Bundle Public Quality, Safety and Performance Committee 20 January 2022

0.0.0 COVID

0.0.1 COVID UPDATE

Please note this item is to receive a COVID update that replaces the Board Briefing previously scheduled for the 13th January 2022.
To be led by Cath O'Brien, Chief Operating Officer,
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

0.0.1 COVID UPDATE Board Meeting - QS&P final 19.1.22.pptx

0.0.2 Gold Command Report

To be led by:
Lauren Fear, Director of Corporate Governance & Chief of Staff
Nicola Williams, Executive Director Nursing, AHPs & Health Science
Cath O'Brien, Chief Operating Officer

GOLD COMMAND_ QSP Highlight Report January 2022_14.01.2022.docx

0.0.2a Appendix 1_Decision making framework.docx

0.0.2b Appendix 2_Impact Assessment Form - Radiotherapy for patients with prostate cancer.pdf

1.0.0 PRESENTATIONS

1.1.0 Velindre Cancer Service - Patient Story

To be led by Vivienne Cooper, Head of Nursing, Patient Experience and Integrated Care,
Supported by Nicola Hughes, Medical Business, Velindre Cancer Service

1.1.0 Final VC Comments Patient Story - SW (002).pptx

2.0.0 STANDARD BUSINESS

To be led by Vicky Morris, Chair of Quality, Safety & Performance Committee

2.1.0 Apologies

2.2.0 In Attendance

2.3.0 Declarations of interest

To be led by Vicky Morris, Quality, Safety & Performance Committee Chair

2.4.0 Review of Action Log

To be led by Vicky Morris, Quality, Safety & Performance Committee Chair

2.4.0 QSP Public action log Jan 2022.docx

3.0.0 CONSENT ITEMS

3.1.0 ITEMS FOR APPROVAL

3.1.1 Draft minutes from the meeting of the Public Quality, Safety & Performance Committee held on 18th November 2021

To be led by Vicky Morris, Quality, Safety & Performance Committee Chair

2.1.1 Minutes - Public Quality Safety Performance Committee 18.11.21(v4).docx

3.2.0 ITEMS FOR ENDORSEMENT

There are 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

To be led by Vicky Morris, Quality, Safety & Performance Committee Chair

2.3.1 Summary Private QSP Committee Minutes 18.11.21(v4).docx

3.3.2 Transforming Cancer Services Programme Scrutiny Sub Committee Highlight Report

To be led by Stephen Harries, Interim Vice Chair and Chair of the Transforming Cancer Services Scrutiny Sub Committee

3.3.2a PUBLIC TCS Programme Scrutiny Committee Highlight Report 25th October 2021 - QSP.docx

3.3.2b PUBLIC TCS Programme Scrutiny Committee Highlight Report 22nd November 2021 - QSP.docx

3.3.3 Review of Information Governance and Trends

To be led by Ian Bevan, Head of Information Governance

3.3.3 20220104-QSP - Information Governance Report Jun - Dec 21 - FINAL.docx

3.3.4 Quality, Safety & Performance Committee Cycle of Business and Deferred Papers

To be led by Emma Stephens, Head of Corporate Governance

3.3.4 QSP COB cover paper Jan 22.docx

App 1. QSP Quality Safety Performance Committee Cycle of Business 2021-22.docx

4.0.0 Velindre Quality & Safety Committee for NHS Wales Shared Services

To be led by Gareth Tyrrell, Head of Technical Services, NHS Wales Shared Services Partnership

4.0.0 Quality Safety Performance Committee - CIVAS@IP5 Jan 2022.docx

4.0.0a CIVAS@IP5 Service Board December.pptx

5.0.0 MAIN AGENDA

5.1.0 Quality, Safety & Performance Reporting

To be led by Cath O'Brien, Chief Operating Officer

5.1.0 QSP NOVEMBER PMF Cover Paper 11.01.2022 FINALCOB .docx

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

To be led by Paul Wilkins, Interim Director, Velindre Cancer Service
VCC 15 step challenge report (7th December 2021)

5.2.0a qs&P VCC Performance Report (Nov 2021).docx

5.2.0b V4 Updated QSP Report.pdf

5.2.0c 15 step challenge prince charles merthyr 7.12.2021.pdf

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

To be led by Alan Prosser, Interim Director, Welsh Blood Service

5.3.0a November. 2021 PMF Report No Arrows.pdf

5.3.0b WBS QSP Monthly Highlight Report December 21 v2.docx

5.4.0 Workforce and Organisational Development Performance Report

To be led by Sarah Morley, Executive Director of Workforce and Organisational Development

5.4.0 Trust-wide WOD Performance Report - November 2021.pdf

5.5.0 Trust Vaccination Programme Board Report

To be led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science

5.5.0 Vaccination Update QSP 20.01.22 (003).docx

5.6.0 Finance Report

To be led by Matthew Bunce, Executive Finance Director

5.6.0 Month 8 Finance Report Cover Paper - QSP Final.docx

5.6.0a M8 VELINDRE NHS TRUST FINANCIAL POSITION TO NOVEMBER 2021.docx

5.7.0 Trust Risk Report

To be led by Lauren Fear, Director of Corporate Governance and Chief of Staff

5.7.0 QSPC Risk Paper Jan 2022-LF.docx

5.7.0a Trust Risk Register VS 12 Public Paper.pdf

5.7.0b Trust Risk Register Vs 14 Public Paper.pdf

5.7.0c Risk appendix 3 for QSP - as at 19.1.docx

6.0.0 INTEGRATED GOVERNANCE

6.1.0 Analysis of meeting outputs

To be led by Vicky Morris, Quality, Safety & Performance Committee Chair

7.0.0 HIGHLIGHT REPORT TO TRUST BOARD

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

8.0.0 ANY OTHER BUSINESS

Prior approval by the Chair required.

9.0.0 DATE AND TIME OF NEXT MEETING

The Quality, Safety & Performance Committee will next meet on the17th February 2021 @ 10:00h via Microsoft Teams.

QS&P Committee Meeting

COVID -19 Update

19th Jan 2022

National Picture

- Incidence of COVID per 100,00 over the last 7 days 529 which is over 1000 lower than last week and compares to 2228 reported 7 Jan.
- Moving to endemic from pandemic.
- Positivity of testing, 35.3% compared to 51.5% reported 7th January.
- Still experiencing rise in inpatients – lag on incidence.
- Services highly pressured across Wales but starting to experience a reduction in staff absences.

COVID UPDATE

- Maintaining Gold/Silver command structure – starting to move to recovery planning.
- Engaged with the multi-agency South Wales Local Resilience Forum – reflecting similar experience in other public sector organisations.
- Maintained service delivery across the holiday period and into January with positive benchmarking against other blood and cancer services.
- Recognition of the overwhelming support and some workforce pressure lifting with reduction in staff absences.
- Frameworks - Clinical Principles, Radiotherapy and SACT, Patient Testing.
- IPC & Microbiology real time oversight of changing guidance – rapid comms when needed.
- Covid cell - application of Covid guidance from WG, site management and workforce wellbeing – focus on support for staff.
- Maintained our position of working from home & closed HQ.

VCC

Service delivery

- **Business continuity** plans enacted based on learning each wave.
- **SACT** – all continued with support from RD&I and redeployment of staff from wards and non patient facing roles. Maintaining service against increased demand with breaches in January 2022 for category 5 and 6 patients only, based on the agreed clinical prioritisation criteria (no/ v low clinical impact)
  - Maximisation of Oral SACT and Sub Cut injection provision, now running at 32% and 21% above pre-covid levels respectively.
  - Third party provision discussion underway.
- **All AU** and Ambulatory care being maintained.
- **Increased OP** virtual appointments.
- **Outreach** provision maintained.

- **RT –** maintained 25% reduction in capacity, major limitations on fleet and reduction in workforce but maintaining service with increase in breaches with prioritisation based on clinical need.
  - Maximising third party provision - 26 patients treated at RCC during December.
- **Inpatient** – maintaining bed numbers and visiting at discretion of staff based on situation.

VCC

Clinical Frameworks – National Guidance COSC

- RT – Prostate changes – A small cohort of prostate cancer patients receiving neo-adjuvant hormone treatment.
- RT – Skin - Basal Cell Carcinomas of the skin has been temporarily deferred.
- Raises in neo-adjuvant referrals (Breast C&V).

Patient Information and support

- Information videos.
- Key messages for one to one discussions.

Staff absence – improving position

- SACT – reduced from 14%, by 1-2%.
- RT - 14% Covid Related Absence, 8% other absences, including mat leave.
- SACT staffing - realignment from wards, senior staff deployed, RD&I capacity utilised to full.
- Med Physics 4%, Radiology 11%, Medical staff 4%.
- HCSW 27%.

Capacity and demand planning

- Demand analysis utilising health board cancer tracker data identified patient delays in reaching VCC in December. Data has shown that the patients are in the system and will present to us at later stages of the pathway.
- Formal operational meetings with Health Board teams to share organisational pressures and challenges and support optimal patient pathway delivery.

December performance

- Dec figures SACT 21 day target
  - Emergency 100%
  - Non Emergency 99%

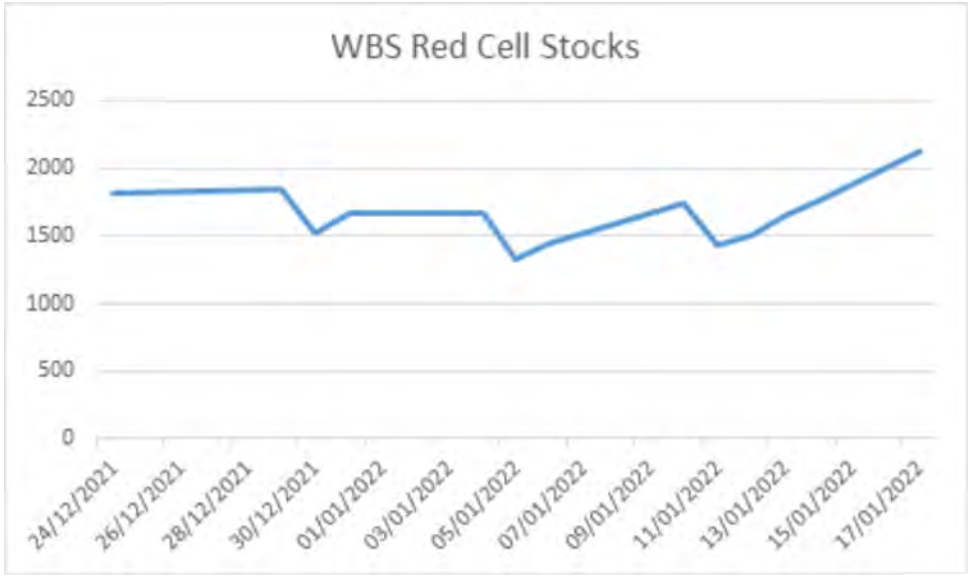
Dec 2021 SACT waiting time data		
Waiting time	Patients	%
0-7 days	148	40.5%
8-14 days	49	13.%
15-21 days	162	44.4%
22 – 28 days	5	1.4%
29 days	1	0.3%
Total	365	

The **invalidated** SACT performance position as of 13th January 2022 is that a potential total of 27 patients have waited more than 21 days to initiate SACT (6 in Dec). This will decrease on validation.

- Radiotherapy
  - Radical 78% - decrease on recent performance
  - Palliative 84% - maintains recent performance
  - Emergency 89% - decrease on recent performance

WBS

- Stock position including red cells and platelets have recovered over last 10 days supported by extra weekend clinics.
- Improved DNA rates on donor attendances achieved.
- TV and radio exposure English and Welsh promoting the need to support service over coming weeks during the winter to be aired.
- Reinforcing criticality of Donors attending session via digital media channels and texts.
- Continued active engagement with UK blood services – All appears to be rebounding and improving stock position.



WBS

- Blue alert lifted on Jan 18th 2022.
- Blood banks continue to work closely with service.
- Staff absences also improving slowly particularly in supply chain operation.

- Risk Assessment and impact assessment of social distancing reductions supported at Gold working within WG guidance
  - Reduction enabled in WG guidance.
  - Capacity enhancement.
  - Complex venue / geography relationship – recovery planning focus - where and when we take clinics and how this aligns with the donation planning.

Covid Risks

5 Risks opened and assessed

- Safety – Corporate and VCC
- Workforce and OD – Corporate
- Performance and sustainability – for WBS and VCC

- The risk profile - Quality, Safety and Performance Committee on 17th, and Trust Board on 27th January.

Additional Interventions – Monitored via the Health and Wellbeing Steering Group

- MH First Aiders
- Leadership and Management Development focus on wellbeing
- Work in Confidence platform
- REACTMH
- Network developments
- H&WB Champions and Network
- Mediation Network
- Healthier Working Relationships and policy development / guidance – focus on Respect and Resolution
- Wellness Action Plans in Divisions
- Learn from colleagues feedback / ongoing surveys / engagement sessions

QUALITY, SAFETY & PERFORMANCE COMMITTEE

GOLD COMMAND HIGHLIGHT REPORT

DATE OF MEETING	20 January 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
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance & Chief of Staff

REPORT PURPOSE	FOR NOTING

ACRONYMS	

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 **15/12/2021** to **13/01/2022**.

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 command and control structure.

The frequency of GOLD COMMAND (strategic) meetings is continually assessed and flexed in line with the needs of the incident and its interface with SILVER COMMAND (tactical). During the reporting period **15/12/2021** to **13/01/2022** GOLD COMMAND has met three times per week.

3. HIGHLIGHT REPORT

The following areas were highlighted for reporting to the Quality, Safety & Performance Committee from the GOLD COMMAND meetings held between the **15/12/2021** to **13/01/2022**.

ALERT / ESCALATE	• **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's ability to meet demand for SACT as a result of the impact of COVID related staff absences with breaches anticipated on the Trust's ability to meet the target of commencing SACT within 21 days. GOLD COMMAND were advised of all the enhanced business continuity measures that are in place to mitigate the risks as far as possible and to ensure service delivery. A robust escalation framework was approved at GOLD in the event of critical treatments not being able to be provided due to staff absenteeism that uses a risk based approach to possibly bring staff back to work outside of national guidance to provide necessary critical treatments if no other options were available. Discussions have also been initiated with Rutherford on how the service can work with them to support SACT delivery. GOLD received assurances that clinical patient prioritisation was underway to ensure that patients who would suffer an adverse impact of delayed SACT treatment would not have treatment delayed. A full impact assessment of the patient prioritisation has been undertaken and is going to the Strategic Clinical Advisory Group on 13th January 2021.

	The Velindre Cancer Service has received two informal complaints from patients with regards to the adverse impact on waiting times and a rapid review of the support systems available for staff to help manage this has also been initiated.
ADVISE	• **COVID RISKS** The risk profile associated with the prevalence of the Omicron variant remains fluid in this fast changing environment and has changed significantly within a short time frame, including: staffing levels; supply and access to testing; and nosocomial transmission. Key operational risks remain around staff absence and potential impact for affecting core service delivery and ability to meet clinical demand both within the Velindre Cancer Service and the Welsh Blood Service. Further details are provided above for ALERT/ESCALATE in respect of the potential risk to SACT. There are also delivery risks within Radiotherapy and a revised approach to prostate radiotherapy has been approved by GOLD and the Strategic Clinical Advisory Group. It should be highlighted that to date there has been no requirement by the Welsh Blood Service to invoke the mutual aid agreement with the UK Services for importation of blood components.
ASSURE	• **REVISED COVID GUIDANCE** GOLD COMMAND has ensured a rapid response to changing COVID guidance is enacted, supported by the Infection, Prevention and Control Team and the COVID Cell, and its command support three tier structure with effective communication channels established where required. This has included: - Review of guidance for use of Filtering Face Piece 3 (FFP3) masks when caring for / treating patients with or with suspected COVID-19 at Velindre Cancer Centre aligned with a review undertaken by the World Health Organisation and the Welsh Government. There are over 50 days of Personal Protective Equipment (PPE) stock in place and no supply issues. - Revised local guidance for staff in contact with COVID-19 positive / or symptomatic household member in line with revised national guidance. - Working principles for extremely clinically vulnerable patients. - Follow up polymerase chain reaction (PCR) tests for those who test positive using a Lateral Flow Test (LFT) in line with national guidelines. • **DECISION MAKING FRAMEWORK in GOLD COMMAND STRUCTURE** At its meeting held on the 31/12/2021, GOLD COMMAND **ENDORSED for BOARD APPROVAL** a revised framework to support decision making through

the incident management structure. This built on the previous Trust Board **APPROVED** Decision Making Framework established during the first and second waves and included updated:

- Framework Principles,
- Command Structure Overview;
- Overview of Decision Making Process;
- Summary of key aspects of the associated Terms of Reference for each group within the operating structure, and
- Next Steps in operationalisation of the framework.

The Decision Making Framework was subsequently **APPROVED** by the Trust Board at its Extraordinary Meeting on the 07/01/2022 and will be formally **NOTED** to this effect at its Public meeting on the 27/01/2022. For **ASSURANCE** the revised Decision Making Framework is included at **Appendix (1)** for **NOTING** by the Quality Safety & Performance Committee.
In accordance with the Trust Board **APPROVED** Decision Making Framework also included at **Appendix (2)** for **NOTING** by the Quality, Safety & Performance Committee is a record of any decisions made and supporting impact assessments by **GOLD COMMAND** during the reporting period **15/12/2021** to **10/01/2022.**

- **ROBUST COMMAND SUPPORT INFRASTRUCTURE**

GOLD COMMAND approved a revised command support infrastructure to ensure effective & agile response to a rapidly changing situation (detail included in ***Appendix 1***). This includes a strengthened clinical meeting infrastructure to ensure that there is timely strategic and operational clinical oversight / decision making / recommendations being made operationally and strategically. Putting clinicians (Medical, Nursing, AHP's, & Health / Clinical Scientists) at the centre of risk based decision making.

- **VELINDRE CANCER SERVICE**

  - **Staff Absenteeism -** Main impact of COVID Wave #4 for the Velindre Cancer Service remains staff absenteeism, with most notable impact on ability to support SACT delivery and radiotherapy as outlined earlier in this report.

  - **Radiotherapy:** The Velindre Cancer Service has seen an increasing number of COVID positive patients undergoing Radiotherapy. The Strategic Clinical Advisory Group have commissioned urgent work in relation to patient prioritisation and treatment risks.

  - **Patient isolation:** The Velindre Cancer Service Clinical Development Group are taking forward a review of patient isolation advice / guidance

	by Public Health Wales with regards to practical application of the 14 day patient segregation. Discussions being taken forward with Public Health Wales within this context. • **WELSH BLOOD SERVICE** o ***Blood / Blood Products Stock levels*****:** Following the holiday period stock position is stable with no requirement for importation to date supported by well-established systems and processes with Health Boards and regular engagement with UK Services. Outlook for collection during mid-January is gradually improving. Blue alert remains in place. o ***Welsh Blood Service Escalation Processes***: The Welsh Blood Service is currently working with the other UK blood services to review the Amber Alert escalation processes and triggers as the potential use of the process identified that modifications could be made to improve and clarify the existing process. Once this is completed the Trust's Decision Making Framework (Appendix 1) may require review to ensure it meets the Amber Alert escalation requirements. • **NOSOCOMIAL TRANSMISSION** There has been no nosocomial transmission to date during COVID Wave #4.
INFORM	• **WORKING FROM HOME** In line with the latest Government guidance all staff are now required to work from home unless there is a reasonable reason not to / exceptional circumstances. This represents a change to previous arrangements where some staff have spent some days in the office on a rota basis. In line with this, the Trust Headquarters building at Nantgarw has been closed from 10/01/2022 and will remain closed until at least 31/01/2022. This will be formally reviewed in line with the community transmission trajectories by GOLD COMMAND on the 26/01/2022.
APPENDICES	• **Appendix (1) – Decision Making Framework** • **Appendix (2) – Gold Command Decision Impact Assessments**

DECISION MAKING FRAMEWORK IN COMMAND STRUCTURE

1. Framework Principles

1.1 Decision making as close to front-line operation as possible

1.2 Each decision for command structure to complete the impact assessment tool (taking 10 minutes to complete)

1.3 Impact assessment process to remain as per previous versions for now. If it is viewed that too many decisions are going to Gold for decision making that should be at Silver level, then this to be reviewed, in line with principle 1.1. Therefore, impact assessment levels as:

- If overall impact 5 – Trust Board level decision
- 3 or 4 – Gold
- 1 or 2 – Silver

1.4 Clinical recommendation for decision to come from:

- Strategic Clinical Advisory Group for Gold or Trust Board level decisions
- VCC Clinical Development Group for VCC clinical Silver decisions
- WBS Clinical catch up group, as required, for WBS clinical Silver decisions

1.5 There may be a need for Bronze level groups at various points, but these will be for coordination and communication purposes, as directorate level meetings, and not part of the formal command structure. Directorate and Departmental meetings will retain their usual decisions making authority in line with usual delegated authority.

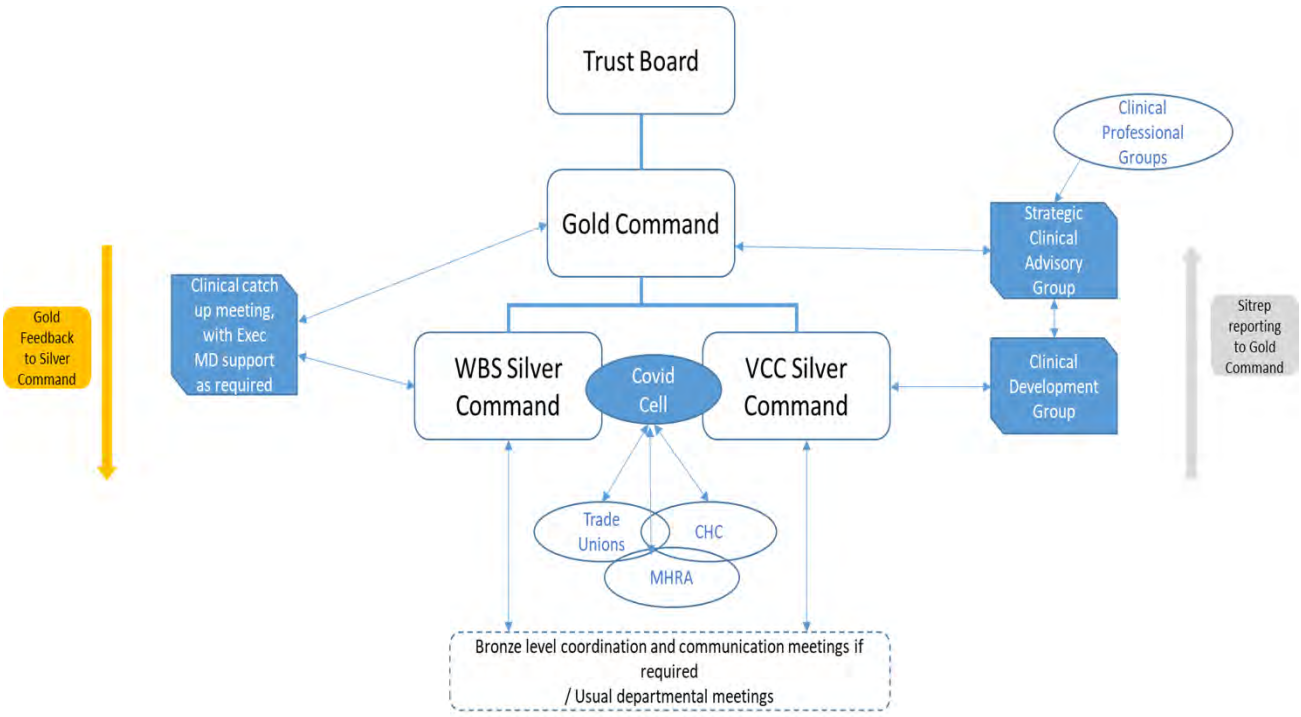
1.6 There will be a pragmatic approach to the provision of papers with less reliance on formal format and rather take a functional approach to ensure time spent in right place on service for patients and donors. The exception to this is the formal impact assessment form which has to be completed. The principles will be to ensure that we make and retain information that will record the rationale and trigger points for actions taken and decisions made. All decisions will be made based on written papers.

1.7 Meeting structure will be in place on agreed timings and frequencies – however timeliness of decision making is paramount, and these will be changed/ increased frequency etc. to ensure decisions made in right place in timely way.

1.8 There will be a straightforward mechanism for decisions to come into the command structure for decision making and feedback from decisions to be received back into the services. There will be clear decision logs at each level using a consistent logging format.

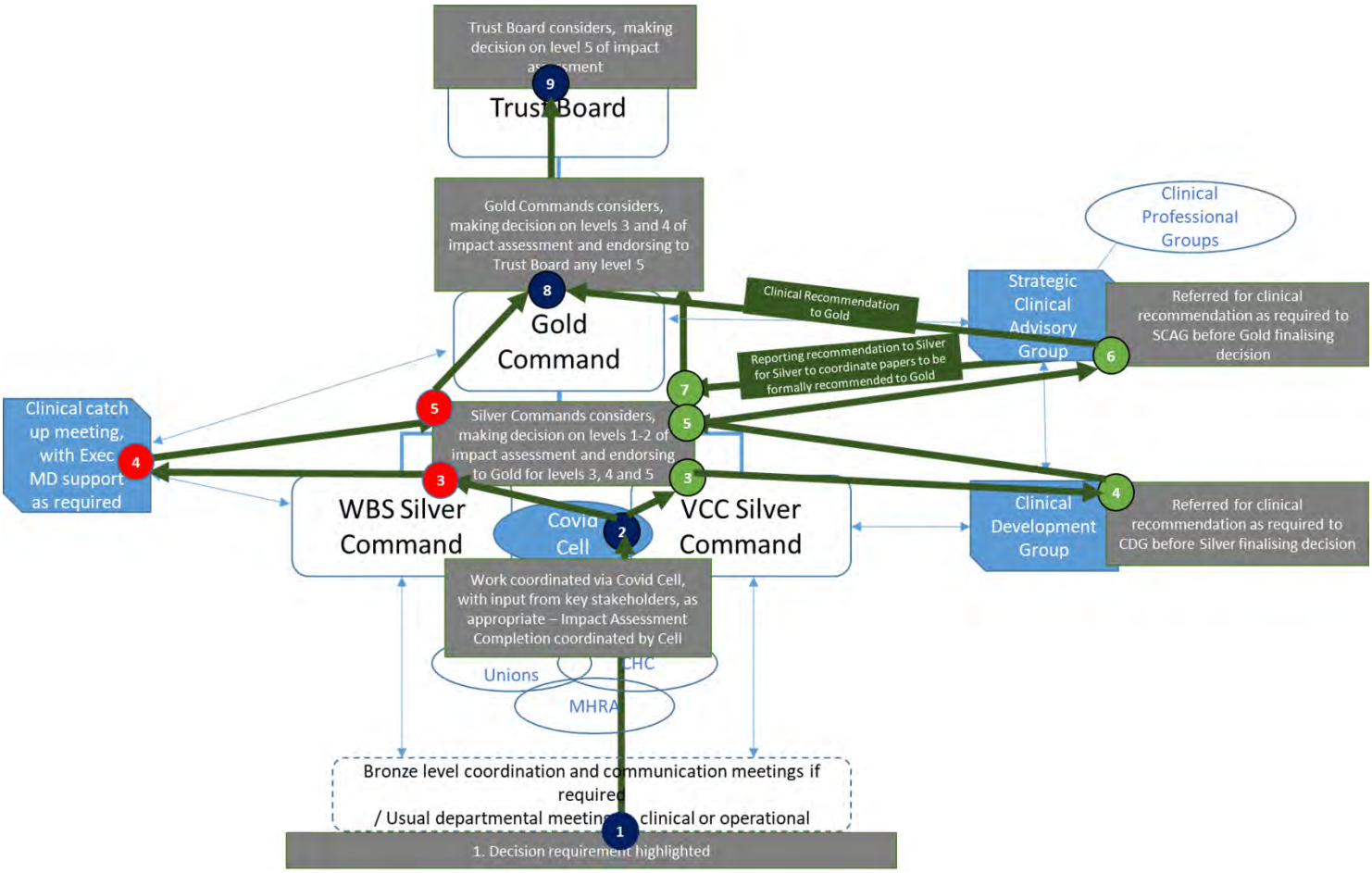
1.9 There will be formal assurance at Trust Board level in the same way as previous cycles, through monthly formal reporting from Gold Command to Quality, Safety & Performance Committee.

2. Command Structure Overview



3. Overlay of Decision Making Process

Decision making process is outlined below:



Although the picture looks busy, the mechanisms can be utilised in an agile and timely way. To summarise the process:

- Following there being a requirement for a decision, any work associated to inform the decision will be coordinated and commissioned by the Covid Cell, on behalf of the VCC and WBS Silver Commands.
- Silver Command(s) then receive the papers, with an Impact Assessment completed.

For VCC:

- Silver Command then request the CDG to undertake initial clinical assessment and make recommendation back into Silver, including a review of the Impact Assessment.
- If Impact Assessment was levels 1-2, then Silver will make the decision.
- If Impact Assessment was levels 3-5 for clinical decisions, then Silver will, taking into account the recommendation of CDG, ask for a clinical recommendation from Strategic CAG. (This process can be virtual and completed quickly)
- Strategic CAG then reports its recommendation to Silver Command, so that Silver Command will ensure the documentation reflects the rationale of the decision made and will report it to GOLD.
- Strategic CAG is therefore providing its clinical recommendation to Gold Command.
- If Impact Assessment was levels 3-4, then Gold will make the decision.
- If Impact Assessment was level 5, then Gold will make a recommendation to Trust Board for decision.

For WBS:

- There are regular clinical catch up meetings, where consideration of a clinical recommendation can be formed if this is required.
- For WBS it can be less straightforward to separate operational issues from clinical so for “clinical/operational” issues these are to be raised via Covid cell, and WBS Silver Command.

4. Summary of ToR Key Points for each Group in Decision Making Framework

Group	Final Decision Making	Input mechanisms	Escalation Process
Trust Board	Impact Assessment Level 5	From Gold Command	To Welsh Government
Gold Command	Impact Assessment Levels 3 and 4	• From Silver Command for decisions ***Or*** • From Strategic CAG for clinical recommendations on any decisions with a clinical element.	To Trust Board

Group	Final Decision Making	Input mechanisms	Escalation Process
Strategic Clinical Advisory Group	None – recommendations into Gold Command only	• From Silver command for decisions at level 4 or 5 prior to being escalated to Gold *Or* • From Gold command for clinical recommendations on any decisions with a clinical element if not already completed	To Gold Command
Silver Command	Impact Assessment Levels 1 and 2	• From Covid Cell which will have considered, coordinated, commissioned or completed work/analysis on matters identified by the service that require a decision *Or* • From CDG for clinical recommendations on any decisions with a clinical element.	To Gold Command
Clinical Development Group	None – recommendations into Silver Command only	• From Silver command for clinical recommendations on any decisions with a clinical element	To VCC Silver Command
Covid Cell	• None – place to consider, coordinate, commission or complete work/analysis on matters identified by the service that require a decision	• Work can be requested of Covid Cell by any of the other groups Or • From the service identifying a requirement for a decision which is coordinated via the Cell	To Silver Commands

1	Insignificant
2	Minor
3	Moderate
4	Major
5	Catastrophic

What is the Decsion?	*Defer radiotherapy for patients with prostate cancer (Prostate EHFRT should be considered as part of the recovery plan) and continue PACE-C recruitment*	

		Is the impact Positive, negative or neutral?	Brief description of impact	If negative, is impact 1-5?
	Quality Impact			
1	Patient outcome - short term (survival and quality)	Negative	Unaffected by delay of radiotherapy, maintaned on hormone therapy. However, impact during hormone treatment on quality of life for men, impotence etc.	3
2	Patient outcome - long term (survival and quality)	Neutral		
3	Outcome for population	Negative	A backlog will be created which will impact on outcomes for future patients - but will hopefully be mitigated by changes to other processes which will reduce demand. Numbers affected will dictate overall impact.	3
4	Quality of care	Neutral	Unaffected by delay of radiotherapy, maintaned on hormone therapy.	
5	Patient / donor experience	Negative	Additional waiting - patients already in the system will be delayed at short notice. Once these have been delayed, subsequent patients will have the situation explained to them from the outset.	2
6	National best practice / guidance / current research evidence	Neutral	Follows current practice guidelines	
7	Dignity and respect	Neutral	Unaffected	
8	Safeguarding	Neutral	Unaffected	
	Workforce Impact			
9	Staff well-being	Negative becoming neutral	Difficult conversations that need support. Then improves wellbeing in radiotherapy department due to improved capacity and planning.	2
10	Staff capacity and capability	Positive	Deferring these patients will allow an increase in available capacity to treat patients and manage the service.	
11	Consistency of approach	Neutral	Follows current guidelines.	
	Reputation/ Public Confidence Impact			
12	Stakeholder Trust	Neutral	Unaffected	
13	Patient/ Donor Trust	Negative	See patient experience above.	2
14	Staff Trust	Neutral	Unaffected	

Patient Story

A concern raised by a patient's wife relating to the care of her late husband

Background

- Consent has been given to share this patient story. It involves a 59 year old male patient referred by the Health Board to one of the Velindre oncologists for ‘maintenance’ chemotherapy for colorectal cancer.
- Patient had not been told of the extent of his disease and therefore assumed Chemotherapy could extend his life by 5-10 years.
- Due to not knowing the full extent of the disease the patient’s wife did not think her husband had made an informed choice about having chemotherapy as he was desperate to extend his life.
- The patient’s first appointment was scheduled for early May 2020 where the patient attended on his own due to COVID restrictions.
- On 2 subsequent appointments to see the consultant and to pick up medication, the patient waited with his wife for over 3 hours in his car in the car park of Velindre Cancer Centre for results and medication but did not see the consultant.
- Patient in lots of pain and was admitted to the Royal Gwent Hospital on 4 separate occasions between July 2020 to August 2020.
- Patient was referred to Palliative care in August 2020 and the patient’s cancer had progressed but was not terminal and was reassured that “he wasn’t dying anytime soon”.
- The patient died mid September 2020.

Actions from the concern

- Complaint received from the patient's wife to the complaints team in October 2021. The complaint had been dealt with by the health board and then been handed to Velindre to respond to the specific issues raised about his care at VCC.
- Medical Directorate Manager spoke to the patient's wife to understand the concerns in more detail. The patient's wife requested a face to face meeting with the oncology and palliative care
- Due to availability of the patient's wife and friend who wanted to accompany her for the meeting, the meeting was scheduled for November 2021.

Meeting with the Patient's Wife

- Discussions:
  - The patient's wife explained how she felt by being unable to attend the appointments with her husband so that she could ask questions about her husband's disease. The patient's wife felt she would have wanted to know more than her husband and would have been more prepared.
  - Sitting in the car for more than 3 hours waiting for results and medication whilst her husband was unwell was not acceptable. Did not get to speak to the consultant.
  - A terminally ill diagnosis was not known and it was assumed chemotherapy would extend the patient's life.
  - Questions were raised about pain relief from the palliative care team towards the end of the patient's life.

Outcome from Meeting

- This felt like a very positive meeting. The patient's wife felt she really needed to speak to us in order for her to explain it from her perspective and how it is being a patient's relative during the COVID period.
- Both Consultants explained the disease and situation in relation to her husband in detail which she confirmed she better understood.
- The meeting was followed up with a letter relating to two of the issues the patient's wife wanted taken forward as learning and to change practice.

Learning from the concern

- During the height of the pandemic where patients were unable to be accompanied by a relative or friend.
  - Consultant to be aware and ask further questions with the patient in order to check the patient's understanding and that the patient felt informed enough to discuss their disease and treatment options and to relay this information back to members of family and or friends as they choose to.
  - During this wave of the pandemic patients were required to wait in their car, subsequently an external waiting area was created, for any patients required to wait in their car (for blood results) or choose to they are assessed by a nurse and or seen by a consultant prior to going to their car. Waiting in a car is no longer a default position following the first wave.
  - A carer's passport has been developed and implemented for those patients who have a specific need to be accompanied to all appointments.

- Communication/links between hospital teams and the community
  - Reflect how information can be shared between teams in different hospitals and the community when there has been a difficult conversation with a patient.
- Pain Relief for patients at home
  - Palliative care to support the improved roll out of "just in case" medication for symptoms such as nausea, vomiting, agitation, and respiratory issues.

QUALITY, SAFETY AND PERFORMANCE - PART A					
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 17/01/2022** – This action is ongoing and will be addressed post PHW re-organisation. 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	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	24/03/2022	OPEN

			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. 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 soon to be appointed Equality, Diversity and Inclusion Manager once commenced in post.		
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 14/01/2022** - It was agreed at the September Committee that an update would be received at the January 2022 Committee. This report has been deferred due to the impact of the Omicron variant on Trust officers and is listed as a deferred report on the cycle of business cover paper agenda item 3.3.4.	20/01/2022	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 06/01/2022** - This has been redrafted and will be presented at February QSP Committee.	17/02/2022	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 06/01/2021** - A paper has been drafted and will be included in the VCC report at the February QSP Committee.	17/02/2022	OPEN
Actions agreed at the 16th September 2021 Committee					
3.1.0	Gareth Tyrrell, NWSSP, to provide the Committee with CIVICA@IP5's response to the MHRA Audit report.	Gareth Tyrrell	**Update 18/11/2021** - This item was addressed at the November QSP Committee and can be closed.	18/11/2021	CLOSED
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 18/11/2021** - It was advised that a full close out report against the recommendations will be received at the January 2022 committee and that all but one action had been closed.	20/01/2022	OPEN
Actions agreed at the 18th November 2021 Committee					
1.4.0	NW and SA to discuss 15 step challenge process and subsequent reporting process.	Nicola Williams	**Update 02/12/2021** - A meeting to discuss this has been scheduled to take place on December 7th 2021.	20/01/2022	CLOSED

4.1.0	AP to revisit reimbursement of travel expenses for donors.	Alan Prosser	**Update 11/01/2021** - Response received from AP communication with WG confirming no planned changes to current policy. This action can be closed.	20/01/2022	CLOSED
4.6.0	LF to include additional narrative in future Trust Risk reports, providing information in terms of actions being taken to reduce / eliminate risks.	Lauren Fear	**Update 06/01/2022** - This has been addressed and included in the January report for QSP Committee. Complete	20/01/2022	CLOSED
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 06/01/2022** - This will be completed and presented at QSP Committee in February.	17/02/2022	OPEN
4.11.0	AE to update the patient / donor experience annual report to include a complete set of patient satisfaction survey results.	Annie Evans	**Update 06/01/2022 –** This has been completed and translated for circulation.	20/01/2022	CLOSED
5.1.0	ES to update the Quality, Safety & Performance Committee Annual Report to provide clarification in relation to membership.	Emma Stephens	**Update 10/12/2021** - Membership details clarified and approved by the Chair in readiness for the November Trust Board which subsequently approved the annual report.	20/01/2022	CLOSED

Minutes

Public Quality, Safety & Performance Committee

Velindre University NHS Trust

Date: 18th November 2021
Time: 10:00 – 12:15
Location: Microsoft Teams
Chair: Stephen Harries, Independent Member and Interim vice Chair

ATTENDANCE		
Prof Donna Mead OBE	Velindre University NHS Trust Chair (in part)	DM
Hilary Jones	Independent Member	HJ
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
Annie Evans	Deputy Director of Nursing, Quality & Patient Experience	AE
Matthew Bunce	Executive Director of Finance	MB
Sarah Morley	Executive Director of Organisational Development & Workforce	SfM
Stuart Morris	Deputy Chief Digital Officer (joined for item 4.4.0)	SM
Alan Prosser	Interim Director of Welsh Blood Service	AP
Emma Stephens	Head of Corporate Governance	ES
Kyle Page	Business Support Officer (Secretariat)	KP

0.0.0	PRESENTATIONS	Action Lead
0.0.1	**Welsh Blood Service – Donor Improvement Story** Led by Alan Prosser, Interim Director, Welsh Blood Service Committee members had received and viewed in advance of the meeting a video by Andrew Harris, Interim Head of Donor Engagement at the Welsh Blood Service, outlining the measures currently being implemented to prevent donors who may be unable to donate (as do not meet the stringent requirements) being able to book a donation session online. These improvements will prevent potential donors having a wasted journey if unable to donate, avoid disruption to clinics, and free up appointments to eligible donors, ensuring the best possible donor experience.	

	AP advised that this had been instigated following feedback received from donors and staff. This identified the need to improve the 'behind the scenes' IT system. The changes made has resulted in a reduction of over 2,000 wasted journeys over the course of the past year. Comments and questions were invited from the Committee. DM drew the Committee's attention to a personal donor experience, whereby on attending their appointment, they were unable to donate due to recently having returned from a country requiring a specific period of time to elapse before blood can be donated. The improvement plan was therefore welcomed and AP advised the replacement of the current in-house appointment system with a donor / customer service management tool will enable alignment with the commercial donor management system. This will be included in the Integrated Medium Term Plan for the coming year. SA noted the importance of the patient / donor voice and viewpoint when instigating positive change and wished to share the story with CHC Colleagues across Wales as part of a report back to the senior administrative team. This was welcomed by the Committee. The Committee commended this work and evidence of ongoing changes the service was making after actively listening to feedback from donors.	
0.0.2	**Medical Engagement Survey** Led by Dr. Jacinta Abraham, Executive Medical Director and Sarah Morley, Executive Director of Organisational Development & Workforce The Committee received a detailed presentation, outlining key findings from the Medical Engagement Scale survey undertaken between December 2020 and May 2021. This was a national survey that the Trust had actively participated in and was undertaken to assess the position post-pandemic, measuring levels of engagement of medical staff within their organisations against 30 key items on the Medical Engagement Scale to enable the identification of emerging themes. Overall, the number of medical staff completing the survey had increased considerably (approximately 60% uptake with 46 completed) in comparison with the previous survey conducted during 2016 and the Trust benchmarked favourably across NHS Wales in relation to levels of engagement. It was noted that work is underway to further explore how the organisation has changed between surveys and emerging themes would be addressed with medical colleagues via a number of engagement sessions. Discussions at the October Senior Medical Staff Committee, followed by an extra-ordinary meeting with the Joint Local Negotiating Committee, identified the following areas for improvement: • Feeling valued • Transparency of job planning processes	

	• Clinical leadership and involvement impeded by workforce pressures DM welcomed the findings and expressed the importance of contextualisation in terms of the timing of the survey as this took place during a pandemic and unprecedented ways of working. PR queried whether similar exercises were planned among professional groups outside medical staff across the Trust. SfM confirmed that the survey had been developed for medical staff alone; however there is the opportunity to conduct national staff surveys by professional group. The Committee **NOTED** the presentation and ongoing work to undertake improvements in relation to staff engagement across the organisation.	
1.0.0	**STANDARD BUSINESS**	
1.1.0	**Apologies** had been received from: • Paul Wilkins, Interim Director of Velindre Cancer Service • Steve Ham, Chief Executive Officer • James Quance, Head of Internal Audit, NWSSP Audit & Assurance Services	
	The Committee **NOTED** that Donna Mead and Jacinta Abraham would leave the meeting at 12:00pm due to other prior commitments.	
1.2.0	**Additional Attendees:** • Tina Jenkins (TJ) – Senior Nurse Safeguarding and Public Protection (for item 4.10.0) • Gareth Tyrell (GT) – Head of Technical Services, NHS Wales Shared Services Partnership (for item 3.0.0) • Jason Hoskins (JH) – Assistant Director of Estates • Peter Richardson (PR) – Head of Quality Assurance, Welsh Blood Service • Emma Rees (ER) – Audit Manager, NWSSP Audit & Assurance Services • Huw Jones (HJ) – Healthcare Inspectorate Wales • Sarah Evans (SE) – Healthcare Inspectorate Wales • Katrina Febry (KF) – Audit Lead, Audit Wales • Stephen Allen (SA) – Chief Officer, South Glamorgan CHC • Muhammad Yaseen (MY) - Head of Infection Prevention & Control • Andrew Paramore (AP) - Project Manager, Velindre Organisational Development & Workforce	
1.3.0	**Declarations of Interest** Led by Stephen Harries, Interim vice Chair and Acting Quality, Safety and Performance Committee Chair	

	No declarations of interest were raised.	
1.4.0	**Review of Action Log** Led by Nicola Williams, Executive Director of Nursing, AHPs and Health Science Committee members advised that they were assured that all actions identified as closed on the action log had been fully instigated. No issues were raised. Items not yet due for completion were not discussed and remain open. The Action Log was reviewed and the following amendments were agreed: • ***Legacy Quality & Safety Action Plan*** **–** It was agreed that NW and LF would discuss progressing this action outside the meeting due to commitments of Public Health Wales colleagues in relation to ongoing management of the pandemic. It was acknowledged that the action has been outstanding for some time; however DM assured the Committee that during a recent review of Employers of Directors of Public Health, the item had been referred to Tracey Cooper, Chief Executive of Public Health Wales. • ***Ref 3.1.0 (16/9) LF and GT to review format of papers received under the NWSSP item / section going forward*** **-** The correct format of papers had been used for the Committee and it was agreed to close the action. • ***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*** **–** It was advised that a full closeout report against the recommendations will be received at the January 2022 Committee. COB confirmed that all actions had been closed pending the replacement of flooring in the Outpatients Department, for which quotes have been received and a budget identified. The Committee **AGREED** the status of all actions as noted above. ***Additional*** – SA requested a meeting with NW to discuss the 15 step challenge process and subsequent reporting process as the Community Health Council were exploring instigating the 15 step challenge methodology as part of their visits.	**LF/NW** **KP** **PW/COB** **NW/SA**
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).	

	The Chair requested that item 2.3.6 (Annual Estates Update) be removed from consent items to the main agenda, to allow for further discussion.	
2.1.0	**ITEMS FOR APPROVAL**	
2.1.1	**Draft Minutes from the meeting of the Public Quality & Safety Committee held on the 16th September 2021** Led by Stephen Harries, Interim Vice Chair and Acting Quality, Safety and Performance Committee Chair The minutes of the Public Quality & Safety Committee held on the 16th September 2021 were **APPROVED** as a true reflection of the meeting.	
2.2.0	**ITEMS FOR ENDORSEMENT**	
2.2.1	**Quality, Safety & Performance Committee Terms of Reference and Operating Arrangements** Led by Emma Stephens, Head of Corporate Governance The Committee **ENDORSED** the amendments to the Trust Board Standing Orders – Schedule 3 as outlined in section 3 of the report.	
2.2.2	**Quality, Safety & Performance Committee Cycle of Business** Led by Emma Stephens, Head of Corporate Governance The Committee **ENDORSED** the proposed revisions to the Cycle of Business for **BOARD APPROVAL** and **NOTED** the additional work to be undertaken to support and underpin further review as part of our commitment to continuous improvement.	
2.2.0	**ITEMS FOR NOTING**	
2.3.1	**Draft summary of the minutes from the meeting of the Private Quality, Safety & Performance Committee held on 16th September 2021** Led by Stephen Harries, Interim Vice Chair and Acting Quality, Safety & Performance Committee Chair The committee **NOTED** the summary minutes from the 16th September 2021 Private Committee.	
2.3.2	**Highlight Report from the COVID-19 Cells** **Test, Trace & Protect (TTP) Cell** Led by Jacinta Abraham, Executive Medical Director The Committee **NOTED** progress on TTP activities as outlined in the dashboard. **Trust Vaccination Programme Update** Led by Nicola Williams, Executive Director of Nursing, Allied Health	

	Professionals and Health Science The Committee **NOTED** the plans and progress in relation to delivery of the Velindre University NHS Trust COVID-19 booster and Influenza Vaccination Programmes.	
2.3.3	**Highlight Report from the Trust-wide Patient Safety Alerts Group** Led by Annie Evans, Deputy Director of Nursing, Quality & Patient Experience The Committee **NOTED** the contents of the highlight report and the level of compliance against the open Safety Alerts.	
2.3.4	**Highlight Report from the Trust Estates Assurance Group** Led by Carl James, Director of Strategic Transformation, Planning & Digital The Committee **NOTED** the contents of the report and actions being taken.	
2.3.5	**Trust 2020/2021 Health & Safety Annual Report** Led by Carl James, Director of Strategic Transformation, Planning & Digital The Committee **NOTED** the 2020 /2021 Trust Health & Safety Annual Report.	
2.3.6	**Trust 2020 / 2021 Annual Estates Report** Led by Carl James, Director of Strategic Transformation, Planning & Digital *This item was discussed outside of consent (before item 3.0.0) at the Chair's request.* The Chair queried the significant increase in gas consumption in the Welsh Blood Service during April 2020. JH advised that the increase was a result of changes made to the ventilation plant due to the Covid-19 situation. Following a review of gas utilisation undertaken during March 2021, amendments had been made to the control strategy going forward. SH noted that the inclusion of additional narrative around such variances would be helpful for future reporting from an environmental perspective (in addition to the metrics presented in the report), such as the potential impact of utility price increases. HJ suggested that where limited assurance had been reported, a broader explanation of the current position in terms of how reasonable assurance can be achieved would be welcomed. CJ advised that ongoing improvements to reporting would continue.	**CJ** **CJ**

	Additionally, input would be welcomed in relation to the development of the decarbonisation plan which will be presented at a number of forums and Committees in the future. The Committee **NOTED** the Trust 2020 / 2021 Annual Estates Report.	
2.3.7	**Infected Blood Inquiry** Led by Cath O'Brien, Chief Operating Officer The Committee **NOTED** the content of the Infected Blood Inquiry report.	
2.3.8	**Internal Audit Reports** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science The Committee **NOTED** the Quality and Safety related Internal Audit reports and the 'reasonable assurance' rating received for reviews of Divisional Incidents, Divisional Risks and Infection Prevention and Control.	
2.3.9	**Transforming Cancer Services Programme Scrutiny Sub Committee Highlight Report** Led by Stephen Harries, Interim Vice Chair and Chair of the Transforming Cancer Services Scrutiny Committee The Committee **NOTED** the contents of the report and actions being taken.	
3.0.0	**Velindre Quality & Safety Committee for NHS Wales Shared Services**	
	Led by Gareth Tyrrell, Head of Technical Services, NHS Wales Shared Partnership The NHS Wales Shared Services Quality & Safety Governance Report was received and discussed and the following was highlighted: • CIVAS@IP5 (a Shared Services delivered medicines preparation service) had been inspected by the Medicines and Healthcare products Regulatory Agency (MHRA) against Good Distribution Practice on 6th September 2021. The inspection report had been received identifying no critical or major service deficiencies. • All action points identified had been completed and that a renewed Medicines licence had been received. • CIVAS@IP5 has also recently assumed responsibility for the packing and distribution of COVID-19 booster vaccines for primary care sites including GP surgeries and pharmacies (over 70,000 vaccines to date). The Committee **NOTED** the recent MHRA inspection and current levels of service performance against the framework of standards set out in EU	

	Good Manufacturing Practice, compliance with which is a legal requirement as a MHRA "Specials" and Wholesale Dealer licence holder.	
4.0.0	**MAIN AGENDA** (This section supports the discussion items for review, scrutiny and assurance).	
4.1.0	**Welsh Blood Service Quality Safety & Performance Divisional Report** Led by Alan Prosser, Interim Director of Welsh Blood Service The Committee received a detailed Welsh Blood Service Quality, Safety and Performance report, providing an overview of performance against key quality, safety, regulatory and performance metrics for the period June 2021 to September 2021. The following areas were highlighted: • Supply of all blood components to meet NHS Wales demand continues to be sustained, despite the difficult operating environment and ongoing challenges presented by the pandemic in relation to staff absenteeism and social distancing affecting the capacity of blood collection venues. • There had been supply challenges in other UK Blood services in recent months. The Welsh Blood Service provides 'mutual aid' support when it can to the other UK services. The positive impact that the recruitment of a fourth collections team had on the service being able to meet demand was recognised. • An increase in sickness has been observed for the first time which has a potential to impact on the ability of the service to meet demand. This is however being appropriately managed in line with NHS Wales policies and procedures. • An increase in 'Did Not Attend' (DNA) rates for the service had been experienced the reasons for this are being explored. • Assurance that all actions to meet the recommendations from the 15 step challenge visit undertaken in a donation clinic on the 17th June 2021 had been undertaken was provided. A subsequent visit to the Apheresis clinic had taken place during October and a number of resulting actions had been progressed and only a small number remain outstanding. • The implementation of the 'For the Assessment of Individualised Risk' (FAIR) study has been successful with continued feedback received from donors within these communities. Ongoing adjustments are being made to the system. • WBS continues to be actively involved in the logistics of the autumn Covid-19 booster / Influenza vaccination programme. • A recent agreement with Welsh Government will result in the inclusion of North Wales in the wholesale agreement of Immunoglobulin supply. • An episode of 'Dom Delivers' was aired on the BBC, following the blood donor journey from the point of donation to the point of patient	

	recipient. This had been an excellent advert for the service and will be available on BBC iPlayer for a year. • The UK Accreditation Service (UKAS) conducted a comprehensive 4 day reaccredication audit of the WBS medical laboratories against ISO 15189 during July 2021, resulting in 27 findings. These were subsequently resolved and accreditation has been renewed for the next 4 year period. • A separate audit of the Histocompatibility and Immunogenetics National External Quality Assurance Scheme was also completed against ISO 17043 during September, resulting in 4 recommendations which have subsequently been resolved and closed. The Committee commended the Welsh Blood Service Team for work undertaken to ensure that the service continues to meet demand across NHS Wales for blood and blood products and **NOTED**: • Progress against current quality safety and performance metrics; • Key priority areas; • Issues, corrective actions and monitoring arrangements in place; and, • The excellent service developments being taken forward within WBS. **15 Step Challenge Report** The Committee received the summary report from the 15 Step Challenge visit undertaken by an Independent Member, Executive Director of Nursing and Business Support Officer within the Apheresis Clinic of Welsh Blood Service on the 5th October 2021. The review was extremely positive with exemplar feedback from donors. A small number of recommendations were made that included reviewing whether travel expenses for donors could be reimbursed as well as strengthening the inclusivity of services. AP agreed to revisit the issue of travel expenses reimbursement with the WBS and reassess feasibility of reinstating this. The Committee **NOTED** the 15 Step Challenge report.	**AP**
4.2.0	**Velindre Cancer Service Performance Report** Led by Cath O'Brien, Chief Operating Officer The Velindre Cancer Service report provided an update on performance against key performance metrics for the period until the end of September 2021. The Committee recognised the work that was underway to redevelop the Performance Framework (due for completion by March 2022) and recognised the limitations of the current report format. It was identified that, until this time, there should be a robust cover paper that provides appropriate explanation and assurances in respect of areas where performance has deteriorated or is not at the required level. The following areas were highlighted:	

- Sustained unprecedented pressure on provision of services across all services, compounded by ongoing high levels of staff absences (some COVID related). Considerable effort is being made to ensure that services are being maintained and that demand is met. Despite these issues, Systemic Anti-Cancer Treatment waiting times currently remain on target.
- ***Inpatient Falls*** – Two falls had been reported (one deemed avoidable / one unavoidable). The narrative requires further contextualisation. It was noted that overall the number of falls was very low and explanations are required in terms of why a fall may have been deemed unavoidable. The revised metric will also include repeat falls. It was noted that a review of the falls scrutiny process will be undertaken by the Senior Nurse, Professional Standards.
- ***Outpatient (30 minute) waiting times*** – Work is currently being undertaken to improve compliance with this standard and it was noted that some instances were in relation to patients receiving blood tests and needing to await results on the same day as their appointment, as this was their preference.
- ***Sepsis Bundle Compliance*** – It was noted that the overall low numbers were skewing the 75% compliance as three of four patients meeting the criteria for a Sepsis Screen had received all elements of the sepsis bundle within the required hour. The documentation was incomplete (one element) for the fourth patient. The Committee were assured that the patient suffered no harm.
- ***Breast (new patient referrals)*** – It was identified that the red reporting status of this measure was a direct result of the reduction in breast screening that had been undertaken nationally during the early phases of the COVID pandemic. As a result, the breast service was now experiencing unprecedented spikes in referrals which is impacting on the Trusts ability to meet this increase in demand.
- ***Healthcare Acquired Pressure Ulcers*** – Enhanced clarification is required in relation to avoidable versus unavoidable pressure ulcers. Nicola Williams advised that an external peer review of the Cancer Service Pressure Ulcer scrutiny process has been commissioned as an additional layer of assurance and will be conducted early in the new year.

Radiotherapy

The Committee received a detailed analysis of the current position in relation to the Velindre Cancer Service ability to meet radiotherapy delivery standards impacting on the Trust's ability to meet the COSC (Clinical Oncology Sub-Committee Stretch) targets for scheduled, urgent scheduled and emergency patients (all reporting on the performance scorecard as red). September had seen a record number of new patient referrals and compliance with targets had also fallen due to a 25% reduction in capacity for the delivery of radiotherapy as a result of social distancing and other infection control measures.

	Significant and detailed discussion took place in respect of the current status. It was advised that currently enhanced business continuity measures are in place in order to mitigate the risks as far as possible and to ensure service delivery, including filling posts in radiotherapy and radiotherapy physics. There is close daily monitoring underway and the situation is being managed through a Silver Command infrastructure. The Board will receive additional detailed analysis via the Chief Operating Officer in respect of this matter. The Committee discussed in detail and **NOTED** the contents of the Velindre Cancer Service Performance Report.	
4.3.0	**Workforce & Organisational Development Performance Report** Led by Sarah Morley, Executive Director of Organisational Development & Workforce The Workforce and Organisational Development Performance Report, detailing key performance indicators for sickness, PADR (personal appraisal and development reviews) and training for the month of September 2021 was received and discussed. The following was noted: • Sickness absence to 15th November 2021 stands at 5.41%. • COVID-related absence – 10 staff currently absent across the Trust with COVID-related absence, with 14 staff on COVID-related special leave (12 within Velindre Cancer Centre – a number of whom are in the same small team). SC acknowledged the current challenges presented due to absence levels and queried action undertaken by the Trust to support staff and staff currently attending the workplace in terms of morale, exhaustion, etc. SfM advised that a wide reaching programme of available interventions exists across the Trust and within local areas, including the employee assistance programme, accessible by all staff and staff family members. This provides psychological and practical support. Additionally, managers are able to access support in addressing issues within their teams via the Manager Assist Programme. SH also queried the Trust's current position in terms of areas of recruitment difficulty. SfM reported that a large scale recruitment campaign for senior and specialist roles is underway in a number of clinical areas, in particular in Radiotherapy. It was noted that the primary focus would now be to address sickness / absence levels, in particular its impact on the fragility of smaller, more specialist teams.	

	The Committee **NOTED** the contents of the Workforce & Organisational Development Performance Report.	
4.4.0	**Digital Service Operational Report** Led by Stuart Morris, Deputy Chief Digital Officer The Digital Service Operational Report was received and the following advised: • September / October had seen a number of significant system upgrades, in particular: o The introduction of WellSky, replacing the outdated IT system within the Pharmacy department, aligning the Trust with the rest of Wales; o A number of changes into the WBS ePROGESA system, supporting the new 'FAIR' regulations for blood donation; o An upgrade to the Synapse solution, used by VCC Radiology to review and report radiology images. o Rollout of the 'Civica' patient experience platform into VCC. • A series of outages had been experienced within Velindre Cancer Service and reported through appropriate channels and SM confirmed that all outages had generally occurred out of hours with zero to minimal impact to patients and services. The Committee **NOTED** the contents of the Digital Service Operational Report.	
4.5.0	**Financial Report** Led by Matthew Bunce, Executive Director of Finance The Trust Financial Report, outlining the financial position and performance for the period to the end of September 2021 (with additional verbal update for October 2021) was received and the following was highlighted: • KPIs at month 6 remain on target in terms of delivery for month 7. • ***Revenue*** – Formal confirmation has now been received that all COVID-19 related funding requirements will be received from Welsh Government. • ***Capital*** – The Trust plans to remain within the capital expenditure limits and has also received additional funding for COVID projects. Further funding (£850,000) has been provided in relation to slippage bids over the last month, to be invested in digital and medical equipment. • ***Payment performance*** – Delays in processing of payments due to staffing issues has improved significantly and it is anticipated that the 95% target will be met by the end of the year. MB also noted that in relation to the medical engagement survey, only	

	40% of medical colleagues understand the potential impact of decisions on resource, finance and outcomes. Work around value based healthcare will be progressed to triangulate this going forward. The Committee **NOTED** the contents of the Financial report, in particular the financial performance to date and year end forecast to achieve financial break-even.	
4.6.0	**Trust Risk Report** Led by Lauren Fear, Director of Corporate Governance and Chief of Staff The Committee discussed the Trust Risk Report that summarised the current status of all risks scoring 12 or greater, ongoing management and mitigation thereof. LF advised that the Trust-wide programme of work to implement changes to our process and systems is accompanied by a review of the risk scores themselves during the transition from Datix 12 to version 14. SA queried whether in terms of the 'risk of increase of transmission of infection due to poor ventilation', there was no assurance in terms of actions undertaken to address this risk. CJ advised that immediate action had been undertaken in terms of a temporary ventilation solution, to facilitate air flow through the first floor inpatient ward. Additionally, active monitoring is being undertaken to ensure there are no airborne infections. The Board has been sighted on a business case which seeks to implement a permanent solution within the first floor ward. The challenge is that the small number of isolation rooms are currently occupied by patients due to the pandemic. Therefore it would be best to avoid reducing capacity of rooms. Various other aspects of the estate are currently being risk assessed through the ventilation group and the plan will be prioritised in terms of investment for ventilation and higher risk areas. A wider aspect of work is currently underway across the Trust to address this. It was suggested that additional narrative should be included in future reports outlining actions being taken to reduce or eliminate these risks in addition to further minor amendments to the presentation of data. LF agreed to take this forward. **The Committee NOTED:** • The risks level 20,16,15 and 12 reported in the Trust Risk Register and the highlighted risks 20, 16 and 15 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.	**LF**
4.7.0	**Quarter 1/Quarter 2 Putting Things Right Report** Led by Annie Evans, Deputy Director of Nursing, Quality & Patient	

	Experience The 2020/2021 Quarter 2 Putting Things Right Report was received, following the review and approval at the Executive Management Board held on 1st November 2021. The following was highlighted: • The main themes of complaints received continue to be around communication, attitude and behaviour. It was noted that the more highly graded complaints mainly relate to communication regarding clinical care, such as perceived miscommunication regarding treatment plans, with lower graded complaints relating to attitude mainly centering on scheduling of appointments. A deep dive review is currently being undertaken to gain better understanding of the issues to facilitate meaningful resolutions and this will be addressed at the next Committee. • 67% compliance rate in relation to closure of formal concerns raised within the 30 working day timeframe, which is below the Welsh Government target of 75%. A number of factors led to this which have now been resolved. Complainants were updated regularly during the response process and no issues had been raised. • Compliance with the 30 working day timeframe for incident investigation and closure is high within Welsh Blood Service but improvement work is currently ongoing at VCC, overseen by the Quality Team at VCC and Corporate Team. The Committee **APPROVED** the 2020-2021 Quarter 2 Putting Things Right Report following the review and approval at the Executive Management Board held on the 1st November 2021.	**AE**
4.8.0	**Health and Care Standards Self-Assessment Action/Improvement Plan** Led by Annie Evans, Deputy Director of Nursing, Quality & Patient Experience The Health and Care Standards Self-Assessment update was received, providing the Committee with the Trust's current position in relation to compliance with the Health and Care Standards for Wales (2015). The following was advised: • This year has seen the introduction of a new quarterly assessment and reporting structure rather than annually. This new approach has been welcomed across teams despite current operational challenges. • Good progress has been made with the improvement action plan in relation to the Healthcare Standards, with only 3 areas not achieving closure by the end of the financial year, mainly relating to vacancies within the workforce team. • Further self-assessments will be undertaken at the end of Quarter 3 and Quarter 4 in addition to an independent review of a sample of assessments undertaken by the internal audit team.	

	The Committee **NOTED:** • The current status and progress being made year to date in respect of the Health and Care Standards Programme; • The overarching Trust compliance scoring table for the Health and Care Standards; • The status in respect of the Health & Care Standard Improvement Plan.	
4.9.0	**Highlight Report from the Trust-wide Infection Prevention & Control Management Group** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science The Highlight Report from the Trust-wide Infection Prevention & Control Management Group meeting held on 21st September 2021 was discussed. The Committee was alerted to the following: • The ongoing delay in completing the urgent Velindre Cancer Centre theatre decontamination refurbishment due to procurement issues. The procurement is being actively managed by the Estates Team, however a date to commence the work is still awaited; • Ongoing work to address the inadequate staff changing facilities resulting in insufficient space for social distancing and inadequate locker facilities, creating COVID-19 transmission risk. The Cancer Centre Senior Management Team has undertaken a full risk assessment and continues to work on the development of a resolution plan. • Environmental audits across Velindre Cancer Service identified a number of estates actions to reduce infection transmission risks such as general decoration and replacement flooring. Each of these are currently being risk assessed and costs quantified by the Estates Team so that a clear resolution plan can be prioritised and implemented. The report also detailed the overall ongoing reduction in Healthcare acquired infections and highlighted that there had not been any COVID related transmission incidences in the last six months. The Committee commended the operational delivery teams for this. The Committee **NOTED** the report and items for escalation.	
4.10.0	**Highlight Report from the Trust-wide Safeguarding & Public Protection Management Group** Led by Tina Williams, Senior Nurse Safeguarding and Public Protection The Highlight Report from the Trust-wide Safeguarding & Public Protection Group was received, providing the Committee with details of key issues considered by the Trust's Safeguarding Group at the meeting held on 3rd September 2021. The Committee was alerted to the following:	

	• Safeguarding training compliance remains below the target of 95% in most areas; a training needs analysis is currently underway to facilitate more accurate reporting, improved compliance and enabling the offer of training to bespoke groups. • There has been a delay in the production nationally of the consultation Code of Practice for the pending new Liberty Protection Safeguards legislation, which may leave the Trust ill-prepared to be able to effectively meet the required legislative changes. All possible preparation is underway but detailed plans cannot be developed without the document. • The Trust currently has no provision for tier 2 dementia training; however a potential agreement with Cardiff & Vale is under development that would more than adequately meet this training requirement. AP commended the work undertaken in relation to raising awareness of Safeguarding week, and the development of pocket-sized guidance for Welsh Blood Service collection teams staff. The Committee **NOTED** the revised Terms of reference and name of the Group to widen its remit to cover vulnerable adults and older persons. The new title is the Safeguarding and Vulnerable Adult Management Group.	
4.11.0	**Patient/Donor Experience 2020-2021 Annual Report** Led by Annie Evans, Deputy Director of Nursing, Quality and Patient Experience The Patient / Donor Experience 2020-2021 Annual Report was received and the following areas were highlighted: • Despite the COVID-19 pandemic and short notice changes to donor and patient services, the teams across both divisions have actively engaged with patients and donors, seeking greater feedback on our services, increasingly via digital means (due to restrictions imposed on traditional means by the pandemic). • Patient and donor feedback has, overall remained positive. However, some feedback linked to concerns relating to communication, staff attitude and behaviour and treatment. • Concerns raised around treatment predominantly related to changes to service provision as a result of the COVID-19 pandemic. It was advised that both divisions are actively reviewing all feedback received and taking appropriate improvement actions. It was noted that the roll out of the electronic patient / donor experience software will facilitate a much higher volume of feedback, and in real time. SH thanked all staff for their agility in adapting to new ways of working during unprecedented circumstances and ongoing work to support staff to further improve the patient / donor experience.	

	HJ noted that there is a direct correlation between staff satisfaction and patient / donor experience and it was suggested that a staff survey could be conducted in parallel to the patient / donor survey. AE reported that the positive feedback received had boosted morale tremendously during this challenging period. The Committee **ENDORSED** the Trust's 2020-2021 Annual Patient and Donor Experience Report prior to provision to Trust Board and publication on the Trust's website, subject to inclusion of a complete set of patient satisfaction survey results.	**AE**
4.12.0	**RD&I Sub Committee Highlight Report** Led by Emma Stephens, Head of Corporate Governance (in Professor Donna Mead's absence) The Research, Development and Innovation Sub-Committee Highlight Report was received, providing the Committee with details of key issues considered by the RD&I Sub-Committee at its meeting on the 21st October 2021. The Committee was alerted to the following: • Ongoing difficulty in undertaking research in some clinical areas due to capacity issues. It was noted that this poses a risk in terms of diminishing research and retention of staff and that strategic discussions will be undertaken through the Executive Management Board to identify potential solutions. • Ongoing challenges in relation to effective communication of research, development and innovation outputs due to the lack of a dedicated resource. It was advised that a communication plan has already been initiated to support more effective communication of research, development and innovation activity and good progress has been made to support this going forward. The Committee **NOTED** the contents of the report and actions being taken, including escalation of items identified for alert to the Trust Board.	
5.0.0	**INTEGRATED GOVERNANCE** (The integrated governance part of the agenda will capture and discuss the Trust's approach to mapping assurance against key strategic and operational risks)	
5.1.0	**Quality, Safety & Performance Committee Annual Report (including Committee Effectiveness Survey Findings)** Led by Emma Stephens, Head of Corporate Governance The Committee received the first Annual report for the Quality, Safety & Performance Committee, summarising the key areas of business activity undertaken by the Committee in its first year of operation. The report also incorporated the findings from the Quality, Safety & Performance Committee first Annual Effectiveness Survey, designed to assess its performance together with any opportunities for continuous	

	improvement. The Committee noted that a recurring theme running throughout the report relates to the Committee's pivotal role in collating information under one umbrella in a more integrated way to allow for more effective triangulation, together with the key areas of focus for the coming year as the Committee continues to mature and further develop. ES advised that this year's survey findings would be used as a rolling benchmark for year on year reporting. Following queries from HJ and SA in relation to membership, it was agreed that clarification would be provided to distinguish between responses from members and attendees, and that additional detail would be added to demonstrate that the Committee is attended by representatives from a number of external organisations that represent the patient viewpoint and regulatory input. The Committee **ENDORSED** for **BOARD APPROVAL** the Quality, Safety & Performance Committee Annual Report for 2020-2021, subject to the inclusion of amendments discussed above approved by the Chair prior to Trust Board.	**ES**
5.2.0	**Analysis of meeting outputs** Led by Stephen Harries, Interim Vice Chair and Acting Quality, Safety and Performance Committee Chair The Chair requested any further comments in relation to key outputs arising throughout the meeting. None were raised.	
6.0.0	**HIGHLIGHT REPORT TO TRUST BOARD**	
	Members were asked to identify items to include in the Highlight Report to the Trust Board: It was agreed that the Chair and Committee Secretariat would agree items for inclusion in the Board highlight report.	
7.0.0	**ANY OTHER BUSINESS**	
	No other business was received.	
6.0.0	**DATE AND TIME OF THE NEXT MEETING**	
	The Quality, Safety & Performance Committee will next meet on the: **20th January 2021 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 (VUNHST)

Date: 18th November 2021
Time: 12:30 – 13:00
Location: Microsoft Teams
Chair: Stephen Harries, Interim vice Chair

ATTENDANCE		
Stephen Harries	Interim vice Chair	SH (Chair)
Hilary Jones	Independent Member	HJ
Carl James	Director of Strategic Transformation, Planning & Digital	CJ
Cath O'Brien	Chief Operating Officer	COB
Matthew Bunce	Executive Director of Finance	MB
Annie Evans	Deputy Director of Nursing, Quality & Patient Experience	AE
Lauren Fear	Director of Corporate Governance and Chief of Staff *(in part)*	LF
Peter Richardson	Head of Quality Assurance & Regulatory Compliance, Welsh Blood Service	PR
Sarah Morley	Executive Director of Organisational Development & Workforce	SfM
Emma Stephens	Head of Corporate Governance	ES
Kyle Page	Business Support Officer (Secretarial Support)	KP

1.0.0	**STANDARD BUSINESS**	
1.1.0	**Apologies:** • Steve Ham, Chief Executive Officer • Professor Donna Mead OBE, Velindre University NHS Trust Chair • Dr Jacinta Abraham, Executive Medical Director • Paul Wilkins, Interim Director of Cancer Services • Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science • Stuart Morris, Chief Digital Officer	
1.2.0	**In Attendance:** • Katrina Febry – Audit Lead (Performance), Audit Wales • Andrew Paramore, Project Manager, Velindre Organisational Development & Workforce	

1.3.0	**Declarations of Interest** Led by Stephen Harries, Interim vice Chair and Acting Quality, Safety & Performance Committee Chair No declarations of interest were raised.	
1.4.0	**Review of Action Log** Led by Stephen Harries, Interim vice Chair and Acting Quality, Safety & Performance Committee Chair There were no actions for review as all outstanding actions had been closed at the 15th July 2021 Committee (*see item 2.1.1 below*).	
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	**Minutes from the meeting of the Private Quality, Safety and Performance Committee held on the 16th September 2021** Led by Stephen Harries, Interim vice Chair and Acting Quality, Safety & Performance Committee Chair HJ indicated that an action following a query raised at September's Committee had been omitted from the action log. This was relating to the testing of the Cyber Security disaster recovery plan which, although recognised as a priority, had not been carried out to date. The Committee **REVIEWED** and **APPROVED** the minutes of the Private Quality, Safety and Performance Committee meeting held on the 16th September 2021 as an accurate reflection of proceedings, subject to the addition of the action in relation to the testing of the Cyber Security disaster recovery plan to the action log.	**KP/SM**
2.2.0	**ITEMS FOR NOTING**	
	There were no items for **NOTING** by the Committee.	
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 Three Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee Highlight Reports were received, providing details of key issues	

	following two ad-hoc meetings held on the 5th and 12th August 2021 and the regular meeting held on 21st September 2021. The reports were NOTED and no comments or questions raised.	
3.2.0	**Trust Risk Register** Led by Emma Stephens, Head of Corporate Governance The 'private' section of the Trust Risk Register that contained commercially or sensitive information was received. The report provided detail in respect of the status of the 'private' organisational risks scoring 12 or more recorded on the Risk Register, their management plans and mitigating action. The Committee **NOTED** the risks scoring a level 12 and greater and the ongoing work to expedite the development of a consolidated risk process and register for the Trust.	
3.3.0	**2021/22 Quarter 2 Claims & Redress Report** Led by Annie Evans, Deputy Director of Nursing, Quality & Patient Experience The Committee received the Quarter 2 Claims and Redress Report, providing an update of the Trust's Claims and redress profile for the second Quarter. The following key points were highlighted: • There are currently 10 active claims; 5 had been closed during Quarter 2 and 2 new claims had been received. • No claims relating to Covid-19 had been received. The Committee **NOTED** the Trust's 2021/2022 Quarter 2 Claims and Redress Report.	
4.0.0	**Analysis of meeting outputs** Led by Stephen Harries, Interim vice Chair and Acting Quality, Safety and Performance Committee Chair	
	Members were asked to convey any necessary comments or key outputs to the Chair following the meeting. None 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** • **For Information**	
6.0.0	**ANY OTHER BUSINESS**	

	Led by Stephen Harries, Interim vice Chair and Acting 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 on the: **20th January 2022 from 10:00 – 13:45 via Microsoft Teams.**	
CLOSE		

QUALITY, SAFETY & PERFORMANCE COMMITTEE

HIGHLIGHT REPORT FROM THE CHAIR OF THE STRATEGIC DEVELOPMENT COMMITTEE

DATE OF MEETING	20th January 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Jessica Corrigan, Business Support Officer
PRESENTED BY	Stephen Harries, Independent Member
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning & Digital

REPORT PURPOSE	FOR NOTING

ACRONYMS	
OBC	Outline Business Case
FBC	Full Business Case
TCS	Transforming Cancer Services
WG	Welsh Government
IRS	Integrated Radiotherapy Solution
IM	Independent Member

1. PURPOSE

1.1 This paper has been prepared to provide the Quality, Safety and Performance Committee with details of the key issues considered by the Transforming Cancer

Service (TCS) Programme Scrutiny Sub-Committee at its public meeting on 25th October 2021.

1.2 This is not considered a full update on the Programme but a high level record of the matters of business conducted by the TCS Programme Scrutiny Sub-Committee.

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

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

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for Alert / Escalation to the Quality, Safety and Performance Committee.
ADVISE	**Finance Report** The finance report for October 2021 was received. A small revenue overspend to October 2021 was noted, with a current year-end forecast of £0.017m. This will be managed within the overall budgets. It was highlighted there is a projected year-end capital overspend of £0.124m for the Integrated Radiotherapy Solution (IRS) Project. This overspend will be managed within the wider Transforming Cancer Service Programme. The sub-committee **noted** the finance report. **TCS Programme Risk Register** The TCS Programme Risk Register report was presented. The latest risk positions for the TCS programme and projects were reviewed and discussed. Risks which relate to programme resources will be updated in the November Scrutiny Sub-Committee, and they will also be included in the financial strategy which will be going to the next Trust Board meeting. The sub-committee **noted** the finance report.

	Project Delivery Updates were received in the following papers which were **noted**: - Charity Interface - Children's & Young Persons Engagement (Minecraft) - Collaborative Centre – Update - Wellbeing & future generations Act (WBFGA) – new Velindre Cancer Centre Status report
ASSURE	**Project 4 – Radiotherapy Satellite Centre** **FBC Timeline Update** A verbal update was given on the FBC timeline. The sub-committee noted the verbal update. **Nuffield Trust Recommendations: Progress** An update on progress with the Nuffield Trust Recommendation was received. The Sub-Committee **Noted** the Paper. **Communications & Engagements** An update was given on communication and engagements. The Sub-Committee **Noted** the Paper.
INFORM	There were no items identified to inform the Quality, Safety and Performance Committee.
APPENDICES	N/A

QUALITY, SAFETY & PERFORMANCE COMMITTEE

HIGHLIGHT REPORT FROM THE CHAIR OF THE TRANSFORMING CANCER SERVICES SCRUTINY SUB-COMMITTEE

DATE OF MEETING	20th January 2022
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Jessica Corrigan, Business Support Officer
PRESENTED BY	Stephen Harries, Independent Member
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning & Digital
REPORT PURPOSE	FOR NOTING

ACRONYMS	
OBC	Outline Business Case
FBC	Full Business Case
TCS	Transforming Cancer Services
WG	Welsh Government
IRS	Integrated Radiotherapy Solution
IM	Independent Member

1. PURPOSE

1.1 This paper has been prepared to provide the Quality, Safety and Performance Committee with details of the key issues considered by the Transforming Cancer

Service (TCS) Programme Scrutiny Sub-Committee at its public meeting on 22nd November 2021.

1.2 This is not considered a full update on the Programme but a high-level record of the matters of business conducted by the TCS Programme Scrutiny Sub-Committee.

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

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

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for Alert / Escalation to the Quality, Safety and Performance Committee.
ADVISE	**Finance Report** A summary was provided for the TCS Finance report as at October 2021. Capital: £1.5M year to date spend, with a year-end forecast spend of £4.3M | Revenue: £400K year to date spend, with a year-end forecast spend forecast of £600K. Projected year-end out-turn currently is £113k overspend on Capital and £17k overspend on Revenue. Within this, it was highlighted there are two financial risks which needed to be brought to the attention of the TCS Programme Scrutiny Sub-Committees attention which are: 1. Project 3a - Integrated Radiotherapy Solution (IRS) Project: due to the delay in procurement this has resulted in a deficit of £116K (Capital). 2. Project 6 - Service Change Project: a £17k Revenue overspend against this Project delivery is the main risk to the outturn position for the programme. The sub-committee **noted** the finance report. **TCS Programme Risk Register**

	The TCS Programme Risk Register report was presented. The latest risk positions for the TCS programme and projects were reviewed and discussed. The sub-committee **noted** the Risk Register.
ASSURE	**Programme Resource Update** The Programme Resource paper was presented to the Sub-Committee. Previously the TCS Programme Scrutiny Sub-Committee members have raised the issue of programme resourcing on a number of occasions as there are a number of risks which have remained with a high-risk rating for an extended period. It was confirmed significant progress has already been made. Further work is required to determine any additional capacity required in Velindre Futures as it takes responsibility for Clinical Transformation. The Sub-Committee **Noted** the Programme Resource Paper. **Communications & Engagements** An update was given on communication and engagements. The Sub-Committee **Noted** the Paper.
INFORM	There were no items identified to inform the Quality, Safety and Performance Committee.
APPENDICES	N/A

QUALITY, SAFETY & PERFORMANCE COMMITTEE

INFORMATION GOVERNANCE REPORT

DATE OF MEETING	20/01/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

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

REPORT PURPOSE	FOR NOTING

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

COMMITTEE OR GROUP	DATE	OUTCOME
Executive Management Board	4 Jan 22	Enhance paper to include: Action plan timetable to reduce IG related DATIX incidents Tabular information to support trend analysis Robust analysis on rationale behind increase in incidents in last two quarters

ACRONYMS	
IG	Information Governance
VCC	Velindre Cancer Centre
WBS	Welsh Blood Service
NWIS	NHS Wales Informatics Service
NWSSP	NHS Wales Shared Service Partnership
ICO	Information Commissioners Office
NIIAS	National Intelligent Integrated Audit Solution
M&S	Mandatory and Statutory

1. SITUATION/BACKGROUND

1.1 To provide the EMB with a review of all Trust wide Information Governance (IG) reported incidents and matters.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

Information Governance incident definition: "a breach of security leading to the accidental or unlawful destruction, loss, alteration, unauthorised disclosure of, or access to, all personal data, whether Employee or Patient, Donor, Service User held on computer or held manually and whether communicated verbally, electronically or in writing"

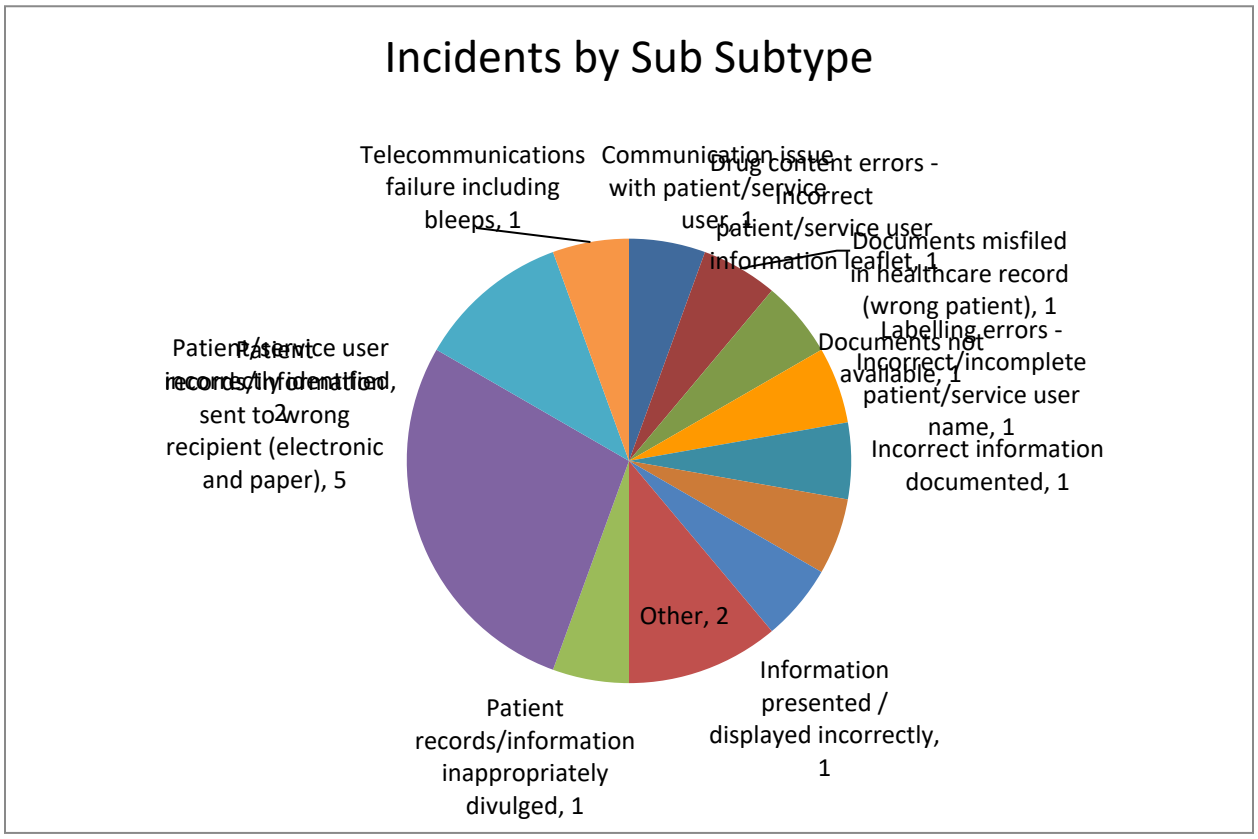
2.1 This report presents to the EMB an analysis of all Velindre Cancer Centre (VCC), Welsh Blood Service (WBS) and NHS Wales Shared Services (NWSSP) reported IG incidents and matters between the period of 1st June 2021 to 30th November 2021.

During this reporting period and in line with Trust Policies, there have been no breach incident reported into Information Commissioners Office (ICO).

2.2 **Velindre Cancer Centre**

Quarter 2

There have been in total 18 IG incidents reported during this period and these are categorised as follows: -

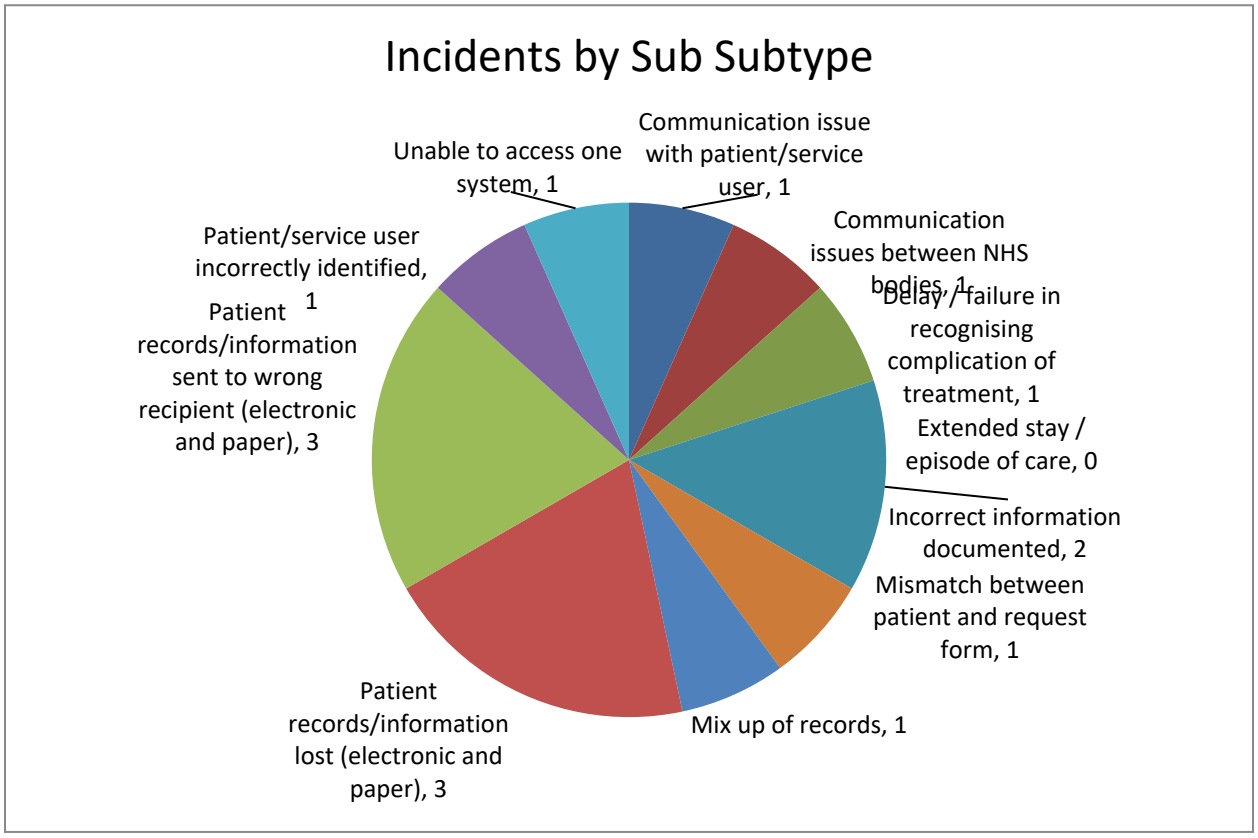


Category	Number of Incidents	Theme(s)
Communications issue with patient/user	1	Incorrect addressing of email
Documents misfiled in healthcare record (wrong patient)	1	Incorrect details on patient record (another patient's details)
Documents not available	1	Incorrect generic e mail address for use by clinicians
Drug content errors - Incorrect patient/service user information leaflet	1	Patient given incorrect medication – human error - investigation complete and IG training undertaken by individual responsible. No incorrect medication administered
Incorrect information documented	1	Incorrect patient details on CANISC
Information presented / displayed incorrectly	1	Software upgrade has incorrect validator details – Quality, Integrity and Accuracy of system not adversely affected

Labelling errors - Incorrect/incomplete patient/service user name	1	Incorrect patient information on label, but corect medication was administered
Other	2	Confidential letter left in plan view
		Incorrect recording of results on patient record for a different patient
Patient records/information inappropriately divulged	1	Form for patient found unattended on premises
Patient records/information sent to wrong recipient (electronic and paper)	5	Prescription on wrong medication
		Appointment letter issued for a different patient than the individual who received the letter
		Incorrect addressing of letters to a patient
		Inappropriate adding of staff members to internal e-mailing lists
		Incorrect e mail address for patient
Patient/service user incorrectly identified	2	Mix up of patient information for two patients on request form
Telecommunications failure including bleeps	1	Incomplete and incorrect patient details on request forms

Quarter 3

There have been in total 15 IG incidents reported during this period and these are categorised as follows: -



Category	Number of Incidents	Theme(s)
Communications issue with paitient/user	1	Patient not received appointment form
Communications issues between NHS Bodies	1	Macmillan survey sent in error
Delay/failure in recognising complication of treatment	1	Reporting of results not in line with policy
Extended Stay/Episode of care	0	This is not an IG issue, however, Datix is not allowing deletion of IG element, raised with DATIX Administrator
Incorrect information documented	2	Incorrect patient information in clinical systems
Mismatch between patient and and request form	1	Incorect patient details on labels for CT Scan
Mix up of records	1	Incorrect patient details
Patient records/information lost	3	PII and Confidential information not protected adequately

Patient records/informaiton sent to wrong receipient	3	Incorrect addressing of information
Patient/service user incorrectly identified	1	Incorrect patient address used
Unable to access one system	1	System ailure which resulted in service delivery impact, reported due to to system holding patient data – investigated and no IG Breach, system back online within 24 hours.

Lessons Learnt/Actions Taken

The new Head of Information Governance started in the role on 29 Nov 21, the incidents are still under investigations in the main, the new incumbent has put time in the diary to address all queries as quickly as possible so that by the next report all historical and emergent issues will have been resolved.

Initial analysis is that most cases could be avoided as human error seems to be the common factor. Some incidents which have been recorded as IG incidents are not IG related, where this has been detected since 29 Nov 21, the records have been annoted, progress notes updated and the report run so that as accurate data as possible is presented to the Committee.

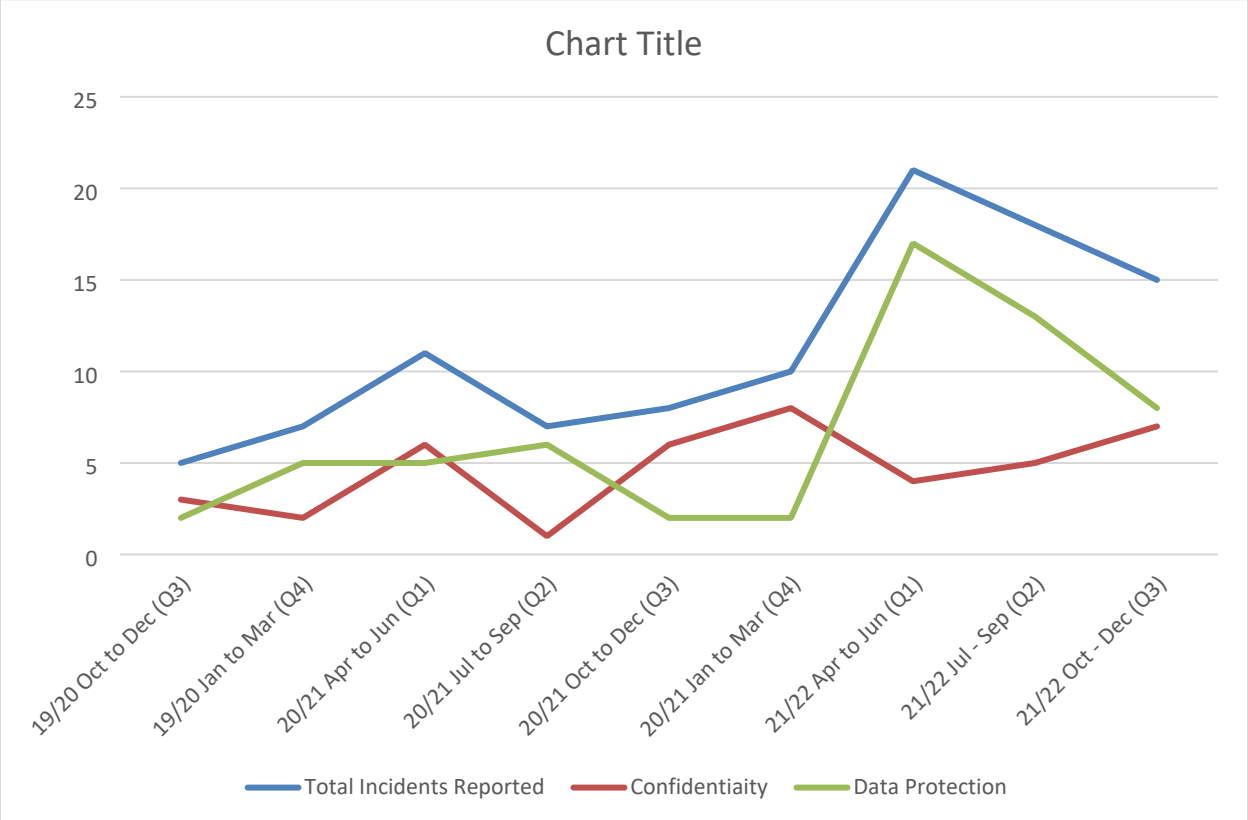
Training and awareness whilst provided within ESR as a video on a two yearly rolling basis can and should be provided as an additional bolt on programme across VCC via Teams on a risk based approach. This will take acocunt of areas where reporting appears to be highest and the training will take in account specimen incidents (without revealing any confidential or identifiable information).

To provide a solid basis, discussions have already taken place with Workforce to re-fresh and re-invigorate training in relation to IG, in particular the emphasis being on practical considerations due to remote working as a result of the Pandemic. The ESR training provision is pre-pandemic. The new HOIG will be raising a discussion of the refresh of the IG training available on ESR in the next IGMAG meeting in Jan 2022.

Induction training is also an aim of the new HOIG so that a positive IG culture is encouraged as soon as a new incumbent joins the Trust. All training for delivery on top of the ESR package will be delivered via a new initiative led by the Workforce Team so that the teams are the centre of training to allow more flexibility for hard pressed staff to be able to compelte their training.

VCC Trend Analysis

To provide the Committee with a trend analysis of all VCC IG reported incidents broken-down by categories Confidentiality & Data Protection over the past two years.



Quarter	Total Incidents Reported	Confidentiality	Data Protection
19/20 Oct to Dec (Q3)	5	3	2
19/20 Jan to Mar (Q4)	7	2	5
20/21 Apr to Jun (Q1)	11	6	5
20/21 Jul to Sep (Q2)	7	1	6
20/21 Oct to Dec (Q3)	8	6	2
20/21 Jan to Mar (Q4)	10	8	2
21/22 Apr to Jun (Q1)	21	4	17
21/22 Jun - Sep (Q2)	18	5	13
21/22 Oct – Dec (Q3)	15	7	8

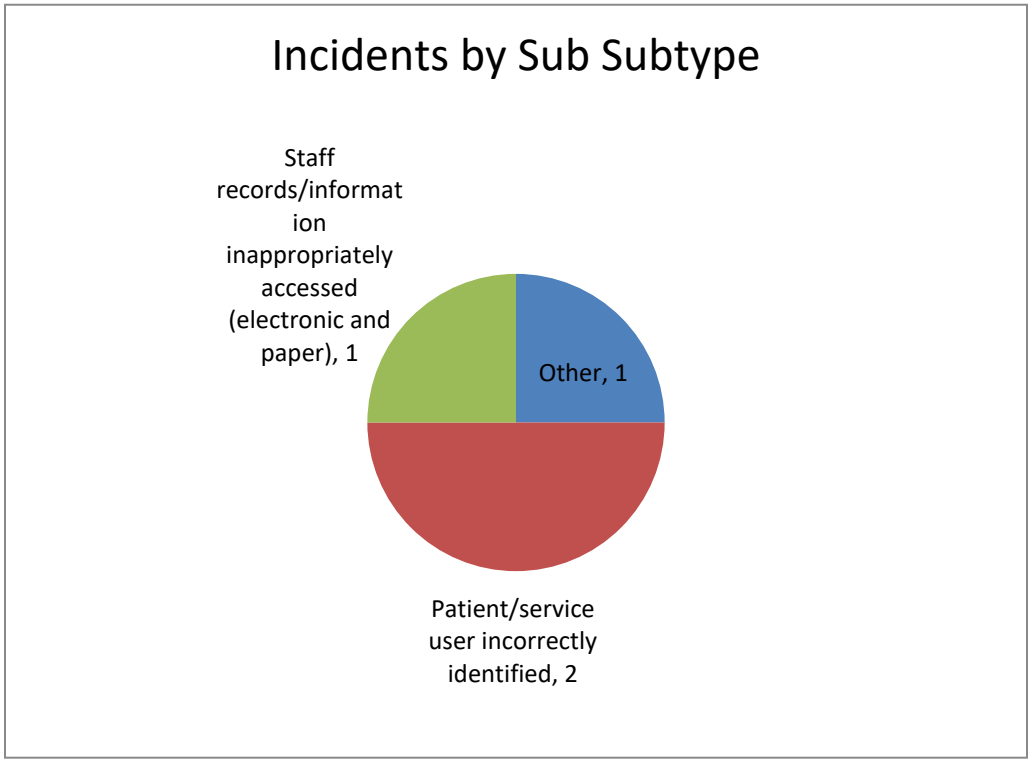
There has been a rise in the amount of incidents in the last three quarters (NB: The last report was only for the period Apr – May 21).

The reasons for this are many, the Head of IG took a snapshot view, consulting DATIX Administrators as well as forming an opinion based on data presented, these are assessed as follows:

- The new DATIX system (One for Wales) went live on 17 May 21, all incidents from 1 Apr 21 onwards have been uploaded.
- The addition of a button in the reporting software " Does this incident have IG Considerations?" may lead an individual to reporting an incident as IG whereas they may have not done so previously within Version 14.
- Reduced add on training as the Information Governance Manager departed Velindre in June 2021.
- DATIX Trainers have encouraged reporting of incidents even if unsure which may lead to an increase in reporting numbers over that previously within Version 14.

2.3 Welsh Blood Service

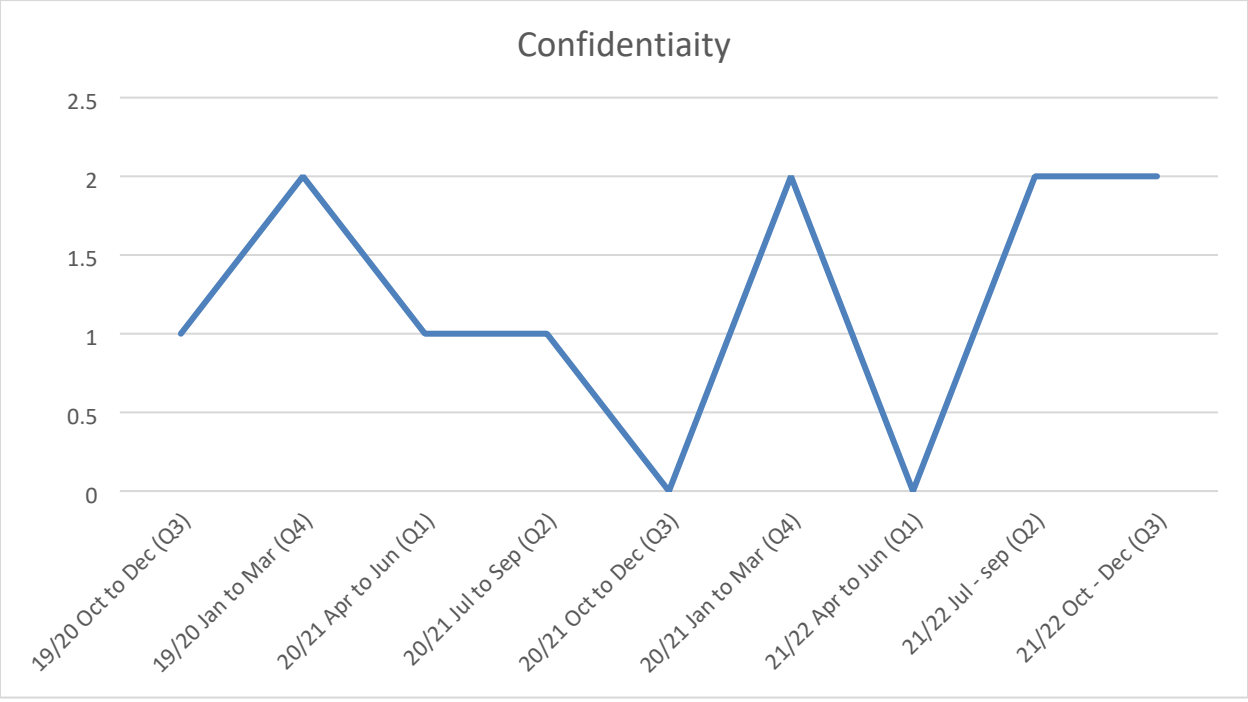
There were 4 IG incidents reported during the period. The are broken down as no incidents in Quarter 1, two in Quarter 2 and two in Quarter 3.



Category	No of Incidents	Theme
Patient/Service User incorrectly identified	2	Donor incorectly identified and incorrect details entered on the clinical records
		Incorect blood group recorded – historical error according to donor
Staff Records/Information inappropriately accessed	1	Unauthorised sharing of user login credentials – further investigation underway
Identification	1	Missing records subsequently found – no breach due to no use by any other user of the facility

WBS Trend Analysis

The chart below provides the EMB with a Trend Analysis of WBS IG reported incidents over the past two years.



Quarter	Incidents reported
19/20 Oct to Dec (Q3)	1
19/20 Jan to Mar (Q4)	2
20/21 Apr to Jun (Q1)	1
20/21 Jul to Sep (Q2)	1
20/21 Oct to Dec (Q3)	0
20/21 Jan to Mar (Q4)	2
21/22 Apr to Jun (Q1)	0
21/22 Jul - Sep (Q2)	2
21/22 Oct - Dec (Q3)	2

2.3 Lessons Learnt/Actions Taken

The incident of missing donation records appears to have been a simple case of paperwork being mislaid, it is important that Staff ensure that they keep records in one place regardless whether as to they are electronic or hard copy records. This incident was closed in July 2021.

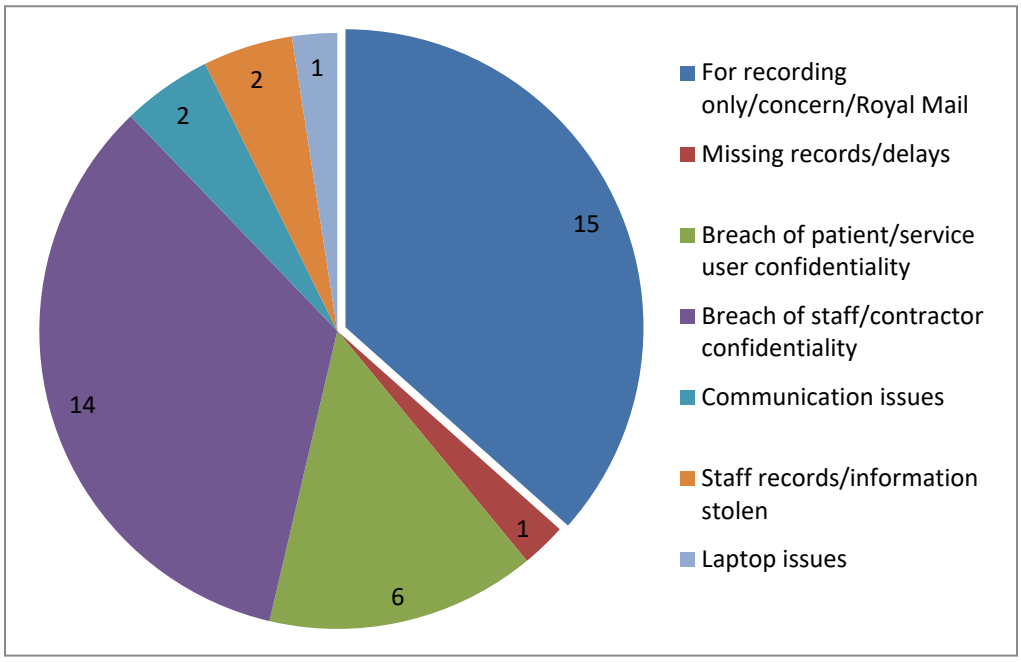
Unauthorised sharing of login details carries with it elevated risk. The requirement for each individual to access systems only using their own NADEX alongside Information Governance Training is recommended for all Staff on a risk-based basis. For this particular case, work is now complete with recommendation made to the line manager to prevent further incidents of this type.

It appears that the amount of incidents remains stable although Q1 of 2021/22 shows that no incidents were reported. There is a mean average of 2 incidents per quarter against an average of 1.14 incidents per quarter for the last 7 quarters.

The new Head of Information Governance started in the role on 29 Nov 21, due to activity that took priority, the backlog of IG incidents recorded in DATIX are under investigation, this includes WBS. Time has been put in the diary to address all queries as quickly as possible so that by the next Committee report all issues will have been resolved and where approproate any emergent issues escalated.

2.4 NHS Wales Shared Services Partnership

There have been in total 26 IG incidents reported during this period, and these are categorised as follows:



2.5 **Subject Access Requests for clinical information and requests from third parties**

During the Quarter 2 and 3 reporting period [Jun 21 – Nov 21 only] a total of 119 requests for access to health records were received. Further broken down into: -

Access to Health Records	Total
Type of SAR	
Data Protection (Live Patients)	97
Access to Health Records Act 1990 (Deceased Patients)	22
Total requests received	119
Requests from:	
Patients and/or relatives [on behalf of patients]	43
Solicitors	35
Trust Concerns Team	13
Other [incl. AHRA]	6
Total requests received	119
Timeframe Breached (Total number of responses issued outside the one month timeframe)	0

2.6 **Information Governance Training**

The effective delivery of healthcare services requires the substantial collection, processing and exchange of personal data. Ensuring the appropriate collection, use and security of this information is a major legal responsibility for healthcare organisations and individual healthcare workers within NHS Wales.

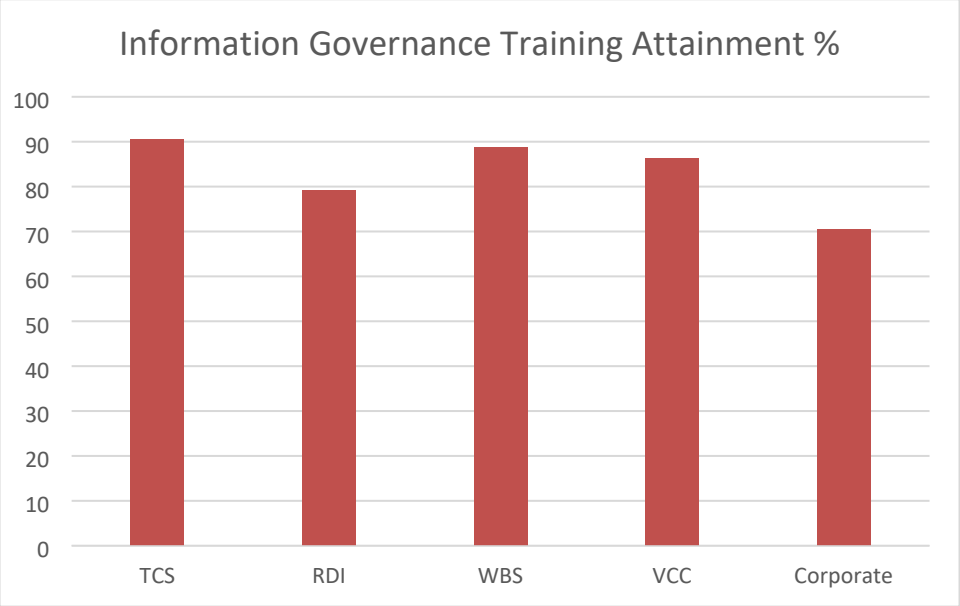
Information Governance training is mandatory and forms part of the wider Trusts Mandatory and Statutory Training Programme of work. All staff are required to undertake IG training, making them aware of their role and responsibilities, on a bi-annual basis. IG awareness also forms part of the Trust Induction Day.

To provide a solid basis for the future with the underlying theory that increased training and awareness will reduce incidents overall, discussions have already taken place with the Workforce Manager to re-fresh and re-invigorate training in relation to IG. The emphasis being on practical considerations due to remote working as a result of the Pandemic as well as traditional practices.

The ESR training package content is pre-pandemic in its delivery, it is currently at the level of post introduction of GDPR but pre-Brexit and COVID 19 Remote Working. The subject will be raised at IGMAG in Jan 2022, but it is understood that it is already being discussed at that forum.

Until ESR training provision is updated to reflect changes in day-to-day working the inclusion of Information Governance reflecting the “new normal” (including Cyber awareness) in induction and Staff update training will take place so that a positive IG culture is encouraged across the Trust. This aligns with a new initiative led by the Workforce Team so that Staff are at the centre of their own training. It is a case of bringing training to them, rather than taking time out of the diary disrupting operational activity. This approach allows more flexibility for hard pressed staff to be able to complete their training.

As of 30 Nov 21, IG training M&S compliance figures for associated services within the Trust:



Department	Information Governance Training Attainment %
TCS	90.48
RDI	79.17
WBS	88.67
VCC	86.24
Corporate	70.55

It should be noted that the target under the NHS Wales IG Toolkit is an attainment percentage rate of 50% or higher.

EMB have noted percentages in the lower areas where the attainment should be higher and will be addressing this over the coming Financial Year so that training attainment is raised by all divisions.

2.7 **National Intelligent Integrated Audit Solution (NIIAS)**

To undertake the proactive monitoring of staff access to clinical systems, Velindre has implemented the National Intelligent Integrated Auditing Solution (NIIAS). As a solution, NIIAS is currently used to monitor staff access to records held on a number of National systems, and specifically for Velindre, the organisation receives NIIAS notifications for the following national systems only: -

- Canisc
- Welsh Clinical Portal
- Welsh Demographic Service

Velindre receives monthly NIIAS usage reports.

The Head of IG received training on 6 Jan 22 and has been given an account. Reports are generated in arrears. There has been no access made to NIIAS in Oct – Dec 21. However, as the new incumbent in now in post it will be checked daily as it is expected that NIIAS is accessed daily with the following areas checked:

- Summary – Summary Page with the tiles on
- UsersBreachList – Page when a tile is accessed
- UserBreachList– Page when a user nadex is checked
- EventDetails – Page when a date/time of a notification is acessed
- PatientReport– Page when a patient notification is checked
- Workflow – Workflow page
- Search – Search Function page
- ReportBuilder2 – Report Builder page

A full report will be made at the next Committee meeting by which time the Head of IG will have conducted activity.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The loss or disclosure of personal information should be an important consideration for all staff on a day-to-day basis as it can seriously damage the Trust's reputation and undermine patients, donors and/or service user's trust.
RELATED HEALTHCARE STANDARD	Effective Care
	Standard 3.4 Information Governance and Communications Technology

EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The accidental or unlawful destruction, loss, alteration, unauthorised disclosure of, or access to, all personally identifiable data may lead to a breach of security and the noncompliance with Data Protection Legislation. Where there is an impact on the rights and freedoms to the Data Subject, this may be reportable to the ICO within 72 hours of the discovery of the breach. Unauthorised access to systems may also lead to further legal ramifications (Computer Misuse Act 1990)
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	In recent years the Information Commissioners Office powers have been strengthened including the power to impose financial penalties (fine of up to 20million euros) and issuing enforcement action. It should be noted that the ICO has launched its review of the Regulatory Action Policy which is due to close in March 2022. A watching brief will be kept and the Committee informed as appropriate, but there may be changes to the powers of the ICO as a result of the consultation.

4. Summary

Initial and short term analysis over four weeks (29 Nov 21 – 6 Jan 22) based on data presented has lead to an assessment that IG incidents have risen within the last three quarters across all areas. The reasons for the increase in incidents appear wide and varied, but on face value it appears likely that the core reasons are:

- Incorrect reporting by those reporting incidents.
- Transition from Version 14 of DATIX to the One for Wales version has added functionality (a new IG button which didn't exist previously).
- Increased reporting due to an active campaign by DATIX trainers encouraging reporting of incidents if unsure.

- Reduced add-on training in addition to the ESR training package.

In addition, there are areas in which standard processes in relation to IG activity are required to be re-freshed (see Appendix 1). The processes when followed logically, address risk, mitigate it where possible and report high risk appropriately.

It is hoped that the re-fresh of the following areas in Q4 2021/22 to Q1-3 2022/23 will lead to a positive impact across the Trust by the end of FY 2022/23:

The Executive Director of Finance will keep the Committee appraised of developments by continued reporting.

5. RECOMMENDATION

5.1 The Committee is asked to **Note** the contents of this report.

Item	Q4 2021/22	Q1 2022/23	Q2 2022/23	Q3 2022/23
Review time expired IG Policies/Equality Impact Assessments and republish	X			
Refresh Data Protection Impact Assessment (DPIA) Screening Process	X			
Review DPIA's in place across VCC	X			
Review DPIA's in place across WBS		X		
Review DPIA's in place across HQ			X	
Instigate and maintain annual review process for all DPIA's	X			
Instigate and maintain annual review process for all Data Processing Agreeements		X		
Maintain current Record of Processing Activity (ROPA) for all divisions of the Trust, cross referring to DPIA tracker appropropriately	X			
Create new Information Asset Register - reporting risks to SIRO annually and Corporate Governance as appropriate		X		
Ensure that the new Information Asset Register contains a risk treatment plan presenting the plan annually to the SIRO for his review		X		
Create and maintain a central register of Non-Disclosure Agreements		X		
Review all Subject Access Request (SAR) activity so that the Trust can be assured that it is compliant with Data Protection/FOI/EIR legislation	X	X	X	X
Review and re-publish the Standard Operating Procedure for FOIA	X			
Clear backlog of DATIX incidents	X			
Conduct reviews of DATIX incidents where IG is a factor – making recommendations and tailoring training proposals as appropriate	X	X	X	X
Re-fresh and re-invigorate IG Training via Teams (and when possible face-to-face) as well as via ESR incorporating lessons learned		X		
Regular reviews of training attainment on ESR to ensure that levels are as high as possible	X	X	X	X
Review historical and current data breaches incorporating trends in to recommendations and training provision with aim of reducing overall amount of incidents	X	X	X	X
2021/22 annual IG Toolkit to be completed by 31 Mar 22	X			
2022/23 annual IG Toolkit to be completed by 31 Mar 23				X


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

QUALITY, SAFETY & PERFORMANCE COMMITTEE

CYCLE OF BUSINESS – JANUARY 2022 DEFERRED REPORTS

DATE OF MEETING	20th January 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	N/A

PREPARED BY	Kyle Page, Business Support Officer
PRESENTED BY	Emma Stephens, Head of Corporate Governance
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**
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 report is to provide the Quality, Safety & Performance Committee with sight of the annual Cycle of Business (***Appendix A***), including reference to papers deferred from the January 2022 Committee agenda and rationale thereof.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

Due to the emergence of Wave #4 of the Coronovairus 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 meeting of the Quality, Safety & Performance Committee 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.

The annual cycle of Business is provided in ***Appendix A***.

Papers due to be received at the January Committee are detailed below:

*COVID Test Trace Protect (TTP) Cell Highlight Report **this is captured via COVID update item 001 and GOLD COMMAND Highlight Report, item 002*
Executive Director Nursing Update
Datix Project Highlight Report
Quality & Safety Framework
Freedom of Information Requests (IG & IM&T)
Radiation Protection Committee Highlight Report
Medical Devices Report
Medical Workforce Update
Medical Examiner's Service & Mortality Framework Report
Medical Education Governance Framework
Trust Operational Annual Plan 2021/2022 Q3 Progress Report

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 Cycle of Business and papers deferred from the January 2022 Committee.

Quality, Safety & Performance Committee Cycle of Business 2021-22 (commencing November 2021)

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- = Item of business previously received by Workforce & Organisational Development Committee
- = Item of business previously received by Planning & Performance Committee
- = Item of business previously received by Research, Development & Innovation Committee

Item of Business	Executive Lead	Author	Session	Reporting Frequency	Nov 2021	Jan 2022	Mar 2022	May 2022	Jul 22	Sep 2022
DONOR / PATIENT / STAFF STORY										
Welsh Blood Service Donor Story	Chief Operating Officer (Cath O'Brien)	Director of Welsh Blood Service (Alan Prosser)	Public	Every other meeting	✓		✓		✓	
Velindre Cancer Service Patient Story	Chief Operating Officer (Cath O'Brien)	Director of Velindre Cancer Service (Paul Wilkins)	Public	Every other meeting		✓		✓		✓
DIVISIONAL / DIRECTORATE REPORTS										
Welsh Blood Service Quality Safety & Performance Divisional Report	Chief Operating Officer (Cath O'Brien)	Director of Welsh Blood Service (Alan Prosser)	Public	Every other meeting	✓		✓		✓	
Velindre Cancer Service Quality Safety & Performance Divisional Report	Chief Operating Officer (Cath O'Brien)	Director of Velindre Cancer Service (Paul Wilkins)	Public	Every other meeting		✓		✓		✓
Digital Service Operational Report	Director of Transformation, Planning & Digital (Carl James)	Deputy Chief Digital Officer (Stuart Morris)	Public	Every other meeting	✓		✓		✓	
PERFORMANCE REPORTS										
Welsh Blood Service Performance Management Framework (PMF) Report	Chief Operating Officer (Cath O'Brien)	Director of Welsh Blood Service (Alan Prosser)	Public	Each Meeting	✓	✓	✓	✓	✓	✓
Velindre Cancer Service Performance Management Framework (PMF) Report	Chief Operating Officer (Cath O'Brien)	Director of Velindre Cancer Service (Paul Wilkins)	Public	Each Meeting	✓	✓	✓	✓	✓	✓
Workforce & Organisational Development Performance Management Framework (PMF) Report	Executive Director of OD & Workforce (Sarah Morley)	Deputy Director of Organisational Development (Susan Thomas)	Public	Each Meeting	✓	✓	✓	✓	✓	✓
Financial Report	Executive Director of Finance (Matthew Bunce)	(Matthew Bunce)	Public	Each Meeting	✓	✓	✓	✓	✓	✓

Item of Business	Executive Lead	Author	Session	Reporting Frequency	Nov 2021	Jan 2022	Mar 2022	May 2022	Jul 22	Sep 2022

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HIGHLIGHT REPORTS										
MEDICAL & RESEARCH DEVELOPMENT										
Highlight Report Medicines Management Group	Executive Medical Director (Jacinta Abraham)	Head of SACT and Medicines Management (Bethan Tranter)	Public	Bi Annually			✓			✓
RD&I Sub Committee Highlight Report	Executive Medical Director (Dr Jacinta Abraham)	Head of Research & Development (Sarah Townsend)	Public	Every other meeting	✓		✓		✓	
Medical Devices Report	Executive Medical Director (Jacinta Abraham)	Medical Physicist (Tim Register)/(Jignesh Raiyani)	Public	Bi Annually		✓			✓	
QUALITY & SAFETY										
Highlight Report from the Trust-wide Infection Prevention & Control Management Group	Executive Director of Nursing, AHPs and Health Scientists (Nicola Williams)	Senior Nurse – Infection Prevention & Control (Hayley Jeffreys)	Public	Every other meeting	✓		✓		✓	
Highlight Report from the Trust-wide Safeguarding & Public Protection Management Group (S&PPMG)	Executive Director of Nursing, AHPs and Health Scientists (Nicola Williams)	Senior Nurse Safeguarding & Public Protection (Tina Jenkins)	Public	Every other meeting	✓		✓		✓	
Highlight Report from the Trust-wide Patient Safety Alerts Group (PSAG)	Executive Director of Nursing, AHPs and Health Scientists (Nicola Williams)	Quality & Safety Manager (Lisa Heydon)	Public	Every other meeting	✓		✓		✓	
Datix Highlight Report	Executive Director of Nursing, AHPs and Health Scientists (Nicola Williams)	Quality & Safety Manager (Lisa Heydon)	Public	Bi Annually		✓			✓	
Infected Blood Inquiry Proceedings	Chief Operating Officer (Cath O'Brien)	Business Support Officer (Suzanne Jones)	Public	Quarterly	✓		✓		✓	
Putting Things Right Report (inc. Incidents, Sis & Complaints)	Executive Director of Nursing, AHPs and Health Scientists (Nicola Williams)	Quality & Safety Manager (Lisa Heydon)	Public	Quarterly	✓		✓		✓	
Quality & Safety Framework	Executive Director of Nursing, AHPs and Health Scientists (Nicola Williams)	Executive Director of Nursing, AHPs and Health Scientists (Nicola Williams)	Public	TBC		✓				
Radiation Protection Committee Highlight Report	Executive Medical Director (Jacinta Abraham)	Head of Radiation Services (Kathy Ikin)	Public	Bi Annually		✓			✓	
Item of Business	**Executive Lead**	**Author**	**Session**	**Reporting Frequency**	Nov 2021	Jan 2022	Mar 2022	May 2022	Jul 2022	Sep 2022

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Medical Examiner's Service & Mortality Framework Report	Executive Medical Director (Jacinta Abraham)	Head of Radiation Services (Kathy Ikin)	Public	Bi Annually		✓			✓	
STRATEGIC TRANSFORMATION, PLANNING & ESTATES										
Highlight Report from the Trust Estates Assurance Group	Director of Strategic Transformation, Planning and Digital (Carl James)	Assistant Director of Estates, Environment & Capital Development (Jason Hoskins)	Public	Every other meeting	✓		✓		✓	
Transforming Cancer Services (TCS) Programme Scrutiny Sub Committee Highlight Report	Director of Strategic Transformation, Planning and Digital	Jessica Corrigan (Business Support Officer)	Public & Private	Each meeting	✓	✓	✓	✓	✓	✓
WORKFORCE										
ANNUAL REPORTS										
Medical Education Governance Framework	Executive Medical Director (Dr Jacinta Abraham)	Interim Medical Business Manager (Nicola Hughes) Louise Hanna	Public	Annually						✓ Annual Report
Annual Assurance Report from the Medical Gas Group (MGG)	Executive Medical Director (Dr Jacinta Abraham)	Head of SACT and Medicines Management (Bethan Tranter)	Public	Annually				✓		
Trust Clinical Audit Annual Report	Executive Medical Director (Dr Jacinta Abraham)	Sara Walters/Peter Richardson (Clinical Audit Manager/Head of Quality Assurance)	Public	Annually					✓	
Trust Clinical Audit Plan	Executive Medical Director (Dr Jacinta Abraham)	Sara Walters/Peter Richardson (Clinical Audit Manager/Head of Quality Assurance)	Public	Annually		✓				
Consent audit report and compliance with the NHS Wales Consent policy	Executive Director of Nursing, AHPs and Health Scientists (Nicola Williams)	Deputy Director of Nursing, Quality & Patient Experience (Nigel Downes)	Public	Annually (TBC)						
Trust-wide Nurse Staffing Levels (Wales) Act 2016 Annual Report	Executive Director of Nursing, AHPs and Health Scientists (Nicola Williams)	Viv Cooper (Head of Nursing)	Public	Annually				✓		
Annual Quality Statement	Executive Director of Nursing, AHPs and Health Scientists (Nicola Williams)	Quality & Safety Manager (Lisa Heydon)	Public	Annually			✓ (first draft)	✓ (final draft)		
Item of Business	**Executive Lead**	**Author**	**Session**	**Reporting Frequency**	Nov 2021	Jan 2022	Mar 2022	May 2022	Jul 2022	Sep 2022
Infection Prevention & Control Annual Report	Executive Director of Nursing, AHPs and Health Scientists	Senior Nurse – Infection Prevention Control	Public	Annually						✓

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	(Nicola Williams)	(Karen Jones replacement)								
Safeguarding & Public Protection Annual Report	Executive Director of Nursing, AHPs and Health Scientists (Nicola Williams)	Senior Nurse – Safeguarding & Public Protection (Tina Jenkins)	Public	Annually					✓	
Putting Things Right Annual Report	Executive Director of Nursing, AHPs and Health Scientists (Nicola Williams)	Quality & Safety Manager (Lisa Heydon)	Public	Annually					✓	
Annual Performance Report	Director of Strategic Transformation, Planning, Performance and Estates (Carl James)	Assistant Director of Planning and Performance (Jason Hoskins)	Public	Annually			✓ (first draft)	✓ (final draft)		
Annual Estates Update	Director of Strategic Transformation, Planning, Performance and Estates (Carl James)	Assistant Director of Environmental, Estates and Capital Development (Jason Hoskins)	Public	Annually						✓
Annual Sustainability Report	Director of Strategic Transformation, Planning, Performance and Estates (Carl James)	Assistant Director of Environmental, Estates and Capital Development (Jason Hoskins)	Public	Annually			✓ (first draft)	✓ (final draft)		
Health & Safety Annual Report	Director of Strategic Transformation, Planning, Performance and Estates (Carl James)	Health & Safety Manager (Helen Jones)	Public	Annually						✓
Local Partnership Forum Annual Report	Executive Director of OD & Workforce (Sarah Morley)	Deputy Director of OD & Workforce (Susan Thomas)	Public	Annually			✓			
Medical Workforce Update	Executive Medical Director (Dr Jacinta Abraham)	Deputy Director of OD & Workforce (Susan Thomas)	Public	Annually						✓
Trust Travel Survey	Director of Strategic Transformation, Planning, Performance and Estates (Carl James)	Assistant Director of Environmental, Estates and Capital Development (Jason Hoskins)	Public	Annually						✓
Welsh Language Annual Report	Executive Director of OD & Workforce (Sarah Morley)	Deputy Director of OD & Workforce (Susan Thomas)	Public	Annually						✓
Gender Pay Gap Report	Executive Director of OD & Workforce (Sarah Morley)	Deputy Director of OD & Workforce (Susan Thomas)	Public	Annually						✓
Item of Business	**Executive Lead**	**Author**	**Session**	**Reporting Frequency**	Nov 2021	Jan 2022	Mar 2022	May 2022	Jul 2022	Sep 2022
Patient & Donor Experience Annual Report	Chief Operating Officer (Cath O'Brien)	Director of VCC & WBS (Paul Wilkins/Alan Prosser)	Public	Annually	✓					
Annual Report from the Controlled Drugs	Andrea Hague (Director of Transformation)	Bethan Tranter	Public	Annually				✓		

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Accountable Officer		(Head of SACT and Medicines Management)								
Committee Annual Report for Trust Board	Director of Corporate Governance and Chief of staff (Lauren Fear)	Head of Corporate Governance (Emma Stephens)	Public	Annually	✓					
INCIDENTS AND CLAIMS REPORTS										
Review of Information Governance Incidents and Trends	Executive Director of Finance (Matthew Bunce)	Head of Information Governance Ian Bevan	Public	Every other meeting	✓		✓		✓	
Review of Integrated Governance Toolkit	Executive Director of Finance (Matthew Bunce)	Head of Information Governance Ian Bevan	Public	Annually				✓		
Quarterly Claims Report	Executive Director of Nursing, AHPs and Health Scientists (Nicola Williams)	Quality & Safety Manager (Lisa Heydon)	Private	Every other meeting	✓		✓		✓	
PROFESSIONAL REGULATION										
Professional Registration/Revalidation	Executive Medical Director (Jacinta Abraham)/ Executive Director of Nursing, AHPs & Health Sciences (Nicola Williams)	Nicola Hughes/TBC	Public	Annually				✓		
Professional Nursing Update Report	Executive Director of Nursing, AHPs & Health Sciences (Nicola Williams)	Senior Nurse Professional Standards & Digital (Anna Harries)/Business Support Officer (Kyle Page)	Public	Bi Annually		✓			✓	
INTEGRATED GOVERNANCE										
Health Care Standards Self-Assessment Action Plan / Improvement Plan	Executive Director of Nursing, AHPs & Health Scientists (Nicola Williams)	Quality & Safety Manager (Lisa Heydon)	Public	Bi Annually	✓		✓			✓
Trust Risk Register	Director of Corporate Governance & Chief of Staff (Lauren Fear)	(TBC)	Public	Each meeting	✓	✓	✓	✓	✓	✓
Freedom of Information Requests (IG & IM&T)	Director of Corporate Governance & Chief of Staff (Lauren Fear)	Communication and Compliance Officer (Julie Mann)	Public	Bi Annually		✓			✓	
Item of Business	**Executive Lead**	**Author**	**Session**	**Reporting Frequency**	Nov 2021	Jan 2022	Mar 2022	May 2022	Jul 2022	Sep 2022
Trust-wide policies and procedures for approval	Executive Policy Lead (various)	Policy Lead (various)	Public	Each meeting (as required)	✓	✓	✓	✓	✓	✓
Trust-wide policies and	Director of Corporate Governance & Chief of Staff (Lauren Fear)	Head of Corporate Governance (Emma Stephens)	Public	Bi Annually			✓			✓

Quality, Safety & Performance Committee Cycle of Business 2021-22 (commencing November 2021)

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procedures report										
COMMITTEE EFFECTIVENESS										
Committee Terms of Reference and Operating Arrangements	Director of Corporate Governance & Chief of Staff (Lauren Fear)	Head of Corporate Governance (Emma Stephens)	Public	Annually	✓					
Committee Cycle of Business	Director of Corporate Governance & Chief of Staff (Lauren Fear)	Head of Corporate Governance (Emma Stephens)	Public	Annually	✓					
Committee Effectiveness Survey Report	Director of Corporate Governance & Chief of Staff (Lauren Fear)	Head of Corporate Governance (Emma Stephens)	Public	Annually	✓					
COVID-19										
Test, Trace & Protect Cell Highlight Report	Executive Medical Director (Jacinta Abraham)	Programme Manager (Andrew Owen)	Public	Each Meeting	✓	✓	✓	✓	✓	✓
COVID Vaccination Programme/Cell Highlight Report	Executive Director of Nursing, AHPs & Health Scientists (Nicola Williams)	Business Support Officer (Kyle Page)	Public	Each Meeting	✓	✓	✓	✓	✓	✓

QUALITY, SAFETY & PERFORMANCE COMMITTEE

(CIVAS@IP5)

DATE OF MEETING	20/01/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Choose an item.

PREPARED BY	GARETH TYRRELL – HEAD OF TECHNICAL SERVICES - CIVAS@IP5
PRESENTED BY	GARETH TYRRELL
EXECUTIVE SPONSOR APPROVED	LAUREN FEAR, DIRECTOR CORPORATE GOVERNANCE & CHIEF OF STAFF

REPORT PURPOSE	FOR NOTING

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

ACRONYMS	
CIVAS	Centralised Intravenous Additives Service
IP5	Imperial Park Building No.5, Celtic Way, Newport, NP10 8BE
TMU	Temporary Medicines Unit

GMP	Good manufacturing Practice https://ec.europa.eu/health/documents/eudralex/vol-4_en
GDP	Good Distribution Practice https://ec.europa.eu/health/documents/eudralex/vol-4_en
MHRA	Medicines and Healthcare products Regulatory Agency
MS	MHRA Manufacturers' "Specials" license
WDA	MHRA Wholesale Distribution Authorisation

1. SITUATION/BACKGROUND

1.1 Health Boards in Wales have increased the number of Intensive Care beds as part of contingency planning for the COVID 19 pandemic. Welsh Government has anticipated increased demand for intravenous infusions as a result of this expansion and established a Temporary Manufacturing Unit (TMU) to supplement existing UHB CIVAS capacity. The staff and non-staff costs were initially funded to 31/3/21. In January 2021, Welsh Government confirmed extension of funding to 31/3/23. Welsh Government advised that "Temporary" should be removed from the name of the unit. The alternative name CIVAS@IP5 has been adopted. The necessary variations to HO and MHRA licences will be made to change the name, in the meantime both the names TMU and CIVAS@IP5 will be used as appropriate.

1.2 The TMU application for General Pharmaceutical Council (GPhC) Premises registration was accepted in June 2020. The GPhC registration was required for cross boundary supply of medicines under Section 10 Exemption From the medicines Act (1968), pending MHRA license application. The TMU has obtained Home office Domestic Controlled Drugs license, MHRA Manufacturers' "specials" license (MS) and Wholesale Distribution Authorisation (WDA). Following the award of MHRA MS licenses, the GPhC Premises registration is no longer required. A Voluntary Withdrawal of GPhC Premises registration application has been made and accepted.

1.3 The CIVAS@IP5 service has prepared over 16000 doses of ready to administer intravenous infusions, which have been supplied to each of the health boards to support critical care during the COVID-19 Pandemic

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 January sees the CIVAS@IP5 unit having been open and licenced by the MHRA for 12 months.

2.2 Attached to this document is the CIVAS@IP5 Service Board Report for Q3. This report identifies the following

- Performance metrics for operational output
- Regulatory performance against EU GMP
- Service development progress

2.3 Operational output has fluctuated, largely as a result of staff shortages resulting from sickness and loss to other sectors, it is anticipated that all posts be recruited into by end Jan 2022.

2.4 Production output and yield is above 95% (industry and NHS standard) despite capacity pressures

2.5 Wholesale dealing of Rixathon continues to provide cost savings across Wales and the development of a ready-to-administer product from CIVAS@IP5 will support clinical and financial pressures further

2.6 CIVAS@IP5 has packed down under the MHRA Specials Licenced just over 150000 vaccine doses to support booster roll out, with a projection of >200000 by the end of Jan 2022.

2.7 Regulatory performance shows excellent adherence to expected EU GMP guidance, and initial MHRA feedback regarding the Quality Management System is further evidence of regulatory compliance

2.8 Current service developments are:

- Development of additional Noradrenaline strength syringe for critical care
- Standardised Potassium Chloride syringe (50mmol in 50mL)
- Rituximab dose banded infusions provided in ready to use format
- Calcium Folinate infusions provided in ready to use format
- Procurement of semi-automated device for preparation of insulin syringes and OPAT pilot

2.9 As well as the regulatory, compliance and assurance framework for the activity itself, it was also important to consider the wider quality governance framework in which this part of the NWSSP model operates in. To support consideration of this, appendix one was compiled which outlines, from various internal and external sources, key elements which make up an Organisational quality governance framework. The right-hand column then articulates how TMU and NWSSP fulfill these elements. The document has been previously discussed and approved in advance of the Committee with Medical Director NWSSP, Executive Medical Director Velindre University NHS Trust and Executive Director of Nursing, AHPs and Health Science.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
	The CIVAS@IP5 was specifically commissioned to ensure equality of access to medicines by supplementing existing aseptic manufacturing capacity.
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	CIVAS@IP5 is operating in compliance with relevant legislation, specifically the Medicines Act (1968), The Human medicines regulations (2012) and the misuse of Drugs act (1971)
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Welsh Government has confirmed continuing funding of revenues for the project to 31/3/23.

4. RECOMMENDATION

4.1 The Quality, Safety and Performance Committee is asked to **note** current levels of service performance against the framework of standards set out in EU GMP and which we are legally required to comply with as an MHRA “Specials” and Wholesale Dealer licence holder. Further update on new products introduced into the CIVAS@IP5 portfolio will be provided in future meetings.

Appendix - TMU Governance Arrangements – notes

1.1	Quality as drive for organisational strategy	Quality and safety priorities clearly defined, documented and periodically reviewed	CIVAS@IP5 operates in compliance with Good Manufacturing Practice (GMP) and Good Distribution Practice (GDP) these internationally recognised standards designed to ensure safe manufacturing, storage and distribution of medicines are clearly defined: https://ec.europa.eu/health/documents/eudralex/vol-4_en https://ec.europa.eu/health/human-use/good_manufacturing_distribution_practices_en The facility and its operation are clearly defined in the CIVAS@IP5 site master file and in standard operating procedures. The CIVAS@IP5 was inspected by the MHRA against GMP and GDP on 15-16th December 2020, AND FOR PACK DOWN OF covid VACCINES ON THR 6TH Sept 2021. All newly licensed manufacturing units are inspected within 12 months of the first inspection a further inspection is anticipated in December 2021. The CIVAS@IP5 will be inspected against GMP and GDP on behalf of WG and the Welsh Chief Pharmacists Group by the All Wales QA Pharmacist during 2021.
1.2		These priorities are reflected in organisation's IMTP	The CIVAS@IP5 development is fully supported by the Shared Service Partnership Committee and Welsh Government. The Minister has provided funding for the TMU project in response to COVID requirements and

			continuity of supply. It is also integral to supporting the COVID vaccination Programme. Given the success and future potential additional funding has been provided by the Minister for a further two-year period and it will form part of the next iteration of the NWSSP IMTP which is due to be agreed by the NWSSP Committee in March 2021.
1.3		Quality and safety strategic risks are reflected in Board Assurance Framework	The CIVAS@IP5 Board Agenda includes an agenda item on project risk. Any significant quality and safety risks will be also highlighted and discussed at the Shared Service Partnership Committee and the NWSSP Senior Leadership Team as part of the normal operational management and reporting within NWSSP. A separate paper outlines the proposed addition of NWSSP business, including CIVAS@IP5, into the Velindre University NHS Trust Quality, Safety & Performance Committee going forwards, the agenda will include a section on associated risks.
1.4		Quality and safety risks central in the risk management strategy and processes of the organisation	Quality and Safety is integral to GMP and GDP quality improvement and quality by design are inherent within the approach to processes within CIVAS@IP5. As above in terms of reporting risks within NWSSP and to the NWSSP part of the Velindre University NHS Trust Quality, Safety & Performance Committee if approved.
2.1	Leadership of quality and safety	Collective responsibility for quality and patient safety across the	The CIVAS@IP5 lines of accountability are clearly defined. There are clearly defined professional roles.

		executive team and clearly defined roles for professional leads	The CIVAS@IP5 Head of Technical Services now reports to the NWSSP Service Director for TrAMS managerially and to the Chief Pharmaceutical Advisor to WG professionally. The CIVAS@IP5 Head of Technical Services also reports to the Service Board, which in turn reports to the Shared Services Partnership Committee. The CIVAS@IP5 Head of Technical Services is the Superintendent Pharmacist for the CIVAS@IP5 General Pharmaceutical Council Premises Registration, and the Site lead, and Person Responsible for Security on the Home Office Domestic Controlled Drugs license. A suitably qualified and experienced individual is employed in the Accountable Pharmacist role. A new accountable pharmacist has been appointed to take over from the incumbent's retirement. The QA and Production Leads report to the CIVAS@IP5 Head of Technical Services. The QA and Production lead are named on the MHRA Manufacturers' "specials" (MS) license as being responsible for Quality and Production respectively. The QA lead is the named Responsible Person on the MHRA Wholesale Distribution Authorisation (WDA). All staff working in the CIVAS@IP5 will be formally engaged to job roles within NWSSP, to ensure

			accountability for the work undertaken. These engagements will be a mixture of: • Honorary Secondments of staff already employed by Health Board or Trust Pharmacy units • Bank Staff engagements • Permanent or where appropriate temporary employment contract All staff have a quality element to their role and an understanding of quality assurance of the operation of the service.
2.2		There is sufficient capacity and support, at corporate and directorate level, dedicated to quality and safety	The CIVAS@IP5 board provides scrutiny of safety, quality and performance and of the service. The board also provides strategic and operational support. The board has met monthly since the service was envisaged in April 2020. The capacity of the board to carry out the oversight and support roles is evidence by the successful MHRA license applications and service delivery, respectively, within the projected project timescales. All health boards through the support of Chief Pharmacists have helped support the creation of the TMU and they are fully supportive and committed to the Unit. NWSSP is about collaboration and support service provision.
3.1	Organisational scrutiny of quality and patient safety	The roles and function of the Quality and Safety Committee is fit	It is proposed that the following are submitted to the Quality and safety Committee

		for purpose and reflects the Quality Strategy, Quality and Safety Governance Framework and key corporate risks for quality and safety	• Annual Quality Statement • Inspection reports (as and when received) • MHRA Update/Action plan
3.2		Independent/Non-Executive Members are appropriately supported to meet their responsibilities through the provision of an adequate induction programme and ongoing development so they can effectively scrutinise the information presented to them	A separate paper outlines the proposed addition of NWSSP business, including CIVAS@IP5, into the Velindre University NHS Trust Quality, Safety & Performance Committee going forwards. Regular updates will be provided as part of the normal course of business to the Shared Service Partnership Committee, which includes representatives from every NHS organisation as the responsible body for shared services.
4.0	Clinical Audit	There is visibility and oversight of clinical audit and improvement activities across divisions/groups/directorates and at corporate level. This includes identification of outliers and maximising opportunities for sharing good practice and learning	The CIVAS@IP5 service is a professional technical service whereby all clinical decisions are made by health board clinicians and not the CIVAS@IP5 staff. The unit is an accredited production unit which has a self-inspection programme for GMP and GDP. The unit is independently inspected by the All Wales QA Pharmacist. Best practice is shared through the Welsh Chief Pharmacists Group's pharmacy technical services sub-group (CPTS) and lessons learned from the development of the TMU have been captured. A number of senior health board technical pharmacy staff have been

			involved in putting in place the quality and operating procedures.
5.1	Organisation promotes a quality and safety focused culture	Organisational values and behaviours support a quality and safety focused culture	The organisational structure of CIVAS@IP5 is designed to ensure adequate supervision of all processes. All grades of staff are empowered and supported in identifying process deviations. The service will operate in line with the values and culture of NWSSP
5.2		Organisation actively participating in quality improvement initiatives	The service has a robust Corrective Action/Preventative Action (CAPA) system built into it's Pharmaceutical Quality System (PQS). This ensures lessons are learnt and appropriate actions taken, within an appropriate timescale. The CAPA system also ensure continuous quality improvement.
5.3		Organisation takes steps to listen to staff and involve them in monitoring service change/improvement	All grades of staff are empowered and supported in identifying process deviations, during manufacturing process or at daily pre and post manufacturing session meetings. Feedback is provided on issues raised.
5.4		Strong culture of learning lessons from staff feedback or concerns	The CAPA system is an essential component of the Pharmaceutical Quality system. Staff training encompasses the PQS and the role of team members in its operation. The management recognise the importance of responding appropriately to staff concerns and providing feedback.

5.5		Quality and safety an integral part of workforce management processes	Quality and safety are pre-requisites for compliance with GMP and GDP
6.1	Organisational structures and processes support delivery of high-quality, safe and effective services	Clear lines of accountability for quality and patient safety across the organisational structure ie 'floor to Board'	Included as point 9 of PQS in Internal Assurance section
6.2		Effective corporate and operational controls to support delivery of high-quality and safe services	Operational controls in PQS in Internal Assurance section Current corporate and operational controls have been extended to cover the operation in line with existing processes. Once fully established the Q&S Committee for Shared Services will also provide an additional level of assurance for NWSSP Committee members
6.3		The oversight and governance of DATIX and other risk management systems ensures they are used as an effective management and learning tool. This should also include triangulation of information in relation to concerns, at a divisional/group/ directorate or corporate level, and formal mechanisms to identify and share learning	The DATIX is used to report clinical incidents and health and safety incidents. It is recognised that the DATIX system does not have the level of detail in classification of incidents for a CAPA system which meets the expectation of the MHRA. The Q-Pulse system is therefore used in addition to DATIX for management of CAPA and other components of the PQS. Complaints will be managed through Q-Pulse, the NWSSP Complaints Management Protocol and if these relate to product quality and or patient safety the MHRA's Defective Medicines Report Centre (DMRC). There is a Recall Procedure, the effectiveness of which is tested annually.

6.4		Enough resource and expertise to support and improve quality governance arrangements	The CIVAS@IP5 Head of Technical Services is an appropriately qualified and experienced Pharmacist. The CIVAS@IP5 Head of Technical Services is supported by QA lead, Production Lead and Production Managers with the necessary qualifications, skills and experience. The senior team is supported by a workforce designed, recruited and trained specifically for the operation of the service. The team has a clear understanding of their required contribution to the PQS. Capacity planning carried out as part of workforce design has ensured that the PQS is appropriately resourced.
6.5		Organisation has comprehensive and timely information for monitoring and reporting on quality and safety	Q-pulse is used to manage the PQS. This system is used to record, monitor and report on information relevant to the PQS: CAPA, facilities and equipment, customer, suppliers, external audit and self-inspection, The working environment is monitored by the team. End of batch tryptone soya broth fills are carried out at the end of each manufacturing batch. Public Health Wales provides Microbiological services, including incubation, species level identification and reporting for the environmental monitoring and end of batch testing. Finished product is quarantined pending confirmation of satisfactory environmental and end batch testing data.

6.6		Quality and patient safety receives effective coverage at both corporate and operational management meetings	The Board receives and reviews a monthly operational report, which includes both quality, safety and operational performance.

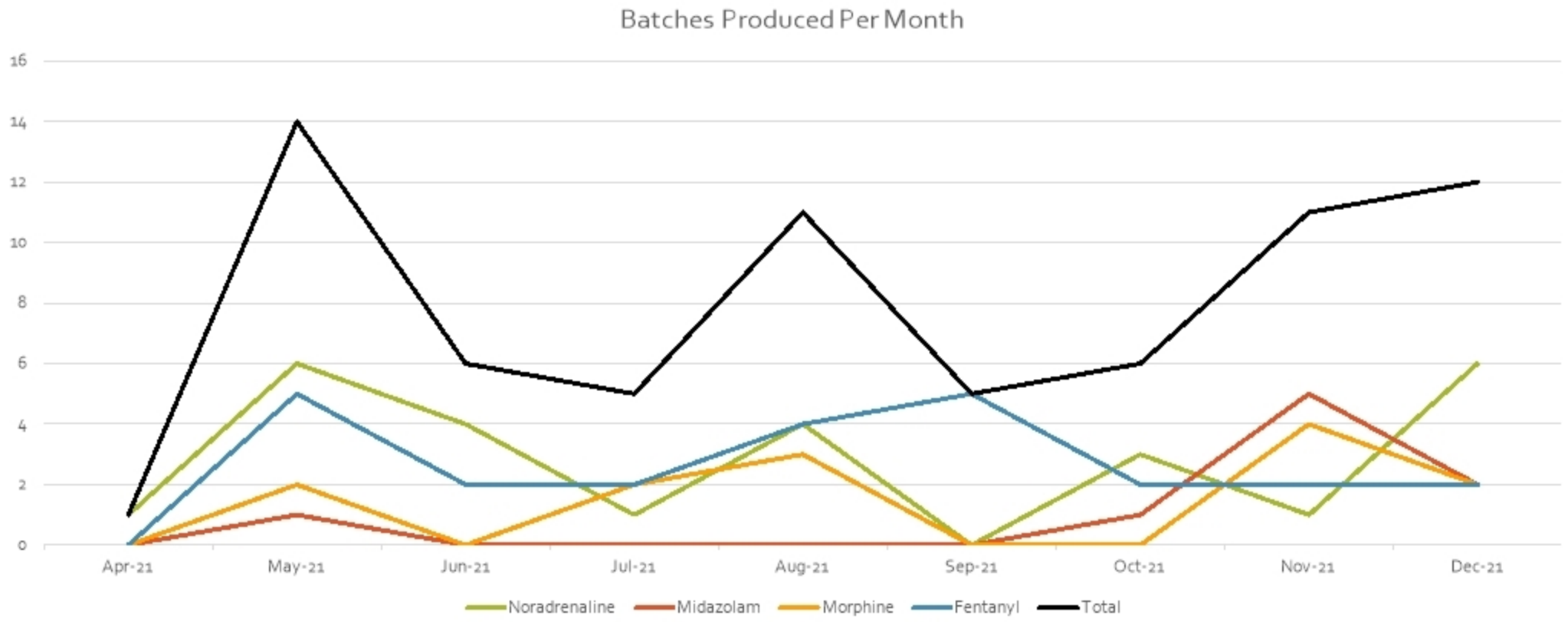
CIVAS@IP5 SERVICE BOARD

Performance Report
October 2021

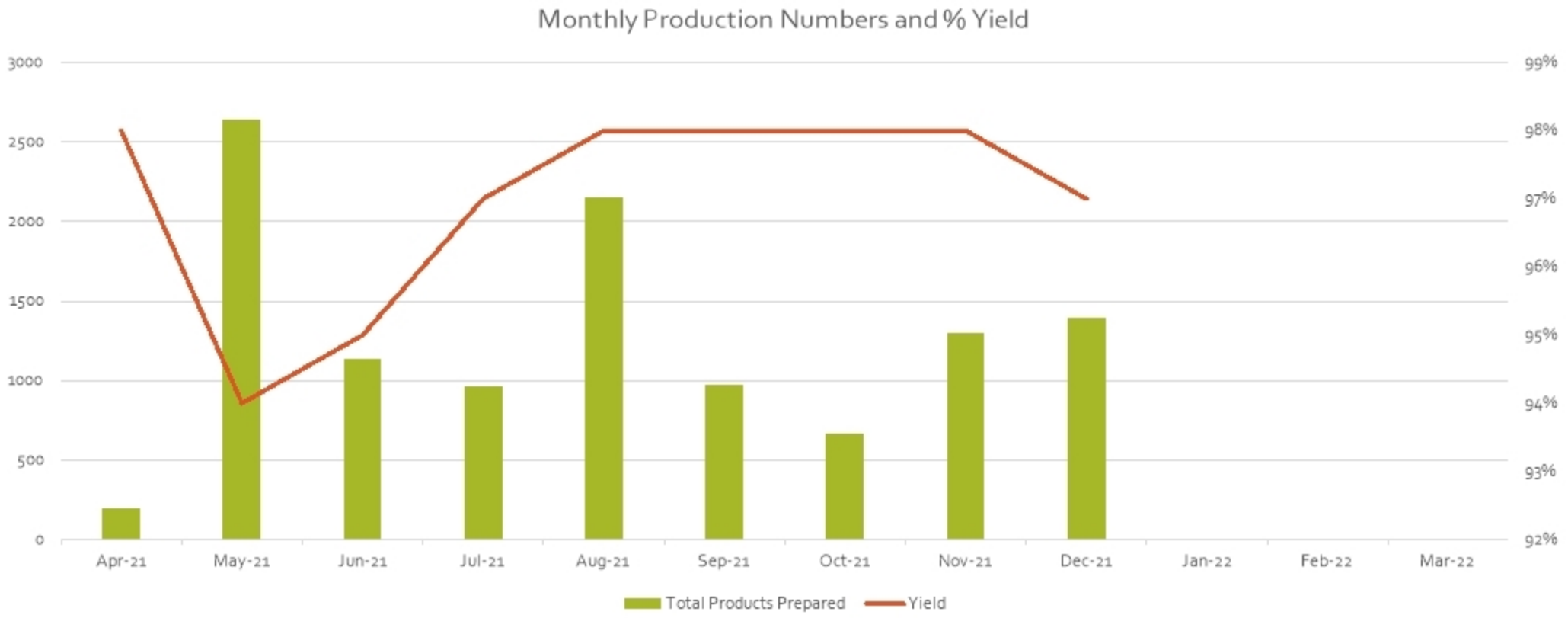
Content

- Service Performance Metrics
- Quality Metrics
- Service Summary
- Questions

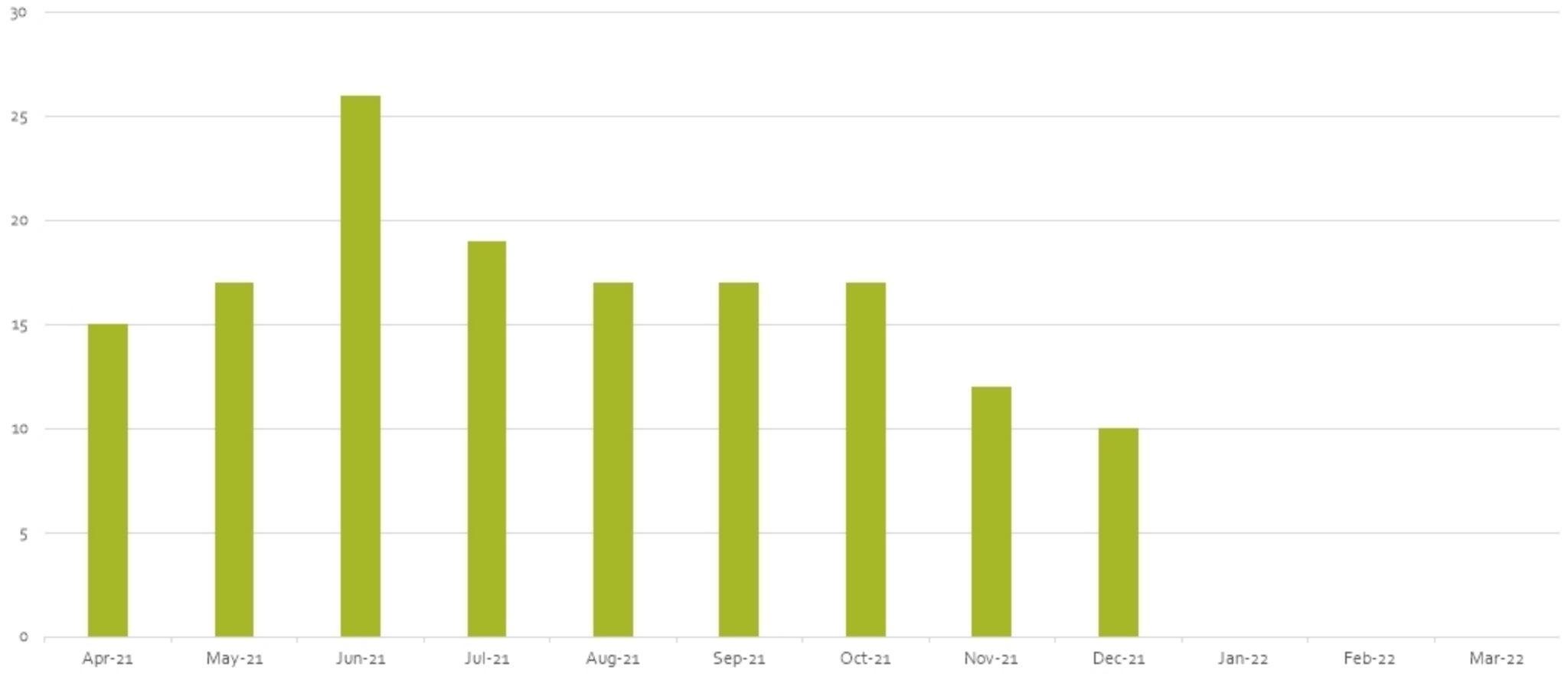
Batch Production



Total Production & % Yield Performance



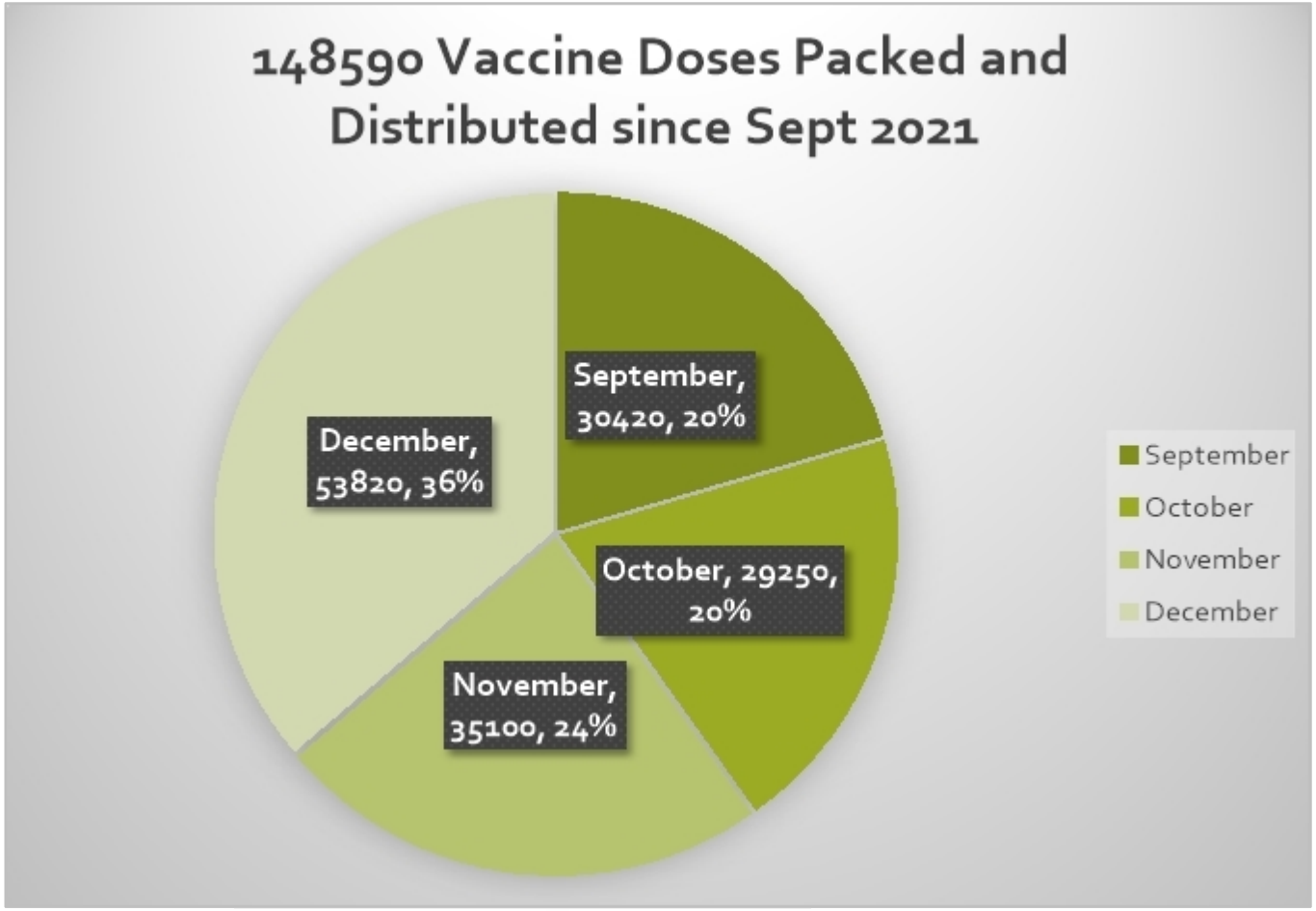
UHB Orders Received



Rixathon WDA Service

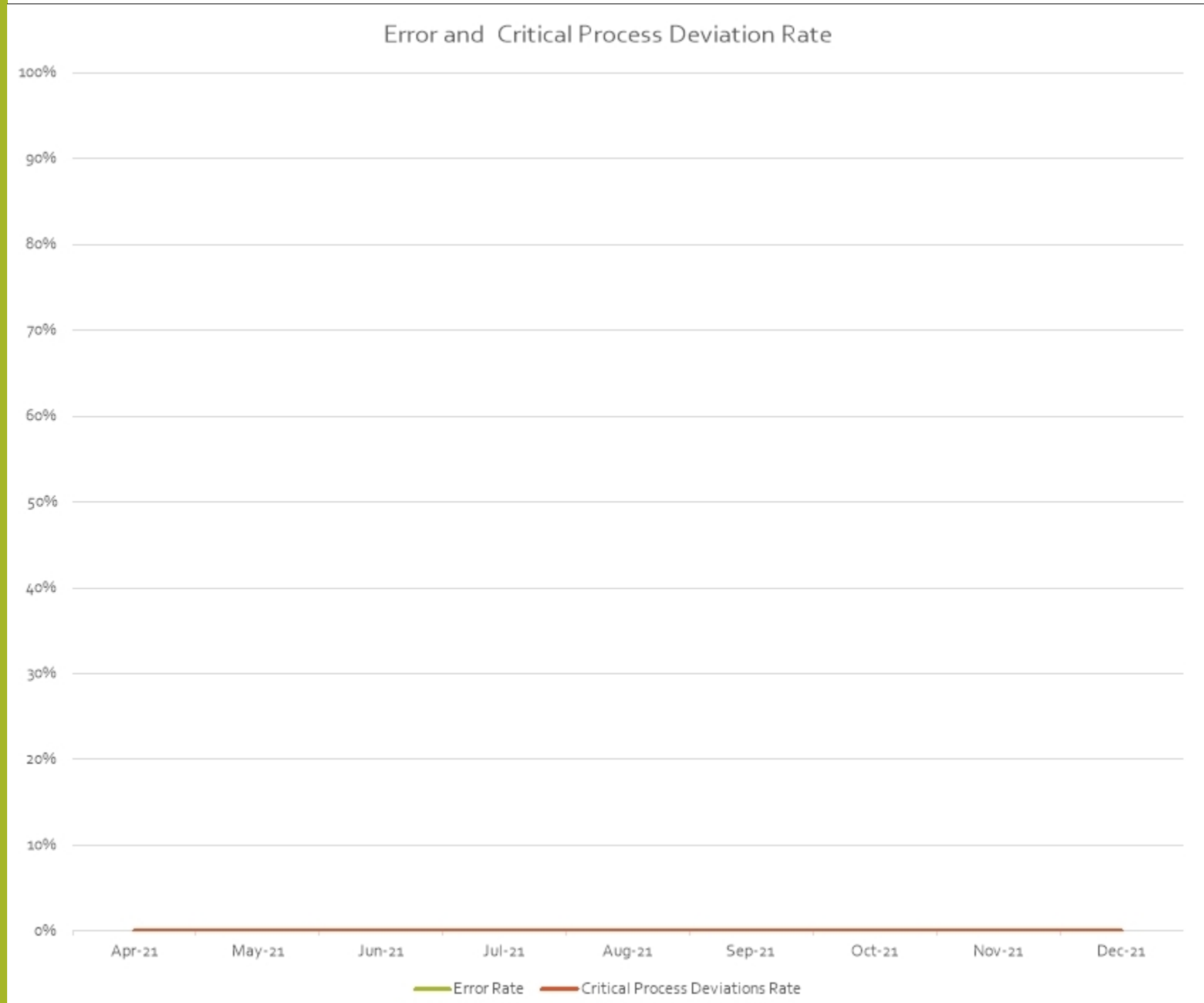
COVID-19 Vaccine Booster Pack Down

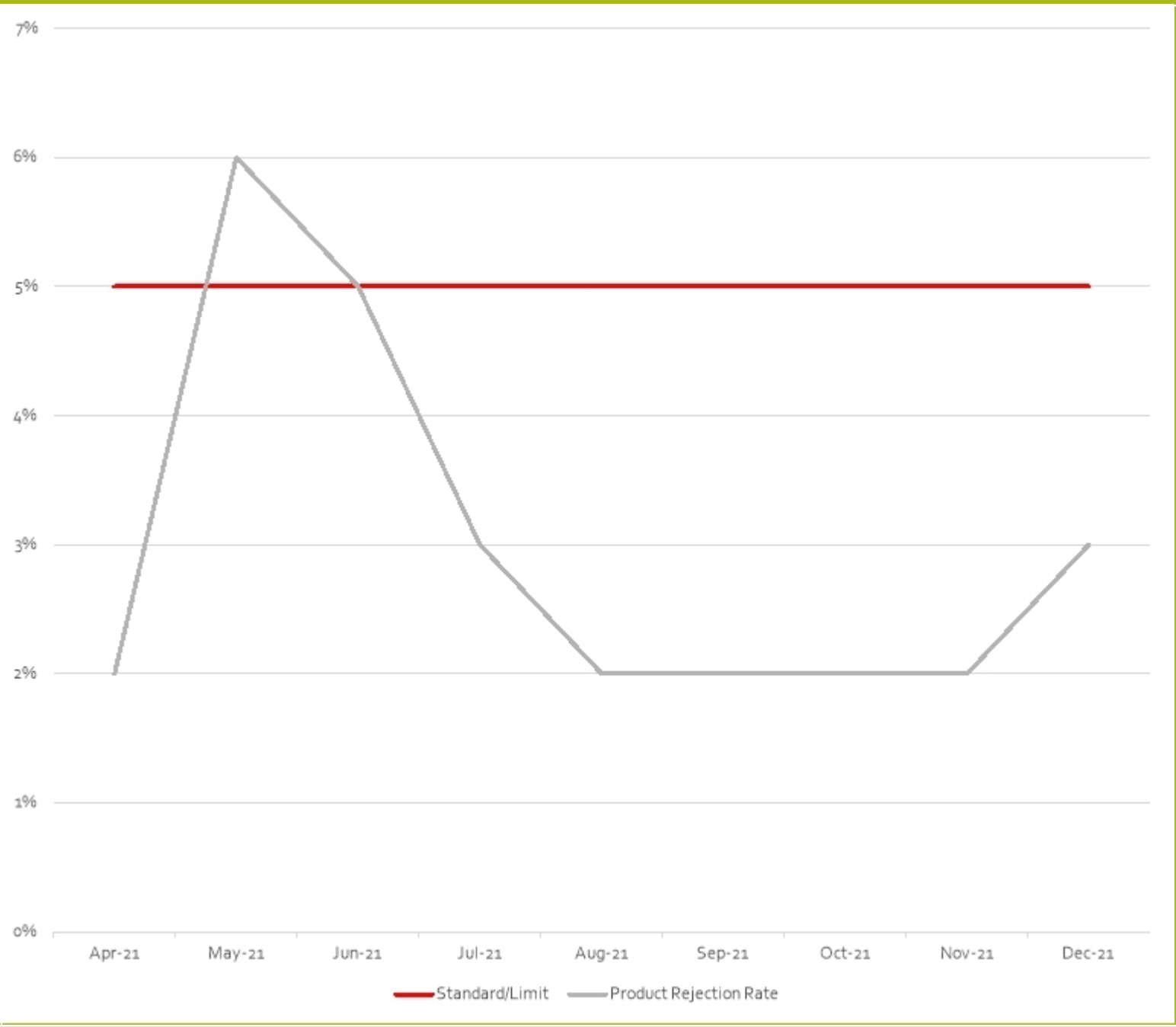
Additional narrative: Unit has prepared and released >5000 supportive diluent packs for vaccination and qualified over 350 customers to support the program in the community.



QUALITY METRICS

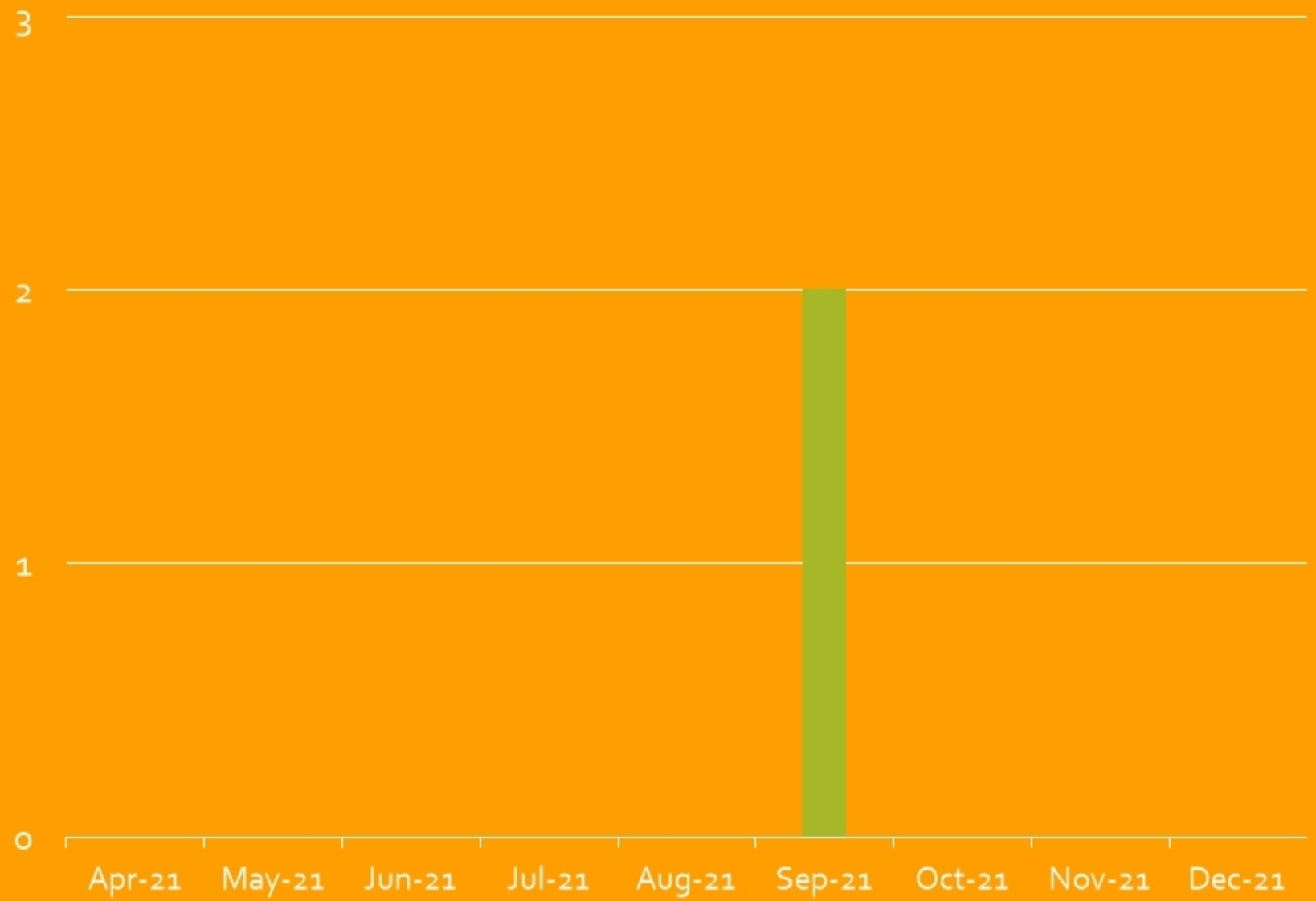
ERRORS AND CRITICAL PROCESS DEVIATIONS





Product Rejection Rate

Facilities Deviations

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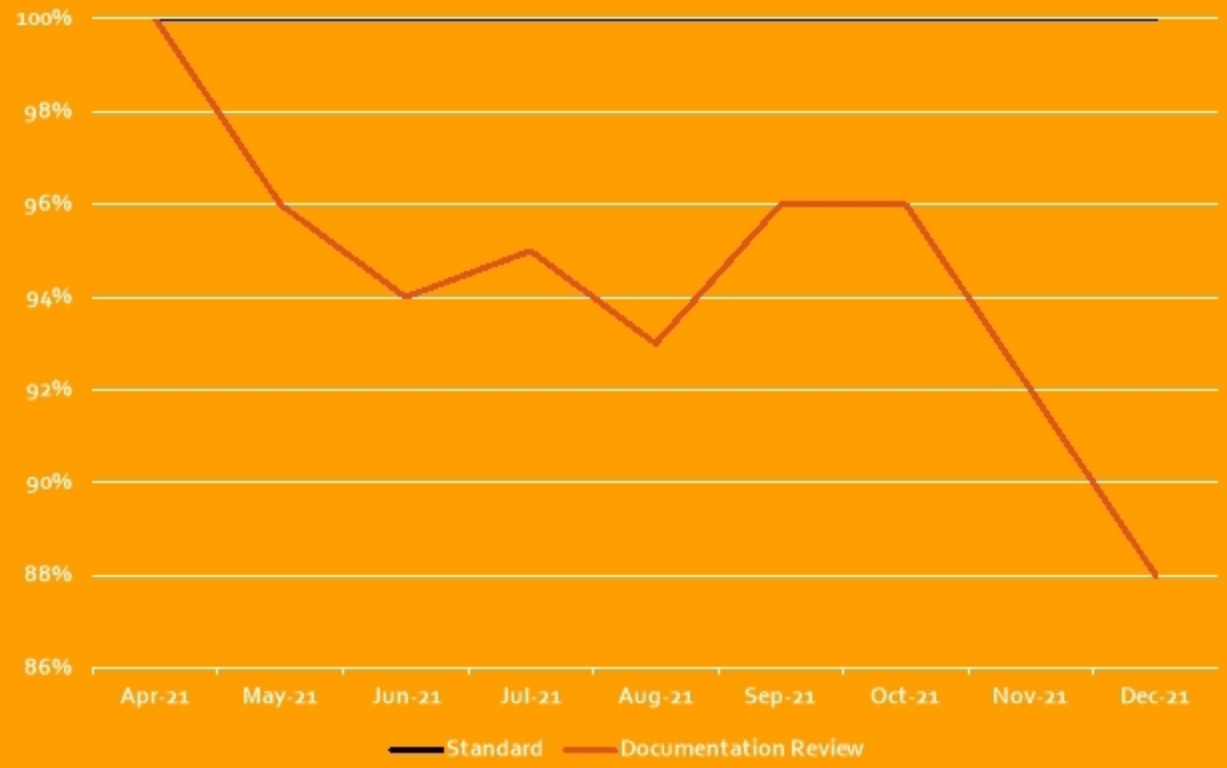
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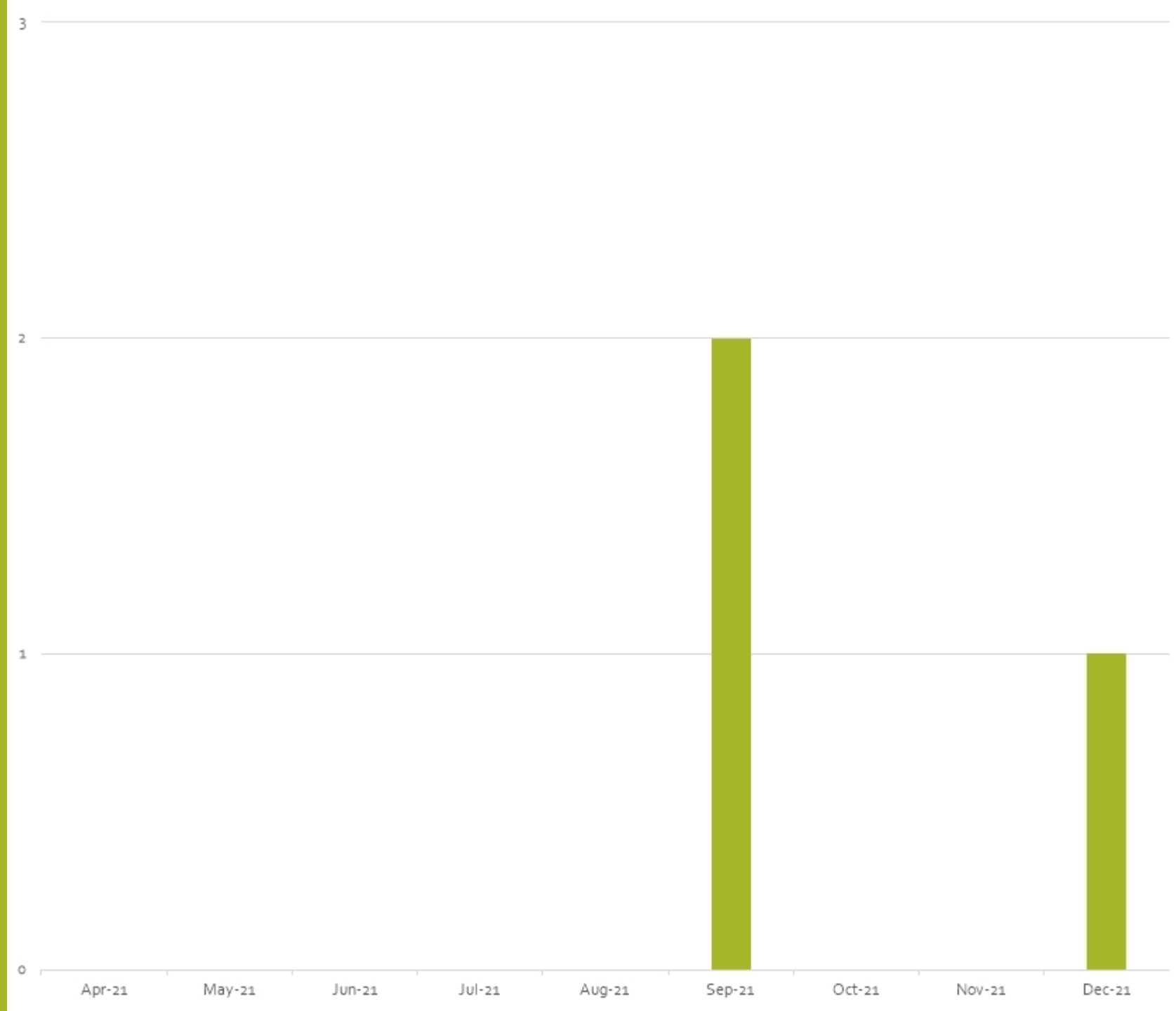
Standard
Documentation Review

Complaints



Service Summary

- November and Dec have seen increase in batch production due to change in release criteria
- Production Lead Appointed – start date Jan 21
- Workforce
  - ATO4 authorised and awaiting Trac
  - ATO3 x 2 for interview first week Jan
  - Another operator validated and operational to manufacture
- Vigo Automated Pump devices received and currently undergoing validation
- Funding received for gas testing equipment and GriFol pump. Both going through procurement process at present
- Finance issues with regards VAT charges – training issue within Team that has now been resolved.
- CIVAS@IP5 new twitter account - @CIVASIP5MedUnit
- 2 new products for 2022 – Potassium Chloride and an additional strength for Noradrenaline

QUALITY, SAFETY & PERFORMANCE COMMITTEE

NOVEMBER PMF COVER PAPER

DATE OF MEETING	20/01/2022

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
PRESENTED BY	Cath O'Brien, Interim Chief Operating Officer
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**
EMB RUN	4.01.2022	Reviewed and Noted
WBS SMT MEETING	17.12.21	Reviewed and Noted
VCC SLT MEETING	20.12.21	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
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 November 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 Corporate Workforce report (**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. 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. Whilst we are still providing excellent care for our patients it is against a significant backdrop of restrictions and challenges.

Despite the challenging environment, only 2 targets were reporting red in November's performance report. These were the palliative radiotherapy within 14 days target and the outpatient 30 minute wait target. In addition the new measure which we are also reporting on for Radiotherapy (COSC) are red and not achieved as we continue to work towards these.

Since April 2021, we have been mandated by the Welsh Government to report against the 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). 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.

The challenge in meeting the revised COSC targets may require significant investment from our commissioners, to enable us to implement the changes required over and above patient pathway efficiency improvements that are already being worked through.

Radiotherapy Waiting Times

Radiotherapy services are under pressure as a result of referrals returning closer to Pre Pandemic levels after a year of reduced referrals. In addition, IPC restrictions continue to reduce treatment capacity by circa 25%. Performance against waiting times targets is worsening and we expect to report more breaches in the coming months as a result of both above. We continue to explore all options for increasing capacity as well as making the best use of existing capacity. This includes further exploring third party provision.

The total number of referrals received in November 2021 (404) represented a marked increase relative to the previous month (351). The number of new referrals in November also far exceeded the average number received in any given month in 2020/21 (315).

Patient delays are reflective of challenges in the capacity for both Brachytherapy and 3D conformal planning and late changes to clinical management intent as a result of changes in patient need. Where there is a change in treatment intent, due to systems the patient is still measured against their original treatment intent and so anomalies are created in the measurements. Future system changes will address this. This is further outlined later in this paper.

There are a number of areas of focus for the Radiotherapy team in addressing the challenges above:

Brachytherapy demand currently exceeds capacity. We are peer reviewing our brachytherapy provision with Clatterbridge cancer centre who have a similar demand profile to ourselves and who have been through a similar process for implementing Brachytherapy. This includes reviewing protocols, standard operating procedures, staffing profiles etc. This will enable us to optimise our pathways and build in the true capacity requirements for the service. The Brachytherapy project board is working with WHSSC to resource the service requirements, while assuring ourselves and commissioners that we have undertaken Peer review to support our future plans.

The growth in the use of 3D Planning continues and the corresponding increase in the medical physics workforce to undertake the work is being addressed but is problematic. We are addressing the requirements within physics by reviewing options including training more existing staff and attracting new staff with these skills.

Increasing workload for medical staff is resulting in some late submission of plans and work is not evenly distributed through the week. Remodelling is underway and it is recognised that there is a pathway wide impact on workforce planning that is complex to remodel. This work is underway with the medical directorate but will not be an immediate solution.

Late changes in patient treatment category, primarily from palliative to emergency results in patients regularly treated outside of the emergency treatment time. Effectively a late change means that the patient will already have exceeded the wait for emergency treatment at the date of change of intent, due to the time the patient has already waited. We are reviewing whether the correct system actions are being taken when making such changes as well as working with the clinical teams to understand why these late changes are occurring frequently.

The forward look for radiotherapy is showing reduced performance for December and January due to increasing numbers of referrals and staffing challenges due to Covid sickness/isolating, and other absences/vacancies. We are working with the Rutherford Cancer Centre to maximize use of their capacity for Breast and Prostate patients.

The management of the patients being referred for Radiotherapy is being undertaken in line with the agreed Clinical Frameworks which includes clinical risk based prioritisation. For example, some patients are able to be managed on alternative treatments while awaiting their radiotherapy.

SACT Waiting Times

The waiting times target for non-emergency SACT was met. This has been achieved in the most difficult circumstances and is becoming difficult to sustain. 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.

7 patients referred for emergency SACT treatment were scheduled to begin treatment in November 2021. 2 patients did not begin treatment within the target time. These patients began treatment on day 6 and day 7 with the agreement of treating clinicians.

There is a challenging picture ahead for SACT provision. Unexpected staff shortages due to Covid/isolating and other sickness are ongoing and alongside growing referrals has resulted in us revisiting clinical priority and SACT escalation procedures. We are experiencing a decrease in performance over December and January. We continue to identify opportunities for additional capacity from third party supplies. Patient clinical prioritisation is being undertaken through the agreed clinical frameworks.

Outpatient waiting times

This target is reporting as red as we are not hitting the 30 minute target. The longest patient wait (148 minutes) and that was due to a complex patient pathway requiring appointment time with Clinical Nurse Specialist, non-medical prescriber and Consultant. The plan is to split the targets into waits from first arriving in the department both to consultant outpatient attendance and to phlebotomy separately and then the wait from phlebotomy reporting to seeing the consultant. Due to staff absences this data was not available for November. Future data will enable reporting of:

- Time to consultant only appointment.
- Time to blood test.

This will then enable us to report waiting for a consultant appointment and waiting time for phlebotomy.

We are currently working through various plans to improve the waiting time. Capital funding has been secured to undertake environmental improvement work in the department. We are looking at a number of options identified by an external consultant to

release capacity and aid patient flow and will produce a Business case in February 2022 with our preferred options. Work is also being undertaken to map patient flow which will form the basis of an improvement project (January 2022).

Therapies

All Therapy waiting times targets were reporting green.

Other areas

Falls –

During November 2021 there 1 fall was reported on first floor ward, a full investigation was undertaken by the VCC Falls Scrutiny Panel. Following investigation, the fall was deemed to have been unavoidable.

The patient had been the subject of a falls risk assessment on admission, but mobilised without staff assistance and fell.

Following the incident the falls pathway was completed and the patient reviewed by a medic. The patient experienced no harm.

Pressure Ulcers – There were no pressure ulcers reported.

Healthcare Acquired Infections – No healthcare acquired infections were reported.

SEPSIS bundle NEWS score

Twelve patients met the criteria for administration of the sepsis treatment bundle in November 2021. All twelve received all elements of the bundle within one hour. Five of the patients subsequently received a diagnosis of sepsis or neutropenic sepsis.

Delayed Transfers of Care (DTOC's)

During November there were no DTOC's.

Further detailed performance data is provided in Appendix 1

2.3 Welsh Blood Service

November's PMF again represents a strong performance by the service. There has been a further improvement in quality incidents closed in 30 days, improvement in our platelet expiry rates and an improvement in our donor experience rates.

Blood stocks in November within Wales are reported as being stable and held up well, in what are proving to be challenging times for UK blood services.

However, the service is continuing to experience high staff absences throughout the blood supply chain operation within both collection teams and laboratory staff across all grades due to a range of issues including Covid, long and short term sickness.

In addition, blood collection continues to be a challenge with social distancing measures, and collection venue constraints. 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.

WBS Christmas campaign launched at the end of November and was promoted across a number of media and digital channels to help maintain supply.

All demand for red cells were met in November and all stock groups continued to be maintained above 3 days with an average of 1409 units issued per week. All clinical demand for platelets was met as well averaging 199 units per week for November.

There were 6 Stem Cell Collections in November. 5 by the Peripheral Blood Stem Cells (PBSC) collection method and 1 by bone marrow harvest.

The VCC apheresis stem cell collection service previously supported through St Joseph's, had its first collection on Monday 8th November.

At the time of writing this report (December 22nd) the service has raised a BLUE alert to blood banks and Health Boards across Wales (December 16th) indicating specific pressure on supply of group O positive red cells is challenging and that pressure on additional blood groups is likely to increase for a sustained period given the onset of the Omicron variant. A number of contingencies were put in place and reported via the divisional silver command group to the Trust Gold group.

In preparing this report post the holiday period, it is of note that the implementation of the BLUE alert enabled stocks to be successfully managed in close collaboration with HBs over the holiday period despite challenges in collections.

2.3.1 Recruitment of new bone marrow volunteers

The inability to hold whole blood donation clinics in schools and Universities, continues to hinder recruitment of new bone marrow donors. The number of new volunteers added to the Welsh Bone Marrow Donor Registry (WBMDR) reached 210 for November. Work is underway to promote the newly introduced buccal swab administration with donors to improve the performance going forwards.

2.3.2 Reference Serology

There were 255 hospital patient referrals in November 2021 compared to average of 181 in 2020. The increase in referrals has resulted in the target for turnaround times not being met. Work continues to be prioritised based on clinical need and all compatibility testing was completed in the required deadline. It should be noted all requests are screened and considered appropriate.

Requests out of hours and on call attendance impacts staff the next day and as a result affects overall performance. WBS are currently reviewing why the numbers of referrals are so high and timings of requests. The results of this audit will be presented and discussed this at the national pathology managers group in early 2022 and an action plan will then be developed.

2.3.2 Quality

Incidents reported to Regulator/Licensing

There were 2 Serious Adverse Events reported to the Human Tissue Authority in November both events related to stem cell collection. The one was a medication error with no donor harm and an action plan in place to address the risk of such an error occurring in future. The second relates to donor feeling unwell post stem cell collection and needing a short hospital admission. The donor has made a full recovery.

Incidents closed within 30 days

The performance against the 'Incidents closed within 30 days' measure has achieved a level that is better than target for November. The revised process for managing low-impact incidents has been in place now for 6 months and new reports are reviewed and

risk assessed daily and the majority of incidents are fully closed within a few days of reporting.

Part Bag Rates

At 2.40% for November, the combined 'Part Bag' rate has reduced although remains within the tolerance level. Targeted interventions are in place.

Failed Venepuncture Rates

The Failed Venepuncture (FVP) rate for November has also reduced, increasing to 1.60% and again remains within the tolerance threshold of 2%. Although these are in target, the review process identifies if there are requirements to put targeted interventions in place and this has been identified a number of individual interventions.

Whole Blood Collection Productivity

Whole Blood Collection productivity whilst having improved from the previous month is below target as there is a continuing requirement to deploy additional resources to clinics due to COVID related infection prevention and control activity. Work is also underway in terms of skill mix review and considering staffing resilience requirements for geographically remote teams.

Manufacturing Productivity

The manufacturing performance figure increased in November due to changes in staff levels due to sick and deployment to vaccine distribution. 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 November approximately 7,500 donors were registered at donation clinics. A total of 10 concerns (0.13%) were reported, of which 9 were managed within as early resolution with 1 formal concern reported in November which will be managed and completed before the 30 day Putting Things Right (PTR) target.

Donor Satisfaction

In November overall donor satisfaction continued to exceed target at 97.2%. In total there were 819 respondents, who had made a full donation and shared their donation experience.

Further detailed performance data is provided in Appendix 2

3.0 Workforce

PADRs

Workforce team continue to support managers to improve PADR compliance by coaching and developing capabilities as line managers and by demonstrating the motivational and organisational value of goal setting for all staff.

Labs and WTAIL departments achieved over 85% compliance

VCC – 70.12%. Overall compliance down from previous month (73.77%). Workforce Operational Team continue to highlight PADR compliance in regular meetings with managers

Sickness absence

a. WBS - Long-term sickness absence has increased in November to 5.48%, short term sickness absence has increased to 2.90%. Some concerns raised by line managers re: Occupational Health referral times, this has been escalated to Workforce who are currently looking at the SLA with Cardiff and Vale HB and Betsi Cadwalader HB.

b. VCC - Short-term sickness is 2.19% and long-term sickness absence is at 3.60%. Workforce and OD operational team are currently undertaking sickness audits, to understand compliance of the policy and support required by management to progress cases.

3. Stat&Mand compliance

a. WBS remain within compliance at 93.36% and will aim to continue

b. VCC has steady increase in compliance once more this month to 84.91%

4.0 IMPACT ASSESSMENT

QUALITY AND SAFETY	Yes (Please see detail below)

IMPLICATIONS/IMPACT	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 May PMF Report
2. WBS May PMF Report

Velindre Cancer Centre Monthly Performance Report Summary Dashboard (November 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.

			Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
Radiotherapy	Patients Beginning Radical Radiotherapy Within 28-Days (page 6) ***(JCCO Measure)***	Actual	92%	95%	97%	92%	89%	95%	94%	97%	96%	97%	96%	92%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Patients Beginning Palliative Radiotherapy Within 14-Days (page 8) ***(JCCO Measure)***	Actual	93%	90%	97%	90%	85%	95%	85%	82%	82%	82%	82%	74%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Patients Beginning Emergency Radiotherapy Within 2-Days (page 10) ***(JCCO Measure)***	Actual	93%	95%	97%	100%	97%	100%	100%	97%	100%	97%	100%	85%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Scheduled Patients Beginning Radiotherapy Within 21-Days (page 11) ***(COSC Measure)***	Actual					35%	28%	37%	35%	31%	27%	36%	36%
		Target	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
	Urgent Scheduled Patients Beginning Radiotherapy Within 7-Days (page 11) ***(COSC Measure)***	Actual					41%	48%	40%	54%	52%	52%	35%	41%
		Target	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
	Emergency Patients Beginning Radiotherapy Within 1-Day (page 11) ***(COSC Measure)***	Actual					83%	88%	85%	82%	86%	82%	86%	77%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

			Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
SACT	Patients Beginning Non-Emergency SACT Within 21-Days (page 15)	Actual	86%	79%	77%	88%	98%	98%	98%	99%	99%	98%	99%	99%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Patients Beginning Emergency SACT Within 2-Days (page 16)	Actual	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	86%
		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 20)	Actual	67%	66%	65%	57%	66%	79%	76%	76%	53%	53%	65%	65%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Did Not Attend (DNA) Rates	Actual	2%	3%	2%	3%	3%	4%	4%	5%	5%	5%	5%	5%
		Target	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%
Therapies	Therapies Inpatients Seen Within 2 Working Days (page 23)	Actual (Dietetics)	97%	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%	100%	95%	100%

			Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-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 23)	Actual (Dietetics)	97%	100%	100%	100%	100%	100%	84%	94%	94%	98%	97%	100%
		Actual (Physiotherapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Occupational Therapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Speech and Language Therapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Routine Therapies Outpatients Seen Within 6 Weeks (page 23)	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%	96%	33%	78%	100%
		Actual (Speech and Language Therapy)	100%	100%	100%	100%	100%	100%	100%	96%	100%	100%	96%	100%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

			Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
Safe and Reliable Care	Number of VCC Acquired, Avoidable Pressure Ulcers (page 25)	Actual	2	0	0	0	1	0	0	0	2	1	1	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0
	Number of Pressure Ulcers Reported to Welsh Government as Serious Incidents	Actual	0	0	0	0	1	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 27)	Actual (Total)	2	1	1	1	2	3	1	3	4	2	3	1
		Unavoidable	2	1	1	1	1	3	1	3	4	1	3	1
		Avoidable	0	0	0	0	1	0	0	0	0	1	0	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0
	Number of Delayed Transfers of Care (DToCs)	Actual	0	0	0	0	0	0	0	0	1	0	4	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 29)	Actual	100%	100%	100%	100%	100%	100%	100%	80%	100%	75%	100%	100%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

			Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
	Healthcare Acquired Infections (page 30)	Actual	0	1 (*C.diff*)	0	0	0	0	0	1 (*C.diff*)	0	0	0	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0
Percentage of Episodes Clinically Coded Within 1 Month Post Episode End Date		Actual	99%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
		Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

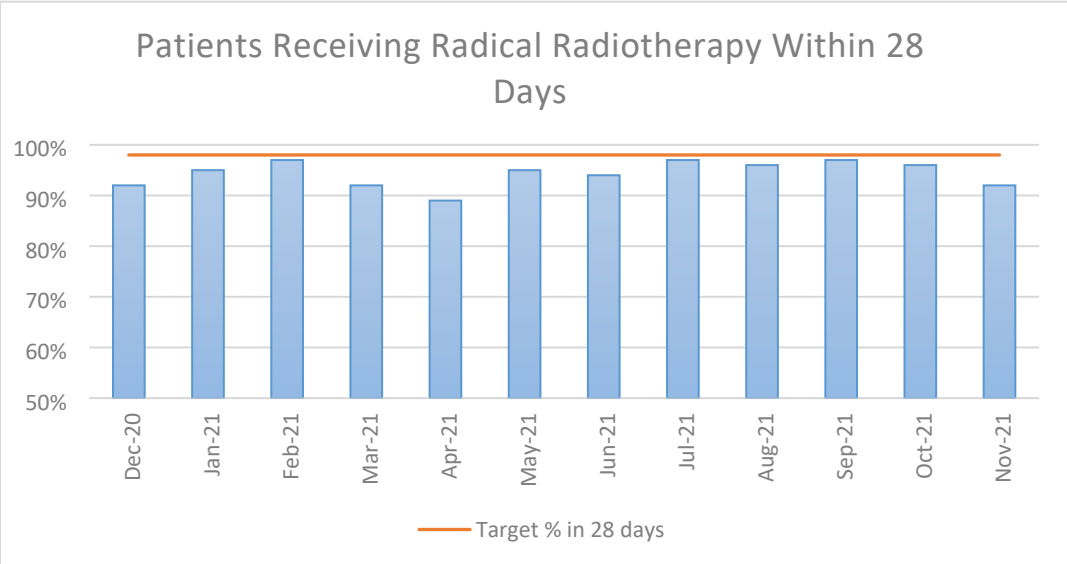
RAG rating above indicates: Green - Target was achieved. Amber - 85% Compliance or above. Red - Target not achieved.

Patients Receiving Radical Radiotherapy Within 28-Days

Target: 98%

SLT Lead: Radiotherapy Services Manager

Trend



The number of patients scheduled to begin radical radiotherapy treatment in November 2021 (186) exceeded the monthly average observed in 2020-21 (150) and was higher than the number scheduled to begin treatment in November 2020 (164).

Current Performance

26 patients referred for radiotherapy treatment with radical intent did not begin treatment within the 28 day target constituting an overall performance rate of 92**%.**

The 26 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)	19	4	3

Summary of delays:

A combination of very specific planning clinic requests made by consultants based on patient need. Brachytherapy treatment demand is in excess of our capacity.

Of the patients waiting over 45 Days, Brachytherapy and Urological capacity caused the delay. The demand for brachytherapy is above commissioned capacity which is being addressed with commissioners.

Social distancing and other infection control measures present particular challenges in the delivery of radiotherapy. Capacity has been reduced by 25% due to these COVID precautions.

Intent	Monthly Average (2019-20)	Monthly Average (2020-21)	Patients Scheduled to Begin Treatment (November 2021)
Radical	167	150	186
	Patients Scheduled to Begin Treatment (November 2019)	Patients Scheduled to Begin Treatment (November 2020)	
	171	164	

There is a process for ongoing review of breaches and remedial action where required while longer term service improvements are being delivered as part of Velindre Futures and IRS.

Action:

- A Peer review exercise with Clatterbridge is underway to assess areas for improvement and development for Brachytherapy.(by April 22)
- Brachytherapy expansion business case being written to obtain support for increased capacity with WHSCC.(by April 22)

Wider Actions

There are a number of actions ongoing that are part of wider service change.
Radiotherapy patient pathway project initiated. Project will identify efficiencies for implementation and areas for overall improvement. This will continue to incorporate changes required for IRS through 2022.

- Project initiated to identify process issues and ensure timely delineation of plans (December 2021).

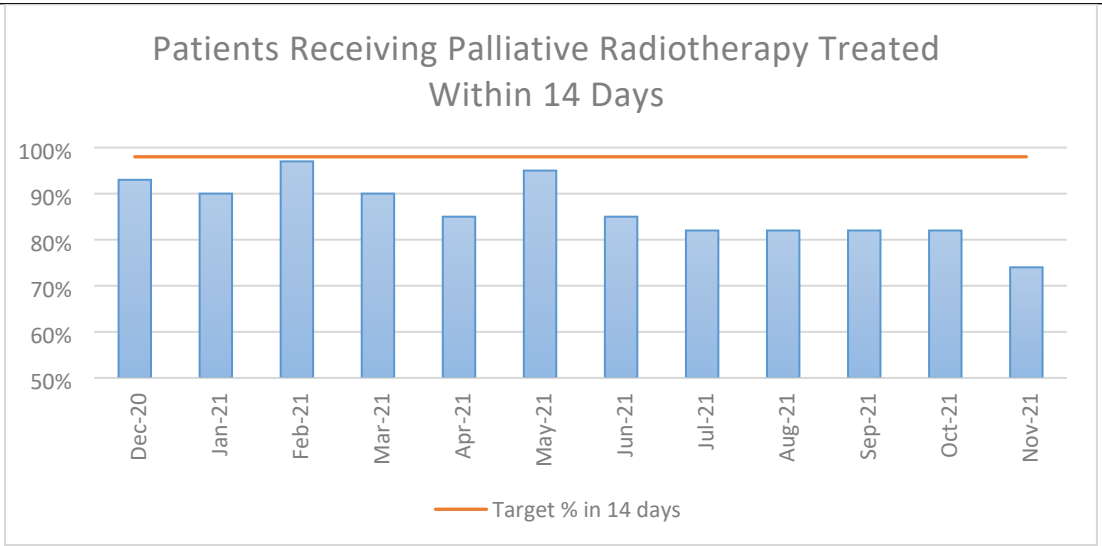
- COSC measure working group – this group is using a pathway approach on a site by site basis

<table>
<tr><td></td><td>to eliminate delays in the process to enable us to meet the new measures. This has been completed for: Head and Neck patients with further work planned for all SST's during 2022.</td></tr>
<tr><td colspan="2">Patients Receiving Palliative Radiotherapy Within 14-Days</td></tr>
<tr><td>Target: 98%</td><td>SLT Lead: Radiotherapy Services Manager</td></tr>
<tr><td>Trend</td><td>Current Performance</td></tr>
<tr><td></td><td>32 patients referred for radiotherapy treatment with palliative intent were scheduled to begin treatment in November. Of this total, 12 patients did not begin treatment within the 14 day target constituting an overall performance rate of 74%.

The 32 patients who did not begin treatment within 14 days, commenced their treatment as follows:

<table>
<tr><th>Treatment Intent</th><th>≤ 20 days</th><th>≤ 25 days</th></tr>
<tr><td>Palliative (14-day target)</td><td>27</td><td>5</td></tr>
</table>

Summary of delays:</td></tr>
</table>



The number of patients scheduled to begin palliative radiotherapy treatment in November 2021 (83) exceeded the monthly average observed in 2020-21 (74) and equalled the number scheduled to begin treatment in November 2020 (73).

Intent	Monthly Average (2019-20)	Monthly Average (2020-21)	Patients Scheduled to Begin Treatment (November 2021)
Palliative	82	74	83
	Patients Scheduled to Begin Treatment (November 2019)	Patients Scheduled to Begin Treatment (November 2020)	
	74	73	

- Request for and development of 3D conformal plans (8) due to the clinical benefit of this is the principle reason for treatment delays.

3D plans is an area of growing volume due to the potential for better patient outcomes through normal tissue sparing.
A clinical decision is made with the patient for a more individual complex plan as a result.

Action:

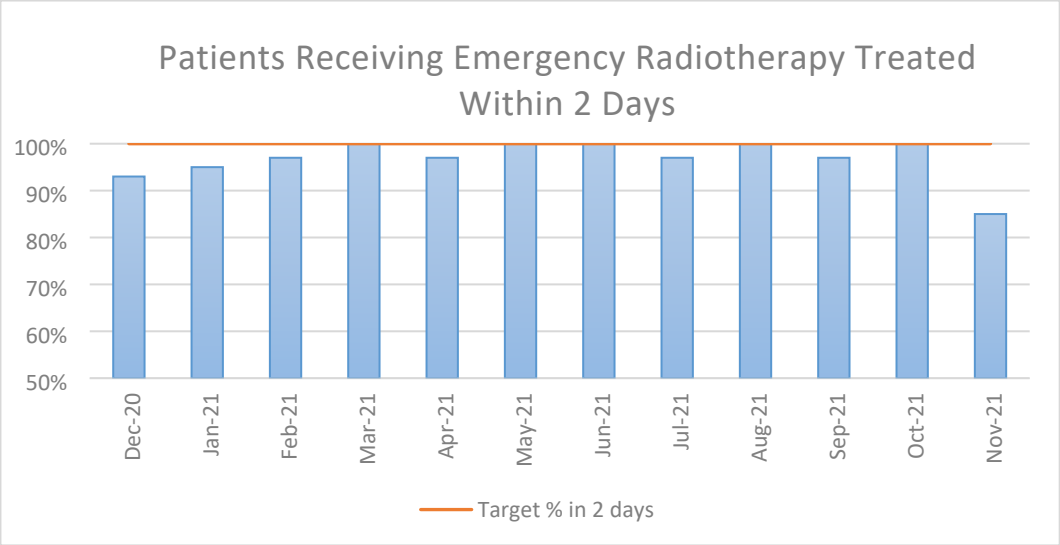
- 3D plan capacity plan to be developed with clinical team as they are the major cause of breaches.

Wider Actions

As above in Radical target actions

Patients Receiving Emergency Radiotherapy Within 2-Days

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



The number of patients scheduled to begin emergency radiotherapy treatment in October 2021 (22) was lower than the monthly average observed in 2020-21 (27) and the number scheduled to begin treatment in October 2020 (33).

Intent	Monthly Average (2019-20)	Monthly Average (2020-21)	Patients Scheduled to Begin Treatment (November 2021)
Emergency	25	27	22
	Patients Scheduled to Begin Treatment (November 2019)	Patients Scheduled to Begin Treatment (November 2020)	
	21	16	

22 patients referred for emergency radiotherapy treatment were scheduled to begin treatment in November 2021. 3 patients did not begin radiotherapy treatment within 2 days of referral constituting an overall performance of **85%.**

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

Summary of delays:

- Consultant request for specific start date.
- Change of treatment intent from palliative to emergency

Actions

Radiotherapy – Operational Context

Latest Performance Consolidated

Measure		Target	VCC Nov-21	SBUHB Jun-21	BCUHB Jun-21
Radical (28-day target)		98%	**92%**	**70%**	**92%**
Scheduled (21-day target)	COSC	80%	**36%**	**31%**	**53%**
Palliative (14-day target)		98%	**74%**	**87%**	**91%**
Urgent (7-day target)	COSC	80%	**41%**	**45%**	**41%**
Emergency (within 2-days)		100%	**85%**	**100%**	**67%**
Emergency (within 1-day)	COSC	100%	**77%**	**100%**	**100%**

The table shown here sets out the latest available performance of the 3 Wales centres relative to the extant time to radiotherapy targets based on Royal College of Radiologists best practice guidance and the novel Clinical Oncology Sub-Committee (COSC) stretch targets.

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

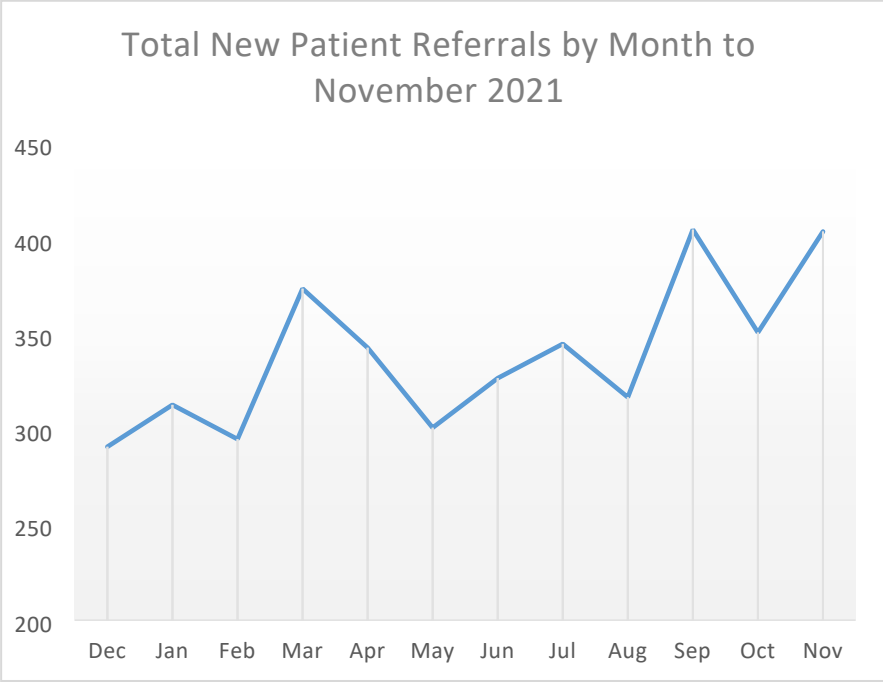
Clinical Oncology Sub-Committee (COSC) Time to Radiotherapy Targets

- 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.
- The challenge in meeting the revised COSC targets may require significant investment from our commissioners, to enable us to implement the changes required over and above patient pathway efficiency improvements that are already being worked through.

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

Scheduled (21 day target)	Urgent (7 day target)	Emergency (within 1 day)
164	73	16

Referral Trends - Overall

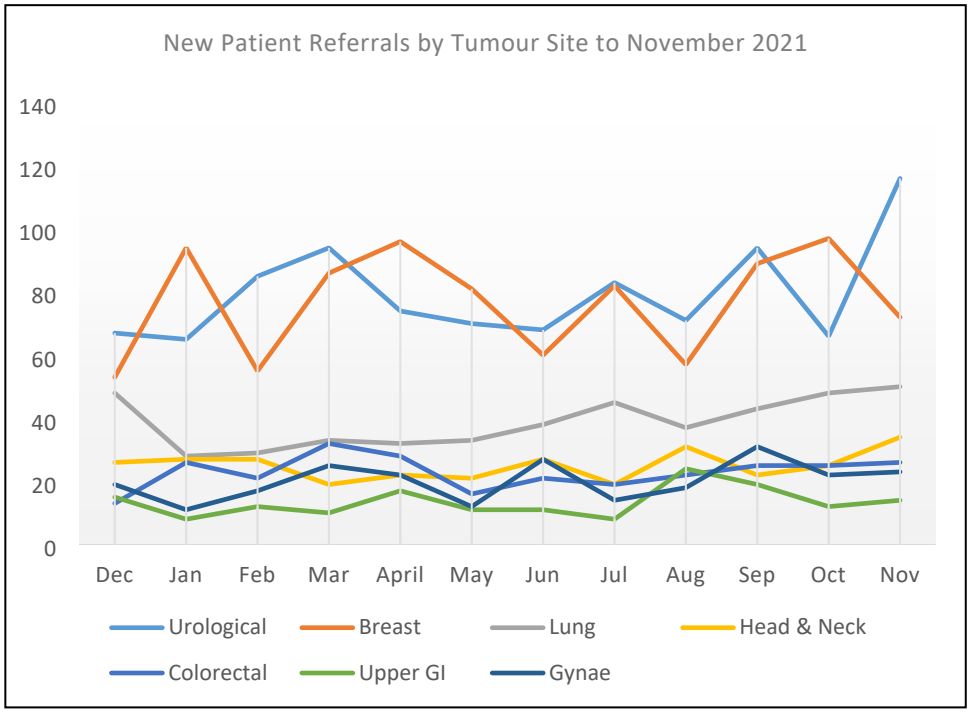


Monthly Average (2019-20)	Monthly Average (2020-21)	Total New Patient Referrals (November 2021)
357	315	404

The total number of referrals received in November 2021 (404) represented a marked increase relative to the previous month (351). The number of new referrals in November far 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 (November 2021)
Breast	**88**	**60**	**-32%**	72
Urology	**82**	**82**	**0%**	116
Lung	**47**	**38**	**-19%**	50
Colorectal	**20**	**22**	**+10%**	26
Head and Neck	**23**	**23**	**0%**	34
Gynaecological	**18**	**18**	**0%**	23
Upper Gastrointestinal	**16**	**13**	**- 19%**	14
Top 7 Tumour Sites by Number of Referrals as Percentage of Total Referrals	**82%**	**81%**		76%

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

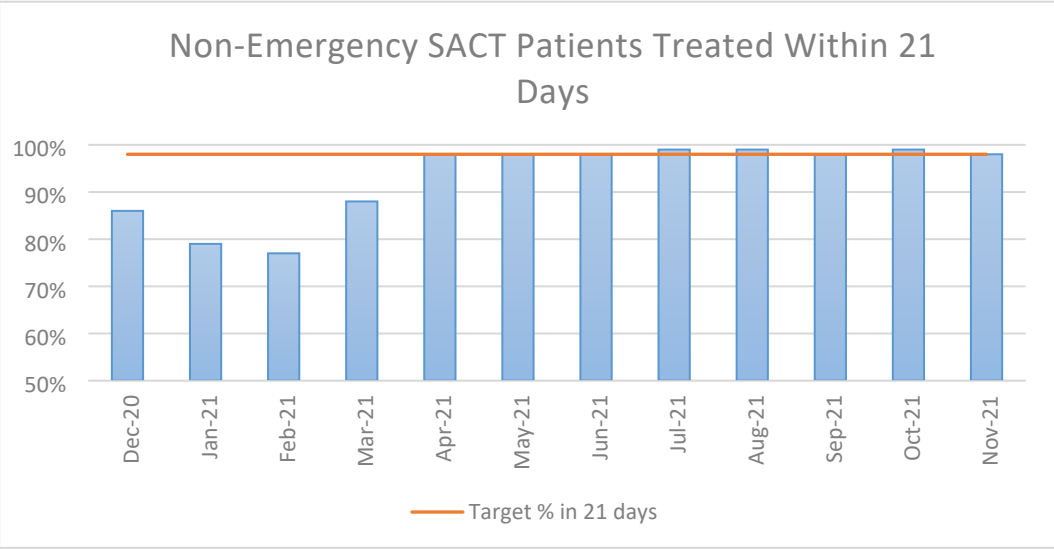
- Referrals overall and across most tumour sites now back to pre Covid levels.
- Surges in referrals weekly from health boards occurring across individual tumour sites, impacting on our ability to meet demand in a timely fashion. Engagement with health boards ongoing to understand their backlog clearance plans.
- All options being explored by SSTs to meet short term surges and to respond to health board backlog clearance.

Non-Emergency SACT Patients Treated Within 21-Days

Target: 98%

SLT Lead: Chief Pharmacist

Current Performance



The number of patients scheduled to begin non-emergency SACT treatment in November 2021 (372) was equal to the monthly average observed in 2020-21 (298) but below the number scheduled to begin treatment in November 2020 (382).

Intent	Monthly Average (2019-20)	Monthly Average (2020-21)	Patients Scheduled to Begin Treatment (November 2021)
Non - emergency	328	298	372
	Patients Scheduled to Begin Treatment (November 2019)	Patients Scheduled to Begin Treatment (November 2020)	
		353	

Trend

372 patients were referred for non-emergency SACT treatment were scheduled to begin treatment in November. Of this total, 5 patients did not begin treatment within the 21 day target, due to capacity challenges, constituting an overall performance rate of 98%.

The 5 patients who did not begin treatment within 21 days, commenced their treatment as follows:

Treatment Intent	≤ 28 days
Non-emergency (21-day target)	5

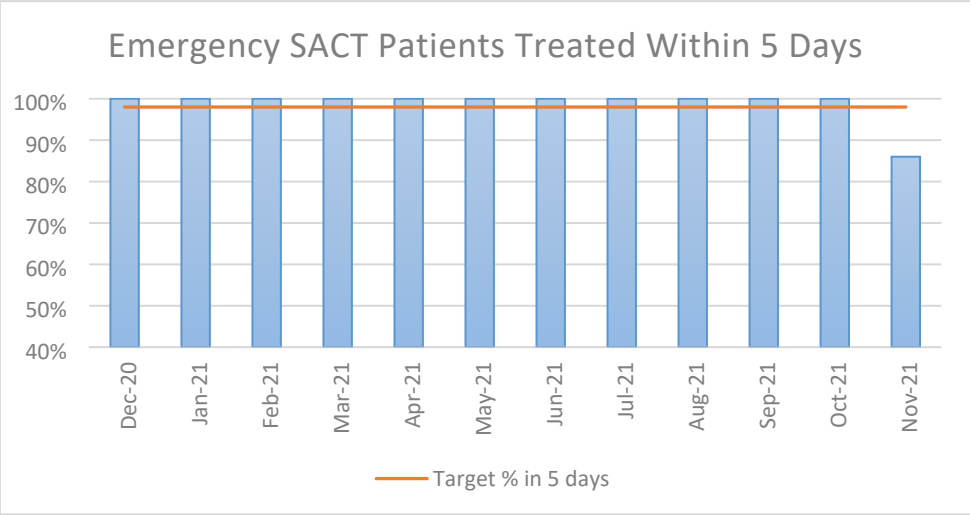
Actions

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 November 2021 due to facility and logistical issues at Neville Hall has been further delayed).

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 October 2021 (7) 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 (November 2021)
Emergency	4	4	7
	Patients Scheduled to Begin Treatment (November 2019)	Patients Scheduled to Begin Treatment (November 2020)	
		5	

7 patients referred for emergency SACT treatment were scheduled to begin treatment in November 2021. 2 patients did not begin treatment within the target time. These patients began treatment on day 6 and day 7 with the agreement of clinicians.

- 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

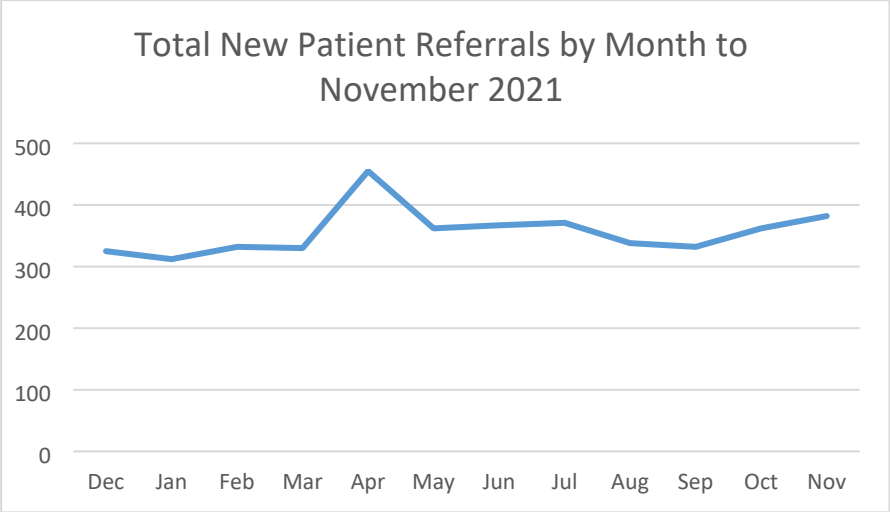
Current Performance Consolidated

Measure	Target	Nov-21
Non-emergency (21-day target)	98%	**99%**
Emergency (5-day target)	98%	**86%**

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 limited service at the Macmillan Unit at the Prince Charles Hospital in Merthyr Tydfil, this remains the case.

Referral Trends - Overall



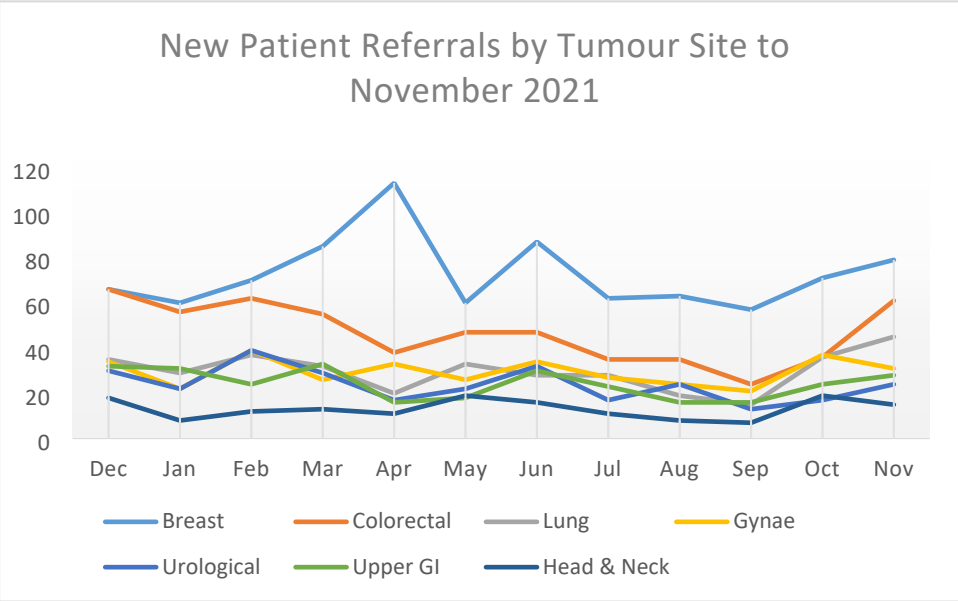
Monthly Average (2019-20)	Monthly Average (2020-21)	Total New Patient Referrals (November 2021)
325	301	382

The total number of referrals received in November 2021 (382) was above the average number received in any given month during 2020-21 (301) and exceeded the number received in October 2021 (362). The number of referrals received in November 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

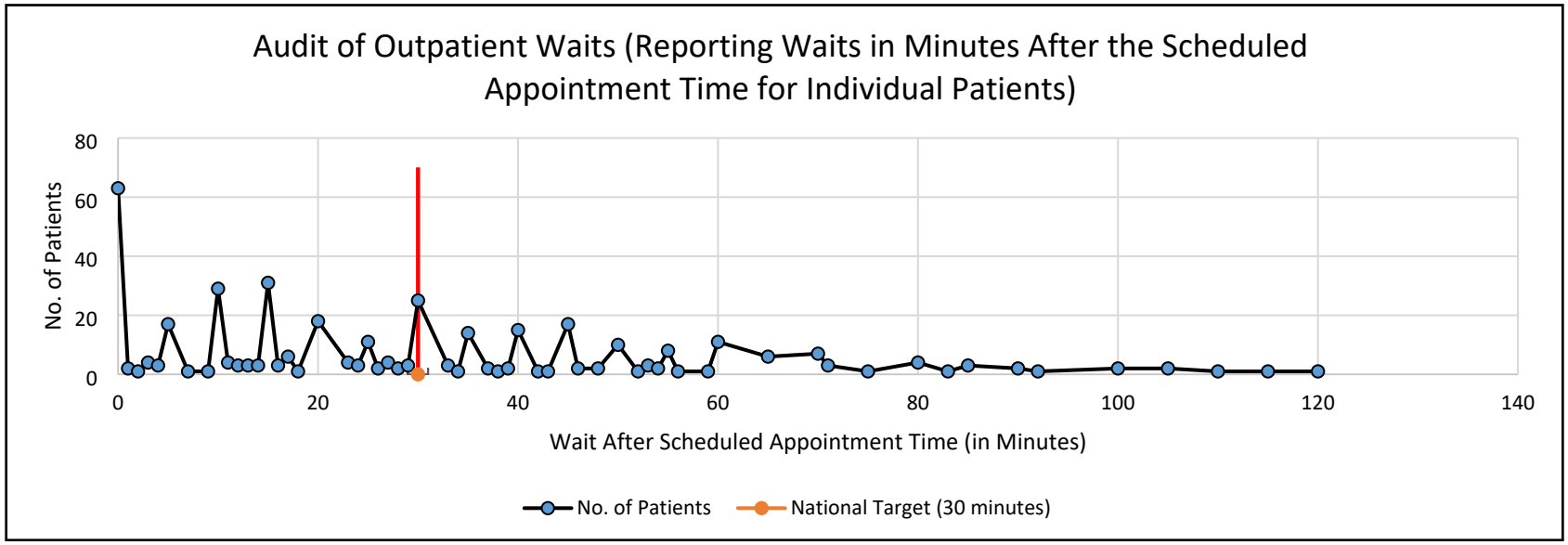
Referral Trends - Tumour Site



Site	Monthly Average (2019-20)	Monthly Average (2020-21)	2020-21 Average Relative to 2019-20 Average	New Patient Referrals (November 2021)
Breast	**92**	**76**	**-17%**	79
Colorectal	**54**	**55**	**+2%**	61
Lung	**33**	**32**	**-3%**	45
Gynaecological	**31**	**31**	**0**	31
Urological	**36**	**26**	**-28%**	24
Upper Gastrointestinal	**18**	**26**	**+44%**	28
Head and Neck	**16**	**14**	**-12%**	15
Top 7 Tumour Sites by Number of Referrals as Percentage of Total Referrals	**86%**	**87%**		74%

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.

New Patient, Other Outpatient and Chemotherapy Assessment Appointments Where Patients Were Seen Within 30 minutes of the Scheduled Appointment Times (National Target)	
Target: 100%	**SLT Lead: Director of Operations**
Current Performance	



Total	No. of Patients Subject to No Wait	Median Wait (50% of Patients Seen)	Mean (Average) Wait	No. of Patients Seen Within 30 Minutes	Longest Wait
389	63 (17%)	20 minutes	27 minutes	247 (65%)	120 minutes (1 patient)

This data is obtained from a manual data collection exercise undertaken by nursing staff for one week each month. This can result in some clinic and waiting time data not being fully captured. The exercise relates only to face-to-face appointments and does not capture virtual interactions

Trend	Actions
Outpatient activity delivered in outreach contexts prior to the advent of the COVID-19 pandemic was repatriated to VCC. Demand for phlebotomy services at VCC, typically delivered in primary and secondary care contexts prior to the pandemic, continues to be extremely high. Longest patient wait (148 minutes) was a complex patient pathway requiring appointment time with Clinical Nurse Specialist, non-medical prescriber and Consultant. The ratio of face-to-face to virtual appointments remains at approximately 50:50. Vacutainer supply issues have delayed the repatriation of some phlebotomy activity to primary care contexts.	• Capital funding has been secured to undertake environmental improvement work in the department. • A number of options have been identified (by a previously commissioned consultant) which are intended to release capacity and aid patient flow. Business case to be developed (February 2022). • Work is being undertaken to map patient flow which will form the basis of an improvement project (January 2022).

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

	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
Dietetics	97%	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%	100%	95%	100%
SLT	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

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

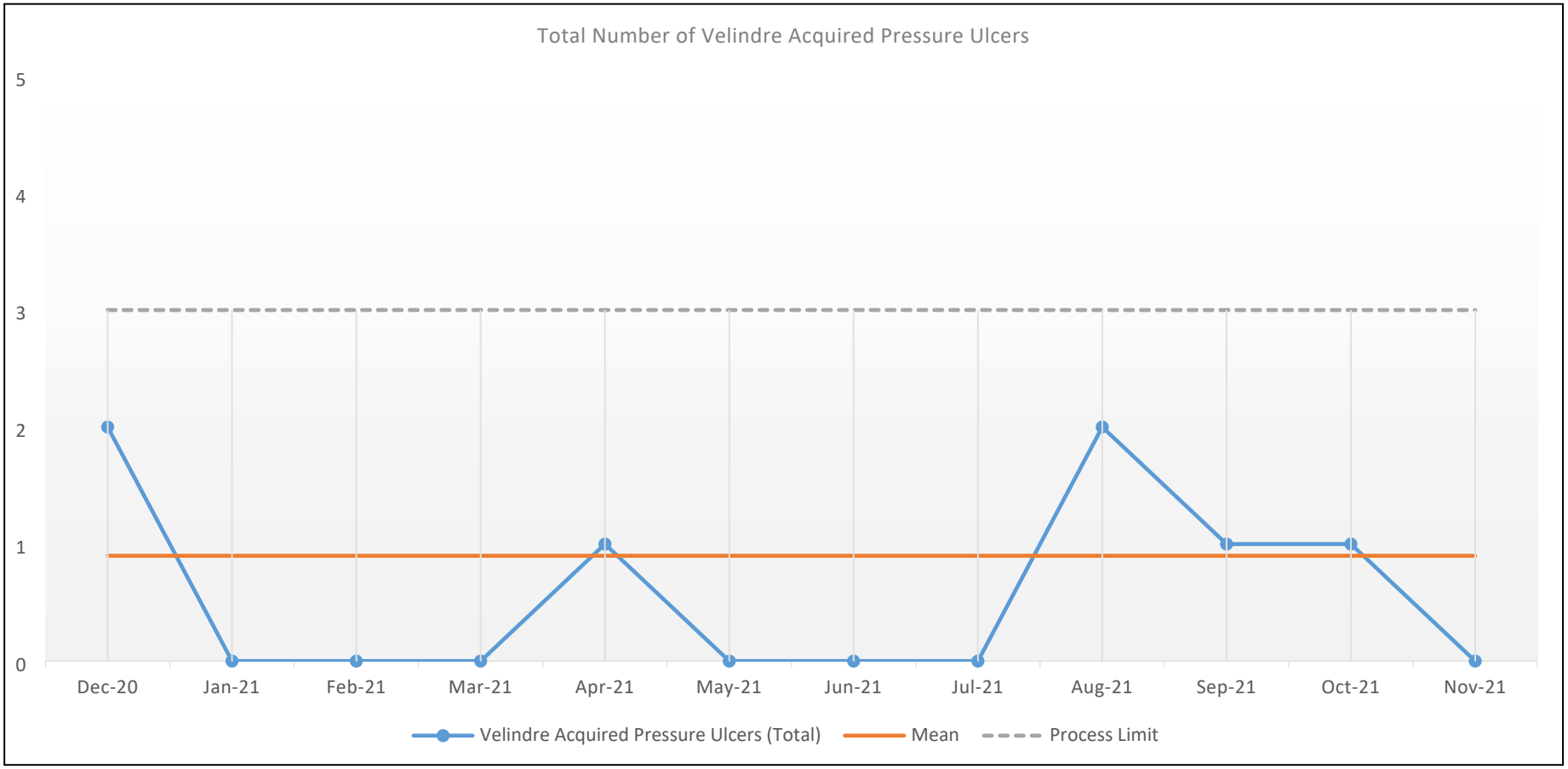
	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
Dietetics	97%	100%	100%	100%	100%	100%	84%	94%	94%	98%	97%	100%
Physiotherapy	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
OT	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
SLT	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Percentage of Routine Therapies (Outpatients) Seen Within 6 Weeks

	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-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%	96%	33%	78%	100%
SLT	100%	100%	100%	100%	100%	100%	100%	96%	100%	100%	96%	100%

All Therapies targets were achieved in November 2021.

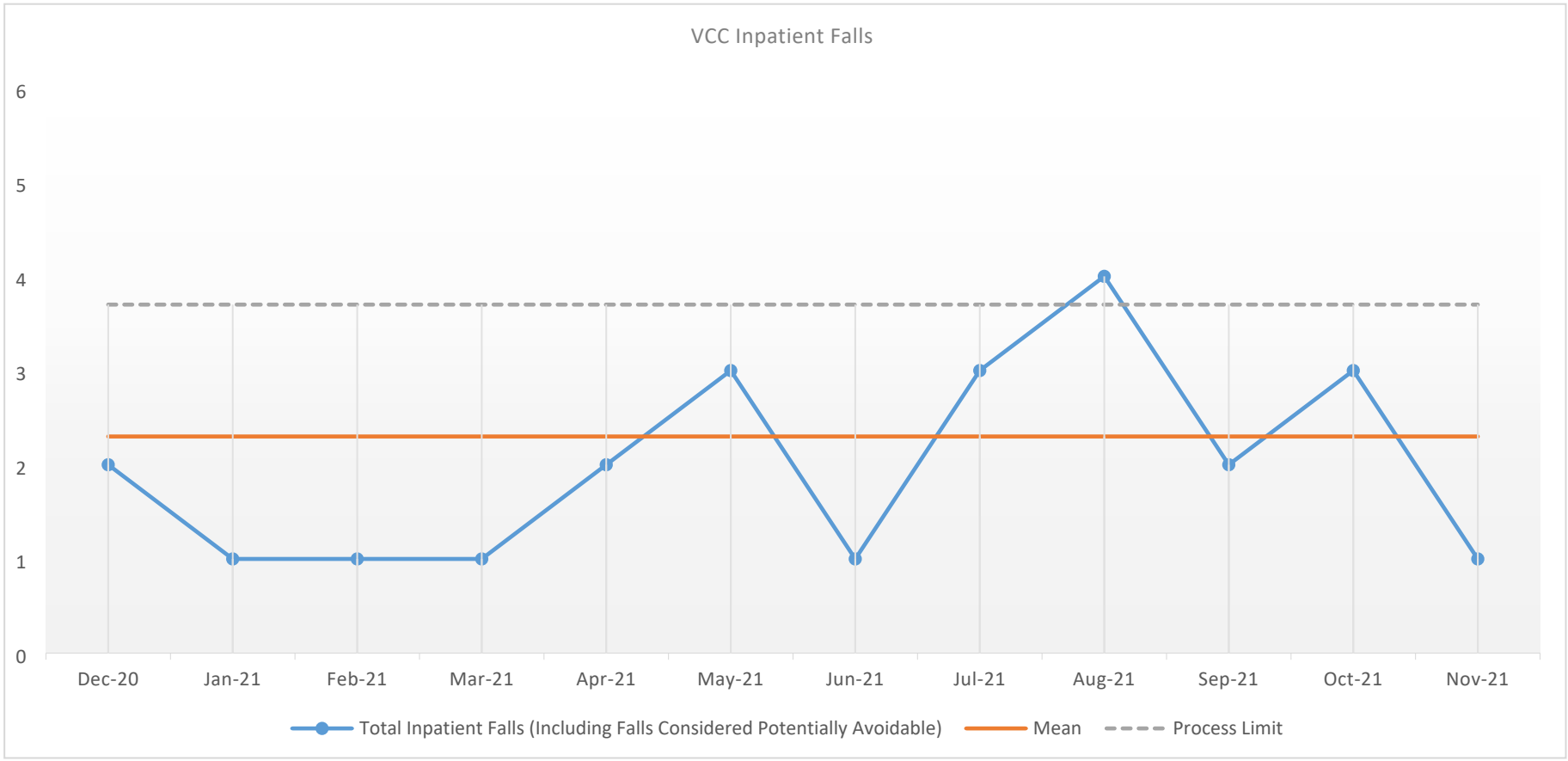
Velindre Acquired Pressure Ulcers	
Target: 0	**SLT Lead: Head of Nursing**
Current Performance	



	Sep-20	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
Velindre Acquired Pressure Ulcers (Total)	1	3	2	2	0	0	0	1	0	0	0	2	1	1	0
Potentially Avoidable Velindre Acquired Pressure Ulcers	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0

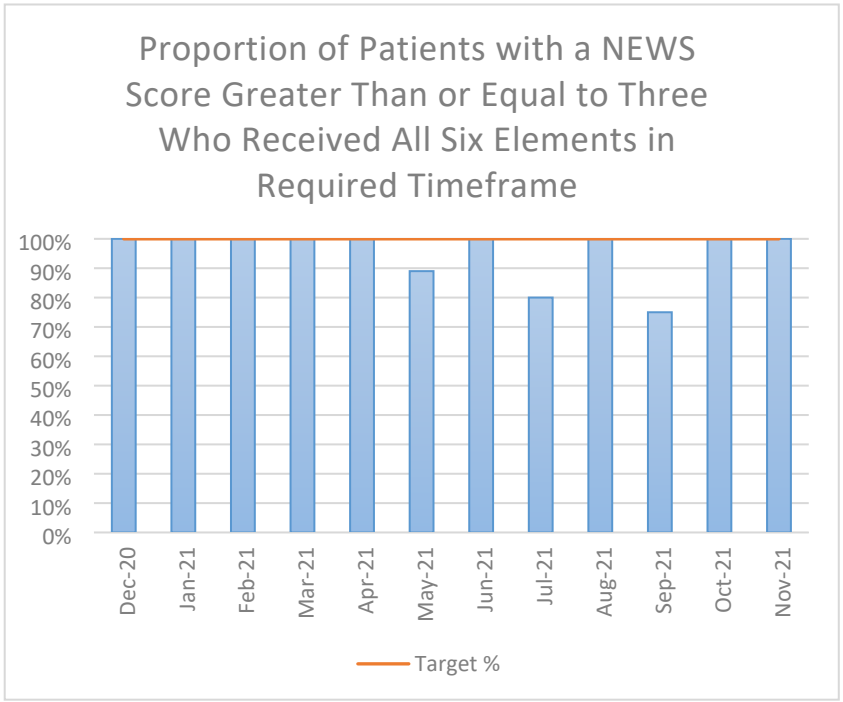
Trend	Action
NO Velindre acquired pressure ulcers reported in November 2021. No Velindre acquired ulcers were reported to Welsh Government as a Serious Incident (SI).	No specific action required.

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



	Sep-20	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
Total Inpatient Falls	3	4	0	2	1	1	1	2	3	1	3	4	2	3	1
Potentially Avoidable Inpatient Falls	0	1	0	0	0	0	0	1	0	0	0	0	1	0	0

Trend	Action
During November 2021 there 1 fall was reported on first floor ward, A full investigation was undertaken by the VCC Falls Scrutiny Panel. Following investigation, the fall was deemed to have been unavoidable.	The patient had been the subject of a falls risk assessment on admission, but mobilised without staff assistance and fell. • Following the incident the falls pathway was completed and the patient reviewed by a medic. • The patient experienced no harm.

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
	Twelve patients met the criteria for administration of the sepsis treatment bundle in November 2021. All twelve received all elements of the bundle within one hour. Five 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

	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
C.diff	0	1	0	0	0	0	0	1	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 November 2021.	

QUALITY, SAFETY & PERFORMANCE

VELINDRE CANCER CENTRE DIVISIONAL REPORT
JULY 2021 - SEPTEMBER 2021

DATE OF MEETING	20th January 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**
Senior Leadership Team	06.01.2022	Approved

ACRONYMS	
VCC	Velindre Cancer Centre
Q&SMG	Quality and Safety Management Group
QSP	Quality, Safety and Performance
C&V	Cardiff and Vale
SACT	Systemic Anti-Cancer Therapy
RT	Radiotherapy
WG	Welsh Government
SCIF	Serious Clinical Incident Forum
SLT	Senior Leadership Team
PTR	Putting Things Right
WRP	Welsh Risk Pool
SST	Site Specific Teams
OfW	Once for Wales
CHC	Community Health Council
DHCW	Digital Health Care Wales
MDT	Multi-Disciplinary Team
UKONS	United Kingdom Oncology Nursing Society
WNCR	Welsh Nursing Care Record

1.0	Overview

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 July 2021 – 30th September 2021 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.

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

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)

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2.0	**Highlight from Velindre Cancer Centre Quality and Safety Management Group**

2.1 The VCC Q&SMG highlight report from the meeting on the 12th August 2021 was submitted to the SLT meeting on the 7th September 2021. There were no issues to alert or escalate to SLT.

3.0	**Safe Care** **Descriptor; avoid harm**

3.1 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.

3.2 **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 399 incidents reported in quarter 2

- 122 were categorised as no harm
- 202 low harm
- 73 moderate harm
- 2 severe reported incidents during this time

There were 28 more incidents reported during Quarter 2 than in Quarter 1 this is not deemed as significant by the Q&S team.

3.2.1 **Severe Incidents**

In this report only incidents categorised as severe are presented in any detail, moderate incidents are presented by theme.

1. A patient had an unwitnessed fall on First Floor ward. The incident was originally categorised as severe when inputted but following investigation it was downgraded to moderate.

2. Fuji synapse was offline for approximately 1 hour at the end of the working day. The incident was originally categorised as severe when inputted but following investigation it was downgraded to moderate

3.2.2. **Moderate Incidents**

A number of the incidents have been “over graded” by the reporter when the Datix form is initially completed. There is the opportunity to update the severity after the investigation has been completed by the investigator however this isn’t always done.

On review, the number of “moderate harm” incidents are lower than the number being reported. Accuracy of the severity can be improved in a number of ways.

1. Work to be done to ensure timely reviews of incidents and the severity of the incident is updated following the review.
2. To run reports on “severity of incident post investigation”.
3. Education of all VCC staff on the severity codes. SOP’s will be produced which are relevant to VCC with examples once the Datix policy has been produced and approved by VUNHST.

Following these improvements VCC will provide reports on incidents based on the severity of incident post investigation. This will provide the most accurate reflection.

Incident Type	No.	Description
Access, Admission	4	Difficulties in accessing Transport Difficulties referring patients from Treatment Helpline to DGH
Accident	7	1 staff needlestick incident 2 patient fall 3 staff with minor injuries Contractor reversed on to bollard in the car park
Assessment, Investigation, Diagnosis	4	1 Staff member potentially working outside of remit. 2 Blood samples issues 1 Poor clinical assessment
Behaviour	1	Patient rude and aggressive over phone to staff
Communication	3	Unable to contact departments
Equipment/ Devices	1	24 hour syringe on multi patient dosing CT Contrast pump became detached and had to be replaced
Information Governance	2	Patient Identifiable breaches
Information Technology	7	2 IT Communication Infected USB used in Fluoroscopy triggering an AV alert 4 Network issues
Infrastructure	6	1 Environmental Issue 3 Staffing levels 1 wifi issue 1 - Sharps bins assembled incorrectly
Medication, IV Fluids	9	3 hypersensitivity reactions 3 SACT prescribing issues 1 SACT fridge not maintaining temperature 1 medication administration 1 Incorrect type of steroid dispensed from pharmacy
Pressure Damage	2	Diabetic ulcer on admission (not a pressure ulcer) Skin failure at end of life (not a pressure ulcer) 6 reported but only 2 categorised as moderate.
Records, Information	6	Incorrect patient referral 4 x Patients not booked into RT follow up clinic Patient appointment incorrect
Transfer, Discharge	5	Referral refused by DGH 5 ambulance incidents
Treatment, Procedure	11	2 extravasations 6 related to RT 2 related to brachytherapy 1 SACT related

3.2.3. **Pressure Damage**

There were 6 pressure damage incidents reported during the period July – September 2021. Of these 6 patients;

- 1 was reviewed by the tissue viability nurse and identified as a diabetic ulcer,
- 2 patients were admitted with pressure damage,
- 1 patient developed unavoidable pressure damage due to end of life tissue failure.
  2 patients developed unavoidable hospital acquired pressure damage. They were identified as unavoidable following the pressure ulcer scrutiny panel. These 2 patients each developed a suspected deep tissue injury (SDTI) of which 1 resolved within 24 hours of recognition therefore not a SDTI but likely a grade 1. The other patient was discharged home for end of life care while the pressure damage was still classed as SDTI grade so therefore not reportable to WG (Grade 3 and 4 only reportable to WG).
  The Pressure Ulcer Scrutiny Panel meet monthly to review the previous months pressure damage incidents. Actions and learning are identified and fed back to the ward and a highlight report sent to QSMG. The Scrutiny Panel is under review and improvements to the process being made now. The Scrutiny Panel is going to be peer reviewed in January 2022 and the findings will be fed back to QSMG.

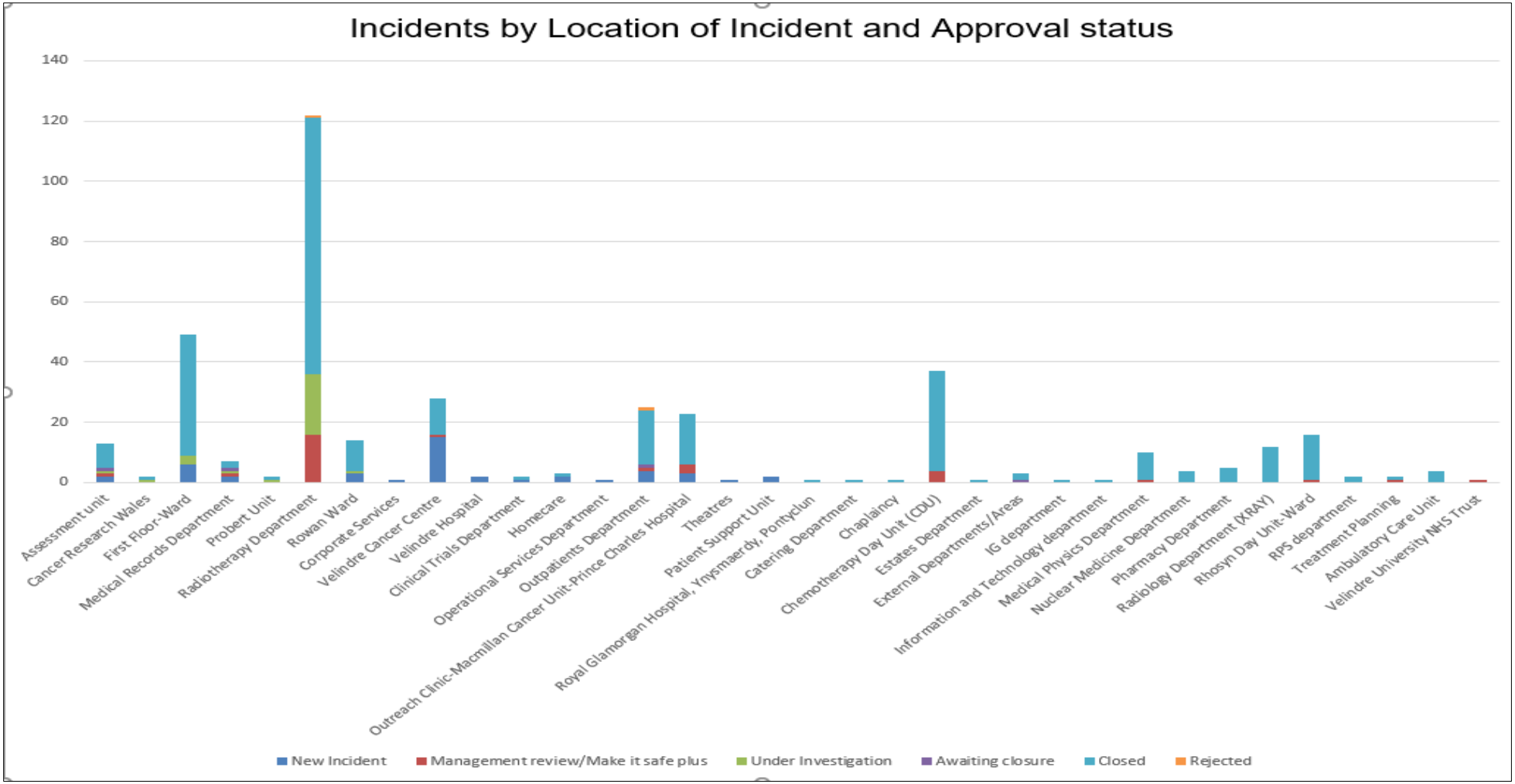
3.2.4 **COVID-19 related incidents**

Seven Covid-19 related incidents were reported across the Cancer Centre during this period. Four of the Covid-19 reported incidents related directly to staff members receiving a positive Covid-19 test. However, there have been no incidences of nosocomial transmission at the Cancer Centre during the Quarter. Three of the incidents remain under investigation.

The formal review of the cases from outbreaks at VCC in 2020 / 2021 have all been undertaken and submitted to the Welsh Government Delivery Unit as per the requirements of the national nosocomial review.

3.2.5 **Graphical analysis of incident location and approval status is shown belo**w.

This data is extracted from the new once for wales system



It is noted that the areas with the highest number of Datix's open are clinical areas under significant pressure due to Covid pandemic and recovery from the first and second waves. The newly formed Quality and Safety team have made it a priority to work with areas who have several Datix cases that remain open. An example of this is that the Q+S team have worked with the SACT department to identify the appropriate allocation of incidents e.g. extravasation incidents to be allocated to the IV access team and prescribing incidents to be allocated to the medical directorate. This ensures a more appropriate and manageable caseload. Over the next few months, we expect this to result in an improving picture with the number of open Datix's.

3.2.5 Lessons Learnt

Identifying themes and lessons and ensuring appropriate service improvement and education is in place is a priority for the Q+S team going forward. This will be done by holding regular assurance meetings between departments, Q+S team, Service Improvement, Education and Clinical Audit but while ensuring that local ownership remains. It will be an expectation that themes, and appropriate actions will be reported from each department to the QSMG and will form part of the report to QSP. Outstanding actions will be allocated the QSMG action log and reviewed regularly.

3.2.6 National Reportable Incidents (replaced Serious Incident in June 2021)

There was 1 nationally reportable incident (NRI) during quarter 2. This is the only open NRI at the moment. It was identified on 7th July 2021 that between March 2020 and July 2021, during a routine medical records audit that a medical secretary may have been working outside of the scope of the role. Make safe actions were implemented immediately and an investigation is in progress. A patient safety review of all identified patients was also undertaken.

3.2.7 Early Warning notifications (replaced No Surprises Incidents in June 2021)

One early warning notification was reported to Welsh Government in relation to a clinical negligence. This was reported on 18th August 2021. Patient is pursuing concerns against Velindre University NHS Trust via the Putting Things Right (PTR) Regulations.

3.3. Radiotherapy/IRMER Compliance/Issues/Incidents

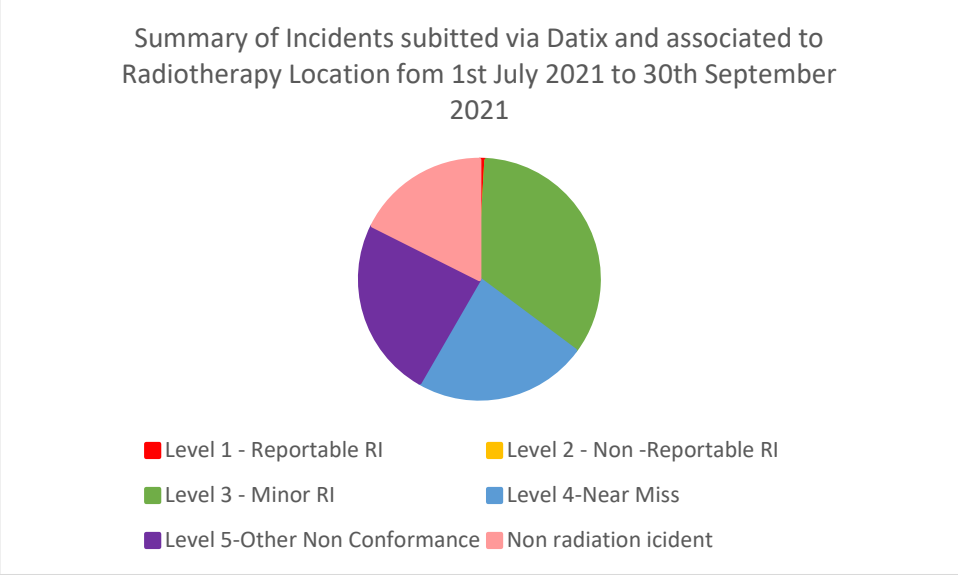
Please note that the following information is specifically related to the Radiotherapy Department location in Once for Wales Datix Incident module. The Q&S team are working with radiation services to consider reporting for the service as a whole.

July 1st to September 30th 2021

Between 1st July and 30th September, 109 incidents were reported in the Once for Wales Datix Incident module and attributed to the Location of Radiotherapy Department. Of the

109 incidents reported, 89 were classed as radiotherapy errors / radiation incidents and coded in line with Towards Safer (TSRT) of which none had a significant outcome.

July 1st 2021 to 30th September 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 incident[1] – a radiation incident that falls into the category of reportable under any of the statutory instruments (IR(ME)R 2017, IRR 2017 and so on). A reportable radiation incident will generally be clinically significant

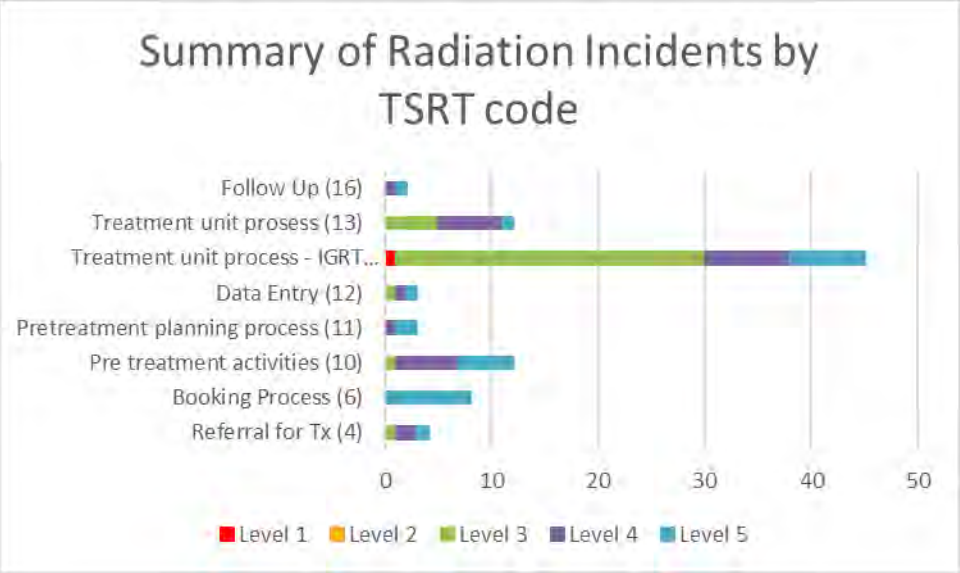
Level 2 Non-reportable radiation incident[1]- A radiation incident that does not fulfil the criteria as reportable under any of the statutory instruments (IR(ME)R 2017, IRR 2017 and so on) but is of potential or actual clinical significance. However, reporting level 2 radiation incidents to the statutory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

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

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

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

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



Level	Number of errors reported
Level 1 - REPORTABLE RADIATION INCIDENTS	**1** Being Investigated by radiotherapy Physics as part of wider XVI issue. See risk 15499.
Level 2 - NON-REPORTABLE RADIATION INCIDENTS	**0**
Level 3 - MINOR RADIATION INCIDENTS	**37** The majority of these incidents are linked to on treatment image verification failures for Elekta XVI and DIBH on La5 & LA6 which are long standing issue that are known to the manufacturers and are regularly reviewed by Radiotherapy Physics and the linear accelerator status group.
Significant outcome	**0**
Level 4 - MINOR RADIATION INCIDENTS	**25**
Significant outcome	**0**
Level 5 - OTHER NON-CONFORMANCE	**26**
Significant outcome	**0**

3.4 **Consent**

Written documentation of informed consent is required for SACT treatment which has a number of significant and potentially life threating toxicities. An audit was undertaken in 2018, to assess the standard of documentation of SACT consent before and after the introduction of new consent forms in the breast team. This audit identified areas for improvement, and it was recommended that an audit of all sites and treatments requiring consent was undertaken.

A task and finish group was set up to discuss the recommendations from the breast cancer consent audit. The group decided that in order to understand the extent of some of the issues identified in the previous audit, an audit of all patients who received both SACT and Radiotherapy should be undertaken. A smaller independent audit of radiology was also instigated by the group. A retrospective review of patients receiving treatment during October 2019 was undertaken and an action plan has been devised.

The audit demonstrated the standards set out by the UK Chemotherapy Board guidance for SACT consent were not met. The percentages were in the high nineties in the majority of cases, however improvements are required to ensure 100% compliance in future. The audit enforced the need to look at the current process for how consent forms are stored. A number of patients had no consent form in their paper or electronic notes and therefore no evidence of written consent. The audit also highlight other areas for improvement such as documentation around contact details, information provided and reconfirmation of consent

There were a number of consent forms used within Velindre, the use of the All Wales form, which is also bilingual was very low. Clarity on which forms should be used is needed.

The task and finish group has been re-established, a clinical lead has been identified and will help drive the changes required. This includes the introduction of the CRUK and RCR consent forms, ensuring we are meeting Welsh language guidelines and have an equivalent option for consent form 4 (Capacity). As well as looking at the pathway for consent and amending the guidelines accordingly. Education and patient information are also key elements in the improvement process. Service improvement are involved with the review of the consent pathway and will be key in implementing any changes. Consent has been added to the planned clinical audit programme for annual review and the next audit is planned for March 2022.

3.5 Mortality

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

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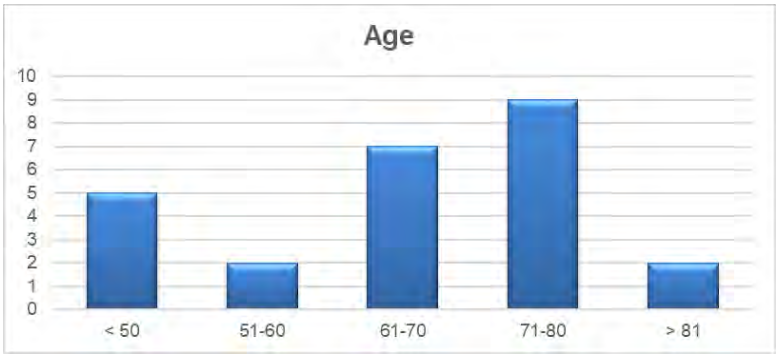
Month	Number of deaths
Jan-21	0
Feb-21	1
Mar-21	2
Apr-21	1
May-21	2
Jun-21	4
July-21	2
Aug-21	1
Sep-21	2
Oct-21	5
Nov-21	1
Dec-21	4

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

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

3.5.3 **Medical Examiner Service Requests and Processes**

We continue to refine our process to receive medical examiner referrals ensuring a robust investigation is undertaken with any learning identified and shared.

A shared VCC email account has been set up to receive information from the Medical Examiner's Office

The Medical Examiners Case Review Panel is responsible for reviewing cases brought to its attention following referral by the medical examiner and for ensuring there are mechanisms in place for providing a substantive report within a timely fashion thereafter. An important role of the Review Panel is to identify any lessons to be learnt and actions needed. This is fed in to the QSMG and actions inputted on the Action Log. The Panel also identify issues on a wider basis that require further investigation by determining breach of duty and harm through the Putting Things Right Regulations or via HM Coroners Courts.

During the reporting period 2 referrals were received from MES. Work is ongoing on improving the MES process within VCC. In future reports we will provide an update on what actions have been taken to progress the learning following the investigation.

Case No.	Issue Identified	Learning Identified	Impact on outcome
Case 1	Family concerns about the support available following the stopping of treatment in Velindre and transferring to care to Primary Care	Case reviewed: Identified need for earlier engagement with community services to ensure optimum continuity of care	No impact on patient's outcome
Case 2	Patients daughter said that consultant oncologist had been in contact to say that they were under the impression that the cancer was under control, that it would unlikely be the cause of death. Discussion with ME review that pancreatic cancer would likely have been the cause of death. The patient's daughter was advised of this information by the ME.	Clinical director is meeting with consultant to discuss learning outcomes.	No impact on patients outcome

3.5.4 **COVID 19 Pandemic update from Quarter 2**

The COVID-19 Pandemic remained ongoing during this reporting period. Full COVID-19 risk reductions measures remained in place at the Cancer Centre. Such measures included: Triage of all visitors / patients to the Cancer Centre, Screening and PCR tests for all patients pre anti-cancer treatment, AMBER / RED pathways in place and staffing lateral flow testing.

The assurance framework around the risk mitigation measures are reviewed at the Cancer Centre's Infection Control Committee, by the Quality and Safety Committee and by the Senior Management Team. Full assurance has been gained through this process that everything possible is being done to maintain the safety and integrity of the Cancer Centre's patients / staff and clinical services.

During this reporting period, there have been no COVID-19 Outbreaks, nor any incidents / evidence of nosocomial transmission. The clinical services have continued as normal.

3.6 **Resuscitation Standards Project**

Historical VCC SLA with Cardiff & Vale University Health Board expired in May 2021 and VCC commissioned external company to take on the role of Resuscitation Officer for VUNHST and work with VCC to ensure compliancy with the Resus Councils Quality Standards which includes setting up a Resuscitation Committee, reviewing key documentation, providing necessary training, assisting with data collection and benchmarking exercises (outlined within an agreed SLA)

Recording and reporting of patient safety incidents in relation to resuscitation and prompt action taken on findings or issues raised	Appropriate and available resuscitation drugs	Trained and competent clinicians and medics with up-to-date lifesaving qualifications (BLS, ILS, ALS)
Fully updated policies relating to resuscitation, cardiac arrest, advanced care planning and treatment of anaphylaxis	BENEFITS	Benchmarking resuscitation and standards of performance against key local and national objectives though regular internal, regional and national audit, e.g. the National Cardiac Arrest Audit.
Fit for purpose, accessible resuscitation equipment	Quality improvement action plans based on audits will be expedited ensuring continuous improvement of the service	Enhanced recording and reporting of patient safety incidents in relation to resuscitation and act on findings or issues raised

3.7 Divisional Risks

The risks shown below were opened and closed within the reporting period.

Opened Risks

ID	Name of Risk	Current Rating	Target Rating	Review Date	Action
2428	There is a risk of increased infection transmission due to poor ventilation.	16	9	31.01.2022	Working group established to develop business case and mitigation plan for service disruption, loss of cubicles and reduction in beds. Co-ordinated approach to be taken through D&D group.
2440	Digital Health & Care Record DHCR046(R) - unable to significantly reduce the capacity of SACT daycase clinics	16	6	26.01.2022	Decisions required to move this forward and which team and resource requirement this will sit with. However, based on current pressures from COVID related capacity. SACT scheduling and reduction of clinical space is anticipated to be affected up until March but there will be a recovery period afterwards of up to 3-4 months based on previous experience. Therefore, if a reduction in SACT treatment or pre-assessment capacity is required for the DH&CR project, this will have a greater impact on wait times and clinical availability for urgent patients. This risk will continue to be monitored. Risk discussed with DSM for SACT & MM

Closed Risks

ID	Risk	Manager
2429	Blood Collection Supply Issue	Eve Gallop-Evans

COVID-19 Pandemic related Risks

During the reporting period, the COVID-19 pandemic has remained ongoing. The patients cared for by the Cancer Centre are mainly within the Clinically Extremely Vulnerable category, and every precaution is taken to try to minimise the risk to this cohort of patients. Nonetheless, there remain a number of risks, namely:

1. Risk of nosocomial transmission – This is of particular concern on the in-patient ward where patients with a COVID positive result are treated on the same ward as those who are in the clinically extremely vulnerable category. This risk is further amplified by the poor ventilation within the ward. This risk is on the corporate Risk Register, and is being addressed via the Estates Team. Full risk reduction measures are in place, and there have been no incidents / outbreaks during the reporting period
2. Risk of compromise to clinical service delivery due to staff shortages – There is a risk that staff may be off work due to being unwell themselves. Each department has a business continuity plan to manage such situations. During the reporting period, there have been no staffing shortages to the extent that clinical service provision has been compromised.
3. Risk to patients of receiving ant-cancer treatment during the Pandemic – patients who are receiving anti-cancer treatment which has the potential to cause immuno-suppression are at an increased risk of contracting COVID 19 and of becoming unwell because of this. Full risk nosocomial risk reduction measures are in place in the cancer centre, and patients are fully informed and educated regarding the measure that they can take to help keep themselves well. All treatment is delivered in line with national guidance

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

4.1 Complaints

Type of concern	No.	KPI Achieved
Early resolution	16	100% closed within 2 days
Putting Things Right (PTR) (formal concern)	8	63% closed within 30 days
Re-opened Putting Things Right (formal concerns)	0	N/A
Redress	3	N/A
Claims	8	N/A

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

Formal concerns	Early Resolutions
Appointments – Patient booked into wrong outpatient clinic Skin Damage – Pressure ulcer development Clinical Treatment / Assessment – Unhappy with clinical opinion/diagnosis Attitude and Behaviour – Attitude of nursing staff to carers/ family Attitude and Behaviour – Attitude of medical staff to patient Clinical Treatment/ Assessment – Delay in receiving treatment Communication Issues – Patient involvement in care decisions	Communication x5 Appointments – Delay x2 Attitudes and Behaviour x3 Infection Control x1 Patient Care – Assistance in Cleaning x1 Clinical treatment/ Assessment x3

4.2 Claims

For the quarter 2 period: -

Current Claims:

Medical Negligence claims – 5
Personal Injury claims - 1

Number of New Claims Opened:
Clinical Negligence claims - 1
Personal Injury claims – 1

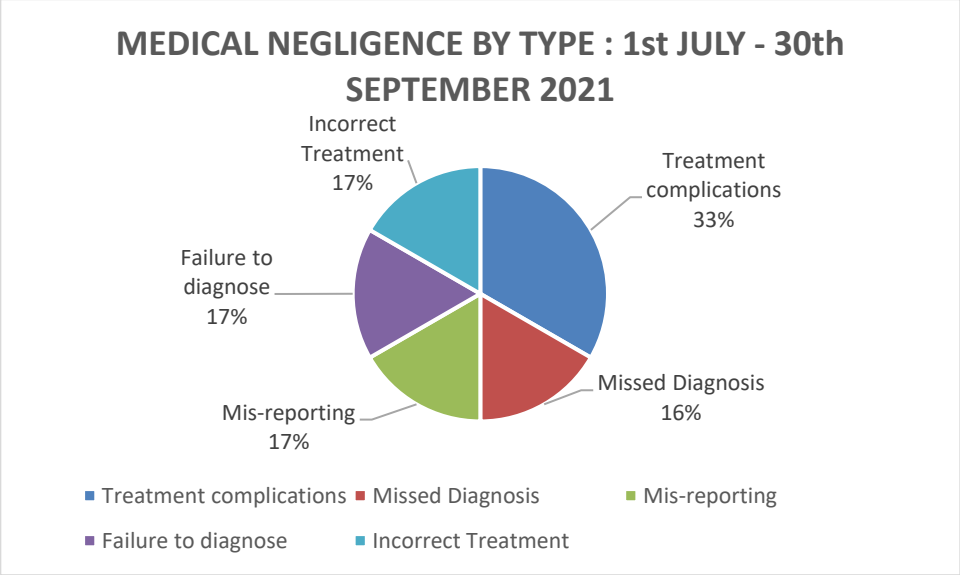
Total number of Claims this quarter, including new claims opened:
Medical Negligence: 6
Personal Injury: 2

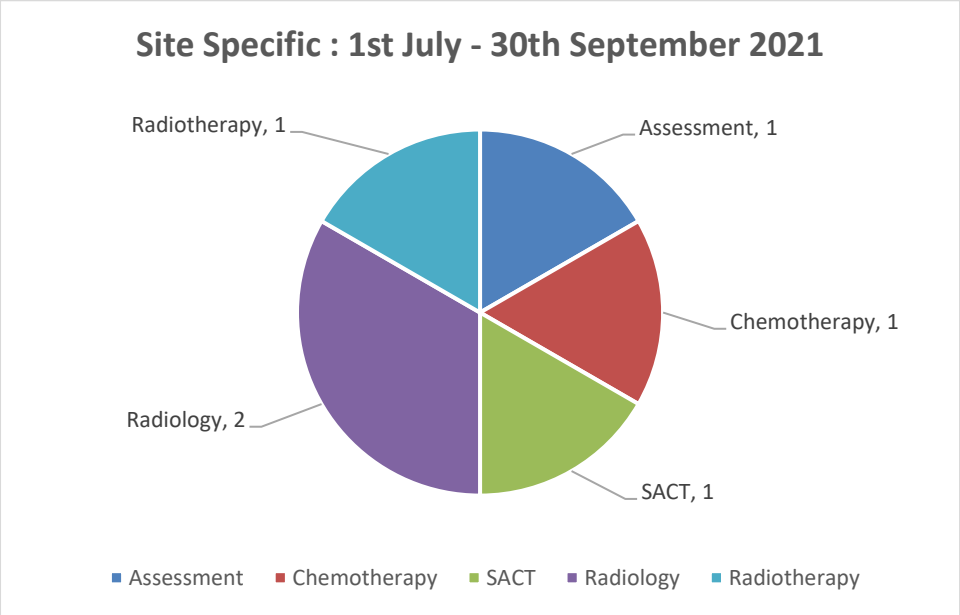
Number of claims closed:
Clinical Negligence claims - 0
Personal Injury claims - 2

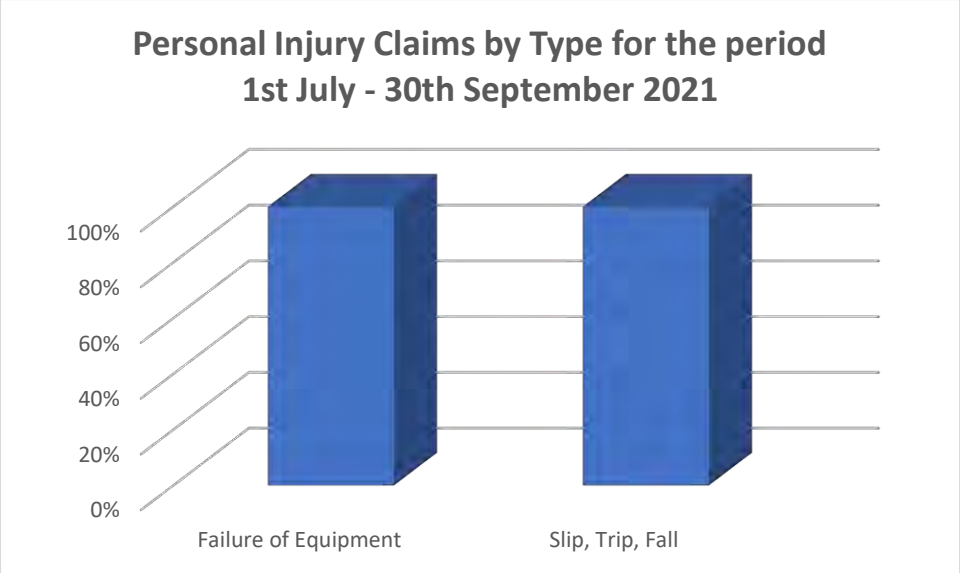
1 medical negligence claim was submitted to the Welsh Risk Pool for financial reimbursement during the quarter period.

Number of Redress Cases: -
There are currently 3 Redress cases open.

Number of Redress Cases Closed
2 Redress cases were closed during the reporting period. No qualifying liability was established which would amount to a remedy under the Redress arrangements in accordance with the Putting Things Right Regulations.




Site Specific : 1st July - 30th September 2021
Radiotherapy, 1
Assessment, 1
Chemotherapy, 1
Radiology, 2
SACT, 1
Assessment
Chemotherapy
SACT
Radiology
Radiotherapy


Personal Injury Claims by Type for the period
1st July - 30th September 2021
100%
80%
60%
40%
20%
0%
Failure of Equipment
Slip, Trip, Fall

4.3 Site Specialist Team (SST) Annual Report Appraisals

Each SST attends an SST Annual Reports Appraisals to monitor and discuss the following:

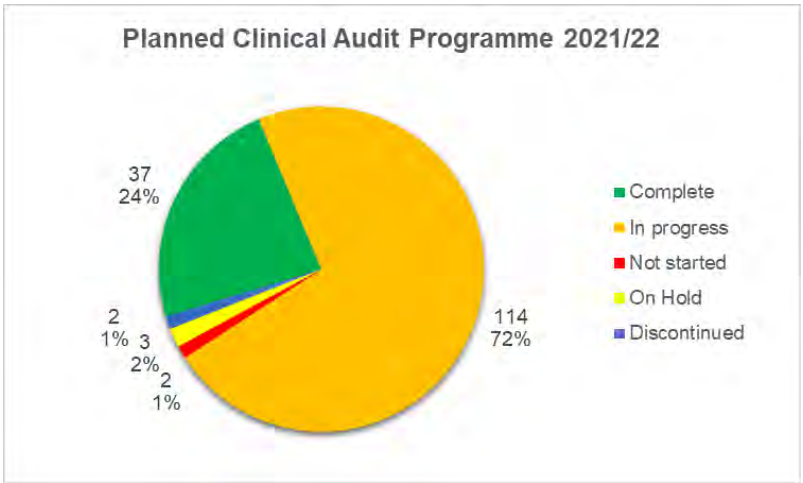
- How the SST are performing.
- What the SST doing well.
- What can SST improve on and how?
- What are the SSTs clinical ambitions and plans?
- To review complaints, concerns, compliments and incidents providing assurance of the learning.
- To monitor quality, effectiveness and timeliness of services according to national standards.
- To recommend appropriate and site-specific key performance indicators and outcome indicators.
- To provide a forum where information can be shared regarding the 'bigger picture' e.g. horizon scanning, organisation wide information sharing and tumour site specific developments, peer review information and education.
- To audit the service to ensure clinical effectiveness.
- To ensure recommendations for service improvement, education and development following national guidance and local audit and service review are considered and effectively implemented.
- To highlight and adopt best practice.

The reports are created with the entire SST and formulated into one concise document that looks back over the previous 12 months. This is then presented in a formal meeting to the Senior Leadership Team and Board Members, at Velindre Cancer Centre on annual activity within the SST, required service changes and approaches to realising these, requesting resource where appropriate. It is linked with the IMTP, Welsh Government objectives and the Cancer Quality Statement. Key members are the entire SST function; Clinical Director; Chief Operating Officer; Director of Cancer Services; SST Peers; Medical Directorate; Head of Nursing and Audit Manager. All members are encouraged to provide SST feedback in order to formulate their delivery plan for the following 12 months. The SST agenda is changing to reflect a quality and safety approach to clinical care delivery, in future this report will include PROMS and KPI data derived from the SST appraisals.

The SST reports have been delayed this year as agreed by the Director of Cancer Services due to ongoing staffing and Covid pressures.

5.0	**Efficient Care** **Descriptor; avoid waste**

5.1 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

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

6.1 WHAT OUR PATIENTS ARE SAYING

6.1.1 Patient Experience CIVICA Feedback

Patient feedback was captured in July and August through the formal questionnaire. 200 questionnaires have been sent to patients each month. As of September 2021, patient feedback has been collected via CIVICA for the first time.

July 2021

- A random selection of **200** patients were sent an experience survey via post to complete and return in a freepost envelope.
- A total of **45 surveys** were returned during July which represents a **22**% response rate
- **91%** of patients **(41/45)** rated their overall experience as excellent (9 or above)
- The highest score was **10 (30)** and the lowest score was **8 (4)**

August 2021

- A random selection of **200** patients were sent an experience survey via post to complete and return in a freepost envelope.
- A total of **130 surveys** were returned during August which represents a **65**% response rate
- **89%** of patients **(116/130)** rated their overall experience as excellent (9 or above)
- The highest score was **10 (95)** and the lowest score was **6 (1)**

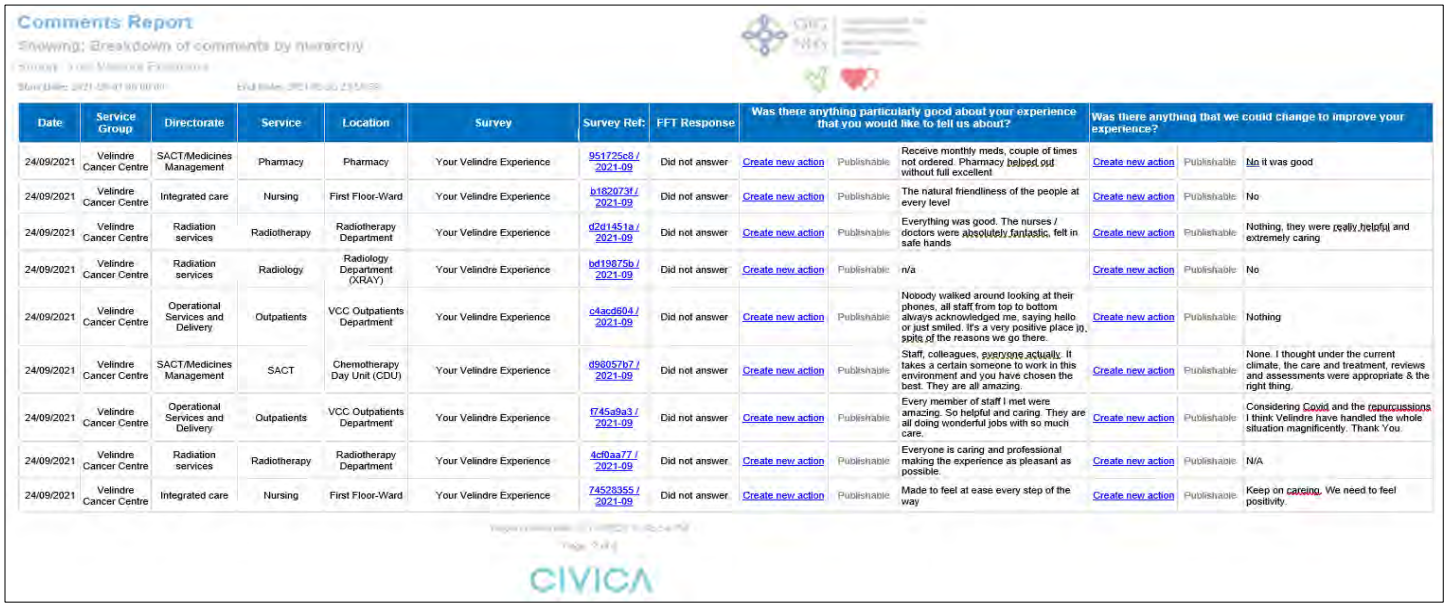
September data has been shared with SLT via CIVICA report
Key themes for improvement are:

- Waiting Times
- Contact with Clinical Teams
- Velindre Estate
- Communication / Behaviours

CIVICA system is new within VCC therefore work is ongoing on identify the learning, actions and service improvement from the feedback. This will be included in future reports

September 2021
48 patients feedback returned via CIVICA. Some patients replied giving both positive feedback and feedback of things that could be improved. There were 41 positive experiences noted and 11 episodes of "anything that could be improved"

A snapshot below of how CIVICA is reported



Comments Report

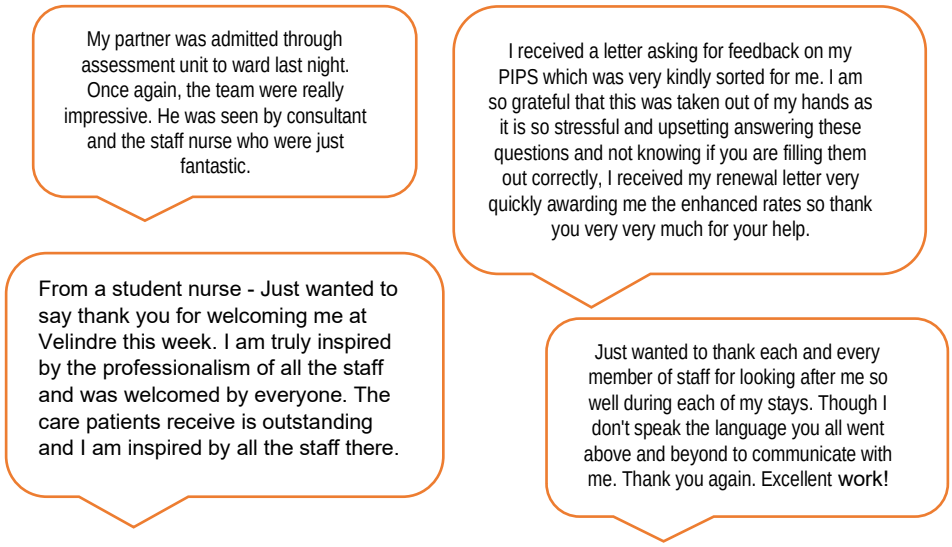
Showing: Breakdown of comments by hierarchy

Date	Service Group	Directorate	Service	Location	Survey	Survey Ref:	FFT Response	Was there anything particularly good about your experience that you would like to tell us about?			Was there anything that we could change to improve your experience?		
24/09/2021	Velindre Cancer Centre	SACT/Medicines Management	Pharmacy	Pharmacy	Your Velindre Experience	951725c8 / 2021-09	Did not answer	Create new action	Publishable	Receive monthly meds, couple of times not ordered. Pharmacy helped out without full excellent	Create new action	Publishable	No it was good
24/09/2021	Velindre Cancer Centre	Integrated care	Nursing	First Floor-Ward	Your Velindre Experience	b182073f / 2021-09	Did not answer	Create new action	Publishable	The natural friendliness of the people at every level	Create new action	Publishable	No
24/09/2021	Velindre Cancer Centre	Radiation services	Radiotherapy	Radiotherapy Department	Your Velindre Experience	d2d1451a / 2021-09	Did not answer	Create new action	Publishable	Everything was good. The nurses / doctors were absolutely fantastic, felt in safe hands	Create new action	Publishable	Nothing, they were really helpful and extremely caring
24/09/2021	Velindre Cancer Centre	Radiation services	Radiology	Radiology Department (XRAY)	Your Velindre Experience	bd19875b / 2021-09	Did not answer	Create new action	Publishable	n/a	Create new action	Publishable	No
24/09/2021	Velindre Cancer Centre	Operational Services and Delivery	Outpatients	VCC Outpatients Department	Your Velindre Experience	c4acd604 / 2021-09	Did not answer	Create new action	Publishable	Nobody walked around looking at their phones, all staff from top to bottom always acknowledged me, saying hello or just smiled. It's a very positive place to, spite of the reasons we go there.	Create new action	Publishable	Nothing
24/09/2021	Velindre Cancer Centre	SACT/Medicines Management	SACT	Chemotherapy Day Unit (CDU)	Your Velindre Experience	d98057b7 / 2021-09	Did not answer	Create new action	Publishable	Staff, colleagues, everyone actually. It takes a certain someone to work in this environment and you have chosen the best. They are all amazing.	Create new action	Publishable	None. I thought under the current climate, the care and treatment, reviews and assessments were appropriate & the right thing.
24/09/2021	Velindre Cancer Centre	Operational Services and Delivery	Outpatients	VCC Outpatients Department	Your Velindre Experience	f745a9a3 / 2021-09	Did not answer	Create new action	Publishable	Every member of staff I met were amazing. So helpful and caring. They are all doing wonderful jobs with so much care.	Create new action	Publishable	Considering Covid and the repurcussions I think Velindre have handled the whole situation magnificently. Thank You.
24/09/2021	Velindre Cancer Centre	Radiation services	Radiotherapy	Radiotherapy Department	Your Velindre Experience	4cf0aa77 / 2021-09	Did not answer	Create new action	Publishable	Everyone is caring and professional making the experience as pleasant as possible.	Create new action	Publishable	N/A
24/09/2021	Velindre Cancer Centre	Integrated care	Nursing	First Floor-Ward	Your Velindre Experience	74528355 / 2021-09	Did not answer	Create new action	Publishable	Made to feel at ease every step of the way	Create new action	Publishable	Keep on carering. We need to feel positivity.

CIVICA

6.1.2 **Compliments**

Compliments received are added to the DATIX system and share with staff via feedback boards in the clinical areas. During July to October 2021 15 compliments were captured on the OfW DATIX system. Some of the compliments include:



6.2 WHAT OUR REGULATORS / EXTERNAL / INTERNAL AUDIT ARE SAYING

6.2.1. Community Health Council First Floor Inpatients Ward visit.

Summary of Visit	
Positive Findings	1. All patients spoken to were very complimentary about the attitude, behaviour and care received from all staff. 2. Food and drink are of a high standard with plenty of choice and are available on request by patients. 3. Excellent communication from staff with regards to treatment and medication. 4. Ward and bathroom cleanliness at a high standard. 5. Patients commended the reception they had received on admission to the ward. 6. Patients noted plenty of privacy when required.
Negative Findings	1. Patients unaware of the changes to visiting rules (i.e only 1 visitor per day) until they were admitted to the ward. 2. Temperature on the ward was very high with no adequate ventilation. The CHC acknowledges that the recent heatwave experienced in Cardiff & Vale will have created temperatures that exceeded those that are usually experienced at this time of the year.
Recommendations	1. Ensure patients due to arrive for admission are informed of the current rules around visitors prior to their arrival and admission to the ward. 2. Consider ways to reduce the temperature of the ward, and increase ventilation. 3. Inform staff of the gratitude of patients with regards to the care they have received, and how they are treated on a personal level by staff on the ward.

6.2.1 Infection Prevention and Control Internal Audit was conducted in September 2021. The audit review assessed adherence to the Velindre University NHS Trust's (the Trust) Infection Prevention and Control (IPC) policies; and the Health and Care Standards.

Assurance Objectives	Assurance
Policies and Procedures	Reasonable
Accountability, ownership and scrutiny	Reasonable
Compliance with procedures	Reasonable

Managing IPC risk	Reasonable
Training and support	Substantial
Arrangements to ensure standards of hygiene	Reasonable
Healthcare-associated infections	Substantial

No significant matters for reporting were identified during our review. Four medium priority findings were identified.

Medium Priority Findings

Matter Arising	Potential Risk	Recommendation
Of the 16 IPC policies and procedures available on the Intranet, we noted than four were overdue for review at the time of the audit.	IPC policies and procedures no longer being up to date with latest practice; • an increase of infection control issues; • poor quality care or patient / donor harm.	The Corporate IPC Team should ensure that there is a programme of on-going review for IPC policies and SOPs, ideally on a three-year cyclical basis in line with good practice guidance.
IPC reporting • Within VCC IPC information not being reported to SLT or Quality and Safety meetings • Trust has not formally reviewed it's IPC KPI's for some time • Trust IPCMG meeting did not include appropriate detail in the lessons learned section	IPC performance may not be adequately scrutinised; • lessons may not be effectively shared and learned by the wider Trust; • poor quality care or patient / donor harm	a. Divisional management should clearly identify the level of IPC reporting they require and ensure this is regularly reported to the appropriate divisional management forum (for example, the divisional Quality and Safety meetings). b. The Trust should review all IPC related KPIs. c. The Trust and divisional IPCMGs should ensure that the lessons learned section in the new IPC report template is used effectively to support the sharing of lessons across all levels of the organisation.
There is no formal IPC audit action tracking system in place to effectively monitor outstanding actions from completed audits.	• identified actions may not be completed; • the Trust may not fully learn from audit outcomes; • poor quality care or patient / donor harm.	Estates is developing an action tracker for estates-related IPC actions. The Corporate IPC Team should expand on this and develop a tracker for all corporate IPC audit actions. The tracker should be regularly monitored by the Trust IPCMG, with divisional actions being monitored by the respective divisional IPCMGs
We identified several instances of non-compliance with IPC SOPs during our site visits across both divisions. • PPE usage • Bare below the elbow • Minor non-compliance	poor quality care or patient / donor harm.	• The Corporate IPC Team should ensure the IPC audit programme focuses on areas of concern highlighted by our testing. • The Corporate IPC Team should issue a Trust-wide communication highlighting the findings of our on-site fieldwork and emphasising the importance of compliance with IPC SOPs. This message should also be communicated through the divisional line management structures, via the divisional IPCMGs.

6.2.2. Incident Management Internal Audit September 2021 was conducted in September 2021 to provide Velindre University NHS Trust (the Trust) with assurance that:

- its divisions and directorates / operational service groups are compliant with Trust incident management policies and procedures; and
- incidents are being effectively managed at a divisional and directorate / operational service group level.

Assurance Summary

Assurance Objectives	Assurance
Policies and Procedures	Substantial
Timeliness/ quality of incident investigations	Reasonable
Incident monitoring and reporting	Reasonable
Learning from incidents	Reasonable

No significant matters were found for reporting. Four medium priority findings were identified.

Medium Priority Findings

Matter Arising	Potential Risk	Recommendation
Timeliness of recording incidents	Inaccurate incident reporting.	Divisional management should remind staff of the requirement to record incidents in Datix within the Policy timeframes. Datix O4W system will have the functionality to report on timeliness of recording in Datix. This should be incorporated into divisional reporting on incidents.
Incident investigation quality	• Inadequate quality of incident investigations; • actions / learning not appropriately identified to ensure incidents do not reoccur.	Recording investigations in Datix a. Divisional management should: • remind staff of the need to record all investigations (or a clear explanation of why an investigation was not undertaken) in Datix; and • ensure that incidents are not closed in Datix until the above has been recorded. Incident management training b. Divisional management should maintain a robust audit trail for incident management training delivered. Quality assurance of investigations c. Divisional management should: ensure that the quality of incident investigations and compliance with the Policy are incorporated into their audit plans on a cyclical basis; and • consider whether a joint audit of investigations should be undertaken to support further identification of inconsistencies, good practice and/or training needs for incident management across the Trust.

Incident reporting and scrutiny:	poor incident management performance not being identified and addressed; • inadequate incident management; • inability to clearly identify, and learn from, trends and themes in incident management.	a. Divisional management should ensure that incident reporting and scrutiny is undertaken regularly at divisional and directorate / OSG level. The approach should be consistent across the Trust, where appropriate. b. Incident reporting at all levels should include: • defined KPIs (including targets) for incident management, for example, timeliness of recording and investigation closure, level of open incidents, recording of investigations and learning in Datix, etc; • trend monitoring on the above KPIs and other metrics, for example, incidents by type, severity and location; • KPIs and narrative around learning (see matter arising 5); and • the requirement to clearly identify of areas of concern. c. Divisional and directorate / OSG meeting minutes should clearly evidence the scrutiny of incident reports.
Learning from Incidents	• actions / learning not appropriately identified to ensure incidents do not reoccur; and • inability to clearly identify, and learn from, trends and themes in incident management.	Divisional management should: a. remind staff of the requirement to record lessons learned in Datix; b. ensure that incident reporting at all levels (see matter arising 4 also) includes: • KPIs around recording lessons learned in Datix; and • the requirement to clearly identify concerns in trends and lessons for wider sharing (the new report template for Infection Prevention and Control performance could be used to develop this requirement). c. ensure consistency of approach across the Trust to lessons learned, including the use of the AAR database. Should this approach be used, it should be logged in Datix rather than maintained as a separate database.

6.2.2 The Audit Wales Quality Audit currently being undertaken across the Trust, commenced in June 2021. VCC are engaged with this work and continue to collate evidence to support the audit programme. Audit findings will be reviewed, shared and an action plan developed to be monitored through the VCC Q&SMG when received.

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

7.1 Treatment Helpline

A large piece of work is underway to review and improve the Treatment Helpline. There is also a national piece of improvement work led by the cancer network across all 3 cancer centres with a view to standardising structures and processes for each cancer centre helpline, which VCC is also participating in. A recent process mapping event which included VCC MDT staff, representatives from primary care, health board acute oncology teams, voluntary sector and network focused on the following issues:

- Increasing number and complexity of calls
- Increasing numbers of patient with complex co-morbidities
- New and emerging treatments requiring complex symptom management and assessment
- Expectations of staff and patients exceed the remit and capacity of the helpline
- Need to understand why so many patients are calling the helpline for general queries
- Need to establish the right staffing model with appropriate skills
- Addressing concerns and complaints

Phase 1 of the Treatment Helpline plan has been completed during Quarter 2. This included:

- Process mapping event
- Questionnaire sent to all relevant VCC staff
- Review of the questionnaire data
- Review of helpline data
- Review of the telephony infrastructure
- Review of concerns raised regarding the treatment helpline.

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

8.1 ASSURANCE / LEARNING

8.1.1 Learning Briefs

There were 5 learning wheels during this reporting period that were generated from claims and redress closed. See table below and **appendix 1**

Summary of Incident/Concern	**Key Learning**	**Actions, Review & Ongoing Assurance Mechanisms**
Incorrect position of brachytherapy vaginal vault applicator for 2 treatment fractions	• Regular review of protocols, procedures, and training packages. • Bench marking practice against other departments delivering similar treatment. • Succession planning and resource ensuring resilience in service.	• Monthly meeting set up to oversee update in training and competence of radiographers. • Regular review of protocols, and training & competence packages.
Mis-reporting a CT scan, Delay in treatment, and lack of appropriate consent and discussion regarding alternative treatment options	For the treating consultant radiologist to undertake reflective practice for the erroneous reporting. To schedule radiology discrepancy meetings to facilitate learning and safe practice with a view to learn from adverse events	Formal review through clinical audit, discrepancy meetings on a bi monthly basis Negotiation to formalise funding of sessional payments enabling identified changes to radiology. Develop process to reduce interruptions for reporting radiologists.
It was alleged that the chemotherapy treatment was given at a lower dose, resulting in a recurrence of cancer. In addition, concerns were raised regarding the treating clinician's attitude and remarks made during a consultant follow up appointment.	An independent expert report was obtained to consider if harm had occurred for not increasing the dosage of chemotherapy following the cardiology letter sent to the treating clinician. The expert found that no harm had occurred as the prognosis, on the balance of probabilities, would have been the same, regardless if the chemotherapy had been increased. The main learning	VCC will continue to increase awareness across the clinical teams on the importance of good communication to encourage best practice. This includes liaising with external sources and external speakers to encourage enhanced NHS clinical conversation to achieve better outcomes, including liaison with PSOW to deliver communication training across teams at VCC.

	related to the need to reflect on practice to prevent a similar occurrence in future.	
Patient received a cancer diagnosis in 2010 for which treatment was palliative only. Hormone therapy was initiated. It was alleged that the diagnosis and prognosis made in 2010 was incorrect and impacted significantly on her life and decision making thereafter. Delays were also experienced in regard to follow up arrangements	The most accurate information in relation to diagnosis and prognosis based upon the clinical conclusion at the time was found appropriate. However, it was identified that there needed to be in place robust processes for follow up arrangements and the way in which discussions around diagnosis, prognosis and information is conveyed to patients	The Medical Records Manager undertakes a review of monitoring follow up processes on a monthly basis. SOPs have been implemented for FUNB, processing clinical outcomes and a review of clinic outcome forms have been undertaken and processes improved to ensure that patients are provided with accurate outcomes and do not get lost to follow up.
Failure to have informed and discussed with the patient further treatment options i.e. biopsy. Failure to have chased up histopathology results. Failure to have referred the patient in a timely manner for a second opinion and a biopsy. Administration error for referring the patient to the incorrect hospital/contact.	Information sharing on the importance of pathology diagnosis. Lack of defined process for Telepath and supplementary reports. No issues with supplementary reports with the current system (TRAK) once reports are uploaded and authorised	Telepath system is no longer is use and no issues have been reported with the new system (TRAK) In terms of the safety net secretaries check that reports are received back on all cases referred out. – Regular audit of the safety net process at Cwm Taf Morgannwg University Health Board covering the MDT. Montgomery and Informed Consent training undertaken by members of the MDT including all medical staff

8.1.3 **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.

8.1.4 **Divisional Learning**

In July 2021 a paper was submitted to SLT for confirmation by directorate leads that all retrospective learning from incident, complaints, concerns has been implemented. SLT was given assurance that all learning has either been implemented or there is a plan in place. SLT agreed to approve and close this piece of retrospective work.

8.1.5 **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 

9.1	**Performance**

9.1.1 **VCC Performance Summary September 2021**

The following is a summary of performance in September 2021 the attached dashboard see **appendix 2**. 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.

6 targets were reporting red in September's performance report. These included all three COSC targets in radiotherapy (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.

The remaining three targets that were red were the National Target for waiting times for patients seen within 30 minutes of the Scheduled Appointment Times, occupational therapy outpatients seen within 6 Weeks and patient falls. These targets, which are red for September, are also themes in the patient feedback and in some of the incident reports. By triangulating this information, it is clear where improvement is needed and it is these areas that will be the focus of the assurance meetings that the Q&S teams will have on a monthly basis with Directorate leads, this will lead to an improvement in compliance with targets, patient feedback, a reduction in incidents and clear lessons learned.

10.0	**Celebration and Exception**

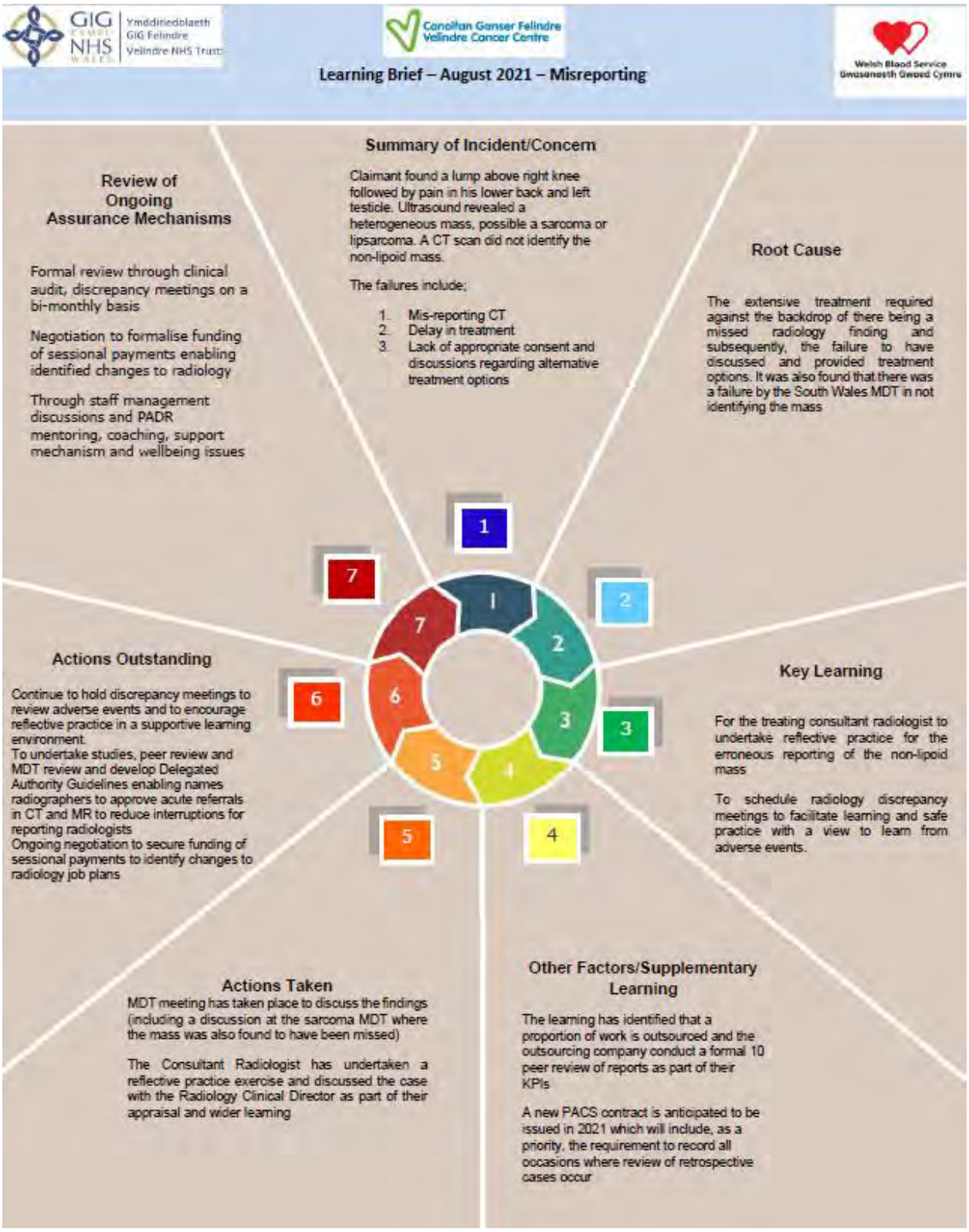
Celebrations

10.1 There are no formal celebration items for this reporting period.

11.0	Conclusions

11.1 This period 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 high levels of 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/complements are being managed appropriately and that lessons learned and actions are implemented and monitored by Directorate leads and their teams but there is more to do.

Appendix 1


Ymddiriedolaeth GIG Felindre Velindre NHS Trust
Canolfan Ganser Felindre Velindre Cancer Centre
Welsh Blood Service Gwasanaeth Gwaed Cymru
Learning Brief – August 2021 – Misreporting
Summary of Incident/Concern
Claimant found a lump above right knee followed by pain in his lower back and left testicle. Ultrasound revealed a heterogeneous mass, possible a sarcoma or lipsarcoma. A CT scan did not identify the non-lipoid mass.
The failures include;
1. Mis-reporting CT
2. Delay in treatment
3. Lack of appropriate consent and discussions regarding alternative treatment options
Review of Ongoing Assurance Mechanisms
Formal review through clinical audit, discrepancy meetings on a bi-monthly basis
Negotiation to formalise funding of sessional payments enabling identified changes to radiology
Through staff management discussions and PADR mentoring, coaching, support mechanism and wellbeing issues
Root Cause
The extensive treatment required against the backdrop of there being a missed radiology finding and subsequently, the failure to have discussed and provided treatment options. It was also found that there was a failure by the South Wales MDT in not identifying the mass
1
2
3
4
5
6
7
Actions Outstanding
Continue to hold discrepancy meetings to review adverse events and to encourage reflective practice in a supportive learning environment.
To undertake studies, peer review and MDT review and develop Delegated Authority Guidelines enabling names radiographers to approve acute referrals in CT and MR to reduce interruptions for reporting radiologists
Ongoing negotiation to secure funding of sessional payments to identify changes to radiology job plans
Key Learning
For the treating consultant radiologist to undertake reflective practice for the erroneous reporting of the non-lipoid mass
To schedule radiology discrepancy meetings to facilitate learning and safe practice with a view to learn from adverse events.
Actions Taken
MDT meeting has taken place to discuss the findings (including a discussion at the sarcoma MDT where the mass was also found to have been missed)
The Consultant Radiologist has undertaken a reflective practice exercise and discussed the case with the Radiology Clinical Director as part of their appraisal and wider learning
Other Factors/Supplementary Learning
The learning has identified that a proportion of work is outsourced and the outsourcing company conduct a formal 10 peer review of reports as part of their KPIs
A new PACS contract is anticipated to be issued in 2021 which will include, as a priority, the requirement to record all occasions where review of retrospective cases occur

GIG CYMRU NHS WALES | Ymddiriedolaeth GIG Felindre Velindre NHS Trust

Canolfan Ganser Felindre Velindre Cancer Centre

Welsh Blood Service Gwasanaeth Gwaed Cymru

Learning Brief – August 2021 – Reduction in chemotherapy treatment and clinical attitude

Summary of Incident/Concern

It was alleged that the chemotherapy treatment (Cisplatin), was given at a lower dose, resulting in a recurrence of cancer.

In addition, concerns were raised regarding the treating clinician's attitude and remarks made during a consultant follow up appointment.

Root Cause

It was identified that the initial reduction in chemotherapy was appropriate and in accordance with the NICE guidelines. It was deemed that this was a necessary precaution given the patient's prolonged QT-syndrome. However, it was established that following a cardiology review of the patient and a subsequent cardiology letter sent to the treating clinician advising that the chemotherapy dosage should be increased at the next cycle of treatment, this did not occur.

Review of Ongoing Assurance Mechanisms

VCC will continue to increase awareness across the clinical teams on the importance of good communication to encourage best practice. This includes liaising with external sources and external speakers to encourage enhanced NHS clinical conversation to achieve better outcomes, including liaison with PSOW to deliver communication training across teams at VCC.

Lessons learnt from individual cases are presented to the Quality and Safety Performance Committee meeting together with the actions taken.

Actions Outstanding

The PSOW is offering a training package which involves communication training across NHS Welsh organisations. Dates are currently being arranged with the PSOW to deliver communication training to clinical teams at VCC.

Communication topics includes:

- Creating options for mutual benefit
- Types of questioning to ask for successful outcome
- Active listening
- Do our customers feel listened to?
- Questioning

Key Learning

An independent expert report was obtained to consider if harm had occurred for not increasing the dosage of chemotherapy following the cardiology letter sent to the treating clinician. The expert found that no harm had occurred as the prognosis, on the balance of probabilities, would have been the same, regardless if the Capecetabine had been increased. The main learning related to the need to reflect on practice to prevent a similar occurrence in future.

Actions Taken

Communication training was delivered on the 7th July 2021 to SMCS, highlighting the importance of communication from analysis of trends and themes for 2020/2021.

Reflective practice exercise undertaken by the treating clinician.

Acronyms :- Public Service Ombudsman of Wales (PSOW)

SMSC – to complete

Other Factors/Supplementary Learning

To discuss learning points with clinical teams/consultants on the importance of good communication.

NST would like to thank Manchester Safeguarding Board and Lancashire Safeguarding Children and Adult Boards for their help with the template and original guidance on 7 minute briefings.

January 2018

National Safeguarding Team
(Public Health Wales)

Learning Brief – August 2021 – Misdiagnosis and delays with follow up arrangements

Summary of Incident/Concern

Patient was diagnosed with a high-grade sarcoma in 2010 for which treatment was palliative only. Hormone therapy was initiated. It was alleged that the diagnosis and prognosis made in 2010 was incorrect and impacted significantly on her life and decision making thereafter. Delays were also experienced in regard to follow up arrangements.

Root Cause

The most accurate information in relation to diagnosis and prognosis based upon the clinical conclusion at the time was found appropriate.
However, it was identified that there needed to be in place robust processes for follow up arrangements and the way in which discussions around diagnosis, prognosis and information is conveyed to patients.

Review of Ongoing Assurance Mechanisms

The Medical Records Manager undertakes a review of monitoring follow up processes on a monthly basis. SOPs have been implemented for FUNB, processing clinical outcomes and a review of clinic outcome forms have been undertaken and processes improved to ensure that patients are provided with accurate outcomes and do not get lost to follow up.

Actions Outstanding

VCC will continue to increase awareness across the clinical teams on the importance of good communication to encourage best practice. This includes liaising with external sources and external speakers to encourage enhanced NHS clinical conversation to achieve better outcomes, including liaison with PSOW to deliver communication training across teams at VCC

Key Learning

To discuss learning points with clinical teams/consultants on the importance of good communication.

Actions Taken

Communication training was delivered on the 7th July 2021, to highlight the importance of communication from analysis of trends and themes for 2020/2021.

Presentation delivered on 3rd November to medical records staff to minimise lost to follow up appointments.

Other Factors/Supplementary Learning

To ensure there are robust processes in place for follow up appointments

Acronyms – FUNB – Follow Ups Not Booked

SOPS – Standard Operating Procedures

NST would like to thank Manchester Safeguarding Board and Lancashire Safeguarding Children and Adult Boards for their help with the template and original guidance on 7 minute briefings.

January 2018

Summary of Incident/Concern

Patient was referred to Velindre in October 2017 with a diagnosis of Ewing's Sarcoma. Concerns were raised regarding;
The initial Sarcoma diagnosis
Whether the patient was given the correct chemotherapy treatment
Whether a request for a second opinion should have been requested sooner?
Whether any of the above had an impact on patient's outcome?

Root Cause

It was identified that the following errors occured;
Failure to have informed and discussed with the patient further treatment options i.e. biopsy. Failure to have chased up histopathology results.

Failure to have referred the patient in a timely manner for a second opinion and a biopsy.

Administration error for referring the patient to the correct hospital/contact.

Review of Ongoing Assurance Mechanisms

Telepath system is no longer is use and no issues have been reported with the new system (TRAK)

In terms of the safety net secretaries check that reports are received back on all cases referred out. – Regular audit of the safety net process at Cwm Taf Morgannwg University Health Board covering the MDT

Actions Outstanding

A formal Standard Operating Practice is currently in progress led by Cwm Taf Morgannwg University Health Board do we know what the SOP is for?

Key Learning

Information sharing on the importance of pathology diagnosis

Lack of defined process for Telepath and supplementary reports. No issues with supplementary reports with the current system (TRAK) once reports are uploaded and authorised.

Actions Taken

Montgomery and Informed Consent training undertaken by members of the MDT including all medical staff

Discussion of case at South Wales Sarcoma morbidity and mortality on 30th June 2021

Training was delivered on the 7th July 2021, to highlight the importance of communication and timeliness from an analysis of complaints/incidents trends and themes for 2020/2021.

Other Factors/Supplementary Learning

Both the sarcoma panel and AWLP now issue their own reports on all referred cases which can be seen on the Welsh Clinical Portal (WCP). When the report is received it is now attached as a supplementary report to the original histology report.

NST would like to thank Manchester Safeguarding Board and Lancashire Safeguarding Children and Adult Boards for their help with the template and original guidance on 7 minute briefings.

January 2018

Summary of Incident/Concern

Patient with diagnosis of osteosarcoma contacted Treatment helpline with red flag symptoms, subsequently admitted to VCC and diagnosed with severe neutropenic sepsis. Patient transferred but sadly died.
Concerns raised relating to;
The dose of chemotherapy
Failure to act on blood results
Failure to provide GCSF (granulocyte-colony stimulating factor) treatment
Failure to document a full toxicity screening

Root Cause

The investigation concluded that the chemotherapy dose prescribed was in accordance with local protocol but was not age adjusted.

No documented evidence of a full toxicity assessment (UKONS) The investigation found that combined with the clinical judgement of the helpline nurse such an assessment may have prompted an urgent medical assessment in a hospital setting rather than in the community

Missed opportunity to identify all significant chemotherapy toxicities that could have triggered an earlier hospital review. Failure to act on abnormal blood test results resulting in delayed diagnosis of sepsis

Review of Ongoing Assurance Mechanisms

A comprehensive review of the treatment helpline is in progress

Staff training provided for all staff that work on the treatment helpline of the appropriate completion of UKONS triage tool.

Review of competency assessment and reassessment has been undertaken

Actions Outstanding

For tumour Site Specific Teams to review their protocols to include age adjustments in the chemotherapy protocols in the chemocare system important to consider co-morbitiies as well as age.

Actions Taken

Treatment helpline standards were reviewed to ensure that all staff are aware of their responsibilities for assessment and documentation

Staff training was undertaken to remind them of the appropriate and robust completion of UKONS triage tool

Call handler competency assessment also updated

Work ongoing with business intelligence to support the enablement of audit of completion of toxicity scoring

Key Learning

The failure to have documented a UKONs tools assessment

Lack of record keeping

To ensure timely admission for assessment and review at hospital to prevent the development of severe sepsis and/or use of GCSF (granulocyte-colony stimulating factor)

25/01/2018

Appendix 2

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

			Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Radiotherapy	Patients Beginning Radical Radiotherapy Within 28-Days (page 6) ***(JCCO Measure)***	Actual	94%	91%	92%	95%	97%	92%	89%	95%	94%	97%	96%	92%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Patients Beginning Palliative Radiotherapy Within 14-Days (page 8) ***(JCCO Measure)***	Actual	82%	91%	93%	90%	97%	90%	85%	95%	84%	82%	82%	74%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Patients Beginning Emergency Radiotherapy Within 2-Days (page 10) ***(JCCO Measure)***	Actual	97%	94%	93%	95%	97%	100%	97%	100%	100%	97%	100%	85%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Scheduled Patients Beginning Radiotherapy Within 21-Days (page 11) ***(COSC Measure)***	Actual							35%	28%	37%	35%	31%	27%
		Target	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
	Urgent Scheduled Patients Beginning Radiotherapy Within 7-Days (page 11) ***(COSC Measure)***	Actual							41%	48%	40%	54%	52%	52%
		Target	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
	Emergency Patients Beginning Radiotherapy Within 1-Day (page 11) ***(COSC Measure)***	Actual							83%	88%	85%	82%	86%	82%
		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	68%	79%	86%	79%	77%	88%	98%	98%	98%	99%	99%	98%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
		Actual	100%	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

			Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
	Patients Beginning Emergency SACT Within 2-Days (page 16)	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 20)	Actual	72%	93%	67%	66%	65%	57%	66%	79%	76%	76%	53%	53%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Did Not Attend (DNA) Rates	Actual	2%	2%	2%	3%	2%	3%	3%	4%	4%	5%	5%	5%
		Target	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%
Therapies	Therapies Inpatients Seen Within 2 Working Days (page 23)	Actual (Dietetics)	95%	96%	97%	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%	100%	100%	100%
		Actual (Speech and Language Therapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Therapies Outpatient Referrals Seen Within 2 Weeks (page 23)	Actual (Dietetics)	98%	96%	97%	100%	100%	100%	100%	100%	84%	94%	94%	98%

			Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-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 23)	Actual (Dietetics)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Physiotherapy)	94%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Occupational Therapy)	100%	94%	100%	100%	100%	100%	100%	100%	100%	100%	96%	33%
		Actual (Speech and Language Therapy)	100%	100%	100%	100%	100%	100%	100%	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 25)	Actual	3	2	2	0	0	0	1	0	0	0	2	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	0	0	0	1	0	0	0	0	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0

			Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
	Number of VCC Inpatient Falls (page 27)	Actual (Total)	4	0	2	1	1	1	2	3	1	3	4	2
		Unavoidable	3	0	2	1	1	1	1	3	1	3	4	1
		Avoidable	1	0	0	0	0	0	1	0	0	0	0	1
		Target	0	0	0	0	0	0	0	0	0	0	0	0
	Number of Delayed Transfers of Care (DToCs)	Actual	1	1	0	0	0	0	0	0	0	0	1	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 29)	Actual	100%	75%	100%	100%	100%	100%	100%	100%	100%	80%	100%	75%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Healthcare Acquired Infections (page 30)	Actual	0	0	0	1 (C.diff)	0	0	0	0	0	1 (C.diff)	0	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0
Percentage of Patients Who Rate Experience at Velindre at 9 or Above		Actual	78%	85%	Routine Reporting Currently Interrupted									
		Target	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%

		Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Percentage of Episodes Clinically Coded Within 1 Month Post Episode End Date	Actual	98%	98%	99%	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.

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.

Welsh Blood Service Monthly Report

November 2021

- All demand for red cells was met, and all stock groups continued to be maintained above 3 days and averaging at 1409 units per week, representing a reduction in demand from the previous month.
- All clinical demand for platelets was met averaging 199 units per week in November, compared to 211 for October.
- Monday 8th November marked the first peripheral blood stem cell collection performed by the Welsh Bone Marrow Donor Registry at the new collection centre within Velindre Cancer Centre.
- The number of new bone marrow volunteers added to the Welsh Bone Marrow Donor Registry (WBMDR) reached 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 97%, the turnaround time for routine Antenatal tests in November remains above the target of 90%.
- There is a 5% improvement for the Red Cell testing metric in November. Work continues to prioritise clinical need with all compatibility testing (>50% of referrals) completed to the required time/date. The Service workload audit continues to progres s.
- At 0.92 Collection Productivity for November is higher than October (0.86) but continues to be below target. The ongoing COVID 19 response need to resource Triage at donation clinics and short term staff absences due to Covid is causing a reduction in session capacity in North Wales, impacting performance for November.
- At 2.40 % for November, the combined 'Part Bag' rate has increased and is higher than October (2.27%) but remains within the tolerance level. The Failed Venepuncture (FVP) rate for November has increased to 1.60 % compared to 1.37% for October but also remains within the tolerance threshold of 2%. Evaluation is taking place to establish the need for any interventions.
- At 96% the performance against the 'Incidents closed within 30 days' measure has exceeded target (90%) for the three month rolling period to November.
- There were two Serious Adverse Events (SAE) reported to the HTA (Human Tissues Authority) in November. Both events are related to Stem Cell Collection and have been investigated to establish root cause and corrective actions identified and completed.
- At 424.30 the manufactoring perfomence for November is closer to the target of 392.00 than the October performance of 325.30. The November performance reflects pressure on existing staffing numbers as a result of increased sickness and support provided for vaccine distribution.
- In November ten concerns (0.13%) from Blood Donors were reported and nine were managed within timeline as early resolution. The one formal concern is being managed under 'Putting Things Right' (PTR) regulations and is expected to be completed before the 30 day target of 28/12/21.
- In November overall donor satisfaction reached 97.2%. In total there were 819 respondents who had made a full donation and shared their donation experience, 135 were from North Wales and 650 were from South Wales.

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

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

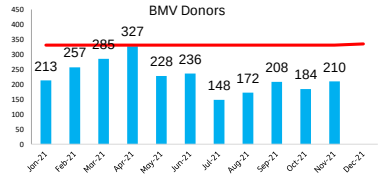
5 Key Performance Indicators were down on the previous month's performance, with 4 achieving target..

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

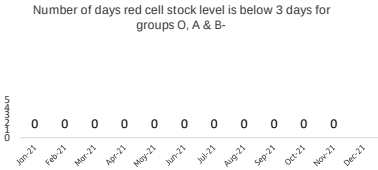
Equitable and Timely Access to Services



Nov-21

Annual Target: 4000 (ave 333 per month)	SMT Lead: Jayne Davey / Tracey Rees	
What are the reasons for performance?	Action (s) being taken to improve performance	By When
There were 210 new bone marrow volunteers added to the Welsh Bone Marrow Donor Registry (WBMDR) in November. The inability to hold whole blood donation clinics in schools and Universities, continues to hinder recruitment of new BMV's (Bone Marrow Volunteers).	The new donor recruitment and retention strategy for the WBMDR became live on 03/08/2021. Further work to raise the public awareness of the strategy to support the desired increase in volunteers is currently being reviewed. WBS SMT has agreed to promote the 'Swab Recruitment' in the main Universities in Wales in an attempt to meet the monthly target of 333 donor recruitments. This work is currently being carried out. WMBDR Communications Group meetings have been established to take place monthly to support raising the profile of this collection.	A new system is in place since 03/08/2021, ongoing monitoring and review in March 2022 to take place

Safe and Reliable Service

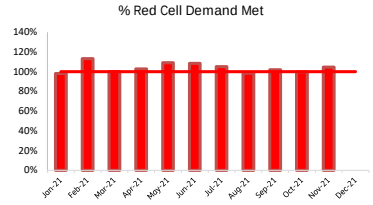


Nov-21

Monthly Target: 0	SMT Lead: Jayne Davey / Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
All stock groups continue to be maintained above 3 days for November	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

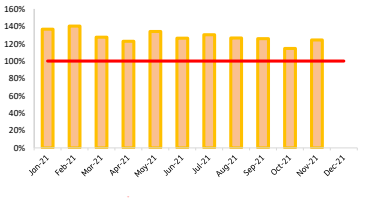
Nov-21



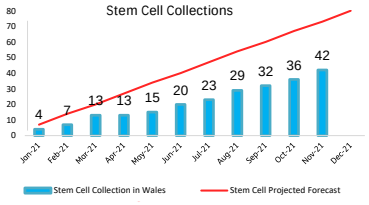
Monthly Target: 100%	SMT Lead: Jayne Davey/ Tracey Rees	
What are the reasons for performance?	Actions(s) being taken to improve performance	By When
All demand for red cells was met. Factors affecting the supply chain include Covid restrictions, winter pressures and staff absence. Close collaborations between the Collections and Laboratory teams continues to enable agile responses to variations of stock levels and service needs. Demand in November (full weeks) averaged at 1409 units per week.	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

Nov-21



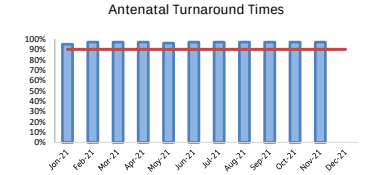
Monthly Target: 100%	SMT Lead: Jayne Davey / Tracey Rees	
What are the reasons for performance?	Actions(s) being taken to improve performance	By When
All clinical demand for platelets was met. Daily communications between the Collections and Laboratory teams enables agile responses to variations of stock levels and service needs. Platelet demand was 199 units per week on average.	The Ambient Overnight Hold (AONH) production process allows flexibility in the production plan for platelets. Adjustments on the weekly production continue to be made to align with demand.	Business as Usual, reviewed daily



Safe and Reliable service

Nov-21

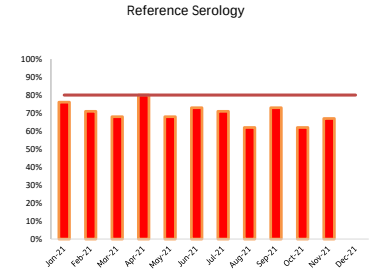
Annual Target: 80 (ave 7 per month)	SMT Lead: Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
There were 6 Stem Cell Collections in November, 5 by the Peripheral Blood Stem Cells (PBSC) collection method and 1 by bone marrow harvest. There were 3 cancellations at the preparation/work up stage which has impacted on collection performance for November, 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.	30/06/2022



Safe and Reliable service

Nov-21

Monthly Target: 90%	SMT Lead: Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
At 97%, the turnaround time for routine Antenatal tests in November 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



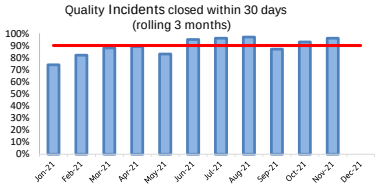
Safe and Reliable service

Nov-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 November. Work continues to be prioritised based on clinical need, and all compatibility testing (>50% of referrals) is completed to the required time/date. Whilst performance did improve, the complexity of referrals, sickness absence, 'Out of Hours' responses and the resulting impact on day to day work impacted performance in November. There were 255 hospital patient referrals in November, with the average number of Hospital Patient referrals at 221/month for 2021 to date, compared to 181 in 2020.	WBS is conducting an audit which is focussing upon the appropriateness of out of hours hospital referrals based on haemoglobin and diagnosis, the urgency of transfusion, how long samples take to reach WBS, if there is any 'overordering', and multiple requests for patients . The results of the audit are not expected to be available until end of January 2022. The implementation of a project aimed to increase automation in RCI (Red Cell Immunohematology) is also anticipated to improve performance in this area.	30/01/2022 Date yet to be decided due to ongoing scoping project work.

Safe and Reliable service

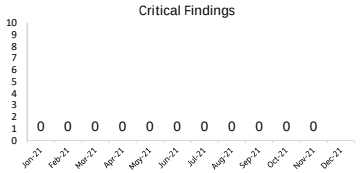
Nov-21



Monthly Target: 90%	SMT Lead: Peter Richardson	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
At 96% the performance against the 'Incidents closed within 30 days' measure exceeded target (90%) for the three month rolling period to November. The September performance against this measure continues to influence the three month rolling performance .	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.

Safe and Reliable service

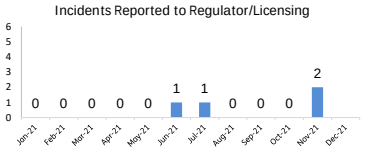
Nov-21



What are the reasons for performance?	Action(s) being taken to improve performance	By When
UKAS undertook an ISO 15189 'Extension to Scope' audit of the WTAIL HPA (Human Platelet Antigen) testing process in November. There were no critical findings from this audit.	The HPA testing process will be audited in December 2021. All previous UKAS findings have been cleared. Actions from previous MHRA inspections are being managed as business as usual via action plans.	Completed.

Safe and Reliable service

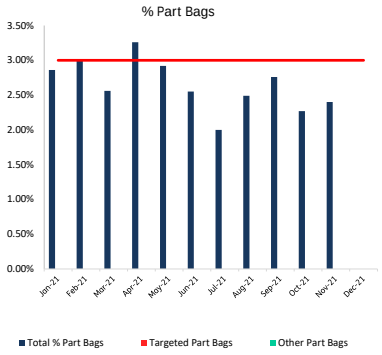
Nov-21



Annual Target: 0	SMT Lead: Peter Richardson	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
There were two Serious Adverse Events (SAE) reported to the HTA (Human Tissues Authority) in November, both involve Stem Cell Donors. The incidents were reported to the HTA and Datix. One is classified as a 'Medication/IV fluids- Administration Error', whilst the other as 'Treatment or Procedure Issues.' System notifications have been issued to relevant staff members, including the Senior staff at Trust and WBS. Details of each event, the root cause analysis and subsequent corrective and preventive actions are recorded in Datix. The Donor involved in the Medication/IV fluids- Administration Error was informed immediately, at the time the event occurred, and did not suffer any adverse effects. The Donor involved in the Treatment or Procedure Issue was hospitalised due to a low platelet count, but discharged the following day, with another platelet count due to be undertaken by WBMDR nurses at two weeks post-discharge.	Corrective and preventive action for the 'Medication/IV fluids- Administration Error' has been defined as: •Member of staff involved in the error has completed reflective practice •Calcium Gluconate is now quarantined in a specific and consistent space within the drug cabinet •All staff will now use a pre-filled sodium chloride syringe, rather than ampoules •The process requires a two person check for IV drug administration is required and will be evidenced by a signature The Head of Welsh Bone Marrow Donor Registry has advised that both HTA reports are closed.	Completed.

Spending Every Pound Well

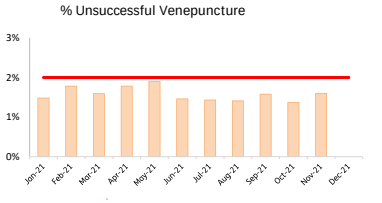
Nov-21



Monthly Target: Maximum 3%	SMT Lead: Janet Birchall	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
At 2.40% for November, the combined 'Part Bag' rate remains within the required tolerance level. Analysis indicates a downward trend for 'South East A' & 'South East B' team performance against this measure. South Wales East C and the Stock Building teams are over tolerance for November at 3.1% and 3.6% respectively. The Stock Building team collect low volumes and the tolerance breach represents 3 part bag events. Investigation of South East C Team performance has identified 4 venepuncturists with higher part bag events than others. Further analysis is now taking place to confirm the significance of this finding. Movement of staff between East teams can make it more difficult to track this performance measure. 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 has identified the performance of four venepuncturists influencing South East C performance. Operation Managers & the Training Team are evaluating the information, and should it be required further interventions (I.e. Individual Support Plans and or Additional Training /Supervision) can be actioned.	31/01/2022

Spending Every Pound Well

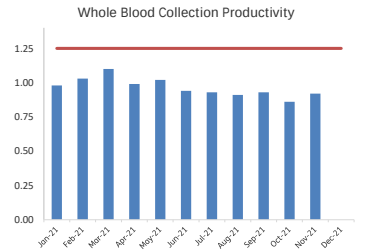
Nov-21



Monthly Target: Maximum 2%	SMT Lead: Janet Birchall	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
The overall Failed Venepuncture (FVP) rate for November is at 1.60 %, an increase compared to October (1.37%) but remains within the tolerance threshold of 2%. The performance trend of the 'South East A' team is now showing an improvement, whilst the 'South East C' team is at tolerance (22 FVP events) and Wrexham team is over tolerance at 2.3% (18 FVP events). The 'Stock Building' team performance is at 2.4% (2 FVP events).	Performance analysis of the Wrexham and South East C teams has identified two venepuncturists of each team with higher FVP rates. Operation Managers & the Training Team are evaluating the information, and should it be required further interventions (I.e. Individual Support Plans and or Additional Training /Supervision) can be actioned. Ongoing monitoring of the Stock Building team performance.	31/01/2022

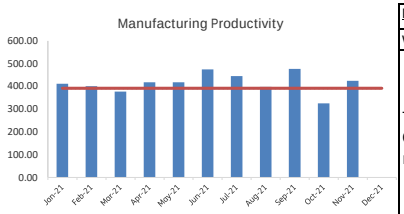
Spending Every Pound Well

Nov-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 0.92 collection productivity for November is higher than October (0.86) but continues to be below target. In November several staff resigned from the Service and recruitment is ongoing to replace them. Covid and Infection Prevention Control (IPC) measures continue to limit donation centre capacity. Meanwhile short term staff absences due to Covid, combined with the reduction in session capacity in North Wales due to staff unavailability has impacted performance for November. 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. Robust sickness management of staff continues and productivity measures will be considered for the Divsion's new Performance Management Framework.	Q1 2022

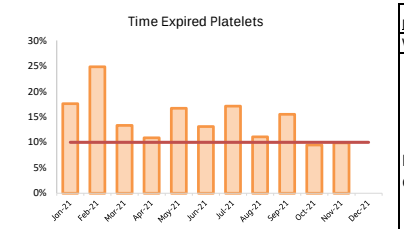
Spending Every Pound Well



Monthly Target 392	SMT Lead: Tracey Rees	
What are the reasons for performance?	Actions(s) bring taken to improve performance	By When
The November manufacturing performance figure is at 424.30 and closer to the 392.00 target than the October performance. The November performance reflects pressure on existing staffing numbers as a result of increased sickness and support provided for vaccine distribution.	This target measures the manufacturing productivity by assessing the staffing levels against the number of blood components being manufactured. This performance measure is being actively considered as part of the new Perforamnce Management Framework.	Q1 2022

Spending Every Pound Well

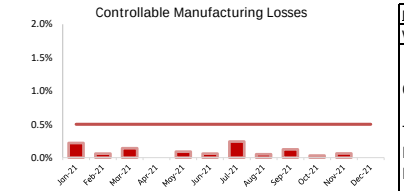
Nov-21



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 within target for November, as result of carefully planned reduction in production, coupled with increased platelet requests from customer hospitals	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

Spending Every Pound Well

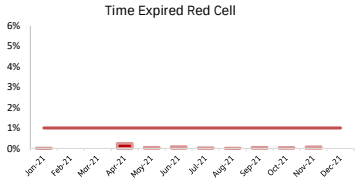
Nov-21



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 November are at 0.1% and remain within tolerance to be below 0.5%. The losses were (units): M&D Operator - Blood Presses :3 units M&D - Heat Seal : 1 unit	Reporting and management of incidents, ongoing monitoring of losses when occurring and lessons learned analysis takes place. The metric for November is within tolerance and represents a very low percentage of processed units.	Business as Usual, reviewed monthly

Spending Every Pound Well

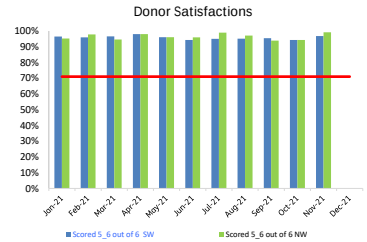
Nov-21



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 November at 0.08% remained very low and significantly lower than the 1% target.	Effective stock management and monitoring	Business as usual, reviewed daily

First Class Donor Experience

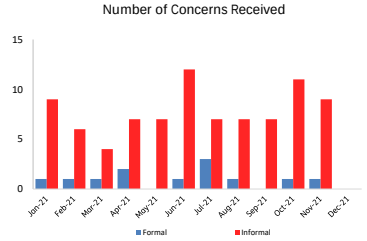
Nov-21



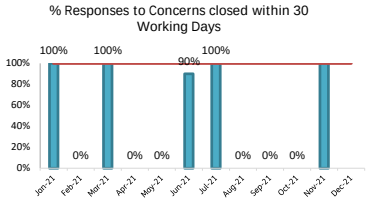
Monthly Target: Minimum 71%	SMT Lead: Jayne Davey	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
In November overall donor satisfaction continued to exceed target at 97.2%. In total there were 819 respondents who had made a full donation and shared their donation experience (some of which are non attributable), 135 were from North Wales and 650 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

Nov-21



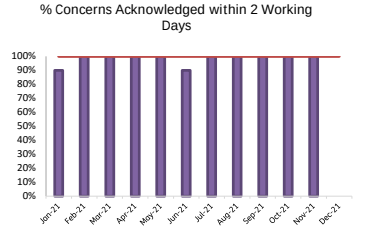
Target: N/A	SMT Lead: Alan Prosser	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
In November 2021, approximately 7,500 donors were registered at donation clinics. 10 concerns (0.13%) were reported within this period, 9 were managed within timeline as early resolution as detailed below. One formal concern recorded in November is being managed under 'Putting Things Right' (PTR) regulations and is expected to be completed before the 30 day target of 28/12/21. The formal concern recorded in October was managed under 'Putting Things Right' (PTR) regulations and was completed 16/11/21, 14 days before the 30 day target of 03/012/21. 1. Donor unhappy the mobile unit does not visit convenient areas of North Wales and enquired whether any consideration has been given to reviewing the decision 2. Donor unhappy with staff approach to wearing a face covering when donor exempt. 3. Two donors booked appointment online, and were turned away at clinic for 'being too soon to donate'. 4. Donor unhappy with lack of gluten free options in post donation care area and information given by staff on ingredient of biscuits 5. Donor was unhappy with staff approach to questioning regarding providing contact details 6. Donor was unhappy with age deferral for donors over the age of 70 years 7. Donor was unhappy with the lack of appropriate awareness of a session being cancelled 8. Donor unhappy with lack of information on website for donors who have ever injected anabolic steroids 9. Donor was unhappy with being turned away from session for being late for appointment	Actions taken to address Concerns: 1. Formal letter issued to explain the reason mobile units are not operating at this time, and further information will be sent to all donors once an update is available. 2. Reception & security staff reminded of the current process for accepting donors who are medically exempt from wearing a face covering when arriving at Talbot Green Centre. 3. A full explanation was provided to the Donor regarding online booking and the process in place to identify donors who book appointments too soon following their most recent donation. 4. Team staff reminded to order enough gluten free options from stores, staff also reminded not to advise donors on the ingredient of biscuits provided. 5. IT have advised that there is now way of recording this information on the WBS system for those donors who do not wish to share their details. WBS staff reminded to be mindful of donor wishes regarding disclosure of personal details at donation. 6. The donor was contacted to discuss and the deferral reviewed and lifted. The donor is able to donate providing acceptance criteria is met. 7. Donors were called by DCC as soon as they became aware of the situation. Unfortunately, the donor was en route and missed the call. Apologies provided to the donor who was offered alternative appointment. An update to the SMS service is being considered to mitigate against similar issues occurring in the future. 8. Work is on going to review website so users can easily identify entries relevant to their query, in addition to adding an entry for 'have you ever injected drugs'. 9. SOP, COL/111 previously updated to assist staff manage this scenario. Full apology given to donor and another appointment made	Business as usual, reviewed daily



First Class Donor Experience

Nov-21

Monthly Target: 100%	SMT Lead: Alan Prosser	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
During November 2021 one new formal concern was received. All formal concerns managed during November 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

Nov-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 November 2021 were managed within timeline.	Continue to monitor initial complaint acknowledgement progress against the 'two working day' target compliance.	ongoing, reviewed daily

QUALITY, SAFETY & PERFORMANCE COMMITTEE

WELSH BLOOD SERVICE QUALITY AND SAFETY HIGHLIGHT REPORT

DATE OF MEETING	20/01/2022

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	(12/01/2022)	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 December 2021 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, at a time when the service has launched its Christmas campaign “the best gift”.

A Blue alert was issued to hospitals on December 16th which has 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.

As such, the service has established a formal SILVER command to support key issues in terms of service provision and issues for consideration/decision by GOLD command.

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 December 2021 874 responses were received (27.9% response rate)
b. Donor satisfaction for those who had successfully donated was:
    - Overall (736) | 97.0%
    - N.Wales (137) | 99.3%
    - S.Wales (599) | 96.5%

c. Donor satisfaction for every respondent, including incomplete donations was:
    - Overall (839) | 94.2%
    - N.Wales (150) | 98.0%
    - S.Wales (689) | 93.3%

d. In total 693 donors scored themselves as 'Totally Satisfied' and were invited to provide more details.

e. **Out of 6,718 donation attendances in December 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 15-Step Challenge feedback:

Mr. L and his daughter are regular blood donors. His daughter has a learning difficultly which previously complicated the booking and donation process for him where he was asked the same questions every donation. With the support of Mr. L a revised process was co-designed which included:

- making it easier for him to book on behalf of his daughter by 'linking' his donor notes with his daughter's record;
- at the donation session, the questions asked on the tablet will be communicated verbally by a member of staff in the privacy of a screening booth.

At their donation session in December, Mr. L was thrilled with the new process (both the booking process and the on-the-day experience) and wanted to pass his thanks on to everyone involved. His daughter felt unwell afterwards but they are both very grateful for the new donation experience. Mr L has also agreed to feature in a video to be shared at a future Quality, Safety and Performance committee.

2.3 Stem Cell Donors

2.3.1 The Stem cell collection service at Velindre Cancer Centre (VCC) has successfully cared for one donor in December with a further 5 collections booked during January.

2.4 Concerns

2.4.1 In December 2021. six concerns (0.09%) were reported, four were managed within timeline as early resolution as detailed below. two formal concerns were managed under 'Putting Things Right' (PTR) regulations, both concerns were closed within 30 working days:

Nature of Concern raised	WBS Action taken as a result
(Formal) Email received from Welsh Language Commissioners office on behalf of a member of the public, regarding the fact that parts of the Blood Service website are not available in Welsh, which includes pages, videos, and audio clips	Formal response letter issued to Welsh Language Commissioner on behalf of complainant. A new refreshed website is being developed and currently due to be launched early 2022. Current website has been reviewed, historic videos and audio stories removed, PDF document and booking portal updated to comply with the medium of Welsh.
Donor 10 minutes late for appointment, would like a little more leeway.	Full explanation given to donor, 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)
Donor was unhappy with staff member's views regarding her occupation	Staff member apologised to donor on realising the upset caused, staff asked to reflect on approach to donor's occupation. File note completed.
Donor was unhappy with the amount of plastic drinking cups used across the teams	Biodegradable cups and compost bags are currently on trial across the West team. H & S manager is working with Veolia the recycling company to maintain environmental, disposable solutions.
Donor was unhappy about being turned away from session for being too soon to donate	DCC and IT are working on a manual process to try and exploring longer term solutions to prevent donors booking their appointments online when too soon to donate
(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.	Formal response letter issued to donor, donor has contacted WBS on five separate occasions since June 2020, all contacts have been to address the same or very similar concerns. Donor has been rude and used aggressive manner towards staff on each occasion. WBS advised no further communications for the same issues will be addressed and a zero-tolerance approach will be taken if donor refuses to co-operate with the services required behaviour.

2.5 Other Regulated Activities

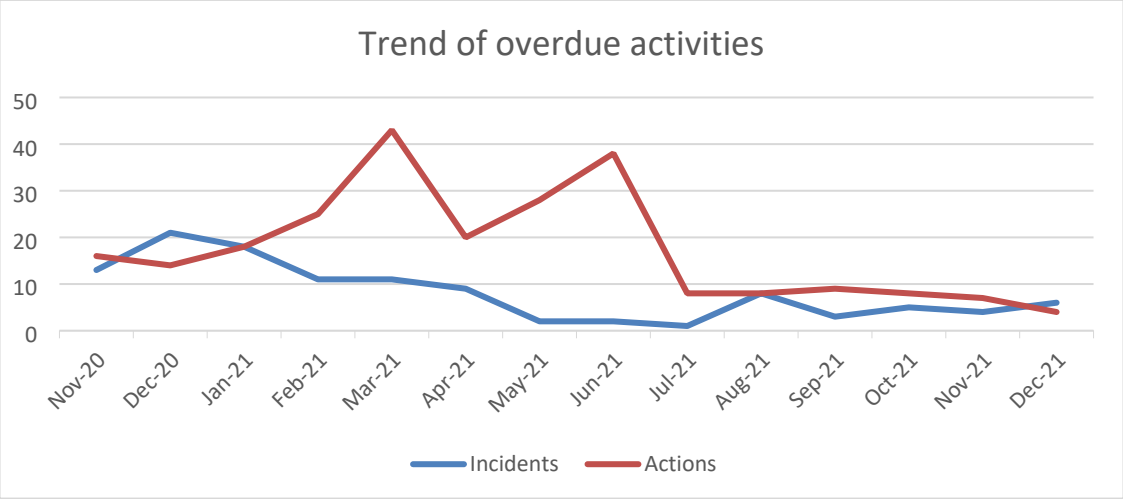
2.5.1 WBS continues to support the All Wales Covid vaccination programme and has significantly stepped up activity in response to the threat from the Omicron Variant. In the 3 weeks leading up to New Years Eve, the Hospital Services team supplied over a million doses to vaccination centres, GP surgeries and community pharmacies across Wales.

2.5.2 In response to global supply issues with plasma-derived medicines, agreement has been reached with Betsi Cadwallader University Health Board for WBS to supply immunoglobulin products under the WBS Wholesale Dealer Authorisation. This service will commence from March 1st and will provide a single, robust supply chain for these products across Wales.

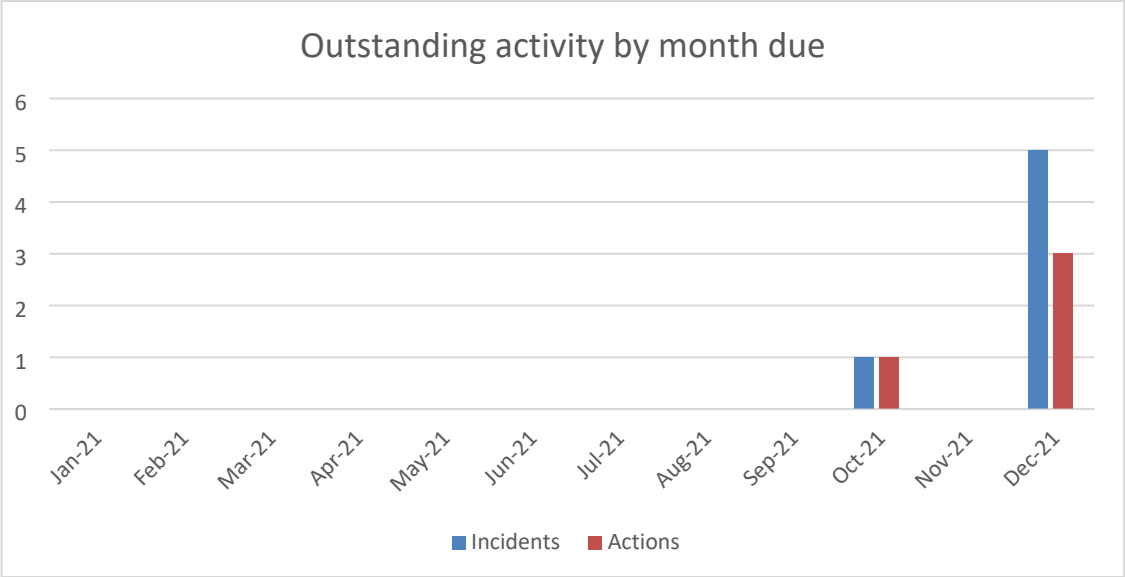
3 Incident Management

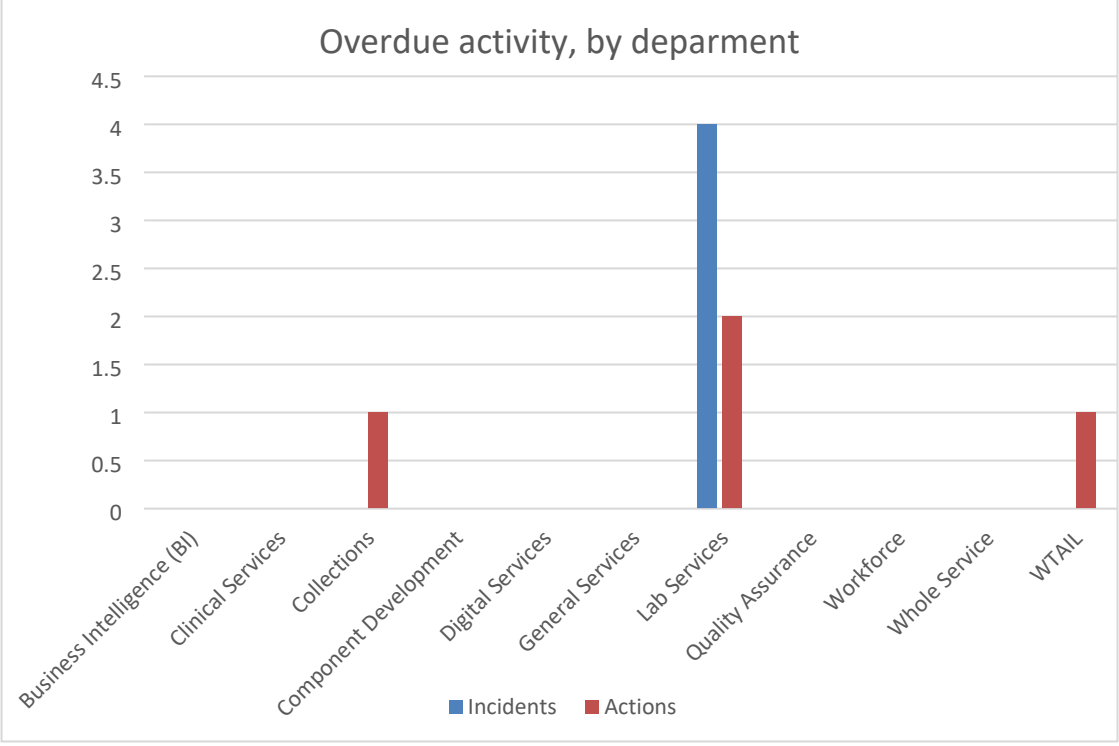
3.1 Overdue activity performance trends

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





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 an incident that occurred in April 2021. The action was for a service engineer to visit Collection teams to deliver additional training in the use of haemaflow devices. This was due for completion in October 2021. The Operations Manager has been contacted to provide an update on progress.

3.2 How safe is our service?

For reporting purposes, WBS sub-divides incident into two types:

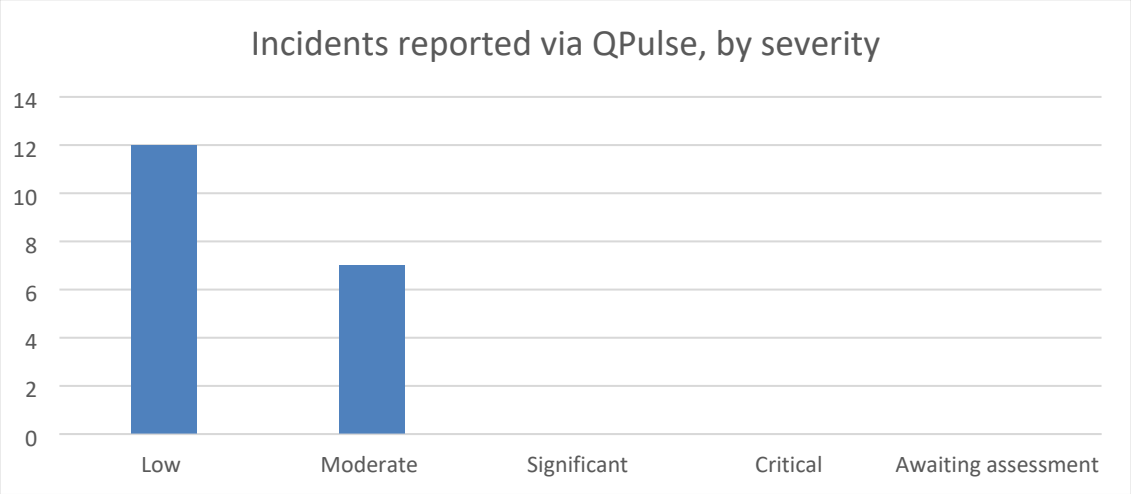
- **Good Manufacturing Practice (GMP) Incidents**, in which our routine process monitoring and checking identifies non-compliance with expected processes or outcomes and responds to prevent further processing or harm to patients. These are reported into Q-pulse and monitored as a critical part of the 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.

18 GMP incidents occurring in December have been reported via QPulse.

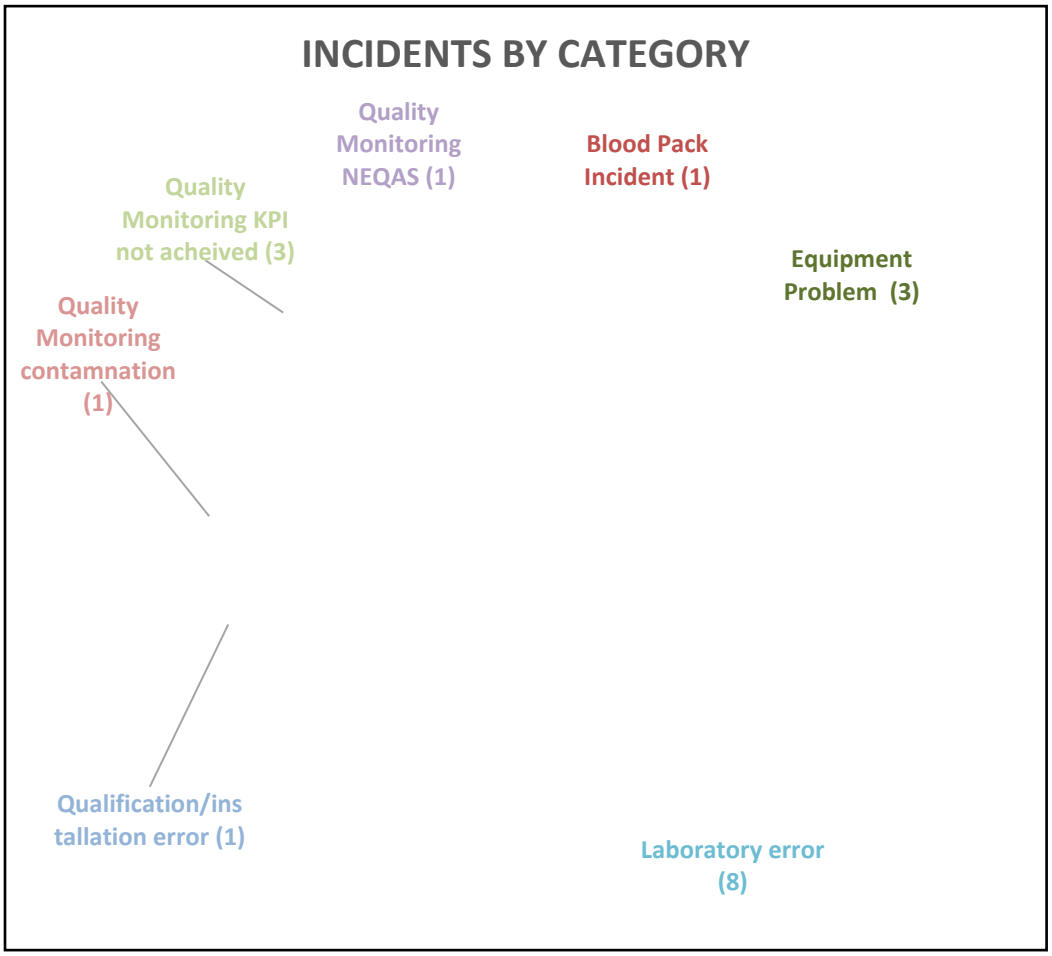
2 of these were reported outside of the 48-hour reporting time frame (excluding weekends); a rationale for late reporting is provided and assessed by the QA team. Where the rationale is deemed unacceptable the relevant Head of Department is advised.

There were 11 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 December. All reported events have been risk assessed.



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



3.3 Areas for concern:

There have been 8 Laboratory errors reported in December. Close attention is being paid to the number of reports being submitted by Hospital Issues which cover mistakes regarding the handling of commercial blood products and the issuing of red blood cells to customer hospitals. Further analysis of root cause is being undertaken to identify and rectify common themes and the effectiveness of previous preventive actions is being monitored.

In the 3 months to the end of December 2021, 90.5% of reported incidents were investigated and closed within 30 days (including GMP incidents reported via Datix OfW).

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.

3.4 Serious Incidents Reportable to Regulators

There were no serious incidents reported to regulators during December.

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

The RAGG meeting scheduled for December was postponed due to the current coronavirus situation and the need to focus operational activity elsewhere; data for November and December will be reviewed at the next meeting, scheduled to take place on 26th January.

3.6 Internal Audits:

The WBS internal Audit program has continued with only minor amendments in response to the ongoing pandemic. Following a risk assessment, planned audits of blood collection clinics during January have been postponed pending the next review of restrictions. This has been assessed as very low risk due to the higher levels of audit activity in collections earlier in the year, and based on the findings from the MHRA inspection during May 2021. The Clinical Services team continue to closely monitor clinical non-compliances in donation clinics and report issues via the Donor Clinical Governance Group into the Regulatory Assurance and Governance Group.

3.6.1 Exceptions / Notes

Three audits scheduled for December have been conducted, plus one audit carrying over from November.

There were 3 'Major' non-compliances raised in December from audits conducted in November/December:

IA31 – **Audit 21/21 Lab Housekeeping**
Of the 10 laboratories visited during this audit, 3 had evidence of food and/or drink within the laboratory area, where one of these had evidence that food had been consumed in the laboratory area at a sample bench. These were:

Automated Testing – Chocolate wrapper on floor
Manufacturing – Leaving gift (food/drink) in lab cupboard
Distribution – Chocolates in lab office

IA32 – **Audit 21/21 Housekeeping Apheresis Clinic**
There were x2 boxes in G102 that stated "Awaiting batch testing" – These boxes should have been quarantined and labelled in-line with SOP: 143/BCP to prevent the harnesses being used for clinical purposes prior to batch testing.

IA33 – **Audit 21/22 Collection Team, East B Incorrect version of documentation**

The Registration File contained 027/COL, Attachment 2 'Triage Questions to Ask All Donors', issues 5 and 6 – these versions are now obsolete and should have been removed from this file.

(This document is now at issue 7 and should be kept in the Triage File, this was observed to be correct at the time of audit).

The Registration File also contained 102/COL, Attachment 4 'Titles & Codes for eProgesa', issue 1. This document is currently at issue 2.

The Ethnic Origin Chart (102/COL, Attachment 1) was found to have the incorrect document control details, was not on headed paper, and did not have the "Official copy" mark down the side. The document stated 004/COL, Attachment 6. It was unclear where this document originated.A correct version of this document was found in the Registration File, and the uncontrolled copy was removed from session and returned to Document Control by the auditor.

The outstanding Major finding, raised in Stores in March (IA25) regarding incorrect use of Quarantine cage and broader issues within this area, is being addressed by relevant members of SMT. A report outlining recommendations to be submitted to SMT by the end of this financial year. The Stores area was audited again on 07/12/2021 where some improvement was observed regarding these issues. Categories of additional findings are detailed in the audit summary below.

3.7 Audit Summary

Total number of audits scheduled for completion in December: 2 **Procedural Audits = 1** **ISO 15189 = 0** **ISO 17043 = 0** **HTA Internal = 1**	**Conducted** **2**	**Total Audits conducted** **4**
Audit carrying over from previous month to be conducted in Dec.: 1 **Audit brought forward from Feb to be conducted in Dec: 1**	**2**	

1 Audit Conducted within December to schedule	**Findings**

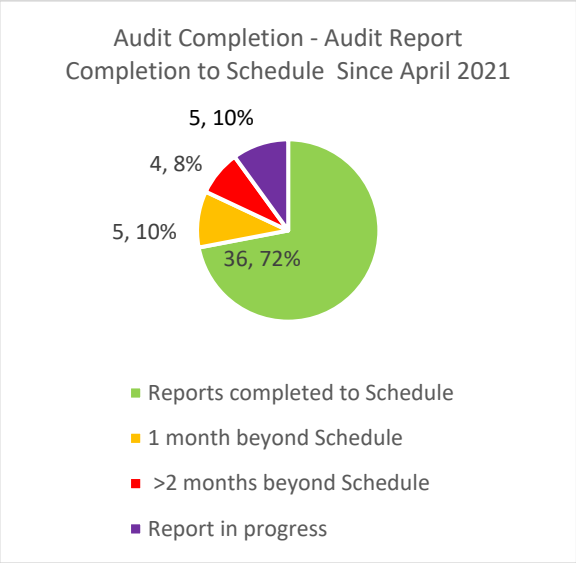
21/26 Procedural: MP-029 Stores (Audit Report received)	Total findings = 4 x1 Training x2 Data Integrity/ ALCOA+ x1 Equipment
21/03 HTA Internal – Equipment and Material	TBC – (Awaiting report)
1 Audit brought forward from February 2022, conducted in December	**Findings**
21/08 ISO 15189: Molecular Genetics – Audit of Test Method (HLA Linkseq) (Audit brought forward due to finding raised within UKAS Extension to Scope inspection)	TBC – (Awaiting Report)
1 Audit carrying over from November and conducted in December	**Findings**
21/06 ISO 15189: Automated Testing (Delay due to absence of Auditees. Audit conducted 07/12/2021)	TBC – (Awaiting Report)

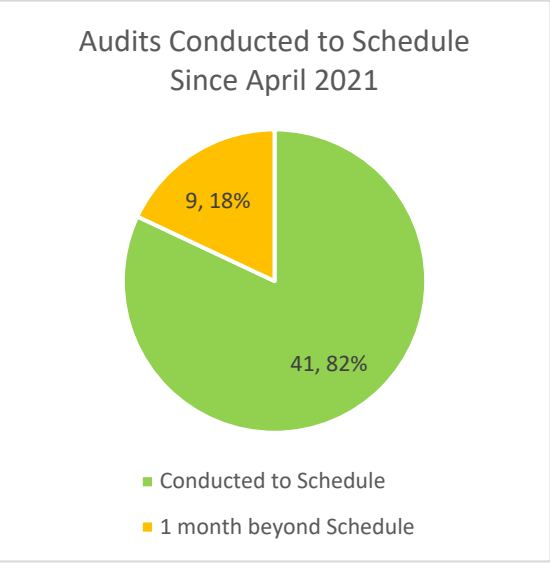
Reports outstanding from audits conducted in previous months	**Findings**
21/19 Procedural: MP-039 Research & Development (Delay in submission of audit report due to auditors current work commitments)	TBC – (Awaiting Report)
21/06 ISO 15189 – RCI (Delay in submission of audit report due to auditors current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

21/05 ISO 15189: RCI - (Delay due to Auditor/Auditees availability)	No Issues raised – (Report received 21/12/2021)

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.

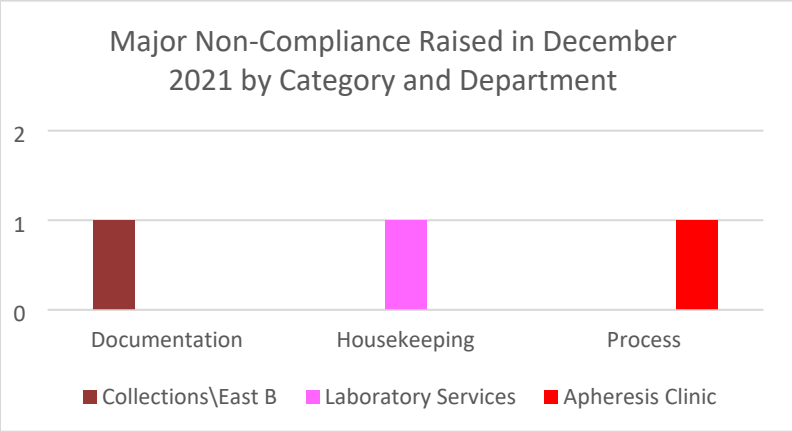
Audit Completion to Schedule, since April 2021:





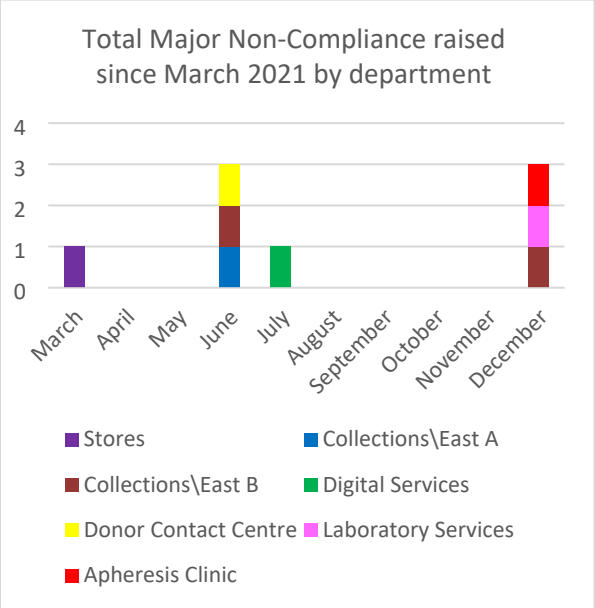
3.8 Corrective and Preventative Actions (CA/PA) Summary

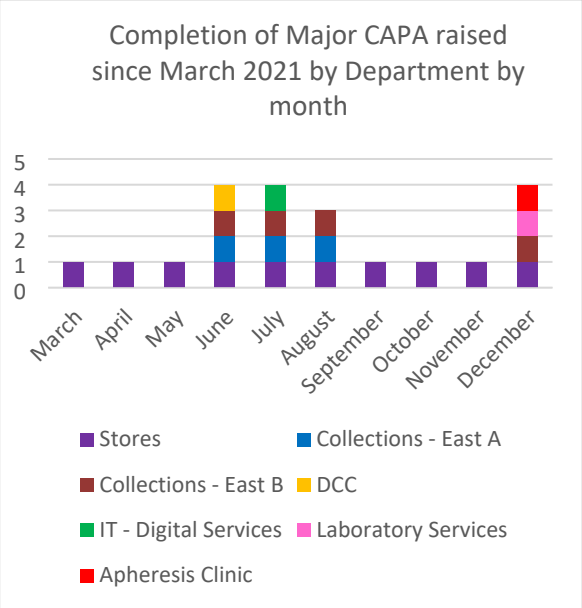
3.8.1 Three major non-compliances raised in December:



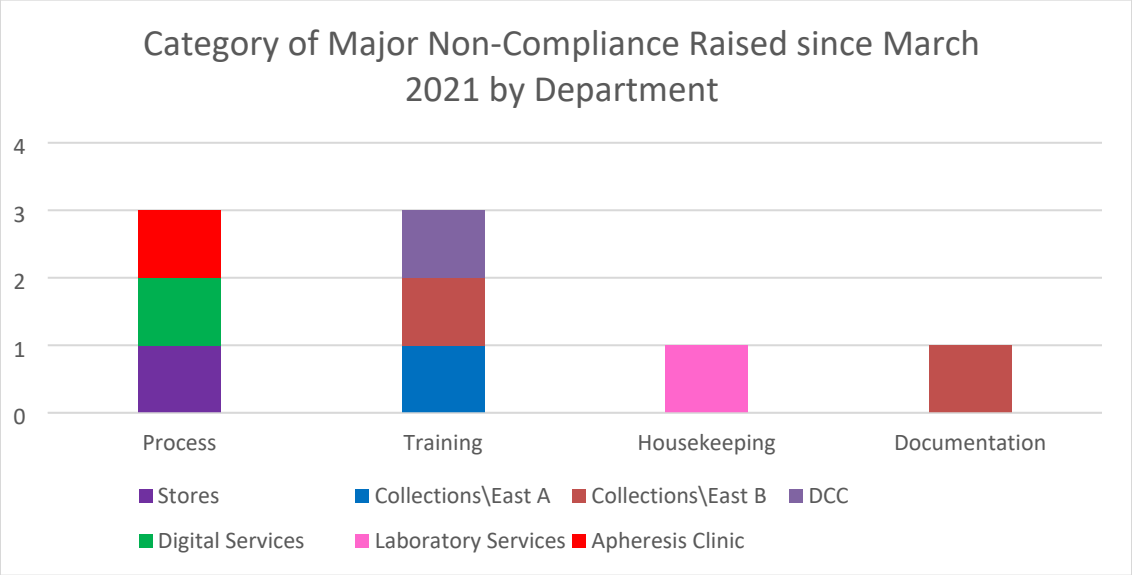
- **Documentation:**
  Audit 21/22 Collection Team, East B: Incorrect version documentation on session.
- **Housekeeping:**
  Audit 21/21 Laboratory Housekeeping Audit: Evidence of Food and Drink within Laboratory areas.
- **Process:**
  Audit 21/21 Housekeeping Audit – Apheresis Clinic
  There were x2 boxes in G102 that stated “Awaiting batch testing” which had not been quarantined and labelled in-line with SOP: 143/BCP.

3.8.2 Total Major Non-Compliance raised since March 2021 and the time taken for departments to perform and close their CA/PA, from the month it was raised





IA25 - Open since March 2021 - Stores: Incorrect use of Quarantine cage and broader issues within this area. Currently under investigation - Target completion date extended to 31 March 2022.



4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
RELATED HEALTHCARE STANDARD	Safe Care
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

5. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to NOTE the contents of this report.

Workforce Monthly Report

November 2021

Workforce Report provides the following:

- Overview of Key Performance Indictors for Sickness, PADR, Statutory and Mandatory training in all Divisions of the Trust, including Corporate Divisions, TCS and Research and Development (excluding hosted);
- Corporate Divisions include Finance, Workforce and OD, Corporate Estates and Planning, Corporate IT, Clinical Governance, Infection Control, Fundraising and Trust Management and Board;
- The report provides a 12 monthly trend report for Sickness, PADR, Statutory and Mandatory training;
- In month Job Planning figures with narrative to notify areas of improvement;
- Usage of Work in Confidence platform.

At a Glance for Velindre (Excluding Hosted)

Velindre (Excluding Hosted	Current Month	Previous Month	Target
	Nov-21	Oct-21	
PADR	72.11	71.69	85%
Sickness	5.48	5.36	3.54%
S&M Compliance	86.06	85.10	85%

Workforce Dashboard

Data below highlights rolling figures for workforce KPI's. This provides a running total of the values of the last 12 months of an indicator providing trend data for the indicators. Granular monthly data is generated for divisions as separate reports. Data Rag Rated for ease of reading.

Key	85%-100%		50% - 84.99%		0% - 49.99%								
These figures exclude Trainee Doctors, those on Maternity, Starters within first 6 Months, those currently off on sickness absence.													
PADR	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
Corporate	45.76	47.46	39.82	41.74	43.44	45.00	49.58	47.01	48.33	50.43	45.69	46.58	44.59
Research, Development & Innovation	77.27	75.00	42.22	34.04	58.33	60.00	64.58	62.50	61.70	65.96	66.67	72.09	90.91
Transforming Cancer Services	50.00	37.50	40.00	64.29	60.00	66.67	68.75	71.43	66.67	60.00	56.25	43.75	62.50
Velindre Cancer Centre	74.23	76.98	78.68	77.53	79.78	81.07	78.88	76.52	74.31	75.17	76.40	73.77	70.90
Welsh Blood Service	69.32	66.18	67.97	73.19	77.25	78.65	82.41	81.74	79.78	78.27	77.93	77.52	82.19
Velindre Organisations	69.89	70.32	70.19	71.32	74.64	76.07	76.77	75.09	73.28	73.58	73.67	71.69	72.11
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)	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
Corporate	69.45	70.47	71.61	70.62	69.47	69.06	70.08	69.08	69.26	70.45	71.36	74.54	72.32
Research, Development & Innovation	76.73	76.25	77.45	82.50	83.73	82.59	83.08	85.69	86.00	85.80	86.25	84.89	84.58
Transforming Cancer Services	70.56	70.56	71.18	69.38	64.12	65.29	70.00	76.00	76.84	85.26	82.50	82.86	83.33
Velindre Cancer Centre	80.13	80.23	80.69	81.53	81.57	80.98	81.77	82.45	82.70	83.16	82.89	83.11	84.91
Welsh Blood Service	91.67	91.42	90.43	89.54	90.90	90.43	92.23	92.39	93.38	92.66	92.21	92.54	93.36
Velindre Organisations	85.59	82.66	82.81	83.06	83.39	82.92	84.09	84.59	84.97	85.24	84.95	85.10	86.06

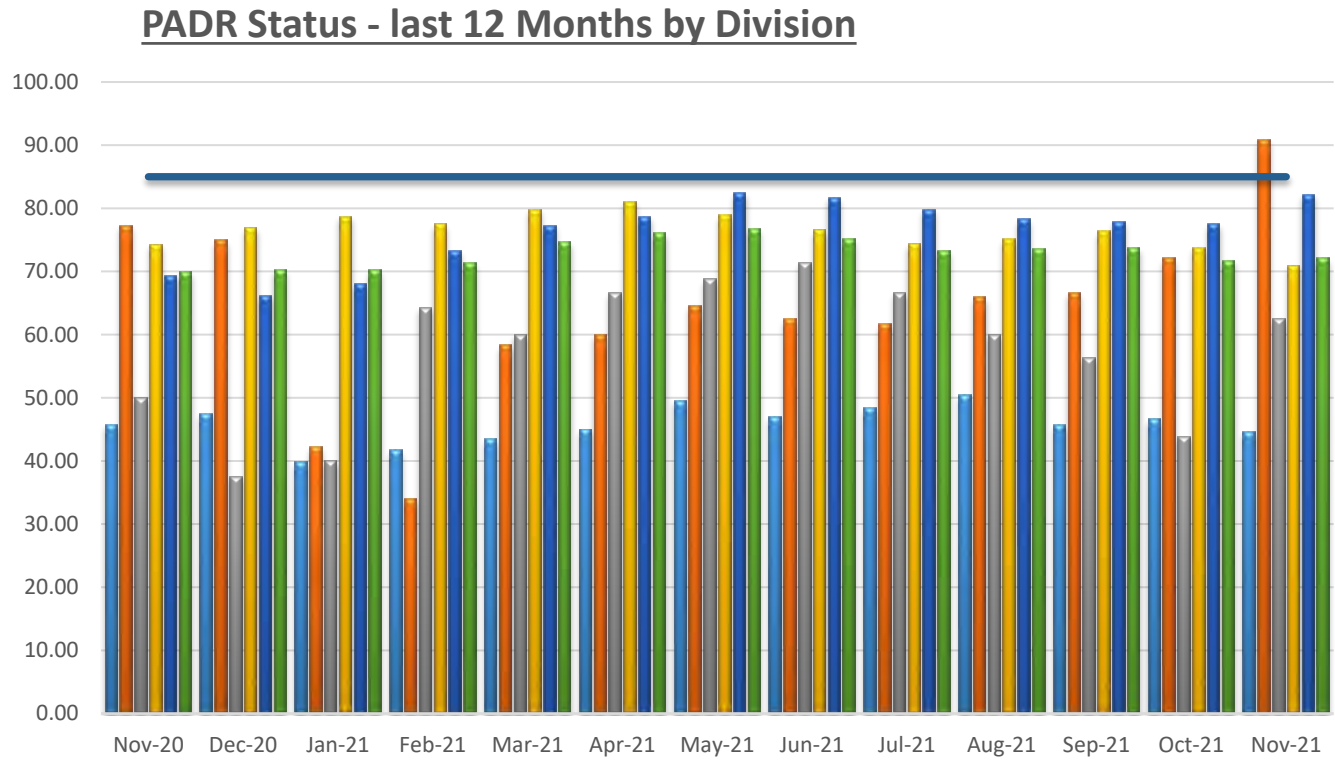
Key	0% - 3.54%		3.55% - 4.49%		4.5 % & Above								
Sickness Rolling %	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
Corporate	5.18	5.20	5.24	5.14	4.85	4.59	4.51	4.44	4.33	4.13	4.15	4.13	4.29
Research, Development & Innovation	4.62	4.60	4.37	4.23	4.01	3.73	3.46	3.16	3.34	3.55	3.95	4.30	4.44
Transforming Cancer Services	2.24	2.46	2.41	2.41	2.01	1.34	0.88	0.41	0.32	0.33	0.40	0.86	1.24
Velindre Cancer Centre	5.76	5.88	5.88	5.97	5.77	5.40	5.38	5.41	5.47	5.47	5.51	5.56	5.60
Welsh Blood Service	4.43	4.43	4.44	4.38	4.24	4.19	4.36	4.57	4.81	5.10	5.41	5.69	5.95
Velindre Organisations	5.21	5.28	5.28	5.29	5.10	4.84	4.85	4.91	5.01	5.09	5.23	5.36	5.48
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	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
Corporate	0.28	0.42	0.55	0.60	0.58	0.53	0.58	0.63	0.67	0.78	0.90	0.97	1.00
Research, Development & Innovation	0.36	0.43	0.45	0.46	0.42	0.35	0.44	0.45	0.45	0.43	0.43	0.43	0.42
Transforming Cancer Services	0.28	0.27	0.26	0.26	0.21	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Velindre Cancer Centre	1.09	1.28	1.39	1.44	1.31	0.96	0.89	0.86	0.87	0.88	0.85	0.87	0.85
Welsh Blood Service	0.30	0.37	0.42	0.44	0.39	0.31	0.29	0.28	0.29	0.29	0.36	0.38	0.36
Velindre Organisations	0.74	0.88	0.96	1.00	0.91	0.68	0.65	0.63	0.64	0.66	0.68	0.70	0.68

Monthly Special Leave Absence Rolling %	0%		0.01% - 0.49%		0.50 % & Above								
Special Leave Non Covid Related	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
Corporate	0.38	0.37	0.30	0.23	0.17	0.11	0.05	0.04	0.06	0.06	0.03	0.09	0.09
Research, Development & Innovation	0.67	0.71	0.74	0.65	0.50	0.46	0.42	0.51	0.60	0.74	0.93	1.06	1.11
Transforming Cancer Services	0.16	0.32	0.51	0.51	0.51	0.51	0.51	0.51	0.53	0.56	0.55	0.54	0.40
Velindre Cancer Centre	0.39	0.40	0.42	0.43	0.43	0.41	0.41	0.42	0.44	0.47	0.49	0.54	0.55
Welsh Blood Service	0.57	0.62	0.63	0.61	0.62	0.58	0.59	0.58	0.59	0.61	0.63	0.65	0.66
Velindre Organisations	0.45	0.47	0.49	0.48	0.47	0.44	0.43	0.44	0.46	0.49	0.51	0.55	0.56

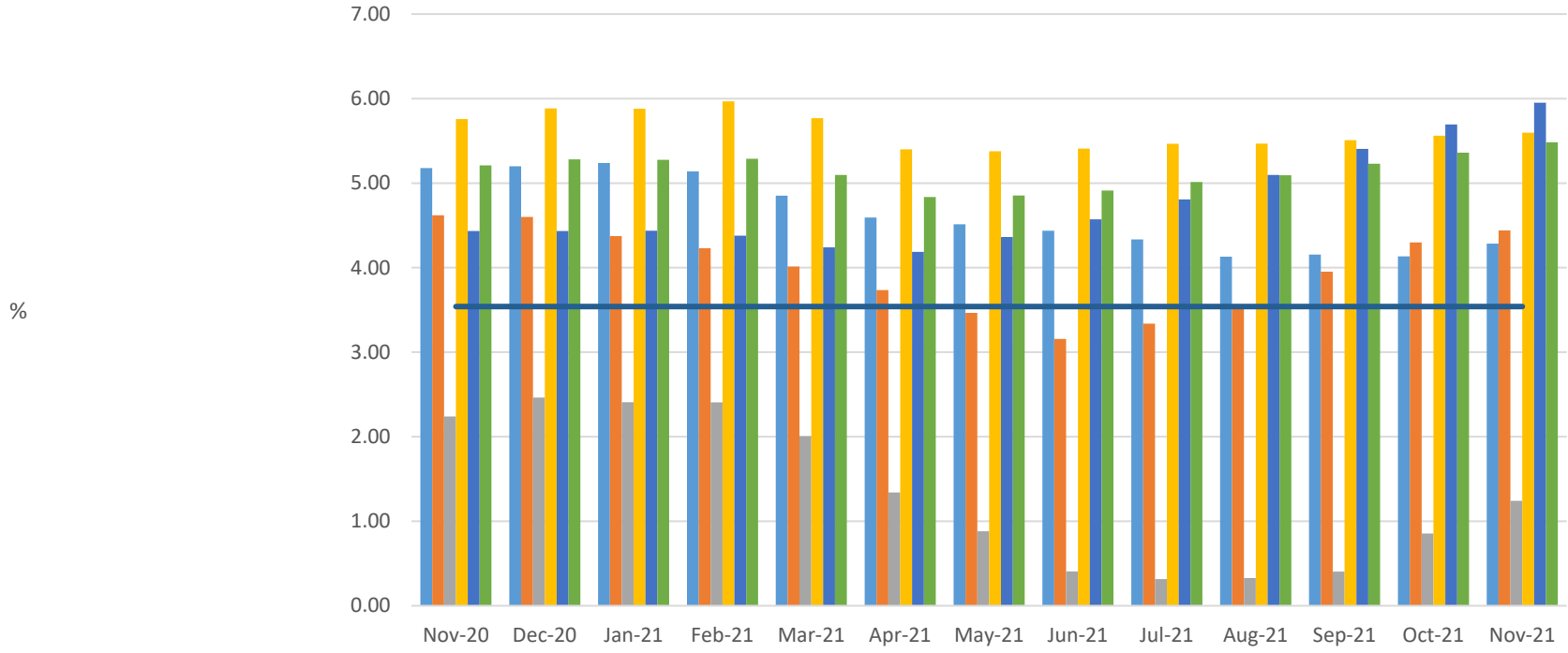
Monthly Special Leave Absence Rolling %	0%		0.01% - 0.49%		0.50 % & Above								
Special Leave Covid Related	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
Corporate	0.59	0.58	0.58	0.57	0.48	0.32	0.25	0.18	0.11	0.03	0.01	0.00	0.00
Research, Development & Innovation	1.99	1.98	1.96	1.95	1.45	1.04	0.76	0.49	0.21	0.13	0.13	0.13	0.07
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	1.97	2.13	2.27	2.36	2.13	1.71	1.40	1.16	0.99	0.88	0.88	0.90	0.84
Welsh Blood Service	1.52	1.62	1.71	1.75	1.65	1.32	1.06	0.82	0.68	0.62	0.67	0.67	0.69
Velindre Organisations	1.68	1.80	1.90	1..96	1.77	1.41	1.15	0.92	0.77	0.68	0.69	0.70	0.67

PADR – The Figures



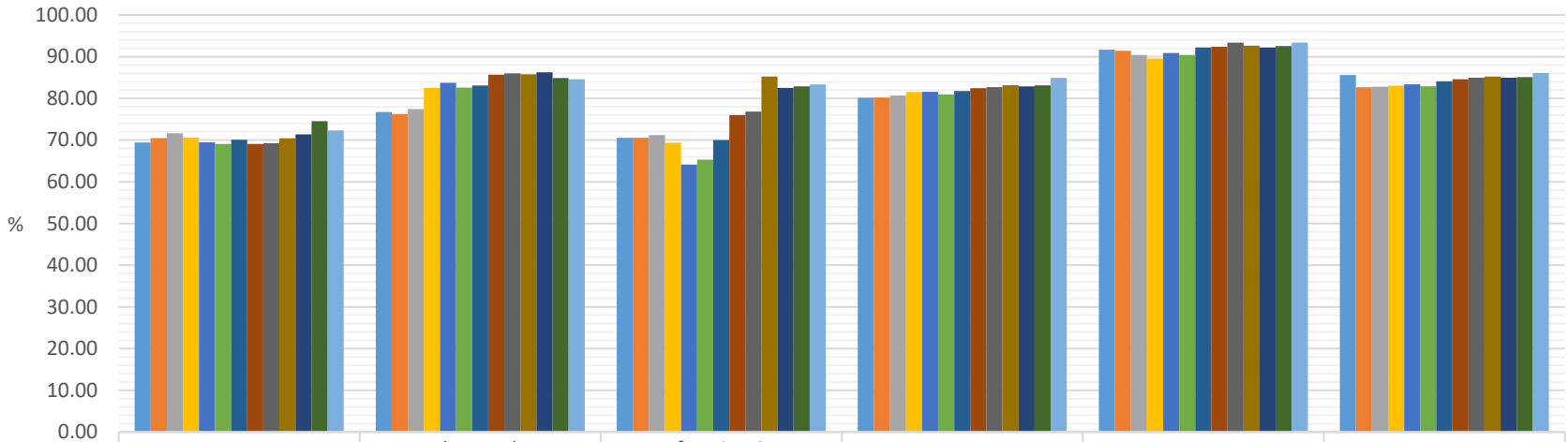
	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
Corporate	45.76	47.46	39.82	41.74	43.44	45.00	49.58	47.01	48.33	50.43	45.69	46.58	44.59
Research, Development & Innovation	77.27	75.00	42.22	34.04	58.33	60.00	64.58	62.50	61.70	65.96	66.67	72.09	90.91
Transforming Cancer Services	50.00	37.50	40.00	64.29	60.00	66.67	68.75	71.43	66.67	60.00	56.25	43.75	62.50
Velindre Cancer Centre	74.23	76.98	78.68	77.53	79.78	81.07	78.88	76.52	74.31	75.17	76.40	73.77	70.90
Welsh Blood Service	69.32	66.18	67.97	73.19	77.25	78.65	82.41	81.74	79.78	78.27	77.93	77.52	82.19
Velindre Organisations	69.89	70.32	70.19	71.32	74.64	76.07	76.77	75.09	73.28	73.58	73.67	71.69	72.11
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85

Sickness Data – The Figures



	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
Corporate	5.18	5.20	5.24	5.14	4.85	4.59	4.51	4.44	4.33	4.13	4.15	4.13	4.29
Research, Development & Innovation	4.62	4.60	4.37	4.23	4.01	3.73	3.46	3.16	3.34	3.55	3.95	4.30	4.44
Transforming Cancer Services	2.24	2.46	2.41	2.41	2.01	1.34	0.88	0.41	0.32	0.33	0.40	0.86	1.24
Velindre Cancer Centre	5.76	5.88	5.88	5.97	5.77	5.40	5.38	5.41	5.47	5.47	5.51	5.56	5.60
Welsh Blood Service	4.43	4.43	4.44	4.38	4.24	4.19	4.36	4.57	4.81	5.10	5.41	5.69	5.95
Velindre Organisations	5.21	5.28	5.28	5.29	5.10	4.84	4.85	4.91	5.01	5.09	5.23	5.36	5.48
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

Statutory and Mandatory Figures – The Figures



	Corporate	Research, Development & Innovation	Transforming Cancer Services	Velindre Cancer Centre	Welsh Blood Service	Velindre Organisations
Nov-20	69.45	76.73	70.56	80.13	91.67	85.59
Dec-20	70.47	76.25	70.56	80.23	91.42	82.66
Jan-21	71.61	77.45	71.18	80.69	90.43	82.81
Feb-21	70.62	82.50	69.38	81.53	89.54	83.06
Mar-21	69.47	83.73	64.12	81.57	90.90	83.39
Apr-21	69.06	82.59	65.29	80.98	90.43	82.92
May-21	70.08	83.08	70.00	81.77	92.23	84.09
Jun-21	69.08	85.69	76.00	82.45	92.39	84.59
Jul-21	69.26	86.00	76.84	82.70	93.38	84.97
Aug-21	70.45	85.80	85.26	83.16	92.66	85.24
Sep-21	71.36	86.25	82.50	82.89	92.21	84.95
Oct-21	74.54	84.89	82.86	83.11	92.54	85.10
Nov-21	72.32	84.58	83.33	84.91	93.36	86.06

Job Planning Figures – VCC & WBS combined

Combined

Role	Assignments	With Expired Plan	% With Expired Plan	With Unsigned Plan	% With Unsigned Plan	With Current Plan	% With Current Plan
Consultant	63	37	58.73%	11	17.46%	15	23.81%
Medical Director	2	0	0.00%	0	0.00%	2	100.00%
Specialty Doctor	12	11	91.67%	0	0.00%	1	8.33%
Grand Total	**77**	**48**	**62.34%**	**11**	**14.29%**	**18**	**23.38%**

VCC

Role	Assignments	With Expired Plan	% With Expired Plan	With Unsigned Plan	% With Unsigned Plan	With Current Plan	% With Current Plan
Consultant	60	36	60.00%	11	18.33%	13	21.67%
Medical Director	1	0	0.00%	0	0.00%	1	100.00%
Specialty Doctor	11	11	100.00%	0	0.00%	0	0.00%
Grand Total	**72**	**47**	**65.28%**	**11**	**15.28%**	**14**	**19.44%**

WBS

Role	Assignments	With Expired Plan	% With Expired Plan	With Unsigned Plan	% With Unsigned Plan	With Current Plan	% With Current Plan
Consultant	3	1	33.33%	0	0.00%	2	66.67%
Medical Director	1	0	0.00%	0	0.00%	1	100.00%
Specialty Doctor	1	0	0.00%	0	0.00%	1	100.00%
Grand Total	**5**	**1**	**20.00%**	**0**	**0.00%**	**4**	**80.00%**

NB

Data on the job plans associated with other 'medical' posts within the Trust have not been included in the above; this is due to the relatively small numbers involved and therefore the immediately identifiable nature of this information.

WBS

To continue to maintain compliance across WBS

VCC

ESR imputing issues from Pall/Care and Medical directorate raised with ESR Central team

Work In Confidence (WIC)

No detail has been provided this month in terms of the number of staff who have accessed the WIC platform, or categorisation of the type of conversations that have taken place; this is primarily the result of low usage of the platform over the last month and therefore the potential to identify those who have made contact.

In all contacts with staff, staff are encouraged, where appropriate, to share their concerns with their Line Manager (or next appropriate Manager), in order to achieve an early, informal resolution. The WOD Team have also been previously involved in facilitating discussions between the Manager and member of staff.

Quality, Safety & Performance Committee

VELINDRE UNIVERSITY NHS TRUST VACCINATION PROGRAMME BOARD UPDATE

DATE OF MEETING	20th January 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**
Vaccination Programme Board	22/12/2021	Items for discussion approved
EMB	04/01/2022	Verbal update provided

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 key outcomes from / decisions made at the Trust's Vaccination Programme Board held on the 22nd December 2021.

The Quality, Safety & Performance Committee is asked to **NOTE** the position in relation to the Trust's 2021 vaccination programme and the next steps.

2. BACKGROUND

The Trust wide Vaccination Programme Board is responsible for the planning and safely delivery of the Public Health Wales Influenza and COVID-19 Vaccinations for the Trust and its eligible employees in line with national policy and guidelines.

With the exception of wave one of the pandemic, when Velindre University NHS Trust supported the wider vaccination programme prior to the mass vaccination centres being established, the Trust has only taken on responsibility to vaccinate eligible staff.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 *COVID Booster Position*

The trust delivered its COVID-19 booster programme in line with national guidelines and advice. This commenced on the 2nd October 2021 and was completed on 17th November 2021. The Trust offered provision on the influenza and booster vaccination at the same appointment. A small number of staff received the booster vaccination at a local mass vaccination centre.

To date, 1,418 out of 1,710 staff members (83%) have received COVID-19 booster vaccinations, 1,250 of which were administered to staff by Velindre University NHS Trust.

Some staff could not receive their booster at Velindre during the booster vaccination period as they were ineligible due to recovering from Covid, being symptomatic or timescales insufficient since their primary doses. As Velindre Vaccination staff were deployed to Health Boards during December 2021 it was agreed that these staff would receive their boosters at their local mass vaccination centres.

3.2.1 Influenza Vaccinations

To date, 1,214 staff (71%) have been provided with their Influenza vaccination by Velindre University NHS Trust. Analysis in relation to frontline staff numbers is currently being undertaken.

There is also a number of staff who may have received their Influenza vaccine elsewhere such as their GP practice.

4. NEXT STEPS

The Vaccination Programme Board will continue to hold short monthly formal meetings in forthcoming months in order to have oversight and review of any changing national guidance / requirements in relation to influenza or COVID-19 vaccinations.

No further vaccination plans are in place for the immediate future but these will be guided by national requirements and decisions.

5. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Positive impact on quality & safety by having staff protected and vaccinated. This will reduce risks of nosocomial transmission and transmission between staff. In addition it should reduce likelihood of covid related absenteeism. High staff absenteeism has a negative impact on quality & safety.
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.

6. RECOMMENDATION

The Quality, Safety & Performance Committee is asked to **NOTE** the current influenza and COVID-19 vaccination status of the Trust and the next steps.

QUALITY SAFETY & PERFORMANCE COMMITTEE

FINANCE REPORT FOR THE PERIOD ENDED 30TH NOVEMBER 2021 (M8)

DATE OF MEETING	20th January 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Matthew Bunce, Executive Director of Finance
PRESENTED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR NOTING

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

ACRONYMS	
IMTP	Integrated Medium-Term Plan
WBS	Welsh Blood Service
WTAIL	Welsh Transplantation and Immunogenetics Laboratory
WG	Welsh Government
VCC	Velindre Cancer Centre

1. SITUATION/BACKGROUND

1.1 The attached report outlines the financial position and performance for the period to the end of November 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	(5)	3	0
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	454	2,964	10,584
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	97.3%	95.2%	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 November is an underspend of **£3k**, 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. These savings have been replaced with non-recurrent vacancy factor savings as the targets will not be achieved this year whilst still in the pandemic as the cost reductions are 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.

The Trust is yet to receive a formal funding letter for the remaining balance of Covid requirement, however 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 94.9%.

PSPP compliance levels have significantly recovered following a temporary dip in performance. 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	278	392	213	179
Cleaning Standards	538	774	367	407
PPE	140	277	147	130
Covid Recovery	1,331	3,222	3,479	(257)
Other Covid Related Spend & Cost Reduction	979	1,475	1,176	299
BFWD Savings Loss	467	700	700	0
Return of Bonus Payment (over allocated)	(83)	(83)	(83)	0
Total Covid Spend /Funding Requirement 2021/22	**3,650**	**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 November '21 is £584k (includes £87k of new commitments) with a further £511k spend forecast for Dec '21 – Mar '22, taking the total forecast spend to £1,095k. The anticipated slippage against the £1.545k is currently expected to be circa £450k due to delays in implementation of several of the investments which are mainly fixed term posts. 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 has commenced by the end of December '21.

The non-recurrent reserves still available to invest and cover new unavoidable cost pressures is £972k. **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

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.

2.7 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. 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).

The net capital overspend in the TCS Programme will be managed within the overall Programme budget and from slippage / contingency within the Trust discretionary programme.

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 November 2021 is an underspend of £3k with a year-end forecast break-even position in accordance with the approved IMTP

4. RECOMMENDATION

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

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.

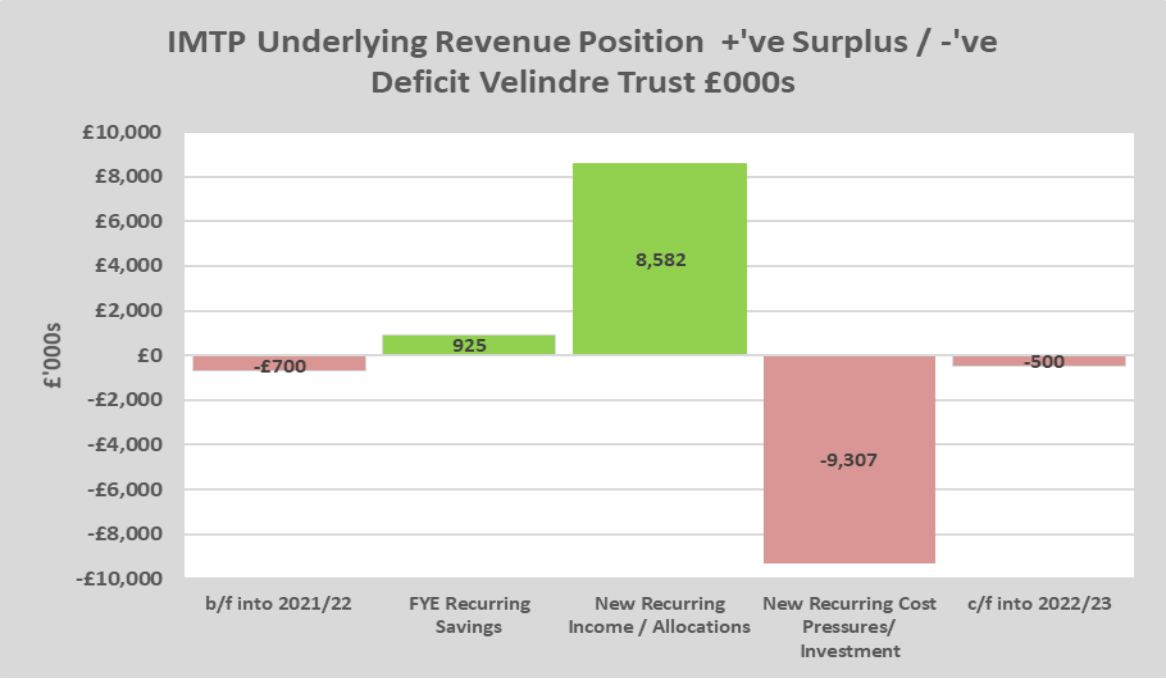
2. Background / Context

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	(5)	3	0
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	454	2,964	10,584
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	97.3%	95.2%	95.0%

Performance against Planned Savings Target

Efficiency Savings	Variance	0	0	0

Revenue

The Trust has reported a **£(5)k** in-month overspend position for November'21, with a cumulative position of **£3k** underspent, and an outturn forecast of **Breakeven**.

Capital

The approved Capital Expenditure Limit (CEL) as at November 2021 is **£10,584k** for 2021-22. This represents all Wales Capital funding of **£8,673k**, Discretionary funding of **£1,911k.** The Trust reported capital spend to November '21 of £2,964k and is forecasting to remain within its CEL of £10,584k.

PSPP

During November '21 the Trust (core) achieved a compliance level of **97.26%** (October'21: 97.67%) of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **95.21%** to the end of November, and a Trust position (including hosted) of **95.76%** compared to the target of 95%.

PSPP compliance levels have significantly recovered following a temporary dip in performance. Finance colleagues working alongside NWSSP are confident that the 95% target will be achieved 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		
£2,571 Underspent				Breakeven		
Type	YTD Budget (£'000)	YTD Actual (£'000)	YTD Variance (£'000)	Full Year Budget (£'000)	Full Year Forecast (£'000)	Forecast Variance (£'000)
Income	(107,307)	(106,958)	(349)	(163,777)	(163,509)	(269)
Pay	47,895	47,499	397	71,708	71,410	298
Non Pay	59,412	59,457	(45)	92,070	92,099	(29)
Total	0	(3)	3	0	(0)	0

The overall position against the profiled revenue budget to the end of November is an underspend of **£3k**, with an underachievement against income offset by an underspend within both 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 November is **£(349)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 **£397k** underspent on Pay and is forecasting an outturn underspend of circa **£298k**.

Expected reduction in current underspend position against forecasted outturn position, is a result of decisions made in VCC to invest in positions that had associated savings placed against the divisional CIP target. Further alignment of staff to non-staff is expected in future months to help reduce the divisional CIP target.

- Allied Health Professionals are experiencing a small overspend to date 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 being funded by WG.

- 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.
- 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. Largest underspends are currently being experienced in both Admin & Clerical and Nursing due to the high level of vacancies being carried.

Non Pay Key Issues

The Trust has reported a cumulative year to date position of **£(45)k** overspend on Non-Pay and is forecasting an outturn overspend of circa **£(29)k**.

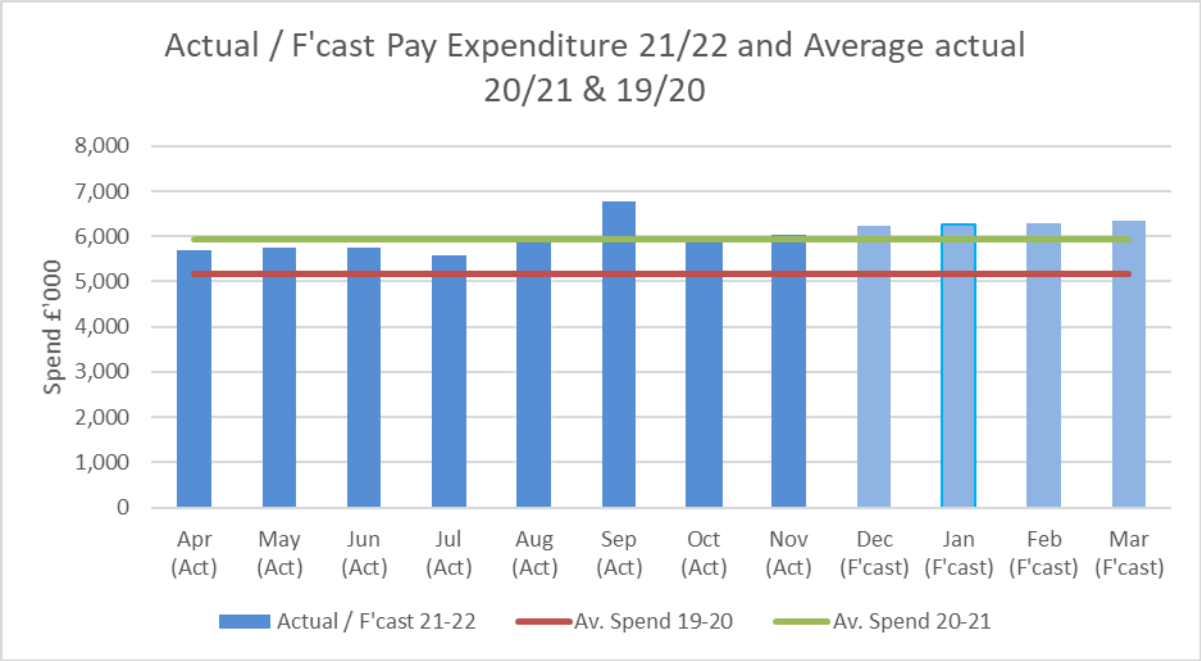
- Large underspend in WBS due to reduced costs from suppressed activity, underspend on Collections Services, Laboratory Services, WTAIL, and General Services
- There are underspends on general drugs in VCC from reduced activity and temporary closure of outreach clinics,
- Facilities Management, along 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 which is starting to offset general staff Travel & subsistence
- 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.

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

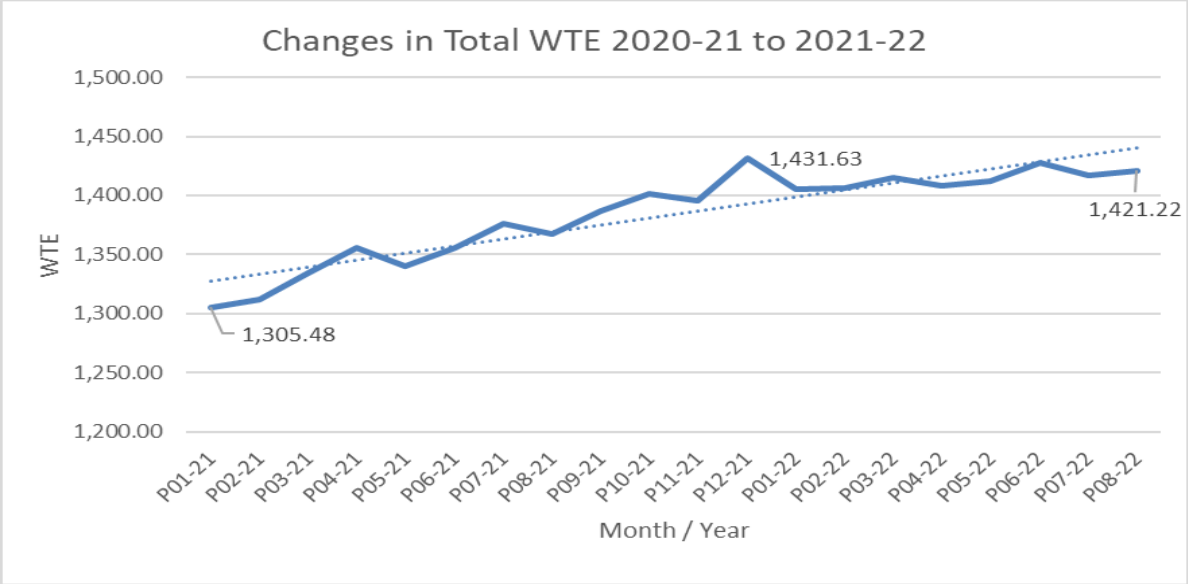
4.2 Pay Spend Trends (Run Rate)

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.

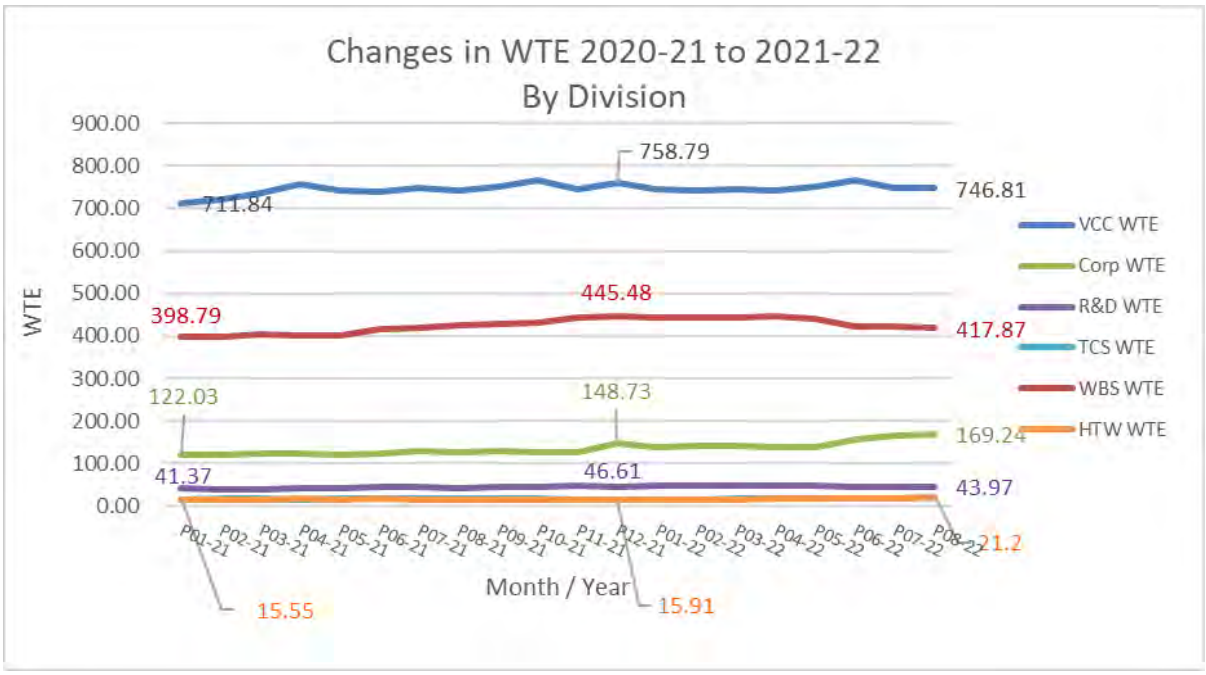
Staff received the 2021/22 pay award of 3% and arrears dated back to April 2021 in their September pay. Excluding the Pay award, spend is still expected to increase with the recruitment of additional posts to meet 'surge' capacity in both VCC and WBS in response to Covid recovery. Whilst the plan was 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.



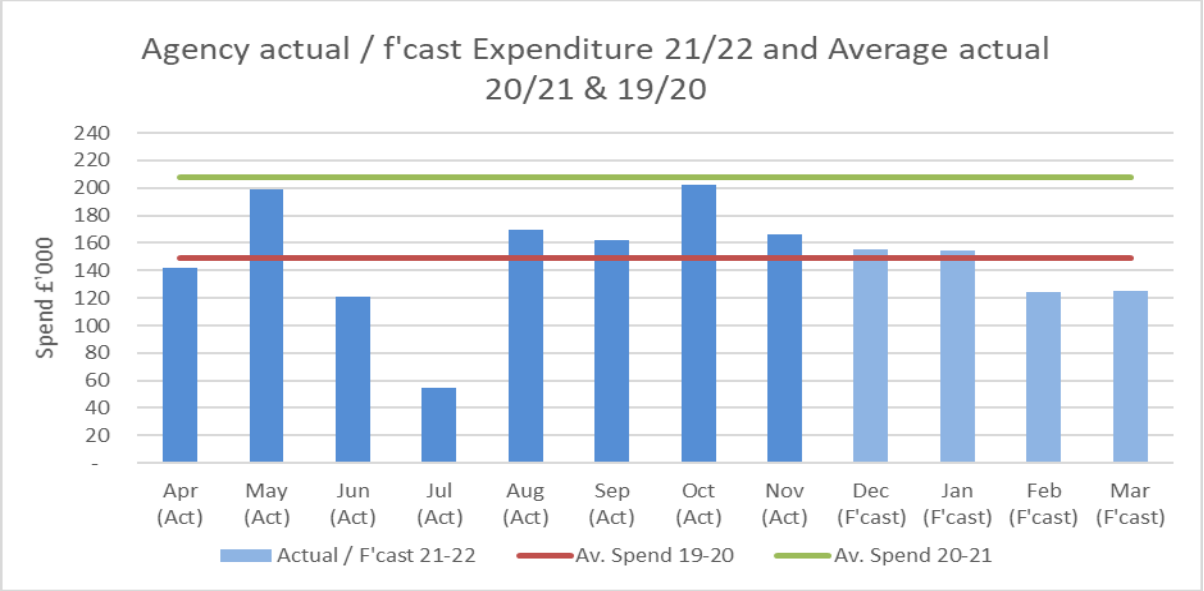
*Sep costs include Pay Award (3%) backdated to April. The perviously reported £2.6m additional pension has been removed as this will be a nominal charge from WG.



*20wte included in period 12 for the Patient Vaccination clinics which have now disbanded. Core Staff increase for 21-22 to October is 10wte.



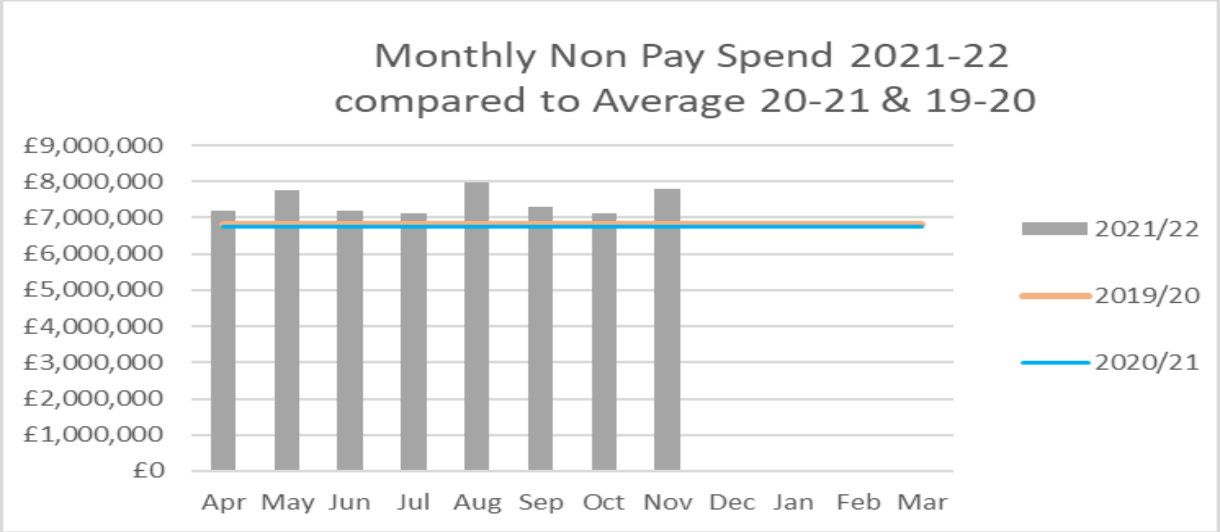
The spend on agency for November was £202k (October £202k), which gives a cumulative year to date spend of **£1,216k** and a forecast outturn spend of circa **£1,776k.** Of these totals the year to date spend on agency directly relating to Covid is £525k and forecast spend is circa £842k.



*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 from the impact of 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	278	392	213	179
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PPE	140	277	147	130
Covid Recovery	1,331	3,222	3,479	(257)
Other Covid Related Spend & Cost Reduction	979	1,475	1,176	299
BFWD Savings Loss	467	700	700	0
Return of Bonus Payment (over allocated)	(83)	(83)	(83)	0
Total Covid Spend /Funding Requirement 2021/22	**3,650**	**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 £3,222k 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 is circa £2,900k above existing forecast which is based on potential demand should the additional capacity be fully utilised. These figures are excluded from the table above.

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 (£298k), 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 (£30k).

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.

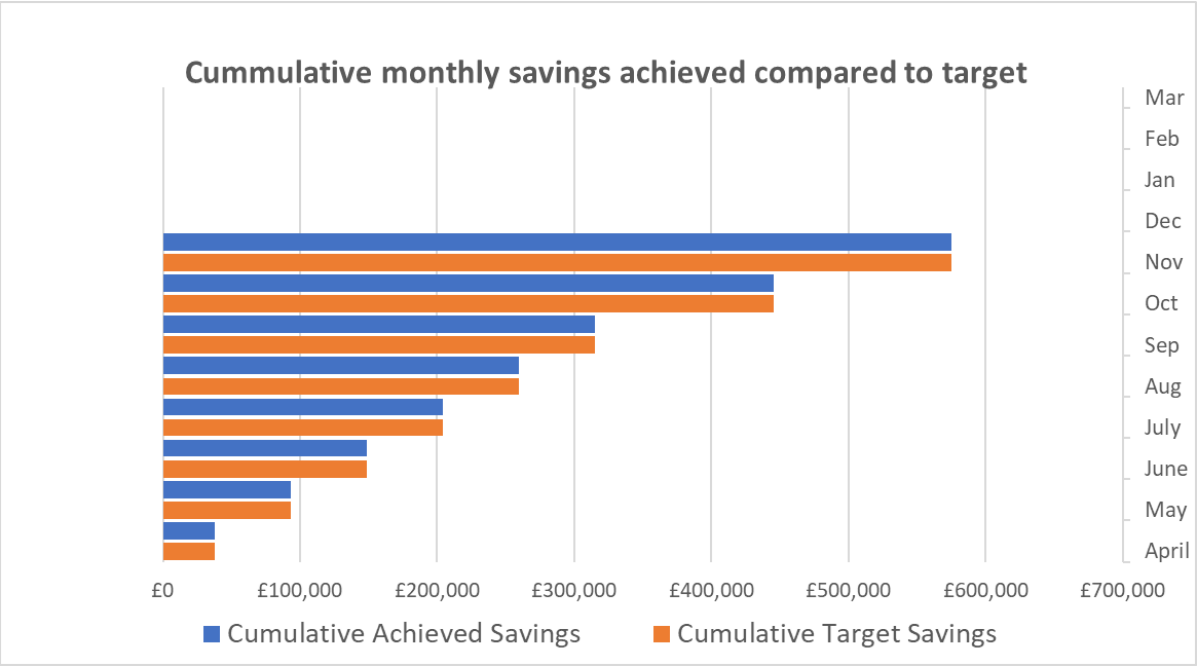
The schemes identified as amber relate to the £200k post Covid savings which have been replaced with non-recurrent vacancy factor savings as the target will not be achieved this year whilst still in the pandemic.

The Divisional share of the overall Trust savings target has been now been re-allocated following the slippage on post Covid savings to VCC £300k (27%), WBS £300k (27%), and Corporate £100k (9%), with £400k (36%) being set at Trust level for combined vacancy factor above the baseline target set by each Division. This was distributed in the September position and included within the divisional savings plans.

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. 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	117	117	0	300	(113)
			100%		73%	
WBS TOTAL SAVINGS	368	200	200	0	300	(68)
			100%		82%	
CORPORATE TOTAL SAVINGS	119	67	67	0	100	(19)
			100%		100%	
TRUST TOTAL SAVINGS IDENTIFIED	900	383	383	0	700	(200)
TRUST ADDITIONAL NON-RECURRENT SAVINGS	200	192	192	0	400	200
TRUST TOTAL SAVINGS	1,100	575	575	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	50	50	0	150	0
Premium of Agency Staffing	Green	100	33	33	0	100	0
Post Covid Savings (VCC)	Red	113	0	0	0	0	(113)
Blood Supply Chain 2020	Green	75	50	50	0	75	0
Blood Supply Chain 2020	Green	25	17	17	0	25	0
Stock Management	Green	200	133	133	0	200	0
Post Covid Savings (WBS)	Red	68	0	0	0	0	(68)
Establishment Control	Green	100	67	67	0	100	0
Post Covid Savings (Corporate)	Red	19	0	0		0	(19)
Total Saving Schemes		**850**	350	350	0	650	(200)
Income Generation							
Maximinsing Income Opportunities	Green	50	33	33	0	50	0
Total Income Generation		**50**	33	33	0	50	0
TRUST ADDITIONAL NON-RECURRENT SAVINGS - VACANY FACTOR		200	192	192	0	400	200
TRUST TOTAL SAVINGS		1,100	575	575	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 November '21 is £584k (includes £87k 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 has commenced by the end of December '21.

The non-recurrent reserves still available to invest and cover new unavoidable cost pressures is £972k. 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 @ M8 £000s	Full Year Actual Spend £000s	Year End Variance £000s
All Wales Capital Programme						
VCC - Transforming Cancer Services	3,711	1,696	0	2,015	3,711	0
VCC Radiotherapy Procurement Solution	312	188	0	124	312	0
IT - WPAS (CANISC replacement phase 2)	993	632	0	361	993	0
Fire Safety	600	140	2	458	600	0
National Programmes - Decarbonisation	109	30	8	71	109	0
National Programmes - Imaging	1,020	0	602	418	1,020	0
Covid Recovery	675	0	0	675	675	0
DHCW - NDR Funding	350	0	0	350	350	0
DHCW - VCC Careflow	60	0	0	60	60	0
HTW Capital	5	5	0	0	5	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	0	450	450	0
Digital Server Infrastructure Tech refresh	85	0	0	85	85	0
Total All Wales Capital Programme	8,673	2,690	613	5,370	8,673	0
Discretionary Capital	1,911	274	316	1,321	1,911	0
Total	10,584	2,964	929	6,690	10,584	0

The approved 2021/22 Capital Expenditure Limit (CEL) as at November 2021 was £10,584k. This includes All Wales Capital funding of £8,673k, 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 November 2021 on the All-Wales Capital Programme schemes was £2,690k, this is broken down between spend on the TCS Programme £1,696k, Integrated Radiotherapy Procurement Solution £188k, IT WPAS £632k, Fire Safety £140k, Decarbonisation £30k, and HTW £5k.

The Trust Discretionary funding has now been allocated for 2021-22 and was approved at EMB on the 2nd August. All funds have been committed to schemes other than a contingency being held for emergencies.

Spend to date on Discretionary Capital is currently £274k with a further £316k 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.

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.

The net capital overspend being reported through the TCS Programme will be managed within the overall Programme budget and from slippage / contingency within the Trust discretionary programme.

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 the remainder of 2021/22 and beyond in conjunction with WG include:

	Scheme	**Scheme Total**	**Stage (i.e., OBC development, FBC development, scoping etc.)**	**21/22**	**22/23**	**23/24**	**24/25**
		£'000		**£'000**	**£'000**	**£'000**	**£'000**
1	VCC Outpatients	800	Feasibility & design study currently being undertaken	0	800	0	0
2	WBS HQ	22,000	PBD approved by WG OBC under development	0	1,000	11,000	10,000

	Scheme	Scheme Total £'000	Stage (i.e., OBC development, FBC development, scoping etc.)	21/22 £'000	22/23 £'000	23/24 £'000	24/25 £'000
3	Ventilation	2,490	BJC to be submitted	0	2,490	0	0
4	IRS	38,429	OBC & PBC approved by WG, FBC under development	0	9,922	7,048	21,459
5	Plasma Fractionation	TBC	Feasibility study to be developed	TBC	TBC	TBC	TBC

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 30 November.

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 relates to the transfer of Capital assets relating to DHCW.

	Opening Balance Beginning of Apr 20	Closing Balance End of Nov-21	Movement from 1st April Nov-21	Forecast Closing Balance End of Mar 21
Non-Current Assets	**£'000**	**£'000**	**£'000**	**£'000**
Property, plant and equipment	136,558	124,700	(11,858)	124,700
Intangible assets	20,821	5,481	(15,340)	5,481
Trade and other receivables	817,142	1,100,574	283,432	1,100,574
Other financial assets	0	0	0	0
Non-Current Assets sub total	974,521	1,230,755	256,234	1,230,755
Current Assets				
Inventories	95,564	85,187	(10,377)	85,187
Trade and other receivables	548,836	110,156	(438,680)	161,637
Other financial assets	0	0	0	0
Cash and cash equivalents	43,263	69,999	26,736	18,518
Non-current assets classified as held for sale	0	0	0	0
Current Assets sub total	687,663	265,342	(422,321)	265,342
TOTAL ASSETS	1,662,184	1,496,097	(166,087)	1,496,097
Current Liabilities				
Trade and other payables	(353,136)	(212,743)	140,393	(212,743)
Borrowings	(8)	0	8	0
Other financial liabilities	0	0	0	0
Provisions	(316,959)	(316,374)	585	(316,374)
Current Liabilities sub total	(670,103)	(529,117)	140,986	(529,117)
NET ASSETS LESS CURRENT LIABILITIES	992,081	966,980	(25,101)	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	141,198	(24,800)	141,198
FINANCED BY:				
Taxpayers' Equity				
General Fund	0	0	0	0
Revaluation reserve	27,978	31,052	3,074	31,052
PDC	122,468	94,597	(27,871)	94,597
Retained earnings	15,552	15,549	(3)	15,549
Other reserve	0	0	0	0
Total Taxpayers' Equity	165,998	141,198	(24,800)	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.

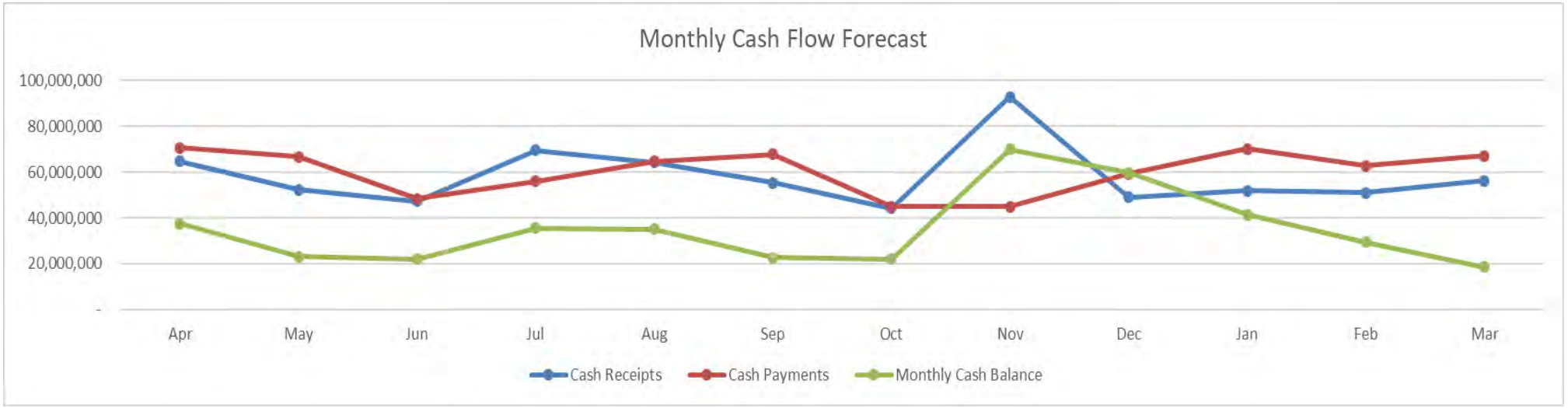
As part of the Brexit emergency planning an additional £5m of stock had been purchased by NWSSP and an additional £2m of commercial blood products were purchased by WBS, to provide resilience for NHS Wales due to the uncertainty around supply chain reliability because of Brexit.

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 January 2022.

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.

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	33,842	35,820	34,002	29,987	372,207
2	WG Income	33,807	26,132	11,582	30,431	27,512	21,398	6,388	56,520	11,842	13,800	14,825	16,832	271,069
3	Short Term Loans													0
4	PDC												7,146	7,146
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	3,280	2,243	2,182	2,300	48,318
8	**TOTAL RECEIPTS**	**64,797**	**52,306**	**47,227**	**69,515**	**64,350**	**55,288**	**44,314**	**92,842**	**48,964**	**51,863**	**51,009**	**56,265**	**698,740**
	PAYMENTS													
9	Salaries and Wages	15,189	22,734	22,015	20,181	19,284	24,383	25,582	24,544	25,157	25,145	25,184	26,547	275,944
10	Non pay items	52,989	43,749	25,742	35,377	45,158	42,830	18,755	19,768	32,320	35,275	34,240	35,446	421,650
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	1,725	2,893	3,420	5,230	18,891
15	Other items													0
16	**TOTAL PAYMENTS**	**70,552**	**66,760**	**48,297**	**56,011**	**64,667**	**67,836**	**44,968**	**44,811**	**59,202**	**70,313**	**62,844**	**67,223**	**723,484**
17	Net cash inflow/outflow	(5,755)	(14,454)	(1,070)	13,504	(317)	(12,548)	(655)	48,031	(10,238)	(18,450)	(11,835)	(10,958)	
18	Balance b/f	43,263	37,508	23,054	21,984	35,488	35,171	22,623	21,968	69,999	59,761	41,311	29,476	
19	Balance c/f	37,508	23,054	21,984	35,488	35,171	22,623	21,968	69,999	59,761	41,311	29,476	18,518	



DIVISIONAL ANALYSIS

(Figures in parenthesis signify an adverse variance against plan)

Core Trust

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Variance £000
VCC	24,002	24,002	0	36,325	36,325	0
RD&I	37	36	0	(365)	(365)	0
WBS	13,350	13,350	0	20,652	20,652	0
Sub-Total Divisions	**37,389**	**37,389**	**0**	**56,612**	**56,612**	**0**
Corporate Services Directorates	6,040	6,040	(0)	8,854	8,854	0
Delegated Budget Position	**43,429**	**43,429**	**0**	**65,466**	**65,466**	**0**
TCS	437	437	(0)	655	655	0
Health Technology Wales	(7)	(8)	0	28	28	0
Trust Position	**43,859**	**43,859**	**0**	**66,149**	**66,149**	**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	**40,084**	**40,298**	**214**	**62,176**	**62,451**	**275**
Expenditure						
Staff	27,010	26,977	33	40,665	40,815	**(150)**
Non Staff	37,076	37,323	(247)	57,835	57,960	**(125)**
Sub Total	**64,087**	**64,300**	**(214)**	**98,500**	**98,775**	**(275)**
Total	**24,002**	**24,002**	0	**36,325**	**36,325**	**0**

VCC Key Issues:

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

Income at Month 8 represents an overachievement of **£214k**. 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, along with additional funding for senior medical non-surgical workforce, increased income against the Radiation protection SLA, and HSST income within Physics Management. 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 **£33k** against staff for November. 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 (£859k to end of November) although £454k 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 8 was **£(247)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.

WBS

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	**14,860**	**14,302**	**(558)**	**20,991**	**20,336**	**(656)**
Expenditure						
Staff	11,332	11,153	179	16,963	16,835	**129**
Non Staff	16,878	16,499	379	24,680	24,153	**527**
Sub Total	**28,210**	**27,652**	**558**	**41,643**	**40,987**	**656**
Total	**13,350**	**13,350**	**0**	**20,652**	**20,652**	**0**

WBS Key Issues:

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

Income underachievement to date is **£(558)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. 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 **£179k** to November, which is above the division's vacancy factor target. Vacancies remain high at 38 as at end of month 8. 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.

Non-Staff underspend of **£379k** 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	**942**	**978**	**36**	**1,238**	**1,225**	**(13)**
Expenditure						
Staff	6,457	6,312	145	9,483	9,164	**319**
Non Staff	525	706	(181)	609	915	**(306)**
Sub Total	**6,982**	**7,018**	**(36)**	**10,092**	**10,079**	**13**
Total	**6,040**	**6,040**	**(0)**	**8,854**	**8,854**	**0**

Corporate Key Issues:

The reported financial position for the Corporate Services division at the end of November 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 an 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 **£(306)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	**1,948**	**1,908**	**(40)**	**3,271**	**3,271**	**0**
Expenditure						
Staff	1,806	1,767	39	2,625	2,625	**0**
Non Staff	179	177	2	281	281	**0**
Sub Total	**1,985**	**1,944**	**41**	**2,906**	**2,906**	**0**
Total	**37**	**36**	**0**	**(365)**	**(365)**	**0**

RD&I Key Issues

The reported financial position for the RD&I Division at the end of November 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	346	346	(0)	537	537	**0**
Non Staff	91	91	(0)	118	118	**0**
Sub Total	**437**	**437**	**(0)**	**655**	**655**	**0**
Total	**437**	**437**	**(0)**	**655**	**655**	**0**

TCS Key Issues

The reported financial position for the TCS Programme at the end of November 2021 is a **breakeven** with a forecasted outturn position of **breakeven.** There is a cost pressure of £17k which it is anticipated will be mitigated.

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	**1,077**	**1,077**	**0**	**1,625**	**1,625**	**0**
Expenditure						
Staff	944	943	0	1,433	1,433	**0**
Non Staff	126	126	0	220	220	**0**
Sub Total	**1,070**	**1,069**	**0**	**1,653**	**1,653**	**0**
Total	**(7)**	**(8)**	**0**	**0**	**28**	**0**

HTW Key Issues

The reported financial position for Health Technology Wales at the end of November 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 NOVEMBER 2021

DATE OF MEETING	15th December 2021

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 08.

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 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 from £0.420m funding provided from Commissioners for 2021-22 to cover direct clinical/management support and Programme Management Allocation from WG 2021-22 revenue pay award funding	**£ 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 has provided revenue funding for Project Delivery The Trust has provided revenue funding for the Judicial Review	**£3.460m** £3.460m	**£0.096m** £0.026m £0.070m
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 Additional funding provided by the Trust for the Project's increased legal and staff costs	**£0.602m** £0.312m £0.290m	**£ 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 Allocation from £0.420m funding provided from Commissioners for 2021-22 to cover direct clinical/management support and Programme Management Funding provided from the Trust's core revenue budget towards the costs of the Project Director post and the Project Manager post Allocation from WG 2021-22 revenue pay award funding	**£ nil**	**£0.313m** £0.180m £0.124m £0.009m
Project 7 – VCC Decommissioning No funding requested or provided for this project to date	**£ nil**	**£ nil**
Total funding provided to date	**£4.312m**	**£0.655m**
	£4.967m	

4. FINANCIAL SUMMARY AS AT 30TH NOVEMBER 2021

4.1 The summary financial position for the TCS Programme for the year 2021-22 is outlined below:

- **CAPITAL** spend is **£1.880m** with a forecast outturn of **£4.304m;** and
- **REVENUE** spend is **£0.448m** with a forecast outturn of **£0.654m**

TCS Programme Budget & Spend 2021-22

CAPITAL	Cumulative to Date			Financial Year		
	Budget to Nov-21	Spend to Nov-21	Variance to Nov-21	Annual Budget	Annual Forecast	Annual Variance
	£	£	£	£	£	£
PAY						
Project Leadership	126,088	122,737	3,351	193,000	191,031	1,969
Project 1 - Enabling Works	100,000	141,977	-41,977	100,000	215,979	-115,979
Project 2 - New Velindre Cancer Centre	435,662	445,966	-10,304	1,008,500	819,895	188,605
Project 3a - Radiotherapy Procurement Solution	272,212	242,520	29,692	346,113	347,049	-936
Capital Pay Total	**933,962**	**953,200**	**-19,238**	**1,647,613**	**1,573,954**	**73,659**
NON-PAY						
nVCC Project Delivery	30,820	27,437	3,383	78,500	78,500	0
Project 1 - Enabling Works	117,000	165,983	-48,983	150,000	707,925	-557,925
Project 2 - New Velindre Cancer Centre	676,977	577,523	99,453	2,180,000	1,689,599	490,401
Project 3a - Radiotherapy Procurement Solution	157,168	155,829	1,338	255,728	254,478	1,249
Capital Non-Pay Total	**981,964**	**926,773**	**55,191**	**2,664,228**	**2,730,503**	**-66,275**
CAPITAL TOTAL	**1,915,926**	**1,879,973**	**35,953**	**4,311,840**	**4,304,457**	**7,383**

REVENUE	Cumulative to Date			Financial Year		
	Budget to Nov-21	Spend to Nov-21	Variance to Nov-21	Annual Budget	Annual Forecast	Annual Variance
	£	£	£	£	£	£
PAY						
Programme Management Office	137,790	138,409	-619	224,833	217,879	6,954
Project 6 - Service Change Team	208,422	215,545	-7,123	312,633	320,906	-8,273
Revenue Pay total	**346,212**	**353,954**	**-7,742**	**537,466**	**538,785**	**-1,319**
NON-PAY						
nVCC Project Delivery	19,117	16,167	2,950	26,000	26,000	0
nVCC Judicial Review	70,000	69,600	400	70,000	69,600	400
Programme Management Office	2,141	8,263	-6,122	21,534	19,263	2,271
Project 6 - Service Change Team	0	178	-178	0	266	-266
Revenue Non-Pay Total	**91,258**	**94,207**	**-2,950**	**117,534**	**115,130**	**2,404**
REVENUE TOTAL	**437,470**	**448,161**	**-10,691**	**655,000**	**653,915**	**1,085**

5. FINANCIAL POSITION FOR TCS PROGRAMME AND ASSOCIATED PROJECTS AS AT 30TH NOVEMBER 2021

CAPITAL SPEND

5.1 ***Project 1 Enabling Works -*** There is a cumulative capital spend to date of **£0.308m** against a budget of **£0.217m**, with a forecast spend for the year of **£0.924m** against a budget of **£0.250m**.

Work package	Spend to 30th November 2021 £m	Forecast Annual Spend £m
Pay	**£0.142**	**£0.216**
Third Party Undertakings	£nil	£nil
Technical Advisers	£0.117	£0.147
Works	£0.012	£0.524
Legal Advice	£0.037	£0.037
Enabling Works Reserves	£nil	£nil
Non-pay	**£0.166**	**£0.708**

Total	**£0.308**	**£0.924**

5.2 ***Project 2 - nVCC -*** There is a cumulative capital spend to date of **£1.174m**, against a budget of **£1.270m**. The forecast spend for the years is **£2.779m** against a budget of **£3.460m**.

Work package	Spend to 30th November 2021 £m	Forecast Annual Spend £m
Pay	**£0.569**	**£1.011**
Project Delivery costs	£0.027	£0.079
Competitive Dialogue – PQQ & Dialogue	£0.574	£1.452
Legal Advice	£0.012	£0.053
nVCC Reserves	-£0.009	£0.184
Non-pay	**£0.605**	**£1.768**
Total	**£1.174**	**£2.779**

Project 3a – Integrated Radiotherapy Procurement Solution

5.3 There is a cumulative capital spend to date of **£0.398m** (£0.243m pay, £0.156m non-pay) for the IRS Project against a budget of **£0.429m**. The Project is currently forecasting a spend of **£0.602m** (£0.347m pay, £0.255m non-pay) against a budget of **£0.602m**.

REVENUE SPEND

Programme Management Office

5.4 The PMO spend to date is **£0.147m** (£0.138m pay, £0.008m non-pay) against a budget of **£0.140m**. The Project is forecasting a spend of **£0.237m** (£0.218m pay, £0.019m non-pay) in the financial year 2021-22 against a budget of **£0.246m**.

Projects 1 and 2 Delivery Costs

5.5 There is a revenue project delivery cost to date for the nVCC and Enabling Works Projects of **£0.016m** against a budget of **£0.019m,** 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

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

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

5.7 Service Change spend to date is **£0.216m** against a budget of **£0.208m,** made up of pay costs. The Project is currently forecasting a spend of **£0.321m** for the year against an increased budget of **£0.313m**. The adjusted overspend of £9k remains a financial risk to the outturn position for the Project, which the Project Team are working to mitigate.

6. Financial Risks & Issues

6.1 The forecast overspend £9k (revenue) for the Service Change Project remains a risk to the outturn position for the Programme, however it is anticipated that this be funded through other TCS Programme underspends.

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
	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)
	See above.

9. RECOMMENDATION

9.1 The TCS Programme Board are asked to **NOTE** the financial position for the TCS Programme and Associated Projects for 2021-22 as at 30th November 2021.

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

TRUST RISK REGISTER

DATE OF MEETING	20/01/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not applicable

PREPARED BY	Lenisha Wright, 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
EMB	04.01.22	N/A
AUDIT COMMITTEE	11.01.22	N/A

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
QSPC	Quality, Safety and Performance Committee

1. SITUATION AND BACKGROUND

The purpose of this report is to present Quality Safety and Performance Committee with information on the status of organisational Risks recorded in the Trust Risk Register, as part of the ongoing management and mitigation of risks. The Trust Risk Register includes risks that meet the Trust Board risk appetite criteria for reporting, which for most risk categories are risks >=12 and risks with an impact of 5.

Risk information for this cover paper includes risks level 20, 16, 15, and 12, and risks with impact of five are highlighted in this cover report, in accordance with the risk appetite levels. To note that no level 25 risks have been recorded in the Trust Risk Register.

As discussed at previous QSPC meetings, we want to report on risks that are up to date in as transparent a way as possible. Risks in the Trust Risk Register were drawn in December. However, given the current changing circumstances regarding Covid, an Appendix is including for noting by Quality, Safety and Performance Committee of current assessments of potential risks and issues emerging from Silver and Gold Structures.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The Trust Risk Register is received and reviewed at Quality, Safety and Performance Committee, other Committees and Trust Board. Risks on the Trust Risk Register presented in this report have been reviewed at Divisional Senior Team meetings on scheduled meeting dates.

Quality, Safety and Performance Committee is requested to note and support the continued work being undertaken on the management of risks in the organisation which includes the ongoing validation, authentication and mitigation of risks. QSPC is requested to scrutinise data in the risk registers including, risk ratings, review dates and identified controls. Quality, Safety and Performance Committee is requested to note the following work that is currently progressing.

- Implementation of the board approved risk process, risk appetite and risk framework;
- Establishing a new risk process;
- Risk mitigation from version 12 to version 14 of Datix;

- User set up and access to the new system (Vs 14);
- Training for staff.

3. THE TRUST RISK REGISTER

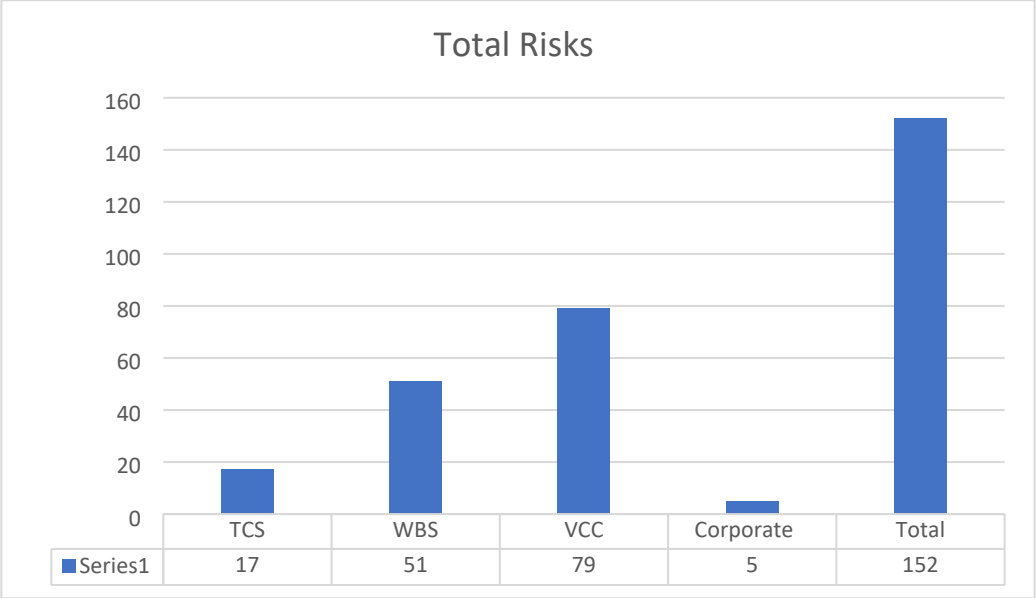
Risks are recorded in two registers currently, version 12 and version 14 of Datix. Trust Risk Registers for Corporate, VCC and TCS are recorded in Vs 14 of Datix, and Risks for WBS is currently recorded in version 12 of Datix. Work is currently progressing with regard to updates on the Risk form in version 14 as well as the development of a paper based Risk form to align requirements ensuring the new process is fit for purpose for all Divisions within the Trust. Following the completion of this process, all risks will be recorded on one risk register, in version 14 of the Datix system.

3.1. Covid Related Risks

The risk profile has changed significantly within weeks in many respects, including: staffing levels; stock levels in WBS; patient isolation guidelines etc. The risk profile extracted from December Datix position prior to Christmas, therefore does not yet reflect many of these fast moving changes. A summary of emerging risks and issues emerging from Silver and Gold structures will be provided in Appendix 3. This will be included in the papers following confirmation through the command structure early w/c 17th January. These risks will then be worked up into the Datix records for February reporting.

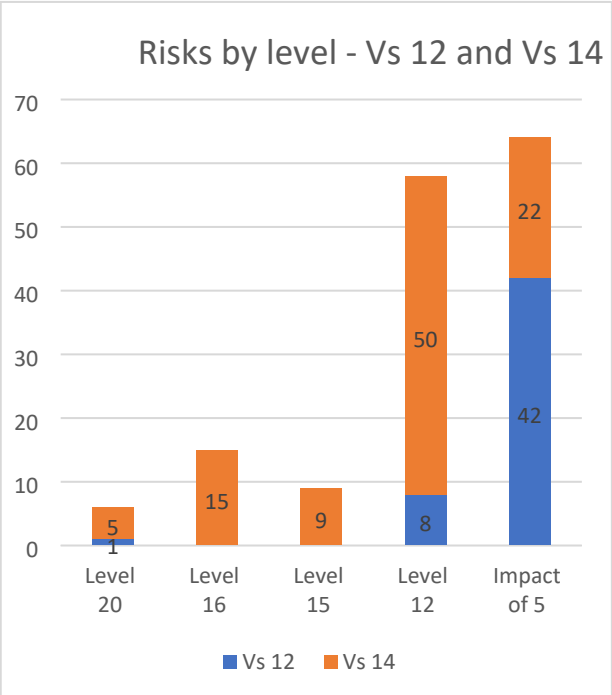
3.2. Total Risks

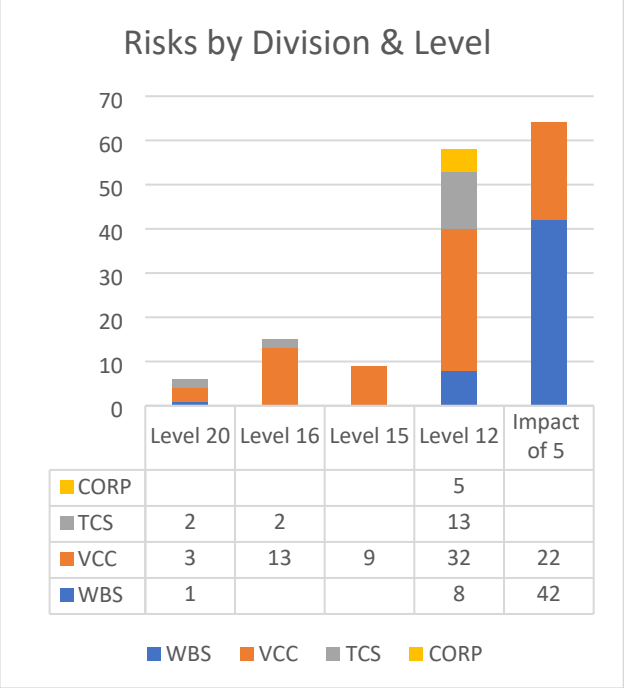
There are a total of **152** risks recorded in Datix Trust Risk Registers, 51 in version 12 and 101 in version 14. This compares to 119 in the November 2021 reporting cycle. The difference is due to risks with an impact of five in version 12 that were not included previously due to technical difficulties which have now been resolved. The graph below provides a breakdown of the total number of risks by Division.



3.3. Risks by level

The graph below provides a breakdown of risks by level across the Trust. A further breakdown of risks by level and Division is also included. Analysis of risks rated 20, 16, 15 and 12 as well as risks with an impact of five are provided under analysis of risks (paragraph 4).





4. Analysis of risks

An analysis of risks by level is provided below. Tables provide detail of each risk including risk type, risk ID, review date and title of the risk.

4.1. Risks level 25

There are no risks with a risk rating of 25 recorded in the Trust Risk Register at the time of the data being extracted from Datix.

4.2. Risks level 20

The table below provides a breakdown of risks level 20. There are currently six risks with a current risk rating of 20 recorded, three for VCC, two for TCS and one for WBS. This compares to five in the November 2021 reporting cycle. Of the six recorded risks with a rating of 20, three relate to performance and service sustainability and three to workforce. Five of these were scored as 20 in the previous reporting cycle (2191, 14764, 2437, 2401 and 2400) with one additional risk has been rescored level 20.

One risk is recorded with an increase in risk score:

- 2200 - has increased from a risk score of 16 reported in the previous period to a score of 20 in this reporting period. The risk relates to resource capacity within radiotherapy and was previously reported as level 16 in the November reporting cycle. The risk score has increased following analysis and assessment. The actions and controls are described as a maximising capacity for radiotherapy document which was written by the Radiotherapy Management Group. The required escalation processes to address capacity challenges is currently underway.

Risk Type	ID	Division	Review date	Title
Performance and Service Sustainability	14764	Welsh Blood Service	06/04/2022	Brexit - Implications of Exiting the EU - No Deal Situation
	2200	Velindre Cancer Centre	31/12/2021	Radiotherapy Capacity
	2191	Velindre Cancer Centre	31/01/2022	Inability to meet COSC / SCP targets
Workforce and OD	2437	Velindre Cancer Centre	29/11/2021	Digital Health & Care Record DHCR042(R) - Delay in new Radiographer graduates starting, likely to be October/ November 2021

	2401	Transforming Cancer Services	04/02/2022	Risk of insufficient resources being made available to the Project
	2400	Transforming Cancer Services	31/01/2022	Risk that there is lack of project support

4.3. Risks level 16

The table below provides information of level 16 risks as per the Risk Register. There are currently a total of 15 risks with a current risk rating of 16, two for TCS and 13 for VCC. This compares to 16 in the November 2021 reporting cycle. 15 risks remain scored 16 and one (Risk ID 2200) increased to a score of 20 (see paragraph 4.2).

New Risks: No new risks have been reported with a score of 16 in this reporting period.

Risk Type	ID	Division	Review date	Title
Compliance	2428	Velindre Cancer Centre	29/11/2021	There is a risk of increased infection transmission due to poor ventilation.
Financial Sustainability	2198	Velindre Cancer Centre	13/12/2021	VCC may face financial loss, legal action, inadequate service provision as a result of no coordinated system for SLAs, contracts
Performance and Service Sustainability	2402	Transforming Cancer Services	31/01/2022	Risk of time-consuming infrastructure work
	2190	Velindre Cancer Centre	31/03/2022	BI Support for reporting of Breaches
	2211	Velindre Cancer Centre	29/11/2021	Digital Health & Care Record DHCR004(R) - Requirements for Standardisation process redesign & agreed Ways of Working
	2203	Velindre Cancer Centre	29/11/2021	Digital Health & Care Record DHCR013(R) - Accelerated Timelines of the DHCR Programme
	2221	Velindre Cancer Centre	29/11/2021	Digital Health & Care Record DHCR019(R) - Clinical Coding Copy Functionality within WPAS
	2329	Velindre Cancer Centre	29/11/2021	Digital Health & Care Record DHCR034(R) - SACT & Medicines Management – Cashing Up Daycase Clinics

	2328	Velindre Cancer Centre	29/11/2021	Digital Health & Care Record DHCR035(R) - SACT & Medicines Management – processes
	2440	Velindre Cancer Centre	29/11/2021	Digital Health & Care Record DHCR046(R) - unable to significantly reduce the capacity of SACT daycase clinics
	2193	Velindre Cancer Centre	01/04/2022	Medical Physics Expert cover for Molecular Radiotherapy (Nuclear Medicine)
	2196	Velindre Cancer Centre	01/12/2021	Radiotherapy Department -COVID Isolation Impact
	2345	Velindre Cancer Centre	06/12/2021	Radiotherapy Dept - Change to service due continued response to Covid19
	2326	Velindre Cancer Centre	31/12/2021	There is a risk that the Service will be unable to significantly reduce the capacity of clinics over the Digital Health & Care
Quality	2403	Transforming Cancer Services	07/01/2022	Risk that enabling works construction exceeds timescale

4.4. Risks level 15

There are currently nine level 15 risks recorded in the Trust Risk Register. All nine risks for this level are recorded for VCC with six relating to performance and service sustainability, one to safety and two to workforce. To note that eight of these risks have remained scored at 15 from the previous reporting period.

New Risk: One new risk has been recorded in this reporting period:

- 2480 – There is a risk that there may be a shortfall of oncologists. The identified risk is based on census predictions that go up to 2025, and highlight potential impact on services. There are a number of control measures identified including: an increase in training placements; developing new multi-professional ways of working; and actively seeking to recruit.

Closed risks: One risk has been closed in this reporting period:

- 2218 - This risk related to parking space at VCC in the West car park. Extended and dedicated parking has now been provided and the risk eliminated.

Risk Type	ID	Division	Review date	Title
Performance and Service Sustainability	2253	Velindre Cancer Centre	01/05/2022	Availability of CANISC System
	2187	Velindre Cancer Centre	31/12/2021	Radiotherapy Physics Staffing
	2205	Velindre Cancer Centre	31/01/2022	CANISC failure
	2296	Velindre Cancer Centre	29/11/2021	Digital Health & Care Record DHCR010(R) - Data Migration Resource
	2252	Velindre Cancer Centre	01/04/2022	Large number of development projects in Radiotherapy
	2220	Velindre Cancer Centre	31/12/2021	Treatment Planning System End of Life
Safety	2185	Velindre Cancer Centre	31/05/2021	Delination Risk treatment delay (16284)
Workforce and OD	2480	Velindre Cancer Centre	23/12/2021	Current and predicted shortfall of oncologists by 2025
	2217	Velindre Cancer Centre	01/12/2021	Medical Capacity for RT Planning in Job Plans

4.5. Risks Level 12

As per the table below, there are currently a total of 58 risks with a current risk rating of 12, five for Corporate Services, Fourteen for TCS, eight for WBS and thirty two for VCC.

New Risks – Two new risks were opened in the reporting period:

- 2486 – There is a risk that the Section 278 application takes longer than expected to be approved leading to delays in overall construction time. The process has started and is being monitored.

Closed Risks - Four risks have been closed in the reporting period:

- 2227 – The inability to comply with Health Protection (Coronavirus Restriction) (Wales) Regulations 2020. There is continuous implementation of IPC and social distancing measures to ensure all patients are triaged and assessed. Other IPC related risks are recorded and managed (see risk ID 2393 and 2397 in the table below).
- 2234 - Non-compliance to COSHH regulations, which may lead to staff injury or ill health when using chemicals not in the SYPOL system. The Alcumus (SYPOL) system is now in place and the risk has been closed.
- 2414 - There was a risk that application to create public right of way could impact enabling works project's ability to use for a Temporary Construction Access Road (TCAR). Allowance has since been made for handling correctly the newly established public right of way through the railway cutting.
- 2235 - There is a risk at VCC of health and safety breaches due to lack of dedicated H&S support. An H&S audit was undertaken and various improvements in COSHH management and processes have been put in place. Operational Services are supporting the division (VCC) in taking this forward. A number of staff and managers have completed professionally accredited H&S training.
- 16883 – There is a risk that the implementation of Oracle Release R12.2.9 (Phase 1) may affect requisitions for catalogue and non-catalogue items. Participation in several phases/iterations of UAT have helped identify issues/errors in the system. Service point tickets are raised when required for issues/errors identified on an ongoing basis.

4.6 Impact level 5

Risks in the table below include risks with an impact of 5 and a score below 12. These risks are included in accordance with the risk appetite levels. Each of these risks are going through review during this cycle and updates on these risks will be republished in the March cycle of papers, in line with service priorities. As mentioned above, further insight and analysis from SLT for VCC and SMT for WBS will be included in versions of the paper for QSP and Board

There are a total of 64 risks with impact of five, 23 relate to VCC and 41 to WBS. Of the 64 recorded risks, eleven relate to compliance, 42 to performance and service sustainability and eleven to safety.

New Risks: No new risks with impact of five have been recorded in the period.

5. 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.

6. RECOMMENDATION

Quality, Safety and Performance Committee is asked to:

- **NOTE** the risks level 20, 16, 15, 12 and impact of 5 reported in the Trust Risk Register and highlighted in this cover paper.
- **NOTE** that a project plan is in place and actions undertaken to expedite progress in establishing a consolidated risk process for the Trust.
- **NOTE** the further work in January to update the profile in light of the recently changing covid risk profile.

- **NOTE** the **APPENDIX**, when received, summarising current assessment of potential risks and issues emerging regarding the current Covid response.

ID	Division	Approval status	RA Date	Title	Description	Controls in place	Current Risk Rating	Review date
16894	Welsh Blood Service	Final approval	28/10/2021	Transfusion associated acute lung injury risk reduction strategy	WBS supply of apheresis platelets from female or previously transfused donors, not screened for HNA antibodies	Donor screening identifies donors that may have experienced sensitising events (previous transfusion/pregnancy) but without HNA antibody screening is not able to mitigate the risk of these antibodies being present.	5	28/01/2022
16900	Welsh Blood Service	Final approval	18/10/2021	Apheresis Premises at Velindre cancer Centre	Velindre Cancer Centre Hospital building	Hospital facilities are inspected by an external contractor (Hurley & Davies). The VCC collection suite has been licenced by the HTA and will be regularly inspected by the WBS. H&S, Fire inspections regularly undertaken.	5	18/10/2022
16883	Welsh Blood Service	Final approval	20/09/2021	Implementation of Oracle Release R12.2.9 (Phase 1)	IPROC module - allows users to order catalogue and non-catalogue for non-stock items from suppliers.	(1) Participation in several phases/iterations of UAT have helped identify issues/errors in the system. Servicepoint tickets were raised when required for issues/errors identified. (2) Smoke testing has been performed by eEnablement which incorporated end-to-end testing.	12	31/12/2021
16809	Welsh Blood Service	Final approval	06/09/2021	Malaria Risk – Delay in Implementation of the Process to Support Amended Malarial Testing for a Specific Donor Group	Non-compliance with donor assessment based on the JPAC Donor Selection Guidelines for donors with MALR, MALF and MALP risks. No malaria discretionary test is undertaken following re-exposure to a malarial risk for donors in this group.	This issue has been fully discussed at JPAC / SACTTI-(Parasites) group. The MHRA have laisied with the Chair of JPAC- the conclusion is that whilst WBS practice is safe, the recommendation is to align WBS practice with other UK Services. By definition all these donors will have tested negative for malaria at their first donation - this part of the process is robust. It is the subsequent testing post re-exposure that is missing.	5	06/09/2022
16762	Welsh Blood Service	Final approval	13/08/2021	Supply Chain disruption of Blood Collection tubes	All other tubes not on the shortage list (10ML, 6ML etc)Update-17/08/2021	"Internal stock take and regular monitoring and management of WBS stock position. Stock holding of 8 weeks supply at present. Stock projection received from BD for coming months and identification of WBS allocation."	10	18/03/2022
16703	Welsh Blood Service	Final approval	23/06/2021	Risks identified for implementation of Oracle R12.2.9	Lack of end to end testing	None	12	17/12/2021
16780	Welsh Blood Service	Final approval	22/04/2021	Transport of Donor Records to and From WBMDR Collection Centre	Transport of paperwork that may contain donor personal identifiable information (PII)	Paperwork transported by WBMDR staff is kept to the minimum required (note: all WBMDR documentation only contains the minimum required PII to facilitate the collection). Staff are aware of the GDPR requirements, and have received training in Information Governance. Information and training provided by the WBMDR and stated in the standard operating procedure for the stem cell/PBL collection (SOP HUB-903). Staff advised to drive directly between the WBS and the collection centre unless absolutely necessary to stop or divert. Paperwork stored together securely (in a closed folder or bag) and out of sight in the vehicle.	5	22/04/2022
16788	Welsh Blood Service	Final approval	16/03/2021	Apheresis Premises at Nuffield The Vale Hospital	Nuffield the Vale Hospital building	Hospital is HIW inspected, HTA licenced and inspected by the WBS. H&S, Fire and HIW inspections regularly undertaken.	5	16/03/2023
16398	Welsh Blood Service	Final approval	11/12/2020	Review of modules used in Oracle Finance & Procurement System - GxP impact	Purchasing - used to manage the procurement of both stocked items (using the Inventory module), and non-stocked items (using the IPROC module).	Functionality verified in CQ test scripts for IPROC and Inventory (Note: issues would only be identified in the Live environment during CQ testing)	12	23/12/2021
16467	Welsh Blood Service	Final approval	27/11/2020	Receipt, Storage and Distribution of Covid 19 Vaccines	Recording time of vaccine removal from -80 freezer	Labels printed with time Print labels before removal of vaccine from freezer risk treatment - validate printed labels	5	22/10/2022
16295	Welsh Blood Service	Final approval	22/09/2020	Use of Female Plasma for Manufacturing Pooled Cryoprecipitate	WBS Cryoprecipitate made from female donors not tested for HLA/HNA antibodies	"Prevention 2) Low level of plasma from each donor, reducing any potential antibody concentration"	5	12/04/2022

16266	Welsh Blood Service	Final approval	15/09/2020	Inability to secure venues during response /recovery plan for Covid-19 - Impact to Blood Supply Chain	Inability to operate clinics at the same efficiency verses pre-Covid 19 due to social distancing and IPC measures/amount of donors able to attend venue due to social distancing measures.	Escalated to the Director of WBS And Chief Operating Officer for VUNHST, Head of Planning Logistics and Resource to submit SBAR outlining emerging situation and required support. Explored with MOD available venues. Ongoing dialog with PHW and WG about conflict between vaccination and WB venues. Update 28/01/2021 - A number of Health Boards have not yet responded to email , those that have showed that there will be some conflict with venues in certain regions. Working on proof of concept for use of trailers in a socially distanced environment, Also looking at options around a potential fixed site.	12	01/08/2022
15973	Welsh Blood Service	Final approval	19/05/2020	Exposure to Potential Pre-symptomatic, Asymptomatic Individuals at Verification Sample Procurement, Donor Information, Medical A	Donor Exposure to potential pre-symptomatic, asymptomatic individuals at VT sample collection - Performed by a Health Care at Home under contract to the WBMDR.	Assurances received from Health Care at Home that correct protocols are being implemented with regards to social distancing and use of appropriate PPE.	5	06/03/2022
16009	Welsh Blood Service	Final approval	18/05/2020	Social Distancing measures within the Laboratory environment (Lab Services and WTAIL)	See attached FMEA	See attached FMEA. Reviewed FMEA attached. Risk further reduced by staff vaccination program. All other measures remain in place. GS, 27/05/21	5	27/05/2022
15937	Welsh Blood Service	Final approval	04/05/2020	Covid-19 implications of handling biological samples within the WBS	Handling of untested or presumed COVID-19 negative samples for laboratory testing	Appropriate staff training, supervision and comptetence. Good laboratory practice. Use of standard laboratory PPE including nitrile gloves and labcoats. Risk treatment plan and recommended actions: All staff should be aware that there is the potential for any sample to be positive for COVID-19, as patients or donors may be asymptomatic. If appropriate, all primary samples should be centrifuged and left for at least 10 minutes before decapping to reduce aerosol risk. Centrifuge bucket lids must be used to reduce aerosol production risk in the event of tube breakage. Aerosol-generating or potential splashing procedures should be performed in a Class-2 microbiological safety cabinet if possible and appropriate. If these cannot be performed in a cabinet these procedures must be identified and additional proportionate controls put in place, such as capping of tubes, safety screens or PPE. Local Risk assessment within each laboratory should be performed to identify these procedures. Update 06/01/2021. Vaccination for all front line/lab staff has ben tolled out, Increased UK testing capability, increased use of PPE for all staff. No evidence of laboratory COVID-19 transmission has been seen, and no evidence (either locally or worldwide) that COVID-19 has been transmitted by aerosol from laboratory samples.	5	05/10/2022
15932	Welsh Blood Service	Final approval	23/04/2020	Impact of COVID-19 stabilisation phase to WBS	Re-introduction of elective procedures including Haematology activities. WBS are aware that WG have written to all Health Boards regarding the re-introduction of this work.	VUNHST planning team and WBS blood health team are liaising with hospitals to determine future demand. Existing MOU with the UK blood services to support in the event of a shortage in a blood component. WBS planning team have forecasted future collection models based on potential scenarios. Currently working on a proof of concept around trailer use in a socially distanced environment and also considering fixed site options.	12	05/11/2021

15746	Welsh Blood Service	Final approval	18/02/2020	Process Risk Assessment - Environmental Monitoring	Heat Sealers - including Blood Press Sealers	Maintenance regime in place to ensure equipment remains in peak performance at all times.	5	21/12/2021
15533	Welsh Blood Service	Final approval	27/09/2019	Manual Double Entry of Test Results in Automated Testing - Contingency Process	Manual entry of test results which are normally interfaced directly from an analyser into BECS.	Components from a positive donation are physically removed from the supply chain by Automated Testing staff.	5	15/12/2021
15456	Welsh Blood Service	Final approval	11/07/2019	Clinical RA for not providing HbS negative red cells	HbS negative blood not supplied by WBS as recommended by JPAC guidance	"- low incidence of HbS in Welsh population (0.02% in 2013) '- Most HbAS units block leucodepletion filters and don't make it to a usable donation"	5	22/02/2022
15373	Welsh Blood Service	Final approval	27/06/2019	Risks associated with MAK-System introduction of new interfacing policy for devices connected to ePROGESA	Increased complexity of networking / integration architecture in respect of the middleware used to interface devices that require interfacing to MAK-System products (e.g. ePROGESA). Additional costs incurred for establishment and maintenance of interfaces to MAK-System products (e.g. ePROGESA).	Ability to liaise with suppliers during procurement to advise on WBS preferences in respect of middleware arrangements for connected devices. MAK have recently confirmed "non partners" will still be permitted to interface devices to ePROGESA and other related MAK services. Subject to ongoing monitoring and discussion via International MAK-System User Group (IMUG).	12	28/02/2022
15398	Welsh Blood Service	Final approval	06/06/2019	Facilities Infrastructure	Electrical circuitry is not installed to current standards	Not installing any new equipment until power supply has been updated..	10	18/02/2022
15297	Welsh Blood Service	Final approval	29/04/2019	WBS Cyber Security Attack or Breach	WBS Systems and Services	Antivirus software deployed to detect threats. Device control deployed to limit access to removable devices. E-mail messages are scanned for threats and spoofing by NWIS. Web browsing is via a proxy server that scans for viruses and malicious content. Software updates are rolled out to address vulnerabilities in operating systems and key applications. Firewalls are enabled at device level as well as network levels to restrict access from unwanted systems. Newer operating system deployments are harden against security baselines recommended by suppliers and NCSC. Regular backups of critical and key data. Vulnerability scanning conducted against WBS devices. Phishing exercises targeted at WBS users	10	22/04/2022
15261	Welsh Blood Service	Final approval	01/04/2019	Microsoft Windows 7 and Server 2008 R2 End of Support	Windows Server 2008 R2 server operating system (ePROGESA)	Server operating systems are protected by local and network firewalls - this limits which devices can access the servers. Antivirus software provides detection and remediation against known threats. Internet usage and E-Mail is generally blocked from servers. System have been hardened against best practices. General users are only able to access limited parts of the ePROGESA environment, for example, Database Servers are not accessible	10	22/10/2021
15262	Welsh Blood Service	Final approval	01/04/2019	Oracle Java 8 End of Support	Oracle Java Runtime Environment	Java environment has been hardened to limit where applications can be launched from. Client operating systems are protected by local and network firewalls - this limits which devices can access the clients. Antivirus software provides detection and remediation against known threats. Removable media controls limit threats from USB/DVD drives. Internet usage is monitored to protect from web and downloadable threats. E-mail messages are scanned for threats. System have been partially hardened against best practices	5	22/04/2022
15189	Welsh Blood Service	Final approval	22/01/2019	Red Cell Antibody detection on the PK7300	Failure to detect high level anti-D on PK7300 - impact on Apheresis donations - not neonatal	None	5	14/01/2022
14764	Welsh Blood Service	Final approval	09/10/2018	Brexit - Implications of Exiting the EU - No Deal Situation	Increased expenditure	Public Contract Regulations Budgeting and financial controls	20	06/04/2022
14744	Welsh Blood Service	Final approval	03/09/2018	Abbott Microbiology Platform	Result Transfer to eProgesa	WBS Procedures Peer Review	5	13/01/2022

14508	Welsh Blood Service	Final approval	09/07/2018	Management of Work Place Related Stress	Could affect every activity within WBS including collections, processing and distribution etc. of blood products	Policy (Trust wide Mental Health , Wellbeing and Stress Management WF43) Toolkit to support Good Mental Health, Wellbeing and Reduce Stress. Employee assistance programme All Wales Wellbeing Tool Kit Stress risk assessment (completed by manager with staff member) Sickness absence policy Manager Training Mindfulness / complementary therapy Team Assistance Organisation Development facilitated discussion and mediation Organisation change RA Blood Supply 2020 relating to stress. Work life balance - flexible working. Health and wellbeing - Cycle to work scheme to promote healthy activities. Monitoring of sickness and absence reasons and levels. PADR process - clear roles and responsibilities. Manager support. Update Oct 2019 Continue to monitor sickness and absence levels WBS Sickness and Absence Deep Dive Stress Related Absence document produced Dec 2018 Ongoing wellbeing initiatives Initiatives introduced to look at finances - Home finances impact on stress Menopause Policy developed and initiatives to look at this introduced (Menopause Café) which impacts on work place stress	12	01/09/2021
14215	Welsh Blood Service	Final approval	06/03/2018	Risks associated with the implementation of Prometheus into WTAIL	Failure of WTAIL to meet its regulatory obligations (e.g HTA)	URS signed off and agreed. Regular meetings with supplier to ensure URS requirements are fulfilled. Regular communication with supplier in respect of changing/ new regulatory requirements. Development complete. Update 13/10/2020 UAT is complete.	10	01/04/2022
13819	Welsh Blood Service	Final approval	21/02/2018	Blood Supply Chain 2020 Initiative - Impact on Staff	Revised roles and contractual changes. New ways of working.	Early engagement with staff. Full support package available on intranet. Occupational Health support available. Potential for staff opportunities. Involvement of staff in decision making.	12	18/11/2021
13311	Welsh Blood Service	Final approval	08/11/2017	Reprinting Group Labels for overweight imported red cells	Reprint group label for imported red cell which is overweight (outside maximum volume parameter)	"NHSBT & SNBTS have an automatic discard set for components that are overweight/ over-volume (i.e. all Blood Services comply to the Red Book Guidelines and have their processes controlled accordingly). Laboratory staff identify non-conforming donations.	5	12/04/2022
12342	Welsh Blood Service	Final approval	29/03/2017	Use of the External Plasma Freezer	Safety of staff whilst using the freezer	None (PPE)	5	01/11/2022

12104	Welsh Blood Service	Final approval	02/02/2017	Movement of WBS personnel within the service yard area	Staff movement in the service yard .	Designated speed limit of 10 mph within the service yard area. Entrance gate controlled from central point (reception). Entrance gate is kept closed and access to the service yard is via intercom. Adequate lighting located in service yard area. All transport department staff and CCA drivers who use the service yard are provided with a service yard awareness briefing. This is undertaken as part of their training and is detailed in the training booklet prepared by transport department. Donor Services personnel and facilities staff are issued with hi visibility jackets /vests to wear when working on service yard area and this is a compulsory requirement. Transport and Facilities staff provide hi visibility jackets/vests to visitors and these visitors are escorted whilst on the service yard. Additional controls include hi vis paint work, periodic service yard inspections, contractor leaflet read and understood before work commences. CCTV coverage of the service yard.	10	01/10/2021
11522	Welsh Blood Service	Final approval	17/10/2016	Antibody detection by Luminex based technology	Detection of HLA antibodies by Luminex based methods	sample collection requirements are stated in WTAIL user guide. samples are only taken by trained phlebotomists and nursing staff. Acceptance of results based on review of patient history as and when available and take into consideration patient own type. Platelet cases require increment data for review of increment levels to determine further support required. Multiple samples are tested for those patients requiring long term support.	10	29/10/2022
9515	Welsh Blood Service	Final approval	03/07/2015	WBMDR Sterile Tube Welder	Sterility	Documented system at Collection centre (by two individuals) to check docking undertaken correctly (recorded on form WBM-551). Use of standard concession system (SOP 566/HUB) in the event of a dock failure. Routine sterility testing of all HPC products (100% testing)	5	04/11/2022
8719	Welsh Blood Service	Final approval	17/12/2014	GMP-0273 (Premises)	Storage area	Restricted access to authorised staff only. Physical segregation of product from routine blood stocks. Clear identification as HPC product	5	20/11/2022
8706	Welsh Blood Service	Final approval	15/10/2014	GMP-0062 (PBSC Collection)	Collection of product	pre-assessment of veins by 2 different healthcare practitioners. BM collection available as possible back-up	5	09/02/2022
8712	Welsh Blood Service	Final approval	15/10/2014	GMP-0066 (Assess Donor Fitness)	Failure to receive completed report in time for 'Final Clearance'.	None	5	09/02/2022
8717	Welsh Blood Service	Final approval	15/10/2014	GMP-0071 (HPC Storage & Transport)	Storage of PBSC/PBL	Stored in GMP monitored area of WBS. Stored in secure area. Controlled product release.	5	05/11/2022
8713	Welsh Blood Service	Final approval	15/10/2014	GMP-0067 (G-CSF administration)	Incorrect dose.	Prescription calculated according to SOP by consultant with nurse. Dosage actually given is recorded on prescription at time of administration.	5	03/03/2022
8715	Welsh Blood Service	Final approval	15/10/2014	GMP-0069 (Final Release)	Product Inspection	Visual inspection of each bag in accordance with documented procedure. Documentation to allow audit trail. Formal concession system to account for any sterile docking failures. 02/11/2016 No change to control measures required.	5	09/02/2022
8707	Welsh Blood Service	Final approval	15/10/2014	GMP-0063 (PBL Collection)	Collection of product.	IDM Testing and Lifestyle questionnaire performed	5	09/02/2022
8708	Welsh Blood Service	Final approval	15/10/2014	GMP-0064 (Whole blood for immunotherapy)	Donor Fitness for purpose	IDM testing and lifestyle questionnaire	5	26/11/2022

7746	Welsh Blood Service	Final approval	02/04/2014	Liquid Nitrogen supply system for TT1-17.	DATIX 2725 - transferred from paper assessment	Wall mounted oxygen depletion sensors- which are regularly serviced and tested (SOP: 008/FAC), linked to an audible and visible alarm in the area and an alarm on the Environmental monitoring system (EMS). In the event of an alarm staff are instructed to leave room TT1-17 immediately: Calibrated personal oxygen depletion monitors in use; Exhaust ventilation for the room, which alarms on the EMS system if it fails; Two emergency stop buttons, one inside the room, one outside to cut-off liquid nitrogen feeding to cryogenic vessels in the event of an over-fill; Overfill or fan failure will cause nitrogen supply to be stopped by emergency cut-off valves, PPE including eye protection BSEN166 (2002) goggles and full-face safety masks (supplied in area), special blue cryoprotective gloves of various sizes. and Lab coats; Safety rules detailed in POL(S)009, including a “buddy system” outside normal hours; Restriction of access, cleaners instructed not to work in the area unless supervised by WTAIL laboratory staff; Safety Training given to new staff at induction; Staff trained to POL(S)-009, and SOP 001/TTY for working with biological agents; Regular servicing of cryogenic refrigerators, and system pipe work by specialist external contractors; Warning signs; Overfill and low pressure alarms on individual units linked to EMS; On-call staff available to respond to alarms out of hours; Laboratory Safety procedures POL(S)-009 instructions on spillages; COSHH assessment completed; First aid; Management of liquid nitrogen system covered by SOP: TTY/112. Annual insurance inspection, CCTV in yard and alarmed external doors near external tank.	5	15/04/2022
7736	Welsh Blood Service	Final approval	31/03/2014	Liquid nitrogen storage and retrieval of frozen cells - room TT1-17	DATIX 3482 - transferred from paper assessment	Wall mounted oxygen depletion sensors- which are regularly serviced and tested (SOP: 008/FAC), linked to an audible and visible alarm in the area and an alarm on the Environmental monitoring system (EMS). In the event of an alarm staff are instructed to leave room TT1-17: Calibrated personal oxygen depletion monitors in use; Exhaust ventilation for the room, which alarms on the EMS system if it fails; Two emergency stop buttons, one inside the room, one outside to cut-off liquid nitrogen feeding to cryogenic vessels in the event of an over-fill; PPE including eye protection BSEN166 (2002) goggles and full-face safety masks (supplied in area), special blue cryoprotective gloves of various sizes. and Lab coats; Safety rules detailed in POL(S)009, including a “buddy system” outside normal hours; Restriction of access, cleaners instructed not to work in the area unless supervised by WTAIL laboratory staff; Safety Training given to new staff at induction; Staff trained to POL(S)-009, and SOP 001/TTY for working with biological agents; Regular servicing of cryogenic refrigerators, and system pipe work by external contractors; Warning signs; Written instructions on safe manual handling displayed on wall; Steps available to aid access to vessels for staff as required; Risk assessment on manual handling carried out by Hu-tech; Laboratory Safety procedures POL(S)-009 instructions on spillages; COSHH assessment completed; First aid; Management of liquid nitrogen system covered by SOP: TTY/112.	5	04/02/2022
7137	Welsh Blood Service	Final approval	07/11/2013	Electrophoresis in WTAIL Molecular Genetics - analysis of PCR-SSP reactions by agarose electrophoresis	DATIX 3486 - transferred from paper assessment	SOP: MOL/022 Safety policies POL(S)-009, POL(S)-007 Training PAT testing Visual inspection during cleaning Intact lids prevent access to energised liquid or electrodes whilst in use. Annual H&S inspection Use of electrophoresis will significantly reduce due to implementation of new technologies - will only be used for HPA typing. Technique will probably be fully superseded in a few years.	5	15/04/2022

7026	Welsh Blood Service	Final approval	03/10/2013	WTAIL liquid nitrogen automated filling system (low pressure) TT1-17	DATIX 3467 - transferred from paper assessment	Cryostorage refrigerators are sited so their open lids cannot damage the piping; The system has a regular Insurance inspection (Zurich); Piping, valves and controllers have regular maintenance by specialist contractors; Room has mechanical ventilation (monitored and alarmed by the EMS system); Laboratory Safety procedure POL(S)-009; Oxygen depletion sensors are present in the room, with audible and visual alarms; Induction training; Liquid Nitrogen emergency cut-off switches present both inside and outside of room to stop flow in event of problem: SOP 112/TTY, Management of the liquid nitrogen system in the Welsh Transplantation and Immunogenetics Laboratory. CryoVent system bleeds Nitrogen gas from lines before filling to prevent splashing. Use of cryo-protective gloves, coats, enclosed shoes and goggles mandatory. Laboratory safety procedures (POL-S 009), includes 'buddy system' for out of hours access.	10	02/02/2022
6987	Welsh Blood Service	Final approval	23/09/2013	Operation of the BacT/ALERT	Operation of the System	Staff trained to SOPs Good Laboratory Practise Process Design Competency Assessment Appraisal Controls	5	06/01/2022
5394	Welsh Blood Service	Final approval	21/05/2012	Remove the class I HLA-A, HLA-B, PCR-SSP result from the UBM database for stem cell donor 15568709	Remove incorrect HLA type from UBM Database	IT working instructions Post implementation check performed	5	15/11/2022
2556	Welsh Blood Service	Final approval	23/04/2010	Missing Hazardous Items	9-4-10:The standard procedures for storage and transportation of all hazardous material created during a blood donation clinic should ensure that none of these items go missing. Hazardous material is defined for the purposes of this SOP as:- "Sharpsafes containing used items e.g. needles "Boxes containing contaminated waste "Vacutainers containing blood samples "Blood transportation boxes containing full blood donations/Non Conforming Donations	9-4-10: Standard operating procedure SOP: 014/BCT. WBS Transport record sheet (SOP: 022/BCT).Donor are health screened, before giving blood, which reduced the risk of contamination with blood borne pathogens. Training to SOP's. Agency Drivers have ID checks.	5	06/09/2022
175	Welsh Blood Service	Final approval	03/07/2007	Processing Platelets for Bacti Monitoring	25-Jun-2007 - Health and Safety Task Based Risk Assessment completed on QA Lab:processing platelets for bacti monitoring. Task: take samples from platelets and insert component into sealed bottle prior to entering into bacti monitoring system. Hazards: Microbiological status unknown, heat sealer, needle stick. See additional checklist.	SOP's in place covering all parts of procedure. Risk reduction process needlestick: rack placed inside microflow only one sample prepared at a time. Microbiological: if samples confirmed as positive process stopped regardless of stage of process. Heat sealer has protective cover - maintenance contact in place. No history of incidents. Ensure training records up to date for all staff performing tasks. 1/4/9 ongoing process. Risk reviewed 14-6-10, ongoing.	5	13/01/2022

ID	Is this a Private & Confidential Risk?	Risk Type	Division	Approval status	Service	Opened	Review date	Closed date	Title	Risk (in brief)	Rating (initial)	Rating (current)	Rating (Target)	RR - Current Controls
2486	No	Quality	Transforming Cancer Services	Accepted	Enabling Works	07/12/2021	07/01/2022		There is a risk that the Section 278 application takes longer than expected to be approved,	S278 Application There is a risk that the Section 278 application takes longer than expected to be approved, meaning that works traffic accessing the 'straight' TCAR are delayed, leading to a delay to construction and longer overall construction timeline.	9	12	6	This application process has started.
2480	No	Workforce and OD	Velindre Cancer Centre	Accepted	Medics	23/11/2021	23/12/2021		Current and predicted shortfall of oncologists by 2025	A recent census (RCR 2021) has predicted a shortfall across Wales in clinical oncologists by 2025. Medical oncologist were not included in the census but should also fall under this risk due to overlapping clinical roles. There is a current shortfall with predictions that this will worsen over the next 5 years (NB this is likely to be a gradual worsening over a period of time; the census predictions only go up to 2025 so no data suggests sudden improvement after that time). Due to the nature of clinical work, these gaps may fall unevenly, for example one team/tumour site could be seriously affected while others are not. Drivers behind this are: increasing clinical care/complexity (increase in patient numbers, increase in treatment options/complexity for each patient), new demands (eg regional AOS delivery), increasing trend to LTFT working and predicted retirements. On top of this there are potential impacts from Covid (ill health), pension tax impact.	15	15	4	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	No	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Whole Service	19/11/2021	31/01/2022		A risk that increase in COVID and the Winter pressures period potentially impacts Int. Care project delivery	COVID-19 and Winter Pressures - A risk that increase in COVID-19 pressures and the Winter pressures period potentially impacts project delivery Cause: Increase in demand that requires project resource to focus solely on clinical work Increase in staff sickness leading to gaps in capacity/back fills requirements/prioritisation of clinical requirements	16	12	8	Update 10.12.21 - Regular meetings continue to take place with PMO to review status of projects and work plan. Activity monitored via the ICOG and sickness levels monitored by HODs. 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
2472	No	Safety	Velindre Cancer Centre	Accepted	Operational Services	18/11/2021	31/03/2022		There is a risk that there is a traffic accident on site which may lead to someone being injured or damage to vehicles	All car parking areas on site. Vehicle movements on site including Staff, patients, deliveries and contractors. Pedestrian walkways on site. Specific risks include adverse interaction of vehicles and or pedestrians, slips trips/ falls, theft and vandalism.	15	10	5	Hazards identified: LPG storage cage close to road with no bollard protection (behind LA 2 and 3) Large vehicles encroach on coming traffic on narrow roads Pedestrians getting hit by cars Poor lighting resulting in slips, trips ,falls List control measures in place: Car park: 5mph speed restriction. Directional flow traffic system and road marking in place. Information signage directing visitors to the different departments on site. Designated ambulance parking areas and Ambulances fitted with audible reversing warning signals. Designated patient drop off/ pick up areas. Designated disabled parking spaces and pharmacy collections. Patient parking located near entrances allowing easier access for users. No parking zones are in place around the site and clearly visible. Dropped kerbs in place with tactile surface for pedestrians. Road and

2460	No	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	29/10/2021	01/05/2022		Cyber Security - Risk of privilege escalation on local user accounts	In the event of a successful cyber attack against Velindre Cancer Centre there is a risk that a local user account could be leveraged, to the spread the attack further due to excessive privileges.	20	5	5	Controls in place include national firewalls, Anti Virus & ACLs.
2458	No	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	29/10/2021	01/05/2022		Cyber Security - End of Life Server Operating Systems on the VCC Network	There is a risk of a cyber security breach as a result of the ongoing presence of servers within the VCC network running the legacy Operating Systems (Server 2003, Server 2008 etc.), which may lead to the disruption or loss of IT services across VCC. There are numerous end of life server operating systems within Velindre Cancer Centre (including Windows 2003 & 2008), which increases the risk of a successful cyber-attack as these devices are not appropriately patched and vulnerable to exploit.	20	10	5	Current controls in place include Firewalls (DHCW), Antivirus software (Mcafee and Defender), access control lists and network segmentation.
2452	No		Velindre Cancer Centre	Accepted	Digital Services	29/10/2021	01/02/2022		Intermittent IP telephony failure	There is a risk of ongoing (intermittent) IP telephony failures as a result of a recent upgrade to the Wi-Fi central controller, which does not fully support the older Cisco 7925 Wi-Fi IP phones in use across VCC, which may lead to telephony disruption for around 150 users.	15	12	3	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.
2451	No	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	29/10/2021	01/05/2022		Cyber Security - No Client Firewalls on VCC devices	There is a risk of a cyber security breach as a result of the lack of client firewalls on VCC devices, which may lead to the disruption or loss of IT services across VCC.	20	10	5	National firewalls in place. Anti-virus may mitigate malicious software, if attempted.
2450	No	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	29/10/2021	01/05/2022		Cyber Security - Inactive Edge Firewalls on VCC Servers	There is a risk of a cyber security breach as a result of VCC server firewalls being in 'passive' mode (meaning communications are not filtered), which may lead to the disruption or loss of IT services across VCC.	20	10	5	National firewalls used as protection for VUNHST.
2449	No	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	29/10/2021	01/05/2022		Cyber Security - VCC Software Patch Management	There is a risk of a cyber security breach as a result of the lack of a formal patch management approach for software being used within VCC, which may lead to the disruption or loss of IT services across VCC.	20	10	5	Migration of VCC patch management onto Trust-wide 'PDQ' solution. Internal and external (NHS Wales) network protections (device / service isolation, firewalls etc.) in place.
2448	No	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	29/10/2021	01/05/2022		Cyber Security - NTLM hashed credentials stored in memory	There is a risk of a cyber security breach as a result of NTLM hashed credentials being stored in memory, which can be leveraged and result in the disruption or loss of IT services across VCC.	20	10	5	Controls in place to prevent attackers from reaching the network i.e Firewalls, ACLs etc. However, if an attacker did access the network there are very little controls in place that would prevent lateral movement.
2447	No	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	29/10/2021	01/05/2022		Cyber Security - Cleartext credentials stored in memory	There is a risk of a cyber security breach as a result of due to the storage of account credentials in 'cleartext' format, which can be leveraged and result in a loss of IT services across VCC.	20	10	5	Controls in place to prevent attackers from reaching the network i.e Firewalls, ACLs etc. However, if an attacker did access the network there are very little controls in place that would prevent lateral movement.
2446	No	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	29/10/2021	01/05/2022		Cyber Security - Weak Passwords in use on Admin / Privileged IT accounts	There is a risk of an external agent compromising VCC admin/privileged IT accounts as a result of the use of weak passwords in use within the VCC Digital Services team, which may lead to a cyber security breach and/or the loss of IT services across VCC, resulting in the disruption or loss of IT services across VCC.	20	10	5	Various Cyber Security tools in place including national firewalls, AV and ACLs which provides defence in depth. Work ongoing to remove weak passwords.
2445	No	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	29/10/2021	01/05/2022		Cyber Security - Risk of malicious payloads not being blocked by anti-virus (McAfee)	There is a risk of a cyber security breach as a result of malicious payloads not being blocked by VCC anti-virus (McAfee),, which may lead to the disruption or loss of IT services across the VCC.	20	10	2	VCC currently migrating to Defender Anti-Virus and will be moving towards Defender DLP. Mcafee still in use on various servers and DLP enabled.
2444	No	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	29/10/2021	01/05/2022		Cyber Security - CVE-2019-0708 BlueKeep Vulnerability	There is a risk of a cyber security breach as a result of the presence of the CVE-2019-0708 BlueKeep vulnerability within the VCC network, which may lead to the disruption or loss of IT services across VCC.	20	10	5	Affected Radiology services are protected behind IT security (firewalls - external to NHS Wales) with access to those systems limited to a small number of named access.
2442	No	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	29/10/2021	01/05/2022		Cyber Security - End of Life Desktop/Client Operating Systems on the VCC network	There is a risk of a cyber security breach as a result of the ongoing presence of devices within the VCC network running the legacy Windows Operating System (Windows 7, XP etc.), which may lead to the disruption or loss of IT services across VCC.	20	10	5	National Firewalls. Anti-virus controls in place.

2440		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	SACT	18/08/2021	29/11/2021		Digital Health & Care Record DHCR046(R) - unable to significantly reduce the capacity of SACT daycase clinics	SACT & MM service are unable to significantly reduce the capacity of SACT daycase clinics and concern re: reducing pre-assessment clinics over the Go-Live period due to cyclical nature of SACT treatment and potential consequences of delays for SACT patients Mimimal amount of SACT treatments can be paused due to nature of service provision. Clinics are monitored regularly to manage ongoing constraints with capacity.	16	16	6	Regular capacity review meetings by SACT & MM leads to discuss ongoing capacity constraints 23/08/21 - There are a small amount of specific regimens where there is scope to reschedule treatment dates and therefore reduce patient numbers for go-live week. Decision to reduce capacity at go live is a strategic level decision requiring project board/SMT/Exec approval. Risk can only be fully considered when go live date is agreed.
2438		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Radiotherapy Services	21/06/2021	29/11/2021		Digital Health & Care Record Risk DHCR043(R) - Completion of process maps and ways of working	Further maps now having to be drafted due to development of e-IRMER and migration issue. e-IRMER workflow maps required, increased workload for project team, with limited resource.	20	12	9	Project team structure undergoing revision & recruitment planned. Workshop to be arranged to finalise workflow process maps with clinical input
2437		Workforce and OD	Velindre Cancer Centre	Accepted	Radiotherapy Services	22/10/2021	29/11/2021		Digital Health & Care Record DHCR042(R) - Delay in new Radiographer graduates starting, likely to be October/ November 2021	Delay in new Radiographer graduates starting, likely to be October/ November 2021. Service will be relying on locum/ agency staff - more staff to train and higher risk of error.	20	20	12	DH&CR training team can offer flexible training sessions to fit around clinical commitments. DH&CR team can provide financial assistance to support additional staff resource.
2436		Workforce and OD	Velindre Cancer Centre	Accepted	Radiotherapy Services	22/10/2021	29/11/2021		Digital Health & Care Record DHCR041(R) - Service expecting a 'surge' in patients end of October 2021	Service expecting a 'surge' in patients end of October 2021. Will place increased pressure on service & staff, difficult to release for training & UAT. Risk of staff burnout.	16	12	12	DH&CR training team can offer flexible training sessions to fit around clinical commitments. DH&CR team can provide financial assistance to support additional staff resource. To continually review & monitor situation via workstream leads
2432	No	Workforce and OD	Velindre Cancer Centre	Accepted	Whole Service	05/10/2021	31/01/2022		Risk that DHCR work may be delayed as result of staff prioritising service demands & patient care	Risk that DHCR work may be delayed as result of staff prioritising service demands & patient care DHCR036(R) - DHCR project support: Availability of Inpatient Staff, Psychology, Therapies, Infection Control, Clinical Coding, Assessment Unit and Supportive Care staff and CNSs, to support DHCR project due to continued increased demand across all these services. 1. Project timelines could be delayed as training, testing may be seen as secondary to providing clinical care. 2.Once ways of working have been identified, time required to employ, train any additional resource required could impact project implementation.	16	12	4	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 Leads to monitor progress in DHCR project, but also to sense check the demands of the services.
2431	No	Performance and Service Sustainability	Transforming Cancer Services	Accepted	Programme	23/07/2021	31/12/2021		There is a risk that the impact of Covid-19 on Programme activity will continue to cause longer-term disruption	There is a risk that the impact of Covid-19 on Programme activity will continue to cause longer-term disruption resulting in potential misalignment of project activity and as such further impacts to Programme Plans and Deliverables	16	12	4	1) Project plans being reviewed with programme support to ensure they are up to date and where projects are now 'unpaused' to bring plans in line with more mature projects. Complete 2) Master Programme Plan updated to reflect update to projects and to show dependencies across projects and programme activity. Complete 3) Review and reporting on Master Plan to PDB and Scrutiny committee. Ongoing

2428	No	Compliance	Velindre Cancer Centre	Accepted	Nursing	02/08/2021	29/11/2021		There is a risk of increased infection transmission due to poor ventilation.	Concerns have been raised around the poor ventilation and seasonal extremes of temperature that exist within inpatient areas at VCC impacting both staff and patients, this risk assessment relates to First Floor (FF) ward. Patients receiving care in the inpatient ward at VCC are often immunocompromised and/or neutropenic and therefore would benefit from improved air quality which can only be guaranteed through a compliant mechanical ventilation system. See document for full description	16	16	9	UPDATE 03.11.21 - Further detailed planning to be undertaken by estates and operational services teams in conjunction with nursing team with timescales and decant plan. * Infection control and prevention measures in line with Trust polices. Including regular audit, training, enhanced cleaning etc. * Additional COVID19 precautions - Use of PPE, regular testing of patients and staff etc. * Full root cause analysis undertaken to ascertain cause(s) of any infections. * Business Case currently under development to seek funding for compliant ventilation system.
2424	No	Safety	Velindre Cancer Centre	Accepted	Therapies	28/07/2021	25/01/2021		Risk of WT breaches & poor patient experience as a result of reduced Dietetic staffing levels	There is a risk that there could be breaches of waiting times, reduced patient experience and outcomes as a result of reduced staffing levels in the Dietetics department which may and stress on the remaining staff members. Due to x1 maternity leave (Clinical Lead DT) and x1 LTS (band 6 PSU cover) with the Dietetic department the workforce is currently reduced from 5wte qualified staff to 3.5wte. Scrutiny approved 1.0wte band 6 DT and an internal upgrade band 6-7. Unfortunately we did not recruit into either of these posts. Our locum also finished on 7th July 2021. Scrutiny have however approved an external band 7 Clinical Lead DT 1.0wte, which is currently out to advert and in the recruitment process. There is therefore a current risk on the workforce that will hopefully be mitigated by recruitment into the vacant post. For the next 2-3 months, there will not be the required capacity to deliver a high quality, timely DT service. This will lead to breaches of waiting times,	12	12	6	Remaining DT staff are trained to appropriate levels and clear re what they can and cannot do Clear prioritisation criteria is in place Discussions with Senior managers and exec colleagues to make them aware of situation Locum agency searches. Temporary cessation of some services will be required. Recruitment for the 1x external Clinical Lead Dietitian vacancy is underway
2423	No	Performance and Service Sustainability	Transforming Cancer Services	Accepted	Integrated Radiotherapy Solution	08/09/2021	04/02/2022		Risk that IRS evaluation process is delayed due to resource pressures	There is a risk that as the nVCC Competitive Dialogue clashes with the IRS Final Tender evalutation, there is pressure on resource availability leading to delays in finalising the evaluation process	12	12	6	1) Works has started to understand which staff and resource are impacted to explore availability and potential impact of this to the Project
2418	No	Reputational	Transforming Cancer Services	Accepted	Programme	05/10/2020	14/01/2022		Risk that TCS Programme does not have support from Stakeholders	Risk that the TCS Programme does not have support from Stakeholders (pts, HB, politicians, WG, clinicians) Causes - Lack of engagement with all relevant stakeholders/ Misinformation shared from external sources / Inconsistent engagement from specialist resource / Change of views over a period of time / Lack of alignment between TCS programme and other strategic priorities across the organisation and individuals / Political leadership change Consequences - WG and LHBs do not support key decisions / Reputational damage for Velindre Trust as an organisation / Petitions & opposition to plans for TCS Programme / Delays to programme and project progress / Failure to deliver some/all of programme benefits	16	12	4	1) Further engagement is being planned with specialist stakeholders – broader and more targeted who are not fully supportive. Programme Communications resource in place & recruitement of additional comms resource to support comms/engagement activities 2) Better use of technology being reviewed and rolled out to share key messages 3) Variety of stakeholder events held over a number of years - complete 4) Clinical workshops held throughout Programme lifetime - ongoing 5) Professional meeting forums held e.g. DoPs, MDs, CEO's etc - ongoing 6) Ongoing engagement with local elected members (MS, MP, Councillors) 7) Dialouge beteen exisiting cancer forums e.g. cancer leads in SE Wales HBs - ongoing through CCLG

2417	No	Reputational	Transforming Cancer Services	Accepted	Programme	08/07/2020	14/01/2022		Risk that there is lack of TCS Programme Comms Plan	There is a risk that there is a lack of TCS Programme wide communications plan resulting in the objectives of projects and interdependant links are not communicated effectively and the wider networked clinical model not understood.	12	12	4	1) Revise TCS website - complete 2) Improve internal TCS teams Comms - complete 3) Improvements to intranet - started 4) Improvements to the link between Programme Governance and Comms - tbc
2416	No	Quality	Transforming Cancer Services	Accepted	Transforming Cancer Services	30/06/2020	31/01/2022		Risk that COVID may lead to delays on Project progress	There is a risk that potential further waves of COVID may lead to delays that effect the development & key activity of the outreach project	20	12	6	Agreement with HBs of ways of working during any possible covid resurgence to ensure that project is able to continue making progress
2415	No	Quality	Transforming Cancer Services	Accepted	Radiotherapy Satellite Centre	17/12/2019	05/01/2022		Risk that key resource involved in a number of projects leading to not enough capacity to fulfill commitments	There is a risk that as key resource are involved in both the RSC, IRS & nVCC Projects which are being managed in parallel could mean there is not enough capacity to fully commit to both projects. This could impact on the quality of the work or the ability to complete the requirements to agreed schedules.	16	12	6	1) A matrix to consider commitments of colleagues to consider priorities and timings to be developed. - ongoing 2) Resource review to understand if additional resource may be required to support project teams. 3) Alignment of meetings and agenda's for 'pressured' colleagues to be looked at to manage this. E.g. when there are items in meetings that are not relevant they can be released from the meeting
2413	No	Performance and Service Sustainability	Transforming Cancer Services	Accepted	Radiotherapy Satellite Centre	29/06/2020	05/01/2022		Risk that Radiotherapy Satellite Centre will not have required skilled staff in place to run facility	There is a risk that the Radiotherapy Satellite Centre will not have required skilled staff in place to run the facility once ready to be operational. This would impact on radiotherapy capacity and resilience for the Trust.	15	12	6	1) An integrated Radiotherapy and Physics workforce plan is required to consider the service as a whole taking account of a full operating model that includes current activity, projected activity, IRS and RSU. 2) Provisions from across the whole service will be reconfigured to meet the requirements of the satellite unit.
2411	No	Partnerships	Transforming Cancer Services	Accepted	Programme	04/11/2020	31/01/2022		Risk that there is potential misalignment of scope and timeliness of decisions between VF & TCS	Risk that there is potential misalignment of scope and timeliness of decisions between VF & TCS Causes - Poor communications between VF & TCS teams Delays in agreement of VF scope & governance arrangements Lack of clarity of scope for VF Lack of understanding of the interdependent timescales and activity Lack of knowledge and understanding of both programme objectives Consequences - key deliverables get missed as not picked up by either TCS or VF Delaying progress of current live projects Change of priorities Adjustment of plans Agreements / decisions have been made already (i.e. could be contractual agreements in place) TCS may not be delivering the agreed VF scope & clinical outputs Disengagement of stakeholders	12	12	6	1) Agree clear scope and role of VF and its programme board. Complete 2) Understand the interfaces that VF has on the scope of TCS and its programme board to be clear about the delegations that result. Complete 3) Communicate the scope of both and any implications for TCS. Complete 4) Prioritisation of key work items and workshops to agree the appropriate routes for decision making. Complete - new ways of working with EMB Shape, Transformation Board & Strategic Infrastructure Board and Velindre Futures in place with clear governance structures in place 5) Understanding and agreement of key stakeholders within and outside the organisation. Stakeholder mapping reviewed, no significant changes within and outside of organisation. Complete
2410	No	Workforce and OD	Transforming Cancer Services	Accepted	Programme	05/10/2020	18/03/2022		Risk that there will be inadequate and / or insufficient workforce capability and capacity to meet needs of the TCS Programme	Risk that there will be inadequate and / or insufficient workforce capability and capacity to meet the needs of the TCS Programme outputs. Causes - Workforce supply not available in required professionals groups or with required skills / Requirements for workforce capacity and capability no longer accurate. Consequences - Inadequate staffing of Velindre facilities across the SE Wales region / Impact on providing treatment and care to patients	12	12	2	1) Service planning is sufficiently developed to facilitate effective workforce planning techniqies to be applied 2)Ensuring each project has clear and well developed workforce plans which are predicated on clear service plans 3) Clarity of expectations for workforce team involvement 4) Clarity of Role & Responsibility for Workforce planning input team in relation to Project & Programme need 5) Workforce team to support service to ensure the right people are available and allocated to support

2408	No	Performance and Service Sustainability	Transforming Cancer Services	Accepted	Integrated Radiotherapy Solution	22/04/2021	04/02/2022		Risk that IRS Project FBC is delayed or not approved	There is a risk that the approval for the FBC for the IRS Project is delayed or not approved, due to changes in approval timescales which would lead to delays to project delay, project abandonment impacting on other TCS Projects (nVCC & RSC) deliverables	16	12	8	1) Engagement with Capital & Treasury teams - ongoing 2) Previous presentations to IIB - complete 3)OBC shared with WG Officers for comment - complete 4)WG notified of timescales for FBC so they can align resources - complete 5)Specialist advisors used to support delivery of Business Case - ongoing
2407	No	Performance and Service Sustainability	Transforming Cancer Services	Accepted	Radiotherapy Satellite Centre	17/01/2020	05/01/2022		Risk of overlapping timeframes and interdependancies between RSC & IRS Projects	There is a risk that as the IRS Project needs to be phased in parallel with RSC Project, due to overlapping timeframes and interdependancies resulting in the RSC project being restricted to planning assumptions until the Equipment Project is concluded which has an inherent risk.	16	12	4	1) RSC project requires a clear view IRS Project Risk landscape and links between the 2 projects in terms of risk registers and project plans 2) Ensure design is flexible and futureproof to allow for IRS solution 3) Review impact of delays to IRS Project on RSC Timeline
2405	No	Quality	Transforming Cancer Services	Accepted	Transforming Cancer Services	30/06/2020	31/01/2022		Risk that projected growth assumptions for Outreach will be less than required	There is a risk that the projected growth assumptions for outreach delivery of SACT, ambulatory care and outpatients is less than will be required, leading to undersized locations.	16	12	6	1) Re-run projections around growth assumptions. 2) Activity model will be re-run with outputs presented to project Board. Any additional requirments will be presented to the Programme Delivery Board with recommendations. Individual meetings with Health Boards to ascertain their requirments will be undertaken.
2403	No	Quality	Transforming Cancer Services	Accepted	Enabling Works	08/06/2020	07/01/2022		Risk that enabling works construction exceeds timescale	There is a risk that enabling works construction, including bridges, exceeds 15 months, leading to delays to nVCC construction and incurring financial loss claims from the MIM contractor.	12	16	9	1. Regular review of possible areas which may cause delay: Most recent review of the plan shows only minimal slack between the end of the enabling works construction and beginning of MIM construction Ongoing 2. Partial mitigation through normal contract condition re liquidated and ascertained damage – where events in the contractors control can result in compensation for costs incurred by the client resulting from time or cost overruns. Need to be within expected reasonable limits. Care required in setting that limit to steer away from punitive damages as few contractor would price the works, pushing up tender prices. Scaling delay damages clause added to tender documentation to ensure contractor is incentivised to complete work on time. Complete 3. Focus to be applied to detailed construction programme following return of EW D&B bids. Complete
2402	No	Performance and Service Sustainability	Transforming Cancer Services	Accepted	Transforming Cancer Services	10/05/2021	31/01/2022		Risk of time-consuming infrastructure work	There is a risk that time-consuming infrastructure work i.e. the refurbishment of a current site or identification of a new build is required to deliver the agreed outreach model of care. This could lead to delays in outreach services not being established or operational ahead of the new VCC as agreed within Programme objectives	16	16	9	1) Identify location 2) Identify refurb / new build required 3) Establish level of local engagement with CHCs/public required 4) Identify appropriate resources from all HBs & VUNHST (inc Project Leads, Planning etc) to ensure project is supported and managed to align with project & programme timelines 5) Establishment of ownership and governance of Project within TCS/VF environment
2401	No	Workforce and OD	Transforming Cancer Services	Accepted	Integrated Radiotherapy Solution	26/02/2021	04/02/2022		Risk of insufficient resources being made available to the Project	There is a risk that insufficient resources (people) being made available to the project will have an adverse impact on the quality of the procurement process	16	20	8	1) Detailed project Plan to identify resource requirements 2) Approved Capital Budget for the Legal & Staffing Costs 3) Regularly monitor staff availability (annual leave & sickness)

2400	No	Workforce and OD	Transforming Cancer Services	Accepted	Transforming Cancer Services	30/06/2020	31/01/2022		Risk that there is lack of project support	There is a risk that the lack of appropriate project support from the programme will lead to delays in developing the solutions required for the project success.	20	20	6	1) Programme Board will look to allocate resources as appropriate. Funding request to WG to support ongoing work - Ongoing 2) Clarification required on whether Outreach Project is an Operational or an Infrastruture Project - Ongoing TBC
2397		Safety	Corporate Services	Accepted	Quality and Safety	18/05/2018	28/10/2021		Infection Prevention & Control Service including staff attendance	1.Reduced capacity in the Infection Prevention and Control Team (IPCT) will reduce service provision within Velindre NHS Trust as operational workload will be prioritized. 2.Reduction in microbiology consultant ward rounds due to decreased capacity within the Public Heath Wales laboratories (PHW). Core service continues but educational opportunities will be missed and robust antimicrobial review may not occur. 3.Multi-disciplinary approach to root cause analysis investigation will not occur due to reduced medical input driven by a reduction in the number of doctors within VCC. This will compromise the quality of the clinical review as medical expertise will be absent and opportunities for learning to inform practice will be missed. 4.There has been persistently poor medical attendance at core IPC meetings such as RCA review, AMT / sepsis leading to reduced engagement. This will hinder required service improvement in clinical audit.	16	12	9	Control Measures in place: 1.Risk assessment in place for ICNet and duplication of data entry but it doesn't take into account additional demands of imminent National Enhanced surveillance. 2.Core Microbiology service provision continues but opportunities for learning and clinical review missed as reduction in weekly microbiology ward rounds to every 3/ 4 weeks
2396		Performance and Service Sustainability	Corporate Services	Accepted	Workforce and OD	20/04/2017	28/10/2021		PADRs	Not all employees are receiving meaningful PADRs -PADRs do not underpin the requirement of the Velindre NHS Trust Integrated Medium Term Plan (IMTP) and the Trust Values. -Failure to complete quality PADRs will have direct impact on the All Wales Pay Progression Policy. -Employees do not understand what is expected of them in their role (objectives not agreed for next 12 months) and do not take responsibility for their own performance and development. -Personal Development Plans are not established for next 12 months - missed development opportunities for employees. -The Trust are not easily able to audit the quality of PADRs undertaken.	9	12	6	-PADRs do not underpin the requirement of the Velindre NHS Trust Integrated Medium Term Plan (IMTP) and the Trust Values. -Failure to complete quality PADRs will have direct impact on the All Wales Pay Progression Policy. -Employees do not understand what is expected of them in their role (objectives not agreed for next 12 months) and do not take responsibility for their own performance and development. -Personal Development Plans are not established for next 12 months - missed development opportunities for employees. -The Trust are not easily able to audit the quality of PADRs undertaken.
2395		Safety	Corporate Services	Accepted	Quality and Safety	26/05/2020	28/10/2021		Deficiencies in compartmentation (fire-resisting construction, fire doors and fire dampers) – Velindre Cancer Centre	Deficiencies in compartmentation (fire-resisting construction, fire doors and fire dampers) – Velindre Cancer Centre	15	12	9	1.As noted above, site has holistic fire strategy where compartmentation plays a key role 2.Site has high level of fire detection to WHTM 05 (Firecode) 3.Provision of fire safety training to support implementation of fire safety strategy 4.Program of fire safety risk assessments and annual fire safety audits including the identification and assessment of compartmentation 5.Inspection of compartmentation by 3rd party accredited surveyors and receipt of report and remedial actions in 2020 6.In support of management and prevent, Department managers responsible for regular workplace inspections including the monitoring of local fire precautions 7.Fire doors subject to regular visual inspection as part of Estates planned preventative maintenance regime 8.Consideration of fire risk assessment findings (including compartmentation issues) as part of Capital Refurbishment schemes.

2394		Performance and Service Sustainability	Corporate Services	Accepted	Governance	21/04/2016	28/10/2021		Fundraising Income Targets	This risk applies to external charities as well as those based on site at Velindre Cancer Centre. However, the control measures and focus of the remainder of this risk assessment relates to onsite charities.	12	12	3	The Trust has a clear fundraising strategy in place. Velindre Cancer Centre's branding guidelines introduced in July 2015 states that: - The Velindre University NHS Trust, NHS Wales, Velindre Cancer Centre and Velindre Fundraising will be the prominent brands on Velindre Cancer Centre premises. - Only 'Velindre Fundraising' and 'Friends of Velindre', charities which raise funds exclusively for Velindre NHS Trust, will be allowed to display publications, materials or media alluding to any form of fundraising on Velindre Cancer Centre premises. - Non-fundraising materials from other charities and organisations will be promoted where there are clear benefits for patients and carers.
2393		Safety	Corporate Services	Accepted	Quality and Safety	19/06/2020	28/10/2021		Infection control	There is a risk that staff could contract COVID-19 in their working environment as a result of poor social distancing or hygiene Majority of control measures in Welsh Government guidance now in place. However the work on site utilisation and linking of this to the capacity planning framework is complex	12	12	9	To be inserted
2389	No	Safety	Velindre Cancer Centre	Accepted	Therapies	28/05/2021	31/01/2022		Risk that patients with altered airways may not receive appropriate care from the MDT clinical team	There is a risk that patients with altered airways may not receive care from the MDT clinical team with the necessary skills and competencies due to the frequency of staff being required to use these competencies (months between patients) and therefore their ability to train and maintain. This situation has been exacerbated by the retirement of a specialist nurse with expertise in airways management. Definition of these patients fall into 3 groups; • Head and neck patients with tracheostomy or laryngectomy stoma. • Respiratory patients requiring suction • Palliative patients requiring suction	12	12	6	Update 10.12.21 - Recruitment underway for a Head & Neck Advanced Nurse Practitioner with interviews taking place w/c 13.12.21. MDT discussions take place pre-admission for this group of patients to assess needs and treatment requirements. Update 03.11.21 - additional mitigating actions: We are currently in the process of recruiting a Head & Neck Advanced Nurse Practitioner whose role will be to provide training for staff in the management of altered airways and ensure that there is appropriate cover for this service. MDT discussions take place pre-admission for this group of patients to assess needs and treatment requirements. Additional training has been sourced from C&V UHB and a Speech & Language Therapist with the relevant skills and expertise has recently been appointed to the VCC Therapies team. •Group 1 patients •1 x SLT works Mon/Tues and Thursday and able to see these patients with good skill level
2388		Safety	Velindre Cancer Centre	Accepted	Nursing	18/06/2021	31/03/2022		There is a risk of high temperatures, increased spread of infection a result of lack of ventilation	OPD Environment - Temperature of the Outpatients department There is a risk that during the summer months, due to a lack of ventilation and air conditioning in the outpatients department, the temperature exceeds that which is comfortable or safe for patients and staff. There is a risk that due to the extremes of heat, patients and staff could become unwell. Wall mounted fans should not be used due to covid restrictions.	12	12	8	Doors and windows left open where possible to increase ventilation. Staff providing cold drinks to patients in the department throughout the day. Increased seating outside the OPD entrance. Staff issued with lightweight scrubs. Staff to take regular breaks to ensure they remain hydrated.

2361		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Radiotherapy Services	12/06/2020	01/12/2021		Radiotherapy Dept - COVID Social distancing	COVID Social distancing – Radiotherapy In response to national guidance to reduce the risk of contraction of COVID-19 due to close contact with persons and objects, social distancing measures have been introduced into the radiotherapy department in line with COVID-19 guidance. This may result in reduced capacity and the contraction of the radiotherapy service.	16	12	2	High-risk staff shielding. Symptomatic staff isolating. Staff aware of social distancing guidelines. See attached risk assessment for controls within each zone. 22.7.20. No change to actions. 20.10.20. Risk reviewed. New lockdown announced 19.10.20. No change to social distancing measures in radiotherapy department pj. 16.2.21. No change to measures in radiotherapy pj. 21/5/2021 – Risk reviewed by PJ & CRD. The risk due to COVID -19 remains despite the relaxation of national regulations. High risk staff are no longer required to shield, but are advised to continue to work from home where possible if a safe working environment with VCC cannot be provided. The need to maintain the controls mentioned above continue, to ensure safety of staff, patients and the radiotherapy service. 4/11/2021 – Risk reviewed CRD. The
2345		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Radiotherapy Services	14/09/2020	06/12/2021		Radiotherapy Dept - Change to service due continued response to Covid19	There is a risk that there will be a continued change to service as a result of Covid 19 measures which may lead to contraction of the service and the creation of a waiting list As the service moves in to the recovery phase there is a continued risk of the availability of staff being impacted through infection prevention and control measures, thus potentially impacting on the service ability to deliver the required capacity to meet demand 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. □	9	16	1	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.OOTL training to add to service payment
2343		Compliance	Velindre Cancer Centre	Accepted	Estates	20/12/2010	27/07/2021		Water Systems - Legionella	Maintaining the water systems free of Legionella at the Velindre Cancer Centre using a range of monitoring and control systems for water treatment and flushing across the VCC site. Continual improvement to remove redundant pipework and upgrade water systems where possible.	20	5	5	Regular monitoring of water temperatures. Regular testing and sampling. HEPA filters on shower outlets in the patient areas. Risk assessment and audit of water system by external consultant. Water Safety Group in place with appropriate members which meet regularly. Water Safety plan and written scheme are in place. Pre-planned preventative maintenance are also on FACTS and are routinely undertaken by competent staff. Removal of redundant pipe work where possible. Legionella management policy in place. Responsible person trained. Water sampling regime has been constructed and reviewed by Water Safety Group members and is currently in place on all sites.

2342		Safety	Velindre Cancer Centre	Accepted	Estates	22/10/2013	03/08/2021		Risk of patient using curtain track as ligature point	Risk of patient using curtain track as ligature point.	10	5	5	Approved contractors will install and validate anti ligature curtain rails where it has been identified via discussions with department managers as they are required.
2341		Safety	Velindre Cancer Centre	Accepted	Estates	02/12/2006	03/08/2021		Risk of injury to staff/contractors when working at height where there is a lack of edge protection	Injury to persons from falling from roof, and exposure to radiation whilst being on the roof.	5	5	5	Method statements and permits to access roofs from contractors. Working at heights has been a topic during team meetings to raise Estates staff awareness. Roof edge protection fitted to commonly accessed areas. Access to roof areas controlled through gate and locking system.
2340		Compliance	Velindre Cancer Centre	Accepted	Operational Services	22/10/2013	03/08/2021		Risk of injury to staff, patients, visitors if equipment hasn't been PAT tested	There is a potential risk of injury to building users if equipment have not been PAT tested.	15	5	5	No equipment to be used on site unless it has a valid PAT sticker. Patients equipment is tested and PAT sticker is applied (staff are responsible for informing Estates via the FACTS system of patients' equipment which requires testing. Industry Guidelines consulted to decide frequency of testing for IT equipment (every three years). Medical equipment is tested by Bio engineering (outside of the Estates remit). All other equipment is tested annually. Asset register of appliances created during testing by contract labour. Department managers are informed prior to annual testing taking place within their department. Any incidents regarding portable electrical equipment are raised on DATIX and discussed at the Electrical Safety Group.
2339		Safety	Velindre Cancer Centre	Accepted	Estates	07/04/2007	03/08/2021		Risk of injury to staff whilst using single and double extension ladders and steps	Risk of injury to staff whilst using single and double extension ladders and steps.	15	5	5	Operative using ladder will inspect before use and report any defects. Safety man should be utilised when required. Barriers are available should they be required. Steps and ladders are regularly inspected and results are documented. Ladder training provided to staff.

2338		Safety	Velindre Cancer Centre	Accepted	Estates	03/11/2005	01/09/2021		Risk of injury or ill health to staff whilst working in subterranean ducts (confined space)	Maintenance staff working in confined spaces such as the subterranean service ducts to either run in new services or to maintain existing ones. The ducts are not full height and therefore staff will have to crawl along these spaces. In the event of a person collapsing, difficulties would arise with emergency evacuation. Issues noted when working in confined areas include, but are not exclusively, cramped conditions, heat, gas, fire/explosion, radon gas, exposure to asbestos and problems carrying out an emergency evacuation in the event of injury or illness.	15	5	5	Staff not trained in confined spaces are prohibited from entering confined spaces under any circumstances, therefore should an occasion arise when entry to a confined space is required out of hours and an untrained Estates worker is on call, he will have to contact one of the confined space trained tradesman to assist. Members of the Estates department have received confined space training and two have received confined space supervisory training. Lighting has been upgraded in the ducts. An asbestos removal has taken place in the ducts, however residual asbestos is still in the Horseshoe and main duct therefore Estates workers are not to enter either the Horseshoe or main duct. An asbestos survey was carried out in the Whitchurch duct and no asbestos was recorded (additional sampling is to take place). Staff have completed Health and Safety training. Hot works permit to works are in use on site. PPE is available for all members of Estates (this includes CAT B disposable suits and over boots, FP3
2336		Safety	Velindre Cancer Centre	Accepted	Estates	08/06/2009	03/08/2021		Risk of injury or ill health to Estates staff whilst working in a lone working environment	Risk of injury or ill health to Estates staff whilst working in a lone working environment and a possible delay in receiving medical treatment in the event of an adverse event. Due to slips, trips and falls, contact with machinery, contact with electricity, serious illness, overcome by noxious fumes, falls from height or coming into contact with an aggressive violent person.	15	5	5	Safety shoes with non-slip soles provided. Hard hat areas identified or hazard tape used to identify bump hazards. Toughened gloves available. Two way radios are available should the Estates worker deem them necessary. Machinery has guards to prevent entrapment. Trained qualified staff to work within their capabilities. Staff carry Cisco WIFI phones and/or mobile phone. Some plant rooms have telephones Permit to work required for electrical work. Ongoing program to barrier roof areas. Violence and aggression training is provided. Health and Safety training is provided. All plant rooms have automatic smoke detection. Co2 detector is fitted in the main boiler house. All boiler rooms have ventilated doors. Regular boiler maintenance is carried out. Basic Life Support training level 1 with practical CPR for maintenance technicians is delivered. Outside stairs are illuminated. Medical staff available on site should a medical emergency occur. Maintenance
2329		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	SACT	09/06/2021	29/11/2021		Digital Health & Care Record DHCR034(R) - SACT & Medicines Management – Cashing Up Daycase Clinics	There is a risk that the 'cashing up' of the daycase clinics in WPAS (including SACT, Clinical Trials, OPs and ambulatory and supportive care) will not be completed as required. Documentation and performance data will not be accurate. Protracted administrative process causing stress to clinical teams whose primary focus is clinical care.	16	16	16	SACT, Clinical Trials, Supportive care an OP daycase are all scheduled via Chemocare therefore the patient record will be complete in Chemocare Explore requirements for administrative role Attendance data is reviewed manually by the nursing administration team when they process the daycase clinics to change certain attendances to WACs as necessary. This is not comprehensive and does not cover all of the clinics at present.

2328		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	SACT	09/06/2021	29/11/2021		Digital Health & Care Record DHCR035(R) - SACT & Medicines Management – processes	The process of booking / admitting patients as they arrive in real time on the unit is time consuming and complex whilst clinical staff are concentrating on safe delivery of care Potential risk to patient safety because clinical staff are distracted by the administrative task Documentation will not be accurate impacting on clinical decision making Protracted administrative process causing stress to clinical teams whose primary focus is clinical care	16	16	16	SACT, Clinical Trials, Supportive care and OP daycase are all scheduled via Chemocare therefore the patient record will be complete in Chemocare Explore requirements for administrative role
2326		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Operational Services	24/05/2021	31/12/2021		There is a risk that the Service will be unable to significantly reduce the capacity of clinics over the Digital Health & Care R	A Minimal amount of outpatient activities can be paused due to the nature of the service provision. Some non-cancer and follow-up clinics can be reduced however. Clinics will be running at normal capacity - ideal situation on a large go-live would be for reduced clinics for a few days after go-live to allow users a little additional time to get used to the new system.	16	16	9	1. Service managers and teams to be available on site. 2. Training champions/super users to support on site during the Go-Live period. 3. Minimise annual leave as much as possible.
2325		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	SACT	09/06/2021	29/11/2021		Digital Health & Care Record DHCR026(R) - SACT & Medicines Management – Affect of Canisc Shutdown on the Department	There is a Risk of Canisc being shut down on 17/09/21 before SACT & MM have completed required activity in Canisc. Clinical teams will be unable to access patient records during Canisc switch off, leading to delays in decision making and potential error, along with poor patient experience There could also be an impact on data migration if all SACT switch off activities are not completed in time	20	12	8	All clinical teams and SACT administration to complete all work before switch off deadline. During this time, SACT & MM have requested that switch off of Canisc be delayed until 19:00 on Friday 17/09/2021. This aligns with RT & OP clinics
2324		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	SACT	09/06/2021	29/11/2021		Digital Health & Care Record DHCR024(R) - SACT & Medicines Management – DH&CR Project Support	DHCR024(R) - DH&CR project support: There is a risk regarding the availability of SACT support for the DH&CR project, due to increased demand on the SACT service if & when SACT surge demand occurs or SACT capacity reduces The SACT DH&CR operational lead also provides clinical leadership for SACT booking services. Impact on clinical patient escalation & prioritisation process for SACT scheduling with potential impact on clinical outcomes if SACT DH&CR operational lead is unable to provide sufficient time to this element of service should SACT demand increase or capacity reduce. Conversely, there is the potential impact on the DH&CR SACT project progressing if resource is focussed on clinical prioritisation	16	12	8	Continuous review of service capacity of SACT and MM clinical team to support clinical prioritisation process. Twice-weekly review undertaken. Daily contact can be made with the booking team if required. If the workstream operational lead is required by the service, this resource would not be able to be replaced.

2296		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	11/01/2021	29/11/2021		Digital Health & Care Record DHCR010(R) - Data Migration Resource	DHCR010(R) - The Head of Information who manages the Business Intelligence (BI) Service within VCC is actively involved with the Data Migration work. This includes assisting the Data Migration Specialist with the development and testing of data migration extracts from Canisc to WPAS. In addition, the Head of Information provides subject matter advice and guidance to the whole project team. There are currently competing priorities on the Head of Information time due and the need to delivery Capacity and Demand planning, ad hoc information requests etc. during the COVID pandemic, whilst supporting a new team. The impact of these competing demands and a number of new team members is the reduced availability of focused time for the Head of Information to undertake the complex data migration work. This has impacted directly on the capacity of the Head of Information to assist in the development and testing of the data migration extract and provided	15	15	6	Clear prioritisation of the BI Service work and Head of Information's workload is required. Notification to service users of unavoidability of BI Head for 3 weeks period in April 2021. A deep dive is planned to support this prioritisation. 09/06/2021 - LM & JH reviewed risk - situation still stands. LM to discuss with WJ.
2290		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Nursing	07/11/2019	31/03/2022		Patients at risk of being lost to follow up	Patients at risk of being lost to follow up Due to the volume of patients and the processes by which patients are booked for follow up appointments, There is a risk that patients could be lost to follow up.	10	12	8	UPDATE June 21 - Third analysis of FUNB ongoing and additional validation also being undertaken. Expected completion date is 30 June 2021. Clinic Outcome Forms to be completed after each patient consultation documenting next steps in patient pathway and ensuring appropriate outcome and that patient not lost to follow up. New Clinic Outcome Form has been implemented and if completed correctly for each patient appointment should help to reduce FUNBs. However, recent audit shows poor compliance. Medical records team to continue to work with SSTs to improve compliance. Further audit to be undertaken next month. Regular FUNB reports submitted to the OP Operational Group.
2262		Safety	Velindre Cancer Centre	Accepted	Estates	16/08/2018	03/08/2021		Releasing passenger lift release	In the event of a person being trapped in a lift, they will need to be released in a manner that will not endanger themselves or others.	10	10	5	The lift release key has been removed from Switchboard and has been placed in the Estates key safe to prevent unauthorised use. Staff will not release people or the lift be lowered by manually hand winding unless they have been trained on that lift in accordance with BS 7255 (training has been provided by OTIS). Furthermore there must be at least three members of staff available if the lift is to be lowered by manually hand winding. Persons trapped within a lift are only to be assisted out of a lift if they are within 200mm of a landing. A maintenance contract for lifts at VCC which includes the releasing of persons have been set up with OTIS Lift Company. Any derogation from the above in an emergency situation must be discussed with a senior member of the Estates Management team prior to any action. British Engineering insurance inspections are also undertaken on all lift throughout the Trust.

2261		Safety	Velindre Cancer Centre	Accepted	Pharmacy	10/12/2015	01/12/2021		Lack of electronic prescribing at Teenage Cancer Trust	There is a potential safety risk to Teenagers and Young Adults who are under the care of VCC and TCT and therefore can be admitted to either facility. Currently VCC and TCT have two different systems, VCC operate an e-prescribing system whilst TCT still use paper prescriptions.	16	10	4	Experienced medical and nursing staff - familiar with both processes. TCT staff have access to CANISC but any changes to dose etc. would be via chemocare. The actual dose prescribed will be transferred to Canisc in the next version of chemocare. Pharmacy staff clinically check script(only if access to medical records/prior treatment). Inpatients will receive visit from pharmacist/med recs/clerking but this is not always the case for outpatients so its probably a highter risk for outpatients. Business case is being developed for an all Wales National e-Prescribing solution (single solution). VCC to provide input and implement procured solution. Timescales to be confirmed. 31.08.20 - Working group has been established between VCC Pharmacy, UHW Pharmacy and wider UHW TCT reps since Feb 2020. An interim work around solution has been developed to enable TCT access to VCC ChemoCare and thus for the
2260		Compliance	Velindre Cancer Centre	Accepted	Estates	02/09/2011	03/08/2021		Control of Asbestos at VCC	Working on the infrastructure or fabric of the building and causing the release of asbestos which may endanger patients, staff, visitors and contractors.	15	10	5	Large areas of Asbestos have already been removed from Velindre Cancer Centre. Trust Asbestos Policy and Management Action Plan in place. Supervision on site has received “Management of Asbestos in Building Training” (P405). VCC has and maintains an asbestos register which Estates staff can access. The maintenance ducts have been identified as having asbestos material within them; maintenance staff have been informed not to enter these ducts. Safe systems of work are in place at VCC, all jobs competed by Estates staff are automated through the FACTS system which locates any asbestos in the working area and records them on the job sheet identifying the risk as Level 1, 2, or 3. Estates staff have completed Asbestos Awareness Training within the last 12 months. Estates staff complete Health and Safety training. Contractors are given tool box talks before being allowed to work on site which includes information on Asbestos
2258		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	SACT	17/05/2021	31/12/2021		Medicines at Home Service:	There is a risk that patient pathways and supporting professional procedures and practices (eg SOPs) will not be appropriately or adequately reviewed because of a lack of resource OR that pharmacist attempts to review in the absence of an alternative suitable clinician are clinically insufficient which may lead to patient safety incidents There is a risk to service continuation and sustainability because of limited alternative clinical leadership within pharmacy (or wider SACT and MM Directorate) for the MaH service which may lead to the service needing to be reduced or discontinued with resultant negative impact on SACT and MM capacity and cost savings opportunities. There is a risk to financial sustainability because lack of service resilience may result in the service prematurely ceasing either because of governance issues which could have been avoided OR because of lack of strategic leadership to continue to	16	12	4	Chief Pharmacist and MaH technician have sufficient baseline knowledge of service to enable short to medium term continuation of the CURRENT service provision

2256		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	SACT	26/03/2020	01/11/2021		SACT / Divisional	Reporting on treatment pathway changes As a result of the COVID-19 Pandemic, it is likely that some patients will not be initiated on a new Systemic Anti-cancer Treatment (SACT) treatment regimen, whilst others will have their current SACT regimens deferred or discontinued earlier than originally planned. It is expected that VCC will be requested to report on the number of patients whose treatment pathway has been affected by the COVID-19 Pandemic. Thus, the number of patients that require deferral or cancellation of their SACT or who are not offered / do not accept SACT must be captured. There is a risk that this data will not be captured correctly / adequately which will result in VCC being unable to report the information	16	12	12	A paper providing an overview of the possible methods which are available to capture this data along with the challenges of doing so was submitted to the VCC Clinical Group on 26.03.20 and accepted. Staff guidelines for clinical staff were sent out in the daily Coronavirus Staff Update via e-mail and also made available in the Coronavirus section of the VCC Intranet 1 - All Clinical Staff to be directed to (where appropriate): - utilise the drop down reason code "COVID-19" on ChemoCare, - include COVID-19 in all Canisc annotations and - include "COVID-19" as the "Description" title when utilising the "Other" tab in Canisc 2 - Clinical Audit Department to lead on the capture on this data and to ensure compliance with these recommendations 3 - Recognition that a solution to
2255		Financial Sustainability	Velindre Cancer Centre	Accepted	Private Patients	24/02/2021	31/03/2022		Private Patients Debt	An internal audit under in 20/21 reviewed debt management as one of its objectives. A key area requiring attention was the management of aged debtors by the Private Patient Service. The conclusion was that the aged debtors are not monitored or acted upon and there was no action plan in place to improve the situation. Also that there is no liaison between the private patient service and the corporate finance team. Analysis has shown that debtors go back a number of years and include self paying individuals as well as insurance companies. As at the time of submitting this risk the outstanding amount is £328,791.	12	12	4	1. Full review of all debtors in 2017 and 2018 to assess current situation and recommendation for follow up to be provided to Director of Finance. 2. Action plan developed for Trust Audit Committee which will be monitored by weekly meetings. 3. All debtors to be written to by 5th March 2021 providing 14 day payment period requirement. 3. Meeting arranged to discuss automation of process options. 4. Private Patient Manager to benchmark systems with other organisations. 5. Private Patient Manager to review current Standard Operating Procedures (SOP's) to improve current process. 6. Head of Operations and Delivery to work with Deputy Director of Finance to review Trust SOP's and engagement process. 7. Regular meetings with Private Patient Manager and corporate Finance lead to be established.
2254		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Estates	16/06/2020	06/06/2022		Lack of mechanical ventilation at the VCC site (including inpatient ward areas)	This risk has 3 elements – 1. Potential for increased risk of infection due to a lack of mechanical ventilation, 2. Staff and patient discomfort in hot weather due to sub-optimal ventilation, and 3. Breach of Health & Safety regulations and Health & Safety Executive regulation to provide ventilation systems that are sufficient to ensure that high risk patients are protected from exposure to potentially harmful airborne microbiological organisms	12	12	4	Taking each of the three key elements of the risk: 1.Increased potential for infection due to sub-optimal ventilation •Full infection prevention processes are in place, and any patient with suspected infection is cared for in a side room which usually has a window for natural ventilation (in the summer months). 2.Staff and patient discomfort in warm weather due to sub-optimal ventilation •Some mitigations are in place, but further work is required with pace to ensure the well-being of staff and patients during the rest of this summer. •An external specialist will be commissioned to provide recommendations to reduce the heat, and a Task & Finish group has been set up w/c 15/06/20 to develop a hot weather business continuity plan •Further mitigations are being assessed, including use of theatre scrub uniforms for nursing staff and washable cooling blankets and

2253	No	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	27/10/2020	01/05/2022		Availability of CANISC System	There is a risk that clinical/patient services across VCC would be critically endangered as a result of the prolonged loss of CANISC, which may lead to significant patient harm and treatment delays due to the lack of availability of critical clinical information for VCC clinical staff. In the event of a catastrophic CANISC system failure, Velindre Cancer Centre would have no electronic patient record and radiotherapy workflow management systems. In this scenario patient care would be seriously compromised, for inpatient admissions and /or outpatient appointments. Electronic access of patient medical histories would not be available or limited to a point in time to guide care decisions. This would lead to the unavailability of clinical information to support decision making. As well as loss of patient administration activities tasks including the booking and processing of outpatient and inpatient activity, clinic lists etc.	15	15	5	Full geographical resilience for CANISC was restored in August 2021 following completion of the migration of national IT services out of the Blaenavon Data Centre (BDC) by DHCW. This means the CANISC service can be 'failed over' to the new 'CDC' data centre in the event of there being issues in the primary 'NDC' data centre. This significantly reduces the risk of the permanent loss of CANISC services. In the event of CANISC becoming unavailable for short periods of time, access to relevant clinical documentation is avialable via alternative systems - e.g. - WCP CANISC Case Note Summary to provide historic record - Chemocare (existing patients) - Welsh Clinical Portal (WCP) for viewing all results, documents and Canisc CaseNote Summary. - WCP is linked to Master Patient Index (MPI) to access patient demographic information - Welsh Results Reporting Service (WRRS) for all VCC radiology reports
2252		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Whole Service	14/09/2020	01/04/2022		Large number of development projects in Radiotherapy	Large number of development project Multiple development and research projects exist There is no single point of oversight or prioritisation of resource There is poor linkage between projects and the risk register or strategic service/ VCC/ Trust priorities. there is a risk that specialist and scarce resources will be required for multiple project simultaneously as a result of which there will be a reduction in patient pathway resource or a delay in the implementation of a number of projects which may lead to patient pathway breaches or delivery delays agreed within the programs Some Physics developments delayed as redirected resource into paperless planning project and increasing resilience in treatment planning. This enabled staff to work from home and prepared for potential staff absences / future increase in demand	20	15	10	Prioritisation process underway. Program to support delivery Medical Physics and RT Ongoing review of major projects. Core team with resilience approach identified to allow scientists back to project work Program plan for Radiation Services being developed will require resourcing input from IRS nVCC and DHCR
2251		Compliance	Velindre Cancer Centre	Accepted	Medical Physics (previously Radiotherapy Physics)	18/03/2016	30/09/2021		XVI imaging termination faults resulting in repeat acquisitions	There is a risk that the patient will require an additional CBCT scan to confirm treatment position as a result of a known fault with XVI which may lead to additional patient imaging dose. Under new IRMER guidance if 3 scans are required to achieve 1 usable dataset this becomes reportable. This fault is known UK wide issue. When using XVI CBCT (Elekta only), faults are occurring intermittently during the image acquisition. This is resulting in repeat image acquisitions needed which increases the overall dose the patient is receiving from imaging. It is also worth noting that these scans usually terminate part-way into the scan. If a full additional scan is acquired the patient will receive a maximum of 2 - 20 mGy additional dose, which is <0.1% of a typical treatment dose. CBCT imaging is essential to verify correct patient position during treatment, ensuring the radiotherapy treatment targets the tumour and spares Organs at Risk and critical structures. This is a known issue nationally and Public Health	15	12	9	1. If a patient is having a routine offline XVI CBCT and the unit faults during acquisition attempts should be made to clear the fault and carry on. If the radiographers cannot clear the fault themselves the engineers should be contacted for advice. One further attempt at a full scan is permitted. If this fails then the CBCT should be repeated on the next fraction on an alternate unit. A Datix should be completed for all failed scans that cannot be continued from the point of failure. Scans that can be continued should still be recorded in the machine log. 2. For online scans the same as above applies but if a second scan fails then the patient should be moved to an alternate machine prior to treatment. 3. When a patient receives a total of 2 extra partial scans due to faults, then a superintendent must be informed, and the patient must be moved by the radiographers on-set to another LA for the remaining imaging fractions. 4. All partial scans to be recorded on the imaging form. 5. Radiotherapyl Physics and the

2249		Financial Sustainability	Velindre Cancer Centre	Accepted	Operational Services	27/02/2020	20/12/2021		Risk of service disruption due to number of posts funded by soft monies leading to financial instabiity,recruitment difficultie	A high proportion of VCC workforce are funded via 'soft monies' from the Trust Charity or Third Sector. This leads to risks around service continuity, recruitment and retention and staff wellbeing. It also poses a financial and reputational risk for the Trust should funding be ceased. For 20/21 there is approximately £2.8 million of charity/3rd sector funding which is supporting service delivery.	12	12	4	Funding ending in the next year to be included in cost pressures for 2020/21. Review posts funded externally to establish: Number of posts, length of funding, contribution to service, and contractual position of postholder. Establish Financial contingency. Through the scrutiny process ensure future risks are considered for all new and extended posts. Prioritise work in order of funding stream end date
2248	No	Safety	Velindre Cancer Centre	Accepted	Nursing	29/10/2020	31/01/2022		There is a risk that non-compliance with COVID-19 Health Regulations may place staff and patients at higher risk of infection	There is a risk a risk that that non-compliance with the Health Protection (Coronavirus Restriction Wales) Regulations 2020 could place patients and staff (FFW, CIU) at increased risk of infection and contracting COVID-19, resulting in illness. Regulation 7A of the Health Protection (Coronavirus Restrictions) (Wales) Regulations 2020 dictates: - that all reasonable steps have been taken for staff to work from home; - when they are in work environment, all reasonable steps have been taken to maintain a 2m distance; - and where people cannot be 2m apart, everything practical done to manage transmission risk.	16	12	12	Update 10/12/21 - Regular updates and guidance given by IPC Team to all staff to remind them of IPC requirements. Enhanced cleaning still in place; social distancing measures remain in place; cleaning wipes and sanitiser freely available along with face masks. Mitigation -Cleaning regime reviewed as part of changes made, e.g. all ward staff including visiting staff wearing suitable PPE (e.g. cleaners, admin, pharmacy, RT etc) -Hand Sanitiser stations installed -Hand washing posters at sinks -Sterilising materials, wipes, spray etc available for all staff -Enhanced hand washing regime -Staff who can work from home being assessed and if applicable currently doing so -Care taken to manage 2m space where applicable -Social distancing posters -If appropriate reduce amount of staff in working area where applicable. The FFW offices, are areas where social distancing is unable to be maintained for hand overs etc.PPE is provided for
2245		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Radiotherapy Services	12/04/2019	31/12/2021		Service impact of delay in equipment replacement	Service impact of delay in equipment replacement Current provisions for Radiotherapy Services at VCC are based on the assumption that a new Cancer Centre and associated Satellite Centre will be clinical by 2021/22. Delays on these projects will impact negatively on the Radiotherapy Department at VCC. Linear Accelerators have a recommended clinical life of 10 years. In 2019, there are currently 3 (out of 8 (38%)) linacs aged 10 years or above. In 2021 there are currently 5 (out of 8 (62%)) linacs aged 10 years or above. Identified hazards are to be found in the risk assessment attached as a document.	15	12	3	Timely / effective communication with Commissioners / Government re. Linac life, performance etc. Older linacs can receive deep services / upgrades with the intention of extending clinical life. Ability to add functions / services to older linacs / equipment such as RPM / DIBH make this viable. Uptime is maximised by good in-house engineering support. Engineers are very experienced at VCC. Service contracts allow access to Manufacturer's engineers when required. Complaints procedure in case of issues with quality of service. Gaps procedure assist with direction in times of breakdown. Experience and skill of staff allow effective dealing with delays and patient issues. RCR guidelines guide protocols for acceptable prolongation of treatment courses prior to compensation (NB. Latest update suggests that standard 3-week course of breast treatment should ideally not be prolonged for more than 2 days).
2244		Workforce and OD	Velindre Cancer Centre	Accepted	Medical Physics (previously Radiotherapy Physics)	14/09/2020	12/02/2021		Senior Management Capacity	Senior Med Physics Management Capacity is under pressure due to some staff being utilised on IRS Multiple major programmes pull senior staff away from service delivery. COVID exacerbates the situation Separation between service and major programme means there is a loss of continuity and ownership	12	12	4	Deputies for the programs to be identified without affecting service delivery

2243			Velindre Cancer Centre	Accepted	SACT	30/06/2021	15/12/2021		SACT staff turnover	There is a risk that SACT Daycase may not be able to deliver care at the current level as a result of staff turnover which may lead to SACT reducing capacity at the SACT Daycase Unit which will impact on patient care and patient experience.	16	12	3	Senior SACT management working in the numbers Clinical trainer working alongside junior staff closed mobile unit on MONDAY Senior staff working on helpline Deputy Director of Nursing undertaking a review on the turnover/retention and education pathways
2239		Safety	Velindre Cancer Centre	Accepted	SACT	06/06/2012	28/01/2022		Pharmacy Stores – inadequate space	There is an increased risk of accidents and injuries to staff and a security of product issue, due to inadequate space in the pharmacy stores, which is leading to products being stored outside official areas.	12	12	9	Staff are trained in manual handling. Regular contact with VCC Manual Handling Advisor. Staff are partially involved in managing risks. 25.06.19 - new aseptic unit expected to be clinically operational September 2019 which will give additional storage space and allow reconfiguration of current stores. Refurbishment of old aseptic unit planned October 2019 which will allow further reconfiguration of stores. Ongoing work between pharmacy and nursing to identify nursing consumables and non-medical dressings to be relocated to nursing stores. 20.01.2020 updated by RWD- new aseptic unit expected to be clinically operational February 2020 which will give additional storage space and allow reconfiguration of current stores. Refurbishment of old aseptic unit planned October 2019 which will allow further reconfiguration of stores. Ongoing work between pharmacy and nursing to identify nursing
2236	No	Quality	Velindre Cancer Centre	Accepted	Operational Services	08/04/2019	03/01/2022		There is a risk of poor patient experience as a result of insufficent space and poor environment	The design of the OPD department is not fit for purpose, there is a lack of available accommodation, insufficient space in waiting area, the reception desk is not ideally placed and the fabric of the area is in poor condition.	15	12	12	1. Nurse 'rounding' in place to monitor patients on regular basis 2. External 'canopy' waiting area 3. Information provided explaining visiting restrictions but process in place to call relatives into consultation if appropriate 4. High level of virtual consultations 40-50% 5. Clinic planning and preparation undertaken daily 6. Task and Finish Group to lead repatriation of OPD and phlebotomy to HB's 7. Service improvement programme to reduce waiting times, improve experience etc 8. Appointment system implemented for phlebotomy appointments
2229		Workforce and OD	Velindre Cancer Centre	Accepted	Operational Services	12/03/2019	24/01/2022		Risk to timely communication/engagement activities as a result of dedicated resource leading to low morale, reputational damage	There is a risk that positive communications are not distributed in a timely manner as a result of lack of dedicated VCC resource therefore positive communication is not provided in a timely manner to staff or externally. VCC has no dedicated specialist communication resource to support the patient and staff experience. This limits the processes that can be developed and also poses a risk to media handling. There is no dedicated support to develop social media policy or channels which limits communication options.	12	12	4	Resource increased within corporate communications and TCS teams.

2224		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Operational Services	07/11/2019	12/01/2022		Demand for services outstripping capacity	Demand for services outstripping current capacity resulting in patients not being seen in a timely manner and waiting time breaches. Also results in overbooked clinics which are extremely busy. In addition, many of the outreach clinics continue to be run from VCC which is adding to the pressure on clinic rooms.	16	12	16	UPDATE June 21 - Risk rating increased to reflect current situation. Increasing referrals are leading to an increase in outpatient attendances resulting in very busy clinics. Continue with planning for any surge in activity due to cancer backlog and latent demand from health boards is being undertaken by VCC. Continue with weekly monitoring of outpatient referrals and activity. Progress with the work of the Demand Modelling group being led by the BI team. Continue to have discussions with health boards re. outreach clinics and likely demand for services.
2223		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Operational Services	21/07/2020	12/01/2022		Delay in re-starting outreach activity	The delay in re-starting outreach activity which is as a result of the COVID-19 pandemic, is impacting on outpatients resources and the availability of clinic rooms in VCC. This is because all outreach services have been repatriated to the cancer centre for the duration of the COVID-19 pandemic.	12	12	12	UPDATE June 21 - Discussions to repatriate outpatients clinics continue with health boards. Previously agreement from ABUHB to re-start outreach clinics in Nevill Hall but subsequently notified that space is not available, although not Royal Gwent. VCC group established to manage repatriation of clinics and SACT to NHH. Continue with ongoing discussions with other HBs as this remains a priority for VCC. SSTs have been asked to review all their clinics and highlight priority clinics for repatriation. Undertake surge planning and discuss impact with health boards
2222		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Nursing	07/11/2017	31/07/2021		Loss of CANISC - compromise patient care	There is a risk that as Canisc is an 'end of life' system, it could fail which could compromise patient care. It could mean that some patients cannot be seen in clinic or some would experience long delays. This can lead to increased patient anxiety, frustration and stress for staff, overcrowding in waiting areas and a possible delay in prescribing chemotherapy.	16	12	12	Update June 2021 – DH&CR project continues at pace which includes plans to replace CANISC with WPAS. Regular meetings taking place to review OPD processes and clinics. CANISC BCP remains in place. Implementation of the Document Management Solution – copy of correspondence available electronically on local infrastructure. Correspondence viewable in the Welsh Clinical Portal. Correspondence sent to the GP electronically (via WCCG). Welsh Clinical Portal to link to the Master Patient Index – in the event of Canisc being unavailable this version of the WCP would be invoked enabling access to documents, test results and the GP Summary. Authorised staff members have direct access to Synapse (local infrastructure) – VCC radiology images and reports available to view. Aria and Mosaiq not reliant on Canisc – Radiotherapy treatment can continue in the event of a Canisc outage. ChemoCare decoupled from Canisc and held of local infrastructure – SACT

2221		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	24/02/2021	29/11/2021		Digital Health & Care Record DHCR019(R) - Clinical Coding Copy Functionality within WPAS	DHCR019(R) - Clinical coding require a 'Copy Coding Functionality' within WPAS. Currently within Canisc VCC Clinical Coding staff are able to choose an option to 'copy exact coding to all linked Radiotherapy (RT) Regular Day Admissions (in same sequence of admissions)'. This means that if a patient has received 10 episodes of radiotherapy the coder can code the first episode and then click the copy function to copy to the other 9 episodes. This saves the coder time and ensures the accuracy of the coding. This functionality is not available within WPAS; therefore it is requested that the functionality be developed. There is a risk that NWIS are unable to deliver an exact replica of the functionality within the timescales - there is also a prerequisite on the Radiotherapy Admissions work completing and the eIRMER development. This could affect the implementation timescales. DHCW confirmed that they are	16	16	12	The proposed interim solution will enable 'manual selection instead of automated selection and copy'. This will enable the user to select multiple episodes across multiple admissions, within a single patient's record, and copy the coding from the 'coded' episode, to all other episodes selected. The user will have to verify that they want to complete this transaction to ensure the correct admissions is selected
2220		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Medical Physics (previously Radiotherapy Physics)	07/11/2018	31/12/2021		Treatment Planning System End of Life	There is a risk that some patient treatment plans cannot be completed as a result of the OMP treatment planning system breaking down and being past end of life, which may lead to inability to plan / treat sites not transferred from OMP. The Oncentra MasterPlan treatment planning system is end of life and is no longer be supported by the manufacturer. A replacement treatment planning system, RayStation, is being commissioned but due to understaffing within physics, and a change of priorities due to Covid, commissioning is taking longer than initially estimated. Should a catastrophic failure of OMP occur at this point in time (March 2021) the centre will be without a planning system for the Varian 2100 machines (breast patients), and 10 MV treatments on Truebeam and Elekta machines. There is a risk that the existing treatment system will fail and without the implementation and alternative no planning system for all breast patients to be treated	15	15	1	Most physics developments are on hold to redirect resource to the commissioning of RayStation. Commissioning plan is in place. Outsourcing contract in place and being utilized with Rutherford Detailed contingency plan is being worked through
2217		Workforce and OD	Velindre Cancer Centre	Accepted	Medics	14/09/2020	01/12/2021		Medical Capacity for RT Planning in Job Plans	Medical time for RT Planning within job plans is not efficient, timely or in many cases, sufficient, particularly with the RCR requirement for peer review. Any time allocated may not be protected due to the increase in clinical admin work and email requests. Outlining delays have a knock-on impact on the pathway which has the potential to delay the patient's treatment start date and increase breaches.	4	15	2	Review job plans to ensure adequate time available. Job Planning is ongoing annual process however it is not always possible to allocate time for RT Planning into the job plan without dropping alternative work. Each case is individually assessed to factor RT Planning into job plans.
2213		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	09/07/2018	01/05/2022		VCC Phone System - External Phone Lines	There is a risk that external telephony services in VCC may be disrupted as a result of the ongoing use of the 'end of life' PBX gateway ISDN30 line, which may lead to the inability to make inbound and outbound external calls, resulting in significant disruption to clinical / patient and administrative services.	16	12	4	22 phone lines are strategically placed around VCC site to enable dialling to public telephones in the event that an ISDN30 line is lost. Discussion with supplier commenced. Capital funding to be secured for delivery of resilient SIP.

2211		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	09/10/2020	29/11/2021		Digital Health & Care Record DHCR004(R) - Requirements for Standardisation process redesign & agreed Ways of Working	Requirements for standardisation, process redesign and agreed Ways of Working - Business Change The scope of the deliverables for the workstreams will change after being signed off and planned and may cause delays. There is a risk that without an element of standardisation; process redesign and agreed ways of working; system configuration, testing and training becomes very complicated and time consuming.	16	16	12	Ways of Working sessions to be held. Key advocates for change, standardisation and process redesign to be involved in the project Project Governance - Workstreams will be established to ensure key decisions are made with all involved in a timely manner required by the project. SMT and Clinical Lead support on standardisation of Ways of Working
2206		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	09/10/2020	29/11/2021		Digital Health & Care Record DHCR003(R) - IM&T Dept - Covid-19 Pandemic	DHCR003(R) - Could impact on key project team members capacity due to service requirements being prioritised, childcare needs, the need to self-isolate etc. The ongoing impact of the Covid 19 outbreak continues to have a significant impact of staff in terms of their well-being, their availability and their ability to absorb new ways of working and new systems within an already stretched environment. Also, additional clinical pressures/ demand on; clinics, inpatient activity, treatments and the presentation of potentially sicker patients, resulting from the impact of COVID19.	20	12	9	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.
2205		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	14/09/2020	31/01/2022		CANISC failure	Currently the CANISC electronic IR(ME)R form is the only way for the Oncologist to request a CT simulation scan and subsequent radiotherapy treatment for all patients bar emergencies. It is also the system used to manage the complex radiotherapy pre-treatment workflow and to document and authorise the detailed dose information for a patient plan prior to treatment. This documentation and authorisation is required under the IR(ME)R 2017 regulations. If CANISC is unavailable, there is no “fall-back” method for the above tasks. Business Intelligence (BI) data is also sourced from the electronic IR(ME)R form in CANISC, the loss of which will reduce the ability for BI reporting, forecasting and modelling. CANISC will no longer be available from September 2021, with the long-term IR(ME)R form replacement (part of the IRS) not being fully procured and in-house until around this time. CANISC will no longer be available	25	15	9	Engagement with NWIS & DCHR to develop MVP ongoing. DCHR-led project underway. Initial option appraisal highlighted high likelihood of gap between CANISC and OIS; several discussions occurring to confirm this and identify optimal bridging solution. Approved Design in place for WCP IRMER as an interim solution - this now is subject to acceptance testing of the software delivery by VCC service leads

2203		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	12/01/2021	29/11/2021		Digital Health & Care Record DHCR013(R) - Accelerated Timelines of the DHCR Programme	Due to the accelerated timelines of the DH&CR Programme, the data migration phase is having to be compressed from 18 months to 6 months. Data Migration Phase 1 (Patient Demographics and casenotes) and Phase 2 (Referrals, activity, Clinics, pathways and waiting lists) both need to be completed by prior to UAT testing which is due to commence in July 2021. There is a risk that any delay to these data migration activities could have a direct impact on the quality of the patient data migrated from Canisc into WPAS as there will be no time to review and cleanse the data prior. There is also a risk that any delay to the data migration activities will have a direct impact on the WPAS implementation date which may lead to the Service having to rely on an unstable and unsupported Canisc instance for a longer period of time.	16	16	8	Data Migration Phase 1 near completion and there are dedicated WPAS team resources working hard to complete all phase 2 activities by the end of April 2021, in line with the current DH&CR Project Plan which has been approved by the DH&CR Project Board.
2202		Workforce and OD	Velindre Cancer Centre	Accepted	Medics	23/02/2021	01/12/2021		Consultant cover for long term absences	Two consultants will be taking Maternity Leave in 2021 in Urology and Breast tumour sites. One Consultant is planning a sabbatical in Spring 2022. One Consultant on Long Term Sick Covid related from Mar 2020.	20	12	4	The Directorate has employed a Consultant for a 1 year post to cover the Urology gap for Mat Leave in 2021 but may require extending the contract to Mid 2022 depending on how long the Consultant will be off on Mat Leave and also to cover the sabbatical in 2022. An additional temporary consultant will be required to cover the breast sessions for the 2nd Mat Leave.
2200		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Radiotherapy Services	01/05/2011	31/12/2021		Radiotherapy Capacity	Availability of sufficient radiotherapy capacity within available financial resource affects achievement against national cancer standards. Patients may not be treated to optimum treatment timescales, which may affect the overall patient experience and lead to poorer outcomes. 2/7/19 update Hazards broken down into safety / quality and service sustainability sections. Narrative clarified – risks defined (PJ). This will be linked to Risk 2245 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. 23/11/2021 - Update Currently we have insufficient capacity to meet demand. The number of hours available is restricted to a maximum due to safe staffing, skills mix, and the age and configuration of the fleet. Any delay in the development of the radiotherapy Satellite centre will	20	20	6	Ongoing monitoring of capacity and demand Ongoing monitoring of breaches of waiting times targets Reports and business cases have been prepared Radiotherapy strategy Discussion underway regarding future radiotherapy configuration through the TCS programme Extended working hours are in place on the treatment machines and in many other areas of the service Agency radiographers in place to support additional hours Updated 23/5/19 (PJ) Ongoing monitoring of capacity, demand breaches and waiting times targets. Extended working hours are in place on the treatment machines and in many other areas of service. Agency Radiographers are in place to support additional hours. Changes made to radiotherapy booking processes, and staff flexibility used to maximise use of resources. Project to be commenced to address
2198		Financial Sustainability	Velindre Cancer Centre	Accepted	Operational Services	29/12/2017	13/12/2021		VCC mayface financial loss, legal action, inaequate service provision as a result of no coordinated system for SLAs, contracts	VCC has numerous contacts and SLA's for services delivered by NHS organisations and external companies. To manage such legal agreements it is crucial to have robust governance structures for the development, management, monitoring and renewal of such documents. There are a lack of processes, clarity regarding responsibility regarding responsibility, management etc and a varied level of monitoring.	16	16	6	Specialist procedure advice via NWSSP Agreement for planning team to take ownership (delayed due to COVID) VCC Planning team to take responsibility for establishing database and monitoring mechanism

2196		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Radiotherapy Services	14/09/2020	01/12/2021		Radiotherapy Department - COVID Isolation Impact	COVID Isolation Impact Staff isolation as a result of coming in to contact with a COVID positive person, exhibiting COVID symptoms or receiving a COVID positive test result will affect the capacity (Linac & Pre-Treatment hours) of the radiotherapy department as the majority of staff are patient facing and are unable to work from home. Resulting in the need to contract the radiotherapy service.	16	16	4	Ability to work from home with relevant IT equipment on completion of DSE risk assessment Isolations rules to be reviewed regularly. 7/5/2021 – risk reviewed by HP & CRD. The risk due to COVID -19 remains despite the relaxation of national regulations. The need to maintain the controls mentioned above continue to ensure safety of staff, patients and the radiotherapy service. 1/11/2021 – risk reviewed by CRD. The risk due to COVID -19 remains despite the relaxation of national regulations. The need to maintain the controls mentioned above continue to ensure safety of staff, patients and the radiotherapy service.
2193		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Nuclear Medicine	05/02/2021	01/04/2022		Medical Physics Expert cover for Molecular Radiotherapy (Nuclear Medicine)	Medical Physics Experts (MPEs) for Nuclear Medicine. This risk combines 8438 (submitted by S Hooper – MPE cover for clinical trials) and 15684 (submitted by M Talboys – Ra223 service) on the current risk register and has been expanded to encompass new developments on the immediate horizon. There is a significant risk is that Velindre Cancer Centre will not be in a position to safely and sustainably offer the Molecular Radiotherapy (MRT) demand, likely to be required in the next 12-18 months. This arises because of a lack of experienced Medical Physics Experts (MPEs), the timescales over which the implementation of new MRTs may be required, the predicted increase in workload and the anticipated number of other significant developments which will lead to not being able to implement MRT MPE cover within Nuclear Medicine for	20	16	2	Current control measures include:- Not participating in clinical trials involving MRT Not implementing any new MRT until a safe, sustainable service can be provided Organising workload to minimise the impact of a lack of MPE back-up. Expectation to date has been to ask C&V Medical Physics to provide any additional MPE cover. However, the depth of MPE cover has been critically eroded over the years and recent resignations mean the current position is there will be only 2.5 WTE physicists left by the end of April (only 2.0 WTE being MPEs). One of those MPE is already providing 1 WTE support to VCC under an SLA for over >30 years. This leave 1.0 WTE MPE at C&V. (C&V provides MPE support to other HB as well as its own).
2191		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Radiotherapy Services	14/09/2020	31/01/2022		Inability to meet COSC / SCP targets	Inefficiencies in current pre-treatment pathways and failure to meet agreed timescales - link to breach report against time to treat targets.	20	20	4	Workforce requirements highlighted Service improvement project to be initiated
2190		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Radiotherapy Services	14/09/2020	31/03/2022		BI Support for reporting of Breaches	BI Support for reporting There is a risk that lack of high quality data informing in real time key activity (demand/ capacity) Key data inputs (RTDS) are done manually Different staff groups only understand their own systems. Resulting in a lack of ability to accurately forecast and model future demand for services which may impact on accurate capacity planning for the scheduling of patient pathways	16	16	10	Large amount of BI is occurring, with better understanding of RT BI and complexity of internal RT processes

2188		Compliance	Velindre Cancer Centre	Accepted	Operational Services	18/04/2018	24/01/2022		There is a risk that services cannot be expanded to meet demand as a result of lack of accommodation which may affect service de	Lack of physical space to accommodate the current service requirements, statutory building note requirements, health and safety standards and other legal requirements at Velindre Cancer Centre. This risk affects all areas within VCC. A number of internal and external audits have demonstrated a significant lack of physical space within all areas of VCC. COVID 19 pandemic has further reduced available site capacity by 40-50%. Increased provision of clinical services and workforce requiring additional space. Requirement for Digital Programme Team to return to VCC site in view of DHCR replacement programme, testing and training requirements etc.	12	12	6	1. Ongoing review of current accommodation to ensure best use and maximisation. 2. Review service models and the balance between on site and outreach services to make best use of all resources. 3. Implement changes in working practices where appropriate (e.g. working from home, extend the working day) 4. Office sharing principles reviewed in light of COVID19 which has led to reduction in available office accommodation due to 2m rule. 7. Open plan and flexible working. 8. Additional space within CRW to be utilised as a temporary measure for Digital Programme Team as part of DHCR Programme. 9. Non-critical staff relocated from VCC site or WFH under COVID principles. 10. Capital bids placed and timelines produced. 11. Business case submitted to WG for Fire Improvement work. 12. Business case being produced for ventilation improvements in clinical areas.
2187		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Medical Physics (previously Radiotherapy Physics)	14/09/2020	31/12/2021		Radiotherapy Physics Staffing	NB - see Progress Notes for latest update 13/09/21 The recently received ATTAIN report highlighted that in comparison to the Institute of Physics and Engineering in Medicine (IPEM) guidance, Radiotherapy Physics were under resourced by approximately 25%. The IPEM recommendations for the provision of a physics service to radiotherapy are recognised as a benchmark for minimum staffing guidance. The Head of Medical Physics retired in November 2019. This post has not been replaced and, consequently, approximately 0.5 WTE of management or Medical Physics Expert (MPE) tasks have been absorbed by the department at the detriment to other tasks as described below. Senior staff are also working significantly over their contracted hours, which can be evidenced as time owed in lieu. The Engineering Section in particular is identified as an area of risk to the	25	15	5	Medical Physics workforce remains below recommended (IPEM) levels. Additional surge funding has been utilised alongside IRS funding to increase recruitment in the short term. The service head has developed an outline workforce plan, looking at roles and responsibilities and demands on the service, mapping out the essential BAU activity, critical projects and programmes of service development to implement a prioritisation if activity and resource utilisation. Whilst the situation to establish a full complement of staff in the service remains a challenge, development of a medium term workforce planning, and long term workforce strategy, with HEIW and W&OD colleagues continues alongside recruitment there will need to be support to focus on service critical projects. These have been determined as DHCR replacement, IRS and nVCC. Recruitment is underway to mitigate this risk, currently at 15, as this resource will cover the business critical programmes. This is subject to
2185		Safety	Velindre Cancer Centre	Accepted	Medical Physics (previously Radiotherapy Physics)	14/09/2020	31/05/2021		Delination Risk treatment delay (16284)	There is a risk of physics planning rework and patient delay as a result of errors in tumour volume delineation / margin growth, which may lead to a reduction in physics capacity and inability to meet planning targets. These errors are generally not picked up at medic peer review or during the physics planning process but by more experienced clinical scientists at final physics check, often the day before treatment. There is a lower risk that errors are missed at physics check and make their way to treatment. A number of Datix incidents have been attributed to target and organ at risk delineation errors. These incidents are generally identified at final physics check and so the effect is treatment delay and repeat work (planning) within physics. However, these errors would be classed as near misses as the errors were not detected during the medic peer review process, approval, or at the physics planning stages. Action is required to ensure these errors do not propagate to treatment.	15	15	9	Discussions at the RMG quality focused meeting to ensure the medical workforce are aware of the issues and to enable discussions and learning within SSTs. Medic peer review processes (for some treatment sites). A physics quality improvement project has been initiated to ensure effective multidisciplinary learning. This should reduce the requirement to replan due to errors not being detected until the final checking stages, and should also reduce the likelihood of a radiotherapy mis-treatment. Further controls required – a Datix medic representative to ensure joint investigations.

The following is the proposed Appendix to the Quality, Safety and Performance Committee Paper for 20th January and for Trust Board on 27th January.
Purpose of discussion at Gold 17th January, following an discussion on an initial version of this Appendix in Gold on 14th January, is to agree on final version of this Appendix for inclusion in Quality, Safety and Performance Committee and Board papers.
APPENDIX

APPENDIX

In light of current changing circumstances regarding Covid, a summary is provided below of current assessments of potential risks and issues emerging from Silver and Gold structures. The below relates to potential risks and issues with a direct or indirect impact on the response to Covid.

Risk Type	ID	Division	Title	Initial View of Inherent Risk Score	Key Controls	Initial View of Residual Risk Score	Risk Trend	Action Plan
Safety	*Datix record being completed*	Trust-Wide	Changing profile of Covid-19 infection risk, impacting our patients, donors and staff	20 (as at late December)	- Re-establishing command structure - Clinical governance strengthened, with establishment of Strategic Clinical Advisory Group at Gold level and Clinical Development Group at Silver level - Covid Cell established - Decision making framework refreshed, approved by Trust Board and reinstated - Changes to Board and Executive Meeting Structure, including increase frequency of Quality, Safety & Performance Committee	12	Stable ↓ *(reducing from 20 to 12)*	- Finalise operational review of Clinical Principles, including trigger points – governed through Gold 13.12.2022 via: - Strategic clinical advisory group - WBS risks based social distancing paper to be completed and approved -

Performance and Service Sustainability	*Datix record being completed*	Velindre Cancer Centre	Risk that Covid-19 related absences for staff could significantly impact on ability to provide core SACT and Radiotherapy Services and Outpatient reviews (including new patients, follow-ups and urgent problems) in the Velindre Cancer Centre	20 (early Jan)	- SACT staffing - realignment from wards, senior staff deployed, RD&I capacity utilised in line with the agreed impact assessment to ensure the R&D/Trials service is able to also fulfil Welsh Government guidance to continue research delivery; increased virtual appointments, further staffing contingency agreed and will be implemented if further SACT nursing staff absences occur - 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.	16	Decreasing in score ↓	- Further focus on demand and capacity modelling, linked to current action plan – subject to Gold review 19th January
Performance and Service Sustainability	*Datix record being completed*	Welsh Blood Service	Risk that stock level risks in January resulted in Blue Alert being issued, could have impact on the ability of the Welsh Blood Service to effectively service the health system	16 (early Jan)	- Various actions have resulted in a significant increase in stock levels currently, with the expectation of further improvements in coming weeks with additional Saturday clinics being added	12	Decreasing in score ↓	- Further review of Blue Alert level w/c 17th January

Safety	*Datix record being completed*	Velindre Cancer Centre	Risk that current regulations in Wales regarding isolation has impacted on patients being able to commence treatment	16	- Research underway into practices nationally conducted via Silver Command for reporting into Gold	16	Stable ↔	- Finalise recommendation for Gold decision, as appropriate, on any changes
Workforce and Organisational Development	*Datix record being completed*	Trust-wide	Risk that changes to working from home policy for the Trust, as a result of changes to regulation, linked to change to national alert level change in late December, could impact on the well-being of impacted staff	12	- Clear communications on reasons for changes required - Consistent approach for all staff in similar roles across Trust - Well-being resources clarified further	8	Decreasing in score ↓	- Decision on approach from end January following expected further changes to national alert levels