Bundle Public Quality, Safety and Performance Committee 14 July 2022

0.0.0 10:00 - PRESENTATIONS

0.0.1 Welsh Blood Service - Staff Story

Led by Alan Prosser, Director of Welsh Blood Service, supported by Stephen Pearce, Head of Manufacturing and Distribution and Lauren Payne, Specialist Biomedical Scientist, Welsh Blood Service. https://youtu.be/_ABqZoqzwJg

1.0.0 10:15 - STANDARD BUSINESS

Led by Vicky Morris, Quality, Safety & Performance Committee Chair

1.1.0 Apologies

Led by Vicky Morris, Quality, Safety & Performance Committee Chair

1.2.0 In Attendance

Led by Vicky Morris, Quality, Safety & Performance Committee Chair

1.3.0 Declarations of Interest

Led by Vicky Morris, Quality, Safety & Performance Committee Chair

1.4.0 10:30 - Review of Action Log

Led by Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience and Jacinta Abraham, Executive Medical Director

1.4.0 Public QSP Action Log.docx

App1. Manual Handling training provision 05 2022.docx

2.0.0 CONSENT ITEMS

2.1.0 10:35 - ITEMS FOR APPROVAL

Led by Vicky Morris, Quality, Safety & Performance Committee Chair

2.1.1 Draft Minutes from the meeting of the Public Quality, Safety & Performance Committee held on the 12th May 2022

Led by Vicky Morris, Quality, Safety & Performance Committee Chair

2.1.1 - Public Quality Safety Performance Committee 12.5.22(v4approved).docx

App 1 to minutes - Near-miss update (WBS).docx

App 2 to minutes - FINAL NWSSP Action Plan_May 2022.docx

2.1.2 Trust-wide Policies and Procedures for Approval

Led by Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience, Carl James, Director of Strategic Transformation, Planning & Digital and David Mason-Hawes, Head of Digital Delivery and Matthew Bunce, Executive Finance Director.
QS03 - Handling Concerns Policy
QS18 - Health, Safety & Welfare Policy
IG01 - Records Management Policy
IG02 - Data Protection and Confidentiality Policy
IG05 - Software Policy
IG06 - Anti-virus Policy
IG08 - FOIA Policy
IG11 - Data Quality Policy
IG13 - Confidentiality Breach Reporting Policy
IG14 - Information Asset Policy

2.1.2a Updated Handling Concerns Policy JULY 22.docx

2.1.2b Health, Safety & Welfare Policy.pdf

2.1.2c Digital Services Policies Update July 2022.pdf

2.1.2d Information Governance Policies Update.pdf

2.2.0 ITEMS FOR ENDORSEMENT

2.2.1 National Imaging Academy - Hosting Agreement

Led by Jacinta Abraham, Executive Medical Director

National Imaging - hosting agreement.pdf

2.3.0 ITEMS FOR NOTING

2.3.1 Draft Summary of the unapproved Minutes from the meeting of the Private Quality, Safety & Performance Committee held on 12th May 2022

Led by Vicky Morris, Quality, Safety & Performance Committee Chair

2.3.1 Summary Private Quality Safety and Performance Committee Minutes 12.05.2022(v2).docx

2.3.2 Professional Nursing Update Report

Led by Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience

2.3.2 Executive Director of Nursing paper June 2022.docx

2.3.3 Datix Project Highlight Report

Led by Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience

2.3.3 Datix Highlight Report June 2022 JULY.docx

2.3.4 Safe Care Together Review

Led by Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience

2.3.4 Safe Care Together Review QSP.docx

2.3.5 Healthcare Inspectorate Wales 2022-2023 Operational Plan

Led by Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience

2.3.5 20220620 -FINAL Operational Plan - HIW.pdf

2.3.6 Highlight Report from the RD&I Sub Committee

Led by Jacinta Abraham, Executive Medical Director

2.3.6 RDI Public Highlight Report 07.04.22.docx

2.3.7 Highlight Report from the Trust Estates Assurance Group

Led by Carl James, Director of Strategic Transformation, Planning & Digital

2.3.7 FINAL Estates Assurance Highlight Report June.docx

2.3.8 Quality, Safety & Performance Committee - Policy Compliance Report

Led by Lauren Fear, Director of Corporate Governance & Chief of Staff

2.3.8 July QSP Policy Compliance Report.pdf

2.3.9 Digital Service Operational Report

Led by David Mason-Hawes, Head of Digital Delivery

2.3.9 FINAL 20220701 Digital Services Operational Report.docx

2.3.10 Transforming Cancer Services Programme Scrutiny Sub Committee Highlight Report

Led by Stephen Harries, Vice Chair and Chair of the Transforming Cancer Services Scrutiny Sub Committee

2.3.10 PUBLIC TCS Programme Scrutiny Committee Highlight Report 19-05-2022 v1.docx

2.3.11 CIVICA Electronic Feedback System Showcase Report

Led by Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience

2.3.11 CIVICA update June 2022.docx

2.3.12 Information Governance Assurance Update Report

Led by Matthew Bunce, Executive Finance Director

2.3.12 Information Governance Assurance Report.pdf

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 Services Partnership

3.0.0 Quality Safety Performance Committee July 2022- CIVAS@IP5.docx

3.0.0a CIVAS New Products.docx

3.0.0b CIVASIP5_T2_Feb_2022.pdf

3.0.0c QSP - Assurance Talk.pptx

4.0.0 MAIN AGENDA

4.1.0 10:50 - Quality & Safety Framework

Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science (This item to be addressed following staff story and standard business, before the consent agenda - item 2.0.0).

4.1.0 Quality & Safety Framework Report.pdf

4.2.0 10:50 - Workforce and Organisational Development Performance Report / Financial Report

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

4.2.0a QSP Finance Workforce Key Risks Paper 14th July 22.docx

4.2.0b Month 2 Finance Report - July QSP.pdf

4.3.0 11:00 - Quality, Safety & Performance Reporting

Led by Alan Prosser, Director of Welsh Blood Service and Rachel Hennessy, Interim Director of Velindre Cancer Service

4.3.0 FINAL VUNHST MAY PERFORMANCE COVER PAPER JULY QSP.docx

4.3.1 11:00 - Welsh Blood Service Quality, Safety & Performance Divisional Report

Led by Alan Prosser, Director of Welsh Blood Service

4.3.1a BS Q+S Report July 22 0.1.docxAP.docx

4.3.1b Final May 2022 PMF Report (inc last qtr)_.pdf

4.3.2 11:10 - Velindre Cancer Service Performance Report

Led by Rachel Hennessy, Interim Director of Velindre Cancer Service

4.3.2 FINAL VCC Performance Report - May 2022 (ver3.0).docx

4.4.0 11:25 - Putting Things Right 2021/2022 Annual Report

Led by Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience

4.4.0 Putting Things Right Annual Report 2021-22.docx

4.5.0 11:30 - Patient & Donor Experience Annual Report

Led by Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience

4.5.0 Annual Patient Donor Experience Report 2021-22.docx

4.6.0 11:35 - Highlight Report from the Infection Prevention & Control Management Group

Led by Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience

4.6.0 IPCMG highlight report July 2022 QSP.docx

4.7.0 11:45 - Infection Prevention & Control Annual Report

Led by Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience

4.7.0 IPC ANNUAL REPORT 2021-2022.docx

4.8.0 11:50 - Highlight Report from the Safeguarding & Vulnerable Adults Group

Led by Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience

4.8.0a Safeguarding Highlight Report MARCH 2022.pdf

4.8.0b Safeguarding Highlight Report JUNE 2022.docx

4.9.0 12:00 - Safeguarding Annual Report

Led by Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience

4.9.0 Safeguarding Annual Report JULY 2022.docx

4.10.0 12:05 - Trust-wide Nurse Staffing Levels (2016) Act - Annual Report

Led by Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience

4.10.0 Trust-wide nurse staffing levels.pdf

4.11.0 12:10 - Highlight Report from the Patient Safety Alerts Group

Led by Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience

4.11.0 PatientSafetyAlerts Management Group Highlight Report.docx

4.12.0 12:20 - Health & Care Standards Annual Report

Led by Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience

4.12.0 Health & Care Standards Annual Report.docx

4.13.0 12:25 - Medical Workforce Update (deferred from May 2022 Committee)

Led by Jacinta Abraham, Executive Medical Director

4.13.0 Annual Medical Workforce Revalidation Progress.pdf

4.14.0 12:35 - Trust Clinical Audit Plan (deferred from May 2022 Committee)

Led by Jacinta Abraham, Executive Medical Director

4.14.0 VUNHST Clinical Audit Plan 2022-2023.pdf

4.15.0 12:45 - Local Partnership Forum Annual Report (deferred from May 2022 Committee)

Led by Sarah Morley, Executive Director of Workforce & Organisational Development

4.15.0 LPF Annual Report 2021-2022.pdf

4.16.0 Trust Risk Report (deferred to September 2022 Committee)

Led by Lauren Fear, Director of Corporate Governance & Chief of Staff

5.0.0 INTEGRATED GOVERNANCE

5.1.0 12:50 - Analysis of triangulated meeting themes

Led by Vicky Morris, Quality, Safety and Performance Committee Chair, supported by all Committee members

Analysis of Quality, Safety & Performance Committee effectiveness

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 for inclusion in the Highlight Report to the Trust Board:
For Alert/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 and Performance Committee will next meet on the 15th September 2022 from 10:00 - 13:00 via Microsoft Teams

QUALITY, SAFETY AND PERFORMANCE - PART A					
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 07/07/2022 -** A summary paper is to be reported to the November Committee.	10/11/2022	OPEN
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. ***Update*** **At the May Committee, the Chair requested a written cross-reference of relevant sections / agreements be included as a supporting**	Lauren Fear	**Update 07/07/2022** - A supporting appendix has been drafted and will be formally reviewed by the Executive Management Board for approval on 1st August 2022. Once approved, this will be published and disseminated across the Trust.	01/08/2022	OPEN

	appendix to the Trust Policy and Procedure for the Management of Trust-wide Policies and other Trust-wide written control documents to enable closure of the action.				
2.3.5	Details of plan / timeline for improving mandatory Health & Safety Training to be provided to Committee members.	Carl James	**Update 06/07/2022** - This has been added as an appendix to the action log for the July QS&P Committee.	14/07/2022	CLOSED
4.4.0	AP to provide an update in relation to the cross-matching error to the Chair of the Committee.	Alan Prosser/Peter Richardson	**Update 16/06/2022** - A written update was provided to the Chair and Executive Director of Nursing on 27/05/2022 and is attached as an appendix to the minutes of the May QS&P Committee.	14/07/2022	CLOSED
Actions agreed at the 12th May 2022 Committee					
2.1.2	NW to include Executive Lead responsibilities in approved MRSA Prevention Policy prior to publication on the Trust website.	Nicola Williams	**Update 20/06/2022** - A copy of the updated MRSA policy was provided to the Chair, therefore closing the action.	14/07/2022	CLOSED
2.3.2	JA to ensure approval process and outcomes of the review of unlicensed and off label medications is included within future Highlight Reports from the Medicines Management Group.	Jacinta Abraham	**Update 06/07/2022** - This will be addressed with the Chief Pharmacist for inclusion in future highlight reports.	15/09/2022	CLOSED
2.3.6	ST to address capture of information in relation to gender identity / transgender / gender re-assignment within Annual Equalities Report.	Susan Thomas	**Update 15/06/2022** - Fields within ESR are currently non-updateable. The possibility of updating the fields will be explored but no immediate work can begin.	14/07/2022	CLOSED

2.3.8	CJ to provide updates against actions / recommendations resulting from the Medical Gas Pipeline Systems audit (amber status) (also to be included as an addendum to the minutes of the May Committee.	Carl James	**Update 06/07/2022** - This has been provided and added as an appendix to the minutes of the May Committee.	14/07/2022	CLOSED
3.0.0	NWSSP Board Assurance Framework to be presented at the July QS&P Committee.	Gareth Tyrrell	**Update 24/06/2022** - Assurance structure will be presented at July QS&P Committee.	14/07/2022	CLOSED
3.0.0	Official letter received by NWSSP following MHRA inspection to be shared with Committee members.	Gareth Tyrrell	**Update 24/06/2022** - This will be included at July QS&P Committee.	14/07/2022	CLOSED
3.0.0	Further support to increase Independent Member awareness, effective oversight and scrutiny of NWSSP quality and patient safety information to be included in the June Board Development session.	Gareth Tyrrell/Lauren Fear	**Update 07/07/2022** - This item was addressed in the June Board Development Session.	14/07/2022	CLOSED
4.2.0	Clarity in relation to reporting financial viability of North Wales Shared Services to be included within the Workforce & OD/Financial Report going forward.	Matthew Bunce	**Update 17/06/2022** - Appropriate wording to be included in reporting going forward, clarifying that financial performance or risks in relation to North Wales Shared Services Partnership are not included as they have a direct relationship with Welsh Government to whom they are accountable for financial performance.	14/07/2022	CLOSED
4.3.0	COB to address conflicting sickness figures between Workforce Report and Overarching Trust Performance Report with WOD Colleagues.	Cath O'Brien	**Update 07/07/2022** - Due to the schedule date changes for Executive Management Board meetings, two performance reports (February and March) were sent to April EMB. For the May QS&P Committee, only March performance data was sent and	14/07/2022	CLOSED

<table>
<tr><td></td><td></td><td></td><td>Workforce had submitted February data, hence differing information. The Workforce report has now combined with the Finance report.</td><td></td><td></td></tr>
<tr><td>4.4.0</td><td>LF/COB to review risk titles to provide further clarity (in particular risks 2513 and 2514).</td><td>Cath O'Brien/Lauren Fear</td><td>Update 07/07/2022 - This item has been addressed and is reflected within the Trust Risk Report to be presented to July QS&P Committee.</td><td>14/07/2022</td><td>CLOSED</td></tr>
<tr><td>4.5.0</td><td>MB to provide an update on areas of deteriorating position within the IG Assurance Report at the July QS&P Committee.</td><td>Matthew Bunce</td><td>Update 06/07/2022 - As noted in the May QS&P Committee when presenting the 2021-22 assessments of the IG Toolkit the DoF pointed out that this was an initial assessment undertaken by the HoIG and as SIRO he had not yet had an opportunity to fully review the assessments, but his initial review was indicating that a number of the assessments where the HoIG had reduced the level would be changed upwards following a full review, as there was evidence of compliance that the DoF was aware of that the HoIG being relatively new in his role had not reflected as part of his assessment. An updated assessment is included in the IG Assurance report for noting. In summary:

<table>
<tr><th>Level number</th><th>Level Achieved 2020/21</th><th>Initial assessment of level achieved 2021/22</th><th>Assessment for 2021/22 following DoF (SIRO) review</th></tr>
<tr><td>Level 0</td><td>0</td><td>5</td><td>1</td></tr>
<tr><td>Level 1</td><td>4</td><td>5</td><td>6</td></tr>
<tr><td>Level 2</td><td>8</td><td>5</td><td>8</td></tr>
<tr><td>Level 3</td><td>0</td><td>1</td><td>1</td></tr>
<tr><td>Not assessed</td><td>4</td><td>0</td><td>0</td></tr>
<tr><td>Total</td><td>16</td><td>16</td><td>16</td></tr>
</table>
</td><td>14/07/2022</td><td>CLOSED</td></tr>
</table>

4.5.0	MB/Head of Information Governance to review use of Level 0 scoring within the IG self-assessment toolkit.	Matthew Bunce	**Update 06/07/2022** - The DoF has confirmed that the IG Toolkit has four levels (0 to 3) of attainment. A link to the DHCW web site which provides details and guidance on the Welsh Information Governance Toolkit is include in the IG Assurance cover paper. This guidance explains for each section of the IG Toolkit the required assurance and controls evidence to achieve each of the assessment levels of 0 to 3.	14/07/2022	CLOSED

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Progress update on increasing capacity and flexible training places

DATE OF MEETING	14/07/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Helen Jones, Health and Safety Manager
PRESENTED BY	Carl James, Director of Strategic Transformation, Planning and Digital
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning and Digital

REPORT PURPOSE	FOR NOTING

ACRONYMS	
VCC	Velindre Cancer Centre
WBS	Welsh Blood Service
C&VUHB	Cardiff and Vale University Health Board

1. SITUATION/BACKGROUND

1.1 There are three levels of manual handling training provided to staff across the Trust, the syllabus for which is defined in the All Wales Manual Handling Passport Scheme which is adopted by all NHS Trusts and Health Boards in Wales. The requirement for each course is identified by Training Needs Analysis

- Module A – available on-line
- Inanimate Load – face to face training
- Patient Handling – face to face training

1.2 The training compliance in some divisions is below the target level of 85% set by the Welsh Government.

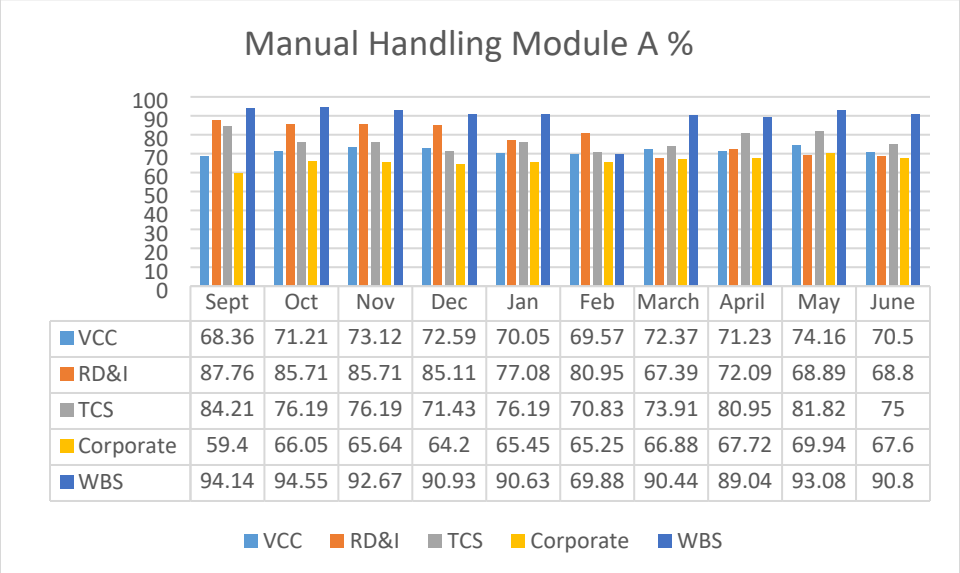
1.3 Training compliance is monitored at Divisional Health, Safety and Fire meetings/Cynefin Group, at the Joint Estates meeting and at the Trust Health, Safety and Fire Board. Compliance is also discussed during the HSG65 Health and Safety Audit.

1.4 This paper outlines the arrangements to increase provision of training for inanimate load and patient handling training

1.5 Further work is underway between the Health and Safety, Fire Safety and Education and Training department with operational colleagues in blood and cancer services to identify how staff can attend the training courses to support increase in compliance. This continues to be challenging given the current services pressures and relatively high levels of sickness absence.

2. BACKGROUND

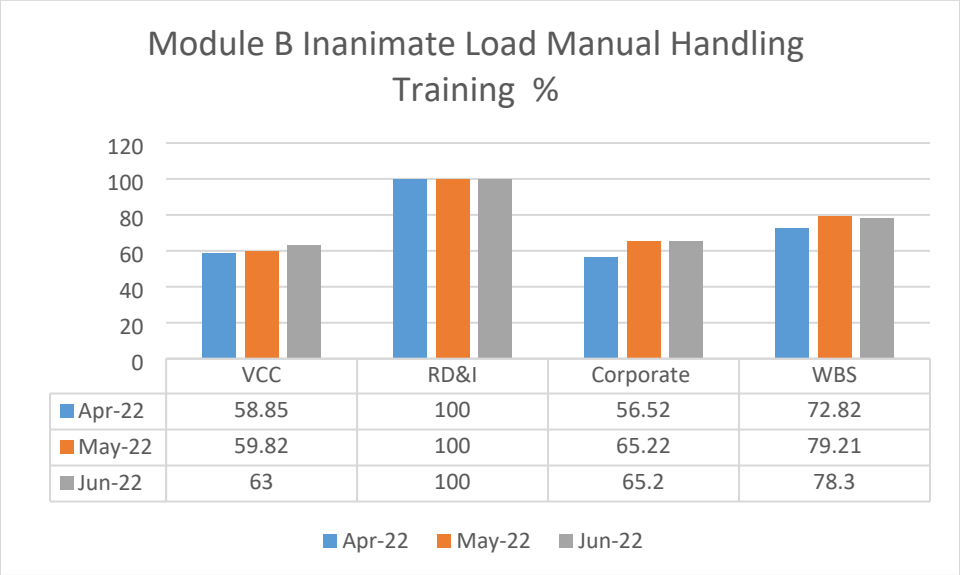
Figure 1 Module A – on-line training



	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June
VCC	68.36	71.21	73.12	72.59	70.05	69.57	72.37	71.23	74.16	70.5
RD&I	87.76	85.71	85.71	85.11	77.08	80.95	67.39	72.09	68.89	68.8
TCS	84.21	76.19	76.19	71.43	76.19	70.83	73.91	80.95	81.82	75
Corporate	59.4	66.05	65.64	64.2	65.45	65.25	66.88	67.72	69.94	67.6
WBS	94.14	94.55	92.67	90.93	90.63	69.88	90.44	89.04	93.08	90.8

2.1 Managers have been working to identify ways in which staff complete mandatory on-line training. Where staff at VCC do not have regular access to IT the provision of the Digi HUB at the VCC site may also enable staff access to IT equipment.

Figure 2: Module B – Inanimate Load Training - Face-to-face training



2.2 Historically Inanimate Load training was delivered in-house by a member of the Education and Development Team. Due to staffing reasons this provision was not available in Quarters 3 and 4 of last year. During that time courses were provided by an external provider in VCC and by the in-house Clinical Training Team at WBS.

2.3 The courses at VCC were not always filled despite being widely advertised, with staffing pressures due to COVID-19 having a significant impact. The Clinical Training Team at WBS have indicated that although they can continue to provide this training to Collection Teams, they cannot continue to deliver it to staff based in the WBS building.

2.4 Additional courses have been held during June 2022 at WBS and VCC provided by the Health and Safety Advisor for VCC.

Table 1 **Additional training sessions have been held at both WBS and VCC during June – (some spaces were able to be filled at the 'last minute' where staff withdrew)**

Division	Date	Type of session	Available spaces	Trained	Attendance
WBS	07/06/2022	Update session x2	24	21	1 DNA
WBS	07/06/2022	Foundation for new staff (X 1)	10	7	
WBS	08/06/2022	Update sessions	24	21	3 withdrew
VCC	13/06/2022	Update sessions x 2	24	15	3 withdrew 3 DNA
VCC	22/06/2022	Update sessions x2	24	14	7 withdraw 7 DNA

Table 2 **Further training planned at VCC and WBS provided by Menter (External Provider)**

Division	Date	Type of session	Maximum on course	Spaces still available (04/07/2022)
VCC	06/07/2022	Foundation	10	1
VCC	07/07/2022	Update x2	2 x 12 max = 24	11
WBS	21/07/2022	Foundation and Update sessions x 2	10 2 x 12 = 24	Numbers to be confirmed. Lab staff to be prioritized initially

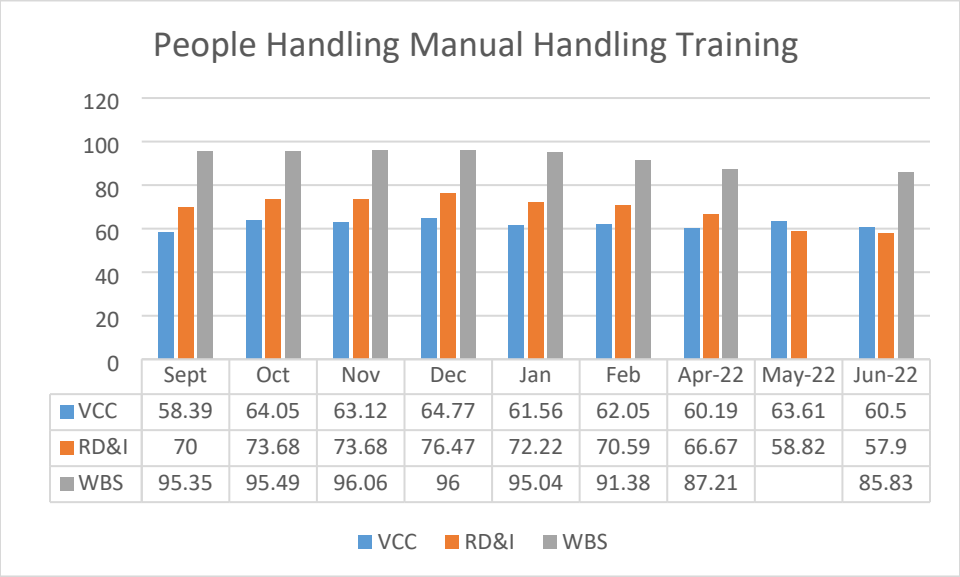
Table 2

2.5 Managers at VCC and Corporate Division have been contacted to advertise the courses, however the courses are not always full due to on-going service pressures. Further discussions are ongoing to see what other solutions may be available to increase flexibility for improved attendance.

2.6 Further sessions using an external provider will be planned over the August/September and pans are being finalised for training provision in North Wales.

2.8 Longer term the Education and Development Team plan to recruit a trainer in Quarter 3 2022, part of whose remit with include Inanimate Load training. In addition, it is planned that a member of the Operational Services will complete the train-the-trainer qualification to provide training directly to that Department.

Figure 3: People Handling Training – Face-to-Face



	Sept	Oct	Nov	Dec	Jan	Feb	Apr-22	May-22	Jun-22
VCC	58.39	64.05	63.12	64.77	61.56	62.05	60.19	63.61	60.5
RD&I	70	73.68	73.68	76.47	72.22	70.59	66.67	58.82	57.9
WBS	95.35	95.49	96.06	96	95.04	91.38	87.21		85.83

Figure 3

Note: WBS data for May and June unavailable 04/07/2022

2.9 Manual handling level 2 training is provided to VCC and RD&I via a Service Level Agreement with C&VUHB.

2.10 The training consists of a Foundation course which staff trained in Wales complete as part of their initial professional training. The Refresher training is on a three-year cycle, whereby competency assessments can be carried out in the workplace three years after initial Foundation training and with staff returning after a further three years for a one-day classroom-based refresher course. This alternating three-year cycle of competency

assessments provided by specifically trained staff and refresher training then continues throughout the staff member's career. If competency assessments are not available, all refresher training can be classroom based.

2.11 The Foundation course lasts one and half days and the Refresher course one day.

2.12 The above arrangements reflect those in place at C&VUHB

2.13 Foundation and Refresher training courses are available to book through C&VUHB and dates are circulated regularly. Places are limited particularly as C&VUHB are seeking to clear their own COVID-related training backlog. Places on the courses fill up very quickly once dates are released. However, places are available for example 04/07/2022 information about the following spaces were circulated to managers:

People Handling Classroom Foundations:
18 & 19-Jul-2022 – H&S Training Unit, UHL (1 space)
20 & 21-Jul-2022 – Denbigh House, UHW (1 space)
22 & 23-September-2022 – Denbigh House, UHW (1 space)

People Handling Classroom Updates:
12-September-2022 – H&S Training Unit, UHL (2 spaces)
16-September-2022 – Denbigh House, UHW (10 space)
19-September-2022 – Denbigh House, UHW (9 space)

2.14 Arrangements are now being put in place for the People Handling training to also be held on the VCC site. One of the Nurse Educators will complete a Train the Trainer course in September (first course available once funding was agreed) and then together with the VCC Health and Safety Advisor will be able to run courses for up to 12 staff for both the Foundation and 16 at Refresher levels of training. The Passport Scheme requires that one of the trainers has a clinical background.

2.15 Locations within VCC have been identified to allow training to be carried out on site. It is proposed that a hybrid approach providing a choice of both in-house training and the Service Level Agreement is put in place allowing maximum flexibility of provision. Courses provided via C&VUHB are paid for on an individual basis. It is hoped that courses being held on the VCC site will encourage attendance and improve training compliance.

2.16 In the meantime a further 30 staff have booked onto training with C&VUHB in July, August and September.

2.17 People Handling training at WBS will continue to be delivered by the Clinical Training Team to the Collection Teams.

3. ASSESSMENT/SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Module A – compliance is monitored and managers continue to be reminded to ensure that staff complete mandatory training

3.2 Inanimate Load Training – Courses have been run in-house, further courses are planned using an external provider although in VCC/Corporate Division take up is not always to capacity. In future plans are in place to re-establish in house provision.

3.3 People Handling – the Service Level Agreement with C&VUHB remains in place and offers places on training course. Plans are also in hand to also be able to offer in-house training from September onwards.

3.4 Further discussions are continuing with operational departments and support services to identify any/more flexible solutions that enable higher numbers of staff to attend the training courses available.

QUALITY AND SAFETY IMPLICATIONS/IMPACT	The content of this report relates to both staff and patient health and safety
RELATED HEALTHCARE STANDARD	Safe Care
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Compliance with the Health and Safety at Work etc Act 1974 and The Manual Handling Regulations
FINANCIAL IMPLICATIONS /	Yes (Include further detail below)

IMPACT	Training of Trust staff to deliver Manual Handling training in-house should lead to a cost saving over using external providers particularly since courses are not always filled to capacity.

4. RECOMMENDATION

4.1 The Quality, Safety and Performance Committee are asked to:

i. **NOTE** the contents of this report regarding the additional provision of training places/locations.

ii. **NOTE** that further discussions continue with operational departments to identify any additional solutions that would support the ability of staff to attend the sessions.

Minutes

Public Quality, Safety & Performance Committee

Velindre University NHS Trust

Date: 12th May 2022
Time: 10:00 – 12:30
Location: Microsoft Teams
Chair: Vicky Morris, Independent Member

MEMBERS		
Vicky Morris	Independent Member and Chair	VM
Stephen Harries	Vice Chair and Independent Member	SHa
Hilary Jones	Independent Member	HJ
Prof Donna Mead OBE	Velindre University NHS Trust Chair (in part)	DM
ATTENDEES		
Steve Ham	Chief Executive Officer	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
Jacinta Abraham	Executive Medical Director	JA
Matthew Bunce	Executive Director of Finance	MB
Alan Prosser	Director of Welsh Blood Service	AP
Peter Richardson	Head of Quality Assurance and Regulatory Compliance, Welsh Blood Service	PA
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
0.0.1	**Velindre Cancer Service – Patient Story** Led by Vivienne Cooper, Head of Nursing, Quality, Patient Experience & Integrated Care – Velindre Cancer Service A powerful video story of a patient with head and neck cancer and his family's journey of care through the Velindre Cancer Service had been received by Committee members in advance of the meeting. The story detailed the difference the Supportive Care Team had made to the patient and his family, without which due to fear he may not have received his much needed treatment. This involved addressing basic	

	fears such as walking into the building and anticipated effects of cancer treatment, in addition to providing education regarding nutrition during treatment, maintaining a sense of normality at work and at home and steering sensitive conversations with his family. The Committee commended the excellent work being undertaken by the Supportive Care Team that is often hidden but making a significant difference to many patients and their families. SA advised that the video had been shared widely with his colleagues across Wales to support staff in helping reduce stress and anxiety in patients in a similar situation.	
1.0.0	**STANDARD BUSINESS**	
1.1.0	**Apologies** had been received from: • Rachel Hennessy (RH) , Interim Director of Velindre Cancer Service • Sarah Morley (SfM), Executive Director of Organisational Development and Workforce	
1.2.0	**Additional Attendees:** • Vivienne Cooper (VC) – Head of Nursing, Quality, Patient Experience and Integrated Care *(for item 0.0.1)* • Tina Jenkins (TJ) – Senior Nurse Safeguarding and Public Protection *(for item 2.3.5)* • Gareth Tyrell (GT) – Head of Technical Services, NHS Wales Shared Services Partnership *(for item 3.0.0)* • David Mason-Hawes (DMH) Head of Digital Delivery *(for item 4.7.0)* • Susan Thomas deputising for Sarah Morley (ST) – Deputy Director of Organisational Development & Workforce • Colin Powell (CP) – Service Director, NHS Wales Shared Services Partnership • Emma Rees (ER) –NWSSP Audit & Assurance Services • Sarah Thomas (ST) – Healthcare Inspectorate Wales • Huw Jones (HJ) – Healthcare Inspectorate Wales • Stephen Allen (SA) – Chief Officer, South Glamorgan CHC	
1.3.0	**Declarations of Interest** Led by Vicky Morris, Quality, Safety & Performance Committee Chair No declarations of interest were raised.	
1.4.0	**Review of Action Log** Led by Nicola Williams, Executive Director of Nursing, AHPs and Health Science	

	Committee members confirmed that there was sufficient information contained on the log to provide assurance that all actions identified as completed could be closed. The remaining open actions were reviewed and the following amendments were agreed: • ***2.1.2 (24/03/2022) – A review of Trust policies adhered to by hosted organisations to be undertaken and documented within the overarching Trust Policy for Policies –*** LF reported this is covered via two areas: The NHS Wales Shared Services Partnership (NWSSP) Hosting Agreement and the Schedule for NWSSP in the Trust's Standing Orders. It was also highlighted that the Health Technology Wales hosting agreement is currently under review and will highlight which policies are relevant and therefore staff would need to work to approved policies. VM requested a written cross-reference of the relevant sections / agreements be included as a supporting appendix to the Trust Policy and Procedure for the Management of Trust-wide Policies and other Trust-wide written control documents to enable closure of the action. • ***2.3.2 (24/03/2022) – 2 x written statements by COB in relation to the Infected Blood Inquiry to be circulated following the March Committee –*** COB confirmed that both written statements had been circulated to Committee members. It was therefore agreed that the ***action can be closed.*** • ***2.3.5 (24/03/2022) – Details of plan / timeline for improving mandatory Health & Safety Training to be provided to Committee members –*** CJ confirmed that following a meeting with the Health & Safety Manager, a two month improvement plan for training is in place. This includes increasing capacity of training providers and locations, in addition to actively encouraging staff to undertake training. A further report will be presented at the July 2022 Committee to demonstrate improvements. The action completion date was updated to July 2022. • ***4.2.0 (24/03/2022) – Further detail relating to agency staff and potential outsourcing to be included in the combined Workforce & OD / Financial report at the May Committee –*** ST advised that this information was included in the Workforce & OD / Financial report. The Committee therefore agreed that this **action can be closed**. • ***4.4.0 (24/03/2022) – AP to provide an update in relation to the cross-matching error to the Chair of the Committee –*** PR assured the Committee that the correct unit of blood had been provided to the correct patient and that the error involved the patient's date of birth. It was agreed that a full written update would	**LF** **Secretariat** **CJ** **Secretariat** **Secretariat** **AP/PR** **Secretariat**

	be provided to the Chair of the Committee before issue with the minutes ahead of the July 2022 Committee. ***This action is to remain open until completed.***	
2.0.0	**CONSENT ITEMS** (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 24th March 2022** Led by Vicky Morris, Quality, Safety & Performance Committee Chair Following the Chair's approval prior to the meeting, the minutes of the Public Quality & Safety Committee held on the 24th March 2022 were **REVIEWED** and **APPROVED** as a true reflection of the meeting.	
2.1.2	**Trust-wide Policies and Procedures for Approval** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science The Committee received the revised ***Policy IPC07 (MRSA)*** for approval. NW advised that following publication of the papers it had been identified that the policy did not include the Executive Lead responsibility and provided assurance that this would be rectified prior to publication on the Trust intranet. The Committee **APPROVED** the revised Policy for the Prevention and Control of Methicillin Resistant Staphylococcus Aureus (MRSA), subject to inclusion of the Executive Lead responsibilities ahead of publication on the Trust website.	**NW**
2.2.0	**ITEMS FOR ENDORSEMENT**	
	There were no items for endorsement.	
2.2.0	**ITEMS FOR NOTING**	
	****** VM advised that item 2.3.9 (Trust Annual Performance Report) would be moved to the main agenda to facilitate opportunity for discussion and for members to make any suggested amendments.	
2.3.1	**Draft Summary of the unapproved Minutes from the meeting of the Private Quality, Safety & Performance Committee held on 24th March 2022** Led by Vicky Morris, Quality, Safety and Performance Committee Chair The Committee **NOTED** the summary minutes of the Private Quality, Safety & Performance Committee held on 24th March 2022. No inaccuracies were raised.	

2.3.2	**Highlight Report Medicines Management Group** *(deferred from March 2022 Committee)* Led by Jacinta Abraham, Executive Medical Director JA advised that the format of the report and level of information provided for assurance purposes in the Medicines Management Highlight Report is currently under review. It is anticipated that further detail will be reported going forward (the next report is due 6 months' time), including compliance with clinical guidelines. VM suggested that reporting specific outcomes of compliance and outstanding actions in relation to national safety alerts is necessary to provide the required level of assurance to the Trust Board. NW advised that a regular comprehensive report is received from the Patient Safety Alerts Group. VM requested sight of the review and approval of unlicensed and 'off-label medications' process and outcomes for assurance purposes. JA agreed that this would be addressed and reported and that the current position in terms of compliance is positive. The Committee **NOTED** the contents of the report and actions to provide **ASSURANCE** via future reports.	**JA**
2.3.3	**2021/2022 Professional Registration / Revalidation** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science and Jacinta Abraham, Executive Medical Director JA noted that Trust compliance is exemplary given the current post-pandemic position. The Committee **NOTED** the 2021/2022 position in respect of Professional Registration/Revalidation compliance across all professional groups, and **NOTED** the actions taken forward in respect of breaches that occurred.	
2.3.4	**Health Inspectorate Wales 2022-2025 Strategic Plan** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science HJ welcomed the sharing of the Strategy with the Committee and advised that there has been an increase in on-site work following a move towards business as usual. The Committee **NOTED** the Healthcare Inspectorate Wales 2022-2025 Strategic Plan.	
2.3.5	**Liberty Protection Safeguards Impact Assessment** Led by Tina Jenkins, Senior Nurse Safeguarding & Public Protection	

	TJ discussed with the Committee the UK and Wales Consultations that are underway in respect of the new Liberty Protection Safeguards that are replacing the previous Deprivation of Liberty Safeguards. A small Trust wide task group had been established to review the draft consultation documents including the Code of Practice to map through the implications for the Trust and to draft a consultation response. It had been identified that potential scenarios / solutions shared within the Code of Practice do not accurately reflect the complex situations faced by the Trust and NHS Wales in general. Discussions with Welsh Government are also underway, who recognise the unique nature of Velindre as the only Trust using the Liberty Protection Safeguards. SA queried the provision of additional support for mental health patients (receiving services through the Trust via another Health Board) which may be required during their stay at VCS. TJ advised that work is undertaken with the relevant Health Board to ensure reasonable adjustments are made for the patient in addition to assessing when use of the Mental Capacity Act or Liberty Protection Safeguards may be required. The Committee **NOTED** 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.	
2.3.6	**Annual Equalities Report 2021-2022** *(deferred from March 2022 Committee)* Led by Susan Thomas, Deputy Director of Workforce and Organisational Development ST reported that improvements will be made in relation to the format of the report for future reports this will include a more appropriate balance of qualitative and quantitative detail. HJ queried whether reported figures could be compared with national figures for the region to identify and target under-represented groups. ST advised that additional benchmarking will take place going forward. It was also noted that reported figures relate to staff only, which will be clarified in the report. DM raised an issue of accuracy in relation to item 2.3.6 and gender identity. The report had stated that the Trust was unable to collect and record data on gender / gender identity. However, a number of tables within the report had used the term 'gender'. DM suggested that it would be more appropriate to label them 'male' and 'female'. The Committee **NOTED** the contents of the 2021-2022 Annual Equalities report as approved by the Executive Management Board	**ST**

	on the 27th April 2022.	
2.3.7	**Annual Report (2021) from the Controlled Drugs Accountable Officer** Led by Jacinta Abraham, Executive Medical Director The Committee **NOTED** the 2021 Controlled Drugs Accountable Officer report.	
2.3.8	**Annual Assurance Report (2021) from the Medical Gas Group** Led by Jacinta Abraham, Executive Medical Director JA advised that joint Executive responsibility for the report would be taken by herself and Carl James going forward due to inclusion of an Estates element. Following the Medical Gas Pipeline Systems audit undertaken in March 2021, VCC had been rated as Amber (as per the previous report). The Committee was assured that the Estates Department has developed an action plan to address the 17 recommendations. CJ advised that updates against the actions / recommendations would be provided to Committee members following the meeting to provide assurance to Trust Board that actions have been taken to implement required improvements. This information will also be published in the public domain as an addendum to the minutes of the Committee. LF advise that the June 2022 Board Development Session will be reviewing how actions are discharged and reported to Committees and Trust Board as part of an Assurance focus in the session. The Committee **NOTED** the contents of the report.	**CJ** **Secretariat**
2.3.9	**Trust 2021/2022 Annual Performance Report** *(moved to main agenda)* Led by Carl James, Director of Strategic Transformation Planning & Digital The Committee received the first draft of the 2021/2022 Annual Performance Report (requirements set out in Welsh Government guidance (Chapter 3 of the NHS Manual for Accounts) and performance against the five harms arising from COVID) ahead of submission to Welsh Government and Audit Wales on the 15th June 2022. Committee members were given an opportunity to discuss the report, ask questions and suggest amendments. The following was requested: • Future reports to contain greater contextualisation (trend lines, % of activity) to allow for more accessible information for the general public. • Further work to be undertaken in terms of triangulation of	

	objectives, targets, performance, safety outcomes, benchmarking, learning and improvement. • Narrative explaining inclusion or exclusion of North Wales Shared Services Partnership and the management of this service. • Further narrative in relation to key targets for VCS and WBS of interest to the public to be included in the report going forward. • The use of a glossary due to the large number of acronyms. • Potential use of comparative data from other Health Boards to enable performance benchmarking. CJ advised that Tier 1 targets for WBS and VCS of interest to the public would be included in the report in addition to amendments requested during the discussion. The Committee **DISCUSSED** and **NOTED** the first draft of the 2021/2022 Annual Performance Report in readiness for inclusion as part of the submission to Welsh Government and Audit Wales.	**CJ**
2.3.10	**Infected Blood Inquiry Update** *(brought forward from July 2022 Committee)* Led by Cath O'Brien, Chief Operating Officer COB informed the Committee that the Infected Blood Inquiry had queried whether all core participants of the inquiry wished to submit evidence. The Trust had sought legal advice and, following discussions with peers at other UK services, had identified this as an opportunity for the affected / infected to make a representation to the Chair of the Inquiry should they wish to do so. Therefore, given this context, the Trust does not intend to make a representation at this juncture as there will be subsequent opportunities to do so. The Committee **NOTED** the contents of the report and that the Trust will not be submitting evidence at this juncture.	
3.0.0	**Velindre Quality & Safety Committee for NHS Wales Shared Services**	
	Led by Gareth Tyrrell, Head of Technical Services, NHS Wales Shared Partnership The NHS Wales Shared Services CIVAS@IP5 Service Performance report was received. The report included the findings of the MHRA (Medicines and Healthcare products Regulatory Agency) inspection which took place on the 15th and 16th February 2022 and resulting action plan. The following was discussed / agreed: • A forensic investigation of the service was undertaken over 2 days, inspected against the Human Medicines Regulations 2012 and covering all licensed activity within the facility.	

	• The service was assigned low-risk status and no further inspections will take place until February 2024. • Positive feedback was reported in relation to training of staff and good processes, no issues with vaccine packdown and good environmental control. • No critical deficiencies were identified. Two major deficiencies (relating to documentation and contamination control) were identified, in addition to three 'other' (relating to product recall procedure). • An action plan to address the above has been developed by the service and accepted by the MHRA, with a number of actions completed. The target date for outstanding actions is end of August 2022 with no issues for completion anticipated. • Following request by VM, it was agreed that the Board Assurance Framework within the NWSSP would be presented at the July 2022 Quality, Safety & Performance Committee and that the official letter received from the MHRA would be shared with Committee members. VM questioned whether a system had been implemented to ensure the three areas of failure did not remain a recurring theme. GT assured the Committee that it is a regulatory requirement to undertake post evaluation of each action raised, involving a 'change control' process; a review and signoff of outcomes is undertaken by the Head of Quality Assurance, followed by submission to the MHRA for approval and signoff. VM welcomed the opportunity for Independent Members to receive further support to enable effective oversight, awareness and scrutiny of information relating to quality and patient safety and requested that this item be included in the June Board Development Session. The Committee: • **NOTED** current levels of service performance against the framework of standards set out in EU Good Manufacturing Practice and which we are legally required to comply with as an MHRA "Specials" and Wholesale Dealer licence holder. Further update on new products introduced into the CIVAS@IP5 portfolio will be provided in future meetings; • **NOTED** the findings and COVIAS@IP5 risk status assigned by the MHRA. The action plan and progress update will be provided as part of this agenda item.	**GT** **GT** **GT/LF**
4.0.0	**MAIN AGENDA** (This section supports the discussion items for review, scrutiny and assurance).	
4.1.0	**Gold Command Report**	

	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 The Gold Command Highlight Report provided details of the key issues considered at Gold Command (COVID) at its meetings held between 23rd March 2022 and 27th April 2022. The following was highlighted: • The COVID outbreak on the First Floor Ward at the Velindre Cancer Service was formally closed on 28th April 2022. The outbreak involved 5 patients (2 infections not acquired within VCC). No breaches in Infection Control standards were identified and a full review will be included as part of the nosocomial patient review. No harm came to patients as a result of contracting COVID. • Due to reduced COVID risk, Gold Command has progressed to the first phase of step down and from 27th April 2022 has been included as a designated part of fortnightly Executive Management Board meetings. SA queried whether staff within the Systemic Anti-Cancer Treatment (SACT) service are more susceptible to contracting COVID due to the high level of staff absence in this area and whether any mitigating measures had been imposed (such as testing of patients pre-admission). NW advised that COVID-related absence is no higher within SACT than in other services and that the impact on this area has been compounded by a number of staff on maternity leave and non-COVID related long-term sickness. SA queried whether there are sufficient stocks of blood group O to meet service demand (following blue alert status). PR advised that all demand for blood at hospitals across Wales continues to be met; however there is increasing difficulty in maintaining contingency stocks and intermittent support for other blood services has been required. The current focus is exploring how best to increase capacity, including venues, staffing and potential additional hours/sessions. The Committee **NOTED** the contents of the report and actions being taken for **ASSURANCE** purposes.	
4.2.0	**Workforce and Organisational Development Performance Report / Financial Report** Led by Susan Thomas, Deputy Director of Workforce and Organisational Development and Matthew Bunce, Executive Director of Finance The Committee received its second iteration of the combined Workforce & Associated Finance Risks report which outlined the risks currently faced by the Trust in respect of workforce and finance and	

	the mitigating actions. The following areas were highlighted: **WORKFORCE** • *Workforce Supply and Shape* – Clear work plans and timelines are under development to help secure the necessary skills required to meet both current and future demand. This includes a review of all fixed term contracts and agency reduction plans. A number of fixed term contracts have been made permanent, increasing stability within the workforce. • *Wellbeing* – Aside from COVID-19 related sickness absence, the main reason for absence remains stress and anxiety. Targeted interventions and support continue, including supporting staff with adapting to a hybrid working model. The current overall sickness level stands at 6.13%. • *Recruitment and Retention* – Increasing challenges due to NHS wide supply issues of critical clinical and scientific posts; this is requiring skill mix reviews to embed 'top of licence' principles across all areas of the Trust. Hotspots within SACT and Collections remain an ongoing challenge and a Trust-wide recruitment and retention programme has commenced. The Committee will receive regular updates on progress. • Work is underway to triangulate issues of staff sickness, maternity leave and other issues which may increase pressure on the Workforce. This includes a review of roles within WBS and issues within VCS at departmental level to enable development of a prioritised action plan; a Trust-wide approach is required with cohesive reporting of associated risks. **FINANCE** • *Risks* - All operational financial risks identified during the year to 31st March 2022 were mitigated within the overall Trust budget for the year. The overall reported financial position for the Trust during 2021-2022 was breakeven. • *Outsourcing* – 10% of Trust capacity will require outsourcing during 2022/23 due to predicted demand, presenting financial risk due to premium costs standing at three times the Trust's own rates. • *Staff vacancies* – The current vacancy rate is 9%, including 100 full time clinical vacancies. Agency use continues as a result, incurring, on occasions premium costs. Work will be undertaken to map posts recruited in response to COVID to current unfilled vacancies. 'COVID response' financial cover from Welsh Government continues in addition to the inclusion of a level of funding in the Trust's Commissioners' financial plans. • MB advised that there is no requirement to reference the financial viability of Shared Services in the report as there is a direct relationship between the organisation and Welsh Government in terms of funding. This will be referenced in future reports. It was acknowledged that Workforce is now emerging as the Trusts	**MB**

	largest risk. Significant work is underway to address these as quickly as possible and delivery of agreed actions will be closely monitored through the Executive Management Board. SH advised that communicating progress of this to staff would provide assurance that recruitment is being addressed as a matter of urgency. It was also noted that the combined report continues to evolve and improved integration of required elements will continue to provide a more comprehensive picture of overall workforce position and potential risks to services provided by Trust. The Committee **NOTED:** • The Finance Workforce key risks paper; • The March 2022 Financial report, in particular the financial performance for 2021-22; • The February 2022 Workforce report.	
4.3.0	**Quality, Safety & Performance Reporting** Led by Cath O'Brien, Chief Operating Officer The March Trust Performance report was discussed and the following key items were highlighted: • *Staff Absence:* Sickness and absence (non-COVID) has increased across both Divisions. A significant amount of work is ongoing within both Divisions to address this. • *Brachytherapy breaches:* Service resilience remains challenging and it is anticipated that there will be further breaches in coming months. Executive led improvements are underway via a task & finish group in addition to an external peer review from the Clatterbridge during May & June 2022. • *Radiotherapy Waiting Times:* A Pathway Lead has been identified to review breaches and improve processes to reduce time to treatment in addition to ongoing engagement with Health Boards to clarify their backlog clearance plans. DM welcomed this development. • *SACT (chemotherapy):* The service remains under considerable pressure due to increasing demand and continued staff absences. A SACT Delivery Task Force is exploring all options available on the SACT treatment pathway, including identifying and securing the required staff resource and most efficient use of staff. It is the intention to double service capacity at the outreach unit at Prince Charles Hospital (pending recruitment and training of staff) and full provision at Neville Hall will become available following reconfiguration of the unit (April 2024). Interim arrangements will are being explored. • *Inpatient Falls:* 9 falls had been reported on the First Floor Ward of the Velindre Cancer Centre during March 2022 involving 5 patients. All incidences have been through a scrutiny panel and assessed as unavoidable. The only common themes related to	

	the complexity of the patients (unrelated complexities). Although all standard systems and processes were in place, a change in approach when managing complex patients is now being considered. An independent falls audit has been undertaken by Anna Harries, Senior Nurse Professional Standards & Digital, and a report is being finalised. • *Delayed Transfers of Care (DToCs)*: COB advised that the minimal number of issues in relation to repatriation of patients is being managed on an individual basis via close contact with the relevant Health Boards. It is anticipated that this challenge will remain while Health Boards continue to suffer sustained pressure. SA queried how contact with family and friends is facilitated for patients at Velindre who would normally reside further afield. COB confirmed that measures implemented during the pandemic and periods of restricted visiting remain in place. Visiting with a purpose and compassionate visiting has remained throughout the pandemic; the current position allows previously scheduled visits for all inpatients, and outpatients may be accompanied by an individual bearing a carer's passport or if circumstances require patient support. SHa noted conflicting sickness figures between the Workforce Report and overarching Trust performance report. COB agreed to address this with Workforce colleagues. The Committee **NOTED** the content of the report.	**COB**
4.3.1	**Velindre Cancer Service Quality Safety & Performance Divisional Report** Led by Cath O'Brien, Chief Operating Officer The Velindre Cancer Service report provided an update on performance against key metrics for the period until the end of March 2022. The following areas were highlighted: • Considerable progress has been made in relation to early resolution of concerns and improvement plans have been embedded. • A Mortality and Morbidity pilot has been undertaken and all deaths occurring within 30 days of SACT will be discussed within a clinical governance meeting / mortality and morbidity meeting format. • 11 compliments from patients had been captured via Datix during February 2022, one of which had been written in the form of a poem. It was recognised that this is not a true reflection of the number of complements received and these require capturing in a timely manner. The Committee **NOTED** the contents of the Velindre Cancer Service Quality Safety & Performance Divisional Report.	

4.3.2	**Welsh Blood Service Performance Report** Led by Alan Prosser, Director of Welsh Blood Service The Welsh Blood Service Performance report provided an update on outcomes and performance against key metrics for the period to the end of March 2022. The following was highlighted: • Recruitment of bone marrow donors has been impacted by the COVID-19 pandemic, impeding the ability of the service to target schools, colleges and universities. The Committee was advised that a review of the recruitment process, in particular increasing the number of young bone marrow donors, is underway. • Serology remains an ongoing challenge due to sustained pressure compounded by staff sickness absence. An audit of out of hours referrals was undertaken and the findings are under review. Referrals continue to be prioritised based on clinical need and are completed in a timely manner. • The closure of quality incidents within 30 days remains below the 90% target for the period January – March 2022. The majority of late closures relate to 'clip failures' (the clip on the donation bag is not fully engaged resulting in an amount of blood over the required limit). Although this renders the unit unusable, it poses no harm to the donor. The team is currently exploring a more appropriate method of reporting such incidents, outside of Datix. The Committee **NOTED** the contents of the Welsh Blood Service Performance Report.	
4.4.0	**Trust Risk Report** Led by Lauren Fear, Director of Corporate Governance and Chief of Staff A progress report was provided in relation to management of risks across the Trust as identified on the Datix system during March 2022. The following was highlighted: • Of the 165 current risks, there is one level 20 risk (relating to Transforming Cancer Services (TCS)) and nine level 16 risks (5 for Velindre Cancer Services, 3 for TCS and 1 for Corporate). There were no level 25 risks to report and 5 risks have closed since the previous reporting cycle. • An extensive review of Velindre Cancer Service risks had been undertaken in addition to recalibration of a number of COVID-related risks. • Current risks in relation to Workforce are being quantified and will be included in the next cycle of reporting. • All remaining elements for the development of the Risk Framework are on track to be delivered by the end of June 2022, which will be followed by migration of WBS risks to Datix version 14.	

	It was agreed to review risk titles to provide further clarity. The Committee **NOTED** the risks level 20 and 16 reported in the Trust Risk Register and highlighted in the report in addition to the ongoing developments of the Trust's Risk Framework. It was recognised that risk reporting will need to continue to mature and develop to provide sufficient detail for assurance to the Committee.	**LF/COB**
4.5.0	**Review of Information Governance (IG) Toolkit** Led by Matthew Bunce, Executive Director of Finance The report provided a transparent position in relation to the management of information relating to patients, donors, service users and staff, including compliance with IG legislation and standards and actions to improve management and reporting of IG risks and incidents and actions from lessons learned. The following was highlighted: • *IG Toolkit self-assessment* – 22 of the 31 self-assessment questions apply to the Trust. The self-assessment had been undertaken and used to prioritise IG activity for 2022/23, including a full review of the comparison between this year's and the last. • *Data Protection Impact Assessments (DPIA)* – 21 DPIAs have been undertaken since October 2021 which are fundamental to providing assurance regarding mitigation of risks. It has been identified that the Trust does not currently have a single visible Contracts Register (irrespective of the contract value) in place to support correct IG processes and documentation, which presents a risk; this is being prioritised for 2022/23. • *Data Protection Act (2018) requests / incidents and investigations* – Most incidents continue to be as a result of human error in relation to incorrect data handling. It was advised that training is now being targeted to all individuals involved as well as hotspot areas. All incidents were investigated within required timescales. VM requested an update in relation to areas of deteriorating position at the July 2022 Quality, Safety & Performance Committee. SHa queried the use of Level 0 scoring as the Toolkit refers to three levels of attainment (1-3). MB confirmed that Level 0 had been applied in instances where assessment Level 1 had not been achieved. This will however be reviewed in detail by MB and the Head of Information Governance. MB advised that reviews to be carried out during 2022-23 (detailed in the work plan) would be prioritised based on risk. The Committee **DISCUSSED** and **NOTED** the 2021/2022 Quarter 4 Information Governance Assurance Report.	**MB** **MB**

4.6.0	**Quarter 4 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 4 Putting Things Right Report provided a summary of concerns, complaints and incidents received during the period 1st January 2022 and 31st March 2021. The following was highlighted: • Of the 46 concerns raised: 91% were graded level 1 (low level); 85% were managed as 'early resolution' (within 2 working days); 15% managed via the Putting Things Right process. No concerns related to the Pandemic. 100% of formal concerns raised were closed within the 30 working days; and top three themes were: appointments, communication, and clinical treatment. • Of the 492 incidents raised, 403 related to VCS and 89 related to WBS. 97% were graded as no harm or low harm. • There was one National Reportable Incident relating to an offsite storage contractor suffering major damage to one of its storage facilities and that hard copy Trust medical / clinical records may have been adversely affected. • There were 10 Ionising Radiation (Medical Exposure) Regulations (IRMER) incidents reported to Healthcare Inspectorate Wales (HIW). All incidents were related to a nationally known equipment fault. It was advised that investigations had concluded and a review is currently looking at how/if other cancer centres using the same equipment are mitigating the known fault. Closure reports had been submitted to and been accepted by HIW. • Formal investigation training has been provided to corporate and divisional staff. ND advised that further contextualisation (including trends and percentages reported over the last three year period) would be provided via the Putting Things Right 2021/22 Annual Report. The Committee **CONSIDERED** the 2021/2022 Quarter 4 Putting Things Right Report and commended the closure of 100% of formal concerns within the 30 working day timeframe.	
4.7.0	**Digital Services Incident Response Plans** Led by David Mason-Hawes, Head of Digital Delivery Two reports were received to update the Committee on the current position in relation to the development of Trust IT and Cyber Security Incident Response Plans. The following was highlighted: • Work has been undertaken to ensure that the Trust's local response plans now align with National response plans. • A separate process for managing incident response outside of the general emergency planning and Business Continuity Plans within	

	the Trust is not required and the IT incident response plan will utilise existing services. • Operational implementation of finalised plans is now underway, beginning with a number of desktop testing exercises. This will be followed by routine testing of both plans on a 6 monthly basis. The Committee was reassured that the publication of the two reports in the public domain would not compromise the safety of the Trust. The Committee **NOTED** the contents of the reports and the work being undertaken and to test Trust plans thoroughly.	
5.0.0	**INTEGRATED GOVERNANCE** (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	**Quality Safety & Performance Committee - Policy Compliance Report** Led by Lauren Fear, Director of Corporate Governance & Chief of Staff The Trust Policy Compliance report provided an updated position 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. The following was highlighted: • 122 of the 157 Trust-wide policies fall within the oversight and remit of the Quality, Safety & Performance Committee. All have now been audited since March 2022 and the status recorded within the report, including supporting risk assessment and any associated actions. • Work following the last Committee has focused on the 53 Workforce & Organisational Development policies. • The next phase of work will focus on policies which fall within the remit of the Trust's other Board Committees, reporting to each Committee as appropriate. Policies outside their review date: • Quality & Safety (4) - Review and consultation will be completed by end of June 2022 for submission to the Quality, Safety & Performance Committee for approval in Q2. • Infection Prevention & Control (2) - It is anticipated these will be approved at Quality, Safety & Performance Committee in Q2. • Information Governance, Digital and Corporate Communications (10, 2 of which are All Wales policies). The 8 remaining policies are currently under review for submission to the Quality, Safety & Performance Committee for approval in Q2.	

	• Estates, Planning and Performance (9) – 5 policies are undergoing the enhanced Equality Impact Assessment and 4 will be approved in Q2. • Workforce & Organisational Development (34, 10 of which are All Wales policies). The 24 remaining policies are currently under review in readiness for submission to the approving body in Q2/Q3. The work undertaken to date to reduce the number of policies overdue for renewal was commended. It was noted that progress is being managed via the Executive Management Board and updates would be provided to the Quality, Safety & Performance Committee until completion of the profile has been achieved (anticipated to be end of September 2022). The Committee: • **DISCUSSED AND REVIEWED** 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. • **NOTED** 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**.**	
5.2.0	**Analysis of triangulated meeting themes** Led by Vicky Morris, Quality, Safety and Performance Committee Chair, supported by all Committee members It was identified that the triangulated core theme arising from across a number of the papers was workforce, impacting on finance and operational delivery. It was concluded that workforce is emerging as the Trust's biggest risk due to a number of factors. The Committee was informed that the increasing workforce risk was currently being re-assessed and that plans are underway to undertake a robust review of current Workforce (including skill mix review), development of a robust 5-year Workforce and recruitment plan to facilitate active and timely recruitment into hotspot areas and a number of continued support mechanisms and interventions to protect the wellbeing of staff. Additionally, inconsistencies were noted in data/figures across a range of papers and a Quality Assurance check before publishing of papers was requested to avoid conflicting reporting. **Analysis of Quality, Safety & Performance Committee**	**Executive Team**

	effectiveness Led by Vicky Morris, Quality, Safety and Performance Committee Chair supported by all Committee members This item was not discussed.	
6.0.0	**HIGHLIGHT REPORT TO TRUST BOARD**	
	Members were asked to identify items to include in the Highlight Report to the Trust Board: 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**	
6.0.0	**DATE AND TIME OF THE NEXT MEETING**	
	The Quality, Safety & Performance Committee will next meet on the: **14th July 2022 from 10:00 – 13:00 via Microsoft Teams.**	
CLOSE		
The Committee is asked to adopt the following resolution: 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).		

Dear Vicky,

Please accept my apologies for the extremely late response to your queries. Whilst we would not normally receive a copy of the final report from the Health Board we have requested it in this case as you advised. We have not received the report yet, but in its absence I can confirm the following:

1. **The first unit of Blood had been transfused which I did not understand in the committee as it was stated that this was a near miss and error picked up at bed side, when in fact 1 of of the 2 units had been transfused.**

   - I feel it is important to emphasise that the correct blood was issued to the correct patient, despite the WBS label containing an error with the date of birth.

   We have requested a copy of the HBB incident investigation to allow us to confirm that correct processes were followed at the hospital:

   - The HBB should log the cross-matched units their computer system and issue new labels generated from their own PAS system.
   - At the point of receipt the data on the WBS label should be checked against the patient information in their system and any discrepancies should be identified
   - On this occasion it seems the WBS labels(with erroneous DOB) were not removed – some HBBs take them off, some don't (inconsistency in practice to be addressed via TLM meeting)
   - It is not known whether every unit contained both the WBS and the HBB label, the HBB report may advise whether this was the case
   - It is possible the person undertaking the bedside check for the first unit checked against the hospital's label (which contained correct DOB), not the WBS label. This would explain why the error wasn't noticed
   - The above should form part of the Hospital's investigation and they should report to SABRE/SHOT if they deem it necessary.

2. **Whilst the hospital itself will have carried out an RCA, there is nil about the impact on the patient in your reports or the fact that you are awaiting the outcome of their RCA if you have not received.**

   - The overall impact on patient safety (from the WBS perspective) is captured via the QPulse incident risk assessment. The likelihood of this particular error re-occurring was assessed as rare, but the severity was deemed major as an incorrect label could result in a delay in treatment with consequences for the patient.

   - In this instance there is no indication of an impact on the safety of the recipient as the blood was issued to the intended patient. Right blood, right patient is a recognised reporting category under the MHRA Serious Hazards of Transfusion (SHOT) scheme. It would be the responsibility for the HBB to report to SHOT separately from the WBS report to SABRE. The MHRA triangulate such reports between blood banks and the blood establishment.

   - We remain unclear about whether the patient was impacted by any delay in transfusing a second unit as result of the labelling error.

   - We weren't awaiting the outcome of their report, we were already aware the units had been given to the correct patient and were looking into addressing the WBS issues, assuming (perhaps incorrectly) that the HBB would be undertaking their own investigation and CAPA for whatever errors may have occurred in their process (e.g. not cutting the WBS label, or querying our error prior to the unit being issued to the ward).

- Ordinarily we wouldn't ask for the Hospital's report as we were satisfied there was no impact to the patient, but following your advice it has now been requested. We will review the HBB report on receipt and determine whether we need to take any further action. **We will update the RCA and share it with you if further action is needed**.

3. **In the one summary report it states some processes do not comply with BSH guidelines "Use of IT in Blood transfusion Labs" (2014)- so really helpful to understand the non- compliance specifically relating to our IT against the standard, what the gap is and where in our risk register it is stated as the standard as this guidance is not new and any Business cases past or in the pipeline to address that gap.**

    - BSH guidelines for the specification, implementation, and management of information technology (IT) systems in hospital transfusion laboratories (2014) offer guidance on safety measure to be incorporated into transfusion practices. Section 2.8 'component labelling and issue' states that *'Units should be authorised, and the labels printed and attached, one patient at a time, at a single workstation location'.*

    - BSH IT guidelines summary of recommendations also states 'Electronic transfer of data provides greater accuracy than manual transcription and thus helps reduce the risk to patient safety.

    - WBS currently use two different, but adjacent workstations to do this – SERIF to authorise units and Blood trace to issue units. The 2 processes are currently distinct and undertaken at separate workstations. A change proposal (PR000307)has been drafted to address this issue and develop software to allow the generation of crossmatch labels using the existing patient demographics on the SERIF system. This will eliminate the risk of incorrect manual entry on cross match labels as seen in this case.

    - Given the high demand for digital resources, prioritisation of the development work will be via the Business planning group and will take into account risk. The formal risk assessment of the current situation to support this change has not been completed due to acute staffing issues in the department including absence of the Head of Department, but the Q-pulse interim risk assessment of the incident indicates a low likelihood of recurrence.

    - The long term solution is to have a LIMS portal that links WBS to the Hospital PAS system, this will be delivered by the Laboratory Information Network Cymru (LINC) Program.

4. **The lack of scanning for bar coded data is clear and the different systems and so useful in future papers to outline the capital cases being developed to reduce the number of systems and therefore reduce the duplication of human inputting.**

    - This is a really helpful observation and we will aim to provide this detail in future reports.

My team and really I appreciate you taking time to feedback on this investigation and giving us a fresh perspective. You have highlighted areas for us to focus on in future as we seek to give assurance, both internally and to regulators, that we have properly understood both the impacts and root causes of incidents. This will help us to ensure our proposed actions are effective in preventing a repeat of the incident.

Regards,

Peter

ACTION PLAN

NWSSP Audit of Operational Management Arrangements for Medical Gas Pipeline Systems (MGPS)

Velindre Cancer Centre

March 2022

Report Ref	Recommendation	Priority	Responsibility	Anticipated Completion Date	Risk RAG Rating	Action update	Action Completed	Date
1.	The Trust should ensure that the Estates Manager completes their MGPS AP refresher course if they are to continue AP duties		Estates Manager	April 2022		Estates Manager attended the refresher course as required	Yes	Jan 2022
2.	The approved MGPS policy should include a signatory section		Estates Manager	April 2022		Documentation amended to include signatory section	Yes	April 2022
3.	The MGPS Operation Policy document is fundamental to the safe operation of the medical gas systems in use within the Trust and should therefore be reviewed on a regular basis. The review period should be yearly not three yearly.		Estates Manager	April 2022		Frequency of review altered to annual	Yes	April 2022
4.	Recommend a full MGPS ppm review is undertaken if in house CPs are to be used for maintenance work. The creation of an asset register would help in this regard.		Estates Manager	April 2022		Full asset collection complete	Yes	April 2022
5.	Formal arrangements for 24/7 AP cover for reactive maintenance work should be made.		Estates Manager	March 2023		Currently recruiting staff to support closure of this action. Site is covered at the moment by a specialist sub-contractor, low risk	No	
6.	Produce an accurate and up-to-date register of documents stored in the estates technical library.		Estates Manager	April 2022		Action complete technical library updated	Yes	April 2022

ACTION PLAN

NWSSP Audit of Operational Management Arrangements for Medical Gas Pipeline Systems (MGPS)

Velindre Cancer Centre

March 2022

Report Ref	Recommendation	Priority	Responsibility	Anticipated Completion Date	Risk RAG Rating	Action update	Action Completed	Date
7.	The Trust should implement procedures to ensure the record drawings are updated and reviewed on a regular basis.		Estates Manager	April 2022		PPM added to CAFM system	Yes	April 2022
8.	The Trust should produce schematic/ isometric drawings for the different systems installed		Estates Manager	April 2022		Schematic drawings updated and available	Yes	April 2022
9.	It is recommended that used permit books are centrally archived in the technical library or archive store. Permit books must be retained for the life of the medical gas system (Refer to HTM 02-01 PT B, Para 6.32, page 24).		Estates Manager	April 2022		Permit books are stored within the technical library as recommended	Yes	April 2022
10.	The CAP (MGPS) is to ensure that all permits are correctly completed and in full.		Estates Manager	Immediate effect		This action was completed with Jonathan refresher training	Yes	Jan 2022
11.	The Vacuum plant O&M manuals should be checked to ascertain manufacturers bacteria filter change periods.		Estates Manager	May 2022		This has been completed and reviewed with current operational procedures	Yes	May 2022
12.	The Trust should produce an action plan to address the non-compliance issues highlights in the compliance report produced by NWSSP-SES.		Estates Manager	Immediate effect		This document is the action plan	Yes	Mar 2022
13.	The APs should be consulted at early project planning stages.		Estates Manager	Mar 2022		The capital procedures reflect the requirement to consult with AP's	Yes	Mar 2022

ACTION PLAN

NWSSP Audit of Operational Management Arrangements for Medical Gas Pipeline Systems (MGPS)

Velindre Cancer Centre

March 2022

Report Ref	Recommendation	Priority	Responsibility	Anticipated Completion Date	Risk RAG Rating	Action update	Action Completed	Date
14.	The Trust's AP (MGPS) should be consulted with respect to the purchase of ALL medical equipment which will require to be connected to the MGPS.		Estates Manager	Mar 2022		Med gas committee agenda reflects this action	Yes	Mar 2022
15.	It is recommended that the Trust arrange to train an additional QC (MGPS) or obtain the service of a QC (MGPS) from another Trust in order to provide cover on the occasions that Pharmacy may not be available.		Estates Manager	August 2023		This action has been discussed at Medical Gas Committee and an action taken to review the options presented. RA currently underway, which will inform a decision which will be made by end of August 2022.	No	
16.	The Trust should consider having plant log books available for all items of plant.		Estates Manager	August 2022		Population of CAFM system	Yes	May 2022
17.	The Trust should consider having a separate folder for MGPS alerts, the policy also needs to reflect where the alerts are retained and who receives confirmation of actions carried out. It is recommended that alerts are an agenda item for the MGPS committee.		Estates Manager	March 2022		Populate updated folder.	Yes	May 2022
18.	Trained DNOs should be formally appointed in writing.		Estates Manager			DNO appointed in writing by CEO	Yes	2019

QUALITY, SAFETY & PERFORMANCE COMMITTEE

Handling Concerns Policy (Ref. QS03)
Update to section 7.11 Welsh Language

DATE OF MEETING	14th July 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Non-applicable

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

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	01/07/2022	Endorsed

1. SITUATION

This paper is provided for the Quality, Safety & Performance Committee to **APPROVE** the ***updated*** Handling Concerns Policy (Complaints, Claims and Patient Safety Incidents) (Ref. QS03), Specifically Section 7.11 – Welsh Language.

2. BACKGROUND

The Handling Concerns policy is in place to ensure that the Trust is meeting its legislative and national requirements with respect of the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011, and the Putting Things Right Guidance (PTR) (2013).

Following approval of the Handling Concerns Policy by the Quality, Safety & Performance Committee in March 2022 the policy has been further updated to reflect the required Welsh Language Standards.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Policy Changes

The only changes made to the Handling Concerns Policy following previous Quality, Safety & Performance Committee approval is to section 7.11 (highlighted in red on pages 16 & 17). These changes have been made by the Trusts Welsh Language lead and are required to ensure the Trust meets its Welsh Language legislative requirements.

The policy is due a complete re-review prior to April 2023 in order to ensure the Trust is prepared to fully implement its Duty of Candor responsibilities.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	These policies are critical to effective Quality & Safety arrangements within the Trust
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	These policies span across all the Health & Care Standards domains

EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
	As these policies are only revisions to existing policies, a new EQIA is not required.
LEGAL IMPLICATIONS / IMPACT	The Trust would not be meeting its Welsh Language legislative requirements if these policy changes are not made.
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 **APPROVE** the slightly amended Handling Concerns Policy (Complaints, Claims and Patient Safety Incidents) (Ref. QS03).

Ref QS03

Handling Concerns Policy
(Complaints, Claims and Patient Safety Incidents)

Executive Sponsor &Function:	Executive Director Nursing, Allied Health Professionals and Health Science
Document Author:	Trust Quality & Safety Manager
Approved by:	Quality, Safety & Performance Committee
Approval Date:	24.03.2022
Date of Equality Impact Assessment:	31.08.2020
Equality Impact Assessment Outcome:	
Review Date:	April 2023
Version:	2

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1. Executive Summary

This policy has been developed to ensure that Velindre University NHS Trust "the Trust" fulfils the requirements for the robust management of concerns, ensure there is organisation wide learning and improvement and also provides assurance to the Board and external bodies about the commitment of the Trust to implement the legislation. National Health Service (Concerns, Complaints and Redress Arrangements (Wales) Regulations 2011 ''the Regulations'', and the Putting Things Right Guidance (PTR) (2013) set out the requirements that all Health Bodies must make arrangements in accordance with the Regulations for the handling and investigation of concerns.

This policy will be implemented in accordance with the following:

- Welsh Government Putting Things Right Guidance on Dealing with Concerns about the NHS (Version 3 – November 2013)
- National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.
- The Trust's Concerns' Toolkit 2021
- Public Service Ombudsman for Wales Act (April 2019)
- The Health and Social Care Quality and Engagement (Wales) Act 2020 (particularly Part 3 – Duty of Candour)

2. Policy Statement

The Trust acknowledges that, as a provider of specialist clinical and non-clinical services, there will be occasions where things will go wrong. The Trusts response to such events will be openness, transparency and to ensure we so everything we can to minimise the potential for reoccurrence of similar incidents in the future. The overriding principle, when concerns are reported, is to be able to understand fully what happened and learn from them rather than attribute blame.

In line with the Health and Social Care Quality and Engagement (Wales) Act 2020, the Trust will implement an open and transparent approach to the management of concerns aligned to the Duty of Quality and the Duty of Candour, and ensure procedures are in place to enable delivery against the Regulations. This policy has been developed in conjunction with a number of key principles:

Handling Concerns Key Principles

A culture of openness will **be promoted**

Staff will be actively encouraged to report incidents and near misses, and patients/donors will be supported to raise feedback & concerns.

Robust & proportionate Investigations will be undertaken

Investigate once investigate well: Concerns will be investigated in accordance with the all Wales concerns grading matrix.

Local concerns arrangements will be in place

Local procedures will be in place to support delivery against the Regulations, which will be communicated to all staff.

Concerns training will be provided to all staff

A range of concerns & Datix training will be made available to all staff based upon their role and responsibility.

Individuals raising concerns will be engaged in the process

Expectations of the person raising the concern will be established and their involvement in the process sought.

Support will be available for staff involved in, or the subject of a concern

A variety of support mechanisms will be available for staff involved in, or are the subject of a concern.

Datix will be used to record all concerns

All investigation information including outcomes and action plans will be recorded in Datix.

Risks will be mitigated to avoid re-occurrences

Actions will be identified to mitigate the risks identified from concerns.

A bi-lingual service will be provided when required

Concerns relating to the Welsh Language will be managed via the language of choice.

Learning will be identified to improve services

Arrangements will be in place to ensure learning from concerns is identified and shared across the Trust.

Early resolution of concerns will be promoted

Wherever possible, concerns will be resolved by the end of the next working day to avoid unnecessary escalation of concerns.

80% of responses will be provided with 30 working days

80% of concerns will be responded to within 30 working days, and none later than 60 working days.

3. Scope of Policy

This policy applies to all staff, permanent and temporary, employed by or working within the Trust (including hosted organisations).

The Policy covers concerns about:

- Services, care & treatment provided by the Trust.
- Services provided by the Trust's employed staff.
- Services provided by independent contractors.
- Services provided by independent or voluntary sector(s) funded by the Trust.
- This policy does not apply to clinical services provided privately, even when provided within Trust premises.

Matters excluded are set out in Regulation 14 of Putting Things Right, including:

- A concern notified by any member of staff relating the contract of employment.
- A concern that is being or has been investigated by the Public Services Ombudsman.
- A concern arising out of an alleged failure of the Trust to comply with a request for information under the Freedom of Information Act 2000 – these would be dealt with by the Information Commissioners Office.
- Disciplinary proceedings that the Trust is taking or proposing to take, arising from the investigation of a concern.
- A concern that becomes the subject matter of Civil Proceedings.
- A concern that is/becomes the subject of a concern related to an Individual Patient Funding (IPFR) Request. Reference should be made to the Welsh Health Shared Services Committee IPFR policy;
- Police criminal investigations.

The Trust will advise the complainant (person who notified the concern), as soon as reasonably practicable, in writing, of the reason(s) for any decision that the concern is excluded from the scope of the Regulations and, thereby, this Policy. If any excluded matter forms part of a wider concern, then there is nothing to prevent the other issues being looked at under the Regulations, so long as they are not excluded as well.

4. Aims & Objectives

The Trust is committed to dealing with concerns in an open, accessible and fair manner, ensuring that learning ad improvement takes place.

The aim of this Policy is to outline how the Trust will comply with the Putting Things Right Regulations (2011) and the Health and Social Care Quality and Engagement (Wales) Act 2020 and ensure systems are in place for the investigation and handling of concerns in a variety of media, formats and languages.

5. Definitions

Adverse event/incident	An adverse incident is an event which causes or has the potential to cause unexpected or unwanted effect involving the safety of the patients, users or other persons.
Claim	Allegations of negligence and/or demand for compensation made following an untoward incident resulting in clinical negligence or personal injury to a member of staff, a patient or a member of the public or damage to property
Complainant	A person notifying the concern/complaint
Complaint	An expression of dissatisfaction, requiring a response.
Concern	Patient/Donor/service user safety incident or expression of dissatisfaction (incorporates safety incidents, complaints, claims)
Duty of Candour	Candour means the quality of being open and honest: transparency, fairness; impartiality. Placing a duty of candour on NHS bodies and primary care providers, through the Health and Social Care (Quality and Engagement) (Wales) Act 2020 [1] ('the Act'), highlights the Welsh Government's commitment to safe, effective and person-centred health services.
Duty of Quality	The Duty of Quality seeks to improve the health services for the people of Wales providing evidence based around the 6 domains of Quality (as defined by the Institute of Medicine)
Early Resolution	Concerns that could potentially be resolved immediately or within 2 working days through discussion, explanation or the provision of information. These generally relate to relatively easy to address issues and as such are handled outside of the PTR regulations
External body / agency	An organisation that has an official advisory or regulatory role that has been mandated to regulate the corporate and professional activities of NHS Trusts
Investigation	A formal approach of gathering information in a systematic and methodical way
Nationally Reportable Incident	An incident or accident where a patient, member of staff, or member of the public suffers serious injury, major permanent harm or unexpected death (or risk of serious injury) on premises where health care is provided, or whilst in receipt of health care, or where the actions of health service staff are likely to cause serious injury.
Never Event	"Never events" are defined as 'serious, largely preventable patient safety incidents' that should not occur if the available preventative measures have been implemented by healthcare providers
Near Miss	A near miss is a situation in which an event or omission, or a sequence of events or omissions, arising during clinical care fails to develop further, whether or not as a result of compensating action, thus preventing injury
Qualifying Liability	A liability in tort owed in respect of, or consequent upon, personal injury or loss arising out of or in connection with breach of duty of care owed to any person in connection with the diagnosis of illness, or in the care or

	treatment of any patient/donor/service user in consequence of any act or omission by a health care professional and which arises in connection with the provision of qualifying services
Redress	The making of an offer of compensation in satisfaction of any right to bring civil proceedings in respect of a qualifying liability in tort; the giving of an explanation; the making of a written apology and the giving of a report on the action that has been, or will be, taken to prevent similar occurrence
Root Cause Analysis	A process for identifying the basic or causal factor(s) that underlies variation in performance, including the occurrence or possible occurrence of a sentinel event.

6. Roles and Responsibilities

The Regulations specifically require every NHS organisation to clarify who is responsible in their organisation, for the undertaking of the distinct roles and regulatory responsibilities as set out below:

6.1 Chief Executive Officer

The Trust Chief Executive Officer has overall responsibility for dealing with concerns and ensuring investigations are undertaken in an appropriate manner, within appropriate timescales and that lessons learned are implemented within the Trust.

6.2 Responsible Officer

The Responsible Officer is accountable for the effective day to day operation of the Trust's arrangements for dealing with concerns in an integrated manner. The Director of Nursing, Allied Health Professionals and Health Science is the Responsible Officer for the Trust and ensures arrangements are in place to:

- Deal with concerns in line with the Regulations.
- Allow for the consideration of qualifying liabilities; and
- For incidents, complaints and claims to be dealt with under a single governance arrangement.

6.3 Strategic Oversight

A nominated Independent Member is responsible for maintaining a strategic overview of the Putting Things Right arrangements and their operation, including:

- Overseeing how organisational arrangements are operating at a local level.
- Ensuring that concerns are dealt with in compliance with the regulations.
- Ensuring arrangements are in place to review the outcome of all investigated concerns to ensure that any failure in provision of service identified during the investigation are acted upon, improved and monitored in order to prevent recurrence

The nominated Independent Member is the Independent Member with responsibility for the Quality, Safety & Performance Committee.

6.4 Trust Quality and Safety Manager

The Trust Quality & Safety Manager is also responsible as Senior Investigations Manager (SIM) as described in the PTR regulations. The SIM is responsible for;

- Oversight of the handling and consideration of concerns in accordance with this Policy.
- Auditing of Trust and Divisional concern management arrangements.
- Robust interface arrangements with the Divisions in relation to effective divisional concern management processes and outcomes.
- The development, integration and embedding of a comprehensive investigation and redress system for concerns.
- Providing assurance to the Executive Management Board (EMB) and Quality, Safety and Performance Committee on the Trust performance regarding concerns.
- Ensuring mechanisms are in place for lessons learnt to be shared across the Trust.

6.5 Corporate / Divisional Directors (including hosted organisations)

Divisional Directors are responsible for ensuring the necessary processes and structures are in place across their Division and to ensure compliance with the PTR Regulations, and this policy. They are required to ensure robust processes are in place within Division for proportionate and timely investigations and to ensure that all earning identified from investigations is appropriately implemented across the division so that the required improvements are embedded, patient / donor experience is enhanced and potential for harm reduced.

Corporate / Divisional Directors, Clinical Directors / Medical Directors, Chief Scientific Officers and Heads of Nursing are responsible for ensuring (within respective Divisions):

- that all concerns are recorded on datix at source including those received verbally;
- that a culture of openness is promoted and encouraged to ensure that staff report all concerns that are patient safety incidents and that concerns are robustly and promptly investigated in line with the Regulations and acted upon;
- effective and practical local arrangements are in place across all provided and commissioned services to ensure full implementation of and compliance with this policy and that these are communicated to staff;
- that staff receive concerns handling, investigation and Datix training pertinent to their roles and responsibilities;
- that there is appropriate cross-divisional and Trust co-ordination and liaison to achieve compliance with this policy;
- that adequate and appropriate support is made available to staff who are involved in/are the subject of a concern;
- that staff trained in investigations analysis within the Trust and are released or have their duties appropriately adjusted to enable them to undertake or support investigations when required;
- that all information pertaining to individual concerns including the outcomes of all investigations are fully and accurately recorded in Datix, that all documents are saved against the Datix record, and all action plans are completed through the Datix system so that compliance can be easily monitored and reviewed;
- that all necessary actions are taken to prevent re-occurrence of issues arising from both individual and aggregated concerns;

- appropriate communication and reporting of relevant information to all appropriate Boards and Committees;
- that lessons are shared across services and the Trust as relevant;
- the creation of a culture across the Divisions where issues are resolved as they arise and informally resolved as far as possible – not allowing unnecessary escalation or protraction of concerns;
- that 80% of concerns being managed through the Division are responded to within 30 working days and no concerns receive a response later than 60 workings days (Regulatory maximum time period);

6.6 Every manager in the Trust is responsible for:

- ensuring all staff, volunteers and contractors are made aware of this policy and the requirements within it;
- creating and maintaining a culture where patient feedback is encouraged and timely action is taken to make any changes required;
- creating and maintaining a culture where all staff are supported and trained to address issues and concerns as they arise as to nip issues in the bud and to ask for help and assistance when required and not allow issues to fester and escalate;
- creating and sustaining an environment whereby staff feel supported to report concerns that are patient safety incidents and feel that these will be taken seriously and dealt with appropriately;
- ensuring appropriate feedback is given to the reporters of patient safety incidents and all staff involved with or the subject of any concern, including any investigation outcomes and actions taken and to ensure that this feedback is clearly documented;
- identifying the training needs of individual members of staff, in relation to use of Datix and the handling of concerns, and ensuring that these training needs are met;
- ensuring that how to raise a concern and Community Health Council posters and leaflets are visible within all patient / donor areas;
- Ensuring that all identified improvement action is taken or if unable to do so, this is escalated through to the Divisional Quality Team;
- Ensure all verbal concerns are recorded in 'real time' on Datix; and,
- ensuring staff are made aware of how to access copies of the Trust's arrangements for handling concerns, in all the formats, so that they may satisfy any reasonable request made of them for this information.

6.7 Responsibility of all Staff

All staff must:

- Treat persons notifying/reporting concerns with respect and courtesy;
- Treat all concerns confidentially;
- Co-operate fully and openly in the investigation of concerns;
- Address issues and concerns as they arise and escalate for assistance if unable to manage any issue affecting the progress of the concerns raised;
- Attend incident/concerns training and Datix training pertinent to their roles and responsibilities;

- Ensure they are aware of the importance of reporting safety incidents, including near misses, and that all staff are aware of their responsibilities for reporting and escalating incidents and near misses;
- Ensure they are aware of the Trust's arrangements for handling concerns, and where to seek advice and information where appropriate, to enable them to satisfy any reasonable request made of them for this information; and,
- Be open, honest and transparent and adhere to this Policy and the supporting procedures that accompany it, at all times.

6.8 Corporate Quality and Safety Team

The Corporate Quality & Safety team is responsible for ensuring the Trust has appropriate policies, procedures, support and training in place for the management of Concerns across the organisation. In particular they are responsible for:

- Receipting and grading Concerns and provision of acknowledgement letters within required timescales
- Development of Concerns / Putting Things Right related policies and procedures
- Provision of appropriate Concerns Management, investigation and Datix Training
- Overseeing appropriate divisional investigative processes and adherence with national timescales
- Leading on 'serious Harm' investigations
- Leading on all Public Services Ombudsman Reviews / investigations
- Leading on all Redress processes
- Leading on all Duty of Candour and Duty of Quality reporting
- Lead on Vexatious Concerns Management
- Auditing compliance with all Concerns / Putting things Right Standards
- Oversight of learning and dissemination of learning
- Provision of Executive Management Board and Quality, Safety & Performance Committee report Lead on liaison and meeting requirements of other external bodies such as: Coroner's Office; Shared Services – Legal and Risk, Police; and Community Health Council.

6.9 Executive Management Board

Concerns are a gift as they offer a valuable opportunity for us to learn and improve. Regular quarterly reports are provided to Executive Management Board. The Executive Management Board is responsible for overseeing the Trusts Concerns Management process and outcomes. This will include appropriate: policies, procedures and reporting in line with legislative and national requirements; training; identification of and compliance with key performance indicators; meaningful analysis; investigative processes; audit and operational assurance mechanisms; that all remedial action is taken; Duty of Candour mechanisms in place; and, appropriate lessons identified and shared.

A quarterly Putting Things Right Report will be presented to Executive Management Board in respect of the above areas as well as an annual report which is also published to ensure full transparency. Following Executive Management Board deliberation appropriate amendments are made and submitted for assurance to the Quality, Safety & Performance Committee.

6.10 Quality Safety and Performance Committee

The Quality Safety and Performance Committee is responsible on behalf of the Board for scrutinising and receiving assurance and / or any exceptions in relation to Putting Things Right and Concern Management. This will include appropriate: policies, procedures and reporting in line with legislative and national requirements; training; identification of and compliance with key performance indicators; meaningful analysis; investigative processes; audit and operational assurance mechanisms; that all remedial action is taken; Duty of Candour mechanisms in place; and, appropriate lessons identified and shared.

The Quality, Safety and Performance Committee provide assurance reports to the Board in respect of how the Trust is meeting its Putting Things Right and Wales Quality and Engagement Act Responsibilities highlighting any exceptions, risks or potential risks in respect of this.

7 Notification of a Concern

7.1 Who May Notify a Concern

Almost anyone may raise a concern. Regulation 12 (PTR Regulations) notes a concern may be notified by:

- People who are receiving or have received services from the Trust.
- Any person who is affected, or likely to be affected by the action, omission decision of the Trust, in relation to the functions of the Trust.
- Any non-officer member of the Trust, e.g. an independent member.
- Any member of staff of the Trust.
- Any person acting on behalf of any person from the above categories (a to d) who has died, is a child, lacks the capacity under the Mental Capacity Act (2005) to notify the concern themselves or has requested the person to act as their representative.
- Assembly Members and Members of Parliament.

Some concerns will not be handled under the formal arrangements for raising a concern under the Putting Things Right regulations. These include concerns that are relatively easy to address and can are normally dealt with by way of early resolution. Such concerns are required to be resolved within 48 hours (or the next working day) from receipt of the concern. Where Early Resolution concerns cannot be addressed within the 48 hour timeframe, provided that the complainant expressly wishes for the concern to remain as an informal complaint, the Trust has five days in which to resolve the concern in accordance with the Early Resolution requirements. After this time, the concern is treated as formal. Concerns that can be dealt with as they arise (informally) should be recorded locally on the Datix OFW Feedback module. A written record of the concern must be made together with the outcome. A copy of the outcome will be given to the person raising the concern, if appropriate.

7.2 Concerns Notified by a third party

When a third party acts as a representative on behalf of another e.g. a child or someone who lacks mental capacity if there are reasonable grounds to conclude that they are not suitable to act on their behalf, for example because it does not appear to be in the persons best interests, then they must be advised in writing. However, an investigation into the

issues raised may still need to be undertaken. In this instance the Trust is under no obligation to provide a detailed response to the person who raised the concern, unless it is reasonable to do so.

7.3 Concerns Received from Assembly Members/Members of Parliament

Concerns received from the Welsh Government or via an Assembly Member/Member of Parliament or other elected members on behalf of their constituent, must be dealt with as soon as possible and a response provided at the earliest opportunity.

For the sharing of personal data, the Trust will rely on The Data Protection (Processing of Sensitive Personal Data) (Elected Representatives) Order 2002, which also covers the disclosure of such data by organisations responding to Members.

7.4 Concerns Relating to Children

Any child or young person under the age of 16 is able to raise a concern if they are considered as having sufficient competency. Where a concern is notified by a child or young person, the Trust has a duty to support and assist in responding to the concerns raised.

Advocacy is to be offered to assist the child or young person and this should be arranged in accordance with the Welsh Government's 'Model for Delivery Advocacy Services to Children and Young People in Wales' (2004) through the local authority services provided. The investigation process will be consistent with the principles of the Carlisle Report (2002) and with appropriate involvement of named advocates and others with nominated responsibility for a child's health and welfare where appropriate.

In instances where child protection issue arise, staff involved should seek advice from their Head of Nursing or the Trust Head of Safeguarding & Vulnerable Groups. The Putting Things Right Procedure for handling concerns should run independently of any child protection investigation. The concern should be investigated by the Investigation Lead; however, advice should also be sought from the Head of Safeguarding & Vulnerable Groups. Where the concern alleges child abuse or neglect by an employee, a multi-agency child protection referral must be made to the appropriate social services department in line with the All Wales' Child Protection Procedures and the Trust Child Protection policy and procedures.

In many cases, a carer (parent/carer/guardian) may raise a concern on behalf of a child. This does not remove the right of the child to take the concern forward by him/herself with appropriate support. The Trust must satisfy itself as to whether the child wishes to raise a concern with assistance and support from a relevant carer/advocate or if they prefer to be represented with appropriate consent to do so.

If the child is unwilling to allow a concern to be investigated, a decision will need to be taken regarding the investigation. Specialist advice will need to be sought if appropriate from the Trust Head of Safeguarding & Vulnerable Groups where issues arise concerning

safety/safeguarding of a child. In such circumstances, it may be necessary to proceed with an investigation even if a child is unwilling.

7.5 Concerns Raised by Prisoners

Prisoners have access to the same quality and range of healthcare services as the general public. Where a prisoner raises a concern, the Trust will handle and investigate the concern in the same way as it does for all concerns in accordance with the PTR regulations. Prisoners must also be informed that they have the right of access to advocacy services provided by Community Health Councils and/or mental health advocates as appropriate.

7.6 Concerns raised by individuals Lacking Capacity or Vulnerable Adults

All concerns are treated seriously, whether an individual lacks capacity or not. This includes people who are also deemed vulnerable adults.

The Trust is aware of the importance of the complaints process being accessible to all. Therefore, the Trust will make reasonable adjustments and/or consider the ways people access the complaints process and how this may affect an individual's ability to make a complaint.

When a person lacks capacity or is deemed a vulnerable adult, such concerns should be processed in compliance with the Mental Capacity Act (2005). Where necessary, the Trust will use a consent process that allows complaints to be made on behalf of people who may lack capacity. This process may include clinical assessment of capacity, whilst ensuring equality and equity processes are followed.

The Trust will also need to be satisfied that the complaint is being made in the best interests of the person on whose behalf the complaint is made. In such instances, and where doubts exist about the reasonableness of the concern, discussion should take place between medical and nursing staff with a relative, friend or advocate, who has permission to act on the persons behalf, and a decision made as to whether the concern should be formally investigated. There is also a need to ensure that a person who lacks capacity or is vulnerable, has access to appropriate advocacy services.

Care must be taken not to overlook a real and serious underlying concern, which may be masked by the patient's disability or incapacity. Investigation Leads must remain alert to any possibility of vulnerable adult abuse, and take immediate advice from relevant senior professional staff, or the Trust Head of Safeguarding & Vulnerable Groups, in cases of doubt.

Where it is deemed appropriate for the issues raised in the concern to be dealt with via the Protection of Vulnerable Adults Policy, the person raising the concern should be informed and the necessary steps taken.

7.7 Concerns raised through Advocacy Services

It is important that those who raise concerns are informed of their right to have involvement of an advocacy service. Advocacy promotes social inclusion, equality and social justice.

Community Health Councils (CHCs) across Wales are responsible for representing independently and without bias, the interests of patients, families and third parties, in order to influence and improve the NHS. CHCs will listen to views expressed about the health service and represent people who wish to raise concerns regarding the health service. They also work closely with the health service to improve the quality of care that is delivered.

Advocacy Support Cymru (ASC) is a registered charity that specialises in the provision of professional, confidential and independent advocacy for those eligible in secondary care and community mental health settings across South Wales.

Independently Mental Health Advocacy (IMHA) support patients with issues relating to their mental health and care. Mental health advocates have a duty to ensure that patients are eligible in accessing IMHA services. The service takes action on behalf of patients to ensure that their interests are represented and that services that are required are obtained for patients.

The Trust recognises the importance of advocacy in the concerns process and encourages patients to take advantage of advocates when raising a concern. This ensures that patients who require support are provided with the necessary access for appropriate representation.

7.8 Concerns from Solicitors / Intention to Litigate /Requests for Compensation

People have a right to raise their concern via a solicitor, provided that the appropriate consent is given to ensure that the solicitor is able to act on the person's behalf. Any concerns that are received via a solicitor are dealt with in accordance with the governance and framework of the PTR regulations. Exceptions to this relate to the following:

When legal proceedings or notification of proceedings have been issued
When the solicitor has issued a letter before claim
Pre-action protocol (eg letter before claim/letter of notification)
Conditional Fee Arrangement (CFA)
After the Event Insurance (ATE)
Part 36 offer
Claim form
Particulars of Claim
Acknowledgement of Service
Response Pack
Defence
Consent Order
Case Management Conference
If there is mention of instructing a barrister.

The above provides an indication that the matter is being pursued as a civil claim under the pre-action protocol. Any letters or communication received from a solicitor should be passed to the Claims Manager and alerted to the possibility that the solicitors are not conducting the matter in accordance with PTR.

Where there is an intention to proceed with a claim and the matter is able to be dealt with in accordance of the PTR Regulations, this should be conveyed to the solicitor via the Claims Manager and a request made to inform the client via the solicitor that PTR is considered appropriate. There is provision with the scope of the PTR Regulations that allows for the time limit to be suspended during the PTR investigation of aconcern.

The Trust Claims Manager should be notified immediately of any concern which has the potential to be considered under Redress or which is likely to result in a legal claim over the financial threshold applicable under the PTR regulations (£25,000).

In the event that legal proceedings are instigated during the PTR process the matter no longer proceeds under the Putting Things Right Regulations and the person raising the concern is duly notified in writing.

Where the Trust accepts, in the absence of legal proceedings, that there is a breach of duty which has potentially or otherwise resulted in harm, the matter is considered under the Redress arrangements to determine if a qualifying liability exists.

7.9 Concerns from people with a disability

In line with the Equality Act 2010, the Trust will make reasonable adjustments to ensure that the concerns process is accessible to service users who have a disability. Advice on reasonable adjustments should be sought from the Trust Equality & Diversity Manager.

7.10 Concerns involving contracted service

The Trust recognise that it remains responsible and accountable for ensuring that the services provided on behalf of a contractor meet current standards in relation to the complaints policy and procedures by ensuring that:

- the contractor complies with this policy and complaints handling procedures and/or
- the contractor has their own complaints handling procedure in place, which fully meets the standards outlined in this procedure.
- The Trust is responsible for ensuring that there is appropriate provision for information sharing and governance oversight involving contracted services to ensure the safe delivery of services that is provided on behalf of the contractor.

7.11 Concerns and Welsh Language

When dealing with concerns or complaints Velindre University NHS Trust will take account of its statutory duties in relation to the provision of services in Welsh.

NHS organisations are legally bound to comply with the duties set under the Welsh Language

(Wales) measure 2011 and the requirements placed upon them through Welsh Language Standards, by the Welsh language Commissioner.

http://www.velindre-tr.wales.nhs.uk/welsh-language

Concerns or complaints relating to the Welsh Language may be about the provision of health services (for example, that a particular service has not been provided through the medium of Welsh and therefore the person's needs have not been met) or about whether the organisation has complied with the Welsh Language Standards

Velindre University NHS Trust is committed to providing bilingual services through the delivery of its Welsh Language Standards and you are welcome to raise your concern directly with the Welsh Language Commissioner if you wish to do so, or come directly to the Trust in the first instance.

http://www.comisiynyddygymraeg.cymru/English/Commissioner/Pages/Complaints-about-the-Welsh-Language-Commissioner.aspx

All concerns received in Welsh will be responded to in Welsh under the same PTR framework and timescales for concerns received in English.

Should you wish to raise a concern then please contact:
Concerns team, by e-mail: Handlingconcerns@wales.nhs or telephone: 02920 196191

Language plays a vital part in the quality of care and the treatment a person receives. The Trust recognises the need to provide Welsh language services, whereby Welsh language users are able to access the complaints processes fairly, without prejudice or discrimination.

Upon establishing the need for communication in Welsh, the Trust will ensure:

- All written communication is provided in Welsh
- Arrange Welsh interpretation for over the phone or face-to-face meetings.
- Ensure there are bilingual complaints leaflets/forms that include the Public Service Ombudsman for Wales guidance and CHC support made available both on the intranet and across sites across the Trust where service users frequent
- Adopt a proactive approach to language choice and need in Wales by:
  - ✓ Ensuring the language needs of Welsh speakers are met.
  - ✓ Ensuring Welsh language provision/services for those who need it.

7.12 Concerns and British Sign Language

The Trust acknowledges that not being able to communicate well with health professionals can affect health outcomes, increase the frequency of missed appointments, the effectiveness of consultations and patient experience.

The Trust is committed to providing high quality, equitable, effective healthcare services that are responsive to all patients' needs and recognises that the British Sign Language (BSL) is a recognised language.

The Trust will take steps to ensure:

1. That there is equality for BSL users to raise concerns
2. That there is access to interpretation and translation services to enable appropriate communication to take place.
3. That there is the opportunity to liaise with an individual via their preferred means of communication.
4. Concerns information is available in alternative formats.
5. Access to an interpreter when required

“Interpreter” is used to mean registered, qualified bilingual and bicultural professionals who facilitate communication between BSL Users and those who use only spoken languages, such as Welsh or English and provide a service for patients, carers and clinicians to help them understand each other**.**

7.13 Concerns and Blind and Partially Sighted Disabilities

The Trust recognises the need for equality and fairness for those who wish to raise concerns who are registered blind or partially sighted and will ensure that there is flexibility within the complaints process that allow for individual needs to be taken into account.

The Trust will also ensure that it has in place alternative methods for communication, with access to Braille information and ability for an individual to raise complaints orally, in addition to ensuring that appropriate services are available for the individual to access and raise concerns.

8. Reporting Concerns

The Trust is required to have a single point of contact for Concerns that should be advertised. This includes concerns relating to Velindre Cancer Service and the Welsh Blood Service. For all concerns the Trusts point of contact is:

Executive Director Nursing AHP's & Health Science
Velindre Trust Head Quarters
2 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff, CF15 7QZ
handlingconcernsvelindre@wales.nhs.uk
Telephone: 029 20196161

8.1 Time limits for notification of a concern

A concern must be notified no later than **12 months** from:

- The date on which the concern occurred, or if later,
- 12 months from the date the person raising the concern realised they had a concern (Where a patient has opted to have a representative act on his/her behalf, this date is the patient's date of knowledge, NOT the date that the representative was informed of the concern by the patient).

To investigate a concern after the 12-month deadline, the Trust must consider whether the person raising the concern has good reason not to provide notification of the concern earlier and whether, given the time lapse, is it still possible to investigate the concern thoroughly and fairly.

A concern under these regulations may not be notified 3 or more years after the date on which the subject matter occurred or after the date that the subject matter came to the notice of the patient/donor. The Trust may, therefore, refuse to consider any such concern under the regulations. (Where a patient/donor has opted to have a representative act on his/her behalf, this date is the patient's /donors date of knowledge, NOT the date that the representative was informed of the concern by the patient/donor).

If the person who raised the concern is a child at the time of injury the three year period does not begin to run until the individual reaches the age of 18years and runs out on their 21st birthday.

If the Trust makes an exception to this it must make it clear to the person who raised the concern that the investigation is not being undertaken under the PTR regulations. In addition, that the investigation will be limited in some aspects based on the information available as key staff may have left the Trust and given the time elapsed memory in relation to the circumstances will be poor and unreliable.

8.2 Withdrawal of Concerns

A concern may be withdrawn at any time by the person who notified the concern. The withdrawal of the concern can be made:

- in writing;
- electronically; or
- verbally in person or by telephone.

If a concern is withdrawn verbally, the Trust will write to the person as soon as possible to confirm their decision. However, even if the concern has been withdrawn, if it is felt that the investigation of the concern is still appropriate, the Trust will continue to investigate.

9. Handling a concern process

9.1 Acknowledging Concerns

All concerns managed under the PTR regulations should be acknowledged in writing within 2 working days of receipt. This written acknowledgement should be done by the corporate Quality & Safety team.
If the concern is not from the patient, consent must be sought from the patient/donor/user. The template acknowledgement letter is available from the Trust Quality and Safety team and includes:

- Name and telephone number of a named contact (not usually the Investigation Lead) for use throughout the handling of the concern
- The offer of an opportunity to discuss with the named contact, either in a meeting or over the telephone, any specific needs and the way in which the investigation will be handled
- The opportunity to meet with relevant staff involved in relation to the concern/s raised
- When a response is likely to be received i.e. 30 days from the date of receipt of the concerns raised
- The availability of advocacy and support, i.e. Community Health Council
- Information advising that a patient's clinical records will need to be accessed as part of the investigation
- A copy of the Putting Things Right leaflet is to be provided at the outset

The concern lead will then refer the concern for investigation. The progress of the concern is monitored by the Trust Quality and Safety Team to ensure the investigation is completed within an appropriate timescale, commensurate with the grading and complexity of issues raised by the concern.

9.2 Time limit for formally responding to a concern

30 working days from the date the concern is received is the deadline for providing ma response/interim report to the complainant.

If this is not possible, the Trust will:

(a) notify the complainant and outline the reason for the delay; and
(b) send the interim report as soon as reasonably practicable and within 6 months
(c) a Regulations 33 response and disclosure of the investigation report must be sent no later than 12 months

9.3 Concerns received from Medical Examiners

Medical examiners are a core part of the process of investigating patient deaths across the NHS in England and Wales. The role of the medical examiners will speak with bereaved families and discuss the cause of death. Where there are concerns raised by bereaved families in relation to any aspect of care or treatment, these are referred to the appropriate NHS provider for consideration.

The Trust has set up the Medical Examiners Panel which sits bi-weekly to look at cases referred by the Medical Examiner. Where it is identified that a concern arises, the Trust's co-ordinator for mortality will write to the family to ascertain if they wish for the concern to be investigated and provide an opportunity to discuss these concerns with the clinical team involved. If the concerns warrant an investigation under the Regulations, the matter is passed to the Trust Quality & Safety Team and thereafter to the relevant Divisional Concerns Lead to investigate and provide a response within the timescales outlined by the PTR Regulations.

9.4 Concerns Referred to Coroner's Inquest

An investigation into a concern should continue regardless of the inquiries of the Coroner, whose role is to determine the cause of death. However, in cases where there is a National reportable incident and/or statements are being taken from staff for the purpose of inquest proceedings, the person raising the concern may need to be informed that the investigation may not comply with the 30-day timeframe to provide a response under the PTR regulations.

A formal response may be issued relating to concerns raised, independent of the inquest if it is appropriate to do so. However, if an outcome from a Coroner's inquest is needed to complete the response, the person raising the concerns is required to know the reason for the delay in the process and must be notified of the expected delay. Where statements are taken as part of the inquest process, the concerns investigation should include reference to these.

The Investigation Lead should discuss the case with the Trust Claims Manager and the Quality and Safety Manager to determine the most appropriate action.

10 Investigation of Concerns

10.1 Concerns Flowchart

Regulation 23 provides that all concerns must be managed and investigated in the most appropriate, efficient and effective way, having regard to the matters that are set out in Regulation 23(1) (a) to (i).

A concern which alleges (implicitly or explicitly) harm or impact experienced by the patient will generally be graded 3, 4 or 5 (see Appendix A) and will be investigated

under the PTR guidance. In such circumstances, a relevant and proportionate investigation will be undertaken following the scoping of the concerns and key issues identified.

The Trust notes in particular Regulation 23(1) (i) which provides that where the concern notified includes an allegation that harm has or may have been caused it will consider:

- the likelihood of any qualifying liability arising;
- the duty to consider Redress in accordance with Regulation 25; and
- where appropriate, consideration of the additional requirements set out in Part 6 of the Regulations.

When considering the "additional requirements of Part 6", the Trust will be mindful of the current financial limit of £25,000 applied to offers of Redress under Regulation 29. Where it is clear from the outset that if a qualifying liability were to be established damages would exceed £25,000, the Redress arrangements will not be triggered. In this situation the Trust will serve a Regulation 24 response, which will not comment on whether or not there is or may be a qualifying liability, and the person who notified the concern will be advised to seek legal advice and will be given the contact details for their local CHC.

10.2 Initial Assessment of a Concern

An initial assessment and grading of the concern is undertaken to determine the level of investigation required.

All concerns will be graded on receipt in terms of severity, from 1(No Harm) to 5 (Catastrophic Harm) in accordance with the All Wales' Grading Framework (see Appendix A). This will determine the level of investigation required in dealing with the issue(s) raised.

The grading of a concern should be kept under review throughout the investigation in case the level of investigation needs to change. For example, the seriousness of a concern may only become evident once an investigation has commenced or has been completed. The grading of a concern may therefore be upgraded or downgraded by the Investigation Lead during the course of the investigation. The Trust procedure for the investigation of concerns should be followed when investigating the concern (complaint/incident).

All concerns (complaints, claims and incidents) must be recorded on Datix upon receipt (formal and early resolution). This ensures robust recording and oversight.

Concerns are managed by the Velindre Cancer Centre Head of Nursing, Deputy Head of Nursing and Quality and Safety Manager with appropriate assistance from Service Leads.

Concerns raised by donors or those acting on behalf of donors to Welsh Blood Service is managed by Donor Experience Manager

10.3 Obtaining independent clinical or other advice

There may be occasions when the Trust considers it is necessary to secure an independent opinion on a matter relating to a concern, with a view to resolving it. The Trust incident and concerns investigation procedure should be followed in these situations.

10.4 Consent to Investigate Concerns

In the majority of cases, the investigation of a concern requires access to medical records and therefore the issue of consent will need to be considered. When consent is required, the Trust procedure for Consent to Investigate a Concern must be referred to thereby ensuring that the appropriate consent is obtained before the sharing of information.

If there is any doubt as to whether the processing of sensitive personal data without the consent of the data subject is unlawful, appropriate legal advice should be sought. Further information regarding consenting issues is set out in the all Wales Guidance (Putting Things Right Regulations) on dealing with concerns.

In the event that the patient/donor contacts the Trust after raising the concern to say that they are unwilling to provide consent for their records to be accessed, then the Trust must take a view on whether the issues raised is of sufficient seriousness to merit an investigation without access to the medical records.

10.5 Consent Involving Other Organisations

Where the Trust is notified of a concern that involves the functions of more than one responsible body/another organisation, it is required to seek the consent of the person notifying the concern to contact the other organisation before sharing information in relation to the concerns raised.

Consent should be sought within 2 working days of when the concern is received. Templates for the consenting process is available from the Trust Quality and Safety team.

Once consent is received, the Trust is required to contact all other relevant organisations involved in the concern within 2 working days of the consent being received.

The Trust must agree with the NHS organisations and person raising the concern, which organisation will take the lead, co-ordinate the investigation and provide the response. All relevant organisations should be included in any meetings arranged to discuss the concern.

11 Nationally Reportable Incidents

A concern which is raised by a complainant may already have been raised by staff as a nationally reportable incident and an investigation may already be underway.

The investigation into the incident should continue to ensure that action is taken to reduce the risk of recurrence and improve patient safety. In this situation the Trust Procedure on the Management of Nationally Reportable Incidents should be relied upon, and the person raising the concern must be kept informed of any delays in regard to the final response.

Where a letter raising a concern is received and it becomes apparent that there has been a serious incident that the Trust was previously unaware of, an on-line incident form should be submitted via OFW Datix Incident Module. The serious incident process will commence and the person raising the concern should be informed that it may not be possible to achieve the 30-day timeframe in which to provide a response. Regular updates should be provided throughout the course of the investigation and the likely timing of when a response will be envisaged.

12 Response

12.1 Delays to the Complaint Response

Regulation 24 requires the Trust to take all reasonable steps to send the response to the person who notified the concern within 30 working days, beginning on the day that the notification of the concern was first received. It is essential the Trust advises the person who raised the concern of the predicted timescale for a response. If the Trust is unable to provide a response within 30 working days, the following actions are required:

1. A written explanation setting out the explicit reasons for the delay must be provided to the person who raised the concern, with estimation or anticipated date for completion of response.

2. Some responses may take up 60 working days (3 months), where a serious patient safety investigation is required. Rarely an investigation may take up to 6 months, however where this is the case close contact with the complainant must be maintained to provide regular updates of the stage of the investigation. Responses should not be sent later than 6 months, from the day that the notification of the concern was first received.

3. Timescales are reported at a divisional and corporate level through the Trust's management structures.

12.2 No Qualifying Liability – Regulation 24

Where appropriate, the lead investigator prepares a written report and drafts a response to the concern under investigation for the responsible officer which:

- Summarises the nature and substance of the matter or matters raised in the concern
- Describes the investigation
- Contains copies of any expert opinions (internal or external) relied upon to inform the investigation
- Contains an offer to provide copy relevant medical records, as appropriate
- Contains an apology as appropriate
- Identifies what action will be taken in light of the outcome of the investigation
- Contains details of the complainant's right to notify the concern to the Public Services Ombudsman for Wales and aligns with provision of section 36 of the Public Services Ombudsman (Wales) Act 2019
- For complaints relating to the Welsh Language, the right to notify the Welsh Language Commissioner
- Offers the complainant the opportunity to discuss the content of the response with appropriate clinical/nursing/administration teams.

The letter is to be written in a language that the person raising the concern will easily understand and must avoid medical or technical jargon. Where there may be difficulties in understanding the response, the Trust will make every effort to provide the appropriate support. Where necessary, people raising concerns should be given the opportunity to receive their response in an appropriately accessible format, e.g. Braille, large print, electronically or on an audio device.

In respect of a concern that alleges that harm has or may have been caused and this has been found not to be the case, the letter must also contain an explanation of the reasons why no qualifying liability exists.

Written responses determined as grade 1 and 2, where no harm is alleged, are signed by the service/hosted organisations director or a person acting on their behalf as their deputy. If the investigation has determined that there is no qualifying liability the response must provide an explanation as to how it reached this decision.

Where approval/sign off is required by the Executive Director Nursing, AHP's and Health Science, the response must be agreed both with the relevant senior professionals involved in the investigation and the Divisional Director. As a matter of good practice, it should also be shared with any staff involved in investigating the concern.

Following approval by the Divisional Director, the draft response and a copy of the original concern is subject to quality assurance by the Trust Quality and Safety Manager and/or Deputy Director of Nursing before forwarding to the Executive Director Nursing, AHP's and Health Science for final approval and signature.

Following issue of the final response, further correspondence may be received when the person raising the concern does not feel that all the issues in the original concern have been addressed. Every effort will be made to address these further issues

satisfactory at a local level including, where appropriate, the setting up of a meeting between the person raising the concern and relevant staff where this has not yet happened. Notes should be taken at such meetings and these will be shared with the person raising the concern.

Further correspondence received from the person raising the concern expressing dissatisfaction will be reopened on the OfW Datix Feedback Module and will be acknowledged within 2 days with a further investigation undertaken of any new issues that are raised.

In the event that a complainant is dissatisfied with their response and there are no new issues to investigate then the complaint will not be reopened but a meeting with the complainant will be offered. Where the complainant remains dissatisfied then he/she will be advised to refer to the Public Services Ombudsman of Wales. Contact details of this must be provided in acknowledgement or response letter to the person raising the concern.

12.3 Interim Report (Regulation 26) – When a Breach of Duty is identified and harm has or likely to have occurred resulting in a possible qualifying liability

If, at the end of an investigation, it is established that harm has occurred and a qualifying liability exists or likely to exist, the matter will be considered by the Trust's Putting Things Right Panel.

Where there is the potential that harm has occurred or has been identified from the investigation, a draft interim response will be prepared for the complainant with input from the Trust Claims Manager, as appropriate.

The interim response will include:

- A summary of the nature and substance of the issues contained in the concern;
- A description of the investigation undertaken so far;
- A description of why in the opinion of the Trust there is or may be a qualifying liability;
- A copy of any relevant medical records;
- An explanation of how to access legal advice without charge;
- An explanation of advocacy and support services which may be of assistance;
- An explanation of the process for considering liability and Redress;
- Confirmation that the full investigation report will be made available to the person seeking Redress;
- An offer of an opportunity to discuss the contents of the interim report with appropriate staff.
- The interim report should receive final approval and signed off by the Executive Director Nursing, AHP's and Health Science.

Once the interim response has issued, the matter is to be forwarded to the Trust Claims Manager for further investigation under the Redress arrangements as referenced within the Putting Things Right Regulations.

12.4 Trust Putting Things Right Panel

The Trust's Putting Things Right panel consists of multi-disciplinary team members who hear presentations to:

- □ Determine and or validate whether a breach of duty has occurred;
- □ Determine whether the breach of duty described has caused harm;
- □ Consider the engagement of an independent clinical expert if a decision on breach of duty cannot be reached;
- □ Consider the engagement of an independent clinical expert in collaboration with the person raising the concern where causation is in question or further clarity as to the degree of harm is required;
- □ Agree how the decision of the panel will be communicated to the person raising the concern, and by whom;
- □ Agree how the decision of the panel will be communicated to staff affected by the concern, and by whom;
- □ Agree an award of financial compensation in cases where a Redress remedy applies
- □ Ensures there is a robust system in place for recording the decisions made.

12.5 Post Closure contact - Public Service Ombudsman of Wales

In accordance with the Public Services Ombudsman (Wales) Act 2019, when an individual remains dissatisfied with a response, he/she has the right to contact the Public Service Ombudsman for Wales, who will review the matter on their behaf. The Ombudsman can accept complaints through his website, by e-mail, in writing, or over the phone.

The Ombudsman's contact details are:
Phone: 0300 790 0203
Email: ask@ombudsman.wales
Website: www.ombudsman.wales
Address: Public Services Ombudsman for Wales, 1 Ffordd yr Hen Gae, Pencoed, CF35 5LJ.

The complainant, or an individual acting on behalf of the complainant, must be advised that if they wish to contact the Ombudsman with a complaint, this will need to be done so promptly. The Ombudsman is able to consider complaints made to him within one year of the matters complained about (or within one year of when it became aware that the complaint could be made). Upon receipt of a response to a concern, the individual will need to inform the Ombudsman within twelve weeks if he/she wishes for the matter to be investigated further.

The Ombudsman will determine on a case-by-case basis whether to consider a complaint. However, he will not generally consider a complaint in relation to matters which happened more than a year ago, unless the complaint to the Trust was made within a year, and the complaint is referred to the Ombudsman within twelve weeks of a response.

12.6 Investigation by the Public Service Ombudsman of Wales (PSOW) - timeframes

In 2019, the legal powers of the PSOW were extended. The PSOW can now accept oral complaints, undertake their own initiative investigations, including the investigation of medical treatment, including nursing care, as part of a patient's health pathway and also investigate the way a complaint was handled by an NHS provider. The new powers also extend to the publication of complaints handling by an NHS provider.

When a complaint is received from PSOW, the Trust has 5 days in which to acknowledge the complaint and 20 days to investigate and respond to PSOW with their findings. If there are difficulties in meeting the timescale and more time is needed, an extension can be requested from PSOW, following discussion with their senior management team. If agreed, PSOW will write to the complainant advising that the issues that have been raised will take longer than expected and will aim to provide an expected timeframe upon which the response can be expected.

12.7 Redress

Redress comprises:

- The making of an offer of compensation in satisfaction of any right to bring civil proceedings in respect of a qualifying liability
- The giving of an explanation
- The making of a formal apology
- The provision of a report on the action/s which has been, or will be, taken to prevent a similar occurrence from arising
- Care/remedial treatment

An initial valuation of the concerns raised is required to ensure that any likely liability will not exceed that of £25,000. Where it is likely that financial compensation will exceed that of £25,000 if liability is admitted, the Trust Claims Manager will discuss with NWSSP Legal and Risk Services and the Welsh Risk Pool to determine if the matter is capable of remaining in Redress in an attempt to reduce litigation costs. Where the value of the case exceeds that of £25,000 and cannot continue under Redress, the person raising the concerns will be advised to seek independent legal advice and no qualifying liability will be admitted.

However, if it is considered that initial valuation is within the remit of Redress and it is established that both a breach of duty and harm has occurred that results in a qualifying liability, it is the duty of the Trust's PTR Panel to confirm a breach of duty and approve whether the breach caused or materially contributed to harm suffered by the patient.

If the Panel determines that no breach of duty exists, the Division is notified and a response under Regulation 24 is issued identifying the reasons why no qualifying liability exists.

If it is not possible to determine whether a breach of duty exists following in-house comments, the Trust can commission an external expert to provide an opinion on breach of duty. Terms of Reference will be undertaken by the Lead Investigator with assistance from the Trust Claims Manager, where appropriate.

Following an opinion from an independent expert, the report findings are shared with the appropriate division and relevant staff members involved in the investigation, as required. If a breach of duty exists, a Regulation 26 response is issued and the matter is referred to the Trust Claims Manager for ongoing management of the concerns under the Redress arrangements.

When a breach of duty is identified and harm remains uncertain, further investigation will be required. This may include obtaining in-house comments from staff members to inform the decision-making on qualifying liability or by way of obtaining an expert opinion on causation/condition/prognosis to determine liability and quantum.

The Terms of Reference to request an expert report is prepared by the Trust Claims Manager in conjunction with relevant staff members involved in the investigation. The Terms of Reference is shared with the person raising the concern or with the person's legal representative and is undertaken on a joint basis.

The Trust Claims Manager will provide a list of experts in the relevant speciality, together with a copy of expert CVs and terms and conditions for reference and agree the expert list with the directorate prior to sharing with the person raising the concern or their legal representative acting on their behalf. The decision to instruct an expert of choice will be taken by the person raising the concern or the legal representative.

Where a person is seeking Redress, the findings of the investigation must be recorded in an investigation report. The investigation report, in accordance with Regulation 31, must be provided to the person who raised the concern and is seeking Redress within 12 months of first receipt of the concern. The investigation report must contain:

- copies of any independent expert advice used to determine whether or not there is a liability;
- a statement by the Trust confirming whether or not there is a liability and
- the rationale for the Trust decision.

However, it is not necessary to provide a copy of the investigation report before

- an offer of Redress is made;
- before a decision not to make an offer of Redress is communicated
- if the investigation of Redress is terminated for any reason or
- if the report contains information which is likely to cause the person or other applicant for Redress significant harm or distress.

Where an investigation report cannot be provided within the set 12 month timescale, then the person raising the concern must be informed of the reason for the delay and given an expected date for response.

Once further investigations have been completed, the case will be re-presented to the Panel to agree the findings and, where harm has been established seek approval at the Panel for an appropriate Redress remedy/remedies to be made. In the event a financial compensation is considered appropriate, the Panel will be asked to agree an offer of financial compensation, which reflects the harm suffered following quantification by the Trust Claims Manager.

12.7.1 Regulation 33 Response

If financial compensation is due, the Trust Claims Manager will be responsible for preparing a Regulation 33 response making an appropriate financial offer to settle the matter on a full and final basis with approval from the Executive Director of Nursing, Allied Health Professionals and Health Science. The person raising the concerns will have six months to accept the offer from the time the response is issued. If, after that time, no response is received, the concern is closed down within 9 months.

12.7.2 CRU Certificate

The Trust Claims Manager is responsible for requesting a CRU certificate from the Department of Work and Pensions where it is established that harm may have occurred. This is in accordance with the Trust's statutory obligation. Where harm is found to have occurred in relation to the NHS Charges/recoverable benefits (CRU), the Trust Claims Manager will arrange the appropriate payment and discharge of the CRU Certificate as necessary. Where the NHS charges/CRU amounts to over £3,000 the matter is passed to NWSSP Legal and Risk Services for advice in accordance with the Welsh Risk Pool guidance.

13 Behaviour, Conduct and Unreasonable Demands during a concerns investigation

People raising concerns have the right to be heard, understood and respected. On occasions there may be times when persons raising the concern acts out of character and become determined, forceful, angry and make unreasonable demands of staff.

The Trust, however, recognises that persons who complain despite being advised on other avenues available to them may be abusive toward, show aggression to and make unreasonable demands of staff or continue to persistently pursue their concern by telephone, in writing, or in person. Behaviours that escalate into actual or potential aggression towards staff are not acceptable. The Trust has a zero tolerance policy on unreasonable, unacceptable abusive or aggressive, or violent behaviour.

Unreasonable, unacceptable abusive or aggressive, or violent behaviour is:

- Behaviour that produces damaging or harmful effects, physically or emotionally on other people.

- Persistent unacceptable behaviour is behaviour that is deemed unacceptable within one event or on a number of occasions within a period of time.

Examples of unacceptable or aggressive or abusive behaviour:

- Verbal threats unsubstantiated allegations or offensive statements can also be termed as abusive violent behaviour.
- Threatening remarks e.g. both written and oral.
- Unreasonable demands e.g. Demands for responses within unrealistic timescales, repeatedly phoning, writing or insisting on speaking to particular members of staff.

If staff encounter situations where a person raising a concern behaves in an unacceptable manner towards staff, appropriate action should be taken in line with the Trust's Zero Tolerance policy.

14 Monitoring Arrangements

It is essential that all responses are full, comprehensive, clear and answer the concerns raised. The response needs to be in layman's terms ensuring a meeting is offered on receipt of the responses. All concerns are monitored to ensure the concern has been adequately investigated, remedial actions put in place and lessons have been learned. The Trust Quality & Safety Performance Committee is responsible for the Trust's arrangements for learning from concerns, and that the Trust has robust processes to drive continuous improvement in the quality of services and care.

For the purposes of monitoring the operation of the arrangements for dealing with concerns Velindre must maintain a record of the following matters:

- Each concern notified to it;
- The outcome of each concern;
- The time period taken to investigate the concern;
- The reasons where any investigation exceeded the 30 day time period.

This record will be reported to the Executive Management Board and Trust Quality and Safety Performance Committee on a quarterly basis.

The Executive Management Board will receive quarterly reports giving an overview of complaints received, setting out what changes have been made as a result of complaints information and, following monitoring of their implementation, what results have been received.

An annual report will also be produced using the template provided in the Putting Things Right guidance, to include:

- An overview of arrangements in place for dealing with Concerns
    - Any planned developments
    - Reference to working with other responsible bodies

- Effectiveness of the arrangements, and how this has impacted on patients/service user and staff
- An indication of services used, for example expert advice, legal advice, alternative dispute resolution, advocacy services.

□ Concerns Statistics and analysis
□ Themes, trends, performance and key issues
□ Lessons learnt, demonstrating how they have contributed to improved service delivery.
□ Conclusion and priorities for improvement

The report will be placed on the Trust's internet site and published as part of the organisation's Annual Quality Statement.

15 Learning from Concerns

The Trust will ensure that it has arrangements in place to review and assess the outcome of any concern that has been subject to an investigation under the Regulations, in order to ensure that any deficiencies in its actions or its provision of services, identified during the investigation, are:

- Recognised, acknowledged, owned and acted upon
- Where improvement requires embedding, an improvement plan will be developed using the template action plan within the complaints manual
- Identify learning for wider sharing across the Trust and share as appropriate, including the means to share across the wider NHS sector if suitable.
- Reviewed and reported regularly within the service divisions and Trust wide to ensure improvements are established minimising the risk of reoccurrence.
- Ensure that learning is used to target any problem areas and consider if there is potential to improve policies, procedures and services.

Learning lessons throughout the Trust and taking action to ensure any necessary improvements are made is critical to avoid such deficiencies recurring. The Trust has a number of mechanisms for sharing learning from patient experience and concerns, e.g. Alerts, newsletters, intranet, training, divisional meetings, SCIF, Shared Listening and Learning Committee for shared learning and improvement.

16 Supporting Staff

16.1 Staff involved in concerns

To support staff involved in concerns investigations the Trust will:

□ Actively promote an open and fair culture that fosters peer support and discourages the attribution of blame. Velindre University NHS Trust will work towards a culture where human error is understood to be a consequence of flaws in the systems, not necessarily the individual

- □ Educate all staff to understand that apologising to service users is not an admission of liability
- □ Provide advice and training on the management of concerns, including the need for practical, social and psychological support, as part of a general training programme for all staff in risk management and safety
- □ Provide information on the support systems currently available for staff including counselling services offered by professional bodies, stress management courses for staff who have the responsibility for leading investigation discussions, and mentoring for staff who have recently taken on a lead investigations manager role.

Further information can be located in the Trust procedure for supporting staff involved in an incident complaint or claim and on the Trust intranet site under 'staff support services'.

16.2 Concerns Containing Allegations against Staff

Where concerns raised contain allegations against a staff member / staff members, the relevant staff member/s should receive a copy of the key issues identified at the beginning of the investigation and support offered where appropriate, including appropriate signposting to support. The line manager will be responsible for discussing the nature of the allegations with the staff member and for identifying and signposting any required support. The member/s of staff will need to be actively involved in investigation. All staff have a duty to actively participate as deemed appropriate by the investigator in this process.

Any staff member identified in the investigation process should have an opportunity to review the response before the relevant Divisional/Hosted Organisation Director/Lead approves it.

17 Concerns and Disciplinary Procedure

If an investigation into a concern indicates the need for a disciplinary investigation, the Investigation Lead must discuss these issues with the staff member's line manager. A decision to initiate a Disciplinary Investigation, rests with the relevant line manager with advice from the relevant professional Head of Service.

If a disciplinary investigation begins before the investigation has been completed, consideration will need to be given as to how far the investigation under the Trust's Handling Concerns Policy and Procedures can continue and whether a disciplinary investigation can run alongside the concerns investigation.

The person raising a concern may not be entitled to know of disciplinary sanctions imposed on any staff member other than action has been taken. A judgement will need to be made between reassuring the complainant that the matter that has been raised has been taken seriously and dealt with satisfactorily, while protecting the confidentiality of the staff member.

18 Equality Impact Assessment

This policy has been screened for relevance to equality. No potential negative impact has been identified so a full equality impact assessment is not required.

The Trust will develop an understanding of why some members of the community who may wish to raise a concern might not feel able to do so. This may be due to cultural, social, gender and other reasons, including sensory loss, any of which might result in ineffective communication. Staff should be mindful of the issues which might act as a barrier to people raising a concern and look for ways to assure people that it is safe for them to raise an issue.

19 Policy Compliance

On an ongoing basis, the Trust will actively promote awareness and understanding of this policy, linking to existing organisational development programmes, where possible.

Service/hosted organisation Directors will implement the policy within their area and ensure local procedures exist to support the policy. The Trust Quality & Safety Manager will advise and oversee the development of local procedures to ensure compliance with the Regulations.

20 Confidentiality – Information Governance

Confidentiality is an important aspect in relation to the concerns handling of a matter. All Trust Staff are required to maintain the complainant's confidentiality and are required to protect personal data as outlined by the Data Protection Act 2018. The Act sits alongside the General Data Protection Regulation (GDPR) 2018, which sets out the key principles, rights and obligations for processing personal information.

The Trust acts as “controller” of information and staff responsible for using personal data has to follow strict rules called 'data protection principles'. They must also make sure that the information is used fairly, lawfully and transparently. There is also the requirement to protect information as outlined by the Caldicott principles, Human Rights Act 1998 and the Freedom of Information Act 2000.

Information in relation to complaints should not be disclosed/copied/ shown to any external agency without the permission of the Responsible Officer or nominated deputies on a “need to know basis”.

All requests for access to such information should be directed to the appropriate manager, or nominated deputy or service lead for the subject of the concern, in the first instance.

In addition to the above, NHS Wales has adopted the Confidentiality Code of Practice for Health and Social Care in Wales. All staff have an obligation of confidentiality regardless of their role and are required to respect the personal data and privacy of others. Staff must not access information about any individual who they are not providing care or treatment for, or in relation to the administration of services unless in a professional capacity. Rights to access information are provided only for staff to undertake their professional role and for work related purposes only. If in doubt, staff must contact their line manager or the Trust Information Governance Manager, regarding concerns relating to the sharing of information.

The Information Commissioner's Office has also prepared detailed guidance on data sharing and has issued a data sharing code of practice.

Further information can be found in the Trust's Privacy Policy and Information Governance Policy available on the Trust's intranet site.

21 Training

The level of training required is outlined in the Training Needs analysis (TNA). Staff need to be informed about and received appropriate training in respect of the operation of the arrangements for the reporting, handling and investigation of concerns. Training should be considered in relation to areas such as:

- □ Customer care
- □ Safeguarding
- □ Records management
- □ Root Cause Analysis training
- □ Human Factors
- □ Being Open
- □ Legal Training/Awareness

Training will take the form of one or more of the following:

- □ Online training
- □ Self-learning: guides, procedures, policies and legislation
- □ Videos
- □ Meetings and conferences
- □ Induction
- □ E-learning

22 Storage and Management of Concerns Files

The concerns files should include the investigating lead's file and any other relevant information concerning the investigation. The (paper and Datix) concerns file must be kept for a period of 10 years and in the case of children, until the child attains the age of 25 (with the minimum 10 year provision).

The concerns file including the investigating lead file should be combined into one full file. It is the responsibility of the Division to ensure that the file is complete and accurate and holds no contentious remarks.

23 Complaints and legal action

The limitation in relation to bringing a claim under the Civil Procedure Rules is 3 years from the date of the incident or from the date when the complainant knew or ought to have known he could bring a claim.

During a PTR investigation, the limitation period to bring a claim under the Civil Procedural Rules is stopped. However, the limitation period resumes once the investigation is completed and the findings shared with the complainant.

If, during the process of the PTR investigation into the concerns raised by an individual, a letter of claim or service of proceedings is received, the matter is no longer suitable to be dealt with by the PTR Regulations and the matter is to be passed to the Trust Claims Manager.

If an individual threatens legal action or a pre-action letter is received from an individual's solicitors, the matter is to be referred to the Trust Claims Manager who will advise as appropriate. The matter is also to be passed to the Trust Claims Manager if any correspondence is received from solicitors concerning a request for medical records on behalf of the patient or patient's representative.

24 Managing Media Interest / Media Communications

The management of media interest/ in relation to incidents, either individually or generally, will be undertaken by the Trust's Communications Department.

25 References

- The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011
- Health & Care Standards Wales
- Putting Things Right
- Civil Procedural Rules

QUALITY, SAFETY & PERFORMANCE COMMITTEE

Health, Safety and Welfare Policy

DATE OF MEETING	14th July 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Helen Jones – Trust Health and Safety Manager
PRESENTED BY	Carl James, Director of Strategic Transformation, Planning and Digital
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning and Digital

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Trust Health, Safety and Fire Management Board	22/02/2022	Endorsed
Executive Management Board	27/04/2022	Endorsed

ACRONYMS	
H&SMS	Health and Safety Management System

1. SITUATION/BACKGROUND

1.1 The Trust Health, Safety and Fire Management Board agreed a revised Health, Safety and Welfare Policy 22nd February 2022.

1.2 The Health and Safety at Work etc. Act 1974 requires organisations to have a Health and Safety Policy, which should be regularly reviewed. Health and Safety Executive guidance states that the Policy should include a Statement of Intent of the Trust's commitment to managing health and safety. The statement must be signed by the Trust Chief Executive. The Policy should list the names, positions and roles of the people who have specific responsibility for health and safety and the arrangements for the management of health and safety.

1.3 The Trust has an existing Health Safety and Welfare Policy which was approved in March 2020 and which required updating to reflect recent changes in health and safety governance arrangements.

1.4 The revised Health Safety and Welfare Policy will need to be agreed by the Trust Board.

2. ASSESSMENT/SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The Health, Safety and Welfare Policy was updated to reflect the introduction of Trust and Divisional level Health, Safety and Fire meetings and to redraft and refresh the roles and responsibilities of key individuals including the Director and Deputy Director of Strategic Transformation, Planning and Digital. The opportunity was also taken to remove duplication of information within the Policy.

2.2 The revised Health, Safety and Welfare Policy is attached at Annex 1.

2.3 Engagement was carried out with key stakeholders including the Trade Unions and an EQIA was completed identifying no negative impact.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
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	Yes (Include further detail below)
	These documents facilitate the Trust's compliance with the Health and Safety at Work Act 1974 and associated legislation
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 asked to **APPROVE** the Health, Safety and Welfare Policy.

Ref: QS18 - HEALTH, SAFETY AND WELFARE POLICY

Executive Sponsor & Function	Director of Strategic Transformation, Planning, Digital and Capital Development Health and Safety Function
Document Author:	Trust Health and Safety Manager
Approved by:	Quality and Safety Committee
Approval Date:	22/02/2022
Date of Equality Impact Assessment:	23/12/2021
Equality Impact Assessment Outcome:	Safer Working Environment
Review Date:	02/2025
Version:	8

CONTENTS

1. Policy Statement

1.1 Velindre University NHS Trust is committed to ensuring, the health and safety, welfare at work of our employees and others affected by our work activities. We recognise that a healthy and safe working environment and culture is vital for delivering our vision of 'Healthy People, Great Care and Inspirational Learning".

1.2 This policy sets out our commitment to health and safety. It outlines our health and safety management arrangements including systems for planning, implementing, checking and reviewing management of health and safety and the specific and general responsibilities of staff. These arrangements are detailed in our health and safety policies and procedures, which form our documented Health and Safety Management System.

1.3 The Chief Executive has overall responsibility for health and safety. Day-to-day health and safety management is delegated to directors of divisions and Hosted Organisations and is detailed within our management system. The Director of Strategic Transformation, Planning, Digital and Capital Development has Board level responsibility for health and safety.

1.4 Whilst overall responsibility to provide and maintain a safe and healthy working environment, equipment and systems of work rests at the highest level of management, every employee has a responsibility to ensure that they cooperate with health and safety management arrangements.

1.5 The Trust will engage and consult with our staff, and in particular, Trade Union appointed Safety Representatives on health and safety matters.

1.6 To implement this policy and enable employees to function efficiently with regard to health and safety; information, instruction, training and supervision, will be provided in accordance with identified needs. We recognise that health and safety is a key responsibility for managers. Health and safety is included in all job descriptions.

1.7 Effective health and safety management is based on identification, understanding and control of the risks. This is achieved through a system which enables suitable and sufficient risk assessment and management.

1.8 The Trust Health, Safety and Fire Management Board supported by Health, Safety and Fire Management Groups at Velindre Cancer Centre and the Welsh Blood Service will oversee and monitor the implementation of the Health and Safety Management System.

Mr. Stephen Ham Chief Executive
Dated: 16/05/2022

2. Scope of Policy

2.1 This policy applies to staff employed or engaged by the Trust, including those within Hosted Organisations, locations for which the Trust has health and safety responsibilities and work activities undertaken by the Trust.

3. Aims and Objectives

3.1 The aim of the policy is to -

- outline health and safety management arrangements within Velindre University NHS Trust;
- eliminate or where this is not possible manage and minimise health and safety risks to staff and others affected by our work activities;
- ensure that the Trust complies with health and safety legislation including the Health and Safety at Work etc. Act 1974 and the Management of Health and Safety at Work Regulations 1999.

3.2 The Policy objectives are to -

a) maintain a safe and healthy working environment for staff patients, visitors contractors and others visiting our premises or affected by our work activities;
b) minimise the number of occupational accidents and incidents of ill health
c) establish a culture of co-operation, communication, competency and control for health and safety
d) comply with all health, safety and other relevant legislation;
e) identify and control hazards to minimise the risk of injury and work-related ill health including risks from Covid19;
f) providing and maintaining safe equipment and ensuring safe storage, use and disposal of hazardous substances;
g) ensure suitable emergency procedures are in place;
h) ensure that health and safety incidents are reported, investigated and acted upon.
i) ensuring our employees, contractors and outsourced functions are competent and provided with such information, instruction, training and supervision as is necessary to enable them to work safely and without risk to health;
j) undertake monitoring of health and safety performance and the adequacy of the Health and Safety Management System at Velindre University NHS Trust;
k) provide adequate resources to effectively manage health and safety;
l) maintaining effective procedures for engagement, consultation and communications with employees and their representatives on health and safety matters;
m) ensure managers and staff are aware of their health and safety responsibilities and are enabled to fulfil them.

4. Responsibilities

4.1. Chief Executive

The Chief Executive has overall accountability for health and safety and must ensure that:

- there is a Director appointed as a Board lead for health and safety and violence and aggression;
- the Trust Board and Executive Management Board is informed as required, on health and safety matters affecting employees and/or the public;
- there are sufficient resources for the implementation of the Trust health and safety management system.

4.2. Director of Strategic Transformation, Planning and Digital

The Director of Strategic Transformation, Planning, Digital and Capital has delegated responsibility health and safety at Trust Board level, chairs the Trust Health, Safety and Fire Management Board and is responsible for ensuring that:

- the Trusts Health, Safety and Welfare Policy is implemented;
- the Trust's Health and Safety management and Governance Systems are implemented;
- competent health and safety advice is available to all Divisions and Hosted Organisations of the Trust;
- regular updates on health and safety issues are reported to the Executive Management Board;

4.3. Executive Director of Organisational Development and Workforce

The Head of Workforce is responsible for ensuring that: -

- there is an effective mandatory and induction training programme that includes health and safety, which is monitored and recorded;
- health and safety is responsibilities are included in job descriptions;
- reports on work related illness or work related ill health are submitted to the Trust Health, Safety and Fire Management Board. This should include information on work related stress and mental health;
- pre-employment screening is carried out and advice provided to managers on any pre-existing conditions identified;
- arrangements are in place for health surveillance of employees and others, such as work experience and students;
- arrangements are in place to support staff health and safety training and development.
- arrangements are in place for consultation on health and safety with employee representatives;
- arrangements are in place for staff to have access to an Occupational Health Service providing as appropriate pre-employment checks, formal health surveillance, health assessments in connection with fitness to work, identification of occupational hazards and risks, along with support and advice for staff.

4.4. Assistant Director of Estates, Environment and Capital Development

The Assistant Director of Estates, Environment and Capital Development is responsible for ensuring: -

- governance arrangements are in place for the management of health and safety at Divisional and Trust level;
- there are appropriate arrangements in place to respond to major incidents and emergencies;

- arrangements are in place to implement and monitor Estates related health and safety obligations;
- health and safety risks in property owned or leased by the Trust are eliminated or where this is not possible managed;
- that health and safety is incorporated at the design stage of any new build or refurbishment to Trust property, including consideration of provision of equipment;
- ensuring that workplaces are safe and meet legal standards and Health Technical Memoranda;
- systems are in place to ensure that contractors are managed;
- overseeing the preparation of an annual health and safety report for submission to the Board;

4.5. Divisional Directors / Directors of Hosted Organisations

Directors have overall responsibility for making sure that operational arrangements are in place:

- ensuring that health and safety management and governance systems are implemented in their division/hosted organisation;
- ensuring there are adequate resources to manage health and safety in their division;
- establishing a health & safety group or equivalent meeting within for their Division/Hosted Organisation;
- liaising with the Trust Capital Planning and Estates department and specialist technical groups/Boards on health and safety matters;
- ensuring that Divisional health and safety procedures are developed in line with the overarching Trust policies;
- ensuring that managers and staff are aware of their health and safety responsibilities;
- ensuring risk assessments are completed and recorded on the Datix system, control measures are implemented and monitored;
- ensuring incidents are reported on the Datix system, investigations are carried out, and actions implemented;
- ensuring that any incidents that may be reportable to the Health and Safety Executive under the Reporting of Incidents, Diseases and Dangerous Occurrences Regulations (RIDDOR) are immediately escalated to the Trust Health and Safety Manager or if not available the Divisional Health and Safety lead.

4.6. Department Managers

Department managers, supported by Health and Safety Leads are responsible for ensuring that arrangements are in place within their Department to:

- implement a health and safety management arrangements including Trust health and safety policies, Divisional health and safety procedures and Departmental health and safety procedures where required;
- attend health and safety meetings as required;
- allocate health and safety responsibilities to specific people including Departmental Health and Safety Leads where appropriate, and ensure that they are aware of their responsibilities and have adequate knowledge and training to fulfil them;
- access specialist advice by liaising with the Trust or Divisional Health and Safety Advisors or the Capital Planning and Estates department;
- carry out and record on the Datix system risk assessments of work activities, implement and monitor control measures;

- ensure that staff to have information about the risks within the department and the control measures in place;
- consult and involve staff and safety representatives;
- ensure that adequate instruction, training and supervision is in place within the Department, including a local Health and Safety Induction;
- identify training needs and ensure staff complete mandatory training;
- action Hazard Warnings and Safety Action Bulletins;
- monitor health and safety performance including arranging for workplace inspections to be undertaken and responding to audit actions.

4.7. Trust Health and Safety Manager

The Trust Health and Safety Manager is responsible for:

- providing competent advice and support to the Director with delegated responsibility for health and safety management across the Trust, Divisional Directors, Operational Managers and Health and Safety Leads;
- ensure specialist advice is available for manual handling and violence and aggression;
- Overseeing and participating in health and safety audits (HSG65);
- Developing and progressing the Health and Safety Priority Improvement Plan;
- Maintaining the Trust documented Health and Safety Management System;
- Acting as a point of contact between health and safety and other key functions including Workforce, Fire Safety Management, Sustainability and Infection Prevention and Control;
- ensuring systems are in place to investigate incidents and report to senior managers on findings and where necessary provide recommendations.

4.8. Individual Employees

All employees must:

- take reasonable care for the health and safety of themselves and others;
- co-operate with Velindre University NHS Trust in fulfilling its statutory health and safety duties and implementing the Health and Safety Management System;
- not to interfere with, or misuse, anything provided in the interest of health and safety, wilful disregard for health and safety may result in disciplinary action in line with the Trust's Disciplinary Procedure;
- report hazardous situations or defective equipment and incidents in line with the Trust Incident Reporting and Investigation Policy;
- undertake health and safety training in line with specific roles and responsibilities.

4.9 Safety Representatives

Employees who are appointed by their Professional Organisation or Staff Side Organisation to act as a health and safety representative for their members are entitled to: -

- make representation to their managers on general matters affecting the health safety and welfare at work of employees;
- represent employees in consultations with Health and Safety Executive inspectors or with any other enforcing authority in relation to health and safety matters affecting employees;
- investigate potential hazards, dangerous occurrences, causes of incidents and complaints by employees, at the workplace;

- carry out inspections of the workplace in accordance with Regulations 5,6 & 7 of the Safety Representatives and Safety Committee Regulations 1977;
- be represented at or attend health and safety meetings at all levels of the organisation.

5. Implementation/Policy compliance

5.1 Any advice required on implementation of this policy can be obtained via the Trust Health and Safety Manager or the Assistant Director of Estates, Environment and Capital Development.

5.2 Monitoring Arrangements

The Trust will put in place arrangements to monitor the implementation and effectiveness of the Health and Safety Management System. The outputs of this monitoring will be reported at Trust Health, Safety and Fire Management Board and Divisional health and safety meetings.

5.3 Internal Monitoring

Divisional Directors and Departmental Managers are responsible for the internal monitoring of the Health and Safety Management System. The Trust Health, Safety and Fire Management Board and the Divisional Health, Safety and Fire Management Groups will oversee the internal monitoring processes including :-

- monitoring of incidents, including compliance with reporting, investigation, identification of themes, lessons learned, review of risk assessments;
- monitoring reporting of incidents required under the Reporting of Incidents, Diseases and dangerous Occurrences Regulations 2013 (RIDDOR)
- monitoring of lessons learned from litigation claims following incidents;
- monitoring that Divisional Health, Safety and Fire meetings are held quarterly
- carrying out Departmental inspections and audits and ensuring all actions are completed in a timely manner
- responding to audits undertaken by the Internal Audit Department;
- monitoring of sickness absence statistics to identify absences resulting from injuries at work/work related ill health;
- monitoring compliance with health and safety related statutory and mandatory training
- ensuring that the documented Health and Safety Management System remains up-to-date and is implemented.
- ensuring there is communication and consultation with staff and the Trade Unions on health and safety matters.
- ensuring that Key Performance Indicators are set and monitored
- an Annual Health and Safety Report is produced for the Trust Board.

Recognised Trade Union and Staff Organisation health and safety representatives for the Trust have a function that includes monitoring health and safety in the workplace.

5.4 External Monitoring

The Health and Safety Executive is the enforcing authority for health and safety legislation at National Health Service premises. The Health and Care Standards, Standards for Health Services in Wales relate to health and safety management compliance and as such the Trust is subjected to regular self assessment and audit by Healthcare Inspectorate Wales.

6. Equality Impact Assessment

6.1 This policy has been screened for relevance to equality. No potential negative impact has been identified.

7. Getting Help

7.1 A copy of the Trust Health and Safety Policy, and related health and safety management system documentation, will be accessible via the Velindre University NHS Trust intranet site, together with information about where to obtain health and safety related advice within the Trust.

7.2 For further information or help regarding this policy contact the Assistant Director of Estates, Environment and Capital Development or the Trust Health and Safety Manager.

8. References

8.1 The Health and Safety Executive provides access to a wide variety of guidance and information via its website at http://www.hse.gov.uk

9. Related Policies

Control of Substances Hazardous to Health (COSHH)	QS33
Fire Safety Policy	PP01
Incident Reporting and Investigation Policy	QS01
Ionising Radiation Safety Policy	QS16
Latex Policy	QS09
Lone working policy	QS30
Management of Violence And Aggression Policy	QS15
Medical Devices Equipment Policy Final	QS24
Risk Assessment Policy	QS06
Risk Management Policy	QS35
Safe Use of Display Screen Equipment Policy	QS26
Safer Manual Handling Policy	QS14
Security Policy	PP02
Asbestos Policy	PP 04
Stress and Mental Health Wellbeing Policy	WF43
Water Safety Policy	PP 09
Business Continuity Management Policy	PP 06
Workplace Equipment Policy	QS36

10. **Training.**

10.1 The Health and Safety Policy and the health and safety management system will be brought to the attention of all new staff at induction.

10.2 Departmental Managers are responsible for identifying training needs and for ensuring that their staff complete mandatory training.

10.3 Staff will be provide with health and safety training identified by training needs analysis for their specific roles and responsibilities. All staff will be required to undertake mandatory training relevant to their role.

10.4 The identified training need, along with training undertaken must be recorded on the Electronic Staff Record.

11 **Key Legislation:**

- Health and Safety at Work etc., Act 1974
- Management of Health and Safety at Work Regulations 1999
- Safety Representatives and Safety Committees Regulations 1977
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013
- Corporate Manslaughter and Corporate Homicide Act 2007
- The Control of Substances Hazardous to Health Regulations 2002
- Provision and Use of Work Equipment Regulations 1998.
- Manual Handling Operations Regulations 1992
- Workplace (Health, Safety and Welfare) Regulations 1992.
- Health and Safety (Display Screen Equipment) Regulations 1992
- The Health and Safety (First Aid) Regulations 1981
- Confined Spaces Regulations 1997
- Lifting Operations and Lifting Equipment Regulations 1998
- The Ionising Radiation Regulations 2017
- Radiation (Emergency Preparedness and Public Information) Regulations 2001
- Dangerous Substances and Explosive Atmospheres Regulations 2002
- Control of Asbestos Regulations 2012
- Construction Design and Management Regulations 2015
- Electricity at Work Regulations 1989
- Health and Safety (Sharp Instruments in Healthcare) Regulations 2013
- Working at Height Regulations 2005
- Personal Protective Equipment at Work Regulations 1992

12 **Key Guidance:**

- Health and Safety Executive – Successful Management of Health and Safety HSG 65
- Health and Safety Executive/Institute of Directors – Leading Health and Safety at Work INDG 417

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

DIGITAL SERVICES POLICIES UPDATE

DATE OF MEETING	14/07/2022

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 & Digital
EXECUTIVE SPONSOR APPROVED	Carl James - Director of Strategic Transformation, Planning & Digital

REPORT PURPOSE	APPROVE

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
EMB	01/07/2022	Endorsed

ACRONYMS	
EMB	Executive Management Board
EQIA	Equality Impact Assessment
SLT	Senior Leadership Team
SMT	Senior Management Team

1. SITUATION/BACKGROUND

1.1 In line with Trust policy to ensure all policies and procedures remain up-to-date and reflect current best practice, a number of Digital Services policies have been reviewed and updated, as follows:

- IG05 Software Policy (appendix 1)
- IG06 Anti-Virus Policy (appendix 2)
- IG11 Data Quality Policy (appendix 3)
- IG14 Information Asset Policy (appendix 4)

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The refreshed policies are attached as Appendices 1 – 4. The policies were endorsed by the Executive Management Board on 1st July 2022.

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	No (Include further detail below)
	All policies have been previously subjected to EQIA.
LEGAL IMPLICATIONS / IMPACT	If applicable, as identified in each case as part of the service design/procurement process.
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 and Performance Committee is asked to APPROVE the refreshed policies as attached in **Appendices 1–4**.

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Ref: IG 05

SOFTWARE POLICY

Executive Sponsor & Function	Director of Strategic Transformation, Planning and Digital
Document Author:	Head of Digital Delivery
Approved by:	
Approval Date:	
Date of Equality Impact Assessment:	
Equality Impact Assessment Outcome:	
Review Date:	16/06/2022
Version:	

SECTION	CONTENTS	Page

1. INTRODUCTION

1.1 Software refers to a set of programs, procedures and routines associated with the operation of a computer system and mobile applications. The term makes a clear differentiation from hardware – i.e., the physical components of a computer system. As such, a set of instructions that directs a computer's hardware to perform a specific task is called a program, or software program.

1.2 It is illegal to make or use unauthorised copies of software. As a result, legal action may be taken against both the organization and Trust employee (penalties for so doing include imprisonment and/or fines). It is the responsibility of staff not to make illegal copies and the responsibility of managers to ensure that this is practice does not occur

1.3 Unauthorised software can seriously jeopardise the operation of IT equipment within the trust and increase the risk of information security breaches. This risk applies to software from all types of sources – e.g., public domain software from magazines; screen savers and other software downloaded from the internet etc. Therefore, only software authorised by the local IT department must be installed on Trust PCs and servers

1.4 The Trust must ensure that all staff are aware of the policy and comply with it. Therefore, the scope is:

- All Trust use of Software
- All Trust staff (outside personnel under Trust staff guidance are the responsibility of that staff member e.g., students, volunteers & visiting colleagues)
- All staff of Velindre hosted organisations
- All Trust Honorary Contract holders
- Third party contractors i.e. medical device manufacturers / support – Note: need to identify how this will be communicated out of the policy i.e. contract terms & conditions

2. STATEMENT REGARDING THE USE OF COMPUTER SOFTWARE

2.1 Velindre University NHS Trust licenses the use of computer software from a variety of external companies and other non-commercial sources. The Trust does not have the right to alter, copy or distribute software unless authorised by the software developer or vendor under the license agreement. Software licensed by the Trust must not exceed license allocation; therefore, software cannot be installed onto additional corporate or home computers without the consent / involvement from the local Digital Services department.

2.2 Software license agreements may apply to single machine use, multiple machines, single or multiple users, or use on Local Areas Networks (LANs). In all circumstances, Trust employees are required to comply with license agreements.

Advice on appropriate licensing arrangements for software should be sought from the Digital Services department.

2.3 Trust employees learning of any misuse of software or related documentation within the Trust must notify the department manager or the local Digital Service Desk.

2.4 According to UK Copyright Law, illegal reproduction of software can be subject to civil damages with no financial limit, and criminal penalties, including fines and imprisonment

2.5 Installation of unauthorised software and / or personal content (including, but not limited to documents, pictures, audio & video files etc.) on any Trust computers can affect the proper operation of those computers and increase the risk of information security breaches or introduce clinical risk and is therefore not permitted.

2.6 Trust employees who make, acquire or use unauthorised copies of computer software or install personal content will be subject to the formal disciplinary process. This may include termination of employment. The Trust does not condone the illegal duplication or use of software

3. OBJECTIVES

- To ensure that Velindre University NHS Trust complies with the law
- To protect our corporate reputation
- To comply with the information security policy
- To protect our investment in IT
- To increase control of software resources
- To increase discipline among staff who under-estimate the value of software
- To ensure corporate machines operate effectively
- To reduce the financial risk through potential litigation
- To ensure the use of software within Velindre University NHS Trust aligns with national (NHS Wales / Welsh Government) policies and standards, such as the requirement to deliver digital services ‘cloud first’.

4. ROLES AND RESPONSIBILITIES

4.1 Organisation

Organisation responsibilities are:

- To provide appropriate solution/resources to fully implement this policy
- To fully endorse, support and implement the controls outlined in this policy

4.2 Trust executive

The executive lead for digital is the director of strategic transformation, planning & digital. The executive lead for information governance is the executive director of finance. They have responsibility to:

- Ensure ALL staff are aware of and adhere to this policy

- Ensure this policy is part of the induction and ongoing awareness process
- Make decisions on disciplinary action required in cases of non-compliance and to empower local IT departments to place immediate orders to legalise software use

4.3 Digital Services Department

- Ensure that auditing / monitoring software is used on an ongoing basis to monitor software licensing compliance and relicense where / when necessary
- Carry out regular audits of software against the list of authorised software within the Divisions of the Trust
- Any non-compliance must be notified to the departmental manager and to the Division Management for immediate action
- Ensure Trust staff are trained in the legal use of software as part of the induction / ongoing training programme
- Ensure appropriate software asset management, to ensure prudent use of Trust funds – for example, ensuring the Trust no longer pays for unused software applications

4.4 Managers

All Managers are directly responsible, ensuring that:

- Users are aware of this policy
- Users are made aware of changes to this policy
- Users are trained appropriately
- Suspected incidents are reported and investigated
- Work in collaboration with the Digital Services department to ensure appropriate plans, business cases etc. are in place to support the procurement, maintenance/support and renewal of critical operational and clinical IT systems

4.5 Users

Users are responsible for their own actions and must:

- Adhere to this policy and associated policies and procedures
- Report incidents to appropriate managers as quickly as possible
- Discuss any identified risks and security issues with the service to the appropriate mangers
- Ensure ongoing awareness of policy
- Advise of any requirements for non-standard software
- Report the use of unauthorised software.

5. IMPLEMENTATION

- Disseminate Trust policy on copyright compliance so that employees are made aware of the implications of installing unauthorised software
- Ensure this policy is communicated to all staff via appropriate Trust / Divisions' means, to include via appropriate training programmes, so that employees and

contracted third parties can be given information related to their obligations under copyright law.

- Ensure all software deployments have the required information security and information governance oversight – specifically, the completion of a Data Privacy Impact Assessment (DPIA) and Cloud deployment risk assessment
- Implement approval process
- Implement a Software Asset Register in which all authorised software in use within each Division is recorded
- Software in use within the Trust is audited at regular intervals to ensure each piece of software is correctly licensed.

6. FURTHER INFORMATION

Further information can be obtained from the local Digital Service Desk.

7. REFERENCES

This policy should be read in conjunction with the following documents:

- Information Security Policy
- IT Anti-Virus Policy
- Internet / Intranet Access Policy
- Information Governance Policy
- Welsh Health Circular (2017) 025 – Guidance on Cyber Security and Information Governance requirements relating to suppliers and the supply chain

WHC (2017) 025:

WHC 3rd parties holding NHS Wales D

Ref: IG 06

ANTI VIRUS POLICY

Executive Sponsor & Function	Director of Strategic Transformation, Planning and Digital
Document Author:	Head of Digital Delivery
Approved by:	
Approval Date:	
Date of Equality Impact Assessment:	
Equality Impact Assessment Outcome:	
Review Date:	16/06/2022
Version:	

1. INTRODUCTION

1.1 For the purpose of this Policy, all forms of malicious code created with the specific intent of disrupting the operation of networks, computer systems or computer-controlled equipment, will be referred to as viruses

1.2 Software viruses are like human viruses in that they can spread from one computer to others, and in the worst case all computers on a network can be affected within a very short period of time. The effects differ significantly depending on the intention of the creator of the virus i.e., in some cases the symptoms can be obvious in that the affected computer begins to malfunction, but in others the actions of the virus can be partially or completely hidden to enable the affected computer to send sensitive information out of the Trust or to disrupt other computers throughout the network, resulting in what's known as a "Denial of Services" attack. Other types of malicious code include Spyware, Malware, Worms & Trojans etc.

1.3 As a result of becoming infected by a virus, the Trust's capability of day-to-day operation may be compromised, or depending upon the virus's capability to traverse interconnecting networks NHS Wales may be negatively impacted as a whole.

1.4 This policy is aimed at raising awareness amongst Trust employees; and by complying with the policy and associated anti-virus procedures, we can minimise the risks to the Trust and other NHS Wales organisations.

The scope of this policy includes (but is not restricted to):

- All Trust computers (PCs, laptops, servers, PDA's and mobile devices)
- All Trust employees
- Personnel under guidance / direction of Trust employees (e.g., students, visiting colleagues, engineers etc.)
- All employees within Velindre hosted organisations
- All Trust Honorary Contract holders

2. STATEMENT REGARDING THE USE OF COMPUTER SOFTWARE

2.1 Infection by software viruses on computers is a very real risk. Local IT staff will implement technical counter measures including installing anti-virus software and updating the necessary virus definition files in an effort to provide an effective control against distribution of viruses. However, potential routes of infection also involve actions by users of computers, hence this anti-virus policy.

The main routes of infection are listed below:

- Downloading unauthorised software from the Internet
- Virus's hidden in e-mail attachments from un-trusted or unexpected sources (e.g. the email sender can sometimes be impersonated or "spoofed")
- Using non-NHS internet-based e-mail systems without approval of your local IT Department / Service Desk (as their use is normally prohibited in Email Policy)
- Insertion of removable media, that may have been used outside the Trust, into a Trust computer without checking for viruses (e.g., CDs, DVDs, memory sticks /

USB memory devices, floppy disks and any other removable media capable of carrying data or programs)
- Connecting a non-NHS Trust laptop or PC (that does not have anti-virus software with up-to-date virus definition files) to the trust's network
- The Software, E-mail and Internet Policies provide further detail on the risks and guidance on risk mitigation

2.2 The effects of viruses can vary from the infection of just one PC to many machines or potentially a whole network resulting in a major information security breach.

2.3 Please Note: Any unusual behaviour of the computer may be due to a virus and should be reported to the local IT Department / Service Desk as soon as possible.

2.4 Installation of unauthorised software and / or personal content (including, but not limited to documents, pictures, audio & video files etc.) on any Trust computers can affect the proper operation of those computers and increase the risk of information security breaches or introduce clinical risk and is therefore not permitted.

2.5 Failure to comply with this policy and associated local IT anti-virus procedures may result in disciplinary action being initiated against the employee.

3. OBJECTIVES

- To ensure all Trust employees are aware of the dangers of malicious code (Spyware, Malware, Worms & Trojans etc.) and their responsibilities to minimise the likelihood and impact of viruses to the trust and NHS Wales
- To protect the Trusts reputation
- To comply with the Information Security policy
- To effectively manage software resources

4. ROLES AND RESPONSIBILITIES

4.1 Organisation

Organisation responsibilities are:

- To provide appropriate solution/resources to fully implement this policy
- To fully endorse, support and implement the controls outlined in this policy

4.2 Trust Executive

- Ensure ALL staff are aware of and adhere to this policy
- Ensure this policy is communicated to all staff via appropriate Trust / Divisions' means, to include via appropriate training programmes
- Ensure the Cyber Security Officer and those staff with IT responsibilities) in the Trust have the resources to purchase, deploy and maintain anti-virus software and to train staff to use the software

4.3 IT Security Officers

- Ensure appropriate local Trust Division anti-virus procedures are in place and updated in accordance with new threats and vulnerabilities.
- Ensure that Anti-virus software is reviewed for efficiency and re-licensed on an ongoing basis

4.3 Local Digital Services Department

Comply with local anti-virus procedures and in particular:

- Deployment of the anti-virus solution appropriately including each new release of the software from the software supplier
- Set-up facilities to automatically update virus definition files for all computers on the network
- Ensure Users awareness is maintained in regard to the recognition and danger of viruses and anti-virus procedures by regular briefings, publicity and training
- Record occurrences of virus infection according to local information security incident procedures. (Note: in the event that a potentially significant infection is identified, management must be made aware that critical services may be affected or systems / services shutdown to avoid further spread of the infection)
- Check Third Party machines for appropriate anti-virus software and virus definition files before allowing connectivity to segregated areas of the trust network
- Any exceptions to this policy e.g., using medical devices without anti-virus installed or maintained must be discussed with the local IT department, in order to identify and agree alternative / compensating controls to reduce the likelihood and impact from infection and cross infection to other devices

4.4 Managers

All Managers are directly responsible, ensuring that:

- Users are aware of this policy
- Users are made aware of any changes to the policy
- Users are trained appropriately
- Suspected incidents are reported and investigated

4.5 Users

Users are responsible for their own actions and must:

- Adhere to this policy and associated policies and procedures
- Report incidents to appropriate managers as quickly as possible
- Discuss any identified risks and security issues with the service to the appropriate managers.
- Comply with local anti-virus procedures and in particular:

  - All suspected occurrences of a virus detected by any means MUST be reported to your local IT Department / Service Desk, and the computer switched off until a technical representative has carried out action according to the local anti-virus procedure and confirmed that the computer is free from infection

- Unauthorised software from whatever source (e.g., screen savers; internet; memory sticks, floppy disks, CD-ROMs, or web sites, etc.) must not be used on Trust computers without approval of your local IT Department / Service Desk and Cyber Security Officer (refer to Trust Software Policy for further details

- All removable media or downloaded files from outside the Trust must be processed in accordance with local anti-virus procedures before being accessed

- Comply with the Trust E-mail and Internet policies to minimise risk of infection

- Users must follow local IT Department / Service Desk procedures to ensure PCs and laptops and other portable computing devices receive regular virus definition updates (e.g., PCs left powered on (but logged off) overnight and portables returned to base at least every 2 weeks).

- Users must not allow Third party IT hardware to be connected to the network without approval from their local IT Department / Service Desk, who will ensure appropriate anti-virus software is installed with the latest virus definitions.

5. FURTHER INFORMATION

Further information can be obtained from the local Digital Service Desk.

6. REFERENCES

This policy should be read in conjunction with the following documents:

- Information Security Policy
- IT Software Policy
- Internet Policy
- Information Governance Policy

Ref: IG 11

DATA QUALITY POLICY

Executive Sponsor & Function	Director of Finance
Document Author:	Head of Digital Delivery
Approved by:	
Approval Date:	
Date of Equality Impact Assessment:	
Equality Impact Assessment Outcome:	
Review Date:	16/06/2022
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1. POLICY STATEMENT

1.1 Maintaining high levels of data quality (often referred to as 'data integrity') is a fundamental requirement of any quality system, to ensure that healthcare services are of the required quality. Velindre University NHS Trust (the 'Trust') is required to ensure high standards of data quality in order to safeguard the quality and safety of patient and donor services and ensure regulatory compliance.

1.2 This policy outlines the principles against which data quality will be managed across the Trust, including all its Divisions and hosted organisations – i.e. Velindre Cancer Centre (VCC), the Welsh Blood Service (WBS) and the NHS Wales Shared Service Partnership (NWSSP).

1.3 The policy recognises the diversity of the respective Divisions and associated organisations under its control.

2. SCOPE OF POLICY

2.1 The Data Quality policy applies to all employees (including honorary contract holders and volunteers) and non-Executive staff of Velindre University NHS Trust.

2.2 Data quality requirements apply equally to both manual and electronic data. Data may be generated by a paper-based record of a manual observation or a variety of simple machines, through to complex, highly configurable computerised systems. As such, the policy applies to all data and information stored in both manual and electronic media / filing systems, including but not limited to:

- Electronic patient / donor records.
- Computer records.
- Printed records.
- Written records.
- Magnetic media; and
- Imaging systems.

It also applies to the collection, dissemination and processing of the information, whether transmitted across networks, mail, facsimile or telephone. It covers all types of activity where data is collected and applies to such data for the entirety of the data lifecycle.

3. AIMS AND OBJECTIVES

3.1 The objectives of this Policy are to ensure that the quality and integrity of Velindre University NHS Trust data is of the highest standard, by ensuring:

- Data quality and integrity has a consistently high profile within the organisation and seen as a key corporate responsibility by the Trust.
- There are processes and procedures in place which monitor data quality standards and requirements; and
- All staff in the organisation are fully aware of their responsibilities in relation to data quality and strive to achieve compliance with data quality standards and requirements.

3.2 The Trust recognises that the existence of a robust framework for the management of data and information is essential to:

- Ensure the provision and delivery of high-quality evidence based healthcare and other services to patients and donors.
- The efficient running of Velindre University NHS Trust; and
- The management of complaints and litigation

3.3 The information stored on electronic patient and donor systems and any other media is only usable if it is recorded correctly in the first place, is regularly updated when required and is easily accessible when needed. The availability of secure, accurate and comprehensive information ensures that the Trust can have confidence in its ability to:

- Support continuity of patient/donor care and effectively aid clinical judgements.
- Ensure the provision of effective services to patients and whole blood / platelet donors.
- Support the day-to-day business of the Trust, which underpins the delivery of care and other services.
- Support sound administrative and managerial decision making.
- Assist clinical and other audits.
- Meet controls assurance standards.
- Support improvements in clinical effectiveness.
- Provide accurate, relevant and meaningful information of high quality; and
- Support clinical research processes.

3.4 This policy sets out the requirements the Trust is expected to meet to ensure compliance with relevant legal and national requirements, such as the GMP standards published in Eudralex Volume 4 (“Good Manufacturing Practice”). Volume 4 of "The rules governing medicinal products in the European Union" contains guidance for the interpretation of the principles and guidelines of good manufacturing practices for medicinal products for human and veterinary use laid down in Commission Directives 91/356/EEC, as amended by Directive 2003/94/EC, and 91/412/EEC respectively.

4. RESPONSIBILITIES

4.1 The Executive Director of Finance is the Trust Board lead for data quality and standards. In addition, the Director is accountable for the strategic development of information, with overall responsibility for the functions of Information and Information Governance. Responsibility for Digital / Information Technology services and programmes resides with the Director of Strategic Transformation, Planning and Digital.

4.2 VCC, WBS and NWSSP Senior Management Teams (SMTs) are responsible for:

- Promotion of the principles of data quality
- Ensuring appropriate resources are provided to ensure data quality. This includes ensuring that non-compliant systems for critical GMP data are replaced with compliant systems
- Ownership of data generated in their areas, throughout the data life cycle
- Ensuring that an open culture is maintained that encourages reporting of data quality issues, and such issue are appropriately addressed in a transparent manner.

4.3 The WBS Head of Quality Assurance and Regulatory Compliance and relevant Service Managers within VCC, and NWSSP are responsible for:

- Ensuring data quality requirements are embedded into the WBS Quality Management System.
- Ensuring training in data quality is available; and
- Ensuring data quality is included in the audit schedule.

4.4 It is the responsibility of all **managers and supervisors** to:

- Ensure their staff are fully aware of their obligations to maintain complete, accurate and timely records. Managers within Velindre University NHS Trust are also responsible for ensuring that the policy and its supporting standards and guidelines are built into local processes and that there is on-going compliance with its requirements.
- Ensure that IT systems are appropriately qualified and validated to ensure compliance with data quality principles.
- Ensure data quality principles are followed throughout the data lifecycle.
- Ensure that user access to IT systems is appropriately managed, and access rights are removed when no longer required.
- Ensure that IT system under their control are appropriately maintained and upgraded as required and any changes are appropriately managed through the change control or database amendment process, as applicable.
- The retention and destruction of data meets the legislative requirements as set out in Trust / division records management policies (i.e., MP-018 & IG 01).
- At least 2 years data is retrievable in a timely manner for the purposes of regulatory inspection.
- Data are regularly backed-up, and the recovery of data is validated.
- Risk assessments for new systems are undertaken to minimise the potential risks to data quality.
- Ensuring that systems with no audit trails are managed appropriately with paper-based audit trails, and are eventually replaced with system with full audit trails; and
- There is a procedure for the review and approval of data, including raw data and should also include the relevant metadata plus the audit trail.

4.5 **Information and data quality is everyone's responsibility**. Therefore, all **staff** are responsible for ensuring they are:

- Responsible for implementing and maintaining data quality within Trust paper-based and electronic systems.
- Obligated to maintain accurate records legally in accordance with relevant legislation and regulatory requirements (e.g., Data Protection Act 2018 (UK GDPR).
- Fully committed to generate reliable data that is accurate, complete and timely.
- Accountable for the quality of the data including generation, recording, reporting and retention.
- Keeping their login or password details secure, and not to share login or password details.
- They are logged-off from IT systems when they are not in use; and
- Required to report situations of improper influence or of data misrepresentation to their departmental manager or local data quality leads.
- Clinical staff within the Trust are also professionally accountable for the quality of information they submit, collect and use in line with relevant professional and clinical standards.
- Follow good documentation practice (WBS – SOP 001/ORG, VCC-008/IG-01).

4.6 The Clinical Coding Service are responsible for the translation of clinical information into international and national coding classifications. Accurate and timely coded information is required to support service improvement and health board key performance information. The Clinical Coding Service provides assurance via the Quality and Safety Committee that data collection and clinical coding processes are robust and meet national and local standards.

4.7 All users are responsible for adhering to the principles of the Data Quality policy and the specific requirements set out in **Appendices 1 & 2**.

5. TRAINING

5.1 Managers and supervisors are responsible for identifying the training requirements of their staff and working with training providers to ensure these needs are met. Staff must be released to attend the appropriate training courses allowing them an adequate level of proficiency in order to carry out their functions effectively.

5.2 It is vital that all staff working with clinical and business information have received training on data quality and understand the importance it commands within the NHS, both for the management and provision of patient / donor care and services. New starters will receive training on data quality as a part of their induction programme. This will be supplemented for existing staff by targeted training as required, and via specific informatics and data quality awareness programmes.

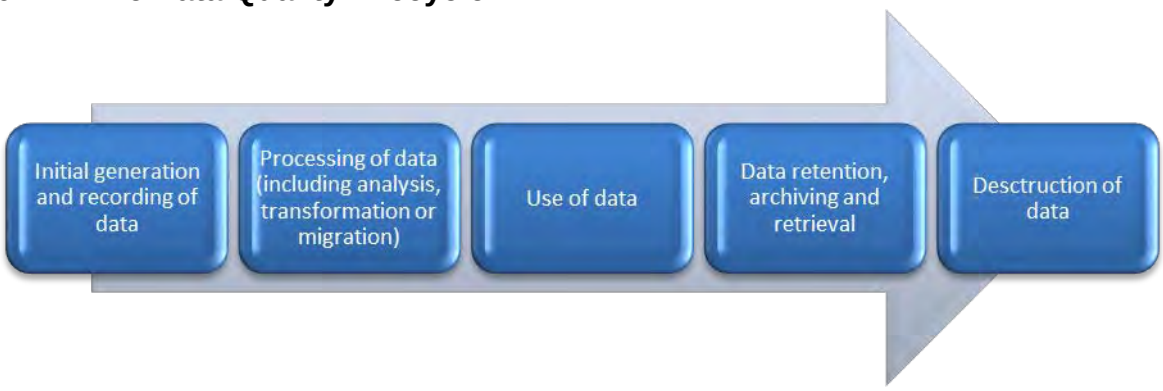
6. DEFINITIONS

6.1 **Audit trails** are metadata that are a record of critical information (for example the change or deletion of relevant data) that permit the reconstruction of activities. It is a chronology of the "who what when and why" of a record.

6.2 **Data Quality / Data Integrity**: The extent to which all data are complete, consistent and accurate throughout the data lifecycle

6.3 **Data governance**: The sum total of arrangements to ensure that the data, irrespective of the format in which is generated is recorded, processed, retained and used to ensure a complete, consistent and accurate record throughout the data lifecycle.

6.4 **The Data Quality Lifecycle**



6.5 **Data processing**: A sequence of operations performed on data in order to extract, present or obtain information in a defined format. Examples might include statistical analysis of individual patient data to present trends or conversion of a raw electronic signal to a chromatogram and subsequently a calculated numerical result.

6.6 **Metadata** is "information or data about data", describing context, content and structure of records and their management through time. E.g. data on the format of the record, the date and time data were created, who created it, who made changes to the data and when.

6.7 **Original data**: Data as the file or format in which it was originally generated, preserving the quality (accuracy, completeness, content and meaning) of the record, e.g., original paper record of manual observation, or electronic raw data file from a computerised system).

6.8 **Primary data**: The record which takes primacy in cases where data that are collected and retrained concurrently by one or more method fails to occur. (The data owner must define which system generates and retains the primary record).

6.9 **Records** are information created, received, and maintained as evidence and information by an organisation or person, in pursuance of legal obligations or in the transaction of business.

6.10 **True Copy**: A copy of original information that been verified as an exact (accurate and complete) copy having all of the same attributes and information as the original.

The copy may be verified by dated signature or by a validated electronic signature. A true copy may be retained in a different electronic file format to the original record, if required, but must retain the nature of the original record.

7. PRINCIPLES

7.1 The mnemonic ALCOA+ (Attributable, Legible, Contemporaneous, Original and Accurate) is commonly used to outline the principle of data quality / integrity – i.e.

ALCOA+ Principles of Data Integrity			
Principle	**Requirement**	**Examples of Good practice**	**Examples of bad practice**
Attributable	Data should identify the individual (or system) who recorded the data, as well as traceability to the source of the data itself. (e.g., study, test system, analytical run, etc.) Changes to data must also be attributable to the person who made them	Use of Signature/ Electronic Signatures. Controlled access and user permissions for IT systems. Audit trails in IT systems.	Use of another person's login. Use of shared logins. Use of databases with no audit trail e.g., spreadsheet databases. Leaving a logged-on database unattended.
Legible	Quality data must also be legible if it is to be considered fit for use.	Data corrections are made with a single line cross-out so that the original entry can still be seen. Scanned copies or photocopies of data are checked to ensure they are still legible.	Poor handwriting on paper records. Use of pencil rather than permanent pen. Use of forms with spaces that are too small for the data entry.

Contemporaneous	Data is to be recorded at the time the observation is made, activity performed, or decision made.	A checklist for recording a work activity is updated as soon as the activity is completed and not left to the end of the shift. Clocks in displaying the correct time.	Use of rough notes to record data. Summertime adjustments to clocks in IT system being missed. Adding dates to documents retrospectively or prospectively.
Original	Original data is generally considered to be the first data that is recorded and therefore the most accurate.	Data entries made directly onto document-controlled paper forms. Storage of raw data from analysers. Bound forms.	Use of rough notes or post-it notes to record data The use of scribes to record data Copying from one form to another to make the data look neater. Use of IT systems with audit trail.
Accurate	Data should be free from errors. Data should be genuine.	Manual data entry into IT system should verified. Correct date formats used.	Rounding of numbers, where the procedure does not permit it. Data falsification. Mistakes. Repeating lab tests until the desired outcome is obtained purely by chance.

Complete	All data should be available including and for electronic system includes relevant metadata. Any data from an original analysis which has been repeated.	Checking forms for completeness.	Missing data entries on forms with no explanation. Use of electronic records with incomplete metadata e.g., word, excel documents.
Consistent	Good Documentation Practices (GDP) should be applied throughout any process, without exception.	Use of controlled documents. System validation. Data review Including review of audit trail.	Use of IT systems with no audit trails.
Enduring	Part of ensuring records are available is making sure they exist for the entire period during which they might be needed. This means they need to remain intact and accessible as an indelible/durable record.	Ensuring data is backed-up and can be recovered. Durable media for recording.	Use of ink that easily smudges or fades over time.
Available	Records must be available for review at any time during the required retention period, accessible in a readable format to all applicable personnel who are responsible for their review whether for routine release decisions, investigations, trending, annual reports, audits or inspections.	Keeping records according to their retention schedule. Ensure record are appropriately indexed.	Unauthorised destruction of records. Misfiling records.

8. RISK MANAGEMENT

8.1 Risk assessments are part of the data lifecycle. They should include impacts upon patient safety, product quality and data quality.
Data criticality may be determined by considering the type of decision influenced by the data e.g. Whether or not a transfusion is safe.

8.2 Data risk assessment must consider the vulnerability of data to involuntary or deliberate alteration, falsification, deletion, loss or re-creation and the likelihood of detecting such actions. Consideration should be given to data recovery in the event of a disaster. Data quality control should be identified as part of the risk management process and be periodically reviewed for effectiveness.
Interfaces should be addressed during validation to ensure that data is transferred correctly.

9. DATA QUALITY STANDARDS

9.1 Processes and procedures must be in place to ensure that where new services are provided or system changes are made, the appropriate action is taken to notify system administrators of changes and ensure that all users are aware of the impact of those changes to maintain information quality.

9.2 All departmental data collection procedure documents should ensure that staff responsibilities in relation to the quality of the data entered onto patient systems are clearly referenced and managers must ensure that these are regularly reviewed and updated.

9.3 It is important to ensure that managers who are responsible for staff and systems which collect data, clearly understand relevant data quality standards and requirements, and are committed to making improvements by acting upon regular data quality monitoring reports. Individual members of staff are also responsible for ensuring they understand and follow these standards and requirements.

9.4 Formal notifications such as Data Set Change Notices (DSCNs) will be logged via the divisional leads of informatics and Quality and Safety Committee and disseminated appropriately.

10. DATA QUALITY MONITORING AND REPORTING

10.1 Procedures must be in place to ensure that Velindre University NHS Trust staff routinely check information with the source and that corrections are routinely made. Liaison should take place with outside organisations with regard to data quality issues.

10.2 Awareness of data quality throughout the Velindre University NHS Trust will be provided via data quality groups and in all patient administration system training and development programmes. Data quality will, in all cases, (as a minimum requirement) be compliant with the data quality standards laid down by the Welsh Government. Monitoring of compliance will be achieved via the national Data Quality Performance Indicators.

10.3 Quarterly performance reports will be submitted to the Trust Quality and Safety Committee and an annual report will also be reported to this meeting before being presented to the Trust Executive Management Board (EMB).
Performance will also be monitored on a monthly basis by the Divisional Business Intelligence / Quality and Safety teams, with feedback provided to directorates, departments and staff where appropriate.

10.4 Significant data quality issues impacting critical Trust Key Performance Indicators (KPIs) will be monitored and reviewed as part of the Trust performance monitoring processes.

11. REPORTING OF DATA QUALITY INCIDENTS

11.1 A data quality incident may result in a personal data breach of data. Under such circumstances, staff are required to ensure the appropriate reporting mechanisms are applied, to ensure Trust compliance with relevant regulations, in particular the Data Protection Act 2018 (UK GDPR).

11.2 Serious breaches must be reported to the Velindre University NHS Trust Data Protection Officer. Please refer to Velindre Trust policy '**IG13 – Confidentiality Breach Reporting Policy**' for more information.

12. POLICY COMPLIANCE

12.1 The Trust reserves the right to take appropriate disciplinary action up to and including termination of employment for non-compliance with this policy.

13. EQUALITY IMPACT ASSESSMENT STATEMENT

13.1 This policy has been screened for relevance to equality. No potential negative impact has been identified.

14. RELATED POLICIES

14.1 This policy is supported by the suite of Information Governance related policies available on the Trust Intranet site via the following link: IG&IM&T Policy Page[1].

APPENDIX 1

DATA QUALITY GUIDELINES

1. Staff must follow best practice guidelines when registering new patients onto systems in order to avoid duplication of patient records.

2. All data items held on Trust computer systems must be valid. Where codes are used, these will comply with national standards or map to national values. Wherever possible, computer systems are programmed to only accept valid entries.

3. All mandatory data items within a data set must be completed. Default codes will only be used where appropriate, and not as a substitute for real data. If it is necessary to bypass a data item in order to progress the delivery of care to a service user, the missing data must be reported by the user to the manager of the relevant system for immediate follow up. (In the case of data items on PAS, this must be reported as soon as possible to the Medical Records Department).

4. Data collection and recording must be consistent throughout the Trust to enable national and local comparisons to be made. Duplicate data items between different systems must be consistent so as not to lead to any ambiguity between different data sources.

5. Data will reflect all interactions and processing transactions associated with attendance at hospital and treatment provided. Correct Departmental procedures are essential to ensure complete data capture and spot checks/audits must be undertaken to identify missing or inaccurate data. Comparisons between data systems must also be used to identify missing or inaccurate data where relevant.

6. All recorded data must be correct when the service user is registered and updated as appropriate thereafter.

7. Staff must take every opportunity to check a service user's demographic details with the individual themselves. Inaccurate demographics may result in incorrect identification of the service user, important letters being mislaid, or incorrect/delayed income for the Trust.

8. Recording of data in a timely fashion is beneficial to the treatment of the patient. Recording diagnoses and operations, recoding the outcome of a patient's visit to an outpatient clinic or keeping up-to-date information on patient admissions/transfers/discharges makes that information available to all involved in treating patients even if they do not have access to the paper records.

9. All data must be recorded in a locally agreed timescale that will enable the data to be submitted in line with local and national deadlines. If data entry is delayed in any system, the relevant activity may not be coded in time, which means that the data will not be submitted, and payment may not be received by the Trust for activities carried out.

10. Compliance with data standards will be monitored via the national and local Data Quality key performance indicators. Where appropriate specific feedback will be provided at Directorate/Department/User level in order to provide additional training and support for users to improve compliance and performance. Where data quality concerns persist following a period of targeted training and support, users may be subject to disciplinary action.

APPENDIX 2

DETAILED GUIDANCE

Data quality arrangements must ensure that the accuracy, completeness, content and meaning of data is retained throughout the data lifecycle. Departments should introduce data governance arrangements that ensure:

Controls for Electronic GXP systems

General:

- Instruments and measuring systems must be maintained in good working order and appropriately calibrated
- Automated data capture should be used where possible to prevent transcription errors
- Data should be saved at the time of the activity
- Clocks in IT systems must be set at the correct UK time and calendars at the correct date.
- All data must be retained. Where data has to be excluded there must be a documented, valid scientific justification for its exclusion
- Electronic data should only be accessible through the instrument software, and not through the computers' operating system. It should not be held in temporary memories where it can be manipulated.
- Electronic data should be stored in a specific location, and protected against erasure
- Disposal or destructions of data must be described by a procedure (e.g., SOP), and be appropriately authorised. Checks should be in place to prevent data that is still required form being destroyed.
- Manual entries into electronic system should be subject to an appropriate secondary check. This check may be done by a second operator or by validated electronic means.

Electronic signatures:
Electronic signature are the electronic equivalent to hand signatures. To be compliant, they must:

- Identify the signer (and not be used by anyone else)
- Give the date and time when the signature was executed
- Give the meaning of the signature, (such as verification, authorisation, review or approval)

Security controls:
Security are required for computer based GxP systems and should include:

- Formal access authorisation (and revocation)
- Password controls (including minimum length and format, and enforced changing)
- Unique user identification
- Idle time logout

- Restriction of write, update or delete access to designated individuals
- Limited use of super user accounts. Super users should generally have no interest in the data
- No shared logins or generic user access

In addition, the system owner should be able to readily demonstrate who has access to the system and the level of access granted, and who had access in the past.

Backup and recovery:

- Systems must be in place for the regular back-up of GXP data and associated metadata. The back-up frequency should be appropriate for how often the data is generated and included in a standard operating procedure.
- The recovery of backed-up and recovery of data must be validated and periodically tested in accordance with relevant standard operating procedures.
- Backup media must be suitable to preserve the data for its retention period.
- The back-up data should be protected from unauthorised access and destruction.
- Back-up data should normally be held in a different location to where it was generated to mitigate against disaster.

Audit Trails:
GXP systems must have a full audit trail which:

- Records data creation, amending and deletion
- Identifies the person who created or changed data
- Records date and time the entry/change was made
- Is switched on. Users (with the exception of system administrator) should not have the ability to amend or switch off the audit trail
- Validation of the system should demonstrate that the audit trail is functioning.
- Audit trails need to be available and convertible to a generally intelligible form and regularly reviewed (annex 11), see below.

NB. Where an electronic audit trail is not an integral part of the system, a version-controlled paper-based audit trail must be used to ensure traceability. This is known as an audit trail. Systems with no audit trail must be replaced if an audit trailed system becomes available.

Direct printouts from electronic systems:
Paper records generated from simple electronic system e.g., balances, pH metres or simple processing equipment which do not store data and provide limited opportunity data alteration. The original record should be signed and dated by the person generating the record and the record kept. This record should be countersigned to verify that the data is representative of all result.

Data Processing:
Data processing must be described by standard operating procedures. Calculation and algorithms must be verified as appropriate.

Processing activity must be limited to specific individuals

Processing should permit reconstruction of all data processing activities.

Audit Trail Review:
Audit trail review should occur as part of normal operational review or approval of data by the department that generated the data and as part of periodic review (e.g., SOP: 023/VLN & IG-01). In the case of periodic review, the review should consider mainly whether the audit trail associated with the data is functioning correctly. Incident investigation and audit can also review audit trails. Review should be based upon original data or a true copy. Data reviews should be documented.

Where there is an operational review of data the audit trail must be reviewed for the following (as applicable):

- Changes to test parameters
- Changes to data processing parameters
- Data deletion
- Data modifications
- Analyst actions
- Data manipulation
- Unauthorised access
- Irregularities in the date and time

Audit trail reviews should be documented. Any unexplained anomalies/error/omissions/deletions must be reported to the head of Quality Assurance and Regulatory Compliance.

Changes to GxP Data:
Changes to GXP data should be managed under the relevant Divisional change control procedures (**WBS only:** MP-044).

Controls for Paper Records
Paper records must be:

- Controlled documents (e.g., WBS SOP 023/ORG, VCC-008/IG-01)
- Completed in accordance with Good Documentation Practice (e.g., WBS SOP 001/ORG, VCC-008/IG-01)
- The use of scribes to record data on behalf of another must only be used in exceptional circumstances e.g., in sterile environments
- Paper records should be indexed and stored in an appropriately secure manner for the required retention period.

Controls for spreadsheets

The metadata of spreadsheets only records information on the last user, not those who have used it in the interim. Therefore, spreadsheets are unsuitable for use as databases for GxP data.

- Spreadsheet may be used as one-off documents and the final version should be either saved as a PDF or printed out, reviewed signed and dated.
- Spreadsheet calculations using template should be validated and document controlled

Spreadsheet may be used within an electronic document management system (EDMS) that controls versions, or with third party software that provides a full audit trail.

Controls for statistical software packages

- Single use statistical tools e.g., supporting one off investigations, should be locked and controlled following completion of the investigation.
- Any templates must be stored in controlled location with limited access
- Authorised users should only be able to copy the template to a different directory where it is used. Users should only be able to add and process data.
- One the results of the analysis have been completed it should be protected against unauthorised changes,
- Any tools used to remove or hide statistical outliers from the data should be manifest.

Archiving Principles

Archive records may be the original data or a ‘true copy’, and should be protected such that they cannot be altered or deleted without detection

The archive arrangements must be designed to permit recovery and readability of the data and metadata throughout the required retention period. In the case of electronic data archival, this process should be validated, and in the case of legacy systems the ability to review data periodically verified

Where ‘cloud’ or ‘virtual’ services are used, particular attention should be paid to understanding the service provided, ownership, retrieval, retention and security of data.

Ref: IG 14

INFORMATION ASSET POLICY

Executive Sponsor & Function	Director of Strategic Transformation, Planning and Digital
Document Author:	Head of Digital Delivery
Approved by:	
Approval Date:	
Date of Equality Impact Assessment:	
Equality Impact Assessment Outcome:	
Review Date:	16/06/2002
Version:	

1. INTRODUCTION AND AIM

1.1 The aim of this policy is to provides assurance to Velindre University NHS Trust Board and the relevant divisional Boards of Directors, Caldicott Guardians, Senior Information Risk Owners (SIRO) and Data Protection Officers, that appropriate frameworks are in place to identify and protect all personal data it holds

1.2 The aim of this Policy is also to set out the responsibilities of any staff responsible for activities covered by this policy.

These responsibilities include, but are not restricted to, ensuring that:

- The availability of information assets are known, clear, concise and maintained in line with current business responsibilities.
- All individuals named within scope of this policy are aware of and understand their obligations

1.3 This policy must be read in conjunction with relevant divisional and associated organisational procedures.

2. POLICY STATEMENT AND OBJECTIVES

2.1 An organisation must be aware of the information that it holds if it is to be able to manage and protect that information. It is the policy of Velindre University NHS Trust that all manual and electronic records containing personal data are identified, categorised, classified, recorded, and managed. In order to achieve this, an Information Asset Register must be used to catalogue all of the organisation's information assets.

2.2 This Policy sets out the high-level intent of the Trust and also recognises the diversity of the respective Divisions and associated organisations under its control.

3. SCOPE

3.1 This policy applies to any member of the workforce of Velindre University NHS Trust with a responsibility connected with this policy to include any member of staff, including employees, students, trainees, secondees, volunteers, contracted third parties and any person undertaking duties on behalf of the Trust.

3.2 This policy applies to all manual and electronic records containing personal data regardless of the location where it is stored.

4. INFORMATION ASSET MANAGEMENT

4.1 Identification of Information Assets

An ‘information asset’ for the purpose of this policy, will be any asset, held manually and/or electronically, which contains information relating to any person whether living or dead.

All information assets must be identified on a system-by-system basis and the flow of information into, through and out of the organisation must be recorded. This process should be regularly reviewed, and new flows added as appropriate to ensure that at all times details of the organisational information assets are as up to date as possible. This activity must be monitored by the Senior Information Risk Owner and the Data Protection Officer. In the case of clinical information, the Caldicott Guardian must also monitor these activities.

4.2 Individual Asset Management

Each information asset must have an assigned Information Asset Owner. The Information Asset Owner will be responsible for implementing and managing controls to protect the integrity of that information.

Responsibility for implementing and managing these controls may be delegated, however accountability must remain with the nominated Information Asset Owner.

The Information Asset Owner must know:

- The information that is held and the nature of that information
- Details of those who has access and the purpose for their access

Information Asset Owner shall provide reports to the Senior Information Risk Owner (SIRO) and the Data Protection Officer (DPO) at least annually to provide assurance on the use of the information asset. This information will be reported to the Board on at least an annual basis via the annual report.

4.3 Categorisation of Information

Information assets which relate to a person, whether living or deceased, must be recorded in a register. A register must hold details of the systems on which the information asset is held.

Information assets shall be categorised as personal data or special categories of personal data. For the purpose of this policy, special categories of personal data will refer to any information that consists of a person’s health or sexual orientation information, religion, race or ethnic origin, political opinion, trade union membership, genetic, and biometric data where processed to uniquely identify an individual.

4.4 Data Quality

Local data quality audits must be undertaken and documented by the Information Asset Owner on a regular basis. Local data quality issue logs must be implemented and maintained.

4.5 Information Risk Management

An Information Asset Owner should undertake a risk assessment for any information assets that they own. The Information Asset Owner must ensure that information risk assessments are performed at least once a quarter. Controls on information must remain in place throughout the lifetime of an Information Asset.

4.6 Business Continuity

Information Asset Owners must have approved Business Continuity Plans in place. This will form part of the wider organisational Business Continuity Plan. Procedures should be in place to detail the specific actions which should be undertaken if the Business Continuity Plan was to be invoked. All staff who access systems which contain an information asset must be notified of business continuity arrangements and receive any training and guidance as may be necessary to implement these arrangements. Business Continuity plans and the associated procedures which relate to asset management must be regularly tested.

4.7 Asset Disposal

Information assets must be retained in line with NHS Wales Policy and guidance. Data must be made available for operational and patient/donor/client use for as long as is necessary to perform the required business function. Any instructions to destroy information must be signed off by the responsible Senior Information Risk Owner, Data Protection Officer or in the case of clinical information, the Caldicott Guardian. Where this occurs, details of the deletion must be held on a register detailing the date, time, method and personnel responsible.

4.8 Requests for information

The NHS in Wales is committed to openness and transparency. Velindre University NHS Trust, its divisions and its hosted organisations ensure that all information it holds is made available where this is a legal requirement to do so.

Information Asset Owners must cooperate in providing information to the designated lead where a request for any information has been received in a timely manner. Designated leads within the organisation must at all times ensure that any disclosure of requested information is lawful and where the request relates to Personal Data protects the rights and freedoms of the Data Subject.

The Head of Information Governance is available to provide professional advice and/or guidance so that the Trust meets its legal obligations in accordance with the Data Protection Act 2018 and Freedom of Information Act 2000 and/or the Environmental Information Regulations 2004.

5. ROLES AND RESPONSIBILITIES

The policy applies to all employees and contractors working for, or on behalf of the Trust. Everyone working for or with the NHS who records, handles, stores, or otherwise comes across information has a personal common law duty of confidence to individuals referred to in that information.

5.1 Chief Executive

The Chief Executive is responsible for ensuring the highest level of organisational commitment to the policy and the availability of resources to support its implementation and any associated legal requirements. Responsibilities may be delegated to the Trust, Senior Information Risk Owner, Data Protection Officer and/or Caldicott Guardian as appropriate.

5.2 Senior Information Risk Officer (SIRO)

The Trust, Senior Information Risk Officer is responsible for taking ownership of the organisation's information risk policy and for acting as an advocate for information risk. The Senior Information Risk Officer is also responsible for monitoring the process by which all information assets are identified and reviewed.

Details of the Senior Information Risk Owner must be made available to all members of staff and members of the public.

5.3 Caldicott Guardian

The respective Trust, divisional and associated organisational Caldicott Guardians are responsible for protecting the confidentiality of health and care information held by their respective organisation and for enabling appropriate information sharing by ensuring that information is used properly. Together with the respective Senior Information Risk Officer, they are responsible for monitoring the process by which all information assets containing patient/donor/service user information are identified and reviewed.

Details of the relevant Caldicott Guardians must be made available to all members of staff and members of the public.

5.4 Data Protection Officer

The Data Protection Officer is responsible for promoting, advising and ensuring the organisation's functions and processes are in compliance with data protection legislation. The Data Protection Officer must report to the Board but operate independently without fear of being penalised or dismissed for carrying out their role.

Details of the relevant Data Protection Officer must be widely published to ensure they are available in any case of complaint.

A glossary is provided in **Appendix A.**

5.5 Managers

Managers are responsible for the implementation of this policy within their department/directorate. In addition, they must ensure that their staff are aware of this policy understand their responsibilities in complying with the policy requirements and are up to date with mandatory information governance training. Breaches of the policy must be reported via local incident reporting processes and dealt with in line with the relevant Workforce and OD policy where appropriate.

5.6 Workforce

The workforce must familiarise themselves with the policy content and ensure the policy requirements are implemented and followed within their own work area as appropriate. Mandatory Information governance training must be undertaken at least every two years. Breaches of this policy must be reported via local incident reporting processes.

6. AVAILABLE GUIDANCE

Guidance on the procedures necessary to comply with this Policy will be made available from the respective divisions and associated organisations of the Trust or on its web pages. Managers will be responsible for ensuring that all their staff are made aware of Trust policies and standards.

The Trust's Head of Information Governance is available for the provision of further advice and guidance should the need arise.

7. TRAINING AND AWARENESS

7.1 The Trust's workforce are to ensure that they are competent in the understanding of information asset management processes to the level required of their role in order to be efficient and effective in their day-to-day activities.

7.2 Training will be provided to all Staff via the ESR system and through a series of face to face (including virtual) meetings and induction and regular intervals so that each member of Staff is confident when they are processing information that they are doing so lawfully.

7.3 Staff who need support in understanding the legal, professional and ethical obligations that apply to them should contact the Head of Information Governance.

8. GOVERNANCE AND REPORTING

8.1 Compliance with this policy (and supporting procedures) will be monitored by the Head of Information Governance. An internal audit on the Trust's arrangements in relation to the Act will be scheduled in line with the Trust's internal audit strategy.

8.2 The Trust notifies details of the personal data it processes to the Information Commissioner for inclusion on the register of Data Controllers. The notification is reviewed annually by the Trust. The register is maintained by the ICO and is available in the public domain for inspection by anyone.

8.3 The policy will be reviewed every 3 years, unless where it will be affected by major internal or external changes such as:

- Changes in Legislation.
- Practice change or change in system/technology; or
- Changing methodology.

8.4 For assurance, details on Information Asset Management activity will be reported to the Quality, Safety and Performance Committee, as well as the Senior Information Risk Owner (SIRO).

9. HEALTH AND CARE STANDARDS

9.1 Authors This Policy and processes described within enable the Trust to comply with Health and Care Standards 3.4 and 3.5 in that*:*

"The health service ensure all information is accurate, valid, reliable, timely, comprehensible and complete in delivering, managing planning and monitoring high quality, safe services. Health services have systems in place, including information and communications technology, to ensure the effective collection, sharing and reporting of high-quality data and information with a sound information governance framework"

10. EQUALITY

10.1 In accordance with the Trust's Equality policy, this Policy will not discriminate, either directly or indirectly, on the grounds of gender, race, colour, ethnic or national origin, sexual orientation, marital status, religion or belief, age, union membership, disability, carer's status, offending background or any other personal characteristic.

11. CONTACTS

11.1 For further advice and/or assistance on how to ensure individual, divisional and associated organisational compliance with this Policy, please contact the Head of Information Governance

12. FURTHER INFORMATION

12.1 This Policy should be read in conjunction with the following Trust policies:

- Data Protection & Confidentiality Policy
- Information Governance Policy
- Confidentiality Breach Reporting Policy
- Records Management Policy
- Freedom of Information Act Policy
- Data Quality Policy
- Information Security Policy
- Email Policy
- Internet Use Policy
- Social Media Policy

APPENDIX 1

Term	Definition
Senior Information Risk Owner(s)	An Executive or Senior Manager on the Board assigned responsibility to take ownership of the organisation's information risks and to act as an advocate for information risk on the Board and provide written advice to the Accounting Officer on the content of their annual governance statement in regard to information risk. **SIRO Roles** • Velindre University NHS Trust, Velindre Cancer Centre & Welsh Blood Service – Director of Finance • NHS Wales Shared Services Partnership - Director of Finance and Corporate Services
Caldicott Guardian	An Executive or Senior Manager on the Board assigned responsibility for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. **Caldicott Guardian Roles** Velindre University NHS Trust – Medical Director Velindre Cancer Centre – Clinical Director Welsh Blood Service – Medical Director
Data Protection Officer	A Senior member of Staff defined in Article 37 UK GDPR as someone who is designated on the basis of professional qualities and, in particular, expert knowledge of data protection law and practices and the ability to fulfil the tasks referred to in Article 39 which are: • To inform and advise the Controller (Trust) and the employees who carry out processing of their obligations pursuant to this regulation and to other UK Data Protection provisions • To monitor compliance with this Regulation with other UK Data Protection provisions and with the policies of the Controller (Trust) in relation to the protection of personal data, including the assignment of responsibilities, awareness-raising and training of Staff involved in processing operations, and related audits. • To provide advice where requested as regards Data Protection Impact Assessments and monitor its performance pursuant to Article 35

	• To co-operate with the Supervisory Authority (Information Commissioners Office) • To act as the contact point for the Supervisory Authority (ICO) on issues relating to processing, including prior consultation referred to in Article 36 and to consult, where appropriate, with regard to any other matter. • The Data Protection Officer shall in the performance of their duties have due regard for the risk associated with processing operations, taking in to account the nature, scope, context and purposes of processing.
Information Asset Owner	The person assigned responsibility for individual or groups of digital information asset
Confidentiality	The requirement to keep information confidential in accordance with the common law duty of confidence and any other legislation
Integrity	The requirement to ensure data is of consistent good quality without any corruptions.
Availability	The requirement to ensure information is available to those who need to access it for the legitimate purposes required by the organisation.

QUALITY, SAFETY AND PERFORMANCE COMMITTEE
CONFIDENTIALITY BREACH REPORTING POLICY **DATA PROTECTION AND CONFIDENTIALITY POLICY** **FREEDOM OF INFORMATION ACT POLICY** **RECORDS MANAGEMENT POLICY**

DATE OF MEETING	14th July 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable – Public Report

PREPARED BY	Ian Bevan, Head of Information Governance
PRESENTED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	1st July 2022	Endorsed by EMB on 1st July 2022

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
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

1. SITUATION

The Trust has a statutory responsibility to patients, donors and the public to ensure that the services it provides, have effective policies, processes and people in place to deliver objectives in relation to holding and using (processing) confidential and personal information.

The purpose of this paper is to provide **ASSURANCE** that the updates and changes made to the following Information Governance Policies are in line with current Data Protection legislation. All Policies have been reviewed by the Head of Information Governance since December 2021:

- Confidentiality Breach Reporting Policy
- Data Protection and Confidentiality Policy
- Freedom of Information Act Policy
- Records Management Policy

The Committee are requested to note that the suite of policies also provide the support framework for the Information Governance workplan.

The recently announced (10th May 2022) ***Data Reform Bill*** means that these policies will be kept under review should UK Data Protection legislation change prior to 2024.

Following endorsement by EMB on 1st July 2022, the Committee is asked to **APPROVE** the Policies.

2. ASSESSMENT/SUMMARY OF MATTERS FOR CONSIDERATION

Confidentiality Breach Reporting Policy

2.2 The Confidentiality Breach Reporting Policy was updated to reflect evolutionary changes in legislation since the introduction of GDPR in May 2018 and the impact of the United Kingdom's transition from membership of the European Union in June 2021 which meant that the UK GDPR replaced the EU GDPR.

2.3 Key changes

- Updates to applicable legislation that underpins UK Data Protection Legislation such as:
    - European Convention on Human Rights
    - Human Rights Act 1988
    - Data Protection Act 2018 (includes UK GDPR)
    - Environmental Information Regulations 2004
    - Computer Misuse Act 1990
    - Access to Health Records Act 1990
- Alignment of the policy to the formatting within the Policy on Policies

Data Protection and Confidentiality Policy

2.4 The purpose of this Policy is to set out the key areas of responsibilities and the Trusts commitment to ensuring the organisation treats all personal data lawfully and correctly. The Policy has been updated to reflect evolutionary changes in legislation since the introduction of EU GDPR in May 2018 and the impact of the United Kingdom's transition from membership of the European Union in June 2021 which meant that the UK GDPR replaced the EU GDPR.

2.5 Key changes

- Update to include the definition of Personal Data as defined in Article 4 of UK GDPR
- Update to include the processing of Personal Data as defined in Article 6 of UK GDPR
- Update to include Special Categories of Personal Data as defined in Article 9 and 10 of UK GDPR
- New section (4.1.4) on Automatic Profiling and Artificial Intelligence as defined in Article 22 of UK GDPR to reflect increased activity in this innovative area
- Update to the Six Data Protection Principles as defined within Article 5 of UK GDPR
- Inclusion of Data Sharing principles in relation to commercial activity which may be undertaken by the Trust
- Update to the requirement to provide training and awareness to Trust Staff
- Insertion of practical considerations (Section 6.3.3) when working remotely in relation to Data Protection legislation
- Insertion of Data Protection considerations when undertaking Procurement activity (Section 6.5)
- Update to applicable legislation and standards such as:
    - European Convention on Human Rights
    - Human Rights Act 1988
    - Data Protection Act 2018 (includes UK GDPR)
    - Environmental Information Regulations 2004
    - Computer Misuse Act 1990
    - Access to Health Records Act 1990
- Alignment of the policy to the formatting within the Policy on Policies

Freedom of Information Act Policy

2.6 The purpose of this policy is to ensure the provisions of the Freedom of Information Act 2000 (herein referred to as “the Act”) are adhered to and in particular that:

- a significant amount of routinely published information about Velindre NHS Trust (the Trust) is made available to the public as a matter of course through the Trust’s website and its Model Publication Scheme.

- other information not included on the Trust's website is readily available on request and that requests for information are dealt with in a timely manner; and

- where the information requested is covered by a public interest non-disclosure exemption, the Trust carefully considers the public interest test as defined by the Act prior to its disclosure.

The Policy has been updated to reflect the relationship between the Act and records management, it also contains the list of Exceptions under the Environmental Information Regulations 2004 which are considered to be part of the Act for practical purposes.

2.7 Key changes

- Update of hyperlink to Data Sets (Sections 11, 19 and 45 of the Act)
- Update to Section 7.3 (Specific requests for information) to ensure that any request may include more than one Exemption/Exception under FOIA/EIR
- Update to Section 7.6 to reflect the inclusion of Exceptions under EIR
- Update to reflect in date hyperlink in Section 7.7.1
- Minor update to Section 8 to reflect that in exceptional circumstances a review period may be extended to 40 working days
- Insertion of Appendix 3 to reflect description of Exceptions under EIR
- Alignment of the policy to the formatting within the Policy on Policies

Records Management Policy

2.8 The purpose of this policy is to ensure that all types of records, administrative as well as medical, are properly controlled, accessible, available, archived, and disposed of in line with national guidelines.

This policy applies to all records the Trust, its divisions and associated organisations hold regardless of how these are accessed, created, handled, received and/or stored, and shall include **all types of media** including (but not limited to) records in paper or electronic form, databases, software, video and sound media.

2.9 Key changes

- Update to Section 4.1 to include the following principles in Records Management which are aligned with Section 46 - Records Management Code of Practice:
    - Create

  - Assure
  - Use
  - Store
  - Access
  - Share
  - Publish
  - Dispose
- Minor update to Section 4.4 (data quality) to cross refer to the Data Quality Policy
- Insertion of Section 4.8 (record sharing) to reflect the requirement to share information in line with Data Protection legislation and Caldicott Principles.
- Update of Section 6 to reflect current legislation and up to date hyperlink to Section 46 - Records Management code of practice
- Update to Governance and Reporting to reflect reporting via EMB to QSP and Board as appropriate
- Alignment of the policy to the formatting within the Policy on Policies

3. 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	Completed for all four policies in December 2021 as part of the policy review process
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.

4. RECOMMENDATION

The Committee is requested to **APPROVE** the Policies which have been **ENDORSED** by EMB.

Ref: IG13

CONFIDENTIALITY BREACH REPORTING POLICY

Executive Sponsor & Function: Executive Director of Finance

Document Author: Head of Information Governance

Approved by: Quality, Safety and Performance Committee

Approval Date:

Date of Equality Impact Assessment: 12 January 2022

Equality Impact Assessment Outcome:

Review Date:

Version: Version Two

Contents Page

1. Aim

The aim of this policy is to ensure that the Trust reports all breaches which may take place in accordance with legislation, ICO Guidelines, NHS Wales Guidelines, Welsh Government Guidelines and best practice. :

Achievement of these aims will detail how the Trust meets its legal obligations. It will further the commitment of the Trust to process all information in a manner that is aligned with applicable legislation. It will promote openness and demonstrate increased transparency of decision making thereby building public trust and confidence.

The policy also aims to provide all employees of the Trust with a framework in which to ensure that any breach is handled in accordance with current legislation, guidelines and best practice.

2. Policy Statement and Objectives

Velindre NHS Trust is responsible for protecting the information it holds and is legally required under data protection legislation to ensure the security and confidentiality of all patient, donor, staff and service user personal data being processed in the Trust.

This policy puts in place a standardised management approach throughout the Trust, its respective divisions and associated organisations in the event of a personal data breach incident to ensure all such incidents are dealt with: -

- Effectively and efficiently;
- Recorded and reported in a consistent manner;
- Responsible officers and managers are alerted;
- To facilitate onward investigation; and
- To learn lessons to reduce the likelihood of a recurrence.

As such, this Policy sets out the high level intent of the Trust and also recognises the diversity of the respective Divisions and associated organisations under its control.

3. Scope of the Policy

The Policy applies to all staff employed within the Trust regardless of status i.e. permanent, temporary, bank, agency, honorary contract holders and volunteers who process patient, donor, staff and service user personal data.

4. Aims of the Confidentiality Breach Reporting Policy

The aim of this policy is to set out a clear process for the reporting of all personal data breaches and to ensure appropriate actions are taken in terms of communication and follow up to minimise the impact of any reported incidents.

4.1 Definitions

A personal data breach incident is a breach of security that leads to the accidental or unlawful destruction, loss, alteration, unauthorised disclosure of, or access to

personal data transmitted, stored or otherwise processed. Data Breach incidents can be categorised[1] into three well-known security principles: -

- "Confidentiality breach" - where there is an unauthorised or accidental disclosure of, or access to, personal data.
- "Availability breach" - where there is an accidental or unauthorised loss of access to, or destruction of, personal data.
- "Integrity breach" - where there is an unauthorised or accidental alteration of personal data.

Although not an exhaustive list, some common examples of a personal data breach incident, include: -

- Accessing unauthorised computer systems fraudently or using/sharing other employee logins, passwords, smart cards etc.
- Disclosing confidential information to individuals who have no legitimate right of access e.g. bogus callers, individuals not involved in service delivery.
- Misdirection of a fax or email.
- The loss of paper files and computer print outs containing personal data.
- The loss of mobile/hardware devices due to crime or an individual's carelessness e.g. laptops, cd's, memory sticks, mobiles, IPADS etc.

4.2 Reporting Arrangements

Whenever a suspected personal data breach incident has occurred it is imperative staff report the incident to their line manager and follow the Trust's Incident Reporting and Investigation Policy (including Serious Incidents) recording as much detail as possible of the incident into the Trust's Incident Reporting System, Datix.

More serious personal data breach incidents must be reported to key Trust staff e.g. Head of Information Governance, Data Protection Officer (DPO), Senior Information Risk Owner (SIRO), Caldicott Guardian, Chief Digital Officer, and the Information Governance (IG) Department, as early notification and preparation is key to dealing with management and investigation of reported personal data breach incidents.

4.3 Personal Data Breach Investigation

The objective of any breach investigation is to identify what actions the Trust, its respective divisions and associated organisations need to take to first prevent a recurrence of the incident and second to determine whether the incident needs to be externally reported (i.e. to the Information Commissioner's Office).

Key to preventing any recurrence is to ensure the Trust, its respective divisions and associated organisations learn from reported incidents, and where applicable share lessons learnt, and consider any trends and identify areas for improvement.

4.4 Incident Classifications

Personal data breaches should be classified according to severity of risk to such data in the table illustrated in **Appendix A**.

[1] Guidelines on Personal data breach notification under Regulation 2016/679 - ARTICLE 29 Data Protection Working Party

Organisations must have appropriate means in place to regularly review personal data breach incidents and where necessary cascaded within the appropriate Trust, divisional and associated organisational forums and Senior Management Teams.

4.5 Notifying individuals or other parties

Depending on the seriousness of the personal data breach, the Trust, divisions and/or associated organisations may be required to inform some or all of the following:

- The individuals concerned;
- The Information Commissioner's Office (ICO);
- Trust, Divisional and Associated Organisational Senior Management, including the Chief Executive;
- Welsh Government;
- Associated organisations i.e. NHS Wales Health Boards and Trusts;
- Police.

Consideration must always be given to informing the individuals concerned or the next of kin of the affected individuals when information about them has been lost or inappropriately placed in the public domain.

4.5.1 Method of Notification

The method of notification will vary depending on the type and scale of the personal data breach and the availability of contact details of affected individuals.

In considering the most appropriate method of notifying a personal data breach, the Trust, divisions and/or associated organisations must ensure that no further confidential data is disclosed, i.e. sending notifications to the wrong home or email addresses.

4.5.2 The Information Commissioners Office (ICO)

The Trust, divisions and/or associated organisations will inform the ICO if the breach involves personal data and:

- Has been assessed in line with the ICO data breach reporting guidelines; or
- A statement is to be made to the Welsh Government and/or a media announcement is to be made; or
- The breach is likely to enter the public domain, to enable the ICO to prepare for any enquiries they might get.

There should be a presumption to report to the ICO where there is a large volume of personal data placed at risk, or the release of personal data could cause a significant risk of individuals suffering substantial harm. Every case must be considered on its own merits, however if unsure whether to report or not, then the presumption should be to report the breach.

The attached scoring system, at **Appendix B**[2], should be used to assist in determining the severity of an incident. Examples of applying the scoring system can be found at **Appendix C**.

[2] Department for Health model as outlined in the Checklist Guidance for Reporting, Managing and Investigating Information Governance Serious Incidents Requiring Investigation.

Reporting to the ICO must be undertaken, without undue delay, and within **72 hours** of the organisation becoming aware of the personal data breach. Where notification is not made within 72 hours, it must be accompanied with reasons for the delay.

5. Responsibilities

All staff have a role to play to ensure a safe and secure workplace and staff must be aware of this Policy to ensure care is taken at all times to protect information and avoid a personal data breach incident.

5.1 Managerial Accountability and Responsibility

The **Chief Executive** of the Trust has overall responsibility for ensuring compliance with applicable legislation and regulation.

The Trust has a legal obligation to appoint a **Data Protection Officer**, whose role will be to undertake tasks to ensure appropriate measures are in place that safeguards personal data from accidental or unlawful destruction, loss, alteration, or unauthorised disclosure in accordance with data protection legislation.

Directors of associated organisations within the Trust are responsible for ensuring the Policy is implemented within their individual organisation, and must ensure: -

- their organisation complies with this policy;
- Ensuring all staff and contractors are aware of the requirements incumbent upon them;
- Delegating the day-to-day responsibility to information governance leads and groups as defined by the divisions/associated organisations and as appropriate to their needs.

The Trust has dedicated **Information Governance leads** in respective divisions and associated organisations. These roles will act as a first point of contact for receiving personal data breach incident notifications and act as an advisor to other managers and employees within their respective areas on compliance with the data protection legislation.

All staff are required to comply with this Policy and respect the personal data and privacy of others in their day to day working practice. Staff must ensure that appropriate protection and security measures are taken to protect against unlawful or unauthorised processing of personal data, and against the accidental loss of, or damage to all personal data.

Non-compliance with this Policy and any employee who is found to compromise security or confidentiality of the Trust, its patients, donors, staff and/or service users may be subject to the Trust Disciplinary Policy.

6. Legislation and Standards

This Policy is written in accordance with current legislation as well as relevant codes of practice and standards that include, but are not limited to, the following:

Human Rights

- European Convention on Human Rights
- Human Rights Act 1998

Rights to Privacy

- Investigatory Powers Act 2016
- Protection of Freedoms Act 2012
- Lawful Business Practice Regulations 2000

Data Protection

- Data Protection Act 2018 (incudes UK GDPR)
- Freedom of Information Act 2000
- Environmental Information Regulations 2004
- Computer Misuse Act 1990
- Access to Health Records Act 1990

Online Privacy

- UK Privacy and Electronic Communications Regulations (PECR)
- UK Privacy and Electronic Communications Amendment 2012 (Cookie Law)

Relevant Codes of Practice and Standards include, but are not limited to, the following:

- Caldicott
- Information Security ISO27001
- Information Commissioners Codes of Practice
- Employment Practices Code (S51 DPA)
- Common Law Duty of Confidence

7. Training and Awareness

All new staff must attend an awareness session where appropriate confidentiality training is given. This must be provided at the earliest opportunity and without delay.

Awareness sessions are scheduled regularly across the Trust and will inform staff of their responsibilities in relation to confidentiality of data, Freedom of Information Act 2000, Data Protection Act 2018 and Records Management in line with Section 46 Code of Practice on the Management of Records. **All staff are required to have undertaken appropriate training before being given access to Trust systems.**

8. Equality

In accordance with the Trust's Equality policy, this policy will not discriminate, either directly or indirectly, on the grounds of gender, race, colour, ethnic or national origin, sexual orientation, marital status, religion or belief, age, union membership, disability, carer's status, offending background or any other personal characteristic.

9. Governance and Reporting

Compliance with this policy (and supporting procedures) will be monitored by the Head of Information Governance. An internal audit on the Trust's arrangements in relation to breach reporting will be scheduled in line with the Trust's internal audit strategy.

For assurance, details on FOI activity will be reported to the Quality, Safety and Performance Committee, as well as the Senior Information Risk Owner (SIRO).

The policy will be reviewed every 3 years, unless where it will be affected by major internal or external changes such as:

- Legislation;
- Practice change or change in system/technology; or
- Changing methodology.

10. Contacts

A copy of this policy and other policies and procedures referenced are available on the Trust's Intranet site. The Head of Information Governance is available to provide advice, guidance and support and can be contacted via e mail on ian.bevan@wales.nhs.uk

11. Further Information

This policy should be read in conjunction with the following Trust policies:

- Information Governance Policy
- Data Protection & Confidentiality Policy
- Freedom of Information Act Policy
- Records Management Policy
- Information Security Policy
- Email Use Policy

In addition there will be underlying divisional, associated organisational protocols and procedures in place to support Trust wide policies.

Appendix A

Information Governance Risk Table

Domain Impacts on	Insignificant	Minor	Moderate	Major	Catastrophic
	Loss of or unauthorised access to: • A single record containing *special categories of personal data • Less than 5 records containing less *special categories of personal data e.g. demographics.	Loss of or unauthorised access to: • Less than 5 records containing *special categories of personal data. • Less than 20 records containing less *special categories of personal data e.g. demographics. Minimal impact on reputation and little or no expenditure required to recover.	Loss of or unauthorised access to: • Less than 20 records containing *special categories of personal data • Less than 300 records containing less *special categories of personal data e.g. demographics. Moderate impact on reputation (local press coverage) and costs – expenditure required to recover. Reportable to ICO.	Loss of or unauthorised access to: • Less than 200 records containing *special categories of personal data. • Less than 1000 records containing less *special categories of personal data e.g. demographics. Major impact on reputation (regional press coverage) and costs – significant expenditure required	Loss of or unauthorised access to: • Over 1000 records containing *special categories of personal data • Record(s) containing **highly sensitive personal data. • More than 1000 records containing less *special categories of personal data e.g. demographics. Huge impact on reputation and costs –

	Short term embarrassment or harm caused. Complaint possible. Able to deal with using internal mechanisms.	Short term embarrassment or harm caused. Complaints possible. Able to deal with using internal mechanisms.	Short term embarrassment or harm caused. Complaints likely. May involve external regulatory bodies. Potential for ICO fine.	to recover. Reportable to ICO. Short term embarrassment or harm caused. Complaints very likely. Likely to involve external regulatory bodies. Potential for ICO fine.	unable to recover situation. Reportable to ICO. Significant long term, permanent harm, damage or death to patients may occur. Complaints inevitable. Very likely to involve external regulatory bodies. Likelihood of ICO fine.

**special categories of personal data is defined in Data Protection Legislation as ‘personal data consisting of information as to data relating to health or sexual orientation information, religion, race or ethnic origin, political opinion, trade union membership, genetic, and biometric data where processed to uniquely identify an individual.

**Highly sensitive personal data includes the NWIS defined list of ‘highly sensitive information’ which are sexually transmitted diseases, human fertilisation & embryology, HIV & AIDS, termination of pregnancy and gender reassignment and for the purposes of risk assessment also includes other information of a higher sensitivity which, if released, would put individuals at significant risk of harm or distress for example child or adult protection information.

Appendix B

SCORING SYSTEM
FOR CATEGORISING OF PERSONAL DATA BREACHES

The scoring system should be followed step by step. A baseline score will establish the base categorisation level for the incident. This score will then be modified as the following sensitivity factors are applied:

- Low – reduces the base categorisation
- Medium – has no effect on the base categorisation
- High – increases the base categorisation

1. Establish the baseline scale of the incident. If unknown, estimate the maximum potential scale point.

Baseline Scale	
0	Information about less than 10 individuals
1	Information between 11-50 individuals
1	Information between 51-100 individuals
2	Information between 101 – 300 individuals
2	Information between 301 – 500 individuals
2	Information between 501 – 1,000 individuals
3	Information between 1,001 – 5,000 individuals
3	Information between 5,001 – 10,000 individuals
3	Information between 10,001 – 100,000 individuals
3	Information over 100,001+ individuals

2. Identify which sensitivity characteristics may apply and the baseline scale point adjust accordingly.

Low: For each of the following factors reduce the baseline score by 1	
-1 for each	No clinical data at risk
	Limited demographic data at risk e.g. address not included, name not included
	Security controls / difficulty to access data partially mitigates risk
Medium: The following factors have no effect on baseline score	
0	Basic demographic data at risk e.g. equivalent to telephone directory
	Limited clinical information at risk e.g. clinic attendance, ward handover sheet

High: For each of the following factors increase the baseline score by 1	
+1 for each	Detailed clinical information at risk e.g. case notes
	Particularly sensitive information at risk e.g. HIV, STD, Mental Health, Children
	One or more previous incidents of a similar type in the past 12 months

	Failure to securely encrypt mobile technology or other obvious security failing
	Celebrity involved or other newsworthy aspects or media interest
	A complaint has been made to the Information Commissioner
	Individuals affected are likely to suffer significant distress or embarrassment
	Individuals affected have been placed at risk of physical harm
	Individuals affected may suffer significant detriment e.g. financial loss
	Incident has occurred or risk incurring a clinical untoward incident

3. Determine final score. Where adjusted scale indicates the incident is level 2 or above, it should be considered for reporting to the ICO.

Final Score	
1 or less	Considered to be non-reportable to ICO
2 or more	Should be considered for reporting to the ICO

Appendix C

EXAMPLES OF CATEGORISING PERSONAL DATA BREACHES USING SCORING SYSTEM

Example A

Imaging system supplier has been extracting identifiable data in addition to non-identifying performance data. A range of data items including names and some clinical data and images have been transferred to the USA but are being held securely and no data has been disclosed to a third party.		
Baseline scale factor	3 (estimated)	
Sensitivity factors	-1	limited demographic data
	0	limited clinical information
	-1	data held securely
	+1	sensitive images
	+1	data sent to USA deemed newsworthy
Final score level 3 so incident is deemed to be reportable		

Example B

Information about a child and the circumstances of an associated child protection plan has been faxed to the wrong address.		
Baseline scale factor	0	
Sensitivity factors	-1	no clinical data at risk
	0	basic demographic data
	+1	sensitive information
	+1	information may cause distress
Final score level 1 so incident is deemed non-reportable		

Example C

Two diaries containing information relating to the care of 240 midwifery patients were stolen from a nurse's car.		
Baseline scale factor	2	
Sensitivity factors	0	basic demographic data
	0	limited clinical information
Final score level 2 so incident is deemed to be reportable		

Example D

A member of staff took a ward handover sheet home by mistake and disposed of it in a public waste bin where it was found by a member of the public. 19 individual's details were included.		
Baseline scale factor	1	
Sensitivity factors	-1	limited demographic data
	0	limited clinical information
	+1	security failure re disposal of data
Final score level 1 so incident is deemed non-reportable		

Ref: IG02

DATA PROTECTION & CONFIDENTIALITY POLICY

Executive Sponsor & Function:

Executive Director of Finance

Document Author:

Head of Information Governance

Approved by:

Quality, Safety and Performance Committee

Approval Date:

Date of Equality Impact Assessment: 24 December 2021

Equality Impact Assessment Outcome:

Review Date:

Version: Version Two

Contents Page

1. Aim

The aim of this Policy is to set out the key areas of responsibilities and the Trusts commitment to ensuring the organisation treats all personal data lawfully and correctly.

For the purposes of this Policy, the Trust takes the view that the principles of confidentiality apply to all personal data, whether employee, patient, donor and/or service user held on computer or held manually and whether communicated verbally, electronically or in writing.

The policy also aims to provide all employees of the Trust with a framework in which to ensure that processing of all data is dealt with lawfully and in conjunction with this policy.

2. Policy Statement and Objectives

Velindre NHS Trust (the Trust) regard the lawful and correct processing of personal data (including patient, donor and staff) by the Trust as vital for maintaining confidence between those with whom the Trust deal and itself. The Trust shall take all reasonable steps to ensure that it treats all personal data in accordance with this Policy.

This Policy sets out the high level intent of the Trust and also recognises the diversity of the respective Divisions and associated organisations under its control.

3. Scope of this Policy

This Policy applies to all personal data being processed within the Trust, its divisions and associated organisations regardless of how the data is being accessed, created, handled, received and/or stored.

4. Data Protection and Confidentiality – Legislation and Standards

This Policy provides all employees of the Trust with a framework to ensure all personal data is acquired, stored, processed and transferred in accordance with associated legislation, namely Data Protection Legislation, NHS standards [i.e. Caldicott Principles], and associated guidance issued by Department of Health, Welsh Government, Information Commissioners Office (ICO) and other professional bodies.

4.1 Overview of Data Protection Legislation

Data Protection Legislation is about the rights and freedoms of living individuals and in particular their right to privacy in respect of their personal data. It stipulates that those who record and use any personal data must be open, clear and concise about why personal data is being collected, and how the data is going to be used, stored and shared. The most common way to provide this information is in a Privacy Notice.

4.1.1 Personal Data

The definition of Personal Data within the Data Protection Act 2018 is: Any information relating to an identified or identifiable natural person (Data Subject). An identifiable natural person is one who can be identified, directly or indirectly, in particular by reference to an identifier such as a name, an identification number, location data, online identifier or to one or more factors specific to the physical, physiological,

genetic, mental, economic, cultural or social identity of that natural person. In practical terms it may includes information necessary for employment such as staff member's names and addresses and details for payment of salary or a patient/donor record. Personal data may also include what is termed as special categories of personal data which is defined further in Section 4.1.3.

4.1.2 Processing of Personal Data

The processing of personal data is lawful only if ONE of the following six lawful basis of processing of personal data applies:

- The Data Subject has given consent to the processing of his or her personal data for one or more specific purposes;
- Processing is necessary for the performance of a contract to which the Data Subject is party or in order to take steps at the request of the data subject prior to entering in to a contract;
- Processing is necessary for compliance with a legal obligation to which the controller (The Trust) is subject;
- Processing is necessary in order to protect the vital interests of the Data Subject or another natural person (to safeguard life)
- Processing is necessary for the performance of a task carried out in the public interest or in the exercise official authority vested in the Controller (The Trust)
- Processing is necessary for the purposes of the legitimate interests pursued by the Controller (The Trust) or by a third Party (Processor as defined in Data Protection Law), except where such interests are overridden by the interests or fundamental rights and freedoms of the data subject which require protection of personal data, in particular where the data subject is a child.

Any information which falls under the definition of personal data and is not otherwise exempt, will remain confidential. In accordance with The Data Protection Act, all personal data should only be processed in accordance with the six lawful basis for processing, on a need to know basis and all outputs must be treated carefully and disposed of in a secure manner. Staff must not disclose personal data outside their line of duty without a justified and lawful reason.

4.1.3 Special Categories of Personal Data

The Trust and its respective divisions and hosted organisations will, at times, be required to process special categories of personal data. Special category Personal Data is defined in the Data Protection Act as the processing of personal data revealing racial or ethnic origin, political opinions, religious or philosophical beliefs, or trade union membership, and the processing of genetic data, biometric data for the purpose of uniquely identifying a natural person, data concerning health or data concerning a natural persons sex life or sexual orientation.

4.1.4 The Six Principles

The Trust shall comply with Data Protection Principles contained within the Data Protection Act 2018 in that Personal Data shall be: -

- Lawfully, Fairly and transparently processed
- Collected for specified, explicit and legitimate purposes and not processed further in a manner that is incompatible with these purposes

- Adequate, relevant and limited to what is necessary in relation to the purpose for which it is processed
- Accurate and where necessary kept up to date
- kept in a form which permits identification of data subjects for no longer than is necessary
- Processed in a manner that ensures appropriate security of the personal data including protection against unlawful or unauthorized processing and against accidental loss, destruction or damage using appropriate technical and organizational measures

4.2 Information Security

The Trust will take appropriate technical and organisational steps to ensure the security of personal data, and manage the risks from internal and external threats.

The Trust will promote good security practice and awareness. All staff working for and/or on behalf of the Trust will use the NHS Wales computer and respective Trust network(s) [i.e. the Public Sector Broadband Aggregation (PSBA)] responsibly and will comply with the Trust Information Security policy together with relevant divisional/associated organisational directions and guidance.

All personal data stored within the Trust must have the appropriate safeguards and systems in place that protects against unlawful or unauthorised processing of personal data, and against the accidental loss of, or damage of personal data.

4.3 Encryption

Encryption technology is adopted within the Trust in order to adequately protect any personal data from unauthorised disclosure, whether by theft or accidental loss and minimising the impact of any inappropriate disclosure, whilst in transit or for those staff working offsite.

The Trust is fully committed to complying with relevant industry standards and NHS guidance in relation to a strong encryption strategy. Each division/associated organisation is to take responsibility for ensuring that all services have a sufficient encryption strategy in place to adequately mitigate the risk associated with each process.

4.4 Closed Circuit Television (CCTV)

CCTV cameras are situated on various Trust premises for the purposes of crime prevention and detection and to help improve the security for our staff, service users and visitors.

To comply with legislation, it is essential that the location of CCTV cameras are carefully considered to ensure they do not infringe on clinical/treatment areas. Where CCTV cameras are situated, signs must be erected indicating their presence and posted in prominent positions, ensuring all staff, visitors and service users are aware they are entering an area that is covered by CCTV cameras. These signs must also include details on the purpose, organisation and responsible officer’s contact details.

4.4.1 Processing of Images

Images, which are not required for the purpose(s) for which the CCTV cameras are being used, should not be retained for longer than is necessary. While images are retained, it is essential that their integrity be maintained, whether it is to ensure their evidential value or to protect the rights of people whose images may have been recorded. It is therefore important that access to and security of the images is controlled in accordance with the requirements of Data Protection Legislation.

Where images are required for evidential purposes in legal or NHS disciplinary proceedings, the Trust reserves the right to make a Data Recording. Any data recordings taken must have appropriate encryption techniques considered and deployed. The Trust will take a considered approach to the taking of data recordings and any such recordings will only be conducted on the basis that there is a suspected breach of either a NHS Wales policy or legislation. On deciding whether such analysis is appropriate in any given circumstances, full consideration is given to the rights of the employee.

4.5 Information, Transfer and Security

The use of telecommunication methods [i.e. post, fax, email, videotelephony] and/or data transportation methods [i.e. offsite transfer, laptops, USB sticks, CDs] as a means to transfer and communicate personal data without the appropriate controls being applied is regarded by the Trust as an insecure method of transferring confidential patient, donor and/or staff information.

Staff must pay particular attention with any need to transfer and communicate personal data via any form of telecommunication and/or data transportation methods, and the Trust expects this type of information to be communicated with care.

It is the responsibility of all members of staff, and in accordance with Trust Policies together with relevant divisional/associated organisational directions and guidance, to exercise their judgement to ensure suitable precautions are being applied to the transmission of all personal data.

Digital Services department implement data loss prevention (DLP) and portable device control via AntiVirus tools in order to manage the security of data transportation methods (as above). If you are still required to transport Trust data via the methods listed above, these must be encrypted.

4.6 Misdirection

Misdirection is the term associated with the accidental sending of personal data via methods to include emails, letters and faxes. Irrespective of whether or not the sending of personal data is sent internally or externally; misdirection is one of the main risks to the Trust. Accidental misdirection may result in a breach of confidentiality if the content identifies patients, donors or staff members.

In accordance with Trust Policies together with relevant divisional/associated organisational directions and guidance, **all staff** must ensure that appropriate protection and security measures are taken, to protect against unlawful or unauthorised disclosure of personal data, when there is a need to covey any personal data to internal or external parties'.

Staff must ensure that the correct recipient details are always selected to avoid the potential consequences of misdirection and/or accidental disclosure of personal data.

4.7 Social Media

Social media is a term for websites based on user participation and user-generated content. These media provide a number of benefits for the Trust as they are recognised as a valuable tool and provide another platform in which to engage with patients, donors and service users, to promote the Trust and it services. It is the responsibility of all members of staff to comply with the Trusts Social Media Policy.

4.8 Information Sharing

The Trust recognises the need to share personal data for the benefit of the users of the service. Such sharing may take place between the public services as well as appropriate private and third sector service providers. Sharing must take place legally, safely and with confidence in order to ensure public services are maintained and in order to improve standards and efficiency.

The Wales Accord for the Sharing of Personal Information (WASPI) is a framework under which information sharing protocols are formed where a regular sharing of personal data is to take place. The Trust has 'signed up' to use this framework and therefore in all instances of regular information sharing an Information Sharing Protocol should be adopted using the WASPI model.

Where personal data is to be shared as part of a commercial contract between the Trust and Suppliers, WASPI will not apply. In such circumstances, a Data Processing Agreement (sometimes known as a Data Sharing Agreement)may be required in addition to the Contract between the Trust and the Supplier. The Head of Information Governance is to be consulted at the beginning of the commercial relationship so that Data Protection requirements can be identified as early as possible within the proposed project. This is known as Privacy by Design and is considered to be best practice.

4.9 Monitoring/Auditing access to Personal Identifiable Data

The Trust reserves the right to monitor/audit staffs access to personal data via Trust systems. The Trust will use appropriate system audit functionality (to include the National Intelligent Integrated Auditing Solution) to detect potential misuse of access rights whereby employees may have abused their access rights to view personal data that they may not be entitled to view.

Any employee who is found to have abused their access rights may be subject to Trust Disciplinary Policy.

5. Subject Access Requests

Data Protection Legislation establishes a framework of rights and duties that are designed to safeguard personal data. Individuals (known as data subjects) or their representatives, have a right to apply for access to information held about them, and in some cases, information held about others.

This is known as a Subject Access Request (SAR) and request for information must be made in writing. Where a request is made to access the records for a deceased person's health record, then the Access to Health Records Act 1990 is applicable.

The respective divisional/associated organisational SAR leads should be notified of all requests, as these personnel are responsible for ensuring that all requests are handled appropriately, and in accordance with Data Protection Legislation.

The Head of Information Governance is available to provide professional and technical advice/guidance relating to the SAR process should it be required.

5.1 Charging

Information is provided **free of charge**. However, the Trust, and its associated organisations can charge a 'reasonable fee' when a SAR is manifestly unfounded or excessive, particularly if it is repetitive.

Charging a reasonable fee can be applied to requests for further copies of the same information. However, it does not mean a charge can be applied to all subsequent access requests. Fees are to be charged based on the administrative cost of providing the information.

5.2 Time Compliance

Information must be provided without delay and at the latest within **one month** of receipt. Where requests are complex or numerous, the Trust and its associated organisations can extend the period of compliance by a further two months. If this is the case, respective organisations **must** inform the individual within one month of the receipt of the request and explain why the extension is necessary.

5.3 Appeal Process

If an individual believes that the Trust has not complied with this Policy or acted otherwise than in accordance with Data Protection Legislation, the individual has a right to refer their concerns to the ICO. However, in the first instance individuals should be offered the right to state a complaint. All complaints should be dealt with at the lowest level, therefore in many cases a complaint can be processed with support from the respective divisional/hosted organisational leads.

6. Roles and Responsibilities

The policy applies to all employees and contractors working for, or on behalf of the Trust. Everyone working for or with the NHS who records, handles, stores, or otherwise comes across information has a personal common law duty of confidence to individuals referred to in that information.

6.1 Managerial Accountability and Responsibility

The **Chief Executive** of the Trust has overall responsibility for ensuring compliance with applicable legislation and regulation.

The Trust has a legal obligation to appoint a **Data Protection Officer**, whose role will be to undertake tasks to ensure that all personal data is being processed in accordance with this Policy and Data Protection Legislation.

Directors of associated areas within the Trust are responsible for ensuring that the Policy is implemented within their individual organisation, and **must** ensure: -

- everyone managing and handling personal data understands they are contractually responsible for following good Data Protection and Caldicott practice;
- everyone managing and handling personal data is appropriately trained to do so; and
- methods of handling personal data are clearly described.

NHS Standards stipulate the Trust is required to have in place identified "**Caldicott Guardians**" with responsibilities for agreeing and monitoring protocols, and the movement and approval of the uses of patient and donor data within and external to the Trust.

The Trust has dedicated **Information Governance leads** in respective divisions and associated organisations. These roles act as a first contact for receiving Data Protection queries and act as an advisor to other managers and employees within their respective areas.

IT System managers responsible for the major information and clinical systems throughout the Trust will ensure that their systems meet the specifics within the data protection notification. They will also be responsible for notifying the respective leads within their organisation, of any changes to their system which may impact on Data Protection.

All staff are required to respect the personal data and privacy of others and must ensure that appropriate protection and security measures are taken against unlawful or unauthorised processing of personal data, and against the accidental loss of, or damage to all personal data. Staff must adhere to all confidentiality requirements as described by the Trust and ensure that any access and use of personal data is only ever for the purposes of fulfilling NHS duties.

Any employee who is found to compromise security or confidentiality of the Trust, its patients, donors, staff and/or service users personal data may be subject to Trust Disciplinary Policy.

6.2 Reporting of Data Protection & Confidentiality Breaches

The Trust takes any potential breach of Data Protection Legislation and confidentiality very seriously. All staff have a responsibility to report any breach of this nature immediately. The Trust, divisions and associated organisations must have a mechanism for reporting incidents and these must be investigated in line with local procedures. Any reporting must be made in conjunction with the Trust Confidentiality Breach Reporting Policy. Staff not reporting incidents of this nature may be subject to Trust disciplinary policy.

6.4 Contracts of Employment

All contracts of employment must include a data protection and general confidentiality clause. Agency, contractors and non-contract staff working on behalf of the Trust are subject to the same rules.

6.5 Procurement

When considering procuring platforms that will by their very nature process personal data, the Head of Information Governance is to be consulted, this is because a risk assessment will need to be undertaken to assess the risk to the rights and freedoms of individuals known as Data Subjects will need to take place. This Process is called a Data Protection Impact Assessment.

It is a legal requirement to undertake this activity when;

- The proposed platform is new, novel or involves processing of large amounts of personal data

It is also considered to be best practice for other projects involving the processing of personal data.

7. Breaches of this Policy

Any suspected breaches of this Policy will be taken seriously and investigated through the Trust's Disciplinary Policy. Breaches of data protection and confidentiality could result in dismissal.

8. Training, Awareness and Practical Considerations

The Trust demonstrates that employees understand their responsibilities to ensure that personal information is protected and processed in accordance with the applicable procedures, taking into account the related security requirements.

8.1 Training

The Trust will ensure that adequate training is provided for all staff involved with processing of personal data and that qualified expertise is available for consultation. All new starters (to include Non-contract staff and those on short fixed term contracts) to the Trust will be given Information Governance training, to include compliance with Data Protection Legislation and general IT security training, as part of the Trust induction process.

8.2 Awareness

Situational awareness is a key requirement in ensuring that members of Staff comply with Data Protection Legislation. Examples of such awareness are:

- Data Protection and Information Governance Policies
- Being aware of their contribution to the effectiveness of data protection and information management policies, including the benefits of improved information management performance

- The implications of not conforming with the Trust's data protection and information management policies.

8.3 Practical Considerations

In a fast moving technological world, training and awareness are linked to the practical considerations that context provides. Trust employees are working in a way which is completely different to a "normal" way of working with more remote working than ever before. The following are considerations that members of Staff must think about when remote working in relation to Data Protection and Confidentiality:

- Removable media – Staff are only to work within the confines of Trust policies relating to the use of removable media, if a member of Staff is permitted to use it, they are to keep the removable media device secure at all times, they are personally responsible for its safekeeping.
- Home Wi-Fi – Member of Staff are to ensure that the password to their home Wi-Fi device is not the factory setting. The password should be set to one that is only known to them and difficult to guess.
- The Data Protection Act – it applies at all times, no matter where the member if Staff is located; Wales, the UK or indeed worldwide.
- Information – it is immaterial whether the information is hard copy or electronic, it is still to be protected at all times, as a member of Staff this responsibility is shared by all. This includes within the home – hard copy or electronic information is not to be left unattended and be available where it may be seen by unauthorized personnel (this includes family members)
- Situational Awareness – Staff are to be mindful of their locations in terms of where they are working, are they near a window which permits their screen to be seen, can they be overheard?, is the work they are doing far too sensitive for the location they are in (including within the home)?. If any of these apply either move position or even it cannot be mitigated the Staff member should not attempt to carry out the work
- Screen Sharing – when sharing a screen as part of video conferencing, Staff are to be mindful of what the other person can see. They are to close all applications prior to the call – this includes e mails, document folders, documents names, the list is not exhaustive
- Locking access to the electronic device – All Staff should operate on a need to know basis, this includes access to information by colleagues and family members. To safeguard information it is imperative that ctrl/alt/del is pressed to lock the screen whenever the machine is not attended. It should be noted that most devices within the Trust are set to lock automatically at the 10 minute point, but within that 10 minutes an intruder may be able to access information, presenting high risk to not only patient confidentiality but the individual's and the Trust's compliance with Data Protection Legislation. The way to protect information in this setting is to lock the screen immediately when the user steps away from their machine.

The Head of Information Governance is the professional source of advice and guidance for the Trust. Should a member of Staff have concerns or wish to raise any issues related to practical considerations, it is strongly recommended that they contact him prior to undertaking any activity.

Guidance on the procedures necessary to comply with this Policy should be made available from the respective divisions and associated organisations of the Trust or on

its web pages. Managers will be responsible for ensuring that all their staff are made aware of Trust policies and standards.

Links to the ICO website also provides a valuable source of information.

9. Complaints

Anyone whose data is processed by the Trust is entitled to make a complaint if they are unhappy with the way their data has been processed.

Data Protection complaints are that same as any other complaint, however, the individual handling the complaint will be the Head of Information Governance who may need to undertake an investigation into the facts surrounding the complaint prior to responding to the complainant.

Members of Staff are to provide the following address for any individual who wishes to complain to the Trust about how their data has been handled:

Mr Ian Bevan via
VNHSTInformationgovernance@wales.nhs.uk
Head of Information Governance
Velindre University NHS Trust
2, Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff / Caerdydd
CF15 7QZ
Tel / Ffon - 029 20196161

It should be noted that an individual has the right not to complain to the Trust, but to the Information Commissioner's Office (ICO) by writing to:

Information Commissioner's Office – Wales
2nd Floor
Churchill House
Churchill Way
Cardiff
CF10 2HH

Tel: 0330 414 6421
Email: wales@ico.org.uk

10. Governance and Reporting

Compliance with this policy (and supporting procedures) will be monitored by the Head of Information Governance. An internal audit on the Trust's arrangements in relation to the Act will be scheduled in line with the Trust's internal audit strategy.

For assurance, details on Data Protection and Confidentiality activity (including complaints) will be reported to the Quality, Safety and Performance Committee, as well as the Senior Information Risk Owner (SIRO).

An annual Caldicott review and audit will be carried out, by associated organisations within the Trust, in respect of the way patient and/or donor information is managed and recommendations for progress established.

The Trust notifies details of the personal data it processes to the Information Commissioner for inclusion on the register of Data Controllers. The notification is reviewed annually by the Trust. The register is maintained by the ICO and is available in the public domain for inspection by anyone

The policy will be reviewed every 3 years, unless where it will be affected by major internal or external changes such as:

- Legislation;
- Practice change or change in system/technology; or
- Changing methodology.

11. References - Specific applicable Legislation and Standards

This Policy is written in accordance with current legislation as well as relevant codes of practice and standards that include, but are not limited to, the following:

Human Rights

- European Convention on Human Rights
- Human Rights Act 1998

Rights to Privacy

- Investigatory Powers Act 2016
- Protection of Freedoms Act 2012
- Lawful Business Practice Regulations 2000

Data Protection

- Data Protection Act 2018 (incudes UK GDPR)
- Freedom of Information Act 2000
- Environmental Information Regulations 2004
- Access to Health Records Act 1990 (where not superseded by Data Protection Legislation)
- Health & Social Care Act 2012

Online Privacy

- UK Privacy and Electronic Communications Regulations (PECR)
- UK Privacy and Electronic Communications Amendment 2012 (Cookie Law)

Relevant Codes of Practice and Standards include, but are not limited to, the following:

- Caldicott
- Information Security ISO27001
- Information Commissioners Codes of Practice

- Employment Practices Code (S51 DPA)
- Common Law Duty of Confidence

12. Equality

In accordance with the Trust's Equality policy, this Policy will not discriminate, either directly or indirectly, on the grounds of gender, race, colour, ethnic or national origin, sexual orientation, marital status, religion or belief, age, union membership, disability, carer's status, offending background or any other personal characteristic.

13. Contacts

For further advice and/or assistance on how to ensure individual, divisional and associated organisational compliance with this Policy, please contact: -

Ian Bevan
Head of Information Governance
Velindre NHS Trust HQ
2, Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Tel – 029 2031 6161

14. Further Information

This Policy should be read in conjunction with the following Trust policies:

- Information Governance Policy
- Confidentiality Breach Reporting Policy
- Records Management Policy
- Freedom of Information Act Policy
- Data Quality Policy
- Information Security Policy
- Email Use Policy
- NHS Wales Internet Use Policy
- Social Media Policy

Ref: IG08

FREEDOM OF INFORMATION ACT POLICY

Executive Sponsor & Function:

Executive Director of Finance

Document Author:

Head of Information Governance

Approved by:

Quality, Safety and Performance Committee

Approval Date:

Date of Equality Impact Assessment:

Equality Impact Assessment Outcome:

Review Date:

Version: 2.0

Contents Page

1. Aim

The aim of this policy is to ensure the provisions of the Freedom of Information Act 2000 are adhered to and in particular that:

- a significant amount of routinely published information about Velindre NHS Trust (the Trust) is made available to the public as a matter of course through the Trust's website and its Model Publication Scheme;
- other information not included on the Trust's website is readily available on request and that requests for information are dealt with in a timely manner; and
- where the information requested is covered by a public interest non-disclosure exemption, the Trust carefully considers the public interest test as defined by the Act prior to its final decision.

Achievement of these aims will detail how the Trust meets its legal obligations. It will further the commitment of the Trust to ensure timely access to information held by its divisions and associated organisations in order to promote greater openness. It will demonstrate increased transparency of decision making thereby building public trust and confidence.

These aims will be balanced against the need to ensure the confidentiality of some information the Trust, its divisions and associated organisations hold relating to such areas as personal privacy, commercial sensitivity and where disclosure would not be in the public interest.

The policy also aims to provide all employees of the Trust with a framework in which to ensure any request for information they receive is dealt with in accordance with the Act and in conjunction with this policy.

2. Policy Statement and Objectives

The Freedom of Information Act 2000 and Environmental Information Regulations 2004 (hereafter known as the Act) provide public access to information held by Public Authorities. Schedule 1, Part 3, paragraph 40 of the Act (A National Health Service Trust established under Section 18 of the National Health Service Wales Act 2006) defines Velindre University NHS Trust as a Public Authority.

The Freedom of Information Act Policy sets out the key areas of responsibility and affirms Velindre NHS Trust's commitment to the underlying principles of the Act enabling it to meet its obligations under the legislation.

The Trust supports the principles of openness and transparency and welcomes the rights of access to information that the Freedom of Information Act 2000 provides. The Trust

seeks to create a climate of openness and transparency by providing improved access to information about the Trust that will facilitate such an environment.

This Policy sets out the high level intent of the Trust and also recognises the diversity of the respective Divisions and associated organisation's under its control.

3. Scope of the Policy

This policy applies to all information the Trust, its divisions and associated organisations hold regardless of how it was created or received. It applies no matter what media the information is stored in and whether the information is current or archived and held on paper or electronic.

4. Legislation and Standards

The Trust and its staff will comply with all existing and new requirements, both legislative and provided as guidance by the Welsh Government (WG), Department of Health, the Information Commissioner's Office (ICO) and other professional bodies.

This policy is written in accordance with current legislation including, but not restricted to, the Act as well as key pieces of guidance and current Trust and divisional/ associated organisational policies and procedures where they overlap with this policy.

The Trust recognises that specific procedures within divisions and associated organisations may vary. However, the requirement to maintain the provisions of the Act and the need to ensure timely access to information whilst promoting openness and transparency will always remain the same.

5. Roles and Responsibilities

Divisions and associated organisations that fall under the remit of the Trust are responsible for promoting compliance with this policy in such a way as to ensure the easy, appropriate and timely retrieval of information.

All Trust employees (including honorary contract holders and volunteers) are subject to this policy and have responsibilities to ensure that any request for information they receive and/or asked to assist with are dealt with in a timely manner in accordance with the Act and in compliance with this policy; failure to comply may result in disciplinary procedures being instigated.

To ensure compliance, Information Governance training provisions within the divisions and associated organisations of the Trust will provide members of staff with an introductory briefing and training on the Act and its procedures.

6. Obligations under the Act

6.1 Right of Access

Under the provisions of the Act individuals have the right to be told whether particular information exists and the right to receive the information. Upon receipt of a request for information the Trust and associated organisations have 20 working days in which to respond. A charge [see section 7.5], set in accordance with the Fees Regulations defined by the Secretary of State, may be made for providing the information.

6.2 Publication Scheme

The Trust has adopted the Information Commissioner's Model Publication Scheme.
The Scheme can be accessed via the Trust's website and sets out the types of information the Trust publishes, the form it is published and details of any charges.

The Scheme will be subject to regular review in terms of content.

6.2.1 Datasets

Section 102 of the Protection of Freedoms Act 2012 added new provisions to FOIA (in particular sections 11 and 19) regarding datasets. A dataset is a collection of factual information in electronic form which concerns the services and functions of the Trust and its associated organisations that is neither the product of analysis or interpretation, nor an official statistic and has not been materially altered. Further guidance can be found here:

Data Sets Sections 11, 19 and 45 of the Freedom of Information Act - Guide

The Trust will as part of its Publication Scheme routinely make available datasets necessary to fulfil all legal and regulatory obligations. Where, following a request a new data set is published, the responsibility of its maintenance will fall to the respective Manager of the department within the Trust or its associated organisations from which it was sourced.

6.3 Specific Requests for Information

Information that is not already made available on the Trust's publication scheme may be accessible through a specific request for information. Any request for information under the Act must be made in a permanent form (i.e. in writing or by email). Where members of the public are unable to access any electronic medium such as email or internet, alternative methods of supplying information must be considered.

In addition, the Environmental Information Regulations (EIR) which in general terms relate to requests regarding topics such as environmental matters (air, water, land, etc), noise,

activities affecting the environment, and some aspects of health and safety, also allows for requests to be made verbally.

The Trust, respective divisions and associated organisations must respond to all requests for information within 20 working days with any response including the need to confirm or deny whether the information is held. The Act operates on the basis that information must be published unless there is a likelihood that harm to the Public Interest would be greater if the information were to be published above that if it were to be withheld.

It is on this basis, that information will be disclosed wherever possible. Where it has been deemed information cannot be supplied in full or in part exemptions or in the case of EIR [see section 7.6] outlined in the Act must be applied. It should be noted that dependent on the contents of the document this may be more than one exemption (or for EIR exception).

Technical advice related to the application of the Act, its time compliance provisions and potential usage of any of the Acts exemptions or exceptions is available from the Trust's Communication and Compliance Officer . Where application of the exemptions/exceptions may be particularly complex or sensitive, the Head of Information Governance is available to provide support as required. From time to time, where it may involve extremely complex legislation, the process may also necessitate the use of external legal support. In these circumstances, the Head of Information Governance's advice/and/or guidance must be sought. .

6.4 Data Protection and Freedom of Information

Personal data which falls within the scope of the Data Protection Legislation is not covered by the Freedom of Information Act 2000 and therefore not publicly accessible. In such cases this is a Data Protection issue and the Head of Information Governance must be contacted for further advice/guidance prior to the exemption being applied and the request for information replied to.

In some instances certain personal data may be released where it relates to senior staff or staff in public facing roles, but only where such information relates to a person's working life. For example contact information and salary grade.

6.5 Charging

In maintaining a culture of openness and transparency the Trust, respective divisions and its associated organisations will not normally charge for the provision of information that is provided as a result of a request. However, it is recognised that should it be estimated the request for information exceeds the appropriate fee limit[1] as set down under section 12 of the Act then the organisation is not obligated to comply with the request for information.

[1] Appropriate limit has been set as a figure of £450 and is calculated at a rate of £25 per hour/18 hours of work

In cases when the information is exempt because the appropriate fee limit has been met, then wherever possible and in line with the duty to provide advice and assistance enshrined within the Act, the Trust, its divisions and associated organisations will work with the applicant to try to reduce the amount of work involved so that some of the information can be provided. In certain circumstances where the amount of work required to meet the request cannot be reduced, the applicant can be offered the option of paying for the information. In this instance the applicant would have to pay the full cost of meeting the request.

In addition to this and under the Act, charges can be applied to cover more administrative tasks such as photocopying/translation of documents, etc. In most circumstances applying charges for such disbursements may be waived; however the Trust, its divisions and associated organisations reserve the right to apply these charges especially in exceptional instances where the request requires an unrealistically large amount of photocopying, or substantial effort to translate or perform a transition of documents into other formats. If disbursements are charged they will be kept to a reasonable level.

Appendix 1 provides information on the rules in place for charging for the supply of information under the Act with further advice available via the Trust Communication and Compliance Officer and/or the Head of Information Governance .

6.6 Exemptions and Exceptions

It is recognised that in some cases the disclosure of information may affect the legal rights of a third party (i.e. where information is subject to the common law duty of confidence, impacts on an industrial partner with whom the Trust is under contract (eg a pharmaceutical company), etc). In such situations it will be necessary to engage with these third parties to seek their opinion on any potential release. However any decision to release or not and where required subsequent application of an exemption/exception under the Act rests with the Trust, its divisions and/or associated organisations. A refusal to consent to disclosure by a third party does not, in itself, mean information should be withheld.

Should it be determined that the information held could be regarded as exempt information under the Act and requires the need to consider the application of an exemption or exception the respective Trust and organisational leads must take the lead in identifying why the exemption or exception should be applied with written evidence provided to the Compliance Officer and/or Head of Information Governance so that logical and clear reasoning behind the decision to withhold information can be identified.

Should the requestor subsequently submit a complaint (See Section 8) regarding the Trust's response the reasoning behind the original assessment will be re-appraised as part of the Internal Review process which involves reviewing the information withheld and the rationale applied within the Public Interest test process for refusal to publish the information in the first instance.

Appendixes 2and 3 provides a full list of all the exemptions/exceptions that can be found under the Act.

6.7 Codes of Practice

The Act sets provisions for the Lord Chancellor and Secretary of State to issue codes of practice to which the Trust should adhere. The applicable codes of practice are detailed below: -

7.7.1 Section 45 Code of Practice – Request Handling

The Section 45 code of practice sets out recommended processes which public authorities should follow when dealing with requests for information under the Act. It provides clear guidance that includes providing advice and assistance to applicants, how to transfer requests to other public authorities, consultation with third parties, how to use confidentiality clauses in contracts and the provision of internal complaints procedures. The hyperlink is below:

ICO Guide: Section 45 Code of Practice

7.7.2 Section 46 Code of Practice – Records Management

The Section 46 code of practice sets out recommended processes with which public authorities should adopt in relation to the creation, storage and management of records. In addition to the end life and destruction of these records. It also describes the arrangements which public record bodies should follow in reviewing public records and transferring them to the Public Record Office (PRO) or to pre-arranged places of archival.

7. Awareness and Training

All Staff will receive a broad overview of the Act to ensure awareness. This training will be delivered as part of induction for new Staff and periodically thereafter by the Head of Information Governance.

Key Staff and members of the Board and EMB will receive more specific training, particularly those in governance functions.

8. Governance and Reporting

Compliance with this policy (and supporting procedures) will be monitored by the Head of Information Governance. An internal audit on the Trust's arrangements in relation to the Act will be scheduled in line with the Trust's internal audit strategy.

For assurance, details on FOI activity will be reported to the Quality, Safety and Performance Committee, as well as the Senior Information Risk Owner (SIRO).

9. Complaints

Anyone who has made a request for information to the Trust under the Act is entitled to request an internal review if they are unhappy with the way their request has been handled

Internal reviews will be carried out afresh by the Head of Information Governance or in his absence another senior member of staff who was not involved with the original decision (appropriate assistance will be provided to requesters with access requirements).

To progress and ensure there is no delay in the handling of any requests for internal review the following process should be adhered to: -

- The request for review should be submitted by the applicant within 40 working days and addressed to the Trust's Head of Information Governance in the first instance.
- The Trust will acknowledge the request for an internal review within three working days and aim to respond within 20 working days of receipt. On occasion and only by exception (where the review is complex) the trust may extend the review period to a maximum of 40 working days.

Any applicant who remains dissatisfied with the outcome of the Trust's internal review is entitled to complain to the Information Commissioner's Office (ICO) by writing to:

Information Commissioner's Office – Wales
2nd Floor
Churchill House
Churchill Way
Cardiff
CF10 2HH

Tel: 0330 414 6421
Email: wales@ico.org.uk

10. Available Guidance and References

Guidance on the procedures necessary to comply with this policy should be made available from the respective divisions and associated organisations of the Trust or on its web pages. Links to the Information Commissioner's Office (ICO) website also provide a valuable source of information and should be quoted at every opportunity.

11. Health and Care Standards

This Policy and processes described within, as well as those contained within the Standard Operating Procedures enable the Trust to comply with Health and Care Standards 3.4 in that*:*

> *"Health service ensure all information is accurate, valid, reliable, timely, comprehensible and complete in delivering, managing planning and monitoring high quality, safe services. Health services have systems in place, including information and communications technology, to ensure the effective collection, sharing and reporting of high-quality data and information with a sound information governance framework"*

12. Equality

In accordance with the Trust's Equality policy, this policy will not discriminate, either directly or indirectly, on the grounds of gender, race, colour, ethnic or national origin, sexual orientation, marital status, religion or belief, age, union membership, disability, carers status, offending background or any other personal characteristic.

13. Copyright

Information provided by the Trust, its divisions and associated organisations in response to a request under the Act remains copyrighted and can only be used for the applicants personal use or for other specific uses permitted in the Copyright, Designs and Patents Act 1988.

If an applicant wishes to use information provided for commercial purposes (including the sale of the information to a third party) they must seek written permission from the Trust, its divisions and/or associated organisations under the directive on the Re-use of Public Sector Information Regulations 2015.

14. Contacts

For further advice and/or assistance on how to ensure individual, divisional and associated organisational compliance with the Act or to obtain lead officer details, then please contact the Trust's Communication and Compliance Officer or Head of Information Governance Manager: -

Julie Heydon-Mann
Velindre NHS Trust HQ
Communication and Compliance Officer
2, Charnwood Court
Heol Billingsley

Parc Nantgarw
Cardiff
CF15 7QZ

Tel - 029 20316951

Ian Bevan
Head of Information Governance
Velindre NHS Trust HQ
2, Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Tel – 029 2031 6161

15. Further Information

This policy should be read in conjunction with the following Trust policies:

- Information Governance Policy
- Data Protection & Confidentiality Policy
- Records Management Policy
- Information Security Policy
- Email Policy
- NHS Wales Internet Use Policy

Appendix 1

Where costs exceed the appropriate limit

When determining whether or not the requested information exceeds the appropriate fee limit under the Act, the Trust and/or its associated organisations are only permitted to include the following activities within their estimation: -

- determining whether the information is held;
- locating the information;
- retrieving the information; and
- extracting the information from a document containing it.

Calculating the costs of the activities

£25 is the standard hourly rate; the limit is £450 which equates to 18 hours' worth of staff time, in which the Trust and/or its associated organisation's must use to calculate the staff costs of answering requests.

Staff time spent redacting exempt information cannot be taken into account if an initial estimation into whether the appropriate limit is exceeded is undertaken.

Fees Notices

As a matter of good practice, if the Trust and/or its associated organisations are offering to provide the information for a fee then a fees notice should be issued to the applicant. There is no statutory requirement to do this because there is no obligation on the organisation to comply under section 12 of the Act. However, it is recommended as this would inform the applicant they have the option of receiving information upon the payment of a necessary fee (Section 9 of the Act). A fees notice should be issued as soon as possible or at least within the 20 working day time period.

Statutory obligations to provide Information

A fee cannot be charged where there is a statutory obligation to supply information in a particular format, such as in the Welsh language (Welsh Language Act 1993) or in Braille, large print or on an audio tape to make reasonable adjustments for disabled persons (Equality Act 2010). The cost of supplying information by the preferred means of communication however is chargeable.

Payment

Should the Trust and/or its associated organisations fail to receive payment within three months of issuing a fee's notice, the Information Commissioner's Office would consider that the organisation is no longer obliged to respond to the request. It is also helpful to mention this deadline in the fees notice.

Appendix 2

Freedom of Information Act 2000 – Exemptions

Absolute Exemptions

- Section 21: Information accessible by other means

- Section 23: National Security - Information supplied by, or relating to, bodies dealing with security matters (a certificate signed by a Minister of the Crown is conclusive proof that the exemption is justified. There is a separate appeals mechanism against such certificates)

- Section 32: Court Records

- Section 34: Parliamentary Privilege - a certificate signed by the Speaker of the House, in respect of the House of Commons, or by the Clerk of the Parliament, in respect of the House of Lords is conclusive proof that the exemption is justified.

- Section 36: Effective Conduct of Public Affairs - so far as relating to information held by the House of Commons or the House of Lords

- Section 40: Personal Information - where the applicant is the subject of the information. The applicant already has the right of ‘subject access' under existing Data Protection Legislation; where the information concerns a third party and disclosure would breach one of the data protection principles

- Section 41: Information provided 'In Confidence'

- Section 44: Prohibitions on disclosure - where a disclosure is prohibited by an enactment or would constitute contempt of court.

Qualified Exemptions

- Section 22: Information Intended for Future Publication

- Section 24: National security (other than information supplied by or relating to named security organisations, where the duty to consider disclosure in the public interest does not apply)

- Section 26: Defence

- Section 27: International relations

- Section 28: Relations within the United Kingdom

- Section 29: UK Economic Interests
- Section 30: Investigations and Proceedings Conducted by Public Authorities
- Section 31: Law Enforcement
- Section 33: Audit Functions
- Section 35: Formulation of government policy and Ministerial Communications
- Section 36: Prejudice to effective conduct of public affairs (except information held by the House of Commons or the House of Lords – see absolute exemptions)
- Section 37: Communications with Her Majesty, the Royal Family or concerning honours
- Section 38: Health and Safety
- Section 39: Environmental Information - as this can be accessed through the Environmental Information Regulations
- Section 42: Legal Professional Privilege
- Section 43: Commercial Interests

Where the Trust, its divisions and/or associated organisations consider that the public interest in withholding the information requested outweighs the public interest in releasing it, the authority must inform the applicant of its reasons, unless to do so would mean releasing the exempt information.

Appendix 3

Environmental Information Regulations 2004 – Exceptions

Subject to the Public Interest Test:

- Regulation 12(4)(a) – Does not hold that information when an applicant's request is received
- Regulation 12(4)(b) – In manifestly unreasonable
- Regulation 12(4)(c) – Is formulated in too general a manner (provided assistance has been given to the applicant with a view to re-forming the request)
- Regulation 12(4)(d) – Relates to unfinished documents or incomplete data
- Regulation 12(4)(e) – Would involve disclosure of internal communications

And if disclosure would adversely affect:

- Regulation 12(5)(a) – International relations, defence, national security or public safety
- Regulation 12(5)(b) – The course of justice, fair trial, the conduct of a criminal or disciplinary inquiry
- Regulation 12(5)(c) – Intellectual Property rights
- Regulation 12(5)(d) – Confidentiality of public authority proceedings when covered by law
- Regulation 12(5)(e) – Confidentiality of commercial or industrial information, when protected by law to cover legitimate economic interest
- Regulation 12(5)(f) – Interests of the person who provided the information
- Regulation 12(5)(g) – Protection of the environment

Please note that if the information requested is related to emissions, exceptions 12(5)(d) to 12(5)(g) cannot be used.

If Personal data is requested then Regulation 13 must be used.

Ref: IG01

RECORDS MANAGEMENT POLICY

Executive Sponsor & Function:

Executive Director of Finance

Document Author:

Head of Information Governance

Approved by:

Quality, Safety and Performance Committee

Approval Date:

Date of Equality Impact Assessment:

Equality Impact Assessment Outcome:

Review Date:

Version: Version 2

Contents Page

1. Aim

The aim of this policy is to ensure that all types of records (regardless of the fact whether they are paper or electronic), administrative as well as medical, are properly controlled, accessible, available, archived, and disposed of in line with national guidelines.

This policy applies to all records the Trust, its divisions and associated organisations hold regardless of how these are accessed, created, handled, received and/or stored, and shall include **all types of media** including (but not limited to) records in paper or electronic form, databases, software, video and sound media.

2. Policy Statement and Objectives

The Velindre NHS Trust Records Management Policy sets out the key areas of responsibility and affirms the Trusts commitment to achieving high standards in records management. This Policy sets out the high level intent of Velindre NHS Trust and also recognises the diversity of the respective Divisions and associated organisations under its control.

As a public body we are required by law to manage our records appropriately; namely in accordance with regulations such as the Data Protection Act 2018, , Section 46 of the Freedom of Information Act 2000, Environmental Information Regulations 2004, Public Records Act 1958, Local Government Act 1972 and the re-use of Public Sector Information Regulations 2015 that set out specific requirements in relation to the creation, management, disposal, use and re-use of records.

3. Scope of the Policy

This is a Trust-wide Policy and applies to all staff and personnel operating under the auspices of the Trust, including employees, locums, contractors, temporary staff, students, service user representatives, volunteers and partner agency staff.

This Policy applies to the three identified types of information processed, transmitted and maintained by the Trust, its divisions and hosted organisations. These are:

- Health and Social Care records (“clinical” records about patients, donors, service users and carers)
- Staff records (“corporate” records about staff)
- Management records (“corporate” records about the Trust)

4. Records Management

Records management is vital to the delivery of our services and supports consistency, continuity, efficiency and productivity and helps us deliver our services in a uniform and equitable manner.

Trust records are our corporate memory and support policy formation and managerial decision-making, protecting the interests of the organisation and the rights of service users, staff and members of the public who interact with the Trust and its respective Divisions and/or associated organisations under its control.

The Trust aims to balance our commitment to openness and transparency with our responsibilities. So we will create and manage records efficiently, make them accessible where possible, protect and store them securely and dispose of them safely at the right time. This policy will provide the Trust with a baseline to improve records management enabling seven main objectives to be delivered, these being:

- **Accountability** – that adequate records are maintained to account fully and transparently for all actions and decisions.

- **Quality** – that records are complete and accurate and the information they contain is reliable and its authenticity can be guaranteed.

- **Accessibility** – that records and the information within them can be efficiently retrieved by those with a legitimate right of access, for as long as the records are held by the organisation.

- **Security** – that records will be secure from unauthorised or inadvertent alteration or erasure, that access and disclosure will be properly controlled and audit trails will track all use and changes. Records will be held in a robust format which remains readable for as long as records are required.

- **Retention and disposal** – that there are consistent and documented retention and disposal procedures to include provision for permanent reservation of archival records.

- **Training** – that all staff are made aware of their record-keeping responsibilities through generic and specific training programmes and guidance.

- **Performance measurement** – that the application of records management procedures are regularly monitored against agreed indicators and action taken to improve standards as necessary.

4.1 Key Principles of Records Management

Effective records management will help ensure that we have the right information at the right time to make the right decisions. Information is essential to the delivery of high quality evidence-based health care on a day-to-day basis and an effective records management service ensures that such information is properly managed and is available:

- To support patient, donor care and continuity of care;
- To support day to day business which underpins the delivery of care;
- To support evidence based clinical practice and improvements in clinical effectiveness through research ;
- To support financial, administrative and managerial decision making;
- To meet legal requirements, including subject access requests from patients, representatives or their carers, donors and staff under the Data Protection Act 2018 (UK GDPR) ;

Good record keeping ensures:

- Staff are able to work with maximum efficiency without having to waste time locating information;
- Where appropriate, there is an audit trail which enables any record entry to be traced to a named individual with a given time/date with the knowledge that all alterations are recorded and can be similarly traced; (NB. health records should never be altered – incorrect information may be crossed through, but remain legible, and additional information inserted)
- Those using the record following another staff members use can see what has been done, or not done, and why; and
- Any decisions made can be justified or reconsidered at a later date.

To ensure that the key principles of the Policy are adhered to, the Trust operates a standard approach to the management of information in line with Section 46 Information Management Code of Practice, these are:

- Create
- Assure
- Use
- Store
- Access
- Share
- Publish
- Dispose

4.2 Records Creation

This policy relates to all operational records. Operational records are defined as information created or received in the course of business and captured in a readable form in any medium and providing evidence of the functions, activities and transactions. These records should not be considered personal property, but corporate assets. This list is not exhaustive but they include:

- Administrative records; (including personnel, letters, memos, estates, financial and accounting records, contract records, litigation and records associated with complaint-handling)
- Health records (including those concerning patients and donors);
- Theatre Registers and all other treatment registers that may be kept;
- X-ray and imaging reports, outpatient records and images;
- Photographs, slides, and other images;
- Microform (i.e. fiche/film), audio and video tapes; and
- Records in all electronic formats - computer databases and their output, including disks etc, and all other electronic records including databases maintained for personal/research purposes.

All records created in the course of the business of the Trust are corporate records and are public records (where defined) under the terms of the Public Records Acts 1958 and 1967 (An Act of parliament which reduces the time that public records may be made available to the public from 50 years under the Public Records Act 1958 to 30 years). This will include emails and other electronic records.

4.3 Records Maintenance (Assure)

The principle of Assure means that we must ensure that our processes are robust enough to protect all information as much as is physically possible. This allows the Trust to assure our patients, donors and service users that our processes are robust enough to safeguard information securely.

Whilst system security in relation to of electronic systems may not provide 100% protection against complex hacking, as an organisation we can mitigate the risk of inadvertent disclosure of information by following a high standard of documentary security, both in the physical and electronic sense, within our daily working practices.

In the same way that the Trust ensures that the data and information it creates is safeguarded securely, the same measures of protection are to be applied for information received within the organisation. All information should only be accessed on a need-to-know basis. By compartmentalising information access, the risk of inadvertent disclosure by unauthorised Staff is reduced. Staff who have access to information are to safeguard it appropriately.

4.4 Records Retrieval (Use)

Accurate recording and knowledge of the content and location of all records is essential if relevant information is to be located quickly and efficiently. Systems will be reviewed and developed as necessary to ensure that as a record moves around the organisation, an audit trail is created and systems are recommended to record the following (minimum) information:

- the item reference number or other identifier;
- a description of the item (e.g. file title);
- it's location i.e. a person, unit, department or other; and
- the date of transfer.

4.5 Records Storage

Whilst there are many options available for Information Asset Owners to follow, the crucial element is the ability to access information easily and quickly which relies on the logical storage of information. The Code of Practice on the management of records issued under section 46 of the Freedom of Information Act 2000 provides a high level overview in terms of what the Secretary of State for Digital, Culture, Media and Sport expects from Public Bodies. The ICO provides more granular guidance in relation to the entire subject of Records Management in its Section 46 - Code of Practice for Records Management . In relation to the storage of Medical Records, the NHS Wales Records Management Code of Practice for Health and Social Care 2022 is to be used by Trust Staff. The HoIG is available to provide advice and guidance to Staff.

4.6 Records Access

Information within the Trust is a corporate asset, but given the nature of its business, the principle of 'need to know' underpins access to information. Staff are not, under any circumstances to access records where there is no business need to do so.

4.7 Sharing of Records

Sharing information is a business-critical function of the Trust. However, it must be done compliantly and in a structured way. Data Protection legislation states that may only be shared with the consent of the originator of the information. Specifically information is not to be shared to third party organisations without prior approval. Prior to any approval to share data, data protection legislation requirements must be met. The ICO's Data Sharing Code of Practice is the underpinning guidance in terms of considering the sharing of personal data. Whenever personal data is to be shared, the advice of the HoIG is to be sought at the beginning of the process.

4.8 Publishing Records

The Communications department are responsible for the public facing aspect of the Trust. The Trust has its own website, which is accessible by the general public.

Information within the website is to meet the high-quality standards of the Trust and should only be published after it has been ascertained that the information does not breach any current legislation (including the Freedom of Information Act 2000) with regards to appropriate content, security and sensitivity.

The Trust adheres to data protection legislation and our Privacy Notice is contained on the website. When requested, staff are able to forward a hyperlink to the Privacy Notice to stakeholders and other third parties.

4.9 Retention and Disposal of Records

Information held by the Trust is to be for explicit and legitimate purposes. It must also be adequate, relevant, accurate and necessary. These are the six principles for the management of information within the Trust. When creating the information, it is prudent practice to estimate the whole life disposition of the information.

It is a requirement that all Trust records are retained for a minimum period of time for legal, operational and safety reasons. The length of time for retaining records will depend on the type of record and its relation to the Trust's functions.

The Trust has adopted the retention periods set out in the NHS Wales Records Management Code of Practice 2022 .

The Trust contracts a confidential waste disposal company, to dispose of physical information securely. All documents must be placed in the receptacles provided which are emptied regularly by the Contractor.

4.10 Data Quality

The Trust will ensure an Executive level focus on data quality and will actively encourage an organisation wide approach to its management. The Data Quality Policy contains more information.

4.11 Security, Confidentiality and Data Protection

The Trust has a legal duty of confidence to service users and staff and a duty to maintain professional ethical standards of confidentiality. Everyone working for or with the Trust and record, handle, store or views personal data, has a common law duty of confidence - even after the death of the service user, or after an employee or contractor has left the Trust. (i.e. duty of confidentiality is for life)

4.12 Contracting-out Information Storage and Retrieval

Where off-site storage is used appropriate security measures must be assured after consultation with the HoIG so that both clinical and legal obligations are met.

4.13 Information Asset Register

The Trust is fully committed to identifying all recognisable bodies of information held on paper or electronic media that are required to support the work of the organisation. In order to identify all records of information that we hold about our patients, donors, staff and service users (incl. families, friends, etc) each division/hosted organisation are required to develop and assemble an appropriate Information Asset Register (IAR).

The IAR is a compulsory component of the Trust's Information Governance framework, as the identification of where and how records are being kept can then enable the Trust, its respective divisions and hosted organisation to better assess the risks associated with how information is being collected, stored and disposed, thereby ensuring compliance with Data Protection Legislation and associated standards.

5. Roles and Responsibilities

The Trust recognises its corporate responsibility and commitment to compliance with Records Management requirements; as stated within statutory provision and good practice guidance, and to further raise staff awareness of good Records Management practice.

The Trust's Quality, Safety and Performance Committee is responsible for approving the content of this Policy.

5.1 Managerial Accountability and Responsibility

The **Chief Executive** of the Trust as the **Accounting Officer** has overall responsibility for ensuring compliance with applicable legislation and regulation

Respective **Senior Information Risk Owners (SIRO)** shall represent any relevant information risk to the Trust Board.

Directors of associated areas within the Trust are responsible for ensuring that the policy is implemented within their individual organisation. They will nominate departmental representatives, who will liaise with the respective Information Governance Leads on the management of records in that division.

Within the Trust there are **Caldicott Guardians** who have responsibility at respective organisational level for ensuring the care of patient/donor data.

The Trust, divisional and hosted organisational **Information Governance leads** are responsible for co-ordinating records management in their respective organisations and identifying key corporate records and providing guidance and advice on their management and retention.

5.2 Individual Responsibility

All members of staff are responsible for any records which they create or use. This responsibility is established by law and in the contract of employment with the Trust. Furthermore, as an employee of the NHS, any records which are created by any employee or contractor of the Trust are public records. It is the responsibility of all staff to ensure that appropriate records of their work in the Trust are kept and managed in keeping with this policy and with any guidance subsequently produced on behalf of the Trust.

Everyone working for or with the NHS who records, handles, stores, or otherwise comes across information has a personal common law duty of confidence to individuals referred to in that information. Data Protection Legislation places statutory restrictions on the use of personal data, including health information.

The Data Protection and Confidentiality Policy contains practical considerations which members of Staff are to follow when processing information within the remit of this Policy.

6. Legislation and Standards

The need to improve NHS records managements and for the Trust to re-consider current practices has arisen from statutory provisions and good practice guidance's that include but is not limited to:

- Data Protection Legislation
- Freedom of Information Act 2000
- Environmental Information Regulations 2004
- Public Records Acts 1958 and 1967
- Caldicott Principles
- Records Management: NHS Code of Practice
- The Lord Chancellor's Code of Practice under Section 46 of The Freedom of Information Act 2000 (superseded by the Secretary of State for Digital, Culture, Media and Sport - Code of Practice on the management of records issued under Section 46 of the Freedom of Information Act 2000)

The Trust recognises that specific procedures within divisions and associated organisations may vary and that this policy should therefore be considered in conjunction with any such policies and/or procedures and not read in isolation.

7. Training and Awareness

The Trust will ensure that adequate training is provided raising the awareness of staff responsibilities for records management and that qualified expertise is available for consultation via the Head of Information Governance.

8. Governance and Reporting

It is the duty of all staff to record and report any incidents or 'near misses' involving records or personal data (including the unavailability and loss) in line with the Trust and divisional and/or associated organisational incident reporting policies/procedures.

The Trust's Head of Information Governance will report a summary of incidents via the EMB to the QSP Committee on a quarterly basis via SIRO so that the Trust Board has an oversight on any breaches of Records Management Policy.

The Committee will further brief the Trust Board as appropriate.

9. Available Guidance

Guidance on the procedures necessary to comply with this policy should be made available from the respective divisions and associated organisations of the Trust or on its web pages. Managers will be responsible for ensuring that all their staff are made aware of Trust policies and standards.

Links to the Information Commissioner's Office (ICO) website also provide a valuable source of information.

10. Health and Care Standards

This Policy and processes described enable the Trust to comply with the
The Health and Care Standard 3.5 on Record Keeping and 3.4 in that:

"The health service ensure all information is accurate, valid, reliable, timely, comprehensible and complete in delivering, managing planning and monitoring high quality, safe services. Health services have systems in place, including information and communications technology, to ensure the effective collection, sharing and reporting of high-quality data and information with a sound information governance framework"

10. Equality

In accordance with the Trust's Equality policy, this policy will not discriminate, either directly or indirectly, on the grounds of gender, race, colour, ethnic or national origin, sexual orientation, marital status, religion or belief, age, union membership, disability, carers status, offending background or any other personal characteristic.

11. Contacts

For further advice and/or assistance on how to ensure individual, divisional and associated organisational compliance with this policy, please contact: -

Ian Bevan
Head of Information Governance
Velindre University NHS Trust
2 Charnwood Court,
Parc Nantgarw,
Cardiff,
CF15 7QZ,
Tel – 01443 622161

12. Further Information

This Policy should be read in conjunction with the following Trust policies:

- Information Governance Policy
- Data Protection & Confidentiality Policy
- Freedom of Information Act Policy
- Data Quality Policy
- Information Security Policy
- Procedure for Media, Filming, Recording and Photography, for and within the Trust
- Email Policy

QUALITY SAFETY & PERFORMANCE COMMITTEE

NHS WALES NATIONAL IMAGING ACADEMY HOSTING AGREEMENT

DATE OF MEETING	14th July 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	

PREPARED BY	Lauren Fear, Director Corporate Governance & Chief of Staff
PRESENTED BY	Lauren Fear, Director Corporate Governance & Chief of Staff
EXECUTIVE SPONSOR APPROVED	Cath O'Brien, Chief Operating Officer Lauren Fear, Director Corporate Governance & Chief of Staff

REPORT PURPOSE	ENDORSE FOR BOARD APPROVAL

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

ACRONYMS	

1. SITUATION

The National Imaging Academy Wales was established in August 2018 to train the next generation of radiologists and imaging professionals. It was established with funding from the Welsh Government and provides part of the Wales Clinical Radiology Specialist Training Programme, which runs two separate schemes in North and South Wales. The Academy delivers the Royal College of Radiologists curriculum in a dedicated environment which is equipped with the latest technology.

The Academy is hosted by Cwm Taf Morgannwg University Health Board. The Health Board and Academy have been working to formalise and build on the hosting agreement principles agreed at inception.

All NHS Wales Health Boards and Trust, on whose behalf the National Imaging Academy Wales will work, are asked to sign up to the Agreement. NHS Organisations have been asking their Boards for approval over the last number of months.

2. KEY MATTERS FOR CONSIDERATION

The Committee is asked to approve the Hosting Agreement for Trust Board approval. The Trust Board will be asked to approve and delegate the signatory to the Chief Executive Officer.

The Head of Radiation Services and confirms the Agreement meets the needs of the service. This has been endorsed by the Chief Operating Officer.

The Director Corporate Governance confirms that the Agreement meets the governance principles of the Trust.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Quality of Radiation services
RELATED HEALTHCARE STANDARD	Staff and Resources

	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Meets governance principles of the Trust
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 Committee are asked to **ENDORSE** the NHS Wales National Imaging Academy Wales Hosting Agreement for Trust Board approval.

Cwm Taf Morgannwg University Health Board

&

NHS Wales Health Boards and Trusts

Hosting Agreement
2021 – 2023

Date: February 2021	**Version:** Final Draft

Purpose and Summary of Document:

This agreement is to enable and facilitate the hosting of the NHS Wales National Imaging Academy Wales by Cwm Taf Morgannwg University Health Board on behalf of NHS Wales Chief Executives.

The agreement is intended to ensure that hosting arrangements are clear and transparent and that the rights and obligations of all parties are documented and agreed. The agreement sets out appropriate financial arrangements and the obligations of all parties to the agreement.

1. Parties to this agreement

The parties to this agreement are:

1. Cwm Taf Morgannwg University Health Board, which is the host body.
2. The NHS Wales National Imaging Academy Wales (the NIAW), which is the hosted unit and, for the purposes of this agreement, includes all subsidiary functions, teams and services forming part of the NIAW.
3. All NHS Wales Health Boards and Trusts, on whose behalf the National Imaging Academy Wales will work.

The signatories to this agreement are:

1. Paul Mears, Chief Executive, on behalf of Cwm Taf Morgannwg University Health Board (Host body)

   Signed: _____

   Date: _____

2. Phillip Wardle, Director, on behalf of the National Imaging Academy Wales

   Signed: _____

   Date: _____

3. Mark Hackett, Chief Executive, on behalf of Swansea Bay University Health Board

   Signed: _____

   Date: _____

4. Judith Paget, Chief Executive, on behalf of Aneurin Bevan University Health Board

   Signed: _____

   Date: _____

5. Jo Whitehead, Chief Executive, on behalf of Betsi Cadwaladr University Health Board

   Signed: _____

   Date: _____

6. Len Richards, Chief Executive, on behalf of Cardiff and Vale University Health Board

   Signed: _____

   Date: _____

7. Steve Moore, Chief Executive, on behalf of Hywel Dda University Health Board

   Signed: _____

   Date: _____

8. Carol Shillabeer, Chief Executive, on behalf of Powys Teaching Health Board

   Signed: _____

   Date: _____

9. Steve Ham, Chief Executive, on behalf of Velindre NHS Trust

   Signed: _____

   Date: _____

10. Jason Killens, Chief Executive, on behalf of the Welsh Ambulance Services NHS Trust

    Signed: _____

    Date: _____

11. Tracey Cooper, Chief Executive, on behalf of Public Health Wales

    Signed: _____

    Date: _____

1 Named points of contact

The following individuals will act as the primary points of contact in relation to any issues that may arise under this agreement:

- For Cwm Taf Morgannwg University Health Board : Executive Director of Planning
- For the National Imaging Academy Wales : Director

2 Purpose and scope of this agreement

This agreement is to enable and facilitate the hosting of the National Imaging Academy Wales by Cwm Taf Morgannwg University Health Board on behalf of NHS Wales Chief Executives.

The agreement is intended to ensure that hosting arrangements are clear and transparent and that the rights and obligations of all parties are documented and agreed.

The National Imaging Academy Wales' annual work plan and performance management arrangements are agreed between the Director of the National Imaging Academy Wales and the Collaborative Executive Group, prior to final sign off by the Collaborative Leadership Forum.

3 Status of this agreement

This agreement is not legally binding and no legal obligations or legal rights arise between the parties from it. The parties enter into this agreement intending to honour its content and spirit.

This agreement is one which is subject to S.7 of the NHS (Wales) Act 2006.

The parties agree that they shall act:

- in the spirit of good faith
- in the interests of minimising costs to themselves
- in the interests of maintaining quality at all times
- in accordance with any applicable statute, directions, orders, guidance or policy.

4 Duration of this agreement

This agreement commences on 1 April 2021 and will run for a period of two years until 31 March 2023.

5 Monitoring and review of this agreement

The Director of the National Imaging Academy Wales will liaise regularly with the Cwm Taf Morgannwg University Health Board, Deputy Chief Executive, to monitor the operation of this agreement and to address and resolve any practical issues that may emerge.

5.1 Six monthly formal review meetings

The Chief Executive, Cwm Taf Morgannwg University Health Board and the Director of the National Imaging Academy Wales (or nominated deputies) will meet six monthly to discuss current/live issues, the NIAW's progress on establishing governance arrangements with the NHS, and any particular issues relating to hosting arrangements. They will also include early discussions on possible changes or additions to the NIAW's role and remit.

5.2 Review meetings

The named points of contact (section 2) will meet at least 6 monthly to discuss hosting arrangements and any particular areas of concern. These meetings will include discussion of:

- matters relating to workforce, finance, procurement, facilities and any other corporate support services (note IT requirements will be met via a separate agreement with NWIS)
- possible changes to the NIAW's remit and any other matter which is likely to impact on the corporate support provided by Cwm Taf Morgannwg University Health Board.
- financial performance and any variance against budget, in particular potential over or underspends.

The NIAW will provide a short written report before each quarterly meeting confirming compliance with policies and procedures (e.g. statutory and mandatory training compliance), highlighting any areas of non-compliance.

5.3 Audit Committee

The Director of the National Imaging Academy Wales will attend the Cwm Taf Morgannwg University Health Board Audit Committee at least annually,

or as requested by the Audit Committee, to provide assurance to the Committee that the NIAW is complying with the Hosting Agreement and to highlight and discuss any areas of risk or non-compliance.

5.4 Annual Assurance Statement

The National Imaging Academy Wales will provide an Annual Assurance Statement to Cwm Taf Morgannwg University Health Board, to confirm that they have complied with the hosting arrangements, highlighting any areas of concern, risk or non-compliance. This statement will inform Cwm Taf Morgannwg University Health Board's Annual Governance Statement.

5.5 Review

The agreement will be reviewed in the fourth quarter of each year by all parties to ensure that it is operating effectively and amendments will be agreed as required.

6 Termination and notice period

The parties acknowledge that if one of the signatories to this document withdraws or otherwise terminates its responsibilities this agreement will terminate twelve months after that event and a new agreement will be drafted and agreed by all the parties that wish to continue to engage with each other in respect of NIAW.

7 Background

In 2016, NHS Wales Chief Executives confirmed their intention to establish an NHS Wales National Imaging Academy Wales to primarily increase the number of Radiology trainees in NHS Wales (with increased classroom training within a dedicated and appropriately equipped facility, significantly enhancing the training capacity, with an economy of scale for required trainer time).

In April 2017 Cwm Taf Morgannwg University Health Board was formally requested to host the National Imaging Academy Wales and its Director and staff. This request was formally accepted by the Cwm Taf Morgannwg University Health Board on 7 July 2017, subject to confirming hosting arrangements via the hosting agreement.

Phillip Wardle was appointed as Director of the National Imaging Academy Wales on 1st November 2018.

8 Nature of the hosting arrangement

Cwm Taf Morgannwg University Health Board, will provide services and facilities as agreed with Health Boards and NHS Trusts under this hosting agreement, to enable the smooth running of the National Imaging Academy Wales, but will not be responsible or accountable for setting the direction of the NIAW or for the quality of the work undertaken by the NIAW. This rests with the Director of the National Imaging Academy Wales reporting directly through the NHS Wales CEO Lead for Imaging to the Collaborative Executive Group and Collaborative Leadership Forum.

9 Appointment of the Director of the National Imaging Academy Wales

The Director of the National Imaging Academy Wales and the Academy staff are employed by Cwm Taf Morgannwg University Health Board, but the Director will be appointed by the Chief Executive of the Host Body (on behalf of NHS Boards and Trusts) on recommendation and appropriate scrutiny through interview led by the Chief Executive Lead for NHS Wales NHS Wales CEO Lead for Imaging, who are also responsible for ensuring continuity of leadership for NIAW.

10 Financial arrangements

10.1 Setting of and responsibility for the National Imaging Academy Wales budget

Whilst complying with Cwm Taf Morgannwg University Health Board's Standing Orders and Standing Financial Instructions (see below), the Director of the National Imaging Academy Wales will be accountable through the Host Body Chief Executive to the Collaborative Executive Group.

The Director of the National Imaging Academy Wales will have an authorisation limit of £100,000 (equivalent to an Executive Director of Cwm Taf Morgannwg University Health Board) and will specify an appropriate scheme of delegation for the management of the NIAW's budget. Expenditure over £100,000 will need authorisation from the Chief Executive / Deputy Chief Executive, Cwm Taf Morgannwg University Health Board (following discussion with the Director of the NIAW and the Lead Chief Executive for Imaging).

Cwm Taf Morgannwg University Health Board will provide the National Imaging Academy Wales with monthly financial budget/expenditure reports. The NIAW will be responsible for checking the accuracy of these reports and for reporting and explaining any variance of expenditure against budget profile.

The initial recurring core budget, and contribution shares, for the NIAW were agreed by all parties in 2017/18.

Recurring and non-recurring changes to the NIAW's core budget will be agreed between the Director of the National Imaging Academy Wales and the Collaborative Leadership Forum. Such changes may include in-year recurring or non-recurring uplifts contributed by health boards and trusts to cover agreed additional activities.

10.2 Additional funding

In addition to its core budget, the National Imaging Academy Wales may receive additional recurring or non-recurring income from individual NHS Wales bodies or from other sources, for specific work undertaken.

The NIAW will inform Cwm Taf Morgannwg University Health Board of all arrangements for additional funding, and the terms under which the funding is being provided. Any external funding from industry partners must be compliant with any related host body Policies.

Any additional capital funding required for the initial project, on-going maintenance and developments, will need to be provided from within the partner organisations' discretionary capital allocations or if significant, be presented via a joint capital bid to the Welsh Government.

10.3 Financial variances

The Director of the National Imaging Academy Wales must achieve a break-even position each financial year. The Director of the National Imaging Academy Wales is responsible for informing the Lead Chief Executive for imaging and the Cwm Taf Morgannwg University Health Board Chief Executive, at the earliest practicable stage, of any significant forecast variances and, in particular, of risks that may result in the underwriting provisions described in section 11.4 below being required.

In the event that there is a predicted under or overspend against the budget for the NIAW in any year, the parties to this agreement shall consider:

- in the case of an under spend, whether there are any alternative uses to which the funds can be put consistent with the role of the NIAW, or whether funds should be returned to contributing bodies

- in the case of an over spend, what steps can be taken to prevent the overspend arising
- any liability that exists as a result of any overspend will be shared on a joint and several basis between the parties signed to this agreement on an agreed risk sharing basis.

10.4 Financial liabilities

Cwm Taf Morgannwg University Health Board shall be the responsible legal entity in relation to liabilities to third parties, save where excepted in this agreement.

The activities of the NIAW will be covered by the Welsh Risk Pool, via Cwm Taf Morgannwg University Health Board, but will be subject to the normal excess arrangements.

The NHS Wales Chief Executives will collectively underwrite the financial liabilities of the NIAW (on agreed risk sharing basis), where such liabilities cannot be met from within the NIAW's budget or are not covered by the Welsh Risk Pool. This includes any costs associated with redundancy, termination or breaches of employment contract, disputes and health and safety matters.

10.5 Levy to cover the costs of hosting the National Imaging Academy Wales

Cwm Taf Morgannwg University Health Board will charge a levy to cover the **additional** costs of hosting the NIAW (above those costs incurred by Cwm Taf Morgannwg University Health Board prior to the establishment of the National Imaging Academy Wales).

On the establishment of the NIAW, an agreed annual recurring revenue requirement of £82,000 will be provided to Cwm Taf Morgannwg University Health Board, to cover its 'core' hosting costs.

This levy will need to be reviewed and adjusted upwards on confirmation of any additional support required by the National Imaging Academy Wales from the host body.

The hosting levy will be reviewed each year, as part of the overall review of this agreement (see section 6.5) and any additional 'core' hosting costs would need to be managed within the overall agreed NIAW revenue allocation.

With the exception of the agreed levy to cover the hosting costs and any agreed costs arising from issues detailed in sections 11.1 and 11.2, no deductions will be made from the National Imaging Academy Wales's budget

by Cwm Taf Morgannwg University Health Board and Cwm Taf Morgannwg University Health Board's Cost Reduction Programme / savings targets will not be applied.

Cwm Taf Morgannwg University Health Board will not fund or be liable for any National Imaging Academy Wales cost pressures, which must be funded within the agreed NIAW budget.

11 Obligations of Cwm Taf Morgannwg University Health Board under this agreement

11.1 General obligations of Cwm Taf Health Board

Cwm Taf Morgannwg University Health Board shall be responsible for providing services and facilities to enable the smooth running of the National Imaging Academy Wales.

In general, unless otherwise specified, these services and facilities will be equivalent to those provided to teams and services directly managed by Cwm Taf Morgannwg University Health Board. NIAW staff are expected to comply with Cwm Taf Morgannwg University Health Board's policies and procedures.

The services and facilities covered by this agreement may be provided directly by Cwm Taf Morgannwg University Health Board or may be procured from third party providers, including, but not limited to the NHS Wales Shared Services Partnership and the NHS Wales Informatics Service (NWIS).

In hosting the National Imaging Academy Wales, Cwm Taf Morgannwg University Health Board shall not be required to in any way act outside its statutory powers, duties, Standing Orders, Standing Financial Instructions or governance and legal obligations.

The NIAW undertakes to indemnify Cwm Taf Morgannwg University Health Board for any liability, losses, costs, expenses and claims that might arise in relation to the management of financial resources and the risk when discharging its duties and it will hold Cwm Taf Morgannwg University Health Board harmless in respect of any claims made by any third party arising out of the operations of the NIA. The management of any such claim will be undertaken by Cwm Taf Morgannwg University Health Board, in liaison with the National Imaging Academy Wales. However, any such claims that arise as a result of Cwm Taf Morgannwg University Health Board not meeting its hosting duties (as detailed in this Agreement), then Cwm Taf Morgannwg University Health Board would be held accountable and manage the claim.

Cwm Taf Morgannwg University Health Board will not be responsible for the validity, efficacy or approval of the National Imaging Academy Wales's budget or other plans and the NIAW will in fulfilling its obligations not place Cwm Taf Morgannwg University Health Board in a position whereby it breaches any Statute, Regulation, Standing Order, Direction, Measure or any other corporate governance requirement.

Specific services and facilities to be provided are set out below:

- Access to some Committees of the Cwm Taf Health Board as appropriate, in order to discharge elements of the Academy's governance arrangements. These include:
- Quality, Safety & Risk Management – Reporting via the Cwm Taf Quality, Safety & Risk Committee.
- Audit & Assurance – Reporting periodically to the Cwm Taf Audit Committee
- Remuneration & Terms of Services Committee (RATS)
- IR(Me)R and other Imaging Governance – Reporting via Radiation Safety Committee including Ultrasound Governance.
- Clinical/Corporate Business Meeting(s) – 6 monthly reviews, including oversight of delivery of hosting agreement

As well as the following:-

- Governance advice and support
- Information Governance, managing overseeing any related Data Subject Access; Freedom of Information requests and related training
- Workplace health & Safety advice & support, including incident reporting and access to Datix
- Limited ad-hoc occasional communications/media support/advice.

11.2 Workforce

Cwm Taf Morgannwg University Health Board will act as the appointing and employing body for all directly employed and existing seconded staff of the National Imaging Academy Wales, including the Director. The following services will be provided to the National Imaging Academy Wales:

- Payroll services (for employed staff), including processing of expenses claims etc.
- Recruitment and selection support (including provision of selection/assessment tools)
- General human resources advice, with first line advice being provided by a named HR point of contact
- Access to occupational health services
- Access to and support of the Electronic Staff Record system
- Access to statutory and mandatory training

Any financial liabilities resulting from the direct employment of staff of the National Imaging Academy Wales (e.g. costs associated with advertising, redundancy, termination or breaches of employment, disputes and health and safety matters) will be met from the core budget agreed for the NIA.

In the event that the core budget has insufficient funds to meet or cover the liability, NHS Wales Chief Executives (and not Cwm Taf Morgannwg University Health Board) will collectively underwrite the financial liabilities of the NIAW (on an agreed fair shares basis).

11.3 Finance and procurement

The National Imaging Academy Wales's budget will be included within the Cwm Taf Morgannwg University Health Board ledger and the Director and any other NIAW budget holders will be provided with an income and expenditure account and the following on the same basis as provided to Cwm Taf Morgannwg University Health Board budget holders:

- Specified budget codes for the sole use of the NIAW
- Budget holder reports and information
- Management accountancy support and advice, with first line advice being provided by a named member of the finance team
- Payment of invoices
- Internal and external audit
- Access to procurement advice and support
- Appropriate access to the Oracle finance/procurement system

Cwm Taf Morgannwg University Health Board will act as the legal entity which enters into contracts and related agreements for goods and services procured on behalf of the National Imaging Academy Wales.

11.4 Accommodation

The National Imaging Academy Wales's core recurring budget includes provision for accommodation. The NIAW will occupy premises procured as part of the business case, agreed with NHS Wales Chief Executives and Welsh Government. The maintenance and running costs of premises will be funded from within the NIA's core budget.

Cwm Taf UHB as host will own & maintain the Academy Building on behalf of NHS Wales. A separate recharge over and above the hosting fee will be charged for buildings maintenance and Facilities management, as per the agreed business case.

11.5 Information Technology

The National Imaging Academy Wales will develop a Service Level Agreement (SLA) direct with the NHS Wales Informatics Services (NWIS) to provide the following:

- network infrastructure
- file servers for document storage
- the NHS Wales network and internet
- desktop IT support
- access to mobile services (which may be charged for separately on an 'at cost' basis)
- procurement of new and replacement IT equipment
- hosting of the NIA's internet and/or intranet sites and technical support in relation to their ongoing maintenance and development

11.6 Other corporate support services

Cwm Taf Morgannwg University Health Board will provide the NIAW with access to various services / support when required. At times there may be a requirement to charge additional costs over and above the core hosting fee for items or levels of support that are not covered within the above arrangements.
This will either be based on the time spent on the activity, or if external advice is required then that will be recharged to the Academy.

This may include, but is not limited to the following:-

a. Strategic and planning support, including help with development of business plans, etc.
b. Finance support for Business case development (both revenue and capital)
c. Additional HR support/advice above the basic core level outlined above, including any costs associated with redundancy, termination or breaches of employment contract;
d. Welsh language / translation services
e. Legal Assistance (this will be provided by NWSSP and recharged)
f. Internal and external audit fees, for audit & assurance purposes
g. A lease car scheme for staff meeting eligibility criteria
h. All aspects of any additional UHB based IT support, as this is all being provided directly by NWIS to the Academy, through a separate Service Level Agreement

12 Reporting

Hosting reporting shall be undertaken as follows:

12.1 Responsible Officer

The Responsible Officer will be the Director of the National Imaging Academy Wales and this person will report to the Chief Executive at Cwm Taf Morgannwg University Health Board.

12.2 Accountable Officer

The Accountable Officer will be the Chief Executive of Cwm Taf Morgannwg University Health Board, who will liaise closely with the lead NHS Wales Chief Executive for Imaging.

12.3 Variation

No variation to the Agreement will be valid unless made in accordance with the Change Control Procedure found at Annex A.

13 Obligations of the National Imaging Academy Wales under this agreement

The National Imaging Academy Wales will comply with Cwm Taf Morgannwg University Health Board's:

- Standing Orders
- Standing Financial Instructions
- All policies and procedures where they are applicable to the activities of the NIAW as a hosted body (e.g. Health and Safety, workforce etc.)

The Director of the National Imaging Academy Wales will have overall responsibility for the appointment of NIAW staff, whilst acting within Cwm Taf Morgannwg University Health Board's recruitment policies. Other than the provision of HR advice and selection tools, or as specifically requested by the NIA, Cwm Taf Morgannwg University Health Board will have no role in the appointment of staff.

The Director of the NIAW will be responsible for ensuring that all NIAW staff undertake applicable statutory and mandatory training, which will be made available by Cwm Taf Morgannwg University Health Board. With the exception of statutory and mandatory training, the responsibility for the organisation and funding of the training and development of NIAW staff will rest with the National Imaging Academy Wales.

The Director of the NIAW is responsible for the management of risk within the National Imaging Academy Wales and its activities. The NIAW will follow Cwm Taf Morgannwg University Health Board's risk management framework

guidance and will monitor and maintain a risk register for the NIAW on the Cwm Taf Morgannwg University Health Board Datix system. Any potential risks which could impact on the business and safety of Cwm Taf Morgannwg University Health Board will be escalated to the Chief Executive and Director with responsibility for Risk in Cwm Taf Morgannwg University Health Board. The Director of the National Imaging Academy Wales will also ensure that the Chief Executives are apprised of any high risks and the arrangements for providing assurance regarding their management.

Cwm Taf Morgannwg University Health Board can request access to the NIA's risk register as required, to inform and provide assurance that the overall governance arrangements of Cwm Taf Morgannwg University Health Board are being maintained.

The Director of the National Imaging Academy Wales will be responsible for ensuring any additional pieces of work taken on by the NIA, including expansion in workforce and budget are to be discussed and agreed with Cwm Taf Morgannwg University Health Board.

14 Intellectual property

Unless otherwise agreed (see below) all intellectual property developed or legitimately acquired by the National Imaging Academy Wales, shall be owned collectively by the NHS Wales health boards and trusts.

If the intellectual property is to be exploited in any way then terms will be agreed between all the parties in this respect.

In some circumstances, the NIAW may (through Cwm Taf Morgannwg University Health Board) enter into agreements (such as joint working agreements with industry partners) where specific conditions relating to the ownership and exploitation of intellectual property may apply.

15 Data Protection and Freedom of Information

For the purposes of data protection and freedom of information, all data and information held by the National Imaging Academy Wales will be deemed to be held by Cwm Taf Morgannwg University Health Board. As a result, any requests for information under relevant Acts will be processed according to Cwm Taf Morgannwg University Health Board's procedures. However, the Director of the NIAW will be informed as soon as possible of any relevant requests received and discussion will take place with the Director before any of the National Imaging Academy Wales's information is released to a third party. The Director of the NIAW will be responsible for sharing relevant requests, and responses provided, with health boards and trusts.

The NIAW may enter into data sharing agreements with health boards and trusts to facilitate the carrying out of its functions. As the host body, Cwm Taf Morgannwg University Health Board will need to be a signatory to such agreements and must be satisfied with their content.

16 Disputes and matters not covered by this agreement

It is inevitable that issues will arise that are not explicitly covered by this agreement. In such cases, and in the event of any disputes, all parties will seek to address these issues and identify appropriate solutions in the common interest of NHS Wales and the public served.

If any party has any issues, concerns or complaints about Hosting, or any matter in this Hosting Agreement, that party shall notify the other parties and the parties shall then seek to resolve the issue by a process of consultation. If the issue cannot be resolved within a reasonable period of time, the matter shall be escalated to the Accountable Officer and the Responsible Officer, who shall decide on the appropriate course of action to take. If the matter cannot be resolved by the Accountable Officer and the Responsible Officer within 21 days, the matter may be escalated to the Welsh Government in accordance with the NHS (Wales) Act 2006.

If any party receives any formal inquiry, complaint, claim or threat of action from a third party (including, but not limited to, claims made by a supplier or requests for information made under the Freedom of Information Act 2000) in relation to Hosting, the matter shall be promptly referred to the Accountable Officer and Responsible Officer (or their nominated representatives). No action shall be taken in response to any such inquiry, complaint, claim or action, to the extent that such response would adversely affect Hosting, without the prior approval of them (or their nominated representatives).

17 Governing law and jurisdiction

This Agreement shall be governed by and construed in accordance with the laws of England and Wales and, without affecting the escalation procedure set out in section 17, each party agrees to submit to the exclusive jurisdiction of the courts of England and Wales.

Annex A

Annex A – Change Control Procedure

1. Changes may be proposed by any party to the Responsible Officer who will then discuss them with the Accountable Officer.
2. The Changes may be agreed or rejected by both of those individuals.
3. All parties will be notified of the decision and any resulting change will be recorded in writing and annexed to this agreement.
4. Any dispute regarding the proposed changes will be dealt with by the escalation procedure except in that different officers of each body will deal with the dispute.

Date of change	**Section No.**

Summary Minutes

Private Quality, Safety & Performance Committee

Velindre University NHS Trust

Date: 12th May 2022
Time: 12:45-13:15
Location: Microsoft Teams
Chair: Mrs Vicky Morris, Independent Member

ATTENDANCE		
Vicky Morris	Independent Member and Quality, Safety & Performance Committee Chair	VM
Stephen Harries	Vice Chair and Independent Member	SH
Hilary Jones	Independent Member	HJ
Prof. Donna Mead OBE	Velindre University NHS Trust Chair	DM
Steve Ham	Chief Executive Officer	SH
Matthew Bunce	Executive Director of Finance	MB
Carl James	Director of Strategic Transformation, Planning & Digital	CJ
Nicola Williams	Executive Director of Nursing, Allied Health Professionals and Health Science *(in part)*	NW
Lauren Fear	Director of Corporate Governance and Chief of Staff	LF
Dr Jacinta Abraham	Executive Medical Director	JA
Nigel Downes	Interim Deputy Director of Nursing, Quality & Patient Experience	ND
Peter Richardson	Head of Quality Assurance and Regulatory Compliance, Welsh Blood Service	PR
Emma Stephens	Head of Corporate Governance	ES

1.0.0	**STANDARD BUSINESS**	
1.1.0	**Apologies:** • Rachel Hennessy, Interim Director of Velindre Cancer Service • Cath O'Brien, Chief Operating Officer • Sarah Morley, Director of Organisational Development & Workforce • Alan Prosser, Director of Welsh Blood Service	
1.2.0	**In Attendance:** • Ian Bevan, Head of Information Governance *(for item 3.1.0)*	
1.3.0	**Declarations of Interest** Led by Vicky Morris, Quality, Safety & Performance Committee Chair	

	No declarations of interest were raised.	
1.4.0	**Review of Action Log** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science 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** (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 24th March 2022** Led by Vicky Morris, Quality, Safety & Performance Committee Chair The Committee **REVIEWED** and **APPROVED** the minutes of the meeting held on the 24th March 2022 as an accurate reflection of proceedings.	
2.2.0	**ITEMS FOR NOTING**	
2.2.1	**Cyber Security – Compliance Update** Led by David Mason-Hawes, Head of Digital Delivery A comprehensive Cyber Security Compliance update was received on the current position in respect of the following two items, with key points highlighted: ***(1) Trust Compliance against the National Cyber Security Centre (NCSC) Framework (self-assessment)*** The report outlined Trust compliance against the 10 steps to Cyber Security as stipulated in the NCSC Framework. A 4.6% increase in overall compliance had been evidenced since September 2021, currently standing at 87.6%. There are no vulnerabilities presented to the Trust and improvements are anticipated over the course of the year; a comprehensive annual report will be received at the September 2022 Quality, Safety & Performance Committee.	

	(2) Outcome of the Trust's Cyber Assessment Framework review by the Cyber Resilience Unit (CRU) (independent external assessment) During October/November 2021, an external review was undertaken with the Cyber Resilience Unit to assess Trust compliance against the Networks and Information Systems Regulations, reporting 70% compliance with 4 overarching objectives. All recommendations will be incorporated into the Trust's Cyber Security Strategic Delivery Plan and further progress of work will be facilitated by the appointment of a new Chief Digital Officer. The Committee **NOTED** the contents of the Cyber Security Strategic Improvement Plan Progress Report and Cyber Assessment Framework Summary Report.	
3.0.0	**MAIN AGENDA**	
3.1.0	**Offsite Records Storage Incident *(Datix Ref: 4411)*** Led by Matthew Bunce, Executive Finance Director, supported by Ian Bevan, Head of Information Governance The Offsite Records Storage Incident paper was received and discussed at length. The paper provided an update on the offsite records storage incident which occurred during February 2022 as a result of serious flooding of one of the storage facilities used by the Trust for records storage. 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, managed via weekly incident management meetings. The subsequent phase of work will involve the transfer of all remaining records to a new storage provider in addition to an exercise to determine the content of the records involved and whether records which are older than the legally required retention period can be destroyed. The Committee **DISCUSSED** and **NOTED** the update report relating to the Offsite Records Storage Incident which took place on 20th February 2022.	
4.0.0	**Analysis of meeting outputs** 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: • **For Escalation** • **For Advising** • **For Assurance** • **For Information**	
6.0.0	**ANY OTHER BUSINESS**	
	Led by Vicky Morris, Quality, Safety & Performance Committee Chair 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 14th July 2022 via Microsoft Teams.**	
CLOSE		

QUALITY, SAFETY & PERFORMANCE COMMITTEE

Professional Nursing Update

DATE OF MEETING	14th July 2022
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	N/A
PREPARED BY	Anna Harries Senior Nurse Professional Standards and Digital
PRESENTED BY	Anna Harries Senior Nurse Professional Standards and Digital & Nigel Downes, Deputy Director Nursing, Quality & Patient Experience
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**
Professional Nursing Forum	17/06/2022	Items for inclusion agreed
Executive Management Board	01/07/2022	Noted

1. SITUATION

This paper provides the Quality, Safety & Performance Committee with a summary of key discussions at the Professional Nursing Forum meetings held between April 2022 and June 2022. The paper also includes a status update in respect of nursing led critical projects.

2. BACKGROUND

The Professional Nursing Forum Meets monthly and it is the forum at which all strategic professional nursing issues and standards are discussed and priorities determined.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The following are the key areas contained within the paper:

- Good News stories presented by all members of PNF.
- Falls Process review – key findings identified and for presentation to Senior Leadership Team.
- Reflections from International Nurses' Day 2022 and conference planning for 2023.
- Update in relation to the development of Trust wide Nursing standards and the Nursing Strategy.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Robust professional governance is a critical element
RELATED HEALTHCARE STANDARD	Effective Care
	If more than one Healthcare Standard applies please list below: **Safe Care**

EQUALITY IMPACT ASSESSMENT COMPLETED	No (Include further detail below)
	Programme specific, but not for paper reporting
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Programme specific, but not for paper reporting
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Programme specific, but not for paper reporting

5. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **NOTE** the Professional Nursing update.

EXECUTIVE DIRECTOR OF NURSING UPDATE PAPER: April - June 2021

1. PURPOSE

This paper details, for the period April-June 2022, key developments in relation to the Professional Nursing priority areas and key Professional Nursing Forum (PNF) discussion points in addition to a status update in respect of nursing led critical projects.

2. PROFESSIONAL NURSING FORUM HIGHLIGHTS

The following is a summary of the key areas of discussion / highlights / outcomes from the Professional Nursing forum between April and June 2022:

2.1 Recognition

- The Nursing Team won a number of awards at the Moondance Cancer Awards, all in the Pioneering Innovation category:

  - Innovation in Treatment – *Virtual Assessment Patient pathway* (Tej Quine, Emma Williams, Ruth Thomas, Chris Davies, Penelope Cox, Cathryn Ball, Ruth Hull)
  - Workforce – *Acute oncology ANP workforce resilience framework* (Ceri Stubbs, Rachel James, Emily Richards, Ailsa Hayes, Lauren Sheppard, Rhonda Power, Melissa Davies, Jolene Williams, Rhoswen McKnight)

- CNO Excellence Award presented by Sue Tranka to Rachel James, Advanced Nurse Practitioner on International Nursing Day for the outstanding work she has been leading on to improve the care of patients in particular in relation to Acute Kidney Injury.

2.2 Falls Audit

An independent audit has been undertaken by the Senior Nurse, Professional Standards & Digital in respect of falls prevention management within the First Floor Ward at Velindre Cancer Centre. The audit has been reported back to falls scrutiny panel and the Professional Nursing Forum and will be also presented to the Senior Leadership Team (SLT). The key matters to note from this audit are:

- There have been significant operational and process improvements within the falls scrutiny processes and staff have been recognised for this.
- Falls investigation Datix accuracy is being scrutinised at each scrutiny panel.
- Inpatient fall Policy needs to be finalised and approved.
- Patient enhanced supervision (those requiring 1-1 care) protocol has been developed.

- Each meeting and any opportunity open, honest and candid practice championed.
- Overall there was reasonable assurance in relation to the falls prevention arrangements in place on First Floor Ward with a small number of improvement areas identified. All recommendations have been accepted and their implementation will be monitored through VCC Quality Group.

2.3 Trust Nursing Standards

Standards play a critical role in a successful organisation and of robust assurance mechanisms. In addition it is an inherent part of 'knowing what good looks like' as described in the Duty of Quality. The Professional Nursing Forum had recognised that whilst developing its nursing assurance framework it was critically important to clearly define its high level nursing standards. The standards were determined in line with NMC and other professional standards as well as through national benchmarking.

Once these are agreed the next steps will be to determine how these will be measured and what assurance mechanisms are required. A Professional Nursing Time Out was held on the 27th June 2022 where the draft nursing standards (covering registered and non-registered nursing staff) were agreed for consultation. These will be consulted on between 1st July 2022 and 31st July 2022. The draft standards that are being consulted on are (in no particular order):

- Maintain NMC professional registration and revalidation.
- To be fully informed and comply with all aspects of NMC/HCSW code and Trust values to uphold the reputation of the profession and the Trust at all times.
- To be responsible for maintaining compliance with clinical skills, professional development and training required to safely and competently fulfil your role.
- To deliver excellent evidence based, kind, safe and effective care whilst working within the limits of your competence and capability.
- To establish what is important to our patients and donors in order to plan and deliver individualised care.
- Be open and candid, including with patients and donors, about all aspects of care and treatment, including when any mistakes or harm may have taken place.
- To demonstrate continued improvement in care delivery through reflection and learning.
- To work collaboratively with colleagues to prioritise safety and to deliver harm-free care, challenging any practice or behaviours to ensure the best possible outcomes for patients and donors.
- To create an environment that is inclusive, without fear of discrimination, and where all forms of discrimination are challenged.

WBS and VCC are considering if there are any division wide nursing standards that are required in addition to these by having discussions with their senior nursing teams.

Following this, work will be undertaken with directorates and teams to define specific nursing standards in relation to these areas and subsequently the assurance measures that will assess how standards are being implemented. These will then be translated into the Tendable electronic nurse audit tool.

2.4 Trust Nursing Strategy Development

The development of the Trust's 5-year nursing strategy is well underway. The strategy is being developed using a full collaborative approach with registered and non-registered staff across all parts of the Trust with the strategy development team going into clinical teams and actively engaging with all members.

- ***Stage 1*** has been completed (initial grass roots engagement to determine strategy themes / priorities). There was very high levels of engagement from nursing staff (registered and non-registered) from across all areas of the Trust. The four themes are:
    - To deliver excellent patient / donor care and provide kind, safe, and effective care.
    - To develop and support nurses across the Trust and improve wellbeing and support staff retention.
    - To maximise research and innovation opportunities across the Trust to deliver excellent evidence based care.
    - To improve listening to people and learning from feedback to continually improve our services.
- ***Stage 2*** the agreed themes have been the basis for discussions across the Trust with visits to The Cancer Centre and collections teams. These visits were undertaken between 20th June and 27th June 2022.

4. DIGITAL UPDATE

4.1 Welsh Nursing Care Record (WNCR) update – This has been fully adopted across VCC in line with national roll out requirements. Not all nursing assessments have been transferred onto the WNCR therefore staff are continuing to use both paper and WNCR.

4.2 CIVICA (Electronic Feedback system) – A Showcase event was held at the end April 2022; this is included in a separate paper presented at board with a demonstration by Anna Harries (Senior Nurse for Professional Standards and Digital). Roll out needs to commence in WBS.

4.3 An update of ***Tendable (previously called Perfect Ward***) - A very successful showcase event was held on the 9th June 2022. The event facilitated showcasing those areas that have advanced with the audit tool and allowed wider areas to learn and consider the direction of implementation. Roll out needs to commence within WBS.

QUALITY, SAFETY & PERFORMANCE COMMITTEE	
DATIX PROJECT BOARD HIGHLIGHT REPORT	
Date of meeting	14th July 2022
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Non-applicable
Prepared by	Sharon Wilson, Datix Support Manager
PRESENTED BY	Nigel Downes, Deputy Director Nursing, Quality & Patient Experience
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, Allied Healthcare Professionals, & Health Science

REPORT PURPOSE	FOR NOTING	
Committee/Group who have received or considered this paper prior to this meeting		
Committee or Group	DATE	OUTCOME
• Datix Extraordinary Project Board Meeting • Datix Project Board	19/06/2022 22/06/2022	AGREED ITEMS FOR HIGHLIGHT REPORT
Executive Management Board	01/07/2022	NOTED

ACRONYMS	
DHCW	Digital Health & Care Wales
OFW	Once for Wales Programme
VCC	Velindre Cancer Centre
WBS	Welsh Blood Service
OFW	Once for Wales Concerns Management Team

1. SITUATION

This paper has been prepared for the Quality, Safety & Performance Committee to:

- Provide a summary of the key developments reported at the Datix Project Board meeting held on the 30th May 2022;
- Provide details of any exceptions in relation to the Datix project plan;
- Provide an update on the Once for Wales (OfW) Project;
- Provide an update on the DatixWeb Version 12 Archive/Risk Transfer Project.

The Quality, Safety & Performance Committee is asked to **NOTE** the progress and exceptions against the Datix project plan, update on the Datix Web Version 12 Archive project and the current status of implementation of the OfW Programme.

2. BACKGROUND

The Datix Project Board is chaired by the Executive Director of Nursing, Allied Health Professionals and Health Scientists, and is attended by key members within the Quality and Safety Teams at the Velindre Cancer Centre (VCC), the Welsh Blood Service (WBS), NHS Wales Shared Services Partnership, and the Trust's Corporate Quality and Safety Team. In addition a key member of the OfW project team is in attendance.

The Project Board oversees the Datix upgrade project and the implementation of the National Once for Wales Programme at the Trust. The Trust migrated to this system on the 17th May 2021 and is continuing to work with the Once for Wales Project Team regarding the phased implementation of further modules, in addition to system refinements.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Datix Version 12 Archiving

The Velindre DatixWeb V12 has been traditionally held on an on-premises server, which is at the end of life and was decommissioned in June 2022. The Executive Management Board approved that, instead of a replacement on-premises server, it would be hosted on a cloud-based platform, operated by the software provider-RLDatix. To relocate the DatixWeb V12 software onto a cloud-based platform, there was a requirement to upgrade the current software to V14 DatixWeb. The work to undertake the transition and validate the former DatixWeb V12 operational product has now been completed and ensures full read-only access to all legacy files. This

archive version for distinction is referred to as V12/14 archive. Due to the delay in WBS migrating over and to facilitate transition of risks held on the legacy system, arrangements have been made for a very small number of users within the WBS to have extended access to the legacy risk module in Read/Write mode for the period 1st June 2022 to 31st March 2023, at an agreed additional cost for the extended contract.

It is important to note that the hosting of this legacy system is separate to the DatixWeb V14 system, which remains live and on a different on-prem server. The DatixWeb V14 cannot, at present, be archived as it is likely to be being used for at least a further year, until the "Risk module" has been fully implemented and therefore this will be currently hosted on a Trust server.

3.2 Transfer of Risks from Datix Version 12 to Version 14

Due to the decommissioning of DatixWeb V12 and transition into V12/14 archive, there is a pressing need to ensure that all the remaining risks on V12/14 archive are transferred to DatixWeb V14. All Trusts risks have been transferred, with the exception of WBS who estimate they will complete this transfer by the end of September 2022.

The original date for transfer of legacy risks within WBS from V12/14 archive to DatixWeb V14 was 31st May 2022. However, due to several pre-requisites of the transfer not being available, there was a delay which necessitated the extension of the contract with RLDatix, as outlined above in section 3.1. The migration onto V12/14 archive resulted in WBS not having access to the electronic risk system for some time. An investigation of the circumstances that led to this has been commenced, which is being led by the Deputy Director of Nursing, Quality & Patient Experience, which is to be concluded by the end of July 2022.

Once WBS validation of the hosted system is complete, WBS will arrange for the migration of risks from V12/14 archive to DatixWeb V14. A target date of the end of September 2022 has been set for completion of this work. The expectation is for WBS to use DatixWeb V14 as the live system for managing risk from 1st July 2022, which is in line with the issue of the new Risk policy and procedure and subsequent staff training.

The Datix Project Board will continue to have monthly oversight of all aspects of the decommissioning/archive system and migration of data.

3.3 Once for Wales implementation

3.3.1 Current Position

The Trust has been live since May 2021 on the Wales Datix system for the Incident, Complaint, Compliment, Claim, and Redress modules with all new cases being reported and managed in the Once for Wales system. The Once for Wales system has been described by staff as being “intuitive” to use, and no significant problems have been reported or experienced.

The new Mortality Module is available in the system and a project group within Velindre Cancer Centre (VCC) is ongoing to implement the new All Wales Mortality Framework within VCC. This Framework will utilise the Datix module as a support tool. Meetings have been taking place, on a monthly basis since October 2021, which scope the use of the module to support the Mortality review process within VCC and deliver the project plan in conjunction with the All Wales Mortality Review Framework Working Group and Mortality Workstream.

Access to the legacy system DatixWeb V14 has been restricted to prevent further input of new Incidents and Complaints into this area of the system. However, access continues to be provided for a small cohort of staff, to allow for existing Incident and Complaint records to be available for reporting purposes.

In line with the output from various module workstreams, development of OFW is ongoing and the latest enhancements to the system will be released in July 2022 in line with the upgrade cycle timelines.

3.3.2 Issues Highlighted:

- **Service and Location Limiting Combo Linking:** Divisions have reported issues whereby staff can inadvertently choose locations and services within the OFW Datix system that are outside of their Division, once these are submitted into the system the appropriate notifications to managers are not being activated and there is the risk that Incidents may not be picked up and actioned or investigated. There is a defect under investigation by RLDatix, with no current fix available. To overcome this issue staff education has been ongoing to ensure staff are aware of the available reporting requirements and further guides have been made available. The OFW team and Trust Datix Team are investigating the ability to link the levels in the system and introduce specification parameters to help alleviate this issue. The situation is ongoing and will be monitored via the Datix Project Board.

3.3.3 Future Once for Wales Modules

The following modules are planned to 'go live' at the following time points:

- ***Safeguarding Module***: Will be piloted in Hywel Dda UHB in July 2022. A general release date will be determined once the results of the pilot have been reviewed.
- ***Risk Module***: Is currently being developed by the All Wales Risk Workstream, which has representation from VCC and WBS to ensure consideration is being given to the specific requirements of the Trust. The pilot version of the module is scheduled for release in September 2022 and subsequent roll out across Wales in 2023.
- ***Safety Alerts Module***: Proposed date for release of end of July 2022. Development work on this module remains underway by RLDatix and the OFW team together with testing by the Wales Delivery Unit. A staged approach to the roll out with follow initially within the Delivery Unit and then expanded to all other organisations across Wales.
- ***Investigations Module***: No specific release date agreed. Development work on this module remains underway by RLDatix and the OFW team.

The Datix Project Board is currently planning for the above. There is not anticipated to be any significant issues relating to the implementation of any of the above modules.

3.4 Datix 2022/23 Audit Plan

Monthly audits of the Datix system, regarding compliance with the closure of incidents within the required 30-day timeframe, continues and is reported to the OFW Datix Project Board.

An All Wales audit plan is currently being scoped and developed by All Wales Local Service Leads Group. The focus will be on auditing the usage of the Datix system, and compliance with the agreed national key performance indicators. An All Wales task and finish group will develop this area of work.

4 IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The DATIX project will improve the reporting and management of concerns and risks across the Trust and will support the on-going development of the Trust safety culture.
RELATED HEALTHCARE STANDARD	Safe Care

	The management of concerns will support the provision of safe care for patients and donors.
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
	Concerns considered to have an impact on equality will be identified during the review of each concern.
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.
	There is a requirement to fund the agreed extension to access for the Datix V12 system.

5 RECOMMENDATION

The Quality, Safety & Performance Committee is asked to:

- **NOTE** the contents of the report and progress made against the Datix version 14 project plan for risks.
- **NOTE** the progress and implementation made with the Once for Wales system.
- **NOTE** the position regarding the legacy v12 Datix system archive plan and migration of risks.

QUALITY, SAFETY & PERFORMANCE COMMITTEE

Safe Care Together Foundational Site Visits

DATE OF MEETING	14th July 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	N/A

PREPARED BY	Nicola Williams, Executive Director Nursing, AHP & Health Science
PRESENTED BY	Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director Nursing, AHP & 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	30/05/2022	NOTED

1. SITUATION

This paper is to inform the Quality, Safety & Performance Committee of planned participation with Improvement Cymru in its programme, being delivered in conjunction with the Institute for Healthcare Improvement (IHI) aimed at enhancing delivery of safe, reliable and effective care, that focuses on locally driven and delivered outcomes by Health Boards and Trusts.

This work is part of a suite of work that the Trust is working with Improvement Cymru on in relation to its quality, safety and improvement delivery infrastructure.

The Quality, Safety & Performance Committee is requested to **NOTE** the planned work to support the Trust in enhancing its infrastructure, systems and processes to deliver safe, reliable and effective care that will include a two day IHI 2-day foundational site visit during July 2022.

2. BACKGROUND

Improvement Cymru is the improvement service for NHS Wales. Its aim is to support the creation of the best quality health and care system for Wales so that everyone has access to safe, effective and efficient care in the right place and at the right time across the whole care system. On behalf of NHS Wales, Improvement Cymru has partnered with the Institute for Healthcare Improvement (IHI) to create the Safe Care Together Collaborative with Health Boards and Trusts across Wales. Details of the approach is attached in ***Appendix 1***.

As part of their partnership with IHI and Health Boards / Trusts, Improvement Cymru is supporting patient safety improvement to spread and scale within organisations. The first stage of this is to undertake a Foundational Site Visit with each organisation to understand the current system-wide priorities, strategies and initiatives, and the quality, safety and clinical excellence capabilities. This will form part of the preliminary work to identify the areas where Improvement Cymru / IHI can support organisations through the Safe Care Together Collaborative moving forward. The overall objective of the Foundational Site Visit is to understand the Trust's current state and the gap between where we are and where we want to be and help develop the learning system to achieve that goal.

This work for the Trust is critical in respect of how we will meet the requirements in respect of the Wales Quality & Engagement Act (2020) requires the Trust to demonstrate ongoing improvement and learning.

3. ASSESSMENT

3.1 Foundational site visits

The Foundational Site Visits are informal, small group discussions where staff and patients, service users and carers, where possible, can openly share their experiences of improvement and their ideas for future improvement methods, topics and support. It's not an inspection of any kind, it's a chance for us to get to know what real life is like for the people providing and receiving care at the trust, in order for us to support the organisation to make improvements where it counts.

The Improvement Cymru and IHI team will be on site across the Trust for two days: 20th & 21st July 2022. The visits will start and end with Executive Team discussions. The visits will entail discussions on a one-to-one basis or with a group, and will take place in person. IHI want to hear and identify specific examples of relevant work/good practice, as well as opportunities for improvement.

After the Foundational Site Visit, Improvement Cymru and IHI will provide an assessment and analysis of findings as it relates to the existing culture, strategies, policies, and priorities and will identify what is needed to adopt a comprehensive and effective framework for building the cultural foundation to promote and sustain safe reliable healthcare and quality improvement. The report will not be *attributable to individuals.*

The report will be shared openly throughout the organisation, including with the Quality, Safety & Performance Committee and particularly with staff who participate in the visit.

This work also includes bringing the Chief Executive Officers from all organisations together to share a summary of the findings and identify common themes.

The findings will be used to make recommendations to propose how NHS Wales and Improvement Cymru will work together to build safe care capability, to spread and scale, across the organisation. Following this visit the Trust will be invited to identify teams who have the desire to strengthen their improvement approach and deliver safe, reliable and effective care. These teams will join a collaboration of teams from across NHS Wales on a shared learning journey, with support from Improvement Cymru and IHI to achieve sustainable and scalable results.

The Trusts visits will comprise of one day at Welsh Blood and the other within Velindre Cancer Service so that a comprehensive / holistic picture of the organisation, as far as is practically possible is gained.

3.2 Trust Co-ordination

Kyle Page, Business Support Officer and Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience will co-ordinate the visits and liaise with the Senior Management Teams to identify the teams of staff / patients / donors to meet with IHI Colleagues.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Positive impact
RELATED HEALTHCARE STANDARD	Safe Care
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Choose an item.
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 requested to **NOTE** the work the Trust is embarking on with Improvement Cymru & IHI.

Appendix 1

IHI Foundational Visits with NHS Wales in support of a national safe and reliable improvement collaborative

Name of Health Board/Trust

The Institute for Healthcare Improvement (IHI) is committed to working in partnership with Improvement Cymru to establish safe and reliable health care systems over the coming two years. In preparation for a safety collaborative that will include all health boards and trusts, IHI will facilitate a Foundational Visit with each health board and trust to understand the current system-wide priorities, strategies and initiatives, and the quality, safety and clinical excellence capabilities. The visit provides the IHI and Improvement Cymru team with an opportunity to spend time with individuals, teams and departments from across the health boards to learn about the realities, opportunities and challenges of delivering and sustaining safe and reliable health care in practice. The process provides an analysis of existing culture, strategies, policies and priorities, and identifies what is needed to adopt a comprehensive and effective framework for building capacity, capability and the cultural foundation to promote and sustain a culture of quality and safety.

Key objectives

The overall objective of the Visit is to understand your current state and the gap between where you are and where you want to be. It brings focus to the strategic direction of the organisation, including leadership, wellbeing and joy in work of staff, current assets, and any existing barriers to improvement and learning. In summary, IHI in collaboration with the health board, will:

- Provide recommendations to support your ambitions for safety to sustain and build on successes so far.
- Learn about your workforce's engagement and sense of agency in affecting improvement;
- Understand decision-making and accountability processes;
- Examine your strategic change initiatives and organisation of improvement teams;
- Discover how leadership and governance processes align with your aims; and
- Assess staff quality improvement (QI) readiness, including how they are trained and coached.

What to Expect

The visit consists of relatively informal, small group sessions where staff can share openly their experiences of safe and reliable care, improvement work and their ideas for future topics and support. Everyone should feel welcome to attend regardless of their involvement in previous improvement efforts. These sessions aim to learn about the reality and a good mix of opinions makes for a healthy conversation. It is beneficial if attendees come prepared to share their experiences of improvement at the health board as well as their ideas and suggestions for the future. The IHI team will be particularly interested to hear about what staff feel would be most valuable to them in terms of support for future improvement activities.

Our discussions will take place on a one-to-one basis or with a group, and will take place in person. We come to

these discussions with a listening ear to hear and learn more from you and identify specific examples of relevant work/good practice, as well as opportunities for improvement – all of this will support our reflections which we will share back with the leadership group for the project.

All the discussions, views and suggestions from the site visits will be taken into account as the IHI and Improvement Cymru team develop their recommendations and a report for the health board. *Reporting of what we hear will not be attributable to individuals and will respect the honest sharing of experience of the people involved in discussions.* IHI recommends that the report is shared openly throughout the organisation and particularly with staff who attend the visit.

The partnership between IHI and Improvement Cymru aims to deliver a national programme for safe reliable and effective care, adopting a focus on locally driven and delivered outcomes by health boards and trusts.
The work is designed to deliver a suite of programmes and facilitated work that will support national collaboration and cross boundary learning. Within each health board and trust, leaders and teams will build on current work and strengthen improvement capability to establish systems for highly reliable and safe care.
At organisational level an aim of this work is to achieve a locally owned and managed safety programme with the infrastructure to support a sustainable quality system.

Components for this overall scope of work:

A Safety Leadership Programme (March to June 2022)
The Safety Leadership Programme is designed to help leaders provide clarity and direction to their health board on the key strategic, clinical, and operational components involved in achieving safe and reliable operational excellence — a "system of safety".
The program, built on the IHI Framework for Safe, Reliable and Effective Care supports leaders to build the steps needed to support the journey to high reliability and operational excellence.
Delivered over 7 virtual sessions, leaders will learn for their own organisation, to establish a plan and to build a network for leaders, developing a culture of safety with a robust learning system.
This immersive program is co-developed with Improvement Cymru with the aim of building and strengthening a learning system for quality and safety in NHS Wales.

Foundational Visits with health Boards and Trusts (May to August 2022)
IHI will co-facilitate with Improvement Cymru, a Foundational Visit with each health board and trust to understand the current system-wide priorities, strategies and initiatives, and the quality, safety and clinical excellence capabilities. The visit provides the IHI and Improvement Cymru team with an opportunity to spend time with individuals, teams and departments from across the health boards to learn about the realities, opportunities and challenges of delivering and sustaining safe and reliable health care in practice and to build relationships and connections with leaders of safety and IAs within the health boards. The process provides an analysis of existing culture, strategies, policies and priorities, and identifies whatis needed to adopt a comprehensive and effective framework for building capacity, capability and the cultural foundation to promote and sustain a culture of quality and safety.

Onsite visits will be conducted over 2 days in collaboration with health boards and a summary report of findings and recommendations.

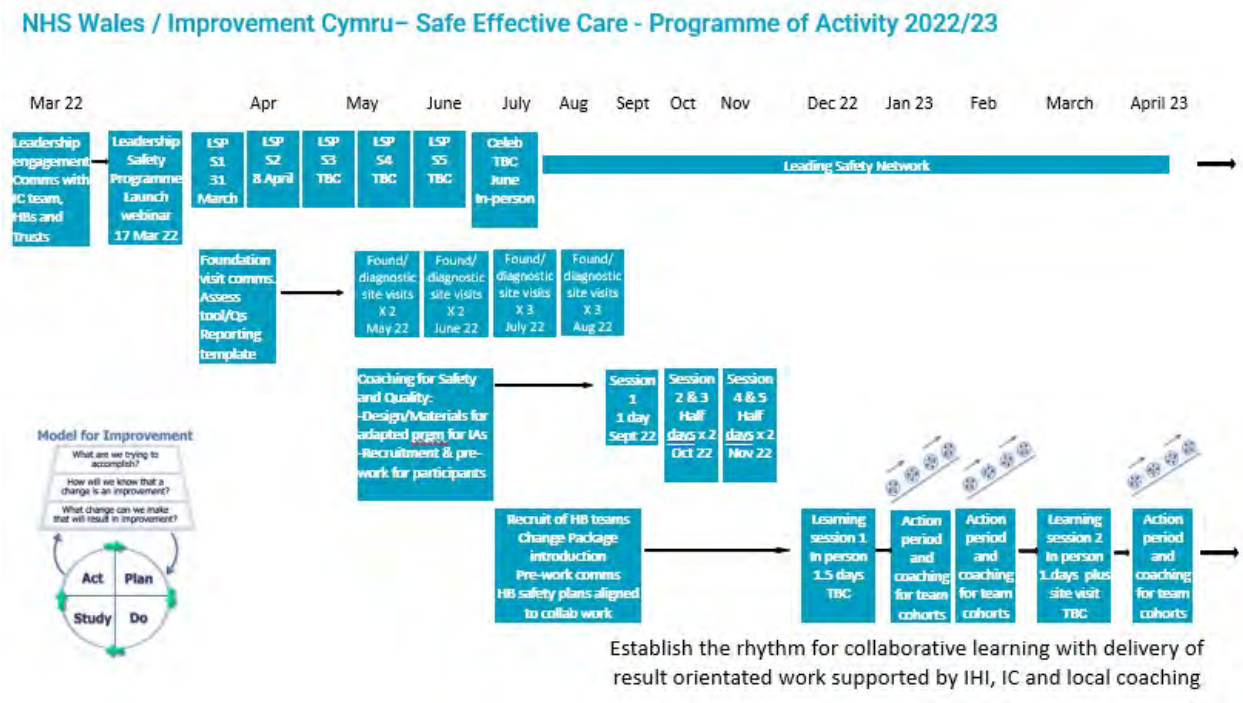
Coaching for Safety and Quality – Strengthening Expertise (September to November 2022)
Recognising the considerable pre-existing capability for improvement that exists in health boards and trusts, IHI have designed a programme for existing Improvement Advisors and Coaches who will support

the work of teams in the safety collaborative. The curriculum supports their continuous development in core tools and techniques for effective coaching of safety improvement activity and is tailored to build a strong coaching network of experts in support of the teams who will participate in the safety collaborative programme. This virtual programme consisting of 5 half day sessions will precede the commencement of the safety programme, ensuring that participants are equipped and ready to engage with local leaders and team to support the collaborative efforts.

Safety Collaborative (December 22 – February 24)

This results focused safety collaborative will be co-designed and co-delivered by IHI and Improvement Cymru, bringing together teams, coaches and executive and senior leaders for safety from across all health boards and trusts. It will align the work of the safety leadership network with teams and coaches engaged in improvement work on identified safety priorities. The collaborative will have a focus on two safety priority topics, applying well evidenced change packages to consistently and reliably deliver results in a small number of test sites in each health board and trust.

By showing what is possible through content specific prototyping and delivery of early results, preparation and planning for spread and scale up can be executed beyond the initial phase of the work. This approach will support the delivery of local leadership plans for the infrastructure to achieve a reliable system for safety and quality. It will offer in-person learning sessions, supported by expert IHI faculty, which will be hosted by different health boards, enabling shared learning from each context.



Arolygiaeth Gofal Iechyd Cymru

Healthcare Inspectorate Wales

OPERATIONAL PLAN

2022 - 2023

CONTENTS

ABOUT US

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of 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 accessing quality healthcare.

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.

OVERVIEW

Welcome to our Operational Plan for 2022 - 2023, this document sits alongside our Strategic Plan and outlines our priorities for the next year.

In our plan we will set out our programme of work for 2022 - 2023, defining our key deliverables and how they will be measured. We have set a challenging work programme for the year and, following a period in which there have been extraordinary pressures on our people, we will focus more than ever on supporting their wellbeing to enable them to provide the best possible service.

We welcome feedback, so please get in touch if you have any comments on our work or wish to feedback on healthcare services in Wales.

FOREWORD

Welcome to our Operational Plan for 2022 to 2023

This year we launched our Strategic Plan for the next three years, with the purpose of influencing and driving improvement across healthcare services in Wales.

This Operational Plan outlines our priorities and actions over 2022 - 2023 to achieve our strategy effectively and efficiently. The deliverables within this plan set out key measurables of how we will meet our actions and statutory duties. This includes a focus this year on driving and strengthening engagement, improving, and modernising our ways of working and understanding our communities better in relation to equality, diversity and inclusion. In response to the pandemic, we have continued to evolve and adapt, and this plan builds upon that work, so we can continue to provide assurance about the quality and safety of the services we regulate and inspect.

We have seen a period of significant change and this plan continues to support how we develop, to ensure we continue to monitor and check that people in Wales are receiving good quality healthcare. We have introduced many new ways of working to continue to fulfil our organisational functions, whilst being flexible to any emerging risks. People are at the heart of what we do, and it is important we strive to share lessons learnt, reflect on what has worked well and take forward this learning to continuously improve. We will continue to listen and support the wellbeing of our people to enable them and our organisation to do the best possible job and keep our communities safe and well.

We have set out a varied work programme for the year and we welcome any feedback, so please get in touch if you have any comments on our work or wish to feedback on healthcare services in Wales.

We want to deliver and drive improvements that make a real difference, and I am confident this plan will support us in doing this.

Alun Jones
Interim Chief Executive

PRIORITY 1

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

Actions

- 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.

Year 1 Deliverables	Measured By	Outcome
Establish a stakeholder advisory group with diverse and inclusive representation	• Explore, build and maintain new working relationships with stakeholders who champion equality, diversity and inclusion considering the needs of the people who use healthcare services in Wales • Continually review and consult on the diverse representation within the group • Evaluate the impact of the group to ensure we are listening and communicating their views effectively to inform our work.	Stakeholder views will have helped to shape our work programme.
Increase the range of tools we have for engaging with people about our work 	• Develop a toolkit exploring the different methods of engagement available • Improve how we establish and run focus groups • Introduce and review new and alternative engagement methods to target new audiences.	Our work will be supported by wider engagement opportunities which will increase our understanding of issues affecting a variety of people from diverse backgrounds.

Year 1 Deliverables	Measured By	Outcome
Develop a new methodology for carrying out onsite inspections of General Practices (GPs) which explores the wider primary care provision that GPs are part of in order to provide patient care	• Implementation of the new methodology framework that reflects the role of GPs within the wider primary care landscape • Roll out training on the new GP methodology for inspectors and peer reviewers • Number of GP inspections carried out using the new methodology • Obtain feedback from GP settings following inspections.	Our assurance work for GP practices will have explored the wider context within which GPs operate, providing HIW with a more holistic understanding of the primary care system and impact on patients.
Design options which enable patient pathways to be built into our inspection and assurance methodology and programme of work 	• Produce a set of strategic principles to complement a risk-based approach to planning our programme of inspection and assurance methodology work • Patient journeys are considered at the point of planning.	Our work will have given greater consideration to the care delivered to patients within different parts of the healthcare system and how this impacts on their care overall.

Year 1 Deliverables	Measured By	Outcome
Review our quality assurance process for applications for registrations	• Circulate case studies of good practice and share lessons learnt • Review the quality of applications received against the revised standards.	Our registration work will provide a source of intelligence on the quality of newly registered providers, which will mean we can undertake assurance work on new services in accordance with risk.
Deliver a programme of national and local reviews which explores the quality of care delivered to patients during their time on a pathway.	• Deliver a national review of patient flow • Commence a national review of planned care • Deliver a local review of mental health discharge in Cwm Taf Morgannwg University Health Board • Commence two other local reviews • Commence a further joint review with Audit Wales of Cwm Taf Morgannwg University Health Board, to review progress from 2019 joint report on the health board's quality governance arrangements.	Our work will have explored national issues of high risk and delivered recommendations which improve the care delivered to patients in Wales.

PRIORITY 2

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

Actions

- 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.

Year 1 Deliverables	Measured By	Outcome
Review our suite of inspection and assurance tools	• Formalise an approach to more complex offsite work • Strengthen our process for offsite assurance work • Evaluate the impact of offsite work.	Our assurance tools will enable us to be agile in the way we deploy our resources, targeting the level of risk with the appropriate assurance tools.
To actively share our findings and recommendations with stakeholders, service providers and the public to influence and drive improvements in healthcare	• Produce and establish a 'Quarterly Insight Bulletin' with a 'learning and insight' section • Develop and embed a new process within core business for the production and circulation of such learning bulletins • Review the number of bulletins issued and their engagement analytics • Development of a partnership section on the HIW external facing website to host such content.	Our findings and recommendations will have been shared regularly and promptly, helping contribute to improvements in healthcare services.
Consult and develop an Engagement Strategy to support us in our work 	• Consult with key stakeholders to obtain a wider understanding of how we can improve our engagement • Produce an initial draft of the strategy.	Our work will be supported by a better understanding of how stakeholders, service providers and the public want us to engage with them.

Year 1 Deliverables	Measured By	Outcome
Ensure all inspection and assurance processes are aligned to any changes to the Health and Care Standards	• Communicate the standards to all HIW service area leads for implementation • Revise and develop assurance methodology to ensure our work aligns with the standards.	Our work will accurately reflect the way in which healthcare services in Wales measure quality within their services.
Ensure all our processes are prepared to reflect the change from Deprivation of Liberty Safeguards (DOLS) to Liberty Protection Safeguards (LPS)	• Review and update the impact assessment for the introduction of LPS • Consider any changes to inspection tools.	Our work programme will be ready to fulfil our statutory responsibilities against the Liberty Protection Safeguards once they are introduced.
Evaluate the Service of Concern (SoC) process for the NHS and update our enforcement approach for independent healthcare services	• Evaluate how the NHS SoC process has been implemented, seeking feedback, with a view to improving it where necessary • Refresh the current enforcement and criminal investigation guidance for the independent sector • Formalise a media and communications process for SoCs in independent healthcare.	Our approach to escalation and enforcement across all healthcare services will be clearly defined and we will be able to confidently apply this to services that are not providing safe patient care.

Year 1 Deliverables	Measured By	Outcome
Continue to deliver a programme of assurance and inspection work to independent healthcare settings in line with our statutory duties and promote the findings	Deliver up to 97 inspections or quality checks to a variety of independent healthcare settings broken down further into: • Up to 9 inspections to private only dental practices (additional work to mixed NHS and private dental practices is accounted for in NHS deliverable) • Up to 45 inspections of laser services • Up to 2 Ionising Radiation Medical Exposure Regulations (IR(ME)R) inspections • Up to 10 mental health hospital inspections • Up to 6 independent hospital inspections • Up to 5 independent hospice inspections • Up to 20 independent clinic inspections • Percentage of reports published within seven weeks of each quality check • Percentage of reports published within three months and one day following each onsite inspection.	We will have checked the quality of care provided to patients at a range of independent healthcare settings across Wales, contributing to improvement in services for patients.

Year 1 Deliverables	Measured By	Outcome
Continue to deliver a programme of assurance and inspection work in the NHS to a range of settings, informed by analysis of risk and promote the findings	Deliver up to a total of 169 inspections or quality checks to a variety of NHS settings broken down further into: • Up to 27 GP inspections • Up to 95 dental inspections (two NHS, 93 to practices providing mixed private and NHS dental contracts) • Up to 5 IR(ME)R inspections • Up to 10 NHS mental health service inspections • Up to 24 NHS hospital inspections • Up to 3 community mental health team inspections • Up to 5 NHS learning disability setting inspections • Percentage of reports published within target time following each inspection and quality check.	We will have checked the quality of care provided to patients at a range of NHS healthcare settings across Wales, contributing to improvement in services for patients.

PRIORITY 3

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

Actions

- 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.

Year 1 Deliverables	Measured By	Outcomes
Consult on a new Equality, Diversity, and Inclusion Strategy	• Design a consultation process to include key stakeholders • Produce an initial draft of the strategy for circulation • Develop an equality impact assessment toolkit and subsequent training.	Our work will have been shaped by our increased understanding of equality, diversity and inclusion within our work.
Undertake a gap analysis with independent healthcare providers to obtain a wider understanding of their preferred communication methods	• Circulate a survey for providers to 'have their say' on preferred communications methods • Produce a report following the survey to review the best methods of engagement • Identify and evaluate any new suggested methods	Our understanding of what independent healthcare providers need to hear from us will be shaped by what they have told us.
Develop the Independent Healthcare area of the external facing website 	• Increase the information available for Independent Healthcare services and create a bespoke area on HIW's external facing website.	Prospective and existing independent healthcare providers will have easier access to information which will help them to provide safe, effective services. 

Year 1 Deliverables	Measured By	Outcomes
Develop a healthcare summit to address emerging issues and priorities	• Evaluate HIW activity and the impact following each summit.	Our work will be shaped by strong partnership working which will provide us with a greater understanding of risks and issues in healthcare services across Wales.
Invest in the development of our peer and patient experience reviewers to continue developing their skills	• Host a series of development sessions • The number of sessions held • Review completed competency assessment forms • Circulate a feedback questionnaire at the end of year to obtain an assessment of the value the sessions • Introduce a section in the Quarterly Insight Bulletin for developing peer and patient experience reviewers.	Our work will be supported by peer and patient experience reviewers who are up to date and engaged with our work.
 Embed a new governance mechanism for further joint working with key stakeholders	• Review the alignment of our inspection and assurance work plans to collaborate better with key stakeholders • Consolidation of the key findings and emerging themes from our joint work and consider how these can inform our future work programmes.	Our impact on healthcare services will be supported by increased partnership working, providing a more holistic view of the issues facing patients.

Year 1 Deliverables	Measured By	Outcomes
Maximise the value of HIW's bespoke data management system known as 'Pwls' through further training	• Develop and implement a training plan for existing and new staff • Review of the quality of data inputted into the system • Feedback from staff on the effectiveness of Pwls • Review how we use data drawn from Pwls to inform our work.	Our staff will be better able to access up to date information about healthcare settings, contained all in one location so that we work more efficiently.
Continue to deliver a service which provides a responsive approach to handling concerns brought to us by members of the public and stakeholders. 	• Evaluate themes and trends of concerns received to inform our work programme • Analyse the outcome of each concern, reviewing the time scale and actions taken.	We will provide a robust process to handling concerns received which will enable us to deal with issues efficiently and effectively.

PRIORITY 4

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

Actions

- 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.

Year 1 Deliverables	Measured By	Outcomes
To review the scope and role of our People Forum to ensure it contributes most effectively to the needs of our staff and the organisation	• Consult and plan an internal relaunch plan for the forum • Hold an all-staff conference and analyse subsequent feedback forms	Our staff will be involved in shaping the ongoing development of the organisation through an established forum into which they can directly feed their experiences and insight.
To further embed HIW's quality strategy into the organisation	• Review HIW output against the quality strategy's aims and objectives organisation • Review structure of organisation to assist in the implementation of the quality strategy • Allocate specific resources to ensure the strategy is delivered effectively	Our work will be challenged and improved through implementation of a continuous quality improvement approach.
Develop a learning and development plan for the year to support staff and the organisation to develop 	• Deliver a regular programme of training and development opportunities for staff • The number of training sessions delivered • Review training feedback forms.	Through a culture of growth and learning our staff will have been given opportunities to develop, this will drive improvements within our own work.

RESOURCING

In line with other public sector organisations, we expect to experience budgetary pressures in the coming years. For 2022 - 2023 we have a budget of approximately £4.3m. This will enable us to continue the delivery of core activity, including work following-up on previous recommendations and the ability to respond to emerging intelligence.

We have posts equivalent to 83 full-time staff as well as a panel of over 200 specialist peer reviewers. We also have specialists in Mental Health Act Administration and a panel of psychiatrists who provide our second opinion appointed doctor (SOAD) service. We have 35 Patient Experience Reviewers and Experts by Experience who work with us on inspections to capture the views of patients.

Team	Posts
Senior Executive	3
Inspection, Regulation and Concerns	39
Partnerships, Intelligence and Methodology	14
Strategy Policy and Engagement	5
Clinical advice (including SOAD service)	4
Corporate Services (including business support)	18
Total	83

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QUALITY, SAFETY & PERFORMANCE COMMITTEE

PUBLIC RESEARCH, DEVELOPMENT & INNOVATION SUB-COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	14/07/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Sarah Townsend, Head of Research & Development
PRESENTED BY	Professor Andrew Westwell, Chair of the Research, Development & Innovation Sub-Committee
EXECUTIVE SPONSOR APPROVED	Dr. Jacinta Abraham, Executive Medical Director

REPORT PURPOSE	FOR NOTING

ACRONYMS	
RD&I	Research, Development and Innovation
QSP	Quality, Safety and Performance Committee

1. PURPOSE

This paper has been prepared to provide the Quality, Safety and Performance Committee with details of the key issues and items considered by the **Public** Meeting of the Research, Development and Innovation Sub-Committee on the 07/04/2022.

Key highlights from the meeting are reported in Section 2.

The Quality, Safety and Performance Committee is requested to **NOTE** the contents of the report and actions being taken.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for **ALERT** or **ESCALATION** to the Quality, Safety & Performance Committee.
ADVISE	• **ASSOCIATE MEDICAL DIRECTOR FOR RESEARCH DEVELOPMENT & INNOVATION** Expressions of interest were sought from individuals to apply for the role of Associate Medical Director with responsibility for Research, Development and Innovation in January 2022. Dr Robert Jones was successful and has taken up the role of Associate Medical Director for RD&I.
ASSURE	• ***MEMORY MATES – BRINGING NURSING RESEARCH TO LIFE*** The Sub-Committee received a presentation on *Memory Mates* and a short animation film from Michele Pengelley, Supportive Care Lead. 'Memory Mates' is the product of an exciting, six-year collaborative partnership between VCC and Cardiff University, the original research dated back to 2015 and it's comprised of a hardworking group of people who are really dedicated to improve the care and support of cancer patients who are experiencing the memory problem. Following the research, data and launch of the Memory Mates, a toolkit of resources was developed, which also include training VCC staff to help support patients with memory problems safely through their cancer treatment. The Memory Mate toolkit includes: • A three-minute animation to run on Velindre social media and on patient information screens throughout the Cancer Centre raising awareness of memory problems in treatment, normalising and signposting to help • A checklist for staff to help recognise a patient with a memory problem.

- An information booklet for patients and carers with techniques and tools to aid memory and help manage through cancer treatments and to seek help, for example, a personalised medicine reminder.
- English and Welsh versions of all resources are available.

The Sub-Committee welcomed learning firsthand more about the toolkit and how this had been an extremely positive experience in what was one of the most difficult and challenging periods of their life.

The Sub-Committee commended the ongoing commitment of staff and the excellent work they are undertaking.

- **TRUST RESEARCH, DEVELOPMENT AND INNOVATION PERFORMANCE REPORT 2021/2022**

The Sub-Committee received the first integrated annual Trust Research, Development & Innovation Performance Report for the Financial Year 2021-22.

This included information on the Trust's national and global achievements and compliance against HCRW key performance indicators, including the following :

Trust
- Enabling research
- Research portfolio
- Finance
- Velindre Futures Cancer RD&I Ambitions
- Nursing and Interdisciplinary Research
- Innovation
- Health and Care standards

Welsh Blood Service
- Key highlights and achievements

Velindre Cancer Centre
- Key highlights and achievements

Operational plan 2020/21 to 2021/22

	The RD&I Sub-Committee recognised the excellent work being undertaken Corporately and within the Divisions of the Trust. However, there were some concerns raised about the balance of reporting and content across both divisions. It was suggested that a Task and Finish Group be established to further discuss and agree structure, content and ways of reporting for discussion at the next RD&I Sub-Committee.
INFORM	• **EXECUTIVE SUMMARY HIGHLIGHTS** The Sub-Committee received a presentation by Dr Jacinta Abraham, Executive Medical Director on key activities relating to Research, Development and Innovation taking place during quarter 4 of the financial year 2021/22. The following key highlights were reported : ➢ The State of Health and Care Research in Wales ➢ UK Portfolio Recovery Task & Finish Group ➢ GMC – Promoting Research for all doctors ➢ Trust Integrated Medium-Term Plan 2022 to 2025 ➢ Associate Medical Director for RD&I ➢ Welsh Blood Service • **WALES CANCER RESEARCH STRATEGY (CReSt)** The Sub-Committee received a presentation by Professor Mererid Evans, Velindre Futures Director and WCRC Director on the Wales Cancer Research Strategy (CReSt). The Strategy had previously been presented to numerous stakeholders; Wales Cancer Network Board, CReSt Board, Chief Medical Officer for Wales, Clinical Reference Group and Wales AHP & Nurse Board. Following today's presentation to the RD&I Sub-Committee, it will be presented to Trust Board for information. This document first sets out some key principles which have underpinned the development of the proposed way forward, and the process through which it has been produced. It provides a summary of the current state of cancer research in Wales, and some of the key issues which need to be tackled. It also describes a number of research

	themes or areas where there is (or could be) a critical mass of research capacity and capability in Wales (*Draft).* The presentation was well received by the Sub-Committee and Professor Evans stated that hopefully the Strategy will be launched in June 2022.
APPENDICES	**NOT APPLICABLE**

3. RECOMMENDATION

The Quality, Safety and Performance Committee are asked to **NOTE** the key deliberations and highlights from the **Public** Meeting of the Research, Development & Innovation Sub-Committee held on the 07/04/2022.

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Highlight report from the Chair of the Trust Estates Assurance Group

DATE OF MEETING	14/07/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Jason Hoskins, Assistant Director of Estates, Environment and Capital Development
PRESENTED BY	Jason Hoskins, Assistant Director of Estates, Environment and Capital Development
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning and Digital

REPORT PURPOSE	FOR NOTING

ACRONYMS	
VCC	Velindre Cancer Centre
WBS	Welsh Blood Service
NWIS	NHS Wales Informatics Service
CSTF	Core Skills Training Framework
NWSSP	NHS Wales Shared Services Partnership
HTW	Health Technology Wales
HSE	Health and Safety Executive
RIDDOR	Reporting of Diseases and Dangerous Occurrences Regulations
nVCC	New Velindre Cancer Centre

1. PURPOSE

1.1 This paper had been prepared to provide the Quality, Safety and Performance Committee with details of the key issues considered by the Trust Estates Assurance Group at its most recent meeting.

1.2 The Trust Estates Assurance Group provides an overview of divisional meetings for Health and Safety, Fire Safety, Environment and Statutory Compliance and as such, this report provides an overview of the Trust position.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	**Health and Safety and Fire Safety Training** Mandatory Training levels are below the required standards in a number of areas. An action plan was put in place to address the situation with an initial focus on increasing the number of training places/locations given the changes in some of the provider's contracts. Further focus is now being placed on supporting staff to take up the training places with a target of December 2022 to achieve compliance. The ability to achieve compliance by the target date of December 2022 is challenging given the continuing service pressures and increased levels of sickness absence. Further discussions are planned with operational/support Directors to identify a final plan/trajectory for compliance. **Environmental / Sustainability** Utility costs remain high due to market pressures. This is being closely monitored and reported working with NWSSP and Health Board colleagues to review costs. **Estates and Statutory Compliance** Nil to escalate.
ADVISE	**Health and Safety** Training remains a challenge although a strategy has been developed to create mixed modes of training through outsourced SLA with Cardiff & Vale University Health Board, and a 'train the trainer' in-house approach is being adopted to make it a sustainable solution. The Education & Development department are working very closely with the Health and Safety Team to ensure all managers are aware of available training. There remains an issue with staff being booked onto courses but the situation is improving. Courses are being run June, July and August 2022 to increase levels of compliance. An asbestos personal injury claim has been received from a former employee. The trust is currently compiling related documentation in order to provide a response. Assistance from the Trust specialist Asbestos Consultant sought to support.

	WBS are currently transferring risks from Datix v12 to Datix 14. New Trust Risk Assessment Policy circulated to senior management for comment. PMF reporting finalized for review. **Fire Safety** A review of current fire safety training strategy is underway in conjunction with Trust Training and Education Team. A paper has been written for consideration by the Trust Education Steering group at its next meeting. A flexible approach to training continues to be taken to support departmental requirements. A review of Emergency Evacuation strategy(ies) across Trust is underway supported by the Fire Safety Manager. The new Key Performance Indicators for the revised Performance Management Framework have been finalised and will be routinely reported to various forums for management and assurance. **Environmental / Sustainability** The Trust Sustainability Strategy was signed off by the Trust Board in May 2022. The new key performance indicators for the revised Performance Management Framework have been finalised and will be routinely reported to various forums for management and assurance. The Trust Decarbonisation Action Plan has been signed off by EMB and has been submitted to NWSSP and Welsh Government. The Arts in Health presentation was delivered to the Trust Board and the Value Add Sponsorship Group with further discussions regarding leadership roles and funding to be finalised over the coming months. A funding strategy is being developed to support the prioritised delivery of the sustainability strategy. **Estates and Statutory Compliance** Point of Use Outlets & Legionella Risk Assessments were undertaken at VCC in October 2021 and we have now received all low, medium and high/urgent defects registers. An action plan to address any defects is developed and will be shared with the Water Safety Group for advice and delivery.

	The Water Safety Policy has been refreshed and an actions plan developed and actively implemented regarding Ventilation Verifications. Funding available through the annual Estates Discretionary Capex. Electrical Safety Actions are in the process of being addressed action plan in place for monitoring and close out purposes.
ASSURE	**<u>Health and Safety</u>** HSG audits have commenced at VCC in support of driving a Health and Safety culture and supporting departments to reach the desired standard. A new Training Needs Assessment (TNA) will be issued for Health and Safety and Fire training to the organisation September 2022 to improve the identification and planning for delivery of training needs across the Trust. Agile working – compliance with HSE DSE working from home guidance – issue being addressed by Agile Working Group. Hybrid Working Principles to be agreed by EMB. **<u>Fire Safety</u>** Fire risk assessments are up to date and a new cycle of review will begin following the completion and submission of the annual fire audit [2021-22] in May 2022. All actions are being monitored through the relevant divisional forums with upward reporting to the Trust Health, Safety and Fire Management Group. **<u>Environmental / Sustainability</u>** Sustainability Strategy Launch and implementation over the next quarter. Decarbonisation Plan implementation over the next quarter. A Travel Plan Launch & Implementation has commenced and will conclude by September 2022. ISO14001:2015 Tender review underway to appoint the ISO accredited auditor to support the Trust over the next term. Environmental Compliance is currently at 80.66%. **<u>Estates and Statutory Compliance</u>** Funding has been approved to appoint key positions within the Estates team to support focus on compliance and to aid transition and management of nVCC. Roles identified have been approved through the scrutiny and job matching process and are being advertised.

	PPM and reactive compliance have improved over the course of the quarter with focus being given to this area, and the appointment of an Estates Officer supporting rectification and active monitoring of the system. VCC Compliance is at 87% WBS and HQ Compliance is 85% A four-year programme of works is being compiled and costed (rough order costs) to support financial planning and the transition to nVCC. The focus will be IP&C, H&S and statutory compliance, with elements of value add. This will be complete by November 2022. The Water Safety Audit has highlighted significant progress in this area.
INFORM	**Health and Safety** Development of a Trust-wide Health and Safety Induction underway. Roll out of paperwork to support the Control of Contactors Policy and CDM. Risk assessment training to be rolled out. Development of a Health and Safety risk assessment procedure to support the implementation of the Risk Management Framework policy. **Fire Safety** Continuation with Fire Safety Improvement & Development plan(s) across Trust. **Environmental / Sustainability** Introduced food waste into all staff kitchens across VCC, figures being managed at operational level and reported to SLT. Successful competition ran and picked up by national Sustainability Partnerships and promoted via their social media, newsletter and website. Staff attended European Health Conference which highlighted world leading schemes on how to embed sustainability in health care and understanding how to address the climate crisis. Various Communications undertaken including: - No Mow May - Weekly updates on the biodiversity benefits - Trust HQ Upgrades - Sustainability Day for Action Communications - Travel Plan Launch

	Estates and Statutory Compliance Asset collection is being mapped against industry standard systems HTM/SFG20 to support automation of reporting underpinning PMF data. All aspects of the Capital Scheme have been tendered with all appointments made, there will be significant progress made over the next quarter with all schemes scheduled to be closed out by November.
APPENDICES	**NOT APPLICABLE**

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

VELINDRE UNIVERSITY NHS TRUST
POLICY MANAGEMENT REVIEW AND COMPLIANCE
STATUS: JULY 2022

DATE OF MEETING	14/07/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable

PREPARED BY	Lenisha Wright, Business Support Officer Kay Barrow, Corporate Governance Manager 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	01/07/2022	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 third tranche of work undertaken on the policy management and review programme in the June to July 2022 Governance reporting cycle. This programme of work forms 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 **24/06/2022,** included at ***Appendices 1 to 8***.

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 A total of **157** Trust wide policies were included in the assessment 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 The first and second tranche of the review, reported through the March and May 2022 Governance reporting cycle 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.

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.

2.5 *Policy Status:* In the assessing and the recording of the Policy Status, Table 1 below has been used to capture the 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 scrutiny and assurance.

Table 1: Policy Status Key

POLICY STATUS KEY:
Policy in date
Policy review date passed – action underway/required
All Wales Policy review date passed – awaiting national review
Policies Archived

2.6 *Policy Risk Assessment:* Each policy passed its review date a Policy Risk Assessment has been undertaken to assess any risks associated with policies with review dates that have passed, and the associated actions required to address this. Table 2 below captures the outcome of this assessment.

Table 2: Policy Risk Assessment Key

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

2.7 *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 8***. Ongoing updates and progress will be captured and recorded in the Document Control Register and will 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. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Policy Compliance Status

A risk-based phased approach has been adopted for the Policy Compliance Audit. The first tranche of work concentrated on an overall review of the Trust wide policies that fall within the remit of the Quality, Safety and Performance Committee and was reported in March 2022.

The second tranche of work assessed the status of policies passed their review dates and engagement with policy leads. Whilst the first tranche audit excluded Workforce and OD Policies due to the volume held, these policies were included as part of the second tranche of this work. The outcome of the second tranche audit was reported in May 2022.

With regards to the Quality, Safety and Performance Committee, the third tranche of work has primarily focussed on monitoring the progress made on the policy review status, consultation and approval of policies that have passed their review date that fall within the remit of the Committee.

There is an ongoing review and follow up of 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/departments:

- Quality and Safety
- Infection, Prevention and Control
- Health and Safety
- Estates, Planning and Performance
- Information Governance
- Digital Services
- Corporate Communications
- Workforce and Organisational Development

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, with progress and updates in May 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 8*****,** and a more detailed overview is provided below under section **3.1.1 'Collaborative Engagement'**.

3.1.1 Collaborative Engagement Exercise

As indicated earlier, following an assessment of the policies currently held on record, continuous collaborative engagement was undertaken with each of the respective policy leads. Table 3 details the Policy Leads for each Directorate:

Table 3: Directorate Policy Leads

Directorates	Policy Lead(s)
Quality and Safety	Quality & Safety Manager, Claims Manager, Chief Pharmacist, Quality & Safety Facilitator, Senior Nurse Safeguarding & Public Protection, Head of Radiation Protection Services, Interim Deputy Director of Nursing, Quality & Patient Experience
Health and Safety	Health and Safety Manager
Infection, Prevention & Control	Head of Infection Prevention and Control
Information Governance	Head of Information Governance
Digital Services	Head of Digital
Corporate Communications	Head of Information Governance
Estates, Planning & Performance	Assistant Director of Estates Fire Safety Manager
Workforce and Organisational Development	Executive Director of Organisational Development and Workforce, Head of Workforce, Equality and Diversity Manager

The purpose of the ongoing engagement exercise is to confirm and validate the following:

- Whether the versions of the policies held on file are 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 during the third tranche of this work:

- ***Quality and Safety***

In March 2022 at the start of the review, six policies **(55%)** were outside their review date. As at the end of June 2022 four policies **(36%)** are outside their review dates, refer to ***Appendix 1*** for detailed overview. The status of these four policies and the work undertaken as well as next steps is summarised in Table 4 below.

Table 4: Quality and Safety Policy Progress Update

Policy Title	Progress March – June 2022		Next Steps
	March – April	May – June	
Medical Gas Cylinders Policy	Review and update of the policy	Consultation	Q3 Submission to approving Body
Ionising Radiation Safety Policy	Review and update of the policy	Submitted to Radiation Committee for discussion and input	Q3 Consultation & submission to Approving Body
International Health Partnership Related Activity Policy	Established that policy requires rewrite	Review and update	Q3 Consultation Q4 Submission to Approving Body
Preceptorship Policy for Newly Registered Nurses and Allied Health Care Professionals	Review and update of the policy	Submission to Professional Nursing Forum	Q3 Consultation & submission to Approving Body

Currently seven Quality and Safety policies are in date with four policies undergoing review and consultation, in readiness for submission to the approving body during quarter 3 outlined above.

- ***Health and Safety***

The policy compliance status of all Health and Safety Policies remains at 100% as reported previously. All Policies on record are in date with no risk assessment required. Although all policies are in date, the Health and Safety Manager has reviewed and updated the Health, Safety and Welfare Policy to align with latest amendments in Legislation. The Executive Management Board approved the policy on 27th April 2022 prior to submission to the July meeting of the Quality, Safety and Performance Committee for approval. Refer to ***Appendix 5*** for more detail.

- ***Infection, Prevention and Control (IPC)***

In March 2022 at the start of the review, four policies **(24%)** were outside their review date. As at the end of June 2022, one policy **(6%)** is outside the review date. The status of this policy and the work undertaken as well as next steps is summarised in Table 5 below. Refer to ***Appendix 2*** for full detailed overview***.***

Table 5: Infection, Prevention and Control Policy Progress Update

Policy Title	Progress March – June 2022		Next Steps
	March – April	May – June	
Management and Control of the Environment **(Cleaning)**	Upon review, it was decided that this remains a Quality and Safety Policy but falls within the remit Operations.	The policy has been reviewed and aligned a number of times to reflect changing COVID measures.	Q3 Finalise review and consultation Q4 Submission to approving body.

The compliance rate for Infection Prevention and Control policies is currently 94% with 16 policies in date and one under review.

- ***Information Governance***

During March 2022, it was identified that four of the five Information Governance policies were outside their review date with the fifth policy passing its review date in April 2022. The newly appointed Head of Information Governance has undertaken a comprehensive review, update and consultation process. This is summarised in Table 6 below. Refer to Appendix ***Appendix 6*** for further detail.

Table 6: Information Governance Policy Progress Update

Policy Title	Progress March - June 2022		Next Steps
	March – April	May – June	
FOI Standard Operating Procedure	Upon review there was a rewrite of the procedure	Further review and updates to align with Legislation	Q3 Consultation and submission to approving body
FOI Policy	Review and update of the policy	Consultation	Submission to EMB and approving body
Records Management Policy	Review and update of the policy	Consultation	Submission to EMB and approving body
Data Protection & Confidentiality Policy	Review and update of the policy	Consultation	Submission to EMB and approving body
Confidentiality Breach Reporting Policy	Review and update of the policy	Consultation	Submission to EMB and approving body

The table above provides detail on the progress made between March to June 2022 and the next steps that will be undertaken for policies outside their review date. Four of the five policies were approved by the Executive Management Board on 1st July 2022 prior to submission to the July meeting of the Quality, Safety and Performance Committee for approval.

- ***Digital Services***

During March 2022, it was identified that four **(67%)** of the Digital Services policies were out of date. A summary of the latest position is detailed in Table 7 below.

Table 7: Digital Services Policy Progress Update

Policy Title	Progress March - June 2022		Next Steps
	March – April	May – June	
Anti-Virus Policy	• All policies were subject to rigorous review and updates • Further review to reflect latest updated Digital guidance was incorporated	Consultation was undertaken internally as well as collaborative exchange with external partners	Submission to the approving body.
Data Quality Policy			
Software Policy			
Information Asset Policy			

The Executive Management Board approved all four policies listed in Table 7 on 1st July 2022 prior to submission to the July meeting of the Quality, Safety and Performance Committee for approval. Refer to ***Appendix 3*** for further details.

- ***Corporate Communications***

The Social Media Policy is outside its review date. It has been clarified that this is an All Wales Policy with Health Education and Improvement Wales (HEIW) who will undertake the lead for the review of this policy. Refer to ***Appendix 7*** for more detail.

- ***Estates, Planning & Performance (EPP)***

At the start of the review, it was identified that nine **(60%)** of the 15 Estates, Planning and Performance policies were outside their review dates, refer to ***Appendix 4***. Table 8 below summarises the progress made between March and June 2022, and next steps.

Table 8: Estates, Planning & Performance Policy Progress Update

Policy Title	Progress March to June 2022		Next Steps
	March – May	June	
Safety and Protocol Prevention of Fire and Arson	Policy Lead assigned – Fire Safety Manager	Policy review and updates resumed	Q3 Consultation Q4 Submission to approving body
Security Policy	Engagement and discussion on remit of the policy	Decision to be taken as to whether the policy falls within Operations or Estates	Q3 Policy review and updates Q4 Consultation and submission to approving body
Protocol for dealing with suspect packages and bomb threats	Policy Lead assigned – Fire Safety Manager	Policy review and updates resumed	Q3 Consultation Q4 Submission to approving body
Environmental Policy	Policy Lead assigned –	Policy review and updates resumed	Q3 Consultation Q4 Submission to approving body
Control of Contractors	Policy Lead assigned – Fire Safety Manager	Policy review and updates resumed	Q3 Consultation Q4 Submission to approving body
Business Continuity Policy	Engagement and discussion on remit of the policy	Decision to be taken as to whether the policy sits within Operations or Estates	Q3 Consultation Q4 Submission to approving body
Waste Management Policy	Policy Lead to be assigned	Policy Lead to be assigned	Q3 Policy review and updates
Water Safety Policy	Policy Lead assigned – Estates Manager	Policy review and updates resumed	Q4 Consultation and submission to approving body
Asbestos Policy	Content and relevance of the policy reviewed	Policy Lead to be assigned	Q3 Policy review and updates

With changes in Welsh Government guidelines around COVID and the impact on the Estates function, the review of these policies has been complex. The Estates Team have engaged in discussions within and outside the Trust to support the review process to ensure the revised policies meet Welsh Government guidelines and other relevant legislation.

- ***Workforce and Organisational Development (WOD)***

The review of the Workforce and Organisational Development (WOD) policies was included in the second tranche of the work. **54** policies were identified as WOD policies. The work carried out in tranche three confirmed that seven policies are to be archived resulting in 47 policies that are now under review (see paragraph 3.1.3 for more detail on archived policies).

Of the 47 policies, 12 **(26%)** are in date and 24 **(49%)** are outside their review date. Twelve policies outside their review dates are All Wales policies, and the responsibility for review of these policies falls outside the remit of the Trust. Table 9 below summarises the progress made between May and June 2022, and next steps. Refer to ***Appendices 8a, 8b & 8c*** for more detail.

Table 9: Workforce and Organisational Development Policy Progress Update

Policy Title	**Progress March to June 2022**	
	May – June	**Next steps**
Study Leave Policy, Procedure & Guidelines	• Policy reviewed – established that significant rewrite is required • Policy lead assigned	Q3 Policy rewrite complete & taken through consultation Q4 Submission to approving body
Voluntary Early Release Scheme	Policy added to WOD tracker	Q3 Policy Lead to be assigned, reviewed and rewritten. Taken through consultation. Q4 Submission to approving body
Maternity, Paternity, Adoption and Parental Leave Policy	Policy Review Completed	Q3 Consultation and submission to approving body.
Working Time Directive Policy	Policy Review Completed	Q3 Consultation and submission to approving body.
NHS Wales Consistency of National T&C's (AFC) Band Outcome Following merger of Organisations	Discussions with NHS Wales as to whether policy is still relevant	Decision taken on relevance of policy
Recruitment of Locum Doctor Policy	• Policy reviewed – established that significant rewrite is required • Policy lead assigned	Q3 Policy rewrite complete & taken through consultation Q4 Submission to approving body

Policy Title	Progress March to June 2022	
	May – June	**Next steps**
Annual Leave and Bank Holiday Policy	• Review underway • Discussion on protocol for Medical and Dental Terms and Conditions	Q3 Finalise policy updates & taken through consultation Q4 Submission to approving body
Disciplinary Policy	*To note the review of this policy is on hold due to focus of NHS Employers on implementation of Respect and Resolution Policy as recommended by Welsh Government.*	
PADR Policy	Policy review underway	Q3 Finalise updates and consultation Q4 Submission to approving body
Sabbatical Leave Policy for Consultant Medical Staff	Policy review underway	Q3 Finalise updates and consultation and submission to approving body
Mental Health, Wellbeing & Stress Management Policy	Policy review underway	Q3 Finalise updates and consultation. Q4 Submission to approving body
Policy for Employing Ex-Offenders and people with a criminal record	Policy Review Completed	Q3 Consultation internally and externally Q4 Submission to approving body
Close Personal Relationships in the Work Place	Policy review underway	Q3 Finalise updates and consultation and submission to approving body
Adverse Weather Policy	Policy review underway	Q3 Finalise updates and consultation and submission to approving body
Homeworking Policy	Policy referred to agile working programme board	Further updates to be advised
Redeployment Policy (Ex OCP Redeployments)	• Review and updates completed • Decision taken to change from policy to procedure	Q3 Finalise updates and consultation and submission to approving body
Redundancy and Security of Employment Policy	• Policy reviewed – established that significant rewrite is required • Policy lead assigned	Q3 Policy rewrite complete & taken through consultation Q4 Submission to approving body

Policy Title	Progress March to June 2022	
	May – June	Next steps
Applying for Incremental Credit for Staff starting or re-joining the NHS	Completed. Change from Policy to Procedure	Q3 Finalise updates and consultation and submission to approving body
Policy on Reimbursement of Removal and Associated Expenses	Policy lead assigned	Q3 Policy Review, updates and consultation Q4 Submission to approving body
Supporting Transgender Policy	Policy lead Assigned	Q3 Policy Review, updates and consultation Q4 Submission to approving body
Equality & Diversity Policy	Review and updates completed	Q3 Consultation and submission to approving body
Dealing with Anonymous Communication Policy	Engagement and discussion between WOD and Corporate Communications	Decision to be taken on remit of policy and whether it sits with WOD or Corporate Communications
Supporting Staff who are Carers	Policy Lead to be assigned	Review and updates to resume
Capability Policy and Procedure	Velindre feedback submitted to NHS Confederation May 2022	To confirm this is an All Wales Policy

3.1.2 Policy Audit Compliance Status

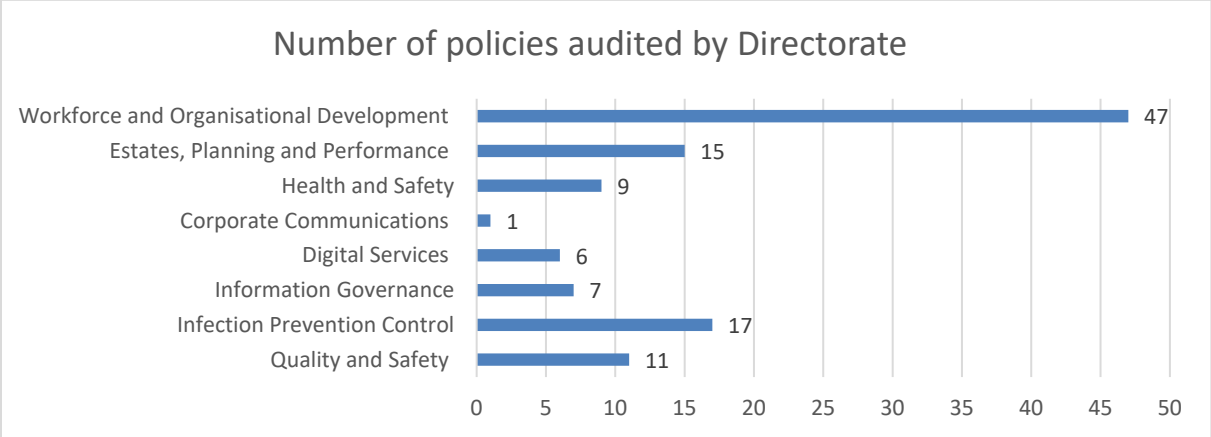
The findings of the Policy Audit Compliance Status for each of the directorates outlined above is reported below against the following categories:

- Policies reviewed by directorate
- An overview of the status of the policies
- Rationale for policies archived
- Policies passed review dates
- Policy risk assessment

- ***Number of Policies audited***

As at 24/06/2022, a total of 123 Trust wide Policies that fall within the remit of this Committee have been included in the review for ongoing monitoring and updates. A breakdown of the number of policies reviewed across each of these directorates is shown in Figure 1 below.

Figure 1: Number of Policies audited by Directorate



- ***Policy Status***

As at 24/06/2022, of the policies under review, **52 (42%)** are in date and **61 (49%)** have passed their review date. Twelve policies are classified All Wales policies, and **10** have been archived.

Table 10 below provides an overview of the overall policy status for those policies that fall within the remit of the Quality, Safety & Performance Committee

Table 10: Overall Policy Status

Policy Status	Number of Policies
Policy in date	**52**
Policy review date passed – action underway/required	**49**
All Wales Policy review date passed – awaiting national review	**12**
Policies Archived	**10**

3.1.3 Archived Policies

As part of the review process, decisions were taken to archive some policies. Table 11 below provides information on the rationale for archiving these policies.

Table 11: Rationale for Archived Policies

Policy Title	Rationale
Standard Infection Control and Transmission Based Precautions	Superseded by National IPC manual
Outbreak Management Policy	Superseded by National IPC manual

Policy Title	Rationale
Policy for the Management of Prevention and Control of Legionellosis	Superseded by Water Safety Policy (under Estates)
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 agreed by NHS employers not a policy
Procedure for Delivering Interpreter Services	This is a procedure not a Policy
Recruitment & Retention Payment Protocol	This is a managers guide not a Policy
Grievance Policy	Superseded by Respect and Resolution Policy
Childcare Voucher Policy	Policy no longer relevant due to Legislation change
Shared Parental Leave Policy	Superseded by new Maternity and Parental Leave Policy

Table 12 below provides an overview of the 123 policies audited per Directorate.

Table 12: 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
Health and Safety	9	0	0	0
Quality and Safety	7	4	0	0
Information Governance	2	5	0	0
Digital Services	1	4	1	0
Corporate Communications	0	0	1	0
Infection, Prevention & Control	15	1	1	3
Estates, Planning and Performance	6	9	0	0
Workforce and Organisational Development	12	24	11	7

4. Policies Passed their Review Dates

Table 13 below provides a summary of the number of policies passed their review dates excluding All Wales Policies.

Table 13: 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	0	0
Quality & Safety	0	1	3
Information Governance	0	0	5
Corporate Communications	0	0	0
Digital Services	0	0	4
Estates	0	0	9
Health and Safety	0	0	0
Workforce & OD	5	1	18

Note: Of the six policies with review dates between 2010 and 2016, all policies are currently under review in readiness for submission to the approving body in Q2 and Q3. It should also be noted that the above figures exclude All Wales policies that have passed their review dates and therefore fall outside of the Trust policy review programme.

5. 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. Table 14 below provides an overall breakdown of policies audited that have passed their review dates by Directorate.

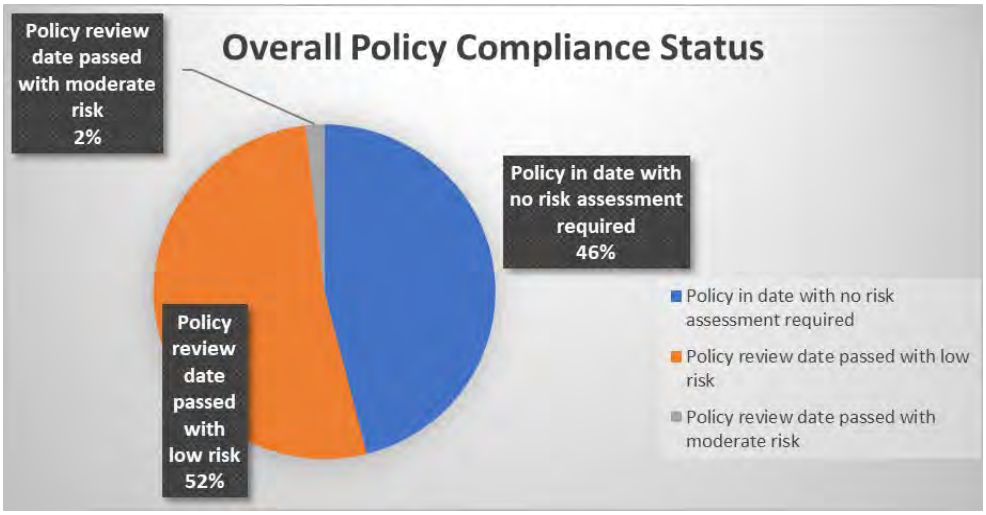
Table 14: Policy Risk Assessment

Policy Directorate	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
Health and Safety	9	0	0	0
Quality and Safety	7	4	0	0
Information Governance	2	5	0	0
Corporate Communications	0	1	0	0
Digital Services	1	5	0	0
Infection Prevention and Control	15	1	1	0
Estates, Planning & Performance	6	8	1	0
Workforce and Organisational Development	12	35	0	0

5.1.1 Overall Policy Compliance Status

Figure 2 below represents the overall compliance status of the audit work on policies as at 24/06/2022 that fall within the remit of the Quality, Safety and Performance Committee.

Figure 2: Overall Compliance



6. NEXT STEPS

In addition to the continuous review and monitoring of those policies that fall within the Quality, Safety and Performance Committee, the remainder of the audit review will continue to focus on the following in the timescales indicated:

- Charitable funds Committee remit – July to August 2022
- Audit Committee remit – August to September 2022

Following which, all Trust wide policies will have been subject to a comprehensive rigorous review as outlined above by September 2022.

7. 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.

8. RECOMMENDATIONS

8.1 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 **24/06/2022,** included at ***Appendices 1 to 8***.

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)	Is the Policy on the Internet (Yes / No)	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	No		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	No		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	Yes		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	Yes		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-23	Yes	Approved: EMB & QSP Trust Board: 26.07	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-23	Yes	Approved: EMB & QSP Trust Board: 26.07	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	Yes	Q2 Review and updates Q3 Submission to 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	No	Q2 Review and updates Q3 Submission to 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	Yes	Q2 Review and updates Q3 Submission to 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	Yes	Q2 Review and updates Q3 Submission to 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	Policy Title	Accountable Executive Lead(s)	Approving Body	Policy Review Date (3 year cycle)	Updated Policy Approval Status	Policy status	Policy Risk assessment
Infection, Prevention and Control	All Wales	Scottish Manual for IPC	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 00	Framework Policy for 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 01	Viral Gastro Enteritis (including Norovirus) Policy & Addendum	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting	Mar-25	Approved by QSP on 24.03.2022	Policy in date	Policy in date with no risk assessment required
Infection, Prevention and Control	IPC 03	ANNT IPC Policy	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 04	Decontamination Policy	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting	Mar-25	Approved by QSP on 24.03.2022	Policy in date	Policy in date with no risk assessment required
Infection, Prevention and Control	IPC 06	Policy for the Management of Occupational Exposure to Blood and High Risk Body Fluids	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 07	Meticillin Resistant Staphylococcus Aureus (MRSA)	Executive Director of Nursing, AHPs and Health Sciences	EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting	May-25	Approved Approved by QSPC 12 May	Policy in date	Policy in date with no risk assessment required
Infection, Prevention and Control	IPC 09	Sharps Safety Policy & Addendum	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	Hand Hygiene Policy	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 11	Specimen Collection, Handling and Transport Policy	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 12	Guidelines on Single Use Medical Devices	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 13	Policy for the Prevention and Control of Transmissible Spongiform	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 15	Control and Management of Multi Drug Resistant Bacteria	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	Tuberculosis Management	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	IPC 19	Infection Prevention and Control within Building Development, Change and Adaptation Policy	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 21	Infection Prevention and Control Policy for the Management of Respiratory Infections and Addendum	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 22	Management and Control of the Environment **(Cleaning)**	Chief Operations Officer	EMB - Endorsement QSP - Approval Trust Board - Policy Update Noting	May-10	Q2 Review, updates & amendments Q3 Approving Body	Policy review date passed – action underway/required	Policy review date passed with moderate risk

APPENDIX 3: DIGITAL SERVICES POLICY REGISTER

Directorate/ Department	Policy Reference	Policy Title	Accountable Executive Lead(s)	Approving Body	Policy Review Date (3 year cycle)	Updated Policy Approval Status	Policy status	Policy Risk assessment
Digital Services	All Wales	Email Use Policy	Director of Strategic Transformation, Planning & Digital	EMB - Endorsing for Trust Adoption QSP - Approval for Adoption Trust Board - Policy update report	Jun-18	N/A	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Digital Services	All Wales	Internet Use Policy	Director of Strategic Transformation, Planning & Digital	EMB - Endorsing for Trust Adoption QSP - Approval for Adoption Trust Board - Policy update report	Jan-23	N/A	Policy in date	Policy in date with no risk assessment required
Digital Services	IG 06	Anti Virus Policy	Director of Strategic Transformation, Planning & Digital	EMB - Endorsement QSP - Approval	Feb-22	Q2 Consultation Submission to Approving Body July	Policy review date passed – action underway/required	Policy review date passed with low risk
Digital Services	IG 11	Data Quality Policy	Director of Strategic Transformation, Planning & Digital	EMB - Endorsement QSP - Approval	Dec-21	Q2 Consultation Submission to Approving Body July	Policy review date passed – action underway/required	Policy review date passed with low risk
Digital Services	IG 05	Software Policy	Director of Strategic Transformation, Planning & Digital	EMB - Endorsement QSP - Approval	Feb-19	Q2 Consultation Submission to Approving Body July	Policy review date passed – action underway/required	Policy review date passed with low risk
Digital Services	IG 14	Information Asset Policy	Executive Director of Finance	EMB - Endorsement QSP - Approval	May-21	Q2 Consultation Submission to Approving Body July	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	Policy Title	Accountable Executive Lead	Approving Body	Policy Review Date (3 year cycle)	Updated Policy Approval Status	Policy status	Policy Risk assessment
Estates, Planning & Performance	PP 01	Fire Safety Policy	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 10	Medical Gas Piped Systems Policy	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	Operational Policy for High Voltage Electricity Supply Systems using a contractor as the Authorised Person (HV)	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	Operational Policy for High Voltage Electricity Supply Systems	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 13	Electrical Low Voltage Policy	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 14	Ventilation Policy	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 01a	Safety and Protocol Prevention of Fire and Arson	Director of Strategic Transformation, Planning & Digital	Quality, Safety & Performance Committee	Feb-21	Q3 Consultation & Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Estates, Planning & Performance	PP 02	Security Policy	Director of Strategic Transformation, Planning & Digital	Quality, Safety & Performance Committee	Nov-21	Q3 Consultation & Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Estates, Planning & Performance	PP 03	Environmental Policy	Director of Strategic Transformation, Planning & Digital	Quality, Safety & Performance Committee	Mar-21	Q3 Consultation & Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Estates, Planning & Performance	PP 05	Control of Contractors	Director of Strategic Transformation, Planning & Digital	Quality, Safety & Performance Committee	Nov-21	Q3 Consultation & Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Estates, Planning & Performance	PP 06	Business Continuity Policy	Chief Operating Officer	Quality, Safety & Performance Committee	Apr-21	Q3 Consultation & Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Estates, Planning & Performance	PP 07	Protocol for dealing with suspect packages and bomb threats	Director of Strategic Transformation, Planning & Digital	Quality, Safety & Performance Committee	Jul-21	Q3 Consultation & Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Estates, Planning & Performance	PP 08	Waste Management Policy	Director of Strategic Transformation, Planning & Digital	Quality, Safety & Performance Committee	Mar-21	Q2 Consultation Q3 Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Estates, Planning & Performance	PP 09	Water Safety Policy	Director of Strategic Transformation, Planning & Digital	Quality, Safety & Performance Committee	Sep-20	Q2 Consultation Q3 Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Estates, Planning & Performance	PP 04	Asbestos Policy	Director of Strategic Transformation, Planning & Digital	Quality, Safety & Performance Committee	Dec-20	Q3 Consultation & 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 6: INFORMATION GOVERNANCE POLICY REGISTER

Directorate/ Department	Policy Reference	Policy Title	Accountable Executive Lead(s)	Approving Body	Policy Review Date (3 year cycle)	Updated Policy Approval Status	Policy status	Policy Risk assessment
Imformation Governance	All Wales	Information Governance Policy	Executive Director of Finance	EMB - Endorsing for Trust Adoption QSP - Approval for Adoption Trust Board - Policy update report	Jan-23	N/A	Policy in date	Policy in date with no risk assessment required
Imformation Governance	All Wales	Information Security Policy	Executive Director of Finance	EMB - Endorsing for Trust Adoption QSP - Approval for Adoption Trust Board - Policy update report	Jan-23	N/A	Policy in date	Policy in date with no risk assessment required
Information Governance	IG 08a	FOI Standard Operating Procedure	Director Corporate Governance and Chief of Staff	EMB - Endorsement QSP - Noting	Apr-22	Q2 Consultation Q3 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Information Governance	IG 08	FOI Policy	Director Corporate Governance and Chief of Staff	EMB - Endorsement QSP - Noting	Feb-21	Q2 Consultation Submission to Approving Body July	Policy review date passed – action underway/required	Policy review date passed with low risk
Information Governance	IG 01	Records Management Policy	Executive Director of Finance	EMB - Endorsement QSP - Approval	Feb-21	Q2 Consultation Submission to Approving Body July	Policy review date passed – action underway/required	Policy review date passed with low risk
Information Governance	IG 02	Data Protection & Confidentiality Policy	Executive Director of Finance	EMB - Endorsement QSP - Approval	Feb-21	Q2 Consultation Submission to Approving Body July	Policy review date passed – action underway/required	Policy review date passed with low risk
Information Governance	IG 13	Confidentiality Breach Reporting Policy	Executive Director of Finance	EMB - Endorsement QSP - Approval	May-21	Q2 Consultation Submission to Approving Body July	Policy review date passed – action underway/required	Policy review date passed with low risk

Appendix 7: Corporate Communications

Directorate/ Department	Policy Reference	Policy Title	Accountable Executive Lead(s)	Approving Body	Policy Review Date (3 year cycle)	Updated Policy Approval Status	Policy status	Policy Risk assessment
Corporate Communications	All Wales	Social Media Policy	Director Corporate Governance and Chief of Staff	EMB - Endorsing for Trust Adoption QSP - Approval for Adoption Trust Board - Policy update report	Jan-18	N/A	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk

APPENDIX 8a: WORKFORCE AND ORGANISATIONAL DEVELOPMENT POLICY REGISTER

Directorate/ Department	Policy Reference	Policy Title	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	Dress Code and Uniform Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/02/2018	N/A	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Workforce & OD	All Wales Velindre adopted	Exit Policy & Procedure	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/06/2016	N/A	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Workforce & OD	All Wales Velindre adopted	Flexible Working Policy and Procedure	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/05/2017	N/A	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Workforce & OD	All Wales Velindre adopted	Managing Attendance at Work Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Endorsement Trust Board - Adopt	01/10/2021	N/A	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Workforce & OD	All Wales Velindre adopted	Menopause Guidance	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Endorsement Trust Board - Adopt	01/12/2021	N/A	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Workforce & OD	All Wales Velindre adopted	Organisational Change Redeployment Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/03/2020	N/A	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Workforce & OD	All Wales Velindre adopted	Pay Progression Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/09/2017	N/A	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Workforce & OD	All Wales Velindre adopted	Procedure for NHS Staff to Raise Concerns (Whistleblowing)	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Endorsement Trust Board - Adopt	01/04/2021	N/A	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Workforce & OD	All Wales Velindre adopted	Protocol on Collective Consultation of Proposed Radiance	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Endorsement Trust Board - Adopt	01/09/2017	N/A	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Workforce & OD	All Wales Velindre adopted	Special Leave Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/01/2022	N/A	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk
Workforce & OD	All Wales Velindre adopted	Upholding Professional Standards in Wales (Medical Staff Only)	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/10/2018	N/A	All Wales Policy review date passed – awaiting national review	Policy review date passed with low risk

APPENDIX 8b: WORKFORCE AND ORGANISATIONAL DEVELOPMENT POLICY REGISTER

Directorate/ Department	Policy Reference	Policy Title	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	Employment Break Scheme	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	All Wales Velindre adopted	Reserve Forces Training and Mobilisation Policy	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	Respect and Resolution Policy	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	Secondment Policy	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	GC 03	Standards of Behaviour Policy	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	GC 03	Standards of Behaviour Policy	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	Employer Pension Contritubtions Alternative Payment Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	Dates missing on front page	Currently updating & formatting policy Q3 Submission to Approving Body	Policy in date	Policy in date with no risk assessment required
Workforce & OD	WF 16	Welsh Language Policy	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	Alcohol, Drugs & Sustance Misuse Policy	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	Professional Registration Policy	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	Violence, Domestic Abuse & Sexual Violence Workplace Policy & Procedure	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	Smoke Free Policy	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 8c: WORKFORCE AND ORGANISATIONAL DEVELOPMENT POLICY REGISTER

Directorate/ Department	Policy Reference	Policy Title	Accountable Executive Lead	Approving Body	Review Due (3 year cycle)	Updated Policy Approval Status	Policy Status	Policy Risk Assessment
Workforce & OD	WF 13	Adverse Weather Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/03/2021	Under Review Q3 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 35	Annual Leave and Bank Holiday Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/03/2020	Q2: Review & updates Q3: Consultation Q4: Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 34	Applying for Incremental Credit for Staff starting or rejoining the NHS	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/06/2021	Q2: Review & updates Q3: Consultation Q3: Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	All Wales Velindre adopted	Capability Policy and Procedure	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/06/2021	Under Review Q3 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 21	Close Personal Relationships in the Work Place	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/02/2021	Under Review Q3 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 48	Dealing with Anonymous Communication Policy	Director of Corporate Governance and Chief of Staff	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/10/2021	Q2 Review & updates Q3 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 02	Disciplinary Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	31/03/2020	Review on hold NHS Employers to focus on implementation of Respect & Resolution policy	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 05	Equality & Diversity Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/09/2021	Review completed Q3 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 45	Homeworking Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/04/2021	Q2 Review & updates Q3 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 29	Maternity, Paternity, Adoption and Parental Leave Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/08/2016	Review completed Q3 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 43	Mental Health, Wellbeing & Stress Management Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/01/2021	Q2 Review & updates Q3 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 47	NHS Wales Consistency of National T&C's (AFC) Band Outcome Following merger of Organisations	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/11/2016	WOD confirming with NHS Wales whether policy still in place or should be archived	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 30	PADR Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/05/2020	Review completed Q3 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	Black 50/ WF19	Policy for Employing Ex Offenders and people with a criminal record	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/01/2021	Q2 Review and updates completed Q3 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 17	Policy on Reimbursement of Removal and Associated Expenses	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/06/2021	Under Review Q3 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 28	Recruitment of Locum Doctor Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/04/2017	Q3 Review and updates Q4 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 52	Redeployment Policy (Exc OCP Redeployments)	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/04/2021	Q2 Review & updates Q3 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 53	Redundancy and Security of Employment Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/04/2021	Q3 Review and updates Q4 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 31	Sabbatical Leave Policy for Consultant Medical Staff	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/01/2021	Q2 Review & updates Q3 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	Black 38/ WF12	Study Leave Policy, Procedure & Guidelines	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/11/2013	Q3 Review and updates Q4 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 40	Supporting Staff who are Carers	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/12/2021	Q2 Review & updates Q3 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 46	Supporting Transgender Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/08/2021	Q2 Review & updates Q3 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	missing	Voluntary Early Release Scheme	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/06/2015	Q2 Review and updates completed Q3 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk
Workforce & OD	WF 44	Working Time Directive Policy	Executive Director of OD and Workforce	EMB- Endorsement LPF - Endorsement QSP - Approval Trust Board - Noting	01/10/2016	Q2 Review & updates Q3 Submission to Approving Body	Policy review date passed – action underway/required	Policy review date passed with low risk

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

DIGITAL SERVICES OPERATIONAL REPORT

DATE OF MEETING	14/07/2022

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
EMB Run	01/07/2022	Noted

ACRONYMS	
ABUHB	Aneurin Bevan University Health Board
BAU	Business As Usual
CANISC	Cancer Information System Cymru
DHCR	Digital Health & Care Record
DHCW	Digital Health & Care Wales
NIS	Networks & Information Systems Directive
PSBA	New Velindre Cancer Centre
nVCC	Public Sector Broadband Aggregation (NHS Wales network)
VCC	Velindre Cancer Centre
VUNHST	Velindre University NHS Trust
WHAIS	Welsh Histocompatibility & Immunogenetics Services
WTAIL	Welsh Transplant & Immunogenetics Laboratory

1. SITUATION/BACKGROUND

1.1 This paper has been produced to inform and update the Quality, Safety and Performance Committee of key projects/programmes of work underway for Digital Services, this includes but is not limited to:

1.1.1 Digital Delivery & Programme Update.

1.1.2 Any significant IT business continuity incidents during the period March 2022 to May 2022 inclusive.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Digital Delivery & Programme Update

The table below outlines the key digital deliverables within the Trust IMTP 2022/23 Objectives:

Action	Timeframe
Velindre Cancer Centre IMTP	
Integrated Radiotherapy Solution – digital enablement	Recruitment due to commence Q2 2022/23.
nVCC – digital enablement	Final tenders under review.
Maximise use of 'virtual consultations' (AttendAnywhere)	Awaiting confirmation of funding position. Aim to re-commence project Q3 2022/23 (post-DHCR).

Action	Timeframe
Digital Health & Care Record (Canisc Replacement)	Target go-live – November 2022 (Q3).
Radiotherapy Satellite Centre – FBC development / digital infrastructure	Digital infrastructure designs complete – FBC approved by Trust Board. Awaiting WG feedback.
Patient Treatment Helpline – review system capability / possible redevelopment	Intention to review in Q2 - Q3 2022/23.
eMedicinesManagement (ePMA)	Business case to be developed – awaiting commencement of Digital Pharmacist.
Welsh Blood Service IMTP	
Develop & Implement Donor Strategy – deploy eDRM	On hold – ePROGESA roadmap under review (see 2.1.3)
Deliver WHAIS IT system for WTAIL	PIN issue February 2022. Supplier engagement sessions – March 2022. URS in development, aim to issue for procurement in Q3 2022.
Laboratory Information Network Cymru (LINC)	Procurement completed, supporting design/build phase (tranche 2), as required.
Implementation of Foetal DNA typing	National project group established, implementation plan to be agreed.
Laboratory Modernisation Programme – digital support	Business in development.
Digital Services – Annual Plan	
Re-procurement of the Blood Establishment Computer System (ePROGESA)	Aim to establish new, 2-year agreement by 14th July 2022 – currently awaiting Board approval.

Action	Timeframe
Implement ePROGESA Delta Release	On hold – ePROGESA roadmap under review (see 2.1.3)
Implement eDRM (Donor Relationship Management)	On hold – ePROGESA roadmap under review (see 2.1.3)
Implement Transition State Labelling	On hold, pending outcome of review of ePROGESA roadmap (see 2.1.3). Deadline for completion is end of 2024.
Chemocare Version 6 Upgrade	Ongoing – aim to complete rollout by end of Q2 2022/23
Initiate Single Sign-on Pilot for Clinicians within Velindre Cancer Centre	On-hold, status to be reviewed post-DHCR.
Upgrade of VCC PSBA network infrastructure	Due to be completed 30 June 2022
Office 365 – increase adoption	New Microsoft agreement signed – due to come into effect 1 July 2022. Office 365 project to be re-established post-DHCR.
DRIS – new IT system for Radiation Protection Service	Target go-live date Q2 2022/23.
Telephony Strategic Plan	New SIP circuits deployed into WBS. Aim to deploy new SIP circuits into VCC Q2 2022/23. Service engagement on new, Trust-wide telephony arrangements to commence Q2 2022/23.

Action	Timeframe
Review of printer estate / management	Ongoing printer issues within VCC. Replacement of 'end of life' equipment ongoing. Proposal for new 'managed service' for VUNHST printing services to be presented to EMB in Q2 2022/23.

2.1.1 **Digital Health & Care Record (DHCR)**

Digital Services resources continue to be prioritised towards the delivery of the DHCR (Canisc Replacement). The go-live for this business-critical programme of work is now November 2022.

The prioritisation of this work programme has resulted in limited capacity within the Digital Services team to support some other programmes of work across the Trust.

2.1.2 **nVCC Competitive Dialogue**

The digital / 'smart' aspirations of the nVCC programme are a key aspect of the design and delivery of the new cancer centre. The digital work stream of the nVCC programme has helped ensure the ongoing competitive dialogue and review of bids has progressed to plan.

At the time of writing, the formal evaluation process of the submitted bids is underway, with the aim of formally reporting back in July 2022.

2.1.3 **System Developments**

A number of key system enhancements have taken place over recent months, summarised below:

- In April 2022 the Digital Services team completed the deployment of a **new IT system for the Welsh Infected Blood Support Scheme** (WIBSS). The system replaced the previous commercial solution, to provide a more tailored solution that better met the needs of the WIBSS team. The new system will enable WIBSS staff to better manage beneficiaries of the scheme, which supports people who have been infected with Hepatitis C and/or HIV as a result of NHS treatment with blood, blood products or tissue in Wales. The work was led by David Howells – an Application Support Analyst / Software Developer – who mentored our two 'Network75' IT Undergraduate Trainees - Ross Sullivan and Brett Kittlety – to deliver the system.

- The Digital Services finalised and confirmed its **IT and cyber security incident reports plans**, via the Quality & Safety Committee, in May 2022. Both plans have been completely refreshed, to ensure a more effective response from the Digital Services team in the event of a significant IT or cyber security incident.

- Following the completion of work to upgrade the WBS and Trust HQ network, the **upgrade of the VCC PSBA network** is scheduled to be completed on 30 June 2022. The upgrade will significantly improve network performance and overall resilience, providing faster connections and general performance of IT services that work across the VCC network, including the use of those services from home.

- A key regulatory change to enable the WBS to test for 'occult' Hepatitis B was deployed by the Digital Services team into the WBS Blood Establishment Computer System – **ePROGESA** – at the end of May 2022. The updates ensure that the WBS has the digital capability to comply with a new UK regulatory change, to test for a form of Hepatitis B which previously may have not been detected from standard testing undertaken by UK blood establishments, including the WBS.

- The VCC-based Application Services team have introduced a new digital approach to process **new user access requests** for a number of VCC IT services. The new process takes advantage of functionality available via Office365, to reduce the amount of paper being produced to support routine 'BAU' transactions and provides a more efficient, fully traceable process for managing requests to access VCC services. Once it is live, the aim is to extend this new process to DHCR, and subsequently other VCC and WBS systems, to provide a single – digital – means for raising new user requests with the Digital Services team.

As part of ongoing conversations with MAK-System in relation to the establishment of a new, 2-year agreement for their **Blood Establishment Computer System (BECS)** platform, MAK-System have advised that the sequencing of the planned development work for ePROGESA and eDRM be reviewed. More specifically, they have confirmed that the version of eDRM which we had intended to go-live with is now unsupported (a consequence of the delays to the eDRM project due to COVID-19) and the current version is not compatible with version of ePROGESA currently being run within the WBS. Following this advice, a review of the ePROGESA roadmap is ongoing – the aim is to agree the revised plan via SMT in July 2022.

As previously reported, the planned January 2022 go-live of the **Prometheus** application into the Welsh Transplantation & Immunogenetics Laboratory (WTAIL) was not successful. Following further work undertaken between the WBS, DHCW and the supplier, a revised go-live date has now been set for 16/17th July 2022.

2.1.4 **Capital Spend – 2022/2023**

Digital Services have been allocated an initial £50 to support their capital requirements in 2022/23. This figure (reduced from the usual £100k per annum) reflects the wider challenges re: availability of capital in NHS Wales in 2022/23. This reduced budget will restrict the ability of the Digital Services team to take forward its usual annual 'refresh' of IT equipment across the Trust. This will mean the use of some equipment for a longer period than is usually allowed due to lower volumes of replacement IT equipment for staff.

The team continue to explore all options to secure further funding, should those opportunities arise.

2.1.5 **ABHB Satellite Radiotherapy Site**

The Digital Services team have continued to support the design and costing of the ABUHB satellite centre, with the aim of submitting a business case to Welsh Government for funding. However, due to the 2022/23 capital position (see 2.1.4 above), this programme of work has been paused, to recommence in 2023/24.

2.2 Significant IT Business Continuity Incidents (March to May 2022 inclusive)

The following incidents took place during the period March to May 2022 inclusive (no incidents were reported in April 2022):

2.2.1 7 March 2022 – G2 digital dictation software unavailable

Due to an IT certificate expiry, no new users were able to log into the G2 dictation software from around 10:00 on the morning of 7th March 2022. The Digital Services worked with the supplier to deploy the required fix into the VCC IT system – this was completed on the evening of 8th March 2022. The fix was delayed as the supplier did not initially have remote access into the VCC network – this was resolved on the afternoon of 8th March 2022.

The issue highlighted an underlying problem with the G2 software being used in VCC, which is several versions out of date from the latest version – this can often result in issues re: support / maintenance and performance. A full upgrade and/or re-procurement of a dictation solution has been delayed due to COVID-19 and associated operational pressures. Discussions have commenced between the Digital Services and Health Records teams, to explore future options to upgrade or replace the current solution. However, the procurement activity required to support this work may need to be deferred until after completion of the DHCR programme.

2.2.2 3 May 2022 – Network Performance Issues

On the morning of Tuesday 3rd May the Digital Services team started receiving multiple calls relating to poor / slow network performance and inability to access clinical systems. Investigations took place throughout the day, until it was identified that Fuji (a commercial supplier of elements of the Radiology IT systems) were performing a large data transfer across their VCC-hosted, non-Production IT infrastructure as part of ongoing work to upgrade the VCC Radiology IT services. This work had not been agreed with the Digital Services team, who were unaware that it was due to take place. Fuji were asked to cease all data transfer activity at around 3.15pm, at which point all services were restored to normal performance.

Given the nature of the incident, as well as other similar incidents over recent months, whereby IT infrastructure work has been agreed with 3rd parties without the involvement of the Digital Services team, we are working with key areas of the service (e.g. Radiology and Medical Physics) to ensure better coordination of change activity, to ensure critical VCC IT services are not disrupted during normal working hours.

There was no patient harm or cancelled activity because of this incident; however, a number of radiotherapy treatments were cancelled because of the disruption to Radiology IT services.

2.2.3 **4 May 2022 – Telephony Outage (Loss of ISDN Telephone Lines)**

At around 11.15am the Digital Services team were notified by Operational Services that VCC telephony services were unavailable. Investigations revealed that a BT engineer working in Node Room B had accidentally disconnected an element of Virgin Media equipment that supports the VCC ISDN telephony circuit. Once reconnected, the Virgin Media equipment would not power up correctly – an engineer was called in to resolve the issue.

Full restoration of services was not completed until approx. 6pm that evening.

2.2.4 **19 May 2022 – Network Performance / Telephony Issues**

Colleagues began reporting network performance issues across multiple services at approx. 4.30pm. The Digital Services team identified that a bug within the network infrastructure, which resulted in performance issues on the servers that support the VCC Call Centre / Switchboard service. External (direct dial) telephone lines were operational for those who knew what number they required; however, outside callers were unable to reach switchboard – the usual route by which many callers contact VCC. Services were fully restored at approx. 8.30pm.

The two incidents above (4th & 19th May) both highlight fragility within the IT infrastructure that supports VCC telephony services. The Digital Services team are already in the process of drafting plans for a full-scale review of telephony services across VUNHST; however, in the immediate term there are plans replace the ageing telephony infrastructure within VCC with new SIP circuits by end of July; this will ensure improved performance and resilience, as well as a significantly reduced risk of downtime for this critical service.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Capacity within the Digital Services team to support timescales for various Trust-wide projects may delay the realisation of the benefits of those programmes of work.
RELATED HEALTHCARE STANDARD	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.
	N/A
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Work is ongoing to develop a resource plan, to enable sufficient resources to move forward at greater pace with the delivery of the Trust's digital ambitions. This includes plans to secure further investment into Digital Services and related areas to enable sufficient capacity to take forward a number of priority programmes of work.

4. RECOMMENDATION

The Quality, Safety and Performance Committee is asked to **NOTE** the contents of this report.

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

HIGHLIGHT REPORT FROM THE CHAIR OF THE TRANSFORMING CANCER SERVICES SCRUTINY SUB-COMMITTEE

DATE OF MEETING	14 July 2022
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Liane Webber, Business Support Officer
PRESENTED BY	Stephen Harries, Independent Member
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning & Digital
REPORT PURPOSE	FOR NOTING

ACRONYMS	
OBC	Outline Business Case
FBC	Full Business Case
TCS	Transforming Cancer Services
WG	Welsh Government
IRS	Integrated Radiotherapy Solution
IM	Independent Member
nVCC	New Velindre Cancer Centre
RSC	Radiotherapy Satellite Centre
TCS	Transforming Cancer Services

1. PURPOSE

1.1 This paper has been prepared to provide the Quality, Safety and Performance Committee with details of the key issues considered by the Transforming Cancer Service (TCS) Programme Scrutiny Sub-Committee at its public meeting on 19 May 2022.

1.2 This is not considered a full update on the Programme but a high-level record of the matters of business conducted by the TCS Programme Scrutiny Sub-Committee.

1.3 Key highlights from the meeting are reported in section 2.

1.4 The Committee is requested to **NOTE** the contents of the report and actions being taken.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for Alert / Escalation to the Committee.
ADVISE	**PROJECT 3A: INTEGRATED RADIOTHERAPY SOLUTION (IRS) STRATEGIC CASE** The Sub-Committee received the Integrated Radiotherapy Solution (IRS) Strategic Case. A number of points were raised in relation to the narrative in the Cover Report on how the key aspects needed to be presented in order to avoid any confusion for the reader. The Sub-Committee endorsed the Strategic Case for the IRS Full Business Case for Trust Board approval, subject to the Cover Report being amended to clearly cross reference where key details could be found in other related agenda items being presented to the Trust Board. **RADIOTHERAPY SATELLITE CENTRE (RSC) STRATEGIC CASE** The Sub-Committee received the Radiotherapy Satellite Centre (RSC) Strategic Case. A number of points were raised in relation to the narrative in the Cover Report. It was clarified that due to the commercially sensitive nature of

	the Full Business Case (FBC), the Sub-Committee was only receiving the Strategic Case in public for approval. The other four elements of the FBC were being considered in the Private Session of the Sub-Committee. It was clarified that a redacted version of all five cases will be placed on the TCS timeline of the Trust's Website for public viewing. The Sub-Committee endorsed the Strategic Case for the RSC Full Business Case for Trust Board approval, subject to the Cover Report being amended to clearly cross reference where key details could be found in other related agenda items being presented to the Trust Board.
ASSURE	There were no items to assure for the Committee.
INFORM	There were no items identified to inform the Committee
APPENDICES	NOT APPLICABLE

QUALITY, SAFETY & PERFORMANCE COMMITTEE

CIVICA UPDATE

DATE OF MEETING	14th July 2022
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Non-applicable
PREPARED BY	Anna Harries Senior Nurse Professional Standards and Digital
PRESENTED BY	Nigel Downes, Deputy Director Nursing, Quality & Patient Experience & Anna Harries Senior Nurse Professional Standards and
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, AHPs 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**
CIVICA SHOWCASE EVENT	25/04/2022	All areas covered
Executive Management Board	01/07/2022	Discussed and approach endorsed

1. SITUATION

This paper is to provide the Quality, Safety & Performance Committee with an update on the implementation of CIVICA (patient / donor electronic 'real time' feedback system) and an overview of the key outcomes and next steps from the CIVICA Showcase event held on the 25th April 2022.

2. BACKGROUND

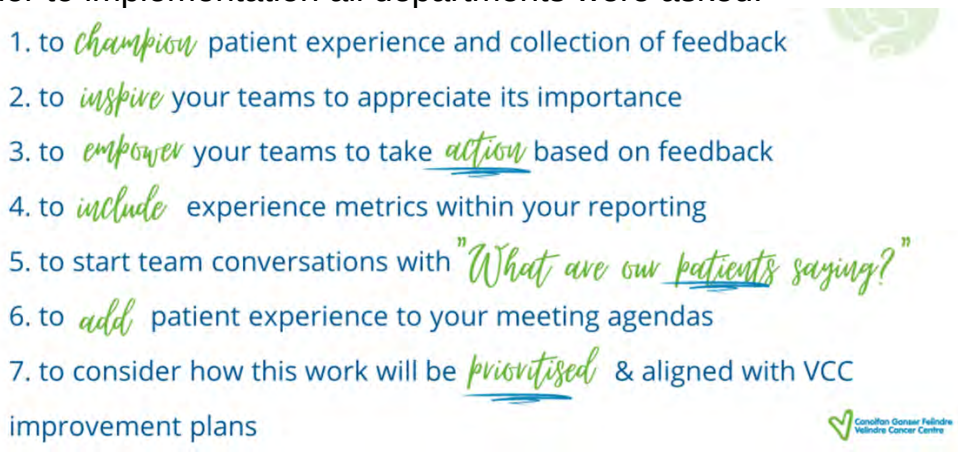
In April 2021 the Trust procured the Patient / Donor Experience Software system CIVICA. This system is now adopted as a Once for Wales system.

Implementation commenced immediately although this has been adversely impeded by the pandemic and digital capacity. It was agreed from inception that the system would be implemented in two phases:

- Phase 1: across all areas of Velindre Cancer Service
- Phase 2: across all areas of WBS.

2.1 Pre CIVICA Implementation

Prior to implementation all departments were asked:



3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 CIVICA implementation - One year on

In June 2021, it was anticipated that the full roll out of the CIVICA system across all areas of the Trust would be completed by 31st March 2022, with further system logistics, including implementation of automated SMS text &/ or emails during 2022/23.

This has not been fully completed as the use of mobile numbers for SMS and email contact details have been problematic, with data quality issues remaining a risk. Work is ongoing within VCC to address this. In addition, roll out is not yet underway at WBS and a date for implementation is not yet agreed. The Executive Director of Nursing, AHPs & Health Science has asked to attend SLT to discuss this further.

Limited digital capacity and infrastructure (connectivity) has created challenges yet progress and many achievements have been made. Although significant progress has been made over the last three months with a number of technical issues being resolved. On a positive note, prior to roll out it was not fully appreciated just how revolutionary this system could be for managers, not only automating and self-serving feedback collection, but also the production of reports within minutes, tailored to the service's need.

3.2 CIVICA VCC Showcase Event

The CIVICA showcase event was arranged, one year on, and as we move to a different phase of the pandemic, to provide management leads with an opportunity to share with the VCC leadership team and the Patient Experience Executive Lead what achievements have been made with the system so far, learn from each other and to re-energise and re-invigorate the ownership of capturing and using to improve, en-masse patient / donor feedback in real time electronically. In summary the CIVICA showcase event was to:

- Recap of the Trust, project and executive objectives.
- Assess what the experience of patients is across VCC departments.
- Department presentations (SBAR format) to showcase achievements and highlight learning for sharing.
- Provide a demonstration of CIVICA Reports and Dashboards.
- Identify learning and areas where further work is required.

The three hour VCC CIVICA showcase event comprised of a mixture of in person

attendance and Teams presentation. Six VCC departments were represented, each at differing stages of implementation. The SBAR format was used facilitating showcasing achievements and learning by others. Nuclear Medicine and Integrated Care shared patient feedback data that could be presented as an outcome dashboard. Whereas Clinical Trials and therapies were in the earlier stages of current data collection.

All areas have access to QR code links. It was noted that large feedback zones at VCC, using screens, were in the final stages of user acceptance testing. Outcomes from the event included:

- Shared learning.
- Idea generation in respect of extended uses (safeguarding Survey produced within a week following the event).
- Urgency of implementation within areas not yet using..
- Realisation of the ease of system and the system was not to be feared
- Barriers discussed and actions agreed
- Welsh Language team presented how the data can be used to influence practice.
- Welsh Blood presented a complete implementation plan for rollout to donation sites across Wales.

Next steps:

- Areas that stated admin required, tasked to discuss in their departments how to approach this internally.
- Device connectivity to be investigated with digital team.
- Large screens and application testing sign off with two weeks.
- Application sign-off.
- Further areas within Velindre to present in next event.
- Drive forward with surveys that are live.

The showcase event tasked all departments to “own the system”, to use the system to its fullest capability to advance the service, and to provide compliance with many aspects of the Health and Social Care (Quality and Engagement) (Wales) Act (2021). https://gov.wales/health-and-social-care-quality-and-engagement-wales-act-summary-html

3.3 Outcomes to Date

The following is the summary of VCC CIVICA outcomes for VCC between January 2022 and April 2022. Initially whilst the system was being electronically configured, paper CIVICA surveys were sent to patients and subsequently entered into the system so that the system configuration could be tested.

Month	Responses
January 2022	63

February 2022	83
March 2022	101
April 2022	73

Each of these are broken down to directorates and provided feedback to the areas for action.

Appendix 1 provides a full month's response (whole Trust) to paper surveys that have then been transcribed into the CIVICA system.

Appendix 2 shows a directorate dashboard example to two questions and use of the free text comments.

QR Code use: All departments have now been provided a QR codes for patients to scan with their devices, however this has proved challenging with connection to the internet on site. Staff have suggested providing the QR code on cards for patients to take out with them and complete at their convenience.

Brachytherapy Service Surveys: The Brachytherapy Improvement Board requested that all Brachytherapy patients over the past 12 months were asked to feedback in relation to the care and treatment they had received to ensure the patients voice is at the centre of our improvement priorities. The Business Intelligence team again identified patients who had used the service; patients were unable to be contacted via email or Mobile as data quality and completeness was inadequate. Around 200 letters were sent with QR codes, asking to make contact if paper or link was preferred. To date the response rate has been approximately 30%. It takes a few moments to generate a live status report (attached in ***Appendix 4).***

Large screen fixed devices: Three large screens are now in place within the VCC: In Outpatients waiting room; Radiotherapy waiting room; and the entrance of CDU.

Hand held devices: iPads with covers have been obtained and, as this is purely application based, this will allow survey completion without the need of connectivity via the cloud (Wi-Fi).

From undertaking a number of visits to areas across VCC, it quickly became obvious that certain areas would require mobile devices (iPads) as patients were unable to access the Large Screen fixed devices.

Velindre Leading the way: The Trust is the first to create a bespoke survey using the CIVICA system and is currently looking to expand this further into using the platform for staff surveys. A group is currently being set up for staff use within School of Oncology, Safeguarding, Information Governance and Radiation Protection.

4.0 IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
RELATED HEALTHCARE STANDARD	Effective Care
	If more than one Healthcare Standard applies please list below: **Safe Care**
EQUALITY IMPACT ASSESSMENT COMPLETED	No (Include further detail below)
	Programme specific, but not for paper reporting
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Programme specific, but not for paper reporting
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Programme specific, but not for paper reporting

5. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **NOTE** the position of CIVICA implementation and its importance for the Health and Social Care (Quality and Engagement) (Wales) Act (2021).

Appendix 1 – Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 101

Survey: Your Velindre Experience

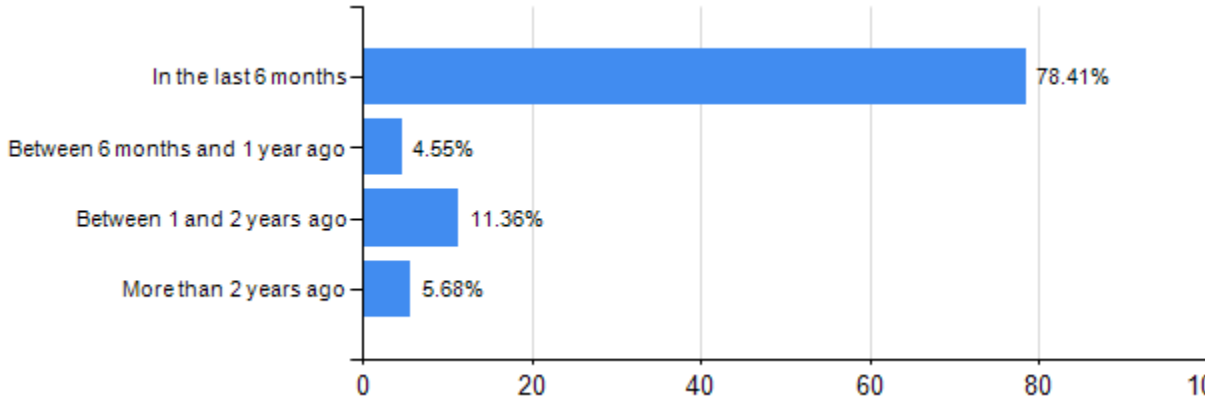
Start Date: 2022-03-01 00:00:00 **End Date:** 2022-03-31 23:59:59

Results from: Velindre Cancer Centre

Question 1: How recent was the experience you are thinking of?

Create new action

Available Answers	Responses	Score (%)
In the last 6 months	69	78.41%
Between 6 months and 1 year ago	4	4.55%
Between 1 and 2 years ago	10	11.36%
More than 2 years ago	5	5.68%
Total	**88**	**100%**



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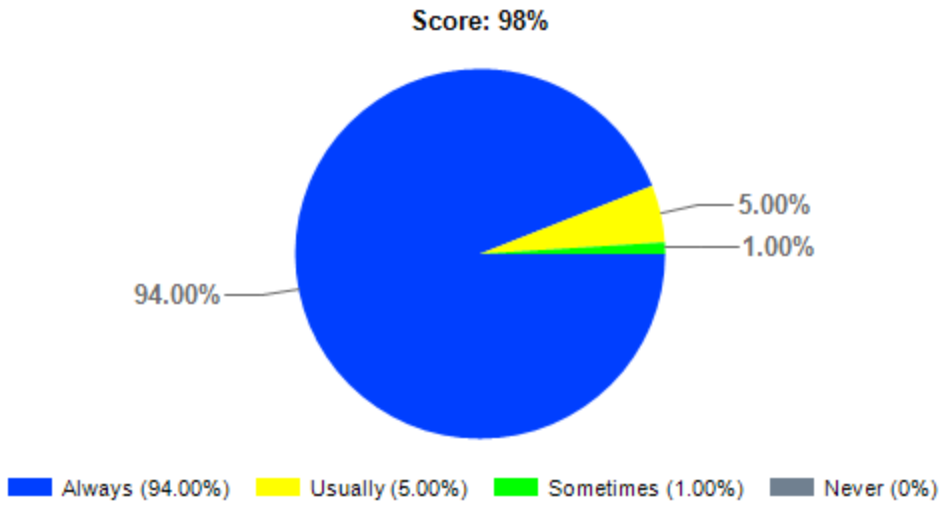
Start Date: 2022-03-01 00:00:00 **End Date:** 2022-03-31 23:59:59

Question 2: Did you feel that you were listened to?

Create new action

Available Answers	Responses	Score (%)
Always	94	94.00%
Usually	5	5.00%
Sometimes	1	1.00%
Never	0	0.00%
Total	**100**	**100%**



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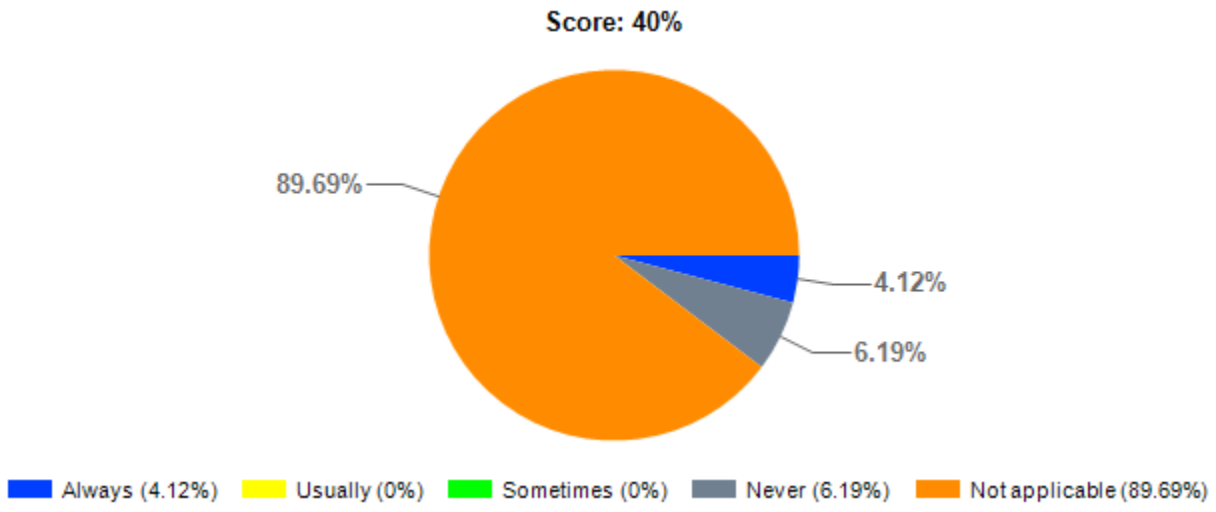
Start Date: 2022-03-01 00:00:00 **End Date:** 2022-03-31 23:59:59

Question 3: Were you able to speak Welsh to staff if you needed to?

Create new action

Available Answers	Responses	Score (%)
Always	4	4.12%
Usually	0	0.00%
Sometimes	0	0.00%
Never	6	6.19%
Not applicable	87	89.69%
Total	**97**	**100%**



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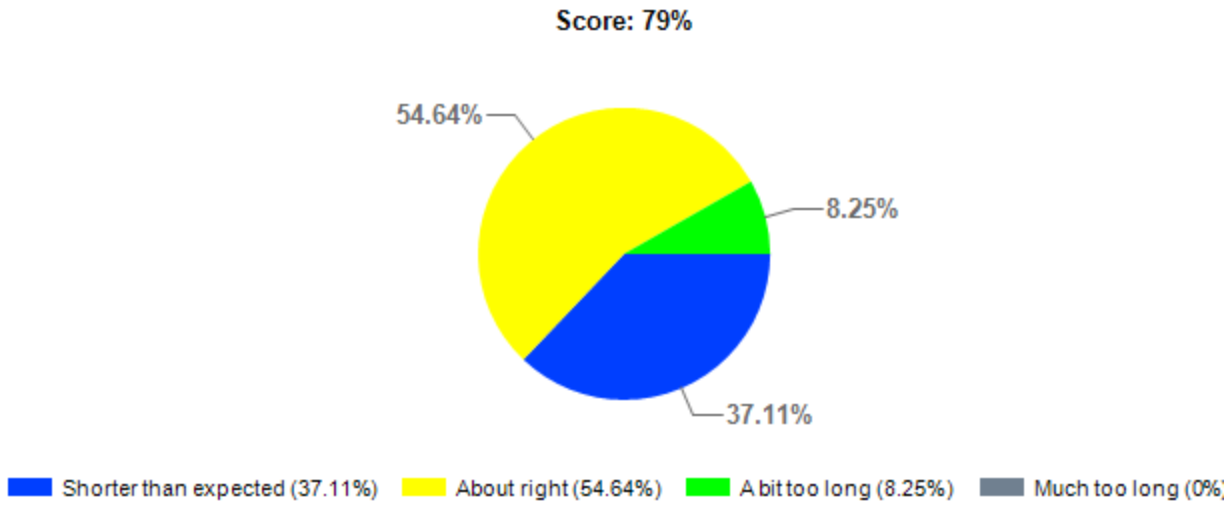
Start Date: 2022-03-01 00:00:00 **End Date:** 2022-03-31 23:59:59

Question 4: From the time you realised you needed to use the service, was the time you waited:

Create new action

Available Answers	Responses	Score (%)
Shorter than expected	36	37.11%
About right	53	54.64%
A bit too long	8	8.25%
Much too long	0	0.00%
Total	**97**	**100%**



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Total Respondents: 101

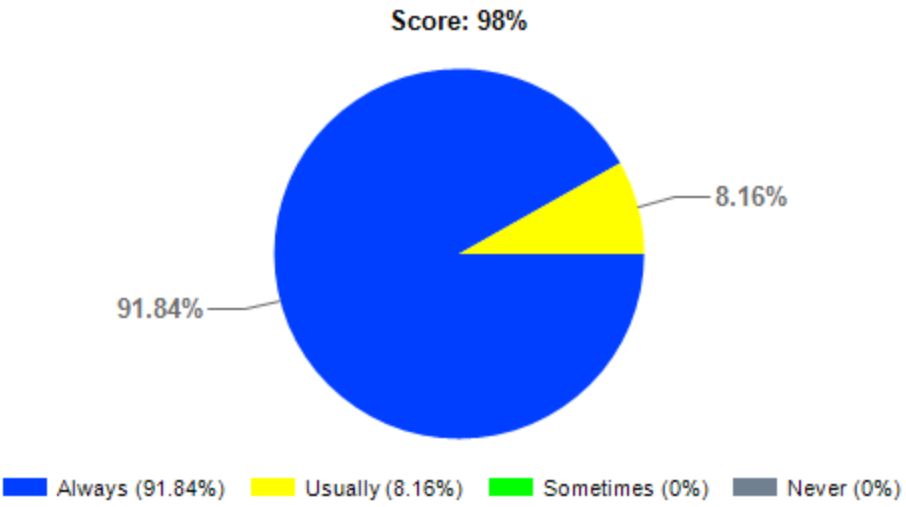
Survey: Your Velindre Experience

Start Date: 2022-03-01 00:00:00 **End Date:** 2022-03-31 23:59:59

Question 5: Did you feel well cared for?

Create new action

Available Answers	Responses	Score (%)
Always	90	91.84%
Usually	8	8.16%
Sometimes	0	0.00%
Never	0	0.00%
Total	**98**	**100%**



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Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 101

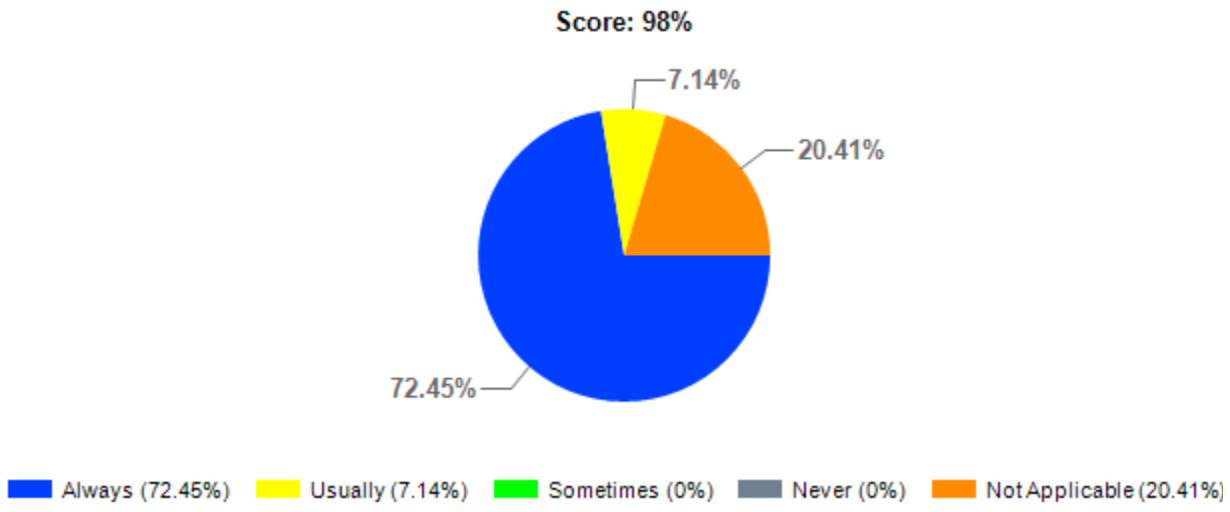
Survey: Your Velindre Experience

Start Date: 2022-03-01 00:00:00 **End Date:** 2022-03-31 23:59:59

Question 6: If you asked for assistance did you get it when you needed it?

Create new action

Available Answers	Responses	Score (%)
Always	71	72.45%
Usually	7	7.14%
Sometimes	0	0.00%
Never	0	0.00%
Not Applicable	20	20.41%
Total	**98**	**100%**



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Total Respondents: 101

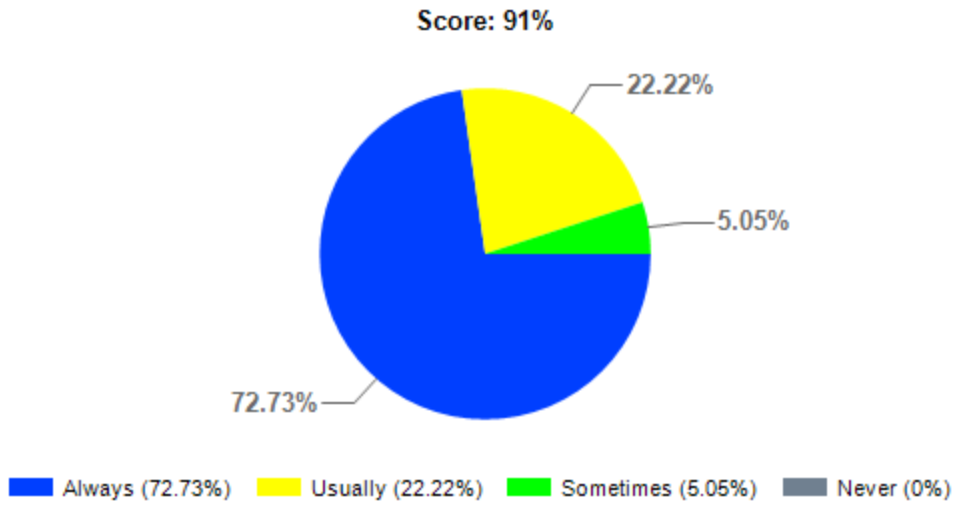
Survey: Your Velindre Experience

Start Date: 2022-03-01 00:00:00 **End Date:** 2022-03-31 23:59:59

Question 7: Did you feel you understood what was happening in your care?

Create new action

Available Answers	Responses	Score (%)
Always	72	72.73%
Usually	22	22.22%
Sometimes	5	5.05%
Never	0	0.00%
Total	**99**	**100%**



Appendix 1 – Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 101

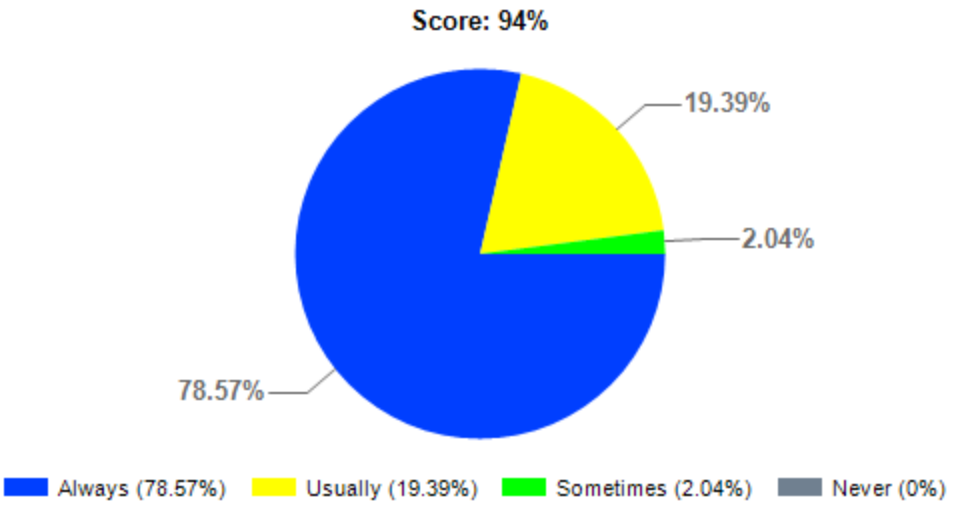
Survey: Your Velindre Experience

Start Date: 2022-03-01 00:00:00 **End Date:** 2022-03-31 23:59:59

Question 8: Were things explained to you in a way that you could understand?

Create new action

Available Answers	Responses	Score (%)
Always	77	78.57%
Usually	19	19.39%
Sometimes	2	2.04%
Never	0	0.00%
Total	**98**	**100%**



Appendix 1 – Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 101

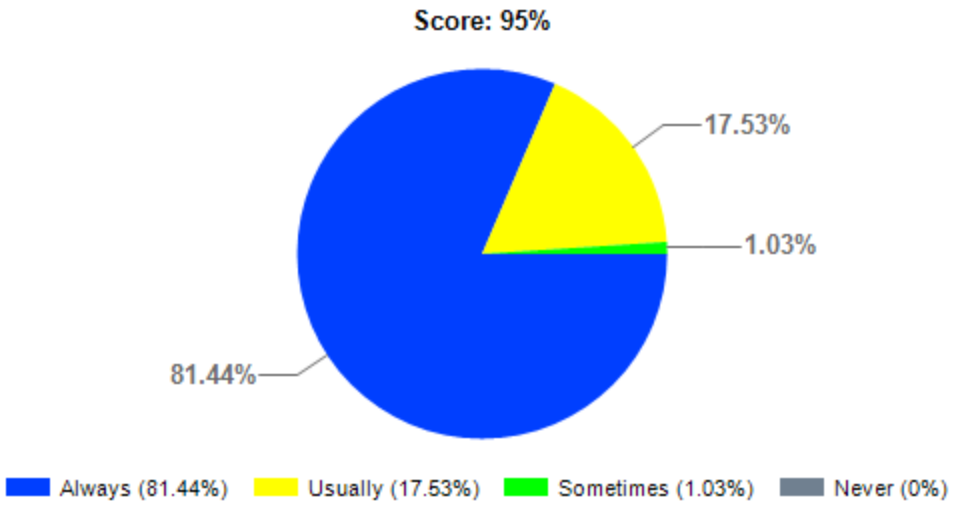
Survey: Your Velindre Experience

Start Date: 2022-03-01 00:00:00 **End Date:** 2022-03-31 23:59:59

Question 9: Were you involved as much as you wanted to be in decisions about your care?

Create new action

Available Answers	Responses	Score (%)
Always	79	81.44%
Usually	17	17.53%
Sometimes	1	1.03%
Never	0	0.00%
Total	**97**	**100%**



Appendix 1 – Survey Summary Report

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Total Respondents: 101

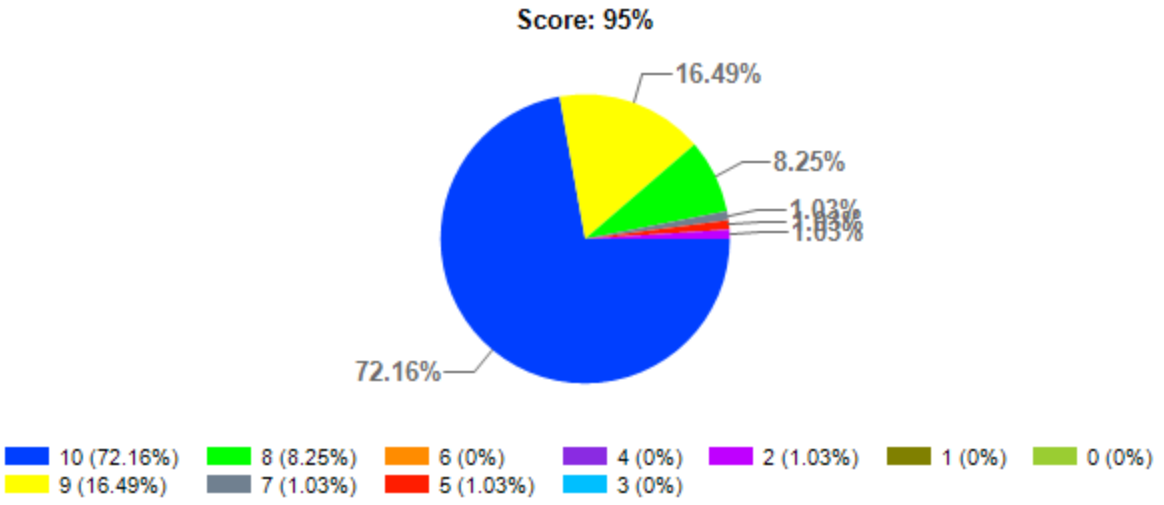
Survey: Your Velindre Experience

Start Date: 2022-03-01 00:00:00 **End Date:** 2022-03-31 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?

Create new action

Available Answers	Responses	Score (%)
10	70	72.16%
9	16	16.49%
8	8	8.25%
7	1	1.03%
6	0	0.00%
5	1	1.03%
4	0	0.00%
3	0	0.00%
2	1	1.03%
1	0	0.00%
0	0	0.00%
Total	**97**	**100%**



Appendix 1 – Survey Summary Report

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Total Respondents: 101

Survey: Your Velindre Experience

Start Date: 2022-03-01 00:00:00 **End Date:** 2022-03-31 23:59:59

Question 11: Was there anything particularly good about your experience that you would like to tell us about?

Create new action

Needed to increase dosage for pain. Spoke on phone and really helpful, explained options and prescription was ready on arrival.	00ff7f85 / 2022-03	Create new action
Could not fault anything	01a73859 / 2022-03	Create new action
Always kept informed about every procedure.	01c5ecdc / 2022-03	Create new action
Everyone was great and I thank you	0285f4e8 / 2022-03	Create new action
The friendliness of all the staff I was always treated like a friend.	05ca50e0 / 2022-03	Create new action
I always got the impression they were listening to me	07660a07 / 2022-03	Create new action
I have been under Velindre since 2017 and have always said the staff, doctors, nurses all do an amazing job and always include me in any discussions about my on going care.	0778f72e / 2022-03	Create new action
Bloods - Good service CT/MRI - Good service	0b050664 / 2022-03	Create new action
All the staff members are wonderful	0b7f77a5 / 2022-03	Create new action
On my last visit to Rowan I felt nausea, the nursing staff were very attentive + guided me through their actions.	0c2808fe / 2022-03	Create new action
Everyone was so kind and patient. I did not feel so worried when I left the hospital. Thank you	0d07a1c4 / 2022-03	Create new action
You always felt that people cared	12d41beb / 2022-03	Create new action
All staff were friendly, helpful and approachable	16424872 / 2022-03	Create new action
Everything was great	1a240266 / 2022-03	Create new action
Very friendly nice people.	1dfed128 / 2022-03	Create new action

Appendix 1 – Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 101

Survey: Your Velindre Experience

Start Date: 2022-03-01 00:00:00 **End Date:** 2022-03-31 23:59:59

All the staff are friendly always a warm atmosphere at Velindre if feels a very safe environment each time I visit. The radiology department are outstanding and caring. Thank you	1e15607b / 2022-03	Create new action
When I had chemo that time was the time I felt the staff were trying to do their best for me.	2356fe1e / 2022-03	Create new action
All the staff are very caring	23e8e9c2 / 2022-03	Create new action
The caring and expertise of ALL staff is amazing	26d86161 / 2022-03	Create new action
Care + dedication of staff	2eca504e / 2022-03	Create new action
I was made to feel ok very relaxed	329dc1e2 / 2022-03	Create new action
How normal everything felt almost like family. Didn't act massively worried, just made me feel welcome. Conversation just like any other day.	330b3743 / 2022-03	Create new action
Private patient side is outstanding so far.	35a53677 / 2022-03	Create new action
Was offered telephone meeting a number of years ago saved having to travel 24 miles. Great success's. In previous meetings had to travel 24 miles and wait in queue for about 1 hour to get results of blood test get pretty well same now over the telephone.	408d73f7 / 2022-03	Create new action
Always felt in good hands. Thank you all for my excellent treatment.	40fd0d4f / 2022-03	Create new action
I cannot think of one person, from a call in the early hours resulting in admission, to the people dealing with checking for Covid at the entrances, who were not kind caring and helpful.	43b76d24 / 2022-03	Create new action
Staff always kind + friendly which was a great help when I was visiting on my own during Covid.	45377750 / 2022-03	Create new action
The doctor was very helpful and took me and my son to her room and explained everything!	485fffbd / 2022-03	Create new action

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Start Date: 2022-03-01 00:00:00 **End Date:** 2022-03-31 23:59:59

The surgeons understudy or whoever she was didn't seem to be very caring but the nurse with her was lovely and I felt a lot more reassured after talking to her.	4ca1e713 / 2022-03	Create new action
All staff concerned were very caring and thoughtful	4e8d7191 / 2022-03	Create new action
I already completed a questionnaire about my immunotherapy treatment last year. I needed some additional follow up and my response is identical to before, in that the people I saw were calm, very professional, personable and diligent, despite all the pressures they are under. They deserve the maximum support for what they do.	4fc3c8f8 / 2022-03	Create new action
From start to finish I was treated with dignity and respect by everyone I came into contact with. I have nothing but the highest praise for the treatment that I received. Well done and thank you!!	52eec63a / 2022-03	Create new action
No	55acb2ce / 2022-03	Create new action
The very short wait before injection. Excellent staff.	583de5c2 / 2022-03	Create new action
The attitude of the nurses in the care of patients in all departments was exemplary. Thyme appreciated that cancer treatment is a debilitating experience and acted accordingly in assuaging patients concern. They set a high benchmark	5b5d785d / 2022-03	Create new action
Couldn't ask for better care	62b4e7e5 / 2022-03	Create new action
Very understanding Doctors and Nurses. Very polite and was put completely at ease. Explained everything to me in terms I understood. Thereby helping me to make my own decisions.	65aea6b3 / 2022-03	Create new action
With all that's been going on (Covid) I have been looked after very well. All my appointment (face to face or over the phone) have been spot on, if I have had any questions my support nurse has been at the end of the phone and she has been a great help.	66033c4d / 2022-03	Create new action

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Total Respondents: 101

Survey: Your Velindre Experience

Start Date: 2022-03-01 00:00:00 **End Date:** 2022-03-31 23:59:59

My bloods and scans have been done regular and I am very grateful for the service I have received.		
Treatment always on time7 staff put me at ease with any queries I had	672170bf / 2022-03	Create new action
I have always felt safe under the superb care of the team. (specialist nurse) is just outstanding and always available to help, support and advise. She is contactable by email which is very convenient.	722ace9d / 2022-03	Create new action
N/A	78771e55 / 2022-03	Create new action
All the staff a nurse I was in contact with were exceptional to my needs	7bc5fa24 / 2022-03	Create new action
Wonderful caring staff	837e8541 / 2022-03	Create new action
We were advised about Covid rules and they were acceptable	8e414584 / 2022-03	Create new action
Staff are all very approachable and always on hand whenever needed.	95ca41b4 / 2022-03	Create new action
Every time I visit Velindre I have a positive experience. Staff are friendly and helpful.	970a91c3 / 2022-03	Create new action
Both the doctors at the clinics and the other staff in outpatients and the chemotherapy day unit were very supportive and caring at all times.	9851abe8 / 2022-03	Create new action
First class service all staff friendly, polite, courteous and informative at all times. My special thanks to Grace in LA4, who explained everything I needed to know.	9b3df32c / 2022-03	Create new action
Yes the doctor was very understanding and made me feel relaxed at all times .	9e81dbe0 / 2022-03	Create new action
Staff are always friendly, efficient and helpful	a14bf851 / 2022-03	Create new action
Canula insertion Snacks	a9e4a28b / 2022-03	Create new action
All staff were kind	b183eb28 / 2022-03	Create new action
Everyone very caring + helpful They go over and above to make me feel assured + comfortable	bc01fc02 / 2022-03	Create new action

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Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 101

Survey: Your Velindre Experience

Start Date: 2022-03-01 00:00:00 **End Date:** 2022-03-31 23:59:59

Trust the staff. Whichever department I have been to the staff have been great.	bc5ffcbb / 2022-03	Create new action
* Pleased to be given the option of a telephone consultation * Investigation of blood, scans etc are efficiently organised * Impressed with the attention to detail by the consultation and team	c2f34218 / 2022-03	Create new action
Treated well on all occasions and very grateful. Thank you	cb08b288 / 2022-03	Create new action
The staff on all the wards were always outstanding and nothing was too much trouble. In fact all the staff that I have met in Velindre have been wonderful. Thank you to you all	cca661a8 / 2022-03	Create new action
Staff are cheery in a difficult working area.	d13c6dab / 2022-03	Create new action
Staff did not appear to be time restricted and that made me feel able to ask questions	d658af97 / 2022-03	Create new action
It was explained and very quick	d65dd0da / 2022-03	Create new action
Staff have an attitude of kindness and care.	d800c588 / 2022-03	Create new action
Staff were caring and very easy to speak to. I was notified of appointments in plenty of time. It all seems very organised.	dc9539af / 2022-03	Create new action
Considering the type of work your nurses undertake, my experience so far is, they are a well run team that makes me feel I'm in good hands.	df88c350 / 2022-03	Create new action
All the staff really kind and caring	e180d051 / 2022-03	Create new action
Everybody is helpful + understanding	e1a7c8f1 / 2022-03	Create new action
All staff are very caring and approachable and very hard working. A credit to the NHS	e2c6eaed / 2022-03	Create new action
Yes the staff are exceptional I think they are all angels. My team are kind, caring and wonderful.	e334ea4e / 2022-03	Create new action

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Total Respondents: 101

Survey: Your Velindre Experience

Start Date: 2022-03-01 00:00:00 **End Date:** 2022-03-31 23:59:59

I have always felt that I was in the most capable hands and as a patient my wellbeing mattered. The staff, everyone of them are amazing.	e626af54 / 2022-03	Create new action
The nurses on the unit I had my chemo were always very friendly and supportive.	e8758372 / 2022-03	Create new action
The doctor and nursing are all very kind I am still under Velindre and the staff do a wonderful job under a lot of pressure.	ed93b82e / 2022-03	Create new action

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Survey: Your Velindre Experience

Start Date: 2022-03-01 00:00:00 **End Date:** 2022-03-31 23:59:59

Question 12: Was there anything that we could change to improve your experience?

Create new action

Never had any problems	00ff7f85 / 2022-03	Create new action
No	01a73859 / 2022-03	Create new action
No five star	01c5ecdc / 2022-03	Create new action
I feel after my treatment I was on my ow. I got really sick and could not get out of bed for 3 weeks. I kept being told not a side effect? its seems strange that I was so sick yet being told it was not a side effect?	0285f4e8 / 2022-03	Create new action
No	07660a07 / 2022-03	Create new action
I live in Barry and would prefer to be able to have bloods done here before consultants but now not able to and have to travel to Llandough.	0778f72e / 2022-03	Create new action
over 1hour wait for only appt. I have attended (usually telephone appointments) at the Velindre. I still have not met my consultant in Person. Most of my appts are by telephone which suits me but I would EXPECT to have met my consultant when I came to The Velindre for an appt. The Lead Nurse seems to deal with everything in the Ovarian cancer dept. Still waiting after 18 MONTHS!	0b050664 / 2022-03	Create new action
No	0b7f77a5 / 2022-03	Create new action
Usually the nursing staff were very attentive but the occasional on/or two would benefit from a course on social skills.	0c2808fe / 2022-03	Create new action
Nothing	0d07a1c4 / 2022-03	Create new action
No	12d41beb / 2022-03	Create new action
Not at the moment. Thank you	16424872 / 2022-03	Create new action
No, everything was great Thank you!	1a240266 / 2022-03	Create new action

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Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 101

Survey: Your Velindre Experience

Start Date: 2022-03-01 00:00:00 **End Date:** 2022-03-31 23:59:59

No	1dfed128 / 2022-03	Create new action
Not really. But when I started treatment there was occasional mishap, like not telling me I need a specimen or in my case my blood pressure was too high so I had to wait a little while it went down	2356fe1e / 2022-03	Create new action
No	23e8e9c2 / 2022-03	Create new action
There was a reluctance to give the worst case scenario - even when it was likely! The physiology was OVER explained but the positive outcomes of failure were not adequately presented. I needed to know I could die.	26d86161 / 2022-03	Create new action
Less waiting time if you have been given a specific appointment time for blood tests.	2eca504e / 2022-03	Create new action
The entrance reception and knowing here to go your first time was confusing but I guess Covid makes it difficult.	35a53677 / 2022-03	Create new action
Arms very sore from putting behind head	3d01992d / 2022-03	Create new action
See above seems ok to me	408d73f7 / 2022-03	Create new action
Coffee shop could have been better.	40fd0d4f / 2022-03	Create new action
No I didn't think of anything!	485fffbd / 2022-03	Create new action
No	4fc3c8f8 / 2022-03	Create new action
NO	52eec63a / 2022-03	Create new action
No	55acb2ce / 2022-03	Create new action
Car Parking - like Llandough & UHW - nightmare An email, txt or even a call would save money and time for such a brilliant service.	583de5c2 / 2022-03	Create new action
No	5b5d785d / 2022-03	Create new action
No over all everybody did everything in a good way	65aea6b3 / 2022-03	Create new action
No. Without exception all staff at Velindre are a credit to the NHS. Velindre is a very special place.	722ace9d / 2022-03	Create new action

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Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 101

Survey: Your Velindre Experience

Start Date: 2022-03-01 00:00:00 **End Date:** 2022-03-31 23:59:59

N/A	78771e55 / 2022-03	Create new action
Not really except I would have liked a relative with me due to my dementia	837e8541 / 2022-03	Create new action
Although waited in the tent outside due to Covid rules it did not at one stage become over the required limit but was soon rectified, maybe a bigger tent?	8e414584 / 2022-03	Create new action
NA	95ca41b4 / 2022-03	Create new action
Nothing as I believe the only problems are caused by Covid and not staff.	970a91c3 / 2022-03	Create new action
N/A	9851abe8 / 2022-03	Create new action
As far as my experience nothing at all	9b3df32c / 2022-03	Create new action
No	9e81dbe0 / 2022-03	Create new action
1 - Waiting time at the unit for chemotherapy to start 2 - There is not always a nurse able to access my portacath for treatment easily available	a14bf851 / 2022-03	Create new action
More chairs for chemo treatment .	a9e4a28b / 2022-03	Create new action
I would like yo have face to face conversations not on the phone	b183eb28 / 2022-03	Create new action
All Good	bc01fc02 / 2022-03	Create new action
no	bc5ffcbb / 2022-03	Create new action
Not really, I'm quite happy!	c2f34218 / 2022-03	Create new action
I have ticked ' a bit too long' in the box - this was the wait from diagnosis in Llandough nd appointment at Velindre.	c7d7cd44 / 2022-03	Create new action
My last visit (2nd Chemo) involved 10% reduction in meds as bloods had not recovered sufficiently. However + only because I mentioned this, I was given the correct dose otherwise I would have been given the full dose. Miss comms somewhere. Was also given piriton when I should not have. This however was not problem as never reacted to this prior. I will however,	d13c6dab / 2022-03	Create new action

Appendix 1 – Survey Summary Report

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Survey: Your Velindre Experience

Start Date: 2022-03-01 00:00:00 **End Date:** 2022-03-31 23:59:59

Have to have it at all remaining treatments.		
I felt that highly qualified people are tasked with delivering simple messages and this does not appear to be a good use of their valuable time	d658af97 / 2022-03	Create new action
No	d65dd0da / 2022-03	Create new action
No	df88c350 / 2022-03	Create new action
Not really	e180d051 / 2022-03	Create new action
Pharmacy waiting time to collect drugs	e1a7c8f1 / 2022-03	Create new action
No I think its run exceptionally well considering how many they deal with.	e334ea4e / 2022-03	Create new action

Appendix 1 – Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 101

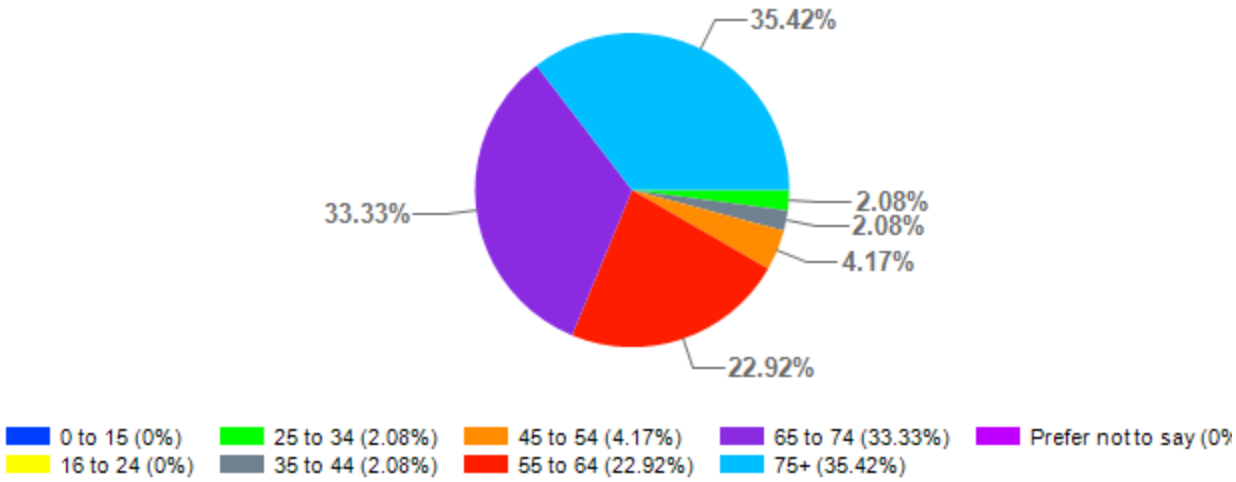
Survey: Your Velindre Experience

Start Date: 2022-03-01 00:00:00 **End Date:** 2022-03-31 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	0	0.00%
25 to 34	2	2.08%
35 to 44	2	2.08%
45 to 54	4	4.17%
55 to 64	22	22.92%
65 to 74	32	33.33%
75+	34	35.42%
Prefer not to say	0	0.00%
Total	**96**	**100%**



Appendix 1 – Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 101

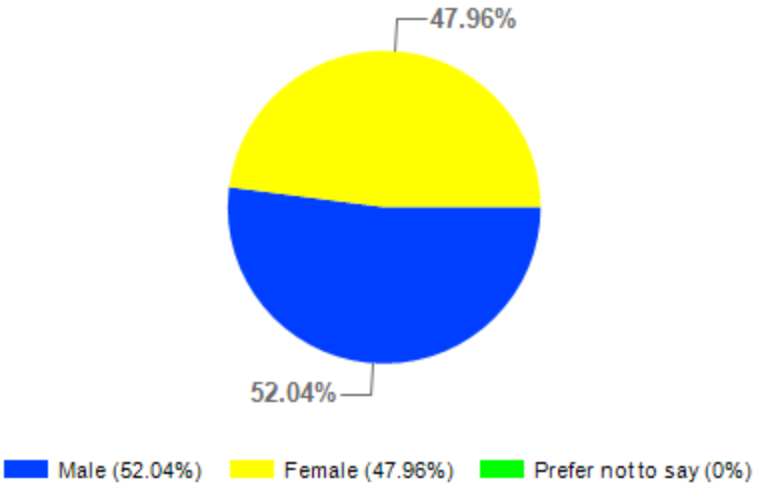
Survey: Your Velindre Experience

Start Date: 2022-03-01 00:00:00 **End Date:** 2022-03-31 23:59:59

Question 14: What is your Gender?

Create new action

Available Answers	Responses	Score (%)
Male	51	52.04%
Female	47	47.96%
Prefer not to say	0	0.00%
Total	**98**	**100%**



Appendix 1 – Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 101

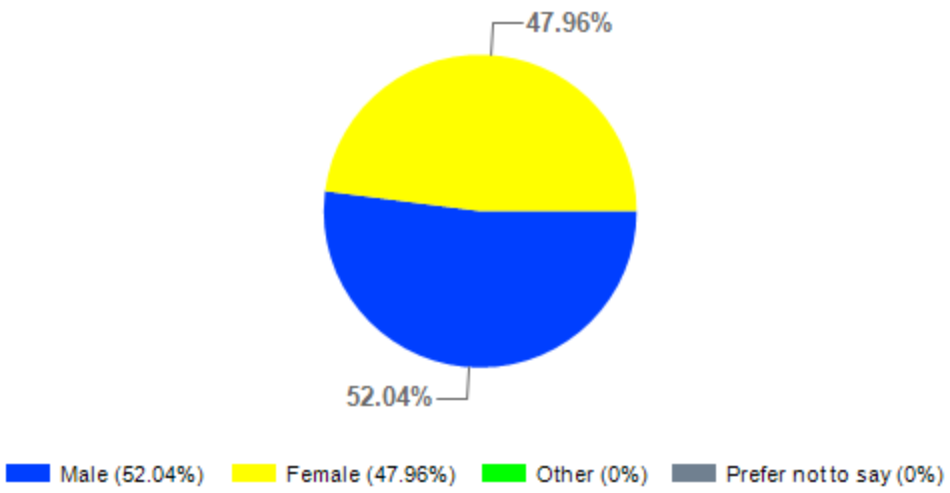
Survey: Your Velindre Experience

Start Date: 2022-03-01 00:00:00 **End Date:** 2022-03-31 23:59:59

Question 15: At birth, were you described as:

Create new action

Available Answers	Responses	Score (%)
Male	51	52.04%
Female	47	47.96%
Other	0	0.00%
Prefer not to say	0	0.00%
Total	**98**	**100%**



Appendix 1 – Survey Summary Report

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Total Respondents: 101

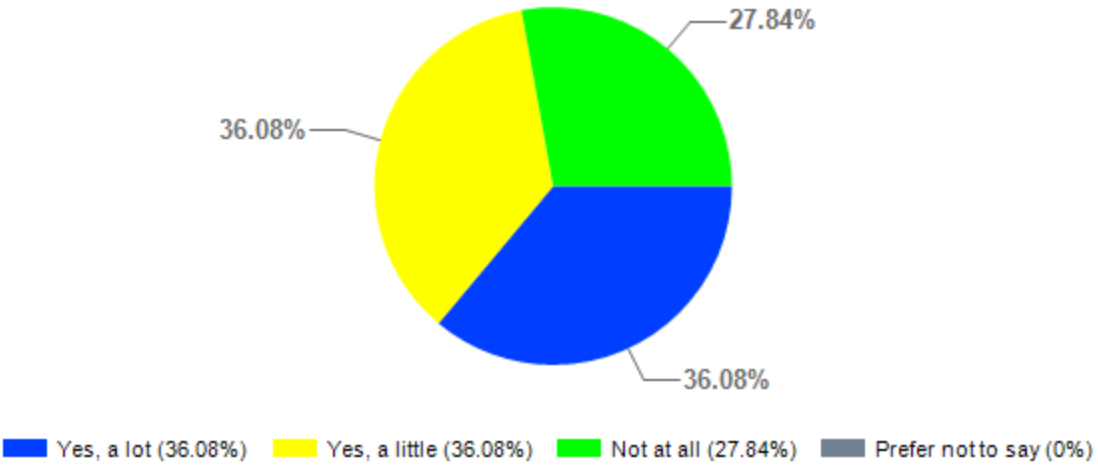
Survey: Your Velindre Experience

Start Date: 2022-03-01 00:00:00 **End Date:** 2022-03-31 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	35	36.08%
Yes, a little	35	36.08%
Not at all	27	27.84%
Prefer not to say	0	0.00%
Total	**97**	**100%**



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Total Respondents: 101

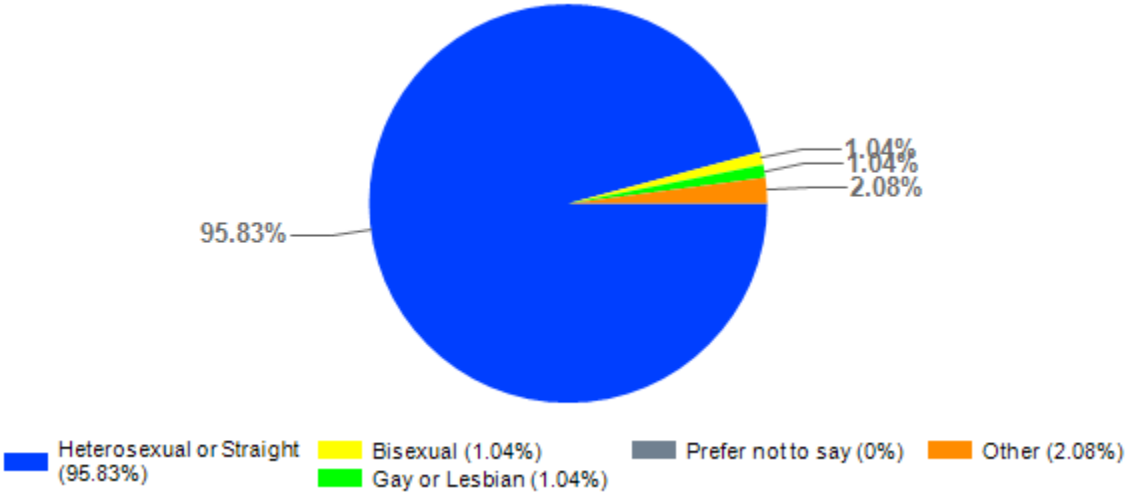
Survey: Your Velindre Experience

Start Date: 2022-03-01 00:00:00 **End Date:** 2022-03-31 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	92	95.83%
Bisexual	1	1.04%
Gay or Lesbian	1	1.04%
Prefer not to say	0	0.00%
Other	2	2.08%
Total	**96**	**100%**



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Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 101

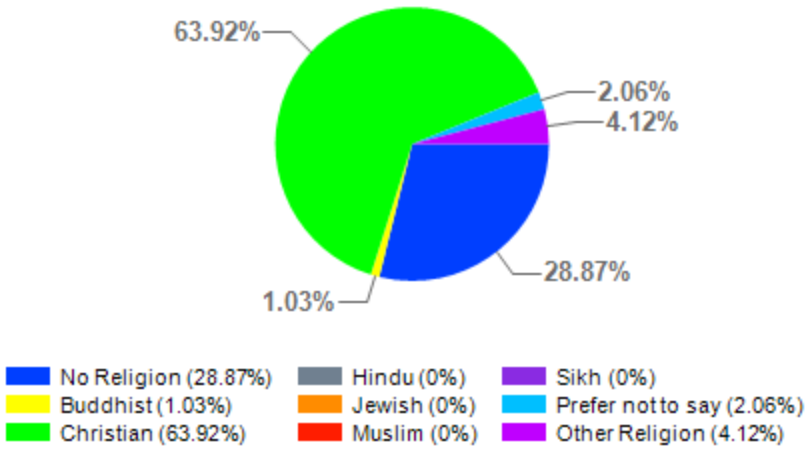
Survey: Your Velindre Experience

Start Date: 2022-03-01 00:00:00 **End Date:** 2022-03-31 23:59:59

Question 18: What is your religion?

Create new action

Available Answers	Responses	Score (%)
No Religion	28	28.87%
Buddhist	1	1.03%
Christian	62	63.92%
Hindu	0	0.00%
Jewish	0	0.00%
Muslim	0	0.00%
Sikh	0	0.00%
Prefer not to say	2	2.06%
Other Religion	4	4.12%
Total	**97**	**100%**



Question 19: Other Religion - please give details in this box:

Create new action

Appendix 1 – Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 101

Survey: Your Velindre Experience

Start Date: 2022-03-01 00:00:00 **End Date:** 2022-03-31 23:59:59

Question 20: What is your ethnic group?

Create new action

Available Answers	Responses	Score (%)
White - British/English/Northern Irish/Scottish/Welsh	93	96.88%
White - Gypsy or Irish Traveller	0	0.00%
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	0	0.00%
Mixed / multiple ethnic group - Other	1	1.04%
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	1	1.04%
Black/African/Caribbean/Black British - African	1	1.04%
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	**96**	**100%**

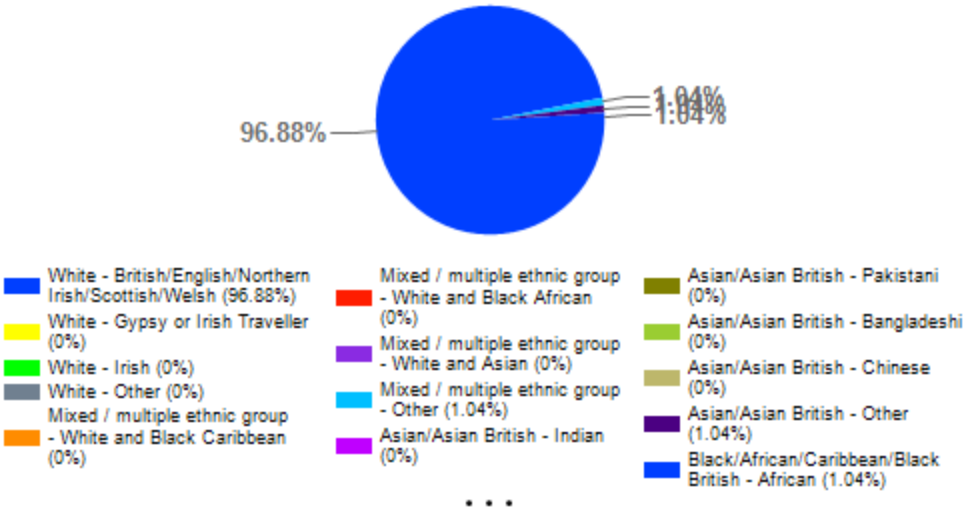
Appendix 1 – Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 101

Survey: Your Velindre Experience

Start Date: 2022-03-01 00:00:00 **End Date:** 2022-03-31 23:59:59



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Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 101

Survey: Your Velindre Experience

Start Date: 2022-03-01 00:00:00 **End Date:** 2022-03-31 23:59:59

Question 21: Other Ethnic Group - please give details in this box:

Create new action

European	1a240266 / 2022-03	Create new action
Cornish	7bc5fa24 / 2022-03	Create new action

Available Filters:

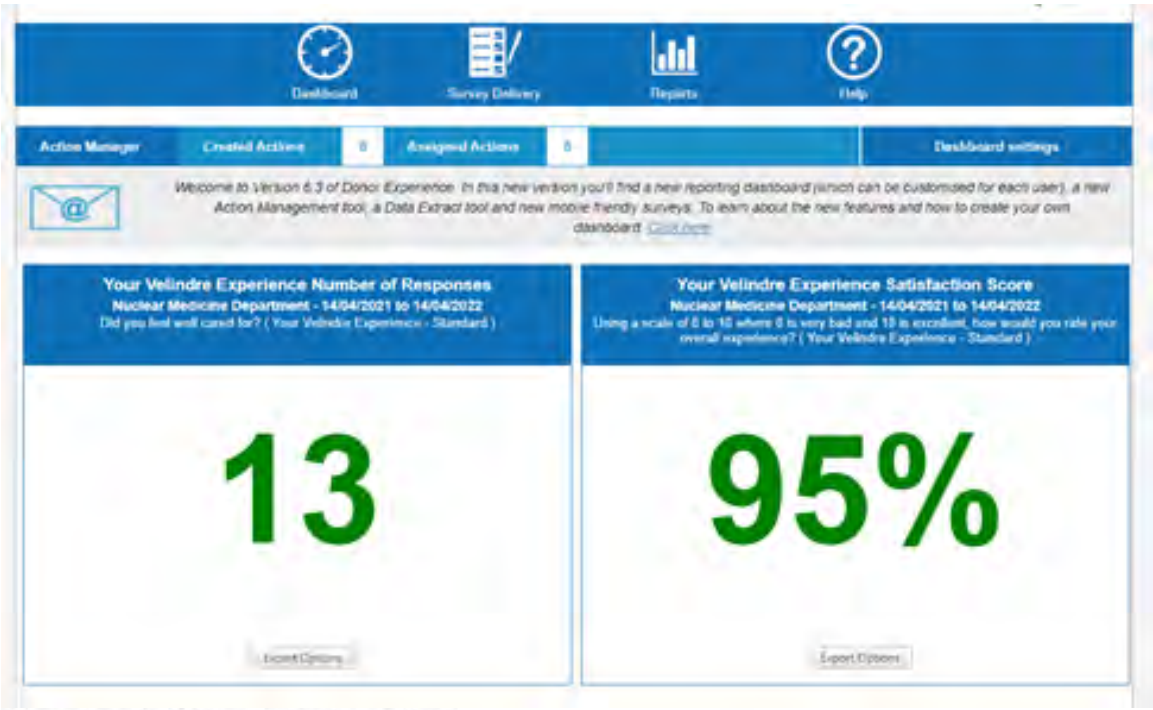
Note: The available filter selection is dependent on the report that is being generated.

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,Transforming Cancer Services
Service	Catering services,Clinical Psychology,Clinical Trials ,Communications & Engagement,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

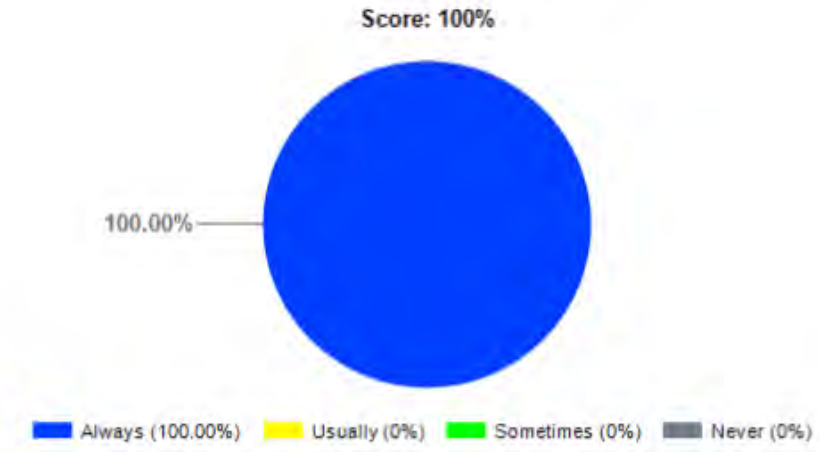
Start Date	2022-03-01 00:00:00
End Date	2022-03-31 23:59:59

Appendix 2. Examples of data reports and dashboard view:



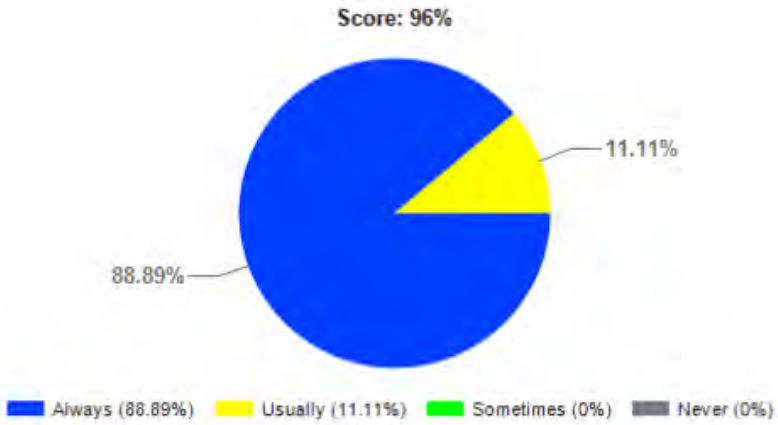
Question 5: Did you feel well cared for?

Available Answers	Responses	Score (%)
Always	9	100.00%
Usually	0	0.00%
Sometimes	0	0.00%
Never	0	0.00%
Total	**9**	**100%**



Question 2: Did you feel that you were listened to?

Available Answers	Responses	Score (%)
Always	8	88.89%
Usually	1	11.11%
Sometimes	0	0.00%
Never	0	0.00%
Total	9	100%



Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 49

Survey: Brachytherapy Patient Survey

Start Date: 2022-05-11 00:00:00 **End Date:** 2022-06-20 23:59:59

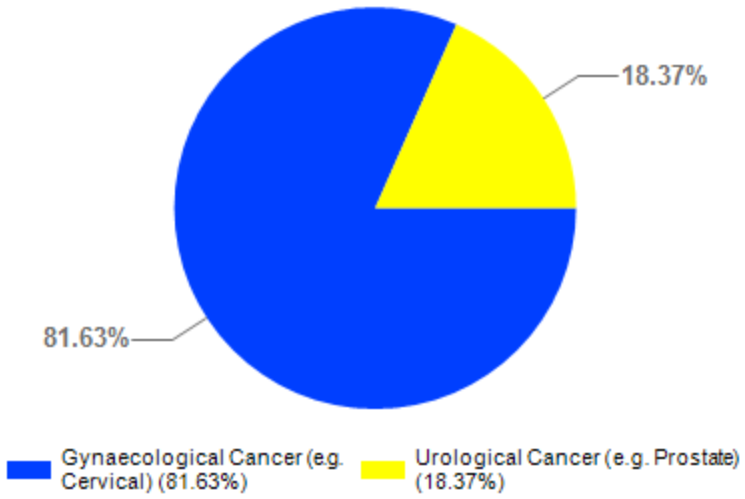
Appendix 3

Results from: All Tiers

Question 1: Please confirm which of the below you are receiving Brachytherapy treatment for

Create new action

Available Answers	Responses	Score (%)
Gynaecological Cancer (e.g. Cervical)	40	81.63%
Urological Cancer (e.g. Prostate)	9	18.37%
Total	**49**	**100%**



Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 49

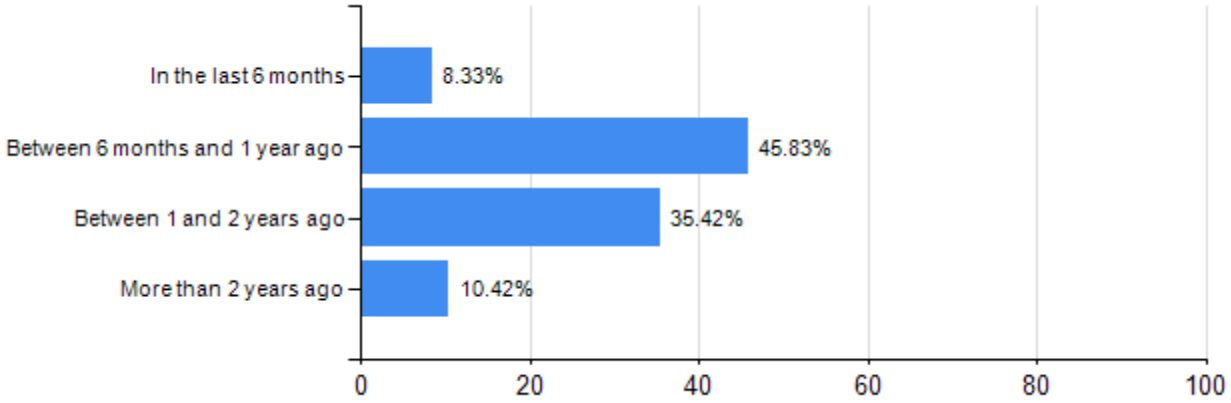
Survey: Brachytherapy Patient Survey

Start Date: 2022-05-11 00:00:00 **End Date:** 2022-06-20 23:59:59

Question 2: How long ago were you diagnosed?

Create new action

Available Answers	Responses	Score (%)
In the last 6 months	4	8.33%
Between 6 months and 1 year ago	22	45.83%
Between 1 and 2 years ago	17	35.42%
More than 2 years ago	5	10.42%
Total	**48**	**100%**



Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 49

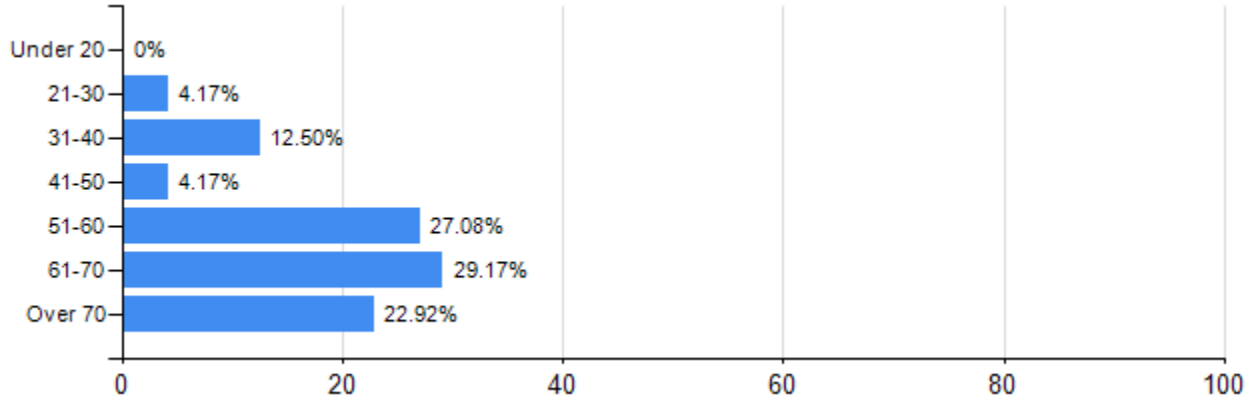
Survey: Brachytherapy Patient Survey

Start Date: 2022-05-11 00:00:00 **End Date:** 2022-06-20 23:59:59

Question 3: Age at diagnosis?

Create new action

Available Answers	Responses	Score (%)
Under 20	0	0.00%
21-30	2	4.17%
31-40	6	12.50%
41-50	2	4.17%
51-60	13	27.08%
61-70	14	29.17%
Over 70	11	22.92%
Total	**48**	**100%**



Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 49

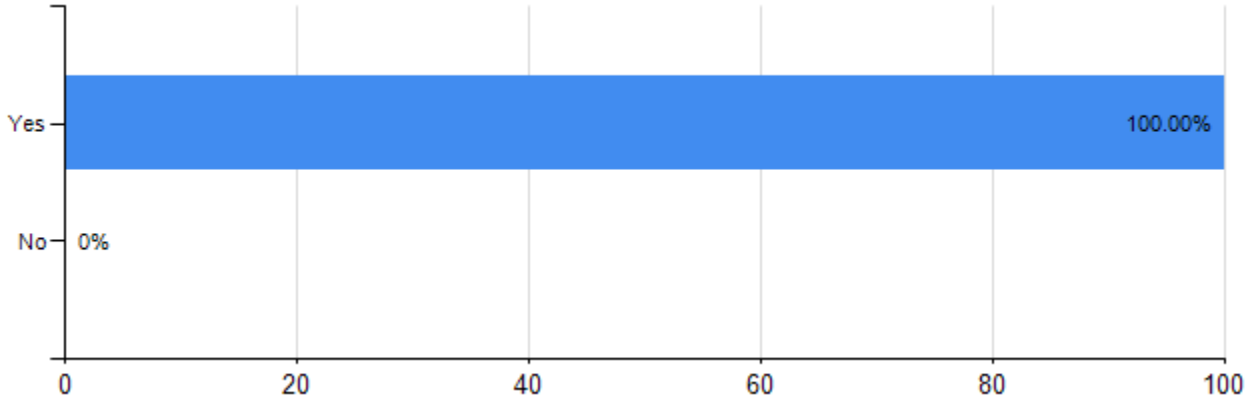
Survey: Brachytherapy Patient Survey

Start Date: 2022-05-11 00:00:00 **End Date:** 2022-06-20 23:59:59

Question 4: At your consultation were you given the opportunity to discuss any relevant issues relating to your diagnosis and treatment?

Create new action

Available Answers	Responses	Score (%)
Yes	46	100.00%
No	0	0.00%
Total	**46**	**100%**



Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 49

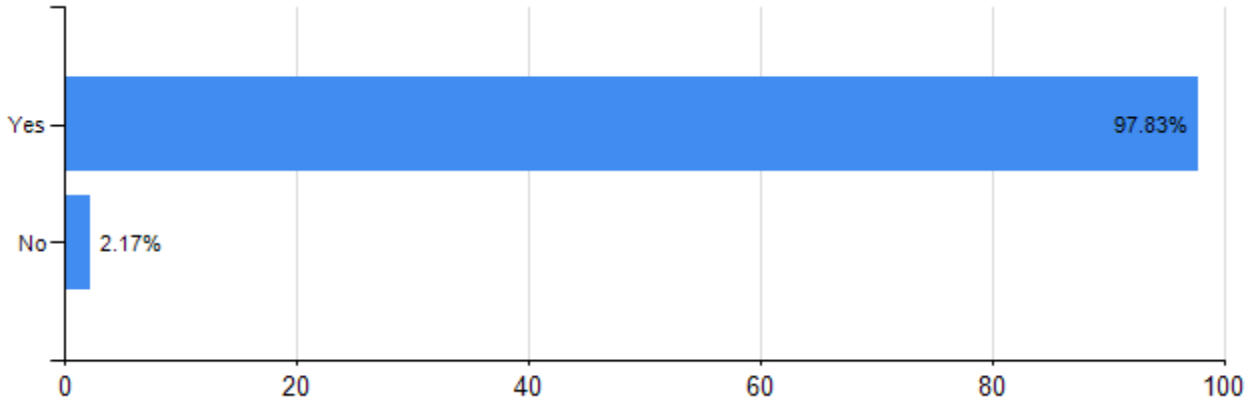
Survey: Brachytherapy Patient Survey

Start Date: 2022-05-11 00:00:00 **End Date:** 2022-06-20 23:59:59

Question 5: Were you given the opportunity to ask further questions?

Create new action

Available Answers	Responses	Score (%)
Yes	45	97.83%
No	1	2.17%
Total	**46**	**100%**



Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 49

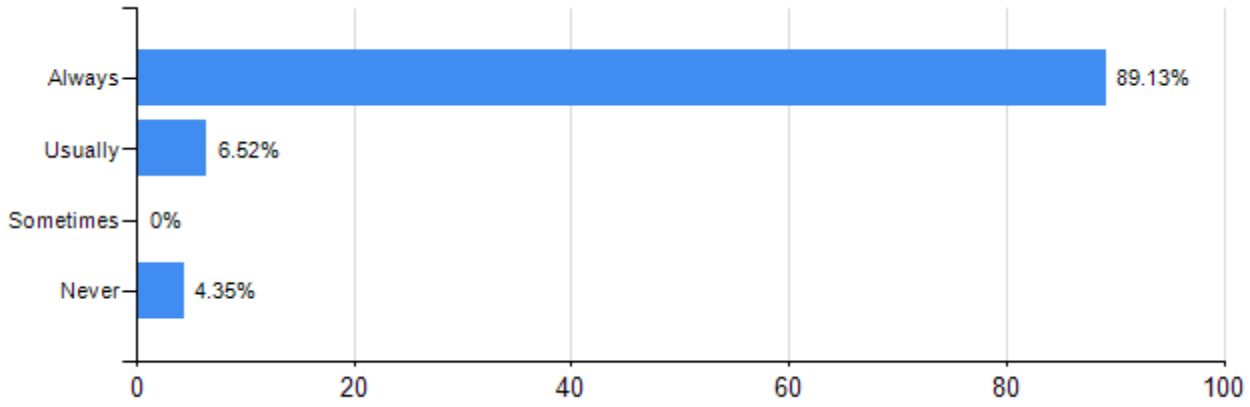
Survey: Brachytherapy Patient Survey

Start Date: 2022-05-11 00:00:00 **End Date:** 2022-06-20 23:59:59

Question 6: Were you involved as much as you wanted in the decision about which treatment to have?

Create new action

Available Answers	Responses	Score (%)
Always	41	89.13%
Usually	3	6.52%
Sometimes	0	0.00%
Never	2	4.35%
Total	**46**	**100%**



Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 49

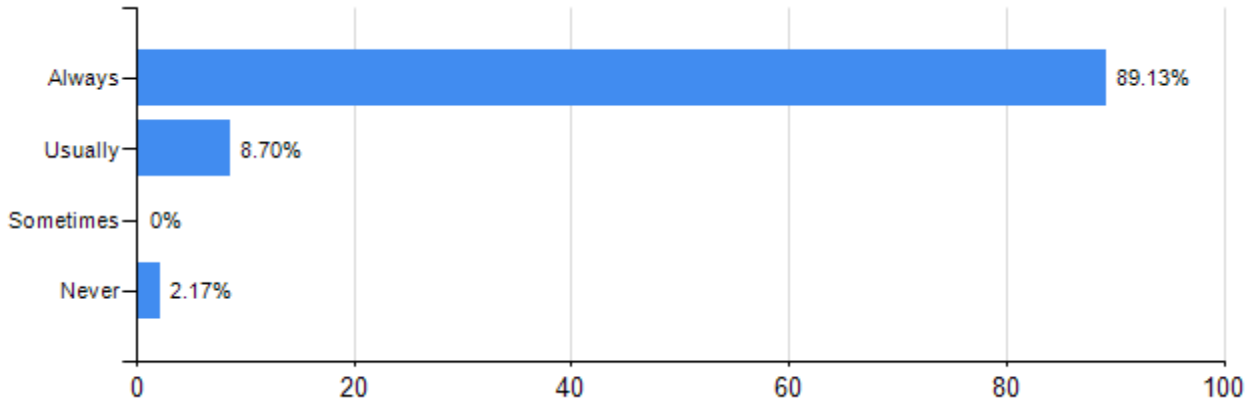
Survey: Brachytherapy Patient Survey

Start Date: 2022-05-11 00:00:00 **End Date:** 2022-06-20 23:59:59

Question 7: Did you feel you were listened to?

Create new action

Available Answers	Responses	Score (%)
Always	41	89.13%
Usually	4	8.70%
Sometimes	0	0.00%
Never	1	2.17%
Total	**46**	**100%**



Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 49

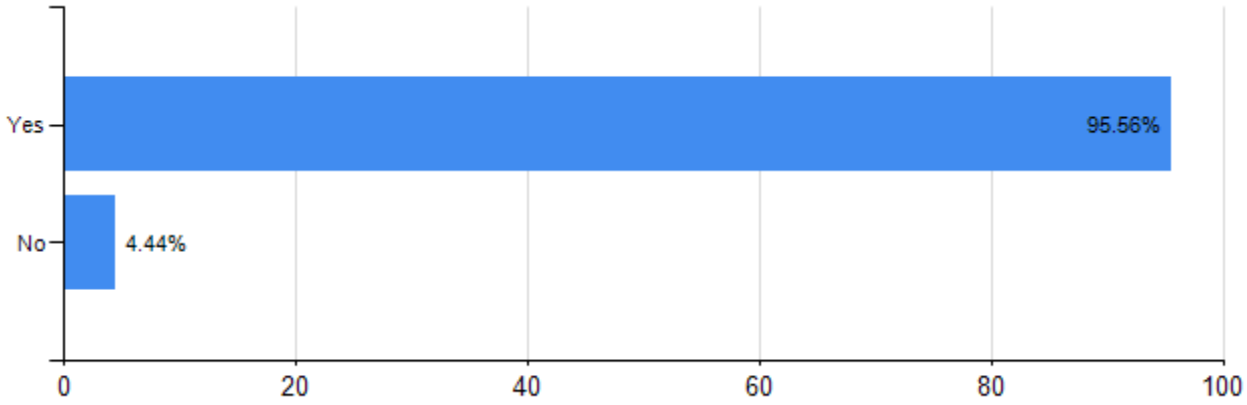
Survey: Brachytherapy Patient Survey

Start Date: 2022-05-11 00:00:00 **End Date:** 2022-06-20 23:59:59

Question 8: Were you given written information about brachytherapy?

Create new action

Available Answers	Responses	Score (%)
Yes	43	95.56%
No	2	4.44%
Total	**45**	**100%**



Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 49

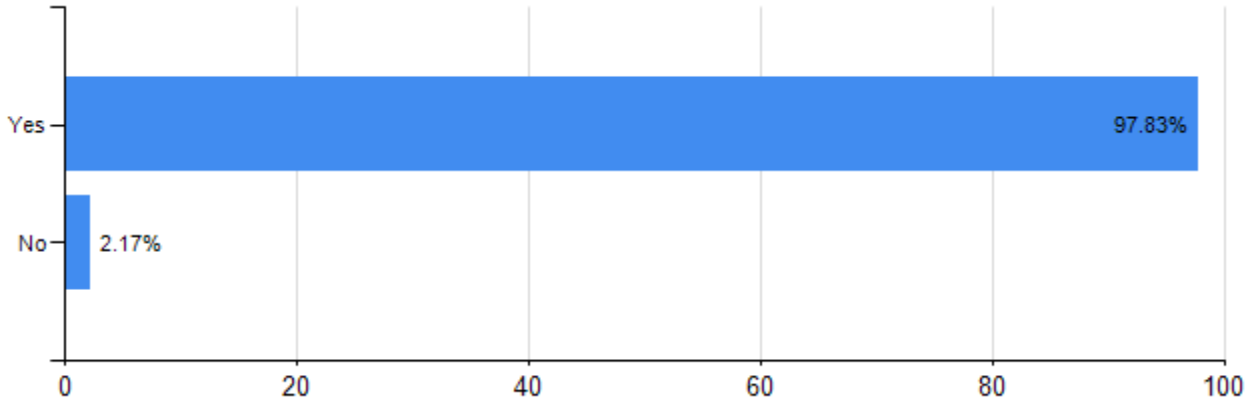
Survey: Brachytherapy Patient Survey

Start Date: 2022-05-11 00:00:00 **End Date:** 2022-06-20 23:59:59

Question 9: Did you feel you were well informed about the brachytherapy procedure?

Create new action

Available Answers	Responses	Score (%)
Yes	45	97.83%
No	1	2.17%
Total	**46**	**100%**



Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 49

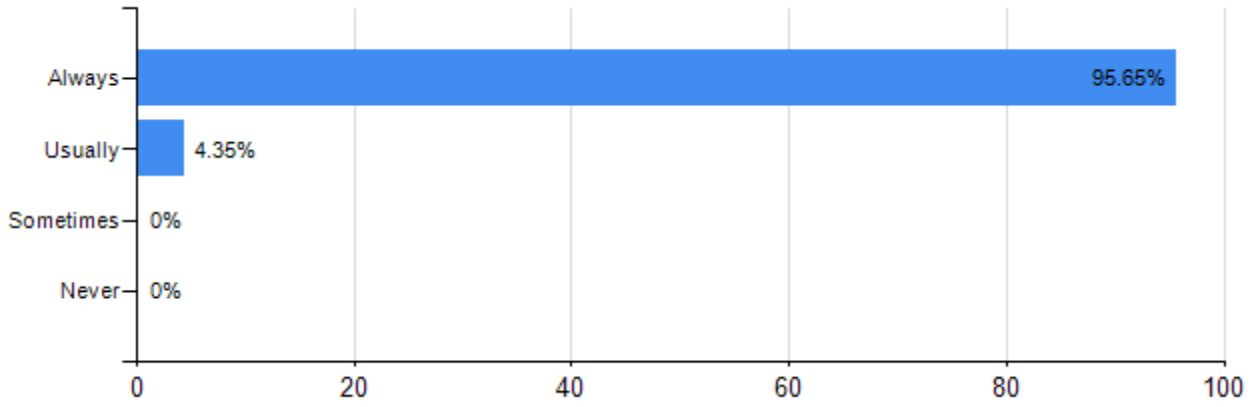
Survey: Brachytherapy Patient Survey

Start Date: 2022-05-11 00:00:00 **End Date:** 2022-06-20 23:59:59

Question 10: Were things explained to you in a way that you could understand?

Create new action

Available Answers	Responses	Score (%)
Always	44	95.65%
Usually	2	4.35%
Sometimes	0	0.00%
Never	0	0.00%
Total	**46**	**100%**



Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 49

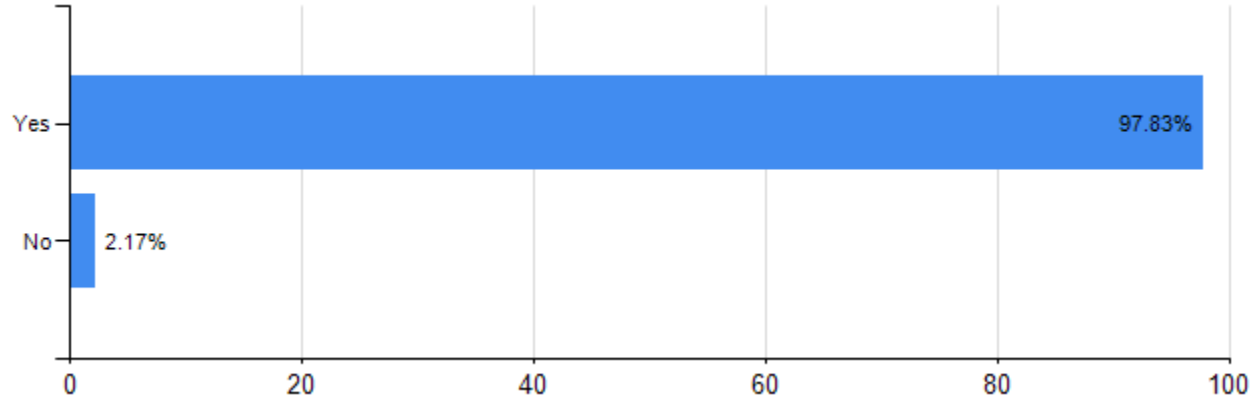
Survey: Brachytherapy Patient Survey

Start Date: 2022-05-11 00:00:00 **End Date:** 2022-06-20 23:59:59

Question 11: Did you feel you were well informed about the side effects you may experience following the brachytherapy procedure?

Create new action

Available Answers	Responses	Score (%)
Yes	45	97.83%
No	1	2.17%
Total	**46**	**100%**



Question 12: If you answered no to any of the questions above, what additional information would you have liked to receive prior to attending Velindre for brachytherapy?

Create new action

Not aware of some of the side effects that I have since experienced	55e825b2 / 2022-06	Create new action
I received two brachytherapy treatments following radiotherapy at Singleton Hospital. Everyone I met at Velindre I found to be kind but very busy and as I was facing the unknown in a busy environment, found it difficult to raise too many questions. I would have appreciated a consultation prior to the treatment, thus giving me the opportunity to ask questions.	c0a98362 / 2022-06	Create new action
The length of time waiting around in between stages. This time was very long and uncomfortable.	d0ee7fda / 2022-06	Create new action

Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 49

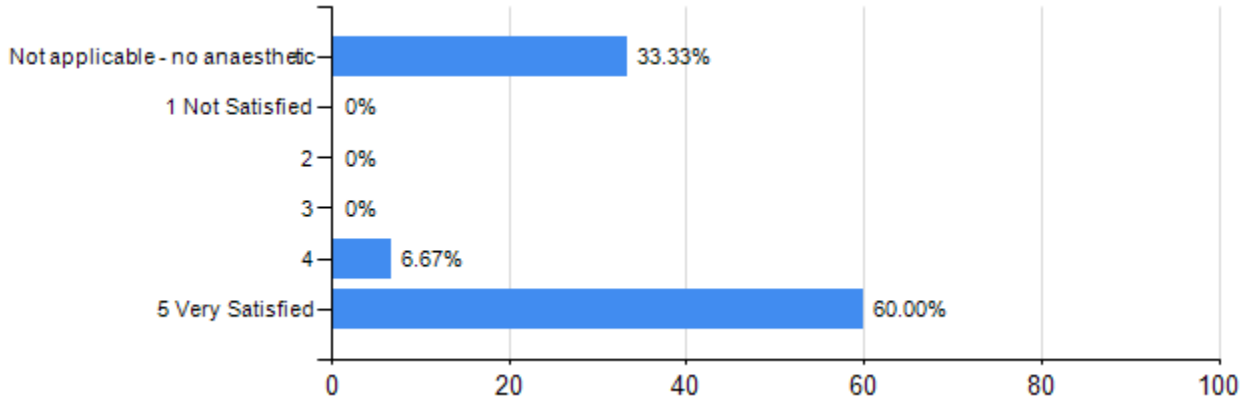
Survey: Brachytherapy Patient Survey

Start Date: 2022-05-11 00:00:00 **End Date:** 2022-06-20 23:59:59

Question 13: On a scale of 1-5 how satisfied were you with the pre-anaesthetic assessment?

Create new action

Available Answers	Responses	Score (%)
Not applicable - no anaesthetic	15	33.33%
1 Not Satisfied	0	0.00%
2	0	0.00%
3	0	0.00%
4	3	6.67%
5 Very Satisfied	27	60.00%
Total	**45**	**100%**



Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 49

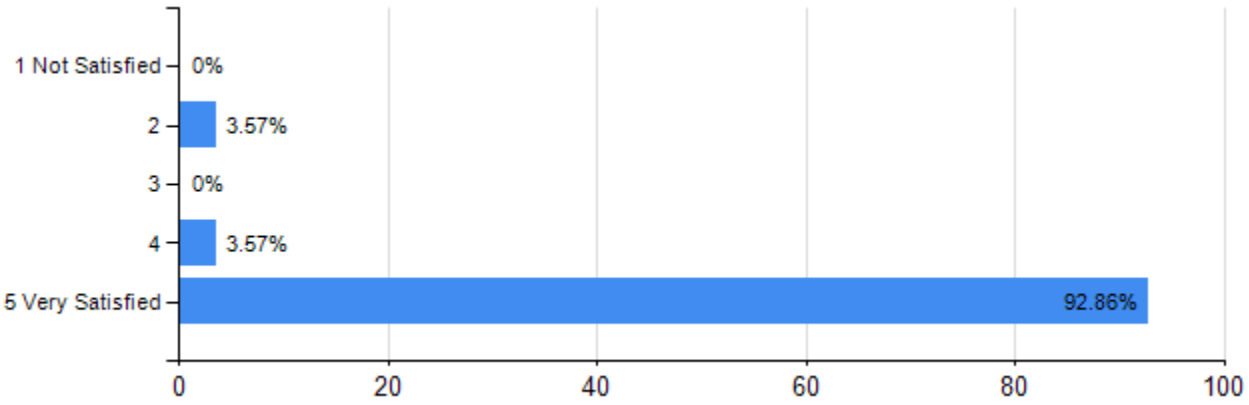
Survey: Brachytherapy Patient Survey

Start Date: 2022-05-11 00:00:00 **End Date:** 2022-06-20 23:59:59

Question 14: On a scale of 1-5 how satisfied were you with the care you had within the day unit / ward at Velindre?

Create new action

Available Answers	Responses	Score (%)
1 Not Satisfied	0	0.00%
2	1	3.57%
3	0	0.00%
4	1	3.57%
5 Very Satisfied	26	92.86%
Total	**28**	**100%**



Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 49

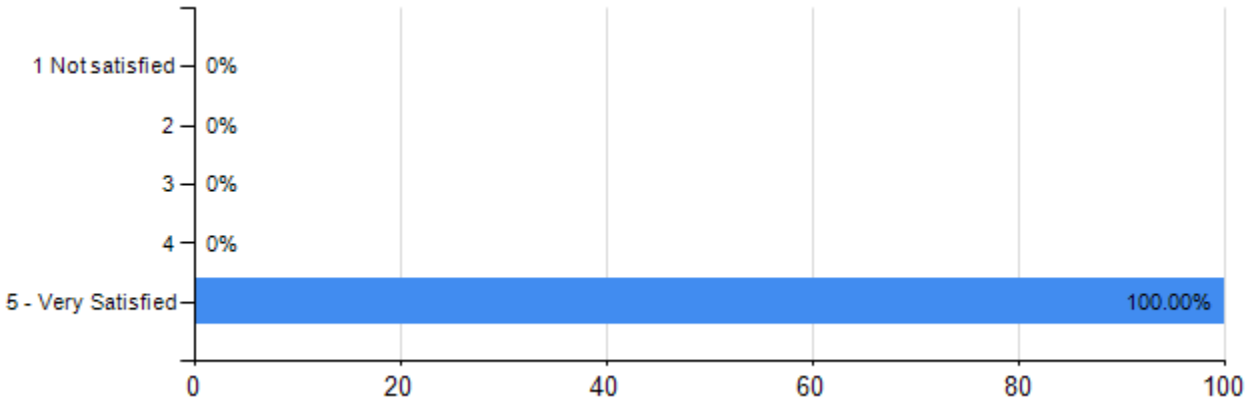
Survey: Brachytherapy Patient Survey

Start Date: 2022-05-11 00:00:00 **End Date:** 2022-06-20 23:59:59

Question 15: On a scale of 1-5 how satisfied were you with the treatment you received in the operating theatre?

Create new action

Available Answers	Responses	Score (%)
1 Not satisfied	0	0.00%
2	0	0.00%
3	0	0.00%
4	0	0.00%
5 - Very Satisfied	28	100.00%
Total	**28**	**100%**



Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 49

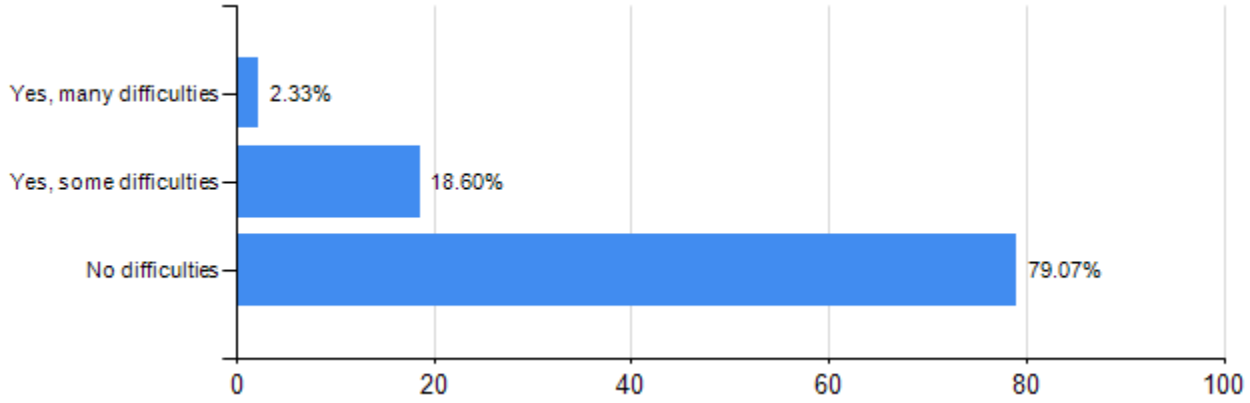
Survey: Brachytherapy Patient Survey

Start Date: 2022-05-11 00:00:00 **End Date:** 2022-06-20 23:59:59

Question 16: Did you experience any difficulties during the procedure?

Create new action

Available Answers	Responses	Score (%)
Yes, many difficulties	1	2.33%
Yes, some difficulties	8	18.60%
No difficulties	34	79.07%
Total	**43**	**100%**



Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 49

Survey: Brachytherapy Patient Survey

Start Date: 2022-05-11 00:00:00 **End Date:** 2022-06-20 23:59:59

Question 17: Please use this space to provide details of any difficulties experienced

Create new action

I woke up whilst the treatment was being admitted, but the staff noticed straight away and put me back to sleep again.	25bc2ebc / 2022-06	Create new action
My buttock received a shear type burn ,blisters which I expect were caused when under anesthesia during transfer from theatre to trolley ..however these were immediately fecognized as I discovered them ,photographed and dressed ..referred immediately to district nurses who attended alternate days to redress ..until healed ..	3eaf6086 / 2022-06	Create new action
I was catheterised prior to returning to the ward to recover post procedure. The catheter became blocked with a blood clot/ blood clots and hence was unable to drain my bladder which continued to be “flushed” with fluid. This became extremely painful at one stage until the anaesthetist was called. He identified the issue quickly - so I went from being on the ceiling with pain to being relaxed albeit warm & wet!!	44c3663e / 2022-06	Create new action
Wrong measurement of equipment to be inserted	55e825b2 / 2022-06	Create new action
Mostly side affects	59733438 / 2022-06	Create new action
Somewhat painful as being treated for secondary vaginal cancer. No anaesthetic.	b64271ef / 2022-06	Create new action
Some water works issues which I was advised in advance could happen So was expecting some discomfort So no issues as far as I am concerned	cde78c70 / 2022-06	Create new action
Very painful because of catheter insertions. I had not been aware that catheters were necessary.	d0ee7fda / 2022-06	Create new action
The only Issue I had really was the self administration of the suppository on the day. I did find this quite difficult	f8465d2f / 2022-06	Create new action

Survey Summary Report

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Total Respondents: 49

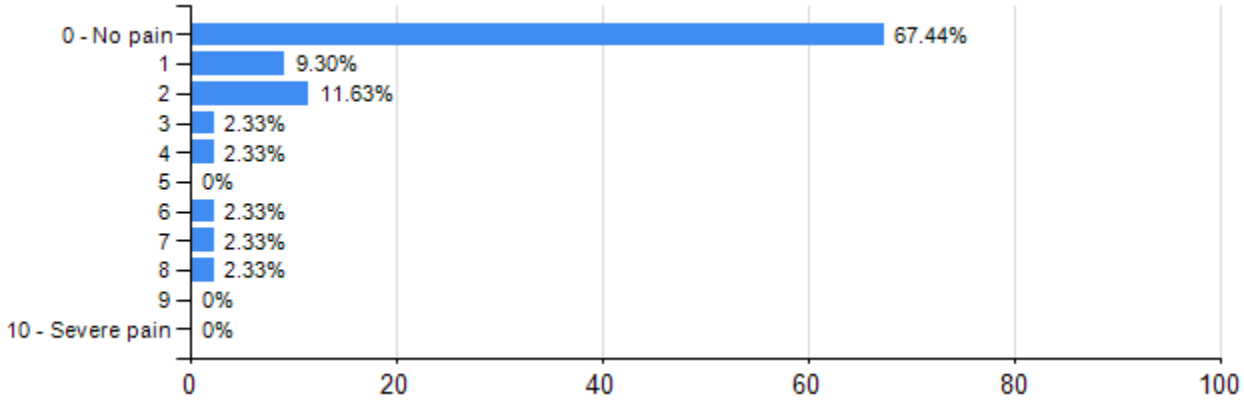
Survey: Brachytherapy Patient Survey

Start Date: 2022-05-11 00:00:00 **End Date:** 2022-06-20 23:59:59

Question 18: On a scale of 1 -10 please rate any discomfort/pain you may have experienced DURING the procedure (0 – No pain, 10 - Severe pain)

Create new action

Available Answers	Responses	Score (%)
0 - No pain	29	67.44%
1	4	9.30%
2	5	11.63%
3	1	2.33%
4	1	2.33%
5	0	0.00%
6	1	2.33%
7	1	2.33%
8	1	2.33%
9	0	0.00%
10 - Severe pain	0	0.00%
Total	**43**	**100%**



Survey Summary Report

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Total Respondents: 49

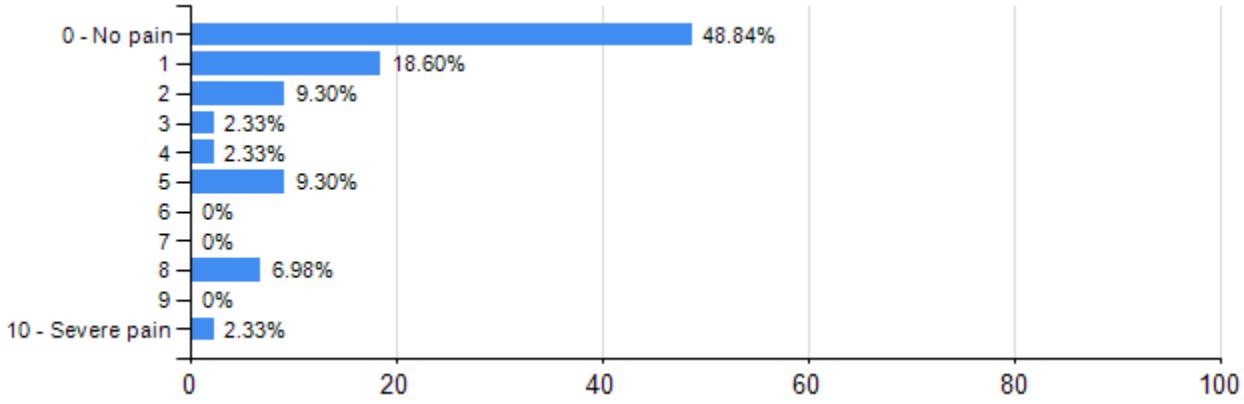
Survey: Brachytherapy Patient Survey

Start Date: 2022-05-11 00:00:00 **End Date:** 2022-06-20 23:59:59

Question 19: On a scale of 1 -10 please rate any discomfort/pain you may have experienced AFTER the procedure (0 – No pain, 10 - Severe pain)

Create new action

Available Answers	Responses	Score (%)
0 - No pain	21	48.84%
1	8	18.60%
2	4	9.30%
3	1	2.33%
4	1	2.33%
5	4	9.30%
6	0	0.00%
7	0	0.00%
8	3	6.98%
9	0	0.00%
10 - Severe pain	1	2.33%
Total	**43**	**100%**



Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 49

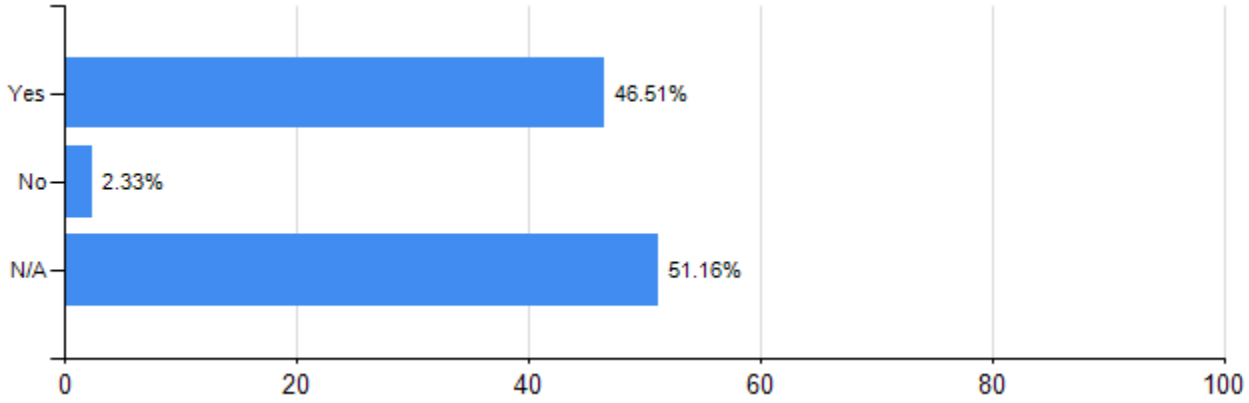
Survey: Brachytherapy Patient Survey

Start Date: 2022-05-11 00:00:00 **End Date:** 2022-06-20 23:59:59

Question 20: Were you given adequate painkillers to manage your pain?

Create new action

Available Answers	Responses	Score (%)
Yes	20	46.51%
No	1	2.33%
N/A	22	51.16%
Total	**43**	**100%**



Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 49

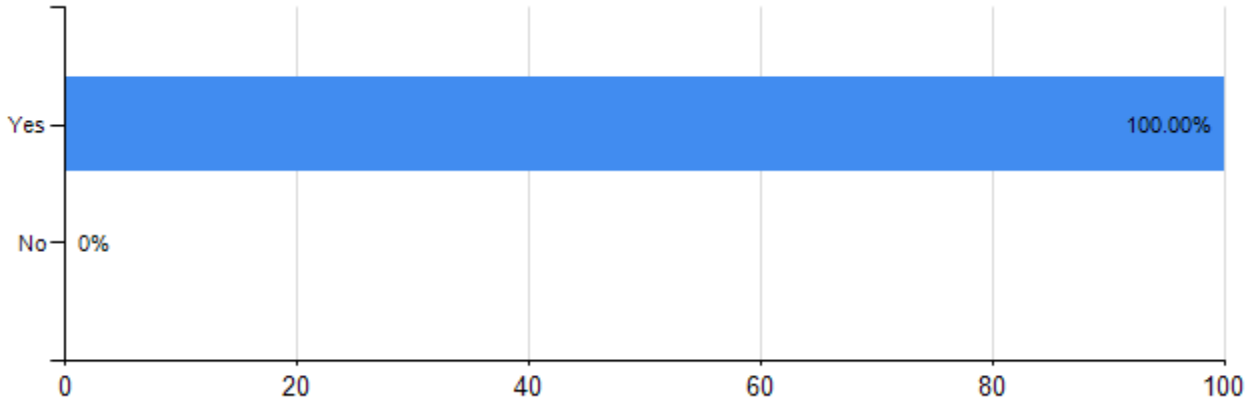
Survey: Brachytherapy Patient Survey

Start Date: 2022-05-11 00:00:00 **End Date:** 2022-06-20 23:59:59

Question 21: Were you given information on who to contact for support and advice after treatment?

Create new action

Available Answers	Responses	Score (%)
Yes	42	100.00%
No	0	0.00%
Total	**42**	**100%**



Survey Summary Report

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Total Respondents: 49

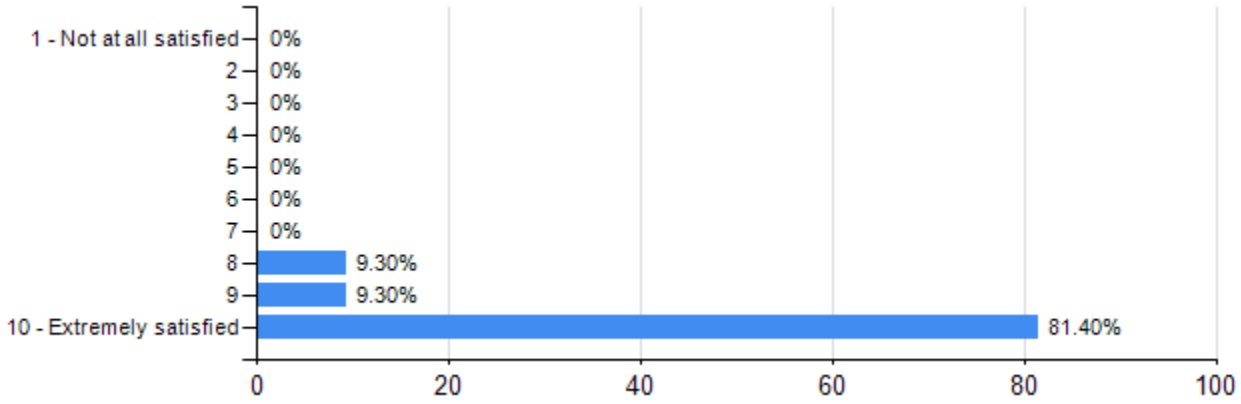
Survey: Brachytherapy Patient Survey

Start Date: 2022-05-11 00:00:00 **End Date:** 2022-06-20 23:59:59

Question 22: Overall, how satisfied were you with your brachytherapy treatment?

Create new action

Available Answers	Responses	Score (%)
1 - Not at all satisfied	0	0.00%
2	0	0.00%
3	0	0.00%
4	0	0.00%
5	0	0.00%
6	0	0.00%
7	0	0.00%
8	4	9.30%
9	4	9.30%
10 - Extremely satisfied	35	81.40%
Total	**43**	**100%**



Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 49

Survey: Brachytherapy Patient Survey

Start Date: 2022-05-11 00:00:00 **End Date:** 2022-06-20 23:59:59

Question 23: Please provide details in the box below with regards to what you think went well during your treatment:

Create new action

All aspects of treatment went well	03afaf53 / 2022-06	Create new action
Very apprehensive to begin with but staff were very good and put me at ease during procedure.	04004643 / 2022-06	Create new action
All the staff at Velindre were so nice to me, the ward staff soo friendly and helped with anything I needed. The surgical team were amazing, as I was very apprehensive about being put to sleep but we were all singing, dancing and laughing and keeping my mind off the surgery. All such wonderful people and great at there jobs, I can't thank them enough.	25bc2ebc / 2022-06	Create new action
Everything was explained to me prior to the procedure. My dignity was maintained throughout and the staff were very reassuring. The appropriate measures were put in place because of covid.	285da726 / 2022-06	Create new action
Nursing team at Velindre were excellent in explaining, putting me at ease and fully supporting me prior to/during and after the brachytherapy procedure.	33143ccd / 2022-06	Create new action
Staff were helpful and informative.	37b14730 / 2022-06	Create new action
The care and treatment ..attendance to me by all staff was absolutely outstanding ,I was never worried or concerned I felt completely safe ..respected ..looked after .. after care was just as good ..	3eaf6086 / 2022-06	Create new action
Everything apart from the minor hiccup regarding my catheterisation which was quickly resolved.	44c3663e / 2022-06	Create new action
Sam kept me well informed of what to expect from start to finish of my treatment. She even answered questions about what to expect in the future with appointments etc. She made the worry of having this treatment very pleasant .	4a59c6d9 / 2022-06	Create new action
Staff were amazing and supportive	55e825b2 / 2022-06	Create new action
I had the most excellent treatment both at	563fc8ce / 2022-06	Create new action

Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 49

Survey: Brachytherapy Patient Survey

Start Date: 2022-05-11 00:00:00 **End Date:** 2022-06-20 23:59:59

The Heath and Velindre at every stage of my treatment and I am most grateful to all concerned. I also tried to remain positive throughout.		
Staff were very nice and put me at ease	59733438 / 2022-06	Create new action
Everything went very well with my treatment. And that is down to the doctors and nurses who took care of me. They were all fantastic and took time to explain everything they were doing and why.	642faf0e / 2022-06	Create new action
The staff were wonderful during my treatment, they were kind and patient and extremely professional, I have no complaints about the service I received	6f0473d6 / 2022-06	Create new action
Excellent communication gave me a clear understanding of what to expect before, during & after treatment. Especially important during Covid times with the uncertainty that entailed.	762a0f6f / 2022-06	Create new action
Always went very well and treated with respect	77f3b680 / 2022-06	Create new action
Excellent service... Lovely professional team who made me feel so comfortable, even the support lady who welcomed me into the waiting area.	7cabcc96 / 2022-06	Create new action
Everything was clearly explained. All staff were very attentive. I feel very fortunate to have received treatment so promptly, particularly given all the pressures on the NHS, at a facility on my doorstep.	8a74aa19 / 2022-06	Create new action
I was well looked after during and after the treatment, nursing staff very kind and caring	a0e484d7 / 2022-06	Create new action
Had to ask very little as everything was explained very well. I was given mobile numbers of two cancers nurses and was told I could ring any time.	a5ba6e8f / 2022-06	Create new action
Despite Covid restrictions every went without a hitch	b5f83481 / 2022-06	Create new action
Staff were very hands on and informative. I felt well looked after.	b64271ef / 2022-06	Create new action
Administration and application of treatment all went well.	c0a98362 / 2022-06	Create new action
I think the whole experience went very well and I am very pleased with all aspects of my care and follow up	cde78c70 / 2022-06	Create new action

Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 49

Survey: Brachytherapy Patient Survey

Start Date: 2022-05-11 00:00:00 **End Date:** 2022-06-20 23:59:59

Hopefully the highly targeted treatment will have the desired effect.	d0ee7fda / 2022-06	Create new action
The atmosphere was friendly & informal. I was put at my ease……..& thankfully there were no problems.	d12976f4 / 2022-06	Create new action
A very quick & painless procedure	ecaa0aac / 2022-06	Create new action
All was very nice towards me and answered any questions I asked and the sergeants/ doctors was great	f8bcf421 / 2022-06	Create new action
Overall very happy with the first class service received throughout all of my post surgery treatment. Staff were well qualified, dealt with matters directly but in a sensitive manner. An outstanding service overall. I have had a lot of bowel and bladder issues since having post op treatment but I know that this is not necessarily as a direct result of brachytherapy and can also be attributed to radiotherapy. Nonetheless an absolute outstanding service with staff who are an absolute credit to Nhs. Thank you	f98571dc / 2022-06	Create new action
all staff were approachable and knowledgeable putting me at ease during a testing time	fdbd9f33 / 2022-06	Create new action
The lady was very nice who treated me. Made me feel at ease	fdc7547c / 2022-06	Create new action

Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 49

Survey: Brachytherapy Patient Survey

Start Date: 2022-05-11 00:00:00 **End Date:** 2022-06-20 23:59:59

Question 24: Please provide details in the box below with regards to what you think could have been improved during your treatment:

Create new action

Cant think of anything that could be improved	03afaf53 / 2022-06	Create new action
I cannot think of anything my treatment went ok	04004643 / 2022-06	Create new action
All except for the one time I woke up during the treatment everything else went perfectly. I can't fault it at all.	25bc2ebc / 2022-06	Create new action
I personally cannot think of anything that needed improvement	285da726 / 2022-06	Create new action
All went well	33143ccd / 2022-06	Create new action
N/A	37b14730 / 2022-06	Create new action
Nothing in my opinion as I asked lots of questions ..the only thing that could have made it better was to be with same ladies that I met during daily radiotherapy..we were all at same stage of treatment and met almost daily for the five weeks .. then all together supporting each other at first brachytherapy session all nervous together....however I never saw these ladies again ..would have been a logistical nightmare to arrange all together ,however would have been good to compare side effects .	3eaf6086 / 2022-06	Create new action
Nothing.	44c3663e / 2022-06	Create new action
Correct measurements of fitting for treatment	55e825b2 / 2022-06	Create new action
Lot of pain passing urine the night after the first procedure I think due to the catheter-like passing needles - second procedure was fine	5a1db517 / 2022-06	Create new action
Everything went very well with my treatment. I was told from the start exactly what was going to happen. And was given help and information every step of the way..I could not have asked for better treatment.	642faf0e / 2022-06	Create new action
No complaints	6f0473d6 / 2022-06	Create new action
Nothing	77f3b680 / 2022-06	Create new action
Nothing to add	7cabcc96 / 2022-06	Create new action

Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 49

Survey: Brachytherapy Patient Survey

Start Date: 2022-05-11 00:00:00 **End Date:** 2022-06-20 23:59:59

At the pre-anaesthestic assessment I saw each team member separately. There was quite a bit of duplication so it all took much longer. Also, sometimes the information given was different and so had to be checked and corrected.	8a74aa19 / 2022-06	Create new action
My treatment was handled sensitively and professionally, I would struggle to think of any way in which it could be improved.	8b28cfc6 / 2022-06	Create new action
I could not have asked for better care	a0e484d7 / 2022-06	Create new action
There was only one time I had to wait longer than my appointment time	a5ba6e8f / 2022-06	Create new action
Nothing	b5f83481 / 2022-06	Create new action
Nothing that I can think of.	beca72d0 / 2022-06	Create new action
An opportunity to discuss procedure immediately before or after. I understand that time is an issue.	c0a98362 / 2022-06	Create new action
Nothing	cde78c70 / 2022-06	Create new action
Less time waiting around	d0ee7fda / 2022-06	Create new action
……if anything just the distance needed to travel.	d12976f4 / 2022-06	Create new action
Nothing	e29e9d18 / 2022-06	Create new action
The only problem I can remember was that some of my consent documentation went briefly missing	e472d9e0 / 2022-06	Create new action
No improvement necessary	ecaa0aac / 2022-06	Create new action
Administration of the suppository. Also I asked to remain on the ward overnight on both my procedures as I did not feel that I would have been comfortable going home straight after the procedure and I was right. I think it should be the default position. It may well be that is the position but I was unsure.	f8465d2f / 2022-06	Create new action
N/a	f8bcf421 / 2022-06	Create new action
Nothing it was first class from my own personal experience.	f98571dc / 2022-06	Create new action
i do not feel my experience could be improved as i feel that the centre is well run clean and friendly All grades of staff were fantastic Thankyou	fdbd9f33 / 2022-06	Create new action

Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 49

Survey: Brachytherapy Patient Survey

Start Date: 2022-05-11 00:00:00 **End Date:** 2022-06-20 23:59:59

Question 25: Please can you tell us what worried you the most during and after your Brachytherapy Treatment:

Create new action

How quickly I could resume normal life	03afaf53 / 2022-06	Create new action
Initial assessment worried about pain but after I experienced pain at first attempt to get right size everything was ok	04004643 / 2022-06	Create new action
During the treatment I wasn't really worried, once awake and in the ward the nurses were always popping to see if I needed anything, even the other people in the ward were lovely, we were all chatting with each other. After brackytherapy I didn't have any worries as I knew if I had any problems I could contact the team	25bc2ebc / 2022-06	Create new action
I felt anxious initially thinking of what side effects I would have experienced. During the months after I did have nausea most days. I still experience this now but to a lesser degree.	285da726 / 2022-06	Create new action
I was most worried whether I would experience short or long term side effects after the treatment.	33143ccd / 2022-06	Create new action
I worried about whether or not it would be painful or if it would return.	37b14730 / 2022-06	Create new action
After treatment the continence issues distressed me	3eaf6086 / 2022-06	Create new action
That the procedure was successful in curing me of my Prostate Cancer.	44c3663e / 2022-06	Create new action
Concern that I may experience pain…but I did not	490fead0 / 2022-06	Create new action
I worried that the process of insertion would hurt after my surgery but did not feel anything.	4a59c6d9 / 2022-06	Create new action
Anticipated pain during treatment t was a worry	55e825b2 / 2022-06	Create new action
That it would have side effects, fortunately it did not.	563fc8ce / 2022-06	Create new action
Side affects	59733438 / 2022-06	Create new action
Blood clot meant passing urine difficult for two days until blood clot passed	5a1db517 / 2022-06	Create new action

Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 49

Survey: Brachytherapy Patient Survey

Start Date: 2022-05-11 00:00:00 **End Date:** 2022-06-20 23:59:59

I was worried about what I was about to go through. But every one who was there to care for me were fantastic. They helped me through a very difficult time..	642faf0e / 2022-06	Create new action
Nothing	6f0473d6 / 2022-06	Create new action
My treatment took place during the Covid period. The intention was for me to return home after my 1st Brachytherapy treatment. However, as I was retaining water, I was kept in overnight in a ward which had a Covid patient. That was concerning at the time.	762a0f6f / 2022-06	Create new action
Nothing	77f3b680 / 2022-06	Create new action
I did not feel worried during treatment. Since treatment I have noticed a slight soreness when I pass urine. Also increased frequency passing urine. I am not unduly worried.	7cabcc96 / 2022-06	Create new action
I was most worried about what any side effects might be.	8a74aa19 / 2022-06	Create new action
I think I was most worried regarding the feeling of being out of control even though I had read all the literature explaining the procedure. I was also worried about the degree of side-effects I might experience afterwards.	8b28cfc6 / 2022-06	Create new action
I was just apprehensive about the procedure itself	a0e484d7 / 2022-06	Create new action
Worried whether the treatment would be successful	a5ba6e8f / 2022-06	Create new action
Nothing worried me as I was in the best place getting the best treatment	b5f83481 / 2022-06	Create new action
During was the discomfort when tube inserted. Afterwards, worry about whether treatment was successful and the side effects.	b64271ef / 2022-06	Create new action
Side effects.	c0a98362 / 2022-06	Create new action
That it would be successful	cde78c70 / 2022-06	Create new action
None	d0ee7fda / 2022-06	Create new action
Just general concerns regarding recovery. Thanks to the staff it made a worrying time more relaxed.	d12976f4 / 2022-06	Create new action
No worries	e29e9d18 / 2022-06	Create new action

Survey Summary Report

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Total Respondents: 49

Survey: Brachytherapy Patient Survey

Start Date: 2022-05-11 00:00:00 **End Date:** 2022-06-20 23:59:59

I don't respond well to general anaesthetic so I was worried about feeling unwell after the procedure (and in fact this sickness turned out to be the most significant acute side-effect of my treatment). I had quite a lot of bleeding after my biopsy, so I was worried that this might reoccur (in fact, I hardly had any problems of this sort). After treatment I was/am concerned about its long-term impact and whether it would be effective (so far good).	e472d9e0 / 2022-06	Create new action
I didn't feel worried	ecaa0aac / 2022-06	Create new action
Would it be successful? Had I made the correct decision rather that surgery? Although I had enough information to make an informed decision. The PSA levels, should I have an MRI to assess the success or not, although I have been assured that PSA monitoring is the best indicator of success.	f8465d2f / 2022-06	Create new action
I was very hopeful to beat it and ,and I'm also very grateful to of had the operation in the end	f8bcf421 / 2022-06	Create new action
I guess I woukd have to say if there was any need for further treatment as a result of non successful surgery and treatment. Some apprehensions with dilators but all well explained.	f98571dc / 2022-06	Create new action
the response of the tumour and after was the affect on my sexlife	fdbd9f33 / 2022-06	Create new action

Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 49

Survey: Brachytherapy Patient Survey

Start Date: 2022-05-11 00:00:00 **End Date:** 2022-06-20 23:59:59

Question 26: Is there anything else you'd like to tell us about your experience?

Create new action

I was back in work as a farmer within two days, and was back cycling within a week.	03afaf53 / 2022-06	Create new action
When i had blood clots and wasn't noticed on the scan	1bb5e6a3 / 2022-06	Create new action
Thank you for the excellent care I had from Velindre in relation to my radiotherapy.	33143ccd / 2022-06	Create new action
The facility was very clean and organized. Also the ceiling decor (flowers) were very soothing.	37b14730 / 2022-06	Create new action
Didn't realise how severe it would be ..however it is slowly improving ..	3eaf6086 / 2022-06	Create new action
All members of staff that worked along side sam were fantastic. All friendly, welcoming and professional	4a59c6d9 / 2022-06	Create new action
Thank you	59733438 / 2022-06	Create new action
The post operative help line was not very good - would have been better with direct contact with ward nurses to discuss urine issues	5a1db517 / 2022-06	Create new action
My experience was faultless, I had days when I was very tired and irritable, the staff were very reassuring, patient and kind. I will NEVER forget their kindness and professionalism.	6f0473d6 / 2022-06	Create new action
First rate service from all at Velindre.	762a0f6f / 2022-06	Create new action
Cannot fault the team	77f3b680 / 2022-06	Create new action
I felt very emotional on completing the treatment. It was an overwhelming mixture of gratitude and relief... I'll never forget the kindness of the staff.	7cabcc96 / 2022-06	Create new action
Overall I was very pleased with the treatment I received.	8a74aa19 / 2022-06	Create new action
Everybody was very kind and empathetic	a5ba6e8f / 2022-06	Create new action
No	b5f83481 / 2022-06	Create new action
As mentioned above, the staff were brilliant !!	b64271ef / 2022-06	Create new action
No.	beca72d0 / 2022-06	Create new action

Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 49

Survey: Brachytherapy Patient Survey

Start Date: 2022-05-11 00:00:00 **End Date:** 2022-06-20 23:59:59

N/A	d0ee7fda / 2022-06	Create new action
Within a short time I became quite ill with heart failure but it wasn't due to the treatment	e29e9d18 / 2022-06	Create new action
I only needed three consecutive weekly treatments & from start to finish it was good	ecaa0aac / 2022-06	Create new action
Just that I was extremely grateful that I had the opportunity to have brachytherapy as a choice. The treatment I received and the follow up has been first class. Velindre is a credit to the NHS in Wales	f8465d2f / 2022-06	Create new action
No	f8bcf421 / 2022-06	Create new action
Thank you to all staff.	f98571dc / 2022-06	Create new action

Survey Summary Report

Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 49

Survey: Brachytherapy Patient Survey

Start Date: 2022-05-11 00:00:00 **End Date:** 2022-06-20 23:59:59

Available Filters:

Note: The available filter selection is dependent on the report that is being generated.

Filter Option	Selection
Service Group	Velindre Cancer Centre,WBS
Directorate	Clinical Services,Collection Services,Facilities,Integrated care,Medicine,Operational Services,Operational Services and Delivery,Palliative Medicine,Radiation services,Research, Development & Innovation ,SACT/Medicines Management,Transforming Cancer Services,WBMDR
Service	Bone Marrow / Stem Cells,Catering services,Clinical,Clinical Psychology,Clinical Trials ,Communications & Engagement,Donor Engagement,General,Medicine,Nuclear Medicine,Nursing,Operational Services,Operations,Outpatients,Palliative care,Pharmacy,Planning / Logistics,Plasma,Platelets,Radiology,Radiotherapy,Radiotherapy/Brachytherapy,SACT,Therapies,Training,Whole Blood
Location	All Filters Selected

Survey	Brachytherapy Patient Survey
Question	All Questions Selected
Response	All Responses Selected
Category	Standard

Start Date	2022-05-11 00:00:00
End Date	2022-06-20 23:59:59

QUALITY, SAFETY AND PERFORMANCE COMMITTEE
2022 / 2023 QUARTER 1 INFORMATION GOVERNANCE ASSURANCE REPORT

DATE OF MEETING	14th July 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**
Executive Management Board	1st July 2022	Endorsed by EMB on 1st July 2022

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) Managing and Securing Records (3) data security incidents & investigations for the reporting period of 1st April 2022 to 31st May 2022.

The Committee is asked to **NOTE** 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 1 report for the period 1st April 2022 to 31st May 2022:

- The three IG Assurance Framework areas being focused on are: (1) IG Toolkit self-assessment, (2) Managing and Securing Records and (3) DPA requests, data security incidents & investigations. Work in these areas will lead to improvements in IG systems & processes.
- An extract of current DPIA activity is also included to provide assurance that DPIA processes are routine business for the delivery of services/systems.
- 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 July 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 four levels (0 to 3) of attainment which have been assessed for the 22 areas.
- The initial assessment was undertaken by the HoIG and included in the April QSP IG Assurance Report. It was highlighted that the assessments had not been fully reviewed by the SIRO, but the initial review was indicating that some of the assessments levels would increase as the SIRO new of evidence that the HOIG was not aware of due to him being relatively new to the role.
- Following a detailed review of the self-assessment by the SIRO and HOIG there have been changes to the assessment levels. The reviewed assessment for 2021/22 is set out in the table below:

Section	Expected attainment level	Level achieved 2020/21	Initial assessment of Level achieved 2021/22	Improvement/No Change/Reduction following initial assessment	Assessment following review	Rationale
Section 2 – Business Responsibilities						
2.2 – Policies and procedures	Level 3	Level 2	Level 2	No change	Level 2	Level 2 Criteria, "*there is a review process in place for all policies and procedures and changes are communicated to Staff*" – level 2 achieved
2.3 – Information Sharing	Level 3	Level 1	Level 2	Improvement	Level 2	Level 2 "*where appropriate Data Sharing/Processing Agreements are recorded in the form of an agreement register*" All DSA/DPA activity linked to DPIA activity, SOP is to consider DSA/DPA during procurement process and review the documents regularly.
2.4 – Contracts and Agreements	Level 3	Level 1	Level 0	Reduction	Level 1	Level 1 "*DP and IG contracts and agreements are in place with all suppliers, contractors, staff and third parties*" Trust has in place BRAVO system for all contracts over £25k, work still required on contract registers under £25k, but must be noted that wide area of the Trust that it will be an ongoing process year on year. It should be noted that there are databases held within VCC/WBS but more work is required in ascertaining granular detail.
2.5 – Data Protection	Level 3	Level 2	Level 2	No Change	Level 2	DPIA Process in place for all new services/systems work completed via a workshop approach

Section	Expected attainment level	Level achieved 2020/21	Initial assessment of Level achieved 2021/22	Improvement/No Change/Reduction following initial assessment	Assessment following review	Rationale
Impact Assessments						
Section 3 – Business Management						
3.2 – IG Risk Register	Level 3	Not assessed previous year	Level 0	n/a	Level 1	Whilst no dedicated IG Risk Register, Risks are recorded via DATIX reporting and escalated to Risk Registers within DATIX
3.3 – Auditing	Level 3	Not assessed previous year	Level 0	n/a	Level 1	Whilst Audits not undertaken personally by HOIG, IG is part of the Trust's Internal Audit plan It should be noted that the SLA in place between the Trust and DHCW for the DPO service which sets out to: 2. Monitor compliance with the GDPR and other data protection laws, and with data protection policies, including managing internal data protection activities; raising awareness of data protection issues, training staff and conducting internal audits.
Section 4 – Individual Rights and Obligations						
4.2 – Right to be informed	Level 3	Level 2	Level 2	No Change	Level 2	Whilst new materials "your information, your rights" now received and will be posted to website shortly, at the time of

Section	Expected attainment level	Level achieved 2020/21	Initial assessment of Level achieved 2021/22	Improvement/No Change/Reduction following initial assessment	Assessment following review	Rationale
						the assessment there was a need to update materials to achieve Level 3
4.4 – Rights related to automated decision making and profiling	Level 3	Not assessed the previous year	Level 1	n/a	Level 1	The Trust must have in place the means of identifying such processing. This is achieved via the DPIA process, and only the RITTA Project has been seen thus far, it is not signed off as not yet satisfied with information from the third party supplier
Section 5 – Managing and Securing Records (Electronic and Paper Records)						
5.1 – Management of Records	Level 3	Level 2	Level 1	Reduction	Level 2	Whilst a recent incident has highlighted concerns, the criteria for Level 2 is "procedures have been embedded and staff are informed", therefore Level 2 achieved.
5.2 – Information Asset Register	Level 3	Level 1	Level 1	No Change	Level 1	Level 1 – *"the organization has an extensive information asset register"* – Confirmed
5.3 – Data Accuracy	Level 3	Level 2	Level 1	Reduction	Level 1	Level 1 " the importance of data accuracy is recognized by the organization and there is supporting guidance and procedures in place to ensure information is updated when necessary" – Confirmed

Section	Expected attainment level	Level achieved 2020/21	Initial assessment of Level achieved 2021/22	Improvement/No Change/Reduction following initial assessment	Assessment following review	Rationale
5.4 – Retention Schedules, Secure Destruction and Disposal	Level 3	Level 2	Level 1	Reduction	Level 2	Level 2 – "*Management of organizational records is embedded within the organization"*
Section 6 – Technical, Physical and Organisational Security Measures						
6.1 – Physical Security Measures	Level 3	Level 2	Level 0	Reduction	Level 2	Level 2 – "*Staff are aware of and encouraged to maintain security measures*" – Assessor was not aware of specific policies and procedures at the time of assessment, has since met with operational services teams.
6.3 Organisational measures (Training and Awareness)	Level 3	Level 2	Level 2	No Change	Level 2	Level 2 achieved 70% mandatory training level as at 1 Jan 22 (attainment was 83.05%) which is below the level 3 attainment level of 85% as at 1 Jan 22 – Confirmed
6.6 – Surveillance Systems	Level 3	Level 1	Level 0	Reduction	Level 1	Level 1 – *The Organisation has defined policies and procedures around the use of surveillance systems including CCTV, Body Worn Cameras and other Surveillance systems*. CCTV is contained broadly y within Policy, HOIG met with TCS Programme Manager for

Section	Expected attainment level	Level achieved 2020/21	Initial assessment of Level achieved 2021/22	Improvement/No Change/Reduction following initial assessment	Assessment following review	Rationale
						new build BWC/CCTV and Estates for legacy CCTV, DPIA for TCS in draft, CCTV DPIA for legacy systems meeting w/c 27 Jun 22 with owners of systems.
Section 8 – Breach Management						
8.1 – Reporting Data Breaches	Level 3	Not assessed previous year	Level 3	n/a	Level 3	Level 3 – improvements are made to reduce the chance of re-occurrence and are reported to Board. A review process is in place to ensure the notification procedure remains relevant and works in practice – Confirmed

Level number	Level Achieved 2020/21	Initial assessment of level achieved 2021/22	Assessment for 2021/22 following review
Level 0	0	5	1
Level 1	4	5	6
Level 2	8	5	8
Level 3	0	1	1
Not assessed	4	0	0
Total	**16**	**16**	**16**

6 areas within sections reviewed and assessed levels remain the same as 2020-21, 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 Regulations
2.7 Privacy Electronic Communication 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
- For further information is available from the DHCW page: Welsh Information Governance Toolkit

DPIAs, contract register and associated Data Processing/Sharing Agreements (retained from previous reporting period to provide assurance)

- 33 DPIA's were commenced since Oct 21, 31 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
- 5 Trust DPIA's have been approved during the quarter, no NHS Wales DPIA's have been approved.
- DPIA's and Data Processing Agreements are not all currently aligned with Contract activity. Work is underway to ensure alignment.

(2) Managing and Securing Records

When considering Records Management and its principles, it is useful to understand the definition of a record, the ISO standard ISO:15489-1:2016 defines a record as:

> "*Information, created, received, and maintained as evidence and as an asset by an organization or person, in pursuance of legal obligations or in the transaction of business".*

This definition applies most accurately in relation to Trust corporate records which support non-clinical activity. In terms of health records (the term health is interchangeable with the term medical) Section 205 of the Data Protection Act 2018 defines a health record:

> *"consists of data concerning health"*
>
> *"has been made by or on behalf of a health professional in connection with the diagnosis, care or treatment of the individual to whom the data relates".*

The following are highlights for the Committee to consider:

- The Trust has in place a Records Management Policy which is aligned with the NHS Wales Records Management Code of Practice for Health and Social Care 2022.
- Velindre Cancer Centre has SOP's and Policies in place which are under review by HOIG to align with legislation, guidance and Trust policy, the review takes account of recent events in relation to Records Management to ensure that SOPs reflect a "desk instructions" approach.
- New electronic systems which process personal data are subject to risk assessment via the DPIA process, examples of which are; The Digital Health Care Record (DHCR) replacement project and the PSA Tracker project.
- Data Protection Impact Assessments for systems that feed data in to the DHCR replacement project have been sighted by HoIG in May 22 and a meeting held with DHCW to ensure that the Trust is aware of any emergent risk to the delivery of the project. One risk has been highlighted to the DHCR Replacement Project Board, which is:

    - *The need to ensure that as systems are decommissioned and data migrated to DHCR that any duplicated data is destroyed compliantly with the requirements of UK GDPR (must not be able to be reconstructed in any way, shape or form)*

- Legacy electronic and non-electronic systems and processes which process personal data and constitute records are under review in terms of ensuring that Data Protection Impact Assessments are in place, priority is being given to those systems that will not be decommissioned as part of the DHCR replacement project to ensure that review activity is proportionate and appropriate.

(3) DPA requests, data security incidents & investigations.

- The top three themes of incidents remain the same as the previous quarter, which as a reminder relate to confidentiality breaches; failure to secure records (lost), records misfiled, disclosed in error (sent/delivered to wrong recipient, divulged in error)
- Key learning throughout each quarter since Q3 2021/22 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
- For VCC 5 incidents are in the process of investigation,4 present low risk which is expected to present no harm. The 5th incident relates to the Offsite Storage Incident, which remains ongoing. NWSSP has undertaken Root Cause Analysis (RCA) on their reported incidents, all of which highlight human error as the common denominator.
- The backlog of incidents under investigation has decreased due to increased efforts of the Head of IG to reduce outstanding items and as a result of the Offsite Incident moving from incident management to legal activity.
- The ICO reportable incident relating to the off-site records storage remains ongoing and has been reported via highlight reporting to VCC SLT and EMB Run/Shape.
- A total of 42 requests for access to health records were received with **0% breaches against the one calendar month response timeframe.**
- 1 request was received for access to information held on an individual from law enforcement. T**here were 0% breaches against the one 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 Committee is asked to **NOTE** the 2022/2023 Quarter 1 Information Governance Assurance Report for **ASSURANCE**.

2022 / 2023 QUARTER 1

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 April 2022 to 31st May 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) Managing and Securing Records (3) data security incidents & investigations. Work in these areas will lead to improvements in IG systems & processes.
- An extract of current DPIA activity is also included to provide assurance that DPIA processes are routine business for the delivery of services/systems.
- Quarterly IG assurance meetings have been established between Mr. Stephen Harries (IM champion for IG), Matthew Bunce (SIRO) and newly appointed Chief Digital Officer to provide additional assurance to the committee. The first meeting will be arranged for July 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 prioritizing activity to be undertaken in 2022/23 and that planned for 2023/24.
    - The IG Toolkit has four levels (0 to 3) of attainment which have been assessed for the 22 areas.
    - The initial assessment was undertaken by the HoIG and included in the April QSP IG Assurance Report. It was highlighted that the assessments had not yet been fully reviewed by the SIRO, but the initial review was indicating that some of the assessments levels would increase as the SIRO was aware of evidence that the HOIG was not due to him being relatively new to the role.

- Following a detailed review of the self-assessment by the SIRO and HOIG there has been improvements to a number of the assessment levels. The reviewed assessment for 2021/22 is set out in the table below:

Section	Expected attainment level	Level achieved 2020/21	Initial assessment of Level achieved 2021/22	Improvement/No Change/Reduction following initial assessment	Assessment following review	Rationale
Section 2 – Business Responsibilities						
2.2 – Policies and procedures	Level 3	Level 2	Level 2	No change	Level 2	Level 2 Criteria, "*there is a review process in place for all policies and procedures and changes are communicated to Staff*" – level 2 achieved
2.3 – Information Sharing	Level 3	Level 1	Level 2	Improvement	Level 2	Level 2 "*where appropriate Data Sharing/Processing Agreements are recorded in the form of an agreement register*" All DSA/DPA activity linked to DPIA activity, SOP is to consider DSA/DPA during procurement process and review the documents regularly.
2.4 – Contracts and Agreements	Level 3	Level 1	Level 0	Reduction	Level 1	Level 1 "*DP and IG contracts and agreements are in place with all suppliers, contractors, staff and third parties*" Trust has in place BRAVO system for all contracts over £25k, work still required on contract registers under £25k, but must be noted that wide area of the Trust that it will be an ongoing process year on year. It should be noted that there are databases held within VCC/WBS but more work is required in ascertaining granular detail.

Section	Expected attainment level	Level achieved 2020/21	Initial assessment of Level achieved 2021/22	Improvement/No Change/Reduction following initial assessment	Assessment following review	Rationale
2.5 – Data Protection Impact Assessments	Level 3	Level 2	Level 2	No Change	Level 2	DPIA Process in place for all new services/systems work completed via a workshop approach
Section 3 – Business Management						
3.2 – IG Risk Register	Level 3	Not assessed previous year	Level 0	n/a	Level 1	Whilst no dedicated IG Risk Register, Risks are recorded via DATIX reporting and escalated to Risk Registers within DATIX
3.3 – Auditing	Level 3	Not assessed previous year	Level 0	n/a	Level 1	Whilst Audits not undertaken personally by HOIG, IG is part of the Trust's Internal Audit plan It should be noted that the SLA in place between the Trust and DHCW for the DPO service which sets out to: 2. Monitor compliance with the GDPR and other data protection laws, and with data protection policies, including managing internal data protection activities; raising awareness of data protection issues, training staff and conducting internal audits.
Section 4 – Individual Rights and Obligations						
4.2 – Right to be informed	Level 3	Level 2	Level 2	No Change	Level 2	Whilst new materials "your information, your rights" now received and will be posted to website shortly, at the time of the assessment there was a need to update materials to achieve Level 3

Section	Expected attainment level	Level achieved 2020/21	Initial assessment of Level achieved 2021/22	Improvement/No Change/Reduction following initial assessment	Assessment following review	Rationale
4.4 – Rights related to automated decision making and profiling	Level 3	Not assessed the previous year	Level 1	n/a	Level 1	The Trust must have in place the means of identifying such processing. This is achieved via the DPIA process, and only the RITTA Project has been seen thus far, it is not signed off as not yet satisfied with information from the third-party supplier
Section 5 – Managing and Securing Records (Electronic and Paper Records)						
5.1 – Management of Records	Level 3	Level 2	Level 1	Reduction	Level 2	Whilst a recent incident has highlighted concerns, the criteria for Level 2 is “procedures have been embedded and staff are informed”, therefore Level 2 achieved.
5.2 – Information Asset Register	Level 3	Level 1	Level 1	No Change	Level 1	Level 1 – *“the organization has an extensive information asset register”* – Confirmed
5.3 – Data Accuracy	Level 3	Level 2	Level 1	Reduction	Level 1	Level 1 “ the importance of data accuracy is recognized by the organization and there is supporting guidance and procedures in place to ensure information is updated when necessary” – Confirmed
5.4 – Retention Schedules, Secure Destruction and Disposal	Level 3	Level 2	Level 1	Reduction	Level 2	Level 2 – “*Management of organizational records is embedded within the organization”*

Section	Expected attainment level	Level achieved 2020/21	Initial assessment of Level achieved 2021/22	Improvement/No Change/Reduction following initial assessment	Assessment following review	Rationale
Section 6 – Technical, Physical and Organisational Security Measures						
6.1 – Physical Security Measures	Level 3	Level 2	Level 0	Reduction	Level 2	Level 2 – "*Staff are aware of and encouraged to maintain security measures*" – Assessor was not aware of specific policies and procedures at the time of assessment, has since met with operational services teams.
6.3 Organisational measures (Training and Awareness)	Level 3	Level 2	Level 2	No Change	Level 2	Level 2 achieved 70% mandatory training level as at 1 Jan 22 (attainment was 83.05%) which is below the level 3 attainment level of 85% as at 1 Jan 22 – Confirmed
6.6 – Surveillance Systems	Level 3	Level 1	Level 0	Reduction	Level 1	Level 1 – *The Organization has defined policies and procedures around the use of surveillance systems including CCTV, Body Worn Cameras and other Surveillance systems*. CCTV is contained broadly y within Policy, HOIG met with TCS Programme Manager for new build BWC/CCTV and Estates for legacy CCTV, DPIA for TCS in draft, CCTV DPIA for legacy systems meeting w/c 27 Jun 22 with owners of systems.
Section 8 – Breach Management						
8.1 – Reporting Data Breaches	Level 3	Not assessed previous year	Level 3	n/a	Level 3	Level 3 – improvements are made to reduce the chance of re-occurrence and are reported to Board. A review process is in place to ensure the notification procedure remains relevant and works in practice – Confirmed

Level number	Level Achieved 2020/21	Initial assessment of level achieved 2021/22	Assessment for 2021/22 following review
Level 0	0	5	1
Level 1	4	5	6
Level 2	8	5	8
Level 3	0	1	1
Not assessed	4	0	0
Total	16	16	16

6 areas within sections reviewed and assessed levels remain the same as 2020-21, 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 Regulations
2.7 Privacy Electronic Communication 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

- **DPIAs, contract register and associated Data Processing/Sharing Agreements**

  - 33 DPIA's were commenced since Oct 21, 31 of which are Trust DPIA's, 2 are NHS Wales national DPIA's
  - Work remains underway to identify all existing Trust systems and where a DPIA has not been completed. A risk-based approach will be taken to prioritizing assessments that can be undertaken in 2022/23
  - 5 Trust DPIA's have been approved during the quarter, no NHS Wales DPIA's have been approved.
  - DPIA's and Data Processing Agreements are not all currently aligned with Contract activity. Work remains underway to ensure alignment.

- **Managing and Securing Records**

When considering Records Management and its principles, it is useful to understand the definition of a record, the ISO standard ISO:15489-1:2016 defines a record as:

> "*Information, created, received, and maintained as evidence and as an asset by an organization or person, in pursuance of legal obligations or in the transaction of business".*

This definition applies most accurately in relation to Trust corporate records which support non-clinical activity. In terms of health records (the term health is interchangeable with the term medical). Section 205 of the Data Protection Act 2018 defines a health record:

> *"consists of data concerning health"*
>
> *"has been made by or on behalf of a health professional in connection with the diagnosis, care or treatment of the individual to whom the data relates".*

The following are highlights for the Committee to consider:

- The Trust has in place a Records Management Policy which is aligned with the NHS Wales Records Management Code of Practice for Health and Social Care 2022.
- Velindre Cancer Centre has SOP's and Policies in place which are under review by HOIG to align with legislation, guidance and Trust policy, the review takes account of recent events in relation to Records Management to ensure that SOPs reflect a "desk instructions" approach.
- New electronic systems which process personal data are subject to risk assessment via the DPIA process, examples of which are The Digital Health Care Record (DHCR) replacement project and the PSA Tracker project.
- Data Protection Impact Assessments for systems that feed data in to the DHCR replacement project have been sighted by HoIG in May 22 and a meeting held with DHCW to ensure that the Trust is aware of any emergent risk to the delivery of the project. One risk has been highlighted to the DHCR Replacement Project Board, which is:
    - *The need to ensure that as systems are decommissioned and data migrated to DHCR that any duplicated data is destroyed compliantly with the requirements of UK GDPR (must not be able to be reconstructed in any way, shape or form)*
- Trust legacy electronic and non-electronic systems and processes which process personal data and constitute records are under review. The aim of the review is to ensure that where appropriate DPIA's are in place. Priority is

being given to those systems that will not be decommissioned nor superseded by the DHCR replacement project.

- **DPA requests, data security incidents & investigations**

Incidents & Investigations for the period 1st April 2022 to 31st May 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	10	0	10	1	9	1	10	5	5	10
WBS	0	0	0	0	0	0	0	0	0	0
NWSSP	4	8	12	0	8	4	12	0	12	12
Total Trust	**14**	**8**	**22**	**1**	**17**	**5**	**22**	**5**	**17**	**22**

- The top three themes of incidents remain the same as the previous quarter. Which as a reminder relate to confidentiality breaches; failure to secure records (lost) and records misfiled, disclosed in error (sent/delivered to wrong recipient, divulged in error)
- Key learning throughout each quarter since Q3 2021/22 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
- For VCC 5 incidents are in the process of investigation,4 present low risk which is expected to present no harm. The 5th incident relates to the Offsite Storage Incident, which remains ongoing. NWSSP has undertaken Root Cause Analysis (RCA) on their reported incidents, all of which highlight human error as the common denominator.
- The backlog of incidents under investigation has decreased due to increased efforts of Head of IG to reduce the amount outstanding items and as a result of the Offsite Storage Incident moving from Incident Management to legal activity.

1. ASSESSMENT OF MATTERS FOR CONSIDERATION

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"

1.1 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.

- Managing and Securing Records – this is how we ensure that the Trust complies with legislation and statutory codes of practice for the management of corporate and health records as defined in ISO:15489-1:2016 and Section 205 of the Data Protection Act respectively.

- Requests, Incidents and Investigations – this provides assurance that the Trust is processing requests for information from members of the public in line with Data Protection Legislation. It also provides assurance that the Trust is investigating and processing incidents in accordance with Data Protection Legislation. That it learns from the incidents and puts in place measures (including where appropriate the change of established procedures) to reduce the chance of re-occurrence of incidents. Follow up awareness and training sessions based on the incidents that are occurring across the Trust. Should there be further administrative action required, this recommendation is communicated by the Head of IG to the Line Manager for further consideration.

1.1.1 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.

For further information the Committee is invited to access information on the DHCW page: Welsh Information Governance Toolkit

Action:

- Update the IG Workplan to reflect on new areas of improvement required
- Sharing of assessments across Wales to support learning and improvements once all toolkits have been made available by DHCW

A comparison table for FY 2020/21 and FY 2021/22 is at **Appendix 1.**

1.1.2 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 in relation to Trust key systems to assess the status of the DPIA's. the initial finding whereby systems in use pre-GDPR (25 May 2018) that DPIA's were not undertaken 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 based on systems that will not be decommissioned nor superseded by the DHCR project so that resources are used wisely.

The workshop approach now appears to be bearing fruit with consultants understanding the value of the process for the delivery of projects (e.g. PSA Tracker Project).

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
33	31	2	Commenced by data Owner
11	11	0	Approved by HoIG

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 based on systems not being decommissioned as part of the DHCR project.

1.1.3 Managing and Securing Records

1.2.3.1 Code of Practice on the Management of Records issued under Section 46 of the Freedom of Information Act 2000

The Code of Practice on the Management of Records issued under Section 46 of the Freedom of Information Act 2000 is a statutory code of practice, the code falls in to three sections:

- Introduction to the Code and its legal basis.
- Sets out the principles of good information management practice.
- Deals with historical records.

The Code outlines the Principles relating to the need to keep information, and these are:

- For accountability and audit
- To comply with regulatory requirements, including the provisions of FOIA.

- To protect legal and other rights and interests.
- As a historical record.

The Code requires the Trust to periodically assess the information that is held, the Trust must know why the information is kept and be able to explain if information is no longer held. This is achieved by keeping a record of decisions as to whether information is to be kept, archived or destroyed. The Principles below allow this decision-making process to be achieved:

- Value – The Trust must understand manage and use information in a way that enables it to understand its value, this allows the Trust to make effective decisions for the benefit of society. It should be understood that the value of information will change over time, the following are broad examples of those changes:

    - Immediate – this is the value when first created, it must satisfy its initial purpose.
    - Operational – this is the value of working information.
    - Evidentiary – this is the value of information for audit, accountability or regulatory purposes.
    - Potential – information used to create new knowledge, improve services or generate income.
    - Historic – the contribution of information to the long-term memory of society as well as the corporate memory of the Trust.

- Integrity – the Trust and all of our stakeholders must be able to reply on and trust the information that we hold.

- Accountability – the Trust's information management must enable us to provide a clear and accurate account of our activity in accordance with our legal and other obligations.

Annex B of the code relates to the Status of the Code and obligation by public authorities such as the Trust to comply. It fulfils the duty of the Secretary of State for Digital, Culture, Media and Sport to provide guidance to the Trust on the practice, in the opinion of the Secretary of State, it would be "*desirable for a public authority to follow in connection with the keeping, management and destruction of records*" (FOIA S.26(1)).

In real terms compliance with the Code means that the Trust is more likely to comply with other legislation on the keeping, management and destruction of records, this includes the Freedom of Information Act 2000, Public Records Act 1958, the Data Protection Act 2018 and other statutory obligations such as the right to inspect documents under the Local Government Act 1972.

The Information Commissioner (ICO) has a statutory duty to promote good practice and to promote compliance with the Code. The ICO may issue a practice recommendation under Section 48 of the FOIA to public authorities whose practice does not conform to the Code.

1.2.3.2 NHS Wales Records Management Code of Practice for Health and Social Care 2022

The Welsh Government issued the NHS Wales Records Management Code of Practice for Health and Social Care 2022 (NHS Wales Code of Practice) in March 2022. The Code of Practice is

embedded within the Trust's Records Management Policy which is presented within a separate paper.

The NHS Wales Code of Practice embodies the intent of the Code of Practice on the Management of Records issued under Section 46 of the Freedom of Information Act 2000 but is centered on the management of health and corporate records for the NHS in Wales. It contains much more granular information which enables clinical and non-clinical staff to comply with the Statutory requirements in both Codes of Practice.

VCC's Medical Records Manager and the Trust's Head of Information Governance are both members of the all-Wales Health Records Management Advisory Group (HRMAG). The HoIG is one of three IG professionals from NHS Wales that sit within the Group with the aim of providing Information Governance advice and guidance. HRMAG reports to the Information Governance Management Advisory Group (IGMAG) which feeds back to the relevant Trust/Health Board any emerging issues/risks/changes in legislation that may affect the Trust/Health Board.

Recent events have highlighted the need for accurate and up to date records, the incident report is a separate paper for consideration by the Committee. An area of ongoing work is the need to ensure that where records are stored and that accurate records of their whereabouts are known at all times.

1.2.3.3 National Inquiries

The NHS in Wales will shortly be subject to two national inquiries that will directly affect Trust Activity. It is therefore crucial that the Trust complies with the NHS Wales Records Management Code of Practice for Health and Social Care 2022.

The following Inquiries are ongoing or are about to commence:

- The Infected Blood Inquiry
- COVID19 Inquiry

The infected Blood Inquiry has been in operation for four years and is expected to continue for at least one more year. It is important to note in respect of the need to retain records, that the following is considered:

> *"organizations have to follow the request of the original letter to Dr Andrew Goodall from Sir Brian Langstaff (5th July 2018) which states the retention of all information which is "potentially relevant to the issues set out in the TOR"*

The upcoming COVID 19 Inquiry has resulted in the setting up of a COVID 19 Preparation Group led by the Director of Governance and Chief of Staff. The aim of the group is to ensure that information is provided in a timely and efficient manner should it be requested. Current information is that requests for information may not arrive until autumn,2022, but there is much to do in preparation. In common with other Trust's/LHB's, the Trust is recruiting an Archivist working under the line management of the Head of Information Governance to support this important piece of work.

To further increase efficiency and use technology as advantageously as possible, The Trust is also examining the use Robotic Process Automation (RPA). RPA would enable the automated extract of documentation related to COVID-19 based on a set of defined search criteria, to significantly reduce the amount of time needed to identify and catalogue documentation which may be required by the enquiry, whilst ensuring compliance with relevant Codes of Practice. The Digital Team are constructing a Business Case for the use of RPA within the Trust – this is a separate piece of work outside the IG Function but is anticipated to support COVID 19 inquiry activity.

1.2.3.4 Digital Health Care Replacement Programme

The Trust's Head of IG has engaged with the DHCW team acting as the link from an IG perspective to ensure that the Trust is kept aware of activity at the national level. The Head of IG is also a member of the Trust's Digital Health and Care Record Implementation Team (CaNISC Replacement) which meets on a monthly basis. At the latest meeting on 15th June 2022, he advised the Team that DHCW had identified a specific risk via the DPIA process in March 2022 in that:

> "*the need to ensure that as systems are decommissioned and data migrated to DHCR that any duplicated data is destroyed compliantly with the requirements of UK GDPR and Trust Policy and Procedures (data must not be able to be reconstructed in any way, shape or form*"

The Head of IG has taken this for further action, updating the risk on DATIX to ensure that risks are managed in line with Trust policy.

Action:

- Ensure that the revised Records Management Policy is communicated effectively to all Trust Staff – see IG Toolkit Section 5.1 (Management of Records)
- Ensure that local SOP's and Divisional Policies are reviewed and aligned with Trust Policy – see IG Toolkit Section 5.1(Management of Records)
- Further embed the NHS Wales Records Management Code of Practice for Health and Social Care 2022 across the Trust – see IG Toolkit Section 5.1 (Management of Records)
- Begin to conduct spot checks based on the retention policies in the Code of Practice during FY 2022/23 – see IG Toolkit Section 5.4 (Retention Policies)
- Head of IG to continue to liaise effectively with DHCW Team IG team – See IG Toolkit Section 2.5 (DPIA's)
- Head of IG to remain fully engaged with the Trust DHCR Implementation Team and Trust Digital colleagues providing advice, guidance and support as necessary as an enabler to achieve project delivery in November 2022 – see IG Toolkit Section 3.2 IG (Risk)
- Head of IG to continue to support the aims and objectives of the COVID 19 Inquiry Preparation Group – See IG Toolkit Section 5.1 (Management of Records)

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 April 2022 – 31st May 2022 a total of 42 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 1 request was made to provide information held on an individual. The request was related to information requested by South Wales Police in connection with a criminal investigation. The request is complete. There were **0% breaches against the one-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) remains ongoing due to its serious nature. And as previously reported was reported to the Information Commissioner's Office, WG and nationally.

Velindre Cancer Centre (VCC) Incidents

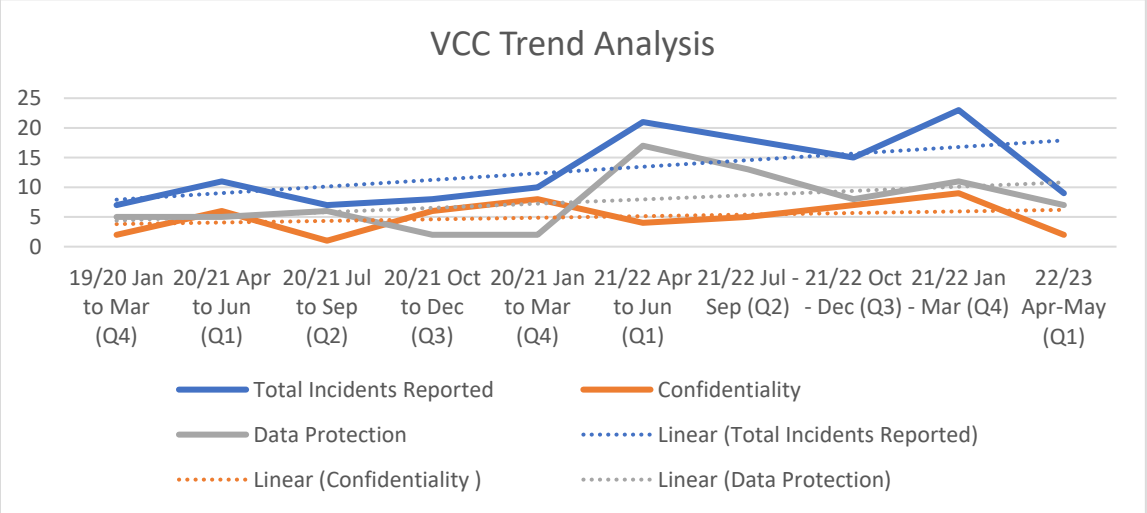
Quarter 1 (1st April 2022 – 31st May 2022)

Reported via Datix

There have been 9 Data security incidents reported within Datix this period, 1 remains outstanding from the previous period (Offsite Storage Incident). The table below illustrates the causes more accurately:

No	Reason	Number of Incidents	Open	Closed	Reported to ICO
1	Care delivered to wrong patient	1	1	0	0
2	Communication issues within unit/ward/teams	1	0	1	0
3	Patient records/information inappropriately accessed (electronic and paper)	1	1	0	0
4	Patient records/information inappropriately divulged	1	1	0	0
5	Patient records/information lost (electronic and paper) (includes offsite storage incident)	2	1	1	1
6	Patient records/information sent to wrong recipient	3	1	2	0
7	Pre-treatment activities/imaging (to include CT, simulation, clinical markup)	1	0	1	0
	Total	10	4	5	1

VCC Incident Trend Analysis



The core reasons for Q1 2022/23 are:

- Lack of attention to detail resulting in simple avoidable errors
- Inappropriate use of receptacles for the storage of confidential waste of which the design of the working area was a contributory factor
- Lack of awareness in relation to contractual arrangements for the secure and compliant disposal of personal data.

The Committee is requested to note that outcomes of incidents and lessons learnt are shared at team meetings, QSMG (where further internal action may be required to address organizational issues) and IG training awareness sessions.

Welsh Blood Service (WBS)

During the period, WBS did not report any incidents related to IG on DATIX.

NHS Wales Shared Services Partnership (NWSSP) reported incidents

Quarter 1 (1st April 2022 – 31st May 2022)

Reported via Datix

There have been **4** (**8** reported where the incident originated outside the organization but was experienced by NWSSP) Data security incidents reported within Datix this period. The table below illustrates the causes more accurately:

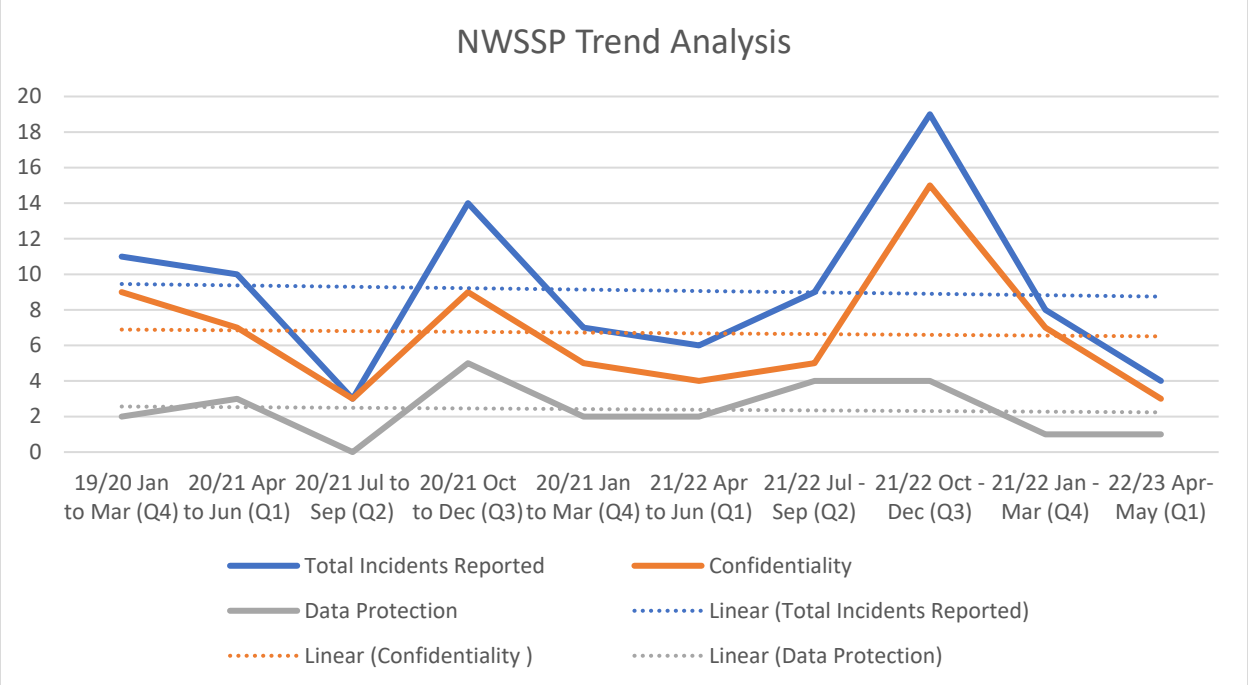
No	Reason	Number of Incidents	Open	Closed	Reported to ICO
1	Information inappropriately divulged	1	0	1	0
2	Breach of staff/contractor confidentiality	1	0	1	0
3	Staff records/information lost	1	0	1	0
4	Patient records inappropriately accessed	1	1	0	0
	Reported as a concern	8	0	8	0
	Total	**12**	**1**	**11**	**0**

The 4 incidents have been broken down into the following departments:

Department	Q1 2022/23
Employment Services	1
Primary Care	1
Procurement Services	1
Single Lead Employer	1
Total	**4**

The removal of the 8 incidents that are classified as recording only/concern leaves the 8 incidents in rows 1-4 above which required further investigation. All incidents are reported as closed. The RCA and lessons learned identify human error as the main cause of incidents.

NWSSP Incident Trend Analysis



VCC IG Root Cause Analysis Investigations

The incidents reported during Q1 2022/23 did not require a Root Cause Analysis investigation outside the process which is undertaken during incident reviews within DATIX.

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 attention to detail, IG awareness and 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 and/or individuals 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 – Updated 16th June 2022

Section	Description of section requirement and expected attainment level	Self-assessment of level achieved 2020/21	Initial Self-assessment of level achieved 2021/22	Assessment Review	Rationale
Section 2 – Business Responsibilities					
2.2 – Policies and Procedures					
0 – The organisation has considered the requirements necessary to progress and confirm action is being taken to working toward these					
1 – The organisation has a number of policies and procedures in the context of IG. National policies such as Information Security, IG and Email use have been adopted and made available to Staff					
2 - There is a review process in place for all policies and procedures and any changes are communicated to staff					
3 - Compliance with policies and procedures are regularly monitored to ensure they have been adopted in practice throughout the organisation					
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: 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: Review of policies and procedures at final stages and ready to be socialised prior to final approval by the Committee via EMB. Spot check procedure to be undertaken to ensure compliance across all areas of the Trust	**Level 2**	Level 2 Criteria, "*there is a review process in place for all policies and procedures and changes are communicated to Staff*" – level 2 achieved

Section	Description of section requirement and expected attainment level	Self-assessment of level achieved 2020/21	Initial Self-assessment of level achieved 2021/22	Assessment Review	Rationale
2.3 – Information Sharing					
0 - The organisation has considered the requirements necessary to progress and confirm action is being taken to working toward these					
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 (UK GDPR) and Data Protection Act 2018 (DPA)					
2 – Where appropriate Information Sharing Protocols or Data Disclosure Agreements are recorded in a 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					
3 – There is a review process in place to ensure that Agreements are kept up to date. Any changes or updates are reflected in the Agreement Register.					
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:	**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. 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	**Level 2**	Level 2 "*where appropriate Data Sharing/Processing Agreements are recorded in the form of an agreement register*" All DSA/DPA activity linked to DPIA activity, SOP is to consider DSA/DPA during procurement process and review the documents regularly.

Section	Description of section requirement and expected attainment level	Self-assessment of level achieved 2020/21	Initial Self-assessment of level achieved 2021/22	Assessment Review	Rationale
		Development of an Agreement Register in order to fully document associated Sharing agreements.			
2.4 – Contracts and Agreements					
0 – The organisation has considered the requirements necessary to progress and confirm action is being taken to working toward these					
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.					
2 – All contracts and agreements are documented to allow easier assessment of current contracts/agreements already in place and due diligence checks are carried out on all potential suppliers, contractors, data processors and third parties.					
3 - A review process is in place to ensure that all contracts and agreements are regularly reviewed and any changes are communicated appropriately					
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: 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**. Whilst the Trust has in place T+C's, DPIA's and DSA/DPA's are required to ensure that all areas are compliant. 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.	**Level 1**	Level 1 "*DP and IG contracts and agreements are in place with all suppliers, contractors, staff and third parties*" Trust has in place BRAVO system for all contracts over £25k, work still required on contract registers under £25k, but must be noted that it is a wide area of estate and that it will be an ongoing process year on year

Section	Description of section requirement and expected attainment level	Self-assessment of level achieved 2020/21	Initial Self-assessment of level achieved 2021/22	Assessment Review	Rationale
2.5 – Data Protection Impact Assessments					
0 – The organisation has considered the requirements necessary to progress and confirm action is being taken to working toward these					
1 - A process to facilitate the completion of Data Protection Impact Assessments (DPIA) is in place to highlight potential risks for new projects/services. All DPIA's are collated to form a register and this is regularly maintained					
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					
3 - DPIA documentation is regularly reviewed and compliance with the process is reported to the Board/Committee					
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. Reporting of DPIA activity only began in Mar 22 and is still being embedded, so assess Level 2 for this year.	**Level 2**	DPIA Process in place for all new services/systems work completed via a workshop approach
Section 3 – Business Management					
3.2 – IG Risk Register					
0 - The organisation has considered the requirements necessary to progress and confirm action is being taken to working toward these					
1 - The organisation analyses IG risks regularly and documents in a formal IG risk register					
2 - There is a clear understanding and management of identified IG risks					
3 - Regular review of processes and the IG risk register are undertaken to ensure they remain up to date, with mitigations regularly checked to ensure they remain effective					
3.2 - Risk Register	Level 3 - Regular review of processes and the IG risk register are undertaken to ensure	**Not assessed the previous year**	**Level 0** - Assessment is the Trust has **not achieved Level 1** - The organisation analyses IG risks regularly and	**Level 1**	*The organization analyses IG risks regularly and documents in a formal IG Risk Register*. Whilst

Section	Description of section requirement and expected attainment level	Self-assessment of level achieved 2020/21	Initial Self-assessment of level achieved 2021/22	Assessment Review	Rationale
	they remain up to date, with mitigations regularly checked to ensure they remain effective		documents in a formal IG risk register.		no dedicated IG Risk Register, Risks are recorded via DATIX reporting and escalated to Risk Registers within DATIX
3.3 - Auditing					
0 - The organisation has considered the requirements necessary to progress and confirm action is being taken to working toward these					
1 - Organisations have audit processes in place to oversee all aspects of the Information Governance agenda					
2 – Audit processes are used to regularly monitor appropriate use of personal information					
3 - There is a review process on all the auditing programmes the organisation undertakes to ensure it remains relevant and feedback is acted on					
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.	**Level 1**	Whilst Audits not undertaken personally by HOIG, IG is part of the Trust's Internal Audit plan
Section 4 – Individual Rights and Obligations					
4.2 – Right to be informed					
0 - The organisation has considered the requirements necessary to progress and confirm action is being taken to working toward these					
1 – The organisation has developed and made available privacy information to respect individuals rights to comply with the General Data Protection Regulations and the Data Protection Act					
2 - Privacy information accommodates a diversity of individuals and is made available by varied means e.g. health board website etc.					
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					

Section	Description of section requirement and expected attainment level	Self-assessment of level achieved 2020/21	Initial Self-assessment of level achieved 2021/22	Assessment Review	Rationale
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. The following should be noted: 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. 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.	**Level 2**	Whilst new materials "your information, your rights" now received and will be posted to website shortly, at the time of the assessment there was a need to update materials to achieve Level 3
4.4 – Rights related to profiling and automated decision making that has an impact on the data subject					
0 - The organisation has considered the requirements necessary to progress and confirm action is being taken to working toward these					
1 - 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 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.					
2 – Individuals are made aware that data protection rights apply to automated decision making. Staff involved in procuring, managing and operating relevant systems are appropriately trained in data protection. DPIA's have been undertaken on any automated decision making that has a significant impact on data subjects.					
3 – Automated decision making systems are regularly reviewed, including for accuracy and bias. Identified staff are authorised to undertake reviews, investigate complaints and necessary change decisions based on their findings. The use of all forms of automated decision making is overseen by the appropriate Board / Committee / Management Team, as appropriate					

Section	Description of section requirement and expected attainment level	Self-assessment of level achieved 2020/21	Initial Self-assessment of level achieved 2021/22	Assessment Review	Rationale
4.4 – 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 / Management Team, as appropriate	**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. 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 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.	**Level 1**	The Trust must have in place the means of identifying such processing. This is achieved via the DPIA process, and only the RITTA Project has been seen thus far, it is not signed off as not yet satisfied with information from the third-party supplier
Section 5 – Managing and Securing Records (Electronic and Paper Records)					
5.1 Managing and Securing Records					
0 - The organisation has considered the requirements necessary to progress and confirm action is being taken to working toward these					
1 - There are processes and procedures for staff to follow for the creation, management, retention, and archiving of records					

Section	Description of section requirement and expected attainment level	Self-assessment of level achieved 2020/21	Initial Self-assessment of level achieved 2021/22	Assessment Review	Rationale
2 – Procedures have been embedded within the organisation and staff informed					
3 - Procedures are regularly reviewed and maintained and spot checks are made to ensure the procedures are enforced across the organisation					
5.1 – Management and Securing 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.	**Level 2** - Procedures have been embedded within the organisation and all staff have been informed	Whilst a recent incident has highlighted concerns, the criteria for Level 2 is "procedures have been embedded and staff are informed", therefore Level 2
5.2 – Information Asset Register					
0 - The organisation has considered the requirements necessary to progress and confirm action is being taken to working toward these					
1 - The organisation has an extensive Information Asset Register (IAR).					
2 – There is a reporting procedure to notify the responsible department of any new/changes with the processing activities and to highlight areas of non-compliance					
3 - The IAR is a working document and the reporting procedure is regularly reviewed to ensure it remains effective and up to date					
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.	**Level 1**	Level 1 – *"the organization has an extensive information asset register"* – Confirmed

Section	Description of section requirement and expected attainment level	Self-assessment of level achieved 2020/21	Initial Self-assessment of level achieved 2021/22	Assessment Review	Rationale
5.3 – Data Accuracy					
0 - The organisation has considered the requirements necessary to progress and confirm action is being taken to working toward these					
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.					
2 - System validation processes exist within the organisation; active steps are taken to address any systems lacking validation.					
3 - All procedures are regularly reviewed and where available spot checks are made to ensure the procedures are enforced across the organisation					
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	**Level 1**	Level 1 " the importance of data accuracy is recognized by the organization and there is supporting guidance and procedures in place to ensure information is updated when necessary" – Confirmed
5.4 – Retention Schedules, Secure Destruction and Disposal					
0 - The organisation has considered the requirements necessary to progress and confirm action is being taken to working toward these					
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.					
2 - Management of organisational records is embedded within the organisation.					
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					

Section	Description of section requirement and expected attainment level	Self-assessment of level achieved 2020/21	Initial Self-assessment of level achieved 2021/22	Assessment Review	Rationale
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: 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. 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	**Level 2**	Level 2 – "*Management of organizational records is embedded within the organization"*
Section 6 – Technical, Physical and Organisational Security Measures					
6.1 – Physical Security Measures					
0 - The organisation has considered the requirements necessary to progress and confirm action is being taken to working toward these					
1 – The organisation holds a set of policies and procedures addressing he security of all premises and departmental areas					
2 – Staff are aware of and encouraged to maintain security measures					
3 - All reasonable steps have been taken to ensure the premises is secure by undertaking regular checks/audits and any improvements are considered and implemented where necessary					
6.1 – Physical Security Measures	**Level 3** - All reasonable steps have been taken to ensure the premises, equipment, records	**Level 2** - Improvements identified by the risk assessment are being made to secure the premises, equipment,	**Level 0** - The assessment is that **Level 1 has not been achieved** (*the Trust has policies and procedures in place addressing security of*	**Level 2**	Level 2 – "*Staff are aware of and encouraged to maintain security measures*" – Assessor was not

Section	Description of section requirement and expected attainment level	Self-assessment of level achieved 2020/21	Initial Self-assessment of level achieved 2021/22	Assessment Review	Rationale
	and other assets are physically secured. Physical security measures are subject to regular risk assessment. Supplementary policies and procedures are regularly reviewed and approved	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: Routine audit inspection process established across the respective areas of the Trust	*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.		aware of specific policies and procedures at the time of assessment, has since met with operational services teams.
6.3 – Organisational Measures (Training and Awareness)					
0 - The organisation has considered the requirements necessary to progress and confirm action is being taken to working toward these					
1 – Information Governance training has been provided to staff in line with the core skills framework. Processes are in place to ensure temporary staff, volunteers and students have received appropriate IG training.					
2 – The Trust is increasing compliance with IG mandatory training. There is a training strategy in place to identify the need and provision of specialist IG training					
3 – The organisation has a high level of mandatory IG training compliance. Training content is regularly reviewed and updated. Feedback is requested where appropriate.					
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	**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	**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	**Level 2**	Level 2 achieved 70% mandatory training level as at 1 Jan 22 (attainment was 83.05%) which is below the level 3 attainment level of 85% as at 1 Jan 22 – Confirmed

Section	Description of section requirement and expected attainment level	Self-assessment of level achieved 2020/21	Initial Self-assessment of level achieved 2021/22	Assessment Review	Rationale
	is able to meet 85% compliance in mandatory training for IG?. Compliance reports are provided? the IG training programme is kept under review by DPO?	students?. The following should be noted: Training programme of work strengthened in order to improve overall Trust wide training compliance	students?. The following should be noted The Trust achieved 83.05% in all areas. Whilst reporting is taking place accurately. Support may be required at EMB level to improve Trust wide attainment of level 1 mandatory training in IG.		
6.6 – Surveillance Systems					
0 - The organisation has considered the requirements necessary to progress and confirm action is being taken to working toward these					
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					
2 – Training has been provided to all staff who manage or operate recording devices. Identified risks are highlighted with current and new recording equipment					
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					
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	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*	**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.	**Level 1**	Level 1 – *The Organization has defined policies and procedures around the use of surveillance systems including CCTV, Body Worn Cameras and other Surveillance systems*. CCTV is contained broadly y within Policy, HOIG met with TCS Programme Manager

Section	Description of section requirement and expected attainment level	Self-assessment of level achieved 2020/21	Initial Self-assessment of level achieved 2021/22	Assessment Review	Rationale
	to the appropriate forum	*other surveillance systems in use within the organisation* was not achieved.			for new build BWC/CCTV and Estates for legacy CCTV, DPIA for TCS in draft, CCTV DPIA for legacy systems meeting w/c 27 Jun 22 due availability of owners of systems.
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 – Information Governance Incident					
8.1 – Reporting					
0 - The organisation has considered the requirements necessary to progress and confirm action is being taken to working toward these					
1 – There are supporting policies and procedures available to inform individuals of the reporting structure of any Information Governance related incidents. Such policies and procedures also details the requirements around the reporting of data breaches to the ICO, data subjects and Welsh Government (when required). These are easily available to staff so that they are aware of their responsibilities					
2 – A confidential system for reporting data security breaches internally is actively used and appropriate communication is had with external contacts by the IG Lead to manage the effects of Data Breaches. IG incidents and near misses are appropriately managed.					
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					
8.1 – Reporting	**Level 3** - Improvements are	**Not assessed the previous year**	**Level 3** -Improvements are made to reduce the chance of	**Level 3**	Level 3 – improvements are made to reduce the

Section	Description of section requirement and expected attainment level	Self-assessment of level achieved 2020/21	Initial Self-assessment of level achieved 2021/22	Assessment Review	Rationale
Data Breaches	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		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. This is kept under regular review to ensure that standards are met.		chance of re-occurrence and are reported to Board. A review process is in place to ensure the notification procedure remains relevant and works in practice – Confirmed

Appendix 2 - Workplan Tables – updated 24th June 2022

Table 1 – FY 2022/23 Quarterly Plan Specific Actions

Achieved	Expected to be achieved in next three months	Expected to be achieved in next three – six months	Expected to be achieved in next six – nine months	Expected to be achieved in next nine – twelve months

Item	IG Toolkit Reference	Q1 2022/23	Q2 2022/23	Q3 2022/23	Q4 2022/23	FY 2023/24	Progress
Review time expired IG Policies/Equality Impact Assessments and republish	Section 2.2	X					Achieved – separate paper
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	Section 5.2			X			WBS have already begun to make their IAR more user friendly, VCC next.
Ensure that the new Information Asset Register contains a risk treatment plan presenting the plan annually to the SIRO for review	Section 5.2 and Section 3.2			X			Not yet started
Instigate a Data Processing/Sharing Agreement Register and align it with the DPIA , Information Asset and Contract Registers	Section 2.3		X				DSA register is now in use and aligned with DPIA register, further work needed to align with IAR and Contract Registers

Item	IG Toolkit Reference	Q1 2022/23	Q2 2022/23	Q3 2022/23	Q4 2022/23	FY 2023/24	Progress
Create or access Contract Register and align with DPIA Register, Information Asset and Data Processing/Sharing Agreement Register	Section 2.4			X			Contract register in place for £25k and above and divisional contract registers, work needed to align.
Instigate a new Data Sharing Agreement template with support from Legal and Risk within NWSSP	Section 2.3	X					Achieved
Refresh the Data Protection Impact Assessment (DPIA) Screening Process	Section 2.5	X					Achieved
Review existing DPIA's in relation to legacy systems in operation across VCC to ensure that they are reviewed in line with legislation	Section 2.5					X	In Progress
Review legacy systems in operation across VCC to ensure that where required a DPIA is in place	Section 2.5					X	In Progress
Review existing DPIA's in relation to legacy systems in operation across WBS to ensure that they are reviewed in line with legislation	Section 2.5					X	In Progress
Review legacy systems in operation across WBS to ensure that where required a DPIA is in place	Section 2.5					X	In Progress
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	Section 2.5					X	In Progress
Review legacy systems in operation across RD&I, TCS & HTW to ensure that where required a DPIA is in place	Section 2.5					X	In Progress

Item	IG Toolkit Reference	Q1 2022/23	Q2 2022/23	Q3 2022/23	Q4 2022/23	FY 2023/24	Progress
Review existing DPIA's in relation to legacy systems in place across Corporate Departments to ensure that they are reviewed in line with legislation	Section 2.5					X	In Progress
Review legacy systems in operation across Corporate departments to ensure that where required a DPIA is in place	Section 2.5					X	In Progress
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	Section 3.2		X				In Progress
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.	Section 6.1		X				Not yet commenced
Undertake a review of all CCTV systems in operations both in vehicles, body worn 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.	Section 6.6		X				In progress – see report
Review and re-publish the Standard Operating Procedure for FOIA	Section 2.6		X				In Progress expected completion Jul 22

Table 2 – Business as Usual Ongoing Activity – FY 2022/23

Item	IG Toolkit Reference	FY 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	Sections 2.3, 2.4 and 2.5	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	Sections 2.3, 2.4 and 2.5	X
Ensure that the Data Processing/Sharing Agreement Register continues to align with the DPIA , Information Asset and Contract Register	Sections 2.3, 2.4 and 2.5	X
Ensure that the Contract Register continues to align with DPIA Register and Data Processing/Sharing Agreement Register throughout the Financial Year	Sections 2.3, 2.4 and 2.5	X
Instigate and maintain an annual review process for all DPIA's including those created since 1 Dec 21	Section 2.5	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	Section 3.2	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	Section 3.3	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	Section 4.2	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	Section 4.4	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	Section 5.1	X

Item	IG Toolkit Reference	FY 2022/23
2022. This work will involve review of the retention of records and ensure adherence to relevant codes of practice		
Undertake spot checks across the Trust to ensure that data processing is accurate and compliant with Data Protection Legislation	Section 3.3	X
Ensure that Data Accuracy and Data Quality are considered within the scope of systems procured with the Project Lead taking ownership of the need to ensure that the principles of data accuracy with UK GDPR are met.	Section 5.3	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	Section 6.3	X
Maintain current Record of Processing Activity (ROPA) for all divisions of the Trust, cross referring to DPIA tracker appropropriately	Sections 2.5 and 5.2	X
Create and maintain a central register of Non-Disclosure Agreements throughout the Financial Year	Section 2.4	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	Section 4.2	X
Continue to ensure that all reasonable steps have been taken to secure physical information assets throughout the Trust via regular risk assessment activity	Section 6.1	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	Section 7	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	Section 8.1	X

Item	IG Toolkit Reference	FY 2022/23
Conduct reviews and/or investigations of DATIX incidents where IG is a factor – making recommendations and tailoring training proposals as appropriate	Section 8.1	X

QUALITY, SAFETY & PERFORMANCE COMMITTEE

(CIVAS@IP5)

DATE OF MEETING	14/07/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	GARETH TYRRELL – HEAD OF TECHNICAL SERVICES - CIVAS@IP5
PRESENTED BY	GARETH TYRRELL
EXECUTIVE SPONSOR APPROVED	

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" licence
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 CIVAS@IP5 application for General Pharmaceutical Council (GPhC) Premises registration was accepted in March 2022. CIVAS@IP5 has also obtained a Home Office Domestic Controlled Drugs license, MHRA Manufacturers' "specials" license (MS) and Wholesale Distribution Authorisation (WDA). The service is now authorized to manufacture, pack down and distribute specials medicines as well as distribute licenced medicines to external organisations.

1.3 The CIVAS@IP5 service has recently been inspected by the MHRA for adherence to the Human Medicines Regulations 2012 and EU Good Manufacturing Practice. The outcome of the inspection awarded the service a "Low Risk" rating and a 24 month inspection interval.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 There are currently no matters the CIVAS@IP5 wish to raise as a concern within the service.

2.2 CIVAS@IP5 have held internal monthly quality meetings as scheduled to address internal governance of EU GMP adherence since creation in Jan 2021.

2.3 The CIVAS@IP5 Service Board have met monthly to ensure that oversight is provided for all performance and quality issues.

2.4 The service operates a complex Pharmaceutical Quality Management System based on the 9 Pillars PQS model for Pharmaceutical Manufacture as outlined in the ICH Q9 and Q10 documents.

2.5 The service has over 180 individual SOP's, workplace instructions form and logs that are reviewed periodically (interval dependent on document) to ensure appropriateness. Staff are digitally tracked to ensure that they have read and acknowledged all documents relevant to their roles.

2.6 The service has 9 medicines manufacturing operators that have all received EU GMP compliant training and have been validated as competent for use. These operators are re-validated for competence every 6 months as well as having batch specific performance reviewed in real time.

2.7 Management of starting materials, quarantined and active stock, including controlled drugs is managed internally by local procedures that comply with all regulatory requirements.

2.8 Deviations from SOPs, errors environmental issues are reported and investigated in real time, with internally assigned target dates and responsibilities.

2.9 Customer and supplier complaints are handled through the Pharmaceutical Quality System

2.10 Ultimate legal responsibility for operations and adherence to medicines law lies with the named Head of Production and Head of Quality on the MHRA Specials License. These responsibilities are devolved by the Head of Pharmacy Technical Services -CIVAS@IP5.

2.11 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)

2.12 Oversight and governance of new products and process are managed internally via the regulatory compliant change control process. New products are submitted to Chief Pharmacists Group for approval, after consultation with experts from each Health Board across Wales. Product development portfolio attached

2.13 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 CIVAS@IP5 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 The facility and its operation are clearly defined in the CIVAS@IP5 site master file and in standard operating procedures. 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. 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. 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. 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. 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 • Bank Staff engagements • Permanent or where appropriate temporary employment contract 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. 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. 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 • Annual Quality Statement • 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. 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. The unit is independently inspected by the All-Wales QA Pharmacist upon invitation and as an ongoing program of Quality Assurance. 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 behaviors 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. 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 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 recognized 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. 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). 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.

			The CIVAS@IP5 Head of Technical Services is supported by QA lead, Production Lead and Production Managers with the necessary qualifications, skills and experience. The senior team is supported by a workforce designed, recruited and trained specifically for the operation of the service. The team has a clear understanding of their required contribution to the PQS. 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, 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. 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 FUTURE PRODUCTS PROPOSAL DOCUMENT

CONTENTS

1. INTRODUCTION

CIVAS@IP5 is an MHRA Licenced “Specials” Manufacturing unit based within Imperial Park Building 5, Newport. As part of NHS Wales Shared Services Partnership, the service holds an MHRA Specials, Wholesale Dealers and Home Office licence.

Originally built and developed to prepare critical care syringes during the pandemic, CIVAS@IP5 is now able to further develop the product portfolio to incorporate other batched “Specials” medicine with an aim to support service needs of Health Boards and Trusts across Wales. Currently the service provides or is in the process of validating the following products:

- Noradrenaline 8mg in 50mL Infusion
- Noradrenaline 16mg in 50mL Infusion
- Morphine 100mg in 50mL Infusion
- Fentanyl 2.5mg in 50mL Infusion
- Rixathon Variable Volume in 0.9% Sodium Chloride

This document has been developed to highlight the key target agents identified across Wales as having a significantly positive clinical or service capacity benefit. Due to facilities restrictions the service is unable to provide cytotoxic medications and so the focus is on CIVAS products. This assessment is based on current service level data for local manufacture and outsourced products, and this document has been reviewed and agreed with the Heads of Technical Services within CPTS . Each chapter will provide a brief outline

of individual products and characteristics proposed for service users. All prices quoted will be accurate as of April 2022.

2. PRODUCT WORKPLAN 2022-23

2.1 ADULT INSULIN SYRINGES 50 units in 50mL

Name	Adult Insulin Syringes
Strength	50 units of Human Actrapid Insulin in 50mL Sodium Chloride 0.9%
Active Ingredient	Human Actrapid Insulin 100units/mL
Diluent	Sodium Chloride 0.9% w/v – 49.5mL
Clinical Uses	Variable rate intravenous insulin infusion
NPSA Risk Rating in Clinical Areas	5
All Wales Usage	Complex to identify. BCUHB produce 500/month for local requirements
Current Method of Preparation	Mixed model of batch manufacture and preparation within clinical areas
Proposed "Specials" Shelf Life	84 days
Benefits Notes	Product price of approx. £5.24/syringe Reduce preparation time by nursing staff. Improved patient safety. Current work underway with All Wales Medicines Safety to further identify safety incidents and need to issue further guidance.

2.2 ATEZOLIZUMAB INFUSION 1200mg in 250mL

Name	Atezolizumab Infusion
Strength	1200mg in 250mL
Active Ingredient	Atezolizumab 1200mg
Diluent	Sodium Chloride 0.9%w/v – 250mL
Clinical Uses	Treatment of Urothelial or non-small cell lung cancer
NPSA Risk Rating in clinical areas	2
All Wales Usage	Approx. 85/month
Current Method of Preparation	Product is obtained as an outsourced item or prepared locally in technical services units
Proposed "Specials" Shelf Life	30 days
Benefits Notes	Outsourced Cost per 1200mg in 250mL = £1355.53 CIVAS@IP5 Cost per 1200mg in 250mL = £1268 Annual Saving - £21120 (potential for additional savings from vial overage use) Capacity saving benefits for local preparation where this occurs

2.3 POTASSIUM CHLORIDE 50mmol/50mL

Name	Potassium Chloride Infusion 50mmol/50mL Syringes
Strength	1mmol/mL
Active Ingredient	Potassium Chloride 1mmol/mL (Licenced Special)
Diluent	N/A
Clinical Uses	Hypokalaemia
NPSA Risk Rating in clinical areas	6
All Wales Usage	Approx. 3000 year in South-west Wales
Current Method of Preparation	Product is obtained as an outsourced item or prepared from vials
Proposed "Specials" Shelf Life	89 days
Benefits Notes	Standardisation of potassium infusion product for critical areas Repatriate outsourced products back into NHS Wales. Cost Approx £6.75/syringe

2.4 NIVOLUMAB INFUSION 480mg in 100mL

Name	Nivolumab Infusion
Strength	480mg in 100mL
Active Ingredient	Nivolumab 480mg
Diluent	Sodium Chloride 0.9%w/v – 100mL
Clinical Uses	Various indications of cancer therapy
NPSA Risk Rating	5
All Wales Usage	Approx. 110 infusions /month
Current Method of Preparation	Product is obtained as an outsourced item or made locally with aseptic units
Proposed "Specials" Shelf Life	30 days
Benefits Notes	Current outsourced cost for 480mg in 100mL = £4125 CIVAS@IP5 Cost per 480mg in 100mL = £3622.50 Annual Saving – Approx £200,000 (potential for additional savings from vial overage use) Capacity saving benefits for local preparation where this occurs

2.5 CALCIUM FOLINATE 350mg in 250mL

Name	Calcium Folinate Infusion
Strength	350mg in 250mL
Active Ingredient	Calcium Folinate 10mg/mL
Diluent	Sodium Chloride 0.9%w/v – 250mL
Clinical Uses	Combination infusions with chemotherapy (particularly 5-Fluorouracil)
NPSA Risk Rating	5
All Wales Usage	Approx. 200 doses monthly
Current Method of Preparation	Product is obtained as an outsourced item or made locally in clinical areas by nurses.
Proposed "Specials" Shelf Life	30 days
Benefits Notes	Current outsourced or prepared in clinical areas. Cost approx. £7.45/infusion Repatriate outsourced products back into NHS Wales. and alleviate local nursing pressures during preparation.

3 SUMMARY

This document identifies CIVAS products that are to be manufactured using validated methods within the CIVAS@IP5 medicines unit under the MHRA Specials Licence. This document has been reviewed and agreed with all Heads of Technical Service across Wales, and Chief Pharmacists Group is asked to note this document and encourage local engagement with the procurement of ready to administer products. Alongside a 6 monthly costing review of the products, the CIVAS@IP5 Medicines Service will review service capacity and along with technical service colleagues, identify further target products for investigation and feasibility study.

CIVAS@IP5 Service Board

CIVAS@IP5 Assurance Structure

Roles and Responsibilities

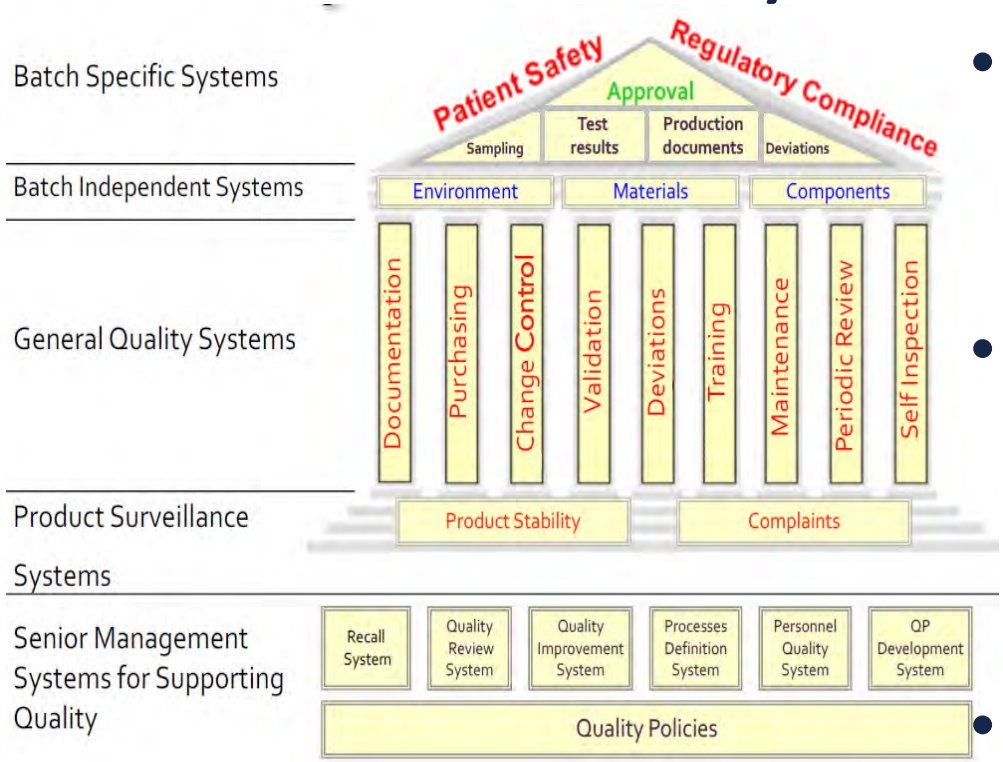
- Head of Production
  - Production and storage of medicines
  - Procedure development, approval and strict implementation
  - Compliant records
  - Maintenance of premises and equipment
  - Validations for products and processes
  - Personnel training
- Head of Quality
  - Approval/rejection of materials, medicines and packaging
  - All required quality testing is carried out
  - Approves all specifications, sampling instructions, methods and QC procedures
  - Qualification of premises and equipment
  - All validations carries out
  - Continuous training
  - Evaluation of all batch records

Roles and Responsibilities

- Joint Role to ensure:
  - Authorisation of all documentation
  - Monitoring of manufacturing environment
  - Approval and monitoring of contracted activities
  - Storage conditions of starting and finished materials
  - Monitoring of compliance with EU GMP
  - Inspection, investigation and taking of samples to assure quality
  - Ensure timely and adequate communication and escalation to senior management exists
  - Management of Pharmaceutical Quality System

- These roles hold ultimate authority, control and legal responsibility for the activities occurring under the MHRA Specials and WDA licences.
- Inspection against Human Medicines Regulations 2012 – legal responsibility to adhere to the contents

9 Pillars Quality Management System



- All aspects of CIVAS@IP5 covered by 9 Pillars approach
- Internal and external audit ensure system functions to regulatory standards
- Managed via All Wales ePQS system – Q-Pulse

QUALITY, SAFETY & PERFORMANCE COMMITTEE

TRUST QUALITY & SAFETY FRAMEWORK

DATE OF MEETING	14th July 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

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

REPORT PURPOSE	FOR APPROVAL

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

1. SITUATION

The Trust 2022-2024 Quality & Safety Framework is provided to the Quality, Safety & Performance Committee for **ENDORSEMENT** prior to submission to the Trust Board for approval.

2. BACKGROUND

The Trust has been developing its Quality & Safety framework over the past two years. The development of the framework was significantly impeded by the COVID-19 pandemic. Significant consultation took place prior to commencing the development of the framework and during 2021 on the draft framework. A number of amendments were made to the framework as a direct result to this consultation.

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

3. ASSESSMENT

3.1 Trust Quality & Safety Framework

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

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

3.2 Quality Improvement Goals 2022/2023

As outlined in the Trust's Quality & Safety Framework, each year the Trust will, by the 31st January, agree the Quality Improvement Goals for the forthcoming year. These will be determined following detailed triangulated analysis and consultation with staff. The Improvement Goals will be determined through the Quality & Safety Governance Group, Clinical & Scientific Strategic Board and the Executive Management Board and approved

through the Quality, Safety & Performance Committee. These will form part of the organisational priorities within the IMTP.

The Quality Improvement Goals will be reviewed each year and will be included as part of the IMTP process. The 2022/23 Quality improvement Goals have been determined through Executive level prioritisation, pending the Quality Framework being finalised, and are a feature of the post COVID-19 pandemic recovery priorities facing the organisation, in addition to the quality & safety framework critical infrastructure work that is required. For 2022 /2023 the proposed Quality Improvement Goals are:

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

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

3.3 Quality & Safety Framework Implementation plan

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

The Implementation plan is attached in ***appendix 2***.

3.4 Quality & Safety Framework Evaluation

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

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

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
RELATED HEALTHCARE STANDARD	Safe Care
	Applicable to all Health & Care standards
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	There will be adverse legal implications in the event of Trust not meeting its quality & safety responsibilities
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	There will be resource requirements to meet this framework responsibilities within divisions and corporately. Resources agreed re restructuring of

	corporate Quality & Safety Team. Resource requirements within VCC require quantifying

5. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to:

- **ENDORSE** the 2022-2024 Quality & Safety Framework prior to submission to Trust Board approval.
- **ENDORSE** the plan to further refine this framework during 2023 to reflect the requirements outlined in the final Duty of Quality & Duty of Candor statutory guidance documents when published.
- **ENDORSE** the 2022/23 Quality Improvement Priorities and the Framework implementation plan.

Welsh Blood Service
Gwasanaeth Gwaed Cymru

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

Canolfan Ganser Felindre
Velindre Cancer Centre

Velindre University NHS Trust Quality and Safety Framework 2022 - 2024

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

DRAFT Version 5 – 21st June 2022

FOREWORD

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

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

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

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

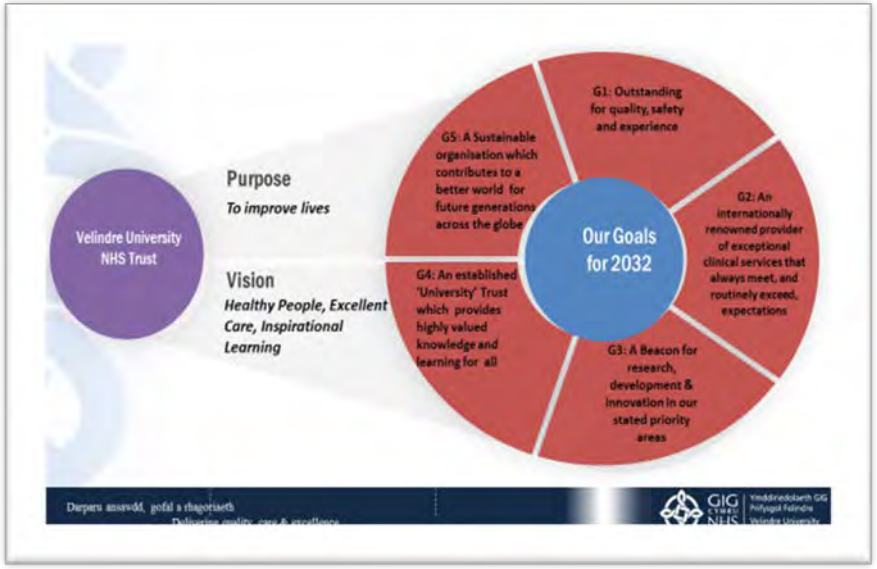
Every day more than a million people are treated safely and successfully in the NHS. However the advances in technology and knowledge in recent decades have created an immensely complex healthcare system. This complexity brings risks, and evidence shows that things will and do go wrong in the NHS; that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

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

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

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

The Velindre University NHS Trust Strategy 'Destination 2032' sets out the Trusts' five strategic goals. Although all 5 strategic goals align to this framework this framework is a key enabler for the delivery of Goals 1 and 2.



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

Strategic Goal One:
Outstanding for quality, safety & experience

Our objectives are to:

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

We will achieve these by:

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

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

Our objectives are to:

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

We will achieve these by:

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

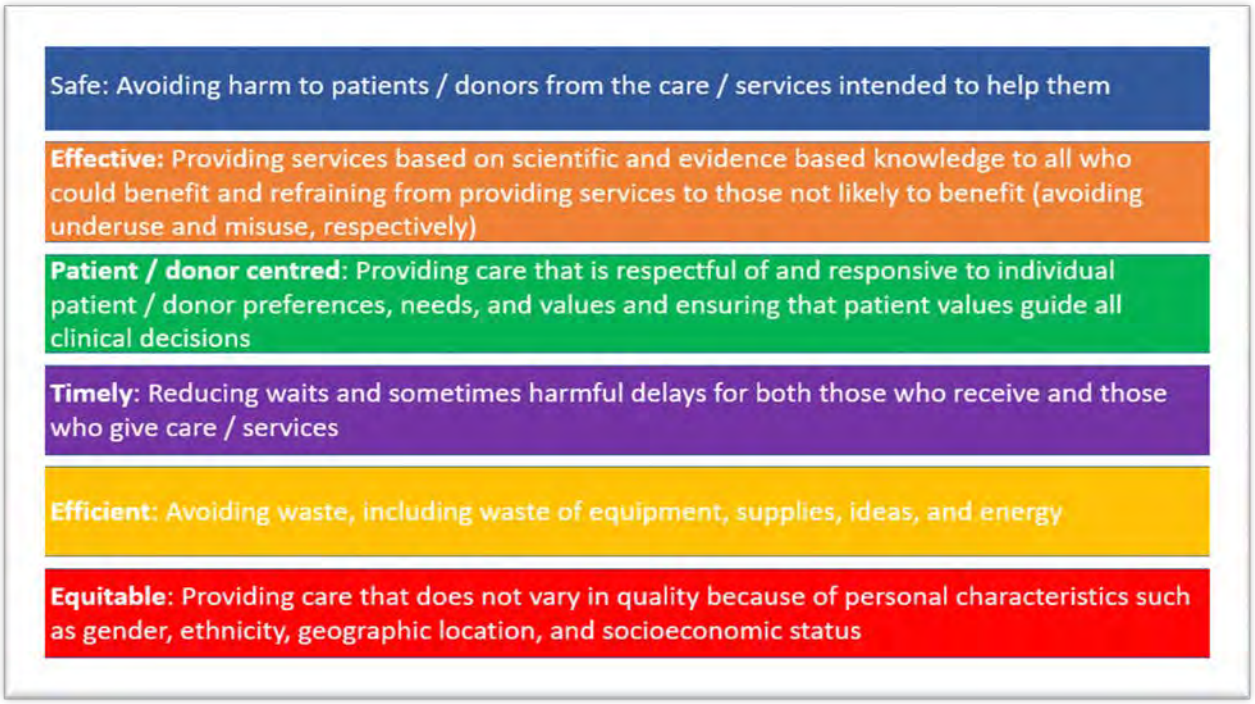
CONTENTS

1. FRAMEWORK AIMS

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

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

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



2. NATIONAL STRATEGIC BACKGROUND

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

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

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

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

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

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

3. ROLES & RESPONSIBILITIES

3.1 Employee Responsibilities

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

Individual members of staff

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

Managers & Clinical Leaders

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

Divisional Senior Leadership Teams

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

Executive Directors / Corporate Directors

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

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

Trust Board Members

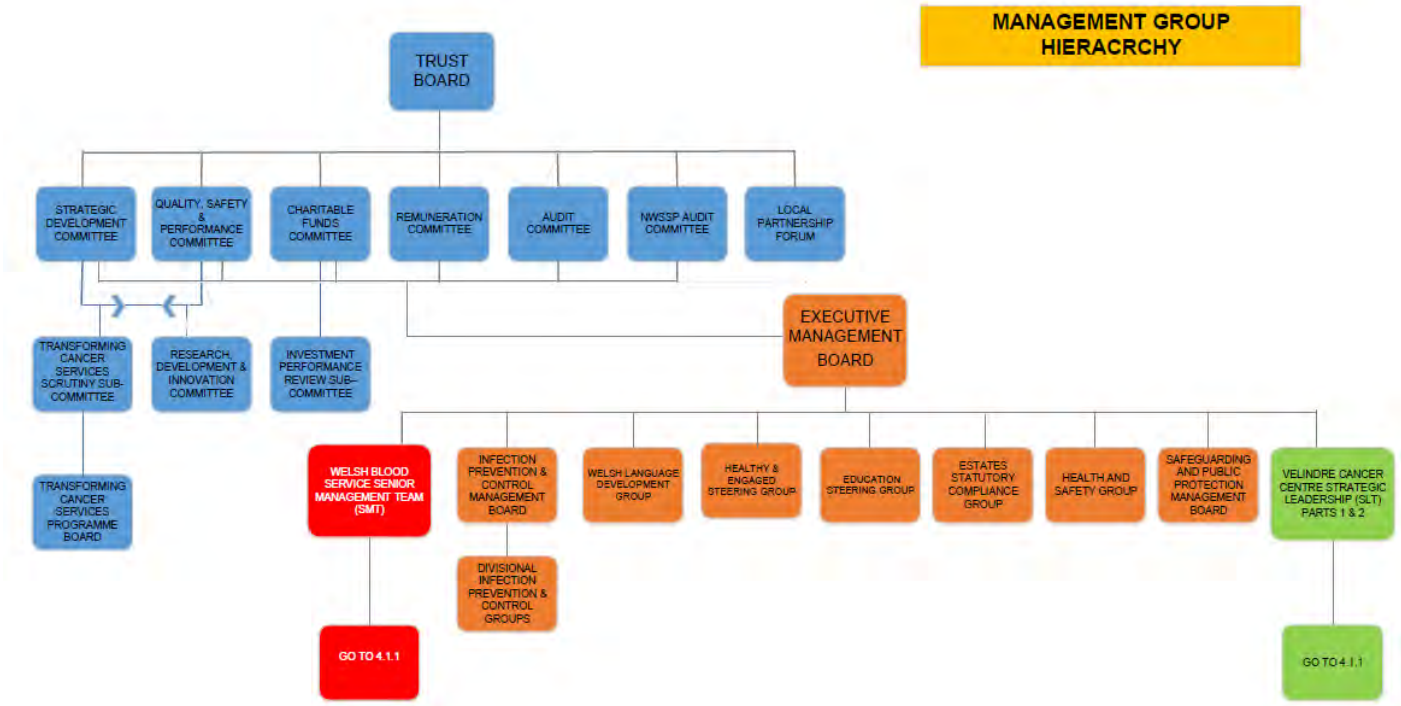
The Trust Board is responsible for Strategy, culture and assurance. The Board therefore are responsible for creating the quality and safety culture for the organisation and ensuring there is a robust infrastructure in place to ensure that quality, safety, experience, learning and improvement is embedded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

Corporate / Divisional Quality, Safety & Regulatory Teams

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

4. QUALITY & SAFETY ASSURANCE / MEETING STRUCTURE

4.1 Meeting structure at a glance:



4.2 Meeting Requirements

Team Meetings

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

Departmental Meetings

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

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

Divisional Quality & Safety Meetings

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

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

Divisional Senior Management Team (SMT) Meetings

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

Quality, Safety & Performance Committee

The Trusts Quality, Safety and Performance Committee provides:

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

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

Corporate and Divisional Responsibilities

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

5. QUALITY CYCLE

5.1 Quality Assurance / Quality Management System

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

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

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

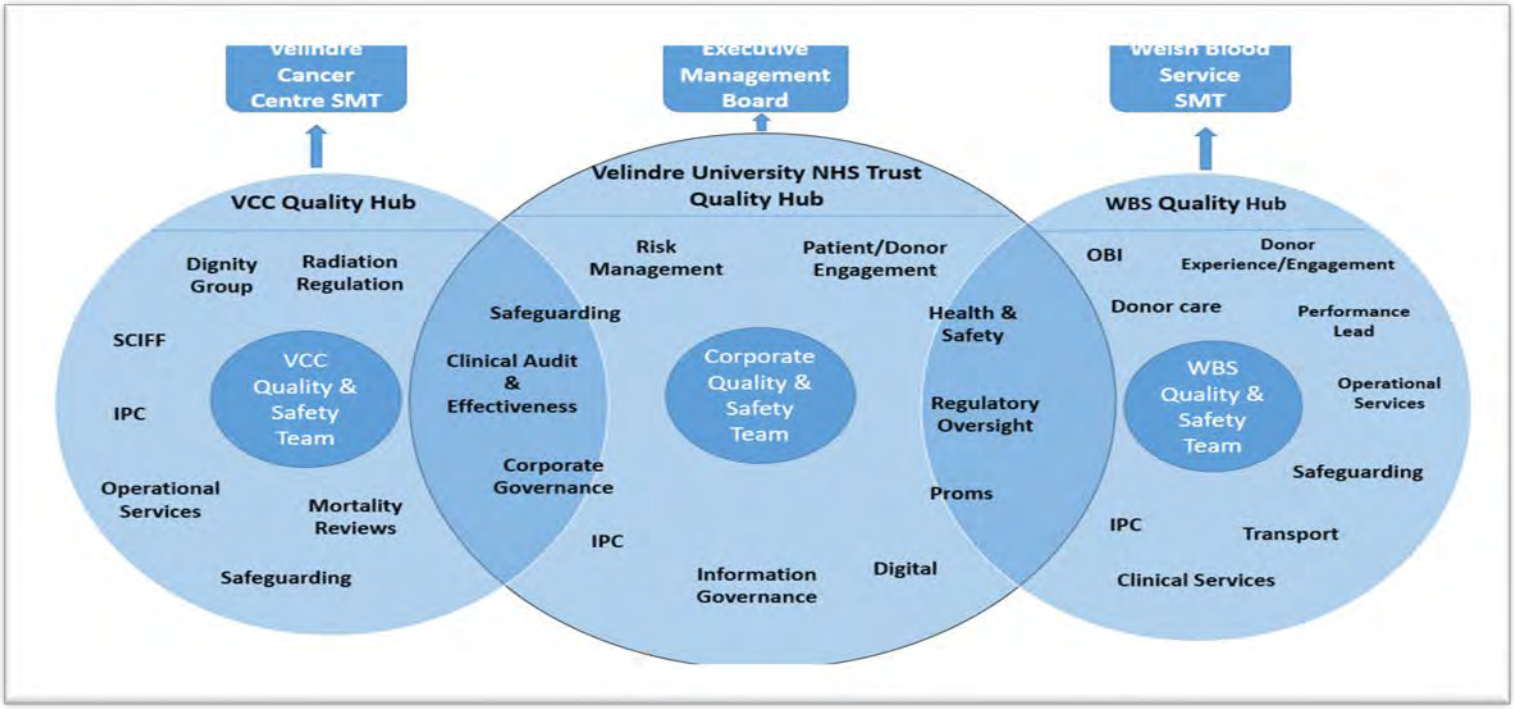
5.2 Quality Hubs

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

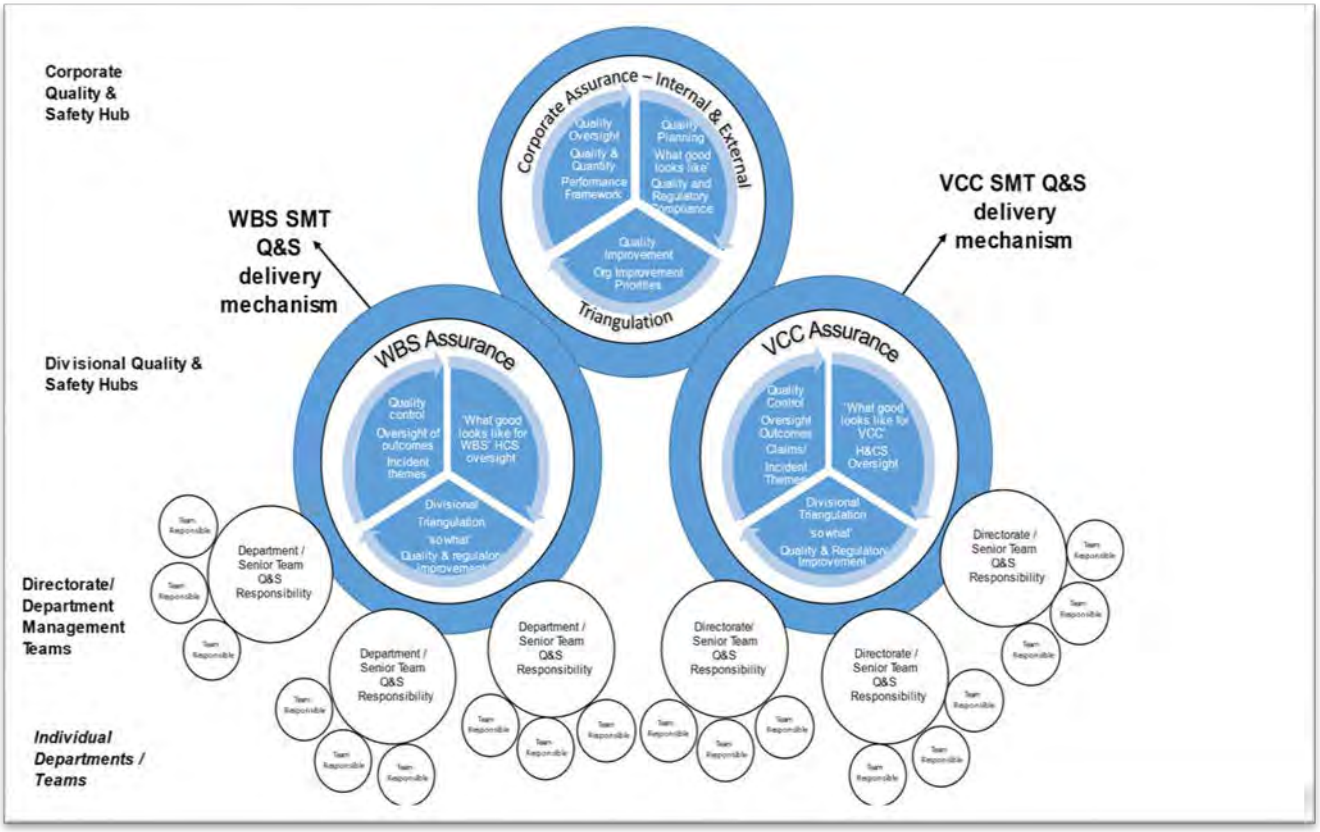
- **The Corporate Quality Hub** will have a central co-ordinating role pulling together all elements of Quality & Safety (that sit under Executive Director of Nursing, Executive Medical Director, Director of Governance and Director of Strategic Transformation, Planning and Digital), will interface significantly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

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

Quality Hubs at a glance



The Divisional Hubs will have oversight of the quality infrastructure within all areas of their division, as detailed below:



5.3 Quality & Safety 5 step framework (keeping it simple)

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

Velindre University NHS Trust Quality and Safety 5 Step Framework

Graduated Service Level to Board Approach

ASSURANCE

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

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

IMPROVING WHAT YOU DO

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

- Innovation

Know HOW YOU ARE DOING?

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

Re-review what you are measuring at lease annually

MAKING YOUR SERVICE GOOD

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

KNOW WHAT GOOD LOOKS LIKE

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

Review at least annually

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

6 MONITORING AND MEASURING

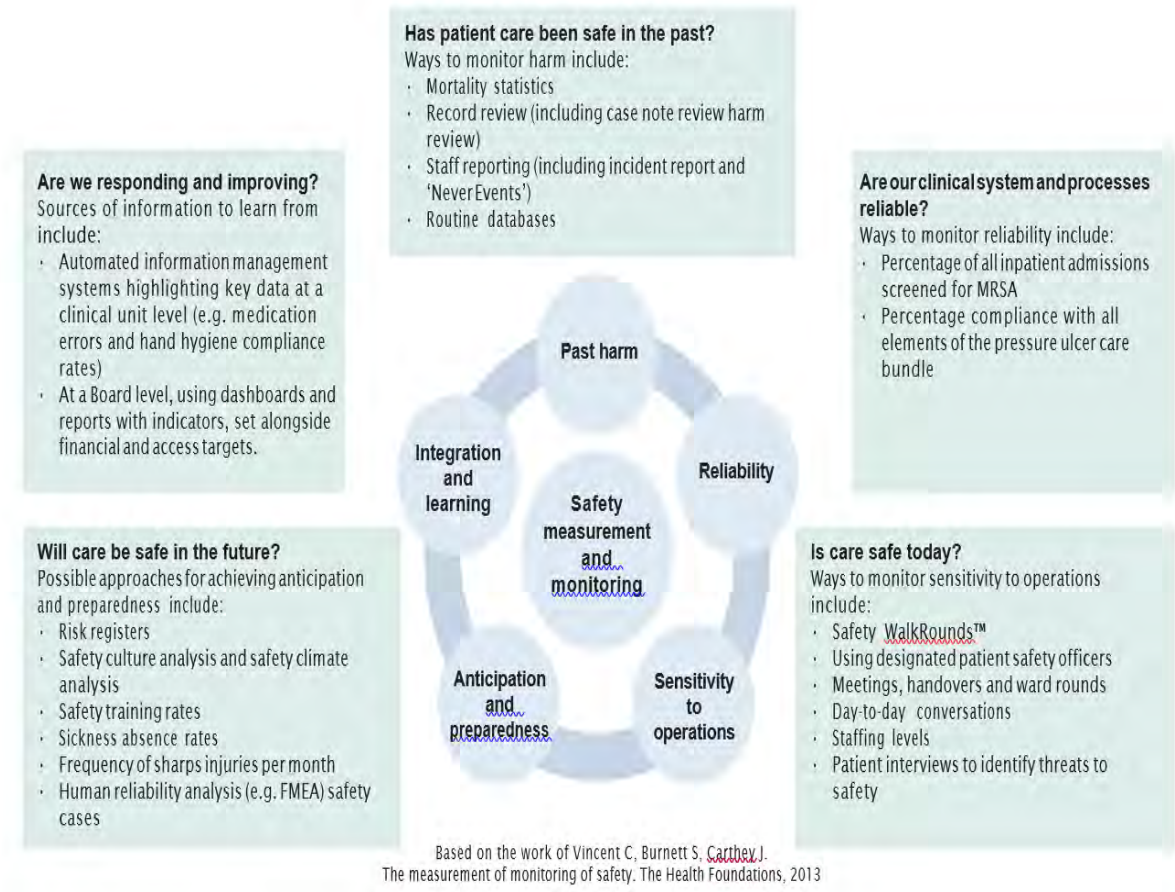
6.1 Safety monitoring framework

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

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

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

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



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

6.2 Harm

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

- ***Delayed or inadequate diagnosis –*** misdiagnosis of cancer or diagnosis or treatment for cancer being delayed
- ***Failure to provide appropriate treatment*** – rapid thrombolytic treatment for stroke, donors being over bled or prophylactic antibiotics before surgery
- ***Treatment*** *–e.g.* the adverse effects of chemotherapy
- ***Over-treatment*** –painful / toxic treatments of no benefit to those at end of life
- ***General harm*** – incorrect pre blood-donation screening outcomes, harm to recipients caused by blood borne infection/virus, or post donation cannulation nerve damage
- ***Psychological harm*** – depression following diagnosis

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

6.3 Safety Culture

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

It is important that all staff, patient / donor facing & leadership teams think of all aspects & factors (the big picture) impacting patient / donor care and see all aspects as offering an opportunity for improvement. Teams should focus on providing excellent care and

services, ensuring staff have the resources they require and are able to eliminate distractions before they become problematic or result in preventable error or an adverse event. Mechanism for supporting this include:

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

6.4 Triangulated Incident Analysis

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

6.5 Integration and Learning

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

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

6.6 Trust Monitoring, Reporting & Assurance Arrangements

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

Quantitative

- Defined metrics to measure against agreed 'What Good Looks Like' standards
- National quality indicators
- Clinical Incident / harm metrics
- Mortality indicators
- Clinical Outcome measures
- Harm Measures
- Patient Reported Outcome Measures (PROMS)
- Percentage recommending rates (from patients / donors/ carers & staff)
- Patient experience metrics

Qualitative

- Voice of Patient / Donor, patient / donor stories, concerns and compliments
- Day in the life of (staff's lived experience)
- 15 step challenge: Board to floor walkabouts which enable discussion with staff and patient / donors about their experience of giving and receiving care with an appreciative enquiry approach focussed on quality and safety of care.
- Establish a robust mechanism for internal (across Trust) and external proactive peer reviews across all our services.

6.7 Triangulated evidence

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

Soft intelligence is invaluable as an early quality trigger where something is potentially of concern. Therefore, it is essential that staff feel empowered to voice and escalate concerns, and that patient / donor experience, both real-time and retrospective, is central to quality and service improvement. Soft intelligence can also be attained through leadership walkabouts and other internal assurance activities (detailed in section 3), and further enables well informed assessment. Experience has shown that where these does not exist, risk is increased and the opportunity to provide safe care is reduced. The Quality and Safety Governance Group will take on this function, of triangulating evidence, for the Trust on a monthly basis.

7 IMPROVEMENT

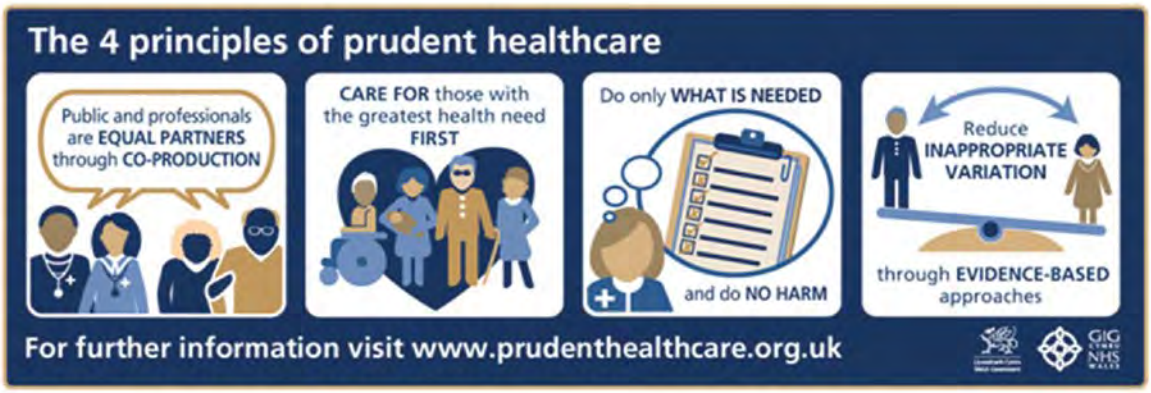
7.1 What quality improvement means within Velindre University NHS Trust

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

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

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

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



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

all healthcare services. The Trust has identified a number of value-based healthcare priorities for 2022/24.

- Culture, Socialisation and Education
- Measurement of Outcomes & Cost in a meaningful way
- Prudent Healthcare and Service Prioritisation

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

7.2 Quality Improvement Goals

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

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

8. CULTURE & VALUES

8.1 Trust Values

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

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

When something fails or goes wrong staff must feel safe, supported and able to speak up, having confidence that they will be listened to. If concerns are raised about the quality of care, they need to be listened to, acknowledged and acted upon (psychological safety). The staff of Velindre University NHS Trust need to know that

concerns are taken seriously, and that they are welcomed, will be listened to and acted upon. When an organisation is open and honest, staff feel able to raise concerns and to implement improvement actions. No health service is perfect and this must be acknowledged in order to feel confident in a continually improving service. The implementation of the duty of candour will support this as an approach.

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

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

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

8.2 Leadership

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

Leading with Compassion

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

8.3 Equality, Diversity & Inclusion

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

The Trust is committed to embedding the principles of the Anti-Racist Wales Action Plan and other national action plans to ensure that all patients, donors and staff are

empowered to have their voice heard and are not subject to discrimination in any part of their interaction with the Trust.

The Trust is committed to capturing the voice of the public in the design, planning and delivery of services, to ensure that the services we provide are meeting the needs of the communities that we serve. To do this the Trust uses a number of engagement methods, which include:

- Patient Liaison group
- Patient and carer representation on Trust Wide strategic groups, such as Patient Dignity group, Equality Impact Assessment group, Quality and Safety committee
- Public events such as BME Health Fair, Pride, National Eisteddfod
- Public engagement forums – Welsh Blood stakeholder sessions
- Staff newsletter, surveys and feedback sessions
- Monthly Patient surveys at Velindre Cancer Centre
- Monthly donor surveys at Welsh Blood Service
- Community, stakeholder and partnership engagement

8.4 Staff Wellbeing

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

Supporting staff with their health and wellbeing through initiatives such as;

- *Stress assessments*
- *Mindfulness programs - including the use of apps*
- *Respite care funding*
- *Childcare School Holiday funding*
- *Complementary Treatments*
- *Provision of an Employee Assistance Programme*
- *Managerial and self-referral services to Occupational Health services*
- *Access to free counselling*
- *Mentoring and coaching services*

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

9.0 Quality and Safety Implementation Plan

This Framework will be delivered through an implementation plan. It is recognised that implementing this Quality Framework will take time. Work undertaken over the last three years has laid some of the foundations for this work, both culturally and organisationally, however further development is required. This work is crucial if the

Trust is to meet the legislative requirements set by the Health and Social Care (Quality and Engagement) (Wales) Act 2020 and the NHS Wales Quality & Safety Framework: Learning & Improving (Welsh Government 2021). It is also recognised that this framework will need to be both formally evaluated and reviewed in 2023, upon publication of the final Duty of Quality & Duty of Candour statutory guidance. Funding has been secured for a one Year Quality Framework Implementation Lead to support the organisation in the work required to make this framework a reality.

APPENDICIES

Appendix 1: National Strategic Background & Links

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

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

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

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

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

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

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

- **MHRA ISO Standards:**

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

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

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

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

- **Welsh Blood Service Regulatory Framework**

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

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

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

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

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

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

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

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

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

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

- **Quality Statement Cancer (2021)** https://gov.wales/quality-statement-cancer-html - Builds on the work of the 2012 and 2016 Cancer Delivery Plans Developed to ensure there is a long-term and consistent approach to improving outcomes. The statement details a number of quality attributes and outlines the role of the NHS Executive, Wales Cancer Network Board and the clinical network in setting out a rolling, three-year implementation plan that identifies and prioritises national cancer service developments based on the quality attributes.
- The recently-published National Clinical Framework (prudent in practice) provides a clinical interpretation of A Healthier Wales and describes a learning health and care system, centred on clinical pathways that focus on the patient, grounded in a life-course approach. In recent years, major health condition delivery plans set out policy expectations for high priority clinical services. These plans came to an end in December 2020 and as described in the National Clinical Framework, will gradually be replaced by Quality Statements. These successor arrangements will help to set out what stakeholders think are important quality attributes of high priority clinical areas, such as cancer, heart disease and stroke services; as well as services such as critical care and end of life care.

Appendix 2: Trust Patient Safety Advisers

The Trust has three trained patient Safety Advisers:

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

Appendix 3: Values into behaviours

TRANSLATING VELINDRE NHS TRUST'S ORGANISATIONAL VALUES INTO BEHAVIOURS

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

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

Being **ACCOUNTABLE** means…

We will:

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

It does not mean that we can:

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

Being **BOLD** means…

We will:

1. Take calculated risks to achieve goals
2. Challenge ourselves and others to consistently improve and achieve “stretch” goals
3. Push forward with important initiatives in the face of uncertainty
4. Move ahead without always requiring a consensus
5. Make recommendations that challenge the status-quo
6. Step forward with a position of principle even when there is ambiguity regarding the facts
7. Give people the feedback they need even in difficult situations
8. Support others who take calculated risks to achieve Velindre NHS Trust goals
9. Take responsibility and stays focused on problems until an effective solution can be found
10. Make decisions through weighing up the cost-benefit and risk implications
11. Take decisions as necessary on the basis of the information available
12. Make decisions without unnecessarily referring to others
13. Involve and consult with internal and external stakeholders early in decisions that impact them
14. Identify potential barriers to decision making and initiates action to move a situation forward
15. Be aware of the Trust’s decision making processes and how to use them
16. Propose options for solutions to presented problems
17. Demonstrate resilience against challenges and obstacles

We will not:

1. Be impulsive or rash
2. Ignore the facts

3. Pass responsibility for decisions inappropriately to others
4. Make decisions without discussing them with those they will affect, or without clear rationale or consideration of their impact
5. Take an unimaginative or narrow approach to solving problems

Being **CARING** means…

We will:

1. Be dedicated to meeting the expectations and requirements of internal colleagues and external donors/patients
2. Take pride in delivering a high quality service
3. Treat all people, both colleagues and service users, with dignity and respect
4. Avoid making statements that may offend or hurt others
5. Consistently communicate even the most difficult messages in a sensitive and supportive manner without compromising on the meaning of the message
6. Consider and respects different opinions, styles, and ways of working
7. Ask questions to identify the needs or expectations of others
8. Consider the impact on colleagues, donors and patients when carrying out our own job
9. Work to remove barriers that get in the way of providing a high quality service
10. Seek feedback from others to assess satisfaction with service being provided
11. Continuously monitor service delivery and act promptly to resolve any problems
12. Endeavour to respond to phone calls and emails promptly; update voice messages and email notification when we're going to be absent from the workplace for more than one half day, advising alternative contact where possible
13. Be punctual and fully prepared for meetings

It does not mean we that we are allowed to:

1. Not deliver the task

2. Avoid difficult decisions

Being **DYNAMIC** means…

We will:

1. Be adaptable and able work effectively with a variety of situations, individuals and groups.
2. Demonstrate flexibility and agility, and not be unduly delayed or stopped by the unexpected
3. Open to new ideas and listen to other people's points of view
4. Demonstrate willingness to change our ideas or perceptions based on new information or contrary evidence
5. Remain focused on strategic priorities when faced with competing demands
6. Make pragmatic reasonable adjustments to ensure maximum effectiveness and motivation of ourselves and others
7. Change our overall plan, goal or project to fit the situation
8. Create and support dynamism by ensuring our processes and procedures don't block quick turnaround and flexibility
9. Weigh up costs and benefits impartially
10. Think laterally, creatively and collaboratively to resolve problems
11. Be willing to investigate options in depth, even when they are the ideas of others
12. Adjust schedules, tasks, and priorities when necessary
13. Anticipate and change strategy before the current method proves to be ineffective
14. Proactively identify and take action to achieve standards of excellence
15. Look for ways to improve services, add value and contribute new ideas
16. Plan ahead for upcoming problems or opportunities and takes appropriate action
17. Recognise and act upon opportunities
18. Exhibit a strong sense of urgency about solving problems and accomplishing work
19. Respond flexibly to changing circumstances

20. Demonstrate openness to changing work priorities and deadlines
21. Use change as an opportunity to improve ways of working, encouraging others' buy-in

It does not mean that we can:

1. Ignore our colleagues views
2. Be unrealistic in our goals
3. Be unaware of the impact of change on others
4. Be resistant to change and trying new things
5. Rush change or change for change sake
6. Do it all ourselves

Quality and Safety Implementation Plan

The implementation plan will be monitored quarterly through the Executive Management Board and six monthly through the Quality, Safety & Performance Committee.

Required Outcome	Implementation Action	Action Lead	Delivery Timescale	December 2023 required status
Dedicated implementation support available to support establishment of Quality Hubs and work with services and teams to determine what good looks like and required measures – Trust meeting Duty of Quality requirements	Recruitment of agreed / resourced one year framework implementation lead	Executive Director Nursing, AHP & Health Science	Recruitment completed by 30th August 2022	75% of clinical teams agreed 'what good looks like', agreed metrics to assess status
Staff across the Trust aware of the framework and what this means for them and their teams	Quality Framework in action animated video to be produced aimed at teams and departments	Executive Director Nursing, AHP & Health Science	30th September 2022	Fully completed
	Quality Framework roadshows to be held within clinical areas and pre-arranged team meetings	Executive Director Nursing, AHP & Health Science	Completed by 30th September 2022	Fully completed

Quality, Safety, outcome and experience measures routinely monitored and used to inform decision making, prioritisation and improvements	Service level to Board quality, outcome & experience measures identified and captured across all services as part of routine monitoring arrangements	Divisional Quality Leads, Head of Quality & Safety & Quality & Safety implementation manager	December 2023	100% of clinical teams agreed 'what good looks like', agreed metrics to assess status
	Quality & Safety Governance Group to be established	Deputy Director Nursing, AHP & Health Science, Head of Quality & Safety	30th September 2022	Fully embedded in how organisation functions
Corporate & Divisional Quality Hubs fully operationalised, undertaking triangulated analysis and supporting the creation of the required quality & safety culture	Quality Hub Lead role specification to be developed	Deputy Director of nursing, Quality & Patient Experience	31st July 2022	Fully completed
	Quality Hub Leads to be identified / appointed	Divisional Directors & Director of Nursing, AHP & Health Science	30th August 2022	Fully completed
	Corporate & Divisional Quality Hubs to be fully operational	Divisional Directors & Deputy Director of Nursing, Quality & Patient Experience	30th September 2022	Quality Hubs fully embedded in how organisation functions
Quality and Quality Improvement is embedded at the centre of all decisions made across the Trust	Trust Quality Management System to be designed and implemented with support from Improvement Cymru	Director of Nursing, AHP & Health Science, Medical Director & Director	30th September 2023	Fully completed

		Corporate Governance		
	The Trust will undertake a review of its quality improvement infrastructure and mechanisms supported by Improvement Cymru	Director of Nursing, AHP & Health Science, Medical Director & COO	March 2023	Fully completed
	2022/23 Quality Improvement Goals met	Executive Directors	March 2023	Fully completed
	2023/2024 Trust Quality Improvement Goals agreed	Executive Directors	31st March 2023	Priorities on trajectory for delivery
Trust safety Monitoring Framework developed and in place	IHI Foundation safety & improvement assessment to be undertaken and any further improvement actions quantified	Director of Nursing, AHP & Health Science, Medical Director & COO	30th July 2022	Fully completed
	Trust Safety Advisors to undertake staff safety survey and repeat annually	Trust Safety Advisers	Initial by 30th September 2022	Two staff surveys completed and analysed to assess culture changes
	Trust Safety Monitoring Framework to be established and implemented across both divisions	Trust Safety Advisers	30th March 2023	Fully operational

	Harm to be defined across all services both potential and actual and harm reduction goals determined	Trust Safety Advisers	July 2023	Defined across all clinical services
	A programme of SLT and Board Safety Walkabouts to be implemented	Trust Safety Advisers	December 2022	Fully established as part of how Trust & Divisions operate
	A Trust wide Quality & Safety learning portal to be developed for cross-sector sharing of good practice and include Welsh Government.	Deputy Director Nursing, Quality & Patient Experience & Chief Digital Officer	March 2023	Fully completed
	Senior Trust Officers & Board Members all trained in strategic safety and improvement	Director of Corporate Governance	December 2022	100% Board members and Divisional SLT members received training
Well-developed Quality & Safety assurance mechanisms in place	Trust Board level Assurance infrastructure and reporting requirements to be clearly defined	Director of Corporate Governance	31st October 2022	Fully Completed
	Trust assurance and performance frameworks aligned with 6 domains of Quality	Director of Corporate Governance & Director of Strategic Transformation, Planning & Digital	31st December 2022	Fully Completed
	Trust meeting Structure to be reviewed to ensure transparency of reporting and removal of any	Executive Directors /	March 2023	Fully completed

	duplication post implementation of the Quality & Safety Governance Group	Divisional Directors		
Clinical Leaders setting Trust clinical quality priorities for future IMTPs	Clinical & Scientific Strategic Board Established	Medical Director, Director of Nursing, AHP & Health Science	30th September 2022	Fully completed
	Trust wide Clinical & Scientific Strategy developed	Medical Director, Director of Nursing, AHP & Health Science	March 2023	Fully completed
Robust and clearly defined clinical effectiveness arrangements across whole organisation	A formal review of Clinical effectiveness and clinical audit infrastructure to be undertaken	Head of Quality & Safety	June 2023	Fully Completed
Values based healthcare principles embedded across organisation	The Trust has identified a number of values based healthcare priorities for 2022/24 – these will be implemented through a project management approach.	Medical Director	December 2023	Top five VBHC priorities delivered

Review date: January 2023 & July 2023

QUALITY, SAFETY & PERFORMANCE COMMITTEE

WORKFORCE & ASSOCIATED FINANCE RISKS

DATE OF MEETING	14th July 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Chris Moreton, Deputy Director of Finance Susan Thomas, Deputy Director of W&OD
PRESENTED BY	Matthew Bunce, Executive Director of Finance Sarah Morley, Executive Director of Organisational Development and Workforce
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance Sarah Morley, Executive Director of Organisational Development and Workforce

REPORT PURPOSE	FOR DISCUSSION / REVIEW

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	01/07/22	Noted for further QSP Consideration

ACRONYMS	
IMTP	Integrated Medium Term Plan
HB	Health Board
LTA	Long Term Agreement
TOIL	Time off in Lieu
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 crystalize in 2022-23, together with the required management action to ensure risk mitigation and performance improvement.

1.2 The paper is structured under the risks identified under the key workforce strategy themes of Workforce Supply and Shape; Wellbeing; Attraction and Retention. Each theme and section of the report will be structured as follows:

1.2.1 Key Workforce and Associated Financial Risks.

1.2.2 Actions to be taken to address WOD and Financial Risks.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Workforce Supply and Shape

Key issues currently and expected to continue into 2022-23 are:

2.1.1 Key Workforce and Associated Financial Risks

Key workforce risk: In response to service demand, traditional staffing models cannot deliver service need, the shape of the workforce has to change. This may require finance to be allocated across different teams and different staff groups. The Trust has key hotspot areas in particular diagnostic radiation services, nuclear medicine, SACT Nursing and medical oncology.

Financial risk: The financial risk associated with workforce planning will be monitored and managed through the pay budget monitoring process. This includes staff who were permanently recruited in response to Covid where funding is no longer available.

The full year pay budget is £68.302m based on 1,572 WTE.

As at May 2022, the current staff in post is 1,407 WTE. The number of vacancies is 165 WTE, which represents 10.5% vacancy rate. The vacancy gap is being met by the use of

agency staff and overtime, which is reported on further in section 3. Attraction and Retention.

Vacancies throughout the Trust remain high however a number of posts in both VCC and WBS have been appointed at risk in response to Covid and forward recruitment on service developments without any funding attached. Work is underway in both divisions to either secure additional funding to support these posts or looking at options to migrate staff into vacancies to help mitigate the current risk exposure.

The Trust has reported a cumulative year-to-date spend of £11.995m on pay against a budget of £12.039m resulting in an underspend position of £0.044m as at May 22. The pay costs include the costs of agency staff and overtime.

2.1.2 **Key workforce risk:** 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. A significant number of contracts (74) have over 4 years' service and require a permanent contractual status. Over 43 have been 2-4 years' service and need to be aligned to our vacancies. Both these actions will alleviate risks associated with the fixed term contracts. The Workforce team are also working on educating managers on application of fixed term contracts. As part of the Deep Dive analysis in both Divisions plans around the shape of the workforce are being undertaken, further update will be provided in next month's report

Financial risk: Analysis is being undertaken to calculate the risk and potential financial impact of this workforce risk.

*2.1.3 **Actions taken to mitigate WOD and Finance Risks related to Workforce Supply and Shape***

The table below provides an over of the Trust's challenges around workforce supply and the interventions that are currently in train to address the issues

Hotspots	Driven by	Interventions (Short to Medium term)
Diagnostic Radiation Services **Nuclear Medicine** **Medical Oncology**	Changing service **demand** Lack of talent management and succession planning (regional and local) Specific/Specialised skill set	Regional recruitment – joint working with C&V Collaborative working with HEIW re: commissioning places Introduction of ANP and plans around Physicians Associates will support a different workforce to move away from a solely medical workforce model
SACT Nursing	Changing service **demand** Structure and shape of the service needs to change to meet demand (Recruitment per se not a problem – assisted by Student Streamlining)	Organisational Changes (Process) ongoing to deliver a service that meets demands. This is changing the way the service and workforce operate – 6-day service provides more flexibility
Collections teams - WBS	**Supply** - Collections assistants – challenging role - High turnover	Ongoing recruitment campaign Retention plans in place-WBS Recruitment Group in place – Action plan agreed and on track

- The finance team are working with W&OD to support departments to 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.
- The W&OD and Finance team will work with departments to manage any associated workforce risk regarding staff recruited permanently due to Covid or other reasons where recurrent funding is no longer available. This will be through re-deployment into vacancies primarily with redundancy as an option if required.

2.1.4 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 associated with these contracts.

2.2 Wellbeing

*2.2.1 **Key Workforce and Associated Financial Risks***

Key workforce risk: The COVID pandemic has resulted in 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 – Please refer to May Workforce Monthly Performance Report Pages 5-7 Sickness Narrative for further details.

Financial risk: The cost of sickness is reflected as an indicative productivity/ efficiency loss. The indicative productivity loss and cost for the last 12 months related to sickness is £2.114m, which is 24,274 days. High levels of sickness may also impact the need to attract more staff through agency costs. This risk is reported under the Attraction and Retention section below. Reduction in sickness absences rates has a direct impact on reducing the variable pay bill to cover absences.

*2.2.2 **Actions taken to mitigate WOD and Finance Risks related to Wellbeing***

The following actions are in train to minimize and address the risk.

COVID has resulted in higher level of sickness absence with stress and anxiety the top reason for sickness. Therefore, a raft of wellbeing interventions are being introduced:

- Trust Health and Wellbeing Plan including
    - Development of physical wellbeing spaces for staff
    - Recruiting a Staff Psychologist to support wellbeing
    - Range of mental, physical, financial wellbeing support for staff
    - Employee Assistance Programme providing 24 hour counselling to staff and staff family
- Enabling infrastructure development to support wellbeing:
    - Respectful Resolution toolkit to support manager and staff and develop a positive culture
    - Hybrid working principles to support a hybrid working environment
    - Programme of work to review values
    - Aligning hotspot areas of sickness with targeted wellbeing interventions

The above are monitored via Trust Healthy and Engaged Action Plan which provides further details.

3. Attraction and Retention

3.1.1 Key Workforce and Associated Financial Risks

Key workforce risk: The Trust is currently carrying 165 WTE vacancies as at the end of May 2022. A Recruitment and Retention plan is being developed with targeted specific intentions in hotspot areas together with work ongoing with regional partners to develop regional interventions. The Trust Attraction and Retention Plan is available that provides further details.

Financial risk: The cost is reflected in the pay costs through use of agency and overtime and provision of TOIL.

The cumulative spend year-to-date as at May 2022 on measures to bridge the vacancy gap include:

- Agency spend £229k
- Overtime spend £76k

The 2022/23 full year forecast outturn for Agency spend is £1,222k compared to £1,906k 2021/22, which is a £684k (36%) expected year-on-year reduction.

Based on the full year 2022/23 cost forecast, £400k is estimated to be premium cost that could be saved if the Trust were able to recruit permanently rather than utilise Agency.

3.1.2 Actions taken to mitigate WOD and Finance Risks related to Attraction and Retention

In order to address hotspot workforce areas the Trust is undertaking a number of regional and local strategies around attraction and retention.

Regional strategies around recruitment and retention that are being employed are as follows:

- **Supporting Aneurin Bevan with AOS recruitment**
  - Evaluate data to understand lack of application
  - Support advert design / role branding
  - Ideas on developing social media presence
- **Radiation Services Diagnostics**
  - Collaborative service design with C&V
  - Joint recruitment in rotational band 7 post

    - Joint training programmes and annex 21 recruitment in Nuclear Medicine
- **Multi-disciplinary Career Pathways**
    - All Wales Non-surgical Oncology Project to look at delivering services aligning multi-disciplinary teams (Lung SST)
- **Recruitment Modernisation Programme**
    - NWSSP are streamlining on-boarding by going back to basics in process
    - T&F groups to look at application process, international recruitment and national hard to fill roles

To address internal attraction and retention issues the following is being undertaken:

- **Review and Streamline Recruitment Process**
    - Develop a Recruitment Policy
    - Make recruitment planning meetings standard practice
    - In collaboration with NWSSP develop better candidate experiences
    - Review current on-boarding process
- **Implement effective attraction strategies**
    - Promote the Velindre 'Brand'
    - Develop attraction channels – social media
    - Target recruitment campaign for high turnover roles
    - Engagement with national recruitment fayres
- **Implement effective retention strategies**
    - Assess and promote flexible working options
    - Review and promote the Total Reward Statements
    - Ongoing review of staff surveys and exit interviews
    - Effective reward and recognition schemes

- The finance team are working with W&OD to support departments with high use of agency to recruit permanently into substantive vacancies as quickly as possible, subject to market conditions.

An Attraction and Retention plan is available that provides further details.

4. Measures to Monitor Improvement

To address improvement the following Key Performance Indicators are being reviewed on a monthly basis:

WOD Risk	Hotspot Risk Areas – Reviewed and Updated monthly via Service and Workforce Performance reports	Key Performance Indicator
Supply and Shape	Monthly Performance reports to address and monitor improvement trajectories	Fixed term contracts reviewed
Wellbeing		Sickness Absence Rates
Attraction and Retention		Vacancy Rate Vacancy turnover rate

5. 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

5. RECOMMENDATION

a. The Committee is asked to **DISCUSS and REVIEW** the workforce risks, opportunities and associated financial impacts as outlined within the contents of the report.

QUALITY, SAFETY & PERFORMANCE COMMITTEE

FINANCE REPORT FOR THE PERIOD ENDED 31ST MAY 2022 (M2)

DATE OF MEETING	14/07/2022

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**
EMB RUN	01.07.22	Endorsed

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 May 2022.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Performance against Key Financial Targets:

	Unit	Current Month £000	Year to date £000	Year End Forecast £000
Revenue	Variance	2	3	0
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	889	2,411	25,856
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	89.2%	94.8%	95.0%

Efficiency / Savings	Variance	0	0	0

2.2 Revenue Budget

At this stage of the financial year the overall revenue budget (excl Covid) remains broadly in line with expectations as planned within the IMTP, with a projected forecast outturn position of breakeven.

The overall position against the profiled revenue budget to the end of May'22 is an underspend of **£3k**, with an underachievement against income offset by an underspend within both Pay and Non Pay.

A large element of the underachievement on planned income relates to WBS WTAIL and Blood Components due to the impact of Covid, for which the Trust is expecting to receive WG funding to cover during the first 6 months of the year, with strategic plans being put in place to mitigate the risk exposure during the latter part of the year.

Cost pressures which have / will surface during the year, in line with normal budgetary control procedures, are managed by budget holders to ensure the delegated expenditure control limits are not exceeded.

Several saving schemes currently remain RAG rated amber and therefore it is extremely important that those schemes that have not yet gone live are reviewed at divisional level with a view to either turn green or find replacement schemes.

The Trust is reporting a year end forecast breakeven position; however, this assumes that all additional Covid-19 costs are fully reimbursed by WG, all planned additional income is received and the savings targets achieved.

2.3 PSPP Performance

PSSP performance for the whole Trust (inc. NWSSP) is currently 94.93% against a target of 95%, with the performance against the Core Trust (exc. NWSSP) currently also just falling short of the target at 94.8%.

Measures have been put in place to target key areas which have been causing 'bottlenecks' in the PSPP process which has been reflected in the May performance figures.

2.4 Covid Expenditure

Covid-19 Revenue Spend/ Funding		
	YTD Actual £000	Plan 2022/23 £000
Mass Covid Vaccination	51	375
PPE	46	325
Cleaning Standards	71	512
Covid Recovery	936	3,762
Covid Response	278	1,051
Total Covid Spend /Funding Requirement 2022/23	**1,382**	**6,025**
WG Funding		1,673
Commissioner Funding		4,352
Balance of Funding Requirement		**6,025**

The overall gross funding requirement related to Covid is £6,025k, with £1,673k being recognised for funding from WG, and the balance of £4,352k being sought from our Commissioners.

The £6,025k represents a significant reduction from what was submitted as part of the Trust IMTP planning stage on 31st March, which is in large due to the news that the Rutherford has gone into liquidation and a considerable reduction in funding required for outsourcing.

Other funding / cost reduction reflects control measures and review of service delivery models to reflect latest WG Covid de-escalation guidance.

2.5 Reserves

The financial strategy for 2022-23 facilitated the development of a recurrent and non-recurrent reserve in support of the Trust transformation and delivery agenda. These reserves could only be accommodated on the basis that all income expectations are received, planned savings schemes delivered and new emerging cost pressures managed. In addition, the Trust holds an emergency reserve of 522k.

At this stage only unavoidable costs pressures should be considered for funding against the Trust reserves, with any new investment decisions being put on hold until the Trust receives confirmation that all Covid related expenditure will be funded.

2.6 Financial Risks

Covid

The Trust is in dialogue with our Commissioners about the balance of the Covid funding requirement to match the anticipated spend, and whilst they recognise our Covid requirement they have not fully committed to providing the full ask of £4,352k.

Revised LTA agreements were issued on the 16th June with discussions ongoing with our commissioners around the Covid funding requirement for 2022/23. This remains a high risk to the Trust.

Savings

Due to the ongoing pandemic and the potential inability to enact several savings schemes there is a risk that some of the savings that are RAG rated amber may not be fully

achieved. Those schemes with risk of delivery are being reviewed at Divisional level with a view to ensure delivery, or to find replacement schemes as the year progresses.

TCS

A non-recurrent revenue funding request of £104k has been made by the TCS Programme relating to shortfalls in funding on the PMO and nVCC project. £60k has previously been agreed for investment by EMB with the remaining balance approved by EMB Run on 1st July. This is to secure the full £104k shortfall in revenue funding compared to forecast spend.

All other financial risks are expected to be mitigated at divisional level, however there is a small risk that operational cost pressures may materialise during the year which is beyond divisional control or the ability to be managed through the overall Trust funding envelope.

2.7 Capital

a) All Wales Programme

Performance against the current agreed All Wales Programme budget allocations are at this stage expected to deliver to budget.

Other Major Schemes in development that will be considered during 2022/23 and beyond in conjunction with WG include, Integrated Radiotherapy Solution (IRS), WBS HQ, WBS Hemoflows, Scalp Coolers, VCC Outpatients & Ventilation and Plasma Fractionation.

b) Discretionary Programme

The Trust discretionary capital allocation for 2022/23 is £1,454mk. This represents a 24% reduction in capital allocation compared to £1,911k in 2021/22 and is reflective of the reduced overall NHS capital budget position.

The discretionary allocation has ringfenced £434k to support the Integrated Radiotherapy Solution (IRS). Discussions are currently taking place with WG colleagues with the ambition that the Trust may receive ALL Wales capital funding for the costs via the IRS business case.

The Trust Discretionary Programme for 2022/23 has recently been agreed by the Capital Planning and Delivery Group for 2022/23 with a paper going to EMB in August for approval.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The Trust financial position at the end of May 2022 is an underspend of £3k with a year-end forecast break-even position in accordance with the approved IMTP

4. RECOMMENDATION

The QS&P Committee is asked to **NOTE**

4.1 the contents of the May 2022 financial report and in particular the financial performance to date, and the year-end forecast to achieve financial break-even and key risk in relation to income to cover Covid backlog additional capacity costs.

4.2 the TCS Programme financial report for May 2022 attached as **Appendix 1**.

4.3 the Velindre Core Trust WG Monthly Monitoring Returns (MMR) for May 2022 attached as **Appendix 2**.

FINANCIAL PERFORMANCE REPORT

FOR THE PERIOD ENDED MAY 2022/23

QS&P COMMITTEE
14/07/2022

1. Introduction

The purpose of this report is to outline the financial position and performance for the year to date, performance against financial savings targets, highlights the financial risks, and forecast for the financial year, outlining the actions required to deliver the IMTP Financial Plan for 2022-23.

2. Background / Context

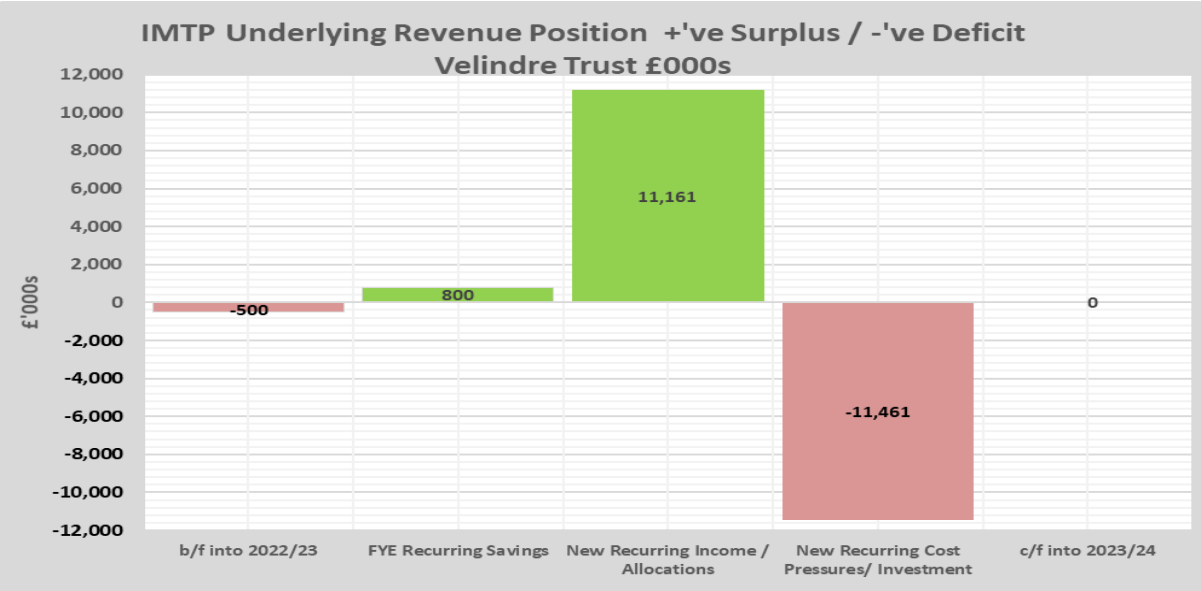
The Trust IMTP Financial Plan for the period 2022-2025 was set within the following context.

- The Trust submitted a balanced three year IMTP, covering the period 2022-23 to 2024-25 to Welsh Government on the 31 March 2022.

- For 2022-23 the Plan (excl Covid) included;
  - an underlying **deficit of -£500k** brought forward from 2021-22,
  - FYE **of new cost pressures / Investment** of -**£11,461k,**
  - offset by **new recurring Income** of **£11,161k,**
  - and Recurring FYE **savings schemes** of **£800k,**
  - Allowing **a balanced position** to be carried into 2023-24.

- The underlying deficit is expected to be eliminated during 2022-23 through the discretionary uplift in funding, enabling a balanced position to be carried into 2023-24.

- **To eliminate the brought forward underlying deficit, the savings target set for 2022-23 must be achieved, all anticipated income is received, and any new emerging costs pressures are either mitigated at Divisional level or manged through the Trust reserves.**



Underlying Position +Deficit/(-Surplus) £000s	b/f into 2022/23	Recurring Savings	New Recurring Income / Allocations	FYE New Cost Pressures/ Investment	c/f into 2023/24
Velindre NHS Trust	- 500	800	11,161	- 11,461	-

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	Year to date £000	Year End Forecast £000
Revenue	Variance	2	3	0
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	889	2,411	25,856
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	89.2%	94.8%	95.0%

Performance against Planned Savings Target

Efficiency Savings	Variance	0	0	0

Revenue

The Trust has reported a **£2k** in-month underspend position for May '22, with a cumulative position of **£3k** underspent, and an outturn forecast of **Breakeven**.

Capital

The approved Capital Expenditure Limit (CEL) as at May 2022 is **£25,856k**. This represents all Wales Capital funding of **£24,402k**, and Discretionary funding of **£1,454k.** The Trust reported Capital spend to May'22 of £2,411k and is forecasting to remain within its CEL of £25,856k.

The Trust's CEL is broken down as follows:

	£k
Discretionary Capital	1,454.00
All Wales Capital:	
Fire Safety	500.00
TCS Programme	22,036.00
TCS Programme adjustment*	1,866.00
Total CEL	**25,856.00**

*Adjustment approved by WG per TCS Programme finance report but confirmation from WG via the CEL Letter awaited.

PSPP

During May '22 the Trust (core) achieved a compliance level of **96.07%** (April 22: 89.23%) of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **94.81%** as at the end of month 2, and a Trust position (including hosted) of **94.93%** compared to the target of 95%.

PSPP has been significantly impacted by the ongoing pandemic and reduced levels of receipting on orders which is due to the high levels of sickness being experienced in the Trust over the past year. The finance team has been working with NWSSP colleagues with a view to help improve performance, which has included a full review the approval hierarchy which has been reflected in the May PSSP figures.

Efficiency / Savings

At this stage the Trust is currently planning to fully achieve the savings target during 2022-23.

Revenue Position

Cumulative				Forecast		
£3,147 Underspent				Breakeven		
Type	YTD Budget (£'000)	YTD Actual (£'000)	YTD Variance (£'000)	Full Year Budget (£'000)	Full Year Forecast (£'000)	Forecast Variance (£'000)
Income	(28,685)	(28,615)	(70)	(174,286)	(174,286)	0
Pay	12,039	11,995	44	68,301	68,301	0
Non Pay	16,646	16,617	29	105,985	105,985	0
Total	**(0)**	**(3)**	**3**	**0**	**0**	**0**

The overall position against the profiled revenue budget to the end of May 2022 is an underspend of **£3k**, with a Pay and Non Pay underspend offsetting an Income under achievement.

The Trust is reporting a year end forecast breakeven position, however this is based on the assumption that all additional Covid-19 costs are fully reimbursed by both WG and the Trust commissioners, that all planned additional income is received, and the planned savings targets are achieved during 2022-23.

4.1 Revenue Position Key Issues

Income Key Issues

Income underachievement to May and is largely where activity is lower than planned on Bone Marrow and Plasma Sales in WBS, with plans being put in place to support recovery in the latter part of the year.

Pay Key Issues

The total Trust vacancies as at May 2022 is 165WTE, VCC (88WTE), WBS (34WTE), Corporate (10WTE), R&D (19WTE), TCS (6WTE) and HTW (8WTE).

Increase in Employers NI rates (1.25%) is currently being offset by divisional reserves, however funding is expected to be secured from WG through the recognition of exceptional national cost pressures.

Vacancies throughout the Trust remain high however a number of posts in both VCC and WBS have been appointed at risk in response to Covid activity backlogs and additional capacity required and forward recruitment for service developments, without agreed funding pending activity undertaken or FBC approval by WG and Commissioners. In addition, work is underway in both divisions to either secure additional funding to support these posts or looking at options to migrate staff into vacancies to help mitigate the current risk exposure.

Both VCC and WBS hold a £450k vacancy factor target, which will need to be achieved during 2022-23 in order to balance the overall Trust financial position.

Non Pay Key Issues

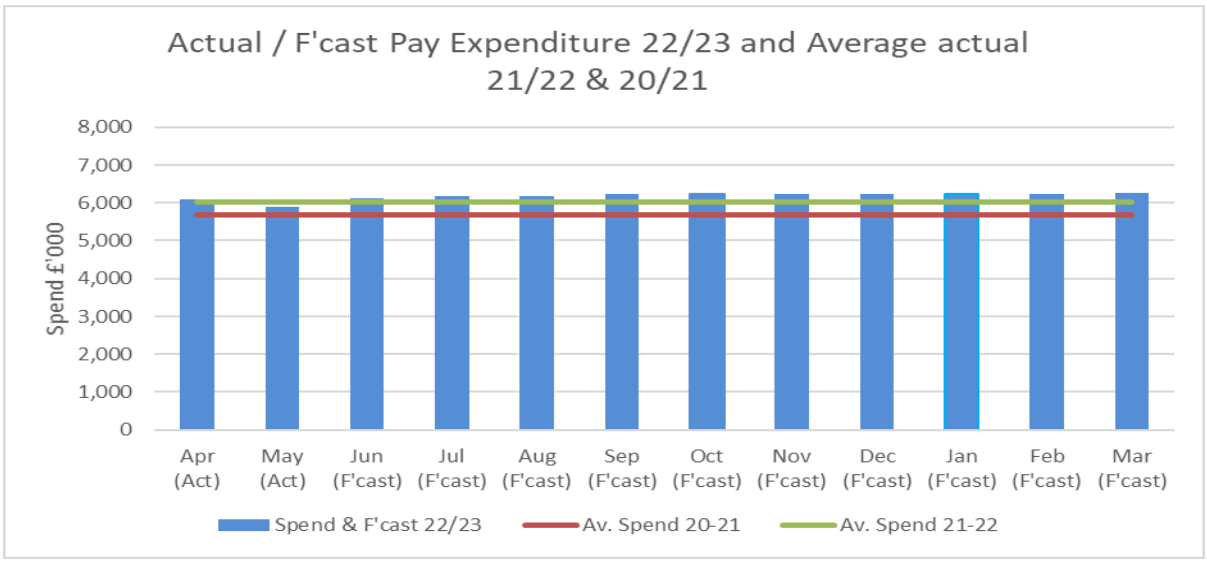
The expected increase in energy prices circa (£912k), has been recognised as an exceptional national cost pressures by WG with the Trust expectation that these costs will be fully funded during 2022/23 although this is yet to be confirmed.

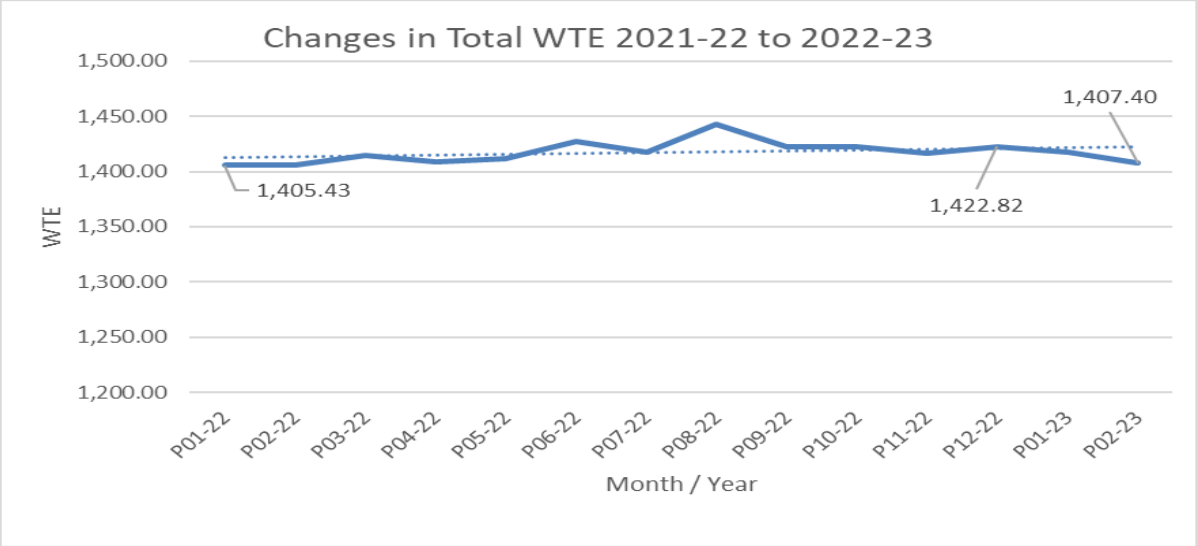
Each Division holds both a general reserve to meet unforeseen costs and a savings target / Cost improvement Plan (CIP). The savings target for each division was set as VCC £700k, WBS £500k and Corporate £100k for 2022-23.

The Trust reserves and previously agreed unallocated investment funding is held in month 12 and will be released into the position to match spend as it occurs throughout the year.

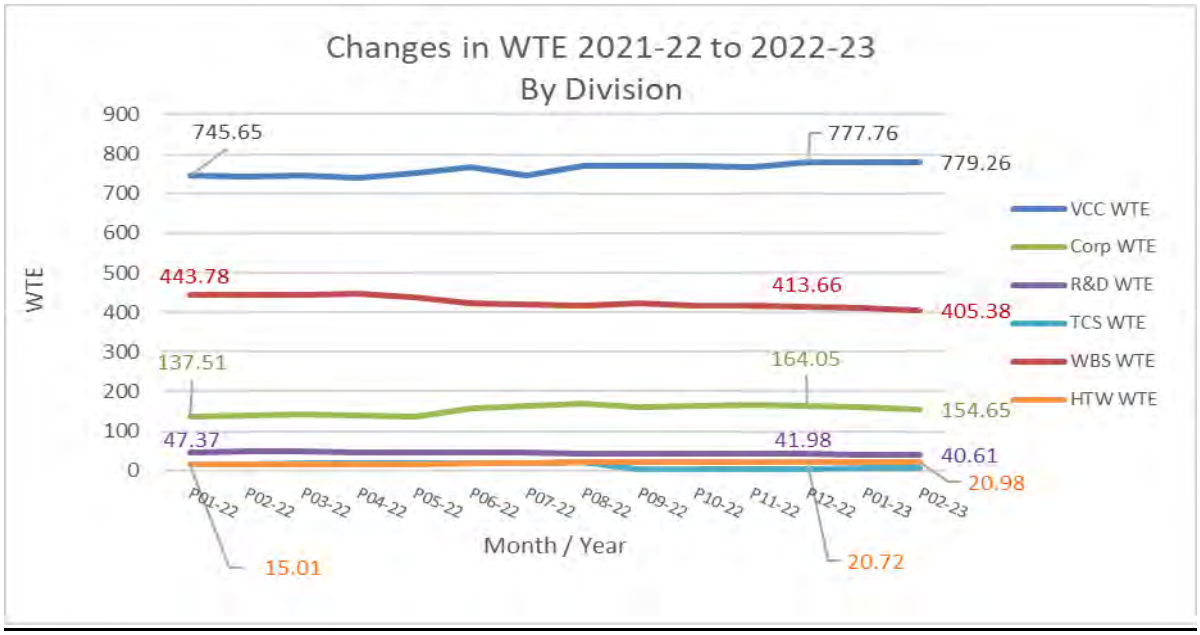
4.2 Pay Spend Trends (Run Rate)

The pay award for 2022-23 is yet to be agreed so these costs are not yet reflected in the pay spend. Agency costs are expected to significantly decrease during 2022-23 largely from the reduction of agency staff that has been used over the past year in response to Covid and through the recruitment into filling vacancies.

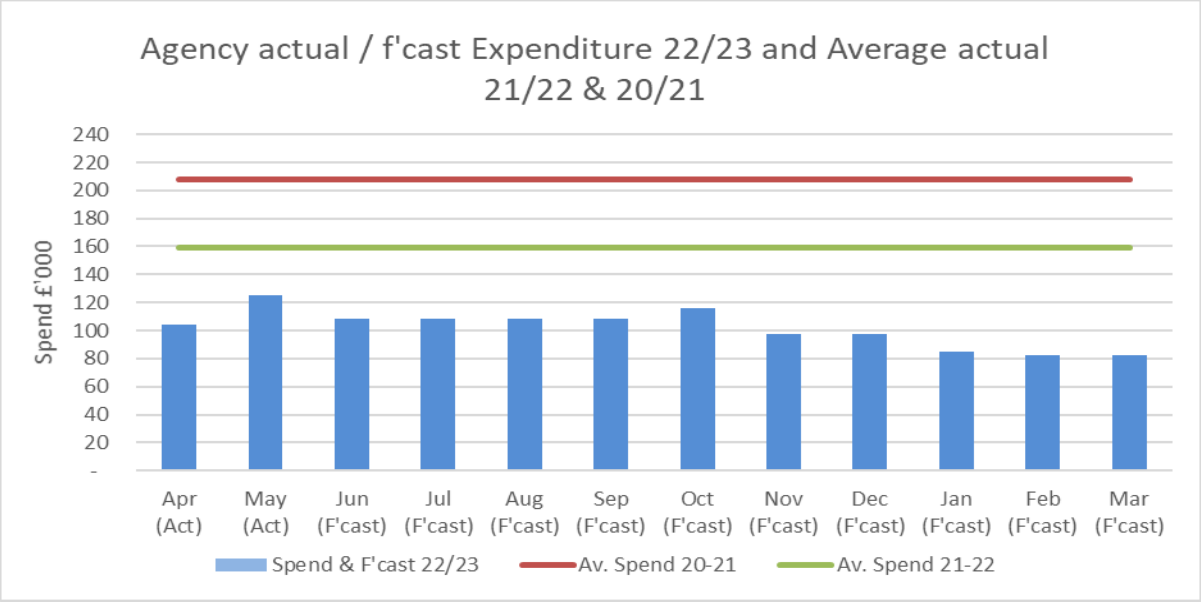




* Reduction in WTE since March 22 is largely due the instruction to cease Covid related staff.

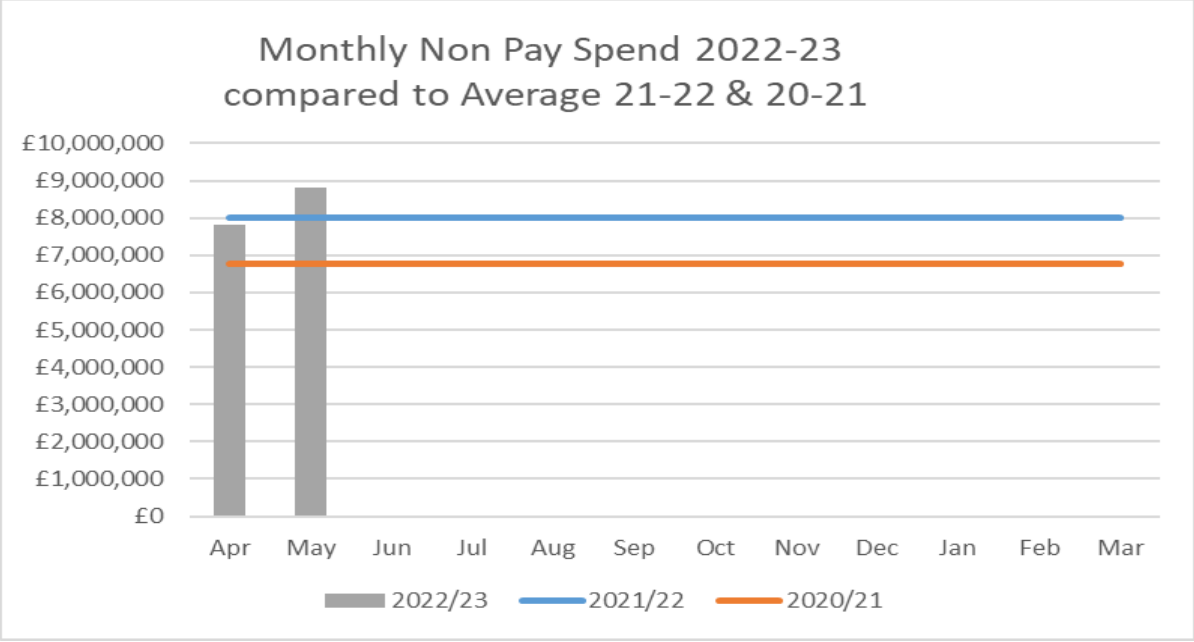


The spend on agency for May'22 was £125k (April £104k), which gives a cumulative year to date spend of **£229k** and a current forecast outturn spend of circa **£1,222k** (£1,906k 2021-22). Of these totals the year to date spend on agency directly relating to Covid as at the end of May is £75k and forecast spend is circa £395k (£826k 2021-22).



4.3 Non Pay

Non-pay 21-22 (c£96m) av. monthly spend of £8m was £1.2m higher than the reported monthly average spend for 20/21 (£6.8m). Most of the monthly average increase (circa £900k) related to the growth in NICE / High Cost drug usage following the recovery and associated surge related to Covid and increase in WBS wholesaling (circa £300k). The average monthly spend for 22-23 is currently £8.3m (3.8%) more than 21-22, which again largely relates to the increase in both NICE / High-Cost drug usage and WBS Wholesaling in response to increased activity.



4.4 Covid-19

Covid-19 Funding			
	WG £000	**Commissioners £000**	**Total £000**
Mass Vaccination	375		375
PPE	325		325
Cleaning	512		512
Other Covid Response	461	590	1,051
Covid Recovery - Internal Capacity		2,943	2,943
Covid Recovery - Outsourcing and Outreach		819	819
Total	**1,673**	**4,352**	**6,025**

The latest Trust funding requirement in relation to Covid for 2022-23 have been revised down to £6,025k which is a significant reduction from the £12,310 that was submitted as part of the Trust IMTP. Of the £6,025k total Covid requirement £1,673k (previously £2,104) is being requested directly from WG, and the balance of £4,352k (previously £10,206k) being sought from our commissioners.

WG funding has been assumed for programme related Covid costs of £700k (Mass Vaccination and PPE), along with other Covid response funding of £1,051 (previously £1,394k) in relation to ongoing cleaning, increase in workforce costs, and capacity and facility costs per letter received from Judith Paget dated 14th March 2022.

Covid-19 Revenue Spend/ Funding		
	YTD Actual £000	**Plan 2022/23 £000**
Mass Covid Vaccination	51	375
PPE	46	325
Cleaning Standards	71	512
Covid Recovery	936	3,762
Covid Response	278	1,051
Total Covid Spend /Funding Requirement 2022/23	**1,382**	**6,025**
WG Funding		1,673
Commissioner Funding		4,352
Balance of Funding Requirement		**6,025**

The Trust Covid expenditure is based on demand forecast modelling and following news that The Rutherford has gone into liquidation, the funding previously required for outsourcing has significantly reduced (by £3,650k). In response the Trust is looking to access additional outreach Capacity at Prince Charles Hospital for SACT with latest forecast cost expectations being circa £320k and is currently developing plans for Radiotherapy capacity internally looking to weekend working which will require WLI and enhanced pay rates.

Other cost reduction reflects control measures and review of service delivery models to reflect latest WG Covid de-escalation guidance.

4. Savings

The Trust established as part of the IMTP a savings requirement of £1,300k for 2022-23, £800k recurrent and £500k non-recurrent, with £750k being categorised as actual saving schemes and £550k being income generation.

The Divisional share of the overall Trust savings target has been allocated to VCC £700k (54%), WBS £500k (38%), and Corporate £100k (8%).

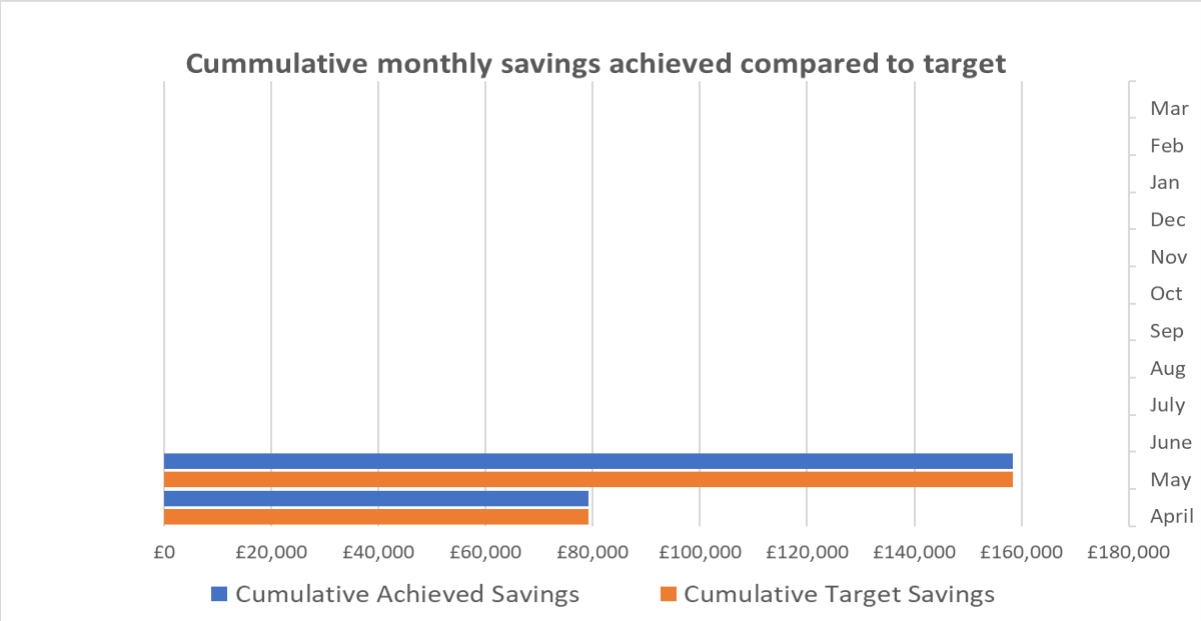
Currently several of the schemes are still RAG rated amber which in large relates to those schemes that are either expected to still be impacted by Covid during 2022-23 or affected by current market conditions where there has been a significant rise in prices.

Service redesign and supportive structures is a key area for the Trust which is about focusing on finding efficiencies in the ways that we are working. Due to the pandemic the savings scheme start date has been pushed back to July, with any implementation of change to the workforce redesign now not expected to take place during the first quarter of the year.

The procurement supply chain saving schemes is again expected to be affected by both procurement constraints and current market conditions during 2022-23, where we have seen a significant increase in costs for both materials and services. NWSSP procurement team are in the process of developing an improvement plan which will include an evaluation of further opportunities through procurement.

It is extremely important that divisions review their current savings schemes, and where delivery may not be achieved alternative schemes are implemented to ensure that the Savings target is met for 2022-23.

Scheme Type	RAG RATING	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	F'cast Full Year £000	Variance Full Year £000
Savings Schemes							
Establishment Control (Corporate)	Green	100	17	17	0	100	0
Laboratory & Collection Model (WBS)	Green	50	8	8	0	50	0
Laboratory & Collection Model (WBS)	Green	50	8	8	0	50	0
Stock Management (WBS)	Green	100	17	17	0	100	0
Stock Management (WBS)	Green	150	25	25	0	150	0
Procurement - Supply Chain (WBS)	Amber	50	8	8	0	50	0
Service Redesign (VCC)	Amber	100	0	0	0	100	0
Supportive Stuctures (VCC)	Amber	100	0	0	0	100	0
Procurement - Supply Chain (VCC)	Amber	50	8	8	0	50	0
Total Saving Schemes		**750**	92	92	0	750	0
Income Generation							
Maximinsing Income Opportunities - Income Attraction (WBS)	Green	50	8	8	0	50	0
Maximinsing Income Opportunities - Income Attraction (WBS)	Geen	50	8	8	0	50	0
Maximinsing Income Opportunities - Private Patients (VCC)	Amber	150	0	0	0	150	0
Maximinsing Income Opportunities - Private Patients (VCC)	Green	100	17	17	0	100	0
Maximinsing Income Opportunities - Income Attraction (VCC)	Green	200	33	33	0	200	0
Total Income Generation		**550**	67	67	0	550	0
TRUST TOTAL SAVINGS		**1,300**	**158**	**158**	**0**	**1,300**	**0**
				100%		**100%**	



5. Reserves

The financial strategy for 2022-23 facilitated the development of a recurrent and non-recurrent reserve in support of the Trust transformation and delivery agenda. These reserves could only be accommodated on the basis that all income expectations are received, planned savings schemes delivered and new emerging cost pressures managed. In addition, the Trust holds an emergency reserve of 522k.

Summary of Total Recurrent Reserves Remaining Available in 2022/23	£k
Recurrent Reserves Available for investment	1,190
Previously Committed Reserves Bfwd 2021-22	(137)
Previously agreed Exec Investment	(973)
New Commitments	(80)
Emergence of Slippage against Recurrent Reserves Commitments	
Remaining Balance	**0**

Summary of Total Non-Recurrent Reserves Remaining Available in 2022/23	£k
Non-Recurrent Reserves Available for investment	1,404
Previously Committed Reserves Bfwd 2021-22	(102)
Previously Agreed Exec Investment	(1,302)
Emergence of Slippage against Non-Recurrent Commitments	
Remaining Balance	**0**

At this stage only unavoidable costs pressures should be considered for funding against the Trust reserves, with any new investment decisions being put on hold until the Trust receives confirmation that all Covid related expenditure will be funded

6. End of Year Forecast / Risk Assessment

The Trust is currently reporting a year end breakeven position against its revenue budget, however there are a number of risks which are being managed and closely monitored. The table below summarises the key financial risks & opportunities highlighted to Welsh Government.

Non-Delivery of Savings - *Risk £250k, Likelihood - Medium*

The Trust as part of the IMTP identified £1,300k of Savings and Income Generation to be achieved during 2022-23. Due to the ongoing pandemic and the potential inability to enact several of these savings there is a risk that some of the amber savings target may not be fully achieved. Those

schemes with risk of delivery are being reviewed at Divisional level with a view to ensure delivery, or to find replacement schemes as the year progresses.

The conclusion of the Microsoft 365 National Deal led to a £157k (incl. VAT) in-year cost pressure, which will be assigned as a Cost Improvement Programme to the Digital Services Team. This includes the standing down of legacy IT infrastructure which is not required due to the MS 365 deal.

Covid Funding via Commissioners – *Risk TBC, Likelihood - High*

The Trust is in discussions with our commissioners who recognise our Covid requirement however they have not currently committed to providing the full reduced ask of £3,852k (£4,352k less £500 outsourcing treatments completed), which is in part due to two of the three South East Wales Health Board commissioners currently do not have balanced financial plans. Commissioners have all stated that any funding required to cover additional Covid recovery costs will only flow through the LTA under the national funds flow mechanism. This mechanism whilst providing enhanced income protection over the normal LTA does not cover premium rates incurred through outsourcing or enhanced internal rates for WLI's. The Trust will continue to liaise with the commissioners around the Covid funding requirement for 2022-23 as a part of the overall LTA agreement which the Trust originally issued to commissioners on 6th May and revised agreements were issued on the 16th June with discussions on going.

Covid Outsourcing- *Risk £500k, Likelihood - High*

The Covid outsourcing relates to the cost of service delivery for activity demand which is beyond Trust internal planned capacity volumes. Following the news that the RCC has gone into liquidation the forecasted costs for outsourcing has significantly reduced from £4,150k to £500k which are the actual costs for the patients that have been treated since 1st April to date. There has been a significant premium cost of outsourcing activity to the RCC of 3 times the Trust costs. Whilst the forecast cost of outsourcing has been significantly reduced given that RCC is no longer an option for delivery of the capacity shortfall from internal capacity to meet forecast demad, the risk remains with the Trust regarding the premium element of the £500k costs incurred (c£333k). Plans to replace the lost outsourced RCC capacity with internal capacity are developed for SACT and is currently being worked up for Radiotherapy, but there will be a premium cost to deliver these as WLI with enhanced pay that the national funding flows model income will not fully cover.

There may be an option for the Trust to utilise the RCC assets to maintain the agreed capacity through a lease arrangement or possible purchase should the current RCC investors agree such a proposal, however this would require agreed revenue and / or capital funding via WG / Commissioners. This option is unlikely to be realisable, but work remains ongoing.

Commissioners have indicated during IMTP discussions that they do not have funding to cover the premium cost of outsourcing or for internal capacity and that they will only fund activity based on the national funds flow model.

Management of Operational Cost Pressures – *Risk £250k, Likelihood - Low*

Cost pressures that have / will surface through the year are expected to be managed in line with normal budgetary control procedures or through utilisation of the Trust reserve. However, due to the current demands on the service there is a small risk that pressures may materialise beyond divisional control or be able to be managed through the overall Trust funding envelope.

7. CAPITAL EXPENDITURE

Administrative Target

- *To ensure that net Capital expenditure does not exceed the Capital Expenditure Limit (CEL) approved by the Welsh Government.*
- *To ensure the Trust does not exceed its External Financing Limit*

	Approved CEL £000s	YTD Spend £000s	Committed Orders Outstanding £000s	Budget Remaining @ M2 £000s	Full Year Actual Spend £000s	Year End Variance £000s
All Wales Capital Programme						
nVCC - project costs	2,089	541	0	1,548	2,089	0
nVCC - Enabling Works	21,813	1,444		20,369	21,813	0
Cancer Project (DHCW CEL Transfer)	0	120	0	(120)	567	(567)
Fire Safety	500	100	0	400	500	0
			0			
Total All Wales Capital Programme	24,402	2,205	0	22,197	24,969	(567)
Discretionary Capital	1,454	206	0	1,248	1,454	0
Total	25,856	2,411	0	23,445	26,423	(567)

The approved 2022-23 Capital Expenditure Limit (CEL) as at May 2022 was £25,856k. This includes All Wales Capital funding of £24,402k, and discretionary funding of £1,454k. As described in Section 3: Executive Summary, an Adjustment of £1,866k has approved by WG per TCS Programme report but confirmation from WG via the CEL Letter is to be confirmed. This adjustment relates to nVCC – Enabling Works.

In January 2022 WG informed the Trust that the discretionary allocation with be significantly reduced during 2022-23 (previously £1,911k), which is reflective of the reduced overall NHS capital budget position.

Allocation of the discretionary programme has recently been agreed for 2022-23 via the Capital Planning and Delivery Group with a paper going to EMB for approval in August.

The discretionary allocation has ringfenced £434k to support the Integrated Radiotherapy Solution (IRS). Discussions are currently taking place with WG colleagues with the ambition that the Trust may be reimbursed for the costs incurred in supporting the procurement phase of the scheme.

Discussions are ongoing with both WG and DHCW around the funding allocation for the Cancer Project, however current indication is that the original agreed funding of £567k may be reduced by circa 30%. Measures are being put in place to reduce this risk exposure should the full funding not flow.

WG have indicated that they are keen for organisation to continue to develop capital proposals should additional funding become available later in the financial year.

Whilst the financial position is going to be challenging the current expectation is that capital requirements can either be manged through the Trust discretionary allocation during 2022-23 or additional funding will be secured from WG.

Performance to date

The actual cumulative expenditure to May 2022 on the All-Wales Capital Programme schemes was £2,205k, this is broken down between spend on the nVCC enabling works £1,444k, nVCC project costs of £541k, Cancer Project £120k, and fire safety £120k.

Spend to date on Discretionary Capital is currently £206k.

Year-end Forecast Spend

The year-end forecast outturn is currently expected to be managed to a breakeven position.

Major Schemes in Development

The Trust has also been in discussions with WG over other projects which it is seeking to secure funding from the All-Wales Capital programme.

Major Schemes in development that will be considered during 2022-23 and beyond in conjunction with WG include:

	Scheme	Scheme Total	Stage (i.e. OBC development, FBC development, scoping etc.)	22/23 £'000	23/24 £'000	24/25 £'000	25/26 £'000	26/27 £'000	27/28 £'000	28/29 £'000
1	WBS HQ	34,125*	FBC being developed	1,016	12,808	9,996	4,434	5,215	608	48
2	IRS	46,921*	OBC & PBC approved by WG, FBC under development (	7,453	9,533	22,832	7,103			
3	Hemoflows	224	SBAR being Completed	224						
4	Scalp Coolers	250	SBAR being Completed	250						

*Cash flow of these schemes is still under review alongside WG.

Other Major schemes which are under discussion internally and WG are sighted on include VCC outpatients, ventilation, and plasma fractionation.

8. BALANCE SHEET (Including Hosted Organisations)

The balance sheet will be reported from Month 3.

9. CASH FLOW (Includes Hosted Organisations)

The cash-flow forecast is important to enable the Trust to plan for sufficient cash availability throughout the financial year to pay its debts, such as payroll, services provided by other health bodies and private companies. The cash-flow forecast ensures that the Trust has an early understanding of any cash-flow difficulties.

As part of the Brexit emergency planning an additional £5m of stock had been purchased by NWSSP and an additional £2m of commercial blood products were purchased by WBS, to provide resilience for NHS Wales due to the uncertainty around supply chain reliability because of Brexit.

To aid the Trust's cash flow while the additional stock was being held for Brexit, Welsh Government provided the Trust with additional cash of £7m during 2019/20. WBS did intend to run down the

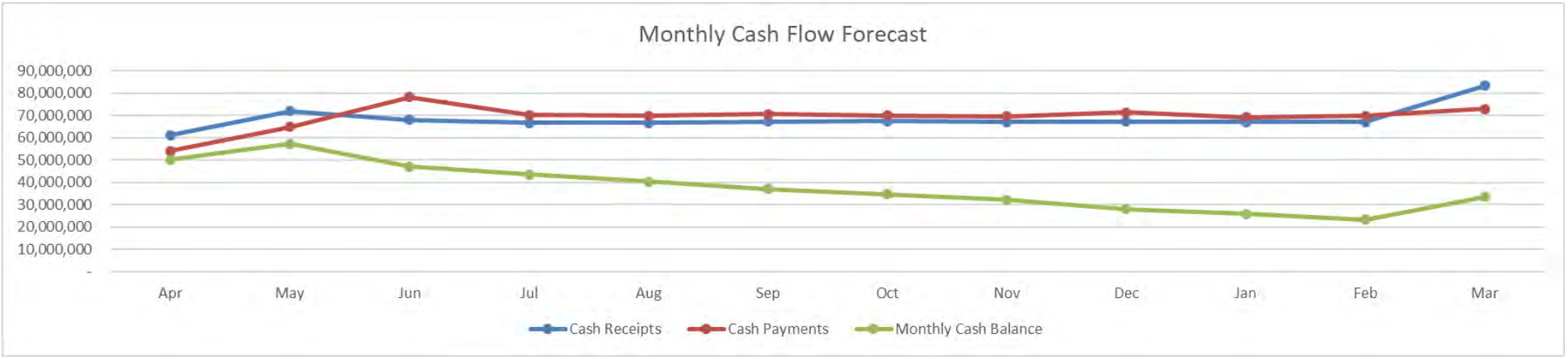
commercial blood stock, however given the uncertain situation with Covid and potential impact on supply chains the Trust continues to hold this stock with assessments ongoing. NWSSP are continuing to liaise with WG regarding the level of Brexit stock to maintain but it is anticipated that the repayment of the additional cash will take place in the second quarter of 2022-23 but will be dependent on the stock being released.

Due to the high levels of purchases relating to Covid within NWSSP, the cash levels over the past year or so have been significantly higher than usual, however this year expectation is that cash balances should return to pre-Covid levels.

Following a request from WG the Trust transferred £5.9m of cash into the Escrow holding account during May for the nVCC programme. These funds will be drawn down in July from WG to reimburse the Trust ensuring that there is no cash risk to the organisation.

Cash levels are monitored daily using a detailed cash flow forecast to ensure the Trust has sufficient cash balances to meet anticipated commitments.

		Apr £'000	May £'000	Jun £'000	Jul £'000	Aug £'000	Sep £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £'000	Totals £'000
	RECEIPTS													
1	LHB / WHSSC income	33,083	40,208	39,525	39,432	39,451	39,509	39,424	39,421	39,421	39,417	39,536	35,218	463,646
2	WG Income	20,937	24,551	24,936	23,972	23,937	24,145	24,620	24,155	24,188	24,158	24,037	24,182	287,816
3	Short Term Loans													0
4	PDC												19,570	19,570
5	Interest Receivable	19	27	19	19	19	19	19	19	19	19	19	19	238
6	Sale of Assets													0
7	Other	7,106	7,289	3,520	3,368	3,367	3,621	3,523	3,518	3,671	3,518	3,516	4,347	50,366
8	TOTAL RECEIPTS	**61,145**	**72,074**	**68,000**	**66,791**	**66,774**	**67,294**	**67,587**	**67,114**	**67,300**	**67,113**	**67,108**	**83,336**	**821,636**
	PAYMENTS													
9	Salaries and Wages	21,735	29,243	30,021	30,068	30,073	30,158	30,171	30,174	30,177	30,229	30,235	30,306	352,591
10	Non pay items	30,543	33,079	38,850	37,561	37,538	37,973	38,241	37,766	37,949	37,706	37,696	38,266	443,166
11	Short Term Loan Repayment			7,000										7,000
12	PDC Repayment													0
14	Capital Payment	1,926	2,567	2,519	2,626	2,280	2,453	1,587	1,660	3,289	1,383	1,849	4,409	28,547
15	Other items													0
16	TOTAL PAYMENTS	**54,205**	**64,889**	**78,390**	**70,254**	**69,891**	**70,584**	**69,999**	**69,599**	**71,414**	**69,318**	**69,780**	**72,981**	**831,305**
17	Net cash inflow/outflow	6,941	7,185	(10,390)	(3,463)	(3,117)	(3,290)	(2,413)	(2,485)	(4,115)	(2,205)	(2,672)	10,355	
18	Balance b/f	43,263	50,204	57,389	46,998	43,536	40,419	37,129	34,716	32,231	28,116	25,911	23,239	
19	Balance c/f	50,204	57,389	46,998	43,536	40,419	37,129	34,716	32,231	28,116	25,911	23,239	33,594	



DIVISIONAL ANALYSIS

(Figures in parenthesis signify an adverse variance against plan)

Core Trust

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Variance £000
VCC	6,356	6,357	(0)	35,497	35,497	0
RD&I	134	134	0	(365)	(365)	0
WBS	3,176	3,194	(18)	19,834	19,834	0
Sub-Total Divisions	**9,667**	**9,685**	**(18)**	**54,966**	**54,966**	**0**
Corporate Services Directorates	1,606	1,584	21	9,696	9,696	0
Delegated Budget Position	**11,272**	**11,269**	**3**	**64,662**	**64,662**	**0**
TCS	92	92	0	551	551	0
Health Technology Wales	5	4	0	28	28	0
Trust Income / Reserves	(11,369)	(11,369)	0	(65,241)	(65,241)	0
Trust Position	**(0)**	**(3)**	**3**	**0**	**0**	**0**

VCC

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Full Year Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	**11,301**	**11,292**	**(9)**	**71,753**	**71,753**	**0**
Expenditure						
Staff	7,183	7,148	35	39,907	39,907	**0**
Non Staff	10,474	10,500	(26)	67,343	67,343	**0**
Sub Total	**17,657**	**17,649**	**9**	**107,250**	**107,250**	**0**
Total	**6,356**	**6,357**	(0)	**35,497**	**35,497**	**0**

VCC Key Issues:

The reported financial position for the Velindre Cancer Centre as at the end of May 2022 was **breakeven**, and an expected outturn position of **breakeven**.

Income at Month 2 represents a small underachievement of **£(9)k**. This is largely from an increase in activity from providing SACT Homecare and the additional VAT savings, and an over achievement on private patient income due to drug performance which is above general private patient performance. This is offsetting the divisional income savings target and the loss of income from the now permanent closure of gift shop, which was initially closed due to Covid, and will now be transformed to make additional space at the Cancer Centre.

VCC have reported a year to date underspend of **£35k** against staff. The division continues to have a high level of vacancies, sickness, and maternity leave predominantly within Inpatients, Pharmacy and Radiotherapy which is above the divisional vacancy factor target and is offsetting the cost of agency (£165k to end of May) although £65k is directly related to Covid. Inpatients underspend relates to the holding off on recruitment due to reduced bed capacity from social distancing measures, however with social distancing measures reducing a review of service model is being undertaken which considers both recruitment requirement, but also additional ambulatory care to help reduce inpatient flow.

Medical costs have increased due to additional temporary staff recruited at risk to ensure that all Jnr Dr rotation placements are filled, and to provide additional resilience against pressured consultants. Additionally, enhanced out of hours service, for advanced life support which will be nursing led is currently still being covered by Jnr Dr's with expectation that the transition to nursing starts to take place from august.

Non-Staff Expenditure at Month 2 was **£(26)k** overspent. There are underspends on general drugs from reduced activity and temporary closure of outreach clinics, and increased consumables costs which are being partly offset through reserves held within the Division. The affect from the increase in price for utilities is included as an exceptional national costs pressure with the expectation that the costs will be funded by WG.

WBS

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	**4,224**	**4,128**	**(96)**	**21,444**	**21,444**	**0**
Expenditure						
Staff	2,742	2,770	(28)	15,506	15,506	**0**
Non Staff	4,658	4,553	106	25,772	25,772	**0**
Sub Total	**7,400**	**7,322**	**78**	**41,277**	**41,277**	**0**
Total	**3,176**	**3,194**	**(18)**	**19,834**	**19,834**	**0**

WBS Key Issues:

The reported financial position for the Welsh Blood Service at the end of May 2022 was an **£(18)k overspend** with an outturn forecast position of **breakeven** currently expected.

Income underachievement to date is **£(96)k**, where activity is lower than planned on Bone Marrow and Plasma Sales. Plasma sales recovery is still being impacted and expected to continue in the short term, but now expected to return to business as usual levels after the summer following attraction of new income. Transitional operating sites for Bone Marrow and increasingly curtailed procedures is resulting in activity being considerably lower than target. Covid funding will be utilised during the first 6 months to offset reduce activity impacted by the pandemic, with the division developing a strategy to increase the panel to help mitigate the risk during the latter part of the year.

Staff reported a year-to-date overspend of **£(28)k** to May. Overspend from posts supported without identified funding source which includes advanced recruitment and service developments have been incurred as a divisional cost pressure particularly in relation to Plasma Fractionation where no WHSSC funding has been secured.

Work is underway to either secure additional funding to support these posts or looking at options to migrate staff into vacancies to help mitigate the current risk exposure.

Non-Staff underspend of **£106k** is largely due to reduced costs from suppressed activity (currently running at 80%), underspend on Collections Services, Laboratory Services, WTAIL, and General Services which is primarily timing of proactive and reactive building maintenance.

Corporate

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected £000
Income	**96**	**224**	**127**	**578**	**578**	**0**
Expenditure						
Staff	1,383	1,400	(17)	8,300	8,300	**0**
Non Staff	319	408	(89)	1,974	1,974	**0**
Sub Total	**1,702**	**1,808**	**(106)**	**10,274**	**10,274**	**0**
Total	**1,606**	**1,584**	**21**	**9,696**	**9,696**	**0**

Corporate Key Issues:

The reported financial position for the Corporate Services division at the end of May 2022 was an underspend of **£21k**. The Corporate division is currently expecting to achieve an outturn position of **breakeven**.

Income overachievement relates to non-recurrent income received upfront which will be utilised throughout the year. In addition, the Trust is benefiting from receiving greater returns on cash being held in the bank due to the rise in interest rates.

Staff expectation is that vacancies within the division, will help offset use of agency and the divisional savings target.

Non pay overspend is **£(89)k** as at month 2 largely relates to upfront payment in relation to contracts which is offset by income, and the divisional savings target £(26)k which is expected to be met in year via staff vacancies and the additional income being received in response to the increase in interest rates.

RD&I

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	**279**	**254**	**(25)**	**3,110**	**3,110**	**0**
Expenditure						
Staff	396	373	23	2,581	2,581	**0**
Non Staff	17	15	2	164	164	**0**
Sub Total	**413**	**388**	**25**	**2,745**	**2,745**	**0**
Total	**134**	**134**	**0**	**(365)**	**(365)**	**0**

RD&I Key Issues

The reported financial position for the RD&I Division at the end of May 2022 was **breakeven** with a current forecast outturn position of **breakeven**.

Reduced income expectations is offsetting staff vacancies.

TCS – (Revenue)

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	**0**	**0**	**0**	**0**	**0**	**0**
Expenditure						
Staff	92	107	(15)	551	551	**0**
Non Staff	0	(15)	15	0	0	**0**
Sub Total	**92**	**92**	**0**	**551**	**551**	**0**
Total	**92**	**92**	**0**	**551**	**551**	**0**

TCS Key Issues

The reported financial position for the TCS Programme at the end of May 2022 is **Breakeven** with a forecasted outturn position of **Breakeven.**

TCS will achieve breakeven on the assumption that the Trust reserves again supports the forecasted non-pay costs of £30k, along with associated costs of the judicial review which is currently £14k.

HTW (Hosted Other)

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	**277**	**210**	**(67)**	**1,664**	**1,664**	**0**
Expenditure						
Staff	243	197	46	1,456	1,456	**0**
Non Staff	39	17	22	235	235	**0**
Sub Total	**282**	**214**	**68**	**1,692**	**1,692**	**0**
Total	**5**	**4**	**0**	**28**	**28**	**0**

HTW Key Issues

The reported financial position for Health Technology Wales at the end of May 2022 was **breakeven,** with a forecasted outturn position of **breakeven** on the basis that any potential slippage will be handed back to WG**.**

Appendix 1

TCS PROGRAMME DELIVERY BOARD

TCS PROGRAMME FINANCIAL REPORT FOR 2022-23 MAY 2022

DATE OF MEETING	14th May 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Eurwen Williams, Senior Finance Officer
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		

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. BACKGROUND

1.1 The purpose of this report is to provide a financial update to the TCS Scrutiny Committee for the financial year 2022-23, outlining spend to date against budget as at Month 2 for the TCS Programme.

2. FINANCIAL SUMMARY AS AT 31ST MAY 2022

2.1 Welsh Government Funding and Capital Expenditure Limit (CEL) 2022/23

The table below sets out the CEL issued by Welsh Government to fund the TCS Programme in 2022/23:

Project	CEL £m	Adjustments Approved by WG £m	Revised CEL £m	Adjustments Pending WG Approval £m	Internal Budget £m
Enabling Works	21.813	(1.866)	19.947	(0.450)	19.497
nVCC	2.089	0.000	2.089	0.450	2.539
IRS	0.000	0.000	0.000	0.000	0.000
Total	**23.902**	**(1.866)**	**22.036**	**0.000**	**22.036**

Welsh Government issued Velindre with CEL's totaling £23.902m for the Enabling Works (EW) and nVCC projects in 2022/23. Two adjustments have been requested by the TCS Programme to WG. A reduction of £1.866m to EW which has been agreed by WG and a transfer of £0.450m from EW to nVCC, which hasn't yet been agreed by WG. The Trust is awaiting authorisation from WG to the £0.450m funding transfer in order to confirm the revised CEL, which has been used for budget setting purposes.

There is no CEL set for the IRS project management costs that will be incurred in 2022/23 due to the delays in the procurement process. It is proposed that the Capital funding requirements are funded from the discretionary capital allocation for the Trust. The Trust's total discretionary capital allocation is £1.454m of which £0.434m is currently ring-fenced for the IRS project for 2022/23.

No revenue funding has been provided by the Welsh Government for the TCS Programme. Revenue funding is provided by Commissioners and the Trust using its emergency revenue reserve.

2.2 TCS Programme Summary Financial Position

The summary financial position for the TCS Programme for the year 2022-23 as at 31st May 2022 is outlined below:

Expenditure Type	YTD spend to 31st May 2022 £m	2022-23 Full Year		
		Forecast £m	Budget £m	Variance £m
Capital	2.056	22.470	22.036	(0.434)
Revenue	0.102	0.655	0.551	(0.104)
Total	**2.158**	**23.125**	**22.587**	**(0.538)**

The full year capital budget figure of £22.036m has been aligned to the revised CEL figure in line with the TCS Programme's submitted request to Welsh Government.

The capital expenditure variance is explained by the requirement of the IRS Project for £0.434m capital funding not yet agreed by EMB. It is proposed that the IRS project management costs up to commencement of the implementation phase (currently estimated to be from 1st October 2022 pending outcome of the procurement standstill process) be funded from the Trust's discretionary capital. A paper seeking approval of the Trust discretionary programme including the IRS project management funding requirement is due to be considered by EMB Run on 30th June.

A non-recurrent revenue funding request of £0.104m has been made by the TCS Programme relating to shortfalls in funding on the PMO and nVCC projects which will be considered by EMB Run on 30th June. This is to secure the £0.104m shortfall in revenue funding compared to forecast spend.

2.3 **TCS Programme Project Level Capital and Revenue Expenditure 2022/23**

Capital Spend by Project for 2022/23 is set out below:

Project Capital Spend	YTD spend to 31st May 2022 £m	2022-23 Full Year		
		Forecast £m	Budget £m	Variance £m
Enabling Works	1.444	19.947	19.497	(0.450)
nVCC	0.541	2.089	2.539	0.450
IRS	0.071	0.434	0.000	(0.434)
PMO	0.000	0.000	0.000	0.000
Service Change	0.000	0.000	0.000	0.000
Total	**2.056**	**22.470**	**22.036**	**(0.434)**

A transfer of funds of £0.450m between Enabling Works and nVCC projects has been requested from Welsh Government. If confirmed, budgets and revised forecasts will be updated to reflect this in the next reporting period.

The programme is currently forecasting a shortfall in capital funding requirement of £0.434m. It is proposed that the IRS Project Capital requirement be funded from the Trust's discretionary capital allocation. Once the discretionary capital allocation process has been confirmed, a budget will be allocated.

Revenue Spend by Programme for 2022/23 is set out below:

Project Revenue Spend	YTD spend to 31st May 2022 £m	2022-23 Full Year		
		Forecast £m	Budget £m	Variance £m
Enabling Works	0.000	0.000	0.000	0.000
nVCC	0.019	0.044	0.000	(0.044)
IRS	0.000	0.000	0.000	0.000
PMO	0.035	0.300	0.240	(0.060)
Service Change	0.048	0.311	0.311	0.000
Total	**0.102**	**0.655**	**0.551**	**(0.104)**

The programme is currently forecasting a shortfall in revenue funding requirement of £0.104m for which a request is being made to EMB for funding from the Trust emergency reserve. Should the request for £0.104m non-recurrent revenue funding be agreed by EMB, the budget will be allocated to the programme.

Further commentary on individual projects is provided below.

Enabling Works (EW)

2.4 In February 2022, the Minister for Health and Social Services approved the Enabling works FBC, with a total capital funding of £28.089m. £19.947m of this funding is expected to be utilised in the financial year 2022-23. The forecast capital spend for this year is as follows:

	£m	£m
Pay		**0.220**
Non-Pay		**19.727**
Design & Build	8.735	
3rd Party Works	5.928	
Utility Costs	1.851	
Supply Chain Fees	0.596	
Non-Works Costs	0.303	
Value Added Works	0.250	
Other Fees	0.234	
Quantified Risk – Trust	1.386	
Quantified Risk – Supply Chain Partner	0.444	

Total EW FBC Budget for 2022-23	**19.947**

2.5 There was an in month spend of £1.003m for May 2022 (£0.020m pay, £0.984m non-pay), with an in year spend of £1.444m (£0.037m pay, £1.407m non-pay).

New Velindre Cancer Centre

2.6 In March 2021, the Minister for Health and Social Services approved the nVCC OBC. A total capital funding of £5.550m has been provided in total, with a forecast utilisation of £2.089m in 2022-23.

2.7 There was an in-month capital spend of £0.328m for May 2022 (£0.117m pay, £0.211m non-pay), with an in year spend of £0.541m (£0.218m pay, £0.323m non-pay).

2.8 No revenue funding has been provided for this project by Welsh Government, however the Trust as in previous years is being requested to provide revenue funding to support the Programme during 2022-23. The revenue spend to date is £0.019m (£0.005m Project Delivery, £0.014m Judicial Review), and the current forecast outturn for the year is £0.044m.

Integrated Radiotherapy Solution Procurement

2.9 Due to a delay in the IRS procurement process, the project has been extended to September 2022. As a result of this delay the project is currently forecasting a shortfall funding requirement of £0.434m capital as described in section 2.2.

2.10 There was an in-month capital spend by the project of £0.049m (£0.027m pay, £0.022m non-pay), and a total spend of £0.071m (£0.050m pay, £0.021m non-pay) to 31st May 2022. The project is forecasting total pay costs of £0.214m and non-pay costs of £0.220m for the financial year 2022-23, which is a total of £0.434m for 2022-23.

Programme Management Office

2.11 There is a total requirement £0.300m revenue funding for the PMO for the current financial year. NHS Commissioners provided £0.240m as part of their annual funding towards the TCS Programme, agreed in December 2018. The Trust is currently being requested to provide a further £0.060m to support the Programme requirement during 2022-23.

2.12 The PMO spend in May 2022 was £0.018m. The spend to date is £0.035m. All spend to date is due to pay costs. The Project is forecasting a spend of £0.300m (£0.286m pay, £0.014m non-pay) in the financial year 2022-23.

Service Delivery, Transformation and Transition (Service Change)

2.13 A total of £0.311m revenue funding has been provided to the Service Change project for the financial year 2022-23, £0.180m from the NHS Commissioners annual funding towards

the TCS Programme, and £0.131m transfer from the Trust revenue budgets to support the Project Director and a Project Manager.

2.14 The in-year spend for the Project to 31st May 2022 totals £0.048m. These costs are for pay only. The project is forecasting pay costs of £0.288m and non-pay costs of £0.023m for the financial year 2022-23, a total of £0.311m against a budget of £0.311m.

Financial Risks & Issues

2.15 There is currently a financial risk that the Programme will overspend against its agreed funding, pending the outcome of EMB decisions in relation to the additional capital and revenue funding being sought.

3. CONSIDERATIONS FOR BOARD

3.1 This report is included as an appendix to the Trust Board Finance Report.

4. 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.

5. RECOMMENDATION

The TCS Programme Board are asked to **NOTE** the financial position for the TCS Programme and Associated Projects for 2022-23 as

Velindre Trust

Period : **May 22**

Summary Of Main Financial Performance

Revenue Performance

		Actual YTD £'000	Annual Forecast £'000
1	Under / (Over) Performance	**3**	**(0)**

Velindre Trust **Period : May 22**

Table A - Movement of Opening Financial Plan to Forecast Outturn

This Table is currently showing 0 errors

Line 14 should reflect the corresponding amounts included within the latest IMTP/AOP submission to WG
Lines 1 - 14 should not be adjusted after Month 1

		In Year Effect	Non Recurring	Recurring	FYE of Recurring		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	In Year Effect
		£'000	£'000	£'000	£'000		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
1	Underlying Position b/fwd from Previous Year - must agree to M12 MMR (Deficit - Negative Value)	-500	0	-500	-500	1	-42	-42	-42	-42	-42	-42	-42	-42	-42	-42	-42	-42	-83	-500
2	Planned New Expenditure (Non Covid-19) (Negative Value)	-23,256	-1,100	-22,156	-22,156	2	-1,678	-1,681	-1,681	-1,719	-1,719	-1,719	-1,719	-1,719	-1,719	-1,719	-1,719	-4,462	-3,358	-23,256
3	Planned Expenditure For Covid-19 (Negative Value)	-2,104	-1,407	-697	-697	3	-168	-168	-168	-168	-171	-201	-171	-171	-171	-171	-171	-202	-337	-2,104
4	Planned Welsh Government Funding (Non Covid-19) (Positive Value)	6,345	600	5,745	5,745	4	300	300	300	300	300	300	300	300	300	300	300	3,043	600	6,345
5	Planned Welsh Government Funding for Covid-19 (Positive Value)	2,104	1,407	697	697	5	166	169	169	169	172	201	172	172	172	172	172	202	335	2,104
6	Planned Provider Income (Positive Value)	16,111	0	16,111	16,111	6	1,343	1,343	1,343	1,343	1,343	1,343	1,343	1,343	1,343	1,343	1,343	1,343	2,685	16,111
7	RRL Profile - phasing only (In Year Effect / Column C must be nil)	0	0	0	0	7												0	0	0
8	Planned (Finalised) Savings Plan	750	150	600	600	8	46	46	46	68	68	68	68	68	68	68	68	68	92	750
9	Planned (Finalised) Net Income Generation	550	350	200	200	9	33	33	33	50	50	50	50	50	50	50	50	50	67	550
10	Planned Profit / (Loss) on Disposal of Assets	0	0	0	0	10													0	0
11	Planned Release of Uncommitted Contingencies & Reserves (Positive Value)	0	0			11													0	0
12		0	0			12													0	0
13	Planning Assumptions still to be finalised at Month 1	0	0			13													0	0
14	**Opening IMTP / Annual Operating Plan**	**0**	**0**	**0**	**0**	14	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
15	Reversal of Planning Assumptions still to be finalised at Month 1	0	0	0	0	15	0	0	0	0	0	0	0	0	0	0	0	0	0	0
16	Additional In Year & Movement from Planned Release of Previously Committed Contingencies & Reserves (Positive Value)	0	0			16													0	0
17	Additional In Year & Movement from Planned Profit / (Loss) on Disposal of Assets	0	0			17													0	0
18	Other Movement in Month 1 Planned & In Year Net Income Generation	0	0	0	0	18	0	0	0	0	0	0	0	0	0	0	0	0	0	0
19	Other Movement in Month 1 Planned Savings - (Underachievement) / Overachievement	0	0	0	0	19	0	0	0	0	0	0	0	0	0	0	0	0	0	0
20	Additional In Year Identified Savings - Forecast	0	0	0	0	20	0	0	0	0	0	0	0	0	0	0	0	0	0	0
21	Variance to Planned RRL & Other Income	0	0			21													0	0
22	Additional In Year & Movement in Planned Welsh Government Funding for Covid-19 (Positive Value - additional)	-430	-430			22	0	-85	-35	-35	-35	-35	-35	-35	-35	-35	-35	-35	-85	-430
23	Additional In Year & Movement in Planned Welsh Government Funding (Non Covid) (Positive Value - additional)	0	0			23													0	0
24	Additional In Year & Movement Expenditure for Covid-19 (Negative Value - additional/Postive Value - reduction)	430	430			24	2	84	34	34	34	34	34	34	34	34	34	35	87	430
25	In Year Accountancy Gains (Positive Value)	0	0	0	0	25	0	0	0	0	0	0	0	0	0	0	0	0	0	0
26	Net In Year Operational Variance to IMTP/AOP (material gross amounts to be listed separately)	0	0			26	-1	2	-3									2	1	0
27		0	0			27													0	0
28		0	0			28													0	0
29		0	0			29													0	0
30		0	0			30													0	0
31		0	0			31													0	0
32		0	0			32													0	0
33		0	0			33													0	0
34		0	0			34													0	0
35		0	0			35													0	0
36	**Forecast Outturn (- Deficit / + Surplus)**	**0**	**0**	**0**	**0**	36	**1**	**2**	**-3**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**2**	**3**	**0**
37	**Covid-19 - Forecast Outturn (- Deficit / + Surplus)**	**0**				37	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Velindre Trust

Period : May 22

Table A1 - Underlying Position

This table needs completing monthly from Month: 1

This Table is currently showing 0 errors

	Section A - By Spend Area	IMTP	Full Year Effect of Actions			New, Recurring, Full Year Effect of Unmitigated Pressures (-ve)	IMTP
		Underlying Position b/f	Recurring Savings (+ve)	Recurring Allocations / Income (+ve)	Subtotal		Underlying Position c/f
		£'000	£'000	£'000	£'000	£'000	£'000
1	Pay - Administrative, Clerical & Board Members				0		0
2	Pay - Medical & Dental	(47)		47	0		0
3	Pay - Nursing & Midwifery Registered	(50)		50	0		0
4	Pay - Prof Scientific & Technical	(195)		195	0		0
5	Pay - Additional Clinical Services				0		0
6	Pay - Allied Health Professionals				0		0
7	Pay - Healthcare Scientists				0		0
8	Pay - Estates & Ancillary				0		0
9	Pay - Students				0		0
10	Non Pay - Supplies and services - clinical				0		0
11	Non Pay - Supplies and services - general	(208)		208	0		0
12	Non Pay - Consultancy Services				0		0
13	Non Pay - Establishment				0		0
14	Non Pay - Transport				0		0
15	Non Pay - Premises				0		0
16	Non Pay - External Contractors				0		0
17	Health Care Provided by other Orgs – Welsh LHBs				0		0
18	Health Care Provided by other Orgs – Welsh Trusts				0		0
19	Health Care Provided by other Orgs – WHSSC				0		0
20	Health Care Provided by other Orgs – English				0		0
21	Health Care Provided by other Orgs – Private / Other				0		0
22	**Total**	**(500)**	**0**	**500**	**0**	**0**	**0**

	Section B - By Directorate	IMTP	Full Year Effect of Actions			New, Recurring, Full Year Effect of Unmitigated Pressures (-ve)	IMTP
		Underlying Position b/f	Recurring Savings (+ve)	Recurring Allocations / Income (+ve)	Subtotal		Underlying Position c/f
		£'000	£'000	£'000	£'000	£'000	£'000
1	Primary Care				0		0
2	Mental Health				0		0
3	Continuing HealthCare				0		0
4	Commissioned Services				0		0
5	Scheduled Care				0		0
6	Unscheduled Care				0		0
7	Children & Women's				0		0
8	Community Services				0		0
9	Specialised Services	(292)		292	0		0
10	Executive / Corporate Areas				0		0
11	Support Services (inc. Estates & Facilities)	(208)		208	0		0
12	**Total**	**(500)**	**0**	**500**	**0**	**0**	**0**

Velindre Trust

Period : **May 22**

This Table is currently showing 0 errors

	Table A2 - Overview Of Key Risks & Opportunities	FORECAST YEAR END	
		£'000	Likelihood
	Opportunities to achieve IMTP/AOP (positive values)		
1	**Red Pipeline schemes (inc AG & IG)**		
2	**Potential Cost Reduction**		
3	**Total Opportunities to achieve IMTP/AOP**	**0**	
	Risks (negative values)		
4	Under delivery of Amber Schemes included in Outturn via Tracker	(150)	Medium
5	Continuing Healthcare		
6	Prescribing		
7	Pharmacy Contract		
8	WHSSC Performance		
9	Other Contract Performance		
10	GMS Ring Fenced Allocation Underspend Potential Claw back		
11	Dental Ring Fenced Allocation Underspend Potential Claw back		
12	Full covid funding requirement not flowing from commissioners	TBC	High
13	Costs of service delivery for outsourced activity beyond internal planned volumes	(500)	Low
14	Management of Operational Costs Pressures	(250)	Low
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			
26	**Total Risks**	**(900)**	
	Further Opportunities (positive values)		
27	Emergency Reserve	500	Low
28	Covid cost reduction (mitgation from opening plan requirement)	TBC	Medium
29	Additional in Year vacancy factor	200	Medium
30			
31			
32			
33			
34	**Total Further Opportunities**	**700**	
35	**Current Reported Forecast Outturn**	**(0)**	
36	**IMTP / AOP Outturn Scenario**	**(0)**	
37	**Worst Case Outturn Scenario**	**(200)**	
38	**Best Case Outturn Scenario**	**700**	

Velindre Trust

YTD Months to be completed from Month: 1
Forecast Months to be completed from Month: 1

Table B - Monthly Positions **Period : May 22**

#REF!
#REF!

	A. Monthly Summarised Statement of Comprehensive Net Expenditure / Statement of Comprehensive Net Income		1 Apr £'000	2 May £'000	3 Jun £'000	4 Jul £'000	5 Aug £'000	6 Sep £'000	7 Oct £'000	8 Nov £'000	9 Dec £'000	10 Jan £'000	11 Feb £'000	12 Mar £'000	Total YTD £'000	Forecast year-end position £'000
1	Revenue Resource Limit	Actual/F'cast													0	0
2	Capital Donation / Government Grant Income (Health Board only)	Actual/F'cast													0	0
3	Welsh NHS Local Health Boards & Trusts Income	Actual/F'cast	7,827	8,495	8,787	8,846	8,864	8,894	8,894	8,894	8,894	8,890	8,890	8,890	16,321	105,065
4	WHSSC Income	Actual/F'cast	4,696	4,456	4,646	4,571	4,571	4,601	4,502	4,502	4,502	4,502	4,502	4,505	9,152	54,556
5	Welsh Government Income (Non RRL)	Actual/F'cast	606	698	798	798	798	798	798	798	798	798	798	798	1,304	9,282
6	Other Income	Actual/F'cast	785	1,052	914	774	773	1,035	937	932	1,085	932	930	1,132	1,838	11,284
7	**Income Total**		**13,914**	**14,700**	**15,145**	**14,988**	**15,006**	**15,328**	**15,132**	**15,127**	**15,280**	**15,122**	**15,120**	**15,325**	**28,615**	**180,187**
8	Primary Care Contractor (excluding drugs, including non resource limited expenditure)	Actual/F'cast													0	0
9	Primary Care - Drugs & Appliances	Actual/F'cast													0	0
10	Provided Services - Pay	Actual/F'cast	6,099	5,896	6,133	6,177	6,179	6,237	6,223	6,223	6,223	6,239	6,240	6,272	11,996	74,141
11	Provider Services - Non Pay (excluding drugs & depreciation)	Actual/F'cast	2,657	3,525	3,529	3,325	3,341	3,605	3,423	3,418	3,571	3,398	3,395	3,068	6,182	40,253
12	Secondary Care - Drugs	Actual/F'cast	4,265	4,570	4,935	4,935	4,935	4,935	4,935	4,935	4,935	4,935	4,935	4,935	8,835	58,185
13	Healthcare Services Provided by Other NHS Bodies	Actual/F'cast													0	0
14	Non Healthcare Services Provided by Other NHS Bodies	Actual/F'cast													0	0
15	Continuing Care and Funded Nursing Care	Actual/F'cast													0	0
16	Other Private & Voluntary Sector	Actual/F'cast	346	156	0	0	0	0	0	0	0	0	0	0	502	502
17	Joint Financing and Other	Actual/F'cast													0	0
18	Losses, Special Payments and Irrecoverable Debts	Actual/F'cast													0	0
19	Exceptional (Income) / Costs - (Trust Only)	Actual/F'cast													0	0
20	Total Interest Receivable - (Trust Only)	Actual/F'cast													0	0
21	Total Interest Payable - (Trust Only)	Actual/F'cast													0	0
22	DEL Depreciation\Accelerated Depreciation\Impairments	Actual/F'cast	530	534	534	534	534	534	534	534	534	534	534	534	1,064	6,406
23	AME Donated Depreciation\Impairments	Actual/F'cast	17	17	17	17	17	17	17	17	17	17	17	17	33	200
24	Uncommitted Reserves & Contingencies	Actual/F'cast												500	0	500
25	Profit\Loss Disposal of Assets	Actual/F'cast													0	0
26	**Cost - Total**	Actual/F'cast	**13,913**	**14,698**	**15,148**	**14,988**	**15,006**	**15,328**	**15,132**	**15,127**	**15,280**	**15,122**	**15,120**	**15,325**	**28,612**	**180,187**
27	**Net surplus/ (deficit)**	Actual/F'cast	**1**	**2**	**(3)**	**0**	**0**	**0**	**0**	**0**	**0**	**(0)**	**(0)**	**0**	**3**	**0**

	B. Cost Total by Directorate		1 Apr £'000	2 May £'000	3 Jun £'000	4 Jul £'000	5 Aug £'000	6 Sep £'000	7 Oct £'000	8 Nov £'000	9 Dec £'000	10 Jan £'000	11 Feb £'000	12 Mar £'000	Total YTD £'000	Forecast year-end position £'000
28	Primary Care	Actual/F'cast													0	0
29	Mental Health	Actual/F'cast													0	0
30	Continuing HealthCare	Actual/F'cast													0	0
31	Commissioned Services	Actual/F'cast													0	0
32	Scheduled Care	Actual/F'cast													0	0
33	Unscheduled Care	Actual/F'cast													0	0
34	Children & Women's	Actual/F'cast													0	0
35	Community Services	Actual/F'cast													0	0
36	Specialised Services	Actual/F'cast	12,157	12,886	13,304	13,144	13,162	13,484	13,288	13,283	13,436	13,278	13,276	12,981	25,044	157,680
37	Executive / Corporate Areas	Actual/F'cast	813	832	848	848	848	848	848	848	848	848	848	848	1,645	10,125
38	Support Services (inc. Estates & Facilities)	Actual/F'cast	397	429	445	445	445	445	445	445	445	445	445	445	826	5,276
39	Reserves	Actual/F'cast	0											500	0	500
40	**Cost - Total (Excluding DEL & AME Non-Cash Charges)**	Actual/F'cast	**13,367**	**14,148**	**14,597**	**14,437**	**14,455**	**14,777**	**14,581**	**14,576**	**14,729**	**14,571**	**14,569**	**14,774**	**27,515**	**173,581**

C. Assessment of Financial Forecast Positions

Year-to-date (YTD)	£'000	
28 . Actual YTD surplus/ (deficit)	3	
29. Actual YTD surplus/ (deficit) last month	1	
30. Current month actual surplus/ (deficit)	2	
		Trend
31. Average monthly surplus/ (deficit) YTD	2	▲
32. YTD /remaining months	0	

Full-year surplus/ (deficit) scenarios	£'000
33. Extrapolated Scenario	23
34. Year to Date Trend Scenario	18

D. DEL/AME Depreciation & Impairments

			1	2	3	4	5	6	7	8	9	10	11	12		
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	Forecast year-end position
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000		
	DEL															
41	Baseline Provider Depreciation	Actual/F'cast	433	433	433	433	433	433	433	433	433	433	433	433	866	5,196
42	Strategic Depreciation	Actual/F'cast	84	84	84	84	84	84	84	84	84	84	84	84	169	1,012
43	Accelerated Depreciation	Actual/F'cast													0	0
44	Impairments	Actual/F'cast													0	0
45	IFRS 16 Leases	Actual/F'cast	12	17	17	17	17	17	17	17	17	17	17	17	29	198
46	**Total**		**530**	**534**	**534**	**534**	**534**	**534**	**534**	**534**	**534**	**534**	**534**	**534**	**1,064**	**6,406**
	AME															
47	Donated Asset Depreciation	Actual/F'cast	17	17	17	17	17	17	17	17	17	17	17	17	33	200
48	Impairments (including Reversals)	Actual/F'cast													0	0
49	IFRS 16 Leases (Peppercorn)	Actual/F'cast													0	0
50	**Total**		**17**	**17**	**17**	**17**	**17**	**17**	**17**	**17**	**17**	**17**	**17**	**17**	**33**	**200**

E. Accountancy Gains

			1	2	3	4	5	6	7	8	9	10	11	12		
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	Forecast year-end position
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000		
51	Accountancy Gains	Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**

F. Committed Reserves & Contingencies

			1	2	3	4	5	6	7	8	9	10	11	12		
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	Forecast year-end position
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000		
	List of all Committed Reserves & Contingencies inc above in Section A. Please specify Row number in description.															
52		Forecast Only													0	0
53		Forecast Only													0	0
54		Forecast Only													0	0
55		Forecast Only													0	0
56		Forecast Only													0	0
57		Forecast Only													0	0
58		Forecast Only													0	0
59		Forecast Only													0	0
60		Forecast Only													0	0
61		Forecast Only													0	0
62		Forecast Only													0	0
63		Forecast Only													0	0
64		Forecast Only													0	0
65		Forecast Only													0	0
66		Forecast Only													0	0
67		Forecast Only													0	0
68		Forecast Only													0	0
69		Forecast Only													0	0
70		Forecast Only													0	0
71		Forecast Only													0	0
72		Forecast Only													0	0
73		Forecast Only													0	0
74		Forecast Only													0	0
75		Forecast Only													0	0
76		Forecast Only													0	0
77		Forecast Only													0	0
78		Forecast Only													0	0
79		Forecast Only													0	0
80	**Total**		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
		Phasing	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	

Velindre Trust

Period : May 22

YTD Months to be completed from Month: 1

This Table is currently showing 0 errors

Forecast Months to be completed from Month: 1

Table B2 - Pay Expenditure Analysis

A - Pay Expenditure

REF	*TYPE*	1 Apr £'000	2 May £'000	3 Jun £'000	4 Jul £'000	5 Aug £'000	6 Sep £'000	7 Oct £'000	8 Nov £'000	9 Dec £'000	10 Jan £'000	11 Feb £'000	12 Mar £'000	Total YTD £'000	Forecast year-end position £'000
1	Administrative, Clerical & Board Members	1,793	1,727	1,818	1,832	1,834	1,842	1,828	1,828	1,828	1,844	1,845	1,877	**3,520**	**21,897**
2	Medical & Dental	1,114	1,049	1,072	1,072	1,072	1,080	1,080	1,080	1,080	1,080	1,080	1,080	**2,163**	**12,939**
3	Nursing & Midwifery Registered	875	833	870	880	880	890	890	890	890	890	890	890	**1,708**	**10,568**
4	Prof Scientific & Technical	214	216	225	228	228	235	235	235	235	235	235	235	**430**	**2,756**
5	Additional Clinical Services	580	580	610	615	615	615	615	615	615	615	615	615	**1,160**	**7,305**
6	Allied Health Professionals	601	600	608	620	620	625	625	625	625	625	625	625	**1,201**	**7,424**
7	Healthcare Scientists	722	706	730	730	730	740	740	740	740	740	740	740	**1,428**	**8,798**
8	Estates & Ancillary	189	178	192	192	192	202	202	202	202	202	202	202	**367**	**2,357**
9	Students	11	8	8	8	8	8	8	8	8	8	8	8	**18**	**96**
10	**TOTAL PAY EXPENDITURE**	**6,099**	**5,896**	**6,133**	**6,177**	**6,179**	**6,237**	**6,223**	**6,223**	**6,223**	**6,239**	**6,240**	**6,272**	**11,995**	**74,141**

Analysis of Pay Expenditure

11	**LHB Provided Services - Pay**	6,099	5,896	6,133	6,177	6,179	6,237	6,223	6,223	6,223	6,239	6,240	6,272	**11,996**	**74,141**
12	**Other Services (incl. Primary Care) - Pay**													**0**	**0**
13	**Total - Pay**	**6,099**	**5,896**	**6,133**	**6,177**	**6,179**	**6,237**	**6,223**	**6,223**	**6,223**	**6,239**	**6,240**	**6,272**	**11,996**	**74,141**
		0	0	0	0	0	0	0	0	0	0	0	0		

B - Agency / Locum (premium) Expenditure
- Analysed by Type of Staff

REF	*TYPE*	1 Apr £'000	2 May £'000	3 Jun £'000	4 Jul £'000	5 Aug £'000	6 Sep £'000	7 Oct £'000	8 Nov £'000	9 Dec £'000	10 Jan £'000	11 Feb £'000	12 Mar £'000	Total YTD £'000	Forecast year-end position £'000
1	Administrative, Clerical & Board Members	23	26	20	20	20	20	28	13	13	8	6	5	**49**	**205**
2	Medical & Dental	5	3	5	5	5	5	5	5	5	5	5	5	**8**	**55**
3	Nursing & Midwifery Registered	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**
4	Prof Scientific & Technical	2	3	3	3	3	3	3	0	0	0	0	0	**5**	**21**
5	Additional Clinical Services	5	0	0	0	0	0	0	0	0	0	0	0	**5**	**5**
6	Allied Health Professionals	39	48	48	48	48	48	48	48	48	40	40	40	**87**	**542**
7	Healthcare Scientists	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**
8	Estates & Ancillary	30	44	32	32	32	32	32	32	32	32	32	32	**75**	**395**
9	Students	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**
10	**TOTAL AGENCY/LOCUM (PREMIUM) EXPENDITURE**	**104**	**125**	**108**	**108**	**108**	**108**	**116**	**98**	**98**	**85**	**82**	**82**	**229**	**1,222**
11	**Agency/Locum (premium) % of pay**	**1.7%**	**2.1%**	**1.8%**	**1.7%**	**1.7%**	**1.7%**	**1.9%**	**1.6%**	**1.6%**	**1.4%**	**1.3%**	**1.3%**	**1.9%**	**1.6%**

C - Agency / Locum (premium) Expenditure
- Analysed by Reason for Using Agency/Locum (premium)

REF	*REASON*	1 Apr £'000	2 May £'000	3 Jun £'000	4 Jul £'000	5 Aug £'000	6 Sep £'000	7 Oct £'000	8 Nov £'000	9 Dec £'000	10 Jan £'000	11 Feb £'000	12 Mar £'000	Total YTD £'000	Forecast year-end position £'000
1	Vacancy	25	33	20	20	20	20	28	13	13	8	6	5	**58**	**214**
2	Maternity/Paternity/Adoption Leave													**0**	**0**
3	Special Leave (Paid) – inc. compassionate leave, interview													**0**	**0**
4	Special Leave (Unpaid)													**0**	**0**
5	Study Leave/Examinations													**0**	**0**
6	Additional Activity (Winter Pressures/Site Pressures)	49	51	53	53	53	53	53	53	53	45	45	45	**100**	**602**
7	Annual Leave													**0**	**0**
8	Sickness													**0**	**0**
9	Restricted Duties													**0**	**0**
10	Jury Service													**0**	**0**
11	WLI													**0**	**0**
12	Exclusion (Suspension)													**0**	**0**
13	COVID-19	29	41	35	35	35	35	35	32	32	32	32	32	**70**	**406**
14	**TOTAL AGENCY/LOCUM (PREMIUM) EXPENDITURE**	**104**	**125**	**108**	**108**	**108**	**108**	**116**	**98**	**98**	**85**	**82**	**82**	**229**	**1,222**
		0	0	0	0	0	0	0	0	0	0	0	0		

Velindre Trust

Period : **May 22**

#REF!

Table B3 - COVID-19 Analysis

A - Additional Expenditure

		1	2	3	4	5	6	7	8	9	10	11	12		
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	Forecast year-end position
A1	***Enter as positive values***	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
1	**Testing (Additional costs due to C19) enter as positive values - actual/forecast**														
2	**Provider Pay (Establishment, Temp & Agency)**														
3	Administrative, Clerical & Board Members													**0**	**0**
4	Medical & Dental													**0**	**0**
5	Nursing & Midwifery Registered													**0**	**0**
6	Prof Scientific & Technical													**0**	**0**
7	Additional Clinical Services													**0**	**0**
8	Allied Health Professionals													**0**	**0**
9	Healthcare Scientists													**0**	**0**
10	Estates & Ancillary													**0**	**0**
11	Students													**0**	**0**
12	**Sub total Testing Provider Pay**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
13	Primary Care Contractor (excluding drugs)													**0**	**0**
14	Primary Care - Drugs													**0**	**0**
15	Secondary Care - Drugs													**0**	**0**
16	Provider - Non Pay (Clinical & General Supplies, Rent, Rates, Equipment etc) **Exclude PPE - see A6**													**0**	**0**
17	Healthcare Services Provided by Other NHS Bodies													**0**	**0**
18	Non Healthcare Services Provided by Other NHS Bodies													**0**	**0**
19	Continuing Care and Funded Nursing Care													**0**	**0**
20	Other Private & Voluntary Sector													**0**	**0**
21	Joint Financing and Other (includes Local Authority)													**0**	**0**
22	Other (only use with WG agreement & state SoCNE/I line ref)													**0**	**0**
23														**0**	**0**
24														**0**	**0**
25														**0**	**0**
26	**Sub total Testing Non Pay**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
27	**TOTAL TESTING EXPENDITURE**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
28	**PLANNED TESTING EXPENDITURE (In Opening Plan)**													**0**	**0**
29	**MOVEMENT FROM OPENING PLANNED TESTING EXPENDITURE**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
A2	***Tracing (Additional costs due to C19) enter as positive values - actual/forecast***														
30	**Provider Pay (Establishment, Temp & Agency)**														
31	Administrative, Clerical & Board Members													**0**	**0**
32	Medical & Dental													**0**	**0**
33	Nursing & Midwifery Registered													**0**	**0**
34	Prof Scientific & Technical													**0**	**0**
35	Additional Clinical Services													**0**	**0**
36	Allied Health Professionals													**0**	**0**
37	Healthcare Scientists													**0**	**0**
38	Estates & Ancillary													**0**	**0**
39	Students													**0**	**0**
40	**Sub total Tracing Provider Pay**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
41	Primary Care Contractor (excluding drugs)													**0**	**0**
42	Primary Care - Drugs													**0**	**0**
43	Secondary Care - Drugs													**0**	**0**
44	Provider - Non Pay (Clinical & General Supplies, Rent, Rates, Equipment etc) **Exclude PPE - see A6**													**0**	**0**
45	Healthcare Services Provided by Other NHS Bodies													**0**	**0**
46	Non Healthcare Services Provided by Other NHS Bodies													**0**	**0**
47	Continuing Care and Funded Nursing Care													**0**	**0**
48	Other Private & Voluntary Sector													**0**	**0**
49	Joint Financing and Other (includes Local Authority)													**0**	**0**
50	Other (only use with WG agreement & state SoCNE/I line ref)													**0**	**0**
51														**0**	**0**
52														**0**	**0**
53														**0**	**0**
54	**Sub total Tracing Non Pay**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
55	**TOTAL TRACING EXPENDITURE**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
56	**PLANNED TRACING EXPENDITURE (In Opening Plan)**													**0**	**0**
57	**MOVEMENT FROM OPENING PLANNED TRACING EXPENDITURE**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

A3	***Mass COVID-19 Vaccination (Additional costs due to C19) enter as positive values - actual/forecast***														
58	**Provider Pay (Establishment, Temp & Agency)**														
59	Administrative, Clerical & Board Members					3	5	3	3	3	3	3	5	**0**	**28**
60	Medical & Dental													**0**	**0**
61	Nursing & Midwifery Registered													**0**	**0**
62	Prof Scientific & Technical													**0**	**0**
63	Additional Clinical Services						27						27	**0**	**54**
64	Allied Health Professionals	7	11	10	10	10	10	10	10	10	10	10	10	**18**	**113**
65	Healthcare Scientists													**0**	**0**
66	Estates & Ancillary						1						1	**0**	**2**
67	Students													**0**	**0**
68	**Sub total Mass COVID-19 Vaccination Provider Pay**	**7**	**11**	**10**	**10**	**13**	**42**	**13**	**13**	**13**	**13**	**13**	**43**	**18**	**197**
69	Primary Care Contractor (excluding drugs)													**0**	**0**
70	Primary Care - Drugs													**0**	**0**
71	Secondary Care - Drugs													**0**	**0**
72	Provider - Non Pay (Clinical & General Supplies, Rent, Rates, Equipment etc) **Exclude PPE - see A6**	15	19	15	15	15	15	15	15	15	15	15	15	**33**	**178**
73	Healthcare Services Provided by Other NHS Bodies													**0**	**0**
74	Non Healthcare Services Provided by Other NHS Bodies													**0**	**0**
75	Continuing Care and Funded Nursing Care													**0**	**0**
76	Other Private & Voluntary Sector													**0**	**0**
77	Joint Financing and Other (includes Local Authority)													**0**	**0**
78	Other (only use with WG agreement & state SoCNE/I line ref)													**0**	**0**
79														**0**	**0**
80														**0**	**0**
81														**0**	**0**
82	**Sub total Mass COVID-19 Vaccination Non Pay**	**15**	**19**	**15**	**15**	**15**	**15**	**15**	**15**	**15**	**15**	**15**	**15**	**33**	**178**
83	**TOTAL MASS COVID-19 VACC EXPENDITURE**	**22**	**30**	**24**	**24**	**27**	**57**	**27**	**27**	**27**	**27**	**27**	**57**	**51**	**375**
84	**PLANNED MASS COVID-19 VACC EXPENDITURE (In Opening Plan)**	24	24	24	24	27	57	27	27	27	27	27	57	**49**	**375**
85	**MOVEMENT FROM OPENING PLANNED MASS COVID-19 VACC EXPENDITURE**	**2**	**(5)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(3)**	**0**

A4	***Extended Flu Vaccination (Additional costs due to C19) enter as positive values - actual/forecast***														
86	**Provider Pay (Establishment, Temp & Agency)**														
87	Administrative, Clerical & Board Members													**0**	**0**
88	Medical & Dental													**0**	**0**
89	Nursing & Midwifery Registered													**0**	**0**
90	Prof Scientific & Technical													**0**	**0**
91	Additional Clinical Services													**0**	**0**
92	Allied Health Professionals													**0**	**0**
93	Healthcare Scientists													**0**	**0**
94	Estates & Ancillary													**0**	**0**
95	Students													**0**	**0**
96	**Sub total Extended Flu Vaccination Provider Pay**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
97	Primary Care Contractor (excluding drugs)													**0**	**0**
98	Primary Care - Drugs													**0**	**0**
99	Secondary Care - Drugs													**0**	**0**
100	Provider - Non Pay (Clinical & General Supplies, Rent, Rates, Equipment etc) **Exclude PPE - see A6**													**0**	**0**
101	Healthcare Services Provided by Other NHS Bodies													**0**	**0**
102	Non Healthcare Services Provided by Other NHS Bodies													**0**	**0**
103	Continuing Care and Funded Nursing Care													**0**	**0**
104	Other Private & Voluntary Sector													**0**	**0**
105	Joint Financing and Other (includes Local Authority)													**0**	**0**
106	Other (only use with WG agreement & state SoCNE/I line ref)													**0**	**0**
107														**0**	**0**
108														**0**	**0**
109														**0**	**0**
110	**Sub total Extended Flu Vaccination Non Pay**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
111	**TOTAL EXTENDED FLU VACC EXPENDITURE**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
112	**PLANNED EXTENDED FLU VACC EXPENDITURE (In Opening Plan)**													**0**	**0**
113	**MOVEMENT FROM OPENING PLANNED EXTENDED FLU VACC EXPENDITURE**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

A5	**Cleaning Standards (Additional costs due to C19) enter as positive values - actual/forecast**															
114	**Provider Pay (Establishment, Temp & Agency)**															
115	Administrative, Clerical & Board Members													**0**	**0**
116	Medical & Dental													**0**	**0**
117	Nursing & Midwifery Registered													**0**	**0**
118	Prof Scientific & Technical													**0**	**0**
119	Additional Clinical Services													**0**	**0**
120	Allied Health Professionals													**0**	**0**
121	Healthcare Scientists													**0**	**0**
122	Estates & Ancillary	46	19	40	40	40	40	40	40	40	40	40	40	**65**	**465**
123	Students													**0**	**0**
124	**Sub total Cleaning Standards Provider Pay**	**46**	**19**	**40**	**40**	**40**	**40**	**40**	**40**	**40**	**40**	**40**	**40**	**65**	**465**
125	Primary Care Contractor (excluding drugs)													**0**	**0**
126	Primary Care - Drugs													**0**	**0**
127	Secondary Care - Drugs													**0**	**0**
128	Provider - Non Pay (Clinical & General Supplies, Rent, Rates, Equipment etc) **Exclude PPE - see A6**	5	1	4	4	4	4	4	4	4	4	4	4	**6**	**48**
129	Healthcare Services Provided by Other NHS Bodies													**0**	**0**
130	Non Healthcare Services Provided by Other NHS Bodies													**0**	**0**
131	Continuing Care and Funded Nursing Care													**0**	**0**
132	Other Private & Voluntary Sector													**0**	**0**
133	Joint Financing and Other (includes Local Authority)													**0**	**0**
134	Other (only use with WG agreement & state SoCNE/I line ref)													**0**	**0**
135														**0**	**0**
136														**0**	**0**
137														**0**	**0**
138	**Sub total Cleaning Standards Non Pay**	**5**	**1**	**4**	**4**	**4**	**4**	**4**	**4**	**4**	**4**	**4**	**4**	**6**	**48**
139	**TOTAL CLEANING STANDARDS EXPENDITURE**	**51**	**20**	**44**	**44**	**44**	**44**	**44**	**44**	**44**	**44**	**44**	**44**	**70**	**512**
140	**PLANNED CLEANING STANDARDS EXPENDITURE (In Opening Plan)**	51	51	51	51	51	51	51	51	51	51	51	51	**101**	**607**
141	**MOVEMENT FROM OPENING PLANNED CLEANING STANDARDS EXPENDITURE**	**(0)**	**31**	**6**	**6**	**6**	**6**	**6**	**6**	**6**	**6**	**6**	**7**	**31**	**94**

A6	**PPE, Long Covid & Other (Additional costs due to C19)** ***enter as positive value - actual/forecast***															
142	**Provider Pay (Establishment, Temp & Agency)**															
143	Administrative, Clerical & Board Members														**0**	**0**
144	Medical & Dental	21	12	19	19	19	19	19	19	19	19	19	19		**33**	**221**
145	Nursing & Midwifery Registered														**0**	**0**
146	Prof Scientific & Technical														**0**	**0**
147	Additional Clinical Services														**0**	**0**
148	Allied Health Professionals														**0**	**0**
149	Healthcare Scientists														**0**	**0**
150	Estates & Ancillary	25	(20)												**5**	**5**
151	Students														**0**	**0**
152	Movement of Annual Leave Accrual														**0**	**0**
153	Other (only use with WG Agreement & state SoCNE/I line ref)														**0**	**0**
154															**0**	**0**
155															**0**	**0**
156	**Sub total Other C-19 Provider Pay**	**46**	**(8)**	**19**	**19**	**19**	**19**	**19**	**19**	**19**	**19**	**19**	**19**		**38**	**226**
157	Primary Care Contractor (excluding drugs)														**0**	**0**
158	Primary Care Contractor (excluding drugs) - Costs as a result of lost GDS Income														**0**	**0**
159	Primary Care - Drugs														**0**	**0**
160	Secondary Care - Drugs														**0**	**0**
161	Provider - Non Pay (Clinical & General Supplies, Rent, Rates, Equipment etc) **Exclude PPE - see separate line**	20	24	19	19	19	19	19	19	19	19	19	19		**44**	**235**
162	Provider - Non Pay - PPE	28	18	28	28	28	28	28	28	28	28	28	28		**46**	**325**
163	Healthcare Services Provided by Other NHS Bodies														**0**	**0**
164	Non Healthcare Services Provided by Other NHS Bodies														**0**	**0**
165	Continuing Care and Funded Nursing Care														**0**	**0**
166	Other Private & Voluntary Sector														**0**	**0**
167	Joint Financing and Other (includes Local Authority)														**0**	**0**
168	Other (only use with WG Agreement & state SoCNE/I line ref)														**0**	**0**
169															**0**	**0**
170															**0**	**0**
171															**0**	**0**
172															**0**	**0**
173															**0**	**0**
174															**0**	**0**
175															**0**	**0**
176	**Sub total Other C-19 Non Pay**	**48**	**42**	**47**	**47**	**47**	**47**	**47**	**47**	**47**	**47**	**47**	**47**		**90**	**560**
177	**TOTAL OTHER C-19 EXPENDITURE**	**94**	**35**	**66**	**66**	**66**	**66**	**66**	**66**	**66**	**66**	**66**	**66**		**128**	**786**
178	**PLANNED OTHER C-19 EXPENDITURE (In Opening Plan)**	94	94	94	94	94	94	94	94	94	94	94	94		**187**	**1,122**
179	**MOVEMENT FROM OPENING PLANNED OTHER C-19 EXPENDITURE**	**0**	**59**	**28**	**28**	**28**	**28**	**28**	**28**	**28**	**28**	**28**	**28**		**59**	**336**
180	**TOTAL ADDITIONAL EXPENDITURE DUE TO COVID**	**166**	**84**	**134**	**134**	**137**	**167**	**137**	**137**	**137**	**137**	**137**	**167**		**250**	**1,674**
181	**PLANNED ADDITIONAL EXPENDITURE DUE TO COVID (In Opening Plan)**	**168**	**168**	**168**	**168**	**171**	**201**	**171**	**171**	**171**	**171**	**171**	**202**		**337**	**2,104**
182	**MOVEMENT FROM OPENING PLANNED ADDITIONAL COVID EXPENDITURE**	**2**	**84**	**34**	**34**	**34**	**34**	**34**	**34**	**34**	**34**	**34**	**35**		**87**	**430**

B - Additional Welsh Government Funding for C19

		1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**		
		Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total YTD**	**Forecast year-end position**
	Enter as Positive values	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
183	**PLANNED WG FUNDING FOR COVID-19**	166	169	169	169	172	201	172	172	172	172	172	202	**335**	**2,104**
184	**MOVEMENTS FROM OPENING PLANNED WG FUNDING FOR COVID-19**	**0**	**(85)**	**(35)**	**(35)**	**(35)**	**(35)**	**(35)**	**(35)**	**(35)**	**(35)**	**(35)**	**(35)**	**(85)**	**(430)**
185	**TOTAL ACTUAL / FORECAST WG FUNDING FOR COVID-19**	166	84	134	134	137	167	137	137	137	137	137	167	**250**	**1,674**
186	**ACTUAL / FORECAST NET IMPACT ON OVERALL FINANCIAL POSITION DUE TO COVID-19**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Velindre Trust

Period : May 22

Table C - Identified Expenditure Savings Schemes (Excludes Income Generation & Accountancy Gains)

This Table is currently showing 0 errors

			1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Full-year forecast	YTD as %age of FY	Assessment		Full In-Year forecast		Full-Year Effect of Recurring Savings
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			*YTD variance as %age of YTD*	Green	Amber	non recurring	recurring	
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000				£'000	£'000	£'000	£'000	£'000
1	CHC and Funded Nursing Care	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
2		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
3		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
4	Commissioned Services	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
5		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
6		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
7	Medicines Management (Primary & Secondary Care)	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
8		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
9		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
10	Non Pay	Budget/Plan	33	33	33	33	33	33	33	33	33	33	33	33	67	400		300	100			
11		Actual/F'cast	33	33	33	33	33	33	33	33	33	33	33	33	67	400	16.67%	300	100	150	250	250
12		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	*0.00%*	0	0			
13	Pay	Budget/Plan	13	13	13	35	35	35	35	35	35	35	35	35	25	350		150	200			
14		Actual/F'cast	13	13	13	35	35	35	35	35	35	35	35	35	25	350	7.14%	150	200	0	350	350
15		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	*0.00%*	0	0			
16	Primary Care	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
17		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
18		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
19	Total	Budget/Plan	46	46	46	68	68	68	68	68	68	68	68	68	92	750		450	300			
20		Actual/F'cast	46	46	46	68	68	68	68	68	68	68	68	68	92	750	12.22%	450	300	150	600	600
21		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	*0.00%*	0	0			
22		Variance in month	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%							
23		In month achievement against FY forecast	6.11%	6.11%	6.11%	9.07%	9.07%	9.07%	9.07%	9.07%	9.07%	9.07%	9.07%	9.07%								

Velindre Trust **Period : May 22**

Table C1- Savings Schemes Pay Analysis

			Month	1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Full-year forecast	YTD as %age of FY	Assessment		Full In-Year forecast		Full-Year Effect of Recurring Savings
				Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			*YTD variance as %age of YTD Budget/Plan*	Green	Amber	non recurring	recurring	
				£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000				£'000	£'000	£'000	£'000	£'000
1	Changes in Staffing Establishment	Budget/Plan		13	13	13	35	35	35	35	35	35	35	35	35	25	350		150	200			
2		Actual/F'cast		13	13	13	35	35	35	35	35	35	35	35	35	25	350	7.14%	150	200	0	350	350
3		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0	*0.00%*	0	0			
4	Variable Pay	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
5		Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
6		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
7	Locum	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
8		Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
9		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
10	Agency / Locum paid at a premium	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
11		Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
12		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
13	Changes in Bank Staff	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
14		Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
15		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
16	Other (Please Specify)	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
17		Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
18		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
19	Total	Budget/Plan		13	13	13	35	35	35	35	35	35	35	35	35	25	350		150	200			
20		Actual/F'cast		13	13	13	35	35	35	35	35	35	35	35	35	25	350	7.14%	150	200	0	350	350
21		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0	*0.00%*	0	0			

Table C2- Savings Schemes Agency/Locum Paid at a Premium Analysis

			Month	1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Full-year forecast	YTD as %age of FY	Assessment		Full In-Year forecast		Full-Year Effect of Recurring Savings
				Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			*YTD variance as %age of YTD Budget/Plan*	Green	Amber	non recurring	recurring	
				£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000				£'000	£'000	£'000	£'000	£'000
1	Reduced usage of Agency/Locums paid at a premium	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
2		Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
3		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
4	Non Medical 'off contract' to 'on contract'	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
5		Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
6		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
7	Medical - Impact of Agency pay rate caps	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
8		Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
9		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
10	Other (Please Specify)	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
11		Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
12		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
13	Total	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
14		Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
15		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			

Velindre Trust

May 22

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Table C3 - Tracker

	£'000	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	Full-year forecast	Non Recurring	Recurring	FYE Adjustment	Full-year Effect
Savings (Cash Releasing & Cost Avoidance)	Month 1 - Plan	46	46	46	68	68	68	68	68	68	68	68	68	92	750	150	600	0	600
	Month 1 - Actual/Forecast	46	46	46	68	68	68	68	68	68	68	68	68	92	750	150	600	0	600
	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	In Year - Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	In Year - Actual/Forecast	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Total Plan	46	46	46	68	68	68	68	68	68	68	68	68	92	750	150	600	0	600
	Total Actual/Forecast	46	46	46	68	68	68	68	68	68	68	68	68	92	750	150	600	0	600
	Total Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Net Income Generation	Month 1 - Plan	33	33	33	50	50	50	50	50	50	50	50	50	67	550	350	200	0	200
	Month 1 - Actual/Forecast	33	33	33	50	50	50	50	50	50	50	50	50	67	550	350	200	0	200
	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	In Year - Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	In Year - Actual/Forecast	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Total Plan	33	33	33	50	50	50	50	50	50	50	50	50	67	550	350	200	0	200
	Total Actual/Forecast	33	33	33	50	50	50	50	50	50	50	50	50	67	550	350	200	0	200
	Total Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Accountancy Gains	In Year - Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	In Year - Actual/Forecast	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	Month 1 - Plan	79	79	79	118	118	118	118	118	118	118	118	118	158	1,300	500	800	0	800
	Month 1 - Actual/Forecast	79	79	79	118	118	118	118	118	118	118	118	118	158	1,300	500	800	0	800
	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	In Year - Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	In Year - Actual/Forecast	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Total Plan	79	79	79	118	118	118	118	118	118	118	118	118	158	1,300	500	800	0	800
	Total Actual/Forecast	79	79	79	118	118	118	118	118	118	118	118	118	158	1,300	500	800	0	800
	Total Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Velindre Trust

Period : **May 22**

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Table E1 - Invoiced Income Streams - TRUSTS ONLY

Ref		Swansea Bay ULHB	Aneurin Bevan ULHB	Betsi Cadwaladr ULHB	Cardiff & Vale ULHB	Cwm Taf Morgannwg ULHB	Hywel Dda ULHB	Powys LHB	Public Health Wales NHS Trust	Welsh Ambulance NHS Trust	Velindre NHS Trust	NWSSP	DHCW	HEIW	WG	EASC	WHSSC	Other (please specify)	Total	WG Contact, date item first entered into table and whether any invoice has been raised.
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	
1	**Agreed full year income**	4,608	34,000	1,084	33,383	23,934	3,514	1,751	1,617	13	0	0	0	1,162	6,214		54,556	11,284	**177,119**	
	Details of Anticipated Income																			
2	DEL Non Cash Depreciation - Baseline Surplus / Shortfall														(1,012)				**(1,012)**	Gary Young M1
3	DEL Non Cash Depreciation - Strategic														1,012				**1,012**	Gary Young M1
4	DEL Non Cash Depreciation - Accelerated																		**0**	
5	DEL Non Cash Depreciation - Impairment																		**0**	
6	DEL Non Cash Depreciation - IFRS 16 Leases														198				**198**	Jackie Salmon M1
7	AME Non Cash Depreciation - IFRS 16 Leases (Peppercorn)																		**0**	
8	AME Non Cash Depreciation - Donated Assets														200				**200**	Gary Young M1
9	AME Non Cash Depreciation - Impairment																		**0**	
10	AME Non Cash Depreciation - Impairment Reversals																		**0**	
11	Total COVID-19 (see below analysis)														1,673				**1,673**	See below analysis
12	Removal of IFRS-16 Leases (Revenue)														(202)				**(202)**	Jackie Salmon M1
13	Energy (Price Increase)														912				**912**	Steve Elliot M1
14	Employers NI Increase (1.25%)														550				**550**	Steve Elliot M1
15	Real Living Wage																		**0**	Steve Elliot M1
16	WRP														(282)				**(282)**	Andrea Hughes M1
17	Band 1 & 2 Increase														19				**19**	Andrea Hughes M2
18																			**0**	
19																			**0**	
20																			**0**	
21																			**0**	
22																			**0**	
23																			**0**	
24																			**0**	
25																			**0**	
26																			**0**	
27																			**0**	
28																			**0**	
29																			**0**	
30																			**0**	
31																			**0**	
32																			**0**	
33																			**0**	
34																			**0**	
35																			**0**	
36																			**0**	
37	**Total Income**	**4,608**	**34,000**	**1,084**	**33,383**	**23,934**	**3,514**	**1,751**	**1,617**	**13**	**0**	**0**	**0**	**1,162**	**9,282**	**0**	**54,556**	**11,284**	**180,187**	

	ANALYSIS OF WG FUNDING DUE FOR COVID-19 INCLUDED ABOVE	Allocated £'000	Anticipated £'000	Total £'000	WG Contact, date item first entered into table and whether any invoice has been raised.
38	Testing (inc Community Testing)			0	
39	Tracing			0	
40	Mass COVID-19 Vaccination		375	375	Richard Dudley M1 Not Raised
41	PPE		325	325	Richard Dudley M1 Not Raised
42	Extended Flu			0	
43	Cleaning Standards		512	512	Richard Dudley M1 Not Raised
44	Long Covid			0	
45	A2. Increased bed capacity specifically related to COVID-19			0	Richard Dudley M1 Not Raised
46	A3. Other Capacity & facilities costs (exclude contract cleaning)		224	224	
47	B1. Prescribing charges directly related to COVID symptoms			0	
48	C1. Increased workforce costs as a direct result of the COVID response and IP&C guidance		237	237	
49	D1. Discharge Support			0	
50	D4. Support for National Programmes through Shared Service			0	
51	D5. Other Services that support the ongoing COVID response			0	
52	E1. Primary Care Contractor (excluding drugs) - Costs as a result of lost GDS Income			0	
53				0	
54				0	
55				0	
56				0	
57				0	
58				0	
59				0	
60				0	
61				0	
62				0	
63				0	
64				0	
65				0	
66				0	
67				0	
68	**Total Funding**	**0**	**1,673**	**1,673**	

Velindre Trust		**Period:**	**May 22**
Table M - Debtors Schedule	**11 weeks before end of May 22 =**	15 March 2022
	17 weeks before end of May 22 =	01 February 2022

Debtor	Inv #	Inv Date	Orig Inv £	Outstand. Inv £	Valid Entry	>11 weeks but <17 weeks	Over 17 weeks	Arbitration Due Date	Comments
			0.00	0.00		0.00	0.00		

Invoices paid since the end of the month		
Total outstanding as per MR submission date	0.00	0.00

Quality, Safety and Performance Committee

MAY 2022 Performance Management Framework COVER PAPER

DATE OF MEETING	14/07/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Anna-Marie Jones, Business Support Manager Wayne Jenkins, Head of Planning and Performance Alan Prosser, Director WBS Sue Thomas, Assistant Director WOD
PRESENTED BY	Cath O'Brien, Chief Operating Officer Sarah Morley, Director WOD
EXECUTIVE SPONSOR APPROVED	Cath O'Brien, Chief Operating Officer

REPORT PURPOSE	FOR DISCUSSION / REVIEW

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
WBS SMT MEETING	8.6.22	Reviewed and Noted
VCC SLT	30.6.22	Reviewed and Noted
WBS PERFORMANCE REVIEW	20.6.22	Reviewed and Noted
VCC PERFORMANCE REVIEW	24.6.22	Reviewed and Noted
EMB RUN	1.7.22	Reviewed and Noted

ACRONYMS	
VUNHST	Velindre University NHS Trust
UHB	University Health Board
VCC SLT	Velindre Cancer Centre Senior Leadership Team
WBS SMT	Welsh Blood Service Senior Management Team
QSP	Quality, Safety & Performance Committee
RCR	Royal College of Radiologists
JCCO	Joint Council for Clinical Oncology
PADR	Performance Appraisal and Development Review
KPIs	Key Performance Indicators
SACT	Systemic Anti-Cancer Therapy
WTE	Whole Time Equivalent (staff)
EMB	Executive Management Board
COSC	Clinical Oncology Sub-Committee
IPC	Infection Prevention Control
RCC	Rutherford Cancer Centre

1. SITUATION/BACKGROUND

1.1 The attached Trust performance reports provide an update to the QSP Committee with respect to Trust-wide performance against key performance metrics through to the end of May 2022 for the Velindre Cancer Centre, the Welsh Blood Service and for VUNHST Corporate Services respectively.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The reports set-out performance at Velindre Cancer Centre **(*appendix 1*),** the Welsh Blood Service **(*appendix 2*)** and the Workforce**.** Each report is prefaced by an '*at a glance*' section which is intended to draw attention to key areas of performance. A number of areas from the reports are highlighted below.

2.1 Velindre Cancer Centre:

The first two months of 2022/23 have seen increased pressure on radiotherapy and SACT services as a result of additional activity commencing in Health Boards. In addition to the projected growth, referrals will continue to increase as Health boards undertake further 'waiting list initiative' activity. Due to the unpredictable nature of this work, it is recognised there will be significant variability in the timing of referrals to VUNHST.

Based on forecasting work for 2022/23 undertaken as part of the IMTP, it is anticipated that referrals will increase further by 8% for radiotherapy and by 12% for SACT by March 2023. The referral prediction for 2022/23 are based on 2021/22 outturn plus a further increase of 8% and 12%. The identified increase in growth based on where organisations were in 2021/22 are national predictions from Cancer Research UK and Wales Cancer Network and are the figures being used across Health Boards.

Whilst the data sets established in 20/21 provide a track of patients in the referral pathways within Health Boards and inform the VUNHST planning, the myriad of operational decisions within each clinical team within each Health Board are creating wide variation in our referrals which are challenging to predict and respond to. Operational meetings with each Health Board have bene initiated to identify these factors and incorporate into planning where possible.

Radiotherapy Waiting Times

Overall referrals to radiotherapy for May (391) exceeded predications (309). Overall attendances for May (3031) significantly exceed predictions, with 3405 actual attendances.

With the exception of urology, referrals across all tumour sites has seen an increase in the monthly average number of referrals for that site when compared to 2020/21 and 2021/22.

We have already seen higher than anticipated and planned referrals for breast cancer patients as Health Boards are commencing a range of activity to target their waiting lists and clear backlogs for breast patients. There is also some anecdotal evidence that more

patients are presenting with greater burden of disease burden at a later stage, which are unsuitable for hypo-fractionation, which adds to capacity challenges. These patients may require more scans and appointments to enable their treatment.

Patient receiving radical radiotherapy within 28 day

Of the 213 patients referred for radical radiotherapy, 17 did not begin treatment within the 28 day target; 12 of these being treated by day 35. Delays with treatment related to constraints with LINAC capacity and planning capacity

There are a range of factors impacting on radiotherapy capacity. Firstly LINAC capacity is subject to ongoing additional requirements that increase time between patients for cleaning. The further aging of the fleet is impacting through additional quality assurance and breakdowns. For planning, the increase in the complexity of the planning and need for 3D plans is creating additional work and the cycle of plan production constrains capacity increases. Work is being undertaken to introduce the planned expansion in capacity through the year. This is heavily reliant on the workforce and the qualification of this year's cohort of new registrants who will join us in Q3.

Additional activity was delivered through the RCC for radiotherapy treatment during this period, although this has now ceased creating additional service pressure.

There are a number of focused immediate actions that are underway as part of the ongoing service capacity review. This includes incremental release of capacity through review of variations in practice by each SST as well as identifying options for increasing planning capacity. Brachytherapy capacity increase is planned and a business case is in process with WHSSC.

SACT Waiting Times

We have continued to see increased pressures on the capacity available to deliver SACT treatment as a result of increased referrals, sickness, maternity and vacancies continue to be significant in nursing and booking workforce.

Sickness levels for nursing were at 11.8% and administration and clerical staff at 8%. Workforce and Organisational Development are working with the Directorate to appropriately manage sickness. Internal mutual aid is being provided from nursing within other departments to support maintaining activity.

Referrals for SACT treatment in May (415) significantly exceeded predictions (376).

As part of managing the forecast demand in referrals for SACT services, a Taskforce has been established to develop a plan to identify additional capacity.

In order to deliver the required additional activity, nursing, pharmacy and workforce resource need to align alongside the estate plan for number of SACT chairs..

To address the nursing vacancies, we will be recruiting additional Band 3,5,6 SACT nurses with interviews scheduled for early July. A rolling recruitment programme is be implemented going forward.

There are a range of activities underway to expand capacity including temporary reassignment of staff to SACT delivery, using other service areas such as Assessment Unit to deliver some treatments that do not require SACT specialist trained staff.

Pharmacy are currently going through an Organisational Change Process (OCP), due to conclude in September, which will provide additional pharmacy resource as a result of change in working patterns.

Adverts are currently out for the booking team to address staffing levels and increase capacity.

Further work will take place through the Taskforce to identify opportunities to provide additional activity. This will include weekend working and re-instating pre-covid levels of activity at Prince Charles hospital.

All new patients and urgent patients are prioritised using Welsh Cancer Network guidance and available clinical best practice information.

Plans were underway in April and May to supplement capacity for SACT provision through circa 50 patients being treated through the Rutherford Cancer Centre in June, however the removal of this option creates ongoing pressure in the system. Plans to maximise SACT delivery at Prince Charles Hospital are underway, including the outsourcing of medication compounding.

Outpatients

Data collection relating to the 30 minute target, was paused in December 2021 due to operational pressures and staff absence as manual collection of individual patient attendances is required. We are reviewing a number of new outpatient KPIs that will enable review of the service in this area. These will form part of the new PMF development.

Therapies

All patients were seen within target in May.

Other areas

Falls

During May 2022, 1 fall was reported on first floor ward, involving a patient in an isolation cubicle. The patient had fluctuating capacity and was COVID positive and was being nursed in an isolation cubicle. While the door of cubicle was closed, in line with infection control requirements, the patient mobilised.
The incident was investigated by the VCC Falls scrutiny panel and was deemed to be avoidable. All standards were followed but an enhanced supervision policy will be implemented in June and there will be increased collaboration with infection control staff on decisions regarding Covid positive patients.

Pressure Ulcers

No pressure ulcers reported for this month.

Healthcare Acquired Infections

There were no reported infections in May 2022.

SEPSIS bundle NEWS score

15 patients initially met the criteria for administration of the sepsis treatment bundle in May 2022. 13 patients received all elements of the bundle within 1 hour, on further review of clinical notes 2 did not satisfy the criteria.
10 patients received a diagnosis of sepsis, 9 of these patients had received all elements of the bundle within 1 hour. The 10th patient did not satisfy the criteria for the administration of the bundle therefore compliance is 100%. There were some gaps in documentation noted which have been highlighted to the team and reminders of the importance of completing all elements of the sepsis pathway documentation will be added to the 'message of the day' morning safety briefing for the acute assessment unit nursing staff.

Delayed Transfers of Care (DTOC's)

There was no Delayed Transfer of Care was reported in May 2022.

Further detailed performance data is provided in Appendix 1

2.2 Welsh Blood Service

Supply Chain Performance

Whilst Covid related sickness continues to be challenging in collecting blood, during May the service continued to meet demand. The Blue Alert to hospitals has continued into May and has been extended to include additional blood groups. A total of 100 units of red cells were provided by NHSBT as part of our mutual aid support to help maintain stocks. Blood banks across Wales continue to work with the service in terms of a reduced stock holding to support our position. It should be noted the extended Jubilee bank holiday in early June will continue to place additional pressure on stock levels.

2.3.1 Recruitment of new bone marrow volunteers

The number of new bone marrow volunteers added to the Welsh Bone Marrow Donor Registry (WBMDR) reached 163 in May compared to 141 in the previous month. The ongoing action plan for increasing bone marrow donors includes donor recruitment promotion at universities and colleges, and engagement team visits will take place in June in a bid to further drive recruitment at the start of the academic year in September. An external marketing campaign has also been commissioned to support additional recruitment for the time.

2.3.2 Reference Serology

The turnaround times continue to be impacted significantly by unavoidable key staff absences, high levels of referrals and remains at 70% as it was last month. Work continues to be prioritised based on clinical need, and all compatibility testing is completed to the required time/date.

Staffing pressures have delayed the validation of the new automated analyser, which will improve efficiency, and work will now begin in June 2022. The testing strategy for patient samples suitable for automated testing has been completed and the findings of the recent Out of Hours Referrals Audit have been reviewed for implementation. A paper regarding service pressures and outlining solutions for maintaining service delivery will be reviewed by WBS Senior Management team in June, with a view to overseeing and improving performance in the short, medium and longer term.

2.3.2 Quality

Incidents reported to Regulator/Licensing

There were no Serious Adverse Events (SAE) reported to regulators during May

Incidents closed within 30 days

This measure has not met target (90%) for the period January to May, however the number of incidents not closed in the required timeframe decreased from 21 to 20 (14 QPulse and 6 Datix). All QPulse incidents have been risk assessed, investigated and closed. Only 1 Datix incident remains open but with preventative action applied.

Whole Blood Collection Productivity

The collection productivity rate has improved, due to efficiencies from donor sessions operating at 1m instead of 2m social distancing, but remain below target. The collections team are actively preparing a recovery plan over the summer to bolster stock in light of the lifting of Covid restrictions and operations returning to pre Covid supply levels. The mobile collection units will be incorporated into donor sessions in late summer to enable the service to extend its community reach.

Number of Concerns Received

Initial responses to 7 of the 8 concerns in May were managed within 2 working days as required by the Putting Things Right (PTR) regulations. There was a delay in responding to 1 concern, due to the failure to utilise the correct reporting pathway as a result of the complexity of the concern, which has resulted in exceeding the 2 day reporting timeline.

Donor Satisfaction

Continues to perform strongly at a national level despite the COVID restrictions in place.

3. WORKFORCE

3.1 PADR

Trust Wide 53.38%, rates decreased
WBS 79.6%, compliance rates slightly increased.
VCC 68.66%, rates slightly increased

Sickness Absence

Trust wide 5.70%, sickness increased on last month.
WBS 5.70%, sickness rates decreasing, as recent Covid cases have reduced, so STS decreased.
VCC 6.25%, sickness decreased, showing impact of WOD operational team offering further support.

3.2 Statutory & Mandatory Compliance

Trust Wide 74.22%, below target whereas previously reported at or above target
WBS 92.36%, well above target
VCC 85.49%, tracking above target

4.0 IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The current performance reporting and monitoring system is predicated upon identifying performance issues and supporting effective decision making at service and operational levels to drive forward continuous improvement in quality, safety and the overall experience of patients and donors.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below: • Staff and Resources • Safe Care • Timely Care • Effective Care.
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Delivery against the performance metrics presented in the attached reports and the work associated with delivering improved performance supports sound financial governance across the Trust.

5.0 RECOMMENDATION

5.1 QSP is asked to **NOTE** the contents of the attached performance reports.

Appendices

1. VCC May PMF Report
2. WBS May PMF Report

QUALITY SAFETY AND PERFORMANCE COMMITTEE

WELSH BLOOD SERVICE QUALITY SAFETY AND PERFORMANCE REPORT

DATE OF MEETING	14/07/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	N/A

PREPARED BY	PETER RICHARDSON, HEAD OF QUALITY ASSURANCE AND REGUALTORY COMPLIANCE, WBS
PRESENTED BY	Alan Prosser, Director WBS & Peter Richardson, Head of Quality and Regulatory Compliance
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**
WBS SMT	13/07/2022	Supported
Executive Management Board	01/07/2022	Supported

ACRONYMS	
WBS	Welsh Blood Service
WTAIL	Welsh Transplant and Immuno-genetics Laboratories
MHRA	Medicines and Healthcare products Regulatory Agency
RAGG	Regulatory assurance and governance group
SAE	Serious Adverse Events
CA/PA	Corrective Action/Preventative Action
SABRE	Serious Adverse Blood Related Event

1. SITUATION

This paper is to provide the Quality, Safety & Performance Committee with an update on the key quality, safety and performance outcomes and metrics for the Welsh Blood Service for the period March to May 2022

The Quality, Safety & Performance Committee are asked to **NOTE**:

- Performance against the six domains of Quality
- Issues, corrective actions and monitoring arrangements in place
- Service developments within WBS

2. BACKGROUND

This report is a summary of key operational, quality, safety and performance related matters being considered by the Welsh Blood Service between March and May 2022, and has been prepared in readiness for Velindre University NHS Trust Board and Committee governance arrangements. The report also highlights key programmes taking place across the Division.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The main report summarises:

- Key performance outliers and associated actions to resolve
- Key quality and safety related indicators and remedial action identified
- Feedback from Donors and the responses to it.
- Regulator and Audit Feedback, assurance and learning themes
- An outline of key service developments in WBS

3.1 Triangulated Analysis

The report provides assurance to the Quality, Safety and Performance Committee that WBS is continuing to meet its Quality, Safety and Performance standards.

To summarise for the reporting period (March to May 2022):

- WBS has completed the introduction of testing for the presence of occult Hepatitis B infections for all donors in line with recent regulatory changes.
- The Medicines and Healthcare Products Regulatory Agency (MHRA) inspected the Wrexham Stock Holding Unit, the Bangor store and North Wales Collection teams, with one 'Major' and three 'Other' observations. Recently introduced services to distribute Immunoglobulins and Vaccines were included in the inspection and no observations reported for either.
- Closure of quality incidents within the required 30 days has remained inconsistent.
- Three Serious Adverse Events (SAE) were reported to the Medicines and Healthcare products Regulatory Agency (MHRA).
- All clinical demand was met for red cells and platelets but this was achieved with support from NHS Blood and Transplant (NHSBT). Red cell stocks remain under pressure and a blue alert to reduce hospital stock remains in place. The service is actively considering its collection recovery plan in light of COVID restrictions being lifted from June and demand increasing.
- Reference Serology turn-around times remain below the target.
- In the period March to May 2022, 25 concerns were reported, 23 were managed within timeline as early resolution as detailed in the table below. Two formal complaints were dealt with and closed within 30 days. Overall donor satisfaction continues to exceed target position at 95.5%.

3.2 Key Actions / Areas of focus during next period

Quality and safety and patient experience remains at the heart of our service during this period in all aspects of service delivery as well as the well-being of our staff. During the June to September 2022 the following areas will be a priority:

- Agree a collections recovery plan to help build and sustain blood stocks, whilst continuing to pursue prudent use across NHS Wales.

- Agree and submit a comprehensive action plan to address the observations from the MHRA Inspection of North Wales site.
- Implement the action plan resulting from the review of the red Cell Immuno-haematology service and as agreed by the Senior Management Team (SMT).
- Complete the introduction of recipient follow-up processes following the introduction of occult Hepatitis B testing, this will be done in partnership with Public Health Wales and Health Boards across Wales.
- A number of initiatives are underway both internally and with the support of the Welsh Government to increase both the number and diversity of bone marrow donors.
- Complete the installation and commissioning of new secondary Blood Group analysers in Automated Testing.
- Present the initial findings of the Platelet strategy review and agree a project plan to implement the recommendations.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The current performance reporting and monitoring system is predicated upon identifying performance issues and supporting effective decision making at service and operational levels to drive forward continuous improvement in quality, safety and the overall experience of patients and donors.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below: • Staff and Resources • Safe Care • Timely Care • Effective Care.

EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)

5. RECOMMENDATIONS

The Quality Safety and Performance Committee is asked to **NOTE** the information in this report.

WELSH BLOOD SERVICE - QUALITY, SAFETY & PERFORMANCE COMMITTEE REPORT

June 2022

INTRODUCTION

This paper outlines the key Welsh Blood Service Quality, Safety and Performance related issues being monitored, reviewed and acted upon within the service and is aligned with the Six Domains of Quality as defined by the Institute of Medicine namely:

1. Safety
2. Effectiveness
3. Patient-centeredness
4. Timeliness
5. Equity
6. Efficiency

1. Safety

1.1 Safety Incidents linked to donors are reported into the Donor Clinical Governance Group and scrutinised at the Regulatory Assurance and Governce Group, These include failed venepuncture where a needle is not properly sited in a vein, and part bags where a donation stops before the full quantity is collected. All of these measures have remained at low levels and within tolerance during the reporting period:

1.2 For reporting purposes, WBS sub-divides incidents into two types:

- **Good Manufacturing Practice (GMP) Incidents**, in which our routine process monitoring and checking identifies non-compliance with expected processes or outcomes and responds to prevent further processing or harm to patients. These are reported into the Q-pulse electronic Quality Management System and monitored as a critical part of the overall Quality Management System (QMS) in line with regulatory standards.

There were 89 GMP incidents occurring between March and May 2022 reported via QPulse. 16 of these were reported outside of the 48-hour reporting time frame (excluding weekends); a rationale for late reporting is provided and assessed by the Quality Assurance team. Where the rationale is deemed unacceptable the relevant Head of Department is advised.

- **Incidents which may lead to redress or could result in harm to donors, patients or staff** – these are reported in Datix Once for Wales (OfW) for consistency across the trust.

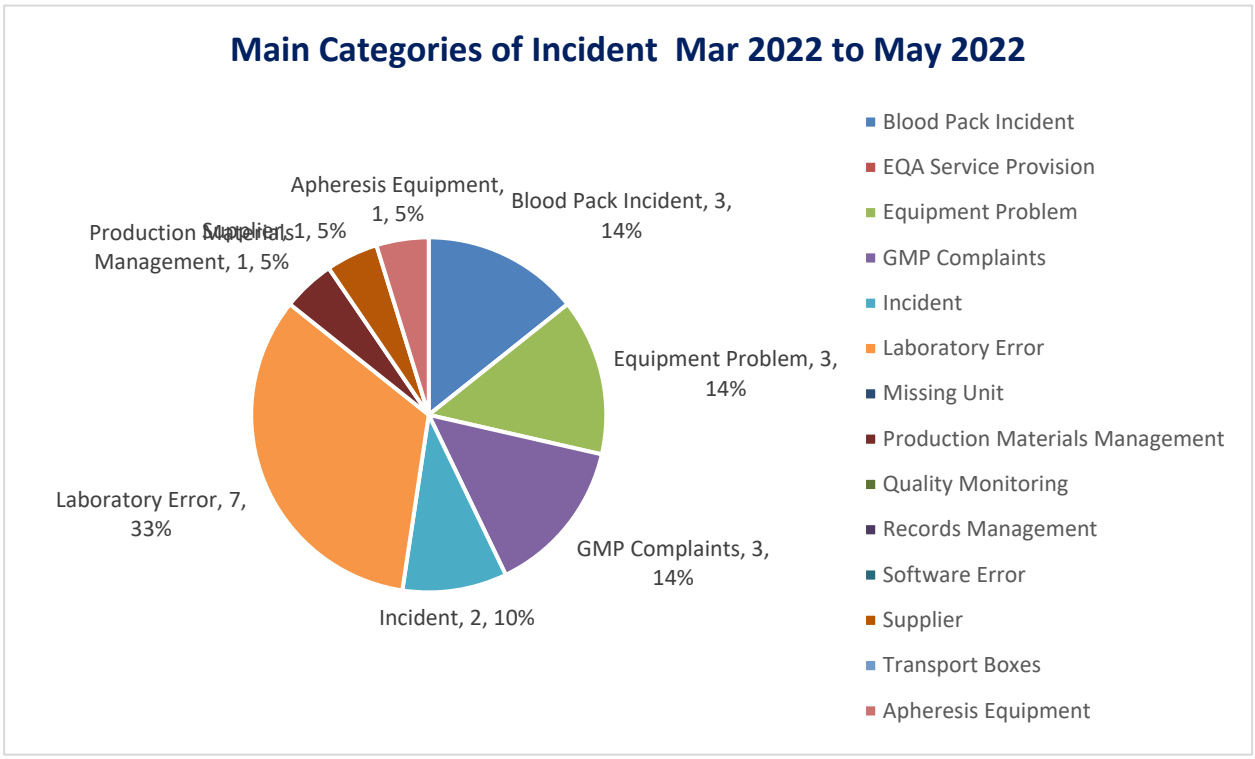
There were 61 incidents reported via Datix (OfW) that could potentially affect the quality and safety of blood/blood components, however, coding of the events within the Datix (OfW) system remains a challenge for easily identification of such incidents so these have not been included in the pie chart detailing incident by category. 55 of these incidents (90%) were closed within 30 days and and the remaining 6 have now been closed

1.3 Areas of concern:

There was one incident with a significant risk rating in this reporting period. Details are included in section 2.4.1. A full root cause analysis investigation has been undertaken and is under review.

At the end of the reporting period 4 events were awaiting risk assessment, these have since been assessed as low or moderate risk events.

The chart below depicts the broad categorisation of incidents reported via QPulse between March and May 2022:



In the 3 months to the end of May 2022, 92% of reported incidents were investigated and closed within 30 days (including GMP incidents reported via Datix OfW). This is an improvement in performance compared with previous months (87%).

The number of incidents not closed within the required timeframe has reduced from 13 in the previous three-month rolling period to 8 in this three-month reporting period. Further to the decline in performance against this measure in January, steps have been taken to ensure incidents that may take longer than 30 days to investigate and review are recognised in advance and reported to the relevant Head of Department and Senior Management Team Lead. This provides assurance that the investigation is being undertaken as swiftly as possible and any risks imposed to operational activity are identified and managed effectively.

1.4 Regulatory Inspections

1.4.1 The Welsh Blood Service North Wales operations were inspected by the MHRA in June 2022. This was their first detailed MHRA inspection since April 2019. Overall feedback from the two inspectors was positive and both commented on the positive quality culture at WBS.

1.4.2 The MHRA classifies inspection findings as follows:

- **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 haemovigilance 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. – **One "Major" deficiency 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.**

1.4.3 The findings from this inspection were as follows:

- **Major:** The system for handling deviations (Incidents) did not ensure that an appropriate level of root cause analysis would be applied and therefore that causes of incidents would be identified and appropriate corrective and preventative actions implemented:
  - There was no requirement to conduct root cause analysis, or document the root cause, for low and moderate priority incidents.
  - The assessment of priority (based on likelihood and severity) was not always accurate, which resulted in significant incidents being assigned inappropriately low priority ratings and therefore not being subject to full investigation, as evidenced by:

- Investigation INV-26, which related to discoloured platelets being identified by a customer, was classified with a low severity despite the potential risk to patients through possible contamination.
- Investigation INV-272, which related to the limited availability of O- red cells, was classified as being unlikely despite a blue alert for low blood stocks which indicated a high likelihood of reoccurrence.
- The process for assessing likelihood based on previous incidents was reliant on staff recollection, rather than by a formal review of records held in the quality system.

- **Other:** Suitable premises, equipment and trained personnel had not been maintained to support the authorised activity of collecting plasma by apheresis at the Wrexham site, following suspension of the convalescent plasma programme in March 2021. There had been no change control or other quality management system record documenting the actions taken to remove the facility from use, and no defined process to re-instate the facility should it be required in the future.

- **Other:** Measures to ensure storage conditions within the Bangor GMP storage area were appropriate were deficient, in that**:**
  - The temperature monitoring diagram in the area was out of date and did not accurately reflect the probe locations identified in the latest temperature mapping study.
  - Discrepancies were evident in manually completed temperature monitoring data, in that a temperature record form described the upper limit as 25°C which differed from the mapped upper limit of 24°C.
  - The temperature mapping exercise conducted in October 2021 did not provide sufficient assurance that it reflected worst case conditions, for example, during typical summer and winter temperatures**.**

- **Other:** Controls to ensure documents were complete, accurate and up to date were deficient in that:
  - The daily venue risk assessment checklist for the Wrexham collection session at St Margaret's Church and Community Hall had been completed on 09 June 2022 and confirmed compliance with the master risk assessment, however the master risk assessment had not been available due to DATIX downtime in order to perform this activity.
  - The incident QA triage process had been identified as not being governed by a procedure, but this had not been formally captured in the Quality Management System.

- **Comments:** The impact of deficiency 3.1 (Maintenance of suitable premises, equipment and personnel) on other sites at Dafen and Wound Centre (also authorised for plasma collection by apheresis and also out of use since March 2021) should be considered and included in the company's response.

- It is reassuring to note that two new services introduced since April 2019 (distribution of Frozen vaccines and distribution of immunoglobulin products) were included in this inspection with no findings reported.

1.4.4 The WBS Quality Assurance team will work with the relevant teams to address the deficiencies in this report and document an action plan to share with the inspectors before July 8th.

1.4.5 Once this action plan is approved the inspectors will re-authorise the Blood Establishment Authorisation for 2 years, this is the maximum allowed. The inspectors will also issue a certificate of compliance with Good Distribution Practice which is valid for five years.

1.5 Serious Incidents Reportable to Regulators

1.5.1 There were three serious incidents reported to MHRA via the Serious Adverse Blood-Related Events (SABRE) portal between March and June 2022. SABRE Reports are used by the MHRA to identify incidents of concern and national trends. Key learnings from these reports are shared with all blood services:

SABRE 99 relates to an incorrect assessment of donor malarial risk
SABRE 100 is linked to SABRE 99 and relates to a failure to immediately follow-up and test donations from this donor for malaria. Subsequent testing showed no evidence of malaria for this donor.
SABRE 101 is related to a blood component being issued to a customer hospital with an incorrect component code.

None of these events resulted in patient harm. Root cause analyses have been completed, including corrective and preventative actions, these reports have all been reviewed and accepted by the MHRA.

2. Effectiveness

2.1 Blood Supply

WBS continues to face challenges in collecting blood and predicting demand for blood products as we emerge from the Covid pandemic. Whilst demand for blood components is returning to pre-pandemic levels collection capacity has been limited by the need to maintain social distancing as well as by sickness levels and staff turnover.

The return to pre-pandemic clinic layouts has created some extra collections capacity but staff sickness and turnover remains the limiting factor. There currently 9 new members of staff expected to complete training by the end of July which will alleviate this pressure.

2.2 Bone Marrow / Stem Cell collections

The absence of blood donation sessions on university campuses has continued to impact the recruitment of young adults as bone marrow donors with consequent impacts on donation and collection activity. The Welsh Bone Marrow Donor Registry is working with the Welsh government as well as internal stakeholders to increase the number and diversity of volunteer donors on the register.

The move to Velindre Cancer Centre (VCC) for collections of stem cells has provided an opportunity to offer training for VCC clinical staff in the care and management of this patient group. This will provide additional resilience as well as offering broader clinical experience for staff.

2.3 Audit Summary

There were 16 audits scheduled for completion March to May.

- 15 audits have been conducted (3 of those are yet to provide the final audit report)
- 1 audit has carried over into June – scheduled for 28/06/2022, the risk from late completion has been assessed as low as this activity has been subject to external and/or internal audit within 2020/2021.

- Two Major Non-Compliance were raised in May as a result of the Supplier Audit of Transmedia (archiving company). These are currently in progress and being discussed with the Subject Matter Expert at VCC.
    - No evidence of WBS Data Protection Impact Assessment (DPIA) completed
    - No evidence of WBS Data Sharing Agreement

There were a number of minor findings and suggestions for approval raised against the supplier. The action plan has been updated by the supplier to include corrective actions and estimated completion dates. All will require submission of evidence.

Total number of audits scheduled for completion in March: 16			Conducted	Total Audits conducted
Procedural Audits	=	12	11	15
ISO 15189	=	3	3	
ISO 17043	=	1	1	
HTA Internal	=	0		
Audits carrying over into June: 1			-	

15 Audits Conducted	Findings/Non-Conformances
11 - Procedural Audits **3 - ISO 15189 Audits** **1 - ISO 17043 UKNEQAS for H&I – This audit has commenced and is ongoing across approximately 3 months (Findings to be confirmed upon completion)**	**Major Findings/Catoegories:** x 2 Supplier – Data Integrity x 1 Process – To be raised in June **Minor Findings/Categories:** Training/Competency Documentation Review Data Integrity/ALCOA+ Contract Review Process

1 Audit carrying over into June	Findings/Non-Conformances
22/05 - Approach to Validation (MP-050) Audit given back and reassigned to alternative auditor. Delay also due to Validation team involvement in HepB core project and availability of requested documentation. Audit scheduled for 28/06/2022	N/A

Reports outstanding from audits conducted	Findings/Non-Conformances
22/04 - Testing of Blood and Blood Components (MP-031) Audit given back and conducted by reassigned auditor within scheduled month	**0 - N/Cs** Suggestions for Improvement only
21/32 – Procedural Irradiation Process Delay due to availability of auditee – audit conducted 06/05/2022	**0 - N/Cs** Suggestions for Improvement only
21/09 - Incident Management (MP-054) Audit involved a number of departments, multiple dates scheduled between March and May. Report in progress	**TBC**

Risk by late completion: Low
The above audits carrying over have been subject to external and internal audit within 2020/2021. Findings are fed back to auditees/HODs at the time of audit, by completion and approval of Summary of Findings Sheet.

3. Service-User Centred

3.1 WBS invites every blood donor to complete a feedback survey in the month after their donation. This is available online, by text message or by completion of a feedback form. The feedback highlights are:

a. During The period March to May 2022 3635 responses were received (17.9% response rate)
b. Donor satisfaction for those who had successfully donated was:
   - Overall (3292) 95.5.5%
   - N.Wales (614) 95.6%
   - S.Wales (2678) 95.5%

c. Donor satisfaction for every respondent, including incomplete donations was:
   - Overall (3521) 93.4%
   - N.Wales (143) 93.5%
   - S.Wales (733) 93.4%

d. In total 2862 donors scored themselves as 'Totally Satisfied' and were invited to provide more details.

e. **Out of 20,205 donation attendances in March to May 2022 a total of 40** donors described themselves as 'Dissatisfied' or 'Totally Dissatisfied' and were invited to provide more details. The responses are analysed and followed up by the Collections Leadership team through their monthly operational service group:

3.2 Changes in response to Donor Feedback

In response to feedback about the lack of donation clinics local to both Llantwit Major and Merthyr Tydfil, the Planning team have set up a new location in Llantwit Major and increased the frequency of clinics in Merthyr Tydfil. Additional Themes from donor feedback are shown in the table below:

Theme	Response
Donating after reaching 70 years of age.	Donors aged 70 or over who will 'lapse' if they do not donate within two years are now contacted manually before lapsing, where possible, the donor is then booked onto an upcoming slot.
Changes to the letter invites	Several donors outlined they could not donate due to booking an appointment within seven days of having dental treatment. Whilst reference to dental treatment has always been a part of the digital eligibility quiz. It has now been included in the invitation letters. Note, letters are being sent out less frequently following Covid-19.
New video explaining current changes to donation clinics.	During the initial weeks of the pandemic, an 'explainer' video was created to help explain to donors how our operations were changing to support the blood supply chain and maintain our high, safety standards. This video was modernised to meet the latest WBS requirements and help donors understand how best to support the Service during covid-19.

3.3 Concerns

3.3.1 In the period March to May 2022, 25 concerns were reported, 23 were managed within timeline as early resolution as detailed in the table below. two formal complaints were dealt with and closed within 30 days.

Month	Early Resolution	Formal	You Said	We Did
March	8	0	1. Donor late for appointment as went to wrong venue, felt the WBS was doing donor a favour. 2. Donor unhappy felt venepuncturist was dismissive. 3. Donor felt like he was being told off by staff member. 4. Session had been cancelled due to unforeseen circumstances unable to contact donors X 2 5. Donor unhappy last appointment had been taken whilst donor was on phone with call handler wanting to book appointment 6. Donor raised concern around the amount of plastic/PPE being used on session 7. Donor raised concern around being able to help her son complete the SAHH and social distancing measures whilst on clinic	1, 2 & 3 OP's Managers discussed each concern raised with Clinical Lead RN's and supervisors who will monitor and support each staff member as identified in donor's care. Action plan developed to support staff where necessary . Apologies and full explanation provided to each donor where concerns have been made around the appointment booking system, 2 x donors were unable to be made aware of session cancellation prior to their attendance despite attempts due to being un-contactable. 1 x last bookable appointment for specific venue had been taken by another donor whilst on the phone due call handler, donor offered alternative venue/date 7. Full explanation provided to donor 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., trial of biodegradable plastics and waste bags across some collection teams 8. Clinic Lead RN gave full explanation of current JPAC guidelines for assisting donors to complete the SAHH and current guidelines around social distancing measures whilst on session
April	9	0	1. Two Donors were unhappy with staff attitude/behaviour during Venepuncture event 2. Two Donors were challenged with the grade of their face coverings 3. A Complainant was unhappy with behaviour of a WBS van driver 4. Donor indicated that they were unhappy with the communication skills of a staff member at registration 5. Donor was unhappy to be turned away from a session having arrived with their 7-month-old baby 6. Donor was unhappy with attitude of staff at a collections event 7. Donor unhappy to be turned away from session	1. Whilst there were no staff competency issues identified, the Clinic Lead Nurse has discussed the donor's concerns with the staff members and will continue to monitor and support staff accordingly 2. Clarity on challenging inappropriate face masks worn by Donors has been provided to Clinic Nurses, supporting collections team member understanding in managing future situations of this nature. 3. The Transport Manager has been made aware of the issue and has since discussed the importance of driver behaviour and organisational reputation with the staff member involved. 4. The Clinic Lead Nurse has discussed the donor concerns with the member of staff and will continue to monitor and support staff. 5. The Clinic Lead Nurse assesses the ability to accommodate babies and children accompanying donors at each donation session making a decision to allow additional family members at a collections event in accordance with current WBS Policy. 6. The Clinic Lead Nurse has discussed the donor concerns with the staff member involved and will continue to monitor and support, utilising the existing relevant SOP and Collections Customer Care Training. 7. Donor attended a collections session without and appointment and was offered alternative appointment but was unable to accept due to work commitments.
May	6	2	1. Formal Concern - Complainant raised concerns about the level of Welsh Translation on website	. The Communications Manager has reviewed issues raised by complainant relating to the level of Welsh translation on WBS website and has update accordingly.

			2. Formal Concern - Donor raised concern about staff conduct 3. Three donors were unhappy with not being able to book a convenient appointment 4. Donor unhappy with receiving text reminders when they don't wish to donate 5. Donor unhappy with communication skills of staff 6. Donor unhappy with on-line booking appointment system as they do not have internet access	WBS launched new website beginning of May 22 and were experiencing some technical issues. Considering this it has been advised all elements of the website are to be reviewed prior to launch in future Updates include: - *amended the website to ensure all quiz questions are available bi-lingually* Availability of video content amended to ensure Welsh Language versions are also available *The guidance pages have been created on the website in Welsh* 2. Observations of Practice undertaken to form part of the investigation, no evidence found to suggest staff member was working outside of standard conduct and donor care 3.Two donors were happy with explanation given around operational issues experienced by service throughout pandemic and ongoing review of venue sights, both donors have book future appointments. The other donor was given opportunity to make contact to discuss and find solution to concerns raised, however no response was received 4. Apologies given to donor, with rational behind the SMS reminder service. Donor has now been made non-notifiable so will not receive future notifications from WBS 5. The Clinic Lead Nurse has discussed the donor's concerns with staff member as identified and will continue to monitor and support them, utilising the existing SOP and Collections Customer Care Package. Staff also reminded of the importance of retaining our donors 6. Donor un-aware donors could book appointment via telephone call into the DCC department, Staff member explained booking process. Donor happy with outcome of conversation and has booked next appointment

4. Timeliness

4.1 Reference Serology Turn-around times

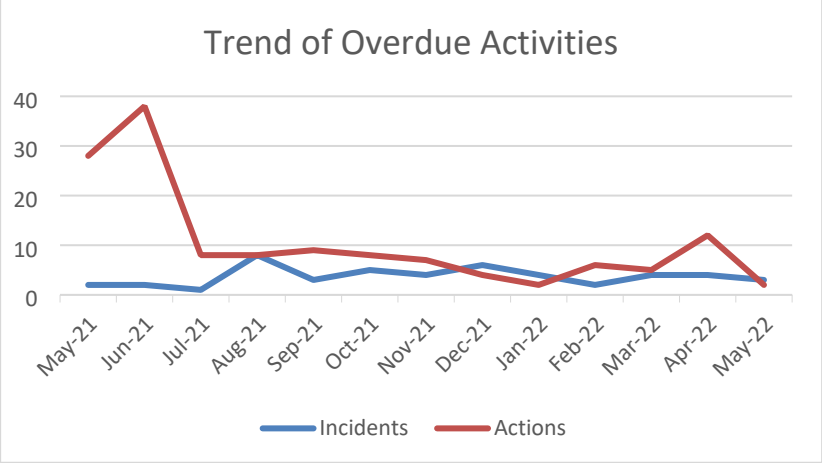
The RCI laboratory has been experiencing workload and staffing pressures, which have been affecting the turnaround times of non-urgent testing requests as well as adding sustained pressure to both the routine staff and the on call system.

Referrals continue to be prioritised based on clinical need and all Compatibility Testing is completed to the required time/date. These requests are time critical and require provision of blood for transfusion, therefore the tests are prioritised to ensure patient care is not affected.

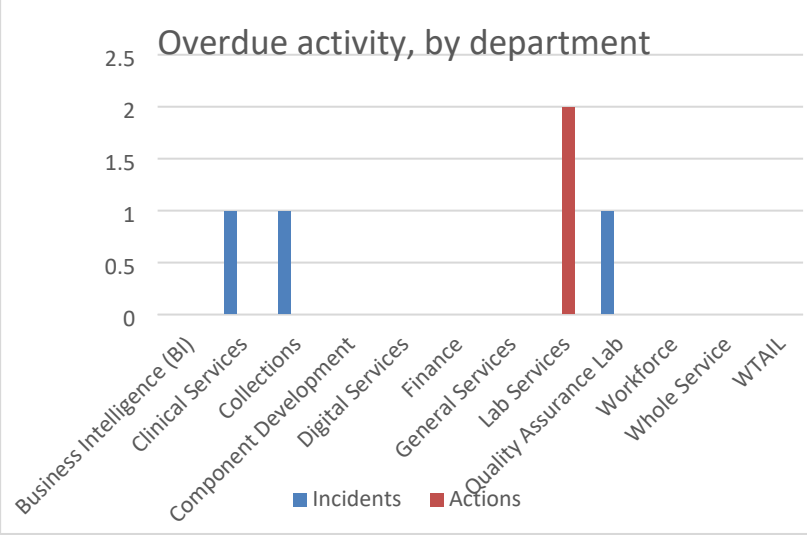
A clinical audit of referrals was completed in March 2022 and further detailed review of the department has now been completed. An action plan has been agreed by the WBS Senior Management Team and this will be a priority for completion during the next quarter.

4.2 Overdue activity performance trends

The following graph provides an overview of the overdue activity performance trends for incidents and preventive actions overdue for closure over the past year. Incident closure has been inconsistent, and a more detailed review of the data has revealed that Q-pulse incidents are not being reported as closed until all corrective actions have been completed which can take a considerable time with complex technical fixes. For comparison Datix reports incidents as closed when actions have been agreed but not necessarily completed. This reporting anomaly will be addressed from July 2022 and Q-pulse reporting will be aligned with Datix for consistency across the trust.



The following graph provides an overview of the overdue activity performance trends for incidents, preventive actions and change proposals over time, and by department at the end of May 2022:



4.3 Areas for concern:

There are no quality deviations (incidents) more than 3 months overdue.

There were 2 overdue actions recorded in QPulse, at the end of May 2022. Both actions have since been closed.

Analysis of incidents reported via Datix Once for Wales (OfW) has identified 3 incidents which were overdue for completion. One of these required investigation by QA Lab and there was confusion regarding managerial responsibility for closure of the Datix report. This has since been resolved by liaison between the Head of QA Laboratory and Head of Nursing and the event is closed. There was no adverse impact because of delayed closure.

Three events were reportable to the Serious Adverse Blood-Related Events Scheme (SABRE). Both investigations are now complete and root cause analyses have been submitted to and agreed by the MHRA.

Quarterly Corrective and Preventative Actions (CA/PA) effectiveness monitoring is ongoing for previously reported significant risk incidents; no concerns have been identified to date.

5. Equity

The Welsh Blood Service strives to give everyone in Wales the opportunity to donate, this has traditionally been achieved through a peripatetic model of collection teams based in regional hubs and visiting visiting community venues across Wales, supplemented by mobile collection vehicles where suitable premises are not available.

The easing of restrictions as we emerge from the Covid 19 pandemic has allowed WBS to plan for a return to the pre-pandemic collection model including a return to venues that have not been available to use for over 2 years.

6. Efficiency

6.1 Whole Blood Collection Efficiency (Target 1.25 units by WTE per hour)

At 0.95 collection productivity for March to May 2022 continues to be below target. Covid and Infection Prevention Control (IPC) measures have limited donation centre capacity.

From 1st June with social distancing no longer a requirement and increased venue capacity this measure is expected to improve. Meanwhile work to ensure adequate ventilation in mobile donor vehicles commenced in May in readiness for future reintroduction to service.

6.2 Manufacturing Efficiency (392 Components per WTE)

Manufacturing efficiency dropped below the target in March but has since improved.

NOTE: The work completed relates to clinical components and does not include other work (such as commercial plasma sales) performed by the department. The Service is currently reviewing it's Key Performance Indicators as part of the wider review of the VUNHST Performance management Framework and will address this anomaly.

6.3 Manufacturing Losses (Tolerance 0.5%)

Controllable losses for March to May 2022 were extremely low at 0.06% and remain within tolerance.

6.4 Time Expired Red Cells (Target 1%)

Red cell expiry for March to May 2022 remains extremely low and within 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.

6.5 Time Expired Platelets (Target 10% expired)

Platelet expiry remained above target for between March and May 2022, the underlying trend was exacerbated by the number of bank holidays during this period when demand for platelets is unpredictable and wastage difficult to avoid with a 7 day shelf-life.It should be emphasised that the majority of date-expired platelets come from whole blood collections rather than apheresis, the donation is therefore only partially wasted.

A review of the platelet strategy has commenced with an initial analysis of supply vs demand and wastage underway. During June to September, this work will be extended to identify quick wins in terms of clinic planning and longer term preventative actions which may require Business Intelligence support to help match production with predicted demand.

Welsh Blood Service Monthly Report

May 2022

Gwasanaeth Gwaed Cymru
Welsh Blood Service

- The Welsh Blood Service continuously monitors the availability of blood for transfusion through its daily resilience group meetings and plans its collection model to meet demand. Whilst Covid related sickness continues to be challenging in collecting blood, during May the service continued to meet demand for red cells with demand for O, A and B positive groups maintained above 3 days. The Blue Alert issued on 21/03/2022 remains in place however the service has extended the alert to also include O and D negative red cells as well. The extended Jubilee bank holiday will place additional pressure on stock levels due to reduced collection opportunities and 100 red cells were provided by Mutual Aid support to help maintain stock. It should be noted that all UK services are experiencing similar issues. WBS continues to work closely with blood banks across Wales and they have reduced their stockholding, which in turn, provides WBS with flexibility in managing the current situation. Demand in May averaged at 1497 units per week, increasing slowly towards pre coved levels.

- The number of new bone marrow volunteers added to the Welsh Bone Marrow Donor Registry (WBMDR) reached 163 in May compared to 141 in April, but is still below target. The service is taking a two-pronged approach to increase the number of bone marrow volunteers which includes promoting 'SWAB' kits and increasing the number of younger donors donating blood. The ongoing action plan for increasing bone marrow volunteers includes donor recruitment promotion at universities and colleges, profiling on social media as well as improving content and visibility on the WBS website. In June, staff will visit local colleges to discuss the recruitment of volunteer bone marrow donors and plan to attend collection sessions at colleges and universities upon the start of the academic year. In addition, the service is commissioning an external marketing campaign to further drive the recruitment of volunteers. Following these actions, increases in bone marrow donors are anticipated from September onwards.

- Stem cell collections in Wales continue to be affected by the COVID pandemic which has impacted on unrelated donor stem cell transplants globally, resulting in lower stem cell collection requests. The service has also seen a higher cancellation rate (30%) compared to that pre pandemic (15%). This is due to patient fitness and the requirement for collection centres to 'work up' two donors simultaneously in order to ensure sufficient number of donors available at the required point of a patient's treatment. The move to apheresis stem cell collection at Velindre Cancer Centre (VCC) has provided additional capacity and has enabled 6 stem cell collections to be planned in June. In addition, the five year strategy currently under development will reappraise the existing collection model and its ambition.

- Against a target of 80%, Red Cell Immunology turn around performance remains at 70% for May and continues to be impacted significantly by key staff absences and a repeated high level of referrals (233). Work continues to prioritise clinical need, and all compatibility testing is completed to the required time/date. Whilst the complexity of referrals continues to impact performance in May, staff absence remains the most significant factor in this. Staffing pressures have delayed validation of the new automated analyser, which will improve efficiency, and work will now begin in June 2022. The testing strategy for patient samples suitable for automated testing has been completed and the findings of the recent Out of Hours Referrals Audit have been reviewed for implementation. A paper regarding service pressures and outlining solutions for maintaining service delivery will be reviewed by WBS SMT in June, with a view to overseeing and improving the performance of the department in the short, medium and long term.

- The collection productivity rate has improved, due to efficiencies from donor sessions operating at 1m instead of 2m social distancing, but remains below target of 1.25. The collections team are actively preparing a recovery plan over the summer to bolster stock in light of the lifting of Covid restrictions and operations returning to pre Covid supply levels. In May, work commenced to ensure adequate ventilation in mobile donor collection vehicles to meet Covid requirements. It is anticipated that a mobile unit will be incorporated into donor sessions in the summer to enable the service to extend its community reach. Collections are looking to maximise efficiency of larger clinics which is expected to positively support performance against this measure.

- At 86%, performance against the 'Incidents closed within 30 days' measure has not met the target of 90% for the 3 month rolling period to May. The number of incidents not closed within the timeframe decreased from 21 to 20 in May with performance via QPulse at 83% and Datix at 90%. All QPulse incidents have been risk assessed, investigated and closed. All Datix incidents were low or no harm events. 5 were closed but exceeded the 31-day closure limit whilst the remaining Datix incidents remain open with preventive action applied. There were no external audits undertaken or any Serious Adverse Events (SAE) reported to regulators during May. It should be noted that an MHRA inspection is planned to take place between the 8-10 June at the WBS Site in North Wales.

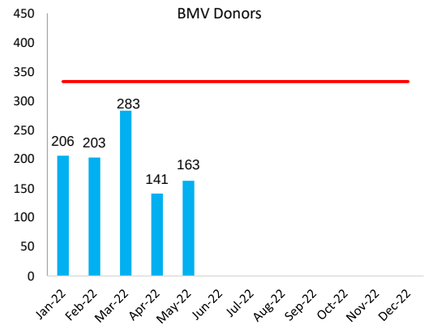
- In May, 7,487 donors were registered at donation clinics. 8 concerns (0.11%) were reported within this period. No formal concerns were due to be completed in May and whilst 2 formal concerns were received in May, both are due to be completed in July under 'Putting Things Right' (PTR) guidelines. Initial responses to 7 of the 8 concerns in May were managed within 2 working days as required by PTR regulations. There was a delay in responding to 1 concern, due to the failure to utilise the correct reporting pathway as a result of the complexity of the concern, which has resulted in exceeding the 2 day reporting timeline. 476 new donors completed a donation in May, 6.68% of the total donations received. During the pandemic, appointment slots have been reduced to match hospital demand resulting in fewer available opportunities for new donors to donate. Detailed planning for the return to universities and colleges will take place from June onwards, whilst school venues (used prior to Covid) are being contacted to reintroduce the sessions once schools return in September and should produce results post September. At 96% donor satisfaction continued to be above target for May. In total there were 1,216 respondents to the donor survey.

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

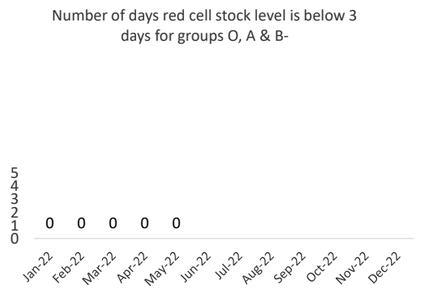
Equitable and Timely Access to Services



May-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 163 in May compared to 141 in April, but is still below target. There were no university or college collection sessions due to the end of the academic year. Coupled with a lower number of eligible (17-30 year old) bone marrow volunteers at community collection sessions, this has contributed to only a small increase in bone marrow volunteers in May.	The Service is taking a two-pronged approach to increase the number of bone marrow volunteers which includes promoting 'SWAB' kits and increasing the number of younger donors donating blood. The ongoing action plan for increasing bone marrow volunteers includes donor recruitment promotion at universities and colleges, profiling on social media as well as improving content and visibility on the WBS website. In June, staff will visit local colleges to discuss the recruitment of volunteer bone marrow donors and plan to attend collection sessions at colleges and universities upon the start of the academic year. In addition, the service is commissioning an external marketing campaign to further drive the recruitment of volunteers. Following these actions, increases in bone marrow donors are anticipated from September 2022 onwards.	Rolling Action Plan

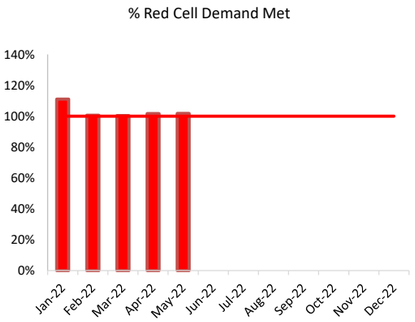
Safe and Reliable Service



May-22

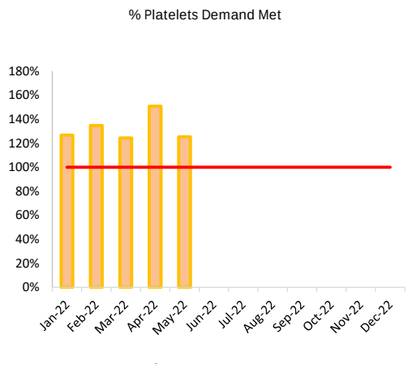
Monthly Target: 0	**SMT Lead: Jayne Davey / Tracey Rees**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
O, A and B positive blood groups continued to be maintained above 3 days. This is core business and is reviewed on a daily basis at resilience meetings and any concerns are escalated via WBS Senior Management Team (SMT) leads for immediate action. The Blue Alert issued on 21/03/2022 remains in place but the service has extended the alert to also include O and D negative red cells as well due to continued low stock levels in these groups.	The Welsh Blood Service constantly monitors the availability of blood for transfusion through its daily 'Resilience Group' meetings which include representatives from all departments supporting the blood supply chain and includes the collections, manufacturing, distribution and blood health team. At the meetings business intelligence data is also reviewed and facilitates operational responses to the challenges identified at each daily review. Appropriate operational adjustments are made to maintain adequate stock levels and minimise blood shortages. In addition regular demand planning meetings take place to consider the more strategic aspects of blood supply.	Business as Usual, reviewed daily

Safe and Reliable service



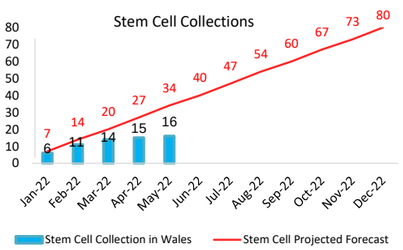
May-22

Monthly Target: 100%	**SMT Lead: Jayne Davey/ Tracey Rees**	
What are the reasons for performance?	**Actions(s) being taken to improve performance**	**By When**
All hospital demand for red cells was met. Given the significant weekly variation in demand, collections and issues were effectively balanced resulting in a steady overall stock position for the month of May. The Jubilee bank holiday will place considerable pressure on stock levels, due to reduced collection opportunities and 100 red cells were provided by Mutual Aid support to help maintain stock levels. Stock management continues to be closely monitored and discussed at daily resilience meetings with immediate escalation to SMT if required. Demand in May (full weeks) averaged at 1497 units per week increasing slowly towards pre coved levels.	The Welsh Blood Service constantly monitors the availability of blood for transfusion through its daily 'Resilience Group' meetings which include representatives from all departments supporting the blood supply chain and includes the collections, manufacturing, distribution and blood health team. At the meetings business intelligence data is also reviewed and facilitates operational responses to the challenges identified at each daily review. Appropriate operational adjustments are made to maintain adequate stock levels and minimise blood shortages. WBS continues to work closely with blood banks across Wales and they have reduced their stockholding, which in turn, provides WBS with flexibility in managing the current situation. In addition, regular demand planning meetings take place to consider the more strategic aspects of blood supply. The collections team are actively preparing a recovery plan over the summer to bolster stock in light of the lifting of Covid restrictions and returning operations to pre Covid supply levels	Business as Usual, reviewed daily to support responses to changes in demand



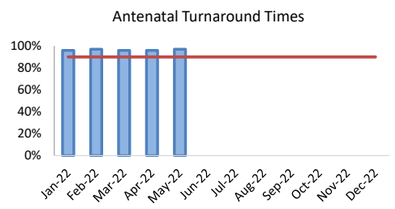
Safe and Reliable service — **May-22**

Monthly Target: 100%	**SMT Lead: Jayne Davey / Tracey Rees**	
What are the reasons for performance?	**Actions(s) being taken to improve performance**	**By When**
All clinical demand for platelets was met. Platelets are produced by two different methods: Donor Apheresis and Manufactured Pools from whole blood. In combination, they provide the total number of units available each month. Due to their short shelf life (7 days), platelet stocks are monitored on a daily basis to ensure adequate response time to any 'spikes' in demand. Daily communications between the Collections and Laboratory teams enables agile responses to variations of stock levels and service needs. For May, platelet demand was 216 units per week on average, higher than pre coved levels. A value over 100% indicates sufficiency in supply over the month, whilst a value less than 100% would indicate shortage of platelets. High values will also increase time expiry of platelets.	The Ambient Overnight Hold (AONH) production process continues to allow flexibility in the production plan for platelets. Adjustments (i.e. increased production) on the weekly targets can to be made to align with increased demand. The service is undertaking a review of platelet production to assess where improvement opportunities lie. Identification and implementation of quick wins will be completed by end of July and development of a longer term strategy to address issues will be completed by end of September.	Reviewed daily



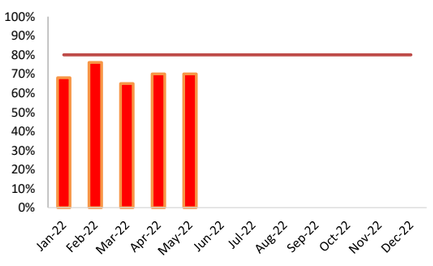
Safe and Reliable service — **May-22**

Annual Target: 80 (ave 7 per month)	**SMT Lead: Tracey Rees**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Stem cell collections in Wales continue to be affected by the COVID pandemic which has impacted on unrelated donor stem cell transplants globally, resulting in lower stem cell collection requests. The service has also seen a higher cancellation rate (30%) compared to that pre pandemic (15%). This is due to patient fitness and the requirement for collection centres to 'work up' two donors simultaneously in order to ensure sufficient number of donors available at the required point of a patient's treatment.	The move to apheresis stem cell collection at Velindre Cancer Centre (VCC) has provided additional capacity and has enabled 6 stem cell collections to be planned in June 2022. In addition, the five year strategy currently under development will reappraise the existing collection model and its ambitions.	31/09/2022



Safe and Reliable service — **May-22**

Monthly Target: 90%	**SMT Lead: Tracey Rees**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
At 97%, the turnaround time for routine Antenatal tests in May remains above the target of 90% Continued monitoring and active management remains in place.	Efficient and embedded testing systems are in place. Continuation of existing processes are maintaining high performance against current target.	Business as Usual, reviewed daily



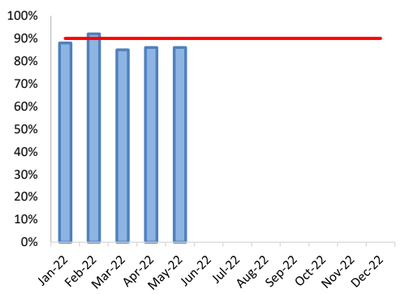
Safe and Reliable service — **May-22**

Monthly Target: 80%	**SMT Lead: Tracey Rees**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
At 70% turn around times for May continued to be significantly impacted by key staff absences and a repeated high level of referrals (the number of samples referred reached 233 in May compared to the average of hospital patient referrals at 226/month for 2021 and 181/month in 2020). Staffing pressures have delayed the validation the new automated analyser, which will improve efficiency, and work will now begin in June 2022. Whilst the complexity of referrals continues to impact performance in May, the more significant impact continues to be due to unavoidable staff absences.	The service conducts specialist tests to confirm hospital results that are difficult to interpret or will undertake additional testing which is not performed in the hospital blood banks. These tests must be performed within 7 days of the sample being taken and are prioritised appropriately to ensure the fastest turnaround possible. The service continues to prioritise compatibility referrals and safe provision of red cells for transfusion. All referrals are prioritised based on clinical need and all compatibility testing is completed to the required time/date. These requests are time critical and require provision of blood for transfusion, the tests are prioritised and patient care was not affected. Work to validate the new automated analyse will now begin in June and this will support improved efficiency. The testing strategy for patient samples suitable for automated testing has been completed and the findings of the recent Out of Hours Referrals Audit have been reviewed for implementation. A paper regarding service pressures and outlining solutions for maintaining service delivery will be reviewed by WBS SMT in June, with a view to overseeing and improving the performance of the department in the short, medium and long term.	30/06/2022

Safe and Reliable service

May-22

Quality Incidents closed within 30 days
(rolling 3 months)

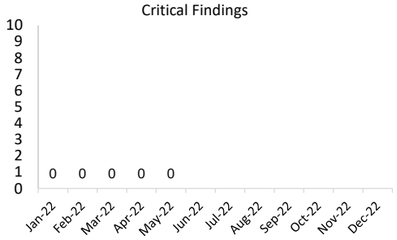


Monthly Target: 90%	**SMT Lead: Peter Richardson**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
At 86%, performance has not met the target of 90% for the 3 month rolling period to May. The number of incidents not closed within the timeframe decreased from 21 to 20 (14 in QPulse and 6 in Datix) in May with performance via QPulse at 83% and Datix at 90%. All QPulse incidents have been risk assessed, investigated and closed. QPulse does not permit closure of the report until all CAPA (Corrective and Preventative Actions) are completed. The reasons for late closure is due to incomplete CAPA and not delayed investigation. Of the 6 Datix incidents, all were low or no harm events. 5 were closed but exceeded the 31-day closure requirement. The remaining Datix incidents remain open but with preventive action applied.	The revised process for managing low-impact incidents within QPulse was implemented on 1st June, new reports are reviewed and risk assessed daily and the majority of incidents are fully closed within a few days of reporting. The QA team send weekly updates alerting owners of incidents recorded within QPulse that are likely to breach close-out deadlines and close attention is paid to the progression of these incidents. The QA triage team also run bi-weekly Datix reports to ensure early recognition of any reports requiring attention. Details regarding the specific incidents that need to be progressed shall be reported to the relevant managers and SMT Leads.	Continue with close monitoring and early recognition of potential timeline breaches.

Safe and Reliable service

May-22

Critical Findings

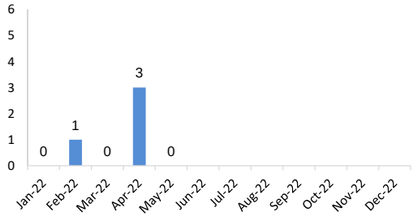


Target: 0	**SMT Lead: Peter Richardson**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
There were no external audits undertaken during May. However, it should be noted that an MHRA inspection is planned to take place between the 8-10 June at the WBS Site in North Wales.	No action required at this time.	Completion of existing action plans for previous external audits is monitored via the monthly RAGG meeting.

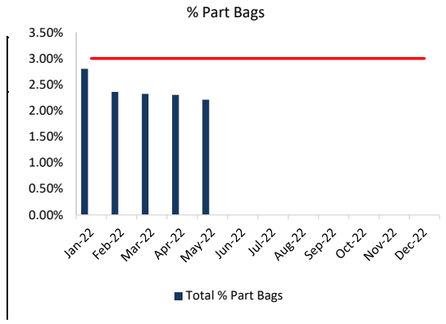
Safe and Reliable service

May-22

Incidents Reported to Regulator/Licensing

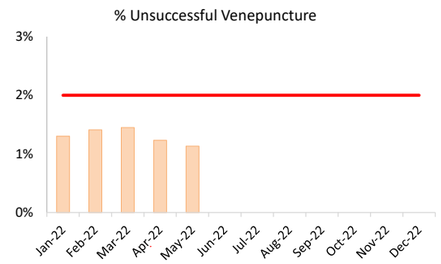


Annual Target: 0	**SMT Lead: Peter Richardson**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
There were no Serious Adverse Events (SAE) reported to regulators during May.	For the previous three reports submitted to SABRE in April, all three investigations are completed. SABRE 99 is closed and the investigation reports for SABRE 100 and 101 are circulating for review and agreement of preventive actions.	The confirmatory report for SABRE 100 was due for submission by 06/05/22, and SABRE 101 by 27/05/22. Both investigations were delayed due to operational challenges and the complexity of the events being investigated. MHRA were notified of delayed submission in advance and have acknowledged the delay. Footnotes on progress have been added within the SABRE reports, to ensure MHRA are kept informed of progress.



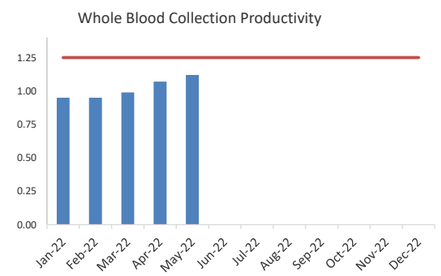
Spending Every Pound Well — **May-22**

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 (3%) at 2.30% during May. All teams were below required tolerance levels, with the exception of the South West team which is at the threshold (3.0%). Further analysis, monitoring and investigation of the part bag rate continue to ensure no practice issues are evident. However, causes of Part Bags are various (needle placement, clinical risk, donor is unwell, donor request to stop donation, late donor information and equipment failure) and at times cessation of donation resulting in a part bag is clinically appropriate. This is a separate factor to Failed Venepunctures (FVPs).	Performance analysis of the South West team is taking place and any emerging performance trend details passed to the Collections, Operational and Training teams to address.	Continued close monitoring and intervention where required



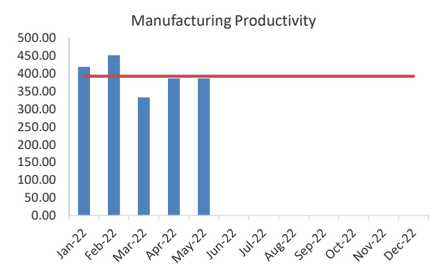
Spending Every Pound Well — **May-22**

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 May remains within the required tolerance (2%) at 1.23%.	Scrutiny of tolerance levels will continue.	Continue with close monitoring and intervention where required



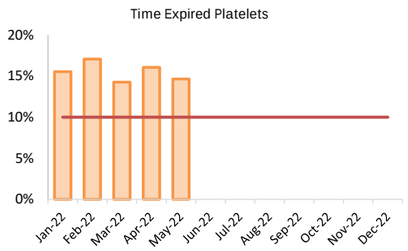
Spending Every Pound Well — **May-22**

Monthly Target: 1.25	**SMT Lead: Jayne Davey**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
The collection productivity rate has improved, due to efficiencies from donor sessions operating at 1m instead of 2m social distancing, but remains below target of 1.25. To ensure blood supply is aligned with the demands of hospitals, collection clinics continue to operate on an appointment only basis, which removes the ability to backfill 'non attendance' on the day with walk in donors.	The reduction in social distancing has improved the economy of scale for all clinics and regional variation has improved. The collections team are actively preparing a recovery plan over the summer to bolster stock in light of the lifting of Covid restrictions and operations returning to pre Covid supply levels. In May, work commenced to ensure adequate ventilation in mobile donor vehicles to meet Covid requirements. It is anticipated that a mobile unit will be incorporated into donor sessions in the summer to enable the service to extend its community reach. Collections are looking to maximise efficiency of larger clinics which is expected to positively support performance against this measure.	31/08/2022



Spending Every Pound Well

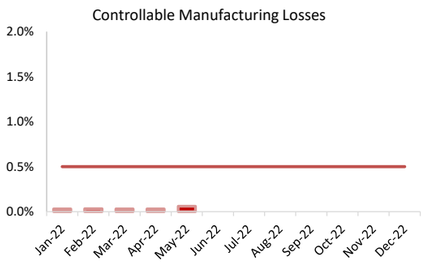
Monthly Target 392	**SMT Lead: Tracey Rees**	
What are the reasons for performance?	**Actions(s) bring taken to improve performance**	**By When**
At 385.90 the manufacturing efficiency performance for May was close to the target level of 400. Manufacturing efficiency, which is a European Blood Alliance (EBA) measure, is calculated by dividing working time available by the amount of work completed. The work completed relates to clinical components and does not include other work (such as commercial plasma sales) performed by the department..	This target is based on the pre Covid operating model and is due to be reviewed as part of the ongoing reporting framework.	Ongoing review



Spending Every Pound Well

May-22

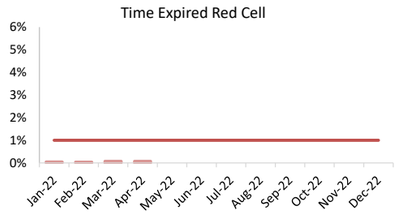
Monthly Target: Maximum 10%	**SMT Lead: Tracey Rees**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Platelet production is increased during the period leading up to Bank Holidays due to increased uncertainty around demand and decreased opportunity to make. Platelet expiry occurred in high numbers the week following the Bank Holiday but were generally low otherwise throughout the month. NB: All demand continues to be met without the need to rely on any Mutual Aid support.	Platelets are being produced by two different methods: Donor Apheresis and Manufactured Pools from whole blood. In combination, the methods provide the total number of units available each month. The introduction of Ambient Overnight Hold process for the manufacturing of blood components has increased flexibility in production of pooled platelets. Daily communications between the Collections and Laboratory teams enables agile responses to variations of stock levels and service needs. Adjustments to the platelet manufacturing targets are made in the laboratory to better align with demand, and take into account the apheresis appointments and donor attendance. Although it should be noted that demand can fluctuate significantly on a daily basis. Given the variability of expired platelets over the past 12 months, initial analysis to understand the current situation has been completed and work is now underway to engage with stakeholders to implement quick wins (completed by end of July) and develop a longer term strategy to address the issues (completed by end of September).	Ongoing and reviewed daily



Spending Every Pound Well

May-22

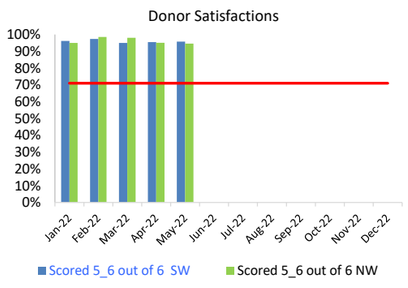
Monthly Target: Maximum 0.5%	**SMT Lead: Tracey Rees**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Controllable losses were extremely low at 0.06% and remain within tolerance of below 0.5%. The losses were (units): M&D Operator - Heat Seal Failure: 3 units M&D Operator - Incorrect storage: 1 unit These levels are well within tolerance and represent good performance. The monthly controllable losses should be considered against total production of approx. 1500 units per week.	Active management of the controllable losses in place, including vigilance and reporting of all units lost. Ongoing monitoring of losses when occurring in order to understand the reasons and consider appropriate preventative measures thus continuously improving practice through lessons learned and analysis.	Business as Usual, reviewed monthly



Spending Every Pound Well

May-22

Monthly Target: Maximum 1%	**SMT Lead: Tracey Rees**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Red cell expiry was 0.00%. The Covid challenges continue to affect the blood collection numbers resulting in faster stock turnover preventing red cells stocks from ageing in storage. This metric remains within the target and there are no concerns around expiry of red cells.	Daily monitoring of age of stock as part of the resilience meetings. Red Cell Shelf life is 35 days, with all blood stocks stored in Blood Group and Expiry Date order and issued accordingly. Continued effective management of blood stocks to minimise the number of wasted units.	Business as usual, reviewed daily

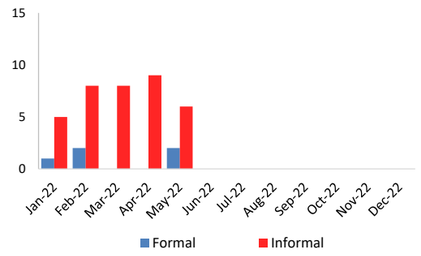


First Class Donor Experience

May-22

Monthly Target: Minimum 71%	**SMT Lead: Jayne Davey**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
At 96% Donor Satisfaction continued to be above target for May. In total there were 1,216 respondents to the donor survey (some of which are non attributable).	Findings are reported at Collections Meeting to address any actions for individual teams.	Business as usual, reviewed monthly

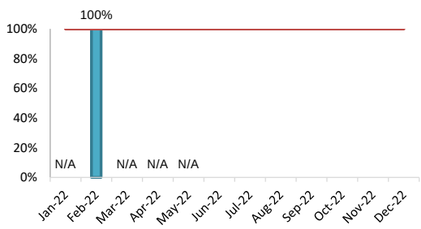
Number of Concerns Received



First Class Donor Experience — **May-22**

Target: N/A	**SMT Lead: Alan Prosser**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
In May 2022, 7,487 donors were registered at donation clinics. 8 concerns (0.11%) were reported within this period. 2 concerns are being managed under 30 day 'Putting things Right' (PTR) Regulations timeline, meaning that they are due to be resolved by the end of July. 6 concerns were managed within timeline as 'early resolution' and are detailed below: 1. Formal Concern - The complainant raised concerns about the level of Welsh language detail on the WBS website. 2. Formal Concern - A Donor raised concern regarding the conduct of a member of staff. 3. Three donors expressed disappointment at not being able to book a more convenient appointment. 4. 1 donor was unhappy receiving text reminders when no longer wishing to donate. 5. 1 donor was unhappy with the nature of the dialogue with a member of staff due to the donor's needle phobia. 6. 1 donor was unhappy, perceiving that booking on-line was the only option to make donation appointments.	All individual concerns have been addressed by Heads of Departments and / or Operational Managers. Following an identified trend in concerns relating to communication and staff attitude during recent months, a focus is being placed upon donor experience, satisfaction and staff communication/interactions. This trend will continue to be monitored going forward and appropriate interventions undertaken. Apart from the complaint detailed in No.3 below where there has been no response to WBS communications, all early resolution concerns have been closed to donor satisfaction within the required timescales. 1. The Communications Manager has reviewed issues raised by complainant relating to the level of bilingual content on the WBS website which has now been has updated accordingly. Welsh language considerations are to be reviewed prior to future website updates or re-launch. Changes to the new WBS website content include: • Website amended to ensure all donor eligibility 'quiz' questions are bi-lingual. • Welsh and English versions of video content now available on the website. • Welsh and English language guidance content now available on the website. 2. Observations of practice are due to commence across the collection teams in June. 3. 2 donors were happy with explanation given with both booking future appointments, whilst there has been no response to WBS communications from the third donor. 4. The explanation was accepted with the donor now categorised as 'non-notifiable' by SMS by request. 5. The Clinic Lead Nurse has discussed the donor's concerns with the staff member and will continue to monitor and provide support. WBS staff have also been reminded of the importance of retaining donors. 6. The donor has been informed that bookings can also be made via telephone and is happy with outcome and has booked their next appointment.	Business as usual, reviewed daily

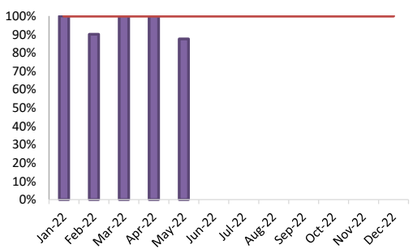
% Responses to Concerns within 30 Working Days



First Class Donor Experience — **May-22**

Monthly Target: 100%	**SMT Lead: Alan Prosser**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
No formal concerns were due to be completed in May and whilst two formal concerns were received in May, both are due to be completed in July 2022 under 'Putting Things Right' (PTR) guidelines. * Under PTR guidelines, organisations have 30 working days to address/close formal concerns. This can result in concerns being received and subsequently closed within separate reporting periods.	Continue to monitor formal complaint response progress and 30 day target compliance. Timescale requirements communicated to all involved in concerns management.	Ongoing reviewed daily

% Concerns Acknowledged within 2 Working Days



First Class Donor Experience — **May-22**

Monthly Target: 100%	**SMT Lead: Alan Prosser**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Initial responses to 7 of the 8 concerns in May 2022 were managed within 2 working days as required by PTR regulations. There was a delay in responding to 1 concern, due to the failure to utilise the correct reporting pathway as a result of the complexity of the concern, which has resulted in exceeding the 2 day reporting timeline.	Continue to monitor this measure against the 'two working day' target compliance. Timescale requirements communicated to all involved in concerns management.	ongoing, reviewed daily

Velindre Cancer Centre Monthly Performance Report Summary Dashboard (May 2022)

			Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Radiotherapy	Patients Beginning Radical Radiotherapy Within 28-Days (page 7)	Actual	94%	97%	96%	97%	96%	92%	78%	92%	92%	92%	87%	92%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Patients Beginning Palliative Radiotherapy Within 14-Days (page 9)	Actual	85%	82%	82%	82%	82%	74%	84%	90%	90%	81%	79%	81%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Patients Beginning Emergency Radiotherapy Within 2-Days (page 11)	Actual	100%	97%	100%	97%	100%	85%	89%	100%	93%	88%	84%	88%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
SACT	Patients Beginning Non-Emergency SACT Within 21-Days (page 12)	Actual	98%	99%	99%	98%	99%	99%	99%	94%	91%	71%	69%	61%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Patients Beginning Emergency SACT Within 2-Days (page 14)	Actual	100%	100%	100%	100%	100%	86%	100%	100%	100%	83%	100%	100%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
Outpatients	New Patient, other Outpatient and Chemotherapy Assessment Appointments Where Patients Were Seen Within 30 minutes of the Scheduled Appointment Times (National Target) (page 19)	Actual	76%	76%	53%	53%	65%	65%	In December 2021 data collection paused.					
		Target	100%	100%	100%	100%	100%	100%						

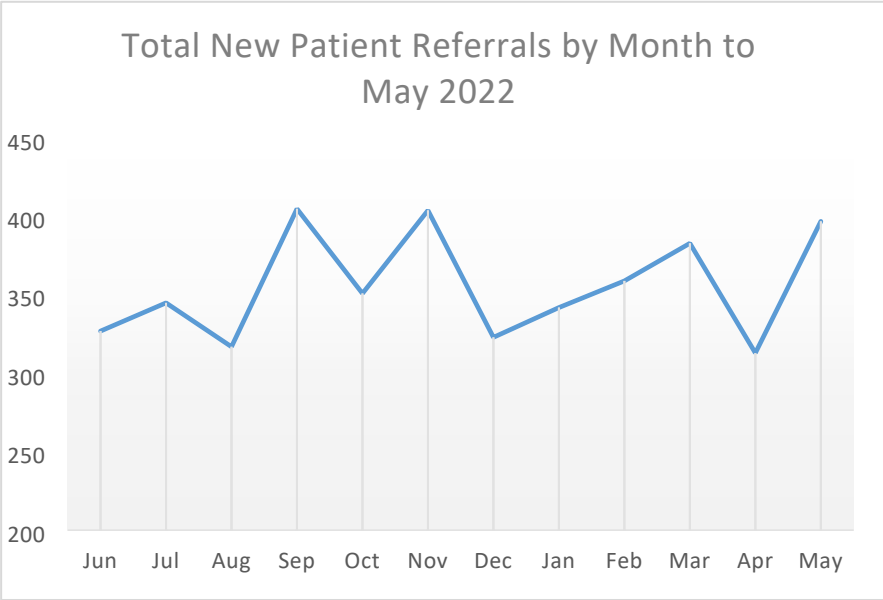
			Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
	Did Not Attend (DNA) Rates	Actual	4%	5%	5%	5%	5%	5%	3%	3%	3%	3%	3%	3%
		Target	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%
Therapies	Therapies Inpatients Seen Within 2 Working Days (page 17)	Actual (Dietetics)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Physiotherapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Occupational Therapy)	100%	100%	100%	100%	95%	100%	100%	100%	100%	100%	100%	100%
		Actual (Speech and Language Therapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	67%	100%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	%
	Therapies Outpatient Referrals Seen Within 2 Weeks (page 17)	Actual (Dietetics)	84%	94%	94%	98%	97%	100%	95%	98%	100%	98%	100%	100%
		Actual (Physiotherapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Occupational Therapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Speech and Language Therapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

			Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
	Routine Therapies Outpatients Seen Within 6 Weeks (page 17)	Actual (Dietetics)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Physiotherapy)	100%	100%	100%	100%	100%	100%	100%	86%	100%	100%	100%	100%
		Actual (Occupational Therapy)	100%	100%	96%	33%	78%	100%	100%	100%	100%	100%	100%	100%
		Actual (Speech and Language Therapy)	100%	96%	100%	100%	96%	100%	100%	100%	100%	100%	100%	100%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Safe and Reliable Care	Number of VCC Acquired, Avoidable Pressure Ulcers (page 19)	Actual	0	0	2	1	1	0	1	0	1	1	0	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0
	Number of Pressure Ulcers Reported to Welsh Government as Serious Incidents	Actual	0	0	0	0	0	0	0	0	0	0	0	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0
	Number of VCC Inpatient Falls (page 21)	Actual (Total)	1	3	4	2	3	1	4	3	2	9	4	1
		Unavoidable	1	3	4	1	3	1	4	2	2	9	3	0
		Avoidable	0	0	0	1	0	0	0	1	0	0	1	1
		Target	0	0	0	0	0	0	0	0	0	0	0	0
	Number of Delayed Transfers of Care (DToCs)	Actual	0	0	1	0	4	0	0	1	4	1	1	0

			Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
		Target	0	0	0	0	0	0	0	0	0	0	0	0
	Number of Potentially Avoidable Hospital Acquired Thromboses (HAT)	Actual	0	0	0	0	0	0	0	0	0	0	0	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0
	Patients with a NEWS Score Greater than or Equal to Three Who Receive all 6 Elements in Required Timeframe (page 24)	Actual	100%	80%	100%	75%	100%	100%	100%	100%	100%	100%	88%	100%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Healthcare Acquired Infections (page 25)	Actual	0	1 (*C.diff*)	0	0	0	0	0	1 (*C.diff*)	0	0	0	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0
Percentage of Episodes Clinically Coded Within 1 Month Post Episode End Date		Actual	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	%
		Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

RAG rating above indicates: Green - Target was achieved. Amber - 85% Compliance or above. Red - Target not achieved.

Radiotherapy Referral Trends – Overall



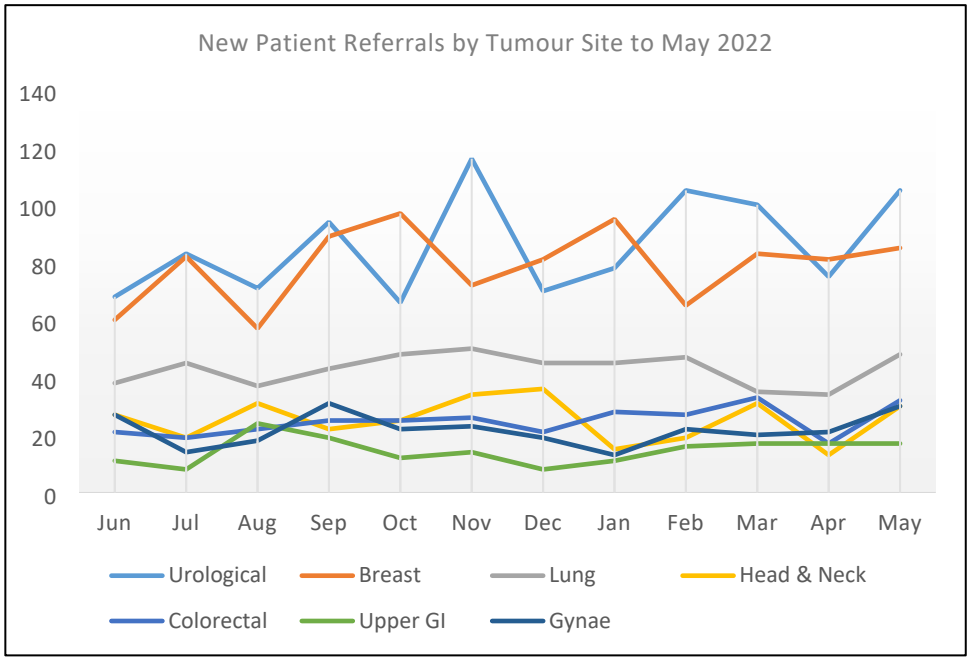
Monthly Average (2020-21)	Monthly Average (2021-22)	Total New Patient Referrals (May 2022)
315	343	397

The total number of referrals received in May 2022 (397) was markedly higher than those received in April 2022 (313). The number of referrals was also higher than the average number received in any month, on average, during 2020-21.

Areas of risk:
Brachytherapy surge due in May 2022. Capacity to meet demand remains limited. This is under active surveillance and subject to a business case to WHSSC for increased capacity

Radiotherapy – Operational Context

Referral Trends - Tumour Site

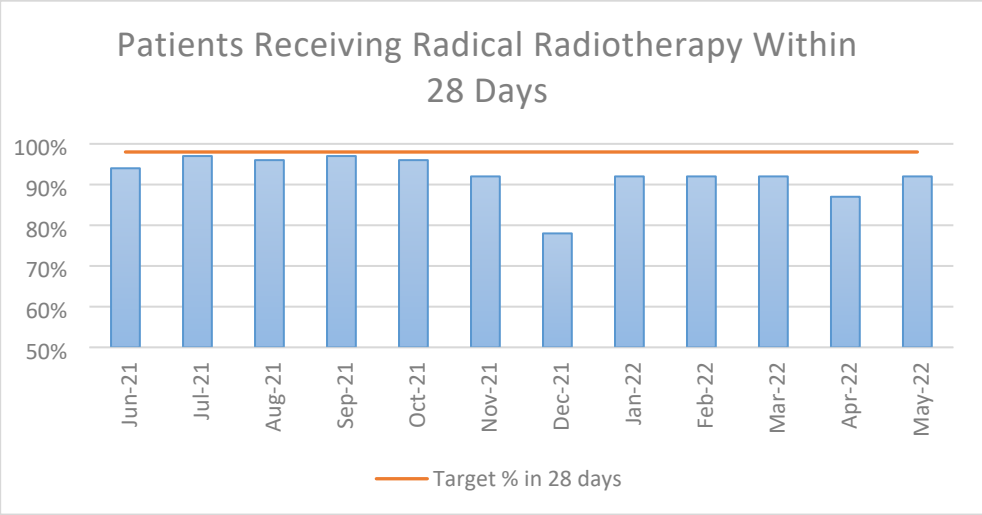


Site	Monthly Average (2020-21)	Monthly Average (2020-21)	Monthly Average (2021-22)	2021-22 Average Relative to 2020-21 Average	New Patients (May 2022)
Breast	**88**	**60**	**81**	**+35%**	85
Urology	**82**	**82**	**78**	**-5%**	105
Lung	**47**	**38**	**40**	**+5%**	48
Colorectal	**20**	**22**	**24**	**+9%**	32
Head and Neck	**23**	**23**	**25**	**+9%**	30
Gynaecological	**18**	**18**	**20**	**+11%**	30
Upper Gastrointestinal	**16**	**13**	**14**	**+8%**	17
Top 7 Tumour Sites by Number of Referrals as Percentage of Total Referrals	**82%**	**81%**	**82%**		87%

The graph and table show the number of patients scheduled to begin treatment in May by the tumour sites most commonly referred for radiotherapy treatment.

- Referrals overall and across some tumour sites now returning to pre-covid levels.
- Referrals in the tumour sites most commonly referred for radiotherapy is up from 82% to 84% against the 2019/20 baseline.
- Weekly variation in referrals from health boards, across individual tumour sites, is impacting on our ability to meet demand in a timely fashion as our LINACs are configured to individual or groups of tumour sites, so limits flexibility. We are reviewing configuration to explore all options to flex to demand. Engagement with health boards ongoing to understand their backlog clearance plans.
- All options being explored by Site Specialist Teams (SST's) to meet short term surges and to respond to health board backlog clearance.

Patients Receiving Radical Radiotherapy Within 28-Days	
Target: 98%	**SLT Lead: Radiotherapy Services Manager**
Trend	Current Performance



The number of patients scheduled to begin radical radiotherapy treatment in May 2022 (213) was significantly more than the monthly average observed in 2021-22 (170), but was larger than the number scheduled to begin treatment in the previous month (188).

Intent	Monthly Average (2020-21)	Monthly Average (2021-22)	Patients Scheduled to Begin Treatment (May 2022)
Radical	150	170	213
	Patients Scheduled to Begin Treatment (May 2020)	Patients Scheduled to Begin Treatment (May 2021)	
	168	159	

17 of the 213 patients referred for radical radiotherapy did not begin treatment within the 28 day target constituting an overall performance rate of 92**%.** 12 of these were treated by day 35.
Breaches were due to capacity constraints and followed an approved clinical prioritisation process to ensure risk to patients and outcomes is minimised.
Capacity secured at the Rutherford centre which has been utilised in the last few months and planned to be used for the next 6 months is now unavailable which will increase the capacity challenge.

There were a number of places in the care pathway where capacity constraints caused the target time to treat to be breached and these are listed below. A number of breaches (5) were due to constrained treatment machine (linac) capacity. 3 breaches were the result of the requirement to undertake a re-scan. Delays associated with planning processes also accounted for a number of delays (4). Limited brachytherapy capacity resulted in 1 breach and 1 was due to a lack of MRi capacity. All patients were subject to clinical prioritisation.
A comprehensive review of service capacity for each element of the service is underway which includes maximising capacity at all stages and scoping options to manage variation in referral patterns and all options for increasing capacity are explored and secured. These are being formally monitored through a weekly capacity and demand meeting.

Breakdown of breach length of waits:

Treatment Intent	< 35 days	≥ 35 days	≥ 40 days
Radical (28-day target)	12	2	3

Short term actions:

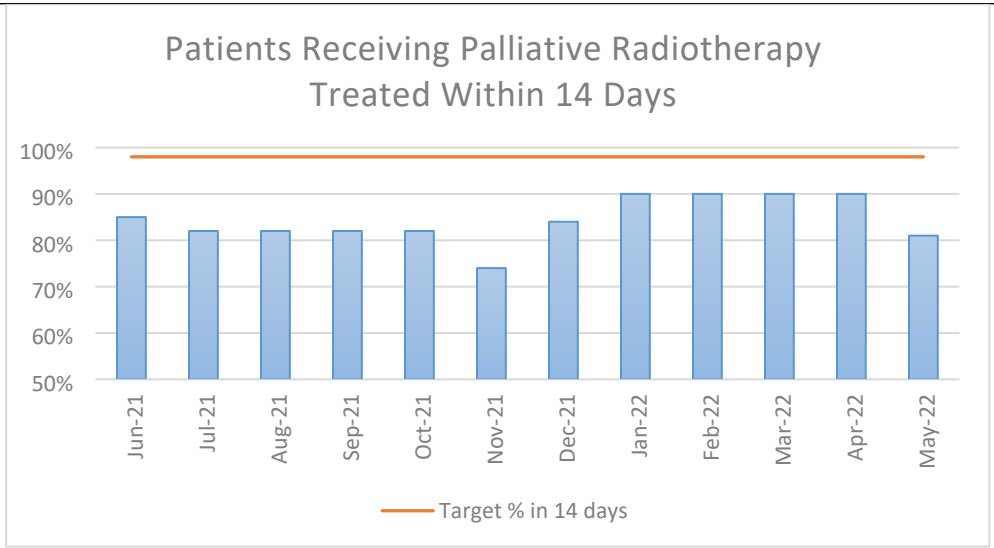
- Escalation processes continue to monitor predicted breaches and prevent breaches where possible through weekly capacity meetings. Delays and cancellations are monitored weekly and reported back to Radiotherapy Management Group and the pathway sub-group (see below)
- Recognising breaches resultant from pressure other than LINAC capacity, the Medical Directorate has identified a pathway lead to review all breaches with the SSTs responsible and to target the areas where there are process variation. This took effect from March 2022.

Medium Term Actions

	• We are working with each SST to develop a tailored capacity delivery plan based on demand projections and treatment options e.g. Brachytherapy, molecular radiotherapy. • Recruitment and appointments in progress for additional front-line resources but will rely on the newly qualified staff who register in the autumn. However, this will not create capacity increases until Q3/4 of 2022 due to lead in time, but we will be maximising capacity from September-December 2022. • Brachytherapy expansion business case has been written and is currently going through internal governance implementation timescales pending approval to begin June 2022.

Patients Receiving Palliative Radiotherapy Within 14-Days	
Target: 98%	**SLT Lead: Radiotherapy Services Manager**
Trend	Current Performance
	Of the 84 patients referred for radiotherapy treatment with palliative intent scheduled to begin treatment in May 2022, 16 did not begin treatment within the 14-day target constituting an overall performance rate of **81%.** Breakdown of breach length of waits:

Treatment Intent	< 21 days	≥ 21 days	45 days
Palliative (14-day target)	7	5	4



The number of patients scheduled to begin palliative radiotherapy treatment in May 2022 (84) was above the monthly average observed in 2021-22 (71) and was higher than the number scheduled to begin treatment in April (76).

Intent	Monthly Average (2020-21)	Monthly Average (2021-22)	Patients Scheduled to Begin Treatment (May 2022)
Palliative	75	71	84
	Patients Scheduled to Begin Treatment (May 2020)	Patients Scheduled to Begin Treatment (May 2021)	
	78	67	

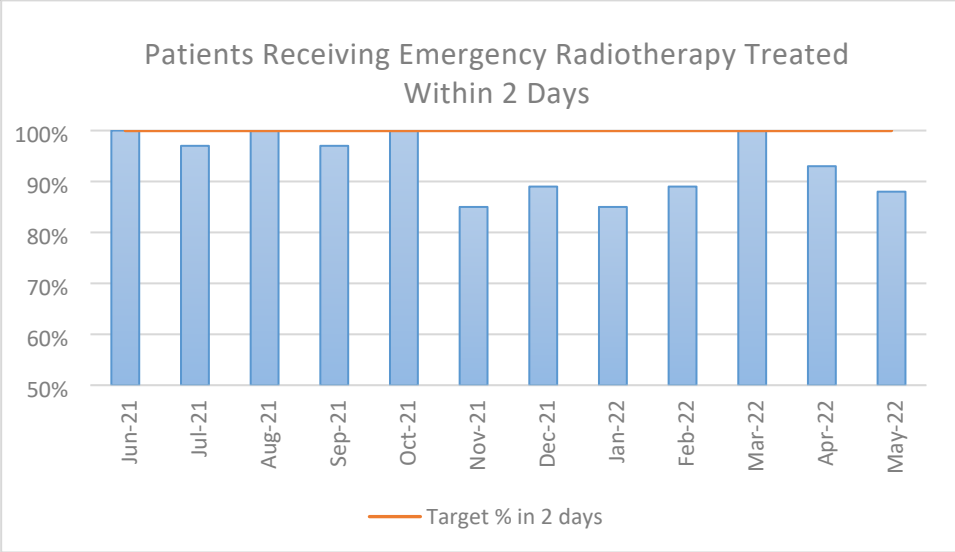
The requirement of 3D planning resulted in 4 breaches (medical physics processes are designed to deliver this in 21 days). 2 further breaches were attributed to limited linac capacity. 1 breach resulted from a change in treatment intent and 1 was attributed to a referral being accepted before all necessary clinical investigations had been completed.

As a result of breaches primarily reflecting issues in areas of pathway not necessarily linac capacity, the Medical Directorate has identified a pathway lead to review all breaches with the SSTs responsible and to target the areas where there are process variation. This process took effect in March 2022.

Medium Term Actions

- Refer to 28 day medium term actions.

Patients Receiving Emergency Radiotherapy Within 2-Days	
Target: 98%	**SLT Lead: Radiotherapy Services Manager**
Trend	Current Performance



The number of patients scheduled to begin emergency radiotherapy treatment in May 2022 (17) was fewer than the number scheduled to begin treatment in the previous month (19).

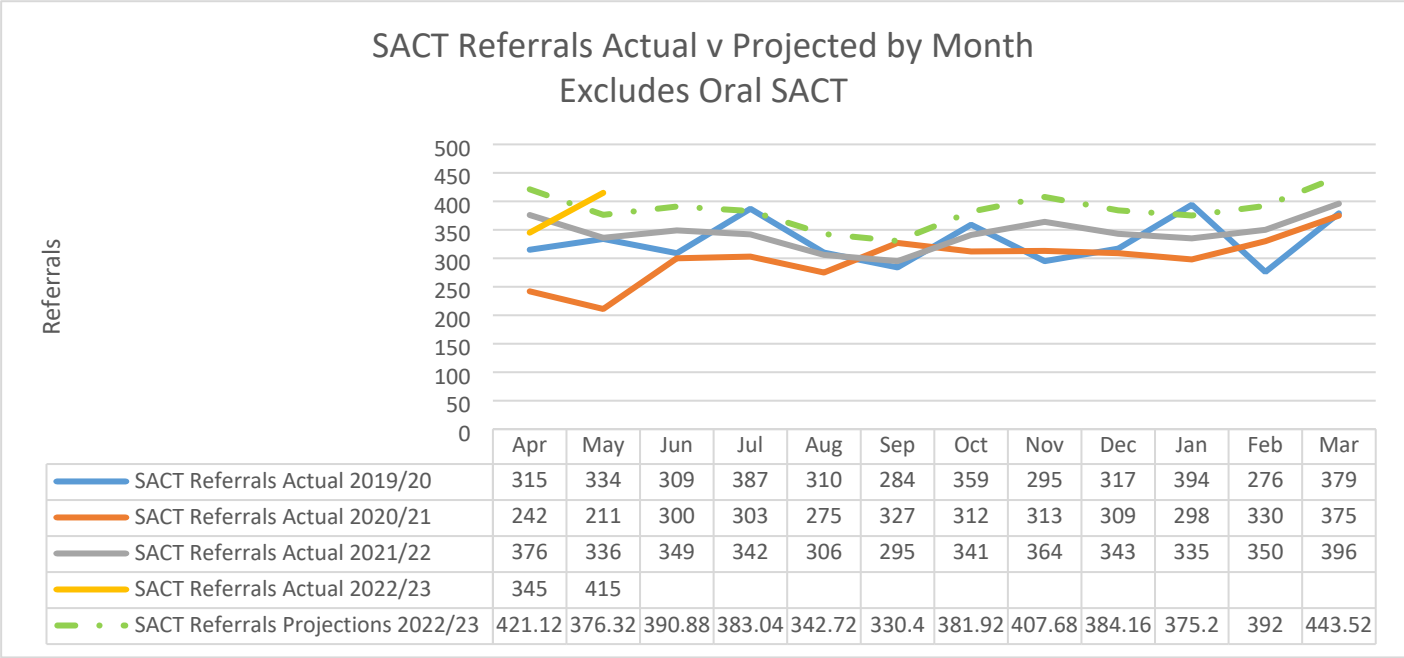
Intent	Monthly Average (2020-21)	Monthly Average (2021-22)	Patients Scheduled to Begin Treatment (May 2022)
Emergency	27	24	17
	Patients Scheduled to Begin Treatment (May 2020)	Patients Scheduled to Begin Treatment (May 2021)	
	21	17	

17 patients referred for radiotherapy treatment with emergency intent were scheduled to begin treatment in May 2022. Of these 2 and did not begin treatment within the 2 day target constituting an overall performance rate of **88%.**

1 patient was treated on day 3 and the second on day 5. One delay was attributed to restricted LINAC capacity and the second to a change of treatment intent.

Wider Actions as above for 28 and 14 day targets

Non-Emergency SACT Patients Treated Within 21-Days	
Target: 98%	**SLT Lead: Chief Pharmacist**
Current Performance	Trend



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
SACT Referrals Actual 2019/20	315	334	309	387	310	284	359	295	317	394	276	379
SACT Referrals Actual 2020/21	242	211	300	303	275	327	312	313	309	298	330	375
SACT Referrals Actual 2021/22	376	336	349	342	306	295	341	364	343	335	350	396
SACT Referrals Actual 2022/23	345	415										
SACT Referrals Projections 2022/23	421.12	376.32	390.88	383.04	342.72	330.4	381.92	407.68	384.16	375.2	392	443.52

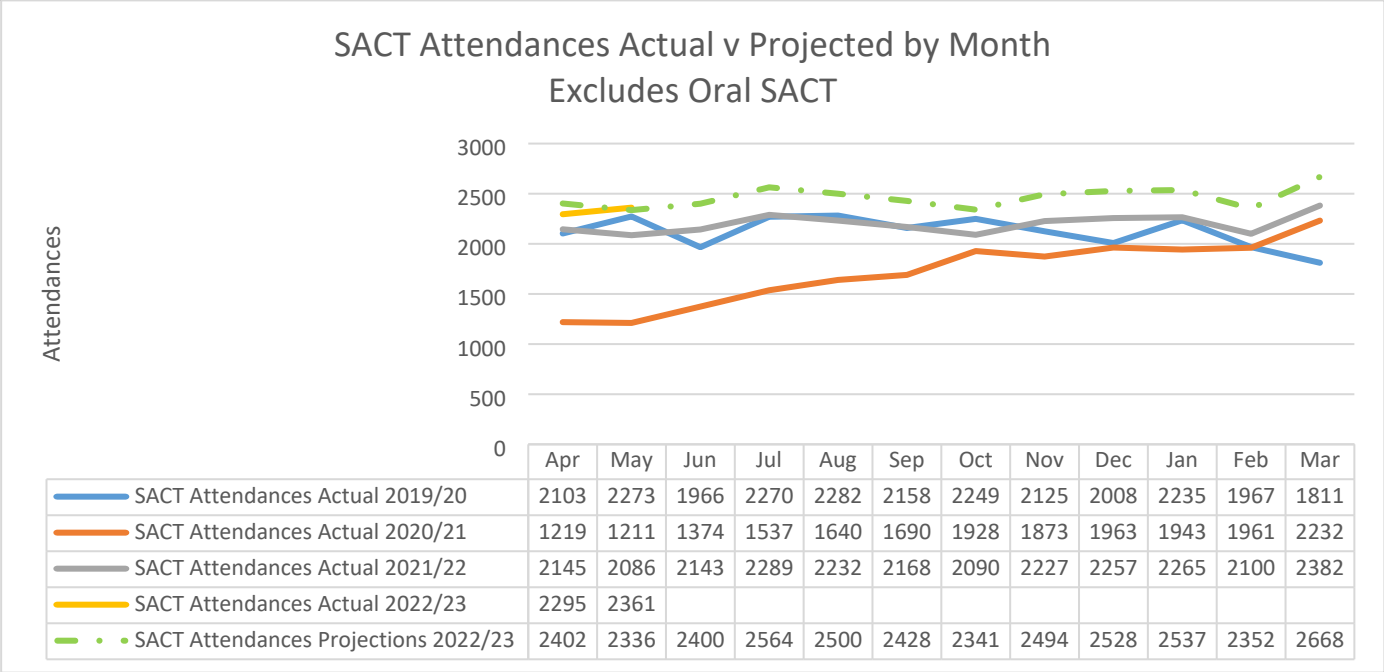
401 patients were referred for non-emergency SACT treatment scheduled to begin treatment in May 2022. Of this total, 158 patients did not begin treatment within the 21 day target, constituting an overall performance rate of 61%.

Of the 158 patients who did not begin treatment within 21-days:

Treatment Intent	≥ 28 days	29 - 35 days	36-42 days	> 42 days
Non-emergency (21-day target)	32	49	54	23

All patients within a Clinical Trial are booked within the trial timeframes to ensure compliance with the trial protocols.

Due to current capacity constraints within SACT, all new patients and urgent patients are prioritised using Welsh Cancer Network guidance and available clinical information. Patient escalation due to clinical priority is reviewed daily. Daily SACT Escalation meetings continue to be held with senior clinical SACT team leads who actively manage this prioritisation



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
SACT Attendances Actual 2019/20	2103	2273	1966	2270	2282	2158	2249	2125	2008	2235	1967	1811
SACT Attendances Actual 2020/21	1219	1211	1374	1537	1640	1690	1928	1873	1963	1943	1961	2232
SACT Attendances Actual 2021/22	2145	2086	2143	2289	2232	2168	2090	2227	2257	2265	2100	2382
SACT Attendances Actual 2022/23	2295	2361										
SACT Attendances Projections 2022/23	2402	2336	2400	2564	2500	2428	2341	2494	2528	2537	2352	2668

process and endeavour to ensure that all patients are treated in as timely a manner as possible according to their clinical prioritisation category and date of referral to the service.

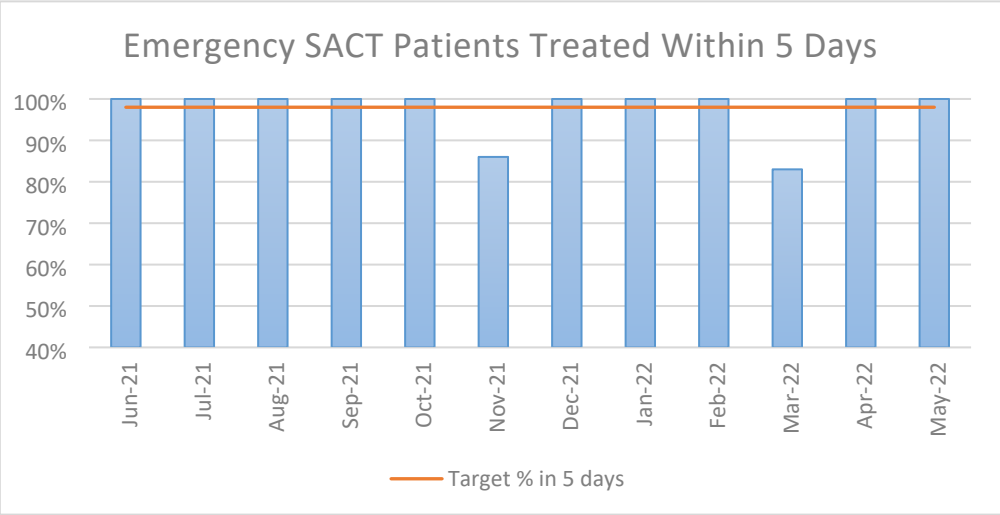
There was an expectation that additional provision from Rutherford Cancer Centre would commence in June to provide parenteral SACT for 50 patients per week as an interim measure while the longer term sustainable plan to move to Prince Charles Hospital and eventually Neville Hall Hospital was delivered. The Rutherford option is no longer available and has increased the challenge in providing capacity requirements.

A comprehensive review of capacity covering all elements of the SACT service including physical space, clinical review of patients and pharmacy drug compounding has been undertaken and phased plans are in development to increase capacity and all options for increasing capacity are explored and secured.

All treatments that can be safely delivered outside of the SACT clinic have now been moved to other areas of the service.

	Actions
	• Mutual aid arrangements from other parts of the service have been recommenced. • Weekend clinics are planned to commence in August. • Treatment regimens which can be delivered in other clinical areas have been actioned and further are being explored to release capacity in the SACT clinic area. • A SACT Taskforce has been established to identify solutions to support the service in increasing capacity, productivity, and sustainability. Commenced June 2022 and ongoing. • Discussions with Aneurin Bevan UHB regarding the reintroduction of services at Nevill Hall Hospital (NHH) as an interim solution have taken place. NHH colleagues are considering options. • A plan to maximise service delivery at Prince Charles Hospital is being enacted.

Emergency SACT Patients Treated Within 5-Days	
Target: 98%	**SLT Lead: Chief Pharmacist**

Current Performance	Trend
 The number of patients scheduled to begin emergency SACT treatment in May 2022 (12) was higher than in April (10).	12 patients referred for emergency SACT treatment were scheduled to begin treatment in May 2022. All patients began treatment within target. • Ring fencing of emergency chair capacity has allowed us to improve the compliance in this area. This took a number of months until the correct balance between ring fencing and chair utilisation was achieved.
	Actions
	• Continue to balance demand and ring fencing with capacity.

Intent	Monthly Average (2020-21)	Monthly Average (2021-22)	Patients Scheduled to Begin Treatment (May 2022)
Emergency	4	7	12
	Patients Scheduled to Begin Treatment (May 2020)	Patients Scheduled to Begin Treatment (May 2021)	
	5	14	

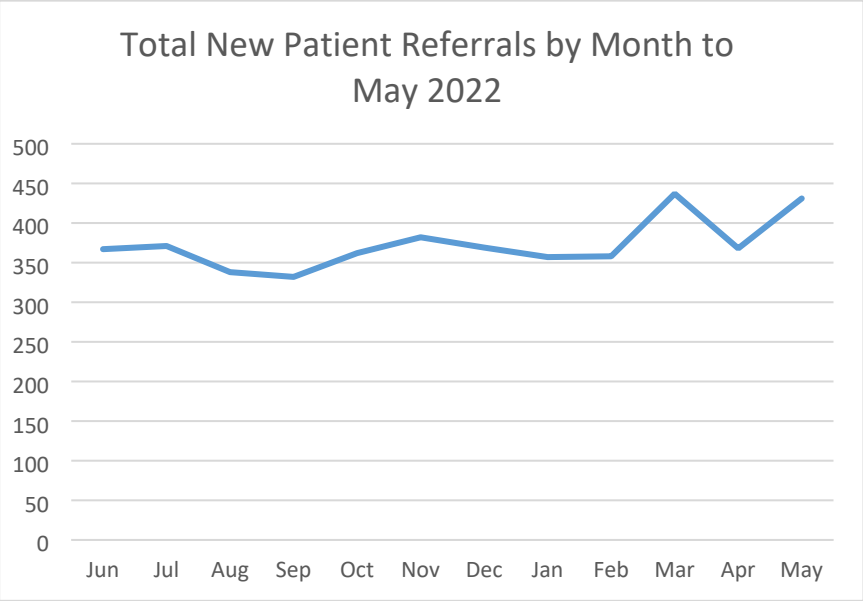
SACT – Operational Context

Current Performance Consolidated

Measure	Target	May-22
Non-emergency (21-day target)	98%	**61%**
Emergency (5-day target)	98%	**100%**

The table shown here sets-out performance relative to the extant time to SACT targets.

Referral Trends - Overall



Monthly Average (2020-21)	Monthly Average (2021-22)	Total New Patient Referrals (May 2022)
301	346	431

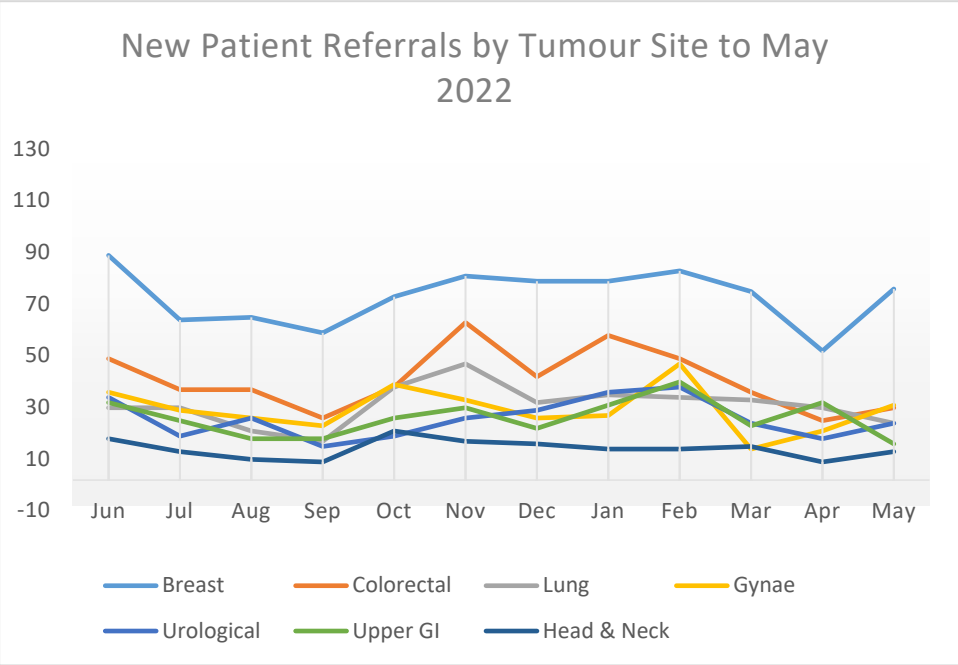
The total number of referrals received in May 2022 (431) was greater than the average number received in any given month during 2021-22 (346) and was greater than the total received in April 2022 (368).

Referrals fell dramatically following the first national lock-down in March 2020. Subsequently, referrals have returned to pre-pandemic levels.

Referrals include new patients for 1st definitive treatment and repeat treatments for patients mid cycle or on a revised treatment cycle.

SACT – Operational Context

Referral Trends - Tumour Site



Site	Monthly Average (2019-20)	Monthly Average (2020-21)	Monthly Average (2021-22)	2021-22 Average Relative to 2020-21 Average	New Patient Referrals (May 2022)
Breast	**92**	**76**	**101**	**+33%**	74
Colorectal	**54**	**55**	**55**	**0%**	28
Lung	**33**	**32**	**37**	**+16%**	22
Gynaecological	**31**	**31**	**34**	**+10%**	29
Urological	**36**	**26**	**30**	**+15%**	22
Upper Gastrointestinal	**18**	**26**	**30**	**+15%**	14
Head and Neck	**16**	**14**	**16**	**+14%**	11
Top 7 Tumour Sites by Number of Referrals as Percentage of Total Referrals	**86%**	**87%**	88%		46%

The graph and table show referrals for the tumour sites most commonly referred for SACT treatment.

SACT referrals are being driven by a high level of internal demand as a result of new/combination regimens, increasing patient treatment cycles etc.

Equitable and Timely Access to Services - Therapies

Target: 100%	SLT Lead: Head of Nursing

Current Performance

Percentage of Therapies Referrals (Inpatients) Seen Within 2 Working Days

	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Dietetics	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Physiotherapy	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
OT	100%	100%	100%	100%	95%	100%	100%	100%	100%	100%	100%	100%
SLT	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	67%	100%

Percentage of Urgent Therapies Referrals (Outpatients) Seen Within 2 Weeks

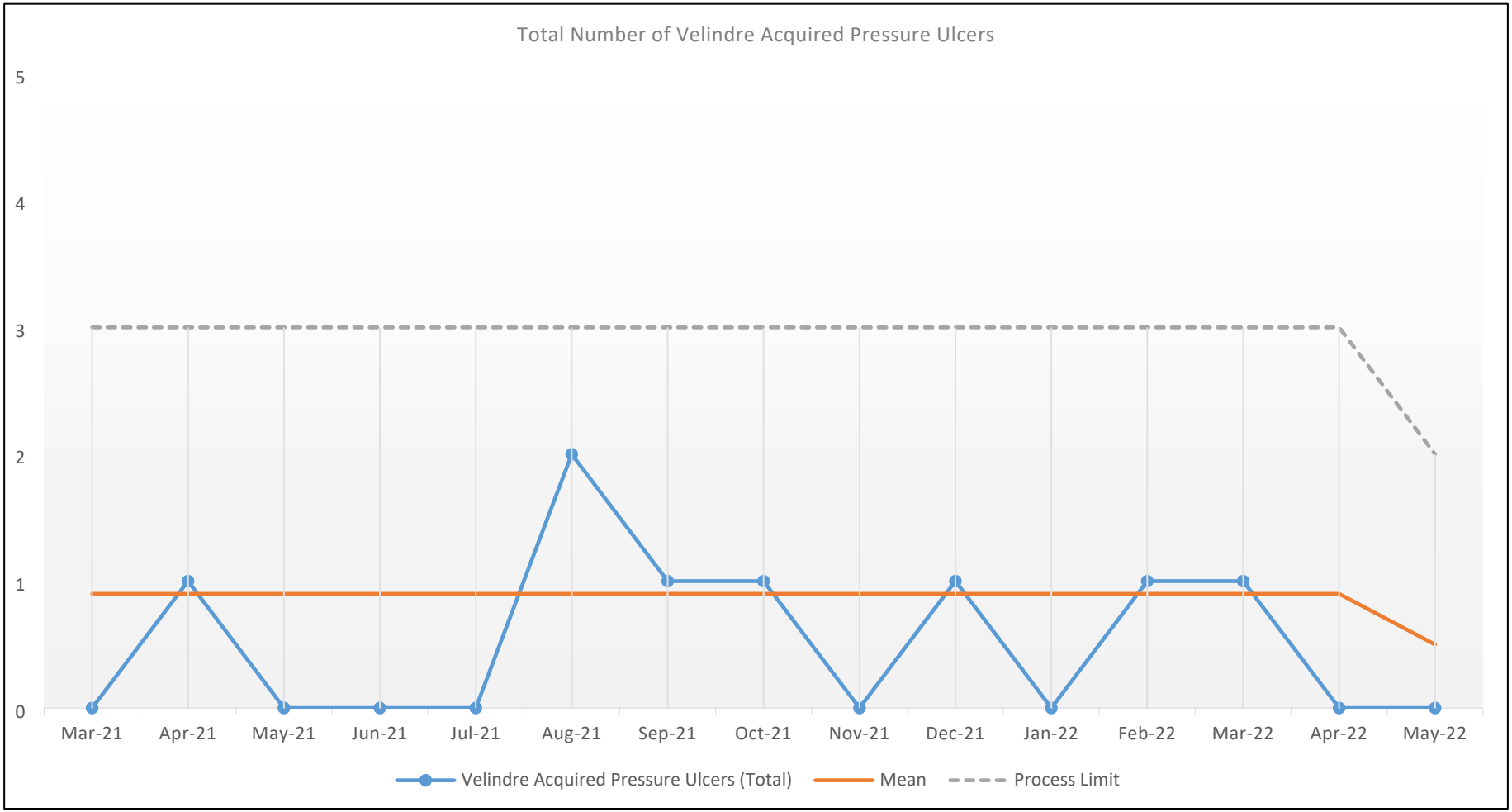
	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Dietetics	84%	94%	94%	98%	97%	100%	95%	98%	100%	98%	100%	100%
Physiotherapy	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
OT	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
SLT	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Percentage of Routine Therapies (Outpatients) Seen Within 6 Weeks

	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Dietetics	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Physiotherapy	100%	100%	100%	100%	100%	100%	100%	86%	100%	100%	100%	100%
OT	100%	100%	96%	33%	78%	100%	100%	100%	100%	100%	100%	100%
SLT	100%	96%	100%	100%	96%	100%	100%	100%	100%	100%	100%	100%

All patients were seen within target during May.	No specific action required.

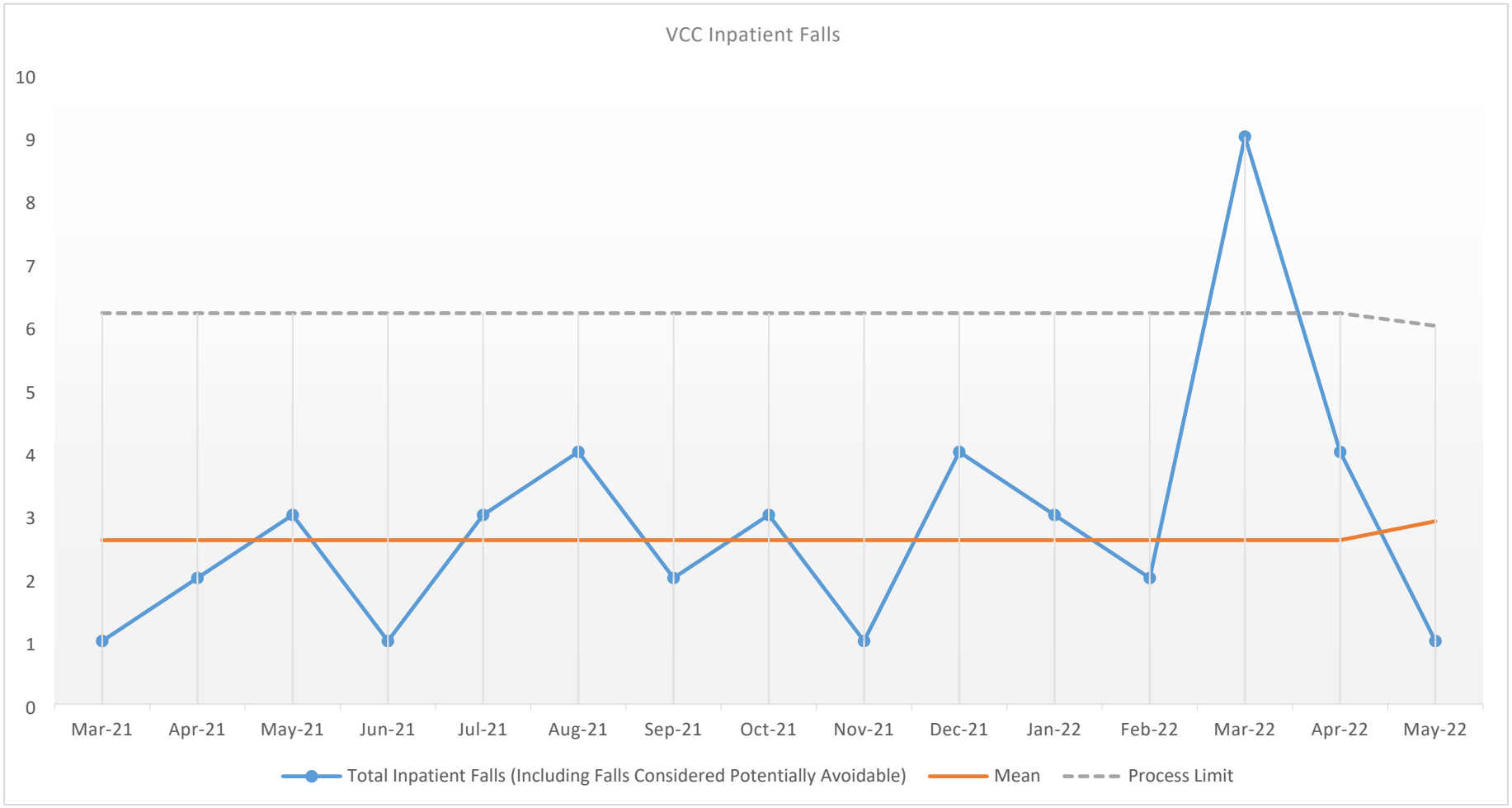
Velindre Acquired Pressure Ulcers	
Target: 0	**SLT Lead: Head of Nursing**
Current Performance	



	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Velindre Acquired Pressure Ulcers (Total)	0	0	1	0	0	0	2	1	1	0	1	0	1	1	0
Potentially Avoidable Velindre Acquired Pressure Ulcers	0	0	1	0	0	0	0	0	0	0	0	0	1	0	0

Trend	Action
No pressure ulcers were reported in May 2022. No Velindre acquired ulcers were reported to Welsh Government as a Serious Incident (SI).	No further action required.

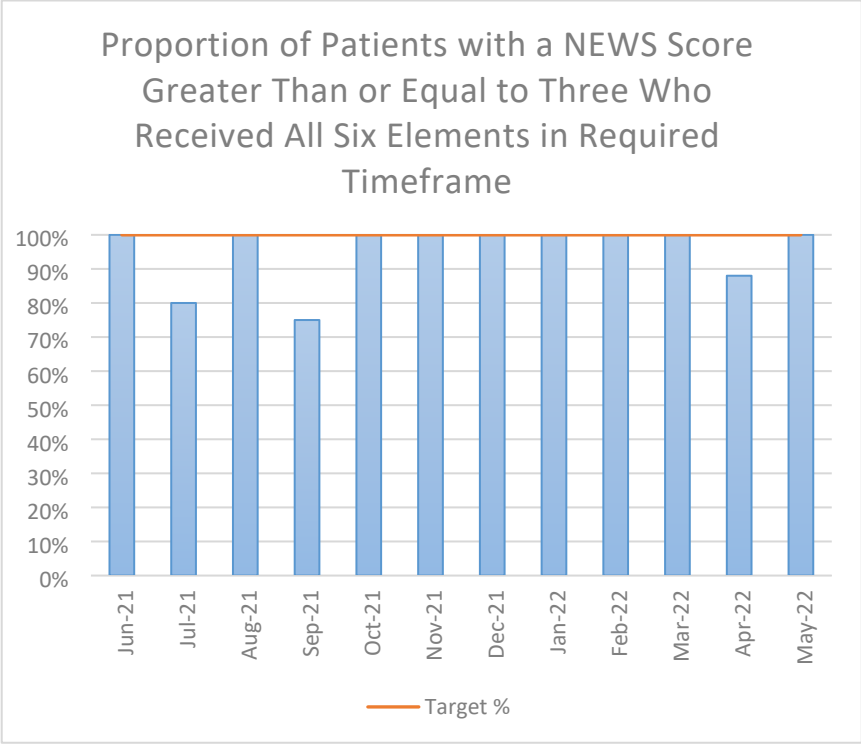
Velindre Inpatient Falls	
Target: 0	**SLT Lead: Head of Nursing**
Current Performance	



	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov - 21	Dec - 21	Jan - 22	Feb - 22	Mar - 22	Apr - 22	May -22
Total Inpatient Falls	1	2	3	1	3	4	2	3	1	4	3	2	9	4	1
Potentially Avoidable Inpatient Falls	0	1	0	0	0	0	1	0	0	0	1	0	0	1	1

Trend	Action
During May 2022, 1 fall was reported on First Floor Ward. The incident has been fully investigated by the VCC Falls Scrutiny Panel which has a wide range of membership with independence provided via a member of the Corporate Nursing. The fall was deemed avoidable. The patient was COVID positive and was being nursed in an isolation cubicle. While the door of cubicle was closed, in line with infection control requirements, the patient mobilised. All assessments were completed in line with standards and appropriate post fall care adjustments made and medical review undertaken.	Although all standards were followed there was some additional learning was identified by the Scrutiny Panel that could further improve standards: • Enhanced supervision policy to be developed and implemented (June 2022). • Involve infection control colleagues in management decisions in the case of patients who are assessed to be at risk of a fall and who are COVID positive (June 2022).

Delayed Transfer of Care	
Target: 0	**SLT Lead: Head of Nursing**
Current Performance	
No Delayed Transfer of Care (DToC) was reported in May 2022.	

Patients with a NEWS Score Greater Than or Equal to Three Who Receive All 6 Elements in Required Timeframe	
Target: 100%	**SMT Lead: Clinical Director**
Current Performance	Trend
	15 patients met the criteria for administration of the sepsis treatment bundle in May 2022. 13 patients received all elements of the bundle within 1 hour. 10 patients received a diagnosis of sepsis, 9 of these patients had received all elements of the bundle within 1 hour. On review, the patients who did not receive all elements of the bundle within 1 hour did not satisfy the criteria for the administration of the bundle. As such, performance was deemed to be 100%.
	Actions
	Staff to be reminded of the importance of completing all elements of the sepsis pathway documentation (June 2022).

Healthcare Acquired Infections (HAIs)	
Target: 0	**SLT Lead: Clinical Director**

Current Performance

	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
C.diff	0	0	1	0	0	0	0	1	0	1	0	0
MRSA	0	0	0	0	0	0	0	0	0	0	0	0
MSSA	0	0	0	0	0	0	0	0	0	0	0	0
E.coli	0	0	0	0	0	0	0	0	0	0	0	0
Klebsiella	0	0	0	0	0	0	0	0	0	0	0	0
Pseudomonas Aeruginosa	0	0	0	0	0	0	0	0	0	0	0	0

Trend	Action
There were no reported infections in May 2022.	No specific action required.

QUALITY, SAFETY & PERFORMANCE COMMITTEE
Velindre University NHS Trust Putting Things Right 2021-2022 Annual Report

DATE OF MEETING	14th July 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Non-Applicable

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

REPORT PURPOSE	ENDORSE FOR BOARD APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	01/07/2022	Endorsed

ACRONYMS	
N/A	

1. SITUATION

The 2021-2022 Velindre University NHS Trust Putting Things Right Annual Report is provided to the Quality, Safety & Performance Committee for **ENDORSEMENT** prior to being submitted to the Trust Board for approval.

2. BACKGROUND

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

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

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

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

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

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

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

3.2 IMPACT ASSESSMENT

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

4. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **ENDORSE** the 2021-2022 Velindre University NHS Trust Putting Things Right Annual Report prior to being submitted to the Trust Board for approval.

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Gwasanaeth Gwaed Cymru
Welsh Blood Service

Canolfan Ganser Felindre
Velindre Cancer Centre

PUTTING THINGS RIGHT

ANNUAL REPORT

2021/2022

Learn it Lead it Live it

LEARN TODAY FOR A BETTER TOMORROW

CONTENTS

1. Introduction

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

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

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

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

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

2. Putting Things Right – Definitions

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

3. Trust arrangements for managing concerns

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

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

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

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

- Have a consistent approach for investigating concerns which is proportionate to the issue raised.
- Ensure that the person raising the concern is properly and appropriately supported, for example, through access to advocacy support at all stages of the process, both from Community Health Council (CHC) advocates and more specialist advocacy services where needed.
- Provide an acknowledgement within 2 working days of the concern being raised, and will aim to respond to all concerns within 30 working days.
- Deal with all concerns openly and honestly.
- Provide a detailed response including clarity about next steps, and an offer to meet to discuss the findings of our investigation.
- Ensure decisions relating to Redress are clearly explained.
- Demonstrate that learning and improvements have resulted from the process

4. Complaints received

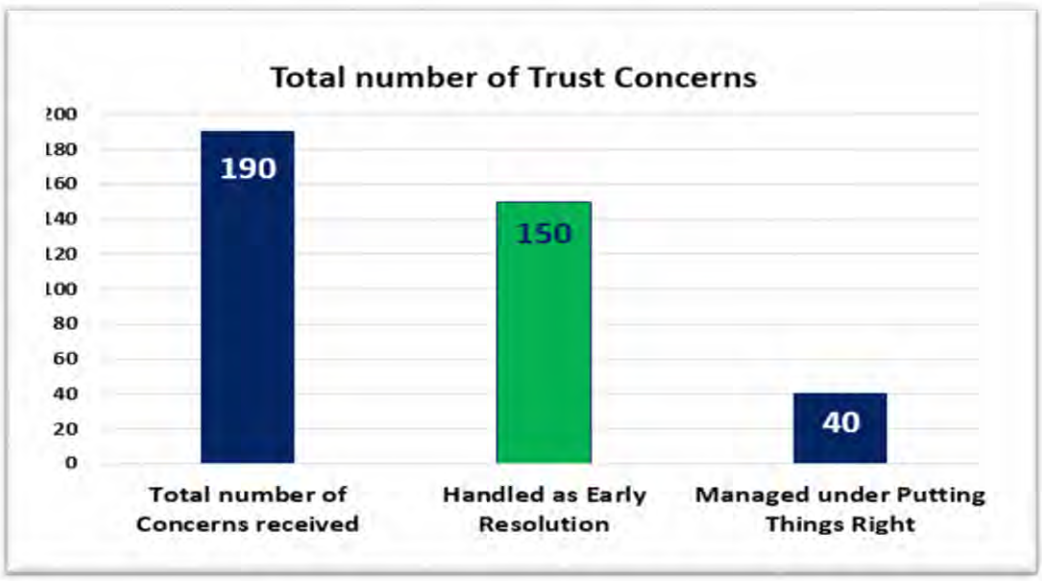
Raising a concern will be easy and information will be widely accessible.
Put the complainant at the centre of the process and provide support for individual requirements.
Listen to concerns and treat everyone with dignity and respect.

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

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

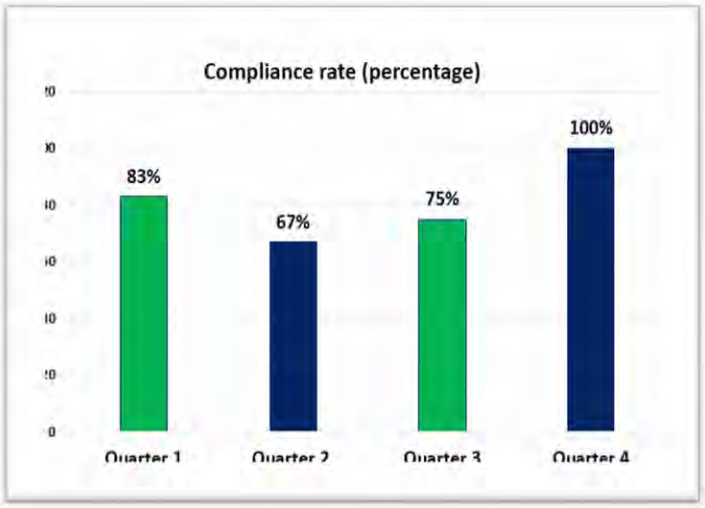
Where it has not been possible to resolve a complaint within this timescale, or where an in-depth investigation is required, the complaint is managed under the Putting Things Right Regulations.

Complaints received between the 1st April 2021 and the 31st March 2022:



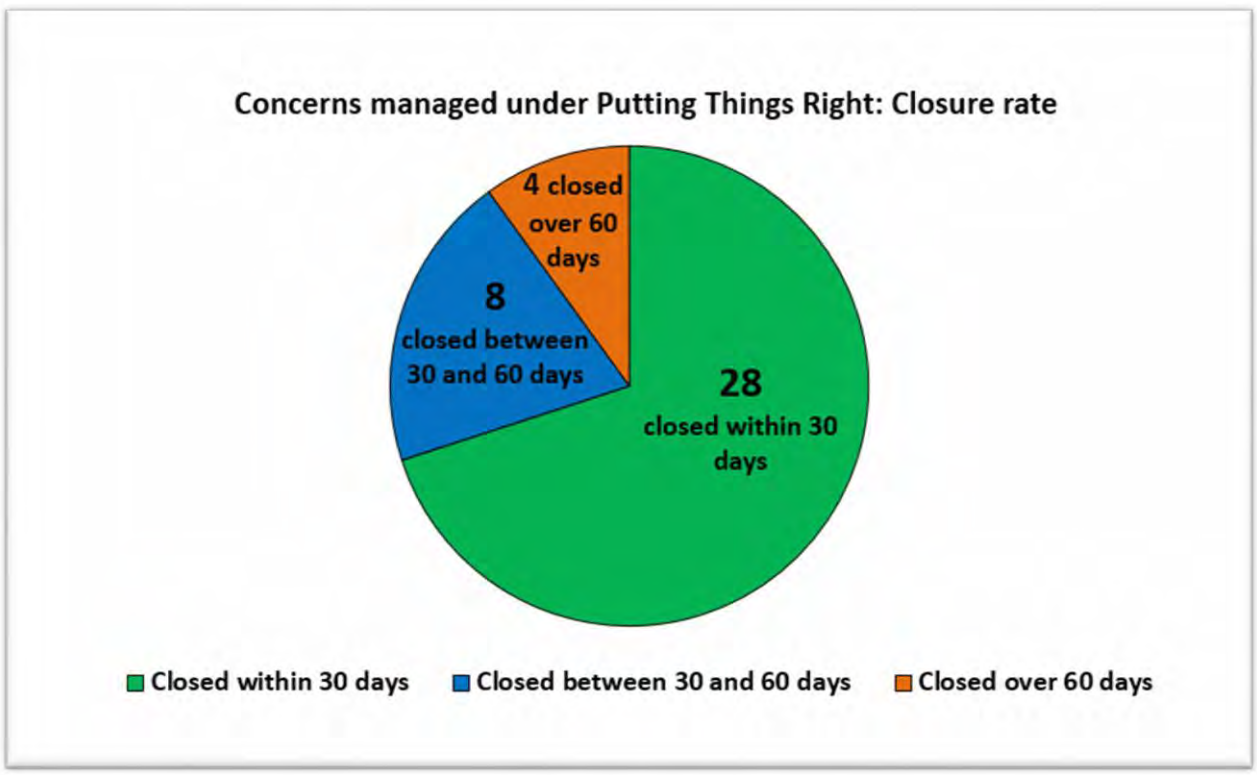
Where a complaint is investigated under Putting Things Right, an acknowledgment should be provided to the complainant within 2 working days of the concern being raised. Welsh Government requires Health Bodies within Wales to thoroughly investigate all complaints received and, that 75% of all complaints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

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



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

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



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

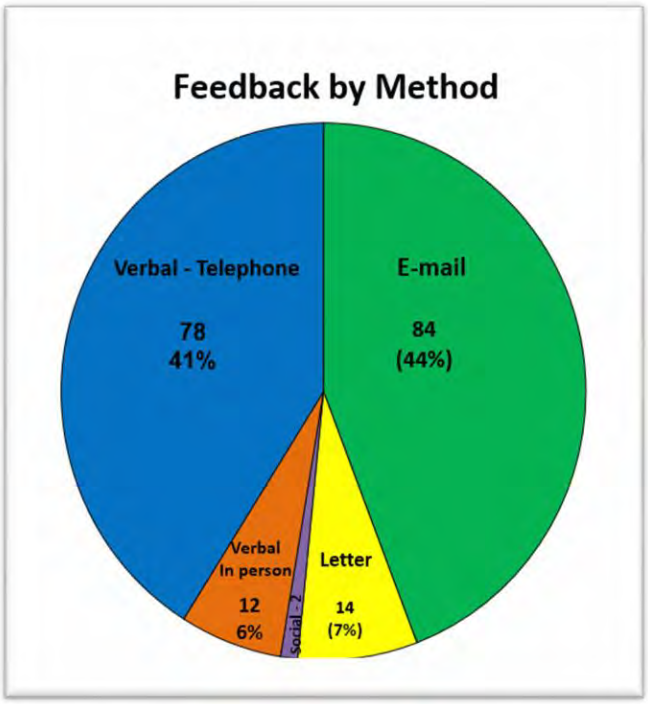
At this time there were significant changes to the complaints management personnel and process, with several complex complaints spanning a number of Health Boards.

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

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

Method of Communication

It is evident that Email communication remains the preferred method of contacting the Velindre University NHS Trust, with **44%** of complaints being received in this way.



The Trust has observed a rise in the number of concerns received via telephone during the year, highlighting a switch in the preferred contact method being used during quarter 4 2021/22. Throughout the Covid pandemic, the adopted method for reporting Concerns has mainly been via email

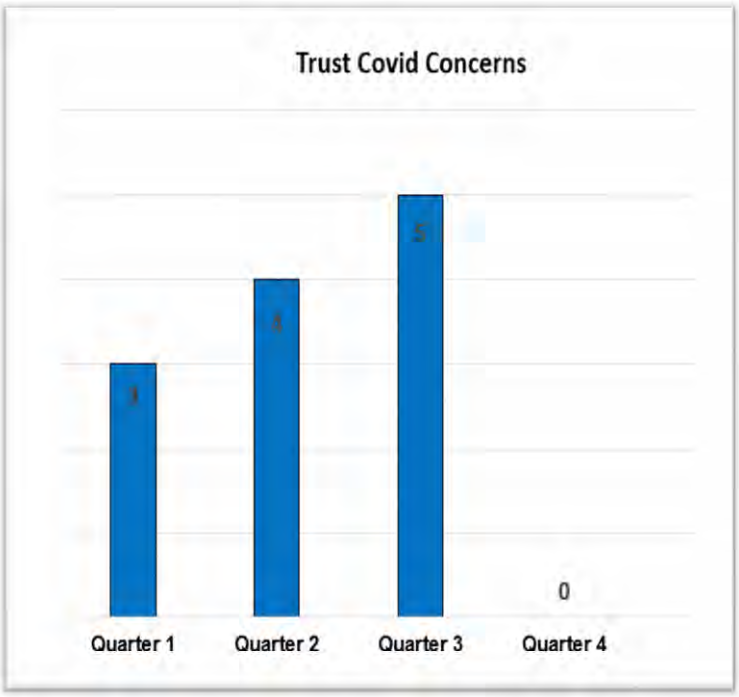
Re-opened Complaints

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

Complaints relating to the Welsh Language

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

Covid related complaints



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

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

Grading Concerns

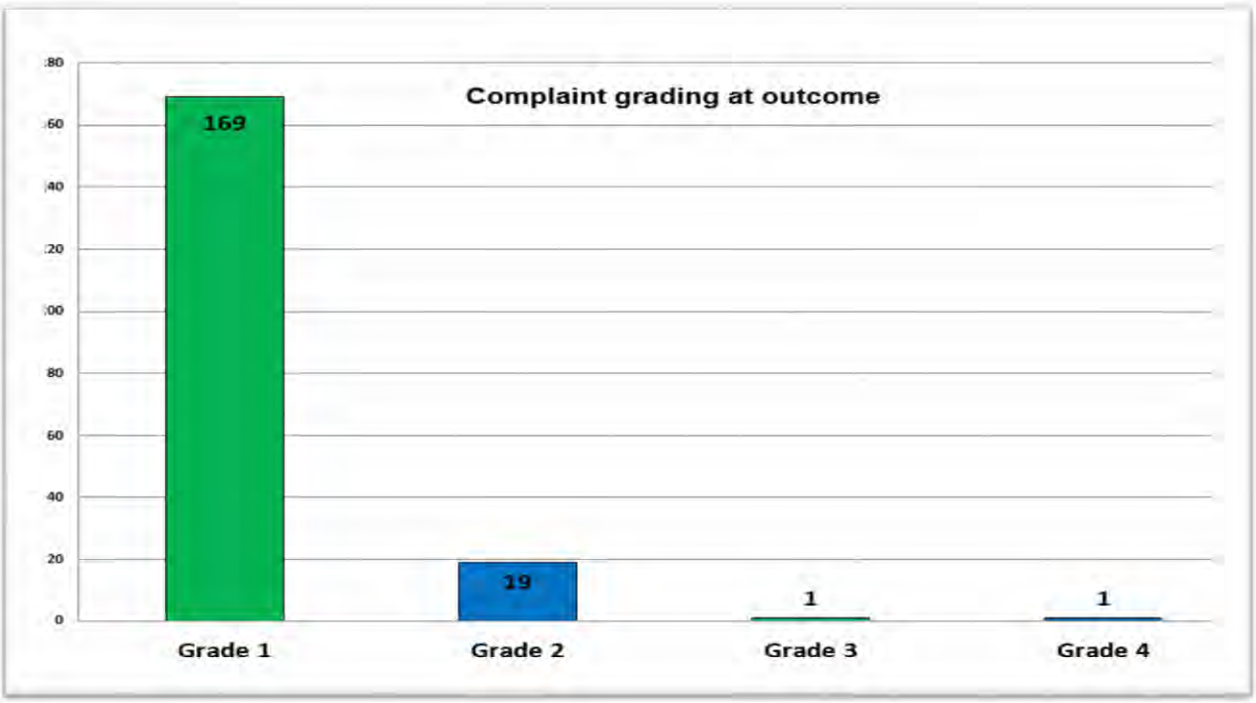
All concerns graded level 2 – 5 undergo an assessment of harm to determine whether the Trust has breached its duty of care, whether a qualifying liability in tort exists and to ensure that the appropriate level of investigation is undertaken. Relevant cases are discussed at the Trust's Putting Things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

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

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

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

Wherever possible, all Trust concerns graded as level 1 should be resolved as an Early Resolution. During the year **169** concerns were graded as level 1 and **150** of those concerns were resolved as an Early Resolution, suggesting **89%** of grade 1 concerns were resolved within 2 working days via the Early Resolution process.



During 2021/22 the Velindre University NHS Trust Handling Concerns and Incident Policies underwent a robust review and were amended to reflect current Trust procedures and practices when handling Concerns. Both the Concerns Handling and Incident Policies were approved at the March 2022 Quality, Safety and Performance Committee and form the basis for Trust conduct when handling all types of concerns raised.

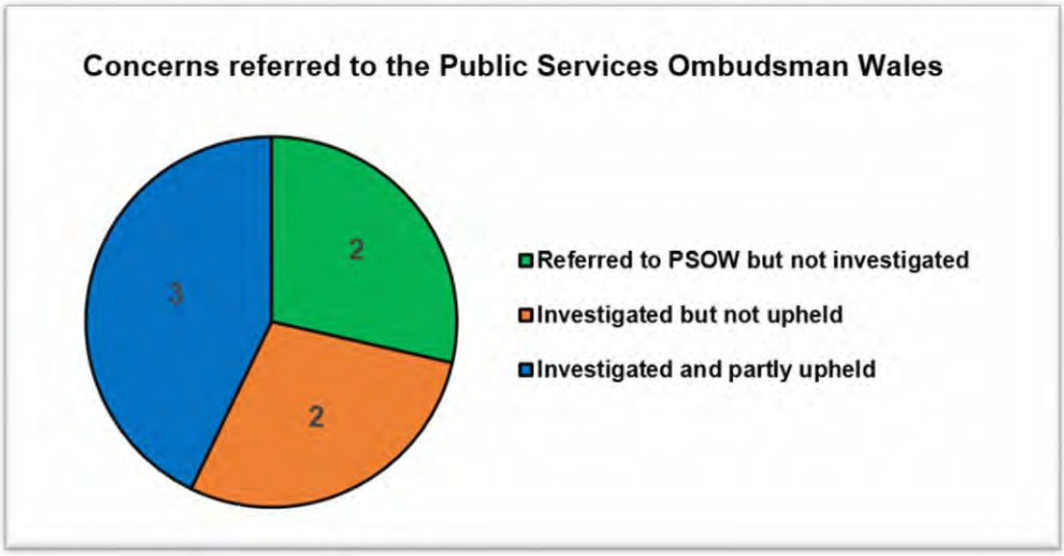
Provide an apology where required and confirm what has been done to Put Things Right
Redress will be considered where appropriate
Offer concerns meetings and details of the Public Services Ombudsman Wales

5. Public Service Ombudsman for Wales

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

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

Concerns referred to the Public Services Ombudsman Wales



6. Redress

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

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

The Redress remedies are as follows:

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

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

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

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

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

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

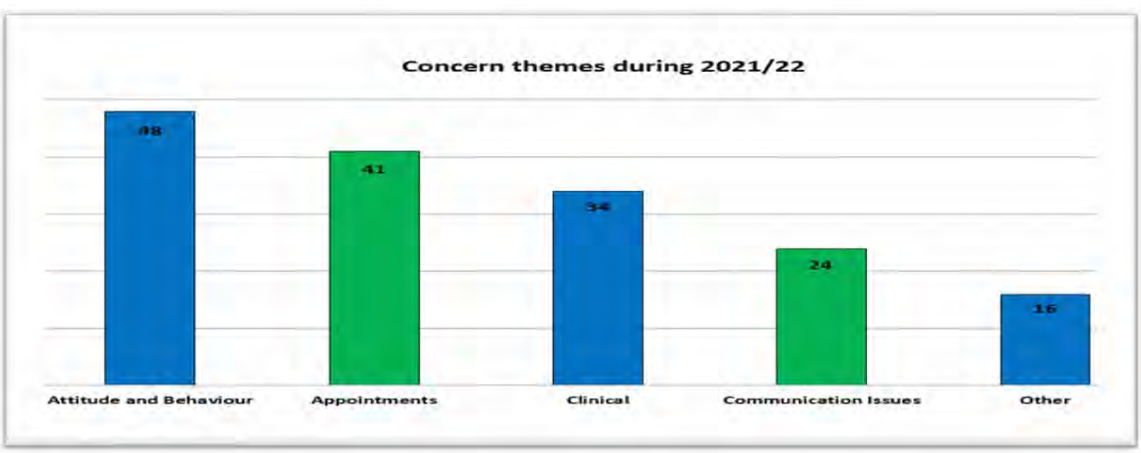
Learning from complaints

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

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

Concern Themes

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



Attitude and behaviour

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

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

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

Appointments

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

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

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

Clinical treatment

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

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

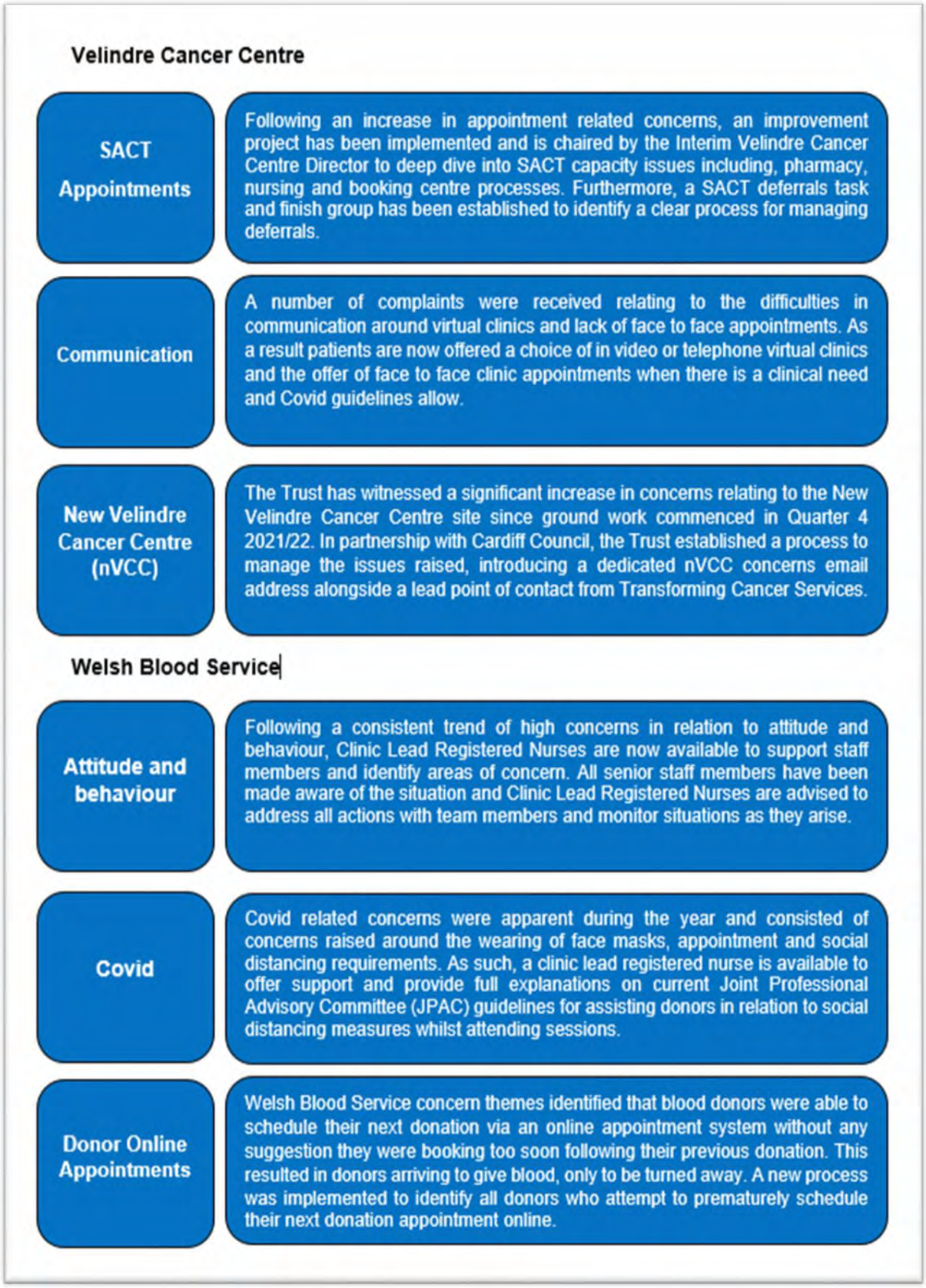
Trust complaint process - Improvement highlights

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

Learning from concerns raised

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

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



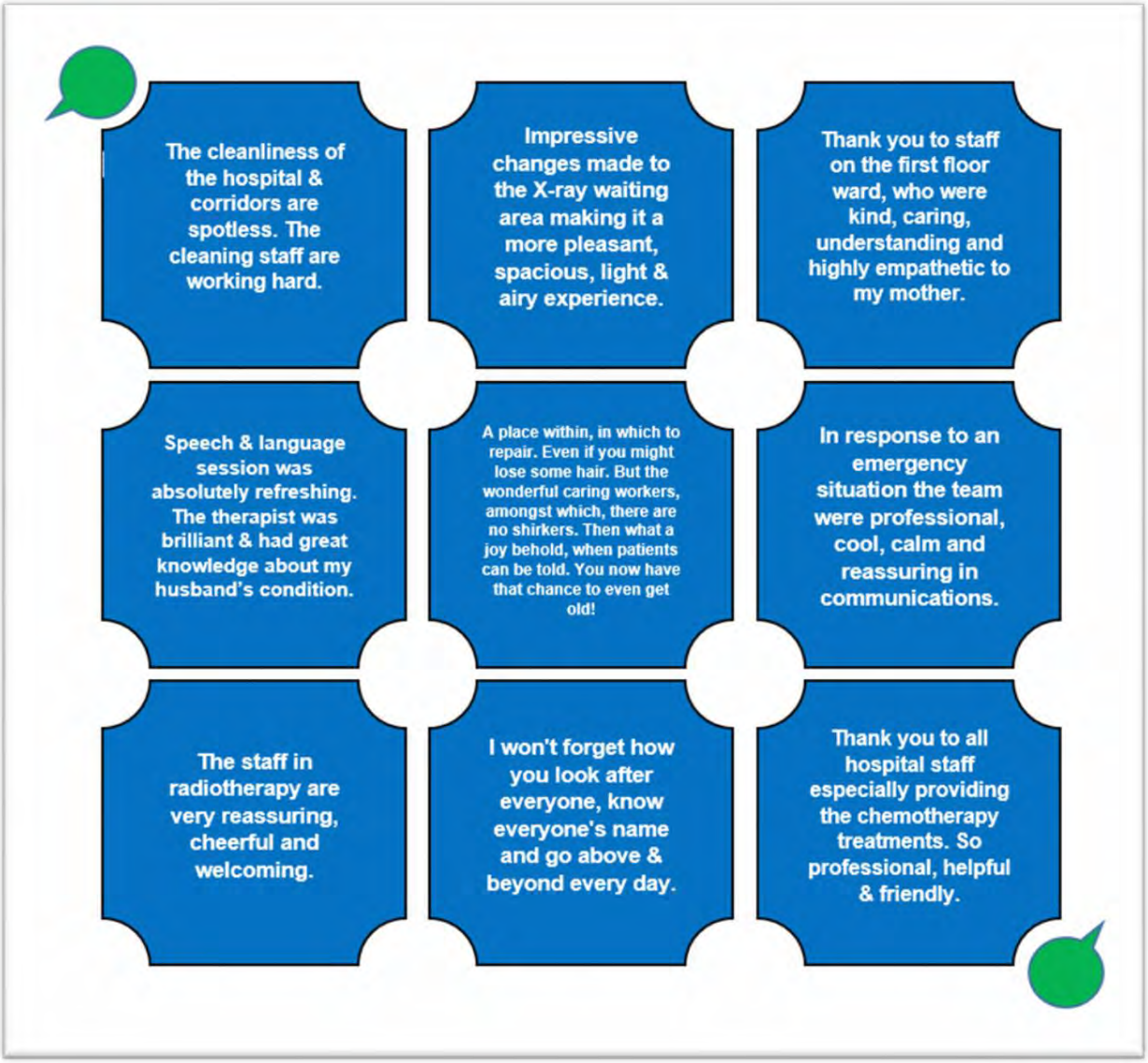
Compliments

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

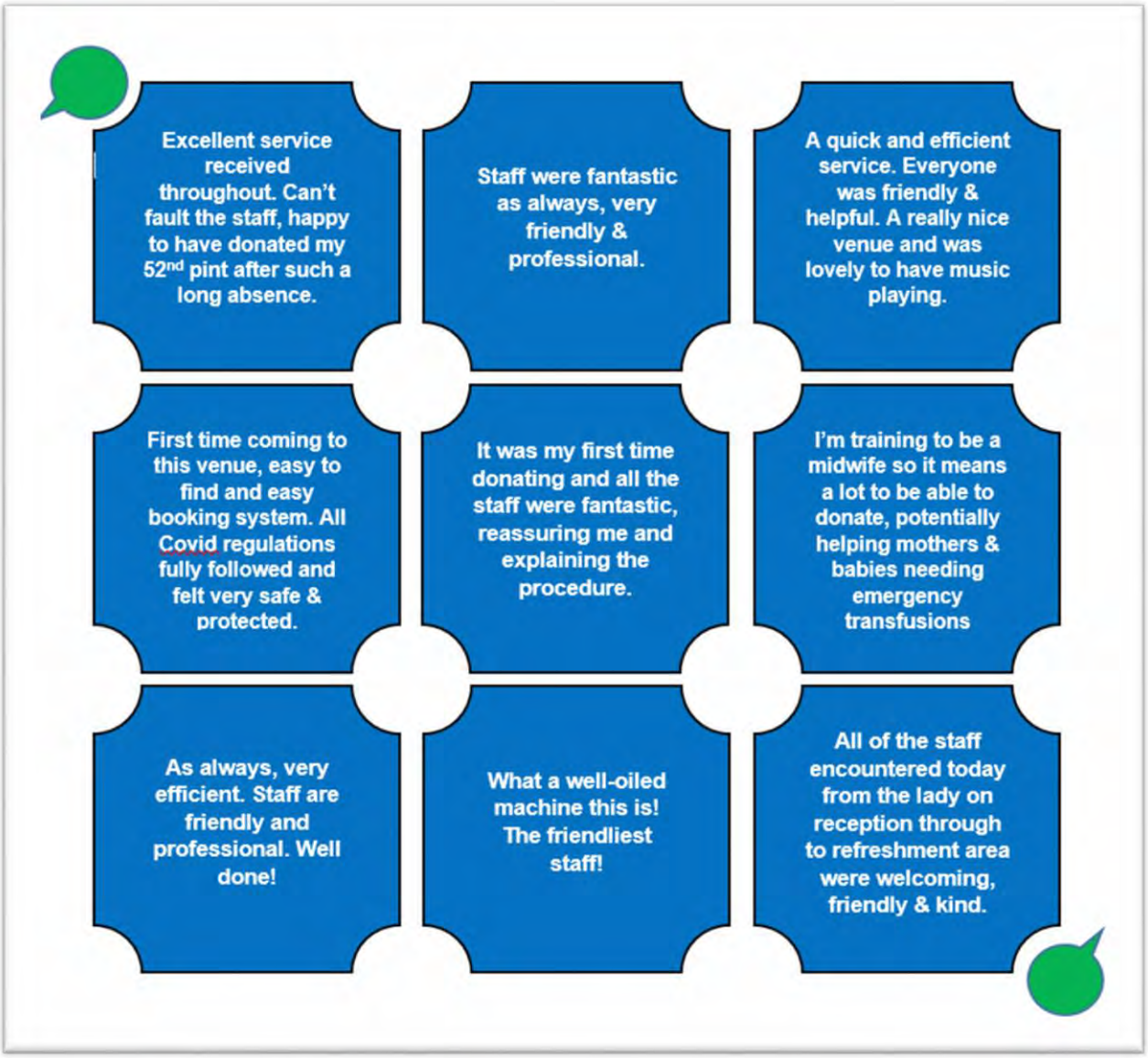
We appreciate the time taken by patients, donors, relatives and carers to let us know how good their experience of our service and care has been. The individuals and teams involved in the care and service provided are pleased and encouraged by such feedback.

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

Velindre Cancer Centre



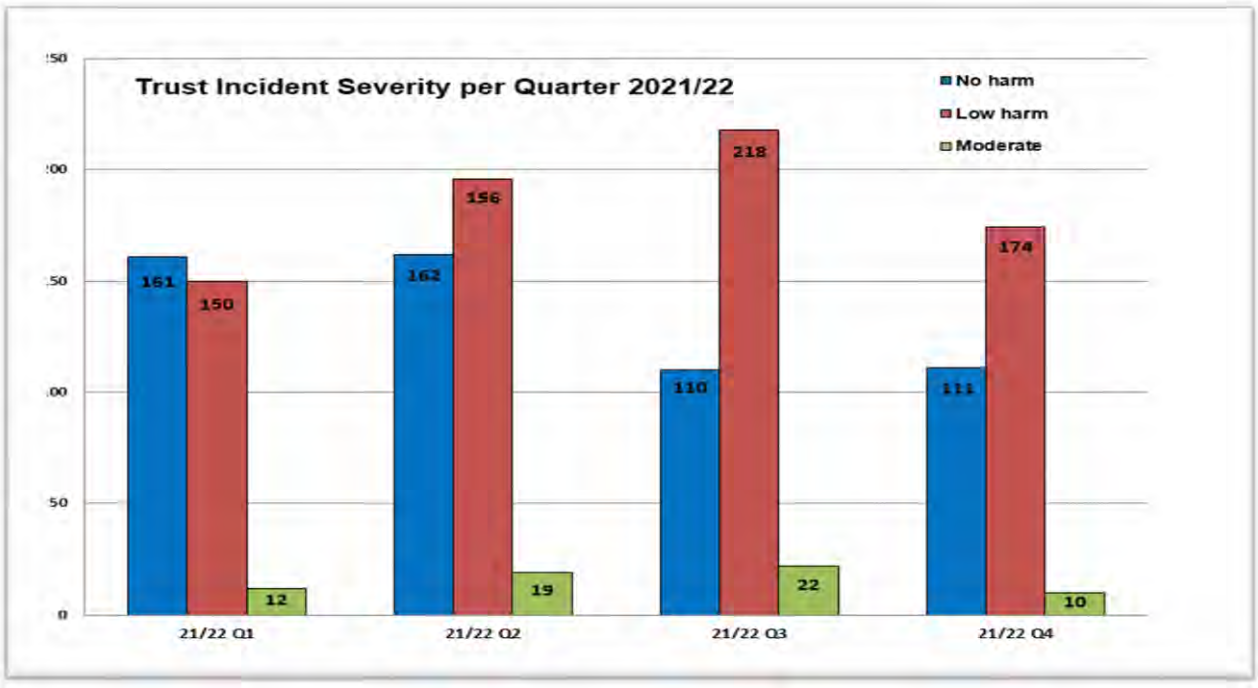
Welsh Blood Service



6. Incidents

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

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



A number of incidents recorded within the Once for Wales system did not determine a severity rating at the point the incident was raised. This has been recognised as a Once for Wales Incident training need throughout the Trust and will form part of the extended training programme that is being rolled out for staff members in order to strengthen our ability to objectively and comprehensively raise, investigate and learn from all incidents.

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

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

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

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

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

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

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

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

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

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

7. Looking Forward to 2022/2023

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

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

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

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

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

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

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

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

8. Further Information

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

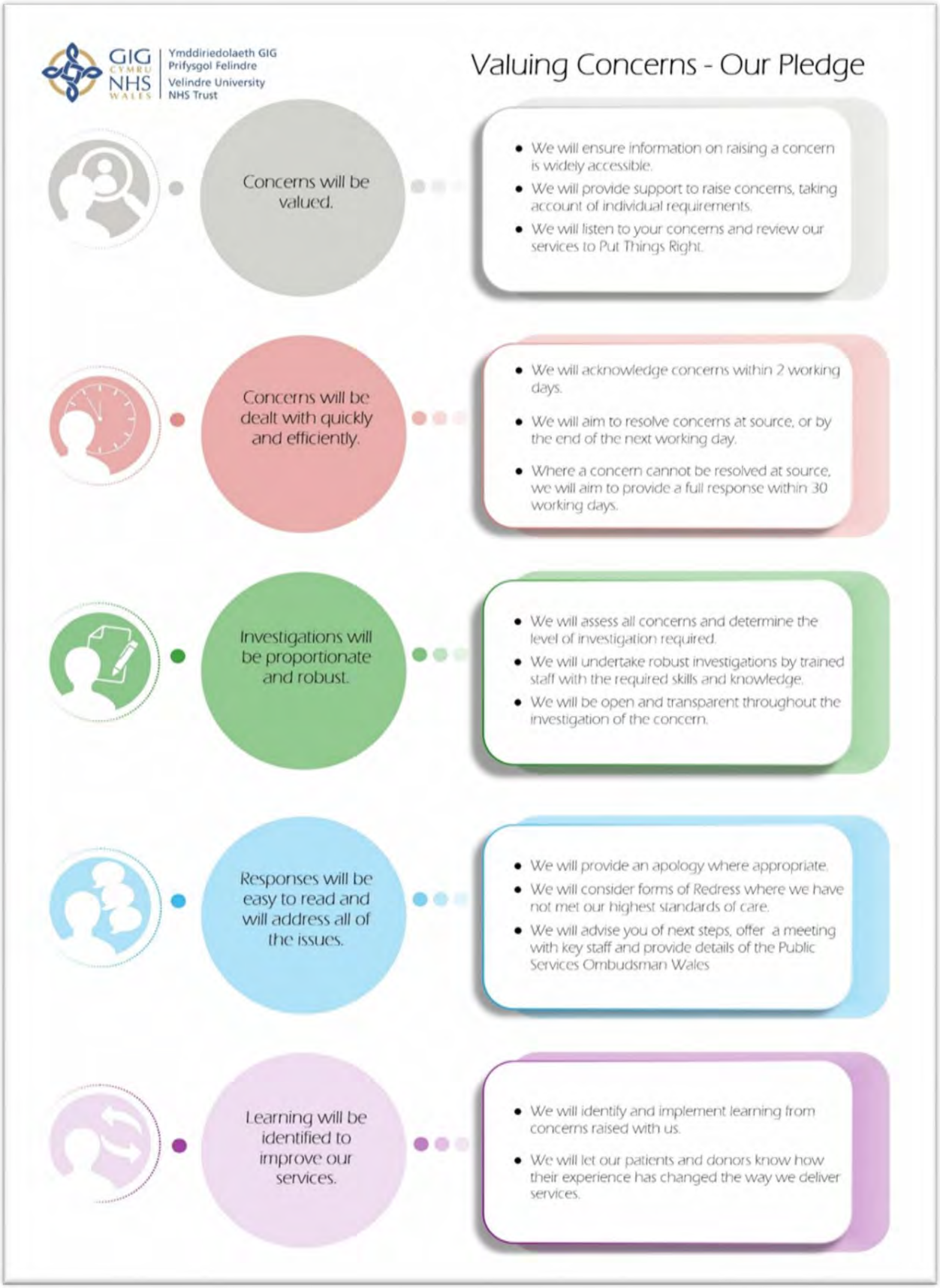
Appendix 1: Grading Framework

GRADING FRAMEWORK FOR DEALING WITH ALL CONCERNS

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

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

Appendix 2: Concerns Pledges



QUALITY, SAFETY & PERFORMANCE COMMITTEE
Velindre University NHS Trust Patient and Donor Experience 2021/2022 Annual Report

DATE OF MEETING	14th July 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Non-applicable

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

REPORT PURPOSE	FOR APPROVAL

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

ACRONYMS	
N/A	

1. SITUATION

The 2021-2022 Velindre University NHS Trust Patient and Donor Experience Annual Report reflects the period between the 1st April 2021 and the 31st March 2022 and is provided to the Quality, Safety & Performance Committee for **DISCUSSION** and **ENDORSEMENT** prior to being submitted to the Trust Board and publication on the Trust's website following Welsh language translation.

2. BACKGROUND

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

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

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

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

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

3.1 Patient and Donor Highlights

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

At Velindre Cancer Centre:

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

At the Welsh Blood Service:

- 10,438 (80.4%) of donors rated their care as 6 out of 6 (i.e.excellent).
- Total appointments booked from calls: 17,553 (13,751 inbound appointments & 3,802 outbound appointments).

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

3.2 IMPACT ASSESSMENT

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

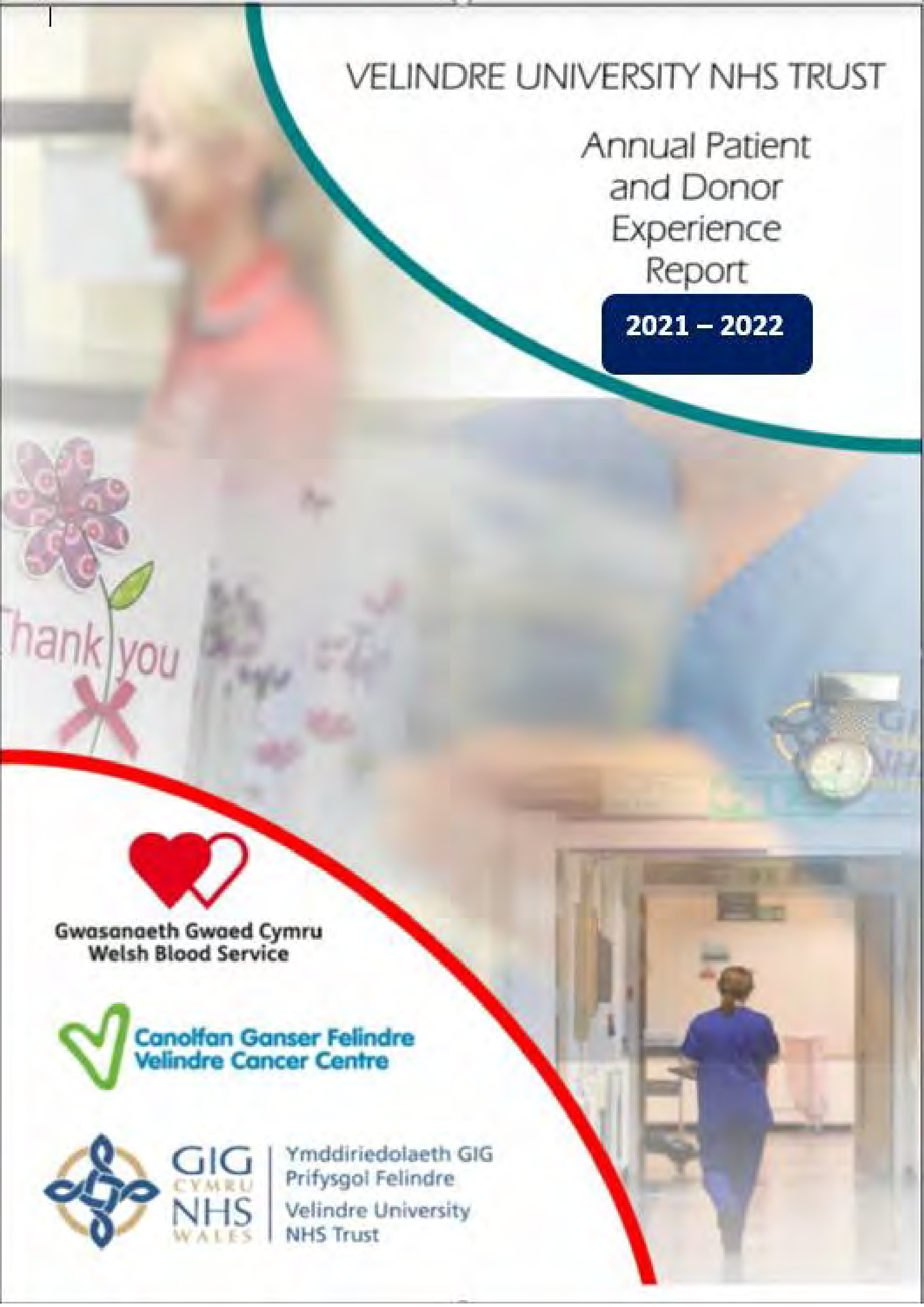
4. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **DISCUSS** and **ENDORSE** the 2021-2022 Trust Patient and Donor Experience Annual Report prior to submission to the Trust Board for approval and publication on the Trust's website following Welsh language translation.

VELINDRE UNIVERSITY NHS TRUST

Annual Patient and Donor Experience Report

2021 – 2022



Gwasanaeth Gwaed Cymru
Welsh Blood Service

Canolfan Ganser Felindre
Velindre Cancer Centre

GIG CYMRU NHS WALES

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

CONTENTS

1.0 EXECUTIVE SUMMARY

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

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

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

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

2.0 INTRODUCTION

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

Welsh Blood Service
Gwasanaeth Gwaed Cymru

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

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

Canolfan Ganser Felindre
Velindre Cancer Centre

2021 – 2022 Context

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

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

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

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

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

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

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

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

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

3.0 CAPTURING PATIENT AND DONOR FEEDBACK

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

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

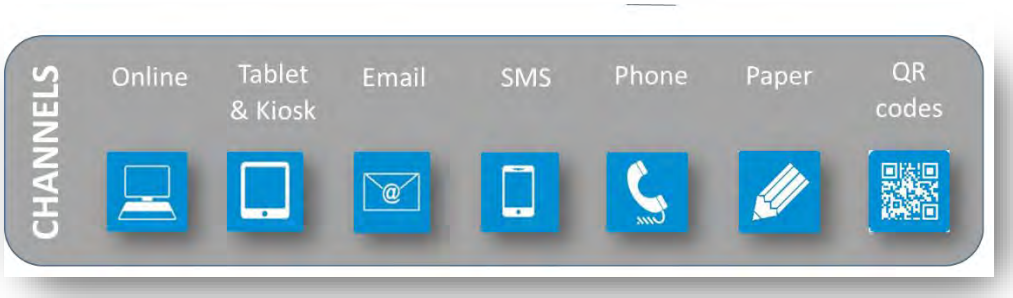
- Online digital surveys linked to social media messaging
- Social media channels were a valuable source of feedback including comments, stories and check-ins
- Provision of a snapshot survey to enable a faster way for patients to share their thoughts, containing just three of the core validated questions
- 'How Did We Do' business cards that patients could pick up and take away as a reminder about how and where to complete the online surveys
- Quickly identifying issues and concerns raised to enable learning to be captured and changes to be made

3.2 Welsh Blood Service: Donor feedback mechanisms in place:

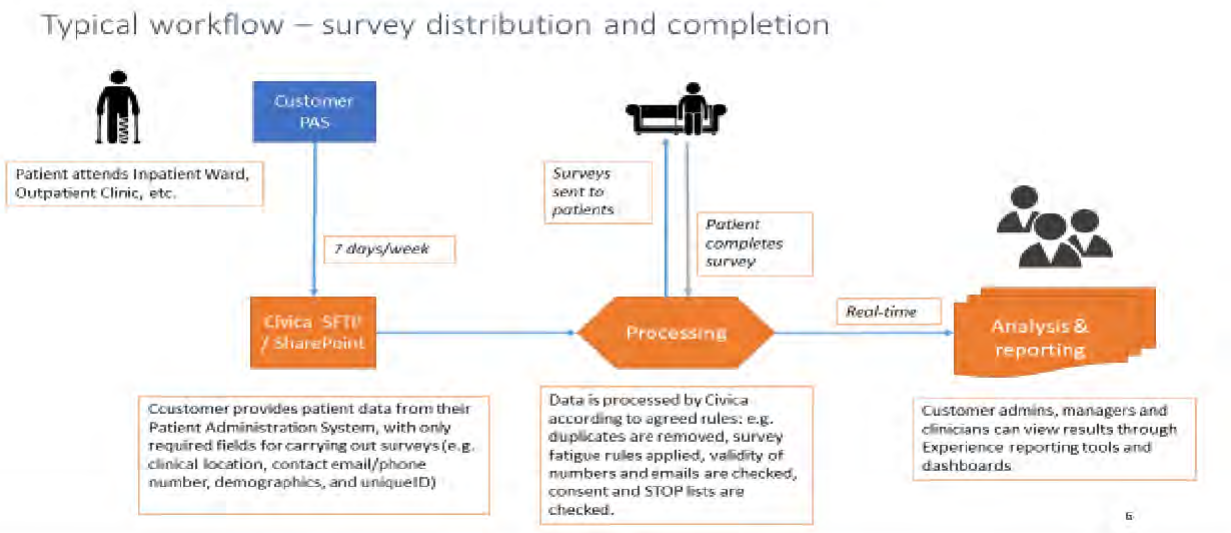
Feedback	Format	Detail
On session	Paper feedback forms	At each donation session, sealable English and Welsh paper feedback forms are made available. Every response is read by the Donor Experience Manager and escalated if necessary.
On session and post-donation	Donor adverse events	Occasionally donors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

3.3 Recent and Future developments in strengthening Feedback Mechanisms

Our key focus is to ensure that patients and donors can provide feedback in an easy, simple and straightforward way. The implementation of the new feedback system (called CIVICA) has provided patients and donors with a wider choice of channels to use to provide their feedback. This will include: including online, paper, phone, SMS and email.



The diagram below demonstrates how the CIVICA system can be used in order that 'real time' insights into patient and donor feedback can be received and reviewed. This will enable rapid actions to be taken to address any areas of concern.

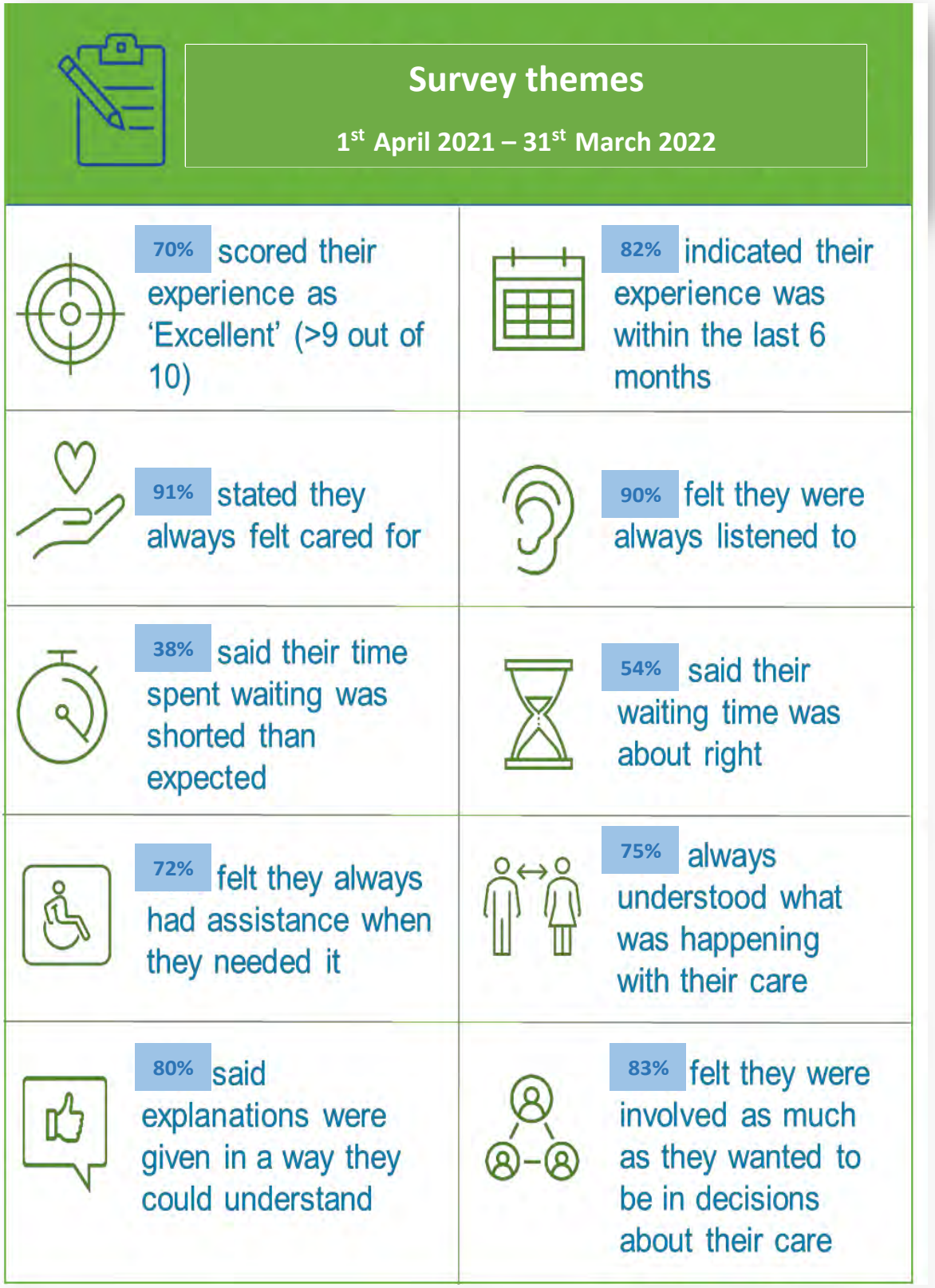


CIVICA has been further rolled out across the Cancer during 2021 – 2022.

4.0 VELINDRE CANCER CENTRE PATIENT SATISFACTION RESULTS

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

4.1 Patient and Carer Satisfaction Results



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

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

1. Did you feel well cared for?

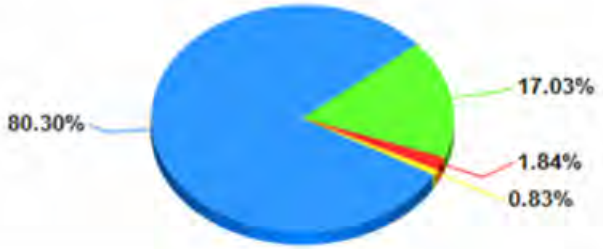
Available Answers	Responses	Score (%)
Always	544	90.82%
Usually	49	8.18%
Sometimes	5	0.83%
Never	1	0.17%
Total	**599**	**100%**

2. Did you feel that you were listened to?

Available Answers	Responses	Score (%)
Always	537	89.65%
Usually	54	9.02%
Sometimes	7	1.17%
Never	1	0.17%
Total	**599**	**100%**

3. Were things explained to you in a way that you could understand?

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

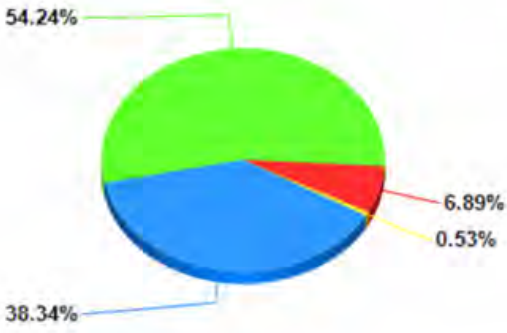


4. Were you able to speak Welsh to staff if you needed to?

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

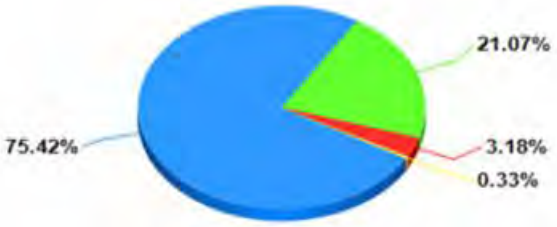
5. From the time you realised you needed our service, how long did you wait for an appointment?

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



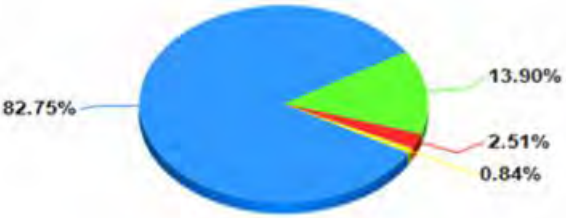
6. Did you feel you understood what was happening in your care?

Available Answers	Responses	Score (%)
Always	451	75.42%
Usually	126	21.07%
Sometimes	19	3.18%
Never	2	0.33%
Total	598	100%



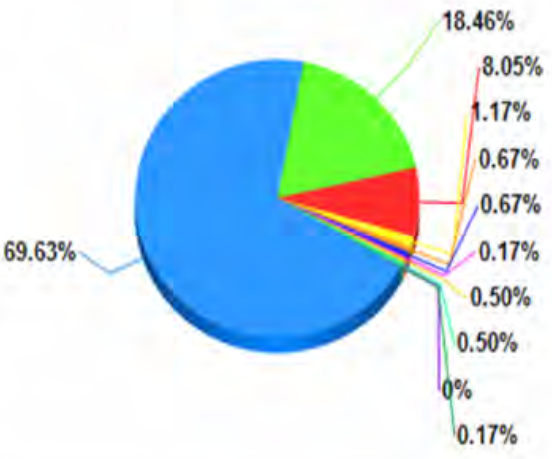
7. Were you involved as much as you wanted to be in decisions about your care?

Available Answers	Responses	Score (%)
Always	494	82.75%
Usually	83	13.90%
Sometimes	15	2.51%
Never	5	0.84%
Total	597	100%



8. Using a scale of 0 to 10 where 0 is very bad and 10 is excellent, how would you rate 'your overall experience?

Available Answers	Responses	Score (%)
10	415	69.63%
9	110	18.46%
8	48	8.05%
7	7	1.17%
6	4	0.67%
5	4	0.67%
4	1	0.17%
3	3	0.50%
2	3	0.50%
1	0	0.00%
0	1	0.17%
Total	596	100%



The results from the satisfaction surveys were generally positive and we continue to undertake both face to face and virtual clinics for some patients. We will continue to use the survey results to improve the experience of our patients who attend them.

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

4.2 Velindre Cancer Centre – You said, we did

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

4.3 Positive comments received from Patients and their Carers

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

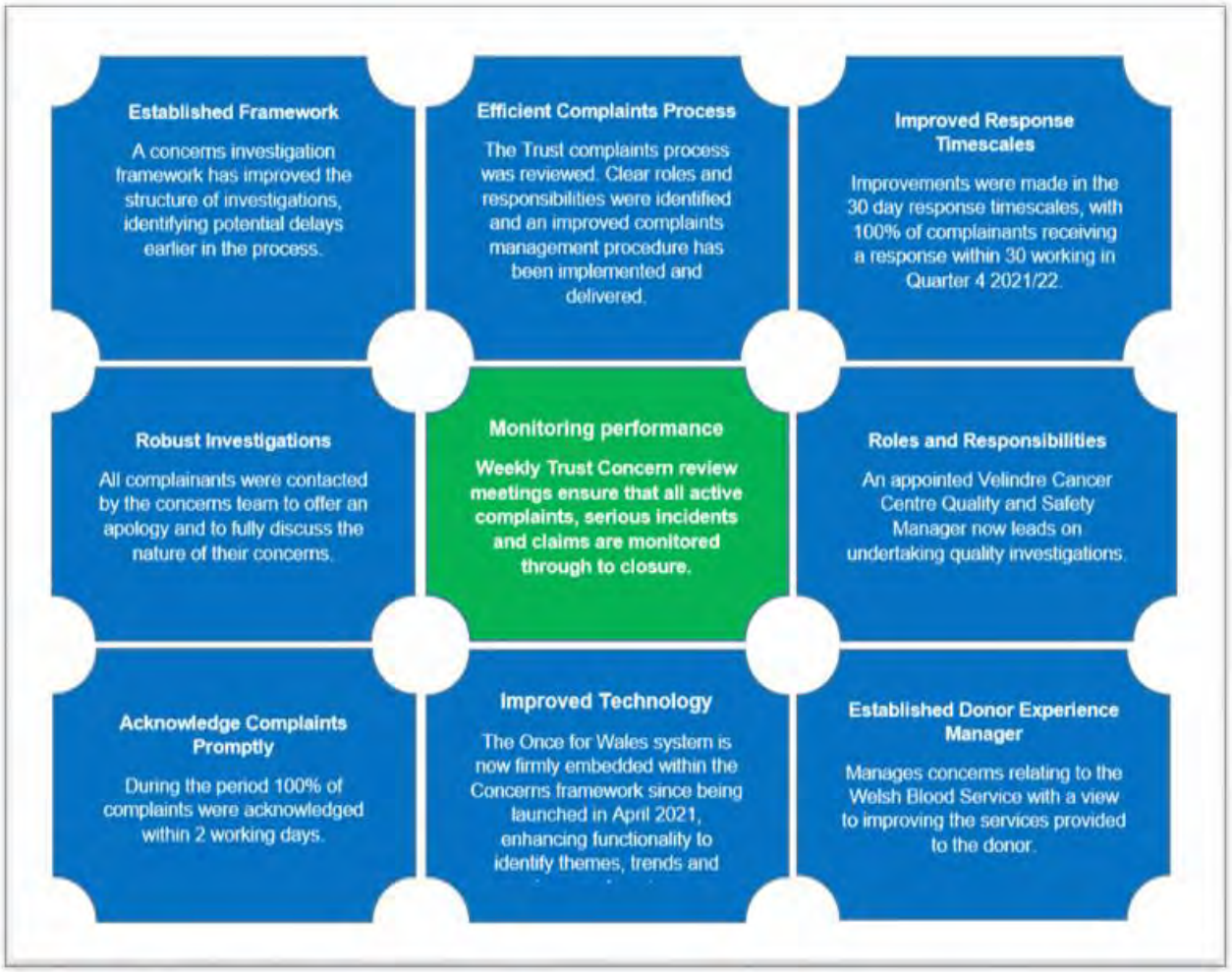
During 2021 – 2022, the qualitative feedback was mainly very positive, and many supportive messages were received from our patients during this time. However, a number of formal concerns were also raised around communication, staff attitude and behavior, appointments and treatment.

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

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

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

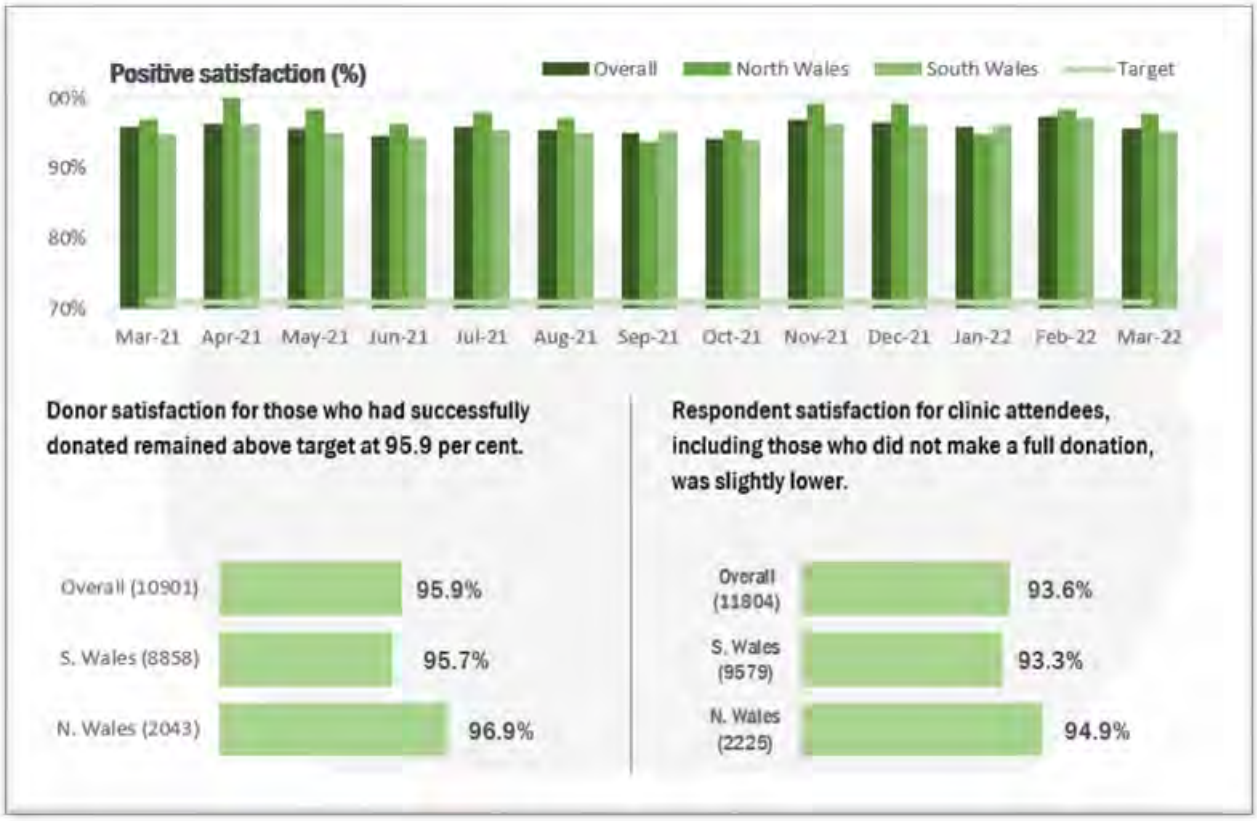
The below detail displays areas of process improvement following complaint themes and trends identified during the year:



5.0 WELSH BLOOD SERVICE DONOR SATISFACTION RESULTS

5.1 Donor Satisfaction Results

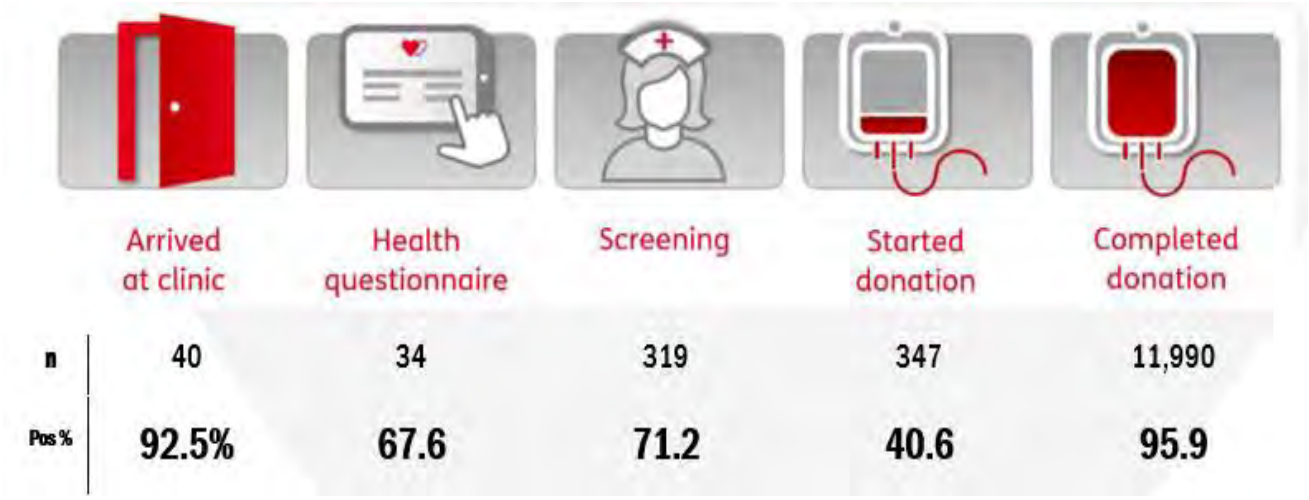
The Welsh Blood Service continues to actively seek and obtain Donor feedback. As part of our questionnaire, we ask respondents questions about the service we provide. The chart below shows National satisfaction scores and the North and South Wales regions' scores over the previous 13 months. The data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



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

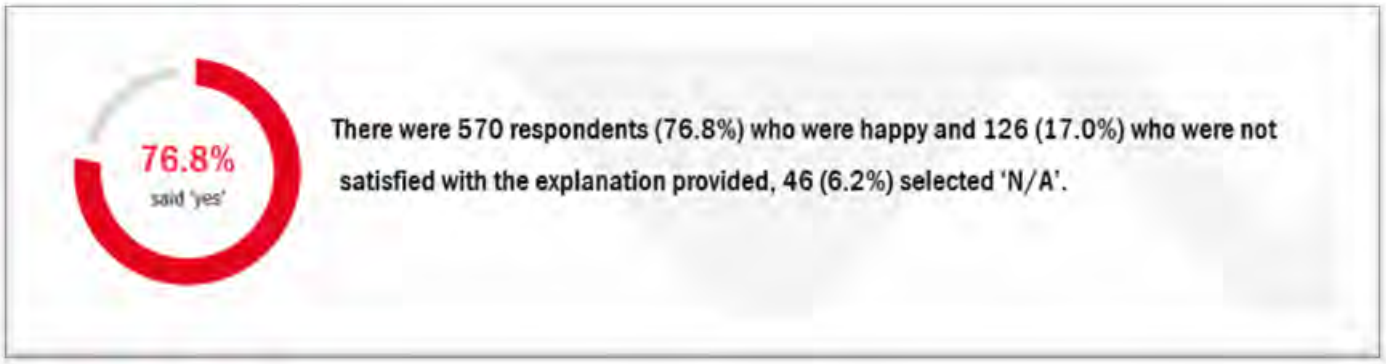
Qualitative response
I am always extremely impressed by the kindness and professionalism of the blood transfusion staff. Over all these years of donating I have never met a miserable one. The staff on the telephone ar3 also extremely pleasant and helpful. I prefer the mobile units that go to the supermarkets but understand they cannot be used at the moment. I would like to return to using the mobile units once we are able. Thank you for all that you do and the way that you do it.
Team are always amazing and could give some fancy restaurants some tips on service excellence. I've been looked after by trainees on my past two visits who were a credit to you
Although I am now retired and will be 74 this year I see no reason why as long as I have good health I can't continue to donate. I think it is very important to donate and only wish more people did it - as I said previously my husband's life was saved by the generosity of people and I always hope that someone will benefit from my contribution too. I have to say that the nursing staff are always pleasant and caring and I was particularly impressed on my last visit with the nurse who attended to me. She had changed jobs as due to the covid outbreak her previous job wasn't viable and she is a credit to your organisation.
It has been a long time since my last donation and I'm astounded by the service improvement including tablets instead of forms. Very efficient. Staff were so polite, encouraging and helpful. Would deffo start donating more frequently.
Whenever I leave the donation centre I am impressed at how smooth and easy the process is , how well run it is and how friendly and professional the staff are .
My son gave for the first time aged 17 and the staff were amazing with him and made him feel valued.
Thank you so much for being so kind to me. I was so disappointed not to be able to donate but I am really thankful for everyone being so kind. I hope I can donate next year.
I think you have coped magnificently in these difficult times, thank you

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



	Arrived at clinic	Health questionnaire	Screening	Started donation	Completed donation
n	40	34	319	347	11,990
Pos %	92.5%	67.6	71.2	40.6	95.9

On certain occasions, and for a number of reasons, Donors may not actually progress to being able to donate blood when they attend the Donation clinic. Each respondent who had not successfully donated was asked if they were happy with the explanation that they received regarding why they were unable to proceed to donate blood. The results are shown overleaf:



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

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

5.2 Venues

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

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

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

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

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

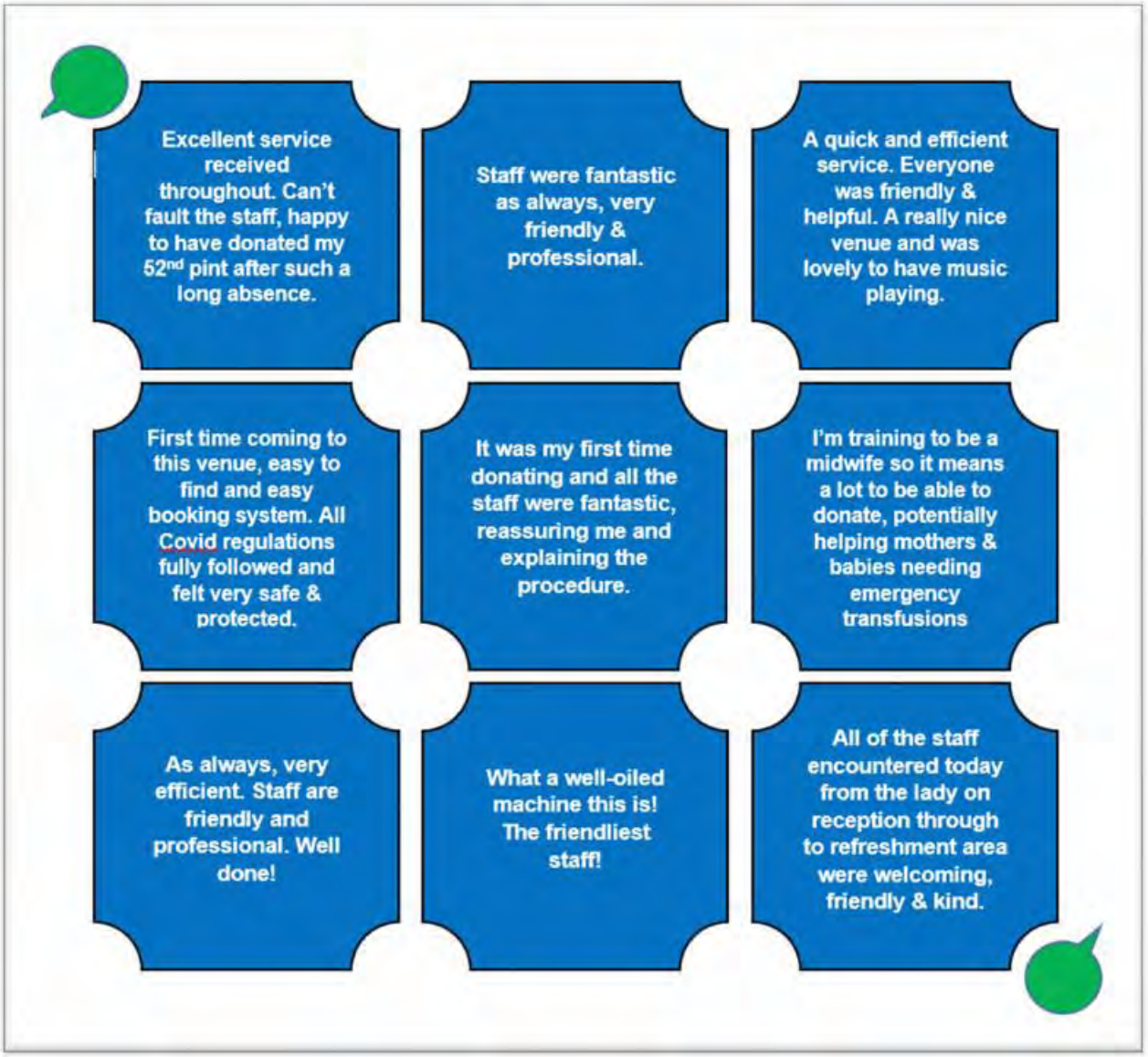
	n	1	2	3	4	5	6	N/A	Mean
Post	13,021	353	171	384	646	957	4,431	6,079	4.94
SMS	13,752	231	148	342	686	1,523	9,388	1,434	5.59
Telephone	12,837	284	132	295	468	704	3,340	7,614	5.07
Overall Contact Centre Experience	**11,617**	**32**	**24**	**103**	**268**	**1,271**	**8,738**	**1,181**	**5.77**

5.3 Welsh Blood Service - You said, We did

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

5.4 Comments received from our Donors

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



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

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

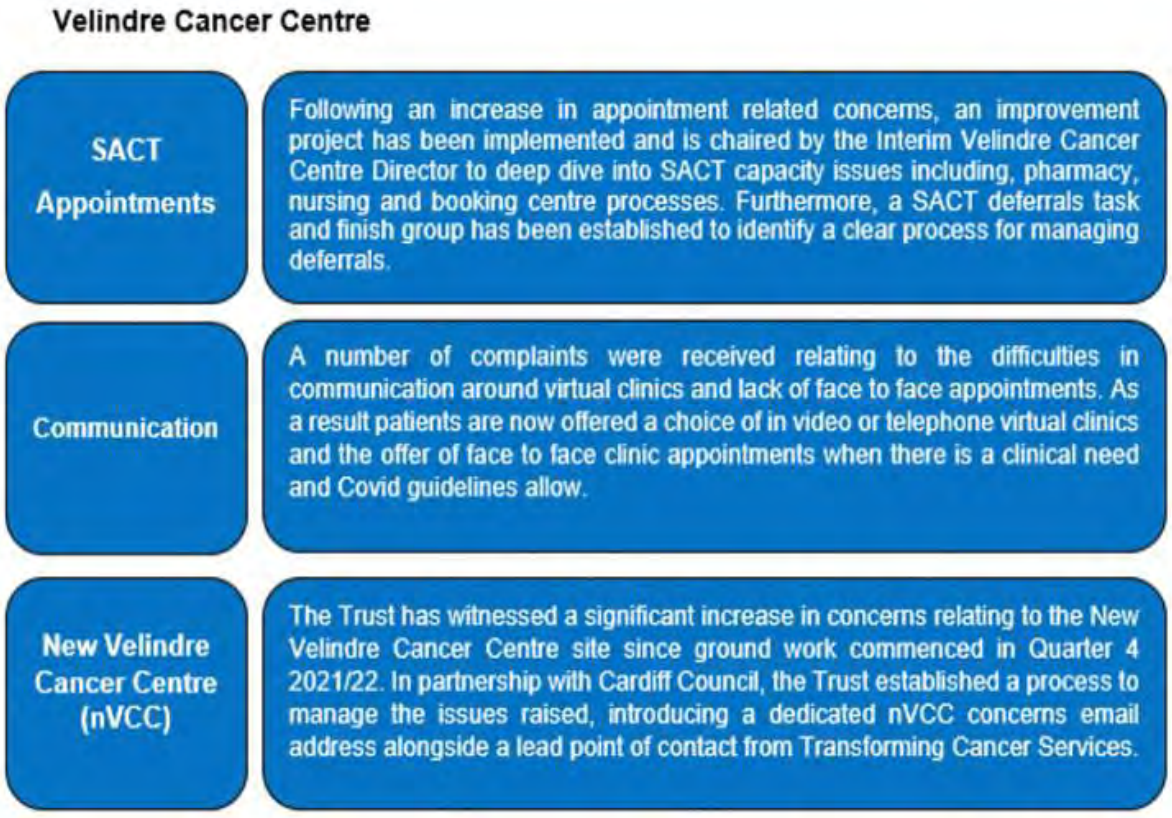
We will continue to actively seek Donor feedback over the next year.

6.0 LEARNING FROM FEEDBACK RECEIVED FROM DONORS AND PATIENTS

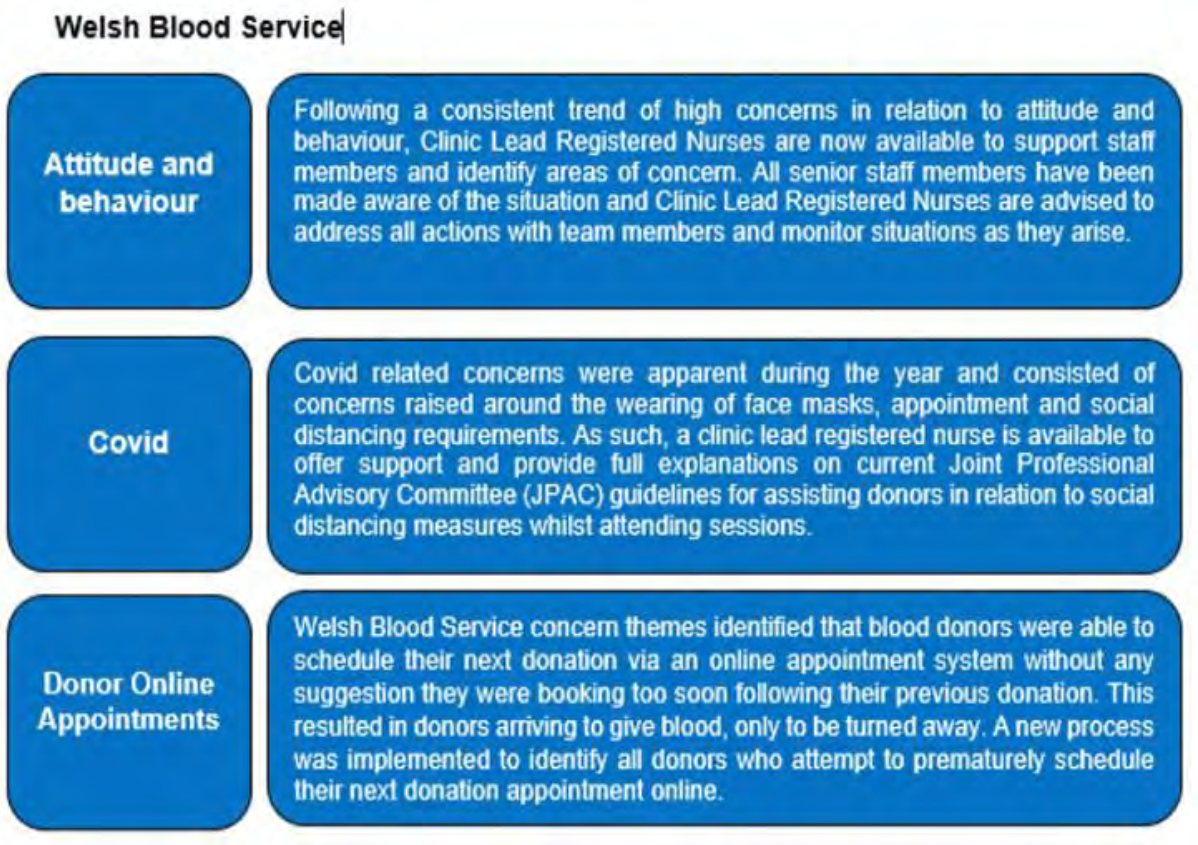
Patient and donor feedback is vitally important to us. It is only through their feedback that we can make meaningful improvements to our services.

6.1 Velindre Cancer Centre Learning

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



6.2 Welsh Blood Service Learning



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

7.0 Patient and Donor Engagement

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

7.1 Patient engagement at Velindre Cancer Centre

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

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

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

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

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

7.2 Donor engagement at the Welsh Blood Service

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

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

Donor Contact Centre

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

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

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

8.0 COMMUNITY PARTNERSHIPS

8.1 Community Health Council

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

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

8.2 Community Partnerships within the Welsh Blood Service

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

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

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

9.0 PRIORITIES FOR PATIENT & DONOR EXPERIENCE IN 2022-23

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

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

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

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

10.0 CONCLUSION

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

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

QUALITY, SAFETY & PERFORMANCE COMMITTEE

INFECTION PREVENTION & CONTROL MANAGEMENT GROUP HIGHLIGHT REPORT

DATE OF MEETING	14th July 2022
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	N/A
PREPARED BY	Muhammad Yaseen, Head of Infection Prevention and Control
PRESENTED BY	Muhammad Yaseen, Head of Infection Prevention and Control & Nigel Downes, Deputy Director Nursing, AHP & Health Science
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science
REPORT PURPOSE	**ASSURANCE**

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

COMMITTEE OR GROUP	DATE	OUTCOME
INFECTION PREVENTION & CONTROL MANAGEMENT GROUP	• 19/05/2022	Areas for inclusion agreed
EXECUTIVE MANAGEMENT BOARD	• 30/05/2022	Noted

ACRONYMS

AMR	Antimicrobial Resistance
HCAI	Healthcare Associated Infections
IPC	Infection Prevention & Control
IPCMG	Infection Prevention & Control Management Group
IPCT	Infection Prevention & Control team
RA	Risk Assessment
(RD&I)	Research Development and Innovation
VCC	Velindre Cancer Centre
VCCSMT	Velindre Cancer Centre Senior Management Team
WBS	Welsh Blood Service
WHC	Welsh Health Circular

1. PURPOSE

This paper has been prepared to provide the Quality, Safety & Performance Committee with details of the key issues considered by the Infection Prevention & Control Management Group (IPCMG) during the meeting held on 19th May 2022.

2. BACKGROUND

The Trust's Infection Prevention & Control Management Group is chaired by the Executive Director of Nursing, Allied Health Professionals and Healthcare Science, and is attended by key personnel from both Divisions. The Group considers all national guidelines relating to Infection Prevention and Control (IPC), and all internal compliance and performance data regarding infection prevention and control standards. The Group reports to the Executive Management Board and the Quality, Safety and Performance Committee.

Prior to the COVID-19 Pandemic, the Group met on a quarterly basis, and during the Pandemic, the frequency increased to monthly meetings. The meetings are now being held on a bi-monthly basis. The Divisional Infection Prevention and Control Summit meetings provide additional oversight and assurance.

3. INFECTION PREVENTION & CONTROL MANAGEMENT GROUP HIGHLIGHT REPORT FROM MEETING HELD ON 19th May 2022

The following are the highlights from the Infection Prevention & Control Management Group meeting held on the 19th May 2022:

ESCALATE/ALERT	• **Delayed Action on Provision of Adequate Staff Changing Facilities:** The Group was advised that delays continued in relation to having adequately sized staff changing facilities at Velindre Cancer Centre (VCC). The Group agreed this was a priority and therefore this issue was to be escalated through to the VCC Senior Management Team, with feedback at the next meeting. • **VCC Facilities Staffing challenges:** The VCC Facilities Lead outlined significant staffing challenges affecting the delivery of the core facilities service, including cleaning and catering. This is caused by the significant delay in progressing the 'Tracs' online

	appointment process, which is resulting in successful appointees taking posts elsewhere. Prioritisation is being given to cleaning but this is impacting on patient catering provision.
ADVISE	• **Antimicrobial Stewardship Report:** The Group received a detailed Antimicrobial Stewardship Report, that included an overview of how the Trust is progressing in relation to its Antimicrobial Prescribing Improvement Goals. The following was highlighted: o Monthly audits are undertaken, and results are fed-back to junior members of the medical team. o Robust medication error reporting systems via DATIX are scrutinised by the Medication Safety Group. o Antimicrobial Pharmacist attends regular external meetings and internal meetings to feedback and share good practice and any lessons learnt. o ***Start Smart Then Focus*:** The compliance with Start Smart then Focus principles had been at 100% in all four elements, however in March 2022 the compliance with one of the elements "Indication documented" reduced to 62%. Immediate action was taken to address this issue and as a result the compliance increased to 90% in April 2022. VCC continues to benchmark favorably with other hospitals (summary of audit findings is attached in ***Appendix 1***). • **Decline in Training Compliance at VCC:** Overall IPC related training compliance has remained stable. However, there were a number of areas at VCC where training compliance had significantly reduced. This was mainly due to batch training being provided in previous years. The compliance tracker is included in ***Appendix 2*.** VCC provided the Group with assurance that targeted action is being taken across all areas where compliance has reduced. These included: o **CNS:** Fit mask testing dates arranged for those out of compliance

- **Inpatients/Ambulatory Care/PSU:** IPC training compliance has been a priority following the outbreak. There is a plan to achieve 100% compliance by the end of week commencing 9th May 2022
- **Theatres:** Plan in place to address Aseptic Non-Touch Technique (ANTT) deficits, by training a local assessor and a targeted training day arranged on 19th May 2022 for hand hygiene and donning & doffing assessments
- **Assessment Unit:** Date arranged for the remaining staff member to undertake ANTT assessment following return to work from maternity leave
- **Medical Staffing:** Implementation of Single Lead Employer has restricted access to training compliance for junior medical staff – Medical Directorate Support Manager in discussions with Single Lead Employer team regarding link to view training compliance.
  Medical Education Team – additional resource to start in post on 23rd May 2022 to assist with training compliance.
- **Radiotherapy:** Training dates arranged for hand hygiene and donning & doffing for week commencing 16th May

- **Reduction in IPC related Training Compliance at Welsh Blood Service (WBS):** Significant reduction in training compliance within laboratory areas for both donning and doffing and hand hygiene compliance, due to:
  1. Vacancy of Education and Practice Development Nurse Role. This key post is responsible for the delivery of IPC training within laboratory areas in partnership with Laboratory Education Lead.
  2. All laboratory staff are trained on an annual basis in March/April, resulting in significant numbers becoming non-compliant in April 2022 due to the above.
  3. Increased levels of staff absence due to sickness and maternity leave have also impacted compliance.

  The Group was assured that there is a clear plan in place to address all laboratory training deficits by the end of May 2022.

- **Increased incidence of COVID-19 among the attendees at Blood Health National Oversight Group (BHNOG) Meeting:** The Trust held a conference for BHNOG on the 27th April 2022 at

	Llanerch Vineyard, Hensol. Initial reports identified up to 68 delegates in attendance and 10 (15%) subsequently tested positive for coronavirus. The incident was investigated, and the main findings were: o There was provision for hand hygiene and for the wearing of masks on entrance to the room. o Food was served to the attendees; however, drinks and puddings were self-service. There was alcohol gel available at point of need. o The importance of the use of masks and hand hygiene were reinforced at the opening of the conference. o All attendees, apart from two, were from Wales. o Attendees who tested positive were not seated at the same table. o There was no explicit request for attendees to undertake a Lateral Flow Test prior to the event.
ASSURE	• **Healthcare Associated Infections (March and April 2022):** The detailed Trust surveillance report was received by the Group. The following key surveillance outcomes were noted: o There has been no Healthcare Acquired Gram negative, MSSA, MRSA or Pseudomonas bacteremia. o Over 8 years since MRSA bacteraemia – last case December 2013. o Two case of Klebsiella Spp. Bacteraemia and two cases of E.coli Bacteraemia, not acquired at Velindre Cancer Centre. o One case of C. difficile, however following review it was identified as being attributed to unavoidable antibiotic therapy. • **Water Safety Group Management report:** The Water Safety Group Report was received and discussed. The following was highlighted:

- 31 Pseudomonas samples were taken in April 2022 – none were positive. This reflects the good practice with water flushing and cleaning Standard Operating Procedure (SOP).
- One sample out of seven tested for Legionella was positive. Action was taken on that result and subsequent samples tested negative.

- **Successful Food Safety Inspection Visit:** The Group were advised that there had been a positive Food Safety inspection that resulted in VCC retaining its Food Hygiene Score of 5. Food Safety Inspection feedback commended the catering team for their knowledge, skills, and education.
- **Acknowledgment of Improved Medical Devices - Decontamination Process during Follow Up Assessment:** A desk top peer review of Trust decontamination processes for medical devices was conducted in May 2022. This was to monitor the progress made after the All-Wales Endoscope Decontamination Survey undertaken in 2018. The assessment was led by Mr. John Prendergast (Senior Decontamination Engineer from NHS Wales Shared Services Partnership). Overall, it was reported that since the visit in 2018, a significant improvement in the overall decontamination process for the service had been made. The following is the summary of the findings and recommendations for further improvement in the process:
  - ***Traceability Systems:*** It is a requirement identified in Welsh Health Circular (WHC) 2015 (050), that organisations implement track and trace systems to link device usage to individual patients. Manual traceability systems have been incorporated into Ultrasound and Theatre. It was recommended that the Ultrasound system documents include details of the manual pre-cleaning activity to go with the reprocessing information from the Trophon equipment duplicating the systems that are already carried out in Theatre. It is recommended the IPC team audit and review systems at quarterly intervals to ensure robust completion of information.
  - ***Manual Cleaning*****:** Great improvement made in respect of the Theatre environment since the previous inspection. In addition,

	there was recognition that the Trust has instigated an automated UV disinfector to present a validated system for the semi critical equipment used within the facility. A change to the local cleaning process was recommended to move from using wipes to immersed with an appropriate detergent at set concentration within validated temperatures. The IPC team to assess this. o **Training:** Training systems have been implemented, however COVID-19 has prevented updates. It was recommended that a robust annual refresher programme is put in place to include all Decontamination User's within the organisation and management responsible. It is recognised that VNHST has secured a place at an accredited centre for formal training of the Decontamination Lead.
INFORM	• **COVID-19 Outbreak in First Floor Ward:** Between 20th and 30th March 2022, five patients were linked to an outbreak on First Floor Ward at Velindre Cancer Centre. Whilst three patients were deemed to have likely hospital-acquired COVID-19 infection, two patients were asymptomatic and deemed likely to have acquired COVID-19 in the community. Three staff members were also tested positive for COVID-19 during this period. All three staff members were symptomatic and tested positive on Lateral Flow Test (LFT). One of the three positive staff members also had external factors that could have led to their positive result. This was managed through formal outbreak meetings. The Outbreak was declared over on the 28th April 2022. A formal Outbreak report has been produced**.** • **Implementation Plan for IPC Level 3 Massive Open Online Course (MOOC) Training:** The Group were advised of the outcome from a nation IP&C Education and Training Content Development Group that was developed to agree an All-Wales Infection Prevention and Control Training, Learning and Development Framework for Health, Social Care, Early Years and Childcare. The key changes are: o Registered practitioners and senior staff in supervisory roles who are responsible for ensuring compliance with good IP&C practices e.g., ward and Departmental clinical managers to undertake the Level 3 supplementary resource (MOOC).

	The Group approved the Implementation of this additional training requirement. • **Quarterly Infection Prevention and Control policy status update:** All Trust policies related to Infection prevention and Control were within date. However, it was noted that some policies are due to expire in June 2022 or July 2022: o IPC10 - Hand Hygiene Policy & Procedure o IPC21 - Policy for the Management of Respiratory Infections o IPC09 - Sharps Safety Policy The Group agreed to temporarily expand expiry date of these policies to August 2022 whilst reviews are being undertaken.
APPENDICES	**YES - (Please Include Appendix Title in Box Below)**
	Appendix 1 - Antimicrobial Stewardship report **Appendix 2** – IPC Training compliance for VCC **Appendix 3.** Training Compliance at Welsh Blood Service

4. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **DISCUSS** and **NOTE** the Infection Prevention & Control highlight report, from the meetings held on the 19th May 2022 and actions being taken to address the areas where compliance / standards are not at the required level.

APPENDIX 1: ANTIMICROBIAL STEWARDSHIP AUDIT FINDINGS

All Health Boards and Velindre NHS Trust will implement the principles of 'Start Smart then Focus - SSTF'

The table below shows the past 6 months SSTF data. The audit target for each measure is 100%.

SSTF measure	Target	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	April 2022
Indication documented	**100%**	91.6%	100%	88%	100%	64.2%*	90%
Compliant with guidance / C+S / Advice	**100%**	100%	100%	100%	100%	100%	100%
Review date documented	**100%**	100%	100%	100%	100%	92.8%	100%
Senior review at 72hrs	**100%**	87.5%	100%	100%	100%	100%	100%

SSTF measure	VCC average (Jan-April 2022)	All Wales average (Jan – April 2022)
Indication documented	**84.75%***	**91%**
Compliant with guidance / C+S / Advice	**100%**	**91.5%**
Review date documented	**98.3%**	**86.7%**
Senior review at 72hrs	**100%**	**90.8%**

**VCC's compliance for 'indication documented' is below the All-Wales Average for months Jan- April 2022. This can be attributed to the poor compliance with this standard in March 2022 (see table above). Despite this, the indication was always documented in the medical notes and was compliant with antimicrobial guidelines. This data has been investigated and the individual prescribers who are not compliant with documenting the indication on the chart have been informed and the importance of this has been reinforced.*

VCC's compliance with the other 3 SSTF standards are currently above the national average.

APPENDIX 2: VELINDRE CANCER CENTER INFECTION PREVENTION AND CONTROL TRAINING COMPLIANCE

				Nursing				
Training	CNS	Estates	Nuclear Medicine IPC Report	Assessment Unit	Inpatients/ Ambulatory Care/PSU	Theatre	Palliative Care	Medical Staffing
Fit Testing	92%	75%	100%	100%	100%	100%	100%	93%
PPE – Donning & Doffing – Core	100%	88%	100%	100%	89%	75%	100%	52%
PPE – Donning & Doffing – Assessment	100%	100%	100%	100%	89%	50%	100%	52%
Hand hygiene	100%	100%	100%	100%	90%	50%	75%	52%
IPC level 1	100%	90%	100%	100%	88%	100%	75%	no data
IPC level 2	100%		100%	100%	79%	100%	75%	no data
ANTT Non-surgical – Core	100%		100%	100%	100%	100%	100%	no data
ANTT Non-surgical – Assessment	N/A			88%	57%	0%	100%	no data
ANTT Surgical								

	Operational Services									
Training	Portering	Domestics	Catering	Outpatients dept	Pharmacy	Radiology dept	Radiotherapy dept	Research, Development & Innovation	SACT	Therapies
Fit Testing				100%		100%	97%	100%	86%	100%
PPE – Donning & Doffing – Core	98%	100%	100%	90%	100%	100%	96%	100%	96%	100%
PPE – Donning & Doffing – Assessment	98%	100%	100%	96%	100%	100%	93%	94%	96%	100%
Hand hygiene	99%	98%	100%	100%	100%	100%	88%	72%	100%	100%
IPC level 1	100%	100%	100%	93%	99%	100%	98%	81%	96%	100%
IPC level 2				93%	98%	100%	96%	81%	96%	100%
ANTT Non-surgical – Core				98%		93%		N/A	98%	
ANTT Non-surgical – Assessment				100%		93%		N/A	98%	
ANTT Surgical										

Appendix 3. Training Compliance at Welsh Blood Service

Aggregated Divisional Compliance: (data as of 5.5.2022)

IPC Level 1	*IPC Level 2*	*Hand Hygiene*	*Donning and Doffing*	*Fit Testing*	*ANTT eLearning*	*ANTT Assess*
96%	*86%*	*67%*	*67%*	*NA*	*100%*	*97.5%*

***Service Level Compliance**:*

Collections

Team	*IPC Level 1*	*IPC Level 2*	*Hand Hygiene*	*Donning and Doffing*	*Fit Testing*	*ANTT elearn*	*ANTT Assess*
All Teams	*88%*	*88%*	*88%*	*88%*	*NA*	*100%*	*95%*
WBMDR Nursing Team	*100%*	*100%*	*100%*	*100%*		*100%*	*100%*

Laboratories

Team	*IPC Level 1*	*IPC Level 2*	*Hand Hygiene*	*Donning and Doffing*
General labs	*87.5%*		*100%*	*100%*
WTAIL	*100%*		*33%*	*33%*
QA Lab	*98%*		*78.5%*	*78.5%*
Automated Serology	*100%*		*60%*	*60%*
Patient Services	*100%*		*50%*	*50%*

QUALITY, SAFETY & PERFORMANCE COMMITTEE

INFECTION PREVENTION & CONTROL 2021-2022 ANNUAL REPORT

DATE OF MEETING	14th July 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

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

REPORT PURPOSE	FOR ENDORSEMENT

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

1. SITUATION

The 2021 / 2022 Trust Infection Prevention & Control Annual Report is provided to the Quality, Safety & Performance Committee for **ENDORSEMENT** prior to submission to the Trust Board for approval and publishing once translated on the Trust's website.

2. BACKGROUND

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

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

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

The following are the key messages emerging from the report:

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

4. IMPACT ASSESSMENT

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

5. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **ENDORSE** the 2021/2022 Trust Infection Prevention & Control Annual Report prior to submission to the Trust Board for approval and publishing following translation on the Trust's website.

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Infection Prevention and Control Annual Report 2021/2022

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1. INTRODUCTION

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

Welsh Blood Service (WBS)

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

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

Velindre Cancer Centre (VCC)

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

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

Infection Prevention and Control Team

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

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

2. KEY ACHIEVEMENTS

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

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

3. GOVERNANCE ARRANGEMENTS AND REPORTING FRAMEWORKS

Figure 1. Infection Prevention and Control Governance and Reporting Framework

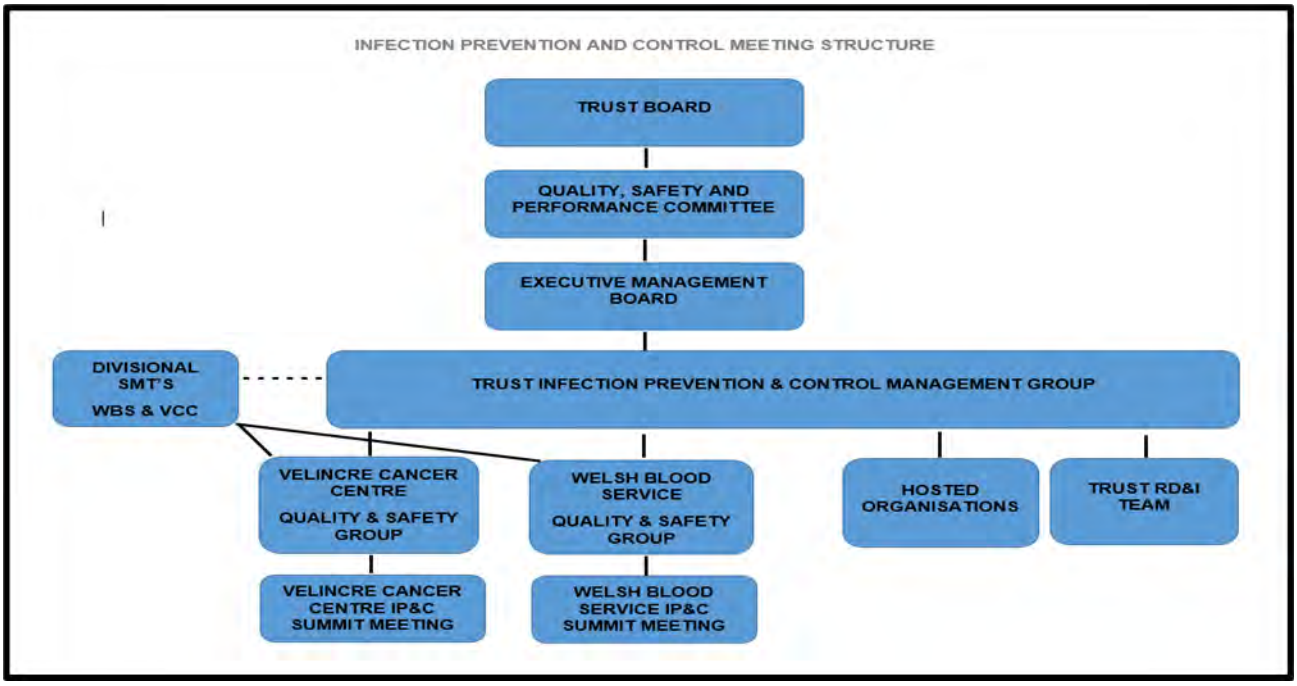


Figure 2. Infection Prevention & Control Team Organisational structure

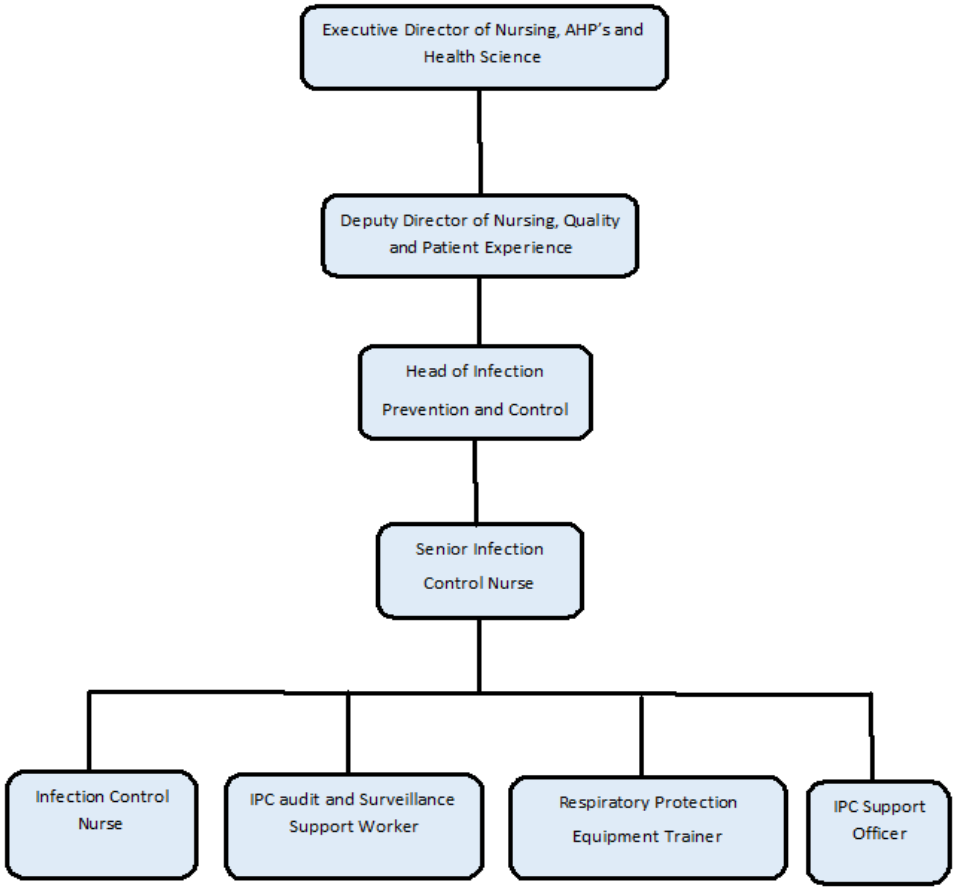


Figure 3. key Infection Prevention and Control leadership roles and responsibilities

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

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

- An integrated "whole system approach" to Antimicrobial Resistance and Healthcare Associated Infections.
- Evidence will be required that an integrated approach is being taken across both community and hospital care settings.
- Ensuring that all antimicrobial prescriptions in hospitals adhere to the principles of "Start Smart then Focus".
- Ensuring that indications for antimicrobial prescriptions are documented in primary care and improving the diagnosis and management of Urinary Tract infections.
- Improving prevention, control and management of infections to deliver significant change in key infections.
- Implementing quality improvement projects to deliver evidence-based interventions to prevent Catheter Associated Urinary Tract Infection, sepsis and Clostridioides difficile disease.

As the Velindre Cancer Centre provides specialist oncological services to surrounding Health

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

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

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

4.1 Healthcare Associated Infection

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

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

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

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

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

- Working closely with staff to increase awareness, and to re-iterate the need for timely sampling to check for Clostridioides *difficile* disease.
- Promoting the need for vigilance in infection prevention and control precautions and hand hygiene.
- Closely monitoring and reviewing all antibiotics prescribed, including the undertaking of antimicrobial ward rounds.
- Enhancing the cleaning of the clinical area with specific disinfectants/sporicidal and utilise ultraviolet disinfection technology.
- Ensuring effective communication between the Infection Prevention and Control Team and clinical staff to share 'lessons learnt' and to ensure the delivery of safe and effective treatment and care.

Table 2. Methicillin Resistant Staphylococcus Aureus(MRSA) Bacteraema

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

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

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

- Continued use of ChloraPrep™ for cleaning the skin prior to insertion of any intravenous devices. ChloraPrep also used during the maintenance of Central Venous Catheters.
- Standardised dressing and cannulation packs.
- Utilising 'Securacath' to secure Peripherally Inserted Central Catheter lines, and employing Biopatch dressings to reduce the risk of infection by releasing chlorhexidine gluconate for our higher risk patients.
- Undertaking a regular review of best practice processes and procedures regarding Peripherally Inserted Central Catheter line insertion, and ensuring that these are implemented.
- Undertaking Methicillin Resistant Staphylococcus Aureus screening at important points of the patient care pathway including:
    - On first admission to Velindre Cancer Centre
    - If admitted from another hospital/healthcare establishment
    - If the patient has had Methicillin Resistant Staphylococcus Aureus infection previously
    - Before any surgical procedures
    - Before a Central Venous Catheter is inserted

Table 3. Methicillin Sensitive Staphylococcus Aureus Bacteraemia (MSSA)

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

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

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

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

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

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

Table 5. Klebsiella Species Bacteraemia

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

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

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

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

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

- **Central Venous Catheter Infection**

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

- **Multi drug-resistant Organisms**

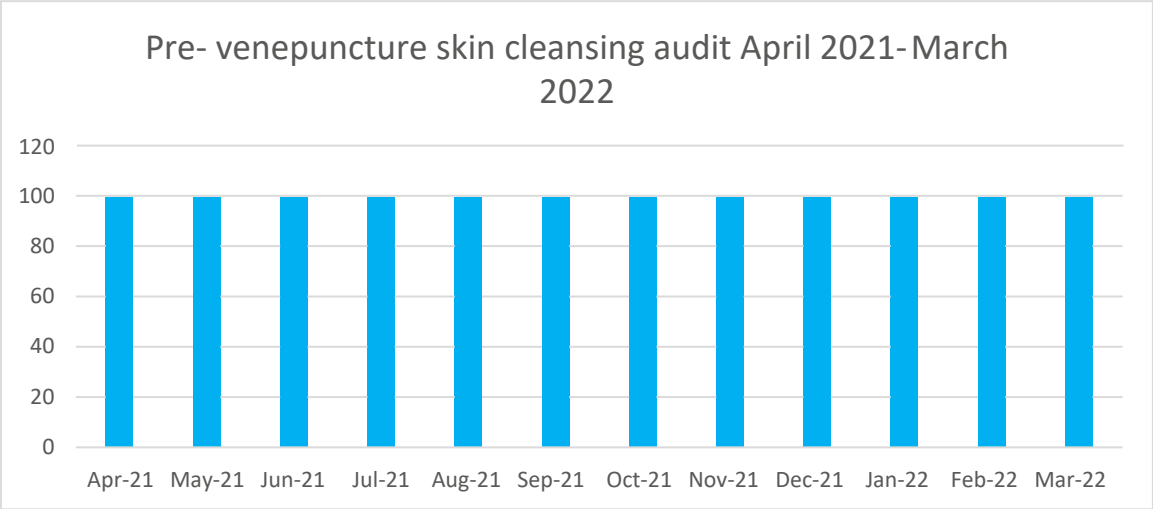
Multidrug-resistant organisms are increasingly recognised as a growing public threat, both within the health care system and in the community.

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

4.2 Infection Prevention and Control Audits

4.2.1 Welsh Blood Service Pre-Venepuncture Skin Cleansing Audit

Figure 4. Pre- Venipuncture Skin Cleansing Audit



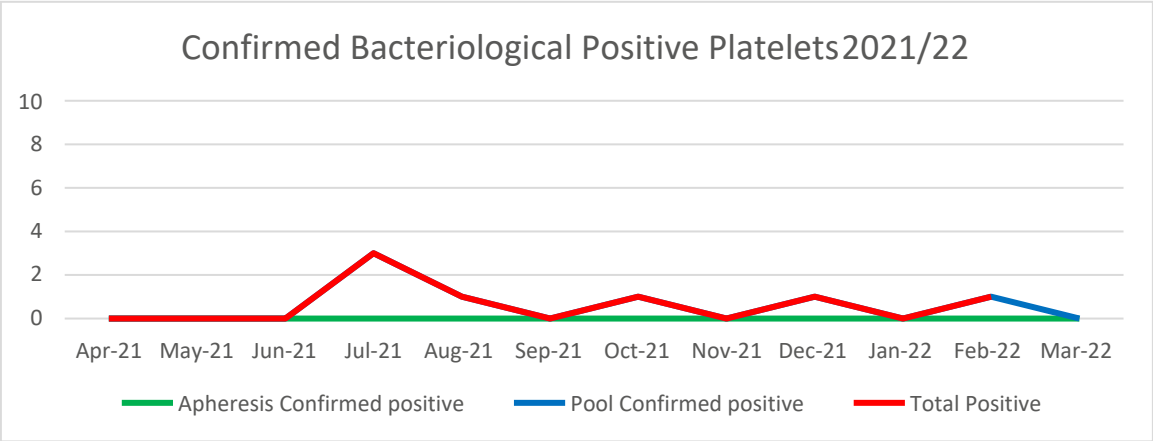
Robust and effective skin cleansing prior to venepuncture is vital in ensuring the safety of the donor, the product, and the recipient. To ensure this key requirement is completed to a high standard, the Welsh Blood Service has developed and implemented a pre venepuncture arm cleansing monthly observational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

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

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

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

Figure 5. Confirmed Bacteriological positive Platelets



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

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

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

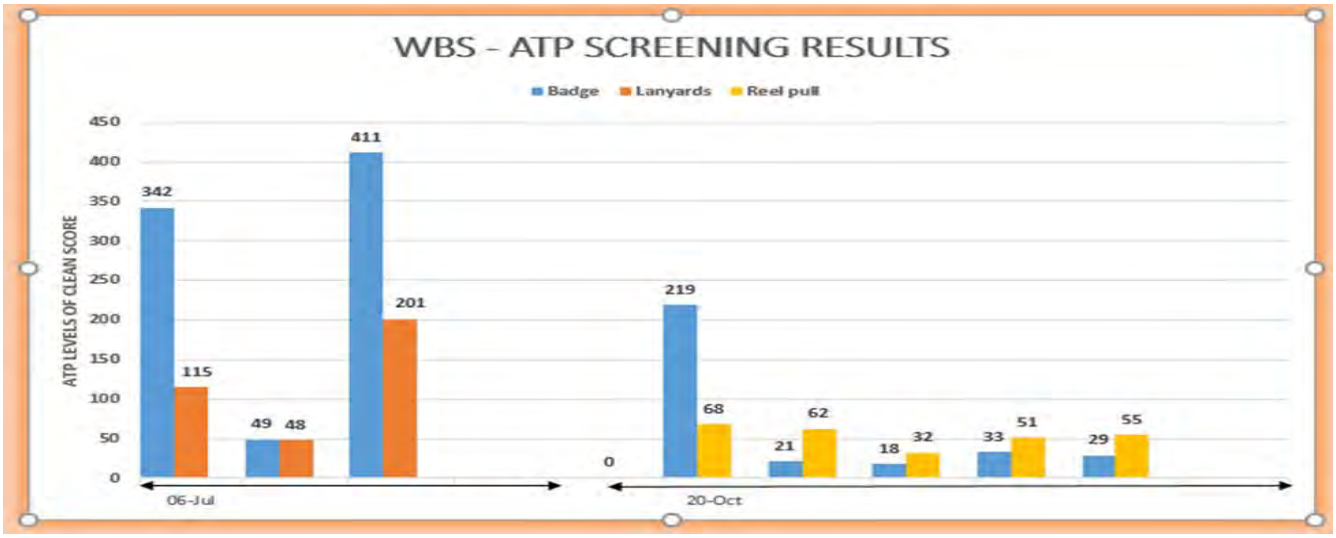
4.2.3 Cleanliness Audit of Identification lanyards & badges at WBS

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

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

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

Figure 6. Identification lanyards & badges screening results



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

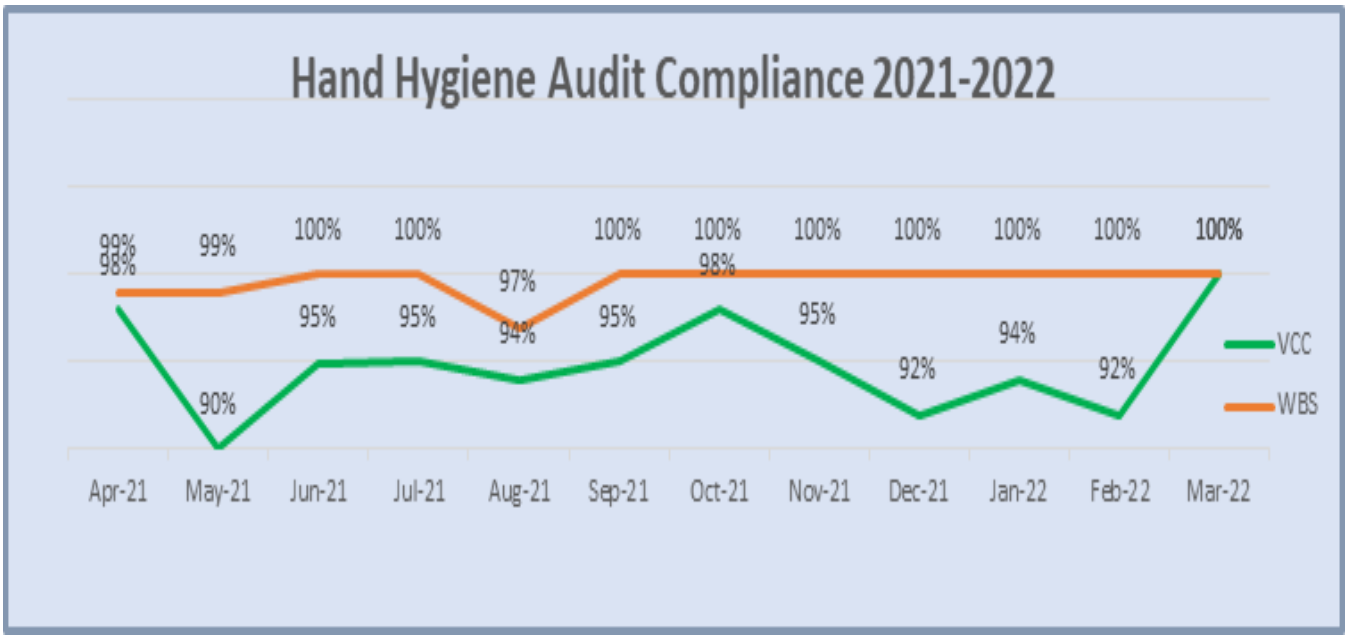
Following the study, the recommendation was to replace lanyards with universal introduction of ID clip pull reels across Welsh Blood Service staff.

4.2.3 Hand Hygiene Audits

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

Significant improvement has been seen throughout the year in WBS with viariable compliance in VCC. This is shown in the table below.

Figure 7. Hand Hygiene Audit Compliance

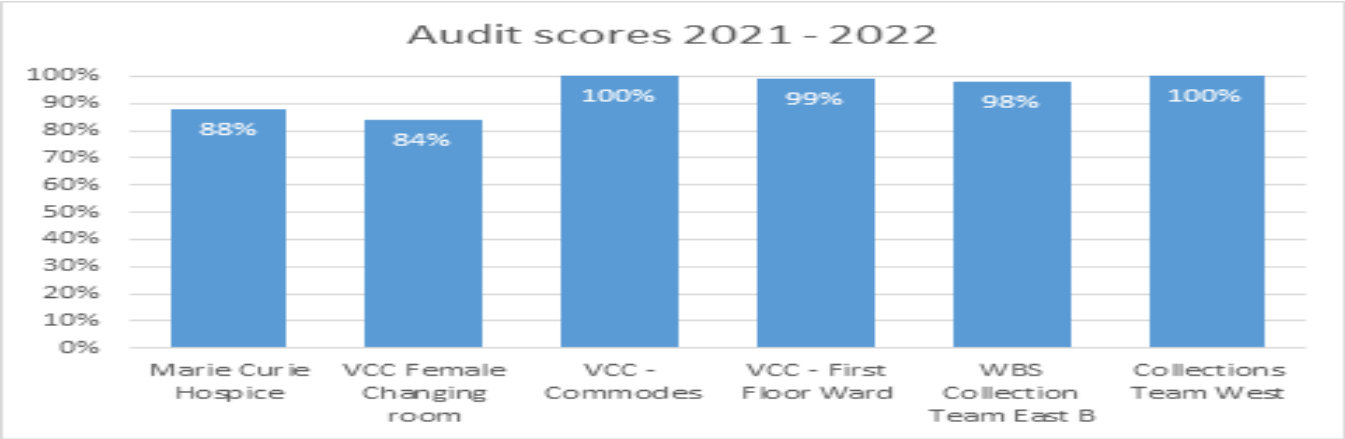


4.2.4 Environmental Audits

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

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

Figure 8. Environmental Audit scores



4.2.5 Clinical Practice Audits

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

4.3 Infection Prevention and Control Training Compliance

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

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

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

Figure 10. Hand Hygiene Training Compliance

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

Figure 11. PPE donning and Doffing Training Compliance

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

Figure 12. ANTT Training Compliance

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

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

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

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

4.4 Vaccination Programmes

4.4.1 COVID-19 Vaccination programme

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

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

- Frontline VUNHST employees
- Frontline Welsh Ambulance Service Trust (WAST) employees
- Other frontline staff groups providing services to NHS Wales patients, including Cardiff and Vale University Health Board staff, third sector and private hospital providers
- Patients of the Cancer Centre who were eligible for the vaccine due to immuno-suppression or because they were included in the 'Clinically Extremely Vulnerable' category.

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

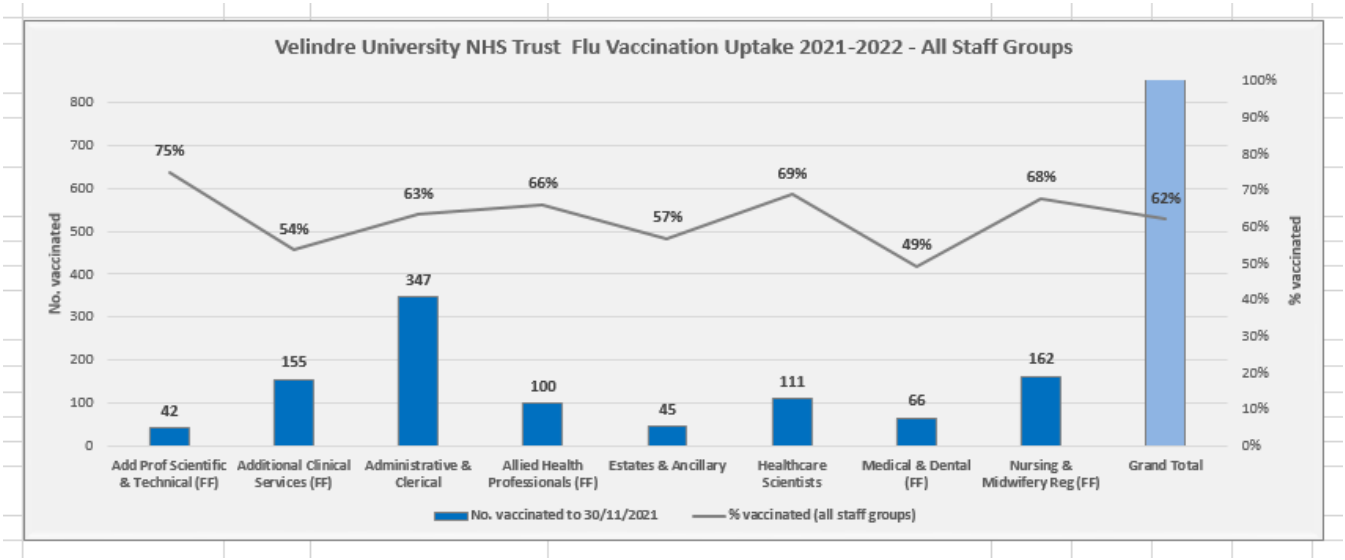
In total, 233 individuals took part in delivering the COVID-19 vaccination Programme at VUNHST. Multiple departments were also instrumental in contributing to the success of the programme, these included Business Intelligence, Digital Facilities, Estates, Finance, Pharmacy, Stores, Transport and Workforce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

4.4.2 Staff Influenza Vaccination Campaign

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

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

Figure 13. VUNHST Staff Flu vaccination uptake



4.5 Antimicrobial Stewardship

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

In particular, Antimicrobial Stewardship aims to:

- Promote the appropriate use of antimicrobial agents
- Improve patient outcomes
- Reduce healthcare associated infections such as Methicillin Resistant Staphylococcus aureus and Clostridioides difficile and
- Prevent antimicrobial resistance

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

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

1. Whether the indication for treatment was documented
2. Whether the prescribed treatment was compliant with either local guidelines, based on the results of cultures and sensitives or based on microbiology advise
3. Whether there was a documented review date / stop date on initiation of treatment
4. Whether there was a documented senior review at 72 hours

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

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

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

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

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

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

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

5. COVID-19 PANDEMIC

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

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

5.1 Infection Prevention and Control (IPC) Assurance for Velindre

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

6. OUTBREAKS / INCIDENCES

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

6.1 First Floor Ward COVID-19 Outbreak

6.1.1 Outbreak Summary

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

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

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

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

6.1.2 Control Measures

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

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

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

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

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

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

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

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

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

6.1.3 Outbreak Conclusion

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

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

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

7. SAFE WATER SYSTEM MANAGEMENT, BUILDING ENVIRONMENTAL IMPROVEMENTS.

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

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

Following an increase in positive pseudomonas water samples, work was undertaken with the Operational Services Department to develop an outlet cleaning standard operating procedure, and to train and assess housekeeping staff in its use. Further work has been undertaken to hold an annual refresher training for staff to ensure the standard of cleaning is maintained. Moreover, this has resulted in a significant improvements in water sampling results relating to Pseudomonas.
The Infection Prevention and Control Team have worked closely with the Estates department on several refurbishment projects including

- Pharmacy dispensary refurbishment
- Temporary ward ventilation First Floor ward
- Water services site schematics
- OPD Flooring works
- Decoration to improve environmental improvements.

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

8. DECONTAMINATION

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

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

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

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

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

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

9. POLICY DEVELOPMENT

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

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

10. ICNet PDATE

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

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

11. INFECTION PREVENTION AND CONTROL AWARENESS CAMPAIGNS

11.1 Infection Prevention and Control Newsletter for staff

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

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

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

11.2 Celebration of Global Hygine Day: 5th May 2021

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

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

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

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

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

12. CONCLUSION

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

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

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

13. PRIORITES FOR 2022-2023

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

- IPC has a role in the Nosocomial Scrutiny Panel which is a part of the national investigation/inquiry work
- Continue to be proactive in the COVID-19 Pandemic response, and to prepare for potential further waves, whilst ensuing that learning from previous waves is embedded
- Along with the wider senior team, to support the Trust’s Vaccination programme; which includes building on the successes of the Influenza staff vaccination campaign and the COVID-19 booster vaccination.
- Review and update the Gap Analysis against the Public Health England Infection Prevention and Control Board Assurance Framework, and to undertake any required actions
- Further enhance the Trust’s Infection Prevention & Control Assurance / Accountability framework
- Continue to increase engagement and collaboration with Infection prevention and control agenda within all divisions of the trust
- Continue to roll out Environmental audits at the Welsh Blood Service
- Work with Public Health Wales to enhance the level of support from the Consultant Microbiologist
- Lead on the sustained reductions in healthcare associated infections within the Trust
- Continue to utilise ICNet and plan to fully transition to the Wales Patient Access Scheme
- Continue to support the Antimicrobial Pharmacist with implementing strategies to further promote Antimicrobial Stewardship
- Work collaboratively to support the Sepsis agenda across the Trust
- Explore ways to improve levels of training across the organisation
- Effectively contribute to refurbishment projects and water management and safety across the Trust, including supporting the design process of the new Velindre Cancer Centre. As well as working in-line with HTM (Health Technical Memoranda) specifications, the work will involve refreshing clinical specifications to reflect the impact of the COVID-19 Pandemic. Work with Digital Nursing team to develop Tendable audit tool for environmental audits.
- Implement the Massive Open Online Course (MOOC) IPC Level 3 training and the national work on how IPC teams should look anywhere?
- Support the de-escalation plans and to remove restrictions that have been in place.

QUALITY, SAFETY & PERFORMANCE COMMITTEE

SAFEGUARDING & VULNERABLE ADULTS MANAGEMENT GROUP HIGHLIGHT REPORT

DATE OF MEETING	14th July 2022
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Tina Jenkins Senior Nurse Safeguarding & Public Protection
PRESENTED BY	Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, AHPs and Health Science
REPORT PURPOSE	**ASSURANCE & ESCALATION**

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
SAFEGUARDING & PUBLIC PROTECTION MANAGEMENT GROUP	08/03/2022	Areas for inclusion agreed
EXECUTIVE MANAGEMENT BOARD RUN	27/04/2022	Noted

1. PURPOSE

This paper had been prepared to provide the Quality, Safety & Performance Committee details of the key issues considered by the Trust's Safeguarding and Vulnerable Adults Group at its meeting held on the 8th March 2022.

2. SAFEGUARDING & PUBLIC PROTECTION MANAGEMENT GROUP HIGHLIGHT REPORT

The Safeguarding & Vulnerable Adults Management Group met on the 8th March 2022 and agreed the following areas for highlighting:

ALERT / ESCALATE	• A paper was presented to the Group to provide an update on the ***Trust Disclosure and Barring Service (DBS) position***. The group did not receive the required assurance in respect of completion of some outstanding DBS checks or the completion date for the Trust DBS policy development. This assurance was requested outside of the meeting.
ADVISE	• The Group received the Safeguarding Risk register and noted that an additional risk has been added in relation to ***Safeguarding training compliance*** as this ESR training data requires cleansing to ensure the training requirements are correctly assigned. Currently compliance is showing as very low for some elements and is showing as below the target of 95% across most areas. This is actively being reviewed by the Workforce & Organisational Development Team but to date there is no completion date for this work. • The Group received an assurance paper in respect of the ***lessons learnt detailed in the report arising from the David Fuller case*** in England (hospital electrician who admitted to sexually assaulting multiple deceased bodies in hospital mortuaries between 2008 and 2020). In November 2021 the Trust Welsh Government requested assurance on the Cold Room Security, specifically Procedures for Body Storage, Premises security including CCTV and General security arrangements to prevent unauthorized access. The group identified that further work was required and requested further

	information in respect of the Trusts position and arrangements. This will be received at the next meeting.
ASSURE	• The Safeguarding and Vulnerable Adults Group previously escalated the lack of a ***chaperone policy***. This has now been addressed and it is agreed that the NHS Wales 'use of Chaperones during Intimate Examinations or Procedures' will be implemented within Velindre Cancer Centre. The Cancer Centre has developed a clear implementation plan that was reviewed and approved by the group. • ***The Health & Care Standard 2.7 quarter 2,*** divisional assessments and Trust priorities were reviewed and discussed. The Trust is scoring a level 4 and both divisions are also scoring a level 4. The score is unchanged from the previous quarter and the previous annual review (2020/21). All identified improvements have been incorporated into the work plan of the Safeguarding and Vulnerable Adults Management Group. • A ***safeguarding training compliance dashboard*** has been developed. The dashboard was presented to the group and the group commended the work of the educational and developed team for developing a document to support training compliance monitoring and reporting. • The Group approved the ***terms of reference for the newly established Trust supporting vulnerable groups forum*** (attached in appendix 1).
INFORM	• The Trust submitted a successful bid for WG funding to enhance its ***Mental Capacity Act Training***. The training has been delivered and has been well evaluated. • Trust employees have historically accessed level 3 safeguarding training with an agreement from Cardiff & Vale University Health Board. This provided staff with a more varied audience. However,

	this is more difficult to access and monitor compliance. Cardiff & Vale Regional Safeguarding Board commissioned, New Pathways in 2021 to develop Level 3 multiagency packages for board use. This training is to be delivered to registrants across the Trust dependent on role. The training commenced in February 2022 and has been well evaluated so far. • A self-neglect tab has been added to the safeguarding intranet pages with useful resources for practitioners.
APPENDICES	**YES - (Please Include Appendix Title in Box Below)**
	Appendix 1: Terms of reference for the Trust supporting vulnerable groups forum

3. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **NOTE** the key deliberations that took place at the Safeguarding and Vulnerable Adult Management Group held on 8th March 2022 and **DISCUSS** the areas for alert / escalation and advise.

Supporting Vulnerable Groups Forum

Terms of Reference & Operating Arrangements

Version: 1 draft
Date Reviewed: Feb 2022
Review Date:
Agreed by:
Approved by:
Approval date:

1. INTRODUCTION

These Terms of Reference and Operating Arrangements are developed to ensure that Velindre University NHS Trust is meetings its' national and statutory requirements in relation to specific areas affecting Vulnerable Groups.

2. PURPOSE

To be responsible for ensuring that the Trust has all the necessary systems, processes, policies, procedures, monitoring, training, oversight and supervision in place so that it is effectively supporting specific vulnerable groups: These include:

- *Older people*
- *People with a learning disability*
- *Dementia*
- *Homelessness*
- *Serious Mental Health Problems*

Specifically, the group will be responsible for ensuring that the Trust meets its responsibilities through:

2.1 Provision of assurance to the Trust safeguarding and Vulnerable Adults Group in relation to the Trust's arrangements with its national and statutory responsibilities, stated objectives and the requirements and standards determined for the NHS in Wales, including:

- The Relevant Health and Care Standards (2015)
- The Mental Capacity Act 2005 and Deprivation of Liberty Standards 2009
- The Mental Capacity (Amendment) Act 2019 Liberty Protection Safeguards
- Social Services and Wellbeing (Wales) Act 2014
- Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015
- Wales Safeguarding Procedures (2019)
- Relevant Clinical Guidance, National Service Frameworks, and Safety Alerts
- The All-Wales Dementia Standards (2021)

2.2 Monitoring activity and ensuring the organisation contributes to audits of practice and compliance with relevant policies and procedures.

2.3 Identifying learning for the Trust from local and national relevant reviews, and developing and monitoring corrective/development action plans as necessary.

2.4 Setting and regularly reviewing standards for training and high level monitoring of compliance with agreed training standards in relation to Dementia and Learning disability.

2.5 To determine Trust wide standards to ensure the: welfare of vulnerable groups including citizens with dementia and learning disabilities; that there are appropriate arrangements in place for reasonable adjustments to be made within our services; and the monitoring of compliance with standards.

2.6 Ensuring the Trust is appropriately represented at local and regional forums in relation to Safeguarding, Public Protection and vulnerable groups.

3. DELEGATED POWERS AND AUTHORITY

3.1 Reporting to the Trust's Safeguarding and Vulnerable Adults Safety Group.

4. MEMBERSHIP

4.1 The core membership of the Committee, is set out below:

Chair: Head of Safeguarding and Vulnerable Groups.

Vice Chair: Head of Digital and Professional Standards

Secretariat: TBC

All members are expected to attend each meeting. In the event of being unable to attend it is the member's responsibility to arrange for a deputy to attend who has full authority to act and make decisions on behalf of the member.

Table 1

TITLE	ROLE & RESPONSIBILITES	REPORTING REQUIREMENTS
Head of Safeguarding and Vulnerable Groups	Chair of Meeting. Leadership and strategic focus in meeting compliance.	National information / requirements Proposed strategy / direction

	Overall responsibility for vulnerable adults & older persons. Provide assurance / escalation to Trust Board members.	
Head of Digital and professional standard's	Vice Chair of Meeting. Leadership and strategic focus in meeting compliance.	As above
Departmental Representatives • Head of Nursing, Welsh Blood Service • Therapies Manager, Velindre Cancer Centre • Radiographer or nominated representative • Senior nurse Supportive Care • Equality and Diversity Manager • Research nomination. • Patient experience manager	To represent service areas and report on assurance and activity. Provide strategic and operational liaison between the Supporting Vulnerable Groups Forum and operational managers to support delivery and compliance with the vulnerable groups agenda.	Reports to be provided on an adhoc basis to provide assurance, include audit and training activity, incidents and complaints, policy/ procedure review and risk register.

Co-Option: with prior arrangement of the Chair/Vice Chair additional members maybe co-opted onto a meeting as relevant to the agenda

5. Supporting Vulnerable Groups Forum Meetings

5.1 Quorum

The Chair / Vice Chair, and a senior decision maker from each Division must be represented in order for a meeting to proceed.

5.2 Frequency of meetings

Meetings shall be held no less frequently than quarterly and otherwise as

the Chair deems necessary in accordance with work plan and level of associated risk.

5.3 Papers and reports

- Draft meeting notes and action log MUST be circulated to all members within 10 days of a meeting taking place.
- All papers are to be provided to the Chair at least 10 days prior to the meeting.
- The agenda and papers will be circulated at least 7 days in advance of the meeting

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 The Group reports directly to the Safeguarding and Vulnerable Adults Group its performance in exercising the functions set out in these terms of reference.

6.2 The Group shall embed the Trust's corporate standards, priorities and requirements, e.g. equality and human rights through the conduct of its business.

6.3 The Group with have relationships with the Velindre Cancer Centre Dignity Group and national and local relevant groups supporting vulnerable groups.

6.4 All papers/reports should be submitted to the Head of safeguarding and vulnerable groups. The agenda will be approved by the Chair prior to issue.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Safeguarding, and Vulnerable Adults Group receive the minimum of a highlight report at each meeting following the Supporting of Vulnerable Groups Forum, that includes details of delivery against all key objectives as well as any exceptions. Additional assurance / exception reports may be required.

8. REVIEW

8.1 These terms of reference and operating arrangements shall be reviewed in 6 months by the Supporting Vulnerable Groups Forum and approved by the Safeguarding and Vulnerable Adults Group.

QUALITY, SAFETY & PERFORMANCE COMMITTEE

SAFEGUARDING & VULNERABLE ADULTS MANAGEMENT GROUP HIGHLIGHT REPORT	
DATE OF MEETING	14th July 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Non-applicable

PREPARED BY	Tina Jenkins Senior Nurse Safeguarding & Public Protection
PRESENTED BY	Nigel Downes, Deputy Director of Nursing, Quality & Patient Experience
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, AHPs and Health Science

REPORT PURPOSE	**ASSURANCE & ESCALATION**

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Safeguarding & Vulnerable Adults Group	13/06/2022	Areas for inclusion agreed
Executive Management Board	01/07/2022	Discussed and approved training standard

1. PURPOSE

This paper is to provide the Quality, Safety & Performance Committee with details of the key issues considered by the Trust's Safeguarding and Vulnerable Adults Group at its meeting held on the 13th June 2022.

The paper is provided for the Committee is asked to **NOTE** the deliberations of the Group and **DISCUSS** the areas identified for escalation.

The Safeguarding & Vulnerable Adults Management Group met on 13th June 2022 and agreed the following areas for highlighting

2. SAFEGUARDING & PUBLIC PROTECTION MANAGEMENT GROUP HIGHLIGHT REPORT

ALERT / ESCALATE	• The Group reviewed the Safeguarding workplan for April 2021 to March 2022 (available from the Executive Director Nursing, AHP & Health Science if required). Due to omicron pressures three actions had not been achieved. o Delays in returns from the Trust safeguarding training need analysis leading to inability to accurately monitor compliance data. Transferred – transferred to quarter one and has subsequently been completed. o National delays with the publication of the Liberty Protection code of practice. This impacted on the Trust ability to fully prepare for the liberty protection safeguards. The consultation has now commenced and the Trust is commencing preparation. Timescales cannot be finalised until final Codes of Practice are published. o The safeguarding champion role was established and a development plan agreed. Further work is required to embed the role in practice, this was delayed by the significant clinical pressures posed by covid. It was agreed that each of these areas would be included in the 2022-2023 workplan. • The Safeguarding Training Needs Analysis had not been finalised as the return was awaited from VCC medical directorate. This was immediately escalated by the Executive Director of Nursing, AHP & Health Science. This has subsequently been resolved. The Group acknowledged the significant work undertaken thus far in respect of enhancing safeguarding training governance and that further data cleansing was underway.

ADVISE	The Group received the *Safeguarding training compliance with the caveat that the* ESR training data requires cleansing to ensure the training requirements are correctly assigned. Currently compliance is showing as very low for some elements and is showing as below the target of 95% across most areas. It was recognised that the national training standard was 85% to account for ESR being unable to account for staff unavailable for training such as those on maternity leave. The group agreed that the target therefore should be reduced to 85% which is the agreed compliance target for NHS organisations. This was subsequently approved by the Executive Management Board. **NHS Standard:** Red >50%, Amber 50% - 85%, Green < 85% Training compliance is included on the Trust safeguarding risk register, this can be closely monitored and data accurately reported on completion of the safeguarding training needs analysis. • A paper was presented to the Group to provide an update on the ***Trust Disclosure and Barring Service (DBS) position and DBS audit report*****.** The report identified management could not locate the Trust's original baseline review against the 22 non-DBS related recommendations included in the Healthcare Inspectorate Wales (HIW) January 2019 report (the HIW report) into Abertawe Bro Morgannwg University Health Board's handling of the employment and allegations made against Mr W. Additionally, their could not be evidenced that the baseline review had been reported to any forum within the Trust, or that formal monitoring had taken place to ensure actions to address the recommendations were completed. The gap analysis against the HIW recommendations was presented to the group. The group requested further information and assurance to be presented at the next meeting against the 24 HIW report recommendations. The DBS checks audit report noted that the Trust does not have a DBS policy. As a result, it is requested that the group add this to the safeguarding risk register until the document is developed

ASSURE	• ***The Health & Care Standard 2.7 quarter 2,*** divisional assessments and Trust priorities were reviewed and discussed. The Trust is scoring a level 4 and both divisions are also scoring a level 4. The score is unchanged from the previous quarter and the previous annual review (2020/21). All identified improvements have been incorporated into the work plan of the Safeguarding and Vulnerable Adults Management Group.
INFORM	• The Group received an assurance paper in respect of the ***lessons learnt detailed in the report arising from the David Fuller case*** in England (hospital electrician who admitted to sexually assaulting multiple deceased bodies in hospital mortuaries between 2008 and 2020). In November 2021 the Trust Welsh Government requested assurance on the Cold Room Security, specifically Procedures for Body Storage, Premises security including CCTV and General security arrangements to prevent unauthorized access. An update was received the group requested further information in respect of the Trusts position and arrangements. This will be received at the next meeting. • The Group received a presentation from Improvement Cymru. The presentation included the dementia hospital charter and how the Improvement Cymru team can support the Trust Supporting Vulnerable Groups forum. A care for VIPs self-assessment will be undertaken in August and findings reported back to the group. • The Group reviewed the new Safeguarding Maturity Matrix self-assessment tool. The Trust are an identified pilot site for the new assessment template.
APPENDICES	

3. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **NOTE** the key deliberations that took place at the Safeguarding and Vulnerable Adult Management Group held on 13th June 2022 and the actions taken to address the areas identified for alerting.

QUALITY, SAFETY & PERFORMANCE COMMITTEE

Safeguarding and Vulnerable Adults 2022-2023 Annual Report

DATE OF MEETING	14th July 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Non-applicable

PREPARED BY	Tina Jenkins, Senior Nurse Safeguarding & Public Protection
PRESENTED BY	Tina Jenkins, Senior Nurse Safeguarding & Public Protection & Nigel Downes, Deputy Director Nursing, Quality & Patient Experience
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, AHPs and Health Science

REPORT PURPOSE	FOR ENDORSING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Safeguarding & Vulnerable Adults Group	13/06/22	Endorsed for submission to EMB
Executive Management Board	01/07/22	Endorsed for submission to Quality, Safety & Performance Committee

1. SITUATION

This paper is to provide the Quality, Safety & Performance Committee with the Trust's Safeguarding and Vulnerable Adults 2021/2022 Annual Report.

The Quality, Safety & Performance Committee is asked to **ENDORSE** the Safeguarding and Vulnerable Adults 2021/2022 Annual Report prior to submission to the Trust Board for approval and publishing on the Trust's website (after translation).

2. BACKGROUND

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

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

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

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

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

4. IMPACT ASSESSMENT

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

5. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **ENDORSE** the Safeguarding and Vulnerable Adults 2021/2022 Annual Report prior to submission to the Trust Board for approval and publishing on the Trust's website (after translation).

Canolfan Ganser Felindre
Velindre Cancer Centre

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

Welsh Blood Service
Gwasanaeth Gwaed Cymru

SAFEGUARDING AND VULNERABLE ADULTS ANNUAL REPORT 2021 -2022

Table of Contents

1. INTRODUCTION

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

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

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

Key Achievements 2021-2022:

The following are the key achievements for the Trust during 2021/2022:

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

Challenges:

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

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

2. GOVERNANCE ARRANGEMENTS

2.1 Responsibility for Safeguarding and Vulnerable Adults within the Trust

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

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

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

2.2 Internal Governance & Assurance

2.2.1 Compliance with the Health and Care Standards (2015)

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

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

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

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

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

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

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

3. Compliance with the Safeguarding Maturity Matrix

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

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

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

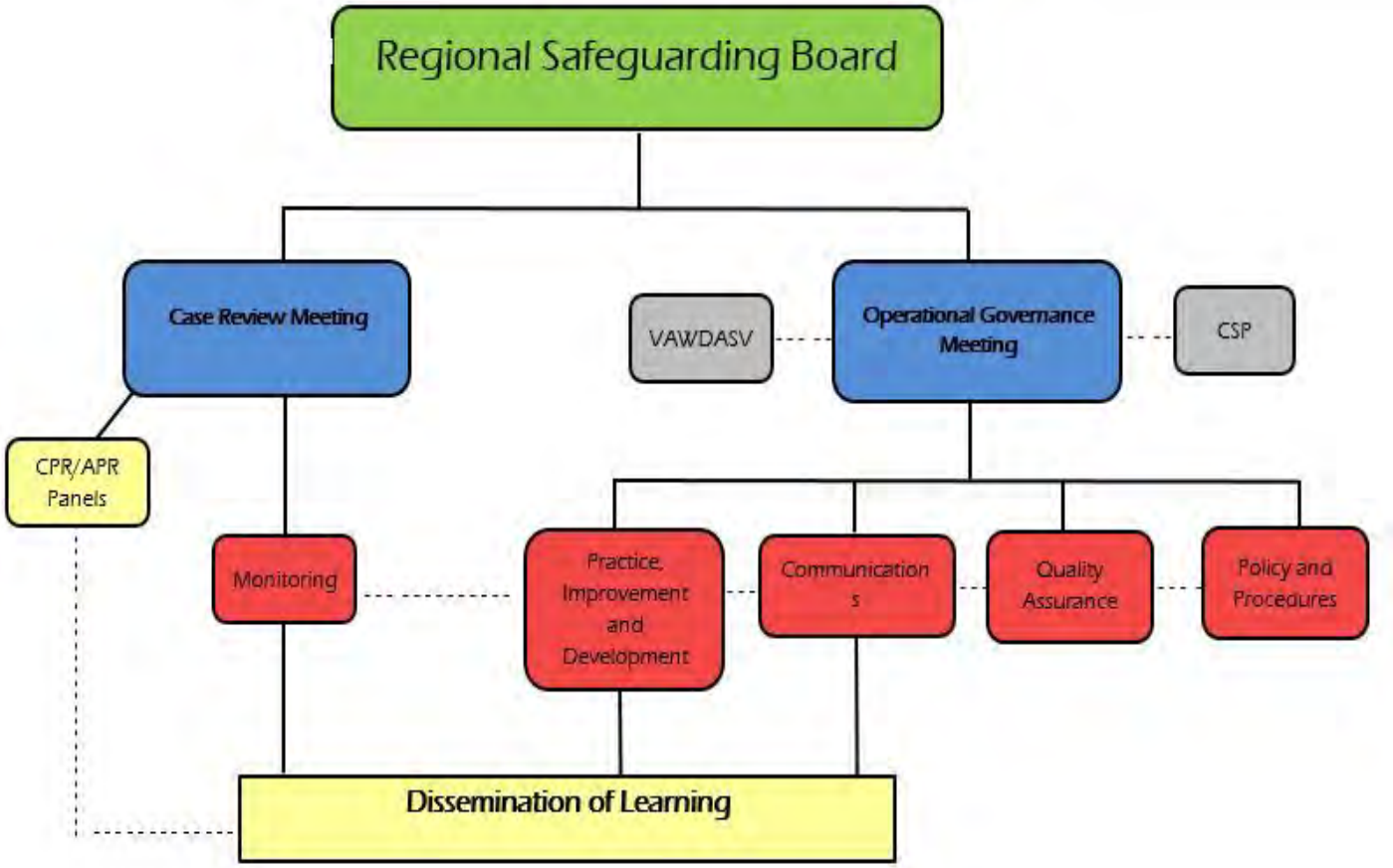
			• Equality and diversity • Mental Capacity Act	
		It has been identified that some staff did not have the required DBS check and the Trust does not have a DBS policy.	A multidisciplinary group has been established and an action plan developed to improve the Trust DBS position. To ensure that all staff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

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

4. MULTI-AGENCY WORKING

4.1 Regional Safeguarding Boards

The work of the Safeguarding Board's subgroups was suspended due to the COVID 19 pressures. During this period, the opportunity was taken to review the subgroups and the structure, with the agreed structure noted below. The requirements of Safeguarding Children Boards and Safeguarding Adults Boards in Wales have been established under section 134 of the Social Services and Well-being (Wales) Act 2014. The Trust is a member of the Cardiff and Vale Regional Safeguarding Board and the following subgroups:



4.2 National Safeguarding Week 15th-19th November 2022

The aim of the National Safeguarding week is to raise awareness about safeguarding issues and to reinforce the message that '*safeguarding is everyone's responsibility'.*

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

5. SAFEGUARDING AND PUBLIC PROTECTION POLICY

Trefniadau Diogelu Cymru
Wales Safeguarding Procedures

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

5.1 Referral Process and Multi-Agency Arrangements

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

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

5.2 Safeguarding and Public Protection Activity

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

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

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

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

5.3 Information Sharing

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

5.4 Female Genital Mutilation (FGM)

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

5.5 Multi-Agency Public Protection Arrangements (MAPPA)

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

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

5.6 PREVENT

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

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

5.7 Violence against Women, Domestic Abuse & Sexual Violence

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

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

6. MENTAL CAPACITY ACT AND DEPRIVATION OF LIBERTY SAFEGUARDS

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

6.1 Trust DoLS activity is summarised in the table below:

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

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

6.2 Liberty Protection Safeguards

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

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

Liberty Protection Safeguards Implementation Plan

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

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

6.3 Liberty Protection Safeguards Consultation

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

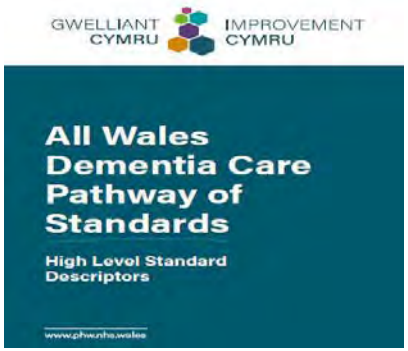
Mental Capacity Act (1 Day)

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

7. SUPPORTING VULNERABLE GROUPS

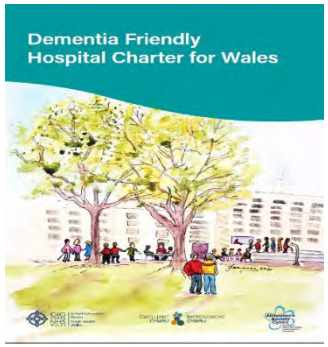
Work has continued to support patients and donors with additional needs and ensure reasonable adjustments are made to enable vulnerable groups to receive the best possible experience of our service. A new group has been established and the terms of reference for the Trust supporting vulnerable groups forum has been approved.

1. A revised training needs analysis was disseminated for dementia training inline with the levels specified in the Good Working dementia learning and development framework. This will ensure that staff have access to training that is relevant to their role in the Trust. Dementia training has been sourced from Cardiff & Vale University Health Board and is available for staff requiring skilled level training.



2. The twenty standards sit within four themes: Accessible, Responsive, Journey, Partnerships & Relationships underpinned by Kindness & Understanding. Scoping has been undertaken with the Trust to ensure we are compliant with the standards and that we provide the best possible care to patients with Dementia.

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



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

8. SAFEGUARDING TRAINING AND LEARNING

8.1 Safeguarding Adults and Children at Risk

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

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

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

8.2 Level 3 Safeguarding and Children

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

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

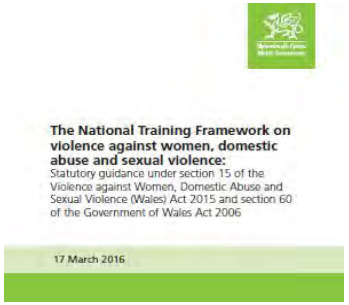
With the profile of our services, the most crucial safeguarding training is Level 2 recognition and responding to abuse. This gives staff the knowledge of how to recognize signs of abuse and clearly explains the statutory duty to report. Level 3 training clearly explains the safeguarding process following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

Given this the Trust has agreed the following training:

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

8.3 Violence against Women, Domestic Abuse and Sexual Violence

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



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

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

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

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

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

8.4 Trust Board Safeguarding Training

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

9. LEARNING FROM CONCERNS AND INCIDENTS

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

9.1 All Wales Pressure Ulcer Investigation

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

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

9.2 Falls scrutiny panel

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

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

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

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

9.4 Thematic Review of Adult Practice Reviews

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

10. STAFF GUIDANCE AND INFORMATION

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

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

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

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

11. LOOKING AHEAD

Exciting Safeguarding and Vulnerable adults' developments for 2022/20

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

QUALITY, SAFETY & PERFORMANCE COMMITTEE

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

DATE OF MEETING	14th July 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Non Applicable

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

REPORT PURPOSE	FOR ASSURANCE

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

1. SITUATION

The Nurse Staffing Levels (Wales) 2021/2022 Annual Report is provided to the Quality, Safety & Performance Committee for **ASSURANCE** purposes and for **REVIEW** prior to submission to the Trust Board.

2. BACKGROUND

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

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

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

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

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

The Executive Management Board and the Trust Board agreed that the inpatient Ward at Velindre Cancer Centre (First Floor Ward) does fit within the wider definition of a medical ward (non-surgical oncology wards in other parts of Wales e.g. Singleton Hospital Ward 12 are included in 25B,C &D of the Act), and therefore has reported as a 25b report ward from the 1st April 2021 has become part of the

full requirements of the Act and its full reporting requirements for a full year now.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Nurse Staffing Act Reporting

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

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

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

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

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

- ***First Floor ward reporting on Nurse Staffing Act (2016) -*** On the 25th March 2021 Trust Board approved that the First Floor Ward at Velindre Cancer Centre would be recognised as a medical ward in line with the requirements of the Nurse Staffing Levels (Wales) Act 2016. Therefore, from the 1st April 2021 the full reporting requirements of the Act in relation to this ward came into effect.

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

- ***Acuity Reviews*** – it is critically important to understand acuity levels across

services if we are doing to appropriately deploy staff and set appropriate staffing levels. There is a 6 monthly national benchmarked acuity review undertaken at present (June & January each year, although moved to July 2020 due to COVID). Inpatient areas in Velindre Cancer Centre have moved to daily acuity capture and there are plans to increase the frequency to at least twice daily and cover other areas rapid throughput (January 2022 Acuity audit is attached in ***appendix 2)***.

- ***Establishment Reviews –*** Following each audit and availability of national benchmarked data is available the Executive Director of Nursing, AHP & Health Science and Head of Nursing will undertake a formal establishment review across all nursing areas within Velindre Cancer Centre. The last review was November 2021 based on the July 2021 Acuity data.

3.3 COVID-19 Response Phase Surge Nursing Staffing Contingency Plan

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

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	There is a strong evidence base that links nurse staffing levels with patient experience and outcomes.
RELATED HEALTHCARE	Safe Care

STANDARD	Individual care, Timely care, Dignified Care, Staff & resources
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required

LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Compliance with the relevant sections of the Nurse Staffing Levels (Wales) Act 2016 is a statutory obligation and will be subject to scrutiny
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Given the duty of the act, in the event of patient acuity and / or numbers increasing the staffing levels will need to be increased accordingly. This will have a financial impact

5. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **REVIEW** the 2021/22 position in respect of the Nurse Staffing Levels Act (Wales) and **ENDORSE** the report prior to submission to Trust Board.

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

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

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

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

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

Extent to which the planned roster has been maintained within <u>both adult medical and surgical wards and paediatric inpatient wards</u>

	Total number of shifts	Shifts where planned roster met and appropriate	Shifts where planned roster met but not appropriate	Shifts where planned roster not met but appropriate	Shifts where planned roster not met and not appropriate	Data completeness
TOTAL	*4,745*	*3,773 (80%)*	*0 Number and (%)*	*972 Number and (20 %)*	*0 Number and (%)*	*100 (%)*

Extent to which the planned roster has been maintained within <u>adult acute medical and surgical wards</u>

	Total number of shifts	Shifts where planned roster met and appropriate	Shifts where planned roster met but not appropriate	Shifts where planned roster not met but appropriate	Shifts where planned roster not met and not appropriate	Data completeness
TOTAL	*4,745*	*3,773 (80%)*	*0 Number and (%)*	*972 Number and (20 %)*	*0 Number and (%)*	*100 (%)*

Accompanying narrative:

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

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

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

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

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

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

	• The Senior Nurse on site is responsible for ensuring safe deployment of staff in line with the Act requirements on a day by day basis. Rostering is now electronic through HealthRoster (ALLOCATE) allowing easy real-time access/review to all rosters From April 2021 Velindre first floor ward has be reclassified as an adult acute Medical inpatient ward and a section 25B reporting ward.

Section 25E (2b) Impact on care due to not maintaining the nurse staffing levels in adult acute medical & surgical inpatients wards

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

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

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

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

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

QUALITY, SAFETY & PERFORMANCE COMMITTEE

HIGHLIGHT REPORT FROM THE TRUST SAFETY ALERTS MANAGEMENT GROUP

DATE OF MEETING	14th July 2022
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Jade Coleman, Quality and Safety Officer
PRESENTED BY	Nigel Downes, Deputy Director Nursing, Quality & Patent Experience
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, AHPs and Health Scientists
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	01/07/2022	Discussed and improvement actions approved

ACRONYMS

VCC	Velindre Cancer Centre
VUNHST	Velindre University NHS Trust
PSN	Patient Safety Notice
PSA	Patient Safety Alert
MDA	Medical Device Alert

1. PURPOSE

This report provides the Quality, Safety & Performance Committee with the key highlights / outputs from the Trust's Safety Alerts Management Group for the period of the 1st January 2022 – 31st May 2022, the outcome of additional audit reviews and details in relation to alerts which are non-compliant.

The Quality, Safety & Performance Committee is asked to **NOTE** the report **CONSIDER** the actions being taken to achieve compliance in relation to the two overdue safety alerts.

2. BACKGROUND

Velindre University NHS Trust regularly receives various types of Safety Alerts which include:

- Patient Safety Notices (advising the Trust on changes to practices/procedures to prevent possible harm to patients)
- Dangerous Incident notifications (which can relate to Estates concerns such as high voltage hazards)
- Medicine updates (such as shortages of particular drugs)
- Medical device notifications
- Covid-19 risk reduction measures, treatment and vaccinations update alerts

The Trust must be able to demonstrate that it has responded appropriately to the requirements of each applicable Safety Alert in order to reduce the risk of harm occurring to patients, staff and service users. The role of the Trust Safety Alerts Management Group is to provide and ensure an effective management system for the distribution, assessment and monitoring of all Safety Alerts received from the Welsh Government.

The Trust Quality & Safety Team undertake an immediate review, dissemination and escalation of any Safety Alerts that the Trust receives. This ensures that prompt action is taken to assess applicability and levels of compliance and areas of action required. In addition, the Trust is a member of the All Wales Patient Safety Reference Group so that it is fully involved in discussions of any 'Alerts of concern', the sharing of best practice and ongoing national network support.

Each safety alert received by the Trust is distributed across the organisation via the Datix reporting safety alert system.

3. ASSESSMENT

3.1 Highlights from the Safety Alert Group for the period of 1st January 2022 – 31st May 2022

ALERT / ESCALATE	**Current Open Safety Alert Position** The Group identified three historical Patient Safety alerts that the Trust is not yet compliant with. However, further review in June 2022 identified that one alert is not applicable for the Trust. This will be considered by the next Group prior to notification to the Delivery Unit. • ***Revised National Steroid Treatment Card PSN057*: (*Original deadline: 31st January 2022)*** The Safety alert has been reviewed on an All Wales basis and is included on the monthly Agenda for the All Wales Patient Safety Solution Reference Group. At Trust level a multidisciplinary working group including nursing, medical and pharmacy staff members are working through localised actions. Pharmacy along with the newly appointed Immunotherapy Operational Nurse are leading on this piece of work. **Current status:** o Much of the outstanding work will be led by the new Immunotherapy Operational Lead Nurse who was recruited at the beginning of May 2022 o The aim is to become compliant with all actions set out in the alert **by September 2022.** • ***The Safe Storage of Medicines: Cupboards PSN055: Original deadline (30th September 2021)*** The Safety alert has been reviewed on an All Wales basis and is included on the monthly Agenda for the All Wales Patient Safety Solution Reference Group. At Trust level an audit of all areas that stock medication was completed throughout January 2021 using the national audit tool associated with this alert. Audit findings were reported back to the Medicines Management Group. Pharmacy are leading on this piece of work.

	Current status: • All audits have been undertaken to identify gaps • A robust action plan of what is easily resolvable and what needs a business/capital gains case to become fully compliant is being worked through. • Decisions required to either undertake the work to action the gaps or, undertake risk assessments where appropriate. • The aim to become compliant with all actions set out in the alert **by September 2022.** • **Ligature and ligature point risk assessment tools and policy PSN928 (*Original deadline: 1st September 2021)*** Non- compliance was identified through the previous alert audits where limited assurance was received. Following detailed review it has been identified that this alert is for those organisations who provide any type of mental health service. This therefore does not apply to the Trust. Despite this a risk reduction plan has been developed and is being worked through by the Operational Senior Nurse and Health & Safety Manager. This will be formally reviewed at the next Safety Alert Group prior to notifying the Welsh Government Delivery Unit.
ADVISE	**Audit** The Group received a detailed audit report that outlined the follow up audit findings from the previous audit undertaken in March 2022 as well as the audit outcomes from the further 10 alerts requested by the Executive Management Board. The 10 remaining alerts (all medicine alerts) were audited and full assurance received. Of the three areas identified in the previous audit where full assurance was not received: • ***Patient Safety Notice 967: Reducing the Risk of Inadvertent Administration of Oral Medication by the Wrong Route*** – full assurance received that this has now been completed and Trust is fully compliant. • ***Patient Safety Notice 920:*** **Revised National Steroid Treatment Card - currently** identified as non-compliant alert. Delivery timescale agreed.

	• ***Patient Safety Notice 819:*** **The Safe Storage of Medicines: Cupboards -** currently identified as non-compliant alert. Delivery timescale agreed.
ASSURE	**63** ***new Safety Alerts*** were received by the Trust during the period of the 1st January 2022 to the 31st May 2022 which is consistent in comparison to previous months. A breakdown of the number and type of alerts received are detailed below: • ***No Patient Safety Alerts*** were received during the period (2 received for same period in 2021). • ***Medication Alerts*** - ***40*** medicine / drug related alerts were received. Each alert was reviewed by our Pharmacy safety alert leads to establish whether the alert was applicable to the Trust. Each drug was stock checked to determine whether the Velindre Cancer Centre were in receipt of that particular drug and also to confirm any last issued dates. 10 of the 40 alerts were assessed as being applicable to the Trust. Pharmacy leads confirmed that Velindre Cancer Centre drug stock was checked against any identified shortages highlighted within the safety alerts ensuring that the Cancer Centre were not impacted and that alternative drug supply was available if needed. • ***Covid-19 Alerts:*** **5** Covid-19 related alerts were received and circulated via the Datix system. The 5 alerts were reviewed and deemed not applicable to Velindre University NHS Trust as any patient requiring specific Covid-19 related treatment is cared for under their Health Board and the Trust are not directly involved in the vaccination of severely immunocompromised patients. • **Estates Alerts: 4** Estates alerts were received and reviewed by the Trust Estates manager confirming that the type of equipment identified in the alerts are not in operation at any of the Trust properties. • **6** additional alerts were received during the time period which were reviewed. Two were assessed as being applicable to the Trust: o Phillips ventilators unexpected shutdown, not applicable as medical device not used at Trust. o Platelet filter systems, not applicable as medical device not used at Trust.

	o Shortening of Penrose drains not applicable as procedure not carried out at Trust. o Paclitaxel drug-coated balloons not applicable as medical device not used at Trust. o Preventing transfusion delays in bleeding and critically anemic patients, Trust compliant, hemorrhage training for the assistant nurse practitioners as a minimum and scenario training for major hemorrhage underway. o Oropharyngeal airway products - reviewed and added to the Agenda of the Velindre Cancer Centre resuscitation meeting, Trust compliant, Colours of the Guedel airways are changing due to additional sizes being available. Current stock will be monitored in line with the expiry date and new orders will be for the new range of colours/sizes. • **8** alerts were received and shared via the Datix system for information only.
INFORM	There were no items for information.
Appendices	**Not applicable**

4. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **NOTE** the report and **CONSIDER** the actions being taken to achieve compliance in relation to the two overdue safety alerts.

QUALITY, SAFETY & PERFORMANCE COMMITTEE

HEALTH AND CARE STANDARDS ANNUAL REVIEW REPORT

DATE OF MEETING	14th July 2022

PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Non-applicable
PREPARED BY	Jade Coleman, Quality and Safety Officer
PRESENTED BY	Nigel Downes, Deputy Director Nursing, Quality & Patient Experience & Jade Coleman, Quality
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director Nursing, Allied Healthcare Professionals and Health Science

REPORT PURPOSE	TO APPROVE

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	01/07/2022	APPROVED

ACRONYMS	
HCS	Health and Care Standards
VCC	Velindre Cancer Centre
WBS	Welsh Blood Service

1. SITUATION

This report is to provide the Quality, Safety & Performance Committee with the outcome of the 2021/22 Health and Care Standards Assessment process and details of the plans and work done to date to further amend and revise the internal oversight and assessment process for the Trust for 2022/23. In particular the Quality, Safety & Performance Committee is asked to:

- **APPROVE** the overarching 2021/22 Health and Care Standards status as a level 4:
- **APPROVE** the end of year 2021/22 Health and Care Standards assessment and Improvement Plan status;
- **NOTE** the Divisional Assurance Highlight Reports;
- **NOTE** the draft 2022/23 Health and Care Standards Improvement Plan.

2. BACKGROUND

The current Health & Care Standards have been in place across NHS Wales since 2015. The Trust reviewed its internal assessment process for the assessment year 2021/22. It was recognised that the standards needed to be more firmly embedded in the core business of Divisions and corporate teams and, therefore, the review included strengthening accountabilities and responsibilities and roles of management oversight groups in monitoring standards compliance. In addition, it was agreed that the frequency of assessments and reviews should increase from an annual process to a more embedded 'live' quarterly review process and this was implemented in April 2021.

2021/2022 is the first year in which the Trust has implemented the strengthened process for the Health and Care Standards. The Divisional and Corporate Teams have undertaken a comprehensive review of their compliance with the Health and Care standards during each quarter of 2021/2022, and have also ensured that the Improvement Plan has been updated.

It was agreed that the assessment scoring criteria would be revised for the 2021/22 process moving from the previously agreed Trust scoring of: compliant; partial compliance or non-compliance to the national scoring criteria detailed below. This was fully embedded.

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

A national review of the Health & Care Standards has commenced in order to ensure they are updated to reflect the requirements of the Wales Quality Bill (2020) as well as the soon to be published national Quality & Safety Framework. The standards will remain unchanged for the 2022/23 assessment year. It is anticipated that these will be replaced with Quality Standards.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 2021/2022 Health and Care Standards Self-Assessment Outcomes

3.1.1 Delivery against revised self-assessment process: As detailed above, Executive Management Board approved a revised self-assessment process for 2021/22. The new financial year saw all standards being reviewed quarterly and regular action plan updates being documented. Divisional senior leadership team reviews and Divisional performance review oversight have taken place quarterly. The Trust have continued to implement Health and Care Standards improvement actions, which have been monitored by the divisional quality & safety groups and the Executive Management Board approved the six month Health and Care Standard review of self assessments and improvement plan.

3.1.2 Stage 1 – Divisional assessment against the Health and Care Standards: The divisional self-assessments have been completed and approved through the responsible Senior Management Teams. The Standard/s Operational Lead/s have undertaken an independent quality check of the Divisional self-assessment and some of this did result in re-scoring. The Divisional Health and Care Standards highlight reports are attached in ***Appendix 1a & 1b***.

3.1.3 Stage 2-Assessment:

In addition to the Operational Lead oversight of the Divisional self-assessments the Operational lead/s also complete an assessment of overarching Trust position in respect of the standards that they are accountable for and assign a Trust wide assessment score for each. The summary of this is detailed in ***Appendix 2***. Standards scored between a level 3 (Trust is 'developing plans and processes and can demonstrate progress with some of our key areas for improvement') and a level 5 (Trust 'can demonstrate sustained good practice and innovation that is shared throughout the organisations/business, and which others can learn from').

Following completion of the 2021/22 Health and Care Standards annual review, self-assessments were reviewed by Divisional leads and responsible officers, and all agreed that the Quarterly review assessment process of the Health and Care Standards has helped embed the Standards in core business from service level to Ward.

The overarching Trust score was identified as a level 4. The Quality, Safety & Performance Committee is requested to **APPROVE** this overarching status.

3.1.4 Delivery against the 2021/22 Health and Care Standards Improvement plan

The Health Care Standards Improvement Plan details the actions that are required per Standard in order to improve compliance, and to ultimately improve the quality of care provided within the organisation. The status of the 2021/22 improvement plan is attached in ***Appendix 3***. The Improvement plan was reviewed and updated every quarter and a number of improvement actions were completed. The remainder actions have been transferred to the 2022/23 Improvement Plan for continued progression.

All actions had work undertaken on them during 2021/22. **61%** of actions were fully completed despite the ongoing operational challenges and positive progress was made with the improvements that had been identified. **39%** of actions will continue to be worked through during 2022/23.

3.2 2022/23 Health and Care Standard Improvement Plan

The 2022/23 Health and Care Standard Improvement Plan **Appendix 4** sets out the current status for the actions listed that will continue to be progressed through 2022/23 in order to improve compliance, and to ultimately improve the quality of care provided within the organisation. These actions will continue to be monitored during the year through to closure.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	The areas considered to have an impact on quality and safety are identified in the Health and Care Standards
RELATED HEALTHCARE STANDARD	All related to the Health and Care Standards.
EQUALITY IMPACT ASSESSMENT	All areas considered to have an impact on equality are identified in the Standards.
LEGAL IMPLICATIONS / IMPACT	There would be potential legal implications of non-delivery of these core standards.
FINANCIAL IMPLICATIONS / IMPACT	There would be financial implications aligned to both delivery and non-delivery of the Health and Care Standards. The non-delivery will be in relation to possible litigation due to non-compliance. Delivery of financial requirements will be worked through as part of local implementation/delivery plans.

5. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to**:**

- **APPROVE** the overarching 2021/22 Health & Care Standards status as a level 4:
- **APPROVE** the end of year 2021/22 Health and Care Standards assessment and Improvement Plan status;
- **NOTE** the Divisional Assurance Highlight Reports;
- **APPROVE** the working draft 2022/23 Health and Care Standards Improvement Plan.

VCC HEALTH & CARE STANDARDS WALES SELF ASSESSEMENT 2021/22
YEAR END DIVISIONAL HIGHLIGHT REPORT

1. SITUATION

The Health and Care Standards Wales 2015 set out the requirements for the delivery of health care in Wales at every level and in every setting. The standards have been designed to fit the seven themes of the NHS Outcomes and Delivery Framework and establish a basis for improving the quality and safety of healthcare services, by providing a framework to identify strengths and areas for improvement.

2. BACKGROUND

The seven themes collectively describe how a service provides high quality, safe and reliable care, centred on the person. Person centred care is positioned in the centre of illustration and the dependence on good governance, leadership and accountability is illustrated by placing them around the seven themes.

The service divisions undertake the self-assessment process and provide assurance reports that detail ongoing evidence of compliance across the Division.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

Improvement actions identified from the self-assessment are included within the divisional and Trust HCS improvement plan and monitored by the divisional SLT and at quarterly Divisional Reviews. A comprehensive update report mid-year and year end will be received at Executive Management Board and the Trust Quality, Safety and Performance Committee.

3.1 FINDINGS

Scores and a summary of compliance against each standard can be found below

Overall compliance with the standards for health services

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

3.1.1 Standard 1 - Staying Healthy

Staying healthy	Score 2021/22	Score Q1	Score Q2	Score Q3	Score Q4	Corporate Score	SLT Lead
	Full						Amanda Jenkins
Standard 1.1 Health Promotion							
TRUST RESPONSE REQUIRED *Additional Information:-* Achievements							

3.1.2 Standard 2 - Safe Care

Safe care	Score 2021/22	Score Q1	Score Q2	Score Q3	Score Q4	Corporate Score	SLT Lead
Std 2.1 Managing Risk and H&S (VC&LM)	Partial	4	4	4	4		Lisa Miller/Viv Cooper
Std 2.2 Preventing Pressure Damage	Full	4	4	4	4		Viv Cooper
Std 2.3 Falls Prevention	Partial	4	4	4	4		Viv Cooper
Std 2.4 Infection Prevention and Control	Full	4	4	4	4		Viv Cooper
Std 2.5 Nutrition and Hydration	Full	4	4	4	4		Viv Cooper
Std 2.6 Medicines Management	Full	5	5	5	5		Bethan Tranter
Std 2.7 Safeguarding	Full	4	4	4	4		Viv Cooper
Std 2.8 Blood Management	Full	5	5	5	5		Viv Cooper
Std 2.9 Medical Devices, Equipment and Systems	Full	4	4	4	4		Kathy Ikin

Additional Information:

Achievements

Standard 2.1
Migration of risk from V12 to V14 of the DATIX system
To establish a revised Health and Safety Management Group that mirrors the proposed new Trust Health and Safety Committee.
The new delivery and development directorate structure is currently being implemented.

Standard 2.2
Sign off and implementation of Tissue Viability and Pressure Ulcer Preventtion and Management Guidelines.
The Pressure Ulcer scrutiny panel has been reviewed to further improve the investigation of both patients who develop pressure ulcers in VCC and those who are admitted to VCC with a pressure ulcer, with an emphasis on the learning and service improvement. Strong governance structures have been established with the scrutiny panel outcomes and learning are shared via the QSMG, SLT, EMB and QSP meetings
Fully transition from current paper version of Pressure Ulcer risk assessment documentation (Purpose T) and care planning documentation to the electronic risk assessment Purpose T- and pressure ulcer care planning documentation

Standard 2.3
Revised Trust falls scrutiny panel to reflect number of patients who have fallen and number of falls. Reported via Trust performance report.
Improvements have been made to the Falls Scrutiny Panel which is monthly with a focus on the learning and service improvement. Strong governance structure has been established with scrutiny panel outcomes being fed into QSMG, QSP, SLT and EMB
Revised delivery options required for manual handling training during this ongoing Covid-19 pandemic

Standard 2.4
Low HCA infection rates against an increasing national trend.
Good compliance with IPC processes and procedures have resulted in low COVID-19 cases being treated in the cancer centre.
Lydia Ayres, RPE trainer, has successfully gained Fit to Fit accreditation. This will enable her to train more departmental trainers in the use of the Portacount machine to increase fit testing compliance.
The IPCT has been working without a full complement of staff for a considerable period of time. The team have worked under pressure but have managed to provide a seamless service in challenging circumstances and continue to deliver the assurance required by the Trust.

Standard 2.5
WNCR in place which includes electronic WAASP nutritional screening tool
Protected mealtime audits quarterly
WAASP audits ongoing
Electronic ordering system in place for catering staff to complete
Continue to provide good, personalised catering support to meeting individual patient needs
Continue to attend AWMF dietetic and operational groups to ensure collaboration with HB's across Wales
Fortnightly menu adhering to All Wales Menu Framework in place
IDDSI fully implemented and training completed

Standard 2.6
Implementation of the ARK chart across VCC.
Initial Work being carried out to support the risk assessment tool for PSN055 Safe Storage of Medication and an action plan of risks has been identified and being worked through.
Implementation of new Hospital Pharmacy System (Wellsky)
Secured funding, purchased and validated a new medicines storage temperature monitoring system across VCC.
ChemoCare worksheets and label module version 5
Scoping work to review process and supporting documentation for the development and delivery of SACT protocols
Develop pharmacy SACT verification procedures to encompass BOPA verification standards.

Standard 2.7
Releasing staff to attend training new training.
Mental Capacity Act and Safeguarding Adults Level 3

Standard 2.8
Safe management of blood products and systems associated with a satellite blood fridge
Excellent training compliance

Standard 2.9
POCT improvement – working towards getting POCT devices results/patient demographics information viewable in the WCP environment and POCT devices. MPI UAT demographic feed requires to be established by Siemens (external provider) before any further UAT work can be conducted. This action has been raised by NWIS to Siemens. Now overdue due to the nature of the work and we now expect this task to be completed by end of Q1, June 2022. Previously there has been no demographics feed for POCT devices, hence no impact on the existing workflow. This is an improvement work so once it is in place, it should improve workflow and patient care.

Database – This task is now complete. We have foundation database that we will start using soon, including remote access to VCC database to the Database supplier (RAM/MRI software). VPN token for remote access will be in place very soon. We expect this to be completed by end of Q1, June 2022.

3.1.3 Standard 3 – Effective Care

Effective care	Score 2021/22	Score Q1	Score Q2	Score Q3	Score Q4	Corporate Score	SLT Lead
Std 3.1 Safe and clinically Effective Care	Full	4	4	4	4		Viv Cooper
Std 3.2 Communicating Effectively	Partial	4	4	4	4		Viv Cooper
Std 3.3 Quality Improvement, Research and Innovation	Full	4	4	4	4		Christopher Cotterill-Jones
Std 3.4 IG and Technology							
Std 3.5 Record Keeping	Full	5	4	4	4		David Mason-Hawes
	Full	4	4	4	4		Lisa Miller

Additional Information: -

Achievements

Standard 3.1
The clinical trials and pharmacy services are subject to strong regulatory standards which are regularly inspected by the MHRA. Work is progressing to ensure all SST's have documented SACT treatment algorithms.

Standard 3.2
In September 2020 in conjunction with Cardiff University, Velindre launched its Memory Mates Initiative to help support any patients with a memory concern to safely receive their treatments. Clinically there is a site specific team that care for patients with neuro related tumours and this includes an Oncologist, CNS and specialist radiographer and AHP's including Speech and Language Therapy, Physiotherapy, Dietetics and Occupational Therapy.

Standard 3.3
RD&I Operational Plan 2020/21 to 2021/22
To incorporate into the RD&I Division's Operational Plan, the ambitions and recommendations from:

- A Cancer Research Strategy for Wales

- The Velindre Futures programme “Overarching Cancer Research and Development Ambitions 2021-31
- The Nuffield Trust report “Advice on the proposed model for non-surgical tertiary oncology services in South East Wales”

The RD&I Division’s Operational Plan 2020/21 to 2021/22 is a living document and is kept under review.

The RD&I Division has been discussing the drafting the RD&I Operational Plan for 2022/23 during Q2 and 3 of 2021/22. With the RD&I strategic priorities for the Integrated Medium-Term Plan 2022 to 2025 recently agreed, the annual RD&I Operational Plan for the financial year 2022/23 can be drafted.

One Site” Wales approach to research delivery (SYMPLIFY)
Velindre University NHS Trust led the coordination across Wales of a research study to assess a multi-cancer early detection test. The study SYMPLIFY is sponsored by the University of Oxford. This is the first research study to adopt the “One Site Wales” coordinated approach outside the COVID19 vaccine arena.

The study, with Professor Dean Harris (Swansea Bay UHB) and Professor Tom Crosby (Velindre University NHS Trust) as Wales Principal Investigators was open to recruitment at 19 district hospitals across six health boards. The study was being coordinated from the Trust R&D Office by Sarah Townsend, Head of Research & Development and Christopher Cotterill-Jones, Research Delivery Manager.

The Trust and six Wales Health Boards worked together to set-up and deliver this study, with Wales being the highest recruiting site, recruiting 1232 participants of 6240 total participants. The Trust continues to lead on the follow up procedures for these patients in collaboration with the six Health Boards and Digital Health Care Wales.

Develop a plan to ensure the Trust has the capability to delivery vaccine research both in its own right and as part of Health and Care Research Wales vaccine infrastructure.
An options appraisal identified that to ensure there was capability to deliver vaccine research the Trust needed to invest in a Biological Safety Cabinet to be sited in Pharmacy at Velindre Cancer Centre.

The Trust agreed to the purchase of a Biological Safety Cabinet as part of the plan to develop the capability to deliver vaccine research, which was delivered to Velindre Cancer Centre in March 2022. Additional work to site the Biological Safety Cabinet in pharmacy and relocate staff currently occupying the space due to COVID restrictions will continue in 2022/23

Review the administrative structure, roles and responsibilities of the research delivery team.
A review of the R&D service’s administrative structure, roles and responsibilities for the delivery of research was carried out.

The review has identified a need to change the service's administrative structure, roles and responsibilities within the staff groups responsible for research delivery. Work to address this and change the existing service structures, roles and responsibilities will continue in 2022/23 with support from Workforce & Organisational Development, as appropriate.

Standard 3.4
Strengthen existing IG training provisions available to staff by means of establishing supplementary training platforms in order to deliver training [i.e. Microsoft Teams]
Trust / WBS / VCC: Develop new Trust wide performance indicators for Digital Delivery *Carried forward from 20-21*

Standard 3.5
Phase 1 pilot is complete.
Phase 2 addition of new assessments and roll out complete of the electronic nursing documentation, influencing design and specification at a national level to ensure compliance with legislation/standards associated with the medical record.
Phase 3 UAT complete, go live date May 2021. Full demographic updates with WPAS implementation.
Development and delivery of the Document Management System Dashboard to monitor and manage compliance against local key performance indicators for clinical correspondence sign off.

3.1.4 Standard 4 – Dignified Care

Dignified care	Score 2021/22	Score Q1	Score Q2	Score Q3	Score Q4	Corporate Score	SLT Lead
Std 4.1 Dignified Care	Partial	4	4	4	4		Viv Cooper
Std 4.2 Patient Information	Partial	4	4	4	4		Viv Cooper

Additional Information: -

ACHIEVEMENTS

Standard 4.1
Continuation of the work of the Dignity Forum, production of a dignity newsletter

Standard 4.2
Responding positively to changes during the Covid-19 pandemic, adapting current information to include covid guidance for cancer patients and their families including bereavement.

Continuing to deliver support services to patients, carers and their children, offering telephone and face to face support, accessing from 1st Jan 2020 - 31st Dec 2021 £6.9 million in benefits and grants to support VCC patients

3.1.5 Standard 5 – Timely Care

Timely care	Score 2021/22	Score Q1	Score Q2	Score Q3	Score Q4	Corporate Score	SLT Lead
Standard 5.1 Timely Access	Full	4	4	4	4		Lisa Miller

Additional Information: -

Achievements
Revised divisional monthly performance report produced. Report better reflects operational context

3.1.6 Standard 6 – Individual Care

Individual care	Score 2021/22	Score Q1	Score Q2	Score Q3	Score Q4	Corporate Score	SLT Lead
Std 6.1 Promote Independence	Partial	3	3	3	3		Eve Gallop-Evans
Std 6.2 Peoples Rights	Full	4	4	4	4		Lisa Miller
Std 6.3 Learning from Feedback	Full	3	3	3	3		Viv Cooper

Additional Information: -

Achievements

Standard 6.1
Significant progress with new ways of working supporting self- management through the pandemic with increased instructional videos and patient information readily available on the website.
Increased collaborative working within and beyond the cancer centre with signposting to 3rd sector organisations for support. Also signposting to C&V rehabilitation pages and covid app so that patients could support themselves whilst remaining safely at home.

Digital innovation and use of virtual platforms. Attend anywhere platform has been used across the Trust to allow for virtual consultations alongside telephone appointments. This allowed people to feel supported in their own homes whilst freeing up 1-1 appointments for those who needed them most. Appointments have also been used to support patients. This digital innovation is a new way of working that will continue beyond the pandemic. **Standard 6.3** Delivery and migration of new OfW DATIX system for incidents, feedback, claims and redress.

3.1.7 Standard 7 – Our Staff

Our staff	Score 2021/22	Score Q1	Score Q2	Score Q3	Score Q4	Corporate Score	SLT Lead
	Full						Amanda Jenkins
Standard 7.1 Workforce							
TRUST RESPONSE REQUIRED *Additional Information:-* Achievements							

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
RELATED HEALTHCARE STANDARD	
	The related healthcare standard will vary.

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 SLT are asked to note that:

Standard 7.1 – Workforce - This will be completed by corporate colleagues

And to;

- **APPROVE** the findings of the Quarter 4 Divisional Health & Care Standards self-assessment.

WBS HEALTH & CARE STANDARDS WALES SELF ASSESSEMENT 2021/22
YEAR END DIVISIONAL HIGHLIGHT REPORT

1. SITUATION

The Health and Care Standards Wales 2015 set out the requirements for the delivery of health care in Wales at every level and in every setting. The standards have been designed to fit the seven themes of the NHS Outcomes and Delivery Framework and establish a basis for improving the quality and safety of healthcare services, by providing a framework to identify strengths and areas for improvement.

2. BACKGROUND

The seven themes collectively describe how a service provides high quality, safe and reliable care, centred on the person. Person centred care is positioned in the centre of illustration and the dependence on good governance, leadership and accountability is illustrated by placing them around the seven themes.

The service divisions undertake the self-assessment process attached (Appendix 1) and provide assurance reports that detail ongoing evidence of compliance across the Division.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

Improvement actions identified from the self-assessment are included within the divisional and Trust HCS improvement plan, and monitored by the divisional SMT and at quarterly Divisional Reviews. A comprehensive update report mid-year and year end will be received at Executive Management Board and the Trust Quality & Safety Committee.

3.1 FINDINGS

Scores and a summary of compliance against each standard can be found below

Overall compliance with the standards for health services

Self-Assessment Rating – Theme 1 - Staying Healthy					
Assessment Level	1 We do not yet have a clear, agreed understanding of where we are (or how we are doing) and	2 We are aware of the improvements that need to be made and have prioritised them, but are	3 We are developing plans and processes and can demonstrate progress with some of our	4 We have well developed plans and processes can demonstrate sustainable improvement	5 We can demonstrate sustained good practice and innovation that is shared throughout

	what / where we need to improve	not yet able to demonstrate meaningful action.	key areas for improvement	throughout the organisation / business	the organisations / business, and which others can learn from

3.1.1 Standard 1 - Staying Healthy

Staying healthy	Score 2020/21	Score Q1	Score Q2	Score Q3	Score Q4	Corporate Score
	4	**4**	4	4	**4**	
Std 1.1 Health Promotion						
Many of the standards are not relevant to WBS, but the division is able to demonstrate compliance with standards 8, 10 and 11.						

3.1.2 Standard 2 - Safe Care

Safe care	Score 2020/21	Score Q1	Score Q2	Score Q3	Score Q4	Corporate Score
Std 2.1 Managing Risk and H&S	4	4	4	4	4	
Std 2.2 Preventing Pressure Damage	N/A	N/A	N/A	N/A	N/A	
Std 2.3 Falls Prevention	N/A	N/A	N/A	N/A	N/A	
Std 2.4 Infection Prevention and Control	5	5	5	5	5	
Std 2.5 Nutrition and Hydration	N/A	N/A	N/A	N/A	N/A	
Std 2.6 Medicines Management	N/A	N/A	N/A	N/A	N/A	
Std 2.7 Safeguarding	5	5	5	5	5	
Std 2.8 Blood Management	4	4	4	4	4	
Std 2.9 Medical Devices, Equipment and Systems	5	5	5	5	5	
WBS continues to engage with the corporate Risk Management project to work through challenges in migrating to a new system. The Q4 target for implementation has not been met, significant work has been done to align WBS quality risk management processes with the proposed new Corporate Risk reporting process. 2 areas of non-compliance with JPAC guidelines and one area of non-compliance with British Society of Haematology guidance remain. These represent a low risk to patients using current						

risk assessment tools. Although the patient outcome could be catastrophic the frequency is much less than yearly. Actions are in place to address them by the end of the year.
Standard 2.8:

- WBS is now fully compliant with the requirement to manufacture cryoprecipitate from male donors only, and the requirement for HNA antibody testing of female apheresis platelet donors.
- The project to introduce Haemoglobin S testing for red cells issued for neonatal use is proving challenging delivery is now likely to slip towards the end of 2022/23.
- The project to address non-compliance to advise monitoring of antenatal patients with anti-D is ongoing with no current agreed timeline.
- A new requirement to test all blood donors for occult Hepatitis B infections will be implemented by the end of Q1 2022/23

Standard 2.9

- WBS has responded to the MHRA consultation on medicines and medical devices legislation, and is awaiting publication of the final draft of the legislation.

3.1.3 Standard 3 – Effective Care

Effective care	Score 2020/21	Score Q1	Score Q2	Score Q3	Score Q4	Corporate Score
Std 3.1 Safe and clinically Effective Care	5	5	5	5	5	
Std 3.2 Communicating Effectively	4	4	4	4	4	
Std 3.3 Quality Improvement, Research and Innovation	5	5	5	5	5	
Std 3.4 Information Governance and Technology	5	5	4	4	4	
Std 3.5 Record Keeping	5	5	5	5	5	

Care, treatment and decision making reflects best practice based on evidence to ensure that donors receive the right care and recipient safety is maintained. Robust governance processes are in place to ensure that research activities follow the highest ethical and scientific standards, including controls on the sharing of tissue samples and confidential data.
Recent communication improvements include the introduction of aids for people who are hard of hearing. Access to welsh-speaking members of collections teams remains a key challenge
The WBS remain non-compliant with JPAC guidance regarding malaria testing of donors but a system fix is due to be applied during Q4.

Robust information governance and technology systems and processes, to support delivery of donor and patient services; however, work ongoing to establish a resilient business intelligence platform to support organisational information and reporting needs.

3.1.4 Standard 4 – Dignified Care

Dignified care	Score 2020/21	Score Q1	Score Q2	Score Q3	Score Q4	Corporate Score

Std 4.1 Dignified Care	5	5	5	5	5	
Std 4.2 Patient Information	5	5	5	5	5	

A range of measures implemented during the Covid 19 pandemic to help donation clinics to maintain staff and donor safety remain in place. The FAIR individualised Donor assessment approach was implemented successfully during Q1 2021/22, and close monitoring during Q2 has not identified any issues with the revised donor questionnaire..

3.1.5 Standard 5 – Timely Care

Timely care	Score 2020/21	Score Q1	Score Q2	Score Q3	Score Q4	Corporate Score
Std 5.1 Timely Access	N/A	N/A	N/A	N/A	N/A	

Whilst the individual standards do not directly apply to WBS as the division deals predominantly with healthy donors, robust clinical governance arrangements are in place to monitor the quality and timeliness of donor care, and the support WBS provides for recipients of our products and services.

3.1.6 Standard 6 – Individual Care

Individual care	Score 2020/21	Score Q1	Score Q2	Score Q3	Score Q4	Corporate Score
Std 6.1 Promote Independence	N/A	N/A	N/A	N/A	N/A	
Std 6.2 Peoples Rights	5	5	5	5	5	
Std 6.3 Learning from Feedback	5	5	5	5	5	

Standard 6.1 does not apply to WBS and Standard 6.2 only applies in part (sub criteria 1-3 only)

3.1.7 Standard 7 – Our Staff

Our staff	Score 2020/21	Score Q1	Score Q2	Score Q3	Score Q4	Corporate Score
	5	5	5	5	5	
Std 7.1 Workforce						

- WBS staff are enrolled on courses run across the trust to support Welsh language skills, mental health and wellbeing and leadership skills. The Clinical Services team is currently working with HEIW and OD to create a bespoke HCSW framework for Collection Teams.
- Collaboration between WBS and colleagues in the hospital clinical transfusion setting has allowed us to improve services for patients by developing All Wales policies and guidance ensuring safer transfusion practice and appropriate use of blood.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
RELATED HEALTHCARE STANDARD	
	All Healthcare Standards have been assessed.
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
	Positive impact through compliance with Standards 3.2 and 6.2
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 standard 2.9 – there is a significant resource required to implement testing and follow-up for Occult Hepatitis B infections

OVERARCHING TRUST COMPLIANCE WITH THE HEALTH & CARE STANDARDS FOR 2021/22

	HCS Standard	VCC self-assessment rating	WBS self-assessment rating	Overarching Trust assessment rating post Executive Review	Comment 2021/22
Governance, Leadership and Accountability	Effective governance, leadership and accountability in keeping with the size and complexity of the health service are essential for the sustainable delivery of safe, effective person centred care.	**4**	**4**	**4**	**Working towards 5**
STANDARD 1 Staying Healthy	**Standard 1.1 Health Promotion, Protection and Improvement** People are empowered and supported to take responsibility for their own health and wellbeing and carers of individuals who are unable to manage their own health and wellbeing are supported. Health services work in partnership with others to protect and improve the health and wellbeing of people and reduce health inequalities.	**4**	**4**	**4**	**Working towards 5**
STANDARD 2 Safe Care	**Standard 2.1 Managing Risk and Promoting Health and Safety** People's health, safety and welfare are actively promoted and protected. Risks are identified, monitored and where possible, reduced or prevented.	**4**	**3**	**4**	**Working towards 5**
	Standard 2.2 Preventing Pressure and Tissue Damage People are helped to look after their skin and every effort is made to prevent people from developing pressure and tissue damage.	**4**	**NA**	**5**	**Overarching score increased to 5 following Exec review**
	Standard 2.3 Falls Prevention People are assessed for risks of falling and every effort is made to prevent falls and reduce avoidable harm and disability.	**4**	**NA**	**5**	**Working towards 5**

	Standard 2.4 Infection Prevention and Control (IPC) and Decontamination Effective infection prevention and control needs to be everybody's business and must be part of everyday healthcare practice and based on the best available evidence so that people are protected from preventable healthcare associated infections.	**4**	**4**	**4**	**Working towards 5**
	Standard 2.5 Nutrition and Hydration People are supported to meet their nutritional and hydration needs, to maximise recovery from illness or injury.	**4**	**NA**	**4**	**Working towards 5**
	Standard 2.6 Medicines Management People receive medication for the correct reason, the right medication at the right dose and at the right time.	**5**	**NA**	**4**	**Working towards 5**
	Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk Health services promote and protect the welfare and safety of children and adults who become vulnerable or at risk at any time.	**4**	**4**	**4**	**Working towards 5**
	Standard 2.8 Blood Management People have timely access to a safe and sufficient supply of blood, blood products and blood components when needed.	**5**	**4**	**4**	**Working towards 5**
	Standard 2.9 Medical Devices, Equipment and Diagnostic Systems Health services ensure the safe and effective procurement, use and disposal of medical equipment, devices and diagnostic systems.	**4**	**5**	**4**	**Working towards 5**
STANDARD 3 Effective Care	**Standard 3.1 Safe and Clinically Effective Care** Care, treatment and decision making should reflect best practice based on evidence to ensure that people receive the right care and support to meet their individual needs.	**4**	**5**	**4**	**Working towards 5**
	Standard 3.2 Communicating Effectively In communicating with people health services proactively meet individual language and communication needs.	**4**	**4**	**3**	**Working towards 4**
	Standard 3.3 Quality Improvement, Research and Innovation Services engage in activities to continuously improve by developing and implementing innovative ways of delivering care. This includes supporting research and ensuring that it enhances the efficiency and	**4**	**5**	**4**	**Working towards 5**

	effectiveness of services.				
	Standard 3.4 Information Governance and Communications Technology Health services ensure all information is accurate, valid, reliable, timely, relevant, comprehensible and complete in delivering, managing, planning and monitoring high quality, safe services. Health services have systems in place, including information and communications technology, to ensure the effective collection, sharing and reporting of high quality data and information within a sound information governance framework.	**4**	**5**	**5**	**Change to overall score following CDO review** **Needs review** **Working towards 5**
	Standard 3.5 Record Keeping Good record keeping is essential to ensure that people receive effective and safe care. Health services must ensure that all records are maintained in accordance with legislation and clinical standards guidance.	**4**	**5**	**4**	**Working towards 5**
STANDARD 4 Dignified Care	**Standard 4.1 Dignified Care** People's experience of health care is one where everyone is treated with dignity, respect, compassion and kindness and which recognises and addresses individual physical, psychological, social, and cultural, language and spiritual needs.	**4**	**5**	**5**	**Work towards maintaining 5**
	Standard 4.2 Patient Information People must receive full information about their care which is accessible, understandable and in a language and manner sensitive to their needs to enable and support them to make an informed decision about their care as an equal partner.	**4**	**5**	**3**	**Change to overall score following Exec review** **Working towards 4**
STANDARD 5 Timely Care	**Standard 5.1 Timely Access** All aspects of care are provided in a timely way ensuring that people are treated and cared for in the right way, at the right time, in the right place and with the right staff.	**4**	**NA**	**4**	**Working towards 4**

STANDARD 6 Individual Care	**Standard 6.1 Planning Care to Promote Independence** Care provision must respect people's choices in how they care for themselves as maintaining independence improves quality of life and maximises physical and emotional wellbeing.	**3**	**NA**	**3**	**Changed to 3 at VCC following consultation with Exec Lead**
	Standard 6.2 Peoples Rights Health services embed equality and human rights across the functions and delivery of health services in line with statutory requirement recognising the diversity of the population and rights of individuals under equality, diversity and human rights legislation.	**4**	**5**	**3**	**Changed to 3 following Exec review** **Working towards 4**
	Standard 6.3 Listening and Learning from Feedback People who receive care, and their families, must be empowered to describe their experiences to those who provided their care so there is a clear understanding of what is working well and what is not, and they must receive an open and honest response. Health services should be shaped by and meet the needs of the people served and demonstrate that they act on and learn from feedback	**3**	**4**	**4**	**Working towards 4**
STANDARD 7 Staff and Resources	**Standard 7.1 Workforce** Health services should ensure there are enough staff with the right knowledge and skills available at the right time to meet need.	**4**	**4**	**3**	**Working towards 4**

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

HEALTH AND CARE STANDARD IMPROVEMENT PLAN 2021 - 2022

Key Rag Rating		
At risk of not being achieved by end of Financial year 2021/22	**On target to be achieved by end of Financial year 2021/22**	**Completed**

2021/22 Improvement Plan			
Q1	**Q2**	**Q3**	**Q4**

Improvement Identified	Action Lead	Executive Lead	Priority	Completion Date	Progress	Completion update	
			High/Medium/ Low			RAG	If action at risk of not being completed by target date please provide reason
Governance Standard **Working towards self-assessment Score 5**							
Clinical Audit – review process for capturing learning and any associated improvement action ensuring there is a robust process for reporting both internally and externally	Clinical Audit Medical Lead	Director of Corporate Governance and Chief of Staff	High	Q4	There has been a structural change for Velindre with the introduction of the PMO, any change resulting from an audit will be led by the PMO. We report activity, results and areas for improvement quarterly to VCC and the Trust, there are also plans in place to re-invent the clinical effectiveness presentations to incorporate all of Quality and report on learning outcomes. On track – good progress being made with the Consent Audit process.		
Cancer Information System CANISC replacement programme – Welsh Patient Administration System (WPAS), Welsh Clinical Portal and Cancer Information System	Director of Cancer Services/ADI	Director of Corporate Governance and Chief of Staff	Medium	Q4	Governance structure with Programme Board and associated work streams in place. SLT leads identified with operational leads provided with dedicated time to undertake role.		

Improvement Identified	Action Lead	Executive Lead	Priority	Completion Date	Progress	Completion update	
			High/Medium/ Low			RAG	If action at risk of not being completed by target date please provide reason
Standard 1 Staying Healthy Working towards self-assessment Score 4							
Launch the Health and Wellbeing Recovery Plan. Supported by the establishment of a H&WB Steering Group and Divisional Working Groups to review, shape and involve, providing governance and accountability. This will require active involvement at a local level and ownership of division, team and community specific actions. It is recognised that the plan will need to be reviewed and revised on a quarterly basis to respond to need.	WOD EMB SMTs	Executive Director of OD & Workforce	High	Q4	First meeting has concluded with an established Steering group and Task and Finish Group in place to complete the plan. Health and Wellbeing plan will run into 2022.		
Deliver the H&WB Recovery Plan – involves the priorities of 2021/22.	EMB SMTs WOD	Executive Director of OD & Workforce	Medium	Q4	Plan is in place and infrastructure established however the delivery will continue beyond 2022.		
Achieve Disability Confident accreditation	WOD SMTs	Executive Director of OD & Workforce	Medium	Q4	Currently have this accreditation but will achieve Disability Leader Level 3 by Sept 2022 – a task and finish group will be established and led by Head of OD		
Standard 2.1 Risk Working towards self-assessment Score 4							
Implement and then work across the Trust to embed the enhancements to the risk module in DATIX	Director of Corporate Governance & Chief of Staff	Director of Corporate Governance & Chief of Staff	Medium	Q3	Risk module V14 is up and running in VCC but not yet live in WBS. Weekly meetings are being held with WBS to ensure transfer of Risks from V12 to V14.		
Complete the implementation of revised incident and risk management processes.	Director of Corporate Governance & Chief of Staff	Director of Corporate Governance & Chief of Staff	Medium	Q4	Trust Incident Policy to be finalised by the Corporate Quality and Safety Team during Q3 2021. Good progress being made with Risk Management processes. Once for Wales Risk Management module to commence Q1 2022/23.		
Review health and safety resources available across the Trust to ensure effective and cost effective use of current resources. Identify any additional resources required and seek investment from EMB and Trust Board.	Assistant Director of Estates	Executive Director of Corporate Governance	Medium	Q4	VCC and WBS have appointed H&S managers within the respective directorates. This will periodically reviewed to establish if further support is required. Professional link to be established between H&S Manger and advisors within divisional departments		
Review health and safety monitoring systems to ensure measures are in place to identify proactive and reactive indicators of compliance.	Assistant Director of Estates	Executive Director of Corporate Governance	Medium	Q4	H&S Board established to support management of H&S matters across the Trust. There are a number of indicators in place which will be used to proactively manage H&S underpinned by the support		

Improvement Identified	Action Lead	Executive Lead	Priority	Completion Date	Progress	Completion update	
			High/Medium/ Low			RAG	If action at risk of not being completed by target date please provide reason
					from the Board. Need to establish H&S audit schedule.		
Standard: 2.2 Preventing Pressure and Tissue Damage – VCC ONLY Working towards self-assessment Score 5							
Sign off and implementation of Tissue Viability Policy.	Deputy Head of Nursing	Executive Director of Nursing, AHP's and Medical Scientists	High	Q3	The Tissue Viability Policy has been signed off by the scrutiny panel and is due to go through the Quality and Safety Management Group on the 9th December 2021. Sign off 16th Feb 2022.		
Undertake a full review of all HCSW staff at Velindre Cancer Centre in relation to sign off and competency against HCSW Clinical Competency 18: Prevention & Management of Pressure Ulcers & ensure any competency / training deficits are addressed	Deputy Head of Nursing	Executive Director of Nursing, AHP's and Medical Scientists	Medium	Q4	The TVN @ VCC has designed some competencies for HCSW for pressure ulcer prevention and is working with the clinical trainer to finalise them they are based on the national HCSW induction competencies and then 'padded them out' with some UK wide tissue viability ones and then included the views of HCSWs on first floor, they will be brought to the PNF for approval. We have been unable to establish the origin of the HCSW Clinical Competency 18: Prevention & Management of Pressure Ulcers checked locally and through the all Wales group.		
Standard: 2.3 Falls Prevention – VCC ONLY Working towards self-assessment Score 5							
Fully transition from current paper version of Falls risk assessment documentation and care planning documentation to the electronic risk assessment and Care Planning in line with the Wales Nursing Care Record.	Deputy Head of Nursing	Executive Director of Nursing, AHP's and Medical Scientists	TBC	Senior Nurse Professional Standards & Digital (in line with All Wales Project)	Falls risk assessment is digital. All Wales Falls care plan is not available digitally on WNC yet – once it is available we will move over to the digital format		
Revised delivery options required for manual handling training during this ongoing Covid-19 pandemic	Education and Development Manager	Executive Director of Nursing, AHP's and Medical Scientists	High	Q3	Manual handling training ongoing with limited numbers. Social distancing continues to preclude a greater attendance at the training sessions. National steer awaited. COMPLETE.		
Revise Trust Falls KPIs to reflect ongoing scrutiny of repeat fallers	Deputy Head of Nursing	Executive Director of Nursing, AHP's and Medical Scientists	High	Q3	A revised risk assessment and care plan is completed when a patient has a fall – in the last 4 months there have been no episodes of repeat falling		

Improvement Identified	Action Lead	Executive Lead	Priority	Completion Date	Progress	Completion update	
			High/Medium/ Low			RAG	If action at risk of not being completed by target date please provide reason
Undertake a call bell audit that includes call bell availability and time taken to respond	Deputy Head of Nursing	Executive Director of Nursing, AHP's and Medical Scientists	High	Q4	Monthly call bell audits are being undertaken which assesses: o The number of patients on the ward o Do all patients have access to a call bell and will discuss with Cheryl to support this audit via Tendable. o Do patients know how to use the call bell? o Are all patient call bells working? Estates have been contacted to produce reports for the ward regarding call bell response time and the testing of call bells. The Ward Manager will review this information.		
Standard 2.4 Infection Prevention & Control & Decontamination Working towards self-assessment Score 5							
Review the Service Level Agreement with Public Health Wales Microbiology to formalise dedicated time for Consultant Microbiology ward rounds, and appoint to the 2 additional sessions which were funded during 2020	Senior Infection Control Nurse	Executive Director of Nursing, AHP's and Medical Scientists	High	Q4	Meeting held with PHW to make some headway with increasing the last part of IP provision that of ICD/PH support (highlighted) this has been held in reserves and not drawn down yet. PHW are recruiting currently and it is anticipation that the increase in sessions from 1 to 3 will be facilitated by 'this summer'. Plan to meet with PHW again in June 2022.		
Deputy Lead IPC Nurse to undertake Decontamination training in order to provide additional resilience within the team to lead on this aspect of the IPC work	Senior Infection Control Nurse	Executive Director of Nursing, AHP's and Medical Scientists	High	Q4	Unable to complete due to Q1 and Q2 competing priorities and vacancy of the lead nurse post. Training booked for Q3 2021. Complete		
Standard 2.5 Nutrition and Hydration – VCC ONLY Working towards self-assessment Score 5							
To ensure continued involvement in the National implementation for the pictorial menu and implement when approved	Head of dietetics and Deputy Operational Services Manager	Executive Director of Nursing, AHP's and Medical Scientists	Medium	Q4	Pictorial menus have been approved nationally but we are still in the implementation phase at VCC.		
Take relevant improvement work to achieve full compliance with protected meal times on ward – in particular in relation to preventing clinical staff meal interruptions	Deputy Head of Nursing	Executive Director of Nursing, AHP's and	High	Q4	• Protected mealtime hour is between 12-1pm.		

Improvement Identified	Action Lead	Executive Lead	Priority	Completion Date	Progress	Completion update	
			High/Medium/ Low			RAG	If action at risk of not being completed by target date please provide reason
		Medical Scientists			• All coordinators and ward staff are aware of the protected mealtimes and are aware to challenge this if staff are not adhering. • Therapies, Medics, Porters, Radiology and Hospital staff are all aware of the protected mealtimes and are challenged if they attempt to interrupt a patient during mealtimes. • Protected mealtime signage is displayed within the FF clinical area.		
Ward staff to encourage & support patients to preferably sit in chair for all meals or / if unable to sit upright in bed	Deputy Head of Nursing	Executive Director of Nursing, AHP's and Medical Scientists	High	Q4	• Where clinically appropriate patients that cannot sit out in a chair for mealtimes are supported to be sat upright in bed. • Where possible patients are proactively encouraged to sit out in their chair for meal times. • Physiotherapy support the ward staff to safely position patients to sit out in their chair for meal times where appropriate.		
Ward staff to ensure all patients are supported to wash / clean hands prior to eating (handwashing or use of hand wipe)	Deputy Head of Nursing	Executive Director of Nursing, AHP's and Medical Scientists	High	Q4	Clinell antibacterial patient hand wipes are provided regularly throughout the day to our patients and specifically at meal times to ensure good hand hygiene prior to consuming food.		
Standard 2.6 Medicines Management – VCC ONLY Working towards self-assessment Score 5							
Review of the SACT prescribing passport and compliance of completion for new staff/new prescribers.	SACT SG	Medical Director	Low	Q4	Nursing staff complete medicines administration competency booklets at induction and additionally SACT handbook as appropriate. All members of SACT nursing staff are working towards completion of the newly introduced SACT Administration Passport and work to the VCC SACT Administration Standards. The SACT Management of Prescribers procedure, which includes the requirement for new SACT		

Improvement Identified	Action Lead	Executive Lead	Priority	Completion Date	Progress	Completion update	
			High/Medium/ Low			RAG	If action at risk of not being completed by target date please provide reason
					prescribers to work according the SACT Prescribing Passport framework.		
Implementation of Q Pulse within the clinical pharmacy services.	Pharmacy	Medical Director	Low	Q4	Pharmacy considering whether to progress in light of new All Wales Technical Services business case for similar system being considered.		
Formalise a process for the monitoring of SACT 'death's in 30 days'.	Clinical Director, Medical Lead for Mortality with support from Quality and Safety Manager	Medical Director	High	Q4	Included as part of the SACT and MM work plan which is being led by the Quality Safety Manager as is part of the larger work on MES. Projected rated as amber. Pilot due to begin in the colorectal SST on the new process of reviewing death within 30 days SACT and rolled out to other SST's. This will be fed up via QSMG and QSP.		
Scoping work to review process and supporting documentation for the development and delivery of SACT protocols and the implementation of SACT closed devices within the SACT day case service at VCC.	SACT SG	Medical Director	Low	Q4	SACT provide update and guidance on new regimes and PIL. Medication Management Group Ruth Hull and Pharmacy work closely with the ward when new treatment regimens are available.		
Implement ChemoCare version 6 worksheet and labels module	Pharmacy	Medical Director	Low	Q4	ChemoCare worksheets and labels module implementation project is currently rated as Green. UAT testing complete and VCC will receive into live environment Sept 2021. The worksheet module is live and we're working towards switching all of the worksheets to the new module. Work will continue this financial year to switch the worksheets, please let me know if you need any more information		
Standard 2.7 Safeguarding Children and Adults at Risk Working towards self-assessment Score 5							
Ensure the Trust has robust plans in place to fully meet the requirements of the new Liberty Protection Safeguards as outlined in the Liberty Protection Safeguards Code of Practice (awaited)	Senior Nurse Safeguarding & Public Protection	Executive Director of Nursing, AHP's and Medical Scientists	Medium	Q4	Paper prepared for the VCC quality and safety management group to consider the risk. No Welsh Government sub group meetings have been held since April 2021. NHS Network group attended and all members are concerned with delayed publication of the draft code of practice. Implementation		

Improvement Identified	Action Lead	Executive Lead	Priority	Completion Date	Progress	Completion update	
			High/Medium/ Low			RAG	If action at risk of not being completed by target date please provide reason
					plan for improving mental capacity act compliance across the trust is under development. Trust notified that LPS implementation is delayed by Welsh Government.		
Develop the role of the safeguarding champion across the Trust to Support and maintain the safeguarding standards and embedding good practice, and support the implementation of the safeguarding action plan.	Senior Nurse Safeguarding & Public Protection Head of Nursing VCC and WBS	Executive Director of Nursing, AHP's and Medical Scientists	Medium	Q4	Trust Champion framework developed and awaits approval to roll out across the Trust. Champion development plan to be agreed at the next SPPMG		
To review the delivery of a Level 3 safeguarding adults and children training package for the Trust.	Senior Nurse Safeguarding and Public Protection	Executive Director of Nursing, AHP's and Medical Scientists	Medium	Q3	Training needs analysis developed for circulation to managers across the Trust.		
To provide a clear mechanism to provide all staff with the required mandatory Mental Capacity Act training.	Senior Nurse Safeguarding & Public Protection	Executive Director of Nursing, AHP's and Medical Scientists	Medium	Q3	Q1. Mental Capacity Act training approved for all staff with direct patient donor/contact. Training package for professional with specific MCA responsibilities under development in line with NICE guidelines and recommendations Q2. Training needs analysis developed for circulation to managers across the Trust. Applied for funding from WG to source external training provision. Q3. WG funding approved A training package agreed with BOND SOLON training company. Training to commence in Jan 2022. Working to develop an MCA pocket guide to provide staff with quick reference MCA guidance. Q4. Training continues, informed by WG that further funding will be available to continue training in the new financial year.		
To improve compliance with safeguarding training to achieve compliance of 95% or above across all relevant areas	Senior Nurse Safeguarding & Public Protection	Executive Director of Nursing, AHP's and Medical Scientists	Low	Q4	Training needs analysis developed for circulation to managers across the Trust. Improving safeguarding training compliance has been on the agenda at SLT in VC and SMT in WBS.		

Improvement Identified	Action Lead	Executive Lead	Priority	Completion Date	Progress	Completion update	
			High/Medium/ Low			RAG	If action at risk of not being completed by target date please provide reason
To implement the Once for Wales Concerns Datix safeguarding module in the Trust to improve safeguarding record keeping and reporting.	Senior Nurse Safeguarding & Public Protection	Executive Director of Nursing, AHP's and Medical Scientists	Medium	Q3	Reporting form presented at regional safeguarding boards awaits decision on pilot site. A pilot is currently being undertaken in Hwyl dda feedback with provided post pilot and the next phase of rollout will commence.		
Standard 2.8 Blood Management Working towards self-assessment Score 5							
VCC to purchase a Blood Trak system.	Head of WTAIL WBS/ VCC Head of Nursing WBS Chief Scientific Officer/ WBS Head of Collections	Chief Operating Officer	High	Q4	Work remains ongoing as part of the Velindre Futures work stream.		
Introduce Haemoglobin S testing for units issued for neonatal use Consider introduction of Haemoglobin S testing for exchange transfusions and 'top up' transfusions for sickle cell patients	Kalinga Perera/ Georgia Stephens	Chief Operating Officer	Low	Q4	Task and finish group has been appointed - Option appraisal preparation is in progress Implementation timeline was reviewed due to other priorities, which include Hepatitis-B core testing. New timeline to initiate procurement exercise in Q1 2022/2023 with implementation in Q3 2022/2023		
HNA antibody testing of female and previously transfused donors donating apheresis platelets.	Kalinga Perera/ Deborah Pritchard	Chief Operating Officer	Low	Q4	Task and finish group has been appointed - Option appraisal preparation is in progress		
Standard 2.9 Medical Devices, Equipment and Diagnostic Systems Working towards self-assessment Score 5							
Implement a robust divisional procedure for the procurement of medical devices and medical equipment, that underpins the Trust policy and ensure that department processes are implemented to support these. This element is not specified within the criteria for the standard but is a fundamental part of the overall standard statement, we have developed procedure and flowcharts and once feedback is provided by procurement we will be in a position to fully develop the divisional procedure	Medical Devices Officer	Chief Operating Officer	Medium	Q4	Awaiting Procurement feedback.		

Working towards implementation QMS and procedures put in place to meet in-house manufacturing and its use requirements as will be defined by MHRA going forward.	Head of Medical Physics	Chief Operating Officer	Medium	Q4	QMS work is ongoing. At present the Quality Manual is being written. Development of the new QMS system (ISO 13485) for in house manufacturing of Medical Devices is challenging due to the amount of documentation required. The service has plans to implement ISO13485. This is resource intensive but on track for the anticipated MDR Q4 2023.		
Continue implementing the equipment database, ensuring its consistency and then the rollout to department leads and other divisions.	Medical Devices Officer	Chief Operating Officer	Medium	Q4	Initial database inventory check has been completed and planning to go live once database software has been updated to new version. This task is now complete. We have foundation database that we will start using soon, including remote access to VCC database to the Database supplier (RAM/MRI software). VPN token for remote access will be in place very soon. We expect this to be completed by end of Q1, June 2022.		
Standard 3.1 Safe and Clinically Effective Care Working towards self-assessment Score 4							
Trust to develop clear systems and processes for assessing, monitoring and providing assurance reporting from divisional level to Board in respect of new / revised guidelines e.g NICE as part of its Quality & Safety Framework	Executive Medical Director & Executive Director Nursing, AHP and HCS	Executive Director Nursing, AHP & HCS	Medium	Q4	Work relating to Quality and Safety Framework is ongoing. The Trust Framework will be publicised during Q3. Recruitment to a designated Quality and Safety project lead is currently in progress (one year fixed term post). Work further delayed due to pandemic will be published in Q1 22/23.		
Both Divisions to ensure there are robust mechanisms in place for monitoring compliance of and escalation of non-compliance in respect of national clinical and benchmarked standards	Medical Director WBS and Clinical Director VCC	Executive Director Nursing, AHP & HCS	Medium	Q4	Work to strengthen the Quality and Safety Framework at the Trust remains ongoing and this will further progress during Q3. Within WBS non-compliance against national clinical guidance/regulation are identified at patient/donor governance gps and reported to RAGG. This maintains high profile and plans for corrective action.		
All clinical services to define ‘what good looks like’ in respect of their services, and agree clear outcome KPIs aligned to these and agree benchmarking / peer review opportunities	Medical Director WBS and Clinical Director VCC	Executive Director Nursing, AHP & HCS	Medium	Q4	A clinical transformation lead will commence in post during Q3 and this work will be prioritised during this period.		

					As above in WBS “good” looks like compliance with guidance/regulation and implementation is progressed as above.		
Trusts audit plan to contain assurance audits in relation to agreed actions arising from critical incidents and complaints as assurance that agreed actions / improvement work has taken place	Medical Director WBS and Clinical Director VCC	Executive Director Nursing, AHP & HCS	Medium	Q4	This work will progress as part of the Quality and Safety Framework. Assurance around this will be monitored by the Corporate Quality and Safety Team. Review undertaken – deep dive analysis of complaints and targeted improvement work within each division. Brachytherapy improvement Group established following review of critical incidents		
Standard: 3.2 Effective Communication Working towards self-assessment Score 4							
Approve a new VUNHST communications and engagement strategy	Assistant Director Communications	Executive Director of Corporate Governance Executive Director of OD & Workforce	Medium	Q4	The June 2020 Communications and Engagement Strategy is being revised and will be presented to the Executive Management Board in January 2021. In development for EMB consideration in May 2022.		
Development of new MURA internet and Intranet pages to include accessible information and links to additional resources for managers and staff to support patients and donors as well as resources for staff needs.	Assistant Director Communications	Executive Director of Corporate Governance Executive Director of OD & Workforce	Medium	Internet template to be in place by Q2, Intranet pages Q4	The new Trust & VCC website have been built using MURA. The new intranet system (sharepoint) is currently being reviewed and will be built by the end of June 2022.		
Continuous rollout of Interpreter on Wheels service for interpreter needs. Currently have 3 mobile units but ability to download service to additional devices. Currently used throughout VCC, but to be expanded to satellite sites and WBS clinics. Training on using the systems to be provided by Equality manager.	Equality & Diversity Manager	Executive Director of Nursing, AHP’s and Medical Scientists	Medium	Q4	The interpreter on wheels device is a stand- alone device used throughout the Cancer centre. Device for Satellite sites by Q2, WBS by Q4.		
Looking at IT systems across the Trust, ensure staff are collecting language choice and recording it as part of the need to provide the ‘Active offer’ – secure KPI’s around collection of Welsh language and new WPAS system (VCC) as an example.	Welsh Language Manager	Executive Director of Corporate Governance Executive Director of OD & Workforce	Medium	Q4	In progress		
Standard 3.3 Quality Improvement, Research and Innovation Working towards self-assessment Score 5							
Subsequent to the review of current Trust R&D processes with a view to integration of Innovation requirements, develop and incorporate identified	RD&I (VCC)	Medical Director	Low	Q4	In progress, on target The RD&I Division has produced a work plan to develop and		

improvements into Trust RD&I, e.g. introduce a quality manual. **Carried forward from 2020/21**					incorporate improvements into the Trust RD&I Division.		
Develop a plan that describes how the Trust will have the capability to delivery vaccine research both in its own right and as part of Health and Care Research Wales vaccine infrastructure	RD&I (VCC)	Medical Director	Medium	Q3	Partially completed Business case/options appraisal developed identifying need to purchase Biological Safety Cabinet. Trust capital funds agreed to allow the purchase of a biological safety cabinet during FY2021/22. Additional Trust capital works to site the biological safety cabinet in Pharmacy to be discussed and progressed during FY2022/23		
Develop a RD&I training programme for Trust staff members, and work with other organisations to provide training opportunities, so that staff: - Understand the role of Trust RD&I in the organisation and the context of NHS research - Understand what managing NHS research entails, including roles and responsibilities, capacity and capability, safety, finance and contracts - Understand how quality research is developed, designed, set-up and carried out - Understand the oversight required for NHS research	RD&I (VCC)	Medical Director	Low	Q4	In progress, on target Discussions underway about what the training programme may look like and how external stakeholder training is included.		
Review the administrative structure, roles and responsibilities of the research delivery team and make recommendations for improvement	RD&I (VCC)	Medical Director	Low	Q4	In progress, on target. Processes identified with Workforce & OD necessary propose the changes. Proposals now under development.		
Develop business intelligence to support the expression of interest/feasibility and set-up and delivery processes	RD&I (VCC)	Medical Director	Low	Q4	In progress, on target. Initial discussions have taken place to identify the work required. Additional scoping work to be begun.		
Standard 3.4 Information Governance & Communications Technology Working towards self-assessment Score 5							

Trust / WBS / VCC: Standardise Processes for Backup, Recovery & Test	Chief Digital Officer	Director of Strategic Transformation Planning & Digital	Medium	Q4	Work ongoing to consolidate / standardise VCC and WBS infrastructure management tasks – revised backup strategy to be developed through 2021/22. Aim to establish consolidated approach by Q4. Largely unchanged. Action aimed for completion by end of Q4. Complete. Key processes aligned, however work ongoing (under BAU) to ensure all processes are identical across the Trust.		
Trust / WBS / VCC: Develop new Trust wide performance indicators for Digital Delivery	Chief Digital Officer	Director of Strategic Transformation Planning & Digital	Medium	Q4	Proposed KPIs developed – initial tranche of SMT/Board-level KPIs to be reported from November 2021 onwards. Wider range of internal/team KPIs developed, with a view to deploying KPI dashboard by year-end. Automated reporting being developed across a number of indicators. Largely unchanged. Action aimed for completion by end of Q4. Complete - KPI's now being reported under PMF.		
Trust / WBS / VCC: New Digital Strategy 2020 – 2025	Chief Digital Officer	Director of Strategic Transformation Planning & Digital	Medium	Q4	Initial draft developed. Engagement session held with Digital Services team, with plans for wider communication / engagement across the Trust towards end of 2021. Proposed to be approved at the January / March 2022 Trust Board. Aim is to take to March 2022 Trust Board.		
Review of current Trust IG policies and update as necessary in order to ensure material remains reflective of current legislation and guidance	Trust Information Governance Manager	Director of Strategic Transformation Planning & Digital	Medium	Q4	Head of IG carrying out final QA work prior to presenting Policies for approval at the SIRO/EMB/QSP levels.		

Strengthen existing IG training provisions available to staff by means of establishing supplementary training platforms in order to deliver training [i.e. Microsoft Teams]	Trust Information Governance Manager	Director of Strategic Transformation Planning & Digital	Medium	Q4	Microsoft Teams now being used to facilitate IG induction and refresh training. Replacement Trust Information Governance Manager due to commence in post December 2021, following departure of previous IG Manager in late-July 2021. Head of IG delivering the first enhanced training session on 28 Jan 22 to the Medical Records team via Microsoft Teams and more events are being planned to build on ESR training, with this in mind, the other date in the diary at this time is: Pharmacy Team – 21 Feb 2022. The extent of training reach will increase as the year progresses.		
Standard 3.5 Record Keeping Working towards self-assessment Score 4							
Implementation of the Digital Health Record and the Welsh Patient Administration System.	Chief Digital Officer	Director of Strategic Transformation, Planning and Digital	Medium	Q1 2022/23	Project in place to progress delivery of the DH&CR and WPAS. Go-live scheduled for May 2022. DHCR – revised timelines for this are being discussed as we speak, since DHCW have just confirmed that they have missed deadline for a range of WPAS and WCP software development activity that was due to be completed by end of last year.		
Strategy for the management of the paper medical record.	Health Records Manager	Executive Director of Finance	Medium	Q4	On target for strategy development.		
Standard 4.1 Dignified Care Working towards self-assessment Score 4							
Standard 4.2 Patient Information Working towards self-assessment Score 4							
Standard: 5.1 Timely Care Working towards self-assessment Score 4							
Develop plans for increasing ambulatory care provision	Dr Hilary Williams Consultant Oncologist	Chief Operating Officer	High	Q4	Patients seen by ambulatory care has increased significantly over the past 2 years. Work to review and strengthen this pathway will be ongoing as part of the Velindre Futures programme. The SDEC project which commenced in		

					November 2021, funded by the Welsh Government, to improve and extend the ambulatory care provision at VCC is progressing well and on track to deliver all Civica objectives.		
Implement VCC specific measures in support of the systemic implementation of the Single Cancer Pathway	Wayne Jenkins Head of Planning and Performance	Chief Operating Officer	Low	Q4	Cancer Network funded Single Cancer Pathway Programme Manager commenced October 2021.Focus for Oct 2021 to Mar 2022 will be on redesign of Breast pathway followed by Urological pathway.Work ongoing and patient pathways are being taken forward by Velindre Futures.		
Standard 6.1: Planning Care to Promote Independence Working towards self-assessment Score 4							
Planning coproduced timetables on ward with patients to timetable their therapy sessions to give increased sense of control over their day.	OT lead and deputy head of nursing	Executive Director of Nursing, AHP's and Medical Scientists	Medium	Q4	Ongoing - Patients are routinely asked what time of day is preferred for their rehabilitation. The Therapies team will link daily with the MDT to ensure this fits in around oncological treatments and nursing needs. Flexibility is key here for individual patients. This will be developed further over the next quarter. This is now embedded as normal practice. Following daily handover with the MDT the therapies team will liaise with the patients to plan the best time for intervention.		
Continue new ways of working during pandemic so that innovation not lost and that care does not revert to being too medicalised.	Head of therapies and Head of nursing	Executive Director of Nursing, AHP's and Medical Scientists	Medium	Q4	Ongoing use of Attend Anywhere for OP appointments where needed. Approx. 50% of all Therapies OP clinics are virtual. Either as individual Therapy sessions or MDT based. A virtual Physical activity pilot is currently underway. Hosted by the physiotherapy team to provide group physical activity sessions over a digital platform. Attend anywhere is now embedded as normal practice where required. Clinicians will decide via a triage process which patients will be seen virtually and which will be seen face to face.		
Standard 6.2: People Rights Working towards self-assessment Score 4							
Patient and Donor engagement to be a priority over the next 12 months, regarding the new hospital needs. Work with Wales Co-Op Center to ensure that	VCC and WBS Engagement Leads	Director of Operations	Medium	Q4	Donor engagement continues to be successful. Progress with strengthening engagement at the		

engagement includes diverse and seldom heard voices, working in partnership with community groups taking account of the socio-economic duty which is intrinsic to decision making.					Cancer Centre and nVCC continues and will be progressed through Quarter 3 and 4.		
Standard 6.3: Listening and Learning from Feedback Working towards self-assessment Score 4							
Implement the Civica feedback system in a phased approach commencing with Cancer Centre.	Patient and Donor Experience Leads Deputy Director of Nursing and Patient Experience	Executive Director of Nursing, Allied Health Professionals and Health Scientists.	High	Q4	The Civica system has been implemented within VCC in a phased manner but further implementation work is required. There is plan to implement the Civica system in WBS in Q4 2021.		
Development a robust mechanism for obtaining and learning from Patient and Donor feedback	Deputy Director of Nursing and Patient Experience	Executive Director of Nursing, Allied Health Professionals and Health Scientists.	High	Q4	The Patient experience strategy will include a robust plan for listening and learning from feedback, this is currently in development. It is an anticipated that this will be completed during Q3 2021. This is behind schedule due to competing priorities. Changes are being made to ways of working within the Corporate Quality and Safety Team in order to strengthen the Patient and Donor Experience agenda.		
Standard 7 Staff and Resources Working towards self-assessment Score 4							
Focused action plan for PADR completion – focus on areas of poor PADR completion	Workforce team	Executive Director of OD & Workforce	High	Q4	Work ongoing with the WOD team to focus on areas of poor PADR compliance – triangulating all WOD data to understand the route cause of the problem. Ongoing into 22/23		
Re-engage with the Virtual reality learning project stepped down through COVID	Workforce team	Executive Director of OD & Workforce	Medium	Q2/3	Re-establish with Swansea university. To be delivered by December 2022		
Identify and manage Alumnus for leadership and management cohort	Workforce team	Executive Director of OD & Workforce	Low	Q3/4	Managed by Education and Development. COMPLETE		
Ensure the Education strategy and plan aligns to work of RD&I within the Trust to maximise potential of Trust University status	Workforce team	Executive Director of OD & Workforce	Low	Q3/4	Part of the Education and Development steering group to ensure alignment. COMPLETE		
Planned and Sustained Workforce							
Develop and Monitor the Welsh Language Compliance Plan	Welsh Language Manger	Executive Director of OD & Workforce	Low	Q4	Ongoing monitoring for Welsh Language and Welsh culture plans		
Evaluate the potential of a Physicians Associate role in VCC following student placement	Workforce team	Executive Director of OD & Workforce	Medium	Q3	Student placement undertaken and being progressed through Medical Education Board. COMPLETE.		
Utilising the delegation framework commence a project in VCC to develop the HCSW role maximising opportunities for this role	Workforce team	Executive Director of OD & Workforce	Medium	Q4	Pushed back to 2022.		

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

HEALTH AND CARE STANDARD IMPROVEMENT PLAN 2022 - 2023

Key Rag Rating		
At risk of not being achieved by end of Financial year 2022/23	**On target to be achieved by end of Financial year 2022/23**	**Completed**

2021/22 Improvement Plan			
Q1	**Q2**	**Q3**	**Q4**

Improvement Identified	Action Lead	Executive Lead	Priority	Completion Date	Progress	Completion update	
			High/Medium/ Low			RAG	If action at risk of not being completed by target date please provide reason
Governance Standard **Working towards self-assessment Score 5**							
Clinical Audit – review process for capturing learning and any associated improvement action ensuring there is a robust process for reporting both internally and externally	Clinical Audit Medical Lead	Director of Corporate Governance and Chief of Staff	High	Q4	There has been a structural change for Velindre with the introduction of the PMO, any change resulting from an audit will be led by the PMO. We report activity, results and areas for improvement quarterly to VCC and the Trust, there are also plans in place to re-invent the clinical effectiveness presentations to incorporate all of Quality and report on learning outcomes. On track – good progress being made with the Consent Audit process.		
Cancer Information System CANISC replacement programme – Welsh Patient Administration System (WPAS), Welsh Clinical Portal and Cancer Information System	Director of Cancer Services/ADI	Director of Corporate Governance and Chief of Staff	Medium	Q4	Governance structure with Programme Board and associated work streams in place. SLT leads identified with operational leads provided with dedicated time to undertake role.		

Improvement Identified	Action Lead	Executive Lead	Priority	Completion Date	Progress	Completion update	
			High/Medium/ Low			RAG	If action at risk of not being completed by target date please provide reason
Standard 1 Staying Healthy Working towards self-assessment Score 4							
Launch the Health and Wellbeing Recovery Plan. Supported by the establishment of a H&WB Steering Group and Divisional Working Groups to review, shape and involve, providing governance and accountability. This will require active involvement at a local level and ownership of division, team and community specific actions. It is recognised that the plan will need to be reviewed and revised on a quarterly basis to respond to need.	WOD EMB SMTs	Executive Director of OD & Workforce	High	Q4	First meeting has concluded with an established Steering group and Task and Finish Group in place to complete the plan. Health and Wellbeing plan will run into 2022.		
Deliver the H&WB Recovery Plan – involves the priorities of 2021/22.	EMB SMTs WOD	Executive Director of OD & Workforce	Medium	Q4	Plan is in place and infrastructure established however the delivery will continue beyond 2022.		
Achieve Disability Confident accreditation	WOD SMTs	Executive Director of OD & Workforce	Medium	Q4	Currently have this accreditation but will achieve Disability Leader Level 3 by Sept 2022 – a task and finish group will be established and led by Head of OD		
Standard 2.1 Risk Working towards self-assessment Score 4							
Implement and then work across the Trust to embed the enhancements to the risk module in DATIX	Director of Corporate Governance & Chief of Staff	Director of Corporate Governance & Chief of Staff	Medium	Q3	Risk module V14 is up and running in VCC but not yet live in WBS. Weekly meetings are being held with WBS to ensure transfer of Risks from V12 to V14.		
Complete the implementation of revised incident and risk management processes.	Director of Corporate Governance & Chief of Staff	Director of Corporate Governance & Chief of Staff	Medium	Q4	Trust Incident Policy to be finalised by the Corporate Quality and Safety Team during Q3 2021. Good progress being made with Risk Management processes. Once for Wales Risk Management module to commence Q1 2022/23.		
Review health and safety resources available across the Trust to ensure effective and cost effective use of current resources. Identify any additional resources required and seek investment from EMB and Trust Board.	Assistant Director of Estates	Executive Director of Corporate Governance	Medium	Q4	VCC and WBS have appointed H&S managers within the respective directorates. This will periodically reviewed to establish if further support is required. Professional link to be established between H&S Manger and advisors within divisional departments		
Review health and safety monitoring systems to ensure measures are in place to identify proactive and reactive indicators of compliance.	Assistant Director of Estates	Executive Director of Corporate Governance	Medium	Q4	H&S Board established to support management of H&S matters across the Trust. There are a number of indicators in place which will be used to proactively manage H&S underpinned by the support		

Improvement Identified	Action Lead	Executive Lead	Priority	Completion Date	Progress	Completion update	
			High/Medium/ Low			RAG	If action at risk of not being completed by target date please provide reason
					from the Board. Need to establish H&S audit schedule.		
Standard: 2.2 Preventing Pressure and Tissue Damage – VCC ONLY Working towards self-assessment Score 5							
Undertake a full review of all HCSW staff at Velindre Cancer Centre in relation to sign off and competency against HCSW Clinical Competency 18: Prevention & Management of Pressure Ulcers & ensure any competency / training deficits are addressed	Deputy Head of Nursing	Executive Director of Nursing, AHP's and Medical Scientists	Medium	Q4	The TVN @ VCC has designed some competencies for HCSW for pressure ulcer prevention and is working with the clinical trainer to finalise them they are based on the national HCSW induction competencies and then 'padded them out' with some UK wide tissue viability ones and then included the views of HCSWs on first floor, they will be brought to the PNF for approval. We have been unable to establish the origin of the HCSW Clinical Competency 18: Prevention & Management of Pressure Ulcers checked locally and through the all Wales group.		
Standard: 2.3 Falls Prevention – VCC ONLY Working towards self-assessment Score 5							
Fully transition from current paper version of Falls risk assessment documentation and care planning documentation to the electronic risk assessment and Care Planning in line with the Wales Nursing Care Record.	Deputy Head of Nursing	Executive Director of Nursing, AHP's and Medical Scientists	TBC	Senior Nurse Professional Standards & Digital (in line with All Wales Project)	Falls risk assessment is digital. All Wales Falls care plan is not available digitally on WNC yet – once it is available we will move over to the digital format		
Undertake a call bell audit that includes call bell availability and time taken to respond	Deputy Head of Nursing	Executive Director of Nursing, AHP's and Medical Scientists	High	Q4	Monthly call bell audits are being undertaken which assesses: o The number of patients on the ward o Do all patients have access to a call bell and will discuss with Cheryl to support this audit via Tendable. o Do patients know how to use the call bell? o Are all patient call bells working? Estates have been contacted to produce reports for the ward regarding call bell response time and the testing of call bells. The Ward Manager will review this information.		

Improvement Identified	Action Lead	Executive Lead	Priority	Completion Date	Progress	Completion update	
			High/Medium/ Low			RAG	If action at risk of not being completed by target date please provide reason
Standard 2.4 Infection Prevention & Control & Decontamination Working towards self-assessment Score 5							
Review the Service Level Agreement with Public Health Wales Microbiology to formalise dedicated time for Consultant Microbiology ward rounds, and appoint to the 2 additional sessions which were funded during 2020	Senior Infection Control Nurse	Executive Director of Nursing, AHP's and Medical Scientists	High	Q4	Meeting held with PHW to make some headway with increasing the last part of IP provision that of ICD/PH support (highlighted) this has been held in reserves and not drawn down yet. PHW are recruiting currently and it is anticipation that the increase in sessions from 1 to 3 will be facilitated by 'this summer'. Plan to meet with PHW again in June 2022.		
Standard 2.5 Nutrition and Hydration – VCC ONLY Working towards self-assessment Score 5							
To ensure continued involvement in the National implementation for the pictorial menu and implement when approved	Head of dietetics and Deputy Operational Services Manager	Executive Director of Nursing, AHP's and Medical Scientists	Medium	Q4	Pictorial menus have been approved nationally but we are still in the implementation phase at VCC.		
Standard 2.6 Medicines Management – VCC ONLY Working towards self-assessment Score 5							
Review of the SACT prescribing passport and compliance of completion for new staff/new prescribers.	SACT SG	Medical Director	Low	Q4	Nursing staff complete medicines administration competency booklets at induction and additionally SACT handbook as appropriate. All members of SACT nursing staff are working towards completion of the newly introduced SACT Administration Passport and work to the VCC SACT Administration Standards. The SACT Management of Prescribers procedure, which includes the requirement for new SACT prescribers to work according the SACT Prescribing Passport framework.		
Implementation of Q Pulse within the clinical pharmacy services.	Pharmacy	Medical Director	Low	Q4	Pharmacy considering whether to progress in light of new All Wales Technical Services business case for similar system being considered.		
Formalise a process for the monitoring of SACT 'death's in 30 days'.	Clinical Director, Medical Lead for	Medical Director	High	Q4	Included as part of the SACT and MM work plan which is being led by		

Improvement Identified	Action Lead	Executive Lead	Priority	Completion Date	Progress	Completion update	
			High/Medium/ Low			RAG	If action at risk of not being completed by target date please provide reason
	Mortality with support from Quality and Safety Manager				the Quality Safety Manager as is part of the larger work on MES. Projected rated as amber. Pilot due to begin in the colorectal SST on the new process of reviewing death within 30 days SACT and rolled out to other SST's. This will be fed up via QSMG and QSP.		
Implement ChemoCare version 6 worksheet and labels module	Pharmacy	Medical Director	Low	Q4	ChemoCare worksheets and labels module implementation project is currently rated as Green. UAT testing complete and VCC will receive into live environment Sept 2021. The worksheet module is live and we're working towards switching all of the worksheets to the new module. Work will continue this financial year to switch the worksheets, please let me know if you need any more information		
Standard 2.7 Safeguarding Children and Adults at Risk Working towards self-assessment Score 5							
Ensure the Trust has robust plans in place to fully meet the requirements of the new Liberty Protection Safeguards as outlined in the Liberty Protection Safeguards Code of Practice (awaited)	Senior Nurse Safeguarding & Public Protection	Executive Director of Nursing, AHP's and Medical Scientists	Medium	Q4	Paper prepared for the VCC quality and safety management group to consider the risk. No Welsh Government sub group meetings have been held since April 2021. NHS Network group attended and all members are concerned with delayed publication of the draft code of practice. Implementation plan for improving mental capacity act compliance across the trust is under development. Trust notified that LPS implementation is delayed by Welsh Government.		
Develop the role of the safeguarding champion across the Trust to Support and maintain the safeguarding standards and embedding good practice, and support the implementation of the safeguarding action plan.	Senior Nurse Safeguarding & Public Protection Head of Nursing VCC and WBS	Executive Director of Nursing, AHP's and Medical Scientists	Medium	Q4	Trust Champion framework developed and awaits approval to roll out across the Trust. Champion development plan to be agreed at the next SPPMG		
To improve compliance with safeguarding training to achieve compliance of 95% or above across all relevant areas	Senior Nurse Safeguarding & Public Protection	Executive Director of Nursing, AHP's and Medical Scientists	Low	Q4	Training needs analysis developed for circulation to managers across the Trust. Improving safeguarding training compliance has been on the agenda at SLT in VC and SMT in WBS.		

Improvement Identified	Action Lead	Executive Lead	Priority	Completion Date	Progress	Completion update	
			High/Medium/ Low			RAG	If action at risk of not being completed by target date please provide reason
To implement the Once for Wales Concerns Datix safeguarding module in the Trust to improve safeguarding record keeping and reporting.	Senior Nurse Safeguarding & Public Protection	Executive Director of Nursing, AHP's and Medical Scientists	Medium	Q3	Reporting form presented at regional safeguarding boards awaits decision on pilot site. A pilot is currently being undertaken in Hwyl dda feedback with provided post pilot and the next phase of rollout will commence.		
Standard 2.8 Blood Management Working towards self-assessment Score 5							
VCC to purchase a Blood Trak system.	Head of WTAIL WBS/ VCC Head of Nursing WBS Chief Scientific Officer/ WBS Head of Collections	Chief Operating Officer	High	Q4	Work remains ongoing as part of the Velindre Futures work stream.		
Introduce Haemoglobin S testing for units issued for neonatal use Consider introduction of Haemoglobin S testing for exchange transfusions and 'top up' transfusions for sickle cell patients	Kalinga Perera/ Georgia Stephens	Chief Operating Officer	Low	Q4	Task and finish group has been appointed - Option appraisal preparation is in progress Implementation timeline was reviewed due to other priorities, which include Hepatitis-B core testing. New timeline to initiate procurement exercise in Q1 2022/2023 with implementation in Q3 2022/2023		
Standard 2.9 Medical Devices, Equipment and Diagnostic Systems Working towards self-assessment Score 5							
Implement a robust divisional procedure for the procurement of medical devices and medical equipment, that underpins the Trust policy and ensure that department processes are implemented to support these. This element is not specified within the criteria for the standard but is a fundamental part of the overall standard statement, we have developed procedure and flowcharts and once feedback is provided by procurement we will be in a position to fully develop the divisional procedure	Medical Devices Officer	Chief Operating Officer	Medium	Q4	Awaiting Procurement feedback.		
Working towards implementation QMS and procedures put in place to meet in-house manufacturing and its use requirements as will be defined by MHRA going forward.	Head of Medical Physics	Chief Operating Officer	Medium	Q4	QMS work is ongoing. At present the Quality Manual is being written. Development of the new QMS system (ISO 13485) for in house		

					manufacturing of Medical Devices is challenging due to the amount of documentation required. The service has plans to implement ISO13485. This is resource intensive but on track for the anticipated MDR Q4 2023.		
Continue implementing the equipment database, ensuring its consistency and then the rollout to department leads and other divisions.	Medical Devices Officer	Chief Operating Officer	Medium	Q4	Initial database inventory check has been completed and planning to go live once database software has been updated to new version. This task is now complete. We have foundation database that we will start using soon, including remote access to VCC database to the Database supplier (RAM/MRI software). VPN token for remote access will be in place very soon. We expect this to be completed by end of Q1, June 2022.		
Standard 3.1 Safe and Clinically Effective Care Working towards self-assessment Score 4							
Trust to develop clear systems and processes for assessing, monitoring and providing assurance reporting from divisional level to Board in respect of new / revised guidelines e.g NICE as part of its Quality & Safety Framework	Executive Medical Director & Executive Director Nursing, AHP and HCS	Executive Director Nursing, AHP & HCS	Medium	Q4	Work relating to Quality and Safety Framework is ongoing. The Trust Framework will be publicised during Q3. Recruitment to a designated Quality and Safety project lead is currently in progress (one year fixed term post). Work further delayed due to pandemic will be published in Q1 22/23.		
Both Divisions to ensure there are robust mechanisms in place for monitoring compliance of and escalation of non-compliance in respect of national clinical and benchmarked standards	Medical Director WBS and Clinical Director VCC	Executive Director Nursing, AHP & HCS	Medium	Q4	Work to strengthen the Quality and Safety Framework at the Trust remains ongoing and this will further progress during Q3. Within WBS non-compliance against national clinical guidance/regulation are identified at patient/donor governance gps and reported to RAGG. This maintains high profile and plans for corrective action.		
All clinical services to define ‘what good looks like’ in respect of their services, and agree clear outcome KPIs aligned to these and agree benchmarking / peer review opportunities	Medical Director WBS and Clinical Director VCC	Executive Director Nursing, AHP & HCS	Medium	Q4	A clinical transformation lead will commence in post during Q3 and this work will be prioritised during this period. As above in WBS “good” looks like compliance with guidance/regulation and implementation is progressed as above.		

Trusts audit plan to contain assurance audits in relation to agreed actions arising from critical incidents and complaints as assurance that agreed actions / improvement work has taken place	Medical Director WBS and Clinical Director VCC	Executive Director Nursing, AHP & HCS	Medium	Q4	This work will progress as part of the Quality and Safety Framework. Assurance around this will be monitored by the Corporate Quality and Safety Team. Review undertaken – deep dive analysis of complaints and targeted improvement work within each division. Brachytherapy improvement Group established following review of critical incidents		
Standard: 3.2 Effective Communication Working towards self-assessment Score 4							
Approve a new VUNHST communications and engagement strategy	Assistant Director Communications	Executive Director of Corporate Governance Executive Director of OD & Workforce	Medium	Q4	The June 2020 Communications and Engagement Strategy is being revised and will be presented to the Executive Management Board in January 2021. In development for EMB consideration in May 2022.		
Development of new MURA internet and Intranet pages to include accessible information and links to additional resources for managers and staff to support patients and donors as well as resources for staff needs.	Assistant Director Communications	Executive Director of Corporate Governance Executive Director of OD & Workforce	Medium	Internet template to be in place by Q2, Intranet pages Q4	The new Trust & VCC website have been built using MURA. The new intranet system (sharepoint) is currently being reviewed and will be built by the end of June 2022.		
Continuous rollout of Interpreter on Wheels service for interpreter needs. Currently have 3 mobile units but ability to download service to additional devices. Currently used throughout VCC, but to be expanded to satellite sites and WBS clinics. Training on using the systems to be provided by Equality manager.	Equality & Diversity Manager	Executive Director of Nursing, AHP's and Medical Scientists	Medium	Q4	The interpreter on wheels device is a stand- alone device used throughout the Cancer centre. Device for Satellite sites by Q2, WBS by Q4.		
Looking at IT systems across the Trust, ensure staff are collecting language choice and recording it as part of the need to provide the 'Active offer' – secure KPI's around collection of Welsh language and new WPAS system (VCC) as an example.	Welsh Language Manager	Executive Director of Corporate Governance Executive Director of OD & Workforce	Medium	Q4	In progress		
Standard 3.3 Quality Improvement, Research and Innovation Working towards self-assessment Score 5							
Subsequent to the review of current Trust R&D processes with a view to integration of Innovation requirements, develop and incorporate identified improvements into Trust RD&I, e.g. introduce a quality manual. **Carried forward from 2020/21**	RD&I (VCC)	Medical Director	Low	Q4	In progress, on target The RD&I Division has produced a work plan to develop and incorporate improvements into the Trust RD&I Division.		
Develop a RD&I training programme for Trust staff members, and work with other organisations to provide training opportunities, so that staff:	RD&I (VCC)	Medical Director	Low	Q4	In progress, on target Discussions underway about what the training programme may look		

- Understand the role of Trust RD&I in the organisation and the context of NHS research - Understand what managing NHS research entails, including roles and responsibilities, capacity and capability, safety, finance and contracts - Understand how quality research is developed, designed, set-up and carried out - Understand the oversight required for NHS research					like and how external stakeholder training is included.		
Review the administrative structure, roles and responsibilities of the research delivery team and make recommendations for improvement	RD&I (VCC)	Medical Director	Low	Q4	In progress, on target. Processes identified with Workforce & OD necessary propose the changes. Proposals now under development.		
Develop business intelligence to support the expression of interest/feasibility and set-up and delivery processes	RD&I (VCC)	Medical Director	Low	Q4	In progress, on target. Initial discussions have taken place to identify the work required. Additional scoping work to be begun.		
Standard 3.4 Information Governance & Communications Technology Working towards self-assessment Score 5							
Trust / WBS / VCC: New Digital Strategy 2020 – 2025	Chief Digital Officer	Director of Strategic Transformation Planning & Digital	Medium	Q4	Initial draft developed. Engagement session held with Digital Services team, with plans for wider communication / engagement across the Trust towards end of 2021. Proposed to be approved at the January / March 2022 Trust Board. Aim is to take to March 2022 Trust Board.		
Review of current Trust IG policies and update as necessary in order to ensure material remains reflective of current legislation and guidance	Trust Information Governance Manager	Director of Strategic Transformation Planning & Digital	Medium	Q4	Head of IG carrying out final QA work prior to presenting Policies for approval at the SIRO/EMB/QSP levels.		
Standard 3.5 Record Keeping Working towards self-assessment Score 4							
Implementation of the Digital Health Record and the Welsh Patient Administration System.	Chief Digital Officer	Director of Strategic Transform ation, Planning and Digital	Medium	Q1 2022/23	Project in place to progress delivery of the DH&CR and WPAS. Go-live scheduled for May 2022. DHCR – revised timelines for this are being discussed as we speak, since DHCW have just confirmed that they have missed deadline for a range of WPAS and WCP software development activity that		

					was due to be completed by end of last year.		
Strategy for the management of the paper medical record.	Health Records Manager	Executive Director of Finance	Medium	Q4	On target for strategy development.		
Standard 4.1 Dignified Care Working towards self-assessment Score 4							
Standard 4.2 Patient Information Working towards self-assessment Score 4							
Standard: 5.1 Timely Care Working towards self-assessment Score 4							
Develop plans for increasing ambulatory care provision	Dr Hilary Williams Consultant Oncologist	Chief Operating Officer	High	Q4	Patients seen by ambulatory care has increased significantly over the past 2 years. Work to review and strengthen this pathway will be ongoing as part of the Velindre Futures programme. The SDEC project which commenced in November 2021, funded by the Welsh Government, to improve and extend the ambulatory care provision at VCC is progressing well and on track to deliver all Civica objectives.		
Implement VCC specific measures in support of the systemic implementation of the Single Cancer Pathway	Wayne Jenkins Head of Planning and Performance	Chief Operating Officer	Low	Q4	Cancer Network funded Single Cancer Pathway Programme Manager commenced October 2021.Focus for Oct 2021 to Mar 2022 will be on redesign of Breast pathway followed by Urological pathway.Work ongoing and patient pathways are being taken forward by Velindre Futures.		
Standard 6.1: Planning Care to Promote Independence Working towards self-assessment Score 4							
Standard 6.2: People Rights Working towards self-assessment Score 4							
Standard 6.3: Listening and Learning from Feedback Working towards self-assessment Score 4							
Implement the Civica feedback system in a phased approach commencing with Cancer Centre.	Patient and Donor Experience Leads Deputy Director of Nursing and Patient Experience	Executive Director of Nursing, Allied Health Professionals and Health Scientists.	High	Q4	The Civica system has been implemented within VCC in a phased manner but further implementation work is required. There is plan to implement the Civica system in WBS in Q4 2021.		
Development a robust mechanism for obtaining and learning from Patient and Donor feedback	Deputy Director of Nursing and Patient Experience	Executive Director of Nursing, Allied Health Professionals and Health Scientists.	High	Q4	The Patient experience strategy will include a robust plan for listening and learning from feedback, this is currently in development. It is an anticipated that this will be completed during Q3 2021. This is behind schedule due to competing priorities.		

					Changes are being made to ways of working within the Corporate Quality and Safety Team in order to strengthen the Patient and Donor Experience agenda.		
Standard 7 Staff and Resources Working towards self-assessment Score 4							
Focused action plan for PADR completion – focus on areas of poor PADR completion	Workforce team	Executive Director of OD & Workforce	High	Q4	Work ongoing with the WOD team to focus on areas of poor PADR compliance – triangulating all WOD data to understand the route cause of the problem. Ongoing into 22/23		
Re-engage with the Virtual reality learning project stepped down through COVID	Workforce team	Executive Director of OD & Workforce	Medium	Q2/3	Re-establish with Swansea university. To be delivered by December 2022		
Planned and Sustained Workforce							
Utilising the delegation framework commence a project in VCC to develop the HCSW role maximising opportunities for this role	Workforce team	Executive Director of OD & Workforce	Medium	Q4	Pushed back to 2022.		

QUALITY, SAFETY & PERFORMANCE COMMITTEE

VUNHST Annual Medical Workforce Revalidation Progress Report 2021-2022

DATE OF MEETING	14/07/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Aisling Butler, Clinical Lead for Appraisal and Revalidation for VUNHST
PRESENTED BY	Jacinta Abraham, Executive Medical Director
EXECUTIVE 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**
EMB	01/07/2022	NOTED

ACRONYMS	
HEIW	Health Education and Improvement Wales

1. SITUATION/BACKGROUND

The Revalidation & Support Unit within HEIW, request an annual feedback report called the Revalidation Progress Report from every Health Board and Trust in Wales who are defined as a Designated Body (DB). The Revalidation Progress Report (RPR) is designed to enable Designated Bodies in Wales to report medical appraisal figures and to carry out a self-assessment of the systems and processes they have in place to support medical revalidation. Bi-Annually the Unit also undertakes an Inspection Meeting which was last held in VUNHST in 2021.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

Section 1 of the report shows the appraisal figures: There are 78 prescribed connections for VUNSHT and 69 completed appraisals which is 88.5%.

Section 2 provides information on the quality assurance of the processes. The RAG rating for 27 of the 29 domains assessed are green. The 2 amber areas identified relate to 2 proposed actions by HEIW for development. Firstly, the involvement of patients and the public in the revalidation process and secondly the involvement of a lay member to provide independent scrutiny and challenge. An action plan is being developed in collaboration with HEIW to address both these areas and adopt a consistent All Wales approach.

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: Safe Care
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	In line with the Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) every licensed doctor who practices medicine must revalidate via the General Medical Council. Revalidation supports non-training doctors to develop their practice, drive improvements in clinical

	governance and gives patients and employers the confidence that the doctor is fit to practice.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. SUMMARY and RECOMMENDATION

The VUNHST position on this annual report is that we are compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and are satisfied with the level of assurance we have about these systems and processes, both now and throughout the year, and the way in which they support and inform revalidation.

The Quality, Safety and Performance Committee is asked to **NOTE** the position and feedback report attached.

REVALIDATION PROGRESS REPORT (RPR) 2021-22

Click or tap here to enter text.

1.1 Name of designated body:	Velindre NHS Trust	Last Year's RPR report:
Name of Responsible Officer:	Jacinta Abraham, Executive Medical Director	
Type of organisation:	Cancer Hospital, Welsh Blood, Hospice and Shared Services	
Name of person completing this report:	Aisling Butler	
Job title of person completing this report:	Clinical lead for Appraisal and Revalidation for VUNHST	

Part 1 - Appraisal Figures

1.2 Appraisal Completion Figures as of the 31.03.22	

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	1	0	1	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)				

Llywodraeth Cymru
Welsh Government

GIG CYMRU NHS WALES

Addysg a Gwella Iechyd Cymru (AaGIC)
Health Education and Improvement Wales (HEIW)

Part 2 – Quality Assurance of Processes

Please include a copy of the DBs Revalidation Action Plan or equivalent as an appendix to this report

2.1 Revalidation Processes. What level of assurance does the DB have:			
2.1.1 That there are sufficient support structures in place to support the RO and revalidation team?		Level of Assurance (RAG):	**GREEN**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan	
The RO is supported with revalidation monitoring and compliance by the Consultant Clinical Lead for Appraisal and Revalidation, the Medical Directorate Manager, The Assistant Medical director for workforce and the Revalidation and Appraisal Manager	Increase the members of staff with access to GMC Connect to ensure robust cover for unexpected illness.	Deputy RO now appointed and in place. Appraisal lead now has access to GMC connect but with limited privileges to avoid conflict of interest.	
2.1.2 That revalidation recommendation decisions are made timely and in line with GMC RO regulations?		Level of Assurance (RAG):	**GREEN**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan	
The Clinical Lead liaises with those Consultants who are due to revalidate to ensure they are compliant and understand the process. The Lead is supported by the Revalidation and Appraisal Manager who provides regular timely reports from MARS.	Continued education and updates via the senior medical staff committee meeting, to be a standard agenda item.	Quarterly meetings are scheduled to allow sufficient time to make a recommendation ahead of revalidation dates. Doctors are contacted by the revalidation team well in advance of their revalidation date to allow time for any outstanding elements to be completed. Revalidation reminder template shared through WRAG meeting.	
2.1.3 That revalidation deferrals decisions are made and managed appropriately?		Level of Assurance (RAG):	**GREEN**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan	

Monthly compliance team ensure that any doctor who may require a referral is identified ahead of the revalidation committee meeting and that all opportunities are available to explore and validate the reason for deferral.	Put in place robust mechanisms to capture every new doctor working for the organisation and its hosted services. Close liaison with HR in the cancer centre, Welsh Blood and Shared Services. All deferrals will be captured and ratified by the revalidation committee.	Internal monitoring is more robust, ensuring that almost all doctors have had sufficient reminders and deferrals had not been required. A current deferral relates to maternity leave, a deferral inherited from a previous designated body is due to have a recommendation issued by the time this paper is submitted.
2.1.4 That there are processes in place for reviewing WPA in the context of appraisal and revalidation?		Level of Assurance (RAG): **GREEN**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan
All doctors and appraisers are aware of the requirement for WPA and the areas that need to be covered. In house training is provided. The clinical lead has attended Appraisal lead training and is up to date with appraisal training and critical analysis of appraisal summaries.	Continued support of appraisers through cascading learning and appraisal training opportunities.	Grand round refresher training has taken place. Appraisal lead is a member of the secondary care appraisal group and has attended Secondary Care appraisal lead meetings, has attended all training available for appraisal leads and cascaded this to appraisers. Appraisal lead attended the AQA event and attends the WRAG meetings. Appraisal lead taking an active role in appraiser training with a bite sized module "appraisal of leaders and managers" in the pipeline. Proposal submitted to HEIW. Recent in house appraiser meeting focused on the "professional context" box, specifically relating to whole practice appraisal. This meeting was also attended by a colleague from the Medical Examiner's office. Specific guidance has been written regarding the appraisal of medical examiners and this has been cascaded to appraisers.

2.1.5 That the RO role can be covered in the event of unplanned absence?		Level of Assurance (RAG): **GREEN**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan
Deputy medical director is now in post, has received RO trained and is authorised to act on behalf of the RO.		Deputy RO now active.
2.1.6 That revalidation processes are reviewed for effectiveness and quality; and that key issues arising from reviews and quality improvement activity are progressed?		Level of Assurance (RAG): **GREEN**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan
The revalidation pro forma presented to the RO includes the dates of the QI activity, this is validated by the clinical lead and the deputy RO, the RO has sight of the entries prior to and at the revalidation meeting.	Through shared learning, appraisal lead is aware of an initiative in a neighbouring health board whereby QIAs identified at appraisal are presented to the exec board, aim to implement a similar initiative in our trust.	Pro forma for revalidation used at every meeting and validated. At least one QI initiative is documented on the pro forma, type of QI activity and the appraisal meeting/summary is referenced.
2.1.7 That all revalidation processes consider equality, diversity and inclusivity issues and are fair and non-discriminatory?		Level of Assurance (RAG): **GREEN**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan

The Trust, Medical Director/RO, Deputy RO and Clinical Lead for Appraisal & Revalidation have undertaken Equality and Diversity Training and are aware of the need to consider equality and diversity issues during the process.	To ensure continued compliance to Equality & Diversity Training for all clinical leads involved in the process in all parts of the organisation	Equality and Diversity Training up to date.
2.1.8 That the DB takes into consideration public and patient views regarding revalidation processes?		Level of Assurance (RAG): **AMBER**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan
Revalidation and appraisal information is available to the Workforce and OD Committee. Members of this committee include lay members and external union representative. Patients contribute to the doctors 360 Appraisal which is part of the revalidation requirement.	Seek to invite a lay member to the revalidation committee meeting. This is something we have discussed and are eager to progress, We require guidance from the GMC and support from HEIW to aid us in this process.	Discussed at panel and compliance meetings, await formal guidance from HEIW.
2.1.9 That the DB engages with national activity relating to revalidation, e.g. WRAG and RO meetings and QA events?		Level of Assurance (RAG): **GREEN**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan
The Revalidation and Appraisal Manager and/or the clinical lead attend RAIG meetings quarterly.	Ensure the revalidation support officer has access to the same level of support from colleagues across wales. To build on this support.	A member of the team has attended all QA, WRAG meetings in the last year, the administrative officer is now in contact with colleagues in other health boards. A request has been made to HEIW to provide training for a new officer that will be out for advert shortly,

The RO/Deputy RO attends the National RO meetings when scheduled. Clinical Lead for Appraisal attend the Secondary Care Appraisal Lead Network.		this has been agreed at the last WRAG meeting.
2.1.10 That thresholds applied for revalidation recommendations are in line with those of other DBs?		Level of Assurance (RAG): **GREEN**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan
The Clinical Lead/AMD and/or Revalidation and Appraisal Manager attend WRAG meetings quarterly and utilises that network to ensure VUNHST is aligned with other Designated Bodies.		All recommendations/changes are discussed with the RO, agreed and implemented. RO chairs Revalidation panel with the Clinical Lead and Revalidation and Appraisal Manager to discuss/agree revalidation of doctors. Appraisal lead joins all network lead meetings and is part of a new sub group of appraisal leads in secondary care. WRAG meetings attended regularly by one or more members of the team.
2.2: Underpinning systems: appraisal. What level of assurance does the DB have:		
2.2.1 That there is sufficient support for doctors to enable them to be appraised? Including number of available appraisers, information about appraisal, support with MARS, access to relevant data		Level of Assurance (RAG): **GREEN**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan
In-house support for doctors is very strong, with direct access to the appraisal lead for advice and individual training and explanation. The Revalidation and Appraisal Manager is fully supportive and liaises with the appraisal lead,	Encourage trained doctors to commence with appraising peers. Recruit new appraisers.	One new appraiser has been recruited, awaiting appraiser update training. Two/three other colleagues have been approached expressed and interest, hoping to train when their job plans change in the next few months.

HEIW/ MARS and ORBIT on behalf of the doctors when necessary.		We currently have enough appraisers to comply, recruiting more will further strengthen the process.
2.2.2 That there is a robust induction process for doctors including appraisal and revalidation guidance for the organisation?		Level of Assurance (RAG): **GREEN**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan
Medical Staff induction has been reviewed by the AMD for Workforce		Appraisal Training and Mars Navigation available for all new doctors. Standard part of Induction for all doctors. Appraisal training has been implemented and availed of.
2.2.3 That all doctors requiring appraisal are appraised when they should be?		Level of Assurance (RAG): **GREEN**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan
Ongoing monitoring of the appraisal and 360 appraisal completion is undertaken – this monitoring results in direct communication from member of the Directorate team with doctors if required by email and verbally.		Monthly monitoring of compliance and direct communication with medical staff is undertaken. Appraisers have been very supportive in scheduling appraisal meetings within required quarters where possible. Requests for change in quarter carefully managed by the workforce compliance officer and AL.

2.2.4 That reasons for non-completion are documented, and non-engagement is managed appropriately?		Level of Assurance (RAG):	**GREEN**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan	
The Trust has developed local guidance for appraisers as how to escalate non-engagement in the appraisal process. Escalation is via the clinical lead to the deputy RO and RO.		Grand round presentation given by the AL and regular updates at the Senior medical staff meeting to ensure doctors understand the requirement to engage and know who to approach is there are difficulties. Appraisal and revalidation update is now a standing agenda item on the senior medical staff committee meetings which take place monthly.	
2.2.5 That appraisers are fit for purpose, appropriately trained and up to date?		Level of Assurance (RAG):	**GREEN**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan	
HEIW offer appraiser training and all appraisers are invited to attend to refresh their skills.	Establish regular in house training via the appraisal lead, this a work in progress	Grand round presentation also included links to appraiser update training. The appraisal lead is in regular contact with all appraisers and due to the size of the organisation is in a position to provide individual clarification at short notice and has. Appraiser lead has attending the AQA and also the appraiser training with a focus on well-being, this training event has been cascaded and was also attended by other appraisers.	

		Quarterly Appraiser meetings now in place.
2.2.6 That appraisers are supported and managed in their role, and are performing the role appropriately?		Level of Assurance (RAG): **GREEN**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan
The appraisers are supported in their role by quarterly Appraisal meetings held by the Clinical Lead and supported by the Revalidation and Appraisal Manager. Appraisers may approach the Clinical Lead, RO/Deputy RO at any time should they have concerns. The Revalidation and Appraisal Manager supports the appraisers when MARS/ORBIT 360 queries arise.	Agree remuneration for the appraisal role, either in sessional time or in displaced activities. This is being looked at in secondary care through the appraisal lead group and we hope to implement this in this organisation. Look to build on pastoral support for appraisers dealing with overwhelmed/"burnt out" doctors which is particularly relevant at this time.	Appraisal lead has attended further training and is in a better position to advise and support appraisers. Appraisal lead actively shares learning which hopes to provide better support to secondary care appraisers. Appraisal lead has attended well-being training. Sessional commitment and remuneration remains outstanding but we are in line with other health boards, the secondary care appraisal leads group are looking at ways to address this on a national basis.
2.2.7 That appraisal outputs (summary and PDP) meet agreed standards?		Level of Assurance (RAG): **GREEN**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan
The Trust has a significant medical engagement score in Wales which is indicative of the positivity	Quarterly appraiser meetings in place from 2021 to discuss standards, PDPs- (SMART) and provide refresher training.	Training has taken place, but ongoing training planned.

of individuals and how they value this process and the support of the Trust. AL lead reviews appraisal summaries on an ad hoc basis to ensure compliance.	AL to undertake a more formal in house peer review process of appraisal summaries and feedback to appraisers.	PDPs and the SMART objectives have been discussed at the grand round presentation.
2.2.8 That appraisal and its outputs are having a positive impact on individuals and on the organisation?		Level of Assurance (RAG): **GREEN**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan
The MARS system reports anonymised constraints identified through individual's appraisals. These are reported through our Senior Medical Staff Committee Meeting. Appraiser feedback via mars analytics is positive. See also comments regarding constraints analysis		This is difficult to evidence but through the regular appraisee and appraiser updates with reminders that during the appraisal meeting that the PDP is to be reviewed in detail and progress towards previous constraints should be reviewed. The doctors are encouraged to take the information from appraisal to inform job planning. Thus far we have positive comments. The annual constraints report is reviewed and a more up to date analysis of constraints takes place on a biannual basis, this is discussed in a meeting with the RO, deputy RO, Clinical director, Deputy CD and medical business manager and an action plan is in place. Supported by the compliance officer and the clinical lead for appraisal and revalidation.

2.3: Underpinning systems: governance. What level of assurance does the DB have:			
2.3.1 That appropriate checks, including regarding their appraisal status and any outstanding concerns, are carried out prior to establishing a connection with a doctor?		Level of Assurance (RAG):	**GREEN**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan	
A doctor may establish a connection with our organisation through the GMC. The Revalidation and Appraisal Manager will confirm that this doctor is employed by the trust or one of its hosted services. The doctor is given induction training and requested to register with mars, all prior appraisals/training equivalent portfolios are requested by the Revalidation and Appraisal Manager and validated by the clinical lead for appraisal and correlated with the stage in the revalidation cycle. RO to RO referral process implemented and recorded. References validated at the time of employment.	Establish more firmly regular cross correlation of doctors registered on MARS with those connected to on GMC connect. Ensure there is a correct understanding of the RO to RO processes inside and outside wales as they differ.	Process are more robust with a stronger team now firmly established. **We have recognised that doctors can affiliate themselves to our DB without RO consent or GMC notification**. We cross reference all doctors on ESR, Mars and GMC who have declared an affiliation to our organisation. All doctors affiliated to us are cross checked to ensure not incorrectly affiliated. As it stands we have updated the records, this is under monthly review.	
2.3.2 That the DBs GMC Connect list is up to date (in terms of both joiners and leavers), and cross-checked against your staff records and / or the MPL?		Level of Assurance (RAG):	**GREEN**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan	
The Medical staffing team at Velindre Cancer centre are closely allied with the Revalidation and Appraisal Manager and all new doctors have appraisal induction and register with mars if in a non-training role. We cross reference our doctors with MARS, GMC and HR. It had been a challenge identifying doctors with a connection to	Ensure that we have robust communication processes in place with all hosted services to identify new doctors. Regular review of GMC connect to identify doctors who connect with us. Ensure all email address and contacts with GMC are up to date.	We now have more people with GMC connect access and have establish more robust links with our hosted organisations. We are aware of those doctors that need to come on the list and leave the list and the list is reviewed regularly. The list is currently correct.	

our DB who lie outside the cancer centre and welsh blood but this has now been addressed. The Revalidation and Appraisal Manager receives a monthly new starters and leavers report from workforce.		
2.3.3 That where concerns arise about doctors with whom you have a prescribed connection, these are managed and inform the revalidation recommendation appropriately?		Level of Assurance (RAG): **GREEN**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan
The deputy medical director supporting workforce is involved in the management of concerns with the clinical director in addition to their role in supporting the medical director in revalidation. All datix incidents and complaints are available to the team should they not be disclosed in appraisal. All doctors must agree the probity section to ensure that the information provided is correct and appraisers validate this at the time of the appraisal meeting.	None identified at this time	As with other sections, processes are more robust as the team are firmly established within the organisation. We have no concerns in this regard. Quarterly meetings with the revalidation team, medical business manager and CD department should mitigate concerns.
2.3.4 That should concerns arise during the appraisal process, these will be shared and managed appropriately?		Level of Assurance (RAG): **GREEN**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan
All appraisers are fully trained and understand when it is time to halt an appraisal meeting and take advise from the appraisal lead, RO or deputy RO.	Continue support for appraisers and enhance their ability to deal with difficult situations through both in house advice, training and links with HEIW.	As per previous.
		Level of Assurance (RAG): **GREEN**

2.3.5 That should concerns arise about a doctor who works for the DB but does not have a prescribed connection with the DB, or no longer has a prescribed connection with the DB, this information is shared appropriately between organisations?			
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan	
Where there are concerns raised about a doctor, this is captured through the medical directors department and the datix reporting system. Due to the crossover of management between medical and clinical directors' departments, appropriate feedback to the DB can be identified and delivered.		Systems in place appropriate.	
2.3.6 That governance information is consistently available relating to all doctors, including for example those who work within the DB for a short period of time?		Level of Assurance (RAG):	**GREEN**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan	
Regular clinical governance and peer review is embedded within the site specific teams and all member of staff are asked to actively engage and contribute. Presentations are made at the senior medical staff committee meetings where non clinical and associate clinical staff can be invited to attend. Governance is also embedded in our Grand Round Programme.		Systems in place appropriate	
2.3.7 That governance data is shared appropriately with those making revalidation recommendations – including for example information about complaints and incidents, and feedback from patients?		Level of Assurance (RAG):	**GREEN**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan	

As above, there is cross correlation between the medical director's department and the revalidation team.		We have established responsible officer advisory meetings whereby the clinical director, medical director, medical business manager and revalidation team meet to ensure all activity has been captured.
2.3.8 That the DB encourages lay involvement in quality assurance processes to provide independent scrutiny and challenge?		Level of Assurance (RAG): **AMBER**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan
Velindre promotes strong patient and stakeholder engagement at every level, from patient feedback through the 360 platform, to the recently undertaken Nuffield review which actively encouraged lay challenge and engagement.	There will be a review of the alignment of the Independent Member portfolios with this work going forwards. We will work with HEIW for their advice and guidance of best practice approach in this respect.	Further discussion has taken place, we will look to HEIW for guidance.
2.3.9 That the organisation's Board is appropriately engaged in / informed about governance and revalidation processes?		Level of Assurance (RAG): **GREEN**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan
The medical director reports to the board, the chief executive is fully informed and signs off the annual and interim reports.	None identified.	The board is fully informed, we have new pathways in place to inform the board of constraints.

2.3.10 That doctors' constraints identified at appraisal are reported to the Board for consideration i.e. to be included in risk register if appropriate?		Level of Assurance (RAG): **GREEN**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan
Biannual report of doctors' constraints reviewed and escalated as appropriately. Feedback given to the senior medical staff committee.		Training through the grand round forum has emphasised the importance of reporting constraints and there is anecdotal evidence that this section is better populated on mars. As documented above, we have set up a biannual constraints analysis meeting, reviewing the All Wales Constraints Report but in addition we analyse constraints in a six monthly basis, taken to board level and as documented elsewhere, feedback taken to the SMSC.
2.3.11 That governance processes are having a positive impact, and informing revalidation appropriately?		Level of Assurance (RAG): **GREEN**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan
Peer review, morbidity and mortality meetings, completed audit cycles which influence change are recognised as quality improvement activities and are informing revalidation.		We are confident in our compliance in this regard.

Llywodraeth Cymru
Welsh Government

GIG CYMRU NHS WALES

Addysg a Gwella Iechyd Cymru (AaGIC)
Health Education and Improvement Wales (HEIW)

Part 3 – Quality Visits, Internal Quality Assurance and Other Projects

3.1 Progress against Quality Visit Actions					
3.1.1 Designated Body Action Plan and Comments (1st, 2nd and 3rd year progress to be completed by DB)				Date of Visit:	
Action	By Whom	Timescale	1st Years Progress	2nd Years Progress	3rd Years Progress

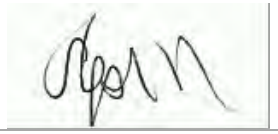
3.2 Internal Quality Assurance exercises (IQA)			
3.2.Have you undertaken an internal quality assurance exercise?	Yes	Date of last exercise	2021
Please provide details of the sample size and parameters that are used	Please proved details of the resources used i.e. RSU calibration video, scoring criteria, sample summaries etc.	Please provide brief details of the outcome of the quality assurance exercise	
Pro forma introduced to document and confirm revalidation requirements	Pro forma attached.	In 2021 we introduced a pro forma to aid the RO in recommendations, all appraisals or AMA's are documented, the date of the 360 discussion is entered and the type and year of the QIA is validated and recorded.	
3.2.2 Please provide a copy of the most recent Internal Quality Assurance outcomes with your RPR return (if applicable).			

3.3 Other Revalidation or Appraisal Projects, including any Quality Improvement undertaken/lessons learned from the pandemic			
3.3.1 Have you have recently completed or currently undertaking a project/QI exercise?	Yes	Date of last project	2021
Project 1. Please provide details of the project.	Project 2. Please provide details of the project.	Project 3. Please provide details of the project.	
Analysis of Virtual Appraisal. (HEIW led)	Questionnaire format.	Positive outcomes	

3.3.2 Please provide a copy of your project report with your RPR return		

Part 4 – DB Statement of Compliance

4.1 Completed report authorised by Responsible Officer		
Name	Signature	Date.
Dr Jacinta Abraham		16/06/2022

4.2 Board statement of compliance			
Signed on behalf of the designated body (Chief executive or chairman, or executive if no board exists)			
Name	Role	Signature	Date.
Mr Steve Ham	Chief Executive		16/06/2022
I can confirm that: The organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) We are satisfied with the level of assurance we have about these systems and processes, both now and throughout the year, and the way in which they support and inform revalidation We are satisfied with the organisation's progress in terms of revalidation, and that there is a clear plan in place to guide further quality improvements			
Or: we have concerns about any of the above, as described below:			

QUALITY, SAFETY & PERFORMANCE COMMITTEE

TRUST CLINICAL AUDIT PLAN 2022-2023

DATE OF MEETING	14/07/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Sara Walters, Clinical Audit Manager VCC Zoe Gibson, Clinical Services WBS
PRESENTED BY	Jacinta Abraham, Executive Medical Director
EXECUTIVE SPONSOR APPROVED	Jacinta Abraham, Executive Medical Director

REPORT PURPOSE	APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
EMB	01/07/2022	ENDORSED

ACRONYMS	
WBS	Welsh Blood Services
VCC	Velindre Cancer Centre

1. SITUATION / BACKGROUND

The purpose of this paper is to provide the Quality, Safety and Performance Committee with the Trust Clinical Audit Plan and seek approval of the plan. This Annual Trust Clinical Audit plan will represent an overview of the Velindre Cancer Centre and Welsh Blood Service Clinical Audit Strategic approach and Programme of work for 2022/23.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 NHS Organisations delivering clinical activity are required to develop a clinical audit Programme which needs to be reflective of the service provided and aligned with the Organisational strategic direction. See WBS / VCC Clinical Audit Programme 2022/23 Appendix 1 & 2.

2.2 In order to ensure that these clinical audits contribute to the overall priorities of the organisation, and clearly improve patient and donor care, there needs to be a process of strategic planning and prioritisation. The resources for clinical audit are finite so the projects that have been proposed need to be reviewed and prioritised in a systematic way.

2.3 In line with national guidance (NHS Wales National Clinical Audit and Outcome Review Plan for 2022/23, Appendix 3), VUNHST should provide the resources to enable their staff to participate in all audits, reviews and national registers of relevance to the service, included in the annual plan.

3. IMPACT ASSESSMENT

RELATED HEALTHCARE STANDARD	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	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 are requested to **APPROVE** the contents of the report.

Velindre NHS Trust

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

CLINICAL AUDIT PLAN 2022/2023

VELINDRE UNIVERSITY NHS TRUST CLINICAL AUDIT PLAN 2022/2023

1. INTRODUCTION

The purpose of this paper is to provide the Quality and Safety Committee with the Trust Clinical Audit Plan and seek approval of the plan. This Annual Trust Clinical audit plan will represent an overview of the Velindre Cancer Centre and Welsh Blood Service Clinical Audit Strategic approach and Programme of work.

2. BACKGROUND

2.1 NHS organisations delivering clinical activity are required to develop a clinical audit programme which needs to be reflective of the service provided and aligned with the organisational strategic direction.

2.2 In order to ensure that these clinical audits contribute to the overall priorities of the organisation, and clearly improve patient and donor care, there needs to be a process of strategic planning and prioritisation. The resources for clinical audit are finite so the projects that have been proposed need to be reviewed and prioritised in a systematic way.

2.3 In line with national guidance (NHS Wales National Clinical Audit and Outcome Review Plan 2022/23), VUNHST should provide the resources to enable their staff to participate in all audits, reviews and national registers of relevance to the service, and ensure these are included in the annual plan. The details of the NHS Wales National Clinical Audit Plan can be found in Appendix 3

3. KEY REQUIREMENTS TO ACHIEVE A TRUST CLINICAL AUDIT PLAN

3.1 The necessary structures should be in place to support and complete engagement included in the Trust Clinical Audit plan.

3.2 A Clinical Lead for each of the divisions is required to provide clinical leadership and act as a local champion and point of contact for national audits and external relationships.

3.3 The full audit cycle should be completed and findings and recommendations from audit should link directly into a quality improvement programme.

3.4 The learning from clinical audit should be shared across the organisation, and communicated to staff and patients, and be used to improve the quality of care.

4. GOVERNANCE and REPORTING

4.1 The Executive Medical Director has overall responsibility for the development of a Trust Clinical Audit Plan and ensuring that this is aligned to the Trust strategic priorities.

4.2 The overall responsibility to complete the annual clinical audit programme for each division is delegated to the Divisional Directors.

4.3 Within each division there is a Clinical Audit or Quality Improvement manager with responsibility for the following:

- Ensuring that all Clinical Audit Activity within their division is registered
- Ensuring there is full participation in national clinical audits as required.

- Ensuring the clinical audit programme meets all clinical, statutory and commissioning requirements e.g. implementation of National Institute for Health and Care Excellence (NICE) guidance.

4.4 Reporting and monitoring of Clinical Audit activity to the Senior Management Team within each division should occur at quarterly intervals.

4.5 A highlight report of Clinical Audit activity from each division should be presented to the Trust Quality Safety Committee at quarterly intervals.

4.6 The outputs of this Clinical Audit plan will feature within the Trust Annual Clinical Audit Report, which is endorsed by both the Trust Quality and Safety Committee, and the Trust Audit Committee and then finally approved by Trust Board. This ensures that there are clear lines of communication with full board engagement in the consideration of audit, the review of its findings and the necessary quality improvements to follow.4.6 Any national audit that provides benchmarking information should be highlighted.

4.7 An escalation process should exist for any areas of risk identified through participation of local or national audit e.g. using the risk registers within each division to assess, document and mitigate risk as appropriate.

5. VELINDRE CANCER CENTRE CLINICAL AUDIT PROGRAMME

5.1 Definition of Clinical Audit at Velindre Cancer Centre (VCC)

The universally accepted definition for both national and local clinical audit as defined by the National Institute for Health and Clinical Excellence (NICE) in their 'Principles for Best Practice in Clinical Audit' is:

"a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes, and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in healthcare delivery." NICE, 2002

5.2 Principles of the Clinical Audit Process at VCC

5.2.1 Within Velindre Cancer Centre (VCC) there is a comprehensive and wide-ranging audit programme that has been developed in conjunction with Site Specialist Teams (SST's), Directorate managers and the Quality & Safety/Improvement Team.

5.2.2 In line with best practice highlighted in a number of key documents including *Clinical Audit: A simple guide for NHS Boards & Partners (Healthcare Quality Improvement Partnership)* and *NHS Wales National Clinical Audit and Outcome Review Plan 2022/23* the VCC programme covers the following areas;

- ✓ Involvement in National Audits and Outcome Reviews
- ✓ Quality and Safety – Audits undertaken in response to serious incidents/adverse incidents/near-misses/complaints, to ensure corrective actions taken to prevent a recurrence have been implemented
- ✓ Cancer Peer Review Outcomes
- ✓ Professionally led and/or SST lead audits - to ensure healthcare professionals are enabled to participate in clinical audit in order to satisfy the demands of their relevant professional bodies (for example, for revalidation and professional development)

- ✓ Internal ‘Must Do’ Audits based on high risk/high profile/tier one target areas etc.

5.2.2 The VCC audit programme has been mapped against the Health and Care Standards for Wales.

5.2.3 The VCC audit programme is signed off by the VCC Quality and Safety Management Group (QSMG) and the Senior Management Team.

5.2.4 The VCC programme for 2022/23 is shown in appendix 1.

5.3 Dissemination of audit results and learning from audit outcomes.

5.3.1 The Multidisciplinary Site-Specific Teams take ownership for the internal audit results and discuss and report these at the regular team meetings. All this data feeds into the VCC Clinical Audit Annual Report which is validated by the Quality Senior Management Team and reported to the Trust Quality and Safety Committee,

5.3.2 The development of a hospital-wide Audit/QI afternoon is underway in order to display the successful audit work taking place within the cancer centre. All professional groups will be invited to present completed projects either in oral or poster formats. A quarterly newsletter highlighting success stories would supplement this.

5.3.2 A full summary of the impact of these audits and outcomes is reported following the meeting and action plans are developed. Any areas of concern identified are escalated through the Site-Specific Team appraisal process and plans to re-audit areas or assess the impact of interventions, is also agreed here.

5.4 Areas of development for VCC

- Integration of Clinical Audit and Service Improvement teams to create a Quality Improvement Hub
- Prioritising a Training and development programme in QI and safety to ensure staff delivering the services are involved and aware of underlying principles of Audit/QI/patient safety and are actively involved in delivery & completion of audit cycles.
- Increase opportunities to disseminate and showcase work across the organisation by setting up Trust Clinical Audit and QI events to share learning and foster a culture of clinical effectiveness and improvement.
- Define the relevance of National Audit data to our local population considering the equity of access to care and clinical outcomes
- The implementation of AMat, which is a web-based Audit Management and Tracking tool to streamline all of auditing requirements into one simple, easy-to-use system. It provides control over audit activity and provides real-time insight and reporting for clinicians, wards, audit departments and healthcare trusts.

6. WELSH BLOOD SERVICE (WBS) CLINICAL AUDIT PROGRAMME

6.1 Clinical audit at the WBS is fundamental in ensuring optimal clinical care outcomes for our service users.

6.2 When carried out in accordance with best practice standards, clinical audit:
- Improves the quality of care and service user outcomes
- Provides assurance of compliance with clinical standards
- Identifies and minimises risk, waste and inefficiencies

6.3 A number of clinical audit activities are embedded into WBS processes which demonstrate a commitment to sustain and improve high quality of care for all of our donors.

6.4 At the Welsh Blood Service clinical audit roles and responsibilities are embedded into clinical roles across the organisation. Audits are reported to the relevant clinical governance group and hence to the Regulatory Assurance and Governance Group. The clinical audit oversight lead role is undertaken by the Deputy Medical Director with the support of the wider clinical service team.

6.5 The Welsh Blood Service continues to embed programmes of clinical audit across the division to enable continuous improvement of services to maximise donor & recipient safety and ensure optimal high quality and evidence-based practice continues to be provided.

6.6 Learning from Clinical Audit

Clinical audits in the WBS generate specific action plans including follow up and cycles of reaudit. The 'Tendable' clinical audit system will be introduced during August 2022 to enable the provision of robust feedback and learning systems for clinical audits to ensure that identified improvements are delivered and embedded into clinical practice.

6.7 Participation in External Audits

The Welsh Blood Service does not directly participate in Welsh national audits of transfusion as the division does not transfuse blood components into recipients. These are undertaken by the Health Boards and the Cancer Centre division of the Trust where blood components are transfused.: The Blood Health Team (BHT) at WBS contributes to the prioritisation, design and coordination of national audits of transfusion in Wales on behalf of the Blood Health National Oversight Group (BHNOG) The BHT completes all-Wales analysis and contributes to the action plans from specific audits and from the ongoing monthly performance indicator data for individual hospitals.

6.8 Participation in U.K/ European Audit and Benchmarking Activities

The Blood Health Team undertake sub analyses of UK wide National Comparative Audits in the field of blood transfusion and work with the BHNOG individual Health Boards and if the audit is relevant to patients with cancer the VCC. The National Comparative Audit program is supported by the four nations of the UK and typically has a high uptake in Wales.

The WBS also participates in international audits of practice, initiating surveys and audits that are priorities for Wales. We are members of the European Blood Alliance (EBA) and the worldwide Biomedical Excellence for Safer Transfusion (BEST) Collaborative

7. IMPACT OF KEY AREAS of DEVELOPMENT on the TRUST CLINICAL AUDIT PROGRAMME 2022-23

7.1 Positioning of Clinical Audit within the Trust Quality and Safety Framework
The Trust Quality and Safety Framework which is in development, will strengthen the position of clinical audit and ensure that there is alignment strategically with the quality and safety agenda across the Trust. The establishment of Quality Hubs will be instrumental in linking in key individuals and pieces of work, to ensure there is coordination, oversight and triangulation of outcomes. As part of the development of a

Quality cycle, there will be a project management infrastructure to strengthen its clinical effectiveness arrangements including Clinical Audit.

7.2 Positioning of Clinical Audit within the National Clinical Framework (NCF)
The National Clinical framework aims to develop Quality Statements for a number of Clinical Networks and disease areas including Cancer and End of Life. This will be a set of clinical priorities that can be used to benchmark against, using Clinical Audit and Quality Improvement to drive change. The NCF also promotes the principles of prudent health and use of quality management systems, in line with our Trust QSF

7.3 Trust Clinical Scientific and Strategic Board
The establishment of the CSSB will provide a strong focus for prioritisation of Clinical Audit in line with the development of a Clinical and Scientific Strategy.

7.4 Trust Value Based Healthcare Programme
The embedding of Value in Health principles across the Trust will shape the focus for Clinical Audit in reducing harm and variation in clinical pathways and also considering the equity of care across the system.

8.0 SUMMARY

The Trust Clinical Audit Plan seeks to provide assurance that there is a systematic process for prioritising and delivering clinical audit across Velindre Cancer Centre and the Welsh Blood Service. The clinical audit programme is well established within Velindre Cancer Centre given its patient facing role and is largely focused to date on the activity of the Site-Specific teams as well as full compliance on national audits. The Welsh Blood Service continues to develop its plan for Clinical Audit and this will be shaped further over the next 12 months. The developments across the divisions and Trust in the areas of Quality, Safety, and Clinical Strategy will undoubtedly shape the next iteration of this plan and broaden its future priorities.

Please see the Appendix for full details on the Clinical Audit Programme 2022/23 :

Welsh Blood Service Clinical Audit Programme 2022/23 Appendix 1
Velindre Cancer Centre Clinical Audit Programme 2022/23 Appendix 2
NHS Wales National Clinical Audit and Outcome Review Plan 2022/23 Appendix 3

APPENDIX 1

Welsh Blood Service Clinical Audit Overview July 2022

Welsh Blood Service Clinical Audit Programme 22/23

Audit	Aim	Frequency
Pre- venepuncture Skin Decontamination	- To prevent bacterial contamination of blood and blood products effective pre-venepuncture skin cleansing is of paramount importance. - To ensure that the arm cleansing techniques are in line with both evidence based practice and regulatory requirements.	Monthly Quarterly Validation Audits
Points of Care	- To ensure compliance with points of care UK evidenced based donation care principles to maximise donor outcomes.	Quarterly & Annual Validation
Hand Hygiene	- To ensure compliance with W.H.O 5 moments of hand hygiene to maintain donor, staff and recipient safety.	Monthly with Quarterly Validation
• **UK National Comparative Audits x 4**	a) Audit of acute upper gastrointestinal bleeding (AUGIB – May 2022) b) Audit of patient blood management in paediatric surgery (June 2022) c) Audit of blood sample collection & labelling (Sept 2022) d) Audit of NICE Quality Standards for Blood Transfusion (date TBC) These are audits of practice undertaken by Health Boards and Trusts in the UK against national guidance. The Blood Health Team facilitates these audits and provides a national report for Wales from the findings. Results are therefore provided for individual Health Boards benchmarked against peers in Wales and across the United Kingdom. The Blood Health Team will be facilitating a re-run of the 4th audit in the list (compliance with NICE quality standards) in 2022 to enable all Health Boards to participate as to date only half have.	3 Specific point audits commencing on the dates stated
Major Haemorrhage Protocol Activations in Health Boards	To promote appropriate use of blood and alternatives to blood. Including monitoring use of O D positive red cells in emergencies before the blood group of the recipient is known, preserving stocks of O D Neg for the patients who need them (females of childbearing potential).	Quarterly
Blood Health National Oversight Group (BHNOG) Performance Indicators	To provide an ongoing measure of practice from each of the Health Boards (HBs) in Wales for the use of O D negative red cells (ODneg) as a percentage of all red cells ordered (target <12%), wastage of ODneg as a percentage of total ODneg (<10%). Wastage of platelets as a percentage of total issues (<15%)	Monthly

Planned Specific Audits 2022/23

- Development of robust clinical audit standards and processes for stem cell collection by apheresis and bone marrow harvest.
- Develop a suite of Nursing Clinical Standards and associated clinical audit programmes within the specialities of whole blood, platelet apheresis and stem cell apheresis
- Clinical Audit of introduction of the For the Assessment of Individualised Risk (FAIR) study principles in Practice.

Significant specific audits in 2021-22

- Anaemia Audit: A follow up audit was undertaken in 2021 to assess impact of the implementation of a pre-operative anaemia pathway for patients across Wales. A significant improvement from the 2020 baseline was seen. In 2020 only 50% of sites had a process. Following implementation of an All Wales pathway in 2021, 94% of sites utilising the diagnostic parameters recommended and 88% complying with intravenous iron recommendations. The most significant challenge to compliance with the pathway being reporting diagnostic test results within 24 hours (47%). (https://wbs-intranet.cymru.nhs.uk/bht/wp-content/bht-uploads/sites/4/2022/01/All-Wales-Pathway-Final-Version-2.pdf).
- NICE Quality standards audit (only half of the Welsh Health Boards undertook it during 2021-22 due to other pressures but it has been agreed that this will be re-run to enable the others to participate see table above).
- We initiated a survey of members of the European Blood Alliance of testing and provision of blood components for haemoglobin S (HbS) as a benchmark for the provision of services for newborn babies and for patients with sickle cell disease. This demonstrated that our current practice was consistent with many peers but that our planned practice would be in the top quartile of quality and safety.
- Audit of Antenatal Anti-D sampling, quantification & reporting practice in RhD negative women in Wales. In 2021 the WBS conducted an audit of antenatal anti-D prophylaxis practice across Wales and identified potential for improvement. Following multidisciplinary working involving midwives, obstetricians and haematologists including a presentation at a Welsh Fetal Medicine Network meeting the process was revised and safer practice implemented.
- Out of Hours Red Cell Immunohaematology (RCI) Referrals: This identified non-urgent referrals of samples out of hours for testing that could more efficiently be dealt with at other times and actions are being developed with Health Board teams to improve this.
- Conservation Gap Analysis: In Dec 2021 a gap analysis was completed to assess each health board's compliance with blood conservation measures and to provide recommendations for areas which were non-compliant. This aimed to alleviate ongoing pressures on the supply chain during the coronavirus pandemic.

APPENDIX 2

Velindre Cancer Centre Clinical Audit Programme

HCS	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
Medical Directorate						
National Audits						
6.2	National Audit of Breast Cancer in Older People	National audit to assess the management of all symptomatic and screen detected breast cancers.	Clinical Audit Dept.	National Audit	Ongoing (Annual)	Ongoing (Annual)
3.1	National audit of lung cancer	The National Audit focuses on four main areas relating to lung cancer; the number of lung cancer cases within the UK, the range of treatments used, regional variations in these treatments and variations in outcomes	Clinical Audit Dept.	National Audit	Ongoing (Annual)	Ongoing (Annual)
3.1	National Prostate Cancer Audit	Looking at diagnosis, management and treatment of every patient newly diagnosed with prostate cancer in England and Wales, and their outcomes.	Clinical Audit Dept.	National Audit	Ongoing (Annual)	Ongoing (Annual)
3.1	NOGCA - National Oesophago-gastric Cancer Audit	To evaluates the process of care and the outcomes of treatment for all OG cancer patients, both curative and palliative.	Clinical Audit Dept.	National Audit	Ongoing (Annual)	Ongoing (Annual)
3.1	National Bowel Cancer Audit	The Audit's main aim is to improve the quality of care and survival of patients with bowel cancer.	Clinical Audit Dept.	National Audit	Ongoing (Annual)	Ongoing (Annual)

HCS	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
3.1	NCEPOD: Assigned Transition from child to adult health services: Organisational questionnaire	To explore the process of the transition of young people with complex chronic conditions from child to adult health services.	Consultant Clinical Audit Dept.	National audit	March 2022	April 2022
Continuous Monitoring – Quality and Safety and Must Do's						
3.1	Secondary Breast Cancer Multidisciplinary Forum (SBCMDF)	To evaluate the SBCMDF service and outcomes	Consultant	Key Indicator of Practice	Ongoing	Ongoing
3.1 3.5	Death within 30 days SACT	Review patients who die within 30 days of SACT	Clinical Audit Dept. SST's	Patient safety	Ongoing (Monthly)	Ongoing (Monthly)
3.1	Mortality reviews	Review inpatients who die at Velindre.	SCIF Clinical Audit Dept.	Patient safety	Ongoing (Weekly)	Ongoing (Weekly)
3.5 4.2	Consent Audit (Including Audit of all Wales consent form 4 (best interests)	To identify if consent forms are available to view and to ascertain completeness of the information	Clinical Audit Dept.	Clinical risk	Ongoing (Annual)	Ongoing (Annual)
Breast Malignancies SST						
3.1	Breast cancer radiotherapy and secondary cancer	Hanna Bramley	Consultant Medical Student SSC Project	Key indicator of practice	May 2022	June 2022

HCS	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
3.1	The impact of the COVID pandemic on our breast cancer patients	To review new patient referrals made to the hospital over a 3 month period prior to the pandemic- April to June 2019 and compare with the stage at which patients are referred following the pandemic in April to June 2021. There is a concern that patients have been at a more advanced stage of the cancer and are less fit now and are therefore able to have less treatment since the pandemic	Consultant Medical student SSC project	Key Indicators of Practice SSC	March 2022	May 2022
3.1	Primrose a national prospective observational study in breast cancer patients with central nervous system involvement in the UK	To report the survival of patients diagnosed with Central Nervous System (CNS) disease secondary to Breast cancer (BC).	SPR	NICE Guidelines/ National project	February 2020	December 2022
3.1	Altra - A national multi-centre audit of long term trastuzumab use in metastatic breast Cancer	National project to assess the long term use of trastuzumab	Consultant SPR	National audit	February 2021	Ongoing
Gynaecological Malignancies SST						
	Outcomes from image guided brachytherapy	To review outcomes of patients receiving Brachytherapy.	Consultant Medical Student SSC Project	Key indicator of practice	May 2022	June 2022
6.3	Late Effects of Radiotherapy Gynae-oncology – Survey	To evaluate patient's experience of the Gynae-oncology Late Effects Clinic.	Consultant	Users views	September 2020	Ongoing

HCS	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
3.1	Review of first line bevacizumab in advanced ovarian cancer in South East Wales	To review the number of patients that have received bevacizimab front line for ovarian cancer and to review the outcomes and toxicities	Consultant SPR	Clinical Effectiveness	May 2021	December 2022
3.1	Service evaluation of image guided brachytherapy	Image guided brachytherapy has been introduced into Velindre Cancer Centre in the last few years. It is important to monitor outcomes following its introduction.	Consultant	Key Indicators of Practice	April 2021	December 2022
3.1	Bevacizumab Induced Hypertension in Gynaecological cancers	Bevacizumab can induce HTN, the aim of this project is to look at the incidence of bevacizumab induced HTN, its management in comparison to NICE guidelines and the follow up.	SPR	NICE Guidance/ VCC Guidelines	February 2022	July 2022
3.1	Effect of covid-19 on vulva cancer referrals to a non-surgical oncology unit	To evaluate the effect of covid-19 on vulva cancer referrals to a non-surgical oncology unit	SPR Consultant	Clinical effectiveness	February 2022	May 2022
Head & Neck SST						
3.1	Head and Neck malignancies. There are several aspects to audit our experience and compare to trial data in both Urology and Head and Neck cancer	TBC	Medical student SSC project Consultant	SSC	May 2022	June 2022

HCS	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
3.1	Review of Enteral feeding in Head & Neck patients undergoing radical radiotherapy during COVID 19	Aim is to review which method of enteral feeding; reactive NGT vs prophylactic GT provides the best outcomes for these patients by comparing practice during pre COVID 19.	Consultant	Clinical effectiveness	February 2021	August 2022
3.1	The impact on swallowing outcome of changing radiotherapy technique for the treatment of T1 and T2 glottis cancers.	To assess the impact of changing radiotherapy technique.	SpR	Clinical effectiveness	April 2021	July 2022
3.1	To assess the use of Pembrolizumab in the metastatic/non resectable HNSCC at Velindre Cancer Centre	To assess the use of 1st line Pembrolizumab in metastatic/unresectable recurrent HNSCC population at Velindre Cancer Centre	SpR	NICE Guidance	December 2021	May 2022
Lung Malignancies SST						
3.1	Metastatic non small cell lung cancer: exploring the role of whole brain radiotherapy in patients with brain metastases in the era of immunotherapy.	TBC	Consultant	TBC	March 2022	June 2022
3.1	Audit of outcomes of patients having radical radiotherapy for NSCLC at Velindre Cancer Centre	Compare VCC outcomes to established best practice (as defined by international clinical trials) – overall survival and progression free survival	SpR	Key indicator of practice	April 2021	December 2022

HCS	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
3.1	Retrospective Data Collection for Lung Cancer Radiotherapy FDG PET Relapse Prediction in NSC Lung Cancer	To update data to date, looking at outcomes and other factors such as genetics and PETS	Consultant	Key indicator Clinical Effectiveness Innovation	July 2020	March 2023
3.1	Real-world experience of carboplatin/etoposide/atezolizumab for SCLC	UK wide retrospective study to review outcomes for a new treatment in SCLC (carboplatin/etoposide/atezolizumab) providing real world experience of how well this treatment works and any side effects that are encountered.	Consultant	Key Indicators of Practice Clinical Effectiveness NICE Guidance	March 2022	June 2022
3.1	TeraVolt	Performing a COVID-19 variant analysis, specifically looking at outcomes between Delta and Omicron variants.	Consultant	Clinical effectiveness	March 2022	March 2023
Urology SST						
3.1	Treatment options in Kidney Cancer.	We currently use immunotherapy to treat renal cancer. This project will involve understanding the outcomes of patients receiving immunotherapy both in terms of toxicity and survival.	Medical student SSC project Consultant	Key indicator of practice	May 2022	June 2022

HCS	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
3.1	Review of Bone Heath in prostate cancer patients	To assess how we are dealing with the bone health of patients with prostate cancer. We will look at patients over a period in 2019 as this will ensure that COVID has not interfered with our management. Comparing the practice of the different health boards that our patients come from. We will then look at ways that we can improve our practice and implement them.	Consultant CNS	NICE guidelines	April 2022	January 2023
3.1	Prospective data collection HDR PROMS and outcome (first 18 months)	To collect patients related outcome measures	Consultant	PROMS	June 2021	January 2023
3.1	SABR / SPACER programme data (first 18 months)	To collect patients related outcome measures	Consultant	PROMS	June 2021	January 2023
3.1	Multi centre audit of treatment and survival outcomes in Renal cancer	To ascertain overall survival and grade of toxicities	Consultant CAD	Key indicator of practice	May 2021	Ongoing
Palliative Care SST						
3.1 3.2	Symptom Control QI Project including POS-S	Evaluation of the use the POS-S within palliative care team	Medical student SSC project Consultant	Clinical effectiveness	May 2022	July 2022

HCS	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
3.1	A review of advance care planning practices locally and in Wales	Review local and national policies incl www.wales.nhs.uk/afcp and write a paper for British medical journal supportive and palliative care	GP ST1 trainee in palliative care	National guidance	March 2021	December 2022
3.1	A review of dry mouth and its management	A QI project with Velindre library to produce a guideline paper, possibly for publication in a palliative care journal and/or European Association for Palliative Care	SpR	National guidelines, literature review	2021	August 2022
3.1	Naloxone use in Velindre- a survey	The BNF has recently changed its recommendation on the dose of Naloxone in Palliative care settings. We review current views on dosing amongst Velindre doctors and there will be a consensus review of the current Pain Guidelines and Naloxone guidance	SpR Consultant	BNF, National Guidelines, local policy (incl Pain policy)	2021	August 2022
3.1 3.5	Re- audit Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Audit	To ensure the patient's wishes are respected, decisions reflect the best interest of the individual and benefits are not outweighed by burdens. A DNACPR decision is clearly recorded and communicated between health professionals.	SpR Consultant	National guidance	March 2021	December 2022
Colorectal SST						
3.1	Investigating the impact of covid 19 on the management of radiotherapy treatment of locally advanced colorectal cancer	Compare the clinical effectiveness of short course Radiotherapy with long course radiotherapy. to see if there was an additional benefit of a combination of giving chemotherapy before and after short course radiotherapy	SpR Consultant	Key indicator of practice Clinical Effectiveness	September 2020	September 2022

HCS	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
3.1	Rectal Simultaneous Integrated Boost (SIB)	TBC	SpR Consultant	TBC	April 2021	September 2022
3.1	Rectal contact Radiotherapy	To Evaluate the selection criteria, and outcomes for patients who are treated with contact radiotherapy for rectal cancer	SpR Consultant	NICE	April 2021	September 2022
UGI SST						
3.1	What is the local practice of identifying and managing immunotherapy-related toxicity compared to the accepted guidelines?	To review local practice of managing immunotherapy toxicity in GI and hepatopancreaticobiliary cancers in Velindre Cancer centre, in comparison to the Guidelines.	Consultant Medical student SSC project	VCC Guidelines	May 2022	June 2022
3.1	Treatment of oesophago-gastric cancer in Velindre	To explore chemo-radiotherapy outcomes for oesophago-gastric cancers in Velindre and compare outcomes in South East Wales with other areas. The secondary aim is to look at data to explore factors contributing to poor outcomes.	Consultant Medical student SSC project	Clinical effectiveness Patient safety SSC	March 2022	July 2022

HCS	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
3.1	Clinical Outcomes of localised Pancreatic Cancer Post-Oncological therapy	To collect and evaluate clinical data of patients with localised pancreatic cancer at Velindre Cancer Centre. To evaluate the outcomes of oncological therapy including chemotherapy and radiotherapy.	Consultant Medical student SSC project	Clinical effectiveness SSC	March 2022	July 2022
3.1	Treatment for advanced pancreatic cancer	To collect and evaluate clinical data of patients with advanced pancreatic cancer at Velindre Cancer Centre. To evaluate the outcomes of oncological therapy including chemotherapy and radiotherapy.	Consultant Medical student SSC project	Clinical effectiveness SSC	May 2022	July 2022
3.1	Management of Oesophageal Squamous Cell Carcinoma within the UK and Ireland: A retrospective multi-centre analysis	Provide an insight into variation across the UK in the use of surgery and dCRT for the potentially curative treatment of OSCC. Review survival outcomes for CRT compared with neoadjuvant treatments plus surgery.	SpR	National Project (NOTCH)	October 2020	March 2022
3.1	Immune checkpoint inhibitor induced liver injury: a multi-centre experience	We aim to determine epidemiology of immune checkpoint inhibitor induced liver injury (CPILI), immune-related adverse events (IRAE) and to study management options and outcomes across different UK centres	Junior Doctors Consultant	Multi centred project	April 2021	March 2023

HCS	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
Neuro-oncology SST						
3.1	Interval GB- Imaging timing after surgery for glioblastoma - an evaluation of practice in Great Britain	A UK and Ireland multi-centre retrospective study of imaging practice after surgery for glioblastoma to identify adherence to NICE guidelines, and evaluate imaging strategies utilised. Primary objective to assess MRI surveillance practice after surgery for patients with glioblastoma, and delineate if adherence to NICE guidelines improves survival.	Consultant Junior Doctor	National Project NICE guidelines	January 2022	August 2022
3.1	Brain/ skull base and spinal tumours - radiotherapy and systemic treatment Paediatric radiotherapy Thyroid cancer	TBC	Consultant Medical student SSC project	TBC	March 2022	June 2022
3.1	Management approaches in Grade III (Malignant) Meningioma: a NOTCH UK multi-centre case series	To gain insight into the radiotherapy approaches currently being used across the UK, both in an adjuvant and disease recurrence setting. Data on systemic management and associated disease response will also be valuable for treating clinicians given the lack of evidence base in this area.	Junior Doctor	National Project	January 2021	December 2022

HCS	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
3.1	Outcomes in patients undergoing surgery for recurrent/progressive glioblastoma in South and Mid Wales	Second-line surgery is a considerable undertaking for patients with limited life expectancies and a consideration for surgical resources. To date, our local practice has not been reviewed and doing so will allow us to better define the patient population most likely to benefit and inform our discussions with patients.	Consultant	Clinical effectiveness	May 2021	March 2023
Sarcoma SST						
5.1	Sarcoma Pathway	Working with the Welsh Cancer Network to develop and assess the pathway.	CNS	Key indicator of practice	Ongoing	Ongoing
Other Sites/Services						
3.1	DPYD Health Technology Assessment Service Evaluation	To conduct a health technology assessment (cost utility analysis) of the *DPYD* genotyping service in Wales.	Consultant	National	February 2021	Ongoing
	How effectively are we diagnosing major endocrinopathies secondary to immune check point inhibitor therapy?	To establish whether diagnosis, investigation, and initiation of secondary endocrinopathies is timely.	Consultant	Patient safety	April 2022	March 2023

HCS	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
COVID-19 Audit/Project Programme						
3.1	The impact of COVID-19 on SACT treatment pathways	To monitor changes to treatment pathways and associated outcomes	Consultant	Key indicator of practice	April 2020	Ongoing
3.1	UK Coronavirus Cancer Monitoring Project (UKCCMP)	To track cases and outcomes of cancer patients affected by COVID-19 infection in the UK	SpR	National Project	April 2020	Ongoing
3.1	COVID Radiotherapy: a National Cancer Research Institute (NCRI) CTRad UK-wide initiative	COVID RT is a national initiative that aims to study the impact of COVID-19 and the recovery plan on radiotherapy patients and the radiotherapy service and help us plan for future pandemics	Consultant	National Project	April 2020	Ongoing
3.1	Lung Radiotherapy during Coronavirus Pandemic (COVID-RT Lung)	To understand the changes in radiotherapy services for patient with lung cancer in the UK during the coronavirus pandemic Assess the outcome of operable patients treated with radiotherapy during the coronavirus pandemic	Consultant SpR CAD	National Project	April 2020	Ongoing
Integrated Care Directorate						
National Audit						
3.1	UK NACEL Audit	NHS Benchmarking project	SPCT	National Audit	Ongoing (Annual)	Ongoing (Annual)
Continuous Monitoring – Quality and Safety and Must Do's						

HCS	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
6.3	All Wales Patient experience framework	To evaluate patients experience at VCC to identify areas from improvement	Patient experience manager	Users views	Ongoing (Monthly)	Ongoing (Monthly)
3.1	Immunotherapy for Adjuvant melanoma	To obtain toxicity and outcome data in the adjuvant setting	CNS	Key indicator of practice	Ongoing	Ongoing
6.3	CIVICA	Independent service to allow patients to feedback their experiences.	Palliative Care team	Users views	Ongoing	Ongoing
	Staff Survey: Safeguarding	To establish if staff are aware of the relevant guidelines and support regarding safeguarding within the trust	Safeguarding lead Clinical Audit Department	Users views	TBC	TBC
	Safeguarding documentation audit	To provide measure compliance with the All Wales Safeguarding Procedures.	Tina Jenkins	All Wales guidelines	TBC	TBC
3.1	Metastatic spinal cord compression (MSCC)	To measure compliance with the standard for referral and assessment for metastatic spinal cord	Physiotherapy	Local & National Guidelines	Ongoing (6 monthly)	Ongoing (6 Monthly)
2.6	Antimicrobial Stewardship – Start Smart Then Focus (SSTF)	To determine whether the indication for treatment is documented either on the medication chart / in medical notes	Pharmacy	National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
2.2	Pressure Sores	Tier 1 target - To provide evidence to support safe effective care in relation to the health care standards	Nursing Ward Manager	Quality assurance	Ongoing (Monthly)	Ongoing (Monthly)

HCS	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
2.3	Slips/Trips/Falls	Tier 1 target - To provide evidence to support safe effective care in relation to the health care standards	Nursing Ward Manager	Quality assurance	Ongoing (Monthly)	Ongoing (Monthly)
2.5	Nutritional Screening including Protected Meal times & fluid balance compliance	To provide evidence to support safe effective care in relation to the health care standards	Nursing Ward Manager	Quality assurance	Ongoing (Monthly)	Ongoing (Monthly)
2.5	Mouth care bundles	Ensure compliance with good practice and all Wales standards	Nursing Ward Manager	Quality assurance	Ongoing (Monthly)	Ongoing (Monthly)
3.1	Sepsis Six compliance	Tier 1 target - To provide evidence to support safe effective care in relation to the health care standards	Acute Oncology ANP	Quality assurance	Ongoing (Monthly)	Ongoing (Monthly)
3.1	Rapid Response to Acute Illness (RRAILS) – National Early Warning Score (NEWS) compliance	Tier 1 target - To provide evidence to support safe effective care in relation to the health care standards	Acute Oncology ANP	Quality assurance	Ongoing (Monthly)	Ongoing (Monthly)
3.1	Oxygen spot-check	To measure compliance with local/national guidelines	Nursing Ward Manager	Quality assurance	Ongoing (Monthly)	Ongoing (Monthly)
2.4 3.1	Catheter associated Urinary Tract Infections (CAUTI)	To measure compliance with all elements for insertion and maintenance of bundles for urinary catheters	IPCT with support from dept. champions	Local & National Guidelines	Ongoing (Weekly)	Ongoing (Weekly)
2.4	Visual Infusion Phlebitis (VIP) Score – Chemotherapy Inpatient Unit (CIU)	To measure compliance with all elements for insertion and maintenance of bundles for peripheral vascular cannula	Ward Manager	Local & National Guidelines	Ongoing (Daily)	Ongoing (Daily)

HCS	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
2.4	Patient data for MRSA/ MSSA/ C diff/ E Coli/ CAUTI/ Bacteremia	Tier 1 target - To monitor infection rates for all Healthcare Associated Infections (HCAIs)	Nursing Ward Manager & IPC Team	Local & National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
2.4	Methicillin Resistant Staphylococcus Aureus (MRSA) Screening	Tier 1 target - To measure compliance with screening for MRSA	Nursing Ward Manager & IPC Team	Local & National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
2.4	Hand hygiene	Tier 1 target - To measure hand hygiene compliance against World Health Organisation (WHO) 5 Moments of Hand Hygiene	IPCT with support from dept. champions	Local & National Guidelines	Ongoing (Weekly)	Ongoing (Weekly)
2.4	Personal Protection Equipment (PPE)/Isolation	To monitor compliance with PPE (donning and doffing)	IPCT with support from dept. champions	Local & National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
2.9	Environment/ commodes/ sharps/ waste/ linen	To monitor against National Standards for IPC (inclusive of key audits- environmental, commodes/ sharps / clinical practice audits	Infection Prevention & Control	Local & National Guidelines	Ongoing (Annual)	Ongoing (Annual)
3.1 4.1 5.1	Delayed Transfer of Care (DTOC)	Tier 1 target	Nursing Ward Manager	Local & National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
3.1	Chaperone audit	To ascertain current practice of documentation regarding the offer of a chaperone	CAD	SI/VCC Guidelines	April 2022	March 2023
3.5 4.2	Record Keeping Audit	Record keeping audit every 6 months to look at compliance to our record keeping guidelines. To then feedback to team and make adjustments/give further education as indicated.	Therapies	National guidelines	February 2022	6 monthly

HCS	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
3.1	Key worker Audit	To review compliance of patients with document key worker	CNS Manager CAD	Key performance indictor	January 2022	Monthly
Breast SST						
3.1	Development of an Intravenous Access Decision tool for breast cancer patients receiving Systemic Anti-Cancer Therapy	Develop and implement an intravenous Access decision tool for breast cancer patients about to commence systemic anti-cancer therapy	Trials Nurse	Clinical Effectiveness Service improvement	March 2021	July 2022
3.1	Audit of the Pathway for Adjuvant Bisphosphonates in Early Breast Cancer	To ensure all adjuvant breast cancer patients eligible to receive adjuvant bisphosphonate with zoledronic acid are managed safely and equally within the treatment pathway	CNS CAD	NICE Guidelines	January 20219	October 2022
Gynaecological SST						
3.1	Chaperone for any intimate examination of gynaecology patients	To audit how many patients we asked re chaperones pre guidelines and then re-audit after the guidelines were published.	Therapies Patient experience manager	National guidelines Patient safety Local concern	May 2020	March 2023
6.3	Patient satisfaction Palliative Patients	To obtain patients views with regards to the Head and Neck service	CNS	Users views	April 2021	April 2022

HCS	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
Colorectal SST						
3.1	The incidence of acute onset nausea and vomiting during oxaliplatin infusions	To identify how frequently this is occurring and if we can identify if there are any factors such as dose or number of cycles administered which can help us anticipate which patients are more at risk.	Nurse	Clinical Risk	April 2021	March 2023
6.3 3.1	Patient support group	support for the CRC cancer patients	CNS	Users views	April 2021	Ongoing
6.3 3.1	Recovery package and treatment summaries	To ensure all adjuvant patients receive rehab recovery package to enable rehab following completion of treatment. Treatment summary to communicate with patients and primary care – treatment given	CNS team	User views Clinical effectiveness	April 2021	Ongoing
3.1	Oxaliplatin induced peripheral neuropathy tool	Develop a tool of assessment to be piloted and accepted by the CRC SST	CNS	Clinical effectiveness	August 2021	December 2023
Other Sites/Services						
6.3	Audit on Measure yourself concerns and wellbeing questionnaire	Assess the effectiveness of complementary therapy in cancer care. We aim to use the data in order to begin a research project.	Therapies	Users views	December 2019	Ongoing

HCS	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
5.1	Single Cancer Pathway – Treatment Pathway Review	Review the treatment pathways for all SST's for patients who receive first definitive treatment at VCC. This will include a retrospective look at what the processes were and how long they took and what the impact of the new pathways will be on service capacity and demand.	Service improvement manager	National guidelines	Ongoing	Ongoing
3.1	All Wales Acute Oncology Project – a trainee led service evaluation of acute oncology activity across Wales during the pandemic	Aim to identify key clinical lessons from this period to guide local QI projects and help awareness to improve patient care currently and in case of further surge in covid19 cases.	Consultant	Key indicator of practice Local concern Patient safety	September 2020	Ongoing
3.1	Service Evaluation Project of the Nurse Led Paracentesis Indwelling Peritoneal Catheter (IPC)	To evaluate the nurse led service and assess whether the service is being delivered within appropriate timeframes. This will also confirm the importance of the service going forward.	Nurse	Key indicator of practice	March 2021	August 2022
3.1	Exploring the definitions of 'value' and 'value-based healthcare' in cancer care	Aims to explore how staff define value-based healthcare and what they consider to add value to patient care. This will be achieved by conducting semi-structured interviews	PHD student	Service Evaluation	March 2019	September 2022
Radiation Services Care Directorate						
3.5	Local Safety Standard for Invasive Procedure (LOCSSIP)	To evidence of compliance with the WHO Surgical Safety checklist and VCC/NICE guidelines	Radiation services	NICE Guidance WHO	Ongoing (Annual)	Ongoing (Annual)

HCS	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
3.1	Is the occurrence of Radiotherapy Human Error related to Group Affective processes within the Radiotherapy team?	To explore affect and group affect processes within the specific Radiotherapy team following a human error	Radiographer	Patient safety	May 2020	October 2023
3.1 5.1	CT PA requests	To create a robust pathway for suspected PE	Radiology		April 2021	On going
SACT & Medicines Management						
2.6	Medication safety thermometer	To measure compliance of the completion of the 'drug allergy section' on the medication chart against national standards.	Pharmacy	National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
2.6	Medication safety thermometer	To measure compliance of the completion of the VTE risk assessment on the medication chart against national standards.	Pharmacy	National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
2.6	Medication safety thermometer	To measure compliance of the completion of 'medicines reconciliation within 24 hours of admission against national standards.	Pharmacy	National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
2.6	Medication safety thermometer	To measure the number of unintentional missed/ omitted medication doses within a 24 hour period against national standards.	Pharmacy	National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)

HCS	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
2.6	Medication safety thermometer	To measure the number of missed doses for 'high risk medications' against national standards. *High-risk medication includes antimicrobials, anticoagulants, opioids, anticonvulsants and oral SACT.*	Pharmacy	National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
2.6	Antimicrobial Stewardship – Start Smart Then Focus (SSTF)	To determine whether the indication for treatment is documented either on the medication chart / in medical notes	Pharmacy	National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
2.6	Antimicrobial Stewardship – Start Smart Then Focus (SSTF)	To determine whether the duration of treatment is recorded either on the medication chart / in medical notes	Pharmacy	National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
2.6	Antimicrobial Stewardship – Start Smart Then Focus (SSTF)	To determine whether the antimicrobial is prescribed in accordance with the trust guidelines / C&S or following microbiology advice	Pharmacy	National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
2.6	Antimicrobial Stewardship – Start Smart Then Focus (SSTF)	To determine whether a senior review was carried out at 48 / 72 hours, and documented on the medication chart / medical notes (including outcome of review).	Pharmacy	National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
2.6	Hospital Acquired Thrombosis	WG Tier 1 target – To identify the number of potentially avoidable Hospital Acquired Thrombosis (HATs)	Pharmacy	National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)

HCS	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
3.1	Snapshot audit of the use of DPYD in clinical decision making.	To inform the future delivery of this important service	Pharmacy	National audit	April 2022	December 2022

Appendix 3

NHS Wales National Clinical Audit and Outcome Review Plan 2022/23 Appendix 3

NCAORP Plan 2022/23

QUALITY, SAFETY & PERFORMANCE COMMITTEE

LPF ANNUAL REPORT 2021-2022

DATE OF MEETING	14.07.2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Mel Findlay, Business Support Officer
PRESENTED BY	Sarah Morley, Exec Director of OD and 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**
Local Partnership Forum	05/07/22	Approved

ACRONYMS	
LPF	Local Partnership Forum

1. SITUATION/BACKGROUND

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

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

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

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

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

3. IMPACT ASSESSMENT

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

4. RECOMMENDATION

4.1 The Quality, Safety & Performance Committee is asked to **NOTE** the content of the 2021 – 2022 LPF Annual Report.

LOCAL PARTNERSHIP FORUM

ANNUAL REPORT

APRIL 2021 – MARCH 2022

1. Introduction

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

2. Role and Responsibilities of the Local Partnership Forum

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

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

3. Purpose of the Local Partnership Forum

The purpose of the LPF is to:

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

4. Duties of the Local Partnership Forum

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

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

5. Local Partnership Forum Agenda Planning Process

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

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

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

6. Local Partnership Forum Operating Arrangements

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

7. Local Partnership Forum Membership, Frequency and Attendance

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

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

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

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

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

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

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

- 2nd June 2021
- 1st September 2021
- 1st December 2021
- 2nd March 2022

8. Review of Local Partnership Forum Activity

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

- **Health and Wellbeing**

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

- **Agile Working Programme**

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

- **Gender Pay Gap Report**

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

- **IMTP General and WOD Specific 2022 / 2025 Updates**

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

- **People Strategy**

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

- **Violence and Aggression**

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

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

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

- **Divisional Updates**

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

- **Disclosure and Barring Project Update**

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

- **Trade Union Updates**

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

- **Industrial Relations and Partnership Working**

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

- **Living Wage**

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

9. Engagement with LPF members

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

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

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

10. Reporting and Communication

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

11. Conclusions and Way Forward

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

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

12. Future Proposed Activity

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

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

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

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

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

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