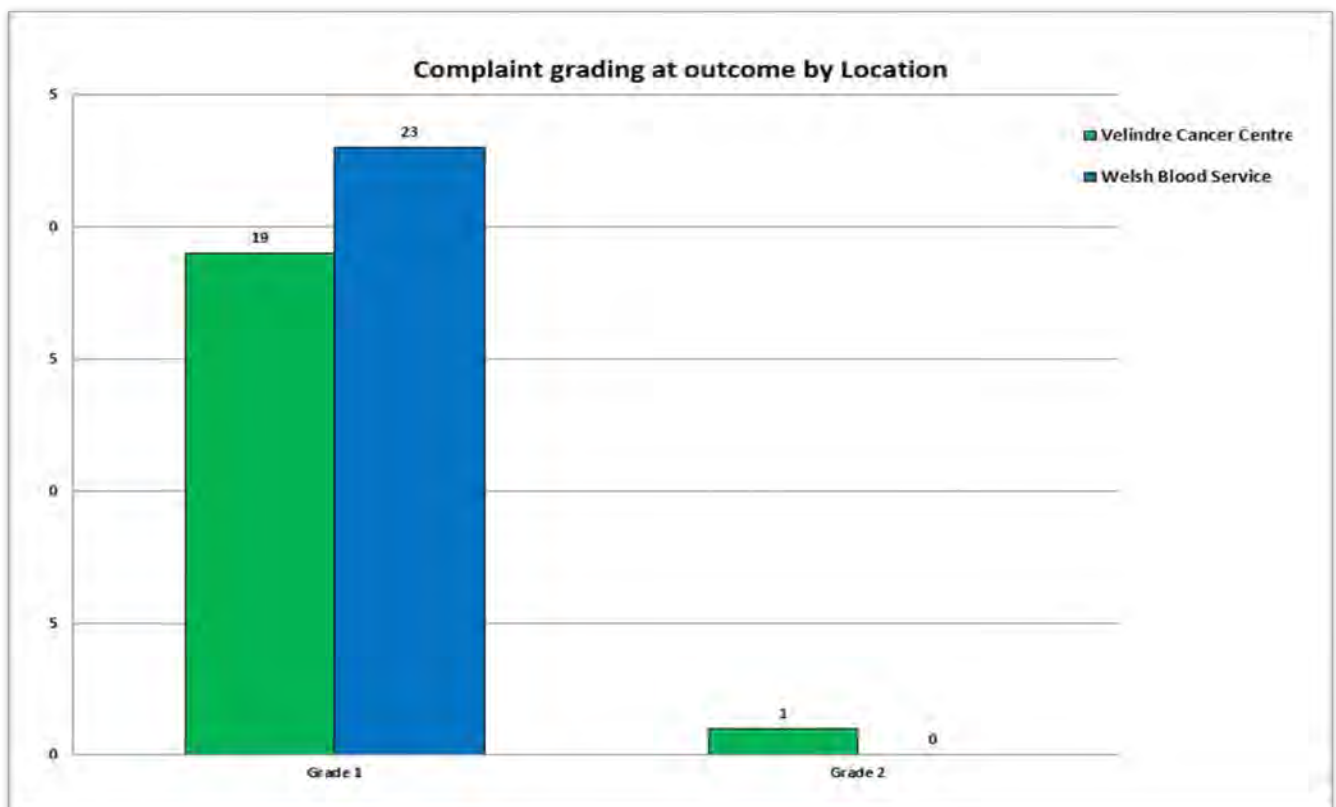
## 1.6 Quality of investigations undertaken

*1.6.1 Public Service Ombudsman:* During the Quarter:
- The Trust received 2 new Ombudsman cases
- There was 1 Ombudsman case closed
- There were 5 ombudsman cases under investigation (case information below):

  o **Case 1**: Relating to the delay in Trust response following initial concerns raised. This case has been subsequently closed following a deadline date for formal response being agreed with the Ombudsman.

  o **Case 2:** Relating to lack of communication with patient and family when multiple Health Boards and multi-disciplinary teams are involved.

  o **Case 3:** Relating to a failure to discuss prognosis and incorrect information provided for the suitability of different drug treatment. The final report from the Ombudsman is anticipated.

  o **Case 4**: Related to the transfer and time management of a patient from Velindre to Cardiff and Vale Health Board. The Ombudsman investigation is underway.

  o **Case 5**: Relating to a failure to communicate essential information to the medical practice which impacted on the last days of life for the patient; communication issues with the family; and, the postponement of treatment.

## 1.7 Learning

| | *Identify and implement learning from concerns raised*<br>*Updating patients and donors as to how learning has improved services* |
|---|---|

Through the investigation and management of concerns, the Trust continues to closely monitor every concern that is received which helps to identify areas for service improvement. The Divisions have mechanisms in place to share learning from complaints, and for monitoring the implementation of recommendations and actions. Work continues across both Divisions to better understand the feedback being received in relation to attitude and behavior and the treatment that patients receive. Work continues to review the access to clinical treatment to ensure timely access and equitable care.

| **Velindre Cancer Centre** |
|---|
| During the quarter an improvement project to look at SACT booking centre processes has been implemented. Patients are offered a choice of in video or telephone virtual clinics and the offer of face to face clinic appointments when there is a clinical need and Covid guidelines allow. Velindre Cancer Centre are also reviewing the process around booking clinic appointments following MRI and CT scans. |
| Following a concern raised relating to the newly introduced speed bumps as patients drive around to Radiotherapy, the speed bumps have been widened reducing the impact on Prostate Cancer patients and placement of speed bumps will be a consideration for future similar requirements and decisions. |

| |
|---|
| As a result of lack of communication and patient involvement in care decisions, it has been identified in some cases that patients are at need of increased support from key workers, these patients are identified and contact person agreed. |
| An overall theme is poor communication, with patients and relatives querying delays in appointments and delays in treatment. The VCC Quality and Safety Manager is completing work alongside the improvement project to fully understand delays in required appointments. |
| **Welsh Blood Service** |
| In relation to attitude and behaviour, Clinic Lead Registered Nurses are available to support staff members and identify areas of concern within WBS, senior staff members have been made aware of the situation. Clinic Registered Nurses are advised to address all actions with team members and monitor the situation. |
| Risk assessments are being undertaken to address the current Covid guideline permits for the North Wales 3 bed blood mobile. |
| Continued support is offered from the clinic lead registered nurse to give full explanations on current Joint Professional Advisory Committee (JPAC) guidelines for assisting donors in relation to social distancing measures whilst on session. |

## 2. QUARTER 4 INCIDENTS

493 incidents were reported during Quarter 4. This is an increase in incidents reported across the Trust from Quarter 3, where 468 were recorded, resulting in approximately 5% increase overall. A further breakdown is provided throughout the report and looks specifically at Velindre Cancer Centre and Welsh Blood Service Incident data.



Quarter 4 Trust Incidents
Corporate Services (1)
Welsh Blood Service 89 (18%)
Velindre Cancer Centre 403 (82%)
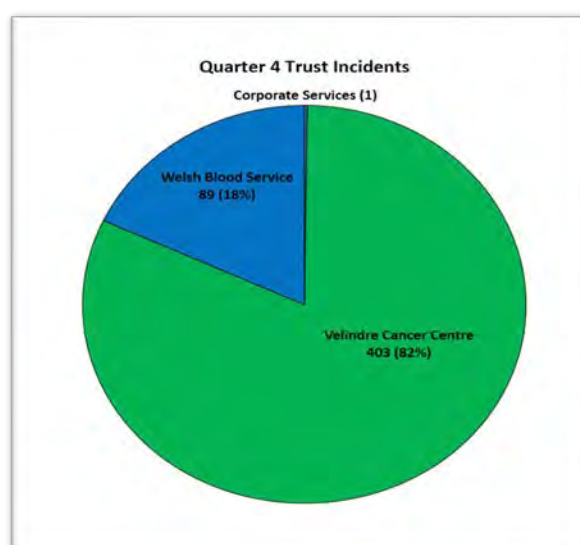
### 2.1 Nationally reportable Incidents (replaced Serious Incidents in June 2021)

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

### 2.2 Early warning notifications (replaced 'No Surprises' in June 2021)

There were no Early Warning Notifications submitted to Welsh Government.

## 2.3 IRMER Incidents reported to Healthcare Inspectorate Wales (HIW)

There were 10 IRMER related incidents reported to HIW during the quarter. All were no or low harm but met the reporting classifications. There had been a delay in a number of these being identified as reaching the threshold for reporting which is why this is showing as a significant increase. The radiation services department has subsequently undertaken a full review of its incident and reporting arrangements in order to ensure that all reportable incidents are identified and reported within the required timescales.

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

## 2.4 Regulatory Incidents

There were no regulatory incidents reported during the quarter.

## 2.5 Velindre Cancer Service Incidents

403 Incidents were recorded relating to Velindre Cancer Service. The graph below also includes the number of corporate related incidents and displays comparative data over the four Quarters during 2021/22. Generally, the number of incidents being reported remains stable, however, Quarter 4 has seen the highest number of incidents reported for the year for the Cancer Centre. The below graph displays incident figures from the 1st April 2021 – 31st March 2022.
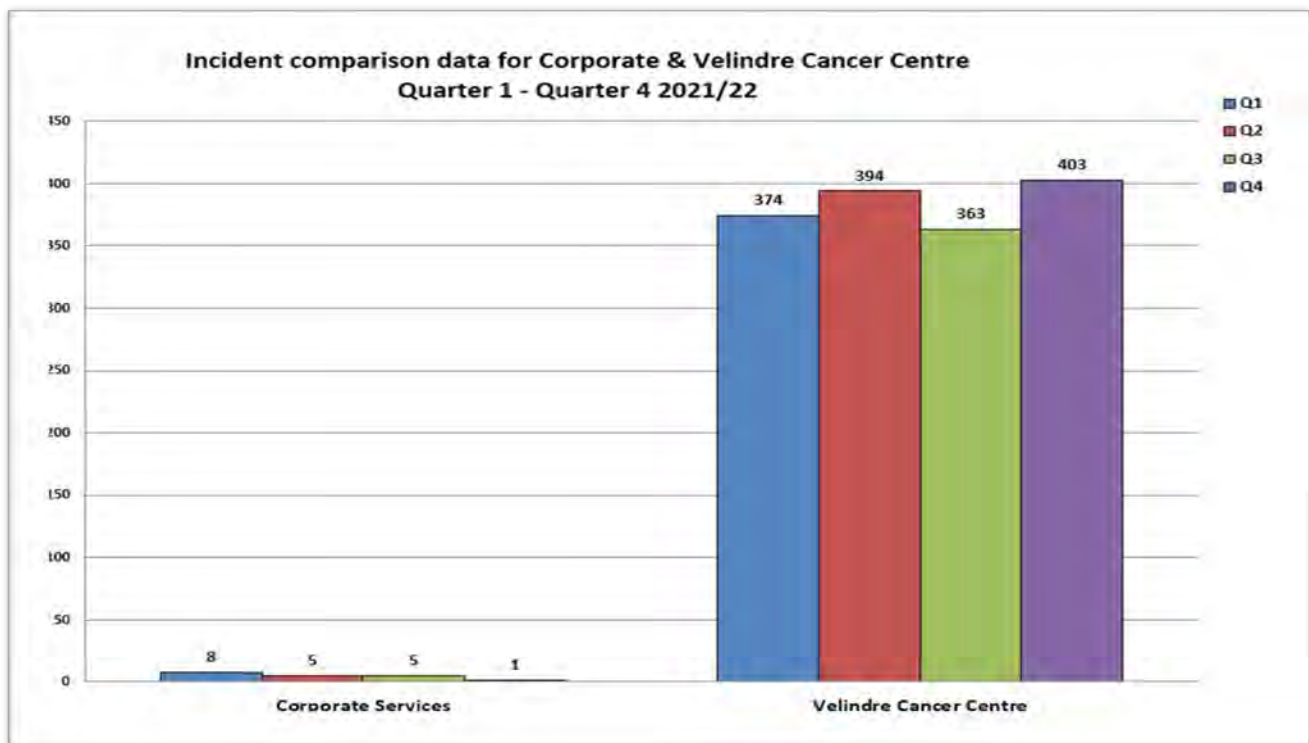


The below bar chart displays the specific location at Velindre Cancer Centre where incidents are recorded. The Radiotherapy department remains the area where the highest number of incidents are reported. These incidents relate to equipment and procedural treatments that are carried out at Radiotherapy on a daily basis. Senior leaders at the Cancer Centre recognise there is much work and improvement needed in this area and have appointed an

interim radiotherapy service manager to focus on the improvement areas. Datix training and investigation training has been organised for the Team with improvement plans, outcomes and anticipated deviations being reported back to the Quality, Safety and Performance Committee. Work continues within Radiotherapy to try and decrease the amount of incidents reported within the department.



Velindre Cancer Centre - Incident location
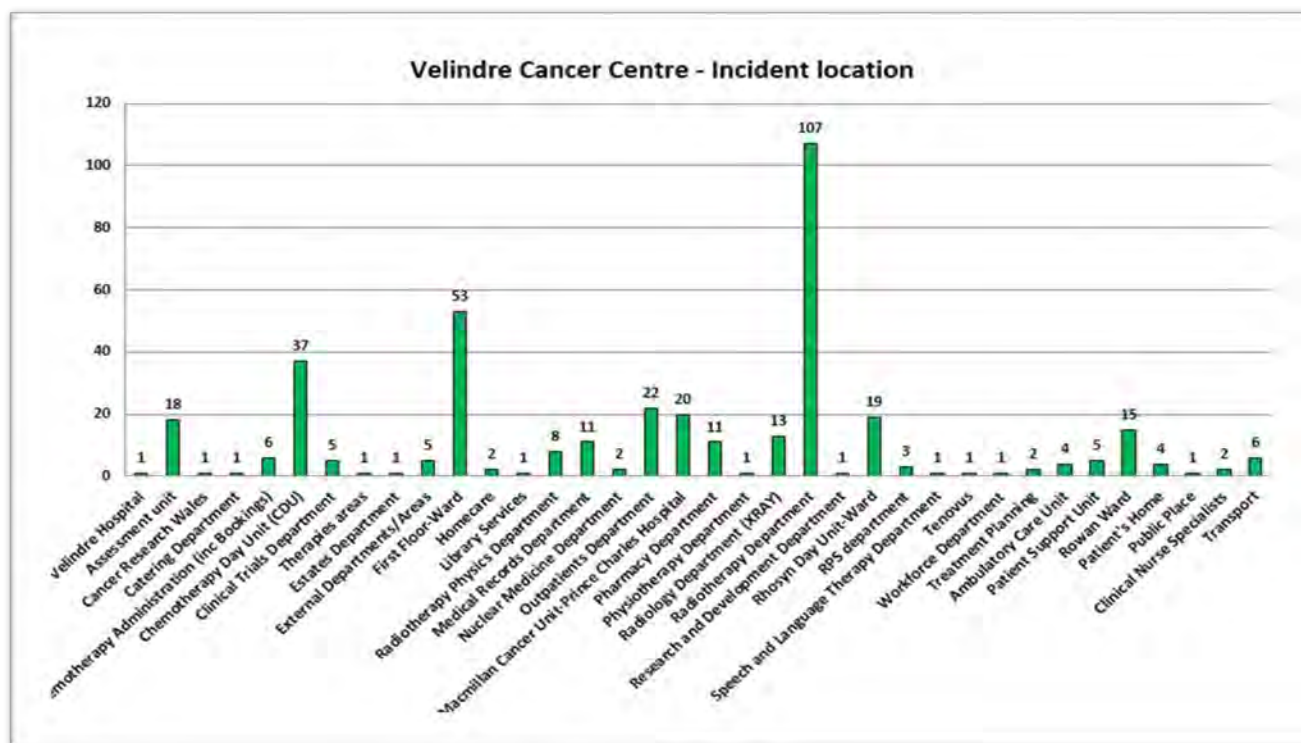
A Further breakdown and key themes of the number of incidents raised during Quarter 4 are shown below:



Velindre Cancer Centre Incident Type
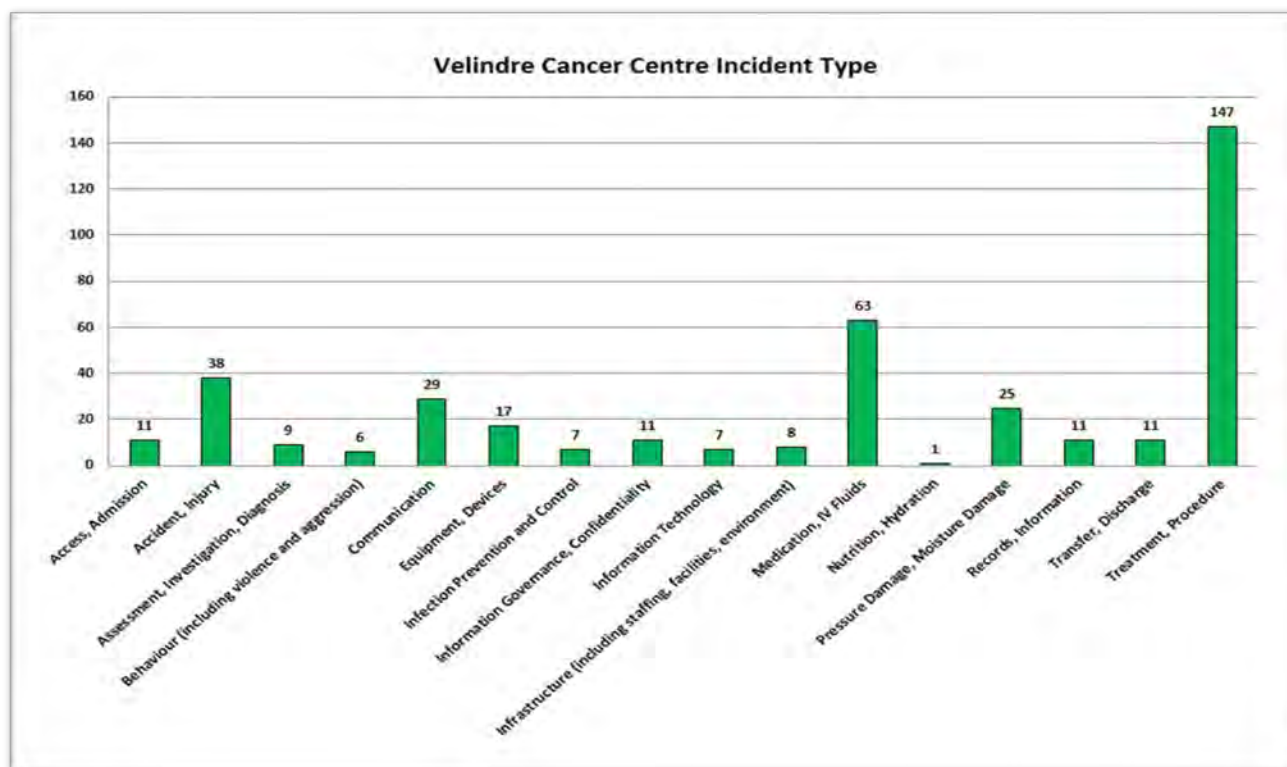
The highest number of reported incidents relate to procedures and treatments received at Velindre Cancer Centre. The below graph displays a breakdown of the highest numbers of

incidents reported, once again evident that Radiotherapy record the most incidents during the Quarter.



**Velindre Cancer Centre Top 10 Incident Types**
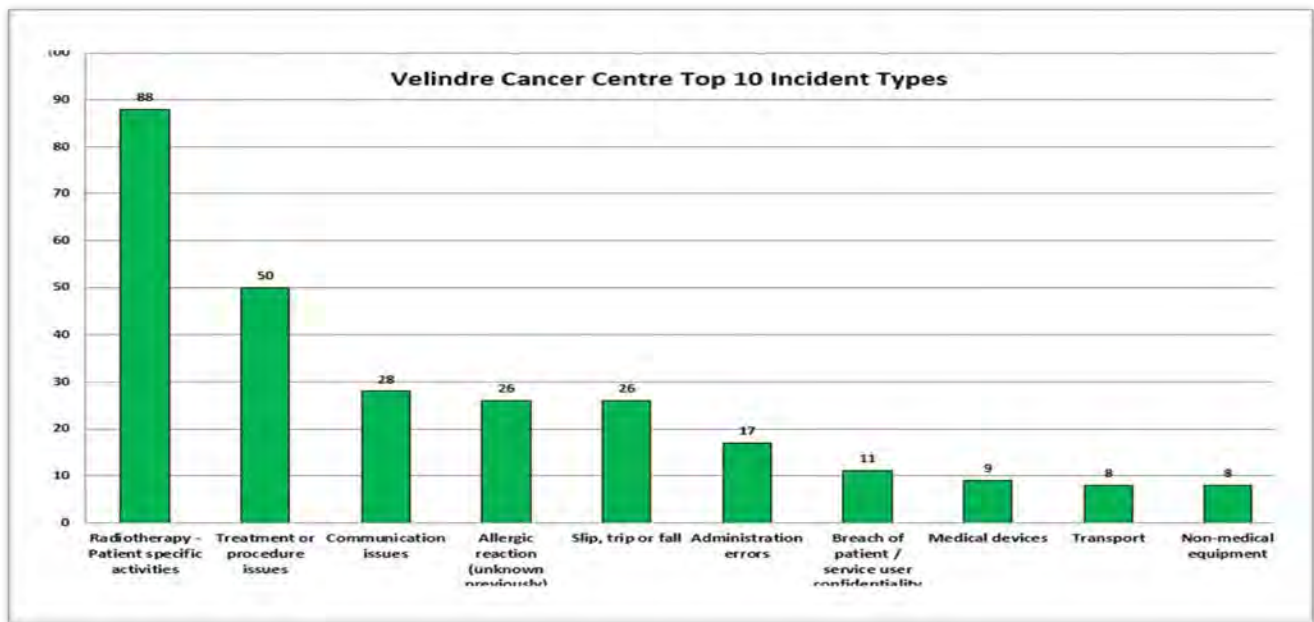
## 2.6 Welsh Blood Service

89 Incidents were recorded relating to Welsh Blood Service during Quarter 4. The below bar chart shows that the number of incidents reported at the Welsh Blood Service have fluctuated throughout the year, with Quarter 4 resulting in what seems to be a steady decrease in incidents reported. This is due to a reduction in clip incidents, heat seal failures and weigher shaker issues. The graph displays incident figures from the 1st April 2021 – 31st March 2022.



Incident comparison data for Welsh Blood Service Quarter 1 - Quarter 4 2021/22
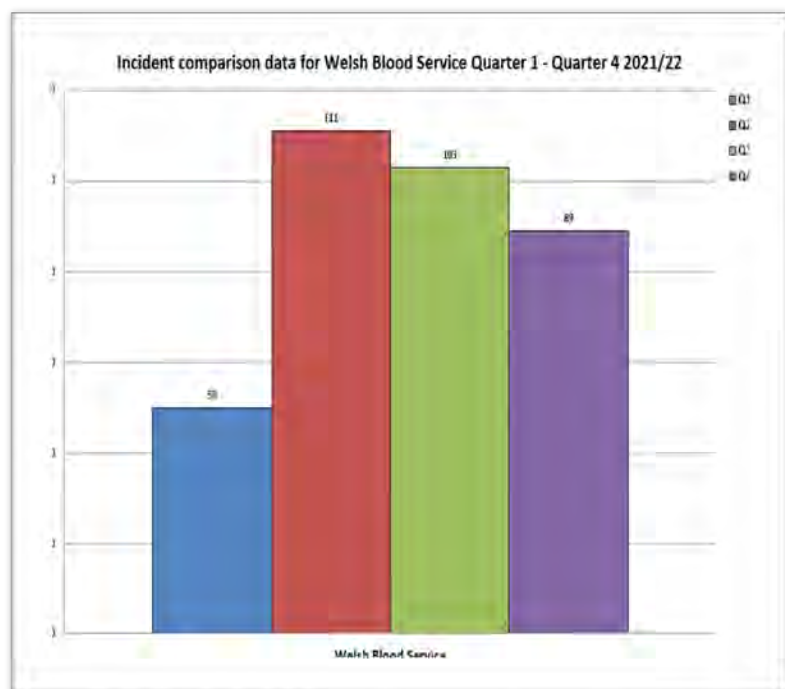
Equipment and device related incidents continue to be the highest number of incidents reported for the Welsh Blood Service, with 52 incidents out of 89 being recorded at community base blood donation clinics. This makes up 58% overall Welsh Blood Service Incidents being reported at Community based donation clinics and, 42% of incidents being linked to Equipment and Devices. A further breakdown of incident types are included in the below bar charts.

**Welsh Blood Service - Incident location**

Bar chart showing incident counts by location:
- WBS Talbot Green: 11
- Community Blood Donation Clinics: 52
- WBS Pembroke House: 4
- WBS Bangor: 1

**Welsh Blood Service Incident Type**

Bar chart showing incident counts by type:
- Accident, Injury: 12
- Assessment, Investigation, Diagnosis: 15
- Behaviour (including violence and aggression): 9
- Communication: 1
- Equipment, Devices: 37
- Ill health (work related): 2
- Infection Prevention and Control: 1
- Information Governance, Confidentiality: 2
- Information Technology: 1
- Infrastructure (including staffing, facilities, environment): 3
- Records, Information: 1
- Treatment, Procedure: 5

The below chart shows the difference in numbers recorded for the top 10 incident types for Welsh Blood Service. Medical Device incidents remain a consistent theme for Welsh Blood and relate to Centrifuge failures and other equipment failures. Senior leaders and team members are fully aware of the issues with Medical Devices and can specify that the incidents are linked to the collection of blood where an electronic process requires a blood bag to be clamped and then tilted back and forth. If the clamp on the bags does not clip on correctly it may result in an overweight bag. Clip incidents relate to a manual process carried out by a member of staff. As a result, staff member techniques are monitored and if the same staff member has 3 tolerance breaches within a month there is an intervention and review of that person's competency.

16

The Welsh Blood Service have a low tolerance for breaches and bleed 7000 units a month with a total of 20 as the maximum tolerance level. Clips incidents are within normal process variation and continued to be monitored to ensure no variance in activity.
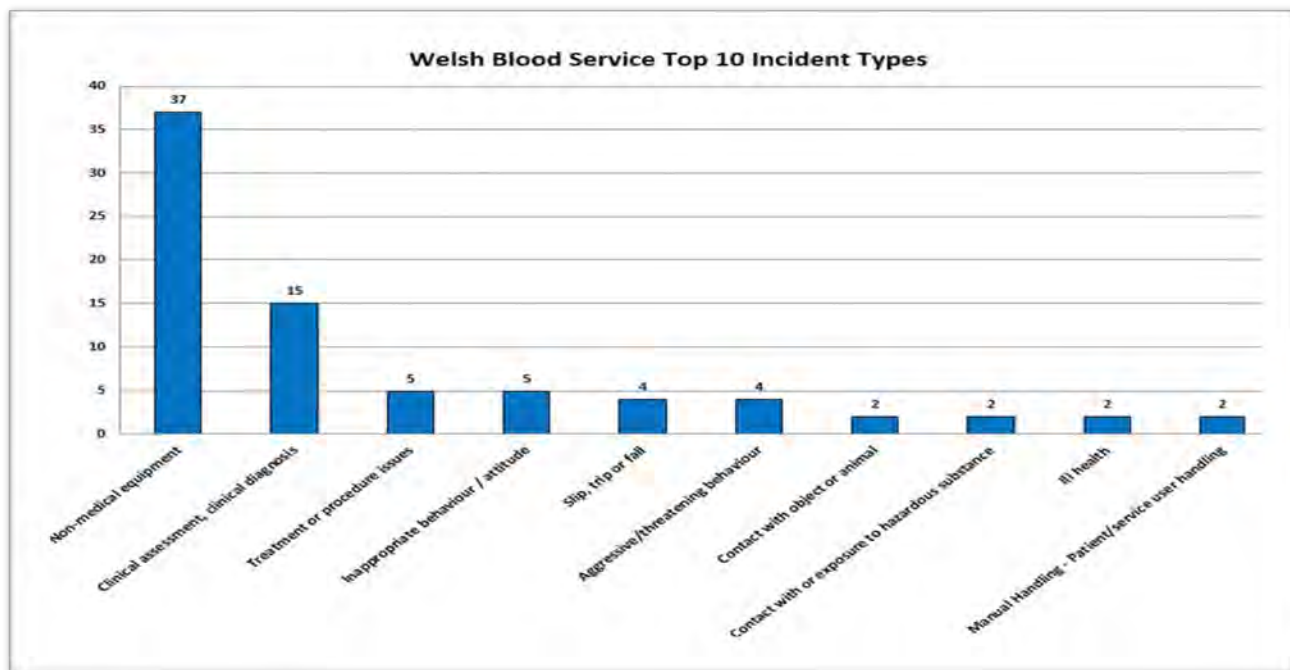


*2.7 COVID related incidents*

There were 20 incidents recorded that related to Covid during Quarter 4. These included: staff members and patients testing positive for Coronavirus; Covid related sickness absence impacting staffing levels and availability; and the attitude and behaviour toward Covid rules i.e. mask wearing. Only 2 out of the 20 Covid related incidents were reported by the Welsh Blood Service and both related to staffing issues and blood donation clinic cover.
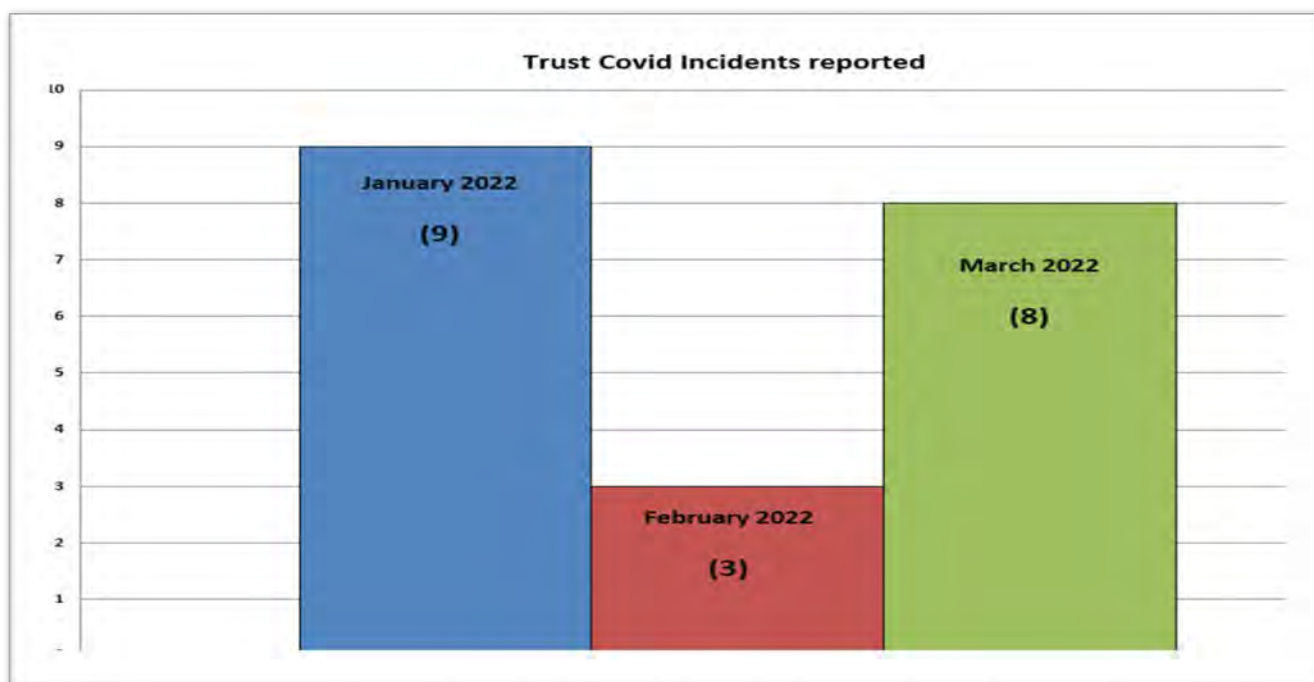
## 2.8 Incident severity

The majority of incidents reported caused low or no harm (97%, increase on Quarter 3) which is a consistent theme for the Trust. Quarter 4 saw no severe incidents reported, however a number of moderate incidents were reported and consisted of,

**VCC:** treatment related incidents and 1 patient developing pressure ulcer damage to the skin whilst being treated at VCC.

**WBS:** donor reactions (feeling unwell) following blood donation and incorrect email address being used.
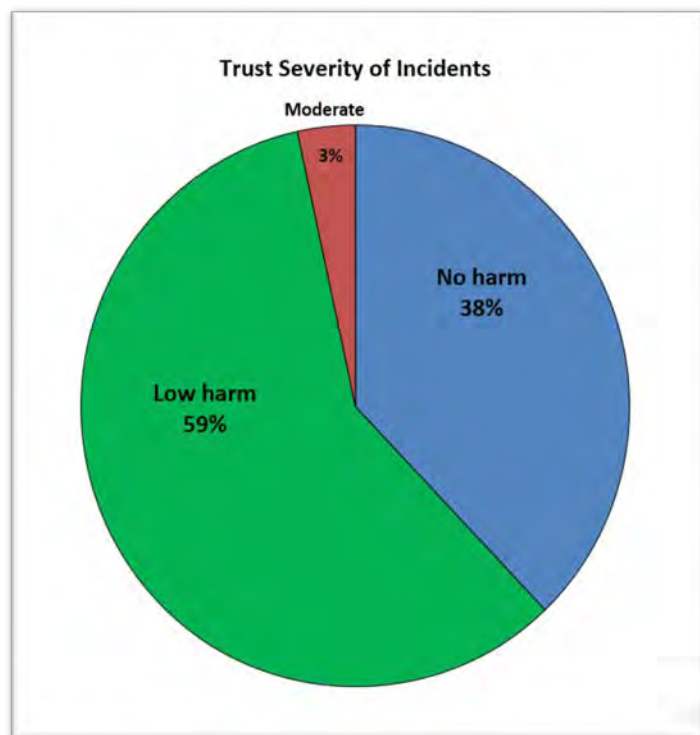


## 2.9 Closed incidents during the Quarter

### 2.9.1 Incidents closed within 30 days

The Trust requires 80% of incidents to be investigated and closed on the Datix system within 30 days. 179 incidents were closed within the Quarter, 123 of which, were closed for Velindre Cancer Centre and 56 incidents were closed relating to the Welsh Blood Service.

Overall, during Quarter 4, Trust compliance exceeded the 80% target and recorded 81% of Trust incidents being closed within 30 days. The longest open incident recorded for the period was 55 days.
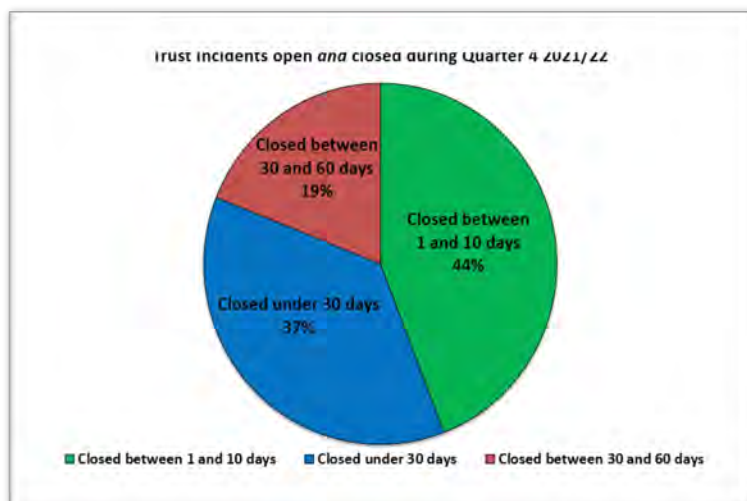
The below pie charts specifies the percentage of how many incidents were opened *and* closed during Quarter 4 for Velindre Cancer Centre and Welsh Blood Service. The Velindre Cancer Centre closed 77% of their incidents within 30 days and Welsh Blood Service closing 89% of their incidents within 30 days.
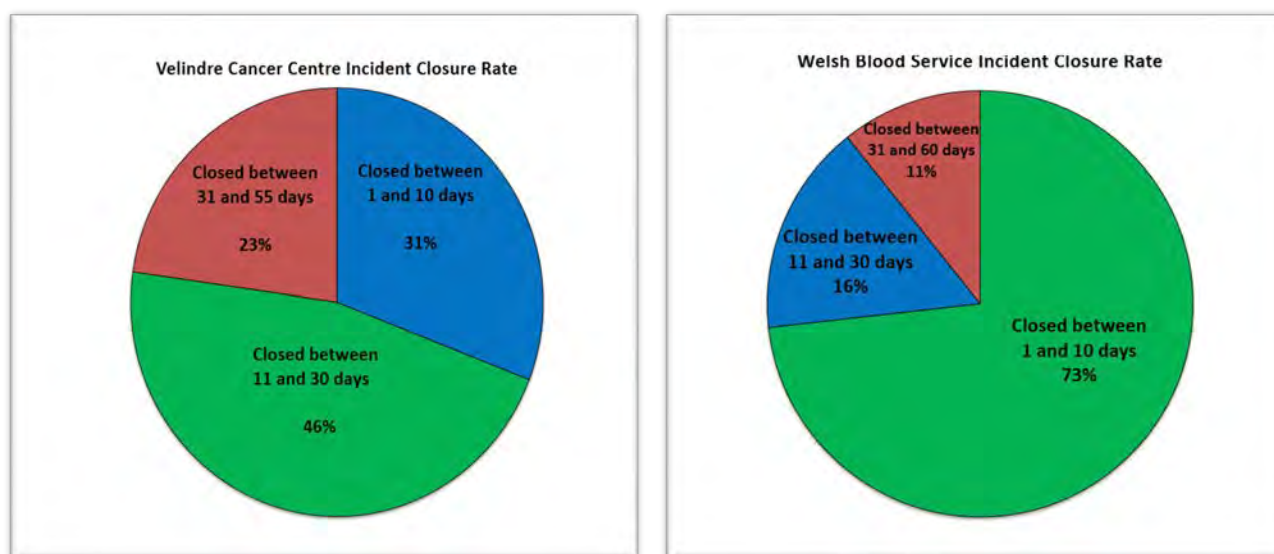


## 3. LEARNING

A summary of the key learning identified from incidents reported and investigated by the Trust during the Quarter is provided below:

| Velindre Cancer Centre |
|---|
| During the quarter there have been a number of reports of cancelled or rescheduled appointments, sometimes at short notice. These incidents are being reviewed as part of the improvement plan. Additionally, it has been reinforced to all staff that it is their responsibility to check waiting areas for late or no show patients just in case they are present in the waiting areas. |
| To reduce poor communication related incidents, it has been advised that Velindre Cancer Centre staff should consider contacting the patient's GP when referring patients to their GP. |
| Following SACT related incidents, Velindre Cancer Centre will improve and develop a process for managing deranged blood results. |
| The CNS Lead Nurse is reviewing key worker roles and responsibilities within site specific teams to establish clear roles and responsibilities in order to reduce the number of incidents that occur at VCC. |
| **Welsh Blood Service** |
| A process to support and identify donors who may potentially book to donate too soon after their last appointment is in place and will reduce incidents related to this. |
| A donor received a full explanation around current government guidelines for correct use and disposal of PPE in Health Care settings. Ongoing work to combat general use of plastic i.e. biodegradable plastics and waste bags across some collection teams is being trialled. |

**4. CONCLUSION: CONCERNS AND INCIDENTS IN QUARTER 4.**

The following overarching conclusions have been drawn for the Trust for Quarter 4:

- Directorate leads are being asked to focus their efforts on learning, retraining and intervention where we have high numbers of incidents and concerns.

- There are many improvement plans in place across the Trust to address some of the themes, these improvement plans are monitored through the Velindre Futures, and Senior Management Teams.

- Quarter 4 was a very busy period clinically with services not only seeing an increase in pre-covid demand but managing the staffing challenges due to Covid infection rates.

- Quality and Safety as a department has been engaged in work to support the upgrades to the OfW Datix system for incidents, setting up systems and processes for managing complaints and concerns and developing as a new team.

- There is evidence that incidents, concerns and compliments are managed appropriately and compliant with the PTR regulations. Lessons learnt and actions are implemented and monitored by Directorate leads and their teams, we recognise there is always room to improve in this area.

- The after-action review database is a central learning database where learning from our complaints are visible and accessible to inform our quality indicators, clinical audits, internal and external audits. The learning database is shared at the Quality Safety Management Group meetings with departments being asked to provide an update on their learning.

- The Trust remains committed to learning from all concerns and incidents raised, and investigation training is currently being procured for all key staff to strengthen our ability to objectively and comprehensively investigate and learn from all concerns and incidents.

- Work is being conducted on a continuous basis to ensure the timely investigation and closure of Incidents. Improvements have been seen at the Welsh Blood Service, and the Cancer Centre is now having a concerted focus on improving compliance with the national timeframes for the investigation of incidents. Dashboards have been created within Datix to show all open incidents and for every directorate. These Dashboards will be shortly included in the monthly directorate meetings.

- Formal training for undertaking investigations and learning from any incidents raised is has been procured and delivered during the Quarter.

## GRADING FRAMEWORK FOR DEALING WITH ALL CONCERNS

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

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

**Appendix 2:** Concerns Pledges

## Valuing Concerns - Our Pledge

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

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

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

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

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

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

# QUALITY, SAFETY & PERFORMANCE COMMITTEE

# DIGITAL SERVICES INCIDENT RESPONSE PLANS (COVER PAPER)

| DATE OF MEETING | 12/05/2022 |
|---|---|

| PUBLIC OR PRIVATE REPORT | Public |
|---|---|

| IF PRIVATE PLEASE INDICATE REASON | n/a |
|---|---|

| PREPARED BY | David Mason-Hawes, Head of Digital Delivery |
|---|---|
| PRESENTED BY | Carl James, Director of Strategic Transformation, Planning, Performance & Estates |
| EXECUTIVE SPONSOR APPROVED | Carl James, Director of Strategic Transformation, Planning, Performance & Estates |

| REPORT PURPOSE | FOR NOTING |
|---|---|

| COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING | | |
|---|---|---|
| COMMITTEE OR GROUP | DATE | OUTCOME |
| WBS Senior Management Team | 13/04/2022 | Review / Discussion |
| VCC Senior Leadership Team | 20/04/2022 | Review / Discussion |
| Executive Management Board | 27/04/2022 | Noted |

## 1. SITUATION/BACKGROUND

1.1    This paper has been produced to inform and update the Quality, Safety & Performance Committee on the latest position in respect of the development of the Trust IT and Cyber Security Incident Response Plans.

1.2    The papers are presented to the committee for NOTING.

## 2. ASSESMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1    Please refer to the following appendices:

2.1.1    Appendix 1 – IT Business Continuity Incident Response Plan

2.1.2    Appendix 2 – Cyber Security Incident Response Plan

## 3. IMPACT ASSESSMENT

| | |
|---|---|
| **QUALITY AND SAFETY IMPLICATIONS/IMPACT** | There are no specific quality and safety implications related to the activity outined in this report. |
| | |
| **RELATED HEALTHCARE STANDARD** | Effective Care |
| | Standard 3.4 Information Governance & Technology |
| **EQUALITY IMPACT ASSESSMENT COMPLETED** | Not required |
| | |
| **LEGAL IMPLICATIONS / IMPACT** | There are no specific legal implications related to the activity outlined in this report. |
| | |
| **FINANCIAL IMPLICATIONS / IMPACT** | There is no direct impact on resources as a result of the activity outlined in this report. |
| | |

## 4. RECOMMENDATION

4.1    The Quality, Safety & Performance Committee is requested to **NOTING** the contents of this report.

**Ref: (<mark>TBC</mark>)**


# CYBER INCIDENT RESPONSE PLAN


**Executive Sponsor & Function**
Carl James – Director of Strategic Transformation, Planning & Digital

**Document Author:**
Sam Griffin – Cyber Security Officer

**Approved by:**
David Mason-Hawes – Head of Digital Delivery

**Approval Date:**
<mark>TBC</mark>

**Date of Equality Impact Assessment:**
<mark>TBC</mark>

**Equality Impact Assessment Outcome:**
<mark>TBC</mark>

**Review Date:**
<mark>TBC</mark>

**Version:**
v0.5 (draft)

# CYBER INCIDENT RESPONSE PLAN

| DATE OF MEETING | 20/04/2022 |
|---|---|

| PUBLIC OR PRIVATE REPORT | Public |
|---|---|

| IF PRIVATE PLEASE INDICATE REASON | n/a |
|---|---|

| PREPARED BY | Sam Griffin – Cyber Security Officer |
|---|---|
| PRESENTED BY | David Mason-Hawes – Head of Digital Delivery |
| EXECUTIVE SPONSOR APPROVED | Director of Strategic Transformation, Planning & Digital |

| REPORT PURPOSE | For APPROVAL |
|---|---|

| COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING | | |
|---|---|---|
| COMMITTEE OR GROUP | DATE | OUTCOME |
| WBS Senior Management Team | 13/04/2022 | Discussion / Review |
| VCC Senior Leadership Team | 20/04/2022 | Discussion / Review |
| Executive Management Board | 27/04/2022 | Noted |

| ACRONYMS | |
|---|---|
| DHCW | Digital Health and Care Wales |
| DS-IRT | Digital Services Incident Response Team |
| GDPR | General Data Protection Regulations |
| ICO | Information Commissioner's Office |
| IT | Information Technology |
| MI | Major Incident |
| NCSC | National Cyber Security Centre |
| NIS | Network and Information Systems (Regulations) |
| OSSMB | Operational Security Services Management Board |
| SWLRF | South Wales Local Resilience Forum |
| VUNHST | Velindre University NHS Trust |
| WG | Welsh Government |

## 1.   Policy Statement

1.1.   Cyber crime is considered by the UK government as a tier 1 threat to the UK. This crime type is ever growing and developing with 48% of businesses identifying at least one breach or attack a month and this statistic is rising significantly. With cyber crime being said by many as the fastest growing type of crime in the world it is imperative that organisations have clearly defined response plans to ensure they can respond effectively to a successful cyber-attack.

1.2.   By their very unpredictable nature, incident response handing requires a variety of actions during each unique instance, depending on the severity, mode and type of attack. However, the process by which the incidents are managed should remain consistent and follow a standard set of guiding principles and a logical order.

1.3.   The current Cyber Security Strategic Plan for Velindre University NHS Trust (VUNHST) is built and measured against the National Cyber Security Centre's '10 Steps to Cyber Security' framework. The work ongoing to ensure compliance with this framework, incorporates best practice guidance for cyber incident management.  This response plan aligns to the best practice defined by the NCSC for when cyber incidents occur. This response plan also aligns to the Network & Information Systems (NIS) regulations requirements for incident response.

## 2.   Scope of Policy

2.1.   The scope of this plan relates to all digital services managed by Velindre University NHS Trust.  This includes those services that are hosted by Digital Health & Care Wales (DHCW) and utilised within VUNHST.

2.2.   This policy is a supporting document to the VUNHST IT Business Continuity Incident Response Plan. Any incidents classified as medium and severe are to be escalated to DHCW and Welsh Government (WG) as per the NHS Wales – Cyber Attack & ICT Incident Response Communications Framework.

2.3.   In addition to the onward reporting criteria, which is associated with the classification of the severity of an incident, communication to key 3rd party suppliers and stakeholders, such as the South Wales Local Resilience Forum (LRF) and law enforcement, may also be required.

2.4.    *Before this policy is invoked, there may be a need to respond to external intelligence and / or cyber incidents that do not happen locally or directly affect VUNHST at the time of discovery / notification – for example, intelligence provided to VUNHST by the NCSC in light of national or international events. Even though this policy does not fall in scope of the prior example, the Cyber Threat Intelligence Response Plan is used as a guide to respond to such incidents. This can be found in Appendix A and would sit before the initiation of this plan.*

3.    **Aims and Objectives**

3.1.    The aim of this policy is to define the procedure for responding effectively to a cyber incident. This plan will outline key communication and escalation routes, drawing from and aligning to the VUNHST IT Business Continuity Incident Response Plan and the NHS Wales – Cyber Attack & ICT Incident Response Communications Framework, to ultimately contain, remediate and recover from a cyber incident.

## 4. Responsibilities

All staff need to be aware of their responsibilities relating to this plan, summarised below:

| Area/Function | Responsibilities |
|---|---|
| Director of Strategic Transformation, Planning & Digital | • Overall responsibility for the VUNHST Digital Services function, with accountability for cyber security within the Trust. |
| VUNHST Exec Team | • Provision of appropriate levels of resource and budget to each team to enable them to perform the work required, to include relevant and applicable resourcing to enable the Digital Services team to reduce the risk of a cyber security incident occurring (i.e. security patching, anti-virus tools, security testing and any necessary remediation).<br>• Ensure that all direct reports are aware of this plan.<br>• Maintain up to date contact lists for all direct reports.<br>• Where applicable, coordinate communications internally and externally. |
| Chief Digital Officer (CDO) | • Operational responsibility for the VUNHST Digital Services function, including cyber security.<br>• Chair the Digital Services Incident Response Team meetings (DS-IRT) – responsibility delegated to Head of Digital Delivery if unavailable. |
| Head of Digital Delivery | • Ownership of this plan.<br>• Chair the Digital Services Incident Response Team meetings (DS-IRT).<br>• Provide reporting to Business Continuity / Quality Assurance teams, to include formal reporting via the VUNHST Business Continuity Group and relevant Trust committees.<br>• Coordinate reporting to the Divisional and/or Executive teams in the event of a cyber incident. |

| Area/Function | Responsibilities |
|---|---|
| Digital Services Infrastructure / Cyber Security Leads | • Implementation and maintenance of this plan.<br>• Development of regular testing scenarios.<br>• Conducting regular testing of the plan and reviewing the outcomes.<br>• Provide latest cyber security information and guidelines to appropriate departments/team leaders.<br>• Manage and maintain the operational security monitoring service.<br>• Responsible for the technical analysis, containment, eradication and recovery of a cyber incident.<br>• Provide regular reporting to the DS-IRT in the event of an incident, whilst keeping accurate logs of decisions/actions.<br>• Ensure that resilience, including backup and recovery, is tested to ensure that it is sufficient. |
| Departmental Heads / Line Managers | • Maintain good awareness of cyber security within their business areas.<br>• Ensure good cyber security controls are implemented to protect services from cyber-attack.<br>• Provide feedback to the Head of Digital Delivery about the ability to respond to a cyber security incident affecting their services.<br>• Ensure that they maintain a good understanding of the processes and procedures needed to restore services within their teams. This includes knowledge of any dependencies on other teams/departments.<br>• Act as a conduit for the dissemination of information, guidelines, programmes of activity etc of staff.<br>• Maintain up to date contact lists for all direct reports, including relevant 3rd party connections.<br>• Ensure any new IT / digital services are appropriately assessed in accordance with Trust policies and procedures, in respect of cyber security and information governance, to ensure adequate protection of patient, donor and staff data. |
| Service Owners / Product Specialists | • Maintain detailed knowledge of business continuity and cyber security investigation within their business areas.<br>• Ensure good cyber security controls are implemented to protect services from cyber-attack.<br>• Ensuring that cyber security response plans are regularly reviewed, tested and exercised for the services that they provide. This includes liaising with Digital Services and end users from departments on which there is a dependency.<br>• Ensure that all necessary reference information required during an investigation is maintained and also available in a crisis<br>• Maintain up to date contact lists for all direct reports, including relevant 3rd party connections. |

| Area/Function | Responsibilities |
|---|---|
| Service Management Leads | • Work with team leaders / product specialists to ensure that cyber security investigation plans are regularly reviewed and tested for services that they provide.<br>• Liaising with end users and any departments on which there is a dependency to perform testing.<br>• Assist with communications to end-users and other stakeholders during the invocation of this plan<br>• Act as a conduit for the dissemination of cyber security planning information to end-users and other stakeholders including service management boards and the South Wales local resilience forum. |
| All Staff | • To continually work in a manner that is secure and protects the interests and assets of VUNHST.<br>• To report and suspicious activity through the standard reporting channels and ensure that the correct severity is applied.<br>• Ensure they complete cyber security e-learning, a statutory and mandatory training requirement in VUNHST. |

## 5.  Definitions

| Term | Definition |
|---|---|
| Incident | The violation (or imminent threat of violation) of computer security policies, acceptable use policies or standard security practices – for example, an attempt (successful or otherwise) to gain unauthorised access to data on a system. Whether an event is considered an incident will depend on the security policies in place within that organisation. |
| Incident Response | The technical components of identifying, containing and recovering from an incident. |
| Service | A complete service offering provided by VUNHST / DHCW to its end users. This includes the IT components, as well as the supporting policies & procedures, required to ensure correct functioning of the service. |
| System | The IT components that comprise a service. |
| Ransomware | Malicious software that encrypts (locks) files. |
| Malware | Short for 'Malicious Software', a term that includes viruses, 'trojans', 'worms' or any code or content that could have an adverse impact on organisations or individuals. |

## 6. Implementation/Policy Compliance

When an IT business continuity incident has been identified, an initial triage will be conducted by Digital Services team to review the available information and to determine if a cyber security incident is the likely cause.

### 6.1. Initiation Process

6.1.1. The list below identifies some events that could start the process. A swift response is essential to ensure a successful outcome and to minimise impact to Velindre University NHS Trust, NHS Wales and the public:

- Digital Services staff identify unusual/suspicious/malicious event
- Antivirus software identifies an unusual event
- Excessively slow responses to services
- Service outages
- NIDS/Log monitoring detects unusual/suspicious/malicious behaviour
- External organisation (ISP, supplier etc.) inform us of unusual/suspicious/malicious behaviour
- Partnering Health Board inform us of unusual/suspicious/malicious behaviour
- Blackmail threat from a third party
- Contact from the public or press
- Defacement of a public facing website

6.1.2. Identification of any further evidence to support these concerns would trigger the plan being invoked. This evidence would include, but not limited to:

- Data theft – this could be either witnessed by the operational support teams (e.g. unauthorised transfer of data outside of the network) or by reports that Trust data is in the public domain.
- Suspected loss/corruption of data (ransomware)
- Antivirus software detecting repeated occurrences of malware

6.1.3. Where the incident is confirmed as not being related to a cyber-attack, the Trust response will be managed in accordance with the VUNHST IT Business Continuity Incident Response Plan.

### 6.2. The Plan

6.2.1. If the results of the initial triage determine that the plan needs to be invoked, a DS-IRT meeting will be convened as per the VUNHST IT Business Continuity Incident Response Plan. This meeting will follow the agenda specified in Appendix B to assess the situation and agree the appropriate response and escalations. This would include the initiation of local business continuity, disaster recovery plans and/or cyber-attack playbooks, as required (see Appendix A).

6.2.2. As part of the initial meeting of the DS-IRT, the frequency of meetings and communications will be agreed, as will the roles & responsibilities regarding the recording all details associated with the incident (e.g. nominated 'Loggist'). The Executive Lead for the incident will also be confirmed.

6.2.3. Depending on the nature of the incident and level of progress made additional members may be required to join the DS-IRT.

6.2.4. A nominated 'Loggist' will be assigned to all cyber incidents, to ensure a full audit trail for all discussions and actions. The 'Loggist' will be assigned to the DS-IRT and will be based with the Digital Services team for the life of the incident.

6.2.5. In the event of a cyber security incident classified as 'medium' or 'severe' being identified (see Appendix C), DHCW will be informed by completing the form in appendix A. This will then trigger the NHS Wales Cyber Attack ICT Incident Response Communications Framework (see Appendix A).

6.2.6. Following the initial meeting, operational staff within the Digital Services team will coordinate the technical response, as per the NCSC incident lifecycle process and update the DS-IRT at regular intervals, as agreed by the DS-IRT.

## 6.1 Core response –The Cyber Incident Response Lifecycle

6.1.1 A high-level incident response lifecycle can be seen in the Appendix D.

6.1.2 The four core response stages of analyse, contain, remediate and recover are considered in sections below. More detail can be found in detail on the following link as outlined by the NCSC[1].

### 6.1.2.1 Analyse / Identification

This stage of the incident involves everything from technical analysis through to a review of social media reactions.

It is important to ensure tasks are prioritised carefully and findings are constantly reviewed and correlated, as these may lead to new tasks.

Usually, the initial priority is to understand enough to take containment/mitigation actions and ultimately remediate the attack.

There is a need to understand the type of event that has been identified and then to agree upon a classification, as specified in Appendix C.

To ensure a consistent review throughout the incident response team, the known information log (see Appendix B) should be used to record all information as it is received.

### 6.1.2.2 Contain / Mitigate

Once it is safe to do so, the Digital Services team, working in conjunction with DCHW, the NCSC and other NHS Wales organisations (as required), will take steps to reduce the impact of the incident and prevent things from getting worse. This usually involves actions such as blocking activity, isolating systems and resetting accounts. It may also involve non-technical actions such as media handling.

This stage may require critical decisions such as taking a core business system offline. It is important to consider the consequences of any such actions, both good and bad.

The Digital Services team will evaluate the possibility that the attacker might react to the Trust response or bury themselves more deeply in the network (often in the case of targeted attacks). In some cases, it may be better to monitor and analyse further before action is taken.

---

[1] https://www.ncsc.gov.uk/collection/incident-management/technical-response-capabilities

Included in this stage of the response are the following actions:

- Preventing further spread of the incident
- Preventing further data theft or loss/corruption of data
- Planning for the eradication and recovery stages
- Initial communications

### 6.1.2.3 Preventing further spread of the incident

Some technical actions/solutions at this stage may be:

- Reconfigure security devices (firewalls, etc) to prevent further spread or exfiltration of data (e.g. blocking all traffic on the internet links or blocking access to/from the data centres on specific ports. In extreme circumstances, this could require network isolation.
- Shutting down servers or entire services
- Forcing password reset of user accounts

There are various aspects to be considered as a result of the choices made above, including clinical risk and patient / donor safety, resource implication, reputational damage and financial consequences.

The following impacts must be considered when making decisions:

- Clinical Risk and Patient / Donor Safety - e.g. the short-term impact on adversely affecting patient / donor care vs. the longer-term consequences associated with potential corruption of data or theft of information.
- Resource implications
- Reputational damage
- Financial consequences

### 6.1.2.4 Communications

An essential part of the containment section is to develop a communication plan for the managing of the incident. The communication approach will be agreed via the DS-IRT and should be underpinned throughout the whole incident response process and would include communication with the following groups:

- Trust staff
- NWIS
- Suppliers
- Public/press
- Information Commissioner's Office (ICO)

All communications outside of VUNHST, or affiliated contractors/3rd party suppliers will be coordinated through the DS-IRT and approved by the nominated Exec lead for the incident.

No staff should communicate with external organisations without prior approval from the DS-IRT.

Communications with the public will be via specified persons appointed by the chair of the DS-IRT or Executive staff and all communications will be approved by the DS-IRT.

If required, formal support via the VUNHST Communications Team will be sought.

### 6.1.2.5   Remediate / Eradicate

The aim of this stage is to fully remove the threat from the Trust network and systems, having identified the high-level plan during the previous stage. This often involves similar actions to containment but is sometimes coordinated so that all actions are carried out simultaneously.

It is important to confirm that remediation has been successful before to moving to the recover stage – this may involve monitoring for a period. Some analysis may continue in this stage too.

A detailed plan for eradicating the incident needs to be developed and then, at the appropriate time, enacted. This will need to be done by all teams involved in providing the affected services and will be overseen by the DS-IRT, so that full governance and assurance is provided.

This stage may require the coordination / cooperation of staff involved in the local departmental business continuity response, if formal business continuity arrangements have been invoked.

It is important to ensure that re-infection does not occur so this needs to be constantly monitored - looking for symptoms observed previously.

When appropriate, the recovery phase for affected systems/services can be initiated. Progress on eradication and discoveries of additional infections must be reported back to the CIRT.

### 6.1.2.6   Evidence Handling and Preservation

As a part of the incident response process it is crucial that evidence such as log files are preserved until the incident has been resolved and any subsequent follow-up actions completed. Not only is this important to retain this information in situations where systems / applications are wiped and re-installed, but also to aid law enforcement investigations should this require their involvement.

The existing storage capabilities for log information should be reviewed to ensure that information won't be lost during purging activities – it might be necessary to take copies of data to an offline location (depending on the availability). Consideration should be given to the taking of printouts and screen shots to preserve any pertinent log information.

As noted above, a nominated 'Loggist' will be assigned to all cyber incidents, to ensure a full audit trail for all discussions and actions.

### 6.1.2.7   Recover

At this point, systems are returned to 'business as usual'. Actions are taken to handle regulatory, legal, or PR issues.

The primary focus of this stage is to prevent a recurrence – in agreeing the timing for reintroducing systems, the Digital Services team will look to strike a balance between restoring services as soon as possible to meet business needs against being able to

control and carefully monitor brining those systems back online as well as collecting evidence.

Options to consider in this phase data include:

- Increasing the frequency of backups to provide additional protection if recurrence of the incident occurs
- Maintaining backups for a longer period, to protect against undetected corruption or loss of data
- The most appropriate recovery mechanism for a service. In some cases it may be better to implement the DR process for a service (e.g. failover between data centres) and in other cases it may be better to recover the primary service
- Priority for recovering services. Where there are competing demands for resources to recover systems, the priorities identified in the " System Restoration Plan for Multiple Concurrent Service Failures " document should be used. It may be appropriate to convene the DRMT to assist with this work

It is important to ensure that the event(s) do not reoccur, therefore there is a need to constantly monitor, looking for signs of previous symptoms.

Before the incident can be closed, the DS-IRT must be satisfied that the 'end-state' as defined during the identification phase has been achieved.  This will usually relate to the full restoration of the affected IT systems and associated operational services to 'business as usual'.

### 6.1.2.8   Review and Close

At this stage of the incident response, it is essential to have a thorough review of the whole process.  The following will be considered:

Documentation:

- Post incident reports are crucial for informing future incident handling activity or outlining areas that require change throughout the process. The review of decision logs will be helpful in understanding the strengths/weaknesses throughout the process. Therefore, it is crucial that these are filled in during the process, as often these can be overlooked.
- In line with Trust policy, all cyber incidents will be logged on DATIX.

Implications across the organisation:

- Consider the implications of an incident for all elements of the business – this does not just mean only the cyber incident handling practices, but also covers the approach to vulnerability assessment and penetration testing, policies around device management, network architecture, information management and many other aspects of business.

Using lessons learnt to enhance the VUNHST Cyber Incident Response Plan:

- Properly capturing lessons, identifying owners for the actions that arise and ensuring that the actions are progressed is a necessity. Where there are areas for improvement, this is the stage where this is captured in a post-incident review and fed back into the response plan and future exercising.

Sharing Learning from the experience with other in NHS Wales via OSSMB:

- The use of existing technical and other governance groups should be used for this.

Notification to the Information Commissioner's Office (ICO):

- The General Data Protection Regulations (GDPR) introduces a duty on all organisations to report certain types of personal data breach to the relevant supervisory authority. This must be done within 72 hours of becoming aware of the breach, where feasible.

- If the breach is likely to result in a high risk of adversely affecting individuals' rights and freedoms, the Trust must also inform those individuals without undue delay.

- The Trust must also keep a record of any personal data breaches, regardless of whether you are required to notify.

Reporting to Welsh Government (WG):

- Where required, the Trust will submit a 'WG No Surprises Form' to WG. The requirement to submit this will be agreed by the Exec on-call and Chief Digital Officer.

- This form is to be reported directly from the Trust, with the intention of providing a high-level summary of a potential major incident that is under investigation. A 'No Surprises' briefing is generally provided at the outset of a potentially significant incident and following its closure.

## 6.2  Regular Testing of the plan

To ensure that this plan remains fit for purpose, it is essential that regular review & testing is performed.  Following each test, if necessary, the plan will be updated to reflect any change of circumstances, where required.

### 6.2.1   At six monthly intervals – full test of the plan using one or more fictitious cyber-security attack scenarios

The objective of this aspect of the testing is to ensure that we continue to have the ability to respond to cyber security incidents, that all necessary documentation is accessible, to ensure relevant staff members are aware of the process and that it remains part of the normal activities.

The security team will devise a suitable scenario to emulate an incident and then present it as an incident to check that the response aligns to the defined staps and actions required by this plan.

6.2.2   At three monthly intervals – verifying accuracy of information in the plan

The objective of this aspect of the testing is to ensure that we continue to have valid and accurate information and that the plan provides all necessary information.

The following details will be checked and updated by the owner of the plan:

- Verifying that up-to-date, off-line information is available
- Validating contact information for all nominated individuals recorded in the plan.
- Verifying that suitable log monitoring is being performed and the results are reviewed
- Verifying that OOB network access is available

## 7. Equality Impact Assessment Statement

| | |
|---|---|
| **QUALITY AND SAFETY IMPLICATIONS/IMPACT** | There are no specific quality and safety implications related to the activity outlined in this report. |
| | n/a |
| **RELATED HEALTHCARE STANDARD** | Effective Care |
| | Standard 3.4 Information Governance & Technology |
| **EQUALITY IMPACT ASSESSMENT COMPLETED** | Not required |
| | |
| | Yes (Include further detail below) |
| **LEGAL IMPLICATIONS / IMPACT** | Failure to establish robust and effective procedures for managing serious IT incidents may expose the Trust to risk of financial penalties under the Networks & Information Systems (NIS) Directive, which requires organisations providing critical services to ensure adequate provisions are in place for preventing and managing IT service disruptions relating to network and information (cyber) security. |
| | Yes (Include further detail below) |
| **FINANCIAL IMPLICATIONS / IMPACT** | Any move towards the establishment of an on-call arrangement for members of the Digital Delivery senior management team would require additional funding to support the associated costs. |

## 8. References

- VUNHST IT Business Continuity Incident Response Plan
- NHS Wales – Cyber Attack & ICT Incident Response Communication Framework
- Network & Information Systems regulations
- NCSC – '10 steps to cyber security'
- ICO – Ransomware and data protection compliance

## 9. Getting Help

- Digital Services Department – 01443 622011

- Digital Services Portal – vunhst.wales/digitalservices

- VUNHST Cyber Security Officer – Sam Griffin | sam.griffin@wales.nhs.uk

## 10. Related Policies

- SP-001 – IT Security Policy
- ITS-159 – Anti-virus software management and updates
- IG03 - All Wales Email US Policy
- ITS-011 – Anti-virus procedure
- IG04 – All Wales Information Security Policy
- IG05 – Software Policy
- IG02 – Data Protection & Confidentiality Policy
- IAR-02 - Digital Services Information Asset Register
- MP-057 – Business Continuity

## 11. Information, Instruction and Training

See section 6.4.

To help prevent the risk of an IT security breach, as a result of a cyber-attack, cyber security training is provided to all staff via the ESR e-learning module. This training has been classified by the Trust as mandatory for all staff – as such, it forms part of the statutory and mandatory training that all staff must complete. Staff area required to 'refresh' their training by re-taking the e-learning every 3 years.

## 12. Main Relevant Legislation

- Network & Information System (NIS) Regulations
- General Data Protection Regulations (GDPR)

## Appendix A - Supporting Documents

Several related documents are referenced in this plan. The links below should be used to access them.

| Document |
| --- |
| VUNHST IT Business Continuity Incident Response Plan<br>[approved copy to be linked to in final version] |
| NHS Wales – Cyber Attack & ICT Incident Response Communications Framework<br>[currently in draft - approved copy to be linked to in final version] |
| Phishing Playbook<br>[approved copy to be linked to in final version] |
| Ransomware Playbook<br>[approved copy to be linked to in final version] |
| Incident Response Reporting Template<br>[approved copy to be linked to in final version] |

## Appendix B - Operational Decision Log

This template should be used during an incident, to record all major decisions that are made and also the supporting reasons for doing so.

Given the fast-moving pace of incident investigation, it is essential that all decisions made are recorded accurately.

| Investigation title | | Investigation lead | |
|---|---|---|---|
| **Page** | | | |
| **Date/time<br>dd/mm/yyyy – hh:mm** | **Action taken & by whom** | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Appendix C – Incident Classifications**

This following Incident Classification has been uplifted from the NHS Wales – Cyber Attack & ICT Incident Response Communications Framework (see Appendix A).

This framework is used as a guide, to understand when to communicate incidents to DHCW and Welsh Government. Local classification of the incident is to take place and then escalated accordingly.

| INCIDENT CLASSIFICATION | | | |
|---|---|---|---|
| **Organisation** | **Classification** | | |
| **Welsh Government (Cyber Communications Framework)** | Severe | Medium | Low |
| **DHCW** | Major | Medium | Minor |
| **VUNHST** | P1 | P2 | P3 |

For ease of clarity the Cyber Communications Framework will have three classifications Severe, Medium and low.

It is the responsibility of DHCW and Health Boards/Trusts to match their classifications to these.

# Appendix D – NCSC Cyber Incident Response Lifecycle

## Preparatory

**Triage**
Assess impact.
Categorise incident.
Assign incident manager.
*Check for false positive*
*Is legal input needed?*

**Escalate**
If required
*Within IR Team or to CIO/CISO who*
*may escalate further*

**Kick off response**
*Who else needs to be involved?*
*IT, Legal, HR, PR?*
*Consider internal and external parties.*

**Reporting**
Consider reporting and evidence capture
requirements.
*For example in the case of a data breach.*

## Core response

**Incident Management** - as required throughout
Oversee, communicate, engage support, escalate, report and notify

**Analyse**
Capture and analyse
data/information

**Contain/Mitigate**
Stop or lower the
impact, prevent
spread of the problems
*Consider the potential*
*impact of all actions*

**Remediate/Eradicate**
Fully remove/stop the incident.
Confirm successful
remediation.

**Recover**
Recover data and systems
if needed.  Resume 'business
as usual.'

*resolved?*

## Close down

**Review and Close down**
*Document and assign*
*improvements*

**Ref: (<mark>TBC</mark>)**


# IT BUSINESS CONTINUITY
# INCIDENT RESPONSE PLAN


Executive Sponsor & Function:
**Carl James – Director of Strategic Transformation, Planning & Digital**

**Document Author:**
David Mason-Hawes – Head of Digital Delivery

**Approved by**
<mark>TBC</mark>

**Approval Date:**
<mark>TBC</mark>

**Date of Equality Impact Assessment:**
<mark>TBC</mark>

**Equality Impact Assessment Outcome:**
<mark>TBC</mark>

**Review Date:**
<mark>TBC</mark>

**Version:**
0.1 (draft)

# IT BUSINESS CONTINUITY INCIDENT RESPONSE PLAN

| | |
|---|---|
| **DATE OF MEETING** | 20/04/2022 |

| | |
|---|---|
| **PUBLIC OR PRIVATE REPORT** | Public |

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|---|---|
| **IF PRIVATE PLEASE INDICATE REASON** | n/a |

| | |
|---|---|
| **PREPARED BY** | David Mason-Hawes – Head of Digital Delivery |
| **PRESENTED BY** | David Mason-Hawes – Head of Digital Delivery |
| **EXECUTIVE SPONSOR APPROVED** | Director of Strategic Transformation, Planning & Digital |

| | |
|---|---|
| **REPORT PURPOSE** | For APPROVAL |

| **COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING** | | |
|---|---|---|
| **COMMITTEE OR GROUP** | **DATE** | **OUTCOME** |
| WBS Senior Management Team | 13/04/2022 | Discussion / Review |
| VCC Senior Leadership Team | 20/04/2022 | Discussion / Review |
| Executive Management Board | 27/04/2022 | Noted |

| **ACRONYMS** | |
|---|---|
| DHCW | Digital Health and Care Wales |
| DS-IRT | Digital Services Incident Response Team |
| GDPR | General Data Protection Regulations |
| ICO | Information Commissioner's Office |
| IT | Information Technology |
| NCSC | National Cyber Security Centre |
| NIS | Network and Information Systems (Regulations) |
| VUNHST | Velindre University NHS Trust |
| WG | Welsh Government |

## 1. Policy Statement

1.1. It is inevitable that from time-to-time IT business continuity incidents (MI's) will occur. These service outages can have a significant impact on the delivery of patient / donor care and may even present a risk to patient safety and have the potential to cause harm.

1.2. It is important that Velindre University NHS Trust (VUNHST) has robust plans in place, to ensure it can rapidly mobilise an effective service response when key IT services are not available and ensure operational delivery is not compromised.

## 2. Scope of Policy

2.1. The scope of this plan relates to all digital services managed by VUNHST. This includes those services that are hosted by Digital Health & Care Wales (DHCW) and utilised within VUNHST.

2.2. This policy aligns with and is supported by the VUNHST Cyber Incident Response Plan, which details the specific (additional) arrangements that need to be put in place in the event of a cyber incident.

## 3. Aims and Objectives

3.1. The aim of this policy is to define the procedure for responding effectively to an IT business continuity incident.

3.2. This plan outlines key communication and escalation routes, drawing from and aligning to other relevant Trust and national (NHS Wales) policies and procedures, to effectively manage and recover from an IT business continuity incident.

## 4.   Responsibilities

All staff need to be aware of their responsibilities relating to this plan, summarised below:

| Area/Function | Responsibilities |
|---|---|
| Director of Strategic Transformation, Planning & Digital | • Executive responsibility for the VUNHST Digital Services function. |
| VUNHST Exec Team | • Provision of appropriate levels of resource and budget to each team to enable them to perform the work required, to include relevant and applicable resourcing to enable the Digital Services team to reduce the risk of a IT business continuity incident occurring (i.e. security patching, deployment of anti-virus tools, replacement of 'end of life' IT equipment and infrastructure etc.).<br>• Ensure that all direct reports are aware of this plan.<br>• Maintain up to date contact lists for all direct reports.<br>• Where applicable, coordinate communications internally and externally. |
| Chief Digital Officer (CDO) | • Operational responsibility for the VUNHST Digital Services function.<br>• Chair the Digital Services Incident Response Team meetings (DS-IRT) – responsibility delegated to Head of Digital Delivery if unavailable. |
| Head of Digital Delivery | • Ownership of this plan.<br>• Chair the Digital Services Incident Response Team meetings (DS-IRT), if CDO unavailable.<br>• Provide reporting to Business Continuity / Quality Assurance teams, to include formal reporting via the VUNHST Business Continuity Group and relevant Trust committees.<br>• Coordinate reporting to the Divisional and/or Executive teams in the event of an IT business continuity incident. |

| Area/Function | Responsibilities |
|---|---|
| Digital Delivery Senior Leadership Team | • Implementation and maintenance of this plan.<br>• Development of regular testing scenarios.<br>• Conducting regular testing of the plan and reviewing the outcomes.<br>• Provide relevant IT information and 'best practice' guidance to appropriate departments/team leaders, as required.<br>• Manage and maintain the operational security and performance monitoring service.<br>• Responsible for the technical analysis, containment, eradication and recovery of an IT business continuity incident.<br>• Provide regular reporting to the DS-IRT in the event of an incident, whilst keeping accurate logs of decisions/actions.<br>• Ensure that resilience, including backup and recovery, is tested to ensure that it is sufficient. |
| Departmental Heads / Line Managers | • Maintain good awareness of IT within their business areas.<br>• Provide feedback to the Head of Digital Delivery about the ability to respond to an IT business continuity incident affecting their services.<br>• Ensure that they maintain a good understanding of the processes and procedures needed to restore services within their teams. This includes knowledge of any dependencies on other teams/departments.<br>• Act as a conduit for the dissemination of information, guidelines, programmes of activity etc of staff.<br>• Maintain up to date contact lists for all direct reports, including relevant 3rd party connections.<br>• Ensure any new IT / digital services are appropriately assessed in accordance with Trust policies and procedures, in respect of cyber security and information governance, to ensure adequate protection of patient, donor and staff data. |

| Area/Function | Responsibilities |
|---|---|
| Service Owners / Product Specialists | • Maintain detailed knowledge of business continuity within their business areas.<br>• Ensuring that local IT business continuity response plans are regularly reviewed, tested and exercised for the services that they provide. This includes liaising with Digital Services and end users from departments on which there is a dependency.<br>• Ensure that all necessary reference information required during an investigation is maintained and also available in a crisis<br>• Maintain up to date contact lists for all direct reports, including relevant 3rd party connections. |
| Service Management Leads | • Work with team leaders / product specialists to ensure that IT incident investigation plans are regularly reviewed and tested for services that they provide.<br>• Liaising with end users and any departments on which there is a dependency to perform testing.<br>• Assist with communications to end-users and other stakeholders during the invocation of this plan |
| All Staff | • To continually work in a manner that is secure and protects the interests and assets of VUNHST.<br>• Immediately report any service issues, incidents or outages to the Digital Services team via the Digital Service Desk.<br>• Report any suspicious activity through the standard reporting channels and also ensure that the correct severity is applied. |

## 5. Definitions

| Term | Definition |
|---|---|
| IT Business Continuity Incident | An incident that causes a serious interruption to one or more IT services, with an immediate impact on the delivery of patient / donor care, or has the potential to cause harm, which must be resolved with the utmost urgency.<br><br>In the context of IT / digital services, this is an IT incident believed to require, or may require support from wider departments or external intervention, due to level of potential risk / impact on the 'business as usual' delivery and requires escalation to Senior Management Team and may require an emergency planning meeting. |
| Incident Response | The technical components of identifying, containing and recovering from an incident. |

| Service | A complete service offering provided by VUNHST / DHCW to its end users. This includes the IT components, as well as the supporting policies & procedures, required to ensure correct functioning of the service. |
|---------|---------|
| System | The IT components that comprise a service. |

## 6. Implementation / Policy Compliance

6.1. The Digital Delivery team, part of the wider Digital Services Directorate, operate a 24/7 support service across both the VCC and WBS, with an out of hours service providing IT support cover outside of normal business hours. This complements an 'in hours' support function provided via the Digital Service Desk[1].

6.2. In addition to providing digital support to a range of service developments across the Trust, the remit of the Digital Delivery team is to provide a swift and effective response to urgent IT issues / incidents.

6.3. DHCW are notified of the nominated Gold / Silver leads within each Health Board via a weekly report, provided to them via Welsh Government (WG). Health Boards provide weekly updates to WG, which are passed onto DHCW via the aforementioned report. As the focus of this report has historically related to acute service (hospital) delivery, **VUNHST does not currently supply this information to WG**. In order to facilitate the approach set out in this document, this weekly information submission will need to be established, to ensure DHCW have details to contact in the event of a national IT incident.

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[1] https://vunhst.wales/digitalservices

6.4.    In broad terms, the VUNHST IT Business Continuity Response Plan is modelled on the ITIL approach for incident management, as follows:



6.5.    A process map summarising the full VUNHST IT Business Continuity Incident response process is shown in Appendix B.


**6.6.    Initiation Process**

6.6.1.  The list below identifies some events that could start the process. A swift response is essential to ensure a successful outcome and to minimise impact to Velindre University NHS Trust, NHS Wales and the public:

- User-reported issue with a service – e.g. unable to access Trust system(s), services not functioning as expected
- Trust notified by DHCW of a national IT incident affecting services or IT infrastructure used by VUNHST
- Trust notified by another Welsh Health Board or other 3rd party (e.g. supplier) of an IT incident with services used by VUNHST
- Service outages or slow service / IT system performance
- Excessively slow responses to services
- Digital Services and/or automated monitoring services (e.g. anti-virus) staff identify unusual / suspicious / malicious event
- Blackmail threat from a third party
- Contact from the public or press
- Defacement of a public facing website

**6.7. The Plan**

6.8. When an IT business continuity incident has been identified, via either local reporting or nationally via DHCW, an initial triage will be conducted by Digital Services team to review the available information and to determine severity of the incident. All incidents will be classified in accordance with national IT Service Management guidelines (see 'NHS Wales IT Service Management – Service Level Target Policy') – i.e. incidents will be identified as P1, P2, P3 or P4 based on an initial assessment of impact vs. urgency.

6.8.1. If the incident is classified as a 'P3' or 'P4' incident (where service impact is minimal and there is no immediate risk to patient / donor care), activities to resolve and remediate the incident will be managed by the Digital Services team, who will liaise directly with the affected service area(s) to manage the incident.

6.8.2. If the incident is classified as a 'P1' or 'P2' incident (i.e. where significant disruption to operational and/or clinical services may occur), the following actions will be taken:

6.8.2.1. If a locally reported issue is considered to potentially result in a wider / national IT incident, the Digital Service desk will raise a call with the DHCW National Service Desk, to initiate national IT incident response procedures.

6.8.2.2. If the incident occurs between 8am – 5pm, the Head of Digital Delivery or a nominated deputy will notify the Chief Digital Officer and the relevant Divisional SMT/SLT and/or Exec on-call.

6.8.2.3. If the incident occurs out of hours, a member of the Digital Services 'on call' will contact the Head of Digital Delivery (or a nominated deputy) to establish the Digital Service response. The Chief Digital Officer will be contacted at the same time, along with, the relevant Divisional SMT/SLT and/or Exec on-call. Thereafter, relevant communication channels will be used to support this escalation process (see 6.6.3).

6.8.2.4. When a national IT incident occurs, DHCW will contacted the named on-call Exec Lead directly. The on-call Exec Lead will contact a member of the Digital Services senior management team, to initiate the local response, as per the below.

6.8.2.5. A Digital Services Incident Response Team (DS-IRT) meeting will be convened. This meeting will follow the agenda specified in Appendix A to assess the situation and agree the appropriate response and escalations. This would include the initiation of local business continuity, disaster recovery plans, as required.

*Please note: as per current arrangements, Divisional SMT/SLT will make the decision as to whether to invoke formal Emergency Planning and/or Business Continuity arrangements. If formal EP/BC arrangements are initiated, the DS-IRT will be the relevant Divisional EP/BC meeting, rather than a separate forum.*

6.8.2.6. The DS-IRT meetings will be chaired by the Chief Digital Officer or a nominated deputy. Membership of the DS-IRT will be drawn from the membership of the divisional Emergency Planning / Business Continuity

meetings. Depending on the nature of the incident and level of progress made additional members may be required to join the DS-IRT.

      6.8.2.7.     As part of the initial meeting of the DS-IRT, the frequency of meetings and communications will be agreed, as will the roles & responsibilities regarding the recording all details associated with the incident (e.g. nominated 'Loggist'). The Executive Lead for the incident will also be confirmed.

      6.8.2.8.     Following the initial meeting, operational staff within the Digital Services team will coordinate the technical response and update the DS-IRT at regular intervals, as agreed by the DS-IRT.

6.8.3.   To facilitate the efficient flow of communications across the Digital Services team, the 'IT Incident Comms Channel' chat within Microsoft Teams will be used for the staff supporting the operational / technical response to share information. If Microsoft Teams is not available, the equivalent WhatsApp group will be used.

6.8.4.   The DS-IRT will meet regularly to ensure appropriate, ongoing coordination of local activities to, where possible, maintain operational / clinical services. This may include the invocation of departmental business continuity arrangements.

6.8.5.   The DS-IRT will continue to meet until affected IT services have been restored and it has been determined that affected operational / clinical services can be restored to 'business as usual'. At this point, the DS-IRT will be stood down.

**6.8.6.  Post Incident Review**

All IT business continuity incidents will be formally reviewed. The following will be considered:

      6.8.6.1.     Documentation:

- In line with Trust policy, all cyber incidents will be logged on DATIX.

- Post incident reports are crucial for informing future incident handling activity or outlining areas that require change throughout the process. The review of decision logs will be helpful in understanding the strengths/weaknesses throughout the process. Therefore, it is crucial that these are filled in during the process, as often these can be overlooked.

      6.8.6.2.     Implications across the organisation:

- The incident review process will consider the implications of an incident for all elements of the business – this does not just mean only the incident handling practices, but also covers the approach to vulnerability assessment, policies around device management, network infrastructure, information / data management and many other aspects of business.

      6.8.6.3.     Using lessons learnt to enhance the VUNHST Cyber Incident Response Plan:

- Properly capturing lessons, identifying owners for the actions that arise and ensuring that the actions are progressed is a necessity. Where there are areas for improvement, this is the stage where this is captured in a post-incident review and fed back into the response plan and future exercising.

6.8.6.4.    Notification to the Information Commissioner's Office (ICO):

- The General Data Protection Regulations (GDPR) introduces a duty on all organisations to report certain types of personal data breach to the relevant supervisory authority. This must be done within 72 hours of becoming aware of the breach, where feasible.  Where a national incident has resulted in a data breach, the Digital Services team will coordinate any ICO reporting with DHCW.

- If the breach is likely to result in a high risk of adversely affecting individuals' rights and freedoms, the Trust must also inform those individuals without undue delay.

- The Trust must also keep a record of any personal data breaches, regardless of whether you are required to notify.

6.8.6.5.    Reporting to Welsh Government (WG):

- Where required, the Trust will submit a 'WG No Surprises Form' to WG.  The requirement to submit this will be agreed by the Exec on-call and Chief Digital Officer.

- This form is to be reported directly from the Trust, with the intention of providing a high-level summary of a potential major incident that is under investigation.  A 'No Surprises' briefing is generally provided at the outset of a potentially significant incident and following its closure.

6.8.7.  **Regular Testing of the plan**

6.8.7.1.    To ensure that this plan remains fit for purpose, it is essential that regular review & testing is performed.  Following each test, if necessary the plan will be updated to reflect any change of circumstances, where required.

6.8.7.2.    *At six monthly intervals – full test of the plan using one or more fictitious IT business continuity incident scenarios*

The objective of this aspect of the testing is to ensure that the Trust continues to have the ability to respond effectively to an IT business continuity incident, that all necessary documentation is accessible, to ensure relevant staff members are aware of the process and that it remains part of the normal activities.

The Digital Services IT Infrastructure team will devise a suitable scenario to emulate an incident and then present it as an incident to check that the response aligns to the defined staps and actions required by this plan.

6.8.7.3.    At three monthly intervals – verifying accuracy of information in the plan

The objective of this aspect of the testing is to ensure that the Trust continues to have valid and accurate information and that the plan provides all necessary information.

The following details will be checked / updated by the owner of the plan:

- Verifying that up-to-date, off-line information is available
- Validating contact information for all nominated individuals recorded in the plan.
- Verifying that suitable log monitoring is being performed and the results are reviewed
- Verifying that OOB network access is available

## 7.     Equality Impact Assessment Statement

| | |
|---|---|
| **QUALITY AND SAFETY IMPLICATIONS/IMPACT** | There are no specific quality and safety implications related to the activity outlined in this report. |
| | n/a |
| **RELATED HEALTHCARE STANDARD** | Effective Care |
| | Standard 3.4 Information Governance & Technology |
| **EQUALITY IMPACT ASSESSMENT COMPLETED** | Not required |
| | |
| **LEGAL IMPLICATIONS / IMPACT** | Yes (Include further detail below) |
| | Failure to establish robust and effective procedures for managing serious IT incidents may expose the Trust to risk of financial penalties under the Networks & Information Systems (NIS) Directive, which requires organisations providing critical services to ensure adequate provisions are in place for preventing and managing IT service disruptions relating to network and information (including cyber) security. |
| **FINANCIAL IMPLICATIONS / IMPACT** | Yes (Include further detail below) |
| | Any move towards the establishment of an on-call arrangement for members of the Digital Delivery senior management team would require additional funding to support the associated costs. |

## 8. References

- VUNHST Cyber Incident Response Plan
- NHS Wales – Cyber Attack & ICT Incident Response Communication Framework
- NHS Wales IT Service Management – Service Level Target Policy
- Network & Information Systems (NIS) regulations
- NCSC – '10 steps to cyber security'
- ICO – Ransomware and data protection compliance

## 9. Getting Help

- Digital Services Department – 01443 622011

- Digital Services Portal – vunhst.wales/digitalservices

## 10. Related Policies

- SP-001 – IT Security Policy
- ITS-159 – Anti-virus software management and updates
- IG03 - All Wales Email US Policy
- ITS-011 – Anti-virus procedure
- IG04 – All Wales Information Security Policy
- IG05 – Software Policy
- IG02 – Data Protection & Confidentiality Policy
- IAR-02 - Digital Services Information Asset Register
- MP-057 – Business Continuity

## 11. Information, Instruction and Training

See section 6.6.7.

## 12. Main Relevant Legislation

- Network & Information System (NIS) Regulations
- General Data Protection Regulations (GDPR)

## Appendix A - Operational Decision Log

This template should be used during an incident, to record all major decisions that are made and also the supporting reasons for doing so.

Given the fast-moving pace of incident investigation, it is essential that all decisions made are recorded accurately.

| Investigation title | | Investigation lead | |
|---|---|---|---|
| **Page** | | | |
| **Date/time**<br>**dd/mm/yyyy – hh:mm** | **Action taken & by whom** | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## Appendix B – VUNHST IT Business Continuity Incident Response Plan
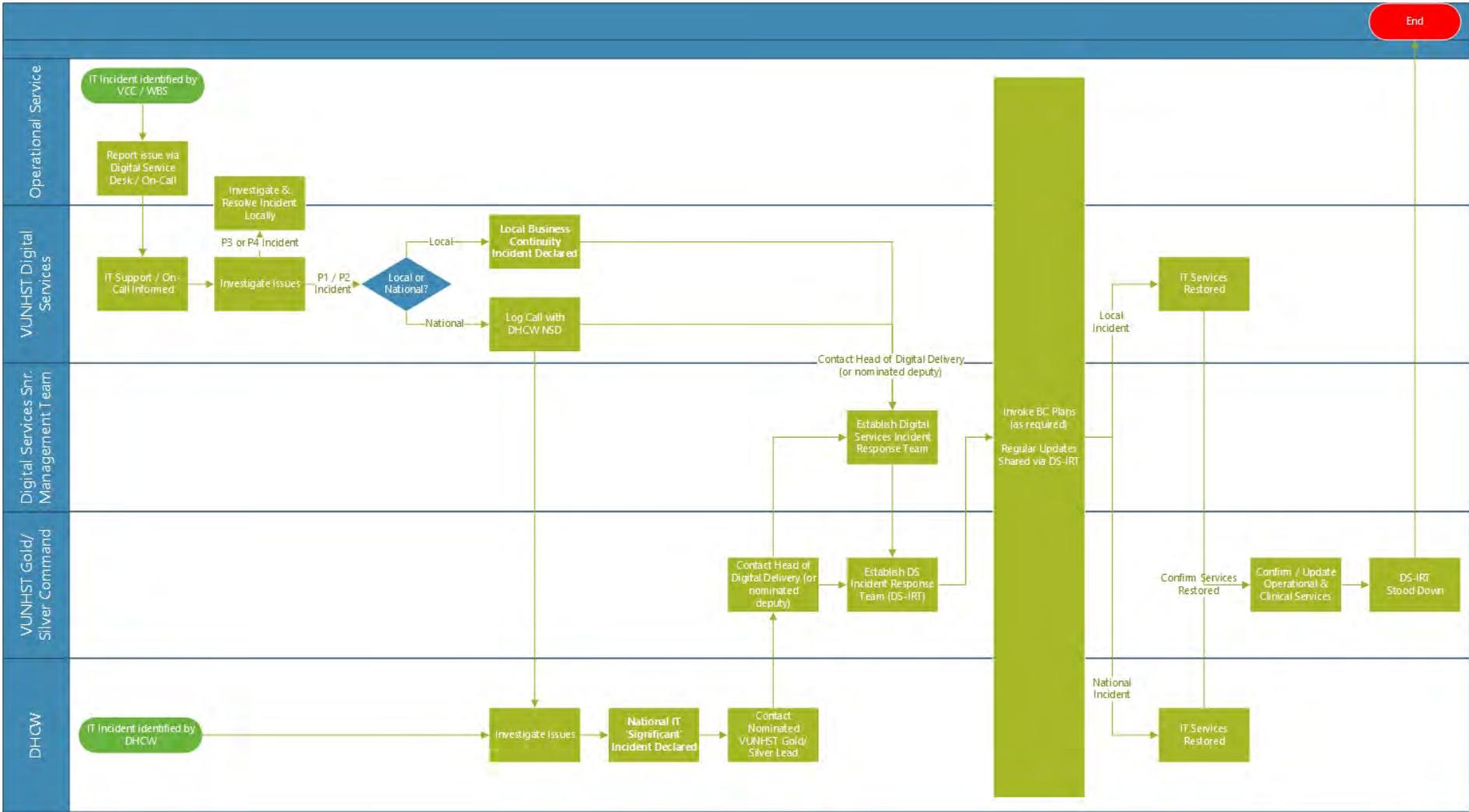
## QUALITY, SAFETY AND PERFORMANCE COMMITTEE

## VELINDRE UNIVERSITY NHS TRUST
## POLICY MANAGEMENT REVIEW AND COMPLIANCE
## STATUS: APRIL 2022

| DATE OF MEETING | 12/05/2022 |
|---|---|

| PUBLIC OR PRIVATE REPORT | Public |
|---|---|

| IF PRIVATE PLEASE INDICATE REASON | Not Applicable |
|---|---|

| PREPARED BY | Lenisha Wright, Business Support Officer<br>Kay Barrow, Corporate Governance Manager<br>Emma Stephens, Head of Corporate Governance |
|---|---|
| PRESENTED BY | Lauren Fear, Director of Corporate Governance & Chief of Staff |
| EXECUTIVE SPONSOR APPROVED | Lauren Fear, Director of Corporate Governance & Chief of Staff |

| REPORT PURPOSE | For **ASSURANCE** |
|---|---|

| COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING | | |
|---|---|---|
| COMMITTEE OR GROUP | DATE | OUTCOME |
| EXECUTIVE MANAGEMENT BOARD | 26/04/2022 | DISCUSSED & NOTED PROGRESS |
| **ACRONYMS** | | |
| VUNHST | Velindre University NHS Trust | |
| QSPC | Quality, Safety and Performance Committee | |

## 1. SITUATION

1.1    The purpose of this report is to provide the Quality Safety and Performance Committee with assurance on the progress that has been made on the second tranche of work undertaken in April 2022, as part of the step change in the governance and management arrangements for all Velindre University NHS Trust (VUNHST) Trust wide Policies, launched in March 2022.

1.2    The Quality Safety and Performance Committee is asked to:

   a.    **DISCUSS AND REVIEW** the findings of the Policy Compliance Status for those policies that fall within the remit of the Quality, Safety and Performance Committee.

   b.    **NOTE** the Quality, Safety & Performance Committee Policies Extract Compliance Report as at **20/04/2022,** included at *Appendices 1 to 6*.

   c.    Receive **ASSURANCE** that progress is being managed via the Executive Management Board.

## 2. BACKGROUND

2.1    A comprehensive review was launched in March 2022 of the existing arrangements in place for the management and reporting of Trust wide Policies. The purpose of which was to identify any areas for improvement to strengthen the operation of the governance framework, increase control to enable effective assurance arrangements and build firm foundations for a step change in the management and reporting of all Trust wide Policies.

2.2    The scope of the audit applies to all Trust wide policies. As such, any locally managed controlled documentation, for example Standard Operating Procedures that only apply to one of the core Divisions of the Trust are excluded from the scope of this work.

2.3    Currently there are circa **157** Trust wide policies that need to be assessed as part of the audit underway. As such, due to the scale and rigor required to complete a comprehensive and robust audit, a phased approach has been undertaken.

2.4    To date, the first tranche of the review, reported in March 2022 included:

   i.    Approval of the revised Trust Policy and Procedure for the Management of Trust Wide Policies and Other Trust Wide Written Control Documents, following a Pan-Wales benchmarking review of the 'Policy on Policy Management' from other Health Boards and Trusts.

   ii.    Root and branch audit of the status of the Trust wide policies that fall within the remit of the Quality, Safety and Performance Committee, initially excluding Workforce and OD Policies due to the large number circa 57.

   iii.    Creation of a new Document Control Register to accurately record the status and risk profile of all Trust wide policies that fall within the remit of the Quality, Safety and Performance Committee, to underpin future reporting and enhanced governance arrangements.

iv.    Assessment of the existing document control management systems in operation across the Trust to consider options available for the electronic management of all Trust wide Policies going forward, and action required to facilitate this.

## 3.    ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

### 3.1    Review of Current Trust Policy GC01 – Policy for the Production, Consultation, Approval, Publication and Dissemination of Strategies, Policies, Protocols, Procedures and Guidelines

A key component to the policy management arrangements was the approval of the revised Trust Policy and Procedure for the Management of Trust Wide Policies and Other Trust Wide Written Control Documents (GC01).

Following approval of GC01 Policy and Procedure for the Management of Trust Wide Policies and Other Trust Wide Written Control Documents by the Quality Safety and Performance Committee and noting by the Quality, Safety and Performance Committee and Trust Board in March 2022, the revised document has been updated on the Trust's intranet and website.

### 3.2    Policy Compliance Status

A risk-based phased approach has been adopted for the Policy Compliance Audit. The first phase of work has concentrated on a review of the Trust wide policies that fall within the remit of the Quality, Safety and Performance Committee and was reported in March 2022.

Whilst the first tranche audit excluded Workforce and OD Policies due to the volume held, these policies have now been included in the second tranche of this work.

The Corporate Governance team continue to review the latest policies held on record in order to collate a report including information on document control, review dates, policy status and risk assessments for the following directorates:

- Infection, Prevention and Control
- Information Governance, Corporate Communications and Digital
- Quality and Safety
- Estates, Planning and Performance
- Health and Safety
- Workforce and OD

Following the collation of data and information based on the review of the policies for the above, a comprehensive preliminary compliance report was compiled to highlight key information and was reported in March 2022.

Further validation and analysis have been undertaken through collaborative engagement with all of the relevant policy leads to determine status, risk profile and any ongoing actions required or underway. A summary of the outcome of this exercise is included at

*Appendices 1 to 6,* and a more detailed overview is provided below under section **3.2.4** **'Collaborative Engagement'**.

### 3.2.1 Policy Status

In recording the policy status, the key below was used to assess and capture various aspects of the policies status, including whether policies were in date or if review dates had passed. For those policies where review dates had passed, actions currently underway and other actions required were also captured which will form part of the ongoing monitoring by the Corporate Governance Team for assurance.

| POLICY STATUS KEY: |
| --- |
| Policy in date |
| Policy review date passed – action underway/required |
| All Wales Policy review date passed – awaiting national review |

### 3.2.2 Policy Risk Assessment

The key below was developed to assess any risks associated with policies with review dates that have passed, and the associated actions required to address this.

| POLICY RISK ASSESSMENT KEY: |
| --- |
| Policy in date with no risk assessment required |
| Policy review date passed with low risk |
| Policy review date passed with moderate risk |
| Policy review date passed with high risk |

### 3.2.3 Document Control Register

A document control register has been compiled to explain the outcome of the audit for effective monitoring and reporting purposes. This is included at *Appendices 1 to 6*. Ongoing updates and progress will be captured and recorded on the Document Control Register and continue to be reported against on a monthly basis until compliance status is 100% at which time the frequency of reporting will reduce to quarterly updates.

### 3.2.4 Collaborative Engagement Exercise

As indicated earlier, following an assessment of the policies currently held on record, collaborative engagement was undertaken with each of the respective Policy leads, namely:

| Directorates | Policy Lead(s) |
| --- | --- |
| Health and Safety | Health and Safety Manager |

| Directorates | Policy Lead(s) |
|---|---|
| Quality and Safety | Quality & Safety Manager, Claims Manager, Chief Pharmacist, Quality & Safety Facilitator, Senior Nurse Safeguarding & Public Protection, Interim Deputy Director of Nursing, Quality & Patient Experience |
| Infection, Prevention & Control | Head of Infection Prevention and Control, Interim Deputy Director of Nursing, Quality & Patient Experience |
| Information Governance and Digital | Head of Information Governance Head of Digital Delivery & Business Systems |
| Estates | Assistant Director of Estates |
| Workforce and OD | Executive Director of Organisational Development and Workforce, Head of Workforce |

The purpose of this engagement exercise was to confirm and validate the following:

- Whether the versions of the policies held on file were correct.
- Clarification on existing policies review dates.
- A risk assessment of policies passed their review date.
- Ongoing actions underway or actions required.

A summary is provided below of information gathered from the engagement exercise:

***Quality and Safety***

There are seven Quality and Safety policies currently in date. The following policies were approved by the Quality, Safety and Performance Committee (QSPC) on 24 March 2022:
- Handling Concerns Policy
- Incident Reporting and Investigation Policy

There are currently four policies outside their review date refer to ***Appendix 1***. Review and consultation for these will be completed by end June 2022 and submitted to QSPC for approval in quarter (Q) 2.

***Health and Safety***

The policy compliance status of all Health and Safety Policies remains at 100%. All Policies on record are in date with no risk assessment required. Clarification and confirmation have been established in discussions with the Health and Safety Manager for the Trust. See ***Appendix 5***.

### Infection, Prevention and Control (IPC)

Fourteen IPC policies are currently in date. The following policy was approved at QSPC on 24 March 2022:
- Viral Gastro Enteritis (including Norovirus) Policy

There are currently three IPC policies that have passed their review dates, refer to **Appendix 2**. The following actions are being taken.
- The Cleaning Policy is being reviewed by the Operations Manager in readiness for approval in Q2.
- The Legionellosis Policy is being reviewed by the Estates team in readiness for approval in Q2.
- The Meticillin Resistant Staphylococcus Aureus Policy will be submitted to Executive Management and in the April and May 2022 reporting cycle.

### Information Governance (IG), Digital and Corporate Communications

The following policies are in date:
- Internet Use Policy (Digital)
- Information Governance Policy (IG)
- Information Security Policy (IG).

There are 10 policies passed their review dates, two of which are All Wales Policies, refer to **Appendix 3**. The remaining eight Policies are currently being reviewed in readiness for submission to the QSPC for approval in Q2.

### Estates, Planning & Performance (EPP)

There are currently six Estates policies in date, however, there are nine policies passed their review date, refer to **Appendix 4**. The following five policies have been reviewed and updated and are currently undergoing the enhanced Equality Impact Assessment (EQIA) by the EQIA Officer:
- Water Safety Policy
- Environmental Policy
- Waste Management Policy
- Safety and Protocol Prevention of Fire and Arson Policy
- Asbestos Policy

The remaining four policies are currently under review and will resume the approval process in Q2.

### Workforce and Organisational Development (WOD)

As outlined earlier, Workforce and OD policies have been audited as part of this second tranche of work and the approach undertaken. Compliance status is outlined below.

The Workforce and Organisational Development (WOD) Team have reviewed the suite of policies against the document control register provided to them by the Corporate Governance Team in order to validate the document control and status.

A total of 53 policies were reviewed to determine compliance status. A summary of that status is provided below.

- 11 policies are currently in date.
- 34 policies have passed their review date, 10 of which are All Wales policies, with the remainder under review in readiness for submission to the approving body in Q2 and Q3.
- The table below provides details of the policies removed, archived and moved to another directorate.
  - Four policies have been removed from the register.
  - Three policies archived.
  - One policy has been moved to Corporate Communications.

| Policy Status | Policy Title | Reason / Note |
|---|---|---|
| Policies Removed | Framework for the Development of Consultant Practitioner Posts | This is a Framework not a Policy |
| | Time off and Facilities for Trade Union Representatives | This is a Framework not a Policy |
| | Procedure for Delivering Interpreter Services | Not classified as a policy |
| | Recruitment & Retention Payment Protocol | This is a guideline document not a policy |
| Policies Archived | Grievance Policy | Replaced by Respect and Resolution Policy |
| | Childcare Voucher Policy | Archived due to Legislation change |
| | Shared Parental Leave Policy | Will form part of the new Maternity and Parental Leave Policy |
| Policy moved to another Directorate | Dealing with Anonymous Communication Policy | Policy moved to Corporate Communications |

**Note:** More detail is provided in the *Appendices 6a, 6b & 6c*. The Appendices are split due to the length of the register.

### 3.2.5   Policy Audit Compliance Status

The findings of the Policy Audit Compliance Status for each of the directorates outlined above is reported below against the following categories:

- Number of policies audited
- Policy status
- Policies passed review dates
- Policy risk assessment

- ***Number of Policies audited***

As at 20/04/2022, an additional 53 Workforce and OD policies have been audited as the next phase of work in April 2022. Therefore, a total of 122 policies have been subject to a comprehensive audit since March 2022.

Figure 1 below provides a breakdown of these policies by Directorate.

**Figure 1: Number of Policies audited by Directorate**



Number of policies audited by Directorate
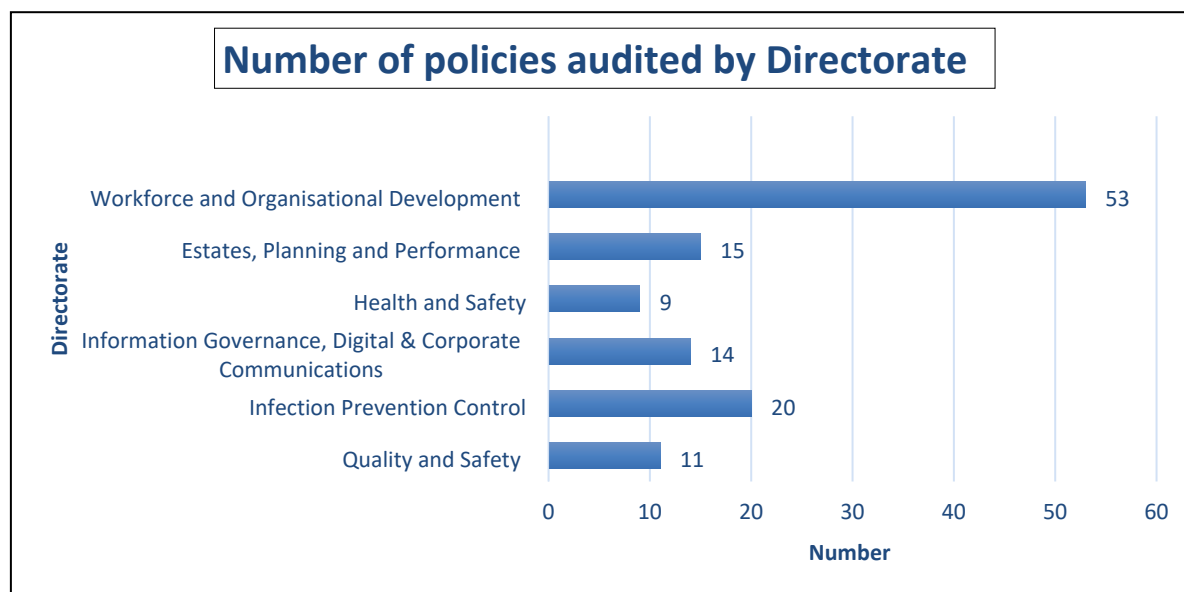
- Policy Status

Table 1 below provides an overview of the overall policy status for those policies that fall within the remit of the Quality, Safety & Performance Committee as at 20/04/2022.

**Table 1: Overall Policy Status**

| Policy Status | Number of Policies |
|---|---|
| Policy in date | 47 |
| Policy review date passed – action underway/required | 54 |
| All Wales Policy review date passed – awaiting national review | 11 |
| Policies Archived | 6 |
| Policies Removed / moved to another Directorate | 4 |
| Total | 122 |

Table 2 below provides an overview of the 122 policies audited per Directorate.

**Table 2: Overall Policy Status by Directorate**

| Policy Directorate | Policy in date | Policy review date passed – action underway/required | All Wales Policy review date passed – awaiting national review | Policies Archived | Policies Removed / moved to another Directorate |
|---|---|---|---|---|---|
| Health and Safety | 9 | 0 | 0 | 0 | 0 |
| Quality and Safety | 5 | 6 | 0 | 0 | 0 |
| Information Governance, Digital & Corporate Communications | 4 | 10 | 0 | 0 | 0 |
| Infection, Prevention & Control | 12 | 5 | 1 | 2 | 0 |
| Estates, Planning & Performance | 6 | 9 | 0 | 0 | 0 |
| Workforce and Organisational Development | 11 | 24 | 10 | 4 | 4 |
| | 0 | 0 | 0 | 0 | 0 |
| Total | 47 | 54 | 11 | 6 | 4 |

- ***Policies Passed their Review Dates***

Table 3 below provides a summary of the number of policies passed their review dates.

- o Seven policies have passed their review dates between January 2010 and December 2016.
- o Four policies have passed their review dates between January 2017 and December 2018.
- o 37 policies have passed their review dates between January 2019 and February 2022.

**Table 3: Policies passed their review dates**

| | Jan 2010 to Dec 2016 | Jan 2017 to Dec 2018 | Jan 2019 to Feb 2022 |
|---|---|---|---|
| Infection Prevention and Control | 1 | 2 | 0 |
| Quality & Safety | 0 | 1 | 3 |
| IG, Digital & Corporate Communications | 0 | 0 | 8 |
| Estates | 0 | 0 | 9 |
| Health and Safety | 0 | 0 | 0 |
| Workforce & OD | 6 | 1 | 17 |
| **Total** | **7** | **4** | **37** |

**Note:** Of the seven policies with review dates between 2010 and 2016, it should be noted that all policies are under review in readiness for submission to the approving body in Q2 and Q3.

- ***Policy Risk Assessment***

The policy audit included an exercise to establish any risks associated with policies that have passed their review date, excluding All Wales policies. The table below provides a breakdown by Directorate/Department and the associated risk assessments.

**Note:** The total number of policies in **Table 4** below is 100, as it excludes All Wales policies, archived and removed policies.

Table 4 below provides an overall breakdown of policies audited that have passed their review dates as well as a breakdown by Directorate/Department.

**Table 4: Policy Risk Assessment**

**Figure 2: Policy Risk Assessment by Directorate**



Policy Risk Assessment

- Policy in date with no risk assessment required
- Policy review date passed with low risk
- Policy review date passed with moderate risk
- Policy review date passed with high risk

| | | Information | | | ce & tional ment |
|---|---|---|---|---|---|
| P w as re | | | | | |
| P d: w | | | | | |
| P d: w ris | | | | | |
| Policy review date passed with high risk | 0 | 0 | 0 | 0 | 0 | 0 |
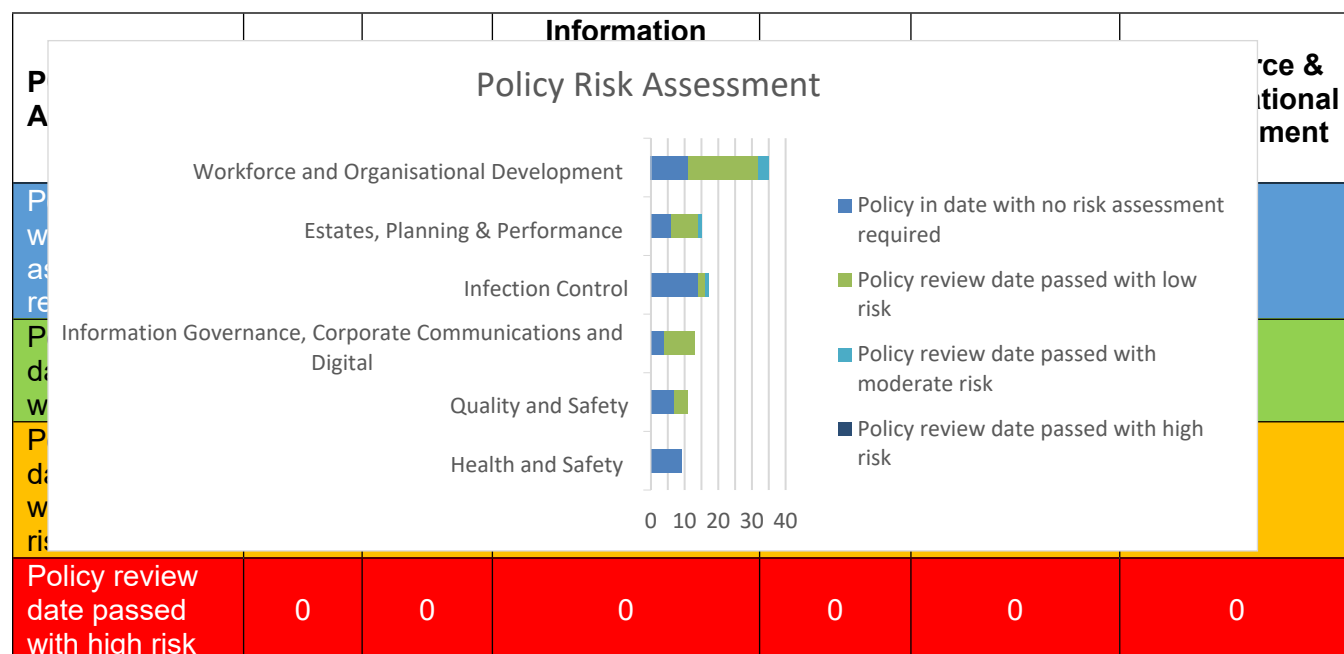
### 3.2.6 Overall Policy Compliance Status

Figure 3 below represents the overall compliance status of the audit work on policies as at 20/04/2022 that fall within the remit of the Quality, Safety and Performance Committee.

**Figure 3: Overall Compliance**

**OVERALL COMPLIANCE**

Policy review date passed with moderate risk
5%

Policy review date passed with low risk
44%

Policy in date with no risk assessment required
51%

## 4. IMPACT ASSESSMENT

| | |
|---|---|
| **QUALITY AND SAFETY IMPLICATIONS/IMPACT** | Yes (Please see detail below) |
| | A robust and clear governance framework for the management of policies is essential to minimise risk to patients, employees and the organisation itself; therefore, the Trust has developed a system to support the development or review, approval, dissemination and management of polices. |
| **RELATED HEALTHCARE STANDARD** | Governance, Leadership and Accountability |
| | If more than one Healthcare Standard applies please list below: |
| **EQUALITY IMPACT ASSESSMENT COMPLETED** | Yes |
| | |
| **LEGAL IMPLICATIONS / IMPACT** | There are no specific legal implications related to the activity outlined in this report. |
| | |
| **FINANCIAL IMPLICATIONS / IMPACT** | There is no direct impact on resources as a result of the activity outlined in this report. |
| | |

## 5. NEXT PHASE OF POLICY AUDIT COMPLIANCE STATUS

The next phase of the audit will include a review of all policies that fall within the remit of the Strategic Development Committee and will be reported in May 2022. This will be followed by a review of all policies that fall within the remit of the Audit Committee and will be reported in June 2022.

## 6. RECOMMENDATIONS

The Quality Safety and Performance Committee is asked to:

a. **DISCUSS AND REVIEW** the findings of the second tranche of the Policy Management Review and compliance status for those policies that fall within the remit of the Quality, Safety and Performance Committee including the Workforce and OD Policies, which had previously been excluded from the first tranche review.

b. **NOTE** the Quality, Safety & Performance Committee Policies Extract Compliance Report as at **20/04/2022,** included at *Appendices 1 to 6* for assurance on the progress that has been made on the second tranche of work undertaken in April 2022*.*

c. Receive **ASSURANCE** that progress is being managed via the Executive Management Board.

## APPENDIX 1: QUALITY AND SAFETY POLICY REGISTER

| Directorate/ Department | Policy Reference | Policy Title | Accountable Executive Lead | Approving Body | Policy Review Date (3 year cycle) | Updated Policy Approval Status | Policy status | Policy Risk assessment |
|---|---|---|---|---|---|---|---|---|
| Quality & Safety | QS 08 | Policy for the management of Safeguarding Allegations/ Concerns about Practitioners and those in a position of trust | Executive Director of Nursing, AHPs and Health Sciences | EMB - Endorsing QSP - Approval Trust Board - Policy Update | Mar-23 | | Policy in date | Policy in date with no risk assessment required |
| Quality & Safety | QS 12 | Safeguarding & Public Protection Policy | Executive Director of Nursing, AHPs and Health Sciences | EMB - Endorsing QSP - Approval Trust Board - Policy Update | Mar-23 | | Policy in date | Policy in date with no risk assessment required |
| Quality & Safety | QS 04a&b | Compensation Claims Policy & Compensation Claims Procedure | Executive Director of Nursing, AHPs and Health Sciences | EMB - Endorsing QSP - Approval Trust Board - Policy Update | Sep-22 | | Policy in date | Policy in date with no risk assessment required |
| Quality & Safety | All Wales | All Wales Model Policy Consent to Examination or Treatment | Executive Director of Nursing, AHPs and Health Sciences | EMB - Endorsing for adoption QSP - Approval for adoption Trust Board - Noting | Jun-22 | | Policy in date | Policy in date with no risk assessment required |
| Quality & Safety | QS 02 | Safety Alert Procedure | Executive Director of Nursing, AHPs and Health Sciences | EMB - Endorsing QSP - Approval Trust Board - Policy Update | Jun-22 | | Policy in date | Policy in date with no risk assessment required |
| Quality & Safety | QS 03 | Handling Concerns Policy | Executive Director of Nursing, AHPs and Health Sciences | EMB - Endorsing QSP - Approval Trust Board - Policy Update | Apr-25 | Approved by QSP on 24.03.2022 | Policy in date | Policy in date with no risk assessment required |
| Quality & Safety | QS 01 | Incident Reporting and Investigation Policy | Executive Director of Nursing, AHPs and Health Sciences | EMB - Endorsing QSP - Approval Trust Board - Policy Update | Apr-25 | Approved by QSP on 24.03.2022 | Policy in date | Policy in date with no risk assessment required |
| Quality & Safety | QS 07 | Medical Gas Cylinders Policy | Executive Medical Director | EMB - Endorsing QSP - Approval Trust Board - Policy Update | Dec-21 | May/June review and consultation July/August Approving Body | Policy review date passed – action underway/required | Policy review date passed with low risk |
| Quality & Safety | QS 19 | Ionising Radiation Safety Policy | Executive Medical Director | EMB - Endorsing QSP - Approval Trust Board - Policy Update | Nov-21 | May/June Consultation July/August Approving Body | Policy review date passed – action underway/required | Policy review date passed with low risk |
| Quality & Safety | QS 31 | International Health Partnership related Activity Policy | Executive Director of Nursing, AHPs and Health Sciences | EMB - Endorsing QSP - Approval Trust Board - Policy Update | Dec-19 | May/June Consultation July/August Approving Body | Policy review date passed – action underway/required | Policy review date passed with low risk |
| Quality & Safety | QS 25 | Preceptorship Policy for Newly Registered Nurses and Allied Health Care Professionals | Executive Director of Nursing, AHPs and Health Sciences | EMB - Endorsing QSP - Approval Trust Board - Policy Update | Mar-18 | May/June Consultation July/August Approving Body | Policy review date passed – action underway/required | Policy review date passed with low risk |

# APPENDIX 2: INFECTION, PREVENTION AND CONTROL POLICY REGISTER

| Directorate/ Department | Policy Reference | Version | Policy Title | Policy Lead | Accountable Executive Lead | Approving Body | Policy Review Date (3 year cycle) | Updated Policy Approval Status | Policy status | Policy Risk assessment |
|---|---|---|---|---|---|---|---|---|---|---|
| Infection, Prevention and Control | IPC 14 | Version 3 | Outbreak Management Policy | Head of Infection Prevention and Control | Executive Director of Nursing, AHPs and Health Sciences | EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting | Sep-13 | | Archived Policy & superceded by National IPC manual | N/A |
| Infection, Prevention and Control | IPC 02 | Version 2 | Standard Infection Control and Transmission Based Precautions | Head of Infection Prevention and Control | Executive Director of Nursing, AHPs and Health Sciences | EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting | Feb-15 | | Archived Policy & superceded by National IPC manual | N/A |
| Infection, Prevention and Control | IPC 01 | Version 4 | Viral Gastro Enteritis (including Norovirus) Policy & Addendum | Head of Infection Prevention and Control | Executive Director of Nursing, AHPs and Health Sciences | EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting | Dec-20 | Approved by QSP on 24.03.2022 | Policy in date | Policy in date with no risk assessment required |
| Infection, Prevention and Control | IPC 04 | Version 3 | Decontamination Policy | Head of Infection Prevention and Control | Executive Director of Nursing, AHPs and Health Sciences | EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting | Jun-21 | Approved by QSP on 24.03.2022 | Policy in date | Policy in date with no risk assessment required |
| Infection, Prevention and Control | IPC 03 | Version 1 | ANNT IPC Policy | Head of Infection Prevention and Control | Executive Director of Nursing, AHPs and Health Sciences | EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting | Jun-22 | | Policy in date | Policy in date with no risk assessment required |
| Infection, Prevention and Control | IPC 09 | Version 4 | Sharps Safety Policy & Addendum | Head of Infection Prevention and Control | Executive Director of Nursing, AHPs and Health Sciences | EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting | Jun-22 | | Policy in date | Policy in date with no risk assessment required |
| Infection, Prevention and Control | IPC 10 | Version 5 | Hand Hygiene Policy | Head of Infection Prevention and Control | Executive Director of Nursing, AHPs and Health Sciences | EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting | Jun-22 | | Policy in date | Policy in date with no risk assessment required |
| Infection, Prevention and Control | IPC 12 | Version 1 | Guidelines on Single Use Medical Devices | Head of Infection Prevention and Control | Executive Director of Nursing, AHPs and Health Sciences | EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting | Jun-22 | | Policy in date | Policy in date with no risk assessment required |
| Infection, Prevention and Control | IPC 21 | Version 3 | Infection Prevention and Control Policy for the Management of Respiratory Infections and Addendum | Head of Infection Prevention and Control | Executive Director of Nursing, AHPs and Health Sciences | EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting | Jun-22 | | Policy in date | Policy in date with no risk assessment required |
| Infection, Prevention and Control | IPC 00 | Version 5 | Framework Policy for Infection Prevention and Control | Head of Infection Prevention and Control | Executive Director of Nursing, AHPs and Health Sciences | EMB - Endorsing QSP - Approval Trust Board - Policy Update Noting | Jul-22 | | Policy in date | Policy in date with no risk assessment required |
| Infection, Prevention and Control | IPC 06 | Version 4 | Policy for the Management of Occupational Exposure to Blood and High Risk Body Fluids | Head of Infection Prevention and Control | Executive Director of Nursing, AHPs and Health Sciences | EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting | Sep-22 | | Policy in date | Policy in date with no risk assessment required |
| Infection, Prevention and Control | IPC 13 | Version 5 | Policy for the Prevention and Control of Transmissible Spongiform | Head of Infection Prevention and Control | Executive Director of Nursing, AHPs and Health Sciences | EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting | Sep-22 | | Policy in date | Policy in date with no risk assessment required |
| Infection, Prevention and Control | IPC 19 | Version 4 | Infection Prevention and Control within Building Development, Change and Adaptation Policy | Head of Infection Prevention and Control | Executive Director of Nursing, AHPs and Health Sciences | EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting | Sep-22 | | Policy in date | Policy in date with no risk assessment required |
| Infection, Prevention and Control | IPC 11 | Version 4 | Specimen Collection, Handling and Transport Policy | Head of Infection Prevention and Control | Executive Director of Nursing, AHPs and Health Sciences | EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting | Dec-22 | | Policy in date | Policy in date with no risk assessment required |
| Infection, Prevention and Control | IPC 15 | Version 2 | Control and Management of Multi Drug Resistant Bacteria | Head of Infection Prevention and Control | Executive Director of Nursing, AHPs and Health Sciences | EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting | Jun-24 | | Policy in date | Policy in date with no risk assessment required |
| Infection, Prevention and Control | IPC 18 | Version 4 | Tuberculosis Management | Head of Infection Prevention and Control | Executive Director of Nursing, AHPs and Health Sciences | EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting | Dec-24 | | Policy in date | Policy in date with no risk assessment required |
| Infection, Prevention and Control | All Wales | Missing | Scottish Manual for IPC | All Wales | Executive Director of Nursing, AHPs and Health Sciences | EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting | Missing | | All Wales Policy review date passed – awaiting national review | Policy review date passed with low risk |
| Infection, Prevention and Control | IPC 07 | Version 3 | Meticillin Resistant Staphylococcus Aureus (MRSA) | Head of Infection Prevention and Control | Executive Director of Nursing, AHPs and Health Sciences | EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting | Jun-17 | Q1 22/23 to EMB | Policy review date passed – action underway/required | Policy review date passed with low risk |
| Infection, Prevention and Control | IPC 22 (previous IP | Version 1 | Management and Control of the Environment (Cleaning) | Operations Manager | Chief Operating Officer | EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting | May-10 | Review Q1 Approval finalised Q 2 | Policy review date passed – action underway/required | Policy review date passed with moderate risk |
| Infection, Prevention and Control | IPC 16 | Version 3 | Policy for the Management of Prevention and Control of Legionellosis | Head of Estates | Director of Strategic Transformation, Planning & Digital | EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting | Jun-18 | Review Q1 Approval finalised Q 1 | Policy review date passed – action underway/required | Policy review date passed with moderate risk |

**APPENDIX 3: DIGITAL, INFORMATION GOVERNANCE AND CORPORATE GOVERNANCE POLICY REGISTER**

| Directorate/ Department | Policy Reference | Version | Policy Title | Policy Lead | Accountable Executive Lead | Approving Body | Policy Review Date (3 year cycle) | Updated Policy Approval Status | Policy status | Policy Risk assessment |
|---|---|---|---|---|---|---|---|---|---|---|
| Digital | All Wales | Version 3 | Internet Use Policy | All Wales Policy | Director of Strategic Transformation, Planning & Digital | EMB - Endorsing for Trust Adoption<br>QSP - Approval for Adoption<br>Trust Board - Policy update report | Jan-23 | | Policy in date | Policy in date with no risk assessment required |
| IG | All Wales | Version 2 | Information Governance Policy | All Wales Policy | Executive Director of Finance | EMB - Endorsing for Trust Adoption<br>QSP - Approval for Adoption<br>Trust Board - Policy update report | Jan-23 | | Policy in date | Policy in date with no risk assessment required |
| IG | All Wales | Version 2 | Information Security Policy | All Wales Policy | Executive Director of Finance | EMB - Endorsing for Trust Adoption<br>QSP - Approval for Adoption<br>Trust Board - Policy update report | Jan-23 | | Policy in date | Policy in date with no risk assessment required |
| Corporate Communications | IG 08 | Version 4 | FOI Standard Operating Procedure | Assistant Director Communications | Director Corporate Governance and Chief of Staff | EMB - Endorsement<br>QSP - Noting | Apr-22 | | Policy in date | Policy in date with no risk assessment required |
| Corporate Communications | All Wales | Version 1 | Social Media Policy | All Wales Policy | Director Corporate Governance and Chief of Staff | EMB - Endorsing for Trust Adoption<br>QSP - Approval for Adoption<br>Trust Board - Policy update report | Jan-18 | | Policy review date passed – action underway/required | Policy review date passed with moderate risk |
| Digital | All Wales | Version 2 | Email Use Policy | All Wales Policy | Director of Strategic Transformation, Planning & Digital | EMB - Endorsing for Trust Adoption<br>QSP - Approval for Adoption<br>Trust Board - Policy update report | Jun-18 | | Policy review date passed – action underway/required | Policy review date passed with low risk |
| Digital | IG 05 | Version 3 | Software Policy | Head of Digital Delivery | Director of Strategic Transformation, Planning & Digital | EMB - Endorsement<br>QSP - Approval | Feb-19 | April/May Consultation June/July Approving Body | Policy review date passed – action underway/required | Policy review date passed with low risk |
| Corporate Governance | IG 08 | Version 1 | FOI Act Policy | Head of Information Governance | Director Corporate Governance and Chief of Staff | EMB - Endorsement<br>QSP - Noting | Feb-21 | April/May Consultation June/July Approving Body | Policy review date passed – action underway/required | Policy review date passed with low risk |
| IG | IG 01 | Version 1 | Records Management Policy | Head of Information Governance | Executive Director of Finance | EMB - Endorsement<br>QSP - Approval | Feb-21 | April/May Consultation June/July Approving Body | Policy review date passed – action underway/required | Policy review date passed with low risk |
| IG | IG 02 | Version 1 | Data Protection & Confidentiality Policy | Head of Information Governance | Executive Director of Finance | EMB - Endorsement<br>QSP - Approval | Feb-21 | April/May Consultation June/July Approving Body | Policy review date passed – action underway/required | Policy review date passed with low risk |
| IG | IG 13 | Version 1 | Confidentiality Breach Reporting Policy | Head of Information Governance | Executive Director of Finance | EMB - Endorsement<br>QSP - Approval | May-21 | April/May Consultation June/July Approving Body | Policy review date passed – action underway/required | Policy review date passed with low risk |
| IG | IG 14 | Version 1 | Information Asset Policy | Head of Information Governance | Executive Director of Finance | EMB - Endorsement<br>QSP - Approval | May-21 | April/May Consultation June/July Approving Body | Policy review date passed – action underway/required | Policy review date passed with low risk |
| Digital | IG 11 | Version 1 | Data Quality Policy | Head of Digital Delivery | Director of Strategic Transformation, Planning & Digital | EMB - Endorsement<br>QSP - Approval | Dec-21 | April/May Consultation June/July Approving Body | Policy review date passed – action underway/required | Policy review date passed with low risk |
| Digital | IG 06 | Version 3 | Anti Virus Policy | Head of Digital Delivery | Director of Strategic Transformation, Planning & Digital | EMB - Endorsement<br>QSP - Approval | Feb-22 | April/May Consultation June/July Approving Body | Policy review date passed – action underway/required | Policy review date passed with low risk |

# APPENDIX 4: ESTATES, PLANNING AND PERFORMANCE POLICY REGISTER

| Directorate/ Department | Policy Reference | Version | Policy Title | Policy Lead | Accountable Executive Lead | Approving Body | Policy Review Date (3 year cycle) | Updated Policy Approval Status | Policy status | Policy Risk assessment |
|---|---|---|---|---|---|---|---|---|---|---|
| Estates, Planning & Performance | PP 10 | Version 1 | Medical Gas Piped Systems Policy | Assistant Director of Estates | Director of Strategic Transformation, Planning & Digital | Quality, Safety & Performance Committee | Aug-23 | | Policy in date | Policy in date with no risk assessment required |
| Estates, Planning & Performance | PP 11 | Version 1 | Operational Policy for High Voltage Electricity Supply Systems using a contractor as the Authorised Person (HV) | Assistant Director of Estates | Director of Strategic Transformation, Planning & Digital | Quality, Safety & Performance Committee | Aug-23 | | Policy in date | Policy in date with no risk assessment required |
| Estates, Planning & Performance | PP 12 | Version 1 | Operational Policy for High Voltage Electricity Supply Systems | Assistant Director of Estates | Director of Strategic Transformation, Planning & Digital | Quality, Safety & Performance Committee | Aug-23 | | Policy in date | Policy in date with no risk assessment required |
| Estates, Planning & Performance | PP 14 | Version 1 | Ventilation Policy | Assistant Director of Estates | Director of Strategic Transformation, Planning & Digital | Quality, Safety & Performance Committee | Aug-23 | | Policy in date | Policy in date with no risk assessment required |
| Estates, Planning & Performance | PP 01 | Version 4 | Fire Safety Policy | Fire Safety Manager | Director of Strategic Transformation, Planning & Digital | Quality, Safety & Performance Committee | Sep-23 | | Policy in date | Policy in date with no risk assessment required |
| Estates, Planning & Performance | PP 13 | Version 1 | Electrical Low Voltage Policy | Assistant Director of Estates | Director of Strategic Transformation, Planning & Digital | Quality, Safety & Performance Committee | Sep-23 | | Policy in date | Policy in date with no risk assessment required |
| Estates, Planning & Performance | PP 09 | Version 1 | Water Safety Policy | Assistant Director of Estates | Director of Strategic Transformation, Planning & Digital | Quality, Safety & Performance Committee | Sep-20 | May/June Consultation July/August Approving Body | Policy review date passed – action underway/required | Policy review date passed with low risk |
| Estates, Planning & Performance | PP 01a | Version 1 | Safety and Protocol Prevention of Fire and Arson | Fire Safety Manager | Director of Strategic Transformation, Planning & Digital | Quality, Safety & Performance Committee | Feb-21 | May/June Consultation July/August Approving Body | Policy review date passed – action underway/required | Policy review date passed with low risk |
| Estates, Planning & Performance | PP 03 | Version 1 | Environmental Policy | Assistant Director of Estates | Director of Strategic Transformation, Planning & Digital | Quality, Safety & Performance Committee | Mar-21 | May/June Consultation July/August Approving Body | Policy review date passed – action underway/required | Policy review date passed with low risk |
| Estates, Planning & Performance | PP 08 | Version 1 | Waste Management Policy | Assistant Director of Estates | Director of Strategic Transformation, Planning & Digital | Quality, Safety & Performance Committee | Mar-21 | May/June Consultation July/August Approving Body | Policy review date passed – action underway/required | Policy review date passed with low risk |
| Estates, Planning & Performance | PP 06 | Version 2 | Business Continuity Policy | Interim Director WBS | Chief Operating Officer | Quality, Safety & Performance Committee | Apr-21 | May/June Consultation July/August Approving Body | Policy review date passed – action underway/required | Policy review date passed with low risk |
| Estates, Planning & Performance | PP 07 | Version 2 | Protocol for dealing with suspect packages and bomb threats | Assistant Director of Estates | Director of Strategic Transformation, Planning & Digital | Quality, Safety & Performance Committee | Jul-21 | May/June Consultation July/August Approving Body | Policy review date passed – action underway/required | Policy review date passed with low risk |
| Estates, Planning & Performance | PP 02 | Version 1 | Security Policy | Assistant Director of Estates | Director of Strategic Transformation, Planning & Digital | Quality, Safety & Performance Committee | Nov-21 | May/June Consultation July/August Approving Body | Policy review date passed – action underway/required | Policy review date passed with low risk |
| Estates, Planning & Performance | PP 05 | Version 1 | Control of Contractors | Assistant Director of Estates | Director of Strategic Transformation, Planning & Digital | Quality, Safety & Performance Committee | Nov-21 | May/June Consultation July/August Approving Body | Policy review date passed – action underway/required | Policy review date passed with low risk |
| Estates, Planning & Performance | PP 04 | Version 1 | Asbestos Policy | Assistant Director of Estates | Director of Strategic Transformation, Planning & Digital | Quality, Safety & Performance Committee | Dec-20 | May/June Consultation July/August Approving Body | Policy review date passed – action underway/required | Policy review date passed with moderate risk |

## APPENDIX 5: HEALTH AND SAFETY POLICY REGISTER

| Directorate/ Department | Policy Reference | Version | Policy Title | Policy Lead | Accountable Executive Lead | Approving Body | Policy Review Date (3 year cycle) | Policy Approval Status | Policy status | Policy Risk assessment |
|---|---|---|---|---|---|---|---|---|---|---|
| Health and Safety | QS 36 | Version 1 | Workplace Equipment Policy | Health and Safety Manager | Director of Strategic Transformation, Planning & Digital | EMB - Endorsement QSP - Approval | Sep-22 | N/A | Policy in date | Policy in date with no risk assessment required |
| Health and Safety | QS 24 | Version 4 | Medical Devices & Equipment Management Policy | Medical devices officer | Director of Strategic Transformation, Planning & Digital | EMB - Endorsement QSP - Approval | Jan-23 | N/A | Policy in date | Policy in date with no risk assessment required |
| Health and Safety | QS 09 | Version 6 | Latex Policy | Health and Safety Manager | Director of Strategic Transformation, Planning & Digital | EMB - Endorsement QSP - Approval | Mar-23 | N/A | Policy in date | Policy in date with no risk assessment required |
| Health and Safety | QS 14 | Version 7 | Safer Manual Handling Policy | Health and Safety Manager | Director of Strategic Transformation, Planning & Digital | EMB - Endorsement QSP - Approval | Mar-23 | N/A | Policy in date | Policy in date with no risk assessment required |
| Health and Safety | QS 15 | Version 7 | Management of Violence & Agression Policy | Health and Safety Manager | Director of Strategic Transformation, Planning & Digital | EMB - Endorsement QSP - Approval | Mar-23 | N/A | Policy in date | Policy in date with no risk assessment required |
| Health and Safety | QS 18 | Version 7 | Health Safety & Welfare Policy | Health and Safety Manager | Director of Strategic Transformation, Planning & Digital | EMB - Endorsement QSP - Approval | Mar-23 | N/A | Policy in date | Policy in date with no risk assessment required |
| Health and Safety | QS 30 | Version 7 | Lone Working Policy | Health and Safety Manager | Director of Strategic Transformation, Planning & Digital | EMB - Endorsement QSP - Approval | Mar-23 | N/A | Policy in date | Policy in date with no risk assessment required |
| Health and Safety | QS 33 | Version 4 | Control of Substances Hazardous to Health (COSHH) | Health and Safety Manager | Director of Strategic Transformation, Planning & Digital | EMB - Endorsement QSP - Approval | Mar-23 | N/A | Policy in date | Policy in date with no risk assessment required |
| Health and Safety | QS 26 | Version 5 | Safe Use of Display Screen Equipment & Appendices | Health and Safety Manager | Director of Strategic Transformation, Planning & Digital | EMB - Endorsement QSP - Approval | May-23 | N/A | Policy in date | Policy in date with no risk assessment required |

# APPENDIX 6a: WORKFORCE AND ORGANISATIONAL DEVELOPMENT POLICY REGISTER

| Directorate/ Department | Policy Reference | Version | Policy Title | Policy Lead | Accountable Executive Lead | Approving Body | Review Due (3 year cycle) | Updated Policy Approval Status | Policy Status | Policy Risk Assessment |
|---|---|---|---|---|---|---|---|---|---|---|
| Workforce & OD | WF 03 | No version | Grievance Policy | All Wales Policy | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting | 01/03/2019 | Archived | N/A | N/A |
| Workforce & OD | WF 37 | No version | Childcare Voucher Policy | Diversity and Equality Manager | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting | 26/09/2016 | Archived | N/A | N/A |
| Workforce & OD | WF 49 | Version 2 | Shared Parental Leave Policy | Deputy Director of OD & Workforce | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting | 01/12/2021 | Archived | N/A | N/A |
| Workforce & OD | WF 48 | Version 2 | Dealing with Anonymous Communication Policy | Deputy Director of OD & Workforce | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting | 01/10/2021 | Moved | N/A | N/A |
| Workforce & OD | 120 | No version | Framework for the Development of Consultant Practitioner Posts | Deputy Director of OD & Workforce | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting | 01/04/2024 | Remove - Not a policy | N/A | N/A |
| Workforce & OD | All Wales Velindre adopted | No version | Time off and Facilities for Trade Union Representatives | All Wales Policy | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Endorsement Trust Board - Adopt | 01/06/2016 | Remove - Not a policy | N/A | N/A |
| Workforce & OD | GC14 | No version | Procedure for Delivering Interpreter Services | Deputy Director of OD & Workforce | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting | 26/09/2016 | Remove - Not a policy | N/A | N/A |
| Workforce & OD | No Ref WF04 | No version | Recruitment & Retention Payment Protocol | Deputy Director of OD & Workforce | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting | 01/04/2020 | Remove - Not a policy | N/A | N/A |
| Workforce & OD | All Wales Velindre adopted | No Version | Reserve Forces Training and Mobilisation Policy | Deputy Director of OD & Workforce | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting | 01/03/2024 | | Policy in date | Policy in date with no risk assessment required |
| Workforce & OD | All Wales Velindre adopted | No Version | Respect and Resolution Policy | Deputy Director of OD & Workforce | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting | 01/04/2024 | | Policy in date | Policy in date with no risk assessment required |
| Workforce & OD | All Wales Velindre adopted | No version | Secondment Policy | Deputy Director of OD & Workforce | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Endorsement Trust Board - Adopt | 01/07/2024 | | Policy in date | Policy in date with no risk assessment required |
| Workforce & OD | All Wales Velindre adopted | | Employment Break Scheme | Deputy Director of OD & Workforce | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting | 02/01/2023 | | Policy in date | Policy in date with no risk assessment required |
| Workforce & OD | GC 03 | Version 3 | Standards of Behaviour Policy | Deputy Director of OD & Workforce | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting | 01/11/2022 | | Policy in date | Policy in date with no risk assessment required |
| Workforce & OD | WF 10 | No Version | Employer Pension Contritubtions Alternative Payment Policy | Deputy Director of OD & Workforce | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting | Dates missing on front page | | Policy in date | Policy in date with no risk assessment required |
| Workforce & OD | WF 16 | Version 3 | Welsh Language Policy | Deputy Director of OD & Workforce | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting | 01/05/2022 | | Policy in date | Policy in date with no risk assessment required |
| Workforce & OD | WF 18 | Version 2 | Alcohol, Drugs & Sustance Misuse Policy | Deputy Director of OD & Workforce | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting | 01/06/2022 | | Policy in date | Policy in date with no risk assessment required |
| Workforce & OD | WF 21 | Version 1 | Professional Registration Policy | Deputy Director of OD & Workforce | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting | 01/06/2022 | | Policy in date | Policy in date with no risk assessment required |
| Workforce & OD | WF 54 | Version 1 | Violence, Domestic Abuse & Sexual Violence Workplace Policy & Procedure | Deputy Director of OD & Workforce | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting | 01/07/2023 | | Policy in date | Policy in date with no risk assessment required |
| Workforce & OD | WF 55 | Version 5 | Smoke Free Policy | Deputy Director of OD & Workforce | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting | 01/06/2022 | | Policy in date | Policy in date with no risk assessment required |

# APPENDIX 6b: WORKFORCE AND ORGANISATIONAL DEVELOPMENT POLICY REGISTER

| Directorate/ Department | Policy Reference | Version | Policy Title | Policy Lead | Accountable Executive Lead | Approving Body | Review Due (3 year cycle) | Updated Policy Approval Status | Policy Status | Policy Risk Assessment |
|---|---|---|---|---|---|---|---|---|---|---|
| Workforce & OD | All Wales Velindre adopted | Version 2 | Dress Code and Uniform Policy | All Wales Policy | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting | 01/02/2018 | All Wales | Policy review date passed – action underway/required | Policy review date passed with low risk |
| Workforce & OD | All Wales Velindre adopted | Version 4 | Upholding Professional Standards in Wales (Medical Staff Only) | All Wales Policy | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting | 01/10/2018 | All Wales | Policy review date passed – action underway/required | Policy review date passed with low risk |
| Workforce & OD | All Wales Velindre adopted | No version | Managing Attendance at Work Policy | All Wales Policy | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Endorsement Trust Board - Adopt | 01/10/2021 | All Wales | Policy review date passed – action underway/required | Policy review date passed with low risk |
| Workforce & OD | All Wales Velindre adopted | No version | Menopause Guidance | All Wales Policy | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Endorsement Trust Board - Adopt | 01/12/2021 | All Wales | Policy review date passed – action underway/required | Policy review date passed with low risk |
| Workforce & OD | All Wales Velindre adopted | No version | Procedure for NHS Staff to Raise Concerns (Whistleblowing) | All Wales Policy | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Endorsement Trust Board - Adopt | 01/04/2021 | All Wales | Policy review date passed – action underway/required | Policy review date passed with low risk |
| Workforce & OD | All Wales Velindre adopted | Version 15 | Organisational Change Redeployment Policy | All Wales Policy | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting | 01/03/2020 | All Wales | Policy review date passed – action underway/required | Policy review date passed with low risk |
| Workforce & OD | All Wales Velindre adopted | No Version | Special Leave Policy | All Wales Policy | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting | 01/01/2022 | All Wales | Policy review date passed – action underway/required | Policy review date passed with low risk |
| Workforce & OD | WF 47 | Version 1 | NHS Wales Consistency of National T&C's (AFC ) Band Outcome Following merger of Organisations | Deputy Director of OD & Workforce | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting | 01/11/2016 | Under Review Submission to Approving Body in Q3 | Policy review date passed – action underway/required | Policy review date passed with low risk |
| Workforce & OD | WF 45 | Version 1 | Homeworking Policy | Deputy Director of OD & Workforce | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting | 01/04/2021 | Under Review Submission to Approving Body in Q3 | Policy review date passed – action underway/required | Policy review date passed with low risk |
| Workforce & OD | WF 52 | Version 4 | Redeployment Policy (Exc OCP Redeployments) | Deputy Director of OD & Workforce | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting | 01/04/2021 | Under Review Submission to Approving Body in Q3 | Policy review date passed – action underway/required | Policy review date passed with low risk |
| Workforce & OD | missing | No Version | Voluntary Early Release Scheme | Deputy Director of OD & Workforce | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting | 01/06/2015 | Under Review Submission to Approving Body in Q2 | Policy review date passed – action underway/required | Policy review date passed with low risk |
| Workforce & OD | WF 29 | Version 1 | Maternity, Paternity, Adoption and Parental Leave Policy | Deputy Director of OD & Workforce | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting | 01/08/2016 | Under Review Submission to Approving Body in Q2 | Policy review date passed – action underway/required | Policy review date passed with low risk |
| Workforce & OD | WF 44 | No version | Working Time Directive Policy | Deputy Director of OD & Workforce | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting | 01/10/2016 | Under Review Submission to Approving Body in Q2 | Policy review date passed – action underway/required | Policy review date passed with low risk |
| Workforce & OD | WF 02 | Version 40 | Disciplinary Policy | All Wales Policy | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting | 31/03/2020 | Under Review Submission to Approving Body in Q2 | Policy review date passed – action underway/required | Policy review date passed with low risk |
| Workforce & OD | Black 50/ WF19 | Version 2 | Policy for Employing Ex Offenders and people with a criminal record | Deputy Director of OD & Workforce | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting | 01/01/2021 | Under Review Submission to Approving Body in Q2 | Policy review date passed – action underway/required | Policy review date passed with low risk |
| Workforce & OD | WF 53 | Version 4 | Redundancy and Security of Employment Policy | Deputy Director of OD & Workforce | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting | 01/04/2021 | Under Review Submission to Approving Body in Q2 | Policy review date passed – action underway/required | Policy review date passed with low risk |
| Workforce & OD | WF 09 | No Version | Capability Policy and Procedure | Deputy Director of OD & Workforce | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting | 01/06/2021 | Under Review Submission to Approving Body in Q2 | Policy review date passed – action underway/required | Policy review date passed with low risk |
| Workforce & OD | WF 34 | Version 4 | Applying for Incremental Credit for Staff starting or rejoining the NHS | Deputy Director of OD & Workforce | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting | 01/06/2021 | Under Review Submission to Approving Body in Q2 | Policy review date passed – action underway/required | Policy review date passed with low risk |
| Workforce & OD | WF 05 | Version 3 | Equality & Diversity Policy | Equality & Diversity Manager | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting | 01/09/2021 | Under Review Submission to Approving Body in Q2 | Policy review date passed – action underway/required | Policy review date passed with low risk |
| Workforce & OD | WF 35 | Version 4 | Annual Leave and Bank Holiday Policy | Deputy Director of OD & Workforce | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting | 01/03/2020 | Under Review Submission to Approving Body in Q3 | Policy review date passed – action underway/required | Policy review date passed with low risk |
| Workforce & OD | WF 30 | Version 1 | PADR Policy | Deputy Director of OD & Workforce | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting | 01/05/2020 | Under Review Submission to Approving Body in Q3 | Policy review date passed – action underway/required | Policy review date passed with low risk |
| Workforce & OD | WF 31 | Version 3 | Sabbatical Leave Policy for Consultant Medical Staff | Deputy Director of OD & Workforce | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting | 01/01/2021 | Under Review Submission to Approving Body in Q3 | Policy review date passed – action underway/required | Policy review date passed with low risk |
| Workforce & OD | WF 43 | Version 2 | Mental Health, Wellbeing & Stress Management Policy | Deputy Director of OD & Workforce | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting | 01/01/2021 | Under Review Submission to Approving Body in Q3 | Policy review date passed – action underway/required | Policy review date passed with low risk |

## APPENDIX 6c: WORKFORCE AND ORGANISATIONAL DEVELOPMENT POLICY REGISTER

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|---|---|---|---|---|---|---|---|---|---|---|
| Workforce & OD | WF 21 | No version | Close Personal Relationships in the Work Place | Deputy Director of OD & Workforce | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting | 01/02/2021 | Under Review Submission to Approving Body in Q3 | Policy review date passed – action underway/required | Policy review date passed with low risk |
| Workforce & OD | WF 13 | Version 1 | Adverse Weather Policy | Deputy Director of OD & Workforce | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting | 01/03/2021 | Under Review Submission to Approving Body in Q3 | Policy review date passed – action underway/required | Policy review date passed with low risk |
| Workforce & OD | WF 17 | Version 2 | Policy on Reimbursement of Removal and Associated Expenses | Deputy Director of OD & Workforce | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting | 01/06/2021 | Under Review Submission to Approving Body in Q3 | Policy review date passed – action underway/required | Policy review date passed with low risk |
| Workforce & OD | WF 46 | Version 2 | Supporting Transgender Policy | Deputy Director of OD & Workforce | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting | 01/08/2021 | Under Review Submission to Approving Body in Q3 | Policy review date passed – action underway/required | Policy review date passed with low risk |
| Workforce & OD | WF 40 | Version 2 | Supporting Staff who are Carers | Deputy Director of OD & Workforce | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting | 01/12/2021 | Under Review Submission to Approving Body in Q3 | Policy review date passed – action underway/required | Policy review date passed with low risk |
| Workforce & OD | All Wales Velindre adopted | Version 8 | Pay Progression Policy | All Wales Policy | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting | 01/09/2017 | All Wales | Policy review date passed – action underway/required | Policy review date passed with moderate risk |
| Workforce & OD | All Wales Velindre adopted | No version | Protocol on Collective Consultation of Proposed Radiance | All Wales Policy | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Endorsement Trust Board - Adopt | 01/09/2017 | All Wales | Policy review date passed – action underway/required | Policy review date passed with moderate risk |
| Workforce & OD | All Wales Velindre adopted | Version 2 | Flexible Working Policy and Procedure | All Wales Policy | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting | 01/05/2017 | All Wales | Policy review date passed – action underway/required | Policy review date passed with moderate risk |
| Workforce & OD | Black 38/ WF12 | No Version | Study Leave Policy, Procedure & Guidelines | Deputy Director of OD & Workforce | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting | 01/11/2013 | Under Review Submission to Approving Body in Q2 | Policy review date passed – action underway/required | Policy review date passed with moderate risk |
| Workforce & OD | Black 51/ WF20 | No version | Exit Policy & Procedure | Deputy Director of OD & Workforce | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting | 01/06/2016 | Under Review Submission to Approving Body in Q2 | Policy review date passed – action underway/required | Policy review date passed with moderate risk |
| Workforce & OD | WF 28 | Version 4 | Recruitment of Locum Doctor Policy | Deputy Director of OD & Workforce | Executive Director of OD and Workforce | EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting | 01/04/2017 | Under Review Submission to Approving Body in Q2 | Policy review date passed – action underway/required | Policy review date passed with moderate risk |