Public Joint Extraordinary Audit Committee and Quality, Safety & Performance Committee

Thu 21 March 2024, 09:00 - 10:00

Microsoft Teams

Agenda

1.0.0 STANDARD BUSINESS

Led by Vicky Morris, Chair

1.1.0 Apologies

Led by Vicky Morris, Chair

1.2.0 In Attendance

Led by Vicky Morris, Chair

1.3.0 Declarations of Interest

Led by Vicky Morris, Chair

1.4.0 Draft Minutes from the Public Part A Extraordinary Audit Committee meeting held on 12 January 2024

Led by Vicky Morris, Chair

1.4.0 DRAFT MINUTES OF THE PART A PUBLIC EXTAORDINARY AUDIT COMMITTEE 12 JANUARY 2024 MBv2.pdf (4 pages)

2.0.0 INTERNAL ASSURANCE AND RISK MANAGEMENT MONITORING

2.1.0 Trust Risk Register

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

2.1.0a TRR Paper - QSPC & AC - Mar 24.pdf (12 pages)
2.1.0b RISK REPORT - March reporting-update 2.pdf (6 pages)

2.2.0 Trust Assurance Framework

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

2.2.0a TAF Paper - QSPC & AC - Mar 24.pdf (6 pages)
2.2.0b V45- TAF DASHBOARD 2.0 - 20.03.2024.pdf (23 pages)

3.0.0 CONSENT AGENDA

Led by Vicky Morris, Chair

3.1.0 Endorse for Approval

3.1.1 Audit Committee Terms of Reference

Led by Matthew Bunce, Executive Director of Finance

- 3.1.1a Audit Committee Terms of Reference Cover Paper.pdf (6 pages)
- 3.1.1b Audit Committee Terms of Reference MB track changes 20.03.24.pdf (9 pages)

3.1.2 All Wales Flexible Working Policy

Led by Susan Thomas, Deputy Director of Organisational Development & Workforce

- 3.1.2 ALL WALES FLEXIBLE POLICY Cover Report.pdf (4 pages)
- 3.1.2 APPENDIX 1a 2024_01_04 LHB Trust Chief Executives All Wales Flexible Working Policy Dec 2023.pdf (1 pages)
- 3.1.2 APPENDIX 1b NHS Wales Flexible Working Policy.pdf (16 pages)
- 3.1.2 APPENDIX 1c NHS Wales Flexible Working Policy Cymraeg.pdf (16 pages)
- 3.1.2 APPENDIX 1d Flexible Working Policy (NHS Wales) EQIA v3.pdf (15 pages)

4.0.0 ANY OTHER BUSINESS

By prior approval of the Acting Chair of the Audit Committee

5.0.0 DATE AND TIME OF THE NEXT MEETING

Audit Committee: Wednesday 10th July 2024 at 10:00AM Quality, Safety & Performance Committee: Thursday 9th May 2024 at 10:00AM

6.0.0 CLOSE

MINUTES OF THE PUBLIC EXTRAORDINARY AUDIT COMMITTEE
VELINDRE UNIVERSITY NHS TRUST HQ / TEAMS
FRIDAY 12 JANUARY 2024 AT 3:30PM

PRESENT:	
Gareth Jones	Acting Chair and Independent Member
Vicky Morris	Independent Member
ATTENDEES:	
Matthew Bunce	Executive Director of Finance
Lauren Fear	Director of Corporate Governance & Chief of Staff
Rachel Hennessy	Interim Director of Velindre Cancer Services
Katrina Febry	Audit Wales
Jonathan Fear	Estates Manager
Steve Wyndham	Audit Wales
Stephen Chaney	Head of Internal Audit for Aneurin Bevan UHB and DHCW (Audit and Assurance Services)
Kyle Page	Business Support Manager

1.0.0	**Standard Business** Led by Gareth Jones, Acting Chair, and Independent Member	**Action**
	Introduction Led by Gareth Jones, Acting Chair, and Independent Member	
1.1.0	**Apologies** Led by Gareth Jones Apologies were received from: • Martin Veale, Independent Member • Steve Ham, Chief Executive Officer • Emma Rees, Deputy Head of Internal Audit • Simon Cookson, Director of Audit & Assurance	
1.2.0	**In Attendance** Led by Gareth Jones Gareth Jones welcomed attendees from Audit Wales and Internal Audit Services. Gareth Jones also welcomed Jonathan Fear, Estates Manager to the meeting.	
1.3.0	**Declarations of Interest** Led by Gareth Jones No declarations of interest were declared.	
2.0.0	**VELINDRE UNIVERSITY NHS TRUST STRUCTURED ASSESSMENT REPORT 2023** Led by Katrina Febry, Audit Wales	
	Gareth Jones invited Katrina Febry to present the report. Katrina Febry informed the Committee that this was a positive report with a small number of recommendations and highlighted the key points below: • The Board and the transparency, effectiveness and cohesion - Found Board and Committee operate well in general, with an ongoing commitment to public transparency and continuous improvement. Hearing from Patient and donors; there are a few small areas where there are opportunities to further enhance transparency of business to the public. • Corporate Systems of Assurance - Found positive improvements to key systems of assurance, particularly in relation to managing performance and sharing this in Board and Committee reports. There is shared understanding of information needed to be included in the Corporate Risk Register. There is some scope to improve Board and Committee reports, but good progress has been made to improve, particularly through the cover paper template.	

	• Trust has effective arrangements for reducing, overseeing, and scrutinising development of the strategies of corporate plans, but the most recent Integrated Medium-Term Plan (IMTP) did not contain clear objectives and actions, supported by timescales in respect of the crosscutting corporate functions. • Trust has good arrangements for financial planning and managing and monitoring its financial position. Gareth Jones and Vicky Morris felt it was good to see a broadly positive report but advised that some of the points contained within the report have been raised in Board and Committees by Independent Members and the report didn't necessarily reference and recognise this. Vicky Morris questioned the timeliness of publishing meeting Minutes and if other Health Boards across Wales are accepting the publication within 15 working days. Lauren Fear assured that a substantial amount of discission on Board and Committee paper publishing timelines has taken place with the Trust Chair. Committee Minutes are always published and confirmed in the next meeting bundle, so instead of waiting for the next meeting bundle this will just be brought forward. Vicky Morris commented that as the Chair and Executive Lead of Committees review the minutes, it would be satisfactory for the Quality Safety and Performance Committee she Chair's that minutes are published within the 15 working day timescale, if it is clear they are unconfirmed minutes. Gareth Jones felt had some concerns with the minutes being in the public domain so soon after the meeting. Independent Members would have to ensure they reviewed the unconfirmed/unapproved minutes as soon as possible , ideally before they have gone into the public domain. He stressed the need for a clear process to enable any corrections of minutes to be made to minutes already in the public domain. Gareth Jones queried if other health organisations are complying with this 15 working day timescale and requested a better understanding of the value of this approach. Katrina Febry confirmed this is a recommendation across the board. Some health organisations record their committee meetings as well as the Board and make those recordings available on the internet reasonably quickly following the meeting, so these would not require minutes to be published within 15 working days. It is for the Health Bodies that do not record and publish the Committee meeting recordings that the recommendation has been made. There is the option to share the recording but the view was that the option of publishing minutes within 15 working days of the meeting would be preferable for Velindre Trust. Lauren Fear confirmed the management response has accepted this action and assured this has been reviewed at an Executive Management Board and the context has been discussed in detail with the Chief Executive and Chair and this is the formal endorsement of the report. Lauren Fear assured the Committee that these recommendations are reflected in the refresh of the Governance Manual and the new minutes process reflects this, including the Welsh translation. ****ACTION: A process needs to be agreed in terms of notifying the Independent Members when unconfirmed/unapproved minutes are available and when the working day 15 publish date is and how feedback on corrections/amendments to the minutes will be managed. This will be brought for discussion in the Independent Members Group.** ****ACTION: The Committee were uncomfortable with publishing the Committee recordings and were of the view that publishing unapproved minutes within 15 working days of the meeting would be the preference but agreed a process around this is needed. The Secretariats and the Corporate Governance Team to discuss and produce a draft process on how this would work.**	**LF** **LF**

	****ACTION: Vicky Morris raised that the report summary states 'the Integrated Medium-Term Plan (IMTP) does not contain clear objectives and actions' and then within the report says 'it is the corporate crosscutting plans that do not contain those clear objectives and actions' so queried which of these was accurate.** **Katrina Febry confirmed she would review paragraph 14 and stated she was pleased with the objectives and specific actions in terms of Velindre Cancer Services (VCS) and Welsh Blood Services (WBS) so that comment does not reflect that. They are SMART actions and in the most recent IMTP they are supported by the intended outcome. She confirmed that the issue refers to the corporate crosscutting plans.**	**KF**
	Gareth Jones questioned if this issue is being addressed in the current draft of the IMTP and if the recommendation is being applied. Matthew Bunce responded that a better understanding of what is meant by the corporate crosscutting plans do not contain clear objectives and actions in terms of financial plans and actions, as the financial plans are a consequence of whatever the IMTP service plans are within the VCS and WBS. The financial plans and any objectives and actions relating them are pulled together as part of the service Division plans. Katrina would need to explain what improvements or changes in the financial plans is needed to meet this recommendation. Katrina Febry confirmed that in previous years the corporate crosscutting plans, objectives and actions were linked into the service plans and it is not articulated particularly well in the current IMTP as to whether they are stand-alone or within the divisions. Lauren confirmed that Carl James had said he wanted to make that clearer.	
	****ACTION: Katrina Febry confirmed that the SMART actions in relation to the Integrated Medium-Term Plan (IMTP) are addressed by a previous recommendation which is being held open which sits in the last appendix of the report. Previous year made recommendations about SMART objectives. Need to check this is being picked up in the current draft of the IMTP.**	**LF and CJ**
	Vicky Morris highlighted the work Lauren Fear and Carl James are doing in terms of cross referencing the IMTP into the Trust Assurance Framework (TAF) requires an action plan in place to mitigate those organisational corporate risks. Therefore, there should be some good evidence, however the last two or three Audit Wales reports are reiterating the point about needing robust implementation plans to support either a strategy or policy. There is a need to pick this point up with the Integrated Quality, Safety and Performance Group in terms of areas of delivery and non-delivery of desired outcomes, as a better narrative with reporting is needed that articulates this. Evidence of why the Trust has not delivered something will transfer across to the TAF in terms of risk and need for actions to resolve, equally delivered actions should mitigate those risks. The IMTP and TAF should cross-reference clearly, but the action plans to mitigate risks need to be there in the first place. Need to follow through as Independent Members. Lauren Fear agreed the importance in terms of triangulation of IMTP, TAF and the Risk Register.	
	****ACTION: Following a request from Gareth Jones for best practice exemplars of Committee papers given the excessive length of Trust papers, Katrina Febry agreed to review if there are any good exemplars from Health Boards. Katrina Febry will feedback to Lauren Fear on this as there are good examples of succinct reports and cover papers, and some which make good use of appendices.**	**KF**
	Vicky Morris stated that there has been lot of benchmarking from Lauren Fear and the Corporate Governance team on best practice report writing and development of the seven levels of assurance	

	approach leading to the Committee Report template proforma changes. A presentation on those improvements to assurance went to the Governance and Risk Group and there was a lot of interesting elements, and it showed ongoing improvement in terms of the structure of reports/papers, but the Trust now need to focus on the risks and mitigation of the actions. ****ACTION: Vicky Morris informed the Committee that within the Quality and Safety Groups Chairs, there are examples of much more succinct papers. Vicky Morris agreed to forward these examples to Lauren Fear.** Lauren Fear took the Committee through the recommendations. The points highlighted during this update and discussion are outlined below: • Recommendation One - Making use of the social media channels, which the Trust did do in the past so just making sure we pick that up again. • Recommendation Two - Use of private meetings, the agenda template now has a summary in public for the items that will be in private. This is a new process that will be implemented in agenda setting meetings following introduction of the template. This is in the refreshed Corporate Governance Manual as a new process. Some commercially sensitive or confidential agenda items would not be listed. What was discussed will be included in the Public Highlight Report in an appropriate summary. • Recommendation Three - Minutes management response to publish within 22 working days, this was more than the 15 working day period as added on a week for Welsh translation and wanted to set a target that could realistically be met. • Recommendation Four – In the updated version of Board and Committee cover report there is a clearer section in terms of the previous governance discussions and there needs to be more clarity when completing this section with succinct points noting any discussions and that they have been addressed. • Recommendation Five - Cover paper for the risk register – Already proposed to close. • Recommendation Six - Around the impact of initiatives and actions being clearer in reports. Executive Leads take more responsibility for the paper and make sure they are comfortable before they are issued for meetings. Gareth Jones highlighted that it would be good to receive Committee actions as soon after the meetings as possible to ensure early sight of these. The AUDIT Committee **RECEIVED** the report **NOTED** the report.	**VM**
3.0.0	**ANY OTHER BUSINESS** Prior Agreement by the Chair Required	
	None.	
4.0.0	**DATE AND TIME OF NEXT MEETING**	
	Tuesday 12 March 2024 at 10:00am.	
5.0.0	**CLOSE**	
	The meeting CLOSED at 2:22pm.	

EXTRAORDINARY QUALITY, SAFETY & PERFORMANCE AND AUDIT COMMITTEES'

TRUST RISK REGISTER

DATE OF MEETING	20th March 2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	ASSURANCE
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Mel Findlay, Business Support Officer
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
APPROVED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SUMMARY	The purpose of this report is to: • Share the current extract of risk registers to allow the Committees to have effective oversight and assurance of the way in which risks are currently being managed across the Trust. • Note the on-going development activity and status of these actions.
RECOMMENDATION / ACTIONS	The Committees are asked to: • **NOTE** the risks of 15 and above as well as

	risks in the safety domain with a risk level of 12 reported in the Trust Risk Register and highlighted in this paper. • **NOTE** the on-going developments of the Trust's risk framework.

COMMITTEE / GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING	
COMMITTEE OR GROUP	**DATE**
Executive Management Board - Out of Committee	19TH MARCH
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	

Please complete this section if you have indicated that the report purpose is for ASSURANCE.

Level 7	Level 6	Level 5	Level 4	Level 3	Level 2	Level 1	Level 0
ASSURANCE RATING ASSESSED BY EXECUTIVE SPONSOR			2 – Comprehensive actions have been identified and addressed. The cause of the performance issue has been identified and is being actively managed.				

APPENDICES	
1	Current risk register data.

1. SITUATION

The report is to inform the Committee of the status of risks reportable to Trust Board, in line with the renewed risk appetite levels. In addition, the report will update on progress against the Risk Framework.

2. BACKGROUND

The risks currently held on Datix, and above the Trust Board approved Risk Appetite level of reporting, are to be considered.

3. ASSESSMENT

3.1 Trust Risk Register

There are a total of 9 risks to report in line with the Trust's risk appetite during this reporting period. This includes 5 risks with a current score over 15 and 4 risks with a current score of 12, reported in the 'Safety' domain. The information is pulled from Datix 14.

Changes since January reporting:

3.2 Reduction in risk scores

There have been two risks which have reduced in score during the reporting period:

- ***2187*** – *"There is a risk to patient safety due to inadequate staffing within the Radiotherapy Physics Department and the need to balance core duties with developmental tasks."*

  This risk has been reviewed by the Head of Service during February and reassessed to a score of 12 from 15 based on the progress in recruiting additional posts. It is a "safety" category of risk and therefore is still included in the risk reporting at Board level according to the Trust's risk appetite thresholds.

  Executive Management Board support this reduction.

- ***2515*** – *"There is a risk to performance and service sustainability as a result of the staffing levels within Brachytherapy services being below those required for a safe resilient service leading to the quality of care and single points of failure within the service."*

  This risk has been reviewed by the Head of Service during February and reassessed to a score of 12 by reducing the impact assessment from 5 to 4. It is a "Performance and service sustainability" category of risk and

therefore it would now not be included in the risk reporting at Board level according to the Trust's risk appetite thresholds.

Executive Management require further rationale to support this reduction and this is to be brought to Executive Management Board in the April meeting.

3.3 New risks opened

There have been four new risks opened during the reporting period:

- ***3338*** *– "There is a risk that Velindre Cancer Services are unable to meet demand for SACT service provision as a result of lack of pharmacy capacity leading to delay in-patient treatment" (score 20)*

- ***3337*** *– "There is a risk that patients are missed as a result of multiple lists being used to manage booking leading to clinical harm." (score 16)*

- ***3293*** *– "There is a risk to Quality, Performance and Service as a result of the timing of the new Velindre Cancer Centre (nVCC) leading to capacity at the current site not being sufficient to meet the demand, resulting in increased waiting time for radiotherapy, failure to meet All Wales time to radiotherapy metric and reduced patient experience." (score 16)*

- ***3277*** *– "There is a risk to Performance, Quality and Safety as a result of the Consultant Therapeutic Radiographer for Head & Neck Cancer retiring leading to reduced capability to provide an adequate on-treatment review service for patients with head and neck cancer, resulting in a poorer patient experience and increase in workload for on-treatment review radiographers and consultant clinical oncologists for head and neck." (score 20)*

- ***3193*** *– "There is a risk to Financial Sustainability as a result of a failing to secure sufficient funding for the delivery of a new Blood Establishment Computer System (BECS) contract and software platform, leading to a degradation of critical WBS (NHS Wales) blood supply chain activities." (score 15)*

- ***3197*** *– "There is a risk to Quality as a result of failing to secure sufficient funding for the delivery of a new Blood Establishment Computer System*

(BECS) contract and software platform leading to degradation of critical WBS (NHS Wales) supply chain activities" (score 15)

Risk 3338 has been discussed during the Gold Command meetings on SACT performance.

Executive Management Board require further discussion on 3337, 3293 and 3277 this is to be brought to Executive Management Board in the April meeting.

3.3. Risks score consistent during reporting period

- **3001 – Risk score remains at 12, as a result of action being taken and external environment continuing to be challenging**

  "There is a risk to safety as a result of work related stress leading to harm to staff and to service delivery. Work related stress is the adverse reaction people have to excessive pressure or other types of demand placed on them. Trust sickness absence figures show mental health issues and stress to be the highest cause of absence from work."

  Executive Management Board confirm that it still agrees appropriate for risk score to remain at 12.

- **3230 – Risk score remains at 12**

  "There is a risk to patient safety, as a result of variation and multiple access routes for new referrals to Velindre Cancer Centre. The impact will be an inability and timeliness to ascertain accurate patient referral information which may impact/delay the delivery of patient care"

  There has been good progress made on the action plan, including: recruitment of additional clinic co-ordinators to manage all activities associated with outpatient appointments (booking, processing, cancellation, clinic amendments/blocking and telephone queries); implementation of an interim electronic solution in April to deliver a standardised new patient referral template for submission in to a centralised, managed e-mail account which is to be piloted in Lung in conjunction with CAVUHB.

The longer term solution, which is to implement new patient e-referral solution (hospital2Hospital solution) in conjunction with DHCW workplan, does not currently have any timescales agreed. Executive Management Board will therefore review the target risk score and action plan in the April meeting.

- **2465 – Good progress made and risk score will start to reduce as actions implemented during 2024**

  "There is a risk to patient safety, caused by the duplication of information, excessive use of email and a lack of alternative communication methods for the processing of clinical information."

  An audit was completed and received at Senior Leadership Team in December - Operational services will now oversee Divisional wide working group to develop plan to develop recommendations and support implementation. Included in draft Integrated Medium Term Plan 2026-27.

  Executive Management Board confirmed that it still agrees appropriate for risk score to remain at 12 until new actions implemented during 2024 begin to have an impact on risk score and this will be considered each reporting period in line with progress.

- **3227 – Risk expected to decrease in line with progress to Financial Close**

  "new Velindre Cancer Centre - There is a risk to financial sustainability as a result of changes during the design development process leading to a design which costs more overall, increasing project costs."

  Executive Management Board confirm that it still agrees appropriate for risk score to remain at 16 until Financial Close process has concluded.

4. KEY MATTERS - Summary of Actions Taken/ In Plan from Recent Governance Cycle

	Matter raised through recent governance cycle	Action Taken/ In plan	Timeframe/ Update	Status to report in January reporting cycle

1	Risk scores and target risk scores	Following Executive Management Board review and Divisional Leadership Team work, a number of scores were challenged and are being reassessed through the December-January cycle	December- January reporting cycle	**Closed** – updated in December Audit Committee and in this paper for January reporting cycle
2	Digital Risks	Separate paper to be brought back on the enterprise digital risk landscape to the next Committee meeting.	January Quality, Safety & Performance Committee	**Closed** – On January Quality, Safety & Performance Committee agenda
3	Administration systems and processes	This will be considered by the Divisional leadership teams and appropriate risk(s) articulated and scored	December- January reporting cycle	**Closed** – No further risks proposed by SLT following consideration
4	15 level risks are related to workforce issues in Velindre Cancer Services – triangulated to TAF 03	Workforce Risk 03 will include this in next review	December- January reporting cycle	**Closed** – addressed in TAF 03
5	Formatting of report to be clear on active risk management in the period	New updates from Datix are included in this cover paper as well as in a separate column in the Risk Register appendix	Addressed in this paper	**Closed** – cover paper style re-vamped and positive feedback in December Audit Committee
6	Datix information for risk 2515 required updating	Updated since November Quality, Safety &	Addressed in this paper	**Closed**

		Performance Committee		
7a	Assurance level considerations by Audit Committee	Active risk management has resulted in a number of scores being reduced however not yet evidence of impact of actions on remaining risks – This will be further addressed and challenged in next period and explicit comment from the Executive Management Board (EMB) will be included for the next report – to demonstrate why EMB is comfortable with the current risk score or if not, what action is being taken.	December- January reporting cycle	**Closed** – Audit Committee confirmed that due to progress made in December reporting cycle that Assurance Level could remain at 2
7b	Assurance level considerations by Audit Committee	In addition, any decrease in scores which result is no longer being currently reported at Trust Board level will be summarised for the next report in a separate table in the cover paper also.	Current risks have been reviewed against the previous report. There are no risks which have reduced to a level below that reportable to Trust Board.	**Closed** – now included in re-vamped style of cover paper
Recommendations from Trust Risk Group				

8	Review of risk domains – particular concern with respect to Clinical safety being clearly part of Quality domain on Datix	Review of Policy by Trust Risk Team, including this. Data pull for Quality and Safety domains during December – (to report on in January) – to review categorisation	May (for Trust Board approval) May	Deep dive work underway for May cycle reporting.
9	When risks first loaded onto Datix, inherent risks reported above risk appetite levels – for assurance on effectiveness of controls	To action for March reporting cycle	May reporting cycle	Process discussed with Risk Group to be implemented for May Board cycle reporting
Requested by December Audit Committee				
10	Risk report to track overall number of risks at different scores in Datix	To action for March reporting cycle	May reporting cycle	

5. IMPACT ASSESSMENT

RELATED TRUST STRATEGIC GOAL(S)	Please indicate whether or not any of the matters outlined in this report impact the Trust's strategic goals. Please indicate here
Please tick all relevant goals: . Outstanding for quality, safety and experience ☒ . An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ . A beacon for research, development and innovation in our stated areas of priority ☐	

. An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ . A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC TRUST ASSURANCE FRAMEWORK RISK	06 - QUALITY & SAFETY
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Tick all relevant domains. Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Cantered ☒ The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). The risk register and associated risk framework are imperative to quality and safety in the organisation.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED	Not required There are no socio economic impacts linked directly to the current risks in paper.
TRUST WELL-BEING GOAL IMPLICATIONS/IMPACT	Choose an item. There are no direct well-being goal implications or impact in the current risks in this paper. The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated

FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	This section should outline the financial resource requirements in terms of revenue and / or capital implications that will result from the Matters for Consideration and any associated Business Case. Narrative in this section should be clear on the following: **Source of Funding**: Choose an item. Please explain if 'other' source of funding selected: Click or tap here to enter text. **Type of Funding:** Choose an item. **Scale of Change** Please detail the value of revenue and/or capital impact: Click or tap here to enter text. **Type of Change** Choose an item. Please explain if 'other' source of funding selected: Click or tap here to enter text.
EQUALITY IMPACT ASSESSMENT	No - Include further detail below
	There is no direct equality impact in respect of this paper, however each risk will have an impact assessment where appropriate.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text.

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	The risk register is detailed in Appendix 1 and throughout the paper.
WHAT IS THE CURRENT RISK SCORE	NA
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	Actions plans for individual risk require further work.
BY WHEN?	
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix	

APPENDIX 1

Detailed Definitions of 7 Levels of Evaluation to Determine RAG Rating / Operational Assurance and Summary Statements of 7 Levels

RAG rating	ACTIONS	OUTCOMES	RAG rating	SUMMARY STATEMENTS OF 7 LEVELS
Level 7	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes over a defined period of time i.e., 3 months.	7	Improvements sustained over time - BAU
Level 6	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement also of desired outcomes.	6	Outcomes realised in full
Level 5	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with little or no evidence of the achievement of desired outcomes.	5	Majority of actions implemented; outcomes not realised as intended
Level 4	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of several agreed actions being delivered, with little or no evidence of the achievement of desired outcomes.	4	Increased extent of impact from actions
Level 3	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Some measurable impact evident from actions initially taken AND an emerging clarity of outcomes sought to determine sustainability, with agreed measures to evidence improvement.	3	Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes
Level 2	Comprehensive actions identified and agreed upon to address specific performance concerns.	Some measurable impact evident from actions initially taken.	2	Symptomatic issues being addressed
Level 1	Initial actions agreed upon, these focused upon directly addressing specific performance concerns.	Outcomes sought being defined. No improvements yet evident.	1	Actions for symptomatic issues, no defined outcomes
Level 0	Emerging actions not yet agreed with all relevant parties.	No improvements evident.	0	Enthusiasm, no robust plan

ID	Risk Title - New	Risk (in brief)	RR - Current Controls	Division	Service	Area	Likelihood (Inital)	Impact (initial)	Rating (Initial)	Likelihood (current)	Impact (current)	Rating (current)	Likelihood (Target)	Impact (Target)	Rating (Target)	Review date	Due date	Description
3227	There is a risk to financial sustainability as a result of changes during the design development process leading to a design which costs more overall, increasing project costs.	changes during the design development process lead to a design which costs more overall, increasing project costs.	1.Costs have exceeded the proposed CAPEX and Value Engineering has been undertaken and shared with WG / Treasury. Commercial bootcamp is scheduled for w/c 09/10/23 to try to finalise commercial position on various issues Ongoing 2. See comments against Action 1. Ongoing	Transforming Cancer Services	Transforming Cancer Services	Velindre Hospital	Probable - Will probably occur/reoccur but will not be a persistent issue.	2 - Minor	8	Probable - Will probably occur/reoccur but will not be a persistent issue.	4 - Major	16	Probable - Will probably occur/reoccur but will not be a persistent issue.	2 - Minor	8	31/10/2023	14/12/2023	Increasing Costs
3277	There is a risk to Performance, Quality and Safety as a result of the Consultant Therapeutic Radiographer for Head & Neck Cancer retiring leading reduced capability to provide an adequate on-treatment review service for patients with head and neck cancer, resulting in a poorer patient experience and increase in workload for on-treatment review radiographers and consultant clinical oncologists for head and neck.	Situation - Consultant Therapeutic Radiographer for Head & Neck Cancer is retiring. Background - The role of Consultant Therapeutic Radiographer for Head & Neck Cancer is a highly specialised role, developed over a number of years in response to the needs of head and neck patients undergoing and recovering from radiotherapy. This role has developed to include aspects of patient care traditionally covered by a Consultant Clinical Oncologist (CCO), such as weekly on-treatment review and side-effect assessment and management, post treatment review and side-effect assessment and management, prescribing of chemotherapy and completing end of treatment letters for all head and neck patients receiving radiotherapy. As a senior member of the radiotherapy team, they are also responsible for a number of roles to support the function of the radiotherapy department such as, department lead for non-medical prescribing and PGD's (Patient Group Directive) prescribing and staff training in assessing and managing side-effects from radiotherapy and chemo-radiotherapy.	When Consultant Therapeutic Radiographer for Head & Neck Cancer is on leave, on-treatment review radiographer informs CCO if patient ok or not after weekly review so chemotherapy can be prescribed.	Velindre Cancer Centre	Radiotherapy Services	Radiotherapy	Expected - Will occur/reoccur and likely to be frequent.	4 - Major	20	Expected - Will occur/reoccur and likely to be frequent.	4 - Major	20	Possible - May occur/reoccur at some time / occasionally.	2 - Minor	6	22/03/2024		
3293	There is a risk to Quality, Performance and Service as a result of any delay in the new Velindre Cancer Centre (nVCC) leading to capacity at the current site not being sufficient to meet the demand, resulting in increased waiting time for radiotherapy, failure to meet All Wales time to radiotherapy metric and reduced patient experience.	Current provisions for Radiotherapy Services at VCC are based on the clinical service model of having 10 clinical linear accelerators, 3 CT simulators, orthovolage and Brachytherapy across the new Cancer Centre (nVCC) and associated Satellite Radiotherapy Unit (SRU). There is an assumption that the new Velindre Cancer Centre will be operational in 2027. Delays on this project will impact negatively on the Radiotherapy Department at VCC.	Monitoring of capacity and demand. Development of breast escalation process to ensure patients are prioritised as per clinical need. Unlimited extended working hours on treatment machines and other areas of the department in response to demand. Limited extended working hours on treatment machines and other areas of the department in response to demand. Limited to safe staffing, skills mix and age and configuration of the fleet. Agency radiographers in place to support additional hours. Unlimited replacement of new linear accelerators on current site. Policies and procedures on how to manage Radiotherapy scheduling and delays. Development of detailed transition plan to be implemented through NVCC project. Once plan is in place to assure operational service commence 2027, risk review may reduce current risk assessment.	Velindre Cancer Centre	Radiotherapy Services	Radiotherapy	Expected - Will occur/reoccur and likely to be frequent.	4 - Major	20	Probable - Will probably occur/reoccur but will not be a persistent issue.	4 - Major	16	Unlikely - Not expected to occur/reoccur but there is some possibility.	2 - Minor	4	21/06/2024		

3337	there is a risk that patients are missed as a result of multiple lists being used to manage booking leading to clinical harm	review of booking systems within SACT services has indicated that the booking team are using multiple lists to manage patient. there is a risk that a patients name may be missed due to the need to coordinate these list when booking patient appointments	daily escalation meetings take place to ensure that patients are identified and managed appropriately	Velindre Cancer Centre	SACT	Chemotherapy Administration (inc Bookings)	Probable - Will probably occur/reoccur but will not be a persistent issue.	4 - Major	16	Probable - Will probably occur/reoccur but will not be a persistent issue.	4 - Major	16	Unlikely - Not expected to occur/reoccur but there is some possibility.	4 - Major	8	29/03/2024		
3338	there is a risk that unable to meet demand for SACT service provision as a result of lack of pharmacy capacity leading to delay in patient treatment	Demand for SACT delivery (oral and parenteral) has exceeded forecast demand for 2023/2024. There is insufficient Pharmacy capacity at VCC to meet this increased demand at present.	daily escalation meetings outsourcing more product to suppport capacity within pharmacy	Velindre Cancer Centre	SACT	Chemotherapy Day Unit (CDU)	Expected - Will occur/reoccur and likely to be frequent.	4 - Major	20	Expected - Will occur/reoccur and likely to be frequent.	4 - Major	20	Possible - May occur/reoccur at some time / occasionally.	4 - Major	12	15/04/2024		
3193	There is a risk to Financial Sustainability as a result of a failing to secure sufficient funding for the delivery of a new Blood Establishment Computer System (BECS) contract and software platform, leading to a degradation of critical WBS (NHS Wales) blood supply chain activities.	There is a risk to PERFORMANCE & SUSTAINABILITY as a result of a failure to secure sufficient funding for the delivery of a new BECS contract and software platform, leading to a degradation of critical WBS (NHS Wales) blood supply chain activities. Failure to secure sufficient funding for the delivery of a new BECS contract and software platform.	Full costs to be confirmed via procurement.	Welsh Blood Service	Whole Service	Affecting whole service	Probable - Will probably occur/reoccur but will not be a persistent issue.	5	20	Possible - May occur/reoccur at some time / occasionally.	5	15	Rare - Would only occur/reoccur in very exceptional circumstances; considered a v	5	5		11/04/2024	Review update

3197	There is a risk to Quality as a result of failing to secure sufficient funding for the delivery of a new Blood Establishment Computer System (BECS) contract and software platform leading to degradation of critical WBS (NHS Wales) supply chain activities	Ability to maintain compliance to Blood Safety Quality Regulations (BSQR) whilst proceeding with implementation of BECS. Ability to maintain current BECS to comply to Blood Safety Quality Regulations (BSQR) if supported through configuration changes.	Ability to deliver configuration changes with current resources, implementation of software changes may not be possible without implementing a version change to the software FE - 11/03/24 - MAK support crucial to this activity. Discussions underway - No change "	Welsh Blood Service	Whole Service	Affecting whole service	Possible - may occire/reoc	5	15	Possible - May occur/reoccur at some time / occasionally.	5	15	Rare - Would only occur/reoccur in very exceptional circumstances; considered a ve	5	5	11/04/2023		Review update

ID	Risk Title - New	RR - Current Controls	Risk (in brief)	Risk Type	Opened	Division	Service	Likelihood (initial)	Impact (initial)	Rating (initial)	Likelihood (current)	Impact (current)	Rating (current)	Risk Decision	Controls in place	Adequacy of Controls	RR - Direction of Travel	Likelihood (Target)	Impact (Target)	Rating (Target)	Review date	Due date	Description
3001	There is a risk to safety as a result of work related stress leading to harm to staff and to service delivery.	People Management Policies and Procedures Infrastructure and resources to support wellbeing Values, behaviours and culture work programmes Leadership development and management training Regular monitoring and analysis of feedback and data This risk is now a standing agenda item at the Healthy and Engaged Steering Group	There is a risk to safety as a result of work related stress leading to harm to staff and to service delivery. Work related stress is the adverse reaction people have to excessive pressure or other types of demand placed on them. Due to the wide range of factors that cause stress, within work and outside of work, no single action will address the issue. Moreover, progress towards stress reduction will take time as new ways of working come into effect. Trust sickness absence figures show mental health issues and stress to be the highest cause of absence from work.	Safety	09/12/2022	Corporate Services	Whole Service	Probable - Will probably occur/reoccur but will not be a persistent issue.	4 - Major	16	Probable - Will probably occur/reoccur but will not be a persistent issue.	3 - Moderate	12	Treat - actions agreed to reduce the level of risk which will be implemented		Adequate	Stable/No Movement	Possible - May occur/reoccur at some time / occasionally.	3 - Moderate	9	31/03/2024	31/03/2024	Divisions/Departments should have proactive stress risk assessments Formal arrangements not in place for the Healthy and Engaged Steering Group to evaluate wellbeing interventions Steering Group to This risk needs a SMART action plan Systemic factors that impact on levels of workforce stress to be described and associated actions plans developed Develop management training in managing stress
3230	REFERRAL PROCESS - There is a risk to patient safety, caused by the duplication of information, excessive use of email and a lack of alternative communication methods for the processing of clinical information caused by the variation and multiple access routes for new referrals to Velindre Cancer Centre. The impact will be an inability and timeliness to ascertain accurate patient referral information which may impact/delay the delivery of patient care	Monitoring the receipt of paper and electronic communications specific to new patient referrals to ensure timely actions to be taken.	Multiple methods for the communication of new patient referrals to Velindre Cancer Centre	Safety	19/10/2023	Velindre Cancer Centre	Health Records	Possible - May occur/reoccur at some time / occasionally.	4 - Major	12	Possible - May occur/reoccur at some time / occasionally.	4 - Major	12	s agreed to reduce the level of risk which will be implemented	and electronic communication sent to Velindre Cancer Centre enable the prioritisation and management of patient referrals.	Inadequate	Stable/No Movement	occur/reoccur in very exceptional circumstances; considered a very remote probability that it could happen / happen again.	4 - Major	4	31/05/2024	26/10/2023	An Action Plan needs to be established Short term central management of new patient referrals Electronic Solution (Long Term) Escalation to the Chief Operating Officer and Chief New Patient Waiting List Referral Discussion with Health Board Colleagues

															Treat - actions	Monitoring of paper to e			Rare - Would only c			Establish Workstream - Referrals and Referral Process
2187	There is a risk to patient safety due to inadequate staffing within the Radiotherapy Physics Department and the need to balance core duties with developmental tasks.	Radiotherapy Physics workforce remains below recommended (IPEM) levels. Additional surge funding has been utilised alongside IRS funding to increase recruitment in the short term. The service head has developed an outline workforce plan, looking at roles and responsibilities and demands on the service, mapping out the essential BAU activity, critical projects and programmes of service development to implement a prioritisation if activity and resource utilisation. Whilst the situation to establish a full complement of staff in the service remains a challenge, development of a medium term workforce planning, and long term workforce strategy, with HEIW and W&OD colleagues continues alongside recruitment there will need to be support to focus on service critical projects. These have been determined as DHCR replacement, IRS and nVCC. The risk rating did reduce to 10 following recruitment of surge posts but has since increased to 15 as the number of Physics posts required for the implementation of the IRS is significantly greater than the posts recruited to, with the resource gap being filled by staff within the service. IRS staffing plan approved and recruitment now underway.	There is a risk to patient safety due to inadequate staffing within the Radiotherapy Physics Department and the need to balance core duties with developmental tasks. Inadequate staffing may result in: - Patient treatment delay and breaches - Key projects not keeping to time with an impact on radiotherapy capacity e.g. commissioning and implementation of IRS systems, system upgrades of essential radiotherapy software and hardware - Suboptimal patient treatment - either due to lack of planning time or lack of developmental time - Radiotherapy treatment errors; individual patient errors or errors affecting multiple patients due to insufficient developmental, commissioning or training time, or too few staff with the specialist skills required. This staff group comprises highly trained, specialist scientific and technical staff key to ensuring quality and safety of radiotherapy treatments. The Engineering Section in particular is identified as an area of risk to the radiotherapy service, with 2 recent retirements and an additional 4 engineers due to retire within the next 4 years. Example of areas of the service currently considered as routine that are detrimentally impacted by the lack of resource include i. Completion of incident investigations, reports and learning, essential to prevent future radiotherapy errors and incidents and improve local practice ii. Inability to provide engineering cover during weekend quality control activities iii. IMPE advice on, and review of, treatment protocols to ensure they are in line with national guidelines whilst also appropriate for local practice iv. RTDS data submissions v. Delays to the commissioning of new treatment techniques / service developments e.g., Partial Breast Irradiation (PBI) and Internal Mammary Node Irradiation (IMN) vi. Delays in performing local RTQA slowing opening of new trials and thus reducing recruitment of Velindre patients to trials compared	Safety	14/09/2020	Velindre Cancer Centre	Medical Physics (previously Radiotherapy Physics)	Expected - Will occur/reoccur and likely to be frequent.	5 - Critical	25	Possible - May occur/reoccur at some time / occasionally.	4 - Major	12	Treat - actions agreed to reduce the level of risk which will be implemented			Risk Increasing	Unlikely - Not expected to occur/reoccur but there is some possibility.	4 - Major	8	31/05/2024	31/01/2023	Recruitment Action Plan 5 year workforce plan Readvertise post that did not recruit Prioritise business critical tasks and ensure detailed project and resource plans are kept up to date

			with other centres (e.g. PACE C) vii. MPE support for imaging activities providing imaging to the radiotherapy service inside and outside VCC. Background The ATTAIN report highlighted that in comparison to the Institute of Physics and Engineering in Medicine (IPEM) guidance, Radiotherapy Physics were under resourced by approximately 25%. The IPEM recommendations for the provision of a physics service to radiotherapy are recognised as a benchmark for minimum staffing guidance. The Engineering Section in particular is identified as an area of risk to the radiotherapy service. Not only are staffing numbers significantly under those recommended by IPEM but the age profile of this team is of concern, with up to 6 engineers planning to retire within 5 years. Linac engineering is a specialist area requiring in depth knowledge of complex machines and requires training to work at																				Log when IRS implementation put on hold to meet clinical demand
2465	There is a risk to patient safety, caused by the duplication of information, excessive use of email and a lack of alternative communication methods for the processing of clinical information.	There is a lack of current controls that enable the mitigation of this risk. As a result a formal internal audit of the underlying causes of this risk is underway. Reporting to VCC SLT is required on a regular basis in order to provide assurance that the issue is being addressed.	There is a risk of severe harm due to the excessive use of email both internally and externally to the Trust. This is because processes and procedures are not carried out in a manner that is appropriate. in particular, emails containing time critical clinical information is being sent to and received by individuals who may not be in work. The impact is severe harm, which may result in National reportable incidents.	Safety	05/11/2021	Velindre Cancer Centre	Medics	Probable - Will probably occur/reoccur but will not be a persistent issue.	4 - Major	16	Possible - May occur/reoccur at some time / occasionally.	4 - Major	12	Treat - actions agreed to reduce the level of risk which will be implemented		Inadequate	Stable/No Movement	Unlikely - Not expected to occur/reoccur but there is some possibility.	2 - Minor	4	29/02/2024	30/06/2023	work progressed as a part of SACT management which includes co-location of SACT scheduling team with outpatient booking and location within outpatient setting which will minimise delays and unnecessary email traffic. training of medical teams on utilisation of outcome function on WPAS taken place in March, which should improve information available for booking whereby reducing email traffic Implementation of an interim electronic solution to deliver a standardised new patient referral template for submission in to a centralised, managed e-mail account – to be piloted in Lung in conjunction with CAVUHB

EXTRAORDINARY QUALITY, SAFETY & PERFORMANCE AND AUDIT COMMITTEES'

Trust Assurance Framework

DATE OF MEETING	20th March 2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	ASSURANCE
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Mel Findlay, Business Support Officer
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
APPROVED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SUMMARY	A review of the Trust Assurance Framework, including a refresh of the Strategic Risks has been undertaken and the refreshed framework was approved by the Trust Board in January 2024.
RECOMMENDATION / ACTIONS	The Committees are asked to **DISCUSS AND NOTE** the Trust Assurance Framework.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board - Out of Committee	19 MARCH
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	

7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	***Report for Noting***

APPENDICES	
1	Trust Assurance Framework

1. SITUATION

An updated set of Strategic Risks were approved by the Trust Board in January 2024.

The work to transition onto a new system has been delayed due to resource issues. This was due for March reporting but will be completed when resource in place.

2. ASSESSMENT

Summary of Actions Taken/ In Plan from Strategic Development Committee, Quality Safety & Performance and Audit Committee:

	Matter raised through recent governance cycle	Action Taken/ In plan	Timeframe
1	Populate refreshed TAF on Power BI template	Work completed in background on Power BI and refreshed information to be populated from March reporting cycle.	To be confirmed
2	Finalise template for remaining two newest TAF risks – TAF 07 and 08	Work continued to progress well since Quality, Safety & Performance Committee with Executive leads.	**Closed** – Included in this paper
3	Alignment to Integrated Medium Term Plan goals and then tracking of progress as part of first line of defence assurance.	Progress made since Quality, Safety & Performance Committee – with the Risk & Assurance lead working with the Planning team to map and then populate with Executive leads at next review.	May reporting cycle – following approval of IMTP
4	Deep dive of two risks at Quality, Safety & Performance Committee going forwards	Following reporting of refresh framework of strategic risks, this will recommence from the next reporting cycle.	May reporting cycle
5 a-c	Governance, Assurance & Risk programme of work development	a. Alignment to Integrated Medium Term Plan annual review b. Embedding through Divisional Leadership and senior management as a valuable management tool c. Trust Board collective time to ensure strategic risks play a central role in how the Trust Board operates it's core functions and responsibilities. This may include further	December- April, in line with completion of current phase and refresh of Governance, Assurance & Risk programme of work.

		Board development time etc.	

3. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: **Choose an item**	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	**Choose an item** All Strategic Risks are related.
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of

	Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). All domains are relevant to this work, as the strategic risks span all areas of the Trust business and are imperative to quality and safety.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
	Click or tap here to enter text. There are no socio economic impacts linked directly to the current risks in paper.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Source of Funding: **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Choose an item**

	Scale of Change Please detail the value of revenue and/or capital impact: **Click or tap here to enter text** **Type of Change** **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT *For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	There is no direct equality impact in respect of this paper, however each risk will have an impact assessment where appropriate.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text
ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	The risks are detailed in the new Trust Assurance Framework dashboard.
WHAT IS THE CURRENT RISK SCORE	NA
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	Action plans for strategic risks are included in the Trust Assurance Framework Dashboard.
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix	

SECTION 1

RISK ID	01	**RISK TITLE**	There is a strategic risk of failure to deliver timely, safe, effective and efficient services for the local population leading to deterioration in service quality, performance or financial control as a result insufficient capacity and resources.	**STRATEGIC GOAL**	1 - Outstanding for quality, safety and experience	**RISK SCORE TREND**	
RISK LEADS	Cath O'Brien	Rachel Hennessey	Alan Prosser	**RISK THEME**	Service Capacity		

SECTION 2

RISK SCORE (see definitions tab)

INHERENT RISK	LIKELIHOOD	IMPACT	TOTAL	16	CURRENT RISK	LIKELIHOOD	IMPACT	TOTAL	12	TARGET RISK	LIKELIHOOD	IMPACT	TOTAL	8
	4	4				3	4				2	4		

SECTION 3

Overall Level of Effectiveness: RATING: PE

Overall Trend in Assurance: THIS WILL INCLUDE A

KEY CONTROLS / **SOURCES OF ASSURANCE**

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
	Trust Risk Register associated risk on Datix. (see section 4)			X								
C1	Blood stock planning and management function between WBS and Health Boards. This includes active engagement with Health Boards in Service Planning including the established annual Service Level agreement,. The overall annual collection plan based on this demand and the active delivery of blood stocks management through the Blood Health Plan for NHS Wales and monthly laboratory manager meetings.	Director WBS	X			E	Annual SLA meetings with Health Boards to review supply. Benchmarking against National and International standards. Annual Blood Health Team review of Health Board supply and prudent use of blood Annual Integrated Medium Term Plan (IMTP) review of previous 3 year demand trend to build resilience to inform and predict any surge demand.	Not Assessed	Senior Leadership Team, COO and EMB Review, QSP committee and Board.	Not Assessed	Welsh Government Quality, Planning and Delivery Review.	Not Assessed
C2	Operational Blood stock planning and management function in WBS. Delivered through annual, monthly and daily resilience planning meetings. Underpinned by the UK Forum Mutual Aid arrangements. Regular meetings with UK Blood Services on position of Blood Supply.	Director WBS	X			E	System pressures can be flagged at an early stage and appropriate action taken through Department Head review with escalation to Senior Leadership Team and Director.	PA	Performance Report to Senior Leadership Team and EMB Review, QSP committee and Board. National Red Cell and Platelet shortage plan please in time for Board.	PA	Welsh Government Quality, Planning and Delivery Review Internal Audit, Wales Audit Office, regulator audits.	PA
C3	Continuity of core service delivery functions supporting Transfusion, Transplantation and Welsh Bone Marrow Donor Registry (WBMDR).	Director WBS	X			E	Business Impact Assessments across service functions identifying Maximum Tolerable Period of Disruption. Contingency equipment, Managed service contracts for critical suppliers, Planned Preventative Maintenance, Additional inventory for contingency of critical supply items. Business Continuity Plans for response. On call provision for Senior Leadership Team and core service functions.	PA	Escalation through VUNHST Business Continuity command structure if system pressures not resolved, invoke Service Level Agreements if appropriate or Technical Agreement with other UK Services.	PA	Invoke UK Blood Services Memorandum of Understanding (MoU) Escalation to Welsh Government EPRR for Health, Local Resilience Forum - SCG. Internal Audit, Wales Audit Office, regulator audits.	PA
C4	Delivery of business as usual core services and capacity to support strategic programmes of work.	Director WBS, VCS	X			E	Implementation group for programmes mapping the interdependencies and pressures. Regular touch point meetings with Senior Leadership Team to review capacity to deliver key programmes of work.	PA	Highlight and performance reports to Senior Leadership Team and EMB Review.	PA	QSP committee and Board and external stakeholders if required. Internal Audit, Wales Audit Office, regulator audits.	PA
C5	National Policy decisions/ Directives that are introduced including Regulatory requirements to ensure the safety of services. (Advancements in medicines to improve patient safety).	Director WBS, VCS	X			E	Horizon scanning and representation at key forums including UK Forum, JPAC, SaBTO Regular liaison with Blood Policy and Tissue, Cells and Organs team in Welsh Government. NICE Guidelines re Cancer drugs	Not Assessed	Trust wide clinical and scientific board. Senior Leadership Team and EMB Review.	Not Assessed	QSP, SDC	Not Assessed
C6	SEW- VUNHST cancer demand modelling programme with HBs and WGDU in place, continues to provide high level assurance on demand projections.	Director VCS	X	X		PE	SE Wales Group	Not Assessed	Performance Report - SLT, EMB, QSP and Board	Not Assessed	Welsh Government Quality, Planning and Delivery Review	Not Assessed
C7	Demand and Capacity Plan for each service area of VCS	Director VCS	X	X		PE	Service area operational planning meeting	Not Assessed	Performance Report - SLT, EMB, QSP and Board	Not Assessed	Welsh Government Quality, Planning and Delivery Review	Not Assessed

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE
Lack of real time data on fating of blood to allow business intelligence data set that links Health Board and activity changes to demand. Addressing this gap would require digital systems to be in place which are out of WBS control. Projects are progressing externally.		A1.1
The demand management for blood still varies across Health Boards and within clinical teams. The Blood Health National Oversight Group work programme continues to address inappropriate use of blood, which impacts demand.		A1.1

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	CURRENT RISK	RISK TREND

2515	There is a risk to performance and service sustainability as a result of the staffing levels within Brachytherapy services being below those required for a safe resilient service leading to the quality of care and single points of failure within the service.	15	Risk Decreasing

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
A1	Exploratory pilot project with Cardiff and Vale Health Board to scope real time digital solution to develop blood fate data set.	Lee Wong	**IA**	Jul-25	National oversight group is currently discussing with CAV in light of new supplier for All Wales LIMS soplution.	14.11.23	No current funding route idetified within LIMS and may be identified as a core recommendation through Infected Blood Inquiry (IBI).	
A1.1	Working with DCHW to support the Blood Transfution Model of the new All Wales LIMS 2.0 , Track Care Lab Enterprise (TCLE).	Lee Wong	**IA**		Discussions ongoing about funding solutions	14.11.23		
A2	Blood Health National Oversight Group key work streams are underway identifying inappropriate use of blood.	Lee Wong	**PA**		Ongoing work under the remit of the BHNOG to support patient blood management initiatives, including	14.11.23	All Wales programmes which will ensure equity of care for patients.	
	review of outpatient activity to determine what could be repatriated back to Health Boards relasing capacity within the outpatient facility and providing care closer to home for the patient	Head of Medical Services			report to be received			
	formal demand and capacity operational group to be established to provide oversight of current and future plans, manage D&C plans and identify areas of concern with mitigations for escalation as appropraite	Head of Medical Services			Key objective for Head of Service on commencing role ?Dec 2023			

SECTION 1

RISK ID	02	**RISK TITLE**	There is a strategic risk of failure to align our strategic objectives and intent with system partners, including within the health and social care system, third sector and industry partners which could result in an inability to deliver required change to achieve our medium to long term objectives.	**STRATEGIC GOAL**	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations	**RISK SCORE TREND**	
RISK LEADS	**Carl James**	**Jacinta Abraham**	**Nicola Williams**	**RISK THEME**	Partnership Alignment		

SECTION 2

RISK SCORE (see definitions tab)

INHERENT RISK	LIKELIHOOD	IMPACT	TOTAL		CURRENT RISK	LIKELIHOOD	IMPACT	TOTAL		TARGET RISK	LIKELIHOOD	IMPACT	TOTAL	
	3	4		12		2	4		8		2	3		6

SECTION 3

Overall Level of Effectiveness:	**RATING**	**PE**	**Overall Trend in Assurance**	THIS WILL HAVE A GRAPH

KEY CONTROLS

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating
	Trust Risk Register associated risk on Datix. (see section 4)			X		
1.3	Performance data and measures to clearly track progress				X	PE
2.1	Blood - core blood services commissioning arrangements			X		E
3.1	Local Partnership Forum		X	X		E
4.1	South Wales Collaborative Cancer Leadership Group system			X		PE
5.1	Partnership Board arrangements with partner Health Boards			X		E
5.2	Partnerhsip with other stakeholders e.g. WAST, HEIW and University partnerships.		X			E

SOURCES OF ASSURANCE

1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
Linked through performance framework	IA	Strategic Development	PA	Wales Audit Office/Welsh Government	PA
Commissioning contracting reporting in	PA	Strategic Development	PA	Regulatory scope re MHRA tbc; clear	E
Feedback from LPF; proven to be effective	PA	Strategic Development	PA	Wales Audit Office	E
Agreed to model for next phase	IA	Strategic Development	PA	Wales Audit Office/Welsh Government	PA
Agreed to model for each organisation	PA	Strategic Development	PA	Wales Audit Office/Welsh Government	E
Good working relationships with regular communication	E	HIW	E	QSP	E

GAPS IN CONTROLS	**GAPS IN ASSURANCE**	**ASSOCIATED ACTION REFERENCE/ RATIONALE**
Across the models of working in strategic partnerships, there are common themes of control effectiveness – with the models largely in place, further	First line and second lines of defence assurance are in place to a certain extent	

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	CURRENT RISK	RISK TREND
	There are currently no associated operational risks according to the risk appetite to include		

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
1.4	Development of Phase 2 of PMF with additionalperfromance measures/quality metrics	Carl James	Mar-24	Design stage commenced		Anticipated it will reduce level of risk by providing additional insight on quality of services	The level of assurance should increase
1.5	Development of Value Based Healthcare programme to provide a range of outcome measures to support view on quality of care	Matt Bunce	Programme outputs to be confirmed	Programme established and staff on-boarded	09/11/2023	Anticipated it will reduce level of risk by providing additional insight on quality of services	The level of assurance should increase
1.6	CCLG: formation of SE Wales Cancer Programme to evolve from CCLG	Carl James (will act as liason)	tbc	1. CEO agreement to Cancer programme sept 23 2. CEO lead identiifed 3. Programme Manager and resources partially identied 4. Commencement of programme (tbc)	target date Feb 2024 (tbc by CEOs	Anticipated it will reduce level of risk by providing strengthening regional partnership arrangments and the quality of cancer services	The level of assurance should increase
1.7	WG review of NHS Wales strategic management / accountabilioty arrangements will potentially identify how	Carl James	April/May 2024	Trust received request to feed into the review process	22-Dec-23	Unknonw at this state	The level of assurance should increase
1.8	Trust included in SE Wales regional strategic planning programme (for wide range of services i.e. not only cancer (e.g. diagnostics etc)	Carl James	tbc subject to the programme dates	Chief Executive/Executive Director of Transformation/Executive Medical Director attended regional workshop to discuss shape of programme/strategic aligment on 6th December 2023	22-Dec-23	Anticpated it will reduce the level of risk regarding strategic mis-alignment between the Trust/partners and the wider healthcare system	The level of assurance should increase

SECTION 1

RISK ID	03	**RISK TITLE**	There is a strategic risk of an optimised workforce supply and shape in order to effectively deliver quality services and achieve our medium to long term objectives.	**STRATEGIC GOAL**	1 -Outstanding for quality, safety and experience	**RISK SCORE TREND**	
RISK LEADS	Sarah Morley			**RISK THEME**	Workforce Supply and Shape		

SECTION 2

RISK SCORE (see definitions tab)

INHERENT RISK	LIKELIHOOD	IMPACT	TOTAL		CURRENT RISK	LIKELIHOOD	IMPACT	TOTAL		TARGET RISK	LIKELIHOOD	IMPACT	TOTAL	
	4	4		16		4	3		12		2	3		6

SECTION 3

Overall Level of Effectiveness:	7 Levels of Assurance(see definitions tab)	**RATING**	**PE**	**Overall Trend in Assurance**	THIS WILL INCLUDE A GRAPH

KEY CONTROLS

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating
	Trust Risk Register associated risk on Datix. (see section 4)			X		PE
C1	Trust People Strategy, approved in May 2022, clearly noting the strategic intent of Workforce Planning - 'Planned and Sustained Workforce'	Sarah Morley	X			E
C2	Workforce Planning Methodology approved by Executive Management Board	Susan Thomas	X			E
C3	Workforce planning - skills development	Susan Thomas	X			PE
C4	Workforce Planning embedded into our Inspire Programme to develop Mangers and leaders in WP skills	Susan Thomas	X			PE
C5	Additional workforce planning resources recruitment to support development of workforce planning approach and facilitate the utilisation of workforce planning methodology	Susan Thomas	X			PE
C6	Educational pathways in place for hard to fill roles in the Trust to support the recruitment of new skills and development of new roles	Susan Thomas	X			PE
C7	Widening access Programme in train to support development of new skills and roles	Susan Thomas	X			PE
C8	Workforce analysis available via ESR and Business Intelligence support	Susan Thomas	X			PE
C9	Hybrid Workforce Programme established to assess implications for planning a workforce following COVID and learning lessons will include technology impact assessments.	Sarah Morley			X	E
C9	Monthly dashboard reports are provided to divisional SLTs to monitor performance, identify and manage any issues. Hotspot areas are identified and managead accordingly, such as establishment of Task and Finish Groups.	Susan Thomas	X	X	X	E

SOURCES OF ASSURANCE

1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
Tracking key outcomes and benefits map – aligned to Trust People Strategy	PA	Performance reporting to Executives and Trust Board	PA	Internal Audit Reports	PA
Staff Feedback	PA	Trust Board reporting against Trust People Strategy	PA	To be completed as per compliance/reg tracker update	IA
Provide operational managers with skills and capabilities to undertake effective	IA	Supply and Shape paper to EMB then QSP	PA	Wales Audit Workforce Planning National Review	IA
Evaluation sheets	IA	Supply and Shape paper to EMB then QSP	PA	Wales Audit Workforce Planning National Review	IA
Staff Meeting to feedback on implementation plan	IA	Supply and Shape paper to EMB then QSP	PA	Wales Audit Workforce Planning National Review	IA
Education and Training Steering Group	PA	Supply and Shape paper to EMB then QSP	PA	Internal Audit Reports	IA
Education and Training Steering Group	PA	Supply and Shape paper to EMB then QSP	PA	Internal Audit Reports - Education Strategy Audit	IA
Performance reports monthly to operational managers with improvemnt plans/actions set out.	PA	Performance reporting to Executives and Trust Board	PA	Internal Audit Reports - Education Strategy Audit	IA
Agile Project and Programme Board - see comments below - programme now closed - updates on any future work progammes via EMB	PA	Policies and proceedures to be imbedded with Hybrid Working Principles	PA	Internal Audit	PA
Regular monitoring at SLTs, where workforce dashboards monitor performance, identify and manage issues.	PA	Regular performance reports and Suply and Shape paper are submitted to EMB and QSP	PA	External Audit Reports - Managing Attendance at Work, Recruitment and Retention and Edication Strategy Audit (ongoing)	PA

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.
Gaps are evident in understanding agreed service models – both internally and regionally	Development of 3rd Line of defence assurance to be completed	
Each of the controls requires further development and progression, the plans for which are at varying levels of maturity	Mapping of relevant sources of assurance and development of that assurance will be also alongside the development of the key controls	

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	INTIAL RISK RATING	CURRENT RISK RATING	TARGET RISK RATING	RISK TREND

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
1.1	The Healthy and engaged workplan to be implemented to support worforce capacity within the Trust	Sarah Morley	IA	Mar-24	The annual workplan has been reviewed at the Healthy and Engaged Steering Group for Quarters 1 and 2, 2022-23. The Trust has appointed a staff psychologist to support mental health and wellbeing and they have developed a model for a staff psychology service which has been shared at the Healthy and Engaged Steering Group. In addition all elements of the Trust wellbeing offer have been added to the national GWELLA platform and on the Trust intranet allowing them to be more easily accessible for staff. The next meeting is on 28.03.24 where the worklplan will be approved. Task and Finish group has been set up to embed the Values and Behaviour Framework into the recruitment process.	20.03.2024	Plan is moniitoted via Health and Engaged Steering group	
1.2	Establish Hybrid working arrangements as a core way in which the Trust undertakes some of its work.	Sarah Morley	PA	COMPLETE	The Hybrid Working project is presenting the details of a desk top booking approach to EMB in January 2023. This business case will then be further developed following EMB feedback. The Hybrid Working Toolkit has been developed in draft and will be finalised and published in February 2023.	21/12/2023	This programme of work is now completed - a close down report was taken to EMB in August 2023. An review of our infrastructure to support Hybrid Working is now being discussed, led by Estates	
1.3	Participate in the NWSSP International nurse recruitment Project	Sarah Morley	IA	COMPLETE	International nurse recruitment has commenced to recruit 17 WTE nurses by December to commence in March 2024. Progress is monitored via EMB. International nurses take up post on 25.03.2024	21/12/2023	13 overseas nurses have been recruited and onboarded and will start in March 2024.	
1.4	Develop and Implementation Plan for the People Strategy	Susan Thomas	PA	COMPLETE	A plan to implement the People Strategy will be presented to EMB in December.	21/12/2023	Presented to EMB Shape	
1.5	Development of a Strategic workforce plan	Susan Thomas	IA	Sep-24	Development of a Strategic workforce plan aligned to the Clinical Services Strategy is ongoing - a draft version of the plan will be presented following agreement of the clinical service strategy. Workforce models will be developed inline with the Clinical and Scientific Strategy	20.03.2024		
1.6	Development of a Trust Retention Plan	Susan Thomas	IA	Apr-24	Retention plan to be developed by the newly appointed Retention Lead. Retention plan updated to EMB monthly. The implementation of the Nurse Retention plan is complete. The model will be used to roll out a Trustwide Retention Plan	20.03.204		
1.7	Review Exit Interview Process	Susan Thomas	IA	COMPLETE	The Exit interview process has been rewritten. There is a new dashboard and automated process and engagement sessions have been delivered. A new procedure will be submitted to EMB	20.03.2024		

SECTION 1

RISK ID	04	**RISK TITLE**	There is a risk of failure to meet or exceed service expectations without the prevelance of a positive working environment, which is characterised by effective values and bahaviours, systems and processes	**STRATEGIC GOAL**	2 -An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations	**RISK SCORE TREND**	
RISK LEADS	Sarah Morley			**RISK THEME**	Organisational Culture		

SECTION 2

RISK SCORE (see definitions tab)

INHERENT RISK	LIKELIHOOD	IMPACT	TOTAL	12	CURRENT RISK	LIKELIHOOD	IMPACT	TOTAL	9	TARGET RISK	LIKELIHOOD	IMPACT	TOTAL	4
	3	4				3	3				2	2		

SECTION 3

Overall Level of Effectiveness:	**7 Levels of Assurance(see definitions tab)**	**RATING**	**PE**	**Overall Trend in Assurance**	THIS WILL INCLUDE A GRAPH

KEY CONTROLS							**SOURCES OF ASSURANCE**					
ID	**Key Control**	**Owner**	**Preventative**	**Mitigating**	**Detective**	**Control Effectiveness Rating**	**1st Line of Defence**	**Assurance Rating**	**2nd Line of Defence**	**Assurance Rating**	**3rd Line of Defence**	**Assurance Rating**
	Trust Risk Register associated risk on Datix. (see section 4)			X								
C1	Trust Strategies and enabling strategies (including people, RD&I and Digital) launched November 2023 to provide clarity and alignment on strategic intent of the Organisation	Carl James	X			E	Working group led by CJ	PA	Trust Board reporting on strategy and controls via cycles of business	PA	To be completed as per compliance/ reg tracker updates	PA
C2	Developed Capacity of the Organisation – set out in the Education Strategy and implementation plan to support the educational development of the Organisation to support the Trust direction	Susan Thomas	X			PE	Education and training steering group	IA	Trust Board reporting on strategy and controls via cycles of business	IA	To be completed as per compliance/ reg tracker updates	IA
C3	Management and Leadership development in place to provide a infrastructure to develop compassionate leadership and managers established via the creation of the Inspire Programme with development from foundations stages in management to Board development	Susan Thomas	X			PE	Education and training steering group	PA	Highlight Report to EMB from Education and Training Steering Group on a quarterly basis	PA	Internal Audit Reports	IA
C4	Values to be reviewed and Behaviour framework to be considered	Susan Thomas	X			PE	Healthy and Engaged Steering Group and Education and Training Steering Group	PA	Reported through EMB Shape to Strategic Development Committee	IA	Internal Audit Reports	IA
C5	Communication infrastructure in place to support the communication of leadership messages and engagement of staff	Lauren Fear	X			PE	Healthy and Engaged Steering Group	IA	Reported through EMB to QSP	IA	Internal Audit Reports	IA
C6	Health and Wellbeing of the Organisation to be managed –with a clear plan to support the physical and psychological wellbeing of staff	Susan Thomas	X			PE	Health and Wellbeing Steering Group	PA	Supply and Shape paper to EMB then QSP	IA	Internal Audit Reports	IA
C7	Governance arrangements in place to monitor and evaluate the implementation of plans	Lauren Fear	X			PE	Workforce and OD steering groups and internal governance	PA	Steering Groups' highlight reports to Executive Management Board	PA	Internal Audit Reports	IA
C8	Performance Management Framework in place to monitor the finance, workforce and performance of the Organisation	Carl James	X			PE	PMF Workling Group	PA	Exucutive Management Board	PA	Internal Audit Reports	IA
C9	Service models in place to provide clarity of service expectations moving forward	Susan Thomas	X			PE	SLT Meetings	IA	Supply and Shape paper to EMB then QSP	IA	Internal Audit Reports	IA
C10	Aligned workforce plans to service model to ensure the right workforce is in place	Cath O'Brien	X			PE	SLT Meetings and Educationa and Training Steering Group	IA	Supply and Shape paper to EMB then QSP	IA	Internal Audit Reports	IA

GAPS IN CONTROLS	**GAPS IN ASSURANCE**	**ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.**
Each of the controls requires further development and progression, the plans for which are at varying levels of maturity	Development of 3rd Line of defence assurance to be completed	
Requires a cohesive and holistic Organisation alignment between performance management, service improvement, leadership behaviours and people practices to deliver the desired culture	Mapping of relevant sources of assurance and development of that assurance will sit alongside the development of the key controls	

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	INTIAL RISK RATING	CURRENT RISK RATING	TARGET RISK RATING	RISK TREND
3001	There is a risk to safety as a result of work related stress leading to harm to staff and to service delivery.	16	12	9	Risk has decreased from initial rating.

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
1.1	Implement a routine of conversations with staff and members of the Executive Team, Divisional Senior Leadership Teams and Extended Leadership Team.	Sarah Morley		May-24	The four leadership teams have a established a working group to implement the 'Working Together to Build our Future' ongoing series of discussions across the organisation. These bagan in September 2023 and will act as a temperature check on how staff are feeling on the ground about the organisation both in routine arrangements and also the changes that are taking place around them. These conversations will also provide the opportunity to talk about the Trust Strategy. Themes from the first eight weeks of conversations have been fed back via a video message. A summary of the themes and proposed actions will be presented to EMB in April 2024. This paper also proposes that the conversations continue as routine in person and virtually.	20.03.2024		
1.2	Consider fedback from Trust data on the culture of the organisation in a holistic overview in order that the Executive Team and Board can evaluate interventions in place and the forward plan to ensure a positive and effective culture.	Sarah Morley		May-24	Data is being triangulated to understand the current climate within the organisation. A plan is being developed to ensure that appropriate interventions are in place or being introduced to support a positive and supportive cultre within the organidation. Many elements of employee voice are being considered as part of this work. results of the NHS Staff survey have begun to be distilled to further develop our work programme	20.03.2024		
1.3	A staff engagement project to understand levels of staff engement and also review the Trust Values	Sarah Morley		COMPLETE	A first report against the review of the Trust values was presented to EMB in December 2022. It was decided at that meeting that a broader piece of work was needed to ensure that Trust values were bulit on the culture the organisation was striving to achieve to deliver its ambitions under the Destination 2033 strategy. a 2nd Phase of engagement activity has been underway with staff, patients and donors. Further opportunities will be provided for Executive management Board and Trust Board to shape this work in November and December 2023.	21/12/2023		
1.4	Implementation of the Speaking Up Safely Framework	Sarah Morley		Mar-24	The Trust is implementing the Welsh Government Speaking up Safely Framework. This Framework is a mechanism that provides assurance that the correct communication, processes and governance are in place for staff to speak up safely without any fear. A page on the Trust intranet site has been established to ensure staff understand the Trust intent re: Speaking up Safely and they know how to act if there are issues. An initial exercise on Employee Voice is being undertaken to gain a baseline on speaking up safely which will link with the ongoing listening exercise within the Trust. An Independent Member Champion in this work has been identified to ensure effective scrutiny and oversight. The full implementation of the framework is expected by March 2024. Updates will be reported via EMB Run.	07.02.2024	A programme of work is in train with three work streams, leads attached.	

SECTION 1

RISK ID	05	**RISK TITLE**	There is a strategic risk that the Trust fails to sufficiently consider, optimise the opportunities and effectively manage the risks of new and existing technologies,	**STRATEGIC GOAL**	5 - A sustainable organisation that plays it part in creating a better future for people across the globe	**RISK SCORE TREND**	
RISK LEADS	Carl James			**RISK THEME**	Digital Transformation		

SECTION 2

RISK SCORE (see definitions tab)

	LIKELIHOOD	IMPACT	TOTAL		LIKELIHOOD	IMPACT	TOTAL		LIKELIHOOD	IMPACT	TOTAL	
INHERENT RISK	4	**4**	**TOTAL**	**16**	**CURRENT RISK**	3	**4**	**12**	**TARGET RISK**	2	**4**	**8**

SECTION 3

Overall Level of Effectiveness:	**RATING**	**PE**	**Overall Trend in Assurance**	THIS WILL BE A GRAPH

KEY CONTROLS / **SOURCES OF ASSURANCE**

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
	Trust Risk Register associated risk on Datix. (see section 4)			X		E						
C1	Trust Digital Strategy - Published Oct '23	Carl James	X			E	Tracking key outcomes and benefits map – aligned to Trust Digital Strategy - Digital Programme Board	PA	EMB Shape	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA
C2	Active work ongoing to leverage existing and deliver on new technologies – e.g. LIMS, IRS, BECS, EPMA	Chief Digital Officer		X		E	Trust Digital governance reporting - WBS Futures - Velindre Futures - Digital Programme Board	PA	EMB Shape	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA
C3	Training & Education packages to develop internal capabilities – including for exec and Board	Chief Digital Officer	X			PE	Staff feedback - KLAS Survey	IA	EMB Shape	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA
C4	Training & Education packages for donors, patients	Chief Digital Officer	X			PE	Patient and Donor feedback	IA	EMB Shape	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	Not Assessed
C5	Ring-fencing digital advancement in Trust budget – benchmark 4%	Chief Digital Officer	X			E	Review of proposals via EMB/Board Digital IMTP	IA	EMB Shape / EMB Run	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	IA
C6	Specifically development of digital resources capacity and capability	Chief Digital Officer	X			PE	Review of proposals via EMB/Board Digital Programme Board	PA	EMB Shape	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit/ Centre for Digital Public Services	PA
C7	Digital inclusiion in wider community	Chief Digital Officer	X			PE	Tracking key outcomes and benefits map – aligned to Trust Digital Strategy Joint plan with Digital Communities Wales	PA	EMB Shape	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit / Digital Communities Wales	Not Assessed
C9	Prioritisation and change framework to manage service requests	Chief Digital Officer	X			PE	Trust Digital governance reporting - WBS Futures - Velindre Futures - Digital Programme Board IMTP	PA	EMB Shape	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA
C10	Levels of unsupported applications/ legacy systems	Chief Digital Officer			X	PE	Trust Digital governance reporting Digital Programme Board	PA	EMB Shape / EMB Run / Cyber Action Plan	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA
C11	Trust digital Governance	Carl James		X		E	Trust Digital governance reporting - WBS Futures - Velindre Futures - Digital Programme Board IMTP	PA	EMB Shape	IA	Wales Audit OfficeSIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA
C12	Framework of lead and lag indicator reporting into Trust digital governance structure, integrated into wider performance framework	Chief Digital Officer			X	PE	Review via Divisional SMT/SLT	PA	EMB Run	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA
C13	Cyber Assurance Controls in place	Chief Digital Officer		X		PE	Review via Divisional SMT / SLT/ Cyber Security eLearning (Stat. & Mand)/ Board Development Sessions.	PA	EMB Shape / EMB Run	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit/WG/CRU as competent authority for NIS	PA
C14	Digital transformation is guided by an agreed digtial architecture.	Chief Digital Officer	X	X		PE	Digital Programme Board Digital Design Authority being established	IA	EMB Shape	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	Not Assessed

GAPS IN CONTROLS	**GAPS IN ASSURANCE**	**ASSOCIATED ACTION REFERENCE/ RATIONALE**
Agreed Digital Inclusion plan - C4,C7	Assurance Arrangements for Digital Architecture will need to be established -	
Digital architecture needs to be developed to guide digital transformation activities - Digital Design Authority is in the process of being set up	Data and Insight prioritisation as this becomes part of the Digital Services team	
Appropriate external standards for benchmarking need to be agreed (e.g. ITIL, Cyber Essentials, ISO27001) as part of the control framework.		

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	CURRENT RISK	RISK TREND
3222	There is a risk to performance & service sustainability as a result of the failure to recruit to the Cyber Security Manager role, leading to the delayed implementation of the services and processes needed to ensure the cyber security posture of VUNHST.	15	Cyber Security Manager has been recruited and has started at the Trust - risk will be closed post induction.
92	There is a risk to COMPLIANCE as a result of the inadequate oversight of supplier contracts, procurement governance etc., leading to difficulties in complying with internal governance for contract management, renewals and procurement activity.	12	Risk trend is increasing with capacity constraints in the procurement teams supporting the Trust
R022 (EPMA)	There is a risk that there will not be a resource available from the Pharmacy team to both lead and support the evaluation panel activities (before and during) from a clinical perspective, caused by staff shortages, resulting in slippage of timescales in publishing and awarding the supplier	16	Lead Digital Pharmacist has now been recruited with the expectation that the risk will trend down to target
R008 (BECS)	There is a risk to QUALITY as a result of failing to secure sufficient funding for the delivery of a new Blood Establishment Computer System (BECS) contract and software platform leading to degredation of critical WBS (NHS Wales) supply chain activities	20	Commercial agreement on BECS contract established with Trust Board - Business case underdevelopment - Risk will remain high until funding is secured.
R008 (WHAIS)	There is a risk that the LIMS solution will not support the required interactions between WHAIS and WBMDR because commercial H&I solutions are not designed to support an integrated donor registry. If no workaround is identified this would prevent WHAIS from being able to maintain its current HSCT clinical services.	20	Part of the remit of the WHAISIT project group is to carefully plan the implementation activities to minimise impact and disruption. This includes identifying the future relationship between WHAIS and WBMDR. Appropriate requirements will be stimulated in the URS.

2651	There is a risk to Financial Sustainability as a result of the introduction of a new interfacing policy by MAK-System for devices connected to ePROGESA, leading to organisational cost pressures, reputational damage and/or delays in realising IMTP and other strategic benefits.	12	Additional funding needs to be made available for a Blood Establishment Computer System re-procurement through to 2027

SMART ACTION PLAN

Action Ref	Action Plan	Ownder	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
1.1	Establishment of a Digital Programme, including key controls for digital inclusion and digital architecture	Chief Digital Officer	PA	Nov-22	Digital Programme has now been established from Oct '23 Now meets on a bi-monthly basis	Dec-23	As the Programme continues to develop the overall level of risk should reduce by reducing the likelihood scores	The level of asurance should increase.
1.2	Create the Trust Digital Reference Architecture to support C14 and others	Chief Digital Officer	IA	Feb-23	Digital Programme has now been established from Oct '23. This includes a Digital Design Authority to oversee the reference architecture. The	Dec-23	Terms of reference for the Digital Programme include the creation of Digital Design Authority which is in the process of being stood up in Q4 23/24	The level of asurance should increase.
1.3	Approve the Digital Inclusion plan so that it can be used as the control point	Chief Digital Officer	IA	Feb-24	Non-Recurrent Revenue has been made avallanble to support the creation of the plan	Dec-23	improvement in the position on C7	The level of asurance should increase.
1.4	C13 - Embed new Head of Cyber Security	Chief Digital Officer	IA	Mar-24	Head of Cyber Security has been appointed from Dec	Dec-23	Dedicated post now in place to lead on cyber - will still be a single point of failure	C13 to move to Effective
1.5	C9 - Prioritisation framework needs to be established for the Data and Insight Service	Chief Digital Officer	IA	Apr-24	Assistant Director of Data and Insight starts in post on 3rd Jan 24. Future model for Data and Insight to be established	Dec-23	Will contribute to reduction in likelihood of risk	C9 would move to Effective
1.6	Identify external benchmark / standards for the Digital Services (e.g. ISO27001 ./ ITIL)	Chief Digital Officer	IA	Apr-24	Will start with identification of standards for Digital Service (through new ITSM tool) and Cyber Security	Dec-23	Will contribute to reduction likelihood of risk	Assurance controls should better represent best practice
1.7	Develop an implementation plan for the Digital Strategy to sit between the strategy and IMTP, including investment	Chief Digital Officer	IA	Mar-24	To be reviewed at March EMB	Jan-24	Will contribute to reduction likelihood of risk	Assurance controls should better represent best practice

SECTION 1

RISK ID	06	**RISK TITLE**	There is a strategic risk that the organisational and clinical governance arrangements do not provide appropriate mechanisms and culture to achieve our medium to long term objectives.	**STRATEGIC GOAL**	1 - Outstanding for quality, safety and experience	**RISK SCORE TREND**	
RISK LEADS	Lauren Fear			**RISK THEME**	Organisational and Clinical Governance		

SECTION 2

RISK SCORE (see definitions tab)

INHERENT RISK	LIKELIHOOD	IMPACT	TOTAL	16	CURRENT RISK	LIKELIHOOD	IMPACT	TOTAL	12	TARGET RISK	LIKELIHOOD	IMPACT	TOTAL	8
	4	4				3	4				2	**4**		

SECTION 3

Overall Level of Effectiveness: Refer to 7 Levels of Assurance (see definitions tab)	**RATING**	E	**Overall Trend in Assurance** Refer to 7 Levels of Assurance (see definitions tab)	THIS WILL INCLUDE A TREND GRAPH

KEY CONTROLS / **SOURCES OF ASSURANCE**

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Trust Risk Register associated risk on Datix. (see section 4)	Lauren Fear		X		E						
C2	Annual Assessment of Board Effectiveness	Emma Stephens			X	E	Annual Board Effectiveness Survey Annual Self- Assessment against the Corporate Governance in Central Governance Departments: Code of Good Practice 2017	6	Audit Committee Trust Board	6	Internal Audit Reports Audit Wales Structured Assessment Programme / Reports Joint Escalation & Intervention Arrangements	6
C3	Board Committee Effectiveness Arrangements	Lauren Fear	X			E	Internal Audit Review	4	Audit Committee Trust Board	4	Internal Audit of Board Committee Effectiveness Audit Wales Structured Assessment Audit Wales Review of Quality Governance Arrangements	4
C4	Board Development Programme	Lauren Fear	X			PE	Programme established	4	Trust Board in Board Development	4	Specialist external input as required, for instance on Socio-economic Duty	4
C5	Quality of assurance provided to the Board	Lauren Fear	X			PE	Quality of Board papers and supporting information effectively enabling the Board to fulfil its assurance role.	4	Trust Board assessment via formal annual and additional effectiveness review exercises	4	Internal Audit Reports. Audit Wales Structured Assessment Programme/Reports	4
C6	External benchmarking of Governance, Assurance & Risk best practice as part of the Governance, Assurance & Risk programme of work	Lauren Fear	X			PE	Full cross-reference of Governance, Assurance and Risk work into TAF 06 in this respect	4	Governance, Assurance & Risk Steering Group and Trust Board in Board Development input	4	Benchmarking input	4
C7	Cross-reference of Integrated Medium Term Plan objectives to strategic objectives in the Trust Assurance Framework	Lauren Fear	X			NE	Exercise to be completed	1	Trust Board in Board Development	1		

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.
None	Third line of defence in respect of C4 - Board Development Programme	Refreshed programme to be discussed and agreed in February 2024 Board Development session

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	CURRENT RISK RATING	RISK TREND
	There are currently no associated operational risks according to the risk appetite to include		

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control

1.0	Develop and implement formal Governance, Assurance and Risk Programme as part of Trust wide Organisational Development programme of work.	Lauren Fear	4	Apr-24	Governance, Assurance and Risk (GAR) Programme of work consisting of 20 projects across the spectrum of work progressing well through 2023/24, final analysis of progress to be confirmed and agreed in February 2024 Board Development session	18.1.24	Impact to be asseessed when programme delviered	
2.0	Refresh of Trust Assurance Framework risks	Lauren Fear	6	Complete	Project TAF 2.0 within the GAR Programme is due to complete in January 2024 Trust Board, risks then to be reviewed on a monthly basis and reported through governance routes accordingly	18.1.24	Requirement for C7 to be put in place	
3.0	Revised reporting mechanism to be developed	Lauren Fear	4	Apr-24	Project TAF 3.0 within the GAR Programme is undertaking a review of the reporting mechanism and aligning with appropriate committees, currently EMB Shape, Strategic Development Committee, Audit Committee and Trust Board. Work has taken place to initiate regular review and process within senior teams. Good progress made however further embedding required with Senior Leadership Teams.	18.1.24	Impact to be asseessed when delviered	
4.0	Trust Assurance Framework will be mapped through Governance Cycle	Lauren Fear	6	Complete	Work is complete to map Trust Assurance Framework through governance cycles, at present the TAF is received at appropriate committees, EMB Shape, Strategic Development Committee, Audit Committee and Trust Board	18.1.24	Requirement for C7 to be put in place	
5.0	External benchmarking of Governance, Assurance & Risk best practice as part of the Governance, Assurance & Risk programme of work	Lauren Fear	4	Apr-24	Full cross-reference of Governance, Assurance and Risk work into TAF 06 in this respect	18.1.24	Impact to be asseessed when programme delviered	
6.0	Cross-reference of Integrated Medium Term Plan objectives to strategic objectives in the Trust Assurance Framework to be completed and agreed with Trust Board	Lauren Fear	1	Apr-24	To be discussed in February 2024 Trust Board development session to then incorporate into reporting from April onwards	18.1.24	Impact to be asseessed when delviered	

SECTION 1

RISK ID	07	**RISK TITLE**	There is a strategic risk that Velindre Cancer Service patient outcomes / experience may be adversely affected due increasing service demands, the need for significant service delivery transformation to meet the rapidly changing and complex treatment regimes, staffing challenges, and lack of consistent quality, outcome and mortality metrics.	**STRATEGIC GOAL**	1 -Outstanding for quality, safety and experience	**RISK SCORE TREND**	
RISK LEADS	Jacinta Abraham	Nicola Williams	Chief Operating Officer	**RISK THEME**	Patient Outcomes		

SECTION 2

RISK SCORE (see definitions tab)

INHERENT RISK	LIKELIHOOD	IMPACT	TOTAL		CURRENT RISK	LIKELIHOOD	IMPACT	TOTAL		TARGET RISK	LIKELIHOOD	IMPACT	TOTAL	
	4	4		16		4	4		16		2	4		8

SECTION 3

Overall Level of Effectiveness: **7 Levels of Assurance(see definitions tab)**	**RATING**	**NE**	**Overall Trend in Assurance**	

KEY CONTROLS							SOURCES OF ASSURANCE					
ID	**Key Control**	**Owner**	**Preventative**	**Mitigating**	**Detective**	**Control Effectiveness Rating**	**1st Line of Defence**	**Assurance Rating**	**2nd Line of Defence**	**Assurance Rating**	**3rd Line of Defence**	**Assurance Rating**
C1	Trust Risk Register associated risk on Datix. (see section 4)			X								
C2	Capacity and demand planning and forecasting	Interim Director VCS / COO	As per TAF 01 C12									
C3	Multiprofessional Workforce Planning	Interim Director VCS / Director OD & Workforce	X	X		NE	Velindre Cancer Service Senior Leadership Team	IA	Executive Management Board	IA	Quality, Safety and Perfromance Committee	IA
C4	Quality and safety monitoring (Via PMF)	Interim Director VCS / Exec Director Strategic Tranformation, Planning and Digital / Exec Director Nurisng, AHP & HCS			X	NE	VCS Quality & Safety Group / VCC SLT / Intergrated Quality and Safety Group	NE	Executive Management Board	NE	Quality, Safety and Perfromance Committee	NE
C5	Pathway delivery programme/Service Improvement Programmes: focus on delivery against national optimum pathways, reduction in variation, quality & safety priorities (via the Safe Care Collaborative), realignment of roles and responsibilities ensuring patients remain at centre of service delivery (also see TAF 01)	Interim Director VCS / COO	X			PE	Pathways Programme VCS/ VCS Quality & Safety Group / VCS Senior Leadership Team	IA	Executive Management Board	NA	Quality, Safety and Perfromance Committee	NA
C6	Effective processes in place to capture patient experience, ensuring effective listening and learning	Interim Director VCS / Exec Director Nursing, AHP & HCS			X	PE	Velindre Cancer Service Senior Leadership Team/Intergrated Quality and Safety Group	IA	Executive Management Board	IA	Quality, Safety and Perfromance Committee	IA
C7	Mortality review process and monitoring	Interim Director VCS / Exec Medical Director			X	NE	Velindre Cancer Service Senior Leadership Team/Intergrated Quality and Safety Group	NA	Executive Management Board	NA	Quality, Safety and Perfromance Committee	NA
C8	Patient reported outcome monitoring (SST level to Board)	Interim Director VCS / Exec Medical Director / Exec Director Finance			X	NE	Velindre Cancer Service Senior Leadership Team/Intergrated Quality and Safety Group	NA	Executive Management Board	NA	Quality, Safety and Perfromance Committee	NA
C9	Velindre Oncology Acadamy establishment	Exec Director Nursing, AHP & HCS	X	X		NE	VOA Implementation Group	IA	Executive Management Board	NA	Quality, Safety and Perfromance Committee	NA
C10	Clinical audit process and systems in place	Head of Nursing / CD VCS / Exec Medical Director	X	X	X	PE	Velindre Cancer Service Senior Leadership Team/Intergrated Quality and Safety Group	IA	Executive Management Board	IA	Quality, Safety and Perfromance Committee	IA
C11	Quality & Safety Tracker (improvement monotoring)	Interim Director VCS / Exec Director Nursing, AHP & HCS		X	X	NE	VCS Quality & Safety Group / VCS SLT	NA	Integrated Quality & Saefty Group / Executive Management Board	NA	Quality, Safety and Perfromance Committee	NA

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.
Service level to Board monitoring of national standards delivery eg. NICE	Quality & Safety Tracker continues to be refined - not at its optimum	A1
Service level to Board intergrated dashboards	Quality Metrics under development	A2
Patient reported outcome measures across all SSTs, with service level to Board reporting	PROMa not in place	A3
Robust and consistent administrative processes for referrals and bookings		A4, A5, A6,A7

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	CURRENT RISK RATING	RISK TREND
2187	Radiotherapy Physics Staffing There is a risk of the radiotherapy physics team being unable to complete core and developmental tasks due to inadequate staffing. This staff group is key in ensuring quality and safety of radiotherapy treatments. This may result in - patient treatment delay - Radiotherapy treatment errors.- key projects not keeping to time e.g. commissioning of essential systems - suboptimal treatment - either due to lack of planning time or lack of developmental time	15	Risk Stable

2465	Number of emails medics are receiving, especially those related to clinical tasks.	16	Risk Stable
2579	There is a risk to performance and service sustainability as a result of training curriculum changing to include acute oncology leading to inability to secure the required number of Palliative Care Trainees	15	Risk Stable
2515	There is a risk that staffing levels within Brachytherapy services are below those required for a safe resilient service. This may result in a lack of resource to develop the service, investigate incidents and cover for absences. This may impact on the quality of care due to a reduction in resilience and development of the service	15	Risk Stable
2612	Acute Oncology Service (AOS) Workforce Gaps	15	Risk Stable

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
Actions also aligned with TAF 01 re capacity and demand mapping and service reconfiguration								
A1	An electronic mechanism to be introdcued to monitor compliance with relevant national standards and guidance, including NICE, delivery plans and national frameworks.	Interim Director VCC	0	Sep-24	Q-pulse being procured. Options appraisal to be undertaken to consider Blue light, Q-Pulse and AmAT systems and agree on which system would be the most effective and efficient	20/01/2024	Change will reduce risk through having enhanced mechanisms to implement new clinical changes in a timely manner	Enhanced control and assurance
A2	AmAT Quality & Safety Tracker to be fully embedded as the tracker across VCS	Interim Director VCC	2	Mar-24	AmAT rolled out and all open improvement plans moved across onto the system. Some teams require ongoing support to keep tracker live and up to date.	20/01/2024	Change will reduce risk by having effective mechanisms to ensure that identified quality and safty improvements have been implemented and had the desired impact	Enhanced control and assurance
A3	Intergrated Quality and Safety dashboards to be developed that align with PMF	Transofrmation, planning, performance and digital	2	Aug-24	Initial quality, safety and outcome metrics& implementation plan agreed	08/01/2024	Should reduce risk	Enhanced control and assurance
A4	Value Based Healthcare patient reported outcome plan to be fully delivered (PROM measures across all SSTs agreed and electronic system implemented)	Exec Medical Director / Exec Finance Director	2	Mar-26	Working Group established within VCS, Lead by the VBHC Team & external company PCS	08/01/2024	Should long term reduce risk	Enhanced assurance
A5	Single electronic patient referral system into the Cancer Service to be developed and implemented	Interim Director VCS / Head of Operations VCS	1	Mar-25	Work commenced	06/03/2024	Reduce risk	Enhanced control
A6	Overall review of booking systems (including SACT) to be undertaken and revised processes implemented	Interim Director VCS / Head of Operations VCS / Head of Nursing	1	Sep-24		08/01/2024	Reduce risk	Enhanced control
A7	Recommendations from SACT treatment helpline peer review to be fully implimented	Interim Director VCS	1	Sep-24	SACT telephone helpline report received and action plan developed	06/03/2024	Change will reduce risk by further enhancing safety of the SACT Telephone helpline	Enhanced control
A8	Transformational multi professional workforce plans across all areas of the cancer service	Director OD & Workforce	1	Mar-26	Opportunities for mult-professional consultant posts being considered	06/03/2024	Reduce risk	Enhanced control
A9	Finalise the delivery of BI solution to ensure robust service level to board mortality data monitoring in line with legislative and best practice standards	Exec Director Transofrmation, planning, performance and digital	1	Jun-24	Data tool in development, system validation issues identified	20/01/2024	Change will reduce risk by having robust mortality monitoring leading to further reviews and identification of further areas for improvement	Enhanced control and assurance
A10	Implement a robust mortality review and reporting infrastructure that includes reviewing how and for what cases mortality reviews are undertaken and outcomes reporting	Exec Medical Director / Exec Finance Director	1	Aug-24	Benchmarking undertaken and Trust process being drafted based on benchmarking outcomes and review of national standards	20/01/2024	Change will reduce risk by having robust mortality monitoring leading to further reviews and identification of further areas for improvement	Enhanced assurance
A11	Fully roll out the Q-Pulse system across all services at VCS and Trust	Interim Director VCS & Director Corportae Governance	1	Mar-25	Project group being established, project leads identified. Trust wide Q-Pulse system procured	20/01/2024	This enhanced document management system will reduce risk by having far greater governance in respect of SOP's, policies procedures, guidelines etc	Enhanced control and assurance
A12	Implementation of the patient engagement framework	Director Corporate Governance e	2	Mar-25		08/01/2024	Reduce risk	Enhanced control and assurance
A13	Fully embed a robust Clinical & Scientific infrastructure including establishment of a robust multi-professional Clinical & Scientific Board	Director / Exec Director Nursing, AHP & HCS	2	Aug-24	Clinical & Scientific Board established. Terms of Reference endorsed by EMB.	20/01/2024	Risk will reduce by having enhanced strategic clinical and scientific direction supporting effectve prioritisation and decision making	Enhanced control
A14	Develop the Clinical & Scientific Strategy with a clear deliverable implementation plan	Director / Exec Director Nursing, AHP & HCS	1	31/06/2024	Strategy under development following extensive engagement. Draft strategy will be developed by March 2024, followed by consultation period. .	20/01/2024	Risk will be reduced by having clear clinical and scientific direction informed by research, national standards and patient / donor requirements	Enhanced control
A15	Undertake a review of the manaement of inpatients with altered airways - including a regional working group and commissioning of an external peer review	Head of Nursing / CD VCS	0	Aug-24	Regional working group established and	20/01/2024	Risk will reduced by ensuring robust safety wrap in respect of patients with altered airways	

SECTION 1

RISK ID	08	**RISK TITLE**	There is a strategic risk that the Trust becomes financially unsustainable if it does not secure sufficient funding for the provision of services and does not maximise its use of resources. Unwarranted variation could impact the value and effectiveness of the care our patients and donors receive.	**STRATEGIC GOAL**	1 -Outstanding for quality, safety and experience 5 - A sustainable organisation that plays it part in creating a better future for people across the globe	**RISK SCORE TREND**	
RISK LEADS	Matthew Bunce			**RISK THEME**	Financial Sustainability and Long-Term Value		

RISK SCORE (see definitions tab)

INHERENT RISK	LIKELIHOOD	IMPACT	TOTAL	16	CURRENT RISK	LIKELIHOOD	IMPACT	TOTAL	12	TARGET RISK	LIKELIHOOD	IMPACT	TOTAL	8
	4	**4**				3	**4**				2	**4**		

SECTION 3

Overall Level of Effectiveness: **7 Levels of Assurance(see definitions tab)**	**RATING**	E	**Overall Trend in Assurance**	THIS WILL INCLUDE A TREND GRAPH

KEY CONTROLS							SOURCES OF ASSURANCE					
ID	**Key Control**	**Owner**	**Preventative**	**Mitigating**	**Detective**	**Control Effectiveness Rating**	**1st Line of Defence**	**Assurance Rating**	**2nd Line of Defence**	**Assurance Rating**	**3rd Line of Defence**	**Assurance Rating**
FSLTV1	Divisional Financial Outturn	Head of Financial Planning & Reporting and Head of Finance Business Partner / Budget Holders			X	E	Budget holders, reports and training	not assessed	Divisional Finance Reports and Performance; Finance Business Partners	PA	Internal Audit / External Audit	PA
FSLTV2	Quarterly Finance Reviews	Deputy Director of Finance / Head of Finance Business Partnering			X	PE	Directorate Level Budget holders, reports and training	not assessed	Divisional Finance Reports and Performance; Finance Business Partners	PA	Internal Audit / External Audit	PA
FSLTV3	Divisional Performance Review	Executive Director of Finance / Deputy Director of Finance			X	PE	Divisional Senior Leadership Teams, reports	not assessed	Executive Finance Reports; Senior Finance Team	PA	Internal Audit / External Audit	PA
FSLTV4	Executive and Trust Board Reporting	Executive Director of Finance			X	E	Executive Budget Holders / Programme SROs	not assessed	Trust Board Finance Reporting; Senior Finance Team; QSP Committee; Trust Board	PA	Internal Audit / External Audit	PA
FSLTV5	Statutory and Mandatory Financial Reporting (inc. Annual Accounts)	Executive Director of Finance			X	E	Executive Budget Holders / Programme SROs	not assessed	Trust Board Finance Reporting; Senior Finance Team; MMRs; Welsh Costing Returns; Audit Committee; Trust Board	PA	Welsh Government / NHS Executive (FP&D) / External Audit	PA
FSLTV6	Finance and Investment: Enhanced Monitoring	Executive Director of Finance			X	PE	Executive Budget Holders / Programme SROs	not assessed	Trust Board Finance Reporting; Senior Finance Team	PA	Internal Audit / External Audit	PA
FSLTV7	Collective Commissioners Review	Deputy Director of Finance		X		PE	Directorate Level Budget holders, reports and training	not assessed	Collective Commissioning Group LTA reporting	IA	LHB Commissioners	IA
FSLTV8	Investment Appraisal	Executive Director of Finance / Executive Director of Strategic Transformation, Planing & Digital	X			PE	Executive Budget Holders / Programme SROs	not assessed	Capital Planning and Delivery Group; Strategic Capital Board; Executive Management Board; Strategic Development Committee; Trust Board; WG Better Business Cases; HM Treasury Greenbook	not assessed	LHB Commissioners / Welsh Government / Internal Audit / External Audit	IA
FSLTV9	Financial Strategy / Medium Term Financial Plan / Budget Setting	Executive Director of Finance	X			E	Executive Budget Holders / Programme SROs	not assessed	Trust Board and Committees	PA	LHB Commissioners / Welsh Government / Internal Audit / External Audit	PA
FSLTV10	Scheme of Delegation and Delegated Financial Authority	Executive Director of Finance	X			PE	Oracle Financial System Controls; Budget holders; Executive budget holders; Programme SROs	not assessed	Trust Board and Committees; Delegated Financial Limits	PA	Internal Audit / External Audit	IA
FSLTV11	Value Based Healthcare programme	Executive Director of Finance / Executive Medical Director	X			PE	Value Based Healthcare project leads; VBH programme SROs	not assessed	Value Based Healthcare steering committee / Executive Management Board	PA	LHB Commissioners / Welsh Government / Internal Audit / External Audit	PA
FSLTV12	Procure to Pay monitoring	Deputy Director of Finance / Head of Financial Operations			X	E	Requisitioners / Budget Holders	not assessed	Finance P2P reporting; Expense reporting; Expenses and Purchasing / Credit Card policy; Losses and Special Payments reporting	PA	Internal Audit / External Audit	PA
FSLTV13	Debtors / Cash monitoring	Deputy Director of Finance / Head of Financial Operations			X	E	Budget Holders; Private Patients lead; reports	not assessed	Debtors Reporting; Senior Finance Team;	PA	LHB Commissioners / Welsh Government (External Financing Limit) / Internal Audit / External Audit	PA
FSLTV14	Discretionary Capital Financial Planning and Reporting	Deputy Director of Finance / Head of Financial Planning and Reporting			X	E	Budget Holders; Heads of Division; Divisional Directors	not assessed	Capital Planning and Delivery Group; Strategic Capital Board; Executive Management Board; Fixed Assets Register Reporting	PA	Internal Audit / External Audit	PA

FSLTV15	Major Capital Programmes monitoring	Chief Executive			X	PE	Executive Budget Holders / Programme SROs; Scheme of Delegation and Governance Framework	not assessed	Capital Planning and Delivery Group; Strategic Capital Board; Executive Management Board	IA	Internal Audit / External Audit	IA
FSLTV16	Counter Fraud	Deputy Director of Finance / Head of Financial Operations		X		E	Budget Holders, reports and training	not assessed	Counter Fraud Reports; Audit Committee	PA	Internal Audit / External Audit	PA
FSLTV17	Tax management	Deputy Director of Finance / Head of Financial Operations			X	E	Budget holders, requisitioners, reports and training	not assessed	Financial Operations Team; VAT working group	PA	External Advisory (EY) / Internal Audit / External Audit / HMRC	PA
FSLTV18	Procurement	Executive Director of Finance / Deputy Director of Finance / Head of Procurement	X			PE	Exec Directors, Divisional Directors, Budget Holders, reporting and training	not assessed	Procurement Compliance reporting; Audit Committee	PA	Internal Audit / External Audit	IA

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.
Scheme of Delegation and Governance Framework for the nVCC to prepare for post financial close	Investment Appraisal assurance process improvement to ensure high quality of business case submissions and education of organisation with regards to appropriate funding routes for service developments and initiatives	F6 (Controls); F4 (Assurance)
	Medicines management requires more clarity on governance, decision making processes and financial implications including links between NWSSP, National forums and impact on local decision making in VCS.	F2

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	CURRENT RISK RATING	RISK TREND
3227	There is a risk to financial sustainability as a result of changes during the design development process leading to a design which costs more overall, increasing project costs. [Note added here outside of Datix that this relates to nVCC]	16	Risk Increasing

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
F1	Development of VBH programme of work to identify areas of unwarranted variation and actions to improve	EDoF / EMD / COO	4	Ongoing	VBH Programme of work under way overseen by the VBH Steering Group, including WBS Pre-Operative Anaemia project; Value Intelligence Centre and Food Mission	Dec-23	Identification of opportunities to reduce unwarranted variation and improved allocation and utilisation of resources will support financial sustainability	tbc
F2	Continuous improvement of Finance and Investment Enhanced Monitoring reporting including identification of Savings Opportunities; Disinvestments and Choices and clear line of sight with Welsh Government Value and Sustainability Board agenda	EDoF / DDoF	4	Ongoing	Pharmacy review has been conducted and will be presented to Exec Management Board early in 2024. Following this a review of medicines management governance (including financial aspects), will be conducted by September 2024.	Dec-23	Identification of opportunities for new savings initiatives and disinvestments / choices will support financial sustainability	tbc
F3	Development and review of Financial Control Procedures	EDoF / DDoF	6	Ongoing	Capital financial control procedure approved by Audit Committee	Dec-23	Strengthened control procedures will support risk mitigation	tbc
F4	Development of Investment Appraisal process and prioritisation framework	EDoF / EDoSTP&D / DDoF / DDoP	4	Sep-24	Criteria have been drafted and Board Reporting Template updated to reflect types of initiatives and sources of funding available for investments	Dec-23	Alignment of investment with strategic priorities will demonstrate goal congruence and increase the likelihood of securing funding for projects / initiatives	tbc
F5	Identification of business development and external funding opportunities	EDoF / EDoSTP&D / EMD / DDoF	4	Mar-24	Cardiff Cancer Research Hub market engagement exercise to identify potential sources of external funding to support development Strengthening private patient cash collection and pricing	Dec-23	Attracting external / alternative sources of income will decrease pressure on WG allocation of funds	tbc
F6	Develop Scheme of Delegation and Governance Framework for the nVCC	EDoF / DDoF	4	Jun-24	Scheme of Delegation and Governance Framework was approved in June-23 by the Trust Board. The first major programme this has been applied to is the IRS programme. A Scheme of Delegation and Governance Framework needs to be developed for nVCC	Dec-23	Mitigate the risks of non compliant procurement and improve budgetary control procedures by ensuring clear accountability for spend.	tbc

RISK DESCRIPTORS			
RISK NUMBER	**RISK THEME/TITLE**	**DRAFT RISK DESCRIPTION**	**RISK OWNER**
01	**Service Capacity**	There is a strategic risk of failure to deliver timely, safe, effective and efficient services for the local population leading to deterioration in service quality, performance or financial control as a result insufficient capacity and resources.	**Cath O'Brien Rachel Hennessey Alan Prosser**
02	**Partnership Alignment**	There is a strategic risk of failure to align our strategic objectives and intent with system partners, including within the health and social care system, third sector and industry partners which could result in an inability to deliver required change to achieve our medium to long term objectives.	**Carl James Nicola Williams Jacinta Abraham**
03	**Workforce Supply and Shape**	There is a strategic risk of an optimised workforce supply and shape in order to effectively deliver quality services and achieve our medium to long term objectives.	**Sarah Morley**
04	**Organisational Culture**	There is a strategic risk of failure to have a positive working environment and high levels of staff engagement through the embedding of appropriate values and behaviours in effective systems and processes.	**Sarah Morley**

05	**Digital Transformation**	There is a strategic risk that the Trust fails to sufficiently consider, optimise the opportunities and effectively manage the risks of new and existing technologies, including considerations of Artificial Intelligence and Information Security	**Carl James**
06	**Organisational and Clinical Governance**	There is a strategic risk that the organisational and clinical governance arrangements do not provide appropriate mechanisms and culture to achieve our medium to long term objectives.	**Lauren Fear**
07	**Patient Outcomes**	There is a strategic risk that Velindre Cancer Service patient outcomes / experience may be adversely affected due increasing service demands, the need for significant service delivery transformation to meet the rapidly changing and complex treatment regimes, staffing challenges, and lack of consistent quality, outcome and mortality metrics.	**Nicola Williams Jacinta Abraham Cath O'Brien**
08	**Financial Sustainability**	There is a strategic risk that the Trust becomes financially unsustainable if it does not secure sufficient funding for the provision of services and does not maximise its use of resources. Unwarranted variation could impact the value and effectiveness of the care our patients and donors receive.	**Matt Bunce**

DEFINITIONS

CONTROL EFFECTIVENESS

Effective	Control in implemented/ embedded; working as designed; with associated sources of assurance	E
Partially Effective	Some aspects of control to be implemented/ embedded; some aspects therefore not yet operating as designed; and may be gaps in associated sources of assurance	PE
Not yet Effective	Significant aspects of control be implemented/ embedded; significant aspects therefore not yet operating as designed; and gaps in associated sources of assurance	NE

ASSURANCE RATING		
Positive assurance	the assuring committee is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the threat or opportunity	PA
Inconclusive assurance	the assuring committee has not received sufficient evidence to be able to make a judgement as to the appropriateness of the current risk treatment strategy	IA
Negative assurance	the assuring committee has received reliable evidence that the current risk treatment strategy is not appropriate to the nature and / or scale of the threat or opportunity	NA
Not Assessed	Assessment of the assurance arrangements is pending.	Not Assessed

LEVELS OF ASSURANCE DESCRIPTORS

First Line of Defence	**Second Line of Defence**	**Third Line of Defence**
functions that own and manage risk	functions that oversee or specialise in risk management	functions that provide independent assurance

Self-Assurance	**Internal oversight/**specialist control teams, such as**:**	**Internal Audit** (provides assurance to the Board and senior management. This assurance covers how effectively the organisation assesses and manages its risks and will include assurance on the effectiveness of the first and second lines of defence); and **external oversight**, such as:
Risk and control management as part of day-to-day business management Staff training and compliance with policy guidance Teams take responsibility for their own risk identification and mitigation	Quality & Safety IT Governance (corporate/Clinical)	External Audit Regulators & Commissioners Wales Audit Office reviews Stakeholder reviews Scrutiny from public, Parliament, and the media
Examples of assurance	***Examples of assurance***	***Examples of assurance***
Management Controls / Internal Control Measures *Local management information / departmental management reporting* *Divisional / Departmental performance reviews, mandates, outcomes frameworks, objectives (Clinical and Nonclinical services)* *Operational planning / Business Plans - Delivery Plans and Action Plans* *Governance statements / self-certification* *Local procedures* *Exceptions reporting* *Targets, Standards and KPIs* *Incident Reporting* *Staff Training Programmes*	*Board, Committee and Management Structures which receive evidence from* *Finance reports* *KPI's and management information* *Quality, Safety and Risk reports* *Training records and statistics* *Performance reports* *BAF, VUNHS risk register* *Policies and Procedures including Risk Management Policy* *Compliance against Policies*	*Recent internal audit reviews and levels of assurance* *External Audit coverage* *Inspection reports / external assessment e.g. HIW / NHS Wales other regulator and Commissioner compliance reviews* *Patient Feedback / Patient experience feedback* *Staff surveys / feedback* *Comparative data, statistics, benchmarking*

STRATEGIC GOALS
1 - Outstanding for quality, safety and experience
2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations

KEY CONTROLS		
CONTROL TYPE	**DESCRIPTION**	**EXAMPLES**
Preventative	These controls are designed to limit the possibility of an undesirable outcome being realised. The more important it is to stop an undesirable outcome then the more important it is to implement appropriate	• Authorisation limits of and separation of duties • Pre-employment screening of potential staff

3 - A beacon for research, development and innovation in our stated areas of priority
4 - An established 'University' Trust which provides highly valued knowledge and learning for all
5 - A sustainable organisation that plays it part in creating a better future for people across the globe

RISK DESCRIPTORS	
Inherent Risk	Score the exposure before any action has been taken to manage it or if existing controls failed entirely
Residual risk	The threat that remains after all existing controls have been applied
Target risk	Where risks are outside acceptable levels, a target risk score is agreed. This is the level that future mitigation that should be achieved which will vary over time

	implement appropriate preventative controls.	
Mitigating	These controls are designed to limit the scope for loss and reduce any undesirable outcomes that have been realised. They may also provide a route of recourse to achieve some recovery against loss or damage.	• Passwords or other access controls • Staff rotation and regular change of supervisors • Exposure reduction by installation on hours worked
Detective	Control is designed to locate problems after they have occurred. Once problems have been detected, management can take steps to mitigate the risk that they will occur again in the future, usually by altering the underlying process.	• Periodic performance reporting • Regular review

RISK SCORE

LIKELIHOOD MATRIX					
LIKELIHOOD (*)					
LIKELIHOOD SCORE	**1**	**2**	**3**	**4**	**5**
DESCRIPTOR	**RARE**	**UNLIKELY**	**POSSIBLE**	**PROBABLE**	**EXPECTED**
Frequency: How often might it/does it happen	Not expected to occur for 10 years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Probability: Will it happen or not?	Less than 0.1% chance	01.-1% chance	1-10% chance	10-50% chance	Greater than 50% chance

RISK RATING MATRIX - IMPACT X LIKELIHOOD					
RISK MATRIX	**LIKELIHOOD(*)**				
CONSEQUENCE(**)	**1- Rare**	**2- Unlikely**	**3 - Possible**	**4 - Probable**	**5 - Expected**
1 -Negligible	1	2	3	4	5
2 - Minor	2	4	6	8	10
3 -Moderate	3	6	9	12	15
4 - Major	4	8	12	16	20
5 - Catastrophic	5	10	15	20	25

IMPACT MATRIX

RISK DOMAINS		Impact, consequence score (severity levels) and examples.				
		1	2	3	4	5
		NEGLIGIBLE	MINOR	MODERATE	MAJOR	CATASTROPHIC
01	Compliance *Statutory duty/ inspections*	No or minimal impact or breach of guidance/statutory duty	Minor breach of guidance/statutory duty Reduced performance rating if unresolved Verbal reports from Regulator	One breach guidance/statutory duty Challenging recommendations Observation reports from regulator	Multiple breaches in statutory duty Enforcement action Improvement notices	Multiple breeches in statutory duty Prosecution Severely critical report
02	Environmental *Environmental impact*	No or minimal impact on the environment	Minor impact on environment	Moderate impact on environment	Major impact on environment	Catastrophic impact on environment
03	Financial Sustainability *Including claims*	Insignificant cost increase Small loss risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim(s) less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Loss of 0.5-1.0 percent of budget Claim(s) between £100,000 and £1million	Loss of >1 per cent of budget Claim(s) >£1million
04	*Information Governance* General Data Protection *Regulation (GDPR)*	Minimal privacy impact requiring no or minimal intervention	Minor impact on an individual's privacy	Moderate privacy impact requiring professional intervention Possible ICO reportable breach Could result in an event which impacts on a moderate (less than 100) number of patients/donors	Major breach leading to possible larger scale privacy breaches Likely ICO reportable breach if IG standard not adhered to Could result in an event which impacts on a major (between 100 and 1000) number of patients/donors	Serious breaches and non-compliance Definite ICO report required if breach occurs Could result in an event which impacts on a major (more than 1000) number of patients/donors
05	Partnerships Relationships with internal and external stakeholders and in working with system partners	No or minimal issues in establishing and maintaining effective relationships with internal and external stakeholders No or minimal misalignment of operational actions or strategic approach with system partners Minimal issues with collaborative working initiatives within our cancer and blood and transplant systems	Minor issues in establishing and maintaining effective relationships with internal and external stakeholders Minor misalignment of operational actions or strategic approach with system partners Minor issues with collaborative working initiatives within our cancer and blood and transplant systems	Moderate issues in establishing and maintaining effective relationships with internal and external stakeholders Moderate misalignment of operational actions or strategic approach with system partners Moderate issues with collaborative working initiatives within our cancer and blood and transplant systems	Major issues in establishing and maintaining effective relationships with internal and external stakeholders Major misalignment of operational actions or strategic approach with system partners Major issues with collaborative working initiatives within our cancer and blood and transplant systems	Failure to establish and maintain effective relationships with internal and external stakeholders Severe misalignment of operational actions or strategic approach with system partners Severe issues with collaborative working initiatives within our cancer and blood and transplant systems

RISK DOMAINS		Impact, consequence score (severity levels) and examples.				
		1	2	3	4	5
		NEGLIGIBLE	MINOR	MODERATE	MAJOR	CATASTROPHIC
06	Performance and Service Sustainability *Business objectives/projects* *Service/business interruption*	Failure to achieve minor objective No or minimal service issue **Programme/ projects** Insignificant cost increase Less than 5 per cent schedule slippage against timescales	Failure to achieve significant/key objective. Minor impact on service. **Programme/ projects** 1-10 per cent over project budget. 5-10 per cent schedule slippage against timescales	Failure to achieve multiple significant/ key objectives. Moderate impact on service. **Programme/ projects** 10-25 per cent over project budget. 10-40 per cent schedule slippage against timescales	Failure to achieve crucial objectives. Major impact on service. **Programme/ projects** 25-50 per cent over project budget. 40-100 per cent schedule slippage against timescales	Gross failure to achieve multiple crucial objectives Service failure **Programme/ projects** >50 per cent over project budget More than 100 per cent schedule slippage against timescales
07	Quality *Quality/complaints/ audit / GxP*	Peripheral element of treatment or service suboptimal Informal complaint/enquiry Temporary insignificant impact upon process or performance with no impact on quality or safety of components produced. Donor/patient/staff discomfort	Overall treatment or service suboptimal Formal complaint (stage 1) Local Resolution Single failure to meet internal standards Temporary minor decline in existing performance or process, no impact on quality or safety of components produced. Donor/patient/staff discomfort, minor interventions required e.g., reassurance.	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Multiple failures to meet internal standards Temporary moderate erosion of existing performance or process, with the potential for impact on quality or safety of components produced. Short term harm, donor/patient/staff requiring treatment from medical practioner.	Non-compliance with national standards with significant risk to patients or donors if unresolved Multiple complaints/ independent review Multiple failures to meet national standards Sustained erosion of existing performance or process, tis has an effect on quality or safety of components produced. Donor/ /staff admission to hospital required, or increased stay in hospital >3days.	Non-compliance with national standards with severe risk to patients or donors if unresolved Inquest/ombudsman inquiry Gross failure to meet national standards Significant uncontrolled erosion of performance or process which has a serious effect on the quality and safety of components produced. Fatal, life threatening, disabling, prolonged hospitalisation, incapacitating the donor or patient if transfused. (SABRE)

08	Reputational *Adverse publicity/ reputation*	Potential for public concern	Local media coverage Minor reduction in public confidence	Local media coverage Moderate reduction in public confidence	National media Coverage with <3 days service well below reasonable public expectation Major reduction in public confidence	National media Coverage with >3 days service well below reasonable public expectation. Gross loss of public confidence
09	Research and Development	Departure from: Established good practice guidelines, and/or Procedural requirements	Departure from: Applicable legislative requirements, and/or Established Good Clinical Practice (GCP) guidelines, and/or	Deficiencies found during regulatory MHRA Good Clinical Practice inspections graded as "major" and/or "other" that leads to recommendations of:	Deficiencies found during regulatory MHRA Good Clinical Practice inspections graded as "critical" and/or "major" that leads to recommendations of:	Deficiencies found during regulatory MHRA Good Clinical Practice inspections graded as "critical" that leads to recommendations of: Communication of the critical findings to external parties, for

RISK DOMAINS		Impact, consequence score (severity levels) and examples.				
		1	2	3	4	5
		NEGLIGIBLE	MINOR	MODERATE	MAJOR	CATASTROPHIC
		has occurred in a Research Study that is not a Clinical Trial of an Investigation Medicinal Product.	Procedural requirements, and/or Good Clinical Practice (GCP) has occurred in a Clinical Trial of an Investigational Medicinal Product (CTIMP) but it is neither "critical" nor "major".	Request for provision of corrective action & preventive action plan (CAPA) updates at periodic intervals	Early re-inspection to determine adequate progress is observed in implementing a corrective action & preventive action (CAPA) plan Request for provision of corrective action & preventive action (CAPA) plan updates at periodic intervals For actions in relation to pending or future clinical trials (for example, suspension or revocation)	example, other competent authorities, other government departments or UK NHS Research Ethics Committees Meetings with senior representatives from the inspected organisations to review the implications of the critical findings, the organisation's proposed actions and the actions Infringement Notice Referral to the MHRA Enforcement Group for investigation with a view to criminal prosecution
10	Safety *Impact on safety of patients, staff or public (physical or psychological harm)*	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a number of patients or donors	Major injury leading to long-term incapacity /disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days RIDDOR/agency reportable incident Mismanagement of patient or donor care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects RIDDOR/agency reportable incident An event which has an effect on a large number of patients or donors
11	Workforce and OD *Human resources/ organisational development/ staffing/ competence*	Short term low staffing level that temporarily reduces service quality (<1day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff. Very low staff morale Very poor staff attendance mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff Very poor staff attending mandatory training /key training on an ongoing basis

DETAILED DEFINITIONS OF 7 LEVELS OF EVALUATION TO DETERMINE RAG RATING / OPERATIONAL

RAG rating	ACTIONS	OUTCOMES
Level 7	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes over a defined period of time i.e., 3 months.
Level 6	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic	Evidence of delivery of the majority or all of the agreed actions, with

SUMMARY STATEMENTS OF 7 LEVELS

RAG rating	SUMMARY
7	Improvements sustained over time - BAU
6	Outcomes realised in full

	causes/reasons for performance variation.	clear evidence of the achievement also of desired outcomes.			
Level 5	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with little or no evidence of the achievement of desired outcomes.		5	Majority of actions implemented; outcomes not realised as intended
Level 4	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of several agreed actions being delivered, with little or no evidence of the achievement of desired outcomes.		4	Increased extent of impact from actions
Level 3	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Some measurable impact evident from actions initially taken AND an emerging clarity of outcomes sought to determine sustainability, with agreed measures to evidence improvement.		3	Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes
Level 2	Comprehensive actions identified and agreed upon to address specific performance concerns.	Some measurable impact evident from actions initially taken.		2	Symptomatic issues being addressed
Level 1	Initial actions agreed upon, these focused upon directly addressing specific performance concerns.	Outcomes sought being defined. No improvements yet evident.		1	Actions for symptomatic issues, no defined outcomes
Level 0	Emerging actions not yet agreed with all relevant parties.	No improvements evident.		0	Enthusiasm, no robust plan

EXTRAORDINARY JOINT MEETING OF THE AUDIT COMMITTEE AND QUALITY, SAFETY AND PERFORMANCE COMMITTEE

AUDIT COMMITTEE TERMS OF REFERENCE

DATE OF MEETING	21/03/2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	ENDORSE FOR APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
PRESENTED BY	Matthew Bunce, Executive Director of Finance
APPROVED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SUMMARY	In accordance with the Audit Committee Cycle of Business, the latest version of the Audit Committee Terms of Reference have been brought to the Committee for review.
RECOMMENDATION / ACTIONS	The Audit Committee is asked to **ENDORSE FOR APPROVAL** the Audit Committee Terms of Reference for Trust Board Approval.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Audit Committee	**12/03/2024**
Executive Management Board	**18/03/2024**
The Audit Committee reviewed the Terms of Reference at its 12th March 2024 meeting and requested these be taken through Executive Management Board meeting, and then back to the Extraordinary Audit & QSP Committee on the 21st March **to be ENDORSED** for Trust Board **APPROVAL**. Executive Management Board reviewed and agreed recommended changes to the Terms of Reference to be **ENDORSED** by Audit Committee **FOR APPROVAL** at Trust Board, at its meeting on the 18 March 2024.	

7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Select Current Level of Assurance

APPENDICES	
Appendix 1	Audit Committee Terms of Reference – with track changes

1. SITUATION

In accordance with the Audit Committee Cycle of Business, the latest version of the Audit Committee Terms of Reference have been brought to the Committee for review.

2. BACKGROUND

3. ASSESSMENT

4. SUMMARY OF MATTERS FOR CONSIDERATION

The Audit Committee Terms of Reference have updated as appropriate since the previous version but today is opened to the Audit Committee members for any comments or recommended changes.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☒ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☒ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	Choose an item
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒

	Efficient ☒ Patient Centred ☒
	Evidence suggests there is correlation between governance behaviours in an organisation and the level of performance achieved at that same organisation. Therefore, enduing good governance within the Trust can support quality care.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	**Choose an item**
	Click or tap here to enter text. Not applicable
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	If more than one Well-being Goal applies please list below:
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Source of Funding: **Choose an item** Please explain if 'other' source of funding selected:

	Click or tap here to enter text **Type of Funding:** Choose an item **Scale of Change** Please detail the value of revenue and/or capital impact: Click or tap here to enter text **Type of Change** Choose an item Please explain if 'other' source of funding selected: Click or tap here to enter text
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required *Not applicable*
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report. Click or tap here to enter text

6. RISKS

This section should indicate whether any matters addressed in the report carry a significantly increased level of risk for the Trust – and if so, the steps that will be taken to mitigate the risk - or if they will help to reduce a risk identified on a previous occasion.

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	*[Please insert detail here in 3 succinct points].*

WHAT IS THE CURRENT RISK SCORE	Insert Datix current risk score
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	*[In this section, explain in no more than 3 succinct points what the impact of this matter is on this risk].*
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Insert Date
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	**Choose an item**
	[In this section, explain in no more than 3 succinct points what the barriers to implementation are].
All risks must be evidenced and consistent with those recorded in Datix	

Audit Committee

Terms of Reference & Operating Arrangements

Reviewed:	January 2023
Approved:	January 2023
Next Review Due:	January 2024

1. INTRODUCTION

1.1 The Trust's standing orders provide that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees*".

1.2 In line with standing orders and the Trust's scheme of delegation, the Board shall nominate annually a Committee to be known as the **Audit Committee**. The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below.

1.3 These Terms of Reference and Operating Arrangements are based on the model Terms of Reference as detailed in the NHS Wales Audit Committee Handbook June 2012.

2. PURPOSE

2.1 The purpose of the Audit Committee ("the Committee") is to:

- ***Advise*** and ***assure*** the Board and the Accountable Officer on whether effective arrangements are in place - through the design and operation of the Trust's **system of assurance** - to support them in their decision taking and in discharging their accountabilities for securing the achievement of the Trust's objectives, in accordance with the standards of good governance determined for the NHS in Wales.

2.2 Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.

2.3 A separate Audit Committee is in operation for the NHS Wales Shared Services Partnership (NWSSP) which has its own Terms of Reference.

3. DELEGATED POWERS AND AUTHORITY

3.1 With regard to its role in providing advice to the Board, the Committee will comment specifically upon:

- The adequacy of the Trust's strategic governance and assurance arrangements and processes for the maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical) designed to support the public disclosure statements that flow from the assurance processes, including the Annual Governance Statement, providing reasonable assurance on:
  - the organisation's ability to achieve its objectives,
  - compliance with relevant regulatory requirements, standards, quality and service delivery requirements and other directions and requirements set by the Welsh Government and others,

- the reliability, integrity, safety and security of the information collected and used by the organisation,

- the efficiency, effectiveness and economic use of resources, and

- the extent to which the organisation safeguards and protects all its assets, including its people to ensure the provision of high quality, safe healthcare for its citizens;

- The Board's Standing Orders, and Standing Financial Instructions (including associated framework documents, as appropriate);

- The accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified, the ISA 260 Report 'Communication with those charged with Governance' and managements' letter of representation to the external auditors;

- The Schedule of Losses, Compensation and Special Payments;

Deleted: and

- The planned activity and results of internal audit, external audit, clinical audit and the Local Counter Fraud Specialist (including strategies, annual work plans and annual reports);

- The adequacy of executive and managements' response to issues identified by audit, inspection and other assurance activity via monitoring of the Trust's audit action plan;

- Anti-fraud policies, whistle-blowing processes and arrangements for special investigations as appropriate; and

- Any particular matter or issue upon which the Board or the Accountable Officer may seek advice from the Committee.

3.2 The Committee will support the Board with regard to its responsibilities for governance (including risk and control) by reviewing:

- All risk and control related disclosure statements (in particular the Annual Governance Statement together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances), prior to endorsement by the Board;

- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;

- The policies for ensuring compliance with relevant regulatory, legal and code of conduct and accountability requirements; and

- The policies and procedures for all work related to fraud and corruption as set out in Welsh Government Directions and as required by the NHS Counter Fraud Authority.

3.3 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from other assurance providers, regulators, directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.

3.4 This will be evidenced through the Committee's use of effective governance and assurance arrangements to guide its work and that of the audit and assurance functions that report to it, and enable the Committee to review and form an opinion on:

- The comprehensiveness of assurances in meeting the Board and the Accountable Officer's assurance needs across the whole of the Trust's activities, both clinical and non-clinical; and

- The reliability and integrity of these assurances.

3.5 To achieve this, the Committee's programme of work will be designed to provide assurance that:

- There is an effective internal audit function that meets the standards set for the provision of internal audit in the NHS in Wales and provides appropriate independent assurance to the Board and the Accountable Officer through the Committee;

- There is an effective counter fraud service that meets the standards set for the provision of counter fraud in the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee;

- There is an effective clinical audit function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee;

- There are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the Board and the Accountable Officer or through the work of the Board's Committees through the effective completion of Audit Recommendations and the Committee's review of the development and drafting of the Trust's Annual Governance;

- The work carried out by key sources of external assurance, in particular, but not limited to the Trust's external auditors, is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity;

- The work carried out by the whole range of external review bodies is brought to the attention of the Board, and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, and the risks of failing to comply;

- The systems for financial reporting to the Board, including those of budgetary control, are effective; and that

- The results of audit and assurance work specific to the Trust, and the implications of the findings of wider audit and assurance activity relevant to the Trust's operations are appropriately considered and acted upon to secure the ongoing development and improvement of the organisation's governance arrangements.

In carrying out this work, the Committee will follow and implement the Audit Committee's Annual Work plan and will be evidenced through meeting papers, formal minutes, and highlight reports to Board and annually via the Annual Governance Statement and Annual Report to the Board.

Authority

3.6 The Committee is authorised by the Board to investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Trust relevant to the Committee's remit, and ensuring patient/client and staff confidentiality, as appropriate. It may seek relevant information from any:

- Employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and

- Any other Committee, sub Committee or group set up by the Board to assist it in the delivery of its functions.

3.7 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

3.8 The Committee is authorised by the Board to approve policies relevant to the business of the Committee as delegated by the Board.

Access

3.9 The Head of Internal Audit and the Auditor General for Wales and his representatives shall have unrestricted and confidential access to the Chair of the Audit Committee at any time, and the Chair of the Audit Committee will seek to gain reciprocal access as necessary.

3.10 The Committee will meet with Internal and External Auditors and the nominated Local Counter Fraud Specialist without the presence of officials on at least one occasion each year.

3.11 The Chair of Audit Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.12 The Committee may, subject to the approval of the Trust Board, establish sub Committees or task and finish groups to carry out on its behalf specific aspects of Committee business. At this stage, no sub Committees/task and finish groups have been established.

4. MEMBERSHIP

Members

4.1 A minimum of three (3) members, comprising:

Chair	Independent member of the Board (Non-Executive Director)
	Two independent members of the Board (Non-Executive Directors) *[one member should be a member of the Quality, Safety & Performance Committee]*
	The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.
	The Chair of the organisation shall not be a member of the Audit Committee.
	It is considered best practice that the Vice Chair of the Trust Board does not chair the Audit Committee.

Attendees

4.2 In attendance:

Chief Executive (*who should be present when the Committee considers the Internal Audit Plan, the Annual Governance Statement, Annual Quality Statement and the Annual Accounts.)*
Executive Director of Finance
Director of Corporate Governance and Chief of Staff
Head of Internal Audit
Head/individual responsible for Clinical Audit
Local Counter Fraud Specialist
Representative of the Auditor General for Wales
Other Executive Directors / Directors will attend as required by the Committee Chair and their attendance will be required when they are Lead for an Audit Report

By invitation — The Committee Chair may invite:

- the Chair of the Trust
- any other Trust officials; and/or
- any others from within or outside the organisation

to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

4.3 Secretary — As determined by the Director of Corporate Governance and Chief of Staff

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Member Appointments

4.4 The membership of the Committee shall be determined by the Board, based on the recommendation of the Trust Chair - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

4.5 Members shall be appointed for a maximum of 3 consecutive years before formally reviewing their role on the Committee. During this time a member may resign or be removed by the Board.

Support to Committee Members

4.6 The Director of Corporate Governance and Chief of Staff, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and
- Ensure the provision of a programme of organisational development for Committee members as part of the Trust's overall Organisational Development programme developed by the Executive Director of Workforce & Organisational Development.

5 COMMITTEE MEETINGS

Quorum

5.1 At least two members must be present to ensure the quorum of the Committee.

Frequency of Meetings

5.2 Meetings shall be held no less than 4 times per year, and otherwise as the Chair of the Committee deems necessary – consistent with the Trust's annual plan of Board Business. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

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Withdrawal of individuals in attendance

5.3 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6 RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES / GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, the Board retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

6.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees to provide advice and assurance to the Board by taking into account:

- Joint planning and co-ordination of Board and Committee business; and
- Sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

6.4 The Committee will consider the assurance provided through the work of the Board's other Committees and sub Committees to meet its responsibilities for advising the Board on the adequacy of the Trust's overall system of assurance by receipt of their annual work plans.

6.5 The Committee shall embed the duty of quality through the Heath and Care Quality Standards through the conduct of its business.

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7 REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- Report formally, regularly and on a timely basis to the Board and the Accountable Officer on the Committee's activities. This includes verbal updates on activity and the submission of written highlight reports throughout the year;
- Bring to the Board and the Accountable Officer's specific attention any significant matters under consideration by the Committee;
- Ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant Committees of any urgent/critical matters that may affect the operation and/or reputation of the Trust.

7.2 The Committee shall provide a written, annual report to the Board and the Accountable Officer on its work in support of the Annual Governance Statements, specifically commenting on the adequacy of the assurance arrangements, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the Committee's self-assessment and evaluation.

7.3 The Director of Corporate Governance and Chief of Staff, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any sub Committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook.

8 APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum *[as per section on Committee meetings]*

Cross reference with the Trust Standing Orders.

9 REVIEW

9.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee with reference to the Board.

10 CHAIR'S ACTION ON URGENT MATTERS

10.1 There may, occasionally, be circumstances where decisions which normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance and Chief of Staff as appropriate, may deal with the matter on behalf of the Committee, after first consulting with two other Independent Members of the Committee. The Director of Corporate Governance and Chief of Staff must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

10.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

EXTRAORDINARY JOINT MEETING OF THE AUDIT COMMITTEE AND QUALITY, SAFETY AND PERFORMANCE COMMITTEE

ALL WALES FLEXIBLE WORKING POLICY

DATE OF MEETING	21 March 2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	ENDORSE TO ADOPT
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Amanda Jenkins, Head of Workforce
PRESENTED BY	Sue Thomas, Deputy Director of Organisational Development & Workforce
APPROVED BY	Sarah Morley, Executive Director of Organisational Development & Workforce
EXECUTIVE SUMMARY	The policy has been developed in partnership and the final version was agreed by the Welsh Partnership Forum on 16 November 2023 and now becomes the contractual policy for the application of flexible working within the NHS in Wales and can only be amended through agreement by the Welsh Partnership Forum.
RECOMMENDATION / ACTIONS	The Committees are asked to **ENDORSE THE ADOPTION** of the All Wales Flexible Working Policy for implementation in the Trust.

APPENDICES	
Appendix 1	All Wales Flexible Working Policy

1. SITUATION

This report provides an update made to Workforce and OD Policies, bringing them up to date with current employment legislation and best practice.

2. SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The All Wales Flexible Working Policy has been developed in partnership and the final version was agreed by the Welsh Partnership Forum on 16 November 2023 and now becomes the contractual policy for the application of flexible working within the NHS in Wales and can only be amended through agreement by the Welsh Partnership Forum.

The policy will be reviewed in accordance with the All Wales Policy Development Protocol at intervals determined by the Welsh Partnership Forum.

The All Wales Flexible Working Policy is a new policy that:

- Encompasses legislative changes for day one rights.
- Incorporates the Principles of hybrid working within NHS Wales.
- Has a detailed process for managing flexible working requests.

3. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals:	
• Outstanding for quality, safety and experience	☒
• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations	☒
• A beacon for research, development and innovation in our stated areas of priority	☐
• An established 'University' Trust which provides highly valued knowledge for learning for all.	☐
• A sustainable organisation that plays its part in creating a better future for people across the globe	☒

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	03 - Workforce Planning 04 – Organisational Culture Having appropriate people related polices ensure staff know the expectations upon them to deliver the role they are employed to undertake.
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	When staff have clear guidance and expectations set through relevant policies and procedures there is improved impact on the work undertaken.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Yes
	Ensuring the trust has adequate policies and procedures that are full assessed against the impact on equality and socio-economic duty ensure that there are no adverse impacts on people who may be at a disadvantage. There are no identified impactors in any of the policies or procedures outlined in the paper.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances
	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	Having a set of standards and principles that all staff work towards, that have been full assessed for their socio-economic impact and equality impact ensures people are clear on the expectations set for them by the Trust. This will provide a healthier workplace where people feel they have physical and mental well-being in the workplace.

FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Yes - please outline what, if any, actions were taken as a result
	All Wales Policy Development Group undertook assessment in line with national guidance. No identified issues but in fact data demonstrates the positive impact of flexible working on protected characteristics.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Not having relevant policies and procedures could lead to employment law challenges because people won't know the expectations upon them from the Trust.

4. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

NHS Wales Employers
Cyflogwyr GIG Cymru

THE WELSH NHS CONFEDERATION
CONFFEDERASIWN GIG CYMRU

NHS Wales Employers is hosted by and operates as a part of the Welsh NHS Confederation

LHB/Trust/SHA Chief Executives
LHB/Trust/SHA Chairs
LHB/Trust/SHA Directors of Workforce & Organisational Development
WPF Members

4th January 2024

Dear colleague,

NHS Wales Flexible Working Policy

Please find attached the Flexible Working Policy for NHS Wales. Text boxes are included in the document for the organisation's name to be inserted.

The policy has been developed in partnership and the final version was agreed by the Welsh Partnership Forum on 16 November 2023 and now becomes the contractual policy for the application of flexible working within the NHS in Wales and can only be amended through agreement by the Welsh Partnership Forum.

I should be grateful if you would make arrangements for the revised policy to be adopted by your Board (or sub-committee) and implemented at the earliest opportunity. Individual organisations will need to consider, in partnership, their own implementation arrangements including the development of joint training programmes and awareness raising for staff at all levels.

The policy will be reviewed in accordance with the All Wales Policy Development Protocol at intervals determined by the Welsh Partnership Forum.

Yours sincerely

Sue Green
Director
NHS Wales Employers
On behalf of the Joint Chairs of the Welsh Partnership Forum

Ty Phoenix, 8 Cathedral Road, Cardiff, CF11 9LJ
Tel: 029 2034 9850

All Wales

Flexible Working Policy

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01 & 02
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Approved by: Welsh Partnership Forum

Issue Date: December 2023

01 & 02

Policy Statement and Scope

Approved by: Welsh Partnership Forum

Issue Date: December 2023

1. Policy Statement

1.1 Within NHS Wales we know that to meet the health and care needs of our population effectively it is important to have a workforce which is healthy, engaged and motivated. We are committed to being a great place to work and learn and to the delivery of a quality service, acknowledging that our workforce is fundamental to our success.
We recognise our responsibility to attract, retain, deploy and develop people to maximise their potential.

One of the ways of achieving this is to develop and maintain a culture where flexible working is seen as an enabler for effective and efficient provision of services which has benefits for colleagues, patients and the organisation. NHS Wales is committed to promoting and encouraging different ways of working in order to recruit excellent people and retain the wealth of knowledge, skills and experience of its current workforce.

1.2 Flexibility in employment helps people to balance work responsibilities with other aspects of their lives and to meet the needs which may arise at different stages of their lives. Key to achieving this is the provision and availability of flexible working opportunities which allow employees to make choices about how and when they wish to work accompanied by policies which support managers to take the time to understand what each person needs.

1.3 The NHS Wales Approach to Flexible Working is set out in statement which was developed and agreed in partnership. The aim of this approach is to support managers to make a cultural shift so that rather than "We can't do this because…" the question becomes "How can we make this happen"?

This means that the default position will be that a request for flexible working will be approved, and every possible avenue explored to facilitate this, unless there are clear business reasons in policy and law to decline it. This Policy sets out the principles underpinning flexible working arrangements that allow people to balance work responsibilities with other aspects of their lives and describes the processes to be followed when making or considering a request.

1.4 Flexibility in employment is a key factor in demonstrating NHS Wales commitment to fair and equal treatment in the workplace and in attracting the highest calibre of employees to work for the organisation. Flexible working opportunities should be considered for all employees and made available as far as practicable, regardless of role, shift pattern, team or pay band and should also be considered for employees who work on rotation.

It is not sufficient for departments who have a traditional way of working to reject an application for flexible working just because it has not been tried before or because 'this is how it has always been done'.

1.5 All NHS organisations should proactively encourage and promote opportunities to work flexibly and use the resources available to them e.g., education, management and leadership programmes to advocate for the benefits of flexible working and move towards a culture which accepts it as the norm. Wherever possible, managers should consider how work can be undertaken flexibly and be supportive of flexible working requests from employees to better manage their work life balance, while maintaining service standards.

1.6 To support a positive culture of flexible working, organisations will need to consider how they support and encourage open conversations about flexible working. Examples of opportunities to talk about flexible working include at one-to-one line management / supervision meetings, team / departmental meetings, as part of wellbeing conversations, or as part of recruitment, induction, and annual appraisal processes.

When advertising a job, employing organisations also need to consider how they promote the right to request flexibility from day one and the availability of flexible working options.

1.7 NHS Wales is committed to treating all people equally and with respect irrespective of their age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion or belief, sex, or sexual orientation. An Equality Impact Assessment of this Policy has been completed.

2. Scope

The policy applies to all employees of the

from day one of their employment. However, flexible working arrangements for doctors in training are arranged by and subject to the approval of the Medical Deanery, HEIW.

03

Principles

03 Principles

3. Principles

3.1 The NHS in Wales is committed to a flexible working culture, which means that a request for flexible working will be approved, and every possible avenue explored to facilitate this, unless there are clear business reasons as set out in this Policy to reject it.

Good flexible working arrangements should balance the needs of the individual with three key organisational factors: patient/service-user experience, service delivery and employee experience.
It may not be possible to agree to the exact request, but managers are expected to discuss alternative arrangements with the individual to ensure that all avenues have been explored before rejecting the request.

3.2 All employees should have equal access to flexible working, as far as practicable, regardless of role, shift pattern, team or pay band and all posts can be considered for flexible working. Although it is recognised that some posts may not be suitable for all types of flexible working arrangements in their entirety, managers should consider whether certain elements of the role can be worked flexibly.

3.3 Employees can request to work flexibly from day one of their contractual employment and can make more than one flexible working request per year regardless of the reasons for them.

3.4 Employees will be treated fairly when having requests for flexible working considered. Each request for flexible working will be received openly by the appropriate line manager and considered individually on its own merits. Any request for flexible working should be approached on the assumption that it will be granted unless there is a legitimate business reason for refusal. However, consideration should be given to any potential impact on other employees and service delivery, including potential additional costs.

3.5 It is important that it is agreed from the outset whether the new working arrangements are permanent or temporary and this must all be documented in writing. Where the arrangement is temporary or for a fixed period, they must be reviewed regularly to ensure the needs of the service and of the individual are still being met.

3.6 Employees who are working flexibly will not be treated less favorably in relation to access to training and development opportunities or promotion opportunities.

3.7 No form of flexible working will allow employees to work in breach of the Working Time Regulations.

3.8 Although there is no limit on the number of requests an employee can make within a 12-month period, employees are asked to not simply re-submit requests that have been rejected without modification and/or a change in circumstances within the department. Instead, they are encouraged to maintain a regular conversation with their manager so that if anything changes both parties are aware and can respond to that change.

3.9 Changes to an employee's contract of employment must be confirmed in writing.

04 Benefits of Flexible Working

04 Benefits of Flexible Working

4. Benefits of Flexible Working

Flexible working benefits individuals not only in allowing them to balance their personal life with their working life but in enhancing general health and wellbeing.

Individuals that are happier with their balance between life in and out of work are generally more productive, produce better quality work and are more caring. For managers, flexible working can help retain employees– and holding onto experienced and skilled people is important in maintaining quality and containing costs.

Offering flexible hours widens the talent pool, so managers should be able to recruit people with more skills; it can also increase commitment and loyalty of employees and can benefit through reducing levels of absenteeism and stress.

Flexible working can also support service redesign through the creation of new blended roles and the reshaping and development of existing roles, in consultation with employees. The creative use of new and redesigned roles can result in improved services for patients and more rewarding careers for our workforce.

05 Flexible Working Request Process

05 Flexible Working Request Process

5. Flexible Working Request Process

5.1 There may be a number of reasons why employees may need to adopt a more flexible working arrangement for a short period (i.e., up to 8 weeks) to address a particular issue. Where this is the case, it may be appropriate for the employee and the manager to discuss and agree this informally, particularly where the change has no impact on their other terms and conditions (e.g., pay). However, the outcome of the discussion should be documented and confirmed in writing.

5.2 Making the request

Where the employee wishes to apply for a form of flexible working on a permanent or longer-term basis, they should complete a Flexible Working Request Form (Appendix 1) or complete the request on ESR and submit it to their line manager. The employee may wish to have an informal discussion with their manager before submitting a formal request and managers are encouraged to facilitate this when requested to do so. However, the request will not be formally considered until it is put into writing.

The request form must contain the following information: -

- It must be dated and specify the change to working arrangements that they are seeking, and when they would like this change to come into effect

- Where applicable, the applicant is encouraged to state if they are making the request in relation to the Equality Act 2010, for example, as a reasonable adjustment for a disability, or on return from maternity leave, or when it is for childcare or dependants care.

5.3 Responding to a Request

5.3.1 Managers should be aware that there is a legal requirement to consider the application and inform the individual of the outcome within 2 months and should take this into consideration to ensure they have an adequate time frame to give the request due consideration.

5.3.2 The manager should arrange to discuss the application with the employee as soon as possible after receiving their request form (this can be in person, by telephone or via MS Teams). This will allow them to get a better understanding of the changes their employee is looking for and how they see things working in practice. The discussion should explore how the proposed working arrangement will work in practice, any potential positive and negative impact it may have on service provision and how it may affect other team members.

Employees have the right to be accompanied by a workplace colleague or a trade union representative at this meeting.

If the manager intends to approve the request, this meeting is not a requirement, but it may still be helpful to discuss practical arrangements.

5.3.3 Managers must consider whether the request is in relation to a reasonable adjustment related to a disability or another protected characteristic. Employees are encouraged to identify where this is the case. Managers should also consider any health and safety issues that might result from the change and identify ways to mitigate them (e.g., if the working arrangements will mean the employee or their colleagues would become lone workers). Advice can be sought from People Services/Human Resources/W&OD, Health and Safety and Occupational Health as appropriate.

5.4 Considering the Request

5.4.1 All requests should be approached with a can-do attitude, with the presumption that they will be granted unless it is genuinely not possible to do so for one of the business reasons set out below. The request should be considered carefully and the benefits of implementing the change should be weighed against any costs. In considering the application line managers must ensure that they do not directly or indirectly discriminate against the employee. If there is any doubt about what that might entail, then advice can be sought from the local EDI or People Services/Human Resources/ W&OD team.

Once a decision is made the manager should inform the employee in writing using part 3 of the request form or via ESR.

5.4.2 If it is decided to approve the employee's application, or accept it with modifications, a discussion should take place to determine how and when the changes might be best implemented. This may include a trial period. The line manager is responsible for ensuring that Payroll are notified if there are any changes to pay.

The employee must discuss and agree how they will organise their work and achieve deadlines in conjunction with their manager. Arrangements must be made between the employee and their manager to ensure that they are informed of the employee's current duties and where / how they will be working.

5.4.3 All endeavours must be made to accommodate the request in full or in part, or by providing an alternative. If, after discussing with the employee and considering all of the alternatives available, the manager feels they are unable to support flexible working in a particular post, they should discuss the application with People Services/Human Resources/ W&OD.

If following this conversation, they still do not feel able to approve the request and cannot find a mutually agreeable alternative they must meet with the employee to explain this to them and provide written, objectively justified reasons for this and give a clear operational reason why this is not practicable. The manager must provide details of the business grounds for refusing the request and how they apply in this case. The only acceptable reasons are:

- Burden of additional cost
- Detrimental effect on ability to meet customer/patient needs
- Inability to re-organise work among existing employees
- Detrimental impact on quality
- Detrimental impact on performance
- Detrimental impact on the ability to meet service demands
- Insufficient work for the periods the employee proposes to work
- Planned structural changes to the department.

5.4.4 There may be occasions when the manager is unsure whether a flexible working arrangement is sustainable, or where there is concern about the possible impact on others in the department. In these cases, the manager may agree to the flexible working arrangements on a temporary or trial basis rather than rejecting the request. Advice should be sought from People Services/Human Resources/W&OD.

5.5. Escalation Stage

5.5.1 This stage should be used if a line manager has not been able to reach agreement on a solution in the exploratory stage. The purpose is to check for other possible solutions including whether the form of flexibility the individual is seeking could be accommodated in a different team, location or role.

If a request for flexible working has not been accommodated, and they no longer feel able to continue to work in that department as they are unable to balance their work / life responsibilities, managers are expected to support the individual in identifying any alternative roles within the organisation which may be more supportive of the individual's circumstances and in line with their request.

5.5.2 When a meeting is arranged to discuss the application, or to consider an appeal, and the employee fails to attend it or one further rearranged meeting without good reason, the manager is able to consider that the request is withdrawn. If the manager regards the application as withdrawn, they must inform the employee of this.

5.6 Timescales

When the manager receives the formal request for flexible working this must be considered and decided on within a period of 2 months from first receipt of the request. This two-month time limit is a legal requirement and cannot be extended unless mutually agreed by the manager and employee.

Managers must be mindful of this 2-month time period when arranging the initial meeting/conversation with the employee to ensure that all applications are dealt with within the required timescales.

NHS Wales employees also have the right to request an appeal if their request is turned down. The timescales for an appeal are set out below.

5.7 More than one request received at around the same time.

It is important that managers consider requests to work flexibly in a fair way but there is no statutory requirement to consider them strictly in the order in which they are received. If they receive more than one request to work flexibly at around the same time it may not be possible to support all the requests received. The manager must then look closely at the impact supporting the requests would have on the service and the potential impact that refusal would have on each employee before coming to a decision.

In deciding how to deal with competing requests, the manager should bear in mind the different legal obligations that apply and can seek advice from the local EDI or People Services/Human Resources/W&OD team.

It will be helpful to have an individual discussion with both (or all) of the applicants to understand the exact nature of their request and to see if any mutually agreeable arrangement can be found.

5.8 Appeals

5.8.1 Where the flexible working request is refused, the employee may lodge an appeal within 14 days of being notified of the refusal of their request by contacting their manager's line manager.

This must be in writing and clearly state the grounds on which they are appealing. These may be:

- Where new information is now available in relation to the request
- Where the employee feels that the application was not handled in line with the policy
- Where the employee may have a proposal that has not been fully considered in relation to a business reason for refusal.

5.8.2 An appeal meeting will be held, normally within one month of receipt of the written appeal. This will be dealt with impartially by a more senior person than the manager who made the original decision.

Employees should be given the opportunity to be accompanied by a trade union representative or work colleague at any appeal meeting. The outcome of the appeals will be communicated in writing within seven days of the appeal meeting. This is the end of the procedure and there is no further appeal, although further requests for flexible working can be submitted.

5.9 Review of Flexible Working Arrangements

5.9.1 Before a final decision is reached about whether or not a flexible working arrangement can be supported, it may be beneficial to have an initial trial period of 3 months and to review the arrangement after this period to ensure that it is working for both the employee and the service.

5.9.2 When a flexible working arrangement has been agreed on a temporary basis, it is important to review it at agreed intervals to determine if it should be extended or come to an end at the agreed date.

In all cases, it is recommended that the flexible working arrangement is discussed annually (e.g., at appraisal) to ensure that it is still working for both parties. Where the arrangements are agreed as permanent from the outset or following the recommended three-month trial, it may not always be possible for the employee to resume their previous working arrangements as other colleagues may have been appointed to cover the shortfall created by the flexible working arrangement or service redesign may have taken place.

This must be explained to the employee during the initial discussions. However, any request to revert to the former working arrangements should be considered by the manager and agreed where it is possible to do so.

5.9.3 Where the manager believes that the flexible working arrangements are no longer sustainable and need to be changed this may be agreed informally between the manager and the employee as part of the ongoing conversation between them. Where the agreement is to be terminated/changed reasonable notice should be given to enable both parties to make the appropriate transitional arrangements however, wherever possible a meaningful discussion should take place and a mutually agreeable arrangement found.

06 & 07

Correspondence & Terms and Conditions Considerations

06 & 07 Correspondence & Terms and Conditions Considerations

6. Correspondence

Copies of all correspondence in relation to requests should be kept on the employee's personal file and details of the arrangements agreed should be recorded on ESR to enable monitoring of the flexible working arrangements in place at an organisational level.

7. Terms and Conditions Considerations

Listed below are the general terms and conditions which apply to flexible working arrangements. Managers should ensure that they discuss them with employees who are interested in working flexibly to ensure that they understand any potential implications. In addition, employees considering making a request for flexible working should consider the effect of the arrangement on their salary and pension and take advice from the NWSSP Payroll/ Pensions Department where necessary.

- **Hours of Duty**
  Where flexible working arrangements are put into place the exact hours and how they are worked should be discussed and agreed before the change is put into place

- **Annual Leave**
  Annual leave will be calculated on a pro rata basis, as appropriate

- **Sick Pay**
  Sick pay entitlement is pro rata and dependent on length of service. Employees working on any flexible arrangements must report sick in the same way as if they were not working flexibly

- **Maternity/ New parent /Adoption/ Shared Parental Leave**
  Pay is pro rata (as appropriate) and is dependent on length of service. Following maternity /adoption or shared parental leave an employee may wish to return to work on adjusted working arrangements to accommodate their changed circumstances. The NHS Organisation has a duty to accommodate this where at all possible. If it is agreed that the employee will return to work on a flexible basis, including changed or reduced hours, for an agreed temporary period this will not affect the employee's right to return to their job under their original contract at the end of the agreed period

- **Pensions**
  Pension contributions will be pro rata for employees working less than full-time hours

- **Expenses**
  All expenses incurred (e.g., subsistence, travelling) will be paid in the same way as for full-time employees. All employees will retain a NHS Organisation base for the purpose of claiming travel expenses

- **Pay**
  Salary will be pro rata for employees on less than full-time contracts. Those on Term Time working and seasonal contracts will be paid in 12 equal instalments each year

- **Additional Hours**
  If employees work beyond their normal hours (but not outside normal full-time hours) this must be by agreement with the line manager and will be paid at plain time rate or taken as time off in lieu

- **Policies and Procedures**
  Employees working flexibly remain subject to all Policies and Procedures of the Health Board/Trust.

08 & 09

Other Associated Documents & Monitoring and Review

8. Other Associated Documents

This Policy should be read in conjunction with other All Wales and local policies on:

- Managing Attendance at Work
- Retirement
- Special Leave
- Maternity/Adoption /Shared Parental Leave
- Home Working
- Agile Working
- Employment Break.

It should also be read in conjunction with:

- ACAS Code of Practice on Flexible Working Requests
- NHS Wales Flexible Working – briefing and guidance.

9. Monitoring and Review

Each Department will keep a record of all formal applications for Flexible Working and a record of approvals/ rejections and appeals.

Organisations should ensure that data relating to applications for flexible working and outcomes of decisions are recorded and regularly reported through the usual joint partnership and governance structures. This information should be included in an organisation's published annual statutory public sector duty reports. The published information should demonstrate outcomes for flexible working applications disaggregated by each protected characteristic of the Equality Act 2010. In addition, organisations should consider reporting outcomes by occupational group and also by department.

10

Appendix 1

Definitions

Flexible working describes a type of working arrangement which gives a degree of flexibility on how long, where, when and at what times employees work. Flexible working aims to accommodate employee's personal needs and meet their unique requirements.

Agile working is the ability to work in the place and at the time most appropriate for the task in hand. While agile working and flexible working may be similar in how they achieve their aim, for example both approaches may allow an employee to work from home, flexible working focuses on the employee, while agile working is focused on the impacts on the business including performance and productivity.

It may be a tool which can supplement or support a Flexible Working arrangement, but it is not a contractual change to an employee's terms and conditions. Agile working offers flexibility for employees that allows them to work in a way that suits them, provided the work happens.

Working remotely is when employees work all or part of their working week at a location remote from their base. This can be at home or elsewhere. Working remotely can be a flexible working arrangement (e.g., if requested by the individual and agreed as a regular, ongoing way of working), but it can also be a form of agile working.

Most NHS Organisations have local procedures to enable employees to request to work remotely. If this is not the case the processes set out in this Policy can be applied

Hybrid working is a mixture of remote working and working from a base.

Types of Flexible Working Covered by this Policy

There are many types of flexible working which employees may be able to apply for. Managers should consider how these options are communicated to all employees at recruitment, induction, and in regular one-to-one meetings. This list is not exhaustive, and organisations will consider other models of flexible working as requested to do so.

Part Time Working
Part-time working is a well-established form of flexible working which means that the employee reduces their contracted working hours below full time (37.5 hours) in order to work less days or shorter days in a pre-arranged, regular pattern. Salary, annual leave and bank holidays are reduced pro rata.

Job Sharing
This is where two employees share the responsibilities, duties and benefits of a single full-time post between them. The combined salary and conditions of service are equivalent to that of a single full-time post and are divided in accordance with the number of hours worked by each job sharer.

The principle of job sharing usually reflects an integrated pattern of working, where some of the work may be shared and other tasks distributed evenly to each sharer. The total hours should not normally exceed those of a full-time post.

In the case of job-sharing, if one sharer leaves, the existing job-sharer should be offered the full-time post (where accepted the manager must complete a changes form). If the existing job sharer does not want to work full-time, the vacant hours of the post must be advertised.

Term Time Working
Term time working is a form of part time working where the employee works only during the school terms and is off work during the school holidays. Time off is made up of a combination of annual leave and unpaid leave. Salary is based on the number of weeks in work and is paid in 12 equal instalments. It is calculated on an individual basis to take account of annual leave entitlement based on length of service and any protection arrangements. Salary, annual leave and related benefits are reduced pro rata. and salary is paid in 12 equal instalments.

Seasonal Hours
Employees work their contracted hours over an agreed period, rather than a set number of days. These are often annualised hours but can be bi-annual, quarterly or monthly.

Compressed Hours
Employees are able to work their full contracted hours over a shorter period than is standard. Contracted hours and pay remain unchanged, but employees are able to have more days or half days off. Examples include a 4½ day week or 9-day fortnight. The non-working day/half day must be mutually agreed and can be flexible to suit the needs of the service.

Voluntary Temporary Reduction in Hours
Employees are able to reduce their contracted hours by between 5 and 50% for a period of no less than 3 months, and no more than one year. At the end of the agreed time, they return to their original contracted hours. Salary/annual leave etc. will be reduced pro-rata for the period of the agreement. Employees are advised to contact payroll to determine whether a change in hours will affect their pension entitlements. If the employee wishes to extend this arrangement for longer than 12 months, they are required to submit a new flexible working request.

Flexi Time
Flexitime is a scheme which allows employees some discretion around the start and end time of the working day, based around core working times.
To benefit from this a department would need to have a Flexi-time arrangement in operation (not all departments would be in a position to accommodate this option).

Employees can build up a debit or credit of hours worked within an agreed period (usually 4 weeks) and consolidate the extra hours into a day or half day off. Flexitime schemes are usually based on detailed, locally agreed procedures which set out:

- the core hours
- limits on early and late working
- the minimum lunch break to be taken
- the maximum number of credit and debit hours which can be accrued
- limits on the number of hours which can be carried over to the next month
- limits on the number of days off allowed in any one period
- limits on the number of employees allowed off at any one time.

Flexible and Partial Retirement
There are a number of ways in which an employee can ease themselves into retirement in a flexible way. Details of the types of flexibilities available and the processes to be followed are set out in the Pension Flexibilities Policy.

Staggered Hours
This allows employees to determine their work pattern on a planned weekly basis. Hours can be staggered through the week or on just one or two days, within specified arrival and departure times, on a permanent or temporary basis.

Split Shifts
This allows employees to complete their working hours in two or more separate shifts, e.g., working between 7am – 11am, then returning to work between 4pm and 7pm.

Employment Breaks
An opportunity to leave the workplace for a specific period of time (usually between one and five years) and to return to the same or a similar position inside the organisation at the end of that period. For further details see the All-Wales Employment Break Policy.

Team based / Self Rostering
Team-based rostering starts from the premise that everyone has work-life balance needs and preferences, and that these need to be openly and collectively negotiated, among all those on each ward roster, within the constraints of service and financial needs. Self-rostering asks individuals to put their personal requirements into the roster each month, often on a 'first come, first served' basis. Team and Self Rostering are rolled out on a department wide basis.

Although it addresses work life balance needs, and the principles of flexible working apply, the request process set out in this Policy will not usually be appropriate for this purpose.

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Appendix 2

Flexible Working Request Form

PART 1 - Employee information	
Name of employee:	
Post:	
Band:	
Employee number:	
Email address:	
Department:	
Service Group:	
Line Manager:	
I would like to make a request to work a flexible working pattern that is different to my current working pattern.	
Requested start date of change:	
I would like this change to be Permanent/ Temporary (please delete as appropriate):	Permanent/Temporary* *For a period of……
Please describe your current working pattern e.g., location/days/hours/ worked etc.:	
Please describe the working pattern you would like to work e.g., days/hours/times worked/at home / in the office etc.	
Is your request for flexible working in relation to the Equality Act 2010 e.g. (disability, maternity, caring responsibilities)? *n.b., You do not have to give this information, but it will help your manager to make a decision on your application.*	Yes/No
If yes, please provide details:	
Employee signature:	
Date of application:	

NOW PASS THIS APPLICATION TO YOUR LINE MANAGER

Flexible Working Request Form

PART 2 - Receipt of request	
Date of receipt:	
Line Manager Name (please print)	
Line Manager Title:	
Date meeting/ conversation has been arranged for:	

Part 3 - Acceptance or Rejection Form	
Either: Further to the meeting that took place on (Date) ……. I have considered your request for a new flexible working pattern. ☐ I am pleased to confirm that I am able to grant your request. With effect from (date). This will be a permanent / temporary change (please delete as appropriate). If temporary to end on (date). ☐ I am able to accommodate your request as a trial basis with effect from (date) to be reviewed on (date) (usually 3 months). ☐ I am unable to accommodate your original request. However, I am able to offer the alternative pattern which we have discussed and which you agreed would be suitable to you. Please set out how the service will be maintained and how any impact on other employees can be mitigated.	
Your new working pattern will be as follows: Or: I am sorry but I am unable to accommodate your request for the following business ground(s) (please tick): ☐ The burden of additional costs ☐ Detrimental effect on ability to meet service user/patient needs ☐ An inability to reorganise work amongst existing employees ☐ A detrimental impact on quality ☐ A detrimental impact on performance ☐ Detrimental effect on ability to meet service demands ☐ Insufficient work for the periods the employee proposes to work ☐ A planned structural change to the department These grounds apply in the circumstances because (you should explain why any work patterns you may have discussed at the meeting are inappropriate. Please continue on a blank sheet, if necessary, **n.b this section must be completed to describe how the reason selected above applies in this case).**	
Start date of new working arrangements (if applicable):	
Line Manager Signature:	
Line Manager Name (in Full):	
Date:	
Please confirm which applies: **This change in working pattern will be a permanent change to your terms and conditions of employment unless otherwise stated and you have no right in law to revert back to your previous working pattern unless previously agreed.** OR: This will be a temporary change to your working arrangements and will be until …… at which time the arrangements will be reviewed.	
If you are unhappy with the decision, you may appeal against it. Details of the appeal procedure are set out below.	
Line Manager Signature:	
Line Manager Title (in full):	
Date:	
If you accept the change outlined above, please sign and confirm receipt of the decision.	
Employee Signature:	
Date:	

To The Employee:

If you are unhappy with the decision, you may appeal against it. Details of the appeal procedure are set out below.

Appeal Process

If an application for flexible working is turned down, the employee has the right to appeal against the decision. Appeals should be in writing, setting out the grounds for appeal, as soon as possible after receiving notice of the decision to reject the application (within 14 days).

The appeal should be submitted to your line manager's manager and heard by a more senior manager than the one who rejected the original application.

The employee has the right to be accompanied at this meeting and should be given advance notice of when it will take place.

Notes:

Part 1 - to be completed by Employee and forwarded to Line Manager.

Part 2, and 3 - to be completed by Line Manager.

Form should be returned to the Employee when completed and a copy kept on their personal file.

A PIF must be completed and submitted to NWSSP where there is a change in hours.

Designed by the NWSSP Communications Team


Cymru Gyfan
Polisi Gweithio Hyblyg

Sections

01 & 02
Datganiad Polisi a Cwmpas

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Egwyddorion

04
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Cymeradwywyd gan: Fforwm Partneriaeth Cymru

Dyddiad cyhoeddi: Rhagfyr 2023

01 & 02

Datganiad Polisi a Cwmpas

1. Datganiad Polisi

1.1 O fewn GIG Cymru, rydym yn gwybod, er mwyn diwallu anghenion iechyd a gofal ein poblogaeth yn effeithiol, ei bod yn bwysig cael gweithlu sy'n iach, yn ymgysylltiedig ac yn llawn cymhelliant. Rydym wedi ymrwymo i fod yn lle gwych i weithio a dysgu ac i ddarparu gwasanaeth o ansawdd, gan gydnabod bod ein gweithlu yn hanfodol i'n llwyddiant. Rydym yn cydnabod ein cyfrifoldeb i ddenu, cadw, defnyddio a datblygu pobl i wneud y mwyaf o'u potensial.

Un o'r ffyrdd o gyflawni hyn yw datblygu a chynnal diwylliant lle mae gweithio'n hyblyg yn cael ei ystyried yn alluogwr ar gyfer darparu gwasanaethau effeithiol ac effeithlon sydd â manteision i gydweithwyr, cleifion a'r sefydliad. Mae GIG Cymru wedi ymrwymo i hyrwyddo ac annog gwahanol ffyrdd o weithio er mwyn recriwtio pobl ragorol a chadw cyfoeth o wybodaeth, sgiliau a phrofiad ei weithlu presennol.

1.2 Mae hyblygrwydd mewn cyflogaeth yn helpu pobl i gydbwyso cyfrifoldebau gwaith ag agweddau eraill ar eu bywydau ac i ddiwallu'r anghenion a allai godi ar wahanol adegau yn eu bywydau. Yn allweddol i gyflawni hyn mae darparu ac argaeledd cyfleoedd gweithio hyblyg sy'n caniatáu i weithwyr wneud dewisiadau ynghylch sut a phryd y maent yn dymuno gweithio, ochr yn ochr â pholisïau sy'n cefnogi rheolwyr i gymryd yr amser i ddeall beth sydd ei angen ar bob person.

1.3 Mae Ymagwedd GIG Cymru tuag at Weithio Hyblyg wedi'i nodi mewn datganiad a ddatblygwyd ac a gytunwyd mewn partneriaeth. Nod y dull hwn yw cefnogi rheolwyr i wneud newid diwylliannol fel bod y cwestiwn yn mynd yn "Sut gallwn ni wneud i hyn ddigwydd" yn hytrach na "Ni allwn wneud hyn oherwydd…"? Mae hyn yn golygu mai'r sefyllfa ddiofyn fydd y bydd cais am weithio hyblyg yn cael ei gymeradwyo, a phob llwybr posibl yn cael ei archwilio i hwyluso hyn, oni bai bod rhesymau busnes clir mewn polisi ac o ran y gyfraith dros wrthod. Mae'r Polisi hwn yn nodi'r egwyddorion sy'n sail i drefniadau gweithio hyblyg sy'n caniatáu i bobl gydbwyso cyfrifoldebau gwaith ag agweddau eraill o'u bywydau ac yn disgrifio'r prosesau i'w dilyn wrth wneud neu ystyried cais.

1.4 Mae hyblygrwydd mewn cyflogaeth yn ffactor allweddol wrth ddangos ymrwymiad GIG Cymru i driniaeth deg a chyfartal yn y gweithle ac wrth ddenu'r gweithwyr o'r safon uchaf i weithio i'r sefydliad. Dylid ystyried cyfleoedd gweithio hyblyg ar gyfer pob gweithiwr a sicrhau eu bod ar gael cyn belled ag y bo'n ymarferol, waeth beth fo'u rôl, patrwm sifft, tîm neu fand cyflog a dylid eu hystyried hefyd ar gyfer gweithwyr sy'n gweithio ar gylchdro. Nid yw'n ddigonol i adrannau sydd â ffordd draddodiadol o weithio wrthod cais am weithio'n hyblyg dim ond am nad yw wedi cael ei roi ar brawf o'r blaen neu oherwydd mai 'dyma sut y mae wedi cael ei wneud erioed'.

1.5 Dylai holl sefydliadau'r GIG annog a hyrwyddo cyfleoedd i weithio'n hyblyg a defnyddio'r adnoddau sydd ar gael iddynt e.e. rhaglenni addysg, rheolaeth ac arweinyddiaeth i eirioli dros fanteision gweithio hyblyg a symud tuag at ddiwylliant sy'n ei dderbyn fel y norm. Lle bynnag y bo'n bosibl, dylai rheolwyr ystyried sut y gellir gwneud gwaith yn hyblyg a bod yn gefnogol i geisiadau i weithwyr weithio'n hyblyg i reoli cydbwysedd eu bywydau gwaith yn well, gan gynnal safonau gwasanaeth.

1.6 Er mwyn cefnogi diwylliant cadarnhaol o weithio'n hyblyg, bydd angen i sefydliadau ystyried sut maent yn cefnogi ac yn annog sgyrsiau agored am weithio'n hyblyg. Mae enghreifftiau o gyfleoedd i siarad am weithio'n hyblyg yn cynnwys mewn cyfarfodydd rheoli/goruchwylio llinell un-i-un, cyfarfodydd tîm/adrannol, fel rhan o sgyrsiau llesiant, neu fel rhan o brosesau recriwtio, ymsefydlu ac arfarnu blynyddol.

Wrth hysbysebu swydd, mae angen i sefydliadau sy'n cyflogi hefyd ystyried sut maent yn hyrwyddo'r hawl i ofyn am hyblygrwydd o'r diwrnod cyntaf ac argaeledd opsiynau gweithio hyblyg.

1.7 Mae GIG Cymru wedi ymrwymo i drin pawb yn gyfartal a chyda pharch, waeth beth fo'u hoedran, anabledd, ailbennu rhywedd, priodas neu bartneriaeth sifil, beichiogrwydd neu famolaeth, hil, crefydd neu gred, rhyw, neu gyfeiriadedd rhywiol. Mae Asesiad Effaith o'r Polisi hwn ar Gydraddoldeb wedi'i gwblhau.

2. Cwmpas

Mae'r polisi yn berthnasol i holl weithwyr o'r diwrnod cyntaf o'u cyflogaeth. Fodd bynnag, trefnir trefniadau gweithio hyblyg ar gyfer meddygon dan hyfforddiant gan ac yn amodol ar gymeradwyaeth y Ddeoniaeth Feddygol, AaGIC.

03

Egwyddorion

03 Egwyddorion

3. Egwyddorion

3.1 Mae GIG Cymru wedi ymrwymo i ddiwylliant gweithio hyblyg, sy'n golygu y bydd cais am weithio'n hyblyg yn cael ei gymeradwyo, ac y bydd pob llwyr posibl yn cael ei archwilio i hwyluso hyn, oni bai bod rhesymau busnes clir fel y nodir yn y Polisi hwn i'w wrthod.

Dylai trefniadau gweithio hyblyg da gydbwyso anghenion yr unigolyn gyda thri ffactor sefydliadol allweddol: profiad cleifion/defnyddwyr gwasanaeth, darparu gwasanaethau a phrofiad gweithwyr. Efallai na fydd yn bosibl cytuno i'r union gais, ond mae disgwyl i reolwyr drafod trefniadau amgen gyda'r unigolyn a sicrhau bod pob llwybr wedi'i archwilio cyn gwrthod y cais.

3.2 Dylai fod gan bob gweithiwr fynediad cyfartal at weithio'n hyblyg, cyn belled ag y bo'n ymarferol, waeth beth fo'i rôl, patrwm sifft, tîm neu fand cyflog a gellir ystyried pob swydd ar gyfer gweithio hyblyg. Er y cydnabyddir efallai na fydd rhai swyddi'n addas ar gyfer pob math o drefniadau gweithio hyblyg yn eu cyfanrwydd, dylai rheolwyr ystyried a oes modd gweithio elfennau penodol o'r rôl yn hyblyg.

3.3 Gall cyflogeion ofyn am weithio'n hyblyg o'r diwrnod cyntaf o'u cyflogaeth gontractiol a gallant wneud mwy nag un cais gweithio hyblyg y flwyddyn, waeth beth fo'r rhesymau drostynt.

3.4 Bydd gweithwyr yn cael eu trin yn deg wrth ystyried ceisiadau am drefniadau gweithio hyblyg. Bydd pob cais am weithio'n hyblyg yn cael ei dderbyn yn agored gan y rheolwr llinell priodol ac yn cael ei ystyried yn unigol ar sail ei rinweddau ei hun. Dylid ystyried unrhyw gais am weithio'n hyblyg gan dybio y bydd yn cael ei roi oni bai bod rheswm busnes dilys dros wrthod. Fodd bynnag, dylid ystyried unrhyw effaith bosibl ar weithwyr eraill a darparu gwasanaethau, gan gynnwys costau ychwanegol posibl.

3.5 Mae'n bwysig cytuno o'r cychwyn cyntaf a yw'r trefniadau gweithio newydd yn barhaol neu dros dro a rhaid dogfennu hyn i gyd yn ysgrifenedig. Pan fo'r trefniant dros dro neu am gyfnod penodol, rhaid ei adolygu'n rheolaidd i sicrhau bod anghenion y gwasanaeth a'r unigolyn yn dal i gael eu diwallu.

3.6 Ni fydd gweithwyr sy'n gweithio'n hyblyg yn cael eu trin yn llai ffafriol mewn perthynas â chyfleoedd hyfforddi a datblygu na chyfleoedd i gael eu dyrchafu.

3.7 Ni fydd unrhyw fath o weithio'n hyblyg yn caniatáu i weithwyr weithio yn groes i'r Rheoliadau Oriau Gwaith.

3.8 Er nad oes cyfyngiad ar nifer y ceisiadau y gall cyflogai eu gwneud o fewn cyfnod o 12 mis, gofynnir i weithwyr beidio ag ailgyflwyno ceisiadau sydd wedi'u gwrthod heb eu haddasu a/neu newid mewn amgylchiadau o fewn yr adran. Yn hytrach, fe'u hanogir i gynnal sgwrs reolaidd gyda'u rheolwr fel bod y ddwy ochr yn ymwybodol os bydd unrhyw beth yn newid ac yn gallu ymateb i'r newid hwnnw.

3.9 Rhaid cadarnhau newidiadau i gontract cyflogaeth gweithiwr yn ysgrifenedig.

04 Manteision Gweithio Hyblyg

4. Manteision Gweithio Hyblyg

Mae gweithio hyblyg o fudd i unigolion nid yn unig o ran caniatáu iddynt gydbwyso eu bywyd personol â'u bywyd gwaith ond hefyd o ran gwella iechyd a llesiant cyffredinol.

Mae unigolion sy'n hapusach gyda'u cydbwysedd rhwng bywyd i mewn ac allan o'r gwaith yn fwy cynhyrchiol yn gyffredinol, yn cynhyrchu gwaith o ansawdd gwell ac yn fwy gofalgar.
I reolwyr, gall gweithio hyblyg helpu i gadw gweithwyr – ac mae dal gafael ar bobl brofiadol a medrus yn bwysig o ran cynnal ansawdd a rheoli costau. Mae cynnig oriau hyblyg yn ehangu'r pwll talent, felly dylai rheolwyr allu recriwtio pobl â mwy o sgiliau. Gall hefyd gynyddu ymrwymiad a theyrngarwch gweithwyr a gall greu manteision trwy leihau lefelau absenoldeb a straen.

Gall Gweithio Hyblyg hefyd gefnogi ailgynllunio gwasanaethau trwy greu rolau cymysg newydd ac ail-lunio a datblygu rolau presennol, mewn ymgynghoriad â gweithwyr. Gall defnyddio rolau newydd a rolau sydd wedi'u hailgynllunio yn greadigol arwain at well gwasanaethau i gleifion a gyrfaoedd mwy gwerth chweil i'n gweithlu.

05

Y Broses Gwneud Cais Am Weithio Hyblyg

05 Y Broses Gwneud Cais Am Weithio Hyblyg

5. Y Broses Gwneud Cais Am Weithio Hyblyg

5.1 Efallai y bydd nifer o resymau pam y gallai fod angen i weithwyr fabwysiadu trefniant gweithio mwy hyblyg am gyfnod byr (h.y. hyd at 8 wythnos) i fynd i'r afael â mater penodol. Os felly, gall fod yn briodol i'r cyflogai a'r rheolwr drafod a chytuno ar hyn yn anffurfiol, yn enwedig lle nad yw'r newid yn effeithio ar ei delerau na'i amodau eraill (e.e. cyflog). Fodd bynnag, dylid dogfennu a chadarnhau canlyniad y drafodaeth yn ysgrifenedig.

5.2 Gwneud y cais

Os yw'r gweithiwr yn dymuno gwneud cais am fath o weithio'n hyblyg yn barhaol neu yn y tymor hwy, dylai gwblhau Ffurflen Gais Gweithio Hyblyg (Atodiad 1) neu gwblhau'r cais ar ESR a'i gyflwyno i'w reolwr llinell. Efallai y bydd y gweithiwr am gael trafodaeth anffurfiol gyda'i reolwr cyn cyflwyno cais ffurfiol ac anogir rheolwyr i hwyluso hyn pan ofynnir iddynt wneud hynny. Fodd bynnag, ni fydd y cais yn cael ei ystyried yn ffurfiol hyd nes y caiff ei gyflwyno'n ysgrifenedig.

Rhaid i'r ffurflen gais gynnwys yr wybodaeth ganlynol: -

- Rhaid iddo gael ei ddyddio a datgan pa newid i'w drefniadau gweithio y mae'n gwneud cais amdanynt, a phryd yr hoffai i'r newid hwn ddod i rym

- Lle bo'n berthnasol, anogir yr ymgeisydd i ddatgan a yw'n gwneud y cais mewn perthynas â Deddf Cydraddoldeb 2010, er enghraifft, fel addasiad rhesymol ar gyfer anabledd, neu ar ôl dychwelyd o absenoldeb mamolaeth, neu pryd y mae ar gyfer gofal plant neu ddibynyddion.

5.3 Ymateb i gais

5.3.1 Dylai rheolwyr fod yn ymwybodol bod gofyniad cyfreithiol i ystyried y cais a rhoi gwybod i'r unigolyn am y canlyniad o fewn 2 fis ac fe ddylid ystyried hyn i sicrhau bod ganddynt amserlen ddigonol i roi ystyriaeth ddyledus i'r cais.

5.3.2 Dylai'r rheolwr drefnu i drafod y cais gyda'r gweithiwr cyn gynted â phosibl ar ôl derbyn ei ffurflen gais (gall hyn fod yn bersonol, dros y ffôn neu drwy MS Teams). Bydd hyn yn ei alluogi i gael gwell dealltwriaeth o'r newidiadau y mae ei gyflogai'n chwilio amdanynt a sut y gallai pethau weithio'n ymarferol. Dylai'r drafodaeth archwilio sut y bydd y trefniant gweithio arfaethedig yn gweithio'n ymarferol, unrhyw effaith gadarnhaol a negyddol bosibl y gallai ei chael ar ddarparu gwasanaethau a sut y gallai effeithio ar aelodau eraill o'r tîm. Mae gan weithwyr yr hawl i ddod i'r cyfarfod hwn gyda chydweithiwr yn y gweithle neu gynrychiolydd undeb llafur.

Os yw'r rheolwr yn bwriadu cymeradwyo'r cais, nid yw'r cyfarfod hwn yn ofyniad, ond gall fod yn ddefnyddiol trafod trefniadau ymarferol o hyd.

5.3.3 Rhaid i reolwyr ystyried a yw'r cais mewn perthynas ag addasiad rhesymol sy'n gysylltiedig ag anabledd neu nodwedd warchodedig arall. Mae gweithwyr yn cael eu hannog i nodi lle mae hyn yn wir. Dylai rheolwyr hefyd ystyried unrhyw faterion iechyd a diogelwch a allai ddeillio o'r newid a nodi ffyrdd o'u lliniaru (e.e. os bydd y trefniadau gweithio yn golygu y byddai'r gweithiwr neu'i gydweithwyr yn dod yn weithwyr unigol). Gellir gofyn am gyngor gan y Gwasanaethau Pobl/Adnoddau Dynol/ Gweithlu a Datblygu Sefydliadol, Iechyd a Diogelwch ac Iechyd Galwedigaethol fel y bo'n briodol.

5.4 Ystyried y cais

5.4.1 Dylid ymdrin â phob cais gydag agwedd 'gallu ei wneud', gyda'r rhagdybiaeth y bydd yn cael ei rhoi oni bai nad yw'n wirioneddol bosibl gwneud hynny am un o'r rhesymau busnes a nodir isod. Dylid ystyried y cais yn ofalus a dylid pwyso a mesur manteision gweithredu'r newid yn erbyn unrhyw gostau. Wrth ystyried y cais, rhaid i reolwyr llinell wneud yn siŵr nad ydynt yn gwahaniaethu'n uniongyrchol neu'n anuniongyrchol yn erbyn y gweithiwr. Os oes unrhyw amheuaeth ynghylch yr hyn y gallai hynny ei olygu, yna gellir gofyn am gyngor gan y tîm Cydraddoldeb, Amrywiaeth a Chynhwysiant neu Gwasanaethau Pobl / Adnoddau Dynol / Gweithlu a Datblygu Sefydliadol lleol.

Unwaith y gwneir penderfyniad, dylai'r rheolwr hysbysu'r gweithiwr yn ysgrifenedig gan ddefnyddio rhan 3 o'r ffurflen gais neu drwy ESR.

5.4.2 Os penderfynir cymeradwyo cais y gweithiwr, neu ei dderbyn gydag addasiadau, dylid cynnal trafodaeth i benderfynu sut a phryd y gellid gweithredu'r newidiadau orau. Gall hyn gynnwys cyfnod prawf. Mae'r rheolwr llinell yn gyfrifol am sicrhau bod PCGC yn cael ei hysbysu os oes unrhyw newidiadau i gyflog.

Rhaid i'r gweithiwr drafod a chytuno ar sut y bydd yn trefnu ei waith ac yn cyflawni terfynau amser ar y cyd â'i reolwr. Rhaid gwneud trefniadau rhwng y gweithiwr a'i reolwr i sicrhau eu bod yn cael gwybod am ddyletswyddau cyfredol y gweithiwr a ble/sut y bydd yn gweithio.

5.4.3 Rhaid gwneud pob ymdrech i ddiwallu ar gyfer y cais yn llawn neu'n rhannol, neu drwy ddarparu dewis arall. Os, ar ôl trafod gyda'r gweithiwr ac ystyried yr holl ddewisiadau amgen sydd ar gael, mae'r rheolwr yn teimlo nad yw'n gallu cefnogi gweithio hyblyg mewn swydd benodol, dylai drafod y cais gyda Gwasanaethau Pobl/Adnoddau Dynol. Yn dilyn y sgwrs hon, os yw'n dal i deimlo nad yw'n gallu cymeradwyo'r cais ac ni allant ddod o hyd i ddewis arall sy'n dderbyniol i'r ddwy ochr y mae'n rhaid iddo gwrdd â'r gweithiwr i egluro hyn iddo a darparu rhesymau ysgrifenedig, gyda chyfiawnhad gwrthrychol drosto a rhoi rheswm gweithredol clir pam nad yw hyn yn ymarferol. Rhaid i'r rheolwr ddarparu manylion am y rhesymau busnes dros wrthod y cais a sut maent yn berthnasol yn yr achos hwn.

Yr unig resymau derbyniol yw:

- Baich costau ychwanegol
- Effaith niweidiol ar y gallu i ateb galw cwsmeriaid
- Anallu i ad-drefnu'r gwaith ymhlith y gweithwyr presennol.
- Effaith niweidiol ar ansawdd
- Effaith niweidiol ar berfformiad.
- Effaith niweidiol ar y gallu i gwrdd â gofynion y gwasanaeth.
- Dim digon o waith ar gyfer y cyfnodau y mae'r gweithiwr yn bwriadu gweithio
- Newidiadau strwythurol arfaethedig i'r adran.

5.4.4 Efallai y bydd achlysuron pan fydd y rheolwr yn ansicr a yw trefniant gweithio hyblyg yn gynaliadwy, neu lle mae pryder am yr effaith bosibl ar eraill yn yr adran. Yn yr achosion hyn, gall y rheolwr gytuno i'r trefniadau gweithio hyblyg ar sail dros dro neu gyfnod prawf yn hytrach na gwrthod y cais. Dylid gofyn am gyngor gan y Gwasanaethau Pobl/Adnoddau Dynol / Gweithlu a Datblygu Sefydliadol.

5.5. Cyfnod Uwchgyfeirio

5.5.1 Dylid defnyddio'r cam hwn os nad yw rheolwr llinell wedi gallu dod i gytundeb ar ddatrysiad yn y cam archwilio. Y diben yw gwirio am ddatrysiadau posibl eraill gan gynnwys a ellid bodloni'r math o hyblygrwydd y mae'r unigolyn yn chwilio amdano mewn tîm, lleoliad neu rôl wahanol.

Os nad yw cais am weithio'n hyblyg wedi'i gymeradwyo, ac nad yw'n teimlo ei fod yn gallu parhau i weithio yn yr adran honno gan nad yw'n gallu cynnal cydbwysedd rhwng ei waith / cyfrifoldebau bywyd, disgwylir i reolwyr gefnogi'r unigolyn wrth nodi unrhyw rolau amgen o fewn y sefydliad a all fod yn fwy cefnogol i amgylchiadau'r unigolyn ac yn unol â'i gais.

5.5.2 Pan drefnir cyfarfod i drafod y cais, neu i ystyried apêl, a bod y gweithiwr yn methu â dod iddo neu un cyfarfod arall wedi'i aildrefnu heb reswm da, gall y rheolwr ystyried bod y cais yn cael ei dynnu'n ôl. Os yw'r rheolwr yn ystyried bod y cais yn cael ei dynnu'n ôl, rhaid iddo hysbysu'r gweithiwr am hyn.

5.6 Timescales

Pan fydd y rheolwr yn derbyn y cais ffurfiol am weithio'n hyblyg, rhaid ystyried a phenderfynu arno o fewn cyfnod o 2 fis ar ôl derbyn y cais am y tro cyntaf. Mae'r terfyn amser dau fis hwn yn ofyniad cyfreithiol ac ni ellir ei ymestyn oni chytunir gan y rheolwr a'r gweithiwr ar y cyd.

Rhaid i reolwyr fod yn ymwybodol o'r cyfnod amser 2 fis hwn wrth drefnu'r cyfarfod/sgwrs gychwynnol gyda'r cyflogai i sicrhau yr ymdrinnir â'r holl geisiadau o fewn yr amserlenni gofynnol.

Mae gan weithwyr GIG Cymru hefyd yr hawl i apelio os yw eu cais yn cael ei wrthod. Mae'r amserlenni ar gyfer gwneud apêl wedi'u nodi isod.

5.7 Derbyn mwy nag un cais tua'r un adeg.

Mae'n bwysig bod rheolwyr yn ystyried ceisiadau i weithio'n hyblyg mewn ffordd deg ond nid oes gofyniad statudol i'w hystyried yn llym yn y drefn y cânt eu derbyn.

Os bydd yn derbyn mwy nag un cais i weithio'n hyblyg tua'r un pryd, efallai na fydd yn bosibl cefnogi'r holl geisiadau a dderbynnir. Yna mae'n rhaid i'r rheolwr edrych yn fanwl ar yr effaith y byddai cefnogi'r ceisiadau yn ei chael ar y gwasanaeth a'r effaith bosibl y byddai gwrthod yn ei chael ar bob gweithiwr cyn dod i benderfyniad. Wrth benderfynu sut i ddelio â cheisiadau sy'n cystadlu â'i gilydd, dylai'r rheolwr gadw mewn cof y gwahanol rwymedigaethau cyfreithiol sy'n berthnasol a gall ofyn am gyngor gan y tîm Cydraddoldeb, Amrywiaeth a Chynhwysiant neu Gwasanaethau Pobl / Adnoddau Dynol / Gweithlu a Datblygu Sefydliadol lleol. Bydd yn ddefnyddiol cael trafodaeth unigol gyda'r ddau (neu bob un) o'r ymgeiswyr i ddeall union natur eu ceisiadau ac i weld a ellir dod o hyd i unrhyw drefniant y gellir ei gytuno ar y cyd.

5.8 Apeliadau

5.8.1 Os gwrthodir y cais gweithio hyblyg, gall y gweithiwr gyflwyno apêl o fewn 14 diwrnod o gael gwybod am wrthod ei gais drwy gysylltu â rheolwr llinell ei reolwr.

Rhaid i hyn fod yn ysgrifenedig a datgan yn glir y sail y maent yn apelio arni. Gallai'r rhain fod:

- Pan fo gwybodaeth newydd bellach ar gael mewn perthynas â'r cais
- Pan fo'r gweithiwr yn teimlo na chafodd y cais ei drin yn unol â'r polisi
- Pan fo gan y gweithiwr gynnig nad yw wedi'i ystyried yn llawn mewn perthynas â rheswm busnes dros wrthod.

5.8.2 Cynhelir cyfarfod apêl, fel arfer o fewn mis i dderbyn yr apêl ysgrifenedig. Bydd hyn yn cael ei drin yn ddiduedd gan uwch berson na'r rheolwr a wnaeth y penderfyniad gwreiddiol.

Dylai gweithwyr gael y cyfle i ddod â chynrychiolydd undeb llafur neu gydweithiwr i unrhyw gyfarfod apêl. Bydd canlyniad yr apeliadau'n cael ei gyfleu'n ysgrifenedig o fewn saith diwrnod i'r cyfarfod apêl. Dyma ddiwedd y weithdrefn ac nid oes apêl bellach, er y gellir cyflwyno ceisiadau pellach am weithio'n hyblyg.

5.9 Adolygiad o Drefniadau Gweithio Hyblyg

5.9.1 Cyn y gwneir penderfyniad terfynol ynghylch a ellir cefnogi trefniant gweithio hyblyg ai peidio, gallai fod yn fuddiol cael cyfnod prawf cychwynnol o 3 mis ac adolygu'r trefniant ar ôl y cyfnod hwn i sicrhau ei fod yn gweithio i'r gweithiwr a'r gwasanaeth.

5.9.2 Pan gytunir ar drefniant gweithio hyblyg dros dro, mae'n bwysig ei adolygu ar adegau y cytunir arnynt i benderfynu a ddylid ei ymestyn neu ddod ag ef i ben ar y dyddiad y'i cytunwyd.

5.9.3 Ym mhob achos, argymhellir bod y trefniant gweithio hyblyg yn cael ei drafod yn flynyddol (e.e. wrth werthuso) i sicrhau ei fod yn dal i weithio i'r ddau barti. Os cytunir ar y trefniadau fel rhai parhaol o'r cychwyn cyntaf neu yn dilyn y cyfnod prawf tri mis a argymhellir, efallai na fydd bob amser yn bosibl i'r gweithiwr ailgydio yn ei drefniadau gwaith blaenorol gan y gallai cydweithwyr eraill fod wedi'u penodi i gyflenwi'r bwlch a grëwyd gan y trefniant gweithio hyblyg neu ailgynllunio gwasanaethau a allai fod wedi digwydd. Rhaid egluro hyn i'r gweithiwr yn ystod y trafodaethau cychwynnol. Fodd bynnag, dylai'r rheolwr ystyried unrhyw gais i ddychwelyd i'r hen drefniadau gweithio a chytuno lle bo'n bosibl gwneud hynny.

5.9.4 Os yw'r rheolwr o'r farn nad yw'r trefniadau gweithio hyblyg bellach yn gynaliadwy a bod angen eu newid, gellir cytuno ar hyn yn anffurfiol rhwng y rheolwr a'r gweithiwr fel rhan o'r sgwrs barhaus rhyngddynt. Lle mae'r cytundeb i gael ei derfynu/ei newid, dylid rhoi rhybudd rhesymol i alluogi'r ddau barti i wneud y trefniadau trosiannol priodol. Fodd bynnag, lle bynnag y bo'n bosibl, dylid cynnal trafodaeth ystyrlon a chytuno ar drefniant sy'n dderbyniol i'r ddau barti.

06 & 07

Gohebiaeth a Ystyriaethau Telerau ac Amodau

06 & 07 Gohebiaeth a Ystyriaethau Telerau ac Amodau

6. Gohebiaeth

Dylid cadw copïau o'r holl ohebiaeth mewn perthynas â cheisiadau ar ffeil bersonol y cyflogai a dylid cofnodi manylion y trefniadau y cytunwyd arnynt ar ESR er mwyn gallu monitro'r trefniadau gweithio hyblyg sydd ar waith ar lefel sefydliadol.

7. Ystyriaethau Telerau ac Amodau

Isod mae'r telerau ac amodau cyffredinol sy'n berthnasol i drefniadau gweithio hyblyg. Dylai rheolwyr sicrhau eu bod yn eu trafod â gweithwyr sydd â diddordeb mewn gweithio'n hyblyg i sicrhau eu bod yn deall unrhyw oblygiadau posibl.
Yn ogystal, dylai gweithwyr sy'n ystyried gwneud cais am weithio'n hyblyg ystyried effaith y trefniant ar eu cyflogau a'u pensiynau a chael cyngor gan Adran Gyflogres/Pensiynau PCGC lle bo angen.

- **Oriau Dyletswydd**
  Lle bo trefniadau gweithio hyblyg yn cael eu rhoi ar waith, dylid trafod a chytuno ar yr union oriau a sut y cânt eu gweithio cyn i'r newid gael ei roi ar waith

- **Gwyliau Blynyddol**
  Cyfrifir gwyliau blynyddol ar sail pro rata, fel y bo'n briodol

- **Tâl Salwch**
  Mae hawl i dâl salwch yn pro rata ac yn dibynnu ar hyd y gwasanaeth. Rhaid i weithwyr sy'n gweithio ar unrhyw drefniadau hyblyg roi gwybod am eu salwch yn yr un modd â phe na baent yn gweithio'n hyblyg

- **Mamolaeth / Rhiant newydd / Mabwysiadu / Absenoldeb Rhiant a Rennir**
  Mae'r cyflog yn pro rata (fel y bo'n briodol) ac mae'n dibynnu ar hyd y gwasanaeth. Yn dilyn cyfnod mamolaeth/mabwysiadu neu absenoldeb rhiant a rennir, efallai y bydd gweithiwr yn dymuno dychwelyd i'r gwaith gyda threfniadau gweithio wedi'u haddasu i fodloni eu hamgylchiadau newydd.
  Mae'n ddyletswydd ar y Bwrdd Iechyd/ Ymddiriedolaeth i gytuno i hyn lle bynnag y bo hynny'n bosibl. Os cytunir y gall cyflogai ddychwelyd ar sail hyblyg, gan gynnwys newid neu leihau oriau, am gyfnod dros dro y cytunwyd arno, ni fydd hyn yn effeithio ar ei hawl i ddychwelyd i'w swydd o dan ei gontract gwreiddiol ar ddiwedd y cyfnod y cytunwyd arno

- **Pensiynau**
  Bydd cyfraniadau pensiwn yn pro rata i weithwyr sy'n gweithio llai nag oriau llawnamser

- **Treuliau**
  Bydd yr holl dreuliau a godir (e.e. cynhaliaeth, teithio) yn cael eu talu yn yr un ffordd ag ar gyfer gweithwyr llawnamser. Bydd pob gweithiwr yn cadw lleoliad Bwrdd Iechyd/ Ymddiriedolaeth at ddibenion hawlio costau teithio

- **Cyflogau**
  Bydd y cyflog yn pro rata i weithwyr ar gontractau llai na llawnamser.
  Bydd y rhai sy'n gweithio yn ystod y tymor ac yn dymhorol yn cael eu talu mewn 12 rhandaliad cyfartal bob blwyddyn

- **Oriau Ychwanegol**
  Os yw gweithwyr yn gweithio y tu hwnt i'w oriau arferol (ond nid y tu allan i oriau llawnamser arferol) rhaid i hyn fod drwy gytundeb gyda'r rheolwr llinell a bydd yn cael ei dalu ar gyfradd amser arferol neu ei gymryd fel amser i ffwrdd yn lle hynny

- **Polisïau a Gweithdrefnau**
  Mae gweithwyr sy'n gweithio'n hyblyg yn parhau i fod yn ddarostyngedig i holl bolisïau a gweithdrefnau'r Bwrdd Iechyd/Ymddiriedolaeth.

08 & 09

Dogfennau Cysylltiedig Eraill a Monitro ac Adolygu

8. Dogfennau Cysylltiedig Eraill

Dylid darllen y Polisi hwn ar y cyd â pholisïau eraill Cymru Gyfan a pholisïau lleol ar y canlynol:

- Rheoli Presenoldeb yn y Gwaith
- Ymddeol
- Absenoldeb Arbennig
- Mamolaeth/Mabwysiadu/Rhannu Absenoldeb Rhiant
- Gweithio Gartref
- Gweithio Ystwyth
- Seibiant Cyflogaeth.

Dylid ei ddarllen hefyd ar y cyd â'r canlynol:

- Cod Ymarfer ACAS ar Geisiadau Gweithio Hyblyg
- Gweithio Hyblyg GIG Cymru – briffio ac arweiniad.

9. Monitro ac Adolygu

Bydd pob Adran yn cadw cofnod o'r holl geisiadau ffurfiol am Weithio'n Hyblyg a chofnod o gymeradwyaeth/gwrthod ac apeliadau.

Dylai sefydliadau sicrhau bod data sy'n ymwneud â cheisiadau am weithio'n hyblyg a chanlyniadau penderfyniadau yn cael eu cofnodi a'u hadrodd yn rheolaidd drwy'r strwythurau cyd-bartneriaeth a llywodraethu arferol. Dylai'r wybodaeth hon gael ei chynnwys yn adroddiadau dyletswydd y sector cyhoeddus blynyddol a gyhoeddir gan sefydliad. Dylai'r wybodaeth a gyhoeddir ddangos canlyniadau ar gyfer ceisiadau gweithio hyblyg sydd wedi'u ddadgyfuno fesul nodwedd warchodedig o Ddeddf Cydraddoldeb 2010. Yn ogystal, dylai sefydliadau ystyried adrodd canlyniadau fesul grŵp galwedigaethol a hefyd yn ôl adran.

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Atodiad 1

Diffiniadau

Mae **gweithio hyblyg** yn disgrifio math o drefniant gweithio sy'n rhoi rhywfaint o hyblygrwydd ar ba hyd, ble, pryd ac ar ba adegau y mae gweithwyr yn gweithio. Nod gweithio hyblyg yw diwallu anghenion personol gweithiwr a bodloni ei ofynion unigryw.

Gweithio ystwyth yw'r gallu i weithio ble ac ar yr adeg fwyaf priodol ar gyfer y dasg dan sylw. Er y gall gweithio ystwyth a gweithio hyblyg fod yn debyg o ran sut y maent yn cyflawni eu nod, er enghraifft gall y ddau ddull ganiatáu i weithiwr weithio gartref, mae gweithio'n hyblyg yn canolbwyntio ar y gweithiwr, tra bod gweithio ystwyth yn canolbwyntio ar yr effeithiau ar y busnes gan gynnwys perfformiad a chynhyrchiant.

Gall fod yn offeryn a all ategu neu gefnogi trefniant Gweithio Hyblyg, ond nid yw'n newid cytundebol i delerau nac amodau cyflogai. Mae gweithio ystwyth yn cynnig hyblygrwydd i weithwyr sy'n caniatáu iddynt weithio mewn ffordd sy'n addas iddyn nhw, ar yr amod bod y gwaith yn cael ei gyflawni.

Gweithio o bell yw pan fydd cyflogeion yn gweithio rhan neu'r cyfan o'u hwythnos waith mewn lleoliad oddi wrth eu lleoliad gwaith arferol. Gall hyn fod gartref neu mewn mannau eraill.
Gall gweithio o bell fod yn drefniant gweithio hyblyg (e.e. os yw'r unigolyn yn gofyn amdano ac yn cael ei gytuno fel ffordd reolaidd, barhaus o weithio), ond gall hefyd fod yn fath o weithio ystwyth.

Mae gan y rhan fwyaf o sefydliadau'r GIG weithdrefnau lleol i alluogi gweithwyr i ofyn am weithio o bell. Os nad yw hyn yn wir, gellir cymhwyso'r prosesau a nodir yn y Polisi hwn.

Mae **gweithio hybrid** yn gymysgedd o weithio o bell ac o weithio o leoliad.

Mathau o weithio hyblyg a gwmpesir gan y polisi hwn

Mae llawer o fathau o weithio hyblyg y gall gweithwyr wneud cais amdanynt. Dylai rheolwyr ystyried sut mae'r opsiynau hyn yn cael eu cyfleu i'r holl weithwyr wrth recriwtio, ymsefydlu, ac mewn cyfarfodydd un-i-un rheolaidd. Nid yw'r rhestr hon yn gynhwysfawr, a bydd sefydliadau'n ystyried modelau eraill o weithio'n hyblyg yn ôl y gofyn i wneud hynny.

Gweithio'n rhan amser
Mae gweithio'n rhan-amser yn ffurf sefydledig o weithio hyblyg sy'n golygu bod y gweithiwr yn lleihau ei oriau gwaith dan gontract islaw llawnamser (37.5 awr) er mwyn gweithio llai o ddiwrnodau neu ddiwrnodau byrrach mewn patrwm rheolaidd a drefnwyd ymlaen llaw.
Mae cyflog, gwyliau blynyddol a gwyliau banc yn cael eu lleihau pro rata.

Rhannu Swydd
Dyma lle mae dau weithiwr yn rhannu cyfrifoldebau, dyletswyddau a buddion un swydd llawnamser rhyngddynt.
Mae cyflog ac amodau gwasanaeth cyfunol yn cyfateb i gyflog un swydd llawnamser ac fe'u rhennir yn unol â nifer yr oriau a weithir gan bob rhannwr swydd. Mae'r egwyddor o rannu swydd fel arfer yn adlewyrchu patrwm gweithio integredig, lle gellir rhannu rhywfaint o'r gwaith a dosberthir tasgau eraill yn gyfartal i bob rhannwr. Ni ddylai cyfanswm yr oriau fod yn fwy na rhai swydd llawnamser.

Yn achos rhannu swydd, os bydd un rhannwr yn gadael, dylai'r person arall sy'n rhannu'r swydd gael cynnig swydd lawnamser (os caiff ei derbyn, rhaid i'r rheolwr lenwi ffurflen newid). Os nad yw'r rhannwr presennol y swydd eisiau gweithio'n llawnamser, rhaid hysbysebu oriau gwag y swydd.

Gweithio yn Ystod y Tymor
Mae gweithio yn ystod y tymor yn fath o waith rhan-amser lle mae'r gweithiwr yn gweithio yn ystod tymor yr ysgol yn unig a'i fod i ffwrdd o'r gwaith yn ystod gwyliau'r ysgol. Mae'r amser i ffwrdd yn cynnwys cyfuniad o wyliau blynyddol ac absenoldeb di-dâl. Mae'r cyflog yn seiliedig ar nifer yr wythnosau yn y gwaith ac yn cael ei dalu mewn 12 rhandaliad cyfartal. Fe'i cyfrifir ar sail unigol i ystyried hawl gwyliau blynyddol yn seiliedig ar hyd y gwasanaeth ac unrhyw drefniadau diogelu. Mae cyflog, gwyliau blynyddol a buddion cysylltiedig yn cael eu lleihau pro rata, a thelir cyflog mewn 12 rhandaliad cyfartal.

Oriau Tymhorol
Mae gweithwyr yn gweithio eu horiau contract dros gyfnod y cytunwyd arno, yn hytrach na nifer penodol o ddiwrnodau. Mae'r rhain yn aml yn oriau blynyddol, ond gallant fod yn chwemisol, yn chwarterol neu'n fisol.

Oriau cywasgedig
Gall gweithwyr weithio eu horiau contract llawn dros gyfnod byrrach nag sy'n safonol. Mae oriau contract a thâl yn parhau heb eu newid, ond gall gweithwyr gael mwy o ddiwrnodau neu hanner diwrnodau i ffwrdd. Mae enghreifftiau'n cynnwys wythnos 4½ diwrnod neu bythefnos 9 diwrnod. Rhaid cytuno ar y diwrnod nad yw'n ddiwrnod gwaith ar y cyd a gall fod yn hyblyg i ddiwallu anghenion y gwasanaeth.

Gostyngiad Gwirfoddol Dros Dro mewn Oriau
Gall gweithwyr leihau eu horiau contract rhwng 5% a 50% am gyfnod o ddim llai na 3 mis, a dim mwy na blwyddyn. Ar ddiwedd yr amser a gytunwyd, byddant yn dychwelyd i'w horiau contract gwreiddiol. Bydd cyflog/gwyliau blynyddol ac ati yn cael eu lleihau pro-rata am gyfnod y cytundeb. Cynghorir gweithwyr i gysylltu â'r gyflogres i benderfynu a fydd newid mewn oriau yn effeithio ar eu hawliau pensiwn. Os yw'r gweithiwr yn dymuno ymestyn y trefniant hwn am fwy na 12 mis, mae'n ofynnol iddo gyflwyno cais gweithio hyblyg newydd.

Amser Fflecsi ("Flexitime")
Mae gweithio oriau hyblyg ("Flexitime") yn gynllun sy'n rhoi rhywfaint o ddisgresiwn i weithwyr o amgylch amser dechrau a diwedd y diwrnod gwaith, yn seiliedig ar amseroedd gwaith craidd. Er mwyn elwa o hyn, byddai angen i adran fod â threfniant Oriau Hyblyg ar waith (ni fyddai pob adran mewn sefyllfa i gynnig yr opsiwn hwn).

Gall gweithwyr gronni debyd neu gredyd o oriau a weithir o fewn cyfnod y cytunwyd arno (4 wythnos fel arfer) a throi'r oriau ychwanegol yn ddiwrnod neu'n hanner diwrnod i ffwrdd. Mae'r cynllun oriau hyblyg fel arfer yn seiliedig ar weithdrefnau manwl y cytunwyd arnynt yn lleol sy'n nodi:

- yr oriau craidd
- cyfyngiadau ar weithio'n gynnar ac yn hwyr
- yr isafswm egwyl ginio y gellid ei chymryd
- uchafswm nifer yr oriau credyd a debyd y gellir eu cronni
- cyfyngiadau ar nifer yr oriau y gellir eu cario drosodd i'r mis nesaf
- cyfyngiadau ar nifer y diwrnodau i ffwrdd a ganiateir mewn unrhyw un cyfnod
- cyfyngiadau ar nifer y gweithwyr a ganiateir i fod i ffwrdd ar unrhyw un adeg.

Ymddeoliad Hyblyg a Rhannol
Mae nifer o ffyrdd y gall gweithiwr gynefino i ymddeol mewn ffordd hyblyg. Nodir manylion y mathau o hyblygrwydd sydd ar gael a'r prosesau sydd i'w dilyn yn y Polisi Ymddeoliad.

Oriau Cyfnodol
Mae hyn yn caniatáu i weithwyr benderfynu ar eu patrymau gwaith yn wythnosol ac wedi'i gynllunio.
Gellir gwasgaru oriau drwy'r wythnos neu ar un neu ddau ddiwrnod yn unig, o fewn amseroedd cyrraedd a gadael penodol, yn barhaol neu dros dro.

Hollti Sifftiau
Mae hyn yn caniatáu i weithwyr gwblhau eu horiau gwaith mewn dau sifft neu fwy ar wahân, e.e. gweithio rhwng 7am ac 11am, ac yna dychwelyd i'r gwaith rhwng 4pm a 7pm.

Seibiant Cyflogaeth
Cyfle i adael y gweithle am gyfnod penodol o amser (rhwng un a phum mlynedd fel arfer) a dychwelyd i'r un swydd neu swydd debyg yn y sefydliad ar ddiwedd y cyfnod hwnnw. Am ragor o fanylion gweler Polisi Seibiant Cyflogaeth Cymru Gyfan.

Yn seiliedig ar Dîm / Hunan Restru
Mae'r gwaith rhestru yn seiliedig ar dîm yn dechrau ar y rhagdybiaeth bod gan bawb anghenion a dewisiadau cydbwysedd rhwng bywyd a gwaith, a bod angen trafod y rhain yn agored ac ar y cyd, ymhlith pawb ar bob rhestr ward, o fewn cyfyngiadau gwasanaeth ac anghenion ariannol. Mae hunan-restru yn gofyn i unigolion roi eu gofynion personol ar y rhestr bob mis, yn aml ar sail 'y cyntaf i'r felin'.

Mae Rhestru Tîm a Hunan Restru yn cael eu cyflwyno ar sail adran gyfan. Er ei bod yn mynd i'r afael ag anghenion cydbwysedd bywyd gwaith, ac egwyddorion gweithio hyblyg yn berthnasol, ni fydd y broses ymgeisio a nodir yn y Polisi hwn fel arfer yn briodol at y diben hwn.

11

Atodiad 2

Ffurflen Gais i Weithio'n Hyblyg

Rhan 1 - Gwybodaeth y gweithwyr	
Enw'r Gweithiwr:	
Swydd:	
Band:	
Rhif y gweithiwr:	
Cyfeiriad e-bost:	
Adran:	
Grŵp Gwasanaeth:	
Rheolwr llinell:	
Hoffwn wneud cais i weithio patrwm gwaith hyblyg sy'n wahanol i'm patrwm gwaith presennol.	
Dyddiad dechrau'r newid y gofynnwyd amdano:	
Hoffwn i'r newid hwn fod yn Barhaol/Dros Dro (dilëwch fel y bo'n briodol):	Parhaol/Dros Dro* *Am gyfnod o……
Disgrifiwch eich patrwm gwaith presennol e.e. lleoliad/diwrnodau/oriau a weithir ac ati:	
Disgrifiwch y patrwm gwaith yr hoffech weithio e.e. diwrnodau/oriau/amseroedd a weithir/gartref/yn y swyddfa ac ati:	
A yw eich cais am weithio'n hyblyg mewn perthynas â Deddf Cydraddoldeb 2010 e.e. (cyfrifoldebau anabledd, mamolaeth, gofalu)? *D.S. Nid oes rhaid i chi roi'r wybodaeth hon, ond bydd yn helpu'ch rheolwr i wneud penderfyniad ar eich cais.*	Ydy/Nac ydy
Os 'Ydy', rhowch fanylion:	
Llofnod y gweithiwr:	
Dyddiad y cais:	

NAWR, RHOWCH Y CAIS HWN I'CH RHEOLWR LLINELL

Ffurflen Gais i Weithio'n Hyblyg

Rhan 2 - Derbyn cais	
Dyddiad derbyn	
Enw'r Rheolwr Llinell (printiwch os gwelwch yn dda)	
Teitl y Rheolwr Llinell:	
Trefnwyd cyfarfod/ sgwrs ar gyfer:	

Rhan 3 - Ffurflen Derbyn neu Wrthod	
Naill ai: Yn dilyn y cyfarfod a gynhaliwyd ar (Date)……. Rwyf wedi ystyried eich cais am batrwm gweithio hyblyg newydd. ☐ Rwy'n falch o gadarnhau fy mod yn gallu cymeradwyo'ch cais. Yn weithredol o (date). Bydd hwn yn newid parhaol/dros dro (dilëir fel y bo'n briodol). Os yw'n newid dros dro, daw i ben ar (date). ☐ Gallaf gymeradwyo'ch cais ar gyfnod prawf i'w weithredu o (date) a'i adolygu ar date). ☐ Ni allaf gymeradwyo'ch cais gwreiddiol. Fodd bynnag, gallaf gynnig y patrwm amgen yr ydym wedi'i drafod a gytunoch y byddai'n addas i chi. Nodwch sut y bydd y gwasanaeth yn cael ei gynnal a sut y gellir lliniaru unrhyw effaith ar weithwyr eraill.	
Bydd eich patrwm gwaith newydd fel a ganlyn: Neu: Mae'n ddrwg gennyf ond ni allaf gymeradwyo'ch cais am y rheswm (rhesymau) busnes canlynol (ticiwch bob un sy'n berthnasol): ☐ Baich y costau ychwanegol ☐ Effaith niweidiol ar y gallu i ddiwallu anghenion defnyddwyr/cleifion y gwasanaeth ☐ Anallu i ad-drefnu'r gwaith ymhlith y staff presennol ☐ Effaith niweidiol ar ansawdd ☐ Effaith niweidiol ar berfformiad ☐ Effaith niweidiol ar y gallu i gwrdd â gofynion gwasanaeth ☐ Dim digon o waith ar gyfer y cyfnodau y mae'r gweithiwr yn bwriadu gweithio ☐ Newid strwythurol wedi'i gynllunio i'r adran Mae'r rhesymau hyn yn berthnasol o dan yr amgylchiadau oherwydd (eglurwch pam mae unrhyw batrymau gweithio y gallech fod wedi'u trafod yn y cyfarfod yn amhriodol. Parhewch ar daflen wag, os oes angen, **D.S. rhaid cwblhau'r adran hon i ddisgrifio sut mae'r rheswm a ddewiswyd uchod yn berthnasol yn yr achos hwn)**	
Dyddiad dechrau'r trefniadau gweithio newydd (os yn berthnasol):	
Llofnod y Rheolwr Llinell:	
Enw'r Rheolwr Llinell (yn Llawn):	
Dyddiad:	
Cadarnhewch pa un sy'n berthnasol: **Bydd y newid hwn mewn patrwm gwaith yn newid parhaol i'ch telerau ac amodau cyflogaeth oni nodir yn wahanol ac nid oes gennych hawl yn ôl y gyfraith i ddychwelyd yn ôl i'ch patrwm gwaith blaenorol oni chytunwyd yn flaenorol.** Neu: Bydd hwn yn newid dros dro i'ch trefniadau gweithio tan…… pan gaiff y trefniadau eu hadolygu.	
Os ydych yn anfodlon gyda'r penderfyniad, gallwch apelio yn ei erbyn. Nodir manylion y weithdrefn apelio isod.	
Llofnod y Rheolwr Llinell:	
Teitl y Rheolwr Llinell (yn llawn):	
Dyddiad:	
Os ydych yn derbyn y newid a amlinellir uchod, llofnodwch a chadarnhewch dderbyn y penderfyniad.	
Llofnod y Gweithiwr:	
Dyddiad:	

I'r Gweithiwr:

Os ydych yn anfodlon â'r penderfyniad, gallwch apelio yn ei erbyn. Nodir manylion y weithdrefn apelio isod.

Proses Gwneudd Apel

Os gwrthodir cais am weithio'n hyblyg, mae gan y gweithiwr yr hawl i apelio yn erbyn y penderfyniad. Dylid cyflwyno apeliadau'n ysgrifenedig, gan nodi'r rhesymau dros apelio, cyn gynted â phosibl ar ôl cael hysbysiad o'r penderfyniad i wrthod y cais (o fewn 14 diwrnod).

Dylid cyflwyno'r apêl i reolwr eich rheolwr llinell, a'i chlywed gan uwch reolwr yn hytrach na'r rheolwr a wrthododd y cais gwreiddiol.

Mae gan y gweithiwr yr hawl i gael cwmni yn y cyfarfod hwn, a dylid rhoi rhybudd ymlaen llaw o ba bryd y bydd yn digwydd.

Nodiadau:

Rhan 1 - i'w chwblhau gan y Gweithiwr a'i hanfon at ei Reolwr Llinell

Rhan 2 a 3 - i'w cwblhau gan y Rheolwr Llinell

Dylid dychwelyd y ffurflen at y gweithiwr pan fydd wedi'i chwblhau a chadw copi ar ei ffeil bersonol.

Rhaid cwblhau Ffurflen Gwybodaeth Bersonol a'i chyflwyno i PCGC lle mae newid i'r oriau.

Designed by the NWSSP Communications Team

Equality Impact Assessment (EQIA) Form		
Ref no:		
Name of the policy, service, scheme or project:	Scope:	
Flexible Working Policy	The policy applies to all employees of the Health Board/Trust from day one of their employment with Health Boards and Trusts in Wales with the exception of doctors in training for whom flexible working arrangements are arranged by and subject to the approval of the Wales Deanery.	
Preparation		
Aims and Brief Description	One of the defining features of the modern British labour market is its flexibility. In Britain the uptake of flexible working arrangements has increased slowly but steadily over the last decade (CIPD, 2019). This policy sets out the principles underpinning flexible working arrangements that allow people to balance work responsibilities with other aspects of their lives. Flexible working contributes to a positive work/life balance, which benefits both NHS employees through improved health and wellbeing, and employers because staff are more productive and satisfied at work. Offering flexible working opportunities is a way of attracting and retaining a diverse workforce and make the workplace more accommodating to diverse needs. According to the CIPD flexible working is a valuable tool in improving workplace equality and creating inclusive cultures. It can help parents return to work, reduce the gender pay gap, help people with fluctuating health conditions stay in work and help carers to balance their work and caring responsibilities There is a strong, unmet demand for more flexible jobs; 87% of people want to work flexibly, but only 11% of jobs are advertised as being flexible!2 • Advertising jobs as flexible can help organisations access a wider and more diverse talent pool – so you can get the best person for the job. Flexible working practices are a key reason for staff at all career stages being satisfied with their work and staying with their employer: flexibility can reduce staff turnover.14 Flexible working: the business case 2 • For senior and managerial staff, flexible working arrangements	

	are pivotal for being able to continue to work and develop as professionals,15 particularly if they become parents. • For entry-level employees, flexible working reduces job-life spillover which in turn improves retention and commitment.16 • Higher levels of engagement, experienced by working flexibly, can reduce staff turnover by 87%.17 both from flexible-working-business-case_tcm18-52768.pdf (cipd.org) (CIPD November 2018) Research by Timewise (2017) People are most likely to say their reason for wanting to work flexibly is work/life balance, or it being generally useful or convenient. Other key reasons include commuting issues, leisure or study interests, and caring responsibilities. The policy aims to: • • to support managers to make a cultural shift so that rather than "We can't do this because…" the question becomes "How can we make this happen"? This means that the default position will be that a request for flexible working will be approved, and every possible avenue explored to facilitate this, unless there are clear business reasons in policy and law to decline it. • Promoting flexible working practices across all levels throughout NHS Wales • Providing a framework for managers and their staff to hold a well-informed, confident and productive discussion around their request to work flexibly and the flexible working options that may be suitable for them. • Promoting the business benefits of flexible working and ensuring that managers are fully engaged and supported to enable flexible working opportunities in their areas • Ensuring that all managers/supervisors understand the principles of flexibility in the workplace and the procedure to be followed. • Ensuring that all applications for flexible working are welcomed from all and considered fairly and equitably The policy follows on from the work undertaken to develop a more agile working culture within the organisation. The policy sets out the process by which staff can apply to work flexibly in order to improve their work life balance and to improve

	recruitment and retention. The Policy takes account of the AFC Terms and Conditions (section 33) and the commitment made by NHS Wales to achieving the highest standards of health care services through recruiting and retaining highly skilled and motivated staff as set out in its **Flexible Working statement**. Managers must consider whether the request is in relation to a reasonable adjustment related to a disability or another protected characteristic and employees are encouraged to identify where this is the case. The Policy states that NHS Wales is committed to treating all people equally and with respect irrespective of their age, disability, gender, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion or belief, or sexual orientation.
Who is involved in undertaking the EQIA	Rachel Pressley, Head of People Assurance and Experience, Cardiff and Vale UHB Vicky Richards, RCM Mitchell Jones, Senior Equality and Inclusion Manager, Cardiff and Vale UHB All Wales Flexible Working Policy Working Group
Have you consulted with stakeholders in the development of this policy?	A working group was established to develop the NHS Wales Flexible Working Policy is working group consisted of NHS Employers, Employers (Workforce) and staff side representatives. The revised policy was then sent out for consultation through: • Workforce Directors • Trade unions
Does the policy assist services or staff in meeting their most basic needs such as; Improved Health, fair recruitment etc	Yes. NHS Wales is committed to an agile working culture, which means that wherever possible requests for flexible working arrangements will be supported unless there is a legitimate reason for refusing them based on business grounds. NHS Wales is also committed to developing and maintaining a flexible working culture to support the most effective and efficient provision of services for the benefit of staff, patients and the organisation. The aim of this approach, as set out in the Flexible Working Statement, is to support managers to make a cultural shift so that rather than “We can’t do this

	because…" the question becomes "How can we make this happen"? Flexibility in employment is a key factor in demonstrating NHS Wales commitment to fair and equal treatment in the workplace and in attracting the highest calibre of staff to work for the organisation. Flexible working opportunities should be considered for all staff and made available as far as practicable, regardless of role, shift pattern, team or pay band. Flexibility means giving people options and allowing them to work in ways that meet their needs while also meeting the needs of your clients and organisation. This kind of adaptability can improve inclusion, diversity, and efficiency while also increasing engagement and performance. According to NVCO (the membership community for charities, voluntary organisations and community groups in England) there is still a stigma surrounding flexible working which can make it hard for people to ask for the working patterns they need to thrive and do their best work. They state that negative attitudes toward flexibility are too often a barrier to people applying for new or more senior roles and that at its heart, flexibility is about inclusion for everyone. Flexible working should be a central part of conversations about social justice, social mobility and how charities become more inclusive, equitable and diverse. We might typically associate flexible working with parents and carers, but there is growing understanding of how flexibility in employment can be of benefit to individuals of all ages, and in many different circumstances, across the voluntary sector.
Who and how many (if known) may be affected by the policy?	The policy will apply to all staff. NHS Wales recognises that staff have different needs at different times in their working lives and flexibility in employment makes it possible for them to make choices about how and when they wish to work, taking into account the needs of the service. Any form of flexible working must meet the business needs of the Health Board/Trust and its commitment and ability to meet the required level and quality of services to our service users and their families. It may not be possible to

	agree to the exact request, but managers are expected to discuss with employees alternatives that might be possible. Flexible Working is now a day one qualification for all NHS staff. Within the NHS there is no limit on the number of applications that can be submitted by an individual each year. This means that it is possible to be more responsive to changes in individual's circumstances.
What guidance have you used in the development of this service, policy etc?	The policy is based on: • NHS Terms and Conditions of Service • NHS Wales Flexible Working Statement, • Existing policies/procedures from NHS Wales organisations • RCN Flexible Working Guide • RCM Flexible Working Guidance • All Wales Flexible Working Key Principles – agreed in partnership in 2014 • Draft All Wales Flexible Working Guidance – under development in partnership • Workforce Partnership Council Report on Flexible and Agile Working – published in December 2022

Equality Duties

The Policy/service/project or scheme Aims to meet the specific duties set out in equality legislation.	Protected Characteristics										
	Race	Sex/Gender	Disability	Sexual orientation	Religion and Belief	Age	Gender reassignment	Pregnancy and Maternity	Marriage & civil Partnerships	Welsh Language	Carers
To eliminate discrimination and harassment	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Promote equality of opportunity	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Promote good relations and positive attitudes	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Encourage participation in public life	-	-	-	-	-	-	-	-	-	-	-
In relation to disability only, should the policy/service/project or scheme take account of difference, even if involves treating some individuals more favorably?			✓								

Key	
✓	Yes
x	No
-	Neutral

Human Rights Based Approach – Issues of Dignity & Respect

The Human Rights Act contains 15 rights, all of which NHS organisations have a duty. The 7 rights that are relevant to healthcare are listed below.

Consider is the policy/service/project or scheme relevant to:	Yes	No	N/A
Article 2: The Right to Life			✓
Article 3: the right not to be tortured or treated in a inhumane or degrading way			✓
Article 5: The right to liberty			✓
Article 6: the right to a fair trial			✓
Article 8: the right to respect for private and family life	✓		
Article 9: Freedom of thought, conscience and religion	✓		
Article 14: prohibition of discrimination	✓		

Measuring the Impact

What operational impact does this **policy, service, scheme or project**, have with regard to the Protected Characteristics. Please cross reference with equality duties

	Impact
consider: **Race** **Sex/gender** **Disability** **Sexual orientation** **Religion belief and non belief** **Age** **Gender reassignment** **Pregnancy and maternity** **Marriage and civil partnership** **Other areas** **Welsh language** **Carers**	According to the Future of Work Report | Equality and Human Rights Commission (equalityhumanrights.com) flexible work accounts for almost a quarter (23%) of the workforces across British nations (6.7 million workers in England, 650,000 workers in Scotland and 370,000 workers in Wales have flexible time arrangements). The national and regional distribution of workers on contracts with flexible time arrangements in Britain is almost identical to the national and regional distribution of all other workers. However, the availability of other types of flexible work varies across nations and regions: for example, Wales has relatively widespread flexibility in terms of the time of work arrangements, but flexibility in place of work and informal flexibility is rarer than in Scotland and England. They show that working flexible hours increased during the COVID-19 pandemic, eventually falling as the labour market started to recover. The number rose by 21% between October to December 2019 and October to December 2020 (from 6.3 million to 7.7 million), before falling to 7.1 million between April and June 2021. Since then, headline employment numbers have continued to improve. As of October to December 2021, the number of people on flexible contracts is 53% higher than it was in 2009 (rising from around 5.1 million to 7.7 million), making up almost a quarter (23%) of all workers, compared to 17% in 2009. The data shows that, since 2009, inflexible employment has declined slightly and flexible employment accounts for all growth. The Future Work report states that It is not clear how much of the increased move to flexible working during the COVID-19 pandemic – whether in terms of time or place – will be permanent. However, as more evidence is collected, it appears that the demand for increasing flexibility continues. Research by the Trades Union Congress (TUC) showed that, in Britain, more than nine out of ten people (91%) who worked remotely during the pandemic wanted to continue working from home at least some of the time after the pandemic (TUC, 2021b). According to the NHS Workforce data briefing September 2023 by Audit Wales NHS Wales is becoming a more flexible and equal employer but there is still more to do. • The participation rate of part time working in NHS Wales shows that generally fewer people are working part time up to the age of 30. Between the ages of 30 and 55 part time working is

increasing and beyond the age of 56, there is a clear movement to more staff working part time. The 'participation rate' is a measure of part-time working across an organisation's workforce. The higher the participation rate the more hours on average, an individual will work each week. 100% participation would mean that all staff are working full working weeks the briefing shows that female employees have a participation rate of 86% and male employees have a participation rate of 94%.

- NHS data on the ethnicity of the total workforce shows increasing employment of minority ethnic groups
- The percentage of staff identifying as disabled has increased over the last 5 years across Wales. The highest proportion of staff identifying as disabled are in Allied Health Professional (4.6%) and Admin and Clerical (4.3%) staff groups.
- Around third (30%) of NHS Wales staff have not stated their Welsh language competency in ESR. But of those who have, 59% of staff have indicated that they have no skills and only around 13% have identified that they have higher or proficient Welsh language skills

AGE:

According to the Future of Work Report | Equality and Human Rights Commission (equalityhumanrights.com) In Britain between 2009 and 2019, workers aged 50 to 69 years old experienced the sharpest increase in flexible working (a 27% increase in the number of older workers in flexible work). This was followed by workers aged 25 to 49 years old (a 10% increase), with no increase for workers aged 16 to 24 years old. In 2009 approximately 5 million workers were employed in flexible work, 6% of people aged 16 to 24, 9% of those aged 25 to 49 and 9% of those aged 50 to 69. Flexible working arrangements increased throughout the COVID-19 pandemic for workers of all ages.
By 2021 those employed in flexible work had increased to 7.7 million workers. Of workers aged 16 to 24, 15% had flexible working arrangements, as did 25% of those aged 25 to 49 and 24% of people aged 50 to 69. Older workers were consistently employed more in flexible work. There are many reasons that could explain this difference, including individual needs and job requirements (CIPD, 2019). For example, older people are more likely to work flexibly to manage health conditions, caring responsibilities and / or to adjust towards retirement.

For many older workers, having access to flexible working opportunities is important for remaining active in the labour market. In particular, for people with additional needs or responsibilities, such as caring for a relative or managing a health condition, flexible working is imperative. (AGE UK)

According to the CIPD report 'Understanding Older Workers', older workers have higher rates of part-time working than younger workers. However, the finding that many would prefer shorter hours suggests there is still not enough flexibility to fully cater to older workers' preferences and employers should consider requests for reduced

hours. Older people are also much more likely to have caring responsibilities. This underlines the importance of ensuring employers take steps to increase the availability and range of flexibility as a means of both attracting and retaining workers as they get older.

The Equal Opportunities Commission says that discriminating against an employee or prospective employee because they are 'too old' or 'too young' is illegal and anyone who is subjected to unfair treatment or treated differently because of their age is considered to be a victim of age discrimination. All staff can apply for flexible working from day one of employment, and the Policy sets out the only reasons which can be given for rejecting an application. However, there may be differences in the ways different groups of staff want to work flexibly, for example, term-time working is designed specifically to assist employees with school age children, and is therefore more likely to be requested by younger workers.

One in eight older workers are forced out by ill health, and others are unable to fit work around caring responsibilities. Ethnically diverse communities and those in low-income jobs far more likely to have to stop work early for health reasons. Flexible working would benefit older workers managing long-term health conditions, needing to reduce their workload or with increased caring responsibilities by supporting them to stay in work longer if they want to. (https://www.tuc.org.uk/research-analysis/reports/extending-working-lives-how-support-older-workers 22 https://www.tuc.org.uk/research-analysis/reports/older-workers-after-pandemic-creating-inclusivelabour-market)

DISABILITY:

According to the Future of Work Report | Equality and Human Rights Commission (equalityhumanrights.com) the number of disabled workers on flexible contracts rose 58% from 2013 to 2019 (19% to 21% of disabled workers), far more than the 8% increase for non-disabled workers (from 18% to 19% of non-disabled workers). This increase continued throughout the COVID-19 pandemic for both groups. The number of disabled workers on flexible contracts increased by 127% (from approximately 540,000 to 1.1 million) from 2013 to 2021, while for non-disabled workers the number rose by 43% (from 4.5 million to 6 million). In 2021, disabled and non-disabled workers were almost equally likely to work flexibly, with 26% of disabled workers and 25% of non-disabled workers having flexible working arrangements, an increase from 19% and 18% respectively in 2013. Many disabled people and representative organisations have advocated for greater availability of flexible and remote working. For some, remote working can be a way to gain and retain employment, as it helps to overcome some accessibility issues (EHRC, 2017). Under the Equality Act 2010, flexible working arrangements can also be a reasonable adjustment for disabled workers.

If an employee is disabled, it may be a reasonable adjustment to allow them to work flexibly if this removes a barrier to them being able to do the job (EHRC Guidance). Employers must make reasonable adjustments to make sure workers with disabilities, or physical or mental health conditions, are not substantially disadvantaged when

doing their jobs. Reasonable adjustments for workers with disabilities or health conditions - GOV.UK (www.gov.uk)

The Equality and Human Rights Commission states that equality law recognises that bringing about equality for disabled people may mean changing the way in which employment is structured, the removal of physical barriers and/or providing extra support for a disabled worker. This is the duty to make reasonable adjustments. The duty to make reasonable adjustments aims to make sure that, as far as is reasonable, a disabled worker has the same access to everything that is involved in doing and keeping a job as a non-disabled person

MATERNITY AND PREGNANCY:

- Employers are legally required to take reasonable steps to protect both the health and safety of pregnant employees and their baby. For example if they are finding it difficult to stand for long periods of time because of their advanced pregnancy, the employer must provide a suitable work space where they can sit down more frequently or take extra rest breaks. If sitting down or taking extra breaks are not feasible, the employer must provide suitable alternative work on similar conditions and terms. If there is no suitable work available, they would be entitled to have a suspension with full pay. (Equal Opportunities Commission)
- The Policy states that If at the end of their maternity leave an employee wishes to return to work on different hours, their manager has a duty to facilitate this wherever possible, with them returning to work on different hours in the same job. If this is not possible, the manager must provide written, objectively justifiable reasons for this and the employee should return to the same grade and work of a similar nature and status to that which they held prior to her maternity leave. These provisions are mirrored for staff on adoption leave and is also available to staff returning from Shared Parental Leave. Employees who return to work following Maternity Leave who are breastfeeding are entitled to frequent breaks, a private room etc. and do not need to access this Policy to achieve this

RELIGION & BELIEF:

- The ACAS guide for Religion or Belief discrimination: key points for the workplace (2018) states that an employer is under no obligation to automatically give staff time off for religious holidays or festivals, time to pray or a place to pray. However, it should consider requests carefully and sympathetically, be reasonable and flexible where possible, and discuss the request and explore any concerns with the employee. Refusing a request without a good business reason could amount to discrimination
- Some religions or beliefs may require their followers to pray at certain times of day, to have finished work by a particular time or to fast for extended periods (EHRC). This may have flexible working implications
- The Equality and Human Rights Commission website has a toolkit to support employers if staff request a change to their working conditions because of their religion, belief or lack or religion or belief. They advise that whether you say yes or no will depend on the circumstances of each case. You need to balance the effect of agreeing to the request on your business and other staff, against the effect on the individual of

not agreeing to the request.

GENDER

- According to the Future of Work Report | Equality and Human Rights Commission (equalityhumanrights.com)Women are more likely to use flexible working arrangements than men in Britain, but since 2009 the use of flexible working arrangements has increased at a faster rate among men. Between 2009 and 2021 in Britain, on average 22% of women in work had flexible working arrangements compared to 16% of men. This is according to our analysis of data from the Labour Force Survey. Literature suggests that this contributes to some disadvantages for women, for example the gender pay gap (Costa Dias et al. 2018), and negative consequences for career progression (Chung, 2020). The COVID-19 pandemic, lockdowns, and widespread working from home for both men and women may have changed some of the negative perceptions around flexible work. Some evidence suggests that the appetite for continued remote working is equally high for men and women, and that the gender care gap narrowed during the pandemic between March and October 2020 (from 6.96 to 4.59 hours per week) (Nicks et al., 2021b). On the other hand, there is evidence to suggest that there were differences between how men and women experienced remote working during the pandemic, with women being more likely to report negative impacts on health, work–life balance and stress (Jones and Bano, 2021; Aviva, 2021). However, this requires further research to distinguish which patterns are long term and which are likely caused by unique circumstances during the pandemic. The number of women on flexible contracts rose 10% from 2009 to 2019, while the number of men on flexible contracts rose by 33% during the same period. This increase continued throughout the pandemic for both sets of workers. As of 2021, the number of women on flexible contracts is approximately 44% higher than in it was in 2009 (an increase from around 3.1 million to around 4.3 million), while the number of men on flexible contracts has risen by 65% (from around 2.1 million to around 3.5 million). The proportion of women on flexible contracts increased from 24% in 2009 to 29% in 2021, and the proportion for men increased from 15% in 2009 to 22% in 2021. Still, in November 2021, over 800,000 more women than men were working flexibly.
(Chung, H. (2020), 'Gender, Flexibility Stigma and the Perceived Negative Consequences of Flexible Working in the UK', Social Indicators Research, vol. 151, pp. 521–545.
Costa Dias, M., Joyce, R. and Parodi, F. (2018) 'IFS Working Paper: The gender pay gap in the UK: children and experience in work'. London: Institute for Fiscal Studies [accessed: 5 April 2022]
Nicks, L., Gesiarz, F. Likki, T., Baynham-Herd, Z. and Lohmann, J. (2021b), 'Impact of changes in flexible working during lockdown on gender equality in the workplace', London: The Behavioural Insights Team [accessed: 7 April 2022].
Jones, P. and Bano, N. (2021), 'The Right to Disconnect', Autonomy Website [accessed: 7 April 2022].

- Women are bearing the brunt of caring responsibilities, with almost six out of 10 avoiding applying for promotion because it was too hard to balance work and care. Research from Business in the Community carried out by Ipsos revealed that one in five women (19%) have left a job because of difficulties balancing work with caring responsibilities. Women account for 85% of sole carers for children, and 65% of sole carers for older adults.

- While women are more likely than men to use flexible working arrangements, since 2009 the uptake of flexible work has been increasing at a faster rate among men. (future of work report)

- Making flexible working available in all but the most exceptional of circumstances promotes greater gender equality. Research has shown that many of the underlying causes of the gender pay gap are connected to a lack of quality jobs offering flexible work. The unequal division of unpaid care and the lack of flexible working in jobs means that women often end up in part time work. (https://timewise.co.uk/article/article-real-reasons-behind-gender-pay-gap/, https://www.tuc.org.uk/sites/default/files/2019-10/BEISFlexibleworking.pdf)

GENDER REASSIGNMENT

- If a request to work flexibly is made because an employee proposes to undergo, is undergoing or has undergone gender reassignment, the employer should consider the request on the same basis as they would consider any similar request made under the right to request flexible working. Employers should not refuse a request or treat it less seriously because it is being made by a transsexual person (EHRC Guidance).

  A Government Equalities Office publication (2015) offering guidance for employers on the recruitment and retention of transgender staff states that "We know that trans people often leave their jobs before transitioning and often take lower paid jobs when they return to the workplace, often because of the possible discrimination they imagine they will face if they stay in their place of work. This can result in a loss of expertise and investment for their original employer."

- CIPD guidance on Transgender and non-binary inclusion at work advises that organisations should not remove someone from duties against their wishes while they're transitioning. However, transitioning employees may request temporary redeployment, flexible working or adjustments to their role. This must be led by the individual's preferences, and you should accommodate requests as far as is possible

SEXUAL ORIENTATION

- A Business in the Community report 'Working with Pride - issues affecting LGBTQ+ people in the

workplace' found that in relation to carers, gay/bi+ people are less likely to be accessing support from line managers, home working and flexible working policies, especially in the case of gay/bi+ male carers.

RACE

- Research commissioned by **Business in the Community**, The Prince's Responsible Business Network and Ipsos UK found that one in three (32%) Black, Asian, Mixed Race and other ethnically diverse people have left or considered leaving a job due to a lack of flexibility compared with one in five (21%) white people. The research also found that some groups were significantly more likely than others to have not applied for a job or promotion, or to have considered leaving or actually left a job, because of challenges combining paid work and care, including Black, Asian, Mixed Race and other ethnically diverse people; those on lower incomes; and shift worker

- According to the Future of Work Report | Equality and Human Rights Commission (equalityhumanrights.com) the number of workers from ethnic minorities on flexible contracts rose by 79% from 2009 to 2019, compared to 7% for White British workers. This saw the proportion of workers on flexible contracts increase from 18% of ethnic minority workers and 19% of White workers to 20% of both groups in 2019. This increase continued throughout the COVID-19 pandemic for all groups, with the number of workers from ethnic minorities on flexible contracts 171% higher in 2021 compared to 2009 (from approximately 700,000 to 1,740,000 workers), while the number of White British workers on flexible contracts only rose by 38% (from 4.5 million to 6 million). In 2021, this increased further, with 26% of workers from ethnic minorities and 25% of White British workers having flexible working arrangements.

OTHER FACTORS

- Flexible working supports a better work life balance, improved wellbeing, improving the experience of work for carers. It also improves productivity, increases staff retention and better recruitment (https://www.tuc.org.uk/research-analysis/reports/future-flexible-work?page=2#section_header)
- In some cases, the Equality Act can also protect carers from being treated unfairly because of their association with the person they care for; Associative discrimination or 'discrimination by association' comes about when someone is treated unfavourably on the basis of another person's protected characteristic. Discrimination by association doesn't apply to all protected characteristics. Marriage and civil partnership, and pregnancy and maternity are not covered by the legislation. Nor does it apply to instances of indirect discrimination by association - it has to be direct. This Policy will support staff in managing their work life balance more effectively (e.g. parents, those with caring responsibilities) Discrimination by Association should be considered when considering requests for flexible working,

- The ability to provide a service to Welsh Speaking patients should be considered when deploying our workforce (e.g. when considering requests for flexible working)
- Numerous studies have found that flexible working arrangements can have a significant positive impact on people's mental health with better sleep and lower stress levels as common outcomes. Equally, someone's mental health can have a significant impact on their ability to perform well in their job.
- CIPD 2018 quoted research which has shown that flexible working can reduce absence rates as it allows employees to manage disability and long-term health conditions, and caring responsibilities, as well as supporting their mental health and stress. Parents and carers (especially those on low incomes) benefit the most – they tend to have increased wellbeing and are less troubled by stress when given access to flexible work
- An ONS report from December 2018 showed that 25.8% of women were economically inactive (i.e. not employed or looking for/available for work, compared with 16.1% of men. The second biggest reason for being ecomically inactive is looking after family or home (the largest category is students)
- The Policy states that flexible working opportunities should be considered for all employees and made available as far as practicable, regardless of role, shift pattern, team or pay band and should also be considered for employees who work on rotation. It is not sufficient for departments who have a traditional way of working to reject an application for flexible working just because it has not been tried before or because 'this is how it has always been done'.
- The Policy states that Managers must consider whether the request is in relation to a reasonable adjustment related to a disability or another protected characteristic. Employees are encouraged to identify where this is the case. Managers should also consider any health and safety issues that might result from the change and identify ways to mitigate them (e.g., if the working arrangements will mean the employee or their colleagues would become lone workers). Advice can be sought from People Services/Human Resources, Health and Safety and Occupational Health as appropriate.

  Research by Timewise has shown that good flexible working can help households manage rising costs. The 2021 Flexible Jobs Index noted that only 1 in 4 jobs are advertised as flexible in any way. There are even fewer part-time jobs advertised (just 1 in 10), and they are clustered at the lowest-paid end of the scale, with very few higher-paid ones available. This is a particular problem for parents, carers or those with health issues or other responsibilities, who simply can't work full-time. Being able to find a quality part-time or flexible role can allow them to get into (or back into, or progress in) the workplace and increase their household income. And the availability of good flexible jobs also has a positive impact on society as a whole. Evidence shows that flexible working can play a part in tackling social inequality, reducing child poverty, supporting social mobility, and increasing workplace diversity.

	Monitoring Arrangements Each Department will keep a record of all formal applications for Flexible Working and a record of approvals/ rejections and appeals. Organisations should ensure that data relating to applications for flexible working and outcomes of decisions are recorded and regularly reported through the usual joint partnership and governance structures. This information should be included in an organisation's published annual statutory public sector duty reports. The published information should demonstrate outcomes for flexible working applications disaggregated by each protected characteristic of the Equality Act 2010. In addition, organisations should consider reporting outcomes by occupational group and also by department.