Bundle Strategic Development Committee 13 October 2022

1.0.0 STANDARD BUSINESS

1.1.0 Welcome & Introductions

Led by Chair: Stephen Harries

1.2.0 Apologies for Absence

Led by Chair: Stephen Harries

1.3.0 Declarations of Interest

Led by Chair: Stephen Harries

2.0.0 CONSENT ITEMS

Nil

3.0.0 ITEMS FOR APPROVAL

3.1.0 Minutes of the Committee Meeting held on 7th July 2022

Led by Chair: Stephen Harries
To approve

3.1 PUBLIC Strategic Development Committee Minutes 07.07.22 - DRAFT - LF_SH.docx

3.2.0 Action Log of the Committee Meeting held on 7th July 2022

Led by Chair: Stephen Harries
To approve

3.2 PUBLIC Strategic Development Committee Action Log 07.07.22.docx

4.0.0 ITEMS FOR ENDORSEMENT

4.1.0 Replacement Laboratory Information Management System (LIMS) for the Welsh Histocompatibility & Immunogenetics Service (WHAIS)

Led by Carl James, Director of Strategic Transformation, Planning and Digital
To endorse

4.1 20221013 SDC Part A WHAISIT Business Case (cover paper).docx

4.1 20221013 SDC Part A WHAISIT Business Justification Case (appendix 1) Strategic Case.docx

5.0.0 ITEMS FOR REVIEW/DISCUSSION

5.1.0 Integrated Medium Term Plan Accountability Conditions

Led by Lauren Fear, Director of Corporate Governance and Chief of Staff & Carl James, Director of Strategic Transformation, Planning and Digital
To discuss and review

5.1 SDC Cover Paper - Trust Board Accountabilities for the IMTP 2022-2025.docx

5.1 SDC Appendix 1 - IMTP Account Conditions 2022.25 version001.docx

5.2.0 Integrated Medium Term Plan 2023-26

Led by Carl James, Director of Strategic Transformation, Planning and Digital (plus accountable Execs)
To note

5.2 SDC - 13th October 2022 - IMTP Planning Process.doc.docx

5.3.0 Trust Assurance Framework

Led by Lauren Fear, Director of Corporate Governance & Chief of Staff
To discuss and review

5.3 TAF Review Paper - September 2022 - SDC- Final.docx

5.3 TAF DASHBOARD - FINAL for SDC.pdf

5.4.0 Welsh Blood Service Infrastructure – Business Case Update

Led by Alan Prosser, Director, WBS
To note

5.4 WBS Infrastructure Programme - SDC Cover Paper Sep 13th October 2022.docx

5.5.0 Hefyd+ Community, Staff and Patient Engagement Programme

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

5.5 Hefyd Summer Update Strat. Dev. Committee Report Oct 2022_D0.1.docx

5.5 Appendix A - Velindre Hefyd Sponsorship Group_0.3_CLEAN.docx

5.5 Appendix B - SUSTAINABLE SUMMER JAMBOREE Report.pdf

5.5 Appendix C - Hefyd Ppt 7.10.pptx

5.6.0 Research, Development & Innovation Sub-Committee Highlight Report

Led by Jacinta Abraham, Executive Medical Director
To note

5.6 RDI Highlight Report to SDC 131022 FINAL.docx

6.0.0 ANY OTHER BUSINESS

Prior agreement by the Chair required

7.0.0 REVIEW OF THE MEETING

Led by Chair: Stephen Harries

8.0.0 DATE AND TIME OF NEXT MEETING

Thursday 8th December at 4-5pm

9.0.0 CLOSE

Strategic Development Committee
Public Session

MINUTES OF THE MEETING
Held on 7th July 2022 @ 14:30-16:30
Trust Headquarters, Nantgarw
(via Teams)

Chair:		
Stephen Harries	Vice-Chair, Independent Member	SHarries
Members:		
Andrew Westwell	Independent Member	AW
In Attendance:		
Steve Ham	Chief Executive Officer	SHam
Carl James	Director of Strategic Transformation, Planning & Digital	CJ
Lauren Fear	Director of Corporate Governance & Chief of Staff	LF
Dr Jacinta Abraham	Executive Medical Director	JA
Philip Hodson	Deputy Director of Planning & Performance	PH
Peter Gorin	Head of Corporate Planning & Performance	PG
Alan Prosser	Director of Welsh Blood Service	AP
Matthew Bunce	Executive Director of Finance	MB
Sarah Morley	Executive Director of OD and Workforce	SfM
Nigel Downes	Interim Deputy Director of Nursing, Quality and Patient Experience	ND
Rachel Hennessy	Acting Director, VCC	RH
Rhian Gard	Principal Auditor, NWSSP	RG
Heledd Thomas	Senior Auditor, Audit Wales	HT
Liane Webber	Business Support Officer/Secretariat	LW
In Attendance for Item 3.4.0		
Cath O'Brien	Chief Operating Officer	COB

1.0.0	STANDARD BUSINESS	ACTION

1.1.0 Welcome & Introductions

SHarries welcomed attendees to the meeting.

1.2.0 Apologies for Absence

Apologies were received from:

- Donna Mead
- Gareth Jones
- Emma Rees
- Nicola Williams
- Stephen Allen
- Cath O'Brien (joined for item 3.4)

1.3.0 Declarations of Interest

There were no declarations of interest.

2.0.0 CONSENT FOR APPROVAL

2.1.0 Minutes of the Committee Meeting held on 16th May 2022

The Committee **approved** the minutes of the meeting held on 16th May 2022.

2.2.0 Action Log

The Committee **approved** the updated action log and the updates provided.

3.0.0 ITEMS FOR REVIEW/DISCUSSION

3.1.0 Welsh Blood Service Five-Year Plan

AP noted an incorrect statement in the cover paper which states that the Five-Year Plan has been developed in conjunction with staff, donors and engagement with the Community Health Council. AP clarified that whilst staff have indeed been widely consulted, engaging with CHC and donors is planned as part of the strategy.

AP outlined the WBS Five Year Plan and thanked RH for her work in leading on the work in its initial stages.

SHarries queried how the Five-Year Plan fits in with the broader Trust strategies. CJ explained that although there is still work to be done to bring all of the work together, the document has been structured to align with the Trust's five strategic goals.

AW highlighted the section, currently incomplete due to the document's draft status, entitled "How will we deliver *(examples to show direction of travel)* and welcomed the inclusion of examples and case studies which AP confirmed are currently being drafted.

SHarries sought further information regarding links with Research, Development & Innovation. AP highlighted Strategic Theme 5 as being one of the areas still under development and the intention is to include Research, Development & Innovation as part of this Strategic Theme.

SHarries also requested clarity of the reference to collaborative working in Strategic Theme 3 (prudent use of blood across Wales) and queried to what extent this applies to management working collaboratively across organisations, or the collaborative working of clinicians across organisations. AP explained that collaborative working in both aspects across Wales is already in place and, although work is still needing to be done, is already proving to be effective. MB noted that a bid has been submitted to the value-based healthcare fund which will help to drive forward the agenda.

AW highlighted the importance of EDI aspects and broadening the diversity of both donor base and future workforce planning. AP reported on recent involvement with WG UK Forum to help diversify blood collection and bone marrow volunteer communities.

The Committee **noted** the Welsh Blood Service Five Year Plan.

3.2.0 Performance Management Framework

CJ gave a presentation on the progress of the Performance Management Framework which was well received. Noted that senior staff members and IMs are being kept informed of progress and are provided with opportunities to offer feedback and comments through a series of 1:1 meetings.

The Committee **endorsed** the Project Management Framework for Trust Board approval.

3.3.0 Plasma Memorandum of Understanding

AP outlined the paper, the purpose of which is to provide an update as to the current status of the service in terms of the critical plasma for medicines issue. AP reported that discussions are ongoing with Welsh Government, who are keen to promote involvement in a UK-wide discussion.

The Committee **noted** the Plasma Memorandum of Understanding.

3.4.0 Update on progress of the Advanced Therapies Wales & Midlands and Wales ATTC Programmes

COB outlined the work undertaken on the Advanced Therapies Wales and Midlands and Wales ATTC Programmes and reported positively on the progress made. Noted that further progress updates will be provided to the Committee in the autumn.

AW queried the UK manufacturing capabilities for cell and gene therapies due to their highly specialised nature. COB advised that the Cell and Gene Therapy Catapult in Stevenage has grown and work is underway to look at the next stage of growth and where it may be located. COB also reported on various options currently being considered in Wales which are currently in their very early stages.

The Committee **noted** the Update on progress of the Advanced Therapies Wales & Midlands and Wales ATTC Programmes

3.5.0 Trust Assurance Framework

LF gave a brief outline of the paper and updates made since its previous submission to the Committee and drew attention to several inconsistencies between the cover paper and appendix (to clarify, risks 1, 5, 8 and 9 - inherent is 16, residual is 12) which, due to time constraints were not able to be corrected prior to distribution to the Committee but will be amended prior to submission to Trust Board.

LF highlighted section 3. which outlines the key developments since the last meeting.

The Committee **noted** the Trust Assurance Framework and Dashboard and **noted** the progress made in terms of continued development.

3.6.0 Nuffield Trust Progress Report

CJ presented the Nuffield Trust Progress Report which was **noted**.

3.7.0 University Status Showcase Event

LF outlined the paper which was produced following attendance at a recent University Status Showcase Event. JA gave further feedback and reportedly positively on the event and its value to the Trust.

SHarries highlighted a comment in the appendices which refers to "…a firm footprint for research at the new Velindre Cancer Centre, particularly to enable cutting-edge radiotherapy research" and queried whether this referred to a physical footprint, to what extent networks of clinicians would be working together and how this will be supported within the current plans. CJ explained that in terms of capability around radiotherapy research, once the winning bidder is approved there is an option included for an additional LINAC which will be used for R&D purposes and this will be in partnership with the University. JA highlighted the existing radiotherapy strategy and noted that radiotherapy research forms part of the ten-year cancer research ambitions, the detail and implementation of which is currently being progressed.

The Committee **noted** the University Status Showcase Event.

4.0.0 ANY OTHER BUSINESS

There we no additional items of business.

5.0.0 REVIEW OF THE MEETING

There were no additional comments or questions.

6.0.0 DATE AND TIME OF NEXT MEETING

Thursday 13th October @ 10.00am

Via Microsoft Teams

Strategic Development Committee

7th July 2022

Action Summary

Minute Ref.	Action	Assigned to	Meeting Date	Target Date	Progress to date	Status (Open / Closed)
4.1.0	Consideration of Trust role in the Regional Partnership Boards. In the May meeting, CJ suggested writing to the regional partnership boards as an organisation to understand what is on their individual agendas, to give a sense of where we can add the most value.	Carl James	12/08/21	~~07/07/22~~ 13/10/22	CJ has written to the Regional Partnership Boards – extract: 'I am seeking to understand what the key priorities are for each Regional Partnership Board for 2022 – 2025 to allow us to enter into further discussions with partners to determine where there is a need that we best assist and add the most value to the work.' To report back to Committee – either in next meeting or beforehand if next steps agreed	**OPEN**
3.1.0	Include further case study examples in the Enabling Strategies.	Carl James	16/05/22	17/10/22	Will be included in final Strategy launch. Final versions will be circulated by week commencing 17th October	**OPEN**
3.8.0	AW gave a brief outline of the RD&I Highlight Report. JA noted that as this was their first Highlight Report to this Committee, feedback from the group in terms of future content is welcomed.	All	16/05/22	07/07/22	To agree closure in the Committee	**CLOSED**

Minute Ref.	Action	Assigned to	Meeting Date	Target Date	Progress to date	Status (Open / Closed)
	Agreed that this should be provided by email outside of the meeting.					

STRATEGIC DEVELOPMENT COMMITTEE

BUSINESS CASE FOR REPLACEMENT LABORATORY INFORMATION MANAGEMENT SYSTEM (LIMS) FOR THE WELSH HISTOCOMPATIBILITY & IMMUNOGENETICS SERVICE (WHAIS)

DATE OF MEETING	13/10/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Felicity May, Clinical Specialist H&I Digital Lead David Mason-Hawes, Head of Digital Delivery
PRESENTED BY	Alan Prosser, Director of Welsh Blood
EXECUTIVE SPONSOR APPROVED	Alan Prosser, Director of Welsh Blood

REPORT PURPOSE	ENDORSE FOR BOARD APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
WBS Laboratories Digital Transformation Board	14/06/2022	IN SUPPORT
WBS Senior Management Team	13/07/2022 10/08/2022	IN SUPPORT
Executive Management Board	03/10/2022	ENDORSED
Strategic Development Committee		
Trust Board		

ACRONYMS	
H&I	Histocompatibility and Immunogenetics
LIMS	Laboratory Information Management System
LINC	Laboratory Information Network Cymru
WHAIS	Welsh Histocompatibility and Immunogenetics Service
WTAIL	Welsh Transplantation and Immunogenetics Laboratory
WBMDR	Welsh Bone Marrow Donor Registry

1. SITUATION/BACKGROUND

1.1 The purpose of this business case is to seek approval to procure a replacement Laboratory Information Management System (LIMS) for the Welsh Histocompatibility & Immunogenetics (H&I) Service (WHAIS).

1.2 WHAIS is part of the Welsh Transplantation and Immunogenetics Laboratory (WTAIL) and provides laboratory results and clinical advice to support kidney, pancreas and stem cell transplantation, selected platelet transfusion and some genetic disease diagnosis.

1.3 The current WHAIS IT system was developed in-house in the early 90s. The system has therefore been in operational use for around 30 years, is no longer fit for purpose and confers a significant risk to the organisation (see quality / safety implications below). This is reflected on the Divisional and Trust risk registers.

1.4 A previous project to replace WHAIS LIMS (LIMS1) was unsuccessful due to a failure of the company to meet the specified requirements. However, there are key differences between LIMS1 and this proposal:

1.4.1 LIMS1 sought a solution for all WTAIL (which includes the WBMDR). This case seeks only a solution for WHAIS, recognising the different requirements for each system and how that points to different IT solutions for each area.

1.4.2 H&I requirements are not supported by the majority of standard LIMS. 10 years ago there were no viable commercial options available on the market so the only option for LIMS1 was to develop a system with the supplier. There are now off-the-shelf commercial systems specifically designed for H&I laboratories.

1.4.3 WHAIS issued a Prior Information Notice to the marketplace and saw demonstrations of at least 5 solutions deemed to be suitable. WHAIS intends to tender for the most appropriate system and adapt our workflows around it rather than extensively develop a system around us.

1.5 Due to the commercially sensitive nature of the information captured within the complete 5-model business case the Strategic Development Committee are asked to **ENDORSE FOR BOARD APPROVAL** the Strategic Case, attached as Appendix 1.

1.6 All other cases, including full details of all projected financial costs etc., are included in the complete 5-model business case.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 We seek support for this business case to progress to Trust Board for final approval.

2.2 Although the WHAIS system was 'decoupled' from the national procurement of the all-Wales LINC solution, the entirety of the WTAIL IT / LIMS requirements remained in scope of the LINC programme. It is recognised within the scoping documents of LINC that the delivery of WTAIL (including WHAIS) IT requirements would be delivered via a separate procurement to the national (pathology) "core" LIMS.

2.3 The intention is to seek financial support from Welsh Government via the LINC programme for the stated staffing, implementation and contract costs.

2.4 The attached document – Appendix 1 – sets out the Strategic Case section from the complete 5-model business case for the review of the Strategic Development Committee.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	• Existing system is built on obsolete/unsupported technology which puts our patient data at increasing risk in terms of stability and security. • WBS only has a single member of staff in the Digital Services team who has the appropriate programming expertise to deal with the system. • The system has had very little development and poorly supports WHAIS operations and requires multiple manual workarounds. • Limitations of the IT system leading to incidents/risk of error with the potential to impact patient care. Only extensive manual checks and staff diligence are currently mitigating this risk. • The limitations of the IT system were attributed to at least three findings in the most recent UKAS (ISO 15189) inspection and the recommendation was to implement a new LIMS
RELATED HEALTHCARE STANDARD	Effective Care
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	See Appendix 1 – Business Justification Case

4. RECOMMENDATION

4.1 The Strategic Development Committee are asked to **ENDORSE FOR BOARD APPROVAL** the Strategic Case, attached as Appendix 1, for the procurement and implementation of a commercial “off-the-shelf” H&I-specific LIMS solution for the WTAIL WHAIS laboratory in the Welsh Blood Service.

Replacement Laboratory Information Management System (LIMS) for the Welsh Histocompatibility & Immunogenetics Service (WHAIS)

SINGLE-STAGE BUSINESS CASE - MEDIUM VALUE AND RISK

SRO:	**Alan Prosser – Director, WBS**
Project Manager:	**Jon Norman – Portfolio Project Manager**
Organisation:	**Welsh Blood Service, Velindre University NHS Trust**

	Name	Signature	Date
Prepared by:	Felicity May Clinical Specialist H&I Digital Lead, WBS		15/07/2022
Reviewed by:	Deborah Prichard WTAIL Laboratory Services Manager, WBS		26/08/2022
	David Mason-Hawes Head of Digital Delivery, VUNHST		26/08/2022
Approved by:	Welsh Blood Service Senior Management Team	n/a	13/07/2022 10/08/2022
	VUNHST Executive Management Board	n/a	03/10/2022
	Strategic Development Committee		
	VUNHST Board		

Contents

Replacement Laboratory Information Management System (LIMS) for the Welsh Histocompatibility & Immunogenetics Service (WHAIS)

1. INTRODUCTION

The purpose of this business case is to seek approval to procure a replacement Laboratory Information Management System (LIMS) for the Welsh Histocompatibility & Immunogenetics (H&I) Service (WHAIS).

This proposal is a strategic priority for the Welsh Blood Service and Velindre University NHS Trust.

WHAIS requires replacement of its existing 'end of life' legacy IT applications / infrastructure to enable the laboratory to modernise its services and improve quality and efficiency.

The national all-Wales WLIMS project (LIMS1) aimed to deliver a replacement LIMS for WHAIS. However, the intended system failed to meet the specialist H&I requirements. Therefore, the legacy IT systems continue their operational use and represent a critical risk for the Service, requiring urgent replacement.

Procurement and implementation of a commercial "off-the-shelf" H&I-specific LIMS solution is the recommended option of this proposal to enable the laboratory to continue to modernise its workflows and comply with data security requirements and quality standards.

IMPORTANT:

This version of the business case sets out the strategic case only. The complete 5-model business justification case is available separately on request.

2. STRATEGIC CASE

2.1 Context

2.1.1 Operational Context of the Welsh Histocompatibility and Immunogenetics Service

The Welsh Blood Service (WBS) is a division of Velindre University NHS Trust (VUNHST) which operates national services supporting the whole population of Wales. WBS is responsible for a range of essential and highly specialised services, including the collection and distribution of blood products and support of national and international transplantation programmes through its Welsh Transplantation and Immunogenetics Laboratory (WTAIL) services.

WTAIL operates the Welsh Histocompatibility and Immunogenetics Service (WHAIS), which provides scientific advice, results and expertise for a range of NHS Wales organisations, including hospitals, transfusion centres and General Practitioners. The services provided by WHAIS include patient/donor compatibility testing for solid organ and stem cell transplantation, testing for genetic disease markers, investigation of transfusion reactions and selected platelet transfusion support. As such, it has a critical role in supporting the matching of solid organ and stem cell donors to Welsh, UK and international patients. WHAIS is the only Histocompatibility & Immunogenetics (H&I) laboratory in Wales.

WHAIS currently manages its services using a bespoke IT platform developed in-house, which has been in operational use for approximately 30 years. This platform – in effect, a series of bespoke, integrated applications – is built on 'end of life' (unsupported) technology and needs to be replaced, to ensure the WHAIS service can continue to meet changing customer and regulatory demands and to ensure appropriate IT and information security of the data it uses to run its day-to-day operations.

2.1.2 Policy Environment

Digital transformation in healthcare is essential for improving access to patient data, reducing errors and improving patient outcomes. The new VUNHST strategy – "Destination 2032" – was developed in recognition of the continuing challenges faced across the health and care system, including the need to adapt services for an aging population and technological innovations. The VUNHST Digital Strategy includes the objective to empower staff to have access to high quality information, equipment and technology to deliver high quality and safe services and maintain resilient hardware and software across the organisation – a central tenet of the "Ensuring Our Foundations" pillar of the strategy.

Replacement of the IT systems in WHAIS with a modern, supported platform is crucial for WHAIS to continue to deliver and modernise its services, meet user needs and align with the Future Wellbeing and Generations Act 2015, A Healthier Wales) and the Welsh Government Digital Strategy.

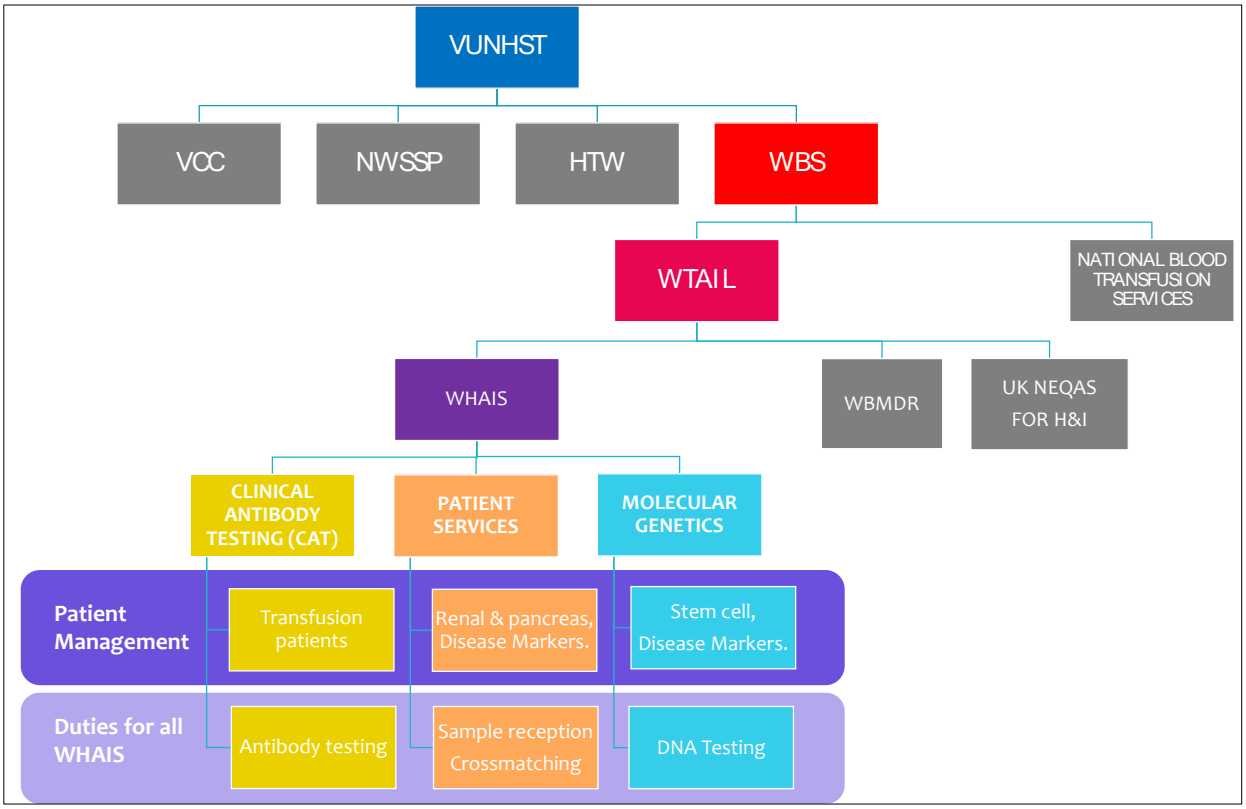


Figure 1: Chart showing the organisational context and duties of the Welsh Histocompatibility and Immunogenetics Service (WHAIS).

Velindre University NHS Trust (VUNHST) operates national (all Wales) services including Velindre Cancer Centre (VCC), NHS Wales Shared Services Partnership (NWSSP), Health Technology Wales (HTW) and the Welsh Blood Service (WBS).

WTAIL is a department of WBS which operates national and international services including the Welsh Bone Marrow Donor Registry (WBMDR), the United Kingdom National External Quality Assessment Service for Histocompatibility and Immunogenetics (UK NEQAS for H&I) and the Welsh Histocompatibility and Immunogenetics Service (WHAIS).

WHAIS is divided into three main laboratory sections: Clinical Antibody Testing, Patient Services and Molecular Genetics. Each section is responsible for management of a distinct group of patients (i.e. platelet transfusion patients, renal and pancreas transplant patients, stem cells transplant patients and patients requiring disease marker testing) and distinct types of H&I testing on behalf of other sections (e.g. a renal transplant patient requires antibody testing, crossmatching and DNA testing, however the Patient Services department is responsible for arranging the testing from each section and reporting the results). Therefore, exchange of information and samples between WHAIS sections is frequent and crucial.

The proposed investment also supports the following Welsh Blood Service Integrated Medium Term Plan (IMTP) objectives:

- Strategic Priority 1: Outstanding for quality, safety and experience
- Strategic Priority 2: An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed, expectations
- Strategic Priority 3: A beacon for research, development and innovation in our stated areas of priority
- Strategic Priority 5: A sustainable organisation that plays a part in creating a better future for people across the globe

2.1.3 Laboratory Information Management Systems

A laboratory information management system (LIMS) is software designed to support laboratory operations, including sample registration, workflow management, analysis and reporting of results. A standard LIMS operates on the premise of a sample being received, tested, analysed and reported in a linear process (i.e. sample → test → report). However, histocompatibility and immunogenetics (H&I) laboratories are distinct from many other specialities in terms of workflows and LIMS requirements:

- H&I laboratories perform testing on donor, as well as patient, samples and must be able to 'link' associated patient/donor records in order to assess compatibility.
- H&I patients require a repertoire of tests combined and interpreted within a single report.
- H&I laboratories receive multiple samples from the same patient, often over the course of several years, while awaiting a suitable donor to be identified. This requires the software to associate multiple sample test requests with a single patient.
- H&I laboratories are frequently required to access and report historic test results. Therefore, migration of historical data from the legacy IT system to the new LIMS is critical.

The original Wales LIMS project (LIMS1, commencing in 2004) aimed to deliver a LIMS for all clinical laboratories in Wales. The user requirement specification (URS) for WTAIL (encompassing both WHAIS and the Welsh Bone Marrow Donor Registry (WBMDR)) was finalised in 2011. However, due to the specialist nature of H&I services, the company awarded the national LIMS contract was unable to deliver an H&I system, and sub-contracted the work to a 3rd party, who developed two systems – one to support WHAIS and the other to replace an element of the WBMDR external communication system.

Work is ongoing to deploy the application that was procured for the WBMDR as part of the contract, with plans being revised to go-live in 2022. However, the application does not cover all aspects of WBMDR requirements and the system intended for WHAIS required a significant amount of development to satisfy the URS which, after 6 years of working with the company, failed to deliver a system that met the requirements of the service. Therefore in 2020, the decision was made to not proceed with implementation of the WHAIS system, and the WHAIS solution was de-scoped from the national LIMS

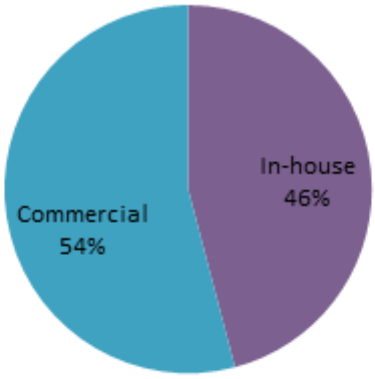
contract (owned by Digital Health & Care Wales). A lessons learnt exercise was completed to identify how a new project may be organised/resourced following the failed implementation.

2.2 Case for Change

The national Laboratory Information Network Cymru (LINC) programme commenced in 2019, with the remit to take forward the procurement of an all-Wales LIMS solution from 2025 onwards. Whilst WBMDR / WHAIS systems are in the scope of the LINC programme, due to lessons learned from the original LIMS1 procurement, any re-procurement activity associated with either service was de-coupled from the 'core LIMS' procurement. This allowed the WTAIL to assess the ongoing feasibility of its WTAIL (WBMDR and WHAIS) implementations, to inform how any further procurement activity could be undertaken as part of LINC.

At the time of the awarding of the LIMS1 contract a market assessment failed to identify any viable commercially available IT systems that would meet the requirements of WTAIL. However, in the 10 years since several H&I-specific LIMS solutions have emerged onto the market and have been successfully implemented in national and international H&I laboratories. A survey issued to H&I laboratories by UK NEQAS for H&I, an international external quality assessment service operated by WTAIL, requested information on their LIMS (Figure 2). 74 laboratories responded, identifying a total of 23 potential commercial LIMS solutions.

Figure 2: Response to the UK NEQAS for H&I Survey question: What Laboratory Information Management System (LIMS) do you currently use? (n=74 responding UK and international H&I laboratories))

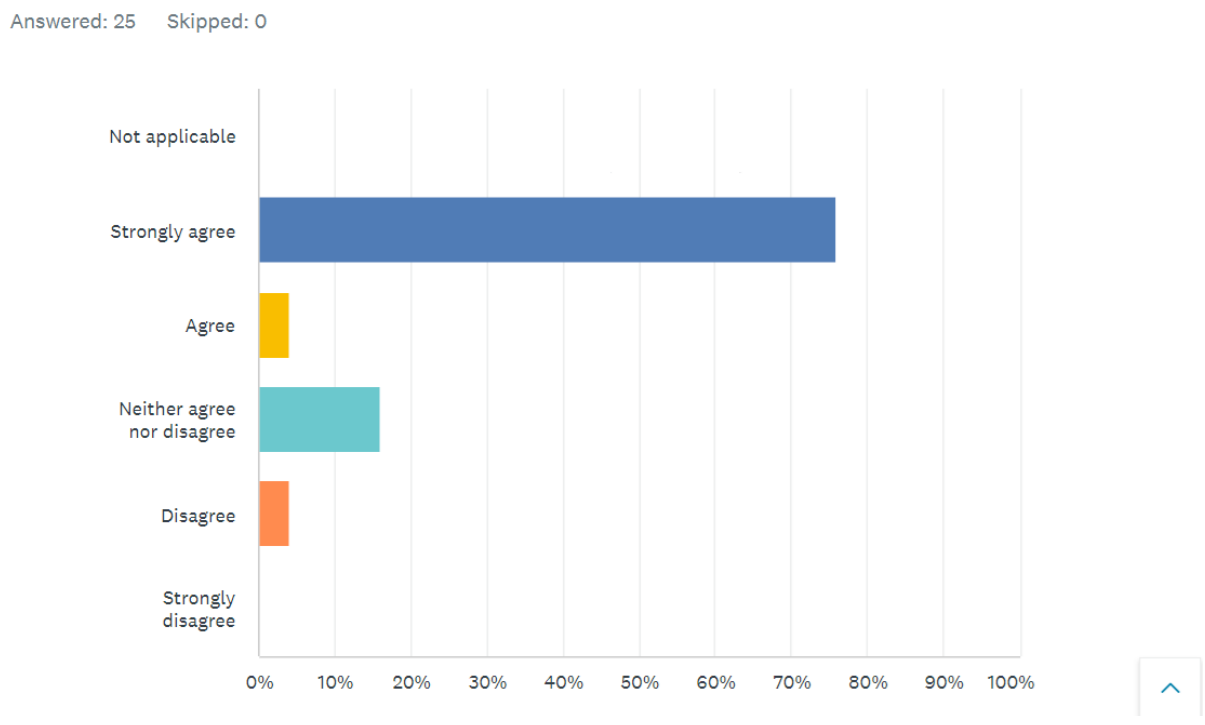


The approach for WBMDR and WHAIS have been separated because WBMDR has specific IT system requirements that are not currently available on the market. This business case seeks to confirm the approach for WHAIS and seeks support – via LINC – for the associated costs of that implementation. The procurement of a WBMDR solution is outside the scope of this case and will be sought separately. However, an interface between the WHAIS and WBMDR solutions will be required to enable transfer of information between the two systems.

In December 2021, WBS created a dedicated project group (the WHAISIT Project Group) to support the procurement and implementation of a WHAIS replacement LIMS. The group supported the publication of a Prior Information Notice in February 2022 and arranged demonstrations with eight responding suppliers. It was evident from the demonstrations that a commercial "off-the-shelf" H&I-specific LIMS was now a viable option for WHAIS.

In January 2022, a stakeholder survey was circulated by the WHAISIT project group to gauge attitudes of WHAIS staff to plans for introduction of a replacement LIMS. The survey results were discussed with staff in a follow-up workshop session. 73.5% (n=25/34) of staff completed the survey, generating useful insights that have informed this business case. For example, "reduction in workarounds", "improved efficiency of working practices" and "reduction in manual transcription and checks" received the highest number of votes as potential benefits of a new LIMS. The vast majority of staff (80%, n=20) support the need for a replacement LIMS (Figure 3).

Figure 3: Response to the WHAISIT Project survey question: "I fully support the requirement for a new LIMS in WHAIS" from n=25 responding WHAIS staff.



2.2.1 Existing Arrangements

WHAIS operates a legacy IT system developed in-house in the 1990s by a dedicated team of WBS IT developers. The system is comprised of multiple applications maintained in-house by WBS-based Application Services staff. As such, there are no associated contract, licencing or maintenance costs. The software was written in a language called Visual Fox Pro (VFP). The last iteration of VFP was released in

2004 (version 9) and received its final update in 2007. Microsoft officially ceased supporting VFP in 2015 meaning that no further support, such as software patches and security updates will be supplied for the software and Microsoft relinquishes all responsibility for any issues / incidents that are associated with the VFP platform.

During the LIMS1 project, development of the legacy WHAIS IT systems was mostly placed on hold, with only urgent fixes to the system being actioned. This has resulted in a system that reflects WHAIS tests and processes from over 14 years ago that is poorly suited to the services' evolving complexity and current changing customer demands. As a result, multiple workarounds (e.g. spreadsheets, paper forms) have gradually been incorporated into routine use to track testing and record data where the legacy system is unable to digitally support local operational workflows.

The following WHAIS activities are supported by the legacy IT system:

- Sample Registration *(approximately 5,000 samples registered p.a.)*
- Patient/donor DNA testing *(approximately 1,000 tests p.a.)*
- Patient/donor antibody testing *(approximately 4,000 tests p.a.)*
- Genetic disease marker testing *(approximately 2,500 tests p.a.)*
- Patient/donor crossmatch testing *(approximately 500 crossmatch tests p.a.)*
- Sample filing/inventory
- Reagent tracking (logging of a reagent lot number against a specific test result)

The legacy system also supports management of following services:

- Specialist platelet/transfusion support patients *(approximately 100 patients per year)*
- Haemopoietic Stem Cell Transplant management *(management of approximately 30 'active' patient cases at any one time, total of approximately 150 patient cases per year)*
- Potential kidney and pancreas transplantation management *(management of a waiting list of approximately 300 patients, support for approximately 100 transplants per year)*

The following aspects of WHAIS Services have significantly changed following the initial development of the legacy IT system:

- Antibody testing

    - Antibody testing is an H&I lab test that has increased in complexity since the legacy system was developed.
    - In the 1990s, WHAIS used simplistic in-house methods to perform antibody testing and interpretation of results was a predominantly manual process, recorded on paper forms.
    - WHAIS has now discontinued in-house antibody testing and uses a technology called 'Luminex' with commercial assays and associated software.

- There are no interfaces between commercial analysis software and the legacy IT system. Therefore, the results need to be printed off and manually entered into the legacy IT system by WHAIS staff, requiring either double entry or verification by a 2nd scientist to ensure quality of results.
- The legacy IT system is not able to capture all the clinically relevant information that the Luminex test generates. Therefore, WHAIS staff frequently need to refer back to the original test results on paper/PDF records in order to view all the relevant information.

- DNA testing

  - As per antibody testing, DNA testing has also increased in complexity since the legacy system was developed.
  - In the 1990s there were ~500 known H&I 'types' (genetic variants) and WHAIS used simplistic in-house methods to perform DNA testing and manual interpretation of results on paper forms.
  - There are now over 30,000 known H&I types, and new variants continue to be discovered by the H&I community on a daily basis.
  - WHAIS has now discontinued all in-house DNA testing and uses a repertoire of commercial DNA testing methodologies with associated analysis software (Next Generation Sequencing, Realtime PCR and Luminex).
  - There are no interfaces between the analysis software and the legacy IT system. Therefore, all DNA test results need to be printed from the analysis software and manually entered into the legacy IT system by WHAIS staff, requiring either double entry or verification by a 2nd scientist to ensure quality of results.
  - The legacy IT system is poorly suited to the frequent discovery of new genetic variants. A written request must be submitted to the Application Services department each time a novel result is identified for a sample, to enable data entry into the legacy system.

- Patient/donor crossmatching

  - Crossmatching is an established assay used to determine patient and donor compatibility, using various methodologies.
  - During the LIMS1 project, WHAIS used two methodologies for crossmatching, flow cytometry and CDC, the latter of which was in declining use in H&I labs and would have required a significant amount of development work from most LIMS suppliers to accommodate it.
  - WHAIS discontinued all CDC testing in 2021 and now uses a combination of flow cytometry and a paper-based methodology known as 'virtual' crossmatching, both of which are in common use by other H&I labs and supported by existing LIMS.

- Workflow management

    - The legacy system was designed to support simplistic workflows and predominantly manual/in-house testing.
    - All new samples are booked into on the legacy system by manually entering the details from paper request forms onto the legacy IT system. However, there is limited functionality for the system to track testing and generate worklists for the analysers. There is some limited functionality to generate audit lists of samples requiring testing. However, these lists do not capture all the required details and WHAIS staff are required to hand-write worklists onto paper forms.
    - The legacy system has some basic functionality to support 'reflex' testing (e.g it is able to generate an audit list for antibody reflex testing on the basis of a positive screening result). However, this functionality is limited and does not cover all WHAIS requirements. WHAIS staff use manual processes (white boards, spreadsheets and paper forms) to ensure the right samples receive the right tests and arrange any required reflex testing.
    - There are no interfaces between the legacy IT system and the analysers, therefore all patient worklists must be manually typed into the analyser software for each test run.

- Reporting

    - Some basic reports can be automatically generated by the IT system (e.g. genetic marker testing). However, the vast majority of H&I reports have increased in complexity and can no longer be supported by the legacy system. These reports need to be manually typed on a Microsoft Word document using version-controlled templates designed by WHAIS staff.
    - Manually generated reports require manual transcription of patient information and complex clinical data, which then needs to be carefully verified by another scientist to ensure patient safety.

- Patient Management

    - Certain information (for example clinical notes, email communications, results from certain H&I tests) cannot be recorded in the system. This information needs to be kept on paper copies, in patient files or in Excel spreadsheets (see Figure 4).
    - There is limited functionality for users to query/extract data from the system (e.g. for monitoring of key performance indicators, clinical audit or RD&I activities). Therefore, manual workarounds or IT helpdesk requests are generally required.

Figure 4: (LEFT) the 152 files required to store paper-based results for just one H&I lab test (Luminex antibody testing), for 'active' patients waiting for a kidney/pancreas transplant. (RIGHT) The patient files used to store results, reports, correspondence etc. that cannot be stored in the legacy IT system.

2.2.2 Business Needs

The legacy IT system is not user friendly when compared to the standards of most modern-day digital applications. It does not hold all required information and there is limited interoperability between applications. This has resulted in time consuming and non-streamlined workflows where multiple programmes and manual steps are required to complete a single task. Furthermore, searching through different applications, patient files and paper copies of results to find crucial information is time consuming and frustrating for staff and service users who may be waiting for answers to queries. A replacement LIMS would improve accessibility of information, enable storage of all relevant information including notes, communications and attachments, streamlining accessibility of data and eliminating requirement for storage of information in paper records or spreadsheets.

The legacy systems are slow to open and run operations, wasting staff time. This is compounded by the number of different applications, and the frequent requirement to access multiple applications for a single task. Furthermore, some WTAIL systems cannot be accessed at the same time, causing further delays for staff waiting for systems to become available. The applications have known errors/bugs, have had limited development since their initial creation. Microsoft no longer supports VFP and, as such, the programming expertise is becoming extinct. Only one current member of the WBS Digital Services team has the appropriate level of expertise in VFP programming to address application development and troubleshooting. Implementation of a commercial LIMS would mean that support and maintenance of the software would be handled by a 3rd party.

There are many examples where the legacy system does not support effective service delivery or has not kept pace with the scientific, technical and clinical developments in H&I/transplantation. In response, WHAIS have been forced to implement manual, time-consuming workarounds to support the shortfall (e.g. spreadsheets, manual checks, paper forms described in section 2.2.2). A replacement LIMS would provide comprehensive sample tracking and automated generation of worklists, reducing the requirement for manual workarounds. Furthermore, a commercial LIMS solution would be regularly updated and upgraded by the supplier in line with WHAIS requirement and those of national and international H&I laboratory clients.

The legacy IT system cannot support upstream and downstream interfacing. The reliance on manual transcription and transfer of information have introduced risks of error. This risk is currently mitigated by staff diligence and built-in resilience steps to detect failures in manual workarounds (e.g. verification steps, checklists etc.). However, the additional checks are resource heavy and time consuming (but generally efficient as they detect errors prior to result release). A replacement LIMS would support interfaces, reduce reliance on manual transcription of information.

An interface between the WHAIS IT system and the Welsh Clinical Portal (WCP) has been requested on several occasions by service users but cannot be achieved with the legacy system. As WHAIS are unable to report results to the WCP, this results in service users being unable to locate paper-based copies of clinical reports. This leads to increased workload for WHAIS staff to answer queries/re-send reports or

deal with unnecessary repeat requests. For example, in 2019-20 repeat sample requests for one of our H&I tests (HLA-B27, a genetic test for which the result does not alter and repeat testing offers no clinical benefit) found that 235 (7%) of samples were repeat requests. Although the samples were not retested, there is a waste of resource for the patient, requester and the H&I lab with samples being taken, and letters sent to the requester with a copy of the original report. A replacement LIMS would enable development of an interface with WCP, which would enable test results to be available to GP practices/hospitals.

The pandemic hastened a rise in remote working, which has continued in WHAIS due to the significant benefits for staff and the organisation. Although remote access to the legacy WTAIL IT System is possible, the functionality and reliability is limited due to the capability of the aging systems and reliance on manual workarounds. Furthermore, there is a potential cyber risk using current methods of access. A replacement LIMS would support delivery of a hybrid working model, enabling highly skilled individuals to work in a flexible and agile fashion with secure remote access.

WHAIS is a UKAS (United Kingdom Accreditation Service) accredited medical laboratory (ISO 15189:2012). The limitations of the legacy IT system were attributed to at least three findings in the most recent UKAS inspection (20/07/2021), notably in the following finding: (220592-03-01-E01629-005) *"The laboratory LIMS is outdated and does not fully meet the needs of the clinical service; the existing systems in use require a significant amount of manual transcription, double entry checking & the use of multiple different Excel worksheets and paper records. The laboratory may wish to consider prioritising obtaining funding for and implementation of a more comprehensive LIMS system better suited to their clinical requirements; this would help to reduce manual transcription & thereby reduce the potential for error*.". Failure to act on this recommendation risks the service losing its accreditation and, consequently, its reputation and the confidence of its service users.

Where we are now	**Where we want to be**
Use of legacy systems which no longer meet the requirements of H&I services.	Use of a modern, commercially supported LIMS that meets the requirements of H&I services.
Increasing reliance of manual workarounds to compensate for deficiencies in IT systems.	A comprehensive LIMS that covers a broad range of WHAIS activities, automates processes and reduces or eliminates the need for workarounds.
Complete reliance on manual transcriptions or test results (absence of any interfaces with laboratory analysers).	Interfaces between the LIMS and relevant analysers and software to enable automated transfer of information and minimise reliance of manual transcription.
Lack of resilience within WBS Digital Systems team in respect of staff with the required VFP expertise to develop existing WTAIL IT systems (single point of failure). Difficulty sourcing expertise for 'end of life' (unsupported) VFP technology due to rarity of resource and high associated costs.	A commercial LIMS based on a supported platform, maintained by a third-party supplier with appropriate staffing and business continuity measures. No requirement for VFP expertise once legacy data has been migrated.

Unable to meet external service specifications and interfaces which impacts on our service provision (e.g. WCP interface).	Use of a modern, commercially supported LIMS that enables interfacing, is regularly updates/upgraded and is flexible to future needs of the service.
Unable to query/extract data which severely limits support for evidenced based decision making/business intelligence.	Use of a modern commercial LIMS with in-built functionality for data mining and generation of statistics.
Ability to improve processes and introduce new laboratory tests is severely limited due to constraints of IT system and limited capacity to support existing number of manual workaround processes in place.	Use of a modern, commercially supported LIMS that is flexible to current and future needs of the service.

2.2.3 Main Benefits

Benefit ID	Benefit Type	Benefit	Beneficiary
B001	Efficiency (Time Saving)	Simplified workflows, faster retrieval of information.	Organisation, Service Users, Patients
B002	Efficiency (Time Saving)	Release of staff time to focus on value-added tasks.	Organisation, Service Users, Patients
B003	Performance Improvement	Increased productivity through improvement of workflows (transfer of data from analysis software, production of reports etc.) and elimination of wasteful steps (duplication, manual transcription etc.)	Organisation, Service Users, Patients
B004	Performance Improvement	Ability to be responsive to future changes to the regulatory and scientific environment in which WHAIS operates	Organisation, Service Users, Patients
B005	Quality & Safety	Improved traceability of samples and workflows	Organisation, Service Users, Patients
B006	Quality & Safety	Reduced error due to automation of processes	Organisation, Service Users, Patients
B007	Donor / Hospital Experience	Greater capacity to meet service user	Organisation, Service Users, Patients

		needs/requests (electronic reporting, generating bespoke reports for complex patients etc.)	
B008	Donor / Hospital Experience	Reduced turnaround times	Organisation, Service Users, Patients
B009	Donor / Hospital Experience	Improved patient experience as clinicians will have access to most up to date information.	Service Users, Patients
B010	Human Resources	Improvement in staff morale and retention	Organisation

2.2.4 Main Risks

Risk ID	Risks	Countermeasures
R001	WBS staff resource for procurement and implementation of the replacement LIMS due to demands on time and priorities of other work	Creation of the WHAISIT Project team including a dedicated Subject Matter Expert (SME) Lead (Clinical Specialist H&I Digital Lead) and Validation Lead, each appointed for a 2 year secondment.
R002	Only one member of staff in Digital Systems with Visual Fox Pro (VFP) programming expertise	Recruitment of additional Digital Services resources to support planning and implementation of a new LIMS: a Business Systems Analyst and an Integration Specialist.
R003	Loss of legacy data or inability to successfully migrate/access data due to data being stored in outdated legacy systems	Migration of legacy data will be a critical aspect of the User Requirement Specification and will be carefully tested and validated.
R004	Failure to identify a suitable LIMS solution, or delays to implementation due to extensive software development, and the impact this will have on WHAIS, service users and patients.	WHAIS has made changes to its services making it better suited to a commercial LIMS (e.g. discontinuing CDC). Research into existing H&I-specific LIMS systems (via supplier demonstrations and engagement with other UK H&I labs) indicates that suitable solutions are available. A new URS is planned, which will be appropriate to current supplier capabilities with an expectation that WHAIS

		will adapt workflows to accommodate an existing solution to minimise requirements for software development.
R005	Service downtime/disruption during implementation and the downstream impact on service users/patients.	Part of the remit of the WHAISIT project group is to carefully plan the implementation activities to minimise impact and disruption. A Service Level Agreement with LIMS supplier will be implemented to ensure appropriate support and system availability.
R006	Failure to secure funding.	Explore funding options via LINC, Welsh Government and/or internal funding opportunities (e.g. Trust discretionary or a combination of sources). If all funding sources are exhausted, this will relate to the suspension of project and a failure to address the issues with the existing systems as described above.

2.2.5 Constraints

Resources:	• Availability of WHAISIT project group members and other relevant WBS staff and their ability to have allocated time to complete required work. • Supply chain issues in respect of provision of required IT infrastructure may impact on delivery timelines. This is likely to be mitigated should a cloud option be selected. • Supplier capacity to support proposed WBS implementation timelines; however, none of the suppliers engaged as part of the initial supplier engagement days flagged this as a concern.
Budget:	• Ability to secure appropriate funding.
Timescales:	• 2-year contracts for dedicated members of the WHAISIT project group, expiring 2023 Q4 (Validation Lead and Clinical Specialist Histocompatibility & Immunogenetics Digital Lead).

2.2.6 Dependencies

The investment proposal is dependent on successful delivery of the following:

Project Name	Details	Start Date	End Date
Laboratory Information Network Cymru (LINC)	Dependency on support of funding application to Welsh Government.	December 2017	March 2025
Welsh Bone Marrow Donor Registry (WBMDR) IT System	Dependency on interface between WBMDR and WHAIS IT solutions to enable transfer of data.	April 2023	March 2024

3. GLOSSARY

CSFs	Critical Success Factors
H&I	Histocompatibility & Immunogenetics
IMTP	Integrated Medium Term Plan
LDTB	Laboratories Digital Transformation Board.
LIMS	Laboratory Information Management System
LIMS1	National all-Wales (W)LIMS project
LINC	Laboratory Information Network Cymru
MHRA	Medicines and Healthcare products Regulatory Agency
PIN	Prior Information Notice
SME	Subject Matter Expert
UAT	User Acceptance Testing
UKAS	United Kingdom Accreditation Service
UK NEQAS	United Kingdom National External Quality Assessment Service
URS	User Requirements Specification
VFP	Visual Fox Pro
VUNHST	Velindre University NHS Trust
WBMDR	Welsh Bone Marrow Donor Registry
WBS	Welsh Blood Service
WHAIS	Welsh Histocompatibility & Immunogenetics Service
WTAIL	Welsh Transplantation and Immunogenetics Laboratory

STRATEGIC DEVELOPMENT COMMITTEE

TRUST BOARD ACCOUNTABILITIES FOR IMTP 2022-2025

DATE OF MEETING	13/10/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	

PREPARED BY	Lauren Fear, Director Corporate Governance and Chief of Staff Carl James, Director Strategic Transformation, Planning and Digital
PRESENTED BY	Lauren Fear, Director Corporate Governance and Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director Corporate Governance and Chief of Staff Carl James, Director Strategic Transformation, Planning and Digital

REPORT PURPOSE	FOR DISCUSSION / REVIEW

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

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 The Integrated Medium Term Plan 2022-2025 was approved by the Minister for Health and Social Service in July 2022.

1.2 The approval was followed by a letter to Steve Ham from the Director General and NHS Wales Chief Executive, which set out some general comments regarding expectations regarding the Trust Board's role in the process and a series of Requirements and Accountability conditions on which the approval was made.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The letter, including the requirements and accountability conditions were attached to the CEO report for the September Trust Board.

2.2 The attached summary of how the requirements and conditions is for discussion in the Committee today and will be noted at next November quarterly reporting cycle into Quality, Safety & Performance Committee and Trust Board.

2.3 The purpose of the discussion in EMB Shape is to collectively review the proposed ways in which the conditions will be fulfilled. This will inform the version of this paper to be discussed at the October Strategic Development Committee.

2.4 The table below sets out the general requirements (to note, given this references behaviours and requirements at Trust Board level – separated into a separate document as not required for quarterly tracking)

General comments from Approval Letter:		
	Trust Board Approach	Actions to complete:
Expect the Board to scrutinise the plan and that progress is monitored effectively over the forthcoming year, in particular against the Ministerial Priorities set out in the NHS Planning	Quarterly monitoring reports via QSP Committee and Trust Board	Reports and cover papers to ensure there is explicit clarity on progress against: - Ministerial Priorities - Ministers Delivery Measures

Framework, the Minister's delivery measures and the specific accountability conditions for Velindre NHS Trust		- Specific Accountability Conditions By – Next reporting cycle in Nov 2022 Owner – CJ to coordinate – all Exec Dirs responsible for their sections
Where necessary, any risks or challenges that need to be further addressed will need to be discussed and agreed at your Board and communicated to Welsh Government via the routine governance arrangements (e.g., IQPD meetings or quarterly reporting against your IMTP). Where this necessitates any material changes to your IMTP in year will require you to advise me of these changes through an Accountable Officer letter.	Chair of QSP Committee and Trust Chair to ensure specific discussion in this regard – which will be appropriately recorded in the minute.	Further focus in this regard on the agenda items covering IMTP tracking. Chair briefs to support. By – Next reporting cycle in Nov 2022 Owner - LF

2.5 Appendix 1 – is the Quarterly tracking template. The requirements and considerations will be incorporated into the forming of next years IMTP also.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

4.1 The Committee is asked to **DISCUSS AND REVIEW** the proposed approach to the IMTP Requirements and Accountability Conditions.

Integrated Medium Term Plan 2022 – 2025 Accountability Conditions Letter Monitoring Document

Accountability Conditions (Judith Paget Letter dated 22/07/22)	Quarterly Actions planned to comply with IMTP Accountability Conditions				Lead Exec *(draft – tbc)*	KEY
	Q1	Q2	Q3	Q4		
General requirement – 'five ways of working and sustainable development It is essential that your organisation continues to build on the progress made to utilise the five ways of working, sustainable development principles, to deliver your integrated plan. The organisation should ensure its well-being objectives are consistent with and continue to be supported by its planning arrangements.					CJ	
General requirement – IMTP The IMTP must be published on public facing Trust website.	Complete					
General requirement – Quarterly progress report on IMTP Action plans to IQPD There should be reporting against the key milestones associated with that quarter, any slippage against the plan, next milestones and the mitigation of any new/emerging risks.	Process in place to provide quarterly updates to SLT which will include escalation of any emerging risks etc.				CJ to facilitate – each Accountable Exec for own sections	

General requirement – Quarterly Minimum Data Set (MDS) refresh The MDS must be refreshed on a quarterly basis.	Dataset will be refreshed quarterly with narrative provided to SLT on any significant changes, discrepancies	Dataset will be refreshed quarterly with narrative provided to SLT on any significant changes, discrepancies etc	Dataset will be refreshed quarterly with narrative provided to SLT on any significant changes, discrepancies	Dataset will be refreshed quarterly with narrative provided to SLT on any significant changes, discrepancies	COB	
Accountability Conditions Cancer Care						
a) Demonstrate how key attributes of the quality statement for cancer are being taken forward	QA6 D&C modelling to be undertaken SACT and treatment planning taskforce est Improvement plans developed for SACT and RT	Modelling complete SACT/RT initiatives commenced Audit of clinical Harm review SOP in place Contingency plan for Linac upgrade to be developed	RT back in balance Contingency plan in place to support linac upgrade SACT back in balance	SACT position sustained	RH - VCC SLT	
b) Demonstrate how access to cancer treatment is contributing to achievement of the suspected cancer waiting time target for the region.	QA20 HB monthly ops meetings in place to monitor pathway issues and opportunities for improvement	Group established with CVUHB/CTMUHB to look at lung pt pthwy in line with 62-day target. Terms of reference agreed. Audit undertaken	Continue improvement actions review of lung pathway. Review referral pathway into VCC process to minimise delays for first appointment.	Implement improvements for Q3 review.	RH - VCC SLT	

c) Demonstrate what mental health support is being provided to patients.	Psychology, Counselling and Supportive Care services already in existence. Health Needs Assessments undertaken. Services include programmes of care for self-management eg fatigue etc. Referral pathways and SOP's in place for referral to specialist services. Range of services to support children including visits to VCC to see treatment areas, bereavement support in conjunction with City Hospice and a range of books developed by VCC.	As Q1	As Q1	As Q1	RH - VCC SLT	

Accountability Conditions Workforce						
a) Demonstrate workforce intelligence that has identified key workforce risks and workforce planning that includes actions to address these key risks.					SM	
Accountability Conditions nVCC						
a) Demonstrate effective management oversight of the development and transition to the new Velindre Cancer Centre, Radiotherapy Satellite Centre and Integrated Radiotherapy Solution.	IRS procurement finalised and transition to implementation began.	IRS monthly transition programme board in place Links with programme leads for nVCC and RSC. nVCC successful bidder identified. Commence highlight reporting to VF board and EMB. Transition programme initiated	IRS contract signed with successful provider finalised. Links provided to construction teams for nVCC and RSC to begin planning for phase 2 and 3 of IRS implementation. WG approval scheduled for IRS and RSC Transition programme milestones to be completed	Key deliverables and work streams of phase 1 IRS implementation in progress. Maintain links to programme leads of nVCC and RSC. Transition programme milestones to be completed	AH – Transition Project & PW - Velindre Futures	
Accountability Conditions Commissioning						

a) Demonstrate leadership in the further development of the networked clinical model, including the Nuffield recommendations					PW - Velindre Futures	
b) Secure agreement to the new commissioning model for radiotherapy with partner organisations					MB	
Accountability Conditions Finance						
a) Demonstrate action is being taken to mitigate exceptional costs throughout the year.					MB	
b) Demonstrate action is being taken to mitigate COVID costs throughout the year as the pandemic response continues					MB	
c) Risks to delivery of saving plan delivery must be reduced to increase confidence in the plan - to be monitored by FDU on a quarterly basis.					MB	
d) Ensure clear agreements are in place with commissioners to support delivery of COVID recovery and required activity.					MB	

KEY:

BLUE	Action successfully completed with benefits being realised
GREEN	Satisfactory progress being made against action in line with agreed timescale
YELLOW	Issues with delivery identified and being resolved with remedial actions in place

AMBER	Delays in implementation / action paused due to external issues beyond our control
RED	Challenges causing problems requiring recovery actions to be identified

VELINDRE UNIVERSITY NHS TRUST STRATEGIC DEVELOPMENT COMMITTEE

Trust Integrated Medium Term Plan

DATE OF MEETING	13th October 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Phil Hodson, Deputy Director of Planning and Performance
PRESENTED BY	Phil Hodson, Deputy Director of Planning and Performance
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning, Performance & Estates

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Velindre University NHS Trust Executive Management Board	26th September 2022	NOTED

ACRONYMS	
VUNHST	Velindre University NHS Trust
IMTP	Integrated Medium Term Plan
WG	Welsh Government

1. SITUATION/BACKGROUND

1.1 The Trust, on 22nd July 2022, received confirmation from the Welsh Government that its IMTP for 2022 – 2025 had been approved in accordance with the requirements of the NHS Wales Planning Framework and the duties set out by section 175 of the National Health Service (Wales) Act 2006. This means that the Trust has had a Welsh Government approved plan for the last nine years and since the introduction of the IMTP planning process (*Note: Annual plans were required in 2020 and 2021 due to COVID pressures*).

1.2 The Trust, therefore, now has a Board and Welsh approved plan through to 2022 – 2025. However, there is a requirement to update and refine our approved plan for the period 2023 – 2026. Although Welsh Government planning guidance is not expected to be issued until October / November 2022 it is assumed that the IMTP (2023 – 2026) will need to be approved by the Velindre University NHS Trust Board no later than the 31st January 2023.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 To facilitate the development of the plan for 2023 – 2026, and to meet the requirements of the Welsh Government, there needs to be agreement in terms of the IMTP planning process and associated timescales. In parallel it is important that a number of opportunities are taken at this juncture. These opportunities include:

- How we can continue to improve the Trusts' overall approach to planning?
- How we can learn from the IMTP process for 2021 - 2022 to identify how it can be further improved for 2022 - 2023 and onwards?
- How we can further strengthen alignment between the various strategies and plans across the Trust?
- How can we better prioritise investment across the Trust?

Draft Planning Guidance

2.2 The Trust planning team has produced draft planning guidance which is intended to provide all services, including support functions e.g. digital services, with the framework for developing the IMTP for 2023 - 2026. All plans should be developed in accordance with the approach set out within this guide to ensure a robust and rigorous plan is developed.

2.3 The guidance has been developed in accordance with the most recent NHS Wales IMTP Planning Guidance (2022 – 2025) and recent updates. However, it should be noted that this guidance is currently being refreshed by the Welsh Government and it is anticipated that revised guidance will be issued to NHS organisations in either late October or early November 2022.

The Requirement

2.4 Velindre University NHS Trust is required to submit a Trust Board approved IMTP to the Welsh Government by 31st January 2023. Prior to approval by the Trust Board the IMTP, or relevant sections, must be approved by the following:

- Welsh Blood Service Senior Leadership Team (WBS service plan)
- Velindre Cancer Centre Senior Leadership Team (VCC service plan)
- Velindre University NHS Trust Executive Management Board (complete IMTP)
- Velindre University NHS Trust Strategic Development Committee (complete IMTP)
- Velindre University NHS Trust Board (complete IMTP)

2.5 In parallel to the above approvals process it is imperative that there is regular and effective engagement with key stakeholders. These will include, but not exclusively, staff, service users, the Welsh Government and the Community Health Council.

2.6 In addition there will be a requirement to undertake an IMTP Equality Impact Assessment and a draft plan for completing this assessment has been developed.

Programme and Process

2.7 In order to deliver against our statutory responsibility of having a Trust Board approved IMTP by 31st January 2023 it is vital that we have a robust programme and process in place for developing the IMTP.

2.8 The programme and process has been approved by the Trust Executive Management Board and is summarised in table 1.

Table 1 – IMTP Programme and Process

IMTP Development Cycle	
Issue of Draft Trust Planning Guidance	October 2022
Agreement of Service Priorities	October / November 2022
Issue of Welsh Government Planning Guidance	October / November 2022
Engagement with Local Health Board Commissioners / Welsh Government	September 2022 – December 2022
Engagement with Community Health Council	September 2022 – January 2023
Joint SLT meetings with EMB	October 2022 – December 2022
EMB Shape / Strategic Development Committee / Trust Board	September 2022 – December 2022
Welsh Government 2022/23 Draft Budgets published	December 2022
Trust IMTP Completed	December 2022
Governance and Approval (Dates are 'completed by' dates)	
Service plans approved by WBS / VCC SLTs	December 2022
IMTP endorsed by Trust EMB	January 2023
IMTP endorsed by Strategic Development Committee	January 2023
IMTP approved by Trust Board	January 2023
IMTP submitted to the Welsh Government	January 2023

2.9 Key aims of the proposed process are:

- To work with the Trust Board, Executive Management Board, VCC / WBS Senior Leadership Teams and key support functions in the development of a clear set of strategic priorities and areas of opportunity.
- To work with the Trust Board, Executive Management Board, VCC / WBS Senior Leadership Teams and key support functions to develop a prioritised programme for investment.

- To agree our financial bassline position, benchmarked against our pre-COVID baseline, and to agree required levels of investment from commissioners and anticipated levels of activity.
- To work with key partners to explore potential solutions for transformation and new models of health and care.
- For VCC and WBS to update their service plans for 2023 – 2025 and to develop a plan for 2026.
- For all enabling functions to update their plans for 2023 – 2025 and to develop a plan for 2026.
- To work in collaboration with our commissioners, and other NHS partners, in the development of our strategic priorities and objectives and in the development of an agreed set of planning and financial assumptions.

Velindre University NHS Trust IMTP (2023 – 2026) – Core Principle

2.10 The core principle in developing our IMTP is our commitment to quality and safety. Our plan will ensure that we put our patients and donors at the centre of everything we do; working towards optimum quality, safety and experience; and continual learning and improving. This is the '*golden thread*' throughout our organisation. Our strategic goals will be achieved by ensuring that all of our services are developed and delivered in collaboration with the patients and donors who use them, continually reviewing outcomes and experience and using these to learn and improve.

2.11 These include:

- Implementing the requirements of the Health and Social Care (Quality and Engagement) (Wales) Act 2021, the National Quality and Safety Framework and the National Clinical Framework to provide services of the highest possible quality
- Implementation of the Cancer Standards (those which are applicable)
- Delivering services that meet the national clinical quality and safety standards and provide an excellent experience
- Treating patients as quickly as possible
- Delivering services which are efficient, effective and productive – Value Based Healthcare
- Providing blood and blood products to our partner Health Boards to support the provision of treatment and care to people across Wales
- Delivering services which are '*COVID safe*' and reducing / eliminating (as far as is possible) the 5 harms from COVID
- Supporting the health and well-being of our staff who have been working in extremely challenging circumstances for the past two years
- Workforce redesign – optimising multi-professional patient / donor cantered care predicated on co-production and top of licence working

2.12 In addition we have identified a number of important strategic areas of work. These include:

- Improving population Outcomes and reducing inequalities
- Regional working, partnerships and collaboration to improve outcomes
- Developing our system leadership role in areas where we can add value
- Delivery of our Transformation Programmes
- Continued delivery of our research, development and innovation Programmes
- Delivery of our programme of work to support the physical, mental and emotional well-being of our staff across a number of areas
- Delivery of our decarbonisation strategy

2.13 The IMTP plan must incorporate, and in the development of service / support function plans, consider the following elements:

Ministerial priorities (*Note: additional priorities to be issued in October through the WG planning framework*)**:**

- A Healthier Wales - as the overarching policy context
- Population health
- Covid - response
- NHS recovery
- Mental Health and emotional wellbeing
- Supporting the health and care workforce
- NHS Finance and managing within resources
- Working alongside Social Care

Trust Vision:

- Excellent care. Inspirational Learning. Healthier people.

Trust Purpose:

- To improve lives.

Strategic 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 and learning for all
- A sustainable organisation that plays it part in creating a better future for people across the globe

Organisational Priorities:

To be developed through the IMTP process.

3. IMPACT ASSESSMENT

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

4. RECOMMENDATION

4.1 The Strategic Development Committee is asked to **note** the IMTP planning process to support the development of the IMTP for 2023 – 2026.

STRATEGIC DEVELOPMENT COMMITTEE

TRUST ASSURANCE FRAMEWORK

DATE OF MEETING	13/10/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	

PREPARED BY	Emma Stephens, Head of Corporate Governance and Mel Findlay, Business Support Officer
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance & Chief of Staff

REPORT PURPOSE	FOR DISCUSSION / REVIEW

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
EXECUTIVE MANAGEMENT BOARD	**26/9/22**	**Discussed**

1. SITUATION / BACKGROUND

1.1 The purpose of this paper is to provide the Committee with an update on:

- The status of the Principal Risks identified in the Trust Assurance Framework (TAF) included at ***Appendix 1,*** which may affect the achievement of the Trust's Strategic Objectives, and the level of assurances in place to evidence the effectiveness of the management of those risks.
- The ongoing work to support the continued development, articulation and operationalisation of the Trust Assurance Framework across the organisation, since the last meeting of the Committee.
- Provide an overview of the scrutiny undertaken at each level of the Trust's Governance and Accountability Framework, aligned with the respective roles of each of the various parts of the Trust Board Governance Structure. This summary view incorporates outcomes from the July reporting cycle in turn informing the **September - October 2022** reporting period.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 **Updated on key developments previously noted to the Committee:**

2.1.1 Link to Risk Register, Performance Framework and Quality & Safety Framework

It was agreed through the July governance reporting cycle that the first step change in the triangulation and linking of the Trust Assurance Framework with the Trust's other key frameworks will be to develop the link between the Trust Risk Management Framework. A preliminary exercise has been undertaken to link the Trust Assurance Framework Strategic Risks to the agreed risk domains on Datix, the outcomes of which are recorded on the Trust Assurance Framework Dashboard in ***Appendix 1***.

In addition, following the development of the Trust Performance Management and Quality & Safety Management Frameworks, key metrics relating to the strategic risks will also be linked during Q3.

2.1.2 Reverse Stress Testing

Reverse stress testing is the identification of a pre-defined adverse outcome, for instance the point at which an organisation may be considered as failing, and severe, but plausible, risks materialising that might result in this outcome are then explored. This is an important development in the organisation's risk maturity and capability.

This work will be progressed with the Trust Board via a targeted workshop at a Trust Board Development Session in early November 2022. The outcome of which will be reported in the subsequent governance reporting cycle.

2.1.3 **Link to Strategy Development**

In reviewing the risk profile, in addition to the reserve stress testing exercise described above, there are two further key suggested inputs:

- Using research and insight on global organisational and health care trends to challenge and support our thinking on macro strategic risks.
- Frame the review in the Trust approved Strategy and Enabling Strategies.

The work will then be progressed in Board development session in early November as outlined in 2.1.2 above.

2.1.4 **Revised reporting mechanism - Integration of Trust Assurance Framework into Datix.**

Collaborative work continues with the Datix Team at Hywel Dda Health Board to support increased automation of the Trust Assurance Framework regarding the development of Principal risks within Datix Version 14. We now have baseline reference information, which is under review and in the process of being cross referenced with the principle risk information for the Trust Assurance Framework for the Trust.

Discussions took place in the Audit Committee regarding Power Business Intelligence for reporting against the Trust Assurance Framework and the benefits this can deliver. It was recognised that currently the availability of such resource within the Trust is extremely

limited, although liaison within the Trust is underway regarding Power Business Intelligence knowledge and resource. Options to explore availability of external resource and support across NHS Wales was discussed. It was agreed that colleagues in Audit Wales will assist in exploring any opportunities that may be available for the Trust to access and tap into the Data Analytics Team within Audit Wales.

2.2 **Further developments discussed and agreed through August and September 2022:**

2.2.1 **Mapping Trust Assurance Framework to governance cycle**

In line with the Board development discussions with Internal Audit and Audit Wales it has been agreed that there should be a clearer link between the Trust Assurance Framework and the governance cycle. This work has commenced and will continue to be progressed during the next reporting period and includes:

- Ensuring that cycles of business provide appropriate consideration of each of the TAF controls and sources of assurance.
- Mapping the relevant actions into governance cycles.
- Ensure each committee scrutinise progress to address gaps in controls and Assurances within its scope – from November Committees onwards.
- EMB to agree Committee oversight:

01	Demand and Capacity	QSPC
02	Partnership Working / Stakeholder Engagement	SDC
03	Workforce Planning	QSPC
04	Organisational Culture	SDC
05	Organisational Change / 'strategic execution risk'	SDC
06	Quality & Safety	QSPC
07	Digital Transformation – failure to embrace new technology	SDC

08	Trust Financial Investment Risk	QSPC
09	Future Direction of Travel	SDC
10	Governance	AC

2.2.2 **Link to Audit tracker**

Executive Management Board also agreed to map the Audit tracker to the third line of defence mapping in the Trust Assurance Framework in order to provide assurance that all current insight, including the impact of open actions on the effectiveness of the control framework, are taken into account. In the September meeting, Executive Management Board agreed to complete this for the next reporting period in November.

2.3 **Trust Assurance Framework Dashboard**

2.3.1 The updated Trust Assurance Framework Dashboard Report is included at ***Appendix 1.***

2.3.2 Overall the Trust Assurance Framework Dashboard is showing that progress updates have been received since the July 2022 Trust Board in respect of the following Principal Risks.

2.3.3 To also note that in the July Strategic Development Committee and Audit Committee, the summary of each strategic risk was discussed and reviewed, in line with the scope of that Committee to ensure that the Principal Risks are being managed in an effective way in order to enable the realisation of the Trust's strategic objectives.

	NO REVIEW TAKEN PLACE
	REVIEWED NO CHANGES
	REVIEWED AND UPDATED

			MAR	APR	MAY	JUN	JUL	SEP
01	Demand and Capacity	**COB**						
02	Partnership Working / Stakeholder Engagement	**CJ**						
03	Workforce Planning	**SFM**						
04	Organisational Culture	**SFM**						
05	Organisational Change / 'strategic execution risk'	**CJ**						
06	Quality & Safety	**NW**						
07	Digital Transformation – failure to embrace new technology	**CJ**						
08	Trust Financial Investment Risk	**MB**						
09	Future Direction of Travel	**CJ**						
10	Governance	**LF**						

2.3.4 **Actions on specific strategic risks**

- **TAF 01: Demand and Capacity**
  - **Residual Risk Score –** 20. This remains unchanged since the previous review.
  - **Overall Level of Control Effectiveness –** This remains as Partially Met (PE)
  - **Sources of Assurance –** There have been no changes to the sources of assurance.
  - **Action Plan for Gaps Identified –** The action plan has been updated is largely progressing on target.

- **TAF 02: Partnership Working and Stakeholder Engagement**
  - **At present Residual Risk Score –** 12. This remains unchanged since the previous review.

- **Overall Level of Control Effectiveness -** This remains as Partially Met (PE)
- **Sources of Assurance –** There have been no changes to the sources of assurance.
- **Action Plan for Gaps Identified –** There have been additional actions included since the last review.

- **TAF 03: Workforce Planning**
  - **At present Residual Risk Score –** 12. This remains unchanged since the previous review.
  - **Overall Level of Control Effectiveness –** This remains as Partially Met (PE)
  - **Sources of Assurance –** There have been no changes or additions to the sources of assurance since the previous review
  - **Action Plan for Gaps Identified –** The action plan has been updated to provide a further level of detail and assurance on the planned timetable for delivery of the associated programme of work to mitigate this risk.

- **TAF 04: Organisational Design**
  - **At present Residual Risk Score –** 9. This remains unchanged since the previous review.
  - **Overall Level of Control Effectiveness -** This remains as Partially Met (PE)
  - **Sources of Assurance –** There have been no changes or additions to the sources of assurance since the previous review
  - **Action Plan for Gaps Identified –** The action plan has been further developed to include the Trust Values Project, which will fulfil a wider brief under the Organisation Design Approach, this work has included engagement work with Board members in the first round of engagement. Additionally, work continues with further programmes being added to the portfolio to ensure this work meets objectives.

- **TAF 05: Organisational Culture**

- **At present Residual Risk Score –** 12. This remains unchanged since the previous review.
- **Overall Level of Control Effectiveness –** A thorough review of the levels of control effectiveness has been carried out resulting in an overall Control Effectiveness rate of Partially Met (PE)
- **Sources of Assurance –** There have been no changes or additions to the sources of assurance since the previous review
- **Action Plan for Gaps Identified –** The action plan is progressing on target.

- **TAF 06: Quality and Safety**

The description of the risk has been amended during this review, now detailed as:
'Trust has just approved (July 2022) its integrated Quality & Safety Framework and is in the process of setting up the required mechanisms, systems, processes and datasets. This includes the ability to on mass learn from patient feedback i.e. patient / donor feedback / outcomes / complaints / claims, incidents and ability to gain insight from robust triangulated datasets and to systematically demonstrate the learning, improvement and that preventative action has taken place to prevent future donor / patient harm. These are not currently in place and could result in the Trust not meeting its national and legislative responsibilities (Quality & Engagement Bill (2020)) and a reduction in public/patient/donor, external agency, regulator and commissioner confidence in the quality of care the Trust provides.'

- **At present Residual Risk Score –** 15. This remains unchanged since the previous review.
- **Overall Level of Control Effectiveness –** This remains as Partially Effective (PE), unchanged since the last review.
- **Sources of Assurance –** Gaps in controls and assurance have been amended following review;
    - Following approval of the Quality and Safety Framework approved in July 2022, implementation commenced.

- Quality and Safety Operational Group Planning meeting held, inaugural meeting arranged in October 2022.

An additional gap in assurance has been identified:

- The current mapped meeting reporting structure does not cover floor to board at divisional level.

- **Action Plan for Gaps Identified –** Amendments have been made to the action plan to address the gaps identified and target dates reviewed.

- **TAF 07: Digital Transformation**
  - **At present Residual Risk Score –** 12. This remains unchanged since the previous review.
  - **Overall Level of Control Effectiveness –** This remains as Partially Effective (PE) despite a shift in some key control ratings individually.
  - **Sources of Assurance –** Amendments and additions to the lines of defence have taken place as part of the review; specifically cyber assurance controls being in place and digital transformation guided by an agreed digital architecture have been added. Gaps in controls have also been highlighted around the development of a digital architecture, appropriate external standards for benchmarking being agreed and the establishment of a digital programme.
  - **Action Plan for Gaps Identified –** Three additional actions have been added to the action plan:
    1. Create the Trust Digital Reference Architecture
    2. Review the scope/scale/need for a Digital Programme
    3. Confirmation on the SIRO/Cyber Security roles and responsibilities

- **TAF 08: Trust Financial Investment**
  - **At present Residual Risk Score –** 12. This remains unchanged since the previous review.
  - **Overall Level of Control Effectiveness -** This remains as Partially Met (PE)
  - **Sources of Assurance –** The reviewed sources of assurance have resulted in some additions:

1. Key objectives of investment framework and relationship to contract performance and value identified.
2. Investment framework to be articulated and agreed by Divisions and Executive Team.
3. Investment framework to be applied within IMTP process.

- **Action Plan for Gaps Identified –** There has been extensive review of the action plan resulting in the addition of new actions being added, detail below the main actions can be seen in Appendix 1:
    1. Review of contracting model for impact of COVID related measures.
    2. Establish Trust Investment Prioritisation Framework

- **TAF 09: Future Direction of Travel**
    - **At present Residual Risk Score –** 12. This remains unchanged since the previous review.
    - **Overall Level of Control Effectiveness -** This remains as Partially Met (PE).
    - **Sources of Assurance –** There have been no changes or additions to the sources of assurance since the previous review.
    - **Action Plan for Gaps Identified –** Dates have been added to the action plan where possible. There remain some dates awaiting dependent on committee outcomes.

- **TAF10: Governance**
    - **At present Residual Risk Score –** 12. There has been no change since the previous review.
    - **Overall Level of Control Effectiveness –** This remains as 'Effective' (E).
    - **Sources of Assurance –** No amendments have been made nor additions since the last review.
    - **Action Plan for Gaps Identified –** A formal programme of work for Governance, Assurance and Risk has been developed reporting into the wider Organisational Development programme for the Trust, this encompasses 20 key projects

underpinning the further development and operationalisation of the Trust Assurance Framework. Key aspects are summarised in Appendix 1.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes
	Please refer to ***Appendix 1*** for relevant details.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

The Committee is asked to:

a. **DISCUSS AND REVIEW** the progress made and next steps in supporting the continued development and operationalisation of the Trust Assurance Framework, as outlined in section 2.

b. **DISCUSS AND REVIEW** the update to the Trust Assurance Framework Dashboard, included at ***Appendix 1.***

RISK DESCRIPTORS			
RISK NUMBER	**RISK THEME/TITLE**	**DRAFT RISK DESCRIPTION**	**RISK OWNER**
01	**Demand and Capacity**	Failure to adequately model demand and capacity and service plan effectively, results in failure to deliver sufficient capacity leading to deterioration in service quality, performance or financial control.	**Cath O'Brien** Chief Operating Officer
02	**Partnership Working / Stakeholder Engagement**	Failure to establish and maintain effective relationships with internal and external stakeholders, and/or align our operational actions or strategic approach with system partners, resulting in confusion, duplication or omissions; threatening collaborative working initiatives; and/or an inability to deliver required change to achieve our medium to long term objectives.	**Carl James** Director of Strategic Transformation, Planning & Digital,
03	**Workforce Planning**	Risk of not having the right staff in right place at right time with right capability, as a result of not having appropriate and effective workforce plan owned in the right place, resulting in deterioration of operational performance, decline in the safety/quality of service provision, threatening financial sustainability and/or impacting our transformation ambitions.	**Sarah Morley** Executive Director of OD and Workforce
04	**Organisational Culture**	The risk of not effectively building a joined up organisation. This is fundamental to the future success for the organisation.	**Sarah Morley** Executive Director of OD and Workforce
05	**Organisational change / 'strategic execution risk'**	Risk that aggregate levels of organisational change underway across the Trust creates uncertainty and complexity, leading to a disruption to business as usual (BAU) operations; an adverse impact on our people/culture; deterioration or an unacceptable variation in patient/donor outcomes; and/or a failure to deliver on our strategic objectives and goals.	**Carl James** Director of Strategic Transformation, Planning & Digital,
06	**Quality & Safety**	Trust does not currently have cohesive and fully integrated Quality & Safety mechanisms, systems, processes and datasets including ability to on mass learn from patient feedback i.e. patient / donor feedback / outcomes / complaints / claims, incidents and ability to gain insight from robust triangulated datasets and to systematically demonstrate the learning, improvement and that preventative action has taken place to prevent future donor / patient harm. This could result in the Trust not meeting its national and legislative responsibilities (Quality & Engagement Bill (2020)) and a reduction in public/patient/donor, external agency, regulator and commissioner confidence in the quality of care the Trust provides.	**Nicola Williams** Executive Director of Nursing, Allied Health Professionals & Health Scientists
07	**Digital transformation - failure to embrace new technology**	Risk that the Trust fails to sufficiently consider, exploit and adopt new and existing technologies (i.e., assess the benefits, feasibility and challenges of implementing new technology; implement digital transformation at scale and pace; consider the requirement to upskill/reskill existing employees and/or we underestimate the impact of new technology and the willingness of patients to embrace it/ their increasing expectation that their care be supported by it) compromising our ability to keep pace and be seen as a Centre of Excellence.	**Carl James** Director of Strategic Transformation, Planning & Digital,
08	**Trust Financial Investment Risk**	There is a risk that the contracting arrangements between Velindre and its Commissioners do not adequately acknowledge future service developments and changes in clinical practices and thus ensure appropriate funding mechanisms are in place and agreed.	**Matthew Bunce** Executive Director of Finance

09	**Future Direction of Travel**	Opportunity risk of the Trust's ability to develop new services and failure to take up and create opportunities to apply expertise and capabilities elsewhere in the healthcare system.	**Carl James** Director of Strategic Transformation, Planning & Digital,
10	**Governance**	There is a risk that the organisation's governance arrangements do not provide appropriate mechanisms for the Board to sufficiently fulfil role and the organisation to then be effectively empowered to deliver on the shaping strategy, culture and providing assurance, particularly through a quality and safety lens.	**Lauren Fear** Director of Corporate Governance & Chief of Staff

LEVELS OF ASSURANCE DESCRIPTORS

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

KEY CONTROLS

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 preventative controls.	• Authorisation limits of and separation of duties • Pre-employment screening of potential staff
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

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
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

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

RISK SCORE

IMPACT MATRIX

	Impact, Consequence score (severity levels) and examples				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/ 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	Major injury leading to long-term incapacity /disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which on a large number of patients
Quality/complaints/ audit	Peripheral element of treatment or service suboptimal Informal complaint/enquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complain (stage 2) complaint Local resolution (with potential to go to independent Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/staffing/competence	Short term low staffing level that temporally 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 No staff attending 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 No staff attending mandatory training /key training on an ongoing basis

Statutory duty/ inspections	No or minimal impact or breach of guidance/statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage short-term reduction in public confidence Elements of public expectation not being met	Local media coverage long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business Objectives/ Projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5-10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance Including Claims	Small loss risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5-1.0 percent of budget Claim(s) between £100,000 and £1million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage loss of contract/payment made by results claim(s) >£1million
Service/ business interruption environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

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

TAF DASHBOARD

DEMAND AND CAPACITY

RISK ID:	TAF 01	We fail to deliver sufficient capacity leading to deterioration in service quality, performance or financial control as a result of capacity or demand planning or the operational service challenges
LAST REVIEW	Sep-22	1 - Outstanding for quality, safety and experience
NEXT REVIEW	Oct-22	RISK DOMAIN: Performance and Sustainability
EXECUTIVE LEAD	Cath O'Brien	

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
4	4	20	4	4	16	2	4	8

Overall Level of Control Effectiveness: Rating and Rag (see definitions tab)	RATING	Overall Trend in Assurance	THIS WILL INCLUDE A TREND GRAPH
	PE		

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	Blood stock planning and management function 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 and inform and predict any surge demand.	PA	Senior Management Team, COO review and EMB Review, QSP committee and Board.	PA	Welsh Government Quality, Planning and Delivery Review.	PA

TAF DASHBOARD

DEMAND AND CAPACITY

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 arrangement	Director WBS	X			E	Department Head review with escalation to Director	PA	Performance Report Senior Management Team and EMB Review, QSP committee and Board	PA	Welsh Government Quality, Planning and Delivery Review	PA
C3	SEW- VUNHST cancer demand modelling programme with HBs and WGDU in place, continues to provide high level assurance on demand projections.	Director VCC (VCS)	X	X		PE	SE Wales Group	IA	Performance Report - SLT, EMB, QSP and Board	IA	Welsh Government Quality, Planning and Delivery Review	IA
C4	Demand and Capacity Plan for each service area	Heads of Service - Each Area	X	X		PE	Service area operational planning meeting	IA	Performance Report - SLT, EMB, QSP and Board	IA	Welsh Government Quality, Planning and Delivery Review	IA
C5	Active operation engagement with health boards on demand	Director VCC (VCS)	X	X	X	PE	SLT	IA	Performance Report - SLT, EMB, QSP and Board	IA	Welsh Government Quality, Planning and Delivery Review	IA

GAP IN CONTROLS	GAPS IN ASSURANCE
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 need digital systems to be in place which are out of WBS control. Projects are progressing externally.	
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 if blood, which impacts demand.	
Lack of visibility of granular level planning data and Health Board activity plans to clear backlog at VCC.	
Lack of a formal oversight of capacity and demand management at a divisional level to recognise the complexity of interdependencies of various functions and services at VCC.	Executive Team oversight of the more detailed capacity and demand plans

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

TAF DASHBOARD

DEMAND AND CAPACITY

Action Plan	Owner	Progress Update	Due Date
Exploratory pilot project with Cardiff and Vale Health Board to scope real time digital solution to develop blood fate data set.	Lee Wong	Project is underway in Cardiff and Vale, supported by WBS. Funding options are being sought	Dec-23
Blood Health National Oversight Group project is underway identifying inappropriate use of blood.	Lee Wong	Gap analysis is underway across Health Boards. The IBI lens will be used on this project	Dec-22
Engaging with Health Boards to seek further information on recovery and wider operational plans; such as waiting time initiatives and to formalise a route for planning and managing demand variation, including clinical choices.	Lisa Miller	Email sent via COO to each HB requesting further meetings to discuss data	Aug-22
A formal demand and capacity review meeting has been established at VCC	Lisa Miller	The group has been established and is currently meeting weekly to address the impact on capacity due failure of third party provision. Currently experiencing above usual demand for SACT	Complete
There is a weekly meeting between the Executive Team and Senior Leadership Team established to provide an opportunity for collaboration and oversight for addressing the immediate challenge at VCC	Steve Ham	This meeting is a short term focused meeting pending revised capacity plans	Complete

RISK ID:	TAF 02	**PARTNERSHIP WORKING AND STAKEHOLDER ENGAGEMENT:** Failure to establish and maintain effective relationships with internal and external stakeholders, and/or align our operational actions or strategic approach with system partners, resulting in confusion, duplication or omissions; threatening collaborative working initiatives; and/or an inability to deliver required change to achieve our medium to long term objectives.								
LAST REVIEW	Oct-22	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations								
NEXT REVIEW	Nov-22				RISK DOMAIN			Partnership		
EXECUTIVE LEAD	Carl James	**RISK SCORE (See definitions tab)**								
		INHERENT RISK			**RESIDUAL RISK**			**TARGET RISK**		
		Likelihood	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**
		3	4	**12**	2	4	**8**	2	3	**6**

Overall Level of Control Effectiveness: **Rating and Rag** (see definitions tab)	**RATING**	**Overall Trend in Assurance**	**THIS WILL INCLUDE A TREND GRAPH**
	PE		

							GAP IN CONTROLS		**GAPS IN 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**
1.1	System structures – core cancer services commissioning arrangements		X			PE	Commissioning contracting reporting	IA	Strategic Development Committee/Quality Safety and Performance Committee	PA	Wales Audit Office/Welsh Government	PA
1.2	Strategic partnerships which support effective delivery of working/ work programmes			X		PE	Supply and demand reporting	IA	Strategic Development Committee/ Quality Safety and Performance Committee	IA	Wales Audit Office/Welsh Government	PA
1.3	Performance data and measures to clearly track progress against objectives				X	PE	Linked through performance framework insight	PA	Strategic Development Committee/ Quality Safety and Performance Committee	PA	Wales Audit Office/Welsh Government	PA

2.1	Blood - core blood services commissioning arrangements			X		PE	Commissioning contracting reporting	IA	Strategic Development Committee/ Quality Safety and Performance Committee	IA	Regulatory scope re MHRA tbc	PA
3.1	Local Partnership Forum		X	X		PE	Feedback from LPF	PA	Strategic Development Committee/ Quality Safety and Performance Committee	PA	Wales Audit Office	PA
4.1	South Wales Collaborative Cancer Leadership Group system model to provide leadership across region		X			PE	Agreed to model for next phase	PA	Strategic Development Committee/ Quality Safety and Performance Committee	PA	Wales Audit Office/Welsh Government	PA
5.1	Partnership Board arrangements with partner Health Boards model;		X			PE	Agreed to model for each organisation	IA				

GAP IN CONTROLS	GAPS IN ASSURANCE
Across the models of working in strategic partnerships, there are common themes of control effectiveness – with the models largely in place, further development required on the ways of working/work programmes and even further development required on the reporting mechanisms	First line and second lines of defence assurance are in place to a certain extent

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Although each of these mechanisms and controls are reported through various mechanisms – a specific action plan against these controls will be developed and reported through governance to support this strategic risk	Carl James	Linked to developments in ways of working for the Trust, the actions to enhance the effectiveness of the controls will be specifically developed and reported on.	Complete

1.2	Consideration of second and third line opportunities for further assurance to be incorporated into action plan as per action 1.1	Carl James		Complete
1.3	Development of CCLG leadership and governance arrangements: towards Alliance System: agree next steps with CEOs	Carl James		Complete
1.5	Further development of South East Wales Partnership Board structure	Carl James & Lauren Fear	Furthering embedding of structures and CAVUHB, CU and CTMUHB and establishment with ABUHB	Jan-22
1.5	Development of relationships with national Regional Partnership Boards, linked to open action in Strategic Development Committee	Carl James & Lauren Fear	Follow up to initial emails of RSP Chairs to develop models of ways of working nationally	Jan-22

TAF DASHBOARD

WORKFORCE PLANNING

RISK ID:	TAF 03	**WORKFORCE PLANNING:** Risk of not having the right staff in right place at right time with right capability, as a result of not having appropriate and effective workforce plan owned in the right place, resulting in deterioration of operational performance, decline in the safety/quality of service provision, threatening financial sustainability and/or impacting our transformation ambitions.
LAST REVIEW	Oct-22	1 - Outstanding for quality, safety and experience
NEXT REVIEW	Nov-22	RISK DOMAIN: Workforce and Organisational Development
EXECUTIVE LEAD	Sarah Morley	

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
4	3	16	4	3	12	2	3	6

Overall Level of Control Effectiveness: Rating and Rag (see definitions tab)	RATING	Overall Trend in Assurance	THIS WILL INCLUDE A TREND GRAPH
	PE		

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	Draft Trust People Strategy clearly noting the strategic intent of Workforce Planning - 'Planned and Sustained Workforce'	Sarah Morley	X			PE	Tracking key outcomes and benefits map – aligned to Trust People Strategy	PA	Internal Audit Reports	PA	To be completed as per compliance/ reg tracker update	PA
C2	Workforce Planning Methodology approved by Executive Management Board	Susan Thomas	X			PE	Staff Feedback	PA	Trust Board reporting against Trust People Strategy	PA	To be completed as per compliance/ reg tracker update	PA
C3	Workforce Planning – Skills Development – Training and Development Package in Place	Susan Thomas	X			PE	Performance reports via divisional and committee	PA				
C4	Workforce Planning embedded into our Inspire Programme to develop Mangers and leaders in WP skills	Susan Thomas	X			PE	Evaluation Sheets	PA				

TAF DASHBOARD

WORKFORCE PLANNING

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	Staff meeting to feedback on implementation plan	PA				
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	Recruitment and retention repots via Board	PA				
C7	Widening access Programme in train to support development of new skills and roles	Susan Thomas	X			PE	Reports via Trust Committee cycle on updates	PA				
C8	Workforce analysis available via ESR and Business Intelligence support	Susan Thomas	X			PE	Performance reports via divisional and committee structures	PA				
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	PE	Agile Project and Programme Board	PA				

GAP IN CONTROLS	GAPS IN ASSURANCE
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

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

TAF DASHBOARD

WORKFORCE PLANNING

Action Plan		Owner	Progress Update	Due Date
1.1	Attraction, Retention and Recruitment Programme established to deliver outputs to support the supply and shape of the workforce	Sarah Morley	The Programme Group has been established and a range of outputs defined to deliver between September 2022 and February 2023.	Feb-23
1.2	The Healthy and engaged work plan to be implemented to support workforce capacity within the Trust	Sarah Morley	The Trust has appointed a staff psychologist to support mental health and wellbeing. In addition all elements of the Trust wellbeing offer have been added to the national GWELLA platform allowing them to be more easily accessible for staff.	Dec-22
1.3	Establish Hybrid working arrangements as a core way in which the Trust undertakes some of its work.	Sarah Morley	The Trust has approved a set of Hybrid working principles. There are now task and finish groups working under the Hybrid working project to develop the operational systems and toolkits that will allow the Trust to fully realise the benefits of hybrid working arrangements.	Dec-22

TAF DASHBOARD

ORGANISATIONAL CULTURE

RISK ID:	TAF 04	**ORGANISATIONAL DESIGN: Failure to establish effective systems and structures built around shared values and behaviours.**								
LAST REVIEW	Oct-22	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations								
NEXT REVIEW	Nov-22					**RISK DOMAIN**		**Performance and Service Sustainability**		
EXECUTIVE LEAD	Sarah Morley	**RISK SCORE (See definitions tab)**								
		INHERENT RISK			**RESIDUAL RISK**			**TARGET RISK**		
		Likelihood	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**
		3	3	**12**	3	3	**9**	2	2	**4**

Overall Level of Control Effectiveness: **Rating and Rag** (see definitions tab)	**RATING**	**Overall Trend in Assurance**	THIS WILL INCLUDE A TREND GRAPH
	PE		

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 Strategies and enabling strategies (including people, RD&I and Digital) to be agreed to provide clarity and alignment on strategic intent of the Organisation	Carl James	X			PE	Working group led by CJ	PA	Trust Board reporting on strategy and controls via cycle of business	PA	To be completed as per compliance/ reg tracker update	PA
C2	Developing 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	PA	Trust Board reporting on strategy and controls via cycle of business	PA	To be completed as per compliance/ reg tracker update	PA

TAF DASHBOARD

ORGANISATIONAL CULTURE

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				
C4	Values to be reviewed and Behaviour framework to be considered Values of the Organisation used in induction, recruitment and via PADR processes	Susan Thomas	X			PE	Healthy and Engaged Steering Group Education and Training Steering Group	PA				
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	PA				
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 & Wellbeing Steering Group	PA				
C7	Governance arrangements in place to monitor and evaluate the implementation of plans	Lauren Fear	X			PE	Executive Management Board	PA				
C8	Performance Management Framework in place to monitor the finance, workforce and performance of the Organisation	Carl James	X			PE	PMF Working Group	PA				
C9	Service models in place to provide clarity of service expectations moving forward	Susan Thomas	X			PE	SLT Meetings	PA				

TAF DASHBOARD

ORGANISATIONAL CULTURE

C10	Aligned workforce plans to service model to ensure the right workforce is in place	Cath O'Brien	X			PE	SLT Meetings Education and Training Steering Group	PA PA				
C11	Development and implementation of a Management Framework that supports cohesive work across the organisation	Carl James	X			PE	To be determined	PA				

GAP IN CONTROLS	GAPS IN ASSURANCE
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

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Development of Organisational Design approach for the Trust to encapsulate both process and cultural elements that need to be inplace to allow the organisation to achieve its strategic goals	Sarah Morley	takeholder engagement has taken place on the rationale for this work and an overview of some of the elements of work that may sit within it with the Executive Team, Divisional Senior Leadership Teams and the Board. The scope of the programme and governance arrangements will be developed and agreed in November, during which the timelines associated with the main elements will be determined. Further programmes have been added to the portfolio to ensure this work meets its objectives.	Nov-22
1.2	A staff engagement project to understand levels of staff engement and also review the Trust Values	Sarah Morley	It has been decided that the Trust Values Project will fulfill a wider brief under the Organisational Design Approach. Interviews have taken place with Board members as first round of engagement activity. This will be followed by wider engagement across the Trust.	Dec-22

RISK ID:	TAF 05	Risk that aggregate levels of organisational change underway across the Trust creates uncertainty and complexity, leading to a disruption to business as usual (BAU) operations; an adverse impact on our people/culture; deterioration or an unacceptable variation in patient/donor outcomes; and/or a failure to deliver on our strategic objectives and goals.
LAST REVIEW	Oct-22	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations
NEXT REVIEW	Nov-22	**RISK DOMAIN** **Performance and Service Sustainability**
EXECUTIVE LEAD	Carl James	

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**
3	4	**16**	3	4	**12**	2	2	**4**

Overall Level of Control Effectiveness: **Rating and Rag** (see definitions tab)	**RATING**	**Overall Trend in Assurance**	**THIS WILL INCLUDE A TREND GRAPH**
	PE		

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**
1.1	Trust strategy to provide clear set of goals, aims and priorities	Carl James	x			E	Executive Management Board review	PA	Strategy Committee/QSP/Internal Audit Review / CHC	PA	Audit Wales	PA
1.2	Integrated Medium Term Plan to translate strategy into clear delivery plans	Carl James	x			E	Executive Management Board review	PA	Strategy Committee/QSP/Internal Audit Review / CHC	PA	Audit Wales	PA
1.3	Performance reporting in place to ensure delivery of required quality/performance in core service	Carl James	x		x	PE	Executive Management Board review/ patient and donor feedback	PA	Strategy Committee/QSP/Internal Audit Review / CHC	PA	Audit Wales	PA
1.4	Risk management framework / arrangements in place to identify/monitor/manage risks at corporate and service level	Lauren Fear		x		E	Executive Management Board review	PA	Strategy Committee/QSP/Internal Audit Review /	PA	Audit Wales	PA

1.5	Well defined change programmes at a local level to manage change effectively (WBS Change programme & Velindre Futures)	Cath O'Brien	x			PE	Executive Management Board review / staff feedback	IA	Strategy Committee/QSP/Internal Audit Review / CHC	IA	Audit Wales	IA
1.6	Effective leadership and management of change at Executive Management Board	Steve Ham	x			PE	Executive Management Board review / staff feedback	IA	Internal Audit Review	PA	Audit Wales/HIW	PA

GAP IN CONTROLS	GAPS IN ASSURANCE
Currently gap in ability to measure all desired outcomes	
Lack of capacity in business intelligence to develop range of information and automate it	
Revised performance management framework not fully implemented	
Not all supporting strategies approved by the Board	

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

Action Plan	Owner	Progress Update	Due Date
Finalise all strategies and plans	Carl James	Drafts well developed with final engagement exercise ongoing - Board approval in May 2022 (on track for May 26th 2022). Trust strategy and enablers developed and approved (with launch in Sept 2022)	Complete
Develop IMTP to provide priority for action and application of resource	Carl James	Final draft going to Board for approval March 2022	Complete
Information requirements being scoped	Cath O'Brien	First phase to support new performance measures developed and will be further discussed with the whole Board in Board Development session on 27th October	Complete
Implement revised performance management framework	Carl James	There will be an additional cycle agreed to test PMF (following the October Board Development session) - target date for live PMF Jan 23 reporting Cycle	Jan-23

TAF DASHBOARD

QUALITY AND SAFETY

RISK ID:	TAF 06	Trust has just approved (July 2022) its integrated Quality & Safety Framework and is in the process of setting up the required mechanisms, systems, processes and datasets. This includes the ability to on mass learn from patient feedback i.e. patient / donor feedback / outcomes / complaints / claims, incidents and ability to gain insight from robust triangulated datasets and to systematically demonstrate the learning, improvement and that preventative action has taken place to prevent future donor / patient harm. These are not currently in place and could result in the Trust not meeting its national and legislative responsibilities (Quality & Engagement Bill (2020)) and a reduction in public/patient/donor, external agency, regulator and commissioner confidence in the quality of care the Trust provides.		
LAST REVIEW	Oct-22	1 - Outstanding for quality, safety and experience		
NEXT REVIEW	Nov-22	Goal 1	RISK DOMAIN	Quality and Safety/ Compliance and Regulatory

EXECUTIVE LEAD	Nicola Williams	**RISK SCORE (See definitions tab)**								
		INHERENT RISK			**RESIDUAL RISK**			**TARGET RISK**		
		Likelihood	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**
		5	5	**25**	3	5	**15**	2	5	**10**

Overall Level of Control Effectiveness: **Rating and Rag** (see definitions tab)	**RATING**	**Overall Trend in Assurance**	**THIS WILL INCLUDE A TREND GRAPH**
	PE		

KEY CONTROLS

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating
C1	Once for Wales Datix System implemented	Nicola Williams			X	PE
C2	CIVICA pt/donor feedback system being implemented	Nicola Williams			X	PE
C3	Trust wide Divisional to Board level Quality & Safety meeting structure in place	EXECS	X	X	X	PE
C4	Quality & Safety Teams in place corporately & in each Division	NW, AP, PW	X	X	X	PE
C5	PMF in place & under review to include experience & outcomes	Carl James			X	NE

SOURCES OF ASSURANCE

1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
Staff feedback	IA	Internal Audit Reviews	Not Assessed	Audit Wales Reviews	Not Assessed
Patient/Donor Feedback	IA	Quality, Safety & Performance Committee	IA	HIW Inspect	Not Assessed
15 Step challenge	IA	Peer reviews	Not Assessed	MHRA	Not Assessed
EMB	IA			Professional bodies	Not Assessed
Divisional Q&S Groups	IA			Delivery Unit	Not Assessed
PMF	IA				Not Assessed
Perfect Ward audits	IA				

TAF DASHBOARD

QUALITY AND SAFETY

							PMD	IA				
C6	Trust Risk Register in place	Lauren Fear	X	X	X	PE	Mortality reviews	IA				
C7	Regular Staff Feedback sought	Sarah Morley			X	PE						
C8	Staff Q&S training & Education	Nicola Williams	X			PE		IA	Internal Audit Reviews	Not Assessed		

GAP IN CONTROLS	GAPS IN ASSURANCE
National standards / best practice standards (including benchmarkable outcome & experience measures) are not explicit across all departments of the Trust & /or regularly reviewed	Currently mechanisms to automatically & systematically review and triangulate & integrate quality & safety information at corporate and VCC Divisional level are insufficiently robust due to lack of cohesive infrastructure
Data / information infrastructure currently insufficient and unable to provide triangulation	Currently the mechanisms to evidence learning and improvement service level to Board remains under development
Quality & Safety Framework approved in July 2022, implementation commenced. Quality & Safety Operational Group Planning meeting held, inaugural meeting arranged in October 2022.	There are gaps in the Quality & Safety reporting mechanisms from service level to Board in respect of meeting structures and reporting lines
National Duty of Quality statutory guidance 12 week consultation due in October 2022 & Duty of Candour regulation changes 12 week consultation commenced on 20th September 2022.	Trust Quality, Safety & Performance Committee needs to further refine its work plan, quality of papers and triangulation methodologies
Work required to ensure consistent and recognized Floor to Board lines accountability & responsibility for Quality & Safety	The current mapped meeting reporting structure does not cover floor to board at divisional level
Work required to ensure robust links between incidents, feedback, complaints, mortality review outcomes clinical audit and improvement plans and to be able to demonstrate improvement	Quality & Safety assurance infrastructure for hosted organisations is unclear
Trust wide and VCC Quality & Safety Teams have insufficient capacity and capability to currently be able to fully execute responsibilities	Quality & Safety Operational Group requires full establishment - to operationally pull together all stands and feed into EMB & QSP

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Trust Quality & Safety Framework to be finalized and implementation plan developed.	Nicola Williams	Framework finalised and approved by Board in July 2022	COMPLETE
1.2	Corporate & Divisional Quality Hubs to be established	Nicola Williams Alan Prosser	Corporate OCP completed and recruitment commenced. WBS Quality Hub requirements determined – minor changes required from existing arrangements	Oct-22

TAF DASHBOARD

QUALITY AND SAFETY

		Paul Wilkins	VCC Quality Hub high level requirements determined - additional / realignment of resources maybe required. Detail needs to be worked through	
1.3	Trust Quality & Safety Framework implementation plan to be completed in line with agreed timescales	Exec Team Divisional Directors	Implementation plan developed and approved	Mar-23
1.4	Instigate a Quality & Safety operational meeting where cross cutting outcome review & triangulation takes place	Nicola Williams	Planning meeting held, draft terms of reference developed and membership agreed. Inaugural meeting planned for October 2022	Oct-22
1.5	Ensure the Action & learning sections within the Once for Wales Datix System are robustly implemented & audited	Nicola Williams	Being picked up through the Datix project Board	Dec-22
1.6	Implement a robust compassionate leadership programme	Sarah Morley	Compassionate Leadership is woven through the Trust 'Inspire' Leadership Programme. A broader Trust wide programme is being developed for all leaders and managers which forms part of the 'Building our Future Together' Portfolio.	Apr-23
1.7	Ensure all responsible officers receive Investigation Training	Nicola Williams Cath O'Brien	Investigation training provided to officers within corporate quality & safety team and both divisions	Jun-22
1.8	Implement National Duty of Candour guidelines / requirements	Jacinta Abraham	Awaiting National statutory Guidance. Nicola Williams Chairing national Duty Quality / Duty Candour Steering group. Consultations planned for Autumn 2022.	Apr-23
1.9	Implement National Duty of Quality guidelines / requirements	Nicola Williams		Apr-23
1.10	Explicitly define the required Quality, Safety & Governance assurance mechanisms for Hosted Organisations	Lauren Fear	Governance and Assurance mechanisms have been agreed and established for Shared Services, reporting through to the Quality, Safety and Performance Committee, Shared Services Audit Committee and Shared Services Partnership Committee. A review is underway of Health Technology Wales and required Governance and Assurance mechanisms. This will be progressed in quarter 1 2022/23. Update 06.10.2022 - Defined project as part of the Building Our Future Together work programme.	Jan-23
1.11	Complete Risk Register Review, transmission onto Datix v14 (04W when available) & ensure regular reviews at all levels in line with Quality and Safety outcomes	Lauren Fear	Regular reviews are taking place and work is ongoing to transfer of all risks to Datix V14, followed by Once for Wales when available.	COMPLETE

TAF DASHBOARD

DIGITAL TRANSFORMATION

RISK ID:	TAF 07	Risk that the Trust fails to sufficiently consider, exploit and adopt new and existing technologies (i.e. assess the benefits, feasibility and challenges of implementing new technology; implement digital transformation at scale and pace; consider the requirement to upskill/reskill existing employees and/or we underestimate the impact of existing and new technology and the willingness of patients to embrace it/ their increasing expectation that their care be supported by it) compromising our ability to keep pace and be seen as a Centre of Excellence.									
LAST REVIEW	Oct-22	5 - A sustainable organisation that plays it part in creating a better future for people across the globe									
NEXT REVIEW	Nov-22				**RISK DOMAIN**			**Performance and Service Sustainability**			
EXECUTIVE LEAD	Carl James	**RISK SCORE (See definitions tab)**									
		INHERENT RISK			**RESIDUAL RISK**			**TARGET RISK**			
		Likelihood	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	
		3	4	**16**	3	4	**12**	3	3	**9**	

Overall Level of Control Effectiveness: **Rating and Rag** (see definitions tab)	**RATING**	**Overall Trend in Assurance**	**THIS WILL INCLUDE A TREND GRAPH**
	PE		

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 Digital Strategy, target approval at Trust Board in May 2022	Carl James	X			E	Tracking key outcomes and benefits map – aligned to Trust Digital Strategy	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA	Wales Audit Office	PA
C2	Active work ongoing to leverage existing and deliver on new technologies – e.g. LIMS, IRS, BECS	Chief Digital officer		X		E	Trust digital governance reporting	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA	Wales Audit Office	PA

TAF DASHBOARD

DIGITAL TRANSFORMATION

C3	Training & Education packages to develop internal capabilities – including for exec and Board	Chief Digital officer	X			PE	Staff feedback	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA	Wales Audit Office	PA
C4	Training & Education packages for donors, patients	Chief Digital officer	X			NE	Patient and donor feedback	IA	Feedback and progress of working with Universities	IA	Wales Audit Office	PA
C5	Ring-fencing digital advancement in Trust budget – benchmark 4%	Chief Digital officer	X			E	Review of proposals via EMB / Trust Board	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA	Wales Audit Office	PA
C6	Specifically development of digital resources capacity and capability	Chief Digital officer	X			PE	Review of proposals via EMB / Trust Board	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA	Wales Audit Office/Centre for Digital Public Services	PA
C7	Digital inclusion – in wider community	Chief Digital officer	X			NE	Tracking key outcomes and benefits map – aligned to Trust Digital Strategy	Not Assessed	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	Not Assessed	Wales Audit Office	Not Assessed
C9	Prioritisation and change framework to manage service requests	Chief Digital officer	X			PE	Trust digital governance reporting	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA	Wales Audit Office	PA

TAF DASHBOARD

DIGITAL TRANSFORMATION

C10	Levels of unsupported applications/ legacy systems	Chief Digital officer			X	PE	Trust digital governance reporting	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	IA	Wales Audit Office	PA
C11	Trust digital governance	Carl James		X		NE	Trust digital governance reporting	Not Assessed	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	Not Assessed	Wales Audit Office	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	Review via EMB / Trust Board	PA	Wales Audit Office	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	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA	Wales Audit Office. WG/CRU as competent authority for NIS	PA
C14	Digital transformation is guided by an agreed digital architecture.	Chief Digital officer	X	X		PE	Digital Programme established. Architectural Review Board	Not Assessed	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	Not Assessed	Wales Audit Office	Not Assessed

TAF DASHBOARD

DIGITAL TRANSFORMATION

GAP IN CONTROLS	GAPS IN ASSURANCE
Each of the controls (with exception of c1,c2) requires further development and progression, the plans for which are at varying levels of maturity – see action 1.1	Development of 3rd Line of defence assurance to be completed in line with the development of the compliance and regulatory tracker see action 1.2.
Digital architecture needs to be developed to guide digital transformation activities.	Mapping of relevant sources of assurance and development of that assurance will be also alongside the development of the key controls, as per action 1.1.
Appropriate external standards for benchmarking need to be agreed (e.g. ITIL, Cyber Essentials, ISO27001) as part of the control framework.	Confirmation on SIRO / Chief Digital Officer responsibilities for cyber assurance alongside Information Governance.
Establishment of a Digital Programme, including key controls for digital inclusion and digital architecture	

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Chief Digital Officer to bring a paper to next Strategic Development Committee with further detail on the plans to develop each of the key controls to an “effective” level	Chief Digital officer	CDO started on 1st July as anticipated, key controls in the TAF reviewed and can be presented at a future SDC	Nov-22
1.2	Create the Trust Digital Reference Architecture to support C14 and	Chief Digital	New Action. Digital Reference Architecture being scoped.	Jan-23
1.3	Review the scope/scale/need for a Digital Programme to provide	Chief Digital	New Action. Digital programme being scoped.	Jan-23
1.4	Confirmation of the SIRO/Cyber Security roles and responsibilities	Chief Digital	Exec discussions taken place and responsibility for Cyber Security sits with the CDO and	Complete

TAF DASHBOARD

TRUST FINANCIAL INVESTMENT RISK

RISK ID:	TAF 08	There is a risk that the contracting arrangements between Velindre and its Commissioners do not adequately acknowledge future service developments and changes in clinical & scientific practices and thus ensure appropriate funding mechanisms are in place and agreed.								
LAST REVIEW	Oct-22	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations								
NEXT REVIEW	Nov-22	**Goal 2**			**RISK DOMAIN**		**Financial Sustainability**			
EXECUTIVE LEAD	Matthew Bunce	**RISK SCORE (See definitions tab)**								
		INHERENT RISK			**RESIDUAL RISK**			**TARGET RISK**		
		Likelihood	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**
		3	4	**16**	4	4	**12**	3	4	**8**

Overall Level of Control Effectiveness: **Rating and Rag** (see definitions tab)	**RATING**	**Overall Trend in Assurance**	**GOING FORWARD THIS WILL INCLUDE A TREND GRAPH**
	PE		

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 Financial Strategy	Matthew Bunce	X			PA	Tracking forecast delivery against financial strategy via Performance Committees and Trust Board	PA	Monthly Performance Review with Executives and Senior Management Teams	PA	Internal Audit cycle of assurance on financial strategy	PA
C2	Active engagement with Commissioners and Welsh Government to ensure inclusion of Velindre requirements within their Financial Planning	Matthew Bunce		X		PE	Inclusion in Health Board IMTP Financial Plans	IA	Monthly Commissioner Meetings held to confirm financial planning requirements	IA		
KEY CONTROLS							**SOURCES OF ASSURANCE**					

TAF DASHBOARD

TRUST FINANCIAL INVESTMENT RISK

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
C3	Active engagement with Trust & Divisions to ensure investment does not exceed available funding	David Osborne	X			PA	Monthly Financial Performance Review Reported to Execs and Senior Management Teams	PA	Quarterly Directorate financial reviews established across both Divisions	PA	Monthly Budget Holder Meetings with Business Partners	PA
C4	Continuous review of contracting currencies and direct WHSCC funding to ensure reflective of efficient cost of delivery	Matthew Bunce		X		PE	Frequent formal Reviews to be established, combined with routine contract reporting	IA	Routine meetings with Depts to support business cases and any impacts on currencies	IA	Annual Review of Contracting Model (focus on pandemic legacy impact)	IA
C5	Benchmarking with appropriate services to ensure value	Matthew Bunce			X	PE	Non Surgical Benchmarking Group with Welsh Cancer Centres	PA	National Costing Cycle	PA		
C6	Routine contracting reporting and discussion with Commissioners to review activity and early identify income volatilities	David Osborne			X	PE	Monthly Financial Performance Review Reported to Commissioners with Monthly Meetings	PA	Annual Review of Contracting Model (focus on pandemic legacy impact)	IA	Introduction of Service Line Reporting	IA

TAF DASHBOARD

TRUST FINANCIAL INVESTMENT RISK

C7	Establish Investment Prioritisation Framework at a Trust and Divisional level to ensure no investment creep and strategic priority alignment	Matthew Bunce	X			PE	Chief Executive Consideration of Investment at a Trust Level	IA	Divisional Senior Management Team investment review	IA		

GAP IN CONTROLS	GAPS IN ASSURANCE
C3 – Governance of investment at Velindre Cancer Centre is being enhanced through the embedding of resource authorization, prioritization and allocation process, linked to Velindre Futures. Framework not fully embedded at present.	Inclusion of Velindre funding requirements with respective Commissioner financial planning requires formal clarification from Commissioners. Whilst requirements may be acknowledged, the financial challenges that Commissioners are prioritizing may not align with Velindre intents, consequently, assurance cannot be given that Velindre requirements will be met.
C4 – Whilst the contracting model has been continuously reviewed, the impact of COVID related measures has had a potential significant shift in cost base. This requires further understanding to identify mitigations.	The impact of COVID on current performance and cost base remains volatile, with recurrent funding also unclear. Capacity and demand modelling being undertaken in key risk areas. Welsh Government and Commissioners engaged on current and future consequences.
C7 – Trust Investment Prioritisation Framework to be established.	Investment is limited in it's prioritisation to the Executive Team and Senior Management Teams discretion and not formally supported by a framework for decision making.

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Support the embedding of investment framework within Divisions	David Osborne	Process continues to be embedded, terms of reference and process established. Communications throughout Division and "live" operation to follow.	Dec-22
	Investment scrutiny with services against commitments made and intended.	David Osborne	Completed and subject to continuous review	Completed
	Key objectives of investment framework and relationship to contract performance and value identified	David Osborne	Completed	Completed
	Investment framework to be articulated and agreed by Divisions and Exec	David Osborne	Due through Q3	Dec-22
	Investment framework to be applied within IMTP process	David Osborne	Due through Q3	Dec-22
1.2	Review of contracting model for impact of COVID related measures	David Osborne	Areas of concern identified, discussions to inform are underway with Services. Board to be advised of present volatility and Commissioners engaged.	Dec-22

TAF DASHBOARD

TRUST FINANCIAL INVESTMENT RISK

	Protected Enhanced rates secured for 22-23	David Osborne	Completed	Completed
	Contract currencies of concern identified and impact assessed	David Osborne	Impact of hyperfractionation reviewed	Completed
	Business Cases completed for Brachytherapy	David Osborne	Business case prepared and agreed	Completed
	Engage with National Funding Flows Group for contract agreements for future financial years	David Osborne	Ongoing, due November	Dec-22
1.3	Establish Trust Investment Prioritisation Framework	Matthew Bunce	Initial proposals prepared, Executive discussions to shape and take forward	Dec-22

RISK ID:	TAF 09	Risk that the Trust's ability to develop new services and failure to take up and create opportunities to apply expertise and capabilities elsewhere in the healthcare system.								
LAST REVIEW	Oct-22	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations								
NEXT REVIEW	Nov-22	Goal 2			RISK DOMAIN		Research and Development			
EXECUTIVE LEAD	Carl James	RISK SCORE (See definitions tab)								
		INHERENT RISK			RESIDUAL RISK			TARGET RISK		
		Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
		3	4	12	2	4	8	2	3	6

Overall Level of Control Effectiveness: Rating and Rag (see definitions tab)	RATING	Overall Trend in Assurance	THIS WILL INCLUDE A TREND GRAPH
	PE		

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	Development of a Trust strategy and other related strategies (R, D& I; digital etc) which articulate strategic areas of priority	Carl James	x			E	Executive Management Board review	PA	Strategic Development Committee	PA	Audit Wales Reviews	PA
C2	Trust Clinical and Scientific Strategy	Nicola Williams	X			PE	Executive Management Board review	NA	Strategic Development Committee	IA	Audit Wales Reviews	PA
C3	Development of a Clinical and Scientific Board to lead clinical direction of travel	Jacinta Abraham				PE	Executive Management Board review	NA	Strategic Development Committee	IA	Audit Wales Reviews	PA
C4	Development of improved local, regional and national clinical commissioning arrangements	Matthew Bunce	x			PE	Executive Management Board review	IA	Strategic Development Committee and performance management framework	IA	Audit Wales Reviews	PA

C5	Agreement of system leadership roles for primary services: 1. Blood Services 2. Cancer Services	Cath O'Brien	x			PE	Executive Management Board review/ patient and donor feedback	IA	Strategic Development Committee	IA	Audit Wales/MHRA & HIW/ regulators	PA
C6	Change in strategic workforce plan to recognize/address any new leadership/clinical/management skills related to strategic growth	Sarah Morley	x			PE	Executive Management Board review	IA	Strategic Development Committee	IA	Audit Wales/MHRA & HIW/ regulators	PA
C7	Refresh of Investment and Funding Strategy	Jacinta Abraham	x			PE	Executive Management Board review	IA	R< D & I Sub-Committee and Performance	IA	Audit Wales/External Research organisations &	PA
C8	Development of commercial strategy	Matthew Bunce	x			PE	Executive Management Board review	IA	R< D & I Sub-Committee and Performance Management Framework	IA	Audit Wales/External Research organisations & Welsh Government	PA
C9	Attraction of additional commercial and business skills	Matthew Bunce		x		PE	Executive Management Board review	IA		IA	Audit Wales/External Research organisations & Welsh Government	PA

GAP IN CONTROLS	GAPS IN ASSURANCE

Lack of clinical and scientific strategy	New PMF not yet in place with revised measures to track delivery of Trust strategy
Limited commercial expertise (capacity) within the Trust	Local commissioning/regional commissioning processes unchanged with no new ways of measuring effectiveness
Robust commissioning arrangements across Wales	
Clear understanding of strategic direction/system design with partner LHBs	
Ability to identify and secure funding	
Lack of clarity about future services and required skills, capacity and capability to leverage the strategic oppor	

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Develop full suite of strategic documents to provide clarity on future direction of travel	Carl James	On track for May 2022. The overarching Trust Strategy "Destination 2032" was approved in the January Trust Board. The Enabling Strategies were subsequently approved, as outlined below, in the May 2022 Trust Board.	COMPLETE
1.2	Board decision on strategic areas of focus/to pursue	Board	Final enabling strategies on track for may 2022 - allowing prioritisation to occur in future IMTPs. Trust Enabling Strategies were approved by the Trust Board in May 2022.	COMPLETE
1.3	Further focus across organisation on key strategic priority programmes of work which will effectively build towards the 2032 Strategic aims	Board	Supported by Q5, initial mapping complete following extensive series of document reviews and interviews across the leadership teams of the organisation. Final version of Transformation Roadmap to be further worked on across the organisation, including discussion as Trust Board in Board development session in October. Final version will be shared in November Board meeting, alongside the IMTP priorities.	Nov-22
1.4	Development of clinical and scientific strategy	Execs	Jacinta Abraham and Nicola Williams leading - ToR for Clinical and Scientific Board agreed in Executive Management Board. Further work underway to set up and identify appropriate resource to support.	Jan-23
1.5	Development of KPIs and PMF to track strategy delivery	Carl James	There will be an additional cycle agreed to test PMF (following the October Board Development session) - target date for live PMF Jan 23 reporting Cycle	Jan-23

1.5	Identify capability required and funding solution/source	Execs	Following the agreement of the Transformation Roadmap, as outlined in 1.3, analysis of the resource and analysis of appropriate allocation will be implemented as a way of working through Executive Management Board.	Jan-23

TAF DASHBOARD

GOVERNANCE

RISK ID:	TAF 10	There is a risk that the organisation's governance arrangements do not provide appropriate mechanisms for the Board to sufficiently fulfil its role and the organisation to then be effectively empowered to deliver on the shaping strategy, culture and providing assurance, particularly through a quality and safety lens.									
LAST REVIEW	Oct-22	1 - Outstanding for quality, safety and experience									
NEXT REVIEW	Nov-22	**Goal 1**			**RISK DOMAIN**		**Compliance and Regulatory**				
EXECUTIVE LEAD	Lauren Fear	**RISK SCORE (See definitions tab)**									
		INHERENT RISK			**RESIDUAL RISK**			**TARGET RISK**			
		Likelihood	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	
		4	4	**16**	3	4	**12**	2	4	**8**	

Overall Level of Control Effectiveness: **Rating and Rag** (see definitions tab)	**RATING**	**Overall Trend in Assurance**	GOING FORWARD THIS WILL INCLUDE A TREND GRAPH
	E		

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	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**	PA	Audit Committee Trust Board	PA	Internal Audit Reports Audit Wales Structured Assessment Programme / Reports Joint Escalation & Intervention Arrangements	PA
C2	Board Committee Effectiveness Arrangements	Lauren Fear	X			E	Internal Annual Review	PA	Audit Committee Trust Board	PA	Internal Audit of Board Committee Effectiveness Audit Wales Structured Assessment Audit Wales Review of Quality Governance Arrangements	PA

TAF DASHBOARD

GOVERNANCE

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
C3	Health & Care Standards Self-Assessment Arrangements: Standard 1.0 - Governance, Leadership and Accountability	Lauren Fear			X	E	Divisional Management Arrangements for overseeing effective implementation and monitoring	PA	The Trust has an established framework through which self-assessment are undertaken and action taken to implement improvements and changes required – reported on a quarterly basis to EMB Run, Quality, Safety & Performance Committee and Board as required	PA	Annual Internal Audit Report against the Health & Care Standards for Wales (20/21 assessment provided substantial Audit Wales review outcomes of report as part of Annual Report - Accountability Report	PA
C4	Board Development Programme	Lauren Fear	X			PE	Programme established PA	IA	Independent Member Group repurposed and second meeting now held. Further embedding through 2022/23	IA		
C5	All-Wales Self-Assessment of Quality Governance Arrangements	Lauren Fear		X		E	Action plan developed in response to self-assessment exercise. All actions complete /on track to complete by end of this financial year.	PA		PA	Audit Wales review of Quality Governance Arrangements	PA
C6	Quality of assurance provided to the Board	Lauren Fear	X			E	Quality of Board papers and supporting information effectively enabling the Board to fulfil its assurance role. IA	IA	Trust Board assessment via formal annual and additional effectiveness review exercises. IA	IA	Internal Audit Reports. Audit Wales Structured Assessment Programme/Reports	PA

GAP IN CONTROLS

GAPS IN ASSURANCE

TAF DASHBOARD GOVERNANCE

None	Third line of defence in respect of C4 – Board Development Programme: no course of action is proposed

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

Action Plan	Owner	Progress Update	Due Date
C4 • Development of a more structured needs based approach to inform a longer terms plan for the Board Development Programme.	Lauren Fear	Supported by the development priorities identified through an externally facilitated programme of Board development underway.	Complete
Ongoing input from the Independent Members via the repurposed Integrated Governance Group	Lauren Fear	Terms of Reference and supporting refreshed standard agenda has been agreed by Independent Members for the Independent members Group.	Complete
Develop and implement formal Governance, Assurance and Risk Programme as part of Trust wide Organisational Development programme of work.	Lauren Fear	This will be picked up in the overall Governance, Assurance and Risk (GAR) Programme of work consisting of 20 projects across the spectrum of work	Dec-23
Appropriate frameworks will be aligned with the Trust Assurance Framework	Lauren Fear	Project TAF1.0 within the Governance, Assurance and Risk (GAR) programme of work is underway to align frameworks with the Trust Assurance Framework. The Risk Framework is currently being mapped.	Mar-23
Refresh of Trust Assurance Framework risks	Lauren Fear	Project TAF 2.0 within he GAR Programme has started, risks are reviewed on a monthly basis and reported through governance routes accordingly	Dec-23
Revised reporting mechanism to be developed	Lauren Fear	Project TAF 3.0 within he 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, led by Execs	Mar-23
Trust Assurance Framework will be mapped through Governance Cycle	Lauren Fear	Work is ongoing mapping the 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	Mar-23

STRATEGIC DEVELOPMENT COMMITTEE

TALBOT GREEN INFRASTRUCTURE PROGRAMME – PROGRESS UPDATE

DATE OF MEETING	13/10/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Sarah Richards, Interim General Services Manager
PRESENTED BY	Carl James, Director of Strategic Transformation, Planning & Digital, Corporate Services
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning, & Digital

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	September 2022	NOTED

ACRONYMS	
GMP	Good Manufacturing Practice
OBC	Outline Business Case
PBC	Programme Business Case
WBS	Welsh Blood Service

1. SITUATION/BACKGROUND

1.1 A Programme Business Case (PBC), setting out a programme of strategic developments in relation to improvements to the current infrastructure at the Welsh Blood Service (WBS), was approved by the Welsh Government in March 2021. These improvements will support the provision of high quality, safe, sustainable, efficient services and help to meet Good Manufacturing Practice (GMP) and recognised standards and regulations.

1.2 They will also ensure a facility that supports the delivery of the VUNHST Sustainability Strategy to achieve net zero carbon emissions by 2030 and the Welsh Government target of carbon neutral for all public sector buildings by 2050.

1.3 In approving the PBC the Welsh Government provided support for the development of an Outline Business Case (OBC) for phase one of the Programme. The OBC requires additional detail, especially in relation to option development, forecast costs and Programme delivery, in comparison to the PBC.

1.4 The Outline Business Case (OBC) is nearing completion and takes into account the impact of both the Laboratory Services Modernisation Programme and the Plasma for Medicines Programme.

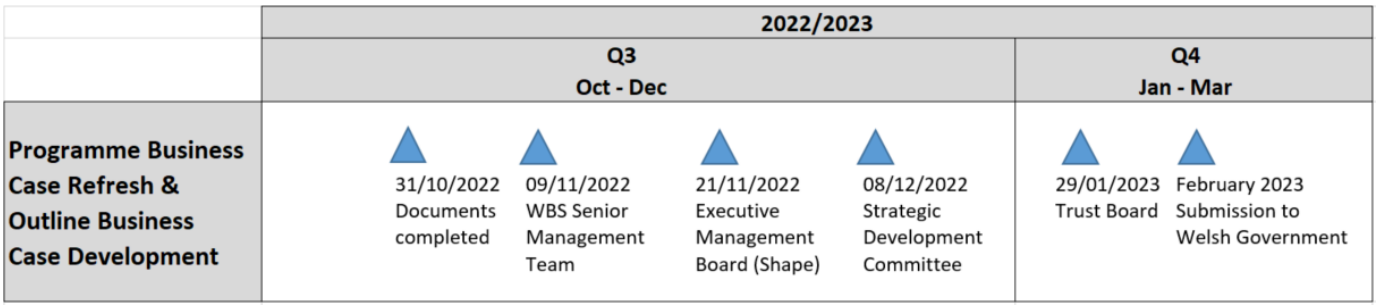
1.5 In parallel the Programme Business Case will also need to be refined and refreshed.

1.6 Both the Programme Business Case and the Outline Business Case (phase 1), once completed, will require approval from:

- Welsh Blood Service Senior Leadership Team
- Trust Executive Management Board
- Trust Strategic Development Committee
- Trust Board
- Welsh Government

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Both the OBC and refresh of the PBC are anticipated to be completed 'in draft' by the end of October 2022. The approval and submission timeline is outlined below.



3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Safe Care
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

4.1 The Strategic Development Committee is asked to **note** the progress in relation to the Talbot Green Infrastructure Programme and to **note** the forecast PBC & OBC timelines for their submission and approval.

STRATEGIC DEVELOPMENT COMMITTEE

HEFYD UPDATE – SUMMER 2022

DATE OF MEETING	13th October 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Hannah Moscrop, Project Manager RD&I
PRESENTED BY	Lauren Fear, Director of Corporate Governance
EXECUTIVE SPONSOR APPROVED	LAUREN FEAR, DIRECTOR OF CORPORATE GOVERNANCE

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
nVCC Project Board	14/09/2022	NOTED
TCS Programme Delivery Board	15/09/2022	NOTED
TCS Programme Scrutiny Sub-Committee	22/09/2022	NOTED

ACRONYMS	
nVCC	New Velindre Cancer Centre
TCS	Transforming Cancer Services [in South East Wales Programme]

1. SITUATION

1.1 The 'Value Added' programme of work has been renamed 'Hefyd' – which means 'Also' in Welsh.

1.2 The paper provides an update on activity undertaken within the Hefyd programme of works, and a forward look on forthcoming activity.

1.3 The Terms of Reference for the Hefyd Programme are provided as **Appendix A**.

2. KEY MATTERS FOR CONSIDERATION

Update on activities undertaken

Sustainable Summer Jamboree

2.1 The nVCC Project and Trust Sustainability Team collaborated on the development of a 'Sustainable Summer Jamboree', hosted in a giant tepee on site at the Velindre Cancer Centre Staff Well-being Hub (**Appendix B**).

- The Jamboree comprised of a series of staff and community engagement events over the summer – linking themes of sustainability, well-being, art and the nVCC and EW Projects.
- The Jamboree was undertaker as a 'soft launch' and 'tester' for the longer-term Hefyd programme, and sought to and highlight future opportunities, which are intended to be rolled out later this year.
- A number of events were targeted at children and young people, paving the way for future work in the Children and Education element of the Hefyd programme.

Green Social Prescribing

2.2 The green social prescribing work provided by Ray of Light at Velindre Cancer Centre has been nominated for the Mental Health and Wellbeing Wales Awards for 'Best Mental Health Support Service'.

Community Benefits / Social Value

2.3 To ensure alignment with the work of Acorn and Walters in the Community Benefits space, social value matters separate from the contractual Community Benefits nVCC Successful Participant Workstream and Walters Community Benefits Project Meeting will be covered in the regular Hefyd Sponsorship Group.

2.4 The Group will continue to meet in person on a quarterly basis to workshop the programme and ideas, as well as holding regular virtual 'touchpoint' meetings in-between.

Forward look – next steps and planned work

Community Panel

2.5 The Digital Community Panel launch will take place later this month, seeking members from across the whole of the Velindre catchment area.

2.6 Members of the Community Panel will be invited to regular online and in-person events across the Velindre region – showcasing different aspects of our work. They will also be first to be offered the opportunity to take part in our green volunteering activities and arts projects, and to give your views on our ongoing and upcoming work.

2.7 The first set of outreach events for the Community Panel will be focused on the Arts Strategy – and will be held in various locations across the South East Wales region.

Green Social Prescribing and Site Enhancements

2.8 A paper has gone to the Enabling Works Project Board in September seeking approval for spend based on outline costs for a number of site enhancement activities, and to commence a programme of green social prescribing work.

2.9 This programme of work will comprise:

- The tepee being set up on the VCC site (by the staff Well-being Centre) to act as a 'workshop' base for green social prescribing activities
- The construction of a roundhouse, cleft fencing, and furniture making with various vulnerable and / or local groups identified by VUNHST – for example, patients and families (where suitable), volunteers from Velindre and the local community.

2.10 Planning permission is being sought for both the tepee and roundhouse – intended as a long-term temporary structure, and it is intended that the programme of work will commence at the start of November 2022. A mini-programme of community engagement activities will be held in the tepee during the school half-term.

Volunteering

2.11 A draft Volunteering Policy developed with the green social prescribing opportunities. This has been provided to the VCC team working on developing the new volunteering set up.

2.12 In due course, volunteering opportunities will be advertised online and people able to sign up to them through the Civica programme. This will include those run by the green social prescribing provider, but may include additional opportunities run through the Hefyd programme (in addition to those within VCC, etc.).

Arts and Culture Programme

2.13 The Arts Strategy is being taken through internal governance for approval in October.

2.14 Following this, the recruitment process for an Arts Co-ordinator post can commence (joint-funded with the Arts Council Wales).

Sustainable Summer Jamboree

2.15 Three key recommendations from the Sustainable Summer Jamboree were taken to SLT in September:

- A permanent space is identified at VCC to host a 'drop in arts and crafts' space – open during key service/operational times (for example, aligned with particular clinics), potentially 'manned' by volunteers – and offering basic arts and crafts activities for people of all ages to join in.
- A regular programme of events for staff well-being is developed in collaboration with staff - to identify suitable times for participation. Programme is long-term and regular to enable planning ahead for attendance. Managers help to facilitate staff to attend well-being events.
- A permanent or semi-permanent space for Ray of Light to host their green social prescribing activities is identified. This space should provide storage, be weather-proof, warm during winter months. Furniture from the tepee to be utilised in this space to promote sustainability.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:

EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

4.1 The Strategic Development Committee is asked to **NOTE** this paper and the attached Appendices.

Velindre Hefyd Sponsorship Group

Terms of Reference

Hefyd ('Added Value' / social value) activities have a broad reach across the TCS Programme – particularly with regards to the Enabling Works build, and nVCC construction and operational terms.

Both the nVCC and Enabling Works contractors have Community Benefits obligations to meet which are outwith of the Hefyd programme. For the nVCC – these will be developed and contractualised through the nVCC Community Benefits and Legal Workstreams. For the Enabling Works – these are monitored at a monthly meeting, and reported on through the Enabling Works Project Board (commencing September 2022).

Purpose:

The Sponsorship Group will bring together these discussions and ensure ongoing sight and alignment for all relevant parties with regards to Hefyd activities.

Functions of the Group include:

- Members updating on their work to help identify opportunities where economies of scale and additional benefits may be realised, and to avoid duplication;
- Ideas generation and allocation (aligned to identified principles **TBC to include regionality and equality**);
- Co-ordination of available inputs (i.e. shared Hefyd Infrastructure: incl. comms and engagement, Community Panel, volunteers, contractor Community Benefits, etc.);
- Facilitating the progression of ideas / projects by the relevant workstream through the provision of / access to inputs;
- Recording outcomes and impact;
- Ensuring the coordination of Comms and Engagement across the piece.

Membership:

Input / Infrastructure	**Membership**
Executives	(Lauren Fear (Lead), Carl James)
Comms and Engagement, including Community Panel	Non Gwilym, Kate Hammond
nVCC Leads and Advisory Support	David Powell, Mark Ash, Andrea Hague, Phil Roberts, David Mason-Hawes

nVCC and Enabling Works PMO	Mark Young, Hannah Moscrop, Tracy Hinton, administration
VCC Operations and Volunteering	Lisa Miller, Volunteering Manager (TBC)
VCC Estates and Sustainability	Jason Hoskins, Rhiannon Freshney
Velindre Arts MDT	Huw Llewellyn, Hilary Williams, Simon Fenoulhet, Velindre Arts Co-ordinator (TBC)
Velindre Fundraising	Alaric Churchill
Down To Earth	Mark McKenna, Seb Haley
Acorn – nVCC Contractors	Richard Coe, Jane McRobbie, Katie John
Walters – Enabling Works Contractors	Thomas Morris
TBC – WBS	
TBC – Whitchurch Sports Clubs	
TBC – IRS Project Representatives	

In scope:

- Identified Hefyd activities, within the following work areas:
    - Nature-based social prescribing and green social prescribing;
    - Site Enhancements works;
    - Children / Educational outreach programme and schools engagements;
    - Arts and Culture Programme.
    - [Potential development of the Maggies centre at nVCC];
    - [Potential development of a local Sports complex on Cardiff & Value UHB land adjacent to the nVCC site and potential 'fly in factory' to aid construction of the above];
    - [Potential to include IRS Project if relevant.]

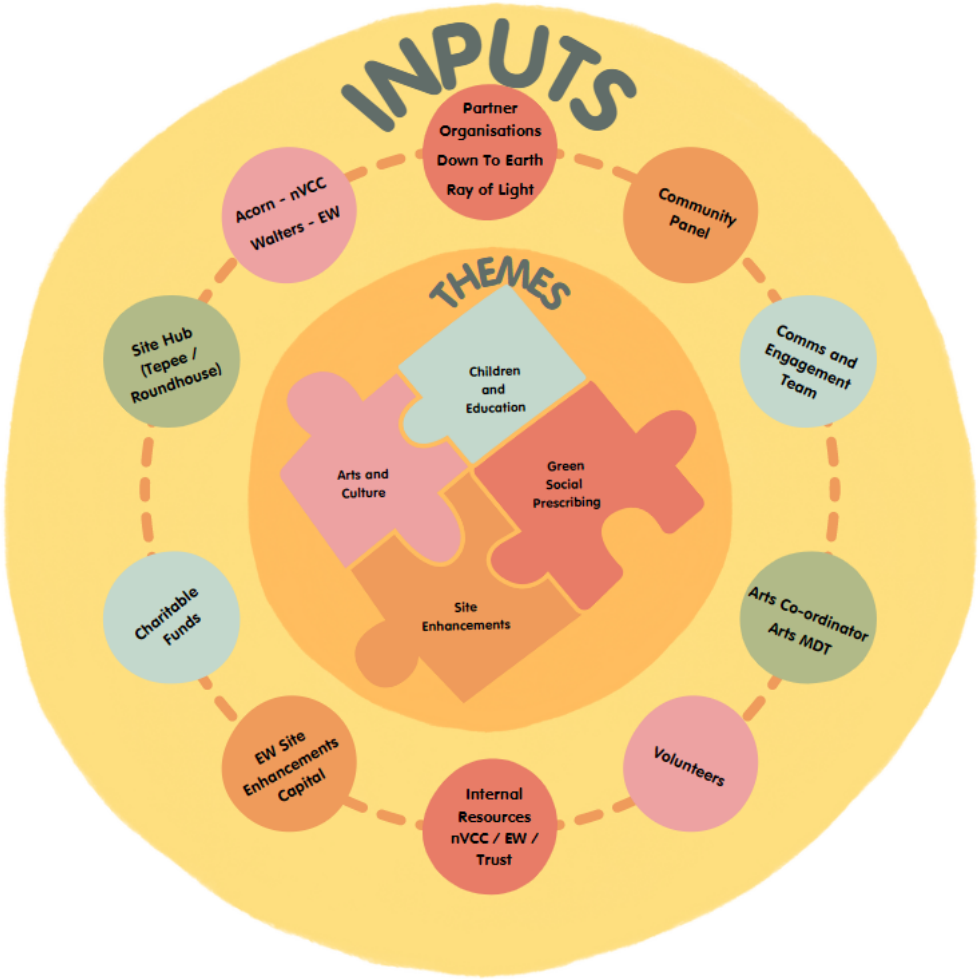
Out of scope:

- Community Benefits as relate to job creation, apprenticeships, and 'standalone' tender-specific offerings.

Meetings:

- Hefyd Sponsorship Group Workshop meetings to be held in person on a quarterly basis;
- Hefyd Sponsorship Group Touchpoint meetings to be held via MS Teams on a monthly basis;
- Internal Hefyd Working Group meets on a weekly basis – hybrid (at TCS offices and on MS Teams);
- nVCC Community Benefits Workstream meets on a monthly basis;
- Enabling Works Community Benefits Meeting held on a monthly basis.

Themes of Work and Resources/ Inputs/ Infrastructure:



Reporting:

- A quarterly Hefyd Update Report is taken to the nVCC Project Board, TCS Strategic Capital Board and TCS Scrutiny Sub-Committee, VCC SLT and EMB Shape.
- Additional reporting for approvals will be taken as required through the Enabling Works or nVCC governance process.

Sustainable Summer

JAMBORI

Haf Cynaliadwy

Event Programme Review

10th Awst|August - 1st Medi |September 2022

Canolfan Ganser Felindre Velindre Cancer Centre

newydd Canolfan Ganser Felindre Velindre Cancer Centre new

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

Gwasanaeth Gwaed Cymru Welsh Blood Service

Hedgehog Helpline
Hedgehog Helpline Cymru
07557 646773

Ray of Light Cancer Support

Codi Arian Canolfan Ganser Velindre Cancer Centre Fundraising

SWEATFIIT

AGAINST breast cancer

FREAKHOUSE Graphics MIKE COLLINS

JillyBond.

MAGGIE'S
Everyone's home of cancer care

Down To Earth
DOING GOOD THINGS TOGETHER

Table of Contents

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

Canolfan Ganser Felindre Velindre Cancer Centre

Introduction

Throughout August, a 'Sustainable Summer Jamboree' was held in the Cancer Centre for staff, patients, families and the local community.

The Trust Sustainability Team together with the new Velindre Cancer Centre project team held a month-long event programme featuring staff, patient and community engagement events over the summer. There was a breadth of different activities, linking themes of sustainability, well-being, art, the new Velindre Cancer Centre and Enabling Works.

The Sustainable Summer Jambori aimed to;

- Engage with staff,
- Engage with the local community,
- Promote and provide the opportunity for staff to input into implementation of the Trust's Sustainability Strategy,
- Promote the Trust's and Projects' sustainability aims,
- Promote the Trust's Well-being Objectives,
- Promote the Well-being of Future Generations Well-being Goals,
- Serotonin boost for Trust staff,
- Connect staff across the Trust -WBS, VCC, TCS and Corporate

The Sustainable Summer Jambori has launched the Hefyd programme, and highlights future opportunities, which will be rolled out from/near the MIM site once the Enabling Works commence.

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Canolfan Ganser Felindre Velindre Cancer Centre

Tepee Goals

A wide-range of events was established within the programme to ensure that there was 'something for everyone' which would appeal to and connect with as many staff, patients and members of the community as possible. The full programme contained events ranging from arts workshops to yoga, bug hotels to pelvic floor health seminars and slow fashion to hedgehog habitats!

1

Improve Staff Well-being

Providing respite for staff through fun and engaging free activities to improve wellbeing, whilst bringing together various parts of the Trust – nVCC and VCC, WBS, Fundraising, HQ.

2

Engagement with the local community

Engaging with the community, including children and young people – something the Future Generations office has previously commended us on. Establishing the tepee as a 'destination' for events and wider community conversations.

3

Promotion and opportunity for staff to input into the implementation of the Trust's Sustainability Strategy

Providing a space for staff to learn about the Sustainability Strategy, how they can get involved and what initiatives and events matter to them.

4

Promotion of the Trust's and new Velindre Cancer Centre Projects' sustainability aims

Gathering feedback on the nVCC design, Trust's work on Future Generations and Well-being, effectiveness and impact of green social prescribing and arts/craft as a well-being tool; Highlighting the Trust's commitment to the Well-being of Future Generations goals, contributing to the Trust's Well-being Objectives and raising awareness of the Act.

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Canolfan Ganser Felindre Velindre Cancer Centre

Communication and Engagement

The breadth of variety in the Jambori programme required a strong multi-channel approach to communications in order to ensure a high level of interest and attendance for each of the sessions.

Recognising that not all staff are digitally connected, floor walks and well-placed signage, posters and leaflets proved to be effective in raising awareness Alongside digital posts in the staff newsletter, intranet news updates and via staff word of mouth.

Our community were kept informed via our social media channels, local radio interview and ITV news coverage, supported by posters and leaflets on display in the Whitchurch area.

AUGUST & SEPTEMBER 2022

SUSTAINABLE SUMMER JAMBOREE

Monday	Tuesday	Wednesday	Thursday	Friday
8 Tepee Installation!	9 Tepee Installation!	10 Arts in Health - Moving House Project Drop in Session! For All	11 Arts, Crafts & Chat! Drop in Session For All	12 Creepy Crawlie Crafts Workshop Drop In - 10am-3pm Families
15 Environmental Awareness & Hedgehog Helpline Cymru Drop In 1-4pm For Staff	16 Ray of Light - connecting with nature Drop In 10:30am-12:30pm For anyone affected by cancer ~ Drop In Afternoon	17 Design a Patient Garden Drop In 10:00am - 12:00pm & 2-4pm For All ~ Pelvic Floor Health Workshop with Jilly Bond 12:30-1:30pm For Staff	18 Arts, Crafts & Chat! Drop in Session For All	19 Fundraising Drop In For All ~ Yoga for Staff 12-12:20pm and 12:30-12:50pm
22 Down to Earth - Green Design Workshop 10-2:30pm For Families - Please Book!	23 Ray of Light - connecting with nature Drop In 10:30am-12:30pm For anyone affected by cancer ~ Drop In Afternoon	24 Young Ambassador Event Invite Only	25 Morning Motivation! Drop In 8:30-9am For Staff Bone Marrow Clinic Drop In 9am-1pm For All Comic Workshop with Mike Collins Drop In 2-4pm For All Sustainable Fashion Party Drop In 5-7pm For All	26 Dementia Friends Training! Drop In 10-11am For Staff ~ Meditation Station Drop In 2-4pm For All
29 Bank Holiday	30 Ray of Light - connecting with nature Drop In 10:30am-12:30pm For anyone affected by cancer ~ Drop In Afternoon	31 Down to Earth - Green Design Workshop 10am - 2:30pm For Families - Please Book!	1 Morning Motivation! Drop In 8:30-9am For Staff ~ Down to Earth - Green Design Workshop 10am - 2:30pm For Families - Please Book!	2 Tepee Taken Down - End of Jamboree!

27 events

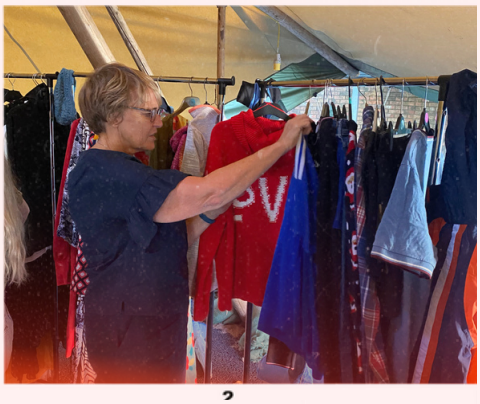
300+ books swapped

1 whole bra bank filled

200+ items donated for Working Wardrobe

"There was nothing but smiles all round"

"It lifted my spirits"



"Definitely my favourite lunch break ever!"

100+
items donated for Clothes Swap

5
planters installed & filled with flowers and sensory plants

14
partners delivered events and initatives

75+
bug hotels donated to attendees

"Kids loved it! We learnt all about hedgehogs"

"The quality and thought that had gone into all of the activities was excellent."

"It was lovely to be able to have the chance to spend time with my grandsons in a fun and relaxing environment"

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Canolfan Ganser Felindre Velindre Cancer Centre

Highlights

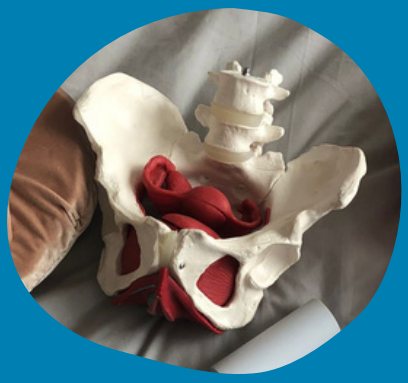
Creepy Crawlie Arts & Crafts Workshop

The first Family Day of the Jambori was a flying success.

Families, staff and local community came together to decorate hotels, got messy making clay leaves & snails and drew pictures to display for patients. Throughout the day we learnt how to look after creepy crawlies in their gardens.

Everyone took home a bug hotel, a colouring book with facts about biodiversity and a whole host of new knowledge about creepy crawlies!

Recommendation
Provide workshops about biodiversity and conservation through fun activities



Pelvic Floor Health Seminar

A Pelvic Floor Health Seminar for staff was held, led by internationally renowned physiotherapist, educator, researcher & speaker Jilly Bond.

The event, held over a lunchtime, had great staff attendance. Additionally, many more staff who were unable to attend said they would love more of these to be available to them.

When promoting the event, it was evident this health topic was of interest to a considerable percentage of Velindre staff.

Recommendation
Consider future workshops during staff-friendly hours on relevant health topics

Moving House Arts Project Launch

A 'soft launch' of a Moving House arts project started to capture memories and feelings held by staff and patients of VCC.

Recommendation
Capture staff stories, memories & feelings about current site

While it's exciting to move to new premises, there is always a thought something will be lost along the way. We can take our memories with us but the places we leave behind have been witness to our teamwork and friendships, our highs and lows, our hopes and ambitions. This Project will capture the spirit of our Velindre in words and images so that we take that story with us when we move.

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Canolfan Ganser Felindre Velindre Cancer Centre

Highlights Continued

Sustainable Fashion Party & Clothes Swap

We were delighted to welcome influencer Rachel Boo, a sustainable style activist who advocates slow fashion to her 23,000+ followers. 'Tickety Boo0', as she's known on Instagram, held a fascinating talk on sustainable and preloved fashion, as well a fun and informative quiz and a Clothes Swap party.

Attendees were inspired to host more Clothes Swaps in the future - and noted the benefits to patients who may experience weight gain or weight loss during treatment, and more widely to those affected by cost of living increases.

Recommendation
Sustainable 'swap' events to be held for staff and local community to help beat cost of living crisis.

Recommendation
Patient 'Clothes Swap' facility available on site.

Comic Book Workshop

Marvel Comics illustrator Mike Collins taught attendees how draw their own comics in this fun & interactive workshop.

Attendees of all ages learnt the tricks of the trade from Mike, who has been drawing comics for over 30 years, his work swings from Spider-Man comics to storyboarding Doctor Who and everything in between!

The group enthusiastically designed characters, and learnt how to draw their own comics, recreate famous superheroes & design their own original characters!

Closing Ceremony

To celebrate the end of the Jambori and all its success, we hosted a Closing Ceremony with live music from local opera singer, Anna Fitzheslop & David, Stef & Mark from the TCS offices.

Scientifically proven to lower stress levels, the celebratory singalong to Beatles classics certainly hit the right note with audience participation and everyone left the tepee with their serotonin levels well and truly boosted by live music!

Recommendation
Provide opportunities for musical performances in the Cancer Centre to boost staff and patient wellbeing - consider using outdoor spaces whilst visitors to VCC are restricted

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Feedback

"Fantastic. Love this. There is such an unmet need for this. Love it!"

A survey was provided for those who wanted to complete before and after undertaking an activity at the tepee. In total, 42 responses were received. It is worth noting that significantly more people attended events at the tepee, but during busier periods, we struggled to get round to asking people to complete the survey.

There was a huge numbers of staff visitors throughout the month. Initially many curious as to what was going on, and word spread quickly.

As the month progressed, repeat visitors and those who had been recommended to come by other attendees – we noted many coming back as they felt comfortable in the space. At the end, people expressed regret that the space was not permanent.

24
different departments attended

88%
of respondents who answered reported feeling less stressed

83%
said they would consider the new activities learnt to make themselves feel better in future

83%
said they would do the new activities

"This is a brilliant way to enable us to feel engaged, relaxed and supported. All whilst learning new fun skills"

"Learnt so much about sustainable fashion, I'll be hitting up the charity shops soon."

"As the session was unexpected it lifted my spirits and I have something to take home to remember the time working on my bug hotel. Thank you"

"Excellent service, bringing people together, helping mentally"

Staff, patients and families noted it was an ***"escape"*** and opportunity to ***"make memories with family members"*** whilst in treatment. On an more basic level, it gave patient's children something free and inclusive to do during the school holidays and during a heatwave.

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Canolfan Ganser Felindre Velindre Cancer Centre

Additional Benefits

Alongside achieving the intended benefits, the programme led to unanticipated for all attendees.

Patient & Families

- Considerable feedback was noted from patients and patient families that the opportunity to do arts and crafts in the tepee made the Cancer Centre a friendly / less scary place.
- Families had a space to make memories whilst waiting for, or after, their appointments.

Recommendation

A permanent space is identified at VCC to host a 'drop in arts and crafts' space – open during key service/operational times (for example, aligned with particular clinics), potentially 'manned' by volunteers – and offering basic arts and crafts activities for people of all ages to join in.

Staff

- Staff noted that many of the events and activities hosted were of interest to them, but that they struggled to attend due to workload, timings, notice and school holidays;
- Many felt that more advanced notice, or regularly programmed events (such as a weekly staff yoga class) would be beneficial - and ongoing, regular occurrence would make it easier for them to plan to attend.

Recommendation

A regular programme of events for staff well-being is developed in collaboration with staff - to identify suitable times for participation.
Programme is long-term and regular to enable planning ahead for attendance.
Managers help to facilitate staff to attend well-being events.

Green Social Prescribing

- Regular and new attendees at Ray of Light noted it was a great space to feel connected with nature and the group outside of the a clinical setting;
- The tepee provided space for the group to go forward regardless of the weather;
- As a longer-term space than their regular gazebo, the tepee was warm, sheltered and decorated - providing a safe, secure and welcoming space.

Recommendation

A permanent or semi-permanent space for Ray of Light to host their green social prescribing activities is identified.
This space should provide storage, be weather-proof, warm during winter months.
Furniture from the tepee to be utilised in this space to promote sustainability.

Acknowledgements

The Sustainable Summer Jambori team would like to thank everyone involved in helping these events come together - in such a short time. The team would also like to thank everyone who attended making every event such a success with their enthusiasm & energy to learn about bugs, art or whittling.

In particular, we would like to thank so many people and organisations who generously donated their time and expertise to us at no cost:

- Hedgehog Helpline Cymru
- Ray of Light Cancer Support
- Rachel Pridmore (Sustainable Fashion Influencer)
- Sweatfiit (Yoga Teacher)
- Mike Collins (Artist)
- Jilly Bond (Pelvic Physiotherapist)
- Welsh Blood Service Bone Marrow Team
- Velindre Cancer Centre Fundraising

The team would particularly thank the Velindre Cancer Centre Operations Team and Communications team who went above and beyond to help make the Jambori a success.

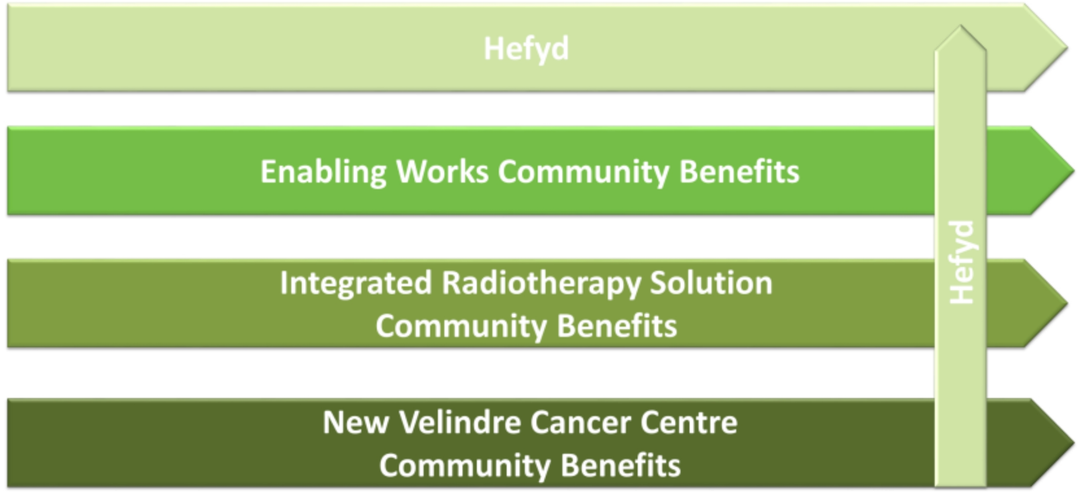
THANK YOU!

Hefyd – now and for the future

Lauren Fear, Director Corporate Governance & Chief of Staff

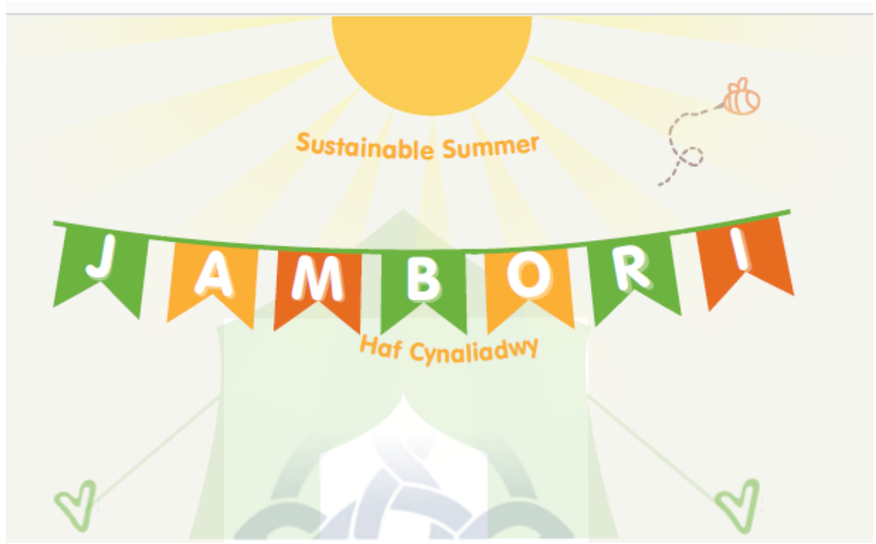
We are…

- focused on the challenges presented by Future Generations Act
- all working to achieve the Trust strategy – Strategic Objective 5 – “A Sustainable Organisation”
- will be maximising the opportunities presented by the Community Benefits associated with our major infrastructure projects
- A motivated multi-disciplinary, multi-professional collaboration group.



newydd
Canolfan Ganser Felindre
Velindre Cancer Centre
new

Recent Progress



Green Social Prescribing Programme

- Purchase of Tipi – October half term and Christmas holidays activity programmes.
- Building of a roundhouse – in Well-being centre on Park Road site – will be moved to nVCC site when appropriate wrt ecological and construction considerations.
- Starting in November – 60 people through a 6 week programme – one day a week – patients, patient families, local community and links to disadvantaged groups – will receive a formal accreditation in sustainable construction.
- Start of on-going programme of volunteering opportunities – including linking with Forest Farm etc

Community Panel – First Topic

Call for Artists, Writers, Photographers!

We're moving to a new site and are looking for a writer and an artist / photographer to help us record in words and images the existing Centre before we move to our new building in a couple of years' time. Moving house is always accompanied by a mixture of anxiety, excitement and anticipation and we want this project to help us capture what is special about the building that we've been in for the last 66 years.

We would like to capture the spirit of Velindre, to depict it in both words and images as a collaboration between a writer and a visual artist / photographer, capturing people's stories about their workplace so they can be celebrated and preserved for the future. Applications may be made jointly or individually. If you are interested in working with us on this project, please contact us for a copy of the full project brief and how to apply:

sustainability.velindre@wales.nhs.uk

newydd
Canolfan Ganser Felindre
Velindre Cancer Centre
new

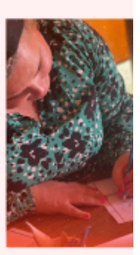
27 events

300+ books swapped

1 whole bra bank filled

200+ items donated for Working Wardrobe

"There was nothing but smiles all round"



"It lifted my spirits"

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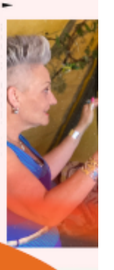

"It was lovely to be able to have the chance to spend time with my grandsons in a fun and relaxing environment"

STRATEGIC DEVELOPMENT COMMITTEE

PUBLIC RESEARCH, DEVELOPMENT & INNOVATION SUB-COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	13/10/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Sarah Townsend, Head of Research & Development
PRESENTED BY	Prof Andrew Westwell, Independent Member and Committee Chair Dr Jacinta Abraham, Executive Medical Director
EXECUTIVE SPONSOR APPROVED	Dr. Jacinta Abraham, Executive Medical Director

REPORT PURPOSE	FOR NOTING

ACRONYMS	
CReSt	Cancer Research Strategy for Wales
CU	Cardiff University
CVUHB	Cardiff and Vale University Health Board
HCRW	Health and Care Research Wales
QS&PC	Quality, Safety and Performance Committee
RD&I	Research, Development and Innovation
WCRC	Wales Cancer Research Centre

1. PURPOSE

This paper has been prepared to provide the Strategic Development Committee with details of the key issues and items considered by the Public Meeting of the Research, Development and Innovation Sub-Committee on the 21/07/2022. Key highlights from the meeting are reported in Section 2.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for **ALERT** or **ESCALATION** to the Strategic Development Committee.
ADVISE	**Robyn Davies, Head of Innovation** Congratulations and farewell wishes were given to Robyn Davies, Head of Innovation who was leaving the organisation on the 29th July 2022. A Legacy Report on all Innovation Activity to be provided prior to Robyn's departure. The Head of Innovation Post was put out to advert and interviews held but the post was not filled and remains vacant.
ASSURE	**RD&I Sub-Committee Endorsed the Annual Report 2021/22** Key achievements highlighted in the Research, Development & Innovation (RD&I) Sub-committee annual report for 2021/22 include: • The formation of a new sub-committee, with refreshed agenda and streamlined Trust RD&I Integrated Performance report. • Despite the pandemic, our continuation to excel in research study recruitment. • Several new key appointments. • The establishment of the WBS component laboratory. • Trust approval of the 10-year Velindre Cancer Research Ambitions.
INFORM	**University Designation Showcase Event** The Trust was invited to attend the University Health Board and Trust Designation Showcase Event on 30th June 2022. This was an opportunity for the Trust to demonstrate strong, dynamic, and evolving partnerships with both the HEI and industry sector showcasing some great examples of good practice. It also provided the opportunity to discuss with colleagues across the NHS and university sector some of the barriers to success and bring some collective thought on how together we address those challenges. The Trust was asked to send two examples of activities that illustrate a transformative or accelerated change undertaken or an activity that has brought added benefit in strengthening the Trust's university designated status. The Trust's examples were: • Professor Mererid Evans presenting on the Cardiff Cancer Research Centre – A Tripartite Partnership. • Chloë George presenting on Right Here, Right Now Right Blood The continuing challenge for Transfusion Medicine. **University Designation Status** The Trust is due to present its mid-year review to the University Status Panel on the 30th September 2022. The requirement for the mid-year review was set out in the Integrated Medium Term Planning Framework 22/23 and remains a mechanism to enable proportionate oversight (internal and external) of the implementation of the designation criteria and the workstreams delivered within and across the three pillars of training and education, research and development and innovation. The mid-year update also

serves as a sounding board for organisations in their activities to continually improve and achieve objectives, including better outcomes for patients and communities.

The pillars of University Status – Research, Learning and Innovation are embedded through our culture and the way we think, the people we have in place and the things we do – as we fundamentally recognise this all grows us as people and an organisation. This includes trust board committee structures, other partnership boards and executive and divisional levels.

Trust Strategy Destination 2032

The Trust Board has approved a new 10 Year Strategy: Destination 2032**,** which has five strategic goals, two of which are directly linked to our University designation status:

- A beacon for research, development and innovation in our priority areas
- An established 'University Trust' which provides highly valued knowledge and learning for all

Cancer Research Strategy for Wales (CReSt)

The first-ever coordinated Cancer Research Strategy for Wales (CReSt), which will bring together the whole research community in the fight against cancer, was published on 6th July 2022.

The strategy has been developed by Health and Care Research Wales (HCRW), the Wales Cancer Network (WCN), and the Wales Cancer Research Centre (WCRC), as well as representatives from VUNHST alongside health board partners, patients, members of the public and cancer researchers. Importantly, it also builds on key strategic advice received from a panel of external experts.

Overarching Cancer R&D Ambitions

Ten year "Overarching Cancer Research & Development Ambitions agreed by Trust Board. The Trust's Research Themes are:

- Putting patients first and at the centre of everything we do.
- Advancing new treatments, interventions and care.
- Driving translational research through connecting the laboratory and clinic.
- Embedding research and innovation within the organisational culture.

The implementation plan has been included in the Trust's Integrated Medium-Term Plan updated for 2022 to 2025 identifying key deliverables and objectives.

Cardiff Cancer Research Hub

- CVUHB, CU and VUNHST have agreed the service specification in principle for the immediate phase and the next steps will be focusing on the delivery and clarifying pace and assumptions.
- The CVUHB, CU and VUNHST partnership board agreed the need for an investment strategy for the CCRH. A successful business case was made to Velindre Charitable Funds committee (VCF) to fund the commissioning of an external agency to carry out this piece of work. There have been meetings with The Christie NHS Foundation Trust and Deloitte MCS Limited to define the scope of the investment strategy.
- Leads from VUNHST, CU and CVUHB are writing a proposal to set out the research priorities of the Hub that will enable the Hub to strategically submit applications, applying for initiatives as a collective.
- Funding for 0.5FTE Clinical Academic post (an Early Phase Trialist) was recently approved at the VCF Committee and the plan will be to secure match funding by Cardiff University. The business case is progressing through Cardiff University processes.

- The Early Phase Trial (EPT) portfolio to be delivered at UHW is gathering pace: 3 trials are being set up that are led by VCC and an interventional drug is to be delivered at the Clinical Research Facility (CRF) on UHW Site.
- The Head of R&D and her team continue to work closely with the Joint Research Office (JRO) to ensure process is in place to efficiently and effectively deliver collaborative research studies that will be delivered through the Cardiff Cancer Research Hub.
- The JRO memorandum of understanding between C&VUHB and CU is still in draft and on hold pending the appointment of the JRO's new Partnership and Business Development Manager who is expected to join the JRO in October. It was agreed that further development of the MoU will include VUNHST in relation to the delivery of research activity from the Hub. Work on the Heads of Terms agreement has also commenced and will be progressed in collaboration with staff from the JRO.
- Recruitment has commenced to include key posts to support the establishment of the Hub. The Senior Operational Team is being set up, which will include nurses, medics and pharmacy staff and R&D and will look at the shared operational delivery of the high and intermediate EP and ATMP trials at UHW.
- A scoping exercise with other UK centres that conduct EPT and ATMP is being worked up. The Senior Nurse once in post will lead this work.
- ECMC, Cardiff's 5-year renewal bid to CRUK (2023-2028) was submitted on the 30th June. If successful, the ECMC bid includes some research nurse capacity that will support the research delivery within the Hub.
- WCRC's bid to HCRW for the next 2 years (2023-2025) was successful. Included in the bid were Clinical Research Fellows that would support the Hub as well as undertake postgraduate training. Also included were other opportunities to build further collaboration with Cardiff University and VUNHST. WCRC is awaiting initial feedback from HCRW.
- A joint approach from VUNHST and CVUHB has been made to HCRW regarding the funding of additional 3.6 WTE posts, the outcome of which is still outstanding.

Integrated Medium-Term Plan

The Trust's Integrated Medium-Term Plan (IMTP) has been updated for 2022 to 2025. The Trust has a strategic goal to be "A beacon for research development and innovation".

The IMTP has been updated with the following RD&I strategic priorities in support of the strategic goal:

- The Trust will drive forward the implementation of its Cancer Research and Development Ambitions 2021-2031.
- The Trust will maximise the Research and Development ambitions of the Welsh Blood Service.
- The Trust will implement the Velindre Innovation Plan.
- The Trust will maximise collaborative opportunities locally, nationally & internationally.

ACHIEVEMENTS:

FAKTION

The Trust sponsored FAKTION trial's latest data was presented by Prof. Rob Jones at the American Society of Clinical Oncology Conference held on the 4th June 2022 and published simultaneously in Lancet Oncology The data shows that Capivasertib gives a significant 19 months extension in overall survival in aromatase inhibitor-resistant ER-positive, HER-2 negative advanced breast cancer patients."

	One Site Wales and the Symplify Study Velindre University NHS Trust successfully led the coordination of delivery in Wales of a research study. The study was open to recruitment at 19 district hospitals across six health boards in Wales. **Moondance Cancer Awards** The SYMPLIFY study team were recognized with the award for ***Innovation in early detection and diagnosis*** in the Pioneering Innovation category at the Moondance Cancer Awards 2022 on 16th June 2022. **MediWales Connects** Head of Research & Development was invited onto the panel in a MediWales Connects 2022 parallel session on 29th June 2022 to present the Trust's experience in using and adapting the "One Site Wales" approach for delivery of the SYMPLIFY study. This was well received and will inform the future research delivery plans in Wales. **RD&I Internal Audit** A review of R&D has been undertaken in line with the 2022/23 Internal Audit Plan. The review seeks to provide the Trust with assurance regarding the effective management of R&D within the Trust. • Fieldwork will take place between July and September 2022. • The Audit Debrief meeting will take place in September 2022. • The review will be presented to the Audit Committee in October 2022. • This will also be reported to the RD&I Sub-Committee at a future meeting
APPENDICES	**NOT APPLICABLE**

3. RECOMMENDATION

The Strategic Development Committee are asked to **NOTE** the key deliberations and highlights from the **Public** Meeting of the Research, Development & Innovation Sub-Committee held on the 21/07/2022.