Bundle Public Quality, Safety and Performance Committee 17 February 2022

0.0.0 PRESENTATIONS

0.0.1 Staff Story - Velindre Cancer Service (COVID-related)

To be led by Jeanette Miller (Chemotherapy Inpatients Ward Manager) and Matthew Walters (Advanced Nurse Practitioner)
https://youtu.be/uZ67a4NKFCA

1.0.0 STANDARD BUSINESS

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 Review of Action Log

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

1.4.0 QSP Public Action Log Feb 2022.docx

2.0.0 CONSENT ITEMS

2.1.0 ITEMS FOR APPROVAL

2.1.1 Draft Minutes from the meeting of the Public Quality Safety & Performance Committee held on the 20th January 2022

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

2.1.1 NOTES - Public Quality Safety Performance Committee 20.01.22(v4VM).docx

2.2.0 ITEMS FOR ENDORSEMENT

There are no items for endorsement.

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 the 20th January 2022

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

2.3.1 Summary Private QSP Committee Minutes 20.01.22(v3VM).docx

2.3.2 Trust Vaccination Programme Board Report

Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science

2.3.2 Vaccination Programme Board Update QSP 17.02.2022.docx

2.3.3 Datix Project Highlight Report

Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science

2.3.3 Datix Highlight Report December 2021.docx

2.3.4 Executive Director Nursing Update

Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science

2.3.4 Executive Director of Nursing paper Dec (005).docx

2.3.5 Quality, Safety & Performance Committee deferred papers

Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science

2.3.5 QSP deferred papers from January 2022 Committee.docx

3.0.0 MAIN AGENDA

3.1.0 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, Cath O'Brien, Chief Operating Officer and Jacinta Abraham, Executive Medical Director

3.1.0 GOLD COMMAND_ QSP Highlight Report February 2022_04.02.2022v3.docx

3.2.0 Financial Report

Led by Matthew Bunce, Executive Director of Finance

3.2.0 QS&P Month 9 Finance Report Cover Paper - FINAL Updated after QSP to NOTE Reportv1.docx

3.2.0a M9 VELINDRE NHS TRUST FINANCIAL POSITION TO DECEMBER 2021 FINAL.docx

3.3.0 Quality, Safety & Performance Reporting

Led by Cath O'Brien, Chief Operating Officer

3.3.0 VUNHST PERFORMANCE COVER PAPER QSP FEB 22 (SFM).docx

3.4.0 Velindre Cancer Service Quality, Safety, Performance & COVID Report

Led by Cath O'Brien, Chief Operating Officer

3.4.0 VCC Performance Report (Dec 2021) -FINAL COB 8.2.22.docx

3.4.0a VCC - Divisional QSP Report for February 2022 meeting.pdf

3.5.0 Welsh Blood Service Quality, Safety, Performance & COVID Report

Led by Alan Prosser, Interim Director, Welsh Blood Service

3.5.0 WBS Q+S cut-down Monthly Highlight Report Jan 22.docx

3.5.0a WBS - December 2021 PMF Report COB.pdf

3.6.0 Workforce & Organisational Development Performance Report

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

3.6.0 QSP Workforce Data Appendix December 2021.pdf

3.7.0 Infection Prevention and Control Management Group Highlight Report

Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science

3.7.0 Trust IPCMG Highlight Report 20.01.2022 1 (003).docx

3.8.0 Safeguarding & Vulnerable Adults Management Group Highlight Report

Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science

3.8.0 Safeguarding highlight report DEC 21 .docx

3.9.0 Trust Risk Report (COVID-related risks only)

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

3.9.0 QSP PUBLIC RISK PAPER - 17.02.2022 - amended 16.02.2022.docx

4.0.0 INTEGRATED GOVERNANACE

4.1.0 Analysis of Meeting Outputs

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

5.0.0 HIGHLIGHT REPORT TO TRUST BOARD

Members to identify items to include in the Highlight Report to the Trust Board:
- *For Escalation*
- *For Assurance*
- *For Advising*
- *For Information*

6.0.0 ANY OTHER BUSINESS

Prior approval by the Chair required.

7.0.0 DATE AND TIME OF NEXT MEETING

The Quality, Safety & Performance Committee will next meet on the Thursday 24th March 2022 @ 10:00h via Microsoft Teams.

QUALITY, SAFETY AND PERFORMANCE – PUBLIC ACTION LOG					
Minute ref	**Action**	**Action Owner**	**Progress to Date**	**Target Date**	**Status (Open/Closed)**
Legacy actions					
(Legacy Q&S)	Discussion following submission of Highlight Report from the Chair of the Infection Prevention & Control Group. Discussions to request a Public Health Wales representative on the Trust Board to be added to the Recovery Phase work Plan. Donna Mead to have further discussions with Steve Ham on how to progress the addition of a Public Health Wales Director to the Trust Board.	Lauren Fear/Nicola Williams	**Update 20/01/2022** - This action is ongoing and will be addressed post PHW re-organisation. A revised date of July 2022 was agreed. Update 18/11/2021 - It was agreed that due to Public Health Wales' ongoing commitments in relation to the management of the pandemic, LF and NW will discuss how this action can be progressed. This item has also been referred to Tracey Cooper, Chief Executive of Public Health Wales.	18/11/2021 (revised to July 2022)	OPEN
Actions agreed at the 18th January 2021 Committee					
2.1.2	Review Policy for Policies to incorporate requirements of the Well-being Future Generations Act	Lauren Fear	**Update 14/01/2022 -** Policy for Policies is currently in the process of concluding a fundamental review. This extends beyond the original scope of the action listed to include a holistic review that aligns with All Wales best practice. The Corporate Governance Manager and Environment Development Officer have completed and embedded the Wellbeing and Future Generations Act into the revised policy which concludes the initial action.	24/03/2022	OPEN

			This will be brought back as a collective final piece of work once the revised Integrated Impact Assessment and socio-economic duty aspects have been incorporated in conjunction with the Equality, Diversity and Inclusion Manager once commences in post. A draft Trust Board/Committee cover paper has been created which incorporates the wellbeing goals and Socio-economic duty. Education sessions with be undertaken for report authors to ensure the template is properly utilised.		
Actions agreed at the 13th May 2021 Committee					
2.2.6	Update regarding plan to take part in national Medical Examiner Service following paper to VCC SMT to be presented at July Committee.	Jacinta Abraham/Paul Wilkins	**Update 10/02/2022** - A paper will be presented at March EMB followed by March QSP Committee.	24/03/2022	OPEN
Actions agreed at the 15th July 2021 Committee					
2.1.4	Interim Handling Concerns Policy to receive a comprehensive review for completion by September Committee.	Annie Evans	**Update 10/02/2022** - This item has been deferred to the March QSP Committee.	24/03/2022	OPEN

2.2.8	BT to update the Committee on status of patients' education in relation to oral SACT at January 2022 Committee.	Bethan Tranter	**Update 10/02/2022** - This item has been deferred to the March QSP Committee.	24/03/2022	OPEN
Actions agreed at the 16th September 2021 Committee					
4.1.1.2	Progress against findings and recommendations of the 15 step challenge to be received as part of Velindre Cancer Services Committee Report.	Lisa Miller/Paul Wilkins	**Update 20/01/2022** - A comprehensive update will be provided in the next divisional report at February Committee.	17/02/2022	CLOSE
Actions agreed at the 18th November 2021 Committee					
4.7.0	Deep dive review of emerging themes in relation to complaints/concerns to be undertaken to gain further understanding and instigate meaningful resolution.	Annie Evans	**Update 10/02/2022** - This item has been deferred to the March QSP Committee.	24/03/2022	OPEN
Actions agreed at the 20th January 2022 Committee					
5.1.0	Deep dive to be undertaken into Radiation Services to be undertaken to explore factors impacting service development opportunities within Radiotherapy.	Cath O'Brien	**Update 10/02/2022** - Meeting to be held with Nicola Williams and Kathy Ikin, with a view to bringing to Board Development Session for discussion.	17/02/2022	CLOSE
5.1.0	Analyse patient pathways in relation to meeting the COSC targets.	Cath O'Brien	**Update 10/02/2022** – Verbal update to be provided at the February QSP Committee.	17/02/2022	OPEN

5.1.0	VCC Performance Report to include summary of relationship between COSC and JCCO and explanation of implementation of COSC measures.	Cath O'Brien	**Update 10/02/2022** - Summary of COSC/JCCO measures will be included in each PMF cover paper and a presentation has been produced for Board Members.	17/02/2022	CLOSE
5.4.0	Workforce report to outline timescales in relation to job planning and supporting narrative to be provided for areas of concern.	Sarah Morley	**Update 10/02/2022** - Data provided via ESR on job planning currently being validated to ensure that it reflects the accurate picture of activity. This work will be completed and brought back to March QSP Committee.	24/03/2022	OPEN
6.1.0	Overview of the wider picture and development in a number of areas to potentially be demonstrated via a presentation. COB to take forward and discuss this with LF.	Cath O'Brien	**Update 10/02/2022** - A meeting has been scheduled to discuss this.	24/03/2022	OPEN

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Minutes

Public Quality, Safety & Performance Committee

Velindre University NHS Trust

Date: 20th January 2022
Time: 10:00 – 13:00
Location: Microsoft Teams
Chair: Vicky Morris, Independent Member

ATTENDANCE		
Prof. Donna Mead OBE	Velindre University NHS Trust Chair	DM
Hilary Jones	Independent Member	HJ
Stephen Harries	Interim Vice Chair and Independent Member	SH
Cath O'Brien	Chief Operating Officer	COB
Jacinta Abraham	Executive Medical Director (in part)	JA
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 Scientists	NW
Nigel Downes	Deputy Director of Nursing, Quality & Patient Experience	ND
Matthew Bunce	Executive Director of Finance (in part)	MB
Sarah Morley	Executive Director of Organisational Development & Workforce	SfM
Alan Prosser	Interim Director of Welsh Blood Service	AP
Peter Richardson	Head of Quality Assurance, Welsh Blood Service	PR
Emma Stephens	Head of Corporate Governance	ES
Kyle Page	Business Support Officer (Secretariat)	KP

0.0.0	COVID	Action Lead
0.0.1	**COVID UPDATE** Led by Cath O'Brien, Chief Operating Officer and supported by: • Lauren Fear, Director of Corporate Governance & Chief of Staff • Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science • Dr. Jacinta Abraham, Executive Medical Director • Sarah Morley, Executive Director of Organisational Development and Workforce All Trust Board members were invited to the start of the meeting to receive a COVID update presentation. It was noted that this replaced the Board Briefing session previously scheduled for the 13th January 2022.	

At the outset staff across the Trust were commended for the amazing efforts undertaken to maintain critical services throughout this wave. The following key items were highlighted:

National picture:

- Marked reduction in the incidence of COVID cases per 100,000 as January 2022 is progressing, with most recent reports indicating 529 per 100,000 in comparison to 2,228 at the beginning of January 2022.
- Evidence of a decrease in the number of positive tests, indicating a potential move from 'pandemic' to 'endemic'.
- Evidence of a reduction in a general reduction of staff absence across Wales.

Trust position:

- Gold and Silver Command structure has been maintained with a move in recent days to recovery planning as well as service maintenance.
- Core service / treatment delivery has been maintained over Christmas and during January 2022, assisted by overwhelming support, commitment and dedication from staff across all services.
- In the last week service pressures are easing due to reduced staff absences.
- Continued application of Welsh Government COVID guidance, facilitated via robust communications and site management; working from home position has been maintained with the temporary closure of Trust Headquarters during January 2022.

Velindre Cancer Service:

- Service delivery has been maintained, with continued SACT delivery supported by deployment of SACT trained staff from wards and non-patient facing roles (e.g. Senior Nurses). Outreach provision at Prince Charles Hospital.
- Outpatients has seen an increase in virtual appointments.
- Radiotherapy has continued with a 25% reduction in capacity due to fleet issues, reduced workforce and COVID restrictions.
- Inpatient bed numbers continue to be maintained and visiting permitted on a case by case basis.
- Availability of patient information videos and support.
- Continued improvement in staff absence.
- Close monitoring of capacity and demand planning via regular meetings with Health Board teams.

Welsh Blood Service:

- A Blue alert (to ensure WBS conserved stocks over the holiday period without the need to rely on mutual support from other UK Blood Services) was issued in December 2021 due to a reduction in stock levels. This was lifted on 18th January 2022. The blood service has continued to provide all required blood and blood products without the need to import. This has been a significant achievement

	given the Christmas bank holiday period and additional COVID impacts. • Evidence of a reduction in donor 'Did Not Attend' (DNA) rates in recent weeks. • Stock position currently healthy (including red cells and platelets) and continued engagement with UK blood services to ensure adequate supply across the UK blood chain. • Promotion of blood donation been enhanced via TV and radio exposure. • Gradual improvement in staff absences. • Risk and impact assessment of social distancing reductions undertaken will enable enhancement of capacity and focus will now be on where and when clinics will be feasible in line with donation planning. ***COVID Risks:*** The risks associated with the prevalence of the Omicron variant have changed rapidly as this wave has progressed. Five current COVID risks have been identified. Four have been decreasing (overall COVID risk: 12; impact of working from home on wellbeing of staff: 8; WBS stock levels: 12; staff absence affecting ability to deliver Systemic Anti-Cancer Treatment (SACT) 16; Radiotherapy: 16). The risk that remains unchanged in recent weeks is isolation regulations impacting on patients being able to commence treatment, remaining at 16. ***Additional Interventions monitored via the Health and Wellbeing Steering Group:*** SfM advised that the wellbeing of staff is considered during the decision making process with the implementation of a number of wellbeing interventions, regularly communicated to staff and managers alike. This includes: • Implementation of Mental Health first aiders, identifying issues presented by sustained work pressures and difficulties experienced during the pandemic, and education of managers to enable remote management of staff wellbeing. • Availability of **'Work in Confidence'** platform to allow for anonymous escalation of issues. • Recognising the long term impact of working remotely in the main and how this can be supported, also enabling staff to share their experience of working remotely. • Collaborative work is underway with a Psychologist to support frontline clinical staff not working remotely. The Committee **NOTED** the COVID update and portrayed their thanks to all staff across the Trust that have gone over and above to keep Trust critical services functioning.	
0.0.2	**Gold Command Report** Led by Lauren Fear, Director of Corporate Governance & Chief of Staff, Nicola Williams, Executive Director Nursing, AHPs & Health Science	

and Cath O'Brien, Chief Operating Officer

The Gold Command Highlight Report provided an overview of the key issues and items considered by Gold Command at its meetings held between 15th December 2021 and 13th January 2022. The Committee was alerted to the following:

Position in relation to Systemic Anti-Cancer Therapy (SACT) provision during January 2022

A small number of new patients (6) in December 2021 waited longer than 21 days for commencement of their SACT; however all were treated very soon after the 21 days. It is anticipated that, in January 2022, despite all endeavours (including additional clinics) this is anticipated to be a greater number predominantly due to the level of staff absence in January 2022 in addition to the level of demand.

Gold Command received updates three times a week in relation to the SACT delivery position and was advised of the range of mitigating and risk reduction measures put in place. This included clinical prioritisation to ensure patients waiting longer than 21 days were no / low risk, no / low risk therapy changes made (conversion to oral or injection rather than infusions) and additional capacity arrangements being put in place with the Rutherford Cancer Centre.

A formal impact assessment in relation to the commencement of clinical prioritisation had been undertaken prior to any changes taking place, and that patients were receiving SACT in order of clinical priority. In addition, all time critical treatment was being delivered in line with required timescales, provided patients were well enough to receive it.

Additional Items highlighted to the Committee:

- No incidences of Nosocomial Transmission of COVID during the current wave have been reported and the small number of patients admitted with COVID have been managed in accordance with the guidelines.
- Strategic Clinical Advisory and Clinical Decision (operational) Groups covering Velindre Cancer Service have been established to ensure clinical oversight, decision making and recommendation lines into both the Silver and Gold command structures.
- A revised Decision Making Framework to support decision making through the incident management structure has been approved.

SH noted reference to bringing staff back to the workplace outside of guidance and sought reassurance that the Trust would only seek to bring back non COVID positive staff. NW confirmed that there are a number of criteria needing to be met before staff would be brought back to the workplace under these circumstances and would only involve the least 'at risk' cohort of patients. Staff who are unwell / within the isolation period will not be brought back into the workplace; however there has

	been no requirement to enact this to date. NW also confirmed that to date, this has not been enacted. The Committee **NOTED**: • A review of the support arrangements in place for staff to ensure proactive management of waiting times has been initiated following the receipt of two informal complaints from patients; • The approval of the Decision Making Framework; • The content of the report and actions being taken.	
1.0.0	**PRESENTATIONS**	
1.1.0	**Velindre Cancer Service – Patient Story** Led by Vivienne Cooper, Head of Nursing, Patient Experience and Integrated Care, Supported by Nicola Hughes, Medical Business, Velindre Cancer Service The Committee had received in advance a patient story that had been shared with Velindre Cancer Service by the family of a deceased patient during a meeting with Clinical teams. The story featured the experience of the patient and his family whilst being required to attend clinical appointments alone due to COVID restrictions. This resulted in the patient's wife not being fully informed of the extent of his cancer and being unable to support him making informed choices regarding his treatment. It was recognised that this occurred at the beginning of the pandemic, during a time of rapid and constant changes to guidelines and ways of working. This was compounded by staffing challenges and mainly virtual communication with the Palliative Care provider for the patient. Significant changes have since been made in relation to how families are involved in difficult conversations. The meeting held between the patient's wife, Oncology and Palliative Care staff provided an opportunity for her to better understand the disease and the events that had taken place. It was recognised at the meeting that there were a number of areas that could be improved as a result of the feedback and a number of changes had already been made as the Trust has progressed through the different waves of the pandemic. The patient's wife welcomed the positive outcomes of the meeting. VC advised that a number of changes have been implemented during the course of the pandemic, such as the introduction of a heated outdoor waiting area and carers' passports to allow patients to be accompanied to appointments. Measures to reduce waiting times in general are also currently being explored; however extended waiting times are often the result of patients waiting for blood test results. This has been mitigated to some degree via informing certain patients (if applicable) that they may return home following blood tests and receive their results by telephone.	

	Issues with uneven flooring and heating within the outdoor waiting area have now been addressed and resolved. As the pandemic is continuing for a more prolonged period than anticipated, a more semi-permanent area is being explored. NW queried whether it was intended to share the patient story widely with the multi-professional teams at the Cancer Centre and how Senior Management would monitor / track the changes and intended outcomes. VC confirmed that this would be addressed during the divisional Quality & Safety meeting, supported by an action / learning log shared with the Senior Leadership Team. The Committee **NOTED** the presentation and actions subsequently taken.	
2.0.0	**STANDARD BUSINESS**	
2.1.0	**Apologies** Apologies were received from: • Steve Ham, Chief Executive Officer • Paul Wilkins, Interim Director of Velindre Cancer Service	
2.2.0	**Additional Attendees** • Gareth Tyrrell, Head of Technical Services, NWSSP (Shared Services) – for item 4.0.0 • Jennie Palmer, Quality & Safety Manager • Martin Veale, Independent Member - for item 0.0.1 • Gareth Jones, Independent Member - for item 0.0.1 • Andrew Westwell, Independent Member - for item 0.0.1 • Katrina Febry, Audit Lead, Audit Wales • Delyth Brushett, Senior Auditor, Audit Wales • Vivienne Cooper, Head of Nursing, Velindre Cancer Service – for item 1.1.0 • Nicola Hughes, Medical Business, Velindre Cancer Service – for item 1.1.0 • Emma Rees, Audit Manager, NWSSP Audit & Assurance Services • Huw Jones, Healthcare Inspectorate Wales • Sarah Thomas, Healthcare Inspectorate Wales • Stephen Allen, Chief Officer, South Glamorgan CHC • Muhammad Yaseen, Head of Infection Prevention & Control (shadowing NW)	
2.3.0	**Declarations of Interest** Led by Vicky Morris, Quality, Safety & Performance Chair There were no declarations of interest.	

2.4.0	**Review of Action Log** Led by Nicola Williams, Executive Director of Nursing, AHPs and Health Science Committee members advised that they were assured that all actions identified as closed on the action log had been fully instigated. Items not yet due for completion were not discussed and remain open. The remaining actions were reviewed and the following amendments agreed: • ***Addition of a Public Health Wales Director to the Trust Board –*** Due to the ongoing impact of the pandemic, it was agreed to expand the completion date to July 2022. DM reported that the action had been raised in the Chairs' peer group meeting and had been assured this would be progressed. This will be re-addressed with Public Health Wales as soon as is feasible. **LF** • ***Ref 2.2.6 (13/5) – Update regarding plan to take part in national Medical Examiner Service following paper to VCC SMT to be presented at July Committee -*** It was confirmed that a paper will be presented at the next Executive Management Board, followed by the February or March Committee. **JA** • ***Ref 4.1.1.2 (16/9) Progress against findings and recommendations of the 15 step challenge to be received as part of Velindre Cancer Services Committee report –*** This has not been included in today's report due to prioritisation of COVID. A comprehensive update will be provided in the next VCC divisional report at Committee. **VC** The Committee **AGREED** the status of all actions as noted above. 4.1.0 (closed action relating to revisiting reimbursement of travel expenses for donors) – DM advised that this had been instigated due to donors having to make longer journeys due to the Trust's use of larger centres and queried whether donor numbers were decreasing as a result. AP advised that Welsh Government guidance had been sought and we are unable to provide travel cost reimbursement. Donation is a gesture. AP advised that plans are underway as soon as COVID allows to return to a community provision model to reduce the travel requirements for donors.	
3.0.0	**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).	
3.1.0	**ITEMS FOR APPROVAL**	
3.1.1	**Draft Minutes from the meeting of the Public Quality & Safety Committee held on the 18th November 2021**	

	Led by Vicky Morris, Quality, Safety and Performance Committee Chair The minutes of the Public Quality & Safety Committee held on the 18th November 2021 were **APPROVED** as a true reflection of the meeting.	
3.2.0	**ITEMS FOR ENDORSEMENT**	
	There were no items for endorsement.	
3.3.0	**ITEMS FOR NOTING**	
3.3.1	**Draft summary of the minutes from the meeting of the Private Quality, Safety & Performance Committee held on 18th November 2021** Led by Vicky Morris, Quality, Safety & Performance Committee Chair The committee **NOTED** the summary minutes from the 18th November 2021 Private Committee.	
3.3.2	**Transforming Cancer Services Programme Scrutiny Sub Committee Highlight Reports** Led by Stephen Harries, Interim Vice Chair and Chair of the Transforming Cancer Services Scrutiny Committee The Committee **NOTED** the contents of the reports and actions being taken.	
3.3.3	**Review of Information Governance and Trends** Led by Matthew Bunce, Executive Director of Finance The Information Governance Report was received, providing a review of Trust-wide Information Governance reported incidents and matters between 1st June and 30th November 2021. MB noted the following: • Following the recent appointment of a new Head of Information Governance, work was underway to review the content and detail provided in the report to increase the level of assurance provided to the Committee. This will be supported by active engagement with Trust officers and Independent Members outside of the Committee in readiness for reporting to the next meeting. • Initial work has been undertaken in relation to the incidents aligning with the new Datix system, with the importance of recording Datix incidents communicated to Divisions. • Adequate time will be required for training and education to facilitate improvements to information governance. DM requested that given the number of breaches detailed in the report further scrutiny and assurance provided to the Committee was required. As such, it was agreed that this report is included on the main agenda going forward to afford a more thorough analysis and discussion. The Committee **NOTED** the content of the Review of Information	

	Governance and Trends.	
3.3.4	**Quality, Safety & Performance Committee Cycle of Business and Deferred Papers** Led by Emma Stephens, Head of Corporate Governance The Committee **NOTED** the Quality, Safety & Performance Committee Cycle of Business and that it was anticipated that all deferred papers would be provided by the March meeting of the Quality, Safety & Performance Committee.	
4.0.0	**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 Quality & Safety Governance Report was received and discussed. GT highlighted the following key items: ***Operational Performance:*** • Provision of a wholesale dealer service; this has continued to provide cost savings across Wales (approximately £400,000 over the past 4 months) and the development of ready-to-administer products will continue to support / reduce financial burden. • Continued support of the booster vaccination programme, assuming responsibility for distribution of 10% of all doses administered in Wales. ***Regulatory Compliance:*** • No errors or critical deviations in manufacturing processes have been identified over the last 9 months. • All facilities and equipment adhere to regulatory standards with the exception of one minor incident which has since been resolved. • 100% compliance with internal audit recommendations. • Three service complaints had been received from NHS bodies in the last 9 months, mainly focused on logistical issues in relation to the vaccination programme. VM queried the sudden deviation within the documentation review visual. GT advised that the reduction in documentation review was a result of a large volume of documentation due for review at the same time and advised that a documentation plan to stagger the review is in place. No issues were anticipated in achieving this. The importance of context was acknowledged and it was agreed that any unusual deviations within visual representations would be supported by a clear narrative going forward. The Committee **NOTED** the current service performance against the	

	framework of standards set out in European Union Good Manufacturing Practice, with which CIVAS@IP5 (Central Intravenous Additives Service) is legally required to comply as a Medicines and Healthcare products Regulatory Agency "Specials" and Wholesale Dealer licence holder.	
5.0.0	**MAIN AGENDA** (This section supports the discussion items for review, scrutiny and assurance).	
	Item 5.6.0 (Finance Report) was discussed at the beginning of the section as the Executive Director of Finance was required to attend another meeting.	
5.1.0	**Quality, Safety & Performance Reporting** **Trust Performance Report** Led by Cath O'Brien, Chief Operating Officer The core elements of the Trust Performance Report was highlighted by COB. These included: • The deep dive into Radiation Services planned to take place during the January development day had not taken place due to the fourth wave. This will be included in a future development day to explore factors impacting service development opportunities within Radiotherapy. • A briefing paper will be presented at the next Board meeting in relation to Brachytherapy to allow for further discussion. • Staffing plans continue to be worked through. DM noted that Velindre Cancer Services had been reporting against both JCCO (Joint Council for Clinical Oncology) and COSC (Clinical Oncology Sub-Committee) targets and measures since April 2021 and understanding the overall position is challenging. It was suggested that one measure would enable a more simple process. Additionally, DM advised that previous discussions had indicated no additional funding would be required to enable the Trust to meet COSC targets; however it was now evident that compliance would not be achieved without investment, presenting additional pressures in an already challenging year. COB advised that reporting against both measures would be discontinued from the beginning of the next financial year with the adoption of the revised Trust Performance Management framework. SA indicated that although reporting is still under development, the paper is also for public consumption and explanation of abbreviations such as COSC would be welcomed. Although abbreviations are listed, the nature / purpose of the organisations is not included. Additionally, narrative to support visual representations would be beneficial,	

	particularly in weaker areas of performance to enable clear public information in terms of how the Trust is performing. CJ indicated that good progress had been made in terms of the Performance Management Framework re-development to date, with timescales still on target to be met. The intention is to include information in relation to the current position, rationale, actions to be undertaken and timelines for improvement, with appropriate communication of this to a range of audiences. It is the intention to bring an updated version to July Committee. The Chair queried when improved performance against COSC targets would be demonstrated. COB confirmed that a project is currently underway looking at patient pathways and where efficiency improvements can be made. COB agreed to review this and provide further detail in relation to the work undertaken and timescales to provide clear assurance of progression to the Board. DM noted that there had been areas of concern for an extended period of time and queried how improvement could be progressed. CJ acknowledged that reporting would ideally show high quality and timely patient care, however the majority of Trusts and Health Boards across the UK are experiencing similar difficulties presented by the current ongoing circumstances, including addressing the backlog of patients. JA suggested that attaching a paper summarising the relationship between COSC and the JCCO would enable better understanding, demonstrating that COSC measures will be implemented increasingly over time, becoming more stringent. The delay in implementation of this has been a result of the pandemic. This action was agreed and further detail will be included at the next Committee. COB advised that analysing pathways would present opportunities to make efficiencies within those requiring resources. A number of the changes that we might seek to make to the patient pathways may impact the way in which the Trust is commissioned. NW indicated that the Committee requires further assurance in relation to how Trust performance reports are presented going forward, potentially including an addendum to the reports to outline the general current position. Additionally, in terms of the current levels of performance within Radiotherapy, sight of a high level delivery plan for Radiotherapy with trajectories mapped against predicted demand going forward in an understandable format would be welcomed at the March 2022 Committee. The Committee **NOTED** the content of the report, subject to the caveats of the discussion above.	**COB** **COB** **COB**
5.2.0	**Velindre Cancer Service Quality, Safety, Performance & COVID Report**	

Led by Vivienne Cooper, Head of Nursing, Velindre Cancer Service

The detailed Velindre Cancer Service report was received, providing an update on performance against key metrics for the period until the end of November 2021. VC highlighted the following:

- The last 2-3 months have focused on providing patient care.
- No further development in relation to reporting structure around the new format (6 domains of quality) due to the current circumstances resulting from the pandemic; this however remains a priority for the Quality & Safety Team and it was acknowledged that this is a work in progress.
- Good progress has been made in relation to the management of complaints and concerns and systems and processes have been implemented to ensure targets are met in terms of putting things right.
- The focus will be triangulation of information, to include waiting times, patient experience, etc.
- Services continue to be delivered safely, evidenced by positive examples of patient experience feedback.
- A work plan is in place to facilitate progression of other areas of work still required.

NW indicated that the delayed reporting period due to the cycle of reporting will be resolved. Additionally, fundamental improvements are being undertaken in relation to the infrastructure around Quality & Safety, in particular the complaints process which has involved initiating contact and meeting with complainants. A clear plan is in place to progress these improvements further.

SA queried the Transfer / Discharge issue and refusal of referral by the patient's local hospital and sought assurance that the reason for this is being explored by the Senior Management and the Health Board involved. VC confirmed that a three-way discussion had been instigated with the Health Board and Welsh Ambulance Service (WAST), identifying a communication issue with the Health Board. It was assured that the patient had remained at VCS overnight and had come to no harm.

15 Step Challenge Report – VCS SACT Outreach Unit

The Committee received the summary report from the 15 Step Challenge visit undertaken by an Independent Member and Executive Director within the Velindre SACT Outreach Unit at Prince Charles Hospital on 7th December 2021. The review was extremely positive with exemplar feedback from patients, who also expressed appreciation for being able to attend appointments locally rather than having to travel to the Cancer Service. NW reported an excellent response to a patient suddenly becoming unwell towards the end of the visit.

	A small number of recommendations were made, including a review of catering arrangements with the hospital to ensure availability of refreshments and snacks for patients during their visit and improved signposting of the unit as a Velindre service. The Committee was advised that the actions arising from these recommendations will be included in the next formal VCS Committee report. The Committee **NOTED:** • The content of the Velindre Cancer Service Quality, Safety, Performance & COVID Report; • The 15 step challenge report and recommendations.	
5.3.0	**Welsh Blood Service Quality, Safety, Performance & COVID Report** Led by Alan Prosser, Interim Director, Welsh Blood Service The Welsh Blood Service report was received, providing an update on performance against key metrics for the period until the end of December 2021. AP highlighted the following: • Ability to deploy staff in challenging circumstances to enable robust and safe delivery of services throughout this period. • Blue Alert has been lifted. • The Welsh Blood Service remains the only service outside NHSBT (NHS Blood & Transplant) that has not 'imported' during the period. • Wide media coverage this week will be supplemented by the Health Minister who will attend WBS as a donor. • Stem cell activity has continued as planned with no disruptions to the service. • Satisfaction scores remain high despite the current challenges. • An update will be provided on the 15 Step Challenge recommendations at the next formal Committee, potentially in the form of a donor story in relation to special needs services. • Having previously been an undisclosed site for the storing and distribution of COVID-19 vaccines or the NHS Wales vaccination programme, this information is now permitted in the public domain. It was reported that over a **million vaccines** have been handled / distributed out of WBS in December 2021 alone. • Confirmation of agreement from Betsi Cadwaladr to join the immunoglobulin supply. • An increase in the reporting of incidents is a result of the unprecedented workload of the team. Internal redeployment of staff and a level of external support has resolved a number of issues. • Planned audit activity is continuing. • Two Serious Adverse Events (SAEs) had been reported to the HTA (Human Tissues Authority) during November 2021. Both events were related to stem cell collection and investigations had identified the cause and corrective actions have been undertaken and completed. DM advised that she had attended a busy donor session (following all COVID requirements) and was impressed by the support provided by	

	experienced staff to those with less experience or experiencing difficulties. Newer staff reported feeling very well supported, having been inducted thoroughly and that they enjoyed their work. All COVID regulations were adhered to and DM was inspired by a number of conversations with donors around their reasons for donating. The Committee **NOTED** the report and commended the wholescale effort of the team at all levels to deliver the vaccine, address blue alert, and continue to meet supply and demand during the current wave. The Committee commended the Welsh Blood Service Team for all the amazing efforts to achieve good blood stocks.	
5.4.0	**Workforce and Organisational Development Performance Report** Led by Sarah Morley, Executive Director of Workforce and Organisational Development The Workforce and Organisational Development Performance Report for the period ending December 2021. SfM highlighted the following: • Organisational headcount at December is 1,885, equivalent to 1,418 Full Time Equivalent (FTE). • Overall Performance Appraisal & Development Review (PADR) rates to December stand at 70.83%. • The sickness rate absence of 5.54% remains higher than pre-COVID but has remained steady for a number of months, with smaller teams and specific areas experiencing the most significant issues. • Statutory Mandatory Training compliance stands at 86.4% at the end of December. It is anticipated this will improve following the immediate COVID response timescale. • Turnover for 2021 stood at 12.75%, the majority of which resulted from promotion or retirement. There is a degree of internal turnover as a result of staff undertaking new roles. • 357 vacancies were advertised during 2021 and an increase of 3% has been evidenced within Nursing. VM requested that a follow up report be brought to the next Committee outlining timescales of the job planning and to include narrative to address performance within areas of concern. JA noted that the information presented does not accurately reflect the wider picture as the information captured from ESR had excluded several medical groups. SfM advised that this would be reviewed and that a follow up report would include more accurate representation of information. HJ queried how the Trust is assured that staff on long term sickness are genuinely unwell and intend to return in addition to how this return can be supported. SfM confirmed that regular contact / discussions are maintained with staff on long term sickness absence by Managers and the wider Workforce team, engaging Occupational Health if required. It	**SfM** **SfM**

	is also clearly stipulated in the policy that staff are not permitted to engage in other employment while absent due to sickness. The Committee **NOTED** the content of the Workforce and Organisational Development Performance Report and **AGREED** a number of enhancements for future reports.	
5.5.0	**Trust Vaccination Programme Board Report** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science The Vaccination Programme Board Report provided an update in relation to the Trust's COVID-19 booster and Influenza vaccination progress and the following was highlighted by NW: • To date, 83% of staff have received a COVID-19 booster vaccination. The small number of staff still to receive vaccinations were transferred to their Health Boards and will receive the booster via this route. • A number of staff had been deployed to assist the vaccination programme within other Health Boards, while others had joined banks. • To date 71% of staff have received their influenza vaccination via the Trust. • Further booster vaccinations remain under review and there are currently no plans in place for further vaccinations in the immediate future. This will, however, be guided by national requirements and decisions. The Committee **NOTED** the Vaccination Board update.	
5.6.0	**Financial Report** *(this item was discussed at the beginning of section 5)* Led by Matthew Bunce, Executive Director of Finance The Finance Report that outlined the financial position for the period ending 30th November 2021. MB highlighted the following: • *Revenue Budget* remains as anticipated and will meet financial target of break even despite a small underspend. • *Capital* plans are on track with a great deal of work underway to ensure capital schemes are delivered on time (which have been impeded by the pandemic). • *Public Sector Payment Performance* targets have been met year to date and also forecast to do so by the end of the financial year. • No major risks are anticipated between now and year end that cannot be managed via emergency reserve monies. • Work is now being undertaken in relation to forward financial planning and some concern remains around the funding of COVID expenditure due to a significant shortfall in funding for Health Boards (who will provide the Trust's COVID funding over the coming year).	

	• *Reserves* – The focus is on how the significant amount of non-recurrent reserve can be utilised to prepare for the forthcoming financial year. DM queried how the current inflation rate (over 5%) would be managed in relation to forward planning. MB confirmed that an all Wales assessment to analyse significant / extraordinary price inflation in key areas such as energy (which has increased by 100%). Significant increases have also been seen within procurement, the Welsh Risk Pool contribution and Microsoft 365 licensing which comes to an end in July 2022. MB confirmed that Welsh Government has been sighted on this and a 2.8% uplift has been provided across the board to allow Health Boards to manage risks appropriately. All pay inflation will be covered. It was **agreed** that the Committee would be kept up to date on the issues discussed above. The Committee **NOTED** the content of the Finance Report, in particular the financial performance to date and year-end forecast to achieve financial break-even.	
5.7.0	**Trust Risk Report** Led by Lauren Fear, Director of Corporate Governance and Chief of Staff The Committee discussed and reviewed the Trust Risk Report, which summarised the status of all risks scoring 12 or greater and those included with a risk impact of 5. VM noted that a number of risks displayed overdue review dates, with no narrative in relation to their management. LF confirmed that further detail will be provided in the next iteration of the Trust Risk Report to demonstrate ongoing management of risks presenting as overdue for review. The Committee **NOTED:** • The risks level 20, 16, 15, 12 and impact of 5 reported in the Trust Risk Register and highlighted in the cover paper; • That a project plan is in place and actions undertaken to expedite progress in establishing a consolidated risk process for the Trust; • The further work in January to update the profile in light of the recently changing covid risk profile; • Appendix 3, summarising current assessment of potential risks and issues emerging regarding the current COVID response.	
6.0.0	**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)	

6.1.0	**Analysis of meeting outputs** Led by Vicky Morris, Quality, Safety and Performance Committee Chair The Chair requested any further comments in relation to key outputs arising throughout the meeting. The following was raised: • NW praised the efforts of both divisions in responding to the current wave of the pandemic, continuing to deliver core services and treatments. • Despite an overall recovered position, ongoing challenges remain within VCC resulting from a culmination of increasing pressure and demands on services in addition to continued COVID-related staff absence. • An emerging theme of assurance throughout the meeting, with a need for increased demonstration of the 'so what' and detail around actions undertaken and progression of areas of work. • JA noted that this challenging period had provided the opportunity to instigate clinical discussions and gain better understanding of how processes can and have been adapted, allowing the Trust to evolve during the pandemic. • COB suggested that an overview of the wider picture and development in a number of areas could potentially be demonstrated in a presentation and agreed to take forward and discuss this with LF.	**COB**
7.0.0	**HIGHLIGHT REPORT TO TRUST BOARD**	
7.1.0	Members were asked to identify items to include in the Highlight Report to the Trust Board: • For Escalation • For Assurance • For Advising • For Information	
8.0.0	**ANY OTHER BUSINESS**	
	No other business was received.	
9.0.0	**DATE AND TIME OF THE NEXT MEETING**	
	The Quality, Safety & Performance Committee will next meet on **Thursday 17th February 2022 for an Extra-ordinary meeting to consider COVID specific issues and deferred items from 10:00 – 12:30 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).		

Summary Minutes

Private Quality, Safety & Performance Committee

Velindre University NHS Trust

Date: 20th January 2022
Time: 13:15 – 13:45
Location: Microsoft Teams
Chair: Vicky Morris, Independent Member

ATTENDANCE		
Vicky Morris	Independent Member	VM (Chair)
Stephen Harries	Interim vice Chair	SH
Hilary Jones	Independent Member	HJ
Carl James	Director of Strategic Transformation, Planning & Digital	CJ
Cath O'Brien	Chief Operating Officer	COB
Nicola Williams	Executive Director of Nursing, Allied Health Professionals and Health Science	NW
Alan Prosser	Interim Director, Welsh Blood Service	
Lauren Fear	Director of Corporate Governance and Chief of Staff	LF
Dr Jacinta Abraham	Executive Medical Director	JA
Sarah Morley	Executive Director of Organisational Development & Workforce	SfM
Emma Stephens	Head of Corporate Governance	ES
Kyle Page	Business Support Officer (Secretariat)	KP

1.0.0	**STANDARD BUSINESS**	
1.1.0	**Apologies:** • Steve Ham, Chief Executive Officer • Professor Donna Mead OBE, Velindre University NHS Trust Chair • Paul Wilkins, Interim Director of Velindre Cancer Service • Matthew Bunce, Executive Director of Finance	
1.2.0	**In Attendance:**	
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 Vicky Morris, Quality, Safety & Performance Committee Chair	

	The Action Log was reviewed and one open action updated. This will be circulated to members with meeting minutes following the meeting.	**KP**
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 18th November 2021** Led by Vicky Morris, Quality, Safety & Performance Committee Chair The Committee **REVIEWED** and **APPROVED** the minutes of the Private Quality, Safety and Performance Committee meeting held on the 18th November 2021 as an accurate reflection of proceedings.	
2.2.0	**ITEMS FOR NOTING**	
2.2.1	**Discplinary Suspension Review** Led by Sarah Morley, Executive Director of Organisational Development & Workforce The disciplinary suspension review paper was received, providing the Committee with assurance on the correct application of the NHS Wales Disciplinary Policy, in particular the arrangements for employees suspended from the workplace during the course of an investigation. It is intended to conclude both current investigations by the end of February 2022. HJ noted that the disciplinary policy states that completion of the investigations should be received and queried when both investigations would be concluded. SfM confirmed that an updated report will be received at the next Committee providing an update in respect of progress with the investigations.	**SfM**
3.0.0	**MAIN AGENDA**	
3.1.0	**Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee Highlight Report** Led by Stephen Harries, Interim Vice Chair and Chair of the TCS Programme Scrutiny Sub-Committee Two Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee Highlight Reports were received, providing details of key issues discussed during meetings held on the 25th October and 22nd November 2021. The Committee **NOTED** the content of the reports and actions being taken.	

3.2.0	**Trust Private Risk Register** Led by Lauren Fear, Director of Corporate Governance & Chief of Staff The 'private' section of the Trust Risk Register containing confidential orcommercially sensitive information was discussed. The report provided detail in respect of the status of the 'private' organisational risks scoring 12 or more recorded on the Risk Register, risks with an impact of 5, and their management plans and mitigating action. Risks currently reported in Private Committee will be further reviewed with all risk owners, ensuring appropriate transparency in public where possible is maintained, whilst retaining in Private section the details of any commerciality and legal aspects. The Committee **NOTED** the risks scoring a level 12 and greater and the risks with an impact level of 5 highlighted in the cover paper.	
4.0.0	**Analysis of meeting outputs** Led by Vicky Morris, Quality, Safety and Performance Committee Chair	
	No comments were raised.	
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** ○ Trust Private Risk Register and progress through another cycle of transparency. • **For Information**	
6.0.0	**ANY OTHER BUSINESS**	
	Led by Vicky Morris, Quality, Safety and 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 **for an Extra-ordinary meeting to consider COVID specific issues and items** on **Thursday 17th February 2022 from 13:15 – 13:45 via Microsoft Teams**	
CLOSE		

Quality, Safety & Performance Committee

VELINDRE UNIVERSITY NHS TRUST VACCINATION PROGRAMME BOARD UPDATE

DATE OF MEETING	17th February 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	N/A

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

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Trust Vaccination Programme Board	17/01/2022	Items for discussion approved
Executive Management Board	07/02/2022	NOTED

ACRONYMS	
JCVI	Joint Committee on Vaccination and Immunisation
WIS	Welsh Immunisation System

1. SITUATION

This paper is to provide the Quality, Safety & Performance Committee with an update in relation to the Trust's COVID-19 Booster and Influenza vaccination progress and plans as discussed and agreed at the Trust's Vaccination Programme Board held on the 17th January 2022.

The Quality, Safety & Performance Committee is asked to **NOTE** the progress of the Velindre University NHS Trust COVID booster and influenza Vaccination Programme during Autumn/Winter 2021 and next steps.

2. BACKGROUND

The purpose of the Trust wide Vaccination Programme Board is to assume responsibility for planning and safely delivering the Public Health Wales Vaccination Programmes for the Trust, to include vaccines for Influenza and the COVID-19 virus in line with JCVI guidelines, frontline categories and age groups on an ongoing basis as required.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 National COVID Booster Vaccination Requirements

The Trust COVID booster vaccination programme commenced in October 2021 and has been delivered in line with JCVI eligibility criteria.

A number of staff were also deployed to assist the vaccination programme within other Health Boards via a Mutual Aid agreement, while others had joined banks.

3.2 Velindre University NHS Trust Vaccination Status

3.2.1 COVID-19 Booster

To date, 1,418 staff (83%) have received a COVID-19 booster vaccination, 1,250 of which were administered by Velindre University NHS Trust. Staff still requiring a booster following the final clinic held at Velindre Cancer Centre on 26th November 2021 were transferred to their respective Health Boards to receive the booster, and surplus vaccines were transferred to Cardiff & Vale University Health Board for use before their expiry date (early December).

3.2.1 Influenza Vaccinations

To date, 1,214 staff (71%) have received their influenza vaccination via Velindre University NHS Trust. The number of vaccinations received elsewhere (and therefore reporting outside of WIS) is currently being analysed.

Number of staff receiving influenza vaccination by group:

Group	Vaccines received
Nursing and Midwifery (Registered)	162
Medical and Dental	66
Healthcare Scientists	111
Allied Health Professionals	100
Additional Clinical Services	155
Administrative and Clerical	347
Estates and Ancillary	45
Additional Professional Scientific and Technical	42

**The remainder include other external contracts and bank staff, staff without employee numbers or staff with employee numbers not on Trust ESR which are currently under review.

A drop-in clinic was held on 26th January 2022 at Velindre Cancer Centre and a further opportunity to receive the influenza vaccine was also offered to Welsh Blood staff during January. However, the lack of uptake suggests that the majority of staff who wish to receive a vaccine have done so. Three members of staff informed the Trust that they had received their influenza vaccine elsewhere.

3.3 Further Vaccination Plans

Further booster vaccinations remain under review and there are currently no plans in place for further vaccinations in the immediate future. This will, however, be guided by national requirements and decisions.

3.4 Clinically Vulnerable Patients

Arrangements for the vaccination of patients within the Extremely Clinically Vulnerable Category (including cancer patients on immunosuppressant treatment) were put in place for the identification and vaccination of these patients within their Local Health Boards.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Potential side effects / inefficacy of vaccine for individuals accidentally receiving the COVID-19 vaccination before the 6 month threshold.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	All associated expenditure will be covered through Welsh Government vaccination funding commitment.

5. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **NOTE** the progress in relation to delivery of the Velindre University NHS Trust COVID-19 booster and Influenza Vaccinations.

QUALITY, SAFETY & PERFORMANCE COMMITTEE

DATIX PROJECT BOARD HIGHLIGHT REPORT

Date of meeting	17th February 2022
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	N/A
Prepared by	Sharon Wilson, Datix Support Manager
PRESENTED BY	Nicola Williams, Executive Director of Nursing, Allied Healthcare Professionals, & Health Science
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, Allied Healthcare Professionals, & Health Science
REPORT PURPOSE	**ASSURANCE**

Committee/Group who have received or considered this paper prior to this meeting

Committee or Group	DATE	OUTCOME
Datix Project Group	14/12/2021	AGREED ITEMS FOR HIGHLIGHT REPORT
Executive Management Board	07/02/2021	APPROVED ARCHIVING OF VERSION 12 DATIX ON DATIX CLOUD.

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 have an overview of the current status of the Datix Project and to outlined key deliberations from the Datix Project Board meeting held on the 14th December 2021.

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, the Welsh Blood Service, and NHS Wales Shared Services Partnership, and the Trust's Corporate Quality and Safety Team.

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 Transfer of Risks from Datix Version 12 to Version 14

Due to the imminent decommissioning of version 12 of Datix, there is a pressing need to ensure that all the remaining risks on version 12 are transferred to version 14. Digital Health Care Wales have agreed to extend the technical support of the server that houses version 12 to June 2022. All risks are transferred with the exception of Welsh Blood Service who are working on these being transferred by the end of March 2022. This is being overseen by the Risk Project Group led by the Corporate Governance Team.

3.2 Datix Version 12 Archiving

Once Version 12 has been decommissioned, it will be archived in a 'read only' format. It was agreed at the Executive Management Board on the 7th February 2022 that version 12 will be hosted in an archive format on Datix cloud.

3.3 Welsh Blood Service Donor Adverse Events reporting

Since the 1st April 2021, the Welsh Blood Service has been capturing all Donor Adverse Events in the new Once for Wales system. However, the team has expressed concern that the coding categorisation structure within the Once for Wales system does not fit Donor specific requirements, and it is reported that staff are finding it challenging to try to "shoehorn" incidents into the current specification. As a result, the team feels that there is a risk of losing of valuable donor / Welsh Blood Service specific data. There are ongoing discussions between the Welsh Blood Service and the Once for Wales teams regarding additional Welsh Blood Service specific coding and categorisation for Incidents. A scoping exercise has taken place and engagement is ongoing with the Once for Wales team and Incidents management Workstream to integrate the coding requirements and is being led by Peter Richardson, Head of Quality Assurance within the Welsh Blood Service.

3.4.1 Current Position

The Trust is now live on the Once for 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. With the exception of the challenges outlined in section 3.3, the Once for Wales system has been described by staff as being "intuitive" to use, and no significant problems have been reported / experienced.

The new Mortality Module was made available in the system with effect from the 1st October 2021 and a project group within Velindre Cancer Service has been established to implement the new All Wales Mortality Framework utilising the Datix module as a support tool.

The Datix team delivered 'refresher' training to divisional staff that commenced in October 2021 and further training sessions focusing on the use of dashboards and reporting functionality have been provided since November 2021.

3.4.2 Issues Highlighted:

- **Active Directory Authentication:** Users of Datix Cymru are authenticated using the Active Directory system. This is operated for NHS Wales by Digital Health & Care Wales. There is an ongoing issue with the use of the Active Directory for access to Datix for some pockets of NHS Wales Shared Services Partnership staff that is still unresolved since the implementation of the Once for Wales system. This has had a major impact on the accessibility of the Once for Wales system for a small number of staff within NHS Wales Shared Services Partnership. Work to address this issue is being progressed by various Informatics colleagues, including Digital Health Care Wales, Velindre Digital Services and RL Datix. This issue has been recently escalated by NWSSP internal IT colleagues and the situation will continue to be monitored via the Datix Project Board.

- **Welsh Blood Service specification:** The Welsh Blood Service Team have reported challenges with the coding specification of the Once for Wales system, and the risk of a losing of Donor specific data. The issue is described in further detail in Section 3.3 of this report.

- **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/investigated. RL Datix are looking into possible solutions. In the meantime staff education is ongoing to ensure staff are aware of what the reporting requirements are and further guides have been made available. The situation will continue to be monitored via the Datix Project Board.

3.4.4 Future Once for Wales Modules

A number of additional modules are planned to ‘go live’ in forthcoming months:

- ***Safeguarding Module***: Currently being piloted in Hywel Dda Health Board.
- ***Risk Module***: Currently being developed and scheduled for release in April 2022. Consideration being given around the Trust being an early adopter of this module.
- ***Safety Alerts Module***: Proposed date for release is the end of February 2022.
- ***Investigations Module***: No specific release date agreed. Development work remains underway by RLDatix and national team.

The Datix Project Board is currently planning for the above, and project plans will be in place. There is not anticipated to be any iissues relating to the implementation of any of the above modules.

3.4 Datix 2021/22 Audit Plan

Monthly audits of the Datix system regarding compliance with the closure of incidents within the required timescales continues and is reported to the Datix Project Board. Work is underway to further refine these reports to include additional areas for analysis.

An All Wales Datix audit plan is also being scoped and developed. This national work is being led by one of the Trusts Datix Administrators. This national audit plan will include compliance with agreed national key performance indicators.

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	Yes (Include further detail below)
	Archiving costs – approved at EMB.

5 RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **NOTE** the paper and the progress being made in relation to the Datix Project.

QUALITY, SAFETY & PERFORMANCE COMMITTEE	
Executive Director of Nursing Update Paper	
DATE OF MEETING	17th February 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	Nicola Williams, Executive Director of Nursing, AHPs and Health Science
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, AHPs and Health Science

REPORT PURPOSE	ASSURANCE

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Professional Nursing forum	02/12/2021	Items for inclusion agreed
Executive Management Board	07/02/2022	Noted

1. SITUATION

This paper provides the Quality, Safety & Performance Committee with a summary of key discussions at the Professional Nursing Forum held on the 2nd December 2021 and additional nursing led critical project updates since the last report. The report covers the period November to December 2021, as the forum did not meet in January due to escalation of site pressures from COVID-19.

2. BACKGROUND

The Professional Nursing Forum usually meets monthly and it is the forum at which all strategic professional nursing issues are discussed and priorities determined.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The following are the key areas contained within the paper:

- Velindre Cancer Centre Support Navigator wins Royal College of Nursing (RCN) Healthcare Support Worker of the Year Award 2021.
- Practice Audit Update – Cannula flushing.
- Senior Nursing Priorities update.

4. 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 Professional Nursing update.

EXECUTIVE DIRECTOR OF NURSING UPDATE PAPER: October - November 2021

1. PURPOSE

This paper details, for the period November to December 2021, key developments in relation to the Professional Nursing priority areas and progress within key nursing projects detailed in the Professional Nursing Forum (PNF) held on the 2nd December 2021.

2. PROFESSIONAL NURSING FORUM (PNF) HIGHLIGHTS

The following is a summary of the key areas of discussion / highlights / outcomes from the Professional Nursing forum held on the 2nd December 2021:

2.1 Diane Rees, (Macmillan Cancer Support Navigator) ***won the RCN Healthcare Support Worker of the Year Award 2021.*** The award was presented by Nicola Williams on the 1st December, accompanied by the Chair of the Trust, Chief Executive, Chief Operating Officer and a number of Macmillan representatives. Diane has been described as an anchor in terms of sharing knowledge, involved in developing a steering group to network and share best practice. Diane is also teaching on a post graduate cancer course in Cardiff University and piloted a virtual group session on colorectal patients. Work will be undertaken to capitalise on this and the award over the coming year and Macmillan are keen to collaborate to develop roles of this nature. Diane has kindly provided a Blog and is attending February's PNF to provide an overview of the role.

2.2 Professional Revalidation and Registration Procedure

Work is ongoing in relation to the development of a Trust Professional Revalidation and Registration Procedure. It is anticipated this will be approved in March 2022.

2.3 Cannulation Practice Audit update

A cannulation practice Audit took place during November 2021 involving 10 different nursing staff being observed performing peripheral venous cannulation. The aim of the audit was to ensure: infection control principles were adhered to; correct cannulation techniques were followed; and the staff member had the correct knowledge of assessment materials.

Compliance with each element of the cannulation standards ranged from 70% - 100%. 6 of 10 elements were 100%; 1 element was 70% (skin preparation for 30 seconds); and 4 elements 80% (2 related to knowledge base, 1 was correct use of needle free connector and 1 cannula correctly and securely dressed).

This generated a very constructive best practice discussion within PNF and reported a positive account in the main, with learning recognised during the audits. Immediate remedial action was taken and significant revision of education and competencies. A follow up audit is being undertaken. The following was agreed:

- Need for standardised practice across the Trust i.e. same standards WBS as VCC – action completed.
- Staff who are cannulating must use cannulation packs with pre-filled saline syringes, unless an emergency situation arises – action completed.
- Audit to be undertaken to ensure that the cannulation packs are being used - underway.
- Ensure additional packs are always available, in the event of the patient / donor requiring re-cannulation – process put in place.

2.4 Digital Update

- ***Health Roster*** (electronic rostering) has been implemented within all Velindre Cancer Centre nursing areas; however, there are a further 300 licenses which require rollout. Plans are being finalized for utilization of these.

- A presentation of ***Tendable (previously Perfect Ward***) was made (Clinical Area Electronic audit tool). Two areas have now completed a month of data and initial feedback is extremely positive and staff are welcoming real time reporting, reducing paper and manual upload to excel. Although Wifi connectivity had been an issue, this has now been resolved and there are no ongoing issues with staff connecting to the Tendable system.

3. TRUST NURSING HUB LAUNCH

Velindre University NHS Trust's nursing electronic hub was successfully launched on the 1st October 2021. It is however identified that this requires too many clicks to reach the desired page, and that an App is required moving forward.

Weekly Nursing blogs have been provided as one element of the hub.

4. TRUST NURSING STRATEGY DEVELOPMENT

Work is well underway on the development of the Trust's 5-year nursing strategy.

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.

Stage 2 will be undertaken during March – May 2022 to finalise the strategy based on the emerging themes / priorities. These will be agreed at Professional Nursing forum in February 2022.

QUALITY, SAFETY & PERFORMANCE COMMITTEE

CYCLE OF BUSINESS – JANUARY 2022 DEFERRED REPORTS

DATE OF MEETING	17th February 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	N/A

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

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
N/A	N/A	N/A

ACRONYMS	

1. SITUATION / BACKGROUND

As part of the Velindre University NHS Trust ongoing commitment to continuous review and improvement to support its Board Committee effectiveness, it has been agreed that the Cycle of Business is included as a standing consent item at every meeting; the purpose of which is to ensure members are aware of items of business that are due to be considered within that meeting and provide explanations for any departures from the Cycle of Business.

As such, the purpose of this paper is to provide the Quality, Safety & Performance (QSP) Committee with sight of papers deferred from its January 2022 meeting, to be received at either the Extra-ordinary February 2022 QSP Committee or the standard March 2022 meeting.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

Due to the emergence of Wave #4 of the Coronavirus pandemic and the prevalence of the Omicron variant, a number of core meetings have temporarily been stood down or adapted to include a high level of COVID related content. As a result, a number of papers due to be received at the January 2022 QSP meeting have been deferred to a future Committee in order to accommodate additional COVID and GOLD COMMAND related content and reflect discussions at Executive Management Board Run.

Papers due to be received at the January Committee and updated dates for receipt are detailed below:

COVID Test Trace Protect (TTP) Cell Highlight Report (Update incorporated within GOLD Highlight Report March 2022)
Executive Director Nursing Update (to be received February and March)
Datix Project Highlight Report (to be received February)
Quality & Safety Framework (to be received March)
Freedom of Information Requests (IG & IM&T) (to be received March)
Radiation Protection Committee Highlight Report (to be received March)
Medical Devices Report (to be received March)
Medical Workforce Update (to be received March)
Medical Examiner's Service & Mortality Framework Report (to be received March)
Medical Education Governance Framework (to be received March)
Trust Operational Annual Plan 2021/2022 Q3 Progress Report (to be received March)

3. IMPACT ASSESSMENT

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

4. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **NOTE** the papers deferred from the January 2022 Committee and their revised reporting status.

QUALITY, SAFETY & PERFORMANCE COMMITTEE

GOLD COMMAND HIGHLIGHT REPORT

DATE OF MEETING	17 February 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Emma Stephens, Head of Corporate Governance
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff Nicola Williams, Executive Director Nursing, AHPs & Health Science Cath O'Brien, Chief Operating Officer Dr. Jacinta Abraham, Executive Medical Director
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance & Chief of Staff Nicola Williams, Executive Director Nursing, AHPs & Health Science Cath O'Brien, Chief Operating Officer Dr. Jacinta Abraham, Executive Medical Director

REPORT PURPOSE	**FOR NOTING**

ACRONYMS	
COVID	Coronavirus
SACT	Systemic Anti-Cancer Treatment
FFP	Filtering Face Piece

1. PURPOSE

This paper has been prepared to provide the Quality, Safety & Performance Committee with details of the key issues and items considered by **GOLD COMMAND** at its meetings held between the **17/01/2021** to **09/02/2022**.

The Quality, Safety & Performance Committee is requested to **NOTE** the contents of the report and actions being taken.

2. BACKGROUND

To ensure a combined and coordinated response to the emergence and prevalence of the Omicron variant the Velindre University NHS Trust re-activated its agreed dedicated incident Command and Control structure on the **15/12/2021**. The structure provides a formal escalation and de-escalation path and is consistent with the nationally recognised three tiered Command and Control structure. This has included a strengthened clinical support infrastructure, ensuring effective agile decision making with robust clinical oversight, placing clinicians (Medical, Nursing, AHP's, & Health / Clinical Scientists) firmly at the centre of risk based decision making.

The frequency of GOLD COMMAND meetings is continually assessed and flexed in line with the needs of the incident and its interface with the Welsh Blood Service and Velindre Cancer Service SILVER COMMANDs. Due to an improving picture and operational delivery impact during week commencing **17/01/2022**, GOLD COMMAND reduced its meeting frequency to twice a week and, from week commencing **24/01/2022** to once a week. SILVER COMMANDs and the COVID Cell also reduced their respective meeting frequency to once a week from week commencing **24/01/2022.**

3. HIGHLIGHT REPORT

The following areas were highlighted for reporting to the Quality, Safety & Performance Committee from the GOLD COMMAND meetings held between the **17/01/2022** and **09/02/2022**.

ALERT / ESCALATE	• **FIRST FLOOR WARD COVID OUTBREAK** Since the **28/01/2022** there have been outbreak arrangements put in place in respect of two or more patients testing positive for COVID linked to the first floor ward of Velindre Cancer Services. This has been managed in line with Outbreak procedures. As of **09/02/2022** there are 4 patients who have tested positive for COVID, one of which was, on

	the balance of probability acquired on the First Floor Ward. Two patients had been patients prior to being admitted to the ward in other hospitals. In addition, there are 8 staff members who have worked on the ward testing positive. All patients have been asymptomatic from COVID. All patients on the ward have been screened. There is a possibility that two were false positives (microbiology opinion). Risk based admissions have taken place into the ward, supported by Microbiology. Daily assurance audits (IPC practices) have been undertaken with 100% compliance and >95% compliance with cleaning standards. The only environmental work required is general painting. This is being planned.
ADVISE	• **DELIVERY OF SYSTEMIC ANTI-CANCER TREATMENT THERAPY (SACT) WITHIN TARGET TIMESCALES (21 DAYS)** GOLD COMMAND received a detailed analysis of the current position in relation to the Velindre Cancer Service ability to meet demand for SACT as a result of the impact of COVID related staff absences. As had been previously anticipated, there has been an increased number of breaches in meeting the 21day new patient target with 94 patients that were due to be treated and 12 patients in escalation. However, there was a SACT day case clinic held on Saturday the **05/02/2022**, 12 patients were scheduled for treatment and all patients that were in escalation as of **04/02/2022** were accommodated. GOLD COMMAND were advised of all the enhanced business continuity measures that remain in place to mitigate the risks as far as possible, and the overall improved position regarding SACT delivery. The Research, Development & Innovation (RD&I) clinical trial staff support for SACT service was paused as the position improved. This will be flexibly used when required in line with service needs. GOLD COMMAND received a robust and comprehensive risk assessment undertaken to review the impact on RD&I of not being able to participate fully in clinical studies in event of staff being redirected to support other services (ref ***Appendix 1***). GOLD COMMAND were advised that this had been endorsed by the Strategic Clinical Advisory Group and a revised overall highest impact score of 3 for both patients and staff determined.

	GOLD COMMAND were advised that there had been additional capacity constraints through the second half of January with staff absences impacting despite additional hours and cross cover and collegiate working across the service to maximise patient treatment. All patients have been treated, however some have breached the waiting time targets. All 42 prostate patients who have had their treatment pathway altered, have now resumed the original planned pathway. This is in line with the All Wales COVID radiotherapy prioritisation plan to minimise any unfavourable disease outcome. • **COVID RISKS** The risk profile associated with the prevalence of the Omicron variant remains fluid in this continually changing environment with key risks remaining: staffing levels; supply and access to testing; and nosocomial transmission. Whilst the peak of the current wave has passed, there is a possibility of further waves National discussions are underway in relation to mainstreaming vaccination and how this might be achieved to help mitigate this risk. To date, there continues to have been no requirement by the Welsh Blood Service to invoke the mutual aid agreement with the four UK Nations for importation of blood components. Of the four UK Blood Services, the Welsh Blood Services remains the soul nation not requiring mutual aid support to ensure service delivery is maintained during Wave #4. However, a number of COVID funded posts are due to end at the end of March 2022, potentially presenting a risk should COVID measures remain in place beyond this. GOLD COMMAND were advised of the ongoing discussions between the Executive Director of Finance and our Commissioners to help mitigate this risk.
ASSURE	• **VELINDRE CANCER SERVICE** ○ ***Staff Absence:*** Main impact of COVID Wave #4 for the Velindre Cancer Service remains staff absence and the resulting impact on ability to provide services to all patients within the required timescales. Although staff absence had reduced as January progressed, this started to increase from week of the 24/01/ 2022. This is a position echoed across a number of NHS organisations in Wales. Children of staff contracting COVID at school is a likely contributory factor to the recent increase. Key staff can cause fragility of services in some areas i.e. prescribing, and the Chief Operating Officer is working closely with the Senior

	Leadership Team to support the service with the ongoing absence of both the Director and Head of Operational Service Delivery. ○ ***Recovery Plan:*** Treatment of deferred prostate patients is to commence from **07/02/2022**. It is also planned to increase Linac capacity from 68 hours to 71 (per Linac) during February 2022 if possible. A detailed review of the Velindre Cancer Service Recovery Plan was undertaken via the Divisional Review meeting held on the **31/01/2022**. GOLD COMMAND will continue to receive progress updates against this. • **WELSH BLOOD SERVICE** ○ ***Blood / Blood Products Stock levels*:** Blue alert was removed on the **18/01/2022** and stock position is stable and evidence of high uptake of appointments with additional appointments provided at Saturday clinics is encouraging. ○ ***Social distancing:*** *GOLD COMMAND approved a* risk based process, if stock levels are at risk to reduce social distancing measures from 2 meters to 1 meter at some whole blood donation clinics in line with Government guidance for a low risk clinical area. This, until community transmission rates reduce further will only be instigated if blood supply is deemed to be a threat. This position will continue to be closely monitored on an ongoing basis.
INFORM	• **STAFF COMMUNICATIONS** Strong messaging has been issued to all staff via the well-established daily communications channel in place, to reiterate and remind staff of the need to adhere to all risk reduction measures for everyone's health and safety as the outbreak coincides with the removal of all legal limits in Wales from **28/01/2022** and a return to **Alert Level 0**. • **WORKING FROM HOME** In line with the latest Government guidance GOLD COMMAND agreed that staff should revert to pre-Omicron arrangements for site attendance effective **31/01/2022**, as Infection Prevention Control / Social distancing measures will remain in place. This return to the previous arrangements was underpinned by clear communication to all staff reiterating the importance of continued application of twice weekly lateral flow tests

	and adherence to all Infection Prevention Control / Social distancing measures. • **ANNUAL LEAVE** GOLD COMMAND received a detailed analysis of the current position in relation to the Annual Leave arrangements for staff. It was confirmed that staff are permitted to carry up to 10 days to the next financial year and / or be sold back. However, staff are to be encouraged where possible to take their remaining Annual Leave from a wellbeing perspective, and it was agreed that this should be aligned with service needs. Funding has been provided by Welsh Government as part of a national agreement with Trade Unions to facilitate these arrangements.
APPENDICES	• **APPENDIX 1:** *Impact Assessment for RD&I Supporting SACT*

QUALITY, SAFETY & PERFORAMNCE COMMITTEE

FINANCE REPORT FOR THE PERIOD ENDED 31ST DECEMBER 2021 (M9)

DATE OF MEETING	7th February 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	ENDORSE FOR BOARD APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
EMB	07.02.22	ENDORSED FOR COMMITTEE APPROVAL

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 December 2021.

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)	5	0
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	705	3,669	10,650
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	91.8%	94.8%	95.0%

2.2 Revenue Budget

At this stage of the financial year the overall revenue budget continues to remain 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 December is an underspend of **£5k**, with an underachievement against income offset by an underspend within Pay.

A large element of the underachievement on planned income relates to WBS WTAIL and Blood Components due to the impact of Covid above the level of forecast reduced income which the Trust is receiving WG funding to cover.

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.

The Trust is currently planning to fully achieve the savings target during 2021-22. There remain £200k of schemes relating to post Covid savings that are RAG rated as amber. Although these savings are being partly generated, they have been replaced with non-recurrent vacancy factor savings whilst we are in the pandemic as the cost reductions are being offset against the additional costs of Covid as required by WG for Covid funding.

Any slippage or non-delivery against savings targets will be managed through implementation of alternative savings / cost avoidance measures, which may be non-recurrent in nature such as additional vacancy factor.

Finance colleagues in WG have provided written assurance that the Trust will be fully funded for Covid related expenditure during 2021-22.

The Trust is therefore reporting a year end forecast breakeven position on the assumption that the savings target for the year is achieved.

2.3 PSPP Performance

PSSP performance for the whole Trust is currently 95.6% against a target of 95%, however the performance against the Core Trust excluding NWSSP is presently falling just short of the target at 94.8%.

PSPP compliance levels had significantly recovered following a temporary dip in performance, however December did see another drop, but expected to rebound. Finance colleagues working alongside NWSSP are confident that the 95% target will be achieved this financial year.

2.4 Covid Expenditure

Covid-19 Revenue Spend/ Funding				
	YTD Actual £000	Plan 2021/22 £000	Funding Recevied / Allocated £000	Balance Remaining £000
Mass & Booster Covid Vaccination	308	392	213	179
Cleaning Standards	592	769	367	402
PPE	148	250	147	103
Covid Recovery	1,331	3,227	3,479	(252)
Other Covid Related Spend & Cost Reduction	1,411	1,502	1,176	326
BFWD Savings Loss	522	700	700	0
Return of Bonus Payment (over allocated)	(83)	(83)	(83)	0
Total Covid Spend /Funding Requirement 2021/22	**4,265**	**6,757**	**5,999**	**758**

The overall gross funding requirement related to Covid is £6,757k which includes £6,140k of directly associated expenditure or cost reduction, £700k in relation to the non-achievement of savings carried forward from 2020/21, and the return of surplus NHS bonus payment £(83)k.

The Trust has received e-mail confirmation from the WG Interim Director of Finance Health and Social Services Group that all the Trust Covid related expenditure identified in table above will be funded.

2.5 Reserves

The financial strategy for 2021-22 facilitated the development of a recurrent and non-recurrent reserve in support of the Trust transformation and delivery agenda. These reserves could only be accommodated on the basis that all income expectations are received, planned savings schemes delivered and new emerging cost pressures managed. In addition, the Trust holds an emergency reserve of 522k.

2.5.1 Recurrent Reserves (budget unallocated):

Summary of Total Reserves Remaining Available in 2021/22	£k
Recurrent Reserve Available 2021/22	617
Further Exec Commitment 2021-22	(144)
Remaining Balance	**473**

The current balance of the recurrent reserves for 2021/22 after investment decisions were made at EMB on 22nd November is £473k, **however this funding has now been committed into future years so is only available for non-recurrent investment during 2021/22.**

2.5.2 Non Recurrent Reserves (budget unallocated):

Summary of Total Non-Recurrent Reserves Remaining Available in 2021/22	£k
Anticipated slippage on NR Allocated reserves	450
Emergency Reserve	522
Remaining Balance	**972**

The Emergency reserve of £522k is set every year and used non-recurrently to deal with any in year unforeseen unavoidable cost pressures. To date none of the Emergency reserves have been utilized.

In addition to the recurrent and emergency reserves, the Executive Management Board (EMB) agreed to make available £1,545k of non-recurrent funding for investment during 2021/22 from the release of accountancy gains. The current spend to December '21 is £596k (includes £90k of new commitments). The anticipated slippage against the £1.5m is currently expected to be circa £450k during 2021/22 due to delays in implementation of several investments which are mainly fixed term posts, although this balance is under constant review with potential further slippage. EMB has agreed that non-recurrent funding of £450k will be re-provided in 2022/23 to enable all the approved investments to be fully implemented, provided it can be demonstrated that recruitment of posts or procurement had commenced by the end of December '21, which is currently being reviewed.

The non-recurrent reserves still available to invest and cover new unavoidable cost pressures is £1,445k (972k+473k), however further slippage is anticipated. **It is important that the Executive Team consider what plans can be implemented in 2021-22 to utilise this available non-recurrent funding to support the significant service challenges in 2022-23.**

2.6 Financial Risks

2.6.1 All new operational financial risks are expected to be managed or mitigated at divisional level. Where this is not possible, or the risk is Trust wide and can not be mitigated the Emergency Reserves will be utilised.

2.6.2 The main financial risk for the Trust during 2021-22 has been its covid expenditure and whether this would be fully covered by WG. WG has confirmed in writing that all the Trust 2021-22 covid costs will be funded.

2.6.3 The Trust has £1,445k of non-recurrent funding remaining which must be spent before 31st March 2022 otherwise will be unavailable to the Trust unless a mechanism is agreed to enable carry forward.

ACTION: by 11th Feb '22 Executive Directors to:

- **review non-recurrent funding allocated to them and provide forecast of spend to 31st March 2022; and**
- **identify alternative realistic proposals to spend by 31st March 2022**

2.6.4 In March '20 Executive Directors agreed a 'Suspension of Charitable Funding' proposal to reduce cost recharges of core VCC costs to Velindre Charity in 2021-22 by c£800k due to ongoing covid pandemic impact on staff ability to undertake the services / plans funded by charity.

Executive Directors to consider a proposal that the same reduction in cost recharges to the Velindre Charity of £800k be made in 2021-22.

Executive Directors to consider seeking agreement from CFC to re-provide the 2 years of reduced funding to the Trust in 2022-23 without requirement for individual business case applications to the Charity, with the sole purpose of contributing to funding the ongoing covid recovery i.e. recharge a proportion of the covid recovery costs to charity up to a maximum of the reduction in cost recharged for 20-21 £800k + 21-22 £800k = £1,600k.

ACTION: Executive Directors to consider:

- **reduction in recharges to Charity of £800k in 21-22**
- **seek a view from CFC to re-provide the 2 years of reduced funding (£1,600k) in 2022-23 to contribute to funding Covid recovery**

2.7 Capital

a) All Wales Programme

The Trust previously received confirmation of £675k funding from WG towards Capital related Covid recovery. This will be used to support additional donor chairs in WBS, urgent ventilation work, and increased capacity in VCC such as improvements to the outpatient area and Bobarth building which now forms part of the CEL.

In addition, following a communication from WG of the availability of additional end of year capital monies, the Trust was successful in receiving £838k of funding against the £1,396k of schemes it submitted. The request was based on prioritised divisional bids of clinical equipment in VCC, equipment to establish a component development Laboratory in WBS, and several Digital / IT refresh & infrastructure requirements.

The Capital Programme is significantly underspend for the period year to date which is a combination of procurement capacity constraints and impact of pandemic on supplier lead times. The Trust is looking to appoint external contractors to support the tender and award of contracts in order to help delivery of Estates approved schemes. Despite the challenges 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 the remainder of 2021/22 and in 2022/23 in conjunction with WG include, Integrated Radiotherapy Solution (IRS), WBS HQ, VCC Ventilation & Infrastructure/ Outpatients, and WBS Plasma fractionation (for medicines).

b) Discretionary Programme

Due to supply chain issues we are starting to see an emergence of slippage against some of the discretionary schemes that were previously approved. This was discussed at the internal Capital Planning Meeting on the 18th October where other Organisational priorities were discussed and agreed to replace the schemes that were would not be fully delivered during 2021/22.

The year-end forecast outturn is currently expected to be managed to a breakeven position, with any further slippage being managed through the Capital Planning and Delivery Group.

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 December 2021 is an underspend of £5k with a year-end forecast break-even position in accordance with the approved IMTP

4. RECOMMENDATION

4.1 Quality, Safety & Performance Committee is asked to **NOTE** the contents of the December 2021 financial report and in particular the financial performance to date, and the year-end forecast to achieve financial break-even.

4.2 Quality, Safety & Performance Committee is asked to **NOTE** that Executive Directors:

4.2.1 reviewed non-recurrent funding allocated to them and provided forecast of spend to 31st March 2022 by 11th Feb ’22; and

4.2.2 identified alternative realistic proposals to spend by 31st March 2022

4.3 Quality, Safety & Performance Committee is asked to **NOTE** that Executive Directors agreed to:

4.3.1 a reduction in recharges to Velindre Charity of £800k in 21-22

4.3.2 seek a view from the Charitable Funds Committee to possible re-provision of the 2 years reduced funding (£1,600k) in 2022-23 to contribute to funding the Covid recovery costs

Canolfan Ganser Felindre
Velindre Cancer Centre

GIG CYMRU NHS WALES
Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

Welsh Blood Service
Gwasanaeth Gwaed Cymru

FINANCIAL PERFORMANCE REPORT

FOR THE PERIOD ENDED NOVEMBER 2021/22

TRUST BOARD
27/01/2022

1. Introduction

The purpose of this report is to outline the financial position and performance for the year to date, performance against financial savings targets, highlights the financial risks, and forecast for the financial year, outlining the actions required to deliver the IMTP Financial Plan for 2021-22.

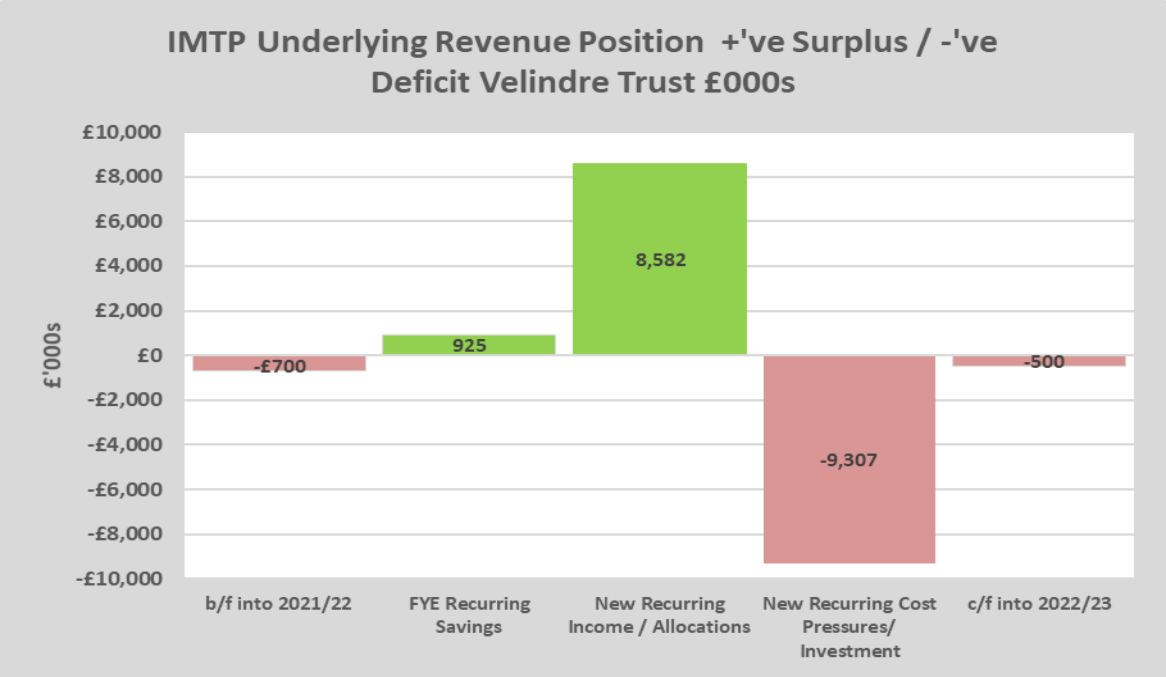
2. Background / Context

The Trust Financial Plan for 2021-22 was set within the following context.

- The Trust submitted a balanced one-year financial plan, covering the period 2021-22 to Welsh Government on the 30 June 2021.

- For 2021-22 the Plan (excl Covid) included;
  - an underlying **deficit of -£700k brought forward from 2020-21,**
  - FYE **of new cost pressures / Investment** of **-£9,307k,**
  - offset by **new recurring Income** of **£8,582k,**
  - and Recurring FYE **savings schemes** of **£925k.**

- Due to the ongoing pandemic and the inability to fully enact savings schemes & cost reduction, the Trust is not expecting to be able to fully eliminate the underlying deficit during 2021-22, however in line with the submitted financial plan the Trust will be aiming to reduce the deficit by £200k to carry forward an underlying position of £500k into 2022-23.
- **To reduce the underlying deficit, the savings target set for 2021-22 must be achieved.**



Underlying Position +Deficit/(-Surplus) £000s	b/f into 2021/22	Recurring Savings	New Recurring Income / Allocations	FYE New Cost Pressures/ Investment	c/f into 2022/23
Velindre NHS Trust	- 700	925	8,582	- 9,307	- 500

3. Executive Summary

Summary of Performance against Key Financial Targets (Excluding Hosted Organisations)

(Figures in parenthesis signify an adverse variance against plan)

Table 1 - Key Targets

	Unit	Current Month £000	Year to date £000	Year End Forecast £000
Revenue	Variance	(2)	5	0
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	705	3,669	10,650
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	91.8%	94.8%	95.0%

Performance against Planned Savings Target

Efficiency Savings	Variance	0	0	0

Revenue

The Trust has reported a **£(2)k** in-month overspend position for December21, with a cumulative position of **£5k** underspent, and an outturn forecast of **Breakeven**.

Capital

The approved Capital Expenditure Limit (CEL) as at December 2021 is **£10,650k** for 2021-22. This represents all Wales Capital funding of **£8,739k**, Discretionary funding of **£1,911k.** The Trust reported capital spend to December '21 of £3,669k and is forecasting to remain within its CEL of £10,650k.

The capital programme is significantly underspend for the period year to date which is a combination of procurement capacity constraints and impact of pandemic on supplier lead times. The Trust is looking to appoint external contractors to support the tender and award of contracts in order to help delivery of Estates approved schemes.

PSPP

During December '21 the Trust (core) achieved a compliance level of **91.8%** (November 21: 97.26%) of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **94.83%** to the end of December, and a Trust position (including hosted) of **95.6%** compared to the target of 95%.

PSPP compliance levels for core Trust dropped again during December following significant recovery between September and November. The Trust continues to work with NWSSP colleagues to improve the target and we are confident that that target will be met for this financial year.

Efficiency / Savings

The Trust is currently planning to fully achieve the savings target during 2021-22. Any slippage or non-delivery against savings targets will be managed through implementation of alternative savings / cost avoidance measures, which may be non-recurrent in nature such as increased vacancy factor. Where non-recurrent savings schemes are implemented this will require additional recurrent savings schemes to be delivered in 2022-23.

4. Revenue Position

Cumulative				Forecast		
£4,889 Underspent				Breakeven		
Type	YTD Budget (£'000)	YTD Actual (£'000)	YTD Variance (£'000)	Full Year Budget (£'000)	Full Year Forecast (£'000)	Forecast Variance (£'000)
Income	(121,248)	(120,857)	(391)	(164,590)	(164,053)	(537)
Pay	53,668	53,255	413	71,706	71,197	509
Non Pay	67,580	67,597	(17)	92,884	92,856	28
Total	(0)	(5)	5	0	(0)	0

The overall position against the profiled revenue budget to the end of December is an underspend of **£5k**, with an underachievement against income offset by an underspend within Pay.

The Trust has now received confirmation that all Covid related expenditure it has forecast will be funded by WG.

4.1 Revenue Position Key Issues

Income Key Issues

- Income underachievement to December is **£(391)k** and is largely where activity is lower than planned on Bone Marrow and Plasma Sales in WBS which is resulting in income loss above Covid support, with assessments as to scale and sustainability ongoing.
- The underperformance in WBS is being partly offset within VCC via an increase in VAT savings from providing additional SACT Homecare.

Pay Key Issues

The Trust has reported a cumulative year to date position of **£413k** underspent on Pay and is forecasting an outturn underspend of circa **£509k**.

The total Trust vacancies as at December is 130wte, (VCC 70wte), (WBS 31wte), (Corporate 5 wte), R&D (17wte), TCS (1wte) and HTW (6wte).

The WTE by pay category is provided within the table below:

Pay WTE By Category			
Pay Type	WTE Budget	WTE Actual	WTE Variance
ADD PROF SCIENTIFIC AND TECHNICAL	58.40	53.88	(4.52)
ADDITIONAL CLINICAL SERVICES	257.78	233.16	(24.62)
ADMINISTRATIVE & CLERICAL	534.23	487.47	(46.76)
ALLIED HEALTH PROFESSIONALS	133.16	128.69	(4.47)
ESTATES AND ANCILLIARY	64.81	68.01	3.20
HEALTHCARE SCIENTISTS	159.56	150.45	(9.11)
MEDICAL AND DENTAL	100.29	73.78	(26.51)
NURSING AND MIDWIFERY REGISTERED	219.90	200.88	(19.02)
STUDENTS	2.47	3.67	1.20
Total Pay by Category	**1,530.60**	**1,399.99**	**(130.61)**

- Allied Health Professionals are experiencing a small overspend to date £(93k) which is due to the use of agency in both Radiotherapy and Medical Physics. VCC is aiming to recruit on a permanent basis against some of these posts which commenced in September. This is expected to create a saving going forward from the removal of the premium cost for agency, however due to the difficulty being experienced in recruiting into these posts along with the requirement to cope with the expected surge capacity, the majority of agency staff will be re-directed to support Covid recovery which is funded by WG.
- Medical costs have increased and are reflecting a year to date overspend of £(264)k due to additional temporary staff recruited at risk to ensure that all Jnr Dr rotation placements are filled and to provide additional resilience against pressured consultants. In addition, enhanced out of hours service, for advanced life support which will be nursing led is currently being covered by Jnr Dr's.
- Each Division of the Trust holds a savings and vacancy factor target which is delivered in year via establishment control. Any forecast adverse variance against the target will be offset through various underspends across numerous staff groups due to vacancies as illustrated in the WTE table above.

Non Pay Key Issues

The Trust has reported a cumulative year to date position of **£(17)k** overspend on Non-Pay and is forecasting an outturn underspend of circa **£28k**.

- Large underspend in WBS due to reduced costs from suppressed activity, underspend on Collections Services, Laboratory Services, WTAIL, and General Services
- There are underspends on general drugs in VCC from reduced activity and temporary closure of outreach clinics.
- Large overspends in VCC on One Wales, and rise in consumable across
- Facilities Management, along with Maintenance & Repairs are under review in WBS with Trust Estates following increased compliance requirements against new contracts which is pushing the outturn into a forecast overspend position.
- Transport underspend is due to non-recurring fuel savings and consequently maintenance costs relating to the fleet following reduction of vehicle use related to Covid.
- Starting to experience additional travel & subsistence costs in relation to increased travel of WBS collections team to clinic. This is starting to offset the savings generated from general staff travel & subsistence which has been a benefit since the pandemic hit and the use of IT resources to conduct meetings.

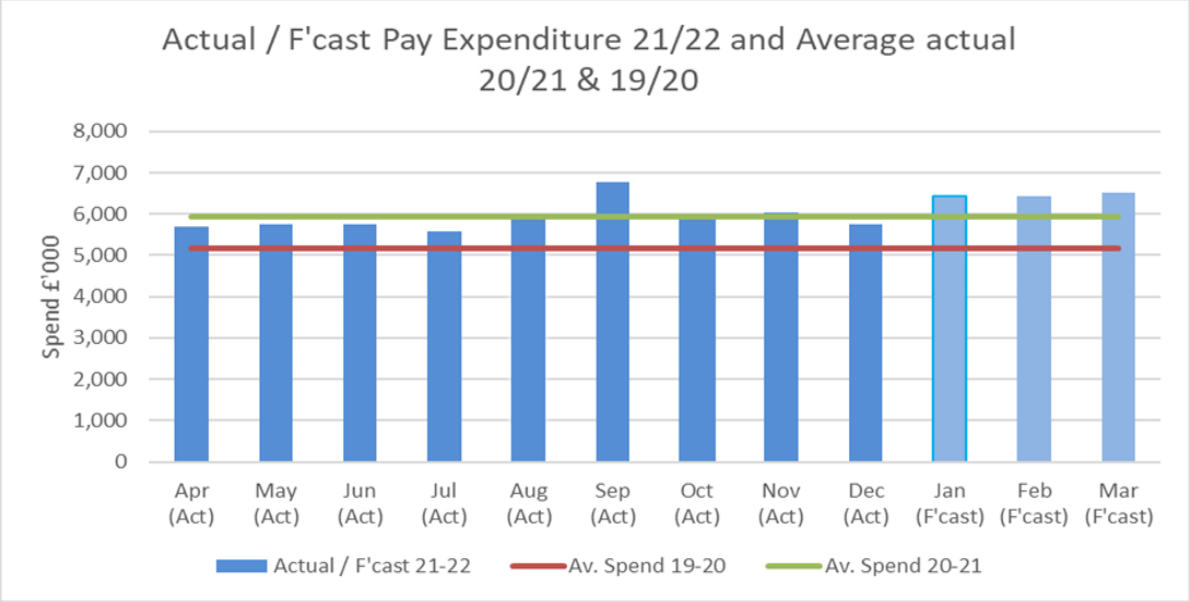
- Printing / Stationary & Postage is underspending due to a reduction in office-based activity and paper-based communications given the increased homeworking. A proportion of this underspend is anticipated to be permanent and will be taken as recurrent saving once the Trust has agreed the operating model of future working arrangements.
- General Reserves / Savings Target relates to the Cost improvement Plan (CIP) targets that are held centrally within divisions. These CIP's will be achieved through the underspends in several areas of non-pay. Additionally, as noted above further alignment of staff underspends to the CIP should result in an underspend within non-staff.
- The Trust reserves and investment funding is held in month 12 and will be released into the position to match spend as it occurs. A significant proportion of the reserves is remaining following slippage against investment decisions.

Further details on performance against Income, Pay and Non-Pay is provided within the Divisional analysis later in the paper.

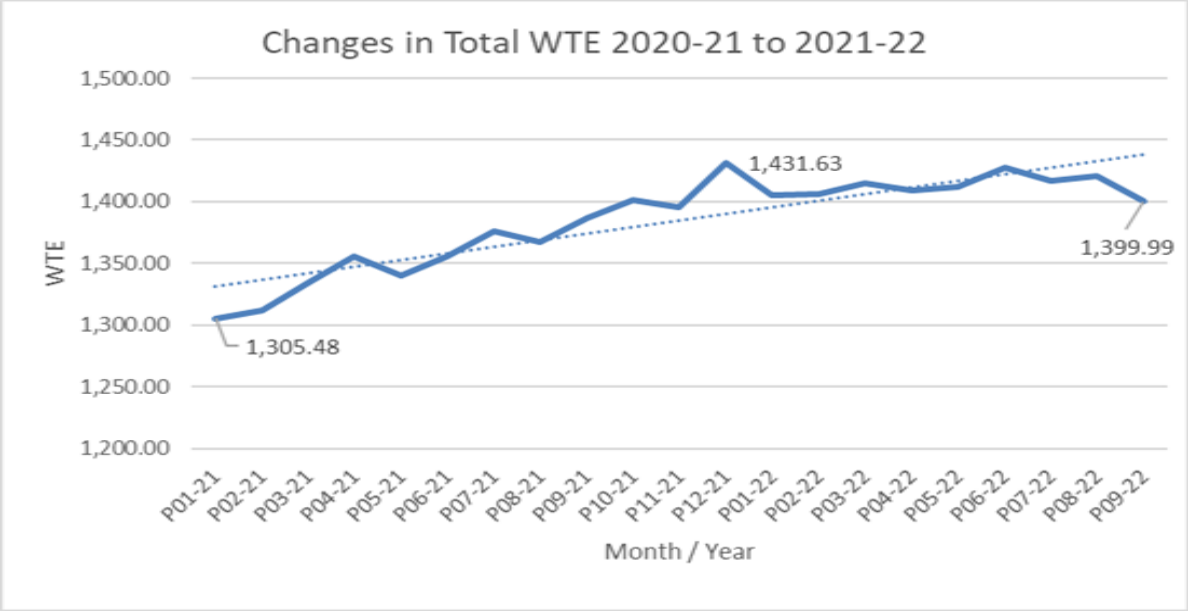
4.2 Pay Spend Trends (Run Rate)

The pay spend for 2020/21 was 14.82% above av. pay in 2019-20. 3% was accounted for by the pay award, 1.14% can be accounted for by an increase in use of agency, 2.3% related to the NHS Bonus Payment with the remaining being the additional staff recruited over the course of 2020/21 (c. 126 wte), and the pay costs associated with Covid.

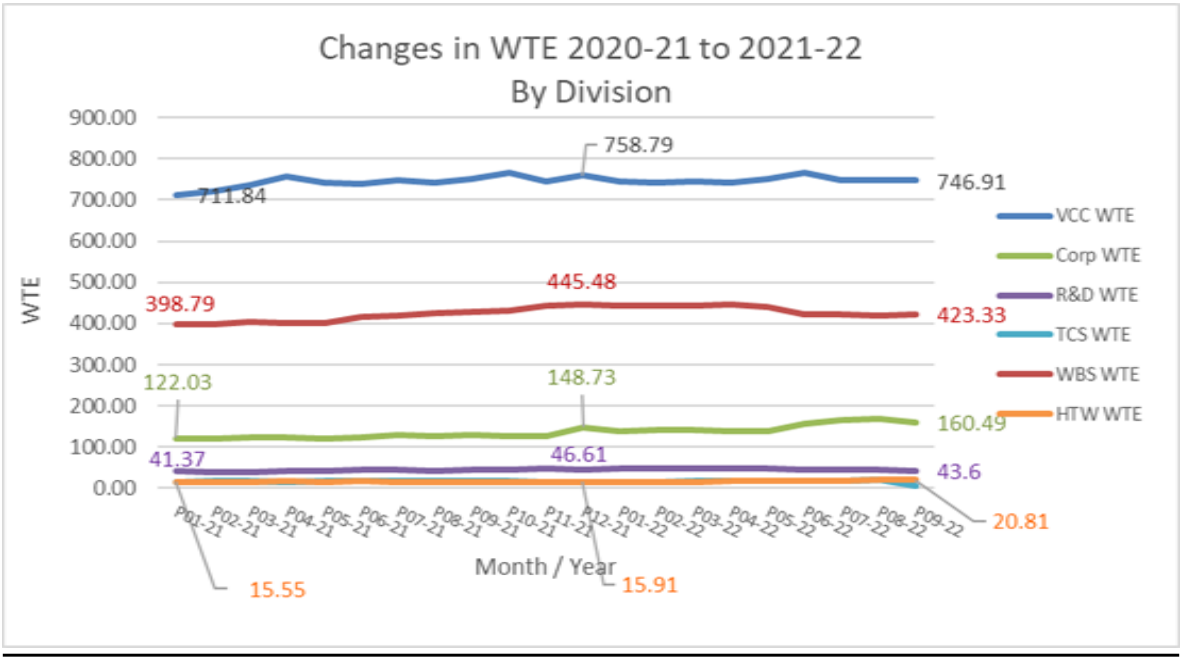
Staff received the 2021/22 pay award of 3% and arrears dated back to April 2021 in their September pay. Excluding the Pay award, spend is still expected to increase with the recruitment of additional posts to meet 'surge' capacity in both VCC and WBS in response to Covid recovery. Whilst the plan was to reduce agency costs within the Trust Core staffing structure, due to the difficulty being experienced in recruitment, the agency staff replaced with substantive recruits will now be utilised as part of the Covid recovery.



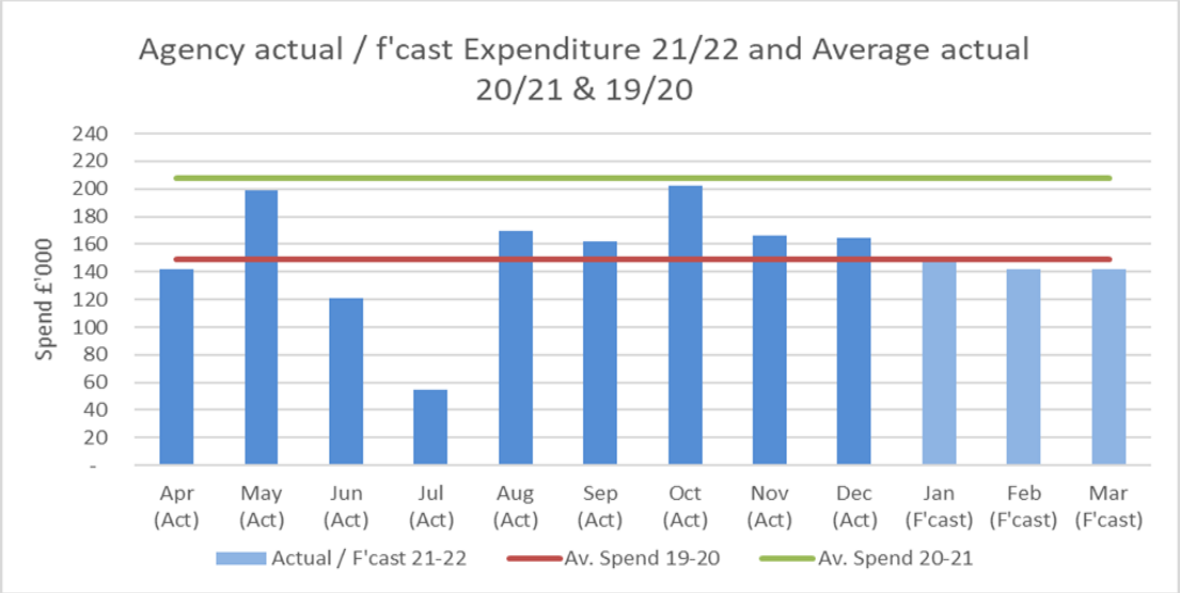
*Sep costs include Pay Award (3%) backdated to April. The perviously reported £2.6m additional pension has been removed as this will be a nominal charge from WG.



* Reduction in WTE since March 21 is due to ceasing of the Patient Vaccination programme.



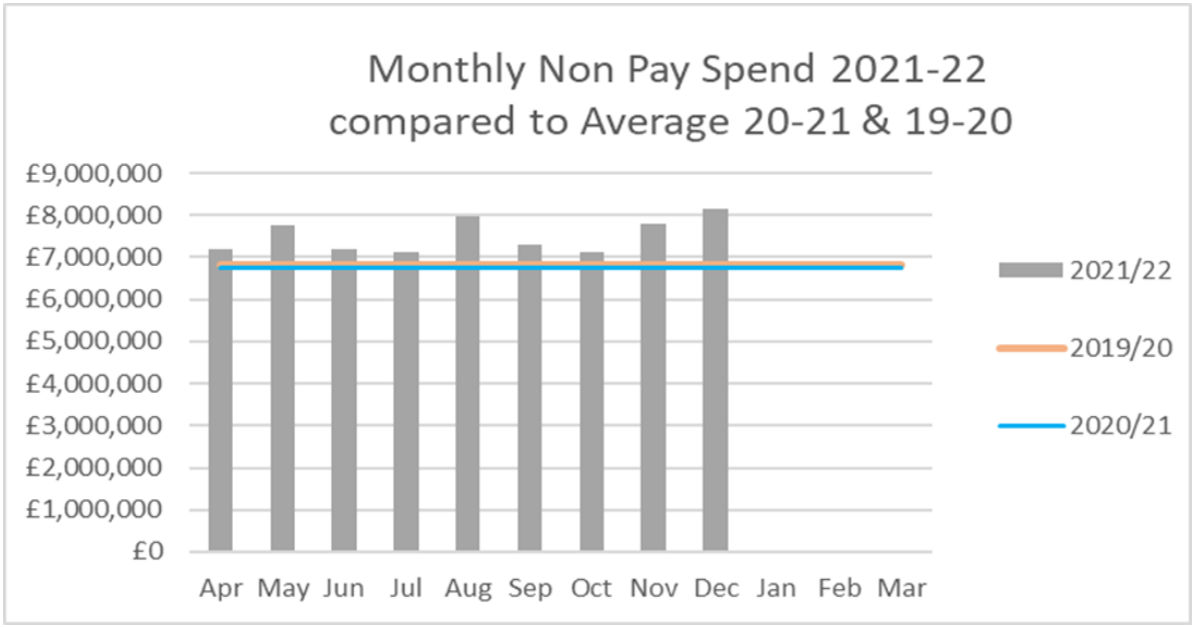
The spend on agency for December was £165k (November £166k), which gives a cumulative year to date spend of **£1,381k** and a forecast outturn spend of circa **£1,816k.** Of these totals the year to date spend on agency directly relating to Covid is £580k and forecast spend is circa £762k.



*The increase in May costs has been reviewed and corrected in July following a full review of agency invoices received against orders raised within VCC.

4.3 Non Pay

Non-pay 20/21 (c£81.2m) av. monthly spend remained static between 19/20 and 20/21 at £6.8m. The average monthly spend for 21-22 is currently £667k (8.98%) more than 20/21, which is largely due to the increase NICE / High-Cost drug usage following the recovery and surge related to Covid.



4.4 Covid-19

Covid-19 Revenue Spend/ Funding				
	YTD Actual £000	Plan 2021/22 £000	Funding Recevied / Allocated £000	Balance Remaining £000
Mass & Booster Covid Vaccination	308	392	213	179
Cleaning Standards	592	769	367	402
PPE	148	250	147	103
Covid Recovery	1,331	3,227	3,479	(252)
Other Covid Related Spend & Cost Reduction	1,411	1,502	1,176	326
BFWD Savings Loss	522	700	700	0
Return of Bonus Payment (over allocated)	(83)	(83)	(83)	0
Total Covid Spend /Funding Requirement 2021/22	**4,265**	**6,757**	**5,999**	**758**

The Trust has currently received or been allocated funding from WG to the sum of £5,999k, £3,479k towards Covid recovery, £1,903k to cover the first six months of Covid response and £700k to cover the underlying savings loss bfwd from 2020/21. The Trust has returned £83k which was surplus money received toward the NHS bonus payment. This leaves funding to be allocated by WG of £758k.

The Trust is yet to receive a formal funding letter for the remaining balance of Covid requirement, however it has received e-mail confirmation from the WG Interim Director of Finance Health and Social Services Group that all the Trust Covid related expenditure identified in the table above will be funded.

Covid Recovery

The spend and funding requirement to deliver Covid Recovery and Surge Capacity comprises direct outsourcing and enablement of additional clinical sessions within VCC, and an additional collection team within WBS. The resources required will provide coverage for an anticipated surge in capacity of up to 20% above pre-Covid levels for VCC and 10% for WBS, although slippage in the current financial year is already being experienced.

Covid recovery funding has been flexibly managed with Covid response requirements, whilst delivering the capacity intended by the funding. This has maintained the overall funding envelope though recovery has been re-categorised to £3,227k via a reduction in outsourcing to date, but forecast to have a sustained increase in utilisation to the end of the Financial Year.

The Trust has received confirmation that the increase in NICE/ High cost drugs will be funded by commissioners. Latest estimate has been updated to circa £1,800k above existing forecast which is based on potential demand should the additional capacity be fully utilised. These figures are excluded from the table above.

The Trust has been informed that £4.5m will be made available to the Hospices for 2021/22, which will pass through the Trust in the same way as it did in 2020/21. Following discussions with WG and Audit at the last financial year end it was agreed that the Trust should not include the Hospice income and expenditure within the Velindre accounts, and therefore they have also been excluded for reporting purposes from the Trust Financial ledger and the tables above. Following a recent request from WG the figures are being included within the Trust monthly financial monitoring returns.

Vaccinations

The Trust is expecting to spend circa £392k on the Covid Mass & Booster Vaccination programme during 2021/22. The £392k revenue spend requirement largely relates to the WBS storage and distribution for NHS Wales (£297k), delivery of vaccinations to front line staff in both Velindre and WAST, and the rollout of the Patient Vaccination programme which has now ended (£63k), with the balance being ringfenced for the booster programme which is also drawing to a close (£32k).

WG have provided reassurance that the ongoing Vaccination programme is a priority and that any costs that may be incurred during 2022-23 will be funded.

5. Savings

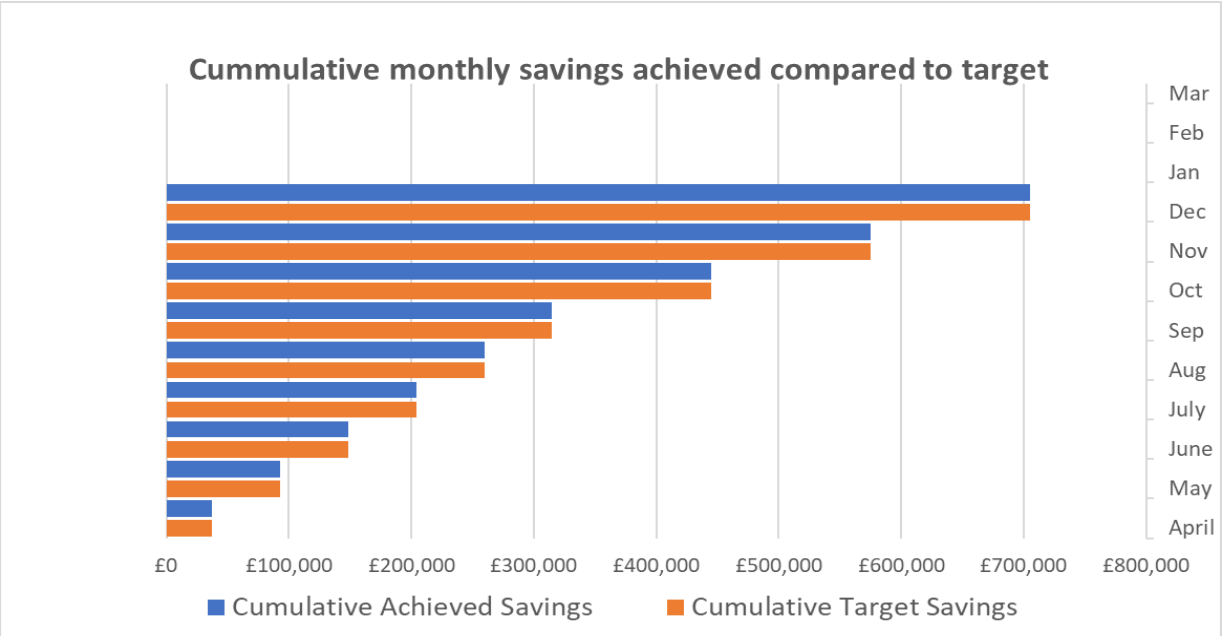
The Trust established as part of the IMTP a savings requirement of £1,100k for 2021-22, £525k recurrent (£925k full year recurrent) and £575k non-recurrent, with £1,050k being categorised as actual saving schemes and £50k being income generating schemes.

The YTD achievement on the 'Post Covid' Savings is £36k and forecast full year is £90k. These savings are not reflected in the tables below as they are being netted of against Covid Spend which is not being drawn down from WG whilst still in the pandemic. The Trust is expected to realise the benefit of these savings post Covid following the new ways of working such as reduced Travel expenses and office consumable spend. For this financial year the savings has been replaced with non-recurrent vacancy factor savings which gives an overall balanced savings position

Any slippage or non-delivery against savings targets between now and the financial year end will be managed through implementation of alternative savings / cost avoidance measures, which may be non-recurrent in nature. Any non-recurrent schemes will need to be replaced by additional recurrent savings schemes in 2022-23.

ORIGINAL PLAN	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	Full Year Actual £000	Variance Full Year £000
VCC TOTAL SAVINGS	413	163	163	0	300	(113)
			100%		73%	
WBS TOTAL SAVINGS	368	225	225	0	300	(68)
			100%		82%	
CORPORATE TOTAL SAVINGS	119	75	75	0	100	(19)
			100%		100%	
TRUST TOTAL SAVINGS IDENTIFIED	900	463	463	0	700	(200)
TRUST ADDITIONAL NON-RECURRENT SAVINGS	200	243	243	0	400	200
TRUST TOTAL SAVINGS	1,100	706	706	0	1,100	0
			100%		100%	

Scheme Type	RAG RATING	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	F'cast Full Year £000	Variance Full Year £000
Savings Schemes							
Premium of Agency Staffing	Green	150	75	75	0	150	0
Premium of Agency Staffing	Green	100	50	50	0	100	0
Post Covid Savings (VCC)	Red	113	0	0	0	0	(113)
Blood Supply Chain 2020	Green	75	56	56	0	75	0
Blood Supply Chain 2020	Green	25	19	19	0	25	0
Stock Management	Green	200	150	150	0	200	0
Post Covid Savings (WBS)	Red	68	0	0	0	0	(68)
Establishment Control	Green	100	75	75	0	100	0
Post Covid Savings (Corporate)	Red	19	0	0		0	(19)
Total Saving Schemes		**850**	425	425	0	650	(200)
Income Generation							
Maximinsing Income Opportunities	Green	50	38	38	0	50	0
Total Income Generation		**50**	38	38	0	50	0
TRUST ADDITIONAL NON-RECURRENT SAVINGS - VACANY FACTOR		200	243	243	0	400	200
TRUST TOTAL SAVINGS		1,100	706	706	0	1,100	0
				100%		100%	



6. Reserves

The financial strategy for 2021-22 facilitated the development of a recurrent and non-recurrent reserve in support of the Trust transformation and delivery agenda. These reserves could only be accommodated on the basis that all income expectations are received, planned savings schemes delivered and new emerging cost pressures managed. In addition, the Trust holds an emergency reserve of 522k.

The current remaining available funding is shown below: -

Summary of Total Reserves Remaining Available in 2021/22	£k
Recurrent Reserve Available 2021/22	617
Further Exec Commitment 2021-22	(144)
Remaining Balance	**473**

The current balance of the recurrent reserves for 2021/22 after investment decisions were made at EMB on 22nd November is £473k, however this funding has now been committed into future years so is only available for non-recurrent investment during 2021/22.

Summary of Total Non-Recurrent Reserves Remaining Available in 2021/22	£k
Anticipated slippage on NR Allocated reserves	450
Emergency Reserve	522
Remaining Balance	**972**

In addition to the recurrent and emergency reserves, the Executive Management Board (EMB) agreed to make available £1,545k of non-recurrent funding for investment during 2021/22 from the release of accountancy gains. The current spend to December '21 is £596k (includes £90k of new commitments). The anticipated slippage against the £1.5m is currently expected to be circa £450k during 2021/22 due to delays in implementation of several investments which are mainly fixed term posts, although this balance is under constant review with potential further slippage. EMB has agreed that non-recurrent funding of £450k will be re-provided in 2022/23 to enable all the approved investments to be fully implemented, provided it can be demonstrated that recruitment of posts or procurement had commenced by the end of December '21, which is currently being reviewed.

It is important that the Executive Team consider what plans can be implemented in 2021-22 to utilise this available non-recurrent funding to support the significant service challenges in 2022-23.

7. End of Year Forecast / Risk Assessment

The Trust is currently reporting a year end breakeven position against its revenue budget, however there are a few risks which are being managed and closely monitored at Divisional level.

8. 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 @ M9 £000s	Full Year Actual Spend £000s	Year End Variance £000s
All Wales Capital Programme						
VCC - Transforming Cancer Services	3,711	2,232	0	1,479	3,711	0
VCC Radiotherapy Procurement Solution	312	198	0	114	312	0
IT - WPAS (CANISC replacement phase 2)	993	713	0	280	993	0
Fire Safety	600	148	89	363	600	0
National Programmes - Decarbonisation	109	30	8	71	109	0
National Programmes - Imaging	1,020	0	920	100	1,020	0
Covid Recovery	675	5	73	597	675	0
DHCW - NDR Funding	350	0	350	0	350	0
DHCW - VCC Careflow	60	0	0	60	60	0
HTW Capital	5	5	0	0	5	0
Linc ETR Funding	25	0	0	25	25	0
Additional DPIF Capital Allocations	41	0	0	41	41	0
End of Year Capital						
Multileaf Collimator (MLC) Motor Replacements	120	0	0	120	120	0
(CDR) function within the WBS.	83	0	0	83	83	0
Patient Specific Quality Assurance (PSQA) Phantom	100	0	0	100	100	0
Digital IT Client tech refresh	450	0	474	(24)	450	0
Digital Server Infrastructure Tech refresh	85	0	0	85	85	0
Total All Wales Capital Programme	8,739	3,330	1,914	3,495	8,739	0
Discretionary Capital	1,911	339	581	992	1,911	0
Total	10,650	3,669	2,494	4,486	10,650	0

The approved 2021/22 Capital Expenditure Limit (CEL) as at December 2021 was £10,650k. This includes All Wales Capital funding of £8,739k, and discretionary funding of £1,911k.

The Trust previously received confirmation of £675k funding from WG towards Capital related Covid recovery. This will be used to support additional donor chairs in WBS, urgent ventilation work, and increased capacity in VCC such as improvements to the outpatient area and Bobarth building which now forms part of the CEL.

In addition, following a communication from WG of the availability of additional end of year capital monies, the Trust was successful in receiving £838k of funding against the £1,396k of schemes it submitted. The request was based on prioritised divisional bids as provided for in the table above.

Performance to date

The actual cumulative expenditure to December 2021 on the All-Wales Capital Programme schemes was £3,330k, this is broken down between spend on the TCS Programme £2,232k, Integrated Radiotherapy Procurement Solution £198k, IT WPAS £713k, Fire Safety £148k, Decarbonisation £30k, Covid recovery £5k and HTW £5k.

The Trust Discretionary funding has now been allocated for 2021-22 and was approved at EMB on the 2nd August. The contingency that was being held has now been released, resulting in all funds being fully committed to schemes.

Spend to date on Discretionary Capital is currently £339k with a further £581k committed.

Due to supply chain issues we are starting to see an emergence of slippage against some of the discretionary schemes that were previously approved. This was discussed at the internal Capital Planning Meeting on the 18th October where other organisational priorities were discussed and agreed to replace the schemes that were would not be fully delivered during 2021/22.

The capital programme is significantly underspend for the period year to date which is a combination of procurement capacity constraints and impact of pandemic on supplier lead times.

Action for Execs to Execs

Expenditure commitment proposal to Board >£100k for Gleeds - (property & construction consultants) to provide additional capacity to progress tenders

Year-end Forecast Spend

The year-end forecast outturn is currently expected to be managed to a breakeven position, with any further slippage being managed through the Capital Planning and Delivery Group although as highlighted above there is a risk to delivery of some of the Estates schemes if Gleeds cannot be appointed in the short term.

Major Schemes in Development

The Trust has also been in discussions with WG over other project funding which it is seeking to secure from the All-Wales Capital programme.

Other Major Schemes in development that will be considered during 2022/2 and beyond in conjunction with WG include:

	Scheme	Scheme Total	Stage (i.e. OBC development, FBC development, scoping etc.)	22/23 £'000	23/24 £'000	24/25 £'000	25/26 £'000
1	VCC Outpatients	2,490	Feasibility & design study currently being undertaken	800			
2	WBS HQ	22,000	PBD approved by WG OBC under development	1,000	11,000	10,000	
3	Ventilation	2,490	BJC to be submitted	2,490			
4	IRS	37,929	OBC & PBC approved by WG, FBC under development	4,711	8,234	14,254	10,730
5	Plasma Fractionation	TBC	Feasibility study to be developed				

9. BALANCE SHEET (Including Hosted Organisations)

The Balance Sheet in NHS Financial Statements is known as the Statement of Financial Position (SoFP). It provides a snapshot of the Trust's financial position including the hosted divisions at a point in time.

The statement shows the Trust's assets and liabilities. As part of the Trust SFIs there is a mandatory requirement to report movement in working capital.

The Trust has now formally removed DHCW from the Trust SoFP, following the transfer of assets and liabilities that took place on the 31 December.

Non-Current Assets

The balance on PPE and intangible assets will move up and down depended on the agreed purchases from the Trust Capital programme (including hosted), offset against the depreciation charges on owned assets.

Trade debtors and receivables will move up and down each month depending on timing of when invoices are raised and consequently paid by organisations.

Current Assets

NWSSP continues to hold high levels of stock in response to Covid which will be passed out to the HB's. In addition, the Trust is still holding £7,000k of contingency stock from 2018-19 which WG asked both NWSSP and WBS to purchase in preparation for Brexit.

The Trust was intending to unwind the contingency stock during 2021-22 and repay the £7,000k cash provided by WG to purchase the Brexit stock, however given the uncertain situation around supply chains which has arisen due to Covid the Trust is currently continuing to hold this stock.

The balance on receivables will move up and down each month depending on the timing of when invoices are raised, and when the cash is physically received from debtors. The Trust actively chases its debts to ensure prompt payment.

Due to the high levels of purchases relating to Covid within NWSSP, the cash levels are fluctuating significantly on a daily / weekly basis. Cash levels are being continually monitored using a cash flow forecast to maintain appropriate levels.

Current Liabilities & Non-Current Liabilities

Liabilities will move up and down each month depending on timing of when commitments are made, and invoices are received and paid.

Taxpayers Equity

The movement on PDC and revaluation reserves relates to the transfer of Capital assets relating to DHCW.

	Opening Balance Beginning of Apr 20	Closing Balance End of Dec-21	Movement from 1st April Dec-21	Forecast Closing Balance End of Mar 21
Non-Current Assets	**£'000**	**£'000**	**£'000**	**£'000**
Property, plant and equipment	136,558	125,111	(11,447)	124,700
Intangible assets	20,821	5,408	(15,413)	5,481
Trade and other receivables	817,142	816,721	(421)	1,100,574
Other financial assets	0	0	0	0
Non-Current Assets sub total	974,521	947,240	(27,281)	1,230,755
Current Assets				
Inventories	95,564	81,580	(13,984)	85,187
Trade and other receivables	548,836	424,302	(124,534)	161,637
Other financial assets	0	0	0	0
Cash and cash equivalents	43,263	35,301	(7,962)	18,518
Non-current assets classified as held for sale	0	0	0	0
Current Assets sub total	687,663	541,183	(146,480)	265,342
TOTAL ASSETS	1,662,184	1,488,423	(173,761)	1,496,097
Current Liabilities				
Trade and other payables	(353,136)	(205,083)	148,053	(212,743)
Borrowings	(8)	0	8	0
Other financial liabilities	0	0	0	0
Provisions	(316,959)	(316,353)	606	(316,374)
Current Liabilities sub total	(670,103)	(521,436)	148,667	(529,117)
NET ASSETS LESS CURRENT LIABILITIES	992,081	966,987	(25,094)	966,980
Non-Current Liabilities				
Trade and other payables	(7,301)	(7,000)	301	(7,000)
Borrowings	0	0	0	0
Other financial liabilities	0	0	0	0
Provisions	(818,782)	(818,782)	0	(818,782)
Non-Current Liabilities sub total	(826,083)	(825,782)	301	(825,782)
TOTAL ASSETS EMPLOYED	165,998	141,205	(24,793)	141,198
FINANCED BY:				
Taxpayers' Equity				
General Fund	0	0	0	0
Revaluation reserve	27,978	30,963	2,985	31,052
PDC	122,468	94,597	(27,871)	94,597
Retained earnings	15,552	15,645	93	15,549
Other reserve	0	0	0	0
Total Taxpayers' Equity	165,998	141,205	(24,793)	141,198

10. CASH FLOW (Includes Hosted Organisations)

The cash-flow forecast is important to enable the Trust to plan for sufficient cash availability throughout the financial year to pay its debts, such as payroll, services provided by other health bodies and private companies. The cash-flow forecast ensures that the Trust has an early understanding of any cash-flow difficulties.

As part of the Brexit emergency planning an additional £5m of stock had been purchased by NWSSP and an additional £2m of commercial blood products were purchased by WBS, to provide resilience for NHS Wales due to the uncertainty around supply chain reliability because of Brexit.

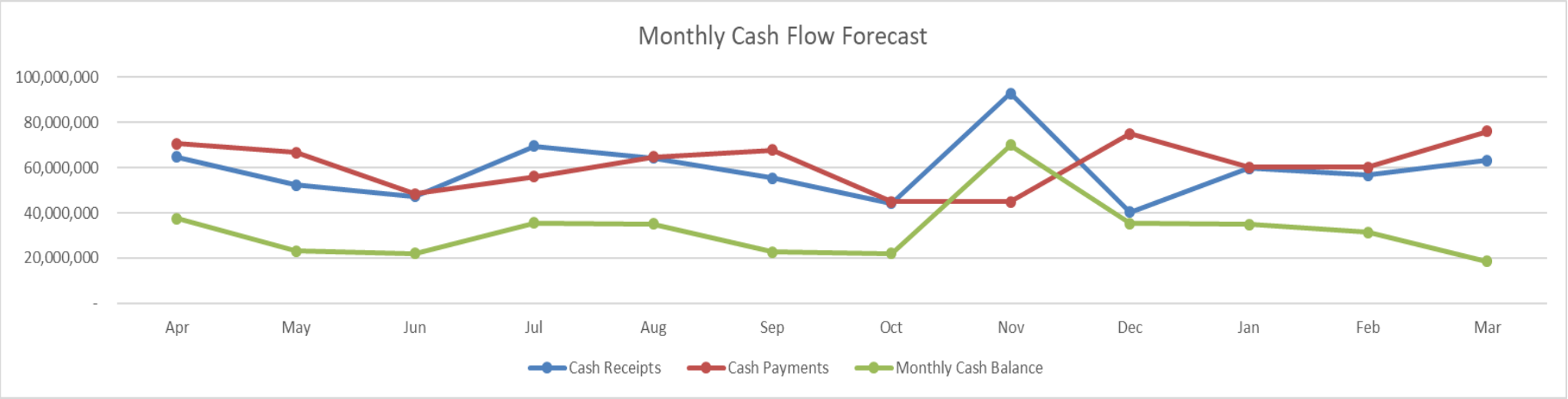
To aid the Trust's cash flow while the additional stock was being held for Brexit, Welsh Government provided the Trust with additional cash of £7m during 2019/20. WBS did intend to run down the commercial blood stock, however given the uncertain situation with Covid and potential impact on supply chains the Trust will continue to hold this stock and assess the situation throughout the year. 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 not take place now until at least March but may be carried forward into 2022/23

Due to the high levels of purchases relating to Covid within NWSSP, the cash levels over the past year or so have been significantly higher than usual and may continue to be above average with ongoing need for Covid related purchases. Due to this, the cash balance can fluctuate significantly on a daily / weekly basis.

WG have asked the Trust to manage the £5.6m transfer of cash into the Escrow holding account for the nVCC programme which will need to take place before the 31st March. This will be done on the basis that the Trust can draw down the funds from the 1st April which ensures 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	23,348	22,492	30,672	34,078	32,225	28,886	33,252	33,603	30,431	38,620	36,928	34,774	379,309
2	WG Income	33,807	26,132	11,582	30,431	27,512	21,398	6,388	56,520	693	18,800	17,625	17,332	268,220
3	Short Term Loans													0
4	PDC												8,763	8,763
5	Interest Receivable													0
6	Sale of Assets													0
7	Other	7,643	3,682	4,973	5,006	4,613	5,004	4,673	2,719	9,139	2,243	2,182	2,300	54,177
8	**TOTAL RECEIPTS**	**64,797**	**52,306**	**47,227**	**69,515**	**64,350**	**55,288**	**44,314**	**92,842**	**40,263**	**59,663**	**56,735**	**63,169**	**710,469**
	PAYMENTS													
9	Salaries and Wages	15,189	22,734	22,015	20,181	19,284	24,383	25,582	24,544	25,089	25,546	25,571	26,868	276,986
10	Non pay items	52,989	43,749	25,742	35,377	45,158	42,830	18,755	19,768	49,260	31,625	31,350	31,246	427,850
11	Short Term Loan Repayment												7,000	7,000
12	PDC Repayment													0
14	Capital Payment	2,375	277	540	453	225	623	631	499	612	2,993	3,220	10,930	23,378
15	Other items													0
16	**TOTAL PAYMENTS**	**70,552**	**66,760**	**48,297**	**56,011**	**64,667**	**67,836**	**44,968**	**44,811**	**74,961**	**60,164**	**60,141**	**76,044**	**735,213**
17	Net cash inflow/outflow	(5,755)	(14,454)	(1,070)	13,504	(317)	(12,548)	(655)	48,031	(34,698)	(501)	(3,406)	(12,875)	
18	Balance b/f	43,263	37,508	23,054	21,984	35,488	35,171	22,623	21,968	69,999	35,301	34,799	31,393	
19	Balance c/f	37,508	23,054	21,984	35,488	35,171	22,623	21,968	69,999	35,301	34,799	31,393	18,518	



DIVISIONAL ANALYSIS

(Figures in parenthesis signify an adverse variance against plan)

Core Trust

Velindre Trust Core Divisional Finance Performance

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Variance £000
VCC	27,022	27,022	0	36,334	36,334	0
RD&I	29	29	0	(365)	(365)	0
WBS	15,095	15,095	0	20,652	20,652	0
Sub-Total Divisions	**42,147**	**42,147**	**0**	**56,621**	**56,621**	**0**
Corporate Services Directorates	6,804	6,799	5	8,891	8,891	(0)
Delegated Budget Position	**48,951**	**48,946**	**5**	**65,512**	**65,512**	**0**
TCS	486	486	0	655	655	0
Health Technology Wales	(15)	(15)	0	28	28	0
Trust Position	**49,422**	**49,417**	**5**	**66,195**	**66,195**	**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	**45,698**	**45,947**	**249**	**62,613**	**62,943**	**330**
Expenditure						
Staff	30,271	30,223	48	40,560	40,660	**(100)**
Non Staff	42,449	42,746	(297)	58,386	58,616	**(230)**
Sub Total	**72,720**	**72,969**	**(249)**	**98,946**	**99,276**	**(330)**
Total	**27,022**	**27,022**	0	**36,334**	**36,334**	**0**

VCC Key Issues:

The reported financial position for the Velindre Cancer Centre as at the end of December 2021 was **breakeven**, and an expected outturn position of **breakeven**.

Income at Month 9 represents an overachievement of **£249k**. This is largely from an increase in VAT savings from providing additional SACT Homecare, a small over achievement against private patient income due to drug performance which is above general private patient performance, additional funding for senior medical non-surgical workforce, increased income against the Radiation protection SLA, and HSST income within Physics Management, along with a number of smaller areas representing income growth. This is offsetting the divisional savings target and loss of income from closure of gift shop and volunteer's office in response to Covid.

VCC have reported an underspend of **£48k** against staff for December. The division continues to have a high level of vacancies, sickness, and maternity leave predominantly in Nurse Management, Inpatients, Pharmacy and Radiotherapy which is above the divisional vacancy factor target and is offsetting the cost of agency (£969k to end of November) although £502k is directly related to Covid. Inpatients underspend relates to the holding off on recruitment due to reduced bed capacity from social distancing measures. Medical costs have increased due to additional temporary staff recruited at risk to ensure that all Jnr Dr rotation placements are filled, and to provide additional resilience against pressured consultants. In addition, enhanced out of hours service, for advanced life support which will be nursing led is currently being covered by Jnr Dr's.

Non-Staff Expenditure at Month 9 was **£(297)k** overspent. There are underspends on general drugs from reduced activity and temporary closure of outreach clinics, Nuclear medicine warranty savings, along with cost avoidance generated from closure of gift shop and volunteer's office. This is in part offsetting the one off spend on uniforms and consumables in Pharmacy, One Wales cost pressure, and cost from NWSSP for sponsorship of overseas students, along with reporting fees and oncotype in Senior Medical. The increase in price for utilities is starting to have an impact and is expected to be significant next year, which is being factored into the Trust IMTP, and will be managed through the discretionary uplift in funding.

WBS

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	**16,589**	**15,987**	**(601)**	**21,323**	**20,599**	**(723)**
Expenditure						
Staff	12,689	12,540	150	17,037	16,797	**240**
Non Staff	18,995	18,543	452	24,937	24,454	**483**
Sub Total	**31,684**	**31,083**	**601**	**41,974**	**41,251**	**723**
Total	**15,095**	**15,095**	**0**	**20,652**	**20,652**	**(0)**

WBS Key Issues:

The reported financial position for the Welsh Blood Service at the end of December 2021 was **breakeven** with an outturn forecast position of **breakeven** expected.

Income underachievement to date is **£(601)k**, where activity is lower than planned on Bone Marrow and Plasma Sales, due to freezer breakdown and Covid suppressed activity. Plasma sales recovery to business-as-usual levels following hire of freezers, although delayed further from original expected return date of November 21 with partial recovery during December. Transitional operating sites for Bone Marrow and increasingly curtailed procedures is resulting in income loss above Covid support, with assessments as to scale and sustainability ongoing.

Staff reported a year-to-date underspend of **£150k** to December, which is above the division's vacancy factor target. Vacancies remain high albeit reducing at 31 as at end of month 9. Plasma fractionation staffing costs to be supported by division during 2021/22. Component development staffing costs incurred as a divisional cost pressure with no WHSSC funding secured.

Trust approval to appoint a 4th collection team in response to NHS Wales surge capacity and meeting blood demand commenced on 6th September 2021 and continues. Confirmation received that these costs will be met by WG in 2021-22.

Potential risks due to implications of cessation of CVP Funding where WG initial funding ended 31st March 2021, PYE funding agreed for 21-22, tenure of RN posts significant as appointed on permanent contracts. SMT approval to partially mitigate the financial risk by transferring CVP permanent posts into team vacancies (where available).

Non-Staff underspend of **£452k** is largely due to reduced costs from suppressed activity, underspend on Collections Services, Laboratory Services, WTAIL, and General Services such as building maintenance and MAK business systems, which is offsetting the divisions savings target.

Corporate

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected £000
Income	**1,028**	**1,053**	**26**	**1,234**	**1,239**	**5**
Expenditure						
Staff	7,224	7,073	150	9,496	9,242	**254**
Non Staff	608	784	(176)	630	889	**(260)**
Sub Total	**7,832**	**7,857**	**(26)**	**10,125**	**10,131**	**(5)**
Total	**6,804**	**6,804**	**(0)**	**8,891**	**8,892**	**(0)**

Corporate Key Issues:

The reported financial position for the Corporate Services division at the end of December 2021 was **breakeven**. The Corporate division is currently expecting to achieve an outturn position of **breakeven**.

Forecast Income underachievement is due to vacancies within fundraising including a period for the Charity Director where the costs were not recharged to the Charity, which is offset by a forecast underspend against the staff in post. Year to date income overachievement relates to income received upfront in IM&T but is expected to be utilised later in the year.

Staff is forecasting a large underspend due to vacancies being held, including the Chief Digital Officer and the Deputy Director of finance which will offset the CIP target and other pressures within non-staff.

The forecast Non pay overspend circa **£(260)k** is due to the divisional savings target £(158)k which is expected to be met in year via staff vacancies. Other main cost pressure relates to the estates budget in VCC which is under immense strain due to the increased repair and maintenance costs of the hospital, recently added costs for statutory compliance and increased material costs, along with general inflation. In addition, several departments have little or no non pay budget to allow for unforeseen and unexpected spend.

RD&I

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	**2,192**	**2,127**	**(65)**	**3,299**	**3,150**	**(149)**
Expenditure						
Staff	2,035	1,971	64	2,653	2,538	**115**
Non Staff	186	185	1	281	247	**34**
Sub Total	**2,221**	**2,156**	**65**	**2,934**	**2,785**	**0**
Total	**29**	**29**	**0**	**(365)**	**(365)**	**0**

RD&I Key Issues

The reported financial position for the RD&I Division at the end of December 2021 was **breakeven** with a current forecast outturn position of **breakeven**.

Currently no issues to report.

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	390	390	0	527	527	**0**
Non Staff	96	96	0	128	128	**0**
Sub Total	**486**	**486**	**0**	**655**	**655**	**0**
Total	**486**	**486**	**0**	**655**	**655**	**0**

TCS Key Issues

The reported financial position for the TCS Programme at the end of December 2021 is a **breakeven** with a forecasted outturn position of **breakeven.**

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	**1,214**	**1,214**	**0**	**1,625**	**1,625**	**0**
Expenditure						
Staff	1,058	1,057	0	1,433	1,433	**0**
Non Staff	142	142	0	220	220	**0**
Sub Total	**1,199**	**1,199**	**0**	**1,653**	**1,653**	**0**
Total	**(15)**	**(15)**	**0**	**0**	**28**	**0**

HTW Key Issues

The reported financial position for Health Technology Wales at the end of December 2021 was **breakeven,** with a forecasted outturn position of **breakeven** on the basis that any potential slippage which is starting to emerge will be handed back to WG**.**

TCS PROGRAMME DELIVERY BOARD

TCS PROGRAMME FINANCIAL REPORT FOR 2021-22 DECEMBER 2021

DATE OF MEETING	17th January 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Mark Ash, Assistant Project Director
PRESENTED BY	Mark Ash, Assistant Project Director
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
N/A		Choose an item.

ACRONYMS	
TCS	Transforming Cancer Services
Trust	Velindre University NHS Trust
PBC	Project Business Case
PMO	Programme Management Office
EW	nVCC Enabling Works
nVCC	New Velindre Cancer Centre
WG	Welsh Government
IRS	Integrated Radiotherapy Solution
SDT	Service Delivery and Transformation

1. PURPOSE

1.1 The purpose of this report is to provide a financial update to the TCS Programme Delivery Board for the financial year 2021-22, outlining spend to date against budget as at Month 09.

2. BACKGROUND

2.1 In January 2015 the Minister for Health and Social Services approved the initial version of the Strategic Outline Programme 'Transforming Cancer Services in South East Wales'. Following the completion of the Key Stage Review in June/July 2015, approval was received from the Minister to proceed to the next stage of the Programme.

2.2 As at March 2021, the Cabinet Secretary for Health, Well-being and Sport, had approved capital and revenue funding for the TCS Programme and associated Projects of £20.710m and £1.678m respectively.

2.3 Included in this approval was funding for the IRS Procurement Project (Project 3a). The PBC for this project was endorsed by WG in 2019-20, providing capital funding of £1.110m from July 2019 to December 2022. The provision was £0.250m in 2019-20, £0.548m in 2021-22, and £0.312m in 2021-22.

2.4 In addition to WG funding, NHS Commissioners agreed in December 2018 to provide annual revenue funding towards the TCS Programme. £0.400m was provided in the initial year of 2018-19, with £0.420m annually thereafter.

2.5 Further revenue funding was provided by Trust in 2019-20 and 2020-21 from its own baseline revenue budget. Funding of £0.060m and £0.030m respectively was provided for nVCC Project Delivery (previously provided by WG until March 2019). Another £0.039m (2019-20) and £0.166m (2020-21) was provided to cover the costs of staff secondment from Velindre Cancer Centre.

2.6 The total funding and expenditure for the TCS Programme and associated Projects by the end of March 2021 was £23.923m: £20.710m Capital, £3.213m Revenue.

3. FUNDING

3.1 Funding provision for the financial year 2021-22 is outlined below.

3.2 In August 2021, the Trust Board approved that the nVCC Project provide interim funding of **c£0.350m** to the EW Project. The funding is to support the work packages associated with tree and vegetation clearance (c£0.250m) and site management and security (c£100k). The EW Project will secure this funding from the approval of its FBC in January 2022. The Project(s) financial plans will be updated in November 2021.

3.3 To date no revenue funding has been provided by WG. The Trust has provided revenue funding of **£0.084m**.

Description	Funding	
	Capital	Revenue
Programme Management Office There is no capital funding requirement for the PMO at present Allocation of £0.240m from £0.420m funding provided from Commissioners for 2021-22 to cover direct clinical/management support and Programme Management was provided in April 2021 Allocation from WG 2021-22 revenue pay award funding was provided in September 2021	**£ nil**	**£0.246m** £0.240m £0.006m
Project 1 – Enabling Works for nVCC Capital funding from WG was provided on 24 March 2021	**£0.250m** £0.250m	**£ nil**
Project 2 – New Velindre Cancer Centre Capital funding from WG was provided on 24 March 2021 The Trust provided revenue funding in September 2021 for Project Delivery The Trust has provided revenue funding for the Judicial Review in between August 2021 and December 2021	**£3.460m** £3.460m	**£0.109m** £0.026m £0.083m
Project 3a – Radiotherapy Procurement Solution Final 9 months of a 28 month project, running from 1st August 2019 to 31st December 2021, with a funding allocation of £0.312m for 2021-22 from an overall funding allocation of £1.110m, provided in April 2021 Additional funding provided by the Trust for the Project's increased legal and staff costs November 2021.	**£0.576m** £0.312m £0.264m	**£ nil**
Project 4 – Radiotherapy Satellite Centre The project is led and funded by the hosting organisation, Aneurin Bevan University Health Board; no funding requirement is expected from the Trust for 2021-22	**£ nil**	**£ nil**
Project 5 – SACT and Outreach Funding has been requested for this project however none has been provided to date	**£ nil**	**£ nil**

Description	Funding	
	Capital	Revenue
Project 6 – Service Delivery, Transformation and Transition	**£ nil**	**£0.313m**
Allocation of £0.180m from £0.420m funding provided from Commissioners for 2021-22 to cover direct clinical/management support and Programme Management was provided in April 2021		£0.180m
Funding provided from the Trust's core revenue budget towards the costs of the Project Director post and the Project Manager post in April 2021		£0.116m
Allocation from WG 2021-22 revenue pay award funding was provided in September 2021		£0.009m
Additional funding provided from the Trust's core revenue budget towards the cost of the Project Manager post in November 2021		£0.008m
Project 7 – VCC Decommissioning No funding requested or provided for this project to date	**£ nil**	**£ nil**
Total funding provided to date	**£4.286m**	**£0.668m**
	£4.954m	

4. FINANCIAL SUMMARY AS AT 31ST DECEMBER 2021

4.1 The summary financial position for the TCS Programme for the year 2021-22 as at 31st December 2021 is outlined below:

- **CAPITAL** spend of **£2.433m** with a forecast outturn of **£4.282m;** and
- **REVENUE** spend is **£0.504m** with a forecast outturn of **£0.668m**

TCS Programme Budget & Spend 2021-22

CAPITAL	Cumulative to Date			Financial Year		
	Budget to Dec-21	Spend to Dec-21	Variance to Dec-21	Annual Budget	Annual Forecast	Annual Variance
	£	£	£	£	£	£
PAY						
Project Leadership	141,895	138,990	2,905	193,000	190,211	2,789
Project 1 - Enabling Works	100,000	161,062	-61,062	100,000	216,012	-116,012
Project 2 - New Velindre Cancer Centre	585,305	524,393	60,913	1,008,500	819,910	188,590
Project 3a - Radiotherapy Procurement Solution	261,642	261,642	0	362,675	362,675	0
Capital Pay Total	**1,088,843**	**1,086,087**	**2,756**	**1,664,175**	**1,588,808**	**75,367**
NON-PAY						
nVCC Project Delivery	37,170	41,519	-4,349	78,500	78,500	0
Project 1 - Enabling Works	141,250	435,558	-294,308	150,000	435,558	-285,558
Project 2 - New Velindre Cancer Centre	1,023,590	726,196	297,394	2,180,000	1,966,196	213,804
Project 3a - Radiotherapy Procurement Solution	140,605	143,301	-2,696	213,165	213,165	0
Capital Non-Pay Total	**1,342,615**	**1,346,573**	**-3,958**	**2,621,665**	**2,693,419**	**-71,754**
CAPITAL TOTAL	**2,431,458**	**2,432,660**	**-1,202**	**4,285,840**	**4,282,227**	**3,613**

REVENUE	Cumulative to Date			Financial Year		
	Budget to Dec-21	Spend to Dec-21	Variance to Dec-21	Annual Budget	Annual Forecast	Annual Variance
	£	£	£	£	£	£
PAY						
Programme Management Office	155,901	152,892	3,009	224,833	220,833	4,000
Project 6 - Service Change Team	234,475	240,680	-6,205	312,633	316,290	-3,657
Revenue Pay total	**390,376**	**393,571**	**-3,196**	**537,466**	**537,123**	**343**
NON-PAY						
nVCC Project Delivery	21,366	18,386	2,981	26,000	26,000	0
nVCC Judicial Review	83,387	83,387	0	83,387	83,387	0
Programme Management Office	4,282	8,263	-3,981	21,534	21,534	0
Project 6 - Service Change Team	0	200	-200	0	266	-266
Revenue Non-Pay Total	**109,035**	**110,235**	**-1,200**	**130,920**	**131,187**	**-266**
REVENUE TOTAL	**499,411**	**503,807**	**-4,396**	**668,387**	**668,310**	**77**

5. FINANCIAL POSITION FOR TCS PROGRAMME AND ASSOCIATED PROJECTS AS AT 31ST DECEMBER 2021

CAPITAL SPEND

Project 1 – Enabling Works

5.1 There is a cumulative capital spend to date of **£0.597m** against a budget of **£0.241m**, with a forecast spend for the year of **£0.652m** against a budget of **£0.250m**.

Work package	Spend to 30th November 2021 £m	Forecast Annual Spend £m
Pay	**£0.161**	**£0.216**
Third Party Undertakings	£nil	£nil
Technical Advisers	£0.139	£0.139
Works	£0.246	£0.246
Legal Advice	£0.112	£0.112
Enabling Works Reserves	-£0.061	-£0.061
Non-pay	**£0.436**	**£0.436**
Total	**£0.597**	**£0.652**

5.2 The potential overspend of £0.402m within the Project has been mitigated by the use of underspends from the nVCC Projects.

Project 2 – nVCC

5.3 There is a cumulative capital spend to date of **£1.431m** against a budget of **£1.788m**. The forecast spend for the years is **£3.055m** against a budget of **£3.460m**.

Work package	Spend to 30th November 2021 £m	Forecast Annual Spend £m
Pay	**£0.663**	**£1.010**
Project Delivery costs	£0.042	£0.079
Competitive Dialogue – PQQ & Dialogue	£0.703	£1.317
Legal Advice	£0.012	£0.053
Planning	£0.015	£0.075
nVCC Reserves	-£0.004	£0.521
Non-pay	**£0.768**	**£2.045**
Total	**£1.431**	**£3.055**

5.4 The forecast underspend will be used to cover the Enabling Works forecast overspend for the year.

Project 3a – Integrated Radiotherapy Procurement Solution

5.5 There is a cumulative capital spend to date of **£0.405m** for the IRS Project against a budget of **£0.402m**. The Project is currently forecasting a spend of **£0.576m** against a budget of **£0.576m**.

Work package	Spend to 30th November 2021 £m	Forecast Annual Spend £m
Pay	**£0.262**	**£0.363**
Legal Advisors	£0.133	£0.175
Financial Advisors	£nil	£nil
Business Case Advisors	£0.008	£0.021
Procurement Advisors	£nil	£nil
IRS Reserves	£0.002	£0.016
Non-pay	**£0.143**	**£0.213**
Total	**£0.405**	**£0.576**

REVENUE SPEND

Programme Management Office

5.6 The PMO spend to date is **£0.161m** (£0.153m pay, £0.008m non-pay) against a budget of **£0.160m**. The Project is forecasting a spend of **£0.242m** (£0.221m pay, £0.022m non-pay) in the financial year 2021-22 against a budget of **£0.246m**. The forecast underspend of £4k will be used to cover the overspend forecast by the Service Change Project.

Projects 1 and 2 Delivery Costs

5.7 There is a revenue project delivery cost to date for the nVCC and Enabling Works Projects of **£0.018m** against a budget of **£0.021m,** with a budget and expected spend for the year of **£0.026m**. This spend relates to costs associated with office costs and project support, such as audit, training and Competitive Dialogue support.

nVCC Judicial Review

5.8 There is a revenue spend to date of **£0.083m** against a budget of **£0.070m** for the legal advice to deliver the requirements of the judicial review process as the Trust is an interested party. This is also the current forecast spend for the year.

5.9 Further costs for this work may be incurred, resulting an increase in the current overspend of £0.014m. Mitigating actions regarding the current in year and forecast underspend are being considered by the nVCC Project Team and Corporate Finance Team.

Project 6 – Service Delivery, Transformation and Transition (Service Change)

5.10 Service Change spend to date is **£0.241m** against a budget of **£0.34m,** made up of pay costs. The Project is currently forecasting a spend of **£0.317m** for the year against an increased budget of **£0.313m**. The forecast overspend of £4k will be covered by the underspend forecast by the Programme Management Office.

6. Financial Risks & Issues

6.1 There are no current financial risks or issues for the TCS Programme.

7. CONSIDERATIONS FOR BOARD

7.1 This report is included as an appendix to the Trust Board Finance Report.

8. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Staff and Resources
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	See above.

9. RECOMMENDATION

The TCS Programme Board are asked to **NOTE** the financial position for the TCS Programme and Associated Projects for 2021-22 as at

Quality, Safety and Performance Committee

DECEMBER PMF COVER PAPER

DATE OF MEETING	17/02/2022

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 Ass Director WOD
PRESENTED BY	Cath O'Brien, Interim Chief Operating Officer Sarah Morley, Director WOD
EXECUTIVE SPONSOR APPROVED	Cath O'Brien, Interim Chief Operating Officer

REPORT PURPOSE	FOR DISCUSSION / REVIEW

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
WBS SMT MEETING	12.01.22	Reviewed and Noted
VCC SLT MEETING	24.01.22	Reviewed and Noted
WBS PERFORMANCE REVIEW	19.01.22	Reviewed and Noted
VCC PERFORMANCE REVIEW	21.01.22	Reviewed and Noted
EXECUTIVE MANAGEMENT BOARD	07.02.22	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
RCR	Royal College of Radiologists
JCCO	Joint Council for Clinical Oncology
PADR	Performance Appraisal and Development Review
KPIs	Key Performance Indicators
SACT	Systemic Anti-Cancer Therapy
WTE	Whole Time Equivalent (staff)
EMB	Executive Management Board
COSC	Clinical Oncology Sub-Committee
IPC	Infection Prevention Control
SPC	Statistical Process Control

1. SITUATION/BACKGROUND

1.1 The attached Trust performance reports provide an update to the Quality Safety & Performance Committee with respect to Trust-wide performance against key performance metrics through to the end of December 2021 for the Velindre Cancer Centre, the Welsh Blood Service and for VUNHST Corporate Services respectively.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The reports set-out performance at Velindre Cancer Centre **(*appendix 1*),** the Welsh Blood Service **(*appendix 2*)** and the Workforce **(appendix 3).** Each report is prefaced by an '*at a glance*' section which is intended to draw attention to key areas of performance. A number of areas from the reports are highlighted below.

2.2 Velindre Cancer Centre:

Covid continues to impact our service planning and delivery. In December an incident command structure was re-established to effectively manage service delivery. Covid related absences, capacity reductions due to IPC measures and increasing patient numbers are all having an impact on our service provision and waiting times. We are expecting the situation to remain challenging in radiotherapy during the next couple of months. We continue to respond in providing excellent care for our patients against a significant backdrop of restrictions and challenges. As a result of the 4th wave of Covid, a cohort of 42 prostate patients received alternative management in line with agreed national clinical prioritisation guidelines. We have now reverted to the originally planned radiotherapy treatment pathway

Three current targets were reporting red in December's performance report. Two of these were radiotherapy JCCO targets; Patients Beginning Radical Radiotherapy Within 28-Days and patients beginning palliative radiotherapy within 14 days target.

The service reintroduced the application of the All Wales Radiotherapy Treatment Prioritisation (10 April 2020), as Omicron began to spread and impact staff capacity. The prioritisation of patients has been consistent with this guidance.

The reduced overall capacity and active prioritisation of patients consistent with the guidance has affected the timeliness of patients beginning palliative radiotherapy within 14 days target, because category 1 patients were prioritised.

The reduction in the number of patients beginning treatment within 28 days was affected by the loss of routine capacity during the additional bank holidays. Service capacity for bank holidays is restricted to high priority Category 1 patients, and emergency patients only.

Since April 2021, we have been requested by the Welsh Government to report against the COSC (Clinical Oncology Sub Committee) targets. These targets align more closely with the direction of travel for reporting against the Single Cancer Pathway. In addition to the JCCO measures, which we are also reporting on COSC measures for Radiotherapy are red and not yet achieved, as we continue to work towards these. These measures are still to be formally mandated by Welsh Government and a data standard agreed so they remain indicative.

The COSC targets present different criteria and different time points of reporting (Scheduled, Urgent and Emergency- within 1 day). Work is underway to ensure that we can appropriately manage patients and report against these COSC measures. Our patient pathways are being redesigned to support health system wide adoption of the nationally agreed optimised clinical pathways, whilst development of the Digital Health and Care Record will in future support automation of reporting against these new definitions and criteria. Data capture and reporting remains a manual process and administrative overhead in the meantime.

The other target that reported red, was the Number of VCC Inpatient Falls, following 4 falls in December (see Inpatient Fall section). Having 4 falls is outside of the statistical process control parameters and so requires highlighting. The review process was undertaken for each and 4 were assessed as unavoidable. There are however actions from the review of these patients that form part of our continuous improvement.

Radiotherapy Waiting Times

The total number of referrals received in December 2021 (323) represented a marked fall relative to the previous month (404), but November was a high demand period. This is a typical seasonal fall which reflects changes in activity in Health Boards. The number of new referrals in December however, still exceed the average number received in any given month in 2020/21 (315)

IPC measures continue to restrict Linac capacity by 20%, resulting in growth in waiting times as referrals are returning to pre Covid levels, thereby exceeding available capacity. The number of patients breaching waiting time targets is xpected to continue over next 6 months as demand grows and is forecast to exceed capacity.

Whilst addressing the immediate capacity challenges from the 4th wave of COVID we are also planning a range of activities to maximise our capacity in the medium and long term. We are maximising the use of private sector capacity in the short term, and we are also reviewing utilisation of the Linac fleet in order to align tumour site groupings to maximise efficiency and flexibility of the use of each pair of machines.

We are maximising the use of hypofractionation to reduce Linac demand, although this does increase workload for the planning team.

We are working with each SST to develop a tailored capacity plan based on demand projections and treatment options eg Brachytherapy, molecular radiotherapy.

Weekly capacity planning meetings are in place reviewing patient prioritisation and resolving live operational issues.

These short term actions are being delivered alongside the major change programmes to introduce a new fleet of machines and the development of the satellite centre.

SACT Waiting Times

The waiting times target for both non-emergency and emergency SACT were met against a background of a 9% increase in demand above pre covid levels. This has been achieved in the most difficult circumstances against a background of significant staff shortages. This performance has been achieved by the hard work of the staff by improving the booking processes, increasing the utilisation of chair capacity and an additional day on the Tenovus mobile unit. In addition we are exploring capacity from third party suppliers to provide short term capacity support. We expect this to be available in May, if not before.

Outpatients

Data collection was paused during December due to operational pressures, this being a manual data capture. This will resume when we have capacity to do so.

Therapies

All Therapy waiting times targets were reporting green, apart from dietetics. 2 patients were not seen by a dietician until early in the third week of treatment and, as such, breached the 2-week urgent outpatient target. This was planned and no patient harm was reported.

Other areas

Falls –

During December, 4 falls were reported on first floor ward (1 was a repeat fall), a full investigation was undertaken by the VCC Falls Scrutiny Panel. Following investigation, all were deemed to have been unavoidable. All cases are reviewed for learning and improvement and there are actions for continuous improvement on how to make a balance of risk between pressure ulcer or normal mattresses for patients at risk of falling out of bed

Pressure Ulcers –

There was 1 Velindre acquired pressure ulcers reported in December 2021. The patient was a day-case/ambulatory care patient. The current Pressure Ulcer Prevention and Treatment Guidelines does not require a risk assessment and skin checks for day case/

ambulatory care patients. The patient was treated and referred to a district nurse for the following day. We are contacting other centres to benchmark heir ulcer prevention processes for day care, and explore learning opportunities for further service improvements we could adopt at VCC .

Healthcare Acquired Infections –
No healthcare acquired infections were reported.

SEPSIS bundle NEWS score

Nine patients met the criteria for administration of the sepsis treatment bundle in December 2021. All nine received all elements of the bundle within one hour. Seven of the patients subsequently received a diagnosis of sepsis or neutropenic sepsis.

Delayed Transfers of Care (DTOC's)

There were no delayed transfers of care in December.

Further detailed performance data is provided in Appendix 1

2.3 Welsh Blood Service

December's PMF again represents a strong performance by the service, despite pressure in December in meeting supply of donations against demand from hospitals.

A Blue Alert (Advisory notice to Health Boards) was put in place across Wales on December 16th, advising hospitals the supply of certain blood products was under strain due to the Omicron strain and was likely to be in place for a prolonged period. As such, the WBS worked closely with hospital Blood Bank managers to manage demand and stock holding.

There was particular pressure on O & A blood groups and platelets, due to higher donor cancellations and DNA's (Did Not Attend). The blue alert was monitored daily via the divisional silver command group. The Blue Alert was lifted across Wales on 18th Jan 2022 and the service maintained supply to patients of Wales without the need to request mutual aid from other UK blood services, which was a significant achievement. The implementation of the BLUE alert enabled stocks to be successfully managed in close collaboration with Health Boards over the holiday period despite challenges in collections.

All clinical demand for platelets was met averaging 215 units per week compared to 199 for November.

Complaints remain low and donor experience continues to perform well. Incident closure within 30 days are also on target and waste levels are also down. There were no external audits/inspections undertaken in the month and no Serious Adverse Events (SAE) reported to regulators during December.

All demand for red cells was met, and all stock groups continued to be maintained above 3 days. The service is continuing to experience high staff absences throughout the blood supply chain operation within both collection teams and laboratory staff.

Infection Prevention Control measures continue to limit donation centre capacity. The effort of the planning, engagement and contact centre team staff continues to be exemplary during this period in ensuring capacity is maximized and alternative venues can be sort at short notice.

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 177 in December compared to 210 the previous month.

Whilst conversion of 17-30 blood donors to bone marrow volunteers has remained consistent throughout Covid-19, the reduction in blood collection due to reduced demand for blood has reduced the number of new blood donors available to convert to bone marrow volunteers.

The Service is preparing a two-pronged approach: a) promoting swab kits and b) supporting the Service to increase the number of younger donors donating blood.

In Q4, the Service will increase the visibility of WBMDR using World Cancer Day (4 Feb) to promote swab kits and engage with Universities as they are slowly reintroduced to the blood collection model.

A website task and finish group was created in January to review and improve the WBMDR sign up process in for 17-30-year-olds.

2.3.2 Reference Serology

Turnaround times have not met target for December. Work continues to be prioritised based on clinical need, and all compatibility testing (>48% of referrals) is completed to the required time/date.

Whilst performance has further improved, the complexity of referrals, sickness absence continues to impact performance in December. WBS is audit this area and is focusing on the appropriateness of out of hours hospital referrals and is benchmarking with other UK blood services. Results of this audit are expected to be produced in February.

2.3.2 Quality

Incidents reported to Regulator/Licensing

There were no Serious Adverse Events (SAE) reported to regulators during December.

Incidents closed within 30 days

Although the target was achieved, the number of incidents not closed within the required timeframe has increased from 4 in the previous three-month rolling period to 10 in this reporting period. 6 of these incidents remain under investigation by the Clinical Governance team; these are low risk investigations which have been difficult to complete in the current challenging operational environment.

Part Bag Rates

The combined 'Part Bag' rate for all whole blood teams remains within the required tolerance level at 2.3%. Causes of Part Bag are various and include: needle placement, donor is unwell, donor request to stop. The situation is been closely monitored.

Failed Vene-puncture Rates

The combined Failed Vene-puncture (FVP) rate for all whole blood teams for December 2021 remains within the required tolerance at 1.9%. The overall combined rate trend is upward - with increases seen in the last two months. The Training Team are reviewing performance with individuals and providing training support to the individuals concerned.

Whole Blood Collection Productivity

Collection productivity for December is higher than November but continues to be below target. This target is unlikely to improve under Covid restrictions as the additional resources to operate in this environment are included in the productivity data.

Manufacturing Productivity

The December manufacturing performance figure is at 407.5 has improved from November. This target is unlikely to improve under Covid restrictions as the additional resources to operate in this environment are included in the productivity data

This metric is based on a pre Covid benchmark with other services and the service has identified a number of anomalies in this metric and it is currently being reviewed.

Number of Concerns Received

In December 2021, there were 6 concerns received out of approximately 6,500 donor contacts. Four were managed within timeline as 'Early Resolution whilst the two formal concerns were managed under 'Putting Things Right' (PTR) regulations and closed in December.

Donor Satisfaction

In December overall donor satisfaction continued to exceed target. There were 1,108 respondents, who had made a full donation and shared their donation experience

Further detailed performance data is provided in Appendix 2

3. WORKFORCE

3.1 PADR

PADR compliance has decreased and is reporting as 70.83% in December (November 21 reporting was 72.11%)

WBS compliance has increased to 83.06% from 82.19% in November. PADR compliance is discussed at all SMT meetings, reminder to organise outstanding PADRs. It was noted here that some areas sit under WBS from a cost code perspective (and therefore form part of these compliance figures) however, PADRs could be the responsibility of another area. Two areas are reporting figures over the 85% target.

VCC compliance rate has declined this month to 67.61% from 70.90% in November, despite a push to improve compliance. Four areas are reporting figures over the 85% target.

Delivery of PADR has been adversely affected by staff absence at all levels, whilst service capacity has been maximised for patients.

3.2 Sickness Absence

Sickness absence has seen a slight increase in monthly sickness absence for December at 5.54% from 5.48% in November. The year's average Jan 2021 – Dec 2021 is 5.17%.

WBS in month figures have slight decrease to 8.27% and with a slight decrease in both short and long-term sickness. The rolling average for December is 6.24%. Mental health related absence continues to be the highest reason for absence at 30.3% of all absences.

VCC is reporting a decrease this month, in month absence reporting as 5.74% with a rolling absence of 5.54%. Mental Health related absence continues to be the highest reason for absence at 35.7% of all absences.

3.4 Statutory & Mandatory Compliance

Statutory & Mandatory compliance is on target for the third month running, and has increased slightly at 86.40% across the organisation from 86.06% in December.

WBS remain within compliance, at 93.56% and will aim to continue to maintain this compliance level. This is a slight increase on November's figure of 93.36%.

VCC has a steady increase in compliance once more this month to 84.93% from 84.91% in November.

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 The Quality, Safety & Performance Committee is asked to **NOTE** the contents of the attached performance reports.

Appendices

1. VCC December PMF Report
2. WBS December PMF Report
3. Workforce KPI data

Velindre Cancer Centre Monthly Performance Report Summary Dashboard (December 2021)

The table below includes two measures for the performance for radiotherapy service provision. The JCCO is the measure that has historically been reported. It defines patients into certain categories as detailed below. The newer COSC measure has been introduced in 2020 and sets a reduction in the days target for treatment commencing that we and other centres are working towards. The measure is based on different categories of patients and new definitions and as a result the two data sets are not directly comparative. We will continue to report both sets of measures to provide the board assurance that we are maintaining service while also providing progress against the new target. The detailed narrative reports against the JCCO target.

			Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Radiotherapy	Patients Beginning Radical Radiotherapy Within 28-Days (page 8) ***(JCCO Measure)***	Actual	95%	97%	92%	89%	95%	94%	97%	96%	97%	96%	92%	78%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Patients Beginning Palliative Radiotherapy Within 14-Days (page 10) ***(JCCO Measure)***	Actual	90%	97%	90%	85%	95%	85%	82%	82%	82%	82%	74%	84%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Patients Beginning Emergency Radiotherapy Within 2-Days (page 12) ***(JCCO Measure)***	Actual	95%	97%	100%	97%	100%	100%	97%	100%	97%	100%	85%	89%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Scheduled Patients Beginning Radiotherapy Within 21-Days (page 13) ***(COSC Measure)***	Actual				35%	28%	37%	35%	31%	27%	36%	36%	33%
		Target	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
	Urgent Scheduled Patients Beginning Radiotherapy Within 7-Days (page 13) ***(COSC Measure)***	Actual				41%	48%	40%	54%	52%	52%	35%	41%	57%
		Target	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
	Emergency Patients Beginning Radiotherapy Within 1-Day (page 13) ***(COSC Measure)***	Actual				83%	88%	85%	82%	86%	82%	86%	77%	84%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

			Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
SACT	Patients Beginning Non-Emergency SACT Within 21-Days (page 14)	Actual	79%	77%	88%	98%	98%	98%	99%	99%	98%	99%	99%	99%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Patients Beginning Emergency SACT Within 2-Days (page 15)	Actual	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	86%	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	66%	65%	57%	66%	79%	76%	76%	53%	53%	65%	65%	Data collection paused during December due to operational pressures.
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	Did Not Attend (DNA) Rates	Actual	3%	2%	3%	3%	4%	4%	5%	5%	5%	5%	5%	3%
		Target	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%
Therapies	Therapies Inpatients Seen Within 2 Working Days (page 22)	Actual (Dietetics)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Physiotherapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Occupational Therapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	95%	100%	100%

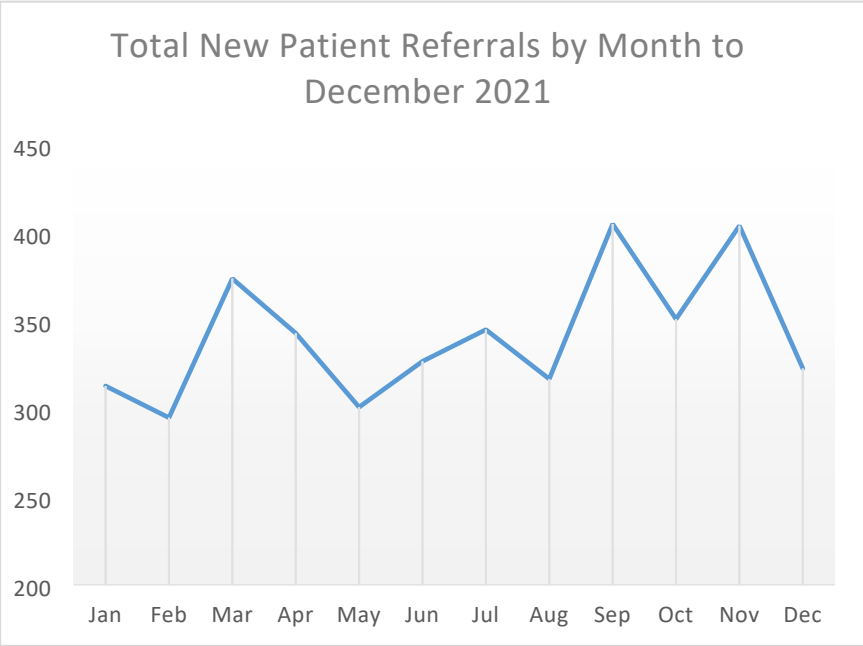
			Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
		Actual (Speech and Language Therapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Therapies Outpatient Referrals Seen Within 2 Weeks (page 22)	Actual (Dietetics)	100%	100%	100%	100%	100%	84%	94%	94%	98%	97%	100%	95%
		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%
	Routine Therapies Outpatients Seen Within 6 Weeks (page 22)	Actual (Dietetics)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Physiotherapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Occupational Therapy)	100%	100%	100%	100%	100%	100%	100%	96%	33%	78%	100%	100%
		Actual (Speech and Language Therapy)	100%	100%	100%	100%	100%	100%	96%	100%	100%	96%	100%	100%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

			Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Safe and Reliable Care	Number of VCC Acquired, Avoidable Pressure Ulcers (page 24)	Actual	0	0	0	1	0	0	0	2	1	1	0	1
		Target	0	0	0	0	0	0	0	0	0	0	0	0
	Number of Pressure Ulcers Reported to Welsh Government as Serious Incidents	Actual	0	0	0	1	0	0	0	0	0	0	0	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0
	Number of VCC Inpatient Falls (page 26)	Actual (Total)	1	1	1	2	3	1	3	4	2	3	1	4
		Unavoidable	1	1	1	1	3	1	3	4	1	3	1	4
		Avoidable	0	0	0	1	0	0	0	0	1	0	0	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0
	Number of Delayed Transfers of Care (DToCs)	Actual	0	0	0	0	0	0	0	1	0	4	0	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0
	Number of Potentially Avoidable Hospital Acquired Thromboses (HAT)	Actual	0	0	0	0	0	0	0	0	0	0	0	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0
	Patients with a NEWS Score Greater to or Equal to Three Who Receive all 6 Elements in Required Timeframe (page 28)	Actual	100%	100%	100%	100%	100%	100%	80%	100%	75%	100%	100%	100%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

			Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
	Healthcare Acquired Infections (page 29)	Actual	1 (*C.diff*)	0	0	0	0	0	1 (*C.diff*)	0	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

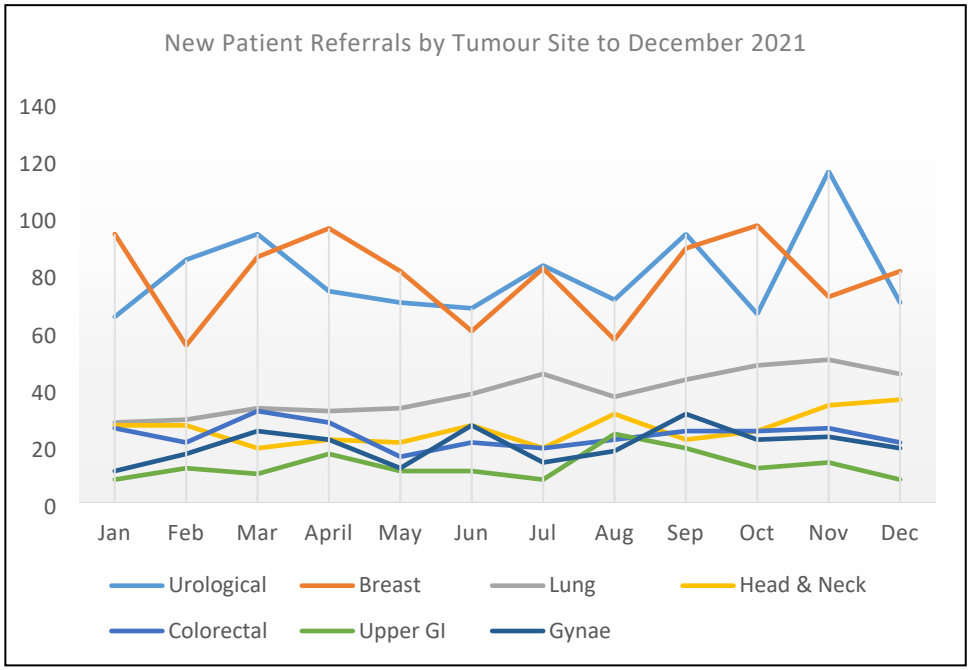


Monthly Average (2019-20)	Monthly Average (2020-21)	Total New Patient Referrals (December 2021)
357	315	323

The total number of referrals received in December 2021 (323) represented a reduction onto the previous month (404). This is a typical seasonal fall reflecting changing activity in Health Boards. The number of new referrals in December however, still exceeded the average number received in any given month in 2020/21 (315).

Radiotherapy – Operational Context

Referral Trends - Tumour Site



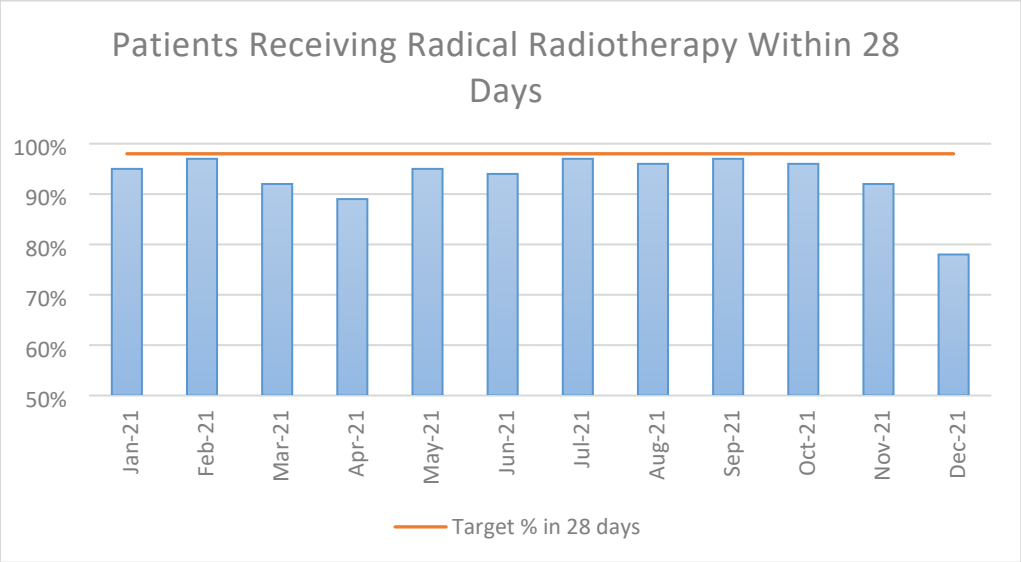
Site	Monthly Average (2019-20)	Monthly Average (2020-21)	2020-21 Average Relative to 2019-20 Average	New Patients (December 2021)
Breast	**88**	**60**	**-32%**	70
Urology	**82**	**82**	**0%**	81
Lung	**47**	**38**	**-19%**	38
Colorectal	**20**	**22**	**+10%**	22
Head and Neck	**23**	**23**	**0%**	36
Gynaecological	**18**	**18**	**0%**	22
Upper Gastrointestinal	**16**	**13**	**- 19%**	8
Top 7 Tumour Sites by Number of Referrals as Percentage of Total Referrals	**82%**	**81%**		87%

The graph and table show the number of patients scheduled to begin treatment in December by the tumour sites most commonly referred for radiotherapy treatment.

- Referrals overall and across some tumour sites now returning to pre Covid levels.
- Demand up from 82% to 87% against the 2019/20 baseline (in the tumour sites most commonly referred for radiotherapy, with maximum 80% capacity due to IP&C measures. Prior to staff absences rising during 4th COVID wave.
- Weekly variation in referrals from health boards, across individual tumour sites, is impacting on our ability to meet demand in a timely fashion. Engagement with health boards ongoing to understand their backlog clearance plans.
- All options being explored by SSTs to meet short term surges and to respond to health board backlog clearance.

Patients Receiving Radical Radiotherapy Within 28-Days

Target: 98%	**SLT Lead: Radiotherapy Services Manager**
Trend	Current Performance



The number of patients scheduled to begin radical radiotherapy treatment in December 2021 (179) exceeded the monthly average observed in 2020-21 (150) and was higher than the number scheduled to begin treatment in December 2020 (165).

Social distancing and other infection control measures present particular challenges in the delivery of radiotherapy. Capacity has been reduced by 20% due to these COVID precautions.

The reduction in the number of patients beginning treatment within 28 days is also impacted by the loss of routine capacity from the additional bank holidays, when service is reduced to high priority Category 1 patients and emergency patients only.

40 patients referred for radiotherapy treatment with radical intent did not begin treatment within the 28 day target constituting an overall performance rate of 78**%.**

The 40 patients who did not begin treatment within 28 days, commenced their treatment at the following points:

Treatment Intent	≤ 35 days	≤ 45 days	≥ 46 days
Radical (28-day target)	30	8	2

Summary of delays:
30 due to linac capacity constraints (breast treatment unit); 6 due to delays to delineation, planning or approval; 1 brachy capacity and 1 planned delay to start date to align with start of clinical trial(patient choice)

IPC measures continue to restrict Linac capacity by 20%, resulting in growth in waiting times as referrals are returning to pre Covid levels, thereby exceeding available capacity.

Breaches expected to continue over next 6 months as demand grows and will continue to exceed capacity.

Current Actions:

Intent	Monthly Average (2019-20)	Monthly Average (2020-21)	Patients Scheduled to Begin Treatment (December 2021)
Radical	167	150	179
	Patients Scheduled to Begin Treatment (December 2019)	Patients Scheduled to Begin Treatment (December 2020)	
	193	165	

- We are maximising the use of private sector capacity in the short term.
- We have reviewed Linac tumour site groupings to maximise efficiency and flexibility of usage.
- We are maximising the use of hyporfractionation to reduce Linac demand, although this does increase workload of the planning team.
- We are working with each SST to develop a tailored capacity delivery plan based on demand projections and treatment options eg Brachytherapy, molecular radiotherapy.
- Weekly capacity planning meetings in place reviewing patient prioritisation and resolving live operational issues.

Medium Term Actions

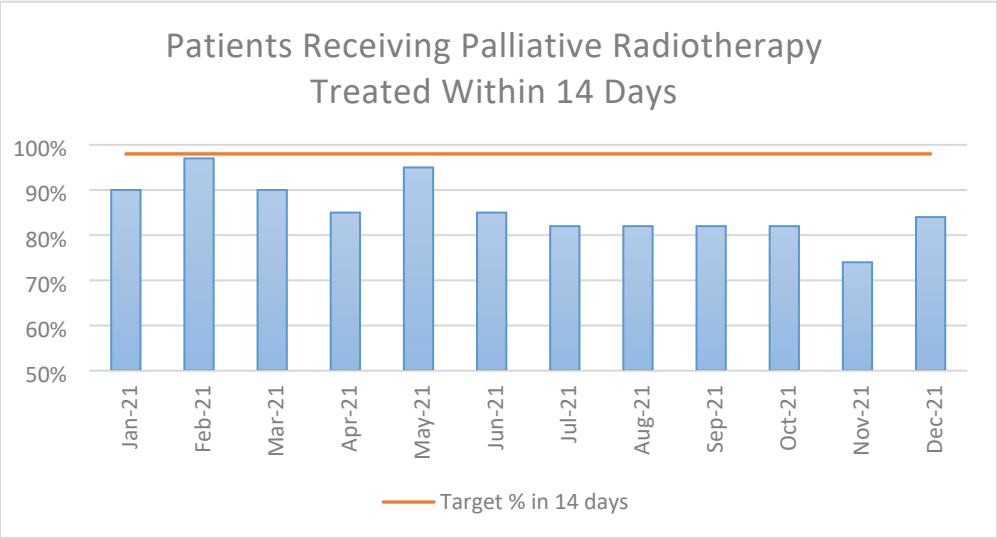
- Recruitment and appointments in progress for additional front line resources, however capacity increases predicted throughout 2nd half of 2022 due to lead in time, maximising capacity from Sept-Dec 2022.
- Peer review with Clatterbridge Trust underway to identify options/service models to put service demand and capacity in balance for Brachytherapy March 2022
- Brachytherapy expansion business case being written to obtain support for increased capacity with WHSCC. Feb 2022
- Assess the options to escalate some or all of the longer term capacity solutions. March 2022

Patients Receiving Palliative Radiotherapy Within 14-Days

Target: 98%

SLT Lead: Radiotherapy Services Manager

Trend



The number of patients scheduled to begin palliative radiotherapy treatment in December 2021 (88) exceeded the monthly average observed in 2020-21 (74), but was lower than the number scheduled to begin treatment in December 2020 (109).

Intent	Monthly Average (2019-20)	Monthly Average (2020-21)	Patients Scheduled to Begin Treatment (December 2021)
Palliative	82	74	88
	Patients Scheduled to Begin Treatment (December 2019)	Patients Scheduled to Begin Treatment (December 2020)	
	114	109	

Current Performance

88 patients referred for radiotherapy treatment with palliative intent were scheduled to begin treatment in December. Of this total, 14 patients did not begin treatment within the 14 day target constituting an overall performance rate of **84%.**

The 14 patients who did not begin treatment within 14 days, commenced their treatment as follows:

Treatment Intent	≤ 20 days	≤ 25 days
Palliative (14-day target)	10	4

Summary of delays:
7 3D conformal plans; 1 change of intent; 6 capacity (Tx unit, SRS, DXR)

IPC measures continue to restrict Linac capacity by 20%, resulting in growth in waiting times as referrals are returning to pre Covid levels, thereby exceeding available capacity.

Breaches expected to continue over next 6 months as demand grows and will continue to exceed capacity.

Current Actions:

- We are maximising the use of private sector capacity in the short term.

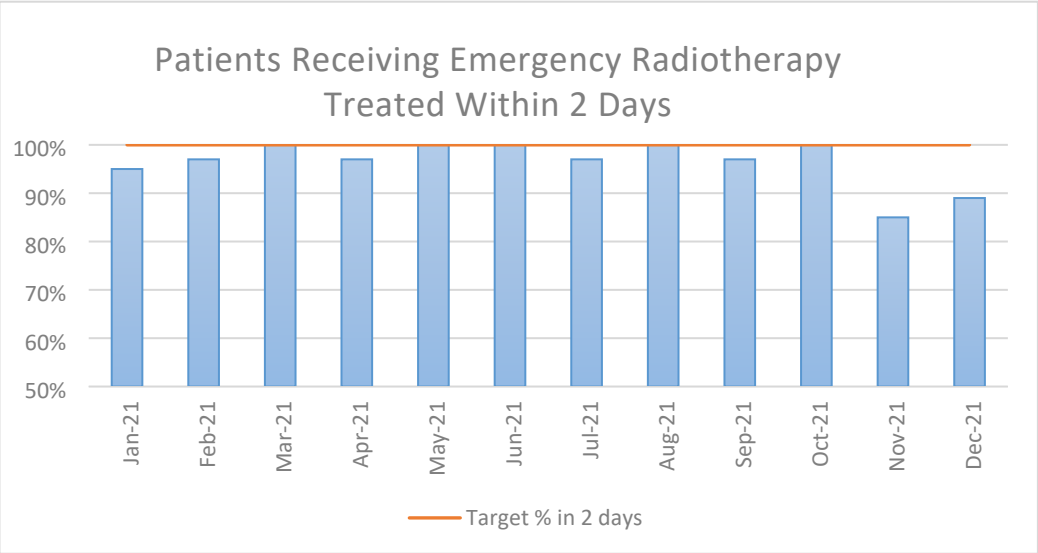
	• We have reviewed Linac tumour site groupings to maximise efficiency and flexibility of usage. • We are maximising the use of hyporfractionation to reduce Linac demand, although this does increase workload of the planning team. • We are working with each SST to develop a tailored capacity delivery plan based on demand projections and treatment options eg Brachytherapy, molecular radiotherapy. • Weekly capacity planning meetings in place reviewing patient prioritisation and resolving live operational issues.
	Medium Term Actions
	• Recruitment and appointments in progress for additional front line resources, however capacity increases predicted throughout 2nd half of 2022 due to lead in time, maximising capacity from Sept-Dec 2022. • Peer review with Clatterbridge Trust underway to identify options/service models to put service demand and capacity in balance. March 2022 • Brachytherapy expansion business case being written to obtain support for increased capacity with WHSCC. Feb 2022 • Assess the options to escalate some or all of the longer term capacity solutions. March 2022

Patients Receiving Emergency Radiotherapy Within 2-Days

Target: 98%

SLT Lead: Radiotherapy Services Manager

Trend



The number of patients scheduled to begin emergency radiotherapy treatment in December 2021 (26) was marginally smaller than the monthly average observed in 2020-21 (27) and the number scheduled to begin treatment in December 2020 (29).

Intent	Monthly Average (2019-20)	Monthly Average (2020-21)	Patients Scheduled to Begin Treatment (December 2021)
Emergency	25	27	26
	Patients Scheduled to Begin Treatment (December 2019)	Patients Scheduled to Begin Treatment (December 2020)	
	27	29	

Current Performance

26 patients referred for emergency radiotherapy treatment were scheduled to begin treatment in December 2021. 3 patients did not begin radiotherapy treatment within 2 days of referral constituting an overall performance of **89%.**

Treatment Intent	≤ Day 5
Emergency (2-day target)	3 on day 3

Summary of delays:
1 patient choice (declined admission for RT, preferred day case); 2 Covid positive (required Covid specific LINAC machine to support effective delivery of IP&C protocols
No specific actions as limited as to what action would have avoided breaches within 2 days

Wider Actions as above for 21 and 14 day targets

Radiotherapy – Operational Context

Latest Performance Consolidated

Measure		Target	VCC Dec-21	SBUHB Dec-21	BCUHB Aug-21
Scheduled (21-day target)	COSC	80%	**33%**	**37%**	**52%**
Urgent (7-day target)	COSC	80%	**57%**	**37%**	**34%**
Emergency (within 1-day)	COSC	100%	**84%**	**100%**	**50%**

The table shown here sets out the latest available performance of the 3 Wales centres relative to the Clinical Oncology Sub-Committee (COSC) stretch targets.

The two other centres commenced COSC implementation a year earlier than VCC.

Clinical Oncology Sub-Committee (COSC) Time to Radiotherapy Targets

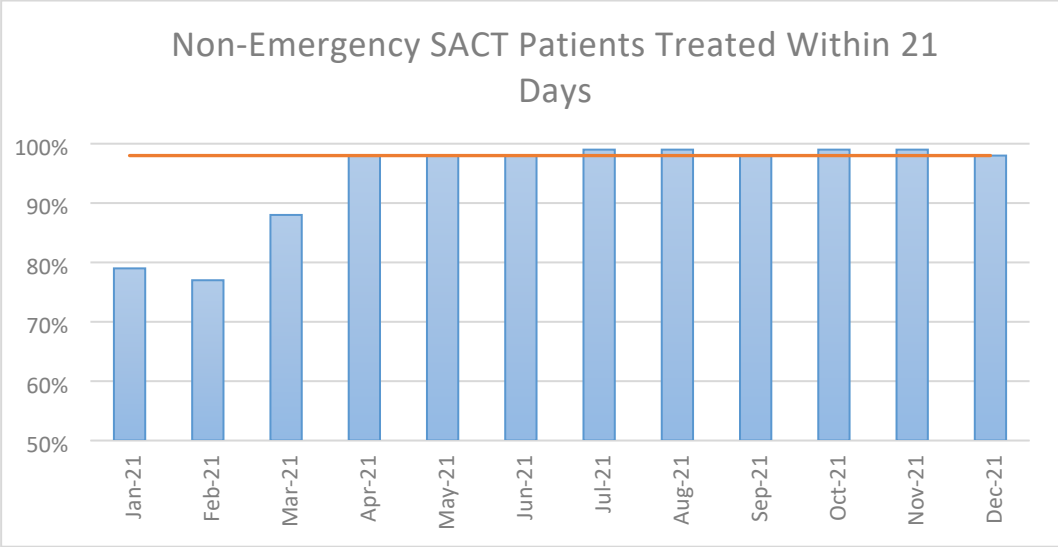
- Velindre Cancer Centre continues to report good Radiotherapy performance against UK agreed targets as set by the Royal College of Radiologists (RCR), particularly given that we are continuing to deliver services within a COVID driven reduced capacity.
- Since April 2021, we have been mandated by the Welsh Government to also report against the Clinical Oncology Sub Committee (COSC) targets. These targets align more closely with the direction of travel for reporting against the Single Cancer Pathway.
- The COSC targets present different criteria and different time points of reporting (Scheduled, Urgent and Emergency- within 1 day). Our systems are not currently designed to intuitively respond to both the criteria and time points for COSC as the patient pathways and the Radiotherapy planning and scheduling systems, have been designed to respond to the original RCR targets.
- The relatively low performance within Velindre Cancer Centre and the other cancer centres across Wales against the COSC targets currently, does not mean that patients are waiting any longer than they were previously under the RCR targets, only that we have changed the way in which we now categorise patients. We are continuing to report against both measures for comparison at present.
- Work is underway to ensure that we can accurately manage patients and report against these newly adopted COSC measures and to ensure our patient pathways are redesigned in order to meet the new criteria definitions.
- Current data published and reported highlights significant issues in consistency of application across the cancer centres.
- Work is underway through a COSC sub group nationally to standardise and mandate data quality in reporting across Wales to inform accurate comparison and to drive improvement.

The table below describes the allocation of individual patients scheduled to begin treatment in terms of the new COSC definitions for December 2021

Scheduled (21 day target)	Urgent (7 day target)	Emergency (within 1 day)
147	64	24

Non-Emergency SACT Patients Treated Within 21-Days

Target: 98%	SLT Lead: Chief Pharmacist
Current Performance	Trend



The number of patients scheduled to begin non-emergency SACT treatment in December 2021 (361) was considerably larger than both the monthly average observed in 2020-21 (298) and the number scheduled to begin treatment in December 2020 (298).

Intent	Monthly Average (2019-20)	Monthly Average (2020-21)	Patients Scheduled to Begin Treatment (December 2021)
Non - emergency	328	298	361
	Patients Scheduled to Begin Treatment (December 2019)	Patients Scheduled to Begin Treatment (December 2020)	
	290	298	

361 patients were referred for non-emergency SACT treatment scheduled to begin treatment in December. Of this total, 5 patients did not begin treatment within the 21 day target, constituting an overall performance rate of 99%.
The 5 patients who did not begin treatment within 21-days, 4 were treated within 28 days and 1 was treated on day 29:

Treatment Intent	≤ 28 days	≥ 28 days
Non-emergency (21-day target)	4	1

A number of category 5 and 6 patients treatment, has been carried over into January 2022, and some of these will be reported as January breaches when treated. This is due to demand exceeding capacity in month.

Actions

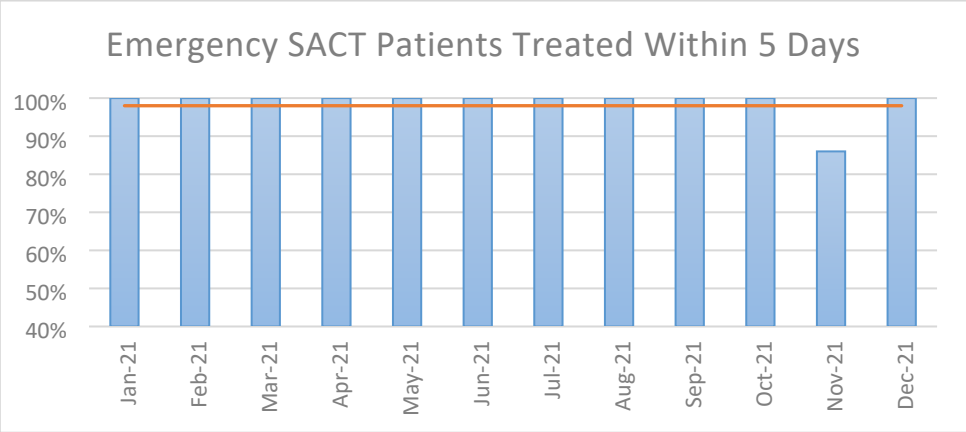
This position has been achieved through:

- Improvements in booking processes.
- Maximising capacity through pre-empting non-attendance rates and overbooking to a compensatory level.
- Improved utilisation of chair capacity across VCC site.
- Additional day on Tenovus mobile unit.
- Increases in oral SACT volumes.
- Streamlined management of non-chair activity, e.g. Sub cutaneous injections.

Delivery of plan focused on reopening Neville Hall SACT delivery capacity (Delayed from May 2021. Anticipated delivery in April 2022 due to facility and logistical issues at Neville Hall).

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 December 2021 (5) was higher than the monthly average observed in 2020-21 (4).

Intent	Monthly Average (2019-20)	Monthly Average (2020-21)	Patients Scheduled to Begin Treatment (December 2021)
Emergency	4	4	5
	Patients Scheduled to Begin Treatment (December 2019)	Patients Scheduled to Begin Treatment (December 2020)	
	3	2	

5 patients referred for emergency SACT treatment were scheduled to begin treatment in December 2021. All patients began treatment within the 5-day 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.

SACT – Operational Context

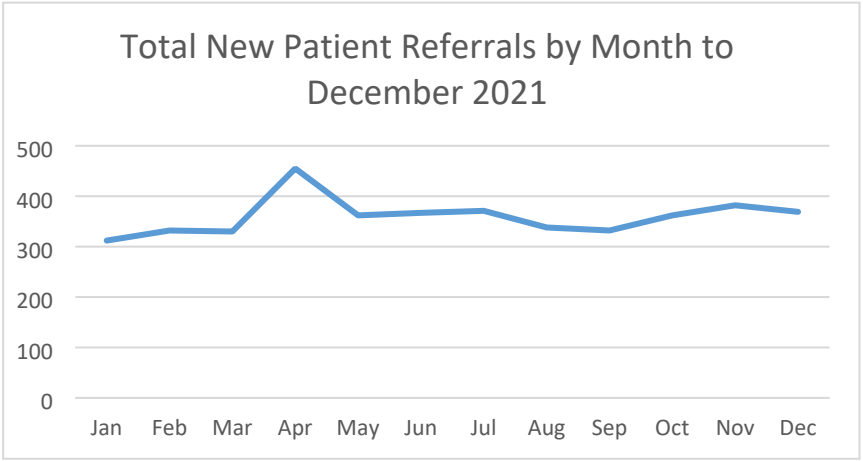
Current Performance Consolidated

Measure	Target	Dec-21
Non-emergency (21-day target)	98%	**99%**
Emergency (5-day target)	98%	**100%**

The table shown here sets-out performance relative to the extant time to SACT targets.

Social distancing and other infection control measures present particular challenges in the delivery of SACT. Additionally, overall delivery capacity remains restricted. All services, previously delivered in outreach contexts, were repatriated to VCC in response to the pandemic. With the exception of a reduced service at the Macmillan Unit at the Prince Charles Hospital in Merthyr Tydfil, this remains the case.

Referral Trends - Overall



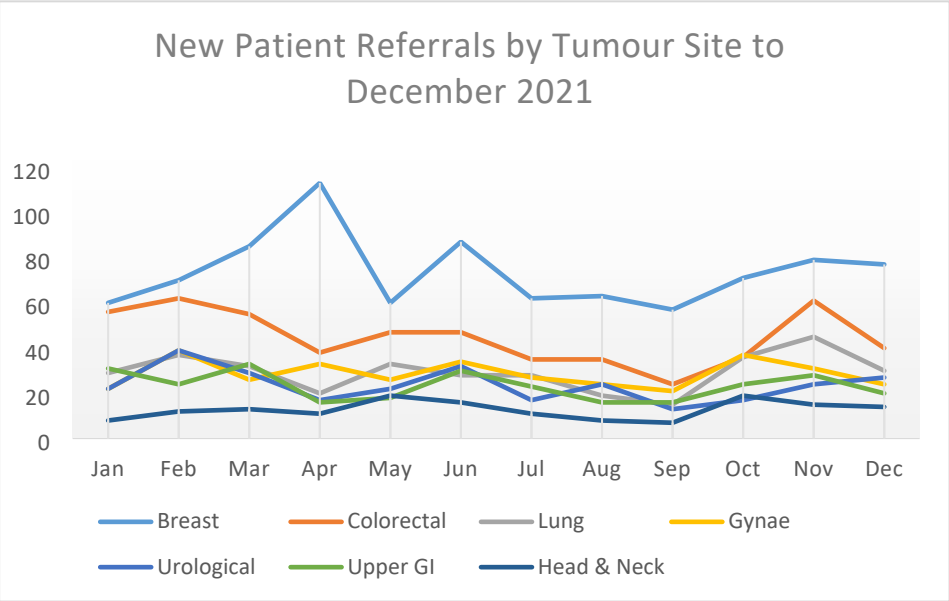
Monthly Average (2019-20)	Monthly Average (2020-21)	Total New Patient Referrals (December 2021)
325	301	369

The total number of referrals received in December 2021 (369) was above the average number received in any given month during 2020-21 (301) and marginally below the number received in December 2021 (382). The number of referrals received in December also exceeds the average number received per month in 2019-20.

Referrals fell dramatically following the first national lock-down in March 2020. Subsequently, referrals have returned to pre-pandemic levels.
Referrals include new patients for 1st definitive treatment and repeat treatments for patients mid cycle or on a revised treatment cycle.

SACT – Operational Context

Referral Trends - Tumour Site



Site	Monthly Average (2019-20)	Monthly Average (2020-21)	2020-21 Average Relative to 2019-20 Average	New Patient Referrals (December 2021)
Breast	**92**	**76**	**-17%**	77
Colorectal	**54**	**55**	**+2%**	40
Lung	**33**	**32**	**-3%**	30
Gynaecological	**31**	**31**	**0**	24
Urological	**36**	**26**	**-28%**	27
Upper Gastrointestinal	**18**	**26**	**+44%**	20
Head and Neck	**16**	**14**	**-12%**	14
Top 7 Tumour Sites by Number of Referrals as Percentage of Total Referrals	**86%**	**87%**		63%

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

	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Dietetics	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Physiotherapy	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
OT	100%	100%	100%	100%	100%	100%	100%	100%	100%	95%	100%	100%
SLT	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Percentage of Urgent Therapies Referrals (Outpatients) Seen Within 2 Weeks

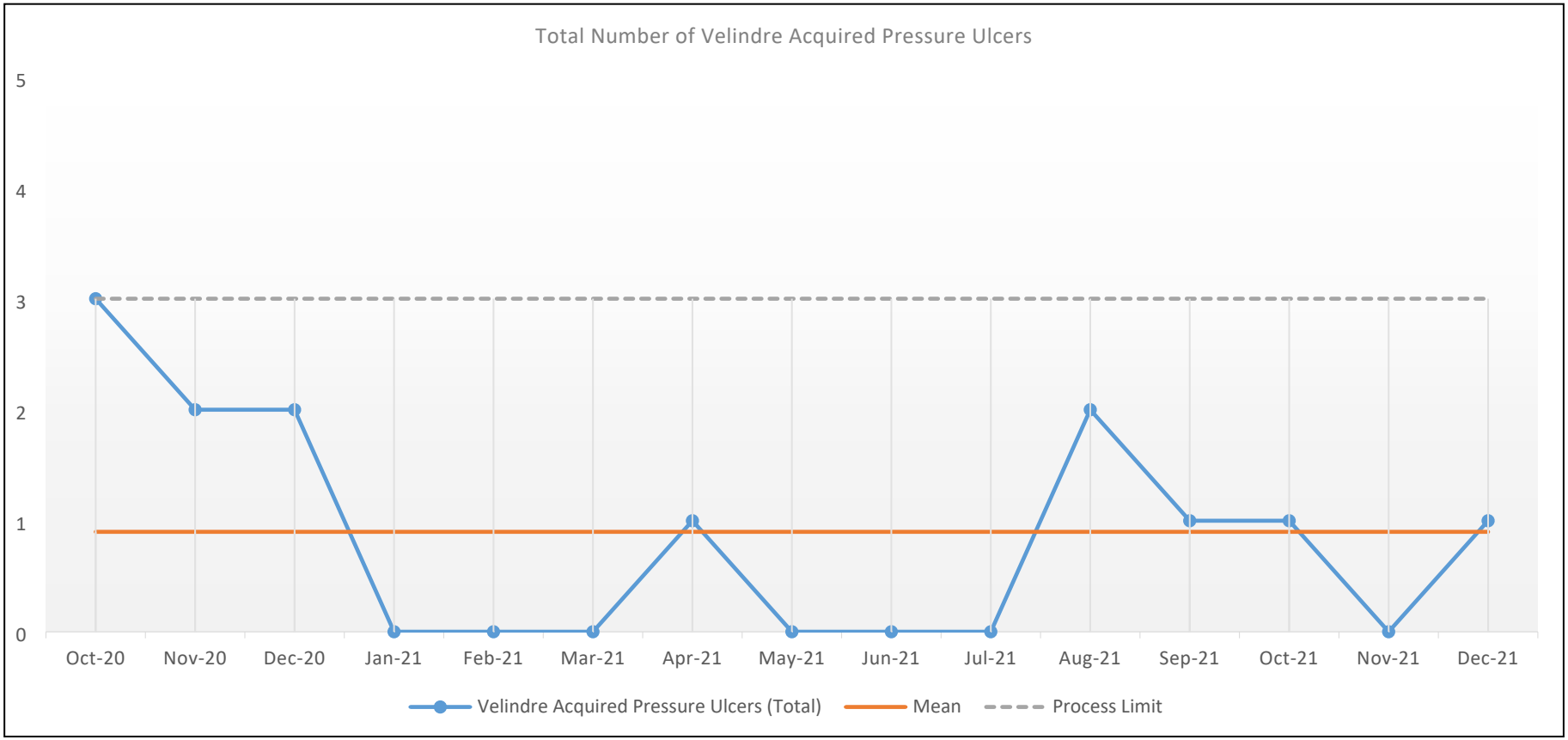
	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Dietetics	100%	100%	100%	100%	100%	84%	94%	94%	98%	97%	100%	95%
Physiotherapy	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
OT	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
SLT	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Percentage of Routine Therapies (Outpatients) Seen Within 6 Weeks

	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Dietetics	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Physiotherapy	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
OT	100%	100%	100%	100%	100%	100%	100%	96%	33%	78%	100%	100%
SLT	100%	100%	100%	100%	100%	100%	96%	100%	100%	96%	100%	100%

In December, 2 patients were not seen by a dietician until early in the third week of treatment and, as such, breached the 2-week urgent outpatient target. This was as part of a planned treatment pathway clinic and no harm to the patient was reported.	No specific improvement action required. Specialist multi-disciplinary clinics occasionally mean a patient may miss one marginally and wait slightly outside the two week wait.

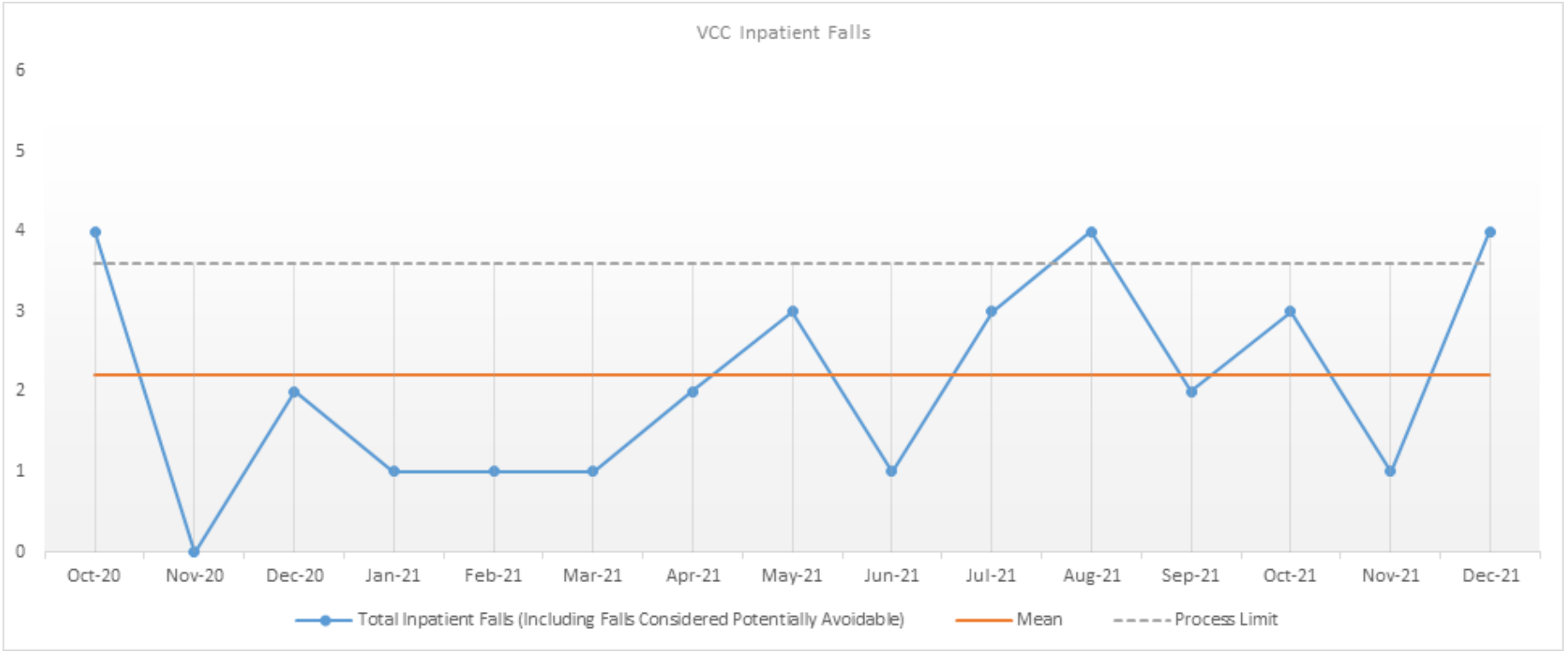
Velindre Acquired Pressure Ulcers	
Target: 0	**SLT Lead: Head of Nursing**
Current Performance	



	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Velindre Acquired Pressure Ulcers (Total)	3	2	2	0	0	0	1	0	0	0	2	1	1	0	1
Potentially Avoidable Velindre Acquired Pressure Ulcers	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0

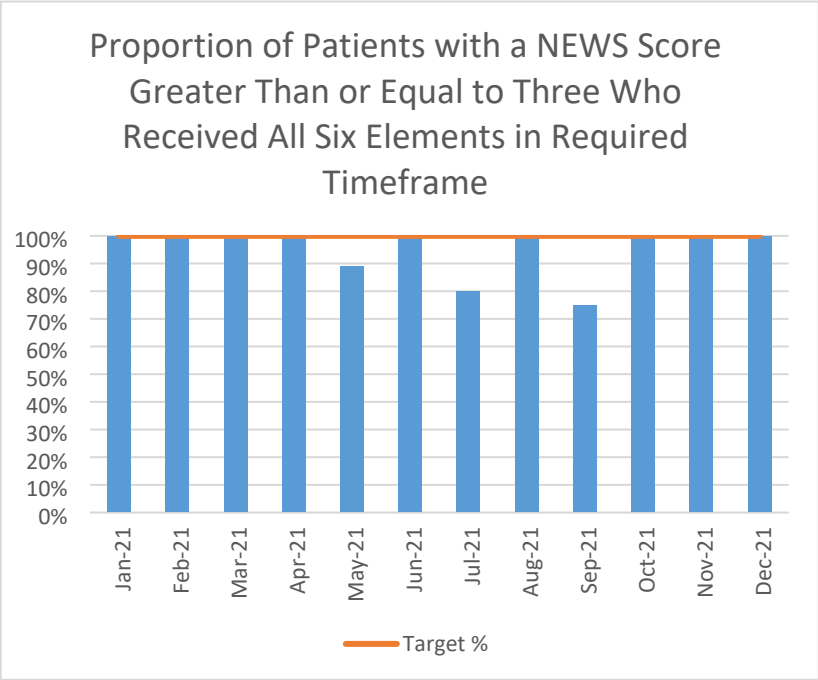
Trend	Action
1 Velindre acquired pressure ulcers reported in December 2021. Patient was a day-case/ambulatory care patient. No Velindre acquired ulcers were reported to Welsh Government as a Serious Incident (SI).	The current Pressure Ulcer Prevention and Treatment Guidelines does not require risk assessment and skin checks for day case/ ambulatory care patients. VCC Tissue Viability Nurse to benchmark how other centres manage patients who have day surgery and require to be in the same position for many hours. The patient was attended by the Tissue Viability Nurse and appropriate treatment delivered. A district nurse referral was made to ensure a review the next day.

Velindre Inpatient Falls	
Target: 0	**SLT Lead: Head of Nursing**
Current Performance	



	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov -21	Dec -21
Total Inpatient Falls	4	0	2	1	1	1	2	3	1	3	4	2	3	1	4
Potentially Avoidable Inpatient Falls	1	0	0	0	0	0	1	0	0	0	0	1	0	0	0

Trend	Action
During December 2021, 4 falls was reported on first floor ward (1 was a repeat fall). A full investigation was undertaken by the VCC Falls Scrutiny Panel. Following investigation, all falls were deemed to have been unavoidable. The repeat fall was of a patient who was readmitted in the month and fell during both separate admission periods. The patient had pressure ulcers and the use of a pressure relieving mattress was a contributory factor in the repeat fall.	Falls risk assessments were undertaken, on admission and readmission, in each case. • In each case, following the incident the falls pathway was completed and the patient reviewed by a medic. • In one instance, the patient suffered a minor abrasion, otherwise no harm was identified. • The use of shower aids, e.g. a chair, will be routinely considered when a patient is identified as being at risk of a fall following an assessment. • The use of pressure relieving mattresses to support mobile patients is being reviewed and the tissue viability nurse is to provide teaching for ward staff on selecting the correct equipment for the individual patient, based on both the falls and pressure ulcer risks.

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
	Nine patients met the criteria for administration of the sepsis treatment bundle in December 2021. All nine received all elements of the bundle within one hour. Seven of the patients subsequently received a diagnosis of sepsis or neutropenic sepsis.
	Actions
	No specific action required.

Healthcare Acquired Infections (HAIs)	
Target: 0	**SLT Lead: Clinical Director**

Current Performance

	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
C.diff	1	0	0	0	0	0	1	0	0	0	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
No healthcare acquired infections were reported in December 2021.	

QUALITY, SAFETY and PERFORMANCE COMMITTEE

VELINDRE CANCER CENTRE DIVISIONAL REPORT
October 2021 – December 2021

DATE OF MEETING	17th February 2022

PUBLIC OR PRIVATE REPORT	PUBLIC

IF PRIVATE PLEASE INDICATE REASON	Not Applicable

PREPARED BY	VIV COOPER, HEAD OF NURSING, QUALITY, SAFETY AND PATIENT EXPERIENCE SARAH OWEN, QUALITY AND SAFETY MANAGER TRACEY LANGFORD, QUALITY & SAFETY OFFICER
PRESENTED BY	PAUL WILKINS, DIRECTOR OF CANCER SERVICES
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**

ACRONYMS	
VCC	Velindre Cancer Centre
QSMG	Quality and Safety Management Group

QSP	Quality, Safety and Performance
C&V	Cardiff and Vale
SACT	Systemic Anti-Cancer Therapy
WG	Welsh Government
RT	Radiotherapy
SLT	Senior Leadership Team
PTR	Putting Things Right
WRP	Welsh Risk Pool
OfW	Once for Wales
CHC	Community Health Council
DHCW	Digital Health Care Wales
MDT	Multi-Disciplinary Team

Overview

The purpose of this paper is to provide the QSP Committee with an update on the key quality and safety outcomes and metrics for VCC for the period 1st October 2021 – 31st December 2021. This report provides the committee with a summary of performance data as comprehensive performance data and narrative is provided and discussed through other reports and committees within the Trust and the Division on a monthly basis. This format of this report is relatively new and is structured around the 6 domains of quality and safety. The Q&S team at VCC are keen to receive feedback/views on the format and content of this paper

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The current quality, safety and performance reporting and monitoring system is predicated upon identifying issues and supporting effective decision making at service and operational levels to drive forward continuous improvement in quality, safety and improving the overall experience of patients and donors.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below: Staff and Resources Safe Care Timely Care Effective Care.
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / **IMPACT**	Yes (Include further detail below)

CONTENTS PAGE

1.0	Introduction

1.1 The purpose of this paper is to provide the Quality, Safety and Performance Committee with an update on the key quality and safety outcomes and metrics for Velindre Cancer Centre for the period 1st October 2021 – 31st December 2021

1.2 The Quality, Safety and Performance Committee are asked to **NOTE**:

- progress against the key priority areas
- issues, corrective actions and monitoring arrangements in place
- identify opportunities for learning and best practice

2.0	Impact Assessment

2.1 This report covers the period of 1st October 2021 – 31st December 2021 (quarter 3) and therefore retrospectively provides VCC service quality and safety data and narrative the purpose of which is to provide assurance. The report is structured around the 6 domains of quality and safety.

3.0	Highlight from Velindre Cancer Centre Quality and Safety Management Group

3.1 The VCC Q&SMG highlight report from the meeting on the 14th October 2021 can be seen at (**appendix 1**). For assurance there were no issues to alert or escalate to the Senior Leadership Team following the 9th December 2021 meeting.

4.0	Safe Care Descriptor; avoid harm

4.1 Incidents/near-misses/complements/feedback are used as indicators of safe care and are captured using the Once for Wales DATIX software system. Assurance regarding the safety of the services provided at Velindre cancer Centre is provided through various routes/reports and committees including:

- Tier 1 reportable indicators (reported via the monthly performance reports)
- Incidents (discussed in each Directorate and reported to the VCC Q&SMG and Trust QSP)
- Complaints discussed in each Directorate and reported to the VCC Q&SMG and Trust QSP)
- Claims (reported to the Trust QSP)

- Compliments discussed in each Directorate and reported to the VCC Q&SMG and Trust QSP) This section will provide assurance that safe care is being delivered in Velindre Cancer Centre and that where there are lessons learned and actions to improve service that there is a monitoring system in place.

4.2 Incidents

Severity (degree of harm) code descriptors in relation to the Once for Wales System are as follows:

No harm	No harm (impact not prevented) - Any incident that ran to completion, but no harm occurred to people receiving NHS funded care
Low	Any unexpected or unintended incident that required extra observation or minor treatment and caused minimal harm to one or more persons receiving NHS-funded care
Moderate	Any unexpected or unintended incident that resulted in a moderate increase in treatment, possible surgical intervention, cancelling of treatment, or transfer to another area, and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care
Severe	Any unexpected or unintended incident that directly resulted in permanent harm to one or more persons
Death	Any unexpected or unintended incident that directly resulted in the death of one or more persons

There were 362 incidents reported in quarter 3. There were 37 fewer incidents reported during quarter 3 than quarter 2. This is not deemed as significant by the Q+S team.

The incidents were initially categorised by the incident reporter as follows:

- 122 no harm
- 186 low harm
- 52 moderate harm
- 2 severe harm

Incidents harm categorisation is reviewed after the investigation has been completed. Of the 362 incidents reported 198 incidents have had their harm categorisation reviewed, the table below shows the change in category of some incidents post investigation, no incidents increased in severity post investigation.

Harm categorisation	Pre-investigation categorisation	Post-investigation categorisation
None	56	67
Low	114	122
Moderate	26	10
Severe	2	0

4.2.1. **Severe Incidents**

In this report only incidents categorised as severe are presented in any detail. There were 2 incidents initially categorised as severe but following the investigation they have both been re-categorised as low, and therefore a narrative for them has not been included.

4.2.2. **Moderate Incidents**

52 incidents were categorised as moderate harm initially by the reporter.
Following a complete investigation, 11 incidents were confirmed as being of moderate harm as follows:

Incident Type	No.	Description
Behaviour	7	Patient rude and aggressive to staff – same patient
Medication, IV Fluids	2	SACT prescribing/ dispensing error
Transfer, Discharge	1	Delayed Transfer of Care

There are a further 20 incidents that remain categorised as moderate but have not had a full investigation completed.
It is possible to close an incident without providing a "severity post investigation", and there are 13 incidents which have been closed without updating the severity. It has been fed back to the Datix team that it is possible to close the incidents without reviewing the harm categorisation, this is outside of our desired process. The VUNHST Datix team will feed this back to the national Datix team to look for a solution. The remaining 7 incidents have not been closed.

Incident Type	No.	Description
Behaviour	2	Patient rude and aggressive to staff – same patient
Communication	1	Communication issue on ward
Transfer, Discharge	3	Unsafe discharge from PCH Inappropriate transfer from DGH Unable to transfer patient to DGH
Fall	1	Unwitnessed fall in SACT
Treatment	12	Medical physics 4 SACT booking issues 3 Hypersensitivity reaction Missed evening dose LMWH Pharmacy dispensary issue Patient took wrong medication – no harm Abnormal blood result not acted on – no harm
Staff	1	DBS checks not completed on 10 members of staff Nursing short staff

- 9 behaviour incidents in total relating to the same patient, actions were taken as per the violence and aggression policy.
- 4 SACT booking related incidents. These incidents are captured in a piece of work to improve the SACT booking centre processes which will be monitored by the VCC QSMG.
- 10 members of staff have failed to complete their DBS checks despite receiving letters and being 'chased' by their line manager(s). Issue escalated to SLT in October 2021 to discuss with their staff members.

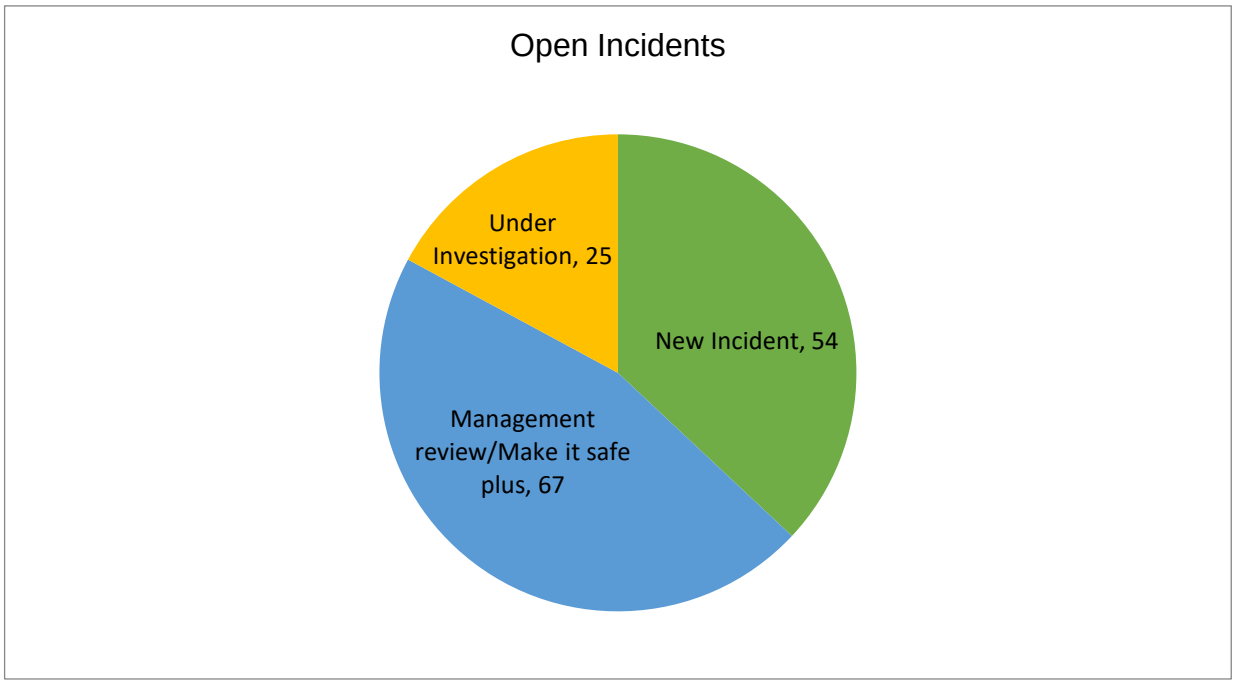
Those staff that have not provided their documents to complete the DBS process are:

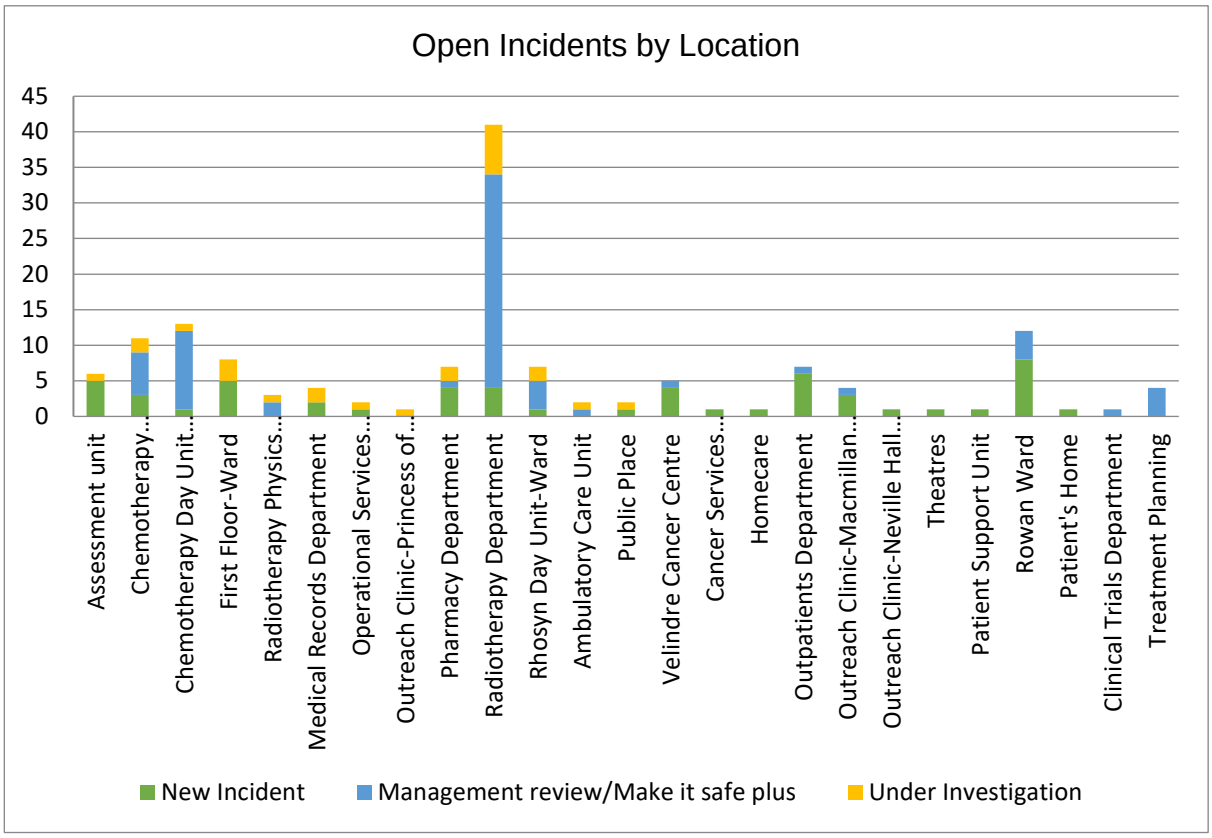
2 x nursing staff
1 x bank nurse
1 x Med Physics
1 x Bank Health Records
3 x Maternity Leave
2 x Long Term Sickness

Directorate leads are working with workforce colleagues to ensure the process is completed for these staff.

4.2.3. Open Incidents

146 incidents remain open. A number of these are incidents that are categorised "for reporting purposes only" such as transport issues, extravasation, and hypersensitivity reactions. The Datix team are looking at the possibility of a "for reporting purposes" only drop-down option.
The high number of open Datix incidents has been fed back to the Directorate Lead for Radiation Services, there are specific service pressures in this area which has led to some delays in reviewing and closing Datix reports.





4.2.4. **National Reportable Incidents (replaced Serious Incident in June 2021)**

There are no National Reportable Incidents for the time period

4.2.5. **Early Warning Notifications (replaced No Surprises Incidents in June 2021)**

There are no Early Warning Notifications for the time period.

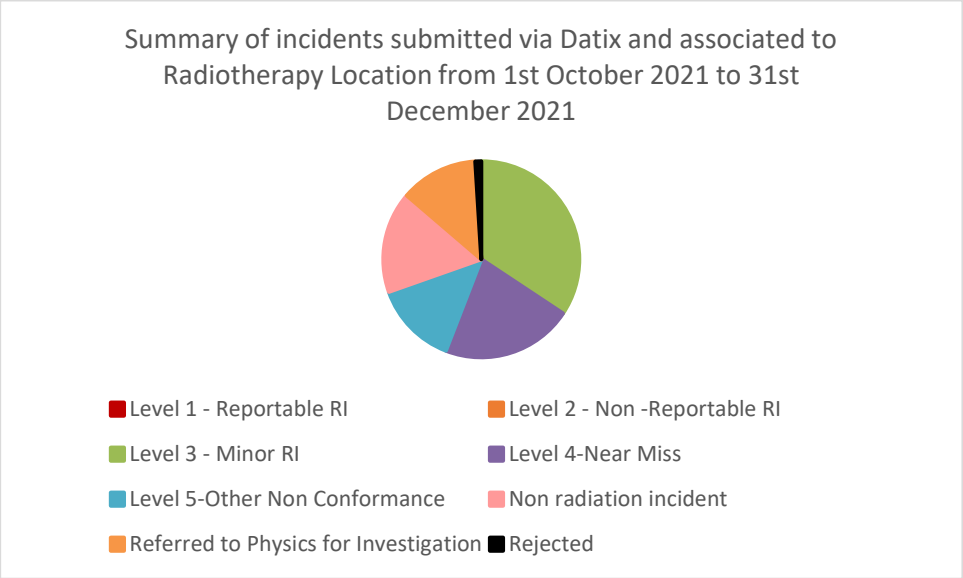
4.3. IRMER Compliance/ Issues/ Incidents

Please note that this information is for Radiotherapy Department location in Once for Wales Datix Incident module and does not include any incidents assigned to Medical Physics Location. Medical physics department have a new clinical governance lead in post and will be providing information in future reports, the aim is to provide one overarching radiation services report.

October 1st to December 31st 2021

Between 1st October and 31st December, 102 incidents were reported in the Once for Wales Datix Incident module and attributed to the Location of Radiotherapy Department. Of the 102 incidents reported, 89 were classed as radiotherapy errors / radiation incidents and coded in line with Towards Safer (TSRT)

October 1st 2021 to 31st December 2021 (from Once for Wales Datix)



Radiotherapy error[1] – A non-conformance where there is an unintended divergence between a radiotherapy treatment delivered or a radiotherapy process followed and that defined as correct by local protocol.

Radiation Incident[1] – a radiotherapy error where the delivery of radiation during a course of radiotherapy is other than that which was intended and which could have resulted or did result in unnecessary harm to the patient.

Level 1 Reportable radiation incident1[1] – a radiation incident that falls into the category of reportable under any of the statutory instruments (IR(ME)R 2017, IRR 2017 and so on). A reportable radiation incident will generally be clinically significant

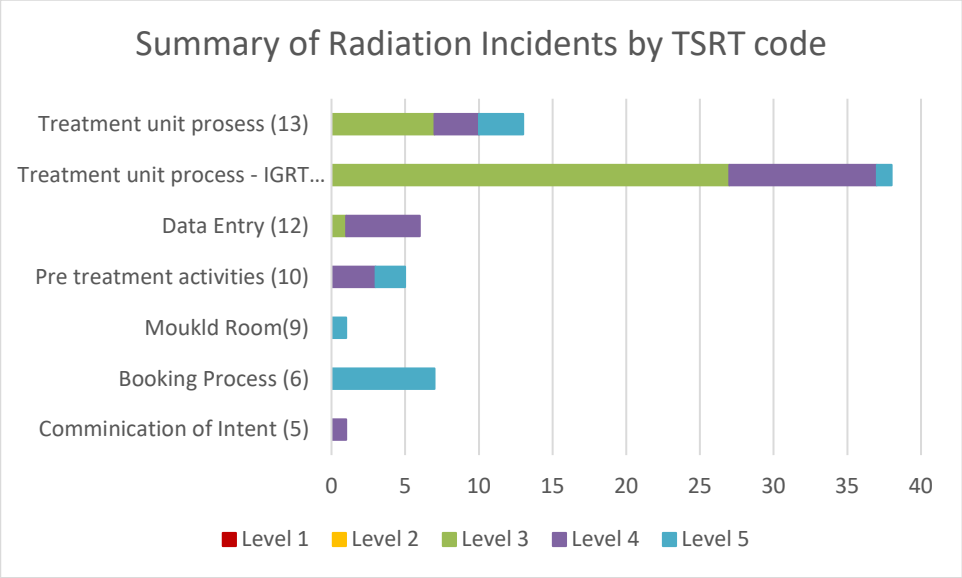
Level 2 Non-reportable radiation incident[1]- A radiation incident that does not fulfil the criteria as reportable under any of the statutory instruments (IR(ME)R 2017, IRR 2017 and so on) but is of potential or actual clinical significance. However reporting level 2 radiation incidents to the statutory authority is good clinical governance even though there is no legal requirement to do so.

Level 3 Minor radiation Incident[1] – A radiation incident in the technical sense but one of no potential or actual clinical significance.

Level 4 near miss[1] – A potential for a radiation incident that was detected and prevented before treatment delivery.

Level 5 Other non-conformance[1] – None of the above; that is non-compliance with some other aspect of a documented procedure but not directly affecting radiotherapy delivery.

1 The Royal Collage of Radiologists, Society and Collage of Radiographers, Institute of Physics and Engineering in Medicine, National Patient Safety agency, British Institute of radiology. Towards Safer Radiotherapy. London: The Royal Collage of Radiologists, 2008



Level	Number of errors reported
Level 1 - REPORTABLE RADIATION INCIDENTS	0
Level 2 - NON-REPORTABLE RADIATION INCIDENTS	0
Level 3 - MINOR RADIATION INCIDENTS Significant outcome	35 The majority of these incidents (27/35) are linked On Treatment Process –Image Guided Radiotherapy Of which, 16/27 can be attributed to on treatment image verification failures for Elexta XVI and DIBH on La5 & LA6, which, are a long-standing issue that are known to the manufacturers and are regularly reviewed by Radiotherapy Physics and the linear accelerator status group. 0
Level 4 - MINOR RADIATION INCIDENTS Significant outcome	22 0
Level 5 - OTHER NON-CONFORMANCE Significant outcome	14 0

4.5 Mortality

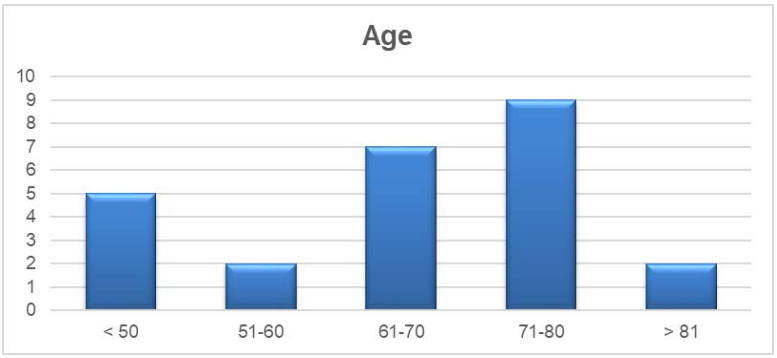
4.5.1 Mortality Reviews continue to be undertaken on all VCC inpatient deaths in line with WG guidance and Medical Examiner Regulations.

.

Month	Number of deaths
Jan-21	0
Feb-21	1
Mar-21	2
Apr-21	1
May-21	2
Jun-21	4
July-21	2
Aug-21	1
Sep-21	2
Oct-21	5
Nov-21	1
Dec-21	4

Cause of Death	Number of Patients
Maliganat Disease	21
1a Candida Septicaemia and Neutropaenia secondary to chemotherapy. 1b . neutropaenia secondary to chemotherapy for non small cell lung cancer	1
1a Chest Infection & Advanced Rectal Carcinoma with Lung mets	1
Pneumonia, Metastatic Colorectal Carcinoma	1
Pneumonia, Metastatic Colorectal Carcinoma & Pulmonary Fibrosis	1

Gender	Number of patients
Female	15
Male	10



4.5.2 There are no trends or concerns identified through mortality reviews carried out by the team at VCC.

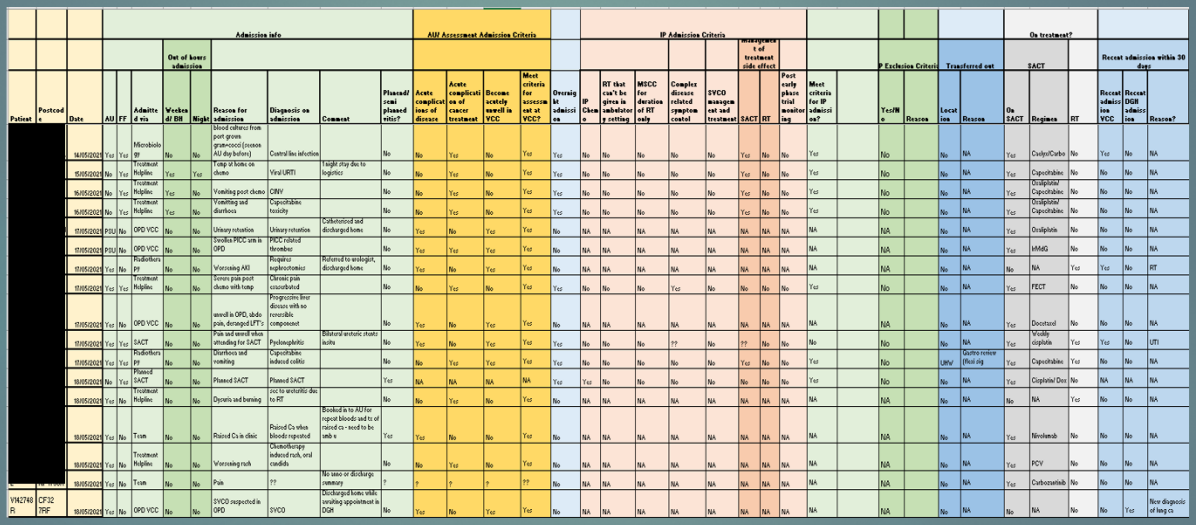
4.5.3. **Medical Examiner Service Reviews**

There were no referrals from the Medical Examiners Services during this reporting period.

4.6. **VCC Admission Audit**

The VCC inpatient admissions criteria was refreshed and implemented in November 2020, retrospective audit against the refreshed criteria, for May 2021, has been undertaken throughout autumn 2021. The admissions policy has been signed off through the relevant governance structures at VCC and implemented including any suggested changes or outcomes from the audit.

Snapshot of data capture against key admission criteria



Admission info											AU Assessment Admission Criteria					IP Admission Criteria															On treatment?					Recent admission within 30 days		
					Out of hours admission																																	
Patient	Postcode	Date	AU	FF	Admitted via	Weekday/ BH	Night	Reason for admission	Diagnosis on admission	Comment	Planned/ semi planned visit?	Acute complication/ toxic of disease	Acute complication of cancer treatment	Become acutely unwell in VCC	Meet criteria for accessing at VCC?	Oversight admission	IP Clerno	RT that can't be given in ambulatory setting	MSCC for duration of RT only	Complex disease related symptom control	SVCD managment and treatment	Emergence of treatment side effect: SACT	Emergence of treatment side effect: RT	Post early phase trial monitoring	Meet criteria for IP admission?		Yes/No	Reason	Local/ion	Reason	On SACT	Regimen	RT	Recent admission VCC	Recent DGH admission	Reason?
[redacted]		14/05/2021	Yes	Yes	Microbiology	No	No	Blood cultures from port grows gram+cocci (reason AU day before)	Central line infection		No	No	Yes	No	Yes	Yes	No	No	No	No	No	Yes	No	No	Yes		No		No	NA	Yes	Cisplat/Carbo	No	Yes	No	NA
		15/05/2021	No	Yes	Treatment Helpline	Yes	Yes	Temp at home on chemo	Viral URTI	Taught stay due to logistics	No	No	Yes	No	Yes	Yes	No	No	No	No	No	Yes	No	No	Yes		No		No	NA	Yes	Capecitabine	No	No	No	NA
		16/05/2021	No	Yes	Treatment Helpline	Yes	No	Vomiting post chemo	CINV		No	No	Yes	No	Yes	Yes	No	No	No	No	No	Yes	No	No	Yes		No		No	NA	Yes	Oxaliplatin/ Capecitabine	No	No	No	NA
		16/05/2021	No	Yes	Treatment Helpline	Yes	No	Vomiting and diarrhoea	Capecitabine toxicity		No	No	Yes	No	Yes	Yes	No	No	No	No	No	Yes	No	No	Yes		No		No	NA	Yes	Oxaliplatin/ Capecitabine	No	No	No	NA
		17/05/2021	PSU	No	OPD VCC	No	No	Urinary retention (+ve/-ve PSCC site in OPD	Urinary retention PSCC related thrombus	Catheterised and discharged home	No	Yes	No	Yes	Yes	No	NA	NA	NA	NA	NA	NA	NA	NA	NA		NA		No	NA	Yes	Oxaliplatin	No	No	No	NA
		17/05/2021	PSU	No	OPD VCC	No	No				No	Yes	Yes	Yes	Yes	No	NA	NA	NA	NA	NA	NA	NA	NA	NA		NA		No	NA	Yes	MMdG	No	No	No	NA
		17/05/2021	Yes	No	Radiotherapy	No	No	Worsening AKI	Required nephrostomies	Referred to urologist, discharged home	No	Yes	No	Yes	Yes	No	NA	NA	NA	NA	NA	NA	NA	NA	NA		NA		No	NA	No	NA	Yes	Yes	No	RT
		17/05/2021	Yes	Yes	Treatment Helpline	No	No	Severe pain post chemo with vomp	Chronic pain exacerbated		No	No	No	No	Yes	No	No	No	No	Yes	No	No	No	Yes		No		No	NA	Yes	FECT	No	No	No	NA
		17/05/2021	Yes	No	OPD VCC	No	No	unwell in OPD, abdo pain, deranged LFT's	Progressive liver disease with no reversible component		No	Yes	No	Yes	Yes	No	NA	NA	NA	NA	NA	NA	NA	NA	NA		NA		No	NA	Yes	Docetaxol	No	No	No	NA
		17/05/2021	Yes	Yes	SACT	No	No	Pain and unwell when attending for SACT	Pyelonephritis	Bilateral ureteric stents/ insitu	No	Yes	No	Yes	Yes	No	No	No	??	No	??	No	No	No		No		No	NA	Yes	Vinorelbine/ cisplatin	Yes	Yes	No	UTI
		17/05/2021	Yes	Yes	Radiotherapy	No	No	Diarrhoea and vomiting	Capecitabine induced colitis		No	No	Yes	Yes	Yes	Yes	No	No	No	No	No	Yes	No	No	Yes		No		UHW	Gastro review (ileal stig	Yes	Capecitabine	Yes	No	No	NA
		18/05/2021	No	Yes	Planned SACT	No	No	Planned SACT	Planned SACT		Yes	NA	NA	NA	NA	Yes	Yes	No	No	No	No	No	No	No	No		No		No	NA	Yes	Cisplatin/ Dox	No	NA	NA	NA
		18/05/2021	Yes	No	Treatment Helpline	No	No	Dysuria and burning	zoc to urolithic doc to RT		No	No	Yes	No	Yes	No	NA	NA	NA	NA	NA	NA	NA	NA	NA		NA		No	NA	No	NA	Yes	No	No	NA
		18/05/2021	Yes	No	Tcsm	No	No	Raised Cs in clinic	Raised Cs when bloods reported	Booked in to AU for repeat bloods and to discuss if raised cs - need to be seen	Yes	Yes	No	No	Yes	No	NA	NA	NA	NA	NA	NA	NA	NA	NA		NA		No	NA	Yes	Nivolumab	No	No	No	NA
		18/05/2021	Yes	No	Treatment Helpline	No	No	Worsening rash	Chemotherapy induced rash, oral candida		No	No	Yes	No	Yes	No	NA	NA	NA	NA	NA	NA	NA	NA	NA		NA		No	NA	Yes	PCV	No	No	No	NA
		18/05/2021	Yes	No	Tcsm	No	No	Pain	??	No sepsis or discharge summary	?	?	?	?	??	No	NA	NA	NA	NA	NA	NA	NA	NA	NA		NA		No	NA	Yes	Carboplatin/etoposide	No	No	No	NA
YM12748 R	CF32 7RF	18/05/2021	Yes	No	OPD VCC	No	No	SYCO respected in OPD	SYCO	Discharged home whilst awaiting appointment in DGH	No	Yes	No	Yes	Yes	No	NA	NA	NA	NA	NA	NA	NA	NA	NA		NA		No	NA	No	NA	No	Yes	Yes	New diagnosis of lung ca

160 assessments/ admissions in VCC May 2021

71 patients admitted
89 patients not admitted

There were 41 planned admissions to First Floor ward and The Assessment Unit for SACT, RT, and planned reviews

14 patients were transferred out of FF and AU

9 out of the 10 patients transferred from FF had met the admission criteria

65 of 71 patients admitted met the strict admission criteria

Key Findings

Of the 14 patients transferred
3 were for non-emergency transfer e.g. hospice
3 transferred for emergency care
8 transferred for specialist care e.g. gastroenterology input for colitis

2 patients admitted met both the exclusion criteria **and** the admission criteria – highlights the complexity of our patients

119 un-planned visits (53 admitted, 65 not admitted)
53 attended via treatment helpline
65 attended from departments **within VCC** e.g. SACT, OPD.

Of the 14 patients transferred, 8 were transferred to UHW – 5 lived in C+V locality, 3 not in locality

4.6. **Divisional Risks**

The following risks were opened between October 2021 – December 2021

ID	**Name of Risk**	**Current Rating**	**Target Rating**	**Review Date**	**Action**
2480	Current and predicted shortfall of oncologists by 2025	15	4	01/02/2022	Training places have increased however will not feed through by 2025. Actively seeking to recruit Developing new multi-professional ways of working (but there are also workforce limitations in other professional groups and the time taken to train new colleagues is a challenge)
2475	A risk that increases in COVID and the Winter pressures period potentially impacts Int. Care project delivery	12	8	31/01/2022	Update 10.12.21 - Regular meetings continue to take place with PMO to review status of projects and work plan. Activity monitored via the Integrated Care Operational Group (ICOG) and sickness levels monitored by Heads of Departments. Mitigating actions: 1. Monitor staff sickness through the IC Operational Group 2. Monitor increase in demands via IC Operational Group 3. Update PM with resourcing issues for further escalation and re-prioritisation. Logged as a Project risk also for Integrated Care as may impact on project work streams
2432	Digital Health & Care Record DHCR036(R) - DHCR Project Support from Service	12	4	23/02/2022	Update 10.12.21 - Regular meetings continue to take with project leads. Ways of working almost completed for IC. Some process maps completed and signed off by service. Update 03.11.21 -Regular update meetings scheduled with project team leads to review progress and outstanding work. Attendance at Project Team meetings. Update 27/10/2021 -Dedicated time made available for operational lead. Continuous review of service capacity across the inpatient workstream prioritisation process. Weekly reviews with the Department Lead to monitor progress in DHCR project, but also to sense check the demands of the services.
2452	Intermittent IP telephony failure	12	3	01/02/2022	New Wifi phones are in stock to replace the critical areas that require upgrades immediately. New Batteries are required to install these which will be ordered ASAP. Plan to replace all 149 handsets ASAP Attempt to fix the issue with the 7925 in the interim.

During October 2021 – December 2021, there were 66 closed risks. The majority of the risks were historic operational services risks, which have now been actioned.

5.0	**Effective Care** **Descriptor; evidence based and appropriate**

5.1. **Complaints**

Type of concern	No.	KPI Achieved
Early resolution	6	100%
Putting Things Right (PTR) (formal concern)	10	90%
Re-opened Putting Things Right (formal concerns)	0	N/A
Redress	0	N/A
Claims	6	N/A

5.1.1. A summary of the key themes is highlighted below. Improvement plans and lessons learnt are being captured and shared where appropriate to demonstrate the learning undertaken.

Formal concerns	Early Resolutions	Lessons Learnt/ Improvements
Attitude and Behaviour – Attitude of Medial Staff to Patient Clinical Treatment/ Assessment – Incorrect/ Insufficient Clinical Treatment/ Assessment – Delay in Receiving Treatment Communication Issues – Incorrect Information Communication Issues - Insufficient Information Attitude and Behaviour – Receptionist Clinical Treatment/ Assessment – Delay in Receiving Treatment Attitude and Behaviour – Competence Appointments – Delay in Appointments Appointments – Delay in Receiving Outpatient Appointment	Attitudes and Behaviour x1 Clinical treatment/ Assessment x1 Medication x1 Nutrition/ Hydration Issues x1 Equipment x1 Communication Issues	Improvement project to look at SACT booking centre processes. Environment improvement for patients while receiving SACT Clearer medical documentation around CT/MRI images.

5.2. **Claims**

Personal Injury Total 2		**Clinical Negligence Total 4**	
Velindre Cancer Centre		**Velindre Cancer Centre**	
Slip, Trip, Fall	1	Alleged Missed diagnosis	1
Defective Equipment	1	Misreported CT scan	1
		Treatment complications	2

Total number of VCC claims: 6

New Claims

No new claims were received during the reporting period.

Re-opened claims

No claims were re-opened during the reporting period.

Potential Claims

3 potential claims remain on the Datix OfW Claims Module for the reporting period for VCC.

- missed referral for a hysterectomy;
- a member of staff working at VCC contracted Covid-19;
- missed follow-up following a mastectomy.

A potential claim comprises of any communication that is received indicating a potential claim may be pursued against the Trust. When there is such an indication, these are uploaded to the Claims portal by the Claims Manager

Notification of a claim or potential claim can come from several sources but usually from the following: -

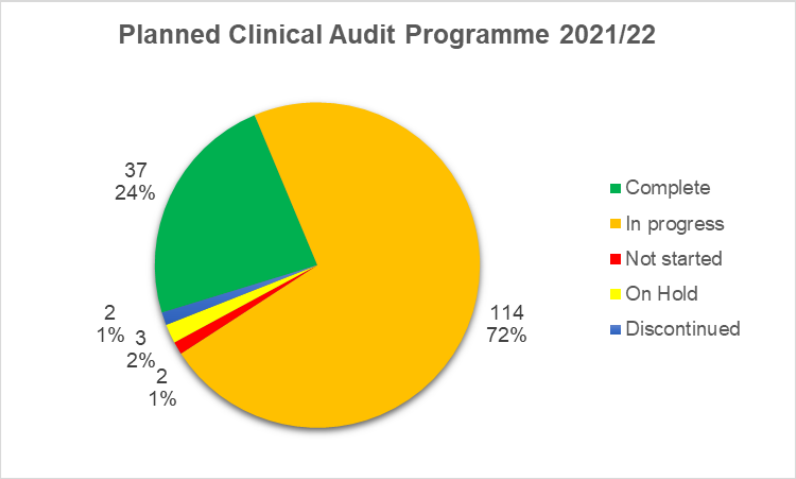
- Request for access to records
- Solicitors letter
- Letter/communication direct from claimant
- Incident outcome
- Notification ET1 (Employment Tribunal) (although these are usually done via OD and Workforce)

Closed claims

A total of 2 clinical negligence claims were closed during the reporting period. An update of any learning from these closed cases is also captured below (in addition to any previous Learning Briefs undertaken).

6.0	**Efficient Care** **Descriptor; avoid waste**

6.2 The Planned Clinical Audit Programme is linked to the Health Care Standards (HCS) and in addition to planned audits it also includes continuous monitoring projects and those rolled over from the previous year.
Project progress is monitored throughout the year and is reported to all SST's. The overall progress is shown in the pie chart below, the key for which is: - red: project has yet to be started, amber: in progress (including continuous monitoring), and green: completed.



The completed projects include a summary of results, areas of good practice or areas for improvement identified and any recommendations. These recommendations are then followed up at the SST meetings quarterly where progress against them is recorded. An annual summary will be included in the report for all national audits and continuous monitoring projects. It is worth noting that any projects submitted throughout the year are added to the programme and their progress will be monitored.
There are currently 158 audits on the programme for 2021/2022; 37 have been completed 114 are in progress, 43 of which are continuous monitoring projects, 2 have not been started, 3 are on hold and 2 have been discontinued.
Projects in progress are at various stages, for example data collection, data entry or analysis.

There are several reasons for non-starting projects: -

Audit Title	Reason for Not Starting
Consent Audit	Work ongoing around consent audit date will be set once changes implemented
Oral SACT consent Audit	Re-audit to start February 2022

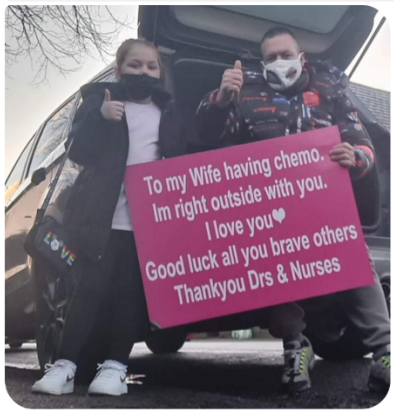
7.0	**Patient Centred Care** **Descriptor; respectful and responsive to the individuals needs and wishes**

7.1 **What are the Patients Saying**

Patient feedback has been collected via CIVICA for this reporting period. Please see full CIVICA report **(appendix 2)**

Patients also provide feedback through our social media platforms;

Thankyou for an amazing job you do on everyone, and the skill and expertise is second to none.
I feel so secure when my Wife is in your hands and she said my sign made a few staff proud today in the chemo area, hope all the other staff also realise they are amazing.
Mark Fredrickson.



Compliments received are added to the DATIX system and share with staff via feedback boards in the clinical areas. During October to December 2021 30 compliments were captured on the OfW DATIX system. Some of the compliments include:

7.2 WHAT OUR REGULATORS / EXTERNAL / INTERNAL AUDIT ARE SAYING

7.2.1. 15 Step Challenge Macmillan Unit, Prince Charles Hospital

Overwhelmingly positive feedback from staff and patients with professional and high-quality care and interaction observed with meticulous attention to COVID & general IPC standards. Themes included signposting and pre-attendance information for patients, some environmental enhancements, optimising this excellent clinical space as far as possible to reduce pressure and risks on VCC site and staffing enhancements (see **Appendix 3**)

Recommendations –

- Increased information on appointment letter and within the clinic;
- Review staffing model to ensure there is sufficient HCSW cover across all clinics;
- Ceiling mounted or trolley TVs for use for patients with headphones to be considered; Consider re-allocated areas to prevent storage in main SACT delivery area;
- The use of ' I am clean tape' to indicate patient items such as commodes are clean and when they were last cleaned to be considered;
- Update resuscitation checks documentation;

- Consider a review so that the PCH Facility could be fully optimised to reduce pressure on VCC and reduce footfall at VCC to include optimisation of the OPD facility and consideration to recommence the PICC service; There needs to be a CIVICA Feedback Zone and information in patient areas regarding how they can made a complaint, suggestion or compliment;
    - Review PHC catering arrangements - including delivery and provision of biscuits for patients.

7.2.3. Risk Management internal audit was conducted in October 2021. To audit was undertaken to provide Velindre University NHS Trust with assurance that its divisions, directorates, and departments are compliant with Trust risk management policies and procedures; and that risks are being effectively managed at a divisional, directorate and departmental level.

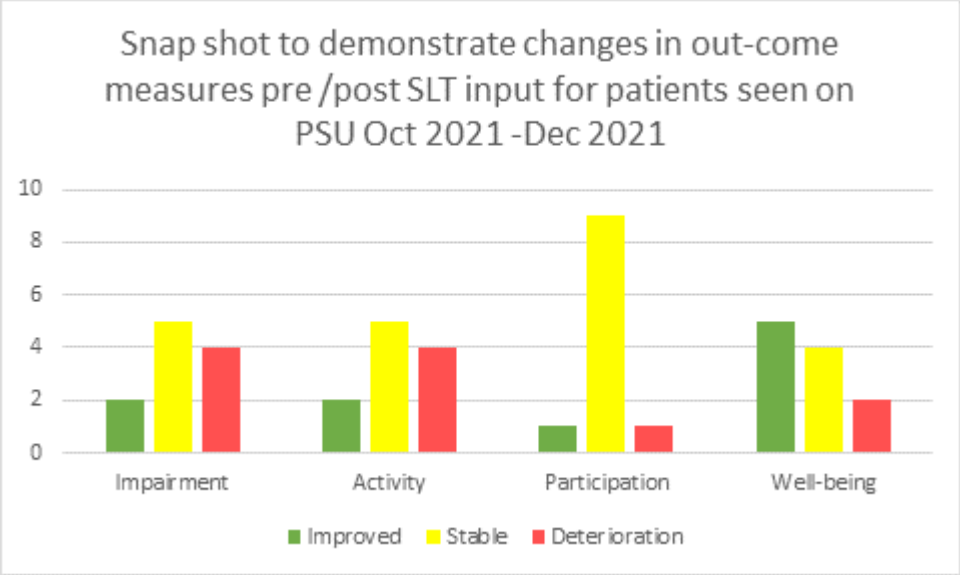
Assurance Objectives	Assurance
Policies and Procedures	Substantial
Identification and management of risks	Reasonable
Risk register scrutiny	Reasonable
Assurance to the Board	Reasonable

No significant matters for reporting were identified during the review. Two medium priority findings were identified.

Medium Priority Findings		
Matter Arising	Potential Risk	Recommendation
VCC was unable to provide an audit trail for training due to the long-term absence of the responsible staff member.□.	Non-compliance with corporate risk management processes; Inconsistency in risk management practice; and Inadequate management of risk.	a. The Trust should ensure: • the new risk management training programme development is completed and rolled out as soon as possible; and • mechanisms are in place to capture attendance at risk management training. b. Divisional management should ensure that attendance at risk management training is monitored at appropriate forums.
Whilst we saw evidence of monitoring of risk registers within SACT and Outpatients, Inpatients was unable to provide such evidence due to its operational meetings being more fluid in response to the Covid-19 pandemic.	Inadequate management of directorate level risks.	a. The Divisional Management Teams should ensure directorate risk registers are monitored and scrutinised frequently at directorate meetings and that meeting minutes evidence this process. b. Whilst we appreciate the challenges of the Covid-19 pandemic, the Trust should ensure that it always appropriately evidences governance processes at all levels of the organisation. This requirement should be communicated to the divisions and directorates.

8.0	**Timely Care** **Descriptor; at the right time**

8.1. Patient Support Unit



8.2. Welfare Rights

VCC Macmillan welfare rights team accessed over £1.087 million in benefits and grants for VCC patients between 1st October 2021 and 31st December 2021.

8.3. IV Access

Examples of service improvement from the IV Access team:

Community Nurse Education for PICC care and Management.
Due to Covid, we have had to adapt how education is delivered to community nurses. Working with all the Health Boards in southeast Wales region, an on line educational programme was devised including documentation for a formal assessment of the practitioners in the community. In addition, as part of the programme a TEAMS training sessions is provided by Velindre to educate and inform the assessors in the community. This will ensure robust training and assessment to improve patient care.

Extravasation training for Radiographers.
Working with the Radiology leads, we standardised the use of one contrast in both departments and to cease using a contrast that could cause more significant extravasation injury. The extravasation guidelines were reviewed and updated, including an easy to follow flow chart to provide instant and accurate guidelines for the management of extravasation. In addition, a training programme was devised specifically for the Radiographers to be delivered by TEAMS. This will improve knowledge and increase their confidence when dealing with extravasation injuries. Ultimately, this will leads to better management and outcomes for patients.

9.0	**Equitable Care** **Descriptor; an equal chance of the same outcome regardless of geography, socioeconomic status**

9.1. Assurance/ Learning

There was 1 learning brief during this reporting period that were generated from claims and redress closed. See table below.

Summary of Incident/Concern	**Key Learning**	**Actions, Review & Ongoing Assurance Mechanisms**
Member of staff had a fall on ice when taking rubbish to the waste yard at VCC.	VCC Inclement Weather Plan has been updated to include the route. Staff reminded that they couldn't access the wrong route for waste disposal. Clear signage and information to ensure staff use the correct route for waste disposal. There is a need for ongoing assessment and site inspections to minimise future risk of slips, trips and falls during inclement weather.	Signs are in place to discourage staff in using the location site to dispose of waste materials. Ongoing assessment and site inspections to minimise future risk of slips, trips and falls during inclement weather The route has been added to the Inclement Weather Plan. New emergency doors have been put in place to limit access to staff New format to internal inspection and mapping zone Case has been discussed at VCC Health and Safety Focus Group Assurance to be provided from Operational Services of ongoing inspection and gritting of routes when required during inclement weather. Operation Services to ensure the doors are not accessed inappropriately

9.1.3 **After Action Review Database**

The after-action review database is a central learning database where learning from our complaints are visible and accessible to inform our quality indicators, clinical audits, internal and external audits. The learning database is shared at the VCC Q&SMG meetings with departments being asked to provide an update on their learning.

9.2. Healthcare Standards

HCS	Score 2021/22	Score Q1	Score Q2
Std 1.1. Health Promotion	Full		
Std 2.1 Managing Risk and H&S (VC&LM)	Partial	4	4
Std 2.2 Preventing Pressure Damage	Full	4	4
Std 2.3 Falls Prevention	Partial	4	4
Std 2.4 Infection Prevention and Control	Full	4	4
Std 2.5 Nutrition and Hydration	Full	4	4
Std 2.6 Medicines Management	Full	5	5
Std 2.7 Safeguarding	Full	4	4
Std 2.8 Blood Management	Full	5	5
Std 2.9 Medical Devices, Equipment and Systems	Full	4	4
Std 3.1 Safe and Clinically Effective Care	Full	4	4
Std 3.2 Communicating Effectively	Partial	4	4
Std 3.3 Q Improvement, Research and Innovation	Full	4	4
Std 3.4 IG and Technology	Full	5	4
Std 3.5 Record Keeping	Full	4	4
Std 4.1 Dignified Care	Partial	4	4
Std 4.2 Patient Information	Partial	4	4
Std 5.1 Timely Access	Full	4	4
Std 6.1 Promote Independence	Partial	3	3
Std 6.2 Peoples Rights	Full	4	4
Std 6.3 Learning from Feedback	Full	3	3
Std 7.1 Workforce	Full		

9.1.5 **Learning Infographics**

The learning infographics below show the themes from incidents, claims and are where Directorate leads are being asked to focus their efforts on learning, retraining and intervention. There are many improvement plans in place in all of the directorates to address some of the themes, these improvement plans are monitored through the Velindre Futures Board and through IMTP for each Directorate.

Velindre Cancer Centre themes from incidents and feedback

Appointments 	Staff Attitude / Behaviour 	Clinical Services/Assessments 
Communications issues (Including Language) 	Equality 	Environment, Facilities & Transport 
Infection Control 	Record Keeping 	Monitoring and Observations 

Access to Services and Resources	Test and Investigation	Patient Care
		

10.1	**Performance**

10.1 **VCC Performance Summary September 2021**

The summary of performance in December 2021 is attached (please see **appendix 4**)**.** This shows the overall performance with targets. The continuing restrictions imposed by Covid, absence of staff due to sickness, and increasing patient numbers are continuing to impact on services provided by us at VCC. We are expecting to get a surge in Breast referrals in January as a result of surgery planned in the Health Boards at present. We continue to look at the overall service challenge and also focus on each tumour site service to prioritise where the hotspots and pinch points will be during the expected surge.

7 targets were reporting red in December's performance report. These included 5 targets in radiotherapy (*Patients Beginning Radical Radiotherapy within 28 days, Patients Beginning Palliative Radiotherapy within 14 days, Scheduled Patients Beginning Radiotherapy Within 21-Days, Urgent Scheduled Patients Beginning Radiotherapy Within 7-Days and Emergency Patients Beginning Radiotherapy Within 1-Day*). Breaches were partly due to specific planning requests made by consultants, Brachytherapy capacity and booking/administrative issues. There were 4 unavoidable falls. The Falls Scrutiny Panel meet monthly to review the previous months inpatient fall incidents. Actions and learning are identified and fed back to the ward manager and a highlight report sent to QSMG. The Scrutiny Panel is under review and improvements to the process are being made now.

11.0	Celebration and Exception

Royal College of Nursing (RCN) Wales HealthCare Support Worker of the Year Award

It was a great privilege for the Trust to announce that the Royal College of Nursing (RCN) Wales HealthCare Support Worker of the Year Award went to Diane Rees.
Diane is one of the Navigators working within the Clinical Nurse Specialist Team at Velindre Cancer Centre, post that are currently funded by Macmillan.

Velindre and All-Wales Medical Genetics Service's pharmacogenetics test wins prestigious 'Scaling up Innovation and Transformation Award'

An innovative new test that can reduce adverse reactions to chemotherapy medications by screening patients in advance of treatment to identify those at risk of severe side effects was awarded the Scaling up Innovation and Transformation Award at the recent MediWales Innovation Awards.

12.0	Conclusions

11.1 This has been a very busy period clinically with services seeing an increase in pre-covid demand and restrictions due to current Covid wave. Quality and Safety as a department has been engaged in work to support the upgrades to the OfW Datix system for both incidents and risk, setting up systems and processes for managing complaints and concerns and developing as a new team. There is evidence that incidents/concerns/compliments are managed appropriately and compliant with the PTR regulations that lessons learned and actions are implemented and monitored by Directorate leads and their teams but we recognise there is more to do.

SENIOR LEADERSHIP TEAM

HIGHLIGHT REPORT - VCC Q&S MANAGEMENT GROUP

DATE OF MEETING	04.11.2021

PUBLIC OR PRIVATE REPORT	Private

IF PRIVATE PLEASE INDICATE REASON	Potentially Idenfiable / Sensitive Information

PREPARED BY	VCC QUALITY & SAFETY OFFICER
PRESENTED BY	Head of Nursing, Quality, Patient Experience and Integrated Care

REPORT PURPOSE	FOR NOTING

1. PURPOSE

1.1 This paper had been prepared to provide the SLT with details of the key issues considered by the VCC Quality & Safety Management Group meeting on the 14.10.2021.

1.2 Key highlights from the meeting are reported in section 2.

1.3 The Board is requested to **NOTE** the contents of the report and actions being taken.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	Nothing to report.
ADVISE	Nothing to report.
ASSURE	15 Step Challenge was undertaken within the outpatients department and carried out Executive Director of Nursing, AHPs and Medical Scientists. A number of recommendations have been identified and an action plan developed. A number of the actions have already been completed (see appendix 1)
INFORM	Trust Health & Safety Manager is holding an MDT meeting to go through all datix that are covid related. Discussions to be held with Managers if further assurance is needed.
APPENDICES	**YES - (Please Include Appendix Title in Box Below)**
	15 Step Challenge Action Plan

APPENDIX C - 15 STEP CHALLENGE ACTION PLAN TEMPLATE

Area visited: Velindre Cancer Centre Outpatients Department
Completed by: Nicola Williams, Executive Director Nursing, AHP & Health Science & Kyle Page, Business Support Officer
Date: 27th August 2021

WELCOMING AND CARING

Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?	Status
Implement a system of nurse rounding		OPD nurse manager	20/09/2021	Outpatient, Medical Records and Private Patients Operational Management Group	Complete
Display board with names of nurses working in clinics and who is in charge. Identifying Welsh speakers		OPD nurse manager	17/09/2021	Outpatient, Medical Records and Private Patients Operational Management Group	Complete
Waiting times display kept up to date. Clinic nurses to ensure it regualy updated.		OPD nurse manager	20/09/2021	Outpatient, Medical Records and Private Patients Operational Management Group	Complete
Cost to be optained for new flooring in OPD		Head of Outpatients	15/10/2021	Outpatient, Medical Records and Private Patients Operational Management Group	Started
Pursue the relocation of phelbotomy to alternative location		Head of Outpatients	15/10/2021	Outpatient, Medical Records and Private Patients Operational Management Group	Started
A reqime of deep cleaning throughout the Department		Operational Services	04/09/2021	Outpatient, Medical Records and Private Patients Operational Management Group Infection Prevention and Control Group	Complete

WELL ORGANISED AND CALM

Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?	Status
Radio to be removed from main OPD waiting area		OPD nurse manager	04/09/2021	Outpatient, Medical Records and Private Patients Operational Management Group	Complete
All displayed information to be up-dated and laminated. Out of date information to be removed.		OPD nurse manager	20/09/2021	Outpatient, Medical Records and Private Patients Operational Management Group	Complete
Daily cleaning checks/audit		OPD manager	04/09/2021	Outpatient, Medical Records and Private Patients Operational Management Group Infection Prevention and Control Group	Complete
Promote use of current survey Monkey until alternative solution (Civica) is implemented		OPD manager	04/10/2021	Outpatient, Medical Records and Private Patients Operational Management Group	Scheduled
Consideration of relocation of reception desk to create more privacy		Head of Outpatients/Medica	Regualr monitoring in an atempt t	Outpatient, Medical Records and Private Patients Operational Management Group	Scheduled

INFORMATIVE

Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?	Status
Information on how to make a complaint/suggestion or provide feedback to be displayed in OPD		OPD nurse manager	30/09/2021	Outpatient, Medical Records and Private Patients Operational Management Group Quality and Safety Management Group	Started
Review appointment letters going out to patients. New WPAS will have abilities to be more specific and have loccaly configerable letter templates accossiated to each clinic.		Medical Records Manager	30/05/2022	Outpatient, Medical Records and Private Patients Operational Management Group Digital Health and Care Record Project	Scheduled
Display a poster explaining all Wales uniforms		OPD manager	30/10/2021	Outpatient, Medical Records and Private Patients Operational Management Group	Scheduled

Survey Summary Report

Full Breakdown Analysis of Survey Results
Velindre Cancer Centre

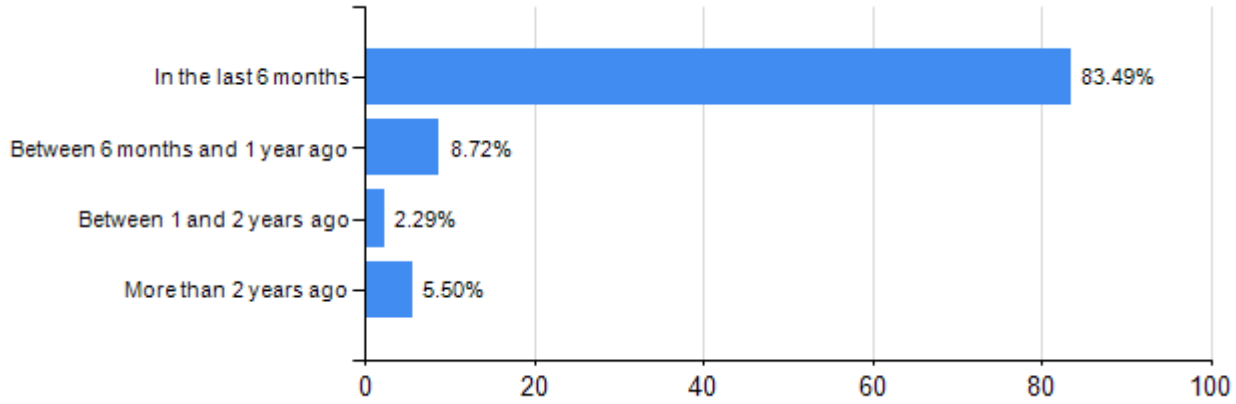
Total Respondents: 238

Survey: Your Velindre Experience

Start Date: 01/10/2021 **End Date:** 31/12/2021

Question 1: How recent was the experience you are thinking of?

Available Answers	Responses	Score (%)
In the last 6 months	182	83.49%
Between 6 months and 1 year ago	19	8.72%
Between 1 and 2 years ago	5	2.29%
More than 2 years ago	12	5.50%
Total	**218**	**100%**



Survey Summary Report

Full Breakdown Analysis of Survey Results
Velindre Cancer Centre

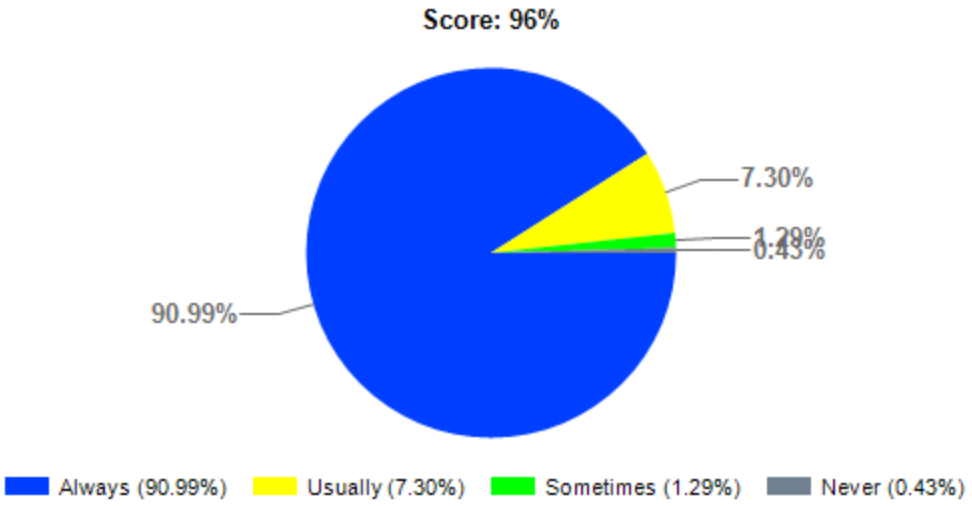
Total Respondents: 238

Survey: Your Velindre Experience

Start Date: 01/10/2021 **End Date:** 31/12/2021

Question 2: Did you feel that you were listened to?

Available Answers	Responses	Score (%)
Always	212	90.99%
Usually	17	7.30%
Sometimes	3	1.29%
Never	1	0.43%
Total	**233**	**100%**



Survey Summary Report

Full Breakdown Analysis of Survey Results
Velindre Cancer Centre

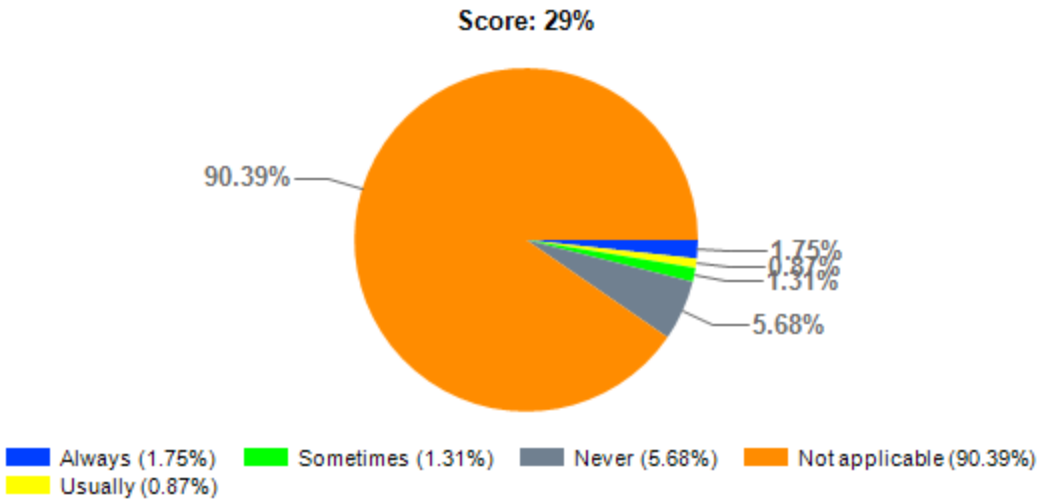
Total Respondents: 238

Survey: Your Velindre Experience

Start Date: 01/10/2021 **End Date:** 31/12/2021

Question 3: Were you able to speak Welsh to staff if you needed to?

Available Answers	Responses	Score (%)
Always	4	1.75%
Usually	2	0.87%
Sometimes	3	1.31%
Never	13	5.68%
Not applicable	207	90.39%
Total	**229**	**100%**



Survey Summary Report

Full Breakdown Analysis of Survey Results
Velindre Cancer Centre

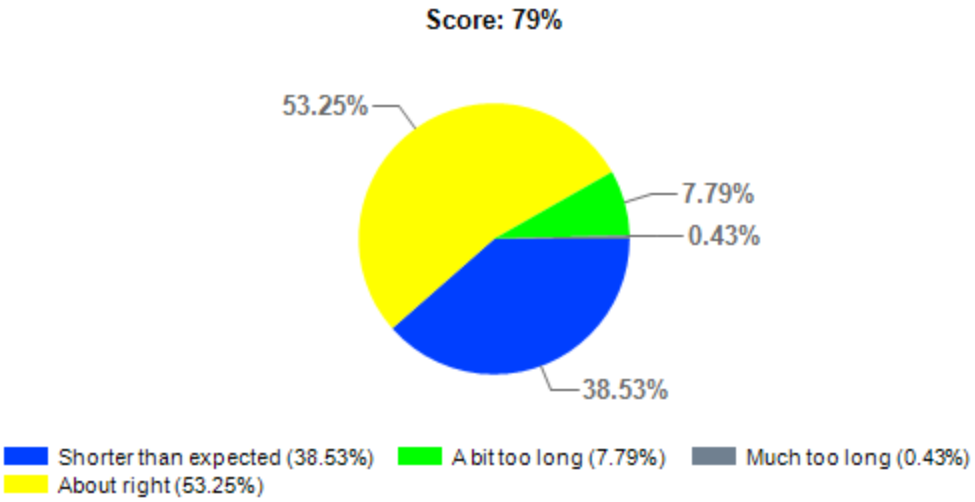
Total Respondents: 238

Survey: Your Velindre Experience

Start Date: 01/10/2021 **End Date:** 31/12/2021

Question 4: From the time you realised you needed to use the service, was the time you waited:

Available Answers	Responses	Score (%)
Shorter than expected	89	38.53%
About right	123	53.25%
A bit too long	18	7.79%
Much too long	1	0.43%
Total	**231**	**100%**



Survey Summary Report

Full Breakdown Analysis of Survey Results
Velindre Cancer Centre

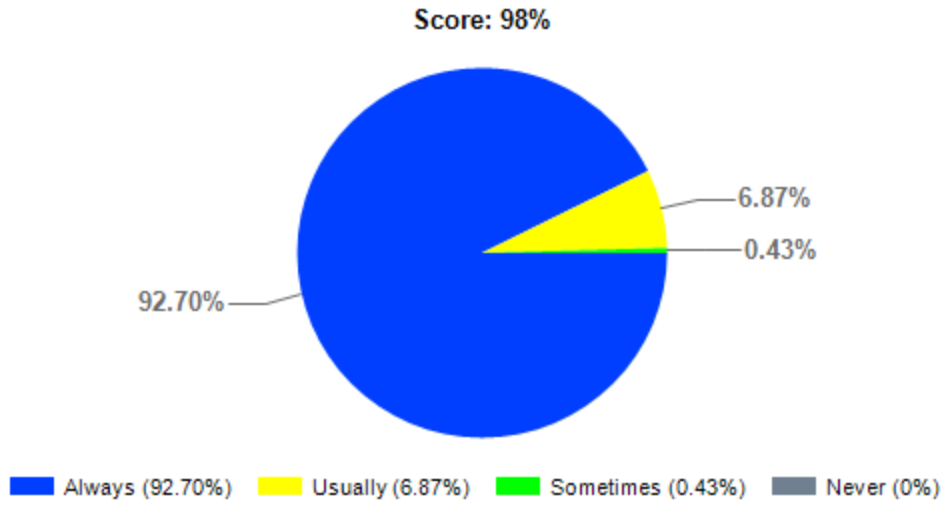
Total Respondents: 238

Survey: Your Velindre Experience

Start Date: 01/10/2021 **End Date:** 31/12/2021

Question 5: Did you feel well cared for?

Available Answers	Responses	Score (%)
Always	216	92.70%
Usually	16	6.87%
Sometimes	1	0.43%
Never	0	0.00%
Total	**233**	**100%**



Survey Summary Report

Full Breakdown Analysis of Survey Results
Velindre Cancer Centre

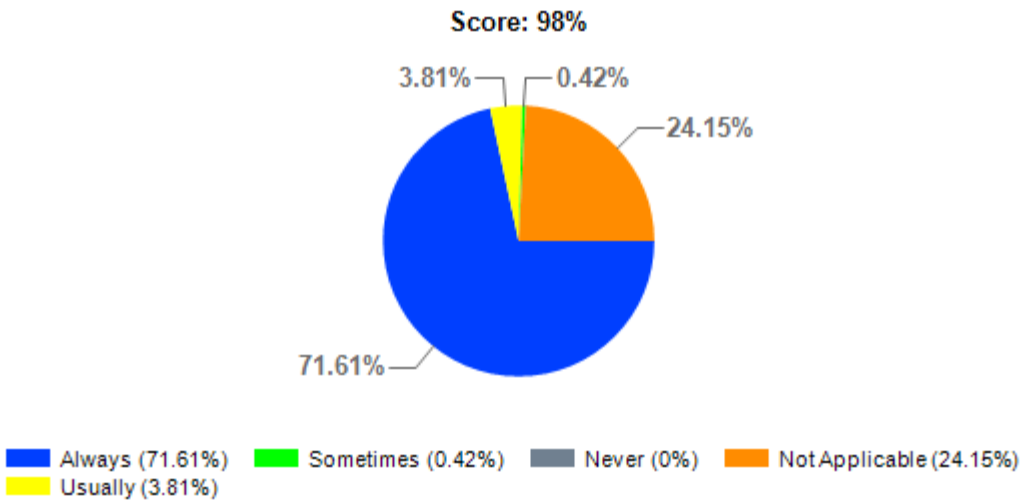
Total Respondents: 238

Survey: Your Velindre Experience

Start Date: 01/10/2021 **End Date:** 31/12/2021

Question 6: If you asked for assistance did you get it when you needed it?

Available Answers	Responses	Score (%)
Always	169	71.61%
Usually	9	3.81%
Sometimes	1	0.42%
Never	0	0.00%
Not Applicable	57	24.15%
Total	**236**	**100%**



Survey Summary Report

Full Breakdown Analysis of Survey Results
Velindre Cancer Centre

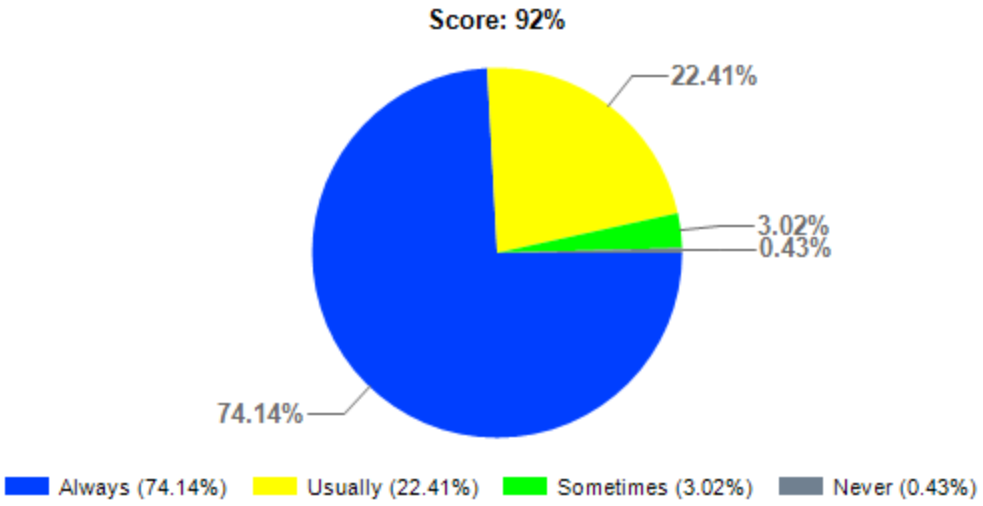
Total Respondents: 238

Survey: Your Velindre Experience

Start Date: 01/10/2021 **End Date:** 31/12/2021

Question 7: Did you feel you understood what was happening in your care?

Available Answers	Responses	Score (%)
Always	172	74.14%
Usually	52	22.41%
Sometimes	7	3.02%
Never	1	0.43%
Total	**232**	**100%**



Survey Summary Report

Full Breakdown Analysis of Survey Results
Velindre Cancer Centre

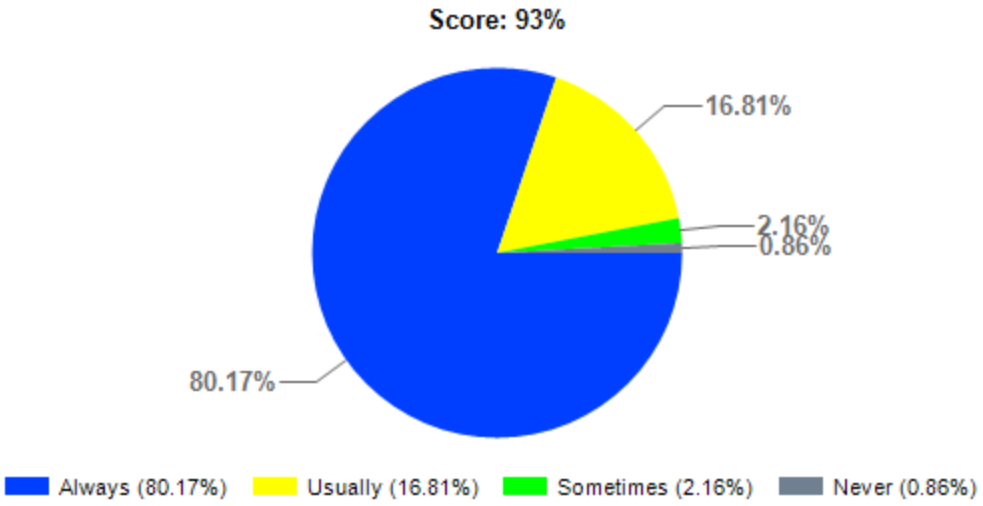
Total Respondents: 238

Survey: Your Velindre Experience

Start Date: 01/10/2021 **End Date:** 31/12/2021

Question 8: Were things explained to you in a way that you could understand?

Available Answers	Responses	Score (%)
Always	186	80.17%
Usually	39	16.81%
Sometimes	5	2.16%
Never	2	0.86%
Total	**232**	**100%**



Survey Summary Report

Full Breakdown Analysis of Survey Results
Velindre Cancer Centre

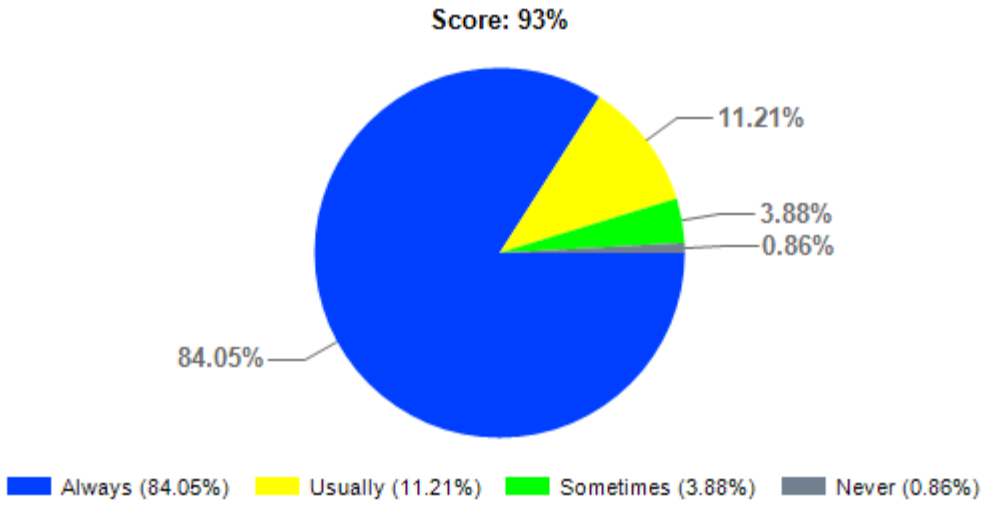
Total Respondents: 238

Survey: Your Velindre Experience

Start Date: 01/10/2021 **End Date:** 31/12/2021

Question 9: Were you involved as much as you wanted to be in decisions about your care?

Available Answers	Responses	Score (%)
Always	195	84.05%
Usually	26	11.21%
Sometimes	9	3.88%
Never	2	0.86%
Total	**232**	**100%**



Survey Summary Report

Full Breakdown Analysis of Survey Results
Velindre Cancer Centre

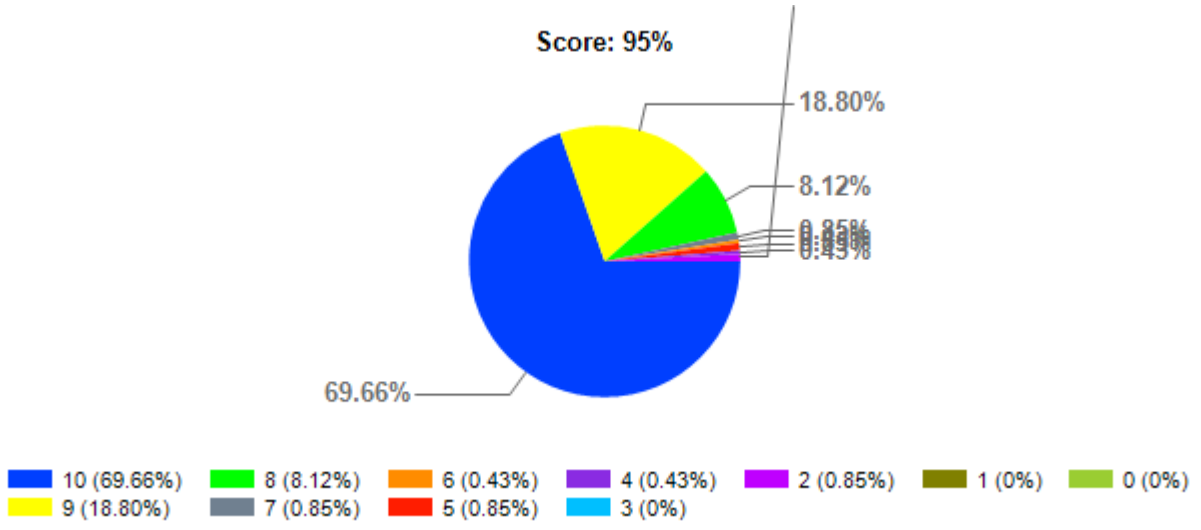
Total Respondents: 238

Survey: Your Velindre Experience

Start Date: 01/10/2021 **End Date:** 31/12/2021

Question 10: Using a scale of 0 to 10 where 0 is very bad and 10 is excellent, how would you rate your overall experience?

Available Answers	Responses	Score (%)
10	163	69.66%
9	44	18.80%
8	19	8.12%
7	2	0.85%
6	1	0.43%
5	2	0.85%
4	1	0.43%
3	0	0.00%
2	2	0.85%
1	0	0.00%
0	0	0.00%
Total	**234**	**100%**



Survey Summary Report

Full Breakdown Analysis of Survey Results
Velindre Cancer Centre

Total Respondents: 238

Survey: Your Velindre Experience

Start Date: 01/10/2021 **End Date:** 31/12/2021

Question 11: Was there anything particularly good about your experience that you would like to tell us about?

The staff in CDU are excellent and timely.
From the start of my journey everyone I've seen and been involved with my treatment have gone above and beyond with the support they've given and made me feel comfortable when explaining what I would be experiencing. Wonderful team work.
Excellent staff. Nice food
I always felt relaxed and not at all anxious
All the staff I encountered were helpful, friendly and patient with me.
Yes was seen to straight away
My daughter was always allowed in with me when I had to see someone so that she understood what was going on
The staff were all amazing and lovely, apart from one phlebotomist
I was really well looked after, my thanks to all concerned...
The staff were very friendly and helpful
The staff was absolutely excellent and so was the aftercare. Desk receptionists were fantastic and very thoughtful and extremely helpful.
Your provision of transport has been exemplary, as being elderly, has been so important. All my contacts with everybody, they have been very caring and reassuring.
The kindness and patience by everyone
I was made to feel as if I was part of a family. All staff very approachable and they all seemed to enjoy their work.
Although it's 3 years since my initial diagnosis where I've had chemotherapy, radiotherapy, and since then have received support by telephone every 6 months (due to covid) about my condition. Last month I attended personally at outpatients. The staff in all units were very professional, caring and nothing was too much trouble.
Every person is very very helpful, very kind understanding puts you at ease, and still after all these years still there for me and others I expect. Thanks all.

Survey Summary Report

Full Breakdown Analysis of Survey Results
Velindre Cancer Centre

Total Respondents: 238

Survey: Your Velindre Experience

Start Date: 01/10/2021 **End Date:** 31/12/2021

I have a very sore lower back and the radiographers were always very careful and concerned when putting me on and off the "table". They also arranged for me to have extra medication. I really was well looked after.

I always felt so well looked after and in such safe hands. Amazing, caring staff.

That I see the same doctor all the time

No

My overall experience was excellent, from the time I went to Outpatients and also when received Radiotherapy. I can’t thank them all for wonderful care I received.

I appreciated the honesty I was treated with.

The quality of care from start to finish. The nurses and doctors worked tirelessly day in, day out and always seemed positive, upbeat and there to help. This couldn't have been easy given the situation at the time.

All the staff were most helpful and friendly

Always made comfortable. Staff always friendly.

From diagnosis to treatment was really quick. Like a rollercoaster ride in the good sense.

I have been under your care for one year and am receiving on going oral treatment (following one dose of radiotherapy) and monthly injections, regular CT scans etc.
The care I have had has been excellent, all staff attentive and everything seems to work really well. I feel in safe hands during the most challenging time of my life.

Bit tired after treatment but still carrying on

The staff are genuinely fantastic.

I was explained that the treatment was the best I could have.

Within all areas of the hospital the care has been consistent, even with the restrictions that are in place due to covid.

Happy with information given and explained during consultations.

All round it was very good

Always caring and willing to help in any way

Survey Summary Report

Full Breakdown Analysis of Survey Results
Velindre Cancer Centre

Total Respondents: 238

Survey: Your Velindre Experience

Start Date: 01/10/2021 **End Date:** 31/12/2021

Yes all the staff and doctors are amazing, they do a wonderful job the care they give people is brilliant. I cannot thank them enough, where would we be without the NHS
No single thing - the whole experience and staff were / are excellent.
I was always put at ease and felt comfortable with all my treatment. Radiotherapy unit 7 & 8 were extremely friendly and explained everything
Always very helpful and listened to. Very lovely staff.
Everyone was very helpful
Not all sickness tablets were given at first chemo. As a result had more sickness than should have. Also bone marrow wasn't given so had to go down to hospital to collect it day after chemo (first)
Everybody was welcoming and friendly
I love Velindre smile a tone of voice- everyone has it. I have never heard it anywhere else. It is so reassuring at a difficult time for patients and families. This kindness isn't restricted to face to face situations- the phone calls to check on how patients are coping is brilliant. Thank you.
All members of staff were very caring and efficient. Appointment times were adhered to.
Transport, your hospital sorted it out so I had less stress, due to other underlying health issues.
I always feel that I am treated as an individual and with great kindness. Although there can be long waits to be seen in clinic, this is balanced by the fact that consultations are never rushed- everyone gets the time they need.
From start to finish, the care that I received was GREAT
Staff always very caring.
I was well cared for after a bad experience with the cold air.
The staff were all very kind and made my time with you less of an ordeal. Thank you - very much!
Everyone was helpful and supportive
The efficiency of staff and friendliness
There is an amazing boost to morale with every visit to Velindre

Survey Summary Report

Full Breakdown Analysis of Survey Results
Velindre Cancer Centre

Total Respondents: 238

Survey: Your Velindre Experience

Start Date: 01/10/2021 **End Date:** 31/12/2021

Your staff were pleasant and efficient, while at the same time they were relaxed and friendly. The atmosphere during treatment was calm and reassuring. Appointments were efficiently organised.
All the staff from the receptionist, nurses, doctors and support staff, could not be any more cheerful and helpful. I could not be more pleased with the care.
I was well looked after by the radiotherapy staff they were always happy and friendly
I was treated very well in everyway.
Staff were very thorough
Staff are amazing
Always felt reassured - staff always cheerfull and helpfull. Can't praise them enough.
Generally very good. Cannot fault overall.
Every department I attend know exactly what is required for me and it certainly makes me feel more relaxed. An amazing place.
Pleased with consultant responses
Always caring
Always friendly staff and helpful, concerned about my welfare
No
Getting the all clear.
All the staff were true professionals and a credit to themselves and the NHS
All members of each unit were very professional and despite all the pressures of Covid-19, happy & cheerful
I was always treated with kindness & respect and all procedures were explained to me
I found the vast majority of the staff particularly helpful.
You are treated as an individual not as a number
I felt really cared for and understood all through my Velindre experience. I was impressed with the level and cleanliness at the hospital
Most impressed with staff. I have involuntary spasms due to osteoarthritis, particularly spine. I must have moved awkwardly and had a period of intense pain. Those on hand waited and simply carried on. I was

particularly surprised and pleased to be treated on this visit.
Punctual appointments - never waiting unduly long. Pleasant helpful staff
Friendly, caring attitude to all patients.
Kindness of all staff. Best hospital that I have ever visited VCC= NHS flagship
How helpful, kind, understanding, knowledgeable, caring and humorous!! Everybody was- clinicians, receptionists, drivers, volunteers, nurses, radiologists etc marvellous
Staff were friendly. Service was very efficient and it was very good to have treatments and clinics carried out at the same time.
As I said on previous questionnaire the staff do their best to make not a particularly pleasant experiences stress free as possible
I could not have had a better team looking after me
Info & treatment good & clear & listened to
Was put at ease when speaking to staff
I was always informed what was happening and therefore I stayed calm and did not feel uneasy
No
No
All the staff treated me as though the treatment was very normal and not something to fear or worry about therefore although I was outside my comfort zone I was made to feel all was well.
Staff very cheerful and helpful, professional
Can't do any more than asked
I felt really safe at all times
Every member of staff I came into contact with was pleasant, polite and I cannot speak highly enough of them
No
My most recent contacts with Velindre have been telephone interviews. The latest phone call was on the 1st, whereas the appointment by letter was scheduled

Survey Summary Report

Full Breakdown Analysis of Survey Results
Velindre Cancer Centre

Total Respondents: 238

Survey: Your Velindre Experience

Start Date: 01/10/2021 **End Date:** 31/12/2021

for 8th. That posed a problem since I was at home on 1st.
The kindness and care of 99.9% of staff
Excellent staff and friendly environment
I appreciated the offer of tea / coffee whilst waiting to be called for my appointment.
Much too long wait refers to pharmacy
My views and needs were listened too.
Everyone is so kind. Each member of staff you pass says hello and if you look lost will offer to help. You feel cared for as soon as you walk through the doors. (contd from next Q) do, I showed my red card but they waited 3hrs before putting me on a drip. I would have felt safer sitting in a treatment chair at Velindre, I was never offered a bed in A&E.
Everyone we came across at the hospital was very kind and helpful
All staff are friendly and upbeat and happy to take time to answer questions
The staff was amazing
I was seen at a peripheral clinic initially in 2016. The care pathway involving Velindre clicked into action very efficiently according to explanations. Follow up at Velindre has been efficiently organised and executed even through the pandemic.
If I had a problem, it was explained why it was happening
Amazing care, outstanding staff. Always return your calls. Couldn't be better.
Having treatment alone due to Covid lockdown was terrible. However the nurses at all appointments were amazing and my husband was allowed in for all results / treatment discussion appointments.
All the staff was great and friendly nothing was too much for the. Thank you every one of you.
Always caring. Always emphatic. Always professional. Thank you
Friendly caring staff, even when tired & working long stressful hours

Survey Summary Report

Full Breakdown Analysis of Survey Results
Velindre Cancer Centre

Total Respondents: 238

Survey: Your Velindre Experience

Start Date: 01/10/2021 **End Date:** 31/12/2021

Never had to wait too long to see doctor or nurse. Usually on time.
All the staff were polite and treated me with respect. All me needs were fulfilled. Grateful thanks for the work you do.
Radiotherapy staff and service was very professional and caring. This also goes for chemotherapy staff
Was concerned when first visiting Velindre but was immediately put at ease from the beginning - from Reception. Bloods, Nurse and then consultant. Excellent.
Everyone has been so lovely
Given that we were in a pandemic (arrangements excellent btw) The time and attention I received was totally everything one could expect. Over and above in every way. Consultant involving, caring, all the staff - without exception - brilliant. Also surprised and grateful for the co-ordinated after-care from support workers. One helped me get Attendance Allowance (actually wrote the form!)
I find my telephone consultations very convenient and everyone was kind and helpful
Overall experience excellent whilst going through a horrible journey, staff always very kind and extremely hard working. Well done Velindre staff!!!
The support was excellent anything I needed was there straight away
Yes the care was excellent
My experience throughout all depts of the hospital was excellent - all staff are kind and caring! Made a distressing time as pleasant as possible. Thank you!
All my radiotherapy treatments were carried out on time with minimal waiting, the one time there was a problem with one of the radiotherapy machines I was told promptly and rebooked. At this difficult time for me my treatment was kind and considerate, I would like to thank everyone involved.
All the staff from doctors nurses receptionist to staff who worked in radiation department were all first class service and I thank you all for what you did for me.
The speed from referral to appointment was excellent.
Waiting time very good, seen to within 15 mins. Excellent.

Survey Summary Report

Full Breakdown Analysis of Survey Results
Velindre Cancer Centre

Total Respondents: 238

Survey: Your Velindre Experience

Start Date: 01/10/2021 **End Date:** 31/12/2021

Chemotherapy was local at Mac Unit Merthyr 15 mins away did not have to travel to Cardiff Velindre all the time.
Pleasant and helpful staff who dealt with me speedily and showed me where to go as I was unfamiliar with the hospital and was still recovering from an unconnected accident. Arranged transport very efficiently both ways - no long waits.
Understanding / helpful
I felt understood
All was good, no complaints
All the staff on the RDU have been very friendly.
During my visit to chemotherapy day unit, the staff were always very friendly and helpful. Made a friend or two!
The nurse offered refreshments to us while waiting outside to be seen in the Summer, which was unexpected
Everyone is kind and caring and gives more than 100% making you feel at ease.
Everybody was very kind and made me feel at ease from start to finish and explained everything I asked. Thank you to all.
My mother was treated with courtesy and patience throughout my mothers treatment and analysis. She has mixed dementia.
Excellent 1-2-1 care nurses, very kind & considerate and obliging
I can't praise Velindre enough, everyone has been fantastic from my Dr, to my special nurse, and all the wonderful staff when having chemo, CT scans and blood tests couldn't wish for better treatment.
Always feel I've had a quality consultation and all questions are answered! 1st class treatment / therapy from all staff
Reception Treatment
All patients were in the same book! All staff had a smile for you and the atmosphere was warm and friendly and had time for you. They put you at rest, as the thought of cancer is a scary thing.
Everything was excellent thank you
Everyone was so friendly to deal with- and helpful. Treatment was good. I am very grateful to you all.

Survey Summary Report

Full Breakdown Analysis of Survey Results
Velindre Cancer Centre

Total Respondents: 238

Survey: Your Velindre Experience

Start Date: 01/10/2021 **End Date:** 31/12/2021

Everyone was kind and helpful. Thank you.
All very satisfying
Very well cared for and helped
All staff that I had contact with I found really lovely and supportive and very patient. It was a horrible time but I am grateful for the staff in Velindre.
Clear and understanding words used by all levels of staff
Clear information given each time of my appointments. All staff were very good and supportive, nothing was too much trouble.
All the staff were helpful, friendly and approachable
I felt sympathy from staff without pity or being put down
The care and nursing staff on the ward was exceptional. The unit downstairs was exceptional care and staff. Radiology exceptional care and staff. Also all catering and domestics.
Friendly, informative, professional staff in all areas encountered. Love the 'dedicated' parking at Merthyr.
A very efficient & informative experience
Speed of response from initial diagnosis - impressive
It was ok
I found the pharmacy staff very helpfull, went out of their way to help me on more than one occasion when the mix up was not their fault or responsibility. Many thanks to them.
Even though my appointment was at the end of the day the staff were extremely welcoming, happy and efficient. I never felt rushed and the care of patients is quite clearly important to the staff. I have attended several departments in Velindre during my treatment and have always been treated with respect and care by extremely positive friendly staff, which is so important during one of the most difficult of times. I feel lucky to have been looked after here and appreciate everything Velindre do.
Everyone was very good at their job
Staff friendly and approachable from the door to exit
Staff were all cheerful and patient.

Survey Summary Report

Full Breakdown Analysis of Survey Results
Velindre Cancer Centre

Total Respondents: 238

Survey: Your Velindre Experience

Start Date: 01/10/2021 **End Date:** 31/12/2021

Very efficient
Staff were particularly helpful in all aspects. I felt very safe with covid procedures. Overall experience was very good. Thank you.
No
The answers to my questions were always clearly explained
All the staff, both in outpatients and radiotherapy (8months ago) were always very attentive and kind
I suffer with bipolar and struggle with things out of my control. All staff were very understanding and very helpful
Staff were always busy but would come back to you if you needed help or answers. They all did they best.

Survey Summary Report

Full Breakdown Analysis of Survey Results
Velindre Cancer Centre

Total Respondents: 238

Survey: Your Velindre Experience

Start Date: 01/10/2021 **End Date:** 31/12/2021

Question 12: Was there anything that we could change to improve your experience?

Create new action

Waiting for consultant on two occasions was too long. Shorten consultant waiting time in outpatients.
No
Not really
My wait at pharmacy might have been shorter, I perhaps could have obtained from my regular pharmacy?
No not really
No
There was a phlebotomist who I felt was always rude and grumpy, luckily I did not see them for bloods every week
Nothing that I can think of...
No
Not that immediately comes to mind at the moment.
Keep being as caring as you all are
Softer tables on the machines (joke)
Nothing. All a positive experience.
No
No.
Stop wasting money on idiotic surveys unless NHS has too much money?
LA4 machine broke down. We had to hold a full bladder in excess of an hour. As a result I ended up in the Heath Hospital and left with a catheter as I could not pass urine after the radiotherapy. We should have been told to empty our bladders and start again instead of being given an option. We thought we were doing the right thing by holding the full bladder.
No
The only issue is waiting in outpatients alone until called, but I understand this is essential given the current ongoing health crisis
No

Survey Summary Report

Full Breakdown Analysis of Survey Results
Velindre Cancer Centre

Total Respondents: 238

Survey: Your Velindre Experience

Start Date: 01/10/2021 **End Date:** 31/12/2021

No.
Satisfied with all treatments.
None
No not at all
During chemo I needed a heater pad on my arm. Everytime this would switch off (part way through) and would cause pain in my forearm as a result.
My experience was very good so cannot comment on improvements
Bit quicker waiting for appointments
No
Make sure all medication is checked before giving to patient
No
Some of the directions inside the centre are a little confusing- I got lost finding the exit from Rhosyn to the outdoors, but that was probably just me!!
Nothing, as I was very pleased with my experience
I haven't had any problem with the way your system works.
Keep the radio volume turned down in outpatients- it can be difficult to hear your name being called out. Re-open the coffee shop and the Velindre fundraising shop as soon as possible miss being able to buy a coffee and newspaper and browsing to pass time.
No
Waiting time was too long once. Had to sit in the car for an hour. My journey took one hour to get there so I felt this was a bit too long to wait.
Nothing.
No.
None.
Not really.
Waiting times were very bad particularly at the pharmacy. We realise that there are staffing shortages this time though!!

Survey Summary Report

Full Breakdown Analysis of Survey Results
Velindre Cancer Centre

Total Respondents: 238

Survey: Your Velindre Experience

Start Date: 01/10/2021 **End Date:** 31/12/2021

No
No
To be honest and truthful with you all I was very happy with the service I received at Velindre Cancer Centre
Not at present
No
Long wait for blood to be taken (1 hour). Receptionist mislaid documentation. Complained then soon rectified.
The timings kept chopping and changing. It would have been helpful to have more consistent times for my daily appointments.
No
No. My only problem was driving back and forth 5 days a week (4 weeks) but to receive the excellent treatment made it all worthwhile.
In my opinion, no. Just keep doing the excellent service you provide.
No
Not really
No
Just keep up the good work!
Impossible`
Nothing
None.
Fill pathway of care, specifically links with surgery
Given what I was there for every box ticked! What a wonderful place Velindre!
Not really.
Nothing that I can think of
Nothing
Perhaps more nurses able to take blood before the appointments with the Dr. I get a bit anxious when the time to see the Dr comes and I still haven't had my bloods taken, sometimes after waiting 3/4 hour.

Survey Summary Report

Full Breakdown Analysis of Survey Results
Velindre Cancer Centre

Total Respondents: 238

Survey: Your Velindre Experience

Start Date: 01/10/2021 **End Date:** 31/12/2021

Keep learning & listening
"Bed-side" manner of some staff, several things but most affected by COVID rules! Co-ordination between different departments
Waiting times for medication. 45 mins to 1 hour is too long!
Listen to patients. Cut the waiting time during treatment. Ask doctors not to pass the buck.
The waiting time in the outpatient area caused concern as time went on not knowing after a hour or more where you are on the list to be seen and being unsure how to confirm where you are in terms of being seen.
No
Not applicable as everything about the hospital and the attention was first class
No
No
Although I am mindful of the reasons behind the decision to close the coffee and gift shop, I have found them a welcome distraction prior to closure of these facilities. In particular I appreciated being able to buy a newspaper / magazine etc
The ability to treat all non surgical complications/ side effects of treatment e.g. immunotherapy mediated hormone deficiency requiring IU hydrocortisone instead of going to casualty no social distancing.
Face to face appointments
The cannula leaked during the 1st chemo treatment, from then I felt under pressure to have a picc line. At the 3rd treatment I walked in to be told to sit in the chair and that a request had been made for someone to try and put the cannula in. If they couldn't I wouldn't be having treatment that day. The nurse appeared to be very angry with me. When my temperature went up after treatment there wasn't a free bed at Velindre & I had to go to A&E. It was frightening because they didn't know what to
no
None really.
No
No

Survey Summary Report

Full Breakdown Analysis of Survey Results
Velindre Cancer Centre

Total Respondents: 238

Survey: Your Velindre Experience

Start Date: 01/10/2021 **End Date:** 31/12/2021

The only thing concerned the surgical part of the treatment and a lack of clarity about bowel preparation for people with stomas. All literature refers to people who have normal colon and bowel. This relates to colonoscopies at Princess of Wales hospital.
No
100% satisfied
Nothing - you are all amazing
I think under the circumstances everything was exceptional.
Not one thing I can't say was bad I would like to say how great everyone was and is to me. Many thanks.
I know it's difficult but having appointments on time or within 1/2 hour would be good.
Phone consultations tend to be shorter than F2F. Sometimes you think of questions after the call- can there be a process where you can ask follow-on questions
I was never told upfront to expect such serious radiation burns, and shown the exact process of the therapy. I was let to know just a spot on part will be treated.
No
No
My main worry was the covid would delay my visits - to date I have been fortunate.
Nothing
Probably not! I can't (in case not obvious) praise everyone involved in my care highly enough. Wonderful group of people from receptionists to nursing / medical staff.
No
Nothing except more funding and staff! Thank you again for all your care!
1. Not having to wait/sometimes for a long period of time in a tent 2. Waiting time at the pharmacy
NIL
Very satisfactory experience. No bad points experienced.

Survey Summary Report

Full Breakdown Analysis of Survey Results
Velindre Cancer Centre

Total Respondents: 238

Survey: Your Velindre Experience

Start Date: 01/10/2021 **End Date:** 31/12/2021

Difficult to navigate areas
Not really something you could change but it was a shame it wasn't in person. Would have liked it to be a bit longer or maybe more refresher calls.
Maybe waiting times, but I realise how busy everyone is
I was asked at the start how I was feeling. I said I was ok but not brilliant as I was just recovering from, what seemed to be, a conflict between the previous treatment and my COVID booster jab. The nurse didn't seem to be bothered, her job seemed to be to administer my treatment, not give me any advice or clarification.
No
No
Nothing specific.
No
Not for me, all excellent
No
On our 1st visit we had trouble parking not knowing the hospital grounds for other parking spaces. COVID has made things very hard for hospitals
Nothing
No. Great care. Thank you all.
No
Be glad to have face to face consultations if this COVID problem is ever sorted
No
On my first session of chemo I was sent home without my injection for District Nurse to administer following day. Had to contact out of hours, I had to return following day to pick it up. Then in the afternoon District Nurse had not been booked so had to ring out of hours again.
Yes - please open cafe to inpatients
No
N/A

Survey Summary Report

Full Breakdown Analysis of Survey Results
Velindre Cancer Centre

Total Respondents: 238

Survey: Your Velindre Experience

Start Date: 01/10/2021 **End Date:** 31/12/2021

N/A
No
No I have always found my visit very well handled. Thank you.
The information sheets given explain how medicines work and reviewed are out of date. Better to leave date off or say regularly reviewed. Also perhaps on your equality monitoring is "other" the right word.
Maybe staff to be more aware of having loud, personal conversations while treating patients. Nobody minds a few comments / jokes but sometimes it's a bit much.
No
I would like to have had more information on follow-up procedures and medication.
No
Nothing at all
No COVID caused most of the issues, the loneliness and isolation

Survey Summary Report

Full Breakdown Analysis of Survey Results
Velindre Cancer Centre

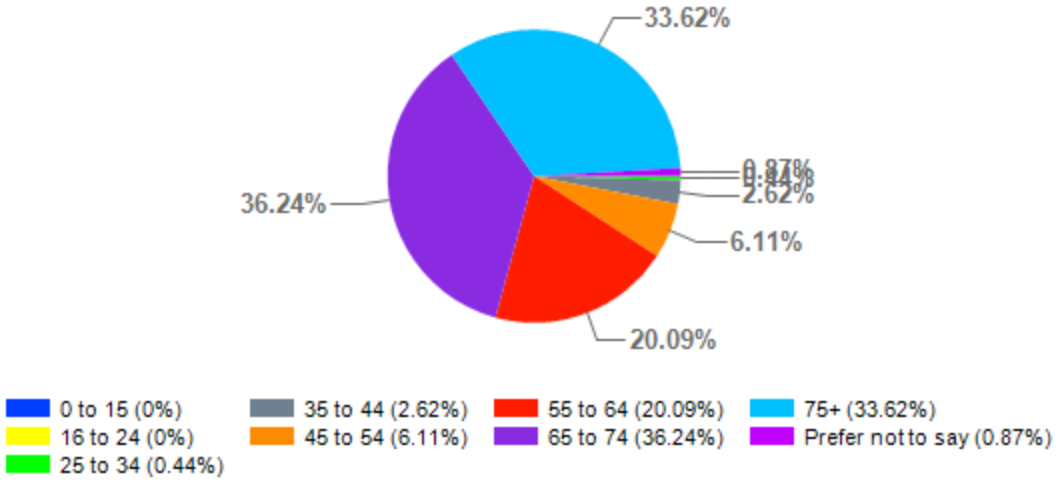
Total Respondents: 238

Survey: Your Velindre Experience

Start Date: 01/10/2021 **End Date:** 31/12/2021

Question 13: What is your age?

Available Answers	Responses	Score (%)
0 to 15	0	0.00%
16 to 24	0	0.00%
25 to 34	1	0.44%
35 to 44	6	2.62%
45 to 54	14	6.11%
55 to 64	46	20.09%
65 to 74	83	36.24%
75+	77	33.62%
Prefer not to say	2	0.87%
Total	**229**	**100%**



Survey Summary Report

Full Breakdown Analysis of Survey Results
Velindre Cancer Centre

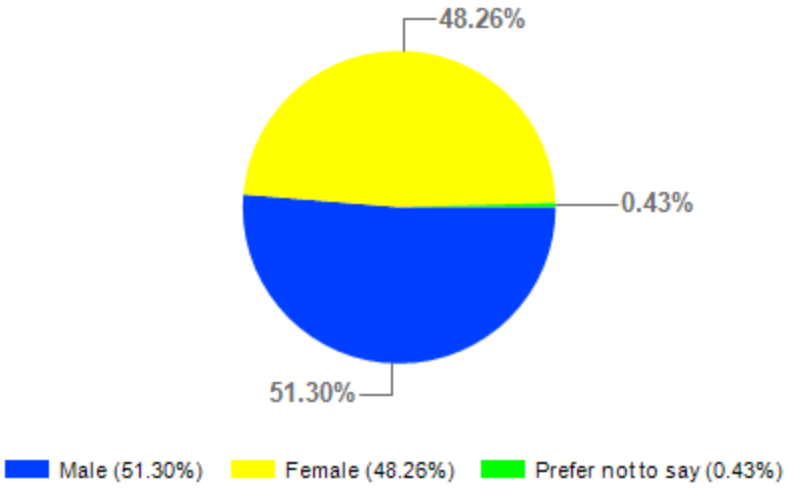
Total Respondents: 238

Survey: Your Velindre Experience

Start Date: 01/10/2021 **End Date:** 31/12/2021

Question 14: What is your Gender?

Available Answers	Responses	Score (%)
Male	118	51.30%
Female	111	48.26%
Prefer not to say	1	0.43%
Total	**230**	**100%**



Survey Summary Report

Full Breakdown Analysis of Survey Results
Velindre Cancer Centre

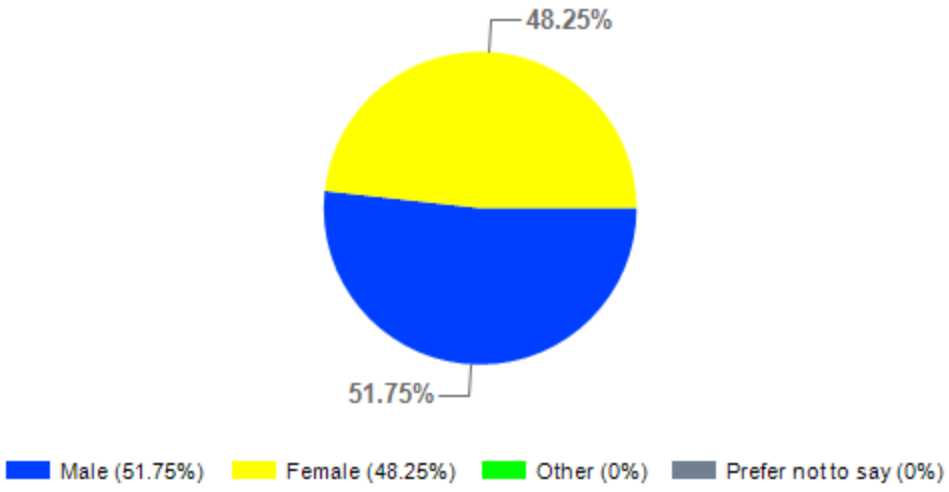
Total Respondents: 238

Survey: Your Velindre Experience

Start Date: 01/10/2021 **End Date:** 31/12/2021

Question 15: At birth, were you described as:

Available Answers	Responses	Score (%)
Male	118	51.75%
Female	110	48.25%
Other	0	0.00%
Prefer not to say	0	0.00%
Total	**228**	**100%**



Survey Summary Report

Full Breakdown Analysis of Survey Results
Velindre Cancer Centre

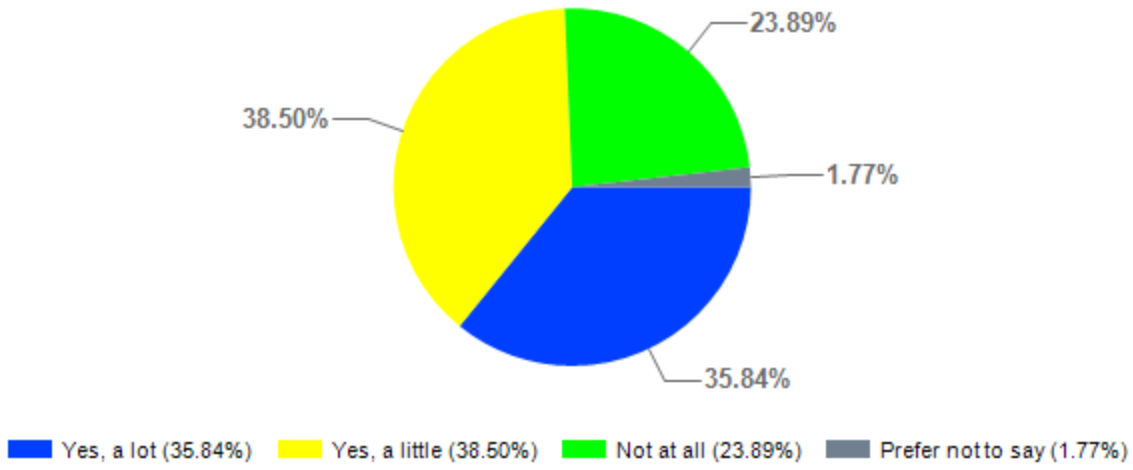
Total Respondents: 238

Survey: Your Velindre Experience

Start Date: 01/10/2021 **End Date:** 31/12/2021

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?

Available Answers	Responses	Score (%)
Yes, a lot	81	35.84%
Yes, a little	87	38.50%
Not at all	54	23.89%
Prefer not to say	4	1.77%
Total	**226**	**100%**



Survey Summary Report

Full Breakdown Analysis of Survey Results
Velindre Cancer Centre

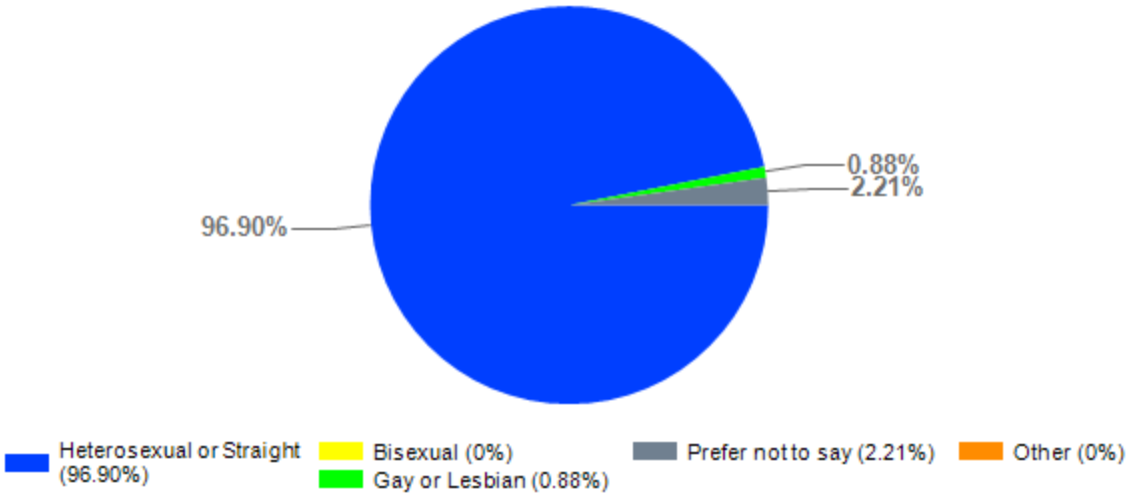
Total Respondents: 238

Survey: Your Velindre Experience

Start Date: 01/10/2021 **End Date:** 31/12/2021

Question 17: Which of the following options best describes how you think of yourself?

Available Answers	Responses	Score (%)
Heterosexual or Straight	219	96.90%
Bisexual	0	0.00%
Gay or Lesbian	2	0.88%
Prefer not to say	5	2.21%
Other	0	0.00%
Total	**226**	**100%**



Survey Summary Report

Full Breakdown Analysis of Survey Results
Velindre Cancer Centre

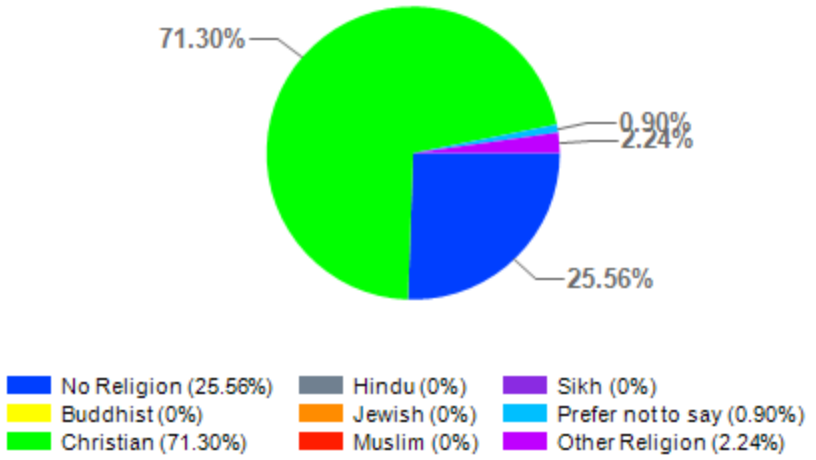
Total Respondents: 238

Survey: Your Velindre Experience

Start Date: 01/10/2021 **End Date:** 31/12/2021

Question 18: What is your religion?

Available Answers	Responses	Score (%)
No Religion	57	25.56%
Buddhist	0	0.00%
Christian	159	71.30%
Hindu	0	0.00%
Jewish	0	0.00%
Muslim	0	0.00%
Sikh	0	0.00%
Prefer not to say	2	0.90%
Other Religion	5	2.24%
Total	**223**	**100%**



Survey Summary Report

Full Breakdown Analysis of Survey Results
Velindre Cancer Centre

Total Respondents: 238

Survey: Your Velindre Experience

Start Date: 01/10/2021 **End Date:** 31/12/2021

Question 20: What is your ethnic group?

Available Answers	Responses	Score (%)
White - British/English/Northern Irish/Scottish/Welsh	221	96.51%
White - Gypsy or Irish Traveller	0	0.00%
White - Irish	1	0.44%
White - Other	6	2.62%
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	0	0.00%
Asian/Asian British - Indian	0	0.00%
Asian/Asian British - Pakistani	0	0.00%
Asian/Asian British - Bangladeshi	0	0.00%
Asian/Asian British - Chinese	1	0.44%
Asian/Asian British - Other	0	0.00%
Black/African/Caribbean/Black British - African	0	0.00%
Black/African/Caribbean/Black British - Caribbean	0	0.00%
Black/African/Caribbean/Black British - Black British	0	0.00%
Black/African/Caribbean/Black - Other	0	0.00%
Other Ethnic Group - Arab	0	0.00%
Prefer not to say	0	0.00%
Total	**229**	**100%**

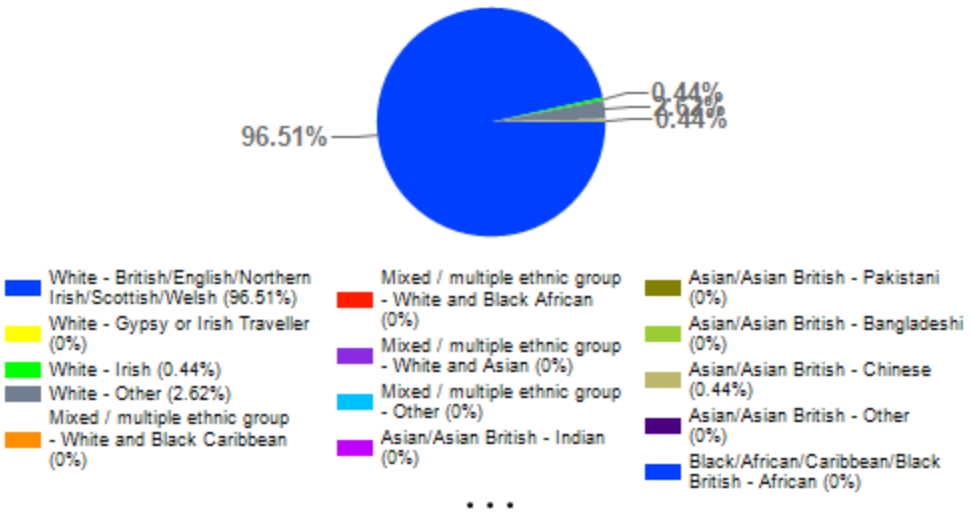
Survey Summary Report

Full Breakdown Analysis of Survey Results
Velindre Cancer Centre

Total Respondents: 238

Survey: Your Velindre Experience

Start Date: 01/10/2021 **End Date:** 31/12/2021



Survey Summary Report

Full Breakdown Analysis of Survey Results
Velindre Cancer Centre

Total Respondents: 238

Survey: Your Velindre Experience

Start Date: 01/10/2021 **End Date:** 31/12/2021

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,SACT/Medicines Management
Service	Catering services,Clinical Psychology,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	2021-10-01 00:00:00
End Date	2021-12-31 23:59:59

APPENDIX A- 15 STEP CHALLENGE PROMPTS - Prince Charles Outreach Clinic

Welcoming and caring:	
Questions to ask yourself	**Comments**
Was it easy to locate the clinic?	SACT Clinic was difficult to locate from both externally and internally. This was echoed by Patients. Enhanced maps and clearer directions required. All signage refers only to Macmillan Unit and no reference to Unit being a Velindre @ service (apart from unit immediate door sign). Signage to include that it is a Velindre service.
On entering the venue, what is my first impression? Which word/phrase describes my feeling?	SACT Clinic clean, uncluttered, calm, warm and welcoming. Feels like a positive clinical area.
What is the atmosphere like - calm/busy/warm/cold/bright/clean?	Positive friendly, warm with good lighting. Good facilities in the Unit for staff.
What is welcoming about the area?	Very welcoming, staff visible and observed that all patients met and triaged immediatley on arrival
Is the process for booking in clear?	All patients met and triaged immediately on arrival.
How do staff greet patients / donors?	Pleasant greeting on arrival by a nurse.
How is dignity and privacy respected?	Chairs well spaced and social distancing in place. Discussions with patients could not be overheard. Privacy curtains available if required.
How are staff interacting with patients?	Professional, polite and friendly interaction observed between staff and patients throughout visit.
What makes me feel less confident?	There was nothing that made team feel less confident
Things to look out for	
Car parking accessible to all? Think about patient / donor mobility.	A small dedicated car park available immediately outside Clinic door. A number of spaces are available. Patients provided with permits and the site security checked for unauthorised parking regularly. Patients reported that they were not advised of this dedicated parking prior to arrival for their first visit.
The route to the clinic is well signed.	There is signage but does not mention Velindre, refers to Clinic as MacMillan Cancer Centre. Clinic was difficult to find from both inside and outside of the hospital - also reported by patients.
Information on how to book in is evident and clear.	N/A as all patients met on arrival.
Staff are visible.	Staff visible at all times.
There is evidence of meeting diverse needs e.g. signs in other languages, the reception desk and waiting areas are accessible for	Evidence of English and Welsh signage.
Do patients have to wait to book in? How is this managed?	There was no waiting evident during visit. All patients met as soon as arrived and triaged.
Staff acknowledge patients on arrival - eye contact, smiles, greetings.	As detailed above - pleasant and warm welcome on arrival.
Staff introduce themselves to patients.	Staff introduced themselves to patients on arrival.
Patient comfort is considered (seating/refreshments).	Comfortable SACT reclining chairs in place - all appeared in good repair and clean. Food and fluid refreshments made available and observed these being offered and provided. The clinic is no longer serviced by the Prince Charles hospital catering team. Staff have to collect sandwiches and milk and patients donate biscuits as these are not provided.
Toilet signs are clear.	Plentiful, well signposted and clean toilets.
Well organised and calm:	
Is the area well set out/organised/uncluttered?	Most areas well organised and uncluttered. Some clinical space being used as storage e.g. phlebotomy room. If not required for that reason, could be repurposed for clinical space e.g. SACT preperation and storage. There were no oupatient clinics being held - 4 consulting rooms empty. Staff advised that OPD clinics are currently only running from PCH 1.5 days a week by two Consultants. The days SACT is being stored whilst awaiting arrival of patients within clinical areas patients are recieving treatment and could not be being observed constantly although staff are always in vicinity.
Does the area look clean/does it smell clean?	Whole area was very clean with no odours. With the exception of an ornament in one of the OPD consultation rooms that was very dusty. Should not have ornaments in OPD Consultation rooms. There were no gloves in sluice room. There was no evidence that 'I am clean tape' was in use on patient items such as commodes.
Are equipment and notes stored tidily with respect for confidentiality?	No issues identified with confidentiality of patient records. - Two weekdays when Resusitation Trolley had not been checked. - The ECG machine was identfied as being broken since 26/11/2021.
If there are other areas (e.g. cupboards, stock room, kitchen) do they look organised, clean and uncluttered?	All areas apeared well organised and uncluttered.
What are my first impressions of staff professionalism, competency and efficiency?	Highly professional at all times. Staff were busy for whole time of visit and provided an aura of professionalism and competency.

What do the interactions between staff, patients and other visitors tell me?	No visitors due to COVID restrictions. Positive and patient focussed interactions observed at all times
Can I observe good team work taking place?	Exellent team work observed.
Things to look out for	
Seating area well set out - comfortable chairs, room for wheelchairs.	socially distancing evident between all seats / SACT chairs - space would be available for wheelchairs.
Well maintained, appropriate and clean condition of floors (non slip)/walls/window/ceilings.	No issues identified.
Clean uncluttered corridors.	Corridors all clear.
Clean toilets.	All toilets clean and well spaced.
Visible clock.	yes clocks visible. However, the clocks in two of the Unit OPD consultation rooms had either stopped or were showing the wrong time.
Patient / donor queues are well managed (not out of doors leading to confusion).	No queues or waiting.
Patients who are transported to the clinic in beds or wheel chairs are transported with dignity and appropriately.	N/A during visit.
Informative:	
Are clinics running to time, how are delays managed?	Treatments were provided within times, there were empty chairs during the whole time of visit (2 hours). No delays.
Are notice boards / patient / donor information stands up to date, clearly set out and holding relevant information?	No issues identified.
Is there information about where I go and wait and what I need to do?	Sinposting pre arival into unit was very poor and patients all reported that when they arrived the first time they got lost whether attending via hospital or externally.
What information is given about the use of mobile telephones?	Patients were using mobile phones as a distraction.
What tells me about the quality of care / services here?	The professionalism and manner in which staff were conducting themselves and care and responses witnessed provided assurance that patient safety was at the centre of what team were doing. Robust adherence to IPC standards was observed and all pandemic measures.
Is there evidence of patient safety and infection control?	Excellent compliance with all IPC / COVID standards Excellent evidence of patient safety observed. A patient became unwell during visit and immediate and proportionate response observed.
Things to look out for	
There is information relevant to patients / donors displayed in a suitable area.	Information was displayed.
Patient / donor information leaflets appear organised.	They were available and well organised.
There is information on who the team are and what the uniforms mean.	Not evident within setting.
Can you tell who is in charge?	The who is in charge was in an area that would not be easily visible to patients atending via both entrances (internal & external) - needs to be clear at entrances who is on duty and who is in charge.
There is information on which consultants/nurses are running clinics.	N/A WBS.
Is the mobile telephone policy clear? It may be acceptable for patients to use mobile telephones to reduce stress.	Yes and patients were using phones as a distraction.
There is information on how to make a complaint, compliment or suggestion.	This was not evident in areas that patients were accessing during the time of the clinic.
There is evidence of encouraging and acting on patient / donor feedback e.g. "You said…we did".	This was not evident that could be easily visualised in the setting.
Feedback from patients/donors/staff	
Staff fed back that they enjoyed working within the SACT service. The following enhancements were suggested from the perspective of the staff: - Additional substantive HCSW support - two per shift at each SACT location would significantly enhance how the SACT sessions operated. This could provide phlebotomy support as well. -Significant more non-medical prescribers required as there is only one at present (although some staff undergoing training) ongoing issues in getting hold of on site medical teams for non emergency matters. -Units are, several times a day recieving calls from the public who, due to signposting and name of the Unit, that the Unit is Part of Macmillan, that nurses are Macmillan Nurses and are asking for general Macmillan support -Staff felt that the Unit could recommence its PIC service as this would take pressure off the VCC site and would be better for local patients - the catering in unit support has been ceased which now requires members of nursing team to collect catering items from catering dept rather than being delivered and a reduction in items now provided. Biscuits for patients are now having to be donated.	Patients provided overwhelmingly positive feedback regarding the care and treatment that had been provided to them by the SACT service. Staff were reported as being caring and friendly. Patients advised of the following feedback to improve their experiences: -Access to televisions at the SACT pods would provide them with something to focus on especially as they could not have anyone with them at present -Patients local to Prince Charles Hospital to be consistently offered an appointment when at all possible at Prince Charles. Patients reported struggling to get to VCC on occasions if not feeling too strong but will manage to travel to PCH as much nearer. - Significantly enhanced external (outside of hospital buidling) and internal (inside hospital buidling) signage to Unit as patients all on first visit found it extremly difficult to locate and it added to distress. In addition the appointment correspondence should include much better directions and map as to where to find the unit at Prince Charles and also advise that there is dedicated parking outside and that they need to come in to recieve a permit. This was also not covered in the pre SACT talk that the patients had received.

APPENDIX B - 15 STEPS CHALLENGE FEEDBACK TEMPLATE

The Reviewers: Stephen Harries, Vice Chair & Nicola Williams, Executive Director Nursing, AHP & Health Science

Clinic/area: SACT Unit @ Prince Charles Hospital, Merthyr Date: 7th December 2021

Welcoming and caring:

Positives	Recommendations
Clinic clean, uncluttered, calm, warm and welcoming. Feels like a positive clinical area. Very welcoming, staff visible and observed that all patients met and triaged immediately on arrival.	Clinic was difficult to locate from both externally and internally. This was echoed by Patients. Enhanced maps and clearer directions required. All signage refers only to Macmillan Unit and no reference to Unit being a Velindre @ service (apart from unit immediate door sign). Signage to include that it is a Velindre service. Possibility of Trust having a google maps pin to locate unit to be considered.
A small dedicated car park available immediately outside Clinic door. A number of spaces are available. Patients provided with permits and the site security checked for unauthorised parking regularly.	Patients reported that they were not advised of this dedicated parking prior to arrival for their first visit. To be included on the appointment letters sent to patients.
All patients met and triaged immediately on arrival. Very positive, friendly and professional approach from staff.	
Comfortable SACT reclining chairs in place - all appeared in good repair and clean. Food and fluid refreshments made available and observed these being offered and provided. The clinic is no longer serviced by the Prince Charles hospital catering team.	The clinic is no longer serviced by the Prince Charles hospital catering team. Staff have to collect sandwiches and milk and patients donate biscuits as these are not provided.
	Develop a plan for all band 6/7 SACT nurses in first instance to be prescribers - increasing to all SACT nurses in time as a competence for an 'expert SACT' Nurse.
	Review staffing model to ensure there is sufficient HCSW cover across all clinics so that registrants can focus on SACT delivery.
	Details of which staff are on clinic and who is in charge to be made available upon entrance of unit for patients arriving to see.

Well organised and calm:

Positives	Recommendations
Exemplar feedback provided from patients regarding the care and treatment provided. Staff professional and welcoming.	Patients found the time whilst having treatment long, exacerbated by being unable to have someone with them due to the pandemic. Ceiling mounted or trolley TVs for use for patients with headphones to be considered.
Whole area clean and robust adherence to IPC measure observed.	Ornament in OPD Consultation room to be removed as this is a clinical space - possibly relocate to waiting area behind glass.
Lovely garden area for patients and family (outside of COVID) to use.	Consider re-allocated phlebotomy room for clinical space e.g. SACT storage to prevent storage in main SACT delivery area.
Good facilities in Unit for staff.	Given the VCC OPD capacity issues and need to socially distance, plans should be formulated to fully utilise the PCH OPD space.
Most areas well organised and uncluttered. Some clinical space being used as storage e.g. phlebotomy room. If not required for that reason, could be repurposed for clinical space e.g. SACT preparation and storage. There were no oupatient clinics being held - 4 consulting rooms empty. Staff advised that OPD clinics are currently only running from PCH 1.5 days a week by two Consultants. The days SACT is being stored whilst awaiting arrival of patients within clinical areas patients are recieving treatment and could not be being observed constantly although staff are always in vicinity.	A locked location to be identified for the days SACT to be stored safely and securely that is not in the direct clinical area that patient care is being provided - consideration to be given for repurposing another space ? Phlebotomy room.
	The use of ' I am clean tape' to indicate patient items such as commodes are clean and when they were last cleaned to be considered.
	Sluice room should always have a supply of gloves.
	There were two days when resuscitation checks not undertaken - if when unit was closed this needs to be documented on check list as Unit closed against said dates. If unit was open on these dates process to ensure daily checks are undertaken should be reviewed.
	ECG machine to be repaired as showing as broken since 26/11/2021.

Informative:

Positives	Recommendations
	Clocks in two of the OPD clinic rooms to be set to the correct time as all stopped or displaying wrong time.
	There needs to be a CIVICA Feedback Zone and information up in patient areas regarding how they can made a complaint, suggestion or compliment.

Feedback from patients/staff	Recommendations
Patients provided overwhelmingly positive feedback regarding the care and treatment that had been provided to them by the SACT service. Staff were reported as being caring and friendly. Patients advised of the following feedback to improve their experiences: - Access to televisions at the SACT pods would provide them with something to focus on especially as they could not have anyone with them at present	Consider Purchase of ceiling or trolley monuted TVs or mobile IPDA devices (that can be decontaminated) that could be used by patients with ear phones to help patients be distracted whilst receiving treatment.
Patients local to Prince Charles Hospital to be consistently offered an appointment when at all possible at Prince Charles. Patients reported struggling to get to VCC on occasions if not feeling too strong but will manage to travel to PCH as much nearer.	Review closer to home access and explanations being provided to patients when treatment venues change.
All patients advised that they could not find the Unit when they attended for the first time. The signage to the Unit both from the hospital grounds and inside PCH was poor and the map and directons did not help them find the Unit. In addition the unit is identified as Macmillan and not Velindre on signage. Patients felt further information needed on specific location and that appointment letters advise of available dedicated parking outside the centre.	Signage of Unit to be reviewed so that it is explicit that services are provided by Velindre. Signposting to Unit on site to be enhanced. Directions to Unit and map on letters to be revised and letters to include reference to dedicated parking. Consideration given to use of Google Pin as a locator.
Staff fed back that they enjoyed working within the SACT service.	Consider recommencing on site PIC service to reduce pressure and risks on VCC site.
PCH has withdrawn some of the previous catering support provided to the unit. Nursing staff now have to collect catering requirements and biscuits for patients are no longer provided and have to be donated to the unit by patients.	Review PHC catering arrangements - including delivery and provision of biscuits for patients.
Additional substantive HCSW support - two per shift at each SACT location would significantly enhance how the SACT sessions operated. This could provide phlebotomy support as well and that significantly more SACT nurse prescribers are required as there is only one at present (although two SACT nurses are currently undergoing training) ongoing issues in getting hold of on site medical teams for non emergency matters.	Further SACT workforce review to be undertaken to include minimal HCSW cover (to facilitate top of licence working) and trajectory of nurse prescribing.
Units are, several times a day recieving calls from the public who, due to signposting and name of the Unit, assume that the Unit is Part of Macmillan, that nurses are Macmillan Nurses and are asking for general Macmillan support.	Name and signposting of the Unit to be reviewed to recognise that the service is delivered by Velindre University NHS Trust.
Staff felt that the Unit and its facilities are not fully optimised as there are empty OPD consultation rooms 3.5 days a week and they feel that the PIC service could be re-commenced as this would take pressure off the VCC site and would be better for local patients.	Consider a review so that the PCH Facility could be fully optimised to reduce pressure on VCC and reduce footfall at VCC to include optimisation of the OPD facility and consideration to recommence the PIC service.

Overall themes and comments:

Overwhelmingly positive feedback from staff and patients with professional and high quality care and interaction observed with meticulous attention to COVID & general IPC standards. Themes included signposting and pre attandance information for patients, some environmental enhancements, optimising this excellent clinical space as far as possible to reduce pressure and risks on VCC site and staffing enhancements.

APPENDIX C - 15 STEP CHALLENGE ACTION PLAN TEMPLATE

Area visited……..

Completed by:…… Date:……..

WELCOMING AND CARING

Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?

WELL ORGANISED AND CALM

Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?

INFORMATIVE

Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?

Feedback from patients/donors/staff

Action required	Strategic theme	Who will do this?	By when?	Where will it be reported?

Velindre Cancer Centre Monthly Performance Report Summary Dashboard (December 2021)

			Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Radiotherapy	Patients Beginning Radical Radiotherapy Within 28-Days (page 8) ***(JCCO Measure)***	Actual	95%	97%	92%	89%	95%	94%	97%	96%	97%	96%	92%	78%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Patients Beginning Palliative Radiotherapy Within 14-Days (page 10) ***(JCCO Measure)***	Actual	90%	97%	90%	85%	95%	85%	82%	82%	82%	82%	74%	84%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Patients Beginning Emergency Radiotherapy Within 2-Days (page 12) ***(JCCO Measure)***	Actual	95%	97%	100%	97%	100%	100%	97%	100%	97%	100%	85%	89%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Scheduled Patients Beginning Radiotherapy Within 21-Days (page 13) ***(COSC Measure)***	Actual				35%	28%	37%	35%	31%	27%	36%	36%	33%
		Target	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
	Urgent Scheduled Patients Beginning Radiotherapy Within 7-Days (page 13) ***(COSC Measure)***	Actual				41%	48%	40%	54%	52%	52%	35%	41%	57%
		Target	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
	Emergency Patients Beginning Radiotherapy Within 1-Day (page 13) ***(COSC Measure)***	Actual				83%	88%	85%	82%	86%	82%	86%	77%	84%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
SACT	Patients Beginning Non-Emergency SACT Within 21-Days (page 14)	Actual	79%	77%	88%	98%	98%	98%	99%	99%	98%	99%	99%	99%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
		Actual	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	86%	100%

			Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
	Patients Beginning Emergency SACT Within 2-Days (page 15)	Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
Outpatients	New Patient, other Outpatient and Chemotherapy Assessment Appointments Where Patients Were Seen Within 30 minutes of the Scheduled Appointment Times (National Target) (page 19)	Actual	66%	65%	57%	66%	79%	76%	76%	53%	53%	65%	65%	Data collection paused during December due to operational pressures.
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	Did Not Attend (DNA) Rates	Actual	3%	2%	3%	3%	4%	4%	5%	5%	5%	5%	5%	3%
		Target	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%
Therapies	Therapies Inpatients Seen Within 2 Working Days (page 22)	Actual (Dietetics)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Physiotherapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Occupational Therapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	95%	100%	100%
		Actual (Speech and Language Therapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Therapies Outpatient Referrals Seen Within 2 Weeks (page 22)	Actual (Dietetics)	100%	100%	100%	100%	100%	84%	94%	94%	98%	97%	100%	95%

			Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
		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%
	Routine Therapies Outpatients Seen Within 6 Weeks (page 22)	Actual (Dietetics)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Physiotherapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Occupational Therapy)	100%	100%	100%	100%	100%	100%	100%	96%	33%	78%	100%	100%
		Actual (Speech and Language Therapy)	100%	100%	100%	100%	100%	100%	96%	100%	100%	96%	100%	100%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Safe and Reliable Care	Number of VCC Acquired, Avoidable Pressure Ulcers (page 24)	Actual	0	0	0	1	0	0	0	2	1	1	0	1
		Target	0	0	0	0	0	0	0	0	0	0	0	0
	Number of Pressure Ulcers Reported to Welsh Government as Serious Incidents	Actual	0	0	0	1	0	0	0	0	0	0	0	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0

			Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
	Number of VCC Inpatient Falls (page 26)	Actual (Total)	1	1	1	2	3	1	3	4	2	3	1	3
		Unavoidable	1	1	1	1	3	1	3	4	1	3	1	3
		Avoidable	0	0	0	1	0	0	0	0	1	0	0	1
		Target	0	0	0	0	0	0	0	0	0	0	0	0
	Number of Delayed Transfers of Care (DToCs)	Actual	0	0	0	0	0	0	0	1	0	4	0	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0
	Number of Potentially Avoidable Hospital Acquired Thromboses (HAT)	Actual	0	0	0	0	0	0	0	0	0	0	0	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0
	Patients with a NEWS Score Greater to or Equal to Three Who Receive all 6 Elements in Required Timeframe (page 28)	Actual	100%	100%	100%	100%	100%	100%	80%	100%	75%	100%	100%	100%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Healthcare Acquired Infections (page 29)	Actual	1 (*C.diff*)	0	0	0	0	0	1 (*C.diff*)	0	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%	%

		Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
	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.

QUALITY & SAFETY COMMITTEE

WELSH BLOOD SERVICE QUALITY AND SAFETY HIGHLIGHT REPORT

DATE OF MEETING	17/02/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Peter Richardson, Head of Quality Assurance
PRESENTED BY	Alan Prosser, Interim Director, Welsh Blood Service
EXECUTIVE SPONSOR APPROVED	Cath O'Brien, Interim 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**
Welsh Blood Service Senior Management Team	(09/02/2022)	NOTED

ACRONYMS	
WBS	The Welsh Blood Service
GMP	Good Manufacturing Practice
MHRA	The Medicines and Healthcare Products Regulatory Agency
UKAS	The United Kingdom Accreditation Service

1. SITUATION

1.1 This report covers key Quality, Safety and donor experience highlights within the Welsh Blood Service (WBS).

1.2 This report contains information for January 2022 during which time the WBS continues to work to a revised collection model in response to the COVID-19 pandemic with the onset of the Omicron variant.

2. BACKGROUND

2.1 WBS continues to face challenges in collecting blood and predicting demand for blood products as a result of the ongoing pandemic. In particular, the availability of venues large enough to support stock-building donation sessions has been limited by competition from the vaccination program for such facilities.

The Blue alert issued to hospitals on December 16th was lifted at the end of January following a significant increase in whole blood collections from additional and extended hours clinics. The period of blue alert helped WBS conserve stocks over the holiday period without the need to rely on mutual support from other UK Blood Services, all of whom face similar or greater challenges in managing supply and demand.

2.2 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 January 2022 1159 responses were received (23% response rate)
b. Donor satisfaction for those who had successfully donated was:
    - Overall (978) 94%
    - N.Wales (159) 93.5%
    - S.Wales (819) 94.2%

c. Donor satisfaction for every respondent, including incomplete donations was:
    - Overall (1040) 96%
    - N.Wales (168) 95%
    - S.Wales (872) 96.2%

d. In total 905 donors scored themselves as ‘Totally Satisfied’ and were invited to provide more details.

e. **Out of 7,762 donation attendances in January a total of 16** donors described themselves as ‘Dissatisfied’ or ‘Totally Dissatisfied’ and were invited to provide more details. The responses will be analysed and followed up by the Collections Leadership team through their monthly operational service group:

2.2 Changes in response to Donor Feedback

2.2.1 A number of donors have fed back about the lack of gluten-free options for post-donation snacks. WBS has always provided gluten free options on request, a separate, clearly labelled, basket of gluten free snacks is now available for self-selection.

2.2.2 An updated graphic is being trialled showing donors the different uniforms worn by our nursing and collection staff. This will help donors to better understand the different roles and responsibilities across the team.

2.3 Concerns

2.3.1 In January 202. six concerns (0.09%) were reported, five were managed within timeline as early resolution as detailed below. one formal is eing managed under 'Putting Things Right' (PTR) regulations and is expected to be closed within 30 working days:

Nature of Concern raised	WBS Action taken as a result
Formal - donor does not want to provide additional contact details such as email or phone number and is unhappy that he is regularly asked to do so.	This concern is still under investigation.
Concern that donors are not provided with one to one attention during the actual donation procedure.	Several contacts have been attempted with the donor including a written invitation to contact the Operations Manager directly to provide explanation of current clinic model - no contact has been made by the donor to date.
Donor was unhappy that he experienced a part bag and was not offered to provide the donation from the other arm.	The nursing team contacted the donor and explained the donor safety rationale for this.
Donor was unhappy that she was not accepted for donation at clinic as she declared that she had been unwell following recent travel. She had previously spoken to DCC who had accepted her for an appointment.	When the DCC call was replayed, the DCCA had asked if she had been well after travel and the donor had said yes. Correct decision was made by DCCA based on information provided by donor during their call and this information was shared with the donor.
Donor was unhappy about being turned away at clinic because she attended with her baby and that there was no information to warn her that this was an issue. Also stated that lack of signage to session at UHW made the venue difficult to find.	Donor was contacted by the operations team to discuss in more detail. The WBS website does provide information re children attending clinics and the donor has since read this. The specific address of venue location at UHW is provided, however teams have been reminded of the need to put out adequate signage.
Donor frustrated that he experienced a part bag.	Donor contacted and full discussion was had around his experience and the reasons why a full donations is sometimes not possible.

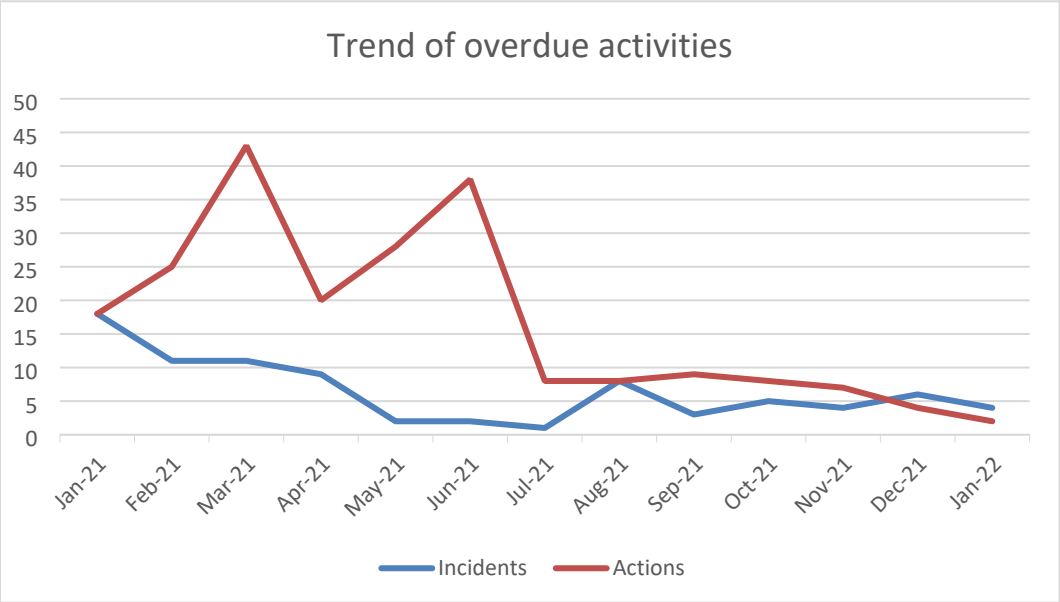
2.4 Other Regulated Activities

2.4.1 WBS continues to support the All Wales Covid vaccination programme and has introduced the paediatric formulation of the Pfizer vaccine into our supply chain. The first dose of this vaccine in the UK was given to a patient in Cardiff January 20th.

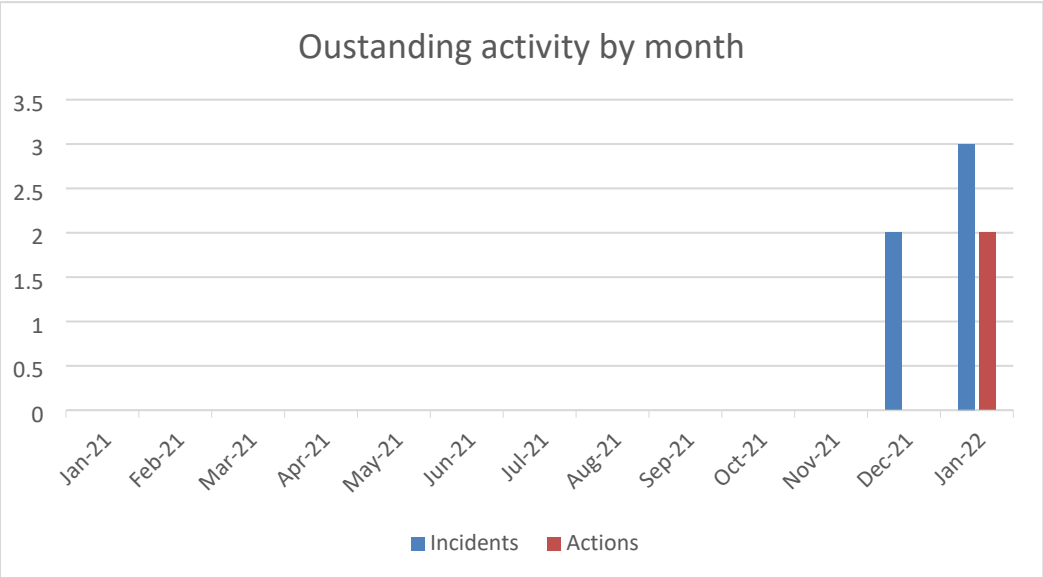
3. Incident Management

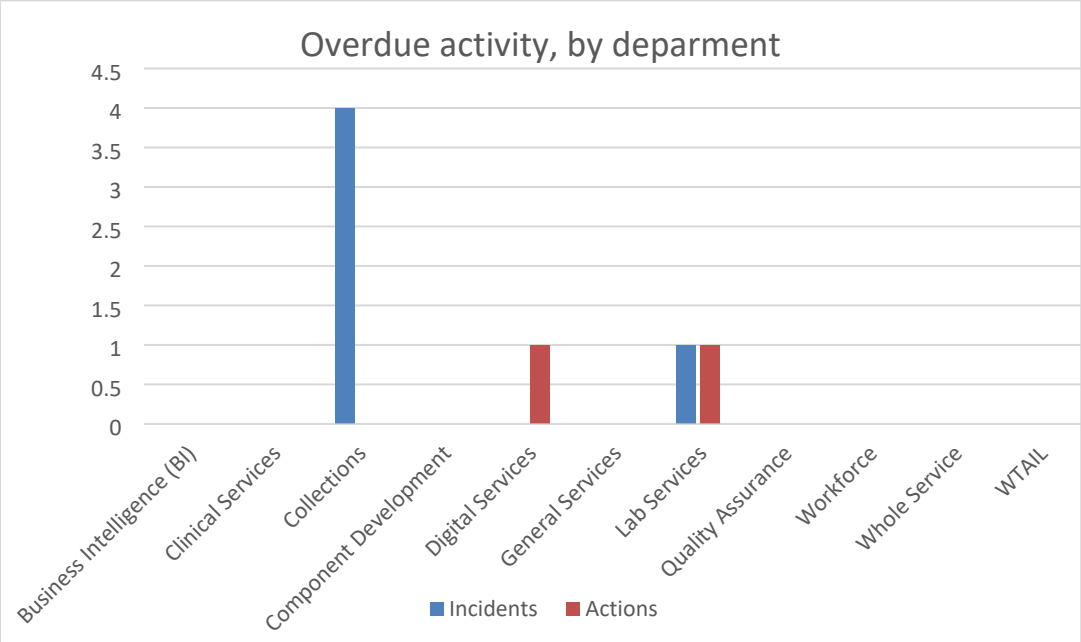
3.1 Activity performance trends

The following graph provides an overview of the overdue activity performance trends for incidents and preventive actions overdue for closure over the past year.



The following graphs provide an overview of the overdue activity performance trends for incidents, preventive actions and change proposals over time, and by department:


Oustanding activity by month
3.5
3
2.5
2
1.5
1
0.5
0
Jan-21
Feb-21
Mar-21
Apr-21
May-21
Jun-21
Jul-21
Aug-21
Sep-21
Oct-21
Nov-21
Dec-21
Jan-22
Incidents
Actions


Overdue activity, by deparment
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
Business Intelligence (BI)
Clinical Services
Collections
Component Development
Digital Services
General Services
Lab Services
Quality Assurance
Workforce
Whole Service
WTAIL
Incidents
Actions

Areas for concern:

There are no quality deviations (incidents) more than 3 months overdue and no significant risk events currently under investigation.

Quarterly Corrective and Preventative Actions (CA/PA) effectiveness monitoring is ongoing for previously reported significant risk incidents; no concerns have been identified to date.

There is one outstanding action recorded in Datix v.12 associated with Implementation of MAK-System fix for BR863 – Scanning of barcodes identified in Smoke testing of semester patch S2_2016.

The action was to upload MAK-System report for incident 77590 to the DATIX incident record. Resource needs to be allocated to work with MAK to identify the root cause and produce a report. Presently Digital Services resource is allocated to other projects and priorities, and although this work is important it is also considered low risk as safety measures are in place to ensure product safety is maintained.

3.2 How safe is our service?

For reporting purposes, WBS sub-divides incident 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 Q-pulse and monitored as a critical part of the Quality Management System (QMS)
- **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.

17 GMP incidents occurring in January have been reported via QPulse.

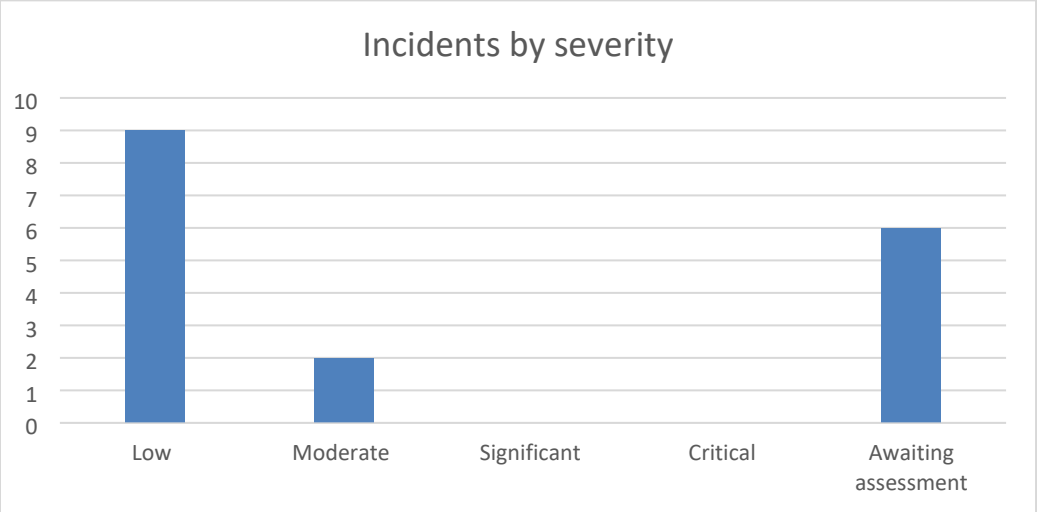
1 of these were reported outside of the target 48-hour reporting time frame (excluding weekends); a rationale for late reporting is provided and assessed by the QA team. Where the rationale is deemed unacceptable the relevant Head of Department is advised.

There were 23 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 does not lend itself to easy identification of such incidents so these have not been included in the pie chart detailing incident by category.

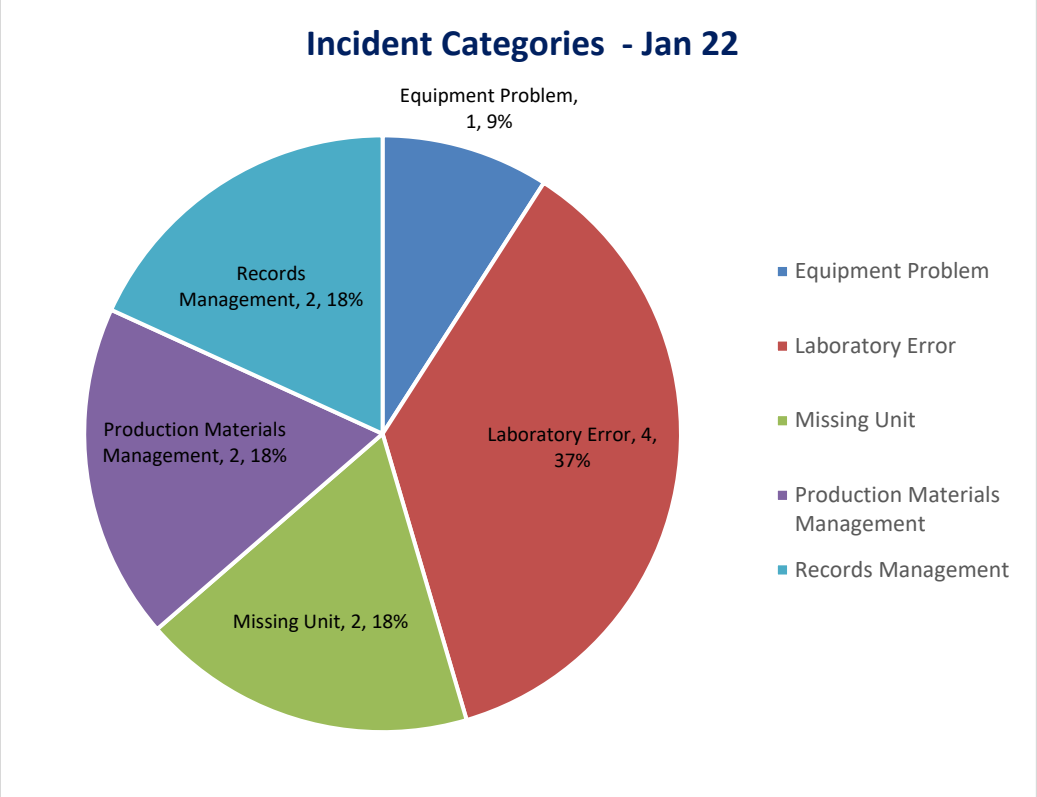
Areas of concern: None.

There were no significant or critical events reported in January.

6 reports are awaiting further information prior to being formally risk assessed by QA, however initial assessment has deemed these to be low risk events.



The chart below depicts the broad categorisation of incidents reported via QPulse in January:



3.3 Areas for concern:

No trends have been noted this month, although close attention is being paid to reports submitted by Hospital Issues, due to a previous trend regarding the handling of commercial blood products and the issuing of red blood cells to customer hospitals.

The effectiveness of previous preventive actions is being monitored.

In the 3 months to the end of December 2021, 88% of reported incidents were investigated and closed within 30 days (including GMP incidents reported via Datix OfW). This is a decline in performance compared with previous months (95%).

The number of incidents not closed within the required timeframe has increased from 10 in the previous three-month rolling period to 13 in this reporting period. 4 of these incidents remain under investigation by the Clinical Governance team; these are low risk investigations which have been difficult to complete in the current extremely challenging operational environment.

3.4 Serious Incidents Reportable to Regulators

There were no serious incidents reported to regulators during January.

3.5 Key Discussions arising from the Welsh Blood Service Regulatory Assurance & Governance Group (RAGG)

The RAGG meeting held 26th January reviewed data for November and December 2021, as the previous meeting had been postponed due to the current coronavirus situation and the need to focus operational activity elsewhere.

There were no areas of concern identified for escalation to SMT or the Quality, Safety & Performance Committee.

The meeting was attended by a member of Wales audit Office. The auditor commented that they were impressed with the way the attendees held each other to account.

4 Internal Audits

4.1 Exceptions / Notes

- All audits from 01/01/2022 until 31/03/2022 were reviewed in order to meet the requirements for WAH set by the Senedd (see page 2) – As a result, there were no audits conducted in January.

4.2 Audit Summary

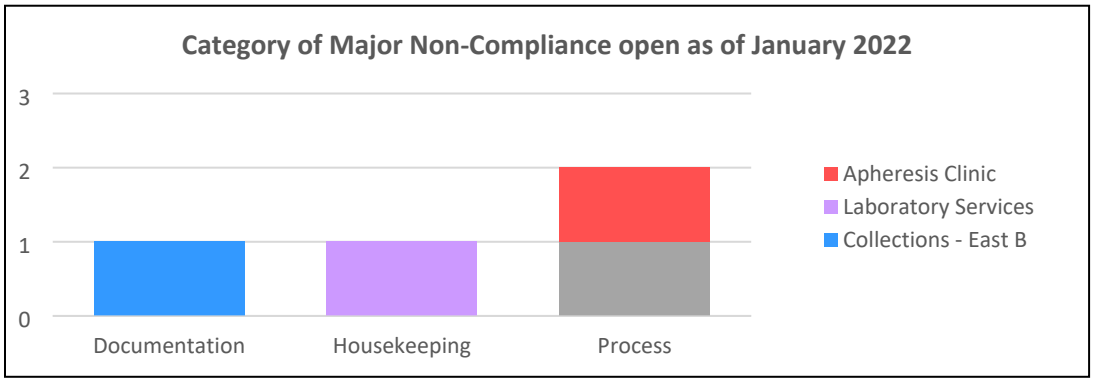
Total number of audits scheduled for completion in January:		**6**	**Conducted**	**Total Audits conducted**
Procedural Audits	**=**	**2**	**0**	
ISO 15189	**=**	**4**		
ISO 17043	**=**	**0**		
HTA Internal	**=**	**0**		**0**
Audits due to be conducted in Jan but risk assessed and closed:		**0**	-	
Audits postponed in Jan as a result of Government guidance:		**6**		

0 Audit Conducted within January to schedule	**Findings**
21/13 – MP-004, Customer and Donor Concerns and Compliments Postponed to March 2022	N/A
21/28 – MP-002, Document Control Postponed to March 2022	N/A
21/07 ISO 15189 (Clauses 5.6.3 – 5.8.3) Automated Testing Postponed to March 2022 – to be merged with 21/08 ISO 15189	N/A
21/07 ISO 15189 (Clauses 5.6.3 – 5.8.3) RCI Postponed to March 2022 – to be merged with 21/08 ISO 15189	N/A
21/07 ISO 15189 (Clauses 5.6.3 – 5.8.3) Serology Postponed to March 2022 – to be merged with 21/08 ISO 15189	N/A
21/07 ISO 15189 (Clauses 5.6.3 – 5.8.3) Molecular Postponed to March 2022 – to be merged with 21/08 ISO 15189	N/A

Reports outstanding from audits conducted in previous months	**Findings**
21/19 Procedural: MP-039 Research & Development (Delay in submission of audit report due to auditors current work commitments)	TBC – (Awaiting Report)
21/06 ISO 15189 – RCI (Delay in submission of audit report due to auditors current work commitments)	TBC – (Awaiting Report)

Risk by late completion: Low
The above audits have been conducted. Findings are fed back to auditees/HODs at the time of audit, by completion and approval of Summary of Findings Sheet.

4.3 Corrective and preventative actions (CA/PA) Summary



4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Demonstrates compliance with current European Good Practice Guidance for Blood, Tissues and Cells in ensuring the safety of donors and patients.
RELATED HEALTHCARE STANDARD	Safe Care
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
	Neutral impact
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 and Safety Committee are asked to NOTE the contents of this report.

Welsh Blood Service Monthly Report

December 2021

Gwasanaeth Gwaed Cymru
Welsh Blood Service

All demand for red cells was met, and all stock groups continued to be maintained above 3 days and averaging at 1467 units per week, compared to 1409 per week in November.

It should be noted that as of 16/12/2021, WBS was on a 'Blue Alert' working closely with hospital Blood Bank managers to manage demand and stock.

All clinical demand for platelets was met averaging 215 units per week compared to 199 for November.

In December the number of new bone marrow volunteers added to the Welsh Bone Marrow Donor Registry (WBMDR) reached 177 compared to 210 for November. The inability to hold whole blood donation clinics in schools and Universities continues to hinder recruitment, however, the Service is actively considering a new strategy to improve this performance.

At 98%, the turnaround time performance improved for routine Antenatal tests in December compared to 97% in November.

The Red Cell Testing metric is at 74% for December, representing a 7% improvement compared to November (Target -80%). Work continues to prioritise clinical need with all compatibility testing (>48% of referrals) completed to the required time/date.

At 87%, the turnaround time for deceased donor typing/crossmatching performance for this critical service exceeded target (80%) for this quarterly metric.

At 0.95 collection productivity for December is higher than November (0.92) but continues to be below target (1.25). In December absences reduced staff numbers on session, but this did not directly impact on service delivery. Covid and Infection Prevention Control (IPC) measures continue to limit donation centre capacity.

The combined 'Part Bag' rate for all whole blood teams remains within the required tolerance level of 2.3% in December 2021. Overall trend on all teams is stable, with the exception of one collection team with December performance under review.

The combined Failed Venepuncture (FVP) rate for all whole blood teams remains within the required tolerance at 1.9%. However the overall trend is upward in December. A performance analysis of venepuncturists on East C and Bangor teams is being undertaken.

At 91% the performance against the 'Incidents closed within 30 days' measure has exceeded target (90%) for the three month rolling period to December.

There were no external audits, inspections undertaken or Serious Adverse Events (SAE) reported to regulators during December.

At 407.5 The December manufacturing performance is closer to the 392.00 benchmark target No. than the November performance.

In December 2021, approximately 7,000 donors were registered at donation clinics. Six concerns (0.08%) were reported within this period, four were managed within timeline as 'Early Resolution' whilst two 'Formal Concerns' were managed within time under 'Putting Things Right' (PTR) regulations.

In December overall donor satisfaction continued to exceed target at 96.7%. In total there were 1,108 respondents, 190 were from North Wales and 872 were from South Wales.

409 new whole blood donors completed a donation in December, 6.7% of the total donations received in the month. There were 11 new apheresis donors in December 2021, and the target for the quarter has been exceeded by 12, with a total of 26 new donors.

11 Key Performance Indicators were above the previous month's performance, 8 achieving target

5 Key Performance Indicators were down on the previous month's performance, with 1 achieving target..

5 Key Performance Indicators remained the same as the previous month's performance, all achieving target.

Reference Table

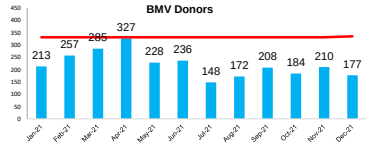
Measure	Target	Timeframe	National / Local
Number of new bone marrow donors aged 18-30 recruited to the Welsh Bone Marrow Donor Registry (WBMDR)	4,000	Annual	Local
Number of days when the Red Blood Cell (RBC) stockholding for O, A & B- fell below 3 days cover	0 days	Monthly	Local
Number of bags of RBCs 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

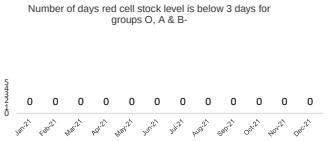
Dec-21



Annual Target: 4000 (average 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 177 in December compared to 210 the previous month. Whilst conversion of 17-30 blood donors to bone marrow volunteers has remained consistent throughout Covid-19, the reduction in blood collection due to reduced demand for blood has reduced the number of new blood donors available to convert to bone marrow volunteers.	The Service is preparing a two-pronged approach: a) promoting swab kits and b) supporting the Service to increase the number of younger donors donating blood. In Q4, the Service will increase the visibility of WBMDR using World Cancer Day (4 Feb) to promote swab kits and engage with Universities as they are slowly reintroduced to the blood collection model. A website task and finish group will also be created to review and improve the WBMDR sign up process in January for 17-30-year-olds.	Reviewed on 19/01/2022

Safe and Reliable Service

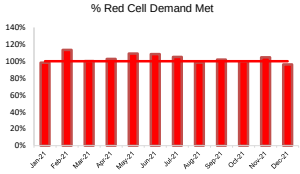
Dec-21



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+ groups continue to be maintained above 3 days for December	Daily Resilience meetings held between blood Collection, Manufacturing/Distribution and the Blood Health teams continue to facilitate operational responses to the challenges in maintaining adequate stock levels to minimise blood shortages.	Business as Usual, reviewed daily

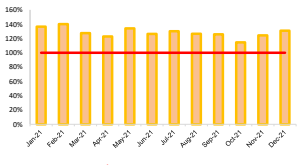
Safe and Reliable service

Dec-21



Monthly Target: 100%	**SMT Lead: Jayne Davey/ Tracey Rees**	
What are the reasons for performance?	**Actions(s) being taken to improve performance**	**By When**
Collections delivered 96.2% of the month's demand resulting in a need to issue 3.8% from reserve stock. Welsh Blood Service issued a Blue Alert 16/12/21 to hospital Blood Banks and during the month there has been pressure on Group O & A blood groups and platelets, due to higher donor cancellations and DNA's (Did Not Attend).	Daily Resilience meetings held between blood Collection, Manufacturing/Distribution and the Blood Health teams continue to facilitate operational responses to the challenges in maintaining adequate stock levels to minimise blood shortages. WBS asked hospitals to reduce their stock holding by 10%. Considered extra clinics in January to help recover the position WBS reminded donors of the imprtance of attending the session or advising the srvice that they could not attend appointments in advance.	Reviewed daily. A Blue Alert was issued in the service to manage supply and demand

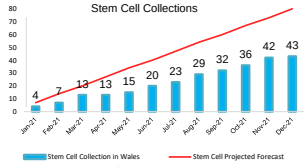
% Platelets Demand Met



Safe and Reliable service — **Dec-21**

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. Daily communications between the Collections and Laboratory teams enables agile responses to variations of stock levels and service needs. Platelet demand was 215 units per week on average.	No Action to note.	Reviewed daily.

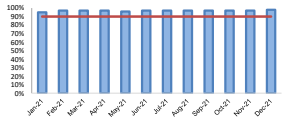
Stem Cell Collections



Safe and Reliable service — **Dec-21**

Annual Target: 80 (average 7 per month)	**SMT Lead: Tracey Rees**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
There was 1 Stem Cell Collection in December, by the Peripheral Blood Stem Cells (PBSC) collection method. The 1 cancellation at the preparation/work up stage has impacted on collection performance for December, and the Year to Date target.	The first stem cell collection via apheresis took place on 8th November at Velindre Cancer Centre. The pandemic has resulted in a global impact on transplants being delivered. The Service is taking time to return to business as usual. WBS has commenced defining and agreeing a future strategy for Stem Cell collection as part of wider review of future strategy for the Welsh Bone Marrow Donor Registry.	31/06/2022

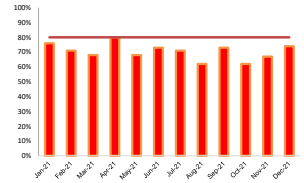
Antenatal Turnaround Times



Safe and Reliable service — **Dec-21**

Monthly Target: 90%	**SMT Lead: Tracey Rees**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
At 98%, the turnaround time for routine Antenatal tests in December remains above the target of 90% Continued monitoring and active management remains in place.	Continuation of existing processes are maintaining high performance against current target.	Business as Usual, reviewed daily

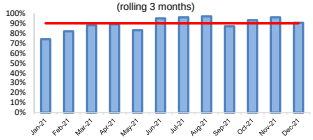
Reference Serology



Safe and Reliable service — **Dec-21**

Monthly Target: 80%	**SMT Lead: Tracey Rees**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Turn around times have not met target for December. Work continues to be prioritised based on clinical need, and all compatibility testing (>48% of referrals) is completed to the required time/date. Whilst performance has further improved, the complexity of referrals, sickness absence continues to impact performance in December. There were 247 hospital patient referrals in December, with the average number of Hospital Patient referrals at 226/month for 2021, compared to 181 in 2020.	WBS audit which is focussing upon the appropriateness of out of hours hospital referrals has now closed. Analaysis of the audit is currently taking place with initial findings expected to be available at 28th February 2022. The implementation of a project aimed to increase automation in RCI (Red Cell Immunohematology) is also anticipated to improve performance in this area.	28/02/2022 Date yet to be decided due to ongoing scoping project work.

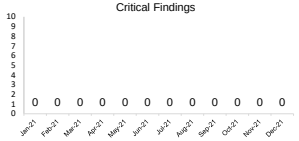
Quality Incidents closed within 30 days (rolling 3 months)



Safe and Reliable service — **Dec-21**

Monthly Target: 90%	**SMT Lead: Peter Richardson**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
At 91% the performance against the 'Incidents closed within 30 days' measure exceeded target (90%) for the three month rolling period to December. The number of incidents not closed within the required timeframe has increased from 4 in the previous three-month rolling period to 10 in this reporting period. 6 of these incidents remain under investigation by the Clinical Governance team; these are low risk investigations which have been difficult to complete in the current extremely challenging operational environment.	The revised process for managing low-impact incidents 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. Datix User Access and Reporting issues remain with the Datix Project Board for resolution.	Continue with close monitoring.

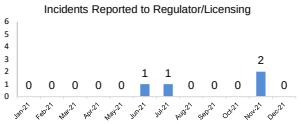
Critical Findings



Safe and Reliable service — **Dec-21**

What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
There were no external audits or inspections undertaken during December	Actions from previous MHRA inspections are being managed as business as usual via action plans.	N/A

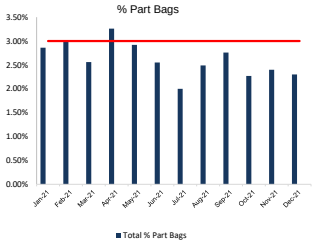
Safe and Reliable service



Dec-21

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 December.	N/A	N/A

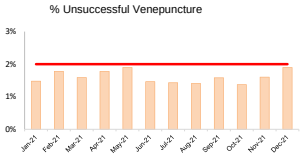
Spending Every Pound Well



Dec-21

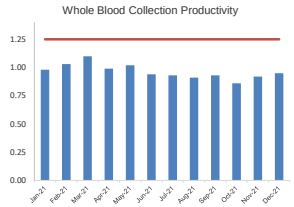
Monthly Target: Maximum 3%	**SMT Lead: Janet Birchall**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
The combined 'Part Bag' rate for all whole blood teams remains within the required tolerance level at 2.3% in December 2021. The overall trend on all teams is stable, with the exception of the Stock Building Team whose rates are skewed by small numbers (4.3% = 6 part bag events). Causes of Part Bag are various and include: needle placement, donor is unwell, donor request to stop donation, and equipment failure. This is a separate factor to FVPs.	Analysis of the 6 events on the Stock Building Team will be reviewed to ensure no repeat venepuncturist issues. Operation Managers & the Training Team will be provided with the relevant information, and should it be required further interventions (I.e. Individual Support Plans and or Additional Training /Supervision) can be actioned.	Continue with close monitoring and intervention where required

Spending Every Pound Well



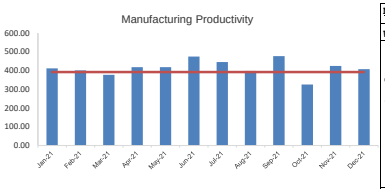
Dec-21

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 December 2021 reamains within the required tolerance at 1.9%. The overall combined rate trend is upward - with increases seen in the last two months. Both East C and Bangor teams have seen an increase in December, both being overtolerance at 2.5%. (26 and 9 FVP events respectively).	A performance review of venepuncturists on East C and Bangor teams has been undertaken. There are no trends emerging realting to north Wales (Bangor) performance, however there are some repeat 'failiures' with staff in the South East C Team. The Training Team are reviewing performance with individuals and providing training support to the individuals in the South East C Team.	Continue with close monitoring and intervention where required



Spending Every Pound Well — **Dec-21**

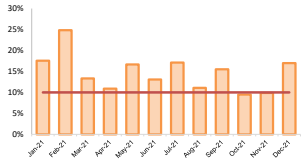
Monthly Target: 1.25	**SMT Lead: Jayne Davey**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
At 0.95 collection productivity for December is higher than November (0.92) but continues to be below target and is due to addtional Infection Precention Control (IPC) measures as a result of COVID-19 Covid and Infection Prevention Control (IPC) measures continue to limit donation centre capacity. Donor sessions are operating on 2m distancing therefore impacting on a reduction of available donor slots in most venues. There are also regional variations in productivity across collection teams which the Service is reviewing, and in part is attributable to skill mix and regional team location.	Whilst the Service continues to operate under Covid conditions, it is extremely limited in being able to improve this performance which is based on a pre COVID operating model.	



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**
The December manufacturing performance figure is at 407.5 and closer to the 392.00 benchmark target No. than the November performance.	This target measures the manufacturing productivity by assessing the staffing levels against the number of blood components being manufactured. This target is based on the Pre COVID operating model	

Time Expired Platelets



Spending Every Pound Well

Dec-21

Monthly Target: Maximum 10%	**SMT Lead: Tracey Rees**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Platelet expiry was above target for December, this was as a result of a planned increase in platelet production in the weeks before, during and after 25th December in order to ensure sufficient platelet supply for the patients of Wales. A variation in demand resulted in excess expiry on 29-31st December.	Adjustments on the weekly production continue to be made to better align with demand and take into account the apheresis appointments and donor attendance. Ongoing platelet production is based on required daily targets, leading to decreased platelet expiry percentages.	Ongoing and reviewed daily

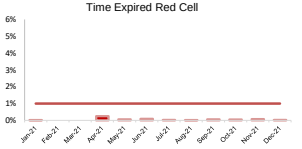
Controllable Manufacturing Losses

Spending Every Pound Well

Dec-21

Monthly Target: Maximum 0.5%	**SMT Lead: Tracey Rees**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Controllable losses for December were extremely low at 0.03% and remain within tolerance to be below 0.5%. November performance was 0.1% The losses were (units): M&D Operator - Blood Presses :2 units	Reporting, management, and ongoing monitoring of losses when occurring continiously improve practice through lessons learned and analysis. Staff experience has increased over the last few months which has a stabilising effect for the laboratory work.	Business as Usual, reviewed monthly

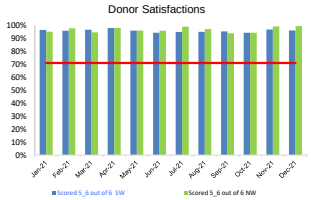
Time Expired Red Cell



Spending Every Pound Well

Dec-21

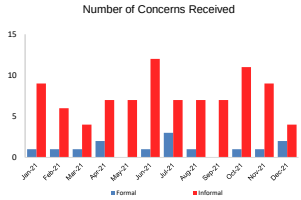
Monthly Target: Maximum 1%	**SMT Lead: Tracey Rees**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Red cell expiry for December remains negligible at 0.03% and significantly lower than the 1% target, and November performance of 0.08% This is due to effective management of blood stock expiry coupled with the Covid 19 challenges affecting blood collections.	Effective stock management and monitoring	Business as usual, reviewed daily



First Class Donor Experience

Dec-21

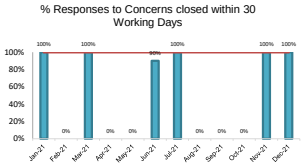
Monthly Target: Minimum 71%	**SMT Lead: Jayne Davey**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
In December overall donor satisfaction continued to exceed target at 96.7%. In total there were 1,108 respondents, who had made a full donation and shared their donation experience (some of which are non attributable), 190 were from North Wales and 872 were from South Wales (where location was able to be defined).	Findings to be reported to management at Collections meeting for actions from individual teams.	Business as usual, reviewed monthly



First Class Donor Experience

Dec-21

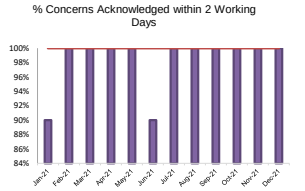
Target: N/A	**SMT Lead: Alan Prosser**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
In December 2021, approximately 6,867 donors were registered at donation clinics. Six concerns (0.08%) were reported within this period. Four were managed within timeline as 'Early Resolution whilst the two formal concerns were managed under 'Putting Things Right' (PTR) regulations as detailed below. The two formal concerns recorded in December and received on 17/12/2021 and 07/12/2021 were closed on 21/12/2021 and 29/12/2021 respectively within PTR timeline. The formal concern recorded in November and managed under 'PTR' regulations and was completed on 21/12/21, 5 days before the 27/12/21 target. 1. Formal - Email received from Welsh Language Commissioner's office on behalf of a member of the public regarding sections of the Blood Service website not available in Welsh - includes pages, videos, and audio clips 2. Donor 10 minutes late for appointment and turned away - would like a little more leeway 3. Donor was unhappy with staff member's "unprofessional" behaviour and comments 4. Donor was unhappy with the amount of plastic drinking cups used across the teams 5. Donor was unhappy about being turned away from session as it was too soon to donate (online booking) 6. Formal - Donor unhappy WBS have removed the tabletop appointment booking option and is unhappy we do not visit a particular venue in North Wales every month	Actions taken to address concerns: 1. A formal response has been issued to Welsh Language Commissioner to address concerns of the complainant, informing them of new to WBS website due to be launched early 2022. Current website has been reviewed and historic videos and audio stories removed, PDF document and booking portal updated to comply with Welsh language requirements. 2. Full explanation informing donor that all clinics are currently being run at 100% appointments to utilise and manage the flow of the clinic, hence no leeway to use 'walk-in' slots. (Donor was offered to wait for an available slot but was unable to stay) 3. Staff member apologised to donor on realising the upset caused, and a follow up contact with the donor was also made. The member of staff has been asked to reflect on thier approach / actions. File note completed. 4. Biodegradable cups and compost bags on trial across the West team. H & S manager is working with Veolia the recycling company to maintain environmental, disposable solutions. Update provided to donor. 5. Donor Contact Centre and WBS I.T. dept. are working to explore longer term solutions to prevent donors booking their appointments online which allow donors to book appointments too soon following most recent donation. 6. A formal response has been issued to the donor. Historically donors are offered the opportunity to book their next appointment on session, this has ceased due to the online system luanch. The donor has made repeated complaints about an established change in process to enable on line bookings, and has been agressive to staff. The donor has been politely advised that the service has a zero tolerance to agressive behaviour to WBS staff and that it is not possible to revert to the previous way of working.	Business as usual, reviewed daily



First Class Donor Experience

Dec-21

Monthly Target: 100%	SMT Lead: Alan Prosser	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
During December 2021 two new formal concerns were received. All formal concerns managed during December 2021 were closed within the 30 day Putting Things Right (PTR) requirement. * Under PTR, Organisations have 30 working days to address/ close formal concerns. This can result in concerns being received and subsequently closed within separate reporting periods.	Continue to monitor Formal complaint response progress, and 30 day target compliance.	Business as Usual, reviewed daily

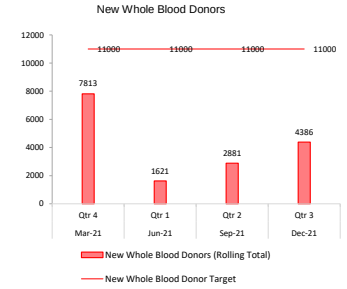


First Class Donor Experience

Dec-21

Monthly Target: 100%	SMT Lead: Alan Prosser	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
All initial responses to all early resolution and formal concerns received in December 2021 were managed within timeline.	Continue to monitor initial complaint acknowledgement progress against the 'two working day' target compliance.	ongoing, reviewed daily

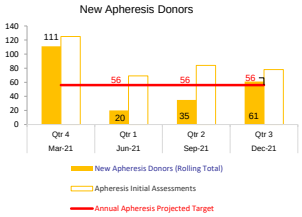
Quarterly Reporting



Equitable and Timely Access to Services

Dec-21

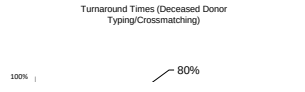
Quarterly Target: 2750	SMT Lead: Jayne Davey	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
409 new donors completed a donation in December, 6.7% of the total donations received in the month. Quarterly donations reached 1505, averaging at 7.6% of all quarterly donations. 557 (8.7%) new donors completed a donation in October and 539 (7.9%) in November. During Covid-19, appointment slots have been reduced to match hospital demand. The reduction has resulted in fewer available opportunities for new donors to donate. The current demand for blood is being sustained despite the decrease in new donors. Appointment slots have reduced, resulting less available opportunities for new donors to donate. As new donors' blood type is unknown, reserving slots for new donors is not prudent as this will increase the number of unknown blood types bookings and decrease the efficiency of blood collection.	The ability to recruit new donors has also been complicated by the reduction of post-5pm donation slots, by the inability to use donation vehicles and the pause on the majority of venues with high numbers of new donors (e.g. Universities). The feasibility of reintroducing universities and school venues is continually reviewed. The next monthly review is due w/c 17 January 2022.	17/01/2022



Dec-21

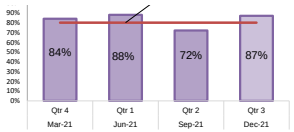
Quarterly Target: 14	SMT Lead: Jayne Davey	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
There were 11 new apheresis donors in December 2021, exceeding the new apheresis donors target for the quarter by 12 donors with a total of 26 new donors over the three months.	Continue to promote Apheresis donations to ensure mainteance of this donation Panel.	**Ongoing reviewed quarterly**

Safe and Reliable service



Dec-21

Quarterly Target: 80%	SMT Lead: Tracey Rees

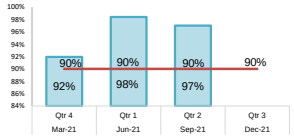


What are the reasons for performance?	Action(s) being taken to improve performance	By When
At 87% the turnaround time for deceased donor typing/crossmatching performance for this critical service exceeded target (80%) for this quarterly metric.	Continued monitoring and active management is in place.	31/06/2022

Safe and Reliable service

Dec-21

Anti D & -c Quantitation



Quarterly Target: 90%	SMT Lead: Tracey Rees	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Full month data not available, due to manual data collection and complex analysis. Complete data usually becomes available during the 2nd week of each month but not yet available, due Covid and Xmas staffing pressures. Expected results anticipated to be in line with October and November reading and meeting target.	Continued monitoring and active management is in place. This performance measure is being actively considered as part of the new Performance Management Framework.	

Velindre (Excluding Hosted	Current Month	Previous Month	Target
	Dec-21	Nov-21	
PADR	70.83	72.11	85%
Sickness	5.54	5.51	3.54%
S&M Compliance	86.40	86.06	85%

Key	85%-100%		50% - 84.99%		0% - 49.99%	

These figures exclude Trainee Doctors, those on Maternity, Starters within first 6 Months, those currently off on sickness absence.

PADR	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Corporate	47.46	39.82	41.74	43.44	45.00	49.58	47.01	48.33	50.43	45.69	46.58	44.59	45.64
Research, Development & Innovation	75.00	42.22	34.04	58.33	60.00	64.58	62.50	61.70	65.96	66.67	72.09	90.91	88.37
Transforming Cancer Services	37.50	40.00	64.29	60.00	66.67	68.75	71.43	66.67	60.00	56.25	43.75	62.50	75.00
Velindre Cancer Centre	76.98	78.68	77.53	79.78	81.07	78.88	76.52	74.31	75.17	76.40	73.77	70.90	67.61
Welsh Blood Service	66.18	67.97	73.19	77.25	78.65	82.41	81.74	79.78	78.27	77.93	77.52	82.19	83.06
Velindre Organisations	70.32	70.19	71.32	74.64	76.07	76.77	75.09	73.28	73.58	73.67	71.69	72.11	70.83
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85

Key	85%-100%		50% - 84.99%		0% - 49.99%	

These figures exclude those on Maternity and those currently off with sickness absence

Stat and Mand Compliance (10x CSTF)	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Corporate	70.47	71.61	70.62	69.47	69.06	70.08	69.08	69.26	70.45	71.36	74.54	72.32	74.40
Research, Development & Innovation	76.25	77.45	82.50	83.73	82.59	83.08	85.69	86.00	85.80	86.25	84.89	84.58	85.83
Transforming Cancer Services	70.56	71.18	69.38	64.12	65.29	70.00	76.00	76.84	85.26	82.50	82.86	83.33	81.43
Velindre Cancer Centre	80.23	80.69	81.53	81.57	80.98	81.77	82.45	82.70	83.16	82.89	83.11	84.91	84.93
Welsh Blood Service	91.42	90.43	89.54	90.90	90.43	92.23	92.39	93.38	92.66	92.21	92.54	93.36	93.56
Velindre Organisations	82.66	82.81	83.06	83.39	82.92	84.09	84.59	84.97	85.24	84.95	85.10	86.06	86.40

Key	0% - 3.54%		3.55% - 4.49%		4.5 % & Above	

Sickness Rolling %	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Corporate	5.18	5.24	5.14	4.85	4.59	4.51	4.44	4.33	4.13	4.15	4.13	4.36	4.54
Research, Development & Innovation	4.62	4.37	4.23	4.01	3.73	3.46	3.16	3.34	3.55	3.96	4.29	4.41	4.29
Transforming Cancer Services	2.24	2.41	2.41	2.01	1.34	0.88	0.41	0.32	0.33	0.40	0.86	1.27	0.99
Velindre Cancer Centre	5.76	5.88	5.97	5.77	5.40	5.37	5.41	5.47	5.47	5.52	5.57	5.63	5.51
Welsh Blood Service	4.43	4.44	4.38	4.24	4.19	4.36	4.57	4.81	5.10	5.41	5.70	5.96	6.24
Velindre Organisations	5.21	5.28	5.29	5.10	4.84	4.85	4.91	5.01	5.09	5.23	5.37	5.51	5.54
Target 3.54%	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54

Monthly Sickness Rolling Covid Only Absence %	0%		0.01% - 0.49%		0.50 % & Above	

Sickness Leave Covid Related	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Corporate	0.42	0.55	0.60	0.58	0.53	0.58	0.63	0.67	0.78	0.90	0.97	1.03	1.01
Research, Development & Innovation	0.43	0.45	0.46	0.42	0.35	0.44	0.45	0.45	0.43	0.43	0.43	0.42	0.37
Transforming Cancer Services	0.27	0.26	0.26	0.21	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Velindre Cancer Centre	1.28	1.39	1.44	1.31	0.96	0.89	0.86	0.87	0.88	0.85	0.87	0.85	0.73
Welsh Blood Service	0.37	0.42	0.44	0.39	0.31	0.29	0.28	0.29	0.29	0.36	0.38	0.37	0.35
Velindre Organisations	0.88	0.96	1.00	0.91	0.68	0.65	0.63	0.64	0.66	0.68	0.70	0.69	0.62

Monthly Special Leave Absence Rolling %	0%		0.01% - 0.49%		0.50 % & Above	

Special Leave Non Covid Related	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Corporate	0.37	0.30	0.23	0.17	0.11	0.05	0.04	0.06	0.06	0.03	0.09	0.10	0.09
Research, Development & Innovation	0.71	0.74	0.65	0.50	0.46	0.42	0.51	0.60	0.74	0.93	1.09	1.28	1.32
Transforming Cancer Services	0.32	0.51	0.51	0.51	0.51	0.51	0.51	0.53	0.56	0.55	0.54	0.40	0.24
Velindre Cancer Centre	0.40	0.42	0.43	0.43	0.41	0.41	0.42	0.44	0.47	0.49	0.54	0.57	0.64
Welsh Blood Service	0.62	0.63	0.61	0.62	0.58	0.59	0.58	0.59	0.61	0.63	0.65	0.65	0.64
Velindre Organisations	0.47	0.49	0.48	0.47	0.44	0.43	0.44	0.46	0.49	0.51	0.55	0.57	0.60

Monthly Special Leave Absence Rolling %	0%		0.01% - 0.49%		0.50 % & Above	

Special Leave Covid Related	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Corporate	0.58	0.58	0.57	0.48	0.32	0.25	0.18	0.11	0.03	0.01	0.00	0.00	0.00
Research, Development & Innovation	1.98	1.96	1.95	1.45	1.04	0.76	0.49	0.21	0.13	0.13	0.15	0.10	0.15
Transforming Cancer Services	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Velindre Cancer Centre	2.13	2.27	2.36	2.13	1.71	1.40	1.16	0.99	0.88	0.88	0.89	0.83	0.81
Welsh Blood Service	1.62	1.71	1.75	1.65	1.32	1.06	0.82	0.68	0.62	0.67	0.67	0.67	0.65
Velindre Organisations	1.80	1.90	1..96	1.77	1.41	1.15	0.92	0.77	0.68	0.69	0.70	0.66	0.64

Quality, Safety & Performance Committee

INFECTION PREVENTION & CONTROL MANAGEMENT GROUP HIGHLIGHT REPORT

DATE OF MEETING	17th February 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	Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science

REPORT PURPOSE	**ASSURANCE**

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
INFECTION PREVENTION & CONTROL MANAGEMENT GROUP	03/12/2022	Areas for inclusion agreed
EXECUTIVE MANAGEMENT BOARD	07/02/2022	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 during the meeting held on the 20th January 2022.

2. BACKGROUND

The Trust's Infection Prevention & Control Management Group is chaired by the Executive Director of Nursing, Allied Health Professionals and Healthcare Scientists, and is attended by key personnel from both Divisions. The Group considers all national guidelines relating to Infection Prevention and Control, 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. It is proposed to move back to quarterly meetings unless the pandemic risks change. 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 20th January 2022

The following are the highlights from the Infection Prevention & Control Management Group meeting held on the 20th January 2022:

ESCALATE/ALERT	No items to escalate.
ADVISE	• **Velindre Cancer Centre Infection Prevention and Control Training Compliance** Velindre Cancer Centre Infection Prevention and Control Divisional Report developed following the Cancer Centre Infection Control meeting held on the 12th January 2022 was discussed. The report covered compliance across all clinical areas of all related IPC training. Overall considerable training improvement had been maintained. However, the Cancer Centre was taking targeted action within the clinical areas, where training compliance was not at the required levels. Action plans have been developed to improve the compliance to the required levels in the months of January and February 2022. The compliance tracker is presented in **Appendix 1**.
ASSURE	• **Levels of Infection Quarter 3** The detailed Trust surveillance report was received (relevant sections are attached in ***Appendix 2***). The following highlights were discussed: ○ There has been no Healthcare Acquired Gram negative bacteremia. ○ Three cases of MSSA bacteremia, these cases were not acquired at Velindre Cancer Centre. ○ One case of Klebsiella Spp. Bacteraemia, not acquired at Velindre Cancer Cenre. ○ There have been no cases of Clostridioides difficile ○ Over 8 years since MRSA bacteraemia - last case December 2013. • **COVID-19 Status** A comprehensive COVID-19 report was received that detailed no issues of COVID-19 transmissions for the period. The Group were advised that no healthcare associated transmission was reported among patients or staff members. Two patients were admitted in December 2021, but both were already known cases and not acquired during hospital stay. • **Antimicrobial Stewardship report**

The Group received a detailed Antimicrobial Stewardship Report that included an overview of how the Trust was progressing in relation to its Antimicrobial Prescribing Improvement Goals. The following was highlighted:

- The Trust's antimicrobial guidelines were based on those of Cardiff and the Vale University Health Board (C&VUHB). From the start of December 2021 Velindre Cancer Centre will use the C&VUHB Microbiology Guide.

- ***Start Smart Then Focus*:** The Antibiotic Review Kit chart was implemented in March 2021. Previously it was reported that Velindre Cancer Centre was ahead of most of the other Health Boards in Wales in implementing the Antibiotic Review Kit chart. However, 100% compliance was not achieved across all measures. Therefore, a documented senior review (a compliance element within the Review Kit) was identified as an area where compliance had reduced, and a root cause analysis was undertaken by the antimicrobial pharmacist to establish why this was happening. An action plan to improve the compliance was developed and as a result over the last three months the compliance has been 100%.

- **Welsh Blood Service (WBS) Infection Prevention and Control Training Compliance**

  The Infection Prevention and Control training compliance for staff at WBS was reported as being sustained above 95%.

- **Research Development and Innovation (RD&I) Infection Prevention and Control Training Compliance**

  The Group received the RD&I Teams assurance report that detailed the considerable improvement that has been undertaken to ensure that within RD&I the required IPC training standards are being met.

- **Water Testing for the growth of *Pseudomonas Aeruginosa***

  The Water Safety Report was presented to the group, and it was mentioned that previous reporting to the group had shown a growth of *Pseudomonas aeruginosa* in 5% of the water samples collected from all water outlets, in Velindre Cancer Centre. Since these findings, corrected measures had been taken and now all repeated water samples have shown negative growth.

	• **Vaccination Program Update** Vaccination Program update was provided to the group, and were advised that, to date, 83% of the staff at Velindre University NHS Trust received COVID-19 vaccine boosters and 71% received influenza vaccine.
INFORM	**Quarterly Infection Prevention and Control policy status update** The quarterly status highlighted that the following Infection Prevention and Control related policies remain out of date: • IPC01 - Gastro-Enteritis Policy • IPC04 - Decontamination of Healthcare equipment prior to inspection, service, maintenance, or report • IPC07 – MRSA were under review The Group were advised that the review of these policies has been completed and all will be considered by the Group in February 2020 and provided to Executive Management Board for approval in March 2022. The reason for the delay in reviews is due to the pandemic and infection control team resources (recruitment on-boarding delays). To ensure ongoing scrutiny, the Trusts Infection Control related policy status will, going forward be an agenda item at each Prevention and Control Management Group meeting.
APPENDICES	**YES - (Please Include Appendix Title in Box Below)**
	Appendix 1 – Velindre Cancer Center Training compliance tracker **Appendix 2-** Surveillance Trends

4. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **DISCUSS** and **NOTE** the Infection Prevention & Control highlight report from the meeting held on the 20th January 2022 and actions being taken to address the areas where compliance / standards are not at the required level.

Appendix 1. Velindre Cancer Centre Training Compliance Tracker

				Nursing					Operational Services										
Training	CNS	Estates	Nuclear Medicine IPC Report	Assessment Unit	Inpatients/ Ambulatory Care/PSU	Theatre	Palliative Care	Medical Staffing	Portering	Domestics	Catering	Outpatients dept	Pharmacy	Radiology dept	Radiotherapy dept	Research, Development & Innovation	SACT	Therapies
Fit Testing	100 %		88%	100%	100%	100%	100%	84%				97%		100%	100%	100%	96%	100%
PPE - Donning & Doffing - Core	58%	100%	100%	80%	79%	100%	100%	79%	98%	98%	97%	100%	70%	94%	91%	95%	91%	100%
PPE - Donning & Doffing - Assessment	70%	100%	100%	80%	62%	100%	100%	78%	98%	98%	97%	100%	95%	100%	75%	95%	91%	100%
Hand hygiene	58%	100%	88%	100%	91%	100%	100%	77%	97%	100%	98%	100%	71%	100%	88%	95%	95%	100%
IPC level 1	77%	100%	100%	100%	89%	100%	100%	no data	100%	100%	100%	97%	91%	100%	97%	95%	98%	100%
IPC level 2	71%		100%	100%	83%	100%	100%	no data				97%	86%	100%	90%	95%	98%	100%
ANTT Non-surgical - Core	72%		100%	83%	95%	100%	90%	no data				100%	?	66%		?	88%	
ANTT Non-surgical - Assessment	27%		0%	83%	68%	?	50%	no data				80%	?	46%		?	63%	
ANTT Surgical																		

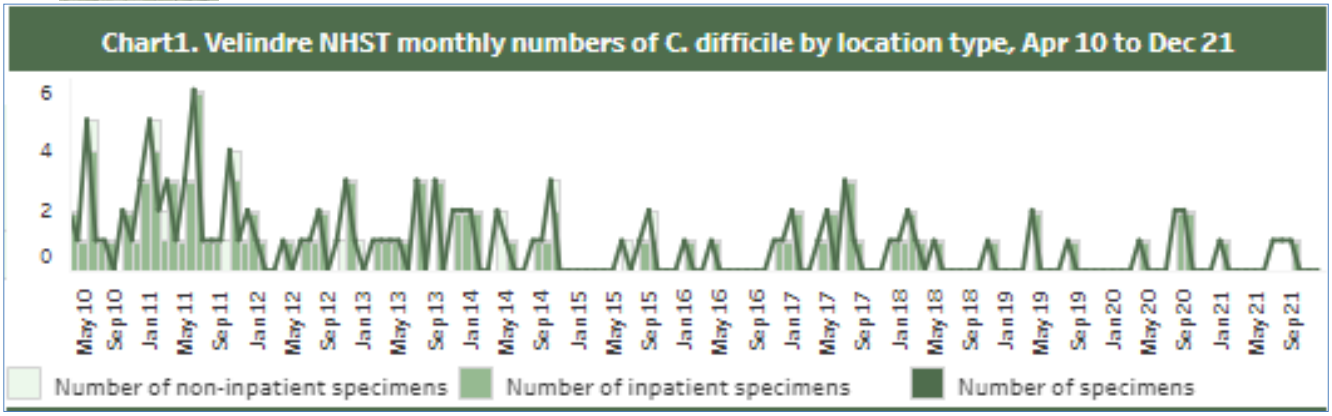
Appendix 2: Trust Surveillance Trends report - (relevant sections full report available on request)

5. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

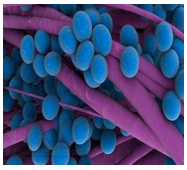
Infection Rates for Period Q3

5.1 *Clostridioides difficile (C. difficile)* infections

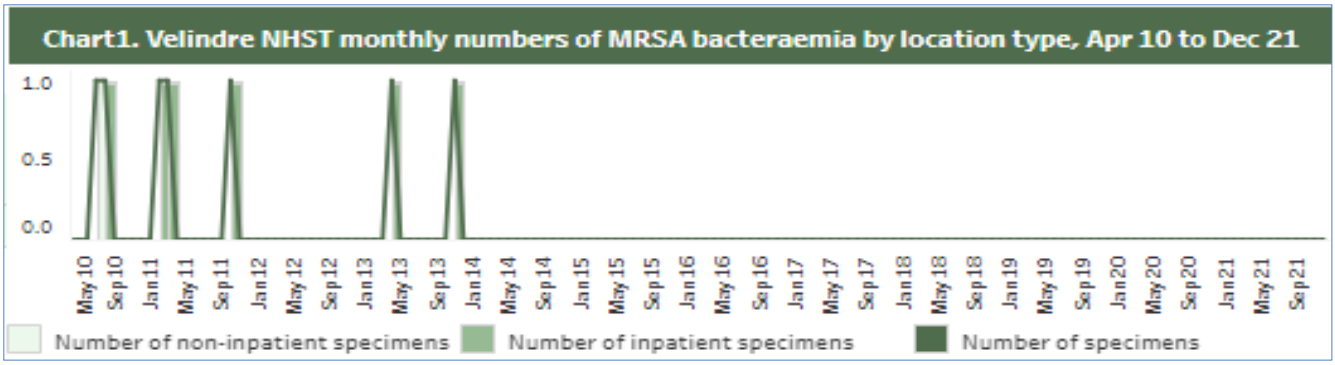
No cases of C. difficile were reported in Q3.



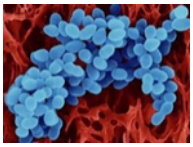
5.2 *Methicillin Resistant Staphylococcus Aureus Bacteraemia (MRSA) Bacteraemia infection*



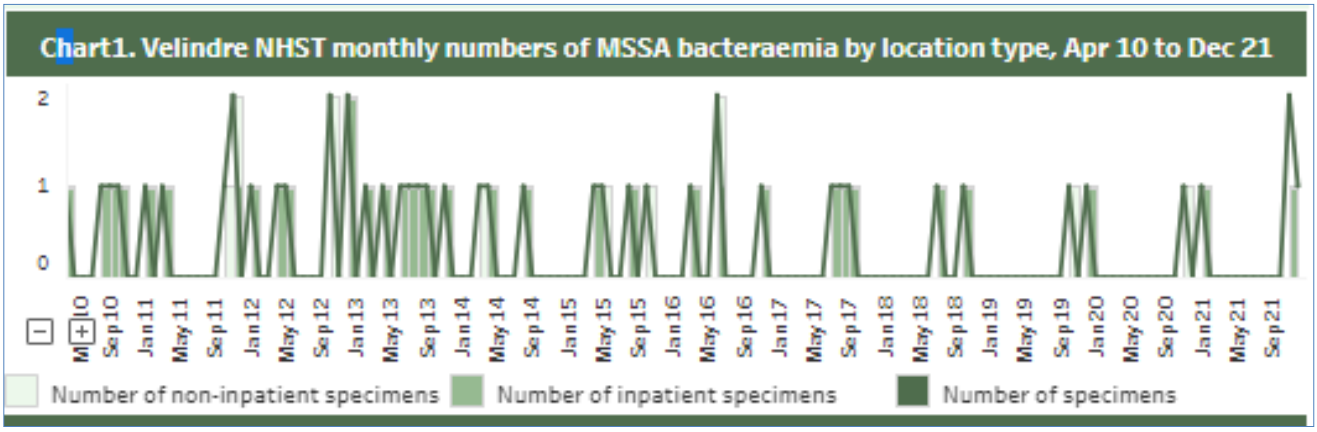
No MRSA bacteraemia cases were reported in Q3. Velindre Cancer Centre has embedded MRSA screening as part of the admission process and before any invasive devices are inserted. There has not been an MRSA bacteraemia since November 2013.



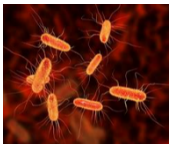
5.3 *Meticillin Sensitive Staphylococcus aureus (MSSA) Bacteraemia* infections



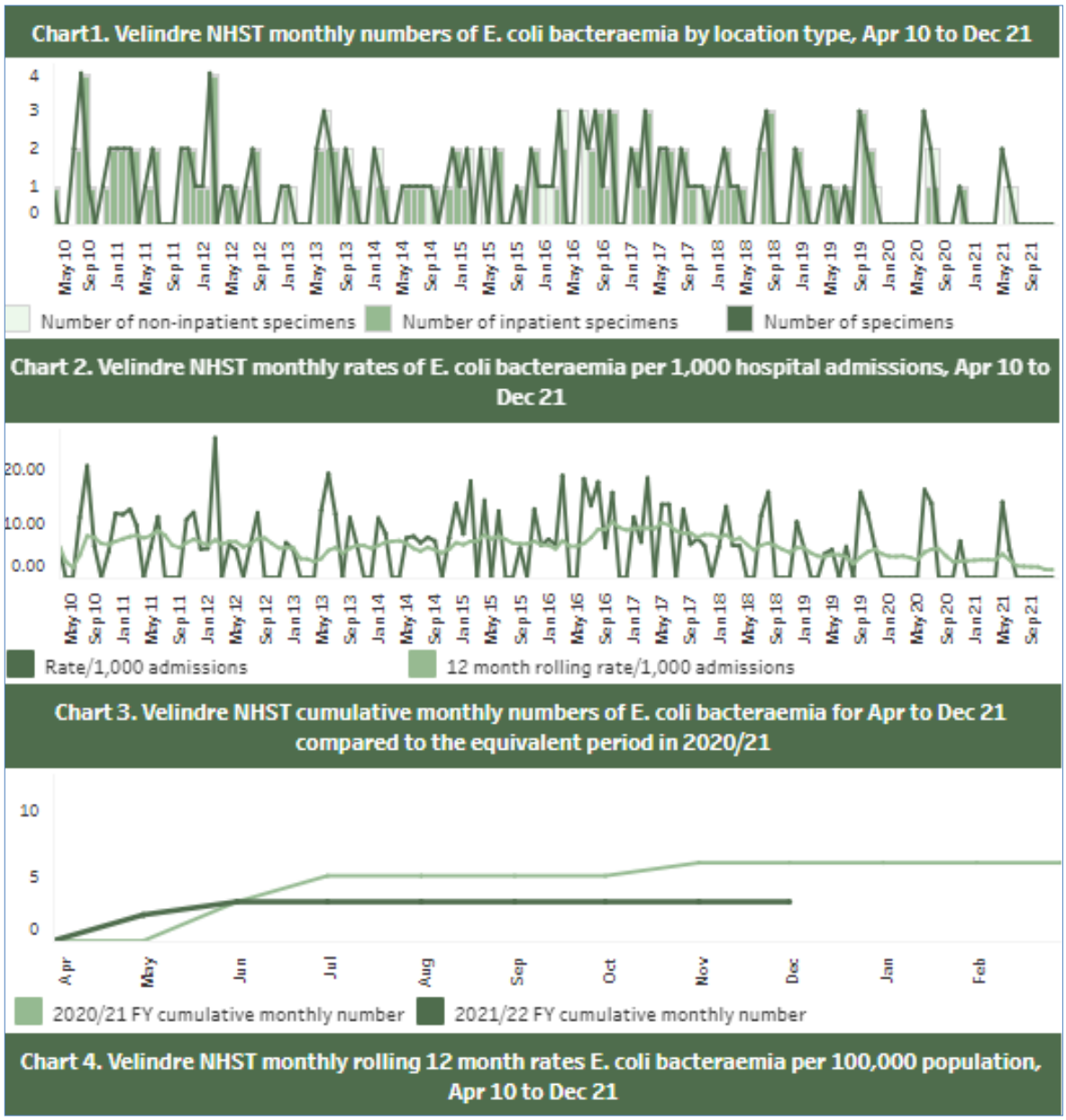
Three cases of MSSA bacteraemia were reported at VCC in Q3. Two cases were reported in November 2021. One of them was deemed community associated and the other was associated to a PICC line and not acquired at VCC. One case was reported in December 2021 which was also associated to a PICC line and not acquired at VCC



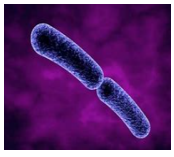
5.4 Escherichia coli bacteraemia (E.coli)



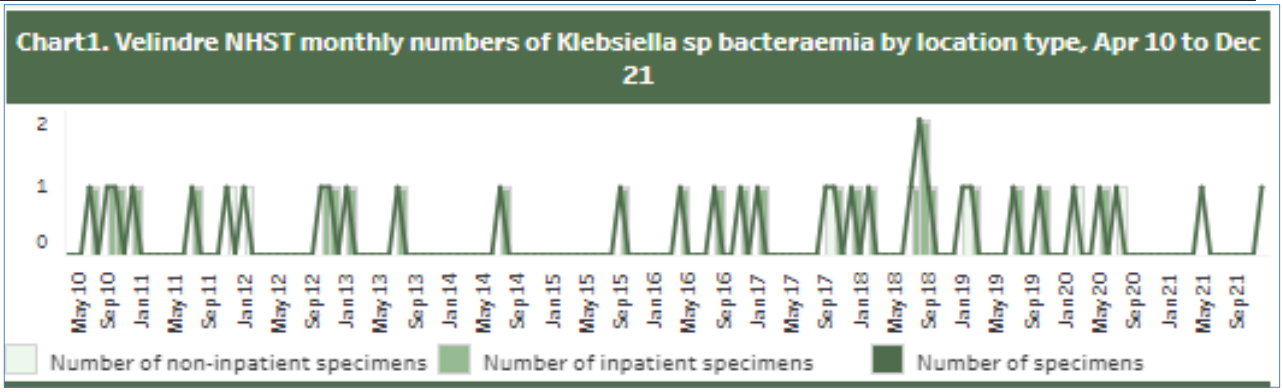
No cases of E. *coli* bacteraemia were reported in Q3.



5.5 *Klebsiella sp. Infections*

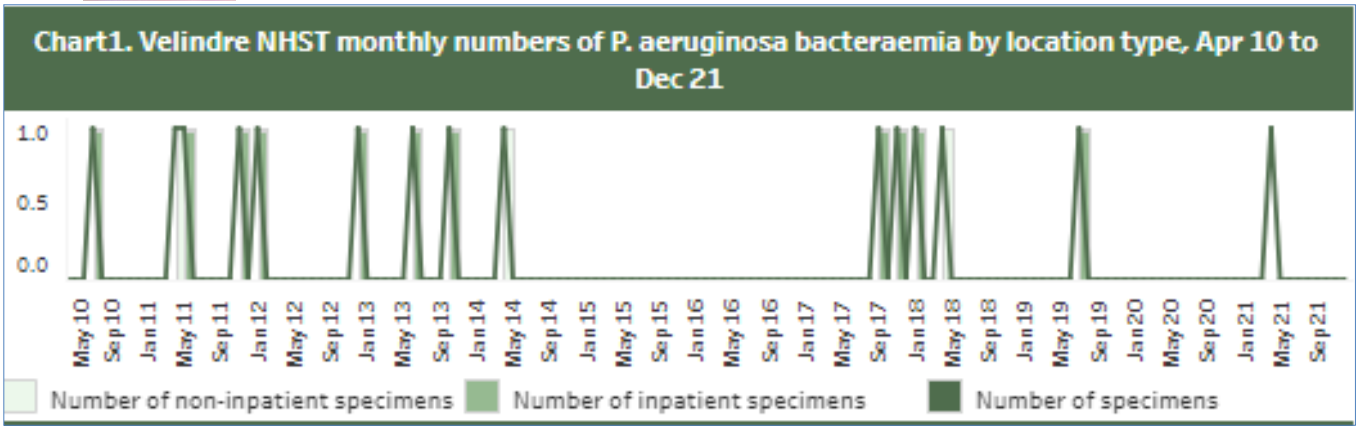


One case of *Klebsiella Spp*. was reported in December 2021. It was not acquired at VCC as the patient was not admitted.



5.6 *Pseudomonas aeruginosa bacteraemia* infections

No cases of *Pseudomonas aeruginosa* were reported in Q3.



QUALITY, SAFETY & PERFORMANCE COMMITTEE

SAFEGUARDING & VULNERABLE ADULTS MANAGEMENT GROUP HIGHLIGHT REPORT

DATE OF MEETING	17th February 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	Nicola Williams, Executive Director of Nursing, AHPs and Health Science
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	03/12/2022	Areas for inclusion agreed
EXECUTIVE MANAGEMENT BOARD	07/02/2022	Noted

1. PURPOSE

This paper had been prepared 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 3rd of December 2021.

2. SAFEGUARDING & PUBLIC PROTECTION MANAGEMENT GROUP HIGHLIGHT REPORT

The Safeguarding & Vulnerable Adults Management Group met on the 3rd December 2021 and agreed the following areas for highlighting:

ALERT / ESCALATE	• ***Safeguarding training compliance*** remains below the target of 95% in most areas. A safeguarding and public protection training needs analysis was circulated in October. There remains issues with the accuracy of the safeguarding training data on ESR that the Workforce & Organisational Development Team are reviewing. The training needs analysis is being revisited post wave 4 with the support from the Trust Education and Development department. The risk associated with Safeguarding training compliance is being added to the risk register and the risk will be considered and approved at the next meeting.
ADVISE	• ***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. • The safeguarding risk register that detailed two safeguarding risks was considered:

	1. The Trust is not prepared for the implementation for the Liberty Protection Safeguards that were due to come into force in April 2022 as the draft statutory guidance is not yet available. This may lead to non-compliance with legislation and patients being unlawfully deprived of their liberty – risk score of 9. The Trust is keeping abreast of national developments in respect of this in real time. 2. There is a lack of safeguarding resilience as the Trust does not have a safeguarding team, rather a single practitioner (Senior Nurse, Safeguarding and public protection) – risk score of 9. The Senior Nurse Professional Standards & Digital and Public Health Wales Designated Nurse will receive additional training to provide support in the event of the absence of the designated Senior Nurse and a 'buddy Health Board' will be idnetified. • A paper was presented to the Group to provide an update on the ***Trust Disclosure and Barring Service (DBS) position***. The group requested further assurance as the report did not indicate completion of the work, as some checks remain outstanding and an update on a Trust DBS policy development position was requested for 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 is now developing an implementation plan. • Both operational safeguarding divisional leads are considering their structures for safeguarding and how ***safeguarding is reported*** in the divisions through the Senior Management Teams. Safeguarding activity reports were reported separately from both divisions to the group. • It has been identified that there is currently no provision for tier 2 ***dementia training*** in the Trust. Agreement has been reached with Cardiff & Vale University Health Board that Trust employees who

	require tier 2 dementia training can access this through Cardiff & Vale Health Board. The training needs analysis (detailed above) will infirm how many staff are required to undertake specific levels of training and dates will be planned for the new year. • A '***champion' framework*** has been developed by the Professional Nursing Forum. The Group had previously agreed the need for safeguarding and Vulnerable Adult champions across clinical areas. The Safeguarding Champion development pack was presented to the group this includes: ➢ Training and education requirements ➢ Continued Professional development log that can be aligned to professional ➢ revalidation processes. ➢ Safeguarding supervision contract. ➢ Reflective accounts templates. ➢ Professional feedback forms that can also be utilized for revalidation. • A task group has been established to review the ***dementia standards*** and provide further assurance of compliance against the standards.
INFORM	• The ***Safeguarding Maturity Matrix*** process is followed by a peer review to consider the NHS practice and share good practice and support a once for Wales approach. This took place in November with Anerian Bevan Health this provided bench marking for the Trust safeguarding processes and identified areas where we could share good practice and joint working. • The Trust submitted a successful bid for WG funding to enhance its ***Mental Capacity Act Training***. This money will be utilized for education and resources for frontline staff to enhance knowledge and ensure we meet our legislative requirements.
APPENDICES	**NOT APPLICABLE**

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 3rd December 2021 and the actions being taken to address training compliance.

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

TRUST RISK REGISTER

DATE OF MEETING	17/02/2022
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not applicable

PREPARED BY	Mel Findlay, Business Support Officer
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance & Chief of Staff

REPORT PURPOSE	FOR NOTING

Committee/Group who have received or considered this paper PRIOR TO THIS MEETING		
Committee or Group	DATE	OUTCOME
Executive Management Board	07.02.2022	Noted
Gold Command	09.02.2022	Noted

ACRONYMS	
VUNHST	Velindre University NHS Trust
VCC	Velindre Cancer Centre
WBS	Welsh Blood Service
TCS	Transforming Cancer Services
SLT/SMT	Divisional Senior Leadership Teams / Senior Management Teams
EMB	Executive Management Board

1. SITUATION AND BACKGROUND

The purpose of this report is to present this extraordinary Quality, Safety & Performance Committee with information on the status of Covid-19 related risks recorded in the Trust Risk Register, as part of the ongoing management and mitigation of risks. Risk information for level 15 and above score risks are highlighted in this report.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The Trust Risk Register is received and reviewed at Executive Management Board. In addition, this extract of the risk register was shared at the Gold Command meeting.

3. THE TRUST RISK REGISTER EXTRACT FOR COVID-19 RISKS SCORE ABOVE 15

ID	Risk Type	Division	Review date	Title	Rating (initial)	Rating (current)	RR - Current Controls
2206	Performance and Service Sustainability	Velindre Cancer Centre	23/02/2022	Digital Health & Care Record DHCR003(R) - IM&T Dept - Covid-19 Pandemic	20	20	Following guidance from VUNHST & Government Project team are all enabled to work from home as required. Early engagement and communication plan in place to keep staff updated and included in the process. Departmental leads being identified to ensure that all departments have a voice at the table and a mechanism to feed in their requirements. DHCR producing Contingency plans as part of COVID-19 response. Canisc will be moved as part of the data centre project, if this failed the contingency would be a single instance of Canisc running in Newport data centre.

2345	Performance and Service Sustainability	Velindre Cancer Centre	06/12/2021	Radiotherapy Dept - Change to service due continued response to Covid19	9	16	Continuing to work through recover phase towards business as usual. Covid contingency plan in place to be deployed if required, ie, deferral of benign, prostate monotherapy, prostate external beam and skin if necessary 'Pod' working in place across radiotherapy clinical delivery service to minimise risk of cross infection Development of outsourcing contract to private provider to deliver external beam for prostate and breast 5/11/2021 - Update Currently we have insufficient capacity to meet demand. The number of hours available is restricted due to safe staffing and skills mix. Mitigation 1.Department is currently working under business continuity, with 2x weekly meeting with SLT, Radiation Service and Radiotherapy Service managers to discuss departmental position and actions being undertaken. 2. Undertaking escalation work to minimise breaches. 3. SSTs being asked to review current dose/# offered to patients. 4. Review of trials. 5. All vacancies out to advert. 6. Outsourcing to Rutherford Cancer Centre.

2505	Performance and Service Sustainability	Velindre Cancer Centre	31/01/2022	Risk that Covid-19 related absences for staff could significantly impact on ability to provide core SACT and Radiotherapy Service	20	16	-SACT staffing - realignment from wards, senior staff deployed, RD&I capacity utilised to full; increased virtual appointments -Radiotherapy - major limitations on capacity due to reduction in workforce but maintaining service with increase in breaches with prioritisation based on clinical need; Changes made to Prostate pathway based on agreed framework; maximising third party provision.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Is considered to have an impact on quality, safety and patient experience
RELATED HEALTHCARE STANDARD	Safe Care
	If more than one Healthcare Standard applies please list below.
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Risks open for extended periods of time without indication that work is being undertaken could expose the Trust that may have legal implications.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	If risks aren't managed / mitigated it could have financial implications.

5. RECOMMENDATION

The Quality, Safety and Performance Committee is asked to:

- **NOTE** the Covid-19 risks scored above 15.