Bundle Public Trust Board Meeting - Velindre University NHS Trust 28 July 2022

1.0.0 10:00 - STANDARD BUSINESS

Led by Prof Donna Mead OBE, Chair

1.1.0 Apologies

Led by Prof Donna Mead OBE, Chair

Apologies received:

1.2.0 In Attendance

Led by Prof Donna Mead OBE, Chair

1.3.0 Declarations of Interest

Led by Prof Donna Mead OBE, Chair

1.4.0 10:05 - MATTERS ARISING

Led by Prof Donna Mead OBE, Chair

1.4.1 Action Log

Led by Prof Donna Mead OBE, Chair

1.4.1 PUBLIC TRUST BOARD ACTION LOG v4.docx

2.0.0 CONSENT ITEMS

Led by Prof Donna Mead OBE, Chair

2.1.0 10:10 - For Approval

Led by Prof Donna Mead OBE, Chair

2.1.1 Minutes from the Public Trust Board meeting held on 26 May 2022

Led by Prof Donna Mead OBE, Chair

2.1.1 Draft Public Trust Board Minutes v2ES-LF- SH.docx

2.1.2 Commitment of Expenditure Exceeding Chief Executives Limit

Led by Matthew Bunce, Executive Director of Finance

Commitment of Expenditure Cover Paper.docx

MB Reviewed Commitment of Expenditure Over Chief Exec Limit_ChemoCare Contract Extension.docx

2.1.3 National Imaging Academy Hosting Agreement

Led by Lauren Fear Director of Corporate Governance and Chief of staff and Cath O'Brien, Chief Operating Officer

2.1.3 National Imaging - hosting agreement.docx

2.1.4 NHS Wales Shared Services Partnership (NWSSP) Patient Medical Records Business Case

Led by Matthew Bunce, Executive Director of Finance

2.1.4a NWSSP PMR Business Case Cover paper.docx

2.1.4b NWSSP Full Business Case.docx

2.2.0 10:20 - For Noting

Led by Prof Donna Mead OBE, Chair

2.2.1 Transforming Cancer Services Programme Scrutiny Sub Committee Highlight Report – 19 May and 21 June 2022

Led by Stephen Harries, Vice Chair and Chair of the TCS Programme Scrutiny Sub-Committee

2.2.1a PUBLIC TCS Programme Scrutiny Committee Highlight Report 19-05-2022 v1.docx

2.2.1b Highlight Report - PUBLIC TCS 21.06.22_SH.docx

2.2.2 Transforming Cancer Services Communication and Engagement Update

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

2.2.2 TCS Communications and Engagement update Trust Board- Finaldocx.docx

2.2.3 Local Partnership Forum Highlight Report - 5 May and 5 July 2022

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

2.2.4a LPF highlight report 05.05_.docx

2.2.4b LPF highlight report 05.07_.docx

2.2.4 Strategic Development Committee Highlight Report – 16 May and 7 July 2022

Led by Stephen Harries, Vice Chair and Chair of the Strategic Development Committee

2.2.6a Highlight Report - PUBLIC SDC 16.05.22.docx

2.2.6b Highlight Report - PUBLIC SDC 07.07.22.docx

2.2.5 Welsh Health Specialised Services Committee Joint Committee Briefing – 12 July 2022

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

2.2.7 WHSCC Joint Committee Briefing (Public) 12 July 2022.pdf

2.2.6 NHS Wales Shared Services Partnership Committee Assurance Report – 19 May 2022

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

2.2.8 SSPC Assurance Report 19 May 2022.doc

2.2.7 Approved Policies Update

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

2.2.9 Approved Policies Update Cover paper - July 2022.docx

a Appendix 1 QS 18 Health Safety and Welfare Policy_v8_July 2022.pdf

b Appedix 2 IG 05 Software Policy_v4_July 2022.pdf

c Appendix 3 IG 06 Anti-Virus Policy_v4_July 2022.pdf

d Appendix 4 IG 11 Data Quality Policy_v2_July 2022.pdf

e Appendix 5 IG 13 Confidentiality Breach Reporting Policy_v2_July 2022.pdf

f Appendix 6 IG01-Records Management Policy_v2_July 2022.pdf

g Appendix 7 IG08-FOIA Policy_v2_July 2022.pdf

h Appendix 8 IG 13 Confidentiality Breach Reporting Policy_v2_July 2022.pdf

i Appendix 9 IG 14 Information Asset Policy_v2_July 2022.pdf

j Appendix 10 IG08-FOIA Policy_v2_July 2022.pdf

k Appendix 11 QS 03 Handling Concerns Policy_v2_July 2022.pdf

3.0.0 PRESENTATIONS AND GUEST ATTENDEES

3.1.0 10:30 - Anti-Racist Wales Action Plan

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

3.1.0 ARWAP Board July 2022 - Publish Version.pptx

4.0.0 KEY REPORTS

4.1.0 10:40 - Chair's Update

Led by Prof Donna Mead OBE, Chair

4.1.0 Chair Update Report 28.07.2022 LF DM.pdf

4.2.0 10:45 - CEO's Update

Led by Steve Ham, Chief Executive

4.2.0 Chief Execs 28.07.2022 v2.docx

5.0.0 ANNUAL REPORTS

5.1.0 10:50 - Putting Things Right Annual Report

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

5.1.0 Putting Things Right Annual Report 2021-22.docx

5.2.0 11:00 - Patient and Donor Experience Annual Report

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

5.2.0 Annual Patient Donor Experience Annual Report 2021-22 (004).docx

5.3.0 11:10 - Trust-wide Nurse Staffing Levels (2016) Act - Annual Report

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

5.3.0 Trust-wide Nurse Staffing Levels Act.docx

5.4.0 11:20 - Safeguarding Annual Report

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

5.4.0 Safeguarding Annual Report JULY 2022 (002).docx

5.5.0 11:30 - Infection, Prevention and Control Annual Report

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

5.5.0 IPC ANNUAL REPORT 2021-2022.docx

5.6.0 11:40 - Local Partnership Forum Annual Report

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

5.6.0a Cover Paper LPF Annual Report.docx

5.6.0b LPF Annual Report 2021-2022.docx

6.0.0 11:50 - BREAK

7.0.0 QUALITY, SAFETY & PERFORMANCE

7.1.0 12:00 - Quality and Safety Framework

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

7.1.0 Quality Safety Framework.pdf

7.2.0 12:10 - Delivering Excellence Performance Report for the Period Ended May 2022

Led by Cath O'Brien, Chief Operating Officer

7.2.0a FINAL VUNHST MAY PERFORMANCE COVER PAPER FOR JULY TRUST BOARD.docx

7.2.0b FINAL VCC Performance Report - May 2022 (ver3.0).docx

7.2.0c Final WBS May 2022 PMF Report (inc last qtr).pdf

7.2.0d Trust-wide WOD Performance Report - May 2022.pdf

7.3.0 12:20 - Financial Report for the Period Ended June 2022

Led by Matthew Bunce, Executive Director of Finance

7.3.0a Month 3 Finance Report Cover Paper - Trust Board 28.07.22 FINAL.docx

7.3.0b M3 VELINDRE NHS TRUST FINANCIAL POSITION TO JUNE 2022 - Trust Board 28.07.022 FINAL.docx

7.4.0 12:30 - VUNHST Risk Register

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

7.4.0 Trust Board Risk Paper -28..07.2022.pdf

7.5.0 12:40 - Trust Assurance Framework

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

7.5.0a TAF Trust Board Cover Paper - 28.07.2022.docx

7.5.0b V8 TAF DASHBOARD - UPDATED 20.07.2022.pdf

7.6.0 12:50 - Audit Committee Highlight Report

Led by Martin Veale, Independent Member and Chair Audit Committee

7.6.0 Audit Committee Highlight Report 03 May 2022.docx

7.7.0 13:00 - Quality, Safety & Performance Committee Highlight Report – 14 July 2022

Led by Vicky Morris, Independent Member and Chair of the Quality, Safety & Performance Committee

7.7.0 Public Quality Safety Performance Committee Highlight Report 14.7.22 (v4VM).docx

8.0.0 ANY OTHER BUSINESS

Prior Approval by the Chair Required

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 MEETING

Thursday 29th September 2022

11.0.0 13:10 - LUNCH

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

VELINDRE UNIVERSITY NHS TRUST

PUBLIC TRUST BOARD MEETING 26 MAY 2022
ACTION LOG

ACTIONS ARISING FROM 27/01/2022					
No.	**Action**	**Owner**	**Target Date**	**Progress to date**	**Status (Open / Closed)**
4.1.0	**Annual Audit Wales Report 2021 – Velindre University NHS Trust** Audit Wales to revise its Annual Report to ensure it is clear that the report is written in the first person by the Auditor General.	Audit Wales		Audit Wales clarified that the Report is written on behalf of Velindre. There will be no change made this year, however, it will be looked at for the next Annual Report.	**CLOSED**
7.2.0	**Cardiff Cancer Research Hub, Proposal for a Tripartite partnership between Cardiff and Vale UHB, Cardiff University and Velindre University NHS Trust** 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.	Deputy Director of Planning and Performance	**November 2022**	All have agreed there is a requirement to develop a commercial and investment strategy (including Heads of Terms). This work will be supported by an external consultant. Update will be provided to the Board in the November meeting.	**OPEN**

ACTIONS ARISING FROM 31/03/2022					
No.	**Action**	**Owner**	**Target Date**	**Progress to date**	**Status (Open / Closed)**
2.1.1	**Minutes from the Public Trust Board meeting held on 27 January 2022** The Chair and Director of Corporate Governance and Chief of Staff agreed to review the level of detail captured in relation to the input of Independent Members and how this is articulated going forward.	Director of Corporate Governance and Chief of Staff	**28 July 2022**	This feedback has been reflected in the draft minutes for the March meeting. A review and agreement of the approach to the style for the minutes will be captured as part of a working group agreed at the June Board Development Session.	**CLOSED**
2.2.3	**Transforming Cancer Services Programme Scrutiny Sub Committee Highlight Report** A meeting to be arranged with the Community Health Council (CHC) to discuss communications and engagement in relation to the programme.	Director of Strategic Transformation, Planning and Digital & Director of Corporate Governance and Chief of Staff	**30 May 2022**	A meeting was held between the Trust and the CHC on 07.07.2022 and an approach was agreed.	**CLOSED**
8.2.0	**Integrated Medium Term Plan 2021-2022 Quarter 3 Update** An explanation for red, amber green to be incorporated into future reporting.	Chief Operating Officer & Deputy Director of Planning and Performance	**28 July 2022**	The below will be added to all future reporting: • Red=challenges causing problems • Amber=issues have been identified • Green=satisfactory progress is being made This will be included in the next reporting cycle for the July Trust Board	**CLOSED**

ACTIONS ARISING FROM 26/05/2022					
No.	**Action**	**Owner**	**Target Date**	**Progress to date**	**Status (Open / Closed)**
2.1.2	**Commitment of Expenditure Exceeding Chief Executives Limit** Executive Director Signature to be added to the Fire Door Replacement Scheme.	Director of Strategic Transformation Planning and Digital	**30 May 2022**	Executive Director signature was added.	**CLOSED**
	Amendment to be made to the Compartmentation Proposal to correctly reflect the value	Executive Director of Finance	**July 2022**	The paper has been amended and will be republished on the website.	**CLOSED**
5.1.0	**Trust Enabling Strategies for Approval** The case studies that are to be included in the Trust Enabling Strategies will be circulated to the Board when finalised.	Director of Strategic Transformation, Planning and Digital	**28 July 2022**	Draft case studies are being progressed and will go through a final quality assurance process prior to being circulated to the Board.	**OPEN**
	Trust Enabling Strategies for Approval The Estates Strategy to be reviewed and amended where it states 'eradicate carbon' to reflect 'zero carbon'.	Director of Strategic Transformation, Planning and Digital	**28 July 2022**	The Strategy has been amended.	**CLOSED**
5.2.0	**Patient Engagement Strategy** A review of the title Patient Engagement Strategy to ensure its scope is made clearer.	Assistant Director of Communications and Engagement	**November 2022**	Following review, it has been determined that the Strategy makes clear that its scope includes patients, their carers and families from the outset.	**CLOSED**

ACTIONS ARISING FROM 26/05/2022					
No.	**Action**	**Owner**	**Target Date**	**Progress to date**	**Status (Open / Closed)**
6.4.0	**Audit Committee Highlight Report - 3 May 2022** An update will be provided to the Board on the status of addressing issues with regard to updates of actions and recommendations in the Trust Audit Action Tracker.	Executive Director of Finance	**28 July 2022**	The Executive Management Board at its meeting on 1st July 2022 endorsed improvements to the Audit Tracker which were subsequently approved at the Audit Committee on the 19th July 2022.	**CLOSED**
7.2.0	**Radiotherapy Satellite Centre Full Business Case** The Executive Summary will be added to the Radiotherapy Satellite Centre Full Business Case.	Director Cancer Services	**November 2022**	The executive summary was included in the Full Business Case and submitted to Welsh Government in May 2022 where it is being reviewed/scrutinised.	**CLOSED**

MINUTES PUBLIC TRUST BOARD MEETING – PART A

VELINDRE UNIVERSITY NHS TRUST LIVE STREAMED
26 MAY 2022 at 10:00AM

PRESENT	
Professor Donna Mead OBE	Chair
Stephen Harries	Vice Chair
Hilary Jones	Independent Member
Professor Andrew Westwell	Independent Member
Gareth Jones	Independent Member
Steve Ham	Chief Executive
Nicola Williams	Executive Director of Nursing, AHPs & Health Science
Matthew Bunce	Executive Director of Finance
Jacinta Abraham	Executive Medical Director
ATTENDEES	
Lauren Fear	Director of Corporate Governance and Chief of Staff
Carl James	Director of Strategic Transformation, Planning & Digital
Emma Stephens	Head of Corporate Governance
Kay Barrow	Corporate Governance Manager
Lenisha Wright	Business Support Manager, Secretariat

1.0.0	STANDARD BUSINESS	ACTION LEAD
	The Chair opened the meeting and welcomed everyone in attendance. It was confirmed that the meeting is to be livestreamed for those joining the meeting remotely, the recording of which will be made available on the Trust Website.	
1.1.0	**Apologies** The Chair noted the following apologies: 1. Cath O'Brien MBE, Chief Operating Officer 2. Vicky Morris, Independent Member 3. Martin Veale, Independent Member 4. Sarah Morley, Executive Director of Organisational Development & Workforce	
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. Stephen Allen, Chief Officer, South Glamorgan Community Health Council 3. David Cogan, Patient Liaison Representative 4. Alan Prosser, Director Welsh Blood Service *(on behalf of Cath O'Brien for the Welsh Blood Service)* 5. Rachel Hennessy, Acting Director Velindre Cancer Service *(on behalf of Cath O'Brien for the Velindre Cancer Service)*	

	6. Susan Thomas, Deputy Director of OD & Workforce *(on behalf of Sarah Morley* The Chair also extended a warm welcome to the following individuals joining the meeting for specific items on the agenda: 1. Non Gwilym, Assistant Director of Communications and Engagement *(item 6.1.0)* 2. Ann Marie Jones, Business Support Manager *(item 6.1.0)* 3. Sarah Evans, Commercial Director, Cwmpas *(item 6.1.0)* 4. Gavin Bryce, Associate Director of Programmes *(item 8.1.0)* 5. Huw Llewellyn, Director of Commercial and Strategic Partnerships *(item 8.1.0)* 6. Andrea Hague, Director Cancer Services *(item 8.2.0)*	
1.3.0	**Declarations of Interest** There were no Declarations of Interest to note.	
1.4.0	**Matters Arising**	
1.4.1	**Action Log** The updates reported in the Action log were noted by the Board. A summary of discussions on two actions is summarised below: • **Action 4.1.0 (27/01/2022)** - It was clarified that the issue raised was that the report is written in the first person by the Auditor General, without there being an explicit reference to the Auditor General title nor name. There will be no change made to this year's report, however, it will be looked at for future reporting. Gareth Jones responded that he understands the current situation , but it is hoped that this is made clearer with the next audit report. Agreed to **CLOSE** this action. • **Action 7.2.0 (27/01/2022)** - The progress made in establishing the Cancer Research Hub was noted and 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. The Chair raised that when drawing up the Heads of Terms, the Velindre University NHS Trust Branding must be considered. Currently, it is called the Cardiff Cancer Research Hub and the Trust name is not included. Dr Jacinta Abraham responded that it has been agreed in principle but is yet to be formalised. The Trust Board **APPROVED** the Action Log and noted the above points.	
2.0.0	**CONSENT ITEMS**	
2.1.0	**FOR APPROVAL**	
2.1.1	**Minutes from the Public Trust Board meeting held on 31 March 2022** The Trust Board **CONFIRMED** the Minutes of the meeting held on 31 March 2022 were an accurate and true reflection.	

2.1.2	**Commitment of Expenditure Exceeding Chief Executives Limit** Gareth Jones queried whether the ***Fire Door Replacement Scheme (Appendix 1)*** should be signed by an Executive Director, as currently it is signed by an Assistant Director. Carl James gave assurance to the Board that his signature will be added. Matthew Bunce noted that a correction will be made to the ***Compartmentation Proposal (Appendix 2)*** to correctly reflect the value, the last three digits will be removed, or a decimal inserted to avoid confusion as the amount is in thousands not millions. The Trust Board noted the above points and **AUTHORISED** the Chief Executive to **APPROVE** the award of contracts summarised within this paper and supporting appendices and **AUTHORISED** the Chief Executive to **APPROVE** requisitions for expenditure under the named agreements. **ACTION:** Executive Director Signature to be added to the Fire Door Replacement Scheme. **ACTION:** Amendment to be made to the Compartmentation Proposal to correctly reflect the value	**CJ** **MB**
2.2.0	**FOR NOTING**	
2.2.1	**Remuneration Committee Highlight Report (24th February 2022)** The Trust Board **NOTED** the contents of the report and actions being taken.	
2.2.2	**Transforming Cancer Services Programme Scrutiny Sub Committee Highlight Report (4th May 2022)** Stephen Harries highlighted that extensive discussions took place at the TCS Scrutiny Sub Committee regarding the Risks and Issues Register, detailed on **page 2** of the report. Independent Members Hilary Jones and Gareth Jones raised that a request has been made for some risks that are now issues to be reviewed and updated. The Trust Board **NOTED** the contents of the highlight reports and points raised.	
2.2.3	**Transforming Cancer Services Communication and Engagement Update** The Trust Board **NOTED** the update report.	
2.2.4	**Welsh Health Specialised Services Committee Joint Committee Briefing - 10 May 2022** The Trust Board **NOTED** the contents of the briefing dated 10th May 2022 which sets out the key areas of consideration and aims to ensure everyone is kept up to date with what is happening in Welsh Health Specialised Services.	

2.2.5	**Shared Services Partnership Committee Assurance Report - 24 March 2022** The Trust Board **NOTED** the work of the Shared Services Partnership Committee and the assurance report from its meeting on the 24 March 2022.	
2.2.6	**Policies Approved Report** The Trust Board **NOTED** the policies that have been approved since the March 2022 Trust Board.	
3.0.0	**PRESENTATIONS AND GUEST ATTENDEES**	
	There were no presentations to note.	
4.0.0	**KEY REPORTS**	
4.1.0	**Chairs Update** The Trust Board **NOTED** the content of the Chair's Update Report.	
4.2.0	**CEO Update** The Trust Board **NOTED** the contents of the CEO Update Report.	
5.0.0	**STRATEGIC DEVELOPMENT**	
5.1.0	**Trust Enabling Strategies for Approval** The Chair noted that each of the Trust Enabling Strategies had been presented at the Strategic Development Committee, providing assurance to the Board that they have received significant scrutiny by the Committee. The Chair invited Carl James, supported by Sue Thomas to present this item. Carl James thanked the Chair and highlighted the following key points: • The Trust Board approved in January 2022 the new purpose, vision and five strategic goals. • Presented today are the enabling strategies which includes Digital, People, Sustainability and Estates. • The overall engagement process spanned over two and a half years, covering 500 to 600 people. Information was gathered from various conversations including with staff, patients, donors and wider community. There was valuable insight gathered from this exercise. • The Board was given assurance that a rigorous process had been followed. Susan Thomas presented the People Strategy to the Board highlighting the following: • The People Strategy focusses on ensuring a sustained workforce. • The priorities incorporated in the Strategy include wellbeing, education, and training. It is a key priority to ensure the wellbeing of the workforce. • The right people in the right place at the right time is of utmost importance.	

	• The Workforce Strategy is aligned with other strategies such as the Digital Strategy. Stephen Harries noted the comprehensive engagement process and extensive discussions held at Strategic Development Committee (SDC). These discussions will be included in the next set of minutes and the Highlight Report which will be submitted to the next Board meeting. Stephen Harries noted the following areas of questioning and scrutiny that were discussed at length at the Strategic Development Committee: • Engagement – Who have been engaged through this process both internally and externally? • How connected are each of these strategies and to what extent do they interact with each other? • How does it support the ***'here and now'*** as well as the ***future***? • How do the strategies work with the Integrated Medium Term Plan (IMTP) and how do they support each other? • The issue of required funding and resources had been discussed. • How do we get the balance between targets that are challenging but achievable, because stretched targets that are actually unachievable and cannot be met will be of no benefit to the Trust? Hilary Jones added that this is a long term strategy, requiring a great deal of work to implement, and queried action plan and supporting timelines. Carl James responded that a plan with timelines will be included in the next stage of the process and will follow approval of the Board today. It was noted to the Board that work in this regard has already resumed. Steve Ham added that this will be prioritised and feature in the IMTP. Gareth Jones noted that the report mentioned case studies will be included in the final versions. ****ACTION: The case studies that are to be included in the Trust Enabling Strategies to be circulated to the Board when finalised.** Hilary Jones noted the ambition to ***'eradicate carbon'*** is mentioned in the paper and questioned if this is achievable. Carl James responded that this will be amended to reflect 'zero carbon' language. ****ACTION: The Estates Strategy to be reviewed and amended where it states 'eradicate carbon' to reflect 'zero carbon'.** Jacinta Abraham added from a Clinical perspective we need to understand what our leadership responsibilities are to Society as well as to the organisation. These are the conversations that need to be held to support the Strategy, which comes with its challenges. The Trust Board **APPROVED** the following, subject to the provision of case studies that will be circulated to the Board: • Sustainability Strategy 2022 – 2032 • People Strategy 2022 – 2032 • Digital Strategy 2022 – 2032	**CJ** **CJ**

	• Estates Strategy 2022 – 2032 The Trust Board **NOTED** that ***'current/future'*** case studies will be included in the final versions.	
5.2.0	**Patient Engagement Strategy** The Chair noted that the Patient Engagement Strategy has also been presented at the Strategic Development Committee and subject to significant scrutiny providing further assurance to the Board. The Chair invited Non Gwilym to present this item supported by invited attendees. Non Gwilym thanked the Chair and began by introducing Ann Marie Jones, Sarah Evans, Hilary Jones and David Cogan who were invited to support the presentation of the Patient Engagement Strategy to the Board. Sarah Evans presented outlined the details of the stakeholder engagement undertaken. At the outset, a review of best practice approaches from other organisations was undertaken. There was involvement from patients and family members. Also included were clinical staff, volunteers and management teams. Hilary Jones echoed that there was extensive engagement and was proud to Chair the Steering Group. The key themes emerging from the engagement exercise included information, communication, feedback, research and digital. Patients wanted more information not just at the start of treatment, but also at the end. There was a request from patients for a place they could go to ask questions. Regarding method of communication, they wanted to be given the opportunity to choose the options best suited to them. There were several requests for digital communication however, they also wanted traditional means available. In addition, there was a huge appetite for more involvement in research where they could play an active role. David Cogan outlined the input received from the Patient Liaison Group, adding that there is a voice for more involvement from a patient liaison point of view. We need to look at how we fulfil these expectations in the future. Non Gwilym presented the Patient Engagement Strategy Goals highlighting the following: • A patient friendly version of the goals will be publicised shortly. • To resource this work, a Patient Engagement Hub will be established at the Velindre Cancer Service. This will help coordinate and publicise ongoing work. The following is a summary of the Board key observations and questions: • Andrew Westwell requested clarity on whether this was a Trust wide or Velindre Cancer Service Strategy. Alan Prosser added that the Welsh Blood Service (WBS) is in the process of developing an Engagement Strategy which will be communicated to the Board in the future. • Stephen Harries added that it is pleasing to hear that former patients have been involved. He queried whether this is only a Patient Engagement Strategy or whether it is intended to include Carers? Non Gwilym	

	responded that it is intended to include engagement with Carers and that the description will be made clearer. ****ACTION: A review of the title Patient Engagement Strategy to ensure its scope is made clearer.** • Stephen Allen noted that it is good to see people have come forward to provide support and wished success for its full implementation. The question was raised about how engagement will take place with the wider community and public. In addition, how will this work to ensure there is one voice to avoid conflicting messages from different spaces between the current model and the future models expected from Welsh Government next year. Steve Ham responded that as the Citizens Voice Body is operational from 2022/23, we need to dovetail this approach into the new working arrangements. Non Gwilym added that the detailed strategy talks about alignment which means this is not a static piece of work. • Carl James noted that this is a great piece of work and requested more information on the infographic for 'Patient Promise' which reads 'excel in our statutory obligations'. We can either meet or exceed our obligations. It was also observed that the infographic is a patient infographic which excludes carers and families. • The Chair congratulated Non Gwilym and the team on an excellent piece of work that has been undertaken. The Trust Board **APPROVED** the final draft of the **Patient Engagement Strategy**, included at ***Appendix 1***.	**NG**
6.0.0	**QUALITY, SAFETY AND PERFORMANCE**	
6.1.0	**Quality, Safety & Performance Committee Highlight Reports (12 May 2022)** Nicola Williams presented the Quality, Safety and Performance Committee Highlight report from its meeting held on 12th May 2022 and highlighted the following key points: • The triangulated core theme arising across a number of reports was workforce, finance and operational delivery, with workforce being the largest risk factor. • Performance was discussed at length and scrutiny of plans. • The Trust have contained the recent COVID outbreak at VCC which was quickly contained with no harm to patients or any identified breaches. This is due to the robust processes that have been put in place around infection control. • There has been an improvement in complaint response times, highlighted in the quarter four Putting Things Right report. • Stephen Harries added that the workforce aspects around wellbeing of staff was discussed at length.. Assurance was provided to the Committee by highlighting what is being done to address staff wellbeing.	

	The Trust Board **NOTED** the key deliberations and highlights from the meeting of the Quality, Safety & Performance Committee held on the 12th May 2022.	
6.2.0	**Delivering Excellence Performance Report for the Period Ended March 2022** **Welsh Blood Service** Alan Prosser highlighted the following key points in respect of performance at the Welsh Blood Service: • There was a blue alert on the blood supply chain at the time of compiling the report due to a strain on stock levels and remains in place. This is a result of a number of factors including the holiday period and demands within the service increasing. Sickness absence and vacancies have also had an impact. However, the Service has performed well. • The Patient Diagnostics Laboratory Service is under some strain. This is due to staffing issues in a highly specialised area. A short, medium and long term plan to address this is in place. • Satisfaction levels are high from donors with a low number of complaints. • The Board was notified of a letter sent by Stephen Allen from the CHC to thank the WBS for the good work undertaken. This was in response to a presentation given to the CHC on some of the challenges and improvements made within the Welsh Blood Service. **Velindre Cancer Service** Rachel Hennessey highlighted the following key points in respect of performance at the Velindre Cancer Service: • The context has changed in recent months. The Service has not achieved some of its targets. • A Radiotherapy Pathway Lead has been appointed to undertake detailed work around process variations to address some of the challenges. • There have been useful conversations with partner organisations to enable increased capacity and bringing in additional chairs to help facilitate some of the work going forward. • Outpatient waiting time performance data has been paused. This is due to the accuracy of the markers. Work is being done to establish a better marker to monitor and record patient experience data. It was noted by the Chair and the Board that outpatients should remain on the performance report to have visibility of the data in the performance report going forward. Susan Thomas provided an update on performance pertaining to Workforce and Organisational Development. • The report presents a triangulation of matters to ensure the data gives broader spectrum of information including Sickness Absence and Performance, Achievement and Development Reviews (PADR). • The report provides information on staff absence due to sickness with some staff having to isolate due to having COVID.	

	• Stress and anxiety remains one of the biggest challenges. Measures are in place to address this. A staff Psychologist has been appointed in the Trust to support health and wellbeing. Trust Board **NOTED** the contents of the performance reports and appendices.	
6.3.0	**Financial Report for the Period Ended March 2022** Matthew Bunce highlighted the following key points: • The Financial Audit is due to be concluded shortly. Assurance is given that all targets have been met. • It was noted that there is a small underspend of £28k. • There are no significant issues to flag to the Board, noting the NHS wide issue regarding pensions has been discussed with the Board previously. Gareth Jones wanted to note that on the final page of the cover paper it should read 'underspend of £28k'. Matthew Bunce advised that this will be corrected. The Trust Board **NOTED** the contents of the March financial report and in particular the financial performance for 2021-22.	
6.4.0	**Audit Committee Highlight Report - 3 May 2022** Matthew Bunce confirmed that the Highlight Report had not been included in the papers as the Chair of the Audit Committee had not had an opportunity to review and approve the report due to coinciding with annual leave. Therefore, an oral update will be provided on items for alert to the Board. Matthew Bunce advised that one item had been identified to alert to the Trust Board regarding the Trust Audit Action Tracker. The Audit committee noted that there were 41 overdue recommendations identified as red. Some with dates that have passed, some requests for extensions and others not. The Audit Committee raised concerns that this was not a satisfactory position. The Committee made it clear that each of these audit reports require executive ownership and owner needs to be included in the audit tracker and reviewed providing assurance back to the Committee. ****ACTION: An update will be provided to the Board on the status of addressing issues with regard to updates of actions and recommendations in the Trust Audit Action Tracker.** The Trust Board **NOTED** the oral update on those items contained under ALERT in the Audit Committee Highlight Report of the 3rd May 2022.	**MB**
6.5.0	**VUNHST Risk Register** Lauren Fear took the Board through the Risk Report and highlighted the following: • The report shares the March 2022 extract of Risk Registers in Datix and summarises updates from the previous Board meeting.	

	• The key final steps to implement the Risk Framework is detailed and expected to be finalised by end June 2022. • Risks level 20 and 16 are contained within the report. There are no level 25 risks. Gareth Jones queried why the highest risk was excluded from the report (page 5, penultimate paragraph) and details of why some review dates have passed (page 8 and 9). Lauren Fear advised that regarding the Digital health and care risks, the way the project team have articulated this has resulted in 3 level 20 risks, and that there was agreement that this is not a clear profile. The appropriate articulation of these risks is currently being undertaken and further details will be provided in the next report. It should be noted that this extract is as at the end of March 2022. Stephen Harries noted that discussions and scrutiny took place at Scrutiny Committee on the Transforming Cancer Services risks prior to submission to the Board. The Trust Board: a) **NOTED** the risks level 20 and 16 reported in the Trust Risk Register and highlighted in this paper. b) **NOTED** the on-going developments of the Trust's risk framework.	
6.6.0	**Trust Assurance Framework** The Chair noted that the Trust Assurance Framework (TAF) has been discussed and reviewed at both the Strategic Development Committee and the Audit Committee prior to being received by Trust Board today. Lauren Fear took the Board through the report and highlighted the following: • The key themes are discussed under 3.3 and the links between the TAF, the Risk register and Performance Frameworks. • There was a point raised at the March 2022 Trust Board about how we view strategic risks across all organisations, locally and globally to frame our review. Further input will be provided going forward. Gareth Jones queried reverse stress testing on Page 10 of the cover paper in terms of timing. Lauren Fear confirmed that it will be done by September. This is important input into the annual review. The Trust Board: a) **DISCUSSED AND REVIEWED** the update to the Trust Assurance Framework Dashboard, included at ***Appendix 1.*** b) **NOTED** the progress made and next steps in supporting the continued development and operationalisation of the Trust Assurance Framework, as outlined in section 3.3.	

6.7.0	**Velindre University NHS Trust Annual Equality Monitoring report** Susan Thomas took the Board through the report and highlighted the following: • This report is compiled in line with the Equality Act and relates specifically to staff. • The Public Sector Equality Duty (PSED) requires all public organisations to produce an Annual Equality Monitoring Report. • Reporting should include actions taken to eliminate discrimination and steps taken to advance opportunities for individuals. • A report with qualitative data up to March 2022 is currently being compiled which will also include benchmarking. • One correction is to be made on pages 7 and 8 which should read 'sex' rather than 'gender'. Hilary Jones requested whether information could be compared with data in the general population. Susan Thomas advised that this will be included in next year's annual report. Gareth Jones requested comparisons on the number of leavers in comparison with other Health Organisations, noting the figures are affected due to numbers included for hosted organisations. Susan Thomas will report this back to the Workforce team for future benchmarking. The Trust Board **DISCUSSED, REVIEWED AND APPROVED** the Annual Equalities Report.	
7.0.0	**TRANSFORMING CANCER SERVICES**	
7.1.0	**Integrated Radiotherapy Solution Outline/Full Business Case** Huw Llewellyn introduced the Integrated Radiotherapy Solution (IRS) Business Case and highlighted that that this work has spanned over a two and a half year period leading up to today's presentation to the Board. The paper provides an overview of the five cases required to present to Welsh Government and the Board, which include economic, commercial, strategic, management and financial business cases. The focus for this action is on the S**trategic case**. Gavin Bryce advised that this is a hybrid business case incorporating the Outline Business Case (OBC) and Full Business case (FBC) and highlighted the following key aspects: • There was a review of the Strategy ensuring alignment with National and Local policies and Cancer Strategies. The Strategic Case sets out a compelling case for investment given the forecast increase in demand, the advances in radiotherapy treatments, inherent inefficiencies of current technology and the age of the Linear Accelerator Fleet at VCC. • The investment objectives are strong and with no change. What is needed is an IRS solution to ensure adequate capacity to meet demands improving experience for patients and staff, and also contributes to research.	

	• The business needs section has been updated and the age for the Accelerator Fleet has been updated. There has also been an update on the attendance figures to include the disruption that COVID has brought. • Benefits and risks are included in the paper which are quantified with senior ownership of the risks. Stephen Harries provided assurance to the Board that this matter underwent extensive review with substantially detailed discussions at the TCS Scrutiny Sub-Committee. Hilary Jones contributed Estates and Planning expertise and Gareth Jones contributed Legal expertise. The Chair noted that the work undertaken is recognised, congratulating Huw Llewellyn and the team on a job well done, which has been a significant undertaking. This has taken skill, expertise and hard work by all involved. The Trust Board **APPROVED** the Strategic Case of the **IRS OBC/FBC**.	
7.2.0	**Radiotherapy Satellite Centre Full Business Case** Andrea Hague took the Board through the Radiotherapy Satellite Centre Full Business Case and highlighted the following: • As part of the TCS programme the need for a Satellite Centre was identified. • After some review Aneurin Bevan was identified as the preferred location for the Satellite. Since then, the Trust has been working with them to develop this case. • This case aligns with the Integrated Radiotherapy Solution case and the new Velindre Cancer Centre Hospital. • The Clinical arguments for the Satellite remain unchanged. • There will be the advantage of local access which has an impact on the uptake of treatments. • It is estimated that more than 65,000 patient journeys will benefit from this. The Chair added that this will also contribute toward sustainability. • It is expected that the Centre could be opened by July 2024. • The case has been approved by Aneurin Bevan's Board yesterday. Stephen Harries recommended the Board Approved the case, reiterating the extensive scrutiny of this at the TCS Scrutiny Sub-Committee. Hilary Jones queried: on Page 1 (Executive Summary) it states **'to be inserted'** does this mean the paper is incomplete? Andrea Hague confirmed that the Executive Summary has been completed and is purely a summary of the business case. The Executive Summary will be added and will not contain any different information. ****ACTION: The Executive Summary will be added to the Radiotherapy Satellite Centre Full Business Case.** The Chair thanked Huw Llewellyn, Gavin Bryce and Andrea Hague for their hard work and diligence which has taken the Trust forward in this regard. This is a very important piece of work.	**AH**

	The Trust Board **APPROVED** the strategic case of the RSC FBC.	
8.0.0	**ANY OTHER BUSINESS** There were no other items.	
9.0.0	**DATE & TIME OF THE NEXT MEETING** Thursday, Thursday 28th July 2022	
10.0.0	**CLOSE**	

TRUST BOARD

BOARD DECISIONS REQUIRED FOR COMMITMENT OF EXPENDITURE EXCEEDING £100K FOR THE PERIOD 28 July 2022 to 29 September 2022

DATE OF MEETING	28 July 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**
Velindre Cancer Service Business Planning Group	26/06/2022	Supported
Divisional Senior Management Team	30/06/2022	Supported
Executive Management Board	30/06/2022	Endorsed for Board Approval

ACRONYMS	
SFIs	Standing Financial Instructions
VUNHST	Velindre University NHS Trust
NWSSP	NHS Wales Shared Services Partnership

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 **28 July 2022 to 29 September 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 decisions being sought from the Trust Board:

Appendix No.	Division	Scheme / Contract Agreement Title	Period of Contract	Total Expected Maximum Value of Contract £ (Inc. VAT)
Appendix 1	Velindre Cancer Service	Chemotherapy electonic prescribing and scheduling system (contract extension)	Start: 01/11/2022 End: 31/10/2024	£ 240,000

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 contracts 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	CHEMOTHERAPY ELECTONIC PRESCRIBING AND SCHEDULING SYSTEM (CONTRACT EXTENSION)
DIVISION / HOST ORGANISATION	Velindre Cancer Service
DATE PREPARED	June 2022
PREPARED BY	Bethan Tranter, Head Pharmacist and Jeff O'Sullivan, Planning and Performance Manager
SCHEME SPONSOR	Rachel Hennessy, Interim Director of Cancer Services

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

1. DESCRIPTION OF GOODS / SERVICES / WORKS

This requirement concerns the provision of a Systemic Anti-Cancer Therapy (SACT) e-prescribing and e-scheduling system which, using a single patient record provides the medication record, clinical information, appointment schedule and pharmacy preparation functionality required for the safe management of cancer patients receiving SACT.

ChemoCare is the current information solution provided by CIS Oncology and is integral to the delivery of SACT services by NHS Wales.

In January 2020, NHS Wales renewed the extant contract providing the e-prescribing system (contract title: Contract for the Support and Maintenance for the Current Oncology Electronic Prescribing and Scheduling System VEL-MINI-41632). At that juncture, it was envisioned that the scoping of requirements for a novel all-Wales, integrated e-prescribing solution would be undertaken, led by Digital Health Care Wales (DHCW), and that a new system would be procured and implemented in anticipation of the end of the new contract term.

The initial term of the new contract is due to end on the 31st October 2022. The contract does provide an option to exercise an extension for a maximum period of two years beyond the terminal date.

DHCW have confirmed that the all-Wales tendering exercise has been delayed due to the requirements of the pandemic response. In conjunction with Cardiff and Vale University Health Board, Swansea Bay University Health Board, Hywel Dda University Health Board and with the

support of NHS Wales Shared Services Partnership, Velindre University NHS Trust is seeking to exercise the maximum two year extension allowed for in the existing contract in order to ensure the on-going support and maintenance of the ChemoCare e-prescribing system after the 31st October 2022.						
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	The initial contract period began on the 15th January 2020. The contract extension, when exercised, will be effective from 1st November 2022.					
Expected End Date of Contract	The initial contract period will end on 31st October 2022. The contract extension, when exercised, will end on the 31st October 2024.					
Contract Extension Options **(E.g. maximum term in months)**	The existing contract allows for a maximum extension of 2 years.					

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**
	☒	☐

The implementation of updates to the existing ChemoCare system is specifically referenced in the IMTP. The use of ChemoCare is otherwise essential to the safe, effective delivery of SACT services at Velindre Cancer Centre.

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 – this option has been declined on the basis that it presents a significant risk that the capability of teams at VCC to deliver a safe, effective SACT service from the 1st November 2022 will be severely compromised.

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option
• On-going support and maintenance of the ChemoCare e-prescribing system will ensure continuity of service pending the implementation of new, all-Wales e-prescribing solution.

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
The service will be unable to maintain an effective e-prescribing system and various essential service capabilities (including prescribing) will be impaired.	• Reactive maintenance work undertaken by VCC staff. • Reactive maintenance work commissioned at a cost premium. • In the event of service outages, implementation of paper based systems to ensure service continuity.

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

The existing contract was procured by means of a mini-competition facilitated by NHS Wales Shared Services Partnership (Link Solutions IT Framework – NHS/16/CR/WAB/8723).

As noted above, at section 1, Cardiff and Vale University Health Board, Swansea Bay University Health Board and Hywel Dda University Health Board have agreed to exercise the contract extension. Following the Velindre University NHS Trust's Board's agreement to commit expenditure, the Trust's Chief Executive will be required to sign an Agreement to Consider a Contract Extension in keeping with established procurement and governance requirements.

6.3 What is the approximate time line for procurement?

Following the Trust Board's agreement to commit expenditure at its July 2022 meeting, the Chief Executive will be required to sign an Agreement to Consider a Contract Extension. This will allow the contract extension to be exercised in anticipation of the 31st October 2022.

6.4 PROCUREMENT ROUTE APPROVAL

The Head of Procurement / Delegated Authority has approved the preferred procurement route	
Head of Procurement Name:	Helen James
Signature:	
Date:	27th June 2022

7. FINANCIAL ANALYSIS

Maximum expected whole life cost relating to the award of contract	**Excluding VAT (£)** **£200,000**	**Including VAT (£)** **£240,000**
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:		

7. PROFILE OF EXPENDITURE

EXPENDITURE CATEGORY	Year 1 (exc. VAT) £	Year 2 (exc. VAT) £	Year 3 (exc. VAT) £	Total Future Years (exc. VAT) £	Total (exc.VAT) £	Total (inc. VAT) £
ChemoCare annual support and maintenance.	£100,000	£100,000	£0	£0	£200,000	£240,000
Overall Total	£100,000	£100,000	£0	£0	£200,000	£240,000

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? E.g. PRINCE 2	ChemoCare is currently in use at Velindre Cancer Centre. Any work relating to its on-going use will be subject to standard project management arrangements.

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:	Rachel Hennessy
Signature:	
Service Area:	Velindre Cancer Centre
Date:	27th June 2022

10. APPROVALS RECEIVED

List and include date of approvals received in support of this scheme.

Divisions	**Date of Approval:**
Business Planning Group or local equivalent	26th June 2022
Divisional Senior Management Team	30th June 2022
Executive Management Board	30th June 2022

Host Organisations	**Date of Approval:**
NWSSP / NHS Wales Shared Services Partnership Committee	N/A
HTW – Senior Management Team	N/A

TRUST BOARD

NHS WALES NATIONAL IMAGING ACADEMY HOSTING AGREEMENT

DATE OF MEETING	28th July 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	

PREPARED BY	Lauren Fear, Director Corporate Governance & Chief of Staff
PRESENTED BY	Cath O'Brien, Chief Operating Officer Lauren Fear, Director Corporate Governance & Chief
EXECUTIVE SPONSOR APPROVED	Cath O'Brien, Chief Operating Officer Lauren Fear, Director Corporate Governance & Chief of Staff

REPORT PURPOSE	APPROVE

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Quality, Safety and Performance Committee	14/07/2022	Endorsed for Approval

ACRONYMS	

1. SITUATION

The National Imaging Academy Wales was established in August 2018 to train the next generation of radiologists and imaging professionals. It was established with funding from the Welsh Government and provides part of the Wales Clinical Radiology Specialist Training Programme, which runs two separate schemes in North and South Wales. The Academy delivers the Royal College of Radiologists curriculum in a dedicated environment which is equipped with the latest technology.

The Academy is hosted by Cwm Taf Morgannwg University Health Board. The Health Board and Academy have been working to formalise and build on the hosting agreement principles agreed at inception.

All NHS Wales Health Boards and Trust, on whose behalf the National Imaging Academy Wales will work, are asked to sign up to the Agreement. NHS Organisations have been asking their Boards for approval over the last number of months.

2. KEY MATTERS FOR CONSIDERATION

The Committee is asked to approve the Hosting Agreement for Trust Board approval. The Trust Board will be asked to approve and delegate the signatory to the Chief Executive Officer.

The Head of Radiation Services and confirms the Agreement meets the needs of the service. This has been endorsed by the Chief Operating Officer.

The Director Corporate Governance confirms that the Agreement meets the governance principles of the Trust.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Quality of Radiation services
RELATED HEALTHCARE STANDARD	Staff and Resources

	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Meets governance principles of the Trust
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

4.1 The Trust Board is asked to **APPROVE** the NHS Wales National Imaging Academy Wales Hosting Agreement.

Cwm Taf Morgannwg University Health Board

&

NHS Wales Health Boards and Trusts

Hosting Agreement 2021 – 2023

Date: February 2021	**Version:** Final Draft

Purpose and Summary of Document:

This agreement is to enable and facilitate the hosting of the NHS Wales National Imaging Academy Wales by Cwm Taf Morgannwg University Health Board on behalf of NHS Wales Chief Executives.

The agreement is intended to ensure that hosting arrangements are clear and transparent and that the rights and obligations of all parties are documented and agreed. The agreement sets out appropriate financial arrangements and the obligations of all parties to the agreement.

1. Parties to this agreement

The parties to this agreement are:

1. Cwm Taf Morgannwg University Health Board, which is the host body.
2. The NHS Wales National Imaging Academy Wales (the NIAW), which is the hosted unit and, for the purposes of this agreement, includes all subsidiary functions, teams and services forming part of the NIAW.
3. All NHS Wales Health Boards and Trusts, on whose behalf the National Imaging Academy Wales will work.

The signatories to this agreement are:

1. Paul Mears, Chief Executive, on behalf of Cwm Taf Morgannwg University Health Board (Host body)

   Signed: _____

   Date: _____

2. Phillip Wardle, Director, on behalf of the National Imaging Academy Wales

   Signed: _____

   Date: _____

3. Mark Hackett, Chief Executive, on behalf of Swansea Bay University Health Board

   Signed: _____

   Date: _____

4. Judith Paget, Chief Executive, on behalf of Aneurin Bevan University Health Board

   Signed: _____

   Date: _____

5. Jo Whitehead, Chief Executive, on behalf of Betsi Cadwaladr University Health Board

   Signed: _____

   Date: _____

6. Len Richards, Chief Executive, on behalf of Cardiff and Vale University Health Board

   Signed: _____

   Date: _____

7. Steve Moore, Chief Executive, on behalf of Hywel Dda University Health Board

   Signed: _____

   Date: _____

8. Carol Shillabeer, Chief Executive, on behalf of Powys Teaching Health Board

   Signed: _____

   Date: _____

9. Steve Ham, Chief Executive, on behalf of Velindre NHS Trust

   Signed: _____

   Date: _____

10. Jason Killens, Chief Executive, on behalf of the Welsh Ambulance Services NHS Trust

    Signed: _____

    Date: _____

11. Tracey Cooper, Chief Executive, on behalf of Public Health Wales

    Signed: _____

    Date: _____

1 Named points of contact

The following individuals will act as the primary points of contact in relation to any issues that may arise under this agreement:

- For Cwm Taf Morgannwg University Health Board : Executive Director of Planning
- For the National Imaging Academy Wales : Director

2 Purpose and scope of this agreement

This agreement is to enable and facilitate the hosting of the National Imaging Academy Wales by Cwm Taf Morgannwg University Health Board on behalf of NHS Wales Chief Executives.

The agreement is intended to ensure that hosting arrangements are clear and transparent and that the rights and obligations of all parties are documented and agreed.

The National Imaging Academy Wales' annual work plan and performance management arrangements are agreed between the Director of the National Imaging Academy Wales and the Collaborative Executive Group, prior to final sign off by the Collaborative Leadership Forum.

3 Status of this agreement

This agreement is not legally binding and no legal obligations or legal rights arise between the parties from it. The parties enter into this agreement intending to honour its content and spirit.

This agreement is one which is subject to S.7 of the NHS (Wales) Act 2006.

The parties agree that they shall act:

- in the spirit of good faith
- in the interests of minimising costs to themselves
- in the interests of maintaining quality at all times
- in accordance with any applicable statute, directions, orders, guidance or policy.

4 Duration of this agreement

This agreement commences on 1 April 2021 and will run for a period of two years until 31 March 2023.

5 Monitoring and review of this agreement

The Director of the National Imaging Academy Wales will liaise regularly with the Cwm Taf Morgannwg University Health Board, Deputy Chief Executive, to monitor the operation of this agreement and to address and resolve any practical issues that may emerge.

5.1 Six monthly formal review meetings

The Chief Executive, Cwm Taf Morgannwg University Health Board and the Director of the National Imaging Academy Wales (or nominated deputies) will meet six monthly to discuss current/live issues, the NIAW's progress on establishing governance arrangements with the NHS, and any particular issues relating to hosting arrangements. They will also include early discussions on possible changes or additions to the NIAW's role and remit.

5.2 Review meetings

The named points of contact (section 2) will meet at least 6 monthly to discuss hosting arrangements and any particular areas of concern. These meetings will include discussion of:

- matters relating to workforce, finance, procurement, facilities and any other corporate support services (note IT requirements will be met via a separate agreement with NWIS)
- possible changes to the NIAW's remit and any other matter which is likely to impact on the corporate support provided by Cwm Taf Morgannwg University Health Board.
- financial performance and any variance against budget, in particular potential over or underspends.

The NIAW will provide a short written report before each quarterly meeting confirming compliance with policies and procedures (e.g. statutory and mandatory training compliance), highlighting any areas of non-compliance.

5.3 Audit Committee

The Director of the National Imaging Academy Wales will attend the Cwm Taf Morgannwg University Health Board Audit Committee at least annually,

or as requested by the Audit Committee, to provide assurance to the Committee that the NIAW is complying with the Hosting Agreement and to highlight and discuss any areas of risk or non-compliance.

5.4 Annual Assurance Statement

The National Imaging Academy Wales will provide an Annual Assurance Statement to Cwm Taf Morgannwg University Health Board, to confirm that they have complied with the hosting arrangements, highlighting any areas of concern, risk or non-compliance. This statement will inform Cwm Taf Morgannwg University Health Board's Annual Governance Statement.

5.5 Review

The agreement will be reviewed in the fourth quarter of each year by all parties to ensure that it is operating effectively and amendments will be agreed as required.

6 Termination and notice period

The parties acknowledge that if one of the signatories to this document withdraws or otherwise terminates its responsibilities this agreement will terminate twelve months after that event and a new agreement will be drafted and agreed by all the parties that wish to continue to engage with each other in respect of NIAW.

7 Background

In 2016, NHS Wales Chief Executives confirmed their intention to establish an NHS Wales National Imaging Academy Wales to primarily increase the number of Radiology trainees in NHS Wales (with increased classroom training within a dedicated and appropriately equipped facility, significantly enhancing the training capacity, with an economy of scale for required trainer time).

In April 2017 Cwm Taf Morgannwg University Health Board was formally requested to host the National Imaging Academy Wales and its Director and staff. This request was formally accepted by the Cwm Taf Morgannwg University Health Board on 7 July 2017, subject to confirming hosting arrangements via the hosting agreement.

Phillip Wardle was appointed as Director of the National Imaging Academy Wales on 1st November 2018.

8 Nature of the hosting arrangement

Cwm Taf Morgannwg University Health Board, will provide services and facilities as agreed with Health Boards and NHS Trusts under this hosting agreement, to enable the smooth running of the National Imaging Academy Wales, but will not be responsible or accountable for setting the direction of the NIAW or for the quality of the work undertaken by the NIAW. This rests with the Director of the National Imaging Academy Wales reporting directly through the NHS Wales CEO Lead for Imaging to the Collaborative Executive Group and Collaborative Leadership Forum.

9 Appointment of the Director of the National Imaging Academy Wales

The Director of the National Imaging Academy Wales and the Academy staff are employed by Cwm Taf Morgannwg University Health Board, but the Director will be appointed by the Chief Executive of the Host Body (on behalf of NHS Boards and Trusts) on recommendation and appropriate scrutiny through interview led by the Chief Executive Lead for NHS Wales NHS Wales CEO Lead for Imaging, who are also responsible for ensuring continuity of leadership for NIAW.

10 Financial arrangements

10.1 Setting of and responsibility for the National Imaging Academy Wales budget

Whilst complying with Cwm Taf Morgannwg University Health Board's Standing Orders and Standing Financial Instructions (see below), the Director of the National Imaging Academy Wales will be accountable through the Host Body Chief Executive to the Collaborative Executive Group.

The Director of the National Imaging Academy Wales will have an authorisation limit of £100,000 (equivalent to an Executive Director of Cwm Taf Morgannwg University Health Board) and will specify an appropriate scheme of delegation for the management of the NIAW's budget. Expenditure over £100,000 will need authorisation from the Chief Executive / Deputy Chief Executive, Cwm Taf Morgannwg University Health Board (following discussion with the Director of the NIAW and the Lead Chief Executive for Imaging).

Cwm Taf Morgannwg University Health Board will provide the National Imaging Academy Wales with monthly financial budget/expenditure reports. The NIAW will be responsible for checking the accuracy of these reports and for reporting and explaining any variance of expenditure against budget profile.

The initial recurring core budget, and contribution shares, for the NIAW were agreed by all parties in 2017/18.

Recurring and non-recurring changes to the NIAW's core budget will be agreed between the Director of the National Imaging Academy Wales and the Collaborative Leadership Forum. Such changes may include in-year recurring or non-recurring uplifts contributed by health boards and trusts to cover agreed additional activities.

10.2 Additional funding

In addition to its core budget, the National Imaging Academy Wales may receive additional recurring or non-recurring income from individual NHS Wales bodies or from other sources, for specific work undertaken.

The NIAW will inform Cwm Taf Morgannwg University Health Board of all arrangements for additional funding, and the terms under which the funding is being provided. Any external funding from industry partners must be compliant with any related host body Policies.

Any additional capital funding required for the initial project, on-going maintenance and developments, will need to be provided from within the partner organisations' discretionary capital allocations or if significant, be presented via a joint capital bid to the Welsh Government.

10.3 Financial variances

The Director of the National Imaging Academy Wales must achieve a break-even position each financial year. The Director of the National Imaging Academy Wales is responsible for informing the Lead Chief Executive for imaging and the Cwm Taf Morgannwg University Health Board Chief Executive, at the earliest practicable stage, of any significant forecast variances and, in particular, of risks that may result in the underwriting provisions described in section 11.4 below being required.

In the event that there is a predicted under or overspend against the budget for the NIAW in any year, the parties to this agreement shall consider:

- in the case of an under spend, whether there are any alternative uses to which the funds can be put consistent with the role of the NIAW, or whether funds should be returned to contributing bodies

- in the case of an over spend, what steps can be taken to prevent the overspend arising
- any liability that exists as a result of any overspend will be shared on a joint and several basis between the parties signed to this agreement on an agreed risk sharing basis.

10.4 Financial liabilities

Cwm Taf Morgannwg University Health Board shall be the responsible legal entity in relation to liabilities to third parties, save where excepted in this agreement.

The activities of the NIAW will be covered by the Welsh Risk Pool, via Cwm Taf Morgannwg University Health Board, but will be subject to the normal excess arrangements.

The NHS Wales Chief Executives will collectively underwrite the financial liabilities of the NIAW (on agreed risk sharing basis), where such liabilities cannot be met from within the NIAW's budget or are not covered by the Welsh Risk Pool. This includes any costs associated with redundancy, termination or breaches of employment contract, disputes and health and safety matters.

10.5 Levy to cover the costs of hosting the National Imaging Academy Wales

Cwm Taf Morgannwg University Health Board will charge a levy to cover the **additional** costs of hosting the NIAW (above those costs incurred by Cwm Taf Morgannwg University Health Board prior to the establishment of the National Imaging Academy Wales).

On the establishment of the NIAW, an agreed annual recurring revenue requirement of £82,000 will be provided to Cwm Taf Morgannwg University Health Board, to cover its 'core' hosting costs.

This levy will need to be reviewed and adjusted upwards on confirmation of any additional support required by the National Imaging Academy Wales from the host body.

The hosting levy will be reviewed each year, as part of the overall review of this agreement (see section 6.5) and any additional 'core' hosting costs would need to be managed within the overall agreed NIAW revenue allocation.

With the exception of the agreed levy to cover the hosting costs and any agreed costs arising from issues detailed in sections 11.1 and 11.2, no deductions will be made from the National Imaging Academy Wales's budget

by Cwm Taf Morgannwg University Health Board and Cwm Taf Morgannwg University Health Board's Cost Reduction Programme / savings targets will not be applied.

Cwm Taf Morgannwg University Health Board will not fund or be liable for any National Imaging Academy Wales cost pressures, which must be funded within the agreed NIAW budget.

11 Obligations of Cwm Taf Morgannwg University Health Board under this agreement

11.1 General obligations of Cwm Taf Health Board

Cwm Taf Morgannwg University Health Board shall be responsible for providing services and facilities to enable the smooth running of the National Imaging Academy Wales.

In general, unless otherwise specified, these services and facilities will be equivalent to those provided to teams and services directly managed by Cwm Taf Morgannwg University Health Board. NIAW staff are expected to comply with Cwm Taf Morgannwg University Health Board's policies and procedures.

The services and facilities covered by this agreement may be provided directly by Cwm Taf Morgannwg University Health Board or may be procured from third party providers, including, but not limited to the NHS Wales Shared Services Partnership and the NHS Wales Informatics Service (NWIS).

In hosting the National Imaging Academy Wales, Cwm Taf Morgannwg University Health Board shall not be required to in any way act outside its statutory powers, duties, Standing Orders, Standing Financial Instructions or governance and legal obligations.

The NIAW undertakes to indemnify Cwm Taf Morgannwg University Health Board for any liability, losses, costs, expenses and claims that might arise in relation to the management of financial resources and the risk when discharging its duties and it will hold Cwm Taf Morgannwg University Health Board harmless in respect of any claims made by any third party arising out of the operations of the NIA. The management of any such claim will be undertaken by Cwm Taf Morgannwg University Health Board, in liaison with the National Imaging Academy Wales. However, any such claims that arise as a result of Cwm Taf Morgannwg University Health Board not meeting its hosting duties (as detailed in this Agreement), then Cwm Taf Morgannwg University Health Board would be held accountable and manage the claim.

Cwm Taf Morgannwg University Health Board will not be responsible for the validity, efficacy or approval of the National Imaging Academy Wales's budget or other plans and the NIAW will in fulfilling its obligations not place Cwm Taf Morgannwg University Health Board in a position whereby it breaches any Statute, Regulation, Standing Order, Direction, Measure or any other corporate governance requirement.

Specific services and facilities to be provided are set out below:

- Access to some Committees of the Cwm Taf Health Board as appropriate, in order to discharge elements of the Academy's governance arrangements. These include:
- Quality, Safety & Risk Management – Reporting via the Cwm Taf Quality, Safety & Risk Committee.
- Audit & Assurance – Reporting periodically to the Cwm Taf Audit Committee
- Remuneration & Terms of Services Committee (RATS)
- IR(Me)R and other Imaging Governance – Reporting via Radiation Safety Committee including Ultrasound Governance.
- Clinical/Corporate Business Meeting(s) – 6 monthly reviews, including oversight of delivery of hosting agreement

As well as the following:-

- Governance advice and support
- Information Governance, managing overseeing any related Data Subject Access; Freedom of Information requests and related training
- Workplace health & Safety advice & support, including incident reporting and access to Datix
- Limited ad-hoc occasional communications/media support/advice.

11.2 Workforce

Cwm Taf Morgannwg University Health Board will act as the appointing and employing body for all directly employed and existing seconded staff of the National Imaging Academy Wales, including the Director. The following services will be provided to the National Imaging Academy Wales:

- Payroll services (for employed staff), including processing of expenses claims etc.
- Recruitment and selection support (including provision of selection/assessment tools)
- General human resources advice, with first line advice being provided by a named HR point of contact
- Access to occupational health services
- Access to and support of the Electronic Staff Record system
- Access to statutory and mandatory training

Any financial liabilities resulting from the direct employment of staff of the National Imaging Academy Wales (e.g. costs associated with advertising, redundancy, termination or breaches of employment, disputes and health and safety matters) will be met from the core budget agreed for the NIA.

In the event that the core budget has insufficient funds to meet or cover the liability, NHS Wales Chief Executives (and not Cwm Taf Morgannwg University Health Board) will collectively underwrite the financial liabilities of the NIAW (on an agreed fair shares basis).

11.3 Finance and procurement

The National Imaging Academy Wales's budget will be included within the Cwm Taf Morgannwg University Health Board ledger and the Director and any other NIAW budget holders will be provided with an income and expenditure account and the following on the same basis as provided to Cwm Taf Morgannwg University Health Board budget holders:

- Specified budget codes for the sole use of the NIAW
- Budget holder reports and information
- Management accountancy support and advice, with first line advice being provided by a named member of the finance team
- Payment of invoices
- Internal and external audit
- Access to procurement advice and support
- Appropriate access to the Oracle finance/procurement system

Cwm Taf Morgannwg University Health Board will act as the legal entity which enters into contracts and related agreements for goods and services procured on behalf of the National Imaging Academy Wales.

11.4 Accommodation

The National Imaging Academy Wales's core recurring budget includes provision for accommodation. The NIAW will occupy premises procured as part of the business case, agreed with NHS Wales Chief Executives and Welsh Government. The maintenance and running costs of premises will be funded from within the NIA's core budget.

Cwm Taf UHB as host will own & maintain the Academy Building on behalf of NHS Wales. A separate recharge over and above the hosting fee will be charged for buildings maintenance and Facilities management, as per the agreed business case.

11.5 Information Technology

The National Imaging Academy Wales will develop a Service Level Agreement (SLA) direct with the NHS Wales Informatics Services (NWIS) to provide the following:

- network infrastructure
- file servers for document storage
- the NHS Wales network and internet
- desktop IT support
- access to mobile services (which may be charged for separately on an 'at cost' basis)
- procurement of new and replacement IT equipment
- hosting of the NIA's internet and/or intranet sites and technical support in relation to their ongoing maintenance and development

11.6 Other corporate support services

Cwm Taf Morgannwg University Health Board will provide the NIAW with access to various services / support when required. At times there may be a requirement to charge additional costs over and above the core hosting fee for items or levels of support that are not covered within the above arrangements.
This will either be based on the time spent on the activity, or if external advice is required then that will be recharged to the Academy.

This may include, but is not limited to the following:-

a. Strategic and planning support, including help with development of business plans, etc.
b. Finance support for Business case development (both revenue and capital)
c. Additional HR support/advice above the basic core level outlined above, including any costs associated with redundancy, termination or breaches of employment contract;
d. Welsh language / translation services
e. Legal Assistance (this will be provided by NWSSP and recharged)
f. Internal and external audit fees, for audit & assurance purposes
g. A lease car scheme for staff meeting eligibility criteria
h. All aspects of any additional UHB based IT support, as this is all being provided directly by NWIS to the Academy, through a separate Service Level Agreement

12 Reporting

Hosting reporting shall be undertaken as follows:

12.1 Responsible Officer

The Responsible Officer will be the Director of the National Imaging Academy Wales and this person will report to the Chief Executive at Cwm Taf Morgannwg University Health Board.

12.2 Accountable Officer

The Accountable Officer will be the Chief Executive of Cwm Taf Morgannwg University Health Board, who will liaise closely with the lead NHS Wales Chief Executive for Imaging.

12.3 Variation

No variation to the Agreement will be valid unless made in accordance with the Change Control Procedure found at Annex A.

13 Obligations of the National Imaging Academy Wales under this agreement

The National Imaging Academy Wales will comply with Cwm Taf Morgannwg University Health Board's:

- Standing Orders
- Standing Financial Instructions
- All policies and procedures where they are applicable to the activities of the NIAW as a hosted body (e.g. Health and Safety, workforce etc.)

The Director of the National Imaging Academy Wales will have overall responsibility for the appointment of NIAW staff, whilst acting within Cwm Taf Morgannwg University Health Board's recruitment policies. Other than the provision of HR advice and selection tools, or as specifically requested by the NIA, Cwm Taf Morgannwg University Health Board will have no role in the appointment of staff.

The Director of the NIAW will be responsible for ensuring that all NIAW staff undertake applicable statutory and mandatory training, which will be made available by Cwm Taf Morgannwg University Health Board. With the exception of statutory and mandatory training, the responsibility for the organisation and funding of the training and development of NIAW staff will rest with the National Imaging Academy Wales.

The Director of the NIAW is responsible for the management of risk within the National Imaging Academy Wales and its activities. The NIAW will follow Cwm Taf Morgannwg University Health Board's risk management framework

guidance and will monitor and maintain a risk register for the NIAW on the Cwm Taf Morgannwg University Health Board Datix system. Any potential risks which could impact on the business and safety of Cwm Taf Morgannwg University Health Board will be escalated to the Chief Executive and Director with responsibility for Risk in Cwm Taf Morgannwg University Health Board. The Director of the National Imaging Academy Wales will also ensure that the Chief Executives are apprised of any high risks and the arrangements for providing assurance regarding their management.

Cwm Taf Morgannwg University Health Board can request access to the NIA's risk register as required, to inform and provide assurance that the overall governance arrangements of Cwm Taf Morgannwg University Health Board are being maintained.

The Director of the National Imaging Academy Wales will be responsible for ensuring any additional pieces of work taken on by the NIA, including expansion in workforce and budget are to be discussed and agreed with Cwm Taf Morgannwg University Health Board.

14 Intellectual property

Unless otherwise agreed (see below) all intellectual property developed or legitimately acquired by the National Imaging Academy Wales, shall be owned collectively by the NHS Wales health boards and trusts.

If the intellectual property is to be exploited in any way then terms will be agreed between all the parties in this respect.

In some circumstances, the NIAW may (through Cwm Taf Morgannwg University Health Board) enter into agreements (such as joint working agreements with industry partners) where specific conditions relating to the ownership and exploitation of intellectual property may apply.

15 Data Protection and Freedom of Information

For the purposes of data protection and freedom of information, all data and information held by the National Imaging Academy Wales will be deemed to be held by Cwm Taf Morgannwg University Health Board. As a result, any requests for information under relevant Acts will be processed according to Cwm Taf Morgannwg University Health Board's procedures. However, the Director of the NIAW will be informed as soon as possible of any relevant requests received and discussion will take place with the Director before any of the National Imaging Academy Wales's information is released to a third party. The Director of the NIAW will be responsible for sharing relevant requests, and responses provided, with health boards and trusts.

The NIAW may enter into data sharing agreements with health boards and trusts to facilitate the carrying out of its functions. As the host body, Cwm Taf Morgannwg University Health Board will need to be a signatory to such agreements and must be satisfied with their content.

16 Disputes and matters not covered by this agreement

It is inevitable that issues will arise that are not explicitly covered by this agreement. In such cases, and in the event of any disputes, all parties will seek to address these issues and identify appropriate solutions in the common interest of NHS Wales and the public served.

If any party has any issues, concerns or complaints about Hosting, or any matter in this Hosting Agreement, that party shall notify the other parties and the parties shall then seek to resolve the issue by a process of consultation. If the issue cannot be resolved within a reasonable period of time, the matter shall be escalated to the Accountable Officer and the Responsible Officer, who shall decide on the appropriate course of action to take. If the matter cannot be resolved by the Accountable Officer and the Responsible Officer within 21 days, the matter may be escalated to the Welsh Government in accordance with the NHS (Wales) Act 2006.

If any party receives any formal inquiry, complaint, claim or threat of action from a third party (including, but not limited to, claims made by a supplier or requests for information made under the Freedom of Information Act 2000) in relation to Hosting, the matter shall be promptly referred to the Accountable Officer and Responsible Officer (or their nominated representatives). No action shall be taken in response to any such inquiry, complaint, claim or action, to the extent that such response would adversely affect Hosting, without the prior approval of them (or their nominated representatives).

17 Governing law and jurisdiction

This Agreement shall be governed by and construed in accordance with the laws of England and Wales and, without affecting the escalation procedure set out in section 17, each party agrees to submit to the exclusive jurisdiction of the courts of England and Wales.

Annex A

Annex A – Change Control Procedure

1. Changes may be proposed by any party to the Responsible Officer who will then discuss them with the Accountable Officer.
2. The Changes may be agreed or rejected by both of those individuals.
3. All parties will be notified of the decision and any resulting change will be recorded in writing and annexed to this agreement.
4. Any dispute regarding the proposed changes will be dealt with by the escalation procedure except in that different officers of each body will deal with the dispute.

Date of change	**Section No.**

TRUST BOARD

NWSSP Patient Medical Records Business Case

DATE OF MEETING	28 July 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	PETER STEPHENSON, HEAD OF FINANCE AND BUSINESS DEVELOPMENT, NWSSP
PRESENTED BY	MATT BUNCE, EXECUTIVE DIRECTOR OF FINANCE
EXECUTIVE SPONSOR APPROVED	MATT BUNCE, EXECUTIVE DIRECTOR OF FINANCE

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
NWSSP Senior Leadership Group	30/06/2022	APPROVED
Shared Services Partnership Committee (scheduled)	21/07/2022	APPROVED

ACRONYMS	
PMR	Patient Medical Record

1. SITUATION/BACKGROUND

The Patient Medical Records Store in Brecon House, Mamhilad, has now reached maximum capacity and consequently, no additional records are able to be accommodated without additional space being procured. In practice this means that not only will no additional GP practices be able to take advantage of this service, freeing up space for additional clinical services, but we will also be unable to take additional medical records from GP Practices who already use the service, from deceased patients, patient movements or practice mergers for example.

The Patient Medical Records store was created in 2015 to enable GP practices to free up space for additional clinical space, reflecting a Welsh Government Directive for new build GP accommodation to promote offsite storage, and the maximisation of current space for patient treatment purposes. Consequently, individual health board primary care estate strategies also reflect this approach and there has been a steady build-up of demand for storage to the point where we are now unable to accommodate any more records within our existing space.

NWSSP currently provide medical records storage for 129 practices (32%) covering 34% of the population of Wales. In addition to records for living patients, we also provide storage for deceased patient's records, and are currently storing patient records associated with the Infected Blood Inquiry. The total number of records currently stored on behalf of GP Practices is 1.1m. It should be noted that this figure, even if no more practices are brought into the scheme, will increase by round 12,000 records per year as more deceased patient records are received than can be removed due to retention restrictions. There are currently an additional 64 Practices waiting to join the service, 15 of which are on a priority waiting list, i.e. it is a key part of extant sustainability plans.

Records are stored in boxes (20 records per box) and each box takes up approximately one square foot. Brecon House provides 55,796 sq ft of space. An annual storage charge is levied of £0.26 per file per year, generating a current annual income of £275,000.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

Without the creation of additional storage space, the Patient Medical Records Service will have to close to new customers and limit additional intake from Practices that already use the service. This will impact on individual practices, health boards, and NHS Wales, as plans to develop additional clinical services in primary care will need to find alternative accommodation. At a time when practices are trying to develop and utilise new roles, such as Physicians Associates, Practice Pharmacists, Care Navigators, Social Prescribers etc., as well as expanding traditional GP and Practice Nurse roles, all of whom require space to practice, this would undoubtedly have an impact on the speed and scale

of this. This, in turn, may impact negatively on the reputation of NWSSP and its ability to support sustainable primary care.

A number of options for expansion of the scheme have been explored in the business case but the preferred option is the acquisition of a further warehouse on a 10-year lease providing a further 75,000 square feet of storage space. Whilst this acquisition provides some funding challenges, these will be met through the generation of additional income; savings resulting from moving PPE from commercial storage facilities to this new warehouse (until we reach capacity on the PMR scheme) and internal savings on the Primary Care budget. The programme will also generate significant non-financial benefits within GP practices providing them with additional space and therefore enable them to provide additional services to patients. Over and above the advantages to NHS Wales through the expansion of the scheme, the proposal also has the following benefits:

- Increased storage capacity will allow records to be stored safely and records will be more accessible, improving staff morale as working space is no cramped;
- The leased buildings will all be on the same site (Mamhilad Park Estate) which will reduce the impact on staff and work processes;
- The landlords are offering discounts on existing leases and total refund of a short-term lease if we take on the additional building, and they have agreed to refurbish Brecon House at no cost to NWSSP, which is badly in need of upgrading and repair;
- There is a five-year break clause in the lease for Brecon House which will provide the ability to re-evaluate accommodation options.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Effective Care
	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 business case includes detail of the financial implications. There will be a funding gap in taking this additional accommodation on, but this will be met internally through generating additional income and through savings.

4. RECOMMENDATION

4.1 The business case has already been subject to approval at NWSSP Senior Leadership Group and the Partnership Committee. It requires approval by the Trust Board only because the Trust has to sign the lease for the additional accommodation.

Brecon House Stores Accommodation Business Case

SINGLE-STAGE BUSINESS CASE - MEDIUM VALUE AND RISK - (£250K TO £2 MILLION VALUE OF PROCUREMENT)

Project Executive:	**Scott Lavender**
Project Manager:	**Jenna Goldsworthy**
Organisation:	**PCS Services – NHS Wales Shared Services Partnership**

	Name	Signature	Date
Prepared by:	Jenna Goldsworthy Alex Martin Sandrine Boucle		07/04/2022
Reviewed by:	Scott Lavender		08/04/2022
Approved by:	Andrew Evans		

Brecon House Stores and Digital Scanning Accommodation

1 INTRODUCTION

The PCS team are undergoing an accommodation review of the Medical Records and stores and distribution teams driven by:

1. Property lease expiry date:
    - Brecon House, Mamhilad Industrial Estate, Pontypool – Lease expires March 2023
    - Additional storage space is required to ensure business as usual can be maintained and to enable the expansion of the medical record service
2. Current set-up of building means there will be a capacity issue impending, preventing growth of the Patient Medical Record storage programme, alongside a need for modernisation and aesthetic improvements to aid staff wellbeing, and bring the space in line with other space we currently occupy.

Historically, we had site closures or movement of premises which included losing Stores space, such as leaving the Oldway Centre, Centurion etc. During these times we moved all records being held at those locations to our stores in Mamhilad Park, Pontypool, without a need for a business case, as we were able to accept and store them at the time, however, instances such as this also lends itself to our current capacity issues in the modern day.

Alternative appropriate accommodation is being sought to address the above and develop the service to meet the needs of our customers. NWSSP PCS propose that additional storage space is leased to ease the current capacity issue and to allow all records that are currently on the waiting list to be brought into the PCS Service. Bringing extra practices into the service will increase the annual revenue for PCS, currently we have a list of 64 practices are awaiting to join the service, in varying states of readiness.

We have received recent feedback in quarterly Health Board SLA meetings that this service is vital to Health Board estate strategy planning, and the re-purposing of space in General Practice to support sustainability issues. Our Specialist Estates team in Shared Services currently plan any General Practice space to exclude Medical Record storage space based on our Patient Medical Record service.

2 STRATEGIC CASE

2.1 Context

The PCS accommodation review covers the teams located in Brecon House Stores. The work that is undertaken by the teams requires staff to work on-site to provide

their services to NHS Wales organisations and other Divisions within NWSSP and Primary Care Services across Wales.

The Brecon House Stores Team, based in Brecon House, Mamhilad Estate, houses several different sub-teams of the Business Support Department. These teams provide critical services to NHS Wales Shared Services Partnerships, Primary Care Services (PCS) stakeholders and customers, both internal and external.

To maintain and develop existing services in line with NWSSP strategic objectives: Service Development and Excellence, it is important that appropriate accommodation is provided to the Services included within this review.

The original PCS Accommodation review was aimed at a review of the accommodation for the Document Scanning Teams based in Cwmbran House, Mamhilad Estate, and Companies House, Cardiff in addition to the teams residing in Brecon House. Following a discussion with the Project Executive and PCS Senior Management in Jan-22, it was agreed that the scope of the project would change to focus on the accommodation review for Brecon House only. The decision was made for the following reasons:

- Changing landscape
- Lack of available warehouse space in the local area
- Teams located in Companies House, Cardiff will fall into the scope of a corporate strategy review

1.2 Case for Change

1.2.1 Spending objectives

The reasons for the Accommodation Review of Brecon House include:

- To improve staff's health and safety by providing fit for purpose accommodation.
- To expand the Medical Records Service (Live Patient Medical Records Storage Service) to additional GP Practices across Wales. This will increase the revenue within the service and free up space within GP Practice buildings. The additional space in GP Practices can be utilised to provide alternative services to patients to help reduce the demand on secondary care.
- To ensure that PCS can continue to support its stakeholders and customers and meet their needs and requirements. In a recent SLA meeting with Cwm Taf, PCS were informed that the PMR service is crucial to their accommodation strategy. There is also a directive from Welsh Government regarding new build GP practices whereby off-site storage of medical records should be considered as opposed to holding medical records on site.
- Increasing our capacity will allow PCS to support other Organisations in emergency situations which could result in additional income being generated. We recently saw a Velindre request for PCS to store archive boxes as they had

records subject to flooding and nowhere to store them securely, in our current situation we were unable to support.
- To increase capacity for the Medical Stores department to provide quality of service to meet customer needs.
- To provide cost effective accommodation to meet the needs of the organisation and the teams on site at Brecon House.

1.2.2 Existing Arrangements

Brecon House Stores

The Business Support Team which is situated in Brecon House currently undertake and provide a range of services to our customers, both internal and external. This includes:

Live Patient Medical Records

- Provision of the Patient Medical Records (PMR) service and the associated medical records movement. PCS currently provide this service to 129 GP Practices across Wales, consisting of 1,119,016 patient records. The service relates to the storage of live patient medical records in our Central archive as opposed to on-site in GP Practices. The service has expanded since being established in 2015, providing opportunity within Primary Care to expand and offer additional services to optimise the use of space in General Practice.
- The impact of COVID-19 with the consequent requirements for social distancing, have exacerbated the space issue for GP Practices and there is an urgent need to relocate medical records off-site to utilise all suitable space for additional consulting rooms or administration office space. Currently, there are approximately 129 practices in the service out of a total of approximately 400 GP practices in Wales with an additional 64 practices allocated to the Priority and Registered interest lists. Of the 64 practices 15 are ready and waiting to join whilst the remaining 49 practices are ready to begin the engagement process.
- When the PMR service was developed, it was projected that PMR would hold 25 medical records per box. In a previous business case when the PMR service was in its infancy, it was calculated that the ground floor of Brecon House would be able to hold 80% of the Welsh population of medical records, which would equate to around 2.6 million records (Total Welsh population 3.2 million). However, based on current statistics, stores can hold approximately 20 medical records in a box, the rationale being that records are thicker in paper content meaning we cannot achieve 25 per box due to the weight and space restrictions in the boxes.

Deceased Medical Records

- Management of an All-Wales archive service for Primary Care Contractors and PCS Staff. Deceased records are stored in line with legal requirements set by Welsh Government:
  - Male records retained for 10 years; and
  - Female records retained for 25 years if the female is under the age of 70 when she dies, if the female is over the age of 70 the record it retained for 10 years.
  - Suspense records are stored in line with legal requirements set by Welsh Government and are retained for 99 years.

Infected Blood Inquiry Records

- In 2018, an independent public statutory Inquiry was established to examine the circumstances in which men, women and children treated by the NHS in the UK were given infected blood and infected blood products, since 1970. Whilst the inquiry is ongoing, the Welsh Government issued a directive to hold all deceased medical records until the resolution of the Inquiry. This has resulted in the need to store approximately an additional 15,900 archive boxes which cannot be reviewed for destruction until the cease on culling is lifted by Welsh Government. The annual intake of deceased records is 36,212 medical records, and when there is not a ban on culling, we would remove between 10,000 and 13,000 medical records annually, this relates only to deceased medical records.

- Stores currently holds approximately 1.1 million records which is an estimated 34% of the population. This difference from the initial projection of 80% of the population is due to the reduced number of medical records per box, storing deceased records and records kept for the ongoing infected blood inquiry. All the records stated are stored in Brecon House and IP5. The space these records take up in Brecon House reduces the space available for PMR records to be stored.

The reasons raised in this section have all contributed to a capacity issue within Brecon Stores.

The requirement for additional warehouse space to store Medical Records, under a multitude of work streams, is to aid Primary Care Services in the continuation of the PMR service and its expansion. Initially it was projected that Brecon House would be able to store 80% of records under the PMR service, which is no longer the case, the additional warehouse space would take us back to the projected figure.

1.2.3 Business Needs

Brecon House Stores

PMR Service Development

The lease of Brecon House is due to expire March 2023 and based on current profiling of activity, stores was due to reach capacity in March 2022. To prevent PCS having to cease the operation and expansion of the PMR Service, thus placing additional space pressures on GP practices, PCS have arranged a 12-month short term lease of storage space on the Mamhilad Estate. The decision to lease the new space was made to allow the continued expansion of the PMR storage service to expand services and eliminate the waiting list. This would have caused reputational damage and loss of income for PCS. The new storage space will also ease the capacity pressure while a suitable long-term solution is sought.

Health & Safety

The lifts are old with limited capacity for archive boxes and equipment thus making the utilisation of the upper floors time consuming and arduous, requiring more manual handling than necessary. There are frequent leaks in the stores causing damages to equipment and medical records.

Staff Wellbeing

The heating system is poor in the office area and there is a lack of natural light in many areas of the building. Due to capacity issues, some areas where staff work are crowded, and this is having a significant impact on staff morale and efficient working practices. Since the start of the COVID-19 pandemic, and due to the staff working processes, proximity risk assessments have been required for the teams.

All Wales Archive Service

Potential Scope and Services

To address the business needs, suitable accommodation needs to be sourced for the Brecon House teams to provide continuity of existing services.

Out of Scope:

Relocation of all other NWSSP Teams currently residing in Cwmbran House, and Companies House as these will be covered by the agile accommodation and corporate strategy reviews.

1.2.4 Main Benefits

Fit for purpose accommodation will benefit NWSSP and key stakeholders as follows:

Non-Cashable benefits

- Safe environment for PCS staff to work in enabling:
    - Improvement of staff wellbeing.

- Reduction or elimination of health and safety concerns.

- Increased capacity for customers which would enable GP practices to generate additional space and maximise efficiencies of their space by adding additional consultation rooms, additional clinics etc. The service provided by PCS allows GP Practices to provide services that directly benefit members of the public and practice staff whilst supporting the GP sustainability agenda.

- Primary Care Services has received feedback from three practices in the PMR service who have stated the following

  "We have gained an additional consulting room so have been able to accommodate more clinicians; not just GP's but also GP Registrars, physiotherapist and attached staff who visit the practice weekly e.g., Mental Health Worker and Frailty Nurse." "The room previously used for storing the medical records has been turned into a meeting/training room which has proved invaluable when we have GP Registrars and medical students. We also have a PC and printer in this room so has also been utilised for administration work. "(Llansamlet Surgery)

  "The biggest positive of having our medical records stored off site has been the space it has created. We have turned our notes storage room into two clinical rooms and small storage area." (Ystwyth Primary Care)

  "Positive impact, more storage space, less admin time filing and retrieving medical records, all records sitting in the Tran search portal so can see at a glance where they are and retrieve to come back to the practice if needed. We are in the process of converting the space now available into much needed clinical room" (Llanfyllin Medical Practice)

- To continue the growth of the PMR storage service we will require the additional space.

Cashable Benefits

- Continue to generate income per annum for the service to cover costs such as rent, service charges etc.
- Increased capacity will generate additional income as follows from on-boarding priority list of practices. Year one higher rate per box based on our previous costing model of 25 records per box.
- As of April 2022, the service will receive additional income followed an agreed 5% uplift for all parties that use the PMR service to store their medical records. This will generate an estimated additional £25,684 over 4 years.

- Additional income will also come from the remodelling of the recharge cost for new practices joining the service (from 25 to 20 records per box) keeping year one rate higher than the following ones. This will generate an estimated additional £141,354 over 4 years.

Table 1: Predicted revenue following increased capacity

This predicted additional income is based on the revised costing model and includes a 5% uplift for existing customers as well as a reviewed recharge for 20 records per box for new customers.

INCOME BASED ON REVISED COSTING MODEL	YEAR 0 2022-2023	YEAR 1 2023-2024	YEAR 2 2024-2025	YEAR 3 2025-2026	YEAR 4 2026-2027	TOTAL
	£31,816	£69,862	£112,889	£172,600	£222,187	**£609,353**

1.2.5 Main Risks

The following risks identified during initial scoping, have been logged in a formal risk register and are being monitored by the Project Manager and the project board team. The risks are reviewed at least monthly.

- Unable to secure fit for purpose accommodation
  - Consideration to all options including extending current lease and applying a phased approach to the solution
- Delays in procuring building material may impact on delivery timescales
  - Early engagement with procurement services and market
- New accommodation may not be ready prior to lease expiry
  - Establish implementation plan and early engagement with Landlord
- Equipment may be damaged during transportation
  - Robust contract with moving company
- Potential Service disruption during the move
  - Establish implementation plan and communication plan
- To fully utilise the space in the new additional building, racking will be required
  - Capital bids for funding for racking will be required in future

Any new risk identified will be added to the register.

1.2.6 Constraints

The constraints have been documented and have counter measures put in place to mitigate these constraints where practicable:

- The limited amount of time available to secure accommodation before leases expire.

- Lack of suitable storage accommodation across South Wales coupled with an increase in demand within the local area.
- Storage space/capacity within existing NWSSP warehouse and other sites.
- To continue with the growth of the PMR service we will require racking for the new space in the coming years.
- Brecon House Stores not included within scope of Agile/Accommodation review.

1.2.7 Dependencies

During the PCS Accommodation review, it has been highlighted that Health Courier Service (HCS) offer an integral support link to Brecon Stores. HCS visit Brecon house multiple times within the working day to undertake arrange of different tasks:

- Movement of GP bags – deliver GP records to appropriate locations.
- Delivery and collection of Scan & Transfer and PMR bags.
- Delivery of contractor stationery to Primary Care.
- Ad hoc duties for PCS such as delivering furniture between different sites etc.

HCS are to be consulted on the outcome of this business case.

2. OPTIONS ANALYSIS

2.1 Critical Success Factors

These are the attributes essential for the successful delivery of the project.

The project has determined the below critical success factors for the investment proposal:

- Value for money – the solution must allow PCS to continue providing a service that enables GP practices to make best use of the space by allocating them to clinical staff while the records are stored with PCS.
- Customers and partners – the solution should enhance the relationships with PCS and stakeholders; namely supporting our PCS sites in Mid & West and North with the ongoing storage of deceased and suspense medical records from their sites.
- Optimisation of cost and benefits – the solution must allow PCS to expand their services to additional PCS stakeholders.
- Staff – the solution must ensure staff are working in an appropriate environment that minimises health & safety concerns.
- Achievability – the solution must be available within 9-15 months from October 2021.

2.2 Main Options

An Options appraisal for each of the options have been considered, which include:

Option No	Option	Description
1	Do minimum	Business as usual
2	Intermediate	Extend the lease for Brecon House and Rent additional storage space in Mamhilad Estate
3	Maximum	Extend the lease for Brecon House and rent additional storage space from third party supplier on a different site.

Table 1: Summary of Options Appraisals

Option 1	**Business as usual (BAU)**
Description: Extend the lease by 10 years in Brecon House and rent additional storage space (5,000sq ft Jan-Apr-22) 13,000 sq. ft (Apr-22 – Apr-23) to remain as business as usual.	
Advantages	**Disadvantages**
• No cost of moving • No disruption to other PCS departments that work with Brecon Stores • The service can maintain business as usual in the short term this only includes PMR emergencies, mergers/closures, and standard PCS archive such as deceased and suspense archive boxes.	• Long-term BAU is not achievable with this option • This option would not allow proactive PMR engagement and intake. • Building damage in Brecon House is damaging vital medical records (The landlord is currently undergoing repair work for the roof, once repairs completed the disadvantage will be removed) • Reputational harm with our PCS Customers as the waiting list grows • Not an efficient work process due to split site working • Moving stock may impact service in the short-term • 13,000sq ft accommodation is only available for 12 months. After this point additional longer-term accommodation would be required to maintain business as usual. • After 2023, the 13,000sq foot building is no longer available and so PCS will need to find space to store all records that will be held in the building at the end of Mar-23.

Conclusion: This option does not meet the project objectives or critical success factors	
Option 2	**Intermediate**
Description: Extend Lease for 10 years in Brecon House (with a 5-year Break clause) and rent additional storage space (75,000 sq. ft) from Johnsey's. *Rationale for 75,000 sq. ft - the largest available space, current market is competitive and difficult to obtain.*	
Advantages	**Disadvantages**
• Allow service to continue in Brecon House Stores • Storage capacity will allow records to be stored safely and records will be more accessible • Storage capacity will allow more medical records to be stored and increase revenue in line with expenditure to reach a balance • Improved efficiencies through easy to access records and better organisation • Improved staff morale as working space is not cramped • The leased buildings will all be on the same site (Mamhilad Park Estate) which will reduce the impact on staff and work processes. • Johnsey's have agreed to upgrade the internal features in Brecon House including carpets and painting etc. Window's will also be replaced. • If PCS were to occupy 2 buildings on the same site and relocate all the non-PMR boxes out of rooms 1-6 in Brecon House, this would allow the vacant space to be dedicated to PMR. This would enable the service to take on additional patient medical records increasing PCS revenue and supporting more GP practices by taking their medical records	• Building damage in Brecon House is damaging vital medical records (The landlord is currently undergoing repair work for the roof) • Not an efficient work process due to split site working • Moving stock may impact service in the short-term • As Brecon House will need to be refurbished, this may cause minimum disruption to services in the short term • IT Infrastructure would have to be setup in the new building. • To maximise the usage of the space, racking will be sought via capital bids over the coming years as the 75,000 sq. ft warehouse is currently unracked.

off premises, which is a Welsh Government initiative. • Based on current statistics, stores can hold around 20 medical records in a box for PMR archive boxes, this would allow PCS to onboard approximately an additional 911,920 medical records into the PMR service. Which coupled with the existing 1.1 million medical records in PMR, would result in PCS holding 63% of the medical records of the Welsh population. • This option will allow us to relocate approximately 45,596 (these will be relocated from the 13,000 sq. ft and Brecon House Stores) archive boxes to a separate site. This would occupy 30,666 sq. ft, based on stacking boxes on pallets or a pallet footprint. (45,596 boxes/24 boxes per pallet = 1,900 pallets required. 1,900 x 16.14 sq. ft (sq. ft of a pallet) = 30,666). • This option would allow PCS the ability to relocate the boxes from IP5. Which is currently circa 16,000 archive boxes occupying approximately 11,000 sq. ft. This would allow the PCS Medical Records to grow the service and create additional income for the service. • This option will recover the rent on short term solution 13,000 sq. ft building in Year 2 • The 5-year break clause in the lease for Brecon House will allow PCS the ability to revaluate their options for accommodation. • Potential to relinquish space occupied by PCS in Repository	

in Companies House, releasing valuable space to be repurposed for NWSSP use.	
Conclusion: This option meets the critical success factors and is the most cost-effective option considering the lack of warehouse space availability in South Wales at present	
Option 3	**Maximum**
Description: Extend the lease for Brecon House and rent additional storage space from third party supplier (86,310sq ft building including a 70,106sq ft warehouse) and 6,642sq ft first floor offices)	
Advantages	**Disadvantages**
• Allow service to continue in Brecon House Stores • Storage capacity to be able to store records easily and safely • Storage capacity to be able to accept more medical records and increase revenue beyond the current waiting list. • Improved efficiencies through easy to access records and better organisation • Improved staff morale as working space is not cramped and the roof will not be damaged • Based on current statistics stores can hold around 20 medical records in a box for PMR archive boxes, this would allow PCS to onboard approximately an additional 911,920 medical records into the PMR service. which coupled with the existing 1.1 million medical records in PMR would result in PCS holding 63% of the medical records of the Welsh population • This option will allow us to relocate approximately 45,596 (these will be relocated from the 13,000 sq. ft and Brecon House Stores) archive boxes to a separate site. This would	• Not an efficient work process due to split site working • Moving stock may impact service in the short-term • As Brecon House will need to be refurbished this may cause minimum disruption to services in the short term • To work on a different site will increase running costs for the team, travel time for tasks, reduce efficiencies in the working processes and will increase PCS carbon footprint. • The office space included is located on the first floor accessed by a small lift unfit for the bulk movement of medical records. • Currently, the option provided is not a secure building and security costs will need to be factored in (see financial assessment table below - Option 3). • IT Infrastructure would have to be setup in the new building as well as installing a Public Sector Broadband Aggregation (PBSA) which would add costs and delays. • Loss of flexibility currently offered by Johnsey's as to when to vacate the 13,000 sq. ft building. • The rent for the 13,000sq ft building in Mamhilad estate (£57,000) in year 1 will not be reimbursed • No 5 year break close in proposal would prevent PCS from reviewing their options for accommodation

occupy 30,666 sq. ft, based on stacking boxes on pallets or a pallet footprint. (45,596 boxes/24 boxes per pallet = 1,900 (pallets required. 1,900 x 16.14 sq. ft (sq. ft of a pallet) = 30,666). • This option would allow PCS to relocate the boxes from IP5. We currently have circa 16,000 archive boxes stored occupying approximately 11,000 sq. ft. This would allow the PCS Medical Records to grow the service and create additional income for the service. • This option provides 15 months' rent free, commencing 24/06/22 • This option provides the potential to relinquish space occupied by PCS in the Repository in Companies House, releasing valuable space to be repurposed for NWSSP use.	• To maximise the usage of the space, racking will be sought via capital bids over the coming years as the room is currently unracked.
Conclusion This option meets the critical success factors; however, it is not the most cost-effective option, and this option would increase the time involved in tasks for Brecon House staff and HCS colleagues due to the second location being so far away from Brecon House.	

2.3 **Recommended option**

After consultation with key stakeholders, the preferred option is option 2. This option will meet the longer-term project objectives, all the spending objectives and critical success factors. Additionally, it has been noted that this option would cause the minimum disruption to services during the implementation period and will be more beneficial that option 3 due to the cost and the fact that the additional storage space is close to Brecon House. This will reduce the amount of travel time and work required for the teams when carrying out the service they provide for the organisation.

3. PROCUREMENT ROUTE

Any necessary purchasing will be procured with the assistance of procurement colleagues to ensure appropriate legal requirements are met. NWSSP and Velindre Trust Board governance requirements will be applied as appropriate.

4. FUNDING AND AFFORDABILITY

4.1 Financial Assessment

Costs per annum or initial set-up costs.

Please note there is a risk to the forecasts with respect to the utilities and rates considering the increased costs in these areas. Costs included in the forecasts below are based on 20-21 figures.

OPTION 1 Brecon House + 13,000sq ft warehouse	YEAR 0 2022 - 23	YEAR 1 2023 - 24	YEAR 2 2024-25	YEAR 3 2025-26	YEAR 4 2026-27	TOTAL
Brecon House Lease **(Based on landlord Increase from 01/08/23)**	£146,407	£230,386	£272,376	£272,376	£272,376	**£1,193,921**
13,000sq ft Lease (13,472 warehouse) **first year rent reimbursed if Option 2 is chosen reflected in Year 2 figure in option 2**	£68,400	£0.00				**£68,400**
Service Charge - Brecon House	£141,896	£92,695	£68,094	£68,094	£68,094	**£438,873**
Service Charge -13,000 sq. ft Included in Rent break clause after 12 months	£0.00	£0.00	£0.00	£0.00	£0.00	**£0.00**
Rates - Brecon House (Based on previous year)	£18,129	£18,129	£18,129	£18,129	£18,129	**£90,645**
Rates -13,000 sq. ft (Estimated based on Brecon house £0.30/sq. ft)	£4,042	£0.00	£0.00	£0.00	£0.00	**£4,042**

Utilities - Brecon House Gas, electricity, water, insurance (Based on previous year)	£57,705	£57,705	£57,705	£57,705	£57,705	**£288,525**
Utilities - 13,000 sq. ft (Estimated based on Brecon House £0.97/sq. ft)	£13,068	£0.00	£0.00	£0.00	£0.00	**£13,068**
Security Cost - **INCLUDED IN SERVICE CHARGE**	£0.00	£0.00	£0.00	£0.00	£0.00	**£0.00**
Removal- archive boxes partial	overtime cost					**£0.00**
Site modifications Not Applicable	£0.00	£0.00	£0.00	£0.00	£0.00	**£0.00**
IT costs - IT infrastructure, PBSA Line,	£0.00	£0.00	£0.00	£0.00	£0.00	**£0.00**
H&S requirements i.e., signage, fire equipment **Unable to estimate**						**£0.00**
Ongoing maintenance costs Brecon House Fire suppression & equipment, racking, emergency lighting (Based on previous year)	£5,309	£5,309	£5,309	£5,309	£5,309	**£26,545**
TOTAL EXPENDITURE	**£454,956**	**£404,224**	**£421,613**	**£421,613**	**£421,613**	**£2,124,019**

NB: This option is not viable long term as the 13,000sq ft warehouse will reach capacity in Year 0 - 2023 and the agreement states PCS has access to the 13,000 sq ft for 12 months only.

OPTION 2 Brecon House + 75,000 sq. ft warehouse on Mamhilad Estate	YEAR 0 2022 - 23	YEAR 1 2023 - 24	YEAR 2 2024-25	YEAR 3 2025-26	YEAR 4 2026-27	TOTAL
Brecon House Lease **(Based on landlord offer reflecting the choice to remain in Mamhilad Increase from 01/08/23)**	£146,407	£207,688	£238,329	£238,329	£238,329	**£1,069,082**
"New Stores" Lease (75,000 warehouse) **(Based on landlord offer starting Year1 (Aug 2023) and minus £57,000 Year 0 rent on 13,000sqft)**	£0	£122,263	£285,995	£285,995	£285,995	**£980,248**
Service Charge - Brecon House (Based on landlord offer)	£141,896	£80,614	£49,974	£49,974	£49,974	**£372,432**
Service Charge - "New Stores" (Based on landlord offer)		£30,020	£45,030	£45,030	£45,030	**£165,110**
Rates Brecon House (Based on previous year)	£18,129	£18,129	£18,129	£18,129	£18,129	**£90,645**
Rates -"New Stores" (Estimated using Brecon House £0.30/sq. ft)		£16,000	£24,000	£24,000	£24,000	**£88,000**
Utilities - Brecon House Gas, electricity, water, insurance (Based on previous year)	£57,705	£57,705	£57,705	£57,705	£57,705	**£288,525**
Utilities - New Stores (Estimated based on Brecon House £0.97/sq. ft)		£51,733	£77,600	£77,600	£77,600	**£284,533**
Security Cost - **INCLUDED IN SERVICE CHARGE**		£0	£0	£0	£0	**£0**
Removal- archive boxes partial		£65,600				**£65,600**
Cost of moving PPE		£18,700	£9,350	£9,350		**£37,400**
Site modifications Included in agreement		£0	£0	£0	£0	**£0**
IT costs - IT infrastructure, PBSA Line,		£10,000	£5,000	£5,000	£5,000	**£25,000**
H&S requirements i.e., signage, fire equipment **Unable to estimate**						**£0**
Ongoing maintenance costs Brecon House Fire suppression & equipment, racking, emergency lighting (Based on previous year)	£5,309	£5,309	£5,309	£5,309	£5,309	**£26,545**

OPTION 2 Continued	YEAR 0 2022 - 23	YEAR 1 2023 - 24	YEAR 2 2024-25	YEAR 3 2025-26	YEAR 4 2026-27	TOTAL
13,000sq ft Lease (13,472 warehouse) **first year rent reimbursed if Option 2 is chosen** **reflected in Year 2 figure in option 2**	£68,400					**£68,400**

Utilities - 13,000 sq. ft (Estimated based on Brecon House £0.97/sq. ft)	£13,068					**£ 13,068**
TOTAL EXPENDITURE	**£454,956**	**£683,761**	**£816,421**	**£816,421**	**£807,071**	**£3,578,630**

NB: During negotiations, rent costs decreased from £272,376 to £238,329 and it was agreed for the 13K warehouse lease from Year 0 to be reimbursed should Option 2 be secured.

OPTION 3 Brecon House + Skewfields (94,955sq ft building incl 6,642 offices+ 88,313 industrial unit (18,207sq ft loading bays/auxiliaries and 70,106 warehouse space)	YEAR 0 2022 -23	YEAR 1 2023 - 24	YEAR 2 2024-25	YEAR 3 2025-26	YEAR 4 2026-27	TOTAL
Brecon House Lease (Based on landlord offer NB increase from 1st Aug 2023)	£146,407	£230,386	£272,376	£272,376	£272,376	**£1,193,921**
Skewfields Lease (70,000sq ft warehouse) (Based on landlord offer) **10-year lease (15-month rent free) with rent increase from year 5**	£0	£369,000	£492,000	£492,000	£492,000	**£1,845,000**
Service Charge - Brecon House	£141,896	£92,695	£68,094	£68,094	£68,094	**£438,873**
Service Charge - Skewfields (Estimated SES 50,000 maintenance for Warehouse + £3.50/sq. ft for Office)	£0	£87,896	£87,896	£87,896	£87,896	**£351,584**
Rates Brecon House (Based on previous year)	£18,129	£18,129	£18,129	£18,129	£18,129	**£90,645**
Rates -Skewfields (Estimated using Brecon house £0.30/sq. ft & Cwmbran House £3.60/sq. ft for office space)	£0	£50,405	£50,405	£50,405	£50,405	**£201,620**
Utilities - Brecon House Gas, electricity, water, insurance (Based on previous year)	£57,705	£57,705	£57,705	£57,705	£57,705	**£288,525**
Utilities Skewfield (Estimated based on Brecon house £0.97/sq. ft & Cwmbran House £6.09/sq. ft for office space)	£0	£126,113	£126,113	£126,113	£126,113	**£504,454**
Security Cost (estimate based on £14.76/hr 24hrs 365 days)	£0	£129,298	£129,298	£129,298	£129,298	**£517,190**
Removal- archive boxes partial	£0	£186,100	£0			**£186,100**
Site modifications **Unable to estimate**	£0					**£0**
IT costs - IT infrastructure, PBSA Line,	£0	£10,000	£5,000	£5,000	£5,000	**£25,000**
H&S requirements i.e., signage, fire equipment **Unable to estimate**	£0					**£0**
Ongoing maintenance costs Brecon House Fire suppression & equipment, racking, emergency lighting (Based on previous year)	£5,309	£5,309	£5,309	£5,309		**£21,236**
13,000sq ft Lease (13,472 warehouse) **first year rent reimbursed if Option 2 is chosen** **reflected in Year 2 figure in option 2**	£68,400					**£68,400**

OPTION 3 Continued	YEAR 0 2022 -23	YEAR 1 2023 – 24	YEAR 2 2024-25	YEAR 3 2025-26	YEAR 4 2026-27	TOTAL
Rates -13,000 sq. ft (Estimated based on Brecon house £0.30/sq.						

TOTAL EXPENDITURE	**£454,956**	**£1,363,036**	**£1,312,325**	**£1,312,325**	**£1,307,016**	**£5,749,658**

* Options 1, 2 & 3 Do not include upgrade costs for Brecon House. The landlord has agreed to cover these costs should PCS choose to rent Brecon House, New Stores and Cwmbran House.
** Options 2 & 3 Do not include costs for installing a sprinkler/fire prevention system. Special Estate Services recommends that the fire suppression system does not represent value for money and there would be no additional capital spent to cover a fire suppression unit in the proposed new building.
*** Option 3 Does not include the costs for site modification, including IT Infrastructure which would be required prior to the move.

4.2 **Revenue Generation**

Table 2: Cost and Funding for the Recommended Option

The table below includes the additional income that would be generated if additional space was agreed, based on average size list of 7,850. From April 2022, the original cost has been uplifted by 5% following no uplift since 2014. The costs below include an additional 1% uplift each year from year 2.

	YEAR 0 2022-23	YEAR 1 2023-24	YEAR 2 2024-25	YEAR 3 2025-26	YEAR 4 2026-27	TOTAL
TOTAL EXPENDITURE	**£454,956**	**£683,761**	**£816,421**	**£816,421**	**£807,071**	**£3,578,630**
PREDICTED INCOME	£31,816	£69,862	£112,889	£172,600	£222,187	**£609,353**
CURRENT PMR INCOME	£275,000	£277,750	£280,500	£283,250	£286,000	**£1,402,500**
POTENTIAL PPE SAVINGS		£137,000	£68,500			**£205,500**
NET COST	**£148,140**	**£199,149**	**£354,532**	**£360,571**	**£298,884**	**£1,361,276**

The figures quoted above demonstrate that the service is currently, and projected to be, loss making to NWSSP, albeit that there will be savings and opportunities for the wider NHS Wales Primary Care Estate due to the freeing up of space in GP Practices to use for additional clinical care. This is undoubtedly the right thing to do for Primary Care and the population of Wales, and it helps to reduce some of the tension on second care care services.

However, it is also our intention to revisit the financial and operational principles of the scheme to evaluate how the additional space can be used more effectively to make the service more sustainable within NWSSP. The scheme is already running at a loss, which is being subsidised within NWSSP, so the table below demonstrates the additional costs that will be needed to be funded from the PCS budget;

PMR Income Model					
Option 2 - New Warehouse from Johnseys					
	2021/22	**2022/23**	**2023/24**	**2024/25**	**2025/26**
	£	**£**	**£**	**£**	**£**
Staff					
Band 3 (9WTE)	241252	241252	241252	241252	241252
Band 4 (1WTE)	30025	30025	30025	30025	30025
Total Staff	***271277***	***271277***	***271277***	***271277***	***271277***
Brecon House					
Lease	146407	146407	207688	238328	238328
Service Charge	141895	141895	80614	49974	49974
Rates	18129	18129	18129	18129	18129
Utilities	57705	57705	57705	57705	57705
Maintenance	5309	5309	5309	5309	5309
Total Brecon House	***369445***	***369445***	***369445***	***369445***	***369445***
Unit C2					
Lease	0	68400	-68400	0	0
Rent	0	4042	0	0	0
Utilities	0	13068	0	0	0
Total Unit C2	***0***	***85510***	***-68400***	***0***	***0***
New Stores					
Lease	0	0	190663	285995	285995
Service Charge	0	0	30020	45030	45030
Rates	0	0	16000	24000	24000
Utilities	0	0	51733	77600	77600
Removal of Archive Boxes	0	0	65600		
Cost of moving PPE	0	0	18700	9350	9350
IT	0	0	10000	5000	5000
Total New Stores	***0***	***0***	***382717***	***446975***	***446975***
Total Costs	**640722**	**726232**	**955039**	**1087697**	**1087697**
Income					
PMR Existing	275000	275000	277750	280500	283250
PMR Additional	0	31816	69862	112889	172600
PPE Savings	0	0	137000	68500	0
Total Income/Savings	**275000**	**306816**	**484612**	**461889**	**455850**
Loss on Year	**365722**	**419416**	**470427**	**625808**	**631847**
Cwmbran House					
Lease	152118	152118	164186	170220	170220
Service Charge	52494	52494	52450	52428	52428
Total Cwmbran House	**204612**	**204612**	**216636**	**222648**	**222648**
Loss + Cwmbran House	570334	624028	687063	848456	854495
Change to 2021/22 Position		**53694**	**116729**	**278122**	**284161**

4.3 **Potential revenue generation**

4.3.1 **Infected Blood Inquest recharge**

There is a potential further savings a recharge be negotiated with Welsh Government for the additional storage of boxes resulting from the Infected Blood Inquest which would add an additional revenue of £102,000 per year.

5. DELIVERY ARRANGEMENTS

The current arrangements which have been put in place to ensure the successful delivery of the investment proposal include:

- Project Executive appointed who will be accountable for the overall project delivery
- The PCS management team will be responsible for organisation and completion of the moves.
- Finance Lead/Partner to determine the associated costs
- Governance arrangements will be through PCS SMT and corporate
- Risks will be maintained and monitored by the Project Manager in the risk register and reviewed by the Project Board regularly throughout the project lifespan
- A transparent change process is essential to Project success. Through each stage of the project there will be a review of proposed changes. All changes will need to be formally raised through the Project Board and agreed. Any changes subsequently agreed will be formally communicated to all members through the minutes of the meeting
- Project Management will be provided by NWSSP PMO, utilising appropriate framework, tailored to suit delivery of the project
- Procurement support will come from NWSSP Procurement
- Post evaluation arrangements and plans will be in place to evaluate whether the project has been delivered to time, cost, and specifications, and to identify lessons learned. A post-implementation review will be undertaken to evaluate outcomes and benefits achieved
- Review reports will be compiled and communicated via internal communication channels and catalogued as part of the Programme Management
- Project progress, plan baselining, and project registers will be captured and reported via the PMO, in the format of action plans, and highlight reports; documents will be shared with relevant stakeholder group via internal or external digital communication.
- Escalation, and management of issues by exception, will comply with the local project governance structure. Project benefits will be identified, assessed, and endorsed by key stakeholders during the early stages of the project and will need to be developed in increasing detail and aligned with each other in later delivery phases. The benefits management strategy will identify, quantify, and deliver tangible and quality related benefits.
- A realistic benefits management strategy is needed to outline the process of benefits identification and tracking and to underpin periodic review of the target benefits and performance measures.

TRUST BOARD

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

DATE OF MEETING	28th July 2022
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Liane Webber, Business Support Officer
PRESENTED BY	Stephen Harries, Independent Member
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning & Digital
REPORT PURPOSE	FOR NOTING

ACRONYMS	
OBC	Outline Business Case
FBC	Full Business Case
TCS	Transforming Cancer Services
WG	Welsh Government
IRS	Integrated Radiotherapy Solution
IM	Independent Member
nVCC	New Velindre Cancer Centre
RSC	Radiotherapy Satellite Centre
TCS	Transforming Cancer Services

1. PURPOSE

1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the Transforming Cancer Service (TCS) Programme Scrutiny Sub-Committee at its public meeting on 19 May 2022.

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

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

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

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for Alert / Escalation to the Committee.
ADVISE	**PROJECT 3A: INTEGRATED RADIOTHERAPY SOLUTION (IRS) STRATEGIC CASE** The Sub-Committee received the Integrated Radiotherapy Solution (IRS) Strategic Case. A number of points were raised in relation to the narrative in the Cover Report on how the key aspects needed to be presented in order to avoid any confusion for the reader. The Sub-Committee endorsed the Strategic Case for the IRS Full Business Case for Trust Board approval, subject to the Cover Report being amended to clearly cross reference where key details could be found in other related agenda items being presented to the Trust Board. **RADIOTHERAPY SATELLITE CENTRE (RSC) STRATEGIC CASE** The Sub-Committee received the Radiotherapy Satellite Centre (RSC) Strategic Case. A number of points were raised in relation to the narrative in the Cover Report. It was clarified that due to the commercially sensitive nature of

	the Full Business Case (FBC), the Sub-Committee was only receiving the Strategic Case in public for approval. The other four elements of the FBC were being considered in the Private Session of the Sub-Committee. It was clarified that a redacted version of all five cases will be placed on the TCS timeline of the Trust's Website for public viewing. The Sub-Committee endorsed the Strategic Case for the RSC Full Business Case for Trust Board approval, subject to the Cover Report being amended to clearly cross reference where key details could be found in other related agenda items being presented to the Trust Board.
ASSURE	There were no items to assure for the Committee.
INFORM	There were no items identified to inform the Committee
APPENDICES	NOT APPLICABLE

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE TCS PROGRAMME SCRUTINY SUB-COMMITTEE

DATE OF MEETING	28th July 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Liane Webber, Business Support Officer
PRESENTED BY	Stephen Harries, Vice-Chair and Chair of the TCS Programme Scrutiny Sub-Committee
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning & Digital

REPORT PURPOSE	FOR NOTING

ACRONYMS	
CCLG	South East Wales Cancer Collaborative Leadership Group
AEDET	Achieving Excellence Design Evaluation Toolkit

1. PURPOSE

1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the TCS Programme Scrutiny Sub-Committee held on 21st June 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	There were no items identified to advise the Trust Board.
ASSURE	The Sub-Committee received and noted the **TCS Programme Finance Report.** **Programme Director's Report** The Sub-Committee received the Programme Director's Report and a number of key points were raised in relation to the three identified priorities for the South East Wales Cancer Collaborative Leadership Group (CCLG). It was highlighted that the CCLG: • will seek views across the region in relation to the three end-to-end tumour sites and pathways; • have accelerated the work to develop the Cancer Alliance approach, both collectively and individually as organisations; • are continuing extensive work on the strategic development of the South East Wales Cancer Workforce (including shared capacity). This will be explored further at the next meeting. Clarification was sought in relation to the potential funding risk regarding a new LINAC machine. It was clarified that this was not an additional machine, but the planned replacement of two machines as part of the overall replacement programme. A brief update on the Radiotherapy Satellite Centre programme was provided and it was noted that progress is currently going according to the programme plan, but with little tolerance left in the project plan regarding timescale. The Sub-Committee received assurance that the first draft of the TCS Programme stocktake would be available in July 2022.

INFORM	**Communications & Engagement** The Sub-Committee received an update and noted that staff and community engagement sessions were taking place which will be recorded and made available for viewing by Sub-Committee Members for those not in attendance. **Radiotherapy Satellite Centre AEDET - Achieving Excellence Design Evaluation Toolkit – Evaluation** The Sub-Committee noted that the AEDET Evaluation had been submitted as part of the Full Business Case.
APPENDICES	None.

TRUST BOARD

Communications and Engagement Update

DATE OF MEETING	28 July 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	NON GWILYM, ASSISTANT DIRECTOR COMMUNICATIONS AND ENGAGEMENT
EXECUTIVE SPONSOR APPROVED	LAUREN FEAR, DIRECTOR CORPORATE GOVERNANCE

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
nVCC project board Enabling Works project board	13 July 2022	Noted
TCS Programme Board	19 July	Noted

ACRONYMS

nVCC	New Velindre Cancer Centre

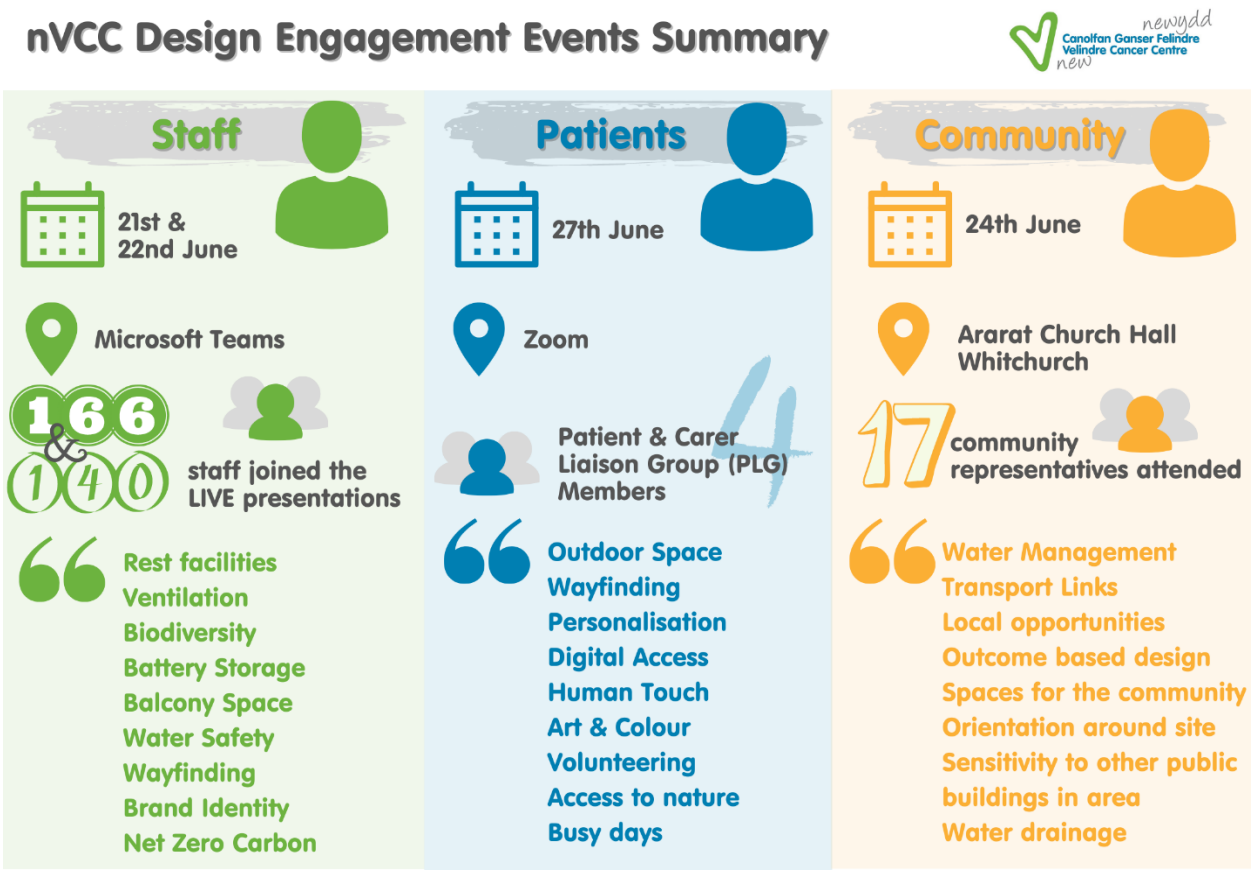
1. SITUATION

This paper provides the Board(s) with an update on communications and engagement since the 26 May meeting.

2. ASSESSMENT

2.1 COMEPTITIVE DIALOGUE ENGAGEMENT EXERCISE

The main focus of activity during the last period has been supporting the competitive dialogue engagement exercise.



Week commencing 11 July, elements of the two designs were made public on the Trust website. The introductory text was accompanied by background slides providing an indicative timeline and key excerpts from the design brief. The presentation slides were chosen by the Bidders.

The public are being asked to tell us what they think of the designs, independent of the formal technical evaluation process, and the responses received before the 25 July will be taken forward as we progress to the next stage of the design process.

2.2 PROGRESS TO NOTE - JUNE 2022

- **Communications and engagement support for the enabling works team focused on** developing digital resources and materials for the purposes of communicating the commencement of works
- **Managing social media commentary and output -** Content driven in the main by proactive posts associated with clearance works
- **Responding to correspondence from a wide range of stakeholders. Publishing a new page on the Trust site on Air Quality.** The page provides background information highlighting the air quality monitoring duties outlined to VUNHST by Cardiff Council as part of the planning permission. Monthly monitoring of concentrations of particulate matter for NO2, PM10 and PM2.5 in the air is presented in a readable format and issued monthly alongside a quarterly report presenting monitoring of NO2 in the air.
- **Political stakeholder meetings** – meetings with the local MS MP have taken place.
- **Supporting the communications and engagement needs in relation to various planning applications**.
- **Supporting and organising the next phase of development of the wider value added programme.**

2.3 NEXT MONTH

For the next month, our main priority is preparing for two key milestones:

- Plan and prepare a comprehensive communication and engagement plan in support of the announcement of the competitive dialogue winner;
- Plan and prepare for the commencement of enabling works.

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 Trust Board is recommended to **NOTE** the paper.

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE LOCAL PARTNERSHIP FORUM

DATE OF MEETING	28/07/2022
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 & Workforce
EXECUTIVE SPONSOR APPROVED	Sarah Morley, Executive Director of OD & 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 College 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 5th May 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 for alerting or escalating to the Trust Board
ADVISE	There were no items to advise the Trust Board
ASSURE	There were no items to Assure the Trust Board
INFORM	**Partnership Working Workshop Actions** The LPF were advised that the Action Plan and Action Log had been updated and will be shared with LPF members when fully completed. As a "Thank You", Unison was organising for an ice-cream van to visit all Velindre sites with the aim of growing their representation base. **Values Project Update** The LPF were informed that the Project will run for 12 months and will include field work with staff members from June to October 2022. For Governance, the Project will be monitored through the Healthy and Engaged Steering Group. **Trade Union Update – Managers in Partnership** The LPF was advised that a Managers in Partnership and Unison event was being organised in VCC to provide a wider range of events to enable further engagement with colleagues. **Risk Management – Covid Enquiry Preparation** The LPF was advised that a Covid Enquiry Preparation Group has been established to prepare for a UK wide enquiry to assess the preparedness and response to Covid 19. Baroness Hallett has been appointed as Chair. The draft Terms of Reference has been published and legal support will be provided by NHS Wales Shared Services Partnership. The LPF will kept updated on progress.
APPENDICES	

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE LOCAL PARTNERSHIP FORUM

DATE OF MEETING	28/07/2022
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 & Workforce
EXECUTIVE SPONSOR APPROVED	Sarah Morley, Executive Director of OD & 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 College 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 5th July 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 for alerting or escalating to the Trust Board
ADVISE	There were no items to advise the Trust Board
ASSURE	There were no items to Assure the Trust Board
INFORM	**Local Partnership Forum Annual Report** The LPF was presented with the Annual Report which had been based on discussions in previous Forums from April 2021 to March 2022. This was approved by the Forum members. **Organisational Design** There was an update provided to the LPF on the Organisational Design Approach being developed for the Trust. With many programmes of work within this approach, more detail to be shared in September LPF meeting as work is developing. The LPF were advised that there will be a programme initiation document produced with the current Governance arrangements around Executive Management Board to provide oversight. **Values Project** The LPF were advised that the Values and Engagement Project has now commenced. There are conversations happening with staff to gain their thoughts on their values and how they align to the Trust. There is also re-engagement with staff regarding the 2020 Staff Survey results as this will help define any changes that may be proposed for the current official Organisational Values. **Pensions Changes** The LPF were updated on the pension contribution changes that were taking place from April 2023. Trade Unions advised they had not received any concerns from their members yet, however were worried that staff may leave the pension scheme with contributions rising for some staff.

	Attraction and Retention Project The LPF were advised that The People Strategy had been approved by the Trust Board. The LPF were also advised on the Attraction and Retention Group that had been established which will report monthly to EMB, with members consisting of Workforce and OD, Trade Union Members, Communications Team and constituents from hot spot areas. The Welsh translation of Job Descriptions has impacted on the recruitment timetable due to current volume of translation required. The LPF were advised on the increased capacity in translation services, there is a SLA agreement with NWSSP, the Trust has employed an additional translator and also memory software has been purchased. A proposal was agreed by EMB, and for the next two months for service critical roles where Welsh was not essential, jobs could be advertised without translation. **Financial Wellbeing** The LPF were updated on information published on the Intranet pages regarding Financial Wellbeing and the contract with Salary Finance, who will provide guidance around financial wellbeing. **Welsh Blood Services Divisional Update** The Divisional Director provided an update to the LPF as the WBS was in 14th week of Blue Alert however no operations had been cancelled even though the Service was under sustained pressure. The LPF were informed on the a recovery plan with the main emphasis on sustained blood for Wales and getting staff in the Collection teams through the consultation process which had been distributed to trade Union Regional Officers. **Velindre Cancer Centre Divisional Update** The LPF were updated on the pressures in the SACT and radiotherapy Services with ongoing weekly meetings with Executive Teams and senior Leadership teams regarding capacity and demand planning. VCC will be using Planned Additional Activity payment rates to support Additional SACT capacity. The LPF were informed that Covid levels were rising again and causing absence levels to go up. **Trade Union Update – Managers in Partnership** The LPF was advised there had been conversations held between Trade Union colleagues since the Trust Partnership Working workshops, key discussion topics being the Joint Chair for LPF and how to work together on joint communication and events. The LPF was advised that WBS collections department induction for new staff included a 10 minute introduction to Unions.

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE STRATEGIC DEVELOPMENT COMMITTEE

DATE OF MEETING	28th July 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Liane Webber, Business Support Officer
PRESENTED BY	Stephen Harries, 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	

1. PURPOSE

1.1 This paper has been prepared to provide the Trust Board with information discussed at the Strategic Development Committee held on 16th May 2022.

1.2 The 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	**Enabling Strategies** The Committee received the following strategies for consideration: • Digital • People • Estates • Sustainability It was highlighted that there was now a consistent style and approach to the content of each strategy which centre around strategic objectives, themes and a small set of key performance measures to track progress; which will be incorporated into the Performance Framework for monitoring and reporting. The Sustainability Strategy was the key overarching enabling strategy that sets the tone and direction of travel for the approach to business for the Trust i.e. sustainability is a central foundation of all activities. The intention for the Trust was to become a net zero organisation by 2030 and a number of plans for this were discussed. The Committee welcomed the case studies included in the Digital strategy and suggested the inclusion of similar case studies for the other strategies as part of their final development. The Committee raised a number of questions regarding the measures regarding ambitious yet realistic target setting. It was clarified that the majority of targets were not statutory/obligatory and not 'pass/fail' in nature but more an indicator to measure organisational progress in achieving the five strategic goals set out in Destination 2032. The Committee was supportive of the People strategy and highlighted the need to address the current urgent workforce challenges together with the longer term vision set out in the strategy. It was clarified that the strategy

provided the strategic intent with one of key priorities being the attraction and retention. It was noted that a Recruitment and Retention Group had been established to address the current key issues.

The Estates strategy included a number of themes to deliver a high quality and sustainable estate e.g. the use of Artificial Intelligence to assist the management of the Trust's estate. The Committee commended the Estates department for their flexibility and agility as a main contributor in successfully navigating the Trust through the pandemic. The need to develop succession plans particularly around apprenticeships was noted to ensure the necessary skillset required for the future workforce.

The Committee endorsed the strategies, subject to the inclusion of case studies and amendments, for approval by the Trust Board at its meeting in May 2022.

Patient Engagement Strategy

The Committee received the Patient Engagement Strategy for consideration.

A number of questions were raised regarding the scope of the engagement strategy whether strategy included former patients or only current patients. It was clarified that this element of the strategy was scoped to support cancer services and would include current patients, former patients post-treatment and their families and carers; seeking their experiences and help continuously improve services.

The Committee noted that a network was to be established with patient engagement leads at health boards to ensure that their patient engagement strategies aligned with the Trust's strategy for cancer patients across Wales.

It was highlighted that the role of the navigator was being reviewed to close any gaps in the delivery of a single cohesive patient information provision. The role of the principal investigator described in Research (goal 4) would also be reviewed in terms of their responsibilities.

A number of questions were raised regarding the use of technology and whether anyone could be excluded from involvement due to not having access to the appropriate technology. It was clarified that this would not be a barrier and would be addressed as part of the equality, diversity and inclusion criteria.

The Committee **endorsed** the Patient Engagement Strategy for Trust Board approval, but **noted** that the staffing of the Patient Engagement Hub will require the appointment of two new posts. An application for funding will be required to be submitted to the Charitable Funds Committee.

	The Committee **endorsed** the Trust Assurance Framework Dashboard for approval by the Trust Board.
ASSURE	**Nuffield Trust Progress Report** The Committee received the Nuffield Trust Progress Report and noted that progress continues to be made. An Unscheduled Care Clinical Summit was being arranged to review the current model of delivery within the cancer service based on the current unscheduled care pressures. Discussion regarding the Welsh Governments view of progress concluded with clarity that the report highlights key progress made in terms of regional working and reflects a real step-change with partnership working i.e. the Nuffield Trust recommendations are a regional responsibility. The Committee noted the report. The Committee received the **Developing the South East Wales Cancer System** report and subject to the amendment of point 1.3 and priority action a. (ii) noted the report.
INFORM	**Performance Management Framework** The Committee received an update on the progress of the Trust's Performance Management Framework. A number of questions were raised about the increased workload created involved with the manual elements of the process. It highlighted that the Business Intelligence element to automate the data collection would be progressed once the final Performance Management Framework had been approved' subject to capacity of the BI function. The Committee noted the progress and the anticipated first draft to be presented at the September meeting. The Committee noted the progress of the **Implementation of Hepatitis B Core Antibody Testing** and that the implementation phase will be reported through the Quality, Safety and Performance Committee. The Committee noted the **Research, Development and Innovation Highlight Report**.

APPENDICES	None.

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE STRATEGIC DEVELOPMENT COMMITTEE

DATE OF MEETING	28th July 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Liane Webber, Business Support Officer
PRESENTED BY	Stephen Harries, 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	

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 7 July 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	**Performance Management Framework** The Committee endorsed the Performance Management Framework for Trust Board approval, noting that senior staff members and Independent Members are being kept informed of progress and given opportunities to provide feedback through a series of 1:1 meetings.
ASSURE	There were no items identified to Assure the Trust Board.
INFORM	The Committee received and noted the draft **Welsh Blood Service Five-Year Plan** which has been structured to align with the Trust's five strategic goals, and noted that whilst staff had been widely consulted, and further engagement with donors, the CHC and wider stakeholders is planned as the next stage of the strategy development process Clarification was sought with regards to the inclusion of Research, Development and Innovation and it was noted that this is to be included as part of Strategic Theme 5 which is currently under development. It was noted that the reference to collaborative working in Strategic Theme 3 (prudent use of blood across Wales) applies to both management and clinicians working collaboratively across organisations which, although still needing work, is already proving to be effective. A bid has been submitted to the value-based healthcare fund which will help to drive forward the agenda. The importance of Equality, Diversity and Inclusion aspects and broadening the diversity of both donor base and future workforce planning was highlighted. It was noted that recent involvement with the Welsh Government UK Forum would help to diversify blood collection and bone marrow volunteer communities.

	The Committee received the **Plasma Memorandum of Understanding** and noted discussions were ongoing with Welsh Government who were keen to promote involvement in a UK-wide discussion. **Update on progress of the Advanced Therapies Wales & Midlands and Wales ATTC Programmes** The Committee noted the work undertaken on the Advanced Therapies Wales and Midlands and Wales ATTC Programmes and the positive progress made. It was noted that further progress updates will be provided to the Committee in the autumn. **Trust Assurance Framework** The Committee received the Trust Assurance Framework and Dashboard, noting the key developments progressed since the last meeting. The Committee noted the **Nuffield Trust Progress Report.** **University Status Showcase Event** The Committee discussed the University Status Showcase Event and clarification was made in relation to the footprint for research and the partnership with the University. The Committee noted the **University Status Showcase Event.**
APPENDICES	None.

WELSH HEALTH SPECIALISED SERVICES COMMITTEE (WHSSC)
JOINT COMMITTEE MEETING BRIEFING – 12 JULY 2022

The Welsh Health Specialised Services Committee held its latest public meeting on the 12 July 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 meeting held on the 10 May 2022 were **approved** as a true and accurate record of the meeting.

2. Action log & matters arising

Members **noted** the progress on the actions outlined on the action log.

3. Recovery Trajectories across NHS Wales

Members received informative presentations on the recovery trajectories across Wales from the NHS Wales Delivery Unit, Betsi Cadwaladr UHB (BCUHB), Swansea Bay UHB (SBUHB) and Cardiff & Vale (CVUHB).

Members **noted** the presentations and requested that an update on the trajectories for paediatric recovery be brought to the next meeting.

4. Chair's Report

Members received the Chair's Report and **noted**:

- No Chair's actions had been taken since the last meeting,
- An update on the letter issued to NHS Chairs requesting support in appointing an interim HB chair for the All Wales Individual Patient Funding Request (IPFR) Panel for a 6 month period from amongst their Independent Members (IMs) to ensure business continuity,
- An update on plans for the recruitment process to fill the WHSSC IM vacancy,
- Attendance at the Integrated Governance Committee (IGC) meeting on the 7 June 2022; and
- Attendance at key meetings.

Members **noted** the report.

5. Managing Director's Report

Members received the Managing Director's Report and **noted** the following updates on:

- Discussions with Welsh Government (WG) concerning the All Wales IPFR Panel and the authority of the Joint Committee to update and approve the panel's Terms Of Reference (ToR), the governance process for updating the All Wales IPFR policy, the briefings given to the Board Secretaries on the 10 June 2022, and to the All Wales Medical Directors Group (AWMDG) on the 1 July 2022 and that a letter confirming next steps was awaited from WG,
- The revised timeline for the draft Mental Health Specialised Services Strategy 2022-2028 engagement process,
- The funding for Cell Path Labs to meet the growing demand for commissioned WHSCC cancer genomic testing; and
- The designation of SBUHB as a provider of Stereotactic Ablative Radiotherapy (SABR).

Members **noted** the report.

6. Neonatal Transport – Update from the Delivery Assurance Group (DAG)

Members received a report providing an update from the Neonatal Transport Delivery Assurance Group (DAG) meeting held on 21 June 2022.

Members (1) **Noted** the report, (2) **Received** assurance that Neonatal Transport was being scrutinised by the Delivery Assurance Group (DAG), (3) **Noted** that further work was being undertaken by the transport service on the reporting to strengthen the assurance; and
(4) **Noted** the update on the implementation of the Neonatal Transport Operational Delivery Network (ODN).

7. Draft Specialised Paediatric Services 5 year Commissioning Strategy

Members received a report presenting the Draft Specialised Paediatric Services 5 year Commissioning Strategy for information and which sought support to share the strategy through a 6 week engagement process to obtain stakeholder feedback.

Members (1) **Noted** the contents of the draft Specialised Paediatric Services 5 year Commissioning Strategy; and (2) **Supported** that the Strategy be issued for a 6 week engagement process to obtain stakeholder feedback, prior to the final version being presented to the Joint for Committee for approval in September 2022.

8. South Wales Cochlear Implant and BAHA Hearing Implant Device Service

Members received a report presenting the process and outcome of a

recent review of tertiary auditory services and the planned next steps for the South Wales Cochlear Implant and BAHA Hearing Implant Device Service.

Members discussed the preferred commissioning option and agreed that the report be updated with more detail on the process undertaken to agree the preferred option for engagement, and that the report be presented the next Management Group meeting for review prior to being brought back to the Joint Committee either virtually or at an extraordinary committee meeting.

Members (1) **Noted** the report, (2) **Noted** and **received assurance** on the assessment process inclusive of a) clinical options appraisal, b) external review against standards and c) financial option appraisal, (3) **Noted** the outcome of the clinical options appraisal for the south Wales centres, the external hearing implant centre and the financial appraisal, (4) **Noted** the preferred commissioning option as the basis of engagement/consultation; and **agreed** a review of the process at the Management Group meeting on the 28 July 2022 and for reconsideration of the proposals either virtually or at a future extra-ordinary meeting of the JC; and (5) **Agreed** to receive the required engagement/consultation documentation and process at the September meeting of the Joint Committee.

9. Hepato-Pancreato-Biliary (HPB) Services for Wales

Members received a report providing a summary on the Hepato-Pancreato-Biliary (HPB) surgery project for South and West Wales, and which sought support for the proposed arrangements to provide assurance to the WHSSC Joint Committee as the future commissioners for the service.

Members (1) **Noted** the report, (2) **Supported** the Hepato-Pancreato-Biliary (HPB) surgery Project Initiation Document (PID) and Action Plan Tracker; and (3) **Supported** the proposals to receive assurance that the outputs of the Hepato- Pancreato-Biliary (HPB) project align with the WHSSC strategic objectives and commissioning intentions.

10. Policy for Policies & EQIA Policy

Members received a report presenting feedback from the stakeholder consultation on the revised WHSSC 'Policy for Policies' Policy and the new Equality Impact Assessment (EQIA) policy, and which sought approval for publishing both documents.

Members (1) **Noted** the report, (2) **Supported** the rationale and process that had been applied when updating the WHSSC 'Policy for Policies' Policy and developing the new EQIA policy; and (3) **Approved** the request to publish the WHSSC 'Policy for Policies' Policy and EQIA Policy following stakeholder consultation.

11. Policy Position for the Commissioning of Drugs and Treatments for Patients aged between 16 and 18 years of age

Members received a report seeking support from the Joint Committee on the preferred policy position for the commissioning of drugs and treatments for patients aged between 16 and 18 years of age.

Members (1) **Noted** the report; and (2) **Supported** the preferred option identified within the report.

12. Supporting Ukrainian Refugees with Complex Health Needs

Members received a report setting out a proposal for managing the complex health needs of Ukrainian refugees arriving in Wales and seeking approval to manage the excess costs (>£20k per annum) within the current funding baselines in year, offsetting against non-recurrent slippage and reserves.

Members (1) **Noted** the report; and (2) **Approved** the proposal to manage the excess costs within the current funding baselines in year, offsetting against non-recurrent slippage and reserves.

13. Name Change Welsh Renal Clinical Network (WRCN

Members received a report informing the Joint Committee of the outcome of the engagement process to consider a change of the name of the Welsh Renal Clinical Network (WRCN) and to ratify the decision of the WRCN Board to change the name to the Welsh Kidney Network.

Members (1) **Noted** the outcome of the engagement process to seek views to change the name of the Welsh Renal Clinical Network (WRCN); and (2) **Ratified** the decision of the WRCN Board to change the name of the WRCN to the "Welsh Kidney Network".

14. Results of the Annual Committee Effectiveness Self-Assessment 2021 -2022 & Joint Committee Development Plan

Members received a report presenting an update on the actions from the annual Committee Effectiveness Self-Assessment undertaken in 2020-2021 and to present the results of the annual committee effectiveness self-assessment 2021-2022.

Members (1) **Noted** the completed actions made against the Annual Committee Effectiveness Survey 2020-2021 action plan, (2) **Noted** the results from the Annual Committee Effectiveness Survey for 2021-2022, (3) **Noted** that the findings were considered by the Integrated Governance Committee (IGC) on the 7 June 2022, (4) **Noted** that the feedback will contribute to the development of a Joint Committee Development plan to map out a forward plan of development activities for the Joint Committee and its sub committees for 2022-2023; and (5) **Noted** the additional sources of assurance considered to obtain a broad view of the Committee's effectiveness.

15. Corporate Risk Assurance Framework (CRAF)

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

Members (1) **Noted** the updated Corporate Risk Assurance Framework (CRAF) as at 31 May 2022, (2) **Approved** the Corporate Risk Assurance Framework (CRAF); and (3) **Noted** that a follow up risk management workshop was planned for the 20 September 2022 to review how the Risk management process is working, and to consider risk appetite and tolerance levels across the organisation.

16. All Wales IPFR Panel Sub-Committee Annual Report 2021-2022

Members received a report presenting the All Wales IPFR Panel Annual Report 2021-2022.

Members **noted** the All Wales IPFR Panel Annual Report 2021-2022.

17. COVID-19 Period Activity Report for Month 1 2022-2023 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.

18. Financial Performance Report – Month 2 2022-2023

Members received the financial performance report setting out the financial position for WHSSC for month 2 2022-2023. The financial position was reported against the 2022-2023 baselines following approval of the 202-2023 WHSSC Integrated Commissioning Plan (ICP) by the Joint Committee in February 2022.

The financial position reported at Month 2 for WHSSC was a year-end outturn forecast under spend of £515k.

Members **noted** the report.

19. 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.

20. 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).

21. AOB

- **WHSSC Specialised Services Strategy** – Members noted that work had commenced to plan the engagement process for developing the WHSSC Specialised Services Strategy and that a workshop would be held at the Joint Committee on the 6 September 2022.

ASSURANCE REPORT

NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE

Reporting Committee	**Shared Service Partnership Committee**
Chaired by	Tracy Myhill, NWSSP Chair
Lead Executive	Neil Frow, Managing Director, NWSSP
Author and contact details.	Peter Stephenson, Head of Finance and Business Development
Date of meeting	19 May 2022

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

Matters Arising – Recruitment Update

Gareth Hardacre, Director of People & OD gave an update on the progress being made on the Recruitment Modernisation Action Plan following the deep dive on this topic in the March Committee.

All organisations are now live on the latest version (3) of NHS Jobs. Progress has been made in letting the IT contract for the Pre-Employment Checks, but this has been slightly delayed as clarification is needed by the Home Office surrounding the cyber security requirements in the product specification. However, the deadline of September 2022, where either face-to-face checks are re-introduced or the IT solution is in place, should still be met.

The Action Plan for revising specific recruitment processes is due to go to Workforce Directors on May 20th and includes the proposal to establish a senior Programme Board to oversee delivery of the Plan. Performance against Recruitment Key Performance Indicators is improving, despite there being no drop in the level of activity across NHS Wales.

It has been agreed that a deep dive on Recruitment will be undertaken with the BCUHB Executive Board and the offer was made to do something similar with other NHS Wales organisations.

The Committee **NOTED** the update.

Medical Examiner Service

Andrew Evans, Director of Primary Care Services and Ruth Alcolado, Medical Director jointly presented to the Committee on progress with the development of the Medical Examiner Service. The service is currently examining around 1000 deaths a month, with a target of 2500 by the time the service is launched on a statutory footing, which is now likely to be April 2023 at the earliest. To date, the

service has been able to identify potential learning for Health Boards and Trusts in approximately 25% of cases reviewed, and it is considered that 10% of cases would benefit from a Stage 2 Mortality Review – these figures are consistent with what is being reported in England. There are however differences in the way that the service is operated in the two countries, and the nature of the set-up in Wales allows greater identification of local, regional, and national issues.

One of the key benefits of the service thus far is to give each family the opportunity to speak with a Medical Examiner Officer. This has been very well received and in many cases the families have expressed their gratitude for the care received by their family member from Health Boards and Trusts at the end of their life.

To further successfully develop the service Health Boards and Trusts need to ensure timely notification of death, availability of clinical notes, and access to the relevant doctor to discuss the cause of death. The commitment from the service to Health Boards includes that all deaths will be scrutinised by the autumn of this year; that there is effective communication on themes and trends; and that there should be effective monitoring of performance.

In summary it was noted that the service is already making a positive contribution to patient safety, and that consultation is underway and/or planned with clinical colleagues to address any issues and to maximise the benefits.

The Committee **NOTED** the presentation.

Chair's Report

The Chair updated the Committee on the activities that she had been involved with since the March meeting. These have included:

- Meeting with the Minister as part of the all-Wales Chairs' Group. It was helpful that the Minister had recently visited IP5 and consequently gained a good understanding of what NWSSP does and had been left with a positive impression of the organisation;
- Attending her first NWSSP Audit Committee which again had been very positive;
- Continuing to meet with senior NWSSP management, and in particular recently from Specialist Estates and the Temporary Medicines Unit, to gain a better understanding of what they do;
- Attending the DHCW Board Development session in April where NWSSP received positive feedback;
- Chairing the Welsh Risk Pool Committee; and
- Arranging to attend the Velindre Trust Board at the end of June as part of their Board Development session.

Looking further forward the Chair is keen to hold a development session with the Committee, ideally in person for a half-day in the autumn and including other members of the NWSSP Senior Leadership Group. This could include a stock-take

session on what works well and what doesn't work so well for the Committee; allow the Committee to better understand what NWSSP does, ensuring that it is aligned to NHS Wales's organisation priorities and also those of the Welsh Government; looking to the future in terms of which services it should provide; and assessing the current structure of the Committee and whether it needs wider (e.g. clinical) representation. A plan for how the session might work will be brought back to the July Committee.

Managing Director Update

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

- Senior NWSSP management participated in the meeting with Welsh Government in early May to review the IMTP. The meeting was very positive, and the IMTP has been well-received with the Outcome Letter expected in June;
- Work has been undertaken with colleagues from Welsh Government and Public Health Wales regarding the future plans for the recently vacated Lighthouse Laboratory at the IP5 facility. Within IP5, the Surgical Materials Testing Laboratory have had a new laboratory completed which will enable them to perform additional tests and to develop new testing regimes for medical devices, which they were unable to do at the existing Bridgend site;
- Progress continues to be made in terms of the overarching Transforming Access to Medicine Outline Business Case, with a number of workshops held to consider site selection. There is on-going discussion with workforce colleagues and Chief Pharmacists regarding the Organisational Change Programme; and
- The recent cyber security assessment, conducted as part of the NHS Wales Cyber Resilience Unit's work to implement the Network Information Security (NIS) Regulation in all health organisations in Wales, demonstrated that generally NWSSP is well protected from cyber-attacks. A formal project has been launched to address the key areas for improvement identified in the report's recommendations. One of the key tasks in the initial phase, a desktop exercise based around a cyber incident, was carried out at the May Informal Senior Leadership Group.

Items Requiring SSPC Approval/Endorsement

Decarbonisation Action Plan

Chris Lewis, Environmental Management Advisor presented the Plan which had been formally submitted to Welsh Government on 31st March. The Committee had previously had the opportunity to review the plan in detail at its November 2021 meeting. Clarity was provided in terms of explaining that this was the inward-facing NWSSP plan and that NWSSP were substantially involved in the production of the national plan which embraces the role that NWSSP plays in supporting NHS Wales organisations to achieve their own decarbonisation targets. Key actions in the internal facing plan include reducing the impact of our buildings, fleet, and

new laundry service, as well as working with staff to help raise the profile of decarbonisation across the organisation.

The Committee **ENDORSED** the Action Plan.

Laundry Detergent Contract

Anthony Hayward, Assistant Director of Laundry Services, attended the Committee to present a paper for endorsement and approval by the Committee. Following the transfer of laundry services to NWSSP from April 2021, there is now the opportunity to tender for laundry detergent on an all-Wales basis. This should provide opportunities for economies of scale compared to the current fragmented arrangements. However, the Laundry Service are also keen to include the provision of dosing pumps and a management information system into the contract which is anticipated to total £2m over a five-year period.

The Committee **ENDORSED** the paper.

Draft Annual Governance Statement 2021/22

The Committee reviewed the draft Annual Governance Statement which will be taken to the NWSSP Audit Committee in July for formal approval. The statement is substantially complete, but the formal Head of Internal Audit Opinion is still to be received and the final energy consumption figures for the year are still being calculated. The Statement is a positive reflection on the past year and there are no significant matters of control weaknesses that need to be included. The final version of the Statement will be brought back to the July Partnership Committee for information.

The Committee **ENDORSED** the Statement **IN PRINCIPLE** recognising that it was still draft, and that formal approval would be sought at the Audit Committee.

Service Level Agreements 2022/23

The Committee received the Service Level Agreements for the core service provided by NWSSP to NHS Wales for formal annual approval. The papers included the overarching Service Level Agreement and a cover paper detailing any amendments to the supporting schedules, none of which were significant. (The schedules were provided separately to Committee members for information). It was however noted that the Procurement SLA element would need to be brought back to the July Committee as it is to be further amended to reflect changes resulting from the implementation of the new Operating Model.

The Committee **APPROVED** the SLAs for 2022/23 noting that the Procurement SLA is due to be further amended and resubmitted for approval.

Salary Sacrifice – Staff Benefits

The Committee was presented with a paper setting out the arrangements for the Home Electronics and Cycle to Work Staff Benefit Schemes. There are currently different arrangements in place across NHS Wales, with some schemes being operated by NWSSP on behalf of NHS Wales organisations and other schemes

being operated and managed within health organisations. As well as potentially not providing optimal value-for-money, there is a risk that staff could fall below minimum wage rates due to being members of schemes administered by different organisations. The paper asked the Committee to approve a tender for a scheme to be administered by NWSSP that would cover home electronics and cycle to work schemes.

The Committee **ENDORSED** the approach being taken by NWSSP in awarding a contract(s) for Home Electronics and Cycle to Work with an aim of having an All-Wales arrangement in place, centrally administered by NWSSP, which will be made available to all Health Board, Trusts and Special Health Authorities.

Finance, Performance, People, Programme and Governance Updates

Finance – The Director of Finance & Corporate Services reported the outturn position, which is currently subject to external audit, and highlighted that a small surplus of £11k had been generated against total income of £870m. The DEL expenditure for the Welsh Risk Pool was £129.615m and the risk share agreement was invoked at the IMTP value of £16.495m. Additional Welsh Government risk pool funding of £4.861m was agreed above the core allocation and risk share funding to account for the additional cases settled in 2021/22. £17.018m capital funding was received in 2021/22 and fully utilised. £12.348m was spent in March 2022, including the purchase of Matrix House which completed on 30th March. The Committee were complimentary of the new style finance report.

Performance – Most KPIs are on track except for those relating to Recruitment Services, where the situation is improving due to the implementation of the Modernisation Plan, which was covered earlier on the agenda, but where there is still further progress to be made.

Project Management Office Update – Of the 24 schemes being managed by the PMO, there is only one that is currently rated as red. This is the project for the replacement of the Student Awards System which is approaching end-of-life and with no option to extend the support contract arrangements beyond March 2023. The deadline to issue a tender for the procurement of a replacement system is 31st May, but currently there is no guarantee of funding for this from Welsh Government.

People & OD Update – Sickness absence rates remain at very low levels with an absence rate of 2.61% for March. Performance and Development Reviews and Statutory and Mandatory training results continue to improve although there is still room for further improvement. Part of the issue is in areas such as the Medical Examiner Service where staff may be on multiple contracts, but a solution is being sought for this. Headcount is increasing due mainly to the additional staff recruited as part of the Single Lead Employer Scheme.

Corporate Risk Register – there remain two red risks relating to the pressures currently being noted within the Employment Services Directorate, and particularly in Recruitment and Payroll Services, and the energy price increase. A new risk has been added relating to the Student Awards system, which was

highlighted earlier in the Project Management Office Progress Report.
Papers for Information
The following items were provided for information only: • Transforming Access to Medicine Progress Report • Information Governance Annual Report 2021/22 • Audit Committee Highlight Report • Quality and Safety Assurance Report • Complaints Annual Report 2021/22 • Finance Monitoring Returns (Months 12 and 1)
AOB
N/a
Matters requiring Board/Committee level consideration and/or approval
• The Board is asked to **NOTE** the work of the Shared Services Partnership Committee.
Matters referred to other Committees
N/A

Date of next meeting	21 July 2022

TRUST BOARD

APPROVED POLICIES UPDATE

DATE OF MEETING	28/07/2022

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 NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Trust Health, Safety and Fire Management Board	22/02/2022	ENDORSED FOR APPROVAL
Executive Management Board	27/04/2022 01/07/2022	ENDORSED FOR APPROVAL
Quality, Safety & Performance Committee	14/07/2022	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 May 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 May 2022 Trust Board are outlined below:

Policy Title	Policy Lead / Function	Approving Body	Effective Date	Appendix
QS 18: Health, Safety and Welfare Policy	Director of Strategic Transformation, Planning, Digital and Capital Development	Quality, Safety & Performance Committee	14/07/2022	**1**
IG 05: Software Policy	Director of Strategic Transformation, Planning, Digital and Capital Development	Quality, Safety & Performance Committee	14/07/2022	**2**
IG 06: Anti Virus Policy	Director of Strategic Transformation, Planning, Digital and Capital Development	Quality, Safety & Performance Committee	14/07/2022	**3**
IG 11: Data Quality Policy	Executive Director of Finance	Quality, Safety & Performance Committee	14/07/2022	**4**
IG 13: Confidentiality Breach Reporting Policy	Executive Director of Finance	Quality, Safety & Performance Committee	14/07/2022	**5**

Policy Title	Policy Lead / Function	Approving Body	Effective Date	Appendix
IG 01: Records Management Policy	Executive Director of Finance	Quality, Safety & Performance Committee	14/07/2022	**6**
IG 08: Freedom of Information Act Policy	Executive Director of Finance	Quality, Safety & Performance Committee	14/07/2022	**7**
IG 13: Confidentiality Breach Reporting Policy	Executive Director of Finance	Quality, Safety & Performance Committee	14/07/2022	**8**
IG 14: Information Asset Policy	Director of Strategic Transformation, Planning, Digital and Capital Development	Quality, Safety & Performance Committee	14/07/2022	**9**
IG 08: Freedom of Information Act Policy	Executive Director of Finance	Quality, Safety & Performance Committee	14/07/2022	**10**
QS 03: Handling Concerns Policy	Executive Director Nursing, Allied Health Professionals and Health Scientists	Quality, Safety & Performance Committee	14/07/2022	**11**

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 May 2022 Trust Board.

Ref: QS18

HEALTH, SAFETY AND WELFARE POLICY

Executive Sponsor & Function	Director of Strategic Transformation, Planning and Digital Health and Safety Function
Document Author:	Trust Health and Safety Manager
Approved by:	Quality, Safety and Performance Committee
Approval Date:	14 July 2022
Date of Equality Impact Assessment:	23 December 2021
Equality Impact Assessment Outcome:	Safer Working Environment
Review Date:	July 2025
Version:	8

CONTENTS

1. Policy Statement

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

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

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

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

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

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

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

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

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

2. Scope of Policy

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

3. Aims and Objectives

3.1 The aim of the policy is to -

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

3.2 The Policy objectives are to -

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

4. Responsibilities

4.1. Chief Executive

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

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

4.2. Director of Strategic Transformation, Planning and Digital

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

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

4.3. Executive Director of Organisational Development and Workforce

The Head of Workforce is responsible for ensuring that: -

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

work, identification of occupational hazards and risks, along with support and advice for staff.

4.4. Assistant Director of Estates, Environment and Capital Development

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

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

4.5. Divisional Directors / Directors of Hosted Organisations

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

- ensuring that health and safety management and governance systems are implemented in their division/hosted organisation;
- ensuring there are adequate resources to manage health and safety in their division;
- establishing a health & safety group or equivalent meeting within for their Division/Hosted Organisation;
- liaising with the Trust Capital Planning and Estates department and specialist technical groups/Boards on health and safety matters;
- ensuring that Divisional health and safety procedures are developed in line with the overarching Trust policies;
- ensuring that managers and staff are aware of their health and safety responsibilities;
- ensuring risk assessments are completed and recorded on the Datix system, control measures are implemented and monitored;
- ensuring incidents are reported on the Datix system, investigations are carried out, and actions implemented;
- ensuring that any incidents that may be reportable to the Health and Safety Executive under the Reporting of Incidents, Diseases and Dangerous Occurrences Regulations (RIDDOR) are immediately

escalated to the Trust Health and Safety Manager or if not available the Divisional Health and Safety lead.

4.6. Department Managers

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

- implement a health and safety management arrangements including Trust health and safety policies, Divisional health and safety procedures and Departmental health and safety procedures where required;
- attend health and safety meetings as required;
- allocate health and safety responsibilities to specific people including Departmental Health and Safety Leads where appropriate, and ensure that they are aware of their responsibilities and have adequate knowledge and training to fulfil them;
- access specialist advice by liaising with the Trust or Divisional Health and Safety Advisors or the Capital Planning and Estates department;
- carry out and record on the Datix system risk assessments of work activities, implement and monitor control measures;
- ensure that staff to have information about the risks within the department and the control measures in place;
- consult and involve staff and safety representatives;
- ensure that adequate instruction, training and supervision is in place within the Department, including a local Health and Safety Induction;
- identify training needs and ensure staff complete mandatory training;
- action Hazard Warnings and Safety Action Bulletins;
- monitor health and safety performance including arranging for workplace inspections to be undertaken and responding to audit actions.

4.7. Trust Health and Safety Manager

The Trust Health and Safety Manager is responsible for:

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

4.8. Individual Employees

All employees must:

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

4.9 Safety Representatives

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

- make representation to their managers on general matters affecting the health safety and welfare at work of employees;
- represent employees in consultations with Health and Safety Executive inspectors or with any other enforcing authority in relation to health and safety matters affecting employees;
- investigate potential hazards, dangerous occurrences, causes of incidents and complaints by employees, at the workplace;
- carry out inspections of the workplace in accordance with Regulations 5,6 & 7 of the Safety Representatives and Safety Committee Regulations 1977;
- be represented at or attend health and safety meetings at all levels of the organisation.

5. Implementation/Policy Compliance

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

5.2 Monitoring Arrangements

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

5.3 Internal Monitoring

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

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

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

5.4 External Monitoring

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

6. Equality Impact Assessment

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

7. Getting Help

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

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

8. References

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

9. Related Policies

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

10. Training

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

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

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

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

11 Key Legislation:

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

12 Key Guidance:

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

Ref: IG 05

SOFTWARE POLICY

Executive Sponsor & Function	Director of Strategic Transformation, Planning and Digital
Document Author:	Head of Digital Delivery
Approved by:	Quality, Safety and Performance Committee
Approval Date:	14 July 2022
Date of Equality Impact Assessment:	January 2019
Equality Impact Assessment Outcome:	Approved
Review Date:	July 2025
Version:	V4

CONTENTS

1. INTRODUCTION

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

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

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

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

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

2. STATEMENT REGARDING THE USE OF COMPUTER SOFTWARE

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

2.2 Software license agreements may apply to single machine use, multiple machines, single or multiple users, or use on Local Areas Networks (LANs). In all circumstances, Trust employees are required to comply with license agreements. Advice on appropriate licensing arrangements for software should be sought from the Digital Services department.

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

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

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

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

3. OBJECTIVES

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

4. ROLES AND RESPONSIBILITIES

4.1 Organisation

Organisation responsibilities are:

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

4.2 Trust Executive

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

- Ensure ALL staff are aware of and adhere to this policy
- Ensure this policy is part of the induction and ongoing awareness process

- Make decisions on disciplinary action required in cases of non-compliance and to empower local IT departments to place immediate orders to legalise software use

4.3 Digital Services Department

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

4.4 Managers

All Managers are directly responsible, ensuring that:

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

4.5 Users

Users are responsible for their own actions and must:

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

5. IMPLEMENTATION

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

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

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

6. FURTHER INFORMATION

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

7. REFERENCES

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

- Information Security Policy
- IT Anti-Virus Policy
- Internet / Intranet Access Policy
- Information Governance Policy
- Welsh Health Circular (2017) 025 – Guidance on Cyber Security and Information Governance requirements relating to suppliers and the supply chain: https://gov.wales/cyber-security-and-information-governance-whc2017025

Ref: IG 06

ANTI VIRUS POLICY

Executive Sponsor & Function	Director of Strategic Transformation, Planning and Digital
Document Author:	Head of Digital Delivery
Approved by:	Quality, Safety and Performance Committee
Approval Date:	14 July 2022
Date of Equality Impact Assessment:	January 2019
Equality Impact Assessment Outcome:	Approved
Review Date:	July 2025
Version:	4

CONTENTS

1. INTRODUCTION

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

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

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

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

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

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

2. STATEMENT REGARDING THE USE OF COMPUTER SOFTWARE

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

The main routes of infection are listed below:

- Downloading unauthorised software from the Internet
- Virus's hidden in e-mail attachments from un-trusted or unexpected sources (e.g. the email sender can sometimes be impersonated or "spoofed")
- Using non-NHS internet-based e-mail systems without approval of your local IT Department / Service Desk (as their use is normally prohibited in Email Policy)

- Insertion of removable media, that may have been used outside the Trust, into a Trust computer without checking for viruses (e.g., CDs, DVDs, memory sticks / USB memory devices, floppy disks and any other removable media capable of carrying data or programs)
- Connecting a non-NHS Trust laptop or PC (that does not have anti-virus software with up-to-date virus definition files) to the trust's network
- The Software, E-mail and Internet Policies provide further detail on the risks and guidance on risk mitigation

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

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

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

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

3. OBJECTIVES

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

4. ROLES AND RESPONSIBILITIES

4.1 Organisation

Organisation responsibilities are:

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

4.2 Trust Executive

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

4.3 IT Security Officers

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

4.4 Local Digital Services Department

Comply with local anti-virus procedures and in particular:

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

4.5 Managers

All Managers are directly responsible, ensuring that:

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

4.6 Users

Users are responsible for their own actions and must:

- Adhere to this policy and associated policies and procedures
- Report incidents to appropriate managers as quickly as possible
- Discuss any identified risks and security issues with the service to the appropriate managers.

Comply with local anti-virus procedures and in particular:

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

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

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

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

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

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

5. FURTHER INFORMATION

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

6. REFERENCES

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

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

Ref: IG 11

DATA QUALITY POLICY

Executive Sponsor & Function	Director of Finance
Document Author:	Head of Digital Delivery
Approved by:	Quality, Safety and Performance Committee
Approval Date:	14 July 2022
Date of Equality Impact Assessment:	February 2014
Equality Impact Assessment Outcome:	Approved
Review Date:	July 2025
Version:	2

CONTENTS

1. POLICY STATEMENT

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

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

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

2. SCOPE OF POLICY

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

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

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

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

3. AIMS AND OBJECTIVES

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

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

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

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

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

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

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

4. RESPONSIBILITIES

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

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

- Promotion of the principles of data quality

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

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

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

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

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

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

- Responsible for implementing and maintaining data quality within Trust paper-based and electronic systems.

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

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

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

5. TRAINING

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

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

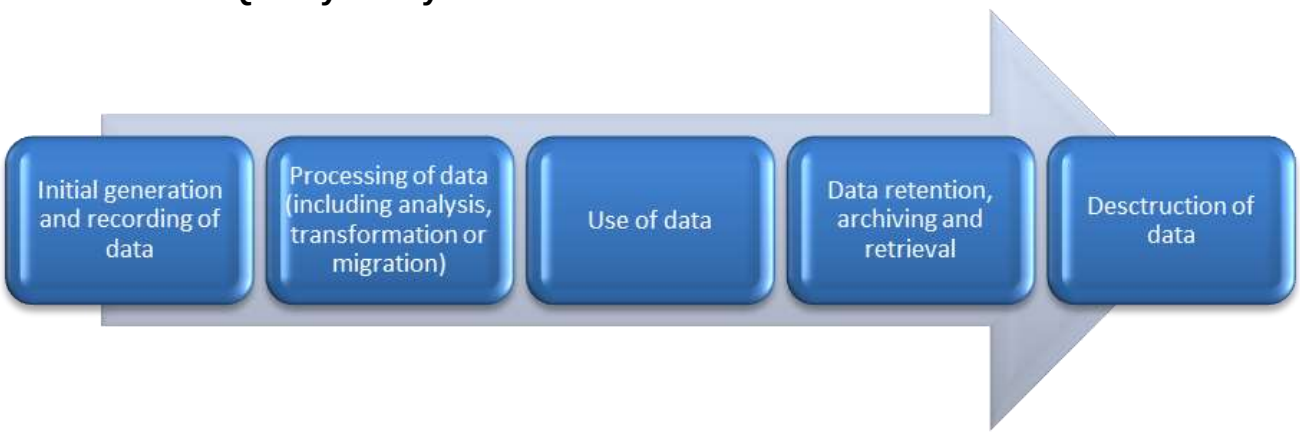
6. DEFINITIONS

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

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

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

6.4 **The Data Quality Lifecycle**



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

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

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

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

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

6.10 **True Copy**: A copy of original information that been verified as an exact (accurate and complete) copy having all of the same attributes and information as the original. The copy may be verified by dated signature or by a validated electronic signature. A true copy may be retained in a different electronic file format to the original record, if required, but must retain the nature of the original record.

7. PRINCIPLES

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

ALCOA+ Principles of Data Integrity			
Principle	**Requirement**	**Examples of Good practice**	**Examples of bad practice**
Attributable	Data should identify the individual (or system) who recorded the data, as well as traceability to the source of the data itself. (e.g., study, test system, analytical run, etc.) Changes to data must also be attributable to the person who made them	Use of Signature/ Electronic Signatures. Controlled access and user permissions for IT systems. Audit trails in IT systems.	Use of another person's login. Use of shared logins. Use of databases with no audit trail e.g., spreadsheet databases. Leaving a logged-on database unattended.
Legible	Quality data must also be legible if it is to be considered fit for use.	Data corrections are made with a single line cross-out so that the original entry can still be seen. Scanned copies or photocopies of data are checked to ensure they are still legible.	Poor handwriting on paper records. Use of pencil rather than permanent pen. Use of forms with spaces that are too small for the data entry.
Contemporaneous	Data is to be recorded at the time the observation is made, activity performed, or decision made.	A checklist for recording a work activity is updated as soon as the activity is completed and not left to the end of the shift. Clocks in displaying the correct time.	Use of rough notes to record data. Summertime adjustments to clocks in IT system being missed. Adding dates to documents retrospectively or prospectively.
Original	Original data is generally considered to be the first data that is recorded and therefore the most accurate.	Data entries made directly onto document-controlled paper forms. Storage of raw data from analysers. Bound forms.	Use of rough notes or post-it notes to record data The use of scribes to record data Copying from one form to another to make the data look neater. Use of IT systems with audit trail.

Accurate	Data should be free from errors. Data should be genuine.	Manual data entry into IT system should verified. Correct date formats used.	Rounding of numbers, where the procedure does not permit it. Data falsification. Mistakes. Repeating lab tests until the desired outcome is obtained purely by chance.
Complete	All data should be available including and for electronic system includes relevant metadata. Any data from an original analysis which has been repeated.	Checking forms for completeness.	Missing data entries on forms with no explanation. Use of electronic records with incomplete metadata e.g., word, excel documents.
Consistent	Good Documentation Practices (GDP) should be applied throughout any process, without exception.	Use of controlled documents. System validation. Data review Including review of audit trail.	Use of IT systems with no audit trails.
Enduring	Part of ensuring records are available is making sure they exist for the entire period during which they might be needed. This means they need to remain intact and accessible as an indelible/durable record.	Ensuring data is backed-up and can be recovered. Durable media for recording.	Use of ink that easily smudges or fades over time.
Available	Records must be available for review at any time during the required retention period, accessible in a readable format to all applicable personnel who are responsible for their review whether for routine release decisions, investigations, trending, annual reports, audits or inspections.	Keeping records according to their retention schedule. Ensure record are appropriately indexed.	Unauthorised destruction of records. Misfiling records.

8. RISK MANAGEMENT

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

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

9. DATA QUALITY STANDARDS

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

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

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

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

10. DATA QUALITY MONITORING AND REPORTING

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

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

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

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

11. REPORTING OF DATA QUALITY INCIDENTS

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

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

12. POLICY COMPLIANCE

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

13. EQUALITY IMPACT ASSESSMENT STATEMENT

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

14. RELATED POLICIES

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

APPENDIX 1

DATA QUALITY GUIDELINES

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

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

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

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

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

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

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

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

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

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

APPENDIX 2

DETAILED GUIDANCE

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

Controls for Electronic GXP systems

General:

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

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

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

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

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

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

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

Backup and recovery:

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

Audit Trails:

GXP systems must have a full audit trail which:

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

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

Direct printouts from electronic systems:

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

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

Processing activity must be limited to specific individuals

Processing should permit reconstruction of all data processing activities.

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

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

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

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

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

Controls for Paper Records
Paper records must be:

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

Controls for spreadsheets

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

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

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

Controls for statistical software packages

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

Archiving Principles

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

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

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

Ref: IG13

CONFIDENTIALITY BREACH REPORTING POLICY

Executive Sponsor & Function:	Executive Director of Finance
Document Author:	Head of Information Governance
Approved by:	Quality, Safety and Performance Committee
Approval Date:	14 July 2022
Date of Equality Impact Assessment:	January 2022
Equality Impact Assessment Outcome:	Approved
Review Date:	July 2025
Version:	2

Contents Page

1. Aim

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

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

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

2. Policy Statement and Objectives

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

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

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

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

3. Scope of the Policy

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

4. Aims of the Confidentiality Breach Reporting Policy

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

4.1 Definitions

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

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

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

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

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

4.2 Reporting Arrangements

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

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

4.3 Personal Data Breach Investigation

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

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

4.4 Incident Classifications

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

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

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

4.5 Notifying individuals or other parties

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

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

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

4.5.1 Method of Notification

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

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

4.5.2 The Information Commissioners Office (ICO)

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

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

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

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

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

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

5. Responsibilities

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

5.1 Managerial Accountability and Responsibility

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

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

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

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

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

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

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

6. Legislation and Standards

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

Human Rights

- European Convention on Human Rights
- Human Rights Act 1998

Rights to Privacy

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

Data Protection

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

Online Privacy

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

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

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

7. Training and Awareness

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

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

8. Equality

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

9. Governance and Reporting

Compliance with this policy (and supporting procedures) will be monitored by the Head of Information Governance. An internal audit on the Trust's arrangements in relation to breach reporting will be scheduled in line with the Trust's internal audit strategy.
For assurance, details on FOI activity will be reported to the Quality, Safety and Performance Committee, as well as the Senior Information Risk Owner (SIRO).
The policy will be reviewed every 3 years, unless where it will be affected by major internal or external changes such as:

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

10. Contacts

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

11. Further Information

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

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

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

Appendix A

Information Governance Risk Table

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

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

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

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

Appendix B

SCORING SYSTEM
FOR CATEGORISING OF PERSONAL DATA BREACHES

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

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

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

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

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

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

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

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

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

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

Appendix C

EXAMPLES OF CATEGORISING PERSONAL DATA BREACHES USING SCORING SYSTEM

Example A

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

Example B

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

Example C

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

Example D

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

Ref: IG01

RECORDS MANAGEMENT POLICY

Executive Sponsor & Function:	Executive Director of Finance
Document Author:	Head of Information Governance
Approved by:	Quality, Safety and Performance Committee
Approval Date:	14 July 2022
Date of Equality Impact Assessment:	December 2021
Equality Impact Assessment Outcome:	Approved
Review Date:	July 2025
Version:	2

Contents Page

1. Aim

The aim of this policy is to ensure that all types of records (regardless of the fact whether they are paper or electronic), administrative as well as medical, are properly controlled, accessible, available, archived, and disposed of in line with national guidelines.

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

2. Policy Statement and Objectives

The Velindre NHS Trust Records Management Policy sets out the key areas of responsibility and affirms the Trusts commitment to achieving high standards in records management. This Policy sets out the high-level intent of Velindre NHS Trust and also recognises the diversity of the respective Divisions and associated organisations under its control.

As a public body we are required by law to manage our records appropriately; namely in accordance with regulations such as the Data Protection Act 2018, , Section 46 of the Freedom of Information Act 2000, Environmental Information Regulations 2004, Public Records Act 1958, Local Government Act 1972 and the re-use of Public Sector Information Regulations 2015 that set out specific requirements in relation to the creation, management, disposal, use and re-use of records.

3. Scope of the Policy

This is a Trust-wide Policy and applies to all staff and personnel operating under the auspices of the Trust, including employees, locums, contractors, temporary staff, students, service user representatives, volunteers and partner agency staff.

This Policy applies to the three identified types of information processed, transmitted and maintained by the Trust, its divisions and hosted organisations. These are:

- Health and Social Care records (“clinical” records about patients, donors, service users and carers)
- Staff records (“corporate” records about staff)
- Management records (“corporate” records about the Trust)

4. Records Management

Records management is vital to the delivery of our services and supports consistency, continuity, efficiency and productivity and helps us deliver our services in a uniform and equitable manner.

Trust records are our corporate memory and support policy formation and managerial decision-making, protecting the interests of the organisation and the rights of service users, staff and members of the public who interact with the Trust and its respective Divisions and/or associated organisations under its control.

The Trust aims to balance our commitment to openness and transparency with our responsibilities. So, we will create and manage records efficiently, make them accessible where possible, protect and store them securely and dispose of them safely at the right time. This policy will provide the Trust with a baseline to improve records management enabling seven main objectives to be delivered, these being:

- **Accountability** – that adequate records are maintained to account fully and transparently for all actions and decisions.

- **Quality** – that records are complete and accurate and the information they contain is reliable and its authenticity can be guaranteed.

- **Accessibility** – that records and the information within them can be efficiently retrieved by those with a legitimate right of access, for as long as the records are held by the organisation.

- **Security** – that records will be secure from unauthorised or inadvertent alteration or erasure, that access and disclosure will be properly controlled, and audit trails will track all use and changes. Records will be held in a robust format which remains readable for as long as records are required.

- **Retention and disposal** – that there are consistent and documented retention and disposal procedures to include provision for permanent reservation of archival records.

- **Training** – that all staff are made aware of their record-keeping responsibilities through generic and specific training programmes and guidance.

- **Performance measurement** – that the application of records management procedures is regularly monitored against agreed indicators and action taken to improve standards as necessary.

4.1 Key Principles of Records Management

Effective records management will help ensure that we have the right information at the right time to make the right decisions. Information is essential to the delivery of high-quality evidence-based health care on a day-to-day basis and an effective records management service ensures that such information is properly managed and is available:

- To support patient, donor care and continuity of care;
- To support day to day business which underpins the delivery of care;
- To support evidence based clinical practice and improvements in clinical effectiveness through research ;
- To support financial, administrative and managerial decision making;
- To meet legal requirements, including subject access requests from patients, representatives or their carers, donors and staff under the Data Protection Act 2018 (UK GDPR) ;

Good record keeping ensures:

- Staff are able to work with maximum efficiency without having to waste time locating information;
- Where appropriate, there is an audit trail which enables any record entry to be traced to a named individual with a given time/date with the knowledge that all alterations are recorded and can be similarly traced; (NB. health records should never be altered – incorrect information may be crossed through, but remain legible, and additional information inserted)
- Those using the record following another staff members use can see what has been done, or not done, and why; and
- Any decisions made can be justified or reconsidered at a later date.

To ensure that the key principles of the Policy are adhered to, the Trust operates a standard approach to the management of information in line with Section 46 Information Management Code of Practice, these are:

- Create
- Assure
- Use
- Store
- Access
- Share
- Publish
- Dispose

4.2 Records Creation

This policy relates to all operational records. Operational records are defined as information created or received in the course of business and captured in a readable form in any medium and providing evidence of the functions, activities and transactions. These records should not be considered personal property, but corporate assets. This list is not exhaustive, but they include:

- Administrative records; (including personnel, letters, memos, estates, financial and accounting records, contract records, litigation and records associated with complaint-handling)
- Health records (including those concerning patients and donors);
- Theatre Registers and all other treatment registers that may be kept;
- X-ray and imaging reports, outpatient records and images;
- Photographs, slides, and other images;
- Microform (i.e. fiche/film), audio and video tapes; and
- Records in all electronic formats - computer databases and their output, including disks etc, and all other electronic records including databases maintained for personal/research purposes.

All records created in the course of the business of the Trust are corporate records and are public records (where defined) under the terms of the Public Records Acts 1958 and 1967 (An Act of parliament which reduces the time that public records may be made available to the public from 50 years under the Public Records Act 1958 to 30 years). This will include emails and other electronic records.

4.3 Records Maintenance (Assure)

The principle of Assure means that we must ensure that our processes are robust enough to protect all information as much as is physically possible. This allows the Trust to assure our patients, donors and service users that our processes are robust enough to safeguard information securely.

Whilst system security in relation to of electronic systems may not provide 100% protection against complex hacking, as an organisation we can mitigate the risk of inadvertent disclosure of information by following a high standard of documentary security, both in the physical and electronic sense, within our daily working practices.

In the same way that the Trust ensures that the data and information it creates is safeguarded securely, the same measures of protection are to be applied for information received within the organisation. All information should only be accessed on a need-to-know basis. By compartmentalising information access, the risk of inadvertent disclosure by unauthorised Staff is reduced. Staff who have access to information are to safeguard it appropriately.

4.4 Records Retrieval (Use)

Accurate recording and knowledge of the content and location of all records is essential if relevant information is to be located quickly and efficiently. Systems will be reviewed and developed as necessary to ensure that as a record moves around the organisation, an audit trail is created, and systems are recommended to record the following (minimum) information:

- the item reference number or other identifier;
- a description of the item (e.g. file title);
- it's location i.e. a person, unit, department or other; and
- the date of transfer.

4.5 Records Storage

Whilst there are many options available for Information Asset Owners to follow, the crucial element is the ability to access information easily and quickly which relies on the logical storage of information. The Code of Practice on the management of records issued under section 46 of the Freedom of Information Act 2000 provides a high-level overview in terms of what the Secretary of State for Digital, Culture, Media and Sport expects from Public Bodies. The ICO provides more granular guidance in relation to the entire subject of Records Management in its Section 46 - Code of Practice for Records Management . In relation to the storage of Medical Records, the NHS Wales Records Management Code of Practice for Health and Social Care 2022 is to be used by Trust Staff. The Head of Information Governance is available to provide advice and guidance to Staff.

4.6 Records Access

Information within the Trust is a corporate asset, but given the nature of its business, the principle of 'need to know' underpins access to information. Staff are not, under any circumstances to access records where there is no business need to do so.

4.7 Sharing of Records

Sharing information is a business-critical function of the Trust. However, it must be done compliantly and in a structured way. Data Protection legislation states that may only be shared with the consent of the originator of the information. Specifically, information is not to be shared to third party organisations without prior approval. Prior to any approval to share data, data protection legislation requirements must be met. The ICO's Data Sharing Code of Practice is the underpinning guidance in terms of considering the sharing of personal data. Whenever personal data is to be shared, the advice of the Head of Information Governance is to be sought at the beginning of the process.

4.8 Publishing Records

The Communications department are responsible for the public facing aspect of the Trust. The Trust has its own website, which is accessible by the general public.

Information within the website is to meet the high-quality standards of the Trust and should only be published after it has been ascertained that the information does not breach any current legislation (including the Freedom of Information Act 2000) with regards to appropriate content, security and sensitivity.

The Trust adheres to data protection legislation and our Privacy Notice is contained on the website. When requested, staff are able to forward a hyperlink to the Privacy Notice to stakeholders and other third parties.

4.9 Retention and Disposal of Records

Information held by the Trust is to be for explicit and legitimate purposes. It must also be adequate, relevant, accurate and necessary. These are the six principles for the management of information within the Trust. When creating the information, it is prudent practice to estimate the whole life disposition of the information.

It is a requirement that all Trust records are retained for a minimum period of time for legal, operational and safety reasons. The length of time for retaining records will depend on the type of record and its relation to the Trust's functions.

The Trust has adopted the retention periods set out in the NHS Wales Records Management Code of Practice 2022 .

The Trust contracts a confidential waste disposal company, to dispose of physical information securely. All documents must be placed in the receptacles provided which are emptied regularly by the Contractor.

4.10 Data Quality

The Trust will ensure an Executive level focus on data quality and will actively encourage an organisation wide approach to its management. The Data Quality Policy contains more information.

4.11 Security, Confidentiality and Data Protection

The Trust has a legal duty of confidence to service users and staff and a duty to maintain professional ethical standards of confidentiality. Everyone working for or with the Trust and record, handle, store or views personal data, has a common law duty of confidence - even after the death of the service user, or after an employee or contractor has left the Trust. (i.e. duty of confidentiality is for life)

4.12 Contracting-out Information Storage and Retrieval

Where off-site storage is used appropriate security measures must be assured after consultation with the Head of Information Governance so that both clinical and legal obligations are met.

4.13 Information Asset Register

The Trust is fully committed to identifying all recognisable bodies of information held on paper or electronic media that are required to support the work of the organisation. In order to identify all records of information that we hold about our patients, donors, staff and service users (incl. families, friends, etc) each division/hosted organisation are required to develop and assemble an appropriate Information Asset Register (IAR).

The IAR is a compulsory component of the Trust's Information Governance framework, as the identification of where and how records are being kept can then enable the Trust, its respective divisions and hosted organisation to better assess the risks associated with how information is being collected, stored and disposed, thereby ensuring compliance with Data Protection Legislation and associated standards.

5. Roles and Responsibilities

The Trust recognises its corporate responsibility and commitment to compliance with Records Management requirements; as stated within statutory provision and good practice guidance, and to further raise staff awareness of good Records Management practice.

The Trust's Quality, Safety and Performance Committee is responsible for approving the content of this Policy.

5.1 Managerial Accountability and Responsibility

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

Respective **Senior Information Risk Owners (SIRO)** shall represent any relevant information risk to the Trust Board.

Directors of associated areas within the Trust are responsible for ensuring that the policy is implemented within their individual organisation. They will nominate departmental representatives, who will liaise with the respective Information Governance Leads on the management of records in that division.

Within the Trust there are **Caldicott Guardians** who have responsibility at respective organisational level for ensuring the care of patient/donor data.

The Trust, divisional and hosted organisational **Information Governance leads** are responsible for co-ordinating records management in their respective organisations and identifying key corporate records and providing guidance and advice on their management and retention.

5.2 Individual Responsibility

All members of staff are responsible for any records which they create or use. This responsibility is established by law and in the contract of employment with the Trust. Furthermore, as an employee of the NHS, any records which are created by any employee or contractor of the Trust are public records. It is the responsibility of all staff to ensure that appropriate records of their work in the Trust are kept and managed in keeping with this policy and with any guidance subsequently produced on behalf of the Trust.

Everyone working for or with the NHS who records, handles, stores, or otherwise comes across information has a personal common law duty of confidence to individuals referred to in that information. Data Protection Legislation places statutory restrictions on the use of personal data, including health information.

The Data Protection and Confidentiality Policy contains practical considerations which members of Staff are to follow when processing information within the remit of this Policy.

6. Legislation and Standards

The need to improve NHS records managements and for the Trust to re-consider current practices has arisen from statutory provisions and good practice guidance's that include but is not limited to:

- Data Protection Legislation
- Freedom of Information Act 2000
- Environmental Information Regulations 2004
- Public Records Acts 1958 and 1967
- Caldicott Principles
- Records Management: NHS Code of Practice
- The Lord Chancellor's Code of Practice under Section 46 of The Freedom of Information Act 2000 (superseded by the Secretary of State for Digital, Culture, Media and Sport - Code of Practice on the management of records issued under Section 46 of the Freedom of Information Act 2000)

The Trust recognises that specific procedures within divisions and associated organisations may vary and that this policy should therefore be considered in conjunction with any such policies and/or procedures and not read in isolation.

7. Training and Awareness

The Trust will ensure that adequate training is provided raising the awareness of staff responsibilities for records management and that qualified expertise is available for consultation via the Head of Information Governance.

8. Governance and Reporting

It is the duty of all staff to record and report any incidents or 'near misses' involving records or personal data (including the unavailability and loss) in line with the Trust and divisional and/or associated organisational incident reporting policies/procedures.

The Trust's Head of Information Governance will report a summary of incidents via the EMB to the QSP Committee on a quarterly basis via SIRO so that the Trust Board has an oversight on any breaches of Records Management Policy.

The Committee will further brief the Trust Board as appropriate.

9. Available Guidance

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

Links to the Information Commissioner's Office (ICO) website also provide a valuable source of information.

10. Health and Care Standards

This Policy and processes described enable the Trust to comply with the
The Health and Care Standard 3.5 on Record Keeping and 3.4 in that:

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

11. Equality

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

12. Contacts

For further advice and/or assistance on how to ensure individual, divisional and associated organisational compliance with this policy, please contact: -

Head of Information Governance
Velindre University NHS Trust
2 Charnwood Court
Parc Nantgarw
Cardiff
CF15 7QZ
Tel – 01443 622161

13. Further Information

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

- Information Governance Policy
- Data Protection & Confidentiality Policy
- Freedom of Information Act Policy
- Data Quality Policy
- Information Security Policy
- Procedure for Media, Filming, Recording and Photography, for and within the Trust
- Email Policy

Ref: IG08

FREEDOM OF INFORMATION ACT POLICY

Executive Sponsor & Function:	Executive Director of Finance
Document Author:	Head of Information Governance
Approved by:	Quality, Safety and Performance Committee
Approval Date:	14 July 2022
Date of Equality Impact Assessment:	December 2021
Equality Impact Assessment Outcome:	Approved
Review Date:	July 2025
Version:	**2.0**

Contents Page

1. Aim

The aim of this policy is to ensure the provisions of the Freedom of Information Act 2000 are adhered to and in particular that:

- a significant amount of routinely published information about Velindre NHS Trust (the Trust) is made available to the public as a matter of course through the Trust's website and its Model Publication Scheme;
- other information not included on the Trust's website is readily available on request and that requests for information are dealt with in a timely manner; and
- where the information requested is covered by a public interest non-disclosure exemption, the Trust carefully considers the public interest test as defined by the Act prior to its final decision.

Achievement of these aims will detail how the Trust meets its legal obligations. It will further the commitment of the Trust to ensure timely access to information held by its divisions and associated organisations in order to promote greater openness. It will demonstrate increased transparency of decision making thereby building public trust and confidence.

These aims will be balanced against the need to ensure the confidentiality of some information the Trust, its divisions and associated organisations hold relating to such areas as personal privacy, commercial sensitivity and where disclosure would not be in the public interest.

The policy also aims to provide all employees of the Trust with a framework in which to ensure any request for information they receive is dealt with in accordance with the Act and in conjunction with this policy.

2. Policy Statement and Objectives

The Freedom of Information Act 2000 and Environmental Information Regulations 2004 (hereafter known as the Act) provide public access to information held by Public Authorities. Schedule 1, Part 3, paragraph 40 of the Act (A National Health Service Trust established under Section 18 of the National Health Service Wales Act 2006) defines Velindre University NHS Trust as a Public Authority.

The Freedom of Information Act Policy sets out the key areas of responsibility and affirms Velindre NHS Trust's commitment to the underlying principles of the Act enabling it to meet its obligations under the legislation.

The Trust supports the principles of openness and transparency and welcomes the rights of access to information that the Freedom of Information Act 2000 provides. The Trust seeks to create a climate of openness and transparency by providing improved access to information about the Trust that will facilitate such an environment.

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

3. Scope of the Policy

This policy applies to all information the Trust, its divisions and associated organisations hold regardless of how it was created or received. It applies no matter what media the information is stored in and whether the information is current or archived and held on paper or electronic.

4. Legislation and Standards

The Trust and its staff will comply with all existing and new requirements, both legislative and provided as guidance by the Welsh Government (WG), Department of Health, the Information Commissioner's Office (ICO) and other professional bodies.

This policy is written in accordance with current legislation including, but not restricted to, the Act as well as key pieces of guidance and current Trust and divisional/ associated organisational policies and procedures where they overlap with this policy.

The Trust recognises that specific procedures within divisions and associated organisations may vary. However, the requirement to maintain the provisions of the Act and the need to ensure timely access to information whilst promoting openness and transparency will always remain the same.

5. Roles and Responsibilities

Divisions and associated organisations that fall under the remit of the Trust are responsible for promoting compliance with this policy in such a way as to ensure the easy, appropriate and timely retrieval of information.

All Trust employees (including honorary contract holders and volunteers) are subject to this policy and have responsibilities to ensure that any request for information they receive and/or asked to assist with are dealt with in a timely manner in accordance with the Act and in compliance with this policy; failure to comply may result in disciplinary procedures being instigated.

To ensure compliance, Information Governance training provisions within the divisions and associated organisations of the Trust will provide members of staff with an introductory briefing and training on the Act and its procedures.

6. Obligations under the Act

6.1 Right of Access

Under the provisions of the Act individuals have the right to be told whether particular information exists and the right to receive the information. Upon receipt of a request for information the Trust and associated organisations have 20 working days in which to respond. A charge [see section 7.5], set in accordance with the Fees Regulations defined by the Secretary of State, may be made for providing the information.

6.2 Publication Scheme

The Trust has adopted the Information Commissioner's Model Publication Scheme.
The Scheme can be accessed via the Trust's website and sets out the types of information the Trust publishes, the form it is published and details of any charges.

The Scheme will be subject to regular review in terms of content.

6.2.1 Datasets

Section 102 of the Protection of Freedoms Act 2012 added new provisions to FOIA (in particular sections 11 and 19) regarding datasets. A dataset is a collection of factual information in electronic form which concerns the services and functions of the Trust and its associated organisations that is neither the product of analysis or interpretation, nor an official statistic and has not been materially altered. Further guidance can be found here:

Data Sets Sections 11, 19 and 45 of the Freedom of Information Act - Guide

The Trust will as part of its Publication Scheme routinely make available datasets necessary to fulfil all legal and regulatory obligations. Where, following a request a new data set is published, the responsibility of its maintenance will fall to the respective Manager of the department within the Trust or its associated organisations from which it was sourced.

6.3 Specific Requests for Information

Information that is not already made available on the Trust's publication scheme may be accessible through a specific request for information. Any request for information under the Act must be made in a permanent form (i.e. in writing or by email). Where members of the public are unable to access any electronic medium such as email or internet, alternative methods of supplying information must be considered.

In addition, the Environmental Information Regulations (EIR) which in general terms relate to requests regarding topics such as environmental matters (air, water, land, etc), noise,

activities affecting the environment, and some aspects of health and safety, also allows for requests to be made verbally.

The Trust, respective divisions and associated organisations must respond to all requests for information within 20 working days with any response including the need to confirm or deny whether the information is held. The Act operates on the basis that information must be published unless there is a likelihood that harm to the Public Interest would be greater if the information were to be published above that if it were to be withheld.

It is on this basis, that information will be disclosed wherever possible. Where it has been deemed information cannot be supplied in full or in part exemptions or in the case of EIR [see section 7.6] outlined in the Act must be applied. It should be noted that dependent on the contents of the document this may be more than one exemption (or for EIR exception).

Technical advice related to the application of the Act, its time compliance provisions and potential usage of any of the Acts exemptions or exceptions is available from the Trust's Communication and Compliance Officer . Where application of the exemptions/exceptions may be particularly complex or sensitive, the Head of Information Governance is available to provide support as required. From time to time, where it may involve extremely complex legislation, the process may also necessitate the use of external legal support. In these circumstances, the Head of Information Governance's advice/and/or guidance must be sought. .

6.4 Data Protection and Freedom of Information

Personal data which falls within the scope of the Data Protection Legislation is not covered by the Freedom of Information Act 2000 and therefore not publicly accessible. In such cases this is a Data Protection issue and the Head of Information Governance must be contacted for further advice/guidance prior to the exemption being applied and the request for information replied to.

In some instances certain personal data may be released where it relates to senior staff or staff in public facing roles, but only where such information relates to a person's working life. For example contact information and salary grade.

6.5 Charging

In maintaining a culture of openness and transparency the Trust, respective divisions and its associated organisations will not normally charge for the provision of information that is provided as a result of a request. However, it is recognised that should it be estimated the request for information exceeds the appropriate fee limit[1] as set down under section 12 of the Act then the organisation is not obligated to comply with the request for information.

[1] Appropriate limit has been set as a figure of £450 and is calculated at a rate of £25 per hour/18 hours of work

In cases when the information is exempt because the appropriate fee limit has been met, then wherever possible and in line with the duty to provide advice and assistance enshrined within the Act, the Trust, its divisions and associated organisations will work with the applicant to try to reduce the amount of work involved so that some of the information can be provided. In certain circumstances where the amount of work required to meet the request cannot be reduced, the applicant can be offered the option of paying for the information. In this instance the applicant would have to pay the full cost of meeting the request.

In addition to this and under the Act, charges can be applied to cover more administrative tasks such as photocopying/translation of documents, etc. In most circumstances applying charges for such disbursements may be waived; however the Trust, its divisions and associated organisations reserve the right to apply these charges especially in exceptional instances where the request requires an unrealistically large amount of photocopying, or substantial effort to translate or perform a transition of documents into other formats. If disbursements are charged, they will be kept to a reasonable level.

Appendix 1 provides information on the rules in place for charging for the supply of information under the Act with further advice available via the Trust Communication and Compliance Officer and/or the Head of Information Governance .

6.6 Exemptions and Exceptions

It is recognised that in some cases the disclosure of information may affect the legal rights of a third party (i.e. where information is subject to the common law duty of confidence, impacts on an industrial partner with whom the Trust is under contract (e.g. a pharmaceutical company), etc). In such situations it will be necessary to engage with these third parties to seek their opinion on any potential release. However any decision to release or not and where required subsequent application of an exemption/exception under the Act rests with the Trust, its divisions and/or associated organisations. A refusal to consent to disclosure by a third party does not, in itself, mean information should be withheld.

Should it be determined that the information held could be regarded as exempt information under the Act and requires the need to consider the application of an exemption or exception the respective Trust and organisational leads must take the lead in identifying why the exemption or exception should be applied with written evidence provided to the Compliance Officer and/or Head of Information Governance so that logical and clear reasoning behind the decision to withhold information can be identified.

Should the requestor subsequently submit a complaint (See Section 8) regarding the Trust's response the reasoning behind the original assessment will be re-appraised as part of the Internal Review process which involves reviewing the information withheld and the rationale applied within the Public Interest test process for refusal to publish the information in the first instance.

Appendixes 2and 3 provides a full list of all the exemptions/exceptions that can be found under the Act.

6.7 Codes of Practice

The Act sets provisions for the Lord Chancellor and Secretary of State to issue codes of practice to which the Trust should adhere. The applicable codes of practice are detailed below: -

7.7.1 Section 45 Code of Practice – Request Handling

The Section 45 code of practice sets out recommended processes which public authorities should follow when dealing with requests for information under the Act. It provides clear guidance that includes providing advice and assistance to applicants, how to transfer requests to other public authorities, consultation with third parties, how to use confidentiality clauses in contracts and the provision of internal complaints procedures. The hyperlink is below:

ICO Guide: Section 45 Code of Practice

7.7.2 Section 46 Code of Practice – Records Management

The Section 46 code of practice sets out recommended processes with which public authorities should adopt in relation to the creation, storage and management of records. In addition to the end life and destruction of these records. It also describes the arrangements which public record bodies should follow in reviewing public records and transferring them to the Public Record Office (PRO) or to pre-arranged places of archival.

7. Awareness and Training

All Staff will receive a broad overview of the Act to ensure awareness. This training will be delivered as part of induction for new Staff and periodically thereafter by the Head of Information Governance.

Key Staff and members of the Board and Executive Management Board will receive more specific training, particularly those in governance functions.

8. Governance and Reporting

Compliance with this policy (and supporting procedures) will be monitored by the Head of Information Governance. An internal audit on the Trust's arrangements in relation to the Act will be scheduled in line with the Trust's internal audit strategy.
For assurance, details on FOI activity will be reported to the Quality, Safety and Performance Committee, as well as the Senior Information Risk Owner (SIRO).

9. Complaints

Anyone who has made a request for information to the Trust under the Act is entitled to request an internal review if they are unhappy with the way their request has been handled

Internal reviews will be carried out afresh by the Head of Information Governance or in his absence another senior member of staff who was not involved with the original decision (appropriate assistance will be provided to requesters with access requirements).

To progress and ensure there is no delay in the handling of any requests for internal review the following process should be adhered to: -

- The request for review should be submitted by the applicant within 40 working days and addressed to the Trust's Head of Information Governance in the first instance.
- The Trust will acknowledge the request for an internal review within three working days and aim to respond within 20 working days of receipt. On occasion and only by exception (where the review is complex) the trust may extend the review period to a maximum of 40 working days.

Any applicant who remains dissatisfied with the outcome of the Trust's internal review is entitled to complain to the Information Commissioner's Office (ICO) by writing to:

Information Commissioner's Office – Wales
2nd Floor
Churchill House
Churchill Way
Cardiff
CF10 2HH

Tel: 0330 414 6421
Email: wales@ico.org.uk

10. Available Guidance and References

Guidance on the procedures necessary to comply with this policy should be made available from the respective divisions and associated organisations of the Trust or on its web pages. Links to the Information Commissioner's Office (ICO) website also provide a valuable source of information and should be quoted at every opportunity.

11. Health and Care Standards

This Policy and processes described within, as well as those contained within the Standard Operating Procedures enable the Trust to comply with Health and Care Standards 3.4 in that:

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

12. Equality

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

13. Copyright

Information provided by the Trust, its divisions and associated organisations in response to a request under the Act remains copyrighted and can only be used for the applicant's personal use or for other specific uses permitted in the Copyright, Designs and Patents Act 1988.

If an applicant wishes to use information provided for commercial purposes (including the sale of the information to a third party) they must seek written permission from the Trust, its divisions and/or associated organisations under the directive on the Re-use of Public Sector Information Regulations 2015.

14. Contacts

For further advice and/or assistance on how to ensure individual, divisional and associated organisational compliance with the Act or to obtain lead officer details, then please contact the Trust's Communication and Compliance Officer or Head of Information Governance Manager: -

Communication and Compliance Officer
Velindre University NHS Trust
Trust Headquarters
2, Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Tel - 029 20316951

Head of Information Governance
Velindre University NHS Trust
Trust Headquarters
2, Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Tel – 029 2031 6161

15. Further Information

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

- Information Governance Policy
- Data Protection & Confidentiality Policy
- Records Management Policy
- Information Security Policy
- Email Policy
- NHS Wales Internet Use Policy

Appendix 1

Where costs exceed the appropriate limit

When determining whether or not the requested information exceeds the appropriate fee limit under the Act, the Trust and/or its associated organisations are only permitted to include the following activities within their estimation: -

- determining whether the information is held;
- locating the information;
- retrieving the information; and
- extracting the information from a document containing it.

Calculating the costs of the activities

£25 is the standard hourly rate; the limit is £450 which equates to 18 hours' worth of staff time, in which the Trust and/or its associated organisation's must use to calculate the staff costs of answering requests.

Staff time spent redacting exempt information cannot be taken into account if an initial estimation into whether the appropriate limit is exceeded is undertaken.

Fees Notices

As a matter of good practice, if the Trust and/or its associated organisations are offering to provide the information for a fee then a fees notice should be issued to the applicant. There is no statutory requirement to do this because there is no obligation on the organisation to comply under section 12 of the Act. However, it is recommended as this would inform the applicant they have the option of receiving information upon the payment of a necessary fee (Section 9 of the Act). A fees notice should be issued as soon as possible or at least within the 20-working daytime period.

Statutory obligations to provide Information

A fee cannot be charged where there is a statutory obligation to supply information in a particular format, such as in the Welsh language (Welsh Language Act 1993) or in Braille, large print or on an audio tape to make reasonable adjustments for disabled persons (Equality Act 2010). The cost of supplying information by the preferred means of communication however is chargeable.

Payment

Should the Trust and/or its associated organisations fail to receive payment within three months of issuing a fee's notice, the Information Commissioner's Office would consider that the organisation is no longer obliged to respond to the request. It is also helpful to mention this deadline in the fees notice.

Appendix 2

Freedom of Information Act 2000 – Exemptions

Absolute Exemptions

- Section 21: Information accessible by other means

- Section 23: National Security - Information supplied by, or relating to, bodies dealing with security matters (a certificate signed by a Minister of the Crown is conclusive proof that the exemption is justified. There is a separate appeals mechanism against such certificates)

- Section 32: Court Records

- Section 34: Parliamentary Privilege - a certificate signed by the Speaker of the House, in respect of the House of Commons, or by the Clerk of the Parliament, in respect of the House of Lords is conclusive proof that the exemption is justified.

- Section 36: Effective Conduct of Public Affairs - so far as relating to information held by the House of Commons or the House of Lords

- Section 40: Personal Information - where the applicant is the subject of the information. The applicant already has the right of ‘subject access' under existing Data Protection Legislation; where the information concerns a third party and disclosure would breach one of the data protection principles

- Section 41: Information provided 'In Confidence'

- Section 44: Prohibitions on disclosure - where a disclosure is prohibited by an enactment or would constitute contempt of court.

Qualified Exemptions

- Section 22: Information Intended for Future Publication

- Section 24: National security (other than information supplied by or relating to named security organisations, where the duty to consider disclosure in the public interest does not apply)

- Section 26: Defence

- Section 27: International relations

- Section 28: Relations within the United Kingdom

- Section 29: UK Economic Interests
- Section 30: Investigations and Proceedings Conducted by Public Authorities
- Section 31: Law Enforcement
- Section 33: Audit Functions
- Section 35: Formulation of government policy and Ministerial Communications
- Section 36: Prejudice to effective conduct of public affairs (except information held by the House of Commons or the House of Lords – see absolute exemptions)
- Section 37: Communications with Her Majesty, the Royal Family or concerning honours
- Section 38: Health and Safety
- Section 39: Environmental Information - as this can be accessed through the Environmental Information Regulations
- Section 42: Legal Professional Privilege
- Section 43: Commercial Interests

Where the Trust, its divisions and/or associated organisations consider that the public interest in withholding the information requested outweighs the public interest in releasing it, the authority must inform the applicant of its reasons, unless to do so would mean releasing the exempt information.

Appendix 3

Environmental Information Regulations 2004 – Exceptions

Subject to the Public Interest Test:

- Regulation 12(4)(a) – Does not hold that information when an applicant's request is received
- Regulation 12(4)(b) – In manifestly unreasonable
- Regulation 12(4)(c) – Is formulated in too general a manner (provided assistance has been given to the applicant with a view to re-forming the request)
- Regulation 12(4)(d) – Relates to unfinished documents or incomplete data
- Regulation 12(4)(e) – Would involve disclosure of internal communications

And if disclosure would adversely affect:

- Regulation 12(5)(a) – International relations, defence, national security or public safety
- Regulation 12(5)(b) – The course of justice, fair trial, the conduct of a criminal or disciplinary inquiry
- Regulation 12(5)(c) – Intellectual Property rights
- Regulation 12(5)(d) – Confidentiality of public authority proceedings when covered by law
- Regulation 12(5)(e) – Confidentiality of commercial or industrial information, when protected by law to cover legitimate economic interest
- Regulation 12(5)(f) – Interests of the person who provided the information
- Regulation 12(5)(g) – Protection of the environment

Please note that if the information requested is related to emissions, exceptions 12(5)(d) to 12(5)(g) cannot be used.

If Personal data is requested then Regulation 13 must be used.

Ref: IG13

CONFIDENTIALITY BREACH REPORTING POLICY

Executive Sponsor & Function:	Executive Director of Finance
Document Author:	Head of Information Governance
Approved by:	Quality, Safety and Performance Committee
Approval Date:	14 July 2022
Date of Equality Impact Assessment:	January 2022
Equality Impact Assessment Outcome:	Approved
Review Date:	July 2025
Version:	2

Contents Page

1. Aim

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

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

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

2. Policy Statement and Objectives

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

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

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

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

3. Scope of the Policy

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

4. Aims of the Confidentiality Breach Reporting Policy

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

4.1 Definitions

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

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

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

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

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

4.2 Reporting Arrangements

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

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

4.3 Personal Data Breach Investigation

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

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

4.4 Incident Classifications

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

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

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

4.5 Notifying individuals or other parties

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

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

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

4.5.1 Method of Notification

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

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

4.5.2 The Information Commissioners Office (ICO)

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

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

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

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

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

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

5. Responsibilities

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

5.1 Managerial Accountability and Responsibility

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

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

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

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

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

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

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

6. Legislation and Standards

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

Human Rights

- European Convention on Human Rights
- Human Rights Act 1998

Rights to Privacy

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

Data Protection

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

Online Privacy

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

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

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

7. Training and Awareness

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

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

8. Equality

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

9. Governance and Reporting

Compliance with this policy (and supporting procedures) will be monitored by the Head of Information Governance. An internal audit on the Trust's arrangements in relation to breach reporting will be scheduled in line with the Trust's internal audit strategy.
For assurance, details on FOI activity will be reported to the Quality, Safety and Performance Committee, as well as the Senior Information Risk Owner (SIRO).
The policy will be reviewed every 3 years, unless where it will be affected by major internal or external changes such as:

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

10. Contacts

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

11. Further Information

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

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

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

Appendix A

Information Governance Risk Table

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

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

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

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

Appendix B

SCORING SYSTEM
FOR CATEGORISING OF PERSONAL DATA BREACHES

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

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

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

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

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

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

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

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

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

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

Appendix C

EXAMPLES OF CATEGORISING PERSONAL DATA BREACHES USING SCORING SYSTEM

Example A

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

Example B

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

Example C

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

Example D

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

Ymddiriedolaeth GIG Prifysgol Felindre Velindre University NHS Trust

Ref: IG 14

INFORMATION ASSET POLICY

Executive Sponsor & Function	Director of Strategic Transformation, Planning and Digital
Document Author:	Head of Digital Delivery
Approved by:	Quality, Safety and Performance Committee
Approval Date:	14 July 2022
Date of Equality Impact Assessment:	April 2018
Equality Impact Assessment Outcome:	Approved
Review Date:	July 2025
Version:	2

CONTENTS

1. INTRODUCTION AND AIM

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

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

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

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

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

2. POLICY STATEMENT AND OBJECTIVES

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

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

3. SCOPE

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

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

4. INFORMATION ASSET MANAGEMENT

4.1 Identification of Information Assets

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

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

4.2 Individual Asset Management

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

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

The Information Asset Owner must know:

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

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

4.3 Categorisation of Information

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

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

4.4 Data Quality

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

4.5 Information Risk Management

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

4.6 Business Continuity

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

4.7 Asset Disposal

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

4.8 Requests for information

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

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

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

5. ROLES AND RESPONSIBILITIES

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

5.1 Chief Executive

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

5.2 Senior Information Risk Officer (SIRO)

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

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

5.3 Caldicott Guardian

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

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

5.4 Data Protection Officer

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

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

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

5.5 Managers

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

5.6 Workforce

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

6. AVAILABLE GUIDANCE

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

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

7. TRAINING AND AWARENESS

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

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

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

8. GOVERNANCE AND REPORTING

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

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

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

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

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

9. HEALTH AND CARE STANDARDS

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

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

10. EQUALITY

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

11. CONTACTS

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

12. FURTHER INFORMATION

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

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

APPENDIX 1

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

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

Ref: IG08

FREEDOM OF INFORMATION ACT POLICY

Executive Sponsor & Function:	Executive Director of Finance
Document Author:	Head of Information Governance
Approved by:	Quality, Safety and Performance Committee
Approval Date:	14 July 2022
Date of Equality Impact Assessment:	December 2021
Equality Impact Assessment Outcome:	Approved
Review Date:	July 2025
Version:	**2.0**

Contents Page

1. Aim

The aim of this policy is to ensure the provisions of the Freedom of Information Act 2000 are adhered to and in particular that:

- a significant amount of routinely published information about Velindre NHS Trust (the Trust) is made available to the public as a matter of course through the Trust's website and its Model Publication Scheme;
- other information not included on the Trust's website is readily available on request and that requests for information are dealt with in a timely manner; and
- where the information requested is covered by a public interest non-disclosure exemption, the Trust carefully considers the public interest test as defined by the Act prior to its final decision.

Achievement of these aims will detail how the Trust meets its legal obligations. It will further the commitment of the Trust to ensure timely access to information held by its divisions and associated organisations in order to promote greater openness. It will demonstrate increased transparency of decision making thereby building public trust and confidence.

These aims will be balanced against the need to ensure the confidentiality of some information the Trust, its divisions and associated organisations hold relating to such areas as personal privacy, commercial sensitivity and where disclosure would not be in the public interest.

The policy also aims to provide all employees of the Trust with a framework in which to ensure any request for information they receive is dealt with in accordance with the Act and in conjunction with this policy.

2. Policy Statement and Objectives

The Freedom of Information Act 2000 and Environmental Information Regulations 2004 (hereafter known as the Act) provide public access to information held by Public Authorities. Schedule 1, Part 3, paragraph 40 of the Act (A National Health Service Trust established under Section 18 of the National Health Service Wales Act 2006) defines Velindre University NHS Trust as a Public Authority.

The Freedom of Information Act Policy sets out the key areas of responsibility and affirms Velindre NHS Trust's commitment to the underlying principles of the Act enabling it to meet its obligations under the legislation.

The Trust supports the principles of openness and transparency and welcomes the rights of access to information that the Freedom of Information Act 2000 provides. The Trust seeks to create a climate of openness and transparency by providing improved access to information about the Trust that will facilitate such an environment.

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

3. Scope of the Policy

This policy applies to all information the Trust, its divisions and associated organisations hold regardless of how it was created or received. It applies no matter what media the information is stored in and whether the information is current or archived and held on paper or electronic.

4. Legislation and Standards

The Trust and its staff will comply with all existing and new requirements, both legislative and provided as guidance by the Welsh Government (WG), Department of Health, the Information Commissioner's Office (ICO) and other professional bodies.

This policy is written in accordance with current legislation including, but not restricted to, the Act as well as key pieces of guidance and current Trust and divisional/ associated organisational policies and procedures where they overlap with this policy.

The Trust recognises that specific procedures within divisions and associated organisations may vary. However, the requirement to maintain the provisions of the Act and the need to ensure timely access to information whilst promoting openness and transparency will always remain the same.

5. Roles and Responsibilities

Divisions and associated organisations that fall under the remit of the Trust are responsible for promoting compliance with this policy in such a way as to ensure the easy, appropriate and timely retrieval of information.

All Trust employees (including honorary contract holders and volunteers) are subject to this policy and have responsibilities to ensure that any request for information they receive and/or asked to assist with are dealt with in a timely manner in accordance with the Act and in compliance with this policy; failure to comply may result in disciplinary procedures being instigated.

To ensure compliance, Information Governance training provisions within the divisions and associated organisations of the Trust will provide members of staff with an introductory briefing and training on the Act and its procedures.

6. Obligations under the Act

6.1 Right of Access

Under the provisions of the Act individuals have the right to be told whether particular information exists and the right to receive the information. Upon receipt of a request for information the Trust and associated organisations have 20 working days in which to respond. A charge [see section 7.5], set in accordance with the Fees Regulations defined by the Secretary of State, may be made for providing the information.

6.2 Publication Scheme

The Trust has adopted the Information Commissioner's Model Publication Scheme.
The Scheme can be accessed via the Trust's website and sets out the types of information the Trust publishes, the form it is published and details of any charges.

The Scheme will be subject to regular review in terms of content.

6.2.1 Datasets

Section 102 of the Protection of Freedoms Act 2012 added new provisions to FOIA (in particular sections 11 and 19) regarding datasets. A dataset is a collection of factual information in electronic form which concerns the services and functions of the Trust and its associated organisations that is neither the product of analysis or interpretation, nor an official statistic and has not been materially altered. Further guidance can be found here:

Data Sets Sections 11, 19 and 45 of the Freedom of Information Act - Guide

The Trust will as part of its Publication Scheme routinely make available datasets necessary to fulfil all legal and regulatory obligations. Where, following a request a new data set is published, the responsibility of its maintenance will fall to the respective Manager of the department within the Trust or its associated organisations from which it was sourced.

6.3 Specific Requests for Information

Information that is not already made available on the Trust's publication scheme may be accessible through a specific request for information. Any request for information under the Act must be made in a permanent form (i.e. in writing or by email). Where members of the public are unable to access any electronic medium such as email or internet, alternative methods of supplying information must be considered.

In addition, the Environmental Information Regulations (EIR) which in general terms relate to requests regarding topics such as environmental matters (air, water, land, etc), noise,

activities affecting the environment, and some aspects of health and safety, also allows for requests to be made verbally.

The Trust, respective divisions and associated organisations must respond to all requests for information within 20 working days with any response including the need to confirm or deny whether the information is held. The Act operates on the basis that information must be published unless there is a likelihood that harm to the Public Interest would be greater if the information were to be published above that if it were to be withheld.

It is on this basis, that information will be disclosed wherever possible. Where it has been deemed information cannot be supplied in full or in part exemptions or in the case of EIR [see section 7.6] outlined in the Act must be applied. It should be noted that dependent on the contents of the document this may be more than one exemption (or for EIR exception).

Technical advice related to the application of the Act, its time compliance provisions and potential usage of any of the Acts exemptions or exceptions is available from the Trust's Communication and Compliance Officer . Where application of the exemptions/exceptions may be particularly complex or sensitive, the Head of Information Governance is available to provide support as required. From time to time, where it may involve extremely complex legislation, the process may also necessitate the use of external legal support. In these circumstances, the Head of Information Governance's advice/and/or guidance must be sought. .

6.4 Data Protection and Freedom of Information

Personal data which falls within the scope of the Data Protection Legislation is not covered by the Freedom of Information Act 2000 and therefore not publicly accessible. In such cases this is a Data Protection issue and the Head of Information Governance must be contacted for further advice/guidance prior to the exemption being applied and the request for information replied to.

In some instances certain personal data may be released where it relates to senior staff or staff in public facing roles, but only where such information relates to a person's working life. For example contact information and salary grade.

6.5 Charging

In maintaining a culture of openness and transparency the Trust, respective divisions and its associated organisations will not normally charge for the provision of information that is provided as a result of a request. However, it is recognised that should it be estimated the request for information exceeds the appropriate fee limit[1] as set down under section 12 of the Act then the organisation is not obligated to comply with the request for information.

[1] Appropriate limit has been set as a figure of £450 and is calculated at a rate of £25 per hour/18 hours of work

In cases when the information is exempt because the appropriate fee limit has been met, then wherever possible and in line with the duty to provide advice and assistance enshrined within the Act, the Trust, its divisions and associated organisations will work with the applicant to try to reduce the amount of work involved so that some of the information can be provided. In certain circumstances where the amount of work required to meet the request cannot be reduced, the applicant can be offered the option of paying for the information. In this instance the applicant would have to pay the full cost of meeting the request.

In addition to this and under the Act, charges can be applied to cover more administrative tasks such as photocopying/translation of documents, etc. In most circumstances applying charges for such disbursements may be waived; however the Trust, its divisions and associated organisations reserve the right to apply these charges especially in exceptional instances where the request requires an unrealistically large amount of photocopying, or substantial effort to translate or perform a transition of documents into other formats. If disbursements are charged, they will be kept to a reasonable level.

Appendix 1 provides information on the rules in place for charging for the supply of information under the Act with further advice available via the Trust Communication and Compliance Officer and/or the Head of Information Governance .

6.6 Exemptions and Exceptions

It is recognised that in some cases the disclosure of information may affect the legal rights of a third party (i.e. where information is subject to the common law duty of confidence, impacts on an industrial partner with whom the Trust is under contract (e.g. a pharmaceutical company), etc). In such situations it will be necessary to engage with these third parties to seek their opinion on any potential release. However any decision to release or not and where required subsequent application of an exemption/exception under the Act rests with the Trust, its divisions and/or associated organisations. A refusal to consent to disclosure by a third party does not, in itself, mean information should be withheld.

Should it be determined that the information held could be regarded as exempt information under the Act and requires the need to consider the application of an exemption or exception the respective Trust and organisational leads must take the lead in identifying why the exemption or exception should be applied with written evidence provided to the Compliance Officer and/or Head of Information Governance so that logical and clear reasoning behind the decision to withhold information can be identified.

Should the requestor subsequently submit a complaint (See Section 8) regarding the Trust's response the reasoning behind the original assessment will be re-appraised as part of the Internal Review process which involves reviewing the information withheld and the rationale applied within the Public Interest test process for refusal to publish the information in the first instance.

Appendixes 2and 3 provides a full list of all the exemptions/exceptions that can be found under the Act.

6.7 Codes of Practice

The Act sets provisions for the Lord Chancellor and Secretary of State to issue codes of practice to which the Trust should adhere. The applicable codes of practice are detailed below: -

7.7.1 Section 45 Code of Practice – Request Handling

The Section 45 code of practice sets out recommended processes which public authorities should follow when dealing with requests for information under the Act. It provides clear guidance that includes providing advice and assistance to applicants, how to transfer requests to other public authorities, consultation with third parties, how to use confidentiality clauses in contracts and the provision of internal complaints procedures. The hyperlink is below:

ICO Guide: Section 45 Code of Practice

7.7.2 Section 46 Code of Practice – Records Management

The Section 46 code of practice sets out recommended processes with which public authorities should adopt in relation to the creation, storage and management of records. In addition to the end life and destruction of these records. It also describes the arrangements which public record bodies should follow in reviewing public records and transferring them to the Public Record Office (PRO) or to pre-arranged places of archival.

7. Awareness and Training

All Staff will receive a broad overview of the Act to ensure awareness. This training will be delivered as part of induction for new Staff and periodically thereafter by the Head of Information Governance.

Key Staff and members of the Board and Executive Management Board will receive more specific training, particularly those in governance functions.

8. Governance and Reporting

Compliance with this policy (and supporting procedures) will be monitored by the Head of Information Governance. An internal audit on the Trust's arrangements in relation to the Act will be scheduled in line with the Trust's internal audit strategy.
For assurance, details on FOI activity will be reported to the Quality, Safety and Performance Committee, as well as the Senior Information Risk Owner (SIRO).

9. Complaints

Anyone who has made a request for information to the Trust under the Act is entitled to request an internal review if they are unhappy with the way their request has been handled

Internal reviews will be carried out afresh by the Head of Information Governance or in his absence another senior member of staff who was not involved with the original decision (appropriate assistance will be provided to requesters with access requirements).

To progress and ensure there is no delay in the handling of any requests for internal review the following process should be adhered to: -

- The request for review should be submitted by the applicant within 40 working days and addressed to the Trust's Head of Information Governance in the first instance.
- The Trust will acknowledge the request for an internal review within three working days and aim to respond within 20 working days of receipt. On occasion and only by exception (where the review is complex) the trust may extend the review period to a maximum of 40 working days.

Any applicant who remains dissatisfied with the outcome of the Trust's internal review is entitled to complain to the Information Commissioner's Office (ICO) by writing to:

Information Commissioner's Office – Wales
2nd Floor
Churchill House
Churchill Way
Cardiff
CF10 2HH

Tel: 0330 414 6421
Email: wales@ico.org.uk

10. Available Guidance and References

Guidance on the procedures necessary to comply with this policy should be made available from the respective divisions and associated organisations of the Trust or on its web pages. Links to the Information Commissioner's Office (ICO) website also provide a valuable source of information and should be quoted at every opportunity.

11. Health and Care Standards

This Policy and processes described within, as well as those contained within the Standard Operating Procedures enable the Trust to comply with Health and Care Standards 3.4 in that:

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

12. Equality

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

13. Copyright

Information provided by the Trust, its divisions and associated organisations in response to a request under the Act remains copyrighted and can only be used for the applicant's personal use or for other specific uses permitted in the Copyright, Designs and Patents Act 1988.

If an applicant wishes to use information provided for commercial purposes (including the sale of the information to a third party) they must seek written permission from the Trust, its divisions and/or associated organisations under the directive on the Re-use of Public Sector Information Regulations 2015.

14. Contacts

For further advice and/or assistance on how to ensure individual, divisional and associated organisational compliance with the Act or to obtain lead officer details, then please contact the Trust's Communication and Compliance Officer or Head of Information Governance Manager: -

Communication and Compliance Officer
Velindre University NHS Trust
Trust Headquarters
2, Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Tel - 029 20316951

Head of Information Governance
Velindre University NHS Trust
Trust Headquarters
2, Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Tel – 029 2031 6161

15. Further Information

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

- Information Governance Policy
- Data Protection & Confidentiality Policy
- Records Management Policy
- Information Security Policy
- Email Policy
- NHS Wales Internet Use Policy

Appendix 1

Where costs exceed the appropriate limit

When determining whether or not the requested information exceeds the appropriate fee limit under the Act, the Trust and/or its associated organisations are only permitted to include the following activities within their estimation: -

- determining whether the information is held;
- locating the information;
- retrieving the information; and
- extracting the information from a document containing it.

Calculating the costs of the activities

£25 is the standard hourly rate; the limit is £450 which equates to 18 hours' worth of staff time, in which the Trust and/or its associated organisation's must use to calculate the staff costs of answering requests.

Staff time spent redacting exempt information cannot be taken into account if an initial estimation into whether the appropriate limit is exceeded is undertaken.

Fees Notices

As a matter of good practice, if the Trust and/or its associated organisations are offering to provide the information for a fee then a fees notice should be issued to the applicant. There is no statutory requirement to do this because there is no obligation on the organisation to comply under section 12 of the Act. However, it is recommended as this would inform the applicant they have the option of receiving information upon the payment of a necessary fee (Section 9 of the Act). A fees notice should be issued as soon as possible or at least within the 20-working daytime period.

Statutory obligations to provide Information

A fee cannot be charged where there is a statutory obligation to supply information in a particular format, such as in the Welsh language (Welsh Language Act 1993) or in Braille, large print or on an audio tape to make reasonable adjustments for disabled persons (Equality Act 2010). The cost of supplying information by the preferred means of communication however is chargeable.

Payment

Should the Trust and/or its associated organisations fail to receive payment within three months of issuing a fee's notice, the Information Commissioner's Office would consider that the organisation is no longer obliged to respond to the request. It is also helpful to mention this deadline in the fees notice.

Appendix 2

Freedom of Information Act 2000 – Exemptions

Absolute Exemptions

- Section 21: Information accessible by other means

- Section 23: National Security - Information supplied by, or relating to, bodies dealing with security matters (a certificate signed by a Minister of the Crown is conclusive proof that the exemption is justified. There is a separate appeals mechanism against such certificates)

- Section 32: Court Records

- Section 34: Parliamentary Privilege - a certificate signed by the Speaker of the House, in respect of the House of Commons, or by the Clerk of the Parliament, in respect of the House of Lords is conclusive proof that the exemption is justified.

- Section 36: Effective Conduct of Public Affairs - so far as relating to information held by the House of Commons or the House of Lords

- Section 40: Personal Information - where the applicant is the subject of the information. The applicant already has the right of ‘subject access' under existing Data Protection Legislation; where the information concerns a third party and disclosure would breach one of the data protection principles

- Section 41: Information provided 'In Confidence'

- Section 44: Prohibitions on disclosure - where a disclosure is prohibited by an enactment or would constitute contempt of court.

Qualified Exemptions

- Section 22: Information Intended for Future Publication

- Section 24: National security (other than information supplied by or relating to named security organisations, where the duty to consider disclosure in the public interest does not apply)

- Section 26: Defence

- Section 27: International relations

- Section 28: Relations within the United Kingdom

- Section 29: UK Economic Interests
- Section 30: Investigations and Proceedings Conducted by Public Authorities
- Section 31: Law Enforcement
- Section 33: Audit Functions
- Section 35: Formulation of government policy and Ministerial Communications
- Section 36: Prejudice to effective conduct of public affairs (except information held by the House of Commons or the House of Lords – see absolute exemptions)
- Section 37: Communications with Her Majesty, the Royal Family or concerning honours
- Section 38: Health and Safety
- Section 39: Environmental Information - as this can be accessed through the Environmental Information Regulations
- Section 42: Legal Professional Privilege
- Section 43: Commercial Interests

Where the Trust, its divisions and/or associated organisations consider that the public interest in withholding the information requested outweighs the public interest in releasing it, the authority must inform the applicant of its reasons, unless to do so would mean releasing the exempt information.

Appendix 3

Environmental Information Regulations 2004 – Exceptions

Subject to the Public Interest Test:

- Regulation 12(4)(a) – Does not hold that information when an applicant's request is received
- Regulation 12(4)(b) – In manifestly unreasonable
- Regulation 12(4)(c) – Is formulated in too general a manner (provided assistance has been given to the applicant with a view to re-forming the request)
- Regulation 12(4)(d) – Relates to unfinished documents or incomplete data
- Regulation 12(4)(e) – Would involve disclosure of internal communications

And if disclosure would adversely affect:

- Regulation 12(5)(a) – International relations, defence, national security or public safety
- Regulation 12(5)(b) – The course of justice, fair trial, the conduct of a criminal or disciplinary inquiry
- Regulation 12(5)(c) – Intellectual Property rights
- Regulation 12(5)(d) – Confidentiality of public authority proceedings when covered by law
- Regulation 12(5)(e) – Confidentiality of commercial or industrial information, when protected by law to cover legitimate economic interest
- Regulation 12(5)(f) – Interests of the person who provided the information
- Regulation 12(5)(g) – Protection of the environment

Please note that if the information requested is related to emissions, exceptions 12(5)(d) to 12(5)(g) cannot be used.

If Personal data is requested then Regulation 13 must be used.

Ref QS03

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

Executive Sponsor & Function:	Executive Director Nursing, Allied Health Professionals and Health Scientists
Document Author:	Trust Quality & Safety Manager
Approved by:	Quality, Safety & Performance Committee
Approval Date:	14 July 2022
Date of Equality Impact Assessment:	August 2020
Equality Impact Assessment Outcome:	Approved
Review Date:	April 2023
Version:	2

TABLE OF CONTENTS

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
Qualifying Liability	A liability in tort owed in respect of, or consequent upon, personal injury or loss arising out of or in connection with breach of duty of care owed to any person in connection with the diagnosis of illness, or in the care or treatment of any patient/donor/service user in consequence of any act or omission by a health care professional and which arises in connection with the provision of qualifying services

Redress	The making of an offer of compensation in satisfaction of any right to bring civil proceedings in respect of a qualifying liability in tort; the giving of an explanation; the making of a written apology and the giving of a report on the action that has been, or will be, taken to prevent similar occurrence
Root Cause Analysis	A process for identifying the basic or causal factor(s) that underlies variation in performance, including the occurrence or possible occurrence of a sentinel event.

6. Roles and Responsibilities

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

6.1 Chief Executive Officer

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

6.2 Responsible Officer

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

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

6.3 Strategic Oversight

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

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

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

6.4 Trust Quality and Safety Manager

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

- Oversight of the handling and consideration of concerns in accordance with this Policy.
- Auditing of Trust and Divisional concern management arrangements.

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

6.5 Corporate / Divisional Directors (including hosted organisations)

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

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

- that all concerns are recorded on Datix at source including those received verbally;
- that a culture of openness is promoted and encouraged to ensure that staff report all concerns that are patient safety incidents and that concerns are robustly and promptly investigated in line with the Regulations and acted upon;
- effective and practical local arrangements are in place across all provided and commissioned services to ensure full implementation of and compliance with this policy and that these are communicated to staff;
- that staff receive concerns handling, investigation and Datix training pertinent to their roles and responsibilities;
- that there is appropriate cross-divisional and Trust co-ordination and liaison to achieve compliance with this policy;
- that adequate and appropriate support is made available to staff who are involved in/are the subject of a concern;
- that staff trained in investigations analysis within the Trust and are released or have their duties appropriately adjusted to enable them to undertake or support investigations when required;
- that all information pertaining to individual concerns including the outcomes of all investigations are fully and accurately recorded in Datix, that all documents are saved against the Datix record, and all action plans are completed through the Datix system so that compliance can be easily monitored and reviewed;
- that all necessary actions are taken to prevent re-occurrence of issues arising from both individual and aggregated concerns;
- appropriate communication and reporting of relevant information to all appropriate Boards and Committees;
- that lessons are shared across services and the Trust as relevant;
- the creation of a culture across the Divisions where issues are resolved as they arise and informally resolved as far as possible – not allowing unnecessary escalation or protraction of concerns;
- that 80% of concerns being managed through the Division are responded to within 30 working days and no concerns receive a response later than 60 workings days (Regulatory maximum time period);

6.6 Every Manager in the Trust is responsible for:

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

6.7 Responsibility of all Staff

All staff must:

- Treat persons notifying/reporting concerns with respect and courtesy;
- Treat all concerns confidentially;
- Co-operate fully and openly in the investigation of concerns;
- Address issues and concerns as they arise and escalate for assistance if unable to manage any issue affecting the progress of the concerns raised;
- Attend incident/concerns training and Datix training pertinent to their roles and responsibilities;
- Ensure they are aware of the importance of reporting safety incidents, including near misses, and that all staff are aware of their responsibilities for reporting and escalating incidents and near misses;
- Ensure they are aware of the Trust's arrangements for handling concerns, and where to seek advice and information where appropriate, to enable them to satisfy any reasonable request made of them for this information; and,
- Be open, honest and transparent and adhere to this Policy and the supporting procedures that accompany it, at all times.

6.8 Corporate Quality and Safety Team

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

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

6.9 Executive Management Board

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

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

6.10 Quality Safety and Performance Committee

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

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

7 Notification of a Concern

7.1 Who May Notify a Concern?

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

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

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

7.2 Concerns Notified by a third party

When a third party acts as a representative on behalf of another e.g. a child or someone who lacks mental capacity if there are reasonable grounds to conclude that they are not suitable to act on their behalf, for example because it does not appear to be in the persons best interests, then they must be advised in writing. However, an investigation into the issues raised may still need to be undertaken. In this instance the Trust is under no obligation to provide a detailed response to the person who raised the concern, unless it is reasonable to do so.

7.3 Concerns Received from Assembly Members/Members of Parliament

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

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

7.4 Concerns Relating to Children

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

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

In instances where child protection issues 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 the 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 (e.g. 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 Concerns and Welsh Language

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

NHS organisations are legally bound to comply with the duties set under the Welsh Language (Wales) measure 2011 and the requirements placed upon them through Welsh Language Standards, by the Welsh language Commissioner.

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

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

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

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

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

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

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

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

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

7.12 Concerns and British Sign Language

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

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

The Trust will take steps to ensure:

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

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

7.13 Concerns and Blind and Partially Sighted Disabilities

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

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

8. Reporting Concerns

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

Executive Director of Nursing, Allied Health Professionals & Health Scientists
Velindre University NHS Trust
Trust Head Quarters
2 Charnwood Court
Heol Billingsley Parc
Nantgarw
Cardiff, CF15 7QZ

Email: 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

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 Once for Wales 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 behalf. The Ombudsman can accept complaints through his website, by e-mail, in writing, or over the phone.

The Ombudsman's contact details are:

Public Services Ombudsman for Wales
1 Ffordd yr Hen Gae
Pencoed
CF35 5LJ

Telephone: 0300 790 0203
Email: ask@ombudsman.wales
Website: https://www.ombudsman.wales/

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 concern 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 oftime.

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 ofstaff.

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

14 Monitoring Arrangements

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

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

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

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

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

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

- □ An overview of arrangements in place for dealing with Concerns
  - Any planned developments

    - Reference to working with other responsible bodies
    - Effectiveness of the arrangements, and how this has impacted on patients/service user and staff
    - An indication of services used, for example expert advice, legal advice, alternative dispute resolution, advocacy services.
- □ Concerns Statistics and analysis
- □ Themes, trends, performance and key issues
- □ Lessons learnt, demonstrating how they have contributed to improved service delivery.
- □ Conclusion and priorities for improvement

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

15 Learning from Concerns

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

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

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

16 Supporting Staff

16.1 Staff involved in concerns

To support staff involved in concerns investigations the Trust will:

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

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

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

16.2 Concerns Containing Allegations against Staff

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

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

17 Concerns and Disciplinary Procedure

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

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

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

18 Equality Impact Assessment

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

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

19 Policy Compliance

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

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

20 Confidentiality – Information Governance

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

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

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

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

In addition to the above, NHS Wales has adopted the Confidentiality Code of Practice for Health and Social Care in Wales. All staff have an obligation of confidentiality regardless of their role and are required to respect the personal data and privacy of others. Staff must not access information about any individual who they are not providing care or treatment for, or in relation to the administration of

services unless in a professional capacity. Rights to access information are provided only for staff to undertake their professional role and for work related purposes only. If in doubt, staff must contact their line manager or the Trust Information Governance Manager, regarding concerns relating to the sharing of information.

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

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

21 Training

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

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

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

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

22 Storage and Management of Concerns Files

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

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

23 Complaints and legal action

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

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

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

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

24 Managing Media Interest / Media Communications

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

25 References

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

Cymru Wrth-hiliol

An Anti-racist Wales

Llywodraeth Cymru
Welsh Government

GIG CYMRU NHS WALES

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Anti-racist Wales Action Plan

Background

An anti-racist Wales.

A pre-consultation was commissioned that involved:

- Evidence Review
- Face-to-face meetings
- Work by the First Minister's Black Asian and Minority Ethnic COVID-19 Advisory Group
- Discussions with the Wales Race Forum
- Community Mentors, and experts on anti-racism policy:
- A series of 'Community-led dialogues
- Policy-themed events:
- Assessing Impact

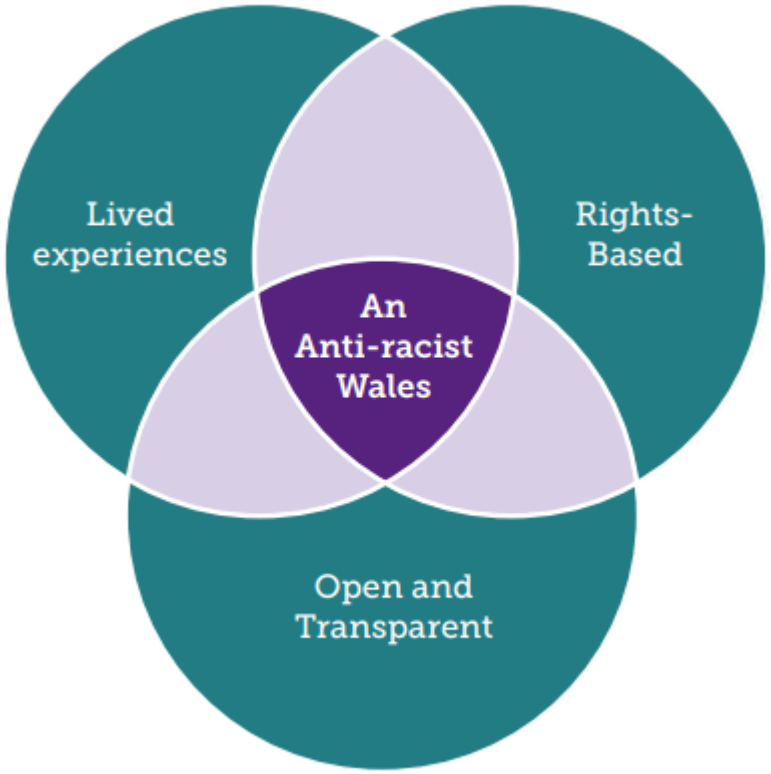
Vision, purpose & values

What we need to know as an NHS organisation

- One of the largest and most diverse employers in Wales, the NHS is also a key provider of essential services.
- Our staff must be able to work in safe, inclusive environments, confident of support to meet their potential, and of visible ally-ship.
- Black, Asian and Minority Ethnic people make a very much valued contribution to the success of the NHS at all levels, and to the wider society in Wales.
- This, in turn, will provide Black, Asian, and Minority Ethnic citizens with access to services suitable to their needs, and will help address historic health inequalities, without fear of racism.

Priority Actions

- 1: Leadership
- 2: Workforce
- 3: Data
- 4: Access to services (NA)
- 5: Health Inequalities



Goal: The NHS in Wales will be anti-racist, and will not accept any form of discrimination or inequality for employees or service users.

Priority action 1.

Require anti-racist leadership at all levels by direction. All NHS Boards, Trusts, and Special Authorities to report demonstrable progress in driving anti-racism at all levels

Actions	Date	Impact
Appointing 'Executive Equality Champions' and 'Cultural Ambassadors	September 2023	Visible representation and allyship at all levels
Implementing a leadership and progression pipeline plan for Black, Asian, and Minority Ethnic staff	September 2023	Leadership pipeline for Black, Asian and Minority Ethnic staff
Providing Ethnic Minority Networks with appropriate levels of resources and access to the Board.	September 2023	Establish an ethnic minority network with a direct line to Board to support annual plans and reporting via IMTP
Develop anti-racism action plans; for both employment and service delivery as a specific part of their wider approach to equality, inclusion and diversity	December **2022**	Implementation of anti-racism action plans will reduce people's experience of racism while being recruited, progressing, and working or accessing services
All NHS Board members will undertake an anti-racist education programme and implement and report progress against personal objectives (for all Board members) to meet vision of an anti-racist Wales.	December **2022**	Visible evidence of development Visible change, where required, in decision making, evidencing that anti-racism, equality, diversity, and inclusion have been considered Visible and transparent allyship and leadership

Goal: Staff will work in safe, inclusive environments, built on good anti-racist leadership and allyship, supported to reach their full potential, and ethnic minority staff and allies; both be empowered to identify and address racist practices.

Priority action 2: Commission an independent audit of all existing workforce policies and procedures

Completed Independent Audit of current workforce policies with recommendations to strengthen anti-racist principles. This will specifically include policies around grievances, complaints and use of Non-Disclosure Agreements. Dec 2022

Each NHS organisation will commit to their involvement in the Aspiring Board Members Programme, ensuring education, mentoring and support to participants who will be from a Black, Asian and minority ethnic background. Dec 2022

Higher Education Institutions (HEIs) and NHS Organisations will co-design anti-racist education programmes with Black, Asian and Minority Ethnic people. Set a requirement for all NHS Staff, NHS Volunteers and students to complete redesigned anti-racist education programmes. Dec 2023

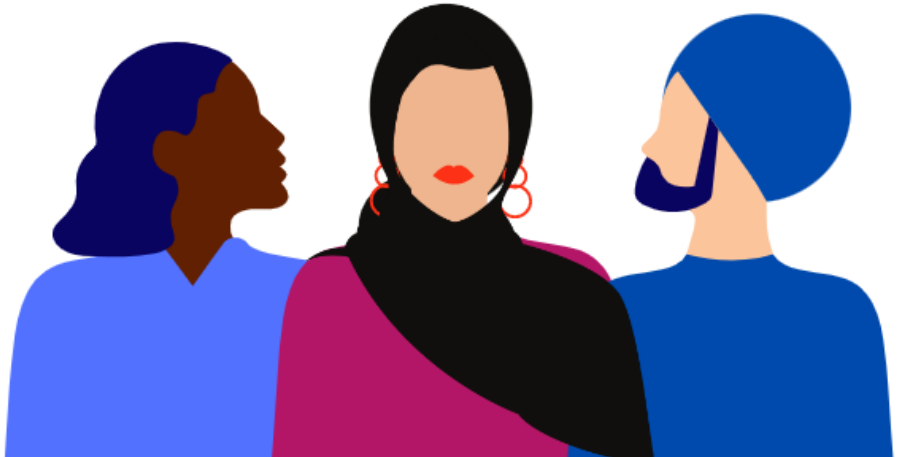
HEIW will ensure all commissioned programmes provide evidence of anti-racist principles and reflect HEIWs Strategic Equality Plan in order to meet objectives regarding differential attainment, widening access and under-representation of Black, Asian and Minority Ethnic people in NHS Wales. Sep 2023

Goal: Data in relation to race, ethnicity, and intersectional disadvantage will be routinely collated, shared, and used transparently, to level inequalities in health and access to health services, and provide assurance that the NHS Wales is an anti-racist and safe environment for staff and patients.

Priority action 3: Improve workforce data quality and introduce a Workforce Race Equality Standard (WRES)

Implemented WRES to include data about NHS Black, Asian, and Minority Ethnic workforce career. progression, leadership representation, discrimination, and bullying by September 2023.

Implement systemic monitoring of concerns of workforce discrimination and bullying raised by staff through the Joint Executive Team process



Goal: We will identify and break down barriers which prevent equitable access to healthcare services for Black, Asian and Minority Ethnic people.

Priority action 5: Establish a dedicated working group on health inequalities to address barriers in accessing services and make recommendations to improve.

- Working Group established, experts and community partners identified and Terms of Reference and meetings scheduled with Welsh Government and SSPHI.
- Ensure our COVID-19 recovery plans are fully inclusive and targeted to address known health inequalities in access to care and service provision.

The Welsh Government Equality, Race and Disability Evidence Units, in partnership with public sector and third sector organisations. Will work together to establish the Equality, Race and Disability Evidence Units made up of:

- Equality Evidence Unit
- Disability Disparity Evidence Unit
- Race Disparity Evidence Unit

Next Steps

Communications

- Engage with Race Equality Trust Network
- Connect and engage through communications
- Engagement sessions with staff

Co-production with Teams

- Establish ARWAP Steering Group
- Publish Trust Action Plan
- Build into Attraction, Recruitment & Retention Project
- Develop Leadership Pipeline Programme

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

TRUST BOARD

CHAIR'S REPORT

Date of meeting	28/07/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Lenisha Wright, Business Support Officer & Lauren Fear, Director of Corporate Governance & Chief of Staff
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 the last Trust Board meeting.

Matters addressed in this report cover the following:

This Chair's report gives an update on the following matters:

- Board Development and Board Briefing Sessions
- Extraordinary Private and Public Board Meetings
- Independent Members Group
- Jubilee Celebrations
- Moondance Cancer Award
- Presentation to Wayne and Jayne Griffiths
- National Healthcare Estates and Facilities Day

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 28 June 2022. The following topics were discussed:

- **Organisational Design**

  The Chief Executive, Steve Ham outlined to the Board an overview of the initial development of an Organisational Design Programme of works which aims to ensure that the Trust is organised appropriately to support delivery of its strategy, with safety and quality of care for patients and donors as the golden thread.

  Ways of working, purpose, effectiveness and realistic authentic leadership was discussed as key elements of the programme. External support for the programme

currently include Emergenetics, Improvement Cymru and Q5. Steve Ham shared that achieving balance between structure and culture is key achieved through effective leadership and prioritisation.

- **Working Together - NHS Wales Shared Services Partnership and the Trust**

  The Trust Board welcomed the newly appointed Chair for NHS Wales Shared Services Partnership (NWSSP), Tracy Myhill and the NWSSP Managing Director Neil Frow. There was a good discussion on: the background to Shared Services; their governance and operating model; highlights of the last two years; and working together arrangements. The Regulations make provision for the establishment of the Shared Services Partnership Committee to include representation from every health body in Wales. Tracy discussed the Committee's role and responsibilities, including the setting up of policy and strategy.

- **Internal Audit and Audit Wales Reflections**

  A presentation was made to the Board by members of Audit Wales of the areas working well and possible areas for learning and further improvements. Amongst the areas working well are the robustness of the Trust Assurance Framework and its links to the Risk Register, Performance Management Frameworks and Quality Frameworks.

- **Board Writing, Process and Templates**

  The Board welcomed Olivia Timbs, Report Writing Training/ Facilitator, who has been leading on training of over 50 staff to date. The Board discussed the insightful feedback and reflections from the training and welcomed supporting staff in continuing to develop in this respect.

  The Board discussed the importance of progressing with work on updating and refreshing templates and processes and agreed to hold another session to specifically discuss and agree on next steps.

- **Style and Approach to Evaluating Assurance**

  The Board welcomed Gillian Hooper, Director Healthhelp Ltd, to share reflections on approaches to evaluating and developing assurance approaches. The Board welcomed the discussion and the opportunities of incorporating key aspects into the governance and assurance programme of work going forwards.

- **Performance Management Framework Update**

  The updated Performance Management Framework was discussed with the Board. The updates to the Framework ensure the Key Performance Indicators are fit for purpose and aligned with the domains of the Quality and Safety Framework: *'safe, patient centred, timely, efficient, equitable, effective'*. Next steps including timelines was discussed with the Board.

- **Risk Training**

  A roll out of Risk Training throughout the Trust will commence during July 2022. There are three levels of training targeting appropriate categories of staff given their responsibilities for risk. Level 1 training will include all staff and will focus on why we manage risk, integral to delivering the Trust Strategy and delivery of safe and high quality care. Level 2 has been arranged for all managers and Level 3 training covers leadership focussing on governance and individual roles. This level 3 Board session covered risk culture, development of the risk framework and the role of the Board and Committees in risk management.

- **Bidder Selection for the new Velindre Cancer Centre**

  An update of the process undertaken and key Governance dates was discussed.

2.2. Extraordinary Public and Private Board Meetings

The Chair would like to note the following Extraordinary Board Meetings took place during this period:

- On **14th June**, an Extraordinary Public Board meeting was held to discuss and approve the Accountability Report and Annual Accounts for 2021-22.

- On **20th July**, an Extraordinary Board meeting was held to agree matters relating to the Bidder Selection for the New Velindre Cancer Centre (nVCC). This meeting was held in private given the confidential nature of this matter.

2.3. Independent Members Group

An Independent Members Group meeting took place on 14th June. A summary is provided below of the matters discussed:

- Discussion of the Intervention Status letter and Actions
- Discussion of the Approach to the new Velindre Cancer Centre Bidder Selection
- Update of agenda items for inclusion at the Board Development Session on 28th June
- Update of the Values Development Work
- Discussion of the approach to working including face to face, online and hybrid meetings
- Discussions on matters relating to the Rutherford Cancer Centre

2.4. Jubilee Celebrations

The Chair is very pleased to recognise that during the Jubilee week in June the operational services catering teams pulled out all the stops hanging up the buntings and union jack flags whilst donning regalia to bring the Platinum Jubilee Celebrations to the patients and staff at the Velindre Cancer Centre. The Chair noted in staff communications that: “The catering staff did an amazing job working incredibly hard laying on a spread fit for a Queen in our Café Barista Bar and a special Jubilee afternoon tea for our patients on the ward. Our staff and patients enjoyed the themed menu and special buffet tea including the infamous platinum pudding that SOLD OUT every day in the Café, which was also served to our patients on the ward.” Special thanks to Sue Sheppard and the team for enabling our staff and patients to celebrate the Jubilee.

2.5. Moondance Cancer Awards

The Moondance Cancer Awards ceremony took place on 16th June 2022 to celebrate people across NHS Wales and its partners who maintained, and innovated cancer services despite the extraordinary circumstances of the last two years. The Chair is delighted to note that the Trust scooped up the following three awards at the prestigious Moondance Cancer Awards Ceremony:

i. **Award for Innovation in ED&D for The SYMPLIFY study** led by Sarah Townsend, Head of Research and Development, Christopher Cotterill-Jones Research Delivery Manager along with the Research and Development Team at Velindre and its University partner.
ii. **Award for Innovation in Treatment** led by the Advanced Nurse Practitioner Tej Quine and her supporting team, Ruth Hull Deputy VAP Lead, Chris Davies, SACT Nurse, Penny Cox SACT Nurse, Kay Leyshon, SACT Nurse, Emma Williams, Pharmacy Technician, Ruth Thomas, Admin Lead and Cath Ball, Administrator
iii. **Award for Workforce Innovation** led by Ceri Stubbs, Lead Advanced Nurse Practitioner and team

2.6. Presentation to Wayne and Jayne Griffiths

Wayne and Jayne Griffiths first became involved with the Trust in 2010 after their beloved daughter Rhian was devastatingly diagnosed with cancer. The bulk of Rhian's treatment was at the Velindre Cancer Centre. Regrettably, though despite everything done, Rhian passed away in June 2012 aged just 25. In honour of Rhian's wishes and in commemoration of her life, Wayne and Jayne Griffiths continued to fundraise in her name known as The Rhian Griffiths Forget Me Not Fund which through excellent support has funded many projects at the Trust.

At an event held at VCC on Tuesday 13th July, Wayne and Jayne Griffiths were presented with the High Sheriff Award for services to the community from the High Sheriffs of both Mid Glamorgan and South Glamorgan, Maria Thomas BEM an Rosie Moriarty Simmonds OBE respectively. Wayne, his wife Jayne and his family have raised an incredible £750K so far. . Wayne and Jayne encompass what fundraising for Velindre is all about and they continue to deliver invaluable support with such passion and grace. The Chair expresses gratitude to

Wayne, Jayne and the entire Griffiths Family and all outlets and donors who have shown such kindness and generosity.

2.7 National Healthcare Estates and Facilities Day

The inaugural National Healthcare Estates and Facilities Day was celebrated at the Trust on 15th June 2022. The day recognises the essential work of estates and facilities staff across the health service. Our services simply could not function without the tireless efforts of these amazing colleagues and we thank them for all they do every single day.

Along with the Chief Executive, the Chair would like to thank all our Estates and Facilities staff including those responsible for food and catering, for their amazing work in ensuring the best possible environment for our patients, donors and staff. We are pleased that there is a National Health Care Estates and Facilities Day, however, the chair noted that we grateful to and aware of the incredibly important contribution of our estates and facilities staff every day.

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:
	Not required

EQUALITY IMPACT ASSESSMENT COMPLETED	
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	28.07.2022

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	Steve Ham, 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 on a number of matters.

Matters addressed in this report cover the following:

- COVID 19
- Approval of Integrated Medium Term Plan 2022-25
- National Blood Donor Week
- Welcome to Carl Taylor, Chief Digital Officer

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 COVID 19

Unfortunately, COVID 19 is still with us with a significant increase in the number of cases over the past few weeks. The Chief Executive would like thank all staff for their continued excellent contribution to protecting our patients, donors and each other during this time. Thank you particularly for the continued leadership from our Infection Control colleagues. Newly revised COVID 19 measures were quickly introduced and communicated, reminding staff to wear masks and minimise footfall where possible.

2.2 Approval of Integrated Medium Term Plan 2022-25

The Chief Executive is pleased to report to Board that the Trust's Integrated Medium Term Plan 2022-25 has been approved by Welsh Government. The Minister has written to the Chair and the Director General and NHS Chief Executive has written to the Chief Executive to confirm this. There are a number of requirements and accountability conditions set out in the letter from the Director General. These conditions will form part of the Trust's internal monitoring and Board assurance going forwards. There will be reporting on the conditions from the next Board meeting onwards, following an initial piece of work to structure the governance, reporting and assurance mechanisms.

2.3 National Blood Donor Week

National Blood Donor Week 13th-17th June is a week where we raise awareness of the lifesaving importance of blood donation. The week also incorporates World Blood Donor Day on June 14th which is an annual event organised by the World Health Organisation. The day is an opportunity to say thank you to our blood donors. The First Minister, Mark Drakeford also donated on the 14th of June making this his 50th blood donation.

2.4 Welcome to Carl Taylor, Chief Digital Officer

The Chief Executive is delighted to welcome Carl Taylor to the Trust as Chief Digital Officer. Carl holds a qualification in Computer Science and a PhD from, with over 30 years' experience in Technology, having his research in Advanced Hyper Media Systems widely published in international journals. He has a PhD from the University of Glamorgan. Prior to joining the Trust, Carl has worked as Chief Technology Officer and similar Digital Leadership roles across a number of sectors including Welsh Water, Defence at QinetiQ and Technology Consultancy.

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.