Prior Approval by the Chair Required

10.0.0   14:55 - CLOSE

The Board 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).

11.0.0   DATE AND TIME OF THE NEXT MEETING

Thursday, 26th May 2022 at 10:00

VELINDRE UNIVERSITY NHS TRUST

PUBLIC TRUST BOARD MEETING
ACTION LOG

MINUTE NUMBER	ACTION	LEAD	STATUS	DUE DATE/ STATUS
25 NOVEMBER 2021				
5.1.0	**Chair's Update**			
	Prof Donna Mead recently received the objectives from the Minister which are being reviewed and will be circulated shortly.	DM	CLOSE	Objectives shared via updated 2022/23 Independent Member PADR forms. In addition, a copy of the Chair's recent appraisal form was shared with the Board on 24th March.
6.1.0	**Quality, Safety & Performance Committee Highlight Report**			
	Nicola Williams to circulate the full patient and donor experience survey following Welsh translation to Independent Members.	NW	CLOSE	Report circulated to Trust Board members 27/01/2022.
27 January 2022				
MINUTE NUMBER	ACTION	LEAD	STATUS	DUE DATE/ STATUS
4.1.0	**Annual Audit Report 2021 – Velindre University NHS Trust**			
	In response to a query raised by Sarah Morley, Katrina Febry agreed to share the checklist pertaining to staff wellbeing, which has been designed for the whole of Wales with each organisation conducting independent self-assessments.	KF	CLOSE	Audit Wales have shared a copy of the report and supporting appendix with the Director of Corporate Governance and Chief of Staff and Executive

				Director of Organisational Development and Workforce. The self-assessment will be brought to the May Audit Committee.
	Clare James also agreed to enquire as to whether the audit report requires signature of the Auditor General.	**CJ**	**CLOSE**	Audit Wales have confirmed that the Trust Audit Annual Report does not require the signature of the Auditor General.
5.2.0	**Chief Executive Officer (CEO) Update**			
	Stephen Allen raised some concerns regarding the build for the new Hospital and requested further engagement by the Trust with the Community Health Council. Following some discussion it was noted that a meeting will be held with Steve Ham and Stephen Allen to work through some of the concerns raised regarding the new build.	**SA/SH**	**CLOSE**	Arrangements have been made for a meeting on 25/04/2022. This is following information being provided to Stephen Allen by the Trust on a number of key questions that were being raised with the Community Health Council.
6.4.0	**Delivering Excellence Performance Report Period November 2021**			
	The Chair requested Cath O'Brien share information on what is being done with regard to any changes to treatment pathways, particularly in relation to prostate cancer patients.	**COB**	**CLOSE**	The performance report has been updated to clarify on this. Please see page 5 paragraph 2.

	Arrangement of a Board Development session on radiation services, to include a section on Brachytherapy.	**LF/COB**	**CLOSE**	This has been arranged for the April Board Development session.
	Cath O'Brien to confirm in the commentary on the next cycle of the performance report that patients are being actively managed whilst awaiting treatment.	**COB**	**CLOSE**	The performance report has been updated to reflect that patients are being actively managed at this point.
	Stephen Allen will circulate a report on General practitioner access to the Board.	**SA**	**CLOSE**	Report circulated to Trust Board members 24/03/2022.
7.1.0	**The Trust Strategy**			
	In response, Steve Ham articulated that the Integrated Medium Term Plan and annual plans delivery mechanisms for Welsh Blood Service and Velindre Cancer Services into enabling functions will be presented at the next Trust Board, where assurance will be given that all documents are appropriately aligned. The section on page 11 will be expanded and referenced.	**PH**	**CLOSE**	The IMTP and annual plans delivery mechanisms for WBS and VCC into enabling functions have now been presented in a standardised format. The IMTP, in this format, has been endorsed by the Executive Management Board and the Strategic Development Committee at their meetings in March 2022. The IMTP will be considered by the Trust Board for approval at its meeting on 31st March 2022.

7.2.0	**Cardiff Cancer Research Hub, Proposal for a Tripartite partnership between Cardiff and Vale UHB, Cardiff University and Velindre University NHS Trust**			
	A concise executive summary needs to be written.	**ME/LB/PH**	**CLOSE**	An executive summary has been written and will be included in the document for the next phase of engagement, which will include further discussion with the Board at appropriate time.
	The next phase of development to include agreement to key principles that will go on to establish a formal Heads of Terms for the model going forwards	**ME/LB/PH**	**OPEN**	A final update will be provided at Trust Board on 26th May 2022.

MINUTES PUBLIC TRUST BOARD MEETING – PART A

VELINDRE UNIVERSITY NHS TRUST HQ/LIVE STREAMED
27th JANUARY 2022 at 10:00AM

PRESENT	
Professor Donna Mead OBE	Chair
Stephen Harries	Interim Vice Chair
Martin Veale	Independent Member
Hilary Jones	Independent Member
Gareth Jones	Independent Member
Vicky Morris	Independent Member
Professor Andrew Westwell	Independent Member
Steve Ham	Chief Executive
Nicola Williams	Executive Director of Nursing, AHPs & Health Science
Matthew Bunce	Executive Director of Finance
Dr Jacinta Abraham	Executive Medical Director
Sarah Morley	Executive Director of Organisational Development & Workforce
ATTENDEES	
Lauren Fear	Director of Corporate Governance and Chief of Staff
Cath O'Brien MBE	Chief Operating Officer
Emma Stephens	Head of Corporate Governance
Lenisha Wright	Business Support Manager, Secretariat

1.0.0	**STANDARD BUSINESS**	ACTION LEAD
	The Chair opened the meeting and welcomed everyone in attendance to the first meeting of the Public Trust Board in 2022, and took the opportunity to wish everyone a Happy New Year.	
1.1.0	**Apologies** The Chair noted apologies from: 1. Carl James, Director of Strategic Transformation, Planning & Digital.	
1.2.0	**In attendance** The Chair welcomed the regular attendees of the Public Trust Board and additional attendees joining for today's meeting: 1. Katrina Febry, Audit Wales Lead 2. Clare James, Audit Wales Director (for item 4.1.0)	

	3. Stephen Allen, Chief Officer, South Glamorgan Community Health Council 4. Brenda Chamberlain, South Glamorgan Community Health Council 5. David Cogan, Patient Liaison Representative 6. Phil Hodson, Deputy Director of Planning & Performance (on behalf of Carl James) 7. Prof Mererid Evans, Director of the Wales Cancer Research Centre (WCRC) (for item 7.2.0) The Chair also took the opportunity to welcome Nigel Downes, the Interim Deputy Director of Nursing, Quality and Patient Experience who was attending the Public Trust Board meeting as an observer following his recent appointment.	
1.3.0	**Declarations of Interest** There were no Declarations of Interest for any agenda items.	
2.0.0	**CONSENT ITEMS**	
2.1.0	**FOR APPROVAL**	
2.1.1	**Minutes from the Public Trust Board meeting held on the 25 November 2021.** The Trust Board **CONFIRMED** the Minutes of the meeting held on 25th November 2021 were an accurate and true reflection.	
2.1.2	**Chair's Urgent Actions Report** The Trust Board **CONSIDERED** and **ENDORSED** the Chairs urgent actions taken between the **16th November 2021 to 14th January 2022.**	
2.1.3	**Commitment of Expenditure Exceeding Chief Executive's Limit** The Trust Board **APPROVED** the Commitment of Expenditure summarised within the report and supporting appendices.	
2.1.4	**Revisions to Velindre University NHS Trust Model Standing Orders Schedule 3** The Trust Board **APPROVED** the Revisions to the Trust Model Standing Orders Schedule 3 subject to a small amendment to the Strategic Development Committee's Terms of Reference at para 3.2 to address a minor formatting/grammatical inconsistency, raised by Stephen Harries. Gareth Jones requested for ease any future revisions to the Trust Standing Orders also include a tracked changed copy in addition to the clean copy and summary changes report already provided for the Board.	**LF**

2.2.0	**FOR NOTING**	
2.2.1	**Remuneration Committee Highlight Report** The Trust Board **NOTED** the contents of the Remuneration Committee Highlight Report from its meeting held on 13th December 2021.	
2.2.2	**Local Partnership Forum Highlight Report** The Trust Board **NOTED** the contents of the Local Partnership Forum Highlight Report from its meeting held on 1st December 2021.	
2.2.3	**Transforming Cancer Services Programme Scrutiny Sub-Committee Highlight Reports** The Trust Board **NOTED** the contents of the Transforming Cancer Services Programme Scrutiny Sub-Committee Highlight reports from its meetings held on the 25th October 2021 and 22nd November 2021.	
2.2.4	**Transforming Cancer Services Communication and Engagement update** The Trust Board **NOTED** the contents of the Transforming Cancer Services Communication and Engagement update report.	
2.2.5	**Audit Committee Highlight Report** The Trust Board **NOTED** the contents of the Audit Committee Highlight report from its meeting held on the 11th January 2022.	
2.2.6	**Strategic Development Committee Highlight Report** The Trust Board **NOTED** the contents of the Strategic Development Committee Highlight report from its meeting held on the 8th November 2021.	
2.2.7	**Brachytherapy Update** The Trust Board **NOTED** the contents of the Brachytherapy Service update report.	
2.2.8	**Welsh Health Specialised Services (WHSSC) Committee Briefing** The Trust Board **NOTED** the contents of the Welsh Health Specialised Services (WHSSC) Joint Committee briefing of 11 January 2022.	

3.0.0	**MATTERS ARISING**	
3.1.0	**Action Log**	

Action Log

The Chair took the Board through the action log and the following was highlighted:

- *Item 5.1* - The Chair advised that her objectives recently received from the Minister are being reviewed and will be circulated shortly. Item to remain open.
- *Item 6.1* – Nicola Williams reported that the full patient and donor experience survey now translated into Welsh will be circulated to Board members before close of business today. This item can be closed subject to receipt of the report by members at close of business.
- *Items 6.3* – An update on the Brachytherapy Business Case has been provided to Board members with papers included under today's consent agenda at item 2.2.7 and the business case will be received in due course. This item to be closed.
- *Item 6.6* – The Clinical Audit Plan has been added to the Audit Committee Cycle of Business and this action can be closed.
- *Item 7.1* - The Chair advised that she has contacted Prof Linda Ross who will discuss the development of spiritual competencies with Sarah Morley, Executive Director of Organisational Development & Workforce and this action can be closed.

The Trust Board **APPROVED** the Action Log and updates captured in the meeting.

4.0.0	**INTEGRATED GOVERNANCE**	
4.1.0	**Annual Audit Report 2021 – Velindre Univeristy NHS Trust**	

Annual Audit Report 2021 – Velindre Univeristy NHS Trust

Clare James, presented the Annual Audit Report 2021 supported by Katrina Febry, Audit Lead.

Clare James advised that the Annual Report encapsulates a summary of work done throughout the year, with the aim of ensuring scrutiny and providing insight where possible. The report includes audits undertaken to review operational planning and governance arrangements, together with an examination of the Trust 2020-21 accounts. Clare James proceeded to highlight the following key outcomes and findings:

- Financial duties have been achieved for the year, with a clear financial plan to deliver. As a result of the pandemic, Audit Wales were unable to obtain the necessary audit evidence, as mandated by professional Auditing Standards for material inventory balances, and so issued a qualified 'limitation of scope' opinion.
- Expenditure has been spent for purposes required.
- Financial internal controls are effective.
- Sound governance arrangements are in place to serve and administer the Trust Board and Committees. This was reiterated by Katrina Febry, citing recent audit reports into these areas.

- There is effective use of resources.

Operational planning and their monitoring are effective with flexibility to respond to changing circumstances.

In conclusion, Clare James summarised that this is a broadly positive Annual Report with a few action points that management are taking forward.

The Chair thanked Clare James and Katrina Febry for their presentation and invited colleagues and Board members present to raise any questions or comments on the report.

Martin Veale raised that it was important to reiterate for members of the Public and the record that the qualified 'limitation of scope' awarded for the Trust's accounts, was as a consequence of the decision taken by Audit Wales due to their own operating procedures during the pandemic not to undertake the physical stock take required, and that this was not as a result of any action(s) taken or not taken by the Trust. Martin Veale sought further assurance from Audit Wales colleagues regarding what action is being taken to ensure that a similar situation does not arise in this year's audit of the Trust's accounts. Clare James acknowledged the unpredictability of the continuing environment in which we operate and that there are regular stock takes which have been undertaken throughout the current financial year, adding that risk assessments have been done and there is more confidence of the current and future position.

In response to a query raised by the Chair, Clare James confirmed that should an expenditure be incurred as a result of the national requirements arising for the NHS pension tax arrangements, this will be funded by Welsh Government with no impact to the Trust.

In response to a query raised by Sarah Morley, Katrina Febry agreed to share the checklist pertaining to staff wellbeing, which has been designed for the whole of Wales with each organisation conducting independent self-assessments. **Action**: Katrina Febry

| KF |

Clare James also agreed to enquire as to whether the audit report requires signature of the Auditor General. **Action**: Clare James

| CJ |

Steve Ham thanked the audit team for the work that has been done and added that the report is a positive statement as to the position of the Trust and that this has been achieved in the midst of challenging circumstances during the COVID-19 pandemic.

The Chair congratulated the Trust on the performance reflected in the report which is largely positive.

The Trust Board **NOTED** the contents of the Velindre University NHS Trust Annual Audit Report 2021 and the actions carried forward.

5.0.0	**KEY REPORTS**	
5.1.0	**Chairs Update**	
	The Chair, presented the Chairs Update Report to the Board and highlighted the following:	
	• The Board Development/briefing sessions have been successful and we have received a number of key updates including development of the Trust Strategy and Integrated Medium Term Plan. The schedule for these sessions has been impacted by the recent Omicron COVID variant however these are to be reinstated shortly. • The Chair attended the MediWales 16th Annual Innovation Awards ceremony held on 2nd December 2021 as a representative for the Trust. • The Chair on behalf of the Board, are proud to congratulate Dr Seema Arif, a Consultant Oncologist for the Trust who has been awarded a Member of the Order of the British Empire (MBE) in the New Year's Honours List, for services rendered to Health Care amongst the Black, Asian and Minority Ethnic Community. • The Chair attended a donor clinic in Ystradgynlais on New Year's Eve to thank staff for their contribution and hard work over the bank holiday weekend. The Chair found a professionally run operation with senior staff providing support to newer members of staff. • The Chair noted the appointment of Tracy Myhill, the newly appointed Chair for Shared Services, wishing her success in her new role.	
	The Trust Board **NOTED** the content of the Chairs update report.	
5.2.0	**Chief Executive Officer (CEO) Update**	
	Steve Ham presented the CEO Report and highlighted the following:	
	• The commitment from staff needs to be commended in terms of support to patients, donors and each other, demonstrating how well people worked together in difficult circumstances, during the pandemic. • The Full Business Case for the Enabling Works project was approved by the Minister and communication has been disseminated to relevant parties and key stakeholders that work will resume on site for the preparation stages of the enabling works. • The application for the interim injunction was being heard on the morning of 27th January 2022. • The work on the Integrated Medium Term Plan is continuing to progress and the Board will receive further updates in Strategic Development Committee and Trust Board in March.	
	Stephen Allen raised some concerns regarding the build for the new Hospital and requested further engagement by the Trust with the	

	Community Health Council. Following some discussion it was noted that a meeting will be held with Steve Ham and Stephen Allen to work through some of the concerns raised regarding the new build. **Action**: Steve Ham and Stephen Allen The Chair added that the Trust also receives frequent correspondence from members of the public which is replied to on a regular basis. This is included in the Transforming Cancer Services Communications and Engagement Update Report provided to the Board. The Trust Board **NOTED** the content of the CEO's update report.	SH/SA
6.0.0	**QUALITY, SAFETY & PERFORMANCE**	
6.1.0	**Quality, Safety & Performance Committee Highlight Report** Vicky Morris, Independent Member and Chair of the Quality, Safety and Performance Committee advised that she was delighted to Chair her first meeting and noted the Executive Team's commitment to drive improvements for patient and donor experience and care, as well actively seeking further opportunities to develop the governance systems in place to provide assurance. Vicky Morris advised that there were no items to alert to the Board over and above those already outlined in the report, and highlighted the following for information: • A salient point out of the Quality, Safety and Performance Committee was the patient story and patient experience during COVID-19 in terms of what the Trust needed to reflect on regarding learning and application of that learning. This is going to be shared with staff in a Trust-wide communication. • The tracking of treatment and outcomes during COVID-19 and the clinical framework to support prioritisation of care, which provides assurance to the Board that formal assessments are undertaken. The Chair added that the detailed Quality, Safety and Performance Committee report addressed important issues in her view also and thanked Vicky Morris for the report. 2. The Trust Board **NOTED** the contents of the Quality, Safety and Performance Committee report.	
6.2.0	**Covid-19 Update Report**	
	The COVID-19 update report was presented by Steve Ham, Chief Executive, supported by Cath O'Brien Chief Operating Officer, Lauren Fear, Director of Corporate Governance & Chief of Staff, Sarah Morley, Executive Director of Organisational Development & Workforce and Nicola Williams Executive Director of Nursing, Allied Health Professions and Health Science. Steve Ham highlighted the following aspects to the Board:	

- The incidents of COVID-19 have reduced as presented in the data, adding that given the nature of the new variant, it is likely that statistics will go through phases of fluctuating scenarios. Testing percentages reflect the same trends with numbers in hospitals having decreased, reflective of the vaccination programme.
- The Trust contributed to the distribution of vaccines within a challenging timeframe of five weeks, being the first to distribute vaccines for children aged 12 and above to vaccination centres. Nicola Williams noted that the Trust deployed a number of staff to support the vaccination centres during December, ensuring maximum use of resources in support of the National programme.
- Service across Wales remains pressured with social distancing and other COVID-19 challenges in the current winter season. Gold and Silver Command meetings have been conducted three times a week but will likely decrease along with other adjustments as the position in Wales is forecast to improve.
- The command structure wave has further matured and developed, applying learning derived from previous waves, including establishment of the Strategic Clinical Advisory Group

Cath O'Brien took the Board through the slide presentation highlighting the following for each Division of the Trust:

The Velindre Cancer Service:
- Clinical prioritisation and frameworks for SACT and Radiotherapy have been applied in line with National guidance.
- In terms of prioritisation, a balance between capacity and patient needs is at the forefront, with active engagement and clear communication to patients.
- For SACT, options for therapies have been maximised to include care at home, staff redeployment and introducing additional clinics to maintain treatment levels.
- All radiotherapy, patients who have had their treatment pathway altered during January 2022 have now resumed their original pathway.
- The Trust has successfully maintained ambulatory, inpatient care and outreach service delivery.
- The impact on the Trust with regard to staff absences, is now recovering.

The Welsh Blood Service
- The decrease in stock levels in December,, meant the service had to work collaboratively with our Health Boards partners to effectively manage stock, which enabled a stock build position by early January 2022.
- The Chair noted that staff at the Welsh Blood Service have been involved in communications, including newspaper articles and appearances on radio and television. A very concerted effort from staff and the Board is very proud of them.
- There has been coverage of powerful stories from donors, and a welcomed visit from the Health and Social Care Minister.

Sarah Morley highlighted the following on Wellbeing:

Wellbeing has been complex with some staff having to work from home, noting that two years into the pandemic has resulted in some staff struggling with the working from home arrangements and different ways of working. Interventions have been put in place to support people, including an opportunity for staff to return to the offices on a rotational basis.

For front line facing staff, who may experience different pressures, one to one psychological and other support has been made available. An agile working project group has also been established, to support ongoing decisions and arrangements for the medium to long term.

The Chair thanked colleagues and invited Board members to raise any questions or comments on the presentation.

Jaz Abraham confirmed that clear records are kept in case notes should decisions for treatment be made differently due to COVID-19. These reasons could include patient safety, patient tolerance, patient choice and COVID-19 positive patients who may need to isolate in line with Welsh Government guidelines.

Nicola Williams added that data and figures in the slides provide good information but may mask the excellent effort of the team at the Velindre Cancer Centre to achieve the level of performance presented. The performance has been closely monitored through the Gold Command structure with all working toward the same goals utilising the clinical principles document and impact assessments, with prioritisation on a case by case basis.

Vicky Morris added that outcomes based on prioritisation will need to be tracked incumbent to decisions made, and learnings from the effectiveness of those decisions.

It was noted that a national COVID-19 public inquiry is expected in the coming months. The Trust has arrangements in place to ensure records are kept in preparation for the inquiry. Lauren Fear added that the structure of the inquiry has not yet been outlined but that more information will be shared once the Terms of Reference have been released.

Cath O'Brien noted a correction on the slide presentation which should read unvalidated and not invalidated.

The Trust Board **NOTED** the contents of the report and the actions being undertaken.

6.3.0	**BREAK: 10 minutes**	
6.4.0	**Delivering Excellence Performance Report Period November 2021**	
	The Chair highlighted to the Board that the Peformance Report has been scrutinised and received prior to today's meeting by the Quality, Safety and Performance Committee and that the individual reports speak to the cover report.	
	Cath O'Brien presented the cover report highlighting that the radiotherapy performance presents a complex picture of therapeutic pathways and cycles of change in terms of development and compliance with targets to achieve, including systems changes. The key challenges and solutions include 3-D planning and Brachytherapy service. As a result the service is looking into expanding capacity for 3-D planning. Brachytherapy services is being developed further to improve efficiency and sustainability, undertaken by the task and finish group led by Nicola Williams.	
	The Chair requested Cath O'Brien share information on what is being done with regard to any changes to treatment pathways, particularly in relation to prostate cancer patients. **Action**: COB	COB
	It was noted that when there are demands that don't meet the capacity available, the framework is used for prioritisation.Jacintha Abraham confirmed thatin prioritising, there is consideration for every option available to reduce potential harm.	
	Stephen Harries added that the long term impact of COVID-19 is not yet known. Communication via the press indicates there could be an increase in the number patients in the systemand whether something can be done now to address any long term challenges. Cath O'Brien provided assurance that a layered approach is being undertaken to understand demand, projections, COVID-19 impact and what is expected to transpire over a period of time. Some of this work is being undertaken internally and also in collaboration with ourHealth Board partners.	
	Stephen Allen raised a question regarding COVID-19 planning and whether the assumptions were correct. Cath O'Brien advised that the patterns reflect our assumptions but that ongoing monitoring and planning is being undertaken, and where relevant assumptions are amended to reflect changing circumstances	
	In terms of communication to patients, verbally, orally and in writing pertaining to waiting times, Cath O'Brien added that there is ongoing communication with patients, and to note that patients are provided with a time in the initial consultation with the clinician and made aware that they can contact the Trust at any time. The Chair added that communications must emphasise that the service have plans in place and the measures being taken.	

	Prof Andrew Westwell queried the demand for Brachytherpy.e. Jacintha Abraham advised that the position on Brachytherapy has changed with new evidence that it allows for targetted treatment and minimising toxicity of soft tissue. Technology has also improved to compliment Brachytherapy. The Chair requested an update on Clinical Oncology Sub Committee (COSC), targets noting that the report states that investment from Health Board partners in order to meet the revised COSC targets. Cath O'Brien agreed the position of COSC required further review. A summary of the Actions are provided below noting that some of these actions can be combined and addressed together. **ACTION:** Cath O'Brien – Arrangement of a board development session on radiation services, to include a section on Brachytherapy. **ACTIO**N: Cath O'Brien to confirm in the commentary on the next cycle of the performance report that patients are being actively managed whilst awaiting treatment. **ACTIO**N: Stephen Allen will circulate a report on General practitioner access to the Board. The Trust Board **DISCUSSED** and **REVIEWED** the contents of the performance report, along with actions identified.	 COB COB SA
6.5.0	**Financial Report Period November/December 2021** In presenting the Financial Report, Matthew Bunce noted that there were no material changes since the report was prepared for inclusion with Board papers and highlighted the following: • Challenges remain around procurement and the supply chain, these were discussed fully and assurance provided at the January Quality, Safety & Performance Committee, with no further outstanding issues to report. • Revenue budget position. • A challenging piece of work around prioritisation of work around COVID-19 is to be taken forward. The Trust Board **NOTED** the contents of the Financial Report and financial performance to date.	
6.6.0	**Trust Risk Register** In presenting the report, Lauren Fear advised that the focus of the reporting was on the risks scoring 12 or greater and the ongoing work to refine and enhance the Trust Risk Register. It was noted that the report provides a summary of the risks recorded by the Trust.	

It was highlighted that the Risk Register had been discussed in detail at both the Quality, Safety & Performance and Audit Committees. Additional narrative will be included in future reports to outline actions being taken to reduce or eliminate risks as may be appropriate. Training will be set up for Board members as discussed at Audit Committee. The formatting of the report will develop further to provide clear rationale for closure of risks and mapping responsibilities for Board Committees in terms of closures. The data in the report was extracted in December which would not reflect the changing landscape with respect to COVID-19. The additional appendix of COVID-19 risks were managed through the Trust incident Command structure and will in future be incorporated into the Risk Register. The consolidated risk register in Version 14 is expected to be completed by end March 2022. Martin Veale noted that the cleansing of data is an enormous task and that added assurance is given from the Risk Framework Internal Audit, with an encouraging view on the progress made with regard to the risk management approach for the Trust. There was general assurance in terms of what has come out of the exercise. The Chair endorsed this view and further acknowledged that the Trust has been on a journey with regard to the management of risk. The Trust Board: • **NOTED** the risks assessed at levels 20, 16, 15 and 12 reported in the Trust Risk Register (Version 12 and Version 14). • **SCRUTINISED** the data in the risk registers including, risk ratings, review dates and identified controls. • **SUPPORTED** the continued work being undertaken on the management of risks in the organisation, which included the ongoing validation, authentication and mitigation of risks. • **NOTED** that a project plan was in place and actions undertaken to expedite progress in establishing a consolidated risk process for the Trust.	
6.7.0	**Trust Assurance Framework** Lauren Fear presented the Trust Assurance Framework Report, adding that following the first iteration of the Trust Assurance Framework, three areas were identified for further focus which are included in the dashboard (Appendix 1), namely: i. Demand and capacity ii. Quality and safety iii. Organisational Culture	

	The report reflects the work progressing by the governance team to improve the management of the framework from a systems perspective to support analysis of trends.	
	Page four summarises the focus linked to the recommendations from audit committee, which involves the following key elements:	
	i. The way in which risks are viewed in line with strategic goals. ii. The way in which the Trust Assurance Framework should evolve and viewed in line with strategic goals.	
	Further discussions will continue at Strategic Development Committee on how strategic risks provide a holistic view of the organisation.	
	The recent Internal audits undertaken by Internal Audit on the Risk Framework and Trust Assurance Framework (TAF) provide assurance in terms of where we are on this journey. Martin Veale added that it has been a journey with movement toward triangulation, and that what we have currently stands up to scrutiny.	
	The Chair noted that good progress has been made providing a good level of assurance to the Board.	
	The Trust Board: • **NOTED** the progress to date. • **NOTED** next steps. • **NOTED** the development paths to fully support operationalisation of this framework.	
7.0.0	**STRATEGIC DEVELOPMENT**	
7.1.0	**The Trust Strategy** Steve Ham introduced the latest iteration of the Trust Strategy and highlighted that triangulation mentioned in the discussion on the Trust Assurance Framework is an important part in linking across the Integrated Medium Term Plan, risk management and overall performance. The work included effective enaggement with staff and with patient,donors and the wider public which is reflected in this latest draft strategy. Phil Hodson highlighted the discussions from the recent Board development session held in December 2021 have also been reflected in the strategy presented today. Vicky Morris added that this is the baseline position of where we are, with the next step being demonstrating how this will be delivered at divisional level. In response, Steve Ham articulated that the Integrated Medium Term Plan and annual plans delivery mechanisms for Welsh Blood Service and Velindre Cancer Services into enabling functions will be presented at the next Trust Board, where assurance will be given that	

	all documents are appropriately aligned. The section on page 11 will be expanded and referenced. ****Action****: PH	PH
	The Trust Board **APPROVED** the Trust Strategy, with the following inclusions and amendments.	
	• Nicola Williams advised that the section on Page four will be strengthened.	NW
	• Jacintha Abraham will add a wider international or United Kingdom research perspective, reflecting the whole spectrum of research.	JA
	• Correction to be made: List of capital programmes and refurbishments of the Welsh Blood Service building appears twice.	PH
7.2.0	**Cardiff Cancer Research Hub, Proposal for Tripartite partnership between Cardiff and Vale UHB, Cardiff University and Velindre University NHS Trust** The Chair highlighted that Board members should ensure that they refer to version 8 which has also been circulated via email for completeness in readiness. The proposal provided is for a tripartite Cardiff Cancer Research Hub at the University Hospital of Wales, a partnership between Cardiff and Vale University Health Board, Cardiff University and Velindre University NHS Trust. Prof Mererid Evans took the Board through a presentation, supported by Phil Hodson, Deputy Director of planning and Performance. The following was highlighted: • The collaborative work took place over seven months with various workshops held. • The focus of the work has been about increasing patient access to advanced therapy opportunities, strengthening the pipeline to lab and clinics encouraging new scientific discovery. • The outcome expected is to attract future funding and trained staff with further innovation and the building of a collective reputation. • The Nuffield Trust recommends the development of a research Hub and university partnership. • The report provides information on various sponsorships and workforce requirements in support of the Hub. • The work is supported by the Cardiff and Vale Partnership Board. • In the first instance, studies will be undertaken with the lowest risks and implementation will be a phased approach which allows for some work to start immediately, while waiting for facilities and infrastructure development. • In the coming five years it is envisaged that suite facilities will be made available, to facilitate overnight stays, as well as examination chairs. Patients will be directed by University Hospital Wales to the Hub.	

- The Hub will be located to facilitate escalated care if required.
- The research looked at other well developed models such as the Oxford model to inform workforce needs, bed numbers, pharmacy and joint research offices, a summary of which is provided in the paper.

A summary of discussions and comments is provided below:

- This work will be included and embedded in the Integrated Medium Term Plan.
- Only activities best serviced at the Hub will be moved from Velindre, following robust governance arrangements.
- Funding has been focussed on clinical aspects until now, more information on funding will be provided in future reporting. It was noted that formal Heads of Terms arrangements are critically important, which should be clarified at the start of the project. Other information for future reporting should include pharmacy, staffing, resourcing, legal and governance arrangements, logistics and estates planning, ambulance services to move patients across buildings and intellectual property.
- The research will look to other research models such as the Oxford Model with ongoing development.
- Matters of detail for example, protection of research beds for the Hub will be looked at in detail.
- Overall governance arrangements are expected to develop as the project develops.

Jacintha Abraham and Phil Hodson added that this was a high level report to the Board, to obtain support and endorsement from the Board for the intent outlined in the Proposal. It was noted that more detail will be provided going forward.

Lauren Fear advised that statutory delegation and decision making for each organisation in the Hub remains.

Jacintha Abraham added that the collaborative work has been excellent up until this point and to note that the leadership of Prof Mererid Evans in her leadership role in the work that has been undertaken.

The Trust Board:
- **ENDORSED** the proposal to establish a Tripartite Research Hub between Cardiff and Vale UHB, Cardiff University and Velindre University NHS Trust with the conditions including setting up heads of terms for intellectual property, legal and governance arrangements.
- **ENDORSED** the development of a phased implementation plan for phase one of the project.
- **ENDORSED** the development of a robust investment and funding strategy supported and agreed by all partners.

ACTION: A concise executive summary needs to be written.

ME/LB

	ACTION: The next phase of development to include agreement to key principels that will go on to establih a formal Heads of Terms for the model going forwards	ME/LB
8.0.0	**ANY OTHER BUSINESS** There were no further items for discussion. No other business	
9.0.0	**CLOSE** The Board 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).	
10.0.0	**DATE AND TIME OF THE NEXT MEETINGS** Thursday, 31 March 2021 at 10:00	

TRUST BOARD

CHAIRS URGENT ACTION MATTER REPORT

DATE OF MEETING	31/03/2022

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 and Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance and Chief of Staff

REPORT PURPOSE	**CONSIDER** and **ENDORSE**

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Trust Board Members – Via Email	10/02/2022	Approved
Trust Board Members – Via Email	10/03/2022	Approved
Trust Board Members – Via Email	11/03/2022	Approved
Trust Board Members – Via Email	17/03/2022	Approved
ACRONYMS		

1. SITUATION/BACKGROUND

1.1 In accordance with Trust Standing Orders, there may occasionally, be circumstances where decisions, which would normally be made by the Board, need to be taken between scheduled meetings and it is not practicable to call a meeting of the Board. In these circumstances, the Chair and Chief Executive, supported by the Director of Corporate Governance & Chief of Staff, as appropriate, may deal with the matter on behalf of the Board – after first consulting with at least two other Independent Members. The Director of Corporate Governance & Chief of Staff must ensure that any such action is formally recorded, and reported to the next meeting of the Board for consideration and ratification. Where issues are included in the Schedule of 'Expected Urgent Decisions' and prior approval is sought from the Board, these issues will not be reported here.

1.2 Chair's action may not be taken where either the Chair or the Chief Executive has a personal or business interest in an urgent matter requiring decision. In this circumstance, the Vice-Chair or the Executive Director acting on behalf of the Chief Executive will take a decision on the urgent matter, as appropriate.

1.3 This report details Chair's Urgent Action taken between the **15 January 2022** to the **17 March 2022**.

2. ASSESMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Option Appraisal / Analysis:

The items outlined in Appendix 1 have been dealt with by Chairs Urgent Action.

3. IMPACT ASSESSMENT

	Yes (Please see detail below)
QUALITY AND SAFETY IMPLICATIONS/IMPACT	This action is by exception and with prior approval from the Chair. The provision to permit this urgent action is to allow for quick decisions to be made where it is not practicable to call a Board meeting and to avoid delays that could affect service delivery and quality.
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)
	Financial impact was captured within the documentation considered by the Board.

4. RECOMMENDATION

4.1 The Board is asked to **NOTE** the Chairs urgent action taken between the **15 January 2022** to the **17 March 2022** as outlined in Appendix **1**.

Appendix 1

The following items were dealt with by Chairs Urgent Action:

1. Velindre Cancer Service – Refurbishment of Ty Bobath

The Trust Board were sent an email on the 10 February 2022, inviting the Board to **APPROVE:**

- The uplift in costs to support delivery of the Ty Bobath scheme at the Velindre Cancer Service, previously approved by the Trust Board in September 2021.

Due to the urgency of this matter, it could not wait until the March 2022 Trust Board meeting.

Recommendation Approved:

- Professor Donna Mead, Chair
- Steve Ham, Chief Executive Officer
- Martin Veale, Independent Member
- Gareth Jones, Independent Member
- Stephen Harries, Interim Vice Chair and Independent Member
- Professor Andrew Westwell, Independent Member
- Sarah Morley Executive Director of Organisational Development & Workforce

A small clarification was sought and subsequently provided. No objections to approval were received.

2. Velindre Cancer Service – Pharmacy Refurbishment

The Trust Board were sent an email on the 10 March 2022, inviting the Board to **APPROVE:**

- The uplift in costs to support delivery of the Pharmacy Refurbishment at the Velindre Cancer Service. The uplift in costs had arisen following the Procurement Tender underway for this scheme that was previously approved by the Capital Delivery Group as part of a successful bid to Welsh Government to secure available COVID Recovery funding.

Due to the urgency of this matter, it could not wait until the March 2022 Trust Board meeting.

Recommendation Approved:

- Stephen Harries, Acting Chair
- Carl James, Acting Chief Executive Officer
- Gareth Jones, Independent Member
- Professor Andrew Westwell, Independent Member
- Vicky Morris, Independent Member
- Martin Veale, Independent Member

No objections to approval were received.

3. Escrow Facility and Project Bank Account

The Trust Board were sent an email on the 11 March 2022, inviting the Board to **APPROVE:**

- Delegation of authority to the Chair and Chief Executive to sign the Escrow Agreement on behalf of the Trust, and provide only their identification instead of ALL of the Trust Board members to fulfill the '**Know-Your-Customer**' requirements to support completion of this process.

Due to the urgency of this matter, it could not wait until the March 2022 Trust Board meeting.

Recommendation Approved:

- Stephen Harries, Acting Chair
- Steve Ham, Chief Executive Officer
- Vicky Morris, Independent Member
- Hilary Jones, Independent Member
- Martin Veale, Independent Member
- Professor Andrew Westwell, Independent Member
- Sarah Morley, Executive Director of Organisational Development & Workforce

No objections to approval were received.

4. NWSSP Purchase of Matrix House

The Trust Board were sent an email on the 17 March 2022, inviting the Board to **APPROVE:**

- The acquisition of Matrix House by NWSSP following the release of capital funding by Welsh Government in support of this purchase.

Due to the urgency of this matter, it could not wait until the March 2022 Trust Board meeting.

Recommendation Approved:

- Donna Mead, Chair
- Steve Ham, Chief Executive Officer
- Stephen Harries, Interim Vice Chair
- Martin Veale, Independent Member
- Vicky Morris, Independent Member
- Professor Andrew Westwell, Independent Member

A small number of clarifications /points were raised and subsequently addressed. No objections to approval were received.

TRUST BOARD

BOARD DECISIONS REQUIRED FOR COMMITMENT OF EXPENDITURE EXCEEDING £100K FOR THE PERIOD 31 March 2022 to 26 May 2022

DATE OF MEETING	31 March 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	Matthew Bunce, Executive Director of Finance
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	APPROVAL

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	Supported
Executive Management Board	21/02/2022	Endorsed for Committee & Board Approval
Strategic Development Committee	23/03/2022	Endorsed for Board Approval

ACRONYMS	
SFIs	Standing Financial Instructions
WBS	Welsh Blood Service
VUNHST	Velindre University NHS Trust

1. SITUATION/BACKGROUND

1.1 Velindre University NHS Trust (VUNHST) has a Scheme of Delegation, as set out in its Standing Orders, together with its Standing Financial Instructions (SFIs), which ensures that there are effective governance arrangements in place for the delegation of financial authority.

1.2 Financial limits apply to the commitment of expenditure. If expenditure is greater than an individual's financial limit, and is more than the limit delegated to the VUNHST Chief Executive, the planned expenditure will require VUNHST Board approval. For extensions of existing contracts in place, this only applies if the provision for extension was not included in the original approval granted by the Trust Board.

1.3 The decisions expected during the period **31 March 2022 to 26 May 2022** are highlighted in this report and are seeking approval for the Chief Executive to authorise approval outside of the Trust Board.

1.4 In line with the review of the process for Commitment of Expenditure over the Chief Executive's Limit, all reports are now received by the Executive Management Board to ensure Executive oversight and scrutiny, to provide the Board with supporting recommendations and additional assurance as required.

2. ASSESMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Please refer to **Appendix 1** for the detailed appraisal undertaken for the expenditure proposal that the Trust Board is asked to **APPROVE**. The table below provides a summary of the decision being sought from the Trust Board:

Appendix No.	Division	Scheme / Contract Agreement Title	Period of Contract	Total Expected Maximum Value of Contract £k (Inc. VAT)
Appendix 1	WBS	Contract Extension: MAK-System BECS	Start: 01/06/2022 End: 31/05/2024 Option to extend: 24 months (fixed) + 12 months (optional)	£1,119,674 (*Inc. VAT TBC)

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
	Due authority is being sought in advance of expenditure to ensure the compliant provision of goods/services to meet operational requirements.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	No (Include further detail below)
	Undertaken on a case by case basis, as part of the procurement process.
LEGAL IMPLICATIONS / IMPACT	If applicable, as identified in each case as part of the service design/procurement process.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Further details are provided in Appendix 1of this report.

4. RECOMMENDATION

4.1   The Board is requested to **AUTHROISE** the Chief Executive to **APPROVE** the award of contract summarised within this paper and supporting appendix and **AUTHORISE** the Chief Executive to **APPROVE** requisitions for expenditure under the named agreement.

COMMITMENT OF EXPENDITURE EXCEEDING CHIEF EXECUTIVE'S LIMIT / BUSINESS JUSTIFICATION

SCHEME TITLE	MAK-System – Blood Establishment Computer System
DIVISION / HOST ORGANISATION	Corporate – Digital Services
DATE PREPARED	Tuesday 4th January 2022
PREPARED BY	David Mason-Hawes – Head of Digital Delivery
SCHEME SPONSOR	Alan Prosser – Interim Director, WBS

All Divisional proposals must be consistent with the strategic and operational plans of Velindre University NHS Trust.

1. DESCRIPTION OF GOODS / SERVICES / WORKS

In 2009, the Welsh Blood Service (WBS) entered into a 5+1+1 contract with MAK-System for its Blood Establishment Computer System (BECS). A 'BECS' refers to the IT system used by a named Blood Establishment to manage its blood supply chain activity – in the case of the WBS, this covers the IT system used to support its donor engagement, blood collection, manufacturing & testing and component issuing activity.

In practical terms, the contract covers the provision of MAK-System's 'ePROGESA' platform and its associated modules – an IT application used in Blood Establishments around the world. Currently the WBS have deployed the main ePROGESA application and are in the process of deploying the eDRM (Electronic Donor Records Management) module of ePROGESA, to provide the required IT platform to underpin a refreshed donor engagement strategy and facilitate improved donor engagement. Deployment of eDRM was due to be completed in 2019/20, but its delivery has been significantly impacted by the COVID-19 pandemic and ability of the Service to operationally support its adoption. eDRM remains a key IMTP objective for the WBS.

The service is hosted locally within the WBS data centres in WBS HQ – Talbot Green. Licencing for ongoing use of the system and maintenance and support is charged annually by MAK-System.

The formal term of the contract commenced upon deployment of the ePROGESA platform in May 2015. In July 2019, the Trust Board approved a request to take up the option of a 2-year (1+1) extension to 30th May 2022, which was subsequently agreed with MAK-System. The Board

approval to extend the main contract included approval to deploy eDRM – Trust discretionary capital funding is being used to support the (one-off) implementation costs of that module.

At the same time, the WBS Business Systems (now Digital Services) and Procurement teams worked with MAK-System to enhance some of the terms and conditions of the original contract, which at the time had become outdated. The agreement to take up the option of a 2-year (1+1) extension to the contract included agreement to the ongoing revenue costs for the live service – approx.

- £171,000 per year fixed costs (software and interface licenses, annual maintenance & support etc.)
- Provision for up to £120,000 ad-hoc costs – i.e. spending that falls outside of maintenance & support agreement, semester patch implementation costs etc.

By May 2022, it is anticipated that the total expenditure against the contract will be as follows:

- Revenue: £2,039,764
- Capital: £2,365,692
- **Total:**   **£4,405,456**

The current contract is due to expire in May 2022. Whilst a formal re-procurement was planned for 2022, it has not been possible to initiate this activity due to various service pressures, including COVID-19. Therefore, with the agreement / advice of the Procurement team, the WBS would like to request an 'as is' '2+1' (2 years fixed, one optional) extension to the current MAK-System contract. This ensures continuity of service, whilst allowing more time to consider procurement options (further outlined below in section 3) ahead of a full re-procurement exercise in 2024/25 or 2025/26. This would include consideration of an alignment of contractual approach between the WBS and other UK services.

To ensure appropriate compliance with relevant legislation, a Voluntary Ex-Ante Transparency Notice (VEAT) would be issued to support the extension. Subsequent to this, formal discussions will be opened with MAK-System to extend the existing contract under the current terms & conditions.

1.1 Nature of contract: Please indicate with a (x) in the relevant box	First time	☐	Contract Extension	☒	Contract Renewal	☐

1.2 Period of contract including extension options:	
Expected Start Date of Contract	1st June 2022
Expected End Date of Contract	31st May 2024 + option of 1-year extension to 31st May 2025.
Contract Extension Options **(e.g. maximum term in months)**	24 months (fixed) + 12 months (optional) (Maximum term = 36 months)

2. STRATEGIC FIT (*Host organisations are not required to complete Section 2*)

2.1 OUR STRATEGIC PILLARS This scheme should relate to at least one of the Trust's five strategic pillars. Please mark with a (x) in the box the relevant pillars for this scheme.	
Goal 1: Be recognised as a pioneer in blood and transplantations services across Europe.	☒
Goal 2: Be a recognised leader in specialist cancer services in Europe.	☐
Goal 3: Be recognised as a leader in stated priority areas of research, development and innovation.	☒
Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all.	☐
Goal 5: An exemplar of sustainability that supports global well-being and social value.	☐

2.2 INTEGRATED MEDIUM-TERM PLAN		

Is this scheme included in the Trust Integrated Medium Term Plan?	**Yes**	**No**
	☒	☐

If not, please explain the reason for this in the space provided.

2.3 SHAPING OUR FUTURE WELLBEING OBJECTIVES
This scheme should relate to at least one of the Trust's wellbeing objectives. Please mark with a (x) in the box the relevant objectives for this scheme.

Reduce health inequalities, make it easier to access the best possible healthcare when it is needed and help prevent ill health by collaborating with the people of Wales in novel ways.	☐
Improve the health and well-being of families across Wales by striving to care for the needs of the whole person.	☒
Create new, highly skilled jobs and attract investment by increasing our focus on research, innovation and new models of delivery.	☐
Deliver bold solutions to the environmental challenges posed by our activities.	☒
Bring communities and generations together through involvement in the planning and delivery of our services.	☐
Demonstrate respect for the diverse cultural heritage of modern Wales.	☐
Strengthen the international reputation of the Trust as a centre of excellence for teaching, research and technical innovations whilst also making a lasting contribution to global well-being.	☒

FIVE WAYS OF WORKING (SUSTAINABLE DEVELOPMENT PRINCIPLES) CONSIDERED
Please mark with a (x) in the box the relevant principles for this scheme.
Click **here** for more information

Prevention	☐	Long Term	☒	Integration	☐	Collaboration	☒	Involvement	☒

3. OPTIONS CONSIDERED
Include 'business as usual' i.e. 'do nothing'

3.1 Please state alternative options considered and reasons for declining
Do Nothing – discounted This option was immediately discounted, on the basis that it would result in the service being out of contract in respect of the primary IT system used to manage its blood supply chain activity.

Undertake Full Re-Procurement Exercise – discounted
When the 1+1 extension was considered in 2019, it was the intention to undertake a full re-procurement exercise ahead of the May 2022 end date of the current contract. However, for various reasons this has not been possible, in part due to the impact of COVID-19 and other service pressures. Discussions between the Digital Services and Procurement teams were re-established in mid-2021; however, it was felt that it would not be feasible to complete a thorough re-procurement in the required timescales due to insufficient time to redraft the specification, requirement to undertake a thorough market engagement exercise and the lack of time to manage any potential change in supplier. Procurement advice was that this would require a full procurement timetable of at least 2-3 years in total, covering service planning, formal competition / tender (estimated 4 months) and implementation.

The current contract stipulates that the Authority (Velindre University NHS Trust) must provide a minimum of 3 months' notice if they wish to terminate the contract. Procurement have advised that it would take approximately 4 months for a full, Open Tender in accordance with PCR – it is likely that any transition to a new supplier would require a minimum of 2-3 years to implement, possibly more (for context, it took approx. 5 years to deploy ePROGESA following contract award). Any new arrangement may require a period of parallel running, to ensure any new system is operating to WBS requirements.

Given the above, a full re-procurement exercise was not considered feasible within the constraints of the current (May 2022) expiry date for the current contract.

Extend Current Contract (2+1) – preferred approach
In light of the above, Procurement proposed that the WBS request a 2+1 extension to the current contract. This advice was given on the basis that a 2024 / 2025 re-procurement would offer the following benefits / opportunities:

- It would allow sufficient time to complete a full procurement exercise, to include full market analysis and opportunities for utilizing other BECS service providers.
- It would align WBS procurement activity with that planned in other UK services, namely the Scottish Blood Transfusion Service (SNBTS) – whilst not confirmed, this may present the opportunity to take forward a collaborative procurement with one or more UK Blood Establishments. NHS Blood & Transplant (NHSBT) plans in regard to their BECS are yet to be defined.
- It would remove pressure to undertake a resource-intensive procurement exercise at a time of significant service pressure, due to COVID-19 and other internal and external (including regulatory) project activities.

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option
Non-Quantifiable • Ensure service continuity – reduce risk of impacting on operational services due to the requirement to deploy and adopt a new IT system. • Prioritized project activity can be appropriately resourced through 2022/23 and 2022/23 period. • Opportunity to mitigate short-term risk of increased costs associated with new contract, through maintenance of an established agreement.

5. RISKS & MITIGATION

5.1 Please state risks of not proceeding with the scheme	5.2 Please state any mitigation to reduce the risk if the scheme is not approved
a) WBS will be out of contract for its BECS.	a) Seek approval on alternative approach to extend current contract on a 2+1 basis.

6. PROCUREMENT ROUTE

6.1 How is the contract being procured? Please mark with a (x) as relevant.			
Competition		**Single source**	
3 Quotes	☐	Single Quotation Action	☐
Formal Tender Exercise	☐	Single Tender Action	☒
Mini competition	☐	Direct call off Framework	☐
Find a Tender (replaces OJEU Public Contract regulations 2015 still apply)	☒	All Wales contract	☐
Click here for link to Procurement Manual for additional guidance			
6.2 Please outline the procurement strategy			

This paper covers the proposal for a 2+1 extension to the existing MAK-System contract. The procurement approach will either be a 'formal tender exercise' or a Single Tender Action, to be informed by the publication and feedback to the VEAT.

As noted above, a 2+1 extension to the current contract with a 2024 / 2025 re-procurement would offer the following benefits / opportunities:

- It would allow sufficient time to complete a full procurement exercise, to include full market analysis and opportunities for utilizing other BECS service providers.
- It would align WBS procurement activity with that planned in other UK services, namely the Scottish Blood Transfusion Service (SNBTS) – whilst not confirmed, this may present the opportunity to take forward a collaborative procurement with one or more UK Blood Establishments. NHS Blood & Transplant (NHSBT) plans in regard to their BECS are yet to be defined.
- It would remove pressure to undertake a resource-intensive procurement exercise at a time of significant service pressure, due to COVID-19 and other internal and external (including regulatory) project activities.

The advice provided by Procurement is that the proposed approach aids to mitigate the likely risks of challenge to any contract extension / new agreement – i.e. the placement of a corrigendum or VEAT confirming justification and placement of PIN to engage with the market for the new requirement. Please note this cannot be guaranteed.

6.3 What is the approximate timeline for procurement?

Aim to complete all procurement activity, including agreement of updated contract with MAK-System, by 31st May 2022 – to include the following milestones:

Activity	Deadline
Procurement strategy approved by WBS SMT	12th January 2022
Procurement strategy approved by Trust EMB Shape	17th February 2022
Procurement strategy approved by Trust Board	31st March 2022
Contract Briefing Paper and WG Notification 10 working days – if no comments received then proceed	1st April 2022
Publication of VEAT Notice	1st April 2022
Finalise contract with MAK-System	1st May 2022
Secure internal approval to award	13th May 2022
Issue WG Notification, allowing 15 working days for comment	13th May 2022
New agreement commences	31st May 2022

6.4 PROCUREMENT ROUTE APPROVAL

The Head of Procurement / Delegated Authority has approved the preferred procurement route	
Head of Procurement Name:	Christine Thorne
Signature:	
Date:	17/02/2022

Maximum expected whole life cost relating to the award of contract	**Excluding VAT (£k)** £1,119,674	**Including VAT (£k)** £TBC* * Awaiting confirmation from Finance re: VAT position.
The nature of spend	**Capital** ☒	**Revenue** ☒

How is the scheme to be funded? Please mark with a (x) as relevant.

    Existing budgets   ☒
    Additional Welsh Government funding ☐
    Other   ☒

If you have selected 'Other' – please provide further details below:

Annual licensing / maintenance & support costs are funded via existing Digital Services (M038) revenue budget.

Trust discretionary capital funding has been provided to support (one-off) implementation costs for eDRM – this project is already underway, having commenced prior to the COVID-19 pandemic. Work is anticipated to complete in late-2022.

7. FINANCIAL ANALYSIS

PROFILE OF EXPENDITURE

By 31st March 2022, it is anticipated that the total expenditure against the original contract will be as follows:

- Revenue: £2,039,764
- Capital: £2,365,692
- **Total: £4,405,456**

The projected further spending associated with a 2+1 extension is as follows:

EXPENDITURE CATEGORY	Year 1 22/23 (exc. VAT) £k	Year 2 23/24 (exc. VAT) £k	Year 3 24/25 (exc. VAT) £k	Total Future Years (exc. VAT) £k	Total (exc. VAT) £k	Total (inc. VAT) £k
REVENUE						
BECS Software License*	£93,154	£145,948	£148,820	-	£387,922	
ePROGESA Interface License	£22,490	£23,164	£23,858	-	£69,512	
Oracle License (BECS)	£57,343	£59,063	£60,834	-	£177,240	
Ad-Hoc Development Costs†	£120,000	£120,000	£120,000	-	£360,000	
CAPITAL						
eDRM	£125,000	-	-	-	£125,000	
Overall Total	£417,987	£348,175	£353,512	-	£1,119,674	

Notes:

- Current MAK contract assumes an 3% uplift to annual charges.

- * Year 2 & Year 3 software license costs include provision for planned increase of £50,000 per annum, to extend maintenance & support for BECS to include eDRM (once fully deployed in late-2022).

- † 120k = maximum spend. In last two years, spend has not exceeded £15k/year due to limited ad-hoc activity, COVID-19 etc. Annual spend can be variable, subject to in-year development activity. However, it may be fully utilized in Years 2 & Years 3 for ePROGESA semester patch, though this intention will be considered against the fact that the contract would be due to expire in 2023/24 or 2024/25.

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? e.g. PRINCE 2	The contract extension will be overseen by a BECS Reprocurement Task & Finish Group, reporting into the WBS Senior Management Team (SMT). Work will be overseen by the Digital Services Portfolio Project Manager and the Head of Digital Delivery.

9. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

The Lead Director, by providing email confirmation, to seek Board approval is making a declaration that all procurement procedures, standing orders and standing financial instructions requirements have been appropriately discharged and observed and that where relevant, appropriate advice and confirmation has been obtained to that effect. Procurement Services retain this confirmation electronically in the tender file.

Lead Director Name:	Alan Prosser
Signature:	
Service Area:	Interim Director – Welsh Blood Service
Date:	15/03/2022

10. APPROVALS RECEIVED

Divisions	Date of Approval:
CPPG	n/a – no capital funding implications
Divisional Senior Management Team	12/01/2022
Executive Management Board	21/02/2022

Host Organisations	Date of Approval:
NWSSP / NHS Wales Shared Services Partnership Committee	n/a
HTW – Senior Management Team	n/a

TRUST BOARD

All Wales Laundry – Transfer of Llansamlet Laundry Asset

DATE OF MEETING	31/3/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not applicable

PREPARED BY	Shared Services Partnership
PRESENTED BY	
EXECUTIVE SPONSOR APPROVED	Managing Director Shared Services Partnership

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME
Shared Services Partnership Committee	March 2019	ENDORSED FOR APPROVAL

ACRONYMS	

1. SITUATION

The paper is to provide the Velindre Trust Board with information around the transfer of the Llansamlet Laundry from Swansea Bay Health Board to NWSSP as part of the ongoing Laundry Transformation Programme which commenced in 2016.

2. BACKGROUND

The NHS Wales Laundry service comprises five laundries across Wales which provide laundry services to the whole of NHS Wales. The laundries are currently located in the following locations with the All-Wales Laundry Service provided by NHS Wales Shared Services.

- Llansamlet Laundry within Swansea Bay Health board region.
- Greenvale Laundry within Aneurin Bevan Health board region.
- Church Village Laundry within Cwm Taf Morgannwg Health board region.
- Glan Gwilli Laundry within Hywel Dda Health board region.
- Glan Clwyd Laundry within Betsi Cadwalladr Health board region.

As part of the transformation programme several key milestones were either approved or endorsed by the Shared Services Partnership Committee as Programme sponsors including:

- March 2019 – Endorsement of a single laundry provider for NHS Wales
- March 2019 – Approval of NHS Wales Shared Services becoming the single service provider for NHS Wales
- March 2021 – Both the Shared Services Partnership Committee and Swansea Bay Health board boards approved the transfer of assets to support the ongoing All Wales Laundry Programme

This was following submission of papers outlining the terms for the transfer of services which also included other key elements such as:

- Finance
- Land
- Workforce
- IT

As a result of this approval further due diligence was requested to support the transfer of the Llansamlet laundry which has now been completed and provided in the form of a solicitor's report.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The All-Wales Laundry Programme now requests the Velindre Board in line with current SSPC Standing orders for operation and transfer of assets section 8 complete the appropriate signing of the TR1 documentation which will allow the Health Board solicitors to complete the transfer activity.

The required documentation for signing has been supplied.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Safe Care
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Without approval the TR1 process cannot be completed which would impact the progress of the planned future development for laundry services in the Swansea locality
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

5. RECOMMENDATION

The NHS Wales Shared Services Partnership Committee has approved the transfer as part of the business case process and in line with the SSPC standing orders is asking Velindre NHS Trust Board is asked to:

APPROVE the All-Wales Laundry Transfer of Llansamlet Laundry Asset to allow execution of the TR1 documentation in line with existing SSPC Standing orders for operation.

SIGNATURE REQUEST BRIEFING

Llansamlet Laundry Transfer

Background Information

As part of the All-Wales Laundry programme, it was approved by both the Shared Services Partnership Committee (March 2021) and Swansea Bay Health Board, board meeting (March 2021), that the transfer of assets pertaining to Llansamlet laundry should be completed. This will support the ongoing development of the All-Wales Laundry programme and also the continued development of an All-Wales Laundry service provided by NHS Wales Shared Services Partnership (NWSSP)

To support this process and provide additional diligence as requested by Velindre, solicitors were engaged for both parities and this process has now concluded with the production of the solicitor's report The report and TR1 form which requires signatures in accordance with the SSPC Standing Orders for Operation are also provided.

Within the report section 3 reference to two areas of concern have been highlighted but have already been addressed by NWSSP.

Japanese Knotweed – A treatment programme has already commenced with great effect and continues to control and eradicate this issue

Asbestos – In line with NWSSP existing Estate compliance, HSG65 and risk management processes there is a robust management plan in place to manage and control this issue

Reason for Llansamlet Laundry Transfer

In accordance with the current SSPC Standing Orders for Operation specifically section 8 , signing and sealing of documents as this is a transfer including land.

Approval Process Undertaken and Signed off by:

The programme commenced in 2016 and has successfully progressed through a number of key milestones in both the SSPC and relevant Healthboard, Board meetings.

The supporting programme business case (PBC) has been developing in accordance with the Five Case model and reached the stage whereby the PBC , which contained the preferred option was submitted to the SSPC for approval before onward consideration at both the Investment Infrastructure board and Welsh Government

Key milestone dates and decisions :

- November 2018 - SSPC Endorsed 3 site option, which Swansea is one.
- March 2019 - SSPC Endorsed the Single service provision of laundry in Wales.
- March 2019 - SSPC Approved that NWSSP become the single service provider.
- Jul 2020 – SSPC Approved the PBC for Welsh Government Submission.
- Nov 2020 – IIB Approval.
- Nov 2020 – Welsh Government Ministerial Endorsement at PBC obtained.
- March 2021 – SSPC Approved the Initial SLA for service provision by NWSSP.
- March 2021 – SBUHB Board Approved the Transfer of assets to NWSSP.

Request to Trust Chief Executive and/or Trust Chair

Please advise who needs to sign the document(s):

Trust Chief Executive and/or Trust Chair

Both - in line with Standing Orders for Operation specifically section 8

Please advise where the document(s) need to be signed by indicating the page number(s).

Execution Box 12 , **Page 4 – Please DO NOT DATE the TR1 form.**

Once signed can we **SCAN** a copy of the signed TR1 form and send to Ian Rose

And send the original **Wet ink** signed TR1 to our solicitor in readiness for completion:

Sarah Clewett
46 Fairwater Grove West
Llandaff
Cardiff CF5 2JQ

Does the document(s) require the Trust Seal?

Yes - The TR1 will need to be executed as a deed in the usual manner with the common seal and two authorised signatories.

HM Land Registry
Transfer of whole of registered title(s)

TR1

Any parts of the form that are not typed should be completed in black ink and in block capitals.

If you need more room than is provided for in a panel, and your software allows, you can expand any panel in the form. Alternatively use continuation sheet CS and attach it to this form.

For information on how HM Land Registry processes your personal information, see our Personal Information Charter.

Leave blank if not yet registered.	1 Title number(s) of the property: WA54254
Insert address including postcode (if any) or other description of the property, for example 'land adjoining 2 Acacia Avenue'.	2 Property: Land lying to the west of Nant- y-Ffin Road, Llansamlet, Swansea
Remember to date this deed with the day of completion, but not before it has been signed and witnessed.	3 Date:
Give full name(s) of **all** the persons transferring the property. Complete as appropriate where the transferor is a company.	4 Transferor: SWANSEA BAY UNIVERSITY LOCAL HEALTH BOARD For UK incorporated companies/LLPs Registered number of company or limited liability partnership including any prefix: For overseas companies (a) Territory of incorporation: (b) Registered number in the United Kingdom including any prefix:
Give full name(s) of **all** the persons to be shown as registered proprietors. Complete as appropriate where the transferee is a company. Also, for an overseas company, unless an arrangement with HM Land Registry exists, lodge either a certificate in Form 7 in Schedule 3 to the Land Registration Rules 2003 or a certified copy of the constitution in English or Welsh, or other evidence permitted by rule 183 of the Land Registration Rules 2003.	5 Transferee for entry in the register: VELINDRE NHS TRUST For UK incorporated companies/LLPs Registered number of company or limited liability partnership including any prefix: For overseas companies (a) Territory of incorporation: (b) Registered number in the United Kingdom including any prefix:
Each transferee may give up to three addresses for service, one of which must be a postal address whether or not in the UK (including the postcode, if any). The others can be any combination of a postal address, a UK DX box number or an electronic address.	6 Transferee's intended address(es) for service for entry in the register: 2 Charnwood Court, Parc Nantgarw, Cardiff CF15 7QZ
	7 The transferor transfers the property to the transferee

8 Consideration

☐ The transferor has received from the transferee for the property the following sum (in words and figures):

☒ The transfer is not for money or anything that has a monetary value

☐ Insert other receipt as appropriate:

9 The transferor transfers with

☐ full title guarantee

☒ limited title guarantee

The implied covenants for title are modified so that:
(a) the covenant set out in section 2(1)(b) of the Law of Property (Miscellaneous Provisions) Act 1994 will not extend to costs arising from the Transferee's failure to:
(i) make proper searches; or
(ii) raise requisitions on title or on the results of the Transferee's searches; and
(b) the covenant set out in section 3 of the Law of Property (Miscellaneous Provisions) Act 1994 will extend only to charges or incumbrances created by the Transferor.

10 Declaration of trust. The transferee is more than one person and

☐ they are to hold the property on trust for themselves as joint tenants

☐ they are to hold the property on trust for themselves as tenants in common in equal shares

☐ they are to hold the property on trust:

11 Additional provisions

1.1   The following definitions apply in this transfer.

LPMPA 1994: the Law of Property (Miscellaneous Provisions) Act 1994.

1.2   The disposition effected by this transfer is subject to:

1.2.1   any matters contained or referred to in the entries or records made in registers maintained by HM Land Registry as at 13 APRIL 2021 at 13:42:51 under title number WA54254;

1.2.2   any matters discoverable by inspection of the Property before the date of this transfer

1.2.3   any matters which the Transferor does not and could not reasonably know about;

1.2.4   any matters disclosed or which would have been disclosed by the searches and enquiries made by the Transferee or which a prudent buyer would have made before entering into a contract for the purchase of the Property;

1.2.5   public requirements; and

1.2.6   any matters which are unregistered interests which override registered dispositions under Schedule 3 to the Land Registration Act 2002.

1.3   All matters recorded at the date of this transfer in registers open to public inspection, are deemed to be within the actual knowledge of the Transferee for the purposes of section 6(2)(a) of the LPMPA 1994, notwithstanding section 6(3) of the LPMPA 1994.

1.4   The Property will not, by virtue of this transfer, have any rights or easements or the benefit of any other matters over land retained by the Transferor other than those (if any) which are expressly mentioned in or granted by this transfer and section 62 of the Law of Property Act 1925 is qualified so as not to include any liberties, privileges, easements, rights or advantages over land retained by the Transferor except as expressly mentioned in or created by this transfer.

The transferor must execute this transfer as a deed using the space opposite. If there is more than one transferor, all must execute. Forms of execution are given in Schedule 9 to the Land Registration Rules 2003. If the transfer contains transferee's covenants or declarations or contains an application by the transferee (such as for a restriction), it must also be executed by the transferee.

If there is more than one transferee and panel 10 has been completed, each transferee must also execute this transfer to comply with the requirements in section 53(1)(b) of the Law of Property Act 1925 relating to the declaration of a trust of land. Please refer to *Joint property ownership* and *practice guide 24: private trusts of land* for further guidance.

12   Execution

EXECUTED as a DEED
by affixing the Common Seal of
**SWANSEA BAY UNIVERSITY
LOCAL HEALTH BOARD**
in the presence of:

…………………………
Authorised signatory

…………………………
Authorised signatory

Examples of the correct form of execution are set out in practice guide 8: execution of deeds. Execution as a deed usually means that a witness must also sign, and add their name and address.

Remember to date this deed in panel 3.

EXECUTED as a DEED
by affixing the Common Seal of
VELINDRE NHS TRUST
 in the presence of:

…………………………
Authorised signatory

…………………………
Authorised signatory

DATED

REPORT ON TITLE

ON

Central Laundry situated on land lying to the west of Nant- y – Ffin Road,

Llansamlet, Swansea

FOR

VELINDRE NHS TRUST

CONTENTS

_____

CLAUSE

SCHEDULE

ANNEX

1.   **Interpretation**

The following terms are used in this report:

Benefits: any right, easement, restriction, stipulation, restrictive covenant, mining or mineral right, franchise or other interest that benefits the Property

Contract: the agreement to be entered into between you and the Seller for the sale and purchase of the Property.

Incumbrances: any right, easement, restriction, stipulation, restrictive covenant, mining or mineral right, franchise or other interest to which the Property is subject

LTT: land transaction tax

Property: The property described in paragraph 5 of this report.

Seller: Swansea Bay University Local Health Board of 1 Talbot Gateway, Baglan Energy Park, Baglan, Port Talbot, Swansea SA12 7BR.

VAT: value added tax chargeable under the Value Added Tax Act 1994.

2.   **Scope of the review and limitation of liability**

2.1   This report has been prepared for the sole benefit of you, **Velindre NHS Trust**, in connection with the proposed transfer of the Property from the Seller and for no other purpose.

2.2   The contents of this report are private and confidential. It must not be relied on by or made available to any other party without our written consent.

2.3   The report is based on our review of the title documents, search results, planning documents and replies to pre-contract enquiries given by the Seller.

2.4   We have not inspected the Property and are unable to advise on the physical condition of the Property. We would advise you to arrange for a survey of the Property to be carried out if this has not already been arranged. A survey should identify any physical defects in the Property and may warn of potential defects. It is important to be aware of any defects in the Property before we complete the transfer. Once you have completed the transfer, you will not be entitled to any compensation from the Seller if you have to put right any defects.

2.5   We have made no enquiries of the actual occupiers of the Property and have not taken any steps to verify independently the information supplied by the Seller in replies to enquiries.

2.6   We express no opinion on the commerciality of the transaction. We are unable to advise on the value of the Property. We recommend that you have the Property professionally valued. You should ensure that the valuer is aware of the matters mentioned in this report, as they may affect the value.

3.   Executive summary

This is a summary of the major issues that we think should be brought to your attention:

3.1   **Japanese knotweed**- we understand that the site on which the Property is situated is affected by Japanese knotweed, the Sellers have not provided any information regarding the location or any treatment of the Japanese knotweed, however Velindre NHS Trust have confirmed that a pre-acquisition survey was undertaken which revealed the knotweed and they have put in place their own treatment programme for the treatment of the knotweed which is underway. I understand that no further enquiries are necessary with regard to this issue, however please let me know if there are any specific enquiries you want me to raise with the Seller before completion.

3.2   **Asbestos**- the Property contains asbestos. The Seller has not provided a current Asbestos Survey, however an Asbestos Management survey dated February 2020 has been provided by the Seller which has revealed the location of some Chrysotile asbestos. A copy of the survey is attached to this report at Annex B. It is advised that Velindre NHS Trust carry out their own Asbestos survey as soon as possible after completion and that an asbestos management plan is put in place as soon as possible. Velindre NHS Trust should notify all staff in occupation of the Property of the location of all asbestos present in the Property.

4.   Purchase price and other contract terms

4.1   This is a transfer for nil consideration from the Seller to Velindre NHS Trust.

5.   The Property

5.1   The Property is the freehold land and buildings known as Land lying to the west of Nant-y – Ffin Road, Llansamlet, Swansea. The Property is registered at the Land Registry under title number WA54254. The class of title is absolute freehold title. Absolute title is the best class of title available.

5.2   If your title to the Property is freehold, it means that you own the Property outright, in perpetuity.

5.3   A plan showing the Property edged in red is attached as ANNEX A. Please check the plan carefully to ensure that it accurately reflects the extent of the land that you believe you are buying. The plan may not show the exact location of the boundaries of the Property. You should inspect the Property and let us know if there are any discrepancies between the plan and the site inspection.

5.4   The registered owner of the Property is the Seller Swansea Bay University Local Health Board.

6.   **Matters benefiting the Property**

The Property enjoys the following Benefits:

6.1   There are no such Benefits revealed in the title documents.

7.   **Matters burdening the Property**

The Property is subject to the following Incumbrances:

7.1   There are no such Incumbrances revealed in the title documents.

8.   **Search results**

8.1   **Index map search**

An index map search confirms whether a property is registered at the Land Registry (and, if so, the title number(s) under which it is registered). If a property is not registered, an index map search will show whether a property is subject to any pending applications for registration or any cautions against first registration.

The result of our index map search confirmed that the Property is registered under the title number(s) stated in paragraph 5.3 of this report.

8.2   **Local land charges search**

A search of the local land charges register shows matters such as compulsory purchase orders, tree preservation orders, planning enforcement notices and financial charges registered against a property. You should note that the search result provides a snapshot of the register on the date of the search. Local land charges registered after the date of the search will still bind a property.

The local land charges search was provided by Thames Water Property Searches. The result of the search did not show any entries that adversely affect the Property.

8.3 **Local authority search (including any optional and additional enquiries**)

A local authority search reveals important information about a property, such as planning permissions and building regulation consents, proposals for road schemes, environmental and pollution notices and whether any part of the property is registered as common land or as a town or village green. A local authority search only reveals matters that affect the property being searched against. It will not disclose matters that affect neighbouring properties. If you require information about neighbouring properties, you should let us know so that further enquiries can be made.

The local authority search was provided by Thames Water Property Searches. The result of the search did not show any entries that adversely affect the Property and revealed the following information:

The Property abuts Nantyffin (South) Road which is a highway maintainable at public expense. However, please let us know if you are aware of anything that may indicate that the Property does not abut the highway, for example, a strip of concrete or a grass verge between the Property and the road surface. Please also let us know if you are aware that access to the Property is gained other than from the highway or if you plan to move the access to the Property from its current position.

No part of the Property is registered as common land or as a town or village green. The possibility of land being common land or a town or village green is significant, as the land may be subject to third party rights and the owner's ability to use or develop the land may be restricted. Even if land is not registered as common land or a town or village green at the date of the search, it is possible for common land or new town or village greens to be registered in some circumstances. You should let us know if you are aware of anyone other than the Seller using the Property for any purpose.

There is no public right of way which abuts on or crosses the Property.

There are no statutory notices subsisting in relation to the Property. The Property is no in a conservation area and there has been no Compulsory purchase order made against the Property. No gas pipeline has been put through on or under the Property.

There are no entries in the register of applications, directions and decisions relating to the consent for the display of advertisements.

There are no listed entries for the Property in the register kept pursuant to s28 of the Planning (Hazardous Substances) Act 1990.

8.4 **Drainage and water enquiries**

The replies to drainage and water enquiries show whether a property is connected to the mains water supply and mains drainage. The replies may also show the location of public sewers within the boundary of a property and other such matters that may restrict development.

Replies to the drainage and water enquiries were provided by Welsh Water. The replies did not show any entries that adversely affect the Property and revealed the following information:

The Property is connected to the mains water supply on a metered basis.

Foul and surface water from the Property drain to a public sewer via a length of private sewer or drain. This means that you may be liable for the cost of maintaining and repairing the private sewer or drain. If use of that sewer or drain is shared with another property, then responsibility for its maintenance may have transferred to the local drainage and water authority.

There is no public sewer, disposal main or lateral drain within the boundary of the Property.

There is a surface water drainage charge payable for the Property at a rate of £1.31 p/m3 of water used for each financial year.

The Property is not recorded as being at risk of internal flooding due to overloaded public sewers, however there is no record in relation to the length of private sewer or drain.

8.5   **Flood risk search**

A flood risk search gives a high-level assessment of the risk to the Property from the four main types of flooding (river, coastal, groundwater and surface water). It is important to know this information before committing to buy a property, as it can affect the value of the Property and the terms of your building's insurance for Property.

The flood risk search was provided by Groundsure Screening. The result of the search showed that the Property is unlikely to be at risk from flooding.

8.6   **Environmental search**

If a local authority determines that land is contaminated, and the party who caused or knowingly permitted the contamination cannot be found, the current owner or occupier of the land may be required to remedy the contamination. This can be an expensive

process, so it is important to assess the risk of land being contaminated before committing to buy a property.

An environmental data search can be used to establish the risk of land being contaminated, by collating information from regulatory bodies, floodplain data and a review of current and historic land uses. This type of search is also known as a "desktop search". An environmental data search does not include a site visit or testing of soil or groundwater samples.

The environmental data search was provided by Groundsure Environmental. The result of the search showed that the Property is unlikely to be classed as contaminated land. Groundsure considers there to be an acceptable level of risk at the site from contaminated land liabilities despite some potentially contaminative land uses being identified, particularly in relation to the historical and current land uses on and off site. These land uses are not considered a significant risk if the site remains in its current use, however if the Property is to undergo a change of use or redevelopment the planning process is likely to require contaminated land investigations. It is recommended this is completed at an early stage of planning.

The Property is assessed to have potential for natural or non-natural ground subsidence. The search revealed that the Property is indicated to lie within an area that could be affected by infilled land. This may lead to potential instability in any future development or alteration of the ground including planting or removing trees. You may with to have a survey carried out if you have any concerns regarding ground instability and please let me know if you wish to do this prior to completion.

A record of planning applications relating to the exploration and extraction of gas and oil have been identified in the locality of the Property, but not in close proximity. Existing or proposed wind installations and solar installations have been identified within 5km of the Property. One or more nationally significant energy infrastructure projects have been identified within 5km of the Property.

The Property is not within a radon affected area. Local levels of radon are considered normal.

The Property is within 250 meters of a railway line or station.

8.7   **Coal mining search**

A coal mining search provides details of past, present and future coal mining activity at a property. The search also indicates if there are mine shafts on the property and whether any mining activities may cause subsidence.

The coal mining search was provided by The Coal Authority. The result of the search revealed the following information:

The Property lies within a coal mining area.

The Property is in a surface area that could be affected by underground mining in 3 seams of coal at 110m to 180m depth, and last worked in 1897. Any movement in the ground due to coal mining activity associated with these workings should have stopped by now.

The Property is not within a surface area that could be affected by present underground mining and the Property is not in an area where the Coal Authority has received an application for nor is it in an area where a licence has been granted to remove or work coal by underground methods.

The Property is not in an area likely to be affected from any planned future underground coal mining. However, reserves of coal exist in the local area which could be worked at some time in the future. No notices have been given under section 46 of the Coal Mining Subsidence Act 1991, stating that the land is at risk of subsidence.

There are no recorded coal mine entries known to the Coal Authority within 20 meters of the boundary of the Property.

The Coal Authority is not aware of any damage due to geological faults or other lines of weakness that have been affected by coal mining.

The Coal Authority has not received a damage notice or claim for the Property, or any Property within 50 meters of the boundary since 31 October 1994.

The Coal Authority has no record of a mine gas emission requiring action.

The Property has not been subject to remedial works by or on behalf of the Coal Authority under its Emergency Hazard Call Out procedures.

8.8   **Chancel repair search**

A chancel repair search shows whether the owner of a property may be liable to contribute towards the cost of repairs to the chancel of a parish church. We would advise you not to contact any parish churches directly in relation to chancel repair liability, as this may limit the availability of indemnity insurance.

The chancel repair search was provided by Chancel check. The result of the search showed that the Property is not within the historical boundary of a parish which continues to have a potential chancel repair liability.

8.9   **Land Registry official search**

A Land Registry official search shows whether the register for a property has changed since the copy of the register was originally issued to the buyer's solicitor. The search also gives the applicant a "priority period". Any new entries that are registered in the priority period will not bind the applicant, as long as the Land Registry receives their application for registration within the priority period.

The result of our Land Registry official search did not show any entries that adversely affect the Property.

9.   Replies to pre-contract enquiries

You should note the following information provided by the Seller in their replies to our pre-contract enquiries:

9.1   The Seller has confirmed that to their knowledge there have been no alterations to the boundaries of the Property and the Seller has maintained the front boundary.

9.2   There are no rights benefitting the Property so far as the Seller is aware save as revealed by the title documents reported on in paragraphs 6 and 7 above, however the Seller has made no enquiries in that regard and the Property is sold subject to any there might be. The Buyer must rely on its own inspection and survey.

9.3   The Seller has not confirmed which utilities serve the Property and has confirmed that the Buyer must rely on its own inspection, survey and enquiries.

9.4   The Seller has confirmed that the existing use of the Property is a laundry, however there are no planning documents confirming the use as a laundry.

9.5   The Seller has confirmed there is no EPC for the laundry. The Property does not fall within an EPC exemption and I would expect one to be produced by the Seller in a transaction on the open market. As this is a transfer between a health board and Velindre NHS Trust, please advise if you require an EPC certificate to be commissioned by the Seller before completion.

9.6   The seller has confirmed that as far as they are aware there have been no disputes affecting the Property its use and occupation.

10.   Planning and building regulations

Our investigations have not revealed an express consent for the use of the Property as laundry. However, we understand that the Property has been used as laundry for a considerable number of years and no enforcement action has been taken by the planning authority.

10.1 The Property has a full plans conditional planning approval for Re-roofing of the existing roof external staircase on roof and railings and barrier system on the perimeter of the roof issued on 12.09.2016. The Seller has confirmed that these works were carried out, however there is no building completion certificate or warranty available for the new roof. The Seller confirmed that the defects liability expired on the 7th November 2018 and they are not aware of any warranties. They also confirmed that there may be some comeback through the main building contract (main contractor) if there were problems in the future, however no further details have been provided.

10.2 The Property has a full plans conditional planning approval for the Single Storey Side extension to form a clean store granted on 26th January 1998. The search does not reveal that a building completion certificate was issued in respect of these works. The Seller cannot provide any further information.

10.3 The Property has a full plans conditional planning approval for the retention of two storey building to provide workshop and changing room which was granted on 17th November 1997. The search does not reveal that a building completion certificate was issued in respect of these works. The Seller cannot provide any further information.

10.4 The Property has a full plans conditional planning approval for a proposed modular building to provide a workshop and changing room granted on 9th September 1996. The search does not reveal that a building completion certificate was issued in respect of these works. The Seller cannot provide any further information.

10.5 No notices have been issued by the Local Authority in respect of the contravention of any building on the Property.

10.6 The Property is not in a radon affected area.

11.   Insurance

The Seller will retain the risk in the Property until completion. You should arrange insurance of the Property from the date of completion.

12.   LTT

The purchase of the Property will not be subject to LTT.

13.   Conclusion

Subject to the matters referred to in this report we are of the opinion that upon completion of the purchase of the Property and registration at the Land Registry you will obtain a good and marketable title to the Property.

....

Signed **NWSSP Legal & Risk**

Dated.....24th January 2022.

ANNEX A   **Annex A: Plan of the Property**

Annex B   **Asbestos Report**

TRUST BOARD

TRUST SEAL REPORT – JANUARY 2022 – MARCH 2022

DATE OF MEETING	31/03/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

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 APPROVAL

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

ACRONYMS	
TCS	Transforming Cancer Services
nVCC	New Velindre Cancer Centre
NWSSP	NHS Wales Shared Services Partnership

1. SITUATION/BACKGROUND

1.1 The contents of the Trust Board Seal Register have been approved by the Chair and the Chief Executive Officer of the Trust at every Seal request (period January 2022 to March 2022).

1.2 Board members are asked to view the contents of the report and further information or queries should be directed to the Director of Corporate Governance and Chief of Staff.

2. ASSESSMENT/SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Option Appraisal/Analysis: Please refer to the Seal Register at Appendix 1.

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	Yes (Include further detail below)
	A record that the Trust Board Seal Register has been approved by the Chair and the CEO of the Trust at every Seal request.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

4.1 The Trust Board is asked to **APPROVE** the contents of the Trust Board Seal Register included in Appendix 1.

Appendix 1 – Seal Register

Date	Document Details	Signed
26 January 2022	Call off Contract for Enabling Works new Velindre Cancer Centre Project Management and full design team services framework schedule 4 incorporating the professional services contract April 2013 (x 2copies)	Prof Donna Mead, Chair Mr. Steve Ham, CEO
26 January 2022	Enabling Works new Velindre Cancer Centre Form of Agreement incorporating the Professional Services Contract April 2013 between Velindre National Health Service Trust and Williams Sale Partnership Limited United Kingdom Limited.	Prof Donna Mead, Chair Mr. Steve Ham, CEO
01 February 2022	Call of Contract for Regional Supply Chain Partner Welsh Blood Service Sustainable Infrastructure (x 2 copies)	Prof Donna Mead, Chair Mr. Steve Ham, CEO
01 February 2022	Call of Contract for Regional Project Manager Welsh Blood Service Sustainable Infrastructure (x 2 copies)	Prof Donna Mead, Chair Mr. Steve Ham, CEO
01 February 2022	Call of Contract for Regional Cost Advisor Welsh Blood Service Sustainable Infrastructure (x 2 copies)	Prof Donna Mead, Chair Mr. Steve Ham, CEO
01 February 2022	Nexus Security National Health Service Wales Velindre Hospital (x 1 copy)	Prof Donna Mead, Chair Mr. Steve Ham, CEO
01 February 2022	Velindre University NHS Trust Contract / Purchase Acceptance Briefing (x 1 copy)	Prof Donna Mead, Chair Mr. Steve Ham, CEO
17 February 2022	new Velindre Cancer Centre Enabling works between Velindre University NHS Trust and Walters United Kingdom Limited (x 1 copy)	Prof Donna Mead, Chair Mr. Steve Ham, CEO
25 March 2022	Engrossment transfer Matrix House Swansea Enterprise Park, Swansea, SA6 8RE (x 1 copy)	Prof Donna Mead, Chair Mr. Carl James, Acting CEO
25 March 2022	Tenancy at Will relating to Part of the Ground Floor of Monthmouth House, Mamhilad Park Estate, Pontypool, NP4 0HZ (x 1 copy)	Prof Donna Mead, Chair Mr. Carl James, Acting CEO

TRUST BOARD

PENSION FLEXIBILITIES POLICY

DATE OF MEETING	31st March 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Sarah Morley, Executive Director or OD and Workforce
PRESENTED BY	Sarah Morley, Executive Organisational Development & Workforce
EXECUTIVE SPONSOR APPROVED	Sarah Morley, Executive Organisational Development & Workforce

REPORT PURPOSE	FOR DISCUSSION / REVIEW

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME
Local Partnership Forum	2/3/22	NOTED
EMB	7/3/22	DISCUSSED
JLNC	10/3/22	NOTED
EMB	21/3/22	ENDORSED FOR APPROVAL

ACRONYMS	
JLNC	Joint Local Negotiating Committee

1. SITUATION/BACKGROUND

The Board is asked to **APPROVE** the draft policy attached.

This policy outlines an option for employees who are current active members of the NHS Pension Scheme (the NHS Scheme) who can demonstrate that they will be affected by the lifetime allowance (LTA) or annual allowance (AA) in respect of their pension savings.

The Policy was Endorsed for Board Approval at EMB on the 21st March following discussion at a number of previous Trust groups.

2. ASSESMENT / SUMMARY OF MATTERS FOR CONSIDERATION

A model policy has been developed nationally by NHS Employers, NHS organisations in conjunction with the BMA. Local NHS Organisations have been asked to consider and adopt the policy.

This policy has been introduced to address operational risks that have been identified as a result of the pension tax regime. In particular, Health Boards/Trusts/SHAs have experienced a number of requests for reduced contractual hours, a reluctance to take on additional work and a desire to focus on private work as a direct result of the pension tax regime. This policy is an attempt to address these operational issues by setting out an alternative option.

Other options for addressing this issue are available and these are set out in the "Pension tax guidance for employers - Local measures to support staff and service delivery" document published by NHS Wales Employers.

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	Staff and Resources
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
	The EQIA will be undertaken in parallel with approvals processes.
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 application of this policy is designed to ensure that the financial impact in cost neutral to NHS organisations.

4. RECOMMENDATION

4.1   The Board is asked to **APPROVE** the policy attached.

Velindre University NHS Trust Employer Pension Contributions - Alternative Payment Policy

Employer Pension Contributions –Alternative Payment Policy

1. Introduction

1.1. This policy outlines an option for employees who are current active members of the NHS Pension Scheme (the NHS Scheme) who can demonstrate that they will be affected by the lifetime allowance (LTA) or annual allowance (AA) in respect of their pension savings. For most employees, it will likely be in their best financial interests to remain in the NHS Pension Scheme. This policy is only intended for those employees affected by the LTA or AA tax issue and sets out one option for these individuals. This may not be the best financial option for affected employees and so individuals should consider this policy and any associated information carefully before making a decision. Employees are strongly encouraged to obtain their own financial advice before making any changes.

1.2. This policy has been introduced to address operational risks that have been identified as a result of the pension tax regime. In particular, Health Boards/Trusts/SHAs have experienced a number of requests for reduced contractual hours, a reluctance to take on additional work and a desire to focus on private work as a direct result of the pension tax regime. This policy is an attempt to address these operational issues by setting out an alternative option. Other options for addressing this issue are available and these are set out in the "Pension tax guidance for employers - Local measures to support staff and service delivery" document published by NHS Wales Employers.

1.3. This policy does not form part of any employee's contract of employment.

1.4. This policy will allow those staff who believe they may be impacted by the LTA or an in-year AA tax charge an alternative choice, allowing them to continue to work in their present role at their present level of service, and continue to develop in their career journey. This policy will operate with an effective date of the 1st April 2022.

1.5. Employers would like to see flexibilities introduced into the NHS Pension Scheme which support continued membership through providing flexibility on the level of an individual's pension accrual. Such flexibilities do not currently exist and the content of this policy will kept under review and considered in the light of any progress on the introduction of pension flexibilities within the NHS Pension Scheme.

2. Purpose

2.1 To provide an optional alternative to pension contribution for those employees who can demonstrate that they are impacted by the LTA or AA pension tax thresholds and decide to opt out of the pension scheme thereby choosing to forego pension tax relief.

3. The options

3.1. Where employees are currently active members of the NHS Scheme, and consider that they will be affected by the lifetime allowance (LTA) or annual allowance (AA) they can:

a. Continue in the NHS Scheme and bear any additional tax charges that arise (in the tax year for an AA charge or at retirement under the LTA arrangements); or

b. Opt out of the NHS Scheme and apply to be paid an alternative payment as explained in 3.2 below ("alternative payment").

Individuals who opt out of the NHS Scheme will become deferred members and will not be able to make any further money purchase, added years or additional voluntary contributions into the NHS Scheme.

3.2 The alternative payment that will be paid in the event of an opt out of the NHS Pension Scheme will be the sum equivalent to the Employer's Contribution (amount that the employer ordinarily pays into the relevant NHS Pension Scheme if the employee were still a member of the NHS Pension Scheme) net of the employer's National Insurance contributions, maintaining cost neutrality to the NHS. This will be paid as a supplement to salary and so will be subject to income tax.

This is circa 12.4% of pensionable pay (14.38% of pensionable pay net of employer's national insurance contributions at a rate of 13.8%). Although the employer contribution increased by 6.3% from 1 April 2019, the funding for this increase is not available to Health Boards/Trusts.

Pensionable pay for the purpose of calculating the alternative payment will be determined by the Trust but will be based on what the pensionable pay would have been for the purpose of calculating employer contributions paid by the Trust to the NHS Scheme had the individual continued to participate in the NHS Scheme.

3.3. Where individuals opt out of the NHS Pension Scheme it is their responsibility to provide the pension scheme administrator with effective notice of the opt-out. Individuals must provide the Trust with a copy of this notification and evidence that the opt-out is effective, before any alternative payment will be paid.

3.4. Where individuals opt out of the NHS Scheme there may be a significant impact on the level of benefits which may be received from the NHS Scheme. In particular, there is likely to be a notable reduction in ill-health benefits and death benefits from the NHS Scheme, and potentially redundancy benefits. Individuals considering the alternative payment should carefully review and consider the impact of opting out of the NHS Scheme on all of their benefits.

3.5. This is only one option that may be available. Other options may be available and the "Pension tax guidance for employers - Local measures to support staff and service delivery" document published by NHS Wales Employers outlines a range of other flexibilities. Where individuals are concerned about this issue, it is suggested that the matter is discussed with the Trust to determine the potential options available.

4. Impact of the alternative payment

4.1. The alternative payment will not form part of base salary and would not be included in the calculation of any overtime, or other entitlements.

4.2. Although not forming part of base salary, the alternative payment will increase the amount paid each month. It will also impact on the following:

a. The amount of holiday and sick pay. Such calculations will include an element to reflect the alternative payment.

b. The amount of any redundancy pay calculation, but only in so far as any statutory cap. Where an individual's weekly pay is higher than any statutory cap applicable at the point of redundancy, then the alternative payment will not be included in the calculation.

c. Income for the purposes of the tapered annual allowance may be higher than before and so the annual allowance may reduce for any pension savings already built up in the tax year. This means individuals may be entitled to a lower amount of tax relief on their pension contributions.

4.3 The alternative payment will be paid in equal monthly instalments in arrears. Payments will be subject to deduction for income tax and national insurance contributions. In deciding on the alternative payment, individuals may wish to consider whether it would be financially beneficial to receive the alternative payment (subject to income tax and national insurance contributions) as compared with paying an additional pension tax charge by staying in the NHS Scheme and also consider the effect on pension benefits and growth by staying in the Scheme versus opting out. Employees who are considering opting out of the NHS Pension Scheme are therefore strongly encouraged to obtain their own independent financial advice.

4.4. The model policy will be reviewed at the start of each financial year and will be considered in the light of any progress on the introduction of pension flexibilities within the NHS Pension Scheme.

5. Making a request for the alternative payment

5.1. In order to make a request under this policy employees must comply with all of the following:

➢ be in the employment of Velindre University NHS Trust.
➢ be an active member of an NHS Pension Scheme at the point of application.
➢ be able to evidence that they have a reasonable expectation of an AA tax charge for the respective financial year or be able to evidence that they have reached the LTA limit.

As indicated above individuals must be reasonably expecting a tax charge for the financial year for which they are making an application for the alternative payment. Given that any tax charge will not be confirmed until after the end of the tax year (saving statements are issued in the October following the end of the respective tax year) an assessment must be made to provide a best estimate to evidence the likelihood of an AA tax charge arising. The NHS Employers Annual Allowance Ready Reckoner may be used to provide an indication of the likelihood of an AA charge.

5.2. Individuals are responsible for obtaining whatever advice is necessary for them to make an informed decision, including where appropriate (though not limited to) professional advice from an accountant or independent financial advisor, guidance from the NHS pension scheme (Member hub | NHSBSA), information from reputable sources such as professional organisations and unions, HM Revenue & Customs.

5.3 As noted in paragraph 3.2 the alternative payment that will be paid will be the sum equivalent to the Employer's Contribution (amount that the Trust would pay into the NHS Pension Scheme in the financial year if the applicant were still a member of that NHS Pension Scheme) net of the employer's National Insurance contributions, maintaining cost neutrality to the NHS. This will be paid as a supplement to salary and so will be subject to income tax.

5.4 Meeting the criteria as set out in paragraph 5.1, does not automatically mean that applications for the payment of employer contributions will be approved. The approval process as set out in section 8 will consider all applications as set against the individual submission and the need for each outcome to be clearly recorded as to the reason for its approval or rejection.

6. Application process and evidence requirements

6.1 The section below provides guidance for individuals on the information required to support an application:

a. Retrospective Evidence that you are or would be affected by the AA. This will usually be in the form of acceptable documentary evidence from NHS Business Services Authority confirming the annual increase in your NHS pension benefits and acceptable documentary evidence confirming that you may be subject to an annual allowance tax charge e.g from the NHS Employers Annual Allowance Ready Reckoner (note that where individuals are subject to the tapered annual allowance this may take the form of proof of earnings from all income sources);

b. Prospective Evidence that you will be affected will typically be in the form of pension/pay modelling data using evidence from sources contained within 5.1 & 5.2 taking into account, for example, incremental pay progression and changes in working patterns and/or proof of projected income from multiple sources in the relevant financial year or a Total Reward Statement reflecting a level of pension accrual which will exceed the LTA

7. Process for applications

7.1 Application for an alternative payment should be made on the application form attached to this policy. All applications should be accompanied by a completed opt out form.

7.2 The application will be verified by the Trust to determine whether applicants meet the eligibility criteria.

7.3 If eligible, payroll will calculate the amount of the alternative payment and notify the applicant of this.

8. Approval

8.1 The Trust will establish an oversight decision making panel with clear accountability to the Chief Executive and Director of OD and Workforce. This oversight panel will comprise Deputy Director of OD and Workforce; Deputy Director of Finance and the Chief of Staff and will co-ordinate the process. The Panel will be under a duty to take into account the eligibility criteria defined in this policy in approving or rejecting applications and must record the justification for each decision.

8.2 The panel will meet monthly so that all applications can be reviewed considered and a decision made and processed within ten working days of receipt of completed application forms, appropriate supporting evidence and completed opt out forms. The Panel will report outcomes to the Chief Executive and Director of OD and Workforce on a regular basis.

8.3 If once the application has been reviewed and processed and is accepted, the employee will be issued a letter confirming this payment (which will be temporary in the case of Annual Allowance approvals), within five working days of the panel's decision.

Implementation

9.1 Where an application has been successfully reviewed and processed, the applicant's opt out of the NHS Pension Scheme(s) will be activated by the employer. The alternative payment will be paid to the employee on a monthly basis in line with usual pay dates.

9.2 Any changes to terms of employment will continue as agreed by the Trust and the continuance of the alternative payment will be subject to the Trust's over-riding legal duties. The alternative payment will apply to an individual's current role only. In the event that an individual in receipt of the allowance changes roles, then the continuation of the alternative payment will be at the absolute discretion of the Trust, although not unreasonably withheld. If individuals subsequently choose to reduce sessions/working hours while in receipt of the alternative payment, this will automatically trigger a review to assess ongoing eligibility.

9.3 For individuals who determined that they would be affected by a AA charge and are in receipt of an alternative payment, this will only be for the duration of the financial year within which the AA charge would have been incurred and will therefore cease at the end of the financial year i.e. 31st March. At this point, the alternative payment will cease and individuals should determine whether they wish to be re-enrolled into the NHS Pension Scheme and make the necessary arrangements. If they choose not to re-join at this point they will remain out with the NHS Pension Scheme until the next date within their organisation for auto enrolment when they will be automatically re-enrolled, providing they meet the necessary auto re-enrolment requirements. An opt-out can then be submitted if desired.

9.4 Where the individual considers that they would be affected by an AA charge in the subsequent financial year a new alternative payment application can be made.

10. Appeals Process

Where a Panel decision review for processing is in dispute this will be referred to the Director of OD and Workforce for a final decision and there is no further right of appeal and no right to raise a grievance under the Respect & Resolution policy about the process or outcome.

APPLICATION FOR AN ALTERNATIVE PAYMENT

Please complete in full and forward to the Director of OD and Workforce

Name:	
Post:	
Payroll Number:	
National Insurance No:	
SB Number for Pension Scheme:	

The alternative payment will start from 1st of the month. Please specify which date: *(note: this should be the 1st of the month, and should be the same as the date given in the opt out form)*	

Please submit this form by 21st of the month preceding the month you wish the alternative payment to commence.

Declaration:

I confirm that I have taken the necessary steps to obtain appropriate advice in respect of my voluntary decision to opt out of the NHS Pension Scheme and understand the consequences of opting out of the NHS Pension Scheme on further and future pension savings and accrual.

I have attached evidence that I have either:

   i.   a reasonable expectation of exceeding the Annual Allowance for pension growth in the current financial year and that this breach is likely to generate a tax charge or;
   ii.   reached the level of pension savings which would generate a Lifetime Allowance Charge

I confirm that to the best of my knowledge the information I have provided on this form is correct, including information I have provided to HMRC and/or NHSBA

I confirm that I understand that opting out of the NHS Pension Scheme will mean I will not benefit from active members provisions including ill health retirement benefits and death in service benefits.

Name…………………………………….…………………………………

Signature ....……………..Date ……………………

Authorised by …………………………………Date……………………

(Chair of Panel)

Authorised by …………………………………Date……………………

(Director of OD and Workforce)

![Velindre University NHS Trust / GIG Cymru NHS Wales logo - Ymddiriedolaeth GIG Prifysgol Felindre]

TRUST BOARD

Gender Pay Gap Report 2020/2021

DATE OF MEETING	31st March 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Claire Budgen: Head of Organisational Development, Paola Spiteri EDI & OD Manager
PRESENTED BY	Sarah Morley, Executive Organisational Development & Workforce
EXECUTIVE SPONSOR APPROVED	Sarah Morley, Executive Organisational Development & Workforce

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME
Executive Management Board	21/03/2022	ENDORSED FOR APPROVAL

ACRONYMS	

1.   SITUATION/BACKGROUND

1.1   The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 apply to a list of 'specified public authorities' in relation to the publication of their gender pay gap data, which came into force on 31 March 2017. These regulations underpin the Public-Sector Equality Duty and require relevant organisations to annually publish their gender pay gap by 30th March each year. This includes the mean and median gender pay gaps; the mean and median gender bonus gaps; the proportion of men and women who received bonuses; and the proportions of male and female employees in each pay quartile.

1.2   It is important for the Trust to analyse its pay data, to gain an understanding of any gaps, what this means for its workforce and as appropriate, use this information and data to develop an action plan that will respond to bridging any identified gender pay gaps.

1.3   The report attached therefore provides the Board with the information to approve the publication of the Trust Annual Gender Pay Gap Report.

1.4   Submitted to EMB on 21st March 2020.

2.   ASSESMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1   The attached report provides data and narrative of activities for the mean and median gender pay gaps; the mean and median gender bonus gaps; the proportion of men and women who received bonuses; and the proportions of male and female employees in each pay quartile to ensure the Trust meets its legal requirements.

2.2   The report shows information of the summery of statistics below that are being detailed in the Gender Pay Gap Report.

| The **Mean Gender Pay Gap** is £0.64 an hour. Women are paid 3.55% less than men. The mean average hourly rate is £17.48 for women and £18.12 for men. | The **Median Gender Pay Gap** is £1.15 an hour. Women are paid 7.35% less than men. The median average hourly rate is £14.50 for women and £15.66 for men. | Men's mean bonus payment is £3,859 more than women's, a **Mean Bonus Pay Gap** of 43.32% |
| | | Men's median bonus payment is £1,223 more than women's, a **Median Bonus Pay Gap** of 22.18% |

2.3 The report includes progress on last reported actions and how the Trust will move forward with findings in 2022.

- o The Trust played an active part in the work of the Wales Public Bodies Equality Partnership Group and improved awareness of gender pay issues across Wales.
- o The Trust developed its approach to Agile Working, to embed hybrid working practices as business as usual.
- o NHS Wales Shared Services Partnership, NWSSP, investigated the reason for a pay gap in relation to bonuses being paid to employees in prescription processing.
- o Information about applying for incremental credit is shared with new staff to encourage women to apply so that they are just as likely as men on appointment to request consideration of previous experience.
- o In June 2021 the Trust Executive Management Team members took on roles as Equality Ambassadors for each protected characteristic including Gender.
- o The Trust has five Strategic Equality Objectives for 2020 to 2024 including an aim to eliminate pay gaps.

2.4 The report highlights the following areas for focus for 2022-23:

1. Pursue the Strategic Equality Objectives including eliminating pay gaps by 2024
2. Support the Gender Executive Equality Ambassador to lead a programme of work offering opportunities for women to develop their leadership skills, build career aspirations and take on more senior roles. There will be a particular focus on female Medical staff in light of the bonus pay implication of the Clinical Excellence Award scheme.
3. Improve recruitment processes and to ensure gender-sensitive language in adverts, gender-blind shortlisting and decision making and unconscious bias training for recruiting managers. Ensure all new staff understand how and when to apply for incremental credit on appointments.
4. To promote inclusive language when working externally in schools, colleges and within education and development training inside our organisation. To keep raising awareness and continue creating a culture of inclusivity.
5. Support all staff equally in developing, through leadership, coaching and mentoring.
6. Undertake further analysis of the year to 31st March 2022 of the core Trust position without hosted organisations to better determine the more granular actions that can be taken. Present this in May 2022 in advance of the next formal Gender Pay Gap 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	Yes (Include further detail below)
	Legal requirement to publish by 30th March
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

The Board is asked to **APPROVE** the Gender Pay Gap report.

GENDER PAY GAP

2020/21 REPORT

FORWARD

Velindre University NHS Trust aims to ensure that people are treated fairly and equally at work. Our focus ensures that staff have the same access and opportunities to reward, recognition and career development.

The Trust believes that it is important to analyse its pay data, to gain an understanding of any gaps, what this means for our workforce and as appropriate, to use this information and data to develop an action plan that will respond to any identified gender pay gaps.

WHAT IS THE GENDER PAY GAP
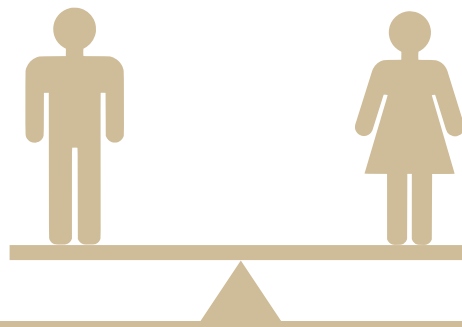
The gender pay gap shows the difference between the average (mean or median) earnings of male and female employees.

It should be noted that gender pay gap analysis differs from that of equal pay issues, which deal with the pay differences between male and female employees who carry out the same jobs, or similar jobs, or work of equal value. It is unlawful to pay employees unequally because of their gender.

The pay gap is expressed as female employees' earnings as a percentage of male employees' earnings. When gender pay reporting is used to its full potential, it provides a valuable tool to assist an organisation to assess levels of equality in the workplace, male and female participation and how effectively talent is being maximised. A high gender pay gap can be an indication that there may be a number of issues which the organisation may need to deal with as a matter of priority. The individual gender pay calculations may help the organisation to identify what those issues are.

This document reports pay data on 31 March 2021. It represents Velindre University NHS Trust as a legal entity which also includes hosted organisations, NHS Wales Shared Services Partnership, NHS Wales Informatics Services and Health Technology Wales.

OUR GENDER PAY PROFILE 2021

On 31 March 2021 VUNHST employed 5,071 people, 2,145 men and 2,926 women, 42% male/58% female.

Men
42%
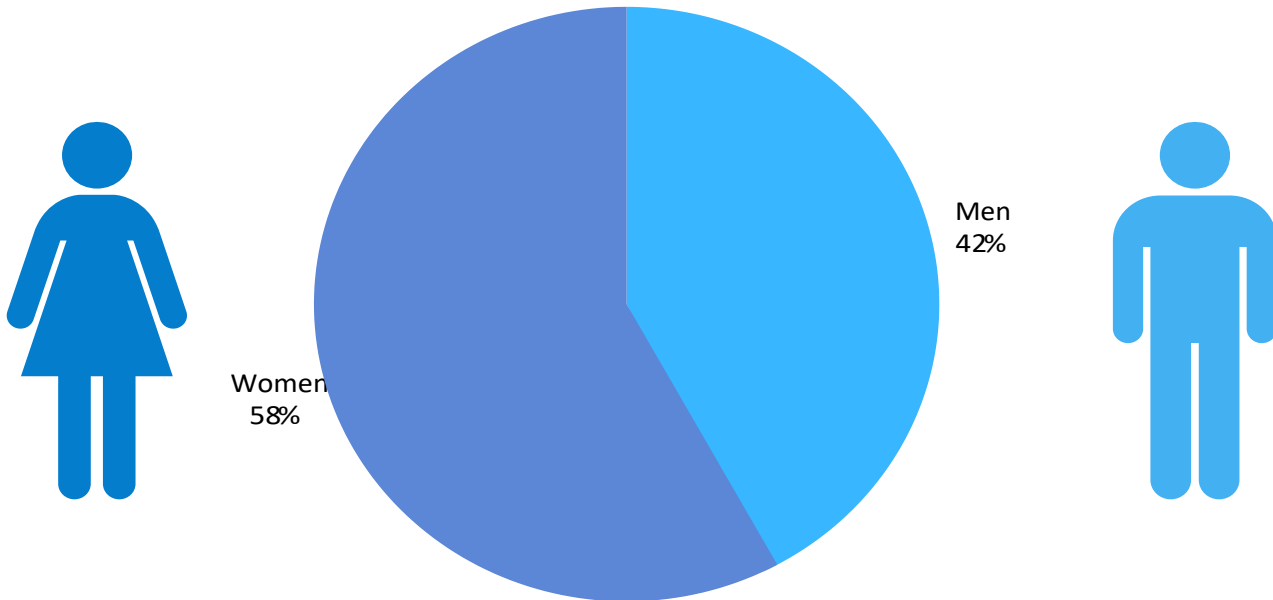
Women
58%

Quartile Range

When dividing the female workforce and the male workforce into four equal parts, men's pay and women's pay show different patterns with women being clustered in the middle quartiles and men more concentrated in the lowest and highest quartiles.

Number of Employees | Q1 = Low, Q4 = High
31st March 2021

Quartile	Female	Male
Quartile 1	669.00	598.00
Quartile 2	811.00	457.00
Quartile 3	736.00	478.00
Quartile 4	710.00	612.00

■ Female ■ Male
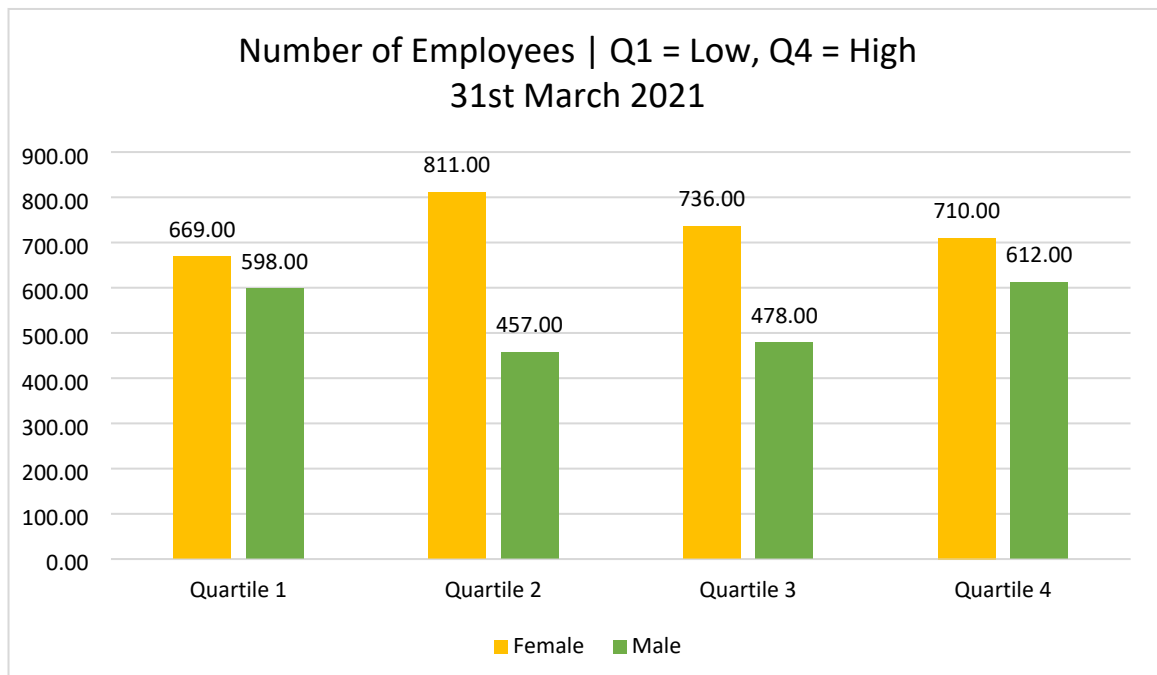
Mean and Median Pay

The **Mean Gender Pay Gap** is £0.64 an hour. Women are paid 3.55% less than men. The mean average hourly rate is £17.48 for women and £18.12 for men.
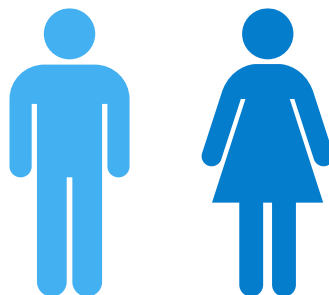
The **Median Gender Pay Gap** is £1.15 an hour. Women are paid 7.35% less than men. The median average hourly rate is £14.50 for women and £15.66 for men.

Bonus Pay

1.47% of men receive a bonus
1.79% of women receive a bonus

Men's mean bonus payment is £3,859 more than women's, a **Mean Bonus Pay Gap** of 43.32%

Men's median bonus payment is £1,223 more than women's, a **Median Bonus Pay Gap** of 22.18%

Movement between 2020 and 2021

The proportion of female staff between the two years has increased. However, the quartile range follows the same pattern with women's pay clustered in quartiles two and three and men's pay gathering in quartiles one and four.

The mean gender pay gap has fallen from 69p to 64p however the median pay gap has seen an increase from 90p to £1.15 an hour. This has caused a further widening of this gap, increasing from 5.82% to 7.35%.

The picture on bonus pay is mixed with the mean pay gap increasing from 40% to 43% whilst the median pay gap has reduced from 33% to 22%. There are two forms of bonus payments contributing to this difference. A bonus is paid to staff who process prescriptions within NHS Wales Shared Services Partnership. Work in that department has enabled staff to improve their work life balance leading to women receiving access to equivalent bonus payments as men. The other form of bonus payments in these calculations are Clinical Excellence Awards and Commitment Awards paid to some Medical Staff. The allocation of these awards is determined at a National level by an independent panel and as such is outside of the Trust control. The Trust has nevertheless taken steps to encourage female medical staff to consider leadership roles to put them into positions where they may be nominated in future. It should be noted that this bonus gap is seen in NHS organisations across the country which has led to reform of the scheme from April 2022 to counteract gender bias in the allocation of awards.

2020 Action Plan and Progress

To address the details described in the previous pay gap report for the year to March 2020 actions were developed. Progress against those actions is detailed below:

Action	Progress
Median Gender Pay Gap The Trust will: • identify why such a significant gap exists; • develop an action plan, in response to the above findings and present this to Trust Board for approval; • keep Trust Board informed of progress to reduce the median gender pay gap hourly rate; • report back findings in the 3 March 2021 Gender Pay Gap Report. The above will be informed via the Trust's active participation in the Wales Public Bodies Equality Partnership group, and the achievement of one of its specific objectives around Eliminating Pay Gaps. This work will involve: • Sharing and standardising systems for collating and analysing data across bodies, supporting staff to disclose information • Agree a standard methodology for defining and collating pay gaps, interpreting/ communicating. • Sharing strategies for workforce planning. • Joining together to create workforce development opportunities. • Joint management and leadership training (HR Group). • Sharing practice on work patterns and ways of working.	The Trust played an active part in the work of the Wales Public Bodies Equality Partnership Group and improved awareness of gender pay issues across Wales. The Trust developed its approach to Agile Working, to embed remote working practices as business as usual. By removing some of the physical location requirements for working, it will reduce barriers to staff participation in work and open up career development opportunities.
Mean and Median Bonus Pay Gap The NWSSP People and OD Team, in conjunction with the Prescription Processing Department, will investigate why such a very significant mean and median bonus payment differential has developed between part time, male and female prescription processing employees between 2019/20. NWSSP will also: • continue the focus on the Prescription Processing Bonus scheme at the Primary Care Services quarterly reviews; • Working in conjunction with the Primary Care Services team, set up a working group to explore the future of the bonus scheme and its equity and fairness of payment, including the development of a performance framework.	NHS Wales Shared Services Partnership, NWSSP, investigated the reason for a pay gap in relation to bonuses being paid to employees in prescription processing. They identified work life balance as being a contributing factor. Changes in work practices, including the impact of remote working, have helped reduce and even remove the pay gap for these employees over the year.

• report back findings in the 31 March 2021 Gender Pay Gap Report.	
Gender Pay Gap The Trust will: • Continue to provide information regarding incremental credit to all applicants in their induction pack information. Advise Managers as part of the recruitment process of the availability of incremental credit, should employees meet criteria.	Information about applying for incremental credit is shared with new staff to encourage women to apply so that they are just as likely as men on appointment to request consideration of previous experience.
Gender Pay Gap The Trust will: • Identify an Equality Ambassador for Gender in both the Executive Team and Workforce and Organisational Development team. • Continue to monitor job adverts for inclusive language as well as the number of male and female applicants, including part time workers • Continue to provide financial support for parents during Summer and Easter school holidays. • Include an objective within our Strategic Equality Plan on Fair Pay • Work with our Staff Diversity Networks on inclusive recruitment and raising awareness • Work with the National Bodies Strategic Equality Objectives partnership to identify best practice to develop inclusive recruitment and workplaces. • Continue to raise awareness through speakers, factsheets and staff training	In June 2021 members of the Trust Executive Team took on roles as Equality Ambassadors for each protected characteristic including Gender. This gives strategic impetus to improving the experience of women and improving women's pay in the Trust. Job adverts have been scrutinised for inclusive language. The Trust has five Strategic Equality Objectives for 2020 to 2024 including an aim to eliminate pay gaps. Staff training has continued through Induction and the Inspire management development programme.

ACTIONS MOVING FORWARD FOR 2022

The results from the 2021 Gender Pay Gap analysis show that Velindre University NHS Trust still has a gap in pay based on gender. This is evident in the average of hourly pay and also in the value of bonuses.

Actions which the Trust is committed to are:

1. Pursue the Strategic Equality Objectives including eliminating pay gaps by 2024
2. Develop and promote a programme of work offering opportunities for women to develop their leadership skills, build career aspirations and take on more senior roles. There will be a particular focus on female Medical staff in light of the bonus pay implication of the Clinical Excellence Award scheme. The Executive Gender Equality Ambassador will be supported to play an active part in this Programme.
3. Improve recruitment processes to ensure gender-sensitive language in adverts, gender-blind shortlisting and decision making and unconscious bias training for recruiting managers. Ensure all new staff understand how and when to apply for incremental credit on appointments.
4. To promote inclusive language when working externally in schools, colleges and within education and development training inside our organisation. To keep raising awareness and continue creating a culture of inclusivity.
5. Supporting all staff equally in developing, through leadership, coaching and mentoring.
6. Undertake further analysis of the year to 31st March 2022 of the core Trust position without hosted organisations to better determine the more granular actions that can be taken. Present this in May 2022 in advance of the next formal Gender Pay Gap Report.

Monitoring of the above actions will take place through the Healthy and Engaged steering groups which meets quarterly.

TRUST BOARD

REMUNERATION COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	31st March 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Mel Findlay, Business Support Officer
PRESENTED BY	Donna Mead, Chair
EXECUTIVE SPONSOR APPROVED	Sarah Morley, Director of Organisational Development and Workforce

REPORT PURPOSE	FOR NOTING

ACRONYMS	

1.   PURPOSE

1.1   This paper had been prepared to provide the Trust Board with details of the key issues considered by the Remuneration Committee on 24.02.2022.

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

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

2. HIGHLIGHT REPORT

ALERT / ESCALATE	• Nothing of note to report
ADVISE	**Voluntary Early Redundancy Payments (VERS)** • The committee provisionally approved one Voluntary Early Release application pending clarification of information.
ASSURE	• Nothing of note to report
INFORM	• Nothing of note to report
APPENDICES	**NOT APPLICABLE**

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE LOCAL PARTNERSHIP FORUM

DATE OF MEETING	02.03.2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Carol Meredith, Business Support Officer
PRESENTED BY	Sarah Morley, Executive Director of OD and Workforce
EXECUTIVE SPONSOR APPROVED	Sarah Morley, Executive Director of OD and Workforce

REPORT PURPOSE	FOR NOTING

ACRONYMS	
LPF	Local Partnership Forum
SLT	Senior Leadership Team
VCC	Velindre Cancer Centre
OCP	Organisational Change Policy
WBS	Welsh Blood Service
RCN	Royal Collage of Nursing

1. PURPOSE

1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the Local Partnership Forum held on 2nd March 2022.

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

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

2. HIGHLIGHT REPORT

ALERT / ESCALATE	Nothing to escalate
ADVISE	Nothing to advise
ASSURE	Nothing to assure
INFORM	**Trade Union Workshop Actions** Local Partnership Forum received an update on actions taken following the Partnership Workshops held in October 2021. Much of this work will centre on information and education with one aim being to grow the number of Trades Union Representatives within the Trust. The action plan will be further refined and work will progress to ensure that partnership working is embedded in the way the Trust carries out its change processes. **Agile Working** The LPF had an update on the work of the Agile Working Group. The group were updated following a number of engagement sessions that have been held for Trust staff along with the work plan for the Operational Group. There was discussion of next steps in the development of Agild Working Principles for the organisation. **People Strategy**

	The LPF received the Draft people Strategy which is currently being sent through Trust Governance processes. This was following previous discussion at LPF on the key themes and actions under the strategy. It was described that more work will be required around measures for success, looking at quality-added measures. The importance of partnership working and engagement with Trade Union colleagues was also highlighted. **Welsh Blood Services Divisional Update** The Divisional Director presented an update on work taking place in WBS one aspect of which was a risk assessment had taken place around reducing social distancing within donation clinics. No concerns were raised at LPF from Trade Unions on this matter. Velindre Cancer Centre Divisional Update The LPF was advised that there are currently gaps in the senior leadership team in VCC currently and the interim arrangements that are in place to mitigate the impact of that. They were also advised that there are a number of complex HR cases within VCC at the moment. Performance Report One key issues was raised by Trades Union colleagues in relation to the use of external providers of Occupational Health support. The rationale for this was discussed and the need to ensure timely access to Occupational Health advice in absence cases. The LPF was advised that the quality of reports obtained through this service has been seen to meet the standards required by the Trust. Pension Tax Guidance Policy A draft policy was shared for comment. This had been developed as a model policy by an All Wales group to solve an operational issue within NHS Wales. This to be discussed at JLNC and EMB before going to Board for approval.
APPENDICES	

TRUST BOARD

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

DATE OF MEETING	31st March 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 Trust Board with details of the key issues considered by the Transforming Cancer Service (TCS) Programme Scrutiny Sub-Committee at its public meeting on 21st December 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.

1.4 The Trust Board 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 Trust Board.
ADVISE	**Finance Report** A summary of the Capital and Revenue budget forecasts costs for all projects within the TCS Programme were provided. The forecasting position shows within budget for the end of the year for TCS Programme. The sub-committee were advised all legal fee requirements for next year have been included in the budget. The sub-committee were assured the team are monitoring the spend of the legal fees. It was confirmed a session will be arranged to go through all the risks and funding for each project. This will allow everyone to be sighted on all the project resources. This Board Development Session will be arranged for the New Year. 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. **TCS Programme Managers Update** • nVCC – Competitive Dialogue An update was given on the Competitive Dialogue. The progress was noted. • Workshop on Developing the South East Wales Cancer System An update was given on the workshop on developing the South East Wales Cancer System. The workshop has been postponed due to unavailability of key personnel across the region. There might be a chance this will be postponed again depending on the impact Covid / Omicron variant has. But everyone is keen for this workshop to be held as soon as possible. • Radiotherapy Satellite Centre The detailed design presentation is scheduled for 27th January 2022 which will include SMART hospital requirements. The Full Business Case completion is now anticipated for April/May 2022. The Sub-Committee highlighted their concerns hopefully the presentation date doesn't get delayed due to the COVID Omicron variant situation. The Sub-Committee **Noted** the Paper. **Project 4: RSC Progress Update and Full Business Case (FBC) Timelines** The RCS Progress update and Full Business Case (FBC) timeline paper was presented to the Sub-Committee. The expected completion date for the scheme is now July 2024. The sub-committee were informed of the recommended several mitigations to reduce the impact of delays. These have been approved and the works started on site in October 2021 with a planned completion date of the first week in April 2022. The FBC is currently due to go to boards in May 2022 with Welsh Government FBC approval anticipated for end of June 2022. However, the project is considering whether it is possible to bring the business case to boards in April 2022. The Sub-Committee **Noted** the Paper.
ASSURE	**Nuffield Trust Report – Progress Update** The Nuffield Trust Report – Progress Update paper was presented to the Sub-Committee. The sub-committee noted the good progress being made.

	The Sub-Committee **Noted** the Paper. **Velindre @ UHW – Progress Update** The Velindre @ UHW – Progress Update paper was presented to the Sub-Committee. • The Cardiff Cancer Research Hub @ UHW: The Project Implementation Team has been appointed. The Strategic Lead has also been appointed and in post. Project Support Officer will start in January 2022 and admin support has been identified. Posts are short-term funding through charitable funds. • Haemato-oncology The workstream is currently delayed whilst internal clinical capacity to support is reviewed. 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 Trust Board.
APPENDICES	NOT APPLICABLE

TRUST BOARD

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

DATE OF MEETING	31/03/2022

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 Trust Board with details of the key issues considered by the Transforming Cancer Service (TCS) Programme Scrutiny Sub-Committee at its public meeting on 19th January 2022.

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

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

1.3   The Board 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 Trust Board.
ADVISE	**Finance Report** The TCS Finance Report highlights the TCS Programme are on track to break even on Revenue and Capital by the end of the financial year. 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. **Verbal Updates:** The TCS Programme Scrutiny Sub-Committee received a verbal update on the following: - Nuffield Trust Report – Progress Update - Project 1: Enabling Works Update - Competitive Dialogue Update - Project 3a: Integrated Radiotherapy Solution Update **Value Add Engagement Programme** TCS Programme Scrutiny Sub-Committee received the **Value Add Engagement Programme presentation. The following was outlined:** - In building a new hospital, it intensifies the opportunities for further areas in which the Trust can lead or collectively sponsor to add further value. - In addition, there are opportunities to enhance the site itself.

	- Within the organisation, there will be a sponsorship group to lead collaboration across the matrix of activities. - We will be led by engagement with our patients, staff and community as to what matters most to them. The Sub-Committee **Noted** the Paper.
ASSURE	There were no items identified to assure the Trust Board.
INFORM	There were no items identified to inform the Trust Board.
APPENDICES	N/A

TRUST BOARD

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

DATE OF MEETING	31st March 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 Trust Board with details of the key issues considered by the Transforming Cancer Service (TCS) Programme Scrutiny Sub-Committee at its public meeting on 22nd February 2022.

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

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

1.3 The Board 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 & Performance Committee.
ADVISE	**Finance Report** The TCS finance report was presented to the sub-committee. It was highlighted that the Trust has provided revenue funding of £0.110m to the nVCC Project. The financial summary position for the TCS Programme for the year 2021-22 as at 31st January 2022 is outlined below: • Capital spend - £2.815m at month 10 with a forecast outturn of £4.282m and variance of £0.004m underspent • Revenue spend - £0.546m at month 10 with a forecast outturn of £0.669m, this being a break-even position. It was confirmed there has been no funding spend or direct revenue expenditure from Project 5: SACT and Outreach. It was confirmed within Project 2: New Velindre Cancer Centre, the Trust has provided £86K of revenue funding for the Judicial Review costs incurred between August 2021 and December 2021. 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.

Project 1: Competitive Dialogue
The Competitive dialogue for the nVCC procurement is progressing towards the Preferred Bidder stage. The project is now in a position to communicate in more detail the steps that will take the project through to selecting a winner – how we will implement the processes outlined at a strategic and technical level in the nVCC Procurement Strategy and the Invitation to Participate in Dialogue. The key milestone dates and activities were highlighted to the Sub-Committee.

The Sub-Committee **Noted** the Competitive Dialogue update paper.

Projects 1 & 2: nVCC Non-Clinical RD&I Group Update Report
The nVCC Non-Clinical RD&I Group update report was presented to the Sub-Committee. In January 2021, the nVCC project began the process of establishing an nVCC Non-Clinical RD&I Group to produce a programme of RD&I project work to inform and learn from the nVCC Project – a Dynamic Project Evaluation process. To ensure visibility of this work and effective alignment across Trust and Project priorities, the Group will provide quarterly updates to the nVCC Project Board, TCS Programme Delivery Board and Trust RD&I Sub-Committee.

The Sub-Committee **Noted** the Projects 1 & 2: nVCC Non-Clinical RD&I Group Update Report.

Projects 1 & 2: Injunction Update
An Extraordinary Trust Board meeting on 2nd December 2021 took place, the Board considered whether to start an application process for an injunction to be in place in relation to the Enabling Works programme for the new Velindre Cancer Centre. The Board approved "the application for an injunction to commence if there is direct action which disrupts the ground investigation works commencing 6th December 2021." The Interim Injunction has been granted by the High Court 17th February.

The Sub-Committee **Noted** the Projects 1 & 2: Injunction Update.

ASSURE	**Project 3a: IRS Update** It was confirmed tenders from both bidders are due back on the 28th February. During March the evaluation process will begin and it is expected to know the outcome of the winning bid by Mid-April. The Sub-Committee **Noted** the verbal update on Project 3a: IRS update. **Communications & Engagements** An update was given on communication and engagements. The Sub-Committee **Noted** the Communication and Engagements Paper.
INFORM	There were no items identified to inform the Quality, Safety & Performance Committee.
APPENDICES	N/A

TRUST BOARD

TCS PROGRAMME SCRUTINY SUB-COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	31/03/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Alison Hedges, Business Support Officer / Lauren Fear, Director of Corporate Governance and Chief of Staff
PRESENTED BY	Stephen Harries, Vice Chair and Committee Chair
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance and Chief of Staff

REPORT PURPOSE	FOR NOTING

ACRONYMS	
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1. PURPOSE

This paper has been prepared to provide the Trust Board with details of the key issues and items considered by the TCS Programme Scrutiny Sub-Committee at its meeting held on the 22nd March 2022.

Key highlights from the meeting are reported in Section 2.

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

2. HIGHLIGHT REPORT

The following areas were highlighted for reporting to the Trust Board from the meeting of the TCS Programme Scrutiny Sub-Committee held on the 22 March 2022:

ALERT / ESCALATE	There were no items for alerting or escalating to the Trust Board.
ADVISE	**TCS Finance Report** The Sub-Committee noted based on the summary of position in month 11 and forecast of year end the capital and revenue are within the funding envelopes that have been agreed for this financial year and plans and forecasts for this financial year. The Sub-Committee noted the projected position for year end of £39,506 underspend on Capital, £10,897 underspend on Revenue. The Sub-Committee **NOTED** the TCS Finance Report. **Further Committee time to complete Agenda** Due to time constraints the agenda was not completed. Therefore a further meeting will be arranged to complete the agenda.
ASSURE	**TCS Programme Risk and Issues Register** The Sub-Committee noted The position and actions and mitigations that are in place. Key changes included: • The addition of a new programme risk, rated 20, regarding project interdependencies. This has been subject to scrutiny by the Committee and the addition of this new risk was welcomed. However, for the next report, further detail on the timescales for the actions noted was requested. • The closure of the programme resource vacancy risk. The Risk register appendices provided further updates to the Committee for all risks with a 12 and above rating. The Sub-Committee noted:

	• The latest risk position for the TCS Programme and Projects. • The changes and updates to Project Risks & Issues. • The latest Risk Register and appendices.
INFORM	

3. RECOMMENDATION

The Trust Board is asked to **NOTE** the contents of this report.

TRUST BOARD

Transforming Cancer Services Communications and Engagement Update

DATE OF MEETING	31 March 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	NON GWILYM, ASSISTANT DIRECTOR COMMUNICATIONS AND ENGAGEMENT
PRESENTED BY	LAUREN FEAR, DIRECTOR CORPORATE GOVERNANCE & CHIEF OF STAFF
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
TCS PROGRAMME DELIVERY BOARD	16/03/2022	Noted
TSC PROGRAMME SCRUTINY SUB-COMMITTEE	23/03/22	Noted

ACRONYMS	
nVCC	New Velindre Cancer Centre

1. BACKGROUND

This paper provides the Board with an update on communications and engagement during the course of February 2022.

The Transforming Cancer Services Programme Communications and Engagement strategy emphasises the importance of good one-to-one stakeholder engagement, building positive relationships and informing our patients, staff and communities of interest.

2. ASSESSMENT

Over the reporting period we focused our efforts on:

- **Strategic counsel and preparing communications and engagement support ahead of site clearance on site**
    1. Delivering, to the best of our ability, a communications action plan for internal and external stakeholders in support of site clearance;
    2. Coordinating responses to correspondence received from the public and elected representatives
    3. Direct mail bilingual letters to be delivered to residents living locally to the site
    4. Sharing content across Velindre Matters channels and monitoring social media, including responding to questions and messages
    5. Liaison with Welsh Government and Cardiff Council communications to provide appropriate updates

- **Managing media enquiries and related social media commentary**
    We have developed several lines to take over the past month to support the enabling works and legal process. We liaised with a journalist from the Voice Wales online platform on this story: https://www.voice.wales/northern-meadows-four-women-hit-with-injunction-speak-out-against-scary-process/ . The article focused on the impact of the injunction process on the four named individuals concerned. Our responses to all questions asked were carried in full by the platform.

- **Responding to correspondence from a wide range of stakeholders.**
  We have received a significant amount of queries, concerns and statements received by the Trust via various avenues over the past month. The key recurring themes are:
  - enabling works impact on LCF and the surrounding area,
  - traffic management,
  - contractors and the required permissions.

  We are also formalising a new process for managing relevant nVCC correspondence/concerns in partnership with Cardiff Council, sensitive to statutory duties and data protection.

- **Political stakeholder meetings** – we continue to hold regular meetings with the local Councillors, MS and MP.

- **Petitions Committee –** we received notification that a discussion on the petitions presented to the Committee in summer 2020 has been tabled for 21 March 2022. The Committee will consider our response to its questions from February 2021 which have not been considered further in the light of both the election of the new Committee and the legal challenge. As such, the relevant updates will be shared with the Committee in advance.

- **Engagement hub space within VCC** – two hubs are now installed in the cancer centre to provide content and related surveys to gain further insight and engagement for the green ambitions and overall plans for the new Velindre Cancer Centre.

- **Supporting the development of a wider value added package –** work is progressing with a visit to the Down to Earth project's at Llandough to further explore "scaling up" opportunities from this work.

- **Recruitment:** we have now appointed to the Senior Engagement Manager post and the Senior Communications Manager post is now live.

For the next month, priorities are as follows:

- Plan for the next phase of enabling works;

- Plan for the evaluation phase of the Competitive Dialogue. A communications and engagement strategy an plan will be the main item of business for the programme Communications and Engagement item at the next Programme Board meeting.

- A visit to the Dwr Cymru facility in Lisvane reservoir to scout their engagement and communication approach;

- Implementing the feedback plan through the engagement hubs at VCC that allows us to track and score staff and patient sentiment, understanding and ideas;

- Publish next issue of Velindre Matters digital newsletter;

- Promote new content on the Velindre Matters social channels;

- Supporting the nVCC research and development working group, alongside its Trust counterpart;

- Support the implementation of the Value Add programme of work,

- Supporting the patient engagement framework and related activities.

3. **IMPACT ASSESSMENT**

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

The Board are recommended to **NOTE** the paper.

TRUST BOARD

CHARITABLE FUNDS COMMITEE HIGHLIGHT REPORT

DATE OF MEETING	31/03/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Alaric Churchill, Interim Charity Director
PRESENTED BY	Professor Donna Mead OBE, Chair
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR NOTING

ACRONYMS	
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1. PURPOSE

This paper has been prepared to provide the Trust Board with details of the key issues and items considered by the Charitable Funds Committee at its meeting held on the 03 February 2022.

Key highlights from the meeting are reported in Section 2.

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

2. HIGHLIGHT REPORT

The following areas were highlighted for reporting to the Trust Board from the meeting of the Charitable Funds Committee held on the 03 February 2022:

ALERT / ESCALATE	There were no items for alerting or escalating to the Trust Board.
ADVISE	**FUNDRAISING** The Committee were advised that following the impact of the Omicron variant, the Fundraising Showcase originally planned for January 2022 has been postponed until the end of May 2022, as the Fundraising team also have a large event in March and April 2022. The Committee noted that income received in October and November 2022 was good although had declined slightly in December 2022 due to the impact of COVID-19. The Committee were advised that total income received in January and February 2022 is expected to be higher following the hugely successful 'Wear Red Campaign' which coincided with the launch of the 6 Nations Championship and have received significant input this year from the Welsh Rugby Union, including support from Scarlets Rugby. The Committee were advised of plans in place to move towards a managed planning cycle for the Charity utilising digital support to increase communication opportunities and support fundraisers and donors more effectively. For example, supporters can now donate at site by application of a QR Code on campaign posters and 9 pubs and bars in North Wales are supporting us with digital development being part of the strategy. The Committee noted how a change in campaign management has helped create a more response driven communications plan. Messaging has been developed to reflect the incredible commitment of staff from Velindre aligned with their wonderful sense of humour and the support given every day. The Committee noted and was pleased to hear of the plans being progressed for fundraising activity in the coming months, with 39 events booked, 15 dates pending and 22 further fundraising initiatives developed of which 17 are fully inclusive. The Committee were advised that going forward there is a clear need to be able to fundamentally put data at the heart of development for the future and this will be core to the new 5 year strategy for the Charity.

FINANCIAL POSITION

The Committee received the Financial position up to the period ending the 31 December 2021 and the following was highlighted:

- **Income**

Income received for the period was overachieving against the planned target of the unrestricted fund by £384,000 and the overall income for the Charity is on course to achieve circa £2.6 million by the end of this financial year (2021-2022). Income for the period has included £548,000 in legacies which have notably helped the year-to-date performance. The Committee received confirmation of further legacies totalling circa £500,000 including one for £425,000, not included in the year-to-date figures but factored into the forecast income.

- **Expenditure**

The Committee noted that expenditure was lower than planned by £482,000, largely due to timing issues as a result of delayed activity due to vacancies against projects. Spend is expected either in the later part of this financial year or is to be deferred over future years.

- **Fund Balances:**

Balances have decreased by £0.6 million during the year from £5.8 million to £5.2million as at 31st December with a total forecast at the end of this financial year of £4.8 million.

- **Investment Performance**

The Investment Portfolio is in a positive position and for the period has increased by £249,000 (4.15%).

- **Reserve Policy**

The unrestricted reserve target has been set based on the current commitments at **£786k** which is an over achievement of **£784k** when compared to the balance of **£1,570k** that was in the charitable funds accounts as at the 31st December 2021.

Velindre University NHS Trust Charitable Funds Trustee Annual Report 2020-2021

The Committee **NOTED** the FINAL signed copy of the Velindre University NHS Trust Charitable Funds Trustee Annual Report 2020-2021 by the Auditor General Wales and that this has been formally submitted to the Charity Commission.

ASSURE	**BUSINESS CASE AND EXPENDITURE PROPOSALS** The Committee **APPROVED** 3 Business Case and Expenditure proposals: **1. Psychology for Staff Business Case** The Committee noted that staff work under considerable pressure and there is an increased need for this service for staff given the ongoing impact of the COVID-19 pandemic. The Committee welcomed that the scheme is part funded by the 'NHS Charity Together' and that future funding strategies should adopt a similar approach of a mixed funding model with less dependence on funding from the Trust Charity. The Committee APPROVED the case, but requested that the 1st year evaluation report reflected future funding options with a clear exist strategy for this scheme. **2. ESOL Business Case** The Committee noted that the ESOL Programme is provided in partnership with Cardiff & Vale College, and provides a valuable resource for its target audience that covers a number of important healthcare topics promoting equality, diversity and innovation in education. The Committee were pleased to learn that the Business Case proposal had been revised to incorporate previous feedback from the Committee and were content to APPROVE the revised expenditure proposal. **3. Innovation Project Manager** The Committee were advised that the Business Case had been through the required governance pathway in advance of its submission to the Committee and had incorporated all feedback received to reflect this. The Committee noted that the scheme is aligned with the new Trust Strategy and Charities mission and will enable a small core team to be established to support driving forward the RD&I Programme of work. The Committee were content to APPROVE 2 years funding for £90,000 and requested that the 1st year evaluation report clearly set out the expected outcome measures. **BUSINESS CASE FUNDRAISING EVALUATION REPORT** The Committee considered three Business Case Fundraising Evaluation Reports, which provide assurance that projects funded by the Charity have delivered or are delivering their expected outputs. This included: • Chaplaincy Annual Evaluation • Patient Information Manager • Psychology for Staff

	The Committee NOTED the evaluation reports and requested some additional information be provided to address a small number of queries raised which are to be reported in advance of the next Committee by the Chief Operating Officer.
INFORM	**WALES WEEK IN LONDON** The Committee **APPROVED** the proposal for Velindre Fundraising to be the chosen charity partner for the fourth year running for the 'Wales Week in London' which takes place in February / March 2022.

3. RECOMMENDATION

The Trust Board is asked to **NOTE** the contents of this report.

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE STRATEGIC DEVELOPMENT COMMITTEE

DATE OF MEETING	31/03/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Lenisha Wright, Business Support Officer
PRESENTED BY	Stephen Harries, Interim Vice-Chair and Chair of the Strategic Development Committee
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning & Digital

REPORT PURPOSE	FOR NOTING

ACRONYMS	
IMTP	Integrated Medium-Term Plan

1. PURPOSE

1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the Strategic Development Committee held on 23rd March 2022.

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

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

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for Alert / Escalation to the Trust Board.
ADVISE	**Integrated Medium-Term Plan: Update** An update was provided to the Strategic Development Committee regarding progress of Integrated Medium-Term Plan in terms of amendments and finalisation for submission to Welsh Government. At the meeting, Committee members discussed the latest plan thoroughly before endorsing the Integrated Medium-Term Plan for consideration by the Trust Board on 31st March 2022. A process was agreed by which the Board could feedback final comments prior to the Trust Board meeting.
ASSURE	**Trust Assurance Framework** An update was given on the Trust Assurance Framework, the status of Principal Risks identified and the ongoing work to support its continued development. At the meeting the Committee discussed and reviewed the Trust Assurance Framework Dashboard to reflect the overall progress since January 2022 in respect of the following Principal Risks: • Demand and Capacity • Partnership Working / Stakeholder Engagement • Workforce Planning • Organisational Culture • Organisational Change / 'strategic execution risk' • Quality and Safety • Digital transformation – failure to embrace new technology • Trust Finance Investment Risk • Future Direction of Travel • Governance

| | The Dashboard outlines the risk score, overall levels of control, sources of assurance and action plans for any identified gaps.

There were three key themes of the discussion:
- The concept of "issues" was discussed, as events which are/have already occurred that may have an adverse consequence. These would be reflected in the Trust Assurance Framework through sources of assurance and also in the control effectiveness ratings of the current control environment.
- The importance of the developing links between key frameworks of assurance, risk and then performance and quality.
- Continuing to mature the organisation's capability regarding the risk framework to effectively understand the impact of the overall profile and the impact of a collection of these risks being brought together. |
|---|---|
| **INFORM** | There were no items identified to Inform the Trust Board. |
| **APPENDICES** | None. |

TRUST BOARD

EXTRA-ORDINARY QUALITY, SAFETY & PERFORMANCE COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	31st March 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Kyle Page, Business Support Officer
PRESENTED BY	Vicky Morris, Chair of the Quality, Safety & Performance Committee
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science

REPORT PURPOSE	FOR NOTING

ACRONYMS	
SACT	Systemic Anti-Cancer Treatment Therapy
COSC	Clinical Oncology Sub-Committee
JCCO	Joint Collegiate Council for Oncology
PADR	Performance Appraisal & Development Review
DBS	Disclosure & Barring Service
IPCMG	Infection Prevention & Control Management Group
SVAMG	Safeguarding & Vulnerable Adults Management Group
HIW	Health Inspectorate Wales
DHCR	Digital Health & Care Record

Velindre University NHS Trust logo (GIG CYMRU NHS WALES / Ymddiriedolaeth GIG Prifysgol Felindre / Velindre University NHS Trust)

1. PURPOSE

This paper has been prepared to provide the Trust Board with details of the key issues and items considered by the Quality, Safety & Performance Committee at its Extra-ordinary meeting held on the 17th February 2022.

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

2. BACKGROUND

The Quality, Safety and Performance Committee meets on a bi-monthly basis and provides an opportunity to triangulate information and data in respect of quality, safety, finance, workforce, performance and digital. The Committee is continuing to mature and actively seek opportunities for improvement in parallel with the ongoing development of reporting formats and additional assurance mechanisms as it enters its second year of operation. In order to respond to the emergency of the prevalence of the Omicron variant and continue the key role of the Quality, Safety & Performance Committee performs in managing the public safety risk associated with the pandemic, the frequency had been amended to include an Extra-ordinary February 2022 meeting. This was consistent with the previous arrangements established at the outset of the pandemic.

3. HIGHLIGHT REPORT

The agenda for the Committee had been amended to take account of the current pressures being faced by the Trust due to the fourth wave of the pandemic that commenced in December 2021. This resulted in enhanced COVID and Divisional reporting and a deferral of a number of items on the cycle of business due in the January 2022 meeting. The Committee was assured by responsible officers that all deferred items would be received by the March 2022 meeting.

During December 2021 the Trust re-commenced its command management infrastructure that included Gold and Silver Commands.

The Committee was **ASSURED** by evidence of an improving position over the past six weeks in respect of the fourth wave of the COVID pandemic. This was evident in both national figures and the impact on the Trust. Throughout this wave, the core services and treatments delivered by both Divisions has continued despite the impact of COVID related staff absence, overall sickness levels, social distancing requirements and in some areas of services an increase in demand. These issues continue to be proactively managed and mitigated via additional staffing allocation / deployment as part of the robust recovery plan.

The Committee **NOTED** that the learning applied from the previous waves of the COVID pandemic has enabled the Trust to continue to evolve and adapt its systems and processes, strengthening its overall position.

The following areas were highlighted for reporting to the Trust Board from the Extra-ordinary Public meeting of the Quality, Safety & Performance Committee held on the 17th February 2022.

ALERT / ESCALATE	There were no items identified for **ALERT** or **ESCALATION** to the Board.
ADVISE	**GOLD Command Highlight Report** The Gold Command Highlight Report provided details of the key issues considered at Gold Command at its meetings held between 17th January 2022 and 9th February 2022. The following was highlighted: • The frequency of Gold Command has been reduced to weekly due to the reduction in overall risk to the organisation at present. • Infection, prevention and control - In relation to the First Floor Ward COVID outbreak initially reported, a review with Public Health colleagues had concluded that it had been categorised as a 'cluster', rather than an outbreak. The Cluster had been managed as an outbreak to ensure robust management. Daily infection control audits undertaken with 100% compliance with all standards (including PPE, donning and doffing, isolation and screening of all patients upon admission). • The number of new patients waiting to commence their SACT (Systemic Anti-Cancer Treatment Therapy) within 21 days during January 2022 is under validation and is currently identified as 24. The Committee was **ADVISED** that a Task & Finish Group has been established to assess available options for increasing capacity for SACT provision wherever possible, including third party provision and onboarding of staff. Updates in relation to this will continue as part of regular reporting. **Financial Report** The Financial Report was received, outlining the financial position and performance for the period ended 31st December 2021 (month 9). The following was highlighted:

- It is anticipated that all Key Performance Indicators (KPIs) in relation to Revenue, Capital and Public Sector Payment Performance will be met and the year-end forecast is to achieve financial break-even.
- The request for a reduction in recharges to Charitable Funds of £800k due to redeployment of staff into COVID related work.
- The Trust is considering how the Charitable Funds Committee may be utilised to temporarily support the overall financial position of the Trust over the next financial year in relation to:

  o The shortfall in provision of COVID-related funding from Health Boards to assist local response and additional capacity necessary for addressing the backlog and general growth in demand;
  o Increased levels of sickness and lost productivity due to enhanced infection prevention and control measures;
  o Maintaining current levels of delivery and resources.

- The Committee was also **ADVISED** that the integrated Finance and Workforce report being prepared for the next meeting would also include a review of how funding is utilised in terms of staffing (including agency costs).

Quality, Safety & Performance Reporting
The Trust Performance report was discussed and the following key items were highlighted:

- Further improvements are required to the narrative within the report in relation to the improvement actions being taken when performance off track.
- Circulation of a paper to Committee members, providing an overview of Radiotherapy targets (historic JCCO (Joint Collegiate Council for Oncology) and new COSC (Clinical Oncology Sub-Committee).
- The current position in relation to the development of Radiation Services, including work undertaken to facilitate meeting the COSC targets once they have become a formal requirement, will be discussed in detail during the April 2022 Board Development Session.
- The current position in relation to pathway work will also be presented at the April 2022 Board Development session followed by a summary / record to be presented at the Quality, Safety & Performance Committee.

- The Brachytherapy Business Case remains under development with completion anticipated within the next few weeks.

Workforce & Organisational Development Performance Report
The Workforce and Organisational Development Performance Report provided information in relation to PADR (Performance Appraisal & Development Review), Statutory & Mandatory compliance and staff sickness / absence. The following was highlighted:

- Presentation of data within the report continues to be developed and a Finance / Workforce triangulation report will be presented at the March Committee.
- It was recognised that although PADR performance had decreased from pre-COVID levels, the level remains high across divisions, with the exception Corporate Services. The Committee was **ADVISED** that discussions are focusing on improvements within this area in particular corporate teams. Executive Directors are taking urgent action to ensure full PADR compliance across all teams.
- Sickness levels have remained at 0.6% above pre-COVID levels of 4.5% for the last 18 months and detailed analysis and monitoring has enabled focused work in recognised areas to actively reduce this.

Infection Prevention & Control Management Group (IPCMG) Highlight Report
The IPCMG Highlight Report provided details of the key issues considered during its meeting held on the 20th January 2022. The following was highlighted:

- Overall healthcare acquired infection rates remain low across all areas and is in contrast to most Health Boards where increases have been seen. Staff were commended for this.
- There has been no MRSA bacteraemia for over 8 years.
- There remains three Infection Prevention and Control related Policies out of date. The plan for each is:

  o IPC01 - Gastro-Enteritis Policy – will be presented at the March Committee for **approval**.
  o IPC04 - Decontamination – will be presented at the March Committee for **approval**.

	o IPC07 – MRSA – currently under review and will be presented at the May Committee for **approval** (further delayed due to COVID taking priority). The Committee was **ADVISED** that no other Infection Prevention and Control related policies are out of date. **Safeguarding & Vulnerable Adults Management Group (SVAMG) Highlight Report** The SVAMG Highlight Report provided details of the key issues considered during its meeting held on 3rd December 2021. The following areas were highlighted: • Safeguarding training compliance - It was noted that Safeguarding training compliance remains below target and that the training needs analysis had been delayed due to the Omicron wave. This will be revisited imminently and will include ESR data cleansing and a role by role training needs analysis. Workforce & Organisational Development are supporting this work. • Tier 2 Dementia training – A historical gap in the Trust's assurance mechanisms in respect of dementia, older persons and learning disability standards has been recognised and plans put in place to address this. One element identified was the provision of tier 2 Dementia training. Arrangements have been put in place with Cardiff & Vale University Health Board to provide this training. The wider remit is now being addressed by broadening the role of the Senior Nurse Safeguarding to include Vulnerable Groups and the broader remit of the Safeguarding Management Group. • Trust Disclosure & Barring Service (DBS) position – Following the recent DBS governance checks it has been identified that 10 staff are yet to submit their DBS. The Committee was **ADVISED** that Management action had been taken to pursue this and that an update would be provided as soon as possible.
ASSURE	**Velindre Cancer Service – Staff Story** *(Presented by Matthew Walters, Operational Senior Nurse)* A video had been received in advance of the Committee outlining First Floor Nursing staff experiences, wellbeing and team working efforts to overcome the challenges faced during the fourth wave of the pandemic. The following was noted: • Staff had consistently endeavoured to support one another, often at very short notice, working additional shifts wherever necessary

and supporting each other's out of work commitments and essential periods of rest.

- Informal 'de-briefs' following challenging situations provided mutual emotional and mental support.
- Rapid and changing learning, improving processes and the environment for both patients and staff, with the patient at the forefront of decision making.
- Provision of support from mental health staff / clinical psychologists.
- Improving communication with patients isolating following admission, providing the best possible care in relation to both physical patient comfort and mental support, including the provision of technology to allow patients to communicate with loved ones in the absence of visiting.

The Committee welcomed the openness of staff and the use of a video prior to the Committee and commended their ongoing commitment during an extended period with many challenges.

Datix Project Board Highlight Report
The Datix Project Board Highlight Report provided an overview of the current status and outline of key deliberations from its meeting held on 14th December 2021. This report was brought into the main agenda for discussion due to questions arising from system difficulties to ensure all risks and incidents have been captured and acted on.

It was noted that issues had been identified with Welsh Blood Service system's difficulty aligning with the coding categorisation structure within the Once for Wales system, presenting challenges when entering incidents and extracting information for reporting purposes.

The Committee was **ASSURED** that all incidents / data have and would be captured via an escalation process with Once for Wales representatives in addition to an escalation point to Shared Services to enable resolution if required. An exercise to integrate the additional coding requirements for WBS is also currently being undertaken. Reporting remains a manual process; however the Committee was **ASSURED** that this will be adequate until the system resolution is achieved.

Velindre Cancer Service Quality, Safety, Performance & COVID Report

The Velindre Cancer Service report provided an update on key quality metrics, outcomes and performance against key metrics for the period to the end of December 2021 and the following items were highlighted:

- Analysis of the significant number of open Radiotherapy incidents had confirmed that many had been identified as low risk and therefore not been prioritised. The Committee was **ASSURED** that all risks are currently undergoing review and prioritisation, facilitated via an assurance board within the team.
- The Committee was **ADVISED** that there had been six radiotherapy (IRMER) incidents reported late to HIW (Health Inspectorate Wales). These were all low exposure / low harm incidents. The delays were a result of internal delays in assessing if low additional exposure incidents met the reporting thresholds. A number of changes have been made across radiation services to prevent such delays in the future.
- In order to mitigate the risk of predicted shortfall of Oncologists, a review of skill mix is currently underway to enable an increase in capacity, in addition to the recruitment of two Physicians' Associates upon qualifying in Autumn 2022.
- The transition to Digital Health & Care Record (DHCR) and analysis of its implementation on ways of working remain in progress with further clarity expected imminently.
- All actions resulting from recommendations following 15 step challenge visits undertaken within VCC Outpatients Department and SACT Outreach Unit at Prince Charles Hospital are in progress or have been completed and will be included as part of regular reporting.
- Due to the relatively recent inclusion of a 'Compliments' section within Datix, the importance of capturing compliments in addition to complaints and concerns will be communicated to staff. The new CIVICA (patient feedback) system has also enabled a more comprehensive follow up of concerns and implementation of improvements to prevent future similar incidents.

Welsh Blood Service Quality, Safety, Performance & COVID Report

The Welsh Blood Service report provided an update on performance against key metrics for the period until the end of January 2022 and the following items were highlighted:

	• Challenges presented during December had been overcome without the requirement for importation and the position had improved during January, particularly in relation to stock levels. • Donor feedback remains very positive in the main, with concerns and complaints followed up individually and actioned on a local or national level as appropriate. • Closeout of incidents within the required timeframe had dropped below target for the first time since May 2021. Despite adhering to reporting, risk assessment and instigation of the appropriate level of investigation, the target had not been met due to delays in review and closure by the Manager as a result of competing pressures. The Committee was **ASSURED** that this had now been escalated and resolved and that potentially extending the deadline for decisions may avoid a reoccurrence. **Trust Risk Report** The Trust Risk Report provided information on the current status of COVID-19 related risks, scoring level 15 and above. All risks identified in the report remain a work in progress, there was a need to have specific and measurable actions being taken and clarity about mitigations and the Committee will be updated on these areas. The Committee **NOTED** that risk reporting was continuing to mature and develop to provide sufficient detail for **ASSURANCE** to the Committee and that the next cycle of reporting at the March Committee would include further amendments to represent specific information, in particular where mitigating actions were unclear.
INFORM	There were no items identified to **INFORM** the Board.
APPENDICES	N/A

4. RECOMMENDATION

The Trust Board is asked to **NOTE** the key deliberations and highlights from the Extra-ordinary Quality, Safety & Performance Committee held on the 17th February 2022.

TRUST BOARD

QUALITY, SAFETY & PERFORMANCE COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	31st March 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Kyle Page, Business Support Officer
PRESENTED BY	Vicky Morris, Chair of the Quality, Safety & Performance Committee
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science

REPORT PURPOSE	FOR NOTING

ACRONYMS	
SACT	Systemic Anti-Cancer Treatment Therapy
COSC	Clinical Oncology Sub-Committee
MHRA	Medicines and Healthcare Products Regulatory Agency
NCSC	National Cyber Security Centre
IMTP	Integrated Medium Term Plan
ISO	Internal Organisation for Standardisation

1. PURPOSE

This paper has been prepared to provide the Trust Board with details of the key issues and items considered by the Quality, Safety & Performance Committee at its meeting held on the 24th March 2022.

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

2. BACKGROUND

The Quality, Safety and Performance Committee meets on a bi-monthly basis and provides an opportunity to triangulate information and data in respect of quality, safety, finance, workforce, performance and digital. The Committee is continuing to mature and actively seek opportunities for improvement in parallel with the ongoing development of reporting formats and additional assurance mechanisms accommodating additional COVID-related reporting as required.

3. HIGHLIGHT REPORT

Since December 2021, in response to the Omicron variant, the Trust re-commenced its command management infrastructure that included Gold and Silver Commands.

The Committee was **ASSURED** by evidence that despite the highest level of staff absence since the beginning of the pandemic, core services and treatments continue to be delivered by both Divisions despite the impact of COVID on overall sickness levels, continued social distancing requirements and in some areas of services an increase in demand. These issues continue to be proactively managed and mitigated via additional staffing allocation / deployment as part of the robust recovery plan arrangements in place.

The Committee **NOTED** that the learning applied from the previous waves of the COVID pandemic has enabled the Trust to continue to evolve and adapt its systems and processes, strengthening its overall position.

The Committee identified that the emerging theme across a number of agenda items related to the impact of the pandemic in relation to the quality, experience and delivery of services, delivery timescales (e.g. Freedom of information Act and policy reviews) and previously agreed plans (including Health & Care Standards and Audits).

The following areas were highlighted for reporting to the Trust Board from the meeting of the Quality, Safety & Performance Committee held on the 24th March 2022.

ALERT / ESCALATE	There were no items identified for **ALERT** or **ESCALATION** to the Board.
ADVISE	**Welsh Blood Service (WBS)– Donor Story** *(presented by Andrew*

Harris, Interim Head of Donor Engagement, Welsh Blood Service)

A video had been received in advance of the Committee, outlining the experience of a teenage girl with learning difficulties when attending a donor clinic. The story detailed how the learning from feedback received during a 15 step challenge visit to a donation clinic led to two donors assisting WBS make a number of changes to the appointment and donation experience for people with a learning disability. The Committee commended the WBS for their approach and how they have actively listened, and made a number of improvements with the help of donors that will benefit many more people.

GOLD Command Highlight Report
The Gold Command Highlight Report provided details of the key issues considered at Gold Command (COVID) at its meetings held between 16th February 2022 and 16th March 2022. The Committee was advised that:

- COVID related staff absence is currently at the highest level since the beginning of the pandemic and is affecting both Divisions. Daily staffing / service delivery meetings have been implemented at Velindre Cancer Centre to ensure sustained delivery of operational services and monitor impact on other additional priorities. Staff within both Divisions continue to go over and above to maintain services, care and treatment.
- Blood stocks at the Welsh Blood Service have reduced in recent weeks due to increasing numbers of donors not attending booked appointments deemed to be COVID related. This is being monitored and managed daily by the Collections team who is working closely with partners and Health Boards to put on additional clinics and actively recruit additional donors.
- Due to the staff COVID absence situation Gold Command will continue at present to meet weekly.

The Committee **NOTED** the current position in relation to COVID and the oversight being provided by Gold Command.

January Quality, Safety & Performance Update
The overarching Trust Performance report was discussed and the following key items were highlighted:

- There continues to be a two month 'lag' in data getting to the Committee due to the data validation requirements and business

	intelligence system constraints within the reporting cycle. The Committee was assured that work is ongoing to reduce this timescale as far as possible and that future reports will incorporate new data as it becomes available during the reporting cycle to ensure documentation is as live as possible. • Work continues in relation to the reporting of COSC (Clinical Oncology Sub-Committee) targets and clarity has been requested from Welsh Government in relation to the position of the COSC targets in Wales. The current working premise is that until such a time as they are national targets they will not be included on the new Trust scorecard. However, reporting data will be retained for use in the event that they are mandated as a formal requirement in the future. **Freedom of Information Requests (FOI) Report** A comprehensive Freedom of Information Act Report was received that detailed how the Trust has complied with requirements during the calendar year 2021. The following was highlighted: • The Trust received 151 requests. The three most significant areas of requests continue to be: renewal dates of digital contracts (19); drug treatment data (12); and matters relating to the building of the new hospital (12). • Overall compliance with completion timescales was 52%; this was due to the pandemic affecting the Trust's ability to respond to requests within the FOI timescales. • It was recognised by Information Commissioner's Office that during the pandemic, organisations' ability to meet timescales would be impeded. • The Trust website indicated that while the Trust would comply with timescales wherever possible, these may be affected by new priorities resulting from the pandemic. • The Committee was **ADVISED** that improvement plans have been developed to ensure a minimum of 80% compliance during 2022.
ASSURE	**NHS Wales Shared Service CIVAS@IP5 Report** The NHS Wales Shared Services CIVAS@IP5 Quality & Safety Governance Report and performance presentation was discussed. The Committee:

- Received an overview of performance against agreed metrics, noting that the last two months had seen a reduction in output resulting from commercial supplier issues and the presence of new staff within the production process.
- Received **ASSURANCE** that Health Boards continue to order consistent amounts of products and that no issues with facilities had been reported and that service remains 100% compliant with internal audit requirements.
- Noted the reporting of one critical deviation only, resulting in the rejection of one batch and one service complaint from a Health Board relating to an incorrect expiry date on a vaccination packdown. The committee requested further detail in future reports to demonstrate learning and improvement after such deviations and complaints.
- Was **ADVISED** that the full MHRA (Medicines and Healthcare Products Regulatory Agency) inspection report would be presented at next Committee.
- Was **ADVISED** that discussions are underway to explore how reporting can evolve going forward to include additional areas of Shared Services activity.

Welsh Blood Service Quality, Safety & Performance Divisional Report

The Welsh Blood Service report provided an update on performance against key metrics for the period until the end of February 2022. The report had been re-configured and was presented under the headings of the six domains of quality. The following areas were highlighted:

- Two safety incidents had been reported; one involving a cross-matching error. The Committee was **ASSURED** that a report had been submitted to the Medicines and Healthcare products Regulatory Agency (MHRA). The second related to a patient death following transfusion where there was a possibility of an infected blood product. A full investigation had been undertaken in conjunction with the relevant Health Board. This concluded that the cause of death was most likely unrelated to the transfusion and following robust sample testing there was no evidence of any bacterial infection within the product supplied. The Committee was **ASSURED** of the robust and swift investigation undertaken by WBS in relation to both matters.
- Due to COVID pressures not all planned WBS audits had been completed. Six had been delayed. The Committee was **ASSURED** that one audit had concluded within the required timeframe and a

further three would remain within the current ISO (Internal Organisation for Standardisation) audit cycle. The remaining two will be undertaken during Quarter 1 of 2022/23.

The Committee commended the revised reporting template and **NOTED** that an update in relation to the cross-matching error would be received in due course.

Velindre Cancer Service Performance Report
The Velindre Cancer Service Performance report provided an update on outcomes and performance against key metrics for the period to the end of January 2022. The following was highlighted:

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

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

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

Workforce and Organisational Development Performance Report/Financial Report
The Committee received its first combined Workforce & Associated Finance Risks Report which outlined the risks currently faced by the Trust and the mitigation actions. The following areas were highlighted:

- A significant amount of work is currently focusing on the development of holistic 'on the ground' workforce plans to ensure

current and future demand requirements are met, in particular Radiotherapy and medical staff which are key areas of risk.

- Work is underway to review all fixed term contracts, with a view to managing down the potential risk of associated redundancy costs, or financial risks associated with recruiting permanent staff as an alternative.
- It was noted that agency costs will continue to be incurred as a direct result of difficulties in recruiting appropriate staff into permanent positions and current levels of staff absence. There is also a lack of specialist agency staff e.g. SACT trained staff which may result in the need to outsource some activity to the private sector, involving further significant financial outlay. Options in relation to the agency position will be provided in the next paper.
- The Trust's finance position for the period ended 31st January 2022 is an underspend of £3K and the year-end forecast is set to achieve financial break-even. The Executive Team is encouraged to consider what plans can be implemented during the remaining weeks of this financial year to utilise as much available non-recurrent funding as possible.
- The Committee was **ADVISED** that more specific plans and timescales would be provided in future reports.

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

- 44 concerns were raised during the Quarter, 89% of which were graded at level 1. 73% of the concerns raised were managed via the Early Resolution process (within 2 working days) and 27% managed via the Putting Things Right process.
- Concerns relating to the COVID-19 Pandemic were significantly reduced.
- 75% of formal concerns raised were closed within the 30 working day timeframe, which is an increase from the previous quarter and equate to the Welsh Government target of 75%.
- The top three themes from concerns were: appointments, attitude and behavior, and Clinical Treatment.
- 468 incidents were raised during the Quarter – 367 from the Cancer Centre and 101 from the Welsh Blood Service. 85% of which were graded as no harm or low harm.
- There was one National Reportable Incident reported relating to

the nature of clinical consultations within a specialty during the pandemic (reported due to volume rather than level of harm).

- The outcome of the 'deep dive' undertaken into incidents and concerns from quarters 1 and 2 was received. Actions are being taken by Divisions to address the issues identified.
- A significant amount of work has been undertaken within the Cancer Service during the last three months to improve how it investigates and responds to concerns raised.

Digital Service Operational Report

A comprehensive Digital Services report was received that provided an update of all operational Digital Services activity for the period October 2021 to February 2022. The following was highlighted:

- A number of elements have been delayed due to significant operational pressures, resulting in deferral to next year's IMTP (Integrated Medium Term Plan).
- GovRoam has now been fully implemented, allowing Trust staff seamless connection with the network when working at other local sites / organisations. Positive feedback has been received from clinical staff.
- The go live of Prometheus has been delayed due to IT issues and application structure. The Committee was **ADVISED** that ongoing engagement will resolve issues identified and provide assurance in terms of managing the infrastructure. A potential revised go live date of June 2022 has been suggested.
- Work is ongoing to improve compliance against the NCSC (National Cyber Security Centre) framework for Cyber Security. The Committee was **ADVISED** that a full progress report would be received at Quality, Safety & Performance Committee twice yearly.
- The Committee received **ASSURANCE** that Business Continuity have confirmed no significant impact on patient and donor care, with resolution of a number of issues achieved via a hardware upgrade.

Trust Risk Report

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

- Of a total of 170 current risks, the February extract provided a breakdown of 9 level 20 risks (5 for Velindre Cancer Centre and 4

for Transforming Cancer Services) and 18 level 16 risks (1 for Transforming Cancer Services, 1 for Corporate and 16 for Velindre Cancer Centre). There were no level 25 risks for reporting to the March cycle.

- The immediate focus for the coming period will be the management of risks and related actions in a prioritised manner.
- Following discussion at Executive Management Board, a further review of the Digital Health and Care Record project risks would be undertaken due to the significant number of risks scoring at 20 and 16. The Committee will be advised of the outcome in the next report.
- Geo-political risks relating to the current war in the Ukraine and their articulation into Datix are currently being worked through by the Business Continuity Group, in particular around potential supply chain disruption and Cyber risks. Updates will continue outside of the reporting Cycle if required.

The Committee **NOTED** that risk reporting continues to mature and develop to provide sufficient detail for **ASSURANCE** to the Committee.

Review of Information Governance Incidents & Trends
The Information Governance report provided **ASSURANCE** in relation to how the Trust manages patient, donor, service user and staff information in accordance with Information Governance legislation and standards and eight domains of information governance. The following was highlighted:

- Application of the Information Governance Toolkit (as is required by all NHS organisations) has facilitated effective assessment of the Trust against all key aspects of Information Governance and the development of a robust work / action plan. This will conclude by the end of March 2022 and will be followed by a self-assessment exercise and shared learning with other organisations to inform the remaining Information Governance Assurance Framework.
- **ASSURANCE** that all systems, irrespective of age and manual /electronic setup, undergo a DPIA (Data Protection Impact Assessment) to minimise risks associated with handling and storage of data. This includes retrospective reviews of existing systems.
- **ASSURANCE** that no breaches of the one month calendar response timeframe had been reported during the period 1st December 2021 - 28th February 2022 for the total of 47 information requests.

Trust-wide Policies and Procedures Report
The Trust wide Policies and procedures report provided a high level overview of the comprehensive review that had been undertaken in relation to policy management arrangements across the Trust, that included details of and early outcomes from an audit of all Trust wide policies that fall within the remit of the Quality, Safety & Performance Committee. The following was highlighted:

- The revised Trust Policy and Procedure for the Management of Trust Wide Policies was received. This policy review had incorporated the findings of a pan Wales' benchmarking exercise to establish best practice and incorporate key changes to statutory requirements. The revised policy also includes the development of a fully integrated impact assessment to support the review of any existing and development of new Trust-wide policies going forward.
- Due to the number of Trust wide policies (157), the audit has been phased to ensure a robust review. Workforce and Organisational Development policies will be audited through April 2022, the results will be reported to the May 2022 Committee, at which time the Committee will have a full and clear audit status of all Trust wide policies that fall within the remit of the Committee.
- Two policies that were audited had long standing review dates (2010 & 2016); the Incident Policy had been reviewed and was approved at the Committee; the ownership of the Cleaning Policy had been amended and a review has commenced.
- Further work is required in respect of the position in relation to Trust Policies and Procedures for hosted organisations. This will be included as a separate appendix to the overarching policy once the governance in relation to this has been clarified and agreed.

The Committee commended the significant amount of work undertaken to date and was **ASSURED** by the progress made to date and the planned additional steps.

Health & Care Standards Self-Assessment Action Plan / Improvement Plan
The Health & Care Standards report provided the current position in relation to Trust compliance with the Health and Care Standards for Wales (2015) and progress against the 2021/2022 Trust Improvement Plan for the period ending December 2021 (Quarter 3). The following was highlighted:

	• An Executive review of scores had identified an increase in a number of scores and a reduction in others, providing **ASSURANCE** that a sufficient level of scrutiny is being applied during the decision making process. • **ASSURANCE** that areas reporting lower scores will undergo improvements with a view to demonstrating adequate evidence of this. • Three Workforce related actions within the Improvement Plan were delayed: Disability Confident Accreditation, the Virtual Reality Learning Project and Development of the HealthCare Support Worker role at Velindre Cancer Centre, due to the pandemic and team capacity issues. Revised delivery timeframes had been identified. • A new set of Quality Standards in line with the Wales Quality & Engagement Act are currently under development for use across all departments post-April 2023.
INFORM	The Committee APPROVED four revised Policies: • Viral Gastroenteritis Policy (Ref: IPC01) • Decontamination of Equipment Policy (Ref: IPC04) • Incident Reporting & Investigation Policy (Ref: QS01) • Handling Concerns Policy (Complaints, Claims and Patient Safety Incidents) (Ref: QS03)
APPENDICES	N/A

4. RECOMMENDATION

The Trust Board is asked to **NOTE** the key deliberations and highlights from the meeting of the Quality, Safety & Performance Committee held on the 24th March 2022.

TRUST BOARD

NHS WALES SHARED SERVICES CIVAS@IP5 REPORT (presented to the March 2022 meeting of the Quality, Safety & Performance Committee)

DATE OF MEETING	31st March 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Kyle Page, Business Support Officer
PRESENTED BY	Vicky Morris, Chair of the Quality, Safety & Performance Committee
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science

REPORT PURPOSE	FOR NOTING

ACRONYMS	

1. PURPOSE

This paper has been prepared to provide the Trust Board with details of the key issues and items contained within the NHS Wales Shared Services CIVAS@IP5 Quality & Safety Governance Report and performance presentation, considered at the public meeting of the Quality, Safety & Performance Committee held on 24th March 2022.

The Board is requested to **NOTE** the content of the report.

ALERT / ESCALATE	There were no items identified for **ALERT** or **ESCALATION** to the Board.
ADVISE	There were no items identified to **ADVISE** the Board.
ASSURE	**NHS Wales Shared Service CIVAS@IP5 Report** The NHS Wales Shared Services CIVAS@IP5 Quality & Safety Governance Report and performance presentation was discussed. The Committee: • Received an overview of performance against agreed metrics, noting that the last two months had seen a reduction in output resulting from commercial supplier issues and the presence of new staff within the production process. • Received **ASSURANCE** that Health Boards continue to order consistent amounts of products and that no issues with facilities had been reported and that service remains 100% compliant with internal audit requirements. • Noted the reporting of one critical deviation only, resulting in the rejection of one batch and one service complaint from a Health Board relating to an incorrect expiry date on a vaccination packdown. The committee requested further detail in future reports to demonstrate learning and improvement after such deviations and complaints. • Was **ADVISED** that the full MHRA (Medicines and Healthcare Products Regulatory Agency) inspection report would be presented at next Committee. • Was **ADVISED** that discussions are underway to explore how reporting can evolve going forward to include additional areas of Shared Services activity.
INFORM	There were no items identified to **INFORM** the Board.
APPENDICES	N/A

2. RECOMMENDATION

The Trust Board is asked to **NOTE** the key deliberations and highlights from the NHS Wales Shared Services CIVAS@IP5 Quality & Safety Governance Report and performance presentation, considered at the public meeting of the Quality, Safety & Performance Committee held on 24th March 2022.

WELSH HEALTH SPECIALISED SERVICES COMMITTEE (WHSSC)
JOINT COMMITTEE MEETING BRIEFING **–** 15 MARCH 2022

The Welsh Health Specialised Services Committee held its latest public meeting on the 15 March 2022. This briefing sets out the key areas of consideration and aims to ensure everyone is kept up to date with what is happening within the Welsh Health Specialised Services.

The papers for the meeting can be accessed at:
https://whssc.nhs.wales/joint-committee/committee-meetings-and-papers/2021-2022-meeting-papers/

1. Minutes of Previous Meetings
The minutes of the meetings held on the 11 January 2022, 18 January 2022 and 8 February 2022 were approved as a true and accurate record of the meetings.

2. Action log & matters arising
Members noted the progress on the actions outlined on the action log.

3. Neonatal Transport Update
Members received an update report on progress to establish an Operational Delivery Network (ODN) for the neonatal transport service.

Members noted that the Joint Committee (JC) had supported that Swansea Bay University Health Board (SBUHB) host the ODN and the intention was that the ODN would be in place by January 2022. However, due to operational pressures and the ongoing pandemic progress had been delayed and the intend**ed "go live" date for the ODN had moved to** June 2022.

Members noted the report.

4. **Chair's Report**
Members received the Chair's Report and noted:
- No chairs actions had been undertaken since the last meeting,
- An update on the substantive appointment of a Chair for the Welsh Renal Clinical Network (WRCN),
- An update on WHSSC Independent Member (IM) Remuneration,
- Attendance at the Integrated Governance Committee (IGC) 28 February 2022; and
- 1 to 1 Meetings with Health Board (HB) CEOs.

Members noted the report.

5. Managing **Director's Report**
Members received the Managing Director's Report and noted updates on:
- The SBUHB Welsh Centre for Burns; and
- The De-escalation of Cardiac Surgery at SBUHB from Level 4 to Level 3.

Members noted the report.

6. Implementing a 12 Week Clinical Pathway for the Management and Treatment of Aortic Stenosis
Members received a report seeking support for the implementation of a 12 week clinical pathway for the management and treatment of aortic stenosis.

Members (1) Noted the report; and (2) Supported in principle the implementation of a 12 week clinical pathway for the management and treatment of aortic stenosis.

7. WHSSC Process for Responding to the Ministerial Measures
Members received a report providing an overview of the recently received Ministerial measures and which proposed a process through which WHSSC could respond.

Members noted the new Ministerial priority measures and the process through which WHSSC will respond to them.

8. Major Trauma Update
Members received a report providing an update on the performance and key issues in the Major Trauma Network covering south, mid and west Wales.

Members noted the report.

9. Disestablishment of the NHS Wales Mental Health and Learning Disability Collaborative Commissioning Group
Members noted that this agenda item had been deferred until the next meeting.

10. All Wales Individual Patient Funding Request (IPFR) Panel Update
Members received a report providing an update regarding proposals to change the terms of reference (ToR) of the All Wales Individual Patient Funding Request (IPFR) Panel. The report also proposed that an engagement process is undertaken related to future changes to the ToR as well as arrangements for a strengthened governance structure for the **Joint Committee's sub**-committee.

Members discussed the ongoing risks to WHSSC and it was agreed that Dr Sian Lewis (SL), Managing Director, WHSSC would meet with Nick Wood, Deputy Chief Executive NHS Wales, Welsh Government (WG) to discuss how to progress the IPFR Governance issue as a matter of urgency within WG; and that the WHSS Team would write to Andrew Evans, Chief Pharmaceutical Officer, WG expressing the Joint Committee's concerns and to provide him with a copy of the meeting report.

Members (1) Noted the progress made and the proposed changes to the All-Wales IPFR WHSSC Panel Terms of Reference (ToR), which are being discussed with Welsh Government, (2) Noted the progress made following discussions with Welsh Government regarding urgent changes to the existing NHS Wales Policy "Making Decisions on Individual Funding Requests (IPFRs)", (3) Supported that the WHSS Team undertake an engagement process around proposals to change the All-Wales IPFR WHSSC Panel ToR; and (4) Approved an uplift to the Direct Running Costs (DRC) budget by £57K per annum to fund the additional governance resource within WHSSC.

11. Corporate Risk Assurance Framework (CRAF)

Members received the updated Corporate Risk Assurance Framework (CRAF) which outlined the risks scoring 15 or above on the commissioning teams and directorate risk registers.

Members (1) Approved the updated Corporate Risk Assurance Framework (CRAF); and (2) Noted that a follow up risk management workshop will be held in summer 2022 to review how the Risk management process is working, and to consider risk appetite and tolerance levels across the organisation.

12. WHSSC Joint Committee Annual Plan of Committee Business 2022-2023

Members received the Joint Committee's Annual Plan of Committee Business for 2022-2023 that outlined the annual business cycle for the work of the Committee.

Members approved the Joint Committee's Annual Plan of Committee Business for 2022-2023.

13. COVID-19 Period Activity Report for Month 9 2021-2022 COVID-19 Period

Members received a report that highlighted the scale of the decrease in activity levels during the peak COVID-19 period and whether there were any signs of recovery in specialised services activity.

Members noted the report.

14. Financial Performance Report – Months 10 and 11 2021-2022

Members received the financial performance reports setting out the financial position for WHSSC for months 10 and 11 of 2021-2022. The financial position was reported against the 2021-2022 baselines following approval of the 2021-2022 WHSSC Integrated Commissioning Plan (ICP) by the Joint Committee in January 2021.

The financial position reported at Month 11 for WHSSC was a year-end outturn forecast under spend of £14,058k.

Members noted the report.

15. Corporate Governance Matters

Members received a report providing an update on corporate governance matters that had arisen since the previous meeting.

Members noted the report.

16. Other reports

Members also noted update reports from the following joint Sub-committees and Advisory Groups:
- Audit & Risk Committee (ARC),
- Management Group (MG),
- Quality & Patient Safety Committee (QPSC),
- Integrated Governance Committee (IGC),
- All Wales Individual Patient Funding Request (IPFR)Panel; and
- Welsh Renal Clinical Network (WRCN).

17. Any Other Business (AOB)

Members received verbal updates on:
- The Annual Committee Effectiveness Exercise for 2021-2022 which will be circulated at the end of March 2022 and all members were encouraged to complete the online survey; and
- Recognition that Ian Phillips, Independent Member (IM) WHSSC, would be resigning from his position, as he had been appointed as the substantive Chair of Welsh Renal Clinical Network (WRCN).
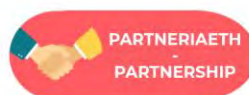
ASSURANCE REPORT

NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE

Reporting Committee	Shared Service Partnership Committee
Chaired by	Tracy Myhill, Chair
Lead Executive	Neil Frow, Managing Director, NWSSP
Author and contact details.	Peter Stephenson, Head of Finance and Business Development
Date of meeting	20 January 2022

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

Support to Vaccination Booster Campaign

A presentation was received from Health Courier Services (HCS) on their role in supporting the booster campaign across Wales. Since Mid-December, almost 1m vaccines have been delivered to 155 separate sites with no delayed or failed deliveries. Over 8,500 journeys have been made to support the vaccination roll-out and 2.3 million miles driven by HCS staff to help NHS Wales to respond to the pandemic. The Committee were very appreciative of the presentation and the work to support their organisations and were keen to understand how they could assist in making the service even more effective through eliminating any unnecessary activities.

Procurement National Operating Model

The Committee also received a presentation on the new national operating model for Procurement Services which is currently out to staff consultation. This will facilitate a more regionalised approach and will enhance the relationship between national sourcing and frontline teams. It should also lead to a greater focus on strategic relationships with key suppliers and support the efforts to promote the Foundational Economy. The Committee were supportive of the proposed changes, and it was agreed that a summary information document would be produced for NHS bodies once the staff consultation period closes.

Chair's Report

This was the first meeting chaired by Tracy Myhill since her appointment to NWSSP on 1 December. Tracy outlined her delight in being appointed, the induction activities that she had undertaken to date, and her intention to meet regularly with key stakeholders across NHS Wales.

Managing Director Update

The Managing Director presented his report, which included the following updates on key issues:

- In response to COVID and the Omicron variant, the NWSSP Planning and Response Group had been stepped up again. Thus far, no major issues have been noted and whilst there was an initial jump in sickness absence, figures have returned to the previous low levels. Where necessary, business continuity plans were implemented for drivers in Health Courier Services to ensure that services to the rest of NHS Wales were maintained;
- A Joint Executive Team meeting with Welsh Government was held on 14 January which generated a lot of positive feedback for NWSSP and during which NWSSP were requested to assist with the establishment of the Citizens Voice Body which will come into being from April 2023;
- The Medical Examiner Service, which is not devolved, is likely to become a statutory service from September 2022; and
- The NWSSP financial position is forecast to achieve a break-even position with all capital monies spent. The business case for the purchase of the Matrix House building in Swansea, has been signed off by the Minister.

Items Requiring SSPC Approval/Endorsement

IMTP

The Committee received the NWSSP IMTP for approval. The Director of Planning, Performance, and Informatics had met individually with SSPC members over recent weeks to inform the plan and has incorporated their comments and feedback into the final version. While, for now, there are no major changes to the overall goals and objectives, there is a greater focus on the Welsh Language, Equality and Diversity and outcome-based measures.

The IMTP is based on a solid foundation where NWSSP has continued to deliver all services despite the pandemic, and where we have a balanced financial plan. New services such as the Temporary Medicines Unit, Laundry Services, and more recently International Nurse Recruitment, have been introduced. The plan reflects ministerial priorities and positions NWSSP at the forefront of many national initiatives, particularly around climate change and the foundational economy.

In respect of the financial plan an additional savings target had been applied across directorates to generate a reserve to invest in IMTP priorities, but the plan will be challenging as it contains significant cost pressures including the hike in the price of energy and the O365 licences. The risk sharing agreement for clinical negligence claims is currently £16.5m but is forecast to rise to £28m in three years' time. The IMTP requires significant capital investment over the next five years particularly in respect of the laundry and TRAMs projects. The recently announced 24% cut in the discretionary budget will cause significant challenges for NWSSP in future years.

The Committee were supportive of the plan and highlighted NWSSP's role as an economic driver for change through the increased use of business intelligence to inform Health Boards and Trusts in both clinical and non-clinical settings. It also stressed the need for the various assurance processes (Internal Audit, Local Counter Fraud, National Counter Fraud, PPV) to be effectively co-ordinated to support delivery of the IMTP, and the Committee recommended that the current arrangements should be reviewed.

The Committee **APPROVED** the IMTP with the proviso that it may need to be revisited if there were any subsequent and significant changes to Health Board plans that impacted NWSSP.

Items For Noting

International Recruitment

The Committee received a paper relating to the recruitment of 436 nurses from overseas prior to financial year-end, to help fill vacancies within Health Boards and support the Covid recovery programme. Welsh Government have approved the funding for this initiative and contracts have been placed. Interviews are now being undertaken and although the deadline is challenging, there is confidence that this will be achieved. Invoices to the recruitment agencies will be paid at the offer acceptance stage, and if for any reason the recruitment is not followed through, the agencies have to find an acceptable replacement nurse or repay the amount. Nurses are only being recruited from countries with surplus staff and who are included on the Home Office Approved List.

The Committee **NOTED** and **ENDORSED** the paper.

Finance, Workforce, Programme and Governance Updates

Project Management Office Update – The Committee reviewed and noted the programme and projects monthly summary report, which highlighted the team's current progress and position on the schemes being managed. It was agreed that the consequences of any slippage in project timelines would be more meaningfully described in the report.

Finance Report – The Committee reviewed the finance report and noted the position at the end of Quarter 3. The outturn position is still forecast to be break-even and there is a plan in place to utilise any additional savings generated in the year. The paper also highlighted the significant sums spent on PPE, and the further donations of PPE to both India and Namibia. The Welsh Risk Pool position is still in line with the IMTP. Capital spend is on schedule, but a large proportion of the funding has only recently been confirmed and/or received. Stock values, which in a normal year would be approximately £3m are currently around £80m due to the need to maintain 16-weeks' stock of PPE. However, this value is reducing and was in excess of £100m last summer.

People & OD Update – sickness absence rates, after an initial spike due to the

impact of the Omicron variant, have now returned back to the lower levels seen over recent months and currently stands at 2.93% for the last quarter. Headcount continues to grow due mainly to the additional staff recruited as part of the Single Lead Employer Scheme. PADR rates were generally good although there were a few directorates where performance needed to be improved. The ESR database has now been modified such that the majority of the facilities it provides can be accessed and delivered in Welsh.

Corporate Risk Register – there is one red risk relating to the pressures currently being noted within the Employment Services Directorate, and particularly in Recruitment and Payroll Services.

Papers for Information
The following items were provided for information only: • Annual Review 2020/21; and • Finance Monitoring Returns (Months 8 & 9).
AOB
N/a
Matters requiring Board/Committee level consideration and/or approval
• The Board is asked to **NOTE** the work of the SSPC and ensure where appropriate that Officers support the related work streams.
Matters referred to other Committees
N/A

Date of next meeting	24 March 2022

TRUST BOARD

APPROVED POLICIES UPDATE

DATE OF MEETING	31/03/2022

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
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance & Chief of Staff

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME
Executive Management Board	07/03/2022	APPROVED
Quality, Safety & Performance Committee	24/03/2022	APPROVED
ACRONYMS		
EMB	Executive Management Board	
QSP	Quality, Safety & Performance Committee	

1.   SITUATION/BACKGROUND

1.1   In accordance with the "Policy for the Management of Policies, Procedures and other Written Control Documents", the Trust Board will receive all approved policy documents for information under the consent agenda.

1.2   The purpose of this report is for the Trust Board to note the policies that have been approved since the January 2022 Trust Board.

2.   ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1   Following approval at the relevant forum the policies below were uploaded to the Trust Intranet and Internet site and circulated via the policy distribution list for immediate implementation.

2.2   The list of Policies APPROVED since the January 2022 Trust Board are outlined below:

Policy Title	Policy Lead / Function	Approving Body	Effective Date	Appendix
GC01: Policy & Procedure for the Management of Trust Wide Policies and Other Trust Wide Written Control Documents	Director of Corporate Governance and Chief of Staff	Executive Management Board	07/03/2022	**1**
IPC01: Viral Gastro-Enteritis Policy (revised)	Executive Director of Nursing, Allied Health Professionals and Health Science	Quality, Safety & Performance Committee		**2**
IPC04: Decontamination of Equipment Policy (revised)	Executive Director of Nursing, Allied Health Professionals and Health Science	Quality, Safety & Performance Committee		**3**
QS03: Complaints, Claims and Patient Safety Incidents Policy	Executive Director of Nursing, Allied Health	Quality, Safety & Performance Committee		**4**

Policy Title	Policy Lead / Function	Approving Body	Effective Date	Appendix
	Professionals and Health Science			
QS01: Incident Reporting and Investigation Policy	Executive Director of Nursing, Allied Health Professionals and Health Science	Quality, Safety & Performance Committee		**5**

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The Trust has a defined process for the management of policies and written control documents. The purpose of which is to ensure staff are aware of their responsibilities with regards to Trust policy documents and to provide a 'model' guide and consistent approach for the development, management and dissemination of the Trusts documents
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

4.1 The Trust Board is asked to **NOTE** the policies that have been approved since the January 2022 Trust Board.

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

Ref: GCO1

POLICY AND PROCEDURE FOR THE MANAGEMENT OF TRUST WIDE POLICIES AND OTHER TRUST WIDE WRITTEN CONTROL DOCUMENTS

Executive Sponsor & Function	Director of Corporate Governance Governance and Chief of Staff Communications Function
Document Author:	Head of Corporate Governance
Approved by:	Executive Management Board
Approval Date:	7 March 2022
Date of Equality Impact Assessment:	August 2013
Equality Impact Assessment Outcome:	Approved
Review Date:	March 2025
Version:	Version 2

SECTION	CONTENTS	Page

1.   INTRODUCTION AND AIM

1.1   Velindre University NHS Trust, subsequently referred to in this policy as the 'Trust', has a statutory duty to ensure that appropriate policies and supporting strategies procedures, protocols, or guidelines (referred to collectively as other Written Control Documents) are in place. Policies and other Written Control Documents help ensure that the Trust complies with legislation, meets mandatory requirements, and provides services that are evidenced-based, safe and sustainable, enabling all staff to fulfil their roles safely and competently to provide effective and appropriate care and services for patients, donors and their colleagues.

1.2   Policies describe the Trust's guiding principles that underpin its decisions, behaviours and actions for everything it does. A Policy statement is a public commitment of our intent. Other written control documents translate these principles into more detailed instructions or guidance including individual responsibilities

1.3   Policies and other Written Control Documents provide the Trust with a clear governance framework to operate within and provide a process of internal control. They define what the organisation does and how it is done, support effective decision making and delegation and provide guidance for staff to follow.

1.4   To ensure the Trust delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, it will develop and describe its "ways of working" in Policies and other Written Control Documents. In this regard, the Trust has approved the Policy and Procedure for the Management of Trust Wide Policies and other Trust Wide Written Control Documents (GC01), commonly referred to as the "*Policy on Policies"*.

1.5   Through this Policy the Trust ensures that there is a process whereby all policy documentation is consistent in format, compilation and dissemination. In addition, there is an effective process for managing and reviewing policies and any other written control documents on a regularised basis, to ensure that documentation remains legally compliant and actions are undertaken in a safe and efficient manner.

1.6   The principles of the policy management process including individual responsibilities for developing and reviewing policies and other written control documents, is summarised in the flow chart on .

2.   OBJECTIVES

2.1   This Policy ensures consistency in the format, compilation, approval and dissemination of all Policies and other Written Control Documents, so that they are:

- Developed and reviewed when required;
- "Owned" – each document will have an owner who has responsibility for making sure that it is regularly reviewed and kept up to date;
- Written in plain language so that they can be understood, and people are clear of what is expected;
- Subject to an Integrated Impact Assessment where required;

- Recorded, stored and archived in accordance with the Trust's Records Management Policy;
- Appropriately co-produced and consulted on;
- Considered and approved at the appropriate level within the Trust by the appropriate advisory group, forum, sub-committee or committee (with delegated powers and authority to do so);
- Shared with staff and stakeholders where required;
- Supported by appropriate learning, education and development where required; and,
- Available to the public, in line with Freedom of Information Act requirements and the Trust's Publication Scheme.

3.   SCOPE

3.1   This policy applies to all staff employed by the Trust in all locations including those with honorary contracts.

3.2   This policy applies to all Trust wide Policies and other Trust wide Written Control Documents which fall within the definitions contained in this policy, both clinical and non-clinical.

3.3   Where written control documents relate to a single Directorate or Division and there is no wider impact on the Trust, they may be approved by the relevant Senior Management/Leadership Management Team.

3.4   In addition to the responsibilities detailed within the Policy, staff also have a responsibility for making sure that they meet the requirements of their role profiles and any other responsibilities delegated to them, which includes the development, review, publication and implementation of Policies and other Written Control Documents within their role.

4.   POLICIES AND OTHER WRITTEN CONTROL DOCUMENT PROCESS AND FLOWCHART

4.1   The reason to develop a new or review an existing Policy or Written Control document can come from a variety of sources, i.e. legislation, national guidance, external reviews, audits, to clarify/improve working practice, to mitigate an identified risk or to adopt an all Wales Policy or other Written Control Document. It is up to managers of a service, staff or function to recognise when a Policy or other Written Control Document is required to minimise risk to patients, donors, staff and the organisation. An example is, as a result of an investigation following incident reporting, which recommends additional system controls to prevent the risk of reoccurrence of a similar incident. This can equally apply to action required following the investigation of a complaint and claims management.

4.2   The first step in the development/review of a Policy or other Written Control Document is the completion of the Document Approval Checklist. The Document Approval Checklist must be completed when the Policy or other Written Control Document is multi-disciplinary and/or multi-agency in nature. The Document Approval Checklist must also be completed for all Wales or jointly developed Policies and other Written Control Documents.

4.3 Any local Written Control Document, which is a local/divisional procedure or guideline which sets out the requirements for staff in a discrete department or professional group and does not have wider implications across the Trust, may not require a Document Approval Checklist. Further clarity can be sought from the Corporate Governance Team.

4.4 The overarching rationale for completion of the Document Approval Checklist is to aid the responsible document author (see section 10) in being clear about the reason for the document, the potential impacts of the document and the support required to facilitate the implementation of the document. It is best practice to consider these prior to developing or reviewing all Policies or Written Control Documents.

4.5 Whilst most Policies and other Written Controls Documents are developed internally for internal use within the Trust, there will be occasions when a Policy or other Written Control Document requires to be developed jointly with another organisation, for example, the Local Authority or other partner agencies. These must follow the process as Trust only Policies and Written Control Documents (page 7).

4.6 Some Policies and other Written Control Documents are issued on an all Wales basis with the expectation of local adoption. These documents must also be subject to formal adoption for use in the Trust (refer to section 6).

4.7 When the requirement for a developing a new or reviewing an existing Policy or other Written Control Document arises, it is recommended that contact is made with the Corporate Governance Manager, subsequently referred to as the 'Policy Process Manager', who will able to provide advice and support about each stage of the Policy and other Written Control Document development/review process.

4.8 The most important thing to note is that the development of a new or review of an existing Policy and other Written Control Document must not be undertaken in isolation and that it must be owned and overseen by the appropriate advisory group, forum, sub-committee or committee. Policies and other Written Control Documents are best developed/reviewed in collaboration with others to ensure that the final document is one that is in line with current legislation, guidance and evidence and can be implemented seamlessly within the organisation.

4.9 In addition, Strategies and Policies only must be sponsored by an Executive/ Director. If not already identified, the advisory group, forum, sub-committee or committee must nominate an author who will be responsible for ensuring that the process outlined in this policy is adhered to, starting with the completion of the Document Approval Checklist (Appendix 1).

4.10 In accordance with the Equality Act 2010, all policies will be subject to Integrated Impact Assessment (refer to Section 10 for further detail and Appendix 5).

4.11 The flow chart on the following page explain the steps to be taken when considering the development of a Policy or Written Control Document. It is important that appropriate engagement and consultation takes place. In the case of employment

policies, (excluding those enforced from Welsh Government following national negotiations and other "All Wales policies"), staff representatives and management will jointly negotiate a draft policy for submission to the appropriate Committee for approval. If there are any issues that cannot be resolved at Committee level, the Policy will be brought to the Trust Board for final consideration and approval.

4.12   The development of Policies and other Written Control Documents must not be undertaken in isolation and will be based on sound evidence, and take account of current legislation, mandatory requirements and national/professional guidance. Sources of information used should be appropriately referenced.

PROCESS FLOWCHART

Identify need for Policy or Written Control Document
Look at definitions – What should the document be called?
Is it a policy or procedure? (see Appendix 2)

Is it a Trust-wide document?

No

Yes

Local Other Written Control Document

Is there a similar document in existence within the Trust or nationally? Authors should complete the initial approval checklist form (Appendix 1) and contact Policy Process Manager.

Develop document ensuring best practice and in consultation with the relevant target audiences locally and nationally, involving appropriate managerial, professional, clinical and staff representation, as necessary

Yes

No

Does this document meet all requirements?

Register intention to develop document with Policy Process Manager

Policy Author to take document to Senior Management/Leadership Team for Approval

Yes

No

Liaise with appropriate Executive/Director Lead and draft document

Speak to document author

Undertake Integrated Impact Assessment if appropriate (Appendix 5)

Executive/Director Lead to take document to Executive Management Board for Adoption by the Trust

Can the existing document be adapted?

Undertake consultation with the relevant target audience/groups involving appropriate managerial, professional, clinical and staff representation as necessary (see Section 12)

Yes

No

Review and update document in association with document author

Executive/Director Lead to take document to Executive Management Board for Approval

Approved/Adopted Policy or Written Control Document

Executive/Director Lead to take document to delegated Committee/Trust Board for Approval if required (see Appendix 3)

Notify Policy Process Manager of approval and inclusion in a locally held Database for audit purposes

Notify Policy Process Manager of approval and inclusion in the Trust Database, intranet and internet

Policy Process Manager to provide Policy Update Reports to Executive Management Board/Committee/Trust Board as appropriate

Staff informed of Approved document

5. DEFINITIONS

5.1 Policies and other Written Control Documents are essential in the delivery of a high quality and safe health services and to ensure the Trust operates within the law. They form an integral element of the governance and assurance framework by which the Trust regulates its activities to achieve its goals and are used as reference points to assist staff in their day to day working.

5.2 Terminology across the range of documentation can often be confusing for both those that develop the documents and to those that use them. Clear definitions for these terms, highlighting the differences and similarities and the appropriate use of each is provided Appendix 2.

6. WHO CAN APPROVE THESE DOCUMENTS AND WHERE ARE THEY PUBLISHED?

6.1 The Standing Orders set out a Scheme of Delegation for the Trust and for organisation-wide documents. Strategies are a matter on which Trust Board approval is required. Certain key policies also require approval by the Trust Board (see Appendix 3) whilst others are delegated to the appropriate advisory group, forum, sub-committee or committee or Executive based Group (see Appendix 3). Any delegated approvals must also be submitted through the relevant Executive Sponsor to the Policy Process Manager. A copy of the relevant minute confirming the approval may be required. Documents that have not gained the required approval **will not be published.**

6.2 **Directorate and Division Specific Documents:** Where written control documents relate to a single Directorate or Division and there is no wider impact on the Trust, they may be approved by the relevant Senior Management/Leadership Management Team. Such documents will still need to be recorded in a suitable database at a local level and subjected to strict version control, issued with a unique reference number and meet the standards set within this policy. There must also be a clearly documented audit trail to indicate where and by whom the document has been considered.

6.3 Some "All Wales" policies are developed by the Welsh Government or by Health Boards and Trusts working together. For some of these documents the Trust must adopt them. Where this is the case, they will be reported to the appropriate advisory group, forum, sub-committee or committee and Trust Board so that there is a record of their adoption.

6.4 Where a document requires only a small amendment which is not material to the aims or objectives of the document, e.g. to reflect a change in working practice, content of supporting documents etc, an interim review may be undertaken. This will be agreed in advance with the Policy Process Manager to ensure that the completion of an interim review does not expose the Trust to an increased level of risk. The change will be reported to the next available meeting of the approving body.

6.5 Once approved, centrally recorded documents are published on the Trust Intranet and Internet sites. Under limited circumstances it may be necessary to redact

[remove or hide] information from a document prior to publication on the Internet e.g. direct dial telephone numbers within the Business Continuity Policy. The advisory group, forum, sub-committee or committee approving the document will determine if it is necessary to redact information prior to publication. Where this has been agreed it will be made clear within the body of the text on the document made available via the Internet.

6.6 The diverse nature of health care means there will be a large number of policies and other Written Control Documents in place. Some will apply across the Trust and be relevant to all staff, and others will be specific to certain areas or activities.

6.7 For ease of reference, all policy documentation will be listed and numbered under a series of headings. An index of Policies and other Written Control Documents will be maintained as part of the on-line database that is in place and maintained to manage the review process. The database will become the central register for all Policies and other Written Control Documents in the Trust.

7. WHO CAN PROVIDE ADVICE ON WHAT TO DO AND HOW DO WE KNOW WHAT DOCUMENTS HAVE ALREADY BEEN DEVELOPED?

7.1 The Director of Corporate Governance and Chief of Staff is responsible for making sure that the Trust has arrangements in place to ensure effective development and management of Policies and other Written Control Documents.

7.2 The Corporate Governance Manager is part of the Corporate Governance team and undertakes the function of Trust-wide "Policy Process Manager", who can provide advice and assistance on any aspect of document development and review. They can be contacted via the generic Policy email account [insert email address when set up].

7.3 The Policy Process Manager maintains a register of all documents that are centrally recorded and will be able to advise if a document already exists. All of these documents are also published on the Trust's Intranet and can be found through either the A-Z Listing or by searching on key words. Most documents are also published on the Trust's Internet site.

7.4 They Policy Process Manager will arrange for approved documents and the accompanying Integrated Impact Assessment (if applicable) to be published on the intranet/internet as appropriate within ten working days of receipt from the policy author or advisory group, forum, sub-committee or committee Secretariat.

8. WHAT ARE THE ROLES AND RESPONSIBILITIES OF EXECUTIVE/DIRECTOR LEADS

8.1 The Chief Executive, as Accountable Officer, has overall responsibility for ensuring the Trust has appropriate Policies and other Written Control Documents in place to ensure the Trust works to best practice and complies with all relevant legislation.

8.2 The delegated responsibilities of Executive/Director Leads are set out in the Scheme of Delegation. They have responsibility for:

- making sure that appropriate Policies and Written Control Documents are produced and kept up to date by identifying a document author (including reallocating responsibility if the author leaves or moves to another role);
- personally checking for accuracy of content prior to submission to an advisory group, forum, sub-committee or committee for approval;
- maintaining a list of these Policies and Written Control Documents, supported by the Policy Process Manager and making sure that these documents are up to date;
- making sure that there are arrangements in place to capture as appropriate, respond to and review documents when external organisations, e.g. Health and Safety Executive, Royal Colleges, publish new and updated information which require action by the Trust;
- making sure that consultation has taken place and an Integrated Impact Assessment, which includes the equality and health impact assessments, have been completed where necessary. Where these have not been undertaken a reason for this will be provided;
- making sure that any training requirements specific to the document have been referenced; and,
- making sure that where a process of audit and/or review has been agreed this is maintained and reported on.

9.   WHAT ARE THE RESPONSIBILITIES OF DOCUMENT AUTHORS?

9.1   Authors are employees who have been given the task of writing or reviewing Policies and Written Control Documents. Employment documents should always have at least two authors i.e. a management representative and a staff representative. Authors must:

- liaise with Executive/Director Leads to make sure Policies and Written Control Documents are implemented appropriately and, where necessary, compliance with these documents is formally audited;
- make sure that documents are reviewed in line with the review date or as a result of changes to practice, organisational structure or legislation;
- work with the Executive/Director Lead and the Policy Process Manager to make sure that appropriate engagement and consultation has taken place with the relevant individuals and groups;
- inform the Executive/Director Lead of any learning, education or development needs and resource implications which must be considered before approval can take place;
- undertake the necessary impact assessments, including equality and health impact assessments, in consultation with the Equality, Diversity and OD Manager and Equality Impact Assessment (EQIA) Group, as required (Appendix 5);
- consider the findings and make sure that appropriate action has been taken in response to equality and health impact assessments.
- send the approved document to the Policy Process Manager for publication within ten working days of approval.

9.2   Authors are responsible for the review of their documents. If an author leaves the Trust or takes up another post, the responsibility for the ongoing maintenance of the

document is taken on by their replacement. Where no direct role replacement is appointed, responsibility reverts to the post holder's line manager. The Executive/Director Lead will be informed of the situation to allow them to identify a replacement author if it is not appropriate for the responsibility to stay within that department.

10. POLICY DEVELOPMENT

10.1 Each Trust-wide policy will be sponsored by a lead Executive. At Directorate/ Departmental level, Policies and other Written Control Documents will be sponsored by the appropriate Director/Head of Department. The Director of Corporate Governance and Chief of Staff will ensure that all Policies and Other Written Control documents are reviewed and appropriately monitored.

10.2 The development of new Policies and other Written Control Documents, or the amendment of existing documentation, will be overseen by the appropriate lead Executive/Director. They will be responsible for ensuring that content and scope are fit for purpose before being presented for approval.

10.3 When the need for a new policy document arises, the Policy Process Manager should be informed before preparation commences to ensure there is not a Policy or other Written Control Document already in existence locally or nationally on the same or similar subject, thus avoiding duplication of effort. Authors should complete the initial Document Approval Checklist (Appendix 1) and send to the generic Policy email account [insert email address when set up].

10.4 Once the need and type of Policy or other Written Control Document is identified, the process for production and approval must follow that contained within this Policy. A flowchart depicting this process is set out on page 7.

10.5 The language used should be plain English, using short sentences and where possible avoiding technical terms. If technical terms are used, they should be explained using a glossary or footnotes. In accordance with the requirements of the Data Protection Act 2018, the names of individuals will not be contained within policies and other written control documents. Individuals with particular responsibilities will be identified by their job title only.

10.6 All Policy and Written Control Document development should be undertaken in line with current legislation, national and professional guidance. Documentation should also be based on sound evidence and be appropriately referenced.

10.7 **Health and Care Standards**
All Policies and other Written Control Documents should outline how they contribute to compliance with the Health and Care Standards and should also indicate to which Standards this area of activity is linked.

10.8 **Well-being of Future Generations (Wales) Act 2015**
The Well-being of Future Generations (Wales) Act 2015 is about improving the social, economic, environmental and cultural well-being of Wales. As a listed body, we are mandated to assess our long-term impact, work better with people and communities and each other, look to prevent problems and take a more joined-up

approach. This will help us to create a Wales that we all want to live in, now and in the future. To make sure we are all working towards the same vision, the Act puts in place seven well-being goals:

- A Prosperous Wales
- A Resilient Wales
- A Healthier Wales
- A More Equal Wales
- A Wales of Cohesive Communities
- A Wales of Vibrant Culture and Thriving Welsh Language
- A Globally Responsible Wales

The Act also lists the 5 Ways of Working:
- Long Term
- Collaboration
- Prevention
- Involvement
- Integration

All Policies and other Written Control Documents must consider provisions and demonstrate that all key goals were considered in the development of the document.

Each Well-being Goal and the 5 Ways of Working are incorporated into the Integrated Impact Assessment, refer to Appendix 5 for further detail. All documentation is required to highlight how it contributes to at least one Well-being Goal and assesses the whether the documentation adheres to the 5 Ways of Working.

10.9 **Integrated Impact Assessment**
The Equality Act 2010 requires the undertaking of various impact assessments and all Trust Policies and other Written Control Documents will require the completion of these before the document is consulted upon. The impact assessments are a process to find out whether a 'policy' will affect people differently on the basis of their 'protected characteristics': age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion, sex or sexual orientation and if it will affect their human rights. It also takes account of Welsh Language issues. It is designed to ensure that the Trust is taking into consideration the needs of all individuals who work for it and/or access its services.

The Trust has adopted an integrated approach to impact assessment, which combines the equality and health assessment alongside environmental impacts, Welsh Language whilst assessing the document against the requirements within the Well-being of Future Generations (Wales) Act 2015 and the Socio-Economic Duty.

A health impact assessment is a process that considers how the health and well-being of a population may be affected by a proposed action, be it a policy, programme, plan, project or a change to the organisation or delivery of a particular public service. Some impacts of policies on health may be direct, obvious and/or intentional, whilst others may be indirect, difficult to identify and unintentional. A health impact assessment is a systematic, objective, flexible and practical way of

assessing both the potential positive and negative impacts of a proposal on health and well-being and suggests ways in which opportunities for health gain can be maximised and risks to health minimised. Health impact assessment looks at health in its broadest sense, using the wider determinants of health as a framework.

Where another Written Control Document has been developed in support of a policy it may not be necessary to undertake a further Integrated Impact Assessment. If an Integrated Impact Assessment has not been completed the reason for this will be explained at the beginning of the document. Where an Integrated Impact Assessment has been completed the impact will be included in the document.

10.10 **Environmental Management**

The Trust is accredited to the Environmental Management System (EMS) ISO 14001:2015 which is the internationally recognised standard for managing the environment. The EMS provides a framework for managing environmental impacts associated with the Trust's activities.

The system applies to both the public and private sectors and demonstrates that the organisation has a formal system in place for managing the environment.

The system is based on the principle of continual improvement and requires the Trust to demonstrate this by the use of Key Performance Indicators and progress towards environmental objectives and targets. This framework allows an organisation to understand, describe and control its significant impacts on the environment, reduce the risk of potentially costly pollution incidents, ensure compliance with environmental legislation and continually improve its business operations.

An environmental impact assessment is undertaken as part of the Integrated Impact Assessment process and is an assessment of the possible positive or negative impact that a proposed project may have on the environment, together consisting of the natural, social and economic aspects.

The purpose of the assessment is to ensure that decision makers consider the ensuing environmental impacts when deciding whether to proceed with a project. Advice on areas that require an environmental impact assessment can be obtained from the Trust's Environmental Development Officer.

11.   DOCUMENT FORMAT

11.1   A document template has been developed to provide guidance on what information should be contained in which policy/other written control document along with some standard clauses that can be used as appropriate (Appendix 4) and indicates fields that are mandatory. It also contains the standard front cover which is to be applied to Trust Policies and other Written Control Documents, together with some specific points regarding formatting. See Appendix 4 and the Policies Intranet page.

11.2   This Template must be used for all Trust-wide, Divisional or multi-departmental documents. Where a document is only applicable within a single Department or, for example consists of a flow chart, an alternative format is acceptable and a "basic

template" is also shown below. As a minimum the principles listed below must still be followed:

- Document must have a clear heading.
- The scope and objectives must be defined.
- The status of the document must be clear e.g. guidance/mandatory requirement.
- Instructions/guidance must be logically recorded.
- Date of approval shown.
- Date of review shown.
- Author's details.
- Pages numbered.

11.3   The language used for all documents should be plain English, using short sentences and where possible avoiding technical terms. If technical terms are used, they should be explained using a glossary or footnotes.

11.4   Policies and other written control documents will not be routinely translated into other languages. However, where staff are aware that this may cause difficulty for patients, donors or their families, they will ensure that the content is explained to them by an interpreter or translated if necessary.

11.5   In accordance with the requirements of the Data Protection Act 1998, the names of individuals will not be contained within policies and written control documents. Individuals with particular responsibilities will be identified by their job title only.

11.6   If the Trust is adopting an externally approved document it will not need reformatting providing it meets the standards set above. These documents will be given a reference number, recorded and uploaded as if they were a Trust document.

12.   ENGAGEMENT AND CONSULTATION

12.1   Policies and other Written Control Documents must not be written in isolation.

12.2   Engagement and consultation on all Policies and other Written Control Documents should take place with the target audience including appropriate stakeholder, service user/carer, managerial, clinical and staff representation. Where appropriate, documents should be co-produced with that target audience.

12.3   The Trust has a range of mechanisms to involve patients, carers, donors and members of the public in its work. This will strengthen the stakeholder involvement with the Trust and demonstrate our commitment to working with the local community and develop our services and policies jointly. Where appropriate, the relevant patient and donor Engagement Leads should be contacted.

12.4   When a final draft has been developed the formal consultation can start. The consultation period should allow enough time to enable the key stakeholders to have had an opportunity to consider and input into the consultation. If necessary, the Policy Process Manager can provide advice.

12.5   The policy author should send the document and Integrated Impact Assessment (if applicable) to the Policy Process Manager who will arrange for the documents to be

uploaded onto the Trust's Policy Page on the Intranet. They will also make sure that they are brought to the attention of appropriate stakeholders in a timely manner. This will include the Community Health Council in accordance with mutually agreed principles.

12.6   The author, in association with the appropriate Executive/Director lead, must document the consultation arrangements and provide assurance to the approving advisory group, forum, sub-committee or committee that this has been conducted thoroughly and that comments have been incorporated into the policy or written control document where appropriate. The groups/individuals consulted will be clearly identified in the report presented to the approving advisory group, forum, sub-committee or committee.

13.   REVIEW PROCESS

13.1   The Policy or other Written Control Document Author who owns the Policy or Written Control Document is responsible for ensuring it remains in line with current legislation, guidance and evidence and therefore is required to review the Policy or other Written Control Document in light of new or updated legislation and/or guidance (NICE, Professional bodies) as it is published.

13.2   All Policies and Written Control Documents should be reviewed on a minimum cycle of three years. With the exception that a small number of documents need to be reviewed annually (and this requirement will be identified in individual documents by their authors). Sometimes, a document which was subject to a three-year cycle will also need to be reviewed earlier in the light of changing practice or Welsh Government guidance/ policy changes etc. However, if no revisions have occurred in the preceding three years, it must be subject to the full Policy or other Written Control Document process. The author of the individual document is responsible for ensuring this takes place.

13.3   Nine months prior to the review date, the Policy Process Manager will contact the document author who owns the Policy or other Written Control Document to notify them that their document is due for reviewing. The author, in conjunction with the Executive/Director lead who owns the Policy or other Written Control Document, is responsible for ensuring that the document is reviewed by the review by date. If it is foreseen that the review date will not be met, the approving advisory group, forum, sub-committee or committee must receive assurance that the current version of the Policy or other Written Control Document is still fit for purpose and agree an extension of up to a maximum of six months. Any material or significant changes to an existing Policy or Written Control Document will require it to be re-approved by the approving advisory group, forum, sub-committee or committee following the Policy and other Written Control Document process.

13.4   Until a document is reviewed, it will remain the extant policy document of the Trust until replaced. It is the responsibility of the policy author to ensure that documents are reviewed in line with their review dates.

13.5   Organisational change can lead to more than one version of a document on a given subject area existing. In such instances the author will take steps to develop a

single version of the document. Should this not be achieved prior to the document reaching three years post approval it will be archived.

13.6   To assist Executive/Director leads to maintain an oversight of the documents approaching three years post-approval, a bi-annual report will be sent to the Executive Management Board and relevant advisory group, forum, sub-committee or committee by the Policy Process Manager providing a summary of the position.

14.   PUBLICATION, DISSEMINATION AND DISTRIBUTION

14.1   The Policies and other Written Control Documents which are approved through the Scheme of Delegation for the Trust are centrally managed through the Corporate Governance Department. A Trust Policy database is in place and once a document has been entered onto the database, approved and published on the internet, this should be regarded as the only official Trust version for dissemination to and use by Trust employees.

14.2   Where a Policy or Written Control Document has been superseded, the archived copy will be held on file by the Policy Process Manager but will no longer be available via the internet. The Trust is required to keep a record of all archived, out of date Policies and other Written Control Documents, in line with WHC (2000) 071 for the Record and Records Management Policies.

14.3   Each department/service which develops/reviews Policies and other Written Control Documents must set up their own local document management system. This must hold all current and out of date Policies and other Written Control Documents. All out of date documents must be kept for **a period of 30 years in line with the WHC (2000) 071 For the Record.**

14.4   All policies and other written control documents that have been ratified appropriately must be forwarded to the Policy Process Manager within ten working days of approval. They will then ensure that the document is:

*   Added/updated on the Trust Policy database;
*   Cascaded in line with the Trust's communications system;
*   Included within the Executive Management Board and Trust Board regular reporting;
*   Uploaded onto the intranet;
*   Included in the Freedom of Information Publication Scheme.

14.5   The Trust's intranet site will be the primary location for all Policies and other Written Control Documents to ensure that staff can access the most up to date versions. Where hard copies need to be circulated, these should be downloaded from the intranet site by the appropriate Line Manager.

14.6   Relevant documentation will also be published on the Trust's internet site, in line with Freedom of Information Act requirements.

14.7   All documents will be subject to version control and archived in line with legal requirements. Once revised Policies and other Written Control Documents are

approved, the Policy Process Manager will e-mail the author/policy lead to inform them in order that they can ensure appropriate dissemination to their staff.

14.8   Once issued, individual Line Managers will be responsible for ensuring that all staff are aware of the revisions and that any out of date versions are taken out of local circulation. Each Directorate/Department will put in place a robust controlled documentation system to ensure that records of distribution of policies and other written control documents are maintained.

14.9   Information on new and revised policies will be cascaded in line with the Trust's communications system. Where appropriate other communication channels may be used to inform staff of policy development (for example, inclusion with payslips).

14.10   It is the responsibility of the author of a Policy or Written Control Document to ensure that when a document is revised, a copy of the original is forwarded to the Policy Process Manager for audit purposes.

14.11   The Director of Corporate Governance and Chief of Staff will ensure that the register of all Policies and other Written Control Documents is reported bi-annually to the Executive Management Board, relevant advisory group, forum, sub-committee or committee and Trust Board.

15.   TRAINING

15.1   All Executive/Director leads will work with the Executive Director of Organisational Development and Workforce to ensure that there is an ongoing training programme for all staff that incorporates the implementation of Policies and other Written Control Documents. Key subject areas will be included at local induction and as part of staff development processes.

15.2   Line Managers must ensure that new starters are aware of this policy, induction arrangements and of their individual departmental processes.

15.3   It is the responsibility of individual Line Managers to inform the Executive Director of Organisational Development and Workforce of the requirement where specific staff training needs are identified, particularly in relation to the implementation of new or updated documents.

15.4   Executive/Director leads will ensure that responsibilities for policy development are clearly outlined in each individual Job Description, in accordance with their role.

16.   IMPLEMENTATION AND POLICY COMPLIANCE

16.1   Any advice required on implementation of this policy should be obtained via the Policy Process Manager.

16.2   All policies should be part of the Trust and/or Directorate/Department auditing process to ensure that they:
* have been implemented effectively;
* are fit for purpose; and
* are being complied with.

16.3	Information regarding the frequency of the monitoring arrangements should be included within the main policy document. If appropriate, questionnaires can be used for staff feedback to evaluate any policy and supporting written control documentation.

16.4	It will be necessary to ensure that all documents are being produced, vetted, approved and disseminated in accordance with this policy. Periodical 'spot checks' will be carried out in all areas to ensure that all policies and other written control documents comply with this policy.

16.5	Compliance will also be monitored as part of the Health and Care Standards for Wales Annual Review process.

16.6	Where documents are submitted for publication but do not meet the pre-publication requirements they will be **not be published**. Such documents will be returned to the Executive Sponsor for action.

## 17.	REVIEW PERIOD

17.1	This policy will be reviewed every three years, or sooner should the author or legal requirements deem it to be relevant or required.

## 18.	ACKNOWLEDGEMENTS

18.1	This policy has been developed following benchmarking with the following:

Aneurin Bevan University Health Board, (ABUHB001) Policy and Procedure for the Management of Policies, Procedures and other Written Control Documents – approved May 2017

Cardiff and Vale University Health Board, (UHB 001) Management of Policies, Procedures and Other Written Control Documents Policy – approved November 2017

Hywel Dda University Health Board, (190) Written Control Documentation Policy and Procedures – approved February 2021

Public Health Wales, (PHW47/TP01) Policies, Procedures and Other Written Control Documents Management Procedure – approved September 2019

Swansea Bay University Health Board, (HB76) Policy for the Management of Health Board Wide Policies, Procedures and Other Written Control Documents (WCD) – approved July 2019.

APPENDIX 1

DOCUMENT FOR APPROVAL CHECKLIST

This form should be completed and approval to proceed obtained before you start producing your document. The Equality and Health Impact Assessment, known as the Integrated Impact Assessment, should also have been started and any Welsh Language requirements considered.

To be completed by document author.

1. Proposed/existing title of document

2. 'Owning group' – which advisory group, forum, sub-committee or committee will own the document?

Name of Group		Chair of Group		
Please indicate (further details may be requested if applicable)	Internal Trust Group	Yes	No
	Multi-Agency Group	Yes	No
	Regional Group	Yes	No

3. What type of document are you proposing/adopting/reviewing? Please select

Policy		Strategy		Procedure		Guideline	
Protocol		Other		Please describe			

New		Existing	

4. Which category will it be/is it?

Clinical		Corporate	

If it is a corporate document will/does it impact on patient/donor care?

Yes		No	

5. **What is the reason for developing/adopting/reviewing this document?**
Please tick the box that is most relevant. If there are no relevant boxes, please tick other and ensure that you specify the reason in the box

	Insert tick for most relevant
Improve/standardise clinical care/organisational procedures	
In response to complaint, incident or claim	
In response to alerts, safety notifications, WHCs, etc.	
Re-organisation of service/department	
New/amended legislation	
All Wales documents / national guidance documents to be adopted for use	
Replacing/updating existing written control documents. If so, which ones (Please include policy reference and full name:	
Other (please specify):	

6. **What will be/is the aim of the document? What risks are being mitigated?**

7. **Which other written control documents will be/are relevant to the document?**

Document Number	Document Name List all document names and numbers that are relevant to this document

8. **What will be/is the scope of this document?**
What service area is covered by the document? Who does it affect? What patient groups? What professional groups or individuals does it affect? What competence is required by staff to use this procedure, e.g. completion of specific training, e-learning, formal qualification, competency framework, is required from users of the procedure?

9. **Collaboration with Key stakeholders – What staff groups/professional groups/clinical specialities/services will be/are responsible for implementing/complying with this document?**
These key stakeholders' will need to be involved in the development/adoption/review of the document to eliminate any barriers to its implementation prior to approval (see policy for guidance).

| |
| |

10. **Collaboration with others**
Involvement is an essential component of developing/adopting/reviewing the document.
Please indicate which of the following need to be considered when developing/reviewing this document

Compliance with legislation / regulation / alert	Please tick √
Consent	
Deprivation of Liberty Safeguards (DOLS)	
Mental Capacity Act (MCA)	
Mental Health Act	
Safeguarding	
Data Protection/Records Management and Information Governance	
Welsh Language	
Counter Fraud	
Equality, Diversity and Inclusion	
Socio Economic Duty	
National Safety Standards for Invasive Procedures (NatSSIPs)	
Alert/NCEPOD	
Interested Parties	
NICE Guidance	
Patient/Donor Information	
Training / Learning and Development	
Legal	
Financial	
Workforce	
Medicines Management	
Medical Devices	
Infection Prevention & Control	
Business Continuity / Emergency Planning / Major Incident	
Health and Social Care (Quality and Engagement) (Wales) Act 2020	

11. **Who will be/is the sponsoring Executive/Director Lead and date they agreed to own this document?**

Job Title	
Date	

12. Who will be/is the lead author/main contact for this document?
An individual's name and details will need to be provided as a contact for this document for any queries arise both during development and after approval.

Name	
Job Title	
Email Address	

Date of Completion:		**Name of person completing this form**	
Chair of the Owning Group:		**Signature of the Chair of the Owning Group:**	

**PLEASE SEND COMPLETED CHECKLIST FORM TO THE
POLICY PROCESS MANAGER [insert Policy inbox email address link]**

APPENDIX 2

TYPES OF WRITTEN CONTROL DOCUMENTS (DEFINITIONS)

Written Control Document – Is a supporting strategy, procedure, protocol, guideline or standard referred to collectively as other Written Control Documents within this Policy.

Strategy - A strategy is a broad statement of an approach designed to accomplish the desired objectives or goals and can be supported by other Written Control Documents. Strategies are always organisational wide and required to be approved by the Board via the Scheme of Delegation.

Policy – A written statement of intent, describing the broad approach or course of action that the Trust is taking with a particular issue. Policies are underpinned by evidenced based procedures and guidelines and are mandatory. Policy documents may be used to support the Trust during legal action.

The formulation of policies allows the Trust to produce formal agreements, which clearly defines the commitment of the organisation and the obligations of individual staff.

Procedure - A standardised method of performing clinical or non-clinical tasks by providing a series of actions to be conducted in an agreed and consistent way to achieve a safe, effective outcome. This will ensure all concerned undertake the task in an agreed and consistent way. These are often the documents detailing how a policy is to be achieved.

Procedures can be written as part of a policy document (in which case they are mandatory) or as 'stand-alone' documents (in which case they are discretionary).

Where procedures are formulated utilising evidence-based knowledge and best practice guidelines, they must include reference of any researched evidence used.

'Stand-alone' procedures give the user the means to carry out specific tasks. This may be within the overall control framework of the organisation or to regulate activities to achieve a quality outcome. 'Stand-alone' procedures do not have the same status in law as a policy; however, failure to follow a specific procedure may prejudice the successful defence of a claim against the organisation.

Protocol - A written code of practice, including recommendations, roles and standards to be followed, which can also include details of competencies and delegation of authority.

Protocols are different from policies as they lack the 'mandatory' element and by allowing for professional judgement, individual cases and competency to play a role they are flexible working documents.

Within a protocol it must be clear by whose authority is it being implemented, what the scope of the protocol is and what procedure is to be followed if practice is to be outside of the protocol.

In the case of clinical protocols, clinicians must be advised in every document that it is for their guidance only and the advice should not supersede their own clinical judgement.

Guidelines - Give general advice and recommendations for dealing with specific circumstances. They differ from procedures and protocols by giving options of how something might be carried out. They are used in conjunction with knowledge and expertise of the individual using them.

Guidelines are not prescriptive. However, whilst guidelines are not mandatory, it could prove difficult to defend a case where agreed guidelines had not been followed.

National Clinical Guidelines - The National Institute Health and Clinical Excellence (NICE) defines guidelines as:

> *"systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances. Research has shown that if properly developed, disseminated and implemented, guidelines can lead to improved patient care" (NICE 1999).*

Standards - The Royal College of Nursing definition is:
> *"to provide a record of service or representation of care which people are entitled to experience, either as a basic minimum or for use as a measure of excellence" (RCN 1997)*

The Health and Care Standards define standards as:
> *"Standards are a means of describing the level of quality health care organisations are expected to meet or to aspire to. The performance of organisations can be assessed against this level of quality" (Welsh Government 2015).*

Standard statements are accompanied by a description of the structure and process needed to attain specified observable outcomes.

Standards are not generally prescriptive; it could prove difficult to defend a case if a standard is not adhered to.

CLASSIFICATION OF DOCUMENTS

Clinical – Clinical Written Control Documents relate to the care and treatment of patients within the organisation and offer an evidence-based approach to making a series of clinical decisions for patients with a given condition.

Corporate – Corporate Written Control Documents relate to the management of the organisation and formulate the organisation's response to known situations and circumstances.

Employment – Employment Written Control Documents relate specifically to the management of employees (however defined) within the organisation and are a written source of guidance on how a wide range of issues should be handled within an employing organisation, incorporating a description of principles, rights and responsibilities for managers and employees.

DOCUMENTS RESERVED FOR APPROVAL BY THE TRUST BOARD AND OR ONE OF ITS COMMITTEES, GROUPS OR FORUMS

AREAS COVERED	DOCUMENT SPONSOR	ENDORSING GROUP	ENDORSING BODY	APPROVING BODY
Standing Orders	**Director of Corporate Governance and Chief of Staff**	**Executive Management Board**	**Audit Committee**	**Trust Board**
Risk Management Trust Assurance Framework	**Director of Corporate Governance and Chief of Staff**	**Executive Management Board**	**Audit Committee**	**Trust Board**
Citizen Engagement & Involvement Partner & Stakeholder Engagement Corporate Governance	**Director of Corporate Governance and Chief of Staff**	**Executive Management Board**	**Quality, Safety & Performance Committee**	**Trust Board**
Standing Financial Instructions Financial Management Financial Governance Commissioning Arrangements	**Executive Director of Finance**	**Executive Management Board**	**Audit Committee**	**Audit Committee**
Information Governance Health Records	**Executive Director of Finance**	**Executive Management Board**	**Quality, Safety & Performance Committee**	**Quality, Safety & Performance Committee**
All aspects of Workforce and Organisational Development including Wellbeing, Equality, Diversity & Human Rights (including all-Wales workforce policies on behalf of the Trust Board). Welsh Language	**Executive Director of Organisational Development and Workforce**	**Executive Management Board**	**Local Partnership Forum Quality, Safety & Performance Committee**	**Trust Board**

AREAS COVERED	DOCUMENT SPONSOR	ENDORSING GROUP	ENDORSING BODY	APPROVING BODY
Clinical Audit & Effectiveness Inquests Clinical Strategy	**Medical Director**	**Executive Management Board**		**Quality, Safety & Performance Committee**
Research & Development Innovation Intellectual Property Policy	**Medical Director**	**Executive Management Board**		**Research, Development & Innovation Sub Committee**
Medicines Management Civil Contingency/Emergency Planning Arrangements	**Chief Operating Officer**	**Executive Management Board**		**Executive Management Board**
Major Incident Plan/Business Continuity	**Chief Operating Officer**	**Executive Management Board**	**Strategic Development Committee**	**Trust Board**
Quality, Safety and Performance of patient and service user centred healthcare Patient Experience including Complaints, Incidents & Litigation Safeguarding Human Tissue Act	**Executive Director of Nursing, Allied Health Professionals & Health Sciences**	**Executive Management Board**		**Quality, Safety & Performance Committee**
Infection Prevention & Control	**Executive Director of Nursing, Allied Health Professionals & Health Sciences**	**Infection Prevention & Control Management Group**	**Executive Management Board**	**Quality, Safety & Performance Committee**
Nursing Services Nutrition Allied Health Professional Services Health Sciences	**Executive Director of Nursing, Allied Health Professionals & Health Sciences**			**Executive Management Board**

AREAS COVERED	DOCUMENT SPONSOR	ENDORSING GROUP	ENDORSING BODY	APPROVING BODY
Integrated Medium Term Plan Performance Management Framework	**Director of Strategic Transformation, Planning & Digital**	**Executive Management Board**	**Strategic Development Committee**	**Trust Board**
IM&T Arrangements and Digital Delivery Health & Safety Performance Arrangements Estate Plans	**Director of Strategic Transformation, Planning & Digital**	**Executive Management Board**		**Quality, Safety & Performance Committee**
Strategy Planning Sustainability/Environment Management	**Director of Strategic Transformation, Planning & Digital**	**Executive Management Board**		**Strategic Development Committee**
Investments Fundraising Bequests Donations	**Executive Director of Finance**	**Executive Management Board**		**Charitable Funds Committee (in conjunction with Charitable Fund Trustees)**

APPENDIX 4

POLICY OR WRITTEN CONTROL DOCUMENT TEMPLATE

Ref: (   )

(DOCUMENT TITLE)

Executive Sponsor & Function

Document Author:

Approved by:

Approval Date:

Date of Equality Impact Assessment:

Equality Impact Assessment Outcome:

Review Date:

Version:

TEMPLATES FOR DOCUMENTS

The template and control sheet should be used by anyone wishing to formulate any written control system. Documents should be formatted in line with Corporate Style as follows:

Electronic format	Microsoft Word - PDF Read only
Front cover	Corporate template
Audit trail	Use Policy process
Body text	Arial 12
Headings	Arial 12 (UPPER CASE)
Tables and charts	Arial (size as appropriate)
Use of bold	Headings only
Alignment	Justified
Line spacing	Body text single
Paragraph spacing	One line between paragraphs. Two lines between main sections.
Underlining	None
Contents page Contents page if >3 pages	As template Use judgement - help reader to find relevant information more easily.
Staff Names	Use titles rather than names.
Logo	Use Trust logo.
Headers and footers	Arial 9
Margins	Top and bottom of page 2.5cm, sides 2.5cm.
Document Title	To be included in the header on every page
Page numbering	To be included in the footer (e.g. page x of x)
Bullets	• Use standard bullets only, as they do not always format across different systems.
Abbreviations	State in full in first usage with abbreviation in brackets.
Printing	A4/double sided.
Referencing	All reference material should be listed in full at the end of every document in Harvard style.
Glossary of terms	As all policy documents are subject to the Freedom of Information Act, they need to be user friendly as they are documents that can be held up to public scrutiny. Therefore, all abbreviations, jargon and specific wording must be clearly explained to the reader.
Version Control	Reference Number provided by the Corporate Governance Manager. Documents to state 'Draft' whilst in development.

COMPONENTS OF A POLICY

All Policies must include the following headings as a minimum

Introduction/Aim	What is the purpose of the document? What is it about? Why is it needed? This should include where necessary reference to external regulations or other relevant guidance. This may require information relating to audit, risk management, quality and safety.
Objectives	What will the document achieve?
Scope/Area of Application	Exactly who the policy applies to and the consequences for non-compliance where appropriate: - All staff? - Directorate/Clinical Department/Corporate Department specific?
Roles and Responsibilities	- Who is responsible for implementation? - Which groups of staff are able to carry out the procedures required? - What action points does the document raise? - Who is responsible for ensuring action points are undertaken? - Who is accountable if the responsibilities are not followed?
Main Body	Show how the document aims and objectives will be achieved. Reference evidence appropriately.
Resources	Are there any resource issues in order for the document to be implemented? Financial/Time/Training – these must be identified as if there are no resources the document will not be achievable.
Training	- Are there any training issues and if so, who is responsible for the training programme? - Who will keep a record of those members of staff who have been trained? - Will there be update training? How often? If the document compliance is not carried out for any length of time at what stage will the person cease to be authorised to carry out that policy? Where appropriate, specify the grade and required education and training of staff implementing the document.

Implementation and Policy Compliance	How will the document be implemented? • Action Plan? • Timescales? • What level of training should they have? This will be the main part of the policy, generally divided into sections and describe in detail what has to be done in order to comply with the policy and achieve the policy objective. The document needs to set out how compliance with the policy is to be measured and reported.
References	Policies must be based on sound evidence and be appropriately referenced. Name any recognised relevant professional body, for example the source of your evidence base. Where appropriate, specify what is required to be documented in patients' notes. Clinical policies should also include a review of the evidence used and a reference list of that evidence.
Health and Care Standards	This section should outline how the policy or written control document contributes to compliance with the Health and Care Standards and should also indicate to which Standards this area of activity is linked.
Integrated Impact Assessment	Has an equality and health impact assessment been carried out? If 'no' the reason for this will be explained at the beginning of the document. If 'yes' the impact will be included in the document and appended. Explain how the document promotes equality of opportunity and/or good relations between different groups. For further information contact the Equality, Diversity and OD Manager
Environmental Impact	Does an Environmental Impact Assessment need to be carried out? For further information contact the Trust's Environmental Development Officer.
Audit	This is required to ensure that the document is appropriate and achievable and that there is compliance with the document by staff. An audit tool must therefore be built into the policy document.
Review	Generally, 3 years unless legislation requires differently – check with Corporate Governance Manager.
Getting Help	Details of the specific office or department to contact for interpretations, resolution of problems and other special situations.

A policy may also need to contain the following additional components	Related Policies and/or written control documents Where other policies are relevant these should be listed. **Information, Instruction and Training** This section is relevant where instruction, training and supervision is necessary for to meet the policy requirements. It should detail when, how often and by whom the action will be taken and any requirement for keeping training records should be indicated. **Main Relevant Legislation** A list of the relevant statutory provisions which influence the organisation's operation in relation to the policy.

CHARACTERISTICS OF POLICIES AND WRITTEN CONTROL DOCUMENTS

The overall goal is for the design to be simple, consistent and easy to use.

Writing Style:
- Factual - accuracy should be double checked
- Should not provide information that may be quickly outdated
- If an acronym is used, it should be in full initially
- Not excessively technical, must be simple enough to be understood by a new member of staff

Policies should:
- Be written in clear, concise and simple language wherever possible
- Identify the rule rather than how to implement the rule
- Be based on sound evidence and be appropriately referenced.
- Be readily available and their authority should be clear.
- Indicate designated "experts" who can interpret documents and resolve problems
- Represent a consistent, logical framework for action

Written Control Documents should:
- Be clear in terms of how the procedure helps the organisation achieve its aims and objectives.
- Be developed with the client/patient/relative/carer/objective in mind. Well-developed and thought-out procedures provide benefits to the procedure user.
- Involve users in their development where appropriate to engender a sense of ownership

Design and Layout of Policy and Written Control Documents
- Use Arial text
- Number paragraphs and pages
- Generous use of white space
- Structure the presentation so that the reader can quickly focus on the aspect of policy relevant to the decision in hand
- Headings need to be consistent, e.g. location on each page, type size, bold etc.
- Footer should contain: the page number

APPENDIX 5

Integrated Impact Assessment Process and Form

The Equality Act 2010 requires the undertaking of equality and health impact assessments and all Trust policies will require the completion of such before the policy is consulted upon. This is a process to find out whether a 'policy' will affect people differently on the basis of their 'protected characteristics': age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion, sex or sexual orientation and if it will affect their human rights. It also takes account of Welsh Language issues. It is designed to ensure that we are taking into consideration the needs of all individuals who work for us and/or access our services.

The Integrated Impact Assessment (IIA) is a process that considers how the health and well-being of a population may be affected by a proposed action, be it a policy, programme, plan, project or a change to the organisation or delivery of a particular public service. Some impacts of policies on health may be direct, obvious and/or intentional, whilst others may be indirect, difficult to identify and unintentional. The IIA is a systematic, objective, flexible and practical way of assessing both the potential positive and negative impacts of a proposal on health and well-being and suggests ways in which opportunities for health gain can be maximised and risks to health minimised. HIA looks at health in its broadest sense, using the wider determinants of health as a framework. This will ensure that any negative or indirect discrimination which could be an outcome of the policy, etc. is identified and risk assessed, linking to the Trust Risk Management Policy and Strategy. All final policies must include reference to the Integrated Impact Assessment that has been undertaken.

Where a procedure or other written control document has been developed in support of a policy it may not be necessary to undertake a further Integrated Impact Assessment. If an IIA has not been completed the reason for this will be explained at the beginning of the document. Where an IIA has been completed, the impact will be included in the document.

IIAs will be published as part of the consultation process and they will be available on our internet and intranet sites alongside the relevant policy or written control document.

One of the key requirements is the need to involve stakeholders in the process, whether internal or external. This ensures that any potential areas for discrimination are identified and solutions are sought to prevent discrimination.

In addition, the Trust's IIA process also includes the Welsh language and carers as well as adopting a human rights-based approach, ensuring dignity and respect are also evaluated in the process.

Equality Impact Assessment (EQIA) Group

The Trust has established an Equality Impact Assessment Group, which has representation from each division and hosted organisations, as well as Sustainability, Quality and Risk, Governance, Workforce and Occupational Development, Finance, Welsh Language and Staff side representation. The group meets monthly to undertake assessments with the relevant policy leads etc. Once the IIAs are complete, the policy/ procedure/ guidance/ business plan/proposed service change can then go out to full

internal consultation, before being submitted to the relevant advisory group, forum, sub-committee or committee and, where required to the Trust Board for approval. This process ensures that the Trust does not approve documents or services changes which have not been appropriately impact assessed and enables the Trust to meet its statutory duties as part of the Equality Act 2010.

The group meets monthly to conduct assessments with the policy or service lead. It you are planning to write a policy, change a procedure and develop a service you need to ensure that it undergoes and assessment and that you attend one of the meetings.

An Integrated Impact Assessment form must be completed as part of the assessment process. Prior to attending the EQIA Group meeting the policy author/lead will be required to complete and forward the first page of the Integrated Impact Assessment form to the Equality, Diversity and OD Manager.

To arrange for your policy or written control document to be assessed at a future EQIA Group, or to attend one of the meetings, please contact the Trust's Equality, Diversity and OD Manager.

Integrated Impact Assessment	
Ref no:	
Name of the policy, service, scheme or project:	
Service Area	

Preparation	
The purpose and aims of the policy, procedure, strategy or decision required Please include: • the overall objective or purpose • the stated aims (including who the intended beneficiaries are • a broad description of how this will be achieved • the measure of success will be • the time frame for achieving this • a brief description of how the purpose aims of the policy are relevant to equality and intended beneficiaries.	
Who is the Executive Sponsor?	**Please Select**
We have a legal duty to engage with people with protected characteristics under the Equality Act 2010 identified as being relevant to the policy. • What steps will you take to engage and consult with stakeholders, (internally and externally)?	

• How will people with protected characteristics be involved in developing the policy, procedure, strategy and or decision from the start? • Outline how proposals have/will be communicated? • What are the arrangements for engagement as the policy/procedure/strategy or decision is being implemented?	
Does the policy assist services or staff in meeting their most basic needs such as; • Improved Health • Fair recruitment etc.	
Who and how many (if known) may be affected by the policy?	
In review of the Well-being of Future Generations Act Which Well-being Goals does this contribute to and how? Please select from drop down box, if multiple, please list. If none, how will it be adapted to contribute to one?	**Please Select**
Evidenced used/considered Your decisions must be based on robust evidence. What evidence base have you used in support? Evidence includes views and issues raised during engagement; service user or citizen journeys, case studies, or experiences; and qualitative and experience-based research, not just quantitative data and statistics.	

Please list the source of this evidence; • Identify and include numbers of staff, broken down by protected characteristics and other relevant information • What research or other data is available locally or nationally that could inform the assessment of impact on different equality groups? Is there any information available (locally/nationally) about how similar policies/procedures/strategies or decisions have impacted on different equality groups (including any positive impact)? Do you consider the evidence to be strong, satisfactory or and are there any gaps in the evidence?	
Who is involved in undertaking the Integrated Impact Assessment?	

Equality Duties, Sustainable Development Principles

Does the policy/procedure, strategy, e-learning, guidance etc meet • Public Sector & specific duties - Equality Act 2010 • Welsh Language Standards (2011) • Sustainable Development Principles?	Protected Characteristics									Additional		Ways of Working				
	Race	Sex/Gender	Disability	Sexual orientation	Religion and Belief	Age	Gender reassignment	Pregnancy and Maternity	Marriage/ civil Partnerships	Welsh Language	Carers	Long Term	Collaboration	Involvement	Prevention	Integration
To eliminate discrimination and harassment	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Promote equality of opportunity	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔					
Promote good relations and positive attitudes	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔					
Encourage participation in public life	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔					
In relation to disability only, should the policy/service/project or scheme take account of difference, even if involves treating some individuals more favourably?	✔															

Key	
✔	Yes
X	No
-	Neutral

Human Rights Based Approach – Issues of Dignity & Respect

The Human Rights Act contains 15 rights, all of which NHS organisations have a duty. The 7 rights that are relevant to healthcare are listed below.			
Consider is the policy/service/project or scheme relevant to:	**Yes**	**No**	**N/A**
Article 2: The Right to Life	✔		
Article 3: the right not to be tortured or treated in an inhumane or degrading way	✔		
Article 5: The right to liberty	✔		
Article 6: the right to a fair trial	✔		
Article 8: the right to respect for private and family life	✔		
Article 9: Freedom of thought, conscience and religion	✔		
Article 14: prohibition of discrimination	✔		

Measuring the Impact

Reason for your decision (including evidence used). Include details of how it might impact on people from this group and how opportunities to advance equality and good relations have been maximised.	
Protected Characteristics & Other Areas	**Impact – operational & financial**
• **Race** • **Sex** • **Disability** • **Sexual orientation** • **Religion belief & non belief** • **Age** • **Gender Identity** • **Pregnancy & maternity** • **Marriage & civil partnership** • **Carers**	
Welsh Language Standards	**Impact – Operational & Financial**

Does the policy, service, or project have positive or negative effects on:
   a) Opportunities for persons to use the Welsh language?
   b) Does it treat the Welsh language less favourably than the English language?
 	
The Welsh language Standards are:
1. Operational Standards – how we operate
2. Service Delivery – how we deliver our services
3. Record Keeping – how we keep a record of our services e.g. language needs of patients or donors
4. Policy making – how we develop our policies
5.Supplementary Standards – how we report on our services	

Wellbeing Goals

How does the policy/procedure, strategy, e-learning, guidance etc. embed, prioritise the Well-being Goals and Sustainability Development Principle of the Well-being of Future Generations (Wales) Act 2015?

Please describe and provide evidence below of how the 5 ways of working have been met, inclusive of the 7 well-being goals, to maximise the social, economic, environmental and cultural wellbeing of people and communities in Wales.
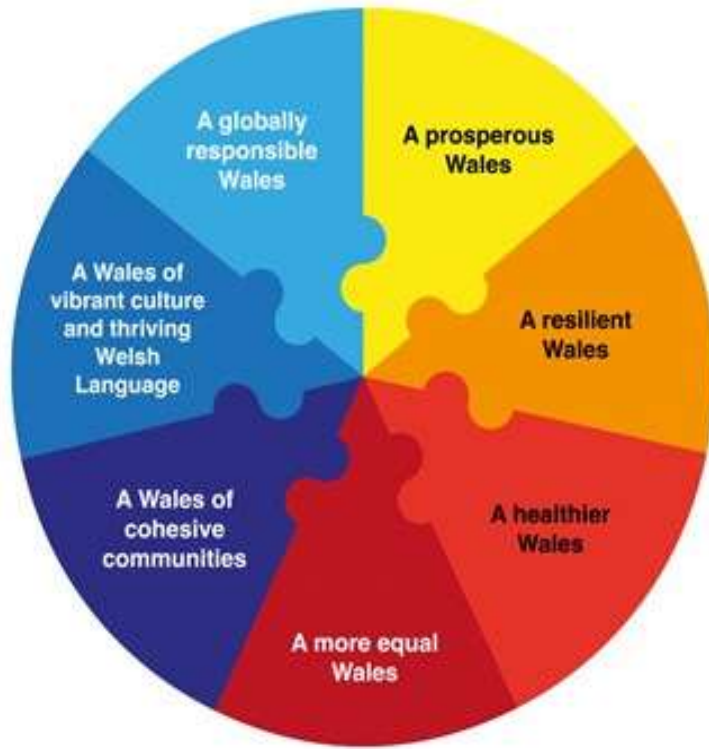
Sustainable Development Principles	
Hirdymor **Long Term** Balancing short term with long term needs	
Cydweithio **Collaboration** Working together to deliver aims and objectives.	
Cynnwys **Involvement** Involving those with an interest and seeking their views	

Atal Prevention Putting resources into preventing problems occurring or getting worse	
Integreiddio Integration Considering impact on all wellbeing goals together and on other bodies	
Social Economic Impact	**Impact – Operational & Financial**
How does the policy/procedure, strategy, e-learning, guidance etc. ensure transparent and effective measures to address the inequality of outcome that result from socio-economic disadvantage? Examples of inequality of outcome might include for example, education attainment, employment and earning potential, health and mental health access to services and goods, opportunity to participate in public life, housing.	

Positive Action	Impact – Operational & Financial
If the policy, procedure, strategy and or decision is intended to increase equality of opportunity through positive action, does it appear to be lawful? **Positive action** is defined as voluntary **actions** employers can take to address any imbalance of opportunity or disadvantage that an individual with a protected characteristic could face.	

Outcome report

Equality Impact Assessment: Recommendations				
Please list below any recommendations for action that you plan to take as a result of this impact assessment				

Action Required	Potential Outcomes	Timescale	Lead Officer	Resource implications
1				
2				
3				
4				
5				

Risk Assessment based on above recommendations – if policy is approved in original format refer to grading in Annex 1

Recommendation	Likelihood	Impact	Risk Grading
1	3	3	9
2	3	2	6

Reputation and compromise position	Monitoring Arrangements
The Trust recognizes the importance of inclusivity and accessibility for patients, their families as well as staff. So, they feel respected and valued and dignity is a priority. Potential discrimination can lead to negative attention as be costly in respect to reputational as well as in monetary terms.	Part of annual benefits review
Training and dissemination of policy	
Training needs to be identified throughout project.	

Is the policy etc. lawful?	Yes	☐	No	☐	Review date
Does the EQIA group support the policy be adopted?	Yes	☐	No	☐	
Signed on behalf of Trust Equal Impact Assessment Group			Signed Lead Officer		
Date:			Date:		

Annex 1

	Impact, Consequence score (severity levels) and examples				
	1	**2**	**3**	**4**	**5**
	Negligible	**Minor**	**Moderate**	**Major**	**Catastrophic**
Statutory duty	No or minimal impact or breach of guidance/statutory duty Potential for public concern Informal complaint Risk of claim remote	Breech of statutory legislation Formal complaint Local media coverage – short term reduction in public confidence Failure to meet internal standards Claims less than £10,000 Elements of public expectations not being met	Single breech in statutory duty Challenging external recommendations Local media interest Claims between £10,000 and £100,000 Formal complaint expected Impacts on small number of the population	Multiple breeches in statutory duty Legal action certain between £100,000 and £1million Multiple complaints expected National media interest	Multiple breeches in statutory duty Legal action certain amounting to over £1million National media interest Zero compliance with legislation Impacts on large percentage of the population Gross failure to meet national standards

LIKELIHOOD DESCRIPTION	
5 Almost Certain	Likely to occur, on many occasions
4 Likely	Will probably occur, but is not a persistent issue
3 Possible	May occur occasionally
2 Unlikely	Not expected it to happen, but may do
1 Rare	Can't believe that this will ever happen

Ref: IPC 01

VIRAL GASTRO-ENTERITIS (INCLUDING NOROVIRUS)

Executive Sponsor & Function	Executive Director of Nursing, AHPs and Health Sciences
Document Author:	Infection Prevention & Control Team
Approved by:	Trust Executive Management Board Quality, Safety & Performance Committee
Approval Date:	TBC
Date of Equality Impact Assessment:	31st August 2021
Equality Impact Assessment Outcome:	*This policy has been screened for relevance to equality. No potential negative impact has been identified.*
Review Date:	3 Years after approval date
Version:	5

1

CONTENTS

ABBREVIATIONS

IPCT	Infection Prevention and Control Team
IPC	Infection Prevention and Control
PPE	Personal Protective Equipment
UHW	University Hospital of Wales, Cardiff

1   POLICY STATEMENT

1.1   This policy describes the infection control best practice for management of sporadic cases and outbreaks of patients and staff with confirmed or suspected viral gastroenteritis.
All staff working must be aware of the contents of the policy and;

- Appropriately assess patients with suspected viral gastroenteritis
- In line with this policy commence correct infection prevention & control precautions, implement appropriate management and follow effective lines of communication.

Managing outbreaks of gastroenteritis is a common event within any healthcare setting especially during the winter months. An outbreak can be defined as two or more cases associated in time and place, therefore the early detection and appropriate management of episodes is therefore essential to minimise service disruption.

Norovirus is highly transmissible, requiring ingestion of as few as 10-100 viral particles to cause illness. The incubation period is usually 24-48 hours although as little as 12 hours has been reported.   The period of infectivity of norovirus is considered to be from the onset of symptoms until 48 hours after the last symptom e.g. diarrhoea, vomiting and abdominal pain although infectivity may precede clinical illness and viral shedding may be prolonged in immunocompromised patients.

Norovirus is the most common cause of outbreaks of gastroenteritis in hospitals and outbreaks can often lead to ward area closure and cause major disruption in service activity. Norovirus can be airborne and can also be spread through direct and indirect contact. Viruses may also be introduced into the service environment via any of these routes.
Symptoms typically consist of nausea, diarrhoea and/or vomiting, but may also include headache or abdominal pain. The condition is self–limiting with symptoms usually lasting between one to three days.

2   SCOPE OF POLICY

2.1   This policy applies Velindre Cancer centre however it is relevant to all Trust staff (including contracted, volunteers and community) and service users.

3   AIMS AND OBJECTIVES

3.1   The purpose of this policy is to provide the required information for staff across the Trust to promptly recognise and take appropriate actions when a patient or staff member is suspected of having gastroenteritis through;

- Ensuring prompt identification of possible cases
- Ensuring required Infection Prevention and Control measures are in place to prevent transmission
- Management of cases in line with national guidance
- Ensuring each patient with viral gastroenteritis is cared for effectively and appropriately in line with national guidance
- Prompt and effective measures are essential in controlling the spread of infection between patients, staff and visitors
- Detect outbreaks quickly and initiate outbreak measures promptly.
- Effective management of possible viral gastroenteritis among staff groups.
- Prevention of outbreaks

4 RESPONSIBILITIES

The Infection Prevention & Control Management Group is responsible for the ongoing updating of this policy as national guidance changes.

Trust Roles and Responsibilities

The overall responsibility for the implementation and promotion of the policy lies with the Chief Executive who will ensure there are effective arrangements for infection prevention and control within the Trust. The Trust Executive Management Board is collectively responsible for minimising the risks of infection to patients, HCW's members and the public. The Executive director for Director of Nursing, AHP's & Health Science is board lead for the IPC organisational structure for the service.

Manager Responsibilities

Managers/supervisors have responsibility to ensure that:

- Staff have access to this policy
- Local risk assessments are carried out where necessary, e.g. to identify the use of appropriate personal protective equipment (PPE), to ensure adherence to safe practices, including the provision of resources and that any incidents that occur are reviewed and subsequent actions taken where appropriate
- Work in partnership with Infection prevention and Control colleagues
- Undertake appropriate actions in response to cases/outbreaks
- Ensuring staff members have compliance with Infection prevention and control training
- Have access to equipment required to manage cases of gastroenteritis
- Ensure that staff are appropriately skilled and trained in line with the requirements of this policy
- Provide support and guidance to staff members reporting possible gastroenteritis symptoms
- Follow workforce and infection prevention and control policies and procedures
- Enforce medical exclusion requirements of staff members

Staff responsibilities

Staff have responsibility to ensure that they:

- Maintain skill and knowledge to be able to manage cases of gastroenteritis in line with this policy
- Undertake required IPC training appropriate to role
- Do not attend work if symptomatic
- Report any signs of gastro enteritis to their line manager as soon as practically possible
- Provide samples, if required, as advised by Occupational Health Departments and the Infection Prevention and Control Team
- Follow Medical Exclusion requirements

Medical exclusion following infectious/notifiable disease (as per WF 08 Sickness Absence Policy)

- Where the absence is the result of diarrhoea and vomiting or other relevant notifiable infectious disease and whilst the employee is suffering from the effects of the disease, the absence will be recorded as a period of sickness in the usual way.
- The manager must obtain information regarding the nature of the illness and obtain advice, if necessary, from the Infection Control or Occupational Health Department as to whether a period of further exclusion is required after the symptoms have subsided and sick leave has ended.
- Where the advice requires the employee, for purposes of infection control to remain off work, this subsequent period will be regarded as a medical exclusion with pay, and not be recorded as sick leave, e.g. 48 hour period following last reported symptoms.

Distribution

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

5. CLINCIAL FEATURES

There is an incubation period of 12-48 hours and the symptoms may last 24-72 hours on average. Symptomatic individuals are infectious for up to 48 hours after the last episode of diarrhoea and/or vomiting and abdominal pain. Other symptoms may include abdominal pain and/or nausea, headaches, muscle aches and fever. Recovery usually takes place within 72 hours of onset of symptoms

Outbreak control measures – key points

Routes of Transmission:
- Airborne – inhalation or ingestion of virus particles when a patient vomits.
- Contact via contaminated hands.
- Person to person via faecal-oral route.
- Ingestion of contaminated food and drink usual prepared by an individual with SRSV illness.
- Environmental contamination of viral particles due to patients shedding.

Patient Management
- A patient with symptoms of suspected gastroenteritis should be isolated in a single room (preferably en-suite) with appropriate infection control measures until at least 48hours symptom free. Refer to Policy IPC 02 SICPs & TICPs.
- In an outbreak situation the numbers of affected individuals may be high, therefore if a case is suspected, it is essential to implement appropriate infection control measures immediately to prevent the spread of infection.
- During the outbreak you must regard all patients, staff and visitors who present with symptoms as infectious.

In patient departments
Single Cases
- **Isolate patients as soon as they become symptomatic.**
- All patients admitted with or who develop diarrhoea and/or vomiting, should be nursed in a single room and remain isolated until asymptomatic for 48 hours
- Inform a member of the IPCT as soon as possible.
- Inform housekeeping services to possible infection to ensure correct cleaning measures
- Reduce footfall to the room and review and visiting to the patient
- Keep doors to cubicle closed and where possible open windows to promote ventilation
- During office hours, contact IPCT or out of hours contact the on-call Consultant Microbiologist at UHW (via switchboard), who will carry out a risk assessment and advise the ward of further infection control measures to be implemented.
- Strict Transmission based precautions should be adhered to including the use of personal protective equipment and hand washing with soap and water as per WHO 5 moments (Appendix 1).
- Facemasks may be considered if there is a risk of droplets or aerosol contamination – following discussion with the infection prevention and control team.

5.1   Outbreak

- If a department has two cases connected to place or time then a meeting will be called of the outbreak team:
  - ➢ Microbiologist
  - ➢ Department manager
  - ➢ General manager of site
  - ➢ Infection prevention and control team
  - ➢ Operational services manager/supervisor
  - ➢ Medical representation
  - ➢ Senior nurse/bed manager
- Where the numbers of symptomatic patients exceeds the number of single rooms, the IPCT will provide advice as cohorting patients may be required – IPCT to advise
- In some cases, bays or the entire ward will need to be closed to new admissions. This will only occur after consultation with the Infection Control Doctor and discussion with other relevant personnel.
- Close affected bay(s) to admissions and transfers.
- Keep doors to single room(s) and bay(s) closed.
- Place signage at ward entrance informing all visitors of the closed status and restricting visits to essential staff.
- Daily assessment will take place to ascertain earliest date for terminal clean and reopening.
- Seek advice from IPCT if a patient needs to leave the ward for investigations in other departments. A patient's treatment should not be compromised whilst the ward is closed, but risk assessments need to take place to reduce the risk of cross infection.
- Communication with the receiving department is essential. The IPCT can be consulted to give advice to minimise the risk of spread of infection.
- Unless unavoidable where ever possible allocate staff to duties in either affected or non-affected areas of the ward.
- Visiting staff such as Physiotherapists, Occupational Therapists and Phlebotomists should if possible, visit the affected ward(s) last or allocated an individual to visit affected wards. Only essential procedures should be carried out on symptomatic patients.
- Ensure all staff receive effective communication of the outbreak situation and how viral gastroenteritis is transmitted.

Staff Cases Across the organisation
- Staff with symptoms of possible gastroenteritis should inform their line. Affected staff should be immediately excluded from work until 48 hours symptom free.

Patient and Visitors Information
- Provide all affected patients with information on the outbreak and control measures they should adopt – available from IPCT.
- Patients'/visitors information leaflets are available from the Infection Prevention and Control Team. Copies of these will be issued to ward staff which is then the responsibility of the nurse in charge to make sure these are distributed to patients and visitors.
- Visitors may contribute to an outbreak of viral gastroenteritis and should be advised to refrain from visiting if they are symptomatic or have not been free of symptoms for 48 hours.
- Elderly visitors, immuno-compromised individuals and young children may be more susceptible to infection and should be advised to refrain from visiting during the outbreak.
- Visitors should be instructed to decontaminate their hands prior to, and after visiting their relative/friend using the ward facilities.
- Visitors should not sit on beds or use patient only toilets.

- An IPC Nurse will visit the ward daily as a minimum in order to review and reassess the situation. Out of hours the ward will be reviewed by telephone by the on call Consultant Microbiologist who can be contacted via switchboard.
- Do not accept admissions while the ward is closed unless approved by the IPCT or medical director.
- A patient's treatment must not be compromised whilst the ward is closed, but risk assessments must take place to reduce the risk of cross infection. Communication with the receiving department is essential. The IPCT can be consulted to give advice to minimise the risk of spread of infection.
- During the working shift, where possible do not transfer staff to other wards if they are working on an affected ward. Agency staff must not work on other wards once exposed to an outbreak ward situation.
- Leaflets are available for patients with Norovirus from the IPCT. The leaflets give details of the action that is being taken and why. (https://phw.nhs.wales/services-and-teams/harp/infection-prevention-and-control/infections1/norovirus-information-leaflet/)
- Information on other types of gastro-enteritis can be obtained from the Public Health Wales site: http://howis.wales.nhs.uk/sitesplus/888/page/34204

When is the patient/ward clear of infection?
- Patients are usually but not always deemed non-infectious 48 hours after their last episode of diarrhoea or vomiting. In the elderly or immunocompromised patient they may continue to excrete the virus for a longer duration.
- Further stool specimens are not required once a confirmed positive sample has been detected or to check if an agent has cleared.
- Usually the ward can be opened when the last patient with symptoms has had no diarrhoea or vomiting for 48 hours. A thorough terminal clean of the ward (environment and equipment) must take place prior to beds being re-opened.
- Following each outbreak a multidisciplinary evaluation should take place to review the outbreak and learn lessons in order to strengthen future plans.

What happens if symptoms recur?
- Contact a member of the IPCT immediately for a further risk assessment.

Patients Discharge
Patients discharge to their own home
This can take place as long as they are medically fit for discharge and do not require nursing or social care at home. **Please note:** if a patient is being 'fast tracked' home for palliative care contact the Infection Control Team for advice.

Patients discharge to another hospital
- It is not necessary to delay the discharge of symptomatic patients or those who may be incubating gastroenteritis.
- Advise them to inform the admitting Doctor/ Nurse if they are readmitted within 48 hours of discharge.
- Patients from closed wards should be discharged directly from the ward.

Patients discharge to nursing or residential homes
- Discharge to a home known not to be affected by an outbreak of diarrhoea and or vomiting should not occur until the patient has been asymptomatic for more than 48 hours.
- However, discharge to a home known to be affected by an outbreak at the time of discharge should not be delayed providing the home can safely meet the individual's care needs.

- Those who have been exposed but asymptomatic patients may be discharged only on the advice of the IPCT.

6   Clinical Settings Infection Prevention and Control Measures

Hand Hygiene
- Hand hygiene is essential in the prevention of cross infection and hand decontamination is compulsory before and after contact with all patients and their immediate environment.
- Patient hand washing should not be forgotten. All patients should be reminded about good hand washing practices and non-ambulant patients must be offered means of decontaminating their hands before eating and after using bedpans/commodes, for example.
- Handwashing with soap and water is recommended over alcohol gel in the presence of diarrhoea.

Personal Protective Equipment (PPE)
- Personal protective equipment must be used when handling faeces and/or vomit, other body fluids and for direct patient contact.
- Disposable aprons and gloves must be removed before leaving the patients room and disposed of as clinical waste.
- Hands should be decontaminated immediately using soap and water.

Environment
- It is essential that environmental cleaning is performed to a high standard and cleanliness is maintained. The operational services department should be notified at the earliest point when an outbreak occurs (Appendix 2).
- Supervisors & Housekeeping staff responsible for undertaking the cleaning must liaise with the ward manager & the infection control team.
- Cleaning procedures should be increased to reduce the accumulation of bacteria in the environment. Special attention must be paid to toilet and bathroom areas, commodes, all horizontal surfaces and frequent touch surfaces such as door handles, flush handles, sinks, taps and nurse call systems.
- Remove exposed foods e.g. fresh fruit in bowls on lockers.
- Staff should not consume food or drink at the nurses' station during an outbreak of viral gastroenteritis. Any exposed food and drink is likely to have been contaminated.

Equipment
- Use single-patient use equipment wherever possible
- Decontaminate equipment immediately after use i.e. commodes
- Red Clinell sporicidal wipes should be used to decontaminate commodes
- Consider use of UVC to decontaminate high use equipment after manual cleaning
- Dispose of soiled bedpans/vomit bowls immediately

Linen
- While clinical area is closed, discard all linen in a water soluble (alginate) bag and then a secondary bag.
- Leave empty beds unmade

Spillages
- Diarrhoea/vomit must be covered immediately, removed and the area decontaminated.
- Decontamination of all vomit or faecal spillage is vital to ensure viral particles are destroyed.
- See appendix 2 for instruction on cleaning solutions.

7. Audit and monitoring

- The IPC Annual Programme of work contains audit programme which incorporates audits of clinical practices to ensure compliance with standard precautions use of PPE, hand hygiene etc.
- In cases of outbreak the outbreak meeting will require results from daily audit of use of PPE, recent environmental cleaning audit, hand hygiene.

8. Implementation

- This policy will be implemented and maintained by the Infection Prevention and Control Team (IPCT).

9. References

National Infection Control Policies

- http://howis.wales.nhs.uk/sites3/page.cfm?orgid=379&pid=30427
- Guidelines for the management of norovirus outbreaks in acute and community health and social care settings: Produced by the Norovirus Working Party: an equal partnership of professional organisations. Published March 2010
- Preparedness, control measures & practical considerations for optimal patient safety and service continuation in hospitals. HPS Norovirus Outbreak Guidance Published 2013

10. Getting Help

a. **Further information and support**

Infection Prevention and Control Team: 02920196129.

11. Related Policies

This policy should be read in conjunction with:

- IPC 02 Policy for Standard Infection Control and Transmission Based Precautions (including isolation of patients)
- IPC 03 Policy for Care of patients with diarrhoea (chemo-induced and Clostridium difficile)
- Workforce 08 Sickness Absence Policy
- IPC 05 - National Infection Prevention and Control Manual

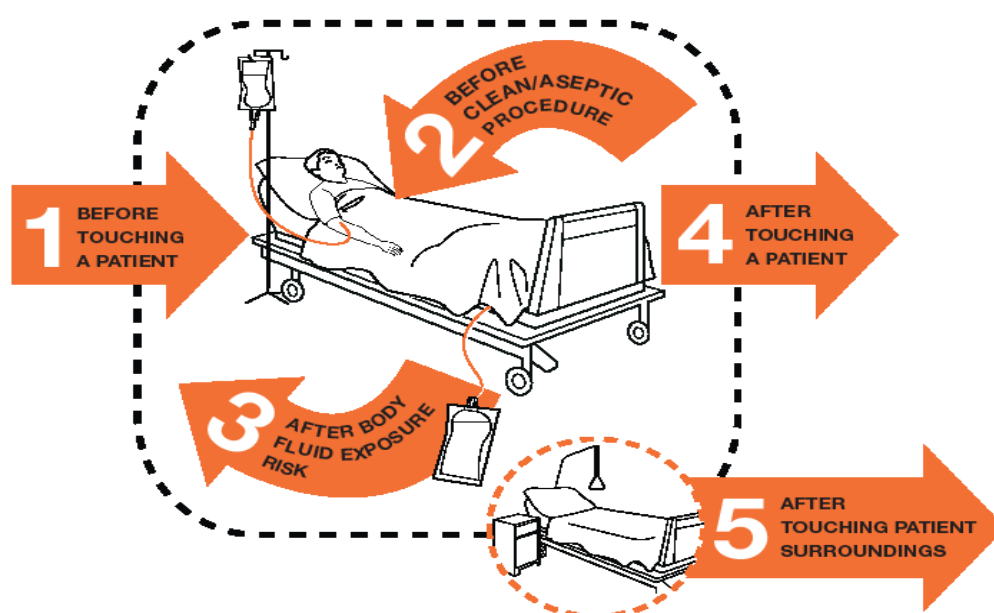## 12. INFORMATION, INSTRUCTION AND TRAINING

Training

- Training about the reporting of staff sickness should be carried out as part of induction training.
- An element of Standard infection control precautions should be included in induction training.
- Full training in Standard Infection Control Precautions & Transmission Based Precautions is carried out during all levels of infection prevention and control training.

13. MAIN RELEVANT LEGISLATION/GUIDANCE

Legislation considered in the development of this policy includes:

- Health and safety at Work Act (1974)
- The Management of Health and Safety at work Regulations (1999)
- Control of Substances Hazardous to Health (COSHH) Regulations (2002) (as amended 2003 & 2004)
- Management of Health and safety at Work regulations (1999)
- Personal Protective Equipment (PPE) at Work Regulations 1992 (as amended 2002)
- Healthcare Standards for Wales (2015)
- NICE Guidelines for the Management of Gastroenteritis (Adults) 2020 - https://cks.nice.org.uk/topics/gastroenteritis/management/adult-gastroenteritis/
- Guidance for the Management of Gastrointestinal infections 2019 - (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/861382/management_of_gastrointestinal_infections.pdf)

Appendix 1 – Five Moments of Hand Hygiene

Your 5 Moments
for Hand Hygiene

1 BEFORE TOUCHING A PATIENT

2 BEFORE CLEAN/ASEPTIC PROCEDURE

3 AFTER BODY FLUID EXPOSURE RISK

4 AFTER TOUCHING A PATIENT

5 AFTER TOUCHING PATIENT SURROUNDINGS

1	**BEFORE TOUCHING A PATIENT**	**WHEN?**	Clean your hands before touching a patient when approaching him/her.
		WHY?	To protect the patient against harmful germs carried on your hands.
2	**BEFORE CLEAN/ ASEPTIC PROCEDURE**	**WHEN?**	Clean your hands immediately before performing a clean/aseptic procedure.
		WHY?	To protect the patient against harmful germs, including the patient's own, from entering his/her body.
3	**AFTER BODY FLUID EXPOSURE RISK**	**WHEN?**	Clean your hands immediately after an exposure risk to body fluids (and after glove removal).
		WHY?	To protect yourself and the health-care environment from harmful patient germs.
4	**AFTER TOUCHING A PATIENT**	**WHEN?**	Clean your hands after touching a patient and her/his immediate surroundings, when leaving the patient's side.
		WHY?	To protect yourself and the health-care environment from harmful patient germs.
5	**AFTER TOUCHING PATIENT SURROUNDINGS**	**WHEN?**	Clean your hands after touching any object or furniture in the patient's immediate surroundings, when leaving – even if the patient has not been touched.
		WHY?	To protect yourself and the health-care environment from harmful patient germs.

World Health Organization | **Patient Safety** A World Alliance for Safer Health Care | **SAVE LIVES** Clean Your Hands

May 2009

Appendix 2 – Environmental Cleaning Recommendations during an Outbreak

Environmental decontamination during an outbreak
• Increase frequency of cleaning using dedicated domestic staff where possible and avoiding transfer of domestic staff to other areas, as directed by the Infection control team. • Clean from unaffected to affected areas, and within affected areas from least likely contaminated areas to most highly contaminated areas • Use disposable cleaning materials including mops and cloths • Where reusable microfibre cloths suitable for use with chlorine releasing disinfectants are in use, the system must be supported by a robust laundry service and adherence to manufacturer's instructions • Dedicate reusable cleaning equipment to affected areas and thoroughly decontaminate between uses e.g. mop handles and buckets • After cleaning, disinfect with 0.1% sodium hypochlorite (1000ppm available chlorine - Chlorclean) • Pay particular attention to frequently touched surfaces such as bed tables, door handles, toilet flush handles and taps • Cleaning staff and other staff who undertake cleaning tasks should follow standard infection control precautions and wear appropriate personal protective equipment (PPE) including disposable gloves and apron • National and local colour coding for PPE and cleaning equipment should be adhered to, in order to avoid cross contamination

Ref: IPC 04

DECONTAMINATION POLICY

Executive Sponsor & Function	Executive Director of Nursing, AHPs and Health Sciences
Document Author:	Infection Prevention and Control Team
Approved by:	Trust Executive Management Board Quality, Safety & Performance Committee
Approval Date:	March 2022
Date of Equality Impact Assessment:	September 2017
Equality Impact Assessment Outcome:	*This policy has been screened for relevance to equality. No potential negative impact has been identified.*
Review Date:	3 years from Approval Date
Version:	5

CONTENTS

ABBREVIATIONS

IPCMG	Infection Prevention and Control Management Group
HCAIs	Healthcare Associated infections
IPCT	Infection Prevention and Control Team
HCW's	Healthcare Workers
HTM	Health Technical Memorandum
HBN	Health Building Note
EMB	Executive Management Board
MHRA	Medicines and Healthcare products Regulatory Agency
WHTM	Welsh Hospital Technical Memorandum
VCC	Velindre Cancer Centre
NIPCM	National Infection Prevention and Control Manual

1   POLICY STATEMENT

1.1   Medical devices play a key role in healthcare, vital for diagnosis, therapy, monitoring, rehabilitation, blood collection and care. Effective management of this important resource is required to satisfy high quality patient and donor care, clinical and financial governance, including minimising the risks of adverse events.

Decontamination of reusable devices is a combination of processes, which if not correctly undertaken, individually or collectively, may increase the likelihood of micro-organisms being transferred to patients, donors or staff. This combination of processes includes acquisition, cleaning, disinfection, inspection, packaging, sterilisation, transportation and storage.

2   SCOPE OF POLICY

2.1   This policy applies to all staff within Velindre University NHS Trust who are involved with decontamination of medical devices/ healthcare equipment. It is also applicable to staff who are involved with decontamination of healthcare equipment prior to inspection, service, maintenance or repair.

2.2   Cleaning and environmental cleanliness is not addressed in this policy and reference should be made to Policy IPC 05 National Infection Prevention and Control Manual

2.3   Please refer to local Standard Operating Procedures for decontamination of specific reusable medical devices.

3   AIMS AND OBJECTIVES   Eliminating preventable healthcare associated infections (HCAIs) requires the proactive involvement of every member of staff across all healthcare settings. In conforming to the principles of Prudent Health and Care, healthcare organisations and individuals involved in providing services are obliged to prevent cross infection when using medical devices in patient care. It is essential that medical devices and care equipment are managed safely to ensure they are used within manufacturer guidance, cannot harbour organisms and can be effectively decontaminated in accordance with this policy. This policy has been produced to ensure the safety of both Velindre University NHS Trust staff and outside contractors who are employed to use, maintain and repair medical equipment.

3.2   To ensure that there is a system in place that ensures as far as is reasonably practicable all reusable medical devices are appropriately decontaminated prior to use and after use and the risks associated with decontamination facilities and processes are adequately managed. (Appropriately = in alignment with manufacturer's instructions and National guidance).

3.3   Effective decontamination of medical devices/ healthcare equipment will be carried out to ensure the device is:
- Safe for further use
- Safe for staff to handle
- Safe for use on the patient/ donor
- Safe for disposal

3.4   The policy objectives are to:
- Provide guidance on the appropriate decontamination of medical devices and healthcare equipment
- Establish processes to ensure that equipment is kept clean, fit for purpose and in a good state of repair at all times during its operational life
- Identify individuals' responsibilities for cleaning and maintaining medical devices/ healthcare equipment within Velindre University NHS Trust, ensuring consistency

- Ensure safe systems of work are adopted to protect patients, donors and staff from the transmission of infection from medical devices and other equipment that comes into contact with patients and donors

4 RESPONSIBILITIES   Trust Roles and Responsibilities

Trust Accountability

The Chief Executive has overall responsibility to ensure this policy is adhered to. Other responsibilities are outlined below.
The Trust Executive Management Board is collectively responsible for minimising the risks of infection to patients, donors, healthcare workers (HCW's) and the public. The Executive director for Director of Nursing, AHP's & Health Science is board lead for the IPC organisational structure for the service.

Trust Responsibilities

The Trust has a responsibility to ensure that:
- All Divisional Directors make staff aware of the policy and provide appropriate equipment and training in the use and decontamination of devices.
- An Executive Board Decontamination Lead (representing the Chief Executive) and the Operational Decontamination Lead are identified.
- The Infection Prevention and Control Team (IPCT) will assist with training as appropriate.
- The IPCT will advise on the use of decontamination processes and products as well assess new devices to ensure they comply with this policy.
- Facilities and equipment used by the Trust for decontamination comply with relevant Health Technical Memoranda (HTM) and Health Building Note (HBN) requirements for good practice as well as Medicines and Healthcare products Regulatory Agency (MHRA) directives.
- Medical devices are managed in accordance with Health Safety & Welfare Policy (QS 18).
- Incidents relating to decontamination processes are monitored and reviewed in a timely manner.

4.2 Decontamination Executive Lead/ Operational Decontamination Lead
The Executive Decontamination Lead will provide the strategic lead for decontamination and will be responsible in ensuring that this policy is implemented in relation to the organisation and takes proper account of relevant national guidelines.

The Operational Decontamination Lead with support from the Consultant microbiologist and the IPCT will be responsible for the production, review and audit of evidence-based policy to provide the Trust with up-to-date information on the decontamination or reusable medical devices and will provide staff with training on this policy where needed.

Assess risks associated with ineffective decontamination processes; determine remedial action and recognise areas for development. Report risks on the Boards Risk Register.

Identification and implementation of lessons learnt to inform and improve future practice.

4.3 Infection Prevention and Control Management Group
The role of the Infection Prevention & Control Management Group is to provide strategic direction and develop a structured approach to the decontamination of reusable medical devices that eliminates or reduces as far as possible the risks associated with the decontamination processes to the patient, user and third parties. The Group is accountable to the Trust and reports to the Quality & Safety Committee and Executive Management Board.

4.4 Authorised Engineer (Decontamination)

The Authorising Engineer (Decontamination) will undertake the duties set out in NHS Wales documents Welsh Hospital Technical Memorandum (WHTM), WHTM 01-01 Part A, WHTM 01-05 and WHTM 01-06 Part A.

4.5   Infection Prevention & Control Team
- Provide specialist advice for the suitability of equipment prior to purchase and during use. This will include approving the design of equipment e.g. difficult to clean areas, dust traps etc. Such advice must be copied to the Decontamination lead.
- Provide information and advice to enable managers and users to undertake risk assessments on levels of decontamination required.
- Assist in and undertake risk assessments as required by the Infection Prevention & Control Management Group.
- Conduct investigations into areas of special risk advising on safe practice.
- Audit practice and monitor standards in line with current legislation and guidance.

4.6   Manager Responsibilities

Managers/supervisors have responsibility to ensure that:
- All staff are notified of this policy and must have access to and understand the contents and local procedures derived from this policy.
- All relevant staff are trained on how to decontaminate equipment and reusable devices as well as manage single use devices appropriately.
- Staff are trained to recognise the symbol for single use and other packaging marks) and expiry dates on all products are checked before use.
- Single use devices are used in accordance with (MHRA) guidance– Single-use medical devices: implications and consequences of reuse (2013) and chosen according to risk over reusable.
- The manufacturer guidance and Trust Waste Policy are followed in the disposal of such devices.
- Failure or inappropriate use of a medical device is reported accordingly via the incident reporting mechanisms i.e. DATIX
- New equipment is not purchased until it has been risk assessed against this policy to ensure it can be adequately decontaminated.

4.7   Staff responsibilities

All staff are responsible for ensuring effective decontamination takes place and they are competent to carry out the appropriate process. Staff involved in any aspect of the decontamination process of reusable medical devices are responsible for adhering to this policy.
In addition, key persons and responsibilities as defined in detail in WHTM 01:01 Part A are in place as follows.

The Executive Lead is identified as the person with ultimate management responsibility for the operation of the premises and the decontamination process.

The Microbiologist is designated to be responsible on microbiological aspects of decontamination.

4.8 Distribution

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

5   DEFINITIONS

5.1 **Please see Appendix 1.**

6   IMPLEMENTATION/POLICY COMPLIANCE

6.1 Requirements for Effective Decontamination

To undertake decontamination effectively all the processes illustrated in the life-cycle (below) must be implemented correctly and consistently –with all appropriate controls and monitoring in place.

The reusable surgical instrument cycle

Fig 1.1
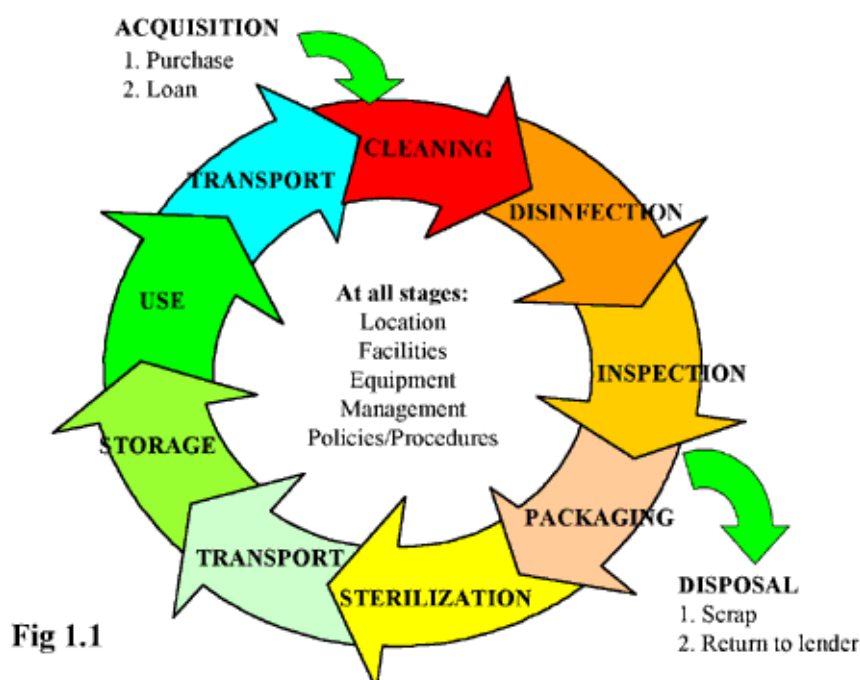
The essential requirements for good decontamination practice are:
- Management controls are in place
- Medical devices are used appropriately and are:.
  - fit for purpose;
  - in accordance with manufactures' instructions;
  - properly maintained, monitored and validated;
  - used by staff who are fully trained and competent;
  - conforming to standards and requirements;
  - track and trace systems link device usage to individual patients;
  - robust records are maintained throughout the process;
    - appropriate facilities are provided for the decontamination process
    - single use instruments are not re-used
    - decontamination is undertaken in a dedicated Sterile service Department accredited to the Medical Device Directive department wherever possible (WHTM 01:01 Part A)

Risk Assessment

The decontamination methods must be chosen according to the risk of infection associated with the use of a particular piece of equipment and according to the risk that inadequate decontamination poses to patients and staff (Table 1).

	Application	Recommendation	Examples

HIGH	• Items in close contact with broken skin or broken mucous membrane • Items which penetrate the skin or are introduced into sterile body cavities • Invasive devices	• Use sterile single use devices where available • Thorough cleaning followed by: • Sterilisation in accredited SSU or high level disinfection using approved chemicals and processors	IV cannula Vaginal or rectal probes Flexible endoscopes e.g. bronchoscopes, nasoscopes Dental equipment Theatre instruments Implants/prostheses
MEDIUM	• Items in contact with intact mucous membranes • Items/ environment contaminated with particularly virulent or readily transmissible organisms • Items prior to use on immuno-compromised patients	• Thorough cleaning followed by disinfection and/or sterilisation or high level disinfection • Single use	Shared patient equipment (as below) after use on any known or suspected infected patient e.g. MRSA, *C. diff.*
LOW	• Items in contact with healthy intact skin • Items/environment not in contact with the patient/ donor	• Thorough cleaning with detergent solution or detergent /disinfectant impregnated wipes	Shared patient equipment e.g. BP cuffs, Tourniquets, Commodes, Stethoscopes, Beds, IV Pumps, Mattresses

Table 1 Risk Stratification for Decontamination of Medical Devices

Decontamination processes are referred to in Appendices.

6.2   Purchasing Medical Devices
Please refer to Quality and Safety Policy QS 24: Medical devices and Equipment Management Policy.

6.2.1   Storage
All devices following decontamination should be stored correctly in a designated area that is controlled and secure and inaccessible to the public.

Sterile packs
- Strict rotation of stock (first in, first out) to control inventory.
- Shelving should be easily cleaned and allow the free movement of air around the stored product.
- Products must be stored above floor level away from direct sunlight and water in a secure, dry and cool environment. Do not store clean or sterile supplies:
  o in corridors
  o on window sills
  o on the floor
  o under sinks

Before being used the sterile product should be checked to ensure that:
- The packaging is intact and the product is still within expiry date.
- The sterilization indicator confirms the pack has been subjected to an appropriate sterilization process.

6.2.2 Decontamination of equipment prior to inspection, service or repair.

Anyone who inspects, services, repairs or transports medical, dental or laboratory equipment, either on hospital premises or elsewhere, has a right to expect that medical devices and other equipment have been appropriately decontaminated; appropriate documentation must be provided to indicate the decontamination status of the item (MHRA 2021)

6.2.3 Transportation of Contaminated/Sterile medical equipment.

Contaminated medical instruments are regarded as UN2814 Clinical Waste, on the basis they are being transported as healthcare waste for the purpose of recycling. Where contaminated instruments are to be transported outside of the healthcare premises onto a public highway, they must be handled collected and transported to their decontamination area in a way that avoids the risk of contamination to patients, staff and any area of the healthcare facility. Those responsible for such transportation must refer to the requirements of the Health and Safety at Work Act 1974 and The Carriage of Dangerous Goods and Use of Transportable Pressure Equipment Regulations 2009 bring into UK law the alternative dispute resolution (ADR) 2015 regulations.

Medical Instruments subject to inspection, maintenance, repair or disposal, either on site or at the manufacturer's or agent's premises, should be decontaminated beforehand. Any loaned items being returned to a manufacturer or supplier should also be decontaminated (see Table.1). Devices intended for single-use only do not require decontamination, except where they are implicated in an adverse incident and may need to be sent to the manufacturer for investigation. In this situation, contact the manufacturer to find out the most appropriate method of decontamination.

If the manufacturer's instructions appear inappropriate or incomplete, the organisation should report this to the MHRA as an adverse incident

Adverse incidents can be easily reported online through the Yellow Card scheme:
https://yellowcard.mhra.gov.uk/

Once decontamination has been completed, the items should be labelled accordingly and a declaration of contamination status form/label completed.

6.2.4 Decommissioning and disposal of devices

Please refer to QS 24: Medical devices and Equipment Management Policy.

6.2.5 Single Use / Single Patient Use Devices
Single-use medical devices
The expression single use on the packaging of medical devices means that the manufacturer:
• Intends the device to be used once and then discarded.
• Considers the device is not suitable for use on more than one occasion.
• Has evidence to confirm that reuse would be unsafe.

Single- use:

The above symbol is used on medical device packaging indicating '**DO NOT RE-USE**' and may replace any wording.

Single Patient Use Devices

Some devices are designated for **Single Patient Use.** This will be clearly stated on the packaging. These devices include such items as nebulisers, disposable pulse oximeter probes, and certain specified intermittent catheters.

Always follow the manufacturer's instructions regarding cleaning and disinfection between uses **on a named patient only. Never reprocess and use on another patient.**

6.3 Audit and Monitoring

Audits as per Annual Audit programme for Infection Prevention & Control.

6.4 Implementation

This policy will be implemented and maintained by the Infection Prevention and Control Team (IPCT).

Please refer to the responsibilities section for further information in relation to the responsibilities in connection with this policy.

7 GETTING HELP

7.1 Further information and support

Infection Prevention and Control Team: 02920196129.

8 RELATED POLICIES

This policy should be read in conjunction with:

- Welsh Health Technical Memorandum WHTM 01-01 Decontamination of Medical Devices within Acute Services Part A: Management & Environment (2016) http://www.nwssp.wales.nhs.uk/sitesplus/documents/1178/WHTM%2001-01%20Decontamination%20Part%20d%20protected%200119.pdf

- Welsh Health Circular (2016) Decontamination of medical devices: A development plan for healthcare organisations https://gov.wales/sites/default/files/publications/2019-07/decontamination-of-medical-devices-a-development-plan-for-healthcare-organisations.pdf

- Managing Medical Devices (2021) Guidance for healthcare and social services organisations. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/982127/Managing_medical_devices.pdf

- National standards for cleaning in Wales – ADDENDUM
  Key Standards for Environmental Cleanliness Revision 2.0 – December 2021

  https://phw.nhs.wales/topics/latest-information-on-novel-coronavirus-covid-19/information-for-health-and-social-care/addendum-key-standards-for-environmental-cleanliness/
  ttps://phw.nhs.wales/topics/latest-information-on-novel-coronavirus-covid-19/information-for-health-and-social-care/sup-029/

- Medical Devices and Equipment Management Policy (QS 242021)
  https://phw.nhs.wales/about-us/policies-and-procedures/policies-and-procedures-documents/clinical-governance-and-infection-control-policies/medical-devices-and-equipment-management-policy/

- QS33 Control of Substances Hazardous to Health (COSHH) Policy

https://www.hse.gov.uk/cleaning/topics/coshh.htm

9   INFORMATION, INSTRUCTION AND TRAINING

9.1 Training

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

10 MAIN RELEVANT LEGISLATION

Legislation considered in the development of this policy includes:

- WHTM 01-01 Decontamination of Medical Devices Within Acute Services Part A: Management and Environment (2018)
- WHTM 01-01 Decontamination of Medical Devices Within Acute Services Part B: Common Elements (2018)
- WHTM 01-01 Decontamination of Medical Devices Within Acute Services Part C: Steam Sterilisation and Steam for Sterilisation (2018)
- WHTM 01-01 Decontamination of Medical Devices Within Acute Services Part D: Washer Disinfectors (2018)
- WHTM 01-01 Decontamination of Medical Devices Within Acute Services Part E: Alternatives to Steam for the Sterilisation of Reusable Medical Devices (2018)
- WHTM 01-06 Parts A-D Decontamination of Flexible Endoscopes (2018)
- Health Building Note (HBN) 13: Sterile Services Department, NHS Estates, Department of Health (2021).
- Medical Device Regulation (EU) 2017/745
- Provision and Use of Work Equipment Regulations (PUWER), 1998
- Managing Medical Devices, Guidance for healthcare and social services organisations, MHRA, January 2021.

Appendix 1 - Definition in Terms

Medical Device	Medical device' means any instrument, apparatus, appliance, software, implant, reagent, material or other article intended by the manufacturer to be used, alone or in combination, for human beings for one or more of the following specific medical purposes: — diagnosis, prevention, monitoring, prediction, prognosis, treatment or alleviation of disease — diagnosis, monitoring, treatment, alleviation of, or compensation for, an injury or disability — investigation, replacement or modification of the anatomy or of a physiological or pathological process or state — providing information by means of in vitro examination of specimens derived from the human body, including organ, blood and tissue donations, and which does not achieve its principal intended action by pharmacological, immunological or metabolic means, in or on the human body, but which may be assisted in its function by such means The following products shall also be deemed to be medical devices: — devices for the control or support of conception — products specifically intended for the cleaning, disinfection or sterilisation of devices as referred to in Article 1(4) and of those referred to in the first paragraph of this point
Cleaning	A process that physically removes contaminants but does not necessarily destroy micro-organisms. The reduction in microbial contamination will depend upon many factors including the efficiency of the cleaning process and the initial level of contamination.
Disinfection	A process following cleaning that is used to reduce viable micro-organisms but not necessarily inactivate some bacterial agents, such as viruses and bacterial spores. Once disinfected, equipment should be stored in a clean environment to prevent recontamination.
High-Level Disinfection	A process following cleaning that is used to significantly reduce the number of viable micro-organisms including viruses and bacterial spores using designated chemicals in a validated reprocessing machine e.g. washer disinfector.
Sterilization	A process following cleaning and disinfection used to render an object free from all viable micro-organisms including viruses and spores but not necessarily prion proteins. Sterilization can be achieved using steam or gas.
Single Use	Items labelled "single-use" or "not for reuse" or with the international single use sign that must not be reused or reprocessed in any way (QS 24).
Single Patient Use	A medical device labelled as 'single patient use' that may be use for more than one episode on **one patient/donor only** which can undergo some sort of reprocessing as specified by the manufacturer guidance e.g. nebuliser.
Reusable or Multi Use	May be used more than once for different patients/ donors subject to proper decontamination. This may include care equipment that is shared e.g. BP cuffs, stethoscopes, beds, infusion pumps etc., or surgical instruments, endoscopes that require a higher level of decontamination.

Appendix 2 – Decontamination Methods (Velindre Cancer Centre)

Operator Protection

Staff should be instructed on how to handle disinfectants carefully and advised what protective clothing is required. Reference should always be made to the COSHH risk assessment for each product and COSHH advisor for further advice. Disinfectants should never be mixed with other

products and always be used in the correct dilution: higher or lower concentrations are wasteful and potentially harmful.

Expiry dates
Certain disinfectants will bear expiry dates and they should not be used after that date. Where chemicals need to be diluted or mixed always use freshly prepared solutions that are dated and labelled accordingly with strength and do not store for longer than advised (usually 24 hours but refer to manufacture guidance).

Note: Welsh Blood Service methods are written into operational procedures

1. Cleaning
Please refer to Cleaning Standards Manual for specific details on cleaning products for clinical and non-clinical areas.
Cleaning removes organic material and many, but not all, microorganisms.

1.1 General purpose detergent and water or detergent wipes
This is the preferred method of decontamination for the vast majority of items such as furniture, fittings and general equipment e.g. mattresses, bed frames, washing bowls etc.

1.2 General principles:
- Where possible immerse the item in a designated bowl or sink of warm water and detergent. If immersion is not possible surface clean with detergent wipes.
- If using detergent wipes, use a sufficient number to prevent drying out.
- Do not use wash-hand basins in ward areas for cleaning equipment. Use a designated sink or bowl.
- Dry thoroughly.
- Store items dry.
- When cleaning equipment check for signs of damage e.g. covers on mattresses, pillows, cushions. If there are signs of damage report this to the department manager who can initiate replacement or repair.

1.3 Cleaning of Surgical Instruments before Sterilization
Effective cleaning to remove all organic material is an essential pre-requisite for sterilization or high level disinfection. **Automated cleaning** in a washer disinfector is the **preferred option** however; some instruments cannot be processed in a washer disinfector or may need manual cleaning prior to processing in a washer disinfector.

To minimise the contamination risk to personnel, splashing and the creation of aerosols must be avoided at all times.

- Always wear appropriate protective clothing when cleaning contaminated equipment e.g. gloves, apron and eye protection
- Fill the clean sink or container (not hand wash basin) with the appropriate amount of water and enzymatic detergent or other appropriate detergent to achieve a working solution (refer to manufacturer's instructions)
- Dismantle or open instrument
- With the exception of power tools*, fully immerse the instrument in the solution for a minimum of 2 minutes
- Drain any excess detergent prior to rinsing with clean water
- Drain the item before drying with a clean non- linting clean cloth
- Visually check to ensure organic material has been removed
- Complete any relevant documentation
- If cleaning solution or rinse water is obviously soiled or contaminated, replace immediately

* Power tools must not be immersed but should be surface cleaned only using a non- linting cloth impregnated with an enzymatic detergent solution. This should be followed by a non- linting cloth dampened with clean water and then dried using a dry non -linting cloth. Alcohol impregnated wipes can be used following the manual cleaning procedure.

2. Disinfection

Disinfection reduces the number of micro-organisms to a safe level for a defined procedure but does not kill bacterial spores and does not necessarily inactivate all viruses.

The following disinfection methods and products are used locally. The use of alternative methods/products must be approved by the Infection Control Team prior to introduction.

2.1 Heat Methods

2.1.1 Washer/Disinfectors

Washer disinfectors can be used to clean and disinfect equipment, such as bed pans, that can withstand wet heat.

2.1.2 Steam cleaners

Steam cleaners can be used to clean and disinfect fabric that cannot be laundered and surfaces that require surface disinfection. To achieve this a steam cleaner with a continuous vacuum extraction facility must be used.

The steam cleaner produces dry steam at temperatures exceeding 130ºC. The water is turned into high temperature microfine vapour, the microscopic water particles penetrate the surface of the item being decontaminated and are subsequently removed by continuous vacuum extraction. The contaminated water then goes into a separate dirty water tank.

2.2 Chemical Methods

Chemical disinfectants are often irritant when allowed contact with skin and mucous membranes or when inhaled as vapor. They can also be corrosive and flammable. A risk assessment, under the Control of Substances Hazardous to Health (COSHH) Regulations, must be undertaken before chemical disinfectants can be introduced.

There is a potential fire hazard associated with all chemical disinfectant products. It is advisable that these products are stored in appropriate sealed containers/cupboards.

Chemical disinfectants may also be damaging to equipment. It is vital, therefore, that equipment manufacturers instructions are reviewed to ascertain compatibility. This should be clarified prior to purchase of new equipment and a decontamination procedure written by the users and approved by the Infection Prevention & Control Team.

2.2.1 Low level chemical disinfection
Alcohol
- Usually in the form of ethyl or isopropyl alcohol this is most active at a concentration of 60 – 90%. It has good bactericidal and fungicidal activity but whilst ethyl alcohol is effective against most viruses, isopropyl alcohol is not.
- Alcohol is available as a bottled solution or, more commonly, as wipes, in tubs or individually wrapped sachets e.g. Cliniwipes, Sanicloth 70.
- Alcohol is useful for surface disinfection of instruments such as power tools, prior to sterilization.
- Alcohol does not penetrate well into organic matter and must only be used on visibly clean surfaces. If an item is obviously contaminated with organic matter it must be cleaned before disinfection.

Chlorine releasing agents
- This includes sodium hypochlorite and di-isochlorocyanurate (NaDcc).
- Wide range of bactericidal, virucidal and fungicidal activity.
- Corrosive to some metals
- A chlorine-based disinfectant solution at a dilution of 10,000 parts per million (ppm) should be used for the disinfection of any equipment contaminated with blood or blood stained body fluids.

- A chlorine-based disinfectant solution at a dilution of 1,000 ppm should be used for the disinfection of equipment that has been in contact with an infected service user, non-intact skin, body fluids (not blood stained) or mucous membranes.

Chlorine dioxide
This is sporicidal disinfectant that can be used in a wipe system i.e. Tristel Trio, for cleaning and disinfecting non lumened flexible endoscopes e.g. nasoendoscopes.

2.3 High level disinfection
This process must be preceded by thorough cleaning.

2.3.1 Vaporised Hydrogen peroxide for disinfection of the environment
Vaporised hydrogen peroxide may be used to achieve high level disinfection of the environment following outbreaks of infection such as *Clostridioides difficile* and Norovirus. It will only be used with the agreement of the IPCT and operated by housekeepers/domestic assistant who have received training to operate the vaporiser. The area to be treated must be free of people when the vaporiser is in use.

2.3.2 Ultraviolet (UV) Light Systems for disinfection of the environment
Ultraviolet light systems aid in reducing environmental contamination after terminal cleaning and disinfection and can be used following outbreaks of infection such as *Clostridioidesdifficile* and Norovirus. It will be used with the agreement of the IPCT and operated by housekeepers/ domestic assistants and nursing staff who have received training to operate the system.

2.3.3 Heat labile endoscope disinfection
There are no flexible endoscopes at VCC.

3. Sterilization
Sterilization is the complete removal or destruction of all viable microorganisms including viruses and bacterial spores. All reusable medical devices used in acute healthcare settings requiring sterilization will be reprocessed in a Medical Device Directive (MDD) accredited facility.

Autoclaving for VCC will be carried out in the Sterile Services Unit at Llandough Hospital as part of the Service Level Agreement.

4. Tracking and Traceability of Surgical Instruments
It is important to be able to trace products through the decontamination processes and also to the patient on whom they have been used. The ability to track and trace surgical instruments and equipment enables corrective action to be taken when necessary. For example in the unlikely event of a sterilisation cycle failure products can then be recalled.

Records should be maintained for all the sets cleaned and sterilised identifying:
- The cleaning and sterilisation method used.
- The name of the person undertaking the decontamination.
- Details of the item being processed.
- Records should be maintained for a minimum of eleven years.

5. Transportation of contaminated surgical instruments and associated equipment
All contaminated reusable medical devices must be handled collected and transported to their decontamination area in a way that avoids the risk of contamination to patients, staff and any area of the healthcare facility. All contaminated surgical instruments present a risk of infection.
To minimise this risk:
- The instruments must be placed in closed, secure containers and transported to the decontamination area as soon as possible following use.
- Contaminated medical devices and equipment are kept separate from clean during transportation; this is achieve by using separate containers to provide physical barriers between clean and dirty items.

- Personnel are trained to handle collect and transport contaminated medical devices/equipment and should wear protective clothing as appropriate.
- Contaminated and clean/sterile instruments must be segregated during transportation. (Records should be kept of vehicles and containers used).
- Transport containers must protect both the product during transit and the handler from inadvertent contamination and therefore must be:
  - Leak-proof
  - Easy to decontaminate
  - Rigid
  - Capable of being closed securely
  - Lockable where appropriate, to prevent tampering
  - Clearly labelled to identify the user and the contents
  - Robust.
  - Labelled

Appendix 3 - Spills of blood and body fluids (Velindre Cancer Centre)

Note: Welsh Blood Service methods are written into their organisational standard operational procedures

Spills of blood or body fluids must be removed immediately. The removal of blood and bodily fluid spills is the responsibility of the clinical staff in that department, not the cleaning staff. Domestic supervisors are responsible for spillage in non-clinical areas within the building. Estates staff are responsible for the grounds of the hospital. However, some common sense and flexibility must be adopted with the priority being to remove the spill as soon as possible.

Do not use your hands if a spillage contains broken glass or sharps use a brush and pan for example and discard into an appropriate sharps container.

Sodium hypochlorite should be used to disinfect equipment or surfaces contaminated by blood or body fluids.

When a spillage occurs, if practical, close off the immediate area.

WEAR APPROPRIATE PROTECTIVE CLOTHING. (Standard Infection Control Precautions (SIPCs) Policy PC 05 National Infection Prevention and Control Manual)
Note: Welsh Blood Service methods are written into operational procedures

Spills of blood
Make up a solution of Sodium Hypochlorite 10,000ppm - pour on to spillage, leave for 5 mins before mopping up with disposable paper towel then cleaning with detergent and water

Sodium Dichloroisocyanurate (NaDCC) Granules
These granules are stocked in Velindre Pharmacy and can be used to soak up larger spillages of body fluids. Use protective clothing and follow directions on containers.

Do not use on urine spillages for these soak up urine in paper towels discard into clinical waste and clean the area with Sodium Hypochlorite 1000ppm or Chlor clean Tablets diluted to 1000 ppm. Wear appropriate protective equipment.

Spillage Kits
Spillage Kits are available in some divisions; the instruction on the kits should be followed.

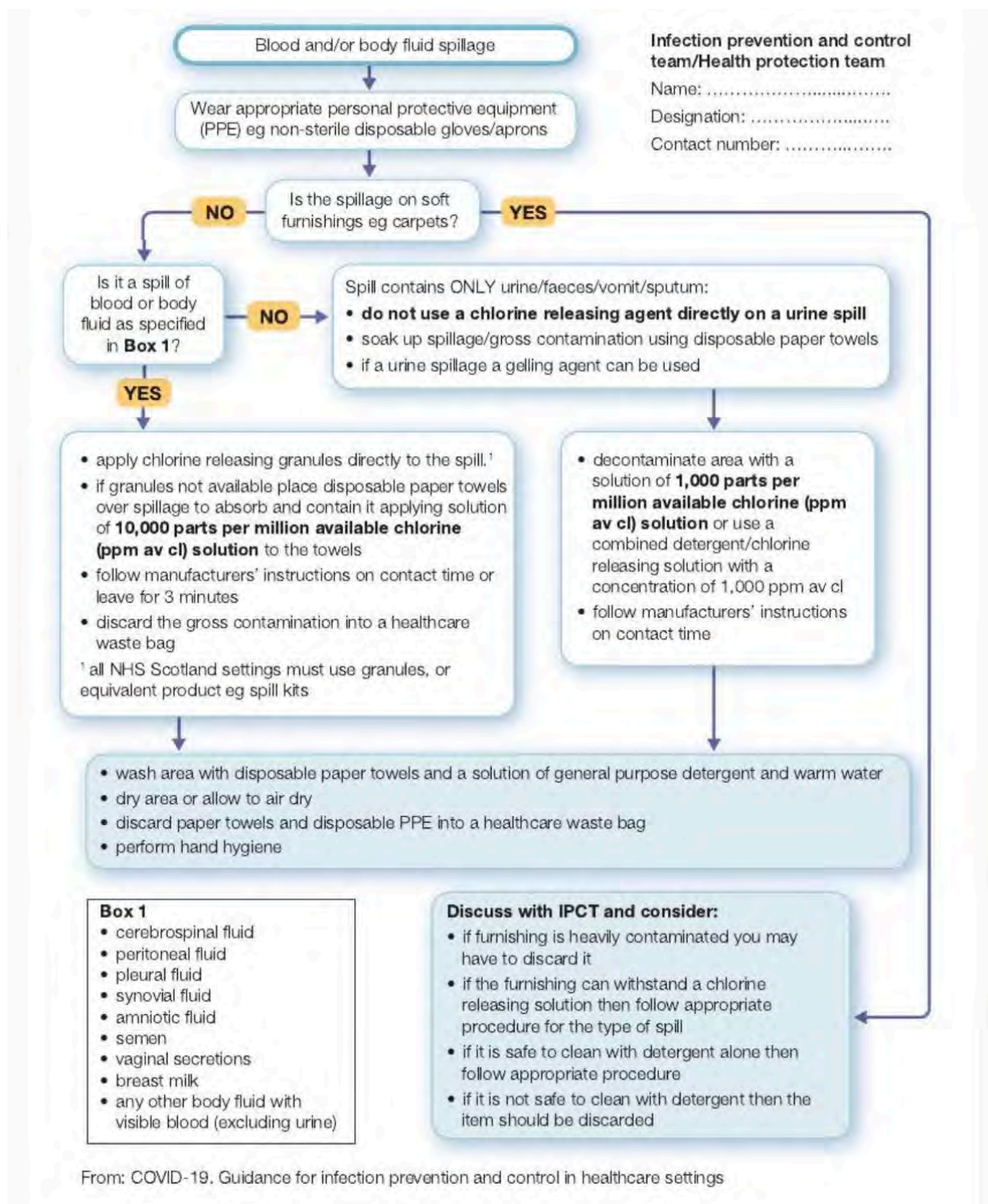**Spills of body fluids not visibly contaminated with blood**
- These include spills of faeces, vomit, urine and sputum.
- Soak up the spill as thoroughly as possible with paper towels.
  Discard the paper towels and any other waste from the spillage into a clinical waste bag.
- Clean and disinfect the area.
- Discard personal protective equipment into the clinical waste bag.

Divisions should follow their Standard Operating Procedures.

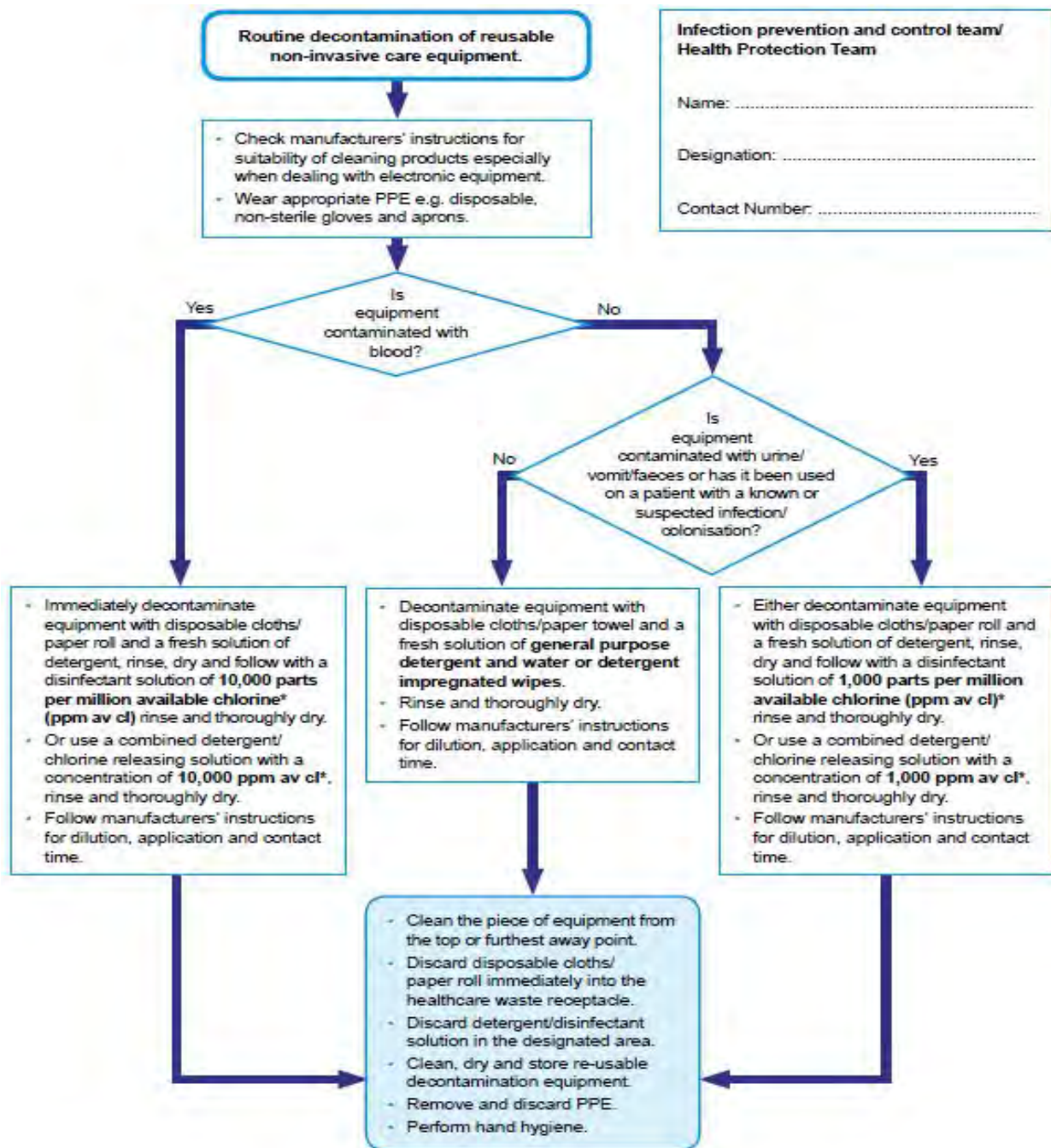**Appendix 4. Best Practice: Management of Blood and Body fluid spillages**

Part of the updated 4 Nations Guidance on infection prevention and control for seasonal respiratory infections including SARS-CoV-2.

Available at:

Blood and/or body fluid spillage

Infection prevention and control team/Health protection team
Name: ....
Designation: ....
Contact number: ....

Wear appropriate personal protective equipment (PPE) eg non-sterile disposable gloves/aprons

Is the spillage on soft furnishings eg carpets?   **NO** / **YES**

Is it a spill of blood or body fluid as specified in **Box 1**?   **NO**

Spill contains ONLY urine/faeces/vomit/sputum:
- **do not use a chlorine releasing agent directly on a urine spill**
- soak up spillage/gross contamination using disposable paper towels
- if a urine spillage a gelling agent can be used

YES

- apply chlorine releasing granules directly to the spill.¹
- if granules not available place disposable paper towels over spillage to absorb and contain it applying solution of **10,000 parts per million available chlorine (ppm av cl) solution** to the towels
- follow manufacturers' instructions on contact time or leave for 3 minutes
- discard the gross contamination into a healthcare waste bag

¹ all NHS Scotland settings must use granules, or equivalent product eg spill kits

- decontaminate area with a solution of **1,000 parts per million available chlorine (ppm av cl) solution** or use a combined detergent/chlorine releasing solution with a concentration of 1,000 ppm av cl
- follow manufacturers' instructions on contact time

- wash area with disposable paper towels and a solution of general purpose detergent and warm water
- dry area or allow to air dry
- discard paper towels and disposable PPE into a healthcare waste bag
- perform hand hygiene

Box 1
- cerebrospinal fluid
- peritoneal fluid
- pleural fluid
- synovial fluid
- amniotic fluid
- semen
- vaginal secretions
- breast milk
- any other body fluid with visible blood (excluding urine)

Discuss with IPCT and consider:
- if furnishing is heavily contaminated you may have to discard it
- if the furnishing can withstand a chlorine releasing solution then follow appropriate procedure for the type of spill
- if it is safe to clean with detergent alone then follow appropriate procedure
- if it is not safe to clean with detergent then the item should be discarded

From: COVID-19. Guidance for infection prevention and control in healthcare settings

Appendix 5 - Decontamination of reusable non-invasive equipment

Part of the National Infection Prevention and Control Manual (NIPCM)

Available at: http://www.nipcm.hps.scot.nhs.uk/

Routine decontamination of reusable non-invasive care equipment.

- Check manufacturers' instructions for suitability of cleaning products especially when dealing with electronic equipment.
- Wear appropriate PPE e.g. disposable, non-sterile gloves and aprons.

Infection prevention and control team/ Health Protection Team

Name: ....

Designation: ....

Contact Number: ....

Is equipment contaminated with blood?

Yes →

No →

Is equipment contaminated with urine/ vomit/faeces or has it been used on a patient with a known or suspected infection/ colonisation?

No ↓   **Yes →**

(Yes - blood)
- Immediately decontaminate equipment with disposable cloths/ paper roll and a fresh solution of detergent, rinse, dry and follow with a disinfectant solution of **10,000 parts per million available chlorine*** **(ppm av cl)** rinse and thoroughly dry.
- Or use a combined detergent/ chlorine releasing solution with a concentration of **10,000 ppm av cl***, rinse and thoroughly dry.
- Follow manufacturers' instructions for dilution, application and contact time.

(No)
- Decontaminate equipment with disposable cloths/paper towel and a fresh solution of **general purpose detergent and water or detergent impregnated wipes.**
- Rinse and thoroughly dry.
- Follow manufacturers' instructions for dilution, application and contact time.

(Yes)
- Either decontaminate equipment with disposable cloths/paper roll and a fresh solution of detergent, rinse, dry and follow with a disinfectant solution of **1,000 parts per million available chlorine (ppm av cl)*** rinse and thoroughly dry.
- Or use a combined detergent/ chlorine releasing solution with a concentration of **1,000 ppm av cl***, rinse and thoroughly dry.
- Follow manufacturers' instructions for dilution, application and contact time.

- Clean the piece of equipment from the top or furthest away point.
- Discard disposable cloths/ paper roll immediately into the healthcare waste receptacle.
- Discard detergent/disinfectant solution in the designated area.
- Clean, dry and store re-usable decontamination equipment.
- Remove and discard PPE.
- Perform hand hygiene.

VELINDRE NHS TRUST

REF: QS 01

Trust Policy

INCIDENT REPORTING & INVESTIGATION

POLICY

Executive Sponsor:
Executive Director of Nursing, Allied Health
Professionals and Health Science

EXECUTIVE SUMMARY

Overview	The incident reporting policy outlines the: • Process involved following all incidents, near misses and work-related injury or ill health and provides guidance on the actions that need to be taken to effectively investigate and to ensure a safe working environment is provided for staff, patients and service users. • Reporting arrangements required to comply with the Health and Safety at Work Act 1974. • Reporting process for notifying external agencies including, Delivery Unit Welsh Government, Medicines and Healthcare products Regulatory Agency and the Health and Safety Executive.
Who is the policy intended for:	All Velindre University NHS Staff, including Service Divisions and Hosted Organisations.

Key Messages included within the policy:	Velindre University NHS Trust outlines a standardised approach for incident reporting and investigation across the organisation. The key messages are:
	• All incidents / near misses should be reported immediately the occur/are known about using the Once for Wales Concerns Management System (OfWCMS) DATIX
	• All staff should be aware of their responsibilities to report incidents and near misses
	• Manager's are responsible for:
	   ○ Reviewing the incident & grading- identifying level of investigation required and commencing timely investigation
	   ○ Making safe, taking necessary immediate remedial action to prevent a re-occurrence
	   ○ Checking on patient / donor / staff safety & wellbeing
	   ○ Provide investigation outcome feedback to relevant staff, patients/donors
	   ○ to ensure all actions to prevent a re-occurrence are taken and sustained
	   ○ Sharing lessons learned
	• Highlighting those incidents that need reporting to external agencies

For more information or advice in relation to the Incident Reporting Policy. Please contact the Trust Quality and Safety team
**Please note this is only a summary of the policy and should be read in conjunction with the full policy document and with local procedures.**

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1. INTRODUCTION

Velindre University NHS Trust is committed to ensuring the health, safety and welfare of its staff, patients, donors, visitors and all users of its premises and services, and its impact on the environment by being pro-active in its approach to reduce the number of incidents and near misses.

Incidents are those unplanned or uncontrolled events or a sequence of events that lead to or result in injury, damage or loss. Near misses are similar but no harm, injury or loss has occurred although there was potential for this to occur. The Trust has a duty to protect its' assets from all threats whether internal, external, deliberate or accidental.

It is essential that all incidents near misses, cases of work-related injury or ill-health and hazards are reported in a consistent manner, this policy outlines the overarching process that all service divisions/hosted organisation will follow. However, further local procedures that support this policy may be in place where additional guidance for staff is required.

Incident Reporting Systems are a major tool in the way organisations manage risks and improve safety. Their purpose is to:
- Ensure that all incidents/accidents (actual and near miss) are reported, recorded and managed
- Prevent the recurrence of preventable adverse clinical and non-clinical events
- Provide 'early warning' of complaints/claims/adverse publicity
- Ensure that sufficient information is obtained:
  - to meet internal and external (e.g. Welsh Government, HSE) reporting requirements
  - to respond to complaints and litigation should these ensue
  - for trend analysis which, in turn, is intended to facilitate the identification and 'learning of lessons' from incidents/mistakes made

This policy is developed in line with the requirements of the following legislation:
- The NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulation 2011
- The Health and Safety at Work etc. Act 1974
- Reporting of Injuries Diseases and Dangerous Occurrences Regulations 2013

If used effectively the incident reporting system will ensure action is taken when incidents / near misses occur to prevent a re-occurrence and enable the Trust to quickly and effectively learn and improve reducing the impact and likelihood of future harm.

The Trust engenders an open and fair culture where staff are comfortable with reporting incidents, near misses and hazards. The aim of reporting and investigating incidents is to prevent reoccurrence, identify the immediate and root cause and learn lessons, and not to blame individuals. This policy also outlines the management responsibilities for reviewing and identifying appropriate investigation and feedback mechanisms to the incident reporter and for sharing lessons learned.

The Policy also highlights the reporting arrangements required for the Trust to comply with its statutory duty in notifying external agencies including the Welsh Government, Healthcare

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Inspectorate Wales (HIW), Information Commissioners Office (ICO), Medicines and Healthcare products Regulatory Agency and the Health and Safety Executive (HSE).

2. POLICY STATEMENT

Velindre University NHS Trust is committed to ensuring the health, safety and wellbeing of all its staff, patients, donors and service users, by providing a safe and secure environment and safe systems of work in which staff can deliver safe and effective services.

All staff / contractors are required to report any incident or near miss that occurs during their working activities. When an incident occurs that causes an injury medical advice and /or first aid should also be sought. The incident must be reported immediately on the Datix system and reported verbally to the person in charge / Manager/supervisor prior to leaving site. The person in charge/Manager/supervisor will discuss the incident, undertake an immediate review, take any required remedial action to prevent a re-occurrence and ensure the wellbeing of all involved.

The Trust promotes an 'open and fair' culture where reporting an incident or near miss will not normally lead to instigation of the Trust Disciplinary Policy unless under exceptional circumstances for example:
- where there is criminal or malicious activity (including malicious reporting)
- acts of gross misconduct or gross negligence
- and repeated unreported errors or violations of procedure.

3. AIMS

To ensure the Trust and all its staff report, investigate, feedback and learn from incidents and near misses in a timely way in order to reduce risk and harm through a culture of openness, transparency, robust enquiry / investigation and no-blame. Therefore that Velindre University NHS Trust will have a positive reporting and learning culture.

4. OBJECTIVES

- To ensure that all incidents, near misses and hazards are reported and managed appropriately and effectively within a supportive framework.
- To promote an open and transparent culture in where incidents are reported and investigated appropriately and to ensure lessons learnt are shared across the Trust.
- To ensure that the Trust is able to effectively manage the risks to which it is exposed, which may arise from hazards or result in incidents and near misses.
- To enable the Trust to comply fully with legislation and mandatory requirements in relation to incident reporting.
- To ensure the Trust proactively monitors incidents to identify emerging patterns or trends so that required system changes can be identified.
- To ensure reflection and learning at an individual, team and wider level.

5. SCOPE

This policy applies to all employees, including temporary or contracted staff who work

within or for Velindre University NHS Trust (The Trust) and covers the service divisions and hosted organisations including all patients, donors or members of the public who are accessing Trust services.

6. OPEN & FAIR CULTURE

In line with the Health and Social Care Quality and Engagement (Wales) Act 2020, the Trust will implement an open and transparent approach to the management of incidents, and ensure procedures are in place to enable delivery against the Regulations. This will enable lessons to be learnt and risks reduced as far as is reasonably practicable.

The Trust encourages all staff to report incidents without fear of personal reprimand or detriment. The emphasis is on the "how" and "why" rather than the "who".

To achieve this, the incident investigation process must be:
- Fair and equitable
- Consistent and systematic
- Focused on learning and change
- Focused on identifying contributory factors and root causes
- Timely

In accordance with the principles of clinical governance, disciplinary action would not normally result from reporting incidents, mistakes or near misses but other procedures may apply.

7. DEFINITIONS

These definitions apply throughout the policy.

The Trust: Velindre University NHS Trust policy and terminology covers all Service Divisions and Hosted Organisations.
Service Division: Defined as any Service Division or Hosted Organisation that have their own internal management structure.
Accident: Any unplanned, unwanted event that results in injury or ill-health to employees, patients, donors or service users visitors, contractors, members of the public on Trust property or results in property damage.
Incident: An event that does not cause harm but has the potential to do so in many organisation termed as near misses
Please note: Only incidents that are related to, or in connection with the Trust activities should be reported. Throughout the policy the term 'incident' covers all incidents, serious untoward incidents and near misses that affect the whole of the Trust regardless of the Service Division or Hosted Organisation.

Nationally Reportable Incident: In general terms an NRI is defined as: *"Something out of the ordinary or unexpected or likely to attract public or media interest."* An incident may be declared as an NRI if it involves a large number of patients/service users, there is a question of poor clinical or management judgment, a service has failed, a patient/service user has died under unusual circumstances or there is a perception that any of these has occurred. Examples of Serious Incidents and the procedure to be followed in the event of such an incident occurring appears **in Appendix 1**
Never Event: Are very serious, largely preventable patient safety incidents that should not occur if the relevant preventable measures have been put in place. Examples appear **in Appendix 9**
Near Miss: A 'near miss' as defined by the Health and Safety Executive (HSE), is any incident, accident or emergency which did not result in an injury but has the potential to
HSE: Health and Safety Executive
Hazard: Anything with the potential to cause harm, injury or loss as defined by the HSE
Risk: A risk is the chance, high or low, of somebody being harmed by the hazard, and how serious the harm could be, as defined by the HSE. Impact x Likelihood= Risk Rating.
RIDDOR: Abbreviation for Reporting Injuries, Diseases and Dangerous Occurrences Regulations.(2013)
Root cause analysis: A method used in investigation process to identify underlying causes of an incident. E.g. Incident Decision Tree, 5 WHYS, Fishbone, Fault Tree Analysis, Failure Modes and Effect analysis.
Risk Assessment: A careful examination of what in the workplace or work activity could cause harm, a documented process that uses a numerical calculation to identify the risk rating. For full details see Trust Risk Assessment Policy
Competence: To establish if a person is competent: The person must have the appropriate and relevant qualification, knowledge, skills and experience to perform their duties.
Duty of Candour: Candour means the quality of being open and honest: transparency, fairness; impartiality. Placing a duty of candour on NHS bodies and primary care providers, through the Health and Social Care (Quality and Engagement) (Wales) Act 2020[1] ('the Act'), highlights the Welsh Government's commitment to safe, effective and person-centred health services.
Duty of Quality: The Duty of Quality seeks to improve the health services for the people of Wales providing evidence based around the 6 domains of Quality (as defined by the Institute of Medicine)
OfWCMS: Once for Wales Concerns Management System DATIX. This is the hosting platform on which incidents, feedback, claims, alerts, mortality review and learning can be capture in a central repository.

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[1] https://www.legislation.gov.uk/asc/2020/1/contents

8. ROLES & RESPONSIBILITIES

8.1 Chief Executive: The 'Chief Executive', carries overall accountability for ensuring compliance with the Health and Safety at Work etc. Act 1974 and associated legislation and for ensuring that the risk management, governance and incident reporting systems are in place and functioning effectively.

8.2 Executive Director of Nursing, Allied Health Professional and Health Science: The Executive Director of Nursing, Allied Health Professionals and Health Science has Board level responsibility for ensuring that a robust and effective quality and safety infrastructure is in place that includes an incident reporting system is in place. The board level role also includes:

- Advising the Chief Executive and Executive Directors regarding incidents that may constitute a Nationally Reportable Incident
- Ensuring there are robust systems in place that relevant external agencies are notified when required
- Ensuring that systems are in place for incident trends to be monitored and reviewed
- Ensuring robust processes for identification of learning.

8.3 Corporate / Divisional / Hosted Organisation Directors: Directors are responsible for ensuring effective incident management systems within their areas of responsibility. Directors are also responsible for ensuring that reporting of incidents and trends to an appropriate Divisional Senior Management Committee or Team takes place and for ensuring that any required local procedures are in place to support the overarching Trust Policy.

8.4 Trust Quality and Safety Department: The Trust Quality and Safety department is responsible for:

- Taking the lead investigators role in all incidents resulting in severe harm or death.
- Providing support to the Service Divisions in relation to the maintenance of the OfWCMS- Once for Wales Concerns Management System-DATIX
- The appropriate reporting to external organisations /agencies
- Providing assistance, support and advice on the investigation process
- Ensuring that Trust wide incident analysis and identification of trends are reported and shared
- Ensuring that demonstration of learning has taken place
- Auditing compliance with this policy and incident processes
- Providing appropriate incident, investigation and Datix training for those that require it.

8.5 Managers: All Managers are responsible for:

- Engendering a positive incident / near miss reporting culture across all areas of responsibility;
- Ensuring all recorded incidents are reviewed and investigated within required time periods and that all such records are held on Datix. This will include;

o to review any incidents occurring in their area
o to identify any remedial action required though an initial management review

o to review and record the severity of actual injury or harm
o to identify those incidents requiring a proportionate review and the appropriate person to conduct the review
o to identify any lessons learnt that can be shared with other departments or committees
o to review in a timely manner
o to record all outcomes and feedback to staff

- Ensuring that staff have received any required Datix, investigation training;
- Ensuring that investigations are undertaken by trained and competent staff and are independent from staff directly involved in the incident;
- Ensuring that their area is a safe environment for staff patients, donors, visitors and service users and where incidents have been reported for ensuring any faulty equipment and estate defects are taken out of use if appropriate and reported to the appropriate personnel for remedial action to be implemented;
- Ensuring prompt identification of any incident that should / may need reporting to an external regulatory body / Organisation and ensuring that this is undertaken within the stipulated time period

8.6 All Staff: All staff are responsible for reporting incidents / near misses that occur during their working activities or shift, in a timely manner via the approved procedure and for making the area safe unless they are injured and ensure they have received the required training / support to be able to do this.

9. TRAINING & AWARENESS

It is the responsibility of all staff to report incidents on the RLDATIX system with the Trust providing training to enable staff to understand where and how this can be done. There is a range of training available across the Trust which includes online e-learning packages and support guides on the intranet pages.

Additional training is provided to staff who will be investigating and managing the review of an incident. This includes access to a suite of short training sessions to include areas around human factors, handling difficult conversations, investigation training, root cause analysis and report writing.

Further specific training is provided within IOSH managing safely and working safely upon request. Competence to deliver training must be in line with core skills framework and reviewed during annual appraisals.

10. INCIDENT REPORTING

The priority on the discovery of an incident is to ensure and maintain the safety and wellbeing of any persons involved and minimizing the risk of harm. If required immediate action such be taken such as escalation emergency services.

The following flow chart, overleaf, captures the process to be undertaking on the discovery of an incident:

10.1 Incident reporting mechanism - OfWCMS- Once for Wales Concerns

Incident identified

Ensure safety and wellbeing of persons involved, taking immediate action as required

Incident to be reported within 24 hours where possible but no later than 72 hours after discovery

Report incident on RLDATIX OFWCMS including all key relevant information

Notification generated to relevant managers of the incident area.

Management review to be undertaken within 48 hours of incident report being generated.

Manager for area in which incident occurred or specialist field such as Health and Safety, Estates, etc undertake initial management review and review incident grading.

Proportionate review required- 30 days

Management actions sufficient

Proportionate review required- 60 days

Detailed RCA competed within 30 days

Detailed RCA completed within 60 days

RCA report and findings shared with Head of Quality and tabled at Divisional quality meetings

Yorkshire Contributory Factors Framework completed

RCA report and findings shared with Head of Quality and tabled at Divisional quality meetings

Incident closed on RLDATIX within 30 or 60 days

Learning captured and shared with incident author and wider teams

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Management System-DATIX

All incidents are recorded into a single incident reporting system (OfWCMS). Any staff member may report directly into an online web based form, which is available via the Velindre UNHST Intranet. An incident for should be completed ideally within 24 hours but no later than 72 hours following the identification of the incident. The form is available on the Trust intranet pages. The RLDATIX user guides are available on the VUNHST intranet and can be reference to support the completion of an incident.

It is important to include all key information relevant to the incident. All sections of the form with a * are mandatory and must be completed. Failure to do so before you submit the form will revert you back to the required section. Once you have input and submitted your form an automatic notification is issued to the relevant Manager of the incident area. It is important to include factual information and including supporting documentation such as photographs where applicable. Patient or donor identifiable data should not be included in any of the free text boxes and capture in the patient information section of the form.

10.2 Incident Coding

Once added to DATIX, all incidents are given a classification 'code'. This enables the same types of incidents to be grouped together, which in turn aides the analysis process in order to identify trends/problems. The coding of incidents in this way also enables the easy identification/selection of the incidents, which must be reported externally.

Within the Trust, the coding and grading of incidents is undertaken by the reporter.

The coding and grading is reviewed by the nominated manager and the Quality and Safety Team or Health and Safety Team.

10.3 Incident Grading

In accordance with national guidance and good risk management practice, all incidents reported within the Trust will be graded using the principles adopted for the proactive risk assessment. Grading is undertaken according to the:

- Actual impact on the affected person(s), whether patient, member of staff or visitor to the Trust
- Actual or potential consequences for the organisation, and
- Likelihood of recurrence

The grading of incidents will assist in establishing the level of:

- Risk associated with a particular incident; and
- Investigation required, for example, concise or comprehensive / root cause analysis.

Table showing levels (grades) of incidents

Level of Harm	Explanation
Level 1:- No harm	A situation where no harm incident occurred, either a prevented patient safety incident or a no harm patient safety incident.
Level 2:- Minor Harm	Any unexpected or unintended incident which required extra observations or minor treatment and caused minimal harm, to one or more persons.
Level 3:- Moderate harm	Any unexpected or unintended incident which resulted in further treatment, possible surgical intervention, cancelling of treatment, or transfer to another area and which caused short term harm, to one or more persons.
Level 4:- Major Harm	Any unexpected or unintended incident that caused permanent or long-term harm, to one or more persons.
Level 5:- Catastrophic Harm	Any unexpected or unintended incident which caused the death of one or more persons.

10.4 Manager's responsibility and guide

The Manager is responsible for incidents occurring in areas under their direct control, e.g. office, department etc. In certain circumstances the estates or facilities Manager will be responsible for the area but not the staff. E.g. Staff member has a fall on the stairs, this is not normally related to their own area it is a shared communal space any investigation will be done by the Estates or Facilities Manager or appointed person.

When an incident has been submitted into the system, the Manager of the incident area should receive an automated notification from OfWCMS that an incident has occurred. The Manager will discuss the incident with the staff member and review the incident, ensuring it is factual and any remedial action is input into the report.

The Manager is responsible for grading the incident based on the actual injury or harm caused, using the risk matrix see **Appendix 2.** The manager will record the grading in the DATIX incident record, where there is no injury or harm caused this must also be recoded.

The Manager will instigate an investigation where required and may decide to perform the investigation or identify an appropriate competent Investigating Officer to perform the investigation.

Where the incident involves a patient, the Manager should consider if the incident is referred to a review group such as the Falls or Pressure Ulcer review panels.

Levels of Investigation within the OfWCMS- Once for Wales Concerns Management System-DATIX are:

- Management Review and Make it Safe Plus - It is the responsibility of the allocated manager to review the incident record and complete the management review/make it safe plus section. This involves checking the information included in the incident

record, to ensure that it is accurate, complete, relevant, reliable and timely. If following Management Review/Make it Safe Plus it is sufficient to close, the Yorkshire Contributory Classification Framework* and conclusion will appear for completion.

- Proportionate Investigation - If following Management Review/Make it Safe Plus a proportionate investigation is required, the form will trigger the following options for the allocated manager to complete.

  - Proportionate Investigation – 30 days
  - Proportionate Investigation – 60 days

If the incident is ready to close following the Proportionate Investigation, the Yorkshire Contributory Classification Framework and Conclusion will appear for completion.

10.5 Reporting a Nationally Reportable Incident (NRI's)

Initially, Nationally Reportable Incidents (NRI's)'s are also reported in the same way as all other incidents. If the reporter or Manager suspects the incident may be an NRI they must take further action. Guidance is available on categorisation of an NRI although the list is not exhaustive see **Appendix 1.**

If the incident is categorised as an NRI, the Service Division will inform and brief the Executive Director of Nursing, Allied Health Professionals and Health Science or the Chief Executive (or other Executive Director in their absence). The Executive Director of Nursing, Allied health Professionals and Health Science will identify the required action.

It is important that NRI's are identified quickly for an investigation to commence, in some circumstances an NRI will not be initially identified, however they may later be re-categorised. This is a preferred option rather than delaying until an investigation has been completed. Exceptionally an incident may only be recognised as an NRI some time after the event. In such cases the member of staff for whom such evidence comes to light must report it immediately.

NRI's will be scored for severity on the potential impact and the potential likelihood, due to their nature. All NRI's will require full investigation using an appropriate root cause analysis technique.

Further information is available from the Wales Delivery Unit.

11. INVESTIGATION

It is important to emphasise that the benefits of the investigation process are to prevent further incidents from occurring. The investigation process will identify failings and underlying causes without apportioning blame and by putting appropriate control measures in place will ensure a safe working environment and improve staff morale.

The Manager will determine the severity of the incident based on actual harm using the matrix in **Appendix 2** and will also identify the level of investigation required and identify a

competent Investigating Officer (IO) or will investigate the incident themselves.

A proportionate investigation may not be needed for all incidents, where incidents have no injury or harm the Manager will discuss the incident with the person affected and identify if any remedial action is required and ensure it is implemented. This information will be recorded in the OfWCMS.

The Manager will collect physical evidence immediately or may identify an appropriate person to do so. This is particularly important where incidents are serious, complex or could result in litigation or prosecution. Evidence to be collected may include physical, documentary and supporting information, and is not limited to the following:

- Photographs of the environment where the incident occurred and of any items contributing to the incident E.g. equipment, machinery, labels on medicines or substances, warning signs etc.
- Maintenance records, for equipment
- Relevant pages of patient notes
- Material safety data sheets
- Documented risk assessments
- Safe systems of work and written instructions given to staff
- Training records
- Observations noted at the time of the incident e.g. weather, lighting, wet floors
- Comments from witnesses who overheard an incident, but may not have seen it
- Witness statements

A systematic process is advised when performing an investigation which is proportionate to the incident. The OfWCMS DATIX system supports the use of the Yorkshire Contributory Tool to support the investigation with information captured on the relevant section on the form.

All additional information that is not directly inputted on to the incident report form must be scanned or uploaded into the documents section of the incident report within OfWCMS. These will include all the correspondence, photographs and documents related to the incident.

12. STAFF SUPPORT

All staff involved in an incident must be offered appropriate support or guidance to ensure staff wellbeing is maintained.

Staff involved in or witnessing significant incidents may become distressed and suffer psychological harm and become anxious when returning to work. Staff may need support and counselling there are a number of support mechanisms in place across the Trust.

Managers and colleagues may offer informal support. Where staff may need professional

help, advice and support is available from Occupational Health, there are two ways to access this service either by speaking to your Manager or HR who may refer you or self-referral is available. The Trust has subscribed to Workplace Options who provide the Employee Assistance Programme which offers a range of counselling services 24/7 and is a free and confidential service. For more advice on staff support see your local procedure/notice boards and the Trust intranet site.

13. REPORTING

13.1 Internal Committees

13.1.1 Divisional
Incident reporting activity will be used to inform quality, safety and governance agendas at departmental and divisional level to enable trend analysis and learning in support of the Duty of Quality and Duty of Candour agendas. Local managers are encourage to use incident data to ensure that those reporting are aware of outcomes and learning.

13.1.2 Trust
The Trust Quality and Safety Committee will receive incident activity reports and analysis of output and learning that has informed service delivery and development.

The Trust Quality and Safety Committee will provide evidence based and timely advice to the Trust Board to assist with discharging its functions and meeting its responsibilities.

The Trust Quality and safety Committee will receive assurance that services are delivery safe care aligned to the evolving requirement under the Duty of Quality and the Duty of Candour.

Specific Trust Board Committees such as the Health, Safety and Fire Management Board will monitor a range of health and safety topics and receive a quarterly health and safety incident report and the health and safety dashboard that includes relevant key performance indicators for discussion and review.

The Health Safety and Management Board will be chaired by the Director of Strategic Transformation, Planning and Digital who will ensure that the Health and Safety Committee meets it statutory obligations and disseminates relevant health and safety information to the Trust Quality and Safety Committee.

Attendance at the Trust Health, Safety and Fire Management Board is attended by the Trust Health and Safety Manager and management representatives from each Service Division/Hosted Organisation, with authority to discuss and explain their Divisional reports.

13.2 External Agencies
All incidents reported to external agencies must be raised and discussed at the appropriate Trust-wide committees to ensure incidents are appropriately discussed internally and any lessons learned can be identified and disseminated. E.g. The Trust Health, Safety and Fire or the Quality and Safety Committee. For advice and guidance on external reporting contact

the Trust Quality and Safety Department.

13.2.1 Health and Safety Executive (HSE)

Reporting Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

All Divisions/Hosted Organisations are responsible for ensuring that an approved process is in place that ensures a competent person is identified to report Divisional incidents directly to the incident reporting centre. All incidents identified as potentially RIDDOR reportable should be discussed with the Trust Health and Safety Manager prior to a report being submitted to HSE. The Trust Claims Manager should also be informed of any incidents reported under this legislation.

Failure to report a reportable injury or a dangerous occurrence or disease in accordance with the requirements of RIDDOR is a criminal offence and may result in prosecution.

Reporting an incident is **not** an admission of liability.

13.2.2 Medicines and Healthcare Products Regulatory Agency (MHRA)
All Divisions/Hosted organisations are responsible ensuring a competent person is identified to reporting directly to the MHRA in line with local procedures.

13.2.3 Welsh Government
The Trust are required to provide the Welsh Government with a range of incident information and statistical report which are co-ordinated via the Trust Quality and Safety Department on a quarterly basis. The Divisions are required to assist in this process upon request.

13.2.4 Delivery Unit
The Trust Datix Support Manager will compile reports from the OfWCMS- Once for Wales Concerns Management System-DATIX of all Patient Safety Incidents, these reports are submitted via the NHS Wales Delivery Unit on a monthly basis.

14. LEARNING FROM INCIDENTS

It is important that learning from incidents is shared throughout the Trust. Divisional/Hosted Organisations information on incidents and trends should be reported and discussed and lessons learned shared at the appropriate Divisional Senior Management Team meeting or other appropriate Health and Safety/Risk Management meeting.
Other appropriate means for learning to be shared Trust wide include:
- Internal alerts disseminated to Service Divisions by the Trust Quality & Safety Department
- Reports and action plans to be monitored at the Organisational Learning Committees
- Feedback from Union Safety Representatives following attendance at

15. FEEDBACK

It is the Manager's responsibility to feedback on any outcome or action to any person reporting and involved in an incident. This will include patients and donors. It is essential to thank the person for reporting the incident and also to provide an update on any action proposed or taken, to demonstrate that their incident was taken seriously.

The feedback process will highlight any repair, replacement or changes to working practices and any outcome of an investigation. This will demonstrate that the learning process is being completed.

It is preferable that the manager provides the feedback with all involved and the person who reported the incident in person. This affords the opportunity for two way dialogue and discussions in relation to the appropriateness and effectiveness of improvement actions that have been put in place. If this is not possible feedback should be provided electronically via email. This feedback should also be recorded in the incident record on Datix.

16. MONITORING

It is necessary to ensure that this policy is disseminated and promoted across the Trust to ensure that a standard approach to incident reporting and investigation is implemented. The Quality and Safety department will monitor compliance by using various methods, a review of incident forms input in a timely manner, completion of the severity of incident closure of incidents etc. The results will be reported to the Service Divisions and discussed in the Trust Health, Safety and Fire Management Board and at the Trust Quality and Safety Committee.

17. EQUALITY IMPACT ASSESSMENT

The Trust is committed to ensuring, as far as is reasonably practicable, the way it provides services to the public and the way it treats its staff reflects their individual needs and does not discriminate against individuals or groups. An equality impact assessment was completed and found that there was **no impact** against individuals or groups.

18. IMPLEMENTATION

The Trust will actively promote awareness and understanding of this policy, linking to existing organisational development programmes, where possible.

Service Directors will implement the policy within their division and ensure where appropriate that local procedures generated support this policy. Additionally, there will be supporting guidance available the intranet site and information disseminated via internal communication channels and dedicated awareness training available upon request.

19. DISTRIBITION

The Incident Reporting and Investigation Policy will be available via the Trust intranet and internet sites. Where staff do not have access to the intranet their line manager must ensure that they have access to a copy of this policy.

20. SUPPORTING POLICIES

The following policies should be read in conjunction with this Policy:

- Trust Health & Safety and Welfare Policy.
- Trust Risk Assessment Policy
- Trust Being Open Policy
- Trust Handling Concerns Policy
- The Whistleblowing/Right to Raise Concerns in the Public Interest Policy for staff to raise specific concerns as identified in the policy.
- Guidance document – Once for Wales Concerns Management System DATIX incident reporting

Nationally Reportable Incidents (NRI)

Delivery Unit/NHS Executive

The Trust is required to report certain incidents to the NHS Wales Delivery Unit. The following definition of a nationally reportable patient safety incident applies:

> "A patient safety incident which caused or contributed to the unexpected or avoidable death, or severe harm, of one or more patients, staff** or members of the public, during NHS funded healthcare*"

The above definition of an incident is applicable to all NHS funded services, regardless of speciality, delivered in all secondary or primary care settings, including community based services.

A patient safety incident will be nationally reported within seven working days from the occurrence, or point of knowledge, if it is assessed or suspected an action or inaction in the course of a service user's treatment or care, in any healthcare setting, has, or is likely to have caused or contributed to their unexpected or avoidable death, or caused or contributed to severe harm.

The following specific categories of patient safety incidents must be reported:
- Suspected homicides where the alleged perpetrator has been under the care of mental health services in the past 12 months
- In-patient suicides
- Maternal deaths
- Never Events (see section 8.6)
- Incidents where the number of patients affected is significant such as those involving screening, IT, public health and population level incidents, possibly as the result of a system failure
- Unusual, unexpected or surprising incidents where the seriousness of the incident requires it to be nationally reported and the learning would be beneficial

The Trust is also required to report the following in specific circumstances:
- Pressure Ulcers (avoidable - Grade 3 / Grade 4 / Unstageable)
- Unexpected deaths in the community of patients known to MH&LD Services
- Safeguarding
- Procedural Response to Unexpected Death in Childhood (PRUDiC)
- Abuse / Suspected Abuse
- Healthcare Acquired Infections (HCAIs)

In all cases the immediate management of the incident is paramount including the safety of the patient affected and other patients. The Divisional Director must be informed of the incident and an incident report form submitted via Datix.

Reporting of nationally reportable incidents to the Delivery Unit will be undertaken by the Trust Quality and Safety Team.

Please record in Datix Risk Management System.

The **Actual** severity level of the injury sustained. Where there is no injury sustained, please record no injury.

Severity Rating =	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
Impact on the safety of patients, staff or public (physical or psychological harm)	Minimal injury requiring no /minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR reportable incident. An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients

Likelihood – MATRIX

	LIKELIHOOD DESCRIPTION
5 Almost Certain	Likely to occur, on many occasions
4 Likely	Will probably occur, but is not a persistent issue
3 Possible	May occur occasionally
2 Unlikely	Not expected it to happen, but may do
1 Rare	Can't believe that this will ever happen

Risk Rating Matrix = Impact x likelihood

	LIKELIHOOD				
IMPACT	Certain 5	Likely 4	Possible 3	Unlikely 2	Rare 1
5 Catastrophic	25	20	15	10	5
4 Major	20	16	12	8	4
3 Moderate	15	12	9	6	3
2 Minor	10	8	6	4	2
1 Insignificant	5	4	3	2	1

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Risk score and Action timetable.

Risk Score	Risk Level	Action and Timescale
1-3	LOW	No action required providing adequate controls in place.
4-6	MODERATE	Action required to reduce/control risk within 12 month period
8-12	SIGNIFICANT	Action required to reduce/control risk within 6 month period
15-25	CRITICAL	Immediate action required by Senior Management

Categories and types of incident.
General guidance (Not an exhaustive list):

Type	Category	Sub category
Health and Safety	Fire Ill health- work related Manual handling (patient) Manual handling inanimate load Sharps Violence and Aggression	Fire alarm activation Work related stress Lifting a patient Lifting a load Needle-stick clean/dirty Verbal abuse
Information Governance	Confidentiality Data protection Freedom of information Records management	Breach of confidentiality Breach of DPA principles Request not processed Consent issues
Clinical Patient & Clients	Blood transfusion issues Chemotherapy issues Communication Complications of treatment Diagnosis error Dignity issue Radiotherapy patient specific Safeguarding issue POVA issue Unsafe clinical environment	
Operational and Organisational	Buildings and plant incident Equipment Security	Buildings fault or failure Equipment failure or fault Information or building security and theft
Quality Assurance	Product defect Research and Development issues	

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Witness Statement

Witness Name:
Job Title:
Work Telephone Number:
Date and Time of incident:
Exact Location of the incident: ……………………………………………………………………… E.g. NWIS Reception, VCC Ward, Corporate HQ first floor open plan, WBS mobile unit Tesco Llantrisant:
FACTUAL ACCOUNT OF EVENT: Please make a note of all FACTS relating to the incident including what you saw, what you heard, what the environment was like and what the weather conditions were (if appropriate).
…… …… …… …… …… …… …… …… …… …… …… ……
This is a factual statement of events: Signature …………………………… date…………………………..

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Investigation Process – Guidance

It is important to emphasise that the benefits of the investigation process is about preventing the incident from happening again and identifying the failings and underlying causes and not apportion blame. Reviewing the Safe Systems of Work with the underlying causes will identify any gaps. Sharing the findings is as important as ensuring the quality of the investigation.

The Manager will determine the level of severity of the incident and will identify a competent Investigating Officer (IO) and in some cases will perform the investigation themselves.

The IO will lead the investigation and will facilitate any assistance required where necessary identifying who will support the review depending on circumstances the following should be considered:
☐   Someone familiar with the work location
☐   Supervisor or Manager of the work location
☐   Senior manager with authority or influence
☐   Health and safety expert and or technical expert
☐   Employee representative
☐   Person involved if possible

The IO or team will collect any further information and will complete any interviews with witnesses, patients, service users and staff. Ensuring documented statements are taken.

The IO or team will analyse all evidence collected as part of the immediate response and ensure where required that an appropriate specialist examines any equipment thought to be faulty and that a report is provided by the specialist on the outcome.

The IO or team will analyse all the evidence collected and using an appropriate root cause analysis tool e.g. Incident Decision Tree, 5 WHYS, Fishbone, Fault Tree Analysis, Failure Modes and Effect analysis. The IO will use the best tool for the incident and identify direct causes and any underlying causes.

Where the incident is general the IO will conduct a proportionate review and capture the content using the Yorkshire Contributory Framework on the DATIX record.

The aim of the review is to identify any immediate or underlying causes and consider any gaps in the process or procedures and recommend remedial action and share information to learn lessons from the incident.

Never Events as identified by the Department of Health

Never events are very serious, largely preventable patient safety incidents that should not occur if the relevant preventable measures have been put in place. The UK Government has identified a list of 25 Never Events. Velindre has reviewed this list and identify with 21 Never Events.

☐ either resulted in severe harm or death or had the potential to do so
☐ there is evidence that the never event has occurred in the past and is a known source of risk (for example through reports to the NRLS or other serious incident reporting system).
☐ there is existing national guidance or safety recommendations, which if followed, would have prevented the incident from occurring.
☐ occurrence of the never event can be easily identified, defined and measured on an ongoing basis.

It is the Managers responsibility to identify if the incident is a never event and to ensure that the incident is classified and reported to NRLS via the Datix Risk Management System.

The manager will also ensure the incident is investigated to identify compliance and the robustness of systems and processes, and also human factors using an appropriate root cause analysis tool and where possible to examine and identify how the issues can be mitigated to prevent recurrence.

The term should not be used for incidents that do not meet these criteria.

1. Wrong site surgery (existing)
2. Retained foreign object post-operation (existing)
3. Wrongly prepared high-risk injectable medication (new)
4. Maladministration of potassium-containing solutions (modified)
5. Wrong route administration of chemotherapy (existing)
6. Wrong route administration of oral/enteral treatment (new)
7. Intravenous administration of epidural medication (new)
8. Maladministration of Insulin (new)
9. Overdose of midazolam during conscious sedation (new)
10. Opioid overdose of an opioid-naive patient (new)
11. Inappropriate administration of daily oral methotrexate (new)
12. Suicide using non-collapsible rails (existing)
13. Falls from unrestricted windows (new)
14. Entrapment in bedrails (new)
15. Transfusion of ABO-incompatible blood components (new)

16. Misplaced naso- or oro-gastric tubes (modified)
17. Wrong gas administered (new)
18. Failure to monitor and respond to oxygen saturation (new)
19. Air embolism (new)
20. Misidentification of patients (new)
21. Severe scalding of patients (new)

Ref QS03

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

Executive Sponsor & Function:	Executive Director Nursing, Allied Health Professionals and Health Science
Document Author:	Trust Quality & Safety Manager
Approved by:	Quality, Safety & Performance Committee
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1. Executive Summary

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

This policy will be implemented in accordance with the following:

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

2. Policy Statement

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

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

Handling Concerns Key Principles

A culture of openness will **be promoted**

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

Robust & proportionate Investigations will be undertaken

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

Local concerns arrangements will be in place

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

Concerns training will be provided to all staff

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

Individuals raising concerns will be engaged in the process

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

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

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

Datix will be used to record all concerns

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

Risks will be mitigated to avoid re-occurrences

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

A bi-lingual service will be provided when required

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

Learning will be identified to improve services

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

Early resolution of concerns will be promoted

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

80% of responses will be provided with 30 working days

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

3. Scope of Policy

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

The Policy covers concerns about:

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

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

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

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

4. Aims & Objectives

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

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

5. Definitions

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

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[1] https://www.legislation.gov.uk/asc/2020/1/contents

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

6.   Roles and Responsibilities

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

6.1 Chief Executive Officer

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

6.2 Responsible Officer

The Responsible Officer is accountable for the effective day to day operation of the Trust's arrangements for dealing with concerns in an integrated manner. The Director of Nursing, Allied Health Professionals and Health Science is the Responsible Officer for the Trust and ensures arrangements are in place to:
- Deal with concerns in line with the Regulations.
- Allow for the consideration of qualifying liabilities; and
- For incidents, complaints and claims to be dealt with under a single governance arrangement.

6.3 Strategic Oversight

A nominated Independent Member is responsible for maintaining a strategic overview of the Putting Things Right arrangements and their operation, including:
- Overseeing how organisational arrangements are operating at a local level.
- Ensuring that concerns are dealt with in compliance with the regulations.
- Ensuring arrangements are in place to review the outcome of all investigated concerns to ensure that any failure in provision of service identified during the investigation are acted upon, improved and monitored in order to prevent recurrence

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

6.4 Trust Quality and Safety Manager

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

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

6.5 Corporate / Divisional Directors (including hosted organisations)

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

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

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

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

6.6 Every manager in the Trust is responsible for:

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

6.7 Responsibility of all Staff

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

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

6.8 Corporate Quality and Safety Team

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

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

6.9 Executive Management Board

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

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

6.10 Quality Safety and Performance Committee

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

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

7 Notification of a Concern

7.1 Who May Notify a Concern

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

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

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

7.2 Concerns Notified by a third party

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

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

7.3 Concerns Received from Assembly Members/Members of Parliament

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

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

7.4 Concerns Relating to Children

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

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

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

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

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

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

7.5 Concerns Raised by Prisoners

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

7.6 Concerns raised by individuals Lacking Capacity or Vulnerable Adults

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

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

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

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

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

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

7.7 Concerns raised through Advocacy Services

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

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

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

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

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

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

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

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

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

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

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

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

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

7.9 Concerns from people with a disability

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

7.10 Concerns involving contracted service

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

- the contractor complies with this policy and complaints handling procedures and/or

- the contractor has their own complaints handling procedure in place, which fully meets the standards outlined in this procedure.

- The Trust is responsible for ensuring that there is appropriate provision for information sharing and governance oversight involving contracted services to ensure the safe delivery of services that is provided on behalf of the contractor.

7.11 <u>Concerns and Welsh Language</u>

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

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

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

7.12 Concerns and British Sign Language

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

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

The Trust will take steps to ensure:

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

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

7.13 <u>Concerns and </u>Blind and Partially Sighted Disabilities

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

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

8. Reporting Concerns

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

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

8.1 Time limits for notification of a concern

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

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

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

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

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

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

8.2 Withdrawal of Concerns

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

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

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

9. Handling a concern process

9.1 Acknowledging Concerns

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

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

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

9.2 Time limit for formally responding to a concern

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

If this is not possible, the Trust will:

    (a) notify the complainant and outline the reason for the delay; and

    (b) send the interim report as soon as reasonably practicable and within 6 months

    (c) a Regulations 33 response and disclosure of the investigation report must be sent no later than 12 months

9.3 Concerns received from Medical Examiners

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

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

9.4 Concerns Referred to Coroner's Inquest

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

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

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

10 Investigation of Concerns

10.1 Concerns Flowchart

Complaints managed through the PTR Formal Process

Where a matter cannot be resolved within 2 working days under Early Resolution, the matter _must_ resort to a formal investigation under the Putting Things Right Regulation

Received by staff – verbal/written/email
Forward to: Handlingconcernsvelindre@wales.nhs.uk

ACKNOWLEDGE
within 2 days - identify relevant consent, key issues, named contact and date deadline within 30 working days in which to supply response –issue CHC support & Putting Things Right leaflets

Allocated to divisional service lead– verbal/written/email

VCC – Send to VCC Quality and Safety Team/Head of Nursing & Quality and Safety	WBS – send to complaints coordinator, Clinical, Quality Governance Manager & Head of Nursing	Corporate –send to Director of Corporate Services Planning – send to Director of Strategic Transformation

Check Consenting process and obtain appropriate consent where required by day 2

Use Grading/RAG Rating for scoping by day 2

INVESTIGATE/INFORMATION GATHERING & ANALYSIS
0-10 days

Prepare draft response or interim report 10 – 18 days

CAPTURE LEARNING – From Events, Feedback, Recommendations, Actions, Progress, Monitoring and Evaluating 18-20 days

Breach of Duty - No	Breach of duty –Yes
No breach of duty – prepare Reg 24 response – Sign off by directorate for grade 1 & 2/ Sign off by Executive Director for concerns graded 3 and above	Identify breach of duty/harm prepare interim Reg 26 response Take case to PTR PANEL FOR APPROVAL Sign off by Ex Lead Director

Seek Quality Assurance Approval 18 days – 20 days

APPROVAL/SIGN OFF
Response by 30 day deadline

If breach of duty identified that implies harm or results in harm pass for Redress process

Update all STAGES IN RL OFW DATIX before Closure

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

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

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

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

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

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

10.2 Initial Assessment of a Concern

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

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

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

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

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

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

10.3 Obtaining independent clinical or other advice

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

10.4 Consent to Investigate Concerns

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

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

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

10.5 Consent Involving Other Organisations

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

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

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

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

11 Nationally Reportable Incidents

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

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

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

12 Response

12.1 Delays to the Complaint Response

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

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

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

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

12.2 No Qualifying Liability – Regulation 24

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The interim response will include:

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

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

12.4 Trust Putting Things Right Panel

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

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

12.5 Post Closure contact - Public Service Ombudsman of Wales

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

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

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

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

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

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

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

12.7 Redress

Redress comprises:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12.7.1 Regulation 33 Response

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

12.7.2 CRU Certificate

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

13 Behaviour, Conduct and Unreasonable Demands during a concerns investigation

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

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

Unreasonable, unacceptable abusive or aggressive, or violent behaviour is:
- Behaviour that produces damaging or harmful effects, physically or emotionally on other people.

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

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

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

14 Monitoring Arrangements

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

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

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

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

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

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

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

  o Effectiveness of the arrangements, and how this has impacted on patients/service user and staff

  o An indication of services used, for example expert advice, legal advice, alternative dispute resolution, advocacy services.

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

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

15 Learning from Concerns

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

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

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

16 Supporting Staff

16.1 Staff involved in concerns

To support staff involved in concerns investigations the Trust will:

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

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

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

16.2 Concerns Containing Allegations against Staff

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

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

17 Concerns and Disciplinary Procedure

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

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

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

18 Equality Impact Assessment

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

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

19 Policy Compliance

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

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

20 Confidentiality – Information Governance

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

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

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

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

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

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

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

21 Training

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

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

Training will take the form of one or more of the following:
- ☐ Online training
- ☐ Self-learning: guides, procedures, policies and legislation
- ☐ Videos
- ☐ Meetings and conferences
- ☐ Induction
- ☐ E-learning

22 Storage and Management of Concerns Files

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

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

23 Complaints and legal action

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

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

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

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

24 Managing Media Interest / Media Communications

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

25 References

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

Annual Report 2021

Technoleg Iechyd Cymru
Health Technology Wales
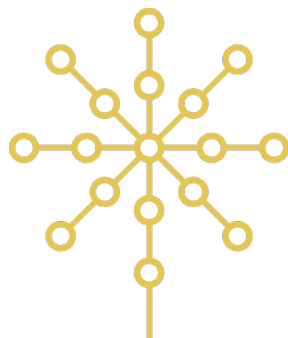
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Ariennir gan **Lywodraeth Cymru** Funded by **Welsh Government**

Foreword

"Welcome to the Health Technology Wales (HTW) Annual Report, which describes the work that we have done during the last year to improve health and social care in Wales.

This has been another challenging but successful year during which we have had to balance our commitments to supporting Welsh Government in their response to the COVID-19 pandemic with maintaining our normal core functions of selecting, appraising and promoting the adoption of novel evidence-based technologies in Wales. We were pleased that HTW was appointed in 2021 as a collaborating partner of the Welsh COVID-19 Evidence Centre enabling us to continue to add methodological and research expertise to the publication of rapid evidence reviews and summaries on important COVID-19 related topics.

During 2021, we considered more than 80 new topic referrals from across the health and care communities and published six new HTW guidance documents, including our first social care guidance, as well as nine new evidence appraisal reports . Since 2017, HTW have now published 23 pieces of guidance and it is estimated that, if implemented, these have the potential to impact 188,680 individuals each year in Wales.

An important remit of HTW is to promote and also audit the adoption of HTW and NICE medical technology guidance in Wales. During the last year, we have worked with Local and Specialist Health Boards to establish a process to support this work. We have initiated a pilot that has selected 8 pieces of previously published HTW guidance, for which individual monitoring plans have been agreed and local adoption data acquired, to assess their impact on local services. The intention is that this pilot project will inform the establishment of a prospective, embedded and rolling process of adoption audit during the coming years.

Engaging with local, national and international stakeholders has remained an important cornerstone of our success and during 2021, the HTW Stakeholder Forum was established. This group comprises senior representatives from across the health and social care systems and will help to support and guide the work of HTW to ensure that it is of most value to the communities it serves. We have worked closely with colleagues in Social Care Wales to develop a better understanding of how our health technology assessment (HTA) processes need to be adapted to support our work in developing and promoting the adoption of social care guidance. We have continued to build on already established links with the life sciences industry through the work of our Industry User Group and through strengthening our collaborations with the Life Sciences Hub Wales.

We have continued our commitment to establishing innovative approaches to Patient and Public Involvement (PPI) in all aspects of the work of HTW and much attention in 2021 has been focussed on understanding how these might best be applied to considering social care topics. The last year has seen us continue to develop our collaborations with other international HTA bodies. We were honoured to be invited to join the Local Organising Committee of the 2021 annual meeting of Health Technology Assessment international (HTAi) which brought together representatives from more than 60 countries in a virtual event in June 2021. HTW was also awarded a prestigious international award - the David Hailey Award - voted on by the members of the International Network of Agencies for Health Technology Assessment (INAHTA) for the best example of impact and learning from a health technology assessment agency.

During 2021, we published the HTW Strategic Plan 2021-2025, that sets out our immediate, medium and longer term strategic goals. This plan was developed through wide engagement with our stakeholders and was supported by Eluned Morgan, Minister for Health and Social Services. Our vision is to continue to develop a world class HTA organisation that ensures that health technologies that have the most promise to improve the health and care of people and offer the greatest value are recognised and adopted in Wales. We look forward to working with you in realising this vision."

Professor Peter Groves
Chair
Health Technology Wales

Dr Susan Myles
Director
Health Technology Wales

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Introduction

HTW was established by Ministerial recommendation in 2017 following the National Assembly for Wales' inquiry into Access to Medical Technologies in Wales. As a national health technology assessment (HTA) organisation we're funded by the Welsh Government and hosted by Velindre University NHS Trust but remain independent of both. HTW's remit covers any technology or model of care and support in health and social care that is not a medicine. For health, this could include medical devices, diagnostics, procedures and pyschological therapies. For social care, this could include equipment or different models for supporting families, children, adults and the workforce. Since its launch HTW has collaborated with partners in the health, social care and technology sectors to optimise the use of non-medicine health technologies in Wales and to raise awareness of their value.

This annual report explores the areas we've worked on during 2021 and reflects our health technology assessment work, engagement activity with key stakeholders and industry and the support we have provided to partner organisations through the COVID-19 pandemic.

COVID-19

Our team has continued to support Welsh decision makers throughout the pandemic. This has enabled them to respond swiftly to new research on the pandemic and its impact on society. In 2021 HTW was appointed a Collaborating Partner of the Wales COVID-19 Evidence Centre enabling HTW to provide methodological and research synthesis expertise to the dedicated centre for COVID-19 topics. HTW has also contributed to key Welsh Government committees, co-authoring three pan-European collaborative reviews and providing scientific advice to industry.

IDENTIFICATION

We respond to the needs of care providers, service users and technology developers by proactively identifying upcoming technologies expected to have a major impact on health and social care in Wales. Anyone can suggest a topic for appraisal by filling in a form on our website. Throughout the year we run campaigns and hold workshop and webinar events to raise awareness of our work. These campaigns are aimed at those working within the health and social care sectors, people using those services and health technology developers. We also signpost technology developers to sources of advice and support on the HTA process.

APPRAISAL

We produce appraisal reports to summarise the evidence that is available on a health technology. These reports, which include input from experts in the respective field, are used by our multi-disciplinary groups to produce HTW guidance. Care commissioners and other decision makers use our authoritative and evidence-based guidance to decide whether to adopt a health technology. It is essential that this guidance is available to these decision makers, to ensure that high quality health and social care services are based on the best available evidence.

ADOPTION

The national guidance provided by HTW has an 'adopt or justify' status. This means that care services in Wales should adopt this advice or justify why it has not been followed. An important part of our remit is to evaluate the impact of our advice by monitoring the uptake of non-medicine health technology guidance across Wales. HTW also encourages disinvestment of technologies that are no longer effective. In 2021 HTW's Adoption Audit function was established to monitor the uptake of HTW guidance and medtech guidance produced by the National Institute for Health and Care Excellence (NICE).

ENGAGEMENT

HTW collaborates with people and organisations across the health and social care sectors in Wales, sharing expertise and gathering insight. In 2021 we established a strong working partnership with Social Care Wales (SCW) to improve our understanding of the social care sector. Throughout the year we have hosted meetings of the HTW Industry User Group to better understand the needs of technology developers. We ensure that the views of those accessing health and social care in Wales are represented through the HTW Patient and Public Involvement (PPI) Standing Group. HTW also works closely with our international counterparts including the International Network of Agencies for Health Technology Assessment (INAHTA), Health Technology Assessment International (HTAi) and the European Network for Health Technology Assessment (EUnetHTA).
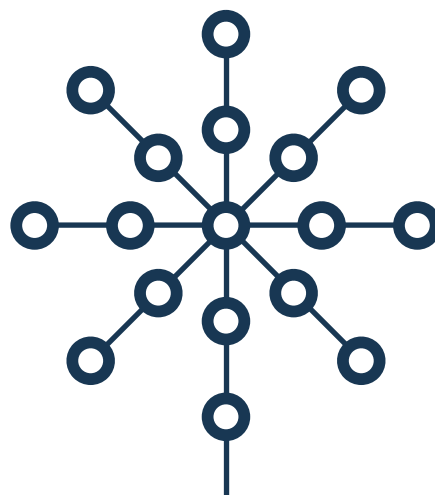
Guidance impact

We want our work to make a real, positive difference to health and care in Wales. Working with Matter of Focus, an evaluation organisation, we've been developing our own evaluation and impact processes so that we can capture how we are making a difference in Wales, as well as how we can continuously improve on our work.

The core aim of HTW appraisals are to:
- Encourage adoption of clinically and cost-effective technologies
- Discourage adoption of technologies that are unsupported by evidence
- Improve quality of care and patient or service user outcomes

308	45	23
Topics proposed to HTW	Topics progressed to evidence appraisal	Pieces of Guidance published

Our recommendations

Our national guidance recommendations fall into three main categories:

Routine adoption:
The evidence supports the adoption of that technology for a general population.

Selective adoption:
The evidence supports the adoption of that technology in a specific subset of the general population.

Insufficient evidence to support adoption:
There is not enough evidence to support the adoption of that technology.

Type of recommendation made in HTW Guidance (2021)

17%
83%
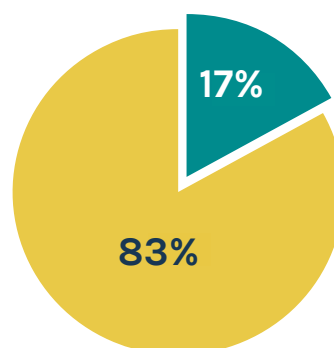
Type of recommendation made in HTW Guidance (2018-2021)

19%
33%
48%
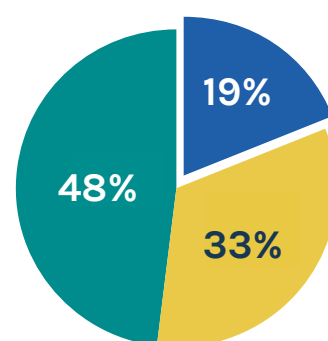
- Selective adoption
- Routine adoption
- Insufficient evidence to adopt

How HTW assesses the value of health technologies

We are aware that care services face a limited budget. Spending more money in one area necessitates spending less elsewhere. We carefully review the evidence on clinical and cost effectiveness for each technology that we appraise to inform difficult spending decisions across multiple disease areas. The approach we take to estimating cost effectiveness reflects this ambition with an aim to maximise the benefits that can be attained from available resources rather than to minimise costs.

HTW Guidance published in 2021
Recommendation: Routine adoption
Corneal crosslinking to treat adults and children with karatoconus (GUI002-02)
Antimicrobial barrier caps for use with haemodialysis catheter hubs (GUI030)
FreeStyle Libre flash glucose monitoring for the management of diabetes (GUI004-02)
Natriuretic peptides to rule-in and rule-out a diagnosis of acute heart failure in adults in the emergency department setting (GUI026)
Strategies for Relatives (START) intervention to improve the mental health of carers of people with dementia (GUI031)
Recommendation: Insufficient evidence to adopt
Point-of-care ultrasound to diagnose gallstone disease (GUI029)

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Strategic Plan 2021-2025
Better Health | Evidence Driven

The HTW Strategic Plan 2021-2025 sets out the organisation's immediate, medium and long-term strategic goals and objectives.

It was developed in consultation with key stakeholders including: Welsh Government; opinion leaders within the Welsh health and social care system; and members of HTW decision making groups including the Executive Group, Appraisal Panel, Assessment Group, Patient and Public Involvement Standing Group, Industry User Group Collaboration and Stakeholder Forum.

The plan was created as a living document that will be continually refined to reflect changing health and social care priorities and demands on HTW resources.

Technoleg Iechyd Cymru
Health Technology Wales

VISION

To develop a world-class HTA organisation that facilitates the identification, appraisal and adoption of health technologies that offer most promise to deliver improved health outcomes and value for the people of Wales.

MISSION

To drive improvements in population health and care services by applying the best available evidence to inform decisions on the appropriate use of health technologies Wales.

HTW VALUES

QUALITY

HTW produces authoritative, independent guidance, developed applying rigorous and transparent evidence synthesis methods, to promote use of health technologies that offer the most benefit and value for Wales.

RESPONSIVENESS

HTW offers timely input to support the decisions needs of services users, policy makers, health and care providers and technology developers across Wales.

COLLABORATION

HTW works in partnerships engaging with stakeholders across Welsh health, social care and technologies sectors to support evidence-informed decision making.

STRATEGIC GOALS

IDENTIFICATION

Identify the health technologies that are expected to have major impact on care services and confer most benefit for the people of Wales

APPRAISAL

Deliver step change in the volume of HTW evidence outputs, promoting a coordinated national approach to evidence-informed decision making on non-medicine technologies across Wales.

ADOPTION

Improve the quality of health and social care by disseminating evidence-based national guidance that encourages adoption of technologies expected to have a major impact in Wales.

ENGAGEMENT

Promote greater understanding and use of HTW Health Technology Assessment (HTA) outputs with key Welsh care system stakeholders.

Our 2021 priority objectives

Within our first Strategic Plan, HTW outlined its top five priority objectives for 2021-2022.

Key achievements in delivering these objectives are set out below. More detail on each can be found via the hyperlinks provided.

Expand HTW's topic identification, prioritisation and selection efforts:
- Increased from one to two annual topic calls
- Received 88 topic referrals for consideration
- Refined the HTW topic selection and prioritisation method

Significantly increase HTW's evidence appraisal and guidance output:
- Produced 49 topic exploration reports
- Produced 9 evidence appraisals
- Issued 6 pieces of national guidance including first piece of social care guidance

Target social and digital care innovations for appraisal:
- Established a collaborative partnership with Social Care Wales
- Held the first HTW social care open topic call
- Established an expert group to target HTW's forthcoming digital topic call

Support time-critical COVID-19 care and policy decision making:
- Became a collaborating partner in the new Wales COVID-19 Evidence Centre
- Produced evidence syntheses to inform pandemic decision making
- Supported key Welsh Government pandemic expert groups

Pilot and roll-out the HTW technology adoption audit function:
- Co-produced the HTW adoption audit infrastructure
- Piloted the first annual adoption audit of HTW and NICE guidance
- Submitted the first annual adoption audit report to Welsh Government

COVID-19

Supporting health and social care partners in the response to the pandemic
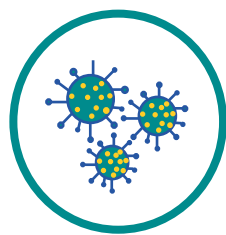
Responding to COVID-19

Since the start of the COVID-19 pandemic, our team has repurposed their diverse skill sets to support the response of Welsh Government and care services to the virus.

Since becoming a Collaborating Partner of the Wales COVID-19 Evidence Centre we have carried out a series of rapid evidence reviews and summaries on topics ranging from transmission among the vaccinated population to the effectiveness of face coverings.

Work carried out in 2021

Rapid evidence reviews

What is the risk of SARS-CoV-2 transmission in vaccinated populations?

Face coverings to reduce transmission of SARS-CoV-2.

Convalescent Plasma Therapy for the Treatment of COVID-19

Rapid evidence summaries

The effectiveness of home monitoring using pulse oximetry in people with COVID-19 symptoms to guide future management.

COVID-19 transmission in semi-outdoor or partially covered settings.

Effectiveness of tests to detect the presence of SARS-CoV-2 virus, and antibodies to SARS-CoV-2, to inform COVID-19 diagnosis: a rapid systematic review

Collaborating partners

The core team of the Wales Covid-19 Evidence Centre works closely with collaborating partners including: Health Technology Wales, Wales Centre for Evidence-Based Care, Specialist Unit for Review Evidence centre, SAIL Databank, Bangor Institute for Health & Medical Research, Health and Care Economics Cymru, and the Public Health Wales Observatory.

We also engaged with Welsh Government, NHS Wales and the UK Health Security Agency.

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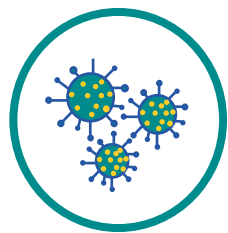
Supporting Welsh decision makers
Working in collaboration with the Wales COVID-19 Evidence Centre

In March 2021 HTW was appointed as a Collaborating Partner in the £3million Wales COVID-19 Evidence Centre.

The centre, which is funded by Welsh Government through Health and Care Research Wales and is hosted by Cardiff University, has played a major role in enabling key decision makers in Wales to respond to emerging evidence about COVID-19.

It was set up with the aim of ensuring that the most up-to-date and relevant evidence is readily available to stakeholders involved in health and social care in Wales to inform their decision making.

The centre's key purpose is to rapidly review and synthesise UK-wide and international research evidence to support COVID-19 policy and practice decision making by stakeholders involved in health and social care policy and practice in Wales.

It works with multiple stakeholder groups across Wales including representatives from Welsh Government and policy groups, social care, the Academy of Medical Royal Colleges (Wales), public and patient involvement organisations, Health and Care Research Wales, NHS Wales service delivery groups, NHS Wales University Health Boards and Trusts and Third Sector Support Wales.

HTW's role as a Collaborating Partner

As a Collaborating Partner in the Wales COVID-19 Evidence Centre, HTW carries out evidence reviews and research into different COVID-19 related topics. Based on this research it produces Rapid Evidence Reviews and Rapid Evidence Summaries of the evidence available.

Before joining the Wales COVID-19 Evidence Centre as Collaborating Partner HTW supported the response to the pandemic by contributing to Welsh Government committees and task forces. It co-authored three pan-European collaborative reviews and provided scientific advice to industry.

What else is HTW doing to support efforts to tackle COVID-19?

HTW has collaborated on several externally published reports in partnership with EUnetHTA. It produces an Evidence Digest of links to websites which collate or synthesise evidence relating to COVID-19 and updates it regularly as required. HTW also offers a free Scientific Advice Service to technology developers who are developing therapeutics and diagnostics related to COVID-19. HTW's advice can help developers with many different aspects of health technology assessments including evidence generation and economic modelling.
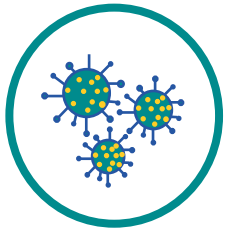
A rapid review of existing research on the effectiveness of Face Coverings to reduce transmission of SARS-CoV-2

What did we do?

In July 2021 we carried out a rapid review of existing research on the effectiveness of face coverings to reduce transmission of SARS-CoV-2 by containing droplets and preventing them reaching susceptible people and/or by preventing inhalation of droplets present in the air.

The aim of the rapid review was to answer the following questions:

1. What is the effectiveness of face coverings to reduce the spread of transmission of SARS-CoV-2 in the community (i.e. non healthcare settings)?

2. What is the efficacy of different types of face coverings designed for use in community settings?

Who with?

The rapid review was shared with key Welsh health and social care decision makers. We also shared our report with other national and international HTA organisations including the Scottish Health Technologies Group (SHTG), Health Information and Quality Authority (HIQA), the National Institute for Health and Care Excellence (NICE), the International Network of Agencies for HTA (INAHTA) and the European Network for HTA (EUnetHTA).

What did we learn?

HTW's research showed that evidence remains limited on the effectiveness of face covering to reduce the spread of transmission of SARS-CoV-2 in the community, that the efficacy of different types of face coverings remains limited and that conclusions rely on low quality sources of evidence with a high risk of bias. The key findings were:

- Evidence suggests that face coverings may provide benefits in preventing transmission of SARS-CoV-2 but higher quality studies suggest these benefits may be modest.

- There was no evidence about face coverings to prevent transmission of SARS-CoV-2 specific to individual community settings (e.g., schools, public transport); for children and adolescents; about seasonality; or the extent of protection for wearers and others.

- Evidence suggests that commonly used face coverings have some efficacy in filtering droplets. Medical masks appear to have a higher efficacy than fabric masks although some studies suggested equivalent efficacy.

- The quality of observational studies could be improved by methods that better address confounding factors.

What difference has this made?

Our findings contributed directly to the Welsh Government 21-day COVID review cycle.

The research was included in Welsh Government's Technical Advisory Cell (TAC) summary of advice 4 February 2022.
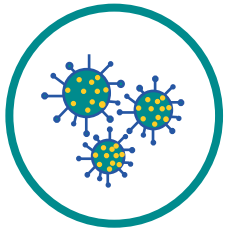
SARS-CoV-2: A rapid review of the transmission risk from vaccinated populations

What did we do?

Vaccination aims to prevent onward transmission by at least two mechanismsm, firstly by reducing symptomatic and asymptomatic infections and therefore the number of infectious individuals, and secondly via reduced onward spread from people infected despite vaccination.

As part of our ongoing work with the Wales COVID-19 Evidence Centre we conducted a systematic literature search for the evidence on transmissibility of SARS-CoV-2 in the vaccinated population in any setting.

What did we learn?

In total, 36 studies were included in this review: one randomised controlled trial (RCT), one analysis of an RCT, 15 prospective cohort studies, 15 retrospective cohort studies and four case control studies. These findings directly contributed to the Welsh Government 21-day COVID review cycle.

The key findings were:

● Earlier findings showed a reduction in transmission from vaccinated people; however, this may have been due to the variant of concern being investigated.

● More recent evidence is uncertain on the effects of vaccination on transmission, which may be due to the replacement of the Alpha variant with the Delta.

● Further research is needed on variants of concerns, in particular the Delta variant.

What difference has this made?

The findings from our rapid review of the transmission risk from vaccinated populations directly contributed to the Welsh Government 21-day COVID review cycle.

The research was included in Welsh Government's Technical Advisory Cell (TAC) summary of advice 21 January 2022.
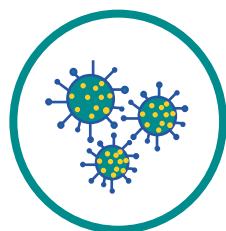
What our stakeholders say

> *It is fantastic to work with Health Technology Wales, who are instrumental as a collaborating partner with the Wales COVID-19 Evidence Centre. Their rapid evidence synthesis work has directly informed advice from the COVID-19 Technical Advisory Cell and Group, as well as wider decision-making within Welsh Government on the emergency response, consideration of direct and indirect harms and recovery.*

Dr Rebecca-Jane Law, COVID-19 Technical Advisory Cell, Welsh Government

> *The Wales COVID-19 Evidence Centre is delighted to be working with HTW as one of its Collaborating Partners. HTW's prior expertise in reviewing technologies, and in particular with a COVID focus already in their workstreams even before the Wales COVIDEvidence Centre was established, has been invaluable. It enabled us to start our work and quickly deliver outputs early in 2021 that address key issues for dealing with the pandemic.*

Professor Adrian Edwards, Director, Wales COVID-19 Evidence Centre

> *Being able to draw on HTW's experience of setting up their process for conducting rapid technology appraisals was invaluable for developing our own methods. It is also an honour to work collaboratively in continuing to improve our methods, in particular as part of the Wales COVID-19 Evidence Centre rapid reviewing methods subgroup, and the production of the COVID-19 digest by the information scientists at HTW.*

Dr Ruth Lewis, Methodology Lead, Wales COVID-19 Evidence Centre

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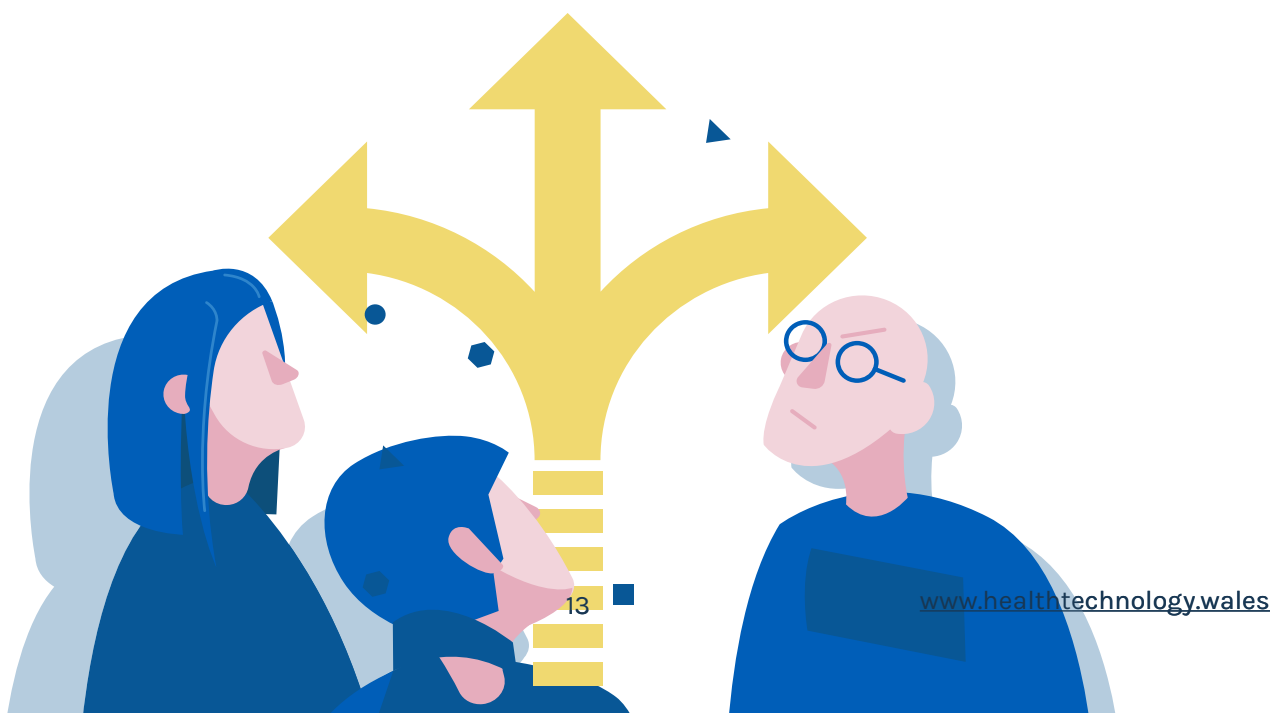
IDENTIFICATION

Responsive to the needs of services users, care providers and technology developers

Identification

Topics proposed to HTW in 2021

88

Topics proposed to HTW since 2017

308
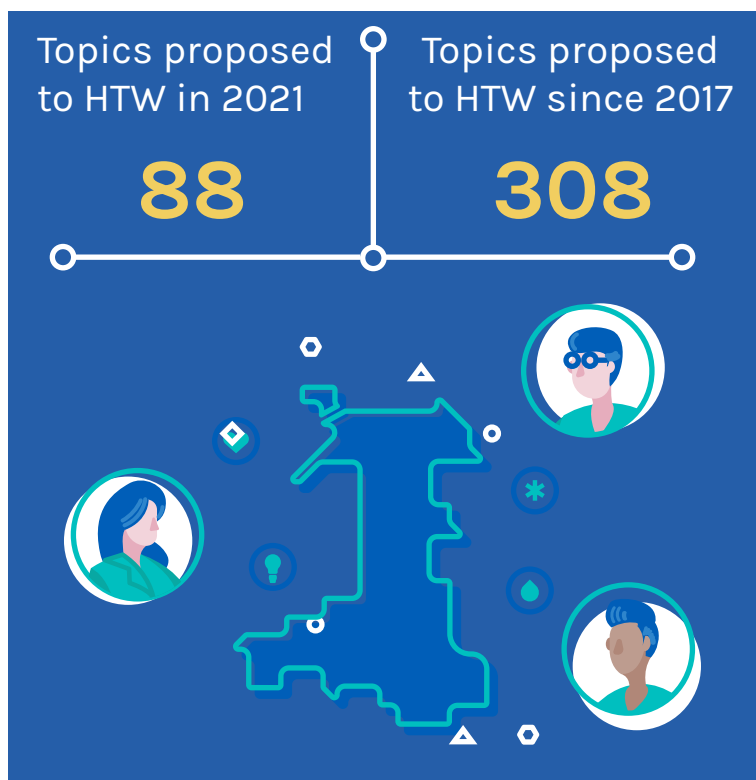
Source of topic referrals in 2021

- Academia
- Welsh Government
- Third Sector
- Industry
- NHS Wales
- Individual

0 5 10 15 20 25 30 35 40 45
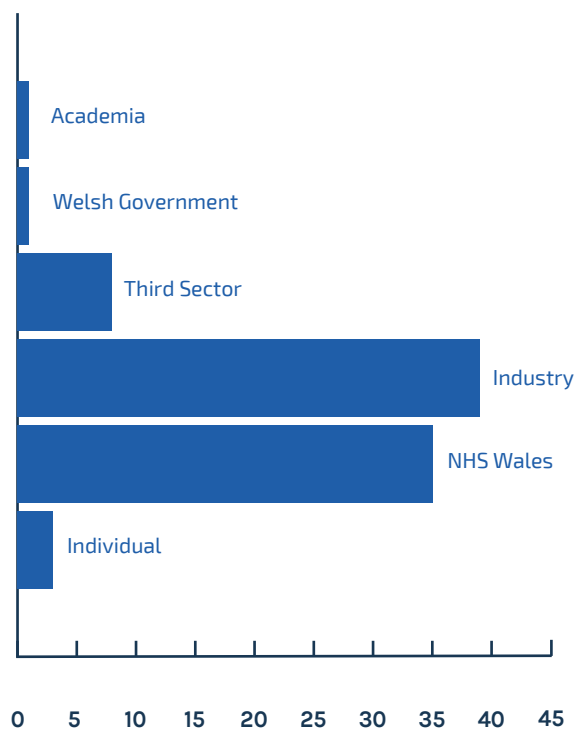
Breakdown of topics referred from the NHS in 2021

- 20%
- 11%
- 6%
- 11%
- 17%
- 23%
- 3%
- 3%
- 6%
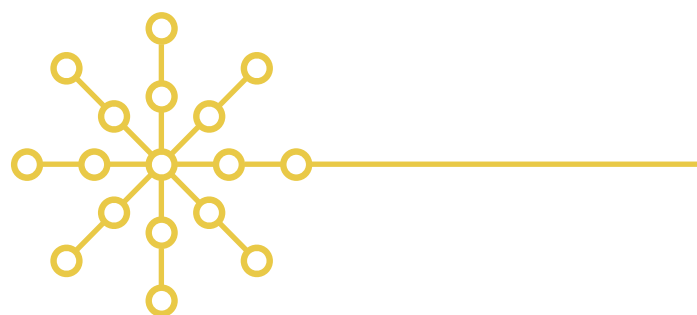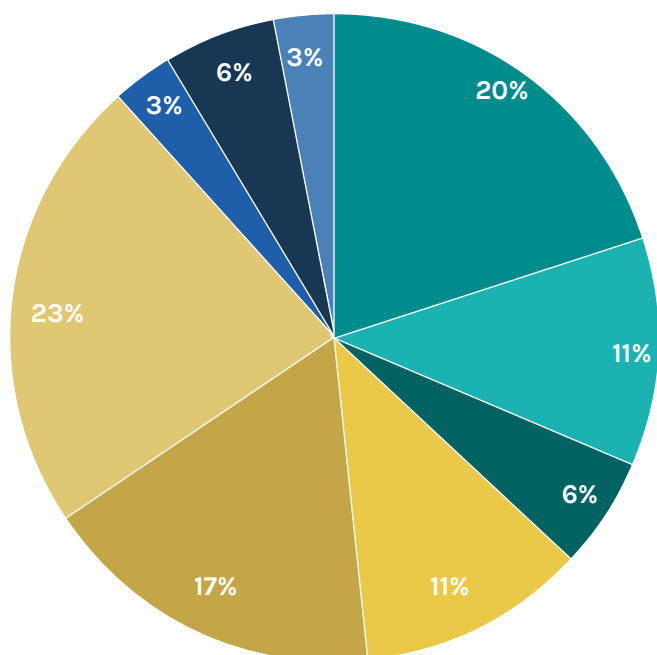
- ■ Nationwide NHS Wales organisations
- ■ Betsi Cadwaladr University Health Board
- ■ Cardiff and Vale University Health Board
- ■ Cwm Taf Morgannwg University Health Board
- ■ Hywel Dda University Health Board
- ■ Swansea Bay University Health Board
- ■ Powys Teaching Health Board
- ■ Velindre University NHS Trust
- ■ Welsh Ambulance Service NHS Trust

HealthTech Connect and the Innovation Service

What did we do?

HTW are data accessors to HealthTech Connect. We have used the resource for the early identification of technologies that will be of potential benefit to Welsh health and care systems and people.

HealthTech Connect is a secure online database that was developed by a range of partner organisations in the health technologies field. It supports new health technologies that offer measurable benefits as they move from inception to adoption in the UK health and care systems.

Companies can register their health technology on HealthTech Connect for free. By signing up, companies can learn what information is needed by decision makers and clarify possible routes to market access. UK health technology assessment (HTA) organisations like HTW can use the information provided by companies to identify whether the technology is suitable for evaluation.

Our research team regularly review the HealthTech Connect database and discuss potentially relevant technologies with our Assessment Group, who quality assure our work and ensure scientific rigour in our processes, as part of our topic identification process.

Since the beginning of 2020, we've identified 43 technologies from HealthTech Connect. All of these have had topic exploration reports published, with input from the company and other stakeholders. We have also produced guidance for two of the technologies.

In 2022, the Innovation Service is scheduled to launch. This service aims to make it easier and faster for companies to develop their innovations and bring them to the NHS, and prepare the NHS to adopt new innovations.

Who with?

Since HealthTech Connect launched in 2018, we've contributed to the HealthTech Connect User Group, which oversees usage and development of the database with input from data accessors and technology developers.

The Innovation Service will replace HealthTech Connect, and HTW are now members of the Innovation Service User Group. Through this group, we have contributed to development and launch of the site, ensuring it meets the needs of HTA bodies like us, and the stakeholders we work with.

In 2020, we helped set up an HTA User Group with other HealthTech Connect users who evaluate or commission non-medicine health technologies. This group was set up to share work plans on technologies selected from HealthTech Connect by each organisation, with the aim of sharing resources and minimising duplication. This group continues to meet to discuss technologies selected from the new Innovation Service and from our wider work programmes.

What difference did this make?

Since setting up the HTA User Group, we have met regularly with the National Institute for Health and Care Excellence (NICE) and the Scottish Health Technologies Group (SHTG). This has fostered closer collaboration and allowed us to share early workplans.

In 2022, we plan to build on this work and explore how this collaboration can be applied across all topic selection and identification processes at each organisation. The group has enabled HTW to learn about opportunities for closer collaboration and to increase the profile of the guidance. we produce.

Our collaboration with HTW on HealthTech Connect has ensured that our resources are optimised to minimise duplication in the technologies we both appraise. Through regular meetings our organisations coordinate our priorities and strategic ambitions. This means patients in England and Wales are able to access medical devices, diagnostic and digital health technologies faster than ever before.

Professor Gillian Leng CBE, NICE Chief Executive

Evidence appraisal on haemodialysis antimicrobial barrier caps (ClearGuard)

What did we do?

We used HealthTech Connect to identify this topic proposed by a technology developer for appraisal by HTW. The topic considered antimicrobial barrier caps for use with haemodialysis catheter hubs to reduce catheter-related bloodstream infections (BSI). We appraised the clinical and economic evidence on the topic, published an Evidence Appraisal Report in March 2021 and issued HTW guidance in May 2021.

Who with?

We engaged with several different stakeholder groups during the development of this appraisal. During the consultation period, we received feedback from consultant nephrologists, a renal consultant, a laboratory director and a representative from ClearGuard, the manufacturer of haemodialysis antimicrobial barrier caps.

What did we learn?

Clinical evidence shows that the use of haemodialysis antimicrobial barrier caps reduces the rate of blood stream infections (BSI) compared to standard caps and this could lead to lower rates of hospital admissions. Economic modelling suggests that the use of ClearGuard HD has the potential to lead to overall cost savings as the additional upfront costs for ClearGuard HD caps may be outweighed by savings accrued through a reduction in BSI events.

What difference did this make?

The HTW Appraisal Panel recommended that the evidence supports the routine adoption of ClearGuard HD antimicrobial barrier caps for use with haemodialysis catheter hubs. The adoption of the technology in NHS Wales could lead to a reduction in the number of catheter-related blood stream infections.

> *It was a pleasure to work with Health Technology Wales (HTW) to examine the clinical benefits and cost-effectiveness of antimicrobial barriers caps in reducing catheter-related bloodstream infections in haemodialysis catheter hubs. The HTW Evidence Appraisal Report is comprehensive and the resulting HTW Guidance is well supported. The inclusion of ClearGuard HD as a case study is a bonus, and we're delighted to see yet another endorsement of how its routine adoption can reduce the rate of bloodstream infections while potentially leading to overall cost savings.*

Douglas Killion, Vice President ClearGuard Commercial Operations at ICU Medical

Supporting innovation with the Small Business Research Initiative

What did we do?

We have provided support to the Small Business Research Initiative (SBRI) by joining project boards for several of the SBRI's challenge driven competitions. As project board members, our role was to question and assess the proposed solutions to the challenges, make decisions on project progression and provide advice and support to the winning applicants.

Who with?

We worked with SBRI, an organisation which aims to connect public sector challenges with innovative ideas from industry. The project boards considered the solutions that industry proposed for specific challenges posed by the SBRI. We joined the Better Lives Closer to Home and Dentistry Face Mask challenges. We are also providing ongoing support to the Simulation Technology Training and Outpatient Transformation challenges.

What did we learn?

We learned about the novel and innovative solutions from industry, which aimed to address the challenges. In the Dentistry Face Mask challenge, we saw solutions which aimed to supply clinical staff with more appropriately fitting, safe and economical respiratory protection. In the Better Lives Closer to Home challenge we heard solutions from industry which aimed to help businesses and communities cope with the long-term impact of COVID-19.

What were the reactions?

> The team from HTW have been very supportive of the SBRI Centre of Excellence over 2021. They have been members of several Project Boards and their knowledge, expertise and guidance has been helpful in progressing developments and solutions. In particular, we have also used the META (Medtech Early Technical Assessment) tool that is used to provide guidance on non-medical technology to the NHS which has helped businesses identify their solutions' value proposition using clinical and economic evidence. We look forward to continue to work with Susan, Matthew and the team in 2022.

Lynda Jones, Centre Manager, SBRI

What difference did this make?

Our contribution to the project boards has helped the SBRI to achieve the aims set out in the challenges as well as its wider aim to enable companies to use new solutions to tackle societal problems while supporting business to develop and grow.

HTW's Scientific Advice Service: overcoming barriers to market access

The HTW Scientific Advice Service (SAS) launched in October 2020 to provide expert advice to health technology developers and innovators on how to optimise their route to market.

It aims to enable developers to overcome barriers to market access by developing evidence and demonstrating value that meets the needs of care commissioners, care providers, patients and service users. The fee-based service can be tailored to meet the needs of technology developers of all sizes and stages of development.

In order to help companies to identify gaps in their existing evidence HTW makes use of the National Institute for Health and Care Excellence (NICE) Medtech Early Technical Assessment (META) Tool, an online structured framework, to deliver the SAS.

APPRAISAL

Using the best available evidence and expertise to independently appraise health and care technologies

Appraisal

12 Topics progressed to evidence appraisals in 2021

6 Pieces of HTW guidance published in 2021

23 Pieces of HTW guidance published since 2017

Visit our website to read HTW reports and Guidance

Our guidance

We evaluate the best available evidence to determine the clinical and cost effectiveness of health and social care technologies. Based on the evidence and the input of experts, we produce national guidance.

HTW guidance summarises the key evidence and implications for care services in Wales. The table below details the topics that have been through our appraisal process and received HTW guidance in 2021.

May 2021	Corneal cross-linking to treat adults and children with keratoconus (GUI002-02)

" The evidence supports the routine adoption of corneal cross-linking (CXL) for children and adults with progressive keratoconus. Compared to standard care, CXL slows the disease progression and may improve visual acuity. It may also reduce or delay the need for corneal transplantation. "

May 2021	Point-of-care ultrasound to diagnose gallstone disease (GUI029)

" The use of portable point-of-care ultrasound to diagnose gallstone disease shows promise, but the current evidence is insufficient to support routine adoption. "

July 2021	Antimicrobial barrier caps for use with haemodialysis catheter hubs to reduce catheter-related bloodstream infections (GUI030)

" The evidence supports the routine adoption of ClearGuard HD antimicrobial barrier caps for use with haemodialysis catheter hubs. Clinical evidence shows that the use of ClearGuard HD caps reduces the rate of blood stream infections compared to standard caps. "

September 2021	Freestyle Libre flash glucose monitoring for the management of diabetes (GUI004-02)

" The evidence supports the routine adoption of Freestyle Libre flash glucose monitoring to guide blood glucose regulation in people with diabetes who require treatment with insulin. The use of Freestyle Libre flash glucose monitoring in these people improves the proportion of time that the blood glucose is in target range and reduces time in hypoglycaemia and hyperglycaemia. "

November 2021	Natriuretic peptides to rule-in and rule-out a diagnosis of acute heart failure (GUI026)

" The evidence supports the routine adoption of N-terminal pro B-type natriuretic peptide (NTproBNP) measurement to rule-in and rule-out acute heart failure in adults presenting to the emergency department in whom there is clinical suspicion of this diagnosis. The addition of NT-proBNP measurement to routine clinical assessment may reduce length of hopital stay and the rate of re-hospialisations. "

November 2021	Strategies for Relatives (START) to improve the mental health of carers of people with dementia (GUI031)

" The evidence supports the routine adoption of Strategies for Relatives (START) intervention for carers of people with dementia. The use of START leads to a reduction in symptoms of depression and an improvement in quality of life of the carer as compared to usual care. Benefits are evident in the short term but are also maintained over a longer time period. "

HTW guidance:
FreeStyle Libre flash glucose monitoring

What did we do?

HTW originally issued guidance on FreeStyle Libre Flash Glucose Monitoring (FLFGM) in November 2018. Following a targeted consultation with stakeholders, HTW agreed that it was appropriate to re-appraise this topic and issue updated guidance because there has been a substantial change in the available evidence since the original guidance was published. HTW guidance is periodically updated when necessary.

The work was generated by evaluating the pieces of secondary and primary evidence that were published since November 2018 and were found relevant to establish the clinical and cost-effectiveness of this technology. New analyses for both the clinical and cost-effectiveness were conducted.

Who with?

We engaged with the original group of stakeholders that participated in the development of the first iteration of guidance on this topic. During the consultation period we received feedback and expert input from the national clinical lead for diabetes as well as other consultants and nurses in diabetology.

Following advice from the HTW Patient and Public Involvement (PPI) Standing Group we conducted a patient experience literature review and sought input from Diabetes Cymru for a Patient Submission. We summarised the literature reports of patient experiences, perspectives and opinions to supplement the Patient Submission from Diabetes Cymru for the use of FGM in adults and children with type 1 and 2 diabetes.

The Appraisal Panel considered the published evidence and input from clinical and patient experts in their decision-making processes. It concluded that the evidence supports the routine adoption of FreeStyle Libre flash glucose monitoring to guide blood glucose regulation in people with diabetes of any type that requires treatment with insulin.

What were the reactions?

Encouraged by the clinical expert team that reviewed the Evidence Appraisal Report, the HTW researchers will be preparing a manuscript to be published in a peer-reviewed journal on the clinical and cost-effectiveness associated with the use of this technology. This will catalyse the efficient dissemination of the findings.

What did people learn?

The use of FLFGM in people with diabetes of any type that requires treatment of insulin can improve the proportion of time in blood glucose target range thus reducing episodes of hypo- and hyperglycaemia. The cost-utility analysis indicated that FLFGM is a cost-effective intervention compared to finger-prick self-monitoring of blood glucose for both type 1 and 2 diabetes.

What difference has this made?

> *Flash glucose monitoring is an important tool that can help people to improve their quality of life, reduce hospital visits and gives patients more confidence in managing their condition. The outcome of the review is a step forward in helping people across Wales to access the right technology to help them live better, happier lives with all types of diabetes.*

Joshua James, Diabetes UK Cymru Policy and Public Affairs Manager

> *We're delighted to see the Health Technology Wales guidance for flash glucose monitoring, meaning many more people with diabetes in Wales will now have access to a technology that can improve the self-management of diabetes and quality of life. We are especially pleased to see the clinical expert opinion which outlines that observational studies are an important part of the appraisal process, as supportive evidence alongside randomised controlled trial data. This is key for data-rich technologies, such as the FreeStyle Libre system, for which there is extensive real-world evidence demonstrating the value in clinical practice rather than just in a clinical trial setting.*

Sam Howard, Market Access Director for Abbottt's Diabetes Care

HTW Guidance:
Strategies for relatives (START) intervention

What did we do?

HTW received a topic submission from Social Care Wales and Carers Trust Wales for the Strategies for Relatives (START) programme and, based on our topic exploration report, it was prioritised and taken forward. During the development of the topic, we worked with the HTW Assessment Group to ensure the scope of the review was achievable and produced an Evidence Appraisal Report summarising the clinical and cost-effectiveness of the programme. Based on this evidence, the HTW Appraisal Panel was able to recommend that START should be routinely adopted for carers of people with dementia across Wales.

Who with?

As part of our broader partnership, we asked Social Care Wales to identify priority topics related to social care. Support for carers was highlighted as an important issue and the START programme was suggested as an intervention that could provide valuable support. Throughout the appraisal, we consulted people with expertise of appraising topics linked to social care to ensure adaptations that we made were appropriate. We also worked with the Alzheimer's Society to facilitate focus groups with people living with dementia and their carers to ensure that their voices were heard during the process.

What were the reactions?

Our guidance on the START programme was well received on publication with stakeholders from local authorities and local health boards welcoming the guidance and highlighting that it aligned with other initiatives to improve services for people with dementia and their carers. Social Care Wales said they were delighted that the guidance could support the delivery of START for carers of people with dementia across Wales.

> As the ICF Dementia Care Programme at Cardiff and Vale University Health Board approaches the end of its 4th year and is on the verge of undergoing some potential re-modelling, the publication of this guidance by Health Technology Wales is very timely. We know that carers play an absolutely vital role in the care of people with dementia. Thank you HTW for appraising this issue of high importance and great topic suggestion.
> It would be great to see the routine adoption of the START intervention to really deliver transformational change for dementia care across the Cardiff and Vale region.

Meredith Gardiner, Chris Ball, Cath Doman, Rachel Jones, Julie Skelton, Cardiff and Vale UHB

What did people learn?

Appraising the START programme gave us an opportunity to assess whether our methods and processes are appropriate for topics related to social care and allowed us to consider adaptations. For our methods, we were able to develop a search strategy that included new databases that include evidence in social care, we learned key lessons about ensuring a realistic scope for appraisal, and we were able to consider how to address issues of perspective. We also reflected on the need to ensure that both health and social care are well represented in our advisory groups.

What difference has this made?

Our guidance provides a recommendation for a specific programme that has been shown to be effective and cost-effective that delivers support to carers of people with dementia. Delivering this type of support for carers is a priority for Welsh Government and our recommendation of START highlights a programme which can address this priority. This guidance and the supporting evidence appraisal sets the expectation that local health boards adopt START or justify why this is not appropriate.

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ADOPTION

Authoritative guidance to inform care comissioning and promote the efficient use of resources

Piloting the HTW adoption audit

When HTW was established, it was highlighted that guidance should have an 'Adopt or Justify' status and that the adoption of guidance should be audited to ensure that it was having an impact on access to effective and cost-effective technologies. An Adoption Audit Task and Finish Group reported findings in 2020 and outlined that HTW should be responsible for leading the adoption audit with support from partners across NHS Wales. This work was paused through 2020 and into early 2021 to avoid drawing attention from the ongoing management of the COVID-19 pandemic and vaccination efforts but has progressed significantly through the year.

We worked with the All Wales Medical Directors national peer group to identify nominated leads in each of the local health boards and other health commissioning bodies in Wales and met with each of the contacts to discuss local arrangements for monitoring responses to our guidance. Based on our findings, we have been able to develop a draft process for our annual adoption audit and have developed standard operating procedures and templates to support a pilot of a selection of our previous guidance. The process is built around trying to gain an idea of the response to guidance from the relevant commissioning bodies, assessing whether changes in procurement data demonstrate adoption, and accessing knowledge on changes to services from local topic experts.

After developing these processes, we identified eight pieces of guidance which reflect the varying characteristics of non-medicine technologies. We then developed individualised monitoring plans for each of these guidance and we have disseminated these to our nominated leads, procurement contacts, and topic experts. We have also been able to offer financial support to each local health board to support their interactions with us on adoption audit. This support should help to develop systems for responding to guidance from HTW, NICE and other bodies and will support adoption of innovation in Wales. In early 2022, we will collate findings for the pilot and provide our first adoption audit annual report.

Through the development of our adoption audit process, we have been able to review approaches to monitoring adoption from other bodies in Wales and the wider UK, as well as working with international partners to learn lessons on how work has proceeded elsewhere. The findings of the pilot will help us understand whether our draft processes are appropriate and we will take feedback from the nominated leads on whether these processes could be improved.

After the pilot, the adoption audit will be completed on a yearly basis. It will provide valuable information about the level of adoption of our guidance and will help ensure that our work is having an impact on people accessing care. It will also provide information to Welsh Government and NHS Wales on the challenges associated with adopting our guidance for Wales.

> We have received great support from Health Technology Wales for the adoption audit project, including the offer of financial assistance to enable us to develop systems and processes to undertake the requirements of the audit. Development of new ways of working using this funding will not only provide benefits for this project but will also contribute towards the delivery of wider Health Board objectives. Colleagues within Health Technology Wales are always helpful and responsive with queries and the Stakeholder Forum that has been established will provide an excellent opportunity to connect with colleagues from across Wales as we progress the annual audit.

Lisa Davies, Head of Effective Clinical Practice and Quality Improvement, Hywel Dda University Health Board

ENGAGEMENT

Collaborating with stakeholders to increase evidence-informed decision making

Engagement in 2021

Throughout 2021 we have engaged with stakeholders from across the health, social care, industry and research sectors in Wales to raise awareness of the importance of evidence informed decision making on the use of non-medicine health technologies.

We also maintain a two way flow of information through our work with the HTW Appraisal Panel, Assessment Group and Executive Group members and by meeting regularly with the Industry User Group and Patient and Public Involvement (PPI) Standing Group.

This year we strengthened our relationships with key partners by setting up a Stakeholder Forum aimed at ensuring that HTW understands the views of stakeholders and enables them to influence its work. As well as supporting HTW's work programme, the Stakeholder Forum will provide guidance on priorities for care services in Wales.

We have also established a new collaboration with Social Care Wales which will enable us to better understand how our work can support the broader care sector in Wales.

Throughout the COVID-19 Pandemic we have worked in collaboration with the Wales COVID-19 Evidence Centre to provide research expertise that supports evidence informed and time critical decision making.

Meanwhile we continue to work closely with our existing partners in the Bevan Commission, Life Sciences Hub Wales, All Wales Therapeutics and Toxicology Centre, All Wales Medicines Strategy Group, Scottish Health Technologies Group and the National Institute for Health and Care Excellence.

Advisory committee meetings hosted:

5	Appraisal panels
10	Assessment groups
3	Executive groups
3	Industry user groups
4	Patient and public involvement (PPI) standing groups

Events:

10	Events (including virtual webinars and workshops)

Website

53,118	Webpage views
15,673	Unique visitors

Social media

1,780	Followers
22,027	Profile visits
233	Mentions
426	Link clicks
618	Likes and retweets

International engagement
Collaboration with global HTA agencies on patient involvement position statement

What did we do?

As a member of the International Network of Agencies for Health Technology Assessment (INAHTA), HTW worked alongside other INAHTA members on the production of a position statement on Patient Involvement in health technology assessment (HTA). This statement reflects members' views on the role of patient involvement in HTA and provides guidance on how HTA organisations can undertake the generation of patient evidence for a technology appraisal. HTW contributed our experiences, methods, processes and lessons learned in conducting Patient and Publc Involvement (PPI) for our health technology assessments to inform this Position Statement and provided guidance in conducting PPI to international members as a result.

Who with?

INAHTA is a network of 50 HTA agencies that support health system decision making that affects over one billion people in 31 countries worldwide. INAHTA members connect together to cooperate and share information about producing and disseminating HTA reports for evidence-based decision making. Patient and Public Involvement (PPI) is recognised by INAHTA as an important and valuable part of health technology assessment and sharing methods, process and principles for conducting PPI is essential for the production of international co-operation establishing best practice.

INAHTA position statements are one of the ways in which best practice methods can be shared so that INAHTA members and others can learn from each other. Position statements focus on general issues, methods, definitions or processes relevant to health technology assessment and to HTA agencies and provide agencies with guidance on best international practice.

What did we learn?

INAHTA's position statement outlines that patients have a right to be involved in the HTA process as the outcome of the assessment could affect them directly. It goes on to say that identifying what matters to patients will ensure that HTA outputs are more responsive to care needs and the wider health goals of society.

Involving patients and the public in HTA can improve the quality of the assessment and supports patient centred decision making.

At HTW, PPI forms an invaluable element in our health technology assessments. We strive to ensure that patient groups and those that could be directly affected by the outcome of an HTA are involved in the appraisal process. Our Patient and Public Involvement Standing Group provides direction and guidance to ensure that HTW maintains effective PPI throughout its work and has worked with our PPI team to create a flexible, dynamic and responsive approach to conducting PPI.

What difference did this make?

The INAHTA position statement highlights the importance of PPI in HTA and supports HTA agencies in their efforts towards engaging effectively with patients to enable them to contribute meaningfully to HTA processes and outputs. This statement describes the different aspects of patient and public involvement in HTA and shares best practice. HTW engagement in this work shares our work internationally and ensures that our PPI work is informed by cutting edge PPI methods as well as allowing other HTA agencies across the globe to make use of our experiences and process as well as our approach to flexible and reactive PPI.

> *Your efforts were both vital and much appreciated in the group. We could have not produced such a high-quality document without your contributions.*

INAHTA Board Members Dr Sophie Söderholm Werkö and Karen Macpherson

International engagement
HTW wins INAHTA impact award

In September 2021 HTW received the prestigious international David Hailey Award for best impact story at the International Network for Health Technology Assessment (INAHTA) Congress. We used our appraisal of autologous haematopoietic stem cell transplantation (AHSCT) for highly active relapsing remitting multiple sclerosis (RRMS) as a case study to demonstrate how we evaluate the impact of our work.

The event's 100 attendees, representing INAHTA's 50 member organisations, voted for HTW to win the prize which is awarded to the HTA agency which presents the best example of the impact an assessment has had and what lessons were learnt from the process.

The commissioning body Welsh Health Specialised Services Committee (WHSSC) submitted the topic to HTW, and the appraisal and guidance were published in July 2020. During the assessment process HTW engaged with an extensive panel of clinical experts including consultant neurologists, consultant haematologists, academics, and other HTA bodies. The organisation also sought direct engagement from two patient organisations, who provided independent patient submissions. Patient organisations later described being included in the appraisal process as invaluable and said that people living with MS were listened to throughout the process.

Professor Peter Groves, HTW Chairman, said: "I am very proud that HTW has been announced as the 2021 winner of the INAHTA David Hailey Award. This reflects the quality of the work done in preparing the guidance on autologous haematopoietic stem cell transplantation (AHSCT) for highly active relapsing remitting multiple sclerosis (RRMS) as well as the collaborative approach that we undertake in our appraisals."

Following publication of HTW's guidance, the WHSSC Prioritisation Panel recommended AHSCT for RRMS as a 'high priority' for funding. The guidance was featured on the MS Trust website and in several news articles and patient groups have since called for clear 'next steps' towards opening specialist treatment centres in Wales.

> *HTW competed against impact stories from agencies around the globe and won this award during the INAHTA Congress 2021. Theirs was scored as the best story by fellow members based on criteria of topic importance, contribution to HTA, impact assessment knowledge and clear story telling. Congratulations HTW!!*

Tara Schuller, MSc
Executive Manager, INAHTA

HTW support the HTAi 2021 event

HTW was asked to join the Local Organising Committee of the 2021 annual meeting of Health Technology Assessment international (HTAi) – a global society for organisations that produce health technology assessments (HTA). The organisation's global network of members from over 60 countries met virtually in June for the event focussed on the role of HTA in leading health innovation.

During the event, members explored how adaptive approaches to HTA can support innovation in health systems as technology continues to evolve and new challenges emerge. They discussed how traditional approaches to HTA are being challenged as decision makers meet the changing needs of local health systems.

The HTAi 2021 Annual Meeting also provided an opportunity for researchers, policymakers, health care practitioners, technology developers and patients to reflect on their role in driving innovation through HTA.

The HTW team chaired panel discussions and gave both oral and poster presentations on topics ranging from innovation in HTA to putting patients at the heart of the innovation pathway.

What our stakeholders say

Since it was established in 2017, Health Technology Wales has met a significant need in the system to systematically appraise health technologies on a once for Wales basis.

I've been really impressed with HTW's exploration of additional opportunities to interface with government, the health and care sector, academia and industry partners. This has added significant value to innovation platforms such as the Welsh Health Hack and Bevan Exemplars programme.

It is also exciting to be involved with newer HTW initiatives such as their Scientific Advice Service and working to co-design the UK government's Innovative Devices Access Pathway; programmes of work that again identify and meet tangible health and care system needs.

Thomas James, Head of Innovation and Technology, Welsh Government

Lauren Elston provided us with an excellent and rapid review on the risk associated with COVID-19 transmission in semi enclosed environments. This was timely and excellent.
The evidence review established that there is a lack of evidence to enable the formulation of robust guidance on semi-enclosed environments.

Professor Davey Jones, Bangor University, Advisor to Welsh Government TAG-E

Evidence documents and final guidance are succinct, clear and well presented.
The committee discussion was well managed and well timed.
The evidence review is of very high quality. It is important that Wales has its own HTA organisation as it can help to ensure patients in Wales have access to the most appropriate treatments at a cost that can be sustained by the system.
I think NICE could learn a lot from HTW and hope we have the chance to work collaboratively in future.

Kimberley Carter, Health Technology Assessment Advisor, NICE

HTW provided clear guidance on the role of natriuretic peptides in heart failure in acute settings.

Mohamed Anwar, Research fellow and registrar, Edinburgh University

HTW listens to our considerations and comments when we study an EAR report. The reports are very well presented and are very thorough and concise.

Suan Jones, volunteer and PPI Standing Group member

HTW Rapid Evidence Summaries provide evidence to support the IPFR Panel decision making process. We have recently received summaries for Functional Neurology Disorder, High Intensity Focussed Ultrasound and Biological Mesh.

HTW Guidance is also helpful in the IPFR Decision Making Process. The IPFR Panel has recently considered the guidance for Corneal Cross-linking.

Zoe Rees, Commissioning Officer, Individual Patient Funding Request (IFPR)

Working with Health Technology Wales on the Social Care Topic Call has really helped to engage a social care audience with health technology assessment in Wales. The collaborative approach has really helped to make the topic call a success and we look forward to seeing how the assessments from the topic call will be used to inform social care practice.

Sarah McCarty, Director of Improvement and Development, Social Care Wales

Industry engagement

Industry User Group Collaboration (IUGC)

Throughout 2021 HTW continued to build on its relationships with industry representatives by hosting quarterly meetings of the Industry User Group (IUG).

The IUGC, a collaboration between industry representatives and Health Technology Wales, was set up with the aim of raising awareness of HTW's work and improving access to technology for NHS Wales.

Members of the group include small and medium sized enterprises and multi-national companies, all of which have links to Wales and are involved in the development and manufacture of innovations for the health and social care sector.

At its quarterly meetings the group discusses updates on HTW and NICE processes and members are provided with guidance on market access routes, meeting regulatory requirements and best practice in developing evidence. The IUGC enables HTW to ensure its methods meet the needs of industry members when it comes to the identification, appraisal, and adoption of non-medicine health technologies. It also provides an opportunity for HTW to keep up to date with the latest industry trends and spot opportunities for improving healthcare in Wales.

Innovative Devices Access Pathway (IDAP) pilot

HTW is collaborating on a new Great Britain-wide supported research and access route for innovative medical technologies that meet a critical need in the health and care system. The Innovative Devices Access Pathway (IDAP) is a joint project between the National Institute for Health and Care Excellence (NICE), the Medicines and Healthcare products Regulatory Agency (MHRA), HTW and the Scottish Health Technologies Group (SHTG). The aim is to develop a pathway that allows technology developers to provide their innovative products to care professionals and service users at the earliest, yet safe, opportunity. The proposed pathway will be piloted in 2022.

Celebrating scientific achievements

In December 2021 HTW took part in the 14th annual MediWales Awards – an opportunity to celebrate the achievements of the NHS, life sciences and health technology sectors in Wales.

HTW sponsored the Scaling Up Innovation and Transformation Award which was won by the All Wales Medical Genomics Service and the Velindre Cancer Centre in recognition of their work in developing a pharmacogenetics test that can predict adverse reactions to chemotherapy. The team established a new innovative test for patients due to receive the chemotherapy drug fluoropyrimidine, which identifies their risk of suffering severe side effects.

Earlier in the year HTW also took part in the MediWales showcase event at which members of Wales' life sciences community gathered to share information about their latest projects.

Working in partnership with Social Care Wales

Using effective health and social care technologies is an important part of delivering the best care to people who need it. There are well-established processes and methods for assessment of health technologies but these may not be fully suitable for assessing technologies or ways of working in social care. Health Technology Wales has committed to ensuring that our work is accessible and appropriate for social care and has made significant progress on this work in 2021.

At the beginning of the year, Health Technology Wales and Social Care Wales launched a partnership to share expertise and understand how HTW methods and processes can be adapted to social care and how we engage with the social care sector in Wales. Through this partnership we have run a series of events to improve awareness of our work and discuss key issues. These have included a social care roundtable for leaders from health and social care, government, academic and policy and a social care workshop for people accessing social care, their carers, and social care professionals. Both allowed us to increase our visibility in social care and improve our understanding of the challenges and opportunities for HTW to contribute to social care. As part of this partnership, Social Care Wales also identified the Strategies for Relatives (START) programme as a high priority for appraisal and we have now developed an Evidence Appraisal Review and guidance recommending routine adoption in Wales.

HTW planned a Social Care Open Topic Call to launch in early 2022. This should promote our work further and bring us a series of topics from social care which we are able to consider for prioritisation for our work programme. To prepare for this open topic call, we have reviewed our website and key documentation to ensure that the language we use clearly signals that social care is within our remit and is accessible to people who may want to submit a topic. We have also developed our communications strategy to support the roll out of this open topic call.

Our key learnings from our work this year have been that there will be a large number of challenges that we will have to face when working with social care. However, there are significant opportunities for us to contribute and we have begun forging links with existing groups and networks that could support our work. We have had positive feedback on our work from Social Care Wales on our genuine commitment to engaging with and learning from partners in social care and adapting our work to support social care.

Key findings from HTW's social care roundtable and workshops

Our Social Care Roundtable ran in May. Our main aim was to discuss what adaptations may be needed to make health technology assessment more appropriate for social care and how this could be supported in Wales. The roundtable was attended by senior leaders from health and social care, government, academic and policy experts and there were a mix of presentations from people with expertise on evidence-based social care and the Welsh context as well as open discussion.

A comprehesive report was published and some of our key findings are highlighted here:

- Participants emphasised that people working within HTA should be aware of the realities of social care that will pose challenges. These may be related to de-centralised and fragmented delivery of care, staffing turnover, and less developed links between social care and research environments.
- A more flexible approach is needed to ensure benefits related to person-centeredness, dignity and respect and abilities are captured and that real world evidence from both research and non-research settings support decision-making. Consideration will also need to be given to how economic evaluation can support assessments of value using adapted methods.
- Efforts will be needed to ensure that there is diverse representation of voices from social care, both to support continuing conversations about adaptations that stem from the roundtable and to inform appraisals and guide decision-making in the longer term.
- Participants were clear that HTA must support change within social care to ensure ongoing buy-in from partners. HTA agencies will need to consider how guidance is communicated to ensure awareness and should explore how adoption of guidance can be promoted and measured.

Our Social Care Workshop ran in June and aimed to better understand how able people felt to interact with HTW and explore how accessible our public facing materials are. The workshop was designed by HTW, Social Care Wales and the Social Care Institute of Excellence and had a mix of presentations, whole group and break out room discussion, and question and answer sessions.

Some key findings are as follows and are available in our workshop report:

- More inclusive language that reflected both health and social care would help remove barriers. Considering a strengths based approach may be beneficial
- People were keen to explore whether the process could be made to feel less one-way with more of a dialogue between the topic proposer and the HTW team and whether additional support could be made available
- Participants also raised that evidence will be a challenge in social care and that HTW should be aware that outcomes may be harder to measure and an adapted approach may be needed.

HTW has developed a Social Care Action Plan to help address the themes which came up across both the roundtable and the workshop and we are committed to continuing this work over the coming years.

Over the last year we've continued to work closely with the team at Health Technology Wales to raise the profile of social care in its work. We've focused on making the HTW processes more accessible and easy to navigate for people in social care and future topic calls will benefit from the improvements now in place. It's been – and continues to be – a true collaboration, and we're looking forward to our future work to promote and embed the practice of health technology assessment in social care in Wales.

Lisa Trigg, Social Care Wales

Patient and public involvement

We've had a busy and exciting year continuing our commitment to conducting innovative patient and public involvement (PPI). Highlights for this year include incorporating greater flexibility into our PPI process for a more reactive and dynamic approach to engagement, holding our first patient and carer focus groups, tailoring our processes for social care topics and presenting our PPI work at the international HTAi conference.

We have also welcomed representatives of patient communities to take part in our appraisal panel discussions, where our national guidance on the use of health technologies is formed. The contributions of patients and the organisations that represent them is an essential and valuable part of HTW appraisals, where the evidence they submit is recorded under a specific part of our Evidence Appraisal Reports and is discussed at Appraisal Panels. We continue to improve and develop this process as we learn from patients, carers, the public and best practice.

5 Topics with PPI

4 Patient submissions received

2 Questionnaires/Surveys circulated

2 Specific patient evidence literature reviews

HTW's PPI team at HTAi 2021

We proudly showcased our PPI work at the HTAi 2021 online conference where we presented at three PPI related panels; 'Patient Participation at the Organisational Level', 'Achieving Effective Patient Engagement in Rapid-Cycle Medical Device HTAs' and 'How to Evaluate the Patient and Public Involvement in HTA'. These panels were watched by over 100 conference attendees and generated thoughtful and involved discussions. Our PPI work was applauded and we received positive feedback from attendees.

As part of the project on 'Patient Participation at the Organisational Level', Alice Evans, Alan Meudell and Susan Duncan took part in a wider project reflecting on the engagement of patients and public representatives across committees and boards in HTA organisations. Alan, a member of HTW's PPISG and a Public Partner, also sits on HTW's Audit and Adoption committee and provided reflections on working within various roles in HTA as a public representative.

Despite the challenges posed by the pandemic it has been a positive that the PPI group and HTW have continued to develop the PPI processes and activities within HTW to make them more effective and to ensure that the experiences of the patients and carers are part of the evidence used in the decision-making process and that their voices are heard. The PPI group and HTW have also recognised the importance of engaging with the global HTA community to share the knowledge we have gained and to learn from other countries' HTA processes. In the last year we have participated in HTAi research which looked at 'Participation in HTA at an organisational level' where HTW and the PPI group shared how this happens in Wales.

Alan Meudell, HTW PPI Standing Group member and Public Partner

The HTAi Patient and Citizen Involvement in HTA Interest Group (PCIG) brings together more than 300 members from different disciplines and stakeholder groups in 43 countries to strengthen patient and public involvement in HTA. HTW has quickly gained international attention for its approach to patient and public involvement. We greatly appreciate the opportunity to learn, share and reflect on practice with HTW, and its staff's generous contribution to panels at the HTAi 2021 Annual Meeting and studies on the impact of patient and public involvement and its role at an organisational level outside of individual assessments.

Ann Single, HTAi Patient and Citizen Involvement Interest Group Chair

Collaborative working with patient groups

Our commitment to flexible and reactive PPI engagement has enabled us to undertake several exciting projects working jointly with patient organisations this year. Joint co-production of patient evidence enables more organisations to work with us on contributing to HTAs using novel methods that have ensured patient voices remain at the heart of technology assessment. As a result, HTW have undertaken several 'firsts' in PPI engagement;

- Our first patient and carer focus groups held jointly with the Alzheimer's Society;

- Our first engagement with patients through social media, held jointly with FND (Functional Neurological Disorder) Action UK across their social media platforms;

- Our first accessible methods of individual patient evidence collection, including telephone calls and virtual consultations;

- Our first effort to combine two or more forms of patient evidence for our revised guidance on flash glucose monitoring devices, where we combined a Patient Submission from Diabetes UK Cymru with a patient evidence literature review.

PPI making a difference in HTA

HTW reviewed our guidance on corneal cross linking and flash glucose monitoring this year in line with our policy to ensure that our guidance is relevant and up to date with recent evidence. Since publishing guidance on these topics in 2018 and 2019 respectively, we established our flexible and responsive PPI process, which enabled us to include patient evidence in the revised guidance conducted this year. We worked with the Keratoconus group for our guidance on Corneal Cross Linking and with Diabetes UK Cymru for our guidance on flash glucose monitoring. Being able to include patient evidence made a big difference to the outcome of the revised guidance, in addition to the clinical and cost-effectiveness evidence. Revised guidance supporting the use of both technologies was published as a result.

PPI in social care

HTW undertook an HTA for our first social care topic this year and our PPISG welcomed a new member, Louise Baker, who has been instrumental in adapting our PPI processes for social care topics. Louise took part in our social care task and finish group, helped to organise and run our PPI engagements with Alzheimer's Society for the START topic and has helped PPISG adapt our PPI tools to be more appropriate for use in social care. A new process for undertaking PPI for social care topics will be developed in 2022 as we look forward to taking on more HTA's for topics in social care settings.

Online resources and training

We are exploring the ways in which we can help improve the understanding of health technologies, health technology appraisal and gathering and presenting patient evidence in patient and public communities across Wales and in the UK. Our PPISG have produced a video informatic on PPI for our website which provides an oversight on PPI and how individuals and organisations can get in touch to learn more. PPISG also held an introductory webinar on health technologies and health technology assessment in December 2020 which was attended by representatives of patient organisations from across Wales and the UK and is now available to watch on our website. We have also started offering one-to-one training on HTW and HTA to patient organisations who are interested in learning more. So far, we have delivered this tailored, in-depth training to:

- Rare Diseases and Genetic Alliance UK
- Alzheimer's Society
- Crohns and Colitis UK
- Cystic Fibrosis UK
- Velindre Cancer Centre Patient Experiences

Working with HTW on their first exploration of social care topics has been such a rewarding experience. I hope that the work I have been helping to shape will be able to encourage more social care topics in 2022 so that a richer sense of the work social care professionals undertake with technology can benefit wider communities in Wales.

Louise Baker, HTW member and Public Partner

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Advanced therapy medicinal products

Over the last few years, cell and gene therapies, also known as advanced therapy medicinal products (ATMPs), have been developed to treat serious conditions. These therapies have the potential to make a big impact on patients and on the health care system.

As part of the Advanced Therapies Treatment Centre Network Programme, we collaborated with the Midlands-Wales Advanced Therapy Treatment Centre (MW-ATTC) and a large network of specialists to deliver on projects to aid the assessment and adoption of ATMPs. The projects aimed to develop tools, frameworks and methodologies to aid the assessment of ATMPs and therefore to facilitate future commissioning decisions.

An ATMPs micro-costing toolkit

We performed a systematic literature review of the resource collection methods employed in previous economic analyses of ATMPs. We then used this evidence and expert input to develop a micro-costing toolkit, which can be used to inform the collection of resource use data across different phases of the delivery of ATMPs. The micro-costing toolkit aims to facilitate the assessment of the full cost of delivering advanced therapies to the NHS. This could inform future assessments of whether different ATMPs deliver sufficient value for money.

Spreading the word about ATMPs

We recorded a webinar which demonstrates how the micro-costing toolkit might be used in practice, which is available here.

The webinar demonstrated how the user is able to switch between different types of advanced therapies. It also shows how the user can select whether a top-down cost is available, or whether more detailed micro-costing is necessary.

Since posting on the MW-ATTC website in September 2021, the webinar has been viewed 36 times. There were also 41 interactions with a Tweet about the webinar and an engagement rate of 5.71% on LinkedIn.

> [The] microanalysis costing toolkit has been well received by third parties and will be incorporated into the pan-ATTC national toolkit as an accessible NHS resource. [The] additional costing review and analysis will be used to inform commercial business models.

Mark Briggs, Head of Cell and Gene Therapy at the Welsh Blood Service

Economic analysis of cell therapy for people with critical limb ischaemia

We used routinely collected data from the Welsh Secure Anonymised Information Linkage (SAIL) database to provide a more detailed understanding of the natural progression of critical limb ischemia. We have used the estimations of disease progression to inform the development of an economic model comparing a revascularisation technique with standard care in people with critical limb ischemia.

Economic analysis of cell therapy for platinum resistant ovarian cancer

We developed an economic analysis on the use of tumour infiltrating lymphocytes (TILs) for platinum-resistant ovarian cancer. The model assessed whether routinely collecting and storing TILs from tumour samples when patients are undergoing surgery for ovarian cancer is less costly than patients having additional surgery to collect TILs at the point when treatment with TILs is needed.

Patient and public perspectives on cell and gene therapies

We worked with MW-ATTC on a research project to understand patient and public knowledge and perspectives of cell and gene therapies. Using systematic review methodology, we undertook a scoping review to identify and synthesise all available evidence on the topic, which was published in the open access journal Nature Communications.

Our paper, 'Patient and public perspectives on cell and gene therapies: a systematic review,' focuses on patient and public knowledge and perspectives of cell and gene therapies, to inform future research, education and awareness raising activities. This review highlights the need for appropriate patient and public education on the various aspects of these therapies, which pose complex logistical, economic, ethical and social challenges for health systems.

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Individual patient funding requests

What did we do?

HTW has a strategic goal to identify technologies likely to have a major impact on health and social care services and to benefit people in Wales. Part of delivering this goal involves reviewing Individual Patient Funding Requests (IPFRs) to identify potential topics for appraisal.

Who with?

AWTTC delivers a portfolio of services in therapeutics and toxicology, including the HTA of medicines. They want to create a healthier, better informed Wales and aim to be the authority on therapeutics and toxicology in Wales. AWTTC has representation on our decision-making committees, including Appraisal Panel and Assessment Group.

Since 2015, AWTTC has worked to strengthen and improve the IPFR process in Wales. One gap identified was the comparative lack of support in summarising available evidence to support IPFR applications on non-medicine technologies. For medicines, this work is already done by AWTTC or local medicines information services. Making use of AWTTC's processes and network of contacts, we now provide Evidence Summaries to health boards as part of IPFR applications for non-medicine technologies on request. Our Evidence Summaries provide a high-level overview of the known evidence on a treatment considered for an IPFR. They also summarise any economic considerations.

What were the reactions?

IPFR co-ordinators and panels passed on their gratitude to our team for the extra support they receive through HTW Rapid Evidence Summaries.

A member of the Cwm Taf Morgannwg University Health Board (CTMUHB) was very complimentary of the support provided by the HTW team, registering that communication with the HTW was excellent and the Rapid Evidence Summaries were really comprehensive and completed in a timely manner.

Consultant and Clinical Lead at the All-Wales Managed Clinical Network in Paediatric Palliative Medicine, of Cardiff and Vale University Health Board (CAVUHB), Richard Hain said:

> " *The evidence presented by HTW was extremely valuable in this very complex case.* "

Of the same Rapid Evidence Summary, a lay member of the CAVUHB panel noted that it was very useful and improved their understanding of the comparative evidence.

What difference did this make?

HTW's work on IPFRs aims to ensure that best practice is followed for all IPFR applications in Wales, and that decision makers on IPFR panels have access to evidence searching, synthesis and health economic support when considering medical technologies. The CTMUHB panel member encouraged other members to use the service and was pleased to find that HTW are producing a more detailed appraisal of FND treatments, which will benefit IPFR panels. The member noted that other panels might consider flagging IPFRs for fuller appraisal by HTW.

The CAVUHB IPFR panel lay member reported that HTW's Rapid Evidence Summary had a major positive impact. The CAVUHB Clinical Lead Richard Hain provided feedback on the impact of the Rapid Evidence Summary on the panel's decision-making:

> " *The evidence concerning the effectiveness was essential in our reaching our decision. It would have been extremely difficult for us to assimilate that evidence without the concise and detailed summary provided by HTW.* "

INAHTA Disruptive Technologies Position Statement

Disruptive technologies are innovations that significantly alter the way health systems operate. These innovations are playing an increasingly important role in the way health systems develop, for example, in the face of challenges associated with the COVID-19 pandemic.

The International Network of Agencies for Health Technology Assessment (INAHTA) is an international network that connects health technology assessment agencies worldwide to enable knowledge sharing and the exchange of information. Its position statements are general declarations that mark a particular point of view or standpoint supported or approved by INAHTA members.

Who with?

The Disruptive Technologies Position Statement task group was made up of volunteers from INAHTA's 50 member agencies. These included representatives from HTA agencies in Germany, Taiwan, Italy, Austria, Canada, Argentina, South Africa, Malaysia and the UK. Support was also provided by the INAHTA secretariat.

What did we do?

In 2018 HTW joined a task group to produce a Position Statement on Disruptive Technologies following the INAHTA Congress 2018 World Café on Disruptive Technologies event. The event was attended by representatives of INAHTA's 50 global member organisations.

Susan Myles, HTW Director and HTW's Information Specialist Jenni Washington, became members of the task group and provided input to the development of the Position Statement.

Jenni drafted a systematic literature search strategy which was critiqued by the information team at INAHTA's Federal Joint Committee (G-BA) based in Germany. She then ran the search and co-ordinated double screening of the results. The task group undertook screening of both abstracts and full text, as well as data extraction.

Throughout the process Jenni and her German Information Specialist counterpart Lydia Jones were instrumental in driving the project forward and in ensuring that task group members had all the information and tools required to prepare and agree the Position Statement.

What difference did this make?

Despite delays caused by the COVID-19 pandemic the Position Statement was finalised through the joint efforts of the task group members.

The resulting Position Statement was supplemented with preparation of a peer reviewed journal article which will be published in a forthcoming edition of the International Journal of Technology Assessment in Health Care (IJTAHC).

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Our future

This year we published our first Strategic Plan, to ensure we continue to support the identification, appraisal and adoption of innovative health and social care technologies that offer most promise to deliver improved health, well-being and value for the people of Wales.

The 5 year plan was developed in consultation with our key stakeholders and endorsed by the Welsh Minister for Health and Social Services. It outlines our ambitious goals to drive improvements in population health and social care services, by applying the best available evidence to inform decisions on the appropriate use of health and social care technology innovations in Wales.

The five priority objectives for 2021 which have guided our work programme, were:

- Expand HTW's topic identification, prioritisation and selection efforts.

- Significantly increase HTW's evidence appraisal and guidance output.

- Target social and digital care innovations for appraisal.

- Support time-critical COVID-19 care and policy decision making.

- Pilot and roll-out the HTW technology adoption audit function.

The full plan can be accessed via our website.

Our team

The work in this Annual Report has been delivered by the Health Technology Wales team. Our team comprises of 25 people including health services researchers, health economists, information specialists, communications, project managers and administrators.

In 2021 the HTW team expanded with the addition of three new Health Services Researchers who joined on a permanent basis and two fixed-term Health Services Researchers appointed to support COVID-19 funded research. An additional Health Economist joined HTW and an Information Specialist was also appointed. Meanwhile five new team members joined the Programme Office department .

This expansion reflects HTW's ambitious plans to significantly increase its evidence appraisal and guidance output and to increase its engagement activity. In addition, in 2021 there were six internal promotions within the HTW team.

We come from a broad range of backgrounds and skillsets and collectively have extensive experience in both the public and private sectors. The team is supported by the invaluable contributions of our external committee members who continue to ensure our work meets the needs of the health and social care sectors in Wales.

Thank you for reading and learning about our work to support a national approach to the identification, appraisal, and adoption of non-medicine health technologies in Wales.

Budget delivery

HTW launched its Strategic Plan for 2021 – 2025 which sets out the organisation's immediate and medium-term strategic goals and objectives. The Welsh Government therefore increased funding from £1 million to £1.5 million for 2021-2022, to fund HTW's core work. HTW received additional income of £145,000 to fund its work as a Collaborating Partner of the Wales COVID-19 Evidence Centre and two years of grant funding to support its work on Advanced Therapy Medicinal Products (ATMPs).

Reporting modest underspends to date, due to recruitment delays. On target to deliver within budget during FY 22/23, once all vacancies are filled.

Supporting a current full time equivalent headcount of 25.6 against a planned headcount of 28 full time equivalent.

Allocating our revenue budget to approx. 80% staff costs and 20% non-staff costs.

Providing adoption audit funding for 5 local health boards.

New income stream implemented through the HTW Scientific Advice Service.

Peter Groves
Chair

Susan Myles
Director

Lisa King
Senior Programme Manager

June Price
Business Operations Manager

Katie McDermott
Project Manager
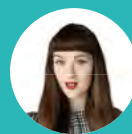
Rebecca Shepherd
Project Support Manager

Alice Evans
Patient and Public Involvement Manager

Elise Hasler
Information Specialist

Jenni Washington
Information Specialist

Matthew Prettyjohns
Principal Researcher, Health Economics

David Jarrom
Principal Researcher, Health Services Research

Gareth Hopkin
Senior Health Services Researcher

Lauren Elston
Senior Health Services Researcher

Thomas Winfield
Senior Health Economist

Sophie Hughes
Senior Health Economist
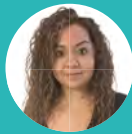
Sasha Barrate
Health Services Researcher

Claire Davis
Health Services Researcher

Jessica Williams
Health Services Researcher
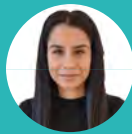
Eleni Glarou
Health Services Researcher

Charlotte Bowles
Health Services Researcher

Rebecca Boyce
Health Economist

Diana Milne
Communications Officer

Llinois Jones
Welsh Language Translator

Caron Potter
Executive Assistant

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Social media
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LinkedIn
'Health Technology
Wales'

We want to understand how our work is having an impact on health and social care outcomes that matter to people in Wales, and where we can improve in the future. Anyone is invited to complete this online survey:

www.healthtechnologywales.onlinesurveys.ac.uk/htw-feedback-survey

Health technology developers and innovators can optimise their evidence plans and route to market with help from the Health Technology Wales Scientific Advice Service.

Our expert consultancy supports developers and innovators in Wales to generate evidence and demonstrate value that meets the needs of care commissioners, care providers, patients and service users in Wales.

Start your service today:
www.healthtechnology.wales/sas

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Health Technology Wales (HTW)

- Welsh Government 2014 'Access to medical technologies in Wales' Report

- An **all-Wales medical technology appraisal** mechanism

- A robust evaluation process to support a **more strategic approach** to the commissioning of new medical technologies in Wales

- Coordinated and streamlined **approach to medical technology adoption**
  - Driven by clinical and population need
  - Evidence-based investment and disinvestment
  - Equity of access for patients
  - Engagement of clinicians, patients, industry and research partners

- The uptake of recommended medical technologies, including those recommended by **NICE**, is measured as part of a **formal audit process**

Our vision and mission

Vision: To develop a world-class HTA organisation that facilitates the identification, appraisal and adoption of health technologies that offer most promise to deliver improved health outcomes and value for the people of Wales.

Mission: To drive improvements in population health and care services by applying the best available evidence to inform decisions on the appropriate use of health technologies in Wales.

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Health Technology Wales
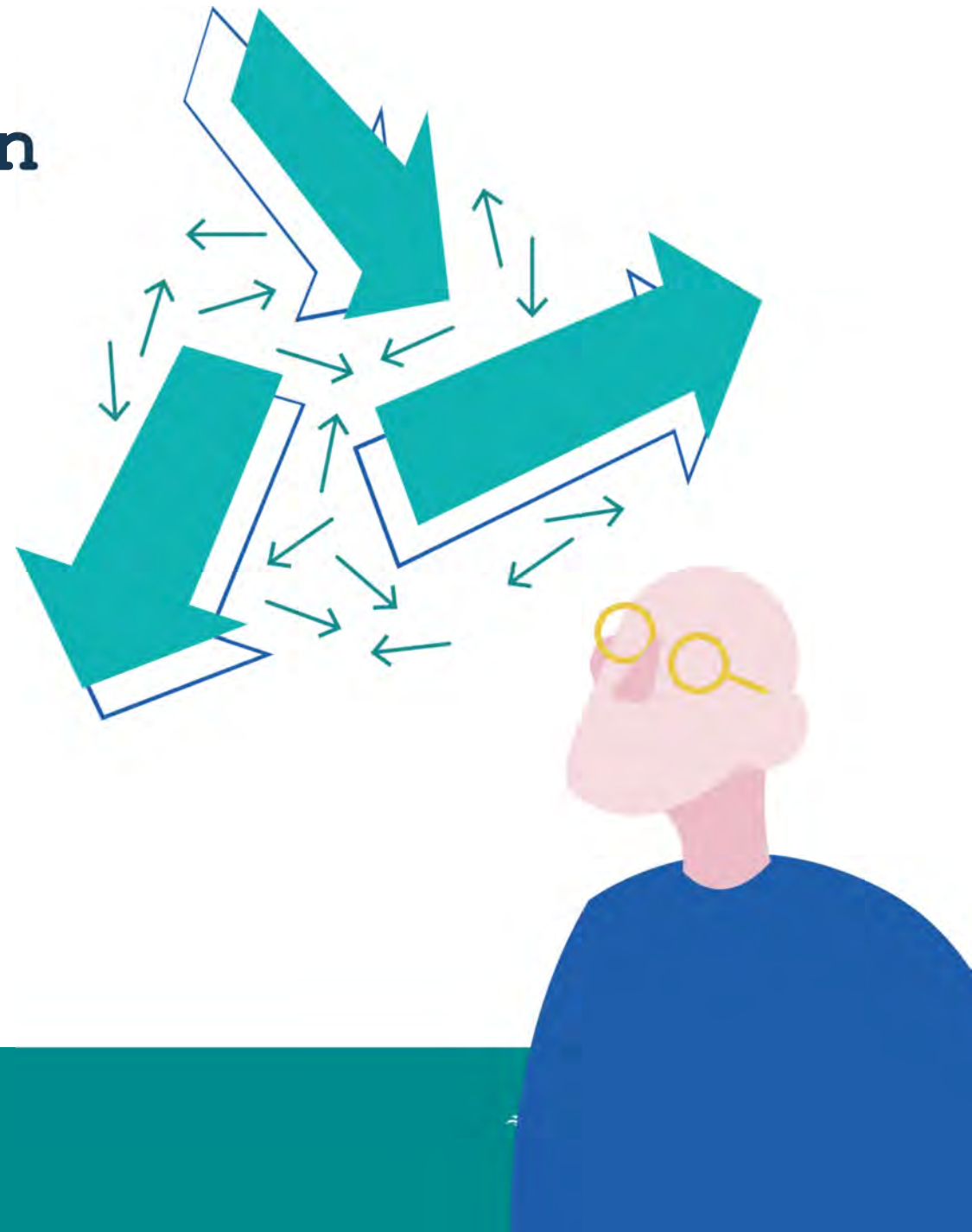
The principles of HTW's work

- Evidence-based

- Transparent and rigorous

- Independent

- Collaborative with experts, public and patients

- Informed by stakeholders from the wider health and social care environment

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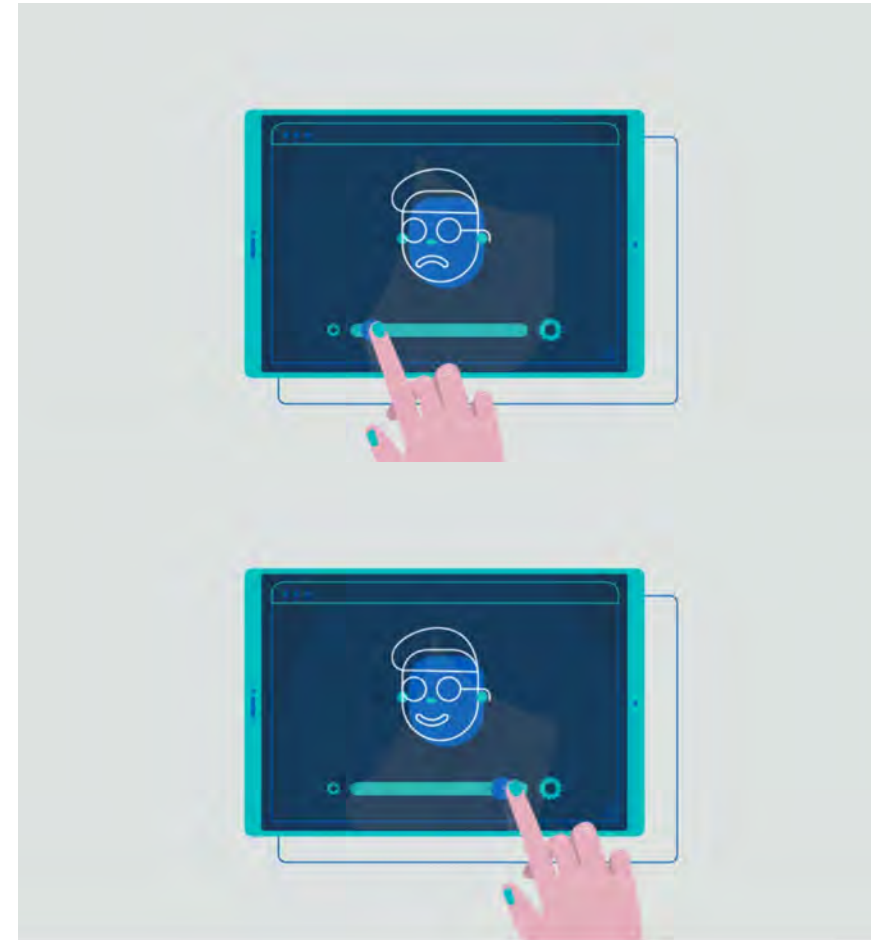
The priorities and core functions of HTW

The HTW team

- Dr Susan Myles, Director of HTW

- 28 posts
  - Health Service Researchers
  - Health Economists
  - Information Scientists
  - Communicators
  - Project Managers
  - Administrators

IDENTIFICATION — APPRAISAL — ADOPTION

The HTW committees

- Assessment Group – oversees topic selection and prioritization; scientific rigour of evidence assessment reports; 11 multi-disciplinary members
- Appraisal Panel – produces medical technology guidance recommendations; facilitates topic uptake and stakeholder engagement; 26 multi-disciplinary members

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HTW Activity 2021

- Health Technology Assessment
- Engagement with key partners and stakeholders
- Support for the Welsh Government COVID-19 pandemic response

Annual Report 2021
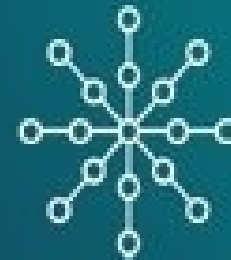
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Topic Identification and outputs 2021

HTW 2021 Annual Report

Health Technology Assessment work

88 topics referred to HTW for consideration

49 Topic Exploration Reports

12 Topics progressed to Appraisal

9 Evidence Appraisal Reports

6 pieces of HTW Guidance published

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HTW topic referrals & outputs since 2017

Source of Topic Referrals
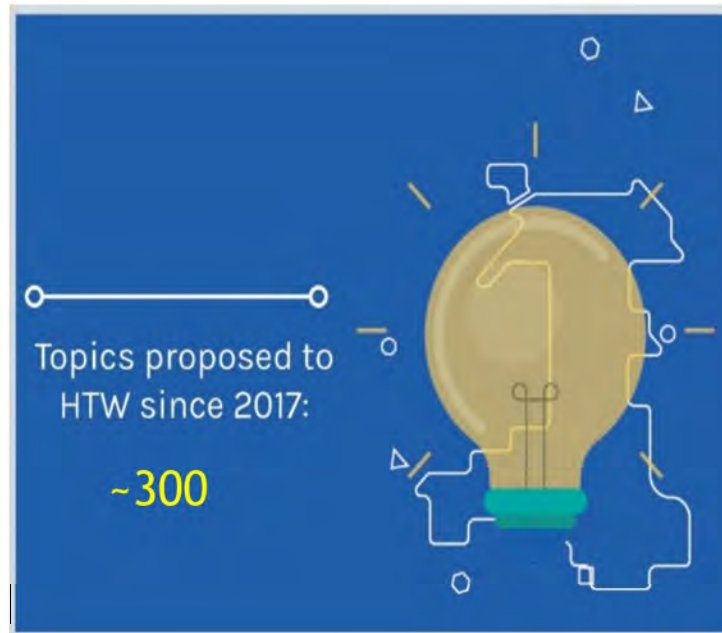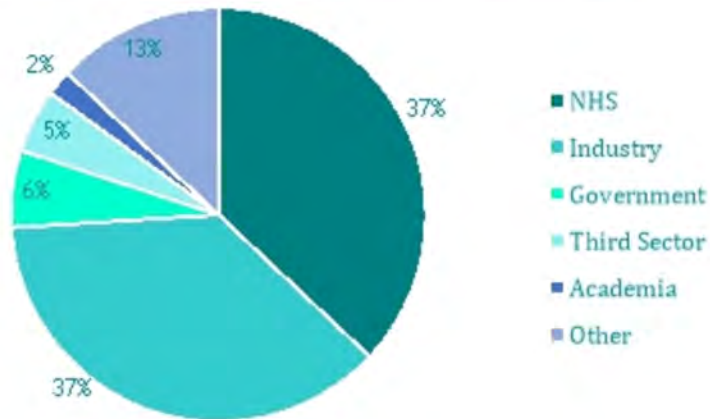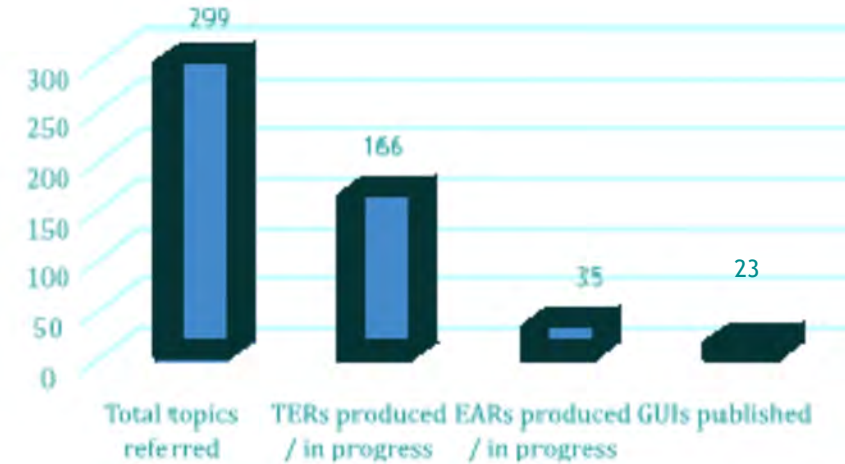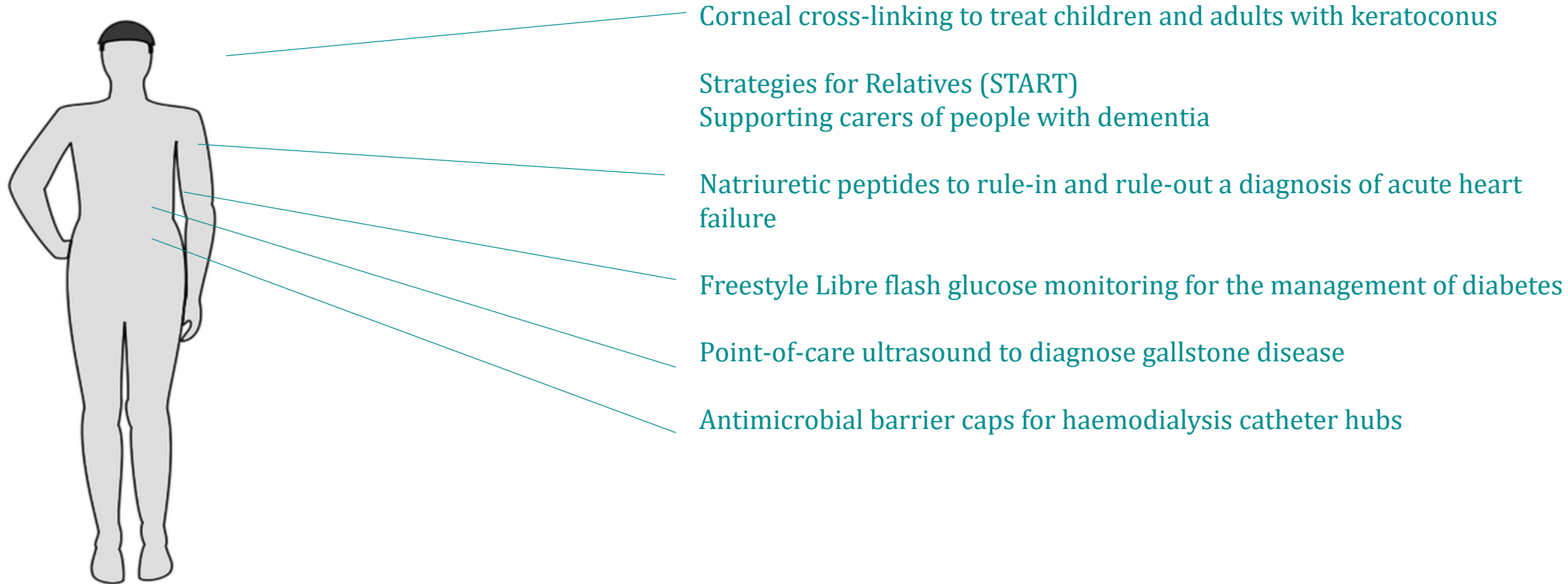
- NHS
- Industry
- Government
- Third Sector
- Academia
- Other

37%, 37%, 6%, 5%, 2%, 13%

Topics proposed to HTW since 2017: ~300

HTW Outputs Since 2017

299 — Total topics referred
166 — TERs produced / in progress
35 — EARs produced / in progress
23 — GUIs published / in progress

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Adoption

- AWMD oversight and lead peer group

- 7 LHB committees and leads nominated

- Both HTW and NICE medical technologies guidance

- Adoption audit methods established

- Pilot of auditing uptake of 8 HTW Guidances

- First HTW Audit report to WG spring 2022

Links and Engagement with LHBs

- **Aneurin Bevan Health Board -** Alex Scott, Quality and Patient Safety Committee

- **Betsi Cadwaladr University Health Board** - Geeta Kumar / Romana Kanwal, NICE Assurance Group

- **Cardiff and Vale University Health Board** - Raj Krishnan, Clinical Effectiveness Committee

- **Cwm Taf Morganwg University Health Board -** Nick Lyons, Quality and Safety Committee

- **Hwyel Dda University Health Board -** Karen Richardson / Lisa Davies - Quality, Safety and Experience Assurance Sub-Committee

- **Powys Teaching Health Board -** Howard Cooper, Experience, Quality and Safety Committee.

- **Swansea Bay University Health Board -** Alistair Roeves, Clinical Outcomes and Efficiency Group

HTW impact 2021

- 188,680 patients per year would benefit from implementation of all HTW guidance

- The INAHTA David Hailey Award for the best HTA impact story

INAHTA

THE DAVID HAILEY AWARD
FOR BEST IMPACT STORY

Awarded to

Health Technology Wales
For the Best Story of HTA Impact

Given by
The International Network of Agencies for Health Technology Assessment
At the INAHTA Congress, 21 September 2021

HTW 2021 Annual Report Engagement and Collaboration

Stakeholder Forum established

10 Assessment groups

3 Executive groups

3 Industry user groups

4 Patient and public involvement (PPI) standing groups

Events:

10 Events (including virtual webinars and workshops)

Website

53,118 Webpage views

15,673 Unique visitors

Social media

1,780 Followers

22,027 Profile visits

233 Mentions

426 Link clicks

Partnership with Social Care Wales In 2021 we held roundtable and workshop events to better understand the needs of the social care sector. This led to the launch of our first Social Care Open Topic Call in February 2022.

International partners Collaboration with INAHTA members from across the world to write position statements on patient involvement and disruptive technologies

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"The HTAi Patient and Citizen Involvement in HTA Interest Group (PCIG) brings together more than 300 members from different disciplines and stakeholder groups in 43 countries to strengthen patient and public involvement in HTA. HTW has quickly gained international attention for its approach to patient and public involvement. We greatly appreciate the opportunity to learn, share and reflect on practice with HTW, and its staff's generous contribution to panels at the HTAi 2021 Annual Meeting and studies on the impact of patient and public involvement and its role at an organisational level outside of individual assessments."

Ann Single, HTAi Patient and Citizen Involvement Interest Group Chair

5 **Topics with PPI**

4 **Patient submissions received**

2 **Questionnaires/Surveys circulated**

2 **Specific patient evidence literature reviews**

HTW Patient and public involvement in 2021

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HTW 2021 Annual Report
COVID-19 Response

- HTW became a Collaborating Partner in the Wales COVID-19 Evidence Centre

- HTW collaborated in externally published reports in partnership with EUnetHTA

- HTW maintained an evidence digest of published studies relating to COVID-19

- HTW offered a free Scientific Advice Service to technology developers for therapeutics and diagnostics relating to COVID-19
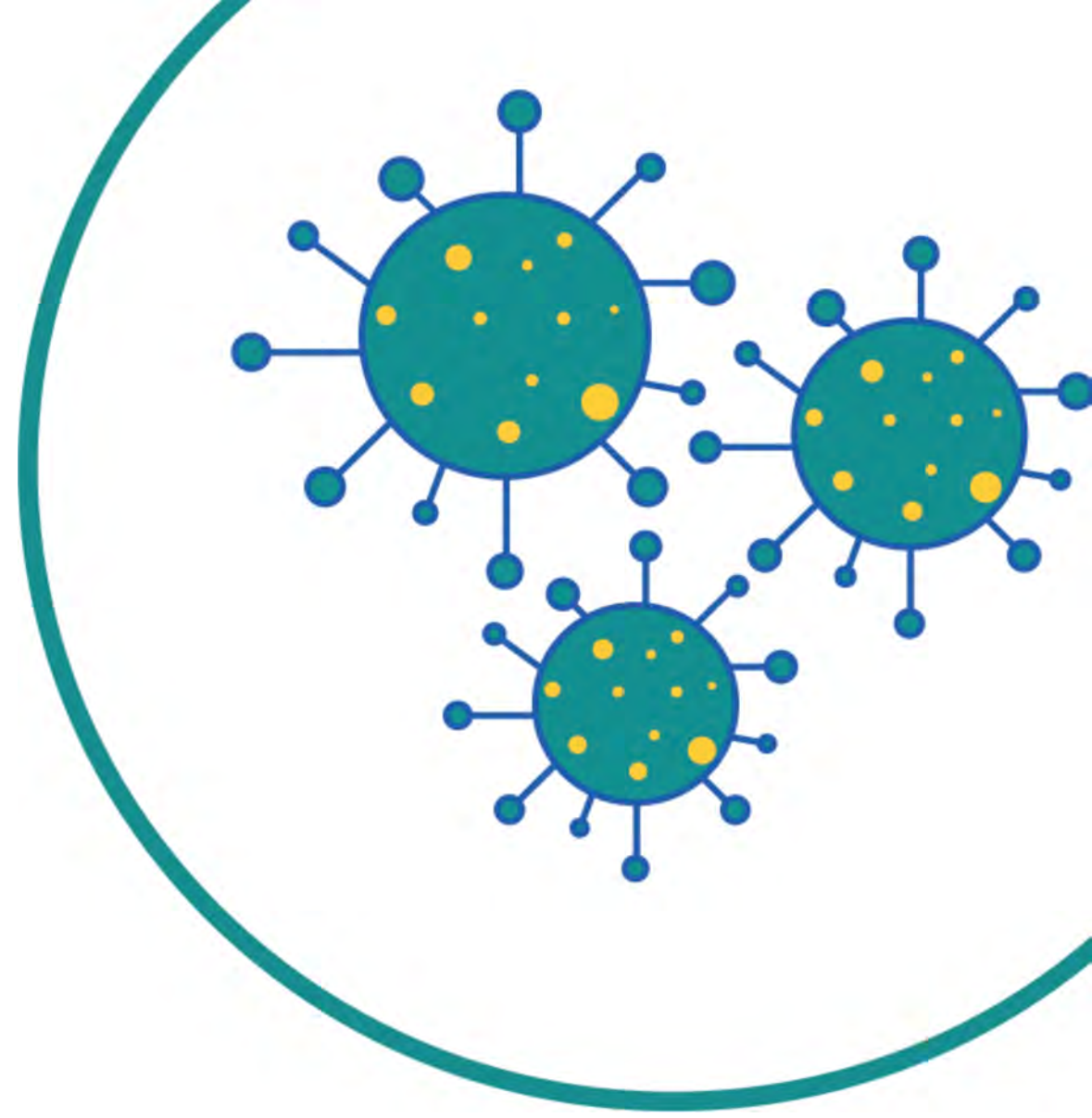
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Wales COVID-19 Evidence Centre collaborating partners

Wales COVID-19 Evidence Centre (WCEC)

- HTW was appointed a Collaborating Partner of the WCEC in March 2021

- HTW provides research and analytical expertise to the WCEC

- HTW has contributed a series of rapid evidence reviews and summaries on COVID-19 related topics

- HTW continues to support WG COVID-19 decision-making groups

Work carried out in 2021

Rapid evidence reviews

What is the risk of SARS-CoV-2 transmission in vaccinated populations?

Face coverings to reduce transmission of SARS-CoV-2.

Convalescent Plasma Therapy for the Treatment of COVID-19

Rapid evidence summaries

The effectiveness of home monitoring using pulse oximetry in people with COVID-19 symptoms to guide future management.

COVID-19 transmission in semi-outdoor or partially covered settings.

Effectiveness of tests to detect the presence of SARS-CoV-2 virus, and antibodies to SARS-CoV-2, to inform COVID-19 diagnosis: a rapid systematic review

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HTW Annual Report 2021

A summary of how we met our 2021 priority objectives

Expand HTW's topic identification, prioritisation and selection work:

- Increased from one to two annual topic calls

- Received 88 topic referrals

- Refined the HTW topic selection and prioritisation method

Significantly increase HTW's evidence appraisal and guidance output:

- Produced 49 topic exploration reports

- Produced 9 evidence appraisals

- Issued 6 pieces of national guidance including the first piece of HTW social care guidance

Target social and digital care innovations for appraisal:

- Established a collaborative partnership with Social Care Wales

- Held the first HTW social care open topic call

- Set up an expert group to target HTW's forthcoming digital topic call

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HTW 2021 Annual Report

How we met our 2021 priority objectives

Support time-critical COVID-19 care and policy decision making:

- Became a collaborating partner in the new Wales COVID-19 Evidence Centre

- Produced evidence reviews and summaries

- Supported key Welsh Government pandemic decision-making groups

Established and Piloted the HTW technology adoption audit function:

- Co-produced the HTW adoption audit infrastructure

- Piloted the first annual adoption audit of HTW guidance

- Preparing the first annual adoption audit report to submit to Welsh Government

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HTW Strategic Plan 2021-2025

The HTW Strategic Plan 2021-2025 sets out our immediate, medium and long-term strategic goals and objectives

It was developed in consultation with key stakeholders, including Welsh Government, opinion leaders within the Welsh health and social care system and members of HTW decision-making groups

The plan was created as a living document that will be continually refined to reflect the changing health and social care priorities and demands on HTW resources

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HTW priority objectives for 2022/23

Identification

- Expand HTW's topic identification, prioritisation and selection efforts
- Develop and promote direct topic referrals from Local Health Boards (LHBs), Local Authorities (LAs), Social Care Wales (SCW), Digital Health and Care Wales (DHCW), Specialist Health Boards
- Digital Topic Call

Appraisal

- Significantly increase HTW's evidence appraisal and guidance output
- Target digital care innovations for appraisal
- Support time-critical COVID-19 care and policy decision making
- Publish HTW appraisal methods and processes to ensure compliance with best international practice

Adoption

- Prepare and submit Annual Audit Report
- Adapt and pilot HTW adoption audit methodology in social care settings
- Further develop the HTW Scientific Advice Service (SAS) to support the Welsh life sciences and innovation landscapes

Engagement

- Further develop collaborative work with other UK HTA bodies ie NICE, SHTG and International bodies ie EUnetHTA, INAHTA
- Update the HTW Communications Strategy to extend and optimise HTW's stakeholder engagement

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Diolch | Thank you

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TRUST BOARD

CHAIR'S REPORT

Date of meeting	31/03/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Lenisha Wright, Business Support Officer
PRESENTED BY	Professor Donna Mead OBE, Chair
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		

ACRONYMS	

1. SITUATION/BACKGROUND

This report provides information to the Board from the Chair on a number of matters. A summary of activities and engagements is included to advise of areas of focus since we last met.

Matters addressed in this report cover the following:

This Chair's report gives an update on the following matters:

- Board Development/ Board Briefing Sessions
- Extraordinary Private Board Meetings
- Independent Members Group
- The Appointment of an Arts Consultant for the new Velindre Cancer Centre
- International Women's Day Celebration
- Duke of Edinburgh Awards
- Wear Red for Wales
- Queens New Year 2023 - Request for Nominations.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

A summary of priorities, activities, engagements and matters of interest is provided by the Chair below.

2.1 Board Development/ Board Briefing Sessions

The Board met as part of its programme of Board Development and Briefing sessions on 17th February. The following topics were discussed:

- **New Velindre Cancer Centre Competitive Dialogue** – The new Velindre Cancer Centre Project Director, David Powell and competitive dialogue team of advisors led the Board through an outline of how the bids were developing from the two consortia.

- **Value Add Collaboration** – Following updates in the public Transforming Cancer Services Sub-Committee, the new Velindre Cancer Centre Project Director, David Powell and Lauren Fear, Director Corporate Governance & Chief of Staff, took the Board through some of the key elements of this work. The work brings together initiatives linked to the building of a new hospital across community engagement, community outreach, sustainability, social/green prescribing, the arts and third sector relationships.

- **Integrated Medium Term Plan** – The Board discussed the key themes and risks in the medium term plan, in order to support understanding and context to the formal Board discussions over the coming weeks.

2.2. Extraordinary Private Board Meetings

The Chair would like to note the following Extraordinary Board Meetings took place during this period:

- On **24th February**, the Board met to approve a particular aspect of the Integrated Medium Term Planning process following specific direction to all NHS Bodies from the Director General.

- On **8th March**, the Board met to approve next steps relating to an application for Judicial Review for the Outline Business Case of the new Velindre Cancer Centre and the Injunction process regarding direct action on site. Both of which are live litigation processes. The Board were also provided with an initial update on the Commercial Approval Process for the new Velindre Cancer Centre. A further update was then shared in Transforming Cancer Services Sub-Committee in March.

- On **24th March**, the Board met to discuss a matter which is commercially sensitive, regarding the development of the new Velindre Cancer Centre.

2.3 Independent Members Group

The Independent Members Group formerly known as the Integrated Governance Group has been established. At the meeting that took place on **9th February 2022** the Group discussed:

- Terms of Reference
- External Peer Groups
- Board Champion Roles
- Board Development and Training Programme

2.4 Appointment of an Arts Consultant for the new Velindre Cancer Centre

The Chair would like to note the appointment of Simon Fenoulhet who is the Arts Consultant for the Transforming Cancer Services Programme. Simon will be leading on an arts strategy

to support the delivery of a variety of initiatives within the Trust in relation to the new Velindre Cancer Centre.

2.5   International Women's Day Celebration

The Chair advises of her attendance to the International Women's Day celebration held at the Angel Hotel in Cardiff, in support of Velindre Fundraising. The event was well attended with various guest speakers, a charity raffle, games and entertainment to raise funds.

In the speech delivered by the Chair, she highlighted the challenges facing women around the world, including the current war in Ukraine, with various comments and questions from key attendees.

2.6   Duke of Edinburgh Awards

The Chair was proud to attend the Duke of Edinburgh Awards event at the Aberdare Community School on **10th March**. The Awards empower young people by supporting them in learning new skills, overcoming obstacles and building confidence and resilience.

At the event at Aberdare Community School, pupils were handed awards for completing their volunteering, physical and skills activities. In spending time with the students, the Chair was impressed with their passion and resilience having completed the programme during the pandemic.

2.7   Wear Red for Wales

The Trust's annual Wear Red Campaign took place on the **4ᵗʰ February** at the start of the Six Nations. Both staff and the public took to 'Wear Red' in support for the fantastic work by Velindre Cancer Centre and Welsh Blood Service. The event received good coverage and media attention.

2.8   Queens New Year 2023 - Request for Nominations

The Trust is collating our nominations for the Queen's New Year 2023 Honours round. The Chair would be pleased to receive any feedback from the Board on any nominations that they would like to be considered.

2.9   Health Technology Wales

Health Technology Wales is a hosted organisation of the Trust with a remit that covers appraisal of technology or models of care in support of health and social care that is not medicine.

The Chair on behalf of the Board would like to congratulate Professor Peter Groves, Chair of Health Technology Wales, on his appointment as NHS Chair on the National Institute for Clinical Excellence Appeals Panel.

3.0 IMPACT ASSESSMENT

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

4.0 RECOMMENDATION

The Board is asked to **NOTE** the content of this update report from the Trust Chair.

TRUST BOARD

CHIEF EXECUTIVE'S REPORT

DATE OF MEETING	31.03.2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
PRESENTED BY	Steve Ham, Chief Executive
EXECUTIVE SPONSOR APPROVED	Carl James, Acting Chief Executive

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	

1. SITUATION/BACKGROUND

This report provides information to the Board from the Chief Executive.

Matters addressed in this report cover the following:

- Ongoing Covid Response and National Day of Reflection
- Staff Health and Wellbeing
- New Velindre Cancer Centre
- World Cancer Day
- Community Partnership with Football Association Wales
- Storm Eunice
- War in Ukraine

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Ongoing Covid Response and National Day of Reflection

The Chief Executive would firstly like to express his gratitude, on behalf of the Board, to all staff in the Trust who continue to respond to the continual changing situation in delivering services for our patients and donors.

Our COVID-19 incident response command structure continues to operate. Gold Command reviewed the current situation and risk in mid-March and the decision was made to continue given the risks and issues COVID-19 continues to have on the Trust. The various implications across our workforce and in our service performance, finance and risk reports have been reported through the Committees and are on the agenda for this meeting.

At a recent all staff Question & Answer session with the executive team, many staff were open about how exhausted they felt, two years into the pandemic. The next section of this report outlines some of the health and wellbeing support we are providing but at the outset of the meeting, the Chief Executive would like to acknowledge this and once again thank staff for their continued outstanding support of each other and their unrelenting excellent commitment to delivering for patients and donors.

National Day of Reflection on 23rd March marked the anniversary of the first Covid-19 lockdown. Staff throughout the Trust observed a minute's silence, to remember the family, friends and colleagues we've lost over the last two years.

2.2   Staff Health and Wellbeing

The Executive Management Team wanted to specifically recognise the pressures all staff have worked through during the pandemic and to thank all staff for their continued efforts and contributions.

As such we wrote a letter to all staff. This was delivered to home addresses, as we are aware that not all our colleagues have access to our regular e-mail newsletters or intranet bulletins. The key message was: *"Now that winter is coming to an end we can look forward to spring, with new beginnings in mind, and thinking about all our different circumstances, we wanted to share with you a short summary of some of the health and wellbeing resources available to you as part of our Trust resources. Please remember 'It's OK not to be OK' and that you can reach out for help at any time."*

In addition the Chief Executive would like to update the Board that the new Wellbeing Centre is on track to open in April. This will be available for all staff and

offers a space to step away from the usual work environment, for a chance to relax and recharge. Over the coming months there will be access to clinical and complementary therapies to help staff maintain emotional and physical wellbeing. Alongside the wellbeing resources there will be a new Digital Services help desk and training suite as a one-stop-shop for IT health and wellbeing.

2.3   New Velindre Cancer

The Chief Executive would like to update the Board on a number of key matters relating to the new Velindre Cancer Centre since the last Board meeting. The competitive dialogue process with the two bidders continues to progress well. Plans are also being finalised for wider patient and community engagement on the proposed designs during the next phases. In addition, work on site in preparing for the Enabling Works is progressing to plan, following approval of the Full Business Case.

2.4   World Cancer Day 4th February

World Cancer Day 2022, is an international day for raising awareness and showing support for people living with cancer. It aims to raise worldwide awareness, improve education and act as a catalyst for personal, collective and government action. The vision is that we are all working together to reimagine a world where millions of preventable cancer deaths are saved and access to life-saving cancer treatment and care is equitable for all.

The Chief Executive would like to recognise the volume of amazing messages which Velindre cancer services staff received on World Cancer Day, thanking them for everything they do. Consultant and Clinical Director for Velindre Cancer Centre,

Dr Eve Gallop-Evans, also recorded a special World Cancer Day message which had an excellent reception.

The Welsh Blood Service were joined on the day by the first person in Wales to donate bone marrow, to call on more 17 to 30-year-olds to help in the fight against blood cancer. The service also used the day as an opportunity to promote the new postal mouth/cheek swab pathway recently introduced as an alternative way to sign up to the Welsh Bone Marrow Donor Registry.

2.5   Community Partnership with Football Association Wales

The Chief Executive would like to highlight to the Board that the Football Association of Wales have featured a special episode of FC Cymru to showcase the Welsh Blood Service community partnership campaign. "Blood Sweat and Cheers" is helping save lives and raise awareness of blood donation. FC Cymru is a monthly digital production commissioned by the Association bringing viewers football related features and stories from around Wales.

2.6   Storm Eunice

In February, there were excellent preparations made across the Trust to rapidly prepare for and then promptly respond to the impact of Storm Eunice. The Chief Executive would like to thank all staff members who worked extremely hard in ensuring our services were maintained whilst keeping people safe.

2.7 War in Ukraine

The Chief Executive would like to recognise the contribution of the Trust to date in responding to the humanitarian crisis in Ukraine. The Welsh Blood Service, in partnership with all UK blood services, have aligned bone marrow requests and are assessing export and importation of cells to support Bone marrow donors to and around countries around the Baltic.

In addition, the Chief Executive would like to recognise the Trust's role in contributing to the medical supplies which have been sent to support Ukraine from Wales. Coordinated by the Shared Services Partnership team, with approval from the Trust Board, shipment of medical supplies including bandages, ventilators and face masks have been dispatched to support the people of Ukraine.

The Trust is currently undertaking a series of other actions in response to the situation. A summary of the wider response will be shared with the Board.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:

EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

The Board is asked to **NOTE** the content of this update report from the Chief Executive.

TRUST BOARD

JANUARY PMF COVER PAPER

DATE OF MEETING	31/03/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Anna-Marie Jones, Business Support Manager Wayne Jenkins, Head of Planning and Performance Alan Prosser, Director WBS Sue Thomas Ass Director WOD
PRESENTED BY	Cath O'Brien, Interim Chief Operating Officer Sarah Morley, Director WOD
EXECUTIVE SPONSOR APPROVED	Cath O'Brien, Interim Chief Operating Officer

REPORT PURPOSE	FOR DISCUSSION / REVIEW

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME
QSP	24.3.22	Noted
EMB RUN	7.3.22	Noted
WBS SMT MEETING	9.02.22	Reviewed and Noted
VCC INDIVIDUAL DIRECTORATE MEETINGS	18.2.22 -24.2.22	Reviewed
WBS PERFORMANCE REVIEW	16.02.22	Reviewed and Noted

VCC PERFORMANCE REVIEW	25.02.22	Reviewed and Noted

ACRONYMS	
VUNHST	Velindre University NHS Trust
UHB	University Health Board
VCC SLT	Velindre Cancer Centre Senior Leadership Team
WBS SMT	Welsh Blood Service Senior Management Team
RCR	Royal College of Radiologists
JCCO	Joint Council for Clinical Oncology
PADR	Performance Appraisal and Development Review
KPIs	Key Performance Indicators
SACT	Systemic Anti-Cancer Therapy
WTE	Whole Time Equivalent (staff)
EMB	Executive Management Board
COSC	Clinical Oncology Sub-Committee
IPC	Infection Prevention Control
SPC	Statistical Process Control

1. SITUATION/BACKGROUND

1.1 The attached Trust performance reports provide an update to the Trust Board with respect to Trust-wide performance against key performance metrics through to the end of January 2022 for the Velindre Cancer Centre, the Welsh Blood Service and for VUNHST Corporate Services respectively.

2.   ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

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

2.2   Velindre Cancer Centre:

Covid continues to impact our service planning and delivery. Covid related absences, capacity reductions due to IPC measures and increasing patient numbers are all having an impact on our service provision and waiting times. We are continuing to experience high staff absences in SACT; some staff are off for an extended period of time. We have reallocated staff from other areas, moved patients to inpatients and the RD&I department are also providing facilities and staff. We are also expecting the situation to remain challenging in radiotherapy during the next couple of months. It is important to note that despite all the challenges we continue to respond in providing excellent care for our patients with only 1 target reporting red.

There was only one current target reporting red in January's performance report. This was healthcare acquired infections, where one C.difficile infection was reported. The patient fully recovered from the infection and there was no transmission to other patients in the ward environment.

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

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

Radiotherapy Waiting Times

The total number of referrals received in January 2022 (342) represented an increase from the previous month, which is expected following the Christmas break. The number of new referrals in January exceeded the average number received in any given month in 2020/21 (315).

IPC measures continue to restrict Linac capacity by c20%, resulting in growth in waiting times as referrals are returning to pre Covid levels, thereby exceeding available capacity. The number of patients breaching waiting time targets is expected to continue over next 6 months as demand grows and is forecast to exceed capacity.

There were 8 patients that breached the palliative JCCO target (14 days). All those patients have now commenced treatment.

13 patients breached the radical JCCO (28 day target). Of those all have commenced treatment now.   See *Appendix 4* for more detail on radiotherapy breaches.

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

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

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

The Brachytherapy plan is progressing with agreement on the resource envelope with WHISC to fully fund the service. There remains a small number of challenges most notably the additional Anaesthetics input required from C&V team which requires an extra day to support. They are working through those options to provide the support required. We are targeting a start date around 6 months from now.

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

These short term actions are being delivered alongside the major change programmes to introduce a new fleet of machines and the development of the satellite centre. The short terms actions have now been completed and all the operational interventions in terms of increasing capacity have been undertaken and we are now concentrating on the medium to long term actions to sustain this capacity. Please find additional information on the Rutherford in *Appendix 5.*

During the peak phase of the recent Omicron wave, a cohort of approximately 45 prostate patients had their radiotherapy treatment delayed – this was in line with national guidance to release radiotherapy capacity to treat priority groups of patients. These patients potentially received a longer than planned duration of hormone treatment prior to the commencement of radiotherapy. These patients have all now either received their radiotherapy treatment, or have dates to commence their treatment in advance of 31/3/2022.

SACT Waiting Times

The waiting times target for emergency SACT was met against a background of increasing demand above pre-covid levels, plus the additional patients who were not treated in December as a result of the holiday season. Performance decreased to 94% for non-emergency patients treated within 21 days. This has been delivered in the most difficult circumstances against a background of significant staff shortages which were Covid and non Covid related. This performance has been achieved by the hard work of the staff by improving the booking processes, increasing the utilisation of chair capacity, redeployment of SACT trained nurses, and an additional day on the Tenovus mobile unit. Support for the SACT service has come from all areas at VCC, with primarily ward based teams and clinical research providing nurses or treating patients in their areas. Staff also cancelled their leave at the beginning of the month in January, so they could ensure that the capacity of work that had planned for was completed. Weekend clinics have also been held to increase capacity with the next one scheduled on the 5thth of March.

All patients are risk assessed, and patients are treated in clinical priority order, with patients 'escalated' for treatment depending on their individual clinical need. Patients are contacted by the Bookings team to inform them of any anticipated delays to starting treatment, and a proactive virtual pre-hab programme has recently commenced for patients who are waiting to start SACT. More work is being considered to better support those patients waiting to start treatment, and a patient experience survey is currently underway to learn from what patients feel would help them.   This was approved by Clinical Delivery Group.

In February, a task and finish SACT group was set up to support the service and identify solutions to the increasing capacity challenges. This is being led by the deputy director of nursing Nigel Downes. In terms of third party providers the task and finish group are looking at bringing forward the start date of April for the extra capacity at the Rutherford and prioritising the provision at Neville Hall. The delivery timescale of the task and finish group is still being finalised.

Outpatients

Data collection paused during December and January due to operational pressures and staff absence

Therapies

Physiotherapy and Dietetic in the All Therapy waiting times targets were reporting amber. 2 patients were not seen by a physiotherapist within the six week target due to staff absence. No patient harm was reported. There are challenges covering specialist staff absences within a small team.   One patient was not seen within the two week urgent referral target in dietetics. The patient replied to their appointment email and their email was directed to the junk folder. The process for checking emails has now been amended.

Other areas

Falls

During January 2022, 3 falls was reported on first floor ward. Of these three falls, 1 was deemed to be avoidable. The patient tested positive for COVID-19 and was moved to an isolation cubicle. The COVID-19 protocol requires the door of the cubicle to be shut, resulting in a limit to the observation required under the falls assessment. The patient had been identified as being at risk of a fall. The patient mobilised within the cubicle without assistance and fell. They suffered a minor abrasion as a result of the fall. Moving forwards a supervision policy is being developed to assess falls and Covid risks together.

Pressure Ulcers

No Velindre acquired pressure ulcers were reported in January 2022

Healthcare Acquired Infections
One case of C.difficile was reported in January 2022. The patient had no previous history of C Diff. The indications are that the C Diff infection is related to treatment with multiple courses of antibiotics. The patient fully recovered from the C Diff infection. There was no transmission to other patients in the ward environment.

An investigation has since been carried out and was discussed at MDT on the 7ᵗʰ of March where it was agreed that this case could have been caused by either antibiotic usage and/or radiotherapy treatment and was deemed unavoidable.

SEPSIS bundle NEWS score

Six patients met the criteria for administration of the sepsis treatment bundle in January 2022. All six 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)

There was one delayed transfer of care reported in January 2022.
The patient was due to be discharged home, but they required a nasogastric (NG) tube and had no close family to support them, so a decision was taken to transfer them to UHW. There was no bed available. When the patient no longer required the NG tube, they were discharged to their own home with a revised care plan.

Further detailed performance data is provided in Appendix 1

2.3   Welsh Blood Service

Supply Chain Performance

The WBS service recovered well in January in terms of the stock position and was able to increase stock by 11% thanks to suppressed hospital demand, additional clinics at weekends and by working closely with blood banks across Wales.

All demand for red cells was met, and all stock groups continued to be maintained above 3 days. Clinical demand for platelets was also met.

2.3.1   Recruitment of new bone marrow volunteers

The Welsh Bone Marrow Donor Registry (WBMDR) has seen an increase of 89 donors in the month of January.   The service has also put together a detailed communications and engagement plan to support increasing and sustaining the recruitment target. The service also used World Cancer Day (4th Feb) to promote swab kits and engage with Universities and the impact of this campaign should be reflected in February's performance.

2.3.2   Reference Serology

Turnaround times have not met the target for January. Work continues to be prioritised based on clinical need, and all compatibility testing (>52% of referrals) is completed to the required time/date. The complexity of referrals and sickness absence continues to impact performance in January. An audit of this service has now completed and benchmarking across UK blood services was undertaken. The findings of the audit is currently with the Clinical Service team for review, with implementation of any agreed actions is expected by end of April 2022. A new testing strategy for samples suitable for automated testing is due to be completed by the end of March 2022, Validation of a new automated analyser and incorporation into routine use is planned to be in place by the end of March 2022 which will improve efficiency.

2.3.2   Quality

Incidents reported to Regulator/Licensing

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

Incidents closed within 30 days

There was a slight decrease in performance in this activity with breaches increased from 10 in the previous three-month rolling period to 13 in this reporting period. These are low risk investigations which have been difficult to complete in the current extremely challenging operational environment, however they are being actively managed.

Whole Blood Collection Productivity

The productivity for January is the same as December and continues to be below target. This target will not improve under Covid restrictions as the additional resources to operate in this environment are included in the productivity data. Work is in hand with the Infection Prevention and Control team to assess removal of triage and reducing social distancing within collections which should help improve this position as Wales begins to lift COVID restrictions.

Time Expired Platelets

Platelet expiry was above target for January as a result of prudently managing the stock over the bank holidays that resulted in higher wastage. Wastage levels are compounded by a 7 day shelf life for this blood component.

Number of Concerns Received

There were six concerns reported in January 2022, from approximately 7,700 donors attending clinics in the month. Five of these were managed within timeline as 'Early Resolution' whilst the one formal concern was managed under 'Putting Things Right' (PTR) regulations.

Donor Satisfaction

Continues to perform strongly at a national level despite the COVID restrictions in place.

Further detailed performance data is provided in Appendix 2

3. WORKFORCE

3.1 PADR

Trust wide performance shows compliance levels at 69.21% for the year to January against a target of 85%.

Despite a steady rise in PADR for most of 2021 (Jan – Nov average 73.49%) the figure has dropped to below 70% for the first time in the past 12 months. This is due in part to the winter pressures experience through the rising omicron situation in December 2021 and January 2022.

WBS, 83.73%: Overall WBS has seen a significant rise in PADR compliance since this time last year (Jan 21, 67.97%). Discussions continue at every SLT to stress the importance of PADR compliance.

VCC, 65.02%: Workforce Operational Team continue to highlight PADR compliance in regular meetings with managers.

3.2 Sickness Absence

Rolling absence levels are 5.66% for the year to January against a target of 3.54%.

Over the 12 month period sickness absence remains relatively stable across the Trust with an average rate of between 5.1 and 5.3%. In comparison to Jan 21 (5.28%) and Jan 22 there has been a slight rise in sickness absence of 0.38% points.

WBS, 6.40%: Both long and short term sickness has declined in January 2021 however sickness absence is still reporting at least 2% points higher when compared with a year ago.

VCC, 6.33%: short-term sickness, despite being relatively low across the division on average continues to rise this month, reporting at 3.18%

3.3 Statutory & Mandatory Compliance

Compliance with the 10 subjects of the Core Statutory Training Framework is at 85.97% against a target of 85%.

Statutory and Mandatory compliance has reported over target for 4 consecutive months within the Trust. WBS compliance sits at 93.78% with emphasis now to continue to maintain target compliance across the Division.

VCC compliance is at 84.73% which continues to improve with targeted intervention and support from WOD. Overall increase in compliance of 4.04% points since Jan 2021.

4.0 IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The current performance reporting and monitoring system is predicated upon identifying performance issues and supporting effective decision making at service and operational levels to drive forward continuous improvement in quality, safety and the overall experience of patients and donors.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below: • Staff and Resources • Safe Care • Timely Care • Effective Care.
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)

	Delivery against the performance metrics presented in the attached reports and the work associated with delivering improved performance supports sound financial governance across the Trust.

5.0 RECOMMENDATION

5.1 Trust Board is asked to **NOTE** the contents of the attached performance reports.

Appendices

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

Velindre Cancer Centre Monthly Performance Report Summary Dashboard (January 2022)

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 comparable. 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.

			Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-21
Radiotherapy	Patients Beginning Radical Radiotherapy Within 28-Days (page 8) (*JCCO Measure*)	Actual	97%	92%	89%	95%	94%	97%	96%	97%	96%	92%	78%	92%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Patients Beginning Palliative Radiotherapy Within 14-Days (page 10) (*JCCO Measure*)	Actual	97%	90%	85%	95%	85%	82%	82%	82%	82%	74%	84%	90%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Patients Beginning Emergency Radiotherapy Within 2-Days (page 12) (*JCCO Measure*)	Actual	97%	100%	97%	100%	100%	97%	100%	97%	100%	85%	89%	100%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Scheduled Patients Beginning Radiotherapy Within 21-Days (page 13) (*COSC Measure*)	Actual			35%	28%	37%	35%	31%	27%	36%	36%	33%	34%
		Target	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
	Urgent Scheduled Patients Beginning Radiotherapy Within 7-Days (page 13) (*COSC Measure*)	Actual			41%	48%	40%	54%	52%	52%	35%	41%	57%	37%
		Target	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
	Emergency Patients Beginning Radiotherapy Within 1-Day (page 13) (*COSC Measure*)	Actual			83%	88%	85%	82%	86%	82%	86%	77%	84%	90%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

			Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-21
SACT	Patients Beginning Non-Emergency SACT Within 21-Days (page 14)	Actual	77%	88%	98%	98%	98%	99%	99%	98%	99%	99%	99%	94%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Patients Beginning Emergency SACT Within 2-Days (page 15)	Actual	100%	100%	100%	100%	100%	100%	100%	100%	100%	86%	100%	100%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
Outpatients	New Patient, other Outpatient and Chemotherapy Assessment Appointments Where Patients Were Seen Within 30 minutes of the Scheduled Appointment Times (National Target) (page 19)	Actual	65%	57%	66%	79%	76%	76%	53%	53%	65%	65%	Data collection paused during December and January due to operational pressures.	
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
	Did Not Attend (DNA) Rates	Actual	2%	3%	3%	4%	4%	5%	5%	5%	5%	5%	3%	3%
		Target	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%
Therapies	Therapies Inpatients Seen Within 2 Working Days (page 22)	Actual (Dietetics)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Physiotherapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Occupational Therapy)	100%	100%	100%	100%	100%	100%	100%	100%	95%	100%	100%	100%

			Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-21
		Actual (Speech and Language Therapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Therapies Outpatient Referrals Seen Within 2 Weeks (page 22)	Actual (Dietetics)	100%	100%	100%	100%	84%	94%	94%	98%	97%	100%	95%	98%
		Actual (Physiotherapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Occupational Therapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Speech and Language Therapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Routine Therapies Outpatients Seen Within 6 Weeks (page 22)	Actual (Dietetics)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Physiotherapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	86%
		Actual (Occupational Therapy)	100%	100%	100%	100%	100%	100%	96%	33%	78%	100%	100%	100%
		Actual (Speech and Language Therapy)	100%	100%	100%	100%	100%	96%	100%	100%	96%	100%	100%	100%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

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

		Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-21
Healthcare Acquired Infections (page 29)	Actual	0	0	0	0	0	1 (*C.diff*)	0	0	0	0	0	1 (*C.diff*)
	Target	0	0	0	0	0	0	0	0	0	0	0	0
Percentage of Episodes Clinically Coded Within 1 Month Post Episode End Date	Actual	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	%
	Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

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

Radiotherapy Referral Trends - Overall
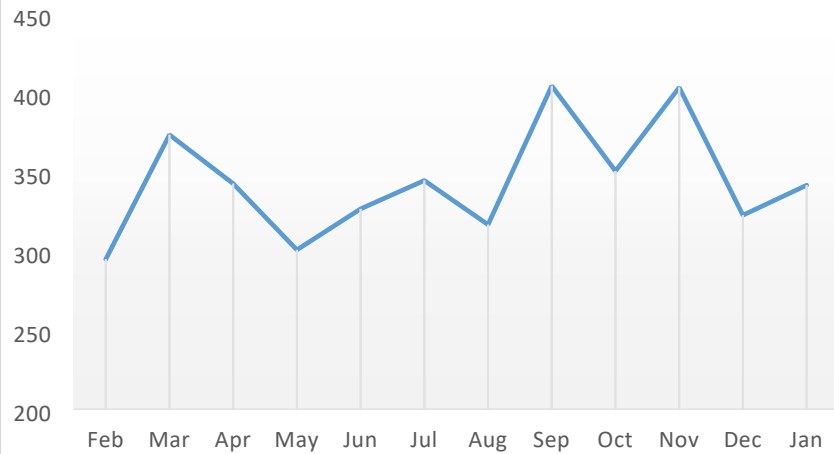
Monthly Average (2019-20)	Monthly Average (2020-21)	Total New Patient Referrals (January 2022)
357	315	342

Total New Patient Referrals by Month to January 2022

The total number of referrals received in January 2022 (342) represented an increase on the number received in December 2021 (322). It is typical to observe a rise in referral numbers following a relative low in December. This pattern is reflective of changing activity in health boards. The number of new referrals in January exceeded the average number received in any given month in 2020/21 (315).

Radiotherapy – Operational Context
Referral Trends - Tumour Site
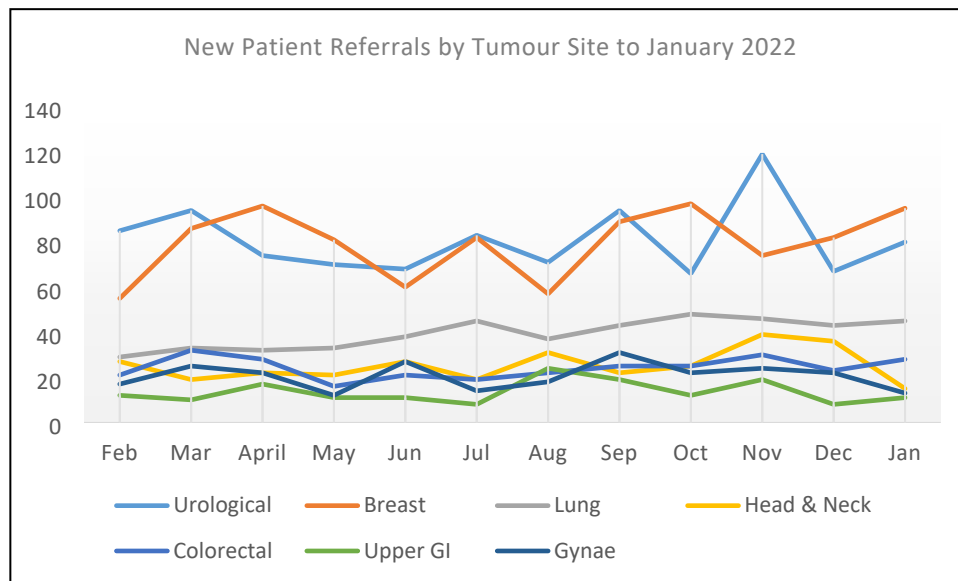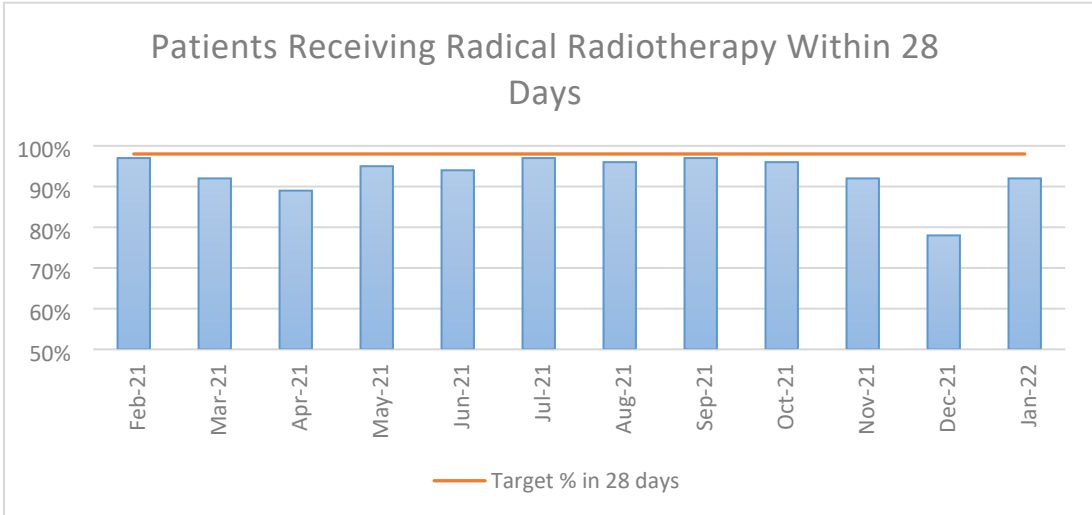
New Patient Referrals by Tumour Site to January 2022

Site	Monthly Average (2019-20)	Monthly Average (2020-21)	2020-21 Average Relative to 2019-20 Average	New Patients (January 2022)
Breast	**88**	**60**	**-32%**	95
Urology	**82**	**82**	**0%**	80
Lung	**47**	**38**	**-19%**	45
Colorectal	**20**	**22**	**+10%**	28
Head and Neck	**23**	**23**	**0%**	15
Gynaecological	**18**	**18**	**0%**	13
Upper Gastrointestinal	**16**	**13**	**- 19%**	11
Top 7 Tumour Sites by Number of Referrals as Percentage of Total Referrals	**82%**	**81%**		84%

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

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

Patients Receiving Radical Radiotherapy Within 28-Days	
Target: 98%	**SLT Lead: Radiotherapy Services Manager**
Trend	Current Performance

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Patients Receiving Radical Radiotherapy Within 28 Days

The number of patients scheduled to begin radical radiotherapy treatment in January 2022 (155) exceeded the monthly average observed in 2020-21 (150) and was higher than the number scheduled to begin treatment in December 2020 (114).

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

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

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

3 patients began treatment in excess of 50 days:

Treatment Intent	≥ 50 days
Radical (28-day target)	3

Additional staffing pressures due to sickness during January as a result of Omicron variant resulted in a curtailment of the service.
Summary of delays:
Planning complexity, and capacity for kilo Voltage, brachytherapy, Space OAR and other specialist treatments alongside general Linac capacity due to staff omicron, were the main reasons for breaches. 3 patients too unwell to commence treatment.

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

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

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Intent	Monthly Average (2019-20)	Monthly Average (2020-21)	Patients Scheduled to Begin Treatment (January 2022)
Radical	167	150	155
	Patients Scheduled to Begin Treatment (January 2020)	Patients Scheduled to Begin Treatment (January 2021)	
	162	114	

available capacity, generally and in respect of specialist treatments such as DXR and STS.
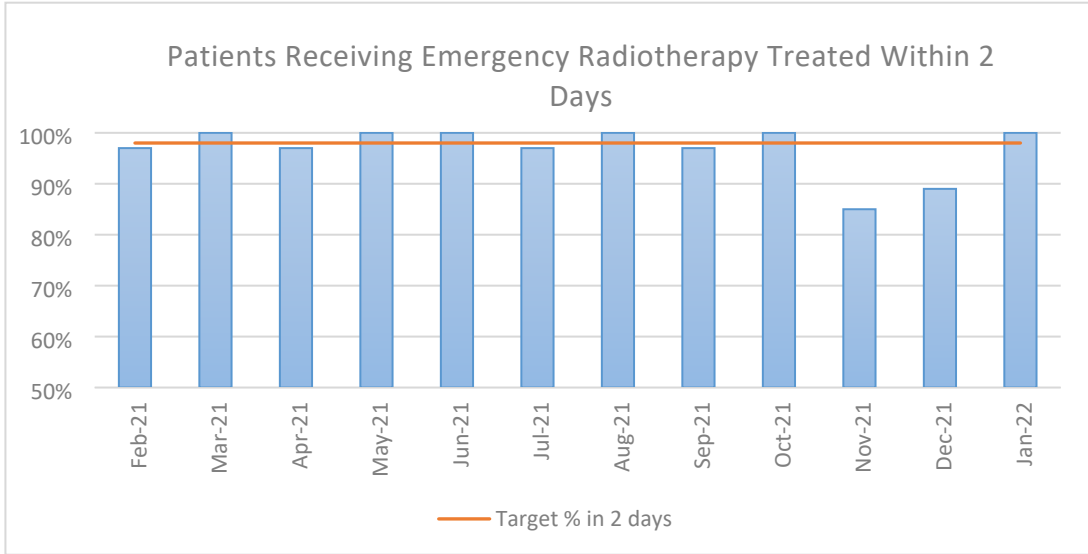
We have completed the short term actions and are now in the detailed planning stage. All operational intervention in terms of increasing capacity have now been undertaken. We are now moving to medium and longer term actions to sustain our capacity.

Medium Term Actions

- We are working with each SST to develop a tailored capacity delivery plan based on demand projections and treatment options eg Brachytherapy, molecular radiotherapy.
- Recruitment and appointments in progress for additional front line resources, however capacity increases predicted throughout 2nd half of 2022 due to lead in time, maximising capacity from Sept-Dec 2022.
- Peer review with Clatterbridge Trust underway to identify options/service models to put service demand and capacity in balance for Brachytherapy March/April 2022
- Brachytherapy expansion business case being written to obtain support for increased capacity with WHSCC. submission Mar 2022
- Assess the options to escalate some or all of the longer term capacity solutions. March 2022.

Patients Receiving Palliative Radiotherapy Within 14-Days	
Target: 98%	**SLT Lead: Radiotherapy Services Manager**
Trend	Current Performance

Patients Receiving Palliative Radiotherapy Treated Within 14 Days

The number of patients scheduled to begin palliative radiotherapy treatment in January 2022 (60) was below the monthly average observed in 2020-21 (74), but exceeded the number scheduled to begin treatment in January 2021 (50).

Intent	Monthly Average (2019-20)	Monthly Average (2020-21)	Patients Scheduled to Begin Treatment (January 2022)
Palliative	82	74	80
	Patients Scheduled to Begin Treatment (January 2020)	Patients Scheduled to Begin Treatment (January 2021)	
	83	50	

80 patients referred for radiotherapy treatment with palliative intent were scheduled to begin treatment in January. Of this total, 8 patients did not begin treatment within the 14 day target constituting an overall performance rate of **90%.**

Additional staffing pressures due to sickness during January as a result of Omicron variant resulted in a reduction of the service. Impact on staffing is ongoing and has resulted in Breach data not being fully validated due to absence of key staff members.

Summary of delays:
The major contributor to the breach position is the requirement of 3D conformal plans and the overall lack of capacity.

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

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

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

Patients Receiving Emergency Radiotherapy Within 2-Days	
Target: 98%	**SLT Lead: Radiotherapy Services Manager**
Trend	Current Performance

Patients Receiving Emergency Radiotherapy Treated Within 2 Days

22 patients referred for emergency radiotherapy treatment were scheduled to begin treatment in January 2022. All of the patients begin radiotherapy treatment within 2 days of referral constituting an overall performance of **100%.**

Wider Actions as above for 21 and 14 day targets

The number of patients scheduled to begin emergency radiotherapy treatment in January 2022 (19) was lower than the monthly average observed in 2020-21 (27), but was marginally greater than the number scheduled to begin treatment in January 2021 (18).

Intent	Monthly Average (2019-20)	Monthly Average (2020-21)	Patients Scheduled to Begin Treatment (January 2022)
Emergency	25	27	22
	Patients Scheduled to Begin Treatment (January 2020)	Patients Scheduled to Begin Treatment (January 2021)	
	29	18	

Radiotherapy – Operational Context							
Latest Performance Consolidated							

Measure		Target	VCC Jan-22	SBUHB Dec-21	BCUHB Aug-21		The table shown here sets out the latest available performance of the 3 Wales centres relative to the Clinical Oncology Sub-Committee (COSC) stretch targets.
Scheduled (21-day target)	COSC	80%	34%	37%	52%		
Urgent (7-day target)	COSC	80%	37%	37%	34%		
Emergency (within 1-day)	COSC	100%	90%	100%	50%		

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

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

The table below describes the allocation of individual patients scheduled to begin treatment in terms of the new COSC definitions for January 2022

Scheduled (21 day target)	Urgent (7 day target)	Emergency (within 1 day)
168	57	18

Non-Emergency SACT Patients Treated Within 21-Days	
Target: 98%	**SLT Lead: Chief Pharmacist**
Current Performance	Trend

Non-Emergency SACT Patients Treated Within 21 Days

334 patients were referred for non-emergency SACT treatment scheduled to begin treatment in January. Of this total, 19 patients did not begin treatment within the 21 day target, constituting an overall performance rate of 94%.

Of the 19 patients who did not begin treatment within 21-days, 12 were treated within 28 days and all had begun treatment before day 42:

Treatment Intent	≤ 28 days	≤ 28 days	≤ 42 days
Non-emergency (21-day target)	12	6	2

A number of category 5 and 6 patients treatment, had been carried over from December 2021 and some of these contributed to the January breaches when treated. This was due to demand exceeding capacity in month where capacity was reduced by bank holidays.

The number of patients scheduled to begin non-emergency SACT treatment in January 2022 (334) was considerably larger than both the monthly average observed in 2020-21 (298) and was greater than the number scheduled to begin treatment in January 2021 (318).

Intent	Monthly Average (2019-20)	Monthly Average (2020-21)	Patients Scheduled to Begin Treatment (January 2022)
Non - emergency	328	298	
	Patients Scheduled to Begin Treatment (January 2020)	Patients Scheduled to Begin Treatment (January 2021)	361
	290	318	

Actions

- Additional capacity being secured from Rutherford cancer centre. April 2022 is the predicted commencement, however discussions have commenced to try and bring this forward.
- Streamlined management of non-SACT chair activity, e.g. simple injections are being moved out of unit to specific weekend clinics, creating extra capacity. March 2022.
- A task and finish group has been established to identify solutions to support the service in increasing capacity, productivity, sustainability. Commenced March 2022 and ongoing.

	• Discussions are being escalated to prioritise the Neville Hall provision, which is the medium term plan for increasing capacity. Next update April 2022

Emergency SACT Patients Treated Within 5-Days	
Target: 98%	**SLT Lead: Chief Pharmacist**
Current Performance	Trend

Emergency SACT Patients Treated Within 5 Days

The number of patients scheduled to begin emergency SACT treatment in January 2022 (5) was higher than the monthly average observed in 2020-21 (4).

Intent	Monthly Average (2019-20)	Monthly Average (2020-21)	Patients Scheduled to Begin Treatment (January 2022)
Emergency	4	4	5
	Patients Scheduled to Begin Treatment (January 2020)	Patients Scheduled to Begin Treatment (January 2021)	
	3	6	

Trend

5 patients referred for emergency SACT treatment were scheduled to begin treatment in January 2022. All patients began treatment within the 5-day target.

• Ring fencing of emergency chair capacity has allowed us to improve the compliance in this area. This took a number of months until the correct balance between ring fencing and chair utilisation was achieved.

Actions

• Continue to balance demand and ring fencing with capacity.

SACT – Operational Context

Current Performance Consolidated

Measure	Target	Jan-22
Non-emergency (21-day target)	98%	**94%**
Emergency (5-day target)	98%	**100%**

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

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

Referral Trends - Overall

Total New Patient Referrals by Month to January 2022
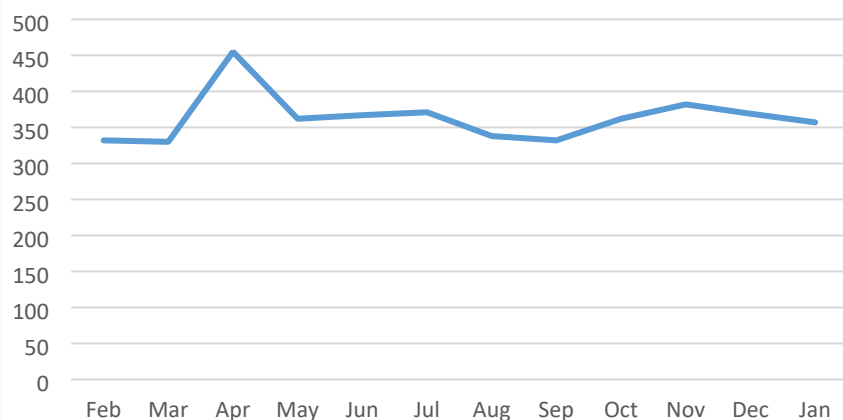
Monthly Average (2019-20)	Monthly Average (2020-21)	Total New Patient Referrals (January 2022)
325	301	357

The total number of referrals received in January 2022 (357) was above the average number received in any given month during 2020-21 (301) and marginally below the number received in December 2021 (369). The number of referrals received in January also exceeds the average number received per month in 2019-20.

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

Referral Trends - Tumour Site

New Patient Referrals by Tumour Site to January 2022

Legend: Breast, Colorectal, Lung, Gynae, Urological, Upper GI, Head & Neck
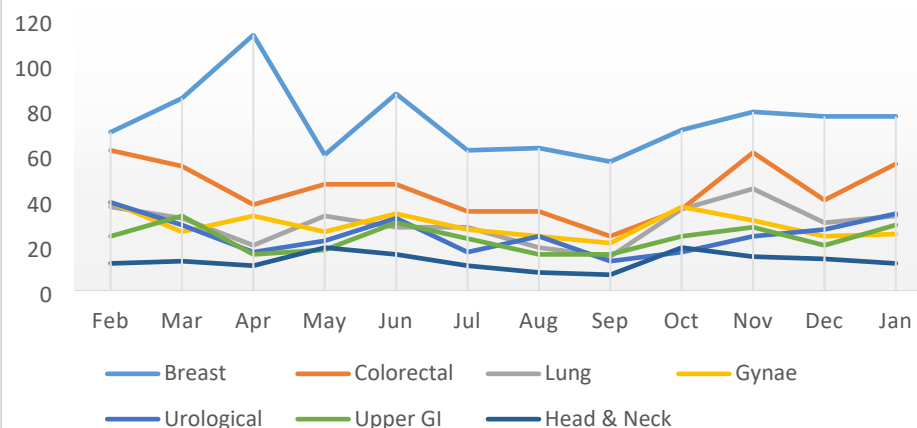
Site	Monthly Average (2019-20)	Monthly Average (2020-21)	2020-21 Average Relative to 2019-20 Average	New Patient Referrals (January 2022)
Breast	92	76	-17%	77
Colorectal	54	55	+2%	56
Lung	33	32	-3%	33
Gynaecological	31	31	0	25
Urological	36	26	-28%	34
Upper Gastrointestinal	18	26	+44%	29
Head and Neck	16	14	-12%	12
Top 7 Tumour Sites by Number of Referrals as Percentage of Total Referrals	86%	87%		75%

The graph and table show referrals for the tumour sites most commonly referred for SACT treatment.

SACT referrals are being driven by a high level of internal demand as a result of new/combination regimens, increasing patient treatment cycles etc.

Equitable and Timely Access to Services - Therapies

Target: 100%	SLT Lead: Head of Nursing

Current Performance

Percentage of Therapies Referrals (Inpatients) Seen Within 2 Working Days

	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
Dietetics	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Physiotherapy	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
OT	100%	100%	100%	100%	100%	100%	100%	100%	95%	100%	100%	100%
SLT	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

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

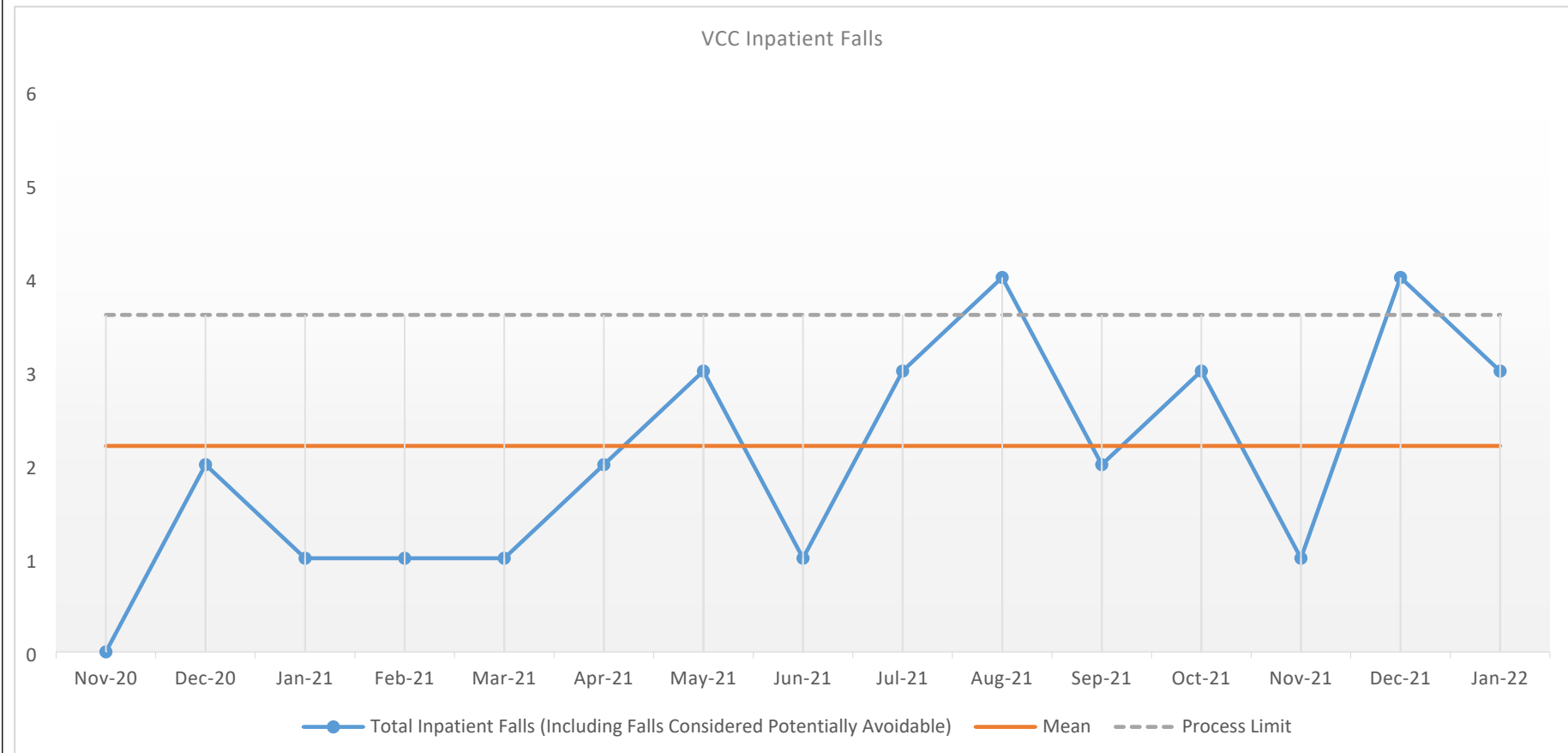|	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
Dietetics	100%	100%	100%	100%	84%	94%	94%	98%	97%	100%	95%	98%
Physiotherapy	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
OT	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
SLT	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Percentage of Routine Therapies (Outpatients) Seen Within 6 Weeks

	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
Dietetics	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Physiotherapy	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	86%
OT	100%	100%	100%	100%	100%	100%	96%	33%	78%	100%	100%	100%
SLT	100%	100%	100%	100%	100%	96%	100%	100%	96%	100%	100%	100%

In January, it was reported that 1 patient was not seen by a dietician within the two-week urgent outpatient referral target. This was due to a communication issue when the patient replied to the appointment offer, their e-mail was directed into a spam folder. The patient was seen on day 1 of the third week following referral. No harm to the patient was reported.	The process for checking incoming appointment confirmations to now include regular review of spam/junk folders.
It was reported that 2 patients were not seen by a physiotherapist within the six-week routine outpatient referral target. Both patients were referred to a scheduled physical activity programme which was delayed due to staff absence. No patient harm was reported.	Specialist services in a small team can result in challenges to cover absences. There is a limit to how much cover can be provided within existing resources.

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

Total Number of Velindre Acquired Pressure Ulcers

Legend: Velindre Acquired Pressure Ulcers (Total) — Mean — — — Process Limit
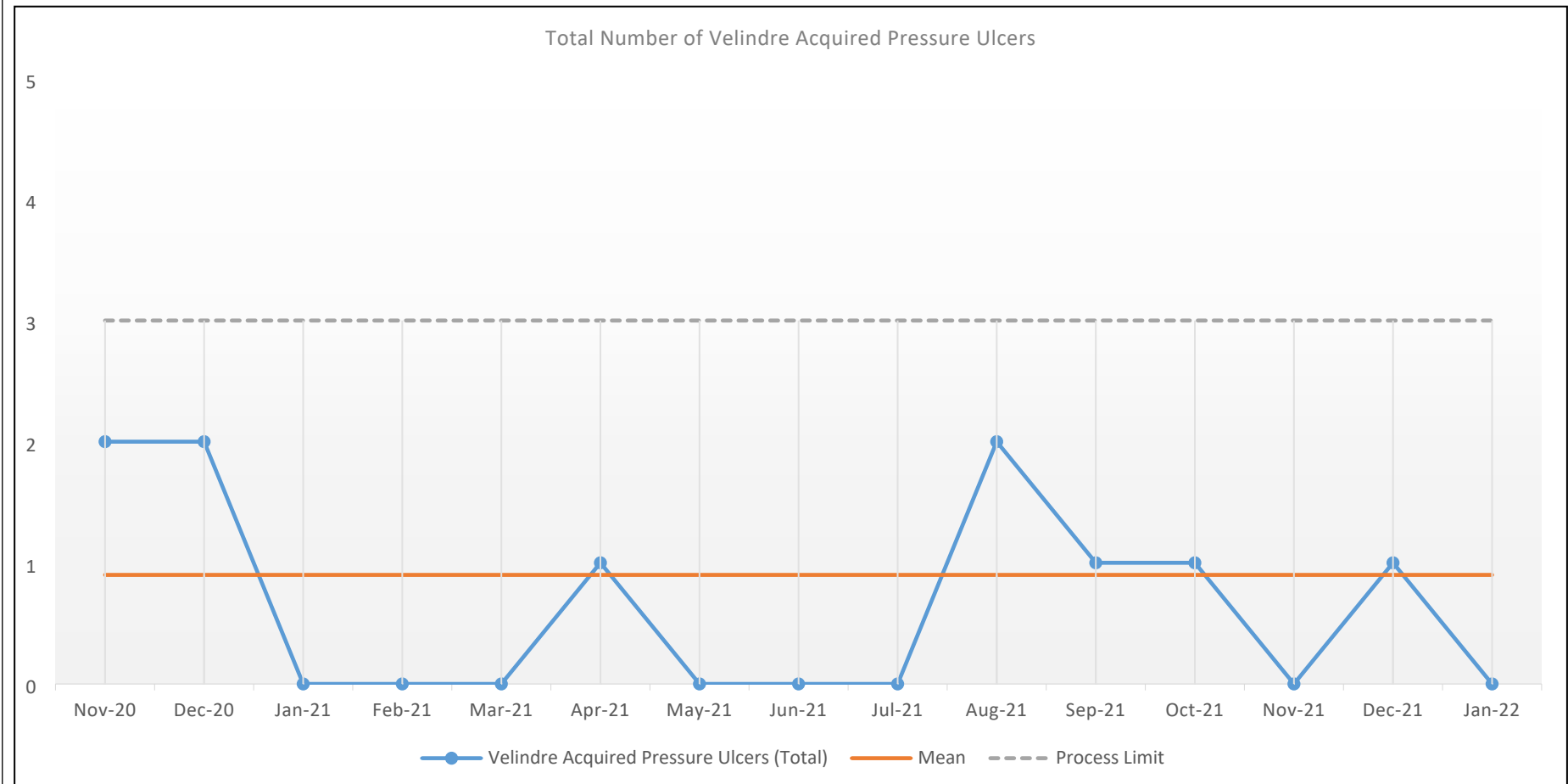
	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
Velindre Acquired Pressure Ulcers (Total)	2	2	0	0	0	1	0	0	0	2	1	1	0	1	0
Potentially Avoidable Velindre Acquired Pressure Ulcers	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0

Trend	Action
No Velindre acquired pressure ulcers were reported in January 2022 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	

VCC Inpatient Falls

Legend: Total Inpatient Falls (Including Falls Considered Potentially Avoidable) — Mean — Process Limit

	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
Total Inpatient Falls	0	2	1	1	1	2	3	1	3	4	2	3	1	4	3
Potentially Avoidable Inpatient Falls	0	0	0	0	0	1	0	0	0	0	1	0	0	0	1

Trend	Action
During January 2022, 3 falls was reported on first floor ward. Of these three falls, 1 was deemed to be avoidable. A full investigation was undertaken by the VCC Falls Scrutiny Panel. Following investigation, 1 fall was deemed to have been avoidable. In this case the patient tested positive for COVID-19 and, as per protocol, was moved to an isolation cubicle. The patient had been identified as being at risk of a fall. The COVID-19 protocol requires the door of the cubicle to be shut, resulting in a limit to the observation required under the falls assessment. The patient mobilised within the cubicle without assistance and fell.	Falls risk assessments were undertaken, on admission, in each case. • In each case, following the incident the falls pathway was completed and the patient reviewed by a medic. • In one instance, the patient suffered a minor abrasion, otherwise no harm was identified. • Patients who are cared for in an isolation cubicle will be subject to increased level of observation. A supervision policy will be developed to ensure the falls risk and the COVID-19 risks are both addressed.

Delayed Transfer of Care	
Target: 0	**SLT Lead: Head of Nursing**
Current Performance	

There was one delayed transfer of care reported in January 2022.

The patient was due to be discharged home. They required an NG tube, but refused to engage with respect to its care and there was no close family to support. The decision was taken to transfer to UHW, but no bed was available at the time. When the patient no longer required the NG tube, they were subsequently discharged to their own home with a revised care plan.

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

Current Performance

Proportion of Patients with a NEWS Score Greater Than or Equal to Three Who Received All Six Elements in Required Timeframe

Trend

Six patients met the criteria for administration of the sepsis treatment bundle in January 2022. All six 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

	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
C.diff	1	0	0	0	0	0	1	0	0	0	0	1
MRSA	0	0	0	0	0	0	0	0	0	0	0	0
MSSA	0	0	0	0	0	0	0	0	0	0	0	0
E.coli	0	0	0	0	0	0	0	0	0	0	0	0
Klebsiella	0	0	0	0	0	0	0	0	0	0	0	0
Pseudomonas Aeruginosa	0	0	0	0	0	0	0	0	0	0	0	0

Trend	Action
1 *C.diff* infection was reported in January 2022. This is the 2nd infection since April 21.	An investigation has been initiated and a full MDT discussion took place on the 7.3.22 where it was agreed that this could have been caused by either antibiotic usage and/or radiotherapy. It was deemed unavoidable. The patient had no previous history of C Diff. The patient fully recovered from the C Diff infection. There was no transmission to other patients in the ward environment.

- All hospital demand for red cells was met, and stock levels increased by 11.1%. 1450 units were issued on average per week.
- All clinical demand for platelets was met, with average demand at 195 units per week, slightly below the year average, and du e to low demand (158) week commencing 3rd January 2022.
- The number of new bone marrow volunteers added to the Welsh Bone Marrow Donor Registry (WBMDR) reached 206 in January compared to 177 the previous month. A communication and engagment action plan to improve performance going forward has been drafted.
- At 96%, the turnaround time for routine Antenatal tests in January remains above target but slightly lower than in December (98%).
- At 68% the Red Cell Testing metric is below target (80%). This is due to a number of contributory factors. An audit has been undertaken alongside benchmarking at a UK level, a plan to address this will be available in March 2022.
- At 0.95 collection productivity for January is the same as December. Covid and Infection Prevention Control (IPC) measures co ntinue to limit donation centre capacity. The service will be actively reviewing the socially distancing requirements with the Infection Prevention Control (IPC) team in the coming months as social distancing restrictions are reduced at a national leve l.
-The combined 'Part Bag' rate for all whole blood teams remains within the required tolerance at 2.3% in January. The overall trend on all teams is stable, however the increase in January part bag rates of the East A and East C teams is being reviewed to ensure no repeat issues
-The combined Failed Venepuncture (FVP) rate for all whole blood teams for January remains within the required tolerance at 1.3%, and is set against a previously upward trend in the previous 3 months.
- At 88% the performance against the 'Incidents closed within 30 days' measure did not meet target (90%) for the three month ro lling period to January. The number of incidents not closed within the required timeframe has increased to 13 in this reporting period. Four of these incidents remain under investigation and are categorised as low risk.
- There were no external audits, inspections undertaken or Serious Adverse Events (SAE) reported to regulators during January.
- The manufacturing efficiency performance exceeded the target (392) for January is 418.5. The increased efficiency performance for January is due to the increased number of donations processed as a result of additional collections clinics planned to boost stock levels.
- In January 2022, approximately 7,700 donors were registered at donation clinics. Six concerns (0.07%) were reported within th is period, five were managed within timeline as 'Early Resolution' with one formal concern being managed under 'Putting Things Right' (PTR) regulations.
- In January overall donor satisfaction continued to exceed target at 96.0%. In total there were 1,096 respondents, who had mad e a full donation, 168 were from North Wales and 872 were from South Wales.
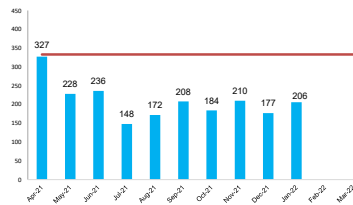
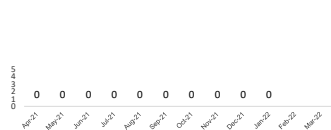| Measure	Target	Timeframe	National / Local
Number of new bone marrow donors aged 18-30 recruited to the Welsh Bone Marrow Donor Registry (WBMDR)	4,000	Annual	Local
Number of days when the Red Blood Cell (RBC) stockholding for O, A & B- fell below 3 days cover	0 days	Monthly	Local
Number of bags of RBCs 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

BMV Donors

Annual Target: 4000 (ave 333 per month)	SMT Lead: Jayne Davey / Tracey Rees	
What are the reasons for performance?	**Action (s) being taken to improve performance**	**By When**
The number of new bone marrow volunteers added to the Welsh Bone Marrow Donor Registry (WBMDR) reached 206 in January compared to 177 the previous month.

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

During Covid-19, appointment slots have been reduced to match hospital demand. The reduction has resulted in fewer available opportunities for new donors to donate. The current demand for blood is being sustained despite the decrease in new donors.

As new donors' blood type is unknown, reserving slots for new donors is not prudent as this will increase the number of unknown blood types bookings and decrease the efficiency of blood collection.

The ability to recruit new donors has also been complicated by the reduction of post-5pm donation slots and the pause on the majority of venues with high numbers of new donors (e.g. Universities). The feasibility of reintroducing universities | The Service is preparing a two-pronged approach: a) promoting swab kits and b) supporting the Service to increase the number of younger donors donating blood.

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

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

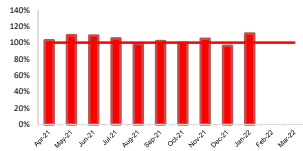Number of days red cell stock level is below 3 days for groups O, A & B-

Monthly Target: 0	SMT Lead: Jayne Davey / Tracey Rees	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
O, A and B+ groups continue to be maintained above 3 days.

Following a challenging Christmas period, the blood stocks position steadily improved during January.

The two main contributory factors for the January performance include; increased collections from staging additional weekend clinics, and reduced hospital demand due to the spread of the Omicron variant (SARS-Cov-2 virus). | The Welsh Blood Service constantly monitors the availability of blood for transfusion through its 'Resilience Group'. Meetings are held on a daily basis and include representatives from all departments supporting the 'blood supply chain' and include the Collections, Manufacturing, Distribution and Blood Health teams.

At the meetings business intelligence data is also reviewed and facilitates operational responses to the challenges identified at daily review meetings. Appropriate operational adjustments are then made in order to maintain adequate stock levels and minimise blood shortages. | Business as Usual, reviewed daily |
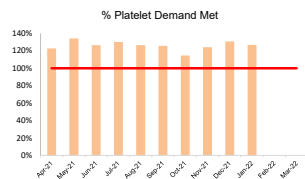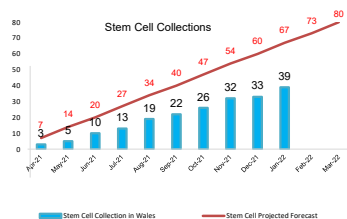
% Red Cell Demand Met

Monthly Target: 100%	SMT Lead: Jayne Davey/ Tracey Rees	
What are the reasons for performance?	**Actions(s) being taken to improve performance**	**By When**
All hospital demand for red cells was met.

The Collections reading reached 111.1% demand meaning stock levels increased by 11.1%

Factors continuing to affecting the supply chain include; Covid restrictions, winter pressures and staff absence.

Continued collaboration between the Collections and Laboratory teams continues to enable responses to variations of stock levels and service needs.

Demand in January (full weeks) averaged at 1450 units per week, in line with the | The Welsh Blood Service constantly monitors the availability of blood for transfusion through its 'Resilience Group'. Meetings are held on a daily basis and include representatives from all departments supporting the 'blood supply chain' and include the Collections, Manufacturing, Distribution and Blood Health teams.

At the meetings business intelligence data is also reviewed and facilitates operational responses to the challenges identified at daily review meetings. Appropriate operational adjustments are then made in order to maintain adequate stock levels and minimise blood shortages. | Business as Usual, reviewed daily |
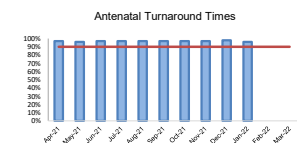
% Platelet Demand Met

Monthly Target: 100%	SMT Lead: Jayne Davey / Tracey Rees	
What are the reasons for performance?	Actions(s) being taken to improve performance	By When
All clinical demand for platelets was met. Platelets are being produced by two different methods: Donor Apheresis and Manufactured Pools from whole blood. In combination, they provide the total number of units available each month. Due to their short shelf life (7 days), platelet stocks are monitored on a daily basis to ensure adequate response time to any 'spikes' in demand. In January platelet demand averaged 195 units per week, slightly below the year to date average of 201. For the week commencing 3rd January demand was low, at 158 units which reduced the January average and contributed to the surplus.	The Ambient Overnight Hold (AONH) production process allows flexibility in the production plan for platelets. Adjustments on the weekly production continue to be made to align with demand.	Reviewed daily

Stem Cell Collections

Annual Target: 80 (ave 7 per month)	SMT Lead: Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
The pandemic has impacted on unrelated donor stem cell transplants globally, which has resulted the number of stem cell collection requests. In addition the Service is experiencing a cancellation rate of around 30% compared to 15% pre COVID pandemic levels whch is in line with the global trend. This is due to patient fitness and the need for collection centres to 'work up' two donors simultaneously, as a result of a reduction of selected donors able to donate at a critical point in patient treatment.	The move to the new Velindre Cancer Centre (VCC) has enabled WBS to offer more options for collections, moving to four day availability compared to two previously available at Nuffield. A five year strategy is being developed seeking to increase the Donor Panel and offer potential collaborations with other Donor registry partners. In addtion as part of the strategy the WBMDR is working closely with the WBS communications team to increase the number of donors recruited to the panel via blood donor sessions and swab recruitment. The service is doing this through social media, attendance at blood clinic via planned bespoke recruitment drives for swab only collection, and use of World Cancer Day (4th Feb) to promote swab donation and engage with Universities.	30/06/2022

Antenatal Turnaround Times

Monthly Target: 90%	SMT Lead: Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
At 96%, the turnaround time for routine Antenatal tests in January remains above the target of 90% Continued monitoring and active management remains in place.	Efficient and embedded testing systems in place. Continuation of existing processes are maintaining high performance against current target.	Business as Usual, reviewed daily

4

Reference Serology

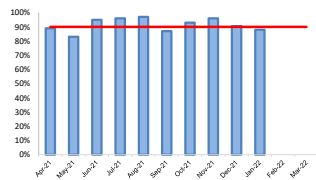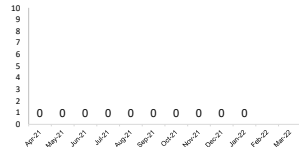| Monthly Target: 80%	SMT Lead: Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
Contributory factors to the January performance of this measure include; staff vacancies, sickness, Covid related absence, compensatory rest due to 'out of hours call out' (47% increase compared to 2021, Pre covid) and an increased training commitment due to the inability to recruit qualified staff.	The service conducts specialist tests to confirm hospital results that are difficult to interpret or will undertake additional testing which is not performed in the hospital blood banks. These tests must be performed within 7 days of the sample being taken and are prioritised appropriately to ensure the fastest turnaround possible. All referrals are prioritised based on clinical need and all Compatibility Testing (>52% of referrals) is completed to the required time/date. These requests are time critical and require provision of blood for transfusion, the tests are prioritised and patient care was not affected. There were 231 hospital patient referrals in January, with the average number of Hospital Patient referrals at 226/month for 2021, compared to 181 in 2020. The list below details the actions being taken to improve the performance against this measure: 1. Continued prioritisation of compatibility referrals and safe provision of red cells for transfusion. 2. Validation the new automated analyser and incorporation into routine use by the end of March 2022. 3. Development a new testing strategy for patient samples that are suitable for automated testing, due to complete by the end of March 2022. 4. A review of the WBS audit aimed to identify the appropriateness of 'out of hours' hospital referrals. The Clinical Team review of the Audit is expected by week beginning 7th March 2022 and implementation of any agreed actions by end of April 2022.	April 30th 2022

Quality Incidents closed within 30 days
(rolling 3 months)

Monthly Target: 90%	SMT Lead: Peter Richardson	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
The reason that incidents have not been completed on time is due to competing pressures of the Collections Management Team as a result of the ongoing 'Blue Alert'. The number of incidents not closed within the required timeframe has increased from ten in the previous three-month rolling period to thirteen in this reporting period. Five 'Datix' incidents two required collection of sensitive information in order to close, requiring a review of data collected over a number of weeks. There were seven 'Q-Pulse' events four of which indicated a trend in hospital issues, needing further time to investigate. Two events were due to errors outside of the control of WBS and required input from external organisations, and one event was an investigation of a trend in packing errors at donation clinics which required a review of clinical data and staffing rota. These incidents remain under investigation by the Clinical Governance team, and are categorised as low risk investigations which have been difficult to complete during the current extremely challenging operational environment.	The revised process for managing low-impact incidents was implemented on 1st June, new reports are reviewed and risk assessed daily and the majority of incidents are fully closed within a few days of reporting. The QA team to review incident management process to include weekly alerting of owners of incidents likely to breach time deadlines. Datix User Access and Reporting issues remain with the Datix Project Board for resolution.	Continue with close monitoring.

Critical Findings

What are the reasons for performance?	Action(s) being taken to improve performance	By When
There were no external audits or inspections undertaken during January.	Actions from previous MHRA inspections are being managed as business as usual via action plans. MHRA have been informed of delays to completion of three long-term actions and have accepted the rationale for delay and the revised timelines for completion. The three outstanding actions noted by MHRA all required IT or equipment upgrades, and the original timelines for the upgrades were based on the most optimistic assumptions. Two of the above actions have now been closed. The original proposed solution for the remaining action has proved difficult to achieve technically, and work is underway to find a simpler resolution. The revised timeline has been approved by the MHRA.	N/A

Incidents Reported to Regulator/Licensing
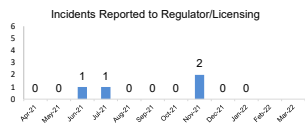
Annual Target: 0		SMT Lead: Peter Richardson	
What are the reasons for performance?		Action(s) being taken to improve performance	By When
There were no Serious Adverse Events (SAE) reported to regulators during January.		N/A	N/A

% Part Bags

- Total % Part Bags
- Other Part Bags
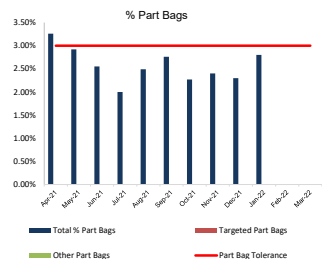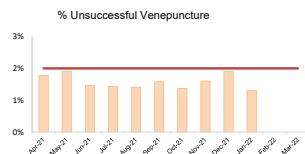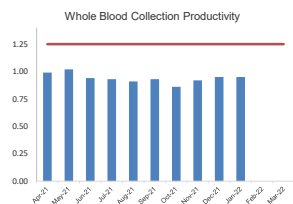- Targeted Part Bags
- Part Bag Tolerance

Monthly Target: Maximum 3%	SMT Lead: Janet Birchall	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
The combined 'Part Bag' rate for all whole blood teams remains within the required tolerance level at 2.8% in January 2022.

The overall trend on all teams is stable, however East A and East C teams have seen an increase in January with both teams being over tolerance at 3.3% and 3.4% respectively.

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 Failed Venepuncture (FVPs). | Analysis of venepuncturist performance on East A and C teams will be undertaken to ensure no repeat venepuncturist issues.

Operation Managers & the Training Team will be provided with the relevant information, and should it be required, further interventions (I.e. Individual Support Plans and or Additional Training /Supervision) can be actioned. | Continue with close monitoring and intervention where required |

% Unsuccessful Venepuncture

Monthly Target: Maximum 2%	SMT Lead: Janet Birchall	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
The combined Failed Venepuncture (FVP) rate for all whole blood teams for January 2022 remains within the required tolerance at 1.3%.   This reduced rate is set against a previously upward trend in the previous 3 months.

Wrexham is the only team to be over tolerance for this factor in January 2022. (2.6% - 19 FVP events). | A review of the Wrexham team venepuncturist performance will be undertaken to determine if there are any trends linked to individual venepuncturists.

Operation Managers & the Training Team will also be provided with the relevant information, and should it be required further interventions (I.e. Individual Support Plans and or Additional Training /Supervision) can be actioned. | Continue with close monitoring and intervention where required |
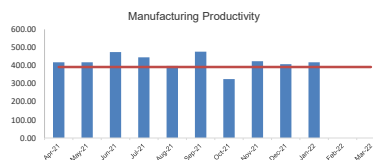
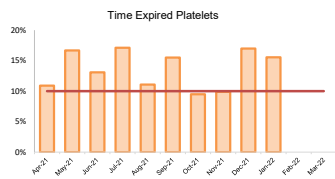| Monthly Target: 1.25	SMT Lead: Jayne Davey	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**

Whole Blood Collection Productivity

This target measures collection productivity by assessing the staffing levels against the collections made. Covid and Infection Prevention Control (IPC) measures continue to limit donation centre capacity. Donor sessions are operating on 2m distancing therefore impacting on a reduction of available donor slots in most venues. There are also regional variations in productivity across collection teams which the Service is reviewing, and in part is attributable to skill mix and regional team location.	Whilst the Service continues to operate under Covid conditions, it is extremely limited in being able to improve this performance which is based on a pre COVID operating model. The service will be actively reviewing the socially distancing requirements with the Infection Prevention Control (IPC) team in the coming months as social distancing restrictions are reduced at a national level.	Review end of Quarter 1 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**

Manufacturing Productivity

Increased productivity was observed in January. The manufacturing efficiency performance for January is due to the increased number of donations processed as a result of additional collections clinics planned to boost stock levels. The number of units manufactured is assessed against the staff resource for the month. At 418.50, figure reflects the increased laboratory activity which enabled the successful production of additional blood components.	This target measures the manufacturing productivity by assessing the staffing levels against the number of blood components being manufactured. As the Service continues to operate under Covid conditions, it is extremely limited in being able to improve this performance which is based on a pre COVID operating model. The service will be actively reviewing the socially distancing requirements with the Infection Prevention Control (IPC) team in the coming months as social distancing restrictions are reduced at a national level.	Quarter 1 2022

Time Expired Platelets (chart)

Monthly Target: Maximum 10%	SMT Lead: Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
Platelet expiry was above target for January, the two main reasons were: 1. Increased production at the end of December in preparation for the Christmas period and at the beginning of January to recover form the lower platelet position following Christmas and New Year holidays. 2. Reduction in platelet demand (at 158 units for week starting 3rd January, usually at approximately 200 units per week) which led to excess platelet wastage from that week. NB. The Platelet shelf life of 7 days is a contributing factor to fluctuations in platelet stocks as well as the requirement for to meet differing specifications such blood group, and other specialist requirements. This adds uncertainty to the system and requires robust stock numbers to also allow and absorb normal variations in clinical demand.	Platelets are being produced by two different methods: Donor Apheresis and Manufactured Pools from whole blood. In combination, the methods provide the total number of units available each month. The introduction of Ambient Overnight Hold process for the manufacturing of blood components has increased flexibility in production of pooled platelets. Daily communications between the Collections and Laboratory teams enables agile responses to variations of stock levels and service needs. Adjustments to the platelet manufacturing targets are made in the laboratory to better align with demand, and take into account the apheresis appointments and donor attendance. Although it should be noted that demand can fluctuate significantly on a daily basis. NB: All demand has been met without the requirement to import routine stock.	Ongoing and reviewed daily

Controllable Manufacturing Losses (chart)

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 January were extremely low at 0.03% and remain within tolerance to be below 0.5%. The losses were (units): Manufacturing & Distribution Operator - Blood Presses :2 units	Active management of the controllable losses in place, including vigilance and reporting of all units lost. Ongoing monitoring of losses when occurring in order to understand the reasons and consider appropriate preventative measures thus continuously improving practice through lessons learned and analysis.	Business as Usual, reviewed monthly

Time Expired Red Cell (chart)

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 January remains negligible at 0.05% and significantly lower than the 1% target. The Covid 19 challenges continue to affect the blood collection numbers resulting in faster stock turnover preventing red cells stocks from ageing in storage.	Daily monitoring of age of stock as part of the resilience meetings. Red Cell Shelf life is 35 days, with all blood stocks stored in Blood Group and Expiry Date order and issued accordingly. Continued effective management of blood stocks to minimise the number of wasted units.	Business as usual, reviewed daily

Donor Satisfactions

Scored 5_6 out of 6 SW Scored 5_6 out of 6 NW

Donor Satisfaction Target

Monthly Target: Minimum 71%	SMT Lead: Jayne Davey	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
In January overall donor satisfaction continued to exceed target at 96.0%. In total there were 1,096 respondents, who had made a full donation and shared their donation experience (some of which are non attributable), 168 were from North Wales and 872 were from South Wales (where location was able to be defined).	Findings are reported to management at the Collections team meeting for actioning by individual teams.	Business as usual, reviewed monthly

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Number of Concerns Received

Formal
Informal

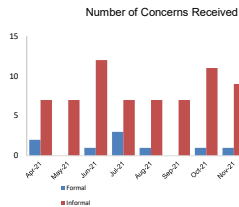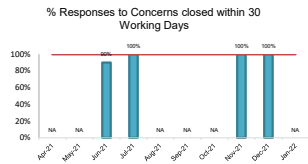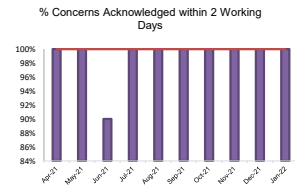| Target: N/A	SMT Lead: Alan Prosser	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
In January 2022, approximately 7,700 donors were registered at donation clinics. Six concerns (0.07%) were reported within this period, five were managed within timeline as 'Early Resolution' whilst the one formal concern was managed under 'Putting Things Right' (PTR) regulations. The formal concern was first managed as Early Resolution, then logged as a formal concern on 11/01/2022 as it was unable to be resolve to the concern within the 2 working day threshold. This is due to donor refusing to provide telephone number or digital means of contact with correspondence is issued via the post. This issue is logged as a 're-opened' concern and remains within PTR timeline. 1. Formal Concern - The donor does not wish to provide additional contact details such as email or phone number and is unhappy that he is regularly asked to do so. 2. The donor was concerned that donors are not provided with one to one attention during donation where possible. 3. The donor was unhappy that he was only able to provide a 'part bag' and was not offered the opportunity to provide the donation from the other arm. 4. The donor was unhappy that she was not accepted for donation at clinic following travel abroad following a previous conversation with DCC staff had deemed her eligible and an appointment made. 5. The donor was unhappy about being turned away at clinic because she attended with her baby and also complained of a lack of signage to session at UHW making the venue difficult to find. 6. The donor was frustrated that he was only able to provide a 'part bag' donation.	Actions taken to address concerns include; 1. A formal acknowledgement letter was issued to the donor within timescale. 2. Several attempts to invite the donor to contact WBS have been made in order to discuss the issue and to provide explanation of current model. At the time of writing there has been no reply received from donor. 3. Contact has been made with the donor to explain the reason for not agreeing to his request to donate from his other arm following a part bag donation. 4. At donation the donor declared that she had been unwell following travel abroad – this meant that the donor was ineligible to donate. A review of the collections booking telephone call confirmed that the discussion at collection was inconsistent to information provided by the Donor to the DCC when booking the appointment . The correct decision was made by DCCA and clinic staff at clinic, and the explanation was provided to donor. 5. The donor has been contacted to discuss their complaint. The WBS website does provide information regarding children attending clinics and the donor has since read this. Collections teams have reminded to ensure venue signage is clear, correct and visible. 6. The donor has been contacted and full discussion took place regarding his experience.	Business as usual, reviewed daily

First Class Donor Experience

% Responses to Concerns closed within 30 Working Days

Jan-22

Monthly Target: 100%	SMT Lead: Alan Prosser	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
During January 2022 one formal concern was received. This concern was acknowledged on time and is on target for closeout within PTR timeline.

* Under PTR, Organisations have 30 working days to address/ close formal concerns. This can result in concerns being received and subsequently closed within separate reporting periods. | Continue to monitor Formal complaint response progress, and 30 day target compliance. | Business as Usual, reviewed daily |

First Class Donor Experience

% Concerns Acknowledged within 2 Working Days

Jan-22

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 January 2022 were managed within timeline.	Continue to monitor initial complaint acknowledgement progress against the 'two working day' target compliance.	ongoing, reviewed daily

Workforce Monthly Report

January 2022

Workforce Report provides the following:

- Overview of Key Performance Indictors for Sickness, PADR, Statutory and Mandatory training in all Divisions of the Trust, including Corporate Divisions, TCS and Research and Development (excluding hosted);
- Corporate Divisions include Finance, Workforce and OD, Corporate Estates and Planning, Corporate IT, Clinical Governance, Infection Control, Fundraising and Trust Management and Board;
- The report provides a 12 monthly trend report for Sickness, PADR, Statutory and Mandatory training;
- Hotspots identified, with in month actions to explain improvement trajectory work. Hotspots defined as areas where KPIs are not met and there has been a downward trend over the last three months;
- In month Job Planning figures with narrative to notify areas of improvement;
- Usage of Work in Confidence platform.

At a Glance for Velindre (Excluding Hosted)

| Velindre (Excluding Hosted	Current Month	Previous Month	Target
	Jan-22	Dec-21	
PADR	69.21	70.83	85%
Sickness	5.66	5.58	3.54%
S&M Compliance	85.97	86.40	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	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
Corporate	39.83	41.74	43.44	45.00	49.58	47.01	48.33	50.43	45.69	46.58	44.59	45.64	44.08
Research, Development & Innovation	31.11	34.04	58.33	60.00	64.58	62.50	61.70	65.96	66.67	72.09	90.91	88.37	84.09
Transforming Cancer Services	80.00	64.29	60.00	66.67	68.75	71.43	66.67	60.00	56.25	43.75	62.50	75.00	63.16
Velindre Cancer Centre	78.68	77.53	79.78	81.07	78.88	76.52	74.31	75.17	76.40	73.77	70.90	67.61	65.16
Welsh Blood Service	67.97	73.19	77.25	78.65	82.41	81.74	79.78	78.27	77.93	77.52	82.19	83.06	83.73
Velindre Organisations	70.19	71.32	74.64	76.07	76.77	75.09	73.28	73.58	73.67	71.69	72.11	70.83	69.21
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)	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
Corporate	71.61	70.62	69.47	69.06	70.08	69.08	69.26	70.45	71.36	74.54	72.32	74.40	72.17
Research, Development & Innovation	77.45	82.50	83.73	82.59	83.08	85.69	86.00	85.80	86.25	84.89	84.58	85.83	84.26
Transforming Cancer Services	71.18	69.38	64.12	65.29	70.00	76.00	76.84	85.26	82.50	82.86	83.33	81.43	77.86
Velindre Cancer Centre	80.69	81.53	81.57	80.98	81.77	82.45	82.70	83.16	82.89	83.11	84.91	84.93	84.73
Welsh Blood Service	90.43	89.54	90.90	90.43	92.23	92.39	93.38	92.66	92.21	92.54	93.36	93.56	93.78
Velindre Organisations	82.81	83.06	83.39	82.92	84.09	84.59	84.97	85.24	84.95	85.10	86.06	86.40	85.97

Key	0% - 3.54%		3.55% - 4.49%		4.5 % & Above								

Sickness Rolling %	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
Corporate	5.24	5.13	4.84	4.53	4.50	4.42	4.31	4.11	4.13	4.18	4.41	4.67	4.73
Research, Development & Innovation	4.37	4.23	4.01	3.73	3.46	3.16	3.34	3.55	3.96	4.29	4.41	4.31	4.49
Transforming Cancer Services	2.41	2.41	2.01	1.34	0.88	0.41	0.32	0.33	0.40	0.86	1.27	0.99	0.95
Velindre Cancer Centre	5.88	5.97	5.77	5.40	5.58	5.41	5.47	5.47	5.52	5.58	5.65	5.55	5.58
Welsh Blood Service	4.44	4.38	4.24	4.19	4.37	4.58	4.82	5.11	5.42	5.72	5.98	6.26	6.45
Velindre Organisations	5.28	5.29	5.10	4.94	4.85	4.91	5.01	5.09	5.24	5.39	5.53	5.58	5.66
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	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
Corporate	0.55	0.60	0.58	0.53	0.58	0.63	0.67	0.78	0.90	0.97	1.02	1.04	1.06
Research, Development & Innovation	0.45	0.46	0.42	0.35	0.44	0.45	0.45	0.43	0.43	0.43	0.42	0.37	0.40
Transforming Cancer Services	0.26	0.26	0.21	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Velindre Cancer Centre	1.29	1.44	1.31	0.96	0.80	0.86	0.87	0.88	0.85	0.87	0.85	0.74	0.78
Welsh Blood Service	0.42	0.44	0.39	0.31	0.29	0.28	0.29	0.29	0.36	0.39	0.38	0.36	0.39
Velindre Organisations	0.96	1.00	0.91	0.68	0.65	0.63	0.64	0.66	0.68	0.70	0.69	0.62	0.66

Monthly Special Leave Absence Rolling %	0%		0.01% - 0.49%		0.50 % & Above								
Special Leave Non Covid Related	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
Corporate	0.30	0.23	0.17	0.11	0.05	0.04	0.06	0.05	0.03	0.09	0.09	0.09	0.08
Research, Development & Innovation	0.74	0.65	0.50	0.46	0.42	0.51	0.60	0.74	0.92	1.08	1.24	1.38	1.54
Transforming Cancer Services	0.51	0.51	0.51	0.51	0.51	0.51	0.53	0.56	0.55	0.54	0.40	0.24	0.07
Velindre Cancer Centre	0.42	0.43	0.43	0.41	0.41	0.42	0.44	0.47	0.49	0.54	0.57	0.65	0.73
Welsh Blood Service	0.63	0.61	0.62	0.58	0.59	0.58	0.60	0.61	0.63	0.65	0.64	0.62	0.58
Velindre Organisations	0.49	0.48	0.47	0.44	0.43	0.44	0.46	0.48	0.51	0.55	0.57	0.60	0.63

Monthly Special Leave Absence Rolling %	0%		0.01% - 0.49%		0.50 % & Above								
Special Leave Covid Related	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
Corporate	0.58	0.57	0.48	0.32	0.25	0.18	0.11	0.03	0.01	0.00	0.00	0.00	0.00
Research, Development & Innovation	1.98	1.95	1.45	1.04	0.76	0.49	0.21	0.13	0.13	0.15	0.10	0.15	0.27
Transforming Cancer Services	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Velindre Cancer Centre	2.27	2.36	2.13	1.71	1.40	1.16	0.99	0.88	0.88	0.89	0.84	0.82	0.92
Welsh Blood Service	1.71	1.75	1.65	1.31	1.08	0.82	0.68	0.62	0.67	0.67	0.68	0.65	0.62
Velindre Organisations	1.90	1.96	1.77	1.41	1.15	0.92	0.77	0.68	0.69	0.70	0.66	0.65	0.70

PADR – The Figures

PADR Status - last 12 Months by Division
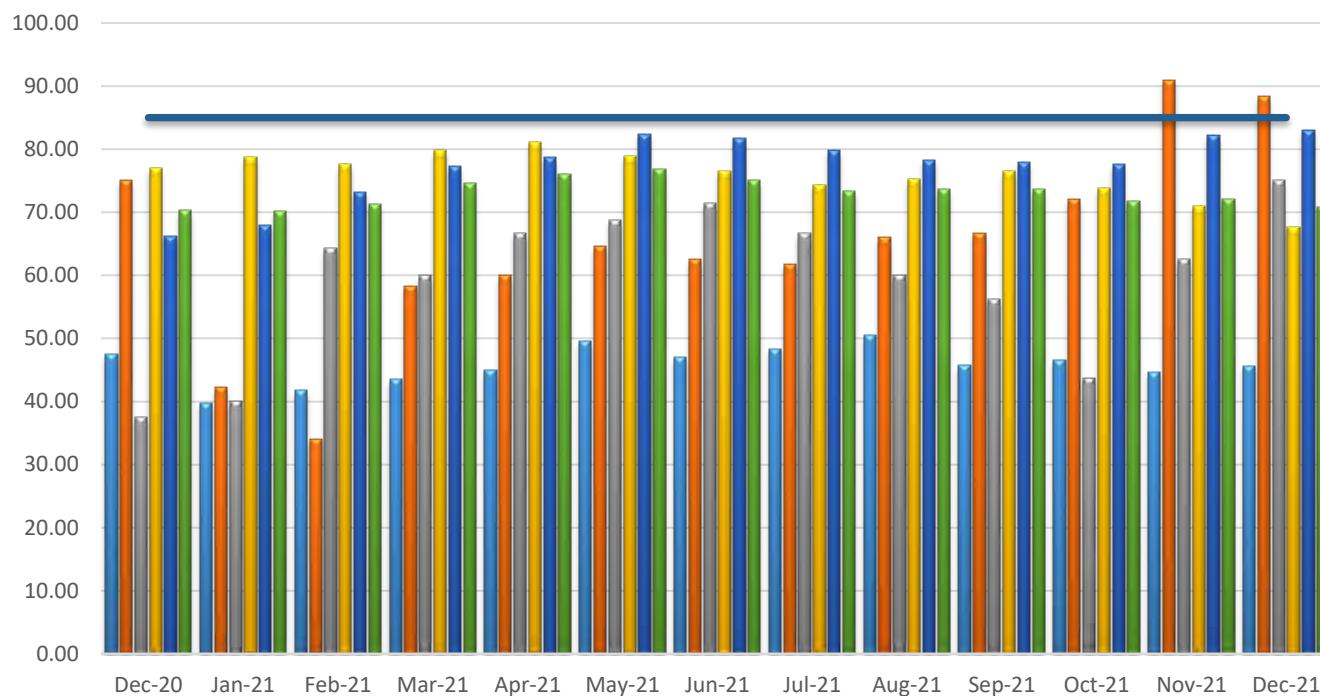
	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Corporate	47.46	39.82	41.74	43.44	45.00	49.58	47.01	48.33	50.43	45.69	46.58	44.59	45.64
Research, Development & Innovation	75.00	42.22	34.04	58.33	60.00	64.58	62.50	61.70	65.96	66.67	72.09	90.91	88.37
Transforming Cancer Services	37.50	40.00	64.29	60.00	66.67	68.75	71.43	66.67	60.00	56.25	43.75	62.50	75.00
Velindre Cancer Centre	76.98	78.68	77.53	79.78	81.07	78.88	76.52	74.31	75.17	76.40	73.77	70.90	67.61
Welsh Blood Service	66.18	67.97	73.19	77.25	78.65	82.41	81.74	79.78	78.27	77.93	77.52	82.19	83.06
Velindre Organisations	70.32	70.19	71.32	74.64	76.07	76.77	75.09	73.28	73.58	73.67	71.69	72.11	70.83
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85

PADR – The Narrative

Performance Indicator	RAG / change from previous month	December Figure	Hotspot Areas	%	Comment to include reasons for change / rates high or low
PADR Compliance (85%)	**69.21%** ⬇	70.83%	**Welsh Blood Service (83.73%)**		
			Collections	82.99%	Continued improvement and increase on last month's figures of 80.90%
			Clinical Services	68.18%	Decrease from Dec 21 (80.95%) no identified reason for the decline.
			Quality Assurance	76.74%	Increase from 71.79 % in Dec 21.
			Velindre Cancer Centre (65.02%)		
			Medical Staffing	47.27%	Decrease on previous month 48.15% however, it must be noted that the 'approved missed appraisal' status continues until April 2022 for all medical staff.
			Radiotherapy	44.44%	Decrease from 50% in December
			Cancer Services Management Office	34.48%	No change on previous month
			Nuclear Medicine	83.33%	Significant improvement on previous month (16.67%) following targeted action in the department.
			Corporate Areas (63.78%)		
			Clinical Governance	12.5%	Same as previous month. No identified reason for low compliance
			Fundraising	14.29%	Inability to complete due to long-term sickness and complex ER cases ongoing in the department.
			WOD	26.32%	Increase on previous month of 17.65%. Due to significant turnover within the department and appointment of new employees in the past 12

					months. Action plan in place to complete by March 2022.

Action/initiatives:

Velindre University NHS Trust

Despite a steady rise in PADR for most of 2021 (*Jan – Nov average 73.49%*) the figure has dropped to below 70% for the first time in the past 12 months. This is due in part to the winter pressures experience through the rising omicron situation in December 2021 and January 2022.

There is considerable work being undertaken across the Trust to look at performance reporting and how we best explore the data available to us to provide an accurate picture of the workforce and any targeted intervention that is required. A new Workforce and OD discussion template is in draft for the team to explore the 6 Trust people goals with managers through the business partnering model on:

1. Wellbeing
2. Shape and Supply
3. Education and Learning
4. Attraction and Retention
5. Digital Ready Workforce
6. Leadership and Succession

The plan is that this new way of discussing performance with the divisions will enable us to collate more qualitative data and provide support in the areas where this is most needed whit a more intergrated and collaborative way of working in the divisions

Welsh Blood Service

Overall WBS has seen a significant rise in PADR compliance since this time last year (Jan 21, 67.97%). Discussions continue at every SLT to stress the importance of PADR compliance.

Workforce Operational Team continue to highlight PADR compliance in regular meetings with managers.

VCC

Workforce Operational Team continue to highlight PADR compliance in regular meetings with managers.

Corporate Areas (including RD&T, HTW & TCS)

All areas are below target this month. Significant work is needed to improve compliance, this will be taken forward following the appointment of the WOD Business Partner for Corporate Areas.

Sickness Data – The Figures

Sickness - Last 12 Months by Division
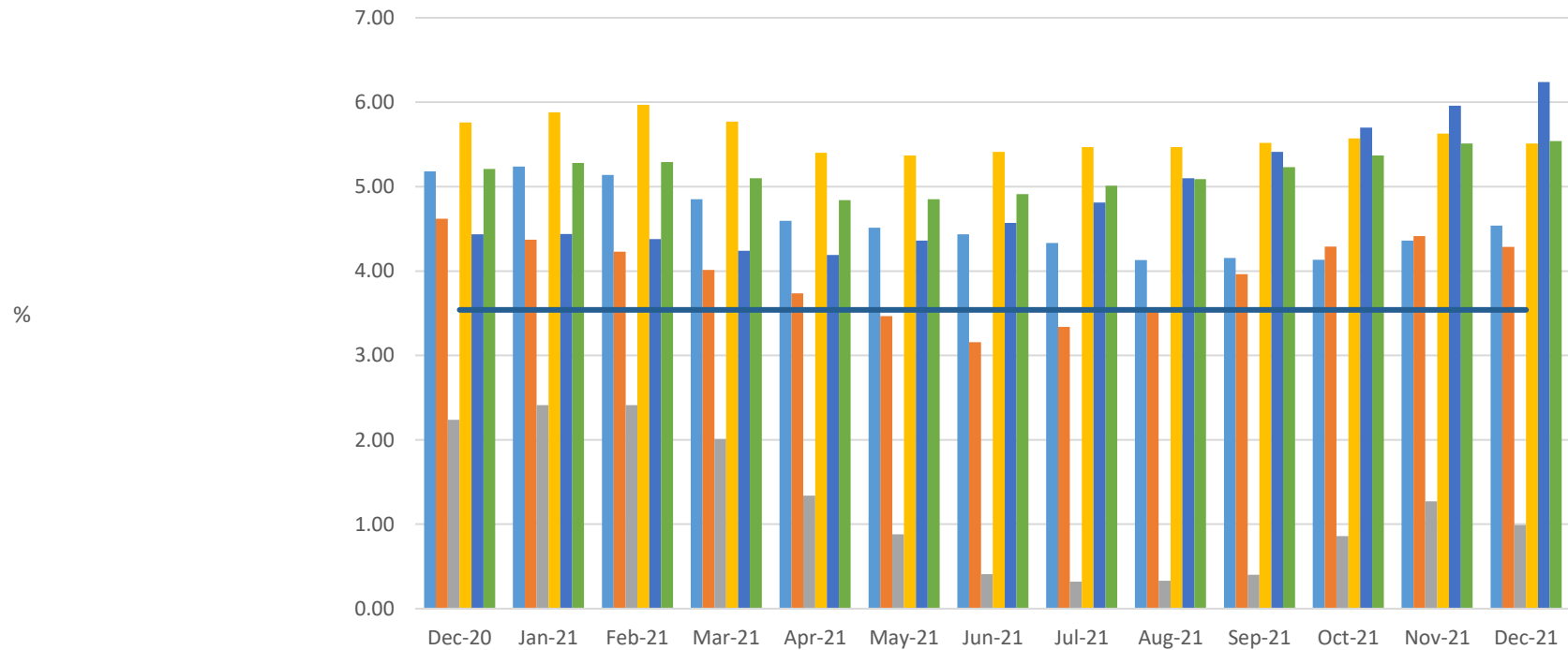
	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Corporate	5.18	5.24	5.14	4.85	4.59	4.51	4.44	4.33	4.13	4.15	4.13	4.36	4.54
Research, Development & Innovation	4.62	4.37	4.23	4.01	3.73	3.46	3.16	3.34	3.55	3.96	4.29	4.41	4.29
Transforming Cancer Services	2.24	2.41	2.41	2.01	1.34	0.88	0.41	0.32	0.33	0.40	0.86	1.27	0.99
Velindre Cancer Centre	5.76	5.88	5.97	5.77	5.40	5.37	5.41	5.47	5.47	5.52	5.57	5.63	5.51
Welsh Blood Service	4.43	4.44	4.38	4.24	4.19	4.36	4.57	4.81	5.10	5.41	5.70	5.96	6.24
Velindre Organisations	5.21	5.28	5.29	5.10	4.84	4.85	4.91	5.01	5.09	5.23	5.37	5.51	5.54
Target 3.54%	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54

7

Sickness – The Narrative

Performance Indicator	RAG/ Change from previous month	August Figure	Hotspot	%	Comment to include reasons for change / rates high or low
Sickness absence (3.42%)	**5.66%** ↑	5.58%	**Welsh Blood Service (6.94%)**		
			Collection Services	8.5%	Decrease on previous month 12.28%
			Laboratory Services	7.31%	Increase on previous month 7.31%
			Quality Assurance	9.02%	Decrease on previous month 10.72%
			Velindre Cancer Centre (6.33%)		
			Nuclear Medicine	11.66%	New hotspot (previous figure 0%) As a small team 1 absence can cause significant rise in absence %
			Outpatients	13.10%	Outpatients continue to manage the LTS cases with support of operational WOD team. Decreased to 2 cases. Short-term sickness is rising with 12 occurrences in Jan 22.
			Operational Services	8.44%	Decease on previous month 10.92%
			Corporate Areas (3.39%)		
			Corporate Management Section	7.44%	Decrease from previous month 10.31%
			Fundraising	16.3%	Decrease on last month 26.52%. Continued targeted intervention from WOD for management facilitate returns.
			TCS	0.95%	TCS has continuously reported below target for the 12 month with an average sickness absence of 1.12%
Action/ initiatives: **Velindre University NHS Trust**					

Over the 12 month period sickness absence remains relatively stable across the Trust with an average rate of between 5.1 and 5.3%

In comparison of Jan 21 (5.28%) and Jan 22 there has been a slight rise in sickness absence of 0.38%

A significant impactor on sickness absence has been the ability to support through occupational health services over the past year due to pressures experiences within our partner organisations. The wait time in January for an appointment was between 4 and 12 weeks. We have now began regular business meetings to target the areas of concern with our providing health boards and interim appointments for urgent cases are being progressed through a private OH provider.

WBS

Long-term sickness absence has decreased in January to 4.71%, short term sickness absence has also decreased to 2.23%. There is a continuing downward trend for long-term sickness absence although it is still tracking at least 2% higher than compared with a year ago.

Stress Related absence continues to be the highest reason for absence at 30.5% of all absences over the last 12 months, followed again by back problems at a decreasing figure of 8.3%.

VCC

Short-term sickness, despite being relatively low across the division on average continues to rise this month, reporting at 3.18%.

Corporate Areas (including RD&T, HTW & TCS)

Huge strides are being made in bringing down sickness absence. This is demonstrating the effectiveness of the management support being offered by the HR Operational Team.

Statutory and Mandatory Figures – The Figures

Statatory & Mandatory Compliance (10x CSTF) last 12 months by Division

	Corporate	Research, Development & Innovation	Transforming Cancer Services	Velindre Cancer Centre	Welsh Blood Service	Velindre Organisations
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
Dec-21	74.40	85.83	81.43	84.93	93.56	86.40

Statutory and Mandatory Figures – The Narrative

Performance Indicator	RAG/ Change from previous month	August Figure	Hotspot		%	Comment to include reasons for change / rates high or low
Stat & Mand Training (85%)	**85.97%** ↑	86.40%	**Welsh Blood Service (93.78%)**			
			All areas above 90% compliance			
			Velindre Cancer Centre (84.73%)			
			Palliative/Chronic Pain		61.30%	Increase on previous month 60.46% The department continue to improve and have increased significantly from 55.41% in September 21
			Medical Staffing		60.76%	Decrease on previous month 62.46%
			Cancer Services Management Office		74.71%	Increase on previous month 73.94%
			Corporate Areas (78.10%)			
			Trust Board		20.00%	Decrease on previous month (22.5%)
			Fundraising		48.57%	Marginal increase from 48.33%. Department inability to complete due to long-term sickness and complex ER cases ongoing in the department.
Action/ initiatives: **Velindre University NHS Trust**						

Statutory and Mandatory compliance has reported over target for 4 consecutive months within the Trust despite the restrictions on face to face training. Through the COVID pandemic the education and training department have worked on the virtual offering and continue to develop this alongside divisions.

WBS

To continue to maintain target compliance across WBS.

VCC

VCC continues to improve with targeted intervention and support from WOD. Overall increase in compliance of 4.04% since Jan 21.

Corporate Areas (including RD&T, HTW & TCS)

Continued increase overall of compliance in corporate services however additional support will be considered following the appointment of the corporate WOD Senior Business Partner.

Job Planning Figures – VCC & WBS combined

Combined							
Role	**Assignments**	**With Expired Plan**	**% With Expired Plan**	**With Unsigned Plan**	**% With Unsigned Plan**	**With Current Plan**	**% With Current Plan**
Consultant	63	25	39.68%	13	20.63%	25	39.68%
Medical Director	2	0	0.00%	0	0.00%	2	100.00%
Specialty Doctor	13	12	92.31%	0	0.00%	1	7.69%
Grand Total	**78**	**37**	**47.44%**	**13**	**16.67%**	**28**	**35.90%**

NB

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

WBS

Schedule outstanding job plan for 1 consultant.

VCC

All areas in VCC continue to book in job plans:

Oncology: 1 outstanding (CD requires scheduling)
Radiology: 3 outstanding (scheduled March 2022)
Palliative Care: 8 outstanding, (1 scheduled March 2022)

Remaining expired plans are due to new starters (less than 6 months), long-term sickness and maternity leave. These will be planned for the return of the individuals or when the new starters reach the point of needing a job plan.

Work needs to be undertaken as part of the implementation of the new SAS contract for specialty doctor job plans.

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.

Radiotherapy Validated Breach data January 2022

Emergency – 0 breaches on validation

Palliative (14 day target) - 8 breaches on validation -

Number of patients	Patients commenced treatment on day	Breach reason	Contributory factors
1	15	Planning pathway	3D palliative plan required
1	16	Planning pathway	3D palliative plan required
1	16	Booking process	Patient booked in to palliative planning clinic- next available appointment
1	18	Planning pathway	3D palliative plan required
2	19	Planning pathway	3D palliative plan required
1	19	Mould- room capacity (specialist services)-	Capacity reduced as a result of increased staff absence Covid Isolation
1	20	Planning pathway	3D palliative plan required

Radical (28 day target) - 13 breaches on validation -

Number of patients	Patients commenced treatment on day	Breach reason	Contributory factors
1	29	Re-plan required	Change in dose requested on day 27-insfficient time to re-plan
1	31	Physics planning capacity	Increased demand –prioritisation process implemented to reduce clinical impact
1	34	Process failure	Planning process not followed – start date not transferred in to CASS (planning system)
1	34	Linac Capacity	Treatment protocol required treatment 2 x daily
1	35	Linac Capacity	Specialist Stereotactic service
1	37	KiloVoltage Capacity	Specialist Skin service
2	49	KiloVoltage Capacity	Specialist Skin service
1	49	Linac Capacity	Capacity reduced as a result of increased staff absence Covid Isolation
1	51	Linac Capacity	Original start date to commence on day 30, further delayed due to rescan and re-plan required
1	61	Process failure	Delay in delineation- unable to plan within agreed timeframe
1	76	Brachytherapy Capacity	Specialist Brachytherapy service

| 1 | 83 | Capacity | SPACER insertion required in advance of commencing treatment |

Radiotherapy referrals to Rutherford Cancer Centre (RCC)

- Pilot breast patient commenced in July 21

- Pilot prostate patient referred to RCC started treatment 9/8/2021

- Outsourcing breast and prostate patients to RCC commenced Sept 2021 following successful completion of pilot.

- RCC capacity plan : up to 4/week till Nov. up to 6/week till Jan. Now up to 10 /week no more than 50% prostate

- Total of 61 patient have been referred to RCC (46 breast & 15 prostate) from the commencement of the pilot to 31/1/22.

Referrals to RCC July 2021- Jan 2022

Prostate ■   Breast ■

28/03/2022
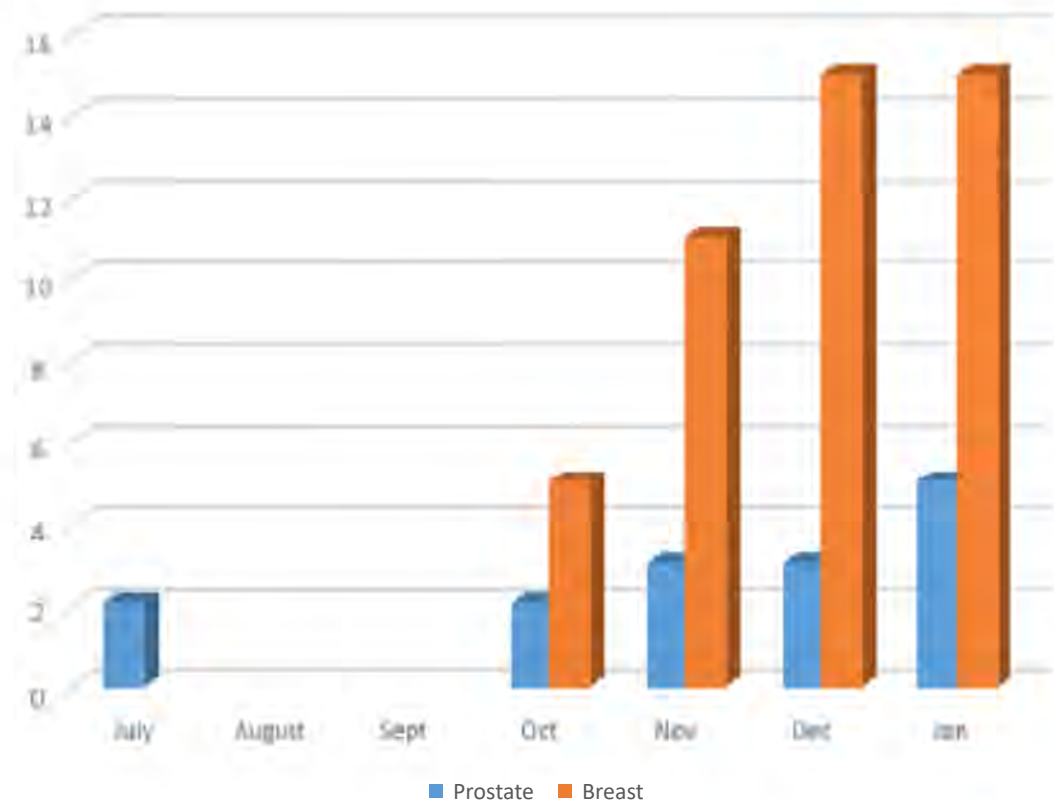
Radiotherapy referrals to Rutherford Cancer Centre (RCC)

- Referral criteria set in accordance with RCC constraints.

- 46 patients have been referred to RCC for radiotherapy to the breast.

- 15 patients have been referred to RCC for radiotherapy to the prostate.

Radiotherapy referrals to Rutherford Cancer Centre (RCC)

Continued developments:

- VCC are working with RCC to maximise referrals - to enable referral from all VCC entitled referrers under IR(ME)R

- VCC are working with RCC to maximise referrals – by expanding the staff groups who are accepted by RCC as able to consent patients for radiotherapy

TRUST BOARD

FINANCE REPORT FOR THE PERIOD ENDED **28 FEBRUARY 2022 (M11)**

DATE OF MEETING	31 March 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Steve Coliandris, Financial Planning & Reporting Manager
PRESENTED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR NOTING

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

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

1. SITUATION/BACKGROUND

1.1 The attached report outlines the financial position and performance for the period to the end of February 2022.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Performance against Key Financial Targets:

	Unit	Current Month £000	Year to date £000	Year End Forecast £000
Revenue	Variance	2	5	0
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	1,219	6,198	10,650
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	93.7%	94.6%	95.0%
Efficiency / Savings	Variance	0	0	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 February is an underspend of **£5k**, with a pay underspend offsetting a non-pay overspend and Income under achievement.

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 now forecasting to overachieve against the savings target during 2021-22 which is due to increased vacancy factor which is above the target that is held within the divisions which will be used to fund the costs associated with the Annual Leave Sell Back Scheme.

There remains £200k of schemes relating to post Covid savings that are RAG rated as amber. Although these savings are being partly generated, they have been replaced with non-recurrent vacancy factor savings whilst we are in the pandemic as the cost reductions are being offset against the additional costs of Covid as required by WG for Covid funding.

The Trust has received or been allocated funding from WG for all Covid related expenditure relating to 2021-22.

The Trust is therefore reporting a year end forecast breakeven position.

2.3   PSPP Performance

PSSP performance for the whole Trust is currently 95.4% against a target of 95%, however the performance against the Core Trust excluding NWSSP is presently falling just short of the target at 94.7%.

PSPP compliance levels had significantly recovered following a temporary dip in performance, however since December performance levels have again fallen. Following investigation, it appears to be largely the result of reduced levels of receipting on orders which is most likely due to the high levels of sickness which currently being experienced throughout the Trust. Finance have been working with service colleagues to put measures in place to help rectify this issue.

The finance teams continue to work with the service and NWSSP colleagues with a view to improve performance and ensure the overall target for the Trust is met for this financial year.

2.4   Covid Expenditure

Covid-19 Revenue Spend/ Funding				
	YTD Actual £000	Forecast Spend 2021/22 £000	Funding Received/ Allocated £000	Variance to Funding allocated £000
Mass & Booster Covid Vaccination	369	392	392	0
Cleaning Standards	716	771	769	2
PPE	161	195	226	(31)
Covid Recovery	2,645	3,222	3,479	(257)
Other Covid Related Spend & Cost Reduction	1,013	1,560	1,274	286
BFWD Savings Loss	638	700	700	0
Return of Bonus Payment (over allocated)	(83)	(83)	(83)	0
Annual Leave Sell Back Scheme	0	187	187	0
Total Covid Spend /Funding Requirement 2021/22	**5,459**	**6,944**	**6,944**	**0**

The overall gross funding requirement related to Covid is 6,944k 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, the return of surplus NHS bonus payment £(83)k, and the costs associated with the Annual leave sell back scheme £187k.

The Trust has now received or been allocated the full funding requirement from WG in relation to Covid.

2.5   Reserves

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

2.5.1   Recurrent Reserves (budget unallocated):

The forecast remaining balance expected on the recurrent reserves as at 31 March is £769k which is a result of further slippage against investment decisions during 2021-22, **however this funding has now been committed into future years so is not available for further investment.**

2.5.2 Non Recurrent Reserves (budget unallocated):

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.

The anticipated slippage against the £1.5m that was previously made available for investment is currently expected to be circa £550k 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 for further slippage before the financial year end.

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 cannot be mitigated the Emergency Reserves will be utilised.

2.7   Capital

a) All Wales Programme

The Capital Programme is representing an underspend for the period year to date which is a combination of procurement capacity constraints, impact of pandemic on supplier lead times and current market conditions where costs have significantly increased over the last couple of months. Despite the challenges performance against the current agreed All Wales Programme budget allocations are at this stage expected to deliver albeit with a small underspend which with agreement from WG will be utilised from the Trust discretionary allocation.

Other Major Schemes in development that will be considered during the remainder of 2021/22 and in 2022/23 in conjunction with WG include, Integrated Radiotherapy Solution (IRS), WBS HQ, VCC Ventilation & Infrastructure/ Outpatients, and WBS Plasma fractionation (for medicines).

b) Discretionary Programme

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

The year-end forecast outturn is currently expected to be managed to a breakeven position including utilization of the All Wales Capital slippage, with any further movement 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 February 2022 is an underspend of £5k with a year-end forecast break-even position in accordance with the approved IMTP

4.   RECOMMENDATION

4.1   Trust Board is asked to **NOTE** the contents of the February 2022 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 FEBRUARY 2021/22

TRUST BOARD
31/03/2022

1. Introduction

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

2. Background / Context

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

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

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

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

- **To reduce the underlying deficit, the savings target set for 2021-22 must be achieved.**
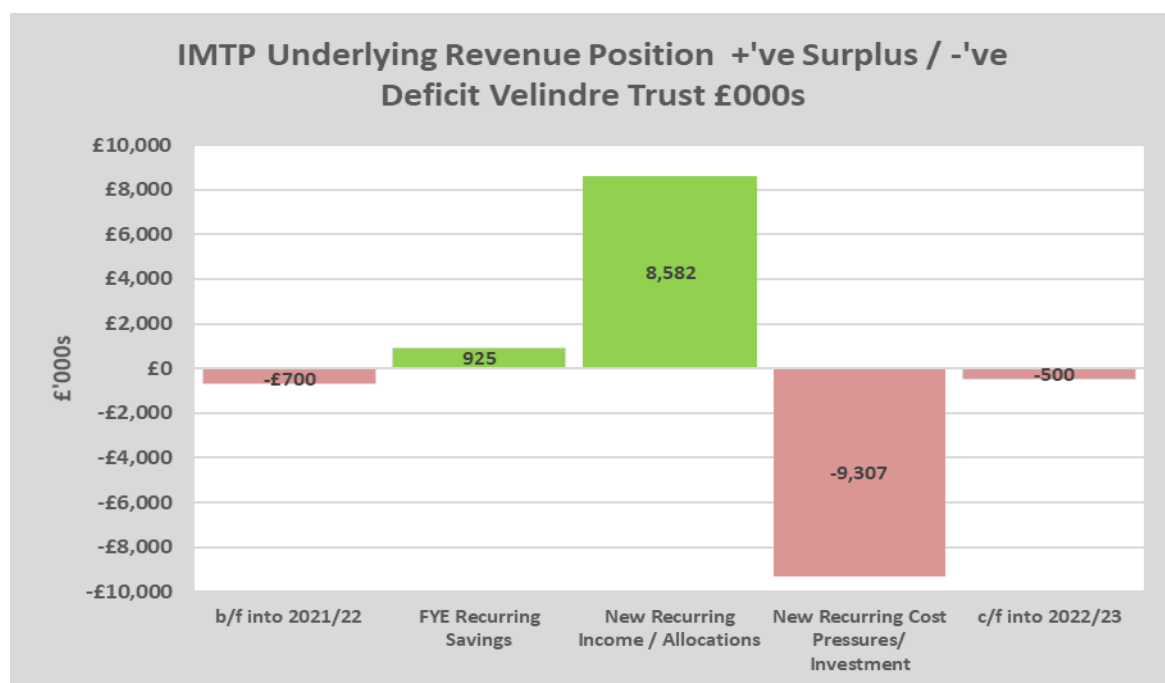
Underlying Position +Deficit/(-Surplus) £000s	b/f into 2021/22	Recurring Savings	New Recurring Income / Allocations	FYE New Cost Pressures/ Investment	c/f into 2022/23
Velindre NHS Trust	- 700	925	8,582	- 9,307	- 500

3. Executive Summary

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

(Figures in parenthesis signify an adverse variance against plan)

Table 1 - Key Targets

	Unit	Current Month £000	Year to date £000	Year End Forecast £000
Revenue	Variance	2	5	0
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	1,219	6,198	10,650
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	93.7%	94.6%	95.0%
Efficiency / Savings	Variance	0	0	0

Performance against Planned Savings Target

Efficiency Savings	Variance	0	0	0

Revenue

The Trust has reported a **£3k** in-month underspend position for February '22, with a cumulative position of **£5k** underspent, and an outturn forecast of **Breakeven**.

Capital

The approved Capital Expenditure Limit (CEL) as at February 2022 is **£10,650k** for 2021-22. This represents all Wales Capital funding of **£8,739k**, Discretionary funding of **£1,911k.** The Trust reported capital spend to February'22 of £6,198k and is forecasting to remain within its CEL of £10,650k.

The capital programme is representing an underspend for the period year to date which is a combination of procurement capacity constraints, impact of pandemic on supplier lead times and current market conditions where costs have significantly increased over the last couple of months, however, is still expected to achieve the overall CEL for 2021-22.

PSPP

During February '22 the Trust (core) achieved a compliance level of **93.7%** (January 22: 93%) of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **94.6 %** to the end of February, and a Trust position (including hosted) of **95.5%** compared to the target of 95%.

Since December the PSPP compliance levels in have experienced a dip in performance which is following recovery being produced in the previous quarter. Urgent measures are being put in place to improve performance which has been significantly impacted by the ongoing pandemic and reduced levels of receipting on orders which is due to the high levels of sickness which currently being experienced in the Trust. The finance teams continues to work with the service and NWSSP colleagues with a view to improve performance and ensure the overall Trust target is met for this financial year.

Efficiency / Savings

The Trust is now forecasting to overachieve against the savings target during 2021-22 which is due to increased vacancy factor which is above the target that is held within the divisions.

Revenue Position

Cumulative				Forecast			
£5,132 Underspent				Breakeven			
Type	YTD Budget (£'000)	YTD Actual (£'000)	YTD Variance (£'000)	Full Year Budget (£'000)	Full Year Forecast (£'000)	Forecast Variance (£'000)
Income	(149,019)	(148,723)	(296)	(165,659)	(165,152)	(507)
Pay	66,062	65,335	727	72,225	71,514	711
Non Pay	82,957	83,383	(426)	93,435	93,638	(203)
Total	(0)	(5)	5	0	(0)	0

The overall position against the profiled revenue budget to the end of February 2022 is an underspend of **£5k**, with a Pay underspend offsetting a non-pay overspend and Income under achievement.

The Trust has received or been allocated funding from WG for all Covid related expenditure relating to 2021-22.

4.1 Revenue Position Key Issues

Income Key Issues

- Income underachievement to February is **£(296)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 and over performance of Private Patient income.

Pay Key Issues

The Trust has reported a cumulative year to date position of **£727k** underspent on Pay and is forecasting an outturn underspend of circa **£711k**.

The total Trust vacancies as at February 2022 is 144wte, VCC (87wte), WBS (30wte), Corporate (1 wte), R&D (19wte), TCS (2wte) and HTW 5wte).

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

Pay WTE By Category			
Pay Type	WTE Budget	WTE Actual	WTE Variance
ADD PROF SCIENTIFIC AND TECHNICAL	58.40	52.26	(6.14)
ADDITIONAL CLINICAL SERVICES	257.57	228.46	(29.11)
ADMINISTRATIVE & CLERICAL	535.23	491.05	(44.18)
ALLIED HEALTH PROFESSIONALS	136.06	127.54	(8.52)
ESTATES AND ANCILLIARY	64.81	63.36	(1.45)
HEALTHCARE SCIENTISTS	164.26	156.58	(7.68)
MEDICAL AND DENTAL	99.49	77.35	(22.14)
NURSING AND MIDWIFERY REGISTERED	220.82	195.45	(25.37)
STUDENTS	2.47	2.84	0.37
Total Pay by Category	1,539.11	1,394.89	(144.22)

- Allied Health Professionals are experiencing an overspend to date of £(153k) which is due to the use of agency in both Radiotherapy and Medical Physics. The Trust has been recruiting on a permanent basis to some of these posts during 2021-22. This is expected to create a saving going forward from the removal of the premium cost for agency, however due to the difficulty being experienced in recruiting into these posts along with the requirement to cope with the expected surge capacity, the majority of agency staff will be re-directed to support Covid recovery which is funded by WG during 2021-22 and beyond.
- Medical costs have increased and are reflecting a year to date overspend of £(192)k due to additional temporary staff recruited at risk to ensure that all Jnr Dr rotation placements are filled and to provide additional resilience against pressured consultants. In addition, enhanced out of hours service, for advanced life support which will be nursing led is currently being covered by Jnr Dr's.
- Each Division of the Trust holds a savings and vacancy factor target which is delivered in year via establishment control. Any forecast adverse variance against the target will be offset through various underspends across numerous staff groups due to vacancies as illustrated in the WTE table above.

Non Pay Key Issues

The Trust has reported a cumulative year to date position of **£(426)k** overspend on Non-Pay and is forecasting an outturn underspend of circa **£(203)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.
- Overspends in VCC on One Wales and a rise in consumable costs across Pharmacy.
- 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.
- Additional travel & subsistence costs in relation to increased travel of WBS collections team to clinic. This is starting to offset the savings generated from general staff travel &

- subsistence which has been a benefit since the pandemic hit and the use of IT resources to conduct meetings.
- Printing / Stationary & Postage is underspending due to a reduction in office-based activity and paper-based communications given the increased homeworking. A proportion of this underspend is anticipated to be permanent and will be taken as recurrent saving once the Trust has agreed the operating model of future working arrangements.
- The increase in energy prices is beginning to take effect with an overspend now being reported against utilities. The exceptional cost pressures which include energy prices have been included within the Trust IMTP with the current assumption that any increase experienced will be funded by WG.
- General Reserves / Savings Target relates to the Cost improvement Plan (CIP) targets that are held centrally within divisions. These CIP's will be achieved through the underspends in several areas of non-pay. Additionally, as noted above further alignment of staff underspends to the CIP should result in an underspend within non-staff.
- The Trust reserves and investment funding is held in month 12 and will be released into the position to match spend as it occurs. A significant proportion of the reserves is remaining following slippage against investment decisions which will now be managed in the overall Trust position for this financial year, which accounts for the reduction in forecasted outturn position.

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 which is in response to Covid recovery. Whilst the plan was to reduce agency costs within the Trust Core staffing structure, due to the difficulty being experienced in recruitment, the agency staff replaced with substantive recruits will now be utilised as part of the Covid recovery.

Actual / F'cast Pay Expenditure 21/22 and Average actual 20/21 & 19/20
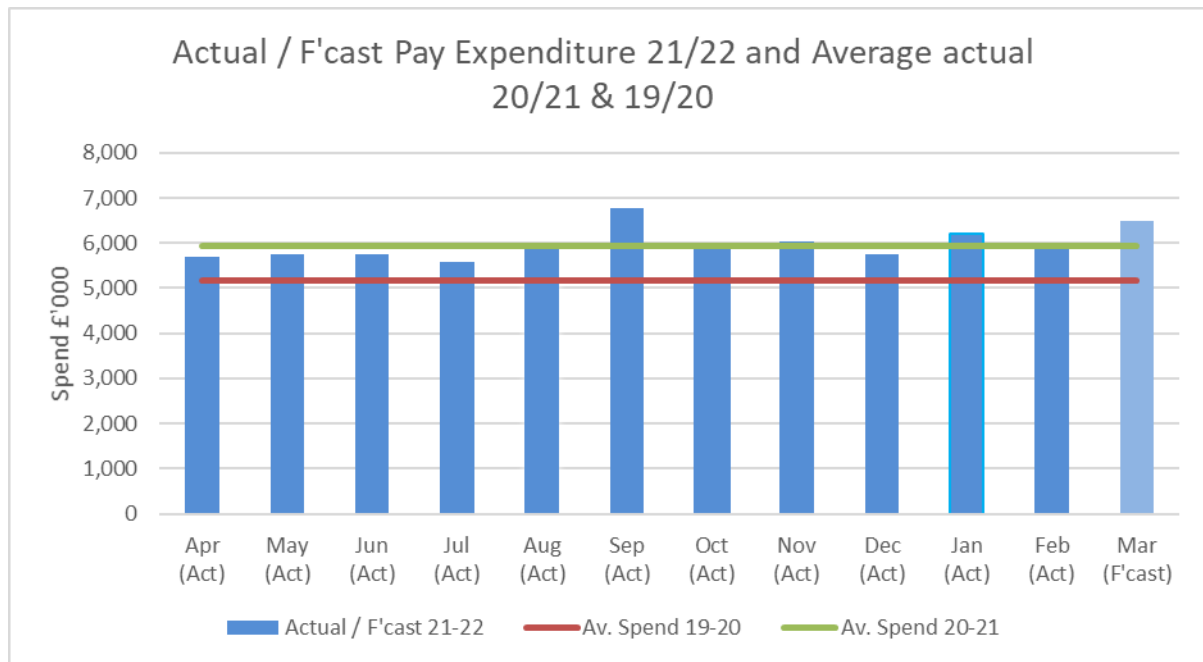
*Sep costs include Pay Award (3%) backdated to April. The perviously reported £2.6m additional pension has been removed as this will be a nominal charge from WG.

*During January Staff who were on bands 1-5 received a 1% non consolidated pay award.

*March pay includes the annual leave sell back and carry forward provision.

Changes in Total WTE 2020-21 to 2021-22
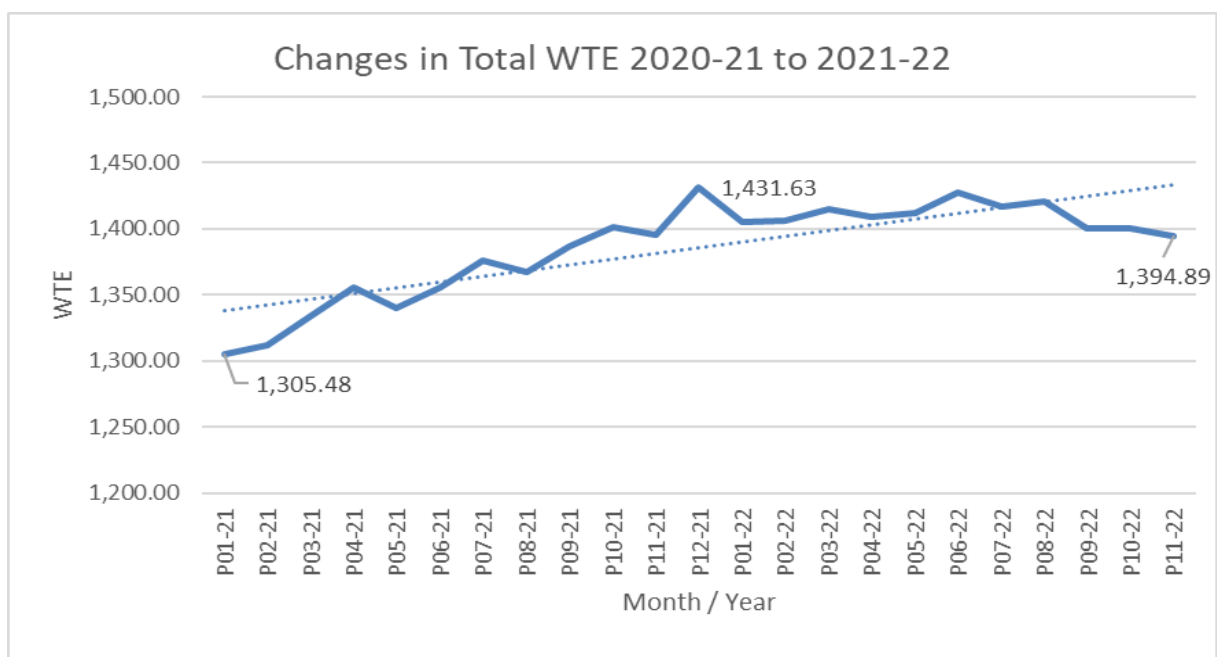
* Reduction in WTE since March 21 is largely due to ceasing of the Patient Vaccination programme.

Changes in WTE 2020-21 to 2021-22 By Division
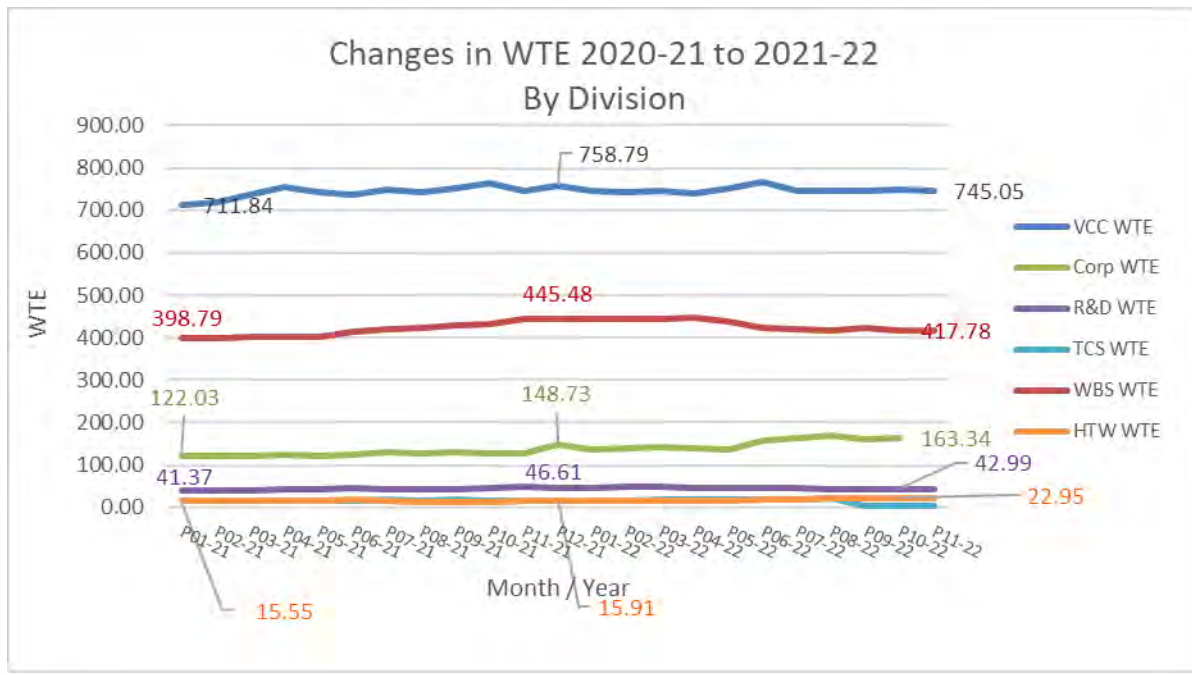
The spend on agency for February was £186k (January £143k), which gives a cumulative year to date spend of **£1,710k** and a forecast outturn spend of circa **£1,863k.** Of these totals the year to date spend on agency directly relating to Covid as at the end of February is £709k and forecast spend is circa £777k.

Agency actual / f'cast Expenditure 21/22 and Average actual 20/21 & 19/20
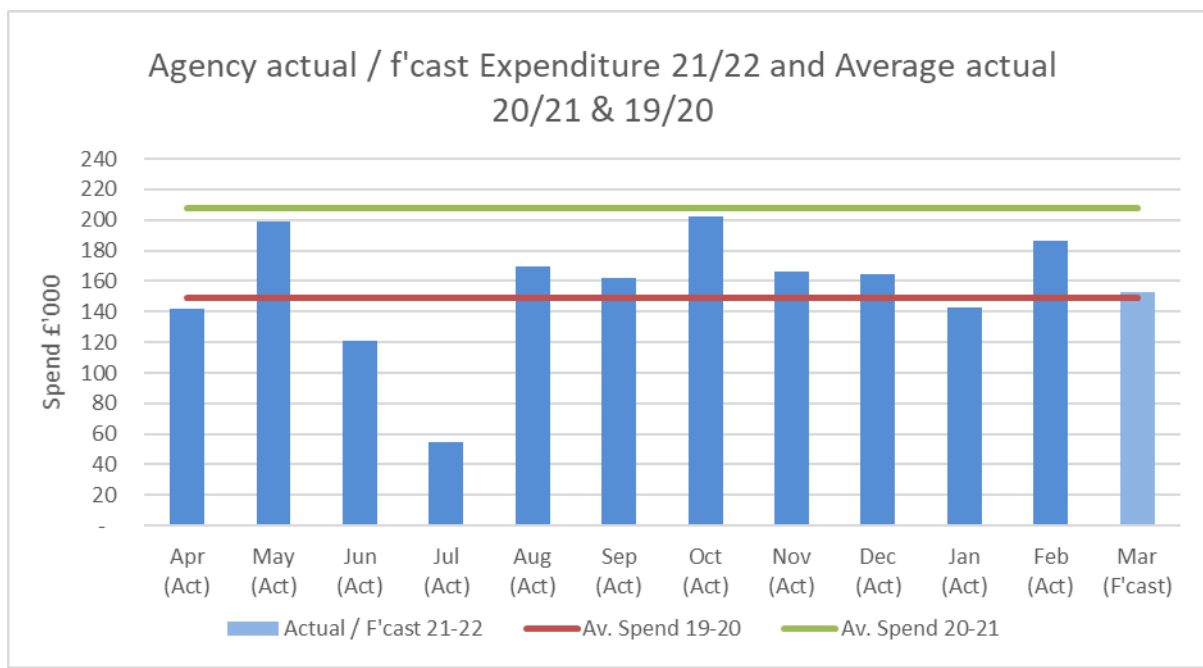
*The increase in May costs has been reviewed and corrected in July following a full review of agency invoices received against orders raised within VCC.

4.3 Non Pay

Non-pay 20/21 (c£81.2m) av. monthly spend remained static between 19/20 and 20/21 at £6.8m. The average monthly spend for 21-22 is currently £735k (10.8%) more than 20/21, which is largely due to the increase NICE / High-Cost drug usage following the recovery and surge related to Covid.

Monthly Non Pay Spend 2021-22 compared to Average 20-21 & 19-20
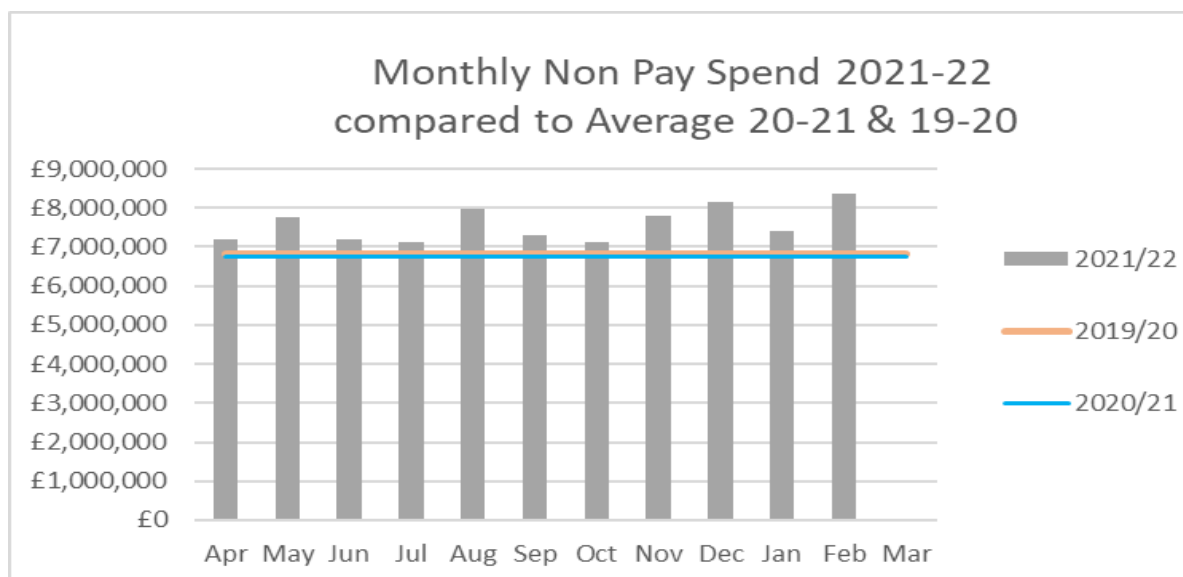
4.4 Covid-19

Covid-19 Revenue Spend/ Funding				
	YTD Actual £000	Forecast Spend 2021/22 £000	Funding Received / Allocated £000	Variance to Funding allocated £000
Mass & Booster Covid Vaccination	369	392	392	0
Cleaning Standards	716	771	769	2
PPE	161	195	226	(31)
Covid Recovery	2,645	3,222	3,479	(257)
Other Covid Related Spend & Cost Reduction	1,013	1,560	1,274	286
BFWD Savings Loss	638	700	700	0
Return of Bonus Payment (over allocated)	(83)	(83)	(83)	0
Annual Leave Sell Back Scheme	0	187	187	0
Total Covid Spend /Funding Requirement 2021/22	5,459	6,944	6,944	0

The Trust has now received or been allocated the full funding requirement from WG in relation to Covid.

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 has been updated to circa £1,800k above existing forecast which is based on potential demand should the additional capacity be fully utilised. These figures are excluded from the table above.

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

Vaccinations

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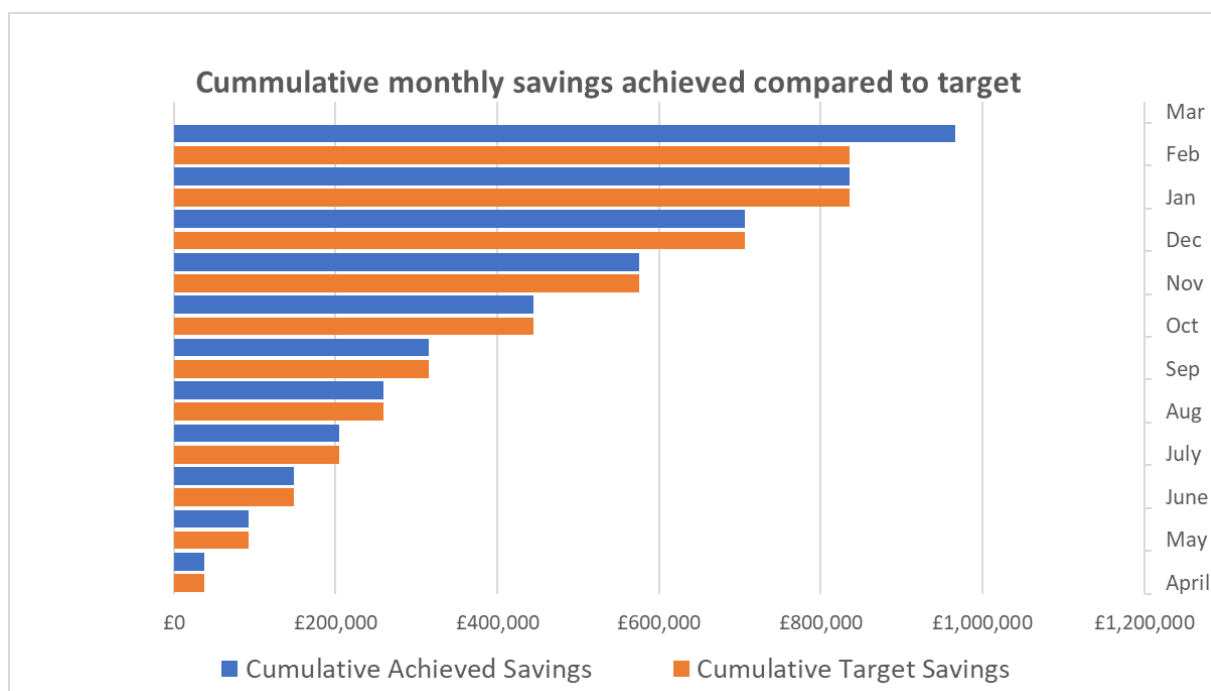
4. Savings

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

The YTD achievement on the 'Post Covid' Savings is £72k and forecast full year is £90k. These savings are not reflected in the tables below as they are being netted of against Covid Spend which is not being drawn down from WG whilst still in the pandemic. The Trust is expected to realise the benefit of these savings post Covid following the new ways of working such as reduced Travel expenses and office consumable spend. For this financial year the savings has been replaced with non-recurrent vacancy factor savings which gives an overall balanced savings position

The Trust is expecting to realise further savings of £145k above the Trust planned vacancy factor target, which will be utilised against the increased Annual leave provision to be carried into 2022/23.

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

ORIGINAL PLAN	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	Full Year Actual £000	Variance Full Year £000
VCC TOTAL SAVINGS	413	254	254	0	300	(113)
			100%		73%	
WBS TOTAL SAVINGS	368	275	275	0	300	(68)
			100%		82%	
CORPORATE TOTAL SAVINGS	119	92	92	0	100	(19)
			100%		100%	
TRUST TOTAL SAVINGS IDENTIFIED	900	621	621	0	700	(200)
TRUST ADDITIONAL NON-RECURRENT SAVINGS	200	347	347	0	545	345
TRUST TOTAL SAVINGS	1,100	968	968	0	1,245	145
			100%		113%	

Scheme Type	RAG RATING	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	F'cast Full Year £000	Variance Full Year £000
Savings Schemes							
Premium of Agency Staffing	Green	150	125	125	0	150	0
Premium of Agency Staffing	Green	100	83	83	0	100	0
Post Covid Savings (VCC)	Red	113	0	0	0	0	(113)
Blood Supply Chain 2020	Green	75	69	69	0	75	0
Blood Supply Chain 2020	Green	25	23	23	0	25	0
Stock Management	Green	200	183	183	0	200	0
Post Covid Savings (WBS)	Red	68	0	0	0	0	(68)
Establishment Control	Green	100	92	92	0	100	0
Post Covid Savings (Corporate)	Red	19	0	0	0	0	(19)
Total Saving Schemes		850	575	575	0	650	(200)
Income Generation							
Maximinsing Income Opportunities	Green	50	46	46	0	50	0
Total Income Generation		50	46	46	0	50	0
TRUST ADDITIONAL NON-RECURRENT SAVINGS - VACANY FACTOR		200	347	347	0	545	345
TRUST TOTAL SAVINGS		1,100	968	968	0	1,245	145
				100%		113%	

Cummulative monthly savings achieved compared to target

Legend: ■ Cumulative Achieved Savings ■ Cumulative Target Savings

5. Reserves

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

The current remaining available funding is shown below: -

Summary of Total Reserves Remaining Available in 2021-22	£k
Recurrent Reserve Available 2021/22	617
Slippage on BFWD Commitments	*152*
Further Exec Commitment 2021-22	(144)
Slippage on Further Exec Support	*144*
Forecast remaining Balance 31 March 2022	**769**

The forecast balance of the recurrent reserves as at the end of 2021/22 is expected to be £769k, however this funding is either ringfenced or has now been committed into future years so is not currently available for investment.

Summary of Total Non Recurrent Reserves Remaining Available in 2021-22	£k
Anticipated Slippage on N/R Allocated Reserves	550
Emergency Reserve	522
Forecast remaining Balance 31 March 2022	**1,072**

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 February '22 is £657k (includes £104k of new commitments). The anticipated slippage against the £1.5m is currently expected to be circa £550k 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.

6. End of Year Forecast / Risk Assessment

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

7. CAPITAL EXPENDITURE

Administrative Target
- *To ensure that net Capital expenditure does not exceed the Capital Expenditure Limit (CEL) approved by the Welsh Government.*
- *To ensure the Trust does not exceed its External Financing Limit*

	Approved CEL £000s	YTD Spend £000s	Committed Orders Outstanding £000s	Budget Remaining @ M11 £000s	Full Year Actual Spend £000s	Year End Variance £000s
All Wales Capital Programme						
VCC - Transforming Cancer Services	3,711	3,370	0	341	3,675	36
VCC Radiotherapy Procurement Solution	312	291	0	21	312	0
IT - WPAS (CANISC replacement phase 2)	993	868	44	81	993	0
Fire Safety	600	204	58	338	600	0
National Programmes - Decarbonisation	109	30	76	3	99	10
National Programmes - Imaging	1,020	4	1,009	7	1,015	5
Covid Recovery	675	20	360	295	675	0
DHCW - NDR Funding	350	350	0	0	350	0
DHCW - VCC Careflow	60	0	0	60	60	0
HTW Capital	5	5	0	0	5	0
Linc ETR Funding	25	0	24	1	25	0
Additional DPIF Capital Allocations	41	0	0	41	41	0
End of Year Capital					0	
Multileaf Collimator (MLC) Motor Replacements	120	0	0	120	120	0
(CDR) function within the WBS.	83	30	8	45	83	0
Patient Specific Quality Assurance (PSQA) Phantom	100	0	0	100	100	0
Digital IT Client tech refresh	450	390	22	38	450	0
Digital Server Infrastructure Tech refresh	85	20	22	44	85	0
Total All Wales Capital Programme	8,739	5,582	1,622	1,534	8,688	51
Discretionary Capital	1,911	615	615	681	1,962	(51)
Total	10,650	6,197	2,237	2,215	10,650	0

The approved 2021/22 Capital Expenditure Limit (CEL) as at February 2022 was £10,650k. This includes All Wales Capital funding of £8,739k, and discretionary funding of £1,911k.

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

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

Performance to date

The actual cumulative expenditure to February 2021 on the All-Wales Capital Programme schemes was £5,582k, this is broken down between spend on the TCS Programme £3,370k, Integrated Radiotherapy Procurement Solution £291k, IT WPAS £868k, Fire Safety £204k, Decarbonisation £30k, Covid recovery £20k , NDR £350k and HTW £5k.

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

Spend to date on Discretionary Capital is currently £615k with a further £615k committed.

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

The capital programme is representing an underspend for the period year to date which is a combination of procurement capacity constraints, impact of pandemic on supplier lead times and current market conditions where costs have significantly increased over the last couple of months.

Year-end Forecast Spend

The year-end forecast outturn is currently expected to be managed to a breakeven position, however as above there have been several challenges which has resulted in some variances now being reported against individual schemes where the forecast spend is different to the approved CEL. This was highlighted to WG colleagues at the latest Capital review meeting who are aware and content with the situation.

Major Schemes in Development

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

Other Major Schemes in development that will be considered during 2022/23 and beyond in conjunction with WG include:

	Scheme	Scheme Total	Stage (i.e. OBC development, FBC development, scoping etc.)	22/23 £'000	23/24 £'000	24/25 £'000	25/26 £'000	26/27 £'000
1	VCC Outpatients	1,250	Feasibility & design study currently being undertaken although unlikely to gain WG funding to supprt during 2022/23	625	625			
2	WBS HQ	22,500	PBD approved by WG OBC end of February. FBC to be developed 22/23	550	8,855	6,810	3,143	3,143
3	Ventilation	2,490	BJC to be submitted (paused during pandemic)		1,868	623		
4	IRS	37,929	OBC & PBC approved by WG, FBC under development (Phasing of costs under review)	4,711	8,234	14,254	10,730	
5	Plasma Fractionation	TBC	Feasibility study to be developed					

*Cash flow of these schemes is still under review alongside WG.

8. BALANCE SHEET (Including Hosted Organisations)

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

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

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

Non-Current Assets

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

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

Current Assets

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

Meetings have taken place recently between NWSSP, Trust and WG leads as to whether the Brexit stock funding will be repaid at the end of March '22 and discussions are still ongoing.

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

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

Current Liabilities & Non-Current Liabilities

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

Taxpayers Equity

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

	Opening Balance Beginning of Apr 20	Closing Balance End of Feb-22	Movement from 1st April Feb-22	Forecast Closing Balance End of Mar 21
Non-Current Assets	£'000	£'000	£'000	£'000
Property, plant and equipment	136,558	128,954	(7,604)	124,700
Intangible assets	20,821	5,103	(15,718)	5,481
Trade and other receivables	817,142	819,007	1,865	819,007
Other financial assets	0	0	0	0
Non-Current Assets sub total	**974,521**	**953,064**	**(21,457)**	**949,188**
Current Assets				
Inventories	95,564	78,540	(17,024)	85,187
Trade and other receivables	548,836	422,937	(125,899)	443,213
Other financial assets	0	0	0	0
Cash and cash equivalents	43,263	34,626	(8,637)	18,518
Non-current assets classified as held for sale	0	0	0	0
Current Assets sub total	**687,663**	**536,103**	**(151,560)**	**546,918**
TOTAL ASSETS	**1,662,184**	**1,489,167**	**(173,017)**	**1,496,106**
Current Liabilities				
Trade and other payables	(353,136)	(212,825)	140,311	(212,743)
Borrowings	(8)	0	8	0
Other financial liabilities	0	0	0	0
Provisions	(316,959)	(316,357)	602	(316,374)
Current Liabilities sub total	**(670,103)**	**(529,182)**	**140,921**	**(529,117)**
NET ASSETS LESS CURRENT LIABILITIES	**992,081**	**959,985**	**(32,096)**	**966,989**
Non-Current Liabilities				
Trade and other payables	(7,301)	0	7,301	(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)**	**(818,782)**	**7,301**	**(825,782)**
TOTAL ASSETS EMPLOYED	**165,998**	**141,203**	**(24,795)**	**141,207**
FINANCED BY:				
Taxpayers' Equity				
General Fund	0	0	0	0
Revaluation reserve	27,978	30,963	2,985	31,058
PDC	122,468	94,597	(27,871)	94,597
Retained earnings	15,552	15,643	91	15,552
Other reserve	0	0	0	0
Total Taxpayers' Equity	**165,998**	**141,203**	**(24,795)**	**141,207**

9. CASH FLOW (Includes Hosted Organisations)

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

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

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

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

WG have asked the Trust to manage the £5.6m transfer of cash into the Escrow holding account for the nVCC programme which will need to take place before the 31st March. This will be done on the basis that the Trust can draw down the funds from the 1st April which ensures that there is no cash risk to the organisation.

Cash levels are monitored daily using a detailed cash flow forecast to ensure the Trust has sufficient cash balances to meet anticipated commitments.

		Apr £'000	May £'000	Jun £'000	Jul £'000	Aug £'000	Sep £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £'000	Totals £'000
	RECEIPTS													
1	LHB / WHSSC income	23,348	22,492	30,672	34,078	32,225	28,886	33,252	33,603	30,431	31,820	36,331	35,468	372,606
2	WG Income	33,807	26,132	11,582	30,431	27,512	21,398	6,388	56,520	693	26,150	2,964	35,400	278,977
3	Short Term Loans													0
4	PDC												18,288	18,288
5	Interest Receivable										3	6	6	15
6	Sale of Assets											31		31
7	Other	7,643	3,682	4,973	5,006	4,613	5,004	4,673	2,719	9,139	2,454	9,591	1,200	60,697
8	TOTAL RECEIPTS	64,797	52,306	47,227	69,515	64,350	55,288	44,314	92,842	40,263	60,427	48,923	90,362	730,614
	PAYMENTS													
9	Salaries and Wages	15,189	22,734	22,015	20,181	19,284	24,383	25,582	24,544	25,089	25,614	25,419	27,170	277,204
10	Non pay items	52,989	43,749	25,742	35,377	45,158	42,830	18,755	19,768	49,260	7,089	48,336	63,349	452,403
11	Short Term Loan Repayment												7,000	7,000
12	PDC Repayment													0
14	Capital Payment	2,375	277	540	453	225	623	631	499	612	2,181	1,386	8,950	18,752
15	Other items													0
16	TOTAL PAYMENTS	70,552	66,760	48,297	56,011	64,667	67,836	44,968	44,811	74,961	34,884	75,141	106,469	755,358
17	Net cash inflow/outflow	(5,755)	(14,454)	(1,070)	13,504	(317)	(12,548)	(655)	48,031	(34,698)	25,543	(26,218)	(16,107)	
18	Balance b/f	43,263	37,508	23,054	21,984	35,488	35,171	22,623	21,968	69,999	35,301	60,844	34,626	
19	Balance c/f	37,508	23,054	21,984	35,488	35,171	22,623	21,968	69,999	35,301	60,844	34,626	18,518	

Monthly Cash Flow Forecast

— Cash Receipts — Cash Payments — Monthly Cash Balance
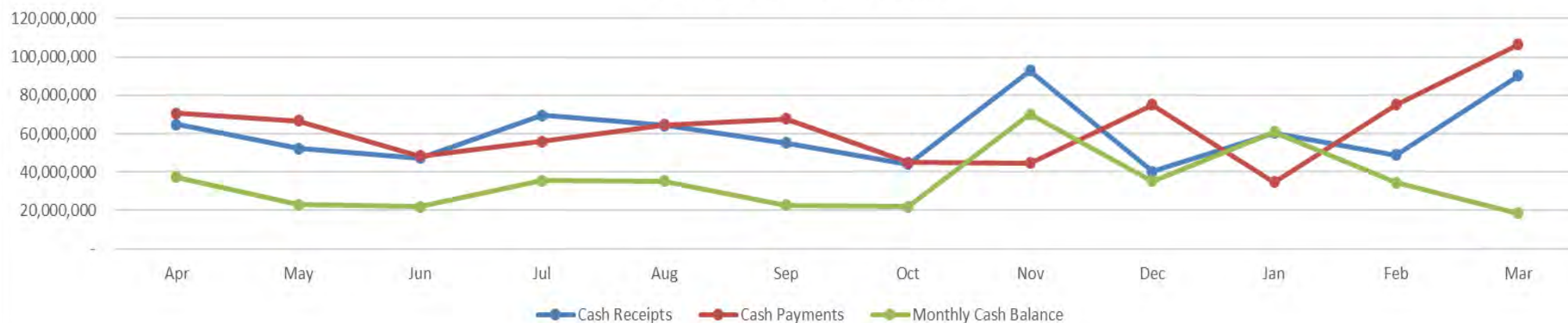
DIVISIONAL ANALYSIS

(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	33,451	33,451	0	36,522	36,522	0
RD&I	131	131	0	(365)	(365)	0
WBS	18,865	18,865	0	20,779	20,779	0
Sub-Total Divisions	**52,447**	**52,447**	**0**	**56,937**	**56,937**	**0**
Corporate Services Directorates	8,367	8,385	(18)	8,959	8,959	0
Delegated Budget Position	**60,814**	**60,832**	**(18)**	**65,896**	**65,896**	**0**
TCS	613	590	23	669	669	0
Health Technology Wales	(30)	(31)	0	28	28	0
Trust Position	**61,397**	**61,391**	**5**	**66,593**	**66,593**	**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	**55,755**	**56,227**	**472**	**62,377**	**62,777**	**400**
Expenditure						
Staff	37,242	37,245	(3)	40,732	40,832	**(100)**
Non Staff	51,964	52,433	(469)	58,167	58,467	**(300)**
Sub Total	**89,206**	**89,678**	**(472)**	**98,899**	**99,299**	**(400)**
Total	**33,451**	**33,451**	0	**36,522**	**36,522**	**0**

VCC Key Issues:

The reported financial position for the Velindre Cancer Centre as at the end of February 2022 was **breakeven**, and an expected outturn position of **breakeven**.

Income at Month 11 represents an overachievement of **£472k**. This is largely from an increase in VAT savings from providing additional SACT Homecare, an over achievement on private patient income due to drug performance which is above general private patient performance, additional funding for senior medical non-surgical workforce, increased income against the Radiation protection SLA, and HSST income within Physics Management, along with a number of smaller areas representing income growth. This is offsetting the divisional savings target and the loss of income from closure of gift shop and volunteer's office in response to Covid.

VCC have reported a small overspend of **£(3)k** against staff for February. 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 (£1,217k to end of February) although £617k is directly related to Covid and funded via WG. Inpatients underspend relates to the holding off on recruitment due to reduced bed capacity from social distancing measures. Medical costs have increased due to additional temporary staff recruited at risk to ensure that all Jnr Dr rotation placements are filled, and to provide additional resilience against pressured consultants. In addition, enhanced out of hours service, for advanced life support which will be nursing led is currently being covered by Jnr Dr's.

Non-Staff Expenditure at Month 11 was **£(469)k** overspent. There are underspends on general drugs from reduced activity and temporary closure of outreach clinics, Nuclear medicine warranty savings, along with cost avoidance generated from closure of gift shop and volunteer's office. This is in part offsetting the one off spend on uniforms and consumables in Pharmacy, One Wales cost pressure, and cost from NWSSP for sponsorship of overseas students, along with reporting fees and oncotype in Senior Medical. The increase in price for utilities is starting to have an impact and is expected to be significant next year, which is being factored into the Trust IMTP, with the current assumption that the Trust will receive WG income to support the increase in energy prices.

WBS

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	**20,335**	**19,633**	**(703)**	**22,278**	**21,437**	**(841)**
Expenditure						
Staff	15,714	15,386	328	17,217	16,763	**454**
Non Staff	23,487	23,112	375	25,841	25,454	**387**
Sub Total	**39,201**	**38,498**	**703**	**43,058**	**42,216**	**841**
Total	**18,865**	**18,865**	**(0)**	**20,779**	**20,780**	**(0)**

WBS Key Issues:

The reported financial position for the Welsh Blood Service at the end of February 2022 was **breakeven** with an outturn forecast position of **breakeven** expected.

Income underachievement to date is **£(703)k**, where activity is lower than planned on Bone Marrow and Plasma Sales, due to freezer breakdown and Covid suppressed activity. Plasma sales recovery to business-as-usual levels following hire of freezers, although this has not occurred as anticipated with only partial recovery taken place since December. Transitional operating sites for Bone Marrow and increasingly curtailed procedures is resulting in income loss above Covid support, with assessments as to scale and sustainability strategy still ongoing.

Staff reported a year-to-date underspend of **£328k** to February, which is above the division's vacancy factor target. Vacancies remain high albeit reducing at 31 as at end of month 11. Long standing vacancies in donor contact centre and transport have now been recruited, resulting in

reduced vacancy factor. Plasma fractionation staffing costs to be supported by division during 2021/22. Component development staffing costs incurred as a divisional cost pressure with no WHSSC funding secured.

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

Potential risks due to implications of cessation of CVP Funding where WG initial funding ended 31st March 2021, PYE funding agreed for 21-22, tenure of RN posts significant as appointed on permanent contracts. SMT approval to partially mitigate the financial risk by transferring CVP permanent posts into team vacancies (where available). This practice is continuing with additional substantive Band 3 posts becoming vacant that has been agreed though Scrutiny to utilise to de-risk the staff group appointed permanently and award to CCA FTC staff to minimise the training required, FTC staff to be recruited to substantive vacancies wef Month 11.

Non-Staff underspend of **£375k** is largely due to reduced costs from suppressed activity, underspend on Collections Services, Laboratory Services, WTAIL, and General Services such as building maintenance and MAK business systems, which is offsetting overspends on utilities, licenses and the Divisions savings target.

Corporate

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected £000
Income	**1,172**	**1,212**	**39**	**1,238**	**1,321**	**82**
Expenditure						
Staff	8,801	8,513	288	9,568	9,361	**207**
Non Staff	738	1,069	(332)	630	919	**(289)**
Sub Total	**9,539**	**9,582**	**(44)**	**10,197**	**10,279**	**(82)**
Total	**8,367**	**8,371**	**(4)**	**8,959**	**8,959**	**0**

Corporate Key Issues:

The reported financial position for the Corporate Services division at the end of February 2022 was a small overspend of **£(4)k**. The Corporate division is currently expecting to achieve an outturn position of **breakeven**.

Income overachievement relates to non-recurrent income received such as HEIW education funding and DHCW Welsh Nurse Care Record funding which will be neutralised through expenditure.

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

The forecast Non pay overspend circa **£(289)k** is due to the divisional savings target £(158)k which is expected to be met in year via staff vacancies. Other main cost pressure relates to the estates budget in VCC which is under immense strain due to the increased repair and maintenance costs of the hospital, recently added costs for statutory compliance and increased material costs, along

with general inflation. In addition, several departments have little or no non pay budget to allow for unforeseen and unexpected spend.

RD&I

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	**2,656**	**2,551**	**(105)**	**3,423**	**3,275**	**(148)**
Expenditure						
Staff	2,525	2,421	104	2,728	2,609	**119**
Non Staff	262	261	1	330	302	**28**
Sub Total	**2,787**	**2,682**	**105**	**3,058**	**2,911**	**0**
Total	**131**	**131**	**0**	**(365)**	**(364)**	**0**

RD&I Key Issues

The reported financial position for the RD&I Division at the end of February 2022 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	485	474	11	527	527	**0**
Non Staff	128	115	13	142	142	**0**
Sub Total	**613**	**590**	**23**	**669**	**669**	**0**
Total	**613**	**590**	**23**	**669**	**669**	**0**

TCS Key Issues

The reported financial position for the TCS Programme at the end of February 2022 is an underspend of **£23k** with a forecasted outturn position of **Breakeven.**

The small underspend being reported through TCS will be managed within the overall Trust position.

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	**1,488**	**1,488**	**0**	**1,624**	**1,624**	**0**
Expenditure						
Staff	1,295	1,295	0	1,453	1,453	**0**
Non Staff	163	163	0	199	199	**0**
Sub Total	**1,458**	**1,458**	**0**	**1,652**	**1,652**	**0**
Total	**(30)**	**(31)**	**0**	**0**	**28**	**0**

HTW Key Issues

The reported financial position for Health Technology Wales at the end of February 2022 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 FEBRUARY 2022

DATE OF MEETING	16th March 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

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

REPORT PURPOSE	FOR NOTING

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

COMMITTEE OR GROUP	DATE	OUTCOME
N/A		Choose an item.

ACRONYMS

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

1. PURPOSE

1.1 The purpose of this report is to provide a financial update to the TCS Programme Delivery Board for the financial year 2021-22, outlining spend to date against budget as at Month 11.

2. BACKGROUND

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

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

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

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

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

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

3. FUNDING

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

3.2 In August 2021, the Trust Board approved that the nVCC Project provide interim funding of **c£0.350m** to the EW Project to support the work packages associated with tree and vegetation clearance (c£0.250m) and site management and security (c£0.100m). The EW Project has now secured funding from the approval of its FBC, awarded in January 2022.

3.3 The Trust has provided revenue funding of **£0.110m** to the nVCC Project.

Description	Funding	
	Capital	Revenue
Programme Management Office There is no capital funding requirement for the PMO at present	£ nil	£0.246m
Allocation of £0.240m from £0.420m funding provided from Commissioners for 2021-22 to cover direct clinical/management support and Programme Management was provided in April 2021		£0.240m
Allocation from WG 2021-22 revenue pay award funding was provided in September 2021		£0.006m
Project 1 – Enabling Works for nVCC Capital funding from WG was provided on 24 March 2021	£2.136m £0.250m	£ nil
Capital funding of £27.393m awarded by WG on 18 January 2022 for the EW FBC, of which	£1.886m	
Project 2 – New Velindre Cancer Centre Capital funding from WG was provided on 24 March 2021	£3.460m £3.460m	£0.110m
The Trust provided revenue funding in September 2021 for Project Delivery		£0.026m
The Trust has provided revenue funding for the Judicial Review costs incurred between August 2021 and December 2021		£0.084m
Project 3a – Radiotherapy Procurement Solution Final 9 months of a 28 month project, running from 1st August 2019 to 31st December 2021, with a funding allocation of £0.312m for 2021-22 from an overall funding allocation of £1.110m, provided in April 2021	£0.576m £0.312m	£ nil
Additional funding provided by the Trust for the Project's increased legal and staff costs in November 2021.	£0.264m	
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 A review of all the Trust Programme & Project resources is being undertaken to identify how these are deployed against Trust priorities. This project is on hold pending this review.	£ nil	£ nil

Description	Funding	
	Capital	**Revenue**
Project 6 – Service Delivery, Transformation and Transition	**£ nil**	**£0.313m**
Allocation of £0.180m from £0.420m funding provided from Commissioners for 2021-22 to cover direct clinical/management support and Programme Management was provided in April 2021		£0.180m
Funding provided from the Trust's core revenue budget towards the costs of the Project Director post and the Project Manager post in April 2021		£0.116m
Allocation from WG 2021-22 revenue pay award funding was provided in September 2021		£0.009m
Additional funding provided from the Trust's core revenue budget towards the cost of the Project Manager post in November 2021		£0.008m
Project 7 – VCC Decommissioning A review of all the Trust Programme & Project resources is being undertaken to identify how these are deployed against Trust priorities. This project is on hold pending this review.	**£ nil**	**£ nil**
Total funding provided to date	**£6.171m**	**£0.669m**
	£6.840m	

4. FINANCIAL SUMMARY AS AT 28TH FEBRUARY 2022

4.1 The summary financial position for the TCS Programme for the year 2021-22 as at 28th February 2022 is outlined below:

- **CAPITAL** spend of **£3.663m to M11** with a forecast outturn of **£6.132m and variance of £0.040m underspent;** and

- **REVENUE** spend is **£0.590m to M11** with a forecast outturn of **£0.658m and variance of £0.011m.**

TCS Programme Budget & Spend 2021-22

CAPITAL	Cumulative to Date			Financial Year		
	Budget to Feb-22	Spend to Feb-22	Variance to Feb-22	Annual Budget	Annual Forecast	Annual Variance
	£	£	£	£	£	£
PAY						
Project Leadership	173,509	174,644	-1,135	193,000	191,724	1,276
Project 1 - Enabling Works	100,000	195,881	-95,881	100,000	213,521	-113,521
Project 2 - New Velindre Cancer Centre	810,891	693,939	116,952	1,008,500	784,748	223,752
Project 3a - Radiotherapy Procurement Solution	332,094	331,561	534	362,675	361,785	890
Capital Pay Total	**1,416,495**	**1,396,025**	**20,469**	**1,664,175**	**1,551,778**	**112,397**
NON-PAY						
nVCC Project Delivery	59,760	60,949	-1,189	78,500	75,604	2,896
Project 1 - Enabling Works	638,916	933,075	-294,159	2,035,599	2,639,744	-604,145
Project 2 - New Velindre Cancer Centre	1,388,820	1,106,120	282,700	2,180,000	1,650,854	529,146
Project 3a - Radiotherapy Procurement Solution	164,792	166,430	-1,638	213,165	213,952	-787
Capital Non-Pay Total	**2,252,288**	**2,266,573**	**-14,286**	**4,507,264**	**4,580,154**	**-72,890**
CAPITAL TOTAL	**3,668,782**	**3,662,599**	**6,184**	**6,171,439**	**6,131,933**	**39,506**

REVENUE	Cumulative to Date			Financial Year		
	Budget to Feb-22	Spend to Feb-22	Variance to Feb-22	Annual Budget	Annual Forecast	Annual Variance
	£	£	£	£	£	£
PAY						
Programme Management Office	201,322	183,425	17,897	224,833	201,923	22,910
Project 6 - Service Change Team	286,581	290,960	-4,380	312,633	312,633	0
Revenue Pay total	**487,903**	**474,386**	**13,517**	**537,466**	**514,556**	**22,910**
NON-PAY						
nVCC Project Delivery	22,293	22,940	-647	26,000	23,883	2,117
nVCC Judicial Review	82,904	84,134	-1,230	84,000	84,134	-134
Programme Management Office	13,978	8,263	5,715	21,534	35,263	-13,729
Project 6 - Service Change Team	0	244	-244	0	266	-266
Revenue Non-Pay Total	**119,175**	**115,581**	**3,594**	**131,534**	**143,546**	**-12,013**
REVENUE TOTAL	**607,078**	**589,967**	**17,111**	**669,000**	**658,103**	**10,897**

5. FINANCIAL POSITION FOR TCS PROGRAMME AND ASSOCIATED PROJECTS AS AT 28TH FEBRUARY 2022

CAPITAL SPEND

Project 1 – Enabling Works

5.1 There is a cumulative capital spend to date of **£1.129m** against a budget of **£0.739m**, with a forecast spend for the year of **£2.853m** against a budget of **£2.136m, with a forecast variance of £0.718m overspend**.

Work package	Spend to 28th February 2022 £m	Forecast Annual Spend £m
Pay	**£0.196**	**£0.214**
Third Party Undertakings (OBC phase)	£nil	£0.030
Technical Advisers (OBC phase)	£0.228	£0.236
Works (OBC phase)	£0.339	£0.414
Legal Advice (OBC phase)	£0.196	£0.278
Enabling Works Reserves (OBC phase)	-£0.195	-£0.195
Construction Costs (FBC phase)	£0.171	£0.339
Utility Costs (FBC phase)	£nil	£0.789
Supply Chain Fees (FBC phase)	£0.148	£0.267
Non Works Costs (FBC phase)	£nil	£0.400
Asda Works (FBC phase)	£0.046	£0.081
Enabling Works FBC Reserves (FBC phase)	£nil	£nil
Non-pay	**£0.933**	**£2.640**
Total	**£1.129**	**£2.853**

5.2 The forecast overspend within the Project has been mitigated by the use of underspends from the nVCC Project.

Project 2 – nVCC

5.3 There is a cumulative capital spend to date of **£2.036m** against a budget of **£2.433m**. The forecast spend for the years is **£2.703m** against a budget of **£3.460m with a forecast variance of £0.757m underspend**.

Work package	Spend to 28th February 2022 £m	Forecast Annual Spend £m
Pay	**£0.869**	**£0.976**
Project Delivery costs	£0.061	£0.076
Competitive Dialogue – PQQ & Dialogue	£1.025	£1.425
Legal Advice	£0.020	£0.020
Planning	£0.088	£0.133
nVCC Reserves	-£0.027	£0.073
Non-pay	**£1.167**	**£1.726**
Total	**£2.036**	**£2.703**

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

Project 3a – Integrated Radiotherapy Procurement Solution

5.5 There is a cumulative capital spend to date of **£0.498m** for the IRS Project against a budget of **£0.497m**. The Project is currently forecasting a spend of **£0.576m** against a budget of **£0.576m with no forecast variance**.

Work package	Spend to 28th February 2022 £m	Forecast Annual Spend £m
Pay	**£0.332**	**£0.0.362**
Legal Advisors	£0.152	£0.175
Financial Advisors	£nil	£nil
Business Case Advisors	£0.013	£0.020
Procurement Advisors	£nil	£nil
IRS Reserves	£0.002	£0.018
Non-pay	**£0.166**	**£0.214**
Total	**£0.498**	**£0.576**

REVENUE SPEND

Programme Management Office

5.6 The PMO spend to date is **£0.192m** (£0.183m pay, £0.008m non-pay) against a budget of **£0.215m**. The Project is forecasting a spend of **£0.237m** (£0.202m pay, £0.035m non-pay) in the financial year 2021-22 against a budget of **£0.246m**.

5.7 There is a forecast underspend in pay costs of £0.023m due to a delay in recruitment of a Programme Administrator. However £0.014m will be used to cover non-pay costs. The remaining £0.009m will remain a risk to the Programme, however the PMO are working to mitigate this risk during March 2022.

Projects 1 and 2 Delivery Costs

5.8 There is a revenue project delivery cost to date for the nVCC and Enabling Works Projects of **£0.023m** against a budget of **£0.022m.** There is a forecast spend for the year of **£0.024m against a** budget of **£0.026m**. This spend relates to costs associated with office costs and project support.

5.9 There is currently a forecast underspend of £2k for project delivery costs, due to a reduced requirement of printing and general supplier as a result of increased home working due to COVID-19.

nVCC Judicial Review

5.10 There is a revenue spend to date of **£0.084m** against a budget of **£0.083m** for the legal advice to deliver the requirements of the judicial review process as the Trust is an interested party. There is expected to be a spend of **£0.084m** against a budget for the year of **£0.084m**.

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

5.11 Service Change spend to date is **£0.291m** against a budget of **£0.287m,** made up of pay costs. The Project is currently forecasting a spend of **£0.313m** for the year against a budget of the same.

6. Financial Risks & Issues

6.1 c£2.4m spend of the projected capital outturn of c£5.556m for Projects 1 and 2 is in last month of the financial year and there is a risk that underspends could occur at the year-end.

6.2　There is a risk of the PMO being £0.023m underspent for 2021-22, however the PMO team are looking into mitigations to reduce this underspend.

6.3　Project 1 and 2 delivery costs for 2021-22 will see an underspend of £2k against a revenue budget of £26k. This is due to increased home working following COVID-19 restrictions, resulting in a decreased demand for office supplier/services. As these are exceptional circumstances which are expected to reverse somewhat with the ease of COVID-19 restrictions, the underspend is not expected to impact on the revenue budget request for project costs for 2022-23.

7.　CONSIDERATIONS FOR BOARD

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

8.　IMPACT ASSESSMENT

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

9.　RECOMMENDATION

The TCS Programme Board are asked to **NOTE** the financial position for the TCS Programme and Associated Projects for 2021-22 as at 28th February 2022.